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

Cabinet

The meeting will be held at **7.00 pm** on **13 July 2022**

Committee Room 2, Civic Offices 3, New Road, Grays, RM17 6SL

Membership:

Councillors Robert Gledhill (Leader), Mark Coxshall (Deputy Leader), Qaisar Abbas, Shane Hebb, Jack Duffin, Deborah Huelin, Andrew Jefferies, Barry Johnson, Ben Maney and Luke Spillman

Agenda

Open to Public and Press

Overview and Scrutiny Committee

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Agenda published on: **5 July 2022**

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DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF

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

Helpful Reminders for Members

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

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

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

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Does the business to be transacted at the meeting

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

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

Disclosable Pecuniary Interests shall include your interests or those of:

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

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

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

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

Pecuniary

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

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

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

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

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

Non- pecuniary

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

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

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 Cabinet held on 15 June 2022 at 7.00 pm

The deadline for call ins is Monday 27 June 2022 at 5.00pm.

Present:	Councillors Robert Gledhill (Leader), Mark Coxshall (Deputy Leader), Qaisar Abbas, Shane Hebb, Deborah Huelin, Barry Johnson and Luke Spillman
Apologies:	Councillors Jack Duffin, Andrew Jefferies and Ben Maney
In attendance:	Matthew Boulter, Democratic Services and Governance Manager, and Interim Monitoring Officer

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

1. Minutes

The Leader and Deputy Leader thanked outgoing Cabinet Members for their hard work within their Portfolios and welcomed new Cabinet Members to their first meeting.

The minutes of the Cabinet meeting held on 9 March 2022 and 23 March 2022 were approved as a true and correct record.

2. Items of Urgent Business

There were no items of urgent business.

3. Declaration of Interests

There were no interests declared.

4. Statements by the Leader

The Leader began his statement and felt it had been good to see Thurrock come together to celebrate the Platinum Jubilee weekend, including community events across the borough such as street parties and five beacon lighting ceremonies, including one at Tilbury Fort. He stated that Thurrock had also been represented in the Thank-You Dance at the Mall on Sunday 5 June with fifty Thurrock volunteers included. He thanked residents for leading and participating in a variety of community events and felt that this proved the excellent and close-knit communities across the boroughs. He added that he had also attended the opening of the Little Thurrock Community Park in Delafields. He stated that the project had turned a stretch of scrubland that

had been little used for decades into an outstanding park. He stated that the work had been undertaken by community volunteers and financed through donors and local businesses in either money or materials, alongside a small input from the Council. He felt that the outcome was a brilliant new open space in Thurrock and provided an excellent example of a community-led project.

The Leader stated that last week planning permission had been granted for a new government funded primary school and nursery in Aveley. He stated that Harrier Primary School was due to be built on land adjacent to the A13 and Love Lane in Aveley, and would provide space for up to 420 prospective primary students and 52 nursery places. He commented that the school was targeted to open in September 2023. The Leader moved on and explained that in the last week Thurrock has seen how important resident reports were in directing action and helping the Council and its partners target resources effectively to deal with the issues affecting them. He stated that an operation involving Environmental Enforcement Officers, the Trading Standards team and Essex Police took place in Aveley, during which officers found stolen motorbikes and three containers of potentially unsafe goods, which were now being investigated by trading standards. He explained that the owners of the site had been issued a Fixed Penalty Notice and a notice to produce documents to prove the correct disposal of waste. The Leader stated that this operation, as well as the criminality it uncovered, proved how important it was that residents report their suspicions to the Council and the police. He explained that this could be done via Thurrock's website; through Essex Police's Digital 101 online service; by calling 101; through Crimestoppers on 0800 555111; or 999 in an emergency.

The Leader moved on and stated that following continued protests across Thurrock, the Council had been successful in extending the injunction that prevented fuel protestors from blocking public roads in the borough. He mentioned that their activities caused widespread disruption and more than £1,000,000 to emergency services, which took away vital services from where they were needed across the borough. He stated that the 222 people named in the injunction had been ordered to pay 50% of the costs of obtaining the injunction.

The Leader added that last week planning permission was approved for the Thames Enterprise Park. He stated that this would be one of the largest and most ambitious brownfield regeneration projects in the Southeast of England, and would breathe new economic life into the former Coryton Oil refinery site. He commented that this would create up 5,500 new jobs and would add more than £350million per year into the economy. He explained that the site would be home to advanced manufacturing, next-generation energy, fuels, and storage businesses, and would therefore position Thurrock at the heart of logistics, distribution and decarbonisation. He added that the Thames Enterprise Park would also play a pivotal role in the long-term success of the Thames Freeport, which would see more than £4.5billion in new public and private investment centred around Thurrock.

The Leader updated Cabinet on the Clean It, Cut It, Fill It programme and stated that during 2021/22: 3,888 potholes had been filled, 99% within target time; 1,953 fly-tips had been cleared; 2,734 tonnes of waste had been removed; and 4,545 fixed penalty notices had been issued. He summarised and stated that Thurrock was expecting very high temperatures for the rest of the week, with forecasts reaching mid-30 degree Celsius on Friday. He urged residents to take good care of themselves during this time by staying well hydrated; cooling off indoors where possible; looking after vulnerable friends and family, particularly the very old and very young; and wearing sunscreen when outside.

5. Briefings on Policy, Budget and Other Issues

There were no briefings on policy, budget and other issues.

6. Petitions submitted by Members of the Public

No petitions had been submitted by members of the public.

7. Questions from Non-Executive Members

No questions had been submitted by non-Executive Members.

8. Matters Referred to the Cabinet for Consideration by an Overview and Scrutiny Committee

Other than those items already contained within the agenda, no items had been referred to the Cabinet for their consideration by an overview and scrutiny committee.

9. Thurrock Health and Wellbeing Strategy Refresh 2022-2026 (Decision: 110610)

Councillor Huelin introduced the report and stated that the report included in the agenda did not contain the Chair's forward, so she requested that an updated version be sent to Cabinet and uploaded onto the website. She explained how the new strategy would form stronger alliances between the NHS and the Council, and would allow the Health and Wellbeing Board to hold bodies such as the NHS accountable. She commented that the Health and Wellbeing Board had a statutory duty to write a Health and Wellbeing Strategy, which the NHS had to take due regard of, and would be one of two high level strategic documents. She explained that the report in the agenda provided a high-level overview and was supported by a 140-page document, which went into more detail regarding areas such as health inequalities. Councillor Huelin added that the strategy sought to undertake a holistic approach to health and wellbeing as it considered other areas such as communities, housing, and the environment, which were outlined in the six domains. She thanked the volunteering sector for their hard work during the consultation phase of the strategy and felt their input had been invaluable. She also thanked the Public Health team and other officers for their hard work

in putting the report together. She summarised and invited Cabinet Members to make comment and review the document.

Councillor Johnson welcomed the report and felt it was detailed and would promote joint working across different areas of the Council. He stated that 26% of the population in Thurrock was under the age of 18 and queried how the strategy would include Thurrock's Local Safeguarding Children Partnership, as a report would be going to Children's Overview and Scrutiny Committee later in the week on this issue. He felt that safeguarding children should be included in the strategy as vulnerable families were not isolated and multi-agency working was needed to ensure the health and wellbeing of vulnerable children. Councillor Huelin replied that the strategy in the agenda provided an overarching, broad picture and was supported by a variety of documents which went into the finer detail of the strategy. She stated that many directorates had worked on the strategy including Children's, and they had particularly focussed on how vulnerable children transitioned to adulthood. Councillor Huelin added that a report would be brought forward to Cabinet that would outline the holistic approach being taken to support young people and their familial relationships. She stated that she would take the feedback to officers to ensure that vulnerable children were re-emphasised in the strategy.

Councillor Spillman felt pleased to see that housing had been included in the strategy and felt that linked up working between the housing and public health departments would improve outcomes for Thurrock's residents. Councillor Huelin thanked Councillor Spillman and housing officers for their support putting together the strategy, and thanked Community Safety Partnership officers for their hard work. Councillor Coxshall highlighted page 26 of the report and felt pleased to see that approximately 750 consultation comments had been received. He also highlighted page 27 of the report and felt pleased that environmental impacts had been considered. He stated that this strategy would help to support the upcoming Local Plan, and would help local residents survive and thrive. Councillor Huelin felt that the consultation for the strategy had been good and had involved many local partners and residents, both online and in-person through events such as supermarket drop-ins.

The Leader drew Cabinet's attention to page 47 of the agenda and felt it was good to see many different communities being included in the strategy, alongside mental health. He queried page 46 and asked for the phrase 'tobacco control' to be amended to read either 'tobacco advice' or 'addiction help'. Councillor Abbas agreed that it was good to see diverse communities included in the strategy. He stated that he would be meeting with marginalised groups later in the month to ensure these communities were engaged with directly and had their issues heard.

RESOLVED: That Cabinet:

1. Reviewed and commented on the final draft Strategy at Appendix 1, considering the proposed Domain and Goals.

Reason for decision: as outlined in the report
This decision is subject to call-in

10. Integrated Care Partnership (ICP) (Decision: 110611)

Councillor Huelin introduced the report and stated that in July 2021 the government had proposed new legislation to increase the level of joined up working between the NHS and local authorities. She explained that this had received royal assent in April 2022, and the report therefore outlined how Thurrock would implement this legislation through the introduction of both an Integrated Care Partnership (ICP) and Integrated Care Board (ICB). She mentioned that both the NHS and local authorities would be equal partners on the ICP, and would be meeting next month to finalise governance arrangements. She felt that Thurrock were already working well with the NHS and hoped that the new ICP would encourage closer working. She stated that recommendation 1.2 asked Cabinet Members to delegate authority to the Director of Public Health to act as a founding representative on the Mid and South Essex ICP, as the partnership required professional experience and knowledge. She added that the Director of Public Health also sat on the Health and Wellbeing Board, so Members would have the chance to discuss the ICP at this forum. Councillor Huelin highlighted page 59 of the report and sought confirmation that the relevant Portfolio Holders had been consulted with. The relevant Cabinet Members confirmed they had been consulted.

Councillor Coxshall felt concerned that there would be no elected Members sitting on the Mid and South Essex ICP, as he felt that partners needed to recognise the democratic nature of local authorities. He asked if the Terms of Reference could come back to Cabinet. Councillor Huelin reassured Councillor Coxshall that she had raised similar concerns with the NHS and been assured that the Health and Wellbeing Board would work with the ICP.

Councillor Johnson highlighted page 76 of the report and felt it was good to see closer partnerships and faster financial alignments to achieve better outcomes. Councillor Huelin echoed these comments and felt that Covid had affected many peoples access to primary care, which had then affected people's health to a greater degree. She stated that the NHS were aware of this issue and were working with Thurrock on the Better Care Fund.

The Leader also felt concerned that regarding the democratic aspects of the Integrated Care Partnership and Integrated Care Board and wanted to ensure that the new boards included elected member participation. He asked that the report be brought back to Cabinet once governance arrangements had been agreed and asked for this to be included at recommendation 1.2

RESOLVED: That Cabinet:

1. Noted the key elements of the Health and Care Act 2022 as set out in Section 2 of the report.

2. Agreed to delegate authority to the Director of Public Health to act as

the Council's founding representative to the Mid and South Essex ICP in order to establish the proposed governance arrangements with health and local authority partners. Agreed that the report be brought back to Cabinet once governance arrangements are agreed.

3. Agreed the draft Terms of Reference at Appendix 2 and delegated authority to the Monitoring Officer to make minor changes to these Terms to ensure appropriate governance requirements are met.

4. Noted that the Corporate Director Adults, Housing and Health will sit on the Shadow NHS Mid and South Essex Integrated Care Board (ICB) to represent the Council's views and interests, and shall continue to sit on the Board as the Councill's representative when the Board is formally established as a statutory body.

Reason for decision: as outlined in the report
This decision is subject to call-in

11. Statement of Community Involvement (Decision: 110612)

Councillor Coxshall introduced the report and stated that it outlined good consultation practice and would help therefore help to increase the number of people engaging with the Local Plan, which was a critical document for the future of the borough. Councillor Hebb felt that it was important to build homes in Thurrock in the right way, and this document would help residents contribute their views. He stated that it would approve the approach of involvement and would make the consultation process easier for residents. Councillor Coxshall added that officers would be working to ensure that the Local Plan consultation was as quick and simple for residents as possible. He felt that the Local Plan would improve outcomes for local communities, as it would not just outline the future of housebuilding, but also open spaces, education, and employment opportunities in Thurrock.

Councillor Huelin felt that the Local Plan and Health and Wellbeing Strategy were intertwined and highlighted the importance of both online and in-person consultation. Councillor Abbas added that consultations should seek to reach people in communities that were typically disengaged, and needed to be in simple English to ensure that everyone could understand.

RESOLVED: That Cabinet:

1. Approved the draft Statement of Community Involvement (Appendix A) for public consultation, and agreed to delegate authority to the Director of Public Realm, in consultation with the relevant Portfolio Holder to make any changes resulting from that consultation and to adopt the final version.

Reason for decision: as outlined in the report
This decision is subject to call-in

12. Appointments to Outside Bodies, Statutory and Other Panels

The Leader introduced the report and stated that it was a statutory duty for Cabinet to nominate Members to sit on a variety of Outside Bodies, and the report outlined Councillors who had sat on Outside Bodies last year. He stated that all Cabinet outside bodies nominations would remain the same, other than Impulse Leisure where Councillor Jefferies would be nominated; and the Mid and South Essex NHS Foundation Trust Council of Governors where Councillor Polley would be nominated.

RESOLVED: That Cabinet:

1. Approved the nominations to Outside Bodies, Statutory and Other Panels, as set out in Appendix 1, to this report.

The meeting finished at 8.10 pm

Approved as a true and correct record

CHAIR

DATE

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

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13 July 2022	Item: 10 Decision: 110613
Cabinet	
Asset Review and 3Rs	
Wards and communities affected: All	**Key Decision:** Key
Report of: Councillor Mark Coxshall, Deputy Leader and Cabinet Member for Regeneration and External Affairs	
Accountable Assistant Director: David Johnson, Interim Assistant Director of Property	
Accountable Director: Sean Clark, Corporate Director of Resources and Place Delivery	
This report is Public	

Executive Summary

This report sets out proposals for the disposal, rationalisation and improvement of property assets. It is government policy that local authorities should dispose of surplus and under-used land and property wherever possible.

The Council has fairly wide discretion to dispose of its assets (such as land or buildings) in any manner it wishes. When disposing of assets, the Council is subject to statutory provisions, in particular, to the overriding duty, under section 123 of the Local Government Act 1972, to obtain the best consideration that can be reasonably obtained for the disposal. This duty is subject to certain exceptions that are set out in the General Disposal Consent (England) 2003.

The way the Council manages its land/property assets can have a significant impact both on the quality of services delivered to the public and the local environment. Effective asset management is essential in bringing 'agility' to land and property assets so that the delivery of the Council's visions and objectives are realised in a sustainable manner, at the right time and on budget.

The assets reviewed represent a mix of locations, uses and a variation of those that could be short, medium or long term as well as being disposed of by private treaty, public auction, tender or on a leasehold basis.

The Asset Review considers the business case for disposing of any assets that are no longer of any use to it and is unlikely to be in the future or which provides only a benefit that is proportionate to the opportunity cost of the capital tied up in the asset.

Each asset disposal is treated on its own merits and nothing in this report will bind the Council to a particular course of action in respect of a disposal.

The report also seeks Cabinet approval to declare a number of operational properties surplus to requirements and further reports will be brought back to Cabinet in the Autumn where applicable to discuss the future of the sites and any alternative delivery considerations.

1. Recommendations

That Cabinet:

1.1 Note the success of the 3Rs program in generating capital receipts totalling £9.3m in the financial Year 2021/22;

1.2 Note the success of the previous review of operational properties in delivering revenue savings and identifying potential sites currently being developed by TRL and HRA;

1.3 Declare the operational properties in section 6.2 of this report surplus to requirements and receive a report back, where applicable, on the future of the sites and any alternative delivery consideration;

1.4 Declare surplus the properties as shown in Appendix 1, 2, 3 and 4; and approve the release or re-use of the properties as outlined; and

1.5 Subject to the agreement to release the assets in Appendix 1, 2. 3 and 4, delegate authority of the disposal to the Corporate Director of Resources and Place Delivery in consultation with the Leader and the completion of a delegated authority decision report.

2. Issues, Options and Analysis of Options

2.1 In considering any disposal the Asset Review would have considered the assets within Appendix 1 against the table and weightings confirmed in the Cabinet Report of 10 March 2021 which enables the Council to consider the rationale for Reuse, Retain or Release.

2.2 This report considers the options available for the properties listed in Appendix 1 which have been assessed as surplus or under-used assets.

2.3 A list of assets for potential release continues to be analysed and scrutinised by the Property Team, Planning, Services, property occupiers (where appropriate/applicable) and Members. Further scrutiny would result in the “release list” being evaluated and prioritised according to factors such as:

- Cost of holding;
- Potential value from disposal;
- Ease of /or constraint on sale;

- Site preparation considerations/de-risking and associated costs; and
- Any wider economic or social benefit of retaining.

Once this has been assessed further disposals of assets maybe brought forward.

3. Option 1: Do nothing – Retain the assets, Business as usual, little need or opportunity for change identified

3.1 These assets have been assessed as needing to be retained to support Council business in their existing position. However, this is not to say that no further work is required on these premises. They will continue to be maintained and in some instances, will require improvement or refurbishment at some future stage. Furthermore, as the review process is established within the Council, their continuing use and occupation will be subject to periodic review and their status

4. Option 2: Reuse – For different services or more intensive or changed use

4.1 Many of the assets within this category are subject to ongoing review by the occupying service directorate and it is envisaged proposals will either come forward at the conclusion of those reviews (e.g. leisure, environmental) or through further discussion between the Service and Corporate Property.

5. Option 3 Release - Dispose of the site immediately or develop for Housing or another beneficial use.

5.1 A review has been undertaken of the properties listed in Appendix 1,2 and 3 and where they are considered appropriate for development by the Council directly this is annotated and where they are not considered appropriate it is recommended that they are released.

5.2 A rationalisation programme to continue with the reviewing of assets, releasing those no longer required in a structured manner to realise capital and or support wider regeneration or housing via affordable housing requirements.

5.3 Release in some instances will free the Council from poor performing properties from a compliance, economic and statutory requirement.

6. Operational Assets Previously declared Surplus – Update

6.1 The cost savings and new revenue from rationalisation of the operational portfolio have previously been identified as an important contribution to the Council's budget arrangements and a target of £1m revenue savings included within the budget forecasts for financial year 2022/23. Cabinet is asked to note the success of the review of operational assets by noting the progress of the below properties previously declared surplus.

6.1.1 Corran Way Depot – Scheduled for demolition which will generate a revenue saving and currently being considered by Housing Regeneration as a potential development site;

6.1.2 CO1 Civic Offices – Subject of a separate Cabinet report as a Housing Development site;

6.1.3 11A Corve Lane – Buildings have been demolished generating a revenue saving and currently being considered by Housing Regeneration as a potential development site;

6.1.4 Richmond Road Campus – Buildings have been demolished generating a revenue saving and currently being considered by Housing Regeneration as a potential development site; and

6.1.5 Riverside Youth Centre - Buildings have been demolished generating a revenue saving and currently being considered by Housing Regeneration as a potential development site.

6.2 **Operational Assets – Additional Surplus Properties**

Property as a resource should act as a facilitator and enabler to the Council's service provision and an overarching review of the entire operational estate and initiatives have been successfully undertaken by several directorates and services and have identified additional savings from those previously considered by the Cabinet from rationalisation of operational properties.

6.3 Cabinet are asked to consider whether the following assets also listed in Appendix 2 are surplus to requirements.

6.3.1 Aveley Children's Centre – Children's Services have move their services provision to Aveley Community Hub and other locations resulting that the property is no longer used as an Operational Asset. Disposal of the asset would generate a capital receipt and a revenue saving;

6.3.2 Stanford-le-Hope Children's Centre – Children's Services have moved their service provision to a small standalone building at the Children's Centre meaning the larger building on the site is no longer used as an Operational Asset. Disposal of the asset would generate a capital receipt and a revenue saving; and

6.3.3 Purfleet Children's Centre – Children's Services have moved their service provision to other operational locations resulting that the property is no longer used as an Operational Asset. The Purfleet Community Forum who currently use the building have expressed an interest in taking the building on. Disposal of the asset would generate revenue saving and provide a community asset.

7. Scout Huts

7.1 The Council is the freeholder of several properties noted in Appendix 3 which are leases on long-term leases to the Scout Association. It is often the case with these properties that the buildings on the sites have been developed with local community or Scout association funding.

7.2 The Management of these assets is revenue costly for the Council compared with the nominal rentals that are being charged to the Scout association. The construction of these buildings often means that they fail EPC's and cannot be re-leased to the Scout Association when the leases expire. Being the freeholder of these sites will enable the Scouts to manage the buildings in a more commercial and less restrictive fashion, access additional sources of grant funding and potentially generate additional income streams and charge the asset.

7.3 It is the intent that these assets are transferred to the Scouts for a nil consideration. Disposal of these assets would generate a revenue saving for the Council, reduce the rental burden on the Scout Association and secure the tenure of these sites for Scout Association use subject to restrictive covenants to ensure that the freeholds remain as assets to benefit the community.

7.4 Cabinet is asked to consider whether the assets listed in Appendix 3 are surplus to requirements.

8. Village Halls

8.1 The Council is the freeholder of several properties noted in Appendix 4 which are leased on long-term leases to various Community bodies. It is often the case with these properties that the buildings on the sites have been developed with local community funding.

8.2 The Management of these assets is revenue and capital costly for the Council compared with the nominal rentals that are being charged to the users by the Council. Disposals of these assets will effectively level the rental obligations for the various Village Hall organisations as currently there is a lack of consistency across the assets in terms of rents.

Being the freeholder of these sites will enable the Village Hall Organisations to manage the buildings in a more commercial and less restrictive fashion, access additional sources of grant funding and potentially generate additional income streams and charge the asset. Most of the current/historic leases are ambiguous with regard to repairing obligations and result in significant Capital expenditure for the Council.

8.3 It is the intent that these assets are transferred to the various Village Hall organisation for a nil consideration. Disposal of these assets would generate a capital saving for the Council, reduce the rental burden on community groups

and secure the tenure of these sites for community use subject to restrictive covenants to ensure that the freeholds remain as assets to benefit the community.

8.4 Cabinet is asked to consider whether the assets listed in Appendix 4 are surplus to requirements.

9. Reasons for Recommendation

9.1 The sites listed in Appendix 1, 2, 3 and 4 have been considered against the criteria above and within the context of the previously agreed decision process and they are considered as Option 3.

9.2 The assets recommended for disposal are in the freehold ownership of Thurrock Council. The assets are not required for future service provision or regeneration initiatives and would therefore provide an opportunity for the Council to realise a capital receipt.

9.3 The capital receipts will support and assist towards any funding gaps in the MTFS and funding the capital programme.

9.4 The 3Rs programme has also considered operational buildings that are considered surplus and/or uneconomical to maintain and a number of operational buildings are included within this report.

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

10.1 There has been consultation with services on the proposed assets in Appendix 1,2 and 3. Further reports on the operational assets have been considered by Corporate Overview and Scrutiny.

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

11.1 Assets that are not required for the delivery of council services directly will add benefit to the residents through alternative ownership be it for additional housing or a community facility.

12. Implications

12.1 **Financial**

Implications verified by: **Sean Clark**

Corporate Director, Resources and Place Delivery

There are two distinct financial benefits from the disposal of surplus assets. Firstly, assets can incur running costs and so this creates a saving. Secondly,

income received from disposal, a capital receipt, can be used to meet the costs of transformational activity and also pay for capital expenditure, thus avoiding the need for prudential borrowing and the associated revenue costs.

The disposals included within this paper will contribute towards the target set out within the budget papers for 2022/23.

12.2 **Legal**

Implications verified by: **Mark Bowen**

Interim Head of Legal Services

The Council is generally empowered to dispose of assets which are underperforming or surplus to requirements. Each asset will need to be checked to ensure its formal ownerships and appropriation enable general disposal with terms to be confirmed.

Some of the highlighted sites are regarded as Public Open Space and will be subject to formal public consultation before disposal.

A final analysis of the legal title and terms of disposal will be included in the final disposal decision report.

12.3 **Diversity and Equality**

Implications verified by: **Rebecca Lee**

Team Manager - Community Development

The Asset Disposal Policy sets out considerations for bringing agility to land and property assets so that the delivery of the Council's goals and objectives are realised in a sustainable manner, at the right time and on budget. The policy itself will be the subject of a Community Equality Impact Assessment to mitigate the risk of negative impact on citizens and communities. Where community assets are identified for disposal, the process set out for the implementation of the CAT Policy and principles of the Collaborative Communities Framework will be applied, this includes the completion of CEIA’s on a case by case basis, engagement with the voluntary and community sector, and an assessment of social value that includes support for Thurrock’s recovery from COVID-19 and building resilience within communities and voluntary sector networks.

12.4 **Other implications** (where significant) – i.e. Staff, Health Inequalities, Sustainability, Crime and Disorder, and Impact on Looked After Children

Assets are used for a range of purposes including direct service delivery, use by community groups and residents.

13. 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

14. Appendices to the report

Appendix 1 – Asset Review, Properties
Appendix 2 – Asset Review, Operational Properties
Appendix 3 – Asset Review, Scout Huts
Appendix 4 – Asset Review, Village Halls

Report Author

David Johnson

Interim Assistant Director of Property

Appendix 1

Vosa, Tank Hill Road, Purfleet, RM19 1SX

Description: Large industrial unit let on a short time lease.

Holding Account	**Site Area**	**USE**	**Title or Deed No**
General Fund	4.10 Acres, 16,596 Sqm	Industrial	EX796642
Ward West Thurrock and South Stifford	**EPC**		

The site is considered suitable for a residential development. It is proposed that the Council's Housing Regeneration look at the viability of a Council led development on the site and depending on the result either develop through the HRA, dispose to TRL or dispose to the open market.

Buckingham Hill (Former Landfill Site), Stanford-Le-Hope

Description: Site is used for the borough's recycle centre.

Holding Account	**Site Area**	**USE**	**Title or Deed No**
General Fund	52 Acres, 212,142 Sqm	Refuse Centre / Open Land	EX936250
Ward East Tilbury	**EPC**		

The site is considered suitable for alternate uses. It is proposed that the Council look at the viability of alternative uses and either use or dispose of as is appropriate.

Former Depot (demolished), Curzon Drive, Grays, RM17 6BG

Description: Industrial site at Curzon Drive Industrial Estate.
The site is currently a mix of tenanted and vacant properties

Holding Account	**Site Area**	**Use**	**Title or Deed No**
Grays Riverside	4.8 Acres, 208,808 Sqm (approx.)	Industrial Site	EX953397
Ward	**EPC**		
Grays Riverside	N/A		

The site is considered suitable for a residential development or other beneficial uses. It is proposed that the Council's Housing Regeneration look at the viability of a Council led development on the site and depending on the result either develop through the HRA, dispose to TRL or dispose of to the open market.

Woodlands Edge PH. South Ockendon, RM15 5RD

Description: Property is situated on a large corner plot, with a large parking area.
Site is let on a land only lease, expiring 24th March 2035.

Holding Account	**Site Area**	**USE**	**Title or Deed No**
General Fund	0.69 Acres, 2,813 Sqm	Public House	EX25346
Ward	**EPC**		
Belhus			

The Council owns a number of freeholds let on long leases to various tenants as Public Houses. The Council is unable to develop these properties and it is proposed that generally the Council should look to dispose of the freehold interests to the tenants initially and then to the open market.

Crooked Billet PH, Billet Lane, Stanford-Le-Hope, SS17 0AR

Description: Public House located within the Billet Recreation ground in Stanford Le Hope. Property is let on an FRI lease, expiring 1st May 2125.

Holding Account	**Site Area**	**USE**	**Title or Deed No**
General Fund	1.27 Acres, 5,153 Sqm	Public House	EX787652
Ward	**EPC**		
Stanford Le Hope West	G		

The Council owns a number of freeholds let on long leases to various tenants as Public Houses. The Council is unable to develop these properties and it is proposed that generally the Council should look to dispose of the freehold interests to the tenants initially and then to the open market.

Park Tavern PH, Aveley, RM15 4PH

Description: Public House situated within the centre of South Ockendon. Property is let out on a land only lease, ending on the 23rd June 2027.

Holding Account **General Fund**	**Site Area** 0.44 Acres, 1,793 Sqm	**Use** Public House	**Title or Deed No** EX26234
Ward Aveley and Uplands	**EPC** D		

The Council owns a number of freeholds let on long leases to various tenants as Public Houses. The Council is unable to develop these properties and it is proposed that generally the Council should look to dispose of the freehold interests to the tenants initially and then to the open market.

Knight of Aveley PH, Derry Avenue, South Ockendon RM15 5LN

Description: Public House situated within the centre of South Ockendon. Property is let out on a land only lease, ending on the 23rd June 2034

Holding Account	**Site Area**	**Use**	**Title or Deed No**
General Fund	0.686 Acres, 2,778 Sqm	Public House	EX25346
Ward	**EPC** D		
Ockendon			

The Council owns a number of freeholds let on long leases to various tenants as Public Houses. The Council is unable to develop these properties and it is proposed that generally the Council should look to dispose of the freehold interests to the tenants initially and then to the open market.

The Archer PH, Garron Lane, South Ockendon, RM15 5JU

Description:
The property is sitauated on the corner of Garron Lane and consist of a public house building, garden area and large car park.
The site is let on a land only lease, expiring 24th March 2036.

Holding Account	**Site Area**	**Use**	**Title or Deed No**
General Fund	0.50 Acres, 1,990 Sqm	Public House	EX25346
Ward	**EPC**		
Belhus	D		

The Council owns a number of freeholds let on long leases to various tenants as Public Houses. The Council is unable to develop these properties and it is proposed that generally the Council should look to dispose of the freehold interests to the tenants initially and then to the open market.

Jack O'Lantern PH, Daiglen Drive, South Ockendon RM15 5AE

Description: Corner land plot held freehold by the Council but let on a long lease for proviosn of a public house. The building is the property of the lessee.
Property has recently been destroyed by a fire.

Holding Account	**Site Area**	**USE**	**Title or Deed No**
General Fund	0.391 Acres, 1,586 Sqm	Currently used as a PH	EX25345
Ward	**EPC** D		
Ockendon			

The Council owns a number of freeholds let on long leases to various tenants as Public Houses. The Council is unable to develop these properties and it is proposed that generally the Council should look to dispose of the freehold interests to the tenants initially and then to the open market.

Daniels (T/A Chadwell Arms) PH, Longhouse Road, Chadwell St Mary, RM16 4QP

Description: Public House situated within the centre of South Chadwell St Mary. Property is let out on a land only lease, ending on the 14th December 2066.

Holding Account **General Fund**	**Site Area** 0.739 Acres, 2,900 Sqm	**Use** Public House	**Title or Deed No** EX847209
Ward Chadwell St Mary	**EPC** E		

The Council owns a number of freeholds let on long leases to various tenants as Public Houses. The Council is unable to develop these properties and it is proposed that generally the Council should look to dispose of the freehold interests to the tenants initially and then to the open market.

Corys Wharf, Purfleet, RM19 1PS

Description: Open land running on the Thames river front.

Holding Account	**Site Area**	**Use**	**Title or Deed No**
General Fund	16.35 Acres, 66,000 Sqm	Open Land	EX371902
Ward	**EPC**		
West Thurrock			

The site is considered suitable for alternate uses to generate revenue. It is proposed that the Council look at the viability of alternative uses and either use or dispose of as is appropriate.

Bennett Lodge Residential Home, Waterson Road

Description: A two storey residential care home let to Runwood Homes Plc with a lease expiring 30th August 2024

Holding Account	**Site Area**	**Use**	**Title or Deed No**
General Fund	1.61 Acres, 6,538 Sqm (approx.)	Residential Care Home	EX682427 EX653187
Ward **Chadwell St Mary**	**EPC**		

The Council currently owns the freehold of two residential homes let to Runwood Homes Plc. Historically it has been difficult to manage the leases effectively due to the Council being both Landlord and client for these homes. It is recommended that the freehold be disposed of to the tenant who have expressed an interest in purchasing

Leatherland Lodge Residential Home, Darenth Lane

Description: A two storey residential care home let to Runwood Homes Plc with a lease expiring 30th August 2024

Holding Account	**Site Area**	**Use**	**Title or Deed No**
General Fund	0.84 Acres, 3,415 Sqm (approx.)	Residential Care Home	EX89963
Ward **Belhus**	**EPC**		

The Council currently owns the freehold of two residential homes let to Runwood Homes Plc. Historically it has been difficult to manage the leases effectively due to the Council being both Landlord and client for these homes. It is recommended that the freehold be disposed of to the tenant who have expressed an interest in purchasing

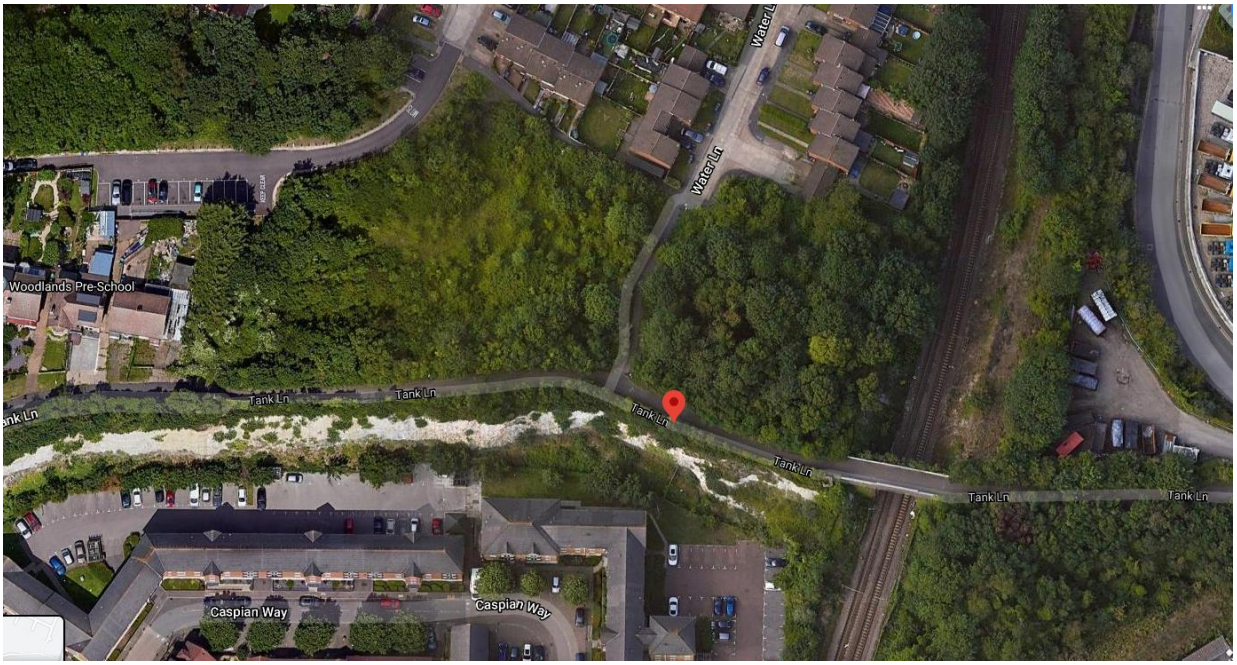
Land adj Arena Essex

Description: Vacant land situated on the roundabout adjacent Arena Essex.

Holding Account	**Site Area**	**Use**	**Title or Deed No**
General Fund	3.04 Acres, 12,307 Sqm	Open Land	EX277479
Ward West Thurrock and South Stifford	EPC N/A		

The site is considered suitable for alternate uses to generate revenue. It is proposed that the Council look at the viability of alternative uses and either use or dispose of as is appropriate.

Land north of Tank Lane, Purfleet



Description: Open land adjacent the Garrison Estate, Purfleet.

Holding Account	**Site Area**	**Use**	**Title or Deed No**
General Fund	2,05 Acres, 8,325 Sqm	Open Land	EX187879
Ward	**EPC** N/A		
Aveley and Uplands			

The site is considered suitable for a residential development or other beneficial uses. It is proposed that the Council's Housing Regeneration look at the viability of a Council led development on the site and depending on the result either develop through the HRA, dispose to TRL or dispose of to the open market.

Whiteacres, Daiglen Drive, South Ockendon

Description: Open Land situated on Daiglen Drive, South Ockendon.

Holding Account	**Site Area**	**Use**	**Title or Deed No**
General Fund	0.89 Acres, 3,611 Sqm	Open Land	EX153605
Ward	**EPC**		
Belhus	N/A Open Land		

The site is considered suitable for a residential development or other beneficial uses. It is proposed that the Council's Housing Regeneration look at the viability of a Council led development on the site and depending on the result either develop through the HRA, dispose to TRL or dispose of to the open market.

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Appendix 2

Aveley Children's Centre, (Discovery Centre) Stifford Road, Aveley RM15 4AA

Description: Children's centre which is part of the Discovery Centre. The property is a former Victorian School building which is used by Council Children Services and multi tenanted sharing an access road with Aveley Primary School Academy.

Holding Account	**Site Area**	**USE**	**Title or Deed No**
General Fund	**1.20 Acres**	Childrens nursery and pre school	EX985044,EX27636
Ward	**EPC**		
Aveley & Uplands	D82		

Children's Serviced have move their services provision to Aveley Community Hub and other locations resulting that the property is no longer used as an Operational Asset. Disposal of the asset would generate a capital receipt and a revenue saving.

Stanford Childrens Centre, Copland Road, Stanford Le Hope, SS17 0DF

Description: Children's centre annexed from Stanford Primary School. Victorian style building.

Holding Account	**Site Area**	**USE**	**Title or Deed No**
General Fund	0.656 Acres, 2,655 Sqm	Child care	AA4409 / EX88462
Ward	**EPC**		
Stanford Le Hope West			

Children's Serviced have move their services provision a small standalone building at the Children's Centre meaning the larger building on the site is no longer used as an Operational Asset. Disposal of the asset would generate a capital receipt and a revenue saving.

Purfleet Childrens Centre (Riverlane Centre), Centurion Way, Purfleet, RM19 1PF

Description: Children's centre situated close to the river. Property consists of a Lobby area, offices, main session area, session room 2 and play store.

Holding Account	**Site Area**	**USE**	**Title or Deed No**
General Fund	0.037 Acres, 151 Sqm	Children's services	EX867258
Ward West Thurrock and South Stifford	**EPC** D		

Children's Serviced have move their services provisions to other operational locations resulting that the property is no longer used as an Operational Asset. The Purfleet Community Forum who currently use the building have expressed an interest in taking the building on. Disposal of the asset would generate revenue saving and provide a community asset.

Appendix 3

Hardie Hall Scouts, Hardie Road, Stanford, SS17 0PB

Description: Scout Hall situated behind Hardie Road and adjacent the Manorway recreation ground.

Holding Account	**Site Area**	**Use**	**Title or Deed No**
General Fund	0.156 Acres, 630 Sqm	Scouts meeting	EX935554
Ward	**EPC**		
Stanford Le Hope West			

Disposal of this asset would generate a revenue saving for the Council, reduce the rental burden on the Scout Association and secure the tenure of this site for Scout Association use subject to restrictive covenants to ensure that the freeholds remain as assets to benefit the community

Waterson Road Scouts, Chadwell St Mary, RM16 4NX

Description: Former council depot situated at the rear of the village halls, Waterson Road. Pre-fabricated built building with a parking area.
Property is leased to the Scout group, expiring 19th January 2022.

Holding Account	**Site Area**	**USE**	**Title or Deed No**
General Fund	0.401 Acres, 1,626 Sqm	Community / Scouts	EX847280
Ward Chadwell St Mary	**EPC** F		

Disposal of this asset would generate a revenue saving for the Council, reduce the rental burden on the Scout Association and secure the tenure of this site for Scout Association use subject to restrictive covenants to ensure that the freeholds remain as assets to benefit the community.

Woodview Scouts, The Dipping, Grays, RM17 5SX

Description: Property is situated within the Dipping recreation ground
The is let to the Scout Group, expiring 18th November 2036

Holding Account	**Site Area**	**USE**	**Title or Deed No**
General Fund	0.111 Acres, 452 Sqm	Community / Scouts	EX857013
Ward Little Thurrock Rectory	**EPC**		

Disposal of this asset would generate a revenue saving for the Council, reduce the rental burden on the Scout Association and secure the tenure of this site for Scout Association use subject to restrictive covenants to ensure that the freeholds remain as assets to benefit the community.

Scouts, Northview Avenue, Tilbury (Former St. Chads School Site), Tilbury, RM18 7RT

Description: Single Storey timber frames Scout Hall and land

Holding Account	**Site Area**	**USE**	**Title or Deed No**
General Fund	**0.204 Acres, 827 Sqm**	Scout Hall	EX798621
Ward	**EPC**		
Tilbury St Chads			

Disposal of this asset would generate a revenue saving for the Council, reduce the rental burden on the Scout Association and secure the tenure of this site for Scout Association use subject to restrictive covenants to ensure that the freeholds remain as assets to benefit the community.

Faymore Gardens, Scouts, South Ockendon, RM15 5NN

Description: An 'L' Shaped property situated adjacent the Dilkes Wood
Property is let to the Scout Group, expiring 31st March 2034.

Holding Account	**Site Area**	**USE**	**Title or Deed No**
General	0.176 Acres, 714 Sqm	Community Use / Scouts	EX52287
Ward	**EPC**		
Belhus			

Disposal of this asset would generate a revenue saving for the Council, reduce the rental burden on the Scout Association and secure the tenure of this site for Scout Association use subject to restrictive covenants to ensure that the freeholds remain as assets to benefit the community.

Stifford Sea Scout Group, Prince Phillip Avenue Scouts Hall, Grays, RM16 2DJ

Description:
Single storey Sea scout hall situated within the parking area at the rear of the residential properties.

Holding Account	**Site Area**	**Use**	**Title or Deed No**
Housing	0.310 Acres, 1,255	Scout Hall	EX859314
Ward Stifford Clays	EPC		

Disposal of this asset would generate a revenue saving for the Council, reduce the rental burden on the Scout Association and secure the tenure of this site for Scout Association use subject to restrictive covenants to ensure that the freeholds remain as assets to benefit the community.

Thors Oak Scouts, Stanford le Hope, SS17 7DD

Description: Pre-fabricated property situated adjacent the Manorway. Lease to the scouts expires 31st March 2016.

Holding Account **General Fund**	**Site Area** 0136 Acres, 0.136 Sqm	**Use** Community / Scout Hall	**Title or Deed No** EX798678
Ward Stanford East and Corrignham	E**PC**		

Disposal of this asset would generate a revenue saving for the Council, reduce the rental burden on the Scout Association and secure the tenure of this site for Scout Association use subject to restrictive covenants to ensure that the freeholds remain as assets to benefit the community.

Horndon Rec Scouts Hut, Hordon on the Hill, SS17 8NR

Description: Scout hut situated within the Horndon recreation ground. The property is let on a lease until 24th December 2021.

Holding Account	**Site Area**	**Use**	**Title or Deed No**
General Fund	0.080 Acres, 326 Sqm	Community Use	EX782627
Ward	**EPC**		
Orsett			

Disposal of this asset would generate a revenue saving for the Council, reduce the rental burden on the Scout Association and secure the tenure of this site for Scout Association use subject to restrictive covenants to ensure that the freeholds remain as assets to benefit the community.

Alf Lowen Scout Hall, Grays Park Leisure Centre Scouts, Richmond Road, Grays, RM17 6DN

Description: The property is let to the Scout Association, expiring 27th April 2036.

Holding Account General Fund	**Site Area** 0.414 Acres, 1,677Sqm	**USE** Scout Hall	**Title or Deed No** EX884584
Ward Grays Thurrock	**EPC**		

Disposal of this asset would generate a revenue saving for the Council, reduce the rental burden on the Scout Association and secure the tenure of this site for Scout Association use subject to restrictive covenants to ensure that the freeholds remain as assets to benefit the community.

Tamarisk Road Scouts, South Ockendon, RM15 6HU

Description: Single storey building situated within a large open space.
The property is let to the Scout Association, expiring 29th September 2026.

Holding Account	**Site Area**	**Use**	**Title or Deed No**
General Fund	0.138 Acres, 560 Sqm	Community / Scout Hall	EX25346
Ward	**EPC**		
Ockendon			

Disposal of this asset would generate a revenue saving for the Council, reduce the rental burden on the Scout Association and secure the tenure of this site for Scout Association use subject to restrictive covenants to ensure that the freeholds remain as assets to benefit the community.

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Belmont Village Hall, Parker Road, Grays, RM17 5YN

Description:
Detached property with a main hall, stores, WCs and kitchen. A 1990s purpose built single story hall of brick construction under a pitched tiled roof situated on the edge of Stifford Primary School in Grays.

Holding Account	**Site Area**	**USE**	**Title or Deed No**
General Fund	0.269 Acres 1089 sqm	Community Hall	EX557072
Ward	**EPC**		
Grays Riverside			

Disposal of these asset would generate a capital saving for the Council, reduce the rental burden on community groups and secure the tenure of these sites for community use subject to restrictive covenants to ensure that the freeholds remain as assets to benefit the community.

Belhus Village Hall, Daiglen Drive, South Ockendon, RM15 5AE

Description: Multi-purpose village hall building run by Management Committee. Leased to Trustees of Belhus Village Hall on IRI terms with effect from 26 July 1989. Hall adjacent Jack O Lantern PH and backs onto South Ockendon Hub/Library

Holding Account	**Site Area**	**USE**	**Title or Deed No**
General Fund	0.392 Acres 1587 sqm	Village Hall	EX25346
Ward	**EPC**		
Ockendon			

Disposal of these asset would generate a capital saving for the Council, reduce the rental burden on community groups and secure the tenure of these sites for community use subject to restrictive covenants to ensure that the freeholds remain as assets to benefit the community.

Brandon Groves Community Hall, Brandon Groves Avenue, South Ockendon, RM15 6TD

Description: A structure circa 100 years old, situated off Brandon Groves Avenue in South Ockendon. Brick construction under a pitched tile roof, comprising a main hall with a bar, store rooms and WCs. There are 10 car parking spaces on the premises. Leased to the hall Trustees for 60 years with effect from 1 October 1997

Holding Account General Fund	**SITE AREA**	**USE** Managed by hall trustees	**Title or Deed No**
Ward Ockendon	**EPC**		

Disposal of these asset would generate a capital saving for the Council, reduce the rental burden on community groups and secure the tenure of these sites for community use subject to restrictive covenants to ensure that the freeholds remain as assets to benefit the community.

Bulphan Village Hall, Church Road, Bulphan, RM14 3RU

Description:
A 1970s single storey structure of wooden frame, measuring 260 sq. m. backing onto public fields in Church Road. Hall has a main hall with a stage, kitchen facilities, WCs and cloak room. Bulphan CIO.

Holding Account General Fund	**Site Area**	**USE** Village Hall	**Title or Deed No:**
Ward Bulphan	**EPC**		

Disposal of these asset would generate a capital saving for the Council, reduce the rental burden on community groups and secure the tenure of these sites for community use subject to restrictive covenants to ensure that the freeholds remain as assets to benefit the community.

Chadwell Village Hall (Small), Waterson Road, Chadwell St Mary, RM16 4NX

Description: Lease granted on FRI terms for 10 years @ £11,500 pa with effect from 15 March 2019

Holding Account	**Site Area**	**USE**	**Title or Deed No**
General Fund		Village Hall	
Ward	**EPC**		
Chadwell St Mary	**E**		

Disposal of these asset would generate a capital saving for the Council, reduce the rental burden on community groups and secure the tenure of these sites for community use subject to restrictive covenants to ensure that the freeholds remain as assets to benefit the community.

Chadwell Village Hall (Large), Waterson Road, Chadwell St Mary, RM16 4NX

Description: lMulti-purpose village hall building run by Management Committee. Lease granted to the Trustees of the Chadwell Hall Management Group from 01/04/1973.

Holding Account General Fund	**Site Area**	**USE** Hall management committee and nursery	**Title or Deed No**
Ward Chadwell St Mary	**EPC** **E**		

Disposal of these asset would generate a capital saving for the Council, reduce the rental burden on community groups and secure the tenure of these sites for community use subject to restrictive covenants to ensure that the freeholds remain as assets to benefit the community.

Corringham Village Hall, Springhouse Road, Corringham SS17 7LE

Description: A 1970s brick building of brick and tile construction in Springhouse Road. Accommodation comprises a hall with stage, offices, kitchen and WCs with 80 car parking spaces. Leased of FRI terms to Trustees and Management Committee effective from 28 March 2013.

Holding Account	**Site Area**	**USE**	**Title or Deed No**
General Fund	0.713 Acres, 2,887 Sqm	Village Hall	EX859229
Ward Stanford East and Corringham	**EPC**		

Disposal of these asset would generate a capital saving for the Council, reduce the rental burden on community groups and secure the tenure of these sites for community use subject to restrictive covenants to ensure that the freeholds remain as assets to benefit the community.

Cowdray Village Hall, 50 London Road, West Thurrock, RM20 3BJ

Description: Multi-purpose hall building. A single storey purpose built hall of traditional brick construction. FRI Lease for 99 years with effect from 11/01/1983 to Trustees of West Thurrock Community Hall

Holding Account **General Fund**	**Site Area** 0.62 Acres	**USE** Village Hall	**Title or Deed No**
Ward West Thurrock and South Stifford	**EPC**		

Disposal of these asset would generate a capital saving for the Council, reduce the rental burden on community groups and secure the tenure of these sites for community use subject to restrictive covenants to ensure that the freeholds remain as assets to benefit the community.

East Tilbury Village Hall, Princess Margaret Avenue, East Tilbury, RM18 8RB

Description: Multi-purpose village hall building run by Management Committee. Leased on IRI terms to Trustees of East Tilbury Hall from 1983

Holding Account	**Site Area**	**USE** Community Hall / Hall management committee	**Title or Deed No**
General Fund	0.111 Acres, 452 Sqm		EX275011
Ward	**EPC**		
East Tilbury			

Subject to relocating the relocating library within disposal of this asset would generate a capital saving for the Council, reduce the rental burden on the tenant community group and secure the tenure of these sites for community use, subject to restrictive covenants to ensure that the freeholds remain as assets to benefit the community.

Horndon Village Hall, High Road, Horndon On The Hill

Description: Village Hall Situated on the main road through Horndon On The Hill, with a parking area at the rear of the property.

Holding Account	**Site Area**	**USE**	**Title or Deed No**
General Fund	0.227 Acres, 922 Sqm	Community Hall	EX516757
Ward	**EPC**		
Grays Riverside			

Disposal of these asset would generate a capital saving for the Council, reduce the rental burden on community groups and secure the tenure of these sites for community use subject to restrictive covenants to ensure that the freeholds remain as assets to benefit the community.

Hugh Delargy Hall, North Road, Purfleet, RM19 1TU

Description: A single storey brick built building located off Wood Avenue in Purfleet. Let to Trustees of JSC on a lease effective from I September 1997

Holding Account	**Site Area**	**Use**	**Title or Deed No**
General Fund	0.057 Acres, 232 Sqm	Judo Club	EX499827
Ward	**EPC**		
Aveley & Uplands			

Disposal of these asset would generate a capital saving for the Council, reduce the rental burden on community groups and secure the tenure of these sites for community use subject to restrictive covenants to ensure that the freeholds remain as assets to benefit the community.

Linford Village Hall, Lower Crescent Road, Linford, SS17 0QP

Description: Multi-purpose village hall run by Management Committee. Leased on IRI terms to the Trustees and Management of Linford Village Hall from 10 June 1971.

Holding Account	**Site Area**	**Use**	**Title or Deed No**
General Fund	0.206 Acres, 834 Sqm	Hall management and trustees	EX863155
Ward	**EPC**		
East Tilbury			

Disposal of these asset would generate a capital saving for the Council, reduce the rental burden on community groups and secure the tenure of these sites for community use subject to restrictive covenants to ensure that the freeholds remain as assets to benefit the community.

Orsett Village Hall, High Road, Orsett RM16 3LD

Description: Multi-use Village Hall building run by Management Committee. Let to Management Committee effect form 5 September 1972

Holding Account General Fund	**Site Area**	**USE** Community Hall- Hall management committee	**Title or Deed No**
Ward Orsett	**EPC**		

Disposal of these asset would generate a capital saving for the Council, reduce the rental burden on community groups and secure the tenure of these sites for community use subject to restrictive covenants to ensure that the freeholds remain as assets to benefit the community.

South Ockendon Village Hall, 65 North Road, South Ockendon RM15 6QA

Description:
Multi-purpose village hall building run by Management Committee.

Holding Account General Fund	**Site Area** 0.196Acres, 802Sqm	**USE** Community Hall	**Title or Deed No** EX862720
Ward Ockendon	**EPC**		

Disposal of these asset would generate a capital saving for the Council, reduce the rental burden on community groups and secure the tenure of these sites for community use subject to restrictive covenants to ensure that the freeholds remain as assets to benefit the community.

South Ockendon Village Social Club, Canterbury Parade, South Ockendon, RM15 6NH

Description: A purpose built hall of brick construction under a pitched roof close to the retail parade in Canterbury parade in South Ockendon. Leased on a 60 year leased to the Hall trustees on IRI terms from 29 March 1973.

Holding Account General Fund	**Site Area** 0.310 Acres, 1.255 sqm	**USE** Community Hall - Hall Trustees and management	**Title or Deed No** EX857218
Ward Ockendon	**EPC**		

Disposal of these asset would generate a capital saving for the Council, reduce the rental burden on community groups and secure the tenure of these sites for community use subject to restrictive covenants to ensure that the freeholds remain as assets to benefit the community.

Seabrooke Rise Community Hall, Sherfield Road, Grays, RM17 6FJ

Description: Purpose built modern community Hall. Leased to Trustees of the Grays Riverside Community Association with effect from 30th July 2017 for 35 years.

Holding Account	**Site Area**	**USE**	**Title or Deed No**
General Fund	0.154 Acres, 623 Sqm	Community Hall	EX863188
Ward	**EPC**		
Grays Riverside	**E**		

Disposal of these asset would generate a capital saving for the Council, reduce the rental burden on community groups and secure the tenure of these sites for community use subject to restrictive covenants to ensure that the freeholds remain as assets to benefit the community.

Drake Road Community Hall, Drake Road, Grays, RM16 6PS

Description: Multi-purpose village hall building run by Management Committee. Leased to hall Trustees of Drake Community Hall from 1993

Holding Account	**Site Area**	**USE**	**Title or Deed No**
General Fund	0142 Acres, 577 Sqm	Village Hall	EX485674
Ward	**EPC**		
Chafford and North Stifford			

Disposal of these asset would generate a capital saving for the Council, reduce the rental burden on community groups and secure the tenure of these sites for community use subject to restrictive covenants to ensure that the freeholds remain as assets to benefit the community.

Tilbury Community Hall, Montreal Road, Tilbury, RM18 8AA

Description: A purpose built building on the junction on Montreal Road and Calcutta Road in Tilbury. Let on a 99 year building lease with effect from 24 June 1965 to the Trustees.

Holding Account General Fund	**Site Area**	**USE** Community Hall - Hall Trustees and Management Committee	**Title or Deed No**
Ward Tilbury St Chads	**EPC**		

Disposal of these asset would generate a capital saving for the Council, reduce the rental burden on community groups and secure the tenure of these sites for community use subject to restrictive covenants to ensure that the freeholds remain as assets to benefit the community.

Homesteads Village Hall, Dunstable Road, Stanford Le Hope, SS17 8QL

Description: Multi-purpose Village Hall building run by Management Committee. Leased to the Homesteads Village Hall Management Committee with effect from 23 January 1998.

Holding Account	**Site Area**	**Use**	**Title or Deed No**
General Fund	0.664 Acres, 2,688 Sqm	Village Hall Management Committee	EX396266
Ward	**EPC**		
The Homesteads			

Disposal of these asset would generate a capital saving for the Council, reduce the rental burden on community groups and secure the tenure of these sites for community use subject to restrictive covenants to ensure that the freeholds remain as assets to benefit the community.

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13 July 2022	Item: 11 Decision: 110614
Cabinet	
Tilbury Town Fund Programme	
Wards and communities affected: Tilbury Riverside and Thurrock Park, Tilbury and St Chads	**Key Decision:** Key
Report of: Councillor Mark Coxshall – Deputy Leader and Cabinet Member for Regeneration and External Affairs	
Accountable Assistant Director: Keith Rumsey, Assistant Director of Place Delivery	
Accountable Director: Sean Clark, Corporate Director of Resources and Place Delivery	
This report is Public	

Executive Summary

The development of the Tilbury Town Fund Programme is progressing in preparation for the submission of the Outline Business Case summaries to the Department of Levelling Up, Homes and Communities (DLUHC) by 5 August 2022. This report sets out the development of the programme to date following the consideration of the initial programme in the Cabinet Report dated 7 July 2021. It also reports the recommendations made by the Tilbury Town Board with regards to a revised programme of projects and delivery strategy in response to stakeholder project feedback and unprecedented cost inflation issues.

The report highlights key contractual and financial implications for the Council associated with progressing with the recommended project programme, budget and delivery strategy. The report then seeks approval of the Tilbury Town Fund programme and budget allocation and to a range of recommendations which will enable the Council to continue to develop and deliver the recommended programme within the programme timetable. It is proposed that, when required, further reports on individual projects will be brought back to the Cabinet for consideration and approval, as project progress is made towards Full Business Case and Contracting stages.

The Gray's Town Fund Programme is due to be considered in the September reporting cycle.

1. Recommendation(s)

That Cabinet:

1.1 Approve the Tilbury Town Fund Programme and Budget allocations as set in Table 1 of this report.

1.2 Delegates authority to the Corporate Director of Resources and Place Delivery, in consultation with the Deputy Leader and Cabinet Member for Regeneration, Strategic Planning and External Relationships and the Assistant Director of Legal Services, to approve the Business Case Summaries; and agree lease, development and contractual terms (including approval to go to tender and award) to support the delivery of the programme.

1.3 Confirms agreement to underwrite the proposed financial settlement to enable the delivery of the Thurrock Youth Zone, as set out in Section 8.1 of this report, and that officers actively seek alternative revenue streams to support the long-term delivery of the Youth Zone.

2. Introduction and Background

2.1 On 15 July 2021 DLUHC announced that Tilbury had been awarded £22.8million from the Town Deal fund. Heads of Terms were signed and returned to the Department on the 5 August and a revised set of projects were submitted to DLUCH on 5 October 2021.

2.2 Tilbury Town Board shortlisted projects for the Town Deal based on their ability to drive the Tilbury regeneration agenda and the available funding. The original programme of projects and their aims are set below:

Heart – £14.35m

2.3 Projects within the 'Heart' theme focus on new buildings and amenities in the Civic Square, including an inclusive Community Hall, Education Zone and bespoke Youth Facility. As a collection of projects there is a real opportunity to transform the Civic Square, with the new buildings acting as a benchmark for quality design and a catalyst for further transformation. These projects will complement the investment going into the Tilbury Integrated Medical Centre (TIMC) and Library. Projects within this collection can be delivered independently allowing the funding to be flexed if required. Officers are working with the youth charity Onside to carry out the design work supporting the development and delivery of a future Thurrock Onside Youth Zone.

Heritage – £5.86m

2.4 The 'Heritage' theme comprises projects on the Tilbury riverfront between Tilbury Town Centre, the Cruise Terminal and Tilbury Fort. Part of the focus of the Tilbury Town Fund programme aims to deliver projects that reconnect Tilbury to its heritage by making more of and celebrating the historic and natural heritage assets of Tilbury riverside. This will be done through a series of enhancements to improve connectivity between the town centre and the

riverside and also improve the settings and connections between key assets, such as Tilbury Fort, the Tilbury Landing Stage and the listed Station Hall and cruise terminal buildings, so they operate as a cultural cluster.

2.5 Partnership working will be critical to the delivery of these projects and officers are already working collaboratively with both English Heritage and the Port of Tilbury on developing plans for improving connectivity to Tilbury Fort and designs for the provision of a Pontoon extension to the existing Tilbury Landing Stage to facilitate increased passenger ferry services.

Hub – £2.59m

2.6 The Hub theme proposes improvements to the public realm either side of the station. There is also a focus on improving the arrival space around Tilbury Town rail station and improve access to and from the station interchange.

3. Issues, Options and Analysis of Options

3.1 Approval of funds to proceed with design development was received from DLUHC on 3 December 2021 and since that date design teams have been appointed to develop project proposals up to RIBA Stage (Concept Design) to allow an outline business case (OBC) to be prepared for each element of the programme. Central to this work has been a sense check on the viability of individual project elements, reviewing both the user demand, specifications and underlying costings.

3.2 This review has highlighted significant budgetary issues related to the costings of the original project programme. A more detailed review of individual project elements questioned the rationale for the need for new build facilities as opposed to the reuse of existing ones and also identified significant budget underestimations and omissions. This combined with significant cost price inflation issues resulted in the need for a comprehensive review of the programme to keep it within budget. The Tilbury Town Board has set the programme priorities for the Tilbury Town Programme and the Board agreed the proposed changes to the delivery programme at the Board Meeting on 26 May 2022. In as far as possible the review has sought to retain and deliver the key priority projects as set by the Board and contained with the Town Investment Plan. The Board agreed to change the status of a number of the Hub public realm projects to reserve, as the Board considered that these could better considered as part of a wider property based regeneration of the area. The Board also requested that officers explore opportunities to link Town Fund expenditure with existing Highway programmes to maximise match funding and spend around the Station Hub.

3.3 Key Programme Changes are:

- The Community Hub delivered through refurbishment of vacated Civic Square buildings (once the library and associated services have been

decanted into the Tilbury Integrated Medical Centre), and refurbishment of Brennan Road facility into dedicated a Adult Skill Centre.

- Reallocation of three Station Hub projects as reserves projects, to be incorporated into a property focused regeneration of the Station area at a later date and officers link town fund expenditure to the current and future Highways programme to maximise match funding opportunities.

- Reallocation of released funds to address budget shortfalls in the priority projects in the programme.

3.4 Table 1 details the revised programme and budget the Cabinet are asked to approve and the section below provides further details supporting the proposed changes to the original programme.

Table 1 Revised Programme and Budget Allocation

Project	**Priority**	**Original Budget £'000**	**Revised Budget £'000**
Heart - Thurrock Youth Zone	1	5,200	6,600
Heart -Parks Improvements	1	1,500	1,500
Heart - Community Hub and Adult Skills Centre	1	7,150	3,012
Heart -Town Centre Parking	1	500	560
Heritage -Tilbury Jetty	1	2,300	5,700
Heritage - Tilbury Fort Works	1	800	2,100
Heritage - Tilbury Heritage Links	1	527	594
Heritage - Tilbury Pier Approach	1	1,025	1,139
Heritage - Tilbury Foreshore	1	1,198	1,216
Station Hub – Phase 1	1	410	379
Original Budget		**20,610**	**22,800**
Project Reassigned to Reserve			
Station Hub - Network Land	2	1,090	1,447
Station Hub - Dock Road Link	2	470	388
Station Hub - Calcutta Park	2	630	520

Heart - Community Hub and Adult Skills Centre

3.5 In testing the demand/need for a new build Community Hub, a service audit of all current and future community facilities was carried out of both council and non-council assets, along with a series of stakeholder meetings. The audit found that community-based services offered to the residents of Tilbury are extensive, but there is a need to centralise services to allow the suitable sharing of facilities to deliver a focussed provision of services based in and

around the Civic Square. The audit and community engagement found that the Tilbury Community is diverse but needs to come together in a space that complements current facilities, including the future TIMC but one that is community managed and flexible enough to deal with the wider range of outreach programmes and informal activities proposed.

3.6 The original Town Fund bid envisaged a new community hub building being provided as part of a cluster of buildings including the TIMC. Once delivered, the Library and Tilbury Hub services will be relocated into the TIMC and this would leave a collection of vacant buildings in the Civic Square. The revised delivery strategy proposes that, once vacated, the Tilbury Hub building is retained and refurbished for use as the identified Community Hub, operating under a community lease.

3.7 Adult Skills provision is currently provided through the Tilbury Hub and Brennan Road facilities. These buildings provide space for wide range of services including many liked to skills and employment including adult literacy and numeracy; adult and children special needs; ESOL; skills training; benefits advice; and IT/digital skills training. The Brennan Road facility provides a limited range of employment services linked to the CLLD programme and in the evening for a programme of youth services.

3.8 The audit concluded that outreach is a consistent theme for the provision of adult skill services and appears restricted principally due to resources available. The Service advised that adult education services, as well as other services, would be best served by need a single volume, multi-function space to enhance provision. In the Service judgement there is a need to better co-ordinate service provision and a better utilisation of current property assets. The Service has expressed a desire to expand the Aspire concept into Tilbury, utilising the Brennan Road facility more intensively to provide a full range of services from this premise. This includes the greater use of outreach provision from partners such as DWP.

3.9 The revised delivery strategy proposes that the current Brennan Road facility should be subject to an extensive refurbishment to address the current service deficiencies around ventilation and layout. It is considered that the provision of the Thurrock Youth Zone as part of the wider Town Fund programme will result in the space and timetable currently used for Youth Service provision becoming available for specific adult skills provision, thus creating capacity. The current Brennan Road facility is not being utilised to its full capacity and consideration will need to be given to the longer-term management of the facility if it is to become a multi-functional and multi-service delivery space. There is also a need to examine synergies for spaces being provided within the TIMC and a refurbished Community Hub building, to avoid duplication and achieve greater space and service efficiencies.

Heart Thurrock Youth Zone

3.10 The Thurrock Youth Zone project forms a key project priority of the original Towns Fund bid and one that directly addresses the needs of young people in Tilbury and the rest of the Borough. A number of sites options have been examined and a preferred site for the Youth Zone has been identified on Anchor Fields. Site investigation work is underway and the outcomes of this will have a bearing on the exact location and will be determined following public consultation and will be the subject of a formal planning consultation proposed to take place later this year.

3.11 To enable the delivery of the Youth Zone the Council be required to enter into a lease with the Onside Charity for the selected site for a term of 125 years at a peppercorn rent with no premium and enter into a series of agreements covering development and future operations. The capital cost for the construction for the Youth Zone, except for site abnormals, will be shared on a 50:50 basis with Onside, with the Town Fund providing the full public sector contribution.

4. Next Steps

4.1 The proposed changes to the programme and outputs will need to be subject to a project change request to DLUHC. The Department have been clear that there is no guarantee that approval will be granted and there is therefore a risk that the value of any funding attached to projects that don't proceed could be lost from the programme.

Progress and Programme

4.2 Below is an overview of the programme:

4.3 For each of the projects further design work is currently being undertaken to deliver RIBA Stage 2 Concept Designs. The Outline business cases are being prepared for each of the key project themes and business case summaries will need to be signed off by the Chair of the Town Board and the Council's S151 Officer prior to submission to the Department by 5 August 2022.

5. Reasons for Recommendation

5.1 The development and delivery of the proposed Tilbury Town Fund programme provides an exciting opportunity to secure much needed funding to address long standing issues and provide opportunities for Tilbury residents, supporting the successful regeneration of Tilbury. The delivery will also address a number of the Council's priorities, as outlined in Section 7 below.

5.2 The deadline for the submission of the business case summaries has been set by DLUCH for 5 August 2022. The final decision on funding is due from the Department by October 2022. Delegated authority to sign off the business case summaries and agree terms for progressing projects is requested to ensure that the Council is able to respond and deliver projects within the required timeframes.

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

6.1 An update report was considered at the Planning, Transportation and Regeneration Overview (PTR) and Scrutiny Committee 1 February 2022. Feedback and comments on the update report to the PTR meeting on 5 July 2022 to be reported verbally to Cabinet.

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

7.1 The Thurrock Local Plan and Economic Growth Strategy identify Tilbury as a Growth Hub where economic regeneration and housing growth are to be focussed. The Tilbury Development Framework produced in October 2017 sets out a vision for Tilbury and describes a range of proposed interventions that follow a strategic arc from the station gateway down to the riverfront. The current programme aligns with the priorities set out in this document. The Thurrock Transport Strategy supports improvements of the transport interchange at Tilbury Station including the quality of the public realm and delivering improved and safer accessibility.

7.2 The emerging priorities and schemes in the programme are consistent with the Council's strategies and priorities, provide a means for close community engagement, and importantly provide a vehicle for securing funds to support delivery.

8. Implications

8.1 Financial

Implications verified by: **Jonathan Wilson**

Assistant Director - Finance

The financial implications are set out in the body of the report. The Council believes it is prudent to revise the programme as recommended. The revised programme in Table 1, approved by the Tilbury Town Programme on 26 May 2022, is consistent with the Council's Asset Strategy: Reuse, Retain or Release. The estimated refurbishment costs for both the Tilbury Hub buildings and Brennan Road are significantly lower than the cost of the new build. The Board took the decision to reallocate three Station Hub projects as reserves projects, and these could be reintroduced if funding becomes available. Given the cost price inflation being experienced across all the programme projects, these changes do provide the Council and Town Board with a degree of financial flexibility to reallocate funds, whilst ensuring that the key transformational aspects of the original bid are still delivered.

Work continues to refine the individual elements of the programme and budgets have been reviewed and adjusted, with appropriate contingencies applied to ensure delivery within the funding available. Individual project contingencies have been reviewed and are now based on the stage of design, detailed cost assessments and projected procurement timelines. The cost plans for both the Thurrock Youth Zone and Pontoon extension have been adjusted to reflect Construction and Tender Price index for Q3 2023, the estimated tendering timeline. Overall the programme contingency has been set at 20% of the total programme budget. The programme will need to be continually reassessed as a whole through each stage of the detailed design and tendering process to ensure projects remain within budget and maximum efficiencies are made. Continued cost price inflation pressure has been identified as a significant and ongoing risk to programme delivery. The Board in refining and reprioritising the programme have provided the flex to respond to further cost challenges, whilst delivering key projects. It is noted the financial risk associated with the delivery of the proposed projects attaches to the Council (as the Accountable Body) and, consequently, must and will be managed by the Council as part of the capital programme.

As part of the operational agreement with the Onside Charity the Council will be required to provide £400k pa revenue for 4 years to be part funded from the Town Fund Allocation (£1m) and Onside will provide £900k pa revenue for 4 years. The required capital funding from the Council, up to a ceiling of £6.6m will be funded from the Town Fund allocation, with the balance of capital funds coming from the Onside private sector contribution. Options to cover the revenue shortfall are being examined and include a project change request to DLUHC to reallocate programme capital to revenue and the use of allocated Freeport Business Rates Retention funds.

8.2 **Legal**

Implications verified by: **Kevin Molloy**

Principal Lawyer / Manager Contracts & Procurement Team

The Council by entering into the Heads of Terms with the Department has created formal obligations on the Council. The proposals whilst bringing forward the potential for significant benefits does carry risk for the Borough, and the Council. In considering this report Members must be mindful that there are several areas of developing detail within the proposals which may leave the Council exposed to material risks or continuing liabilities in the future.

All projects within the programme are being developed with a view to limiting any future contractual or financial liability falling to the Council. Specific terms of any formal agreements between Onside and the Port of Tilbury will need to be carefully reviewed to ensure that the Council is protected against risks which may arise through contract tendering and implementation (including cost increases, and third party risk). There is at this moment insufficient information to allow the Council to make a formal decision to dispose or appropriate its land assets for the purposes of delivering the proposed projects. Accordingly the Council can only make a decision in principle to agree outline heads of terms and delegate authority to negotiate the lease terms and associated development agreements and tender packages. Some parts of the proposed land which may be included in the proposals are public open space; before a decision can be made to commit the use of this land the Council must undertake statutory consultation under s123 of the Local Government Act 1972 and consider any representations received.

The Council is being asked to be the accountable body for significant public funds from government, the use of some of which may be managed by partner organisations potentially including those in the private sector. Whilst risk can be mitigated through the use of appropriate contracts the ultimate risk will remain with the Council if deliverables are not met. There is scope for the Council to have to repay funds or ensure delivery of projects with the resultant implications. This type of arrangement exists in a number of settings, and can be managed effectively. The Council has in principle the necessary statutory powers to engage in these arrangements at this point, and deliver the proposed projects. However it must be recognised that in doing so it is not making determinations under specific statutory frameworks particularly around matters such as planning where future decision making will be necessary. A number of the projects will require consents form third party bodies / regulators (such as the Port of London and Environment Agency) whilst the projects can be designed to mitigate difficulties this risk must be reflected in the consideration of the Councils overall risk as accountable body, and the terms of the grant agreement. Where projects require works to be undertaken, or the entering into of long term service contracts formal procurement rules will have to be followed by the Council, following both the statutory requirements and the Councils procurement policies. During the course of the formal business case development and the shaping of the final proposals further formal decision making will be required by the Council to exercise its statutory functions, particularly in relation to the disposal or acquisition of land and use of its other statutory powers.

Any contracts to be entered into will need to be in accordance with national procurement law and the Council's own internal procurement rules, and Legal Services will need to be consulted to ensure compliance as this project proceeds.

8.3 **Diversity and Equality**

Implications verified by: **Roxanne Scanlon**

Community Engagement and Project Monitoring Officer

The Town Board and its Advisory Group include a full range of representation of stakeholders. The Advisory Group is open to others to join. Stakeholder engagement has built on existing engagement exercises carried out in Tilbury over recent years.

As part of the process of developing the TIP, the Council and the Towns Board have carried out extensive community engagement.

The Town Board has committed to ongoing engagement through the process for submission and project development. The TIP will include different projects, each of which will require a community equality impact assessment. The TIP engagement plan will seek to ensure that proposals understand and, where possible, improve equality and diversity.

8.4 **Other implications** (where significant) – i.e. Staff, Health Inequalities, Sustainability, Crime and Disorder, and Impact on Looked After Children

None

9. 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

10. Appendices to the report

N/A

Report Author

Kevin Munnelly

Strategic Regeneration Lead Interim (East)

13 July 2022	Item: 12 Decision: 110615
Cabinet	
Thurrock Supported Bus Services	
Wards and communities affected: All Wards	**Key Decision:** Key Decision
Report of: Councillor Ben Maney, Cabinet Member for Highways and Transport	
Accountable Assistant Director: Leigh Nicholson, Assistant Director, Planning, Transportation and Public Protection	
Accountable Director: Julie Rogers, Director of Public Realm	
This report is Public	

Executive Summary

Thurrock Council supports through financial contribution three local bus services within the borough. These services, tendered by the council in 2019 are funded through a corporate budget. The services are operated by the bus operator NIBS on a three-year contract, which concluded in March 2022, with an option to extend by up to a further two years. Due to uncertainty in the market, and the impacts of the pandemic, a twelve-month extension has been implemented. The tendered cost of these services was approximately £452,000 per annum, but due to cost pressures, has risen significantly this year. With the receipt of a grant from the Department for Transport, the additional liability for this year is up to £50,000, which will form a corporate budgetary pressure on the council.

This report sets out a recommendation to review the provision of these supported services, through consultation with communities which are served by the three bus routes.

1. Recommendations:

1.1 Cabinet to approve the commencement of consultation within the community for a period no less than 12 weeks on the need and impact of the three bus services supported by Thurrock Council.

1.2 Cabinet to note that during the consultation period any necessary profiling of user groups is to be undertaken together with a Community Equalities Impact Assessment.

1.3 A further report scheduled for December 2022 will be presented to Cabinet to consider the outcome of the consultation, the Community Equalities Impact Assessment and recommended options for future service provision into 2023 and beyond.

2. Introduction and Background

2.1 Thurrock Council subsidises the operation of three local bus services within the borough. These services provide access to and from locations and for communities which would not be otherwise supported by commercially sustainable bus services. These three services, the 11, 265 and 374, are further detailed below, with a route map appended to this report.

2.2 Service 11 serves Purfleet-on-Thames, Aveley, South Ockendon, North Stifford, Thurrock Hospital/proposed IMC, Grays, Chadwell St Mary, Orsett, Horndon-on-the-Hill, Stanford-le-Hope, Corringham, Fobbing, Basildon Hospital and terminating at Basildon bus station. This bus departs every two hours from approximately 7am until 7pm Monday to Friday only, with one bus in each direction.

2.3 The 265 operates twice a day with a solitary bus on Mondays, Wednesdays and Fridays only, connecting Grays, Socketts Heath, Orsett, Bulphan and West Horndon, with departures in each direction between 10am and 2pm.

2.4 Lastly the 374 serves Grays, Socketts Heath via Hathaway Road, Chadwell St Mary, West Tilbury, Coalhouse Fort, East Tilbury, Linford, Stanford-le-Hope, Corringham, Fobbing, Basildon Hospital and terminates at Basildon bus station. These buses run Monday to Friday, departing approximately every 90 minutes between 7am and 6pm, with one bus in each direction, and every three hours on Saturdays.

2.5 The communities of East Tilbury Village, Fobbing and Horndon-on-the-Hill have no alternative public transport provision and Bulphan has no other provision linking it with any other part of Thurrock. East Tilbury and Linford have no other bus provision, but do have access to rail services, although it should be noted that some parts of East Tilbury are a significant distance from the railway station. In addition, these services provide direct links between communities which are not offered by commercial services. For example, there are no alternative direct links between Purfleet and Aveley, or Aveley and South Ockendon.

2.6 Prior to a formal tender in 2019, papers were submitted to Overview and Scrutiny Committee and Cabinet to agree the continuation of the services. A three-year contract with a two-year extension option was awarded to NIBS.

2.7 The contract was tendered on a “revenue risk” basis, where the council does not pay for the full cost of delivering these services but provides a guaranteed sum to the operator. All fares and revenues collected remain with the operator, providing an incentive to the operator to increase patronage, helping

to reduce cost to the council, and placing a risk with the operator if revenues do not meet their projections.

2.8 In 2019, the three services carried 89,040 passengers. The subsidy provided by Thurrock Council for these three services for that year totalled £454,318.20. This equated to a subsidy of £5.10 per passenger. Of those 89,040 passengers, approximately a third are fare paying passengers, with the overwhelming majority of the remaining riders being older person or disabled concessionary pass holders. Respective figures for 2020 and 2021 are significantly skewed due to the impacts of the pandemic, coupled with government guidance and changes in travel behaviours. In 2020/21 patronage was 30,758, and in 2021/22 patronage was 65,008. This equated to a passenger subsidy of £14.56 in 20/21 and £6.95 in 21/22. This trend in patronage can be seen on all bus services across the country. While the number of fare paying passengers are recovering to pre-pandemic levels - April and May 22 ticket sales have surpassed the corresponding months in 2019, it is concessionary passengers which have not recovered. This has had an impact on the patronage per bus journey, with 12 trips per journey in 2019/20, reducing to just under 9 trips per journey in 2021/22.

2.9 These services could provide key community, social, and health and wellbeing benefits to users. For example, in 2019, 54% of all passengers on the 11 service are concessionary pass holders, and these are most likely to be older persons. For the 374, this was 64%, and 89% for the 265. This totalled 53,789 passengers in 2019, or 60% of all passengers on these three services. Concessionary pass holders do not pay to use the bus anywhere in England from 9.30am onwards, and this is a statutory provision. In Thurrock, this provision is allowed from 9am. Thurrock Council has a duty to fairly compensate bus operators for concessionary travel, and this is provided from a separate grant and budget, which for that year was £52,017.

2.10 All other bus routes in Thurrock, except those franchised by Transport for London, and an Essex County Council service which serves Bulphan from Brentwood, are commercially operated services delivered by Ensign Bus and First Buses Essex.

3. Issues, Options and Analysis of Options

3.1 The initial three-year term of the contract came to an end in March 2022. As such, the council has extended the provision of the service through the available contract extension by a further twelve months. This will see the price rise by up to a maximum of £100,000, but based on likely revenue income and other grants, this is likely to be minimised to £80,000. A £50,000 grant has been received by the council from the Department for Transport as a final Covid-support payment, limiting the council's additional liability to a maximum of £50,000 for this year only. This increase has been caused by rises in cost to fuel, drivers wages, cost of parts, as well as other increased costs. Over the contracted three-year period, the price had remained the same to the council.

3.2 These circumstances provide an opportunity to review the need for these services, and to ensure they present value for money. With increase in costs, and patronage not yet recovered, there is the chance to identify if these services should be maintained in their present form, or if there are opportunities to revise the provision. As part of this process, in consultation with the Communities Team and Legal Services, there is legitimate expectation by our communities to consult with them on considerations of this nature. It is an expectation of communities to be consulted where services are considered for significant alteration or potential for withdrawal, in particular where budgetary pressures are a key underlying factor.

3.3 Therefore it is advised that the council should undertake a consultation with all communities which are supported by these services. A minimum 12-week consultation would be in line and consistent with the Governments Code of Practice on consultation. Consideration would have to be made of the communities and service users and the process would have to be fair and appropriate. It would be insufficient and inappropriate to hold an online only consultation, and the council would likely need to actively engage within these communities, given the rural locations of those affected.

3.4 Alongside a consultation, the council is also recommended to undertake a Community Equalities Impact Assessment, given the nature of the proposals, and the corporate and community risk arising from failure to meet due regard requirements set out in the Public Sector Equality Duty. The council does not have a high level of profiling of users, but this community impact assessment work has already commenced, as some details are required prior to any consultation, to help the council identify the most appropriate consultation process and methodology.

4. Reasons for Recommendation

4.1 In light of the detail identified within the report, it is recommended that the council consult with the community and residents of the ongoing need and the impact and implications of potential alterations or possibly withdrawal of the three bus services supported by Thurrock Council. This consultation is undertaken for a minimum period of twelve weeks as recommended by the advice from the Communities and Legal teams within the council. Concurrently with the consultation, officers complete the necessary profiling of users and undertake a Community Equalities Impact Assessment. In addition, options for revising service provision are also developed, which may also need to consider withdrawal. Upon completing these actions, and reviewing consultation responses, an informed recommendation can be returned through the council's democratic processes and to Cabinet to determine the most appropriate action. By following this recommendation, a report would need to be reviewed by Overview and Scrutiny Committee, and Cabinet by December 2022, with any subsequent actions implemented following that meeting.

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

5.1 Consultation for this report has been undertaken internally with key teams within the council. Namely these have been with the Communities team to understand more about the impact and procedures for potential changes to these services, and with the Legal team to understand more about the contract and legal matters relating to service provision. Specialist legal support has also been sought on matters relating to bus service provision, in consultation with the council's legal services. Ultimately, this report sets the framework for potential to consult with the community on all of these matters.

5.2 In addition, this report is to be submitted to Planning, Transportation and Regeneration Overview and Scrutiny Committee, scheduled to meet on 5 July 2022. Any outcomes from O&S are to be shared with the Portfolio Holder for Transport and Highways to share with Cabinet alongside this report.

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

6.1 This report has made aware the provision the three supported bus services provide to communities, particularly those without alternative transport services. Any changes in the availability of transport services to residents and communities could potentially have a negative impact on them, making access to facilities, workplaces, and education more difficult or expensive.

6.2 There are a number of corporate policies and strategies which directly and indirectly support the provision of bus services allowing access to key urban areas of destinations from rural and smaller communities. This can be seen in the Corporate Vision and Priorities for Thurrock, where accessibility interlinks with all three priorities of People, Place and Prosperity. The Economic Growth Strategy – 'Backing Thurrock' identifies within its "Recovery: Our immediate actions" section and "Building Resilience and a Return to Growth" – the medium to long-term goals – both speak about enabling access to employment, and supporting the economy, which are enabled by these services. The Health and Wellbeing strategy though its Objectives and Goals matrix links to the need for communities to have accessibility to key facilities and services.

6.3 Within the existing Thurrock Transport Strategy, bus service provision links directly with its Accessibility priorities, specifically Objective ACC1: to improve accessibility to services, especially education, employment and hospitals, with policies TTS2: Improving access to sustainable transport to key services and facilities; and TTS8: Mobility and Access for all being key. Additionally, the adopted Bus Service Improvement Plan sought to increase bus service provision for these services, in particular the 374 and the 265, enabling them to become more reliable for users.

6.4 The community impacts of these services are being assessed, with identification of users, origins and destinations, and demand to help better understand how these services support communities and residents. When

combined with engagement of affected communities, this community impact assessment will help to identify and show any ongoing need for provision of supported services within Thurrock.

7. Implications

7.1 Financial

Implications verified by: **Laura Last**

Senior Management Accountant

The Thurrock Supported Bus Services contract has been extended by a further 12 months. The initial three year contract had a budget of £452,000 per annum, funded through a dedicated corporate budget. The budget for 2022/23 remains £452,000 and therefore any price increase in the extension is currently unfunded and will cause a budgetary constraint. This is currently £50,000 for the year 2022/23. If the services were to be, withdrawn, this will create an annual budgetary saving of £452,000 per annum, commencing April 2023.

7.2 Legal

Implications verified by: **Gina Clarke**

Corporate Governance Lawyer and Deputy Monitoring Officer

It is not a statutory requirement for the Council to fund any public local bus services. However, the Council does have powers under the Transport Acts 1985 and 2000 and Local Transport Act 2008 to enter into agreements with public transport operators to provide subsidies for services which are not available commercially.

Any withdrawal of subsidies for bus services will need to be justified and such a decision would need to be based on robust evidence and analysis. The decision-making process would need to be supported with consideration by Cabinet of the outcome of the consultation and consultation response, an Equality Impact Assessment, the Public Sector Equality Duty (PSED) requirements under Section 149 of the Equalities Act 2010 as detailed in paragraph 7.3 of the of report, together with any other relevant factors such as budget constraints.

7.3 Diversity and Equality

Implications verified by: **Roxanne Scanlon**

Community Engagement and Project Monitoring Officer

There is a need for an Equality Impact Assessment to be undertaken to support any decision made on these services, to ensure compliance with Public Sector Equality Duty. These should also be supported by formal consultation with residents and affected communities, taking into consideration existing users and their locations of residence, ensuring the consultation process is fair and accessible.

7.4 **Other implications** (where significant) – i.e. Staff, Health Inequalities, Sustainability, Crime and Disorder, and Impact on Looked After Children

Changes to these services will likely have an impact on residents who are reliant on these supported bus routes and do not have access to alternative modes of travel. This may then result in costs transferred to other parts of the council or health services, providing access to services and facilities, including hospitals and education, as well as access to food and other retail services.

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

- Cabinet, 10 October 2018, Item 11 – Procurement of Local Bus Services

9. Appendices to the report

- Appendix 1: Supported Services Route Map

Report Author:

Navtej Tung

Strategic Transport Manager

Transport Development

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thurrock.gov.uk

Thurrock supported bus services

N

Legend

Service 11

Operates Mondays - Fridays.
2 hourly frequency

Service 265

Operates Mondays, Wednesdays, Fridays.
Occasional Journeys

Service 374

Operates Mondays - Fridays.
90 mins frequency.
Saturday. 3 Hourly frequency

Scale 1:50,000

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13 July 2022	Item: 13 Decision: 110616
Cabinet	
Abandoned Trolley Cost Recovery Policy	
Wards and communities affected: All	**Key Decision:** Key
Report of: Councillor Andrew Jefferies – Cabinet Member for Environment and Air Quality	
Accountable Assistant Director: Daren Spring – Assistant Director for Street Scene and Leisure	
Accountable Director: Julie Rogers – Director for Public Realm	
This report is Public	

Executive Summary

Abandoned shopping trolleys blight the local environment and can lead to further littering and fly- tipping. There are approximately 20 shopping trolleys a day that have been abandoned on our streets and housing estates in Thurrock, equating to over 400 shopping trolleys per month.

The Council can adopt statutory powers that would enable them to collect abandoned shopping trolleys and luggage trolleys from land open to the public, return them to the owner and recover the Council's reasonable costs of doing so. If a scheme is not put in place with the stores and the trolleys are not collected the Council can recover full costs for their collection, storage and disposal.

This policy statement provides details of the relevant legislation, outlines the proposals and provides information on the resource implications. The report also sets out the requirement for a formal consultation and seeks support to recommend to Cabinet the adoption of the relevant statutory powers.

1. Recommendation:

1.1 That Cabinet approve the initiation of the process for the adoption of the new abandoned trolley cost recovery policy, as recommended by the Cleaner, Greener and Safer Overview and Scrutiny Committee.

2. Introduction and Background

2.1 Shopping trolleys of all descriptions, but mainly supermarket shopping trolleys, are routinely found abandoned across the Borough. Up to 400 are taking a long time to be collected or are remaining uncollected. Shopping trolleys are also the subject of complaints from residents. Abandoned trolleys not only look unsightly but can be left in roads creating traffic hazards. Abandoned trolleys on housing estates can attract anti-social behaviour including fly tipping and generally detract from the local environment.

2.2 Shopping trolleys are often damaged beyond repair, full of rubbish or left abandoned in locations that make collection difficult. These factors can mean there is little benefit in owners recovering them. The local authority is able to follow the legal notice processes contained within the Environment Protection Act 1990 (the 'EPA'), but with no power to recover the costs involved in trolley retrieval from the owners.

2.3 The Council also relies on the goodwill of local stores recovering their own trolleys, in many cases they have a contract with Trollywise to collect and return their trolleys and put measures in place to prevent them from being taken out of the environs of the store in the first place.

2.4 The council's Environmental Enforcement Service may issue a Community Protection Warning [CPW] and Notice [CPN] in accordance with section 48 Anti-Social Behaviour Act 2014 for abandoned trolleys.

3. Relevant legislation and application

3.1 Section 99 of the Environmental Protection Act 1990 - Environmental Protection Act 1990 (legislation.gov.uk)

Schedule 4 of the Environmental Protection Act 1990 - Environmental Protection Act 1990 (legislation.gov.uk)

3.2 Schedule 4 of the Environmental Protection Act 1990 (EPA) does however enable local authorities to adopt powers enabling them to take enforcement action against the owners of trolleys and to resolve problems associated with abandoned trolleys.

These powers can be summarised as follows:

- They apply to abandoned trolleys found in the open air.
- This does not include land from where the trolley originated (e.g. Supermarket car parks), or which is designated for trolleys (trolley stores), or with respect to luggage trolleys, to rail/tram/bus stations or airports.
- A trolley abandoned on public land may be seized and removed to such place under the authority's control as it thinks fit. On occupied land, a trolley may only be removed with the consent of the occupier, or after expiry of a 14 day notice served on the occupier if consent is not forthcoming.
- A seized trolley can be sold or disposed of after six weeks.

- If the owner of the trolley is known, the local authority must advise the owner that the authority has removed the trolley and where it is being kept and that if it is not claimed, the authority may dispose of it.
- If the owner claims the trolley, the local authority must deliver the trolley back to the owner on payment of such charge as the authority requires.

3.3 The Clean Neighbourhoods and Environment Act 2005 (CNEA) further amended the Environment Protection Act so as to additionally enable local authorities to recover their costs whether the owner wants it back or not. The process remains the same but the new provision states that after the specified retention period of 6 weeks, if the owner of the trolley is known, that person can be charged for its removal, retention and disposal. The owner has no choice in this, and the charge is payable on demand and is recoverable as a debt. This means that where the owner of the trolleys is known, authorities will be able to recover their costs incurred in removing, storing and disposing of those trolleys.

3.4 It is estimated that each return or disposal would incur a cost of between £120.00 and £230.00 (dependent on early collection/storage/disposal).

After an analysis of the real projected costs, the following charging structure for the trolley retrieval service is recommended:

Collection fee	£70.00
Admin fee	£35.00
Storage fee	£15.00 per week (maximum 6 weeks)
Disposal fee	£35.00

Where a retailer agrees a scheme with Thurrock Council, a set fee of £85 is recommended to have the trolleys returned to store.

4 Reasons for Recommendation

4.1 It is proposed that the Council formally adopts Schedule 4 of the Environmental Protection Act 1990 which facilitates the collection of abandoned trolleys from open land, the return of them to the owner and the recovery of the costs of doing so. Currently, abandoned trolleys are collected and treated as waste and therefore incur a cost to the authority. The main costs of the process as envisaged are those of collection, storage and return. Further costs will be incurred by staff carrying out the legal searches and paperwork. As the legislation suggests that cost recovery is a major driver in this new process.

4.2 The above enforcement powers are only available to the Council if it formally adopts schedule 4 of the Environmental Protection Act (1990). If a resolution to adopt is passed, the Council must advertise that fact in a local newspaper. The Council can then implement the powers in Schedule 4 three months from the date of the resolution.

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

5.1 As required we will consult with people who'll be affected before we start removing trolleys and from time to time. This usually includes:

- local retailers who offer trolleys to their customers
- representative bodies, for example, the British Retail Consortium, the Association of Town Centre Management and the Association of Convenience Stores
- local residents
- rail, tram, road transport or airport operators who provide trolleys
- local police
- the Environment Agency

5.2 This report was presented at Cleaner, Greener and Safer Overview and Scrutiny Committee on the 14 June 2022. The committee supported the adoption of the new Abandoned trolly cost recovery policy.

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

6.1 This relates to the corporate priority – Green Environments that everyone has reason to take pride in.

7. Implications

7.1 Financial

Implications verified by: **Laura Last**

Senior Management Accountant

There will be a small initial cost to set up the scheme, administer it and to store the trollies, this however should be able to be achieved within current staffing numbers and budgets. There will also be an income to the council at the start of the collection and charging process which is predicted will drop off to a lower level once the stores are compliant.

7.2 Legal

Implications verified by: **Mark Bowen**

Interim Head of Legal Services

The Council may resolve to adopt Schedule 4 of the Environmental Protection Act 1990 which provides powers for local authorities to deal with abandoned shopping and luggage trolleys. The schedule would come into force in Thurrock on the day specified in the resolution which must be at least 3

months from the date the resolution is passed. Notice of the passing of the resolution must be published in a local newspaper circulating in the area. In deciding whether to adopt the provisions. Before reaching a decision section 99(3) of the Environmental Protection Act 1990 requires consultation with certain organisations and individuals and the Cabinet should take full and proper account of the response received to the consultation.
Under paragraph 4 of Schedule 4, any charges must be fixed at a level sufficient taking one financial year with another, to cover the cost of removing, storing and disposing of trolleys.

7.3 **Diversity and Equality**

Implications verified by: **Roxanne Scanlon**

Community Engagement and Project Monitoring Officer

There are no equality and diversity implications arising from this report.

7.4 **Other implications** (where significant) – i.e. Staff, Health Inequalities, Sustainability, Crime and Disorder, and Impact on Looked After Children

- N/A

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

- N/A

9. Appendices to the report

- **Appendix 1** – Wording for the consultation letter to retailers

Report Author:

Vincent Taylor

Strategic Lead – Clean and Green Services

Public Realm

Appendix 1 – Wording for the consultation letter retailers

Dear Site/Store Manager,

Formal Consultation on Thurrock Council proposals to deal with abandoned shopping & luggage trolleys.

Environmental Protection Act 1990 – Sec 99 and Schedule 4 Clean Neighbourhood and Environment Act 2005

Thurrock is a vibrant and growing place in which to live, visit or do business and spends a significant amount of money each year keeping the Borough clean and tidy for the benefit of all. We take many different actions and work with numerous partners in order to achieve this.

One specific problem in many communities is that caused by shopping trolleys, and other types of trolley which have been taken away from their site and abandoned somewhere in the local neighbourhood.

The Environmental Protection Act 1990 (EPA), Schedule 4 contains powers which formally allow a local authority to seize and remove abandoned trolleys, retain them and then sell or dispose of them. The authority cannot remove trolleys from private occupied land without the consent of the occupier or without having informed the occupier by Notice that it intends to remove the trolley. If an owner wishes for the trolley to be returned, they may ask for the trolley to be returned at a cost. Schedule 4 of the EPA provides further details if you are interested. This can be found at:
www.opsi.gov.uk/acts/acts 1990

The Clean Neighbourhood and Environment Act 2005 now adds to the EPA and brings the opportunity for the Council to collect, remove and dispose of an abandoned trolley. The Council can then charge the owner for the costs of removal, storage and disposal. This charge is payable on demand and can be recovered as a statutory debt.

As a user of trolleys, it will become important that you actively prevent/minimise trolley losses, as it could add a significant cost burden to your business. Such steps as coin deposit mechanisms, or magnetic wheel braking are 2 ways that may help to reduce losses.

At the moment, Schedule 4 of the EPA does not apply to Thurrock. Abandoned trolleys are simply collected and dealt with as waste. Thurrock Council is to seek a resolution that Schedule 4 of the EPA applies to the whole of its area. Under Section 99 of that Act, this letter is consulting you on these proposals. It is proposed to actively use these powers and Thurrock Council would seek to recover the costs of recovery, storage and disposal of abandoned trolleys from the trolley owners in the future. The costs proposed below reflect the actual costs of collection, administration, storage, staff costs and overheads.

Collection fee	£70.00
Admin fee	£35.00

Storage fee	£15.00 per week (maximum 6 weeks)
Disposal fee	£35.00

Where a retailer agrees a scheme with Thurrock to have the trolleys returned to store for a set fee £85 is recommended

If you have any observations or comments to put forward you have the opportunity to do so in writing to the address below. These should be received before **XX XX 2022**.

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13 July 2022	Item: 14 Decision: 110617
Cabinet	
Housing Strategies 2022-2027	
Wards and communities affected: All	**Key Decision:** Key
Report of: Councillor Luke Spillman, Cabinet Member for Housing	
Accountable Assistant Director: Ewelina Sorbjan – Assistant Director of Housing	
Accountable Director: Ian Wake – Corporate Director, Adults, Housing and Health	
This report is Public	

Executive Summary

As a local authority, it is important that Thurrock Council has a document that states its ambitions and goals regarding housing in the borough. The current Housing Strategy was adopted in Thurrock in 2015.

A new Housing Strategy has been developed which considers current legislation, regulation and market trends, the impact of recent welfare reforms, and new opportunities for meeting the housing needs of Thurrock's residents whilst considering the turbulence and uncertainty brought about during and following COVID-19 pandemic.

This report summarises the strategic aims and objectives of the Housing Strategy 2022-2027. It also presents and summaries the strategic aims and objectives of two supporting strategies – the Housing Asset Management Strategy 2022-2027 and the Housing Resident Engagement Strategy 2022-2027.

1. Recommendation(s):

1.1 It is recommended that Cabinet agree the adoption of the vision, aims, objectives and actions proposed in the draft Housing Strategy 2022-2027.

1.2 It is also recommended that Cabinet agree the adoption of the aims, objectives and actions proposed in the draft Housing Asset Management Strategy 2022-2027 and draft Housing Resident Engagement Strategy 2022-2027.

2. Introduction and Background

2.1 It is important that Thurrock Council has a document that shares the aims and ambitions of the organisation regarding housing in the borough. The council adopted its previous Housing Strategy in 2015. It required renewal, considering changes in legislation and regulation, market trends, the impact of recent welfare reforms, and new opportunities for meeting the housing needs of Thurrock's residents. Unlike the previous strategy, it is necessary that this document also reflects the turbulence and uncertainty that resulted from the COVID-19 pandemic.

2.2 The Housing Strategy addresses the range of tenures available in Thurrock - social housing, owner-occupiers, and the private rental sector. It is important to note that this strategy will consider housing need and services in the borough and the barriers residents may face with accessing safe and secure accommodation. The Housing Strategy does not analyse options or sites for housing provision.

2.3 Developed alongside the Housing Strategy 2022-2027 were two other critical documents for the Housing service, supporting and providing supplementary information. These are:

2.3.1 The Housing Asset Management Strategy 2022-2027, which outlines the council's approach to managing, maintaining and investing in Housing assets to ensure that properties provide attractive, good quality council-owned homes for current and future residents.

2.3.2 The Housing Resident Engagement Strategy 2022-2027 which will sets the aims and ambitions of the Housing service in improving its interaction and communication with those who live in and around Thurrock Council's homes and neighbourhoods.

3. Housing Vision

3.1 Housing and health are intrinsically linked. Access to a safe, secure, stable, warm, and affordable home will provide people with a solid foundation upon which they can better protect their health and support their wellbeing. If a home is lacking any of these factors, it will have a detrimental impact on the physical health, mental health, and general wellbeing of all those in the household.

3.2 A safe home can mean many things, such as being hazard free, or maintained in line with compliancy measures such as gas servicing and electrical testing. A safe home goes beyond physical maintenance and bricks and mortar; it can also relate to a resident's perception of safety in their home and in the neighbourhood or estate in which it is located.

3.3 A secure home can refer to the security of tenure, giving residents peace of mind and stability by having that solid foundation to build their vision of a good

life, or it can again be considered in like with the perception of safety within the home from any outside harms.

3.4 The factors that determine a suitable home are wide ranging and tailored to the housing needs of each household. It can relate to the size, type, location, and accessibility of a property, but can also refer to the standard in which the property is kept, ensuring good quality accommodation is provided and that it remains well maintained.

3.5 The definition for an affordable home is also aligned with the specific needs and commitments of every household. Affordability of home is linked with many wider consequences, such as fuel poverty and impacts on physical and mental wellbeing.

3.6 Health and wellbeing run through every aspect of this strategy. This document's strategic aims and objects are rooted in the fundamental aim of tackling health inequalities through housing to support Thurrock residents to live healthy lives.

3.7 With the above detail in mind, shared below is the vision for the Housing Strategy 2022-2027:

Every Thurrock resident will have access to a safe, secure, suitable, and affordable home that meets their needs and aspirations, serving as a foundation to support their health and wellbeing.

Residents will be supported at home and in their local area through connected services, neighbourhoods, localities, and communities to achieve their vision of a 'good life'.

3.8 This vision, as well as the following Housing principles, also underpin the Housing Asset Management Strategy 2022-2027 and Housing Resident Engagement Strategy 2022-2027.

4. Housing Principles

4.1 The Housing Strategy 2022-2027 has been developed in part to set the basis for a new way of working for housing support and services in Thurrock. This strategy, the Housing Asset Management Strategy 2022-2027, the Housing Resident Engagement Strategy 2022-2027, and the new way of working all follow the below eight principles:

4.1.1 **What is important to you?**
We work in partnership with residents to understand the things that matter to them in the context of their lives and the neighbourhoods in which they live.

4.1.2 **Right time, right place and high quality**
We work to provide people with services that are high quality, easy to access, and offer appropriate support.

4.1.3 **Supports health and wellbeing**
We will relentlessly focus on reducing health inequality. We will ensure that resources are distributed in a way that accounts for variation in need at neighbourhood level

4.1.4 **Minimises bureaucracy**
The amount of resource we spend on bureaucracy is kept to a minimum ensuring maximum resources are available to provide people with the solutions they require.

4.1.5 **Local, strength based solutions**
Our solutions look to use the assets within neighbourhoods and do not consist only of the services we provide.

4.1.6 **Doesn't break the law and meets statutory duties**
We empower resident facing staff to make decisions in the context of each resident they serve rather than being constrained by thresholds and *one size fits all* service specifications.

4.1.7 **Flexible and adaptable**
We are flexible enough to respond and adapt delivery to changes in individual, neighbourhood and place circumstances

4.1.8 **Partnership working and collaborations**
Responsibility for housing is shared between individuals, neighbourhoods, our workforce and partners. We do *'with'*, not *'to'*. We constantly co-design and co-produce.

5. Housing Strategy Aims and Objectives

5.1 The four aims and their respective objectives set out in the Housing Strategy 2022-2027 will support the council in achieving its housing vision. They also align with and support the work and actions identified within the Joint Health and Wellbeing Strategy 2022-2026 as well as the Better Care Together Thurrock: The Case for Further Change strategy.

The aims of the Housing Strategy 2022-2027 are:

- Deliver Housing Support and Service
- Meet Housing Need
- Protect Resident Safety
- Strengthen Community Engagement and Empowerment

5.2 Information regarding each of these aims and their respective objectives are presented in this report. Further details regarding specific actions that have been proposed can be found within the draft Housing Strategy 2022-2027 document.

5.3 **Deliver Housing Support and Services**

5.3.1 This aim proposes a reframing of the approach taken to support households interacting with the council. Instead of viewing a set of ‘problems’ requiring resolution by disconnected teams, the Housing Strategy 2022-2027 encourages a strengths-based ‘whole person’ approach, connected within a wider system that includes adult social care, children’s services, public health, NHS partners, the wider community, voluntary and faith sector, and existing assets within the community, that can all positively support people to live healthily and well.

5.3.2 The objectives within this section of the strategy are:

- Embed a person-centred approach to housing support and services
- Develop locality and neighbourhood models for integrated housing services

5.4 Meet Housing Need

5.4.1 Identifying and understanding housing need can be complex, and any unmet need can have a significant and lasting impact on the health and wellbeing of people. This aim sets an approach to use a range of information sources to build an accurate understanding of current and future housing need, creating the evidence base for directing housing development.

This aim considers how the council can explore, understand, and address the diverse housing needs of the borough’s population. It also shares residents' priorities regarding the standard of homes in Thurrock and how homes can be developed and improved in the borough.

The development and quality of homes have direct relationships with the health and wellbeing of individuals. The adherence to suitable space standards, ample provision of affordable housing and the inclusion of appropriate green and open space in new developments will positively affect the lives of residents who will live there.

5.4.2 The objectives within this section of the strategy are:

- Identify and provide the right homes for Thurrock based on household need
- Address the housing affordability crisis in Thurrock
- Prevent homelessness and end rough sleeping in Thurrock
- Deliver sustainable estate and housing regeneration
- Review the model of Sheltered Housing provision

5.5 Protect Resident Safety

5.5.1 This aim is focused on protecting people and working to prevent them from experiencing harm to their physical and mental health. It considers the physical environment relating to property conditions, fuel poverty, property accessibility and adaptations, and harm experienced from anti-social

behaviour, crime, and domestic abuse. It also addresses and the general perception or feeling of safety in and around the home and neighbourhood.

The safety and security of residents in Thurrock are of paramount importance. They can be considered in two ways – the actions taken or required to protect physical safety and the actions taken or required to support people to feel safe. Although these are often aligned, it cannot be guaranteed that ensuring physical safety will result in a person feeling safe, and vice versa.

5.5.2 The objectives within this section of the strategy are:

- Improve warmth, safety, and standards in private sector homes
- Invest in and maintain quality council-owned homes
- Strengthen community safety and prevent anti-social behaviour
- Tackle domestic and sexual abuse and violence
- Support vulnerable adults and children
- Improve estate standards

5.6 Strengthen Community Engagement and Empowerment

5.6.1 The COVID-19 pandemic led people to experience significant periods of social isolation and separation from their friends, family, and wider support networks. It also saw communities come together, with people supporting one another through immensely challenging and testing circumstances. The collective strength and resilience showed within communities

This aim considers how relationships are built and strengthened between residents, the areas in which they live, the communities of which they are a part, and the organisations and groups that provide support and the council.

A significant ambition of this strategy is to support communities to build resilience and to broaden engagement with them. This strategy seeks to use the wider system and its networks to take an integrated approach in supporting communities, giving residents active and meaningful roles in matters that affect them in the context of housing and their estates and neighbourhoods.

5.6.2 The objectives within this section of the strategy are:

- Improve resident satisfaction and access to information
- Strengthen, integrate and diversify community and resident engagement

6 Housing Asset Management Strategy 2022-2027

6.1 Background

6.1.1 Thurrock's Housing Asset Management Strategy 2022-2027 provides a framework detailing how the council will manage, maintain and invest in its assets, ensuring that they offer quality and affordable homes for current and future residents. The strategy demonstrates how the council's housing

portfolio will meet its priorities. It provides the strategic direction for those involved in the day-to-day management of the stock and future housing asset investment decisions.

This strategy aligns with the council's corporate values, the Housing Strategy 2022-2027 and the national policy context. It works alongside the HRA Business Plan in identifying the levels and timing of investment required to ensure the asset is maintained appropriately.

6.1.2 This strategy provides a set of guiding principles that allow the council to maintain and enhance its housing stock in both the short-term and the future. It ensures the council works transparently, keeping residents engaged throughout the processes and fosters a sense of joint ownership.

This strategy also recognises that for some assets, further investment may not represent the best value or meet the community's future needs. Buildings in this category would go through an asset review process that fully considers resident views. This full appraisal of the different options will inform the most appropriate decision for the future of the asset.

6.1.3 The council's strategic ambition is to ensure the delivery of good homes in well-connected neighbourhoods. The council seeks to invest in its assets and the local environment, creating places that support and promote the health, happiness and wellbeing of residents in the borough.

New and emerging legislation around building safety, decent homes standards and the net zero carbon agenda, in conjunction with an ageing stock, place significant financial pressures on the Housing Revenue Account. It is acknowledged that the council will need to explore external funding and continue to lobby central government for additional financial support to enable it to deliver this strategy.

6.2 Housing Asset Management Strategy 2022-2027 Aims and Objectives

6.2.1 The strategy demonstrates how the council can make the housing portfolio meet its priorities and those of supporting strategies. It responds to both national and corporate priorities as well as the feedback from residents. There are three core aims that will ensure the properties continue to offer good quality homes for current and future residents at an affordable cost.

6.2.2 The aims of the Housing Asset Management Strategy 2022-2027 are:

- Deliver High Quality Homes
- Maximise the Value of Assets
- Plan for a Sustainable Future

Further details regarding specific actions that have been proposed can be found within the draft Housing Asset Management Strategy 2022-2027 document.

7 Housing Resident Engagement Strategy 2022-2027

7.1 Background

7.1.1 The Housing Resident Engagement Strategy 2022-27 sets out the aims and ambitions of the Housing service in improving its interaction and communication with those who live in and around Thurrock Council's homes and neighbourhoods.

The Housing service interacts with over 10,000 households across the borough across a broad range of services and recognises that each these households is unique. As a result of this diversity, those who access Housing services must have the opportunity for their voice and views to be listened to, not just heard.

7.1.2 The significance of meaningful engagement with residents may never have been higher than it is currently. The impact of and response to the tragedy at Grenfell Tower shows how important it is for residents and communities to be able to access information, express their views and opinions on changes, and play an active part in the way that duties are fulfilled and services are delivered by the Housing department.

This strategy aims to set the framework for future action, which is meaningful and valuable to residents and communities, reinforcing the understanding that residents and communities must be at the centre of all that the Housing service does.

7.1.3 The document seeks to establish an approach that will see resilient and respectful partnerships formed and maintained between the Housing department and those who access its services. The strategy sets aims to strengthen resident participation in the scrutiny and governance of the Housing service, which will offer greater transparency into how the Housing service operates.

Through this strategy, the Housing department lays the foundations to improve the experience residents and communities have when interacting with its services and further improve those services through continuous learning. This approach will ensure that the Housing department remains responsive, adaptable and flexible to residents' and communities broad and changing needs.

7.1.4 In developing this strategy, the Housing service has worked alongside its Excellence Panel, representing the residents who live in and around the Council's homes neighbourhoods.

7.2 Housing Resident Engagement Strategy 2022-2027 Aims and Objectives

7.2.1 Five key aims have been identified through the process of designing and developing the Housing Resident Engagement Strategy 2022-2027. Together with their corresponding objectives, an action plan will be informed that

addresses the engagement requirements set out in the regulatory framework for social housing providers and meets the engagement standards as recommended by Tpas.

7.2.2 The aims of the Housing Resident Engagement Strategy 2022-2027 are:

- Strengthen Community Engagement and Empowerment
- Protect Resident Safety and Security
- Improve Communication and Interaction
- Enable Resident Scrutiny and Participation
- Deliver Opportunities for Engagement

Further details regarding specific actions that have been proposed can be found within the draft Housing Resident Engagement Strategy 2022-2027 document.

8. Alignment with other strategic documents

8.1 The Housing Strategy 2022-2027, Housing Asset Management Strategy 2022-2027 and Housing Resident Engagement Strategy 2022-2027 were not developed in isolation.

8.2 Due to the simultaneous development of the Thurrock Joint Health and Wellbeing Strategy 2022-2026, the Local Plan and the Better Care Together Thurrock: The Case for Further Change strategy, it was possible to ensure that the development of the Housing strategies were undertaken with due regard and read across to these other key strategic documents.

8.3 Throughout the Housing Strategy reference is made to the aims and ambitions of these other documents. A significant degree of alignment has been achieved, providing a foundation for all documents to have a broader reach, greater influence, stronger acceptance and more opportunities to deliver successful outcomes than any single strategy could achieve in isolation.

9. Reasons for Recommendation

9.1 As outlined, the current Housing Strategy which has been adopted by the council, requires a refresh as it is was due for renewal in 2020.

9.2 Furthermore, the council requires documents such as the Housing Asset Management Strategy 2022-2027 to ensure that housing assets receive appropriate levels of investment to maximise the amount of good quality homes available to residents, and such as the Housing Resident Engagement Strategy 2022-2027 to ensure that the residents are empowered to have their voices heard so that services are designed and provided that are fit for purpose and meet identified needs.

10. Engagement (including Overview and Scrutiny, if applicable)

10.1 Collaboration has been a key principle in the design and development of Housing strategies presented in this report. There was an aspiration for wide-

ranging consultation to take place with a variety of key partners and stakeholders and this was achieved within the guidance and legislation in effect during the engagement period between August 2021 and January 2022.

10.2 Those that collaborated in the development of these documents include:

- Residents of Thurrock
- Community forums and resident groups
- Elected members
- Council officers from a range of services, including Housing, Adults Social Care, Children's Services, Public Health, Planning, Regeneration and Housing Development
- NHS representatives
- Housing associations
- Partner organisations
- Organisations from the voluntary sector
- Other social housing providers

10.3 Examples of engagement activity used in the development of these strategies included face-to-face and online sessions with residents, council staff, partners and key stakeholders, online surveys, statistical analysis, Teams virtual briefings and workshops, and presentations to key Council services, committees and boards.

10.4 Specific activity with members of the Housing Overview and Scrutiny Committee took place in October 2021 to ensure that all appropriate stakeholders and issues as identified by members could be included throughout the engagement period.

10.5 The draft strategic documents introduced by this report were presented to members of the Housing Overview and Scrutiny Committee on 22 June 2022. Members were asked to comment on the vision, aims, objectives and actions within the Housing Strategy 2022-2027 and the aims, objectives and actions of the Housing Asset Management Strategy 2022-2027 and the Housing Resident Engagement Strategy 2022-2027.

11. Implications

11.1 Financial

Implications verified by: **Mike Jones**

Strategic Lead Finance

Through robust financial management and assessment of plans to improve existing stock, develop new housing and deliver housing services across the borough, the council will ensure that the Housing Strategy 2022-2027, Housing Asset Management Strategy 2022-2027 and Housing Resident Engagement Strategy 2022-2027 have the appropriate resources to deliver against the objectives and actions identified through the development stages.

11.2 **Legal**

Implications verified by: **Simon Scrowther**

Litigation Lawyer

The Deregulation Act 2015 abolished the statutory requirement for English authorities to produce a housing strategy as previously required by section 87 of the Local Government Act 2003.

Meeting the Council's statutory housing obligations is reflected in the objectives of the housing strategy: statutory homelessness duty; provision of housing advice and landlord responsibilities.

The refreshed Housing Strategy 2022-2027, Housing Asset Management Strategy 2022-2027 and Housing Resident Engagement Strategy 2022-2027 will ensure that the council is enabled and empowered to deliver on its statutory duties as both a local authority and a social housing provider, especially in light of pending changes to legislation and regulation proposed through the social housing white paper.

11.3 **Diversity and Equality**

Implications verified by: **Roxanne Scanlon**

Community Engagement and Project Monitoring officer

Engagement activity took place with other public bodies, voluntary organisations, service users and other identified stakeholders during the development of this new strategy is implemented. A broad range of stakeholders throughout the community were identified and involved in the activity to develop a holistic strategy. A Community Equality Impact Assessment will be completed prior to implementation of the strategy to identify and address any issues affecting those within the protected characteristics.

11.4 **Other implications** (where significant) – i.e. Staff, Health Inequalities, Sustainability, Crime and Disorder, and Impact on Looked After Children

Not applicable

12. 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

13. Appendices to the report

- Appendix 1: Draft Housing Strategy 2022-2027

- Appendix 2: Draft Housing Strategy 2022-2027 Executive Summary
- Appendix 3: Draft Housing Asset Management Strategy 2022-2027
- Appendix 4: Draft Housing Resident Engagement Strategy 2022-2027

Report Author:

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Business Improvement - Housing

Housing Strategy

2022-2027

Thurrock Council

Chapter 1

Chapter 2

Chapter 3

Foreword

Everyone should have access to a safe, stable, secure and suitable home.

This Housing Strategy sets Thurrock Council's direction and ambitions for housing support and services for the next five years. Through this strategy, the council aims to provide a housing service that not only delivers on its targets but does so in the most human and empathetic way.

Crucially, this strategy delivers a new vision and key principles that truly place residents at the centre of all that we do. It aims to minimise bureaucracy, increase flexibility and focus more on what matters to residents.

Thurrock Council is on your side.

The council will work over the next five years and into the future to deliver housing support and services that are fit for purpose for families and individuals in the borough.

We are committed to effectively ending the need for any Thurrock resident to experience rough sleeping in our borough and will see to understand the true need for accommodation for Thurrock residents, delivering homes that people will be proud of accordingly.

We will prioritise and protect residents' safety in their homes and neighbourhoods, whether they live in a council-owned home or in the private sector, and we will work hard to ensure that all residents are empowered to have their voices heard through meaningful engagement.

I'm delighted with what our teams have managed to achieve over the past two years, despite the challenges faced.

119 new council-owned homes have been handed over and let, the number of families in out-of-borough temporary accommodation placements is at its lowest in over three years and ever-closer work between the housing service and other council departments means that more support and positive outcomes are being delivered for those who are most vulnerable in our communities.

The actions put forward in this strategy present an opportunity to go even further, with scope for major estate regeneration to provide more genuinely affordable council-owned homes, end out-of-borough placements entirely unless for safeguarding reasons or through choice, and deliver new integrated operating models in housing and with other partners to better focus on delivering the things that matter to residents in their different localities.

I look forward to seeing the successful delivery of the aims and objectives of this strategy as those within the council work closely with residents and partners across the public, private and third sectors.

Together, we can work to ensure that every Thurrock resident will have a home that meets their needs and aspirations, serving as a foundation to support their health and wellbeing and their springboard to achieve their vision of a 'good life'.

Cllr Luke Spillman
Cabinet Member for Housing

Chapter 1

Introduction

It is important that Thurrock Council has a document that shares the aims and ambitions of the organisation regarding housing in the borough.

The council adopted its previous Housing Strategy in 2015. It required renewal, considering changes in legislation and regulation, market trends, the impact of recent welfare reforms, and new opportunities for meeting the housing needs of Thurrock's residents. Unlike the previous strategy, it is necessary that this document also reflects the turbulence and uncertainty that resulted from the COVID-19 pandemic.

The Housing Strategy addresses the range of tenures available in Thurrock - social housing, owner-occupiers, and the private rental sector. It is important to note that this strategy will consider housing need and services in the borough and the barriers residents may face with accessing safe and secure accommodation. The Housing Strategy does not analyse options or sites for housing provision.

Corporate Context

Vision and Priorities

The Housing Strategy is underpinned by Thurrock Council's vision and corporate priorities, adopted in January 2018. The council's vision is for Thurrock to be **an ambitious and collaborative community which is proud of its heritage and excited by its diverse opportunities and future.**

Sitting alongside the vision are the three corporate priorities of People, Place and Prosperity.

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 together to improve health and wellbeing
- communities are empowered to make choices and be safer and stronger together

The Housing Strategy must appropriately address and meet the challenges set within this priority. Resilient partnerships across sectors and empowered communities are integral to any Housing Strategy's meaningful development and success. They will ensure that services consistently meet and reflect those who use them.

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

This means:

- 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

While the housing service has specific responsibility for maintaining and developing homes and neighbourhoods managed by the council, this document goes beyond council-owned stock to consider all tenure types. This strategy will improve understanding of households' strengths and needs across the borough, identifying the requirements for homes and infrastructure that will support current and future Thurrock residents.

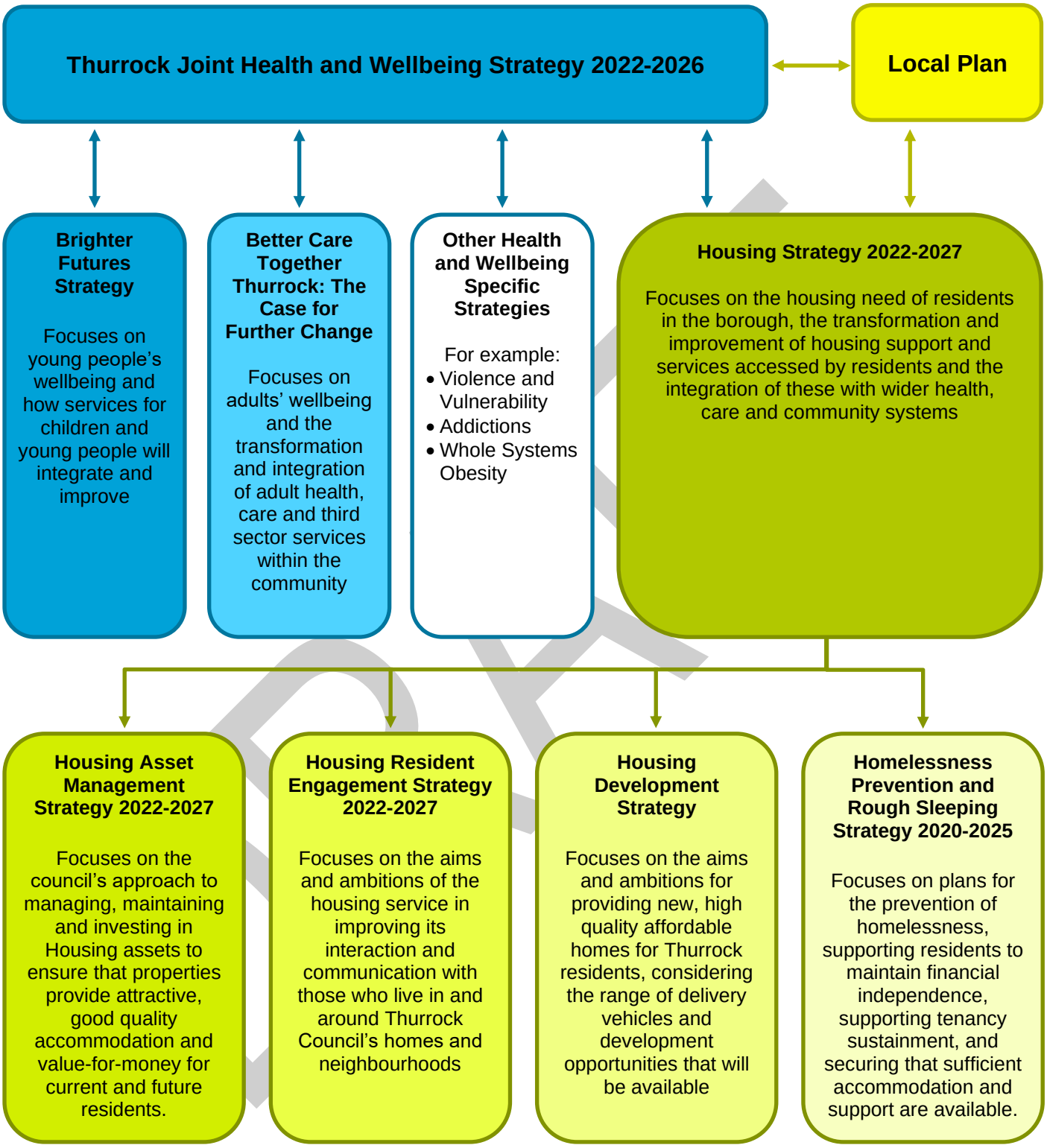
Prosperity – a borough which enables everyone to achieve their aspirations.

This means:

- 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

The Housing Strategy aims to deliver opportunities for residents to achieve their aspirations, including accessing skills training with partner organisations. The strategy also seeks to expand relationships with other housing providers to increase affordable housing levels in the borough.

Strategic Context



Thurrock Joint Health and Wellbeing Strategy 2022-2026

The Thurrock Joint Health and Wellbeing Strategy 2022-2026 is the highest-level strategic document that describes our collective plans to improve the health and wellbeing of residents. The theme of the strategy is *Levelling the Playing Field,* and the strategy sets out high level actions to address health inequalities across the six domains of:

- Healthier for Longer including mental health
- Building Strong and Cohesive Communities
- Person Led Health and Care
- Opportunity For All
- Housing and the Environment
- Community Safety

The Joint Health and Wellbeing Strategy therefore addresses the wider determinants of health including education, employment, crime and community safety, and housing, as well as healthy lifestyles and health and care. It concentrates on the 'what' and the 'why' and points to additional more detailed and topic specific strategies that deal with delivery of individual objectives (the 'how').

As housing and the environment features as a domain of health inequality in the Joint Health and Wellbeing Strategy, there is a strong link with the aims and objectives of this Housing Strategy. Both documents will drive forward positive improvements for the health and wellbeing of Thurrock residents.

Thurrock Local Plan

The local plan sets a vision and framework for the future development of Thurrock, drawn up by the local planning authority with wider engagement and consultation with the community. Once in place, the local plan becomes part of the statutory development plan. The statutory development plan for the area is the starting point for determining local planning applications.

A local plan can consist of either strategic or non-strategic policies, or a combination of the two.

The local plan addresses many issues affecting local people. There are policies that cover spatial development issues in relation to education, health, community safety, energy management, sustainable development, climate change and flood management. It also contains policies on more traditional, but important, planning activity such as housing, employment, leisure and sport, natural and historic environment, and community facilities.

Where the Housing Strategy sets strategic aims and objectives regarding housing need, the local plan supports the practicalities of providing new homes, through the identification for sites and areas where development is permitted and the creation of planning policy that meets priorities in the borough. The housing strategy will feed into the development of the new local plan, ensuring alignment.

Better Care Together Thurrock: The Case for Further Change

The *Case for Further Change* strategy sets out a collective plan to transform, improve and integrate health, care and third sector services aimed at the borough's adults and older people to improve their wellbeing. It has been developed and agreed by the Thurrock Integrated Care Alliance (TICA) and its partner organisations. Partners across Thurrock have a long history of working together to agree and deliver shared outcomes.

The *Case for Further Change* proposes a transformation from the current system architecture and ways of working to move instead towards integrated locality teams. It intends to create a single Integrated Locality Network of professionals who will be able to collaborate more easily and effectively with each other, and with residents. The overall aim is to embed the maximum amount of care and support at locality and neighbourhood level within a multi-disciplinary network of staff who can collaborate to design integrated solutions with residents rather than make onward referrals.

Backing Thurrock: A five year strategy for economic recovery, resilience and a return to growth

The Backing Thurrock Strategy sets out actions that will help the council to strengthen and grow the economy through supporting major strategic projects such as the Thames Freeport, improving skills within the workforce, helping businesses to become more productive and competitive and delivering economic infrastructure. It a key element of the council's response to the COVID-19 pandemic.

Alongside the Local Plan, *Backing Thurrock* will form the strategic framework to drive the borough's return to growth and has been developed in collaboration with public, private, and voluntary sector organisations.

It aims to shape a strong economy where residents and businesses are helped to focus on their strengths and adapt to take advantage of new opportunities such as the Thames Freeport as growth resumes. Priorities include green growth, continued investment in broadband and helping the most vulnerable in the community tackle issues, develop their skills and find work.

South Essex Strategic Housing Market Assessment 2022

This document provides an assessment of housing need in Thurrock in partnership with neighbouring authorities. It identifies the scale and mix of housing and the range of tenures that the local population is likely to need over the duration of the Local Plan period. It allows the council to understand household and population projections and the requirements for distinct types of housing, including affordable housing and those that will meet the needs of diverse groups.

Healthy Housing for the Third Age: Improving Older People's Health through Housing - Annual Public Health Report 2018/2019

Housing is widely accepted to be a key determinant of health and can impact positively and negatively on an individual's physical and mental health, in turn affecting the demand for and use of health and social care resources. The annual public health report from 2018/2019 aimed to answer the following questions for the population aged 65+:

- What impact will demographic change have on the needs for new and existing housing stock across all tenures in the next 20 years?

- What types of housing do our elderly population want and what are the impacts of choosing to move to a home more suitable for later life?
- When considering a move to more suitable housing, what would make the option attractive to our elderly population?
- What impacts does housing have on health and how can we enhance the positives and mitigate against the negatives? And how can we ensure they are better understood by those affected, thereby enabling them to better care for themselves?

Youth Violence and Vulnerability: The Crime Paradox and a Public Health Response - Annual Public Health Report 2019/2020

The 2019/2020 annual public health report focused on the issue of serious youth violence and urban street gang activity, using the Public Health Approach methodology to identify and address the vulnerabilities of the young people concerned. It considered issues such as:

- Serious youth violence against the person including assault, serious assault, actual bodily harm, grievous bodily harm, stabbing/knife crime and gun crime and street robbery.
- Urban street gangs including gang related violent crime and drug related crime
- Local drugs markets
- County Lines
- Child criminal exploitation through gangs

Collaborative Communities Framework

Thurrock's *Collaborative Communities Framework* encapsulates our strengths and assets-based approach to how we work with communities. Co-produced via our *Stronger Together* partnership over three years, the framework sets out how we will work and enable our communities to co-design and influence decisions, address their own challenges and realise their own ambitions. It recognises the importance of the council (and partners) reducing the red-tape that often hinders community-led action, devolving power and enabling different ways of working so that communities alongside statutory partners and the third sector are better enabled to achieve locally determined outcomes and outcomes that make a significant impact on the individual's quality of life.

Opportunity for all: Single Equality Scheme and Corporate Equality Framework

This framework sets out the council's commitment to helping to build pride, responsibility and respect with residents and employees, promoting equality and embracing the diversity of Thurrock's communities.

Chapter 2

Vision, Principles, Aims and Objectives

Housing Vision

Every Thurrock resident will have access to a safe, secure, suitable, and affordable home that meets their needs and aspirations, serving as a foundation to support their health and wellbeing.

Residents will be supported at home and in their local area through connected services, neighbourhoods, localities, and communities to achieve their vision of a 'good life'.

Housing and health are intrinsically linked. Access to a safe, secure, stable, warm, and affordable home will provide people with a solid foundation upon which they can better protect their health and support their wellbeing. If a home is lacking any of these factors, it will have a detrimental impact on the physical health, mental health, and general wellbeing of all those in the household.

A safe home can mean many things, such as being hazard free, or maintained in line with compliancy measures such as gas servicing and electrical testing. A safe home goes beyond physical maintenance and bricks and mortar; it can also relate to a resident's perception of safety in their home and in the neighbourhood or estate in which it is located.

A secure home can refer to the security of tenure, giving residents peace of mind and stability by having that solid foundation to build their vision of a good life, or it can again be considered in like with the perception of safety within the home from any outside harms.

The factors that determine a suitable home are wide ranging and tailored to the housing needs of each household. It can relate to the size, type, location, and accessibility of a property, but can also refer to the standard in which the property is kept, ensuring good quality accommodation is provided and that it remains well maintained.

The definition for an affordable home is also aligned with the specific needs and commitments of every household. Affordability of home is linked with many wider consequences, such as fuel poverty and impacts on physical and mental wellbeing

Health and wellbeing run through every aspect of this strategy. This document's strategic aims and objects are rooted in the fundamental aim of tackling health inequalities through housing to support Thurrock residents to live healthy lives.

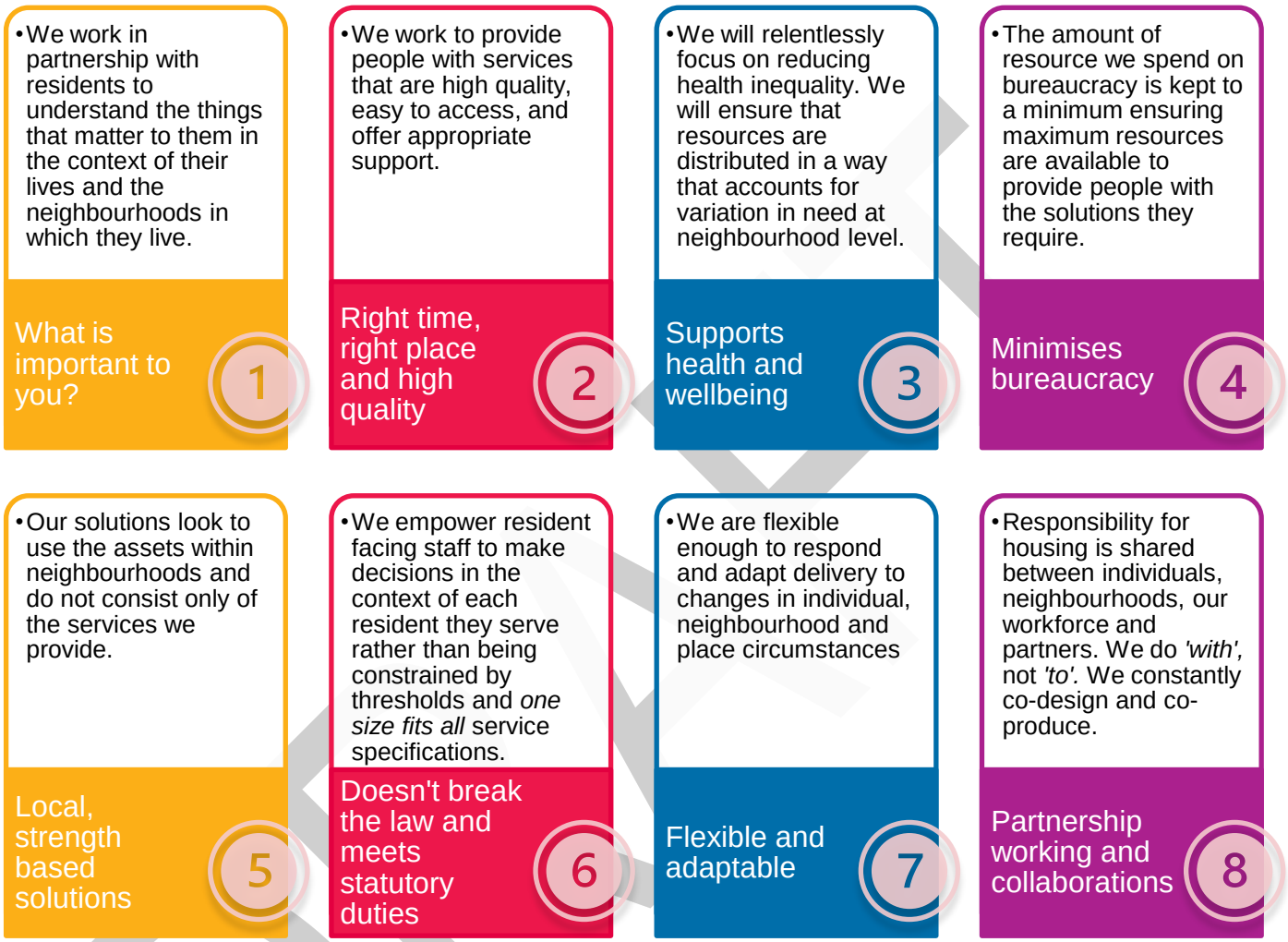
The vision for the Housing Strategy 2022-2027 is aligned with the aims of Domain 5 – Housing and the Environment within the Health and Wellbeing Strategy 2022-2026, outlined below:

Fewer people will be at risk of homelessness, and everyone will have access to high quality affordable homes that meet the needs of Thurrock residents.

Homes and places in Thurrock will provide environments where everyone feels safe, healthy, connected and proud.

Housing Core Principles

This Housing Strategy has been developed in part to set the basis for a new way of working for housing support and services in Thurrock. This strategy and the new way of working follow the below eight principles:



Housing Aims and Objectives

The aims and objectives set out in this strategy will support the council in achieving its housing vision. They also align with and support the work and actions identified within the Joint Health and Wellbeing Strategy as well as the Better Care Together Thurrock: The Case for Further Change strategy.

Deliver Housing Support and Services

- Embed a person-centred approach to housing support and services
- Develop locality and neighbourhood models for integrated housing services

Meet Housing Need

- Identify and provide the right homes for Thurrock based on household need
- Address the housing affordability crisis in Thurrock
- Prevent homelessness and end rough sleeping in Thurrock
- Deliver sustainable estate and housing regeneration
- Review the model of Sheltered Housing provision

Protect Resident Safety

- Improve warmth, safety, and standards in private sector homes
- Invest in and maintain quality council-owned homes
- Strengthen community safety and prevent anti-social behaviour
- Tackle domestic and sexual abuse and violence
- Support vulnerable adults and children
- Improve estate standards

Strengthen Community Engagement and Empowerment

- Improve resident satisfaction and access to information
- Strengthen, integrate and diversify community and resident engagement

Chapter 3 – Background and Context

Legislative and Regulatory Framework

The Housing Strategy has been developed within and reflects current legislation and regulation.

Legislation

Thurrock Council has many housing duties and responsibilities, with only some of these relating to its role as a social housing provider. The council has duties towards homelessness prevention and relief, enforcing property standards and licensing in the private rental sector, and strategic assessments of the borough's current and future housing needs.

At the time of writing this strategy, there a number of new acts and proposed bills that will affect the way that housing support and services are provided during the expected lifetime of this strategy.

Domestic Abuse Act 2021

The Domestic Abuse Act aims to raise awareness and understanding about the impact of domestic abuse on victims and their families. It intends to further improve the effectiveness of the justice system in providing protection for victims of domestic abuse and bringing perpetrators to justice. It also aims to strengthen the support for victims of abuse by statutory agencies.

Fire Safety Act 2021

The Fire Safety Act places additional duties on responsible persons for multi-occupancy residential buildings, with the legal responsibility of proactively identifying potentially dangerous external wall systems and other structural issues and putting in place measures to deal with them. Responsible persons must make sure that they are up to date with government guidance regarding dealing with dangerous external wall systems and, where necessary, that they engage with competent fire safety professionals to make sure the steps they are taking are suitable and sufficient to deal with the risks posed.

Building Safety Bill

The objective of the Building Safety Bill is to strengthen the overall regulatory system for building safety. It aims to establish a comprehensive new building safety regime concerning the design, construction, and occupation of higher-risk buildings. It aims to achieve this by ensuring there is greater accountability and responsibility for the design and construction of buildings, as well as throughout the lifecycle of buildings.

Social Housing Regulation Bill

The Social Housing Regulation Bill aims to deliver against the commitments made in the social housing white paper for those who live in poor quality social housing. It makes provision for residents to be given performance information so landlords can be held to account and aims to ensure that when residents make a complaint, landlords take quick and effective action to put things right.

In general, new legislation, and in particular new regulation, bring new duties, responsibilities, and burdens on the council. This can pose a risk due to the need to understand and implement measures correctly. Such activity can cause confusion and distraction from service delivery during initial rollout and embedding, and new reporting requirements can be cumbersome and resource intensive. The effective use of technology and analytics applications can go a long way to reducing the level of manual effort required in such circumstances.

The full impact of new regulation and legislation cannot be completely understood until sometime after implementation. However, changing legislation and regulation also provide opportunities to better meet the needs of residents, and in the longer term should improve the level of service and support offered. New legislation can tackle long-standing issues that prevent positive outcomes for residents, as evidenced through the changes introduced by the Domestic Abuse Act.

The list below is not exhaustive; however, it indicates other significant legislation that set the council's housing responsibilities.

- Landlord and Tenant Act 1985
- Housing Act 1985
- Housing Act 1996
- Housing Grants, Construction and Regeneration Act 1996
- Local Government Act 2000
- Homelessness Act 2002
- Housing Act 2004
- Equality Act 2006
- Housing and Regeneration Act 2008
- Localism Act 2011
- Welfare Reform Act 2012
- Housing and Planning Act 2016
- Welfare Reform and Work Act 2016
- Homelessness Reduction Act 2017
- Homes Fit for Human Habitation Act 2018

Regulation

At present, the Regulator of Social Housing has set four consumer standards and will intervene where failure to adhere to the standards has caused or would risk causing serious harm to tenants. As a social housing provider, the council must adhere to these standards.

The four consumer standards are:

- Homes Standard
- Neighbourhood and Community Standard
- Tenancy Standard
- Tenant Involvement and Empowerment Standard

The Regulator of Social Housing has also set three economic standards. However only the rent standard is currently applicable to the council as a local authority. This standard establishes the maximum weekly social and affordable rents that social landlords can charge.

There are current proposals to introduce a Social Housing Regulation Bill, which would deliver changes to the consumer regulation of social housing. It would strengthen the accountability of landlords for providing safe homes, quality services and treating residents with respect. It would also implement some specific changes to the economic regulation of social housing. These are likely to be introduced during the lifetime of the Housing Strategy 2022-2027.

National Context

The housing landscape is ever-changing, impacted by alterations to government policy, periods of economic change, noteworthy events in the housing sector and other national influences.

Whilst Thurrock does have localised challenges, some of which are outlined in the next section, the strategic approach towards housing in the borough is equally affected by the national context.

The Charter for Social Housing Residents: Social Housing White Paper

In late 2020 the Government published its social housing white paper, The Charter for Social Housing Residents. Within this document, the Government set out its intentions to ensure that residents in social housing are safe, listened to, live in good quality homes, and have access to redress when required.

The charter outlines the following seven elements that every social housing resident should be able to expect:

- to be safe in your home
- to know how your landlord is performing
- to have your complaints dealt with promptly and fairly
- to be treated with respect
- to have your voice heard by your landlord
- to have a good quality home and neighbourhood to live in
- to be supported to take your first step into ownership

Further to establishing these aspects, the Government announced plans to strengthen the Regulator of Social Housing. It aims to empower the regulator to be proactive in monitoring and enforcing the consumer standards that social housing landlords are held to, and requiring landlords to:

- be transparent about their performance and decision-making so that tenants and the regulator can hold them to account
- put things right when they go wrong
- listen to tenants through effective engagement

Whist the white paper outlines these intentions, the timelines for implementing all the policies and measures announced in the document remain unclear. However, there is now progress regarding the Social Housing Regulation Bill, and steps have been taken regarding building safety.

It is expected that the Government will undertake periods of engagement and consultation and introduce legislation during the lifetime of the Housing Strategy 2022-2027. However, the housing service has already begun to work proactively to ensure that the council is in a strong position to meet and address the white paper proposals as more information becomes available regarding implementation.

Building and Fire Safety

The Grenfell Tower Fire on 14 June 2017 brought both fire and building safety into sharp focus for housing providers, building managers and residents of high-rise properties across the country. The tragedy triggered a wave of activity, such as tenant engagement roadshows by housing ministers, the development of a social housing green paper, and the commissioning of a review of building regulations and fire safety led by Dame Judith Hackitt.

Published in May 2018, *Building a Safer Future: Independent Review of Building Regulations and Fire Safety* set out over 50 recommendations for government to improve and strengthen regulation in the sector.

The report identified many areas of failure within the existing system. It made recommendations to introduce a new regulatory framework, strengthen enforcement powers to ensure safety, and define better the role of duty holders with responsibility for the safety of a whole building.

In addition, the report drew particular attention to the importance of engaging with residents, strategies for engagement, and ensuring that residents had access to information and involvement in decision making.

The report also highlights the strength of structured engagement through residents' associations and tenant panels and the need for cultural change in the relationship between landlords and residents.

The council's duties and obligations relating to building and fire safety are likely to be broadened in the coming months and years due to the progression of the Building Safety Bill and the commencement of the Fire Safety Act 2021. As such, the Housing Strategy must respond to these and flex with any newly introduced duties or responsibilities.

Climate and Sustainability

The Climate Change Act 2008 set a target in legislation to reduce UK emissions of carbon dioxide and other greenhouse gasses to net-zero by 2050. More recently, measures have been introduced to support this aim, such as the intention to phase out gas-fired boilers in new properties by 2035 and increase the use of electric vehicles across the country by mandating that all new homes must have charging points provided.

In October 2019, Thurrock Council passed a motion whereby it declared a climate emergency and set out to take urgent action to reduce its carbon emissions to net-zero by 2030. Initial plans are being developed to respond to the climate crisis by ensuring that council operations are carbon-neutral by this time. As a social housing provider with around 10,000 properties in its stock, to achieve net-zero by 2050, many significant financial and logistical challenges will need to be addressed.

COVID-19 and Housing

Concerns remain across the Housing sector that the impact of the COVID-19 pandemic on housing and homelessness has not yet fully emerged.

Initiatives such as 'Everyone In' and the Coronavirus Job Retention Scheme, and legislation to temporarily ban evictions and extend eviction notice periods, provided some stability and security

to households during significant uncertainty throughout much of 2020 and 2021, but these were not permanent resolutions.

With these temporary protections now removed and considering growing inflation levels and household costs, there are fears of a surge of households experiencing financial hardship and, therefore, at risk of homelessness. The full extent of the impacts on the private rental sector and the broader housing market in Thurrock is uncertain; however, the Housing Strategy aims to consider these factors to adapt and respond in the event of any such spike.

Levelling Up White Paper

The Levelling Up White Paper outlines 12 'missions across four broad areas with the aim to reduce inequality and transform the UK by spreading opportunity and prosperity. These areas are:

- boosting productivity and living standards by growing the private sector, especially in those places where they are lagging
- spreading opportunities and improving public services, especially in those areas where they are weakest
- restoring a sense of community, local pride and belonging, especially in those places where they have been lost
- empowering local leaders and communities, especially in those places lacking local agency.

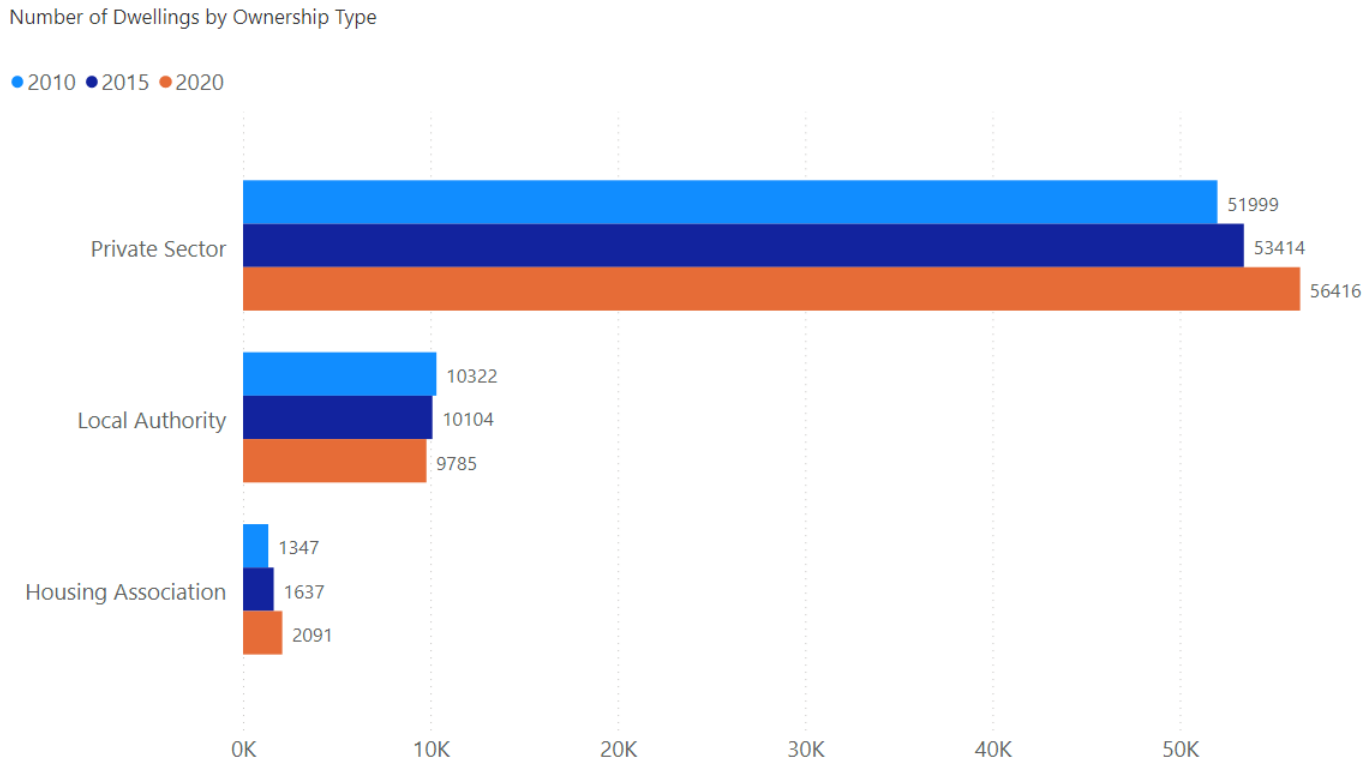
It also sets an aim under mission 10 that by 2030, renters will have a secure path to ownership with the number of first-time buyers increasing in all areas and an ambition for the number of non-decent rented homes to have fallen by 50%, with the biggest improvements in the lowest-performing areas.

Local Context

Housing Tenure Mix in Thurrock

This section of the strategy provides information on the current housing landscape in Thurrock, setting out estimates of the tenure mix in the borough and outlining the shifting distribution of tenure types over time.

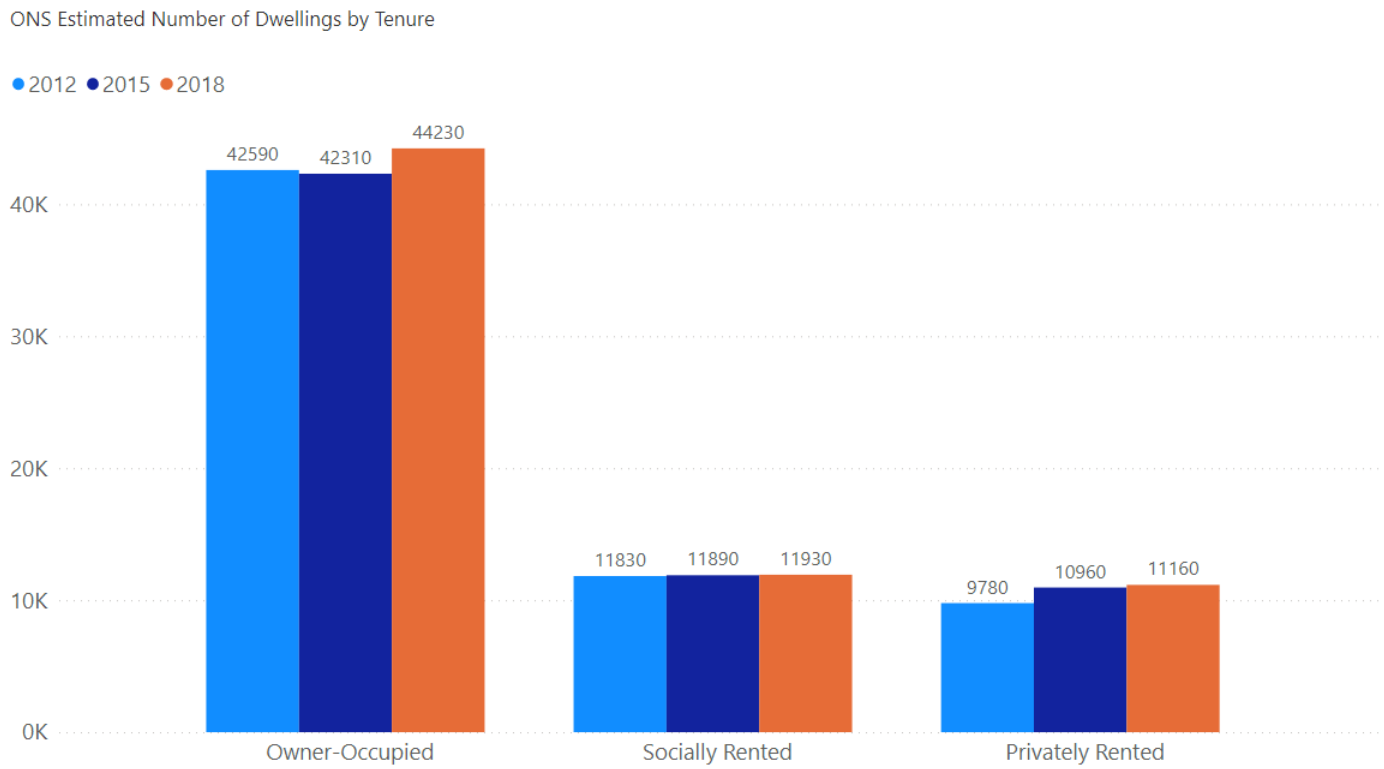
The chart below provides estimates of the number of dwellings in Thurrock, broken down by ownership type.



This chart illustrates a net reduction in the number of properties owned by the local authority; however, an increase can be observed in the number of properties owned by housing associations (also known as private registered providers of social housing or registered social landlords).

The chart also indicates an increase in the number of privately owned dwellings in Thurrock. These figures, published by the Department for Levelling Up, Housing and Communities (DLUHC), do not provide any details to determine which privately owned dwellings are owner-occupied or used in the private rental sector.

Alternative estimates by the Office for National Statistics (ONS) indicate the split between privately rented properties and those occupied by the owner. It should be noted that these are not official statistics, but they do provide an illustrative figure for comparison. In this chart, socially rented refers to the combined number of dwellings owned by the local authority and those owned by housing associations.



These figures show that all tenures saw net increases in the number of dwellings between 2012 and 2018; however, the proportion of owner-occupied and socially rented properties fell during this period. Conversely, the proportion of properties in Thurrock being used in the private rental sector increased significantly.

Although both charts above are presented as estimates, they confirm that there has been an increase in the number of dwellings in Thurrock and appear to support the anecdotal evidence that recent years have seen an increase in the number of private rental sector properties in the borough.

During Census 2021, a range of tenure and housing-related data was collected. Once this has been published, it will be possible to reconcile these estimates against accurate figures provided through the Census activity. The ONS aim to confirm the final release schedule in February 2022.

Affordability

Affordability of accommodation in Thurrock is an ongoing challenge, both in the private rental sector and for those aiming to purchase properties.

Further detail outlining the affordability crisis in the borough is explored in Chapter 4 of this strategy.

Social Housing Provision

In Thurrock, the council is the primary provider of social housing. Based on data published by MHCLG (now DLUHC), as of 31 March 2020, it was estimated that 14.3% of dwellings in Thurrock were owned by the council, with other registered providers of social housing owning less than 3.1% of homes in the borough.

The impact of these figures means that for every 47 council-owned dwellings, there were 10 registered provider-owned dwellings, representing the fifth-lowest ratio for stock-retaining local authorities in England at the time of writing.

Although the number of registered provider-owned dwellings has been increasing over time, this imbalance has led to additional pressure and demand on Thurrock Council from households as it is seen to be the primary provider of affordable accommodation in the borough.

Thames Freeport

It was announced in October 2021 that the Thames Freeport, one of eight announced in the UK, would be able to commence operations. It is anticipated to deliver transformational change across the entire borough, creating thousands of new jobs and attracting substantial investment into Thurrock over the next 25 years.

The successful delivery of the Thames Freeport in Thurrock is expected to contribute significantly to achieving wider place agenda ambitions. It will bring together physical, economic, social, and environmental renewal to improve the wellbeing of communities, provide opportunities and help ensure places are fit for the future.

The expected creation of jobs is likely to impact housing need in the local area. As the Thames Freeport develops and progress on the Local Plan continues, it is expected that this impact can be quantified, and measures identified to address housing need.

Purfleet-on-Thames

Purfleet Centre Regeneration Limited is a joint venture between Urban Catalyst and Swan Housing in partnership with Thurrock Council to regenerate over 140 acres to create Purfleet-on-Thames.

Developed on healthy town principles, Purfleet-on-Thames will create a new waterfront destination on the River Thames; an international create hub and high quality new residential with place making at its core. The vision for Purfleet-on-Thames includes:

- A state-of-the-art film and TV studio facility and related creative industry hub
- Attractive new waterfront commercial and retail space
- Up to 2,850 new homes, including significant health and education facilities
- Community facilities
- Leisure uses
- Upgraded and additional public transport facilities

Lower Thames Crossing

National Highways proposes building a new Lower Thames Crossing that will include a major highway through Thurrock. Project proposals include two new 2.5-mile tunnels under the River Thames, 14.5 miles of new road and the construction and alteration of structures, including bridges, buildings, utilities, and tunnels.

The proposals for the Lower Thames Crossing have been assessed as directly and substantially compromising the ability to meet the need for new housing in Thurrock in a sustainable manner. It would lead to the direct loss of approximately 20 existing dwellings, and it is estimated that 1,400 homes would be affected by blight.

The impact on local housing would not only be affected upon completion of the project. During the construction phases of the Lower Thames Crossing, there will be the need for accommodation for over 900 workers involved with the construction of the northern parts of the project in Thurrock. It is expected that this need would be met through a combination of rented properties visitor accommodation such as hotels and owner-occupied homes. This would significantly increase demand and may negatively impact affordability and supply for Thurrock residents and may be a matter of significant concern should the Lower Thames Crossing construction project be awarded a Development Consent Order.

Chapter 4

Deliver Housing Support and Services

This chapter proposes a reframing of the approach taken to support households interacting with the council. Instead of viewing a set of ‘problems’ requiring resolution by disconnected teams, the Housing Strategy encourages a strengths-based ‘whole person’ approach, connected within a wider system that includes adult social care, children’s services, public health, NHS partners, the wider community, voluntary and faith sector, and existing assets within the community, that can all positively support people to live healthily and well.

Embed a person-centred approach to housing support and services

Context

Thurrock residents approach and interact with council services, delivery partners and other organisations regarding a range of housing-related matters every day. Whilst all will aim to help achieve positive outcomes or resolve any presented issues that fall within their defined remit, the current approach can create barriers to success as few challenges can be appropriately addressed by any one party in isolation.

Homelessness, for example, cannot be addressed in Thurrock solely by the housing service of the council – it requires far greater collaboration and partnership. It also requires all those working alongside individuals and households to see 'whole human beings' with their strengths, which may have further needs beyond the lack of a safe, secure or suitable home.

This strength-based 'whole person' approach should be embraced and adopted by those working with residents in the borough, considering all the elements and factors that may have contributed to their experience.

Rather than responding to people approaching the council as a collection of fragmented teams and services, each trying to tackle their own 'problem', it is intended that we move in a direction where parties are connected and operating within a wider system beyond traditional organisational boundaries. Housing forms one part of this, alongside others such as adult social care, children's services, public health, NHS partners, the wider community, voluntary and faith sector, and existing assets within the community.

When viewing an individual or household through the lens of a wider system, greater opportunities are available for the coordination of more holistic approaches to support relating to their housing need and other personal circumstances, which also complement their strengths.

A key focus within the housing service and with those the council engaged with in the development of this strategy is tenancy sustainment – supporting those who may find it difficult to maintain their tenancy or risk losing their home for whatever reason. The factors affecting the health of a tenancy can be complex. A 'whole person' approach adopted within a wider housing system allows the opportunity to explore underlying causes for the vulnerability of the tenancy and work together to implement appropriate early interventions to reduce the risk of that household reaching the point of crisis.

As teams and services operate within this broader system, every interaction with a resident or household will present an opportunity for continuous engagement, learning, and improvement. This can be in the context of supporting those individuals by learning about the barriers preventing positive outcomes and designing ways to overcome them, or by identifying systemic issues through shared experience and practice that would require wider resolution.

Impact

The current system fragmentation impacts the ability to work with residents and reach positive health, wellbeing and housing outcomes, ultimately affecting resident aspirations to achieve their vision of a good life.

The impact of current ways of siloed working explored above impacts upon residents achieving what matters to them due to referrals, handoffs, thresholds, and inefficiency in existing processes.

This inefficiency and disconnection between those working to support Thurrock residents leads to a greater number of uncoordinated interventions, increases levels of failure demand and further underlines ineffective uses of available resources.

Available support provision is currently based on previous professional experience, rather than fully considering the needs and strengths of individuals or what the community is available to offer without reliance on formal services.

By moving in a direction where support and services exist within a person-centred system offering a truly 'human' approach, residents will be empowered to be able to achieve more of what matters to them and reach their version of a good life.

This approach will improve working relationships, knowledge sharing and positive outcomes across the system.

Support will be provided in collaboration with the community and focuses first and foremost on what the community can offer. Residents will maximise opportunities to stay as healthy as possible, require fewer interventions from services and achieving better outcomes as a result.

Importantly, residents will be able to find the right solution for them, first time and in the right place, mitigating against the risks and detrimental impacts of crisis and driving down the cost of failure demand experienced by individuals and organisations.

Recent action

Many of the most successful areas of transformation in Thurrock are already operating using person-centred system principles. These include the council's Local Area Coordinators, Community Led Solutions, Community Builders, Wellbeing Teams, and Integrated Primary and Community Mental Health Care.

These teams are delivering better outcomes for residents by freeing frontline staff from pre-defined service specifications, KPIs and bureaucracy. Instead, they are empowered to co-design bespoke solutions with residents, responding to individual context.

The housing service has started to develop and embed person-centred approaches into the way staff work with and support residents, including pilots in the Housing Operations and Housing Solutions service areas.

Action Plan

What?	How?	Impact?
We will embed the housing core principles and person-centred approach to housing services in service provision in order to provide tailored and bespoke support to residents	We will launch test and learn pilots in the housing operations and housing solutions services to develop the person-centred approach to housing We will take the learning from these pilots to inform and implement a plan to embed person-centred principles across the wider housing service	Residents will be experience support that is bespoke, tailored and co-designed to meet their specific circumstances and needs Residents will benefit from housing services that focus on prioritising the things that matter in order for residents to achieve their vision of a good life above all else

What?	How?	Impact?
We will reduce bureaucracy in order to deliver outcomes that matter to residents at pace	We will minimise delays due to service eligibility thresholds and management decision-making wherever possible by devolving decision making authority and accountability to resident facing staff	Residents will receive quicker outcomes, removing the frustration and anxiety experienced through protracted referral or decision-making pathways
We will adopt a whole system approach to supporting residents in order to reduce fragmentation and duplication of services	We will explore the system from a housing perspective through the test and learn pilots. We will use this learning to identify where duplication exists in the wider system and find opportunities for where effective coordination can lead to better outcomes for residents	Residents will experience greater opportunities for the coordination of more holistic approaches to support relating to their housing need and other personal circumstances which also complement their strengths

Develop locality and neighbourhood models for integrated housing services

Context

Housing support, much like public services more broadly, is often fragmented into specific areas that each focus on resolving single ‘problems’. However, people want to be recognised and supported by a system that views them as a complex individual aiming to achieve their vision of a good life.

Thresholds and eligibility criteria exist across the public sector, and housing support and services are no exception. Support may only be provided to those identified as ‘eligible’, and that support is often standardised and focussed solely on one single need, determined on a borough-wide level.

People are likely to have multiple interconnected needs that would benefit from the support of multiple teams or organisations, but the current approach to obtaining that support is often lengthy, fragmented and features with elements of duplication. Support is often provided through formal services when community organisations and assets may already exist to be able to meet these needs.

During the time that an individual attempts to navigate referral pathways and evidence their eligibility, it is highly likely that the need for housing support will become greater. This in turn will exacerbate any other connected or related support need, driving the individual towards crisis rather than prevention or early intervention.

This way of working increases rather than manages demand. It increases bureaucracy, costs, delays and wasted resource and has negative impacts on those seeking support as well as those providing it.

Impact

Thurrock requires a system that people can access at any point, mostly from within their local community, to get the support they require. This support must be coordinated and focused on achieving what matters most to them. Those providing a service must work together in the community and with the community to deploy resources effectively, overcome organisational boundaries, navigate unhelpful process and bureaucracy, and deliver an integrated bespoke solution. Resource must be used collectively, with solutions provided incorporating community assets, technology and provision that is creative and diverse.

The *Better Care Together Thurrock: Case for Further Change* strategic document seeks to address this issue, primarily from a health and care perspective, however it combines this with a broader view to also include other areas that can affect (or can be affected) by these needs. One such area relates to housing.

The *Case for Further Change* proposes a transformation from the current system architecture and ways of working to move instead towards integrated locality teams. It intends to create a single Integrated Locality Network of professionals who will be able to collaborate more easily and effectively with each other, and with residents. The overall aim is to embed the maximum amount of care and support at locality and neighbourhood level within a multi-disciplinary network of staff who can collaborate to design integrated solutions with residents rather than make onward referrals.

The *Case for Further Change* suggests the incorporation of specific housing services into these Integrated Locality Networks, and the Housing Strategy 2022-2027 supports this intention.

Recent action

Thurrock has a team of Local Area Coordinators (LACs), each aligned to specific localities and neighbourhoods within the borough. The primary role of the LAC is to develop a detailed understanding of community assets, networks, services, organisations and groups within their area, but also more broadly across the borough. LACs then work with residents to find pragmatic solutions to problems, drawing on these community resources before considering commissioned or statutory services.

The service always starts with the question “What does a good life mean to you?”, making it holistic and bespoke. Instead of simply assessing or referring residents into services they:

- invest enough time in understanding what a good life looks like to the individual or family, and how they could get there
- help people to build their own capacity and connections, so that they can stay strong and independent
- build new community connections or capacity where they do not exist

LACs work in a truly integrated way and are able to navigate across services and organisations to find solutions and overcome barriers with the aim of preventing people from reaching crisis.

Community Led Support (CLS) is an approach to social work that means that social work teams build networks with other professionals within a specific locality so that they can be mobilised to provide a joined-up response, rather than one that purely considers adult social care needs.

Teams are based in the community and aligned with the four Primary Care Network (PCN) areas. These teams work solely within their locality, based out of a number of different community settings.

The approach representatives a radical departure from traditional social work models based on assessing deficits and prescribing commissioned services.

CLS has been successful with numerous case studies showing how people have been effectively supported in a different way. Early successes have included reduced waiting times, improved access – with regular ‘drop in’ sessions being organised close to where people live and working with other professionals and organisations in the area, including community-based groups and the community, voluntary and faith sector, to develop innovative and streamlined ways of delivering what people required and how they required it.

The learning from LAC and CLS has provided a blueprint for redesigned local integrated care and support. Such approaches do not rely on thresholds and eligibility before they help someone. They identify what the person requires to live a good life, and in doing so, they help to put in place a plan that focuses on preventing that person’s health and wellbeing from declining.

Both CLS and LAC initiatives have shown the power of place-based working and of taking time to have conversations with people that focus on what matters to them. This has led to very different solutions being developed, many of which have prevented and reduced the need for services or helped to reduce the reliance on a service response.

Action Plan

What?	How?	Impact?
We will develop a neighbourhood model for housing services in order to better focus on delivering what matters to residents in different localities	We will support the ambition of the *Case for Further* Change by bringing housing together at locality level and will empower front line staff from across housing to form relationships and networks across the system, to work together with residents to design and deliver meaningful, personal and holistic solutions We will create opportunities to pool budgets and resources, simplify existing complex decision pathways and reduce the number of referrals made by offering support directly	Residents will be supported by housing staff with an understanding of local priorities, networks and assets, improving the range of positive outcomes that can be delivered
We will expand housing locality working into the Integrated Locality Network in order to collaborate more effectively with residents and other professionals	We will embed housing support and services within the Integrated Locality Networks encompassing a wide range of health, care and third sector partners, allowing staff to collaborate with each other and with residents to co-design bespoke integrated solutions rather than making referrals	Residents will experience improved integration between related but historically disjointed services, increasing and improving access to information and sources of support
We will expand the knowledge and skills of housing staff in order to better support residents	We will expand the knowledge of housing officers relating to health, care and social needs to improve the support that can be offered directly to residents within localities We will provide training and share knowledge relating to housing services and support with others across the Integrated Locality Networks to strengthen the shared understanding of all partners	Residents will be better supported by housing staff with broad knowledge and skills that are able to directly help with matters relating to health and care, and which can navigate the wider system to identify the most appropriate course of action
We will create new Community Case worker 'blended roles' able to co-design integrated, bespoke solutions with residents	We will use test and learn pilots to create new 'Community Caseworker roles' that are able to deliver a wider range of solutions to residents, with skills traditionally delivered in silos by different teams within Adult Social Care, NHS functions, housing, debt and the community, voluntary and faith sector	Residents with more complex problems that traditionally needed input from multiple different teams and services will find it easy to access a bespoke solution that genuinely solves their problem

Chapter 5

Meet Housing Need

Identifying and understanding housing need can be complex, and any unmet need can have a significant and lasting impact on the health and wellbeing of people. This chapter sets an approach to use a range of information sources to build an accurate understanding of current and future housing need, creating the evidence base for directing housing development.

This chapter considers how the council can explore, understand, and address the diverse housing needs of the borough's population. It also shares residents' priorities regarding the standard of homes in Thurrock and how homes can be developed and improved in the borough.

The development and quality of homes have direct relationships with the health and wellbeing of individuals. The adherence to suitable space standards, ample provision of affordable housing and the inclusion of appropriate green and open space in new developments will positively affect the lives of residents who will live there.

Identify and provide the right homes for Thurrock based on household need

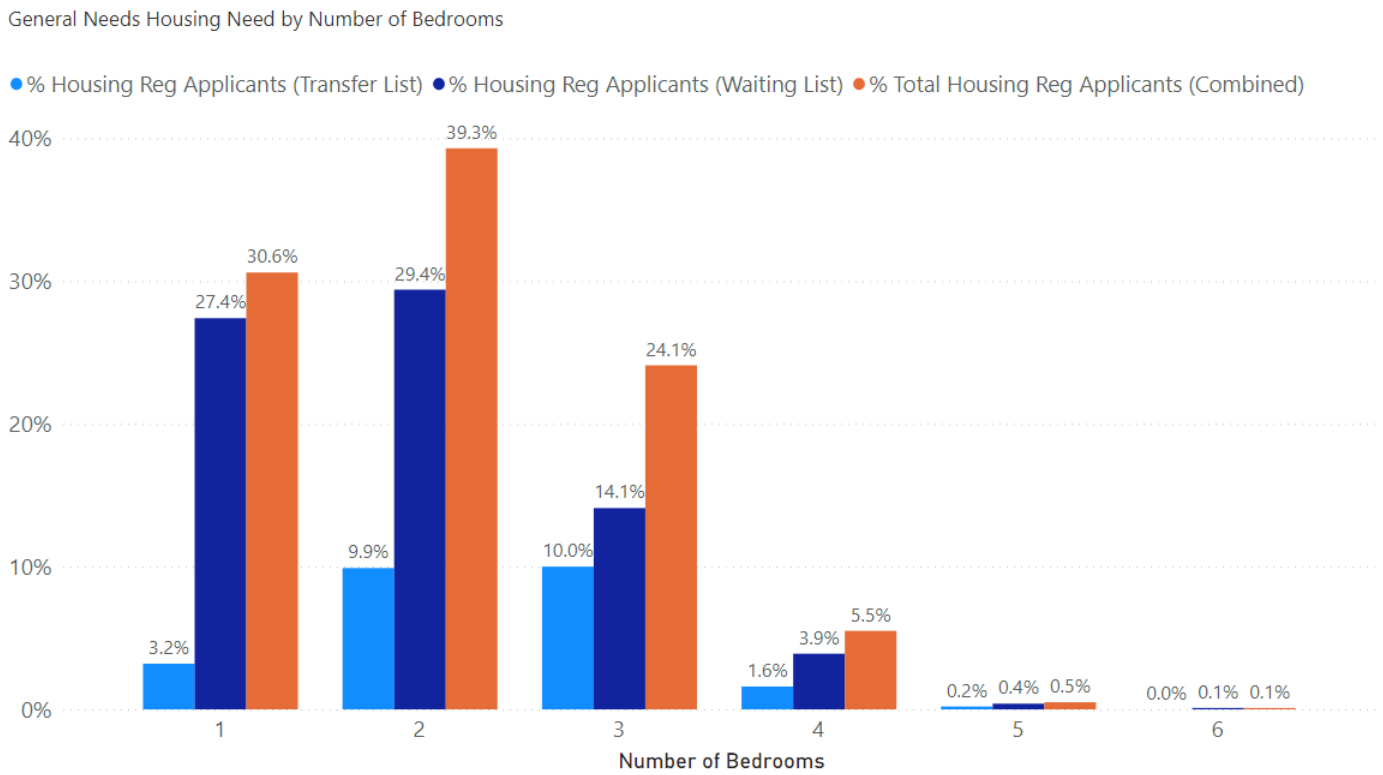
Context

Every household has a housing need that is aligned to and reflective of their circumstances at that point in time. Housing need can relate to:

- property affordability
- the number of bedrooms required by a household
- property location
- any adaptations, alterations, or specific property types to ensure accessibility
- care or support services
- independent living

During the engagement and development of this strategy, many residents were concerned that the right types of accommodation were insufficiently available to meet their needs. Affordability was cited as one of the most significant barriers to securing accommodation within Thurrock with growing inflation, increasing household costs and the continuation of welfare reforms placing incomes under pressure. Residents also highlighted difficulties in accessing adapted or adaptable properties in the borough.

The chart below presents a snapshot of general needs housing need by property size. It includes applicants that have placed at least one bid in the past two years or have had their application registered in the past two years.



Based on the council's housing register data, the greatest demand is for two-bedroom properties, followed by one-bedroom properties.

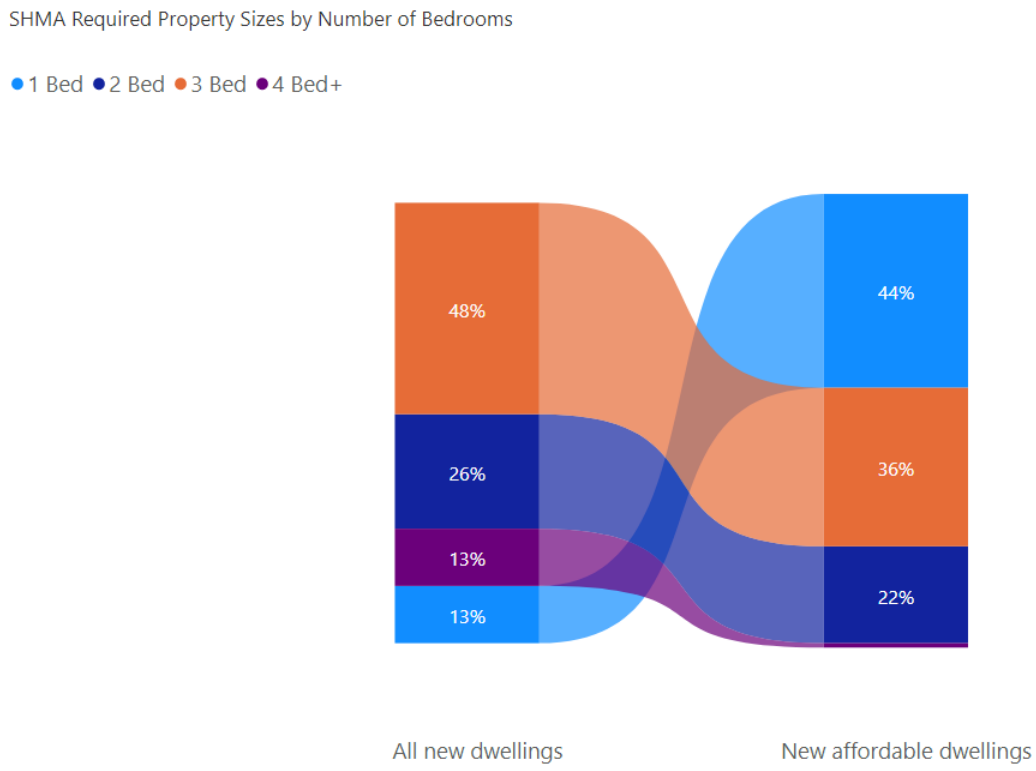
The most recent Strategic Housing Market Assessment (SHMA) was produced in 2017. A SHMA is a technical study intended to help the council's planning and housing services to understand how many homes will be needed during the assessment period – in this case, between 2014 and 2037.

The approach to produce a SHMA uses demographic modelling to estimate how the population and household profile could change, assuming that housing needs are met in full by estimating size and type of housing needed based on tendencies of existing households. It provides a separate calculation of affordable housing need, accounting for backlog and newly arising need and considering the role of different products, like First Homes.

Finally, the SHMA gives specific consideration for the needs of different groups identified, such as:

- Older people
- People with disabilities
- Families
- Young people
- Privately renting households
- Self-builders

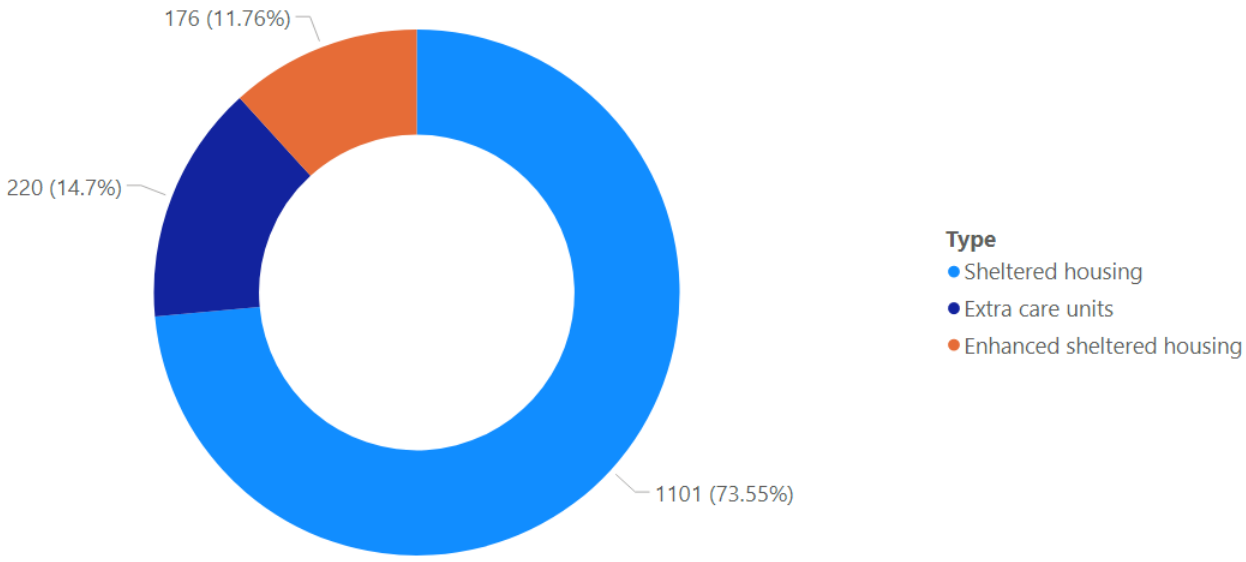
The 2017 assessment indicated an objectively assessed need of 1074 to 1381 properties per annum across all tenures for Thurrock between 2014 and 2037, identifying a net annual affordable housing need of 472 new dwellings. The proportions for the required property sizes identified through the SHMA are shared in the chart below.



There are significant variations between the proportions suggested by the existing SHMA and the data available for the council's housing register. It should be noted that the SHMA considers the housing need for the entire current and future population of Thurrock and recommends that the council continues to monitor the number of bedrooms required by households in priority need on the housing registers.

The SHMA identified the potential need for additional specialist older persons housing in Thurrock over the assessment period, including residential care housing. The total requirements across the assessment period for each type of specialist older persons' housing are presented below, alongside the average number of dwellings needed per annum.

SHMA Specialist Older Persons Housing Requirements (2014-2037)



Feedback during the development of this strategy and evidence presented above identify concerns with regards to affordability and availability of homes for Thurrock residents, in relation to home ownership as well as property rental. Residents also shared views regarding the availability of new homes that are adapted or adaptable for accessibility requirements.

There is a clear need for good quality, sustainable and affordable housing to be provided in the borough. It is key to the wider growth agenda, enabling residents to live healthy and well lives and means that local residents are available to take up the new employment opportunities created by growth in the borough.

As a social housing provider, the council has a pipeline of future development projects aligned with identified local need.

Following the abolition of the HRA borrowing cap in October 2018 Thurrock Council, as a local authority with an HRA, is no longer constrained by government controls over borrowing for housebuilding. Instead, the council is now able to borrow against their expected rental income.

Additional flexibilities regarding the use of Right to Buy sales receipts were introduced in March 2021, including included raising the proportion of project costs that can be funded from the

receipts from 30% to 40%, permitting their use in developing shared ownership homes, and extending the period by which they must be used by from three to five years after receipt.

These changes mean that there will be wider scope to fund the development of new council-owned homes, and there is currently a pipeline of future projects aligned with identified local need that can now be taken forward.

Land that is suitable for these types of developments could include:

- plots of available land in areas where there is existing social housing
- smaller developments in mixed development areas on existing council land
- redevelopment of existing housing stock where due to its age or condition will need to be redeveloped. This can include both small-scale development and large-scale housing regeneration projects.

Given the demand for smaller sized properties as evidenced within this strategy, much of the focus of council-owned developments in the near future is anticipated to primarily be one and two-bedroom homes; however, there will be a mix of homes including three and four-bedroom developments for growing families which can in turn make smaller homes available to be relet where the new occupiers are moving from an existing council-owned property.

Thurrock Regeneration Ltd (TRL) offers another route for the provision of new, high-quality housing across the borough. As a development company set-up and funded by loans from Thurrock Council, it can deliver properties for market sale, private rent, affordable rent and shared ownership, and then reinvest any profits into further housing development or to support services. TRL can support brownfield redevelopment and ensure that sites can be taken forward where other developers may be deterred by feasibility by accessing funding via partners such as the local enterprise partnership, the Association of South Essex Local Authorities (ASELA), and Homes England.

However, the council cannot meet the needs of all households in Thurrock in isolation. As such, work is needed to encourage and attract other registered providers of social housing and housing developers to construct homes in the borough, either directly or through joint ventures with the council, to meet the needs evidenced through local analysis and in the strategic housing market assessment.

Impact

There is an evidenced shortfall in the number of new dwellings in Thurrock compared to the identified need in the 2017 SHMA. Based on forecast need of 1074 to 1381 properties per annum since 2014, between 2016 and 2020 the cumulative total number of new dwellings required would be in the region of 5370 to 6905.

The DLUHC figures shared in the local context section of this strategy estimate that the number of dwellings in Thurrock increased by 3137 during this period. This is between 42% and 55% lower than required.

It is likely that the data provided in the SHMA update in 2017 is not accurately representative of present need given the length of time that has passed and the ambitious economic development and growth plans that are now in place for Thurrock; however, anecdotal evidence suggests that

the number of new properties required per annum is unlikely to be lower than the previously published recommendations.

This undersupply compared to demand is one factor in the significant challenges for residents to find and securing suitable accommodation in Thurrock.

Demand that exceeds supply contributes to the rising levels of housing unaffordability within Thurrock. In the private rental sector high demand has led to landlords seeking to increase rental costs, whereas in the property market demand has raised asking prices, putting first time buyers under further pressure due to the requirement for larger deposits.

This undersupply has also led to fewer homes being developed to allow overcrowded families and those with adult children living at home to move into a property that is the right size for their needs and has also impacted upon the supply new homes built with adaptability in mind.

Pressures exist not only in the private sector but also within social housing. Demand far outstrips supply for the council's stock and there is a disproportionately small amount of housing association properties within the borough as an alternative.

Recent action

The development of a new SHMA is currently underway to update the understanding of local housing need, jointly commissioned by the local authorities across South Essex. This piece of work is anticipated to identify the housing need for Thurrock until 2040 and will guide the development of the new Thurrock Local Plan.

The council does have a pipeline of new build schemes, and these plans are informed by regular reviews of the council’s Housing Register to provide an indicator of social and affordable housing demand, including any additional support needs or property adaptations that may be required.

This information has also been used to guide developments undertaken by other registered providers of social housing, collectively working to increase the number of affordable properties available to local residents in Thurrock.

Focussing on a particular subset of housing need, the 2018 Thurrock Council Annual Public Health Report considered the topic of older people’s health and housing. Through the development of this document, partners, and stakeholders from across the council came together to explore and demonstrate the link between good housing and health, and the significant role that the home plays in the lives of older people.

An affordability joint strategic needs assessment has progressed well in partnership with the council’s Public Health team. The detailed findings and understanding provided by that assessment will be taken forward as actions of this strategy. They will feature alongside the development of a ‘Thurrock Affordability’ standard that considers local costs of living, local income, and housing market prices.

Over the past two years, 119 new council-owned homes have been built in the borough. In the 2020-21 financial year 29 new homes were provided at the Alma Court development in South

Grays and a further 53 new homes constructed at Heathlyn Close and Claudian Way in Chadwell St Mary.

Case Study - Healthlyn Close/Claudian Way New Build Development

The Heathlyn Close/Claudian Way development project delivered 53 homes arranged around a new focal point for Chadwell St Mary.

The site for the development was located on an open green space in the centre of Chadwell St Mary, near the much larger Orsett Heath. It was well located regarding existing schools, public transport, and community facilities.

Most residents that attended engagement events that the council held agreed that the Claudian Way site was suitable for residential development and favoured an approach which included bungalows and a small mixture of flats and family houses. This approach met the needs of the local community and gave local residents confidence that they would not be overlooked by the proposed new buildings.

A mixture of property sizes and types were provided at the development to respond to the differing needs of the community.

- 8 x 1-bedroom flats
- 14 x 2-bedroom flats
- 15 x 1-bedroom bungalows
- 3 x 2-bedroom bungalows
- 1 x 2-bedroom wheelchair adapted bungalow
- 2 x 3-bedroom wheelchair adapted bungalows
- 10 x 3-bedroom houses

All homes were handed over into the council's ownership to be let at affordable rents within Local Housing Allowance rates.

A local lettings plan set out that 75% of the first offers of flats and houses within the plan would be made to current residents of Chadwell St Mary. The 21 bungalows at this site were not included in the local lettings plan as a reflection of the borough-wide need for these types of properties.

In total, 31 properties at Healthlyn Close/Claudian Way were let to existing residents of Chadwell St Mary through the local lettings plan and usual allocations process, including all the houses, over two-thirds of the flats and six of the bungalows at the development.

The remaining 21 properties were let to Thurrock residents who lived outside of the Chadwell St Mary ward, including one care leaver supported into independent accommodation.

Further to this, in 2021-22 the council let 35 properties built to HAPPI standards at Beaconsfield Place in Tilbury and two further wheelchair accessible homes in an innovative scheme at Defoe Parade in Chadwell St Mary.

Planning approval has been secured for the provision of four new council homes at Loewen Road in Chadwell St Mary and for a multi-tenure project at Culver Centre and Field in South Ockendon, to be delivered through Thurrock Regeneration Limited.

There is also an existing pipeline of proposed projects, such as the redevelopment of part of the Civic Offices site for further council-owned homes. The current number of potential dwellings on new build projects under consideration is 504, featuring a mix of council-owned properties and other delivery approaches.

Any sites that become approved for housing development and are held within the General Fund may be offered to Thurrock Regeneration Limited, subject to Cabinet approval. Those sites will generally be required to deliver 35% affordable housing in line with planning policy with the affordable housing offered for sale to the Housing Revenue Account.

The council has also acquired over 120 existing properties from the local housing market for use within its housing stock, utilised as part of a wider plan to transform the council's temporary accommodation offer.

Action Plan

What?	How?	Impact?
We will use housing knowledge and data to influence and support the development of the Local Plan to ensure that future planning policy is representative of the needs of Thurrock residents	We will continue to support the development and delivery of the Local Plan, using a data and evidence-based approach that takes into consideration the feedback and priorities of residents	Residents will benefit from the development of planning policy that is fit for purpose, fit for the future and encourages the types of homes and community infrastructure that will provide the foundations for good lives
We will identify and understand housing need in Thurrock in order to deliver more social and affordable housing for households in the borough	We will use data from the SHMA 2022 and the council's housing register, alongside engagement with residents on their experiences of living in our properties and their preferences for homes for the future to steer the development of council-owned homes and the plans of other providers of social housing in Thurrock We will use local letting plans for all council-led developments to safeguard that at least 75% of new homes are provided to residents with connections to the surrounding area	Residents will have access to a range of new build homes that are affordable, support their housing need and that prioritise providing housing for people with an established connection to the local area
We will build homes that can respond and adapt to changing housing needs throughout life in order to ensure individuals live independently in suitable accommodation for longer	We will develop and implement an older persons' housing strategy that will direct the future development of council-owned housing for older people, aligned to principles such as HAPPI and Lifetime Homes, and inform the developments of others to deliver homes that align to HAPPI We will include accessible homes and HAPPI standards in new council-led development schemes	Residents will have access to housing that is adaptable and will facilitate independent living for longer, allowing households to remain settled in their home and avoiding the upheaval and disruption associated with moving home
We will tackle direct and indirect discrimination in order to ensure that every Thurrock resident can access suitable accommodation	We will examine the factors leading to discrimination in housing that limit and prevent access to accommodation and implement a plan to tackle these	Residents will not experience housing discrimination and will be able to secure safe, suitable and affordable accommodation

What?	How?	Impact?
We will deliver and refresh the council's housing development programme in order to identify new opportunities to provide at least 500 new social homes for rent	We will continue to deliver homes as part of the council's housing development programme, championing high standards of design and construction on new affordable housing projects We will continue to identify and progress new sites for the programme pipeline with consideration to the range of delivery methods We will undertake regular assessments of existing and emerging housing delivery options, relating both to construction and provision to ensure that the viability of any such opportunities can be understood and progressed as appropriate	Residents will have greater access to good quality social housing across the borough as a result of increased supply

Address the housing affordability crisis in Thurrock

Context

Nationally, housing affordability has worsened over the past 20 years, with London and the South East containing some of the country's most unaffordable areas. There has been a decline in the proportion of owner occupiers and an increase in the proportion of people in private rented accommodation.

While private rental has advantages such as greater flexibility to move home, currently the sector also contains the highest proportion of poor-quality homes, offers the least stability, and is the most expensive relative to the monthly cost of social rent and mortgage fees.

Although definitions and schemes exist to explain what affordable housing can be, there is no single methodology or model for determining what constitutes 'affordable' housing.

The revised National Planning Policy Framework, published in July 2021, defines affordable housing as "housing for sale or rent, for those whose needs are not met by the market" and falls into one or more of the following:

- Affordable housing for rent
- Starter homes
- Discounted market sales housing
- Other affordable routes to homeownership

The document goes into greater detail for each of the above four categories, referring to schemes and models such as shared ownership, equity loans, social rent, and affordable rent. However, many of these 'affordable' housing products would not be affordable to lower-income households.

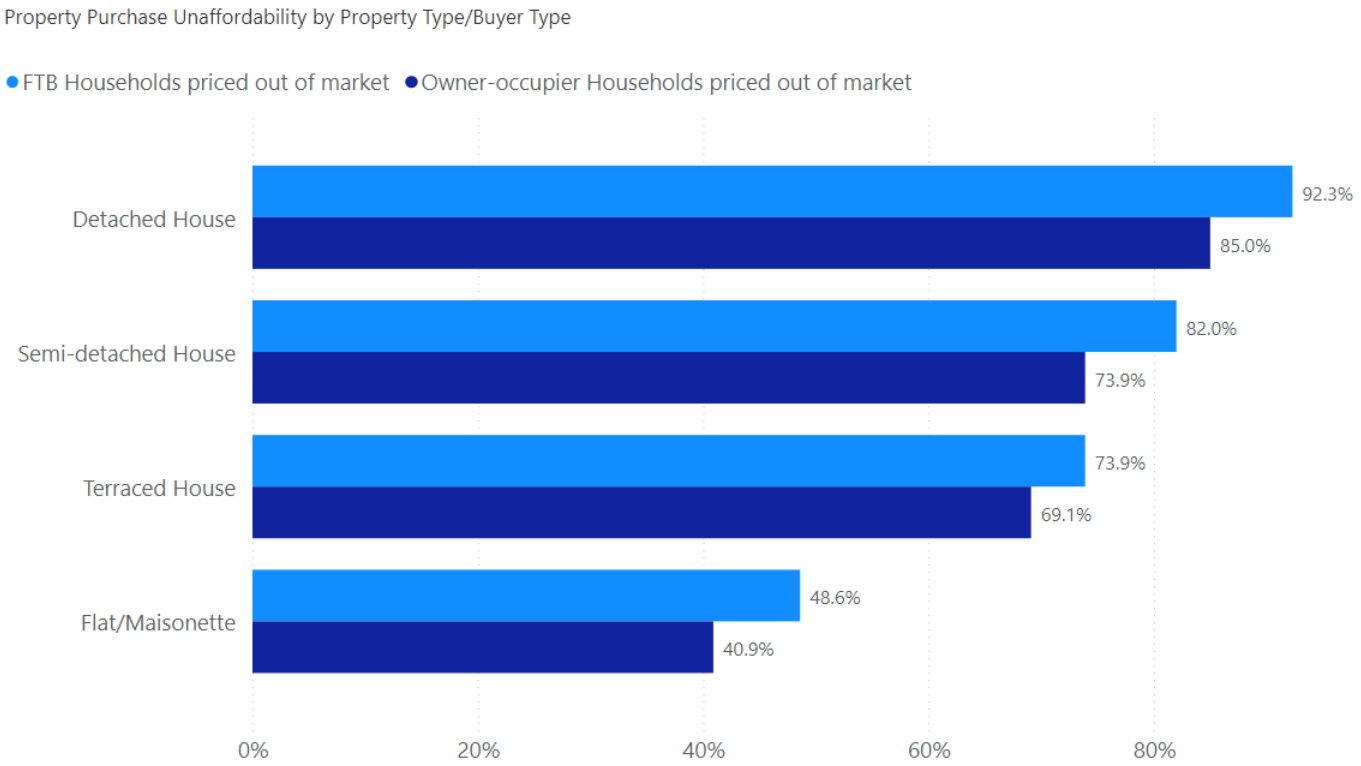
There are models for affordability, such as the Housing Costs to Income Ratio (HCIR), that suggests that if a household is spending more than a third of its net income on rent or mortgage costs, that accommodation would not be deemed to be affordable. The HCIR does not take into consideration other property related bills such as council tax or utility costs. There is also the standard measure outlined in an earlier section of this report of 'Affordable Rent' being 80% of median market rents.

The greatest challenge in defining affordability is that it is subjective and heavily influenced by each household's circumstances and housing needs. Determining what 'affordable' means based solely on market rents does not consider the disparity between the incomes of households, nor does it consider the source of those incomes.

Data assessed as part of an affordability joint strategic needs assessment identified that although Thurrock continues to be slightly more affordable than its surrounding neighbouring areas, it is still much less affordable than many other areas in the country. It has also become increasingly more unaffordable over the past five years compared to other local areas. Those in the lower income quartiles are worst affected.

Affordability concerns are also prevalent for those wanting to buy in Thurrock. The chart below indicates the percentage of the first-time buyer and existing owner-occupier households in the

borough that would be priced out of the market, based on 4x household incomes, local property prices and national loan-to-value statistics.



This means that there is likely to be a considerable number of households for whom home ownership is not an option, in turn increasing the number of households looking to privately rent or socially rent. There is a need to ensure that these options are available and affordable for these households. There is also a need to ensure that these options are of suitable quality and security to mitigate against potential poor health effects of unhealthy housing.

The table below provides a snapshot of average weekly rental values and measures in Thurrock based on tenure type.

Number of Bedrooms	Local Housing Allowance Rate	Social Rent (Council)	Affordable Rent (Council)	30th Percentile Market Rent	80% Median Market Rent	Median Market Rent
1	£161	£77	£130	£172	£146	£183
2	£201	£85	£153	£219	£185	£231
3	£247	£105	£199	£289	£244	£305
4	£307	£118	-	£365	£313	£392

- LHA Rate – Local Housing Allowance, the maximum amount of Housing Benefit or the housing costs element of Universal Credit that eligible residents can claim. This has been frozen since April 2020.
- Social Rent – the average social rent charged (excluding service charges) for properties owned by the council

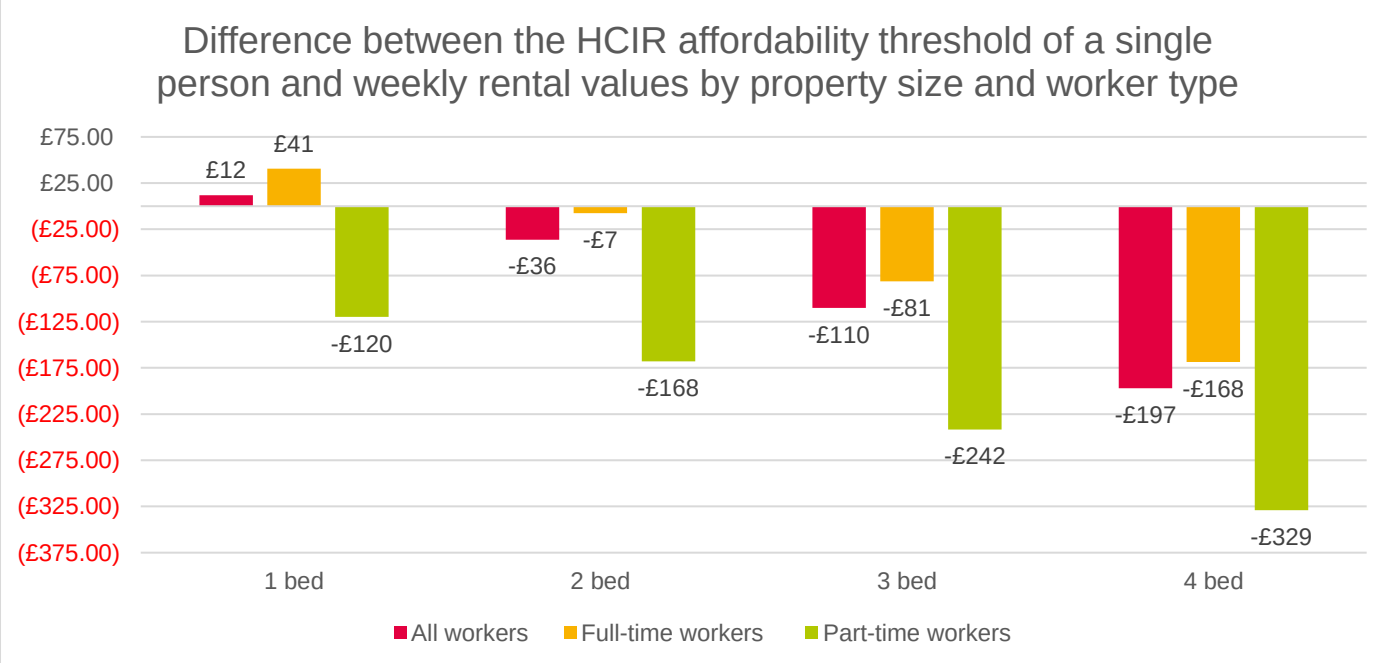
- Affordable rent – the average affordable rent charged (excluding service charges) for properties owned by the council.
- 30th Percentile – 30% of private market rents fall below this value, and this measure was used as the benchmark to set the LHA rate in April 2020. Whilst LHA rates have been frozen since this time, market rents have continued to increase
- 80% Median – 80% of the value of the average market rent, used for calculating 'affordable rent' in line with the Government definition
- Market Rent – indicates the value in the middle of the range of private market rents.

There is then the challenge of households living in properties that may be deemed affordable, but that comes at the cost of quality, standard of living and decency of accommodation.

The table below provides details of median earnings for Thurrock residents alongside an affordability threshold calculated using the HCIR model.

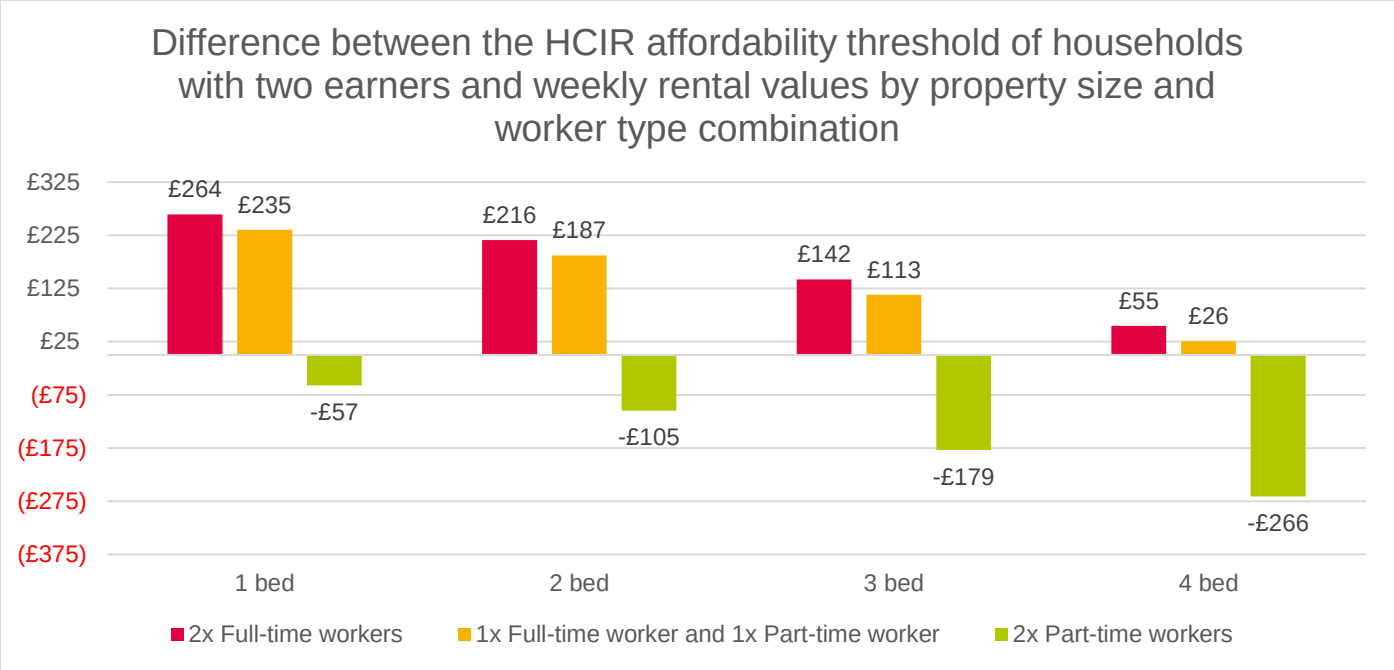
	Median Weekly Earnings	Affordability threshold (HCIR)
All Workers	£584.50	£194.83
Full-time Worker	£670.60	£223.53
Part-time Worker	£189.30	£63.10

The following chart compares median weekly earnings for a single person to median weekly market rents by property size. It evidences the difference between the affordability threshold of a single person and rental values in Thurrock. Negative figures represent the amount by which weekly rental values exceed HCIR affordability thresholds, effectively indicating unaffordability.



Single full-time workers appear to be more likely to find one-bedroom properties affordable within the private rental sector; however, for other property sizes, and for other worker types across property sizes affordability is significantly impacted.

Finally, the below chart provides an indication of possible household combinations based on worker types compared to median weekly market rents, showing the difference between the household affordability threshold and rental values. As with the above chart, negative figures represent the amount by which weekly rental values exceed HCIR affordability thresholds.



The above chart illustrates that households with two earners where at least one is a full-time worker will find the private rental market more affordable with an affordability buffer of between £26 and £264 per week depending on property size. For households with no full-time earners, accessing properties with median market rents is extremely unaffordable, with rental values exceeding affordability thresholds by £57 to £266 per week, depending on property size.

Impact

Housing can have positive and negative impacts on health that may be direct and indirect. Good quality homes, that are suitable for the needs of the people living in them offer a strong base from which people can study, work, raise a family and enjoy life in as they grow into their later years.

Those experiencing challenges with affordability in Thurrock will often find that the properties within their budget will be of poorer quality, will be less secure and will be less suitable housing for residents. These residents therefore experience an unequal distribution of housing related health risks.

A poor-quality home, for example one that is damp, mouldy, and cold, can exacerbate physical health problems, negatively impact mental health and may impact on the residents' ability to study, work and otherwise use and enjoy their home.

Due to current house prices and household incomes in Thurrock, data indicates that homeownership is unaffordable for almost half of all first-time buyers looking to purchase flats or maisonettes in the borough. As property sizes increase, so too does the proportion of first-time buyers and existing owner-occupiers that would find purchasing unaffordable.

The impact of current rental levels compared to earnings means that, for many, this is not an affordable option either. Although a single full-time worker earning the median weekly pay would

find themselves approximately £41 within the HCIR affordability threshold for a one-bedroom property based on median market rents, a full-time worker receiving a weekly pay at the 30th percentile would have a buffer of less than £2 per week.

Households on the lowest incomes in Thurrock who need to rent privately are at highest risk of tenancy insecurity due to unaffordability, often requiring financial assistance such as Housing Benefit or Universal Credit. Rising rental value levels mean that there are shortfalls between maximum LHA rates and private market rents across Thurrock. The table below indicates the discrepancies that residents eligible to receive the maximum amount of Housing Benefit or the housing element of Universal Credit would face in relation to 30th percentile and median market rents.

	30th Percentile Market Rents – Weekly Shortfall	Median Market Rents – Weekly Shortfall	30th Percentile Market Rents – Annual Shortfall	Median Market Rents – Annual Shortfall
1 bed	-£11	-£22	-£572	-£1,144
2 bed	-£18	-£30	-£936	-£1,560
3 bed	-£42	-£58	-£2,184	-£3,016
4 bed	-£58	-£85	-£3,016	-£4,420

The table above shows the growing shortfall between rising market rents and maximum LHA rates. In a little under two years since LHA rates were realigned with the cheapest third of private rental sector properties, the discrepancy has grown to between £572 and £3,016 per year, and between £1,144 and £4,420 when LHA rates are compared to median market rents.

For households reliant on the housing element of Universal Credit or Housing Benefit for their housing costs, if these are insufficient to meet the actual rental costs of their property, they have little option but to use benefits provided for non-housing expenditure to meet the shortfall. This challenge of private sector affordability directly relates to the ever-increasing demand for accommodation at social and affordable rents.

There is also a challenge with relying on HCIR as a model to determine affordability, as it only considers the cost of rent or mortgage. It has no capacity to reflect the cost of living in Thurrock, the costs of energy and other utilities, nor the varied levels of earnings and income in the borough. Whilst it does provide an indication of sorts, it underestimates the scale of the affordability challenge. Resident and stakeholder feedback stressed the need to develop some other measure by which affordability can be expressed and defined, specifically for Thurrock.

Recent action

The council has introduced approximately 200 homes into its housing stock since the start of the 2020/21 financial year, comprising a mixture of new build properties and acquisitions from the housing market. Every one of these properties are offered at weekly rental levels within the LHA rates applicable in Thurrock, making these properties the most affordable homes for rent in the borough.

This is the case across the approximately 9,900 homes in the council's housing stock, all of which are offered at social and affordable rent levels.

The council has committed that it will continue to deliver new homes through both estate regeneration and smaller scale development within affordable rent levels, continuing to ensure affordable housing is available to those most in need in Thurrock. Further details regarding these developments can be found within later sections of this chapter.

Action Plan

What?	How?	Impact?
We will introduce and maintain a 'Thurrock Affordability Standard' in order to accurately inform service delivery, policy design and housing development	We will use the Affordability JSNA to understand drivers of unaffordability in Thurrock along with data and resident feedback relating to the cost of living in the borough to establish an affordability standard that is realistic for Thurrock households We will identify gaps in service provision, for example by using the affordability standard in comparison with financial eligibility criteria in the Housing Allocations Policy, and revise these so they remain fit for purpose and offer routes to housing to those in need We will keep this standard under regular review to reflect the ever-changing landscape in the borough	Residents receiving support relating to housing will have their affordability measured against this standard to ensure routes into housing are identified and proposed that meet locally assessed affordability levels rather than generic calculations
We will deliver at least 500 new council-owned affordable homes by 2027	We will provide at least 500 new homes at rent levels that are within those set by the Thurrock Affordability Standard (when established) and Local Housing Allowance rates We will assess affordability on a development-by-development basis alongside household costs and incomes in Thurrock at that time in order to ensure that rents can be offered at appropriate levels We will always assess the viability for any new development against Local Housing Allowance rates and the Thurrock Affordability Standard (when established)	Residents will have access to good quality new build homes in council-led developments that are within realistic affordability levels for Thurrock households
We will maximise the delivery of genuinely affordable housing in new developments in order to boost access and availability	We will use development management, the Housing Strategy, and the Local Plan as vehicles for delivering a minimum provision of 35% of the total number of residential units built to be affordable housing We will embed the Thurrock Affordability Standard in assessments of local housing need	Residents will have greater opportunities to access affordable housing across the borough, allowing them to live in areas of their preference

What?	How?	Impact?
We will support households to maximise their income in order to increase the range of affordable housing options	We will build meaningful and lasting partnerships with the community and voluntary sector in order to allow residents to be better supported through knowledge and information sharing, timely and appropriate signposting and access to training and employment opportunities We will continue to provide financial inclusion support for Thurrock residents	Residents experiencing difficulties in accessing or sustaining homes due to financial pressures will have improved affordability and can more easily find or maintain settled accommodation
We will establish a social lettings agency for Thurrock in order to expand private housing options for residents	We will engage with and support private sector landlords to increase the supply of affordable and good quality private rental sector properties, and explore opportunities for direct property acquisition	Residents will have greater choice and availability within the private rental sector for good quality homes offered at affordable levels in Thurrock

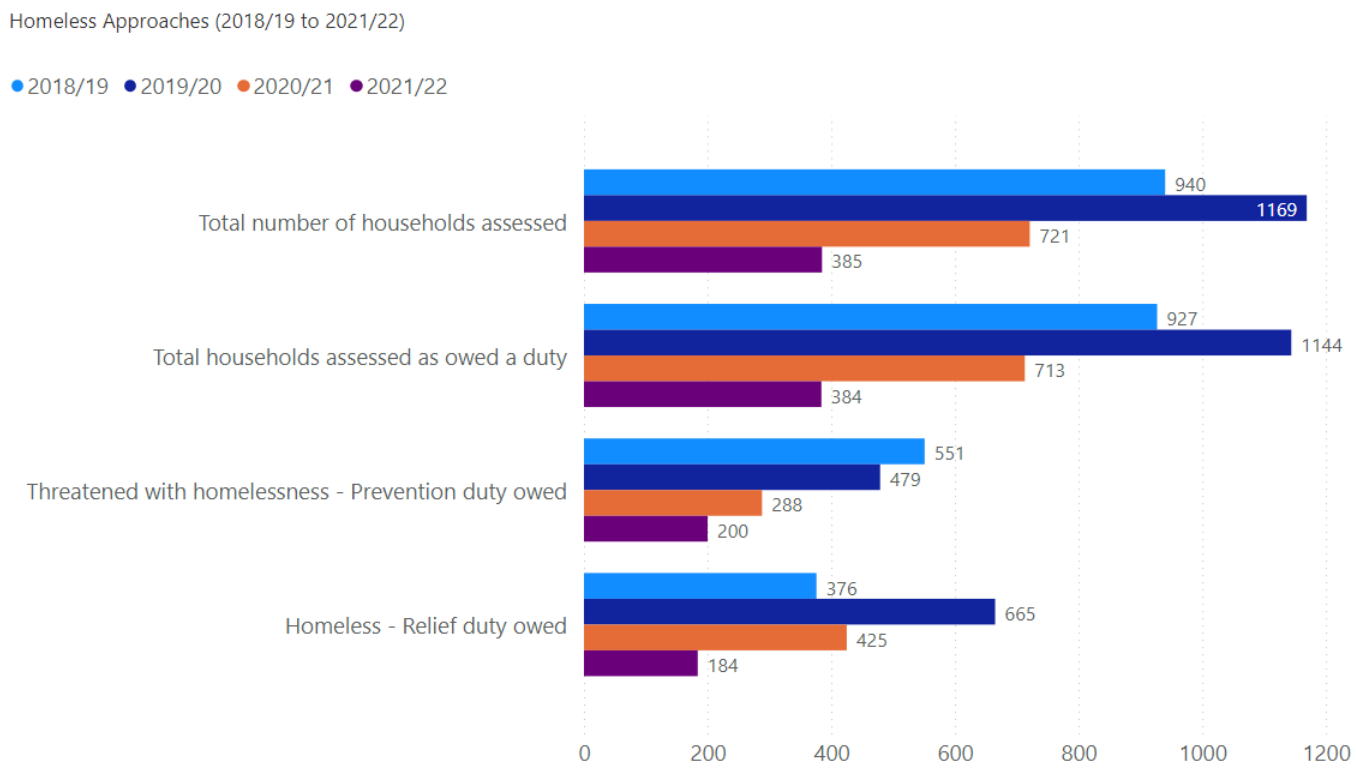
Prevent homelessness and end rough sleeping in Thurrock

Context

Homelessness is a complex societal issue. The impact on the lives of individuals and households, and the response required from public and third sector organisations is significant.

Homelessness detrimentally effects the physical and mental health and wellbeing of individuals, impacts their access to health and care services, is a factor in increased drug and alcohol misuse, and disrupts the work, education, and support networks of households.

The introduction of the Homelessness Reduction Act in April 2018 saw the council experience an increase in the number of households approaching the organisation for assistance regarding homelessness. The chart below indicates the number of households that approached the council for assessments since the start of the 2018/19 reporting year. All figures for 2021/22 are based on the latest available statutory returns (April 2021-September 2021).



The initial assessment identifies if the council has a statutory homeless duty to the household that submitted the application. A household may be owed the prevention duty if the household is eligible for assistance and threatened with homelessness, in which case the local authority must take reasonable steps to help the household to secure that accommodation does not cease to be available for their occupation.

Alternatively, a household may be owed the relief duty if the household is experiencing homelessness and is eligible for assistance. In this case, the local authority must take reasonable steps to help the applicant secure that accommodation becomes available for at least six months.

A reduction in assessments can be observed after the end of the 2019/20 reporting year can be directly and primarily attributed to the impact of measures implemented by the Government to support people to remain in secure and settled accommodation during the COVID-19 pandemic. These measures included the extension of eviction notice periods, which returned to pre-pandemic lengths in October 2021, and the prevention of bailiff enforced evictions that was lifted in May 2021.

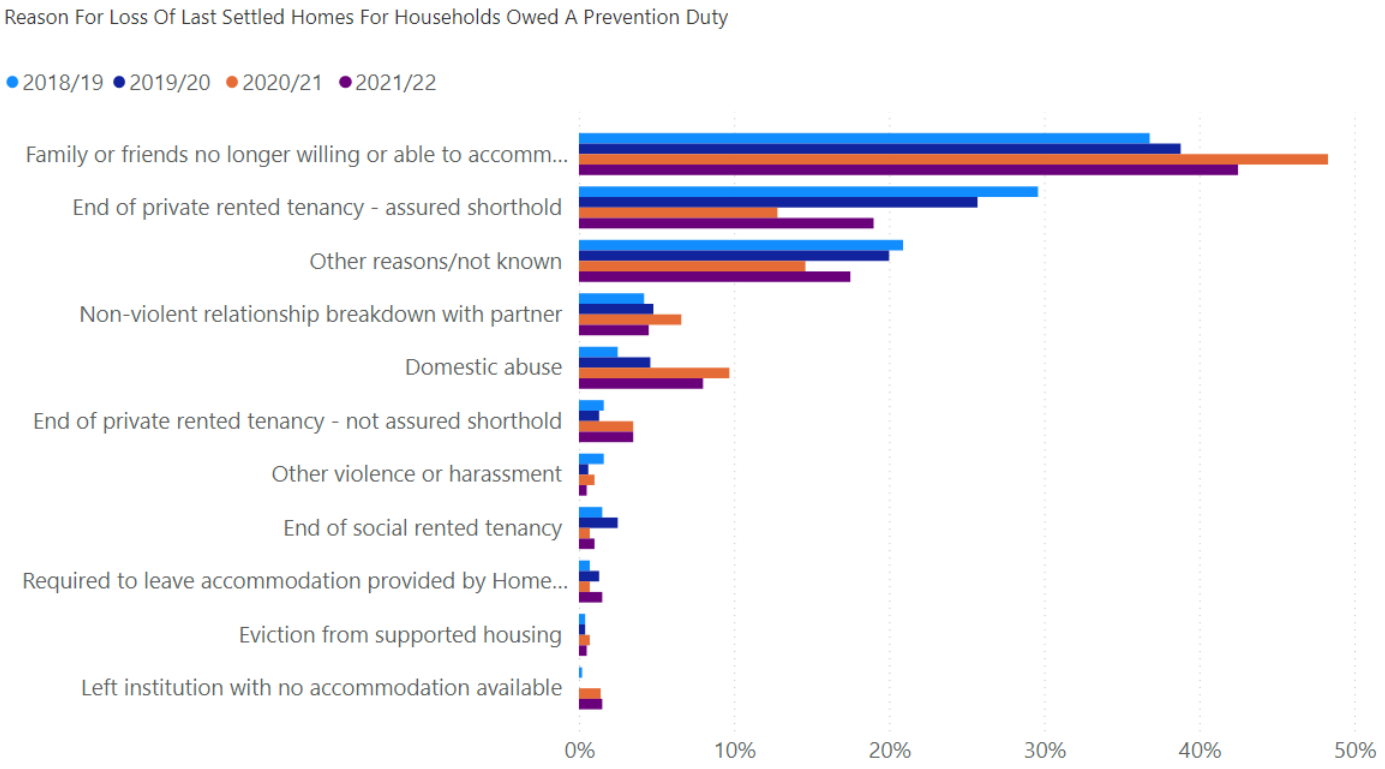
In 2018/19 and 2019/20, households approaching the council for a homelessness assessment were more likely to be owed the prevention duty as they were threatened with homelessness, rather than the prevention duty that would have been owed if they were experiencing homelessness.

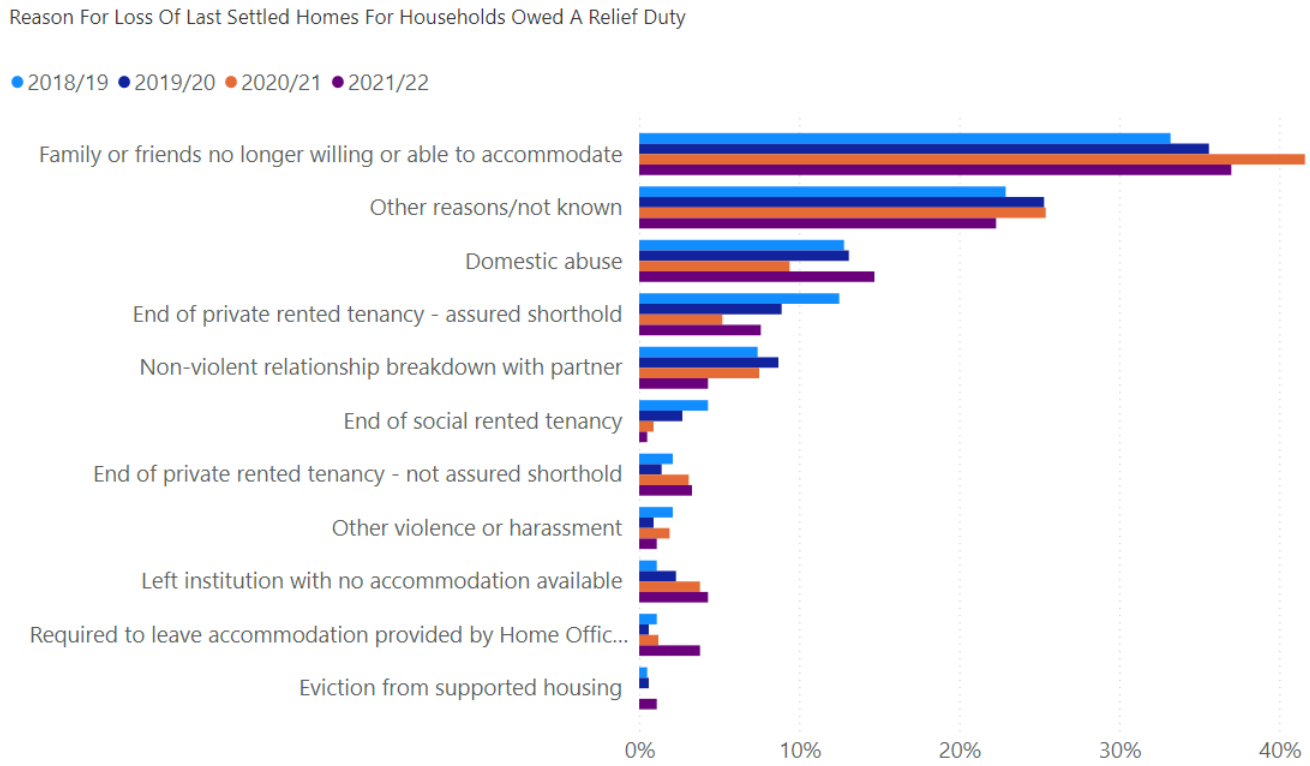
In 2020/21 this balance reversed, with more households owed the relief duty than the prevention duty. As already outlined, during the COVID-19 pandemic support was in place to keep renters and homeowners in their settled homes, including mortgage payment holidays, leading to fewer households facing homelessness due to the threat of eviction or repossession.

These reasons for homelessness tend to have advanced warning or notice, meaning that action can be taken to sustain tenancies; however, other reasons for the loss of accommodation require swifter support and action.

For example, the proportion of applicants that lost their accommodation due to domestic abuse and owed the relief duty is higher than those who would be owed the prevention duty.

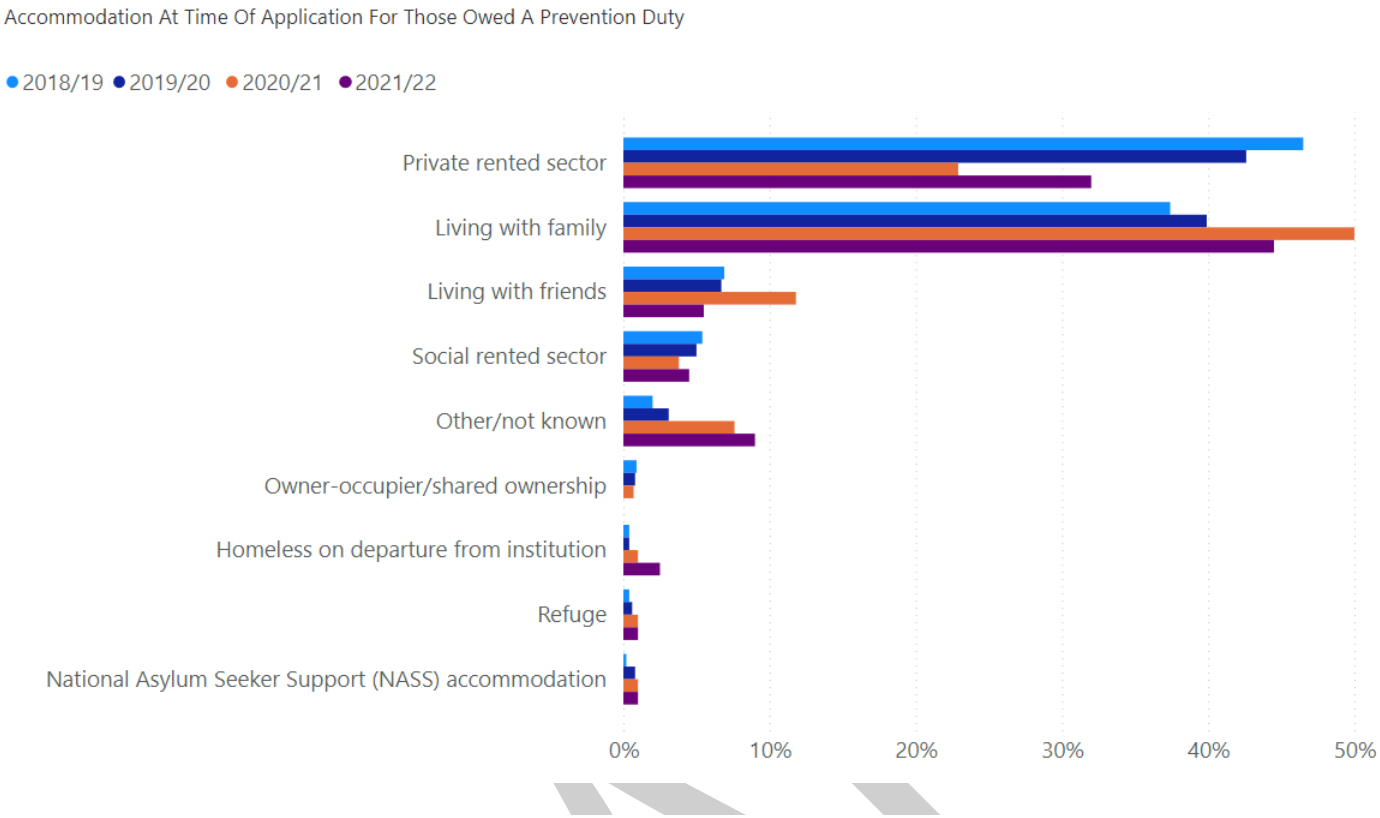
The tables below present further information regarding the reasons for the loss of settled accommodation, split by the households owed the prevention duty and households owed the relief duty. Within the tables, the classification *other reasons/not known* includes fire/flood/other emergency, left HM forces, mortgage repossession, property disrepair, other or unknown reasons for the loss of settled accommodation.

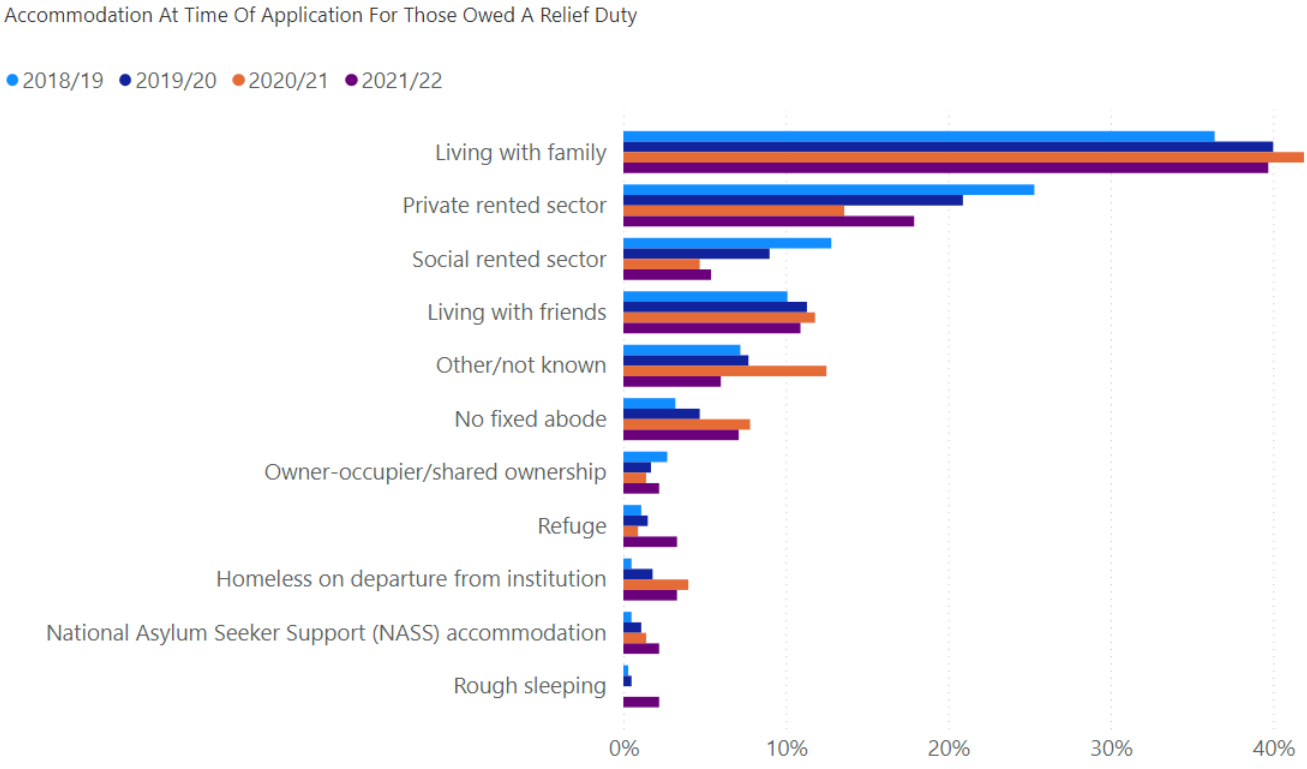




Both charts demonstrate the sharp reduction after March 2020 in the proportion of households owed prevention or relief duties due to the end of a private rental sector tenancy. Family and friends no longer willing or able to accommodate remained the most prevalent reason for the actual or threat of loss of settled accommodation in Thurrock, with the proportion increasing noticeably in the 2020/21 financial year.

The charts below present data regarding the type of accommodation at the point that a homelessness application was submitted, again split by those owed the prevention duty and those owed the relief duty. Other/not known includes caravan/houseboat, student accommodation, looked after children placement, tied accommodation, Armed Forces accommodation, other and unknown types of accommodation.

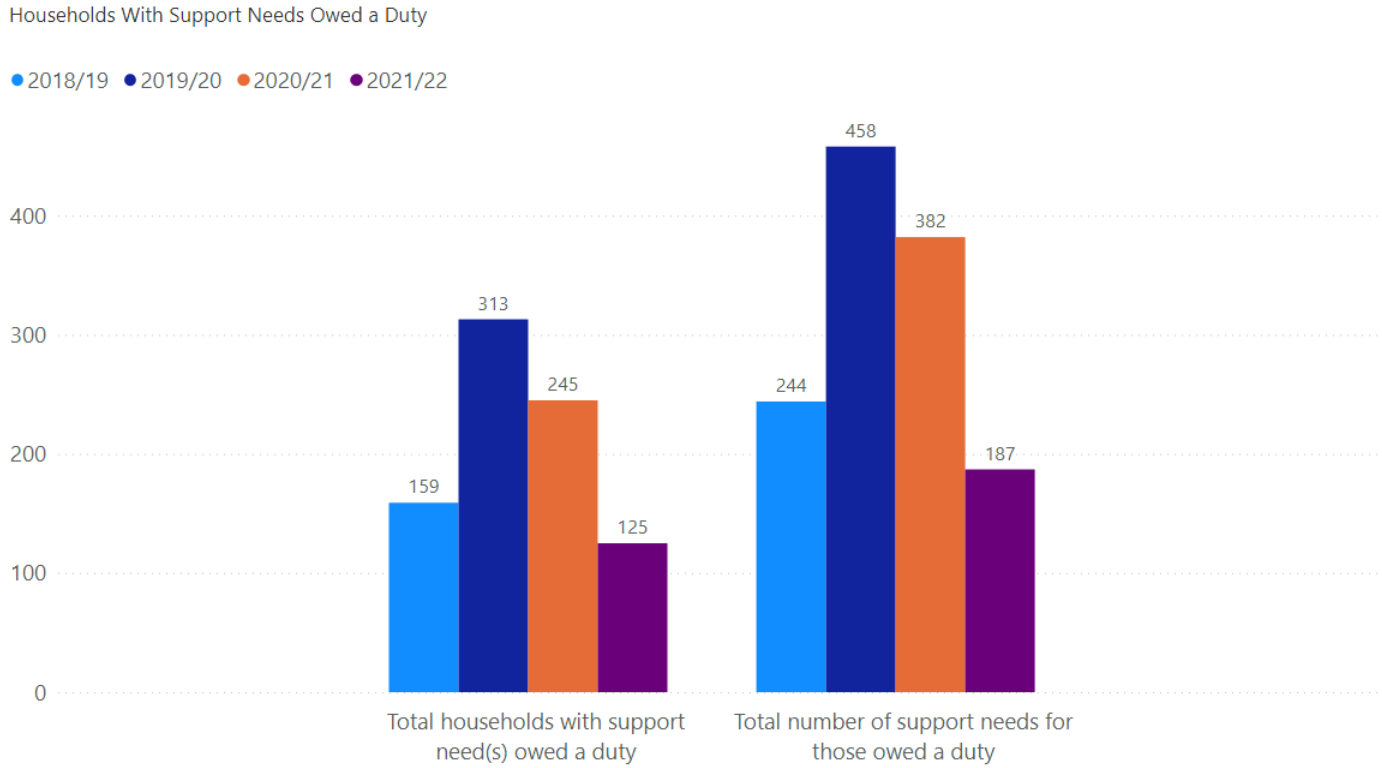




Again correlating with the protections for private rental sector tenants, a reduction in the proportion of the loss of private rental sector accommodation can be seen from 2020/21 compared to previous years. Over the past two years, the largest proportion of those owed the prevention and relief duties were those living with family.

When considering the types of households experiencing or threatened with homelessness in Thurrock, the proportion of single adult males and single adult females seeking assistance have generally increased over the past four years, and with single adult males accounting for more than two in every five household types owed the relief duty.

When submitting and progressing through a homelessness application, household support needs are identified. The proportion of households with support needs owed either the prevention or relief duties has generally been increasing over the past four years.



The most prevalent support need for applicants in Thurrock has consistently been where there has been a history of mental health problems within the household, followed by those with physical ill health and disability and those at risk of or have experienced domestic abuse.

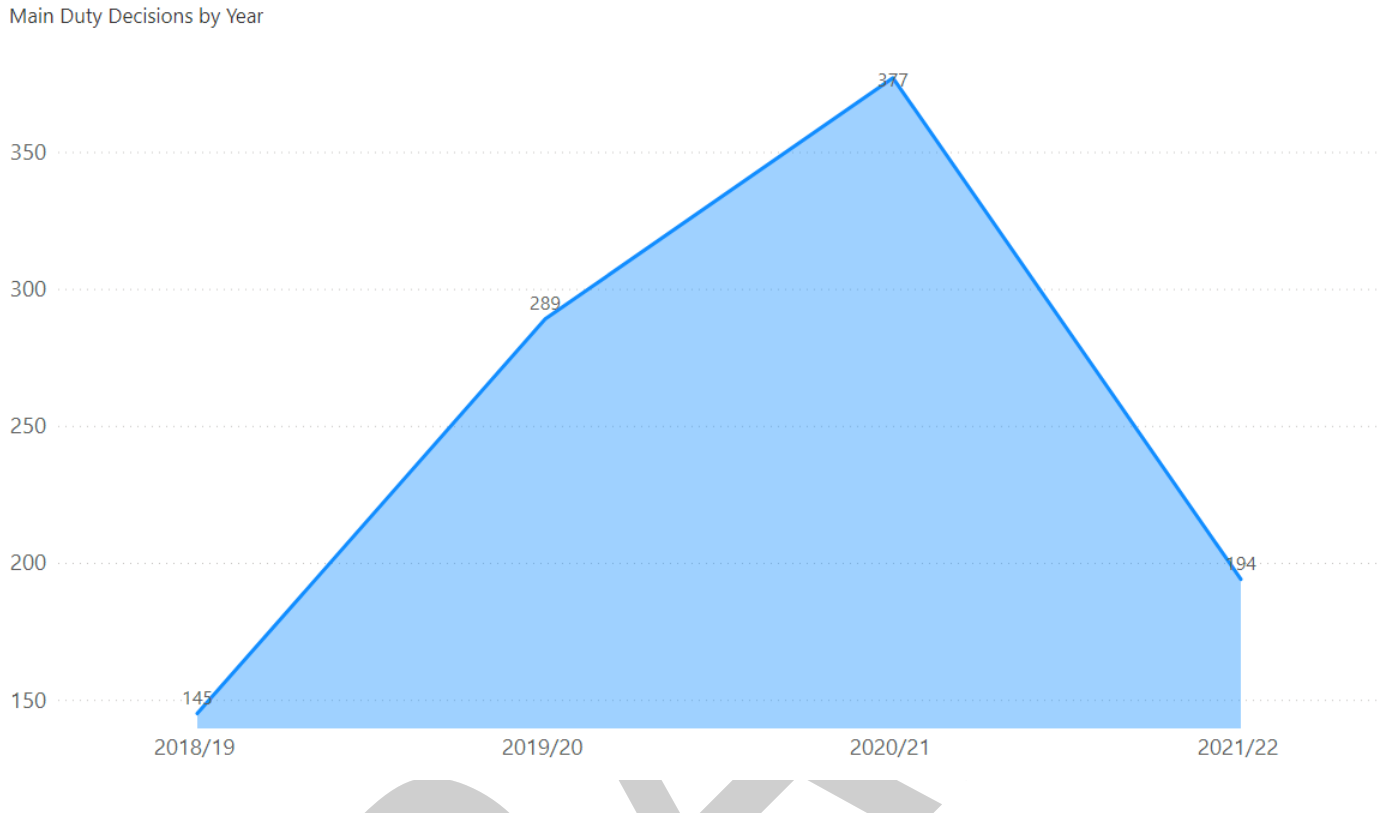
The council's Veteran's Charter recognises that those who have served in the armed forces may experience issues in accessing and securing accommodation. Although the above chart presents a comparatively low number of applicants approaching the council for assistance that had served in the armed forces, there should be proactive identification of veterans approaching the council's homelessness service to ensure that specialised advice and information is offered to support former armed forces members to secure safe and suitable accommodation.

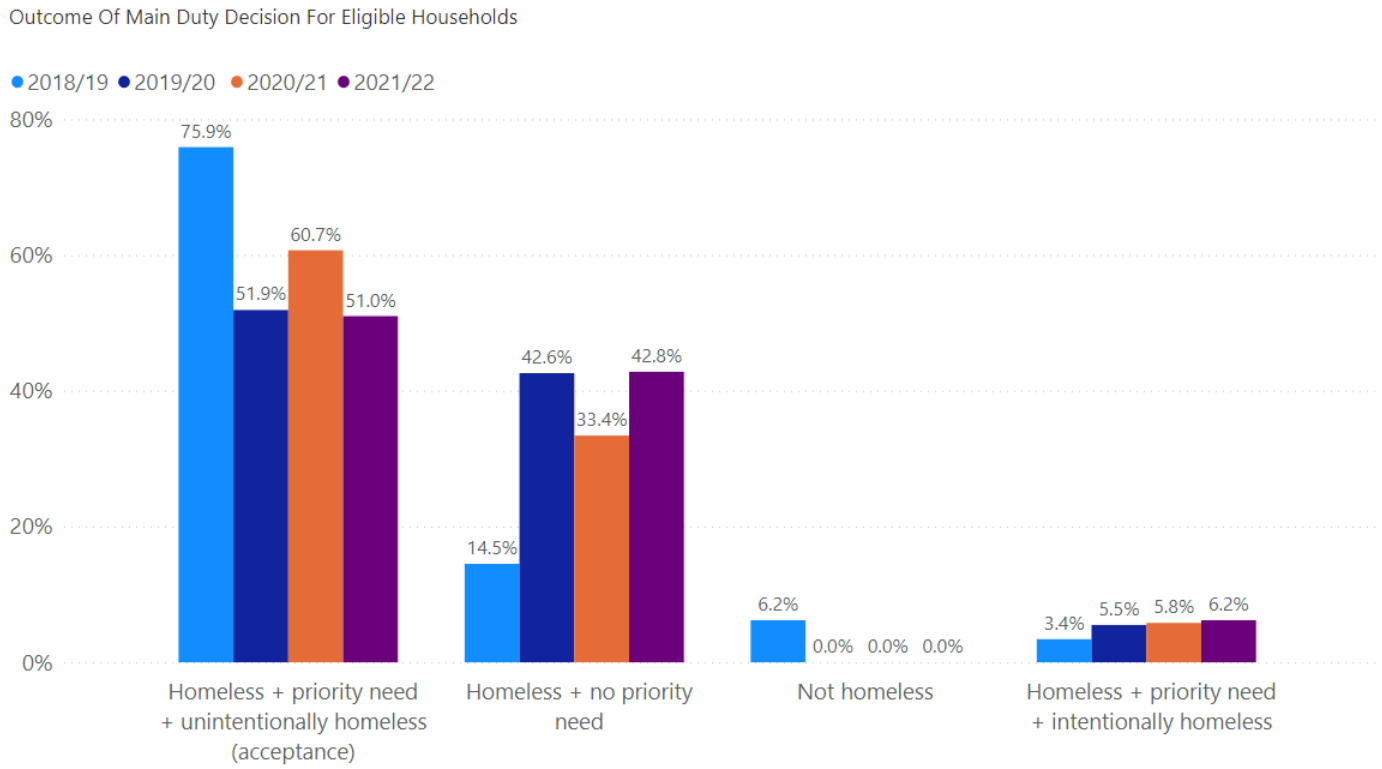
In general, where homelessness can be prevented or relieved, the most prevalent type of accommodation offered is in the private rental sector, and this has been the case for a number of years.

Action the local authority can take to prevent or relieve homelessness include helping households to secure accommodation found by the applicants (with and without financial payment), directly securing accommodation through the housing options services, negotiation, advocacy and mediation, and other financial payments, such as those to reduce arrears.

If accommodation cannot be sustained through the prevention duty or assistance to secure accommodation is not successful during through the relief duty, a further assessment is

undertaken to understand if the household is owed the main housing duty. The main housing duty owed by a local authority to someone who is homeless, eligible, has a priority need and is not intentionally homeless.

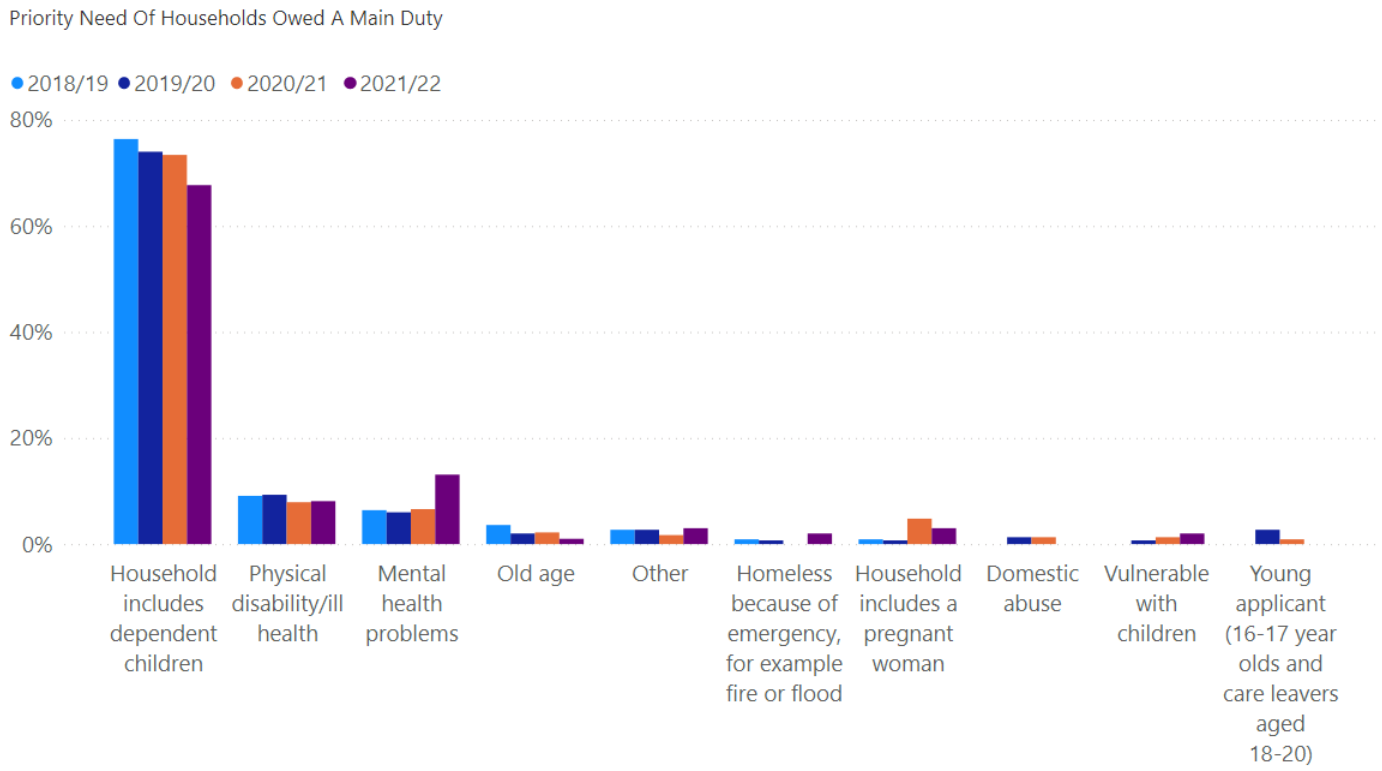




A number of factors are considered to determine whether a homeless household has a priority need for housing. Some groups of people, such as pregnant women, households with dependent children and victims of domestic abuse must be accepted as in priority need.

Others, such as those with physical disabilities or mental health illnesses and disabilities may also be in priority need if they would be significantly more vulnerable than an ordinary person would be if they became homeless.

The chart below provides an indicator of the priority need of households owed the main housing duty by Thurrock Council. The table, the classification 'other' incorporates alcohol/drug dependency, learning difficulty, time spent in care, in custody, in HM forces or as former asylum seeker, and those fleeing home because of violence other than domestic abuse.



Although the proportion of households with dependent children within all those owed a main duty has seen a slight year-on-year reduction, it remains the most significant priority need in homeless households Thurrock. There has been a noticeable increase in the proportion of households identified in priority need of housing as a result of mental health problems, with physical disability and ill health remaining a consistent factor for priority need.

Unlike accommodation secured through the prevention and relief duties, most of the accommodation offered to households owed the main housing duty was social housing, however the use of private rental sector properties has been increasing in recent years.

Impact

It is generally recognised that prevention is more effective and less costly than responding to crisis, and with homelessness this is no different. If the balance of homelessness assessments continued as evidenced in 2020/21 with the number of relief duty cases outweighing prevention duty, it would mean that there would be increased pressures on the resources and finances of

public services, and far greater numbers of Thurrock residents experiencing the distress and harms of homelessness.

A focus on proactive identification of households in Thurrock at risk of or threatened with homelessness provides far better opportunities to support and prevent reaching the point of loss of their settled accommodation.

The data indicates a range of diverse support needs in the households that approach the council for homelessness assistance in Thurrock. To appropriately prevent or relieve homelessness, sufficient levels of suitable accommodation are required in Thurrock, however previous sections of this chapter have illustrated the undersupply of new homes in recent years, exacerbating pressures on existing properties.

The above data indicates that there are greater opportunities to prevent and relieve homelessness by accessing properties in the private rental sector, however if homelessness cannot be relieved that the vast majority of households identified to be in priority need are made offers of social housing.

Again, the information in this chapter evidences a chronic shortage of affordable social housing in Thurrock. Without appropriate homes for people to move to there is a risk that vulnerabilities can be exacerbated, stays in temporary accommodation extend and alternative locations are considered, and households experiencing homelessness will be pushed further into crisis.

The information on assessments shared above indicates that rather than there being an overall downward trend and reduction of households experiencing homelessness, it suggests that certain causes of homelessness were suppressed in recent years. Caution remains regarding the possibility of an increase in households seeking homelessness advice and assistance because of the COVID-19 pandemic, which would place additional pressures on the Housing Solutions service, social housing stock and the private rental sector in Thurrock.

With rising inflation, stretched household budgets and a potential backlog of possession proceedings to progress through the courts that were held up during 2020 and 2021, it is highly likely that there will be a surge in Thurrock households experiencing financial hardship and at risk of homelessness in the months and years ahead.

To minimise the risk of harm that homelessness can cause to individuals, the consequences of COVID-19 must be kept under close review throughout the lifetime of this strategy until evidence suggests that the risk has been successfully mitigated or addressed appropriately.

Recent action

Although the Homelessness Reduction Act 2017 generally directed local housing authorities to place much greater focus on homelessness prevention through general service provision, Thurrock Council's housing service has taken significant action to sustain tenancies and prevent homelessness.

A number of roles have been created and exist in the service to target specific areas of challenge or priority regarding homelessness, with some funded in part or full from DLUHC grants. These roles include:

- rough sleeper coordinator, whose close links to the community, voluntary and faith sector facilitates not only the identification of those experiencing rough sleepers but also those who may be at risk reaching crisis and losing their homes
- landlord and tenant liaison officer, exclusively tasked with preventing tenancy breakdown, negotiating with landlords and preventing illegal evictions
- tenancy sustainment officer, working with the rough sleeping cohort
- private lettings officer, specialising in supporting those with a history of rough sleeping, working and negotiating with landlords to secure accommodation and overcoming barriers such as guarantors and references
- financial inclusion officer, supporting residents to maximise their incomes, claim applicable benefits, establish budgets and payment plans, and prioritise debts appropriately
- mental health senior practitioner, seconded from adults social care into the housing solutions team to undertake assessments and assist households in identifying and accessing support to meet their needs

The ongoing temporary accommodation transformation plan has delivered successful outcomes to date, reducing the number of households in emergency and temporary accommodation significantly below pre-pandemic levels.

The council has access to a funding pot which can be used flexibly to help prevent homelessness, supporting in particular those unlikely to be in priority need. An allocation of £50,000 was also awarded to the council by the European Social Fund to set up and manage an ex-offenders housing and employment project in Tilbury.

There are also a number of cross-service initiatives that aim to support households at risk of or experiencing homelessness. An arrears panel has been established focussing on council tenants at risk of eviction. The panel features wide representation from across the council with a sole focus on the prevention of tenancy breakdown, with opportunity for interdepartmental working to tackle issues and avoid homelessness.

Briefings and training sessions have been delivered by housing solutions staff to colleagues in adults social care and children's services around the Homelessness Reduction Act 2017, the council's allocations policy, expectations and rights relating to homelessness and early warning indicators of homelessness that staff can look out for and refer accordingly for appropriate intervention. There are aims to deliver these sessions to other frontline and resident facing staff across the organisation.

Multi-disciplinary groups have been established to review case studies from the different perspectives of partners in the wider system, developing a shared understanding of existing challenges and aiming to identify areas of good practice and where improvement can be made to reach positive outcomes for households in the future.

Action Plan

What?	How?	Impact?
We will effectively eliminate rough sleeping in Thurrock	We will provide appropriate and timely support for people experiencing rough sleeping by making an offer of accommodation to every verified rough sleeper, and sharing knowledge between partners to help identify those individuals	Residents experiencing rough sleeping face some of the most severe health inequalities and report much poorer health than the general population, and those who experience rough sleeping over an extended period are, on average, more likely to die young Proactive work to tackle rough sleeping will significantly reduce the likelihood of people experiencing these severe health inequalities
We will support residents experiencing hardship across all tenures in order to prevent homelessness and sustain their homes	We will identify people at risk of homelessness early, preventing homelessness by adopting a holistic approach across the wider system where concerns and early indicators can be referred to the housing service for action We will monitor and review the impact and consequences of COVID-19 on the security of tenure for Thurrock households	Residents at risk of losing their homes will be proactively supported to avoid crisis and prevent the experience and harms of homelessness
We will work in partnership across the system in order to improve access to health, care and support services for those at risk of or experiencing homelessness	We will establish an initiative to bring together community and voluntary sector organisations, health partners and other support services in a physical location to directly support those who are at risk of or who are experiencing homelessness We will co-design bespoke solutions with each resident to address all the factors that may be contributing to their homelessness or risk of homelessness, such as addiction, mental health and debt	Residents at risk of or experiencing homelessness would receive meaningful, personal and better target support which is specific to their circumstances with the aim of securing appropriate settled accommodation
We will ensure that any households requiring temporary accommodation remain within the borough wherever possible and for as little time as possible	We will increase and maintain the number of council-owned properties for use as temporary accommodation in the borough, and only look to make out-of-borough placements where it is for safety reasons or in the best interests of the household by purchasing or leasing up to 115 properties by 2023, prioritised for those at risk of homelessness	Residents requiring temporary accommodation placements will experience significantly less disruption through the use of in-borough council-owned by ensuring that they are provided with better quality homes and remain close to any places of work or education and existing support networks This approach will also reduce the financial pressures associated with costly nightly-let style temporary accommodation

Deliver sustainable estate regeneration

Context

Estate regeneration provides the opportunity to enhance estates, address issues of health inequalities and deprivation whilst increasing the provision of housing on site. The council has identified key areas requiring significant investment that would benefit from wider regeneration to deliver new and better-quality housing.

Council investments in existing housing stock need to be continually reviewed to ensure that programmes achieve the best outcomes for residents and maximise the overall value of assets. The aim is to ensure future reinvestment in properties that are well located, meet housing needs and are efficient to manage.

Investments also need to be made to ensure that homes and neighbourhoods support the health and wellbeing of residents in the local area.

Much of the council's existing housing stock is considered maintainable in the long-term; however, the council recognises that some property archetypes present challenges in ongoing maintenance and the living environment due to their age or build type.

For such properties, it may be that an alternative use could be more appropriate. Alternative uses may include using the land or housing assets to build additional homes to increase the number of council-owned and managed dwellings available, of the type and quality needed and in areas where people want to live.

Further practical options could include:

- Re-designation or re-use of properties
- Remodelling of properties
- Infill development or full site redevelopment
- Development on previously undeveloped or cleared land

Several potential locations have already been identified to be taken forward for housing redevelopment and regeneration, such as the Blackshots high-rise tower blocks, blocks of flats at Teviot Avenue, and part of the Civic Offices site in Grays.

The high-rise blocks at Blackshots experience problems with damp and mould and attract the most with complaints about this issue across all high-rise blocks in Thurrock. There are interim plans to address some immediate issues at the Blackshots blocks in respect of the existing external cladding system, the ventilation of the communal areas and weatherproofing of the structure; however, this will not address the overall design and layout of these properties which does not meet the requirements of today's modern living. For example, the kitchens cannot accommodate all modern-day appliances, and there is no separate clothes drying space within the blocks.

Teviot Avenue, Aveley, contains 36 flats constructed of pre-cast reinforced concrete of the 'Cornish' type. These dwellings were of a type designated as defective initially under the 1984 Housing Defects Act, consolidated into the 1985 Housing Act, due to their construction material and manufacture.

A refurbishment was scheduled for Teviot Avenue in the next 5 to 10 years, so a survey was instructed to assess the condition of the structures and record the location of defects, and also to provide commentary on the remedial works and improvements required to maintain the blocks in the medium term.

However, the survey identified several issues with the flats at Teviot Avenue, including inherent structural defects due to the construction method. These defects can only be remediated by substantial reconfiguration of the overall structure. Therefore, the reconsideration of options was required for the estate and long-term sustainability.

After the completion of a stock options appraisal and initial engagement with residents, the preferred option to be progressed is to redevelop the site and provide more homes.

The position on redeveloping Civic Offices 1 (CO1) for residential accommodation and the benefits of providing a new council facility in the Civic Office extension were agreed at Cabinet in September 2019, with the benefits of developing CO1 for residential accommodation being a contributory factor in bringing the Civic Offices Project forward.

An initial range of designs and cost plans were developed that considered options from refurbishing the existing accommodation as apartments through to a range of demolition and new build alternatives of differing levels of height and density. Following review, the preferred option was for a new build project of approximately 80 homes.

Options for a market sale or private rented sector development proved not to be financially viable, however a scheme based on 100% council-owned social housing has been proposed and offers a financially sustainable model for developing the site.

Through extensive resident engagement, stock evaluations and options appraisals, it is anticipated that further regeneration possibilities will arise throughout the lifetime of this strategy.

Impact

Redevelopment and regeneration of housing and estates has short- and longer-term impacts and consequences. In the short term, to allow for major works to take place in existing residential areas, households living in properties identified for regeneration will need to be supported to move into alternative temporary or permanent accommodation elsewhere in the borough.

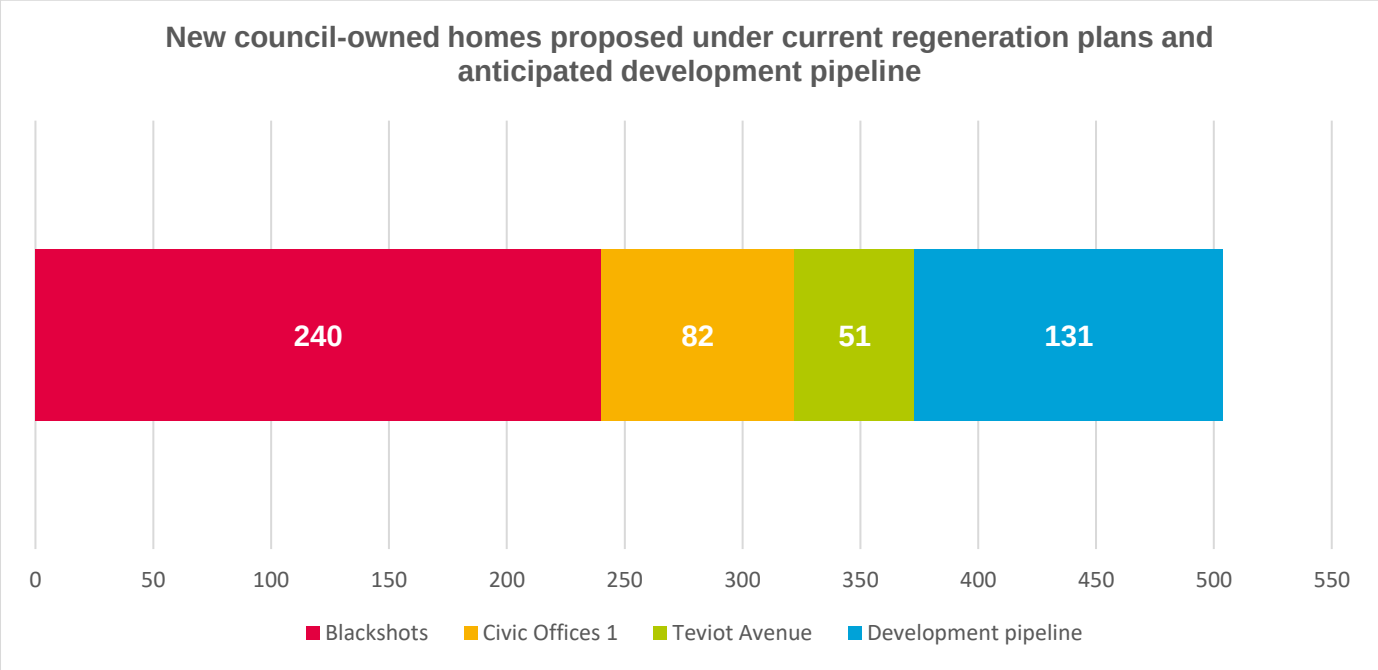
In both Blackshots and Teviot Avenue proposals, remediation works would prove costly and only extend the life of accommodation that had already been identified as falling short of meeting the needs and expectations of tenants and modern day living. In the longer term, the proposals to redevelop these sites (and others in the future) will deliver new homes and neighbourhoods meeting higher quality standards, with modern technology built-in to maximise thermal and energy efficiency.

These outcomes will directly benefit the residents that will live in these homes in the future, improving general health and wellbeing and reducing the risk of experiencing fuel poverty. Regeneration will also offer the opportunity to embed active travel, reduce dependency on car use and improve cycling infrastructure in new developments across Thurrock, improving health and wellbeing outcomes.

Recent action

The most significant regeneration project in Thurrock currently underway is the investment in over 140 acres at Purfleet-on-Thames, delivering up to 2,850 new homes. Purfleet Centre Regeneration Limited is a joint venture between Urban Catalyst and Swan Housing, in partnership with Thurrock Council. The first phase of 61 homes is currently anticipated to be handed over in Spring 2023.

Specific projects have commenced to take forward regeneration opportunities for council-owned homes at Blackshots, Teviot Avenue and Civic Offices 1. Initial resident engagement activity has already been completed with households at Blackshots and Teviot Avenue, with very high proportions in favour of redevelopment.



Although the schemes are still in early stages, the chart above provides an indication of the number of properties that each project is currently anticipated to be able to deliver.

Action Plan

What?	How?	Impact?
We will establish and embed a clear vision and deliver against ambitious plans in order to direct future housing development and regeneration	We will deliver a Housing Development Strategy to regenerate and improve council estates We will undertake options appraisals for wider estate regeneration to establish proposals to improve the quality of homes and neighbourhoods for residents	Residents will benefit from well designed homes and estates as a direct result of council-led development that improve the local area and renew existing poorer quality housing

What?	How?	Impact?
We will deliver the major regeneration projects at Blackshots, CO1 and Teviot Avenue to provide modern, sustainable homes that are fit for the future	We will progress and deliver the regeneration of Blackshots, Civic Offices 1 and Teviot Avenue, delivering up to 373 new homes	Residents in Blackshots and Teviot Avenue will be supported to move into good quality homes that eliminate the current issues experienced in those locations, with new housing opportunities for residents across the borough at CO1
We will embed resident engagement in estate regeneration in order to deliver projects that meet local needs	We will work closely with our residents to understand their priorities, identify required estate improvements, and progress opportunities for new housing to transform and enhance neighbourhoods	Residents will have direct input, influence and opportunity to shape future council-owned developments and ensure that they meet their needs and priorities
We will target the regeneration approach in order to maximise the value of housing assets	We will undertake full stock appraisals of assets where property archetypes continue to present challenges due to age or build type or where land redevelopment could offer opportunities to improve stock and provide better value for money We will ensure these appraisals consider, need and demand, and social, economic and neighbourhood sustainability factors We will use these appraisals to inform and recommend future programmes of investment or redevelopment to address identified issues	Residents will be assured that new developments offer value for money, are financially viable and can be delivered
We will embed active travel in new developments in order to encourage sustainable transport and improve wellbeing	We will encourage a shift away from traffic growth in new developments and regeneration projects and help connect more residents to key services and facilities and to open space and nature We will embed cycling infrastructure into new developments	Residents will benefit from better connected homes and neighbourhoods that do not rely on private car use for access or transport

Review the model of Sheltered Housing provision

Context

Housing providers throughout the country have recognised that the traditional approach to Sheltered Housing model may no longer be fit for purpose or match the lifestyles and aspirations of older people today. Sheltered housing stock and complexes can also appear dated.

The consequences of these factors combined leads to lower levels of demand, increased numbers of vacant properties, loss of rental income for housing providers as well as missed council tax revenue.

This challenge has been known and growing for some time nationally, with the Joseph Rowntree Foundation publishing housing research in December 1995 regarding the causes and consequences of difficulties letting sheltered housing properties.

The table below shows a snapshot of voids and lettings performance for council-owned sheltered housing properties in Thurrock since 2018/19.

	2018/19	2019/20	2020/21	2021/22	Current Void
Number of properties let in financial year (or currently void)	109	96	118	102	18
Number of properties advertised more than 4 times	4	1	23	26	6
Number of properties advertised more than 12 times	0	0	6	10	1
Number of properties advertised more than 20 times	0	0	0	5	0
Average number of bidding cycles per property	1.7	1.1	3.3	4.6	4.1
Average number of calendar days void	47.8	34.1	73.3	56.4	64.9

Thurrock Council operates a choice-based lettings system, whereby housing register applicants can place up to two bids each week on a list of advertised properties that meet their household needs each week. These are known as bidding cycles.

The above table shows that the average number of calendar days that a sheltered property is vacant has increased since the end of 2019/20. The increase in 2020/21 can be explained in part because of steps taken to suspend all choice-based lettings from 23 March 2020 until 11 June 2021 in response to the Government's 'Stay at Home' guidance. Allocations were still made for risk-assessed homeless households and applicants whose safety was at risk where they live, such as those experiencing domestic abuse.

The table also indicates that since 2020/21 there has been a significant increase in the average number of bidding cycles required for a successful offer of a sheltered housing property to be made to an applicant. Sometimes properties need to be readvertised if the shortlisted candidates refuse the property or withdraw from the allocation process, however sometimes the readvertisement is due to a lack of interest from applicants in that bidding cycle.

The increase in number of void days for 2020/21 cannot be explained by the choice-based lettings suspension entirely, however, as the average number of bidding cycles per property also increased which suggests that the extended void periods were more likely a result of the lack of interest from an appropriate housing register applicant. This trend appears to have continued into 2021/22, for properties that have been let as well as those that are currently void.

To better understand the drivers for increased void turnaround times and increased numbers of bidding cycles, lettings data can be broken down into property types. The table below is combined data for the period between 2018/19 and 2021/22.

Property Type	Number of properties let	Average number of bidding cycles per property	Average number of calendar days void
1 bed ground floor flat	205	1.2	41.4
1 bed first floor flat	189	4.6	68.1
1 bed second floor flat	7	3.3	100.0
1 bed third floor flat	3	1.0	42.0
1 bed bungalow	19	1.2	29.8
2 bed bungalow	2	1.0	66.5

The above table provides a clearer picture of applicant demand based on property types. In the reporting period, the number of 1 bed ground floor flats and 1 bed first floor flats are broadly similar. However, the successful letting of a 1 bed first floor flat takes almost four times as many bidding cycles than needed for a 1 bed ground floor flat and void periods are on average 64.5% longer. 1 bed second floor flats, whilst requiring fewer bidding cycles than 1 bed first floor flats, experience the longest void periods.

The relative difficulty in letting properties above the ground floor in sheltered housing may reflect concerns or preferences regarding accessibility of such properties for residents that meet the criteria for sheltered housing in Thurrock – a factor exacerbated by the fact that very few council-owned sheltered housing complexes with more than one floor have lifts.

Impact

Difficulties in letting properties, regardless of property type, impacts both the council and housing register applicants. The longer that a property remains vacant the greater the amount of lost revenue that could have otherwise been reinvested back into housing services, however it also means that the property is sitting vacant rather than providing a safe, suitable, and affordable home for a household in need.

If sheltered housing properties are not meeting the needs of eligible housing register applicants or existing residents, action must be taken. A human-centred approach can be explored to broaden the range of households eligible to move into sheltered housing, such as where an individual is below the current age threshold, but the sheltered housing environment would positively affect their quality of life. This type of approach can help to achieve aspirations of intergenerational living, but lettings must be made sensitively.

There is likely to continue to be a need for supported and specialist housing for older people in Thurrock, however significant consideration is needed to ensure that any new developments avoid the pitfalls of existing complexes with regards to accessibility.

Recent action

During the past two years, the Sheltered Housing team have continued to deliver a valuable service to all tenants. The service has been enhanced in response to the COVID-19 pandemic by ensuring tenants had a contact at least twice weekly and supporting residents with food shopping and medication delivery.

The 'Oomph' wellness programme has been reinstated tenant attendance has been strong. The aim of Oomph is to provide fun activity and exercise sessions to benefit physical and mental wellbeing and reduce loneliness.

Several actions have been taken within the service to address underperformance in void turnaround, specifically regarding properties above the ground floor. A dedicated Sheltered Housing Officer has been assigned to this area to improve performance and is currently:

- proactively contacting tenants to support them to move from larger properties
- part of the decommissioning working group, supporting tenants to move and targeting harder to let properties
- working with the Allocations Team to identify suitable tenants and prioritise offers

Case Study - Alexandra Court Decommissioning

Residents are being supported to live independently in Sheltered Housing properties for longer and later in life. Whilst this is positive, as people age and their mobility reduces, they may face additional challenges due to the condition of the communal access points for their homes, subsequently impacting upon their quality of life and independence.

A 2019 report considered the condition of communal entrance points in the Sheltered Housing complexes across the council's housing stock.

This review included the 36 properties at Alexandra Road and the four properties at Dunlop Road, which collectively form the 'Alexandra Court' Sheltered Housing complex in the Tilbury Riverside and Thurrock Park ward.

The assessment of the access to the blocks at the Alexandra Court Sheltered Housing complex indicated that they did not meet the accessibility standards which the council aims to achieve.

Due to the scale of the suggested works for the Alexandra Court blocks to meet these standards, the disruption residents would face, the challenging space constraints at the site and the internal accessibility issues that would remain, such as stairs-only access to the first-floor flats, it was decided to decommission this complex in late 2020.

Whilst this decision posed a level of disruption to residents, a comprehensive package of support was designed to help them to move to alternative accommodation suitable for their needs. This included two dedicated officers assisting with key elements of moving home, such as:

- packing and removals
- assisting with the home loss and disturbance payments

- general moving requirements
- providing a smooth transition from one property to another

The nearby construction of Beaconsfield Place, a council-owned development using HAPPI principles for older people's housing, provided an opportunity for residents to move to a new home within their current community designed with accessibility requirements in mind. The development has 31 one-bedroom flats and 4 two-bedroom duplex flats, indoors communal spaces, private communal gardens for residents, ample parking and mobility scooter storage. The support of a sheltered housing officer will be provided at this new development.

Tenants from Alexandra Court were prioritised for the Beaconsfield Place development, if they wished to move there, and all residents were awarded the highest priority on the council's housing register to allow them to consider moving to another Sheltered Housing complex or appropriate property elsewhere in Tilbury or across Thurrock.

15 households were successfully supported to move into other sheltered housing complexes of their choice across Thurrock. A further 18 households from Alexandra Court moved to Beaconsfield Place following its handover into the council's housing stock in February 2022.

In the longer term, decommissioning this complex will allow the entire site to be considered as a redevelopment opportunity to provide new council-owned family-sized homes for the borough.

The Sheltered Housing Team is working with other services across the council to identify suitable applicants, making person-centred decisions relating to the age eligibility where a move to sheltered housing would have a beneficial impact on the health and wellbeing of a household.

Action Plan

What?	How?	Impact?
We will implement a new delivery model for Sheltered Housing in order to ensure this type of supported provision meets resident needs	We will explore options for changes and improvements with residents to provide a new delivery model for Sheltered Housing, including opportunities to include the delivery of an outreach independent living service	Residents requiring this type of supported living will be able to access a service that is person-centric, appropriate for their needs and reflects modern living
We will rationalise Sheltered Housing stock in order to identify opportunities to provide new housing	We will investigate options for the potential decommissioning of Sheltered Housing complexes which are underused or no longer fit for purpose and offer opportunities to redevelop into new housing	Residents in homes where accessibility is a challenge will be supported to move to accommodation that is better suited for their needs Residents will have access to newly developed homes that meet varied needs in existing and well-connected communities
We will overhaul the approach to allocating Sheltered Housing properties in order to support more people to benefit from this type of accommodation	We will reassess the eligibility criteria for Sheltered Housing within the Allocations Policy and introduce a new approach to 'sensitive lettings' to improve access for residents	Residents that may benefit from the environment and style of living offered in sheltered housing complexes will be offered the opportunity to do so under a redeveloped lettings approach

What?	How?	Impact?
We will invest in Sheltered Housing complexes in order to improve the day-to-day experience of residents	We will develop new ways and opportunities for residents in Sheltered Housing to engage and collaborate with the housing team, other council services and external partners by increasing the use of technology in complexes We will invest in Sheltered Housing stock to improve conditions through internal and external decorating programmes We will continue the work to improve resident access to communal spaces in line with Equalities Act	Residents living in sheltered housing complexes will be better connected to their neighbours and local area, reducing accessibility difficulties and tackling causes of social isolation

Chapter 6

Protect Resident Safety

This chapter is focused on protecting people and working to prevent them from experiencing harm to their physical and mental health. It considers the physical environment relating to property conditions, fuel poverty, property accessibility and adaptations, and harm experienced from anti-social behaviour, crime, and domestic abuse. It also addresses and the general perception or feeling of safety in and around the home and neighbourhood.

The safety and security of residents in Thurrock are of paramount importance. They can be considered in two ways – the actions taken or required to protect physical safety and the actions taken or required to support people to feel safe. Although these are often aligned, it cannot be guaranteed that ensuring physical safety will result in a person feeling safe, and vice versa.

Improve warmth, safety, and standards in private sector homes

Context

All residents living in the borough must have access to good quality housing.

A significant amount of feedback was provided by residents during the development of this strategy relating to standards in the private sector. Responses suggested that action was required to ensure that all HMOs and other privately rented properties in Thurrock operate appropriately and safely, and to support vulnerable homeowners to live in warm and safe homes.

Private sector conditions

In 2021 the council commissioned a study to gather intelligence on the private housing stock in the borough. Through this, the council gained insight on the tenures, property conditions, likely instances of fuel poverty and geographical distribution of properties.

In recent years, Thurrock has seen growth in the number of properties used in the private rental sector, both as dwellings let in their entirety and as houses of multiple occupation (HMOs). The private rented sector, including HMOs, have an important role as housing provision in Thurrock. The 2021 study estimated that the size of the private rental sector in Thurrock had increased by 76.3% compared to the findings of the 2011 census.

The council uses a risk-based evaluation tool called the Housing Health and Safety Rating System (HHSRS) to help identify potential risks and hazards to health and safety from any deficiencies identified in dwellings. The HHSRS is used to determine whether residential premises are safe to live in, or whether a hazard exists that may cause harm to the health and safety of a potential occupant.

The system assesses 29 types of housing hazard and provides a rating for each one. Those which score highly on the scale are called category 1 hazards and the council has a duty to take the appropriate enforcement action. Those that fall lower down the scale and pose a lesser risk are called category 2 hazards.

Physiological requirements

- Hygrothermal Conditions – damp and mould growth, excess cold and excess heat
- Pollutants (non-microbial) – Asbestos, biocides, carbon monoxide and fuel combustion products, lead, radiation, uncombusted fuel gas, and volatile organic compounds

Protection against accidents

- Falls – falls associated with baths etc, falling on level surfaces etc, falling on stairs etc, and falling between levels
- Electric shocks, fires, burns and scalds – electrical hazards, fire, and flames, hot surfaces etc
- Collisions, cuts and strains – collision and entrapment, explosions, position and operation of amenities etc, and structural collapse and falling elements

Psychological requirements

- Space, security, light and noise – crowding and space, entry by intruders, lighting, and noise

Protection against infection

- Hygiene, sanitation, and water supply – domestic hygiene, pets and refuse, food safety, personal hygiene, sanitation and drainage, and water supply

The data provided in the private sector stock condition survey estimated that 11% of properties in the private sector are estimated to have at least one category 1 hazard. The table below provides a breakdown by private sector tenure type as well as an indication of the proportion of properties in disrepair. In this table, disrepair is based on the former Decent Homes Standard criteria which states that a dwelling fails this if it is not in a reasonable state of repair – this is based on the dwelling age and condition of a range of building components including walls, roofs, windows, doors, electrics and heating system

		Owner-occupied properties (% of total)	Private rental sector properties (% of total)
HHSRS category 1 hazards	At least one hazard	10.7%	10.6%
	Excess cold	1.6%	1.7%
	Fall hazards	8.5%	7.5%
Disrepair		3.0%	4.1%
Fuel Poverty (Low-income, high costs)		8.8%	16.8%
Low-income households		12.1%	29.5%

The private sector stock condition survey estimated that highest concentration of all HHSRS hazards is found in the wards of Grays Thurrock, Little Thurrock Rectory, and East Tilbury, with the highest concentration of properties experiencing excess cold located in East Tilbury, Orsett and Grays Thurrock.

The above table also provides an estimate of the number of properties experiencing fuel poverty, using a measure that considers a household to be in fuel poverty if their required fuel costs are above average, or spending that amount would leave the household with a residual income below the official poverty line (considered in this data to be 60% of the median UK household income, after housing costs).

The wards of Tilbury St Chads, Tilbury Riverside & Thurrock Park, and Belhus featured the highest concentrations of households of fuel poverty in Thurrock.

Fuel poverty is driven by three main factors: low household incomes, high energy costs, and poor property energy efficiency such as insufficient insulation or ineffective heating systems.

Since 1 April 2020, landlords have no longer been able to let or continue to let properties covered by the Domestic Minimum Energy Efficiency Regulations if the property has an Energy Performance Certificate (EPC) rating below E, without a valid exemption in place. Band ratings are divided into bands A to G, with the band A representing the highest level of energy efficiency.

Through the stock condition survey 2.9% of privately owned dwellings and 2.9% of private rented dwellings in Thurrock were estimated to have an EPC rating below band E.

Houses of Multiple Occupation (HMOs)

HMOs can present greater risks to the health, safety, and wellbeing of residents than comparable single occupancy homes. Risks such as dangerous gas appliances, faulty electrical systems and inadequate means of escape and other fire precautions are examples of some of the hazards that the private housing team investigate in Thurrock on a regular basis.

We estimate that there are 2501 HMOs in Thurrock. Grays Riverside ward has the highest number of HMOs, followed by West Thurrock & South Stifford, and Grays Thurrock.

The below table presents estimates of the stock condition survey, comparing the risks and hazards of non-HMO rental sector properties to HMO private renal sector properties.

		Non-HMO private rental sector properties (% of total)	HMO private rental sector properties (% of total)
HHSRS category 1 hazards	At least one hazard	10.4%	11.9%
	Excess cold	1.7%	2.1%
	Fall hazards	7.4%	8.4%
Disrepair		3.9%	5.3%
Fuel Poverty (Low-income, high costs)		17.6%	12.9%
Low-income households		29.2%	30.7%

Through the stock condition survey, we estimate that at least one category one hazard is present in 26% of HMOs in Grays Thurrock, 23% of HMOs in The Homesteads and 22% of HMOs in Little Thurrock Rectory. 12% of HMOs in Grays Thurrock are also estimated to be in disrepair

The purpose of licensing, especially for HMOs, is to ensure that residential accommodation within the private rented sector is safe, well managed and of good quality with a particular focus on safety.

A licence is needed for all properties that are occupied by five or more people, living together as two or more households. There are additional licensing rules for HMOs in certain areas in Thurrock until May 2024.

Disabled Facilities Grants

Mandatory disabled facilities grants (DFGs) are available from local authorities to fund or part-fund the completion of a range of adaptations for disabled occupants. DFGs are issued for works that are necessary and appropriate for the property to meet the needs of the disabled occupant, and that are reasonable and practicable to carry out. DFGs are tenure neutral.

Purposes for DFGs include works to facilitate access to and from the dwelling and any garden space, and access to or the provision of specific areas of a dwelling, such as the principal family room, a bedroom, appropriate personal hygiene facilities, and an appropriate space for food preparation and cooking. In addition, DFGs must be approved for works to make the dwelling safe for the disabled occupant and other persons residing with them.

The most prevalent harms removed in Thurrock properties between April 2019 and March 2021 as a result of disabled facilities grants were relating to personal hygiene, sanitation and drainage, falls with baths, and falls on stairs.

Impact

Property standards, regardless of tenure, affect the health and wellbeing of residents. The Marmot Review, published in 2010, concluded that housing is a 'social determinant of health', affecting and impacting upon physical and mental health inequalities throughout life.

Poor quality, sub-standard and unsafe private sector homes in Thurrock, whether owner-occupied or privately rented, are more likely to lead to injury and illness for residents than homes that are well-maintained and hazard free.

One in every ten private rental sector properties and just under one in every eight HMOs in Thurrock are estimated to have at least one category 1 HHSRS hazard, defined as hazards posing serious and immediate risks to the health and safety of residents.

The negative outcomes associated with such properties affect the quality of life of residents, place additional pressures on health and care services, and may lead to housing instability and insecurity for households seeking safer accommodation in the borough.

Although enforcement powers and measures are available to the council to use to tackle hazards in private properties, taking such action is largely reactive and only implemented following a report from an affected resident. In the private rental sector, tenants may be less likely to report any concerns to the council formally in fear of retaliatory eviction by their landlord. Except for HMOs under the mandatory and additional licensing schemes in Thurrock, there is no enforced structure for the proactive inspection of properties intended to be offered for rent. This means that hazards may exist in a property and remain unreported for some time, increasing the risk of harm for any resident living in that home.

These consequences are also applicable to households experiencing fuel poverty. Cold homes are associated with a range of poor health outcomes, including an increased risk of developing and exacerbating physical health conditions and mental health problems such as depression and anxiety.

Home adaptations, supported by the effective and timely administration of DFGs in Thurrock, provide many benefits for individuals with disabilities. Changes to an individual's home can bring about significant enhancements to independence as well as overall health and wellbeing. Adaptations can also reduce the risks associated with a poorly accessible home, such as the risk of falls, hospital admissions, thereby reduce the need for the reliance on carers, or other informal and formal support such as residential care.

An accessible and well-adapted home can enable an adult or child with a disability to remain in their home for longer, with dignity and with pride, and the earlier this is achieved, the sooner the benefits can be realised.

Recent action

As a direct result of interventions by the Private Sector Housing team, 2642 category 1 and 2 hazards were removed from properties in Thurrock between 2018-19 and 2020-21.

The council was also awarded £61k in grants from the Ministry of Housing, Communities and Local Government to tackle criminal landlords and drive up standards in the private rental sector.

An additional HMO licensing scheme was introduced in 2019 and has seen 213 HMOs licensed to date. Work to explore a selective licensing scheme for the private rental sector has also commenced.

Through proactive and targeted action, civil penalty fines have been used as a method of enforcement action, generating up to £220k for HMO and housing related offences.

Thurrock Council launched its Well Homes scheme in 2014 to improve the housing conditions and the health and well-being of residents living in private properties.

The Well Homes scheme:

- offers help to make homes safer by reducing the risk of ill health or accidents – for example, unsafe stairs or wiring, or providing improvements to your heating system
- puts residents in touch with health and lifestyle services that can improve quality of life – for example, help to stop smoking, health checks, debt advice, housing adaptations

The council secured a Warm Homes Fund grant of £453k for first time central heating systems under the ECO3 scheme and was allocated £1.8m under Local Authority Delivery Phase 2 (LAD2), a Government funded local-authority scheme that makes energy-saving improvements to the homes of people who struggle to pay their heating bills and keep their homes warm in the winter.

Between 2017-18 and 2020-21, the council awarded over £1.9m of Disabled Facilities Grants to 310 applicants to fund essential adaptations to give disabled people better freedom of movement into and around their homes, and to give access to essential facilities within the home.

Action Plan

What?	How?	Impact?
We will drive up the standards and quality of homes in the private sector in order to ensure greater availability of safe and suitable homes for Thurrock residents	We will develop targeted and data-driven interventions and work with private sector landlords to improve housing standards and living conditions for those renting in the private sector We will work with and support vulnerable owner-occupiers to remove HHSRS (Housing Health and Safety Rating System) hazards in their homes to support independent living and protect safety	Residents will have greater access to safe private sector homes, as well as to programmes such as Well Homes that have significant benefits to priority groups such as people living with long-term health conditions, physical disabilities and mental health needs.

What?	How?	Impact?
We will tackle hazards in the private rental sector in order to improve resident safety	We will continue to remove significant health and safety hazards from private rental sector properties by using the full extent of enforcement powers available to the council	Residents will be able to live in safe homes in the private rental sector with the confidence that any safety concerns can be raised with the council and appropriate action will be taken
We will encourage private sector residents to access available support in order to live independently in their homes for longer	We will encourage and signpost Disabled Facilities Grant usage where appropriate as a method to removing hazards and improve the health and wellbeing of households in Thurrock	Residents receiving Disabled Facilities Grants, regardless of tenure, will be empowered to live independently in their home by improving accessibly and removing hazards, thereby improving quality of life and reducing the risk of harm
We will develop a strategic approach to reduce fuel poverty in Thurrock in order to address the harm this causes to residents	We will develop a fuel poverty strategy for housing in Thurrock during the lifetime of this Housing Strategy and implement an action plan to address its causes and symptoms We will support improvements to the EPC ratings of private homes across the borough by designing and delivering initiatives targeted at poor energy efficiency We will use technology, data, and predictive analytics to identify and proactively support households at greatest risk of experiencing fuel poverty	Residents will benefit from proactive intervention and access support to improve the thermal and energy efficiency of their homes, removing the harms to health and wellbeing of cold homes and fuel poverty

Invest in and maintain quality council-owned homes that are fit for the future

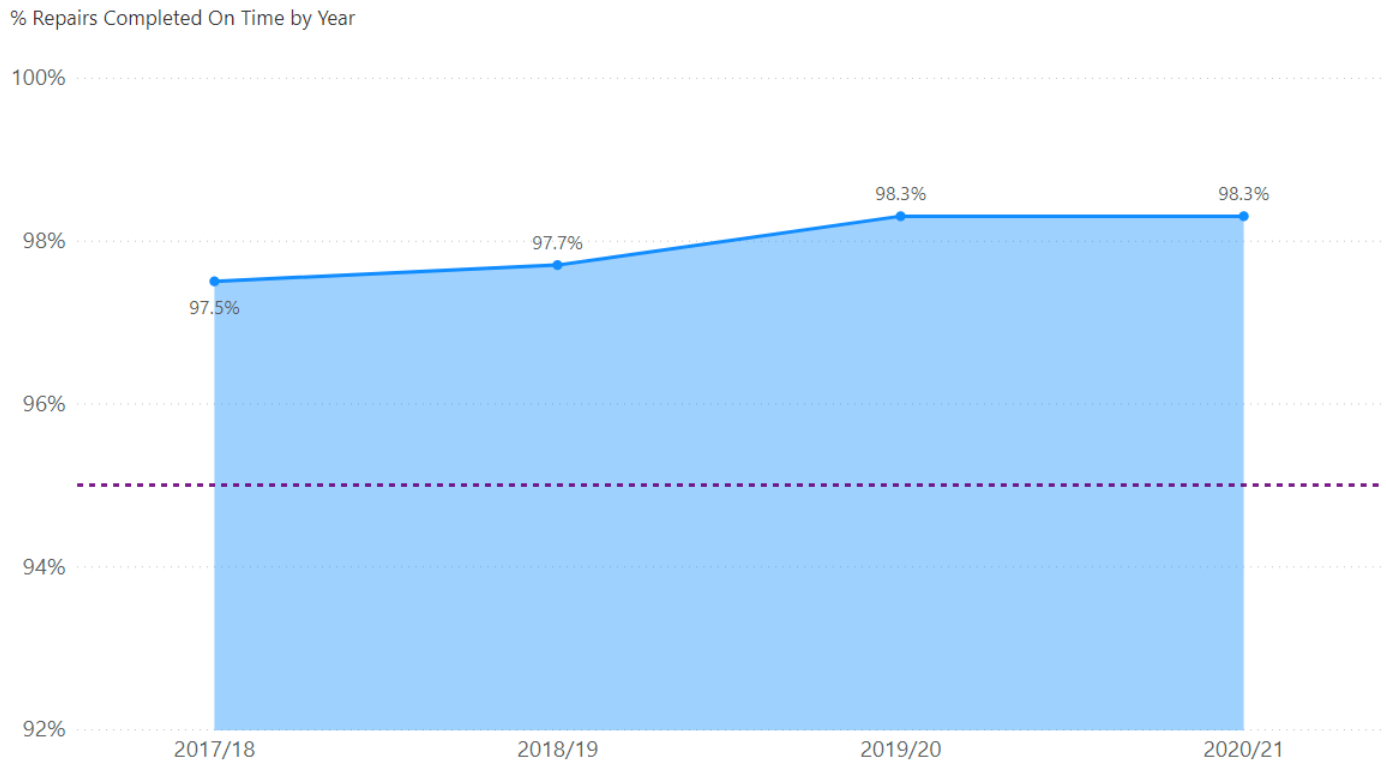
Context

The council's aims for its homes and estates are that they should be places where residents enjoy living and working, where they take pride in their homes and can enjoy being part of a thriving community. The aspiration is to invest in and maintain high-quality accommodation that demonstrates the benefits of the council's repairs and capital investment programmes and positively influences the health and wellbeing of our tenants and residents.

The council owns and manages just under 10,000 homes, with some dating back to the late 19th Century, and its stock includes over 1,000 sheltered housing properties across the borough. Half of the council's general needs properties are three-bedroom homes, and the remaining majority comprise one and two-bedroom flats.

A 2017 stock condition survey demonstrated that the stock was in a fair to good condition with specific themes emerging such a need to prioritise work to property exteriors.

The council provides an effective and responsive day-to-day repairs and maintenance services that keep properties in good repair. The repairs service is delivered through third party contracts, providing a responsive repairs service to all housing tenants in line with government and locally set standards and timeframes. The chart below illustrates the percentage of responsive repairs completed within target timescales since 2017/18, evidencing the consistent strong performance of this area of work.



Building and fire safety are matters of significant importance for any party or organisation involved in the management or maintenance of residential properties, and the responsibilities must not be taken lightly.

To meet its responsibilities, the council has a compliance regime to provide complete assurance to residents that their homes are well managed and meet required safety standards. Specific fire safety policies are in place to set how the housing service will manage and maintain its assets following the regulatory framework.

The housing service has begun to proactively develop an action plan to ensure that the council is in a strong position to meet and address the Social Housing White Paper proposals.

The housing service also stands ready to ensure compliance with the emerging Building Safety Bill, the implementation of recommendations made within the '*Building a Safer Future*' report following the Grenfell Tower fire, and any new duties or responsibilities introduced by the Fire Safety Act 2021. This aligns with the Charter for Social Housing Residents, as set out in the Social Housing White Paper.

Resident engagement is also crucial from the perspective of building management and safety. As part of the '*Building a safer future'* report published following the Grenfell Tower tragedy, the introduction of a 'golden thread' was made. This golden thread aims to serve as a tool to manage buildings as holistic systems, allowing people to use information to design, construct and operate their buildings safely and effectively.

Damp and mould

Damp and mould in social housing is an issue across the UK. It is widely recognised as one of the most challenging aspects for landlords and residents to prevent and manage. It is for this reason that the Housing Ombudsman undertook a thematic review and recently published a report on this subject, entitled '*Spotlight on damp and mould – It's not lifestyle'*.

Analysis of council repairs data between 1 April 2019 and 31 March 2021 shows that damp and mould repairs are relatively uncommon as a proportion of all repairs. During this time, 2242 responsive damp and mould repairs were completed, representing 4.1% of the total repair demand.

During the reporting period, 2197 damp and mould related works orders were completed at 1,123 council-owned properties, reflecting 11.4% of the council's housing stock.

Further analysis of repairs data demonstrates that tenants of most of these properties only reported damp and mould once during the two-year period, with only 2% of those living in council's housing stock reporting damp and mould concerns more than once during this same period.

There are over five times as many damp and mould works orders completed in January compared to August and damp and mould issues are clearly positively associated with older stock which is less likely to be thermally well insulated. Both findings suggest that the primary cause of damp is condensation, where warm humid air inside the property condenses on cold walls, more commonly occurring in older properties, during the winter months.

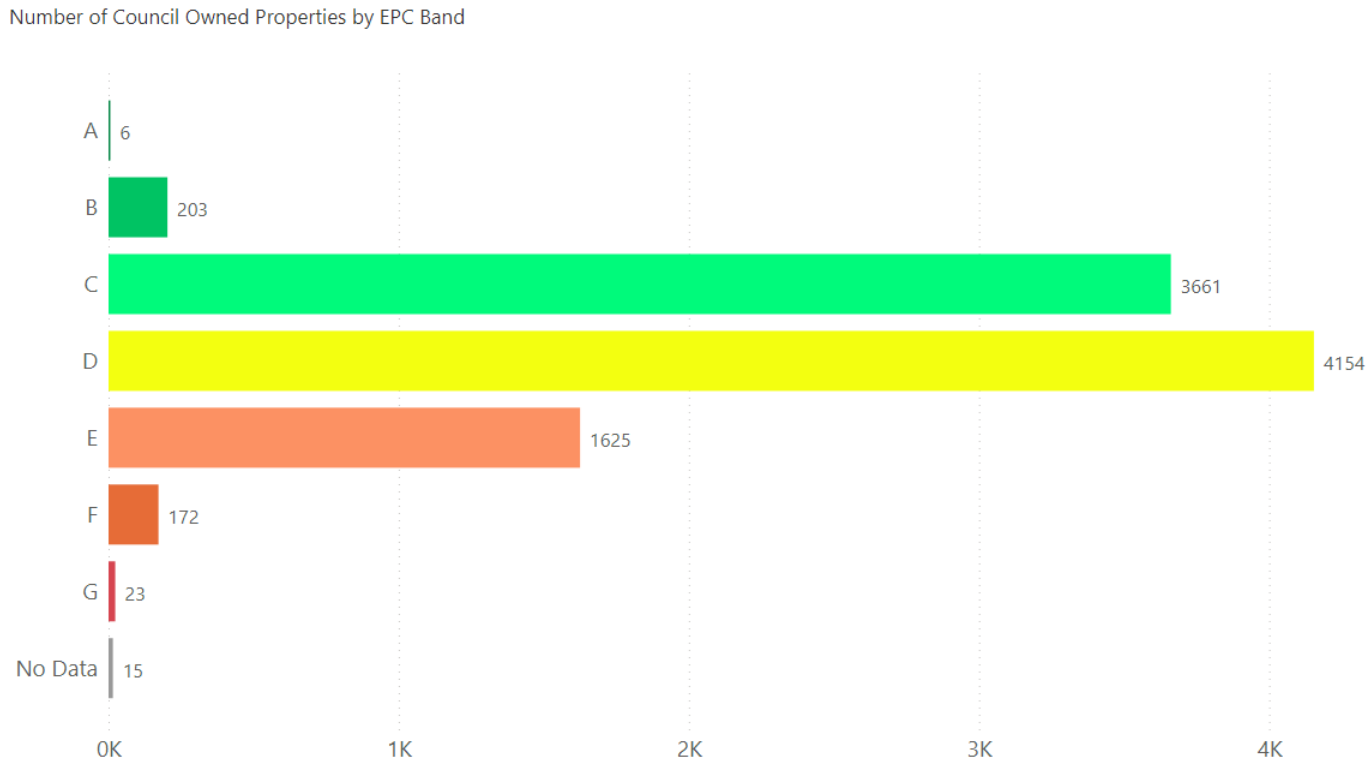
The *'Spotlight on damp and mould – It's not lifestyle'* report produced 26 recommendations for landlords, including Thurrock Council to take into consideration for action to improve property conditions. The recommendation asks landlords to shift their approach to damp and mould:

- from reactive to proactive
- from inferring blame to taking responsibility

- from disrepair claims to resolution
- from complaints to a learning culture

Energy efficiency

Energy performance certificates (EPCs) are a rating scheme, summarising the energy efficiency of buildings. Assessed buildings are given ratings between A (very efficient) and G (inefficient). The assessment used to produce an EPC examines key items such as insulation, boilers, hot water tanks, radiators and heating controls, and windows. The below chart demonstrates the EPC ratings of properties within the council's housing stock.



As part of the Government's Clean Growth Strategy, all social housing providers are targeted with ensuring that 100% of homes within their stock have an EPC rating of C by 2030.

Decarbonisation

In October 2019, the council passed a motion to declare a climate emergency and to take urgent action to reduce its carbon emissions to net-zero by 2030. The council has committed to reducing its carbon footprint to zero. The council's initial plans to respond to the climate crisis is by making sure the council's operations are carbon neutral by 2030,

Over 34% of all emissions in the UK are attributed to the provision of heat. Electrification of heat is a key part of the Government's strategy for achieving net-zero carbon by 2050. Ground-source or air source heat pumps provide a solution to fully decarbonise heating in social housing assets coupled with the provision of clean energy. The installation of the low carbon heating systems is expected to provide at least a 70% reduction in carbon emissions.

The council is committed to continually investing to improve the overall thermal efficiency of homes, whilst effectively supporting the borough's most vulnerable residents out of fuel poverty.

This strategy supports the decarbonisation agenda while improving the overall energy efficiency of the assets, ensuring the homes provide affordable thermal comfort.

To achieve this the council will review the performance of the existing housing assets and identify range of appropriate interventions for the various property archetypes within the borough. The council will ensure all retrofit works will be integrated into all asset investment plans, taking a fabric first approach to ensure they achieve the best outcomes value.

Impact

There is a clear requirement for ongoing investment in the council's stock to protect resident safety, provide good quality homes and meet the decarbonisation challenge.

The housing service must set a robust budget in order to meet the ongoing repairs, maintenance and stock improvement obligations. For 2022/23, a repairs and maintenance budget has been set at £12.893m.

The council must be committed to the management and investment required to tackle and minimise cases of damp and mould within residents' homes. It is recognised that it is not possible to fully eradicate the presence of damp and mould due to the array of factors that cause it; however, the council will need to ensure a fully coordinated approach to the ongoing prevention and management of this problem, put in place a policy for this aspect of property management and will work in line with the recommendations set out in the Housing Ombudsman report '*Spotlight on damp and mould – It's not lifestyle'*.

The funding requirements for the five-year capital investment programme between 2022/23 and 2026/27 has been identified as £105.839m. Of this, £51.500m has been identified for the ongoing Transforming Homes programme, £15.200m for decarbonisation of high-rise tower blocks, £8.254m for other carbon reduction works and £3.000m for the renewal of heating systems across the stock.

There will be further significant investment required in order to meet the carbon reduction targets. A report published by Savills in 2021 entitled Decarbonising the Housing Sector estimated average costs of £24,250 per flat and £37,060 per 3-bed houses would be required to meet the requirements. Current estimates based on figures produced for this strategy indicate that around 40% of all homes owned by Thurrock Council currently achieve the Clean Growth Strategy target of EPC band C.

The level of investment required to improve EPC ratings for the remaining proportion of properties by 2030 will far exceed the funds available in the HRA business plan, therefore the council will need to seek to maximise the use of available funding streams. In preparation, the council will develop an opportunity overview of funding streams and ensure schemes are 'bid ready'.

Recent action

Since 2017 capital works totalling over £46m have been undertaken across the council's housing stock to address priorities areas. The Transforming Homes programme, which ensures the council-owned homes meet the required standard, completed internal improvement targets in 2019 and moved on to prioritising the external refurbishment, including the replacement of any remaining single glazing. Between 2019/20 to 2020/21, 732 properties benefitted from external refurbishment and double-glazed window replacement, including street properties and 90 blocks of flats.

A new stock condition survey targeting a further 30% of the stock is being undertaken in the winter months of 2021/22. The aim is to update overall stock condition data rather than diagnose specific repairs and defects, which the council would be made aware of through day-to-day reporting processes. The survey targets the winter months to gain an accurate picture of any properties suffering from seasonal damp or mould problems. The outcome of this survey will further inform the investment programmes over the next 5-30 years.

A pilot was launched to support the safety of vulnerable residents living in the council's high-rise blocks. It introduced personal emergency evacuation plans (PEEPs) that detail the support required for a resident who would be unable to independently leave their property if required in the event of an emergency. The effectiveness of these will be reviewed, and consideration will be given to the broader adoption of these documents across the council's housing stock in advance of any mandatory instruction by the Government.

The council has introduced a proactive approach to identifying properties experiencing damp and mould. Rather than relying solely on residents raising repair requests, new questions have been introduced in the general perception, repairs, gas repairs, gas servicing and new tenancy surveys undertaken on behalf of the council to seek out instances of damp and mould.

Through these questions, residents are asking if they have damp and mould in their property, if they have reported it, and if there is any action required to resolve. If a concern is reported, an alert is sent directly to the repairs quality assurance team, triaged, and sent to repairs contractor to raise a repair. This new approach was introduced as a direct result of the council's engagement with the Housing Ombudsman study and report produced on the subject of damp and mould.

It is estimated that this question will be asked in approximately 9,000 surveys per year. Residents are generally surveyed only once within any six-month period to prevent survey fatigue.

Residents who have suffered from damp and mould in their homes are given advice on the ongoing management of the home environment. This is delivered through resident liaison visits and the provision of printed information. The Council offer this advice in a supportive manner to help residents to live in their homes without the reoccurrence of mould and is alongside remedies to any structural defects, if found. In some cases, residents have raised concerns because they feel that the responsibility lies with the Council as a landlord, but to successfully eradicate damp in any home, some household management is required.

The council's resident liaison officers (RLOs) have been trained by the national fuel poverty charity NEA. In addition to advising on how to best manage the home environment, they are able to help residents to understand how to manage their resources and their heating systems. Where necessary the RLO help can help residents claim fuel poverty grants and liaise with our financial inclusion officers to ensure they are accessing all the financial support they are entitled to.

Between April 2019 and March 2021 £408,961 has been invested in servicing of mechanical ventilation and heat recovery units, repairing and replacing rainwater goods and completing the repair works under the specific mould remediation and prevention programme. A total of 4820 properties have benefited from these works.

In addition, the council invested £5,219,307 in improving overall building efficiency. These works included the replacement of central heating boilers in 1807 homes, the replacement of windows and/or doors in 331 homes and to replace the roof and improve insulation for 87 homes.

In February 2022 it was announced that the council would receive £3.2m following a successful bid under the first wave of the social housing decarbonisation fund. This funding has been specifically awarded to deliver a new ground-source heat pump project to the three high-rise tower blocks in Chadwell St Mary. It will connect all 273 individual flats to a shared ground loop heat pump system, replacing older and less efficient storage radiators and hot water systems within these three high-rise residential tower blocks.

All of the properties at the council's most recent new build developments – Bruyns Court, The Echoes, Bracelet Close, Alma Court and Heathlyn Close – have EPC ratings of at least C. 23% of these new build properties have this rating, with 75.2% rated B and 1.8% achieving A ratings.

Action Plan

What?	How?	Impact?
We will listen to the views of residents and understand their priorities in order to design, develop and deliver stock improvement programmes that target the things that matter	We will proactively engage with residents on their experiences of living in council-owned properties and their priorities for making homes fit for the future by embedding active engagement into the design of asset investment	Residents will be able to have their voices heard and priorities understood regarding what matters to them in future investment programmes in their homes and estates
We will invest in and embed new asset management technology in order to effectively direct housing investment for maintenance and improvement	We will implement an integrated asset management solution and load the results of the 2021/22 stock condition survey to form the foundation for investment modelling and the design of planned maintenance programmes and monitor compliancy We will introduce BIM to support the design, construction, operation, and maintenance of council assets, and explore smart technology and IoT (Internet of things) solutions to enable real-time monitoring of stock condition	Residents living in council-owned homes will benefit from fiscally responsible property improvements that deliver value for money and improvements to living conditions Through BIM, residents will experience improvements in the ability of the council to respond to and resolve maintenance and repairs concerns in applicable buildings Residents will benefit from the use of IoT through unintrusive solutions, allowing the council to be alerted to stock condition issues affecting the property and for remedial action to be arranged swiftly and proactively
We will embed proactivity in the approach to maintaining council-owned homes in order to achieve a good standard and mitigate the need for reactive repairs	We will identify properties requiring significant investment over the next five to ten years by using detailed stock analysis and findings from the 2021/22 stock condition survey We will use this information to inform plans for planned and cyclical maintenance programmes to ensure properties are safe and comply with legislative requirements with components serviced regularly to extend their lifespan and reduce the need for reactive repairs	Residents will live in well maintained homes, benefitting from investment at the right time and reducing the disruption of responsive repairs due to the failure of components

What?	How?	Impact?
We will proactively share information relating to building and fire safety in order to support residents to feel safe in their homes	We will develop a communications plan to ensure consistency in the approach taken by the council in communicating about safety We will use the plan as an opportunity to share information with residents about how their building operates and the steps and actions, they can take to protect their safety within the home	Residents will be supported to better understand their homes in the context of building and fire safety to address any concerns they may have about the safety of their building and prevent them from experiencing harm in the event of any incident
We will develop a holistic approach to damp and mould in council-owned properties in order to significantly reduce occurrences	We develop and deliver against an action plan based upon the recommendations set out in the Housing Ombudsman *Spotlight on damp and mould* report, including a dedicated policy for this aspect of property management We will analyse the data from a stock condition survey undertaken in the winter months of 2021/22 to gain an accurate picture of any properties suffering from seasonal damp or mould problems We will ensure a fully coordinated approach with partners to the ongoing prevention and management of damp and mould and embed technology, modelling and predictive analytics to identify properties likely to be experiencing these issues	Residents will experience fewer instances of damp and mould in their properties as a result of the proactive approach to identification based on stock condition survey data and predictive analytics, allowing preventative work to be carried out in their home Where instances of damp and mould do occur, residents will receive support free of the stigma and judgement traditionally associated with the term 'lifestyle' in the context of this issue
We will support residents out of fuel poverty in order to improve health and wellbeing and quality of life	We will achieve EPC band C ratings across all housing stock by 2030 through direct investment in council homes from the housing revenue account and maximising the use of available funding streams We will ensure that officers undertake fuel poverty awareness training and are provided with the tools and knowledge to best support residents	Residents will benefit from proactive intervention, significant investment and access support to improve the thermal and energy efficiency of their homes, removing the harms to health and wellbeing of cold homes and fuel poverty

What?	How?	Impact?
We will increase the use of sustainable and renewable technology in our stock in order to improve energy efficiency, reduce carbon emissions and support the council's green agenda	We will support the shift away from the use of fossil fuels by installing new, renewable technologies for heating and hot water needs in new developments We will reduce carbon emissions in the new build developments through installing renewable energy sources, using well-insulated materials in the new homes, fitting LED lights and installing efficient communal heating and hot water systems We will replace the electric storage radiators to 273 properties in three high rise blocks to provide a more efficient heating system linked to a ground source heat pump We will work with the council's suppliers and partners to reduce their carbon footprint, considering carbon emissions and contributions towards achieving net-zero when undertaking procurement activity	Residents will live in new and existing homes that have higher levels of thermal and energy efficiency, leading to reduced household costs relating to energy bills and more effective heating and lighting systems that are fit for the future

Strengthen community safety and prevent anti-social behaviour

Context

The council holds considerable responsibilities to protect its residents from crime and anti-social behaviour by providing strategy, policy, and frontline enforcement services.

Crime is a broad and complex issue, impacting upon the health and wellbeing of victims and survivors, and wider society. Abuse and exploitation have the greatest and longer lasting impacts on victims and survivors.

Anti-social behaviour is any act that causes – or is likely to cause – harassment, alarm, or distress. It is also any act that can cause nuisance or annoyance related either to housing or the affected person's occupation of their home.

The quality of the local environment is impacted in part by anti-social behaviour in Thurrock. Examples include littering, nuisance vehicles, and drug dealing and use. These factors impact on perceptions among the community of safety and the interest in communities to enjoy their local area.

The *Charter for Social Housing Residents* sets out that every social housing resident should have a good quality home and neighbourhood to live in. In relation to anti-social behaviour, it outlines that social housing tenants have a right to feel safe in their homes, without the stress, fear, and tensions that anti-social behaviour and crime can cause and encourages landlords to develop practical solutions to tackle crime and anti-social behaviour in their areas.

The topic of anti-social behaviour featured heavily as a priority throughout the engagement for the development of this strategy, with particular concerns raised regarding the perception of feeling unsafe.

Most crimes remain unreported for several reasons. Instances of abuse and exploitation remain particularly hidden, leading to challenges in identifying, safeguarding, and supporting those who experience these harms.

The ways in which crimes are committed is changing. Greater sophistication and use of technology have further enabled crimes such as online abuse, exploitation, scams, fraud and drug trafficking. This requires us to constantly adapt our approaches to preventing crime, protecting, and safeguarding our residents, particularly those who are most vulnerable.

Certain groups are more likely to be the victims of crime, including women and girls, children and young people, the elderly and those with learning difficulties and disabilities. Crimes disproportionally affecting these groups include but are not limited to domestic violence and abuse, sexual violence and abuse, hate crime, fraud, scams and cuckooing, as well as other forms of abuse and exploitation.

The rates of recorded violent crimes are higher in Thurrock compared to England and have risen sharply since 2013. The Thurrock Youth Offending Service are seeing young people with a more entrenched pattern of offending, further exacerbated by gang activity within the borough and an increase in the county lines model of offending. Concerns are also noted regarding the use of knives and weapons.

Thurrock's Community Safety Partnership brings together local organisations with the shared goals of reducing crime and the fear of crime, anti-social behaviour, alcohol and drug misuse and reducing re-offending.

The 2022/23 priorities for the Thurrock Community Safety Partnership are:

- Tackling disproportionality in relation to Violence Against Women and Girls – including sexual offences, stalking and rape, whilst recognising that men and boys can also be victims
- Breaking the cycle of Domestic Abuse – in line with the Domestic Abuse Duty and needs assessment
- Violence and Vulnerability – tackling gang related activity and offensive weapons to reduce drug driven violence
- Counter Extremism and Terrorism – preventing violent extremism locally
- Reduce harm to and safeguard victims from Hate Crime – including gender-based hate crime (misogyny and misandry)
- Tackling Community based Anti-social Behaviour and Safeguarding victims - including off road motorbike nuisance
- Human Trafficking and Modern-Day Slavery and Organised Immigration Crime
- Safer streets through increased visibility and community engagement
- Tackling offending – reducing high volume crimes e.g., burglary

Impact

Fear of crime is linked to poorer mental health and lower quality of life and can also be barrier to engaging in health improving activities outdoors (e.g., walking and running). Consistently heightened stress levels caused by feeling unsafe can also lead to a range of health problems. Those with poor health and fear of crime are more likely to suffer repeat victimisation. We want people feeling safer within their communities and increase public perceptions of safety.

Experiencing crime can have significant impacts on physical health, mental health and emotional wellbeing. These impacts are often dependent on the type of crime experienced and potentially affect many aspects of their life, including their housing, education, finances, and ability to work. Impacts can persist long after the abuse has ended with wider impacts including the effects on the victims' loved ones as well as societal impacts on the health service, social care and criminal justice system.

We want to improve our local, joined up response to crime, particularly abuse and exploitation. This includes improving approaches to prevention, responses to disclosure and providing victims/survivors with access to appropriate and holistic support that is trauma informed where appropriate.

Recent action

An action was undertaken in 2021/22 to implement a new noise nuisance reporting app, aimed at reducing duplication and allowing residents to report issues with greater ease. This has been implemented, offering an effective alternative to diaries and logs which would have been used traditionally.

Across the council, work is underway to develop and implement a new Community Safety Operating Model to improve the council's delivery of its community safety partnership strategy.

In conjunction with this, a new Community Safety Service is being developed. It will bring together the CCTV and Concierge teams from the housing service under a single structure along with the anti-social behaviour, community engagement, environmental enforcement, and civil enforcement teams.

Proposals have also been made to develop a new integrated centre for crime and enforcement (ICCE) within a central location that will house an advanced CCTV, command and control capability, supported by police and new community safety officers.

Action Plan

What?	How?	Impact?
We will work in partnership to reduce local levels of crime and opportunities for crime to take place in order to reduce the number of victims of crime and make Thurrock a safer place to live	We will work across the organisation to form a new *Community Safety Service* for Thurrock We will support the implementation of a new *Community Safety Operating Model* to improve the council's delivery of its Community Safety Partnership Strategy and a new *Integrated Centre for Crime & Enforcement* (ICCE) supported by police and new Community Safety Officers We will work across housing services to support the priorities identified by Thurrock Community Safety Partnership annually We will combat fly-tipping in our estates through targeted responses and enforcement powers where necessary	Residents will feel safer in their homes and neighbourhoods in Thurrock, resulting in improvements to quality of life and more positive perceptions of the local area
We will work in partnership to prevent and deter crime for those with increased risk of experiencing crime in order to better protect their safety and wellbeing	We will promote the Stay Safe Campaign, delivering multi-agency pop-up events to promote the safety of women travelling around the borough late at night We will develop a multi-agency data monitoring tool to ensure all reports of anti-social behaviour to all community safety agencies, can be identified. The tool will assist with identifying trends and analysis of data on repeat victims and perpetrators, including hate incidents and crimes	Residents who would otherwise be more likely to experience crime will feel safer and be at a reduced risk of harm

What?	How?	Impact?
We will improve the local response to supporting victims/survivors of crimes to improve their health and wellbeing	We will improve the local response to victims of anti-social behaviour and crime to improve their health and wellbeing using a person-centred approach	Affected residents will be supported to ensure that underlying trauma is not left unresolved, and interventions promote and result in the resolution of issues
We will adopt new technology in order to better to record and monitor antisocial behaviour incidents and outcomes	We will invest in and develop a Power BI dashboard to monitor real-time outcome data, and employ innovative technical solutions to improve ways to report and record antisocial behaviour incidents for residents We will develop an evidence and data-led approach to understanding the wider impact of anti-social behaviour and reduce the risk of harm to residents and communities We will examine data to focus on the effective anti-social behaviour interventions and update processes	Residents will experience timely and coordinated approaches to addressing and investigating their antisocial behaviour concerns Residents will benefit from the introduction of a data-led approach to tackling anti-social behaviour as it will provide evidence for more effective actions that can be taken to resolve their concerns
We will communicate effectively about action taken to tackle anti-social behaviour in order to reassure residents	We will ensure direct, effective, and rapid responses to reports of anti-social behaviour and focus on reassurance and publicity for positive outcomes	Residents will be encouraged to make reports of anti-social behaviour concerns as a result of evidence of positive outcomes Those reporting concerns will feel better supported due to swift and effective communication, mitigating any anxiety or uncertainty after submitting their report or concern
We will embed safety principles in new developments in order to reduce the likelihood of crime or anti-social behaviour in the future	We will continue to deliver new council-owned developments to ‘Secured by Design’ standards	Residents living in new council-owned developments will feel safer and experience fewer concerns relating to crime at home and in their local area

Tackle domestic and sexual abuse and violence

Context

Domestic abuse and sexual abuse are still largely hidden crimes and measuring the true scale of the issue is complex. Domestic abuse and sexual abuse happen in all communities, regardless of:

- gender
- age
- disability
- gender reassignment
- race
- religion or belief
- sexual orientation
- marriage or civil partnership
- pregnancy or maternity

The Domestic Abuse Act 2021 was passed into law in April 2021. The Act provided a new statutory definition of domestic abuse, introduced new laws and changes to existing laws, and placed new duties on local authorities, the Government, and other public bodies, such:

- The provision of safe accommodation for all survivors of domestic abuse
- Ensuring that fleeing abuse does not result in the loss of right to lifetime or assured tenancies when these were in place
- Ensuring that homeless people identified as survivors of domestic abuse are given priority

Domestic abuse and sexual abuse disproportionately affect women. Often the abuse is perpetrated by men and is more likely to happen to women who have a disability.

Information collected by Thurrock Refuge between April 2018 and March 2021 indicates that 295 victims of domestic abuse were provided with safe accommodation – 120 refuge clients with 175 children. The average age of domestic abuse victims in safe accommodation was 35, however the ages ranged from 21 to 71.

72% of those provided accommodation had children, and 7% were pregnant. 88% of Thurrock Refuge clients were British nationals, however 5% of clients had no recourse to public funds.

The top four areas (unitary or district level local authority) where Thurrock's Refuge residents were most likely to come from were Southend-on-Sea (13%), Thurrock (11%), Basildon (10%) and Barking and Dagenham (8%). Combined, these areas made up approximately two-fifths of all victims staying in Thurrock.

There is a strong association within some data sets and the deprivation levels across wards in Thurrock. On average, 52% of residents in safe accommodation in Thurrock were unemployed while approximately 42% of residents' employment status was unrecorded in the same time frame, based on a three-year cohort.

The unemployment rate is high which could be for a range of reasons, such as mental health needs, or given that 5% of residents required an interpreter and 9% of residents' first language was not English theses may also be potential barriers in accessing and navigating employment or being financially able to continue to alternative accommodation.

Individuals identifying themselves as having a disability was an emerging trend in the data. Although numerically small, there is limited understanding of these needs and therefore requires greater focus. Mental health support emerged as the largest need for residents, corroborated by the understanding that emotional or psychological and jealous or controlling behaviour abuse types affected over half of residents each year.

The Domestic Abuse Act has defined children as victims in their own right, therefore data recording across agencies will have to capture this with greater accurately for future assessments. The specific needs of children residing in refuge is not known and will be a focus for future assessments.

This assessment has highlighted that there is a need for a regular multi-agency analytical product, overlaying partnership data sets and reviewing them all together rather individually within own organisations. This would be of significant benefit to the local domestic abuse partnership board in assisting the local authority to deliver the duties under the Domestic Abuse Act.

‘No space or capacity to provide support’ was the second most recorded reason for being refused safe accommodation. There is a lack of specialised accommodation for minority groups or individuals who face additional barriers to reporting or for those who cannot/may not feel comfortable residing in current safe accommodation provision, such as males and LGBTQ+ people.

Impact

The recent assessment of the needs of domestic abuse victims residing in safe accommodation in Thurrock identified a number of characteristics and support needs of residents living in Thurrock Refuge. The following broad actions were recommended in order to appropriately meet these needs:

- improve provision to meet the needs of those residing in safe accommodation
- review current safe accommodation options to increase accessibility for all
- improve data collection and data sharing

As with many other areas of this strategy, the under provision of safe, suitable and affordable accommodation in Thurrock for those with specific support needs is a factor in limiting positive outcomes for survivors of domestic and sexual abuse and violence.

Challenges evidenced in this strategy regarding the provision of safe and stable housing for those fleeing abuse, include:

- a lack of social housing stock to meet ‘move on’ needs
- turning to private sector renting can contribute to financial instability and insecure tenure
- engagement with specific groups requires different approaches to improve underreporting

Extending safe accommodation buildings and capital spending is outside of the Domestic Abuse Act new burdens funding remit, however this has emerged as gap in current service within Thurrock and will require further exploration.

Recent action

The council has conducted a review its of policies and processes to achieve DAHA accreditation – the benchmark for how housing providers should respond to domestic abuse. Through this work, a new Domestic Abuse policy has been developed.

To reflect the council's commitment to tackling domestic abuse, the policy introduces several measures to ensure that residents receive a dedicated approach, considering the circumstance of each individual and always upholding best practice.

The policy sets out that residents can expect the council to:

- Get our response right first time
- Work with specialist services
- Be flexible in our approach
- Assist and guide survivors to obtain tailored support
- Ensure that survivors can remain in their property if they wish through the sanctuary scheme
- Safeguard survivors and their families
- Take a survivor centred approach
- Adopt a coordinated multi-agency response
- Proactively engage with 'hard-to-reach' groups
- Promote awareness of our zero tolerance support services
- Asist survivors to find alternative safe accommodation, and continue to provide support
- Ensure staff safety

Work to achieve the DAHA accreditation will continue into Spring and Summer 2022 and will demonstrate the council's commitment and coordinated community response to domestic abuse in areas such as case and risk management, inclusivity and accessibility, partnership working, and publicity and awareness.

Case study – Survivor-centred approach

A Tenancy Management Officer referred Client C to the Housing Safeguarding Team, following a disclosure of domestic abuse from her partner. Client C had mobility difficulties and her partner was her carer. Together, they held a joint tenancy and lived in a ground floor property.

The couple had left this property due issues within the neighbourhood and told the council that they had been targeted. Initially, they both moved into Client C's parents' home, however when she disclosed the domestic abuse that she had experienced from her partner, he left the property and the relationship ended.

The domestic abuse (DA) officer completed a Domestic Abuse, Stalking and Harassment (DASH) risk assessment and identified a medium risk. The DA officer then completed a tailored intervention and safety plan based on conversations around the outcome of the assessment. Client C's parents were homeowners and had installed CCTV. As such, Client C felt safe there, however it was not appropriate for her long-term accommodation. A key part of the plan was to achieve independence for Client C with support for her mobility challenges.

The DA officer working alongside Client C asked if she would consider a sole tenancy, with any required adaptations provided in the property. Client C had not reported the domestic abuse to the police and did not wish to. She also shared that she did not wish to return to the joint tenancy; another key part of the intervention and safety plan was to ensure that Client C did not become homeless as a result.

The DA Officer arranged to complete some one-to-one sessions with Client C to help build her confidence and understand the effect of DA on self-esteem. During the first session, they completed the 'empowerment star' – a

method of learning and rebuilding confidence, assisting to jointly understand the help and support required. Client C completed a genogram, helping to identify the nature of the relationships they have within their family members. We understood that the domestic abuse had affected the positive family relationships, and as these had broken down the support which could have been offered by these relationships was absent.

Through the sessions, Client C was able to see that the break-up of her relationship with her partner was due to his abusive behaviour and decided she would report to the police. Client C was assisted to make a report to 101 and the DA officer arranged to be present when she gave her statement. While she was giving her statement, Client C also disclosed sexual abuse from her ex-partner. A referral to SERICC (South Essex Rape and Incest Crisis Centre) was made, and they were able to offer the specialist support relating to with the sexual abuse she had experienced.

The DA officer worked with an anti-social behaviour (ASB) officer to take possession action on the joint tenancy on the grounds of DA. The therapeutic tools and Client C's statement was used to evidence the domestic abuse and the civil court granted possession of the joint tenancy to the council.

This was the first time the council had taken possession action on the grounds of DA in the housing service. Client

Action Plan

What?	How?	Impact?
We will commit to tackling domestic and sexual abuse effectively, professionally, and appropriately in order to achieve the best outcomes for survivors of abuse	We will implement and embed the new Housing Domestic Abuse policy, introducing measures to ensure that residents receive a dedicated approach that considers the circumstances of each individual and always upholds best practice We will deliver expert advice through a single route to support regarding housing, skills, employment, and other needs of people experiencing or who have experienced domestic and/or sexual abuse and/or violence	Residents experiencing domestic and sexual abuse and violence will be supported using a person-centred, human and holistic approach
We will work to improve pathways into safe accommodation in order to best support those fleeing abuse	We will review and revise the existing joint protocol for supporting those at risk of homelessness because they are fleeing domestic and sexual abuse through a coordinated approach with all those who are stakeholders We will improve access to safe and stable housing for survivors of domestic and sexual abuse and violence, across all housing tenure types by sourcing new accommodation options and improving existing properties and by developing housing options and initiatives to give people the choice to either relocate or remain in their existing accommodation	Residents fleeing abuse will be able to access safe, secure and affordable accommodation that meets their needs at the point of move on and into the future, and are able to exercise choice in determining the outcome in line with their vision for a good life

Support vulnerable adults and children into housing

Context

There is an urgent need to reform the accommodation and care pathway for vulnerable residents in Thurrock, such as those with mental illness, and those leaving care.

The role that housing plays in mental health support for individuals is crucial. Therefore, providing the right type of housing is fundamental to the help individuals to recover and live well in their community, as well as reducing demand on statutory services.

Accommodation and care for individuals with the highest levels of need coupled with challenging behaviour has been identified as the most difficult to source and sustain in Thurrock.

The accommodation and care provision for individuals in Thurrock with mental illness consists of residential care, supported living and floating support. Anecdotal evidence across housing, health and social care indicates that there is a gap in provision for a 'missing middle' – people with needs that are too complex and challenging for supported living and are inappropriate for residential care, and for whom the gap between general needs housing and supported living is too great.

The current model does not accommodate the fluctuating needs of people with mental illness. Unlike other groups, mental illness is not a linear condition and without the right support and boundaries may result in instances of frequent admissions and placement breakdowns. An individual may require one or all levels a model of accommodation and care provision, at different times, for short or long periods of time. The majority will require a multi-agency approach to their support in the community; however, when this support is delivered directly by each responsible agency can add to the feeling of overwhelm and chaos for the individual.

Locally, there are instances of multiple high-cost placements that do not deliver the quality and outcomes aspired to. A lack of concerted focus on achieving what is important to the individual and little opportunity to review plans and adapt, mostly occurring at times of crisis, has led to a drive to transform supported living.

Local authorities have a duty, as a corporate parent, to ensure continued involvement in supporting young people as they leave care and move into independence until they are 25 years of age. This approach should mean that bureaucratic processes are overridden, and decisions are made with the child's needs in mind and as a priority.

Young people in care and leaving care can be highly vulnerable and at risk of experiencing multiple accommodation moves. They can often struggle to cope with the challenges of living independently at a young age without a family network, and they may need help to access services or deal with specific problems they face. Unfortunately for some this means they may end up at risk of experiencing homelessness.

Good practice guidance published by the Government in 2020 recommends that council housing departments and children's services should produce a joint protocol that sets out how they will work together to ensure:

- each care leaver has a tailored support plan as they transition to independent living
- those at risk of homelessness are identified early and action is taken to prevent it
- a quick, safe, and joined up response for care leavers who go on to become homeless

Impact

Current approaches to supported living experience a gap in provision, as outlined in the above section. The consequences of this are felt throughout the system in terms of delays to discharges and the provision of appropriate levels of support. Additionally, and more importantly for the individuals, this can lead to multiple placements in relatively short periods of time, out of borough placements leading to disconnect with their community and support systems, and spiralling costs.

Although there is an established pathway in place for care leavers through Head Start Housing, this initiative was not introduced to be the sole route into accommodation, meaning that there are care leavers whose needs are either being under or over-provided for through this route, resulting in the ineffective use of resource and impacting on the possible deliver of positive outcomes.

Properly directed investment of resources in appropriate housing related support services for vulnerable adults and children can eliminate waste and generate savings across the entire system, in addition to the fundamental benefits for individuals regarding choice, control, and independence in their lives.

Recent action

In March 2016, children's services and the housing service developed a strategic partnership to support Thurrock's young people to access suitable accommodation at affordable rates.

In December 2018, Head Start Housing was launched, aiming to provide suitable accommodation for Thurrock's care leavers and a safe space to live and learn before moving on to a private rental or social housing tenancy. It has a portfolio of properties ranging from one to five-bedrooms, with varying levels of floating support to 24/7 provision.

The skills and behaviours of each care leaver are considered alongside their needs to enable selection of the right type of accommodation. Care leavers receive support from their personal adviser and from the Head Start Housing officer who ensures the property is and remains compliant with health and safety, is furnished with essential items, has access to wifi, and that utility bills are paid.

Care leavers are supported to access housing benefit and, when they are ready, education, employment or training using the home as a foundation.

The housing service made a commitment to provide spaces for 30 individuals to Head Start Housing by end of 2023, and by the end of 2021, 24 spaces had been identified.

The Head Start Housing strategy made provision to return as many care leavers as possible to accommodation in Thurrock by the end of 2023. For care leavers in education or with established networks out of borough, Head Start Housing remains committed to provide suitable accommodation out of borough and fulfils the council's legal obligation to do so.

Considerable progress has been made in the past three years, and the Head Start Housing Strategy has been refreshed to shape and drive positive change over the next 5 years.

An integrated primary and community care (IPCC) locality model has been developed in response to challenges facing the delivery of mental health services. Practitioners such as social workers and LACs frequently feel frustration as a point of contact for people defined as the 'missing middle' but are subsequently unable to help until people were ill enough to meet the thresholds in place.

More broadly, it was recognised that the way mental health services had been organised left residents with a service that was difficult to access, fragmented and that focused on only biomedical aspects of treatment.

The new model has focused on:

- developing a seamless offer for those who need more support than primary care would provide but do not meet the thresholds for secondary care
- defining care packages to meet the needs of those in Outpatient caseloads to enable clinically safe transfer of care to the Primary Care Network Integrated Mental Health Teams with an embedded step-up and step-down function with a particular focus on psychological interventions,
- releasing capacity for the consultants to provide additional support to the Primary Care Networks and develop a more therapeutic service offer for those with complex needs ensuring quality specialist and personalised care.
- developing a holistic offer that allowed wider determinants of mental health such as housing and employment to be addressed together with the positive role that social and community connections can play in recovery.

The new model provides an inclusive and integrated service that blurs the previous hard referral boundaries between primary and secondary care, providing specialist support to practices, holistic support to residents and reduces the number of onward referrals and fragmentation within the previous system.

Having successfully piloted the model in one PCN, we are currently in the process of rolling out to all four at pace.

Thurrock Council has actively supported and participated in the Government's Afghan Relocation and Assistance Policy and Afghan Citizens Resettlement Scheme. A cross-organisational group was established to ensure a coordinated approach and private sector landlords were engaged to supply appropriate properties for this project.

The Well Homes team in the housing service has provided landlords and new tenants with support to ensure the smooth running of tenancies, as well as ongoing resettlement support after arrival in the UK. This support includes help with medical needs, arranging English lessons if required, setting up bank accounts, finding jobs and getting children into education.

The council has successfully worked to increase the amount of council-owned temporary accommodation located in the borough in recent years and has taken significant steps to date which includes the purchase of Brook House, now operating as a ten-unit temporary accommodation hostel. Feedback to date from households currently placed in Brook House has been positive with regards to the support and advice from officers and the quality of accommodation.

Thurrock Council has also been operating a Housing First programme for a number of years. This programme provides intensive support to people who are long term or recurrently homeless and have high ongoing support needs. The project has so far successfully supported seven individuals who were homeless or threatened with homelessness. They had faced persistent barriers to accessing housing, some of which were caused by a variety of health conditions and addictions resulting in complex needs.

Action Plan

What?	How?	Impact?
We will improve the supported and specialist housing offer in Thurrock in order to address shortfalls for vulnerable residents	We will work across the broader health, care, and housing system to better understand the gaps in supported and specialist housing provision in the borough and work towards meeting these needs	Residents will be able to access accommodation with the right level of support or care to empower them to live independently as possible in their local community Residents will be able to access support at the right level at the right time as a result of expanding the availability and range of supported housing provision
We will align housing staff with Integrated Locality Networks in order to implement an integrated approach to care and support planning	We will align housing allocations and homelessness staff within single Integrated Locality Networks around each Primary Care Network to design and implement an integrated approach to care planning, delivering bespoke solutions to residents with mental health problems that address their housing, addiction, mental health and other needs at the same time	Residents with mental health problems will experience fewer barriers and thresholds to securing appropriate accommodation as all support needs will be considered through a holistic, person-centred approach
We will continue to support the Head Start Housing initiative in order to provide suitable accommodation for care leavers as a foundation for their future	We will provide a further ten properties below market rental rates with space for 22 individuals to the Head Start Housing initiative by the end of 2027	More residents leaving care will have the opportunity to receive support from Head Start Housing where this is the approach most appropriate to their personal circumstances and needs

Improve estate standards

Context

As a landlord, the council is responsible for managing and maintaining large areas of communal space, both indoors and out.

The *Charter for Social Housing Residents* seeks to ensure that all social housing residents can enjoy good homes and neighbourhoods. Through the white paper, the Government states it would review the Decent Homes Standard and consider whether it needs to be updated to ensure it is delivering what is needed for safety and decency now.

In the white paper the Government went further, outlining that the Decent Homes Standard review would also consider how improvements to communal space around social homes could make places more liveable, safe, and comfortable.

Around 3,500 council-owned properties are located on estates or in areas with outside communal space that the housing service is responsible for maintaining.

Feedback from Thurrock residents during the development of this strategy included concerns about feeling safe in and around the borough's neighbourhoods, in particular relating to anti-social behaviour, drug crime and misuse, road and footpath safety, and inadequate street lighting.

Residents expressed that improvements to specific estates and neighbourhoods should be made following engagement with those who live in those areas, ensuring that local needs, priorities and concerns are fully considered.

Through recent satisfaction survey activity, the responses of tenants who gave satisfaction ratings of ‘fairly dissatisfied’ or ‘very dissatisfied’ were analysed. 40.9% of the dissatisfied responses related to the quality of work carried out, specifically relating to standards of cleaning and litter either not being picked up or left behind. 34.1% was due to the frequency of the caretaking, with perceptions that extending periods of time pass without any work being carried out.

Similar analysis was undertaken regarding drivers of dissatisfaction relating to grounds maintenance in and around the council’s housing stock. Over half of the responses (54.5%) related to the frequency of grass cutting and cleaning of the area. A quarter of responses referred to the general quality of work with the majority of these mentioning cutting and trimming of grass and bushes, and 13.5% of tenants said that waste was left behind and the area was left untidy.

Impact

Dissatisfaction with the maintenance and upkeep of communal spaces and estates will significantly impact upon the overall perception of the environment within which residents live. If there is a feeling that estates are not being appropriately managed it detrimentally impacts upon resident pride in the local area and reduces overall levels of civic responsibility.

The same applies to resident perceptions relating to anti-social behaviour in and around estates. Without coordinated and visible action, undertaken in partnership with residents and the local community to address what matters, the fear that estates are unsafe places will continue to grow and perpetuate.

Both of these factors cause harm to the health and wellbeing of households living in the area, who would feel that neither their homes nor neighbourhoods were liveable, safe or comfortable as expected within the social housing white paper.

A potential action that an affected household could take would be to seek to move to other accommodation elsewhere in Thurrock, however as previously evidenced there are a shortage of properties, critical demand for affordable and social housing, and a significant number of other households with diverse housing needs requiring support.

Recent action

The council commissioned an industry review of caretaking and estate services to be undertaken by in Summer 2021, with the final report and recommendations being received in November 2021.

The group that undertook the review have extensive experience in supporting organisations to achieve excellence through effective use of data, benchmarking performance and the processes that are driving that performance and have an extensive data set to enable such comparisons across the sector.

An overall service improvement plan has been developed incorporating the recommendations and actions from the review that seeks to improve estate standards and service delivery across the council's homes and neighbourhoods.

A new vision for estate services has also been set as a result. The council aims to provide proactive and flexible estate services, working together with communities to provide safe and clean neighbourhoods that meet residents' needs, delivering value for money and supporting health and wellbeing.

The proposals for new housing development schemes led by the council, in particular those with communal spaces, integrate the principles of "Secured by Design" to help reduce crime and anti-social behaviour and improve resident feelings of safety. This also includes potential to deliver improvements to existing housing areas, such as plans for development at Broxburn Drive that will deliver public realm enhancements, enable higher quality new housing designs and allow better integration with the existing homes and residents.

Action Plan

What?	How?	Impact?
We will implement a new approach to estate inspections in order to protect resident safety in estates and communal areas	We will ensure that estates and communal areas remain safe and clear by delivering and embedding a new estate inspections quality and safety framework, supported by a new inspection regime We will rigorously inspect council-owned assets by accessing homes and communal areas more frequently to assess and remove health and safety risks including fire hazards and contacting hard-to-reach residents	Residents will experience improved physical safety and feeling of safety around the estates and neighbourhoods where the council's housing stock is located Residents will be protected from repetitive and severe hazards as a through the use of appropriate enforcement action available to the council

What?	How?	Impact?
We will adopt a collaborative approach to improve safety on estates in order to address the issues that matter to local residents	We will work across housing, with our community partners and with residents to make our estates clean, attractive spaces where residents feel safe, using lighting, CCTV, and environmental improvements to do this We will establish a programme of resident and ward councillor estate walkabouts to improve the connection to and understanding of the local area and the issues that matter most to those who live there	Residents will benefit from targeted action and improvements in their neighbourhoods and estates that are informed by and aligned with their priorities, thereby strengthening connection with the area and improving perceptions of safety
We will invest in and embed technology in order to facilitate robust management of estate standards	We will improve monitoring of standards and compliance by implementing and enable new technological solutions We will seek to use this data to provide transparency to residents regarding estate maintenance and standards in their locality	Residents will have greater transparency regarding the provision of estate caretaking and maintenance services
We will implement new approaches in order to tackle issues of nuisance parking on estates and improve the appearance of local areas	We will replace high-cost wooden knee rails and bollards that are easy to remove with green infrastructure such as hedging and shrub plants in order to deter nuisance parking and improve the quality of environment	Residents will benefit from more effective and attractive deterrents to nuisance parking, improving the overall quality of the area around their homes

Chapter 7

Strengthen Community Engagement and Empowerment

The COVID-19 pandemic led people to experience significant periods of social isolation and separation from their friends, family, and wider support networks. It also saw communities come together, with people supporting one another through immensely challenging and testing circumstances. The collective strength and resilience showed within communities

This chapter considers how relationships are built and strengthened between residents, the areas in which they live, the communities of which they are a part, and the organisations and groups that provide support and the council.

A significant ambition of this strategy is to support communities to build resilience and to broaden engagement with them. This strategy seeks to use the wider system and its networks to take an integrated approach in supporting communities, giving residents active and meaningful roles in matters that affect them in the context of housing and their estates and neighbourhoods.

Improve resident satisfaction and access to information

Context

The Charter for Social Housing Residents seeks to ensure that landlords remain transparent and accountable to their tenants at all times. The white paper sets out that every social housing resident should be able to expect to know how their landlord is performing.

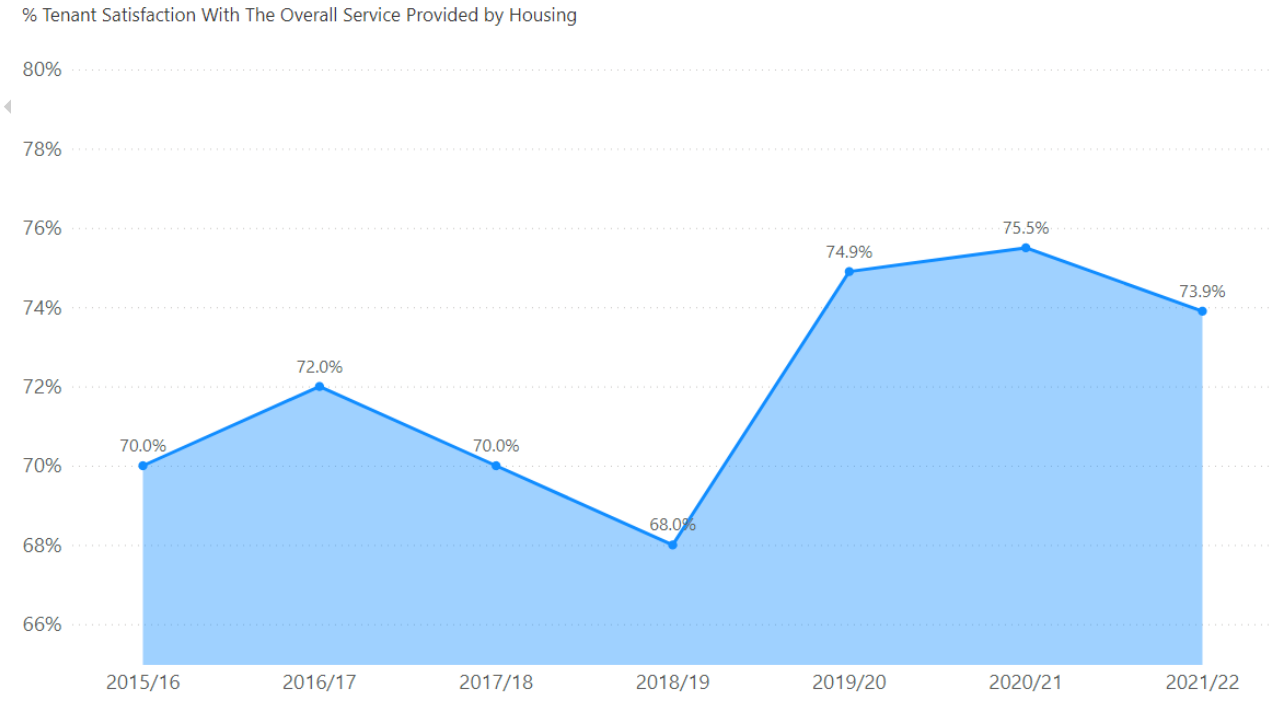
As a mechanism to achieve this, the Regulator of Social Housing is seeking to introduce a suite of tenant satisfaction measures for all registered providers of social housing, including local authorities. Whilst the specific measures are still to be determined, the indicative measures provided for consultation were grouped under the following headings:

- Overall satisfaction
- Keeping properties in good repair
- Maintaining building safety
- Effective handling of complaints
- Respectful and helpful engagement
- Responsible neighbourhood management

In addition to greater transparency, these measures aim to inform the regulator about landlord compliance with the consumer standards under a more proactive consumer regulation regime as proposed in the social housing white paper.

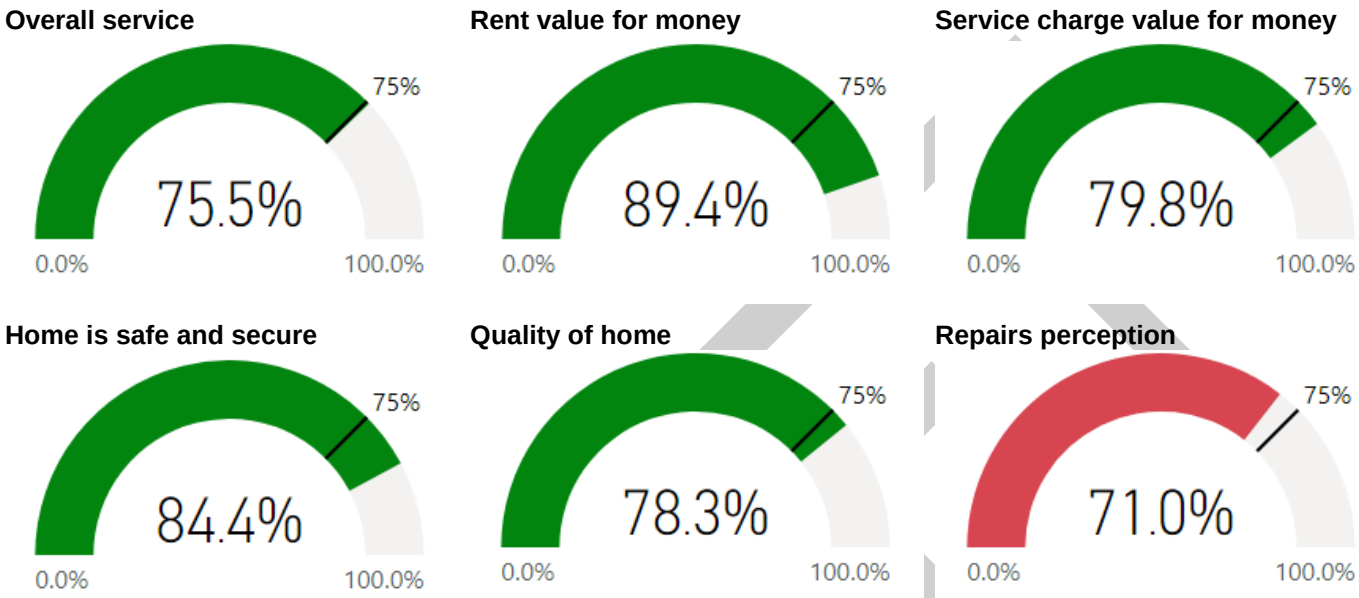
The chart below indicates resident satisfaction levels with housing services in Thurrock between 2015/16 and 2021/22 (to date).

There has been a generally positive trend in recent years, however levels of resident satisfaction with housing services appear lower in 2021/22 to date.



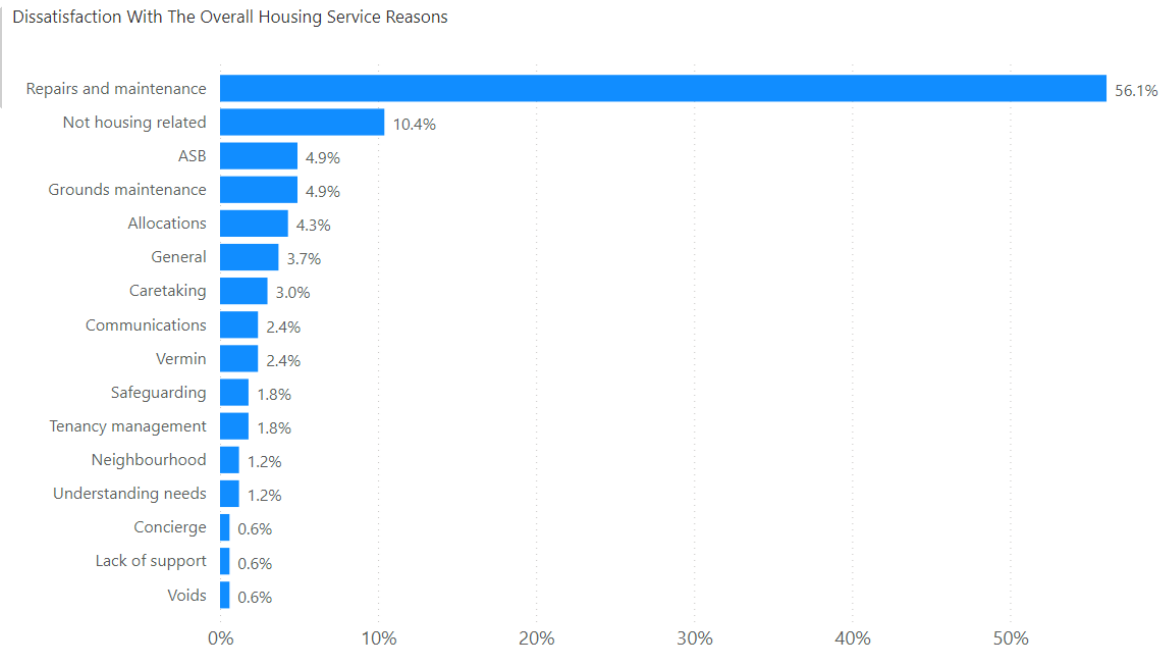
In 2020/21, the last full reporting year, a total of 1983 ratings were provided by residents. Of these, 1497 reported that they were fairly or very satisfied with the overall service provided by housing. 234 residents provided neutral responses, and 252 shared that they were fairly or very dissatisfied.

The visuals below show the resident satisfaction relating to several key measures for the 2020/21 reporting year, set against a target of 75%.



Whilst satisfaction was reported as being very high in some areas such as rent value for money and the perception that homes are safe and secure, the perception of the repairs service fell below the target set for the reporting year.

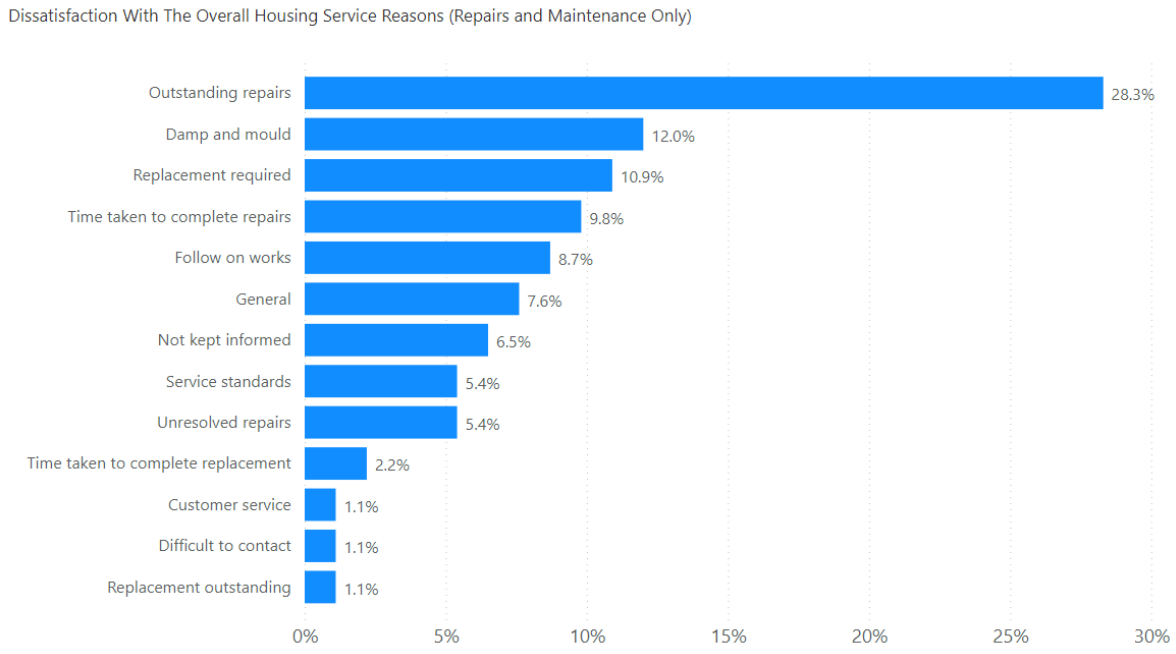
Analysis and categorisation of recent resident feedback indicates that presently, the repairs and maintenance service is the main factor for dissatisfaction with over half of all comments (56.1%) relating to it.



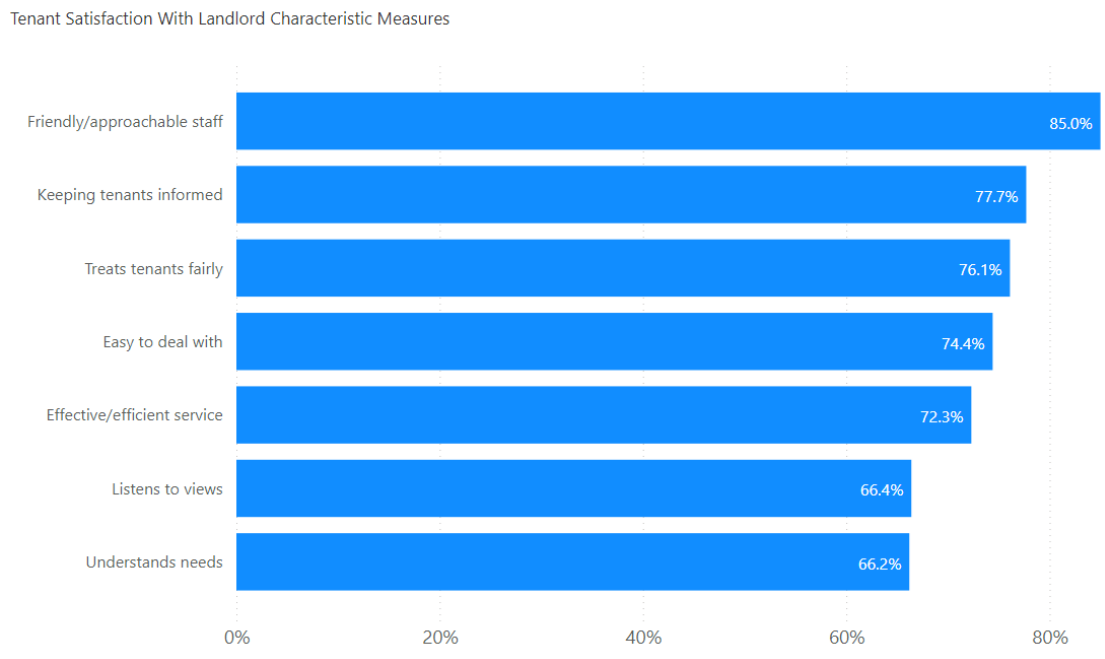
Within the repairs and maintenance category for dissatisfaction, outstanding repairs represented 28.3% of the feedback received.

Sheltered Housing tenants with a tenancy length of between 10 to 15 years, 15 to 20 years and under a year were 100% satisfied with the repairs service and the least satisfied have been a tenant between one and five years (70%).

Tenants within general needs properties that have lived in their property for 10 to 15 years were most satisfied (76.2%), and those who had held their tenancies for between 15 and 20 years are the least satisfied (53%).



Further to these key measures, tenants are also asked to either indicate whether they agree or disagree with measures relating to landlord characteristics. The results of this section for 2020/21 are shown in the chart below.



General feedback provided indicates that tenants find housing staff to be friendly and approachable, working to keep tenants informed and treating them fairly. Some concerns were raised by tenants regarding the ease of interaction with the housing service and how effective and efficient that service is.

However, the greatest proportions of dissatisfaction relate to tenant perception regarding the housing service listening to their views and understanding their needs.

The visualisation to the right is a word cloud of key terms used by tenants expressing their dissatisfaction when asked for their perception on whether the felt the housing service listened to their views and is helpful as an indicator of similar themes from different residents.

Listen, nothing and *done* all feature prominently in the word cloud visualisation. Analysis of underlying tenant responses show that these are related – among dissatisfied tenants there is the perception and experience that they do not see action taken when feedback is asked for or given about the things that matter to them.

Impact

It is important that the council tackles the drivers of resident dissatisfaction, as it can lead to wide ranging and harmful consequences for both residents and the council.

Dissatisfaction, as evidenced above, tends to arise from service failure of some form. Examples in the data include repairs remaining outstanding, tenants not being kept informed or updated, and not feeling listened to about what matters to them.

If dissatisfaction in these areas continue, there are avenues for formal expressions of concerns, including complaints and housing ombudsman investigations. Whilst these are legitimate routes of escalation available to residents when they feel something has gone wrong, they only offer the opportunity to react to a perceived or actual failure and tend to place parties in opposition, rather than proactively working in partnership to prevent the failure from occurring.

Tenant dissatisfaction, especially when it related to the landlord characteristics measures, can impact upon the trust that tenants have with housing services, and can reflect upon the wider council too. If tenants don't feel listened to, don't have access to the information they need and don't feel that their needs and priorities are understood, the damaged trust can be extremely difficult to repair, and will lead to broader challenges relating to community reception to possible changes introduced by the council.

Low levels of tenant satisfaction, in particular relating to feelings of being treated fairly by the council, can lead to tension within the community if there is an imbalance in equity and equality. This can be a contributory factor in other issues discussed in this strategy, such as antisocial behaviour, resident safety and estate standards.

Finally, tenant dissatisfaction can have an impact on staffing, leading to a greater turnover of officers. This, in turn, can lead to greater inconsistency in service, leading to further detrimental impacts on satisfaction and less time spent addressing what matters to residents.

Recent action

In June 2020 the housing service upgraded its Housing Online portal for tenants and housing register applicants. The system offers great potential for improving resident interaction with the council's housing services and the ability reports and concerns to be submitted directly, for example relating to issues of anti-social behaviour.

An improved Housing Options offer is also possible through the Housing Online portal which will reduce duplication for staff, offer a more joined-up experience for residents, and increase the quality of data and reporting which are available.

Between July 2020 and October 2020, a full postal tenant satisfaction survey was undertaken by the council's service provider, KWEST Research Ltd, which was sent to every tenant. The project used a multi-mode approach, comprising a postal census survey targeting all the Council's tenant households, accompanied by email invitations and an online version to broaden survey reach and accessibility.

The survey results provide confirmation that the homes and services provided by the Council are meeting the needs of most residents. This is demonstrated by high proportions of residents expressing satisfaction with many key service areas including rent value for money, quality of home, home is safe and secure, neighbourhoods as a place to live and the overall Housing service.

The housing service has successfully made use of technology to send specific and tailored text messages to its tenants for a range or reasons, such as to provide information and support for rent accounts, share information about resident engagement days and to alert tenants to issues that may be affecting their blocks, such as lift repairs and maintenance.

Action Plan

What?	How?	Impact?
We will implement digital solutions in order to improve resident access to information and housing services	We will develop a digital strategy for housing and deliver against an action plan. We will improve digital access to housing services by enhancing the existing online tenant portal and developing new approaches for interaction, engagement and communication using technology	Residents will find it easy to access housing services digitally and be able to interact with housing staff through digital devices, if that is their preference
We will demonstrate our commitment to listen to residents in order to better understanding their needs and priorities	We will explore the reasons for dissatisfaction in relation to each individual satisfaction measure by deliver focus groups with tenants. We will close the contact loop with tenants by responding to the issues they raise, progress any actions required as a result and providing evidence of the outcome	Residents will be able to share their issues with the council directly, ensuring that the action required to address the issue is understood, with trust in the council that their feedback will be acted upon

What?	How?	Impact?
We will tackle the drivers of dissatisfaction in order to make positive changes and improvements to the things that matter most to residents	We will use continuous learning make significant progress to address the causes of dissatisfaction by acting upon the feedback we are given from tenants	Residents will experience greater levels of satisfaction with their home, local area and the service they receive from the council
We will utilise technology and data analytics in order to better understand drivers of resident satisfaction and dissatisfaction	We will ensure that all feedback received is analysed and acted upon by developing a suite of integrated and connected dashboards for resident satisfaction, allowing for the relationship between multiple pieces of feedback to be understood and facilitating detailed assessment	Residents will find that the reasons for their dissatisfaction are better understood and will experience targeted responses to address the causes
We will proactively prepare to report against new national tenant satisfaction measures in order to make our performance as a landlord more visible to our tenants	We will implement a robust approach to recording, monitoring and reporting against the new tenant satisfaction measures that will be published by the Regulator of Social Housing by April 2023, to meet the first submission of data in Summer 2024	Residents will be better informed about the performance of the council as their landlord, and they will be empowered to hold the council to account through new regulation

Strengthen, integrate, and diversify community and resident engagement

Context

The *Charter for Social Housing Residents* sets an expectation for residents to have their voice heard by their landlord. Within the social housing white paper, the Government sets out that it will:

- expect the Regulator of Social Housing to require landlords to seek out best practice and consider how they can continually improve the way they engage with social housing tenants
- deliver a new opportunities and empowerment programme for social housing residents, to support more effective engagement between landlords and residents, and to give residents tools to influence their landlords and hold them to account
- review professional training and development to ensure residents receive a high standard of customer service.

The white paper also expects that the Regulator of Social Housing will require landlords to show how they have sought out and considered ways to improve tenant engagement.

Traditional forms of engagement, such as consultation and surveys, are not always effective and can even have an adverse impact upon wellbeing if people feel pressurised to take part or communities suffer from consultation fatigue.

Tpas, the tenant participation advisory service, recommends through its engagement standards that residents should have access to an appropriate range of engagement opportunities that reflects the resident profile. It also encourages landlords to respond to different needs in relation to equality and any additional support, evidenced in the delivery of services, engagement activities and communications to promote widespread engagement.

During the development of this strategy, residents stressed the importance of diversifying and expanding the opportunities and methods used for engagement. Recent years have seen significant growth of digital communication technology in homes, such as video calling and meetings, and the decline in face-to-face interaction due to the COVID-19 pandemic.

Engagement can take many forms, but the crucial factor for the future is that it is tailored appropriately. There may be residents who want to proactively engage with policy design, for example, and others who may simply want to know that they are being considered in the way the council implements change and keeps residents them informed.

Broader community engagement also includes elected members. Mechanisms are already in place through Housing Overview and Scrutiny Committee, Cabinet and Council to ensure that members are informed and engaged in matters relating to housing. This strategy will strengthen the relationship and information sharing between housing services and elected members relating to matters affecting the wards and communities they represent.

Voluntary sector organisations make a difference to the lives of communities, whether area-based or a community of interest. Many charities and voluntary organisations perform essential work that contribute to the fabric of our society. Often, they act as a vital referral resource for public services.

So much can be achieved through meaningful collaboration with voluntary sector organisations, rather than working in service-centric silos. The experience of working together to support communities through COVID-19 demonstrated the level of trust that already exists between the

public and voluntary sectors. Now more than ever, it is imperative that we support a sustainable third sector in Thurrock.

In Thurrock, the council recognises the value of a strong voluntary sector. In 2021, the council published its Collaborative Communities Framework to set out how it will improve the way it engages with communities, talks about shared concerns, and works better together.

The housing system is complex and ever-changing, and voluntary sector groups and organisations play a significant role in supporting and advocating for residents and communities.

Impact

The impact of traditional forms of consultation is that residents act as passive recipients of services provided by the council, providing feedback only when approached. Residents do not live their lives through our services, but through localities and neighbourhoods where many different factors combine to influence the quality of their lives. We need to move from an approach where we consult multiple times on services on strategies determined by us, to a single integrated approach based around place. Engagement needs to shift from being purely consultative to one of genuine co-design and co-production of new approaches to improve the quality of life of our residents.

Frontline staff have hundreds of interactions with residents every week, and staff groups like our tenancy management and sheltered housing officers have real insight into the needs of our neighbourhoods and communities, yet we never systematically collect this intelligence and use it to inform future strategy or delivery.

Locality based resident engagement provides the opportunity to develop offers of support and services that are designed specifically to meet the needs of that area. This makes the offered service more meaningful, prioritising what matters most to those in the local area and actively demonstrating evidence that resident feedback is being used constructively.

This approach would contribute towards a growing sense of community empowerment, with individuals becoming far more active citizens as they experienced a genuine sense of involvement and influence. It would also enable feedback to be delivered more consistently and quickly than is currently possible.

To further strengthen community empowerment, community reference and investment boards can be explored at estate or neighbourhood level, aligned with the approach set out in the *Case for Further Change*.

The principle of these boards is to devolve power from public sector organisations to communities for the funding of integrated services and deliver locally identified solutions, rather than centrally determined actions. To support this, the *Case for Further Change* proposes pooled funds at each locality level, so further exploration of this would be required to replicate this within a housing context.

Recent action

The housing services have strengthened its approach to resident engagement activity recently, working to share more information with tenants about subjects that matter to them.

In 2021, the council published a *Collaborative Communities Framework* for Thurrock to share the strengths and assets-based approach for how the council and its services intends to work with communities.

Co-produced through the *Stronger Together* partnership over three years, it sets out how we will work and enable our communities to co-design and influence decisions, address their own challenges and realise their own ambitions.

Case Study – Avon Green Garden

Avon Green comprises of 48 low rise flats. Prior to this project, the only space that residents could access were areas of hardstanding for washing lines, or small areas of grass at the front of the apartments. Spaces were uninspiring, had no function, and as a result were underused.

Through the COVID-19 pandemic, a local resident had become increasingly aware of how isolated she and many of the residents had become, especially older people and parents with young children. To tackle this social isolation and support community cohesion, they suggested the creation of a therapy garden, providing a space where residents could come together to garden, chat and enjoy the space.

The local community was engaged from start to finish to secure real ownership of the garden and to tailor support that would meet the needs of the residents who would use and manage the garden. Engagement started by asking residents about their preferences for the space and images were provided to represents elements that could be included within the community garden. 79% of all residents were in favour of the garden.

From this activity an indicative design was produced to show residents all the elements included and what the garden would look like.

To ensure a sense of ownership and care residents were empowered to have their say on how the garden will look and be used. The indicative was shared with the local community for feedback and comments, and residents were asked what they would like to grow and if they would like support to get the garden up and running. We had 40% response rate with residents requesting a mix of flowers, herbs, vegetables and salad crops, and sensory plants.

A percentage of residents signed up to a capacity building programme to develop skills to support the use and maintenance of the garden.

Some residents shared concerns that the garden may attract anti-social behaviour or be damaged, however positive discussions took place with the local community which reflected the benefits the garden would bring.

In order to get the garden up and running we worked in partnership, engaging and consulting with teams across service areas; the Capital Programme Delivery Team supported to secure funding for the project through its partnering contractor Wates. The Tenancy Management Team and Caretaking Services were consulted on location and what could be included, with the Health and Safety Team and Corporate Risk Insurance Team providing advice on installation of the garden and what would be needed to ensure safe use and maintenance of the garden for our residents.

The launch event at Avon Green Community Garden was held in November 2021.

Seven residents and their families have signed up to the gardening group, agreeing to maintain and take care of the garden.

A training programme delivered through the growing season will be held at the community food growing garden and will provide the skills and confidence needed to plan, plant, harvest and maintain the garden. Training will be structured around the growing season for ‘real time’ learning. Sessions will run every six weeks to ensure success through the first year of growing and that everyone knows what they are doing and when.

The publication of the Housing Strategy 2022-2027 and the *Case for Further Change* provide an opportunity and starting point to build on the foundation of the Collaborative Communities Framework, strengthening the relationship and engagement between housing services, residents and the wider community, voluntary and faith sector in Thurrock.

Action Plan

What?	How?	Impact?
We will embed an approach for co-design and improvement of services in order to meaningfully involve and empower residents and communities	We will adopt an approach across housing services that empowers residents to formally and informally co-design solutions and provision, influence and make decisions, raise issues, input in the tendering of new contract arrangements and address challenges relating to housing in Thurrock We will achieve the Tpas Resident Involvement Accreditation for Landlords by completing the accreditation process to demonstrate our commitment to resident involvement and ensure our approach is effective and offers the best value for money	Residents will benefit from meaningful involvement in the way that housing services are provided and improved, ensuring that local priorities are properly understood and acted upon Residents will not have to rely on traditional consultative forms of engagement to have their views heard, and can trust that feedback provided through everyday interactions for service improvement will be taken forward and implemented
We will implement community reference and investment boards at neighbourhood level in order to strengthen community empowerment	We will develop proposals by following the approach for community reference and investment boards as set out in the *Case for Further Change* which will include exploring options for pooled locality funds We will work together with communities and the voluntary sector to deliver at a more local level, only centralising that which cannot be provided effectively in neighbourhoods and localities	Residents will benefit from devolved power from public sector organisations to communities for the funding of integrated services and delivery of locally identified solutions, rather than centrally determined actions
We will embed professional standards in housing services in order to ensure high service standards and consistency	We will ensure professionalism in Housing services by providing training opportunities for staff across the service that meet or exceed requirements for training standards as set out by the Regulator of Social Housing	Residents will be treated with respect by knowledgeable, skilled, ethical, and inclusive housing staff.
We will develop opportunities to educate about housing in order to develop skills for independent living	We will build stronger links and relationships with the schools and colleges within Thurrock and create platform to engage with children and young people regarding housing and skills for living independently	Residents will benefit from the sharing of skills, knowledge, and information relating to housing in adult life

Chapter 8

Monitoring and Review

The Housing Strategy must be kept under constant review. This is partly due to the increased likelihood that legislation will be introduced during the lifetime of the document, which may have a material effect on the aims, objectives and actions outlined in the Housing Strategy. In addition, as the impact of the COVID-19 pandemic on housing becomes more apparent in the months and years after the document's publication, new priorities or actions may emerge.

The monitoring and review of the Housing Strategy will be undertaken by a new Housing Strategy Deliver Board that will be established. This Board will be responsible for monitoring the progress of the action plan published alongside the strategy. The action plan will be kept as a live document and regularly updated to ensure progress and that key actions are delivered within defined timeframes.

The Housing Strategy Delivery Board will absorb the Homelessness Partnership Board, forming a single body with responsibilities for the progress of key strategic documents relating to housing.

As outlined above, it is anticipated that new actions will be added to the action plan during the lifetime of the strategy. Additions may be a reaction to changes in external factors (such as legislation) or proactively if an opportunity arises. These additions will be managed appropriately and ensure that the key themes continue to be reflected throughout the action plan.

An annual update will be provided to Housing Overview and Scrutiny Committee to ensure appropriate oversight of the action plan.

Housing Strategy – Executive Summary

2022-2027

Thurrock Council

Contents

Foreword

Everyone should have access to a safe, stable, secure and suitable home.

This Housing Strategy sets Thurrock Council's direction and ambitions for housing support and services for the next five years. Through this strategy, the council aims to provide a housing service that not only delivers on its targets but does so in the most human and empathetic way.

Crucially, this strategy delivers a new vision and key principles that truly place residents at the centre of all that we do. It aims to minimise bureaucracy, increase flexibility and focus more on what matters to residents.

Thurrock Council is on your side.

The council will work over the next five years and into the future to deliver housing support and services that are fit for purpose for families and individuals in the borough.

We are committed to effectively ending the need for any Thurrock resident to experience rough sleeping in our borough and will see to understand the true need for accommodation for Thurrock residents, delivering homes that people will be proud of accordingly.

We will prioritise and protect residents' safety in their homes and neighbourhoods, whether they live in a council-owned home or in the private sector, and we will work hard to ensure that all residents are empowered to have their voices heard through meaningful engagement.

I'm delighted with what our teams have managed to achieve over the past two years, despite the challenges faced.

119 new council-owned homes have been handed over and let, the number of families in out-of-borough temporary accommodation placements is at its lowest in over three years and ever-closer work between the housing service and other council departments means that more support and positive outcomes are being delivered for those who are most vulnerable in our communities.

The actions put forward in this strategy present an opportunity to go even further, with scope for major estate regeneration to provide more genuinely affordable council-owned homes, end out-of-borough placements entirely unless for safeguarding reasons or through choice, and deliver new integrated operating models in housing and with other partners to better focus on delivering the things that matter to residents in their different localities.

I look forward to seeing the successful delivery of the aims and objectives of this strategy as those within the council work closely with residents and partners across the public, private and third sectors.

Together, we can work to ensure that every Thurrock resident will have a home that meets their needs and aspirations, serving as a foundation to support their health and wellbeing and their springboard to achieve their vision of a 'good life'.

Cllr Luke Spillman
Cabinet Member for Housing

Introduction

It is important that Thurrock Council has a document that shares the aims and ambitions of the organisation regarding housing in the borough.

The council adopted its previous Housing Strategy in 2015.

It required renewal, considering changes in legislation and regulation, market trends, the impact of recent welfare reforms, and new opportunities for meeting the housing needs of Thurrock's residents.

Unlike the previous strategy, it is necessary that this document also reflects the turbulence and uncertainty that resulted from the COVID-19 pandemic.

The Housing Strategy addresses the range of tenures available in Thurrock - social housing, owner-occupiers, and the private rental sector. It is important to note that this strategy will consider housing need and services in the borough and the barriers residents may face with accessing safe and secure accommodation. The Housing Strategy does not analyse options or sites for housing provision.

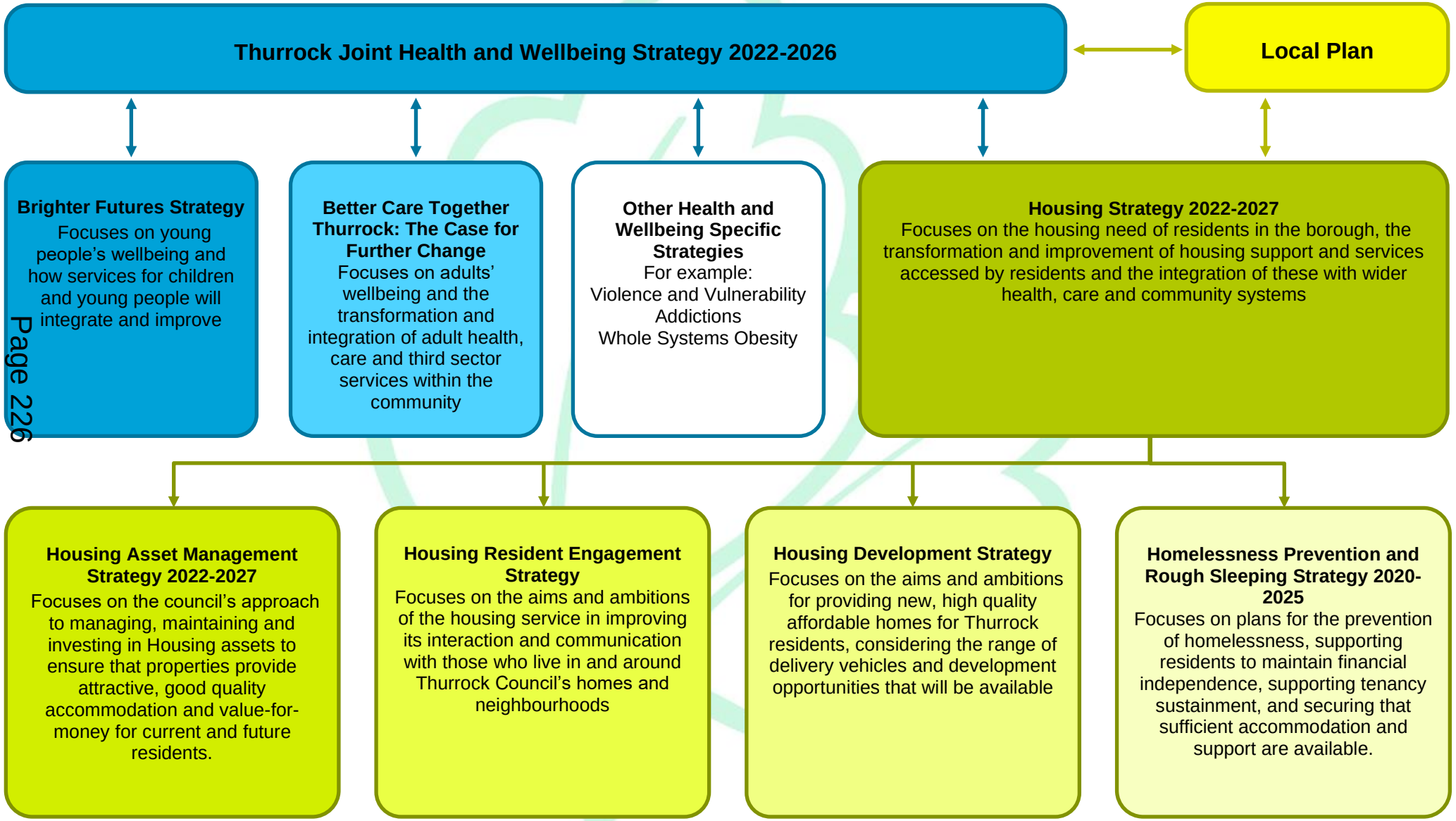
Corporate Context

Vision and overview of corporate priorities

The Housing Strategy is underpinned by Thurrock Council's vision and corporate priorities, adopted in January 2018. The council's vision is for Thurrock to be **an ambitious and collaborative community which is proud of its heritage and excited by its diverse opportunities and future.** Sitting alongside the vision are the three corporate priorities of People, Place and Prosperity.

People	Place	Prosperity
A borough where people of all ages are proud to work and play, live and stay.	A **heritage-rich borough which is ambitious for its future.**	A **borough which enables everyone to achieve their aspirations.**
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	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	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
The Housing Strategy must appropriately address and meet the challenges set within this priority. Resilient partnerships across sectors and empowered communities are integral to any Housing Strategy's meaningful development and success. They will ensure that services consistently meet and reflect those who use them.	While the housing service has specific responsibility for maintaining and developing homes and neighbourhoods managed by the council, this strategy goes further to consider all tenure types. This strategy will improve understanding of strengths and needs across the borough, identifying the requirements for homes and infrastructure to support current and future Thurrock residents.	The Housing Strategy aims to deliver opportunities for residents to achieve their aspirations, including accessing skills training with partner organisations. The strategy also seeks to expand relationships with other housing providers to increase affordable housing levels in the borough.

Strategic Context



Strategic Context

Joint Health and Wellbeing Strategy 2022-2026

The Thurrock Joint Health and Wellbeing Strategy 2022-2026 is the highest-level strategic document that describes our collective plans to improve the health and wellbeing of residents. The theme of the strategy is *Levelling the Playing Field,* and the strategy sets out high level actions to address health inequalities across six domains.

- Healthier for Longer including mental health
- Building Strong and Cohesive Communities
- Person Led Health and Care
- Opportunity For All
- Housing and the Environment
- Community Safety

As housing and the environment features as a domain of health inequality in the Joint Health and Wellbeing Strategy, there is a strong link with the aims and objectives of this Housing Strategy. Both documents will drive forward positive improvements for the health and wellbeing of Thurrock residents.

The local plan sets a vision and framework for the future development of Thurrock, drawn up by the local planning authority with wider engagement and consultation with the community.

Better Care Together Thurrock: The Case for Further Change

The *Case for Further Change* strategy sets out a collective plan to transform, improve and integrate health, care and third sector services aimed at the borough's adults and older people to improve their wellbeing. It has been developed and agreed by the Thurrock Integrated Care Alliance (TICA) and its partner organisations. Partners across Thurrock have a long history of working together to agree and deliver shared outcomes.

The *Case for Further Change* proposes a transformation from the current system architecture and ways of working to move instead towards integrated locality teams. It intends to create a single Integrated Locality Network of professionals who will be able to collaborate more easily and effectively with each other, and with residents. The overall aim is to embed the maximum amount of care and support at locality and neighbourhood level within a multi-disciplinary network of staff who can collaborate to design integrated solutions with residents rather than make onward referrals.

Local Plan

The local plan addresses many issues affecting local people. There are policies that cover development issues in relation to education, health, community safety and sustainable development. It also contains policies on more traditional, but important, planning activity such as housing, employment, leisure and sport, natural and historic environment, and community facilities.

Where the Housing Strategy sets strategic aims and objectives regarding housing need, the local plan supports the practicalities of providing new homes, through the identification for sites and areas where development is permitted and the creation of planning policy that meets priorities in the borough. The housing strategy will feed into the development of the new local plan, ensuring alignment.

Vision, Principles, Aims and Objectives

Housing Vision

Every Thurrock resident will have access to a safe, secure, suitable, and affordable home that meets their needs and aspirations, serving as a foundation to support their health and wellbeing.

Residents will be supported at home and in their local area through connected services, neighbourhoods, localities, and communities to achieve their vision of a 'good life'.

Page 123

Housing and health are intrinsically linked. Access to a safe, secure, stable, warm, and affordable home will provide people with a solid foundation upon which they can better protect their health and support their wellbeing. If a home is lacking any of these factors, it will have a detrimental impact on the physical health, mental health, and general wellbeing of all those in the household.

A safe home can mean many things, such as being hazard free, or maintained in line with compliancy measures such as gas servicing and electrical testing. A safe home goes beyond physical maintenance and bricks and mortar; it can also relate to a resident's perception of safety in their home and in the neighbourhood or estate in which it is located.

A secure home can refer to the security of tenure, giving residents peace of mind and stability by having that solid foundation to build their vision of a good life, or it can again be considered in like with the perception of safety within the home from any outside harms.

The factors that determine a suitable home are wide ranging and tailored to the housing needs of each household. It can relate to the size, type, location, and accessibility of a property, but can also refer to the standard in which the property is kept, ensuring good quality accommodation is provided and that it remains well maintained.

The definition for an affordable home is also aligned with the specific needs and commitments of every household. Affordability of home is linked with many wider consequences, such as fuel poverty and impacts on physical and mental wellbeing

Health and wellbeing run through every aspect of this strategy. This document's strategic aims and objects are rooted in the fundamental aim of tackling health inequalities through housing to support Thurrock residents to live healthy lives.

The vision for the Housing Strategy 2022-2027 is aligned with the aims of Domain 5 – Housing and the Environment within the Health and Wellbeing Strategy 2022-2026, outlined below:

Fewer people will be at risk of homelessness, and everyone will have access to high quality affordable homes that meet the needs of Thurrock residents.

Homes and places in Thurrock will provide environments where everyone feels safe, healthy, connected and proud.

Vision, Principles, Aims and Objectives

Housing Core Principles

This Housing Strategy has been developed in part to set the basis for a new way of working for housing support and services in Thurrock. This strategy and the new way of working follow the below eight principles:

- We work in partnership with residents to understand the things that matter to them in the context of their lives and the neighbourhoods in which they live.

What is important to you? 1

- We work to provide people with services that are high quality, easy to access, and offer approprate support.

Right time, right place and high quality 2

- We will relentlessly focus on reducing health inequality. We will ensure that resources are distributed in a way that accounts for variation in need at neighbourhood level.

Supports health and wellbeing 3

- The amount of resource we spend on bureaucracy is kept to a minumum ensuring maximum resources are available to provide people with the solutions they require.

Minimises bureaucracy 4

- Our solutions look to use the assets within neighbourhoods and do not consist only of the services we provide.

Local, strength based solutions 5

- We empower resident facing staff to make decisions in the context of each resident they serve rather than being constrained by thresholds and *one size fits all* service specifications.

Doesn't break the law and meets statutory duties 6

- We are flexible enough to respond and adapt delivery to changes in individual, neighbourhood and place circumstances

Flexible and adaptable 7

- Responsibility for housing is shared between individuals, neighbourhoods, our workforce and partners. We do *'with',* not *'to'.* We constantly co-design and co-produce.

Partnership working and collaborations 8

Vision, Principles, Aims and Objectives

Housing Aims and Objectives

The aims and objectives set out in this strategy will support the council in achieving its housing vision. They also align with and support the work and actions identified within the Joint Health and Wellbeing Strategy as well as the Better Care Together Thurrock: The Case for Further Change strategy.

Deliver Housing Support and Services

- Embed a person-centred approach to housing support and services
- Develop locality and neighbourhood models for integrated housing services

Meet Housing Need

- Identify and provide the right homes for Thurrock based on household need
- Address the housing affordability crisis in Thurrock
- Prevent homelessness and end rough sleeping in Thurrock
- Deliver sustainable esate and housing regeneration
- Review the model of Sheltered Housing provision

Protect Resident Safety

- Improve warmth, safety, and standards in private sector homes
- Invest in and maintain quality council-owned homes
- Strengthen community safety and prevent anti-social behaviour
- Tackle domestic and sexual abuse and violance
- Support vulnerable adults and children
- Improve estate standards

Strengthen Community Engagement and Empowerment

- Improve resident satisfaction and access to information
- Strengthen, integrate and diversify community and resident engagement

Legislative and Regulatory Framework

The Housing Strategy has been developed within and reflects current legislation and regulation.

Legislation

Thurrock Council has many housing duties and responsibilities, with only some of these relating to its role as a social housing provider. The council has duties towards homelessness prevention and relief, enforcing property standards and licensing in the private rental sector, and strategic assessments of the borough's current and future housing needs.

At the time of writing this strategy, there a number of new acts and proposed bills that will affect the way that housing support and services are provided during the expected lifetime of this strategy.

Domestic Abuse Act 2021

The Domestic Abuse Act aims to raise awareness and understanding about the impact of domestic abuse on victims and their families. It intends to further improve the effectiveness of the justice system in providing protection for victims of domestic abuse and bringing perpetrators to justice. It also aims to strengthen the support for victims of abuse by statutory agencies.

Fire Safety Act 2021

The Fire Safety Act places additional duties on responsible persons for multi-occupancy residential buildings, with the legal responsibility of proactively identifying potentially dangerous external wall systems and other structural issues and putting in place measures to deal with them. Responsible persons must make sure that they are up to date with government guidance regarding dealing with dangerous external wall systems and, where necessary, that they engage with competent fire safety professionals to make sure the steps they are taking are suitable and sufficient to deal with the risks posed.

Building Safety Bill

The objective of the Building Safety Bill is to strengthen the overall regulatory system for building safety. It aims to establish a comprehensive new building safety regime concerning the design, construction, and occupation of higher-risk buildings. It aims to achieve this by ensuring there is greater accountability and responsibility for the design and construction of buildings, as well as throughout the lifecycle of buildings.

Social Housing Regulation Bill

The Social Housing Regulation Bill aims to deliver against the commitments made in the social housing white paper for those who live in poor quality social housing. It makes provision for residents to be given performance information so landlords can be held to account and aims to ensure that when residents make a complaint, landlords take quick and effective action to put things right.

In general, new legislation, and in particular new regulation, bring new duties, responsibilities, and burdens on the council. This can pose a risk due to the need to understand and implement measures correctly. Such activity can cause confusion and distraction from service delivery during initial rollout and embedding, and new reporting requirements can be cumbersome and resource intensive. The effective use of technology and analytics applications can go a long way to reducing the level of manual effort required in such circumstances.

The full impact of new regulation and legislation cannot be completely understood until sometime after implementation.

However, changing legislation and regulation also provide opportunities to better meet the needs of residents, and in the longer term should improve the level of service and support offered. New legislation can tackle long-standing issues that prevent positive outcomes for residents, as evidenced through the changes introduced by the Domestic Abuse Act.

The list below is not exhaustive; however, it indicates other significant legislation that set the council's housing responsibilities.

- Landlord and Tenant Act 1985
- Housing Act 1985
- Housing Act 1996
- Housing Grants, Construction and Regeneration Act 1996
- Local Government Act 2000
- Homelessness Act 2002
- Housing Act 2004
- Equality Act 2006
- Housing and Regeneration Act 2008
- Localism Act 2011
- Welfare Reform Act 2012
- Housing and Planning Act 2016
- Welfare Reform and Work Act 2016
- Homelessness Reduction Act 2017
- Homes Fit for Human Habitation Act 2018

Regulation

At present, the Regulator of Social Housing has set four consumer standards and will intervene where failure to adhere to the standards has caused or would risk causing serious harm to tenants. As a social housing provider, the council must adhere to these standards.

The four consumer standards are:

- Homes Standard
- Neighbourhood and Community Standard
- Tenancy Standard
- Tenant Involvement and Empowerment Standard

The Regulator of Social Housing has also set three economic standards. However only the rent standard is currently applicable to the council as a local authority. This standard establishes the maximum weekly social and affordable rents that social landlords can charge.

There are current proposals to introduce a Social Housing Regulation Bill, which would deliver changes to the consumer regulation of social housing. It would strengthen the accountability of landlords for providing safe homes, quality services and treating residents with respect. It would also implement some specific changes to the economic regulation of social housing. These are likely to be introduced during the lifetime of the Housing Strategy 2022-2027.

National Context

The housing landscape is ever-changing, impacted by alterations to government policy, periods of economic change, noteworthy events in the housing sector and other national influences.

Whilst Thurrock does have localised challenges, some of which are outlined in the next section, the strategic approach towards housing in the borough is equally affected by the national context.

The Charter for Social Housing Residents

Building and Fire Safety

Climate Change and Sustainability

COVID-19 and Housing

Levelling Up White Paper

The Charter for Social Housing Residents

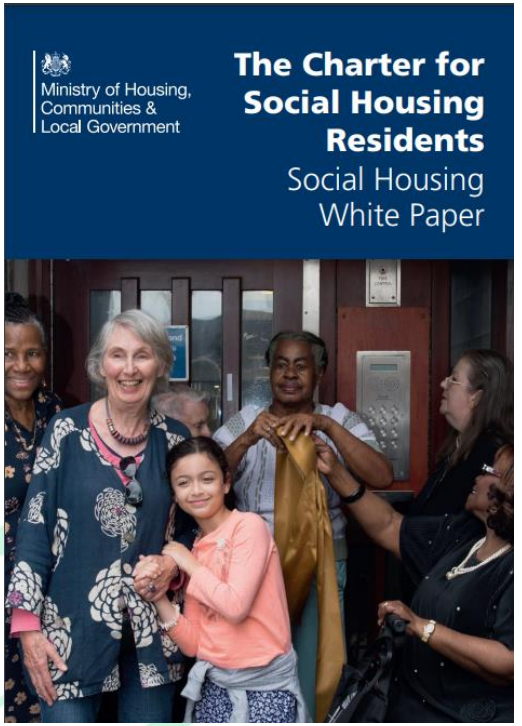
In late 2020 the Government published its social housing white paper, The Charter for Social Housing Residents. Within this document, the Government set out its intentions to ensure that residents in social housing are safe, listened to, live in good quality homes, and have access to redress when required.

The charter outlines the following seven elements that every social housing resident should be able to expect:

- to be safe in your home
- to know how your landlord is performing
- to have your complaints dealt with promptly and fairly
- to be treated with respect
- to have your voice heard by your landlord
- to have a good quality home and neighbourhood to live in
- to be supported to take your first step into ownership

Further to establishing these aspects, the Government announced plans to strengthen the Regulator of Social Housing. It aims to empower the regulator to be proactive in monitoring and enforcing the consumer standards that social housing landlords are held to, and requiring landlords to:

- be transparent about their performance and decision-making so that tenants and the regulator can hold them to account
- put things right when they go wrong
- listen to tenants through effective engagement



Building and Fire Safety

The Grenfell Tower Fire brought both fire and building safety into sharp focus for housing providers, building managers and residents of high-rise properties across the country. The tragedy triggered a wave of activity, such as the commissioning of a review of building regulations and fire safety led by Dame Judith Hackitt.

Published in May 2018, *Building a Safer Future: Independent Review of Building Regulations and Fire Safety* set out over 50 recommendations for government.

The report drew particular attention to the importance of engaging with residents, strategies for engagement, and ensuring that residents had access to information and involvement in decision making.

The council's duties and obligations relating to building and fire safety are likely to be broadened in the coming months and years due to the progression of the Building Safety Bill and the commencement of the Fire Safety Act 2021. As such, the Housing Strategy must respond to these and flex with any newly introduced duties or responsibilities.

Climate Change and Sustainability

The Climate Change Act 2008 set a target in legislation to reduce UK emissions of carbon dioxide and other greenhouse gasses to net-zero by 2050. More recently, measures have been introduced to support this aim, such as the intention to phase out gas-fired boilers in new properties by 2035 and increase the use of electric vehicles across the country by mandating that all new homes must have charging points provided.

In October 2019, Thurrock Council passed a motion whereby it declared a climate emergency and set out to take urgent action to reduce its carbon emissions to net-zero by 2030. Initial plans are being developed to respond to the climate crisis by ensuring that council operations are carbon-neutral by this time. As a social housing provider with around 10,000 properties in its stock, to achieve net-zero by 2050, many significant financial and logistical challenges will need to be addressed.

COVID-19 and Housing

Concerns remain across the Housing sector that the impact of the COVID-19 pandemic on housing and homelessness has not yet fully emerged.

Initiatives such as 'Everyone In' and the Coronavirus Job Retention Scheme, and legislation to temporarily ban evictions and extend eviction notice periods, provided some stability and security to households during significant uncertainty throughout much of 2020 and 2021, but these were not permanent resolutions.

With these temporary protections now removed and considering growing inflation levels and household costs, there are fears of a surge of households experiencing financial hardship and, therefore, at risk of homelessness. The full extent of the impacts on the private rental sector and the broader housing market in Thurrock is uncertain; however, the Housing Strategy aims to consider these factors to adapt and respond in the event of any such spike.

Levelling Up White Paper

The Levelling Up White Paper outlines 12 ‘missions across four broad areas with the aim to reduce inequality and transform the UK by spreading opportunity and prosperity. These areas are:

- boosting productivity and living standards by growing the private sector, especially in those places where they are lagging
- spreading opportunities and improving public services, especially in those areas where they are weakest
- restoring a sense of community, local pride and belonging, especially in those places where they have been lost
- empowering local leaders and communities, especially in those places lacking local agency.

It also sets an aim under mission 10 that by 2030, renters will have a secure path to ownership with the number of first-time buyers increasing in all areas and an ambition for the number of non-decent rented homes to have fallen by 50%, with the biggest improvements in the lowest-performing areas.

Local Context

There are a number of factors that specifically impact upon housing within Thurrock. These factors relate closely to the affordability of housing in the local area, and is determined in part by the mix, supply and availability of different tenure types. The factors set out in this section can be seen below.

Housing Tenure Mix in Thurrock

Affordability

Social Housing Provision

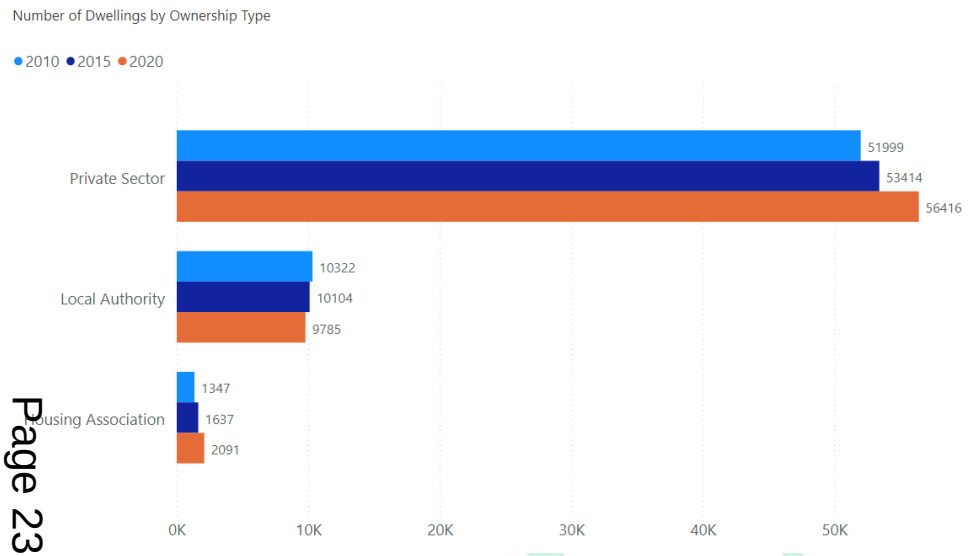
Thames Freeport

Purfleet-on-Thames

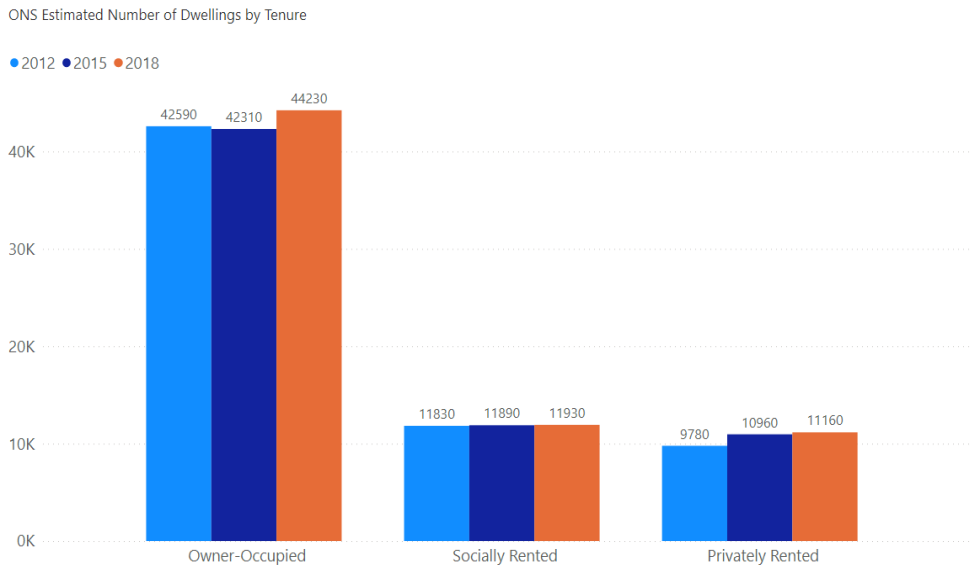
Lower Thames Crossing

Housing Tenure Mix in Thurrock

The chart below provides estimates of the number of dwellings in Thurrock, broken down by ownership type.



Alternative estimates by the Office for National Statistics (ONS) indicate the split between privately rented properties and those occupied by the owner. It should be noted that these are not official statistics, but they do provide an illustrative figure for comparison. In this chart, socially rented refers to the combined number of dwellings owned by the local authority and those owned by housing associations.



Affordability and Social Housing Provision

Affordability of accommodation in Thurrock is an ongoing challenge, both in the private rental sector and for those aiming to purchase properties.

In Thurrock, the council is the primary provider of social housing. Based on data published by MHCLG (now DLUHC), as of 31 March 2020, it was estimated that 14.3% of dwellings in Thurrock were owned by the council, with other registered providers of social housing owning less than 3.1% of homes in the borough.

The impact of these figures means that for every 47 council-owned dwellings, there were 10 registered provider-owned dwellings, representing the fifth-lowest ratio for stock-retaining local authorities in England at the time of writing.

Although the number of registered provider-owned dwellings has been increasing over time, this imbalance has led to additional pressure and demand on Thurrock Council from households as it is seen to be the primary provider of affordable accommodation in the borough.

Thames Freeport

It was announced in October 2021 that the Thames Freeport, one of eight announced in the UK, would be able to commence operations. It is anticipated to deliver transformational change across the entire borough, creating thousands of new jobs and attracting substantial investment into Thurrock over the next 25 years.

The successful delivery of the Thames Freeport in Thurrock is expected to contribute significantly to achieving wider place agenda ambitions. It will bring together physical, economic, social, and environmental renewal to improve the wellbeing of communities, provide opportunities and help ensure places are fit for the future.

The expected creation of jobs is likely to impact housing need in the local area. As the Thames Freeport develops and progress on the Local Plan continues, it is expected that this impact can be quantified, and measures identified to address housing need.

Purfleet-on-Thames

Purfleet Centre Regeneration Limited is a joint venture between Urban Catalyst and Swan Housing in partnership with Thurrock Council to regenerate over 140 acres to create Purfleet-on-Thames.

Developed on healthy town principles, Purfleet-on-Thames will create a new waterfront destination on the River Thames; an international creative hub and high quality new residential with place making at its core. The vision for Purfleet-on-Thames includes:

- A state-of-the-art film and TV studio facility and related creative industry hub
- Attractive new waterfront commercial and retail space
- Up to 2,850 new homes, including significant health and education facilities
- Community facilities, leisure uses and upgraded and additional public transport facilities

Lower Thames Crossing

National Highways proposes building a new Lower Thames Crossing that will include a major highway through Thurrock. Project proposals include two new 2.5-mile tunnels under the River Thames, 14.5 miles of new road and the construction and alteration of structures, including bridges, buildings, utilities, and tunnels.

The proposals for the Lower Thames Crossing have been assessed as directly and substantially compromising the ability to meet the need for new housing in Thurrock in a sustainable manner. It would lead to the direct loss of approximately 20 existing dwellings, and it is estimated that 1,400 homes would be affected by blight.

The impact on local housing would not only be affected upon completion of the project. During the construction phases of the Lower Thames Crossing, there will be the need for accommodation for over 900 workers involved with the construction of the northern parts of the project in Thurrock. It is expected that this need would be met through a combination of rented properties visitor accommodation such as hotels and owner-occupied homes. This would significantly increase demand and may negatively impact affordability and supply for Thurrock residents and may be a matter of significant concern should the Lower Thames Crossing construction project be awarded a Development Consent Order.

Deliver Housing Support and Services

This chapter proposes a reframing of the approach taken to support households interacting with the council. Instead of viewing a set of 'problems' requiring resolution by disconnected teams, the Housing Strategy encourages a strengths-based 'whole person' approach, connected within a wider system that includes adult social care, children's services, public health, NHS partners, the wider community, voluntary and faith sector, and existing assets within the community, that can all positively support people to live healthily and well.

Embed a person-centred approach to housing support and services

Thurrock residents approach and interact with council services, delivery partners and other organisations regarding a range of housing-related matters every day. Whilst all will aim to help within their defined remit, the current approach can create barriers to success as few challenges can be appropriately addressed by any one party in isolation.

Homelessness, for example, cannot be addressed in Thurrock solely by the housing service of the council – it requires far greater collaboration and partnership, and all those working alongside individuals and households to see 'whole human beings' with their strengths.

This strength-based 'whole person' approach should be embraced and adopted by those working with residents in the borough.

Rather than responding to people approaching the council as a collection of fragmented teams and services, each trying to tackle their own 'problem', it is intended that we move in a direction where parties are connected and operating within a wider system beyond traditional organisational boundaries. Housing forms one part of this, alongside others such as adult social care, children's services, public health, NHS partners, the wider community, voluntary and faith sector, and existing assets within the community.

When viewing an individual or household through the lens of a wider system, greater opportunities are available for the coordination of more holistic approaches to support relating to their housing need and other personal circumstances, which also complement their strengths.

As teams and services operate within this broader system, every interaction with a resident or household will present an opportunity for continuous engagement, learning, and improvement. This can be in the context of supporting those individuals by learning about the barriers preventing positive outcomes and designing ways to overcome them, or by identifying systemic issues through shared experience and practice that would require wider resolution.

What will we do?
We will embed the housing core principles and person-centred approach to housing services in service provision in order to provide tailored and bespoke support to residents
We will reduce bureaucracy in order to deliver outcomes that matter to residents at pace
We will adopt a whole system approach to supporting residents in order to reduce fragmentation and duplication of services

Develop locality and neighbourhood models for integrated housing services

Housing support, much like public services more broadly, is often fragmented into specific areas that each focus on resolving single 'problems'. However, people want to be recognised and supported by a system that views them as a complex individual aiming to achieve their vision of a good life.

Thresholds and eligibility criteria exist across the public sector, and housing support and services are no exception. Support may only be provided to those identified as 'eligible', and that support is often standardised and focussed solely on one single need, determined on a borough-wide level.

People are likely to have multiple interconnected needs that would benefit from the support of multiple teams or organisations, but the current approach to obtaining that support is often lengthy, fragmented and features with elements of duplication. Support is often provided through formal services when community organisations and assets may already exist to be able to meet these needs.

During the time that an individual attempts to navigate referral pathways and evidence their eligibility, it is highly likely that the need for housing support will become greater. This in turn will exacerbate any other connected or related support need, driving the individual towards crisis rather than prevention or early intervention.

This way of working increases rather than manages demand. It increases bureaucracy, costs, delays and wasted resource and has negative impacts on those seeking and providing support.

The *Better Care Together Thurrock: Case for Further Change* strategic document seeks to address this issue, primarily from a health and care perspective, however it combines this with a broader view to also include other areas that can affect (or can be affected) by these needs. One such area relates to housing.

The *Case for Further Change* proposes a transformation from the current system architecture and ways of working to move instead towards integrated locality teams. It intends to create a single Integrated Locality Network of professionals who will be able to collaborate more easily and effectively with each other, and with residents. The overall aim is to embed the maximum amount of care and support at locality and neighbourhood level within a multi-disciplinary network of staff who can collaborate to design integrated solutions with residents rather than make onward referrals.

The *Case for Further Change* suggests the incorporation of specific housing services into these Integrated Locality Networks, and the Housing Strategy 2022-2027 supports this intention.

What will we do?
We will develop a neighbourhood model for housing services in order to better focus on delivering what matters to residents in different localities
We will expand housing locality working into the Integrated Locality Network in order to collaborate more effectively with residents and other professionals
We will expand the knowledge and skills of housing staff in order to better support residents
We will create new Community Case worker 'blended roles' able to co-design integrated, bespoke solutions with residents

Meet Housing Need

Identifying and understanding housing need can be complex, and any unmet need can have a significant and lasting impact on the health and wellbeing of people. This chapter sets an approach to use a range of information sources to build an accurate understanding of current and future housing need, creating the evidence base for directing housing development.

This chapter considers how the council can explore, understand, and address the diverse housing needs of the borough's population. It also shares residents' priorities regarding the standard of homes in Thurrock and how homes can be developed and improved in the borough.

The development and quality of homes have direct relationships with the health and wellbeing of individuals. The adherence to suitable space standards, ample provision of affordable housing and the inclusion of appropriate green and open space in new developments will positively affect the lives of residents who will live there

Identify and provide the right homes for Thurrock based on household need

Every household has a housing need that is aligned to and reflective of their circumstances at that point in time

During the engagement and development of this strategy, many residents were concerned that the right types of accommodation were insufficiently available to meet their needs. Affordability was cited as one of the most significant barriers to securing accommodation within Thurrock with growing inflation, increasing household costs and the continuation of welfare reforms placing incomes under pressure. Residents also highlighted difficulties in accessing adapted or adaptable properties in the borough.

Based on the council's housing register data, the greatest demand is for two-bedroom properties, followed by one-bedroom properties.

The most recent Strategic Housing Market Assessment (SHMA) was produced in 2017. A SHMA is a technical study intended to help the council's planning and housing services to understand how many homes will be needed during the assessment period – in this case, between 2014 and 2037.

The 2017 assessment indicated an objectively assessed need of 1074 to 1381 properties per annum across all tenures for Thurrock between 2014 and 2037, identifying a net annual affordable housing need of 472 new dwellings. The proportions for the required property sizes identified through the SHMA are shared in the chart below.

There are significant variations between the proportions suggested by the existing SHMA and the data available for the council's housing register. It should be noted that the SHMA considers the housing need for the entire current and future population of Thurrock and recommends that the council continues to monitor the number of bedrooms required by households in priority need on the housing registers.

There is a clear need for good quality, sustainable and affordable housing to be provided in the borough. It is key to the wider growth agenda, enabling residents to live healthy and well lives and means that local residents are available to take up the new employment opportunities created by growth in the borough.

As a social housing provider, the council has a pipeline of future development projects aligned with identified local need.

Following the abolition of the HRA borrowing cap in October 2018 Thurrock Council, as a local authority with an HRA, is no longer constrained by government controls over borrowing for housebuilding. Instead, the council is now able to borrow against their expected rental income.

Additional flexibilities regarding the use of Right to Buy sales receipts mean that there will be wider scope to fund the development of new council-owned homes, and there is currently a pipeline of future projects aligned with identified local need that can now be taken forward.

Given the demand for smaller sized properties as evidenced within this strategy, much of the focus of council-owned developments in the near future is anticipated to primarily be one and two-bedroom homes; however, there will be a mix of homes including three and four-bedroom developments for growing families which can in turn make smaller homes available to be relet where the new occupiers are moving from an existing council-owned property.

Thurrock Regeneration Ltd (TRL) offers another route for the provision of new, high-quality housing across the borough. As a development company set-up and funded by loans from Thurrock Council, it can deliver properties for market sale, private rent, affordable rent and shared ownership, and then reinvest any profits into further housing development or to support services. TRL can support brownfield redevelopment and ensure that sites can be taken forward where other developers may be deterred by feasibility by accessing funding via partners such as the local enterprise partnership, the Association of South Essex Local Authorities (ASELA), and Homes England.

However, the council cannot meet the needs of all households in Thurrock in isolation. As such, work is needed to encourage and attract other registered providers of social housing and housing developers to construct homes in the borough, either directly or through joint ventures with the council, to meet the needs evidenced through local analysis and in the strategic housing market assessment.

What will we do?
We will use housing knowledge and data to influence and support the development of the Local Plan to ensure that future planning policy is representative of the needs of Thurrock residents
We will identify and understand housing need in Thurrock in order to deliver at least 500 new social and affordable homes for households in the borough
We will build homes that can respond and adapt to changing housing needs throughout life in order to ensure individuals live independently in suitable accommodation for longer
We will examine and tackle the factors leading to discrimination in housing that limit and prevent access to accommodation and implement a plan to tackle these
We will deliver and refresh the council's housing development programme in order to identify new opportunities to provide more social homes for rent

Address the housing affordability crisis in Thurrock

Nationally, housing affordability has worsened over the past 20 years, with London and the South East containing some of the country's most unaffordable areas. There has been a decline in the proportion of owner occupiers and an increase in the proportion of people in private rented accommodation.

While private rental has advantages such as greater flexibility to move home, currently the sector also contains the highest proportion of poor-quality homes, offers the least stability, and is the most expensive relative to the monthly cost of social rent and mortgages.

Although definitions and schemes exist to explain what affordable housing can be, there is no single methodology or model for determining what constitutes 'affordable' housing.

The revised National Planning Policy Framework, published in July 2021 goes into detail for four categories, referring to schemes and models such as shared ownership, equity loans, social rent, and affordable rent. However, many of these 'affordable' housing products would not be affordable to lower-income households.

There are a range of models for 'affordability', however the greatest challenge in defining affordability is that it is subjective and heavily influenced by each household's circumstances and housing needs. Determining what 'affordable' means based solely on market rents does not consider the disparity between the incomes of households, nor does it consider the source of those incomes.

Affordability concerns are prevalent for those wanting to buy in Thurrock. There is likely to be a considerable number of households for whom home ownership is not an option, in turn increasing the number of households looking to privately rent or socially rent. There is a need to ensure that these options are available and affordable for these households. There is also a need to ensure that these options are of suitable quality and security to mitigate against potential poor health effects of unhealthy housing.

There is then the challenge of households living in properties that may be deemed affordable, but that comes at the cost of quality, standard of living and decency of accommodation.

Based on analysis, it was observed that single full-time workers appear to be more likely to find one-bedroom properties affordable within the private rental sector; however, for other property sizes, and for other worker types across property sizes affordability is significantly impacted.

Households with two earners where at least one is a full-time worker will find the private rental market more affordable. For households with no full-time earners, accessing properties with median market rents is extremely unaffordable.

What will we do?
We will introduce and maintain a 'Thurrock Affordability Standard' in order to accurately inform service delivery, policy design and housing development
We will deliver at least 500 new council-owned homes by 2027
We will maximise the delivery of genuinely affordable housing in new developments in order to boost access and availability
We will support households to maximise their income in order to increase the range of affordable housing options
We will establish a social lettings agency for Thurrock in order to expand private housing options for residents

Prevent homelessness and end rough sleeping in Thurrock

Homelessness is a complex societal issue. The impact on the lives of individuals and households, and the response required from public and third sector organisations is significant.

Homelessness detrimentally affects the physical and mental health and wellbeing of individuals, impacts their access to health and care services, is a factor in increased drug and alcohol misuse, and disrupts the work, education, and support networks of households.

The introduction of the Homelessness Reduction Act in April 2018 saw the council experience an increase in the number of households approaching the organisation for assistance regarding homelessness.

A reduction in assessments can be observed after the end of the 2019/20 reporting year can be directly and primarily attributed to the impact of measures implemented by the Government to support people to remain in secure and settled accommodation during the COVID-19 pandemic. These measures included the extension of eviction notice periods, which returned to pre-pandemic lengths in October 2021, and the prevention of bailiff enforced evictions that was lifted in May 2021.

In 2018/19 and 2019/20, households approaching the council for a homelessness assessment were more likely to be owed the prevention duty as they were threatened with homelessness, rather than the prevention duty that would have been owed if they were experiencing homelessness.

In 2020/21 this balance reversed, with more households owed the relief duty than the prevention duty. As already outlined, during the COVID-19 pandemic support was in place to keep renters and homeowners in their settled homes, including mortgage payment holidays, leading to fewer households facing homelessness due to the threat of eviction or repossession.

These reasons for homelessness tend to have advanced warning or notice, meaning that action can be taken to sustain tenancies; however, other reasons for the loss of accommodation require swifter support and action.

There was a sharp reduction after March 2020 in the proportion of households owed prevention or relief duties due to the end of a private rental sector tenancy. Family and friends no longer willing or able to accommodate remained the most prevalent reason for the actual or threat of loss of settled accommodation in Thurrock, with the proportion increasing noticeably in the 2020/21 financial year.

Correlating with the protections for private rental sector tenants, a reduction in the proportion of the loss of private rental sector accommodation can be seen from 2020/21 compared to previous years. Over the past two years, the largest proportion of those owed the prevention and relief duties were those living with family.

The proportion of single adult males and single adult females seeking assistance have generally increased over the past four years, and with single adult males accounting for more than two in every five household types owed the relief duty.

When submitting and progressing through a homelessness application, household support needs are identified. The proportion of households with support needs owed either the prevention or relief duties has generally been increasing over the past four years.

The most prevalent support need for applicants in Thurrock has consistently been where there has been a history of mental health

problems within the household, followed by those with physical ill health and disability and those at risk of or have experienced domestic abuse.

In general, where homelessness can be prevented or relieved, the most prevalent type of accommodation offered is in the private rental sector, and this has been the case for a number of years.

Action the local authority can take to prevent or relieve homelessness include helping households to secure accommodation found by the applicants (with and without financial payment), directly securing accommodation through the housing options services, negotiation, advocacy and mediation, and other financial payments, such as those to reduce arrears.

If accommodation cannot be sustained through the prevention duty or assistance to secure accommodation is not successful during through the relief duty, a further assessment is undertaken to understand if the household is owed the main housing duty. The main housing duty owed by a local authority to someone who is homeless, eligible, has a priority need and is not intentionally homeless.

A number of factors are considered to determine whether a homeless household has a priority need for housing. Some groups of people, such as pregnant women, households with dependent children and victims of domestic abuse must be accepted as in priority need.

Others, such as those with physical disabilities or mental health illnesses and disabilities may also be in priority need if they would be significantly more vulnerable than an ordinary person would be if they became homeless.

Although the proportion of households with dependent children within all those owed a main duty has seen a slight year-on-year reduction, it remains the most significant priority need in homeless households Thurrock. There has been a noticeable increase in the proportion of households identified in priority need of housing as a result of mental health problems, with physical disability and ill health remaining a consistent factor for priority need.

Unlike accommodation secured through the prevention and relief duties, most of the accommodation offered to households owed the main housing duty was social housing, however the use of private rental sector properties has been increasing in recent years.

What will we do?
We will effectively eliminate rough sleeping in Thurrock by providing appropriate and timely support, making an offer of accommodation to every verified rough sleeper, and sharing knowledge between partners to help identify those individuals
We will support residents experiencing hardship across all tenures in order to prevent homelessness and sustain their homes by adopting an approach across the wider system where concerns and early indicators are referred to the housing service for action
We will work in partnership across the system in order to improve access to health, care and support services for those at risk of or experiencing homelessness. We will bring together community and voluntary sector organisations, health partners and other support services in a physical location to directly support those who are at risk of or who are experiencing homelessness. We will co-design bespoke solutions with residents to address all the factors that may be contributing to their homelessness or risk of homelessness, such as addiction, mental health and debt
We will ensure that any households requiring temporary accommodation remain within the borough wherever possible and for as little time as possible through increasing the number of council-owned properties for use as temporary accommodation in the borough, and only looking to make out-of-borough placements where it is for safety reasons or in the best interests of the household

Deliver sustainable estate regeneration

Estate regeneration provides the opportunity to enhance estates, address issues of health inequalities and deprivation whilst increasing the provision of housing on site. The council has identified key areas requiring significant investment that would benefit from wider regeneration to deliver new and better-quality housing.

Council investments in existing housing stock need to be continually reviewed to ensure that programmes achieve the best outcomes for residents and maximise the overall value of assets. Investments also need to be made to ensure that homes and neighbourhoods support the health and wellbeing of residents in the local area.

Much of the council's existing housing stock is considered maintainable in the long-term; however, the council recognises that some property archetypes present challenges in ongoing maintenance and the living environment.

It may be that an alternative use could be more appropriate, including using the land or assets to build additional homes of the type and quality needed and in areas where people want to live.

Several potential locations have already been identified to be taken forward for housing redevelopment and regeneration, such as the Blackshots high-rise tower blocks, blocks of flats at Teviot Avenue, and part of the Civic Offices site in Grays.

The high-rise blocks at Blackshots experience problems with damp and mould. There are interim plans to address some immediate issues at the Blackshots blocks; however, these will not address the overall design and layout of these properties which does not meet the needs of modern living.

Teviot Avenue, Aveley, contains 36 flats constructed of pre-cast reinforced concrete of the 'Cornish' type.

A survey was undertaken to assess the condition of the structures which identified several issues with the flats. A stock options appraisal was completed and initial engagement with residents demonstrated the preferred option is to redevelop the site and provide more homes.

The position on redeveloping Civic Offices 1 (CO1) for residential accommodation and the benefits of providing a new council facility in the Civic Office extension were agreed at Cabinet in September 2019. A scheme based on 100% council-owned social housing offers a financially sustainable model for developing the site.

It is anticipated that further regeneration possibilities will arise throughout the lifetime of this strategy.

What will we do?
We will establish and embed a clear vision and deliver against ambitious plans in order to direct future housing development and regeneration
We will deliver the major regeneration projects at Blackshots, CO1 and Teviot Avenue to provide modern, sustainable homes that are fit for the future
We will embed resident engagement in estate regeneration in order to deliver projects that meet local needs, working closely with our residents to understand their priorities, identify required estate improvements, and progress opportunities for new housing to transform and enhance neighbourhoods
We will target the regeneration approach in order to maximise the value of housing assets
We will embed active travel in new developments in order to encourage sustainable transport and improve wellbeing

Review the model of Sheltered Housing provision

Housing providers throughout the country have recognised that the traditional approach to Sheltered Housing model may no longer be fit for purpose or match the lifestyles and aspirations of older people today. Sheltered housing stock and complexes can also appear dated.

The consequences of these factors combined leads to lower levels of demand, increased numbers of vacant properties, loss of rental income for housing providers as well as missed council tax revenue.

This challenge has been known and growing for some time nationally, with the Joseph Rowntree Foundation publishing housing research in December 1995 regarding the causes and consequences of difficulties letting sheltered housing properties.

Since 2020/21 there has been a significant increase in the average number of bidding cycles required for a successful offer of a sheltered housing property to be made to an applicant. Sometimes properties need to be readvertised if the shortlisted candidates refuse the property or withdraw from the allocation process, however sometimes the readvertisement is due to a lack of interest from applicants in that bidding cycle.

The increase in number of void days for 2020/21 cannot be explained by the choice-based lettings suspension entirely. Analysis suggests that the extended void periods were more likely a result of the lack of interest from an appropriate housing register applicant.

To better understand the drivers for increased void turnaround times and increased numbers of bidding cycles, lettings data can be broken down into property types. The successful letting of a first floor flat takes almost four times as many bidding cycles than needed for a ground floor flat and void periods are on average 64.5% longer. Second floor flats, whilst requiring fewer bidding cycles than first floor flats, experience the longest void periods.

The relative difficulty in letting properties above the ground floor in sheltered housing may reflect concerns or preferences regarding accessibility of such properties for residents that meet the criteria for sheltered housing in Thurrock.

What will we do?
We will implement a new delivery model for Sheltered Housing in order to ensure this type of supported provision meets resident needs
We will investigate options for the potential decommissioning of Sheltered Housing complexes which are underused or no longer fit for purpose and offer opportunities to redevelop into new housing that meet current and future needs in Thurrock
We will overhaul the approach to allocating Sheltered Housing properties, reassess the eligibility criteria within the Allocations Policy and introduce a new approach to ‘sensitive lettings’ to improve access to this form of supported accommodation
We will invest in Sheltered Housing complexes in order to improve the day-to-day experience of residents by investing to improve conditions through internal and external decorating programmes, and by developing new ways and opportunities for residents to engage and collaborate with the housing team, other council services and external partners by increasing the use of technology in complexes

Protect Resident Safety

This chapter is focused on protecting people and working to prevent them from experiencing harm to their physical and mental health. It considers the physical environment relating to property conditions, fuel poverty, property accessibility and adaptations, and harm experienced from anti-social behaviour, crime, and domestic abuse. It also addresses and the general perception or feeling of safety in and around the home and neighbourhood.

The safety and security of residents in Thurrock are of paramount importance. They can be considered in two ways – the actions taken or required to protect physical safety and the actions taken or required to support people to feel safe. Although these are often aligned, it cannot be guaranteed that ensuring physical safety will result in a person feeling safe, and vice versa.

Improve warmth, safety, and standards in private sector homes

A significant amount of feedback was provided by residents during the development of this strategy relating to standards in the private sector. Responses suggested that action was required to ensure that all HMOs and other privately rented properties in Thurrock operate appropriately and safely, and to support vulnerable homeowners to live in warm and safe homes.

Private sector conditions

In 2021 the council commissioned a study to gather intelligence on the private housing stock in the borough. Through this, the council gained insight on the tenures, property conditions, likely instances of fuel poverty and geographical distribution of properties.

In recent years, Thurrock has seen growth in the number of properties used in the private rental sector, both as dwellings let in their entirety and as houses of multiple occupation (HMOs). The 2021 study estimated that the size of the private rental sector in Thurrock had increased by 76.3% compared to the findings of the 2011 census.

The council uses a risk-based evaluation tool called the Housing Health and Safety Rating System (HHSRS) to help identify potential risks and hazards to health and safety from any deficiencies identified in dwellings. The HHSRS is used to determine whether residential premises are safe to live in, or whether a hazard exists that may cause harm to the health and safety of a potential occupant.

The system assesses 29 types of housing hazard and provides a rating for each one. Those which score highly on the scale are called category 1 hazards and the council has a duty to take the appropriate enforcement action. Those that fall lower down the scale and pose a lesser risk are called category 2 hazards.

The data provided in the private sector stock condition survey estimated that 11% of properties in the private sector are estimated to have at least one category 1 hazard.

The private sector stock condition survey estimated that highest concentration of all HHSRS hazards is found in the wards of Grays Thurrock, Little Thurrock Rectory, and East Tilbury, with the highest concentration of properties experiencing excess cold located in East Tilbury, Orsett and Grays Thurrock.

The wards of Tilbury St Chads, Tilbury Riverside & Thurrock Park, and Belhus featured the highest concentrations of households of fuel poverty in Thurrock.

Fuel poverty is driven by three main factors: low household incomes, high energy costs, and poor property energy efficiency such as insufficient insulation or ineffective heating systems.

Houses of Multiple Occupation (HMOs)

HMOs can present greater risks to the health, safety, and wellbeing of residents than comparable single occupancy homes. Risks such as dangerous gas appliances, faulty electrical systems and inadequate means of escape and other fire precautions are examples of some of the hazards that the private housing team investigate in Thurrock on a regular basis.

We estimate that there are 2501 HMOs in Thurrock. Grays Riverside ward has the highest number of HMOs, followed by West Thurrock & South Stifford, and Grays Thurrock.

Through the stock condition survey, we estimate that at least one category 1 hazard is present in 26% of HMOs in Grays Thurrock, 23% of HMOs in The Homesteads and 22% of HMOs in Little Thurrock Rectory. 12% of HMOs in Grays Thurrock are also estimated to be in disrepair.

The purpose of licensing, especially for HMOs, is to ensure that residential accommodation within the private rented sector is safe, well managed and of good quality with a particular focus on safety.

A licence is needed for all properties that are occupied by five or more people, living together as two or more households, with additional licensing rules for HMOs in certain areas in Thurrock until May 2024.

Disabled Facilities Grants

Mandatory disabled facilities grants (DFGs) are available from local authorities to fund or part-fund the completion of a range of adaptations for disabled occupants. DFGs are issued for works that are necessary and appropriate for the property to meet the needs of the disabled occupant, and that are reasonable and practicable to carry out.

In addition, DFGs must be approved for works to make the dwelling safe for the disabled occupant and other persons residing with them. The most prevalent harms removed in Thurrock properties between April 2019 and March 2021 as a result of disabled facilities grants were relating to personal hygiene, sanitation and drainage, falls with baths, and falls on stairs.

What will we do?
We will drive up the standards and quality of homes in the private sector in order to ensure greater availability of safe and suitable homes for Thurrock residents by developing targeted, data-driven interventions and working with private sector landlords to improve housing standards and living conditions and support vulnerable owner-occupiers to remove HHSRS hazards from their homes
We will tackle hazards in the private rental sector in order to improve resident safety by using the full extent of enforcement powers available to the council
We will encourage private sector residents to access available support in order to live independently in their homes for longer through Disabled Facilities Grant usage where appropriate as a method to removing hazards and improve the health and wellbeing of households in Thurrock
We will develop a strategic approach to reduce fuel poverty in Thurrock in order to address the harm this causes to residents, supporting improvements to the EPC ratings of private homes across the borough by designing and delivering initiatives targeted at poor energy efficiency and using technology, data, and predictive analytics to identify and proactively support households at greatest risk of experiencing fuel poverty

Invest in and maintain quality council-owned homes that are fit for the future

The council's aims for its homes and estates are that they should be places where residents enjoy living and working, where they take pride in their homes and can enjoy being part of a thriving community. The aspiration is to invest in and maintain high-quality accommodation that demonstrates the benefits of the council's repairs and capital investment programmes and positively influences the health and wellbeing of our tenants and residents.

The council owns and manages just under 10,000 homes and its stock includes over 1,000 sheltered housing properties across the borough. Half of the council's general needs properties are three-bedroom homes, and the remaining majority comprise one and two-bedroom flats.

A 2017 stock condition survey demonstrated that the stock was in a fair to good condition with specific themes emerging such a need to prioritise work to property exteriors.

The council provides an effective and responsive day-to-day repairs and maintenance services that keep properties in good repair. The repairs service is delivered through third party contracts, providing a responsive repairs service to all housing tenants in line with government and locally set standards and timeframes.

Building and fire safety are matters of significant importance for any party or organisation involved in the management or maintenance of residential properties, and the responsibilities must not be taken lightly.

To meet its responsibilities, the council has a compliance regime to provide complete assurance to residents that their homes are well managed and meet required safety standards. Specific fire safety policies are in place to set how the housing service will manage and maintain its assets following the regulatory framework.

The housing service has begun to proactively develop an action plan to ensure that the council is in a strong position to meet and address the Social Housing White Paper proposals.

The housing service also stands ready to ensure compliance with the emerging Building Safety Bill, the implementation of recommendations made within the '*Building a Safer Future*' report following the Grenfell Tower fire, and any new duties or responsibilities introduced by the Fire Safety Act 2021. This aligns with the Charter for Social Housing Residents, as set out in the Social Housing White Paper.

Resident engagement is also crucial from the perspective of building management and safety. As part of the '*Building a safer future'* report published following the Grenfell Tower tragedy, the introduction of a 'golden thread' was made. This golden thread aims to serve as a tool to manage buildings as holistic systems, allowing people to use information to design, construct and operate their buildings safely and effectively.

<u>Damp and mould</u>

Damp and mould in social housing is an issue across the UK. It is widely recognised as one of the most challenging aspects for landlords and residents to prevent and manage. It is for this reason that the Housing Ombudsman undertook a thematic review and recently published a report on this subject, entitled '*Spotlight on damp and mould – It's not lifestyle'*.

Analysis of council repairs data between 1 April 2019 and 31 March 2021 shows that damp and mould repairs are relatively uncommon as a proportion of all repairs. During this time, 2242 responsive damp and mould repairs were completed, representing 4.1% of the total repair demand.

During the reporting period, 2197 damp and mould related works orders were completed at 1,123 council-owned properties, reflecting 11.4% of the council's housing stock.

Further analysis of repairs data demonstrates that tenants of most of these properties only reported damp and mould once during the two-year period, with only 2% of those living in council's housing stock reporting damp and mould concerns more than once during this same period.

There are over five times as many damp and mould works orders completed in January compared to August and damp and mould issues are clearly positively associated with older stock which is less likely to be thermally well insulated. Findings suggest that the primary cause of damp is condensation, where warm humid air inside the property condenses on cold walls, more commonly occurring in older properties, during the winter months.

The *'Spotlight on damp and mould – It's not lifestyle'* report produced 26 recommendations for landlords, including an ask of landlords to shift their approach to damp and mould.

Decarbonisation

In October 2019, the council passed a motion to declare a climate emergency and to take urgent action to reduce its carbon emissions to net-zero by 2030. The council has committed to reducing its carbon footprint to zero. The council's initial plans to respond to the climate crisis is by making sure the council's operations are carbon neutral by 2030.

The council is committed to continually investing to improve the overall thermal efficiency of homes, whilst effectively supporting the borough's most vulnerable residents out of fuel poverty.

What will we do?
We will listen to the views of residents and understand their priorities in order to design, develop and deliver stock improvement programmes that target the things that matter
We will invest in and embed new technology in order to effectively direct housing investment for maintenance and improvement
We will embed proactivity in the approach to maintaining council-owned homes in order to achieve a good standard and mitigate the need for reactive repairs by analysing detailed stock condition survey data to identify properties requiring investment over the next five to ten years. This information will inform plans for planned and cyclical maintenance programmes to ensure properties are safe and comply with legislative requirements
We will proactively share information relating to building and fire safety in order to support residents to feel safe in their homes
We will develop a holistic approach to damp and mould in council-owned properties in order to significantly reduce occurrences by delivering against an action plan based upon the *Spotlight on damp and mould* report and embedding technology, modelling and predictive analytics to identify properties likely to be experiencing such issues
We will support residents out of fuel poverty in order to improve health and wellbeing and quality of life by achieving EPC band C ratings across all housing stock by 2030 through direct investment in council homes from the housing revenue account and maximising the use of available funding streams
We will increase the use of sustainable and renewable technology in our stock in order to improve energy efficiency, reduce carbon emissions and support the council's green agenda

Strengthen community safety and prevent anti-social behaviour

The council holds considerable responsibilities to protect its residents from crime and anti-social behaviour by providing strategy, policy, and frontline enforcement services.

Crime is a broad and complex issue, impacting upon the health and wellbeing of victims and survivors, and wider society.

Anti-social behaviour is any act that causes – or is likely to cause – harassment, alarm, or distress. It is also any act that can cause nuisance or annoyance related either to housing or the affected person's occupation of their home.

The quality of the local environment is impacted in part by anti-social behaviour in Thurrock. Examples include littering, nuisance vehicles, and drug dealing and use. These impact on perceptions among the community of safety and their ability to enjoy their local area.

The *Charter for Social Housing Residents* sets out that every social housing resident should have a good quality home and neighbourhood to live in. In relation to anti-social behaviour, it outlines that social housing tenants have a right to feel safe in their homes, without the stress, fear, and tensions that anti-social behaviour and crime can cause and encourages landlords to develop practical solutions to tackle crime and anti-social behaviour.

The topic of anti-social behaviour featured heavily as a priority throughout the engagement for the development of this strategy, with concerns raised regarding the perception of feeling unsafe.

Certain groups are more likely to be the victims of crime, including women and girls, children and young people, the elderly and those with learning difficulties and disabilities.

Thurrock's Community Safety Partnership brings together local organisations with the shared goals of reducing crime and the fear of crime, anti-social behaviour, alcohol and drug misuse and reducing re-offending.

What will we do?
We will work in partnership to reduce local levels of crime and opportunities for crime to take place in order to make Thurrock a safer place to live, forming part of a new *Community Safety Service* for Thurrock and working across housing to support the priorities identified by Thurrock Community Safety Partnership annually
We will develop a multi-agency data monitoring tool to ensure all reports of anti-social behaviour to all community safety agencies, can be identified, enabling the identification of trends and analysis of data on repeat victims and perpetrators, including hate incidents and crimes to better inform to joint approach to tackling such issues
We will improve the local response to supporting victims/survivors of crimes to improve their health and wellbeing by fully adopting a person-centred and strength-based approach to such individuals
We will adopt new technology in order to better to record and monitor antisocial behaviour incidents and outcomes
We will communicate effectively about action taken to tackle anti-social behaviour in order to reassure residents by using direct, effective, and rapid responses to reports of anti-social behaviour and encouraging others to make reports of anti-social behaviour concerns as a result of evidence of positive outcomes
We will embed safety principles such as 'secure-by-design' and natural surveillance in new developments in order to reduce the likelihood of crime or anti-social behaviour in the future

Tackle domestic and sexual abuse and violence

Domestic abuse and sexual abuse are still largely hidden crimes and measuring the true scale of the issue is complex. Domestic abuse and sexual abuse happen in all communities.

The Domestic Abuse Act 2021 was passed into law in April 2021. The Act provided a new statutory definition of domestic abuse, introduced new laws and changes to existing laws, and placed new duties on local authorities, the Government, and other public bodies, such:

- The provision of safe accommodation for all survivors of domestic abuse
- Ensuring that fleeing abuse does not result in the loss of right to lifetime or assured tenancies when these were in place
- Ensuring that homeless people identified as survivors of domestic abuse are given priority

Domestic abuse and sexual abuse disproportionately affect women. Often the abuse is perpetrated by men, and is more likely to happen to women who have a disability.

Information collected by Thurrock Refuge between April 2018 and March 2021 indicates that 295 victims of domestic abuse were provided with safe accommodation – 120 refuge clients with 175 children. The average age of domestic abuse victims in safe accommodation was 35, however the ages ranged from 21 to 71.

72% of those provided accommodation had children, and 7% were pregnant. 88% of Thurrock Refuge clients were British nationals, however 5% of clients had no recourse to public funds.

There is a strong association within some data sets and the deprivation levels across wards in Thurrock. On average, 52% of residents in safe accommodation in Thurrock were unemployed while approximately 42% of residents' employment status was unrecorded in the same time frame, based on a three-year cohort.

The unemployment rate is high which could be for a range of reasons, such as mental health needs, or given that 5% of residents required an interpreter and 9% of residents' first language was not English theses may also be potential barriers in accessing and navigating employment or being financially able to continue to alternative accommodation.

Individuals identifying themselves as having a disability was an emerging trend in the data. Although numerically small, there is limited understanding of these needs and therefore requires greater focus. Mental health support emerged as the largest need for residents, corroborated by the understanding that emotional or psychological and jealous or controlling behaviour abuse types affected over half of residents each year.

The Domestic Abuse Act has defined children as victims in their own right. The specific needs of children residing in refuge is not known and will be a focus for future assessments.

What will we do?
We will offer support to survivors of domestic and sexual abuse effectively, professionally, and appropriately by introducing measures to ensure that residents receive a dedicated approach that considers the circumstances of each individual
We will work to improve pathways into safe accommodation in order to best support those fleeing abuse

Support vulnerable adults and children into housing

There is an urgent need to reform the accommodation and care pathway for vulnerable residents in Thurrock, such as those with mental illness, and those leaving care.

The role that housing plays in mental health support for individuals is crucial. Therefore, providing the right type of housing is fundamental to the help individuals to recover and live well in their community, as well as reducing demand on statutory services.

Accommodation and care for individuals with the highest levels of need coupled with challenging behaviour has been identified as the most difficult to source and sustain in Thurrock.

The accommodation and care provision for individuals in Thurrock with mental illness consists of residential care, supported living and floating support. Anecdotal evidence across housing, health and social care indicates that there is a gap in provision people with needs that are too complex and challenging for supported living and are inappropriate for residential care, and for whom the gap between general needs housing and supported living is too great.

The current model does not accommodate the fluctuating needs of people with mental illness. Unlike other groups, mental illness is not a linear condition and without the right support and boundaries may result in instances of frequent admissions and placement breakdowns. An individual may require one or all levels a model of accommodation and care provision, at different times, for short or long periods of time. The majority will require a multi-agency approach to their support in the community; however, when this support is delivered directly by each responsible agency can add to the feeling of overwhelm and chaos for the individual.

Locally, there are instances of multiple high-cost placements that do not deliver the quality and outcomes aspired to. A lack of concerted focus on achieving what is important to the individual and little opportunity to review plans and adapt, mostly occurring at times of crisis, has led to a drive to transform supported living.

Local authorities have a duty, as a corporate parent, to ensure continued involvement in supporting young people as they leave care and move into independence until they are 25 years of age. This approach should mean that bureaucratic processes are overridden, and decisions are made with the child's needs in mind.

Young people in care and leaving care can be highly vulnerable and at risk of experiencing multiple accommodation moves. They can often struggle to cope with the challenges of living independently at a young age without a family network, and they may need help to access services or deal with specific problems they face.

Good practice guidance published by the Government in 2020 recommends that council housing departments and children's services should produce a joint protocol that sets out how they will work together.

What will we do?
We will improve the supported and specialist housing offer in Thurrock in order to address shortfalls for vulnerable residents
We will align housing staff with Integrated Locality Networks in order to implement an integrated approach to care and support planning
We will continue to support the Head Start Housing initiative in order to provide suitable accommodation for care leavers as a foundation for their future

Improve estate standards

As a landlord, the council is responsible for managing and maintaining large areas of communal space, both indoors and out.

The *Charter for Social Housing Residents* seeks to ensure that all social housing residents can enjoy good homes and neighbourhoods.

In the white paper the Government announced a Decent Homes Standard review that would also consider how improvements to communal space around social homes could make places more liveable, safe, and comfortable.

Around 3,500 council-owned properties are located on estates or in areas with outside communal space that the housing service is responsible for maintaining.

Feedback from Thurrock residents during the development of this strategy included concerns about feeling safe in and around the borough's neighbourhoods, in particular relating to anti-social behaviour, drug crime and misuse, road and footpath safety, and inadequate street lighting.

Residents expressed improvements to specific estates and neighbourhoods should be made following engagement with those who live in those areas, ensuring that local needs, priorities and concerns are fully considered.

Through recent satisfaction survey activity, the responses of tenants who gave satisfaction ratings of 'fairly dissatisfied' or 'very dissatisfied' were analysed. 40.9% of the dissatisfied responses related to the quality of work carried out, specifically relating to standards of cleaning and litter either not being picked up or left behind. 34.1% was due to the frequency of the caretaking, with perceptions that extending periods of time pass without any work being carried out.

Similar analysis was undertaken regarding drivers of dissatisfaction relating to grounds maintenance in and around the council's housing stock. Over half of the responses (54.5%) related to the frequency of grass cutting and cleaning of the area. A quarter of responses referred to the general quality of work with the majority of these mentioning cutting and trimming of grass and bushes, and 13.5% of tenants said that waste was left behind and the area was left untidy.

What will we do?
We will implement a new approach to estate inspections in order to protect resident safety in estates and communal areas by delivering and embedding a new estate inspections quality and safety framework, supported by a more frequent inspection regime to assess and remove health and safety risks
We will adopt a collaborative approach to improve safety on estates in order to address the issues that matter to local residents. We will establish a programme of resident and ward councillor estate walkabouts to improve the connection to and understanding of the local area. We will use this information across housing, with our community partners and with residents to make our estates clean, attractive spaces where residents feel safe, using lighting, CCTV, and environmental improvements to do this
We will invest in and embed technology in order to facilitate robust management of estate standards
We will implement new approaches in order to tackle issues of nuisance parking on estates and improve the appearance of local areas, such as replacing high-cost wooden knee rails and bollards with green infrastructure such as hedging and shrub plants in order to deter such behaviour and improve the quality of environment

Strengthen Community Engagement and Empowerment

The COVID-19 pandemic led people to experience significant periods of social isolation and separation from their friends, family, and wider support networks. It also saw communities come together, with people supporting one another through immensely challenging and testing circumstances. The collective strength and resilience showed within communities

This chapter considers how relationships are built and strengthened between residents, the areas in which they live, the communities of which they are a part, and the organisations and groups that provide support and the council.

A significant ambition of this strategy is to support communities to build resilience and to broaden engagement with them. This strategy seeks to use the wider system and its networks to take an integrated approach in supporting communities, giving residents active and meaningful roles in matters that affect them in the context of housing and their estates and neighbourhoods.

Improve resident satisfaction and access to information

The Charter for Social Housing Residents seeks to ensure that landlords remain transparent and accountable to their tenants at all times. The white paper sets out that every social housing resident should be able to expect to know how their landlord is performing.

As a mechanism to achieve this, the Regulator of Social Housing is seeking to introduce a suite of tenant satisfaction measures for all registered providers of social housing, including local authorities.

In addition to greater transparency, these measures aim to inform the regulator about landlord compliance with the consumer standards under a more proactive consumer regulation regime as proposed in the social housing white paper.

There has been a generally positive trend in resident satisfaction levels recent years, however levels of resident satisfaction with housing services were lower in 2021/22.

In 2020/21, the last full reporting year, a total of 1983 ratings were provided by residents. Of these, 1497 reported that they were fairly or very satisfied with the overall service provided by housing. 234 residents provided neutral responses, and 252 shared that they were fairly or very dissatisfied.

Whilst satisfaction was reported as being very high in some areas such as rent value for money and the perception that homes are safe and secure, the perception of the repairs service fell below the target set for the reporting year.

Analysis and categorisation of recent resident feedback indicates that presently, the repairs and maintenance service is the main factor for dissatisfaction with over half of all comments (56.1%) relating to it.

Within the repairs and maintenance category for dissatisfaction, outstanding repairs represented 28.3% of the feedback received.

Sheltered Housing tenants with a tenancy length of between 10 to 15 years, 15 to 20 years and under a year were 100% satisfied with the repairs service and the least satisfied have been a tenant between one and five years (70%).

Tenants within general needs properties that have lived in their property for 10 to 15 years were most satisfied (76.2%), and those who had held their tenancies for between 15 and 20 years are the least satisfied (53%).

Further to these key measures, tenants are also asked to either indicate whether they agree or disagree with measures relating to landlord characteristics.

General feedback provided indicates that tenants find housing staff to be friendly and approachable, working to keep tenants informed and treating them fairly. Some concerns were raised by tenants regarding the ease of interaction with the housing service and how effective and efficient that service is.

However, the greatest proportions of dissatisfaction relate to tenant perception regarding the housing service listening to their views and understanding their needs.

Analysis of key terms used by tenants expressing their dissatisfaction when asked for their perception on whether the felt the housing service listened to their views is helpful as an indicator of similar themes from different residents.

Listen, nothing and *done* all feature prominently in the word cloud visualisation. Analysis of underlying tenant responses show that these are related – among dissatisfied tenants there is the perception and experience that they do not see action taken when feedback is asked for or given about the things that matter to them.

What will we do?
We will implement digital solutions in order to improve resident access to information and housing services
We will demonstrate our commitment to listen to residents in order to better understanding their needs and priorities by exploring the reasons for dissatisfaction, delivering focus groups with tenants and closing the contact loop with tenants by responding to the issues they raise, progress any actions required as a result and providing evidence of the outcome
We will tackle the drivers of dissatisfaction in order to make positive changes and improvements to the things that matter most to residents by using continuous learning and acting upon the feedback we are given from tenants
We will utilise technology and data analytics in order to better understand drivers of resident satisfaction and dissatisfaction
We will proactively prepare to report against new national tenant satisfaction measures in order to make our performance as a landlord more visible to our tenants by implementing a robust approach to recording, monitoring and reporting against the new tenant satisfaction measures that will be published by the Regulator of Social Housing by April 2023

Strengthen, integrate, and diversify community and resident engagement

The *Charter for Social Housing Residents* sets an expectation for residents to have their voice heard by their landlord. Within the social housing white paper, the Government sets out that it will:

- expect the Regulator of Social Housing to require landlords to seek out best practice and consider how they can continually improve the way they engage with social housing tenants
- deliver a new opportunities and empowerment programme for social housing residents, to support more effective engagement between landlords and residents, and to give residents tools to influence and hold landlords to account
- review professional training and development to ensure residents receive a high standard of customer service.

The white paper also expects that the Regulator of Social Housing will require landlords to show how they have sought out and considered ways to improve tenant engagement.

Traditional forms of engagement, such as consultation and surveys, are not always effective and can even have an adverse impact upon wellbeing if people feel pressurised to take part.

During the development of this strategy, residents stressed the importance of diversifying and expanding the opportunities and methods used for engagement. Recent years have seen significant growth of digital communication technology in homes, such as video calling and meetings, and the decline in face-to-face interaction due to the COVID-19 pandemic.

Engagement can take many forms, but the crucial factor for the future is that it is tailored appropriately.

What will we do?
We will embed an approach for the co-design and improvement of services in order to meaningfully involve and empower residents and communities. Approaches will include formally and informally co-designing solutions and provisions, influencing and making decisions, raising issues, inputting in the tendering of new contract arrangements and addressing challenges relating to housing in Thurrock
We will implement community reference and investment boards, as set out in the *Case for Further Change,* which will explore options for pooled locality funds at neighbourhood level in order to strengthen community empowerment, and we will work with communities and the voluntary sector to deliver at a more local level, only centralising that which cannot be provided effectively in neighbourhoods and localities
We will embed professional standards in housing services in order to ensure high service standards and consistency by providing training opportunities for staff across the service that meet or exceed requirements for training standards as set out by the Regulator of Social Housing in line with emerging legislation and regulation
We will develop opportunities to educate about housing in order to develop skills for independent living by building stronger links and relationships with the schools and colleges within Thurrock and creating a platform to engage with children and young people

Recent Achievements and Action to Date

Delivering Housing Support and Services

Many of the most successful areas of transformation in Thurrock are already operating using person-centred system principles. These include the council's Local Area Coordinators, Community Led Solutions, Community Builders, Wellbeing Teams, and Integrated Primary and Community Mental Health Care.

These teams are delivering better outcomes for residents by freeing frontline staff from pre-defined service specifications, KPIs and bureaucracy. Instead, they are empowered to co-design bespoke solutions with residents, responding to individual context.

The housing service has started to develop and embed person-centred approaches into the way staff work with and support residents, including pilots in the Housing Operations and Housing Solutions service area.

Meeting Housing Need

Identifying and providing the right homes for Thurrock based on household need

The development of a new SHMA is currently underway to update the understanding of local housing need, and is anticipated to identify the housing need for Thurrock until 2040 and will guide the development of the new Thurrock Local Plan.

The council does have a pipeline of new build schemes, informed by regular reviews of the council's Housing Register to provide an indicator of social and affordable housing demand, including any additional support needs or property adaptations that may be required.

This information has also been used to guide developments undertaken by other registered providers of social housing in Thurrock.

An affordability joint strategic needs assessment has progressed well in partnership with the council's Public Health team. The detailed findings and understanding provided by that assessment will be taken forward as actions of this strategy. They will feature alongside the development of a 'Thurrock Affordability' standard that considers local costs of living, local income, and housing market prices.

Over the past two years, 119 new council-owned homes have been built in the borough. In the 2020-21 financial year 29 new homes were provided at the Alma Court development in South Grays and a further 53 new homes constructed at Heathlyn Close and Claudian Way in Chadwell St Mary.

Further to this, in 2021-22 the council let 35 properties built to HAPPI standards at Beaconsfield Place in Tilbury and two further wheelchair accessible homes in an innovative scheme at Defoe Parade in Chadwell St Mary.

Planning approval has been secured for the provision of four new council homes at Loewen Road in Chadwell St Mary and for a multi-tenure project at Culver Centre and Field in South Ockendon, to be delivered through Thurrock Regeneration Limited.

There is also an existing pipeline of proposed projects, such as the redevelopment of part of the Civic Offices site for further council-owned homes. The current number of potential dwellings on new build projects under consideration is 504, featuring a mix of council-owned properties and other delivery approaches.

The council has also acquired over 120 existing properties from the local housing market for use within its housing stock, utilised as part of a wider plan to transform the council's temporary accommodation offer.

Addressing the housing affordability crisis in Thurrock

Every new build property and home acquired from the housing market have been offered at weekly rental levels within LHA rates applicable in Thurrock, making these properties the most affordable homes for rent in the borough, and is also the case across the approximately 9,900 homes in the council's housing stock, all of which are offered at social and affordable rent levels.

The council has committed that it will continue to deliver new homes through both estate regeneration and smaller scale development within affordable rent levels, continuing to ensure affordable housing is available to those most in need in Thurrock.

Preventing homelessness

Although the Homelessness Reduction Act 2017 generally directed local housing authorities to place much greater focus on homelessness prevention through general service provision, Thurrock Council's housing service has taken significant action to sustain tenancies and prevent homelessness.

A number of roles have been created and exist in the service to target specific areas of challenge or priority regarding homelessness, with some funded in part or full from DLUHC grants.

The ongoing temporary accommodation transformation plan has delivered successful outcomes to date, reducing the number of households in emergency and temporary accommodation significantly below pre-pandemic levels.

There are a number of cross-service initiatives that aim to support households at risk of or experiencing homelessness. A pre-eviction panel has been established focussing on council tenants, featuring wide representation from across the council with a sole focus on the prevention of tenancy breakdown.

Briefings and training sessions have been delivered by housing solutions staff to colleagues in adults social care and children's services, with aims to deliver these sessions to other frontline and resident facing staff across the organisation.

Multi-disciplinary groups have been established to review case studies from the different perspectives of partners in the wider system, developing a shared understanding of existing challenges and aiming to identify areas of good practice and where improvement can be made to reach positive outcomes for households in the future.

Delivering sustainable estate regeneration

The most significant regeneration project in Thurrock currently underway is the investment in over 140 acres at Purfleet-on-Thames, delivering up to 2,850 new homes. Purfleet Centre Regeneration Limited is a joint venture between Urban Catalyst and Swan Housing, in partnership with Thurrock Council. The first phase of 61 homes is currently anticipated to be handed over in Spring 2023.

Specific projects have commenced to take forward regeneration opportunities for council-owned homes at Blackshots, Teviot Avenue and Civic Offices 1. Initial resident engagement activity has already been completed with households at Blackshots and Teviot Avenue, with very high proportions in favour of redevelopment.

Reviewing the model of Sheltered Housing provision

During the past two years, the Sheltered Housing team have continued to deliver a valuable service to all tenants which has been enhanced in response to the COVID-19 pandemic.

Several actions have been taken within the service to address underperformance in void turnaround, specifically regarding properties above the ground floor. A dedicated Sheltered Housing Officer has been assigned to this area to improve performance.

The Sheltered Housing Team is working with other services across the council to identify suitable applicants, making person-centred decisions relating to the age eligibility where a move to sheltered housing would have a beneficial impact on the health and wellbeing of a household.

Protecting Resident Safety

Improving warmth, safety, and standards in private sector homes

As a direct result of interventions by the Private Sector Housing team, 2642 category 1 and 2 hazards were removed from properties in Thurrock between 2018-19 and 2020-21.

An additional HMO licensing scheme was introduced in 2019 and has licensed over 230 HMOs to date. Work to explore a selective licensing scheme for the private rental sector has commenced.

The council was awarded £61k in grants from DLUHC to tackle criminal landlords and drive-up standards. Through proactive, targeted action, civil penalty fines have been used as a method of enforcement action, generating up to £220k for housing related offences.

The council launched Well Homes in 2014 to improve the housing conditions and the health and well-being of residents living in private properties. The Well Homes scheme offers help to make homes safer by reducing the risk of ill health or accidents and puts residents in touch with health and lifestyle services that can improve quality of life.

The council secured a Warm Homes Fund grant of £453k for first time central heating systems and was allocated £1.8m scheme that makes energy-saving improvements to the homes of people who struggle to pay heating bills and keep their homes warm in the winter.

Between 2017-18 and 2020-21, the council awarded over £1.9m of Disabled Facilities Grants to 310 applicants to fund essential adaptations to give disabled people better freedom of movement into and around their homes, and to facilities within the home.

Investing in and maintaining quality council-owned homes that are fit for the future

Since 2017 capital works totalling over £46m have been undertaken across the council's housing stock to address priorities areas. Between 2019/20 to 2020/21, 732 properties benefitted from external refurbishment and double-glazed window replacement, including street properties and 90 blocks of flats.

A new stock condition survey targeting 30% of the stock is being undertaken in the winter months of 2021/22 to gain an accurate picture of any properties suffering from seasonal damp or mould problems.

The council has also introduced a proactive approach to identifying properties experiencing damp and mould, with new questions in the general perception, repairs, gas repairs, gas servicing and new tenancy surveys undertaken on behalf of the council.

This new approach was introduced as a direct result of the council's engagement with the Housing Ombudsman study and report produced on the subject of damp and mould.

The council's resident liaison officers (RLOs) have been trained by the national fuel poverty charity NEA. They are able to advise residents on how best to manage the home environment and how to manage their resources and their heating systems. RLOs can help residents to claim grants and liaise with financial inclusion officers to ensure they are accessing all the financial support they are entitled to.

Between April 2019 and March 2021 £408,961 was invested in servicing of mechanical ventilation and heat recovery units, repairing and replacing rainwater goods and completing the repair works under the specific mould remediation and prevention programme. A total of 4820 properties have benefited from these works.

In addition, the council invested £5,219,307 in improving overall building efficiency. These works included the replacement of central heating boilers in 1807 homes, the replacement of windows and/or doors in 331 homes and the roof and insulation for 87 homes.

In February 2022 it was announced that the council would receive £3.2m under the first wave of the social housing decarbonisation fund to deliver a new ground-source heat pump project to the three high-rise tower blocks in Chadwell St Mary, replacing older and less efficient storage radiators and hot water systems.

Strengthening community safety and preventing anti-social behaviour

A noise nuisance reporting app aimed at reducing duplication and allowing residents to report issues with greater ease has been introduced, offering an effective alternative to diaries and logs.

Across the council, work is underway to develop and implement a new Community Safety Operating Model to improve the council's delivery of its community safety partnership strategy.

In conjunction with this, a new Community Safety Service is being developed, bringing together the CCTV and Concierge teams from the housing service under a single structure with other related teams.

Proposals have also been made to develop a new integrated centre for crime and enforcement within a central location that will house an advanced CCTV, command and control capability, supported by police and new community safety officers.

Tackling domestic and sexual abuse and violence

The council has conducted a review its of policies and processes to achieve DAHA accreditation – the benchmark for how housing providers should respond to domestic abuse – and developed a new Domestic Abuse policy.

To reflect the council's commitment to tackling domestic abuse, the policy introduces several measures to ensure that residents receive a dedicated approach, considering the circumstance of each individual and always upholding best practice.

Supporting vulnerable adults and children into housing

In March 2016, children's services and the housing service developed a strategic partnership to support Thurrock's young people to access suitable accommodation at affordable rates.

In December 2018, Head Start Housing was launched, aiming to provide suitable accommodation for Thurrock's care leavers and a safe space to live and learn before moving on to a private rental or social housing tenancy. It has a portfolio of properties ranging from one to five-bedrooms, with varying levels of floating support to 24/7 provision.

Care leavers are supported to access housing benefit and, when they are ready, education, employment or training using the home as a foundation.

The housing service made a commitment to provide spaces for 30 individuals to Head Start Housing by end of 2023, and 24 spaces had been identified by the end of 2021.

Considerable progress has been made in the past three years, and the Head Start Housing Strategy has been refreshed to shape and drive positive change over the next 5 years.

Thurrock Council has actively supported and participated in the Government's Afghan Relocation and Assistance Policy and Afghan Citizens Resettlement Scheme. A cross-organisational group was

established to ensure a coordinated approach and private landlords were engaged to supply appropriate properties for this project.

Landlords and new tenants were supported to ensure the smooth running of tenancies alongside ongoing resettlement support, such as arranging English lessons if required, setting up bank accounts, finding jobs and getting children into education.

The council has successfully worked to increase the amount of council-owned temporary accommodation in the borough and has taken significant steps to date which includes the purchase of Brook House, now operating as a ten-unit temporary accommodation hostel.

Thurrock Council continues to operate a Housing First programme, providing intensive support to people who are long term or recurrently homeless with high support needs. The project has so far successfully supported seven individuals who were homeless or threatened with homelessness and faced persistent barriers to accessing housing, some of which were caused by health conditions and addictions.

Improving estate standards

The council commissioned a review of caretaking and estate services, with the report and recommendations being received in November 2021.

An overall service improvement plan has been developed incorporating the recommendations and actions from the review that seeks to improve estate standards and service delivery across the council's homes and neighbourhoods.

A new vision for estate services has also been set. The council aims to provide proactive and flexible estate services, working together with communities to provide safe and clean neighbourhoods that meet residents' needs, delivering value for money and supporting health and wellbeing.

The proposals for new housing development schemes led by the council integrate the principles of "Secured by Design" to help reduce crime and anti-social behaviour and improve resident feelings of safety.

Strengthening community engagement and empowerment

Increasing resident satisfaction and access to information

In June 2020 the housing service upgraded its Housing Online portal for tenants and housing register applicants. The system offers great potential for improving resident interaction with the council's housing services and the ability reports and concerns to be submitted directly, for example relating to issues of anti-social behaviour.

An improved Housing Options offer is also possible through the Housing Online portal which will reduce duplication for staff, offer a more joined-up experience for residents, and increase the quality of data and reporting which are available.

Between July 2020 and October 2020, a full postal tenant satisfaction survey was undertaken by the council's service provider, KWEST Research Ltd, which was sent to every tenant. The project used a multi-mode approach, comprising a postal census survey targeting all the Council's tenant households, accompanied by email invitations and an online version to broaden survey reach and accessibility.

The survey results provide confirmation that the homes and services provided by the Council are meeting the needs of most residents. This is demonstrated by high proportions of residents expressing satisfaction with many key service areas including rent value for money, quality of home, home is safe and secure, neighbourhoods as a place to live and the overall Housing service.

The housing service has successfully made use of technology to send specific and tailored text messages to its tenants for a range or reasons, such as to provide information and support for rent accounts, share information about resident engagement days and to alert tenants to issues that may be affecting their blocks, such as lift repairs and maintenance.

Strengthening, integrating, and diversifying community and resident engagement

The housing services have strengthened its approach to resident engagement activity recently, working to share more information with tenants about subjects that matter to them.

In 2021, the council published a *Collaborative Communities Framework* for Thurrock to share the strengths and assets-based approach for how the council and its services intends to work with communities.

Co-produced through the *Stronger Together* partnership over three years, it sets out how we will work and enable our communities to co-design and influence decisions, address their own challenges and realise their own ambitions.

The publication of the Housing Strategy 2022-2027 and the *Case for Further Change* provide an opportunity and starting point to build on the foundation of the Collaborative Communities Framework, strengthening the relationship and engagement between housing services, residents and the wider community, voluntary and faith sector in Thurrock.

Monitoring and Review

The Housing Strategy must be kept under constant review. This is partly due to the increased likelihood that legislation will be introduced during the lifetime of the document, which may have a material effect on the aims, objectives and actions outlined in the Housing Strategy. In addition, as the impact of the COVID-19 pandemic on housing becomes more apparent in the months and years after the document's publication, new priorities or actions may emerge.

The monitoring and review of the Housing Strategy will be undertaken by a new Housing Strategy Deliver Board that will be established. This Board will be responsible for monitoring the progress of the action plan published alongside the strategy. The action plan will be kept as a live document and regularly updated to ensure progress and that key actions are delivered within defined timeframes. The Housing Strategy Delivery Board will absorb the Homelessness Partnership Board, forming a single body with responsibilities for the progress of key strategic documents relating to housing.

As outlined above, it is anticipated that new actions will be added to the action plan during the lifetime of the strategy. Additions may be a reaction to changes in external factors (such as legislation) or proactively if an opportunity arises. These additions will be managed appropriately and ensure that the key themes continue to be reflected throughout the action plan.

An annual update will be provided to Housing Overview and Scrutiny Committee to ensure appropriate oversight of the action plan.

Acknowledgements

This strategy has been developed in partnership with a range of individuals, groups and organisations.

We are very grateful for each and every contribution made by residents, colleagues and partners that fed into the development of this strategy.

We would like to acknowledge the support of the chairs of the borough's community forums, the members of the WELCOM Forum, Purfleet-on Thames Community Forum and Orchards Community Forum, and members of the Housing Overview and Scrutiny Committee and the Lower Thames Crossing Taskforce for their active engagement in this work.

We would also like to acknowledge the Housing Resident Engagement team for facilitating the in-person tenant engagement sessions in Tilbury, Ockendon, Purfleet and Grays.

The support of the members of the Housing Management team, Housing Business Improvement Team and Housing Strategy Development Oversight Group was of great value in the development of this document

A large number of people contributed to this piece of work; however, we would especially like to thank and acknowledge the important contributions and support offered by the following people:

Ian Wake – Corporate Director, Adults, Housing and Health
Ewelina Sorbjan – Assistant Director, Housing
Ryan Farmer – Housing Strategy and Quality Manager
Robyn Riseborough – Housing Strategy Officer
Joanna Bale – Housing Strategy Officer
Claire Devonshire – Housing Quality Officer

Housing Asset Management Strategy

2022-2027

Thurrock Council

Contents

Introduction

Thurrock Council's Housing Asset Management Strategy 2022-2027 sets out the strategic principles to be applied for all future housing asset investment decisions. It provides a framework to be applied when considering future options for investment in the housing assets, ensuring that they continue to offer quality and affordable homes for current and future residents, optimising generated income to achieve the best value for residents.

The strategy demonstrates how the council's housing portfolio will meet its priorities and sets the strategic direction for those involved in the day-to-day management of the stock and future housing asset investment decisions. The housing service manages circa 10,000 council homes, including approximately 900 leasehold properties. The council has made a significant investment in its stock through the Transforming Homes programme and is committed to efficiently managing, maintaining, and investing in these homes.

This strategy aligns with the council's corporate values, the Housing Strategy 2022-2027 and the national policy context. It works alongside the HRA business plan in identifying the levels and timing of investment required to ensure the asset is maintained appropriately.

This strategy provides guiding principles that allow the council to maintain and enhance its housing stock in both the short-term and the future. It ensures the council works transparently, keeping residents engaged throughout the processes and fosters a sense of joint ownership.

Effective maintenance is essential to ensure council properties continue to meet housing needs and remain sustainable. A reactive maintenance policy supports this strategy, alongside a fit to let standard, health and safety procedures, a fire safety policy, and a suite of investment and development programmes. These ensure that the council manages its housing assets to meet the needs of residents and meets all regulatory requirements.

This strategy also recognises that further investment may not represent the best value for some assets or meet the community's future needs. Buildings in this category would undergo an asset review process that fully considers resident views. This full appraisal of the different options will inform the most appropriate decision for the future of the asset.

The council's strategic ambition is to ensure the delivery of good homes in well-connected neighbourhoods. The council seeks to invest in its assets and the local environment, creating places that support and promote the health, happiness and wellbeing of residents in the borough.

This strategy presents approaches to improve the council's housing stock by working with residents to invest in areas that will deliver the best outcomes and build pride in well maintained and improved homes.

The resident's voice is a crucial factor when delivering improvements. Communication and engagement will ensure the council works together with residents and delivery partners to refine the home improvement approach via retrofit. Through continued engagement and listening to feedback, the council aims to achieve high resident satisfaction with their home.

New and emerging legislation around building safety, decent home standards and the net-zero carbon agenda, in conjunction with an ageing stock, place significant financial pressures on the Housing Revenue Account. It is acknowledged that the council will need to explore external funding and continue to lobby central government for additional financial support to enable it to deliver this strategy.

Corporate Context

Thurrock Council's vision and corporate priorities, adopted in January 2018, underpin this Housing Asset Management Strategy. The council's vision is for Thurrock to be **an ambitious and collaborative community which is proud of its heritage and excited by its diverse opportunities and future.**

Sitting alongside the vision are the three corporate priorities of People, Place and Prosperity.

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 together to improve health and wellbeing
- communities are empowered to make choices and be safer and stronger together

Delivering high-quality housing across all tenures is central to ensuring positive health and wellbeing outcomes for residents. The council will ensure that services represent value for money, going over and above statutory duties, with high levels of customer satisfaction.

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

This means:

- 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

This strategy supports the corporate aims by ensuring the council's properties provide well-maintained quality homes suitable for residents' needs and in which they are proud to live.

In October 2019, the council passed a motion to declare a climate emergency and take urgent action to reduce its carbon emissions to net-zero by 2030. This strategy supports the decarbonisation agenda while improving the overall energy efficiency of the assets, ensuring the homes provide affordable thermal comfort.

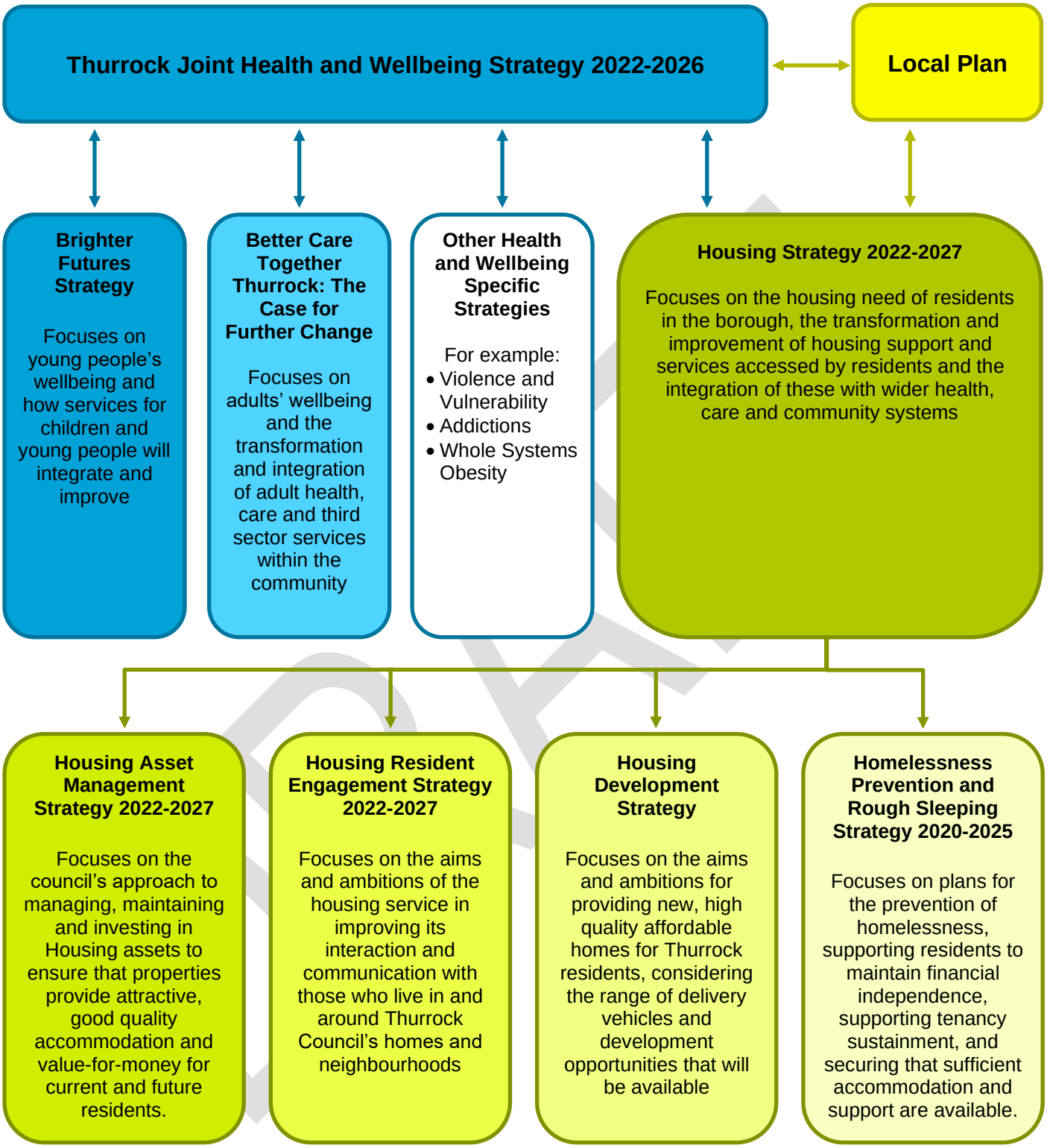
Prosperity – a borough which enables everyone to achieve their aspirations.

This means:

- 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

The strategy supports the local economy with employment and training opportunities and the additional community benefits secured through contracting partnerships as social value.

Strategic Context



Joint Health and Wellbeing Strategy 2022-2026

The Thurrock Joint Health and Wellbeing Strategy 2022-2026 is the highest-level strategic document that describes our collective plans to improve the health and wellbeing of residents. The theme of the strategy is *Levelling the Playing Field,* and the strategy sets out high level actions to address health inequalities across six domains.

- Healthier for Longer including mental health
- Building Strong and Cohesive Communities
- Person Led Health and Care
- Opportunity For All
- Housing and the Environment
- Community Safety

As housing and the environment features as a domain of health inequality in the Joint Health and Wellbeing Strategy, there is a strong link with the aims and objectives of this Housing Strategy. Both documents will drive forward positive improvements for the health and wellbeing of Thurrock residents.

The local plan sets a vision and framework for the future development of Thurrock, drawn up by the local planning authority with wider engagement and consultation with the community.

Better Care Together Thurrock: The Case for Further Change

The *Case for Further Change* strategy sets out a collective plan to transform, improve and integrate health, care and third sector services aimed at the borough's adults and older people to improve their wellbeing. It looks at specialist housing specifically designed for older adults, promoting independence by improving housing choices and provision for older people today.

Local Plan

The local plan addresses many issues affecting local people. There are policies that cover development issues in relation to education, health, community safety and sustainable development. It also contains policies on more traditional, but important, planning activity such as housing, employment, leisure and sport, natural and historic environment, and community facilities.

The local plan supports the practicalities of providing new homes, through the identification for sites and areas where development is permitted and the creation of planning policy that meets priorities in the borough. The Housing Asset Management Strategy will feed into the development of the new local plan, ensuring alignment.

Housing Vision and Principles

Housing Vision

Every Thurrock resident will have access to a safe, secure, suitable, and affordable home that meets their needs and aspirations, serving as a foundation to support their health and wellbeing.

Residents will be supported at home and in their local area through connected services, neighbourhoods, localities, and communities to achieve their vision of a 'good life'.

Housing and health are intrinsically linked. Access to a safe, secure, stable, warm, and affordable home will provide people with a solid foundation upon which they can better protect their health and support their wellbeing.

A safe home can mean many things, such as being hazard free, or maintained in line with compliancy measures such as gas servicing and electrical testing. A safe home goes beyond physical maintenance and bricks and mortar; it can also relate to a resident's perception of safety in their home and in the neighbourhood or estate in which it is located.

A secure home can refer to the security of tenure, giving residents peace of mind and stability by having that solid foundation to build their vision of a good life, or it can again be considered in line with the perception of safety within the home from any outside harms.

The factors that determine a suitable home are wide ranging and tailored to the housing needs of each household.

The definition for an affordable home is also aligned with the specific needs and commitments of every household. Affordability of home is linked with many wider consequences, such as fuel poverty and impacts on physical and mental wellbeing.

The vision for the Housing Strategy 2022-2027 is aligned with the aims of Domain 5 – Housing and the Environment within the Health and Wellbeing Strategy 2022-2026, outlined below:

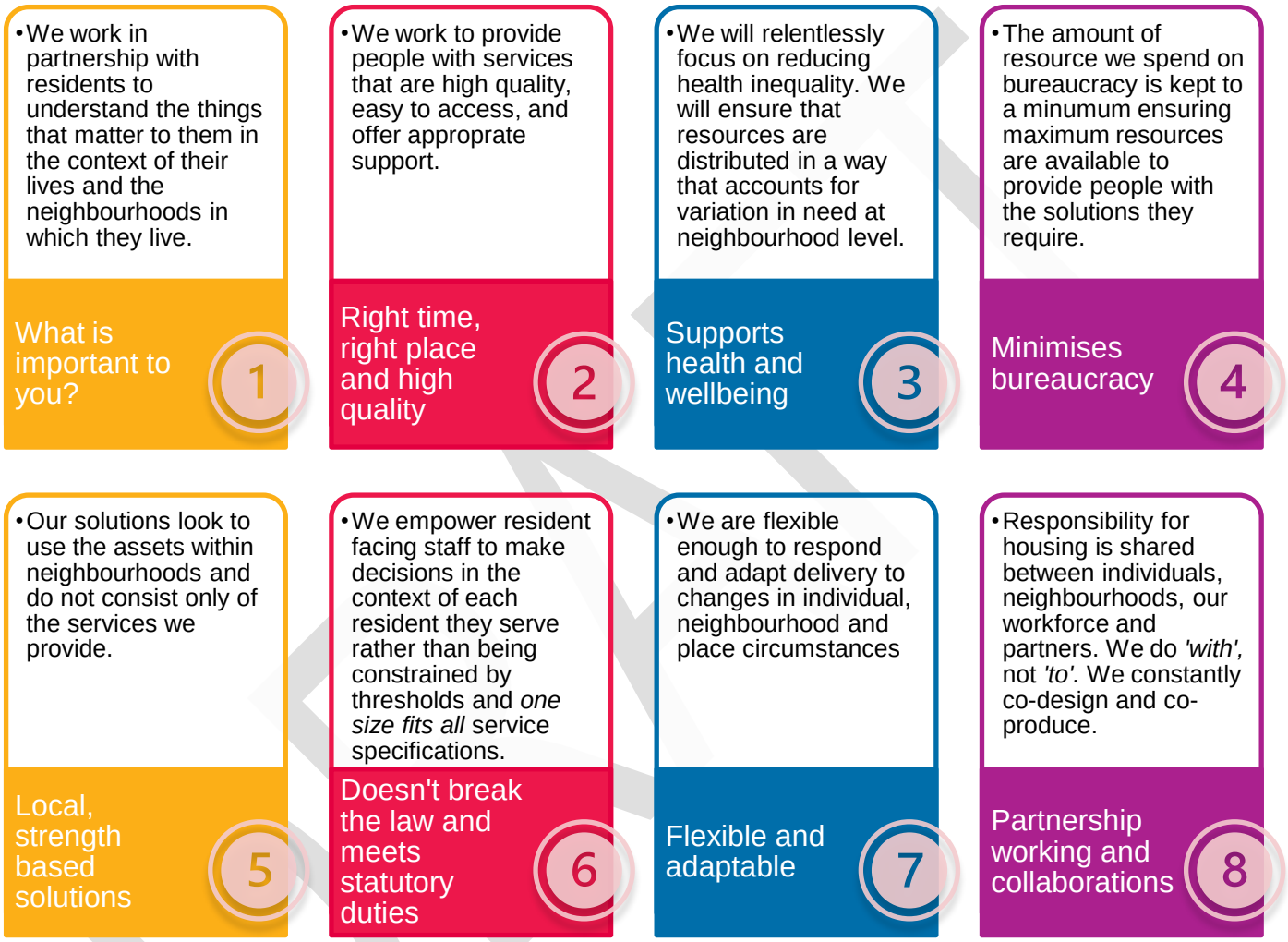
Fewer people will be at risk of homelessness, and everyone will have access to high quality affordable homes that meet the needs of Thurrock residents.

Homes and places in Thurrock will provide environments where everyone feels safe, healthy, connected, and proud.

Housing Core Principles

The Housing Asset Management Strategy 2022-2027 sets out the strategic principles to be applied for all future housing asset investment decisions.

It works in support of the Housing Strategy 2022-2027 that set the basis for a new way of working for housing support and services in Thurrock. These strategies and the new way of working follow the below eight principles:



Legislation and Regulation

The Housing sector continues to see significant changes to the regulatory framework that sets the standard for resident and building safety. The tragic event at the Grenfell Tower shook public trust and placed a spotlight on how the housing sector and construction industry operates; the investigations that followed revealed significant failings across the industries.

This led to the fundamental changes introduced through the social housing white paper, *A Charter for Social Housing Residents.*[1]These documents aim to place residents back at the heart of building safety and deliver changes to ensure that every social housing resident is safe in their home.

The publication of the draft Building Safety Bill[2] in July 2020 has set the parameters of what owning and managing residential buildings will look like in the future.

The underlying aim of the new legislation is to create a new era of accountability within the industry and to set clear roles and responsibilities for managing building safety in relation to fire and structural safety.

The government has produced a Fire Safety Bill, which became the Fire Safety Act 2021 and passed into law on 29 April 2021. The act supports the government's implementation of the specific recommendations arising from the Grenfell Enquiry Phase 1.

These documents supplement the Regulatory Reform (Fire Safety) Order 2005, and the council must maintain policies and procedures to ensure compliance with these. A key underlying principle in this area is competence. Therefore, the council must ensure that through the delivery of all works, its staff and external delivery partners have the necessary skill, knowledge and experience to undertake the work they are involved in.

The council has always aimed to ensure safe environments for its residents and will work to achieve full compliance with the Building Safety Bill

[1] The social housing white paper, *A Charter for Social Housing Residents*, can be found at: https://www.gov.uk/government/publications/the-charter-for-social-housing-residents-social-housing-white-paper/the-charter-for-social-housing-residents-social-housing-white-paper

[2] A copy of this document can be found here: https://www.gov.uk/government/publications/draft-building-safety-bill.

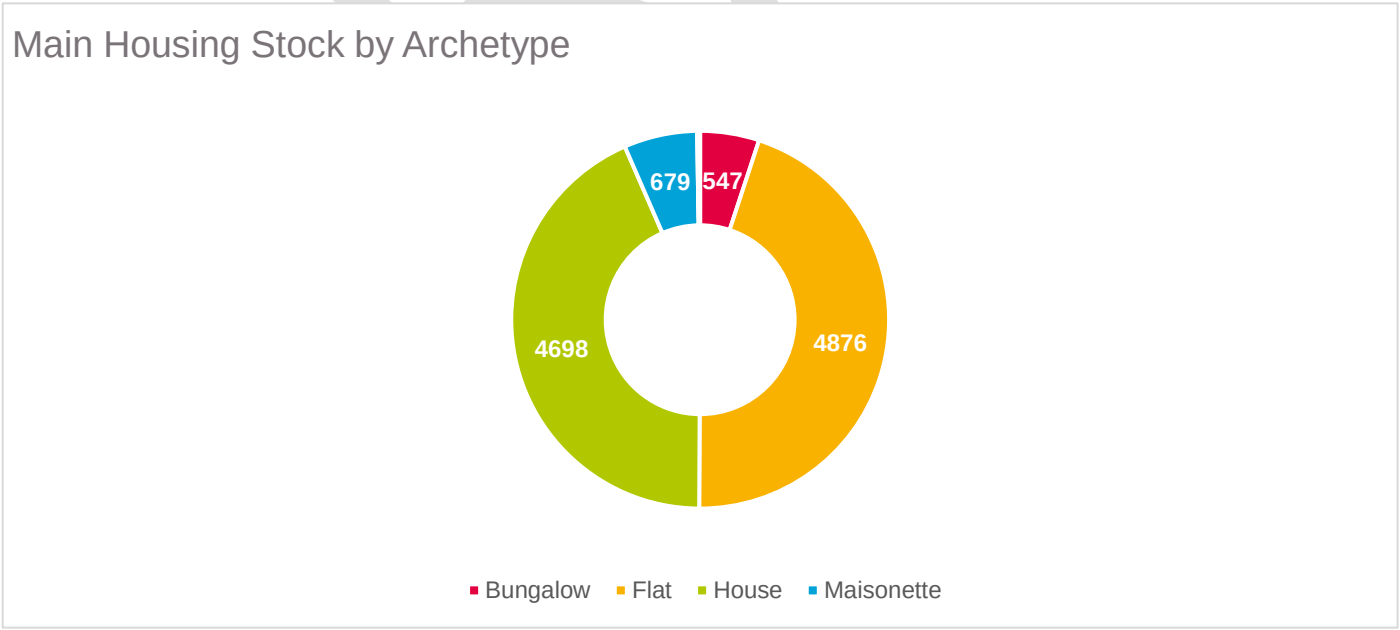
Local Context

Current stock

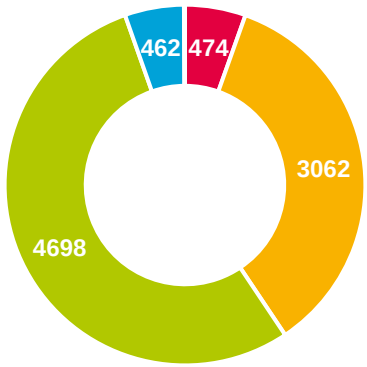
The council owns around 10,000 homes, which includes over 1,000 sheltered housing properties across the borough. Half of the council's general needs properties are three-bedroom homes, and the remaining majority comprise one and two-bedroom flats. The tables below show a more detailed breakdown of stock by archetype.

Housing stock by archetype

Property Type	0 bed	1 bed	2 bed	3 bed	4 bed	5 bed	6 bed	Total
Bungalow	56	446	22	22	1	0	0	547
Flat	439	2615	1567	255	0	0	0	4876
House	0	22	818	3608	237	10	3	4698
Maisonette	107	0	89	478	5	0	0	679
HMO Rooms	0	8	0	0	0	0	0	8
Total	602	3091	2496	4363	238	10	3	10808
Leasehold	344	226	175	147	0	0	0	892
Travellers site pitches	-	-	-	-	-	-	-	64

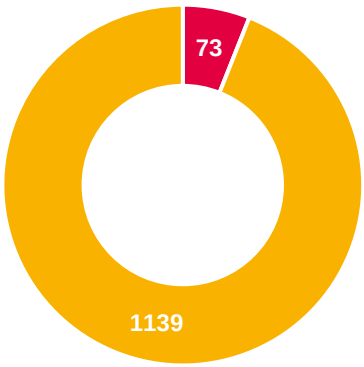


General Needs Housing



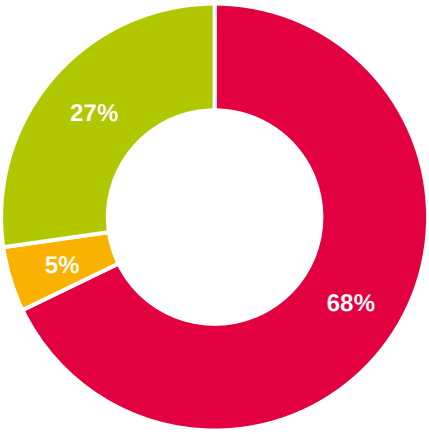
Bungalow Flat (inc 55+) House Maisonette

Sheltered Housing Stock



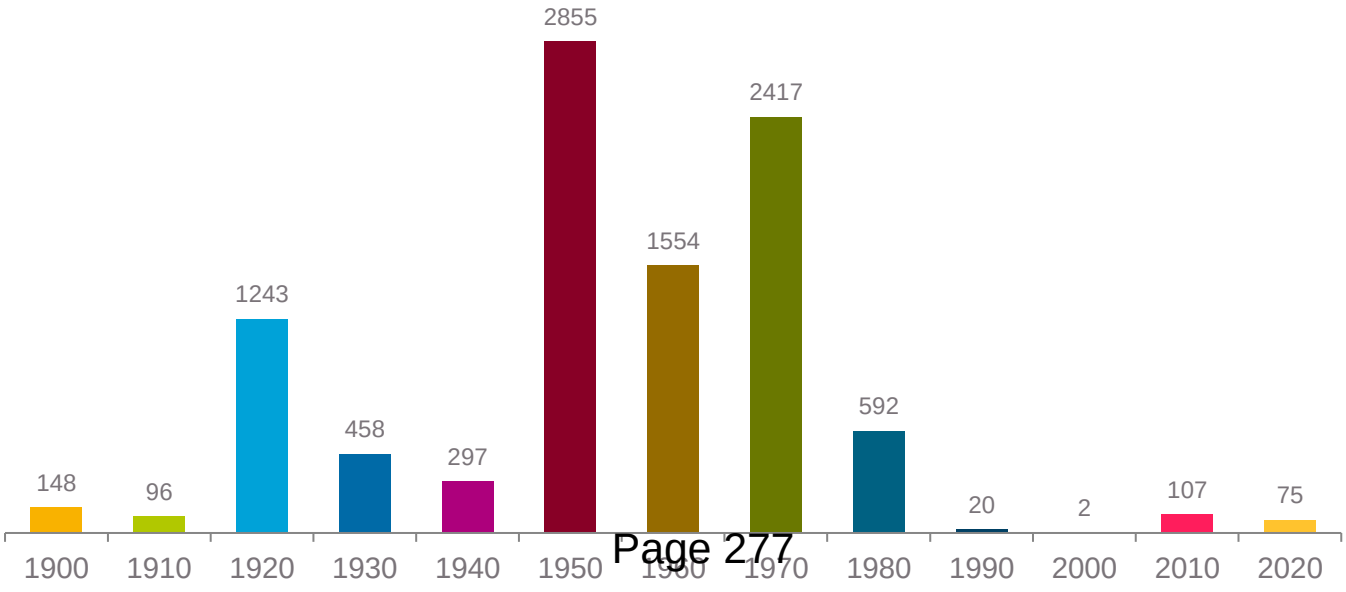
Bungalow Flat

General Needs Flatted Accommodation

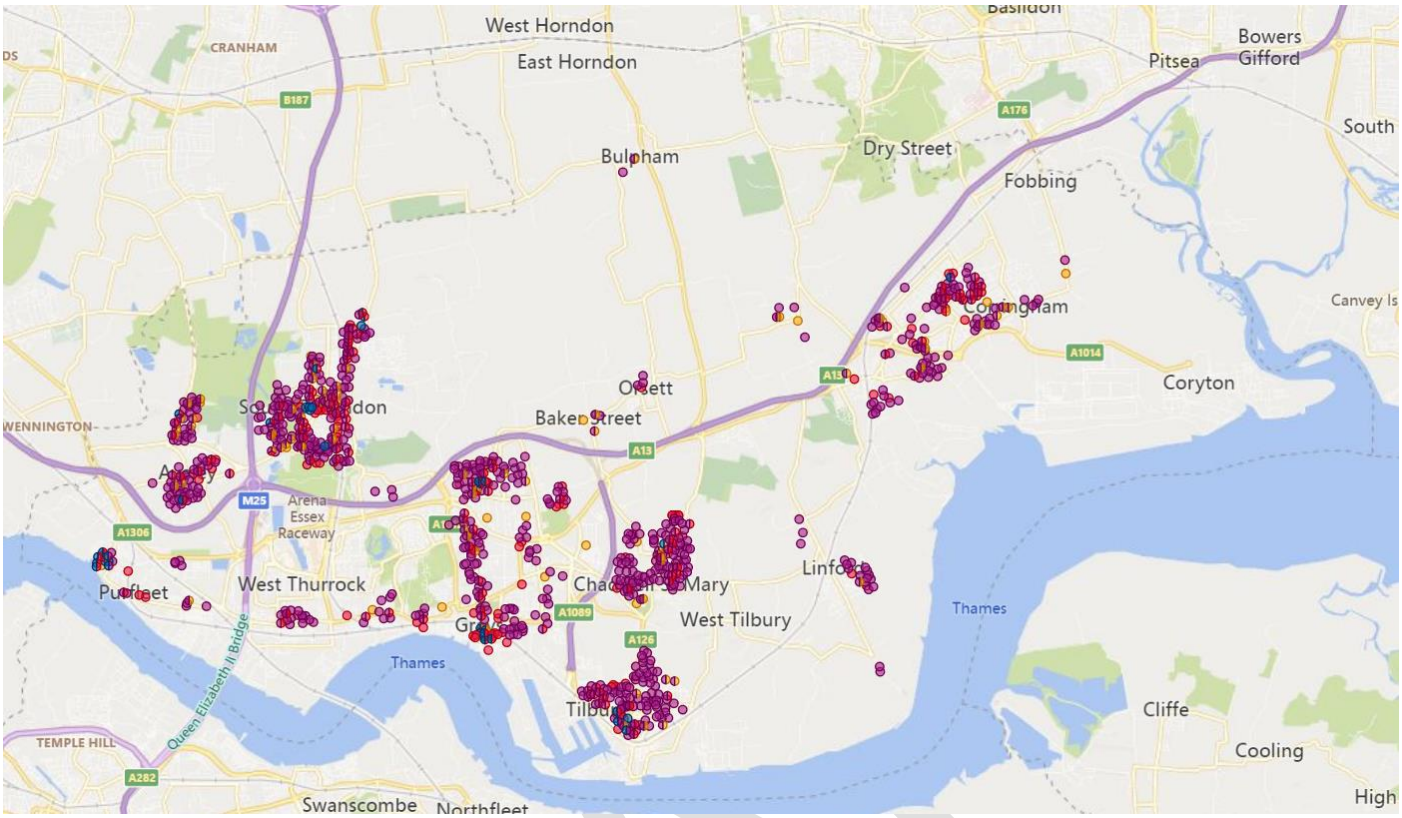


low rise: 1 - 3 storeys medium rise: 4 - 5 storeys high rise: 6 storeys and above

Property Age Bands



Location of housing stock in Thurrock



Stock Condition

One of the most critical aspects of active asset management is maintaining accurate records of the stock's condition, attributes and performance. To ensure the integrity of the stock data, the council aims to undertake condition surveys of a percentage of the stock every 3 to 5 years.

The council maintains this critical information on an asset management database that records all property attributes, anticipated lifespan and energy performance. This information will be recorded using new software in 2022 that will support ongoing compliance monitoring with a central record of all servicing and certification.

The majority of the current asset data has been informed by a condition survey undertaken in 2017, when the council undertook 3223 surveys.

These surveys covered internal and external elements of the buildings, communal areas, parking areas, garages, outbuildings and recreational areas on housing owned land and provided an overall energy assessment of the properties.

Overall, the condition survey demonstrated that the stock was in a generally fair to good condition, this being the case with 70% of the properties. Specific themes emerged, noting that the elements that required prioritisation primarily concerned property exteriors.

The 2017 survey identified an optimum level of financial investment in the stock over a 30-year period which exceeded the amount of capital expenditure factored into the HRA Business Plan, with significant investment required in non-residential assets such as garages.

Since 2017 capital works totalling over £46m have been made in the residential stock to address the priorities identified. The Transforming Homes programme, completed internal improvement

targets in 2019 and moved on to prioritising the external refurbishment, including the replacement of any remaining single glazing. Between 2019/20 to 2020/21, 732 properties have benefitted from external refurbishment and double-glazed window replacement, including street properties and 90 blocks of flats.

A further stock condition survey targeting 30% of the stock started the winter months of 2021/22. The aim being to update overall stock condition data rather than diagnose specific repairs and defects, which the council would be made aware of through day-to-day reporting processes. The survey has targeted the winter months to accurately picture any properties suffering from seasonal damp or mould problems. This survey will further inform the investment programmes over the next 5-30 years.

Non-traditional build properties

Within the Thurrock housing stock, the council have 418 non-traditionally constructed properties, all of which are tenanted family-sized homes.

The term non-traditional generally refers to prefabricated building systems, frames and construction methods known as Prefabricated Reinforced Concrete (PRC) properties. These properties are designated defective within the meaning of the Housing Defects Act 1984,[3] now part of the Housing Act 1985.[4] They have the potential for corrosion of embedded steel reinforcements and are generally considered by lending institutions not suitable for mortgage.

These properties require significant investment to bring them up to today's standards and continue to provide suitable homes for residents. In 2019/2020, the council reviewed all the housing owned PRC properties. Some properties and locations presented options for improved housing through redevelopment. However, this approach is not possible in the majority of sites. A prioritised investment programme is in place to refurbish properties where redevelopment is not an option.

In addition, the council owns properties on the Flowers estate in South Ockendon of a construction type known as 'Lecaplan'. These properties were constructed in the late 1960s and replaced the earlier PRC properties built initially. Although these properties are still of non-traditional construction, they are not designated defective and, as such, are considered mortgageable by most lenders. Many of the original council homes on this estate have been purchased by former tenants under the Right to Buy. The council, however, still owns over 180 of these properties.

Property Type	Total
PRC Design designated defective	234
Lecaplan	184
Total non-traditional council owned properties	418

[3] https://api.parliament.uk/historic-hansard/acts/housing-defects-act-1984
[4] https://api.parliament.uk/historic-hansard/acts/housing-act-1985

Housing Development

The strategic need for units by size, type and tenure (such as shared ownership) is driven by the Housing Strategy with regard to the levels of the existing supply of unit types and demand from those eligible under the council's housing allocations scheme.

The council have established a target to construct up to 500 new council homes between 2019 and 2029. Ninety-three have been completed, with a further 35 new homes under construction and an established pipeline of new sites.

These new homes will arise from a range of opportunities. They could be delivered directly by the council or in partnership with other developers across the housing sector. The produced asset must meet high design and construction standards consistent with the council's need to maintain stock condition, be affordable to build and live in, meet modern standards, and achieve residents' aspirations.

The following objectives guide the development programme:

- To develop good quality, well-designed and sustainable homes that contribute to placemaking
- Build homes that meet borough-wide needs and are affordable to live in
- Take a planned approach to development opportunities that provide value for money whilst maximising supply within targets.
- Use procurement practices that support local business, provide good value and encourage social value outcomes.
- Adopt a range of delivery routes that encompass direct delivery alongside working with the private sector.

Sheltered Housing

Thurrock Council has 1212 sheltered housing properties, which are a mix of low-rise flats and bungalows. These properties all have adapted bathrooms for improved accessibility. A recent programme has also improved the accessibility to the communal entrances of the blocks.

Some complexes and properties are more difficult to adapt to meet the modern standards of accessibility. Where this is the case, these properties will be subject to a full review and are considered for possible decommissioning from sheltered status. This review considers the viability of improvements to bring the stock up to the necessary standards and the availability of alternative suitable sheltered properties in the area. If a decision is taken to decommission, all existing residents are offered more suitable alternative accommodation.

Garages and Garage Sites

Thurrock Council holds a stock of 2275 garages and 290 garage plots located across the borough. The garages are brick or concrete purpose-built structures located in many settings varying from standalone blocks in large sites to small, isolated buildings on small sections of land to garages located under townhouses and blocks of flats.

The overall garage portfolio is in a "fair" condition. It would require a significant level of investment if the council is to maintain and improve all of these assets in the coming years.

The council has been reviewing long term regeneration and development opportunities across the garage stock and plans to undertake a refreshed stock condition survey of the garage portfolio. This survey will include a structural appraisal and allow the council to ensure that the garage portfolio is being maintained appropriately to ensure that these assets are safe and secure. Additionally, it will inform a longer-term investment and management strategy to identify the appropriate level of long-term investment and potentially identify garage sites that can be considered for other uses that would better serve the community and the wider borough.

The aim is to identify under-utilised or uneconomical garage and plot sites which have the potential to be converted into new housing developments.

Connectivity

A number of the council's housing assets have mobile / satellite infrastructure on the rooftops that are owned, maintained and operated by various national and international mobile network providers. A number of individual wayleave agreements cover this infrastructure, and the council must continue to manage these agreements and consider them when managing and maintaining the portfolio.

This strategy supports the council's digital connectivity agenda. The housing service will continue to work with external organisations to build the connectivity network around Thurrock for the betterment of all residents in Thurrock in relation to digital networks.

The housing department also supports the potential development and delivery of an IoT wireless network around the Thurrock borough. A network of this type would facilitate and support smart infrastructure in residents' homes and Council assets that can improve safety and living conditions.

Resident Engagement

The council's Housing Resident Engagement Strategy 2022 – 2027 sets out the council's plans over three years, focusing on the council's customers and committing to developing greater opportunities for resident involvement and feedback

This strategy enforces the council's commitment to a partnership with tenants, leaseholders and the local communities, especially within the Housing sector. It sets out how the council will work with tenants and leaseholders to comply with the regulatory framework and effectively prioritise council services. The strategy applies to current and future tenants and leaseholders and the people in the local communities to whom the council provides a service.

The asset management strategy supports this commitment and seeks to foster a sense of joint ownership through the continuous engagement of residents in the ongoing management of their homes. The methods of engagement are continually evolving and adapting to the needs of local communities. Current examples of engagement in asset management are:

- a panel of trained residents assist in the procurement of all asset management works and services contracts
- residents are engaged in the monitoring of major contracts
- a team of trained residents monitor the ‘fit to let’ standard of properties through void inspections
- all leaseholders are engaged ahead of any major investment works for their properties
- resident engagement sessions are held ahead of any major improvement projects
- colour and finish choices for major products such as kitchens, worktops, flooring or wall finishes are chosen by the Excellence Panel

Engaging residents in the requirements of their Tenancy Conditions is also an important priority to ensure resources address lifecycle replacement appropriately and are not diverted to tackle avoidable property damage or rectify unauthorised alterations.

During the consultation on this Asset Management Strategy, several themes emerged from residents, and these have been taken into consideration in forming this overall strategy. The key points raised were:

- Improved insulation and energy efficiency measures of council homes
- Consideration of electrical charging for vehicles
- Provision of homes that can accommodate modern living needs
- Homes that can be adapted for changing needs
- Improved outside communal areas

Engagement with Leaseholders

The housing portfolio includes over 900 leasehold properties. There are statutory requirements concerning the engagement of leaseholders and local aims to actively engage leaseholders in the ongoing management of the buildings in which they own properties. The council must charge leaseholders for the relevant portion of costs for capital works to their buildings, as set out in the terms of their lease.

Considering the impact of these costs, the council has put in place a number of payment options for leaseholders, with enhanced options for resident leaseholders.

In line with the Leasehold Reform Act 2002, the council will ensure the following:

- provide leaseholders with up-to-date information on investment plans before they purchase a property
- ensure Section 20 notices are issued on time and accompanied by frequently asked questions
- offer all leaseholders who are affected by major works costs the opportunity for individual appointments to discuss the planned works and individual payment options
- monitor the satisfaction of leaseholders with the works undertaken

Resident Satisfaction

Satisfaction surveys undertaken on behalf of the Housing service are conducted following HouseMark STAR methodology where possible, which is the leading satisfaction framework for the UK Housing sector.

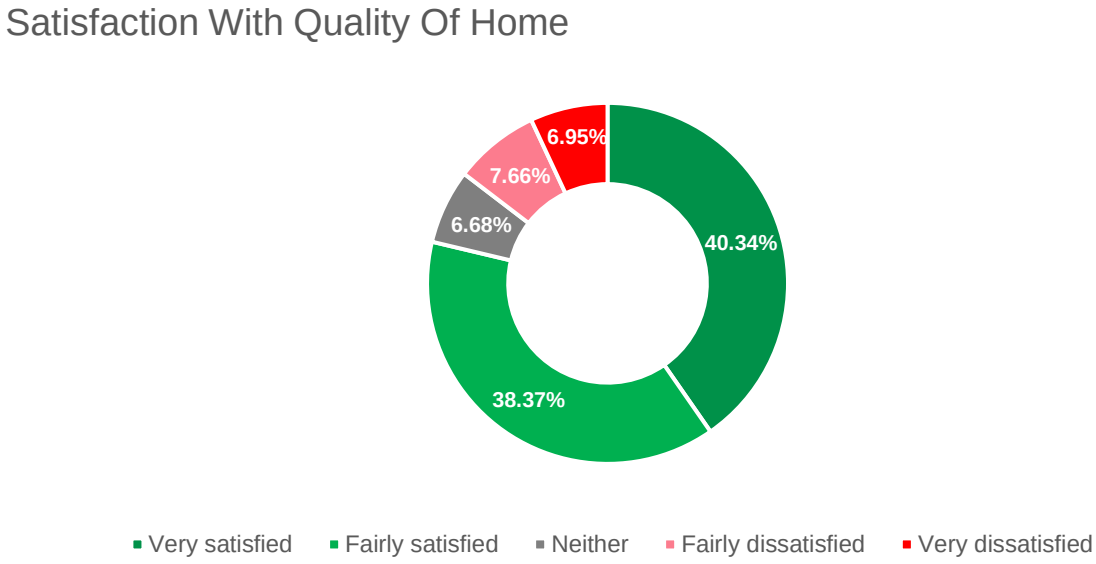
The data used to measure satisfaction is collected on the council's behalf over the telephone with residents by a third-party independent research contractor that specialises in conducting satisfaction surveys for the Housing sector.

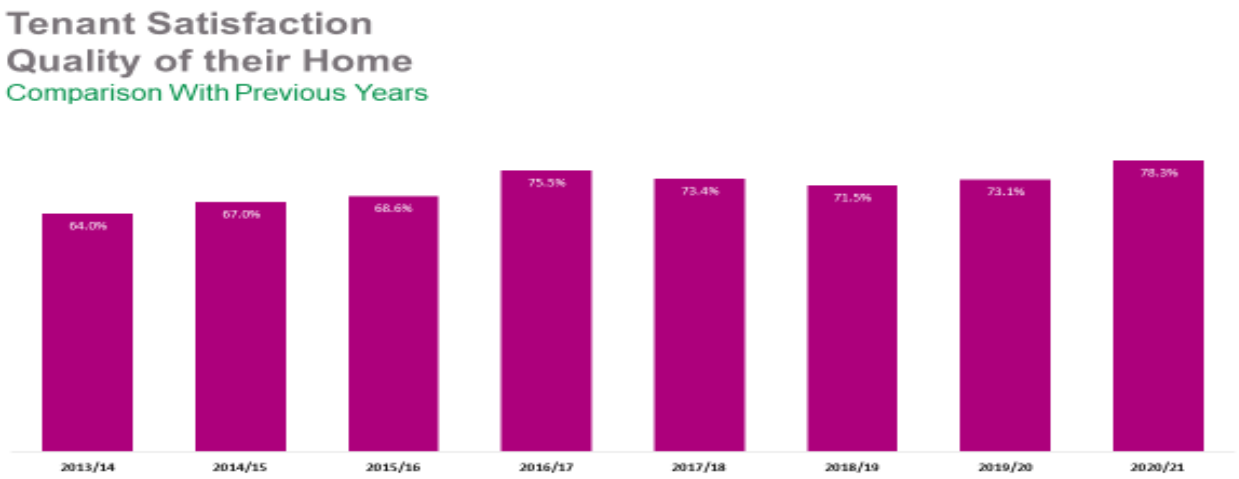
Both quantitative data in the form of ratings and qualitative data in free-text feedback are collected.

Satisfaction rates are calculated using the combined numbers of “very satisfied” or “excellent” and “fairly satisfied” or “good” ratings only.

Tenant Satisfaction with Quality of Home

The data produced in 2020/2021 shows that over 78% of current Housing tenants are satisfied with the quality of their homes. Compared to previous years in the second chart, this shows an improvement in overall satisfaction.





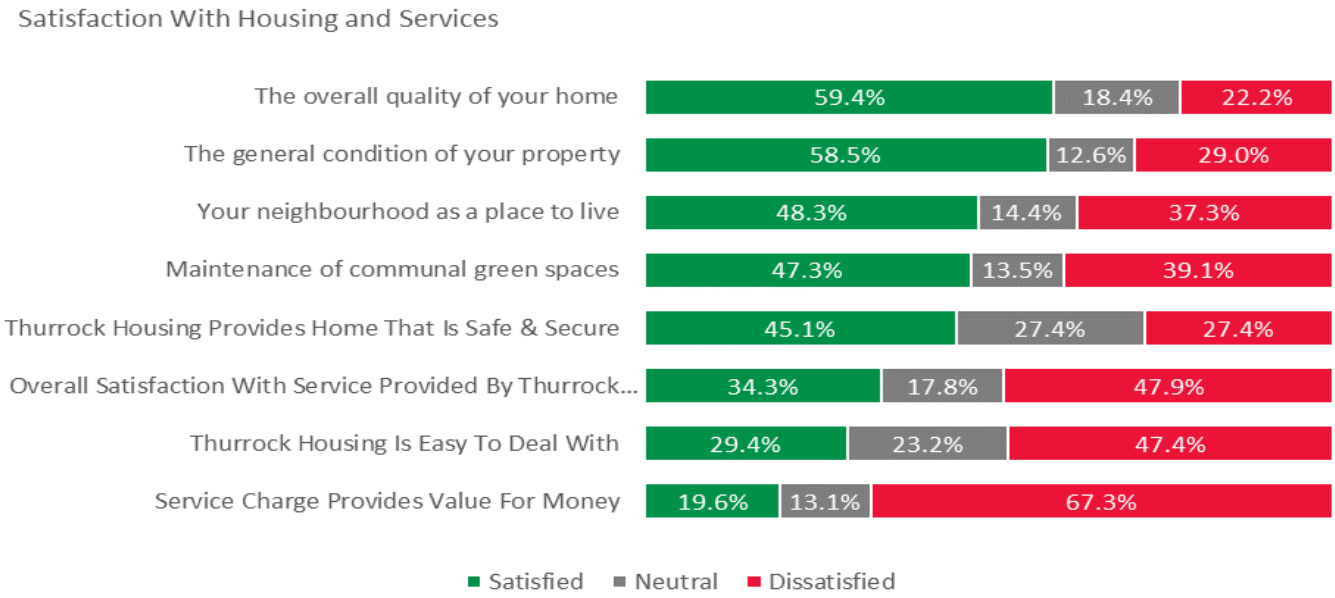
For the year 2020/21, satisfaction was above 75% on all measures relating to the management of the building services. Themes from this feedback have been fully considered in forming this strategy alongside the feedback received from consultation with the Tenant Excellence Panel and the wider Housing Strategy consultation exercise.

Leaseholder Satisfaction

Leaseholders are responsible for all repairs and maintenance within their properties, but the council are responsible for the management and maintenance of the external and communal aspects of the buildings.

Between July and October 2020, the housing service commissioned its satisfaction survey provider to facilitate a complete postal leaseholder satisfaction survey.

The survey indicated that leaseholders are less satisfied than tenants with the current service. All feedback from surveys, complaints and councillor enquiries is carefully analysed to identify learning and improvements in the delivery of these services with the aim of continuous improvement.



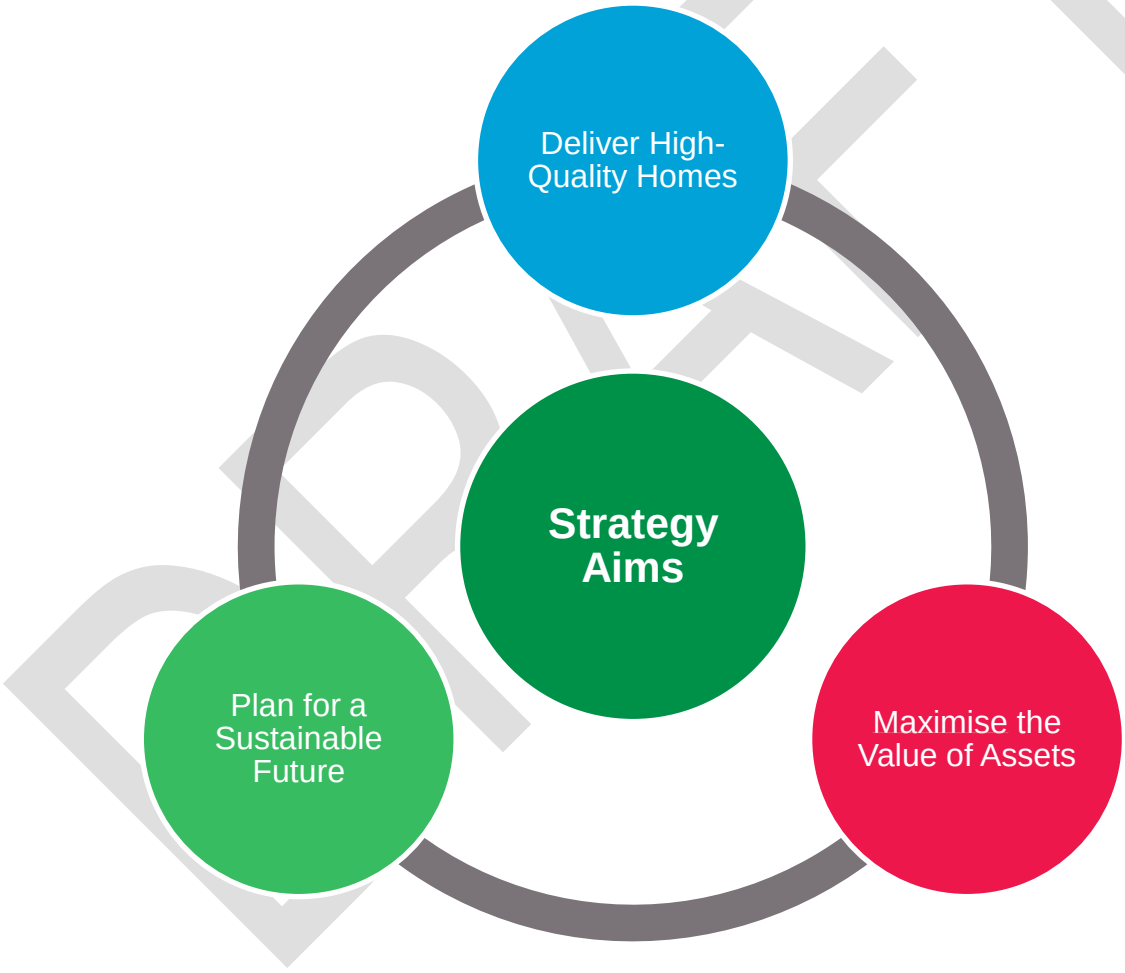
Housing Asset Management Strategy Aims and Objectives

This Strategy sets out the strategic principles to be applied for all future housing asset investment decisions.

It provides a framework to be applied when considering future options for investment in the housing assets, ensuring that they continue to offer quality and affordable homes for current and future residents.

The strategy demonstrates how the council's housing portfolio will meet its priorities and sets the strategic direction for those involved in the day-to-day management of the stock and future housing asset investment decisions.

It responds to both the national and corporate priorities, and the feedback from our residents as set out above. Three core aims will ensure the properties continue to offer good quality homes for current and future residents at an affordable cost.



Deliver High-Quality Homes

We want our homes and estates to be places where residents enjoy living and working, where they take pride in their homes and can enjoy being part of a thriving community. We aim to provide high-quality accommodation that demonstrates the benefits of our repairs and capital investment programmes and positively influences the health and wellbeing of our tenants and residents.

Procurement and Social Value

Ensuring value for money is fundamental to delivering an Asset Management service and the procurement of asset management third party contracts, ensuring that there is always a consistent quality service. We will always consider a range of options to identify the most appropriate procurement and partnership arrangements considering cost certainty, quality and added value to the community, such as local employment, apprenticeships, training opportunities, and community grants and sponsorship.

We will adopt an outcome-based approach focused on the whole life value, performance, and cost to promote a shared focus on outcomes rather than scope, enabling innovation and driving continuous improvement.

We will develop long term plans for key asset programmes to drive greater value and, where applicable, pursue longer-term contract arrangements that make it economically viable for contractors to invest in new technologies and deliver improved products and efficiency savings and managed risk.

Social value maximises the benefits of public procurement by encouraging positive outcomes for the local communities. Every tender brief will include a clearly defined specification of social value expectations and required outcomes for local community commitments. These commitments will become part of the key contractual performance measures monitored through contract governance. All contractual Key Performance Indicators will be proportionate to the size and complexity of the project or programme.

Use of Smart Technology

The council will explore the use of smart environmental sensors to remotely monitor the temperature and humidity conditions of properties. This would enable the proactive identification of the need for remedial repairs. This will be considered where it can demonstrate efficiencies and improved service to residents.

Day to Day Repairs and Maintenance

The council will ensure the provision of effective and responsive day to day repairs and maintenance services that keep our properties in good repair while achieving high levels of resident satisfaction. The council's day to day housing repairs service is delivered through third-party contracts that deliver a responsive repairs service to all housing tenants in line with government and locally set standards and timeframes as set out in the Housing Repairs Policy. [5]

Resident Safety

The council will maintain a compliance regime that guarantees residents that their homes are well managed and meet all the required safety standards. This is provided through periodic risk

[5] https://www.thurrock.gov.uk/sites/default/files/assets/documents/housing-repairs-policy-v01.pdf.

assessments and inspection and maintenance programmes. These work programmes are delivered through specialist third party contracts and apply to domestic and commercial gas supplies, passenger lifts, asbestos management, water hygiene, electrical supplies, fire safety systems, portable appliances and all other specialist plant and equipment.

We will ensure full compliance with the Building Safety Bill and the implementation of recommendations made from the Grenfell enquiry. This is in line with the Charter for Social Housing Residents, as set out in the Housing White Paper.

The council are committed to achieving 100% compliance with all applicable safety standards.

Fire Safety

The housing department maintains a fire safety policy that reflects the required approach to ensure that the council provide safe and secure housing. As noted previously within this document, the building and fire safety landscape has seen the biggest change in the last decade. The council must adapt appropriately to meet the requirements of the most recent and forthcoming regulations.

The Fire Safety Act 2021, the RRFSO 2005 and the Building Safety Bill place a specific legal duty on building owners. In 2021 the housing department created Building Safety Manager roles in readiness for these pending changes. This has allowed the council to compile building safety cases for "in scope" buildings with the housing portfolio. This new regulatory framework will also give power to the national regulators to judge the competence of an accountable officer such as the Building Safety Manager. The council is proactively taking forward the relevant training to ensure that appointed officers meet the proposed competency framework that will be part of the new legislation.

Governance in this area is strengthened further through regular business assurance reporting and the creation of the Tenant Scrutiny Board.

At the time of implementing this asset management strategy, the fire safety policy for the council's housing department 2021 is being reviewed and updated to ensure that it reflects all the required and emerging legislative documents and information.

Capital Investment

To ensure the integrity of the asset is maintained and that the council fulfils its duty to provide residents with affordable warmth in homes with future-proofed facilities, there is an ongoing need for capital investment.

The Housing Capital Programme, known as the Transforming Homes Programme, invests in the long-term integrity of the council's assets and brings significant improvements to the health and wellbeing of residents through improvements to their living conditions and reducing fuel poverty through improved energy efficiency.

Through this programme, the council will ensure a 'whole asset' approach is taken to ensure investment programmes offer value for money and deliver the best outcomes. To improve the sustainability and efficiency of the stock, it will integrate retrofit principles into asset investment planning to ensure a fabric first approach is taken.

Adapting Homes for Specific Needs

The council aims to meet the changing needs of current and potential residents by adapting existing properties and providing new accessible properties recognising that our older residents will increasingly want to:

- stay in control
- prepare in good time to step up to the next stage in their lives
- have a choice of homes that support their health and well-being

Within our existing properties, the council carry out adaptations to meet the needs of people with physical disabilities to enhance their lifestyle and, where appropriate, enable them to remain in their current home.

It is sometimes the case that the original beneficiary no longer requires adaptations. This equipment may be of use to another of the council's tenants. Adaptations are often expensive, so a register of adapted properties is maintained, enabling re-letting to a household with similar needs.

Product Specification and Standards

The focus for specifying products for use in the housing assets is quality over cost. The aim is to use products of sufficient quality to withstand day to day wear and tear with a minimum of ongoing maintenance. This reduces disruption to residents in their homes and contributes to the council's broader sustainability objectives providing value for money in the longer term.

Prevention of Damp and Mould

Damp and mould in social housing is an issue across the UK. It is widely recognised as one of the most challenging aspects for landlords and residents to prevent and manage. For this reason, the Housing Ombudsman undertook a thematic review and recently published a report on this subject.

The council is committed to the management and investment required to tackle and minimise cases of damp and mould within our residents' homes. It will work in line with the recommendations set out in the Housing Ombudsman report *Spotlight on damp and mould – It's not lifestyle'.* It is recognised that it is not possible to fully eradicate the presence of damp and mould due to the multitude of factors that cause this. The Council will ensure a fully coordinated approach to the ongoing prevention and management of this problem.

New Development

All new development plans will follow a specific process to ensure they achieve the Housing Strategy Objectives:

This will include ensuring the Employers Requirements suite of documents sets the quality and operational standards, reflects current legislative and good practice requirements, and ensures ease of maintenance and repair in use.

- We will develop plans in close consultation with the council's planning and urban design services to ensure residential development proposals are appropriate in scale, use and density for the locality. We will ensure that they meet high standards of design quality, contribute to safer communities and placemaking, support priorities for sustainable transport and are reviewed early to identify impacts of local infrastructure.

- Ensuring new homes meet required environmental and sustainability criteria, consider the cost of using durable and sustainable construction methods and components.
- Ensure new residential homes meet the needs of people with a range of physical disabilities through close collaboration with occupational therapy services
- Review the opportunity at a scheme-by-scheme level to take advantage of modern methods of construction, including modular construction methods
- Ensuring tenders for construction work evaluate and take account of contractor's proposals for social value outcomes.
- Plans will follow a comprehensive member, resident and stakeholder engagement strategy to ensure residents are fully informed of development proposals and members have early sight of proposals that affect their constituents.
- Satisfaction surveys with new tenants will be undertaken 6 and 12 months after completion to identify areas of high satisfaction with new homes completed or areas for review and improvement.

What?	How?	Impact?
All investment programmes offer value for money to deliver positive and tangible outcomes	We will take a 'whole asset' approach considering the current and future use of assets	Residents will be assured that investment programmes offer value for money and deliver improvements to their living conditions
Provide consistent, reliable and fit-for-purpose repairs and planned maintenance services that meet legislative requirements	We will ensure that repairs and planned maintenance are completed in line with the council's repairs policy, and service components regularly to extend their lifespan and reduce the need for reactive repairs	Residents will have access to a repairs service that responds promptly and appropriately, supporting a good quality of life in and around their home. We will achieve at least 85% resident satisfaction in the repairs and planned maintenance services
Be proactive in maintaining council-owned homes in order to achieve a good standard and mitigate the need for reactive repairs	Identify properties requiring significant investment over the next five to ten years using detailed stock analysis and findings from the 2021/22 stock condition survey We will use this information to inform plans for planned and cyclical maintenance programmes to ensure properties are safe and comply with legislative requirements	Residents will live in well-maintained homes, benefitting from investment at the right time and reducing the disruption of responsive repairs due to the failure of components. We will achieve at least 85% resident satisfaction for capital investment programmes

What?	How?	Impact?
Develop a holistic approach to damp and mould in council-owned properties in order to significantly reduce occurrences	Work in line with the recommendations set out in the Housing Ombudsman *Spotlight on damp and mould* report We will analyse the data from a stock condition survey undertaken in the winter months of 2021/22 to accurately picture any properties suffering from seasonal damp or mould problems Ensure a fully coordinated approach with partners to the ongoing prevention and management of damp and mould. Use sensors to remotely monitor the environment in home to proactively identify where preventative interventions are required	Residents will experience fewer instances of damp and mould in their properties Where instances of damp and mould do occur, residents will receive support free of the stigma and judgement traditionally associated with the term 'lifestyle' in the context of this issue
Engage and listen to the views of residents and understand their priorities in order to design, develop and deliver stock improvement programmes that target the things that matter	Proactively engage with residents on their experiences of living in council-owned properties and their priorities for making homes fit for the future	Programmes designed to deliver on residents priorities. Improved resident satisfaction in the quality of their homes
We will refresh the council's housing development programme in order to identify new opportunities to provide more social homes for rent	Deliver new homes as part of the council's housing development programme, championing high design and construction standards on new affordable housing projects Continue to identify and progress new sites for the programme pipeline with consideration of the range of delivery methods Undertake regular assessments of existing and emerging housing delivery options, relating both to construction and provision to ensure that the viability of any such opportunities can be understood and progressed as appropriate	Residents will have greater access to good quality social housing across the borough as a result of increased supply
We will develop and build new properties in line with clear and consistent requirements in order to ensure high-quality homes are made available for local residents	We will learn from all completed developments and changing regulatory and sustainability standards to inform and drive updated employers' requirements Apply and monitor employers' requirements for new build properties to ensure high operational and quality standards of new homes	Residents benefit from the provision of new homes that are both fit for purpose and fit for the future. All new homes provided by the council meet mandated high standards

Maximise the Value of Assets

Council investments in existing housing stock needs to be continually reviewed to ensure maintenance programmes achieve the best outcomes for residents and maximise the asset's overall value. The aim is to ensure future reinvestment in properties that are well located, meet housing needs and are efficient to manage.

Much of the current housing stock is considered long-term sustainable; however, the council recognises that some property archetypes present challenges in ongoing maintenance and the living environment due to their age or build type.

The age of our stock is another factor. The council will consider carefully whether we can regenerate some of the housing assets or whether replacing them will deliver better long-term quality of homes for our residents.

There is, therefore, a need to undertake stock appraisals of these archetypes to inform recommendations for either further investment or redevelopment of those assets in the future. Complete stock options appraisals consider the need and demand, social, economic and neighbourhood sustainability factors and are designed to determine the potential options and, ultimately, a preferred course for intervention. Any significant decisions arising from appraisals of this nature are subject to Cabinet approval.

Appraisals may identify properties for which an alternative use might be more appropriate. These alternative uses may include using the land or housing assets to build additional homes to increase the number of council-owned/managed properties available of the type and quality needed and in areas where people want to live. Recommended interventions arising from the full appraisal of the performance of the asset can include:

- Re-designation or re-use of properties
- Remodelling of properties
- Infill development or whole site redevelopment
- Development on previously undeveloped or cleared land

What?	How?	Impact?
Implement a new asset management system to maintain accurate stock condition data, inform decisions from strategic planning through to operational delivery, and effectively direct housing investment for maintenance and improvement	We will implement an integrated asset management system and load the 2021/22 stock condition survey results. This will form the foundation for investment modelling and the design of planned maintenance programmes and monitor compliance We will use technology to support the design, construction, operation, and maintenance of council asset. We will explore remote sensor solutions to enable real-time monitoring of stock condition	Residents will benefit from fiscally responsible improvements to living conditions Residents will experience improvements in the ability of the council to respond to and resolve maintenance and repair concerns. Remotely monitored sensors will enable remedial action to be arranged swiftly and proactively

What?	How?	Impact?
Take a targeted approach to asset investment and regeneration in order to protect and maximise the value of housing assets	Undertake full stock appraisals of properties where archetypes continue to present challenges due to age or build type Ensure these appraisals consider need and demand and social, economic and neighbourhood sustainability factors Use this information to recommend future programmes of investment or estate redevelopment Take forward recommendations for asset interventions through the process set in the council's constitution	Residents will be assured that new developments offer value for money, are financially viable and deliver homes fit for the future
Embed resident engagement in investment programmes and estate regeneration in order to deliver projects that meet local needs	Work closely with our residents to understand their priorities, identify required estate improvements, and progress opportunities for new housing to transform and enhance neighbourhoods	Residents will have direct input, influence and opportunity to shape future council-owned developments and ensure that they meet their needs and priorities
Maximise the social value and investment in the local economy that can be derived from investment in both existing and new build housing assets	Ensure firm emphasis on this requirement throughout the tendering, contract management and programme development phases	Residents benefit from improved community assets, training and employment opportunities, and greater value for money from the delivery of substantial investment programmes

Plan for a Sustainable Future

Carbon Neutral Commitment

In October 2019, the council passed a motion to declare a climate emergency and to take urgent action to reduce its carbon emissions to net-zero by 2030. The council has committed to reducing its carbon footprint to zero. The council's initial plans to respond to the climate crisis is by making sure the council's operations are carbon neutral by 2030.

Over 34% of all emissions in the UK are attributed to the provision of heat. Shifting away from the use of fossil fuels and installing new renewable technologies for heating and hot water needs is a key part of the government's strategy for achieving net-zero carbon by 2050. Ground-source or air source heat pumps provide a solution to fully decarbonise heating in social housing assets coupled with clean energy. The installation of the low carbon heating systems is expected to provide a 70%+ reduction in carbon emissions.

The council is committed to continually investing in improving the overall thermal efficiency of homes whilst effectively supporting the borough's most vulnerable residents out of fuel poverty. This strategy supports the decarbonisation agenda while improving the overall energy efficiency of the assets, ensuring the homes provide affordable thermal comfort.

To achieve this, the council will review the performance of the existing housing assets and identify a range of appropriate interventions for the various property archetypes within the borough. The council will ensure all investment schemes follow the PAS 2035 approach. We will integrate retrofit works into all asset investment plans taking a fabric first approach to ensure they achieve the best outcomes value.

Significant investment will be required to meet the carbon reduction targets. A report Decarbonising the Housing Sector published by Savills in October 2021 estimated average costs of £24,250 per flat and £37,060 per 3-bed house would be required to meet the requirements. Therefore, it is clear that this will far exceed the funds available in the HRA business plan. Therefore the council will seek to maximise available funding streams to support the significant investment required. In order to do this, the council will therefore develop an opportunity overview of funding streams and ensure schemes are 'bid ready.'

The council will also work with suppliers to reduce their carbon footprint, considering carbon emissions when procuring contracts.

Electric Vehicles - Charging Points

Electric Vehicle (EV) ownership is growing quickly, and the council is working to ensure that it is as convenient as possible to transition to an EV.

Thurrock Council intends to focus on specific local areas of high pollution by providing an accessible network of electric vehicle charging points that will play a vital role in facilitating the uptake of electric vehicles and is a necessity to meet these Air Quality targets.

Tenants of street properties who require electric charging points are able to request permission for an alteration to their property to ensure any installation meets the council's required standards.

The council's housing service will work to complement the corporate plans for EV charging across the borough. It will consider the needs of specific sheltered sites or housing estates alongside this. Where there is a perceived need, residents will be consulted in order to assess the expected

requirements. The council will seek funding opportunities to support the cost of a programme of this nature.

Green Spaces

The importance of access to green spaces for exercise and mental wellbeing is vital for those without private gardens.

It is crucial for all communities, including those in social housing, and for all age groups to access a range of open and green spaces for leisure, recreation and play. These spaces should be well defined, easily accessible and safe with high-quality landscaping, including trees where appropriate, to support the physical health and wellbeing of all.

As part of this strategy, the housing development team will ensure that new developments improve access to green spaces for leisure, recreation, and play.

What?	How?	Impact?
Increase the use of sustainable and renewable technology in new and existing stock in order to improve thermal efficiency, reduce carbon emissions and support the council's green agenda	We will support the shift away from the use of fossil fuels by installing new, renewable technologies for heating and hot water needs in new developments We will reduce carbon emissions in the new build developments by installing renewable energy sources, using well-insulated materials in the new homes, fitting LED lights and installing efficient communal heating and hot water systems We will select components and design and build new homes that meet sustainability standards and support the council's carbon reduction aims We will replace the electric storage radiators to 273 properties in three high rise blocks to provide a more efficient heating system linked to a ground source heat pump We will work with the council's suppliers and partners to reduce their carbon footprint, considering carbon emissions and contributions towards achieving net-zero when undertaking procurement activity	Residents will live in new and existing homes that have higher levels of thermal and energy efficiency, leading to reduced household costs relating to energy bills and more effective heating and lighting systems that are fit for the future
We will maximise the use of available funding in order to deliver thermal efficiency and carbon reduction improvements beyond the funding capacity of the Housing Revenue Account	We will develop an opportunity overview of funding streams and ensure schemes are developed that are 'bid ready'	Residents benefit from investment in their homes and neighbourhoods that may otherwise have been undeliverable, with a significantly reduced impact on existing programmed investments through the Housing Revenue Account

What?	How?	Impact?
We will support residents out of fuel poverty in order to improve health and wellbeing, and quality of life	We will achieve EPC band C ratings across all housing stock by 2030 through direct investment in council homes from the housing revenue account and maximising the use of available funding streams Officers and partners undertake fuel poverty awareness training and are provided with the tools and knowledge to best support residents We will develop a sustainability profile of housing assets in order to identify and prioritise assets for improvement	Residents will benefit from proactive intervention, significant investment and access support to improve the thermal and energy efficiency of their homes, removing the harm to health and wellbeing of cold homes and fuel poverty

Risk Management

Evaluation of risk is an essential part of effective asset management. Major decisions taken about the future use of the asset base in the absence of risk assessment may have a long-term detrimental effect on the sustainability of communities and the financial viability of the business plan.

Developing and maintaining a Housing Asset Management Strategy and carrying out the associated action plans on time demonstrates that the council effectively manages its risk of non-compliance across its property assets. When property decisions are made decisively, eliminating a siloed approach, and taken from a strategic perspective, they create the best outcomes for the council financially, for its staff and most importantly, its residents.

The main strategic risks and constraints are identified below:

- **Achieving Net Zero –** The strategy establishes the long-term vision and responds to the council's ambitious net-zero targets. It is recognised that this requires significant investment and available expertise. The ability to deliver requires the council to successfully secure external grant funding.
- **Capacity and expertise –** The council will need a specific organisational focus to implement some of the identified themes. Additional technical expertise is required in the Asset management team to support bidding for grant funding and achievement of sustainability. Additional resources will also need to be procured in the capital programme to ensure that the quality of delivery is managed effectively.
- **Financial certainty –** The ability to develop accurate cost projections is fundamental to the effectiveness of the HRA business plan.
- **Organisational resilience –** It is essential that organisational resilience is developed with a suitable skill base to allow for the long-term implementation of the strategy and that training and development programmes are implemented to support staff retention and succession planning.

This strategy recognises that housing assets can also become liabilities, threatening the viability of the HRA and significantly impacting residents' lives, carrying the following risks:

- Failure to manage Health and Safety compliance could put residents, staff and contractors at risk.
- Failure to meet statutory standards can carry significant criminal and financial penalties and damage the organisation's reputation.
- Poor quality stock investment will be a key driver of satisfaction levels.
- Poor value for money in asset management will significantly impact council finances as this represents a considerable proportion of business plan spend.
- Internal and external factors impact expenditure, making it the element of landlord operations most vulnerable to increased costs.

Regular processes to identify and assess risks are in place, and actions are agreed to manage risks to minimise impact

Monitoring, Measuring and Review

We will implement a robust monitoring and review process to measure progress against the strategic priorities presented in this document.

Firstly, an action plan will be developed, aligned with the priorities and themes of this strategy, developed alongside residents and other key stakeholders with reviews undertaken at regular intervals.

It is intended that progress towards the delivery of this action plan will be monitored on an annual basis by an established group of residents and the Housing Strategies Delivery Board.

Throughout the lifespan of this strategy, there is an expectation that new actions will be added to the action plan, reacting to changes in external factors (such as legislation) or proactively if an opportunity to do so arises. These additions will be managed appropriately and will ensure that they continue to reflect the key themes of this strategy.

Appendix A – HRA Business Plan

Investment in Existing Stock	2022/23 Base Budget	2023/24 Base Budget	2024/25 Base Budget	2025/26 Base Budget	2026/27 Base Budget
	£'000	£'000	£'000	£'000	£'000
Transforming Homes	10,300	10,300	10,300	10,300	10,300
Disabled Adaptations	100				
Major Adaptations	200	200	200	200	200
Fire Safety Works	1,000	1,000	1,000	1,000	1,000
Tower Block Refurbishment	8,137	0	0	0	0
Carbon Reduction Requirements (Tower blocks)	4,700	0	2,250	2,750	5,500
Non-Traditional Refurbishment	3,500	0	0	0	0
HRA Garages	500	500	500	500	500
Heating Replacement Programme	600	600	600	600	600
Lifts Refurbishment	190	190	190	190	190
Door Entry Installation	500	500	500	500	500
Water Mains	160	160	160	160	160
Staffing Costs Capital Programme	160	160	160	160	160
Highways and Lighting	400	400	300	300	300
Carbon Reduction Requirements External	300	2,000	2,000	2,000	1,954
Electrical infrastructure testing - Check Revenue implications	500	250	250		
Total Capital Programme	**31,247**	**16,260**	**18,410**	**18,660**	**21,364**
Financed By:					
RCCO	**(10,719)**	**(11,046)**	**(11,307)**	**(11,574)**	**(11,847)**
Carbon funding bid	**(3,210)**				
Borrowing Requirement	**17,318**	**5,214**	**7,103**	**7,086**	**9,517**
Borrowing Cost @ 2.2% interest	**381**	**115**	**156**	**156**	**209**
Cumulative Interest Cost	**840**	**955**	**1,111**	**1,267**	**1,476**

Housing Resident Engagement Strategy

2022-2027

Thurrock Council

Contents

Introduction

The Housing Resident Engagement Strategy 2022-27 sets out the aims and ambitions of the Housing service in improving its interaction and communication with those who live in and around Thurrock Council's homes and neighbourhoods.

The Housing department interacts with over 10,000 households throughout the borough across a broad range of services and recognises that each these households is unique. As a result of this diversity, those who access Housing services must have the opportunity for their voice and views to be listened to, not just heard.

The significance of meaningful engagement with residents may never have been higher than it is currently. The impact of and response to the tragedy at Grenfell Tower shows how important it is for residents and communities to be able to access information, express their views and opinions on changes, and play an active part in the way that duties are fulfilled and services are delivered by the Housing department.

This strategy aims to set the framework for future action, which is meaningful and valuable to residents and communities, reinforcing the understanding that residents and communities must be at the centre of all that the Housing service does.

The document seeks to establish an approach that will see resilient and respectful partnerships formed and maintained between the Housing department and those who access its services. The strategy sets aims to strengthen resident participation in the scrutiny and governance of the Housing service, which will offer greater transparency into how the Housing service operates.

Through this strategy, the Housing department lays the foundations to improve the experience residents and communities have when interacting with its services and further improve those services through continuous learning. This approach will ensure that the Housing department remains responsive, adaptable and flexible to residents' and communities broad and changing needs.

In developing this strategy, the Housing service has worked alongside its Excellence Panel, representing the residents who live in and around the Council's homes neighbourhoods.

Corporate Context

Thurrock Council's vision and corporate priorities, adopted in January 2018, underpin this Housing Resident Engagement Strategy. The Council's vision is for Thurrock to be **an ambitious and collaborative community which is proud of its heritage and excited by its diverse opportunities and future.**

Sitting alongside the vision are the three corporate priorities of People, Place and Prosperity.

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 together to improve health and wellbeing
- communities are empowered to make choices and be safer and stronger together

At the centre of this strategy is the intention to continually improve Housing services to meet the needs of those who access them. The strategy sets out that partnerships with residents and communities are integral to the success of both this document and the wider Housing service.

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

This means:

- 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

The Housing service is responsible for estates and neighbourhoods across the borough, and by working in partnership with residents and communities, their priorities can be better understood. This improved understanding will allow the Housing service to proactively address concerns and facilitate areas where residents can take pride.

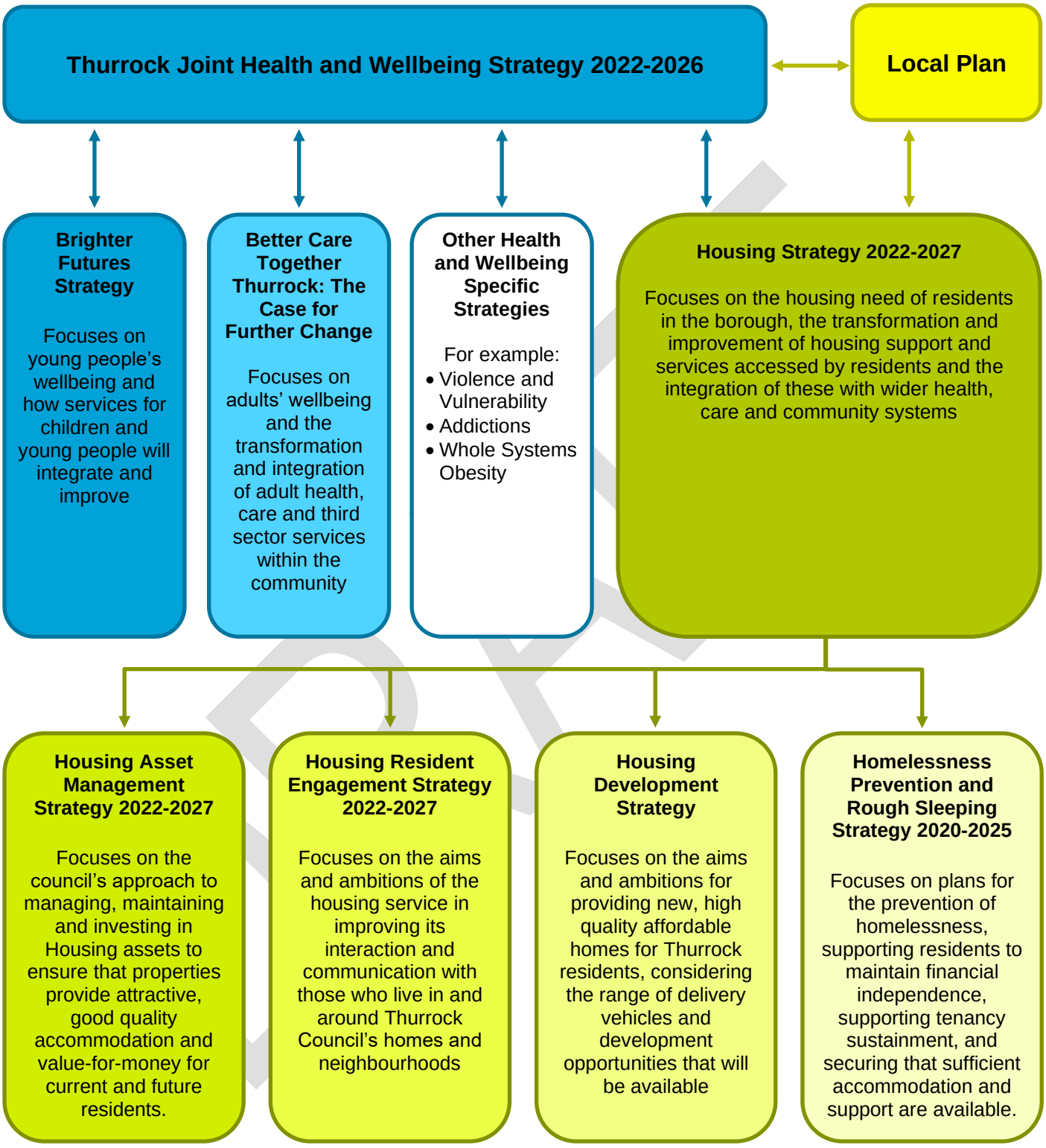
Prosperity – a borough which enables everyone to achieve their aspirations.

This means:

- 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

Through the key themes and strategic actions identified within this Housing Resident Engagement Strategy, the Housing service aims to build upon already successful and established partnerships to increase and further enhance the benefits and opportunities available to those who live in and around the Council's homes and neighbourhoods.

Strategic Context



Housing Vision and Principles

Housing Vision

Every Thurrock resident will have access to a safe, secure, suitable, and affordable home that meets their needs and aspirations, serving as a foundation to support their health and wellbeing.

Residents will be supported at home and in their local area through connected services, neighbourhoods, localities, and communities to achieve their vision of a 'good life'.

Housing and health are intrinsically linked. Access to a safe, secure, stable, warm, and affordable home will provide people with a solid foundation upon which they can better protect their health and support their wellbeing. If a home is lacking any of these factors, it will have a detrimental impact on the physical health, mental health, and general wellbeing of all those in the household.

A safe home can mean many things, such as being hazard free, or maintained in line with compliancy measures such as gas servicing and electrical testing. A safe home goes beyond physical maintenance and bricks and mortar; it can also relate to a resident's perception of safety in their home and in the neighbourhood or estate in which it is located.

A secure home can refer to the security of tenure, giving residents peace of mind and stability by having that solid foundation to build their vision of a good life, or it can again be considered in like with the perception of safety within the home from any outside harms.

The factors that determine a suitable home are wide ranging and tailored to the housing needs of each household. It can relate to the size, type, location, and accessibility of a property, but can also refer to the standard in which the property is kept, ensuring good quality accommodation is provided and that it remains well maintained.

The definition for an affordable home is also aligned with the specific needs and commitments of every household. Affordability of home is linked with many wider consequences, such as fuel poverty and impacts on physical and mental wellbeing

Health and wellbeing run through every aspect of this strategy. This document's strategic aims and objects are rooted in the fundamental aim of tackling health inequalities through housing to support Thurrock residents to live healthy lives.

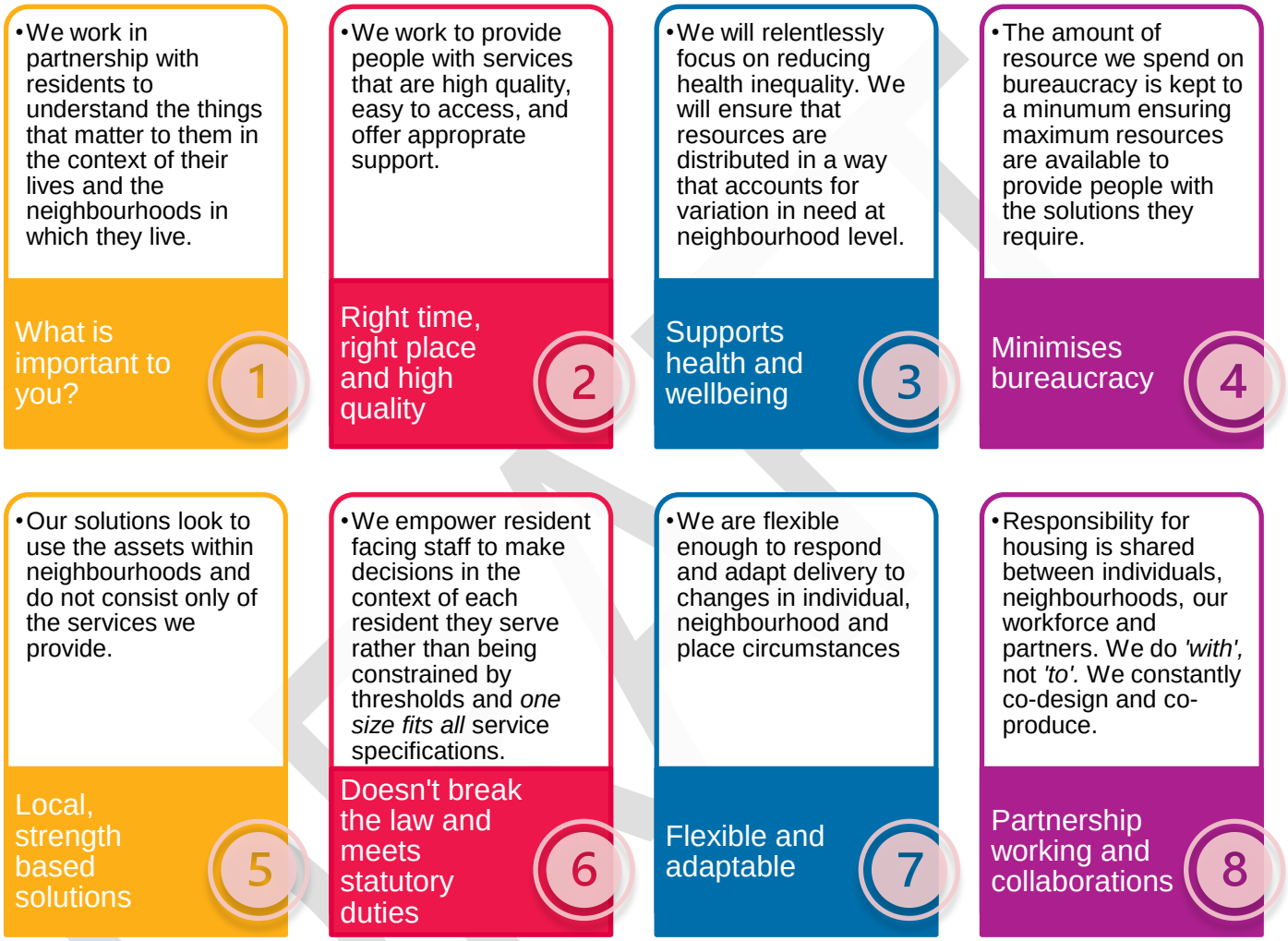
The vision for the Housing Strategy 2022-2027 is aligned with the aims of Domain 5 – Housing and the Environment within the Health and Wellbeing Strategy 2022-2026, outlined below:

Fewer people will be at risk of homelessness, and everyone will have access to high quality affordable homes that meet the needs of Thurrock residents.

Homes and places in Thurrock will provide environments where everyone feels safe, healthy, connected and proud.

Housing Core Principles

The Housing Resident Engagement Strategy 2022-2027 has been developed to support the Housing Strategy 2022-2027 that set the basis for a new way of working for housing support and services in Thurrock. These strategies and the new way of working follow the below eight principles:



Regulatory and Best Practice Framework

This section summarises the key regulatory elements that define social housing providers' duties and obligations towards engagement with tenants and residents and other best practice examples in the sector.

Tenant Involvement and Empowerment Standard

The Tenant Involvement and Empowerment Standard is one of four consumer standards with which registered providers of social housing must comply.

It sets expectations for registered providers of social housing to provide choices, information and communication that is appropriate to the diverse needs of their tenants, a clear approach to complaints and a wide range of opportunities for them to have influence and be involved.

Neighbourhood and Community Standard

The Neighbourhood and Community Standard sets expectations for registered providers of social housing to keep the neighbourhood and communal areas associated with the homes they own clean and safe, co-operate with relevant partners to promote the wellbeing of the local area and help prevent and tackle anti-social behaviour.

National Tenant Engagement Standards - 3rd Edition (2021)

Tpas, the tenant engagement organisation in England, published their revised National Tenant Engagement Standards following the release of the Government's social housing white paper, *the charter for social housing residents.* Within the National Tenant Engagement Standards, Tpas reflects the renewed focus on recognising the importance of the residents' voice.

The document is not statutory nor regulatory, but it clarifies the standards, expectations, and commitments that social housing organisations should meet to ensure that resident participation is active, valuable, and meaningful.

The National Tenant Engagement Standards provides a framework of seven key activities that support a positive engagement approach and reflect best practice. These activities are:

- governance and transparency
- scrutiny
- business and strategy
- complaints
- information and communication
- resources for engagement
- community and wider engagement

This framework has been considered in the development of this strategy. It will feature further in the ongoing delivery of its actions and wider resident engagement activity across the Housing service.

National Context

The Charter for Social Housing Residents: Social Housing White Paper

In late 2020 the Government published its social housing white paper, The Charter for Social Housing Residents. Within this document, the Government set out its intentions to ensure that residents in social housing are safe, listened to, live in good quality homes, and have access to redress when required.

The charter outlines the following seven elements that every social housing resident should be able to expect:

- to be safe in your home
- to know how your landlord is performing
- to have your complaints dealt with promptly and fairly
- to be treated with respect
- to have your voice heard by your landlord
- to have a good quality home and neighbourhood to live in
- to be supported to take your first step into ownership

Further to establishing these aspects, the Government announced plans to strengthen the Regulator of Social Housing. It aims to empower the regulator to be proactive in monitoring and enforcing the consumer standards that social housing landlords are held to, and requiring landlords to:

- be transparent about their performance and decision-making so that tenants and the regulator can hold them to account
- put things right when they go wrong
- listen to tenants through effective engagement

Whist the white paper outlines these intentions, the timelines for implementing all the policies and measures announced in the document remain unclear. However, there is now progress regarding the Social Housing Regulation Bill, and steps have been taken regarding building safety.

It is expected that the Government will undertake periods of engagement and consultation and introduce legislation during the lifetime of the Housing Strategy 2022-2027. However, the housing service has already begun to work proactively to ensure that the council is in a strong position to meet and address the white paper proposals as more information becomes available regarding implementation.

Grenfell Tower Fire and Building Safety

The Grenfell Tower Fire on 14 June 2017 brought tenant and resident engagement into sharp focus for providers of social housing across the country. The tragedy triggered a wave of activity, such as tenant engagement roadshows by housing ministers and the development of a social housing green paper by the Ministry of Housing, Communities and Local Government in 2018.

Most significantly, Dame Judith Hackitt was commissioned to undertake a review of building regulations and fire safety. The final report, entitled *Building a Safer Future*, was published in May 2018.

Among other recommendations, the report drew particular attention to the importance of engaging with residents, having appropriate strategies for engagement in place, and ensuring that residents had access to information and involvement in decision making.

The report also highlights the strength of structured engagement through residents' associations and tenant panels and the need for cultural change across the sector regarding the relationship between landlords and residents.

Although the report made these recommendations in the context of building and fire safety, they are applicable and appropriate to apply across the range of services provided by the Housing department.

Resident and Community Engagement during COVID-19 pandemic

The COVID-19 pandemic significantly impacted how people interacted with others, including with organisations like local authorities and housing providers. Local authorities were required to engage with their residents and communities in new ways, in increased volumes and at a significant pace.

Although the COVID-19 pandemic restricted and prevented traditional face-to-face interaction and engagement activity with those who access the Council’s Housing services, there were opportunities to find new ways to stay connected with residents and communities.

There was greater use of social media to share information with residents, the introduction of video calling in place of property visits and streamlined digital approaches to other general interaction. The level of contact with residents also increased to ensure that those most vulnerable could receive the support they needed through exceptionally challenging times.

The experience of the COVID-19 pandemic demonstrated that there is demand for developing new ways of engagement that take advantage of digital tools and resources available whilst retaining the capacity for traditional and in-person approaches to resident participation and sharing information.

Housing Resident Engagement Strategy Aims and Objectives

Five key aims have been identified through the process of designing and developing the Housing Resident Engagement Strategy 2022-2027. Together with their corresponding objectives, an action plan will be informed that addresses the engagement requirements set out in the regulatory framework for social housing providers and meets the engagement standards as recommended by Tpas.

Strengthen Community Engagement and Empowerment

Housing resident and community engagement is often fragmented into specific areas of responsibly or aligned by function. However, people want to be recognised, supported and engaged by a system that views them as a complex individual aiming to achieve their vision of a good life.

Engagement activity can often be standardised and traditional in its delivery, focussed solely on one single topic or issue determined on a borough-wide level.

Traditional forms of consultation mean that residents act as passive recipients of services provided by the council, providing feedback only when approached. Residents do not live their lives through our services, but through localities and neighbourhoods where many different factors combine to influence the quality of their lives.

People are likely to have multiple interconnected needs that would benefit from the support of multiple teams or organisations, but the current approach to sharing information about those needs is often lengthy, fragmented and features with elements of duplication.

This way of working increases rather than manages demand and does not realise the full potential that engagement opportunities can bring. It increases bureaucracy, costs, delays and wasted resource, and has negative impacts on those seeking to engage.

We need to move from an approach where we consult multiple times on services on strategies determined by us, to a single integrated approach based around place. Engagement needs to shift from being purely consultative to one of genuine co-design and co-production of new approaches to improve the quality of life of our residents.

Frontline staff have hundreds of interactions with residents every week, and staff groups like our tenancy management and sheltered housing officers have real insight into the needs of our neighbourhoods and communities, yet we never systematically collect this intelligence and use it to inform future strategy or delivery.

Locality based resident and community engagement provide the opportunity to develop offers of support and services that are designed specifically to meet the needs of that area. This makes the offered service more meaningful, prioritising what matters most to those in the local area and actively demonstrating evidence that resident feedback is being used constructively.

Broader community engagement also includes elected members. Mechanisms are already in place through Housing Overview and Scrutiny Committee, Cabinet and Council to ensure that members are informed and engaged in matters relating to housing. This strategy will strengthen the relationship and information sharing between housing services and elected members relating to matters affecting the wards and communities they represent.

This overall approach would contribute towards a growing sense of community empowerment, with individuals becoming far more active citizens as they experienced a genuine sense of involvement and influence. It would also enable feedback to be delivered more consistently and quickly than is currently possible.

What?	How?	Impact?
We will embed an approach for co-design and improvement of services in order to meaningfully involve and empower residents and communities	We will adopt an approach across housing services that empowers residents to formally and informally co-design solutions and provision, influence and make decisions, raise issues, input in the tendering of new contract arrangements and address challenges relating to housing in Thurrock We will achieve the Tpas Resident Involvement Accreditation for Landlords by completing the accreditation process to demonstrate our commitment to resident involvement and ensure our approach is effective and offers the best value for money	Residents will benefit from meaningful involvement in the way that housing services are provided and improved, ensuring that local priorities are properly understood and acted upon Residents will not have to rely on traditional consultative forms of engagement to have their views heard, and can trust that feedback provided through everyday interactions for service improvement will be taken forward and implemented
We will achieve more diverse representation in resident engagement and participation in order to better reflect the households which live in and around the Council's homes and neighbourhoods	We will undertake a project to identify the barriers that prevent residents from participating in existing engagement activity, such as involvement with the Excellence Panel We will take this learning and develop options and opportunities that encourage and empower residents and communities to participate and engage	Residents will be listened to regarding any challenges that may be preventing them from more active participation in engagement activity, and will be empowered by the Housing service acting, wherever possible, to remove or mitigate those challenges
We will develop a neighbourhood model for housing services in order to better focus on delivering what matters to residents in different localities	We will bring housing together at locality level and will empower front line staff from across housing to form relationships and networks across the system, to work together with residents to design and deliver meaningful, personal and holistic solutions	Residents will be supported by housing staff with an understanding of local priorities, networks and assets, improving the range of positive outcomes that can be delivered
We will collaborate more effectively with residents and other professionals that work across the Council's homes and neighbourhoods in order to improve health and wellbeing outcomes and reduce social isolation.	We will embed housing support and services within the Integrated Locality Networks encompassing a wide range of health, care and third sector partners, allowing staff to collaborate with each other and with residents to co-design bespoke integrated solutions rather than making referrals	Residents will experience improved integration between related but historically disjointed services, increasing and improving access to information and sources of support

Protect Resident Safety and Security

The *Charter for Social Housing Residents* sets out that every social housing resident should have a good quality home and neighbourhood to live in. In relation to anti-social behaviour, it outlines that social housing tenants have a right to feel safe in their homes, without the stress, fear, and tensions that anti-social behaviour and crime can cause and encourages landlords to develop practical solutions to tackle crime and anti-social behaviour in their areas.

The topic of anti-social behaviour featured heavily as a priority throughout the engagement for the development of this strategy, with particular concerns raised regarding the perception of feeling unsafe.

The council's aims for its homes and estates are that they should be places where residents enjoy living and working, where they take pride in their homes and can enjoy being part of a thriving community. The aspiration is to invest in and maintain high-quality accommodation that demonstrates the benefits of the council's repairs and capital investment programmes and positively influences the health and wellbeing of our tenants and residents.

Building and fire safety are matters of significant importance for any party or organisation involved in the management or maintenance of residential properties, and the responsibilities must not be taken lightly.

To meet its responsibilities, the council has a compliance regime to provide complete assurance to residents that their homes are well managed and meet required safety standards. Specific fire safety policies are in place to set how the housing service will manage and maintain its assets following the regulatory framework.

The housing service has begun to proactively develop an action plan to ensure that the council is in a strong position to meet and address the Social Housing White Paper proposals.

The housing service also stands ready to ensure compliance with the emerging Building Safety Bill, the implementation of recommendations made within the '*Building a Safer Future*' report following the Grenfell Tower fire, and any new duties or responsibilities introduced by the Fire Safety Act 2021. This aligns with the Charter for Social Housing Residents, as set out in the Social Housing White Paper.

Resident engagement is also crucial from the perspective of building management and safety. As part of the '*Building a safer future'* report published following the Grenfell Tower tragedy, the introduction of a 'golden thread' was made. This golden thread aims to serve as a tool to manage buildings as holistic systems, allowing people to use information to design, construct and operate their buildings safely and effectively.

What?	How?	Impact?
We will work with partners, residents and other Council services in order to improve community safety across the Council's neighbourhoods	We will work across the organisation to form a new Community Safety Service for Thurrock We will work across housing services to support the priorities identified by Thurrock Community Safety Partnership annually	Residents will feel safer in their homes and neighbourhoods in Thurrock, resulting in improvements to quality of life and more positive perceptions of the local area

What?	How?	Impact?
We will adopt a collaborative approach to improve safety on estates in order to address the issues that matter to local residents	We will work across housing, with our community partners and with residents to make our estates clean, attractive spaces where residents feel safe, using lighting, CCTV, and environmental improvements to do this We will establish a programme of resident and ward councillor estate walkabouts to improve the connection to and understanding of the local area and the issues that matter most to those who live there	Residents will benefit from targeted action and improvements in their neighbourhoods and estates that are informed by and aligned with their priorities, thereby strengthening connection with the area and improving perceptions of safety
We will proactively share information relating to building and fire safety in order to support residents to feel safe in their homes	We will develop a communications plan to ensure consistency in the approach taken by the council in communicating about safety We will use the plan as an opportunity to share information with residents about how their building operates and the steps and actions, they can take to protect their safety within the home	Residents will be supported to better understand their homes in the context of building and fire safety to address any concerns they may have about the safety of their building and prevent them from experiencing harm in the event of any incident
We will listen to the views of residents and understand their priorities in order to design, develop and deliver stock improvement programmes that target the things that matter	We will proactively engage with residents on their experiences of living in council-owned properties and their priorities for making homes fit for the future by embedding active engagement into the design of asset investment	Residents will be able to have their voices heard and priorities understood regarding what matters to them in future investment programmes in their homes and estates

Improve Communication and Interaction

The *Charter for Social Housing Residents* sets an expectation for residents to have their voice heard by their landlord. Within the social housing white paper, the Government sets out that it will:

- expect the Regulator of Social Housing to require landlords to seek out best practice and consider how they can continually improve the way they engage with social housing tenants
- deliver a new opportunities and empowerment programme for social housing residents, to support more effective engagement between landlords and residents, and to give residents tools to influence their landlords and hold them to account
- review professional training and development to ensure residents receive a high standard of customer service.

The white paper also expects that the Regulator of Social Housing will require landlords to show how they have sought out and considered ways to improve tenant engagement.

Traditional forms of engagement, such as consultation and surveys, are not always effective and can even have an adverse impact upon wellbeing if people feel pressurised to take part or communities suffer from consultation fatigue.

Tpas, the tenant participation advisory service, recommends through its engagement standards that residents should have access to an appropriate range of engagement opportunities that reflects the resident profile. It also encourages landlords to respond to different needs in relation to equality and any additional support, evidenced in the delivery of services, engagement activities and communications to promote widespread engagement.

Engagement can take many forms, but the crucial factor for the future is that it is tailored appropriately. There may be residents who want to proactively engage with policy design, for example, and others who may simply want to know that they are being considered in the way the council implements change and keeps residents them informed.

During the development of this strategy and the Housing Strategy 2022-2027, residents stressed the importance of diversifying and expanding the opportunities and methods used for engagement. Recent years have seen significant growth of digital communication technology in homes, such as video calling and meetings, and the decline in face-to-face interaction due to the COVID-19 pandemic.

What?	How?	Impact?
We will build meaningful channels of communication between the Housing service and its residents and communities in order to allow information and feedback to pass freely	We will assess current modes and models of communication to determine their reach and effectiveness and identify any gaps where new communication solutions could be introduced to maximise the flow of feedback and information	Residents will have greater confidence that their feedback is being listened to and will receive updates in a swift and timely manner

What?	How?	Impact?
We will design tailored approaches to engagement and communication in order to meet resident and community preferences and maximise interaction	We will develop an engagement framework that offers residents the opportunity to share their communication preferences and specify service areas of interest	Residents will have greater opportunities to have their voices heard regarding the subjects or areas that matter most to them, through a channel or format that matches their preference
We will embed resident engagement in estate regeneration in order to deliver projects that meet local needs	We will work closely with our residents to understand their priorities, identify required estate improvements, and progress opportunities for new housing to transform and enhance neighbourhoods.	Residents will have direct input, influence and opportunity to shape future council-owned developments and ensure that they meet their needs and priorities
We will implement and strengthen digital engagement and solutions in order to improve resident access to information and housing services, and increase diversity and participation through the use of technology	We will improve digital access to housing services by enhancing the existing online tenant portal and developing new approaches for interaction, engagement and communication using technology We will establish a layered and interactive approach to digital engagement which goes beyond the use of social media in isolation	Residents will find it easy to access housing services digitally and be able to interact with housing staff through digital devices, if that is their preference.

Enable Resident Scrutiny and Participation

The Charter for Social Housing Residents seeks to ensure that landlords remain transparent and accountable to their tenants at all times. The white paper sets out that every social housing resident should be able to expect to know how their landlord is performing.

As a mechanism to achieve this, the Regulator of Social Housing is seeking to introduce a suite of tenant satisfaction measures for all registered providers of social housing, including local authorities. Whilst the specific measures are still to be determined, the indicative measures provided for consultation were grouped under the following headings:

- Overall satisfaction
- Keeping properties in good repair
- Maintaining building safety
- Effective handling of complaints
- Respectful and helpful engagement
- Responsible neighbourhood management

In addition to greater transparency, these measures aim to inform the regulator about landlord compliance with the consumer standards under a more proactive consumer regulation regime as proposed in the social housing white paper.

What?	How?	Impact?
We will expand and develop the Excellence Panel and its subgroups in order to achieve greater representation of the diverse communities in the borough	We will review the current levels of scrutiny activity undertaken by the Excellence Panel and work with the group to adjust this accordingly so that appropriate levels of oversight are achieved We will use the learning from the project to identify barriers that prevent residents from participating in existing engagement activity to understand the challenges and implement a plan to achieve more diverse resident representation	Residents will be better represented by the membership of the Excellence panel and have greater opportunities to participate through an extended and expanded engagement offer
We will increase resident participation in the governance and scrutiny of the Housing service in order to remain transparent and accountable to residents	We will strengthen existing arrangements and develop new opportunities for residents to oversee the decision-making processes and shape Housing services where appropriate We will offer support, training and networking opportunities to those who want to engage in this way, helping to build knowledge, skills and capacity	Residents will have greater oversight of the operations of the Housing service. Residents will obtain greater clarity on Housing operations and have increased opportunities to shape and steer the direction of Housing services

What?	How?	Impact?
We will demonstrate our commitment to listen to residents about their experiences in order to better understanding their needs and priorities	We will explore the reasons for dissatisfaction in relation to each individual satisfaction measure by deliver focus groups with tenants We will close the contact loop with tenants by responding to the issues they raise, progress any actions required as a result and providing evidence of the outcome	Residents will be able to share their issues with the council directly, ensuring that the action required to address the issue is understood, with trust in the council that their feedback will be acted upon
We will proactively prepare to report against new national tenant satisfaction measures in order to make our performance as a landlord more visible to our tenants	We will implement a robust approach to recording, monitoring and reporting against the new tenant satisfaction measures that will be published by the Regulator of Social Housing by April 2023, to meet the first submission of data in Summer 2024	Residents will be better informed about the performance of the council as their landlord, and they will be empowered to hold the council to account through new regulation

Deliver Opportunities for Engagement

The *Charter for Social Housing Residents* sets an expectation for residents to have their voice heard by their landlord. Within the social housing white paper, the Government sets out that it will:

- expect the Regulator of Social Housing to require landlords to seek out best practice and consider how they can continually improve the way they engage with social housing tenants
- deliver a new opportunities and empowerment programme for social housing residents, to support more effective engagement between landlords and residents, and to give residents tools to influence their landlords and hold them to account
- review professional training and development to ensure residents receive a high standard of customer service.

The white paper also expects that the Regulator of Social Housing will require landlords to show how they have sought out and considered ways to improve tenant engagement.

Traditional forms of engagement, such as consultation and surveys, are not always effective and can even have an adverse impact upon wellbeing if people feel pressurised to take part or communities suffer from consultation fatigue.

Tpas, the tenant participation advisory service, recommends through its engagement standards that residents should have access to an appropriate range of engagement opportunities that reflects the resident profile. It also encourages landlords to respond to different needs in relation to equality and any additional support, evidenced in the delivery of services, engagement activities and communications to promote widespread engagement.

What?	How?	Impact?
We will share key information openly with residents and communities in a regular and timely manner in order to ensure transparency	We will share information across a range of formats and mediums, including the publication of an Annual Report co-designed with residents	Residents will be able to access information with greater ease and will be able to hold the Housing service to account accordingly, in line with the Social Housing White Paper proposals. Residents will have the opportunity to take ownership of the development of an Annual Report for the benefit of residents in and around the Council's homes and neighbourhoods, ensuring that residents are formally informed about the actions of the Housing Service
We will proactively engage with communities across the Council's neighbourhoods in order to establish stronger relationships between the Housing service and residents	We will expand and strengthen the physical and digital opportunities for engagement on a locality and neighbourhood basis, providing more regular localised opportunities for residents to engage on the topics that matter most in their area	Residents will have greater opportunities to share and participate in activities that will directly support or benefit their local areas and communities

What?	How?	Impact?
We will adopt a data and case study led approach to assess the impact of engagement activity in order to provide residents with useful and valuable opportunities for engagement	We will develop a new framework for assessing the effectiveness of engagement activity using qualitative and quantitative data We will monitor and review the feedback and collected data related to engagement activity in order to steer, design and tailor future events according to resident wants and needs	Residents will be empowered to have their voices heard regarding the engagement events and activities that the Housing service offers, ensuring that these reflect good value for money and are aligned with resident priorities
We will learn from best practice and innovation across the social housing sector in order to coordinate engagement activities and events that are meaningful and of value to residents	We will regularly review the Housing service's approach to Resident Engagement against that of leaders in the sector and use peer partnerships to identify areas for development	Residents will benefit from the continual advances in approaches to engagement and the use of technology that other social housing providers are pioneering with their tenants

Monitoring, Measuring and Review

A robust monitoring and review process will be implemented to measure progress against the strategic priorities presented in this document.

Firstly, an action plan will be developed, aligned with the priorities and themes from this strategy, developed alongside residents and other key stakeholders with reviews undertaken in regular intervals.

It is intended that progress towards the delivery of this action plan will be monitored on an annual basis by an established group of residents and the Housing Strategies Delivery Board.

Further to this, and building on the Deliver Opportunities for Engagement theme, the Housing service will seek to co-produce an annual report with residents, highlighting each year's projects and successes.

Finally, a system for recording resident feedback on engagement and project delivery will be established. This approach will utilise case studies to reflect on positive outcomes and identify areas for improvement.

Throughout the lifespan of this strategy, there is an expectation that new actions will be added to the action plan, reacting to changes in external factors (such as legislation) or proactively if an opportunity to do so arises. These additions will be managed appropriately and will ensure that they continue to reflect the key themes of this strategy.

13 July 2022	Item: 15 Decision: 110618
Cabinet	
Integrated Community Equipment Service Reprocurement	
Wards and communities affected: All	**Key Decision:** Key
Report of: Councillor Deborah Huelin – Cabinet Member for Adults and Health	
Accountable Assistant Director: Les Billingham, Assistant Director, Adult Social Care and Community Development	
Accountable Director: Ian Wake, Corporate Director Adults Housing and Health	
This report is Public	

Executive Summary

This report outlines the duty under the Care Act 2014 and the Children and Families Act 2014 to supply Community Equipment for those with eligible need. It details the current arrangements and the options that have been explored for future procurement.

This report seeks agreement from Cabinet that the procurement for this service should take place under the current arrangements which are a collaborative approach to commission services with the Greater Essex Commissioning Partnership Group. The Commissioning Partnership Group is comprised of Essex County Council, Mid Essex Clinical Commissioning Group, Basildon and Brentwood Clinical Commissioning Group, Thurrock Clinical Commissioning Group, East Suffolk and North Essex NHS Foundation Trust, Mid Essex Hospital Trust, Castlepoint and Rochford Clinical Commissioning Group (CCG), Essex Partnership University Trust (EPUT) and Thurrock Council.

1. Recommendation(s):

1.1 That Cabinet agree that the procurement for this service should take place under the current arrangements, which are a collaborative approach to commission services with the Greater Essex Commissioning Partnership Group

1.2 That Cabinet agree to delegate authority to the Corporate Director for Adults, Housing and Health and the Portfolio Holder to award the contract of Community Equipment following completion of the procurement process.

2. Introduction and Background

2.1 The Integrated Community Equipment Service (ICES) contract is currently delivered by Essex Cares Limited through a Partnership Agreement with the Great Essex Commissioning Partnership Group. The current contract ends 31 March 2023, and the new contract will start on 1 April 2023.

2.2 The Greater Essex Commissioning Partnership took the decision not to extend the current arrangement but to go to the open market. A benchmarking and market engagement exercise has been undertaken and has indicated that there is an opportunity to transform and improve the services from end to end and make efficiencies. This would result in better value to all partners and quality for the end user. Thurrock Council has a duty to provide Community Equipment to support residents who are eligible under the Care Act (2014) and the Children and Families Act (2014). Community Equipment provides functional support to assist with care delivery and promotes independence i.e., grab rails, hoists. Community equipment also supports timely Hospital Discharge and has ensured that Thurrock has remained with very low hospital delays throughout the pandemic and beyond, an excellent outcome for our residents.

2.3 Adult Social Care adopts a strength-based approach, focusing on the strengths and abilities of the individual and aims to connect them to support from friends, family and the wider community. By adopting an ethos of providing the right care at the right time in the right place, this equipment services enables individuals to remain at home and part of their local communities.

2.4 Once equipment is no longer required, where it is possible to do so, items are collected, cleaned, and re-used for other residents and so this contract aligns itself to the wider greener goals of Thurrock Council.

2.5 Thurrock Council currently contribute **£662k** per annum towards the £12 million total budget of the overall contract per annum. This provides items of equipment to approximately 1,900 residents at any one time.

2.6 The contract will be in place for 3 year with the option to extend for a further year, the total being £2,648,000 for 4 years. This however is a demand driven service so the total cost can fluctuate if demand increases, this is acknowledged within the budget and managed very closely.

3. Issues, Options and Analysis of Options

3.1 To ensure value for money Thurrock has previously undertaken options appraisals for alternative commissioning methods to deliver ICES. The options were:

- Collaboration with other Unitary Authorities
- Bringing the service in house.
- A Thurrock only procurement.

- Continue with current partnership.

3.2 This type of service is a specialist service provided by a niche market of three main suppliers. Therefore, limiting collaboration with other Unitary Authorities, or procuring this independently is very unlikely to yield either financial efficiencies or a high quality of service. To bring this service in house would be economically unviable due to the cost of establishing a new service, we would have to purchase equipment, find warehouse space, have high quality cleaning facilities, provide transport to deliver the equipment and employ staff to deliver the overall service. This would not be financially viability given the contract size, and the fragility of the market. It would cost significantly more than £662K a year. The most viable option is to continue the current commissioning partnership.

3.3 The current commissioning partnership provides Thurrock Council with:

- Increased purchasing power.
- Stability of supply.
- Value for money

The economies of scale this Commissioning Partnership provides more than could not be found in any of the highlighted options, especially so in such financially challenging times.

4. Reasons for Recommendation

4.1 The current contract with the provider, Essex Cares Limited, is coming to an end and a new contract for Integrated Community Equipment Service is required.

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

5.1 The report was presented to Health and Well Being Overview and Scrutiny Committee on the 7 June 2022.

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

6.1 The Integrated Community Equipment Service contract impacts on the following Council Priority.

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

7. Implications

7.1 **Financial**

Implications verified by: **Mike Jones**

Strategic Lead Finance

Provision has been made within the 2022/23 Adult Social care budget to fund the service, in line with the amounts detailed within the report.

7.2 **Legal**

Implications verified by: **Kevin Molloy**

Senior Contracts Lawyer

I confirm I have considered the legal implications of this report and am satisfied that the commissioning body will be obliged to follow the same national procurement rules as are currently upon the Council.

7.3 **Diversity and Equality**

Implications verified by: **Rebecca Lee**

Team Manager - Community Development

The Council has a legal duty to provide community equipment to support residents in line with regulations set out in the Care Act (2014) and the Children and Families Act (2014). Social value has been considered as part of the commissioning process for this service and will be monitored as part of the standard contract review cycle with the agreed supplier.

7.4 **Other implications** (where significant) – i.e. Staff, Health Inequalities, Sustainability, Crime and Disorder and Impact on Looked After Children

N/A

8. Background papers used in preparing this report (include their location and identify whether any are exempt or protected by copyright):

N/A

9. Appendices to the report

None

Report Author:

Ian Kennard

Commissioning Manager

Adults, Housing and Health

13 July 2022	Item: 16 Decision: 110619
Cabinet	
Adult Integrated Care Strategy	
Wards and communities affected: All	**Key Decision:** Key
Report of: Councillor Deborah Huelin, Cabinet Member for Adults and Health	
Accountable Assistant Directors: Les Billingham, Assistant Director of Adult Social Care and Community Development Ewelina Sorbjan, Assistant Director of Housing Rita Thakaria, Thurrock Partnership Director Jo Broadbent, Director of Public Health	
Accountable Director: Ian Wake, Corporate Director of Adults, Housing and Health	
This report is public	

Executive Summary

This report introduces *Better Care Together Thurrock - The Case for Further Change* – Thurrock's new adults' Integrated Care Strategy.

Better Care Together Thurrock - The Case for Further Change sets out ambitious and detailed plans for transforming Thurrock's health, care, housing and wellbeing services and provides a blue-print for service integration to form one place-based and integrated care system, designed to deliver *'better outcomes for individuals that take place close to home and make the best use of health and care resources'*.

The Strategy is the mechanism by which goals 1 and 3 of the refreshed Health and Wellbeing Strategy will be delivered.

1. Recommendation

1.1 That Cabinet agree *Better Care Together Thurrock – The Case for Further Change*.

2. Introduction and Background

2.1 Over the last 30 years, the operating model for health and care has evolved to focus on that of delivering discrete services and interventions, determined in advance, designed to address pre specified needs and conditions. This has

resulted in a health and care system that waits until people are in crisis, have significant need or are sufficiently ill before acting. Siloed pathways and processes have evolved that underpin a fragmented system. The unique strengths and assets of the resident themselves, their friends and their community are too often side lined, with professionals alone determining what people are entitled to and what services they will receive.

2.2 Many residents have complex needs and face multiple challenges that overlap. For example, there is clear evidence about the strong correlation between mental ill health, housing, debt, addiction, and social isolation.

2.3 Paradoxically, the more complex a resident's needs are, and the greater their need is for help, the more difficult it is for them to access a solution because the system is designed in a way that requires them to navigate an often-bewildering service landscape of multiple teams and services, all with different thresholds, referral criteria, and waiting times. We call this the *need paradox.* Different services within the system often fail to talk to one another. This has resulted in a system that fails see 'the whole person', often falling short of delivering what residents actually require to improve their wellbeing and adopting an inflexible 'tick box' mentality.

2.4 Thurrock recognised the *need paradox* a number of years ago – starting on its transformation journey in 2011 when the 'Commission of Enquiry into Cooperation between Housing, Health and Social Care in South Essex' (the Enquiry) identified the need for the health and care system to shift to a position where it focused on improving wellbeing and did not respond solely to pre-determined deficits. The shift that ensued included promoting what the community had to offer and acted as a catalyst for a person-centred and person-driven culture.

2.5 Since 2011, significant transformation of our local health and care system has already been delivered. A partnership with between the NHS, Council and the third sector, known as Stronger Together Thurrock, was formed and has been responsible for shifting the existing system to a position where community strengths and assets are seen as fundamental to the overall aim of enabling people to 'live their version of a good life'. Key initiatives such as Local Area Coordination - where Thurrock was an early adopter, Micro Enterprises and Community Led Support were introduced. This gave people real choice, recognising that people did not just want their 'care' or 'health' needs to be met, but most importantly wanted to continue to enjoy the aspects of life that made it worth living – whatever their circumstances.

2.6 In 2017, the then Director of Public Health wrote *'The Case for Change – A New Model of Care'* setting out three key programmes of work to improve the access and quality of primary care, improve long-term condition case finding and clinical management, and pilot a holistic model of home care through *Wellbeing Teams.* The *Case for Change* was able to build on some of the initiatives already in place. This included Local Area Coordination, Social Prescribing, Asset Based Community Development, and Thurrock First – our

integrated health and care single point of access. The *Case for Change* also enabled join up with other planned system-change initiatives, thus enabling an entire change programme for the health and care system to evolve.

3. Better Care Together Thurrock - The Case for Further Change

3.1 Following the testing of and learning from initiatives stemming from the 2017 '*Case for Change'*, *Better Care Together Thurrock – The* Case for Further Change' is a strategy that sets out a hugely ambitious and collective plan to radically transform, improve and integrate health, care, housing, and third sector services and an approach, aimed at the Borough's adult population and designed to improve their wellbeing. The Strategy sits under the refreshed Thurrock Joint Health and Wellbeing Strategy as it is responsible for delivering or contributing to the delivery of its high-level goals and objectives related to transformation and integration of health, care, wellbeing and housing services – in particular responsibility for delivering goals 1 and 3.

3.2 The Strategy has been developed through a process led by the Corporate Director of Adults, Housing and Health of extensive consultation and collaboration with NHS, housing, adult social care and third sector partners, and more broadly through resident engagement.

3.3 The Strategy's overarching goal is to achieve *'better outcomes for individuals that take place close to home and make the best use of health and care resources*. The ten chapters within the strategy set out how this will be achieved and describe the shape of the future health and care system. The main strategy is in effect, six individual strategies in one document (Chapters 4 to 9) that deal with transformation of different elements of the system.

Chapter	Title
1	Introducing Thurrock
2	Our Vision, Aims, Principles and Values
3	Our Integrated Wellbeing Model
4	Community Engagement and Empowerment – Leveraging the Power of People
5	Transforming Primary Care
6	Improved Health and Wellbeing through Population Health Management
7	Integrated Care and Support in the Community
8	Integrated Support in the Home
9	Reimagining Supported Living, Residential and Intermediate Care
10	Making it Happen: Integrated Governance, Delivery and Commissioning

3.4 The Strategy describes an overall model of integrated care – with the constituent elements described in detail within each of the chapters above based on a *Human Learning Systems* (HLS) approach set out in Chapter 2. In adopting an HLS approach, the Strategy aims to transform radically the

way that public service is delivered. Where historically, multiple fragmented teams of professionals were constrained to delivering pre-determined interventions in silos, in the future they will work collaboratively with each other and residents to co-design bespoke and integrated solutions that solve residents' problems. Over time, new 'blended roles' will be creating with the ability to deliver functions such as housing, addictions and mental health historically separated between different teams and organisations. Bureaucracy, assessment and onward referral will be kept to an absolute minimum, freeing up more time, capacity and resources to deliver front line care.

3.5 Importantly, the Strategy aims to reduce the number of 'front doors' people have to go through to access the support they require – developing a response that provides integrated solutions that can span functions. The Strategy also aims to strike a balance between what the community can offer, and what the individual can do for themselves, ensuring that services are not always seen as the default first option.

3.6 At the heart of our model sits transformed Primary Care Networks (PCN) (Chapter 5) and an Integrated Locality Network of Community Support (Chapter 7) that wraps around it. Through four new Integrated Locality Networks based around PCN geography, professionals historically fragmented into distinct teams and functions across the NHS, Adult Social Care, Housing and the voluntary sector will collaborate together to build relationships with residents and design strengths-based solutions to meet their needs. This builds on the already highly successful approach of our Community Led Support Teams and their community-based 'Talking Shops'.

3.7 Plans to transform care from reactive to proactive and preventative through Population Health Management approaches and better use of data and intelligence are set out in Chapter 6. Integrated Care and Support at Home is delivered via a new Health and Wellbeing Teams model set out in Chapter 8 that brokers support from the Integrated Locality Network, and also encompasses reablement and proactive hospital discharge planning. A new vision for Residential and Intermediate Care is set out in Chapter 9, and like Wellbeing Teams, the model also encompasses clinical in-reach from the Integrated Locality Network and supports hospital discharge. The power of people communities and assets, and of 'doing with' not 'doing to' runs through the entire strategy, but our approach to community development and co-design and leveraging the power of communities is also described in detail within Chapter 4 – with strong links to the Collaborative Communities Framework.

3.8 Finally, Chapter 10 sets out new governance, delivery, and commissioning arrangements. These reflect how the health and care system at a place-based level (Thurrock) will be governed, ensuring delivery of the strategy's vision and aims. The strategy will be owned in partnership by Thurrock Integrated Care Alliance (TICA) and will be governed through the delivery structures set out within the chapter. System funding will be managed through the already

established Better Care Fund – with TICA having the responsibility for ensuring resources across Thurrock are used to ensure required outcome are achieved. This includes decisions about de-investment and re-investment. A new 'devolution' agreement between the Mid and South Essex Integrated Care System and the Thurrock Integrated Care Alliance will be developed and negotiated that will set out devolved commissioning and delivery responsibilities, outcomes and resources.

4. Issues, Options and Analysis of Options

4.1 Detailed plans are set out within the main strategy document, summarised within the Executive Summary document.

4.2 The Strategy builds on a long history of transformation and reflects how the existing health and care system needs to change to ensure people are able to achieve the outcomes they require and that resources are used in the most effective way. In line with *Human Learning System* principles set out in Chapter 2, further *i*ssues and options will continue to be identified and tested through ongoing 'test and learn' initiatives that will help to shape how the Strategy and its aims are delivered.

5. Reasons for Recommendation

5.1 To enable partners to work with Thurrock's communities to build a health and care system that works for people and helps them to achieve the outcomes that are most important to them.

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

6.1 The Strategy builds on previous and ongoing engagement with communities and stakeholders – this will continue throughout the life of the Strategy and is an essential aspect of identifying how the Strategy is delivered.

6.2 Thurrock Health and Wellbeing Overview and Scrutiny Committee endorsed that Strategy at its meeting of 7 June 2022.

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

7.1 The Strategy is a contributor to a number of key corporate policies and priorities. This includes a significant contribution to the Council's priority for 'People', and delivery of a goals 1 and 3 within the refreshed Health and Wellbeing Strategy. Embodied within the Strategy are the principles contained within the Collaborative Communities Framework.

7.2 The Strategy has a key focus on engaging with communities to inform what is delivered and how it is delivered. A new approach to engagement will ensure that all communities have the opportunity to influence and own how we deliver health and care and how we use our collective resources to improve wellbeing

outcomes. A principle of this Strategy is to shift power and ownership to communities and individuals.

8. Implications

8.1 Financial

Implications verified by: **Mike Jones**

Strategic Lead Finance

The shift to an integrated and preventative model will deliver system efficiencies through reducing 'failure demand' on the highest cost elements of the system: by reducing bureaucracy and system running costs, and by addressing the 'need paradox' by fundamentally transforming how public service is delivered.

The Strategy can be delivered within existing budgets. The Better Care Fund will be used as the vehicle through which partner resources will be pooled and managed for the purpose of delivering the ambitions of the Strategy. This will be governed through Thurrock Integrated Care Alliance, Thurrock Health and Wellbeing Board, Cabinet and the MSE ICS' Integrated Commissioning Board.

The Strategy also proposes to invest new system funding streams in a proportionate way that addresses current inequality.

8.2 Legal

Implications verified by: **Sarah Dawkins**

Barrister (Consultant)

On behalf of the Chief Legal Officer, I have read the report with attachments in full.

Clause 26 of the Health and Care Bill proposes to amend the Local Government and Public Involvement in Health Act 2007 so that the integrated care board and all upper-tier local authorities that fall within the area of the integrated care board must establish an integrated care partnership. This will be a joint committee of these bodies made under the new section inserted in the Act. The partnership must include members appointed by the integrated care board and each relevant local authority. The integrated care partnership may determine its own procedures and appoint other members.

The strategy must consider how NHS bodies and local authorities could work together to meet these needs using section 75 of the NHS Act 2006, using agreements to pool budgets or lead commissioning arrangements between local authorities and NHS bodies. The strategy may also state how health-related services (defined as services that may influence the health of

individuals but are not health services or social care services) could be more closely integrated.

In preparing this strategy, the integrated care partnership must have regard to the NHS mandate and guidance published by the Secretary of State, and it must involve the local Healthwatch and people who live or work in the integrated care partnership's area.

The integrated care strategy must be published and shared with each responsible local authority, and the relevant integrated care board in that area.

Health and wellbeing boards in response to an integrated care strategy, must prepare a 'joint local health and wellbeing strategy' that sets out how the local authorities, integrated care board and NHS England will meet population needs in that area. An ICB, in the preparation of its joint-forward plan must also reference how the plan implements any relevant joint local health and wellbeing strategies to which the ICB is required to have regard.

Local authorities and integrated care boards must have regard to the joint strategic needs assessment, the integrated care strategy, and the joint local health and wellbeing strategy when exercising their functions and NHS England must have also regard to them when exercising their functions related to the provision of health services in the area.

The Key ICP requirements in the Health and Care Bill are

- The Health and Care Bill proposes that the Integrated Care Board (ICB) and all upper-tier local authorities that fall within the footprint of the ICB must establish an Integrated Care Partnership (ICP).
- The ICP may make their own procedures including appointing the Chair and further members and determining the ICP's arrangements.
- The ICP must prepare a strategy on how to meet the needs of the population – as identified in the joint strategic needs assessment from the health and wellbeing board/s that fall within the area of the ICB – through the exercise of functions by the ICB, NHSE and the upper tier local authorities.
- The strategy must address whether the needs could be met more effectively through the use of NHS/local authority section 75 agreements and may include a view on how health and social care could be more closely integrated with health-related services.
- The ICP must have regard to the Secretary of State's mandate to NHS England (national NHS priorities) and the statutory guidance on the integrated care strategy; and the ICP must involve Healthwatch and local people and communities in preparing the strategy.

- When an upper tier local authority and an ICB receive an integrated care strategy, they must produce a joint local health and wellbeing strategy to meet the needs through the exercise of their (and NHS England's) functions.
- The upper tier local authorities, ICBs and NHS England must have regard to the integrated care strategy and the joint local health and wellbeing strategy in exercising their functions, including the preparation of the joint-forward plan.

Accordingly, the Better Care Together Thurrock - Case for Further Change, Thurrock's Adult Integrated Care Strategy set out within this paper as part of transforming residential care provision meets the requirements anticipated for ICP provision under the Bill and I confirm there appears to be no adverse external legal implications arising from the recommendations proposed.

Moving forward, the Council's internal Legal and Assets teams will provide support on ensuring that the required agreements with Health partners adequately protect the Council's position.

8.3 **Diversity and Equality**

Implications verified by: **Rebecca Lee**

Team Manager – Community Development

There are significant health inequalities across the Borough. A Community Equality Impact Assessment has been completed demonstrating that delivery of the Strategy will support a reduction in health inequalities not least through co-production with communities to ensure that health and care system are designed to their requirements. Embedding the Collaborative Communities Framework, the Strategy aims to lead on a new approach to engagement – enabling all communities to be involved in identifying what is important to them, what the challenges are to improving their own wellbeing, and also passing to them ownership of issues and solutions that they wish to lead on. This will ensure that we move to a state where public sector organisations deliver what communities want them to deliver, and communities are able to deliver what they wish to deliver – enabling a true partnership between people and state to develop.

8.4 **Other implications** (where significant) – i.e. Staff, Health Inequalities, Sustainability, Crime and Disorder, or Impact on Looked After Children

Health Inequalities – the Strategy will contribute to the reduction of health inequalities.

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

- The Case for Change – A new Model of Care

10. Appendices to the report

- Appendix A: Better Care Together Thurrock: Further Case for Change – Executive Summary
- Appendix B: Better Care Together Thurrock: Further Case for Change – Full Version

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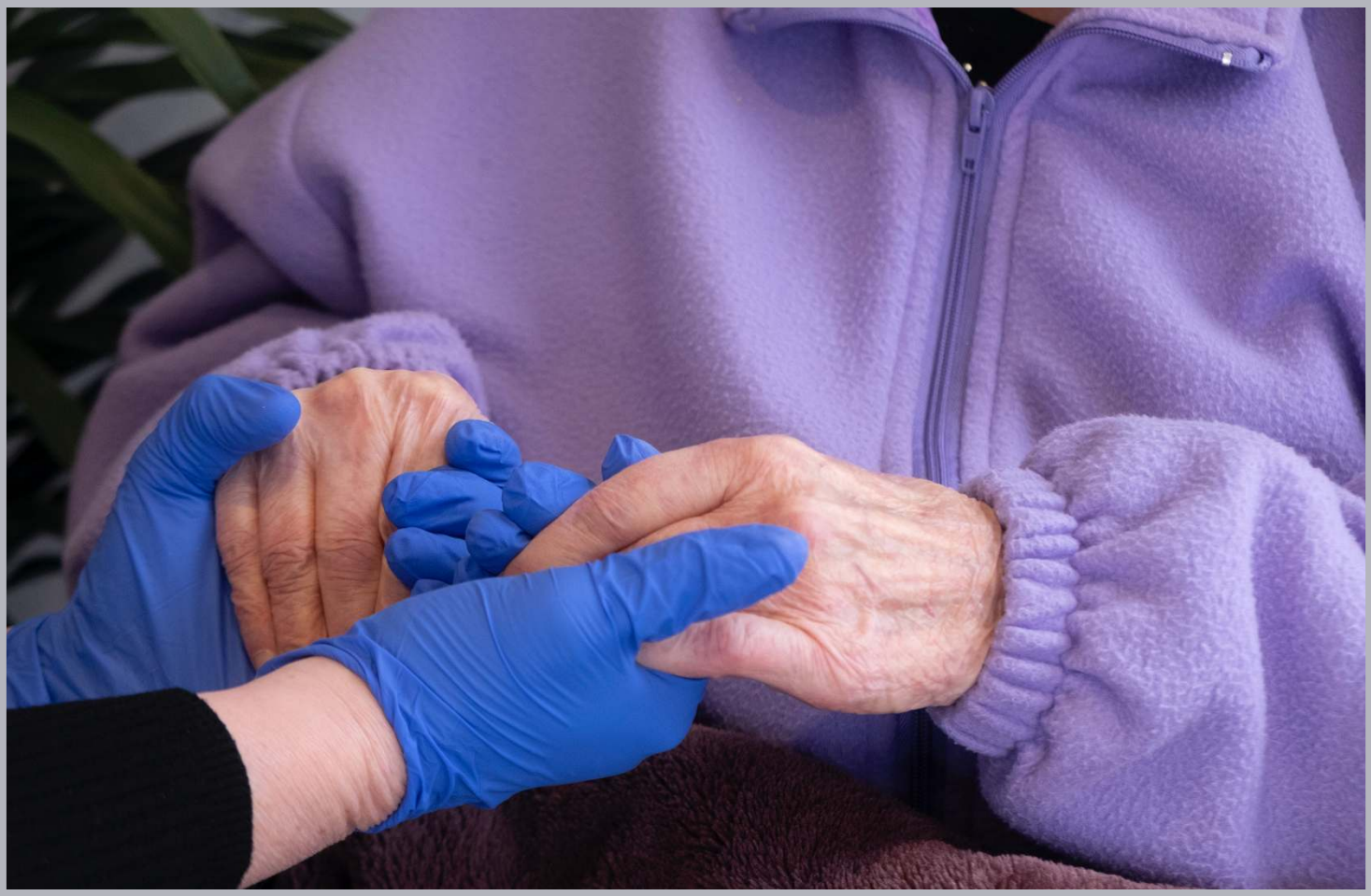

Better Care Together Thurrock:
The case for further change 2022-2026

EXECUTIVE SUMMARY

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Introduction

This document provides an Executive Summary of Better Care Together Thurrock - Case for Further Change strategy. The main strategy sets out Thurrock's ambitious and collective plans to transform, improve and integrate health, care and third sector services for adults and older people. in order to improve their wellbeing.

This strategy has been developed and agreed by the Thurrock Integrated Care Alliance (TICA) and its partner organisations. Partners across Thurrock have a long history of working together to agree and deliver shared outcomes. The approach taken has been inclusive, bringing together commissioners, providers and colleagues from Thurrock Council, the NHS, third/voluntary sector and Healthwatch.

In late 2019, following a review of local arrangements, partners agreed to strengthen, further embed and accelerate collaborative arrangements by establishing the Thurrock Integrated Care Alliance. TICA is the highest strategic level officer only partnership responsible for health, care and third sector service strategic transformation across the borough including developing and overseeing the deployment of the Better Care Fund.

The current membership of TICA is shown below.

How the main *Case for Further Change* strategy is structured.

The main document starts by providing an overview of Thurrock and the health and wellbeing needs of is population. It sets out the collective vision, aims, principles and values that all TICP partners have developed jointly and which underpin our approach. These are based on a Human, Learning Systems approach, which is also described.

The current health, care and wellbeing landscape is complex comprising of a series of different elements that interact together in a whole system approach. We have developed a new model of care for Thurrock that describes how these elements will interact seamlessly moving forward, set out in the strategy.

The main document then dedicates six individual chapters that describe our detailed plans for transforming the six key elements of the system. It is, in effect a collection of six interconnected strategies in one document, setting out our ambitious plans for each element:

1. Our strengths and assets based approach to community engagement and development, and how we will put residents, communities and the third sector at the heart of our plans to co-design and co-produce new models of care.
2. Our plans to transform primary care to improve the access and quality of General Practice in the context of the new Primary Care Networks.
3. Our approach to shifting the focus of our system from reactive care, to proactive and preventative using Population Health Management.
4. How we will build an integrated health, housing care and wellbeing workforce around each PCN, to deliver proactive, strengths based, integrated care solutions to our residents, maximising the opportunities of the new Integrated Medical Centres and other community assets.
5. How we continue to transform and integrate care delivered at home, building on the successes of our Wellbeing Teams model..
6. How we will re-imagine and deliver new models of intermediate and residential care through our proposals for an "Extra Care Plus" facility at the Whiteacres site in South Ockendon.

The main document also sets out further details on a new governance structure and implementation, to support the transition of the Thurrock Integrated Care Partnership to act as Thurrock's Place/Alliance Board for the Mid and South Essex ICS's Integrated Commissioning Board, with delegated resources and decision making responsibilities.

The complexity of the task of transforming and reimagining our entire system, together with the scale, depth and breadth of our ambition has resulted in a comprehensive and detailed main Case for Further Change document. The six main chapters are designed to be read in isolation and give a detailed explanation of our transformation plans for each element of the system that will be of interest to different system actors.

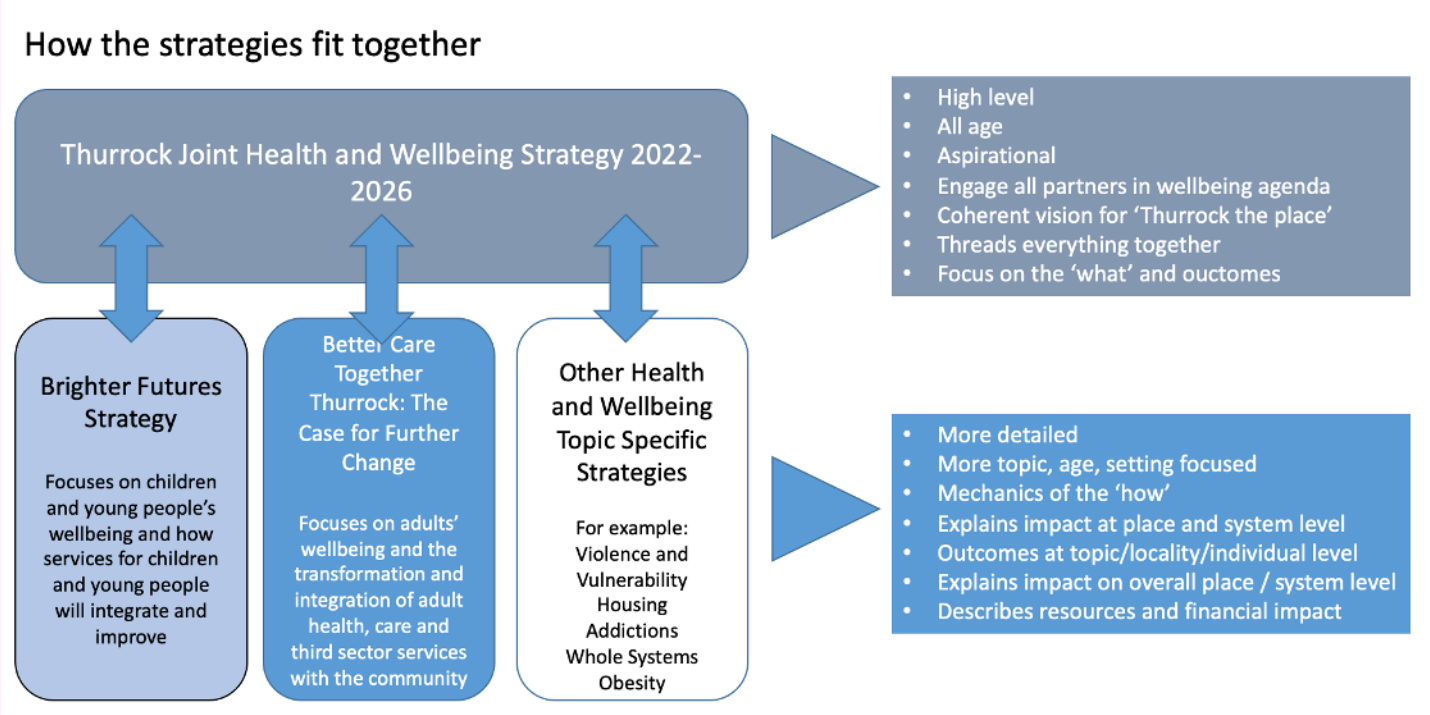
Conversely, this document has been designed to give the reader a high level overview of the strategy as a whole, and capture the key strategic actions set out in each chapter of the main document.

Strategic Context

From April 2022, Thurrock will be one of four *Alliance Places* that sit under the Mid and South Essex Integrated Care System (MSE ICS). The Kings Fund has recognised that 70% of health care integration and transformation operates at a geographical level below ICS boundaries, and the new MSE ICS has recognised the key principle of *subsidiarity*, that decision making on the planning and delivery of health and care services should be made at the lowest possible geographical level.

As such, the MSE ICS has proposed making the four *Alliances* sub committees of the Mid and South Essex Integrated Commissioning Board with the opportunity to negotiate significant delegated decision making authority and resources based on agreement of strategic plans at *Alliance/Place* level.

This strategy forms part of a suite of three documents that describe Thurrock's *Place Based Strategy* as shown below



The Thurrock Joint Health and Wellbeing Strategy 2022-2026 is the highest level strategic document that describes are collective plans to improve the health and wellbeing of our residents. The theme of the strategy is *Levelling the Playing Field* and the strategy sets out high level actions to address health inequalities across the six domains of:

- Healthier for Longer including mental health
- Building Strong and Cohesive Communities
- Person Led Health and Care
- Opportunity for All
- Housing and the Environment
- Community Safety

The Joint Health and Wellbeing Strategy therefore addresses the wider determinants of health including education, employment, crime and community safety, and housing, as well as healthy lifestyles and health and care. It concentrates on the 'what' and the 'why' and points to additional more detailed and topic specific strategies that deal with delivery of individual objectives (the '*how*').

Two key additional documents sit under the Joint Health and Wellbeing Strategy, of which, this is an executive summary of one.

The second is the *Thurrock Brighter Futures Strategy,* which sets out our collective plans to improve the health and wellbeing of children and young people in the borough.

Chapter 1: Introducing Thurrock

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1.1 Welcome to Thurrock

Based at the heart of the Thames Gateway in close proximity to the east of London, Thurrock is a busy borough with picturesque towns, reams of beautiful countryside and 18 miles of river frontage. We are a borough of contrasts with urban areas of Grays, Tilbury and Purfleet to the south and rural villages and open countryside to the north. Our borough boasts more than 18 miles of beautiful river front and his proud of its rich heritage and growing cultural scene. 70% of Thurrock is greenbelt, with several rural villages and many areas of wildlife and natural beauty.

Opportunity and Growth

Thurrock is a unique place and its geography, economy and demographic profile distinguish it from neighbouring authorities. We are home to some of the most exciting opportunities in the county. Our growth programme is perhaps the largest and most ambitious in England. £6Bn has already been invested by the private sector in Thurrock up until 2017, with 7,000 new jobs created and 1,170 new businesses choosing Thurrock including leading ports and logistics centres, retail and creative industries.

More broadly, over 1,000 acres of land are ready for commercial development with 30,000 new homes likely to be built. Thurrock is at the heart of global trade and logistics, with no fewer than three international ports. We are well position on the M25 and A13 corridors with excellent transport links west into London, north and east into Essex, and south into Kent.

Purfleet on Thames

Purfleet Centre Regeneration Limited is a joint venture between Urban Catalyst and Swan Housing in partnership with Thurrock Council to regenerate over 140 acres to create Purfleet-on-Thames. Developed on healthy town principles, Purfleet-on-Thames will create a new waterfront destination on the River Thames; an international create hub and high quality new residential with place making at its core. It will include film and art studios, 2,850 new homes, upgraded transport and leisure facilities and an attractive new waterfront commercial and residential space.

Thames Freeport

A successful bid backed by Thurrock Council to create a Thames Freeport will deliver transformational change across the entire borough, create 25,000 direct new jobs and up to another 20,000 indirect job opportunities, and will see unprecedented inward investment. Thames Freeport is an economic zone connecting Ford's word-class Dagenham engine plant to the global ports at London Gateway and Tilbury. Businesses looking to expalnd or reshore their operations will be able to take advantage of the tax benefits of establishing within the Freeport and being part of a customs zone, which makes it easier and cheaper to move goods into and out of the country.

1.2 The Health of Our Residents

Thurrock is home to a diverse population of residents that is increasing by over 10% every decade. Our current population is estimated to be 178,300. Structurally, our population is younger than England's with 22% being aged 14 and under. 19% of our residents are from a non-white British background.

The main causes of death amongst Thurrock residents in 2020 were cancer, cardio-vascular disease, dementia and respiratory disease. For premature (under 75) mortality, they were cancer, cardio-vascular disease.

Health Inequalities

Health inequalities remain a significant issue in Thurrock with our more deprived populations suffering lower levels of both total life expectancy and the numbers of years of their life that they can expect to live without disability.

Figures 1.1 shows life expectancy and disability free life expectancy for females in Thurrock by IMD 2019 deprivation decile. It demonstrates the clear health inequity link between both total life expectancy and disability free life expectancy linked to deprivation, with both measures increasing as deprivation decreases. Only the least deprived 35% of our population are likely to reach retirement age before reaching the end of disability free life. A similar pattern can be observed in men.

Comparative Health Need

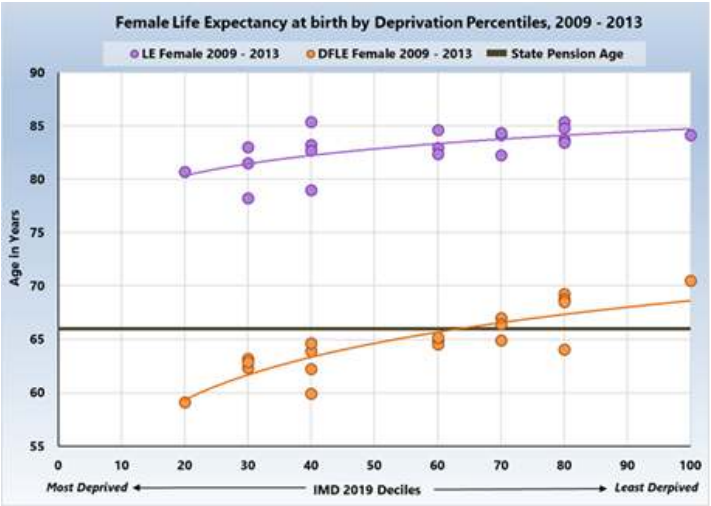
The Mortality Attributable to Socioeconomic Inequality (MASI) index is a measure of the total number of deaths per 100,000 population attributable to socio-economic deprivation. Thurrock has the third worst MASI index in Mid and South Essex, with 2,522 being attributable to socio-economic causes between 2003 and 2018.

Figure 1.3 (overleaf) summarises some of the key health outcome metrics and compares Thurrock to regional and national averages.

Thurrock's population is generally less healthy than that of the East of England and England. This reflects the higher levels of deprivation and health inequalities faced by many of our residents within the borough.

The more flexible way in which Integrated Care Systems can allocate resources presents an opportunity to distribute funding in a fairer and more equitable way to address the needs of Thurrock residents compared to more affluent communities within our ICS geography.

Figure 1.1



1.3 Thurrock's Transformation Journey

Thurrock has a national reputation for excellence and innovation in health and social care, and has been transforming its services since 2011. They key milestones and programmes that make up our transformation journey to date are shown in figure 1.2 below.

Figure 1.2: Thurrock's Transformation Journey

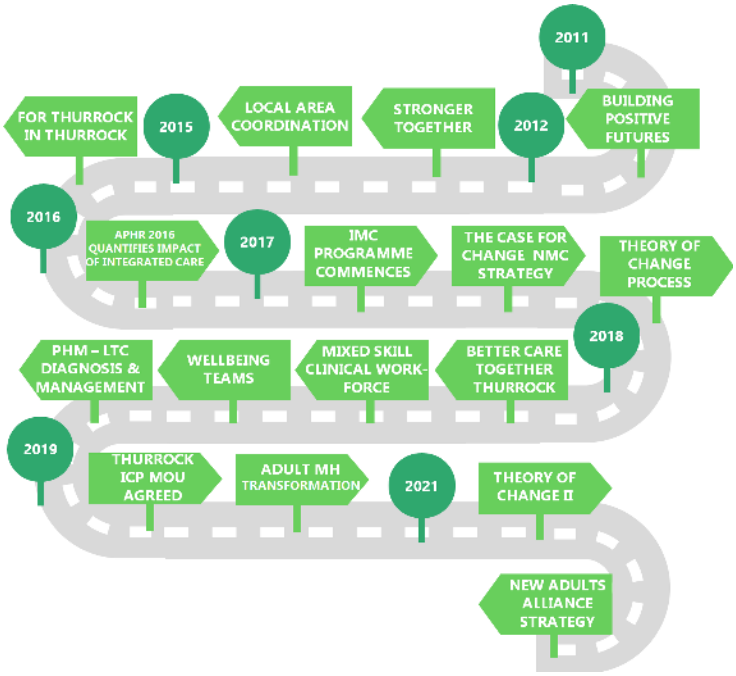
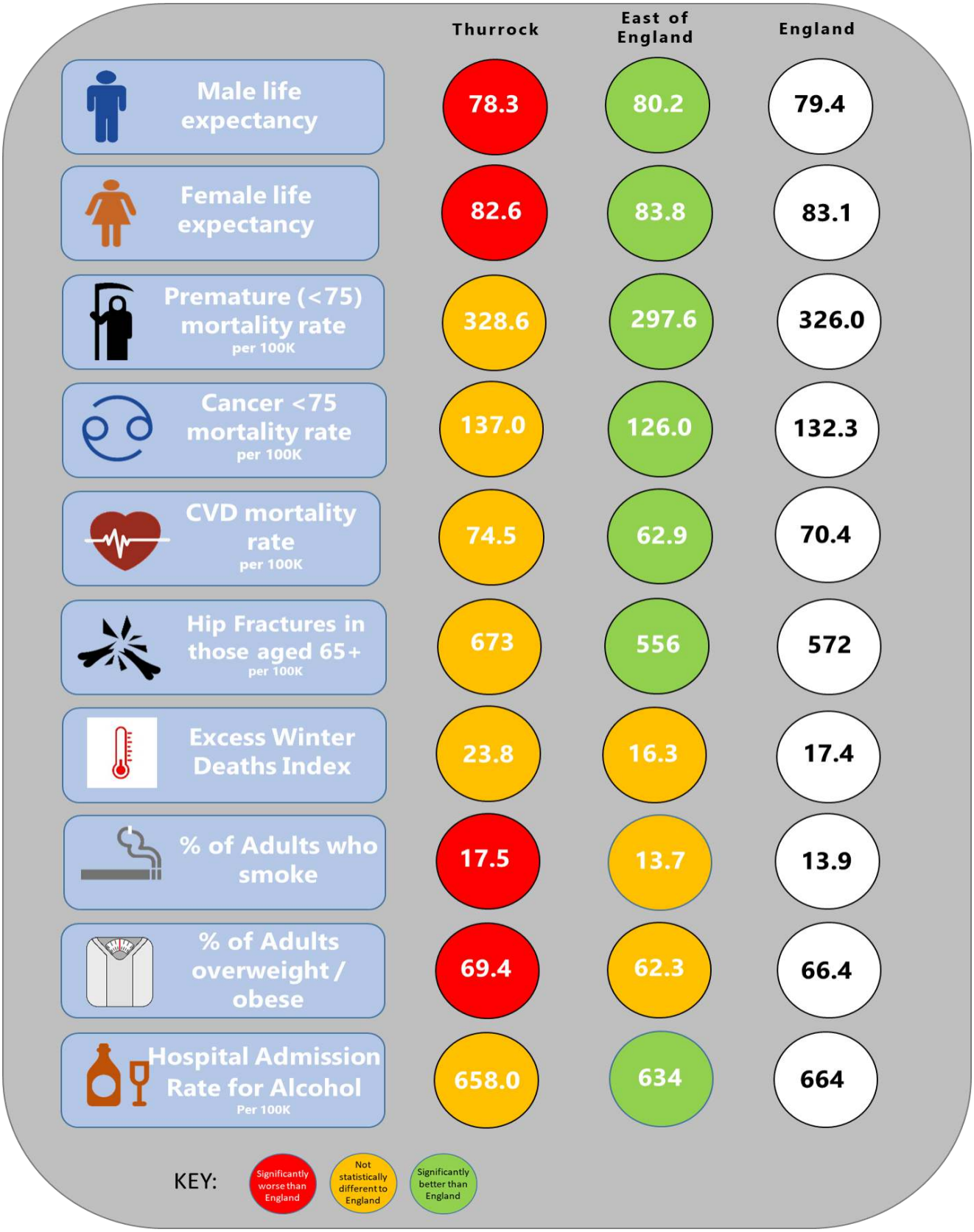


Figure 1.3: Comparative Health Need of Thurrock Residents to East of England and England



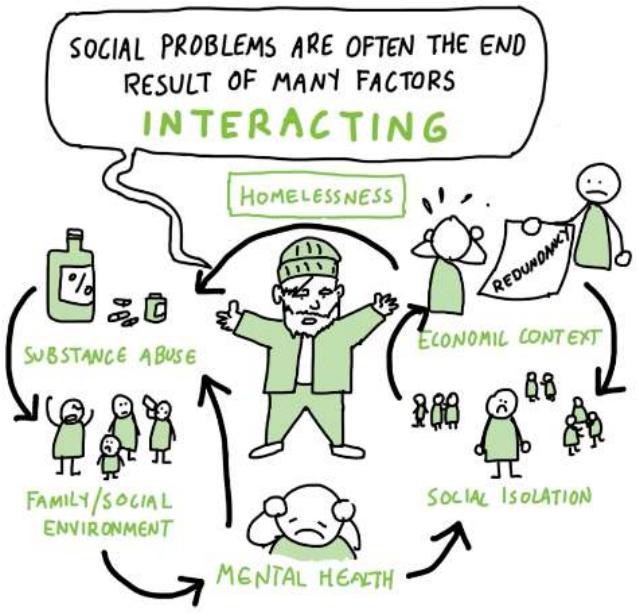
Chapter 2: Our Vision, Aim, Principles and Values

Chapter 2: Our Vision, Aim, Principles and Values

2.1 Introduction

The space in which health, care and wellbeing providers operate is complex and messy because it is based on human relationships, and each one of our residents is unique and complex. If we want to contribute to creating positive social outcomes for our residents, we must learn to embrace this complexity.

- People are complex: everyone's life is different, everyone's strengths and needs are different.
- The issues we are trying to solve are complex; whether it be diabetes, obesity, mental health or homelessness, with many tangled and interdependent causes and drivers
- The systems that respond to these issues are complex: the range of people and organisations involved in creating 'outcomes' for residents are beyond the management control of any one single person, team or organisation.



Complex problems need integrated solutions, yet the way we have designed our system requires residents to access help from many different teams and services that each deal with only one element of the solution. This help is often only available through referrals, assessment and meeting 'threshold' criteria. The more in need the resident is, and the more complex their problem, the more difficult we make it to access help because the greater number of services that need to obtain help from.

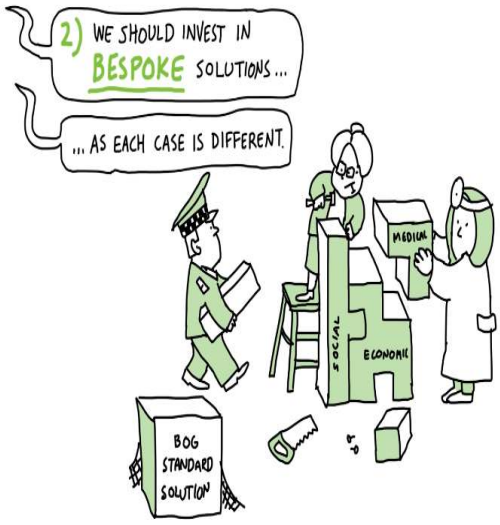
2.2 Human Learning Systems

In Thurrock, we share a collective passion to move from a 'one size fits all', fragmented, top down, centralised and deficit driven approach, to one that recognises human uniqueness and the need to co-design integrated human solutions based on strengths and assets in the context of a whole system managed through learning. This is called a Human, Learning Systems Approach

Human

A human approach to public service means recognising the variety of human need and experience, building empathy between people so that they can form effective relationships, understanding the strengths that each person brings to the relationship and working to create a trusting space from which solutions drop out.

It is about liberating workers from assessments, thresholds, procedures and onward referrals, and empowering them to co-design bespoke integrated solutions with residents that solve their problem. Those solutions are likely to include elements of what has traditionally been delivered by many different teams and organisations. They will also draw on the resources that the resident, their family, friends and community can bring. Commissioners and managers must give up the illusion of control that they can specify solution in advance through detailed service specifications or standard operating procedures.. For example, what works to solve one person's mental health problem may not be effective for another person.



LEARNING

An HLS approach to Learning recognises that in order to design bespoke solutions with residents rather than predetermined interventions, a continuous process of learning is required to discover the right solutions in the context of the individual resident's life, needs and strengths. It also recognises that systems we operate in are in a constant state of change. What works in one neighbourhood may not work in another. What works will change over time. *Continuous learning* becomes the key strategic outcome and mechanism through which we manage the system and leaders need to signal this. We need to commission a learning environment to constantly test, embed and refine *what works*. Our workforce needs to be empowered and given permission to test new approaches and report what works and critically where things don't work or stop working. We need to capture and use data and intelligence in a different way to support learning including qualitative data and resident stories. We need to bring different professionals together to reflect regularly and share learning.

SYSTEM

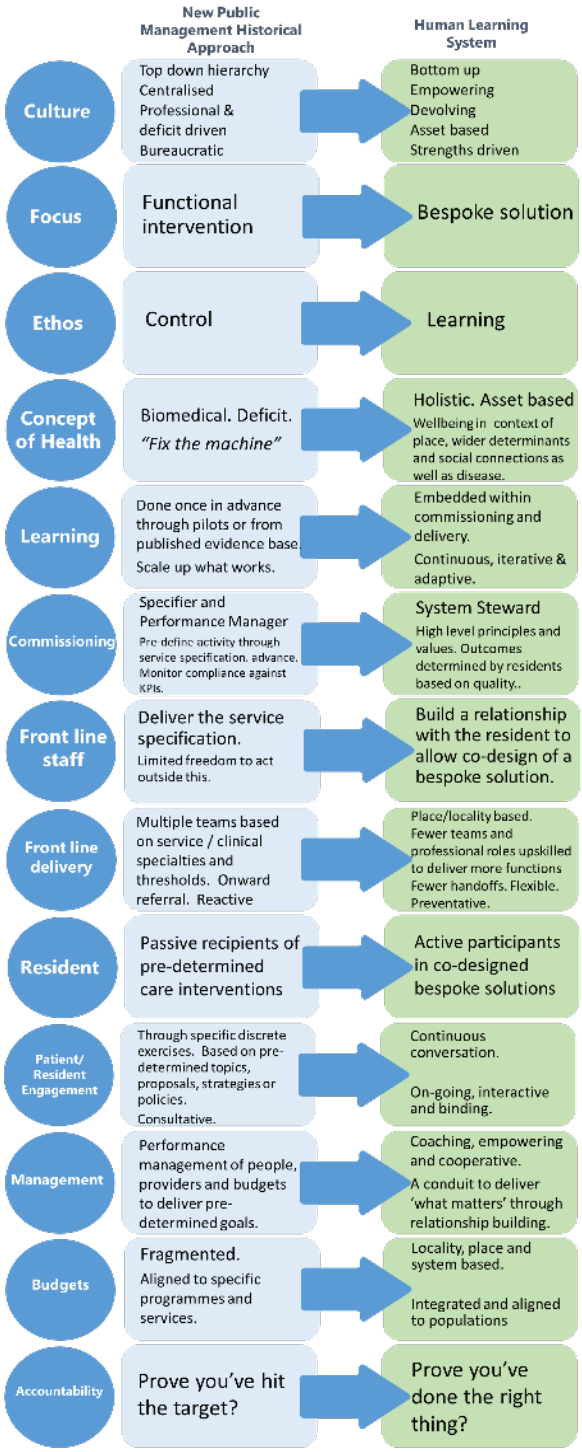
Finally, people adopting an HLS approach recognise that interaction of many variables, services and people working within a whole system that produces outcomes to complex problems, rather than individuals, services, programmes or organisations. Consequently, to improve outcomes, we must create healthy systems in which people are able to coordinate and collaborate more effectively.

The role of leaders and commissioners shifts from one of specifiers and performance managers to 'system stewards', improving the health of the system and fostering trust and collaboration between all of the actors within it. It means agreeing the scope of the system, and developing a shared vision and purpose amongst the all within it.

Implementing an HLS Approach in Thurrock

Many of the most successful elements of our local transformation programme to date are already working using HLS principles. These include Local Area Coordinators, Community Led Solutions, Wellbeing Teams and our new Integrated Primary and Community Mental Health Teams. They are delivering outcomes for residents by freeing staff from pre-defined service specifications, KPIs and bureaucracy and empowering them to co-design solutions with residents.

However, our successes still operate within a wider context of 'old world' *New Public Management* thinking with too many fragmented services delivering pre-defined tasks based on deficits that we determine are important to 'fix'. Moving forward, we will transform our entire Alliance on HLS principles. The change we will create is set out overleaf.



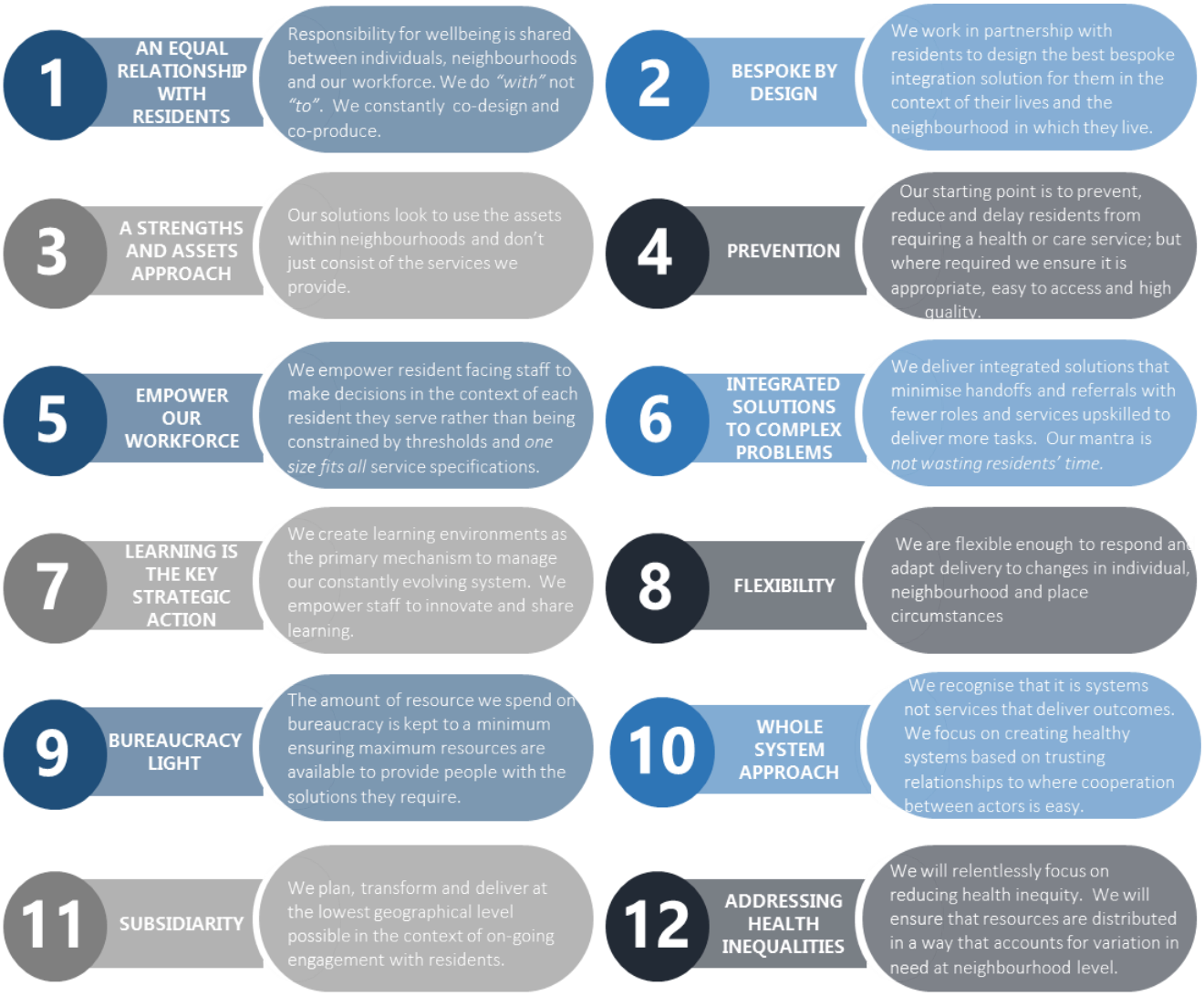
2.3 Our Shared Goal and Principles

In 2020, Thurrock CVS facilitated a second *Theory of Change* process consisting of a series of workshops that brought Thurrock's health, care, well-being and third sector system leaders together to debate and agree our vision, goals and principles that under pin our local transformation.

Our Overarching Goal

Better outcomes for individuals, that take place close to home and make the best use of health and care resources.

Our 12 Principles



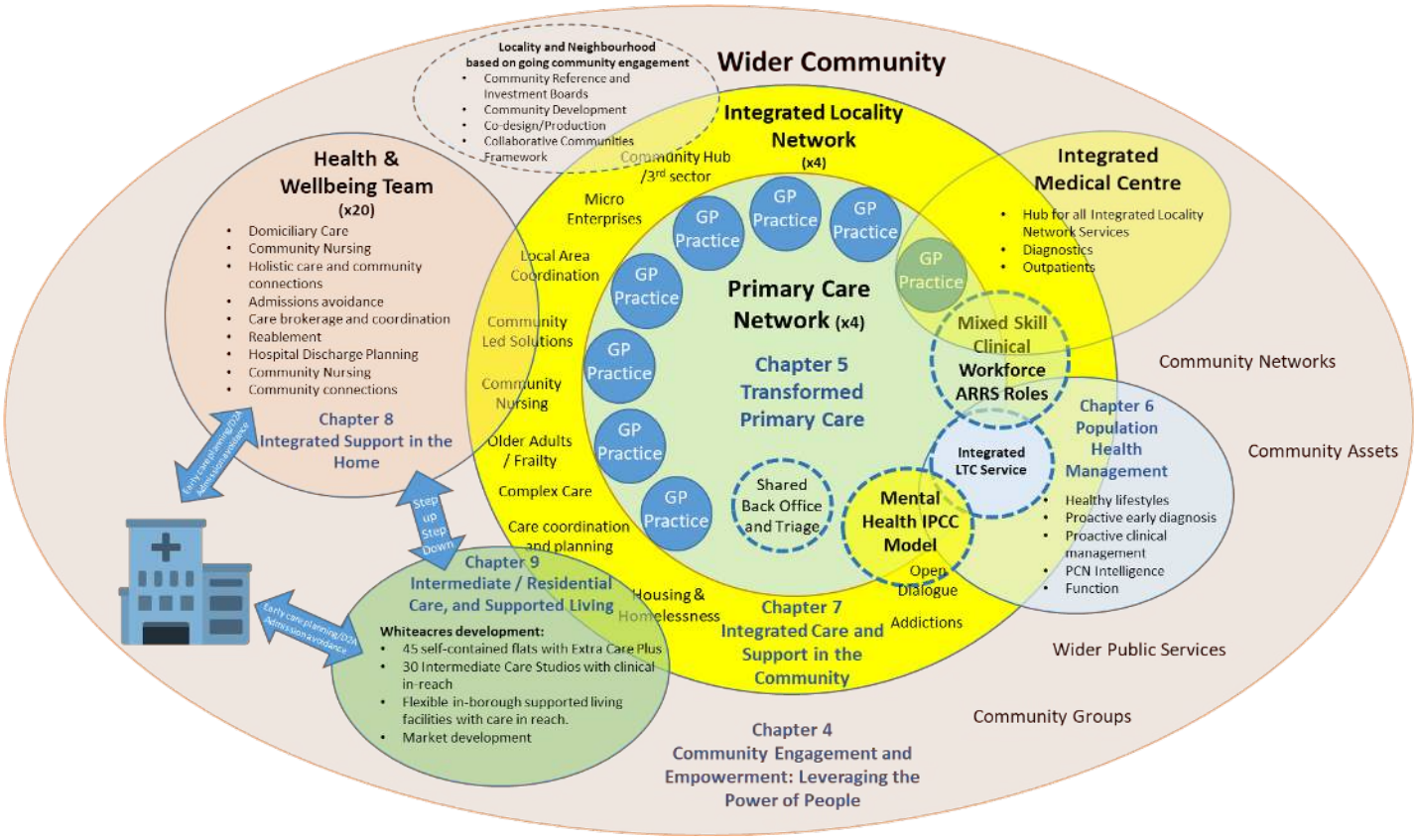
In developing a whole system approach to health and care transformation, we have tried to make it as easy as possible for front line staff to collaborate with each other and residents to co-design single integrated solutions, keeping bureaucracy, assessment and onward referral to an absolute minimum, freeing up staff to spend more time delivering care.

Figure 3.1 shows our re-imagined and transformed system, our Integrated Wellbeing Model and the remaining chapters within this strategy to provide more detail on each element:

Chapter 3: Our Integrated Wellbeing Model

Chapter 3: Our Integrated Wellbeing Model

Figure 3.1



Our overall model of integrated care is set out in figure 3.1. Its constituent elements are described in detail in the main strategy and summarised in Chapters 4 to 9 of this Executive Summary.

In developing a whole system approach to health and care transformation, we have tried to make it as easy as possible for resident facing staff to collaborate with each other and with residents to co-design single integrated solutions, keeping bureaucracy, assessment and onward referral to an absolute minimum, freeing up time to spend more time delivering care.

At the heart of our model sits transformed Primary Care Networks (PCN) (Chapter 5) and an Integrated Locality Network of Community Support (Chapter 7) that wraps around it. Our approach to transforming care from reactive to proactive and preventative is set out in Chapter 6.

Care at Home is delivered via our new Health and Wellbeing Teams model (Chapter 8), that brokers support from the Integrated Locality Network, and also encompasses reablement and proactive hospital discharge planning. Our new vision for Residential and Intermediate Care is set out in Chapter 9, and like Wellbeing Teams, the model also encompasses clinical in reach from the Integrated Locality Network and supports hospital discharge.

The power of people, communities and assets, and of 'doing with' not 'doing to' runs through the entire strategy, but our approach to community development, co-design/production and leveraging the power of communities is also described in the next chapter. (Chapter 4).

Chapter 4: Community Engagement and Empowerment

Leveraging the Power of People

Chapter 4: Community Engagement and Empowerment. *Leveraging the Power of People*

4.1 Introduction

Our partnership with the strong, diverse and vibrant communities that we serve is at the heart of everything that we do in Thurrock. We are incredibly fortunate to have a vibrant and committed community and voluntary sector within the borough, and we are rightly proud of our deep and long-term relationship with them, cemented recently through Thurrock Council's Collaborative Communities Framework.

Involving the community and its assets can have a very positive impact upon the delivery of solutions that support improved health and well-being in our citizens. Power and influence sharing techniques, such as co-production and co-design, have a been proven to deliver better services and outcomes for residents.

4.2 Asset Based Community Development

Asset Based Community Development (ABCD) is a powerful method for facilitating the shift in power essential for successful transformation in the Thurrock model; shifting people away from being passive recipients of service to active citizens fully engaged in their health and well-being. Its premise is that communities themselves can drive real improvement in wellbeing by mobilising existing but often unrecognised assets. As a challenge to established forms of commissioning and delivery it asks that we consider:

- What can communities can do for themselves if professional services get out of the way?
- What can communities do with some support from organisations?
- What is left that is appropriate for organisations to deliver?

Thurrock already has a number of key operations and personnel that operate within their communities and are accessible to citizens in a range of ways including:

- Community Builders
- Social Prescribers operating from GP surgeries
- Talking shops based within the community led by our Community Led Solutions Teams
- Community Hubs that allow residents to meet, access information and support and reflect on local issues and solutions.
- Micro Enterprises; support to residents to set up small businesses that provide community support.

Communities of Practice (CoPs)

We will build on this success by setting up two Community of Practice (CoPs), one resident led and a second for staff involved in the direct delivery of care. A CoP can been defined as *"a process of social learning that occurs when people who have a common interest in a subject or area collaborate over an extended period of time, sharing ideas and strategies, determine solutions, and build innovations".*

In Thurrock we will use this mechanism to establish two Communities of Practice on each of the four PCN footprints to bring together people with vested interests in those locales to ensure delivery and design are coordinated and based upon community concerns and choices.

Improving local intelligence

We need to improve the collection of local intelligence without adding to the burden that local communities feel when constantly being asked to respond to consultations. One obvious way would be to capture intelligence from interactions between professionals and members of the public to inform priority setting and future transformation. We will deliver this through procurement and use of the Air Table system that captures and analyses themes from intelligence gathered from resident facing staff.

Resourcing the Community

In order to break down silo budgeting, we need to create four genuine pooled funds at locality level. These funds can then be used from which to commission integrated services that respond to the needs and deliver the solutions identified within the four localities. Figure 4.1 sets out our approach. We will create four Community Reference and Investment Boards and pooled funds through which local priorities can be agreed and solutions to address them commissioned, with a wide range of community representatives to oversee the process. A shared fund provides the opportunity to commission genuine solutions at place and neighbourhood level to address resident concerns and represents genuine power sharing. A fund held by the third sector also has the opportunity to attract additional grant and private sector funding.

Figure 4.1

Micro Enterprise Development

Since the inception of the programme in 2015, we have supported the development of well over a hundred micros enterprises. They provide a variety of services, the majority in the care and well-being sector. These enterprises have added a hugely positive dynamic to the communities they serve, and their success has generated much interest, hence the continued expansion of Micros. The programme supports the local economy with bespoke, person centred services and has social benefit for both the people both receiving and providing the service.

Thurrock currently has one full time officer supporting this programme who is becoming increasingly stretched as more services require support. There is a danger that we are missing out on the establishment of a range of local entrepreneurs, with excellent ideas, who could provide exciting and much needed local economic activity, whilst also creating a very positive impact upon their own, and others, well-being and sense of purpose.

We will therefore expand the programme to deliver a "Community Economic Unit" (CEU), in each of the Primary Care Network areas, that could support both the ongoing development of Micro Enterprises and provide the kind of practical advice and guidance needed to support other forms of community economic development. CEUs will work closely with the new Community Reference and Investment Boards.

SUMMARY OF STRATEGIC ACTIONS

4.1 We will adopt a new approach to integrated commissioning and delivery of health, housing and third sector services based on Human Learning System principles.

4.2 We will build *User-Led* and *Direct Delivery* Communities of Practice within each PCN footprint, piloting in one PCN locality and scaling up as the mechanism to foster innovation and continuously learn and adapt 'what works'.

4.3 We will commission the *Air Table* system to provide the infrastructure to capture intelligence from resident facing staff and residents to inform our transformation continuously.

4.4 We will create four Community Reference and Investment Boards and four pooled funds at PCN/locality level to drive integrated commissioning and power sharing with residents.

4.5 We will build on the success of the Micro Enterprises scheme to create a Community Economic Unit (CEU) within each PCN/locality geography to drive community economic development.

Chapter 5: Transforming Primary Care

Chapter 5: Transforming Primary Care

5.1 Introduction

Ensuring high quality Primary Care that is easy to access and responds both proactively and reactively to resident need is fundamental for improved population health and system sustainability. Primary care is the healthcare setting most accessed by our residents. It acts as the gatekeeper for a wider range of more specialist services and is the setting in which most secondary preventative activity is delivered that keeps residents with long term conditions as well and independent as possible. Poor quality, inadequately resources and difficult to access primary care will inevitably lead to both preventable and avoidable serious adverse health events and drive residents to more expensive elements of the health and care system, most typically hospital through A&E.

There are 27 different GP practices in Thurrock, operating over 38 premises. Quality in terms of CQC ratings has improved significantly during the last six years but since the inception of the NHS in 1948, the model of primary care has changed little, with surgeries operating as separate small businesses. This model worked well for much of the last century, where the primary needs of patients related to acute illness and episodic care. However, in today's world where the majority of the NHS budget is spent on treating long term chronic conditions, it is no-longer fit for purpose:

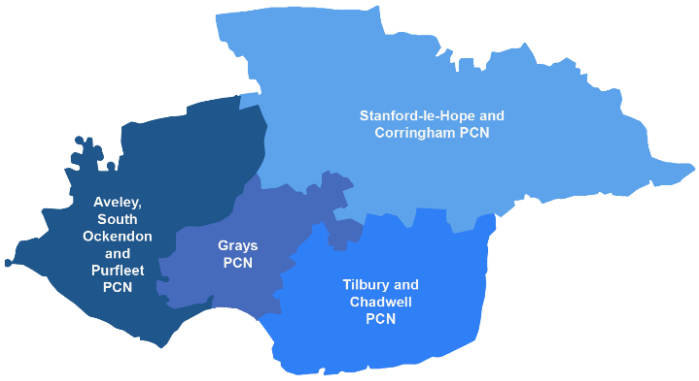
- There are too many different operating models between practices making it difficult to adopt best practice borough wide
- There is significant variation in workforce skill and speciality between practices, with barriers to sharing workforce skills
- Resilience at individual surgery level remains low in some cases.
- Investment and capacity in individual surgeries varies and does not necessarily adequately reflect variation in practice population need. Too often, the most deprived populations face the worst ratio of clinicians to patients.

The inception of new Primary Care Networks where surgeries come together over a larger geographical footprint to collaborate and share resources provides an opportunity to reimagine how we deliver a general practice model fit for the 21st century. We need to drive improvement in access and quality and address variation, levelling up the provision of care within all of our surgeries around best practice and capitalising on the 'at scale' opportunities that PCNs bring.

We also want to foster greater integration of practices and PCNs with the wider community services through the development of blended roles that work beyond organisational walls to deliver coordinated and joined up care in conjunction with other community services.

Thurrock has four PCNs based around the four locality geographies set out in figure 5.1. Each has a designated Clinical Director, who are General Practitioners from local member practices, to drive their development. We will seek to organise all future health and care services around these four localities wherever possible.

Figure 5.1 - The four Thurrock Primary Care Networks



5.2 Improving Primary Care Access

Primary Care is currently under enormous pressure with demand for appointments are currently at record highs. caused by the temporary scaling back of some services during 2020/21 in order to free up capacity to respond to the COVID-19 pandemic. Although the number of appointments offered is now higher compared to pre-pandemic levels, demand continues to outstrip supply. Where routine monitoring of non term conditions were paused, patients are now presenting with more complexity with multiple pathologies requiring more frequent and regular appointments. Backlog in the other parts of the health and care system has also had an adverse impact on primary care, stretching capacity further.

Old telephony systems have been unable to cope with new demands placed upon them caused by the increased demand and increased use of telephone consultations. This has further added to the frustrations of residents who are either unable to get through on the limited telephone lines available or have to wait for a long time before they can speak to a receptionist or clinician.

The national patient satisfaction survey shows satisfaction amongst our residents with GP access to be significantly worse than England's with dissatisfaction on four key access metrics being lower than England's in every PCN area except Stanford le Hope with the lowest levels found in ASOP PCN area.

Analyses by the Thurrock Public Health Team also showed that appointment availability correlated poorly with overall population health need within different PCNs, with the greatest level of inequity between appointment availability and population health need found also in ASOP. By triangulating these data, we can see that in order to improve resident satisfaction with access, we need to both ensure that appointment availability adequately reflects variation in need, and ensure that as a minimum, the same level of equity between need and availability enjoyed by Stanford-le-Hope residents is replicated in every PCN area.

How We Will Improve Access

Levelling Up Through Investment to Close the Equity Gap

We will use Stanford-le-Hope as a baseline for equity, and seek to bring appointment availability in the three other PCNs up to their level of equity, essentially "levelling up". As future growth funding becomes available, we will prioritise investment in a way that first closes the equity deficit between ASOP and Thurrock and then brings appointment availability of all PCNs up to the level of equity against population need found in Stanford-le- Hope.

Integrated Medical Centres

Mid and South Essex Health ICS, local NHS providers and Thurrock Council have a shared commitment to build four new Integrated Medical Centres (IMCs) in the borough, one per locality and provide a wide range of integrated health, care and third sector provision. Each IMC will contain at least one GP practice and will act as a locality hub from which a wide range of additional services for all practice populations and staff within the PCN can benefit.

IMCs will provide wrap around services to the entire PCN and be an attractive place for clinicians to practice, making it easier to attract the brightest and best to the borough.

The wide range of additional support provided from each IMC working in a coordinated way to a single integrated model will make most efficient use of resources, ultimately impacting positive on access and freeing GP time to concentrate on more complex patients.

A Mixed Skill Clinical Workforce

Our 2017 *Case for Change* strategy highlighted research suggesting that for 27% of GP appointments, the resident would have been better served by having direct access to a different type of health professional, avoiding the need for on-ward referral.

Since 2017, we have made considerable investment into these additional clinical roles, initially in Tilbury and Chadwell, and more recently within other PCNs. We will build on this existing workforce through the new NHS England Additional Roles Reimbursement Scheme to recruit a wide range of additional clinical roles to each PCN including physiotherapists, clinical pharmacists, mental health practitioners, nursing associates, OTs, and paramedics. Recruitment will be based on a workforce skills gap analyses.

Cloud Telephony System and Standardisation of Patient Triage

It is imperative that the existing GP telephony systems are upgraded to improve access and general practices' ability to embed new models of care. We are piloting an innovative project incorporating cloud-based telephony run by specialist staff in care navigation in two PCNs. Operating at PCN rather than practice level, this also frees up individual practice telephone lines for virtual consultations. If successful we will seek to roll out across the borough.

It is envisaged additional functionality such as direct booking for same day face to face appointments in community pharmacies could be added to this service during the pilot phase.

New ways of working – Virtual triage, Online and Video Consultation

Although there has been concern raised both nationally many residents find telephone or technology appointments more convenient, particularly for routine issues as it saves an unnecessary trip to the surgery. Moving forward, we need to implement a hybrid model that both provides choice and delivers the maximum number of appropriate appointments from the workforce capacity that we have available.

Implementation of virtual triage, increased use of digital platform and video consultation work was being undertaken prior to the COVID-19 pandemic, however due to the nature of the changes required to ensure continued access to Primary Care during the pandemic, this work will be accelerated to meet demand.

We will also seek to leverage the positive impact that our single point of contact - ***Thurrock First*** has on preventing avoidable demand on primary care by delivering a comprehensive communications campaign to increase resident knowledge of the service and what it can offer.

5.4 Improving Quality and Addressing Variation in Outcomes

There is currently significant and unacceptable levels of variation in health outcomes for residents between different practice populations both within Thurrock and nationally.
The reasons behind variation in outcome are likely to be complex and multifactorial and include differences in practice population based need and behaviour. However variation in funding, workforce, estate, operating models and silo working are likely to also be causes.

5.4.2 How we will Reduce Variation in Outcome and Improve Quality

Integration and the Sharing and Standardisation of Best Practice at PCN and Locality Level to "Level Up" Quality.

The recent formation of Primary Care Networks provides a huge opportunity to reimagine how we deliver primary care to our residents over a wider footprint, sharing clinical capacity, best clinical practice, back office function and intelligence to "level up" the quality of care delivered to every resident. We will use the newly formed Clinical Professional Forum and Network meetings as a mechanism to share best practice and facilitate collaboration.

We will also encourage PCNs and Practices to provide certain back-office functions and clinical services collaboratively from a merged central location. This will not only help rationalise and make best use of existing estates and address variation but will also reduce duplication and drive efficiencies.

To facilitate a more consistent way of working for the ARRS staff, every PCN will be offered a PCN wide clinical SystmOne unit which both PCN practices and ARRS staff have access to. This will allow ARRS staff to access the record of any patient registered within the PCN without the need to travel to the individual surgery to which the patient is registered, reducing travel time and empowering staff to design and deliver PCN wide clinical services. We will also develop single integrated Long Term Conditions Management Services at PCN level providing a 'one stop shop' where patients with multiple long term conditions can receive holistic treatment for all conditions in one go, reducing duplication and allowing better cohorting of patients at different levels of risk.

Improving Quality through Continuity of Care

Evidence suggests that providing continuity of care in primary care, i.e. being able to see the same clinician on many different occasions is important for many residents, particularly those with more complex needs and multi-morbidity. We will support surgeries to develop clinical operating models at PCN level that prioritise continuity of care where possible.

Supporting Integration through Commissioning

We will support integration at PCN level by ensuring that future enhanced non-core services are commissioned on PCN footprint. This will encourage greater integration of PCN member practices and drive standardisation and inequity in outcome. We will start by commissioning our Stretched QOF contract at PCN level.

Quality & Patient Safety and Education

We will engage with practices to reinstate the pre-covid face to face proactive practice visits with joint CCG and Public Health teams so that a holistic overview of the practice can be taken to share best practice and provide support in required areas of concern. We will also seek to build on previous good practice, looking not only at quality at practice, but at PCN level and replacing annual profile cards with real time data through building informatics capacity within each PCN. This approach is discussed in more detail in the next chapter.

We will prioritise performance improvement on LD and SMI health checks, connecting practices with additional support through Thurrock Lifestyle Solutions and by ensuring EPUT Mental Health Practitioners are embedded in every PCN.

Alongside national and MSE wide communications strategies, we will undertake further work ito communicate new models of care locally to residents by various methods of patient education. We will use the Community Reference Boards and Communities of Practice to involve patients in co-designing new service models.

Desired Outcomes

- A levelling up of the Primary Care offer across Thurrock with appointment levels against population need at least in all PCNs as good as the level of equity currently available within the Stanford-Le-Hope PCN
- At scale provision of many Primary Care services at PCN rather than practice level, with improved sharing and clinical skill mix and adoption of best clinical practice within all surgeries
- Development of blended staff roles able to deliver a broader range of functions, and integration between Primary Care staff and wider health and care services at PCN/locality level.
- Improvement in patient satisfaction across the borough to at least the level currently experienced only in Stanford-le-Hope PCN
- Residents actively engaged in co-design of on-going Primary Care transformation
- A shift from reactive to preventative care
- Improved continuity of care.
- Fit for purpose estates to provide integrated services, e.g. Integrated Medical Centres, supporting practices with their Estate Improvement Plans.

Chapter 6: Improved Health and Wellbeing Through Population Health Management

From reactive to proactive care

Chapter 6: Improved Health and Wellbeing through Population Health Management

6.1 Introduction

Too often, our health and care service waits until people become seriously unwell before providing a service. We need to shift focus from this 'reactive' care model to one that is genuinely proactive and preventative; empowering residents to address unhealthy behaviours, diagnosing chronic disease conditions earlier and providing high quality clinical management to ensure people can stay as healthy as possible for as long as possible. Population Health Management (PHM) – using integrated data and intelligence to identify risks earlier and intervene provides new opportunities to tailor proactive care at different cohorts of residents to improve their health and manage their long term conditions. Thurrock has been an early adopter of population health management approaches and our PHM approach has already significantly improved cardio-vascular disease outcomes in our population and prevented hundreds of strokes and heart attacks. But to date, this work has largely been delivered in clinical silos, considering different conditions in isolation, and in organisational silos, focusing action and individual GP surgery level.

Chapter 6 sets out the next phase of our transformation on proactive and preventative care and a detailed PHM strategy for Thurrock. This Executive Summary is only able to pick out some of the highlights.

6.2 Segmenting the Thurrock Population

Figure 6.1 shows a high level segmentation of Thurrock residents aged 18+, considering the total spend on Adult Social Care and hospital A&E attendance and inpatient services (both elective and emergency). It demonstrates that almost 50% of the total Adult Social Care, A&E attendance and Hospital Inpatient budgets is attributable to only 1% of the population, with a 6% consuming a further 35% of the budget. The characteristics of the different population segments are different and in order to deliver better health outcomes for residents and make our system more financially and operationally sustainable we need to tailor different care interventions at different population cohorts, and act in a proactive way to prevent residents health deteriorating and moving upwards through the segments.

Figure 6.1

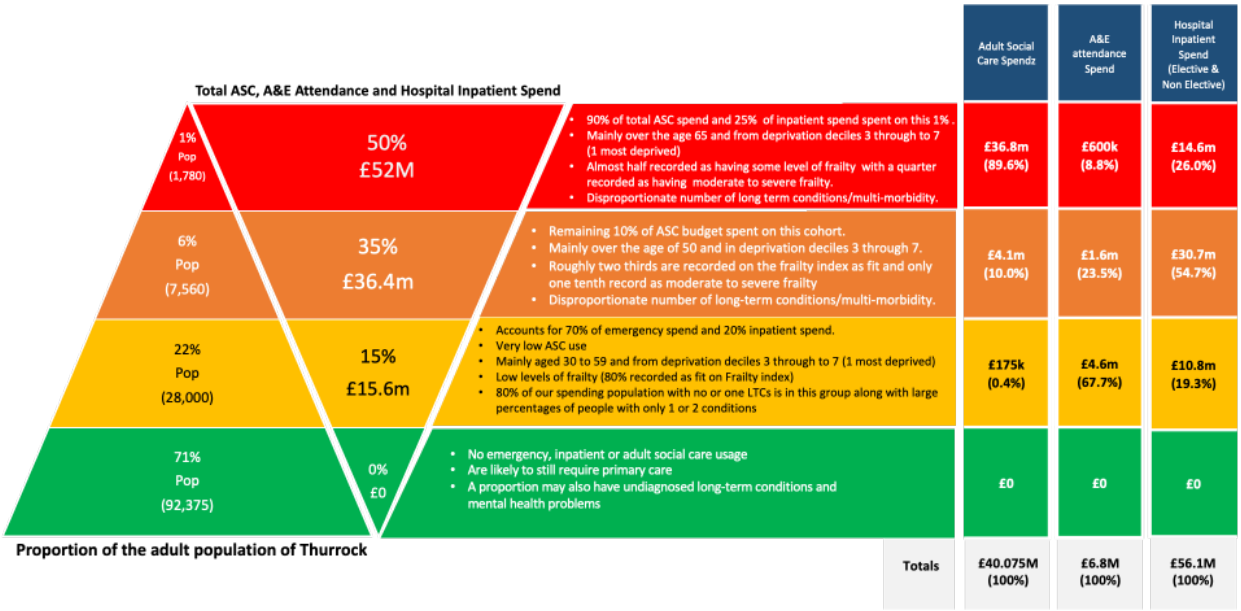
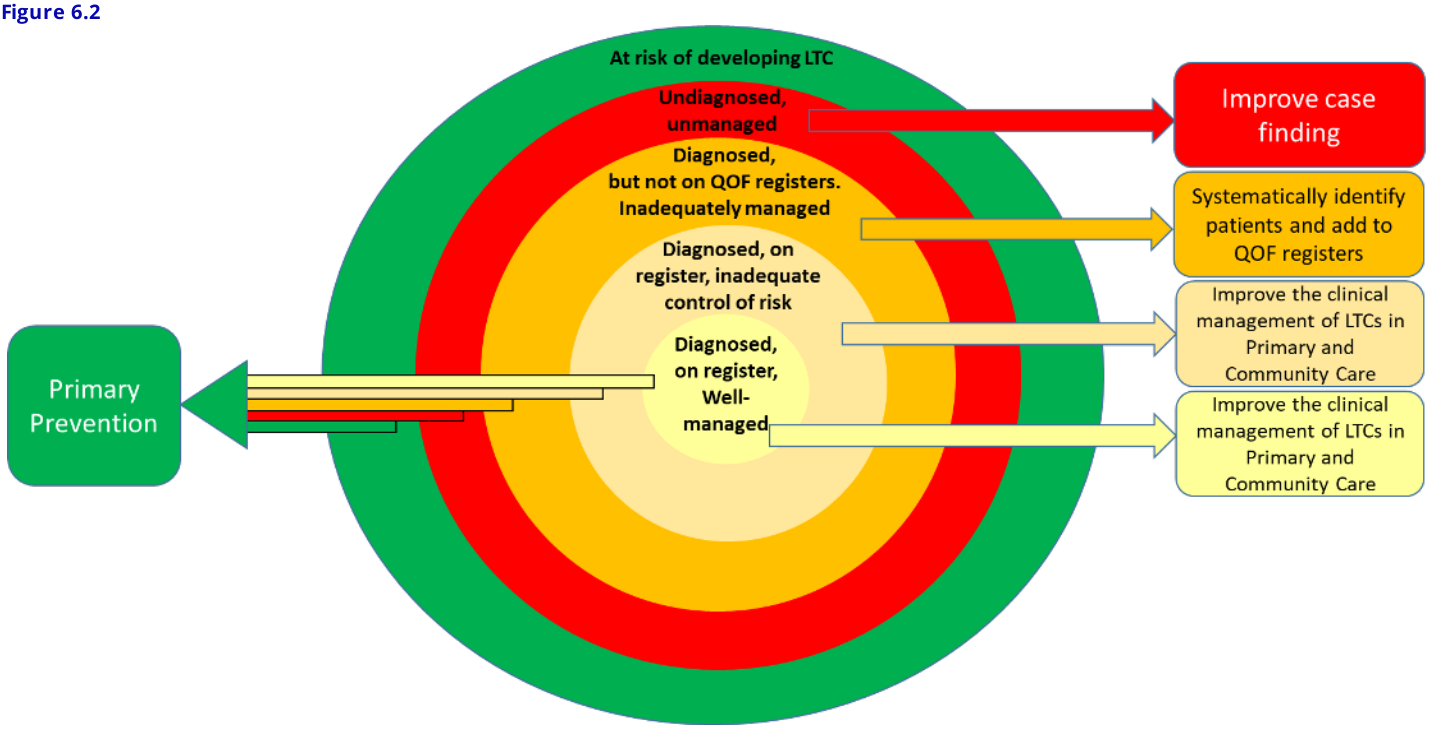


Figure 6.2



As a population, we are living longer but not necessarily healthier lives. Increasingly, residents are living with one or more chronic health conditions like diabetes or high blood pressure that can be treated but not cured. 70% of the NHS budget is now spent on managing these types of condition..

More than one-third of our residents have already been diagnosed with at least one long-term condition, and of this cohort, 43% have been diagnosed with two or more conditions.

Many more have conditions that remain undiagnosed or treated, or have behavioural risk factors like smoking and obesity that put them at elevated risk of developing long-term conditions in the future.

We can further segment our population into risk cohorts based on long-term condition risk, as shown in figure 6.2 and tailor different proactive interventions to them in order to help them stay as well and independent for as long as possible.

6.3 Primary Prevention

Primary prevention refers to programmes or activity that prevent disease occurring by modifying risk. As noted in chapter 2, the two biggest risk factors within our population of smoking and obesity where Thurrock has significantly greater prevalence compared to England and regional averages. We calculate the cost of smoking along in Thurrock to be £42.6M

Both of these issues are complex and multifactorial. We need to address them through whole system approaches.

Both of these issues are complex and multifactorial. We need to address them through whole system approaches.

On smoking, we will bring forward and implement a whole systems strategy to Tobacco Control based on the detailed analyses contained within our recent Tobacco Control JSNA.

We will also re-launch the Tobacco Control Alliance to oversee the implementation of the strategy and provide system leadership to reduce smoking prevalence. We will also embed a smoking cessation offer within clinical pathways in community and secondary care services, prioritising mental health, cardio-vascular and respiratory services. Finally, we will align our current Thurrock Healthy Lifestyles Service within the four integrated care models that we will build around the four PCNs.

On obesity, Thurrock has already developed a Whole Systems Obesity Strategy and approach, centred around five goals relating to children and young people/schools, community activity, improving the food environment, increasing physical activity, and the better identification and treatment of obesity.

We will refresh and review the action plans that sit under the strategy in light of the COVID-19 pandemic and restart the approach based on Human Learning System principles.

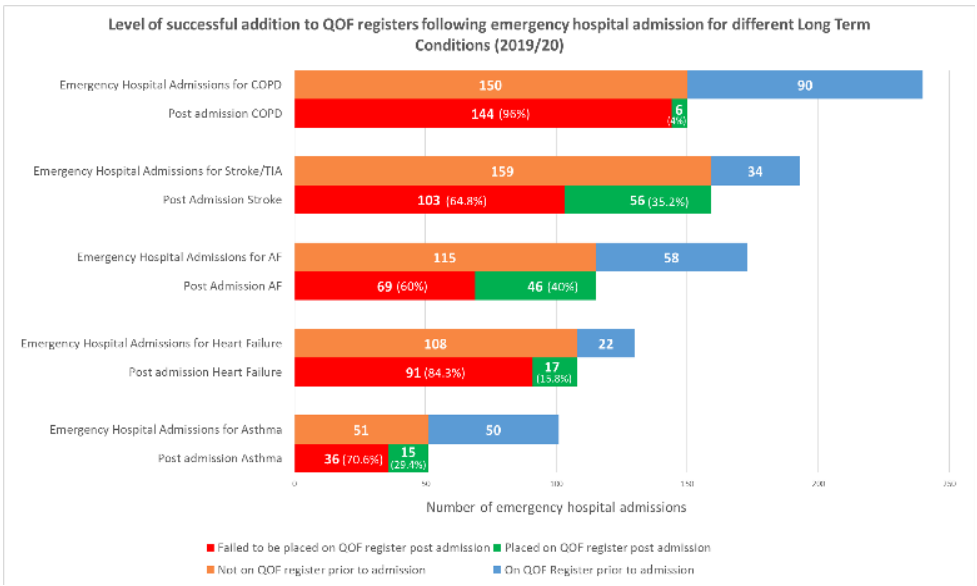
We will also build on the successful pilots in Stanford and Corringham PCN to use Population Health Management techniques to deliver holistic and personalised responses to residents at high risk of obesity.

6.4 *Find the missing thousands.* Improving diagnosis of undiagnosed long term conditions.

We know that many residents in Thurrock are living with long-term health conditions that remain undiagnosed and therefore untreated. Over 11,000 of our residents have undiagnosed high blood pressure, over 8,000 have undiagnosed Coronary Heart Disease and over 7,000 have undiagnosed depression.

Our analyses also shows us that these undiagnosed cohorts of residents are at significantly increased risk of hospital admissions and that the majority of hospital admissions for the most common long term conditions are in those who were not on GP Quality Outcomes Framework Disease registers and so were not getting proactive treatment and management for their conditions to keep them well (the orange bars in figure 6.4 below). More extraordinarily, even after a hospital admission for their condition, only a small minority were placed on the correct QOF register to ensure they received systematic preventative care (the green bars), with the vast majority (the red bars) remaining untreated.

Figure 6.3



Diagnosing and treating residents with undiagnosed chronic conditions highly cost effective in preventing serious health events and avoidable hospital demand. For example, for every 15 residents with undiagnosed high blood pressure that we diagnose and treat, we prevent one hospital admission that year for stroke.

We calculate that **there is a total opportunity to prevent up to 546 hospital admissions for stroke, heart failure, COPD, atrial fibrillation, diabetes and high blood pressure** amongst Thurrock residents by more effective diagnoses and treatment of the undiagnosed. **We estimate that this would save over £5.4M to NHS and almost £2.6M to adult social care budgets in Thurrock every year.**

Action we will take to improve the diagnoses of undiagnosed long-term conditions (Case Finding).

The main strategy sets out detailed action that we will take systematically to improve the diagnoses of long term conditions. This includes expanding our existing successful hypertension case-finding programme to include Atrial Fibrillation and depression through use of our Stretched QOF contract and bringing forward a detailed Case Finding strategy in 2022/23 co-designed with local clinical leaders. We will embed opportunistic case-finding in settings where evidence suggests it yields the greatest results including AF case-finding as part of flu vaccination clinics and community podiatry clinics.

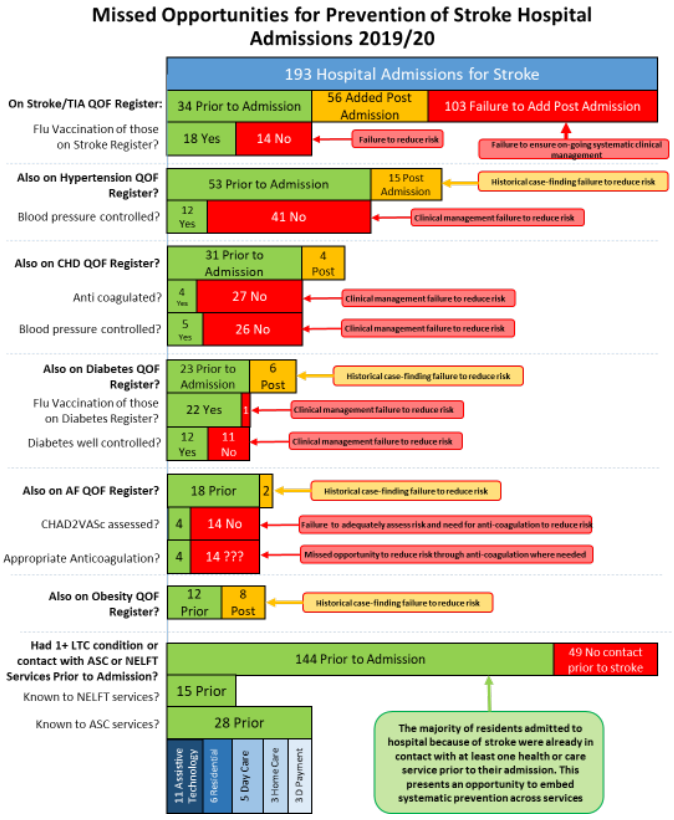
We will also exploit the capabilities of integrated data to improve diagnoses and treatment. For example, we will construct automated reports that will interrogate prescribing, primary care and hospital datasets to identify patients likely to have been diagnosed with long-term conditions but who have not yet been added to QOF disease registers and so will not be receiving systematic preventative care. We will also use linked patient data set and informatics capabilities to flag for review or automatically write patients details where diagnosis is confirmed in hospital, back onto GP QOF records to ensure systematic preventative care starts within the community following a hospital admission.

6.5 Improve the Clinical Management of Residents with Long Term Conditions. *Treat the Missing Hundreds.*

Almost four in ten of our adult residents have already been diagnosed with a long-term condition and are receiving clinical management in primary care via the QOF contract. The majority are well managed and their conditions well controlled, a significant minority do not receive the most effective care to keep them well. Our analyses shows that it is this cohort that remain at greatest risk of hospital admissions.

This can be demonstrated in figure 6.4 below, which through Thurrock's integrated data capabilities can now identify multiple 'up-stream' prevention failures in those 193 residents admitted to hospital because of a stroke/TIA in 2019.

Figure 6.4



There were a total of 91 case finding failures pre admission and a further 103 stroke patients failed to be added to the Stroke/TIA QOF post admission, substantially increasing the risk of on-going failure of secondary preventative activity, systematic clinical management and further strokes.

In addition, there were at least 147 missed opportunities relating to optimal clinical management prior to stroke admission that increased residents' risk of a stroke. These included failure to control high blood pressure, failure to control diabetes, and failure to assess vascular risk score and anti-coagulate appropriately.

It is also striking that of the 193 admissions, 144 were already receiving care for a long-term condition from their GP and/or NELFT, and/or services from Adult Social Care. This demonstrates the opportunity for embedding systematic action to improve long-term conditions care across the wider local health and care workforce, rather than delivering it through silos within primary care.

Through analyses set out in the main strategy using our linked data, we estimate that **there is a potential total opportunity to prevent 384 hospital admissions** in Thurrock residents for stroke, heart failure, atrial fibrillation, high blood pressure and diabetes through optimising long-term condition management and that in doing so **we could prevent £2.1M of cost to local NHS budgets and a further £837K of cost to Adult Social Care budgets.**

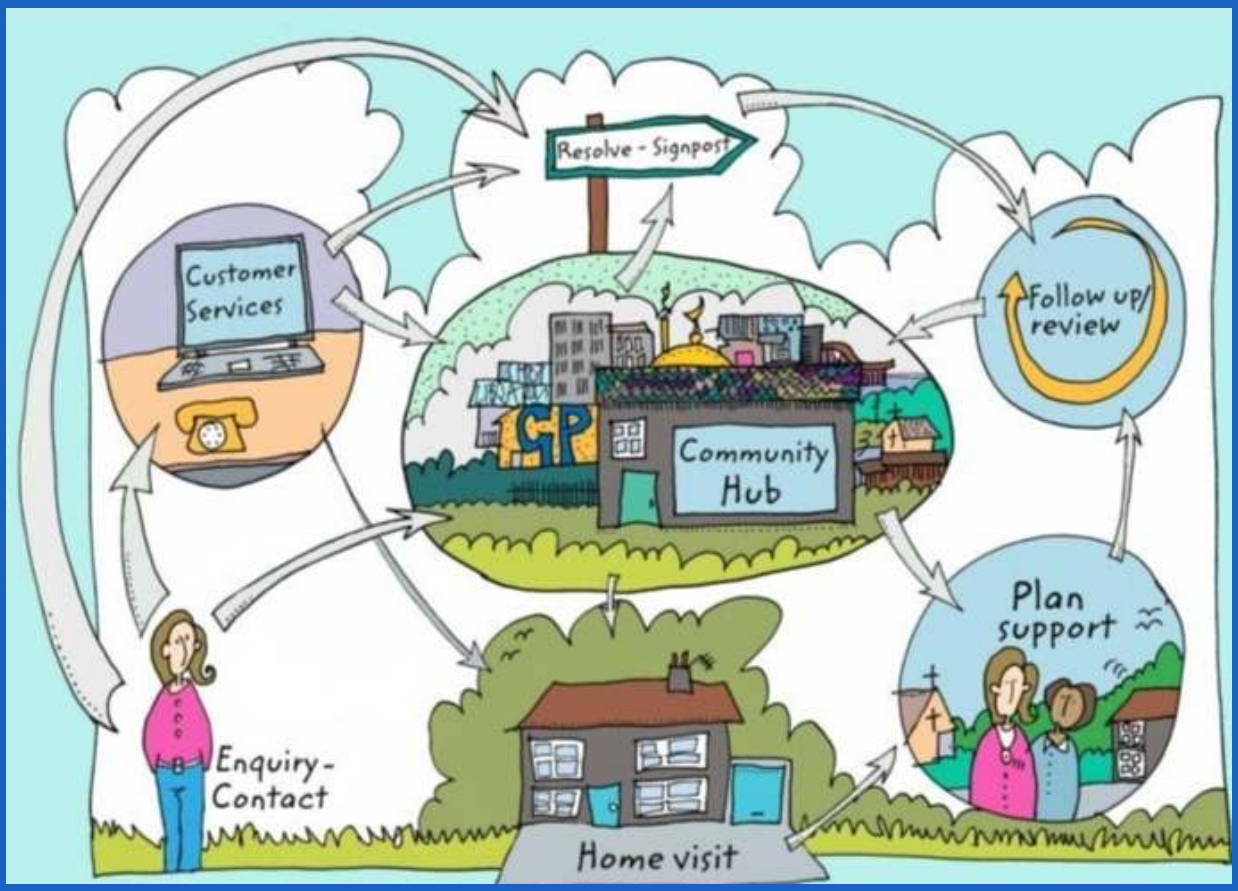
Action we will take to improve the clinical management of long-term conditions

This main strategy details a comprehensive set of actions that we will take to build on Thurrock's existing PHM programme that operated before the COVID-19 pandemic and had already halted and reversed the historical upward trend in cardio-vascular admissions.

Historically every GP surgery has managed long-term conditions in isolation, and usually treating different conditions in different appointments. The advent of PCNs allows us to deliver a more integrated model. We will embed integrated long-term conditions clinics at PCN level, starting with cardio-vascular and diabetes, and integrating wider behavioural and lifestyle support as 'one stop shops'. We will revise our Stretched QOF contract to support this approach, rewarding practices on the basis of outcomes across multiple long-term conditions and at PCN as well as practice level.

Our long-term conditions profile cards and practice visits have supported surgeries to action plan and improve outcomes but are based on year-old data. We will use new integrated data capability and enhanced informatics capability built at PCN level to provide data on long-term conditions management in near real time dashboards as a clinical support mechanism to better management. We will also encourage PCNs to share workforce capability and deliver new integrated models of care for different patient cohorts with different risk profiles.


SUMMARY OF STRATEGIC ACTIONS FROM MAIN STRATEGY
6.1
We will develop and implement a whole systems Tobacco Control Strategy based on the analyses and recommendations of the Thurorck Tobacco Control JSNA
6.2
We will Ireconstitute and relaunch the Thurrock Tobacco Control Alliance to oversee the implementation of the strategy and provide system leadership on the issue of tobacco control.
6.3
We will embed a smoking cessation offer within clinical pathways in community and secondary care inpatient and outpatient services, prioritising cardio-vascular, respiratory and mental health.
6.4
We will align and embed the Thurrock Healthy Lifestyles Service within the four Integrated Care models built around our four PCNs.
6.5
We will collate and analyse feedback from the recent community engagement exercise on the Whole Systems Obesity Strategy to understand the impact of COVID-19
6.6
We will refresh our Whole Systems Obesity Strategy action plan in the light of the above and continue to implement a whole system approach to obesity based on Human Learning System principles
6.7
We will build on the successful pilots in Stanford and ASOP PCNs to use Population Health Management techniques to deliver holistic and personalized responses to residents at risk of obesity
6.8
We will expand the successful hypertension screening programme to include AF and depression through use of stretched QOF and by identifying PCN and practice clinical leads
6.9
We will embed opportunistic case-finding into the day job of a broad range of resident facing staff including Wellbeing Teams and the Integrated Locality Networks
6.10
We will embed opportunistic case-finding in settings where evidence suggests the best results are yielded including AF screening in flu vaccination clinics and community podiatry.
6.11
We will co-design and implement a detailed case-finding strategy with PCN, NELFT & EPUT clinical leaders setting out revised screening protocols for hypertension, AF and depression.
6.12
We will create PCN Intelligence functions to provide near real-time intelligence to GP practices on long-term conditions and secondary care discharge to improve clinical management
6.13
We will use the new intelligence functions to systematically interrogate patient data sets against QOF to identify patients that need to be added to QOF registers.
6.14
We will develop clinical protocols with local PCN clinicians allowing the most obvious patients from the above to be automaticall re-written to QOF, for example those with a confirmed hospital diagnosis.
6.15
We will bring forward a business case for PCN level Clinical Review Resource, to support the review and where appropriate, addition to QOF of patients identified through remote digital clinical audit.
6.16
We will encourage individual surgeries to share workforce across PCNs to deliver LTC PCN level LTC integrated care models with cohorting of patients based on risk profile.
6.17
Through use of PCN level Intelligence Functions & real-time PHM data, we will create LTC dashboards that identify patients in need of review & intervention as a replacement to current profile cards.
6.18
We will re-design and recommission stretched QOF to incentivise practices to collaborate at PCN level based on care bundle outcomes, maximising impact on hospital admission avoidance.
6.19
We will create single PCN level multi-morbidity LTC clinics starting with cardio-vascular diseases and diabetes, with Consultant and Specialist Nursing Input and access to diagnostics.
6.20
We will embed behaviour risk modification services, social prescribing & ASC support into multi-morbidity models, providing holistic services and motivational interviewing.



Chapter 7: Integrated Care and Support in the Community

Bespoke solutions in a complex world

Chapter 7: Integrated Care and Support in the Community

7.1 Introduction

Within the community, there currently exists a dizzying array of individual teams and services, provided by different organisations, each with their own referral criteria, thresholds and standard operating procedure, each designed to 'fix' a single issue clinical or social problem. However, we know many of our residents do not live their lives like this; they face complex challenges with multiple causes needing support from many different places.

The way we have designed our system in this fragmented way is no-longer fit for purpose. It hinders collaboration between professionals, it delivers 'one size fits all' simple solutions and it is hugely inefficient to administer. Worst of all, too often it fails meet the complex needs of many of our residents, leading to 'failure demand' where residents end up accessing the most expensive elements of our system like Accident and Emergency because either their health has deteriorated from lack of earlier support, or simply because it is the 'front door of last resort'. Paradoxically, the greater the resident's need and the more complex a resident's problem is, the more difficult we make it for them to access the support they require, because the more teams and services they need to navigate.

We have told ourselves that the way to manage demand is to restrict care based on thresholds. In reality, this way of working increases rather than manages demand, waiting for residents to deteriorate until they need a more expensive intervention. It ignores the importance of building trust between the individual and those providing care and support, exacerbating bureaucracy and cost, increasing delay and building significant amounts of waste in to the system. Ultimately, it is costly for both the system and for residents requiring support.

In short, how the system is constructed and how it operates makes no sense to the people who need it and little sense to the people working within it. Both parties know this but feel powerless to do anything about it.

The recent case study (right) of an actual Thurrock resident, demonstrates the impact that the current design of our system has on people and their lives, and the resource wasted in 'failure demand' caused by a failure to design an integrated solution.

Case Study: Owen

Owen is a 60 year old man who lives alone. Owen lost his wife a few years ago and has become isolated and depressed. He always drank heavily, but since his wife died, his drinking has spiralled downwards into alcoholism and he is drinking five bottles of wine a day. Owen's health has declined, and with it his mobility. He current receives an externally commissioned care package to help him with personal care.

Owen's GP referred to him to the Occupational Therapy Team to try and improve his physical functionality. When the OT attends Owen's home, they find Owen slumped in a chair, unable to move, and uncommunicative. Owen's carers have just left. Owen's mobility has declined so much due to his alcoholism that they are unable to lift him out of his chair. The OT can't help because Owen is so inebriated.

Owen's Adult Social Care Support Planner attend's Owen's home. Owen needs a short term residential care placement because he is unsafe to be left at home as he cannot cook, use the lavatory or dress unaided, but his Support Planner is unable to find a residential care placement to accept Owen because they are all concerned that they will be unable to manage his withdrawal from alcohol.

Alcohol Treatment Services are not providing any home visiting at the time, and have been commissioned to only offer an assessment for alcohol treatment in the community within two weeks of a referral. To receive a community detox, Owen would need to first go through a separate assessment process. Fast tracking of alcohol treatment requires another referral for a further assessment by a panel. Owen has no transport to support him to access their services.

The Support Planner is left with no other option than to call an ambulance to convey Owen to hospital. The hospital will hopefully provide an alcohol detox as an inpatient and then discharge Owen back into the community where he will start drinking again. He knows this, because he has already been around the same loop five times in the past year.

For Owen to access community alcohol rehabilitation support, another separate referral is required.

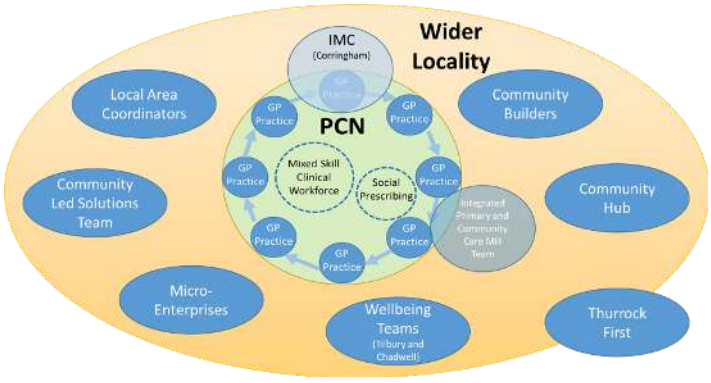
7.2 Learning from Transformation Undertaken to Date

We need a system that people can access at any point, mostly from within their local community, to get the support they require. This support must be coordinated and focused on achieving what matters most to them – which may mean accepting an element of risk. Those providing a service must work together in the community and with the community to deploy resources effectively, overcome organisational boundaries and unhelpful process and bureaucracy, and to deliver an integrated bespoke solution. Resource must be used collectively and in its widest sense – with solutions provided incorporating community assets, technology and provision that is creative and diverse.

In order to work in this way, we need to focus resource at locality level. We reject fundamentally reject the maxim that efficiency is always gained by delivering services over a larger geographical footprint. Our experience tells us that often the reverse is true. Place and locality working allows professionals to form relationships with each other rather than making onward referrals, design integrated solutions and use community assets as part of those solutions rather than always prescribing services or interventions. This is cheaper, more effective, less bureaucratic and most likely to prevent 'failure demand'.

Thurrock has already transformed many services to work in this integrated, strengths-based, holistic and ultimately more human way as shown in figure 7.1

Figure 7.1



Thurrock First

Thurrock First is our single point of access across community health, mental health and adult social care. Operating 365 days a year, it provides integrated first point of contact provision across primary care, community and mental health care and adult social care.

Operating 365 days a year, the service provides integrated first point of contact provision across primary care, community and mental health care and adult social care. It reduces, prevents and delays the need for more significant care by intervening earlier and working closely with the Urgent Care Response Team who can be mobilised to attend residents' houses when they are in crisis.

Local Area Coordination

Thurrock now has 14 Local Area Coordinators (LACs), each aligned to specific neighbourhoods within the Borough. The LAC's primary role is to develop a detailed understanding of all of the community assets, networks, services, organisations and groups within their neighbourhood and more broadly across the borough, and then work with residents to find pragmatic solutions to problems, drawing on these resources before considering commissioned or statutory services.

Community Led Support

Community Led Support (CLS) is an approach to social work that means that social work teams provide a coordinated response building networks with other professionals within a specific locality so that they can be mobilised to provide a joined-up response and not a response that purely considers adult social care needs. Teams are based in the community and aligned with the four Primary Care Network (PCN) areas and work solely within their locality out of a number of different community settings. The approach represents a radical departure from traditional social work models based on assessing deficits and prescribing pre-commissioned services.

Mental Health Integrated Primary and Community Care Locality Model

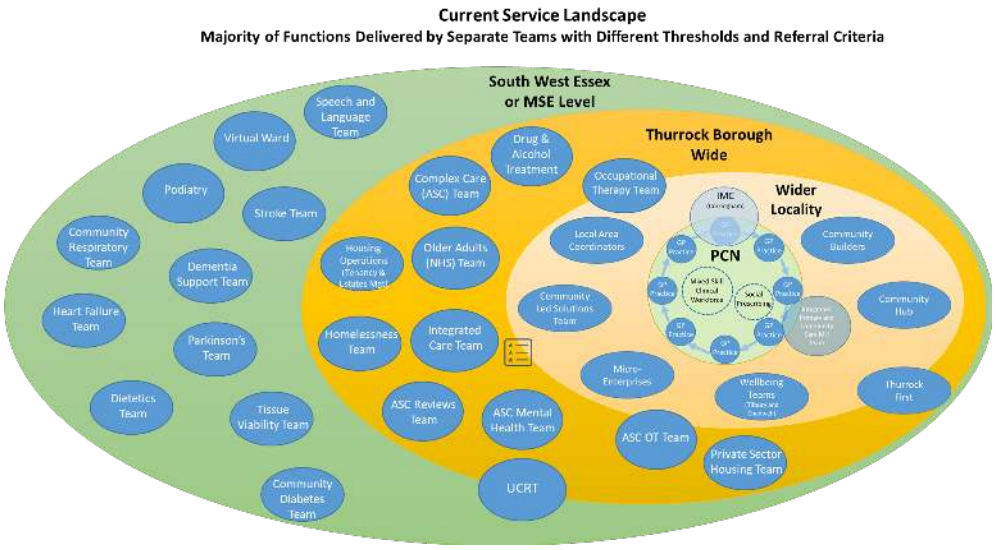
Through an extensive process of co-production, we have transformed and completely reimagined how we deliver mental health services through an Integrated Primary and Community Care Mental Health service offer at PCN level. The process brought together clinicians from primary and secondary care, users of services, carers and families, the voluntary sector organisations, public health specialists and commissioners from both NHS Thurrock CCG and Thurrock Council.

The new model has focused on developing a seamless offer for those who need more support than primary care would normally provide but don't meet the threshold for traditional secondary services. It delivers a holistic offer that allows wider determinants of mental health such as housing, employment and social support to be addressed alongside specialist psychiatric nursing, psychology, and Consultant input.

7.3 A New Model of Integrated Locality Working

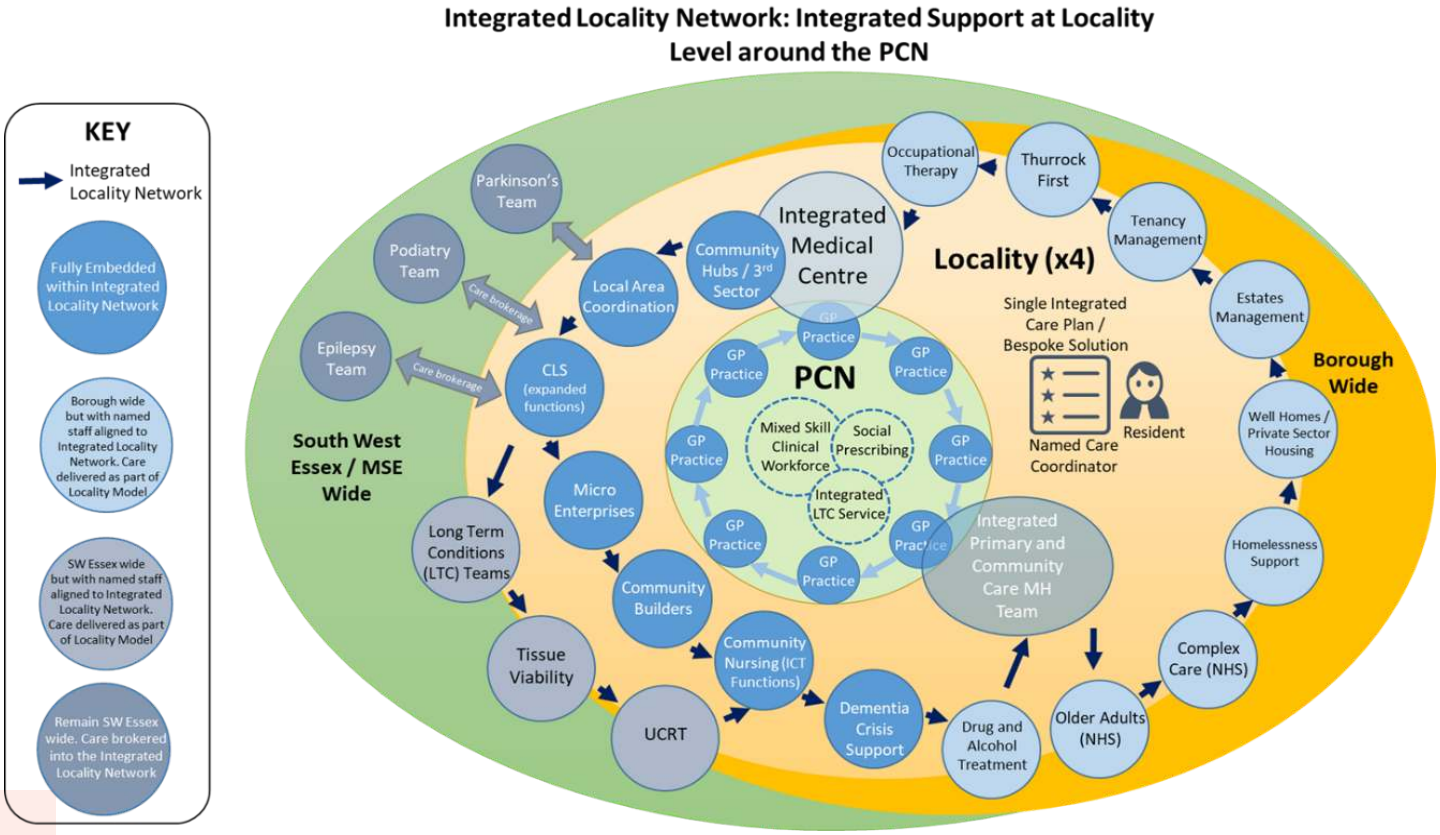
However, these models of best practice sit within a wider landscape of too many individual and fragmented teams and services, delivered on too big a geography to enable place or strengths-based working, all with different referral criteria and thresholds, as shown in figure 7.2. We need to reform and transform these based on our principles, values and learning to date, so that they too can operate in a way that empowers professionals to work alongside residents to design bespoke, integrated solutions.

Figure 7.2

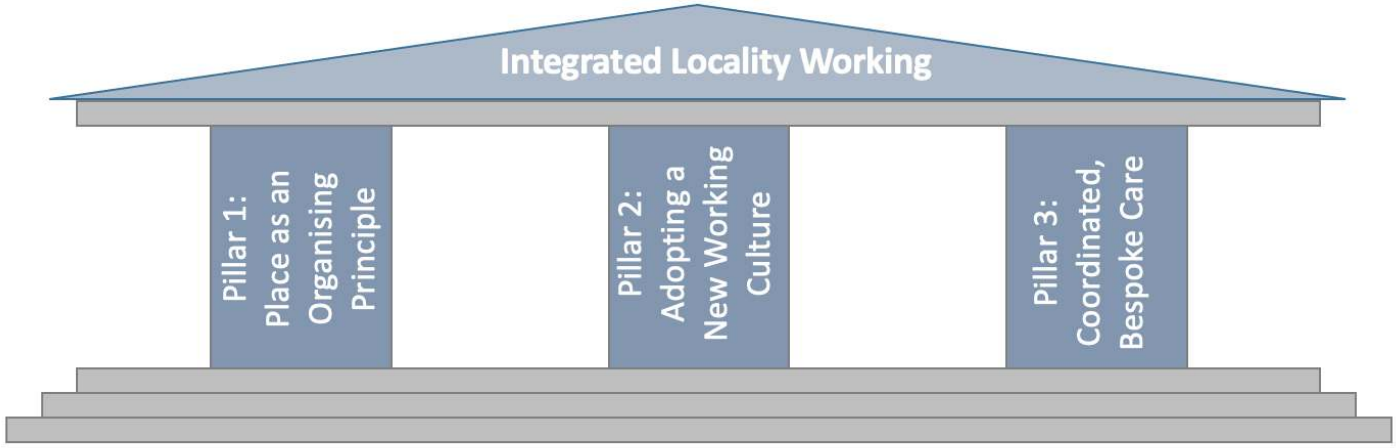


To achieve this change, we will embed as many services as possible into four Integrated Locality Networks, around each of our four PCNs. Where services cannot be fully embedded, named professionals within them will be aligned to one of the four Integrated Locality Networks. The networks will allow professionals to build relationships with each other and residents to co-design integrated solutions rather than making assessments or referrals. For residents with more complex needs, a single care plan will be developed and one named professional will be responsible for coordinating all care. The new Integrated Locality Network is shown in figure 7.3 and Chapter 7 of the main strategy gives a detailed explanation of how services will be embedded and aligned.

Figure 7.3



Our model for integrated care and support will be underpinned by the three key pillars set out in figure 7.4 based on our learning to date and the values and principles set out in Chapter 2.



Place as an Organising Principle

PCN Locality as the Planning Footprint. Health, Care, Housing, Third Sector multi-disciplinary team approach at locality (PCN) and neighbourhood (sub-locality) level.

The Integrated Medical Centre acts as the locality 'hub'

A Single Integrated Locality Network. Staff build relationships and collaborate to co-design, develop and deliver single integrated solutions rather than refer on or sign post.

Larger teams organised on and based at the locality footprint. Smaller teams that can't be fully embedded have named staff aligned to each Integrated Locality Network

Support from small specialist teams brokered in by the locality network. Specialist teams used to upskill locality network.

A New Working Culture

Empowered Staff free to use their professional judgement to 'do the right thing' within a broad framework of principles rather than being constrained by standard operating procedures.

Solutions not services. Staff build relationships with communities and use community assets and third sector support and embed within solutions rather than automatically prescribing a statutory service.

A Learning Culture adopted as the way of managing and transforming the complex system. Staff encouraged to innovate and share learning across the network.

Focus on what matters to residents. Staff start by building relationships, finding out what matters to them, and let solutions drop out of the relationship. The resident will define their own goals.

Coordinated, Bespoke Care

Bespoke Solutions to Complex Problems Residents with problems requiring different types of support will access it in one integrated solution at the same time. Solutions will be bespoke and potentially broader than traditional NHS or ASC interventions.

Care Coordination. A single named person within the Integrated Locality Network coordinate and broker all care required as part of the solution. This is likely to be the person whom the resident has the best relationship with.

Single Integrated Care Plans will be developed for the most complex individuals, linked to the goals that the resident has set for themselves. The plan will set out all input required from NHS, ASC and 3rd sector services.

We envisage the transformation from the current system architecture to integrated locality teams occurring over two phases. We estimate the first phase taking 12 to 18 months during which we will further develop our existing locality architecture and create a single *Integrated Locality Network* of professionals who will be able to collaborate more easily and effectively with each other.

In phase two, we will use the learning from small 'test and learn' pilots based on Human Learning Systems methodology to seek to create new 'blended roles'; staff with skills and responsibilities to deliver health and care functions historically delivered by different teams or organisations, for example a Complex Needs role that can deliver addictions, mental health and housing support.


SUMMARY OF STRATEGIC ACTIONS FROM MAIN STRATEGY
7.1
We will create four new Integrated Locality Network of professionals aligned around each IMC/ PCN based on the three underpinning pillars of 'Place as an organising principle', 'Adopting a new working culture' and 'Bespoke coordinated care'. (Phase 1)
7.2
We will embed the Integrated Care Teams, Dementia Crisis Support, Community Builders, Micro Enterprises, Community Led Solutions, Local Area Coordination and Third Sector Support within the Integrated Locality Network (Phase 1)
7.3
We will embed the ASC Review, Complex Care, and Mental Health Teams within Community Led Solutions. (Phase 1)
7.4
We will align borough wide Addiction Treatment, Older Adults, Complex Care, Homelessness Support, Well Homes, Estates & Tenancy Management, Thurrock First and OT Teams to each Integrated Locality Network, with named aligned staff.
7.5
We will align South West Essex/MSE UCRT, Tissue Viability and Long Term Conditions Management Functions to each Integrated Locality Network, with named staff aligned to each network (Phase 1)
7.6
We will integrated some of the care functions undertaken by Diabetes, Heart Failure and Stroke LTC Teams within an Integrated PCN level CVD & Diabetes Long Term Conditions Service
7.7
We will develop a Community of Practice within each locality as a mechanism through which staff can develop the Integrated Locality Network, collaborate and innovate
7.8
We will build one IMC per locality to act as a 'hub' for service integration and the Integrated Locality Network, informed by the locality Community of Practice and Locality Community Reference and Investment Board
7.9
We will seek to use specialist support from current teams in a different way, with care being brokered into and by the Integrated Locality Network rather than through on-ward referral, and specialist skills within the teams being used to upskill locality clinical capacity.
7.10
We will use HLS 'test and learn' methodology to creae new 'blended roles' upskilled to undertake care currently delivered by different teams and organisations, further rationalising the number of different involved in designing care solutions with residents.
7.11
We will design and implement Single Integrated Care Plans for the most complex individuals, with a named care coordinator.
7.12
We will prioritise investment in the Older Adults Wellbeing Functions, Comprehensive Geriatric Assessments and Frailty Support, expanding the capacity and reach of the function.
7.13
We will build on the success of the IPCC mental health model and pilot an Open Dialogue Approach to managing people with serious mental health problems in crisis.
7.14
We will implement a new flexible and holistic model of mental health supported living.
7.15
We will seek to pool funding between organisations, to create single locality/place budgets from which all services are commissioned and where savings from prevention/failure demand reduction can be reinvested.

Chapter 8:
Integrated Support in the Home

Holistic care from fewer people

Chapter 8: Integrated Support in the Home

8.1 Introduction

The home is increasingly becoming a critically important setting in which to deliver health and care to our residents. As our population ages, a greater proportion are likely to need integrated care interventions delivered at home. The home may often be the more appropriate setting in which to deliver care:

- It is the environment in which we live, allowing care assessment and planning to take into account social and environment factors that impact on our wellbeing.
- It is the setting in which we feel most safe, and for most residents, receiving care at home is preferable and more convenient to a hospital or residential care admission
- Delivering care within the home promotes the dignity and independence of our residents, giving them maximum control over their own lives.

The way we have historically commissioned and delivered care at home is based on a fragmented *New Public Management* time and task model that is outdated and inefficient. Health and care delivered to someone in their home is delivered based on whether the person is eligible for a particular service, with the service being designed to respond to set needs and conditions. Many different teams and people undertaking different tasks are required to enter a resident's home; services focus only on bio-medical needs - fixing people rather than focusing on what really matters to them. They are reactive rather than preventative and offer inadequate scope for long-term care relationships and care continuity and to spot when a resident may be improving or deteriorating. Lack of integration adds cost and results in avoidable 'failure demand to the wider system.

In Thurrock almost 60% of those in receipt of home care received it from a private sector provider, with the remainder receiving care from Thurrock Care at Home, the council's in-house care provider.

Externally commissioned providers operate on low margins, care staff often receive low rates of pay, and the existing home care provider market is extremely fragile. Workforce recruitment and retention remains challenging. Providers are commissioned to deliver the same pre-determined set of tasks each day, with no flexibility to respond to the varying needs of residents. Traditional commissioner-provider relationships based on contract management reinforce outdated delivery models and stymie innovation.

8.2 Our Vision for Transformed Home Care: Wellbeing Teams

An integrated, flexible and person-centred model

Our engagement work with residents has clearly demonstrated that those in receipt of homecare want a service that is flexible, treats them as a whole person, is based on long-term empowering relationships, and minimises the number of different individuals entering their home.

Thurrock has already developed and piloted a home support model that is flexible, person-centred and focuses on delivering what matters to the person. ***Wellbeing Teams*** were first introduced in 2019 in an attempt to deliver what we know as domiciliary care (home care) in a different way. Wellbeing Teams operate in a completely different way from traditional home care, using from the four building blocks of the Dutch Buutzorg model based on universal human values:

- People want control over their own lives for as long as possible;
- People strive to maintain or improve their own quality of life;
- People seek social interaction; and
- People seek 'warm' relationships with others.

Buurtzorg, and models like it, focus on small neighbourhood based teams (of no more than 12 staff members). They start by considering:

- What the person can do for themselves;
- What informal networks can offer; and
- What 'service' response is required – ensuring that the response if required is flexible and joins up with other professionals.

Teams are self-managed, organising themselves as required to provide the best response to the individual.

Thurrock has tested two neighbourhood Wellbeing Teams of 12 people within the Tilbury and Chadwell PCN area. Working with up to 200 hours each, they use the hours allocated to someone following initial assessment to work out the best solution for them. This means working with the individual to devise their own personal support plan – which can involve a mixture of formal and informal options and focuses on what matters most to them. For example it may mean that someone articulates that they want to continue to enjoy their garden or to connect with friends and family. Importantly, Wellbeing Teams can work with people at all levels of complexity in a flexible way. Care plans are reviewed regularly so that changes can be made as often as is required.

The sub-locality geography allows Wellbeing Workers to develop a detailed understanding of the community assets and networks within their neighbourhood and connect service users into them. The small nature of the team allows the formation of long-term care relationships and strong continuity of care. Workforce challenges are addressed by creating more interesting and flexible salaried roles, with staff empowered to make decisions based on the best interests of their clients.

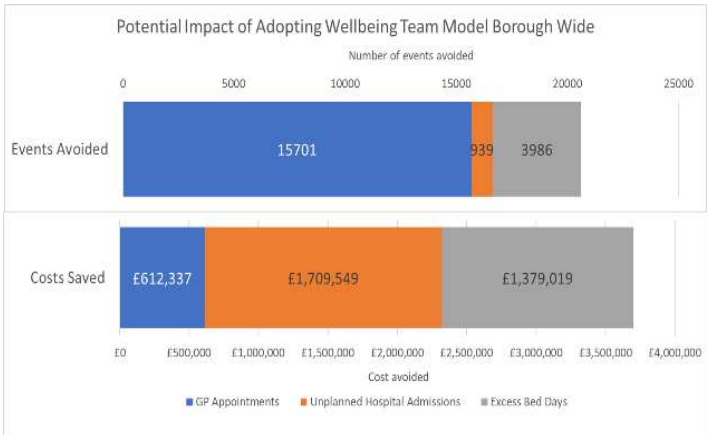
Evaluation of Impact

Early evaluation of the programme suggests some significant positive differences in outcomes for residents receiving care from a Wellbeing Team. Those cared for by a Wellbeing Team had up to a 32 fold lower rate of GP appointment use compared to standard home care and were three times less likely to be admitted to hospital. When they were admitted, their length of stay was considerably lower and they experienced no excess bed-days.

Whilst highly encouraging, some care needs to be taken before over-interpreting the potential positive impact of Wellbeing Teams compared to historical care models as the numbers in each cohort were relatively small given that the Wellbeing Teams Pilot only consisted of two teams. However, if further larger scale evaluation were to confirm these results, the positive impact, extrapolated across all Thurrock residents in receipt of a domiciliary care package, is significant.

Figure 8.1 demonstrates this potential impact of replacing historical domiciliary time and task care models with Wellbeing Teams in terms of avoided GP appointments, hospital admissions and excess bed-days. It shows the significant potential opportunity of the Wellbeing Teams model in reducing GP appointment usage and hospital admissions and excess bed days, and the associated potential savings.

Figure 8.1



8.3 Further expansion of the Existing Wellbeing Teams Model

We will start expanding Wellbeing Teams through transforming Thurrock Council's in-house homecare provider - ***Thurrock Care at Home,*** to deliver an approach based on the same principles as Wellbeing Teams – ultimately developing in to Wellbeing Teams.

The first phase of the approach will see eight locality based teams being implemented in the Tilbury and Chadwell area. The focus, in keeping with the Wellbeing Teams model, will be on achieving outcomes rather than completing tasks. The service will not be time limited and will therefore not hand over from one team to another; instead, one team offering a more holistic service and ongoing reablement continuously supports the person from day one and promotes their choice, independence and wellbeing. Workers will be upskilled and given more autonomy to enhance their job satisfaction which should assist with job retention and recruitment.

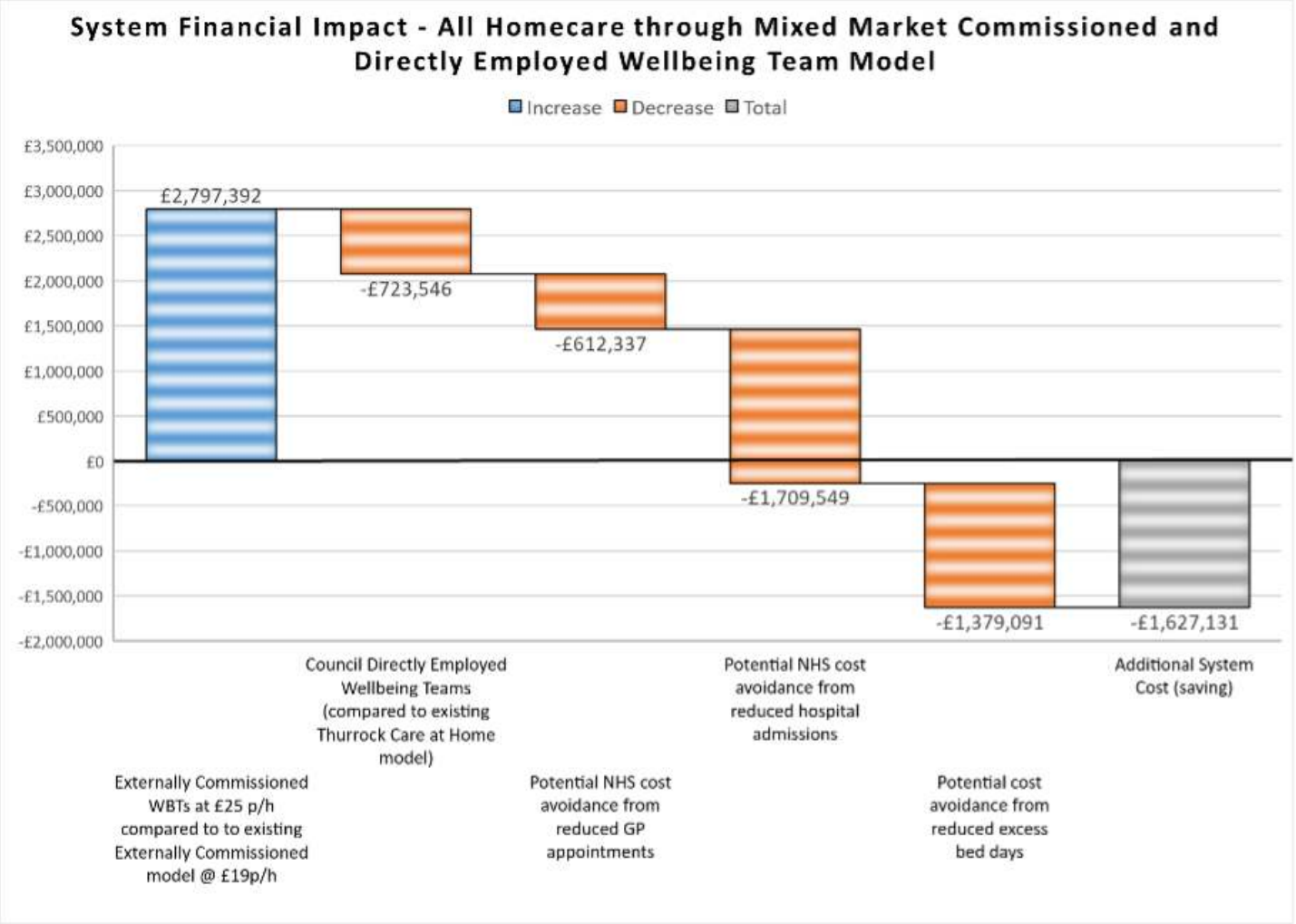
Following testing of the above approach, *Thurrock Care at Home* Community Teams will move in phase two to adopt the full Wellbeing Teams model.

For 2022/23, **Wellbeing Teams will cost £32.12** per hour of direct care provided. This is significantly less than the **Thurrock Care at Home overall direct care rate of £41.67** per direct care hour, and so transforming Thurrock Care at Home has the opportunity to deliver better outcomes at a chapter cost. However, externally commissioned home care costs significantly less at £19.00 per hour, making roll out of a directly provided service borough wide, unaffordable.

Retaining a level of in-house provision for homecare brings significant advantages in terms of control and ability to 'test and learn' new innovation and has served the local health and care system extremely well in being able to mitigate the pressures of the COVID-19 pandemic. However, the model is more expensive and a mixed in-house and externally commissioned approach provides the best solution. We will therefore undertake future market developed to shape the local care market and to deliver Wellbeing Teams through a mixed market model including external commissioning, starting with some preferred providers who have expressed interest. We accept that the costs to commission a Wellbeing Team model are likely to be higher for external care agencies, and we have modelled the overall impact of commissioning Wellbeing Teams through external providers at £25 per hour; a £6 per hour increase on the current rate.

As our evaluation suggests that the Wellbeing Teams model has the potential to deliver savings to the NHS through delivery of better outcomes for residents and avoided subsequent GP and hospital usage, there may be an opportunity to build a system business case to fund Wellbeing Teams, given that they deliver potential cost savings to NHS outcomes as well as better outcomes for residents. Figure 8.2 shows the potential financial impact of this mixed externally commissioned and directly provided model. At system finance level, it may be possible to deliver Wellbeing Teams across the borough whilst delivering system savings of over £1.6M.

Figure 8.2



As previously stated, the current model has been built using evaluation data over only one year based on a relatively small sample size. In order to ensure that any future commissioning is based a more robust model, we will continue to collect evaluation data over 2022/23 with the view to bringing forward a system business case for roll out of Wellbeing Teams borough wide from the last two quarters of 2023/24.

8.4 Further Transformation of the Existing Wellbeing Team Model

Blended Roles: *A Health and Care Wellbeing Worker*

There is considerable opportunity both to upskill existing Wellbeing Team workers to undertake certain tasks and activities currently carried out by other health professionals thus improving continuity of care, reducing duplication, and freeing up specialist capacity.

Blended roles across traditional health and care team/organisation functions allow staff to expand their skills to enable them to undertake both routine clinical and care tasks as well as using time allocated to focus on supporting the person to do things that enhance their wellbeing.

In order to implement this, we will undertake a scoping exercise to identify residents who are currently receiving support from different service areas at the same time and ascertain the opportunities for a new *Blended Health and Care Wellbeing Worker* to undertake more of these tasks whilst supporting the resident, reducing the overall number of visits needed, freeing up NHS capacity and rationalising the number of people involved in a residents care. This will improve care continuity, helping us to spot problems earlier and avert crises.

Blended *"Health and Care Wellbeing Worker"* roles will require staff training and skills development but also offer the opportunity of career development, higher status, higher pay and more variety and responsibility compared to the traditional domiciliary care worker. This in turn provides a solution to the current workforce crisis in social care, hopefully attracting and retaining staff.

Hospital Discharge Planning and Reablement

The current hospital discharge pathway is fragmented with multiple handoffs. A resident leaving hospital may be discharged into a community bed, then the hospital bridging service, then a separate reablement service and then receive an externally commissioned home care package. In future, we envisage Wellbeing Teams taking responsibility for liaising with the hospital and resident to commence discharge planning, including brokering appropriate health, care and third sector with the aim of early discharge back home, allowing proactive 'pull though' of residents from secondary care back into the community.

We will also incorporate reablement within Wellbeing Teams, seeing it as integral to on-going care and support rather than a separate, time limited function accessed only by those who meet a pre-defined threshold. Reablement will be explicitly linked to the goals that the resident wishes to achieve; the goals that align with their vision of a good life.

Specialist Clinical Support

We will align current community NHS health provision will be aligned with each PCN locality and form part of a health and care locality network. This will include enabling integrated care and support plans and a blended roles approach. Our Integrated Care Team nurses will work alongside Health and Wellbeing Workers with named nurses aligned to each Wellbeing Team to undertake more specialist clinical tasks and provide clinical leadership and supervision.

GPs and Primary Care Networks play a vital role in the development of integrated support in the home. Linking with other professionals across the network – including providers, social workers and a range of health professionals, they often provide the vital link between all parties and are often the first point of contact for someone requiring additional support.

There are currently a number of 'specialist' condition-specific teams that provide support to people in their home – or provide a hybrid model where support in the home will be provided if required for example the Older Adults Health and Wellbeing Team and Dementia Crisis Support.

In our transformed model, Specialist Teams although not necessarily locality-based, dependent upon the specialism and size of team, will form part of the Integrated PCN/locality Teams discussed in Chapter 7 and build good relationships with other health and care professionals operating in the patch. Formal referrals to specialist teams will not be necessary and their input will be 'brokered into' the Wellbeing Team by the named individual responsible for coordinating care to provide advice and support rather than residents needing to navigate their way through separate pathways. Any specialist support will form part of the single integrated plan overseen by one professional taking the lead as overall 'coordinator'. There will be a constant focus on reducing or aligning visits, preventing hand-offs and removing the need for onward referrals.

Voluntary and Community Sector

The Voluntary and Community Sector will form a vital part of any support arrangements and be a key part of support delivered within the home. Existing services run by the VCS such as *By Your Side* are already playing a critical role in the borough, facilitating hospital discharge and preventing readmission by providing essentials such as basic food provisions and ensuring appropriate equipment has arrived and making sure residents' homes are safe, warm and ready to welcome them.

Technology

Technology is a key enabler and will be used to aid a preventative and integrated approach to the provision of support in someone's home. Health and care have a successful and innovative Technology Enabled Care group in place. This ensures that a range of technological options can be tried and tested – enhancing existing health and care solutions, or enabling new solutions to be developed. For example this may include tools such as Whizan, which enables the monitoring of vital signs. There are a range of technologies that will be tried and tested as part of the development of integrated support in the home.

8.5 Implementation and Impact

Figure 8.12 shows the overall model for transformed Wellbeing Teams including core and brokered functions.

Figure 8.12

Adopting a Human Learning Systems approach

We are committed to adopting the principles of HLS in delivering this transformation. Being self-directed, resident facing staff working within or providing brokered support into Wellbeing Teams will be freed from constraints of thresholds or standard operating procedures and empowered to deliver human, bespoke solutions based on goals agreed in partnership with the resident. This ultimately will deliver better outcomes, reduce duplication and prevent 'failure demand'.

SUMMARY OF STRATEGIC ACTIONS

8.1 We will expand Wellbeing Teams through transforming Thurrock Council's in-house homecare provider - Thurrock Care at Home, to create eight additional locality based Wellbeing Teams in Tilbury and Chadwell.

8.2 We will collect wider evaluation data on the impact of the Wellbeing Team model throughout 2022/23 in order to create a robust system impact model.

8.3 We will bring forward a system business case based on our system impact model to allow roll out of Wellbeing Teams borough wide from the last two quarters of 2023/24.

8.4 We will work shape the external care market with a view to commissioning the Wellbeing Teams model externally. This initially will consist of a pilot project with one of our existing homecare providers.

8.5 We will further transform the WBT Model to create *Health and Wellbeing Teams* with a blended Health and Care WBT Worker roll upskilled to deliver both routine health and care tasks

8.6 We will transform the hospital discharge care pathway and embed responsibility for Reablement and Hospital Discharge Planning within the Wellbeing Team in conjunction with the ASC Hospital Team.

8.7 We will align current Community Nursing (Integrated Care Team) functions to Wellbeing Teams with a named Community Nurse for each team.

8.8 We will implement Single Integrated Care Plans between NHS, ASC and the 3rd sector, with a named care coordinator and systems to broker specialist support into the team to minimize referral and handoff.

8.9 We will maximise use of community assets, voluntary sector support and technology enabled care as part of a holistic package of home support within the Wellbeing Team.

Chapter 9: Reimagining Supported Living, Residential and Intermediate Care

Dignity and independence with more intensive support

Chapter 9: Reimagining Supported Living, Residential and Intermediate Care

9.1 Introduction

In this chapter, we describe our plans to re-imagine how we deliver older people's housing, supported living, and residential and intermediate care including our proposals for an "Extra Care Plus" facility at the Whiteacres site in Thurrock. As discussed in the last chapter, we recognise the value of supporting people for as long as possible in their own homes. However, for some, there remains a need for more round the clock intensive support. This needs to be provided to the highest standard in settings that enable to retain control, independence and dignity.

What is needed is new thinking about ageing well in our communities, recognising that the so called baby boomers who have built their homes and lives in Thurrock, will want to look forward to their years in the 21st century, no less in command of their futures. We need to reimagine how we transform and integrate housing and care in older age with a much greater plurality of options to support choice.

9.2 Specialist Housing

There are many gains from a programme of new housing specifically designed for older adults: manageable, accessible, warm homes with low running costs and bringing a lower risk of falls and accidental injury, will enable individuals to maintain their independence, see income go further, and avoid unnecessary admissions to hospital and care homes. For many older people, purpose-built accommodation also brings a social life that protects against isolation and loneliness. And, for some, it also means releasing capital to make life easier in retirement.

Bruyn's Court: An Exemplar Scheme

As part of its ambitious transformation programme, the Council has invested in aspirational housing developments, specifically designed for older people, in South Ockendon and Tilbury.

Designed in line with the recommendations of the report Housing Our Ageing Populations (HAPPI)[1], Bruyn's Court provides 25 self-contained, one and two bedroom flats, located close to South Ockendon town centre amenities, and overlooking a courtyard garden. The flats are designed to wheelchair accessibility standard, are easy to heat, and to keep cool in summer and each has a private balcony or terrace garden.

A communal lounge is provided to facilitate art and craft work, and social events. Residents can receive care and support in their home from visiting services, including Well Being Teams and community nurses.

Developments of this type also enable people to "right size", often freeing up larger homes which can be more costly to heat and maintain. We will continue to encourage development of similar schemes in all parts of the Borough.

Planning, Regeneration and Partnership with Private Sector Developers

Thurrock is committed to working in partnership with local developers to stimulate to market to deliver a plurality of more specialist housing for our residents. We recently held a Developers' Summit to mobilise support for a private sector housing development programme specifically targeted at older people. We are committed to support developers by:

- Providing profiles of the housing needs of older people in Thurrock's communities
- Engaging with local people so that they understand the benefits of specialised housing for older people
- Providing flexibility in relation to planning requirements, for example, parking if the site is well served by access to local facilities and transport
- Exploring the potential for joint ventures with private sector developers
- A one-stop service to facilitate scheme discussions at any point, not just at the pre-planning application stage.

We will also continue to ensure new housing development supports older people's independence through Thurrock's Housing & Planning Advisory Group (HPAG); a multi-agency panel, reporting to Thurrock's Health and Wellbeing Board, that considers the health and well-being implications of major planning applications and provides advice and guidance on the health, social care and community impacts of proposed new developments. The group aims to influence planning policy and ensure that planning applications, when received, have already considered impact on health and wellbeing. From 2022, HPAG will be guided by Thurrock's JSNA for the Built Environment.

The 2018/19 Annual Public Health Report provided a detail assessment of older people's housing need in Thurrock and strategic action that needed to be undertaken to ensure that future housing in Thurrock supported older people's independence but work then paused due to the COVID-19 pandemic. We will take forward the recommendations in the APHR, developing and implementing an Older People's Housing Strategy based on its finding.

9.3 Reimagining Residential and Intermediate Care

Whilst our current residential care offer is of high quality, the majority of us hope that we will never need the services of a residential care home in old age, and few of us relish the often difficult decision to place a relative into residential care out of necessity because there is no other viable option available. When we enter residential care, we have to trade the loss of privacy, independence, control and choice that we had at home in order to gain the enhanced and intensive care they provide.

Like home care, the residential care market remains fragile, with a recent Competition and Market's Authority report concluding that many were not in a financially sustainable position.

Residents in their 80s are already the largest users of residential care, so without effective intervention to mitigate this trend of decreased mobility, the need for additional residential care homes is likely to increase substantially.

Our vision is to reimagine older people's residential and nursing care, providing the same levels of care intensity currently available in traditional models, but through a new 'Extra-Care Plus' care complex that provides residents with the dignity, privacy and freedom own self-contained flat and front door coupled with additional communal facilities on site.

We propose that the Whiteacre / Dilkes Wood sites in South Ockendon should be developed to provide a range of homes for older people needing care. This is seen as an opportunity both to address the growing demand for care, and to invest in innovation in care, and so to set new higher standards for housing with on-site care in the Borough. It will also act as a 'proof of concept' scheme that we imagine could be replicated by private sector developers and providers in the future.

The Box overleaf details Park Place, Portland, Oregon that has successfully delivered residential care using a similar model to our vision.

Park Place Portland, Oregon

Inspired by the negative experiences that her mother was having of nursing care in terms of loss of privacy, control and freedom, Keren Brown Wilson built her first Assisted Living Complex of 112 units in Portland, Oregon in the 1980s.

Wilson's mother's had suffered a devastating stroke in her 50s leaving her unable to stand, bathe, toilet or cook and needed intensive physical care support needs but her mental faculties remained unaffected. Over and above her care, Wilson's mother's living needs were modest: she wanted a small place with her own kitchen, bedroom and bathroom where she could lock her own door, control the heat, have her pets, be surrounded by all of her own furniture and things, and get up when she wanted. She wanted to live in a place where no-one would tell her what she could and could not do, and have privacy if she wanted.

Wilson set out creating a new facility, with the primary emphasis on *home* and the agency of residents. Her vision was simple[3]: at Portland Place, each unit was a self-contained apartment where residents had exactly the same amount of control over what they did as someone living in general needs housing. They chose who shared their space with, how they managed their time, what they did each day, their furniture, pets, decorations, possessions and heating.

But residents also had access to all of the additional help they may need on site: food, personal and nursing care, medication that could also be summoned in an emergency by pushing a button. There was also help with maintaining a high quality of life if residents wanted it: having company, keeping up connections with the outside world, continuing the activities residents valued most.

The level of care available matched what was delivered in standard nursing care, but the fundamental differences were *control* and *agency*. When provided, the carers were entering *the resident's home*, and the resident, not the carers, set the schedule, ground rules, and chose the level of risk they were comfortable with.

The concept was immediately widely popular and the 112 units sold out almost immediately and a second complex of 142 units was built and was again almost immediately filled. But the authorities were worried about the safety of what they saw as a radical experiment that was risking the health and safety of residents, and required Wilson to track closely the health, cognitive abilities, physical functioning and life satisfaction of the tenants.

The results of the study were published in 1988 and were a revelation: Not only had the residents not traded their health for freedom; residents' health was maintained whilst life satisfaction had increased significantly. Physical and cognitive functioning improved and incidence of major depression fell. The cost of residents on government support was 20% lower than if they had been cared for in a nursing home.[4]

9.3.1 Whiteacre / Dilkes Wood – our next exemplar scheme:

We have appointed architects who have developed vision for the proposed scheme - *Whiteacres* at the Dilkes Wood site in South Ockendon, including addressing how the development may be phased to deliver the new residential offer for older people based on the Park Place, Portland Oregon model above, and also, potentially, the redevelopment of the adjacent 1950s era health centre should that be agreed with NHS partners.

The architects' report concluded that the Whiteacre / Dilkes Wood site offers an opportunity to provide exemplary residential accommodation for people with varying levels of need, while creating a new community-led focus to the town centre. The scheme also unlocks the potential for the phased development of a new community health facility to replace existing provision in the South Ockendon Health Centre. The new facilities would also encompass the existing community hub, that provides a wide range of popular services and activities, creating a strong community focus.

The Whiteacre / Dilkes Wood scheme will provide 45 self-contained, easily maintained one and two bedroomed flats designed for frail elderly people, with associated care facilities (loungers, restaurant, treatment rooms, laundry etc. The accommodation is designed to a high standard and includes underfloor heating and separate ventilation systems for each unit.

Our vision is to provide specialised, care-ready accommodation, where residents can enjoy all the comfort and privacy of a self-contained home specifically designed for older age with the availability of on-site social care and nursing care services when residents need them at a level consummate with traditional residential care. This will enable residents with high levels of care need who would traditionally be placed in residential care, to retain (and regain) their independence and live well.

For frail older people, a single shared assessment, care co-ordination and an on-site wraparound well-being service, based on the model described in Chapter 7, will ensure their care needs are met in a way that promotes their strengths and enables them to make full use of local amenities. Visiting Integrated Locality Teams will provide advice on self-care and assistance with the management of long term conditions including diabetes, respiratory disorders and heart failure. The adjacent health centre will provide a range of GP and other primary care services, and in time will be developed with a wider range of clinical services as a health and well-being hub.

The scheme will also include 30 studio flats for Intermediate Care use, supporting earlier hospital discharge, CHC assessment in a residential rather than hospital setting, and short stays for those requiring intensive reablement services.

Initial financial modelling set out in main strategy suggests that through use of rental income (through housing benefit for those eligible) and savings realised through reduced use of community hospital beds, there is an opportunity to deliver a better care model at a cheaper over all system cost. We will bring forward a full business case early in 2022/23.

9.4 Supported Housing for Residents with Mental Health Problems

Supported Living placements provide accommodation to residents usually in shared houses with on-site support from carers to assist with daily living. The current model commissions external providers to deliver a core support offer with additional commissioned hours based on a previous assessment of the individual's needs.

Ideally, Supported Living provision should promote independence in the people being supported, with support packages starting at a higher level and then reducing as the resident being supported gains new skills and become more independent. However, the current process of assessment and then commissioning a fixed package of core support and set hours is inflexible and unable to adjust and flex support sufficiently in response to individual circumstances. The current model also fails to integrate with other key health services including mental ill-health treatment and addictions services, and placements often break down as a result.

We are currently developing a new model of care for Supported Living for people with mental health problems. We will purchase two additional four and three bedroomed houses within the Borough and commission a trusted provider to deliver a more flexible, holistic and integrated model of care. Fixed commissioned hours will be replaced by care that flexes in response to the needs of each resident on a daily basis. There will be a keen focus on maximising recovery and stability so each individual can reach the maximum level of independence and achieve what is important to them

We will 'test and learn' this new model as a pilot in 2022/23 with a view to broader market development based on the evaluation.


SUMMARY OF STRATEGIC ACTIONS
9.1
We will develop and implement an Older People's Housing Strategy based on the findings of the 2018/19 Annual Public Health Report to ensure development of housing and wider community regeneration to support older people's independence.
9.2
We will ensure that planning policy encourages future development of a plurality of housing that supports older people's independences through use of the Health Planning Advisory Group, 2022 JSNA on the Built Environment and Local Plan
9.3
We build an exemplar model of residential care at the Whiteacres site containing 45 self-contained flats, giving residents the dignity and independence of their own home, but with the same level of care currently provided in residential and nursing facilities
9.4
We will include 30 self-contained studio units within the Whiteacres site for intermediate care and reablement use, facilitating earlier discharge from hospital, with 24/7 specialist care on site and clinical in-reach from our Virtual Ward model
9.5
We will bring forward and agree a business case with Cabinet and NHS partners for Whiteacres in 2022/23.
9.6
We will develop and implement a new flexible exemplar model of supported living for residents with mental health problems, starting by purchasing two dedicated properties in 2022/23, with flexible care 'in-reach'.

Chapter 10:
Making It Happen

Integrated Governance, Delivery and Commissioning

Chapter 10: Making it Happen: Integrated Governance, Delivery and Commissioning

10.1 Introduction

The establishment of good governance arrangements is essential to delivering the vision and aims set by any organisation or contained within any strategy. These arrangements are core to being successful. Chapter 10 of the main strategy document sets out detailed proposals on governance between the ICB and Thurrock integrated Care Alliance (TICA), a place-based delivery mechanism for the strategy, and a new integrated commissioning approach to support delivery.

The arrangements set out within this Chapter reflect how the health and care system at a place-based level (Thurrock) will be governed – meaning how the system will ensure the delivery of our Strategy's vision and aims. This will include the adoption of a new 'learning' culture by all partners involved.

10.2 Governance between the MSE ICB and TIA

Thurrock's health and care system will be based on the principle of subsidiarity and be governed through Thurrock's Integrated Care Alliance (TICA). Arrangements will confirm how Thurrock's system will co-exist with the broader Mid and South Essex Integrated Care System – with the relationship and responsibilities between the two systems to be contained within a devolution and delegation agreement. Governance must be enabling and focus on delivering the best outcomes for Thurrock people at all times. The devolution agreement will set out clear expectations on both sides and will establish a series of key high level place-based outcomes against which performance could be routinely evaluated. The arrangement will need to specify what mitigation would be taken and by whom when performance levels were not being achieved and agree a form of escalation and, ultimately of sanction when mitigation did not drive anticipated improvements.

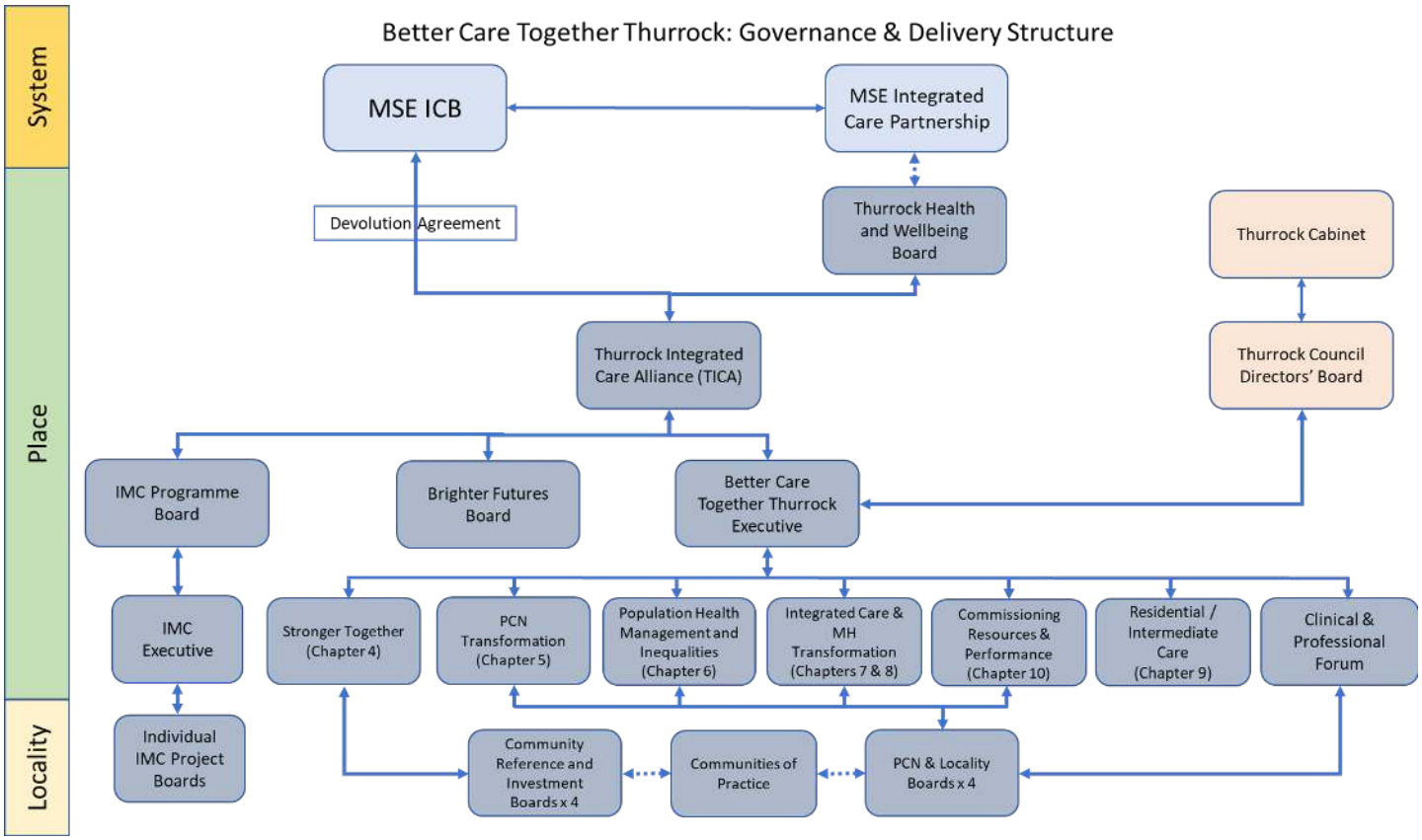
10.2 Governance and Delivery at Thurrock level

With system funding being managed through a reviewed Better Care Fund, TICA will have the responsibility for ensuring resources across Thurrock are used to ensure required outcomes are achieved. This includes decisions about de-investment and re-investment.

Most organisational and partnership governance arrangements correspond to the attributes of New Public Management (NPM). This reinforces a system based on 'command and control' and on outputs over outcomes. Our arrangements will be underpinned by the attributes of Human Learning Systems – meaning that they will start and end with the individual and the outcomes they wish to achieve. We will develop governance that is collaborative – working across organisations and communities alike and sharing the power often held by the few. Most importantly, the organisations responsible for the health and care system will be held to account by communities.

Delivery structures too will shift away from NPM and embrace a collaborative and distributive format. An Alliance representing all key partners will act as a 'steward' for the local system, with a range of mechanisms, including boards and focus groups to facilitate and enable good delivery. Figure 10.1 overleaf sets out draft arrangements which will be kept under review.

Figure 10.1



Governance and delivery arrangements are not about one board or group, but about a set of inextricably linked functions underpinned by certain conditions – conditions that epitomise an enabling and person-led approach.

The functions essential for good governance include, amongst others, performance, risk, financial management, information and data, policy and procedure, and commissioning.

10.3 Changing the Commissioning Landscape

One of the foremost governance functions considered within the chapter is 'commissioning'. A new model of commissioning will be adopted that aids the move away from traditional silo model to one that works to deliver bespoke solutions for people requiring support. The shift will mean:

- Flexibility within contracts – building trusting relationships with and between providers;
- Operating around complexity – across service and organisational boundaries;
- Commissioning for learning – enabling providers to be part of testing and changing what they deliver – including doing so collaboratively with other providers;
- Pooling of funding – introducing the pooling of resource across 'place' through use of the Better Care Fund to enabling commissioning solutions that are multi-faceted and cut across organisations and services more easily;
- Broadening the market place and the breadth of choice; and
- Ensuring communities can have a direct role in the commissioning process – shifting to a 'community-led' approach to commissioning.

A number of bespoke pieces of work will be carried out to take the chapter forwards, and these are detailed under the 'Strategic Actions' section.

10.4 Summary of Strategic Actions from Main Strategy

SUMMARY OF STRATEGIC ACTIONS

GOVERNANCE

10.1	We will develop and agree a 'Devolution Agreement' between the ICB and TICA that sets out respodevolved commissioning and delivery responsibilities, outcomes, and resources
10.2	We will develop a new Alliance agreement between all partners for the Thurrock Alliance setting out local governance arrangements, a place based outcomes framework and any financial risk and reward share between partners

DELIVERY

10.3	We will establish the delivery structure set out in 10.1 of this strategy, with named chief officers accountable for delivery of each of the boards and clear TORs
10.4	We will develop and implement one year Thurrock Integrated Care Alliance Delivery Plans based on the strategic actions within this strategy with named SROs for each action and associated business cases

COMMISSIONING

10.5	We will devise a series of 'learning experiments' to shift the working practice of commissioners and providers to one based on HLS principles – establishing 'learning cycles' as a way of working between commissioners and providers
10.6	We will establish a 'learning infrastructure' and mechanisms to capture and share learning between all system actors to inform commissioning, delivery and practice
10.7	We will implement 'system steward' training for all existing commissioners
10.8	We will refresh our existing Market Development Strategy to take into account the principles of HLS and place-based commissioning.
10.9	We will undertake a full review of the Better Care Fund to establish it as the financial delivery mechanism for Thurrock single pooled place and locality budgets and the strategic actions set out within this strategy.
10.10	We will test, evaluate and establish single models of commissioning the span a number of different service areas across the NHS & council, with accompanying pooled budget and governance arrangements

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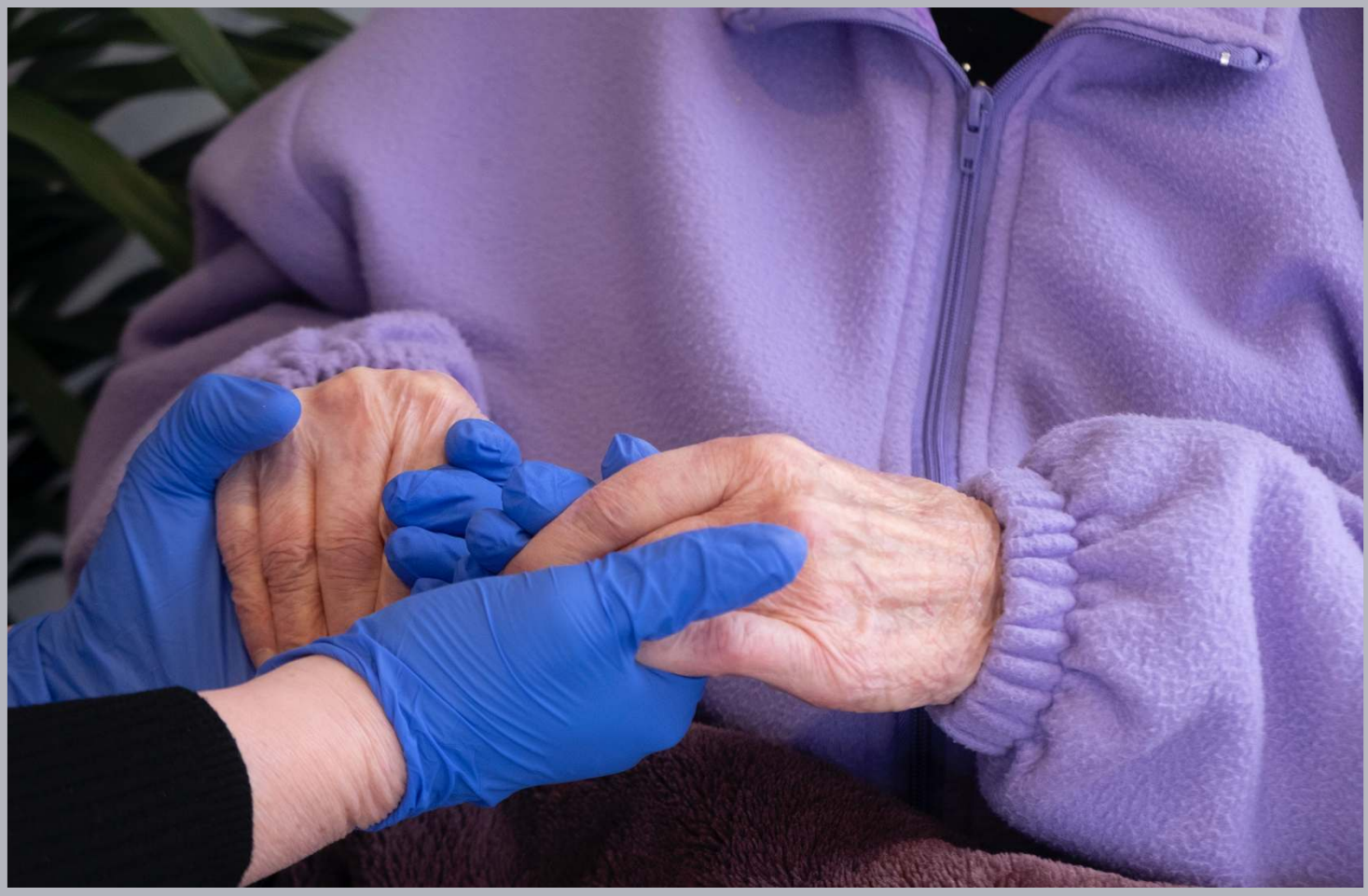
Appendix B



Better Care Together Thurrock

The Case for Further Change 2022-2026

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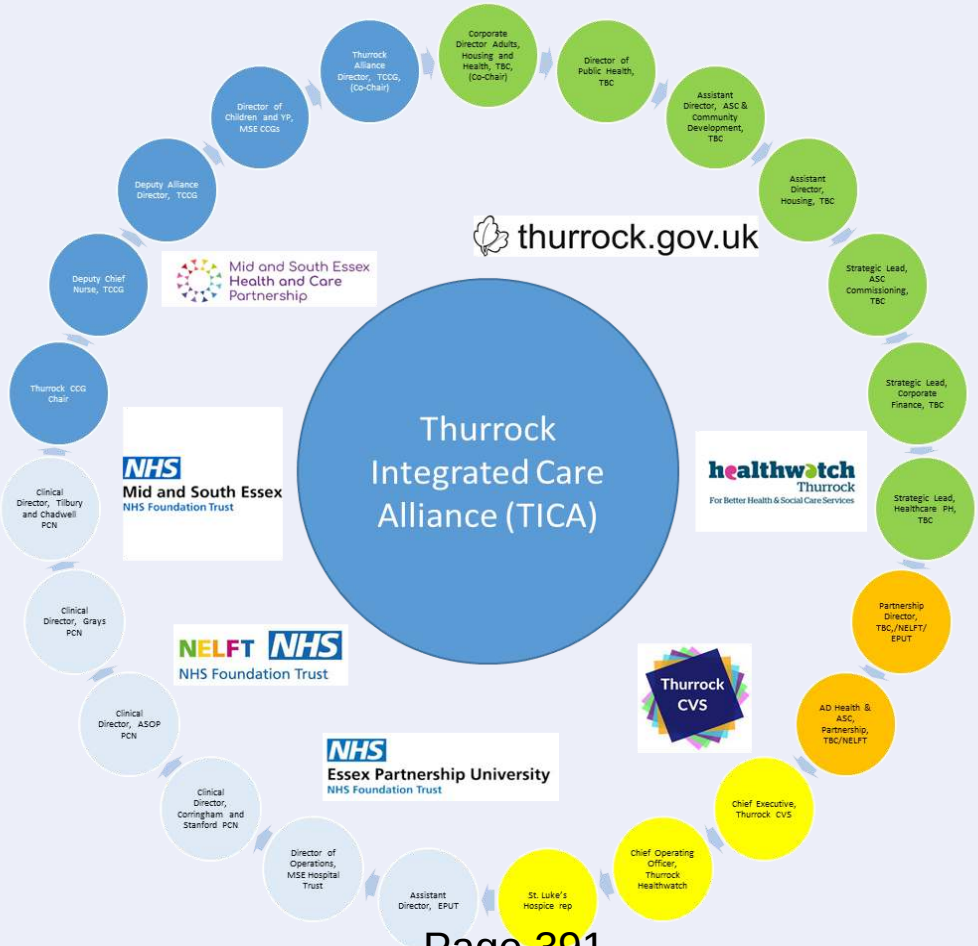
Introduction

This *Case for Further Change* strategy sets out a collective plan to transform, improve and integrate health, care and third sector services aimed at the borough's adults and older people to improve their wellbeing.

This strategy has been developed and agreed by the Thurrock Integrated Care Alliance (TICA) and its partner organisations. Partners across Thurrock have a long history of working together to agree and deliver shared outcomes. The approach taken has been inclusive, bringing together commissioners, providers and colleagues from Thurrock Council, the NHS, third/voluntary sector and Healthwatch. It also reflects on-going comprehensive engagement with residents including co-design and co-production approaches.

In late 2019, following a review of local arrangements, partners agreed to strengthen, further embed and accelerate collaborative arrangements by establishing the Thurrock Integrated Care Alliance. TICA is the highest strategic level officer only partnership responsible for health, care, housing and third sector service strategic transformation across the borough including developing and overseeing the deployment of the Better Care Fund.

The current membership of TICA is shown below.

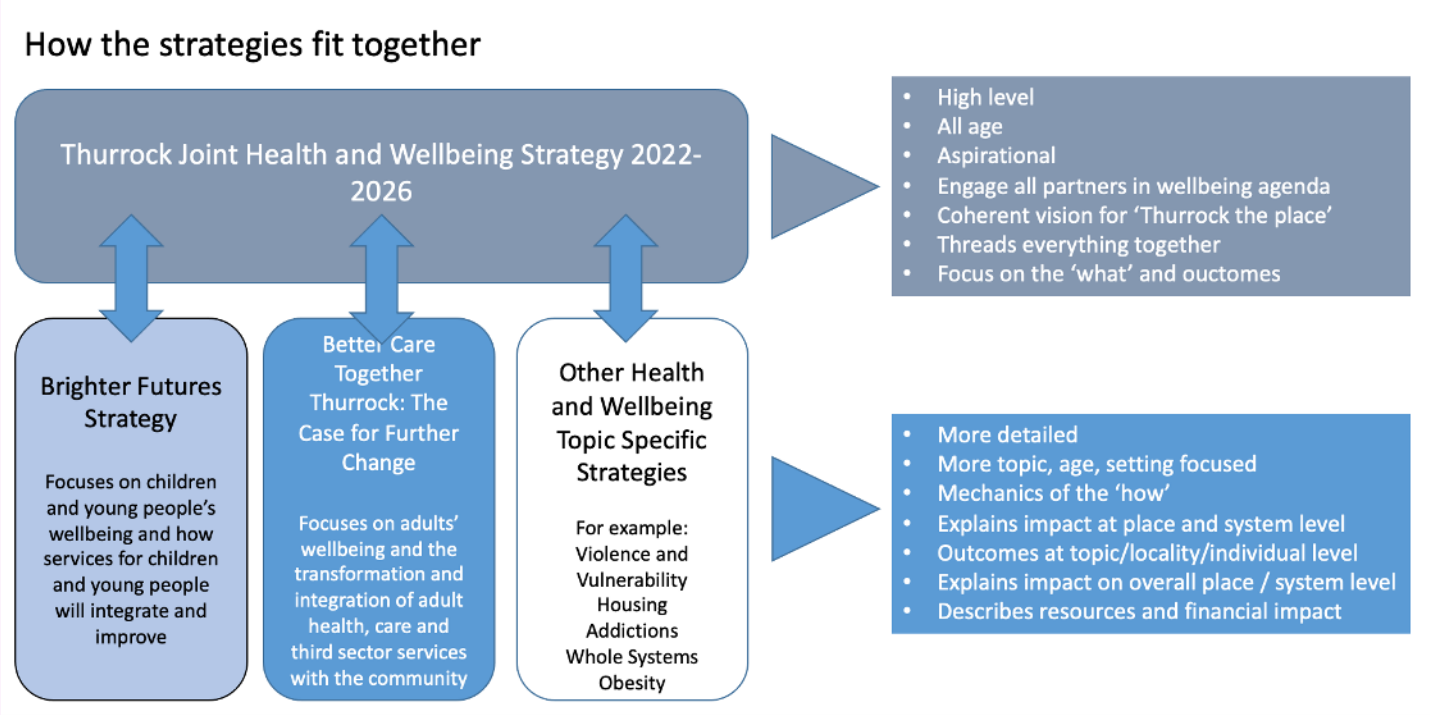


Strategic Context

From April 2022, Thurrock will be one of four *Alliance Places* that sit under the Mid and South Essex Integrated Care System (MSE ICS). The Kings Fund has recognised that 70% of health care integration and transformation operates at a geographical level below ICS boundaries, and the new MSE ICS has recognised the key principle of *subsidiarity*, that decision making on the planning and delivery of health and care services should be made at the lowest possible geographical level.

As such, the MSE ICS has proposed making the four *Alliances* sub committees of the Mid and South Essex Integrated Commissioning Board with the opportunity to negotiate significant delegated decision making authority and resources based on agreement of strategic plans at *Alliance/Place* level.

This strategy forms part of a suite of three documents that describe Thurrock's *Place Based Strategy* as shown below



The Thurrock Joint Health and Wellbeing Strategy 2022-2026 is the highest level strategic document that describes our collective ambition to improve the health and wellbeing of our residents. The theme of the strategy is *Levelling the Playing Field* and the strategy sets out high level actions to address health inequalities across the six domains of:

- Healthier for Longer including mental health
- Building Strong and Cohesive Communities
- Person Led Health and Care
- Opportunity for All
- Housing and the Environment
- Community Safety

The Joint Health and Wellbeing Strategy therefore addresses the wider determinants of health including education, employment, crime and community safety, and housing, as well as healthy lifestyles and health and care. It concentrates on the 'what' and the 'why' and points to additional more detailed and topic specific strategies that deal with delivery of individual objectives (the '*how*').

Two key additional documents sit underthe Joint Health and Wellbeing Strategy, of which, this is one.

The second is the *Thurrock Brighter Futures Strategy,* which sets out our collective plans to improve the health and wellbeing of children and young people in the borough.

How this strategy is structured

Chapter 1 provides an introduction to Thurrock and sets out the high level health needs of our residents, our ambitious place based regeneration plans and our collective transformation journey over the past decade.

Chapter 2 describes the collective vision, aims, principles and values that all partners have signed up to, and that underpin our work. It also describes the *Human, Learning, Systems* approach on which the next phase of our transformation journey is based.

Chapter 3 describes our overall new model of care on which this strategy is based and how the respective elements fit together.

Chapters 4 to 9 unpack the detail behind our six strategic actions to transform, integrate and improve care:

Chapter 4 builds on our vision and values to explain how we will make them real, and critically, how we will engage the third sector and communities as equal partners in our strengths and asset based approach moving forward.

Chapter 5 details our plans to improve access and quality of General Practice in the context of the new Primary Care Networks

Chapter 6 sets out our approach to transforming care from reactive to proactive and preventative using Population Health Management Techniques to deliver improved primary prevention and the diagnosis and management of long term conditions

Chapter 7 describes how we will build an integrated health and care community workforce around each PCN to deliver proactive holistic, strengths based care to our residents, maximising the opportunities of the new Integrated Medical Centres.

Chapter 8 details our plans to transform care at home including the next phase of our Wellbeing Teams model.

Chapter 9 describes our plans to re-imagine how we deliver residential and intermediate care through our proposals for an "Extra Care Plus" facility at the Whiteacres site in Thurrock.

Chapter 10 discusses the practical delivery enablers we require to make this strategy an reality including governance, integrated budgets, integrated commissioning, management and development of the market and how we will monitor performance and quality.

Chapter 1: Introducing Thurrock

Chapter 1. Introducing Thurrock

1.1 Welcome to Thurrock

Based at the heart of the Thames Gateway in close proximity to the east of London, Thurrock is a busy borough with picturesque towns, reams of beautiful countryside and 18 miles of river frontage. We are a borough of contrasts with urban areas of Grays, Tilbury and Purfleet to the south and rural villages and open countryside to the north. Our borough boasts more than 18 miles of beautiful river front and his proud of its rich heritage and growing cultural scene. 70% of Thurrock is greenbelt, with several rural villages and many areas of wildlife and natural beauty.

Historic Thurrock

The borough is home to two historic forts that were built to protect the Thames estuary. Tilbury Fort is where Queen Elizabeth I delivered her stirring speech to troops gathered to battle the Spanish Amadea, whilst Coalhouse Fort was built in the latter half of the 19th century as part of a new front line defence. The Thurrock Museum in Grays showcases 250,000 years of the borough's eventful past.

Opportunity and Growth

Thurrock is a unique place and its geography, economy and demographic profile distinguish it from neighbouring authorities. We are home to some of the most exciting opportunities in the county. Our growth programme is perhaps the largest and most ambitious in England. £6Bn has already been invested by the private sector in Thurrock up until 2017, with 7,000 new jobs created and 1,170 new businesses choosing Thurrock including leading ports and logistics centres, retail and creative industries.

Purfleet on Thames

Purfleet Centre Regeneration Limited is a joint venture between Urban Catalyst and Swan Housing in partnership with Thurrock Council to regenerate over 140 acres to create Purfleet-on-Thames. Developed on healthy town principles, Purfleet-on-Thames will create a new waterfront destination on the River Thames; an international create hub and high quality new residential with place making at its core. The vision for Purfleet-on-Thames includes:

- A state of the art film and TV studio facility and related creative industry hub
- Attractive new waterfront commercial and retail space
- Up to 2,850 new homes, including significant health and education facilities
- Community facilities
- Leisure uses
- Upgraded and additional public transport facilities

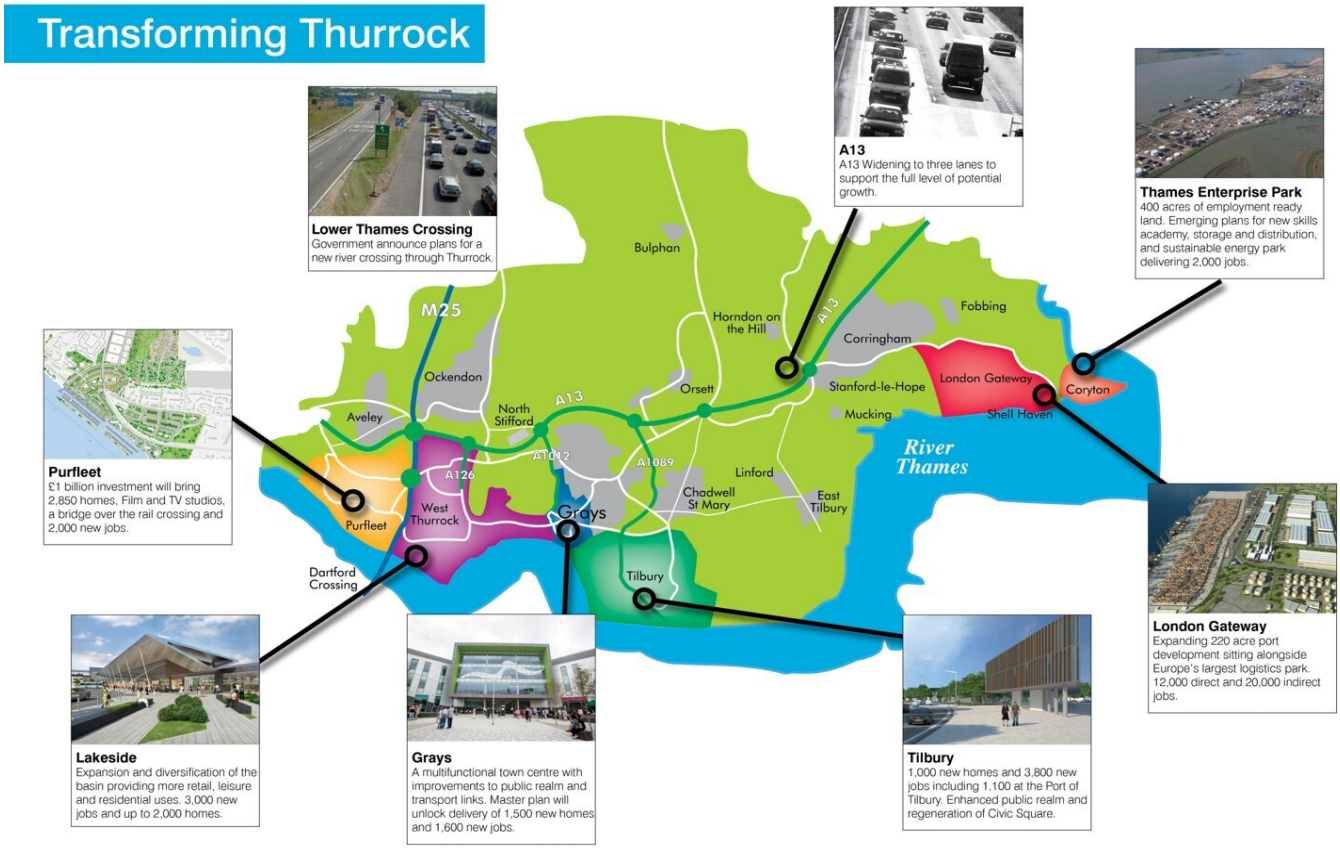
Thames Freeport

A successful bid backed by Thurrock Council to create a Thames Freeport will deliver transformational change across the entire borough, create 25,000 direct new jobs and up to another 20,000 indirect job opportunities, and will see unprecedented inward investment. Thames Freeport is an economic zone connecting Ford's word-class Dagenham engine plant to the global ports at London Gateway and Tilbury. Businesses looking to expalnd or reshore their operations will be able to take advantage of the tax benefits of establishing within the Freeport and being part of a customs zone, which makes it easier and cheaper to move goods into and out of the country.

More broadly, over 1,000 acres of land are ready for commercial development with 30,000 new homes likely to be built. Thurrock is at the heart of global trade and logistics, with no fewer than three international ports. We are well positioned on the M25 and A13 corridors with excellent transport links west into London, north and east into Essex, and south into Kent.

Figure 1.1 below shows the extent of our regeneration plans.

Figure 1.1



1.2 The Health of Our Residents

Thurrock is home to a diverse population of residents that is increasing by over 10% every decade. Our current population is estimated to be 178,300. Structurally, our population is younger than England's with 22% being aged 14 and under.

The 2011 census found that 81% of our residents were White British and 19% from a non White British background with Black African, Caribbean and black British being the second most common ethnicity at 7.82%

Mortality

The main causes of death amongst Thurrock residents in 2020 were cancer, cardio-vascular disease, COVID-19, dementia and respiratory disease. For premature (under 75) mortality, they were cancer, cardio-vascular disease and COVID-19. (Figures 1.2 and 1.3)

Figure 1.2

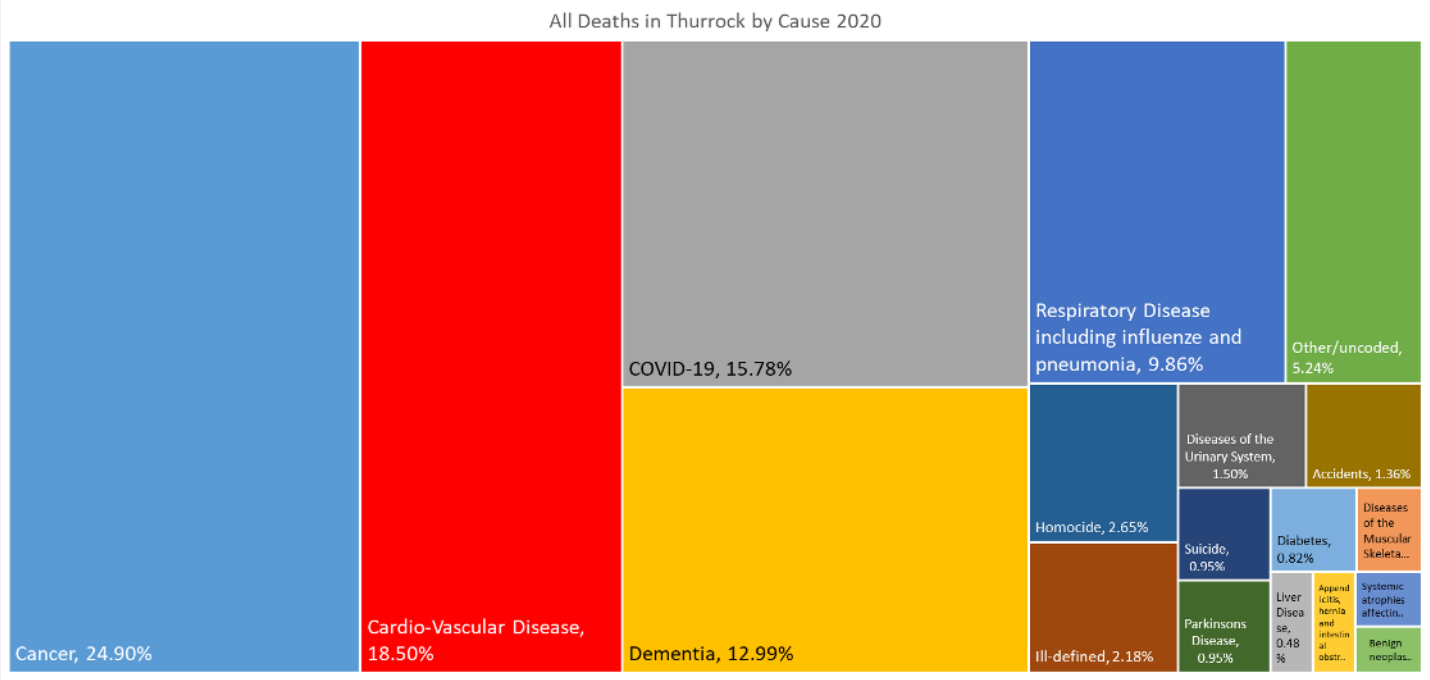
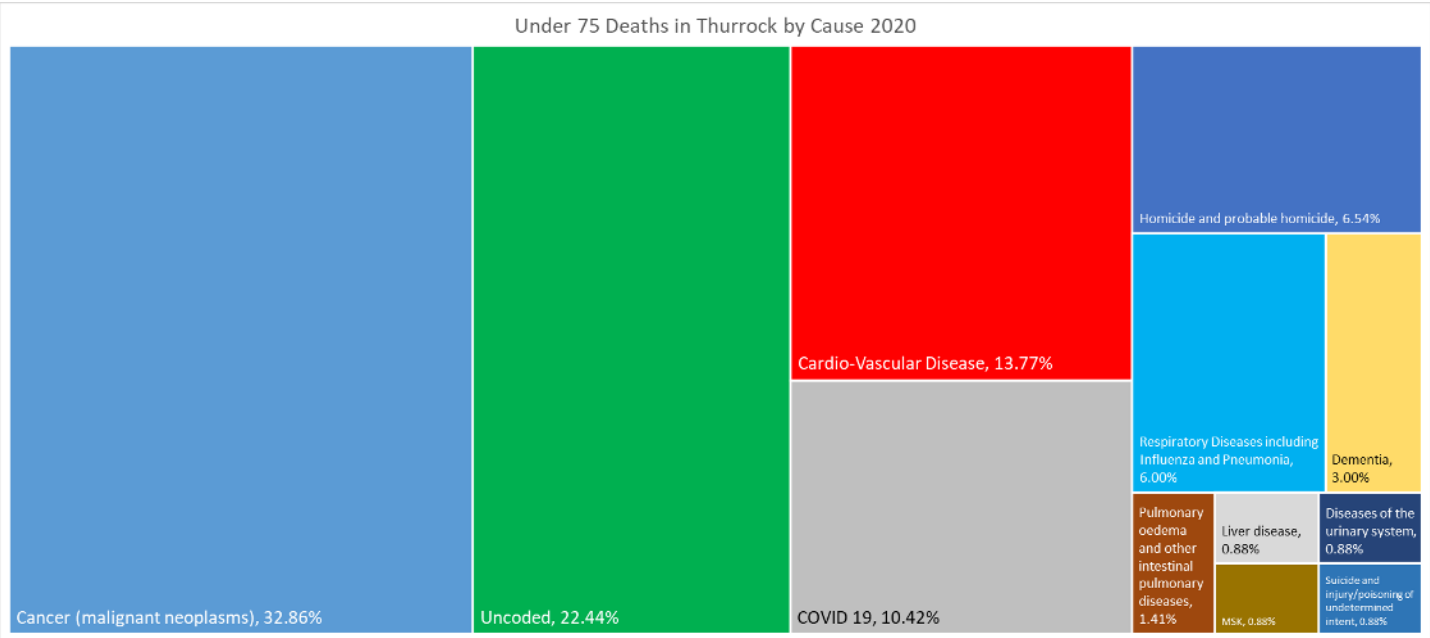


Figure 1.3



Health Inequalities

Health inequalities remain a significant issue in Thurrock with our more deprived populations suffering lower levels of both total life expectancy and the numbers of years of their life that they can expect to live without disability.

Figures 1.4 and 1.5 show life expectancy and disability free life expectancy for males and females in Thurrock by IMD 2019 deprivation decile. They demonstrate the clear health inequity between both total life expectancy and disability free life expectancy linked to deprivation, with both measures increasing as deprivation decreases. Only the least deprived 35% of our population are likely to reach retirement age before reaching the end of disability free life.

Figure 1.4

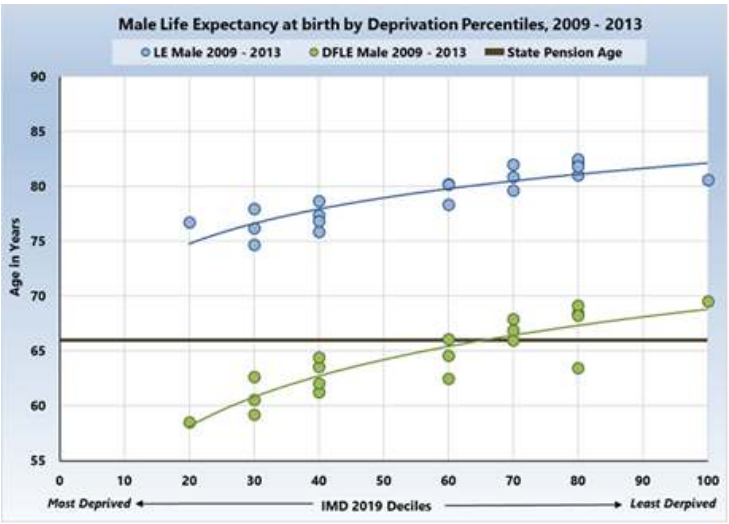
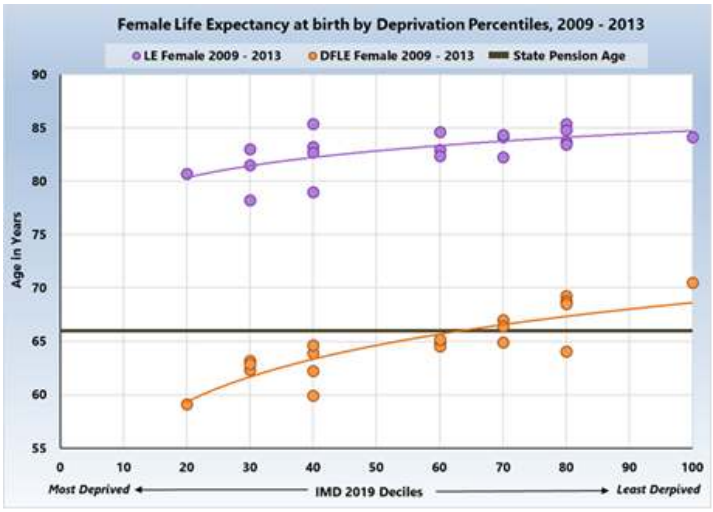


Figure 1.5



The Mortality Attributable to Socioeconomic Inequality (MASI) index shows the total number of deaths and mortality rate per 100,000 population attributable to socio-economic deprivation. Thurrock has the third worse MASI in Mid and South Essex with 2,522 deaths being attributable to socio-economic causes between 2003 and 2018 (Figure 1.6).

Figure 1.6

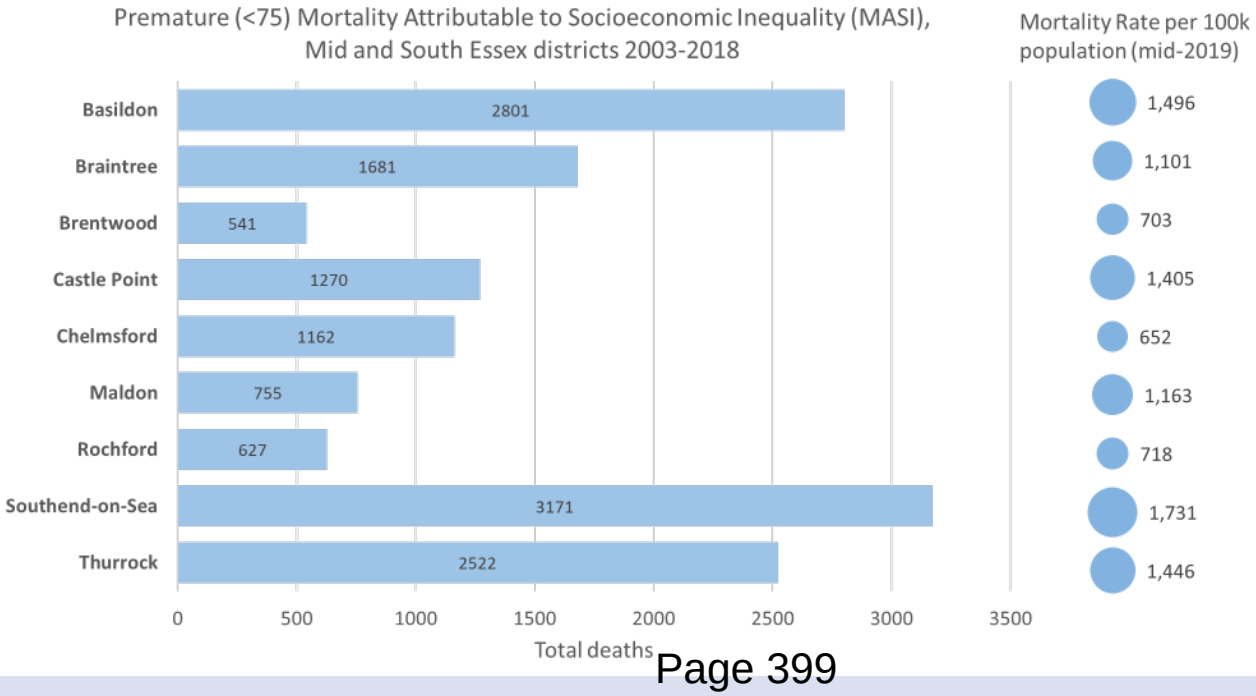
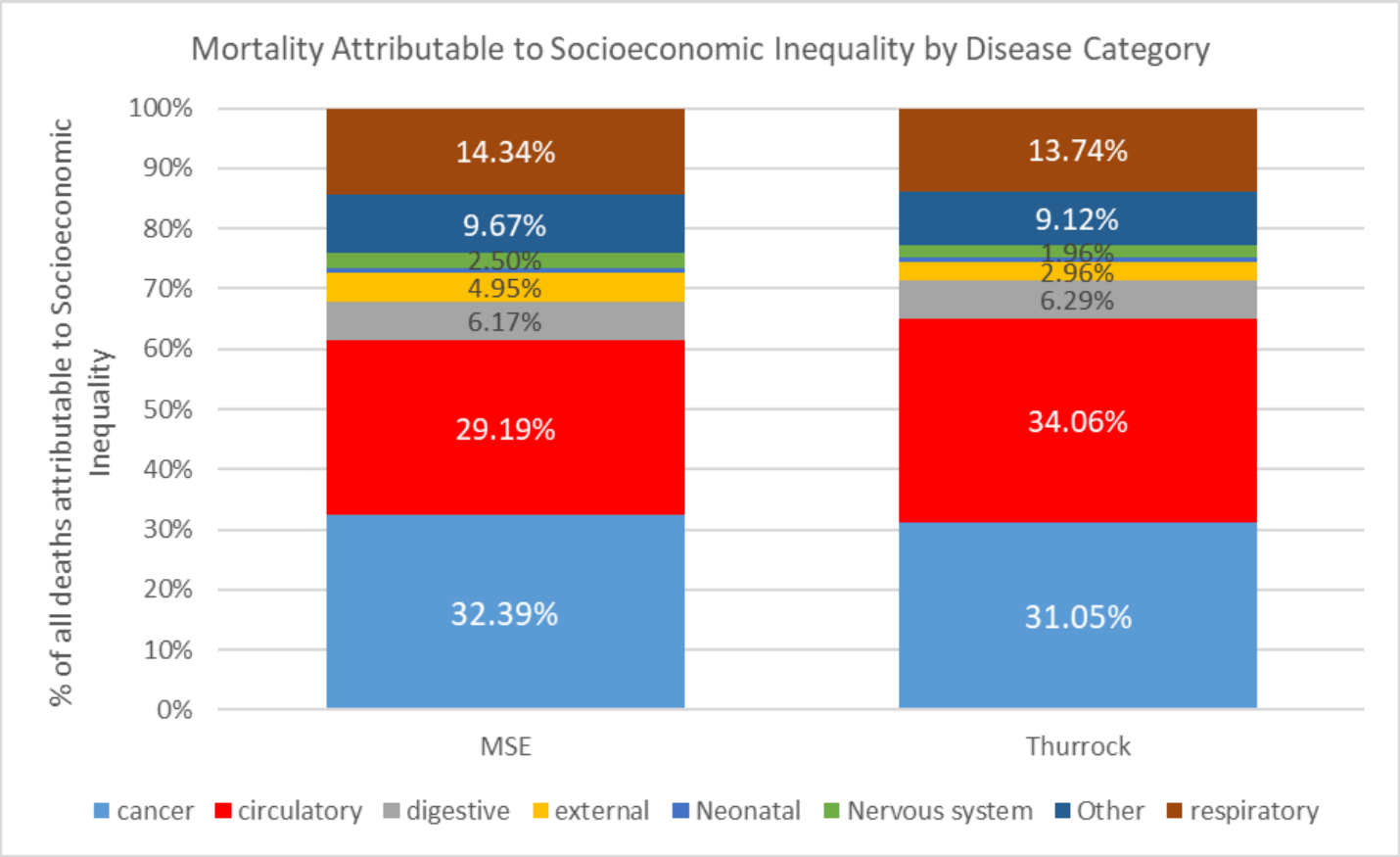


Figure 1.7 shows the underlying causes of deaths due to socio-economic inequality for Mid and South Essex and Thurrock. Thurrock's main cause of death due to socio-economic inequality in cardio-vascular disease. This differs from Mid and South Essex where cancer is the most common cause of death driven by socio-economic inequality.

Figure 1.7



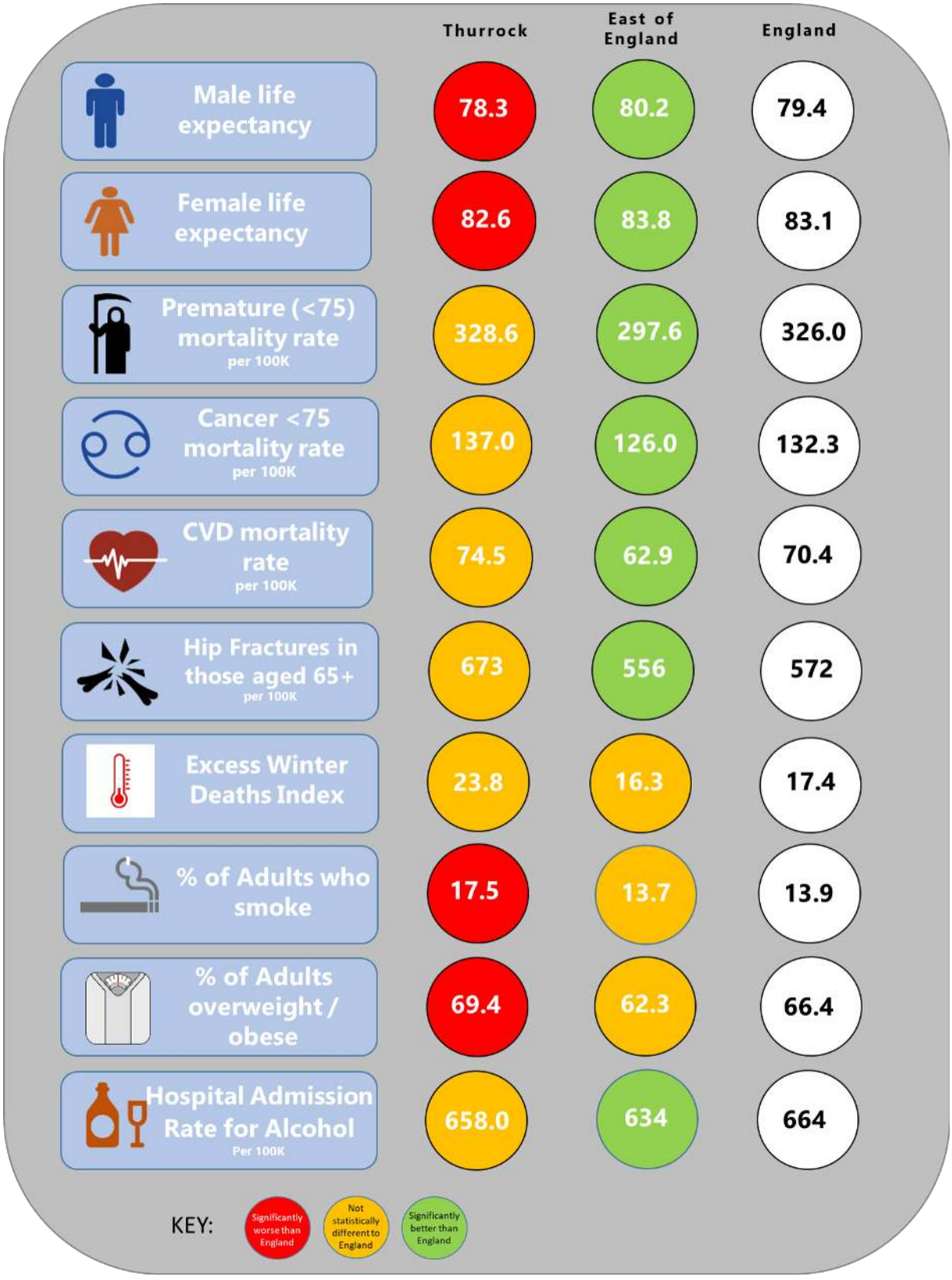
Comparative Health Need

Figure 1.8 overleaf summarises some of the key health outcome metrics and compares Thurrock to regional and national averages.

Thurrock's population is generally less healthy than that of the East of England and England. This reflects the higher levels of deprivation and health inequalities faced by many of our residents within the borough.

The more flexible way in which Integrated Care Systems can allocate resources presents an opportunity to distribute funding in a fairer and more equitable way to address the higher health needs of Thurrock residents compared to more affluent communities within our local system..

Figure 1.8 Comparative Health Need of Thurrock Residents to East of England and England



1.3 Thurrock's Transformation Journey

Thurrock has been developing and refining its vision for the local health and care system since 2011 when the Commission of Enquiry into Cooperation between Housing, Health and Social Care across local authorities in South Essex produced its report. Responding to the Ageing Well agenda, the Commission of Enquiry identified the need to shift the health and care system to a position where it focused on improving wellbeing rather than being designed to respond to need. This introduced a focus on what the community itself had to offer and started the move away from the 'service knows best' approach that had tended to dominate public service. The Commission of Enquiry announced the arrival of the first health and care transformation programme – **Building Positive Futures** (BPF), and the first step towards changing the construct of the local health and care model.

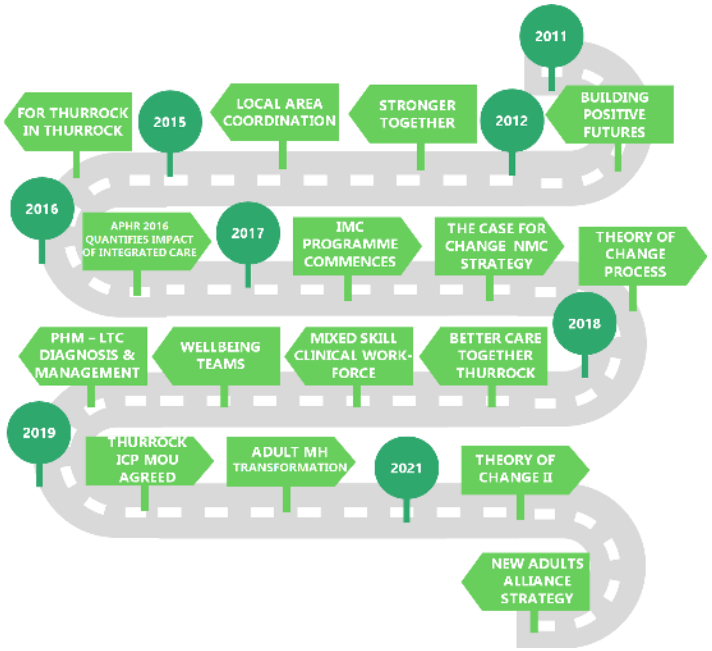
Stronger Together: developing an holistic and asset-based offer

Such was our belief in the power of communities to enhance people's lives, that the **Stronger Together Partnership** was established. The partnership was very much a collaboration of people who wanted to do things differently and saw the value of the community and its assets. Led by Thurrock's Community and Voluntary Service (CVS), and working in partnership with council, local NHS and local community and voluntary sector groups, Stronger Together Thurrock introduced a programme of initiatives based on developing and embedding a strengths and assets based approach. A range of innovative programmes were developed including Micro-Enterprises, Time Banking, Social Prescribing and Community Hubs.

Local Area Coordination - achieving a 'good life'

The introduction by the Partnership of Local Area Coordination (LAC) helped show that there was a different way of supporting people often on the cusp of entering services, at the point of crisis, or deemed 'complex' by the existing system. It also showed that there was a different way of delivering public service.

Thurrock's Transformation Journey



LAC proved that people with the most complex circumstances could build their own vision 'for a good life' and be empowered to find pragmatic and innovative solutions – drawing on family and community resources, before considering commissioned or statutory services. Local Area Coordinators were released from the bureaucracy associated with public service to have the time needed to help people realise their version of a 'good life', help people build connections and capacity so that they became more resilient, and build new community connections and capacity where it did not already exist.

Local Area Coordinators were able to build trusting relationships with the people they supported and others within the community as well as finding ways to work across organisations and services. The lessons from LAC and Stronger Communities were the catalyst for rethinking how public service operated and its relationship with the people it was there to support. Ultimately, it was about moving public service from 'doing to' and 'doing for' to 'doing with' – or ultimately people 'doing by themselves'.

For Thurrock in Thurrock

For Thurrock in Thurrock proposed a new model of health care that would place greater emphasis on care based within distinct areas (localities). Health and social care teams would work closely together to deliver care closer to home, moving away from the current more complex system.

The proposals aimed to see less fragmentation between services and less reliance on services. There was a focus on the delivery of local care with greater integration between providers to ensure best use of available funds.

Achievements under For Thurrock in Thurrock included:

- Commissioning the delivery of ***Social Prescribing*** (via Stronger Together Thurrock and Thurrock CVS)
- The implementation of ***Thurrock First*** - an integrated single point of contact across community health, mental health and adult social care
- The implementation of the ***Rapid Response and Assessment Service (RRAS)*** - a joint team by Thurrock Council and NELFT comprising of advanced nurse practitioners, social workers and healthcare assistants that provides rapid health and social care assessment for residents and their carers approaching crisis. The team aims to provide immediate care and support with a view to preventing avoidable hospital and residential care admissions.
- Other local initiatives such as ***Shared Lives***, which enabled people with care needs to live with a carer or family in their home, and ***Time Bank Thurrock***, which encouraged volunteering and the sharing of assets within communities.

The Integrated Medical Centre Programme

In 2015 the Care Quality Commission highlighted a major crisis in Primary Care, rating the majority of our GP surgeries as 'Requiring Improvement' or 'Inadequate'. Thurrock was highlighted as the fourth most under-doctored area in England with ratios of Full Time Equivalent GPs:Patients reaching 1:13,000 in some surgeries.

After undertaking locality needs assessments, our Public Health Team recommended the creation of four Integrated Healthy Living Centres (since renamed Integrated Medical Centres) as one solution to both improve primary care capacity and create attractive working environments that would attract new GPs to the Borough.

The recommended blue print saw the inception of a programme agreed with system partners to create four Integrated Medical Centres as a new focus from which to deliver integrated health and wellbeing services including a new and expanded Primary Care offer, diagnostics, secondary care outpatient clinics, health improvement and lifestyle modification programmes, community and mental health treatment, and services to address the wider determinants of health including community and voluntary grups, libraries and community hubs, housing advice and local area coordination.

The Case for Change: A New Model of Care

Chronic under-doctoring in Thurrock helped to accelerate system change in Thurrock and helped to further the new architecture for health and care. The production of a new strategy - ***The Case for Change - A New Model of Care*** was designed to enhance capacity in Primary Care, but also improve the identification and management of Long Term Conditions, and enable the health and care system to shift to focus on enabling people to 'achieve a good life'. This piece of work developed by the then Director of Public Health introduced a 'New Model of Care' for the local health and care system.

The findings and recommendations encompassed whole system change and led to the initial phase of the Better Care Together Thurrock transformation programme. It concluded that:

- Funding and patients were in the wrong part of the system (Acute) with the system set up to react to crisis and a need to shift demand from the 'acute' end 'upstream' to the community;
- Inadequate capacity in Primary Care was contributing to inadequate quality (and increased pressure on the rest of the system) meaning that people with Long Term Conditions were potentially not being identified and managed and that a priority for system redesign should include increasing capacity in Primary Care, Community Healthy and Adult Social Care;
- Solving the capacity and quality issues would mean that money would be freed up; and
- Solving the quality issues would mean integrating the system – and the money.

Better Care Together Thurrock

The Case for Change - A New Model of Care led to a ***Theory of Change*** process where system partners came together to agree new transformation system priorities. This led to the creation of ***Better Care Together Thurrock*** - our agreed programme of adult health and care transformation to implement the *Case for Change* strategy. It included a number of initiatives being introduced and tested in one particular area of the Borough (Tilbury and Chadwell). These included:

- The development of a Primary Care Network (prior to the introduction of PCNs as part of the NHS Long-Term Plan) – bringing GP practices in Tilbury and Chadwell together with the opportunity to share resources and capacity;
- Enhancing the capacity of Primary Care through the introduction of a mixed skilled clinical team – moving away from people always seeing a GP when they did not need to or where it was more appropriate for them to see a different clinician;
- A Population Health Management Programme focussing on improving the diagnosis and management of Long Term Conditions.
- The creation of Wellbeing Teams as a radically different way to deliver integrated, person centred health and care to residents with high levels of care acuity (see below)

Through this work, a strong focus on redefining the current system around 'place' and 'neighbourhood' was emerging and would become the organising principle for the future health and care system. The *Case for Change* also marked the time that all system players would sign up to an agreed 'direction of travel' and therefore the basis for redesign.

The emergence of a 'blue print' for the future system

At the same time, work was developing to provide additional capacity for Primary Care through the introduction and testing of new models of enhanced skills workforce. Adult Social Care introduced two key 'test and learn' initiatives utilising the same PCN geographical 'footprint'. Whilst the initiatives were introduced to help shape and redesign social care, they also provided the opportunity to test a collaborative and place-based approach to working with health and the community – plus other organisations and services key to delivering improved outcomes for people. A future health and care 'blue print' was starting to emerge.

The key initiatives that were introduced would test a completely new way of delivering social care and provide the basis from which an integrated health and care system could be developed further:

Community Led Support – located within the community, CLS social work teams focused on reducing unnecessary bureaucracy and challenging anything that stopped the team from doing what was right for the individual.

They created easier ways for people to access advice and support and co-created solutions with individuals that were based on 'what mattered' rather than needs and conditions. Much of the approach mirrored the principles that had made Local Area Coordination so successful. In addition, CLS principles were consistent with recommendations and learning that had emerged from Building Positive Futures and with the Case for Change:

- Co-production brings people and organisations together around a shared vision;
- There is a focus on communities and each will be different;
- People can get support and advice when they need it so that crises are prevented;
- The culture becomes based on trust and empowerment (with and across organisations);
- People are treated as equals, their strengths and gifts built on;
- Bureaucracy is the absolute minimum it has to be; and
- The system is responsive, proportionate and delivers good outcomes.

Wellbeing Teams – were designed to respond to the fragility of the current domiciliary care market, but more importantly test the delivery of a very different approach to providing support in the home. Consisting of small self-managed teams, Wellbeing Teams moved away from a traditional 'time and task' approach to domiciliary care and instead co-produced the support required with the individual focusing again on what mattered most. Team members were recruited against values rather and were recruited on a salary.

Like CLS, Wellbeing Team principles were consistent with what had been learnt through the development of Building Positive Futures, Stronger Together Thurrock, and A Case for Change. Both Wellbeing Teams and CLS showed what could be achieved when working at a locality level and provided a sound base from which to construct the health and care system people required rather than the system provided.

A Memorandum of Understanding across the Integrated Care System – defining the role of place in delivering population health

With the NHS White Paper establishing Integrated Care Systems (ICS) that would cover a geography far greater than the boundaries of Thurrock, it was key that the overriding vision for a place-based agenda was agreed not only by local system partners, but also by partners across the broader ICS.

An ICS partnership Memorandum of Understanding (MoU) was developed based on the principle of subsidiarity and a population health system. The nature of the agreement contained a commitment to:

- Prevention;
- Partnership;
- Whole Systems Thinking;
- Strengths and Asset Based Approach;
- Subsidiarity;
- Empowering Staff to 'do the right thing';
- Pragmatic Pluralism;
- Leverage Health Intelligence and the Evidence Base; and
- Innovation.

The MoU recognised *'the critical and increasing importance of localities and PCNs'* and supported *'the principle of subsidiarity; that the starting point for planning, transforming and delivering services should be at the most local level practicable'.*

Furthermore, the MoU cemented the *'aspiration to deliver Community-Led Commissioning/Resource prioritisation'* and recognised the need *'to shift power from organisations to communities, allowing them to drive what is commissioned, what it looks like, and to be part of the decision-making process'.*

The MoU acknowledged Thurrock as a defined 'place' – one of four across the Mid and South Essex Integrated Care Partnership.

Adult Mental Health Service Transformation

Following issues highlighted by Thurrock Healthwatch and a Local Government Peer Review Team, Thurrock embarked on a major programme of mental health service transformation including a new crisis care pathway and new Integrated Primary and Community Care model of care based around each PCN and co-designed with primary and secondary care clinicians and the community. This is explored further in Chapter 7.

Chapter 2: Our Vision, Aim, Principles and Values

Chapter 2: Our Vision, Aim, Principles and Values

2.1 Introduction

Chapter 1 set out our transformation journey to date. This chapter builds on that journey, and sets out our vision and aim for transformed and integrated health, wellbeing and care in Thurrock moving forward.

We share a collective passion to move from a 'one size fits all' top down, centralised and deficit driven approach to one that recognises the uniqueness of each resident and the need to co-design human solutions based on strengths and assets in the context of a whole system managed through learning. Section 2.2 of this chapter describes the failure of the paradigm of *New Public Management* through which we have historically delivered much public service over the last 30 years, and proposes a new *Human Learning Systems* approach and values that we will adopt to deliver transformational change.

Section 2.3 translates this theory to practice in Thurrock. It sets out our shared vision, goal and principles through which we will deliver transformation in Thurrock based on the *Theory of Change* workshops that all senior Thurrock leaders have participated in, and from wider stakeholder engagement at our recent *Better Care Together* three day conference.

2.2 Human Learning Systems

The space in which the MSE ICS and Thurrock Integrated Care Alliance operate in is multi-factorial and messy. Every one of our residents is unique and complex.

People have different strengths and skills and face different challenges that they respond to in a myriad of different ways. The issues we are trying to solve are complicated and difficult. Challenges such as obesity, diabetes, mental ill health or homelessness are caused by a tangled web of different interdependent causes. The systems designed to respond to these challenges are complicated and are not necessarily designed to deliver the outcomes people want – they often deliver 'interventions' in silo and have traditionally applied a 'one size fits all' approach to a 'problem'. The range of people and organisations involved in creating outcomes for residents is usually beyond the management control of a single person or organisation. For example, what arrives at the 'front door' of adult social care is often a result of actions that occurred at the hospital, by the community health provider, by the GP practice and/or within the family or community itself.

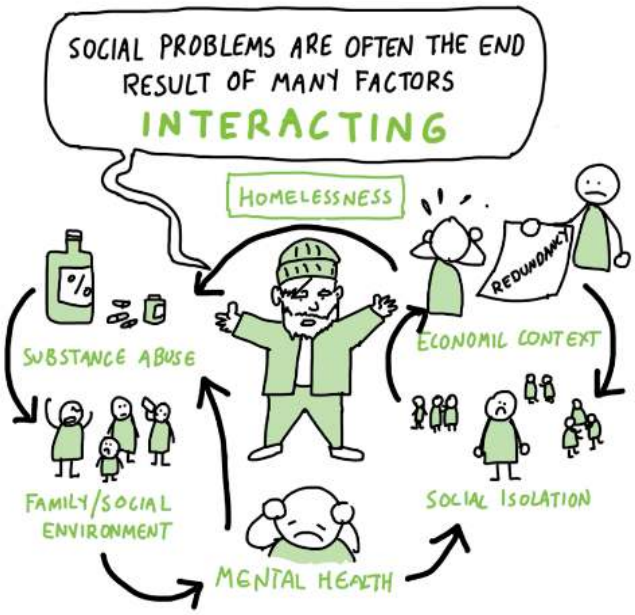
Such systems can be conceptualised as complex. It is the system and the interaction between all of the variables and system actors within the system that delivers the outcome. The variables within the system are not connected in neat linear ways, the system is constantly changing and the system does not necessarily respond in a predictable or repeatable way to defined inputs. We know we are in the territory of complex systems when:

- The system is built on human relationships;
- There are a wide variety of strengths and needs and these look different from different perspectives;
- The outcome is produced by the system itself, namely by the many factors within the system interacting together in an ever-changing way; and
- Individuals are working in systems that are beyond the control of any one of the system actors.

As public servants, we have aimed to respond to this level of complexity by trying to simplify the situation by developing services or programmes that respond to a particular 'need' or 'condition'. We have applied a 'New Public Management Approach' of *metrics, managerialism and markets*. We believed that the best way to manage the complexity was to specify SMART targets in advance for each element of the system, employ commissioning managers to turn these targets into specifications and provider managers to manage each system element against these specs. We believed in performance managing providers using performance data from pre-defined KPIs. We believed that we could improve cost efficiency through requiring providers to compete for contracts against these pre-defined KPIs.

However, this is entirely the wrong paradigm through which to understand how outcomes are made for residents in complex systems, as it is not individual programmes or services that deliver outcomes, but the interaction of a dynamic and messy system.

Most of the intractable problems that complex systems are trying to solve, whether that be the mental health crisis, homelessness crisis, obesity epidemic, or health and care financial sustainability are getting worse. Most of the demand on the most expensive parts of our system, i.e secondary and tertiary care relate to failures further upstream. Our historical approach has failed and that we need a new approach.



Paradoxically, in seeking to make complex systems easier to manage by applying a *New Public Management (NPM)* approach we actually make outcomes more difficult to achieve because when we pre-define services, processes, programmes and targets in advance and measure performance against these, a series of terrible things happen:

- We constrain front line professionals' ability to respond to the lived reality of individual residents; the individual needs and strengths of the people whom they seek to support and the underlying drivers behind these needs and strengths. We do '*to*' not '*with*'; we deliver *one size fits all* approaches, and; we fail to harness the power and strength of the individual and their immediate environment

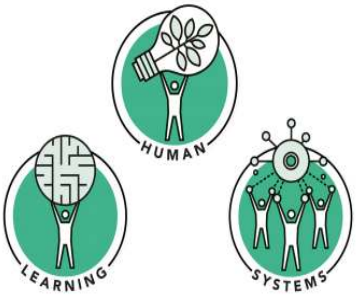
- We fragment the system into thousands of different services or programmes that operate independently of each other, commissioned from hundreds of different discrete budget lines held across multiple organisations. In doing so, we inhibit our ability to coordinate action across the system to respond to the complexity and variety of underlying needs of different residents in the equally varied context in which they live their lives. The system elements treat symptoms not causes. The system is bewildering to residents, impossible to coordinate and extremely expensive to administer.

- In fragmenting the system, we fragment the system's resources. Siloed, discrete budgets aligned to multiple teams incentivise individual managers to act in a way that protects their own service budget, not the system budget as a whole. Individual organisations are disincentivised from making investments that would improve the overall financial health of the system if another organisation reaps the financial benefit from the investment.

- Prevention is marginalised and separated from treatment. It happens in a different element of the system, often in a different organisation. Savings that flow from prevention are not re-invested in more prevention as another organisation usually reaps the benefit. NPM prescribes that the way to manage system demand is to establish eligibility thresholds for each service in order to keep people with low level needs away from the front door. The majority of services are set up to wait until a resident deteriorates to a point where they meet the threshold for intervention; the system is largely reactive rather than proactive. However, at a system level, this approach exacerbates rather than reduces demand; the system waits until people reach 'crisis point' before it responds, or sends them (via a complicated referral route) to someone else's front door – often A&E. People end up going round and round a system of our making without any real or lasting resolution.

- As no single programme can deliver high level outcomes, performance management focuses on multiple process or output KPIs as a proxy for outcomes. There is a focus on measuring quantitative data and very little focus on measuring the impact of the commissioned service on the outcomes someone wishes to achieve. We also fail to measure the overall outcome of the system because it is beyond the sphere of influence of any one system element. In short, in focusing on thousands of proxy process and output KPIs of each element of the system, we become guilty of what the philosopher Fredrich Nietzsche deemed *'the greatest form of human stupidity'; we* forget what we were trying to achieve.

- We limit our overall operating capacity. Resources are confined to those awarded to individual organisations largely through taxation. Opportunities arising from use of resources within the private sector and grant funding available to third sector organisations are marginalised. We fail to harness community assets and resources and the human resource of the residents we are engaging with and their family and friends; they become passive recipients of our services as opposed to equal partners in their care journey.
- Because we have specified each element of the system in advance based on needs assessments that consider deficits, we tend to end up with a very biomedical and deficit driven approach. Individual services are set up to 'fix' a problem that we have pre-defined. Humans are defined in the narrow term of a biological machine, and the purpose of the commissioned service is to *fix the machine*. Variation in wider determinants of health that account for between 75-80% of variation in health outcomes between residents are largely ignored.



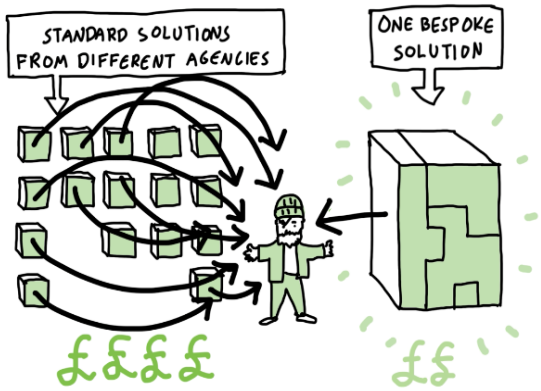
This strategy offers an alternative paradigm for public management. We call this paradigm Human Learning Systems (HLS). HLS is based on a different set of fundamental beliefs, and therefore has a different set of mutually supportive management practices. The HLS approach to public management continuously explores the messy reality of how the outcomes that matter to each person might be achieved in their unique life context. The job of public management – of organising this work – is to create the conditions whereby public service makes this possible in the most efficient and effective way. It is public service for the real world.

HUMAN

Human public service is informed by the beliefs that every resident that access one of our services is a complete, complex and unique individual with a unique set of strengths and needs. **The aim of human public service is to build a relationship with each resident we seek to serve to understand their unique context and co-design a bespoke solution with them** to empower them to address their needs. Building a trusting relationship is the starting point for human public service as the fundamental basis to allow solutions to be co-designed. Solutions need to be bespoke to the individual resident and may contain elements of service provision historically provided in multiple different services across different organisations.

To respond in a human way, we need to stop seeing people in the historical way we have set up our services, for example in terms of someone with a housing problem, a mental health problem or an obesity problem and start from their own perspective. We need to ditch our individual service thresholds that determine who can and cannot be considered eligible for a specific intervention. We need to empower front line workers to make the right decisions and do the right thing for resident sat in front of them in the context of that resident's life. As a result, commissioners need to give up the illusion of control and the belief that they can pre-determine or pre-specify one size fits all operating models for individual services. We need fewer service specific roles and a workforce upskilled to deliver a wider range of interventions. We need to ditch assessments based on our own predefined deficits and limit handoffs and onward referrals.

People who work in a way that is informed by complexity use the language of *'being human'* to describe what they do. This means recognising the variety of human need and experience, building empathy between people so that they can form effective relationships, understanding the strengths that each person brings, and deliberately working to create trust between people. Managers talk about 'liberating' workers from attempts to proceduralise what happens in good human relationships, and instead focus on the capabilities and contexts which help enable these relationships. They talk about providing support that is bespoke. For funders and commissioners, being human means creating trust with and between the organisations they fund. Trust is what enables funders and commissioners to let go of the idea that they must be in control of the support that is provided using their resource.



LEARNING

Everyone agrees that learning is important, so how is learning different in an HLS approach? Old world NPM theory proscribes that we start with a problem, test potential solutions, find something that works and then scale it up. "What works" is published in evidence based for others to replicate.

However, in a complex system, this strategy is limited, as it assumes that the system is static and linear when in fact it is dynamic and every changing. As such 'what works' is also changing and evolving. What might work to solve one resident's depression may not work for another resident. What might work in one community may be ineffective in another. There are cultural differences, community differences and policy differences and these are ever changing. COVID-19 has radically changed how our society operates, yet most of the published evidence base is based on experiments undertaken before COVID.

An HLS approach to Learning recognises both the dynamic nature of the system we operate in that delivers outcomes for residents, and the differences between different systems. In order to learn in an HLS approach, we need to learn continuously to keep pace with these changing differences. ***Continuous learning*** **becomes the key strategic outcome and mechanism through which we manage the system and leaders need to signal this.** We need to commission a learning environment to constantly test, embed and refine *what works.* Our workforce needs to be empowered and given permission to test new approaches and report what works and critically where things don't work or stop working. We need to capture and use data and intelligence in a different way to support learning including qualitative data and resident stories. We need to bring different professionals together to reflect regularly and share learning.

Commissioning for Learning

- Co-design / co-produce
- Continuously test what is working and what is not during the contract and flex and adapt the contract

Commissioning a Learning Culture

- Trust and collaboration rather than competition providers and provider-commissioner
- Reflective practice
- Positive error culture
- Separating performance and funding conversations
- Empower staff to try new approaches and share results
- Focus performance data on collection of learning results

Accountability:

- Wider use of data and intelligence including qualitative data and resident stories
- Against a broader set of principles and values
- Require front line professionals to account of their actions and whether they solved the resident's problem in the *context* they found themselves in to:
    - Peers
    - Service Users
    - Managers

SYSTEM

If we accept that it is the interaction of all of the many variables in the system that create positive outcomes for residents, rather than individual services or programmes, then we need to ask ourselves a new question: '*How do we create healthier systems?*', because healthier systems create better outcomes.

The role of system leaders and commissioners shifts from one of specification and performance management to one of *system stewards*; their function is to look after the health of the system. System Stewards start by building trusting relationships between all of the system actors. They ask questions like:

- Who are all of the system actors who have a role in delivering the system outcome?
- How can a build relationships between the system's actors based on trust?
- How can we collectively develop a sense of shared purpose?
- How can we ensure that we can learn together?
- How easy is it for us to collaborate together and share information?

There then needs to be processes of co-design, experimentation, finding out what works and embedding that practice within the system. This will inevitable change the system and so the cycle repeats as the new system needs to be re-revealed. This is shown in figure 2.2 overleaf

Systems operate at different scales. A system could be a resident's life, an individual service, an organisation, a neighbourhood, a borough, or a specific outcome. A system that delivers the outcome of obesity will look different to a system that delivers the outcome of good mental health.

Figure 2.1 Systems at Different Scales

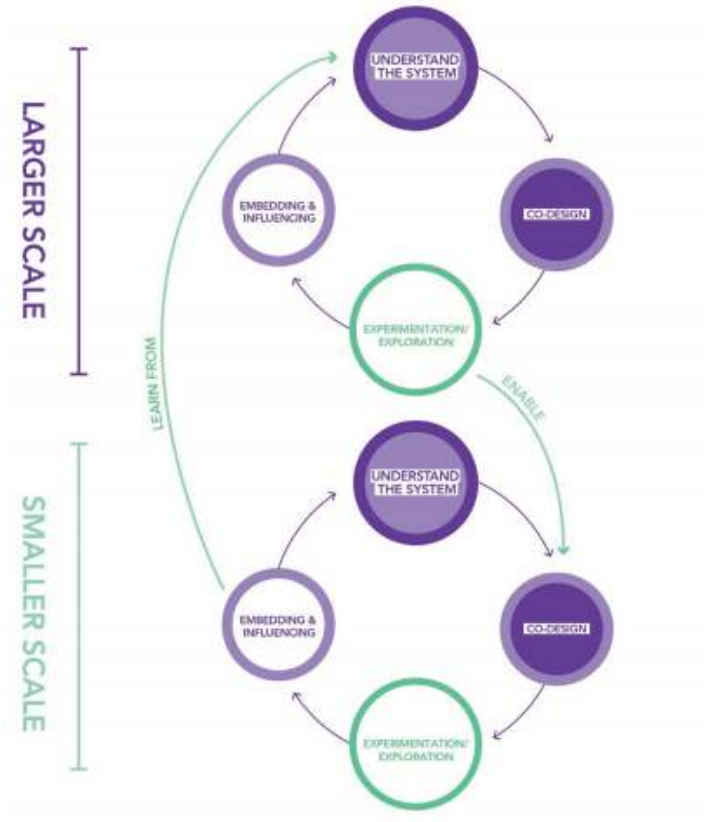
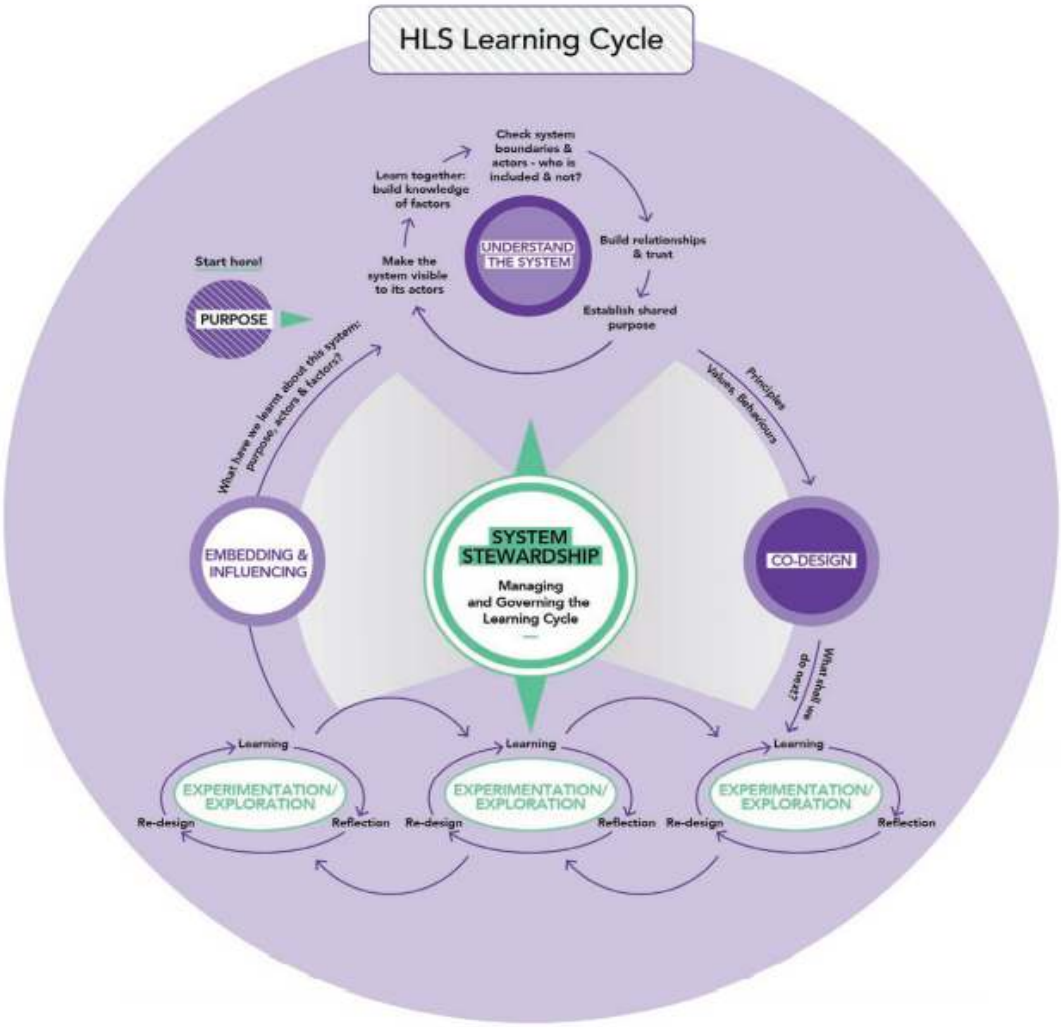


Figure 2.2. The HLS Learning Cycle



Implementing an HLS Approach in Thurrock

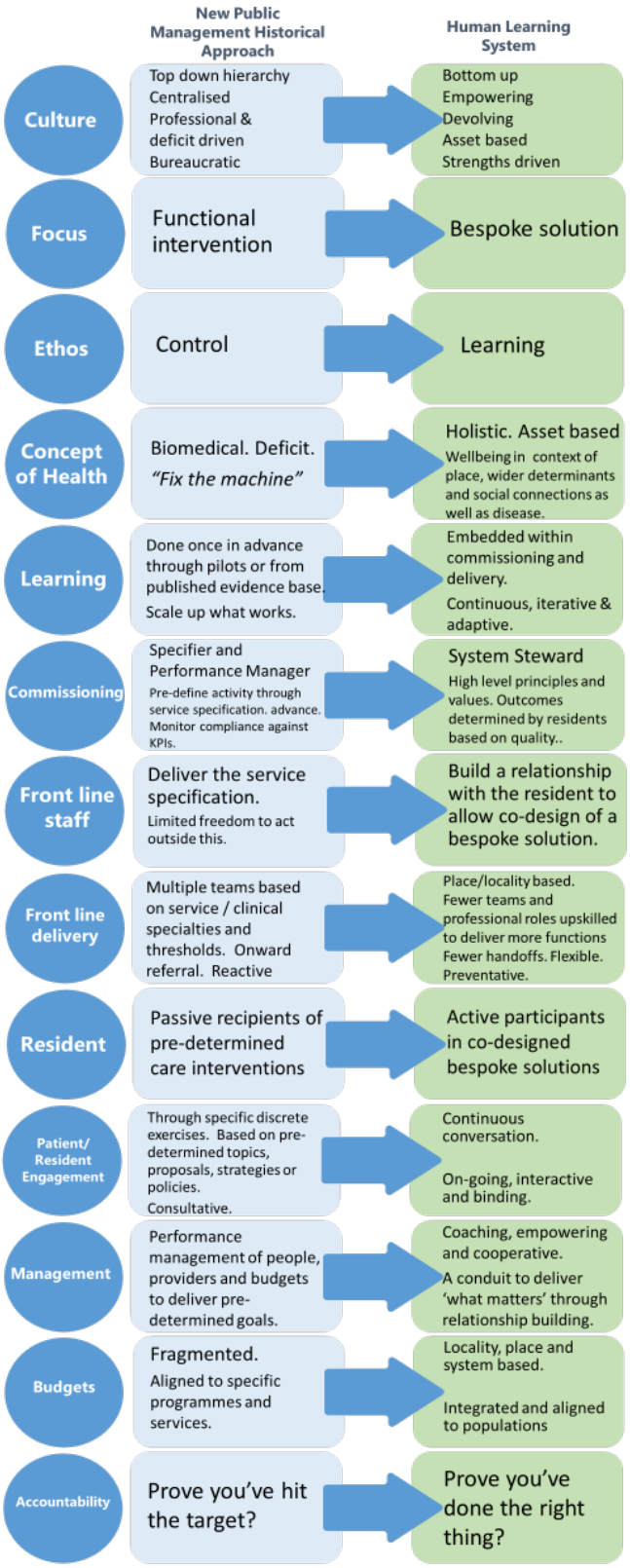
Many of the most succesful areas of transformation in Thurrock are already operating on HLS principles. These include our Local Area Coordinators, Community Led Solutions, Community Builders, Wellbeing Teams, and Integrated Primary and Community Mental Health Care. They are delivering better outcomes for residents by freeing front line staff from pre-defined service specifications, KPIs and bureaucracy and empowering them to co-design bespoke solutions with residents that respond to individual context.

Similarly, our *Theory of Change* process has formed the basis of a shared vision between Thurrock leaders based on long-term trusting relationships and a sense of shared purpose.

However, our successes still operate in a wider context of *New Public Management* with too many discrete services and thresholds, onward referral and pre-defined operating models.

Moving forward, we will transform our entire Alliance on HLS principles, delivering bespoke solutions co-designed with residents. This requires a systemic shift in the way we conceptualise and deliver public service in health, wellbeing and care across our borough. The transformative change we will deliver is set out in Figure 2.3 overleaf.

Figure 2.3: The Change We Will Create



2.3 Our Shared Goal, Desired Impact, Outcomes and Principles

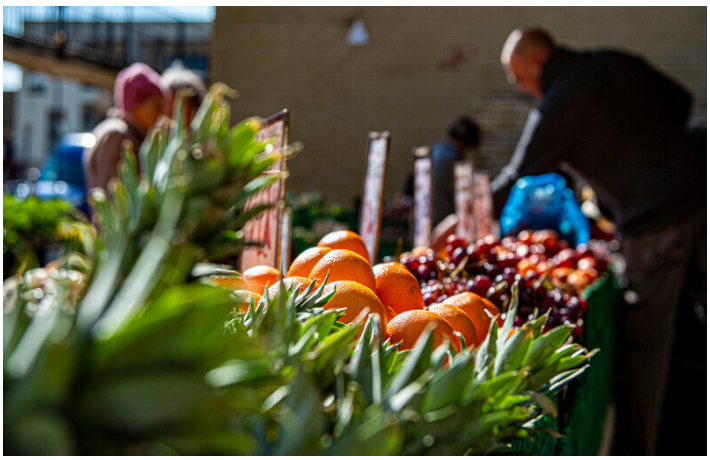
A HLS approach is based on the concept that we need to create healthy systems to deliver healthy outcomes. A healthy system is underpinned by strong relationships between all system actors based on respect and trust and a shared vision and understanding of the system.

In 2020, Thurrock CVS facilitated a second *Theory of Change* process consisting of a series of workshops that brought Thurrock's health, care, well-being and third sector system leaders together to debate and agree our vision, goals and principles that under pin our local transformation. This built on the original *Theory of Change* workshops that were undertaken in 2017. We believe that much of our transformational success to date in Thurrock is due to the strength of our local long term partnership relationships and shared values.

From the second *Theory of Change* process, we agreed the following:

Our Overarching Goal

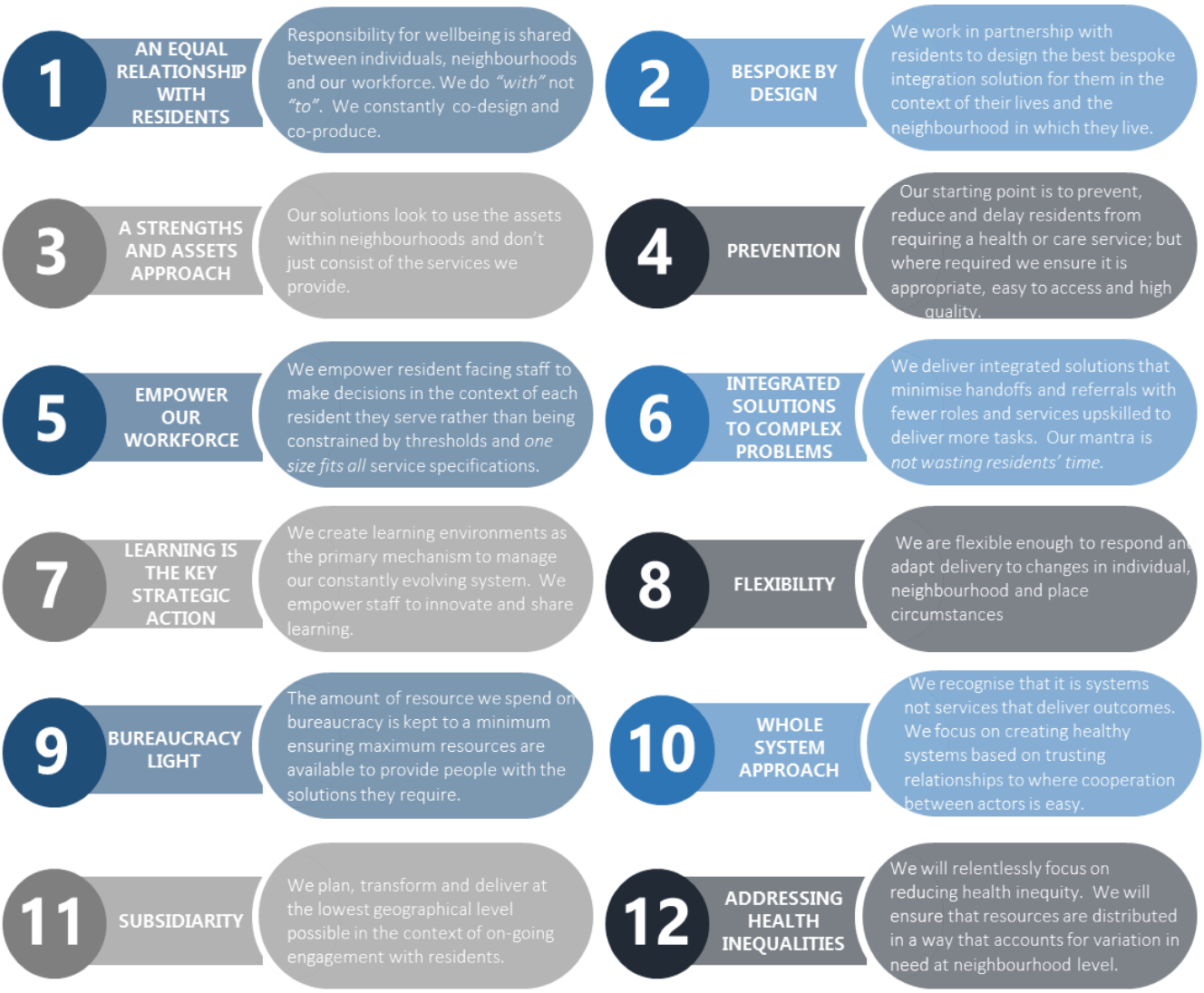
Better outcomes for individuals, that take place close to home and make the best use of health and care resources.



Our Desired Outcomes

- Residents are able to achieve more of what matters to them
- Support is provided in collaboration with the community and focuses first and foremost on what the community can offer
- Residents maximise opportunity to stay as healthy as possible and require fewer interventions from services.
- Residents are able to find the right solution for them first time and in the right place.
- Residents are empowered to achieve their version of a good life
- Our alliance and system resources achieve better outcomes through earlier intervention and preventative integrated solutions that reduce 'failure demand'.

Our 12 Transformation Principles



Chapter 3: Our Integrated Wellbeing Model

Chapter 3: Our Integrated Wellbeing Model

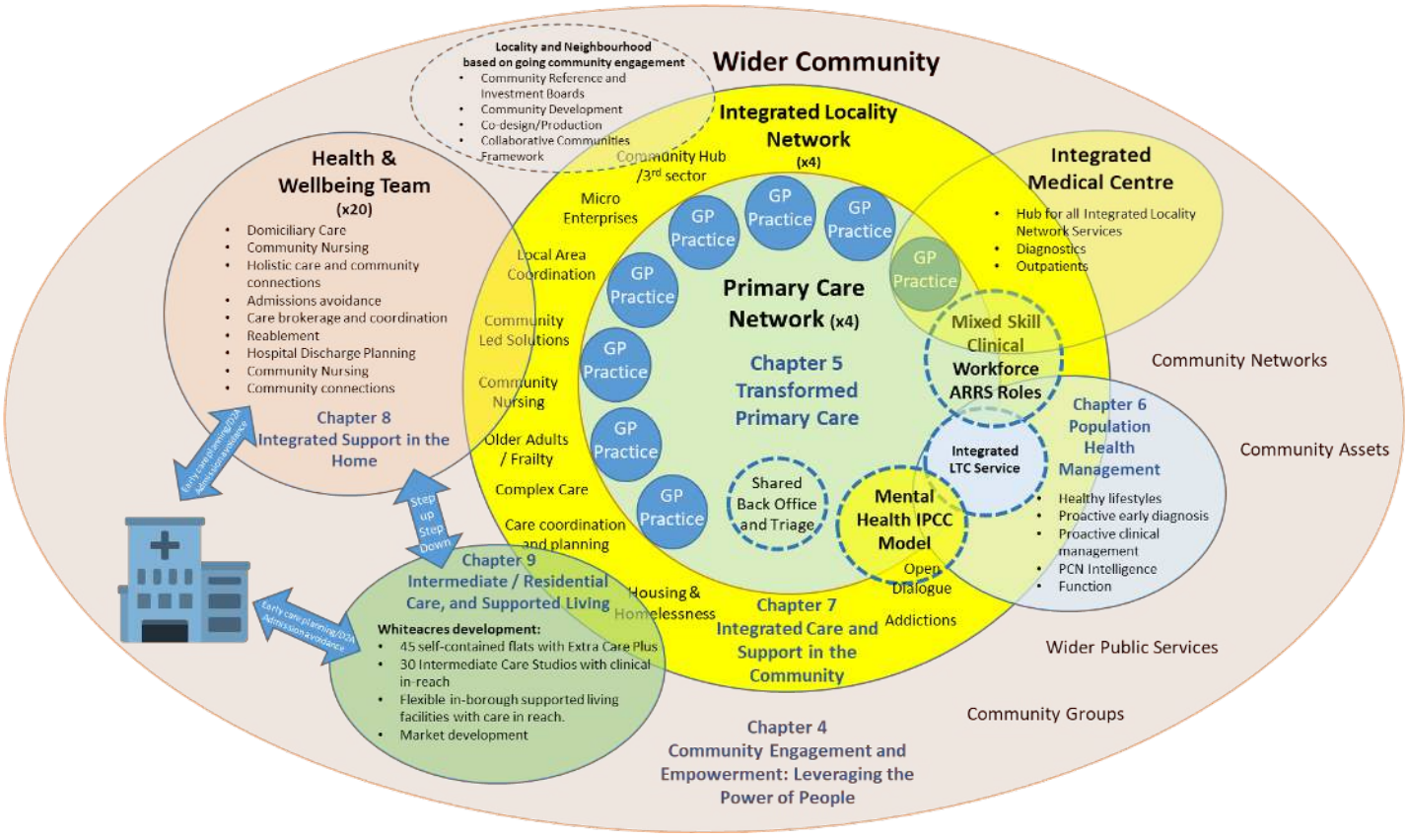
This chapter provides an overview of our wellbeing model and how the different elements interact. Chapters 4 to 9 unpack each element individually and act as individual strategies in and of themselves that can be read independently and provide a blue print for transformation of specific system elements.

However, as we noted in Chapter 2, in a complex system, it is the interaction of variables, elements and ultimately people that deliver outcomes rather than individual teams or programmes. It is therefore important to understand the interdependencies between the chapters and their respective transformation plans.

In developing a whole system approach to health and care transformation, we have tried to make it as easy as possible for front line staff to collaborate with each other and residents to co-design single integrated solutions, keeping bureaucracy, assessment and onward referral to an absolute minimum, freeing up staff to spend more time delivering care.

Figure 3.1 shows our re-imagined and transformed system, our Integrated Wellbeing Model and the remaining chapters within this strategy to provide more detail on each element:

Figure 3.1



Leveraging the Power of Residents and Communities (Chapter 4)

At the heart of our plans are residents and communities. Historically, we have too often seen the world through teams, services and problems that we have defined in advance rather than through the eyes of residents. Residents don't live their lives through our services and the 'deficits' we define need fixing but through their own communities and neighbourhoods.

Thurrock already has a long tradition of working in a strengths and assets based way; starting with 'what's strong' rather than 'what's wrong'. Programmes like Stronger Together, our Collaborative Communities Framework, Micro Enterprises and Local Area Coordination recognise the power of harnessing the skills, abilities and ingenuity of those with whom we work, their families, friends, neighbourhoods and communities. We are proud and extremely fortunate to have exceptionally strong partnerships with a vibrant and diverse community and voluntary sector, and our Community Hubs already provide places from which residents come together to help each other. However, too often our engagement with residents remains in silos, centred around services or strategies that we think are important, and is consultative rather than binding. We recognise that we need to go further; building Community Reference and Investment Boards as single mechanisms to have an ongoing conversation with residents and genuinely co-design and co-commission in a way that addresses their neighbourhood and locality priorities. We will build on our successes to date and extend the strengths and assets based ethos across our entire health, care and wellbeing system. Chapter 3 sets out our plans to do this.

Transformed Primary Care (Chapter 5)

In the centre of our transformed system is primary care. Ensuring high quality and easily accessible primary care is critical to our residents, and whilst the quality of primary care locally has improved significantly over the past six years, we know that satisfaction locally lags behind national benchmarks. The ratio of general practitioners and practice nurse to patients in Thurrock has historically been significantly worse the England and in a competitive workforce market, we need to create a system attractive to future clinicians to attract the brightest and best to the borough.

The inception of Primary Care Networks (PCNs) provides a huge opportunity to "level up" primary care services locally, providing the ability to deliver more services once at scale, share best clinical practice and share and expand the existing workforce; improving access and reducing variation in outcomes between individual practice populations. Our plans to do this are set out in detail in Chapter 5.

Preventative and Proactive Approaches through Population Health Management (Chapter 6)

Too often, our health and care service waits until people become seriously unwell before providing a service. We need to shift focus from this 'reactive' care model to one that is genuinely proactive and preventative; empowering residents to address unhealthy behaviours, diagnosing chronic disease conditions earlier and providing high quality clinical management to ensure people can stay as healthy as possible for as long as possible. Population Health Management (PHM) – using integrated data and intelligence to identify risks earlier and intervene provides new opportunities to tailor proactive care at different cohorts of residents to improve their health and manage their long term conditions. Thurrock has been an early adopter of population health management approaches and our PHM approach has already significantly improved cardio-vascular disease outcomes in our population and prevented hundreds of strokes and heart attacks. But to date, this work has largely been delivered in clinical silos, considering different conditions in isolation, and in organisational silos, focusing action and individual GP surgery level. Chapter 6 sets out the next phase of our transformation on proactive and preventative care including embedding healthy lifestyle services within each Primary Care Network, creating Integrated Long Term Conditions clinics where multiple chronic diseases can be managed in a one-stop-shop, and leveraging the power of integrated data to support clinicians and other front line staff to deliver proactive, tailored interventions to residents.

Integrated Care within the Community around the Primary Care Network (Chapter 7)

Beyond the Primary Care Network, there currently exists a dizzying array of individual teams and services, provided by different organisations, each with their own referral criteria, threshold and standard operating procedure, each designed to 'fix' a single issue clinical or social problem. However, we know many of our residents do not live their lives like this; they face complex challenges with multiple causes needing support from many different places. The way we have designed our system in this fragmented way is no-longer fit for purpose. It hinders collaboration between professionals, it delivers 'one size fits all' simple solutions and it is hugely inefficient to administer. Worst of all, too often it fails meet the complex needs of many of our residents, leading to 'failure demand' where residents end up accessing the most expensive elements of our system like Accident and Emergency because either their health has deteriorated from lack of earlier support, or simply because it is the 'front door of last resort'. Paradoxically, the greater the resident's need and the more complex a resident's problem is, the more difficult we make it for them to access the support they require, because the more teams and services they need to navigate.

Radical change is required to address this fragmentation. We will bring a wide range of professionals from multiple teams together in a single Integrated Locality Network at locality level around each PCN. Our Integrated Locality Network model will make it easy for different professionals to build relationships with the PCN and each other, to co-design single integrated bespoke solutions with residents and negating the need to make individual referrals or assessments. For the most complex problems, this will include a single integrated care plan and care coordination. We also want move all provision to adopt a strengths and assets based coordinated approach. Ultimately, through further test and learn pilots, we will create new 'blended roles' within the Integrated Locality Network; staff trained to undertake common tasks traditionally undertaken by different teams and organisations, for example a new Community Case Worker role that is able to deliver mental health, housing, debt advice and addictions support. Chapter 7 of this strategy details our plans for Integrated Locality Networks.

Integrated Support within the Home (Chapter 8)

As our population ages, care is increasingly delivered within the home. Historically, this has been fragmented into a failed, fixed 'time and task' model of domiciliary care, supplemented by multiple health professionals from different teams coming into the home to deliver different tasks. This model is inefficient, in personal, inflexible and reactive. Our Wellbeing Team model has already demonstrated a better way of delivering home care; small self-directed teams of Wellbeing Workers forming long-term relationships with those whom they care for and with their families and friends, to deliver a more flexible, holistic and preventative approach. We want to build on our learning from the Wellbeing Team pilot and roll out the model across the borough. But we also want to go further, upskilling Wellbeing Workers to undertake more routine clinical tasks, aligning Community Nursing functions, and embedding early hospital discharge planning and reablement within the teams. This will facilitate early supported discharge and discharge to assess approaches, improve care continuity, rationalise the number of different professionals needing to visit residents at home and creating truly Health and Care Wellbeing Teams. Teams would also be responsible for brokering in more specialist support from the Integrated Locality Network where necessary and for care coordination around a single integrated plan. Our evaluation shows that residents cared for by Wellbeing Teams have significantly lower rates of hospital admissions and GP appointments. Through our new approach, we believe that we can deliver higher quality outcomes for residents, a more personal and preventative service at a reduced overall system cost. Our plans for the next phase of Wellbeing Teams are set out in Chapter 8.

Intermediate and Residential Care, and Supported Living (Chapter 9)

Finally, we know that there are some residents whose health and care needs are such that they are unable to remain in general needs housing, or are unable to be discharged home directly from hospital and so are placed in either residential/nursing care or intermediate care beds. Our residential care providers have performed magnificently throughout the COVID-19 epidemic by continuing to provide high quality care to some of our most vulnerable residents. However, entry into residential care is almost inevitably due to necessity rather than choice, with residents having to trade the privacy and independence of living in their own home for the additional intensity of care available on site in residential and nursing facilities. In Chapter 9, we aim to address this by reimagining and setting out plans to build new type of "Extra Care Plus" facility where residents are able to live independently within their own apartment but with the same level of 24/7 care on-site that is delivered in traditional residential care settings. Our proposed development at the Whiteacres site in South Ockendon will also encompass 30 intermediate care studios, again with access to 24/7 specialist care on site and additional clinical in-reach from the Integrated Locality Network as an alternative to Community Hospital Intermediate Care beds.

The chapter also sets out exciting new plans to purchase dedicated housing stock in which to provide additional supported living facilities within the borough with flexible 'care in-reach' from the Integrated Locality Network as an alternative to traditional models of supported living for people with mental health problems, where care packages are commissioned in advance and fixed. We believe this new model will support independence and 'move on' back into the community for those struggling with their mental health in a way that traditional models of supported living are failing to do.

Chapter 4: Community Engagement and Empowerment

Leveraging the Power of People

Chapter 4: Community Engagement and Empowerment. *Leveraging the Power of People*

4.1 Introduction

Our partnership with the strong, diverse and vibrant communities that we serve is at the heart of everything that we do in Thurrock. We are incredibly fortunate to have a vibrant and committed community and voluntary sector within the borough, and we are rightly proud of our deep and long-term relationship with them. As we described in Chapter 1, they have been front and centre of our transformation journey to date.

Chapter 2 set out our shared values and principles including a commitment to strengths and asset-based working and Human, Learning Systems principles. In January 2021, Thurrock Council's Cabinet approved our *Collaborative Communities Framework* that encapsulates this shared commitment to work in partnership with residents and the third sector. In this chapter, we dive deeper into this area and discuss in more detail our partnership with the third sector and residents and their critical role in the next phase of our transformation journey as we devolve more power down to community level and build on our existing success in Asset Based Community Development and strengths/asset-based community approaches to delivering services in partnership.

Case Study One: John

John is 70 years old and lives alone in Grays. He fell down the stairs at home and was discovered on the floor by a delivery driver who called an ambulance. John was admitted to hospital where he was found to have unmanaged health conditions and an addiction to alcohol.

On discharge planning, Thurrock's Adult Social Care Hospital Team referred John to *By Your Side*, the borough's voluntary sector community support service. Buy Your Side worked alongside John's social worker and Local Area Coordinator to enable a smooth discharge from the acute hospital by sorting out practical problems that would otherwise have delayed his discharge home. John's property and possessions were found unsuitable for him to return straight home to, and so the service organised a cleaning team to get the property ready.

Over a six week period, *By Your Side* supported John with volunteers and through community connections by:
- Collecting equipment from Thurrock Hospital prior to John's discharge.
- Sourcing donated bedding and clothing from local projects, to replace items after the clear up of his home.
- Shopping for new clothing on John's behalf.
- Making welfare calls to John every other day, to check in on him and ensure he felt safe and was not anxious.
- Undertaking John's food shopping.

By facilitating a smooth discharge, and providing six weeks' support to John, *By Your Side* used knowledge of community assets and networks to help John regain his independence and confidence whilst he settled back into his home. They encouraged him to look for ways to support himself going forward by signposting to the *Thurrock Micro Enterprises Scheme*. They also connected John to other residents in the community with shared interests to improve his mental and social wellbeing and provide an alternative to drinking alone in the house.

As the above case study demonstrates, involving the community and its assets can have a very positive impact upon the delivery of solutions that support improved health and well-being in our citizens. It is therefore no surprise that most emerging strategies in health and social care put the importance of engagement, both at a community and individual level, as a central principle in their plans to transform the way that services are delivered. Alongside this, various power and influence sharing techniques, such as co-production and co-design, have a significant role within such plans. However, there is also evidence that involving communities and individuals in their health and care can prove counterproductive if the techniques used do not take account of how people and communities organise their lives, or if the involvement seems to be no more than lip service:

Whilst the evidence suggests that for some individuals there are a range of clear and identifiable benefits from community engagement, across the review studies the range of methods and approaches used varies and are not consistently replicated across all settings and initiatives to allow the evidence to demonstrate which is the most successful. It is difficult, therefore to attribute specific benefits to any one approach or method. Evidence from a number of studies [1] [2] does suggest however, that individuals are less likely to find community engagement a positive experience where *consultation* is the main method employed by professionals and no real power to effect change is ceded to community members.

Therefore, if the approach used in Thurrock is to continue to have the impact required to significantly improve the overall well-being of our individuals and communities it must guard against such pitfalls. These include:

- A failure to effectively engage because the ways in which engagement is delivered do not reflect the ways in which individuals and communities organise themselves
- Top down approaches, such as surveys and formal consultations, where the subject matter is predetermined by professionals and limited in scope and where the method is difficult to access
- Feedback is poorly relayed (or worse not provided at all), which further emphasise the common belief that consultation and engagement is pointless and changes nothing where there is no evidence of the essential power shift away from professionals and organisations and towards citizens and communities; this shift being crucial to feelings of authentic influence emerging from active community involvement
- Where engagement activity is badly co-ordinated and organised, leading to a large number of such activities, often asking very similar questions, landing in communities all at once; this creates "engagement fatigue" so often a characteristic within communities
- Where engagement becomes the property of a few very active and vocal citizens, who do a valuable job in representing themselves, but who cannot claim to be truly representative of the diverse and complex communities that exist
- Failure to ensure real investment is made in the infrastructure within communities (along with our crucial local third sector) meaning that growing expectations on them amount to *"asset stripping"* rather than a greater reliance upon community assets.

There is therefore a need to design a representative, bottom up, flexible and multi-faceted local methodology for community engagement and co-design if the Thurrock Place Based Strategy is to deliver transformation; a transformation that provides clear evidence that these agreed priorities are at the heart of the local transformation in health, care and well-being.

4.2 Our solution: Asset Based Community Development

Asset Based Community Development's (ABCD) premise is that communities themselves can drive real improvement in wellbeing by mobilizing existing, but often unrecognised assets. As a challenge to established forms of delivery, particularly commissioning, it asks that we consider:

- What can communities can do for themselves if professional services get out of the way?
- What can communities do with some support from organisations?
- What is left that is appropriate for organisations to deliver?

This radical challenge to the statutory and third sector creates a useful analytical tool for understanding the extent to which the "professions", in the broadest sense, have encroached on and usurped areas within which individuals and communities are best placed to identify and manage their own solutions; it therefore resonates with emerging themes such as self-care and prevention.

By adopting an asset based approach, Thurrock, through the Stronger Together Partnership, has successfully introduced a number of innovations (Local Area Coordination, Time banking, Social Prescribing, Community Builders, etc.) since 2013, however more can be done.

ABCD is a powerful method for facilitating the shift in power essential for successful transformation in the Thurrock model; shifting people away from being passive recipients of service to active citizens fully engaged in their health and well-being. Our approach empowers residents to contribute to how, when, where, and the way they receive the support necessary to them realising their vision for a good life (Figure 4.1).

Figure 4.1 – Citizen Power Progression

Commissioning for Change

As we learnt in Chapter 2, the historical *New Public Management* model of how the public sector has commissions services has led to a fragmented and confusing service landscape that fails to solve residents' problems and disempowers them from engaging as equal partners in action to improve their wellbeing. Commissioners set the model that they require, often with little involvement of those to be supported, select through a restrictive procurement process that vastly favours big organisations above SMEs and the Third Sector, and then set a series of performance indicators that have little to do with achieving the outcomes people would choose for themselves.

Conversely, Thurrock's Human Learning Systems approach, which has already underpinned some of our most successful transformation, seeks to deliver bespoke, integrated human solutions in partnership with residents. In many ways, this is antithetical to the traditional model of commissioning now used. Transforming commissioning to support HLS will require a change in culture, with all involved: commissioners, providers, practitioners and the public having to work for or with support systems in a more relational, collaborative and open way. It will also generate significant challenges to accepted models of governance and regulation. However, it is a challenge worth meeting.

This approach also provides the opportunity to embed our commitment to the realisation of social value through commissioning, reflecting community priorities at PCN/neighbourhood level in a refreshed version of our Social Value Framework. We will continue to explore the approach to support a sustainable third sector with community investment that keeps bureaucracy to a minimum.

Model of Good Practice:
Liverpool City Region Combine

Rather than develop a service specification that stated *'for the next three years you need to deliver these outcomes'*, the specification allowed the provider/commissioner always to evaluate and develop delivery models/services to ensure that they continued to respond to the variety of needs demonstrated by the client group, reflect best practice and have a clear learning impact on future delivery and commissioning.

4.3 Thurrock's Transformation Proposals for Our Next Phase of Asset Based Community Development

Improving engagement/co-design

As has already been stated, the traditional forms on engagement (such as consultation and surveys) are not effective and can even have an adverse impact upon well-being with people feeling pressurised to take part or communities suffering from "consultation fatigue".

Instead, we need to build an infrastructure to allow engagement and influence to become part of the DNA within a given locality, and to improve drastically our ability to collect the background noise found in every interaction that takes place between staff employed in their given localities and citizens.

Building the infrastructure

Thurrock already has a number of key operations and personnel that operate within their communities and are accessible to citizens in a range of ways:

Community Led Adult Social Care Support Teams (CLS).

Our CLS teams operate across the four quadrants within Thurrock that match the four Primary Care Networks (PCN) already established.

They operate a series of Talking Shops, utilising a range of accessible community assets such as supermarkets and libraries, within which members of the public drop in to address any social care needs, or often other types of support requirements, can be discussed and solutions identified or information and advice is provided.

Social Prescribers

Working out of GP surgeries the social prescribers provide a wide range of information, support or signposting to assist people to identify the solutions they require across a very wide range of well-being issues.

Alongside these two examples we have a range of other community based support services that provide direct support utilising community assets, such as Local Area Co-ordinators, Housing officers and the Micro Enterprise Scheme, or who provide localised statutory support such as Community Health providers and Well-Being teams.

However, in order to co-ordinate these schemes better and to fully involve citizens and professionals in the design and delivery of localised support we will further enhance the PCN based infrastructure through the development of Communities of Practice in each location.

Community Builders

Our Community builders operate across the four localities within Thurrock, helping communities to have a voice and connect in their local area and to take part in local decisions. They met with local groups and residents helping them to access opportunities.

Community Hubs

Community Hubs act as a physical anchor to bring people together where they live to enjoy time together, reflect on and discuss local issues and potential solutions, and access information about activities and support available locally. Being able to meet different people where you live is essential to building cohesive communities in a borough that is facing growth and demographic change. By sharing concerns and aspirations, citizens are more likely to create resilient and strong communities. Most hubs are co-located in Thurrock libraries and are organised on PCN footprints.

A Nitter-Natter Group at one of the Thurrock Community Hubs

Communities of Practice (CoP)

A Community of Practice can been defined as *"a process of social learning that occurs when people who have a common interest in a subject or area collaborate over an extended period of time, sharing ideas and strategies, determine solutions, and build innovations".*

In Thurrock we will use this mechanism to establish two Communities of Practice on each of the four PCN footprints to bring together people with vested interests in those locales to ensure delivery and design are coordinated and based upon community concerns and choices.

Community of Practice (User Led)

The first CoP will be formed from a wide variety of interested groups and individuals across the locality in question and be charged with agreeing priorities, designing strategies and solutions to meet those priorities and ensuring local intelligence feeds into all decision making processes from a neighbourhood to a system wide scale. As such, it will be the major forum to ensure community interests are represented at every level of decision making.

Community of Practice (Direct Delivery)

The second CoP will be formed from paid staff and others who are directly involved in the delivery of transformed support services across the PCN footprint. Having this CoP will ensure that the support being provided stays within the design principles as set out within this strategy, and vision and local priorities that emanate from the user led CoP. It will be a forum for learning and discussion, using HLS methodology, where those with a key responsibility for improving local outcomes will have an open and transparent opportunity for exploring emergent themes and issues and collaborating to ensure learning informs the evolution of solutions to meet changing circumstances identified from local intelligence and the wider system.

The Communities of Practice infrastructure will be started in one PCN area, to allow a test and learn approach to be used before scaling up across Thurrock.

Improving local intelligence

We need to improve the collection of local intelligence without adding to the burden that local communities feel when constantly being asked to respond to consultations. One obvious way would be to capture intelligence from interactions between professionals and members of the public.

To do so successfully organisations need a way of capturing this constant flow of information in a centralised and coordinated way; thereby having the ability to analyse the data, use it constructively and, where possible, ensure a constant feedback loop is in place so that citizens see evidence of their opinion being used constructively.

This would quickly be seen as an authentic use of people's perspective, not just a service led, top down exercise in gathering information having already decided what is to be done. This approach would contribute towards a growing sense of community empowerment, with individuals becoming far more active citizens as they experienced a genuine sense of involvement and influence.

There are a number of platforms that can support the collection of real time intelligence, enabling information to flow, be analysed, and used to inform the evolution of the system in a very timely and direct way. It would also enable feedback to be delivered more consistently and quickly than is currently possible. We will provide such a platform through the *Air Table* system as part of our improved community engagement and co-design strategy, building on the HLS priorities of collaboration and learning as crucial components of the transformed system.

Resourcing the Community

In order to break down siloed budgeting, we need to create four genuine pooled funds at locality level. These funds can then be used from which to commission integrated services that respond to the needs and deliver the solutions identified within the four localities. Figure 4.2 sets out our approach.

Figure 4.2

These four Community Investment Funds will provide a mechanism by which to deliver solutions at locality geography that addresses multiple needs that historically would be the responsibility of different organisations or teams within organisations, hence delivering a more integrated system and holistic response. A shared fund provides opportunities to access additional funding streams open to public and voluntary sector including bidding for third sector grant funding against matched funding already held within the Community Investment Fund. It also provides a mechanism to capture additional resource from the private sector.

We will create Community Reference and Investment Boards comprising of a range of community leaders to oversee the process.

By placing responsibility on the Community Reference and Investment Board for distribution of funds, we devolve power from public sector organisations to communities. The process will follow HLS principles by commissioning for learning and on high level principles and values rather than predetermined actions, empowering providers to offer bespoke solutions to residents and separating decisions about funding from decisions about performance. In short, it will foster collaboration rather than competition.

Again, the proposal is to develop a single board, on the same PCN geography as that in which the Communities of Practice test and learn site is being deployed, to ensure there is time to fine tune any issues prior to scaling up Thurrock wide.

Micro Enterprise Development

Thurrock council, in partnership with Community Catalysts, has driven the development of a Micro Enterprise scheme locally for the past four year. Micro enterprises are small, local businesses, very often sole traders, who provide a vast range of needed services to their community. Typically, micro enterprises (Micros) are started by people who are marginalised, either through underlying factors such as ill health or loss of a long term career, consequently they are individuals who struggle to enter, or return, to employment.

Developing Micros has a number of key benefits:

- They create supply that is needed in the local economy.
- This supply is often "bespoke". For example, in the care field, the partnership between the cared for and the carer creates a service based on the unique situation of the person supported, not on the restrictions that inevitably exist with large provider organisation.
- The money flow stays within the local economy.
- The impact upon the well-being of the person running the micro is very significant. This results from a growth in sense of purpose that was not previously present, or, which returns, as a result of making a positive contribution.

Since the inception of the programme in 2015, we have supported the development of well over a hundred micros enterprises. They provide a variety of services, the majority in the care and well-being sector. These enterprises have added a hugely positive dynamic to the communities they serve, and their success has generated much interest, hence the continued expansion of Micros.

Thurrock currently has one full time officer supporting this programme who is becoming increasingly stretched as more services require support. There has also been a shift in the type of contact received, at times moving away from the usual individual who wishes to start a micro, towards people who have very innovative ideas, but whose start-ups would be best suited to establishing a Social Enterprise or charity and not a sole trader type of provision. There are a number of local schemes that can provide support: CVS, the School for Social Entrepreneurs, Business Link, DWP etc., but none of these provide the longer term practical support required to give these start-ups a good chance of success. There is a danger that we are missing out on the establishment of a range of local entrepreneurs, with excellent ideas, who could provide exciting and much needed local economic activity, whilst also creating a very positive impact upon their own, and others, well-being and sense of purpose.

We will therefore expand the programme to deliver a "Community Economic Unit" (CEU), in each of the Primary Care Network areas that could support both the ongoing development of Micro Enterprises and provide the kind of practical advice and guidance needed to support other forms of community economic development.

The CEU would work closely with the coterminous Community Reference and Investment boards and the Communities of Practice to provide a comprehensive local economic infrastructure capable of supporting micro and macro support to all aspects of commercial activity in their area.

It seems abundantly clear that one of the most significant long term consequences of the pandemic will be a down turn in overall economic activity, with the already disadvantaged hit particularly hard in terms of employment opportunities. This programme has the potential to link with skills investment opportunities though the *Levelling Up* agenda to help ensure disadvantaged groups can access real opportunities for this cohort of our society to find meaningful employment, utilising their own initiative and creativity, thereby having a significant impact upon their sense of self-worth.

Case Study 2: The Power of Micro Enterprises

A is a young man in his 30s who was introduced to Thurrock's Micro Enterprises Scheme by the DWP. He had formerly held a senior position in local industry, however the pressurised environment in which he worked had led to an episode of mental ill-health that had also led to his involvement in substance misuse and subsequent job loss.

Whilst in rehabilitation, A's Community Led Solutions Team supported him to take up a hobby, and he found that angling supported his wellbeing and recovery. He became passionate about the sport and was interested in setting up his own angling business. His aim was not only to earn a living but also to support others who found themselves in a similar position to himself.

Working in partnership with the DWP, Thurrock Council, and other organisations, the Micro Enterprises Scheme supported A to set up his business, find funding to purchase equipment and apply for his coaching badge. A is now set to launch his business in the Spring of 2022 and is already receiving enquiries about his new venture.

A said:
"Spending time outside in nature by the water dramatically improved my well-being. It was like I had found a whole new world that I wanted to live in again. My anxiety and depression became manageable without the use of substances. I have been clean ever since. I owe my life to fishing, and I intend to share this new world with as many new people as possible. I honestly believe that fishing can help change many lives for the better, and possibly even replace anti-depressants".

This statement shows the power of the Scheme in transforming residents' lives. Not only does it provide different, low or no-cost alternatives to people, it also gives the person behind the micro-enterprise that all important sense of purpose and control, fundamental to improving their wellbeing.

4.4 The Impact of Thurrock's Approach and System 'Ask'

Impact

The impact of such a wide scale cultural and delivery transformation will be system wide and extensive. They will achieve the following significant but far from exhaustive outcomes:

- Making co-design a reality
- Achieve massive culture change from 'doing to' to 'doing with' (Strengths based)
- Transform the commissioning landscape – moving to collaboration and stewardship
- Radically challenge the current performance culture that encourages organisational performance 'gaming' and is largely meaningless to the people we support
- Encourage culture change in providers – moving from competition to cooperation in the pursuit of best outcomes
- Improve preventative services – reduce demand
- Improve models of self-care – reduce demand
- Reduce duplication-improve efficiency
- Create more resilience in communities and individuals

It is clear that the health and care system is failing and in need of radical transformation if it is to be fit for purpose for the 21st Century. Moving to more localised organisation and delivery of services, based upon what people can do rather that what they cannot, involving citizens more directly in their care and producing a dynamic system that can constantly learn and develop seems to offer an evidence based and cogent alternative. This strategy and our collective approach will deliver this paradigm; the real question is, if not this, then what?

Our ask of Mid and South Essex ICS

Whole System Support

A recent report by the Kings Fund[3], reviewing the opportunities created by the establishment of Integrated Care Systems made the following observation *"Social care and local government have a strong history of mobilising assets around the needs of the individual and tackling inequalities. They have wide experience of engaging with communities and have proven expertise in working within constrained budgets. They bring this strength to ICS partnerships".*

To take full advantage of these strengths, and therefore to deliver on a number of key system priorities, it will be vital to empower local authorities and the third sector, to do more of what they do best; deliver preventative, personalised services at place.

To enable this empowerment to fully be achieved, the whole system will need to value and support the leadership that local authorities and the third sector can make by devolving significant authority and resource down to enable significant local decision making. The proposals set out in this chapter for power sharing, co-design and co-production with residents and the third sector start with the need for an effective infrastructure at neighbourhood level to enable an on-going conversation with residents. This infrastructure requires resourcing.

Subsidiarity

The principle of subsidiarity, which is the idea that a central authority should have a subsidiary function, performing only those tasks which cannot be performed at a more local level, is central to our transformation programme. Wherever practicable, decision making has been cascaded down to the front line, empowering people to take decisions without having to face the encumbrance of a lengthy and costly bureaucratic process, and enabling staff to use their experience and creativity to innovate and find solutions. Local evidence to date shows that this improves outcomes for people, improves staff morale and therefore retention and generates efficiency; alongside this there is no evidence to date that this approach increase risk, either to the individual or to organisations, often cited by centralising, hierarchical organisations as a rationale for not distributing power and decision making. This principle would need to be replicated between the whole system and Thurrock to enable authentic place based working to be fully realised.

Sovereignty of Thurrock Integrated Care Partnership

In addition to the above conditions for success, organisational and system sovereignty would need to be ceded to the local care alliance. This would enable integration between roles without the need for cumbersome formal agreements to be in place and for the devolution of budgets, necessary if radical reform can take place such as delivering financial control in some areas to communities via the proposal to create Community Reference and Investment Boards.

Furthermore, it will become increasingly important to redirect resources within the system, to invest in those things that are having the most impact in improving outcomes whilst creating system efficiencies. Traditionally this has proven extremely difficult, resulting in a system that has resources often tied up in the wrong place. To invest in the things where the evidence proves their impact on outcomes and savings it will be necessary to create processes that enable the money to be moved easily where the case to do so is overwhelming.

Chapter References

1. Bickerstaff K, Walker G. Shared Visions, Unholy Alliances: Power, Governance and Deliberative Processes in Local Planning. Urban Studies. 2005;42(12):2123-2144. doi:10.1080/00420980500332098

2. The experience of community engagement for individuals: a rapid review of evidence. Pamela Attree PhD,Beverley French PhD,Beth Milton PhD,Susan Povall PhDEt Al (2010) ↑

3. Integrated care systems and social care: | The King's Fund (kingsfund.org.uk) ↑

Chapter 5:

Transforming Primary Care

Chapter 5: Transforming Primary Care

5.1 Introduction

This chapter focuses on how primary care provision in Thurrock can be further transformed whereby it plays a pivotal role in improving outcomes through developing communities of practice and integration with wider wellbeing services on a Primary Care Network (PCN) footprint. This chapter will also discuss some of the historic and current challenges facing primary care, and how our new primary care vision of integrated care will respond to these challenges.

Ensuring high quality Primary Care that is easy to access and responds both proactively and reactively to resident need is fundamental for improved population health and system sustainability. Primary care is the healthcare setting most accessed by our residents. It acts as the gatekeeper for a wider range of more specialist services and is the setting in which most secondary preventative activity is delivered that keeps residents with long-term conditions as well and independent as possible. Poor quality, inadequately resourced and difficult to access primary care will inevitably lead to both preventable and avoidable serious adverse health events and drive residents to more expensive elements of the health and care system, most typically hospital through A&E.

Although since the introduction of PCNs, General Practice in Thurrock has been providing some services on a PCN footprint, core service delivery continues to be delivered in silos with practices running varied operating models. This has meant variation in quality of care provision to different practice populations and has limited individual practices' resilience to respond to adverse circumstances, highlighted during the COVID-19 pandemic. To drive improvement in access and quality, there is a need to 'level up' the provision of care within all of our surgeries around best practice and to capitalise on the 'at scale' opportunities that PCNs bring by integrating both back-office functions and clinical services on a PCN footprint. In order to drive improved quality, we want to work with our practices to ensure no Thurrock surgery is CQC challenged. We also want to foster greater integration of practices and PCNs with the wider community services through the development of blended roles that work beyond organisational walls to deliver coordinated and joined up care. This will ensure key principles around delivering right care at the right time within the limited resources with reduced duplication can be achieved.

5.2 Background and Overview

Thurrock CCG, established on 1st April 2013, has been responsible for commissioning (buying) healthcare services to meet the needs of residents in Thurrock (a GP registered population of circa 183k), which includes acute care, community services, mental health and some specialist services.

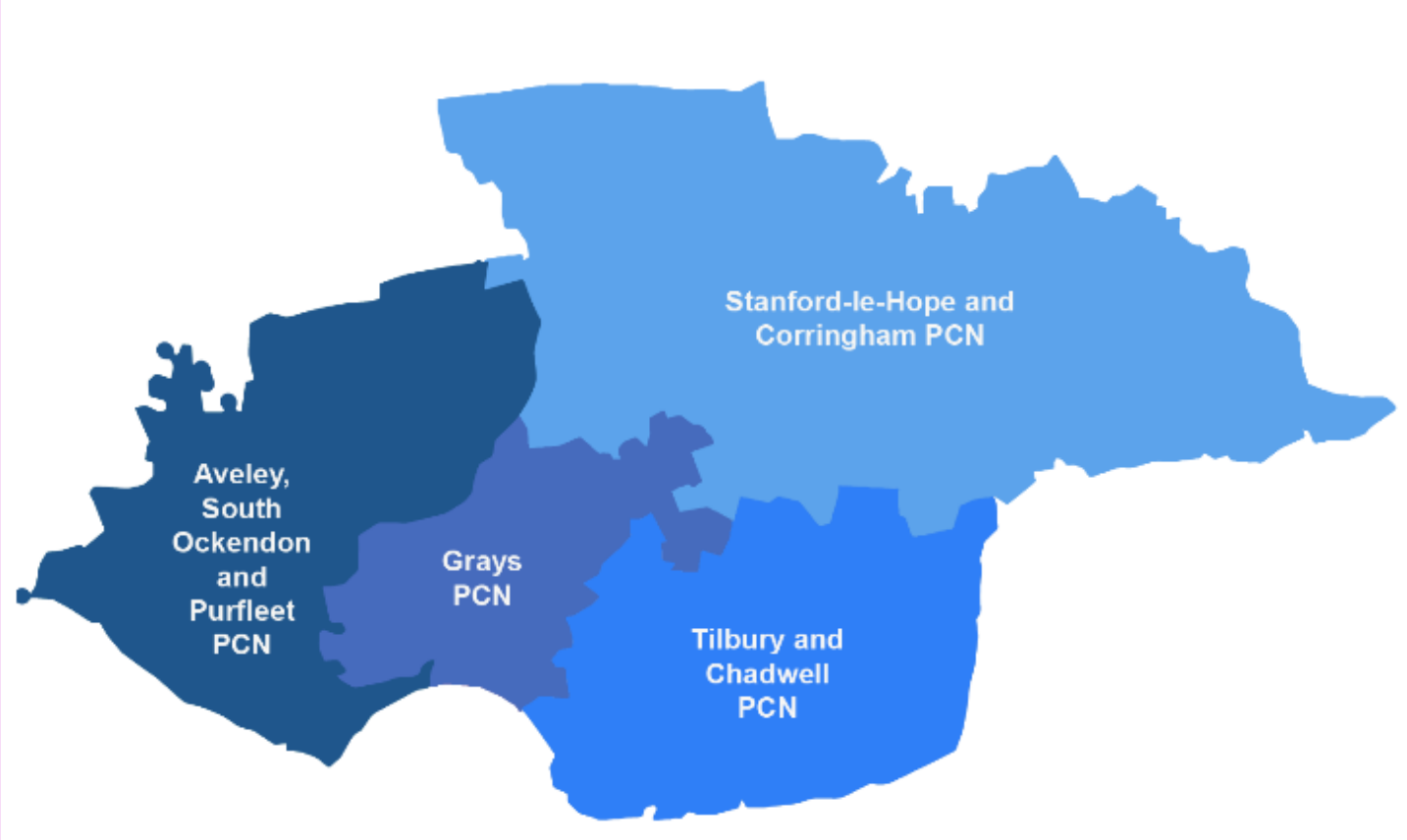
In 2017, as part of the original *Case for Change* strategy, Thurrock CCG worked closely with Thurrock Public Health Team to implement a new model of care via Tilbury and Chadwell due to the fragile state of primary care in Tilbury and Chadwell following the CQC (Care Quality Commission) closure of three GP practices in the area. This locality working model pre-empted national strategy and MSE (Mid and South Essex) Primary Care Strategy. This included recruitment of additional clinical roles to support GPs including nurse prescribers, practice based pharmacists, physicians associates and paramedics, and action to improve quality including practice based profile cards, quality visits and action planning and programmes to improve the diagnosis and management of long term conditions set out in the next chapter.

From April 2021, Thurrock CCG has taken on primary care delegation. This has helped plan and shape future primary care service in Thurrock in a way that will benefit the patients. NHS England (NHSE) continue to commission services such as dentists, pharmacists and ophthalmology. These responsibilities will shift to the Mid and South Essex ICS Integrated Commissioning Board from July 2022.

The primary care GP practice landscape in Thurrock consists of 27 practices delivering services from 38 premises with seven being single handed. There are a variety of GMS, PMS and five APMS contracted practices who are grouped into four Primary Care Networks (PCNs) ranging from the largest with 10 practices and the smallest being 6 practices within a PCN (figure 5.1 overleaf). PCNs consist of groups of general practices working together with a range of local providers, including across primary care, community services, social care and the voluntary sector, to offer more personalised, coordinated health and social care to their local populations

The PCNs each has a designated Clinical Director, who are General Practitioners from local member practices, to drive their development.

Figure 5.1 - The four Thurrock Primary Care Networks



In 2021, the Mid and South Essex Health and Care Partnership agreed that a refresh of the 2018 Primary Care Strategy was required.

The strategy refresh built on the existing 2018 strategy focusing heavily on the element of collaborative working and taking account of changes in national and local policy including the *NHS Long Term Plan* (2019), *Investment and Evolution: A five year-framework for GP contract reform* (2019), the *MSE Health and Care Partnership Five Year Delivery Plan* (2019) and, the recent publication of the DH&SC White Paper.

In summary the MSE Primary Care strategy refresh highlights the ambition for Primary Care Networks:

- Locality based community of practice which will be the vehicle for collaborative working at the local level, and
- Improving population health and driving local integration

The refreshed Mid and South Essex Primary Care Strategy has already resulted in further transformation of the primary care landscape in Thurrock, supporting:

- Integrated working between surgeries and PCNs to deliver the COVID-19 vaccine programme in the borough under a single collaborative agreement
- Formation of the Thurrock Clinical Professional Forum and the Networking meetings to consider clinical pathway redesign to improve patient access to services.
- Implementation of Population Health Management in three of the four PCNs through the Obesity pilot PCN Accelerator Programme and an NHS England/Improvement PHM programme.

However, we wish to go much further, and the next sections of this chapter set out our plans to improve primary care access, improve quality and address inequity, improve primary care estates, and address workforce issues.

5.3 Improving Primary Care Access

5.3.1 Current Issues with Access

Primary care access across the country has been impacted by COVID-19 over the last 23 months. From March 2020, primary care was expected to deliver services in a new way and in response to the pandemic, evolving from *'in person'* services to total virtual triage with increased reliance on IT and digital technology. This has meant most appointments are undertaken remotely, either through video, online and telephone consultations and face to face appointments reserved for urgent and where clinically indicated, to ensure compliance with the national Infection & Protection Control (IPC) guidelines.

Since the publication of the new Standard Operating Procedure and IPC guidelines in April 2021, primary care services have been in recovery and reset, working towards business as usual whilst ensuring continued safety measures. Incrementally the Standard Operating Procedures have been relaxed by NHS England in July 2021 to ensure primary care returns to pre-pandemic activity levels.

Figure 5.2 shows the monthly number and type of GP practice appointments delivered in the borough between April 2019 and November 2021; pre, during and post pandemic.

Figure 5.2

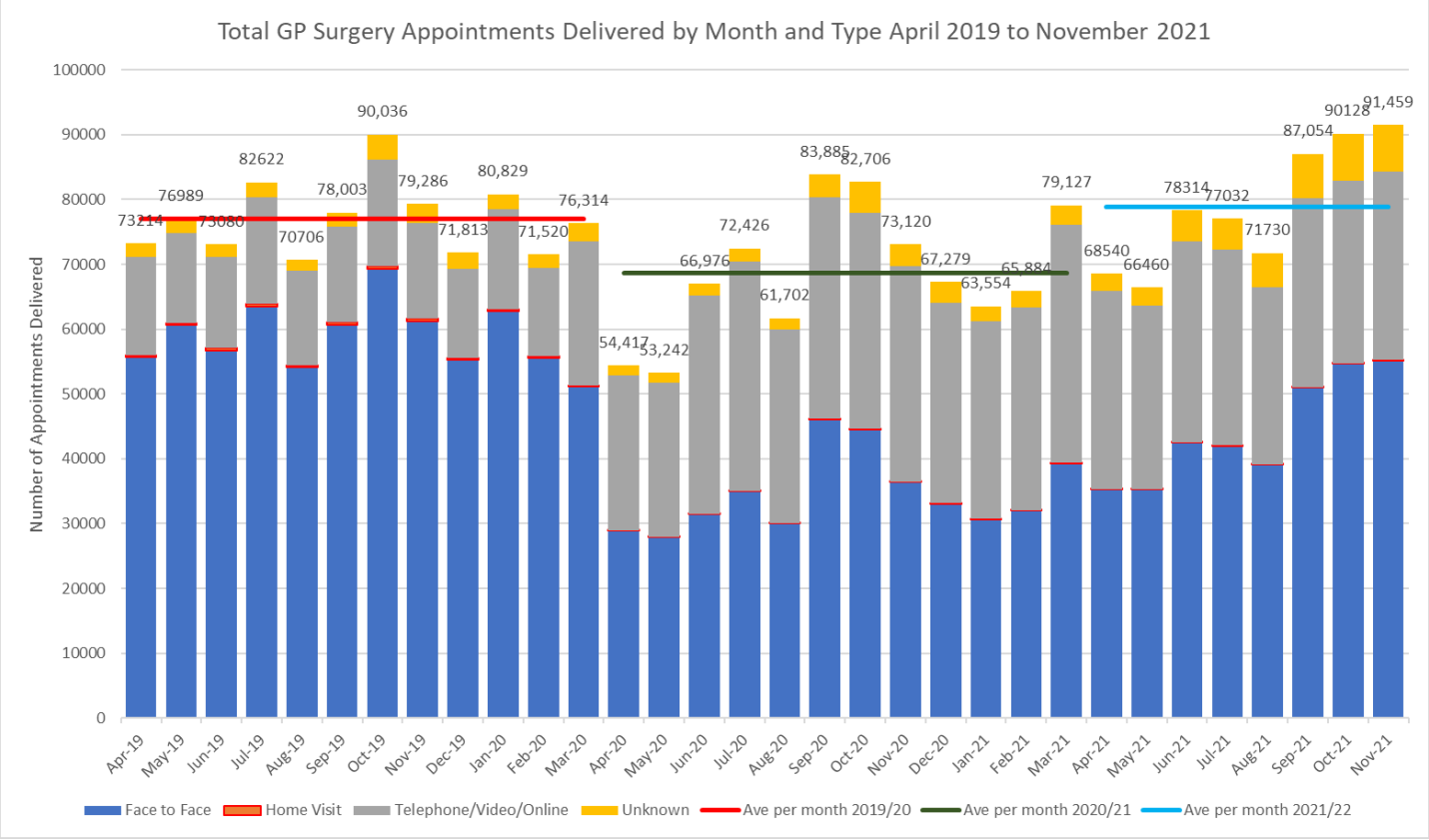
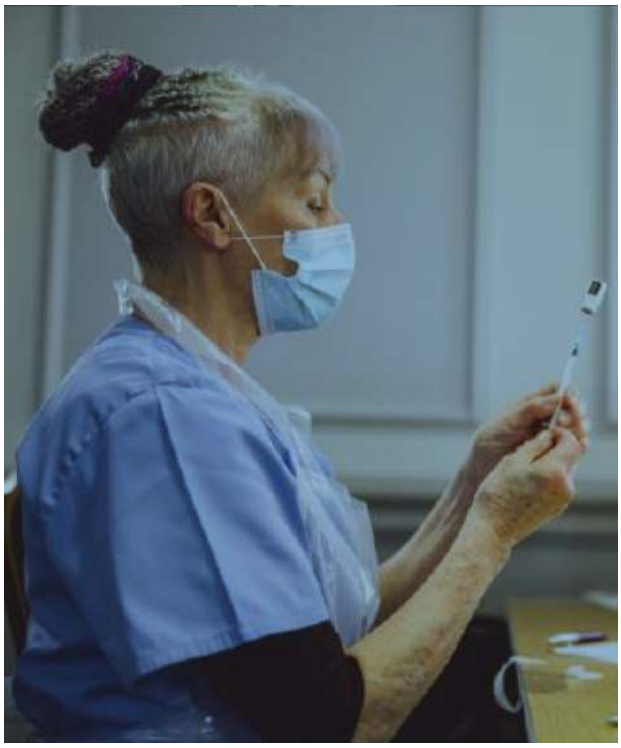


Figure 5.2 shows that average number of appointments per month dropped in 2020/21 compared to 2019/20 as the COVID-19 pandemic hit. This was likely a function of both reduced demand as residents were reluctant to access health services in general during the early stages of the pandemic, and the need to divert existing primary care capacity to support the pandemic response. There is also much greater proportion of appointments delivered by telephone/video/online compared to face-to-face in 2020/21 compared to 2019/20 in line with the revised infection prevention and control guidance and standard operating procedures mandated by NHSE for the safe operation of primary care.

Despite ongoing additional demands on primary care in 2021/22 due to COVID-19, particularly the roll out of the vaccination programme, overall appointments delivered have recovered steadily from a low in April 2021 and are now at levels well exceeding the 2019/20 mean. The proportion of face to face appointments has also increased but are below 2019/20 levels. This reflects are more permanent move to a hybrid model.

> Appointments delivered in GP surgeries in the last three months to December 2021 now significantly exceed pre-pandemic levels, despite the significant additional demands placed on surgeries due to COVID-19 and the impact of lockdown and scaling back of some non-COVID19 services during 2020/21. This is an extraordinary testament to the hard work and dedication of all GP practice staff in Thurrock



Like much of the NHS, primary care has experienced unprecedented demand in 2021/22 caused by the temporary scaling back of some services during 2020/21 in order to free up capacity to respond to the COVID-19 pandemic. Although the number of appointments offered is now higher compared to pre-pandemic levels, demand continues to outstrip supply. Where routine monitoring of long- term conditions were paused, patients are now presenting with more complexity with multiple pathologies requiring more frequent and regular appointments. Backlog in the other parts of the health and care system has also had an adverse impact on primary care, stretching capacity further.

Frequent COVID-19 outbreaks in practice premises, general practice having to resource the vaccinations sites and operate on a seven-day model have resulted in staff shortages that have limited practices' ability to increase capacity for their core work.

Increased reliance on virtual and telephone triage / consultations has required almost all practices to operate on old telephone systems that are unable to cope with the increased demands placed upon them. This has further added to the frustrations of residents who are either unable to get through on the limited telephone lines available or have to wait for a long time before they can speak to a receptionist or clinician.

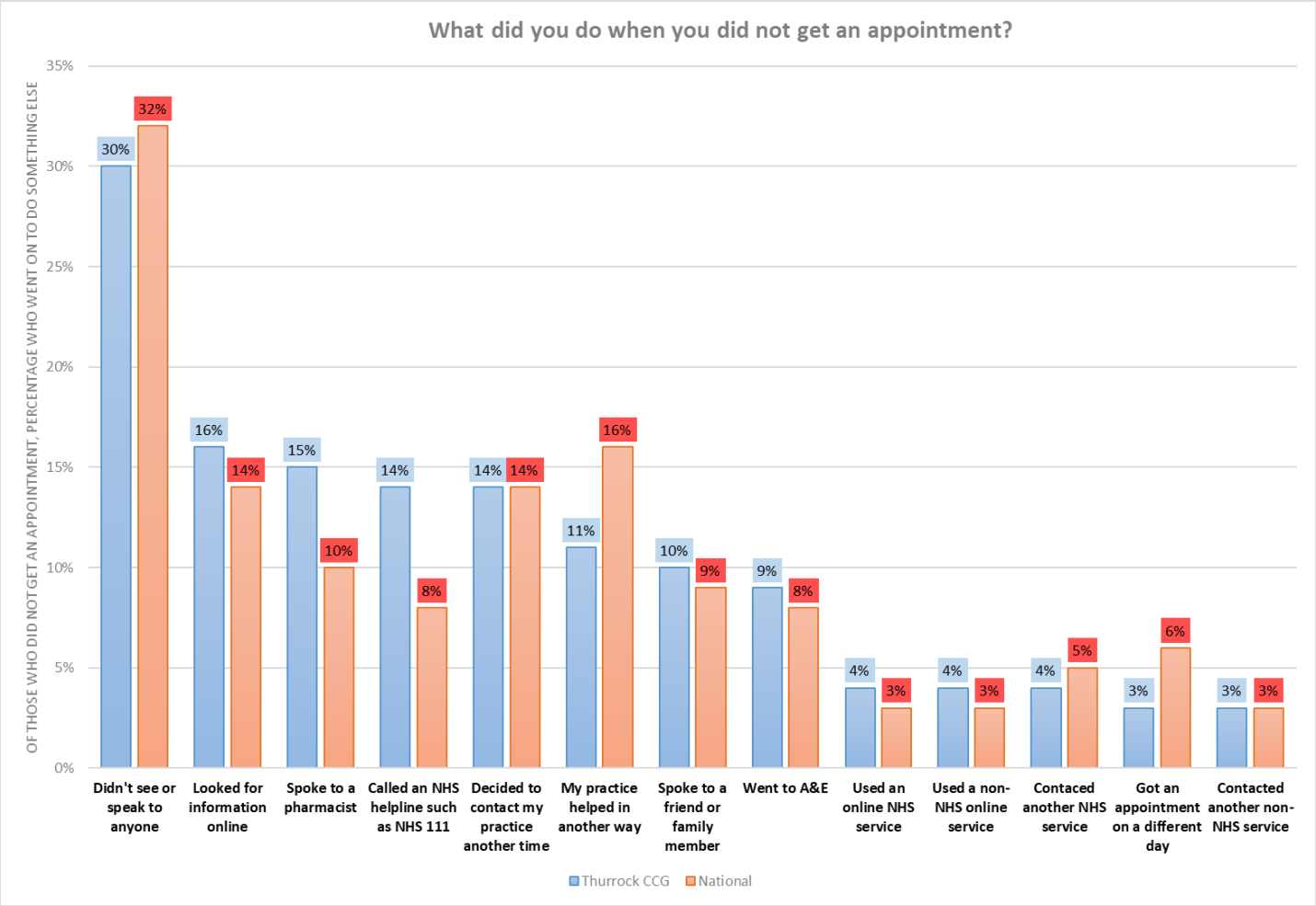
A recent survey undertaken by the CCG has highlighted a stark difference in the operating model of the practices:

1. Variations in the way practices triage patients.
2. Variations in the way practices offer same day, urgent and routine appointments.
3. Variations in the way patient can access their practices for appointments.
4. Variation in the way face to face and virtual appointments are split.
5. Physical opening times of the premises.

This variation in the practice operating model appears to be contributing to poor access to primary care and to health inequalities. Evidence shows that when patients do not get an appoint in Primary Care, the following happens as shown in Figure 5.3 overleaf.

- 14% will re-contact practice later
- 15% will use the pharmacist
- 14% will use another service, for example, NHS 111
- 16% will go online for advice
- 11% felt their practice helped in another way
- 10% got help from friends and family
- 9% will go to A&E

Figure 5.3



GP Patient survey

Some of the challenges facing primary discussed above is reflected in the most recent GP patient survey shown in figure 5.4 overleaf. The GP Patient Survey is an independent survey run by Ipsos MORI on behalf of NHS England. The results show how people feel about their GP practice through a range of questions.

Overall, Thurrock patients:

- Have been less satisfied with General Practice services compared to 2019 and are less satisfied with General Practice services compared to patients, on average, in England
- Reported a greater reduction in satisfaction during the pandemic compared to the England average.
- Where patient satisfaction scores have increased between 2020 and 2021, they have generally done so more slowly in Thurrock than in England (figure 5.3)

The trend shows in the last two years, patients were least satisfied in the top four areas detailed below:

1. Access via the phone
2. Appointment times available
3. Overall experience making an appointment
4. Choices of appointments (at last booking)

Figure 5.4

		POSITIVE SATISFACTION		CHANGE SINCE 2020	
No.	Question	CCG result (%)	National result (%)	CCG result (%)	National result (%)
30	Overall experience of GP practice (likely IAF indicator)	72 →	83 ↑	0	+1
1	Ease of access to practice via phone	55 →	68 ↑	0	+3
2	Helpfulness of practice receptionist	84 ↑	89 →	+1	0
4	Ease of use of online services	66 ↓	75 ↓	-2	-1
6	Satisfaction with appointment times available	60 ↑	67 ↑	+5	+4
14	Choice of appointment when last booked	61 ↑	69 ↑	+8	+9
15	Satisfaction with type of appointment offered	75 ↑	82 ↑	+11	+9
20	Overall experience of making an appointment	60 ↑	71 ↑	+4	+6
26	Mental health needs recognised and understood	80 ↓	86 ↑	-1	+1

Figure 5.5 below show aggregated results for Thurrock PCNs and how the results compare to national and CCG averages.

Figure 5.5

Of the four key indicators shown in figure 5.5, only Stanford-le-Hope PCN has patient satisfaction levels above the England mean for 2020/21.

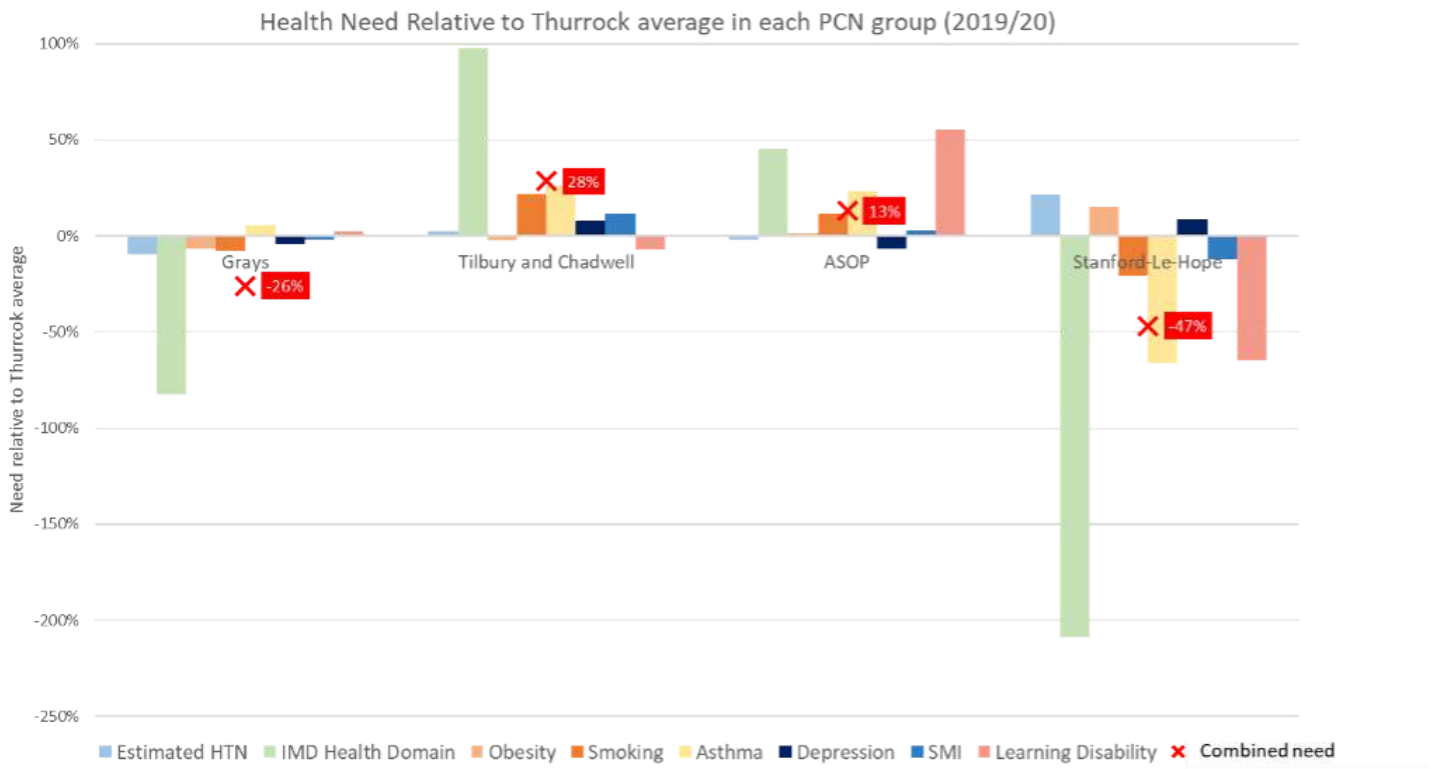
5.3.2 Inequalities and Unwarranted Variation in Current Capacity

Chapter 2 set out evidence on the significant health inequalities within our population. Many of the drivers of these are socio-economic and beyond the control of health services alone, however there is also an inequitable distribution of resources between different practice populations, with the most deprived practice populations generally experiencing the poorest ratio of clinicians to patients.

Inequalities in health outcomes occur when differing health needs between populations, cohorts or groups of individuals are not sufficiently met. To address health inequalities, we need to ensure that primary care services are resourced in a way that is equitable. This is not the same as resourcing all practices equally on the basis only of their list size; we also need to take into account the increased health need and hence demand from practice populations experiencing greater levels of poorer health caused by greater levels of deprivation. Left unaddressed, the practice populations with the greatest need for appointments will experience the greatest difficulty in accessing appointments, perpetuating existing inequalities. This phenomenon was first identified nationally in 1971 by Tudor-Hart who named it *the Inverse Care Law.*[1]

Comprehensive analyses undertaken by the Thurrock Public Health Team demonstrates this point as shown in figure 5.6

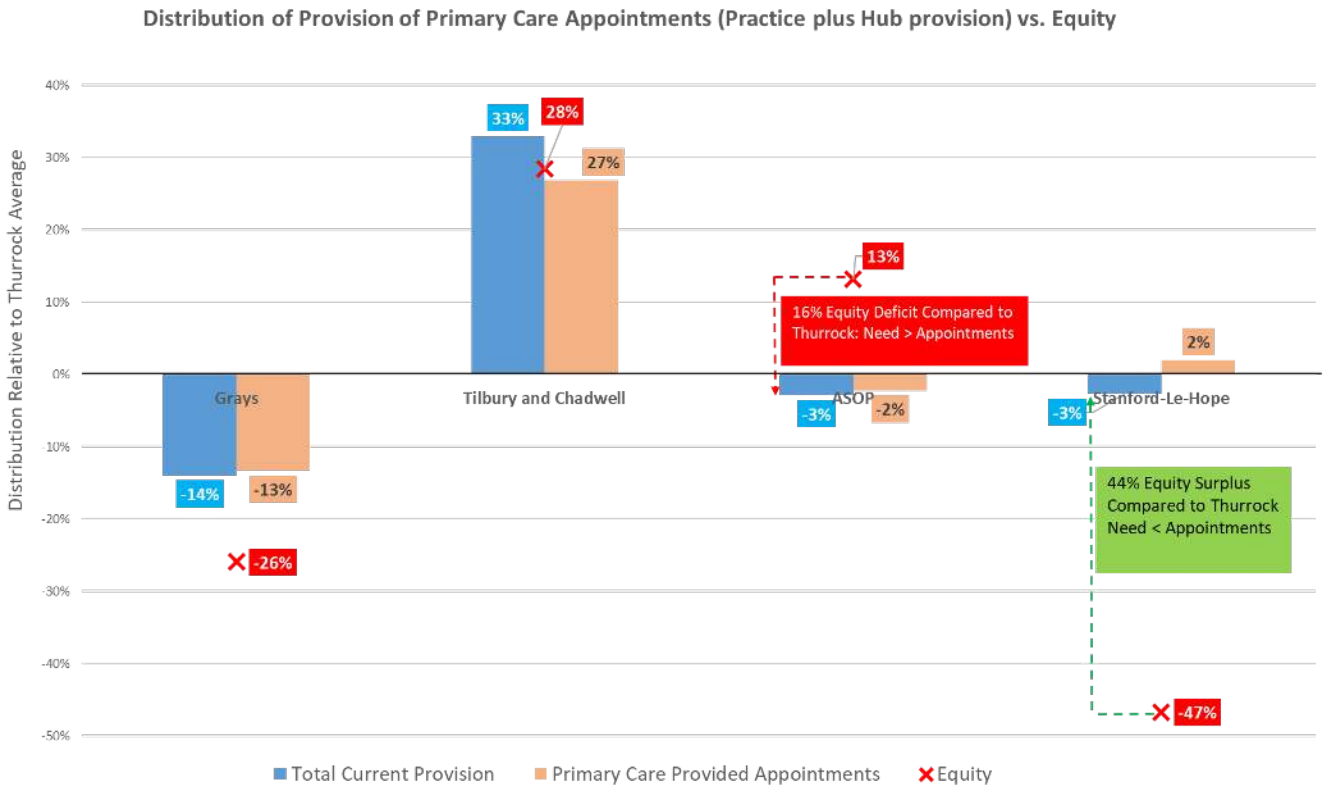
Figure 5.6



We considered a basket of eight indicators covering estimated hypertension (high blood pressure) prevalence, the Index of Multiple Deprivation health domain, and prevalence of smoking, obesity, asthma, depression, serious mental ill-health and learning disability at PCN level. Bars in figure 5.5 show how much greater (bars above the zero) or less (bars below the zero) need and hence demand is on each indicator compared to Thurrock as a whole. **Negative bars do not necessarily suggest a low overall need; only that that need is lower, relative to the borough as a whole.** We have also created a 'combined need' score shown by the red cross for each PCN. For example, overall need in Tilbury and Chadwell across all indicators is 28% greater than Thurrock as a whole, whilst in Stanford-le-Hope it is 47% less than across the entire borough.

Figure 5.7 triangulates this variation in PCN level population need against primary care appointment availability to show differences in equity between population level need in each PCN and appointment availability relative to Thurrock as a whole. The pink bars show appointment availability provided within the PCN's GP surgeries, the blue bars show all appointment availability including addition provision provided by the GP hubs, and the red "X" shows variation in need.

Figure 5.7



By comparing overall PCN population need relative to appointment availability, we are able to determine equity surpluses or deficits between need and appointments in different PCNs in Thurrock, relative to the borough as a whole.

ASOP has the greatest equity deficit gap between need and appointment availability. It has overall PCN population level need that is 13% above Thurrock's but an overall level of appointment availability that is 3% below Thurrock's giving a 16% deficit.

Conversely, Stanford-le-Hope PCN has the greatest equity surplus. It has overall practice population need that is 47% lower than Thurrock's but appointment availability only 3% lower, giving a 44% equity surplus compared to Thurrock overall. This does not mean that the population of Stanford-le-Hope has low overall health needs; only that they are lower than those in the population of Thurrock as a whole.

Tilbury and Chadwell has near equity between need and appointment availability compared to Thurrock as a whole. It has significantly greater need, but a significantly greater level of appointment availability compared to Thurrock as whole. This perhaps reflects the additional resources and investment provided to Tilbury and Chadwell through the original *Case for Change* strategy of primary care transformation

It is striking how these findings correlate strongly with resident satisfaction of GP services data presented earlier. ASOP has the lowest level of satisfaction, whilst Stanford-le-Hope has satisfaction levels above the England mean.

5.3.3 How We Will Improve Access

Levelling Up Through Investment to Close the Equity Gap

The analyses presented in figure 5.7 clearly demonstrates that appointment availability is not currently distributed in an equitable way between PCNs that sufficiently takes account in differences in need and demand, and suggests a link between this inequity and patient satisfaction with access to GP surgeries.

However, the analyses only compares resources ***between*** Thurrock PCNs yet we also know that the borough as a whole is under-doctored and under-nursed, with overall patient satisfaction scores around access significantly worse than England's, and worse in all three PCNs other than Stanford-le-Hope. **It would therefore be wrong simply to redistribute existing resources between PCNs, as whilst this may create a more equitable situation within Thurrock, it would still result in poorer access to primary care appointments for our residents compared to England's and likely bring satisfaction for Stanford-le-Hope residents back down below the England's mean, essentially "levelling down".**

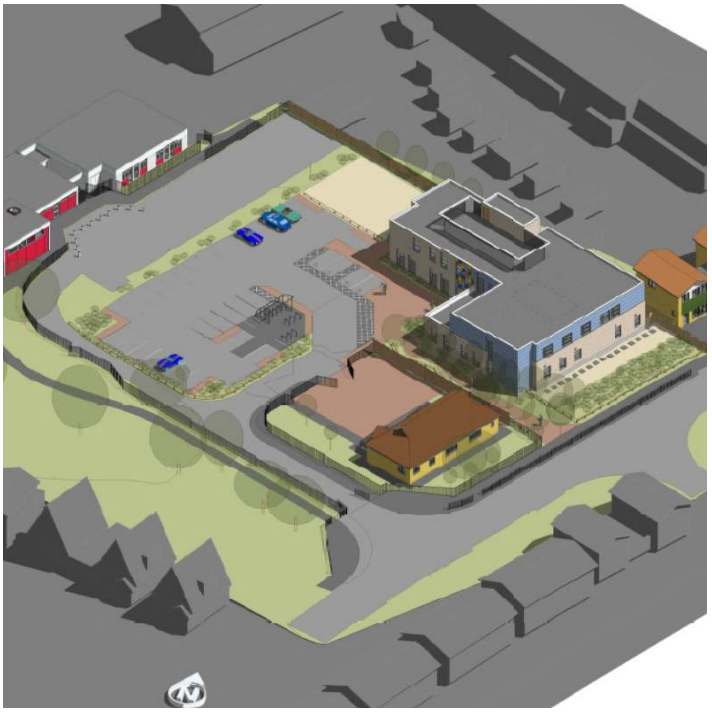
Instead, we need to use Stanford-le-Hope as a baseline for equity, and seek to bring appointment availability in the three other PCNs up to their level of equity, essentially "levelling up".

The creation of Integrated Care Systems and system budgets affords the potential opportunity to redistribute system resources in a more equitable way and as a Thurrock Integrated Care Partnership we will continue to make the case to the Mid and South Essex ICS for re-distribution of resources to address the equity gap in ASOP, Grays and Tilbury and Chadwell compared to Stanford-le-Hope.

As future growth funding is made available, we will prioritise investment in a way that first closes the equity deficit between ASOP and Thurrock and then levels up the three other PCNs to Stanford-le-Hope levels of appointment availability.

Integrated Medical Centres

Increasing practice resources to address the health equity gap alone will not be sufficient. Thurrock operates in a competitive market for GPs and other clinical specialities that operate within Primary Care. To attract the brightest and the best to the borough, we need to create a working environment that is highly attractive to clinicians. We see our new IMCs and wider locality model as the solution to this:



Mid and South Essex Health ICS, local NHS providers and Thurrock Council have a shared commitment to build four new Integrated Medical Centres (IMCs) in the borough, one per locality and provide a wide range of integrated health, care and third sector provision.

This will include services that address wider determinants of ill health, a place for community assets and voluntary groups to offer a wide range of local support including, Local Area Coordination, Community Led Solutions, Health and Wellbeing Teams, Employment, Education and Training advice, Housing and benefit advice, and where possible cafes and community hub and library facilities. In addition, the IMCs will offer an opportunity for a new and expanded Primary Care Offer, diagnostic facilities, secondary care outpatient clinics for the most common conditions, health and wellbeing improvement and healthy lifestyle programmes, community and mental health treatment, Social Care and third sector services.

IMCs will include at least one GP practice within them, and act as the locality 'hub' from which a wide range of additional services will be provided, that will integrate with all GP practice provision within the PCN and wider locality provision in a single locality model. Details of our new Integrated Locality Model are set out in Chapter 7.

We envisage this new way of working will provide an attractive environment in which to deliver clinical services for GP practice staff, allowing easier access to a wide range of integrated provision including services that address wider social and environmental causes of ill-health. This in turn should free up the time of GPs to concentrate on more complex patients with easier access to Consultants, and allow other practice clinical staff to work in a more coordinated and integrated way within a wider network, making a most efficient use of existing resources that will ultimately impact positively of access. It will also allow Thurrock to attract new GPs to the borough.

A Mixed Skill Clinical Workforce

Our 2017 *Case for Change* strategy highlighted research suggesting that for 27% of GP appointments, the resident would have been better served by having direct access to a different type of health professional, avoiding the need for on-ward referral. For example, Practice Based Pharmacists can undertake medication reviews far more quickly than General Practitioners. Similarly, one in six GP appointments are for musculoskeletal problems; we can deliver better outcomes for this patient cohort if they can book an appointment directly physiotherapist for assessment and treatment within the surgery, rather than seeing a GP first and then waiting for a referral.

The strategy demonstrated that in the context of a national shortage of General Practitioners, diversifying the clinical workforce within surgeries to include Nurse Practitioner, Practice Based Pharmacists, Physiotherapists, and Paramedics could allow surgeries to offer a better service to patients and free up GP time to concentrate on more complex patients.

Since 2017, we have made considerable investment into these additional clinical roles, initially in Tilbury and Chadwell, and more recently within other PCNs.

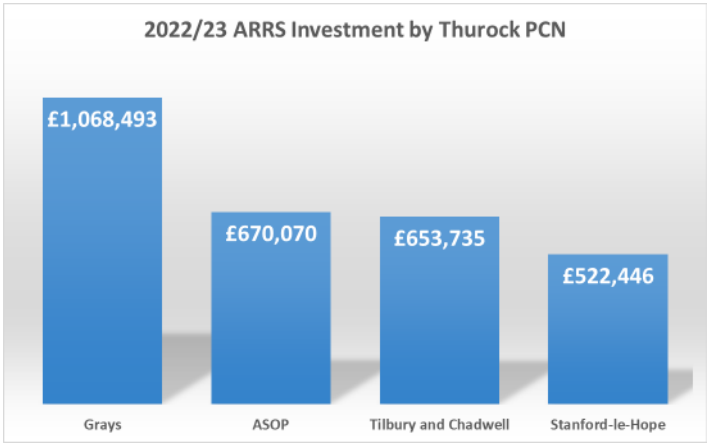
In February 2020, NHS England and Improvement (NHSEI) and the British Medical Association (BMA) published the 2020/21 GP Contract Deal. This new deal included major investment through the Additional Roles Reimbursement Scheme (ARRS), with the aim of securing an additional 26,000 staff across primary care. The ARRS is the most significant financial investment element within the Network Contract Direct Enhanced Service (DES) and is designed to provide reimbursement to Primary Care Networks to build workforce capacity, create bespoke multi-disciplinary teams that work at scale to deliver population health interventions and make support available to patients where it is most needed.

The ARRS enables PCNs to recruit a selection of roles and claim 100% reimbursement for all positions recruited. 15 roles are available to recruit via the scheme in 2021/22, which includes the following:

- Clinical Pharmacist
- Physiotherapist
- Paramedic
- Physicians Associate
- Podiatrist
- Occupational Therapist
- Dietitian
- Pharmacy Tech
- Mental Health Practitioner
- Social Prescribing Link Worker
- Health and Wellbeing Coach
- Nursing Associate
- Trainee Nursing Associate
- Care Coordinator
- Advanced Practitioner

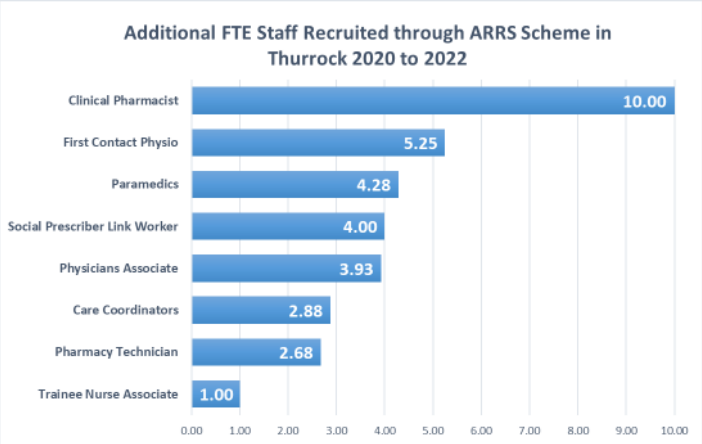
Figure 5.8 below shows the additional investment provided by NHS England to support in scheme in 2022/23.

Figure 5.8



To date, Thurrock PCNs have recruited a total of 34.02 full time equivalent additional primary care front line clinical staff through the ARRS scheme. The skill mix is shown in figure 5.9

Figure 5.9



The introduction of the nationally funded ARRS roles and recruitment to date is building additional capacity within PCNs, plugging some of the workforce gap. However, recruitment remains challenging at least one PCN, and there is a need to carry out a skills gap analysis, triangulating the skills mix in the existing workforce with demographic needs.

Sharing capacity at PCN level through integrated clinical models, rather than assigning roles simply to work within individual practices, provides further opportunity for more efficient use of the new capacity.

We will continue to expand the skill mix of the PCN workforce in 2022/23 through the ARRS scheme and undertake a workforce skills gap analysis to inform future recruitment and ensure that the most appropriate roles are recruited.

Cloud Telephony System and Standardisation of Patient Triage

It is imperative that the existing GP telephony systems are upgraded to improve access and general practices' ability to embed new models of care. Whilst this has been recognised and work is underway nationally, it is important we accelerate the implementation locally.

Two Thurrock PCNs are piloting an innovative project incorporating cloud-based telephony run by staff specialising in care navigation. Centralised cloud technology operated on a PCN footprint will not only improve access to patients but will also free up individual practice phone lines for virtual consultations.

It is envisaged additional functionality such as direct booking for same day face to face appointments in community pharmacies could be added to this service during the pilot phase.

Successful implementation would represent progress towards merging and providing standardised centralised patient triage and wider back-office function at scale. This is the only pilot project of its type across MSE, so learning and best practice will be shared across the system once the pilot is complete.

New ways of working – Virtual triage, Online and Video Consultation

Although there has been concern raised both nationally and locally about difficulties that some patients experience in being able to see a GP in person, many residents find telephone or technology appointments more convenient, particularly for routine issues as it saves an unnecessary trip to the surgery. Moving forward, we need to implement a hybrid model that both provides choice and delivers the maximum number of appropriate appointments from the workforce capacity that we have available.

Implementation of virtual triage, increased use of digital platform and video consultation work was being undertaken prior to the COVID-19 pandemic. However, due to the nature of the changes required to ensure continued access to Primary Care during the pandemic, this work was accelerated to meet demand.

Our *Virtual Triage Model* was introduced in March 2020 when COVID-19 changed the way GP practices delivered care to their registered population. National guidance and standard operating procedure were produced for all GP practices to ensure patients receive safe and standardised care despite being registered with different practices.

Over the last two years, Online Consultation (OC) and Video Consultations (VC) have been widely used by practices with face-to-face consultation reserved for clinically appropriate patients and urgent appointments. Given the national direction of travel, these newer consultation modes are expected to become part of the 'new normal', alongside the need to offer face to face appointments as part of a hybrid model.

A single online consultation platform was procured centrally by the five Mid and South Essex CCGs to replace existing platforms procured by practices. However, this 'one size fits all' solution has been unpopular with many practices and there has been a wide variation and inconsistent use. In order to encourage greater adoption of on-line and video consultations, we will therefore learn lessons from this previous procurement, and ensure that in future, practices are offered a choice of online consultation platform providers to suit their needs.

Thurrock First

Thurrock First is our single point of access across community health, mental health and adult social care. The service consists of a team manager who is a qualified social worker, two senior co-ordinators, 17 Thurrock First Advisors who take telephone calls, a Community Psychiatric Nurse, a Mental Health Act Assessment Coordinator plus casual bank staff.

It aims to reduce, prevent and delay the need for more significant care by intervening early and works closely with the Urgent Care Response Team (URCT) who can be mobilised to attend residents' houses where they are in crisis.

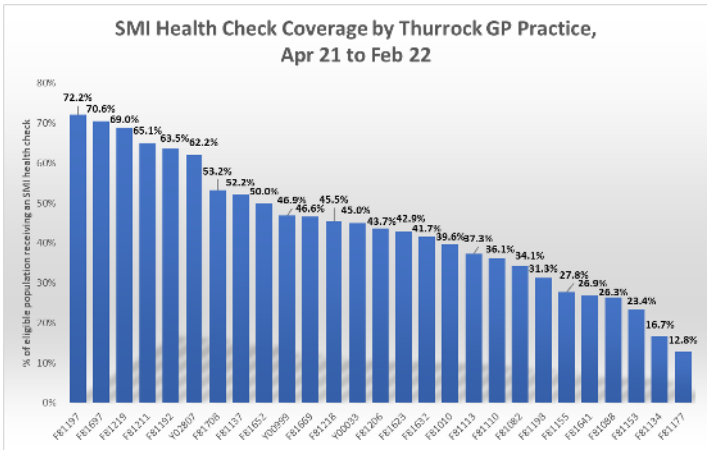
Evaluation evidence suggests that the service has a significant positive impact on reducing 'failure demand' and preventing residents from otherwise needing to access Primary Care. However, we believe that it has potential to be used by a greater number of residents and awareness of the service and its capabilities amongst residents could be improved.

In 2022/23 we will invest in a comprehensive communications campaign to promote Thurrock First to residents as a mechanism for reducing demand on overstretched Primary Care services.

5.4 Improving Quality and Addressing Variation in Outcomes

There is currently significant and unacceptable levels of variation in health outcomes for residents between different practice populations both within Thurrock and nationally. Figure 5.9, which shows the coverage of Serious Mental Ill-Health (SMI) Health Checks between different practice populations demonstrates this. In two practice populations, over 70% of the eligible cohort had received an SMI health check by February 2022, whist in one practice population, this figure falls to only 12.8% of the patient cohort.

Figure 5.10



5.4.1 What is causing these inequalities in health outcomes?

Inequalities in health outcomes are complicated and multifactorial, caused by a mixture of socio-economic and demographic differences, geographical differences, ethnicity and cultural differences, and differences in health behaviour between different practice populations. The way we have designed our health and care system historically has constrained clinical staff in addressing the root causes of ill-health and limited them largely to reacting to demand that has resulted from them by prescribing medication or onward referral. We have already discussed our plans to address these issues through four new Integrated Medical Centres and a new Integrated Locality Model. Chapter 7 sets on in more detail.

However, the way we have historically commissioned and delivered primary care has also contributed to inequity and variation in outcome. Section 5.3.2 has already highlight inequity in provision of appointments between PCNs when the health needs of the residents they serve is taken into account.

Current variation in outcomes have a number of possible causes including:

1. Variation in provision of General Practice services
2. Variation in clinical skill mix between different surgeries. For example, one surgery may have a practice nurse specialising in respiratory conditions, another with a specialism in diabetes.
3. Variation in quality of care between practices (measured by QOF)
4. Variation in resources made available to primary care vs demand
5. Variation in clinical operating models and clinical practice
6. General Practice working in silo, so pathways are not co-ordinated for patients
7. Variation in estates between different practices, that may limit for facilitate better clinical practice.

CQC Inspections and Ratings

CQC inspections and rating of individual GP practices are considered as the barometer of quality of care provided by general practices. Table 5.1 shows the current CQC inspection overall ratings for each GP practice in Thurrock.

Table 5.1

SURGERY NAME	OVERALL CQC RATING	COMMENTS
Aveley Medical Centre	REQUIRES IMPROVEMENT	Last inspection 26/08/2021
Balfour Medical Centre, Grays	GOOD	Last inspection 21/02/17
Chafford Hundred Medical Centre	GOOD	Last inspection 26/10/17
Commonwealth Health Centre, Tilbury	GOOD	Last inspection 05/02/19
Dell Medical Centre, Grays	GOOD	Last inspection 02/11/17
Derry Court Medical Centre,	GOOD	Last inspection 13/07/17
East Thurrock Medical Centre	GOOD	Last inspection 16/05/17
East Tilbury Medical Centre (College Health)	NOT YET INSPECTED	Not inspected whilst under new provider
Hassengate Medical Centre, SLH	GOOD	Last inspection 29/02/16
Horndon Surgery	GOOD	Last inspection 28/04/16
Kadiim Primecare Medical Centre, Grays	GOOD	Last inspection 28/09/16
Milton Road, Grays	GOOD	28/08/18
Neera Medical Centre	GOOD	Last inspection 16/01/17
Oddfellows Hall Health Centre	GOOD	Last inspection 01/05/19
Pear Tree Surgery, South Ockendon	GOOD	Last inspection 31/07/17
VH Doctors Ltd, Purfleet Care Centre	GOOD	Last inspection 30/07/16
Rigg Milner Medical Centre, East Tilbury	INADEQUATE	Last inspection 28/05/2021
Sai Medical Centre, Tilbury	GOOD	Last inspection 11/10/16
Sancta Maria Centre, South Ockendon	GOOD	Last Inspection 10/07/18
South Ockendon Health Centre	GOOD	Last inspection 06/08/19
Southend Road Surgery, Stanford-le-Hope	GOOD	Last inspection 28/11/18
Stifford Clays Health Centre	GOOD	Last inspection 06/10/16
The Grays Surgery	GOOD	Last inspection 29/08/18
The Sorrells, Stanford-le-Hope	GOOD	Last inspection 04/10/16
The Surgery, Orsett	GOOD	Last inspection 5/2/16
Thurrock Health Centre (College Health)	GOOD	Last inspection 5/6/19
Tilbury & Chadwell Group (College Health)	GOOD	Last inspection 9/4/19

As table 5.1 shows, the vast majority of GP practices in Thurrock are rated 'Good', with only two practices receiving a *Requires* Improvement or *Inadequate* rating. The Primary Care Team at Thurrock CCG has worked incredibly hard in conjunction with individual surgeries over the last six years to improve quality and this has undoubtedly delivered substantial improvement.

In 2015, when this work began, the majority of surgeries had received CQC ratings of either *Requires Improvement* or *Inadequate*

As a result of routine primary care activity, health checks and QOF (primary prevention and long-term conditions diagnoses and management) work was paused during March 2020, patients are now presenting with complex conditions, multiple pathologies, and poorly controlled long-term conditions. Significant back logs for specialist services, investigations and monitoring have adversely affected the quality of care provided to the service users.

Improving care and quality to service users remains a challenging but imperative as the health and care system resets and recovers.

Primary Care Estates

The poor quality of Primary Care estates in some parts of Thurrock is making service delivery in certain practices more challenging, impacted by the lack of adequate space, an increasing workforce and growing population. In addition, aging estates are impacting on Infection Protection and Control (IPC) guidelines. This has impacted on the patient perception of their practice's ability to deliver services.

Thurrock Council's new Local Plan will set out proposals to build in excess of 30,000 new homes over the next 30 years and so it is imperative that we ensure current and future estates are fit for the future to accommodate the additional demand on primary care services.

Primary Care Workforce

Thurrock has one of the highest levels of under-doctoring and under-nursing in primary care in England, with the highest GP to patient ratio across Mid and South Essex. Workforce data shows a decrease in GP Partners alongside an increase in salaried GPs with an overall small decrease in GP workforce from March 2019 to March 2021. Thurrock has also experienced a decrease in nursing capacity in Primary Care. However, direct patient care roles and admin/non-clinical staff numbers have increased slightly from March 2019 to March 2021.

Evidence shows that the clinical workforce in Thurrock has a significantly higher proportion of older (over 55) staff compared to the England and MSE average. This has had an impact during the pandemic as there have been staff who have taken early retirement and moved onto pastures new due to burnout. A proportion of practice clinical staff have also been categorised as *"shielding"* and Clinically Extremely Vulnerable (CEV). This has negatively impacted on the resilience of our primary care workforce.

5.4.2 How we will Reduce Variation in Outcome and Improve Quality

In order to reduce health inequity, we also need to shift the balance from reactive to proactive care, preventing, diagnosing and intervening at the earliest possible opportunity to prevent conditions from worsening.

Surgeries also need to work in collaboration other elements of the NHS, council and third sector to deliver integrated solutions with residents that address health needs including socio-economic factors. We have already started this transformation by embedding social prescribers within our four PCNs and we believe the plans set out in both Chapter 6 and 7 will shift the balance from reactive to proactive and preventative care.

Integration and the Sharing and Standardisation of Best Practice at PCN and Locality Level to "Level Up" Quality.

Practices have historically been commissioned to operate as individual and separate small businesses, largely in silos, and to some extent, in competition with each other. It is therefore unsurprising that there is significant variation in clinical practice, operating models and workforce skill mix. This is well evidenced in the Thurrock Local GP Access Questionnaire. Historically, Thurrock has had too many small surgeries with insufficient resilience and skill mis to deliver a primary care model fit for the 21st century.

The recent formation of Primary Care Networks provides a huge opportunity to reimagine how we deliver primary care to our residents over a wider footprint, sharing clinical capacity, best clinical practice, back office function and intelligence to "level up" the quality of care delivered to every resident.

PCNs are on a journey to work collaboratively with system partners like local authority, community services providers, secondary care providers and voluntary services to ensure the population receives a seamless service from all providers involved. Siloed working has been the historic method of working in primary care and transforming this is the way forward in providing an integrated model of health and social care and will help in improving the patient journey at all touch points. The Integrated Medical Centres (IMCs) presents us with a unique opportunity to provide services that are delivered in a truly integrated way. We will empower staff to redesign services and develop integrated care solutions in conjunction with residents, supported with an interoperable IT system

To facilitate a more consistent way of working and best clinical practice we will encourage and facilitate collaboration between practices, building on the work we have already begun through our Clinical Professional Forum and Network Meetings.

We will also encourage PCNs and practices to provide certain back-office functions and clinical services collaboratively from a merged central location. This will not only help rationalise and make best use of existing estates and address variation but will also reduce duplication and drive efficiencies. A couple of Thurrock PCNs are being supported to centralise certain functions as part of their accelerator project.

To facilitate a more consistent way of working for the ARRS staff, every PCN will be offered a PCN wide clinical SystmOne unit which both PCN practices and ARRS staff have access to. This improves patient safety and allows merging of central functions to deliver a better service to patients as well as improve staff retention figures.

ARRS staff, although PCN aligned, currently need to deliver clinical services at individual surgery because they are only able to access clinical information from the records of patients at the surgery that the patient is registered. This necessitates extensive travel between surgeries to deliver their clinical interventions something that is inefficient and is having a negative impact on staff retention. To address this, we will offer every PCN a single PCN wide SystmOne unit (the database that stores patient medical records). Having a PCN based S1 unit for ARRS roles will allow ARRS clinical staff to work out of fewer sites, for example that PCN's IMC, reducing travel time and increasing capacity for front line care. It will also promote integration of ARRS clinical functions with other diagnostic and outpatient capacity and wider clinical and wellbeing services, and empower staff to redesign and transform the local offer.

We will also encourage PCNs to use existing staff with special interest and ARRS staff to provide care for patients with LTC on behalf of all the practices from a central clinical space, and through Integrated Long-Term Conditions Management Services that provide a 'one stop shop' for management of all cardiovascular conditions and diabetes. This will present opportunities to cohort patients on levels of complexity with best and most appropriate use of clinical skill mix, ensuring a consistent and standardised care across PCN.

The implementation of PCN-led clinics for speciality areas of LTC will enable residents from neighbouring practices to be seen at a dedicated location, by the team specialising in their condition. Establishing direct links with consultants will reduce referrals to secondary care and unplanned attendances. Further implementation of the improvement measure below is expected to reduce variation and improve health outcomes for residents of Thurrock. Our plans on Long Term Condition Quality Improvement are set out in detail in Chapter 6.

More broadly, the development of a high quality Primary Care offer in Thurrock is reliant upon the ability to collaborate effectively with local people and local communities. Our Strategy introduces a new framework for engagement and collaboration based on the development of communities of practice as set out in Chapter 3. These allow people who have a common interest in a subject or area to collaborate over an extended period of time – sharing ideas and strategies, determining solutions and building innovations. The impact of this form of engagement will be to ensure that services and solutions (and decisions about services and solutions) are built to reflect what people want and need and how they wish those services and solutions to be delivered.

We also see the ARRS and wider primary care workforce being part of a single Integrated Locality Network of front line professionals who will come together to co-design single integrated solutions with residents, minimising bureaucracy and on-ward referral between different teams, and addressing the holistic health and wellbeing needs of residents within a single solution. Chapter 7 discusses these plans in more detail.

Improving Quality through Continuity of Care

Evidence suggests that providing continuity of care in primary care, i.e. being able to see the same clinician on many different occasions is important for many residents, particularly those with more complex needs and multi-morbidity. Care provided primarily through the same clinician negates the need for the resident to tell their story multiple times, and allows the clinician time to develop a more detailed understanding of the needs of residents and spot changes or patterns in health and wellbeing over time. One systematic review which considered the impact of continuity of care on patient satisfaction concluded significantly higher patient satisfaction levels when they received interpersonal continuity of care.[2] A second, which considered impact on health outcomes and costs, concluded that interpersonal continuity of care is associated with improved outcomes, lower hospitalisation rates, improved preventative care and lower costs.[3]

As we seek to spread best practice between different GP practices through a PCN based model, and deliver broader integration of primary care with other services and professionals through our Integrated Locality Network and Integrated Medical Centres, we will support surgeries to develop clinical operating models that prioritise continuity of care where possible.

Supporting Integration through Commissioning

We will support integration at PCN level by ensuring that future enhanced non-core services are commissioned on PCN footprint. This will encourage greater integration of PCN member practices and will drive standardisation of care and reduce health inequality.

This commissioning will be based on population health management/ population cohort model. We will seek to commission services on a PCN footprint with payments on achievement on outcomes as opposed to transactions. This will help drive up standards with challenge and support provided from member practices to low uptake practices. We will start by revising our Stretched QOF commissioning arrangements to reflect these new arrangements

Workforce Collaboration and Resilience

Sharing the existing practice clinical workforce more broadly between practices across the PCN including the new ARRS roles will increase workforce resilience at individual surgery level and improve clinical skill mix.

There is an opportunity to upskill practice and ARRS staff to reduce variation of working practices. We will work to support PCNs to ensure that future ARRS role recruitment is aligned with PCN need and skills gap analysis. This helps to address the disproportionate variation in service provision and gives everyone an equity of offer based on population needs. All future resources should be maintained at that distribution of need level.

Evidence suggests training practices tend not to suffer from staff shortages. For all future procurements of core primary care services, prospective providers will be required to achieve or work towards achieving training practice status.

Quality & Patient Safety

This has been a success story for Thurrock where the CQC rating of vast majority of practices have improved to GOOD through dedicated and bespoke support to practices by the CCG's primary care, quality and patient safety and medicines management team. The support needs to continue to ensure improvements achieved over the years are sustainable with an ambition to have no CQC challenged practices in Thurrock.

As the last section demonstrated, quality, as defined by CQC ratings has already improved substantially since 2015. Regular quality visits comprising where our GP profile cards containing benchmarked quality metrics, together with joint action planning with surgeries has improved standards.

Over the last two years, COVID-19 has temporarily altered the way in which we have been able to engage with practices, with a move to a completely virtual model. Moving forward, we will engage with practices to reinstate the pre-covid face-to-face proactive practice visits with joint CCG and Public Health teams so that a holistic overview of the practice can be taken to share best practice and provide support in required areas of concern. We will also seek to build on previous good practice, looking not only at quality at practice, but at PCN level and replacing annual profile cards with real time data through building informatics capacity within each PCN. This approach is discussed in more detail in the next chapter.

There is a concerted effort to support primary care to increase the number of annual Learning Disability Health Checks and Serious Mental Illness Health Checks too. This will support in the reducing variation in quality of care as well as standardising care for specific cohorts. We are now actively engaging practices on performance of SMI and LD health checks, sharing their current data and providing support to improve. This includes linking practices with the ELDP and Thurrock Lifestyles Solutions for additional support on LD health checks, and ensuring that EPUT Mental Health Practitioners are embedded in every PCN in Thurrock through our new Mental Health Integrated Primary and Community Care model. More details are set out in Chapter 7.

We are also extending support on quality improvement to adult social care. A Lead Nurse for care homes and home care works in partnership with Thurrock Council's safeguarding team and contract team to monitor and support the adults in residential placements in Thurrock. All care home residents now also have a named GP and clinical in-reach support from an extended Primary Care team. The aspiration for this is that all residential providers in Thurrock achieve a rating of good alongside ensuring that the providers are quality employers that attracts people to work in Thurrock.

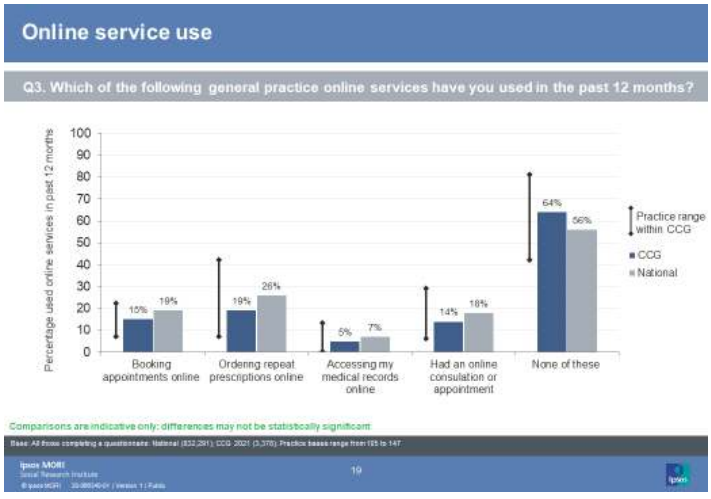
Alongside national and MSE wide communications strategies, further work is required to communicate new models of care locally to residents by various methods of patient education.

Patient Education and Access to information

The following graph shows the online level of activity undertaken by Thurrock residents and this also shows that further work with patients is required in this area too.

In addition, schemes are required to assist with digital poverty, enabling residents to access the new models of care. Working with third and voluntary sector partners, to provide digital access and education.

Figure 5.11



Residents need to be at the heart of further transformation of primary care and the re-design of services. We will ensure primary care representation on the new resident engagement and participation mechanisms set out within Chapter 3 of this strategy including Community Reference and Engagement [illegible]s and Communities of Practice.

Primary Care Estates

The MSE Estates Strategy is looking at primary care estates per PCN and assessing how primary care estates need to be made future proof especially with the increasing PCN workforce. The MSE wide strategic estates committee is working towards ensuring that primary care estates are used and fit for purpose. The Integrated Medical Centres are clearly part of our solution, but there is a need to bring all GP practice estate up to a standard fit for the future.

Workstreams are in place to support individual practice improvement requests, for example, extensions to existing premises, improving current premises, using the estate in a different way by centralising some of the back-office functions which frees up overall PCN space.

Virtual integration models are being implemented across MSE, including PCN Clinical Units to enable integrated working across PCN roles.

Local integration is being driven by locality-based community in practice models where locality-based solutions are being mapped out so a holistic delivery of services can be achieved.

5.5 Conclusion and the Desired Outcomes We Will Achieve From Our Plans

Primary care is at a critical point where some of the transformation initiatives that were implemented since 2015 had started to show some gains and improvements in quality and care provided by primary care. The practices' CQC rating across the primary care landscape in Thurrock is a testimonial of the improvements made pre pandemic. These gains to some extent have built resilience that helped practices to weather the pandemic.

The two-years of the pandemic presents primary care with a series of complex challenges of its own in terms of built-up backlog but also presents us with some opportunities where there was greater collaboration between practices, and wider health and care providers, roll out of the digital model of care and provision of some services at scale on PCN footprint.

It is therefore important to build up on some of these opportunities and initiative discussed in the chapter.

We believe that implementing the plans set out in this chapter will deliver the following desired outcomes and ultimately improve population health and reduce health inequalities.

Desired Outcomes

- A levelling up of the Primary Care offer across Thurrock with appointment levels against population need at least in all PCNs as good as the level of equity currently available within the Stanford-Le-Hope PCN currently, addressing the "inverse care law" and reducing health inequalities.
- At scale provision of certain elements of Primary Care services at PCN rather than practice level, with improved sharing and clinical skill mix and adoption of best clinical practice within all surgeries
- Development of blended staff roles able to deliver a broader range of functions, and integration between Primary Care staff and wider health and care services at PCN/locality level.
- Improvement in patient satisfaction across the borough to at least the level currently experienced only in Stanford-le-Hope PCN
- Residents actively engaged in co-design of on-going Primary Care transformation
- A shift from reactive to preventative care
- Improved continuity of care.
- Fit for purpose estates to provide integrated services, e.g. Integrated Medical Centres, supporting practices with their Estate Improvement Plans.

5.7 Our Ask To the System

1. Recognise the importance of high-quality primary care in preventing demand on more expensive elements of the system including hospital front door and that there is inequity in Primary Care in Thurrock, both between the borough as a whole and England, and within the borough. Distribute and prioritise future system resources and growth funding to allow us to address these issues.
2. Devolve power and decision making to Thurrock level to allow us to transform Primary Care locally, in conjunction with our local clinicians and residents
3. Support integrated care and the provision of real time linked data to PCNs through development of a single shared care record.

Chapter References

1. Tudor-Hart, J. The inverse care law. *The Lancet*. 1971; 297(7696): 405-412. THE INVERSE CARE LAW - The Lancet ↑

2. Saultz JW, Abedaiwi W. Interpersonal continuity of care and patient satisfaction: a critical review. *Annals of Family Medicine* 2004;2:445-51. ↑

3. Saultz JW, Lochner J. Interpersonal continuity of care and care outcomes: a critical review. *Annals of Family Medicine*, 2005;3:159-66. ↑

Chapter 6: Improved Health and Wellbeing Through Population Health Management

From reactive to proactive care

Chapter 6: Improved Health and Wellbeing through Population Health Management

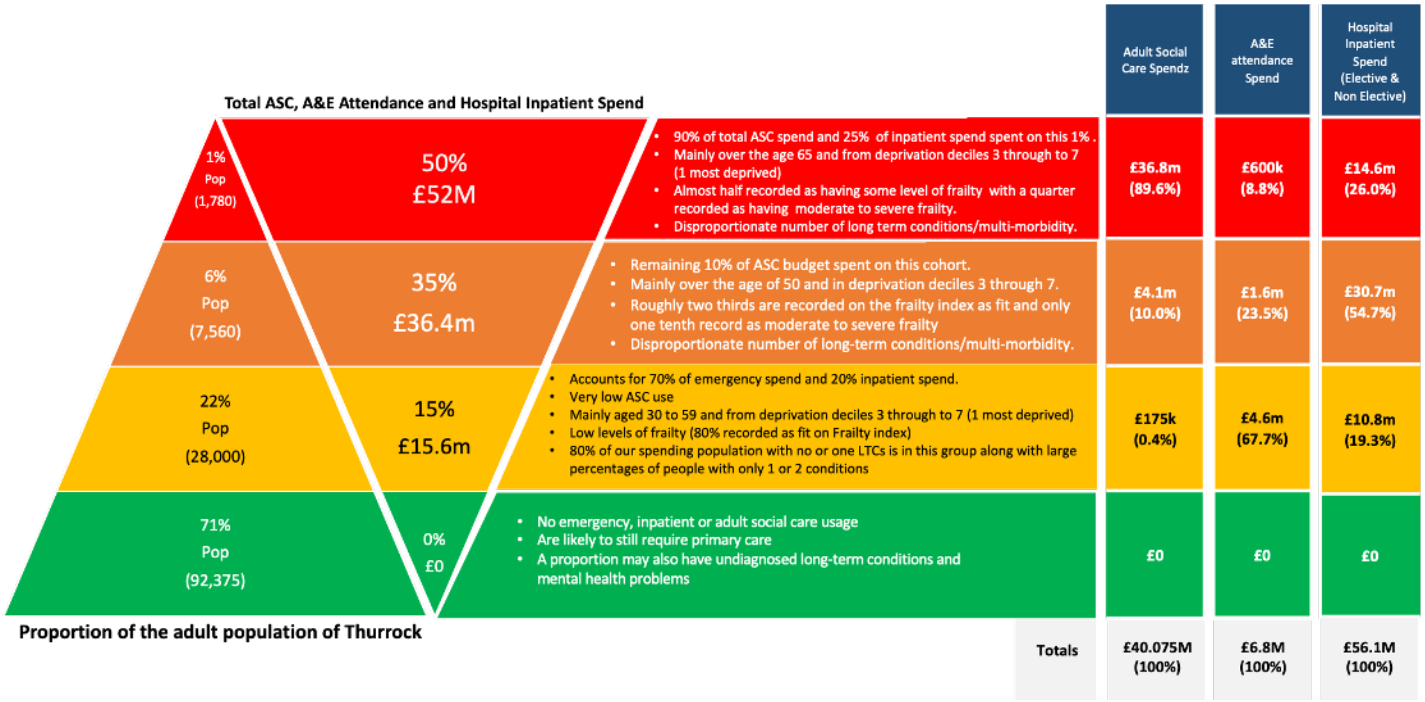
6.1 Introduction

This chapter sets out collective action that we will take in Thurrock to deliver proactive care to our residents using insights through Population Health Management. Population Health Management (PHM) is an approach that uses data and intelligence to understand the differing needs of different cohorts of residents and then provide proactive tailored interventions to the each cohort to respond to those needs and to keep them as well and independent as possible for as long as possible.

6.2 Segmenting the Thurrock Population

Figure 6.1 shows a high level segmentation of Thurrock residents aged 18+, considering the total spend on Adult Social Care and hospital A&E attendance and inpatient services (both elective and emergency).

Figure 6.1



50% of the entire spend on ASC and hospital A&E/inpatients can be attributed to only 1% of the population (1,780) residents (shown as the red segment). A further 35% of the entire spend is attributable to only 6% of residents (shown as the orange segment). 22% of the population consume the remaining 15% of ASC and hospital A&E/inpatient spend (the yellow segment) and that remaining 71% of residents consume no ASC and hospital A&E/inpatient spend.

The most resource consuming 1% are most likely to be over the age of 65, have a high level of frailty and a disproportionate number of long term conditions/multimorbidity. Almost 90% of the total ASC budget and over a quarter of hospital inpatient spend is spent on this segment and as such are highly likely to include residents with learning disabilities and/or mental health care needs. They are most likely to need integrated health and care services to help them maintain wellbeing and independence for as long as possible. These are discussed in Chapters 7, 8 and 9.

The second most resource consuming 6% are mainly over 50 and use almost all of the remaining ASC budget. They have lower levels of frailty but are also diagnosed with a disproportionate number of long-term conditions. Over half of the total hospital inpatient budget is spent on this cohort. They are likely to require high quality integrated health and care services within the community to diagnose and manage their long term conditions and keep them as independent as possible for as long as possible. Action to prevent future high cost demand on adult social care needs to focus on this cohort.

The third (yellow) cohort that consumes the remaining 15% of the budget are adults mainly aged 30 to 59 with low levels of recorded frailty. They are most likely to be diagnosed with one or two long term conditions. They consume almost no ASC spend but almost a fifth of the hospital inpatient budget and two thirds of spend in A&E. They are likely to need high quality management of their existing long term conditions in the community to prevent them needing to access A&E and to prevent their conditions worsening such they consume more health services. This is the most important segment to focus coordinated secondary prevention on, in order to prevent future hospital inpatient spend.

The 71% majority of the population who are not consuming hospital inpatient, A&E or ASC budgets are the most likely to be healthy. They may still have lifestyle risk factors that if not addressed will cause them to require hospital or ASC services in the future. They are also likely to be accessing primary care services episodically and may also have undiagnosed or diagnosed long term conditions being managed in primary care. Providing effective diagnosis of undiagnosed long term health conditions, good access to primary care and services that assist in their general wellbeing and address unhealthy lifestyles are likely to be most important to this cohort in order to prevent them from progressing into a higher cost segment.

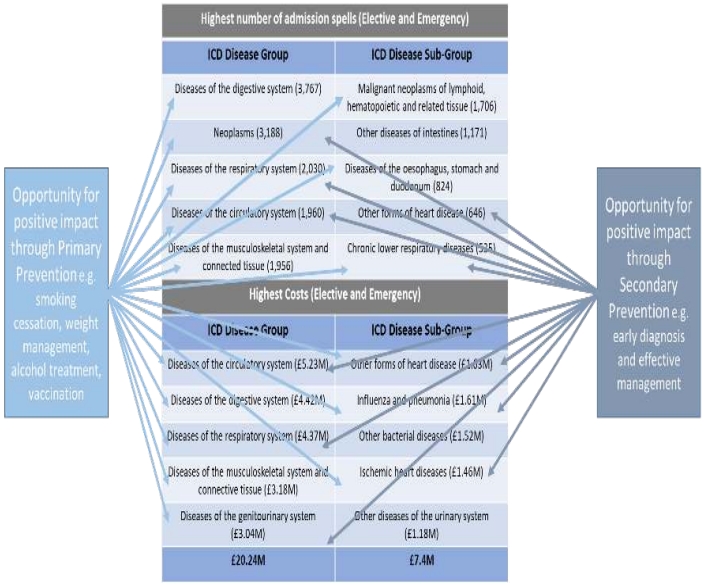
6.3 A proactive and preventative care approach

An inadequate or too reactive approach to the health and care of segments two, three and four (orange, yellow and green) is likely to result in conditions worsening, risks increasing, outcomes deteriorating and residents moving upwards into a higher cost segment. Conversely, intervening early through systematic primary and secondary prevention activity is the most effective way of keeping residents well and preventing them progressing to higher cost segments.

- **Primary Prevention** relates to programmes or activity to intervene to prevent adverse health events or disease occurring by modifying risk. Examples would include smoking cessation, weight management or treatment of alcohol addiction.
- **Secondary Prevention** describes programmes or activity that aim to diagnose and treat conditions as quickly and effectively as possible to prevent them progressing or deteriorating. Examples include the effective diagnosis and management of blood sugar levels in those with diabetes, or the management of Atrial Fibrillation through anti-coagulation therapy to prevent an AF related stroke.

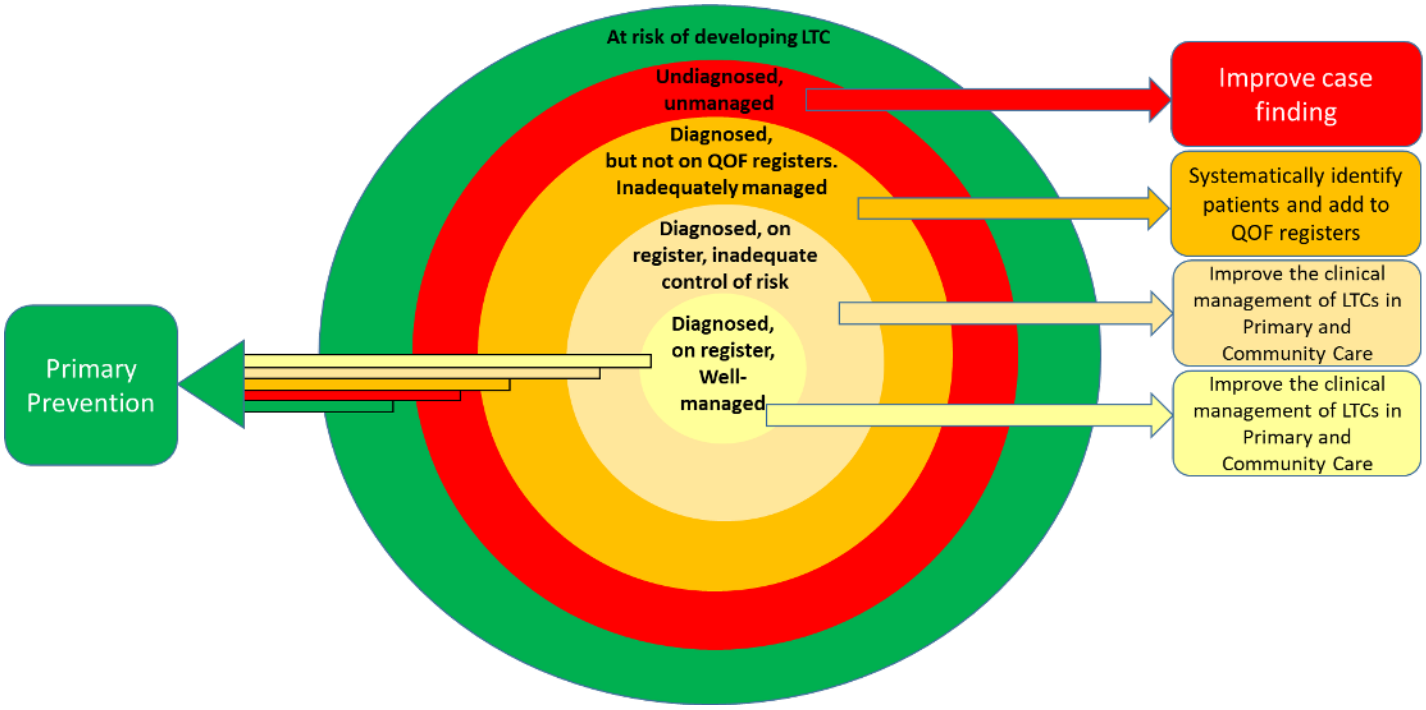
Figure 6.2 shows the ICD Disease Groups and Disease Sub-Groups that are responsible for the most frequent hospital admissions in Thurrock, and for the most costly. It demonstrates the significant opportunity for both primary and secondary prevention activity on reducing both hospital admission demand and cost.

Figure 6.2



The population of Thurrock residents can be further segmented by their long-term conditions and how effective local health and care services are at responding to them. However, some residents may fall into different segments for different conditions. This is shown in figure 6.3 overleaf.

Figure 6.3



Many residents may be at risk of developing long-term conditions as a result of their lifestyle or wider determinants of health but are yet to do so. These are shown in the green segment. Primary prevention for example, empowering residents to live healthier lives, addressing wider determinants of health and vaccination is the most effective way of preventing long term conditions from developing in the future. Primary prevention is the single set of interventions that will benefit the outermost green segment, but will also potentially benefit all other segments where there are existing individual lifestyle risk factors that could also be mitigated.

The red segment represents the cohort of residents who have already developed long-term conditions but these are yet to be diagnosed. As a result, these long-term conditions will not be being effectively managed and over time, the health of residents in this cohort is likely to deteriorate, placing them at high risk of more serious health events and admission to hospital. The most pressing need of this cohort is quick diagnosis and effective management.

The orange segment represents the cohort of residents who have received a diagnosis and may even be receiving some form of treatment for a long-term condition, but who have not been added to the appropriate QOF disease register.

As a result, their long-term conditions will not be being managed in a systematic way and they may not be receiving all of the appropriate monitoring and clinical management to keep them as well as possible.

The two most inner segments represent the total population of residents already diagnosed and on QOF registers. The beige segment represents those who whilst diagnosed, do not have their clinical biomarkers adequately controlled. This may be as a result of poor patient engagement; other individual risk factors such as deprivation, lifestyle, age or genetics; inadequate clinical management, or; general complexity. As a result, they are at high risk their condition deteriorating, more serious adverse health events occurring and hospital admission. Their primary need to improved management of their existing long-term conditions to bring clinical biomarkers back in range and their risk reduced. In complex cases, this may require specialist clinical input. Conversely, the yellow segment represents the cohort of residents who are well-managed, in receipt of all recommended clinical interventions and with their clinical biomarkers in range with a low risk of serious adverse health events or hospital admission. They require on-going monitoring and management to maintain their lower risk profile.

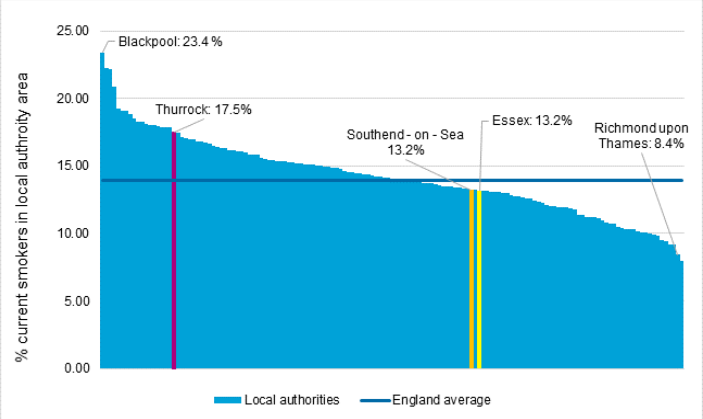
Sections 6.4 to 6.8 of this chapter deal with our plans to deliver the five different categories of intervention that will most benefit each cohort.

6.4 Primary Prevention

Tobacco Control

Although declining, Thurrock has a significantly high prevalence of smoking in adults compared to both the East of England and England (Figure 6.4). Smoking prevalence is highly correlated with deprivation and differences in smoking prevalence between deprived and affluent communities are the single biggest factor explaining differences in health inequity.

Figure 6.4

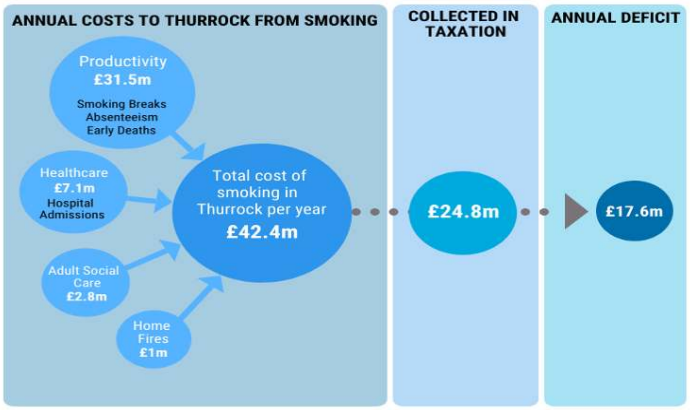


BOX 6.1: THE IMPACT OF SMOKING IN THURROCK

Thurrock has:

- **25% high smoking attributable mortality than England's**
- **27% higher smoking attributable hospital admissions than England's**
- **Higher smoking attributable hospital admissions for asthma**
- **Half of all smokers living in the eight most deprived wards**

Figure 6.5



We calculate the total cost of smoking in Thurrock to be £42.4M with an annual local financial deficit of £17.6M (Figure 6.5).

Action to Reduce Smoking Prevalence

At present, part of the Public Health Grant is used to commission a range of programmes and services to assist Thurrock smokers to quit and reduce smoking prevalence. These include:

- Stop smoking services in GP practices and pharmacies
- A stop smoking service through Vape Shops
- The Allen Carr Easy Way stop smoking service
- An 'in house' specialist stop smoking service provided by Thurrock Healthy Lifestyle Solutions.
- Targeted enforcement action to reduce the supply of illegal and counterfeit cigarettes.

In 2020/21, the Thurrock Public Health Team completed a detailed Joint Strategic Needs Assessment Product on Tobacco Control with 14 specific recommendations that can be found on the council's website.

Reducing smoking prevalence within our population is a complex and multifactorial problem that requires a whole system approach, and is worthy of a separate strategy in and of itself. The JSNA provides a detailed analyses of the current issues and this now needs to be converted into a whole system response.

The JSNA demonstrated that smokers are not uniformly distributed throughout our population, and there are disproportionate rates of smoking in deprived wards and amongst those with serious mental ill health.

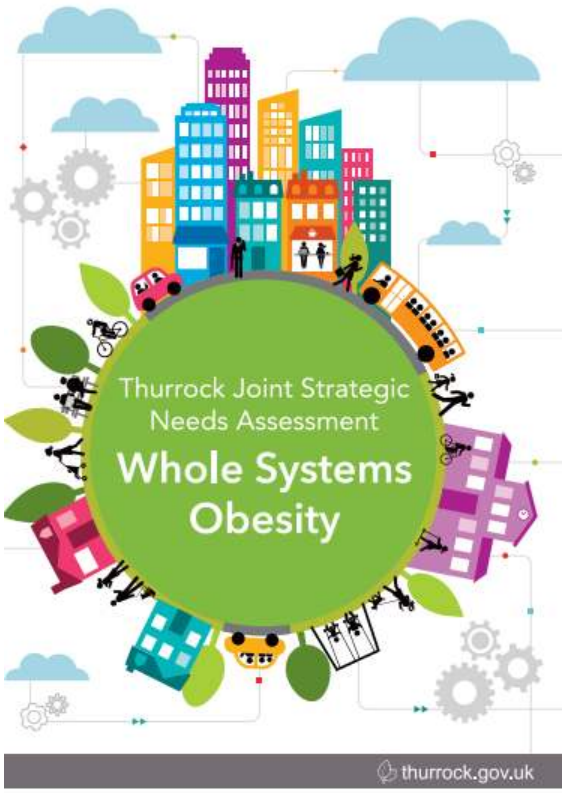
At present smoking cessation services sit separately to other health and care services and remain largely the responsibility of the Public Health Team. There is an opportunity to deliver a more integrated model, aligning and embedding the existing Thurrock Healthy Lifestyles Service within the integrated care models we will create around the PCNs. (See Chapter 7). There is a need to make it a priority for all health and care partners in Thurrock and to embed a stop smoking offer within community and secondary care pathways, particularly respiratory, cardio-vascular and mental health.

We will take the following strategic action as TICP to reduce smoking prevalence in Thurrock:

Obesity

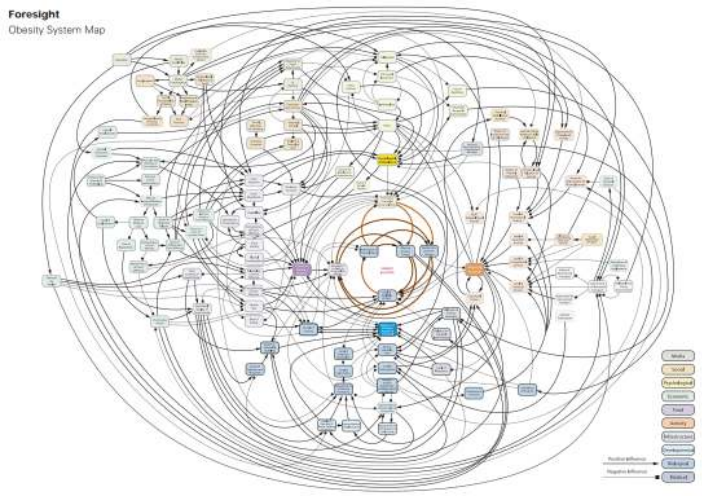
It is well-evidenced that obesity is both a risk factor for development of certain long term conditions, and a contributing factor itself to disease complications and higher service use/cost. For example, an obese woman is 13 times more likely to develop type 2 diabetes than a healthy weight woman. Co-morbid obesity also significantly increases treatment costs of other long term conditions with obese patients estimated to have approximately 30% higher medical costs than non-obese patients. Similarly, research by Public Health England 2015 also found that severely obese people are over 3 times more likely to require social care than those of a normal weight, with examples of requirements including housing adaptations, carers or provision of appropriate transport and facilities. The same research also cited that obesity reduces life expectancy by an average of 3 years, and severe obesity could reduce life expectancy by an average of 8-10 years.

As shown in Section 1.2, Thurrock has a significantly greater proportion of it adult population who are overweight or obese compared to England and the East of England, and also higher levels of adult physical inactivity.



Like tobacco control, obesity is a highly complex and multifactorial problem requiring a whole systems approach. The 2007 Foresight map (Figure 6.6) identified 148 variables that interact as a system at community level to determine levels of obesity in a given population. As such, our response to obesity needs to be a Human Learning Systems one; we cannot commission our way out of obesity through individual lifestyle modification programmes.

Figure 6.6 – The Foresight Map (2007) – factors that influence obesity



Thurrock developed a detailed Joint Strategic Needs Assessment product on Obesity in 2018 followed by a Whole Systems Obesity Strategy based on the JSNA. The JSNA and Whole Systems Obesity Strategy can be found on the www.thurrock.gov.uk website.

Our Whole Systems Obesity Strategy centres action around the six goals:

- **GOAL A: Enabling settings, schools and services to contribute to children and young people achieving a healthy weight**
- **GOAL B: Increasing the opportunity for positive community influences on obesity** including coordinated action of a wide range of partners to deliver improvements o nutritional health and physical activity
- **GOAL C: Improving the food environment and food choices** with action to create a healthier food environment in Thurrock and improved opportunities for access to healthy good
- **GOAL D: Improving the physical activity environment and getting the inactive active** including action around improving the borough's built environment to increase physical activity and wellbeing, the prioritisation of active travel in transport and planning policies, and commissioning programmes to support physical activity.
- **GOAL E: Improving the identification and management of obesity** including improved obesity case finding and support within primary care, improving education in the prevention of obesity and ensuring equitable and high quality weight management services.

A review and refresh of the current action plans under each goal is in progress following the COVID-19 pandemic. This will include refreshing the plan in the context of wider strategic work to ensure that environments in Thurrock are designed to enhance and maintain both physical and mental health and well-being to tackle the obesogenic environment including:

- Thurrock Active Place Strategy
- Engagement in Thurrock's Local Plan and Design Strategy via the Design Charrettes process and production of a dedicated Local Plan JSNA.
- Thurrock's Active Travel Needs Assessment and new Transport Visioning Strategy work.
- Health Impact Assessment – through the Health and Planning Advisory Group (HPAG) to feed in health impacts of planning applications or respond to health impact assessments which are submitted as part of planning applications.

We are also using Population Health Management techniques to identify and respond to the needs of specific population cohorts at high risk of complications from obesity. The Population Health Management Team is working with clinicians in the Stanford and Corringham and ASOP PCNs to pilot an innovative new personalised approach to Obesity set out in Box 6.2 that addresses inequalities and social deprivation factors associated with obesity as well as traditional physical activity and nutritional approaches (Box 6.2)

Box 6.2 Combatting Obesity through PHM

The Combating Obesity in ASOP and Stanford-le-Hope project has been supported by the PHM Team to develop a personalised care service that targets both obesity and associated health inequalities due to social deprivation.

Population Health Management analyses reveals that Thurrock is in the worst quartile for obesity rates across all ages, inactivity and diet. Furthermore, there is a high correlation between obesity and deprivation requiring for the approach to supporting patients to be holistic.

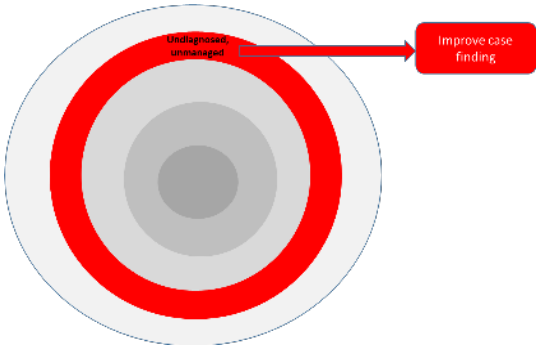
A project group was established with strong clinical leadership. The PHM Team supported by identifying the highest risk cohort of 550 people based on a risk model informed by evidence. The criteria used includes high clinical risk and other Long Term Conditions diagnoses, poor Hb1Ac levels and whether residents are of a high risk ethnicity.

Further to identifying the cohort, the Thurrock team were supported with completing a logic model and identifying and engaging with stakeholder activities, which sit at the core of developing the right interventions for the cohort.

A high level operating model has been established and the next steps for the group are to recruit the required staff, develop the right tools in the GP systems, and to finalise the estates and equipment for the model.

We will take the following actions as the Thurrock Integrated Care Partnership to address obesity within our population:

6.5 *Find the missing thousands.* Improving diagnosis of undiagnosed long term conditions.

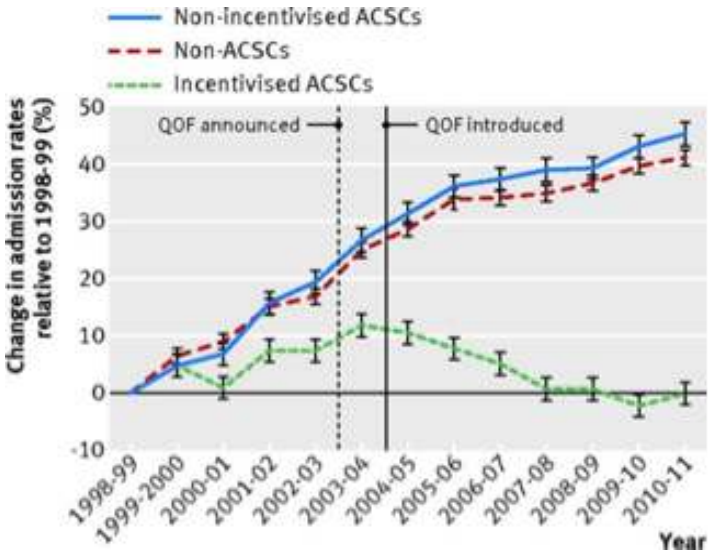


6.5.1. Incompleteness of Thurrock Long Term Condition (QOF) Registers

The Quality Outcomes Framework (QOF) is the mechanism through which GP practices provide evidence-based secondary preventative clinical care to manage long-term conditions and keep residents as well and independent as possible for as long as possible. After a diagnosis for a long-term condition, residents should be added to the specific QOF disease register for that long-term condition and ten receive appropriate monitoring and clinical interventions to prevent their long-term condition deteriorating or more serious adverse health events such a strokes, heart attacks and hospital admissions from occurring.

There is clear evidence of the effectiveness of QOF as a secondary prevention programme. Figure 6.7 shows the impact that QOF had on ambulatory sensitive care conditions that were incentivised under the scheme, compared to those that were not included.

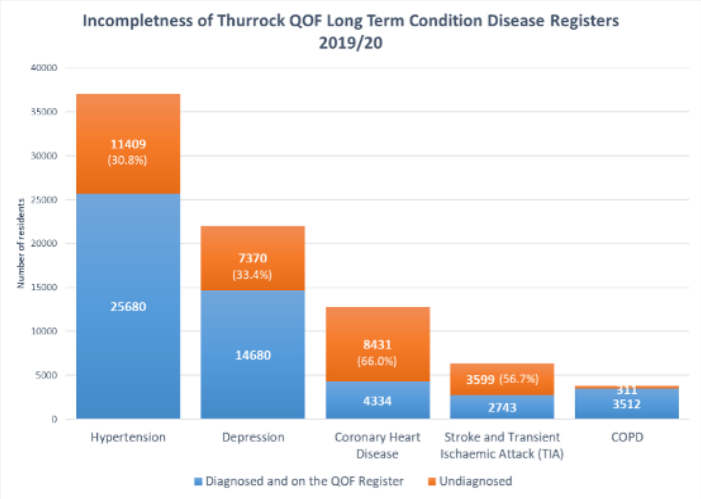
Figure 6.7



Many QOF disease registers in Thurrock remain incomplete and don't reflect the total number of residents living with each long-term condition. We know this from modelled estimates from Public Health England produced for some disease registers that estimate the expected prevalence of specific long-term conditions within Thurrock based on the demographic characteristics and health status of our residents. We have used these models and updated them to account for demographic population growth since they were first produced. By comparing the updated figures to numbers of our residents on different disease registers we can estimate the numbers of residents with undiagnosed long term conditions.

Figure 6.8 (overleaf) shows numbers of diagnosed and undiagnosed residents with hypertension (high blood pressure), depression, coronary heart disease, COPD and stroke/TIA.

Figure 6.8

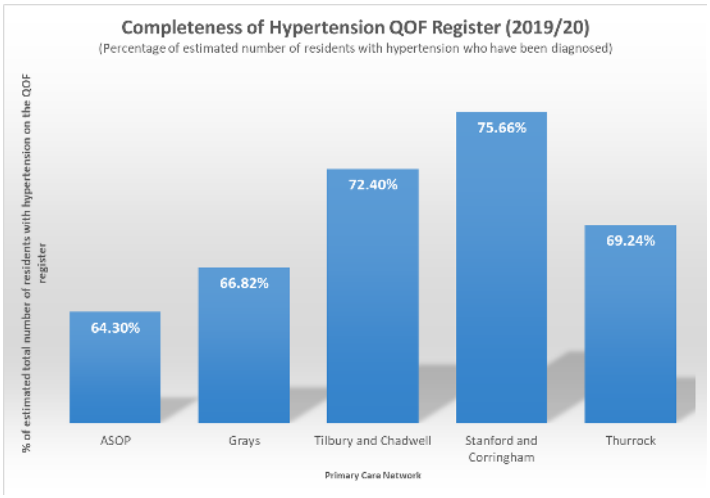


The most incomplete disease register in percentage terms is the Coronary Heart Disease register with an estimated 66% of residents with CHD undiagnosed. The disease register with the largest absolute number of undiagnosed residents is Hypertension, with an estimated 11,409 residents in Thurrock who are unaware that they have high blood pressure.

Population level case-finding of both undiagnosed CHD and stroke/TIA remains difficult because of the need to undertake complex diagnostic processes. However, population screening for high blood pressure and depression can be undertaken using simple diagnostic tests and offers further scope for improvement.

There is also significant variation at GP practice an PCN level in the completeness of QOF registers. For example Figure 6.9 shows the completeness of hypertension QOF registers between the four Thurrock PCNs.

Figure 6.9



Identifying patients with long term health conditions who are unaware that they have them ("find the missing thousands"), is a key priority if we are going to intervene early with excellent clinical management to prevent chronic diseases progressing and residents' deteriorating towards more serious adverse health events requiring hospital admission and adult social care intervention. It delivers a return both in population health and system operational and financial sustainability terms.

6.5.2 The Impact of Incomplete QOF Registers

Using Thurrock's Medeanalytics linked data-lake, we are now able to understand the impact that case-finding of long-term conditions has on emergency hospital admissions. Figure 6.10 shows the number and proportions of residents admitted to hospital as an emergency for different conditions, who were previously diagnosed and on the appropriate QOF register or were not previously diagnosed and on the appropriate QOF register.

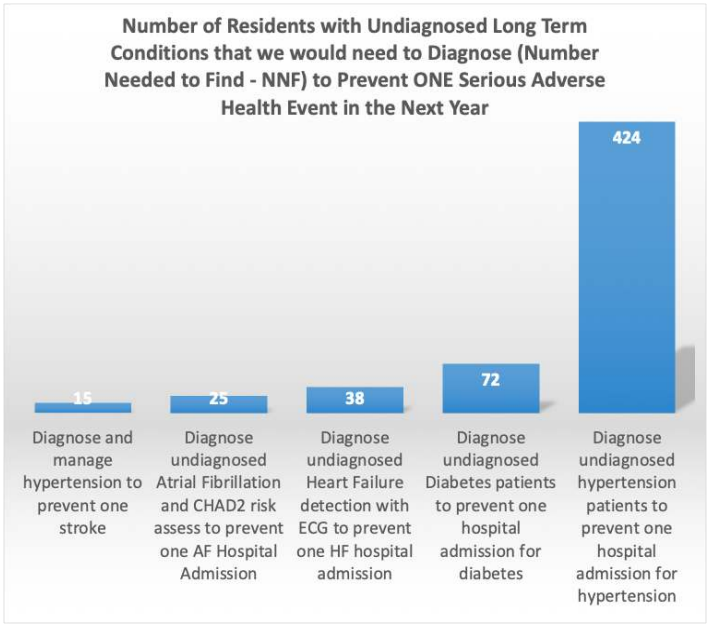
Figure 6.10

Figure 6.10 demonstrates just how reactive the local NHS system remains. Across all emergency admissions for long term conditions, the majority of residents were not previously diagnosed and on the correct QOF register. For stroke/TIA and heart failure, the proportion was more than four in five.

By failing to identify, diagnose and provide proactive preventative care to residents with long-term conditions, we wait for serious adverse health events to occur before intervening. This produces poorer population health outcomes and wastes system resources. However, it demonstrates the significant positive impact we can have in both health and financial terms by systematic action to improve case-finding.

Figure 6.11 shows the number of residents with different undiagnosed long term conditions that we would need to diagnose and add to the appropriate QOF register to prevent **one** serious adverse health event in the next 12 months. (The Number Needed to Find - NNF). The smaller the NNF, the fewer residents we need to diagnose to prevent the adverse health event. The case finding activity with the smallest NNF is diagnosing undiagnosed hypertension in order to prevent strokes. For every 15 undiagnosed residents with hypertension placed that we diagnose and treat, we prevent one stroke. Similarly we only need to diagnose 25 residents with undiagnosed Atrial Fibrilliation (AF) to prevent one hospital admission for AF and 38 undiagnosed heart failure patients to prevent one heart failure admission.

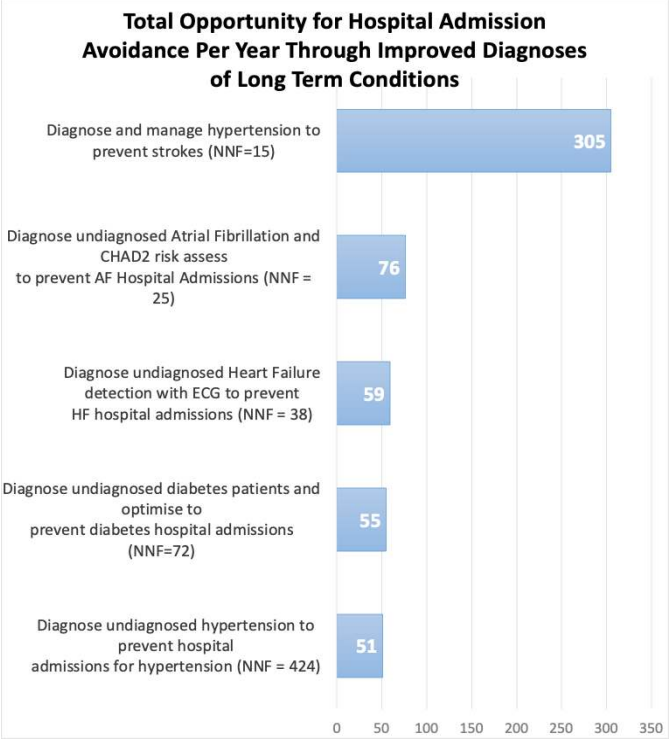
Figure 6.11



For every 15 residents with undiagnosed hypertension that we diagnose and treat, we prevent one hospital admission that year for stroke.

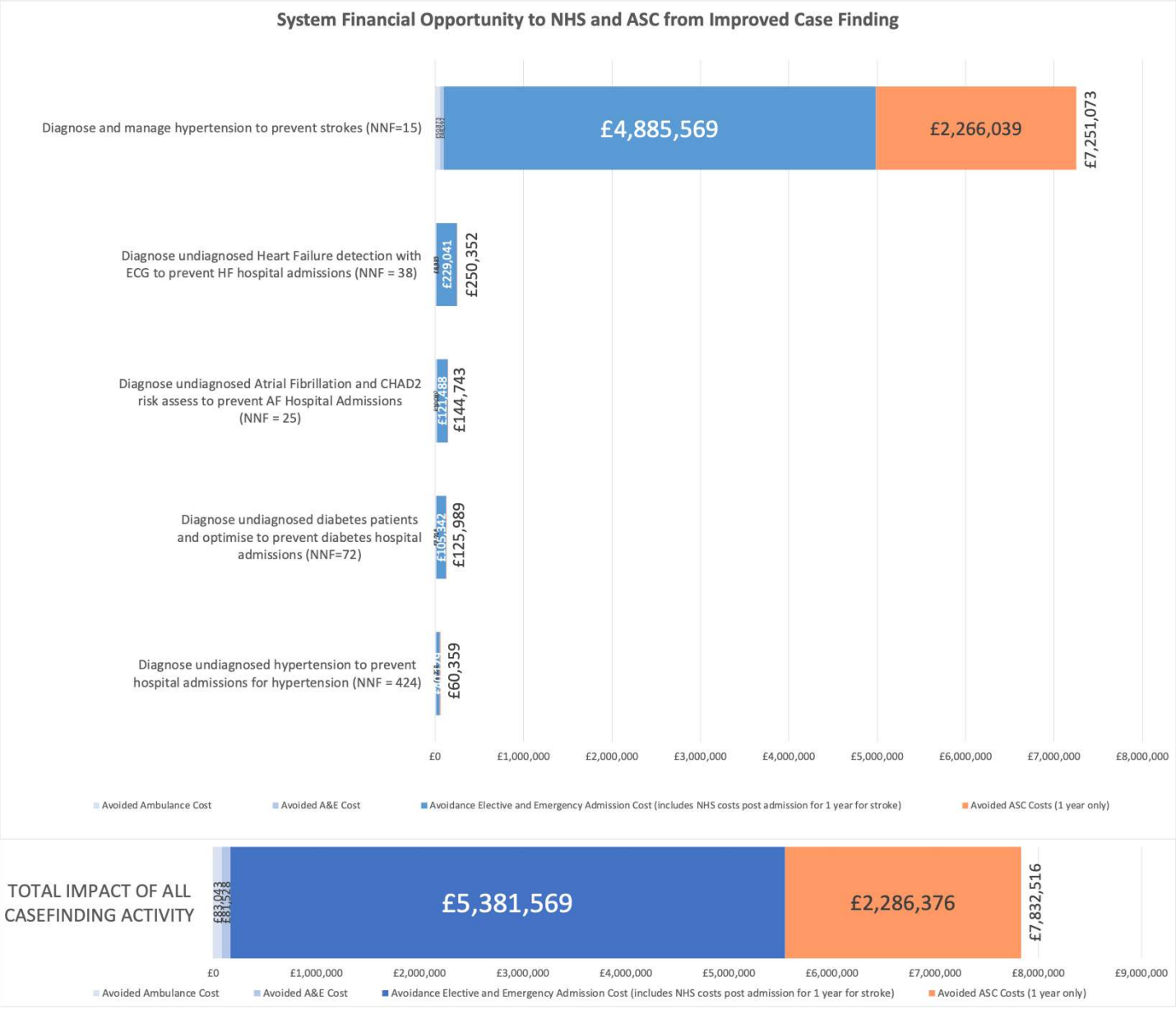
Figure 6.12 shows the total hospital admission avoidance opportunity per year through case finding (i.e. effective diagnosis of all patients with undiagnosed long term conditions and addition to QOF registers so that they could receive treatment). We calculate that there is potential to prevent 546 hospital admissions in Thurrock per year from improved case finding, demonstrating significant positive impact that case finding activity can have of the health of our residents and on the operational sustainability of our health and care system.

Figure 6.12



There is significant potential financial opportunity that can be gained by maximising diagnoses of un-diagnosed long-term conditions. Figure 6.13 shows a potential to deliver almost £8M in cost avoidance (almost £5.4M of avoided cost to the NHS and almost £2.29M to Adult Social Care) in Thurrock if case finding operated at 100%. The biggest opportunity lies in diagnosing and management of hypertension to prevent strokes.

Figure 6.13



6.5.3 Improving Case-Finding of Specific Long Term Conditions

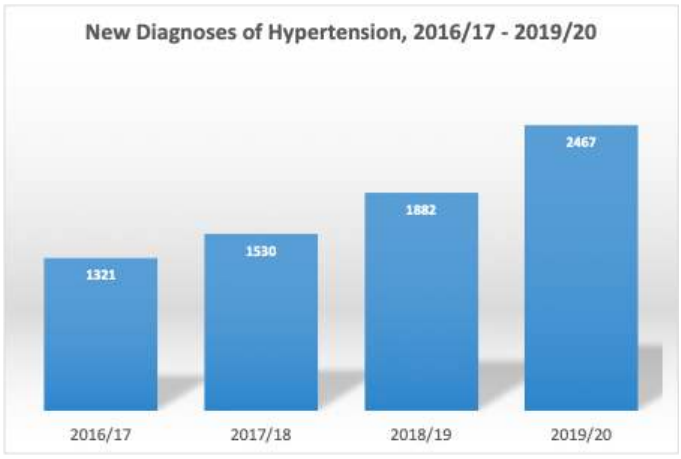
Hypertension Case finding

The 2017 *Case for Change* strategy set out ambitious plans to improve the diagnoses of hypertension including:

- Blood pressure monitoring machines in GP practices and other health care settings.
- Additional funding to GP practices to systemically record blood pressure through the *Stretched QOF* contract
- Use of the third sector and community assets to measure blood pressure including Community Hubs

Figure 6.14 shows the success of this programme to date. Since 2017/18, 5879 new diagnoses of hypertension have been made, with significant year on year increases against the 1321 2016/17 baseline.

Figure 6.14



Atrial Fibrillation Case Finding

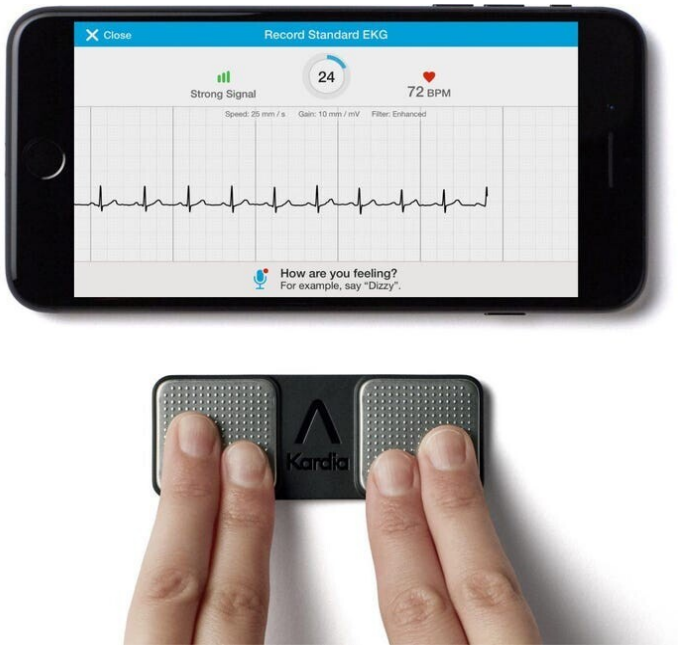
Individuals with untreated atrial fibrillation (AF) face a fivefold increased risk of ischaemic stroke compared with those without the condition. Evidence suggests that one-third of all patients with ischaemic stroke had previously known or recently diagnosed AF.[1]

AF-related stroke is, on average, more severe than non-AF-related stroke and associated with worse outcomes but risk can be significantly reduced by appropriate use of anticoagulation therapy in patients characterised as medium or high risk using the CHAD2VASc scoring[3]. As such, early and accurate diagnosis of AF is an essential step in gaining protective coverage from anticoagulation therapy in order to prevent stroke.

A major diagnostic challenge relates to those with paroxysmal or asymptomatic (silent) AF. Studies indicate that even short episodes of 'silent' AF are associated with increased stroke risk.[4] However, residents with asymptomatic AF will be much less likely to have their condition diagnosed until an ischaemic stroke event has occurred.

AF risk increases with age and other cardio-vascular disease risk markers including hypertension, underlying heart disease and obesity. Many studies have reported the benefits of singe time-point screening of older patients >=65 years. Handheld devices such as the AliveCor provide heart rhythm readings to a mobile phone that can then be read by a clinician. A systematic review of 30 studies covering over 122,000 patients, increased AF prevalence by 2.1% (one new case detected for every 48 people screened) using single-time point screening. 67% of screen detected new AF cases were subsequently indicated for oral anticoagulation.[5]

AliveCor Testing Device for AF Screening



Targeting single time-point AF screening in specific healthcare settings can yield even better results. For example, one study that systematised AF screening in community podiatry clinics resulted in an AF detection prevalence of 4.6% or 1 in every 22 people screened.[6]

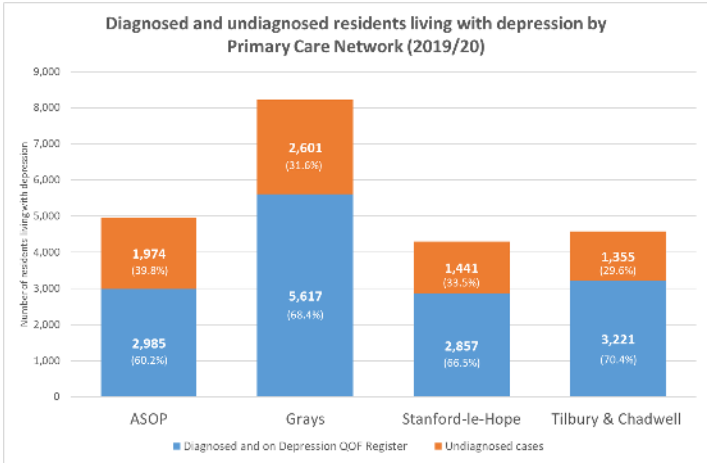
A potential issue with single time-point screening is the possibility of 'missing' an AF signal in patients with paroxysmal (silent) AF who may not be experiencing an AF episode at the time of screening. Longer term screening of higher risk groups addresses this flaw. The Swedish STROKESTOP study used twice-daily screens over a two week period and increased AF prevalence in the screening cohort by 3% (detecting one additional case for every 33 people screened). The ASSERT-II study used implantable subcutaneous ECG monitoring devices over a 16-month period in patients with higher CHA2DS2VASc score of 4.1 and found 34.4% of participants had at least one episode of AF lasting five minutes or more; one in every 2.9 people screened.[7]

Patients with AF are not only at an increased risk of overt stroke, but are also more likely to suffer a clinically silent vascular brain lesion and can occur whether or not AF is silent or persistent.[8] Research indicates a link between AF and cognitive decline including both vascular and Alzheimer's dementia even in patients with no history of stroke. Anticoagulation was associated with a 39% reduction in incidence of dementia.[9]

Depression Case Finding

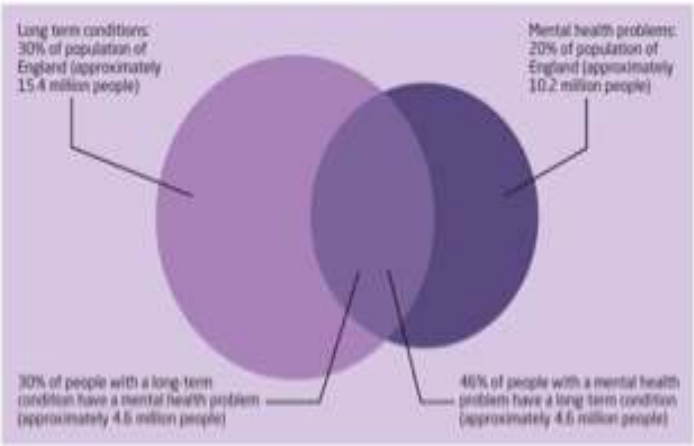
Under-diagnosis of depression remains a significant issue in Thurrock, as shown in figure 6.15. We estimate that there are 22,050 residents living with depression in Thurrock, of whom 7,370 remain undiagnosed. The depression QOF registers are most incomplete in ASOP with only 60% of depression cases diagnosed.

Figure 6.15



There is a bi-directional relationship between depression and other long term health conditions and significant overlap between both cohorts as shown in figure 6.16. People with depression may be more at risk of developing other long term conditions, and those with other long term conditions may be more at risk of becoming depressed.

Figure 6.16



Evidence also shows that those with physical long-term health conditions and co-morbid depression have poorer outcomes and cost the health and care system more money. [10]

A patient with a physical long term condition (LTC) without depression is estimated to cost the NHS £1,760 a year less than a patient with both a long term condition and co-morbid depression (£3,910 vs £5,670). Early identification and subsequent management of depression would delay and reduce higher level interventions later on.

If 46% of the cohort of residents of Thurrock with undiagnosed depression have other co-morbidities, diagnosing and treating their depression presents an opportunity for delivering better outcomes and delivering savings to the local health and care economy of almost £6M per annum.

We have already implemented a range of measure through *Better Care Together Thurrock* to improve depression diagnosis in primary care including embedding PHQ2/9 screening tools in SystmOne together with electronic IAPT referral and encompassing depression screening as part of the NHS Health Check.

6.5.4 Future Proposed Action to Improve Case Finding of Undiagnosed Hypertension, Atrial Fibrillation and Depression.

Implementation of the approach taken on hypertension case finding in the original *Case for Change Strategy* has yielded significant positive results and we will continue action to systematise hypertension case finding within primary care and other health and community settings and through stretched QOF, enhancing current success by use the Primary Care Networks to spread best practice between surgeries. Building on this success, we will seek to use these mechanisms to incentivise and fund primary care to improve diagnoses of AF and depression. We will work with each GP practice and PCN to identify a case finding lead to coordinate further work within each surgery and PCN area, and develop a network of best clinical practice.

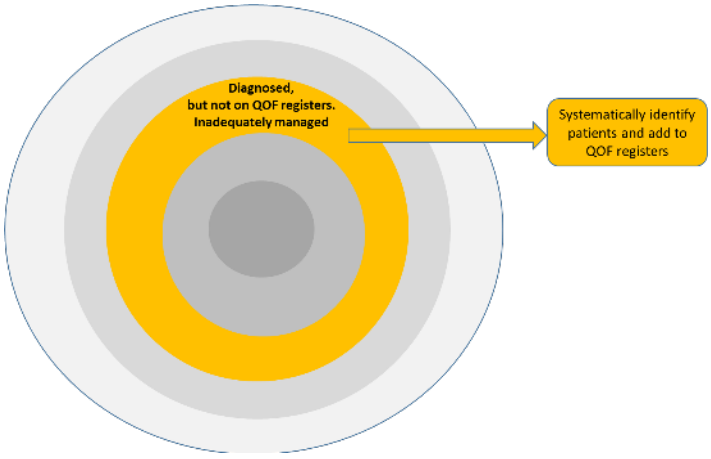
The Better Care Together Thurrock PHM work stream has already implemented digital solutions to remind clinicians of case finding opportunities. For example, a SystmOne template now prompts clinicians to undertake a PHQ9 depression screen when undertaking reviews of other physical long term conditions with patients. We will seek to expand this approach and create additional screening prompts on SystmOne for clinical staff reviewing other high risk groups.

However we wish to go further, embedding hypertension, AF and depression case finding in the roles of front line clinical and adult social care staff across Thurrock including Wellbeing Teams and the Integrated Care Teams that we will build across the four PCNs (see Chapter 7).

In order to improve AF case finding, we will expand the number of AliveCorr devices available to resident facing staff caring for older residents. We will seek to embed route single-time point AF screening in settings accessed by target populations, where evidence has suggested they have yielded positive results elsewhere including community podiatry and flu vaccination clinics. Using Human, Learning, Systems methodology, we will encourage staff to test and learn screening in other settings.

The Public Health Team will co-develop a more detailed Case Finding strategy covering hypertension, AF and depression in 2022/23 in conjunction with clinical leaders within the PCNs, NELFT and EPUT. The strategy will set out in more detail, revised screening protocols including target groups, staff training requirement, targets and resources.

6.6 Ensure prompt inclusion into QOF following a Long Term Condition Diagnosis



6.6.1 Case Finding through Digital Clinical Audit

Following diagnosis of a specific long-term condition, it is vital that the resident concerned is added to the appropriate QOF register promptly to ensure that they receive systematic monitoring and clinical intervention to prevent their long-term condition deteriorating.

The 2017 Case for Change Strategy recommended a digital solution to interrogate GP clinical systems to identify those residents who may have received a long-term condition diagnosis but had not been added to the appropriate QOF register and so may not be receiving systematic clinical management. A company called Interface Clinical Services was commissioned through the Better Care Together Thurrock Population Health Management work stream to construct and run the queries on SystemOne.

Their system undertook remote digital clinical audit of Thurrock GP surgery records, searching for patients who had indicators in their medical records that would suggest that they had been diagnosed with a long-term condition, but who were not on the correct QOF register, for example patients prescribed anti-hypertensive medication who weren't on the Hypertension QOF register. The work identified 8,459 potential patients who required review by individual surgeries, and a considerable potential to increase both QOF prevalence across most domains. As individual surgeries receive part of their income through levels of QOF prevalence, the work was also able to identify significant additional potential income into Thurrock GP surgeries.

However, the solution whilst identifying significant potential numbers of additional residents that may need to be added to QOF registers, still required individual surgeries to review these patients before adding them to QOF registers. Due to capacity limitations in some surgeries, actual numbers of patients added to QOF varied considerably.

Interface Clinical Services

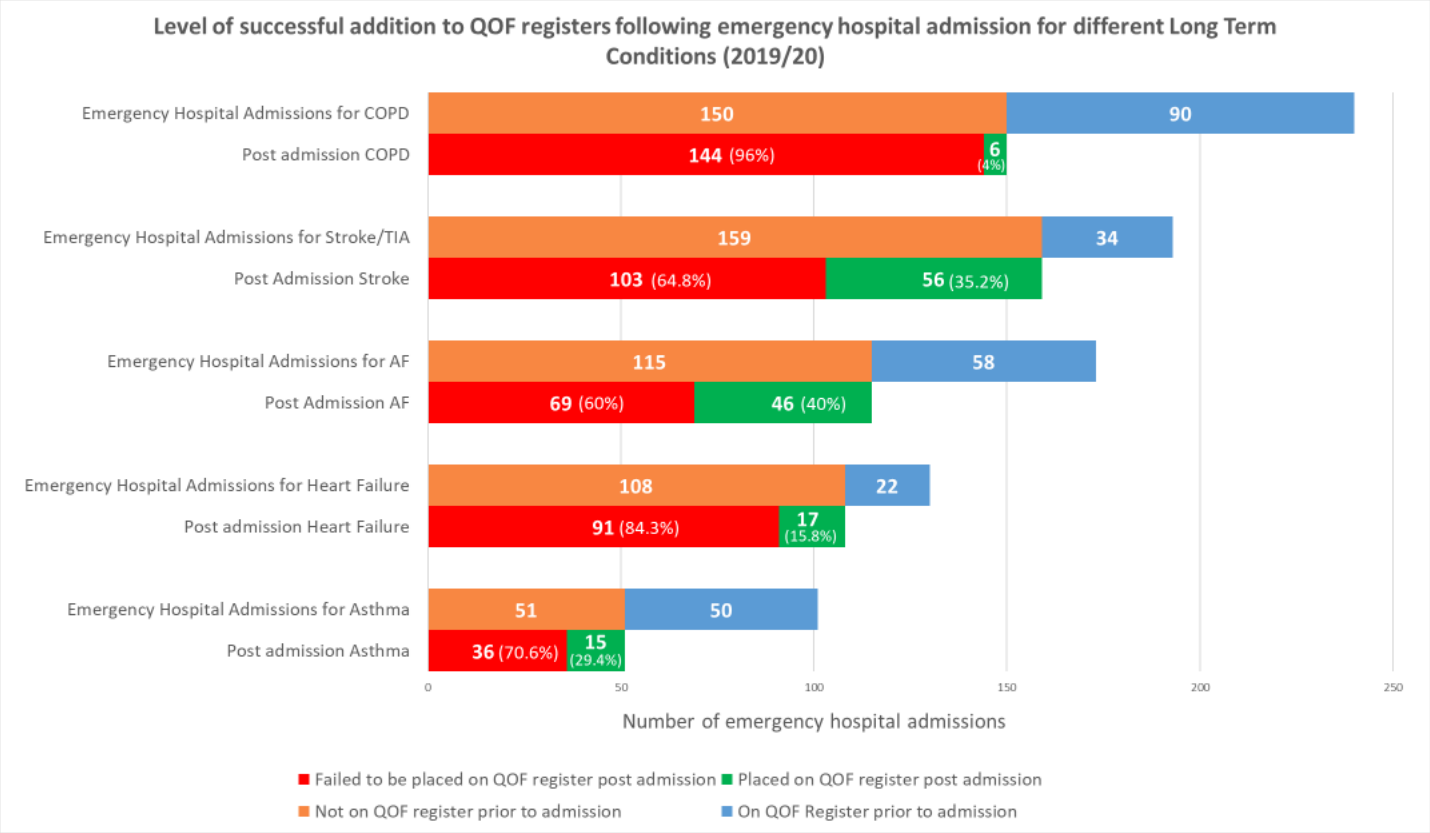
6.6.2 Adding Residents to QOF Registers Following Diagnosis after an Emergency Hospital Admission

In 6.5.2 we demonstrated that the majority of hospital admissions for the most common long-term conditions were from residents that were not previously on the appropriate QOF register and therefore not being appropriately/systematically managed clinically.

Further analyses of the Thurrock Mede-Analytics data-lake demonstrates that even after a long-term condition related emergency hospital admission, far too few residents are successfully added to the appropriate QOF register. In the cohort of residents admitted to hospital and not previously on a QOF register, for every long-term condition analysed, as a system, we fail to add them to the QOF register in the majority of cases post admission following hospital diagnosis. As such, for significant numbers of residents, systematic secondary preventative activity, monitoring and clinical management fails to occur post hospital diagnosis, needlessly elevating the risk of further deterioration and re-admission.

The scale of this failure is set out in figure 6.17. For example of the cohort of residents not on the COPD QOF register prior to a hospital admission for COPD, 96% failed to be added to the COPD QOF register post admission and so potentially missed out on onward systematic management of their COPD on discharge. For Stroke/TIA patients, as a system, we failed to add almost 65% to the QOF register, and for Heart Failure patients, we failed to add over 84%.

Figure 6.17



Ensuring all residents admitted to hospital as an emergency because of a long-term condition receive on-going appropriate preventative clinical management by addeding to the appropriate QOF register is a 'quick win' in terms of population health gain and system financial and operational sustainability

6.6.3 Action to Improve QOF Register Completeness Following Diagnosis

The work of Interface Clinical Services in 2018 demonstrated that there was a significant cohort of residents who had likely received diagnoses for long-term conditions but were not being managed systematically through QOF. This is both bad for residents and causes a loss of potential national funding into our local primary care system. The suspension of QOF during 2020/21 and again in the final quarter of 2021/22 due to COVID-19 pressures, the completeness of QOF disease registers is likely to have degraded further. The analyses in the last section, also clearly demonstrates a systemic failure in the interface between Primary and Secondary Care following long-term condition hospital admissions, with the majority of patients admitted who were not previously on QOF registers, failing to be added post admission. Addressing both of these issues presents a 'quick win' opportunity in terms case-finding and a 'win-win' opportunity in terms of resident health outcomes and avoidable demand and cost through a reduction risk of future emergency hospital admission.

As the Mid and South Essex Population Health Management Programme and creation of a MSE linked dataset through the Arden Gem DESCRO progresses at pace, it will soon be possible to create a more sophisticated in-house Intelligence Function at PCN/Alliance level to support with remote digital clinical audit in real time. Such a function, with access to linked patient level hospital admission data, prescribing data and clinical biomarker datasets could then regularly interrogate patient records on behalf of practices to identify patients who have received a long-term condition diagnosis but are not on QOF registers.

One of the barriers to success of the 2018 Interface Clinical Services case-finding work was a lack of capacity within surgeries to manually review patient records identified as potentially needing to be added to QOF, and make the addition. The subsequent formation of Primary Care Networks provides an opportunity to undertake this work once per PCN at scale through a single function. In order to overcome previous capacity barriers, we go further than the 2018 programme with two new strategic actions:

Firstly, the Thurrock Public Health Team will work with local clinical leaders to develop and agree clinical protocols that allow the highest risk and most obvious patients to automatically be added to the correct QOF register. For example, patients with an existing diagnosis for a long-term condition made in secondary care following an emergency hospital admission and correct diagnostic procedure.

Secondly, in 2022/23, we will bring forward a business case for investment into a dedicated clinical resource to review patients identified through the dedicated PCN/Alliance Intelligence Function and Digital Clinical Audit Programme in order for appropriate patients to be added to disease registers at pace. We envisage such a function to quickly become financially self-sustaining through improved clinical management of patients at high risk of hospital admissions, and the resulting admission avoidance.

SUMMARY OF STRATEGIC ACTIONS

6.12 We will create single back office PCN/Alliance level Primary Care Intelligence Function, capitalising on the 'at scale' opportunity provided by PCNs to provide near real time intelligence to practices on patients long-term condition and to improve the intelligence interface between Primary and Secondary Care following admission/discharge

6.13 We will use the new Intelligence Function to regularly systematically interrogate linked hospital-prescribing-clinical biomarker datasets against QOF in order to identify patients who are yet to be added to QOF registers, but whose clinical records suggests there is a high probability that they should be

6.14 We will develop and agree clinical protools with local PCN clinical leaders that allow the highest risk and most obvious patients to be automatically added to QOF, for example those with an existing hospital admission related to a long-term condition with supporting diagnostics

6.15 In 2022/23, we will bring forward a business case for dedicated Clinical Review resource, shared at PCN level to support in the review and where appropriate, addition to QOF of patients identified through systematic remote digital clinical audit.

6.7 Improve the Clinical Management of Residents Diagnosed with Long Term Conditions. *Treat the Missing Hundreds.*

6.7.1 Diagnosed Long-Term Conditions within the Thurrock population

Almost 4 in every 10 residents in Thurrock are living with one or more long term conditions that have been successfully diagnosed, and have been added to GP Practice QOF disease registers.

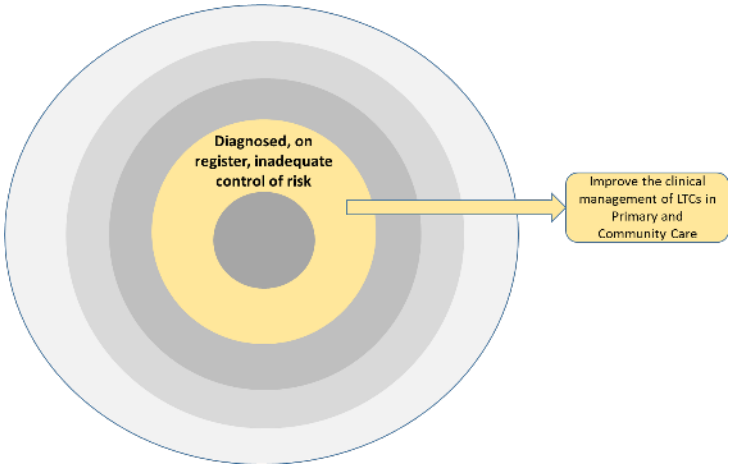
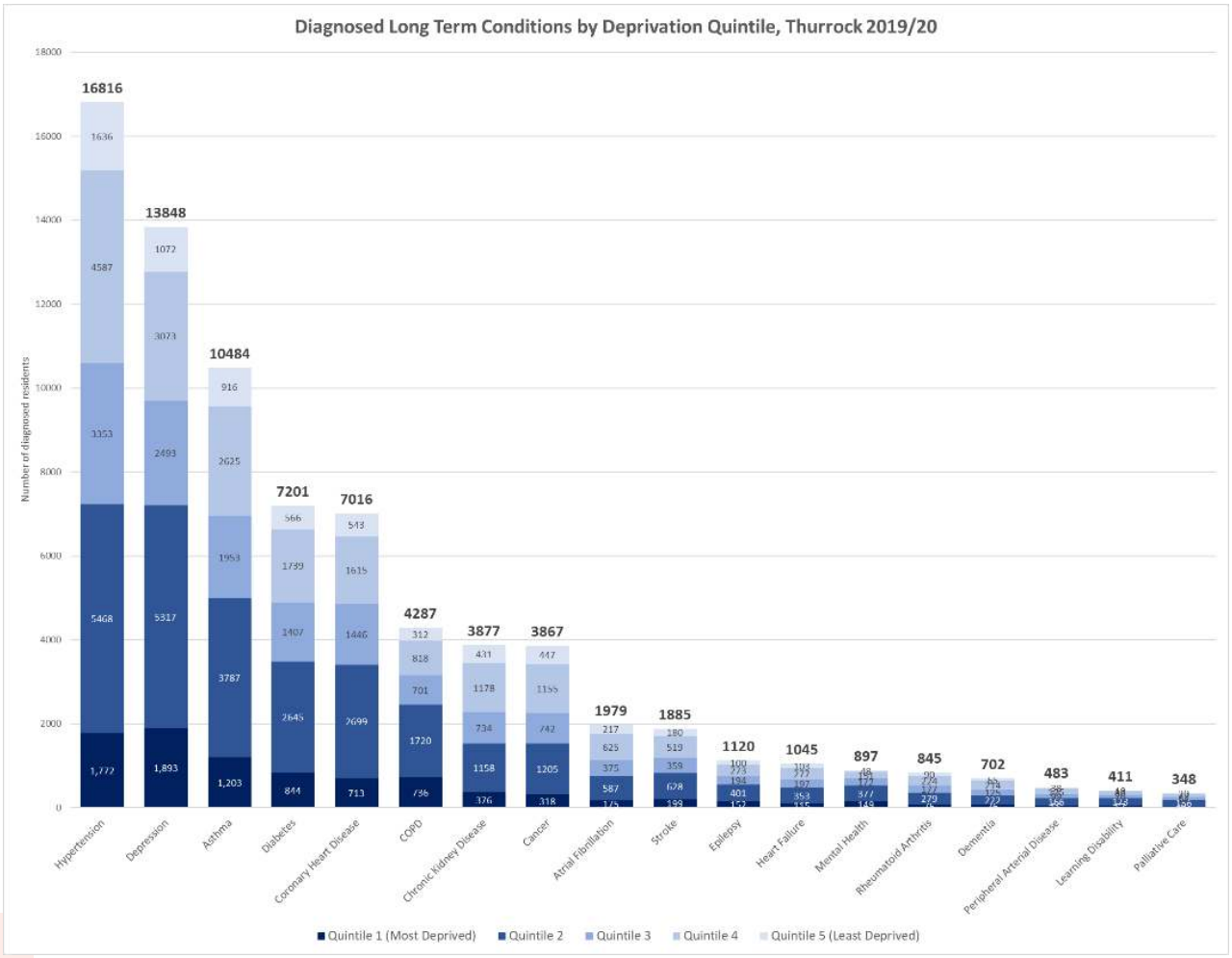


Figure 6.18 shows numbers of residents in Thurrock diagnosed with different long-term conditions and on different QOF registers in 2019/20 by deprivation quintile. The most common diagnoses relate to cardio-vascular (hypertension, CHD, AF and Stroke), respiratory conditions (asthma and COPD), and diabetes. Figure 6.18 demonstrates the impact that social determinants of health play in long-term condition diagnoses, with residents from the more deprived quintiles 1 and 2 being over-represented on the individual QOF registers, and those in the least deprived quintiles 4 and 5 being under-represented.

Figure 6.18



6.7.2 Current Management of Long Term Conditions in Thurrock

Clinical management of resident's long-term conditions is provided primarily through their GP practice via QOF, with additional clinical support provided through specialist NELFT teams for respiratory, heart failure, stroke rehabilitation and diabetes. The new Integrated Primary and Community Care PCN Mental Health services and IAPT will also provide clinical support to some residents with common mental health disorders such as depression and anxiety.

About 70% of the NHS budget is spent on the treatment of residents with long-term conditions. The majority of residents in Thurrock with long-term conditions are well-managed but a minority show clinical biomarkers that place them at higher risk of their condition deteriorating and more serious adverse health, emergency hospital admissions and entry into the Adult Social Care system. Optimising the clinical management of long-term conditions in Thurrock is one the most effective interventions that we can make to improve population health and prevent demand on the most expensive elements of the system.

Table 6.1 shows the percentages by PCN, of residents on some of the long-term conditions QOF registers, who have either not received the specified key clinical intervention for that indicator or whose clinical biomarkers are outside the optimum range specified by the indicator. It demonstrates the further scope for improvement in long-term conditions management of our residents and also variation in performance across indicators between different Primary Care Networks.

Table 6.1

QOF indicators	ASOP	Grays	Stanford-Le-Hope	Tilbury & Chadwell
	Numbers show % patients on registers not receiving treatment (%)			
AF006 – AF, stroke risk assessed (CHADS2 VASc), last 12 months	1.5	0.57	6.3	0.8
AF007 – AD CHADS2-VASc >= 2, not treated anti-coagulation	6.9	2.7	8.1	2
AST003 – Asthma, no asthma review 12 months	17.5	20	22.6	14.5
CHD005 – CHD, not taking aspirin/anti-platelet therapy/anti-coagulant	9.2	2.5	7	4
COPD003 – COPD, no review – MRC scale	7.2	5.7	11.2	7.9
COPD008 – COPD review, dyspnoea scale >= 3, no offer referral to pulmonary rehab	8	5.5	26	16
DM006 – DM, nephropathy or micro-albuminuria, no ACE-I or ARBs	16.5	14	12.8	22
DM012 – DM, no foot examination, 12 months	13	10.7	12.7	9.8
DM023 – DM and CVD, not treated with statin	5.4	6	5.3	4.9
HYP003 - <80, hypertension, BP > 140/90	23.1	23	24	21.1
HYP007 - >79, hypertension, BP > 150/90	15.8	6.5	11.5	9.1
MH002 – SMI, no comprehensive care plan in place	21.3	6.4	33.1	26.7
STIA007 – Stroke, no anti-platelet agent/anti-coagulant	3.6	1	3.1	2.7
HF002 – HF confirmed by echocardiogram 3-12 months from registered	5.8	2.9	5.6	5.9
DEP003 – New diagnosis depression reviewed 10-56 days following diagnosis	15.6	13.3	31.5	16.2

>20%	>15-20%	>10-15%	>5-10%	>2-5%	<=2%

6.7.3 Missed Opportunities for Secondary Prevention through Long-Term Conditions Management

Failure to optimise the management of long-term conditions in every Thurrock resident leads to the health status of a minority of residents deteriorating unnecessarily, causing preventable serious adverse health events requiring emergency hospitalisation. Through interrogation of the Thurrock Mede-Analytic Linked Patient Data Lake, we are now, for the first time, able to quantify this 'failure demand', namely the missed opportunities for prevention on cohorts of Thurrock residents admitted to hospital as an emergency because of deterioration in their long-term health condition.

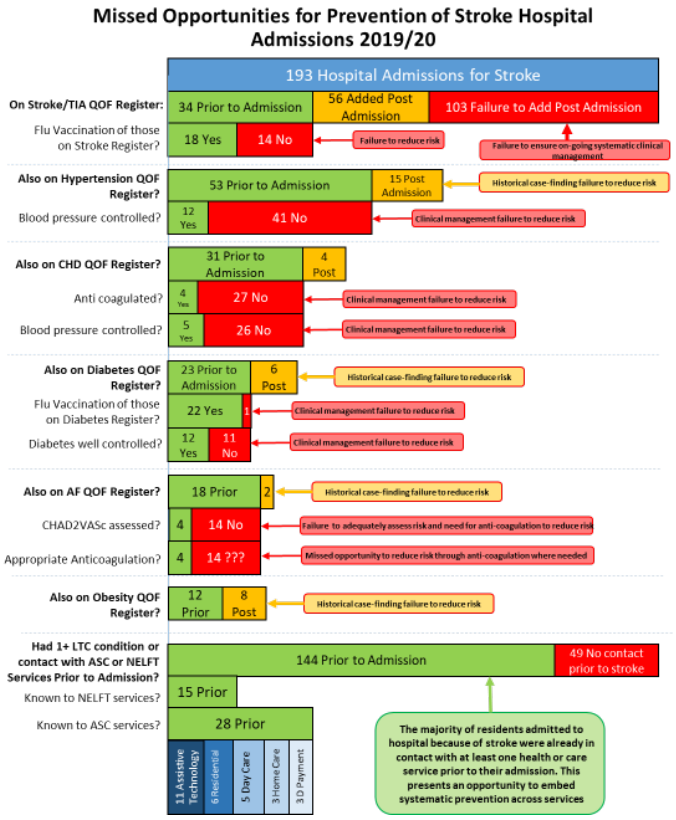
The reasons behind this failure demand are likely to complex and multi-factorial and are likely to include insufficient sufficient capacity and capability within primary and community care to undertake proactive clinical management, fragmentation of the service landscape, inadequate systems to identify and proactively manage all patients and resident behaviour (for example a failure to access care in a timely way or a failure to comply with the advice of clinicians).

In highlighting failure demand, we do not seek to make simplistic judgements or blame on any one group of clinicians or residents; simply to highlight that a collective systemic failure in proactive care underlies and drives serious adverse health events and hospital admissions that could be prevented.

Missed Opportunities for Stroke Prevention

Figure 6.19 shows the missed opportunities for prevention in cohort of 193 Thurrock residents admitted to hospital because of a stroke in 2019/20.

Figure 6.19



There were a total of 91 case finding failures pre admission and a further 103 stroke patients failed to be added to the Stroke/TIA QOF even after their admission for stroke, substantially increasing the risk of on-going failure of secondary preventative activity, systematic clinical management and further strokes.

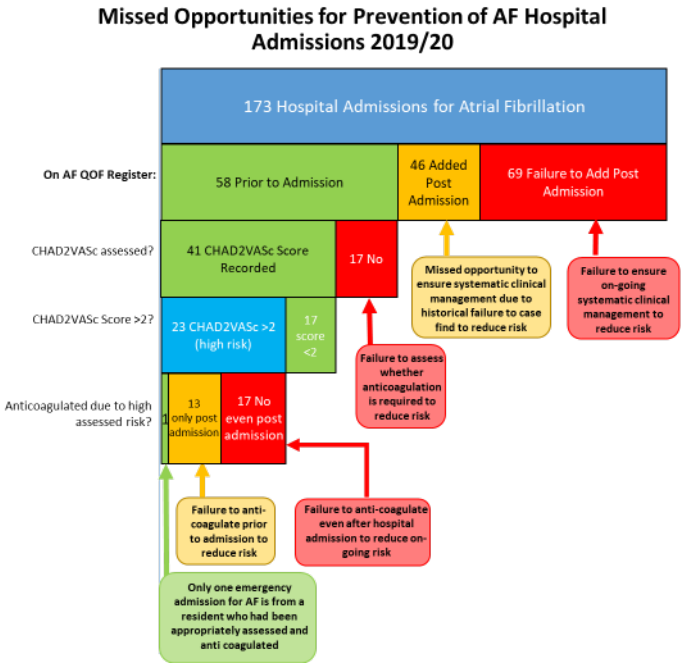
In addition, there were at least 147 missed opportunities relating to optimal clinical management prior to stroke admission that increased residents' risk of a stroke. Of those stroke patients on the hypertension and CHD QOF registers, 77% and 83% respectively had uncontrolled blood pressure. Of those on the Atrial Fibrillation register, 77% had not received a CHAD2VASc assessment to ascertain the need for anti-coagulation and so had not received appropriate anti-coagulation if needed; the single most effective intervention at reducing stroke risk in patients with AF. Of those on the diabetes QOF register, almost half had diabetes that was poorly controlled.

Of the 193 hospital admissions, it is striking that almost three quarters (144 residents) were already receiving care for a long-term condition from their GP and/or NELFT, and/or services from Adult Social Care. This demonstrates the opportunity for embedding systematic action to improve long-term conditions care across the wider local health and care workforce.

Missed Opportunities for Prevention of Atrial Fibrillation Emergency Hospital Admissions

Figure 6.20 shows the missed opportunities for prevention in cohort of 173 Thurrock residents admitted to hospital because of atrial fibrillation in 2019/20.

Figure 6.20



There were 115 missed opportunities for case-finding AF prior to hospital admission that could have resulted in systematic preventative care being provided to residents to prevent the admission. There was a failure to add 69 (40%) of the 173 residents admitted to the AF QOF register even after the admission making proactive and preventative on-going management of their AF unlikely and significantly increasing the risk of further hospital admissions.

Of those already on the AF register prior to hospital admission, there was a failure to CHAD2VASc risk assess 29.3% of residents to ascertain the need for anti-coagulation to reduce their risk of AF and stroke admissions. Of those 23 residents that were assessed as needing anti-coagulation (CHAD2VASc score >2) only one resident (4.3%) was receiving appropriate anti-coagulation therapy prior to admission , and a further 17 failed to receive anti-coagulation even after hospital admission.

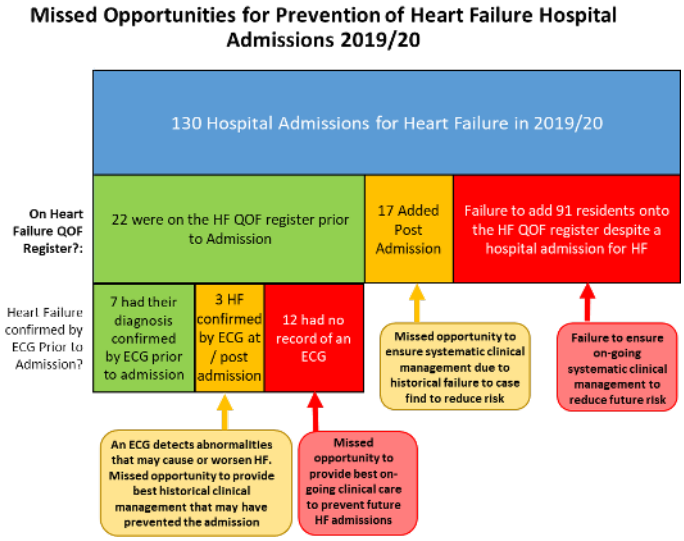
The failures in case-finding, CHAD2VASc score assessment and anti-coagulation therapy meant that only one of the 173 residents admitted to hospital for AF was anti-coagulated prior to admission. Addressing this failure represents a 'quick win' that would yield significant population health and system demand reduction benefits in a very short time period

The failures in case finding, CHAD2VASc score assessment and anti-coagulation therapy meant that only one of the 173 residents (0.58%) admitted to hospital for AF was receiving anti-coagulation therapy prior to admission. Addressing this failure represents a 'quick win' that would yield significant population health and system demand reduction benefits in a very short time period.

Missed Opportunities for Prevention of Heart Failure Emergency Hospital Admissions

Figure 6.21 shows the missed opportunities for prevention amongst the 130 residents admitted to hospital as an emergency because of heart failure in 2019/20.

Figure 6.21



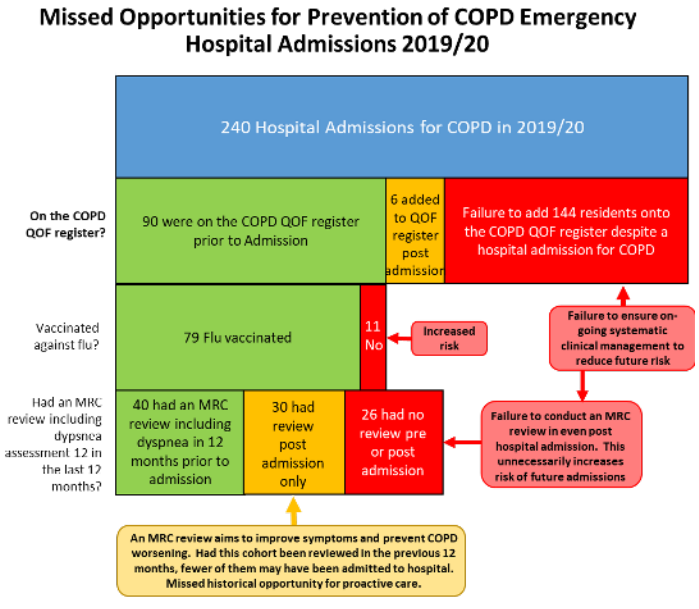
In total there were 108 case-finding missed opportunities, with the majority (83%) of emergency hospital admissions for heart failure being from residents who were not previously on the Heart Failure QOF register. There was a failure to add 91 residents (84%) of this cohort to the register even after their hospital admission, making systematic and proactive on-going heart failure care unlikely and increasing the risk of further hospital admissions and a deterioration in their condition.

Of the 22 residents admitted to hospital who were already on the Heart Failure QOF register, only seven had had their heart failure confirmed by an ECG prior to admission. An ECG allows clinicians to detect abnormalities that may cause or worsen heart failure and provide appropriate clinical management. Three residents received an ECG either on or after admission, but 12 (55%) had no record of an ECG even after hospital admission. Through analyses our analyses of the Thurrock Medeanalytics data lake comparing outcomes of HF residents receiving an ECG and appropriate clinical management with those who do not, we calculate that had an ECG been obtained prior to admission, two of these heart failure admissions could have been prevented.

Missed Opportunities for Prevention of COPD Emergency Hospital Admissions

Figure 6.22 shows the missed opportunities for prevention amongst the 240 Thurrock residents admitted to hospital as an emergency because of COPD in 2019/20.

Figure 6.22



In total there were 150 case-finding missed opportunities, with almost two-thirds of emergency hospital admissions for COPD being from residents who were not previously on the COPD QOF register. There was a failure to add 144 residents (96%) of this cohort to the register even after their hospital admission, making systematic and proactive on-going COPD care unlikely and increasing the risk of further hospital admissions and a deterioration in their condition. A further 30 residents received an MRC review after their hospital but 26 residents had no MRC review either pre or post admission making it more difficult for them to receive appropriate clinical management and potentially increasing the risk of further exacerbations and hospital admissions.

Of the 90 residents admitted to hospital who were already on the COPD QOF register, flu vaccination coverage was good (88%) with only 11 having not received a flu vaccination in the previous 12 months. However less than half (44.4%) had received an MRC review including dyspnoea in the 12 months prior to admission. An MRC review assesses the degree of breathlessness in patients with COPD in order to assist clinicians provide appropriate management of a patient's condition to prevent it from deteriorating. 30 residents received an MRC review post hospital admission but there was a failure to conduct a review in 26 residents even after hospital admission for COPD making systematic management and preventative care of their condition less likely or effective.

Missed Opportunities for Prevention of Asthma Emergency Hospital Admissions

Figure 6.23

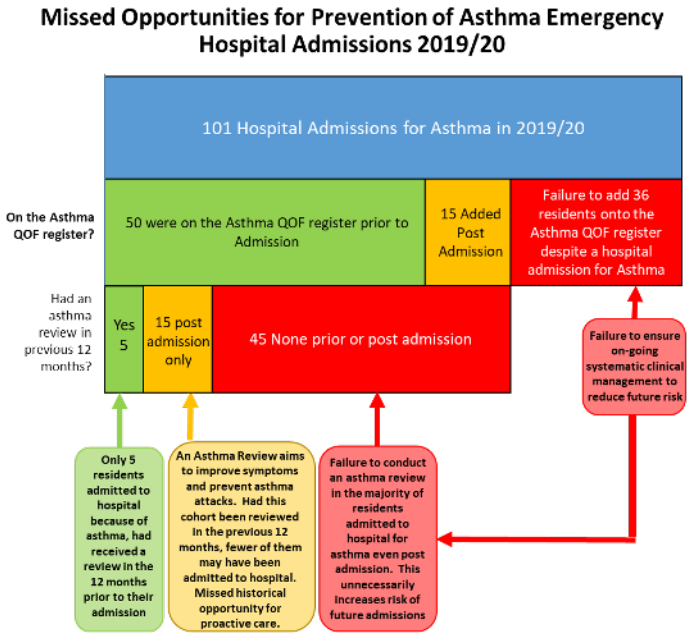


Figure 6.23 shows the missed opportunities for prevention amongst the 101 Thurrock residents admitted to hospital as an emergency because of asthma in 2019/20.

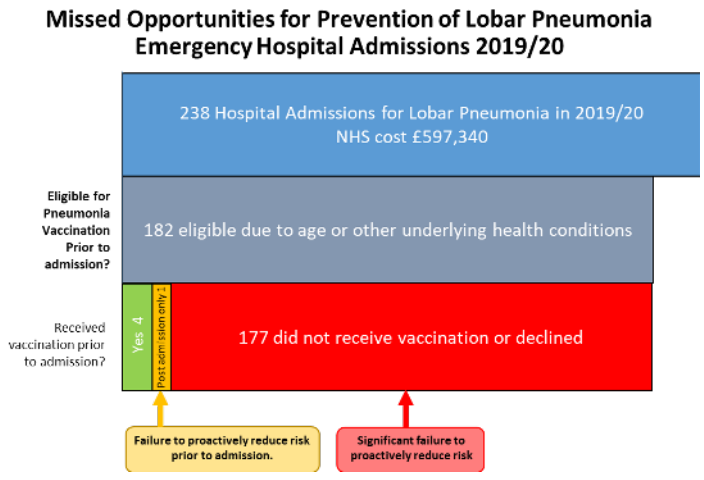
In total there were 51 case-finding missed opportunities, with over half of emergency hospital admissions for asthma being from residents who were not previously on the asthma QOF register. There was a failure to add over two-thirds (71%) of this cohort to the register even after their hospital admission, making systematic and proactive on-going asthma care unlikely and increasing the risk of further hospital admissions and a deterioration in their condition.

Of those residents on the QOF register prior to admission, only five had received an asthma review in the previous 12 months (5% of all admitted patients). Only a further 15 received an asthma review post admission. An asthma review aims to improve symptoms and prevent future asthma attacks. Failure to conduct reviews in the majority of residents both pre and post hospital admission significantly increases the risk of further deterioration in their condition and future hospital admissions.

Missed Opportunities for Prevention of Emergency Hospital Admissions due to Lobar Pneumonia

Figure 6.24 shows missed opportunities for prevention of the hospital admission of the 238 Thurrock residents because of Lobar Pneumonia in 2019/20.

Figure 6.24



Lobar pneumonia is a lung infection causing a build-up of fluid in the lungs to reduce the effectiveness of the alveoli to oxygenate blood.

Pneumococcal vaccination is recommended for adults aged 65+ and younger adults with other underlying health conditions that elevate their risk of pneumonia including those with chronic lung, liver and renal disease and those who are immune supressed. Whilst vaccination doesn't eliminate risk of pneumonia completely, it significantly reduces risk it.

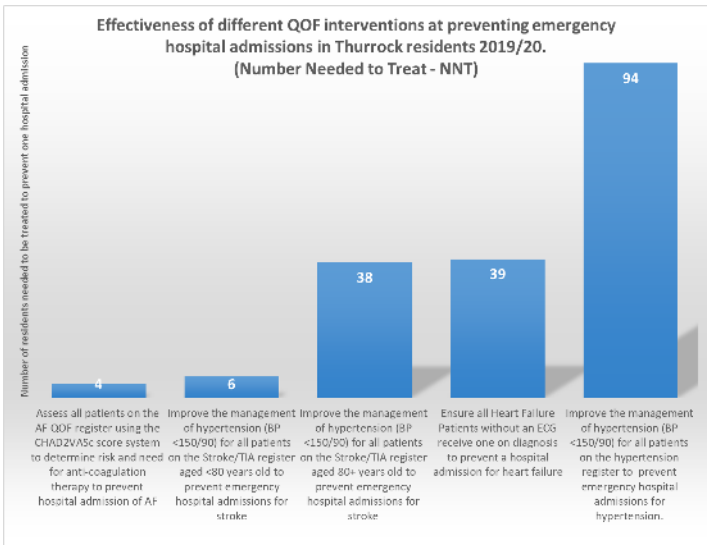
Of the 238 residents admitted to hospital for lobar pneumonia, 182 (76%) were eligible for pneumococcal vaccination. Almost all of the eligible cohort admitted to hospital (98%) were unvaccinated and only one resident received vaccination post admission.

Increasing pneumococcal vaccination coverage in eligible cohorts is a 'quick win' to prevent significant numbers of hospital admissions for pneumonia.

6.7.4 The Potential Opportunities of Optimising Long Term Conditions Management on Preventing Hospital Admissions

Through analyses using the Thurrock Medeanalytics Linked Data Lake, we are able to calculate the impact that different clinical interventions specified under QOF have on hospital admissions. Figure 6.24 shows the number of residents that we would need to treat using different QOF interventions to prevent one hospital admission (the 'Number Needed to Treat' or NNT). The smaller the NNT, the fewer number of residents need to receive the intervention to prevent one hospital admission and so the comparatively, the more effective the intervention is at preventing a hospital admission.

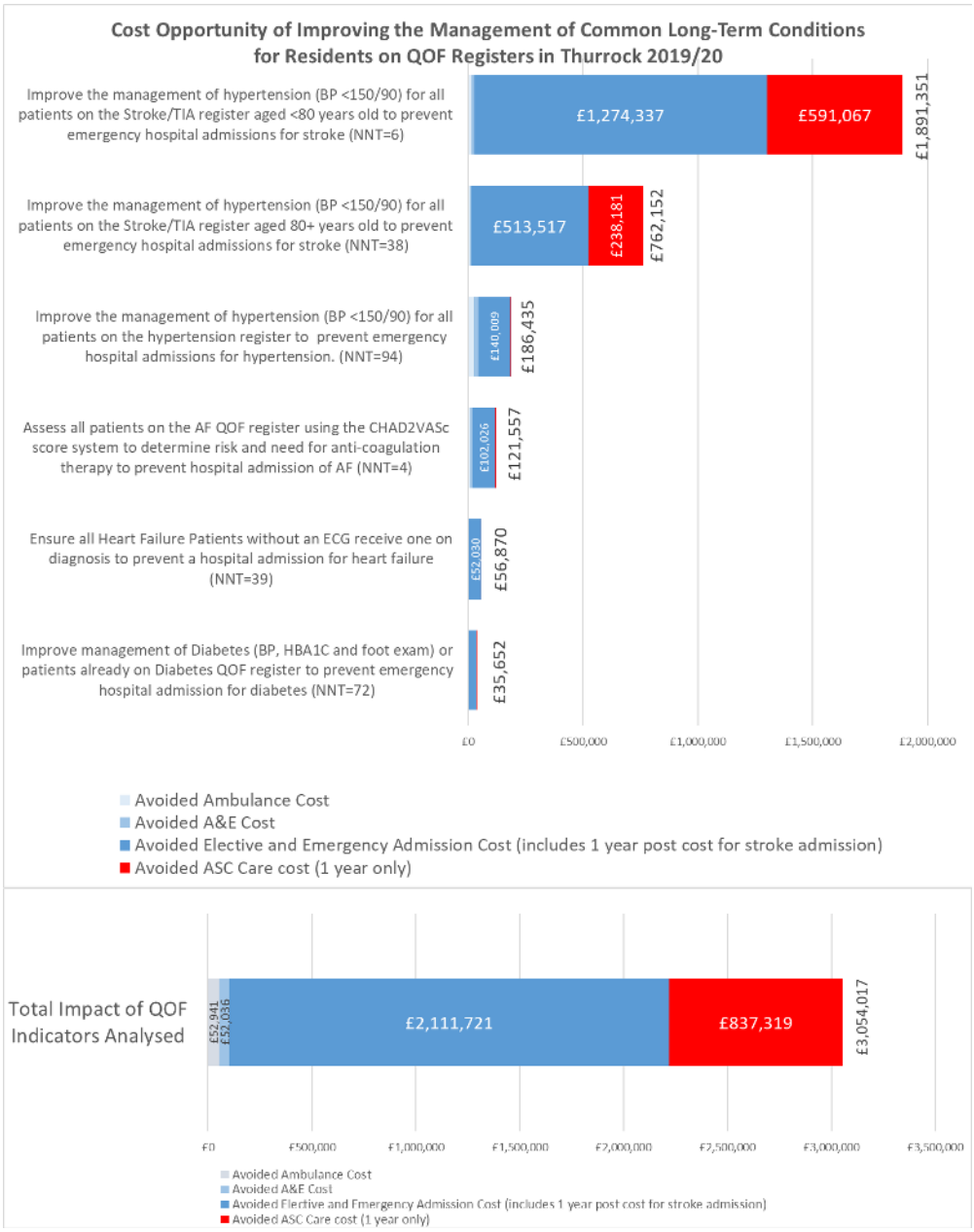
Figure 6.25



The most effective interventions (with the smallest NNTs) are risk assessing residents on the AF CHAD2VASc score and prescribing anti-coagulant therapy to those at high risk, and managing blood pressure on those with existing stroke/TIA history who are aged under 80. Delivering these interventions to only 4 and 6 residents respectively will prevent one of them experiencing a hospital admission in the next 12 months.

By comparing health and care service use between cohorts of Thurrock residents with long-term conditions who do and do not receive successful QOF interventions using the Thurrock data lake, we can now accurately calculate the opportunity to reduce demand and cost on different services within our local system through improving long-term condition management. This is shown in figure 6.26 for the most cost effective clinical interventions.

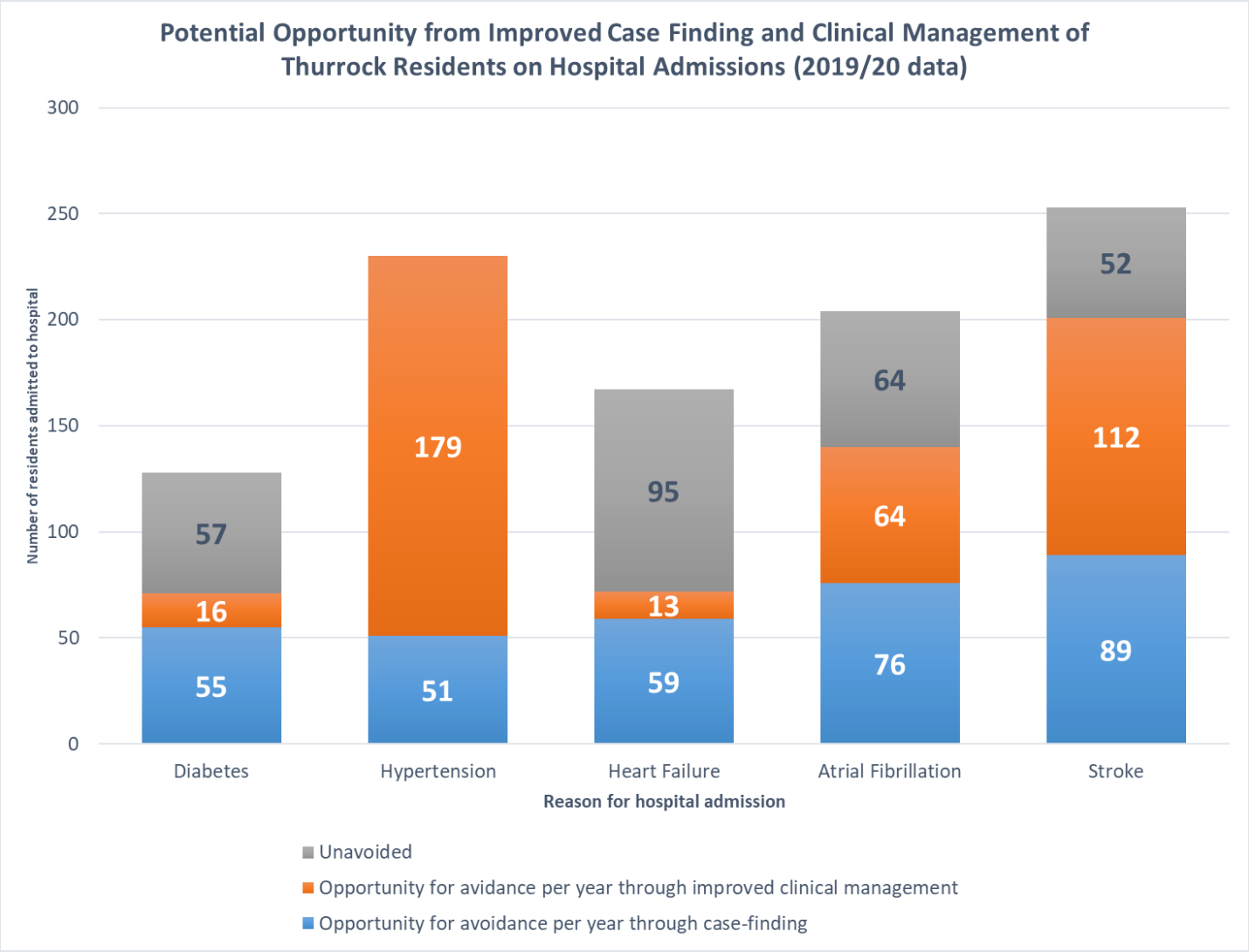
Figure 6.26



In total, at full optimisation of all residents against the six QOF indicators analysed (only a very small proportion of all QOF indicators), there is an opportunity to deliver a total of £2.112M savings through avoided NHS ambulance and hospital demand and a further £837,319 to Adult Social Care. This demonstrates significant opportunity to improve the financial and operational sustainability of the local health and care system through further improvements in long-term condition management within Primary and Community Care. From the analyses undertaken, the biggest opportunity rests in improving the optimisation of residents with a history of stroke/TIA.

We are also able to calculate the potential impact that improved case-finding and optimising clinical management (of the QOF indicators analysed above) could have on prevention of hospital admissions for different long-term conditions amongst Thurrock residents. This is shown in figure 6.27.

Figure 6.27



Our analyses demonstrates that a significant proportion of hospital admissions are preventable and avoidable through improved case-finding and clinical management, delivering a win-win of both improved population health outcomes for residents and operational and financial sustainability to health services.

6.7.5 The Thurrock Population Health Management Programme to date

Thurrock's 2017 *Case for Change* strategy set out a series a strategic recommendations for improving the management of diagnosed long-term conditions that have been successfully implemented through the Population Health Management Programme within *Better Care Together Thurrock:*

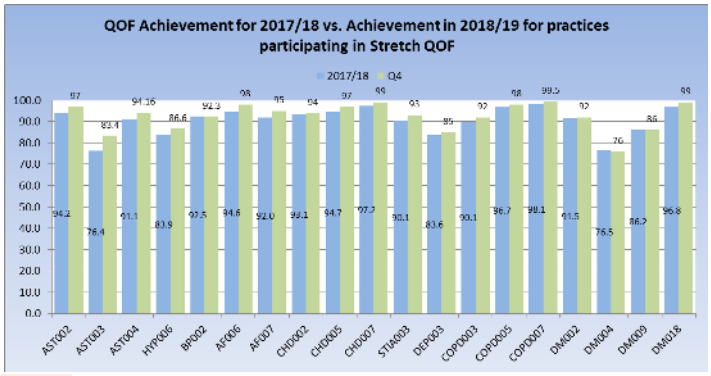
Stretched QOF

The national QOF framework financially incentivises individual GP practices to deliver clinical interventions and/or ensure clinical biomarker optimisation to a certain proportion of residents on individual QOF disease registers (typically between 80-95% depending on the clinical indicator). However this still leaves between 5-15% of patients on the register where resources are not provided to practices to deliver the intervention, and these remaining patients are likely to be those hardest to reach and least likely to engage with the surgery. As such, it can be argued that QOF national commissioning perpetuates existing health inequalities.

The Thurrock Stretched QOF contract, first introduced in 2018 addresses this inequity by providing additional financial incentive to practices to deliver clinical management to the remaining cohort of residents on the QOF indicators identified as having the biggest positive impact on population health. Our evaluation of the contract suggests has delivered a saving in avoided adult social care and NHS demand of £3.28 for every £1 invested by preventing serious adverse health events. For example, we estimate the contract has prevented 40 strokes, delivering £873,000 in avoided Adult Social Care and NHS treatment costs.

Figure 6.28 shows the impact that the Stretched QOF contract had in improved performance on the indicators incentivised compared to the previous year's baseline before the contract was introduced.

Figure 6.28



Cardiovascular Disease Upskilling Programme

We commissioned a CVD Upskilling Programme for Primary Care clinicians between July 2018 and February 2019. The Programme, accredited by the Royal College of General Practitioners consisted of six modules covering:

- Heart Failure
- ECG Interpretation
- Echo report Interpretation and Valve Disease
- Stable Angina/CAD CV Risk Assessment, Prevention and Diabetes
- Atrial Fibrillation
- Palpitations and Arrythmia

The modules aimed to increase primary care clinicians' knowledge and confidence in the diagnosis and management of cardio-vascular disease and was attended by 29 clinicians from 23 surgeries.

The evaluation from the programme was incredibly positive. Some of the comments from clinicians attending the course are below

"*My knowledge was sorely out of date, worse still, having rated myself at 4, I had no insight!*",
GP attending Diabetes Module

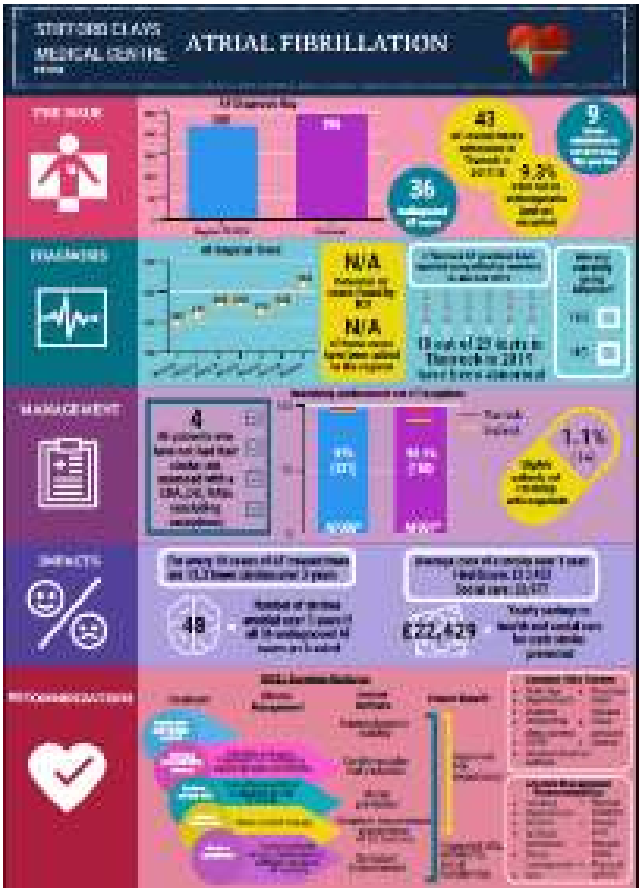
"*This programme should be mandatory for all GPs*",
GP after attending Heart Failure module

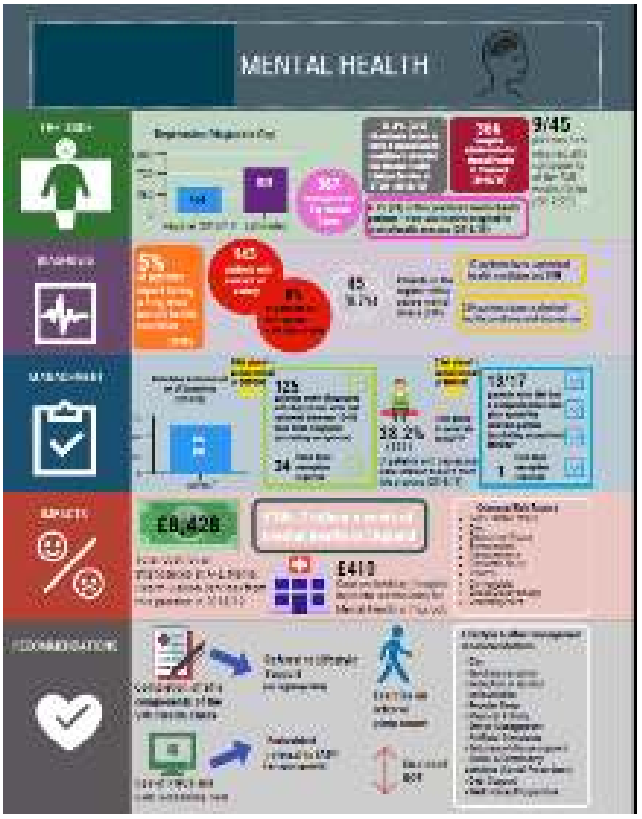
"I will completely change my clinical practice following this module".
GP attending AF Module

Long Term Condition Practice Based Profile Cards

The Public Health Team has produced dedicated Long Term Conditions Profile cards for every surgery since 2018, benchmarking long term condition management performance of the surgery against a range of indicators relating to long term condition management together with their referral behaviour and practice population's hospital admission rates for Ambulatory Sensitive Care Conditions. The cards form the basis of bi-annual Quality Improvement visits where a public health specialist meets with practice clinicians to discuss their data and agree a quality improvement action plan to improve clinical practice and performance.

More recently, additional topic specific profile cards for each practice on Mental Health and Atrial Fibrillation have also been developed.





Impact of Thurrock's Population Health Management Programme to date

Early evaluation of the PHM programme appears to show a positive overall impact on population health outcomes. The upward trend in cardio-vascular emergency hospital admissions is reversed in the year after the programme was introduced was reversed and begins to fall for both heart failure and stroke. (Figures 6.29 and 6.30 below).

Figure 6.29

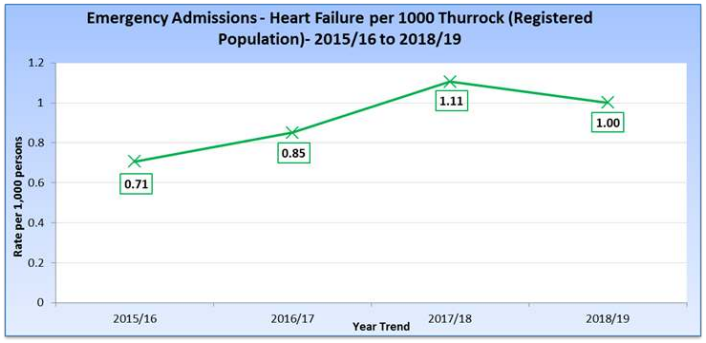
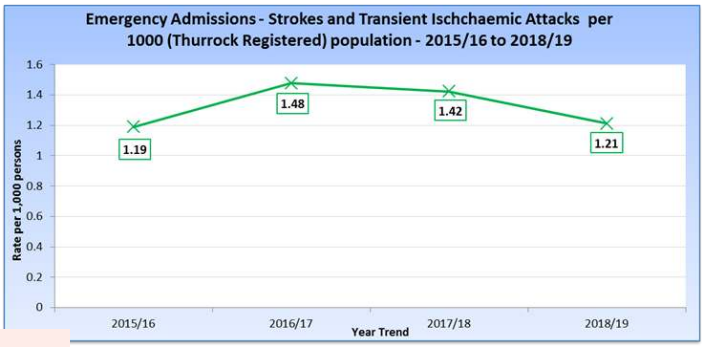


Figure 6.30



6.7.5 Future Strategic Action to Improve Long-Term Conditions Management

Whilst the evaluation data in the previous section on the impact of our Population Health Management Programme to date is encouraging, it is worth noting that it pre-dates the COVID-19 pandemic.

During the last 20 months, QOF has been suspended for two years running as Primary and Community Care capacity and capability was diverted into mitigating the negative effects of the pandemic. Whilst understandable and necessary, this has almost certainly had a negative impact on the previously hard-won improvements in long-term condition management. We are now seeing in impact of pausing secondary prevention activity within the community in the form of significant increases in the clinical complexity and numbers of residents, very unwell with non-COVID conditions arriving at the hospital and adult social care front doors.

Demand on Primary Care is at record levels and GPs report huge difficulty in continuing to be able to deliver proactive care in a context of reactive demand that significantly outstrips supply. Chapter 5 sets out our plans to address this capacity-supply gap and doing so successfully is fundamental to re-starting effective proactive long-term conditions management. Chapter 7 sets out additional action that we will take to build integrated community teams around PCNs and surgeries to provide additional capability to deliver proactive care.

Addressing Multi-Morbidity and Leveraging the Opportunities of PCNs

Increasing primary and community care capacity is only part of the solution. It is vital that we also use the capacity that we have in the most efficient and effective way deliver the greatest impact at population level. When the original PHM programme was introduced in early 2018, Primary Care Networks did not exist and QOF was organised at GP practice level. Every surgery was responsible for delivering every indicator on every disease domain independently. This is undoubtedly not the most efficient way of delivering QOF. Different surgeries have different clinical skill mixes with different specialities. One may have a practice nurse specialising in diabetes, another with a GPwSI specialising in heart failure. These differences can cause variation in outcome for residents.

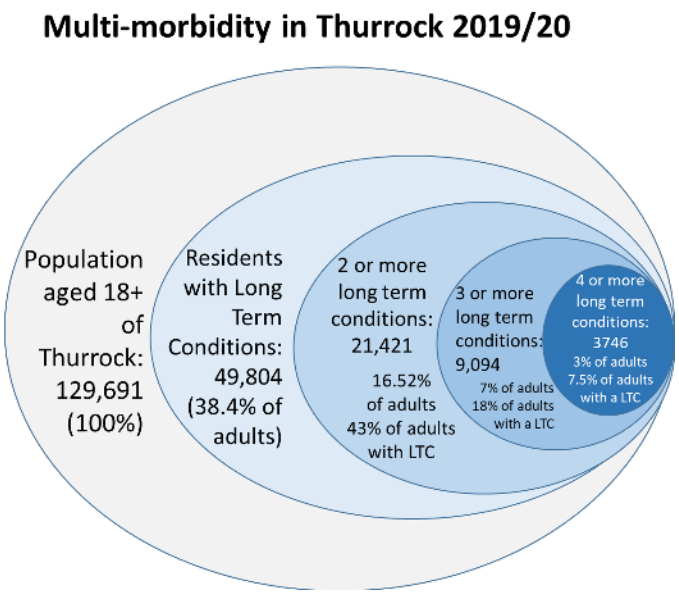
Similarly, residents with the same long-term condition have differing needs. The majority are likely to be well controlled and need only annual monitoring. Some may have some clinical bio-markers moving out of control and need more intensive support. A minority are likely to be complex and may need intensive specialist clinical input. The skills and qualifications of the clinicians to manage these three different cohorts also varies. The most complex are best managed by specialist GPs with Consultant input, the first can be well managed by practice nurses.

Engagement with Thurrock GPs suggests that they often report difficulty accessing Consultant input or advice without making a hospital outpatient referral that may have a waiting list of many months. As a result, where a more timely and urgent response is required they are forced to send patients to A&E. This is an inefficient use of system resources and inconvenient for patients.

Thurrock has already pioneered a new Integrated Primary and Community Care model for mental health, co-designed through bringing GPs together with Consultant Psychiatrists to devise a more effective way of working together. The model, based around each PCN, marries Primary Care staff with specialist psychiatric nursing and psychology staff with dedicated Consultant Psychiatry Session input, blurring the lines between primary and secondary care and addressing the historic fragmentation between and within care pathways. We intend to use it as a blue print for other long-term conditions management, working with PCNs and their constituent practices to co-design integrated long-term conditions management functions at PCN with shared capacity and a better staff skill mix including consultant input into specialist clinics. The new Integrated Medical Centres with their access to secondary care diagnostics and outpatients plus third sector support provide a unique opportunity for better patient cohorting based on risk and new integrated and holistic models of long-term condition care.

The second issue with our historic approach to QOF and stretched QOF is that it fails to recognise and address the fact that many residents with long-term conditions are living with more than one long term condition (multi-morbidity). In 2019/20, of the cohort of residents diagnosed with Long Term conditions, 43% have at least two, 18% have at least three and 7.5% have at least four or more long-term conditions respectively, as shown in figure 6.31 (overleaf)

Figure 6.31



QOF and Stretched QOF requires surgeries to treat long-term conditions entirely independently. This is both inefficient for staff and wastes the time of residents who may need to attend many different appointments from different services for each long term condition. The Thurrock Mede-Analytics Linked Data Lake now allows us easily to understand the overlap between different QOF registers. For example, figure S shows the overlap between the cohort of residents on:

- CVD (Heart Failure, CHD and Stroke/TIA) QOF registers – orange circle
- The Diabetes QOF register – yellow circle
- The Hypertension QOF register – grey circle

Almost 30% of this cohort are on more than one of the three categories of register. Conversely, only 11% of those on the diabetes register are not on any of the other registers, and only 6.6% of the CVD cohort are not on either of the other two registers.

Our analyses using the Thurrock data lake also demonstrates rapidly elevating risk of an emergency hospital admission within one year as the number of long-term conditions a resident is diagnosed with increases, particularly for some combinations of long-term condition.

Figure 6.32

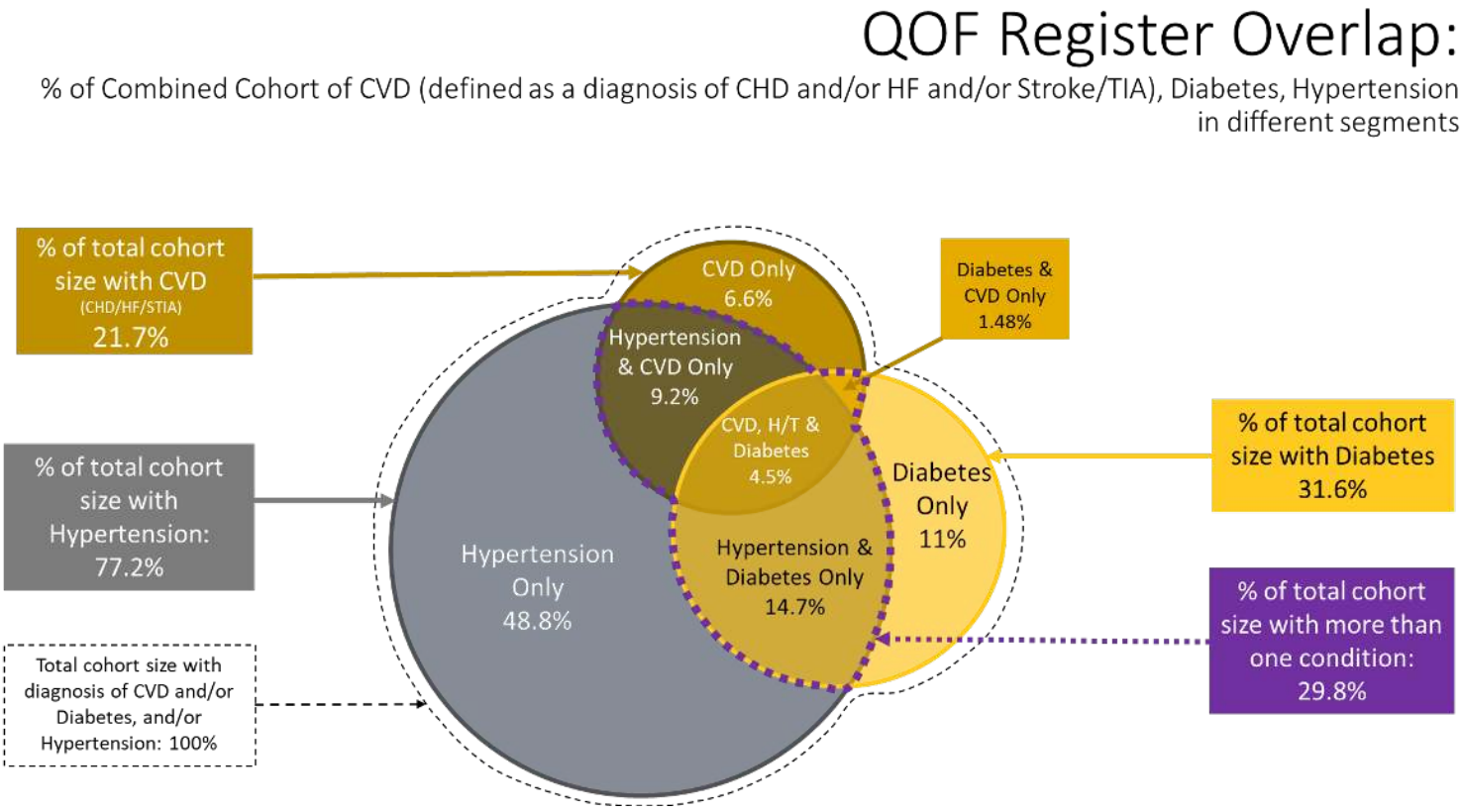
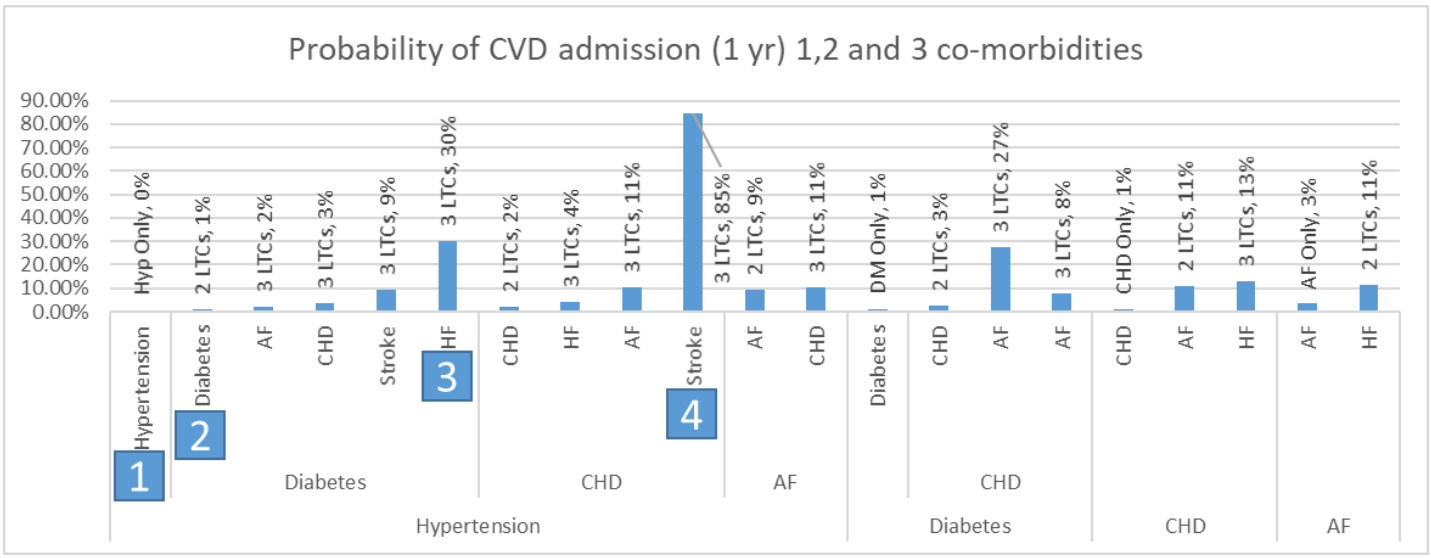


Figure 6.33 shows the probably of an emergency hospital admission for residents with either hypertension, diabetes, CHD or AF only and then each of these four base conditions combined with additional long-term conditions. For example the probably of a hospital admission within a year for a resident only with hypertension is virtually 0% (Point 1). This rises to 1% when the resident also has diabetes (Point 2) but 30% where the resident has hypertension, diabetes and heart failure. Similarly where a resident has hypertension, CHD and a history of stroke/TIA, the probability rises to a massive 85% (Point 4)

Figure 6.33



We will therefore work within PCN, community NHS and secondary care clinical leaders to create multi-morbidity clinics at PCN level starting with a single service to manage more complex patients with multiple cardio-vascular disease conditions and/or diabetes. The services will have secondary care consultant and specialist nursing input. They will be based within the new Integrated Medical Centres when built giving further integration with diagnostics and outpatient services.

We will co-design the new services with residents using Human Learning Systems principles to ensure that they are truly holistic and respond to resident needs. We will embed existing fragmented lifestyle modification services commissioned from the Public Health Grant within the services and create new 'blended health coach' role that can address wider determinants of health, lifestyle issues such as addiction, social health needs, social prescribing, self-care and in-depth motivational interviewing.

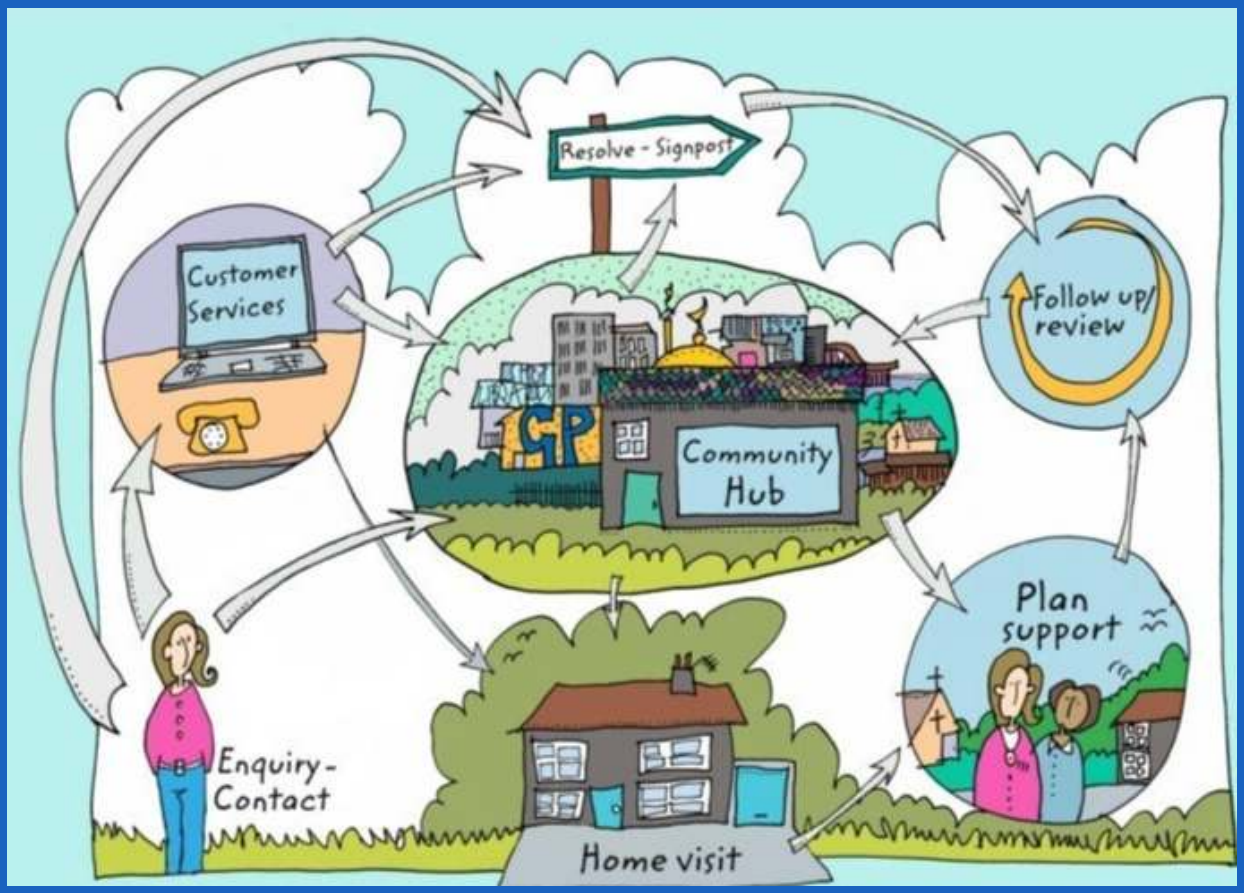
In order to further support this new way of working, we will re-design the Stretched QOF contract to provide financial incentives to practices to collaborate to support this new model of care, with payments made on performance at PCN level and where bundles of clinical care interventions are successfully delivered. We will continue to make use of PHM integrated data to identify and incentivise the clinical management activity that will have the greatest positive impact on population health and avoidable hospital and adult social care demand and resources, creating a virtuous positive reinforcement circle where savings from avoided high cost activity can be re-invested in further primary and secondary prevention at PCN level.

We will further support PCNs to achieve maximum levels of long-term condition optimisation through the dedicated Intelligence Functions that we will create at PCN level (as set out in Strategic Action 6.12. These will access Population Health Management Data in near real time using the new linked dataset being constructed through the Arden Gem DESCRO, allowing practices, PCNs and the new multi-morbidity services to be able to quickly identify residents requiring review and clinical management.

We will create a series of real-time data dashboards using this new informatics capacity that will replace the bi-annual profile cards, allowing earlier and more systematic management of all residents with long term conditions.

Chapter References

1. Friberg L, Rosenqvist M, Lindgren A, et al. High prevalence of atrial fibrillation among patients with ischemic stroke. Stroke. 2014;45:2599–2605. ↑
2. Jørgensen HS, Nakayama H, Reith J, et al. Acute stroke with atrial fibrillation. The Copenhagen Stroke Study. Stroke. 1996;27:1765–1769. ↑
3. National Institute for Health and Care Excellence. Atrial fibrillation: management. Clinical guideline [CG180] [Internet]. [updated August 2014]. Available from: https://www.nice.org.uk/guidance/cg180 ↑
4. Healey JS, Connolly SJ, Gold MR, et al. Subclinical atrial fibrillation and the risk of stroke. N Engl J Med. 2012;366:120–129 ↑
5. Lowres N, Neubeck L, Redfern J, et al. Screening to identify unknown atrial fibrillation. A systematic review. Thromb Haemost. 2013;110:213–222. ↑
6. AF-detection-in-GSTT-podiatry-paper-for-podiatry-now-1.pdf (aftoolkit.co.uk) ↑
7. Healy J, Connolly S et.al, ASSERT Investigators, Subclinical atrial fibrillation and the risk of stroke. *N England Journal of Medicine* 2012,366:120-129. ↑
8. Kalantarian S, Ay H et.al, Association between atrial fibrillation and silent cerebral infarctions: a systematic review and meta-analysis. Ann Intern Med 2014; 161:650-658 ↑
9. Kim D, Yang PS, Yu, HT et.al. Risk of dementia in stroke-free patients diagnosed with atrial fibrillation: data from a population based cohort. *Eur Heart J*, 2019;40:2313-2323 ↑
10. Naylor C, Parsonage M, McDaid D, Knapp M, Fossey M, Galea A. Long-term conditions and mental health: the cost of co-morbidities. London: The King's Fund; 2012. Available at: www.kingsfund.org.uk/publications/long-term-conditions-and-mental-health ↑



Chapter 7: Integrated Care and Support in the Community

Bespoke solutions in a complex world

Chapter 7: Integrated Care and Support in the Community

7.1 Introduction

In this chapter we discuss the next phase of our wider adult health, care and wellbeing service transformation to create truly integrated and responsive teams at Primary Care Network (PCN) Locality level based on Human Learning Systems principles. Through our transformation journey to date, we have already built many of the 'ingredients' for change; teams such as Local Area Coordination, Community Led Solutions and our new Mental Health Integrated Primary and Community Care models are already working within in the community in partnership with residents on strengths and asset based principles to deliver holistic and bespoke care.

However at present, this good practice is still operating in a wider *New Public Management* based fragmented landscape, and too often still within silos. We want to go further and faster, creating new *blended roles* that can deliver a wider range of functions traditionally split between different teams within health and care, and to create single PCN/locality based integrated networks that will respond in a coordinated and integrated way to deliver care in partnership with residents. This will ensure key principles around getting things right first time and continuity of care with reduced duplication can be achieved.

7.2 The Historical Approach to Delivering Community Care

In Chapter 2 we discussed the complex environment in which residents live. A wide variety of different social, environmental, economic, behavioural and biomedical factors interact together to determine wellbeing. However we have fragmented public services to deal with single 'problems' defined in advance by us, driven by processes that reinforce that focus. What people actually want is a system that treats them as individuals and supports them to achieve or maintain a fulfilled life whatever the circumstances.

Currently, people needing support will have to meet set criteria and thresholds. The support that they then receive, if deemed eligible, will be standardised and focused on a single need, and rarely sufficiently tailored or personalised. Residents' lives are rarely like this. They often have multiple interconnected needs requiring support from different teams and organisations. They need an integrated solution, but are required to navigate a bewildering public sector landscape and try and access multiple different services, each likely to be provided in isolation, and each having its own referral route and eligibility criteria.

The net impact of this is to distance people from their care and support, creating a professional "firewall" around the intervention. Evidence suggests that when people see themselves as invested in their own health and wellbeing their outcomes improve.

> *People do not live their lives in silos; they experience care and support across many different services. We know that for many people, the issues they face are about the lack of co-ordination of services around their needs.*[1] *Moreover, gaps in care co-ordination disproportionately affect those with the greatest needs and the poorest outcomes*[2] **From: Understanding Integration: How to listen to and learn from people and communities**[3]**.**

All of this can take a significant amount of time; time in which the resident's health and wellbeing can decline. The more 'needs' the resident has, the greater the difficulty they will experience in interacting with the system, and the more fragmented the response will be.

This way of working increases rather than manages demand. It ignores the importance of building trust between the individual and those providing care and support, exacerbating bureaucracy and cost, increasing delay and building significant amounts of waste in to the system. Ultimately, it is costly for both the system and for residents requiring support.

The current system design disempowers both the resident seeking support and the staff attempting to provide it. Power and control sits almost exclusively with those who have centrally planned and commissioned the system. Over the years, 'choice' and 'personalisation' have dominated the health and care agenda, but what has emerged is neither. An individual may be able to choose where they receive treatment or be in receipt of a direct payment so that they can arrange their own care, but what they actually receive is rarely any different than would have been offered by the 'system'. This is especially true for older people.

In short, how the system is constructed and how it operates makes no sense to the people who need it and little sense to the people working within it. Both parties know this but feel powerless to do anything about it.

The actual case studies (names have been changed) below of Thurrock residents demonstrate the impact this has on people and their lives and the resource wasted in 'failure demand' caused by a failure to design an integrated solution.

Case Study: Owen

Owen is a 60 year old man who lives alone. Owen lost his wife a few years ago and has become isolated and depressed. He always drank heavily, but since his wife died, his drinking has spiralled downwards into alcoholism and he is drinking five bottles of wine a day. Owen's health has declined, and with it his mobility. He current receives an externally commissioned care package to help him with personal care.

Owen's GP referred to him to the Occupational Therapy Team to try and improve his physical functionality. When the OT attends Owen's home, they find Owen slumped in a chair, unable to move, and uncommunicative. Owen's carers have just left. Owen's mobility has declined so much due to his alcoholism that they are unable to lift him out of his chair. The OT can't help because Owen is so inebriated.

Owen's Adult Social Care Support Planner attend's Owen's home. Owen needs a short term residential care placement because he is unsafe to be left at home as he cannot cook, use the lavatory or dress unaided, but his Support Planner is unable to find a residential care placement to accept Owen because they are all concerned that they will be unable to manage his withdrawal from alcohol.

Alcohol Treatment Services are not providing any home visiting at the time, and have been commissioned to only offer an assessment for alcohol treatment in the community within two weeks of a referral. To receive a community detox, Owen would need to first go through a separate assessment process. Fast tracking of alcohol treatment requires another referral for a further assessment by a panel. Owen has no transport to support him to access their services.

The Support Planner is left with no other option than to call an ambulance to convey Owen to hospital. The hospital will hopefully provide an alcohol detox as an inpatient and then discharge Owen back into the community where he will start drinking again. He knows this, because he has already been around the same loop five times in the past year.

For Owen to access community alcohol rehabilitation support, another separate referral is required.

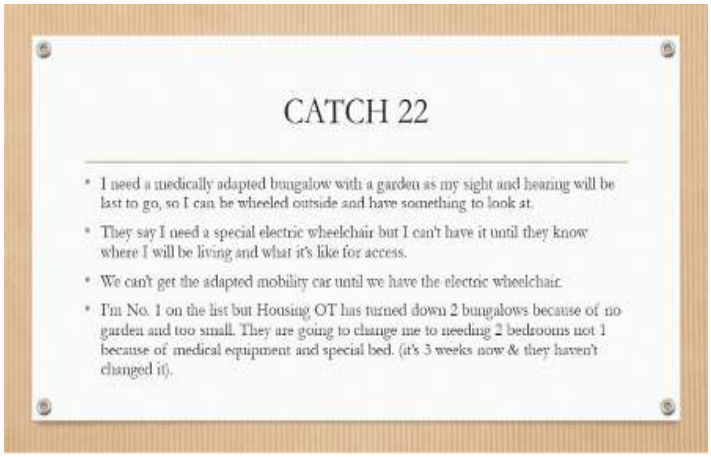
Case Study: George

George has mobility difficulties and needs the support of two home carers with transfers. He lived in a private rented room until he was made homeless. He has since been placed in a temporary rented room in a House of Multiple Occupation (HMO), however the room is inadequate for George as it is a first floor room with no lift.

If he is to improve his mobility, George needs to have physiotherapy and the space to practice exercises. However, George's physiotherapist has assessed his home environment as unsafe to the the exercises.
George is currently supported with a home care package that has provided 21 hours a week of double-handed home care for the last nine months. The cost of the care package is £700 per week.

George is unlikely to improve until he has the right living environment. He is stuck upstairs and he has become very depressed. As a result, he has had to access Mental Health services and is waiting for a further assessment from the Housing team.

Figure 7.1 – The Catch



7.3 Learning from the Transformation We Have Undertaken to Date

In Chapter 2 (section 2.2), we set out the fundamental change principles that we want to introduce across our Thurrock Alliance based on Human Learning System theory and in Chapter 3 we set out our approach to community engagement and strengths based working.

We need a system that people can access at any point, mostly from within their local community, to get the support they require. This support must be coordinated and focused on achieving what matters most to them – which may mean accepting an element of risk. Those providing a service must work together in the community and with the community to deploy resources effectively, overcome organisational boundaries and unhelpful process and bureaucracy, and to deliver an integrated bespoke solution. Resource must be used collectively and in its widest sense – with solutions provided incorporating community assets, technology and provision that is creative and diverse.

From the learning we have already gained from our transformation journey, we know that we need to transform our current services in the following ways:

From Fragmented to Coordinated and Integrated.

Our learning has already helped us to identify ways of working that reflect a coordinated and integrated approach based around localities that cover the same geography as Primary Care Networks. By bringing different teams together at locality level, different front line staff are forming relationships and networks that allow them to design integrated solutions in conjunction with residents.

From Specific Need or Condition-Led to Strengths-Based

Chapter 3 has already discussed our strengths and asset based approach.

The learning from strengths-based working has enabled us to start to shift the way that the workforce operates including changing existing process and practice so to focus more on the strengths that the individual has or are available to the individual as part of any solution. Adopting a strength-based culture is essential for shifting power to individuals and communities (Figure 7.2).

Figure 7.2

From One-Size-Fits All to Personalised and Bespoke

The learning from our transformation programme has meant that we have started to shift the way we work to be able to offer a response that is personalised and tailored to the individual. Whilst bespoke may sound more expensive we have found that by providing the right response first time we limit failures and the revolving door, therefore also providing the most cost effective intervention in the long run.

From Top Down to Bottom Up, Centralised to Localised

In Thurrock, we fundamentally reject the maxim that efficiency is always gained by centralising services over a bigger geographical footprint. Our learning demonstrates the reverse; by bringing teams together at locality level allows resident facing staff to work more effectively and creatively with residents to solve problems, preventing 'failure demand'.

Our transformation approach reflects a strong place-based focus with 'subsidiarity' being a key principle. Different areas of the Borough have different requirements, and developing a system that can identify and respond to these different requirements remains vital.

From Reactive to Preventative

Our original 2017 *Case for Change; New Model of Care* strategy made an incontrovertible case that demonstrated the resources within our system were too often in the wrong place, with a shift from acute to community being the aim, and a shift of focus from reactive treatment to proactive prevention being the solution. Since then, we have already transformed key elements of our local operating model to focus on preventing, reducing and delaying the need for health and care.

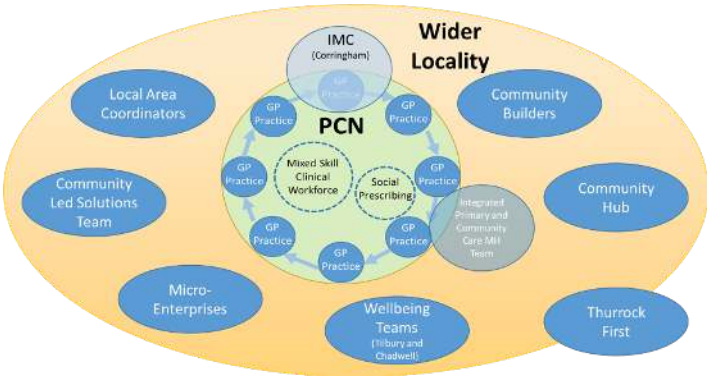
Traditionally, public sector services have attempted to control cost by setting eligibility thresholds to determine who can and cannot access the service. Our learning has taught us that paradoxically, by failing to act early, we increase cost, often by driving residents to the most expensive parts of the system. Instead of waiting until people are 'ill enough' or in sufficient 'need' to meet criteria for support, we have transformed many system elements to intervene earlier and proactively keep people well.

Learning from approaches such as *Local Area Coordination*, *Community Led Support* and our new Mental Health IPCC model all described in the next section helped to start to shift the system to focus on prevention by default. Eligibility thresholds have been shelved; all of these initiatives work on the two 'first principles' of: *Early intervention* and on *focussing on reducing the need for or reliance on future services*. They also aim to provide a coordinated approach that deals not with one issue at a time, but all of the key requirements that the person has to achieve the outcomes that are important to them. For example, this might need to incorporate a plan of action that spans housing requirements, health requirements and care requirements – as well as social requirements.

7.4 Examples of Locality Based Services We Have Already Transformed In Line With Our Principles and Values.

Our transformation journey to date has helped us to identify how to achieve the change we require and we have already reimagined and rebuilt many services in Thurrock based on our transformational change principles and strength and assets based approach as set out in figure 7.3.

Figure 7.3



Thurrock First

Thurrock First is our single point of access across community health, mental health and adult social care. The service consists of a team manager who is a qualified social worker, two senior co-ordinators, 17 Thurrock First Advisors who take telephone calls, a Community Psychiatric Nurse, a Mental Health Act Assessment Coordinator plus casual bank staff.

Thurrock First operates between 7am to 7pm, 365 days a year, taking calls via a single telephone number directly from residents and their families, and from health and care professionals. It aims to reduce, prevent and delay the need for more significant care by intervening early and works closely with the Urgent Care Response Team (URCT) who can be mobilised to attend residents' houses where they are in crisis.

Advisors are trained to undertake proactive ASC assessments on the phone including carer assessments and can work proactively with residents to find a bespoke solution. They also have a direct link into EPUT services, with the CPN within the team acting as a backup resource for AMP Mental Health Assessments where required. They also work closely with the Adult Social Care Hospital Team to facilitate timely hospital discharge by making sure community health, care and social needs are in place.

We are currently aligning advisors to our *Community Led Support* locality teams to allow them to develop even more knowledge of community assets within specific localities, allowing them to build more create solutions with residents.

Local Area Coordination

Thurrock now has 14 Local Area Coordinators (LACs), each aligned to specific neighbourhoods within the Borough. The LAC's primary role is to develop a detailed understanding of all of the community assets, networks, services, organisations and groups within their neighbourhood and more broadly across the borough, and then work with residents to find pragmatic solutions to problems, drawing on these resources before considering commissioned or statutory services.

The service always starts with the question *'What does a good life mean to you?'*, making it holistic and bespoke. This means that instead of simply assessing or referring residents into services they:

- Invest enough time in understanding what a good life looks like to the individual or family, and how they could get there.
- Help people to build their own capacity and connections, so that they can stay strong and independent.
- Build new community connections or capacity where they do not exist.

Local Area Coordinators also work in a truly integrated way. They are able to navigate across services and organisations to find solutions and overcome barriers that prevent people reaching crisis point.

In keeping with our model of distributive leadership we have moved the LAC team in to a self-managing model with a single coach overseeing the team.

This has proved a highly effective and an efficient model since its inception a couple of years ago; streamlining the structure from having one manager and two deputies, thereby losing two management posts with no reduction in performance.

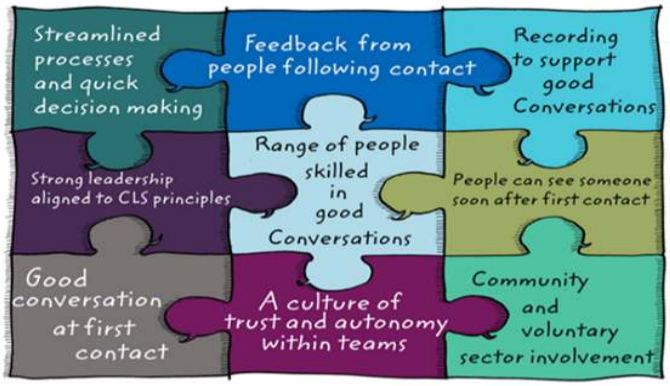
Community Led Support

Community Led Support (CLS) is an approach to social work that means that social work teams provide a coordinated response building networks with other professionals within a specific locality so that they can be mobilised to provide a joined-up response and not a response that purely considers adult social care needs. Teams are based in the community and aligned with the four Primary Care Network (PCN) areas and work solely within their locality out of a number of different community settings.

The approach representatives a radical departure from traditional social work models based on assessing deficits and prescribing pre-commissioned services.

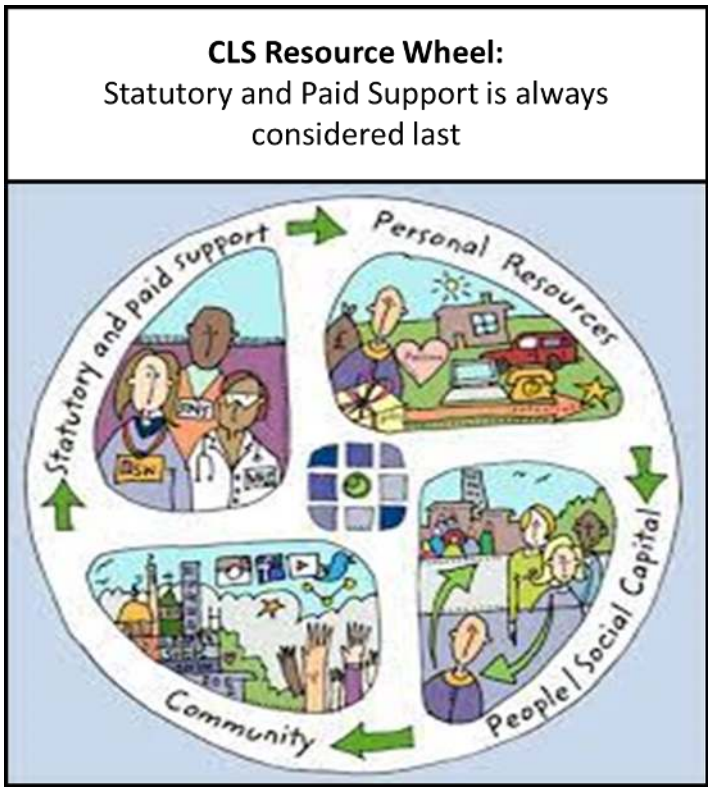
We challenged social work teams to reimagine how they worked and the processes required to support them, based on CLS principles shown in figure 7.4. This helped professionals to start to make the shift from providing automatically prescribing a pre-commissioned service, to providing wide ranging solutions that are tailored to the individual.

Figure 7.4



The use of a resource wheel helped professionals to consider a multitude of options before considering statutory and paid support.

Figure 7.5



CLS has been extremely successful with numerous case studies showing how people have been effectively supported in a different way. Early successes have included reduced waiting times, improved access – with regular 'drop in' sessions being organised close to where people live, and working with other professionals and organisations in the area, including community-based groups and the Voluntary Sector, to develop innovative and streamlined ways of delivering what people required and how they required it.

The success of the pilot has led to teams being implemented in each of the four Primary Care Network (PCN) area, providing Borough-wide coverage. The learning from LAC and CLS has provided a blueprint for redesigned local integrated care and support.

Approaches such as CLS do not rely on thresholds and eligibility before they help someone. They identify what the person requires to live a good life, and in doing so, they help to put in place a plan that focuses on preventing that person's health and wellbeing from declining.

Both CLS and LAC initiatives have shown the power of place based working and of taking time to have conversations with people that focus on what matters to them. This has led to very different solutions being developed, many of which have prevented and reduced the need for services or helped to reduce the reliance on a service response. In addition, the impact on staff morale has been significant, with staff enjoying the trust invested in them to make the right decisions and the freedom to develop innovative and impactful solutions. Thurrock has an excellent record of retaining staff and of recruiting new staff members who have joined the Authority as a result of what they have heard about the approach Thurrock has implemented.

Technology Enabled Care

We have introduced a model for the use of technology within our communities that builds on the principles of recognising and promoting individual and community strengths, early support and prevention of need arising, improving accessibility by reducing bureaucracy, and fostering innovative thinking and practice across statutory services and community organisations.

For the last few years, practitioners in Thurrock have been encouraged to view technology, in its widest sense, as both an enabler of independent living and an approach to support individuals to achieve their goals and aspirations.

Social Care practitioners are able to explore and support access to an identified technology solution from a conversation, rather than leading an individual through a formal assessment processes. Access to support will be quicker, and will be supported where the rationale for support can achieve the best possible outcome for the individual; even where eligibility may not be satisfied, and reduces or delays the need for both formal and informal care in the future.

This does not prevent individuals from being able to access more complex or expensive technology solutions, with practitioners still able to directly commission these following a simple and quick approval process via team managers, or in the case of very complex or expensive solutions, via the Principal Occupational Therapist in Adult Social Care.

An information suit and package of training has been developed, and has been rolled out to many practitioners. A practitioner led group has also been established, which together cultivates trust and empowers staff to access and self-approve the provision of reasonably priced technology solutions.

The new principles and processes have been in place for some time for core social care teams, and the adoption of this model continues to evolve. There is a desire to improve accessibility and promote technology further through place based Community Led Support and an integrated approach to supporting local communities. This will enable housing officers, health partners and eventually wider community teams to support individuals to access technology solutions.

There is an emerging evidence base showing that this change can deliver better outcomes, increased independence and cost savings; especially through the use of exciting technology such as "Brain in Hand", and with greater awareness and accessibility, these can be realised sooner.

Primary Care Networks and Enhanced Primary Care Teams

Primary Care has suffered locally from acute capacity shortages. Responding to this led to the creation of enhanced teams operating within and around four locality-based Primary Care Networks (PCNs). Enhanced teams are made up of posts such as paramedics, pharmacists, assistant physicians and physiotherapists. PCNs started to bring professionals together, working at place and sharing both knowledge and resource. Through the development of PCNs, professionals have been able to better understand the area they serve and the issues faced by the local population. The development of and learning from PCNs in Thurrock has helped the workforce start to organise themselves in to locality-based health and care system networks – ensuring that the whole system can provide an integrated and coordinated approach that is responsive to the requirements of local people.

Mental Health Service Transformation and the Mental Health Integrated Primary and Community Care Locality Model

Mental illness is the single largest cause of disability in the UK and a major driver of health inequalities. In response to Thurrock's Adult Mental Health JSNA, LGA Peer Review, and extensive community engagement research led by Healthwatch Thurrock, we have piloted a new integrated model of holistic mental health care embedded within PCNs.

Our analysis of the historical model of mental health service delivery showed that of the circa 2,000 residents a year receiving secondary care services, 65% of need was related to social as opposed to clinical demand. The majority of these patients had a diagnosis of Personality Disorders. A high proportion who received a referral to EPUT from Primary Care were discharged back into the care of their GP as they failed to meet threshold criteria. Consultant Psychiatrists routinely questioned the need to keep people on caseload when they are receiving little medical intervention. This was inefficient for the system and bad for residents.

We also identified a cohort of residents whom we called *'the missing middle'*, too unwell to be treated within Primary Care or by IAPT but not unwell enough to receive a secondary mental health care service. They were often left without adequate support and were high users of A&E.

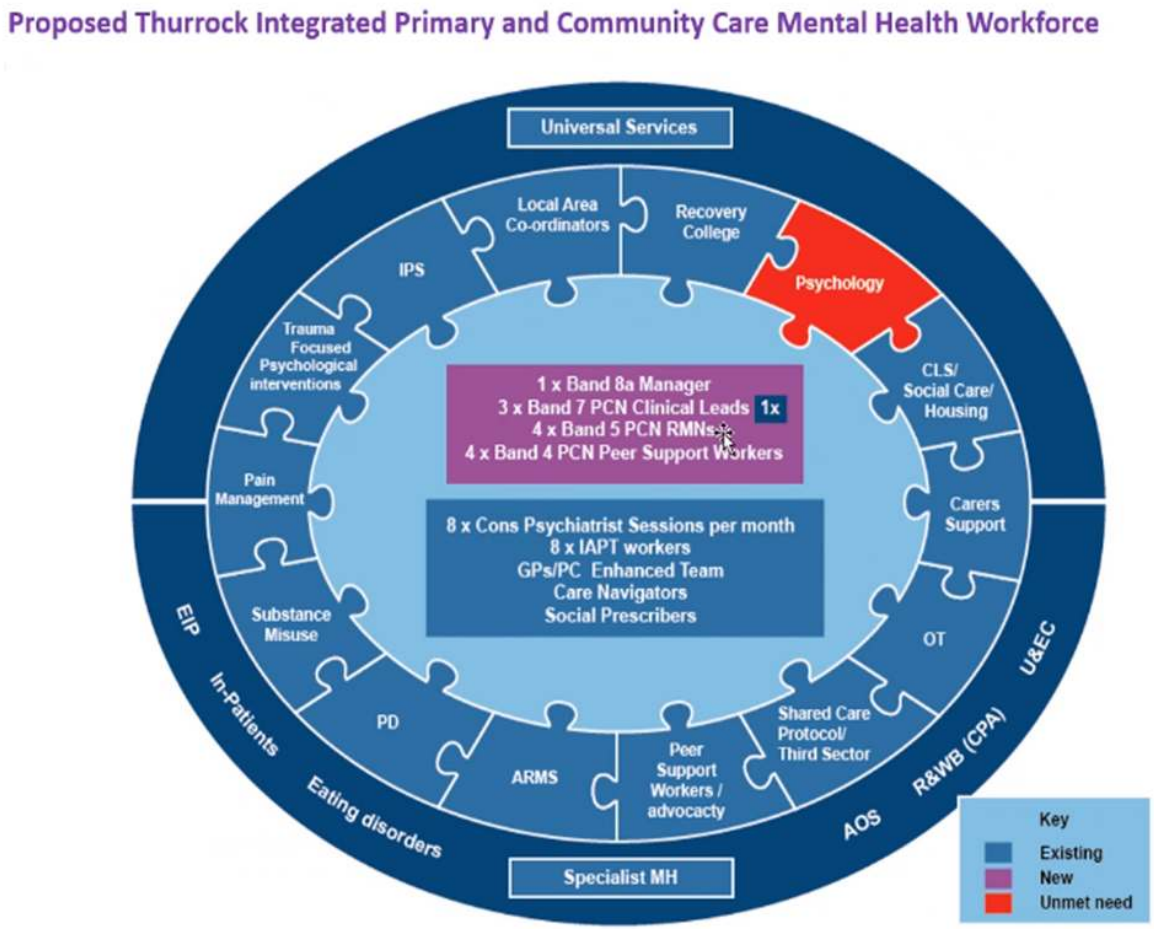
Practitioners such as social workers and LACs often felt frustrated as they would often be a point of contact for people defined as the 'missing middle' but would be unable to help until people were ill enough to meet the thresholds in place. More broadly, we recognised that the way mental health services had been organised left residents with a service that was difficult to access, fragmented and that focused on only bio-medical aspects of treatment.

Through an extensive process of co-production, we have transformed and completely reimagined how we deliver mental health services through an Integrated Primary and Community Care Mental Health service offer at PCN level. The process brought together clinicians from primary and secondary care, users of services, carers and families, the voluntary sector organisations, public health specialists and commissioners from both NHS Thurrock CCG and Thurrock Council.

The new model has focused on:

- Developing a seamless offer for those who need more support than primary care would provide but don't meet the thresholds for secondary care,
- Defining care packages to meet the needs of those in Outpatient caseloads to enable clinically safe transfer of care to the Primary Care Network Integrated Mental Health Teams with an embedded step-up and step-down function with a particular focus on psychological interventions,
- Releasing capacity for the consultants to provide additional support to the Primary Care Networks and develop a more therapeutic service offer for those with complex needs ensuring quality specialist and personalised care.
- Developing a holistic offer that allowed wider determinants of mental health such as housing and employment to be addressed together with the positive role that social and community connections can play in recovery.

Figure 7.6: Our our new model of care.



The model consists of a core specialist mental health team within each PCN consisting of specialist psychiatric nursing support, mental health practitioners, peer support workers, IAPT workers, care navigators, with additional clinical supervision and clinical in-reach from Consultant Psychiatrists. Around this sits a comprehensive array of additional support services from which input can be brokered.

As part of the transformation approach, a number of Mental Health Nurses have been employed to be part of each PCN, establishing relationships with professionals working within the local area and ensuring that mental health is both holistic and also integrated within health and care.

The new model provides a holistic and integrated service that blurs the previous hard referral boundaries between primary and secondary care, providing specialist support to practices, holistic support to residents and reduces the number of onward referrals and fragmentation within the previous system.

Having successfully piloted the model in one PCN, we are currently in the process of rolling out to all four at pace.

Dementia Friendly Communities

People with dementia and their family carers want to be able to do everyday things in their community. It is important to them to continue to go to the shops, socialise, access leisure and outdoor spaces and feel confident to use transport. However, due to concerns around stigma and misunderstanding, people with dementia often withdraw and lose the confidence and ability to live the life they want.

Fewer than half of people with dementia feel a part of their community and this becomes lower the more advanced a person's dementia is. 9% of people with dementia have stopped doing everything they did within their community before their diagnosis.

One third of people with dementia say they are lonely, and a quarter of carers of people with dementia say they have become 'cut off' from their community.

With the predicted increase in people with dementia in Thurrock, it is imperative that Thurrock becomes a community where people with dementia, feel valued and understood. This will not only improve wellbeing but delay the reliance on expensive statutory services. Due to the asset and strengths-based approaches in Thurrock, we have firm foundations on which to build a more inclusive community, ensuring that a person with dementia and their carers live a good life,

Thurrock has reenergised its Dementia Action Alliance and is hoping for reaccreditation this year. A wider group of stakeholders, from care, health, police, fire, community and voluntary services, retail have come together to take action to remove the stigma and ensure people with dementia and their carers remain a part of their community rather than lonely and isolated (loneliness has even further impacts on health and wellbeing.

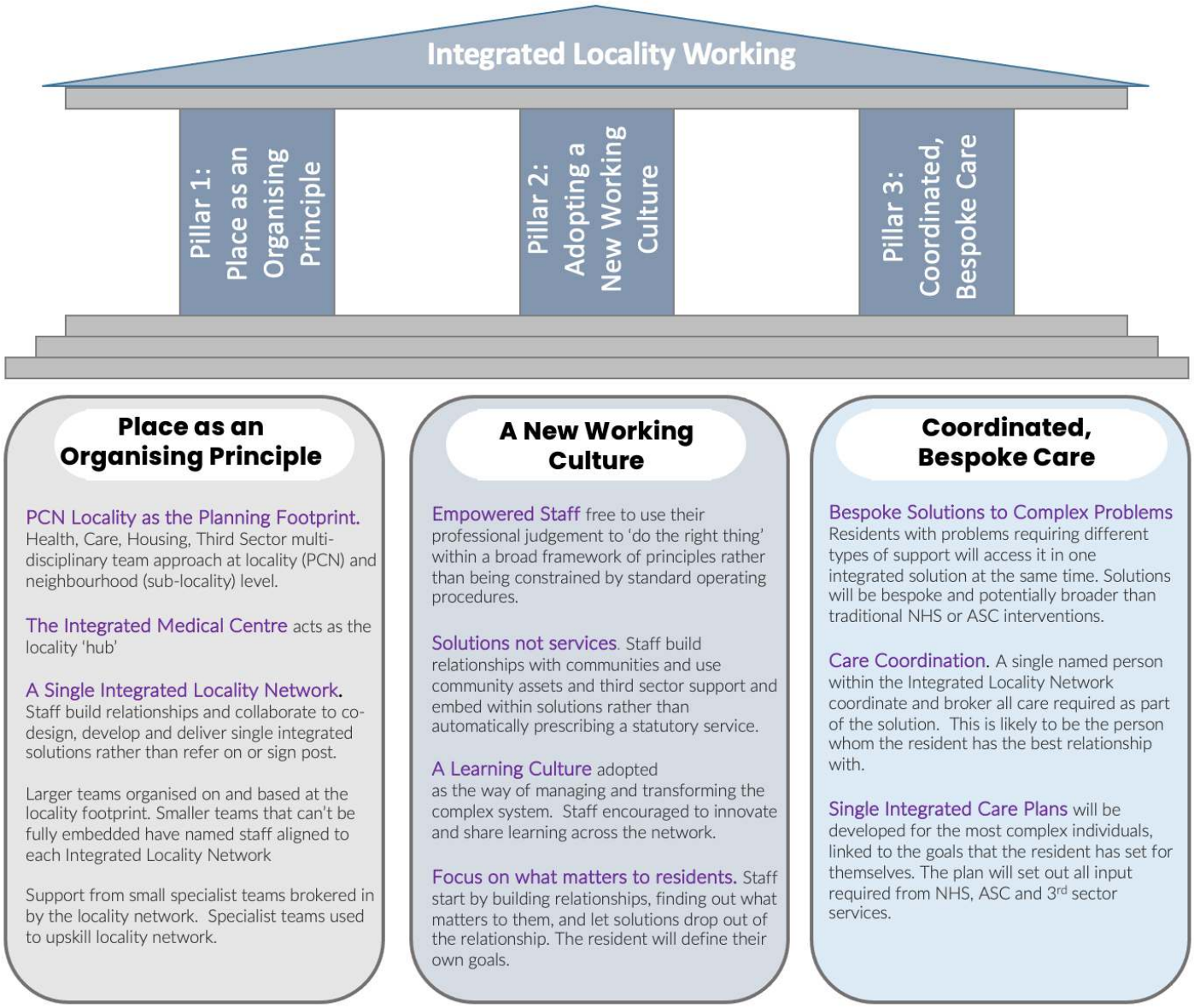
7.5 Further Locality Based Transformation: Integrated Locality Care and Support

Our plan is to focus on expanding and joining up the work we have tested, applying our learning to developing an integrated and coordinated health and care model that wraps around each Primary Care Network and core services delivered by GP practices. The model will operate in line with the principles discussed in chapter 2.

7.5.1 The Three Underpinning Pillars of our new Locality Model

Our model for integrated care and support will be underpinned by the three key pillars set out in figure 7.7 based on our learning to date and the values and principles set out in Chapter 2.

Figure 7.7



7.5.2 Further Transformation – Phase I (first 18 months): Locality Working and Integrated Locality Networks

We envisage the transformation from the current system architecture to integrated locality teams occurring over two phases. We estimate the first phase taking 12 to 18 months during which we will further develop our existing locality architecture and create a single *Integrated Locality Network* of professionals who will be able to collaborate more easily and effectively with each other.

Our overall aim will be to embed the maximum amount of care at locality and neighbourhood level within a multi-disciplinary network of staff who can collaborate to design integrated solutions with residents rather than make onward referrals.

Community Led Support

We will expand the functions of CLS teams to include the current discrete Adult Social Care Complex Care, Reviews and Mental Health team functions. Through further testing, we will seek to encompass other functions within CLS, for example housing, mental and community health colleagues and LACs. Work will also take place as part of phase I to integrate further the role of CLS within the out of hospital care pathway and ASC hospital team.

Drug and Alcohol Treatment

As the first case study of Owen demonstrated, the way we have commissioned drug and alcohol treatment services in the Borough historically as a separate service accessed through a different referral pathway inhibits other resident-facing staff from delivering integrated solutions.

Moving forward, we will recommission an integrated treatment service with drug and alcohol treatment and outreach workers aligned to and operating within Community Led Support teams, with assertive outreach and timely access to treatment for those with the most complex needs.

Integrated Community Teams (ICT) Community Nursing Teams

Our ICT Teams currently operate across Thurrock but we recognise the value of aligning this resource both at PCN/locality level and into our Wellbeing Teams (discussed in detail in Chapter 8) in order to integrate their work with all elements of health and care.

In order to facilitate this integrated locality based working model, we have recruited two senior nurses to work with PCN localities to identify how ICTs can shift to a locality-based operation and how existing ways of working will alter – for example working alongside care providers to deliver blended roles and to enhance knowledge and skills and working as part of an integrated locality network.

The learning from this initiative will be incorporated within the next phase of transformational activity.

Older Adults Wellbeing Teams

NELFT's Older Adults Wellbeing Team provides a wrap-around service for frailty both within the home and to care homes. The service undertakes Comprehensive Geriatric Assessments (CGAs), and provides falls prevention.

There is strong evidence of the significant impact that community based CGAs and community geriatrics teams can have on improved outcomes for older people, maintain independence, and prevent failure demand and need for higher cost care services as shown in the box below. If a new drug that could deliver the same impact were brought to market, there would be a population wide clamour for approval of its use and availability.

Impact of Community Geriatric Teams

Researchers from the University of Minnesota studied 568 men and women over the age of 70 who were living independently but at high risk of becoming disabled because of health problems, recent illnesses or cognitive changes. With their permission, they assigned each person to one of two groups: those who would continue to receive standard medical care, and those who would receive care from a dedicated team of geriatric nurses and Consultant Geriatricians.

Within 18 months, 10% of both groups had died. However, patients receiving care from the Geriatrics Team were a quarter less likely to become disabled, half as likely to develop depression, and 40% less likely to require adult social care services.[4]

The service currently operates on a Borough-wide level. We will prioritise expanding the capacity and reach of this service through future growth funding and through re-investing savings from prevention and seeking to align it to the four Integrated Locality Teams.

Long Term Conditions (LTC) Management Clinics – Diabetes, Respiratory and Heart Failure.

These three discrete teams currently receive referrals from Primary Care and other community professionals of more complex patients and undertake direct management, patient education and self-care advice (including Pulmonary Rehabilitation), prescribing advice and medicines review, and in the case of the respiratory team, oxygen therapy. They are currently organised on a South West Essex level.

We will seek to align capacity within these teams to the Integrated Locality Networks, and transform care to be delivered as part of the PCN Long Term Conditions Management services set out in Chapter 6.

Dementia Crisis Support Team.

This team supports those in the community with dementia, offering initial support, occupational therapy, and supports early discharge. It is currently organised at South West Essex level. We will seek to integrate it fully within the Integrated Locality Network. We are also using an Asset-Based Community Development approach to introduce dementia friendly communities.

Virtual Wards

Phase I will see the testing of 'Virtual Wards' in Thurrock (respiratory and frailty Virtual Wards will be tested initially). The initiative will see people with urgent care needs (high levels of acuity) being treated and supported within their own home. People who are part of the scheme will be monitored daily by a multi-disciplinary team against goals that are personal to the individual. The Team will be overseen by a consultant.

Learning from Virtual Wards will support the development of other schemes such as Wellbeing Teams and CLS and will help to ensure that the acute sector is part of any community-based integrated care and support model.

Integrated Primary and Community Care Mental Health Teams and Open Dialogue

In 2021, Thurrock Council moved its team of Mental Health Social Workers from Grays Hall to work within the community on the basis that this would allow them to deliver a more strengths based and holistic approach. The Team will integrate within CLS teams and the new IPCC model of care within each PCN.

Open Dialogue is a social network approach to support and treatment for residents experiencing serious mental ill-health and crises that also includes family members, friends and others who are concerned. It was developed in Finland in the 1980s and is being piloted in other areas of the UK at present and is summarised in the box to the right.

Open Dialogue is an approach that very much reflects the principles of our health and care redesign being that it is a) strength-based; b) shifts away from a 'clinical' view of treating the person; c) is holistic – in that it features the wider determinants of health and wellbeing that may impact the individual's ability to achieve a good life; and d) is person-led.

We will also work with the Mental Health Social Workers and other professionals within the IPCC model to test an Open Dialogue approach, initially within one of our four localities.

Open Dialogue Approach to Treating Residents with Serious Mental Ill Health

Open dialogue shifts the conceptualisation of mental ill-health from something that is going wrong in the brain, to something that is going wrong in the space between the patient and their environment. The approach operates by providing a team of two or three trained therapists who meet the person in crisis within 24 hours of first contact, daily until the crisis is resolved.

Hospitalisation is rejected on the grounds that it is an untherapeutic environment, and people are usually treated within their own home. The use of anti-psychotic medication is also avoided wherever possible.

The same team of therapists work with the person in crisis throughout the intervention and the family and friends of the resident are also encouraged to participate.

The main purpose of meetings are to encourage dialogue between the person in crisis, their family and friends and therapists, giving a voice to all concerned, putting the person in crisis at the centre and letting solutions emerge from the conversations. Broader holistic therapies and support are also offered including employment support, individual therapy and occupational therapy.

Mental health experiences are understood as something (usually traumatic or stressful) for which there has been no language. Over time, a shared meaning is developed that establishes a context for those experiences and bespoke solutions that aid recovery.

The results of follow up studies have been remarkable, for example a five-year follow-up by Seikkula et al.[5] found that compared to standard care, the Open Dialogue approach delivered:

- A decline in DUP (duration of untreated psychosis) to three weeks
- Two-third reduction in antipsychotic drugs
- 83% of patients in the Open Dialogue cohort returned to full employment
- Few new schizophrenia patients: Annual incidence declined from 33 (1985) to 2-3 /100,000 (2005)
- Almost no usage of mental health in-patient secondary care beds.

Care and Support in the Home

Our model for transformed home care is set out in Chapter 8, based on the same principles set out in this chapter.

Housing Solutions (Allocations, Registrations, Homelessness Prevention)

The Housing Solutions service is responsible for preventing homelessness as a priority, and relieving homelessness when homelessness cannot be prevented. They are also responsible for reducing and ultimately eliminating rough sleeping within the borough. Overall the service seeks to understand the challenges and complexities around homelessness today, the impact on families and single people, as we seek to ensure that Thurrock residents are catered for. They support residents threatened with homelessness by agreeing personal housing plans; taking action to prevent them from becoming homeless and where this is not possible, identify alternative accommodation before the eviction takes place. They also provide employment advice and casework and work with external partners such as Friends of London, Essex Homeless, Beam and Open Door.

Allocations staff within the *Housing Solutions* function administer the process of matching those eligible for council properties with suitable stock and support people who need to move when their current property no-longer meets their needs.

We will align named staff from the Housing Solutions function into each of the four Integrated Locality Networks to allow housing need to be more easily addressed as part of single integrated solutions.

Estate Services

Estates Services Teams are responsible for reporting of repairs and maintaining the cleanliness of both internal and external areas of estates, signposting residents to appropriate services.

Estates Officers have a unique and often detailed understanding of the needs of residents. They are in an excellent position to work in line with locality model principles and we will align them to the Integrated Locality and Neighbourhood networks.

Tenancy and Neighbourhood Services

The Tenancy Management Team is responsible for managing General Needs Tenancies, resident engagement and neighbourhood inspections on Housing owned land without a caretaking service. The Team support residents in maintaining their tenancies/ licences in a prompt and proactive way including sheltered housing provision. This includes undertaking property audits, signposting residents to other services and presenting cases to a range of panels to ensure they are adequately housed and supported in line with their needs.

Tenancy Management Officers currently work on a patch basis. They report to three area managers: Central, East and West. This team is well poised to align their working to the locality model and start delivering services within the localities in greater partnerships.

Private Sector Housing Team

This Team is responsible for keeping private sector housing conditions under review for improvement and provides support and advice to residents and landlords. This includes landlord/owner occupier liaison, improvement grants and loans, housing enforcement, tackling rogue landlords, licensing houses of multiple occupation/caravan sites and supporting the wellbeing of residents and helping save energy in their homes.

A Well Homes Team, which forms part of the Private Sector Team (manager and 3 officers), works in a way that can easily be aligned to the Locality Network model.

Blended Role Test and Learn Small Scale Pilots

We will use HLS principles and methodology to understand the most appropriate generic functions that could be better combined into single blended roles. The two case studies below demonstrate how Gateshead and Plymouth have achieved this

We will undertake a similar 'test and learn' HLS approach in Thurrock, creating a two or three dedicated multi-agency teams with small caseloads of specific categories of high intensity service users or complex individuals, likely to be homelessness, repeat hospital admissions and mental health supported housing. These will take place with the support of the Human Learning Systems network.

Plymouth's HLS Approach to Residents with Complex Needs

Plymouth Integrated Care Partnership, through a process of appreciative enquiry with residents and staff, noticed a significant overlap between residents with mental health problems, addiction problems, homelessness and offending. However the system responses to these issues sat in four different discrete teams/organisations, each with their own specialist staff, commissioned separately.

Through a similar HLS approach, they were able to create a new "Complex Needs Specialist" role, with competencies to undertake the most common value activities in all four functions, commissioned from a single pooled budget.

The approach saw significant reductions in overall drug and alcohol treatment costs, a 90% improvement in drug and alcohol DNA rates, improved outcomes and a significant reduction in 'failure demand' from this cohort of residents in other high cost areas of the wider system including A&E attendances and hospital admissions. Total savings of £750,000 were delivered whilst improving outcomes. These savings were re-invested in further integrated prevention work.

Gateshead Council's HLS Approach to Create Community Case Worker Blended Roles

Gateshead Council used HLS to imagine their system response to debt. They identified a cohort of residents with the highest levels of council tax debt and used this debt level as an indicator of other wider problems. Rather than responding in a traditional 'New Public Management' process way of sending letters, court action, bailiffs and evictions, they formed a multi-disciplinary team consisting of a council tax officer, housing officer, a DWP worker, a CAB worker and mental health worker. The aim of the team was to build a relationship with each family and co-design a solution to their debt problem.

The team were given two high level boundaries in which they must operate - 'don't break the law', and 'don't do any harm', and some high level operating principles:

- Don't assess people
- Start by building a relationship in order to understand the problem
- Make decisions with people not to or for people
- Do not make any onward referrals. Broker expertise into your team if you need it.
- Capture the learning including the current barriers in the system that are preventing you solving the problem

By mapping their learning, the MDT was able to identify barriers where the wider environment prevented them solving residents problems, for example a housing policy determined that they should evict a tenant in rent arrears, but the underlying problem was the tenant's unsolved mental health problem. This allowed wider action to be taken to transform and address systemic barriers.

They also mapped the frequency of 'value activities' - those actions that helped solve resident debt. From this intelligence, they were able to create a "Community Case Worker" blended role with the skill mix to undertake the most frequent 'value activities'. These included the ability to process Universal Credit Applications from start to finish, make housing allocation decisions and provide mental health and debt advice and support.

The pilot concluded that up to 90% of benefits awarded to the cohort had been incorrect. In addition, 70% of people supported by the team reported that their life was better and their was between a 60-90% reduction in demand for wider services in those whom the pilot supported.

Creating Single Integrated Locality Networks to Drive Transformation and Integration

Building and further developing our existing strengths based provision at locality level around PCNs is only the first stage in the process. In order to deliver integrated care, we also need to ensure collaboration and integration between the teams. We see three primary mechanisms to achieve this:

1. Integrated Medical Centres (IMCs)

Four IMCs are planned in Thurrock, one per PCN locality, with the first at Corringham on track to open in July 2022, followed by IMCs for Corringham and Tilbury in 2024 and Grays in 2025. Each IMC will act as the 'hub' for provision of integrated services at locality level and will provide a wide range of community and mental health, care, diagnostic and outpatients services together with space for third sector groups and organisations to operate from and in the case of Tilbury, the library and Tilbury Community Hub. At least one of the existing GP surgeries within the locality's PCN will operate from the IMC, but all other services within each IMC will be available to all residents with the locality, and in many cases, Borough wide.

We see the IMCs as critical to replace ageing existing estate, attracting the best workforce to Thurrock and as a footprint in which front line clinical and resident facing staff can be empowered to deliver further transformation and integration of services.

Once launched, how the buildings function will continue to evolve, constantly reflecting the requirements of the local community. We will use *Local Communities of Practice* and the *Community Reference and Investment Boards* set out in Chapter 4 to ensure that this evolution reflects local interests and the views of residents and staff.

2. Integrated Locality Networks through Communities of Practice (CoPs)

A key aim is to ensure that our health and care workforce can see themselves as part of one locality 'team' regardless of who employs them or what they have been employed to do. We want our staff to work under the same culture and to be united by the same vision and aims, in particular helping to ensure that local people are supported to achieve or maintain what matters to them.

Whilst a change of culture will take time to achieve, there are key steps along the way. Most health and care staff involved in providing community-based care will do so on a locality basis and place themselves within a locality.

Teams will work together as part of a single *Integrated Locality Network*. This will be developed through relationship building, but also through the development of practitioner-based communities of practice who will meet to information share and problem-solve. Staff will be enabled to work across organisational boundaries so that integrated solutions can be developed ensuring the reduction of hand overs and cross-referrals to other services. The first practitioner community of practice will be tested during 2022.

We will also undertake a review of current IT provision including access to and permissions within *SystmOne* in order for staff to more easily view and share information related to the provision of care. Intelligence from our GPs suggests that current restrictions in SystmOne mean that existing teams can only view elements of patient records pertaining to their current team task. This is in duplication of task requests being raised in *SystmOne* by different teams for the same patient, causing unnecessary additional workload and potentially wasting time and resources.

3. Care Coordination and Single Integrated Care Plans.

Delivering genuinely integrated and bespoke solutions to residents may require input for many different elements of the NHS, council and third sector. For complex patients this requires the development of single shared care assessment and planning and excellent care coordination. In Phase I, we will develop and test a single process for assessment and single care plan for residents with complex needs, together with a named care coordinator. The work will link to the HLS pilots as some care coordination will take place through the development and testing of blended and generic roles (see next section).

Whether a specific 'care coordinator' role is required will also be reviewed, but if the starting point is the individual rather than their 'need' or 'condition', we envisage that an integrated and coordinated way of working across functions should enable any one of a number of professionals to undertake the role, with the most appropriate person likely to be the individual who has most contact with the resident. We also discuss care coordination and Single Integrated Care Plans in the context of home care and Wellbeing Teams in the next chapter.

Figures 7.8 (the current service landscape) and Figure 7.9 (an Integrated Locality Model) overleaf demonstrate and summarise the change we want to see at the end of Phase I. There will be fewer teams, and the vast majority of those teams will either be embedded within the Integrated Locality Network, or aligned to it, delivering integrated care at locality or neighbourhood level. Where teams remain separate, care will be brokered by the locality.

Figure 7.8

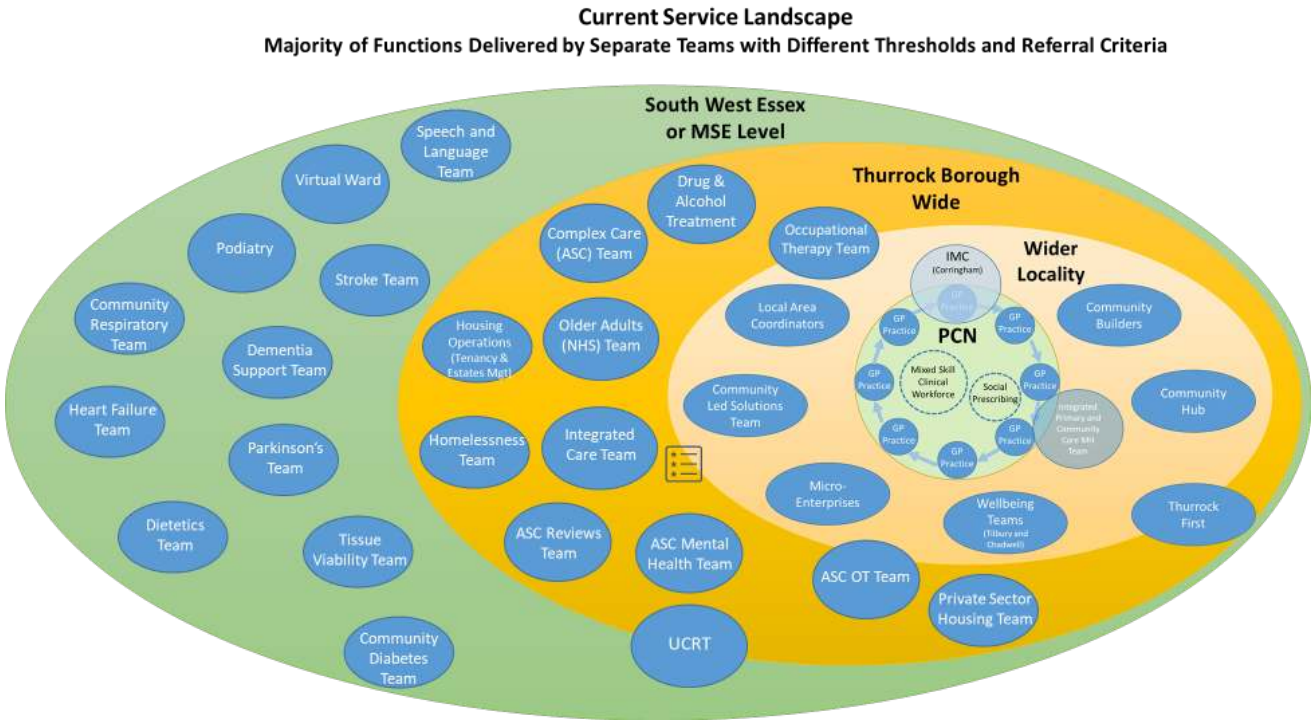
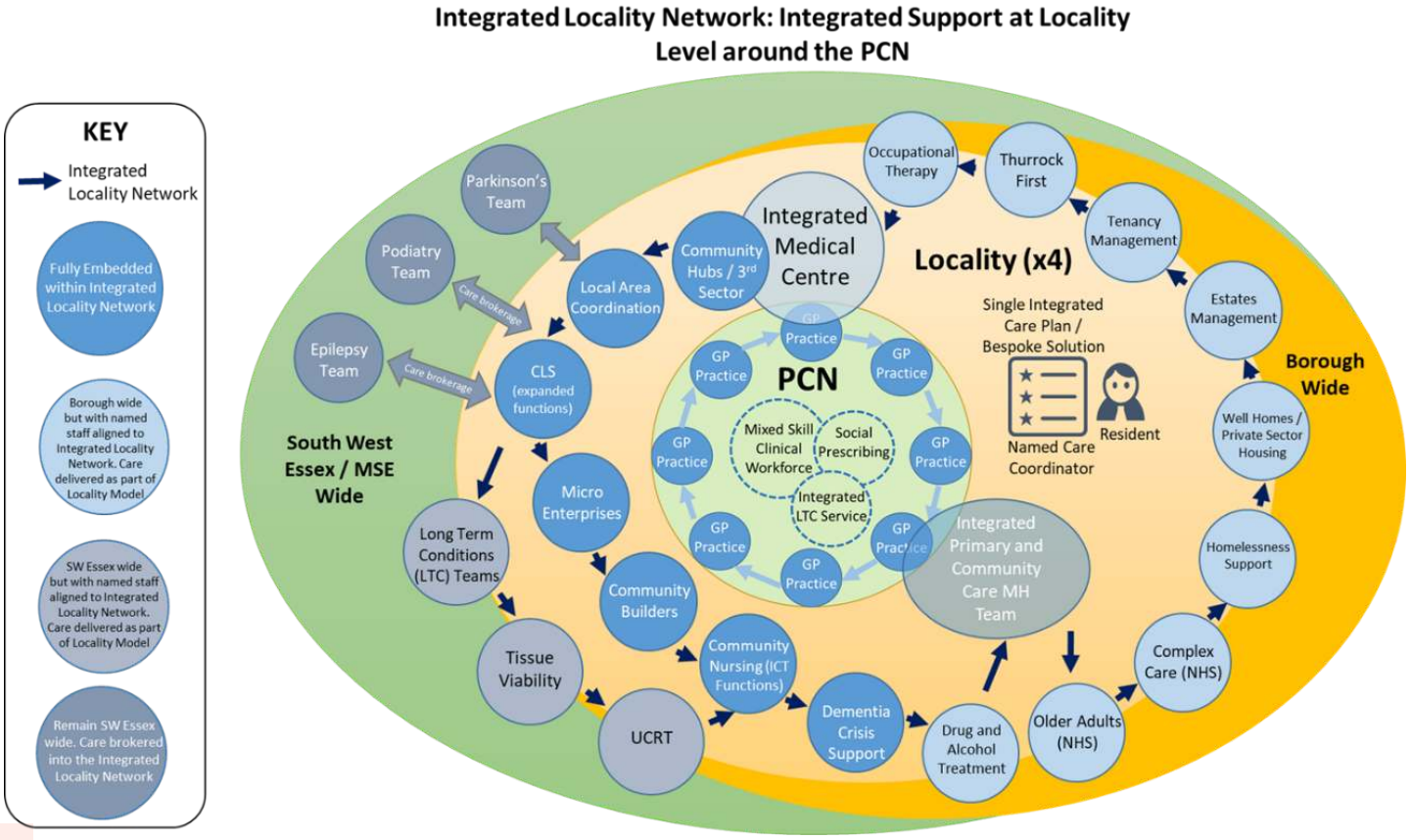


Figure 7.9



7.5.3 Phase II – Further Transformation – Phase II (18 months onwards)

In Phase II we will build on learning from the small scale pilots of Phase I to move from collaboration through the Integrated Locality Network to develop genuinely new blended roles that can deliver a range of common functions currently delivered by different professional roles and organisations, in order to minimise the different numbers of teams and individuals that need to be involved to co-designing solutions with residents.

We will seek to align commissioning, governance and resources at locality level and create single locality or place budgets from which all locality provision is commissioned. This will allow savings from prevention of failure demand to be re-invested in more prevention, creating a virtuous positive feedback loop.

Phase II will also see the establishment, following the testing and learning from Phase I, of a fully locality-based (around each of the four PCNs) integrated and coordinated health and care system. Key elements will include:

- Coordinated and integrated plan of support for those who require it – following any point of access;
- Support plans include a mixture of resources – focusing initially on what is available within the community and only considering formal services once all other options have been exhausted;
- One professional to have oversight for coordinating support when coming from numerous sources;
- Establishment of a number of generic roles with the capability to provide the highest frequency 'value activities' at one time working in collaboration with residents to help solve their problems, preventing onward referral and 'failure demand'.
- All professionals having strength based conversations that focus on how best to deliver what matters to the person;
- Removal of referrals to other services operating within the locality – meaning reduced waiting times and reduction of people getting to crisis point;
- Learning culture embedded within the way staff work – via HLS approach;
- Staff within localities being able to broker specialist support easily as and when required to provide deliver bespoke, integrated care.
- Staff operating across organisational boundaries fluidly and flexibly to provide the best solutions for individuals within the locality;
- Processes for overcoming barriers and challenges to change in place as part of new system governance arrangements;
- IT systems that support the new way of integrated locality working including the sharing of information to all professionals involved in the direct care of residents.

The shape of the care and support system provided by locality will continue to evolve. The development of community engagement as described in chapter 3 will help to ensure that the system reflects what matters to local people.

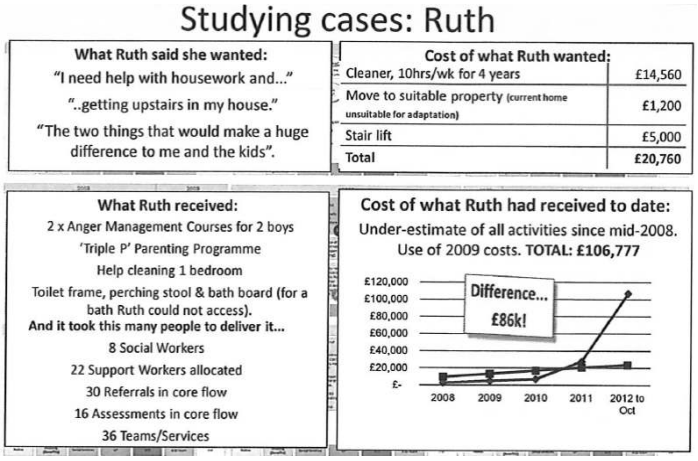
7.5.4 Impact of the Transformation We Will Deliver

The impact of the health and care system working predominantly on locality footprints in a coordinated and integrated way has already been tested. The case study is one of many examples that demonstrate the power of integration at locality level.

The case study reflects the benefit to the individual and the system of a person led and coordinated approach – following CLS and Human Learning System principles.

A more efficient system with better use of resources and a reduction in failure demand.

There are significant amounts of waste in the current system. Mapping how the current health and care system responds to people shows extremely high levels of bureaucracy. For example, Hillary Cottam (Radical Help) mapped the involvement of Public Service with one 'complex' family and showed that up to 80% of time and resource was spent on process and bureaucracy, with only 20% of time spent on direct support. Cottam's challenge to the system was to reverse these figures, so 80% of time and resource was put to good use. The case study below reflects Cottam's observations.



Designing the system around what matters and enabling staff to work in a way that responds to what matters focuses on removing waste and focusing on what adds value. As the last case study demonstrated, the actions of one individual working with the person to have a good conversation and finding the right solution to deliver what mattered to the individual resulted in significant improvement for the person. It also resulted in reduced reliance on services.

Case Study – the Impact of a New Way of Working

D was introduced to the Tilbury and Chadwell CLS Team. Her mental health had declined, she was calling emergency services several times daily, she was also calling the Local Area Coordinator, Adult Social Care, Housing, the GP, Mental Health and numerous other services. She was known to Safeguarding and she had also been arrested twice for misuse of emergency services. She had had several Mental Health assessments but did not fit the threshold. She had been referred for counselling but was not suitable. Her health had declined and she was stuck on one floor of her house and unable to get out. She had ongoing anti-social behaviour issues with neighbours. She was unable to bid for a different property as she was in debt. She was in full crisis.

A member of the CLS team went to see D and had a conversation with her. It was important to build a good relationship and gain trust. Through conversations, it was possible to understand what was important to D and how she might best achieve it. This included a mixture of formal and informal aspects to one overall solution. For example, she wanted to be able to move to a single floored property and enjoy a garden and also regain contact with her family with whom she had become estranged.

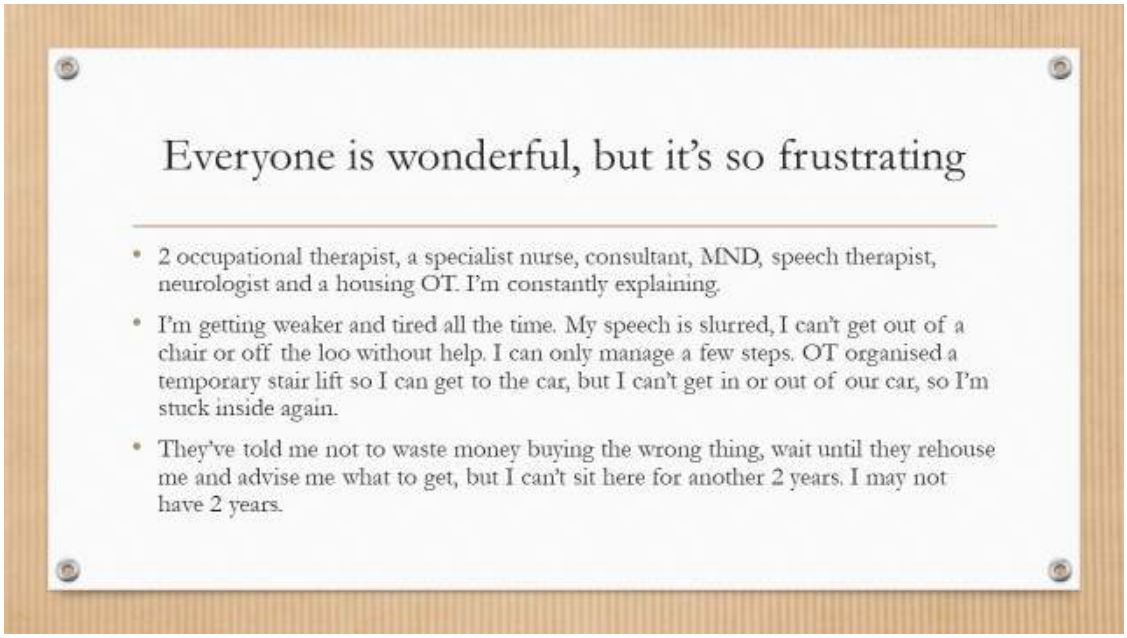
The CLS worker coordinated the response which included liaising with Housing, Mental Health and the Police. It also led to D having a personal budget which mean she could employ and choose who supported her. The solution also provided D with a contact that she could call if she felt she needed to talk to someone.

The CLS worker spoke about D's experience.

'She cried as she reflected on what a bad place she had been in when we first met and how she couldn't see it at the time, she was excited to show me around her flat and all the new things she had brought, she beamed as she spoke about plans for her garden that was her next project. She explained that her family had reached out to her and now once a week her and her sister met for lunch and are building their relationship back up.'

The Impact of failing to change

What do we achieve if we continue to do more of the same?



7.6 Our 'Ask' to Integrated Care System and Alliance Partners

1. Agreement of the principles, values and proposals set out in this chapter including the 'three pillars' of locality working

2. A review of governance and accountability arrangements to support the proposals and as protection from collapsing back in to the 'old' system.

3. A commitment to a distributed leadership approach and devolving decision making authority and accountability down to resident facing staff with freedom to act within an agreed broader principles and values framework.

4. Support of the use of the HLS methodology set out within this chapter to create genuinely new blended roles that can deliver a broader range of high frequency 'value' activities historically delivered by different organisations and teams.

5. Protecting staff when they take a risk, try something new and do not succeed in order to create a culture of innovation.

6. Support for a review of current IT and IG arrangements to create more integrated patient/client record systems to facilitate appropriate sharing of information directly related to patient/client/resident care to all involved in the integrated care of that individual

7. Support in principle of resource between organisations to create single locality/place based budgets and agreement to participate in further work to explore how best to move from current budgeting arrangements to integrated pooled budgets.

8. Agreement to pool sovereignty by organisation to create sovereignty at place and locality level

SUMMARY OF STRATEGIC ACTIONS

7.1 We will create a new Integrated Locality Network of professionals for each of the four Thurrock localities, aligned around each PCN and IMC based on the three underpinning pillars of 'Place as an organising principle', 'Adopting a new working culture' and 'Bespoke coordinated care'. (Phase 1)

7.2 We will embed the Integrated Care Teams, Dementia Crisis Support, Community Builders, Micro Enterprises, Community Led Solutions, Local Area Coordination and Third Sector Support within the Integrated Locality Network (Phase 1)

7.3 We will embed the ASC Review, Complex Care, and Mental Health Teams within Community Led Solutions. (Phase 1)

7.4 We will align borough wide Addiction Treatment, Older Adults, Complex Care, Homelessness Support, Well Homes, Estates & Tenancy Management, Thurrock First and OT Teams to each Integrated Locality Network, with named staff aligned to each network. (Phase 1).

7.5 We will align South West Essex/MSE UCRT, Tissue Viability and Long Term Conditions Management Functions to each Integrated Locality Network, with named staff aligned to each network (Phase 1)

7.6 We will integrated some of the care functions undertaken by Diabetes, Heart Failure and Stroke LTC Teams within an Integrated PCN level CVD & Diabetes Long Term Conditions Service

7.7 We will develop a Community of Practice within each locality as a mechanism through which staff can develop the Integrated Locality Network, collaborate and innovate

7.8 We will build one IMC per locality to act as a 'hub' for service integration and the Integrated Locality Network, informed by the locality Community of Practice and Locality Community Reference and Investment Board

7.9 We will seek to use specialist support from current teams in a different way, with care being brokered into and by the Integrated Locality Network rather than through on-ward referral, and specialist skills within the teams being used to upskill locality clinical capacity.

7.10 We will use HLS 'test and learn' methodology to creae new 'blended roles' upskilled to undertake care currently delivered by different teams and organisations, further rationalising the number of different involved in designing care solutions with residents.

7.11 We will design and implement Single Integrated Care Plans for the most complex individuals, with a named care coordinator.

7.12 We will prioritise investment in the Older Adults Wellbeing Functions, Comprehensive Geriatric Assessments and Frailty Support, expanding the capacity and reach of the function.

7.13 We will build on the success of the IPCC mental health model and pilot an Open Dialogue Approach to managing people with serious mental health problems in crisis.

7.14 We will implement a new flexible and holistic model of mental health supported living.

7.15 We will seek to pool funding between organisations, to create single locality/place budgets from which all services are commissioned and where savings from prevention/failure demand reduction can be reinvested.

Chapter 7 References

1. National Voices, Principles for Integrated Care. 2013 Available at: Principles for integrated care | National Voices ↑

2. Williams, E., Buck, D, and Babola, G. What are health inequalities? Kings Fund. 2020. Available at: www.kingsfund.org.uk/publications/ what-are-health-inequalities ↑

3. Thorstensen-Woll, C., Wellings, D., Crump, H., and Graham, C. Understanding Integration: how to listen to and learn from people and communities. Kings Fund. 2021. Available at: Understanding integration: how to listen to and learn from people and communities | The King's Fund (kingsfund.org.uk) ↑

4. Boult C., Boult, L.B., Morishita, L. Dowd, B., Kane, R.L. and Urdangarin, C.F. A randomised clinical trial of outpatient geriatric evaluation and management. *Journal of American Geriatric Society.* 2001. 49:351-59. ↑

5. Seikkula, J., Alakare, B., Aaltonen, J., and Holma, J. Open Dialogue Approach: Treatment Principles and Preliminary Results of a Two-Year Follow-up on First Episode Schizophrenia. *Ethical Human Psychology and Pschiatry*. January 2003. 5(3): 163-182 ↑

Chapter 8:
Integrated Support in the Home

Holistic care from fewer people

Chapter 8: Integrated Support in the Home

8.1 Introduction

The home is increasingly becoming a critically important setting in which to deliver health and care to our residents. As our population ages, a greater proportion are likely to need integrated care interventions delivered at home. The home may often be the more appropriate setting in which to deliver care:

- It is the environment in which we live, allowing care assessment and planning to take into account social and environment factors that impact on our wellbeing.
- It is the setting in which we feel most safe, and for most residents, receiving care at home is preferable and more convenient to a hospital or residential care admission
- Delivering care within the home promotes the dignity and independence of our residents, giving them maximum control over their own lives.

In this chapter we discuss the topic of integrated care delivered at home and set out our plans to transform and further integrate home health and care services based on our successful Wellbeing Teams model pilot.

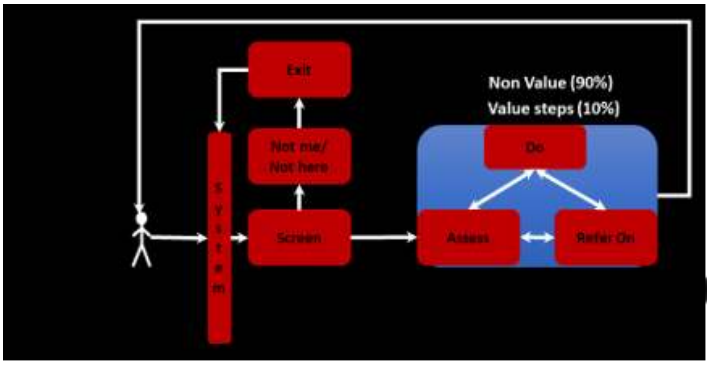
8.2 The historical approach to delivering homecare

Our existing health and adult social care home care providers have done a magnificent job in continuing to deliver care during the extremely challenging circumstances of the COVID-19 pandemic. However, the way we have historically commissioned and delivered care at home is based on a fragmented *New Public Management* time and task model that is outdated and inefficient. Health and care delivered to someone in their home is delivered based on whether the person is eligible for a particular service, with the service being designed to respond to set needs and conditions.

As also discussed in Chapter 7, this approach has led to a fragmented *'one size fits all'* response that focuses on whether someone is 'ill enough' or has sufficient 'need' to qualify for a response. Therefore if a person requires a nurse to change a wound dressing but also needs support with dressing and washing, they will be visited by a community nurse and a domiciliary care worker. If the person has recently left hospital, they may receive a re-ablement service after which their care and support requirements will be passed on to other social care and health teams; this will be after they have been assessed separately. If an individual has both physical and mental health needs, the number of assessments required and individuals to respond to assessed 'needs' will multiply further still, with physical and mental health interventions being dealt with by separate teams.

Lack of integration adds cost and demand to the existing system resulting in significant levels of 'failure' demand.

Figure 8.1



The approach builds significant levels of 'failure' demand in to the system. This means that a great proportion of the resource available is not being used effectively – or could even contribute to someone's deterioration.

Example of failure demand that exist currently within the current model of providing support in the home across different services and functions are:

- Duplication of visits and tasks;
- Carrying out the same task at the same frequency and time;
- Hand overs and referrals;
- Numerous systems (both in terms of IT and processes/policy);
- Failure to find out what matters to people means addressing or focusing on the wrong things – leads to a 'revolving door';
- Separate budgets and thresholds prevent people from doing the right thing and focus on ensuring people are sick enough or in enough need to receive care;
- Lack of partnership working and joint ownership for the person's outcomes means that everyone only does their 'bit' – meaning issues that could have been resolved are not

Led by 'conditions' and 'needs'

As we have discussed previously, eligibility criteria and service thresholds are designed to ensure that people are 'needy' or 'ill' enough to warrant a service response. Until that point, service intervention is largely absent, with little in place to support people who do not fall in to the 'eligible' category. The question of 'what matters to the person' or doing what is required to prevent, reduce and delay the person from needing a service has historically not existed. Perversely, this leads to people declining more quickly and being more likely to require a greater service intervention.

The Homecare Market in Thurrock

In Thurrock, in 2019/20, whilst health providers are relatively static and remain part of the NHS, almost 60% of residents receiving a domiciliary homecare package received it from a private sector provider with the remainder receiving a service from *Thurrock Care at Home*, the council's in-house homecare provider. Externally commissioned providers operate on low margins, care staff often receive low rates of pay, and the existing homecare provider market is extremely fragile. As a result, care providers are at high risk of handing back contracts or financial failure. Due to the nature of how commissioning takes place, larger providers with greater levels of resource are by default more likely to provide care and secure contracts than small grass roots organisations.

Most traditional systems have a process similar to the above to decide whether someone is a) eligible enough to receive support, and b) what support is available to them. That support is then supplied at the same frequency and in the same way until some form of review is carried out – and dependent upon the review, potentially another assessment or form of screening.

For each 'condition' or 'issue' that the individual has, a similar process will be carried out.

Commissioning

The commissioning function is currently delivered by organisation and by service type. This prevents health and care solutions from being integrated and focuses on contract specifications that are determined by time, task and service type rather than being able to flex to deliver an individual's goals and outcomes in their entirety. Providers are commissioned to provide the same pre-determined set package of care hours to residents each day. This allows no flexibility for the provider to respond to the varying needs of residents on a daily basis and can also result in different carers entering a resident's home on different days, minimising opportunities for care continuity and limiting provider opportunity to identify where a resident may be improving or deteriorating.

The relationship built with providers is based on formal 'commissioner' and 'provider' relationships, including contract management, which reinforces traditional delivery methods and stymies innovation.

Finance and Resource

Budgets and resource across health and care are aligned by organisation and service rather than by systems. Performance regimes and additional grant funding serves to reinforce this regime. This has made it difficult to pool monies across organisations and service areas for the purpose of achieving jointly shared outcomes. Shifting budgets so that they are pooled and focused on outcomes will enable providers to behave differently and make it easier for organisations and service areas to work together around the individual. There is a wealth of resource available with local communities that contributes significantly to the delivery of people achieving good outcomes which needs incorporating within the definition of 'finance and resource'.

Workforce

Workforce is currently recruited to respond to and deliver the current system's requirements – e.g. the delivery of tasks often at set times. The health and care workforce has rarely worked across organisational or service boundaries. Teams and services are predominantly designed on traditional structures with little opportunity for empowerment and delegated decision making.

Recruitment and retention is difficult, especially so in the care sector where pay and conditions are poor and the sector is often not seen as a career choice. Health and care organisations will often target the same people to fill posts which puts them in direct competition with each other. This is especially true of providers within the care sector – the majority of staff who leave remain in the sector suggesting that they leave one provider to work for another. In addition, care providers compete in a workforce market with other sectors like retail, which often offer staff better pay and conditions. This is exacerbating the current workforce crisis.

Processes

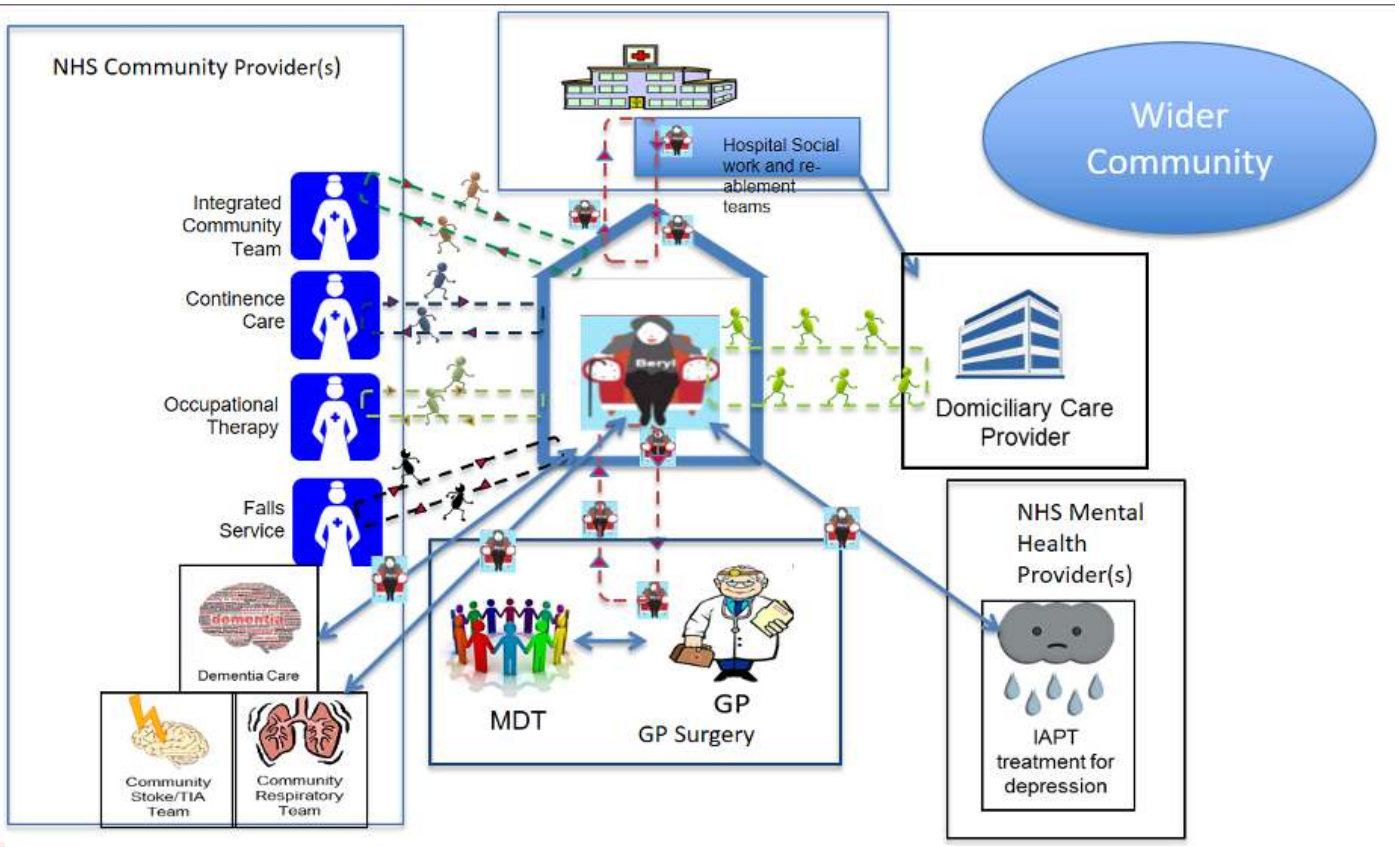
Existing processes enforce a traditional and rigid way of doing things, making it difficult for the system and individuals working within it to deliver the best outcomes for those requiring support. This includes assessments that are specific to organisations and services, referrals from one part of the system to another, performance metrics and targets that focus on throughput and output rather than outcome impact, computer systems that do not talk to one another, and budgets that are specific to that particular team remit or service. Many of the processes in place are disabling and reinforce an approach that requires significant redesign.

The current landscape

There are a number of services provided by health and care in Thurrock to people in their own homes. Due to the current system's design, people with a number of different 'needs' and 'conditions' will be in receipt of services provided by multiple professionals all working to different health and care requirements and specifications.

Figure 8.2, from a real case study, reflects the current fragmentation and duplication in the system – and the detrimental impact to the individual who experiences multiple different types of health and care staff entering her home to 'fix' different parts of her.

Figure 8.2



8.3 Our Vision for Transformed Home Care: Wellbeing Teams

An integrated, flexible and person-centred model

Our engagement work with residents has clearly demonstrated that those in receipt of homecare want a service that is flexible, treats them as a whole person, is based on long-term empowering relationships, and minimises the number of different individuals entering their home. We recognise that it is the system rather than individual services that need changing. Our redesigned system will work as one flexible entity with a focus on supporting people to achieve their version of a good life – regardless of their circumstances. Creating a system focused on people will mean that it will incorporate and respond to any aspect affecting that person's wellbeing. This means that we will have a system that extends its reach beyond the delivery of health and care and is flexible to respond to people and their different situations.

Thurrock has already developed and piloted a home support model that is flexible, person-centred and focuses on delivering what matters to the person. ***Wellbeing Teams*** were first introduced in 2019 in an attempt to deliver what we know as domiciliary care (home care) in a different way.

Wellbeing Teams operate in a completely different way to the traditional domiciliary care model, using learning from the Dutch *Buurtzorg* (literally translated as 'neighbourhood care' model). Buurtzorg is built around four building blocks for independence - based on universal human values:

- People want control over their own lives for as long as possible;
- People strive to maintain or improve their own quality of life;
- People seek social interaction; and
- People seek 'warm' relationships with others.

These values reflect and underpin how Wellbeing Teams operate.

Buurtzorg, and models like it, focus on small neighbourhood based teams (of no more than 12 staff members). They start by considering:

- What the person can do for themselves;
- What informal networks can offer; and
- What 'service' response is required – ensuring that the response if required is flexible and joins up with other professionals.

Teams are self-managed, organising themselves as required to provide the best response to the individual.

Whereas Buurtzorg models in the UK have tended to focus on 'health' provision, Wellbeing Teams provide a model based on the same principles but focus on people in receipt of domiciliary home care.

Thurrock has tested two neighbourhood Wellbeing Teams of 12 people within the Tilbury and Chadwell PCN area. Working with up to 200 hours each, they use the hours allocated to someone following initial assessment to work out the best solution for them. This means working with the individual to devise their own personal support plan – which can involve a mixture of formal and informal options and focuses on what matters most to them. For example it may mean that someone articulates that they want to continue to enjoy their garden or to connect with friends and family. Importantly,

Wellbeing Teams can work with people at all levels of complexity as all people are able to articulate and achieve what is actually important to them. Plans are reviewed regularly so changes can be made as often as is required. Their sub-locality geography allows Wellbeing Workers to develop a detailed understanding of the community assets and networks within their neighbourhood and connect their service users into them.

Because the teams are sub-locality based, Wellbeing Team workers develop a detailed understanding of the community assets within their neighbourhood and connect their service users to them. The small nature of the team allow workers to provide continuity of care and build long term care-relationships with service users, their families and the friends. This maximises opportunities for prevention and allows any deterioration to be spotted and addressed at the earliest opportunity.

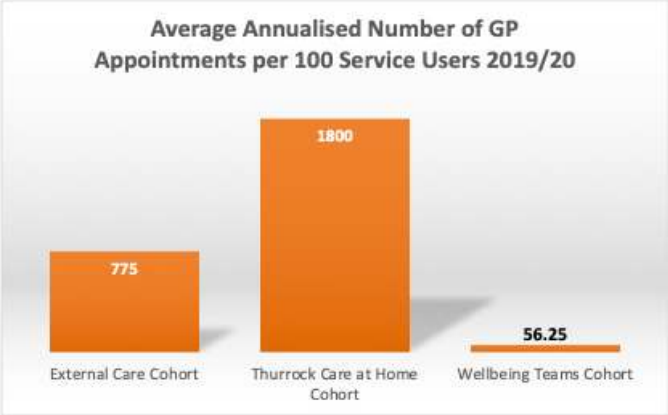
The Wellbeing Teams model also responds to the workforce challenges faced by the current care model. It employs team members on salaries rather than hourly pay, and recruits according to values essential to the role, which in doing so attracts a range of people who would not have ordinarily considered a care role (50% of staff recruited to the two Wellbeing Teams had not had a role within the care sector before).

Evaluation of Impact

Early evaluation of the programme suggests some significant positive differences in outcomes for residents receiving care from a Wellbeing Team. Using the Thurrock Medeanalytics Integrated Datalake, we tracked the care journey over the course of the year 2019/20 of a cohort of residents cared for by a Wellbeing Team with cohorts receiving standard domiciliary care services based on the historical model, from either an externally commissioned provider or Thurrock Care at Home. Residents in each cohort were matched at the start of the study on age, other demographic factors and levels of acuity.

Figures 8.3 to 8.6 show the differences in rates of GP service access, unplanned hospital admissions, average length of hospital stay per admission and excess hospital bed days per hospital admission, between the three cohorts.

Figure 8.3



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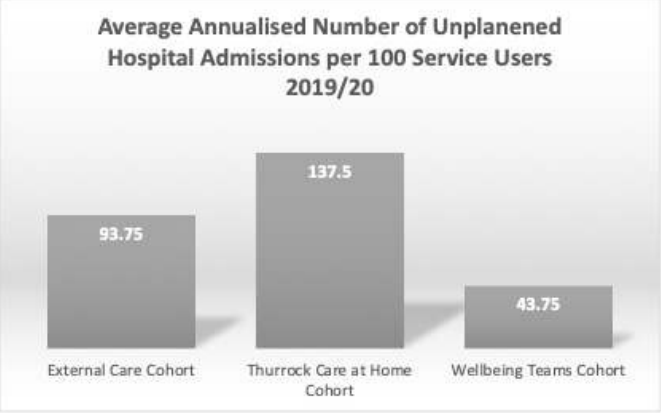


Figure 8.5

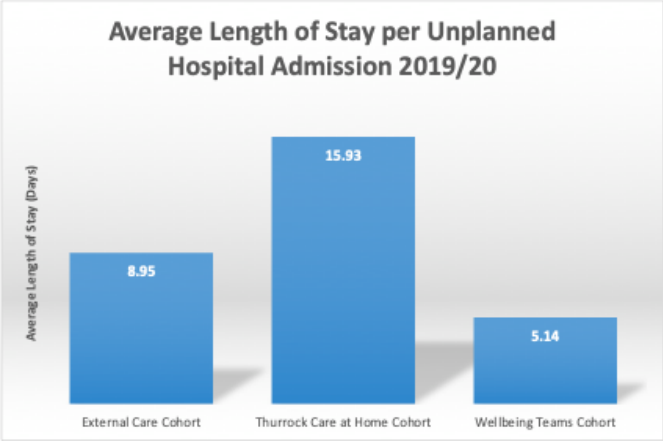
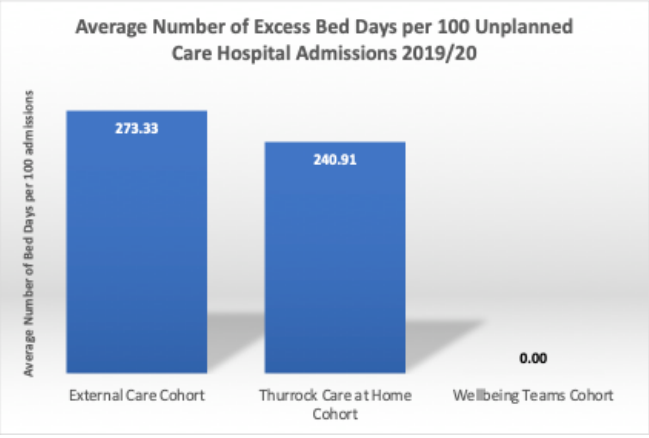


Figure 8.6



The Wellbeing Team cohort had almost a 14-fold and 32-fold lower rate of GP appointment use compared to the External Care and Thurrock Care at Home cohorts respectively. They were also three times less likely to be admitted to hospital as an emergency than the Thurrock Care at Home cohort and more two times less likely to be admitted to hospital as an emergency compared to the cohort cared for by externally commissioned providers. When they were admitted, their length of stay in hospital was considerably lower and unlike the other two cohorts, they experienced no excess bed days.

Whilst highly encouraging, some care needs to be taken before over-interpreting the potential positive impact of Wellbeing Teams compared to historical care models as the numbers in each cohort were relatively small given that the Wellbeing Teams Pilot only consisted of two teams. However, if further larger scale evaluation were to confirm these results, the positive impact, if we extrapolate them across all Thurrock residents in receipt of a domiciliary care package, is significant. Figures 8.7 and 8.8 demonstrate this potential impact of replacing historical domiciliary time and task care models with Wellbeing Teams. We have modelled the low rates of GP and hospital admission/use that the evaluation found in the Wellbeing cohort across all residents in receipt of a homecare package in 2019/20 to estimate the potential total number of GP appointments, hospital admissions and excess bed days that could be prevented and the associated costs saved to the health and care system as a result.

Figure 8.7.

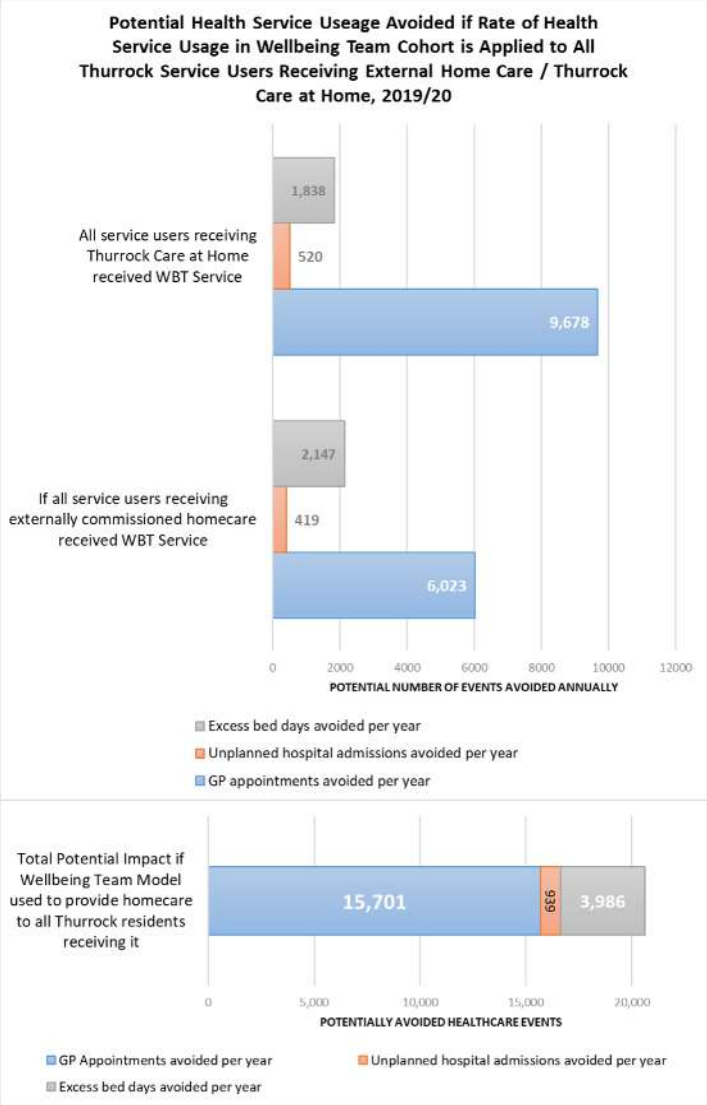
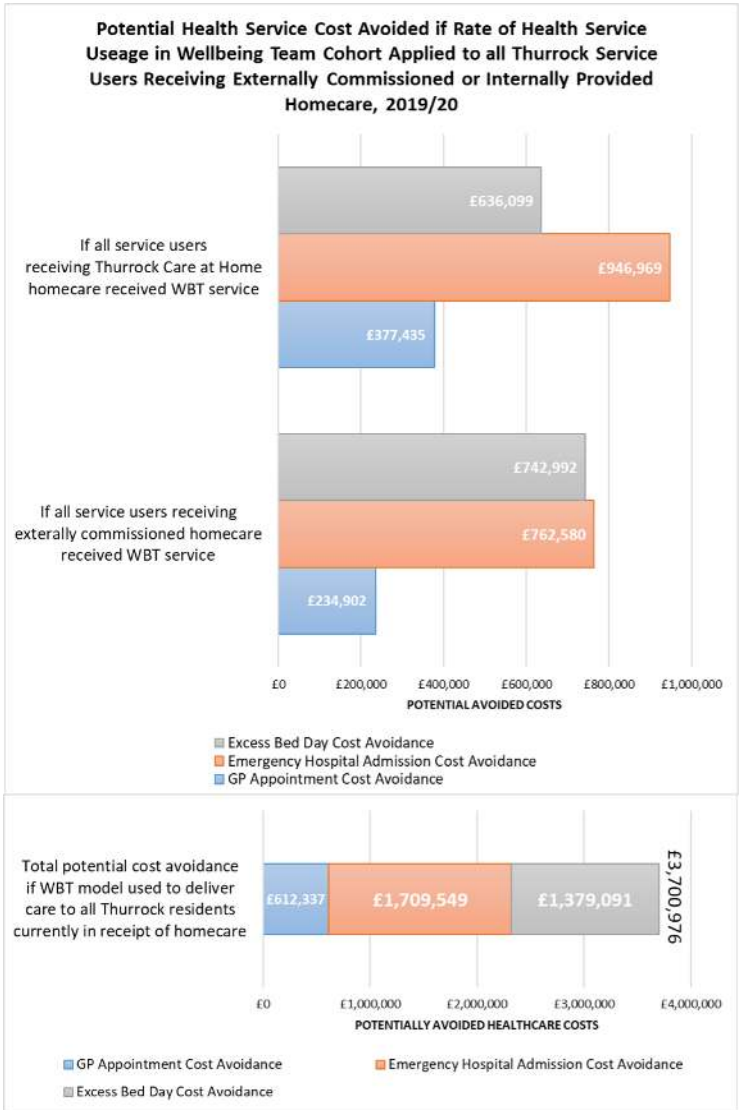


Figure 8.8



8.4 Further expansion of the Existing Wellbeing Teams Model

Caring for Thurrock (formally called Thurrock Care at Home)

We will start expanding Wellbeing Teams through transforming Thurrock Council's in-house homecare provider - ***Caring for Thurrock*** (formally called 'Thurrock Care at Home') to deliver an approach based on the same principles as Wellbeing Teams – ultimately developing in to Wellbeing Teams.

Caring for Thurrock currently delivers 1200 hours of home care per week – mainly to the Tilbury and Chadwell PCN area. It also acts as the provider of last resort, providing a contingency for external providers who may hand back contracts and hours or fail. *Caring for Thurrock* provides a service based along traditional lines.

Caring for Thurrock suffers with the same workforce challenges as external provision. The majority of staff have less than 5 years' experience, the service relies heavily on overtime to meet demand and 36% of the existing workforce will be eligible to retire within ten years' time.

Caring for Thurrock has a transformation plan in place which aims to respond to current challenges and aims to further test the Wellbeing Teams approach. As a result of current Provider Service structures, a phased approach will be used to move the service to a Wellbeing Teams model.

The first phase of the approach will see four locality based teams being implemented in the Tilbury and Chadwell area. The focus, in keeping with the Wellbeing Teams model, will be on achieving outcomes rather than completing tasks. The service will not be time limited and will therefore not hand over from one team to another; instead, one team offering a more holistic service and ongoing reablement continuously supports the person from day one and promotes their choice, independence and wellbeing. Workers will be upskilled and given more autonomy to enhance their job satisfaction which should assist with job retention and recruitment.

Following testing of the above approach, *Caring for Thurrock* Community Teams will move in phase two to adopt the full Wellbeing Teams model.

External Provision

We will work to shape the market to reflect the home support model we require, developing an integrated commissioning strategy that will enable the market to reflect the vision set out in this strategy.

We will work with our providers to test the development of the integrated support model in the market place. This initially will consist of a pilot project with one of our existing homecare providers. We have already started early discussions with providers to test this new approach.

Through an integrated commissioning strategy we will develop the market to provide choice and flexibility. With 60% of care being provided externally, the market must be sufficiently developed as must the way in which we commission what we need provided.

Cost of Expanding the Current Model Borough Wide

In order to compare the relative costs of current externally commissioned care, Caring for Thurrock and Wellbeing Teams, we have calculated the cost per hour of delivering direct care to residents through each model, incorporating all on-costs including management support and staff development, and expressed this as an hourly cost of care.

For 2022/23, **Wellbeing Teams will cost £32.12** per hour of direct care provided. This is significantly less than the **Caring for Thurrock overall direct care rate of £41.67** per direct care hour, although it is worth pointing out that the current acuity of residents accessing C4T services is likely to be higher as the service also provides care through the Joint Re-ablement Team and to the Piggs Corner Extra Care facility. **Externally commissioned care is the least expensive at an estimated £19.00 per hour** for 2022/23.

We can then calculate the overall cost impact of replacing the current ASC domiciliary home care provision with directly employed Wellbeing Teams for all Thurrock residents in receipt

Table 8.1

	Historic Externally Commissioned Care model @ £19 per hour	TC@H historic model @ £41.67	Directly Employed WBTs @ £32.12 per hour	TOTALS	Difference from Thurrock Council Baseline
Predicted 2022/23 Costs if Current Arrangements Retained	£8,858,408	£3,157,086	£1,125,742	**£13,141,236**	**£0**
Cost to Thurrock Council if only TC@H switched to WBT model	£8,858,408	£0.00	£3,559,281	**£12,417,689**	**(£723,546)**
Cost to Thurrock Council if only externally commissioned care switched to WBT model	£0	£3,157,086	£16,101,114	**£19,258,199**	**£6,116,964**
Cost to Thurrock Council if all care provided through a directly employed WBT	£0	£0	£18,534,653	**£18,534,653**	**£5,393,418**

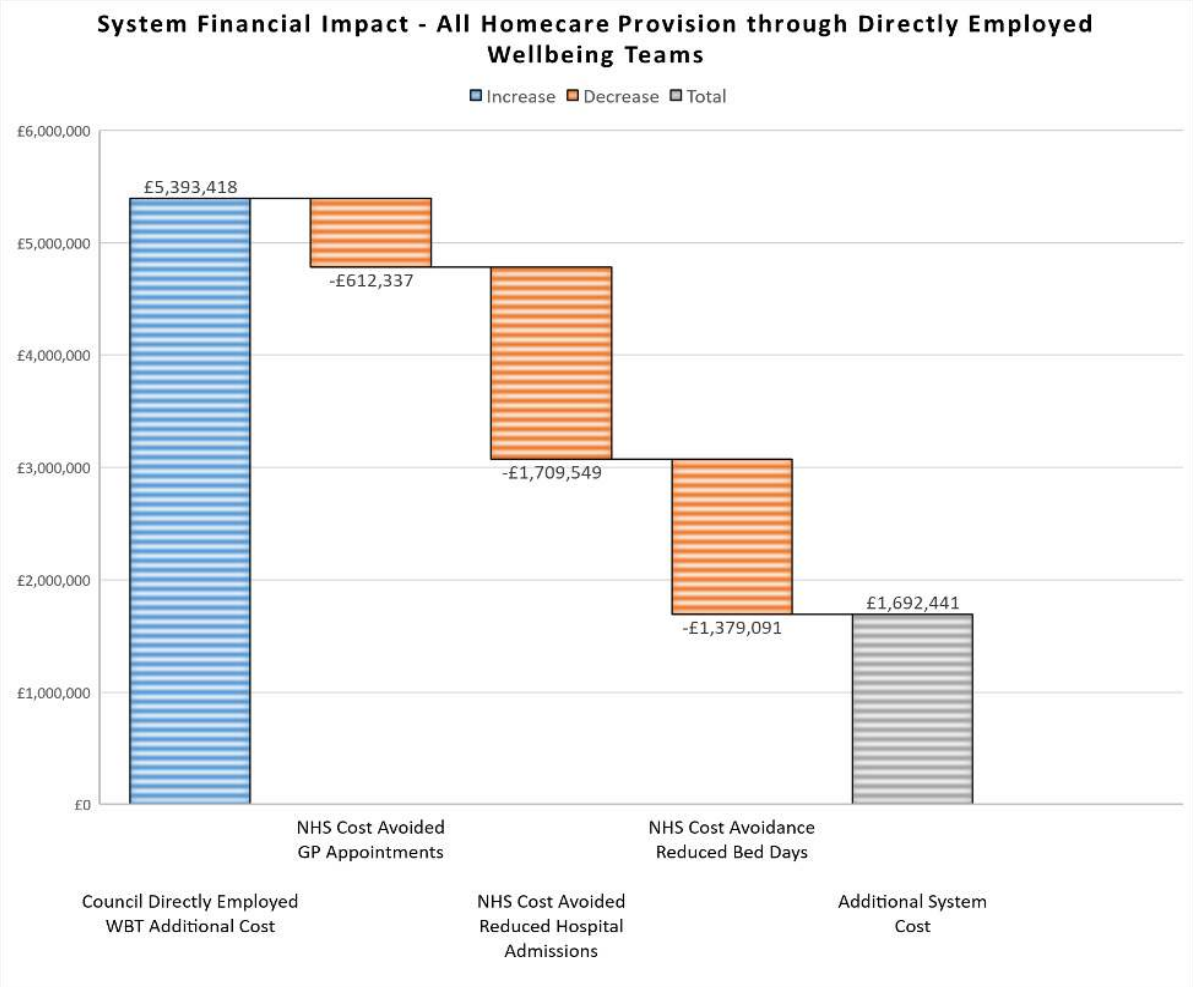
We calculate that replacing the current Caring for Thurrock model with a Wellbeing Team model has the potential to deliver over £723,000 savings. However, if we replaced the significantly cheaper externally commissioned care with a directly employed Wellbeing Team model, this would cost an additional £6,117M. The overall impact of replacing all current homecare provision with a directly employed Wellbeing Team to the council is a requirement to increase the homecare budget by an additional £5.393M per year which is currently unaffordable (Table 8.1).

However, early evaluation suggests that the Wellbeing Teams model has the potential to deliver savings to the NHS through delivery of better outcomes for residents and avoided subsequent GP and hospital usage. By using the modelling set out in figures 8.6 and 8.7 against cost differentials between Externally Commissioned Care, C4T and Wellbeing Teams, and the numbers of hours of care currently delivered by each service model, it is possible to estimate the costs of providing a Wellbeing Service to every Thurrock resident currently receiving domiciliary home care.

With potential new financial freedoms that Integrated Care Systems can bring and a requirement to consider *system* rather than *organisational* budgets, there may be an opportunity to build a system business case to fund Wellbeing Teams, given that they deliver potential cost savings to NHS outcomes as well as better outcomes for residents.

We have therefore modelled the cost of the entire Wellbeing Teams model to the NHS and Social Care system in Thurrock (figure 8.9), including potential savings that accrue to the NHS. This brings the overall Thurrock health and care system cost of providing all homecare through a directly employed Wellbeing Team model down to £1.692M per year which is more affordable to the health and care system than it is to Thurrock Council alone, but still would represent a significant cost pressure.

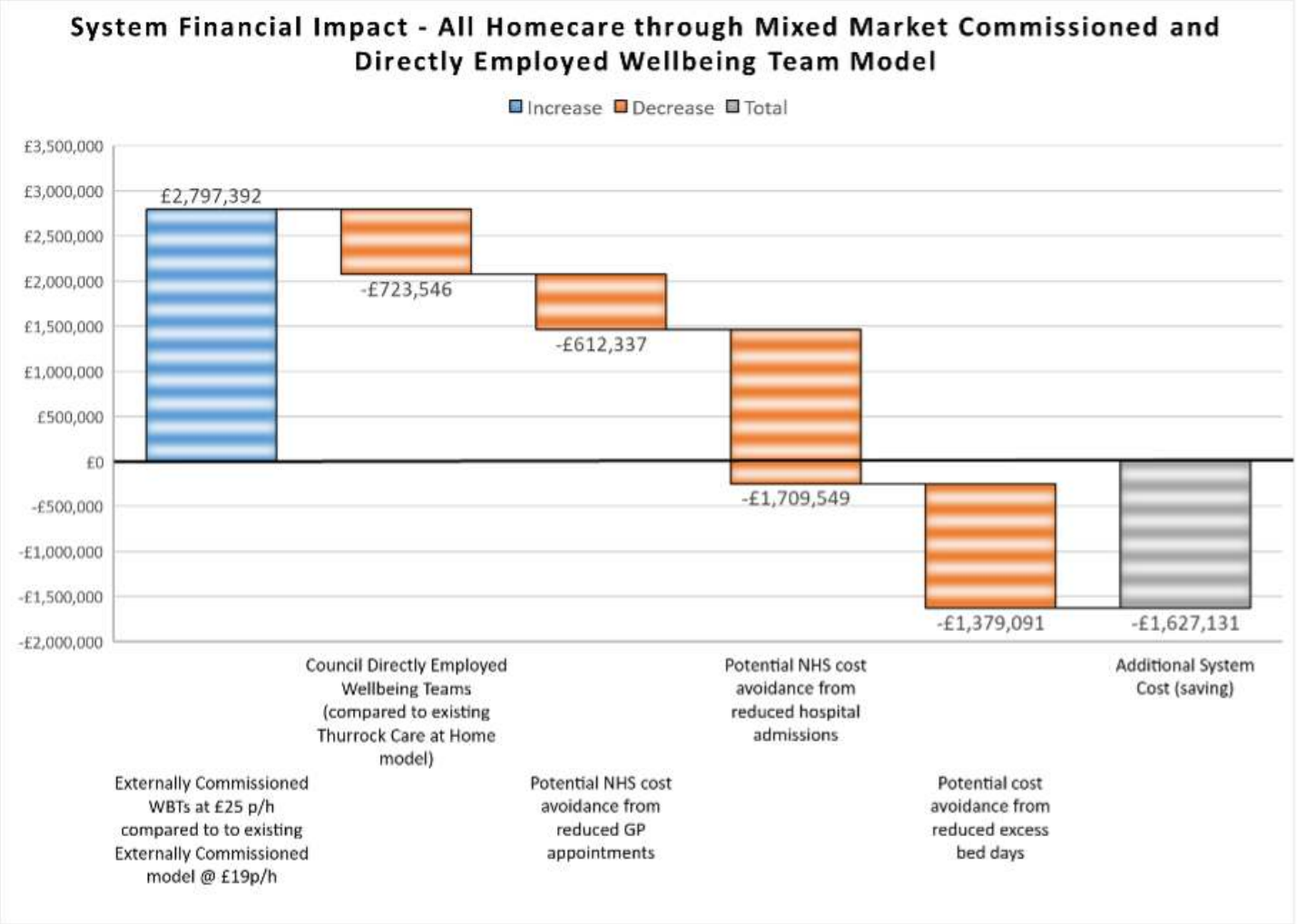
Figure 8.9



Retaining a level of in-house provision for homecare brings significant advantages in terms of control and ability to 'test and learn' new innovation and has served the local health and care system extremely well in being able to mitigate the pressures of the COVID-19 pandemic. However, directly employing staff on Thurrock Council or NHS contracts is usually more expensive than commissioning external care agencies. It may therefore be possible in the future to shape the local care market and to deliver Wellbeing Teams through a mixed market model of directly employing some Wellbeing Teams and commissioning the best external care providers to deliver a Wellbeing Team model. We accept that the costs to commission a Wellbeing Team model are likely to be higher for external care agencies, and we have modelled the overall impact of commissioning Wellbeing Teams through external providers at £25 per hour; a £6 per hour increase on the current rate.

Figure 8.10 shows the potential impact of this mixed externally commissioned and directly provided model.

Figure 8.10



At £25 per hour for an externally commissioned Wellbeing Team provision (a £6 per hour uplift) is set against system savings for all other elements of the model, the overall impact is a potential £1,627M system spend reduction that could be reinvested into further prevention, whilst also delivering a better care model to residents.

As previously stated, the current model has been built using evaluation data over only one year based on a relatively small sample size. In order to ensure that any future commissioning is based a more robust model, we will continue to collect evaluation data over 2022/23 with the view to bringing forward a system business case for roll out of Wellbeing Teams borough wide from the last two quarters of 2023/24.

8.5 Further Transformation of the Existing Wellbeing Team Model

The current Wellbeing Team model describes an approach that relates to people in receipt of a social care domiciliary care service. As it is now, the model does not enable an integrated approach across health and care to be delivered. This means that a number of different professionals could still potentially visit a person, all working to different processes and requirements. To address this, we want to increase significantly the functions of existing Wellbeing Teams to include tasks historically undertaken by health professionals to create truly holistic and self-directed 'Health and Care Wellbeing Teams'

8.5.1 Core Functions of a Transformed Health and Care Wellbeing Team

Blended Roles: *A Health and Care Wellbeing Worker*

There is considerable opportunity both to upskill existing Wellbeing Team workers to undertake certain tasks and activities currently carried out by other health professionals thus improving continuity of care, reducing duplication, and freeing up specialist capacity.

Blended roles across traditional health and care team/organisation functions allow staff to expand their skills to enable them to undertake both routine clinical and care tasks as well as using time allocated to focus on supporting the person to do things that enhance their wellbeing.

In order to implement this, we will undertake a scoping exercise to identify residents who are currently receiving support from different service areas at the same time and ascertain the opportunities for a new *Blended Health and Care Wellbeing Worker* to undertake more of these tasks whilst supporting the resident

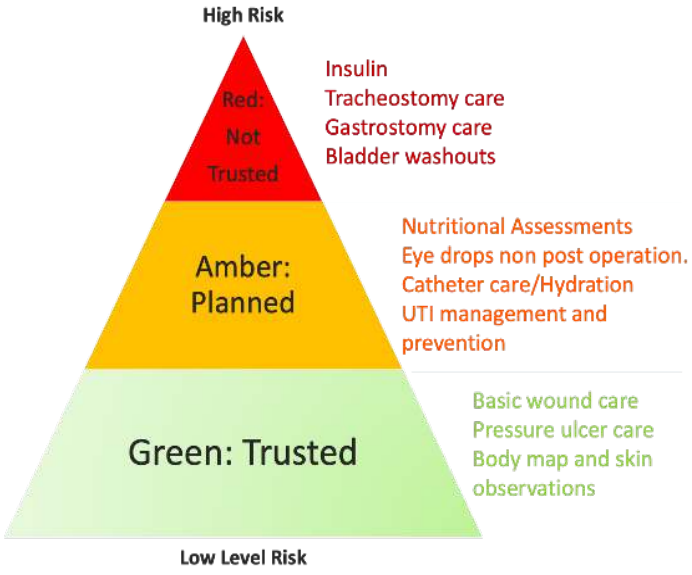
This will reduce the overall number of visits needed, freeing up NHS capacity, and rationalising the number of people potentially involved with the same resident and improving care continuity. In addition, blended roles can have a greater role in identifying signs of deterioration and using technology to monitor vital signs – all helping to prevent, reduce the delay the need for health and care and helping to avoid crises.

In order to create a blended *"Health and Care Wellbeing Worker"* role will require staff training and skills development but also offers the opportunity of career development, higher status, higher pay and more variety and responsibility compared to the traditional domiciliary care worker. This in turn provides a solution to the current workforce crisis in social care, hopefully attracting and retaining staff.

Thameside Council implemented a '*blended roles trail blazer*', looking at high intensity users receiving a service within their home from both health and care providers. They identified tasks, starting with those requiring a low level of expertise – but also identifying tasks of medium and high complexity that with training they felt care staff could deliver (Figure 8.11).

The pilot showed significant 'repurposing of community nurse visits and a positive impact on staff and residents receiving support.

Figure 8.11



We will test a blended roles approach the learning from which will be used to further develop the Integrated Support model. Test and learn work will also take place with existing external providers – again with learning used to develop future commissioning and procurement approaches.

Potential future expansion to the role could see teams taking on responsibility for housing-related issues and Mental Health concerns, forming a truly multi-disciplinary team much more adept at dealing with a number of commonplace issues without requiring the involvement of other parts of the system. These roles would have access to specialist support when required for any complex needs that fell outside of their remit.

In addition, their neighbourhood-based deployment would open up the opportunity to support others, for example those who are socially isolated or those who have recently come home from hospital and are without formal or informal support, maximising their presence on the patch to deliver prevention and early intervention alongside their main function.

Hospital Discharge Planning

Delayed discharges in Thurrock have remained incredibly low throughout the COVID-19 pandemic; testament to our transformation work to date. However the current hospital discharge pathway is fragmented with multiple handoffs. A resident leaving hospital may be discharged into a community bed, then the hospital bridging service, then a separate reablement service and then receive an externally commissioned homecare package.

In future, any resident admitted to hospital will be flagged immediately to the Wellbeing Team, who will be responsible for liaising with the hospital and resident to commence discharge planning, including brokering appropriate health, care and third sector with the aim of early discharge back home.

This will allow proactive 'pull through' of residents from secondary care back into the community as soon as possible

The discharge process from hospital will be reviewed as part of the development and scope of Wellbeing Teams – linked to the deployment of reablement. This will aim to ensure that the:

- Assessment of ongoing support needs is made at home rather than a hospital setting (unless there is a specific reason for this not to happen);
- A period of stabilisation at home prior to a longer term assessment; and
- A multi-agency approach is established so that discharge arrangements are coordinated and integrated from the earliest point.

Reablement

Reablement is the care and therapy process through which residents' physical and mental functionality and wellbeing is maximised following a spell of serious illness. Currently, reablement is provided through a separate Joint Reablement Team following an assessment of individuals typically leaving hospital. The assessment follows a medical model and defines reablement in medical rather than holistic terms.

The existing system incorrectly assumes that not everyone has the capacity to be re-abled and that reablement should be time limited. In reality, almost everyone has some reablement capacity – which may require only a few days or can continue for many months or even years.

We believe that everyone leaving hospital should be seen as having reablement potential. This means that in future, reablement should be unique and tailored to each individual, be articulated by the resident, and form part of an integrated support plan.

Our new model for Integrated Support in the Home will incorporate reablement within Wellbeing Teams, seeing it as integral to on-going care and support rather than a separate, time limited function accessed only by those who meet a pre-defined threshold. Reablement will be explicitly linked to the goals that the resident wishes to achieve; the goals that align with their vision of a good life.

There will be a range of reablement requirements – some requiring support that cannot be offered by the Wellbeing Team itself. Colleagues providing specialist support will be part of the locality network and will work alongside the Integrated Support Team so that the right solution can be delivered and that it is delivered in an integrated and coordinated way. Staff will have the ability to pull in those sitting outside the immediate Team if required – ensuring join up.

Community Nursing: The Integrated Community Team (ICT)

As we discussed in Chapter 7, we will align current community NHS health provision will be aligned with each PCN locality and form part of a health and care locality network. This will include enabling integrated care and support plans and a blended roles approach.

NELFT's Integrated Care Team (ICT) current provides a wide range of nursing care to people who are unable to leave their homes even with the support of family, friends or carers – including people who are likely to decline rapidly or be at crisis point. The service's response includes wound management, administering injections, catheter care and end of life delivered largely by Community Nurses and Health Care Assistants.

We have already discussed how *Health and Care Wellbeing Workers* could be trained to undertake some of these tasks. In our new model of care, ICTs need to be able to work alongside Wellbeing Workers and other resident facing staff in a seamless way. We will also align the current ICTs to Wellbeing Teams with a named Community Nurse for each team able to undertake more specialist clinical tasks and provide clinical advice to the team.

Integrated Care Plans

To support this integrated health and care approach, we will develop single integrated care plans for each resident who needs one, linked to goals that the individual has identified for themselves and their overall wellbeing. Where appropriate, this will include informal support provided by and within the community.

The Integrated Care Plan will have a single named individual to act as care coordinator for the plan. The care coordinator will be the most appropriate person for the resident depending on their needs and wishes and could be a Health and Care Wellbeing Worker, Community Nurse or other professional. If more than one professional is involved in delivering care to residents, a decision will be made about who is best to coordinate the Integrated Care Plan and who is best placed to deliver tasks and outcomes. For example, it may be an upskilled Wellbeing Worker who now delivers a task historically undertaken by a health professional (blended roles).

This new integrated model will improve care continuity, rationalise the number of different people entering the resident's home and shift from time and task focussed community health care to a truly holistic model.

8.5.2 Additional Support that can be brokered into the Wellbeing Team

GPs and PCN Support

GPs and Primary Care Networks play a vital role in the development of integrated support in the home. Linking with other professionals across the network – including providers, social workers and a range of health professionals, they often provide the vital link between all parties and are often the first point of contact for someone requiring additional support.

PCNs and GPs will also be key to providing the advice and support required by others – such as Wellbeing Teams. Whilst time will be required to provide advice and support, benefits should include a reduction in the people supported needing GP appointments or GP interventions with far more taking place in the person's home through teams providing support to the individual.

This will enable far more to be done in the person's home rather than in the surgery – including checking for and monitoring vital signs and deterioration to prevent, reduce and delay the need for greater health and care support and intervention. GPs and PCN staff can also play a key navigation role in identifying the professional who should take the lead in someone's care. GPs will often be aware if someone is requiring some support as they are isolated or recovering from poor health but with no support. This information will be vital if the system is to prevent, reduce and delay the need for care and support.

Specialist Teams

There are currently a number of 'specialist' condition-specific teams that provide support to people in their home – or provide a hybrid model where support in the home will be provided if required. Current provision includes the Older Adult Health and Wellbeing Team; Dementia Crisis Support, Secondary Care Mental Health and the Urgent Community Response Team. The Teams that provide a hybrid model and provide support in the home if required are: Diabetes, Dietetics, Epilepsy, Equipment and Home Loans, Falls, Heart Failure, Pulmonary Rehabilitation, Home Oxygen, COPD, Targeted Lung Health, Tissue Viability Service, Early Supported Discharge, Adult Speech, Parkinsons, Continence Service.

In our transformed model, Specialist Teams although not necessarily locality-based, dependent upon the specialism and size of team, will form part of the Integrated PCN/locality Teams discussed in Chapter 7 and build good relationships with other health and care professionals operating in the patch. Formal referrals to specialist teams will not be necessary and their input will be 'brokered into' the Wellbeing Team by the named individual responsible for coordinating care to provide advice and support rather than residents needing to navigate their way through separate pathways. Any specialist support will form part of the single integrated plan overseen by one professional taking the lead as overall 'coordinator'. There will be a constant focus on reducing or aligning visits, preventing hand-offs and removing the need for onward referrals.

Voluntary and Community Sector

The Voluntary and Community Sector will form a vital part of any support arrangements and be a key part of support delivered within the home. Existing services run by the VCS such as *By Your Side* are already playing a critical role in the borough, facilitating hospital discharge and preventing readmission by providing essentials such as basic food provisions and ensuring appropriate equipment has arrived and making sure residents' homes are safe, warm and ready to welcome them.

The service consists of paid staff and volunteers. Welfare visits also take place so that any arising issues can be dealt with before they lead to or contribute to crisis. Services such as By Your Side will work as part of the Integrated Support in the Home model and not be separate to it. They have had significant success in reducing readmissions.

Technology

Technology is a key enabler and will be used to aid a preventative and integrated approach to the provision of support in someone's home.

Health and care have a successful and innovative Technology Enabled Care group in place. This ensures that a range of technological options can be tried and tested – enhancing existing health and care solutions, or enabling new solutions to be developed. For example this may include tools such as Whizan, which enables the monitoring of vital signs. There are a range of technologies that will be tried and tested as part of the development of integrated support in the home.

8.6 Implementation and Impact

Figure 8.12 shows the overall model for transformed Wellbeing Teams including core and brokered functions.

Figure 8.12

Adopting a Human Learning Systems approach

We are committed to adopting the principles of HLS in delivering this transformation. Being self-directed, resident facing staff working within or providing brokered support into Wellbeing Teams will be freed from constraints of thresholds or standard operating procedures and empowered to deliver human, bespoke solutions based on goals agreed in partnership with the resident. This ultimately will deliver better outcomes, reduce duplication and prevent 'failure demand'.

We will empower front line staff to build on the principles and vision set out in this chapter to develop solutions that work for Thurrock residents. Two senior nurses have already been seconded to a project to test a new way of working alongside other health and care colleagues within PCN areas. Their remit is to challenge and identify how the existing model of community health can and should change and what that looks like at a locality level. The learning gained will inform how best to implement the transformation.

Enabling partners to work together and develop shared responsibility for people requiring their support is key to making best use of available resource and to improving people's outcomes. This means that specialist expertise will only be pulled in when required, and staff having the greatest interaction and relationship with the individual will be able to build a care coordination role. They will also be able to learn from those they are working with so that they have a better understanding of how to improve outcomes and identify issues early.

Some of this will need to be quantified through testing, but the approach will release specialist capacity which in turn will speed up throughput and reduce delay. The approach will also enable partners to work together to develop integrated solutions that prevent referrals and duplication and allow individuals to be far more preventative.

Our 'Ask' of System and Alliance Partners

Achieving what is set out within this chapter requires the following from system partners at all levels:

Integrated Care System

- Delegate necessary responsibilities to the local system;
- Accept the need to change existing 'system conditions' to enable best use of resource and the achievement of best outcomes for the individual – e.g. delegated or redesigned performance and contract management, reporting requirements, delegation of budgets and budget integration etc;
- Work with Thurrock to redesign hospital discharge pathways to support the Wellbeing Team model including early identification and flagging of residents admitted to hospital so that discharge planning can commence at the earliest opportunity.

Local Alliance Partners (Place)

- Enabling and supporting staff to embark on a 'learning' approach to developing alternative ways of delivering support within the home and ensuring people are able to achieve outcomes that are most important to them;
- Overcoming barriers that stand in the way of making necessary change;
- Reducing organisational sovereignty so that people feel part of a single place team rather than just an organisation.

PCN / Locality / Neighbourhood Partners

- Commitment to work as part of a locality network;
- A commitment to genuine co-design. Ensuring that nothing is implemented in a top down way but involves all of the community at the earliest possible stage.
- Full involvement of all working in the locality area and communities themselves (especially those in receipt of services) to ensure the development of community-led solutions and operating models;
- Commitment to adopt a HLS approach to testing and learning;
- Pooled budgets by locality to allow easier integration of support solutions.


SUMMARY OF STRATEGIC ACTIONS
8.1
We will expand Wellbeing Teams through transforming Thurrock Council's in-house homecare provider - Thurrock Care at Home, to create eight additional locality based Wellbeing Teams in Tilbury and Chadwell.
8.2
We will collect wider evaluation data on the impact of the Wellbeing Team model throughout 2022/23 in order to create a robust system impact model.
8.3
We will bring forward a system business case based on our system impact model to allow roll out of Wellbeing Teams borough wide from the last two quarters of 2023/24.
8.4
We will work shape the external care market with a view to commissioning the Wellbeing Teams model externally. This initially will consist of a pilot project with one of our existing homecare providers.
8.5
We will further transform the WBT Model to create *Health and Wellbeing Teams* with a blended Health and Care WBT Worker roll upskilled to deliver both routine health and care tasks
8.6
We will transform the hospital discharge care pathway and embed responsibility for Reablement and Hospital Discharge Planning within the Wellbeing Team in conjunction with the ASC Hospital Team.
8.7
We will align current Community Nursing (Integrated Care Team) functions to Wellbeing Teams with a named Community Nurse for each team.
8.8
We will implement Single Integrated Care Plans between NHS, ASC and the 3rd sector, with a named care coordinator and systems to broker specialist support into the team to minimize referral and handoff.
8.9
We will maximise use of community assets, voluntary sector support and technology enabled care as part of a holistic package of home support within the Wellbeing Team.

Chapter 9: Reimagining Supported Living, Residential and Intermediate Care

Dignity and independence with more intensive support

Chapter 9: Reimagining Supported Living, Residential and Intermediate Care

9.1 Introduction

In this chapter, we describe our plans to re-imagine how we deliver older people's housing, supported living, and residential and intermediate care including our proposals for an "Extra Care Plus" facility at the Whiteacres site in Thurrock.

Thurrock is a place that has an ambitious plan for improvement and growth as illustrated earlier in this strategy. The Thurrock Integrated Care Alliance recognises the need to support people for as long as possible within their own homes, and we have already achieved significant success with this objective as set out in Chapter 8. However, for some, there remains a need for more round the clock health and social care to be available, and these need to be provided to the highest standard, enabling people to retain the independence and control they desire.

This includes greatly enhancing the offer we make to our older residents and other groups who cannot be supported in general needs housing. It means ensuring genuine accommodation choices that meet the aspirations of our residents for their later life, and high quality intermediate care and supported living facilities when residents need them.

In Thurrock, as elsewhere, demand for care is rising inexorably not only from an ageing population but from the increasing number of people living with complex, chronic or multiple conditions, such as diabetes, cancer, heart disease and dementia. The total number of years people can expect to live in poorer health is steadily growing. The pressure this is placing on health and care services and budgets has been documented for some time. As an Alliance, we are considering how our whole range of functions, and the strengths and assets within our communities, can enable our older residents to enjoy a good life in old age.

What is needed is new thinking about ageing well in our communities, recognising that the so called baby boomers who have built their homes and lives in Thurrock, will want to look forward to their years in the 21st century, no less in command of their futures. We need to reimagine how we transform and integrate housing and care in older age with a much greater plurality of options to support choice. Factors driving the need for transformation include not just an ageing population but also:

- The increasing complexity of providing for multiple medical conditions;
- Insufficient capacity for the provision of care across the system;
- A residential care market unable to sustain the current levels of care under the current funding model, with an ageing care home estate, and declining investment in new facilities;
- A health care system primarily designed to treat ill health rather than prevent, reduce and delay the need for care;
- Difficulty recruiting and retaining social care staff – carers in particular; and
- The intense pressure on successfully discharging people from hospital to deal with the exponential demand for acute services; particularly as we move from COVID pandemic to endemic status.

9.2 Specialist Housing

There are many gains from a programme of new housing specifically designed for older adults: manageable, accessible, warm homes with low running costs and bringing a lower risk of falls and accidental injury, will enable individuals to maintain their independence, see income go further, and avoid unnecessary admissions to hospital and care homes. For many older people, purpose-built accommodation also brings a social life that protects against isolation and loneliness. And, for some, it also means releasing capital to make life easier in retirement.

Of course many will be safe, healthy and happy growing old in their existing home, adapted if necessary to their health and care needs. This may be the best choice and must be respected. However there are also a significant number who would be safer, healthier and happier moving home, and growing old in a different property more suited to their needs. They should be supported to do that. Whatever their choice, Thurrock recognises that our older citizens will increasingly want to:

- stay in control;
- prepare in good time to step up to the next stage in their lives;
- have a choice of homes that support their health and well-being.

9.2.1 Achievements to date: an exemplar scheme at Bruyn's Court

As part of its ambitious transformation programme, the Council has invested in aspirational housing developments, specifically designed for older people, in South Ockendon and Tilbury.

Designed in line with the recommendations of the report Housing Our Ageing Populations (HAPPI)[1], Bruyn's Court provides 25 self-contained, one and two bedroom flats, located close to South Ockendon town centre amenities, and overlooking a courtyard garden. The flats are designed to wheelchair accessibility standard, are easy to heat, and to keep cool in summer and each has a private balcony or terrace garden. A communal lounge is provided to facilitate art and craft work, and social events. Residents can receive care and support in their home from visiting services, including Well Being Teams and community nurses.

A further benefit of developments of this type is that they enable people to "right size", often freeing up larger homes which can be more costly to heat and maintain. These homes are much needed by families. The Council and its partners are keen to explore the possibility of developing similar schemes in all parts of the Borough.

Bruyn's Court Design Considerations

Ease of access

- The building is designed to be easy to navigate and accessible for all. An open main entrance with direct access/views to the garden room and the garden beyond gives on to the vertical circulation cores.
- Flats are clustered around two vertical access cores. The provision of two cores negates the requirement for corridors. Circulation space benefits from excellent natural light and ventilation.
- Sensitive use of colour differentiation and wayfinding between different areas of the building will be considered as part of the interior design to support residents with dementia.

Garden Aspect

- All flats are arranged with a western view across the adjacent garden.
- Generous, full width balconies provide attractive private amenity looking out across the garden.
- A large proportion of the flats are dual aspect.
- A communal garden room on the ground floor provides residents with a space for socialising with direct views and access to the garden.

Typical Dwelling Plans

- Generously dimensioned hallways.
- Large store, adaptable as a wheelchair storage space.
- Oversized to allow for adaptation into a fully wheelchair accessible bathroom, plus 'soft spot' in master bedroom partition.
- Kitchens are generously proportioned to provide ease of circulation for residents who are mobility impaired or use a wheelchair.
- A sliding screen gives an open, spacious quality. Flexibility of use for second bedroom.
- All rooms open onto a generous external balcony overlooking the new communal garden.
- Windows to the kitchen allow for natural light and allow views to the communal areas.
- Shelving/seating adjacent to flat entrances

9.2.2 The role of the private sector as development partners

Local Housing Authorities and their partners can only provide a small proportion of the new homes that will be needed by an ageing population. In recognition of this Thurrock held a Developers' Summit to mobilise support for a private sector housing development programme specifically targeted at older people. The Summit received presentations from the Homes and Communities Agency, the co-authors of the HAPPI Report, PTE Architects and the Council's Director of Planning, spoke about the need to drive up quality and to address the housing needs of older people. A commitment was made that if developers would work with the Council to improve the quality of housing for older people, the Council could offer a range of help including:

- Providing profiles of the housing needs of older people in Thurrock's communities
- Engaging with local people so that they understand the benefits of specialised housing for older people
- Flexibility in relation to planning requirements, for example, parking if the site is well served by access to local facilities and transport
- Exploring the potential for joint ventures with private sector developers
- A one-stop service to facilitate scheme discussions at any point, not just at the pre-planning application stage.

The Council's Assistant Director of Adult Social Care summarised the challenges and opportunities:

- The health of older people is exacerbated by poor housing, particularly poorly-heated homes, making older people vulnerable to conditions such as respiratory and cardiovascular diseases, more likely to have falls and fractures, and to be less active and, as a result, more socially isolated and depressed
- The opportunity provided by Thurrock's regeneration & housing development programmes to create well designed, well insulated homes to mitigate many of the problems associated with ageing
- Significant numbers of older residents have equity in their homes and, if the offer is right, may want to invest in a new home with all the benefits that will result in terms of positive health outcomes.

Thurrock's previous experience demonstrates a demand for good quality housing for older people; a 65 unit Extra Care Housing scheme had seen the 18 shared ownership flats sold in a very short space of time through the government's Homebuy scheme.

Learning from the Developers Summit: Key Discussion Points

- Flexibility is key; not just in terms of the product but also in financing and management.
- A real obstacle is that we currently don't have the right product and so it is difficult to demonstrate there is a demand for it.
- Significant numbers of older residents choose to occupy two rooms because of the heating costs, so there may be pent up demand for more manageable sized homes.
- There is a real difficulty in describing the product as retirement housing because increasing numbers of people will be expected to work beyond 65.
- Research into the types of housing older residents want would help to refine the range of products which may be needed (from small developments of flats to 150 unit extra care schemes). It could also clarify how best to market them.
- Ideally, specialised housing would be developed on larger sites to ensure a mix of dwelling types and house prices.
- Research could also give useful information about what housing might come back onto the market if older residents move to specialised housing, so helping to inform the broad mix of development needed in an area.
- In terms of support from the Council, there was an appetite for risk sharing, especially where the Council owns the land which it could release at a lower value pending sales, when the return could be adjusted to reflect the sales value achieved.
- A real issue is that specialist schemes cost more to develop and this could affect viability and the cost of borrowing.
- The recommendations of the HAPPI report may need to be applied flexibly in Thurrock, which developers see as very price sensitive. Alternatively there may be a case for subsidy for some of the elements which make the design suitable for an ageing population.
- Developers generally want risk to be minimised although higher risks may be palatable in higher value areas.
- Flexibility on planning gain is needed, particularly in relation to education. This was seen as a major issue which could delay development.
- The case could be made to the Homes and Communities Agency to provide grant to local authorities to release sheltered housing sites to build specialist housing.

Following the success of the Developers' Summit, Thurrock invited developers to join it in a coalition to promote specialist housing for older and vulnerable people.

9.2.3 Keeping a strategic focus: the role of the Housing and Planning Advisory Group

A further example of work to help shape future housing development to better meet the needs of an ageing population is Thurrock's Housing & Planning Advisory Group. This is a multi-agency panel, reporting to Thurrock's Health and Wellbeing Board, that considers the health and well-being implications of major planning applications and provides advice and guidance on the health, social care and community impacts of proposed new developments.

The Advisory Group comprises representatives from Thurrock Clinical Commissioning Group, NHS England, the Community and Voluntary Sector, as well as officers from Planning, Housing, Adults, Health, Public Health, Regeneration, Children's Services and Essex Police. It has a significant role in articulating the Health and Wellbeing Board's vision and priorities in relation to housing and the built environment.

The Group aims to influence ***planning policy*** and thereby developers so that planning applications when received, have already taken into consideration the impact of the proposed development on health and wellbeing. The Group plays a role in promoting good design and sustainable communities as well as specifically influencing ***planning applications*** for the provision of housing for older people and people with disabilities, drawing on a range of exemplary practice including the HAPPI Report, the Secure by Design crime prevention initiative, and the National Planning Policy Framework guidance for housing for older and disabled people.

From 2022 the work of the Advisory Group will also be guided by Thurrock's Joint Strategic Needs Assessment for the built environment, spatial design and health. The aim of the JSNA is:

To systematically address the wider determinants of health, specifically via the built and natural environment, and improve the quality of life of residents through the Local Plan.

The 2018/19 Annual Public Health Report provided a detail assessment of older people's housing need in Thurrock and strategic action that needed to be undertaken to ensure that future housing in Thurrock supported older people's independence but work then paused due to the COVID-19 pandemic.

We will therefore now take forward the recommendations in the APHR, developing and implementing an Older People's Housing Strategy based on its findings. We will also encourage future development of a plurality of housing that supports older people's independence, including HAPPI principles through continued use of the Health and Planning Advisory Group, 2022 JSNA on the the Built Environment, and new Thurrock Local Plan, ensuring planning policy reflects the older people's needs

9.3 Reimagining Residential and Intermediate Care

Our residential care homes are generally of high quality and have done a magnificent job of caring for some of our most vulnerable residents during the incredibly challenging period of the COVID-19 epidemic.

However, the majority of us hope that we will never need the services of a residential care home in old age, and few of us relish the often difficult decision to place a relative into residential care out of necessity because there is no other viable option available. When we enter residential care, we have to trade the loss of privacy, independence, control and choice that we had at home in order to gain the enhanced and intensive care they provide.

The CQC, in its State of Care report for 2017/18, noted that in the face of growing need "The capacity of adult social care provision continues to be very constrained: the number of care home beds dropped very slightly in the year, but what was noticeable were the wide differences across the country. Across a two-year period, from April 2016 to 2018, changes in nursing home bed numbers ranged from a 44% rise in one local authority to a 58% reduction in another. Almost a third of adult social care directors (32%) said they had seen home care providers close or cease trading in the previous six months."

Further, in November 2018 the Competition and Market's Authority reported on its undertaking the most complete study of profitability in the sector in recent years[2]. Amongst its findings was that "many care homes, particularly those that are most reliant on LA-funded residents, are not currently in a sustainable position". Moreover "they are not able to cover any additional investment costs. This means that while they might be able to stay in business in the near term, they will not be able to maintain and modernise facilities". The CMA also found that "the sector is not able to attract the investment required to meet the future increase in demand to serve LA-funded residents."

The pandemic has poses a further challenges for care home providers who experienced volatility in occupancy in the early stages of the pandemic with levels in some cases down to 60%. It is not clear whether care homes, which have generally not been designed for self-isolation, and where facilities for barrier nursing may not be readily available, may face further periods where older people are reluctant to be admitted. Although the speed by which Thurrock care homes have returned to close to full occupancy, suggests strongly that the capacity within Thurrock is, at best, right sized and will quickly become under resourced in view of anticipated demographic growth.

The Thurrock Public Health team has made an assessment of the need for residential care in the Borough. The assessment uses Department of Health planning tools to estimate the number of people over 65 years in Thurrock who cannot undertake even one mobility activity alone, and who may therefore require adult social care. Whilst the total number in 2017 was 4,201, this is projected to increase to 6,801 by 2035, which is an increase of 61.89%. The largest increase is seen in the 85+ year age group, which sees an increase of 95.38% between 2017 and 2035. In relation to dementia, the assessment shows the estimated number of people aged 65+ with the condition could increase from 1,503 in 2015 to 2,401 in 2030 – an increase of 59.7%, with the largest proportional increases are seen in the 80-84 year olds (82.9%) and 90+ year (88.6%) age groups.

Residents in their 80s are already the largest users of residential care, so without effective intervention to mitigate this trend of decreased mobility, the need for additional residential care homes is likely to increase substantially. Another projection of demand growth taken from the Public Health Team's assessment shows a need for a further 410 beds in residential care in Thurrock by 2035:

Our vision is to reimagine older people's residential and nursing care, providing the same levels of care intensity currently available in traditional models, but through a new 'Extra-Care Plus' care complex that provides residents with the dignity, privacy and freedom own self-contained flat and front door coupled with additional communal facilities on site.

We propose that the Whiteacre / Dilkes Wood sites in South Ockendon should be developed to provide a range of homes for older people needing care. This is seen as an opportunity both to address the growing demand for care, and to invest in innovation in care, and so to set new higher standards for housing with on-site care in the Borough. It will also act as a 'proof of concept' scheme that we imagine could be replicated by private sector developers and providers in the future.

The Box overleaf details Park Place, Portland, Oregon that has successfully delivered residential care using a similar model to our vision.

Park Place Portland, Oregon

Inspired by the negative experiences that her mother was having of nursing care in terms of loss of privacy, control and freedom, Keren Brown Wilson built her first Assisted Living Complex of 112 units in Portland, Oregon in the 1980s.

Wilson's mother's had suffered a devastating stroke in her 50s leaving her unable to stand, bathe, toilet or cook and needed intensive physical care support needs but her mental faculties remained unaffected. Over and above her care, Wilson's mother's living needs were modest: she wanted a small place with her own kitchen, bedroom and bathroom where she could lock her own door, control the heat, have her pets, be surrounded by all of her own furniture and things, and get up when she wanted. She wanted to live in a place where no-one would tell her what she could and could not do, and have privacy if she wanted.

Wilson set out creating a new facility, with the primary emphasis on *home* and the agency of residents. Her vision was simple[3]: at Portland Place, each unit was a self-contained apartment where residents had exactly the same amount of control over what they did as someone living in general needs housing. They chose who shared their space with, how they managed their time, what they did each day, their furniture, pets, decorations, possessions and heating.

But residents also had access to all of the additional help they may need on site: food, personal and nursing care, medication that could also be summoned in an emergency by pushing a button. There was also help with maintaining a high quality of life if residents wanted it: having company, keeping up connections with the outside world, continuing the activities residents valued most.

The level of care available matched what was delivered in standard nursing care, but the fundamental differences were *control* and *agency*. When provided, the carers were entering *the resident's home*, and the resident, not the carers, set the schedule, ground rules, and chose the level of risk they were comfortable with.

The concept was immediately widely popular and the 112 units sold out almost immediately and a second complex of 142 units was built and was again almost immediately filled. But the authorities were worried about the safety of what they saw as a radical experiment that was risking the health and safety of residents, and required Wilson to track closely the health, cognitive abilities, physical functioning and life satisfaction of the tenants.

The results of the study were published in 1988 and were a revelation: Not only had the residents not traded their health for freedom; residents' health was maintained whilst life satisfaction had increased significantly. Physical and cognitive functioning improved and incidence of major depression fell. The cost of residents on government support was 20% lower than if they had been cared for in a nursing home.[4]

9.3.1 Whiteacre / Dilkes Wood – our next exemplar scheme:

Pollard Thomas Edwards architects have already been commissioned to develop a vision for the proposed scheme including addressing how the development may be phased to deliver the new residential offer for older people and also, potentially, the redevelopment of the adjacent 1950s era health centre should that be agreed with NHS partners.

Their report showed a number of case study examples in which progressive developers have been exploring new ways of better integrating residential and nursing care with the local community. These approaches are consistent with Thurrock's vision for transformation, with new models of care to ensure people who need residential and/or nursing care can be supported to remain recognisably part of their community, rather than being cared for in an institution. It also reflects the collaboration between Council and NHS partners to develop integrated care pathways for older people, to avoid unnecessary acute admissions and delayed transfers of care, by making more care available closer to home.

Preparatory phase: Design and Realising Development Potential

The appointment of the Design Team enabled detailed plans to be drawn up for the scheme and allow early consultation with a range of stakeholders, including the local community, about both the vision for care and support for an ageing population, and the proposals for the site. The designs will also allow cost consultants to provide firm estimates of the construction and operating costs of the facilities.

Exploring options: site assembly and the potential for a joint venture with NHS partners

The Pollard Thomas Edwards report also concluded that the Whiteacre / Dilkes Wood site offers an opportunity to provide exemplary residential accommodation for people with varying levels of need, while creating a new community-led focus to the town centre. The scheme also unlocks the potential for the phased development of a new community health facility to replace existing provision in the South Ockendon Health Centre.

The South Ockendon Health Centre on an adjacent site on Darenth Lane is currently occupied by a single handed GP Practice, a branch surgery of an Aveley Practice, and a range of other clinical services including Health Visitors and dentists. NHS partners have confirmed the building is no longer fit for purpose, and they see potential benefits in redeveloping the site to create a new health centre. This could bring together other surgeries from the local area, and be equipped with a fuller range of primary care and associated facilities, reflecting the new model of care being pioneered at the Integrated Medical Centres.

The report by Pollard Thomas Edwards noted the existing South Ockendon Centre / community hub has proved popular with residents since its opening in 2013. It has a wide range of services and activities, and creates a strong community focus. However, their report argues the community hub could be better connected to the town centre if it was located on the Whiteacre / Dilkes Wood site.

The proposed mix of housing and care provision

The Whiteacre / Dilkes Wood scheme will provide a range of homes for older people needing care: from small easy to maintain flats designed for frail elderly people, to retirement living for those who wish to downsize to a care ready environment, including potentially a mix of one and two bedroom dwellings for rent.

We aim to replicate and build on the values, ethos and care model already demonstrated at Park Place, Portland, Oregon.

The project aims to provide social care and nursing care in a specialised setting of 45 self-contained dwellings with associated care facilities (lounges, restaurant, treatment rooms, laundry etc.). There are two self-contained accommodation types:

- Type 1 – Older Person's Flat: 56m2 self-contained apartment including bedroom, living/ dining/kitchen and bathroom provided. External private balcony. Storage space provided. Possibility for open plan or more traditional layouts.
- Type 2 – Older Person's Flat: 67m2 self-contained apartment including two bedrooms, living/dining/kitchen and bathroom. External private balcony provided. Storage space provided. Possibility for open plan or more traditional layouts.

In addition, a further 30 studio flats are proposed for Intermediate Care use:

- Type 3 – Intermediate Care Unit - 27m2 care studio with en-suite bathroom. Storage space for wheelchairs, MEP, personal belongings etc. Good visibility from bed to bathroom, door and window..

The accommodation is designed to a high standard, and includes underfloor heating and separate ventilation systems for each unit. The self-contained nature of the accommodation, and separate ventilation will help manage any infection including COVID. Careful consideration is being given to landscaping including the retention of as many trees as possible.

A new capability for independent living, reablement and intermediate care

Supporting independent living for frail older people

Specialised, care-ready accommodation, where residents can enjoy all the comfort and privacy of a self-contained home specifically designed for older age, has much to offer frail older people. The availability of on-site social care and nursing care services when residents need them, will enable them to retain (and regain) their independence. In combination, the facilities and services will help residents to live well, on their own or with their partner, to maintain day to day links to families and friends, to make use of local facilities, and to continue to contribute to their communities.

For frail older people, a single shared assessment, care co-ordination and an on-site wraparound well-being service, based on the model described in Chapter 7, will ensure their care needs are met in a way that promotes their strengths and enables them to make full use of local amenities. Visiting Integrated Locality Teams will provide advice on self-care and assistance with the management of long term conditions including diabetes, respiratory disorders and heart failure. The adjacent health centre will provide a range of GP and other primary care services, and in time will be developed with a wider range of clinical services as a health and well-being hub.

Reablement Away from Home and Intermediate Care

The Whiteacre / Dilkes Wood scheme will also make a major contribution in supporting strategies for reablement, reducing delayed transfers of care, and other initiatives to provide care out of hospital, care closer to home, and virtual wards. In addition to the permanent homes on site, the 30 self-contained studios will widen the housing and care offer locally, so that we can more readily avoid admissions by offering a home from home, and step up/step down care for those who need it. This will include:

- Intermediate care in a residential setting for people who cannot live in their own home at present but have no long term need for care in a residential setting;
- Short stays for those requiring intensive reablement services in a residential setting;
- Short stays to allow assessments (including Continuing Healthcare – CHC assessments) to be undertaken outside an acute setting when they cannot be undertaken in the patient/service user's home.

The provision of specialised accommodation, an integrated assessment and care plan provided by a team with blended roles, and bringing the capability of a range of clinical disciplines, will mean in future fewer older people will require admission to hospital.

And those that have been admitted because of the need for treatment which can only be provided in a hospital can return to a homely setting even if they have to wait for adaptations to be made to their own home, or to have technology enabled care deployed in their home, or if they need to convalesce in a setting which will help them regain the strength and skills for independent living before returning home.

Financing

The costs of developing the Council owned site as a high quality residential facility with on-site care is considerable. However, in the context of a shrinking private sector residential care offer the partnership must be in a position to offer the care required by local residents. The capital funding for the 75 residential units, and associated care facilities, will be funded as part of the agreed capital programme.

Revenue funding to cover the loan costs, as well as management and maintenance of the facility, will be available from rents and service charges for the 45 self-contained flats. Proving care through is tenancy model as the additional advantage that Local Housing Allowance can be claimed (for those eligible), and this additional rental income can be used to offset borrowing (and potentially some care costs). The care and support in the scheme will be provided by Well-Being Teams, and the service provided will be chargeable in line with the Council's policy for domiciliary care.

The revenue funding cost for providing the 30 interim beds is estimated to be circa £1,400 per week. This funding would form part of the business case for the scheme to be agreed with NHS partners as part of a new strategy for Intermediate Care. The interim beds could be offered to other authorities if the local demand profile for intermediate care changes, or if necessary, the service could be remodelled and operated as residential care beds (and so chargeable at the locally declared rate.

Combining the model with the Integrated Locality Network model set out in Chapter 7, where by community clinical teams would provide a model of 24/7 care on-site with clinical in-reach provided from the Integrated Locality Network. This may be attractive to NHS partners in reducing reliance on costly community hospital beds, allowing potential savings from medical on-site staffing to be reinvested within the Locality Network and a virtual ward model.

9.3.2 The Opportunity to Re-think Collins House

The Council has one purpose built residential home, Collins House, in Springhouse Road, Corringham, Stanford-le-Hope SS17 7LE. It is designed to the standards for residential care current in the 1970s and 1980s and is registered to provide personal care and accommodation in single rooms for a maximum of 45 older people, some of whom may be living with dementia related needs. Collins House is well regarded by residents and their families, and the Care Quality Commission gave the home an overall rating of Good in its latest inspection report dated 5 April 2016. However, it does have some limitations: the bedrooms are small, and none have en-suite bathrooms. Moreover, the building places limitations on the care that can be provided: it is not possible to place in Collins House some older adults who cannot weight bear because the size of some of the rooms prohibits the use of hoists to allow such residents to transfer from bed to chair or bath or WC.

The Whiteacre / Dilkes Wood offers an opportunity both to address the growing demand for residential care, and to invest in innovation in care, and to set new higher standards for residential provision in the Borough. It will also provide the opportunity to understand more fully how the facilities and services at Collins House could be improved, building on its existing strengths.

9.4 Supported Housing for Residents with Mental Health Problems

Supported Living placements provide accommodation to residents usually in shared houses with on-site support from carers to assist with daily living. The current model commissions external providers to deliver a core support offer with additional commissioned hours based on a previous assessment of the individual's needs.

Ideally, Supported Living provision should promote independence in the people being supported, with support packages starting at a higher level and then reducing as the resident being supported gains new skills and become more independent. However, the current process of assessment and then commissioning a fixed package of core support and set hours is inflexible and unable to adjust and flex support sufficiently in response to individual circumstances.

Furthermore, feedback from providers suggests that many clients have addiction problems that prevented recovery and that the way we have historically commissioned drug and alcohol treatment as a separate service meant that in many cases, support was fragmented and difficult to access.

A proportion of placements for service users with the most challenging behaviour break down, requiring the council to commission new provision at short notice, sometimes out of borough and usually at increased cost. An analyses of Thurrock's Supported Living data concluded that for the majority of residents with mental health problems placement costs remain static or increase over time, suggesting the current model may not be delivering the outcome of increased independence as well as it could.

We are currently developing a new model of care for Supported Living for people with mental health problems. We will purchase two additional four and three bedroomed houses within the Borough and commission a trusted provider to deliver the model. The model reflects a strengths based approach and the principles of Open Dialogue where all elements key to an individual's care and wellbeing will work together, with a shared understanding of what matters most to the person and a focus on stabilisation and where appropriate, recovery. The model will not be 'one size fits all' with a pre-specified number of care hours, but will flex to the requirements of the individual on a daily basis.

The majority of people accessing supported housing require a multi-agency approach to be able to achieve their goals. Phase I will see the development of a holistic model of care staffed by specialists who can easily and swiftly tap into other elements of mental health to enable the right intensity of care at the right time. The ability for staff to benefit from bespoke support, for example from a dual diagnosis substance misuse worker, will enhance the offer and increase the opportunities for a greater level of integrated care with outcomes including a reduction in relapse and admission to inpatient services. There will be a keen focus on maximising recovery and stability so each individual can reach the maximum level of independence and achieve what is important to them

We will 'test and learn' this new model by purchasing two properties within Thurrock and commissioning a high quality provider to deliver flexible 'in-reach' support to residents in conjunction with a dedicated addictions worker.

Chapter References

1. HAPPI - Design - Topics - Resources - Housing LIN ↑

2. 3 Competition and Markets Authority, Care homes market study, published 30 November 2017 ↑

3. Wilson, K.B. Historical Evolution of Assisted Living in the United States, 1979 to Present, *Gerontologist,* 47, special issue 3 (2007): 8-122.

4. Wilson, K.B., Ladd, R.C., and Saslow, M. Community Based Care in an Institution: New Approaches and Definitions of Long-Term Care, paper presented at 41st Annual Scientific Meeting of the Gerontological Society of America, San Francisco, No. 1988. Cited in Wilson "Historical Evolution" ↑

Chapter 10:
Making It Happen

Integrated Governance, Delivery and Commissioning

Chapter 10: Making it Happen: Integrated Governance, Delivery and Commissioning

10.1 Introduction

The vision and proposals set out in this strategy are ambitious and comprehensive and describe a fundamental shift in the way we have traditionally to delivered health and wellbeing services from one that is siloed and top down to one which is resident centred and integrated.

This final chapter describes the governance and delivery architecture required to turn our vision into a reality, and new high-level principles around commissioning arrangements to support the transformation. This work will be developed further during 2022/23 in negotiation with Mid and South Essex ICS and local health, care and third sector partners, as ICS governance arrangements emerge.

10.2 Background

The recent government white paper *Joining up Care for People, Places and Populations* emphasised the importance of *place* – geographical localities below ICS level as the primary planning footprint for integration of health and care services and budgets supported by single place-based outcomes frameworks.

Governance arrangements between the Mid and South Essex (MSE) Integrated Care Partnership (ICS) and the Thurrock Integrated Care Alliance (TICA) will need to support this national policy direction whilst reflecting two requirements; the need for the ICS, and ultimately NHS England, to be reassured that the use of resources and delivery of well-being services in Thurrock are achieving the outcomes required by these partners, and the need for autonomy in decision making within the Thurrock system. This dichotomy can be seen to reflect the inherent tension in having a top down or bottom-up approach to system oversight.

To fully realise the potential for service transformation inherent in this *Case for Further Change* strategy, a devolution of resource and delivery decision making between Mid and South Essex ICS and Thurrock needs to must be agreed. This is the basis upon which the idea of subsidiarity is grounded, however ultimate accountability for much of the system will remain with the ICS, who must be assured that the Thurrock Strategy is performing well and meeting the expectations of the wider system.

One way of overcoming this tension would be to create two distinctive governance structures: one to cover the devolution arrangements between the ICS and TICA, and another to manage this through a collaborative governance arrangement at the local level.

10.3 Governance

10.3.1 Governance Between the ICS and TICA

Future arrangements need to build upon the existing structures for governance within the wider ICS system and include a formal devolution and delegation agreement that set out clear expectations on both sides and established a series of key high-level place-based outcomes against which performance could be routinely evaluated. The arrangement will need to specify what mitigation would be taken and by whom when performance levels were not being achieved and agree a form of escalation and, ultimately of sanction when mitigation did not drive anticipated improvements.

The arrangement would need to be watertight and contain clear processes to enable the ICS to feel assurance that any perceived risks were mitigated, and that control could be and would be re-established centrally where performance required it.

Similarly, TICA would need to feel that the necessary autonomy required to achieve significant change was enshrined in the agreement, otherwise local decision making could be severely compromised by bureaucratic delay and subject to outside changes over which it had little or no control. In terms of deficit management, it may be necessary to agree a form of gain share so that both parties would benefit from efficiencies generated by new ways of delivery.

10.3.2 Governance Between TICA and Local Partners

This would require a system of Collaborative Governance to be agreed between all partners operating with the Thurrock Alliance, including communities and other user-led or citizen-led associations.

This model is becoming more common place and has been defined as follows:

> *Collaborative governance is most broadly defined as a process involving state and non-state actors jointly addressing an issue, be they civil society, public or private organisations, or individual citizens.*[1]

The Thurrock strategy is based upon a number of key principles including:

- Subsidiarity
- Co-production and design
- Equalising power between citizens and professionals
- Supporting self-help through shared solution finding
- Population health theory and a focus upon the broader determinants of health and
- Ending health inequalities.

It would be impossible to promote these principles in a system that still maintained centralised control and where there was limited autonomy in decision making. This shift requires a fundamental change in culture and mindset:

> *Public managers must revisit their outlook on the roles that they and the public should play in public services. The ways in which organisational cultures mediate patients' empowerment matters. Patients make a transition from simple users and choosers to makers and shapers of health services.*[2]

Working through how this collaborative governance arrangement is established and implemented within the Thurrock system is still being developed, including arrangements on governance, devolution and delegation between the ICS and TICA. However, they are both critical elements of the overall strategy if the transformation of services, with the corollary of improved outcomes and more effective use of resources, is to be realised in Thurrock.

10.3.3 The Role and Function of the Health and Wellbeing Board

Health and Wellbeing Boards (HWBB) are responsible for setting out a plan for improving the health and wellbeing of their local area – known as the Health and Wellbeing Strategy (HWBS). This *Case for Further Change* strategy is responsible for delivering or contributing towards a number of the priorities contained within the newly refreshed HWBS. As such, the HWBB is very much part of the governance arrangements of this strategy.

HWBBs also have a key role in delivering governance and oversight arrangements for the Better Care Fund (BCF) and Better Care Fund Plan. The Better Care Fund is a pooled fund across health and adult social care for the local (HWBB footprint) area. Its purpose is to enable integration across the health and care system and promote the identification and delivery of jointly agreed aims and objectives. This strategy proposes that the BCF is used as a vehicle through which system budgets in their totality are pooled and used to deliver its aims and objectives. This will require a complete review of the current BCF Plan and arrangements.

HWBBs across Mid and South Essex are currently undertaking a review of their functions in the light of forthcoming legislation on Integrated Care Systems. Part of the review will assist Boards to understand future governance and functionality requirements, including how they will influence and support the delivery of improved health outcomes through key strategies such as this *Case for Further Change*. The review will also help to identify the governance arrangements required between 'place' – i.e. Thurrock, and the ICS and how they should operate – including potential areas of conflict, overlap and responsibility. This will help to shape the aforementioned devolution and delegation agreement between the ICS and Thurrock Integrated Care Alliance (TICA).

10.3.4 How is Good Governance enforced?

The HLS principles that shape our governance arrangements must also shape the conditions that drive how the partnership functions and drive how decisions are made. Typically, these are:

- Commissioning arrangements
- Performance management
- Information and data management
- Policy and procedure
- Procurement
- Interpretation of legislation and regulation
- Process
- Risk management
- Finance and resource management

A review of these (to ensure they are set against the principles of HLS) will be carried out as part of a strategic action linked to this chapter.

10.5 Delivery Arrangements

Each of the chapters within this strategy will be accompanied by delivery plans – detailing actions and milestones set over each of the next four years. Delivery plans will be coproduced with staff and communities. Coproduction with communities will take place as set out within chapter four of the Strategy – a new approach to engaging with communities.

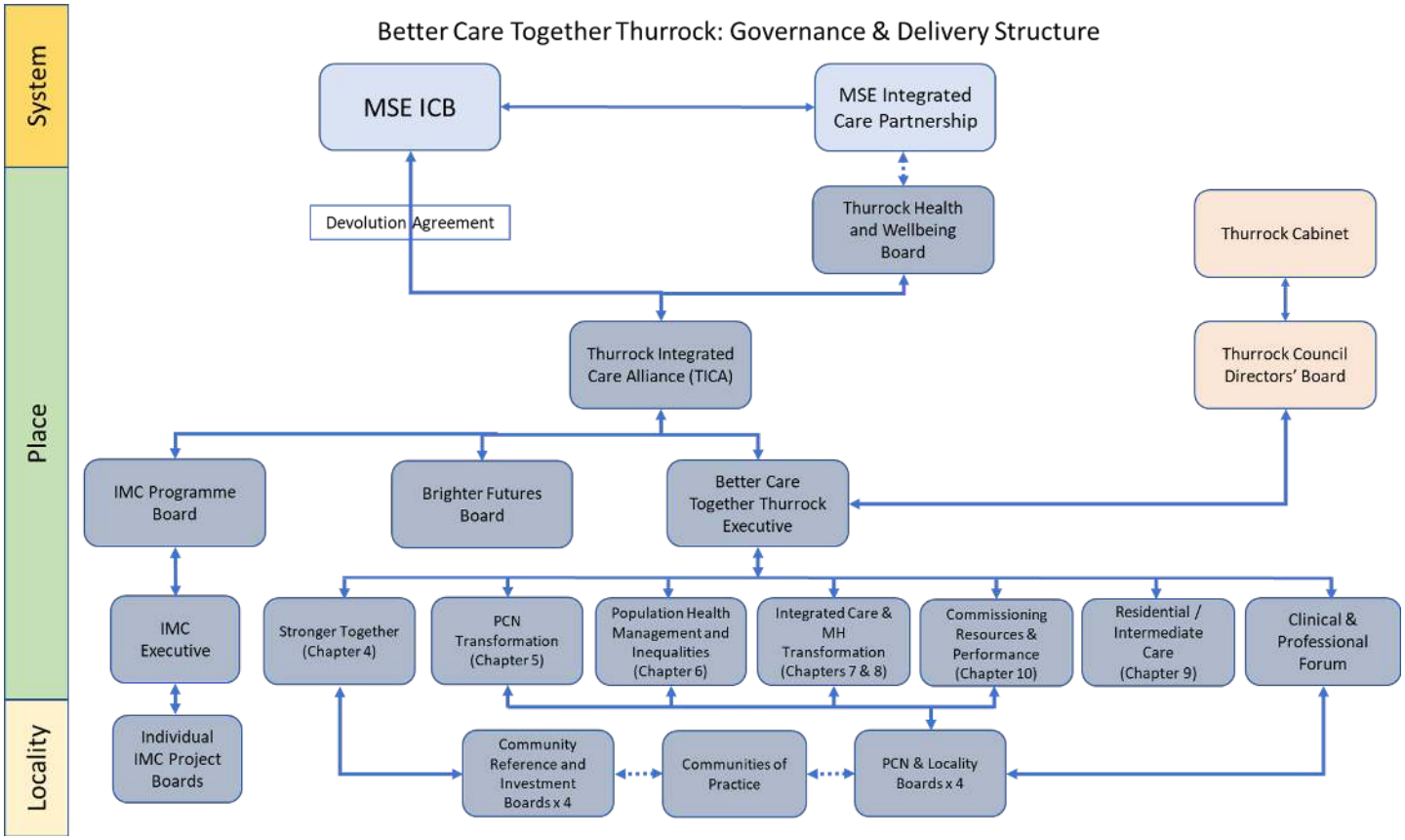
The draft structure, through which the strategy's delivery will be monitored and overseen, is detailed below. This will be for further review and redesign as the strategy starts to be implemented, ensuring that we test and learn and adapt as necessary. Delivery boards will have set responsibilities for different aspects of the strategy and will be responsible for unblocking and escalating barriers to progression. Delivery Boards will a have a system stewardship role, ensuring staff are enabled and empowered to take forward actions and initiatives set out within delivery plans and are able to take forward any learning. In keeping with HLS, delivery boards will form and be part of learning cycles.

All key system partners will be represented on delivery boards and be part of governance arrangements and it is a key principle of the delivery structure that governance and delivery arrangements are not 'top down', but facilitative and inclusive – ensuring appropriate distribution of power and permission. This will mean considering a mix of staff involvement throughout the structure and ensuring that 'leaders' are held to account for their facilitating and enabling role by staff – and communities.

Due to the contribution of this Strategy to the Health and Wellbeing Strategy, reporting arrangements will incorporate those of the Health and Wellbeing Strategy to the Health and Wellbeing Board.

Figure 10.1 sets out the proposed governance and delivery structures:

Figure 10.1



10.5.1 Thurrock Integrated Care Alliance (TICA)

Thurrock's ICA (TICA) has overall responsibility for the 'place' based health and care system in Thurrock and for managing the relationship and responsibilities between 'place' and 'system' – e.g. the interaction between Thurrock health and care and the Mid and South Essex care system (ICS).

TICA will also oversee budgetary responsibilities spanning the health and care system, which will include integrated commissioning via the Better Care Fund.

10.5.2 Better Care Together Thurrock Executive

Better Care Together Thurrock is the name of Thurrock's integrated Health and Care transformation programme. The Executive will be responsible for ensuring that the transformation programme is being delivered and will oversee that delivery through the effective functioning of the delivery boards. The Executive will report to the TICA who oversee the health and care system in Thurrock.

10.5.3 Other Delivery Boards

Delivery Boards will be responsible for overseeing the delivery of particular chapters of the Strategy. This will include the development of action plans spanning the five years – although these will be reviewed and revised at regular intervals. Delivery Boards will be responsible for identifying ways of measuring success and evaluating impact. They will also be responsible for ensuring staff are empowered to test and learn through the development and implementation of learning cycles, and that communities are being engaged through the delivery and development of effective engagement processes (chapter four refers).

10.6 Changing the Commissioning Landscape

If we are to achieve the vision and objectives set out within our Strategy, we must identify and enable the change identified to take place. Doing this requires the review and potential redesign of the functions and 'system conditions' that act to facilitate or prevent success from occurring. Often, transformation programmes fail because the design and operation of key supporting functions remain consistent with *New Public Management (NPM)* operating principles. The focus of transformation is often only on redesigning front-line and operational services.

Success is dependent on our ability to identify and ensure that all functions and conditions within our redesigned health and care system operate to the principles and behaviours of the new operating model – as set out predominantly within chapter two of The Further Case for Change.

The conditions and functions this may apply to have already been referenced earlier and form part of ensuring good governance.

This section focuses on the role and function of commissioning given the importance of this function to ensuring overall success.

> *"If we accept that it is the interaction of the many variables in the system that create positive outcomes for residents, rather than individual services or programmes, then we need to ask ourselves a new question: 'how do we create healthier systems?', because healthier systems create better outcomes.*
>
> *The role of system leaders and commissioners shifts from one of specification and performance management to one of 'System Stewards'; their function is to look after the health of the system."*

Chapter 17 of Human Learning Systems, Public Service for the Real World [3] describes why current forms of commissioning working to traditional NPM do not work. In summary:

- The lives of individuals are complex and not linear – yet we often commission 'one size fits all' services;
- Approaches to commissioning and funding tend to focus on compliance and control as a means of delivering positive outcomes – but this hinders rather than enables bespoke or flexible solutions; and
- Funders and commissioners tend to stimulate competition between providers rather than fostering the collaboration required for joined-up solutions required by individuals.

In addition, NPM has shaped the commissioning models we see in public service today through a reinforcement of the following:

- Task and service-focused specifications;
- Contract management based on restrictive and transactional measures;
- Commissioning that favours larger organisations and restricts smaller and grass-roots local providers;
- One size fits all specifications that fail to identify or allow flexibility to deliver what is required by different communities;
- Limited or non-existent engagement with the relevant communities – or 'co-production' with a small group of go-to users of services;
- Lack of power sharing or transfer of power with communities and users of services;
- Lack of innovation and experimentation.

10.6.1 Adopting a Different Commissioning Model

Adopting the principles of HLS set out in Chapter 2, and developing a people-led health and care system means developing a very different model of commissioning.

Providers must be able to provide flexible, bespoke support that responds to an individual's specific circumstances. Commissioning must operate differently to enable this to take place and the following describes how this will be achieved.

10.6.2. Recognising that Flexible Trusting Relationships are Key to Delivering 'Human' Solutions

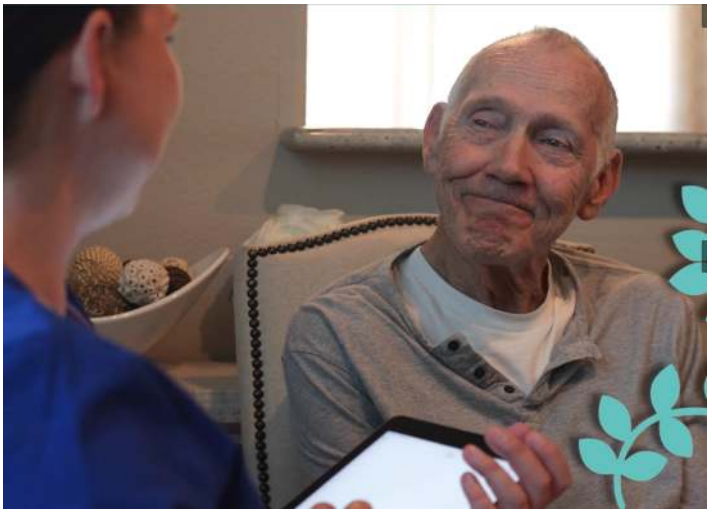
Establishing a commissioning model that enables this to occur by promoting providers who:

- Build effective and meaningful relationships with those they serve;
- Understand and respond to the unique strengths and needs contained by each person; and
- Act collaboratively with others to deliver what is required by the person.

This would mean ensuring that specifications, contract management and market development are consistent with these new conditions, and that a new type of partnership arrangement with potential providers was established.

This also means making sure that we commission for learning and not solely for service provision – ensuring that providers co-design solutions alongside the people they are supporting and, depending upon the circumstances, provide solutions for those people living in the community to whom they are not necessarily directly supporting – e.g. delivering activities designed to reduce isolation and increase connectedness.

> *"Nurturing trusting relationships at all levels, between citizens and providers, between organisations, and between funders and funded, leads to improved outcomes; micromanaging outcomes does not."*
>
> **Public Service for the Real World**



10.6.3 Looking Beyond a Narrow Service Lens: Operating Around Complexity

One of limitation of a NPM model of commissioning is that services are often commissioned in silo. Different commissioning teams will often commission services related to their respective areas of focus – for example Adult Social Care, Housing, Public Health, NHS.

As we know, people do not fit in to the neat boxes NPM operating models have helped to create. Their requirements often span services and can vary from one week to the next. As human beings, we need solutions that reflect us and what matters to us – this is not delivered by a one-size-fits-all service focused on transactions.

Commissioning to complexity and to the bespoke and varied outcomes of individuals means:

- The ability to pool commissioning budgets across different service areas (and organisations);
- Commissioning of integrated contracts and specifications that span different functions – e.g. Adult Social Care, Mental Health, Housing;
- Enabling flexibility within contracts to enable providers to have the freedom and autonomy to use resource as required to deliver on outcomes;
- Expecting providers to collaborate in order to provide integrated functions and solutions – or for providers to potentially be asked to provide a broader set of functions on the behalf of a number of commissioning partners;

- Enabling providers to 'buy in' support that they do not directly provide – for example through an Individual Service Fund type approach; and
- Adopting success indicators that are based upon whether people are achieving the outcomes they have identified as being important to them.

Achieving this will include identifying which budgets to bring together and which commissioning contracts – many of which will currently span a number of different service areas, providers and organisations. Test and learn initiatives will help develop the arrangements required.

Commissioners (and providers) will also have to identify how they can utilise the assets that exist within communities and individuals as part of this model.

10.6.4 Place-Based Funding

The Better Care Fund will be the vehicle through which a place-based commissioning budget will be grown. The Better Care Fund already contains the entire Adult Social Care budget for Thurrock and a significant proportion of the Thurrock CCG's budget for Community Health and Mental Health.

The Better Care Fund is a tool put in place by NHS England and was established initially to manage hospital activity. In Thurrock the Fund has become far more – being aligned with the vision for health and care in Thurrock, placing a significant focus on prevention and early intervention.

A review of the Better Care Fund (and section 75 agreement) will ensure that it operates to the principles of this *Case for Further Change* strategy. It will include considering additional funds currently sitting outside the BCF that need to be part of it – e.g. Housing. In addition, consideration will need to be given to what is commissioned by and for Place, and what is commissioned by and for the ICS and therefore outside the scope of the BCF.

The Governance of the BCF will be through Thurrock Integrated Care Alliance – in addition to BCF sign-off and reporting to the Health and Wellbeing Board.

10.6.5 Commissioning a Learning Environment

One of the three pillars of HLS is 'learning'. This means developing a culture of learning for all involved in the development and delivery of public service.

Commissioning functions can ensure that learning is prioritised through:

- Development of a 'positive error culture' – moving from performance management of contracts and providers that focus on "holding people and organisations accountable for delivering predefined programmes of work and predefined outcome targets" to an approach that uses "honest conversations" between providers and commissioners "about what they are learning and how they need to adapt their approach to do what's best for the people they are supporting."
- Encouraging and promoting on-going learning – both with providers and commissioners, and with learning sessions across providers, commissioners, users of services etc. Learning sessions could include providers having honest conversations with commissioners about what they want and need from them.
- Learning that is built into the commissioning model as a continuous process

10.6.6 Commissioning as a 'System Steward'

Key to building a commissioning function on the principles of HLS is redesigning the function to be able to take on a role as 'System Steward'. The HLS approach (Public Service for the Real World) states that System Stewardship assumes that:

"*those who work in the public and third sectors are motivated in their work to support others, generally can be trusted, and therefore do not require top-down control from managers or from funders and commissioners.*"

This will mean:

- Shifting from a model that focuses on 'the performance management of funding' to a model that engages in and enables complex system change;
- Looking at funding collaborations and partnerships rather than the allocation of resource to single providers – removing providers being in competition with each other and instead looking at what they can collectively offer;
- Taking responsibility for developing trusting relationships with providers and other commissioners;
- Creating space for learning and reflection – including being led by learning rather than 'operational outcome targets';
- Enabling providers to be autonomous and learning from their experiences on the ground;
- Playing a crucial role to remove bureaucracy.

This potentially means a fundamental redesign of how relevant commissioning functions currently operate – especially those commissioning health, social care and housing provision. It may also mean relooking at how in-house provision is 'commissioned'.

We will bring forward an OD programme for existing commissioners to develop system stewardship skills.

10.6.7 Learning about the Community

This Strategy proposes a new approach to community engagement and empowerment (chapter 4). Thurrock's communities must be at the heart of decision making. Traditionally, this has taken place through consultation exercises, user groups, and latterly through Healthwatch Thurrock. Work tends to take place in a piecemeal rather than an ongoing way. Typically, this leads to 'consultation fatigue' or complaints of not working with a broad enough representation of the community. This can mean decisions made about commissioning and developing services are not necessarily made based on the best information and power remains with the Council rather than shared with or transferred to communities themselves.

Communities of Practice are being established across Thurrock – aligned with each Primary Care Network (PCN) area. User-led CoPs will be formed from a wide variety of interested groups and individuals across the locality in question and be charged with agreeing priorities, designing strategies and solutions to meet those priorities and ensuring local intelligence feeds into all decision-making processes from a neighbourhood to a system wide scale. As such it will be the major forum to ensure community interests are represented at every level of decision making.

A direct-delivery CoP will also be established, made up of professionals operating in the locality. This network will ensure, with the information gathered from the user-led CoPs and any other information gathered from people living in the local area, that professionals are aware of any emerging themes and issues and can check that system design reflects what people want and need. This ensures that community intelligence is reflected in what is being commissioned and how it is being commissioned.

With budgets aligned to locality areas and pooled across different functions, the aim is to get to a point where resources can be shifted to communities and to CoPs (becoming Community Investment Boards), with communities having a direct say in how resources are used. This goes back to the principles of Asset Based Community Development, with communities identifying: 1. What they want services to do for them; 2. What they want services to do in partnership with them; and 3. What they want to do for themselves.

Given the significance of the change, this work will be developed over a period of time and take a phased approach – starting with the establishment of Communities of Practice in one area of the Borough.

10.6.8 The Market Place

The development of this Strategy will potentially mean the development of a very different marketplace. As part of the Care Act 2014, Local Authorities have a statutory duty to develop a Market Development Strategy. The purpose of the MDS is to clearly articulate the vision for the future and what Commissioners intend to do to make that vision a reality. The Strategy ensures that the market can offer sufficient choice for people requiring support and tells providers what the Council is likely to be commissioning.

The marketplace for health and social care has changed significantly over the past decade – but still fails to offer sufficient choice and still too often provides services that are traditional and focused on 'time and task' – with a formula of needs (y) equating to service offer (x). Direct Payment and Individual Health Funds have been established but these are typically used to buy services in the same mould as those commissioned by the Council or NHS.

Through our Stronger Together Partnership, work has taken place to establish a successful and growing Micro Enterprise scheme, but this provides a small fraction of the support required by those who need it.

The market in Thurrock must develop to be able to respond to intelligence gathered through the new model of engagement (chapter 4) and must also be developed to be able to reflect the principles of HLS. This includes supporting smaller grass roots providers as well as supporting existing providers to deliver an offer bespoke to the individual. The marketplace must also consider less traditional provision – including that which the community itself can offer.

10.6.9. Case Studies

Plymouth Alliance

The work began with exploring a more systemic approach to complex needs with a view to a radical redesign.

"An HLS approach looking at an Alliance contract was awarded to seven services in 2019 and along with three commissioners the CEOs form an Alliance Leadership Team of 10 members, operating on a principle of one person one vote and unanimous decision making. The contract is for up to 10 years (5+2+2+1) and all of the annual spend (£7.7 million) is devolved into the Alliance which has autonomy to spend it as it chooses.

In addition, the Alliance has a subcontracting relationship with other providers to deliver approximately 20 additional services. The Alliance uses demand-led budgets e.g. Bed and Breakfast and has a risk sharing agreement with the council where overspends are split 50/50. The aim of The Plymouth Alliance is to coordinate a complex needs system which will enable people to be supported flexibly, receiving the right help, at the right time, in the right place."

Liverpool Combined Authority

Liverpool CA introduced HLS as part of delivering a homeless assertive outreach approach.

"To help navigate and understand the system and support a service that is working across six Local Authorities with various needs and requirements, we very quickly understood we would need to employ a Systems Steward – someone who looks after the 'health of the system'. This role is led by the Contract and Review Lead.

As the Assertive Outreach service has been designed to be flexible and responsive, adopting a learning approach to contract monitoring has been imperative over the last six months. To do this, the focus of the Contract and the Review Lead has been the following:

- To develop trusting and honest relationships between all actors involved in the commissioning and delivery of the service, particularly amongst the core providers
- To be led by learning rather than influenced by ensuring operational delivery met outcomes
- To increase understanding of HLS and what it means for the commissioner-provider relationship and contract monitoring
- To create space for reflection and learning within the commissioner-provider-delivery team relationships".

10.6.10. The impact of Forthcoming Changes to NHS Legislation

NHS England and NHS Improvement are in the process of reviewing current procurement rules. The focus is on establishing a set of more flexible arrangements that are currently in place to support the NHS ambition for greater integration and collaboration between NHS organisations and their partners. Changes will be made through regulation made under the forthcoming Health and Care Bill.

There is also an expectation as part of the Bill that even though ICSs have statutory commissioning responsibilities on behalf of the NHS, they will delegate commissioning and budget decision making to place and provider collectives. This means that Thurrock Integrated Care Alliance will be able to make and steer all commissioning decisions that benefit residents and communities of Thurrock.

Establishing arrangements such as a collaborative commissioning alliance in Thurrock, will enable mechanisms to be put in place that shift the commissioning environment from once the commissions 'services' and 'functions', to one that commissions solutions and outcomes for people – through the application of a Human Learning Systems approach.

Chapter References

1. Donahue J. On collaborative governance. Corporate social responsibility initiative Working Paper. 2004 Mar;2. ↑

2. Cornwall A, Gaventa J. From users and choosers to makers and shapers repositioning participation in social policy1. IDS Bulletin. 2000 Oct;31(4):50-62. ↑

3. Lowe, T. et. Al. Human Learning Systems, Public Service for the Real World. Collaborate 2021. https://www.centreforpublicimpact.org/assets/documents/hls-real-world.pdf ↑

Published by:

Thurrock Council
Civic Offices
New Road
Grays, Essex
RM20 4AS

May 2022

Email: dkristiansen@thurrock.gov.uk.

13 July 2022	Item: 17 Decision: 110620
Cabinet	
Hackney Carriage Fares	
Wards and communities affected: All	**Key Decision:** Key
Report of: Councillor Rob Gledhill – Leader and Cabinet Member for Public Protection and Anti-Social Behaviour	
Accountable Assistant Director: Leigh Nicholson, Assistant Director Planning, Transport and Public Protection	
Accountable Director: Julie Rogers, Director of Public Realm	
This report is: Public	

Executive Summary

Local Authorities have a power to set fares for hackney carriages. A request from representatives of the hackney carriage trade has been received for an increase in the Taxi Fare, this report seeks agreement to allow for public consultation in accordance with the statutory requirements.

1. Recommendation(s):

1.1. That Cabinet agrees for the proposed table of fares, as set out in Appendix A, to go out for public consultation, in accordance with the statutory requirement.

2. Introduction and Background

2.1 Local Authorities have the power to set fares for Hackney Carriage vehicles.

2.2 The setting of fares relates to the Council fixing the rates or fares within the district, this may include what is charged for time and distance travelled and all other charges in connection with the hire of a vehicle or with the arrangements for hire of a vehicle

2.3 The rate or fares set is known as the “table of fares".

2.4 This fare is the maximum amount that can be charged, an individual driver does have the ability to charge below the amount prescribed in the table of fares if they chose to do so.

2.5 The table of fares were last set with effect from November 2012; details are provided in **Appendix A**.

2.6 The cost of providing and running a hackney carriage vehicle has significantly increased since the fare was set in 2012, this increase is being requested to rebalance to costs with the income achieved to ensure that a living wage can be achieved.

2.7 The power to set fares is provided by Section 65, Local Government (Miscellaneous Provisions) Act 1976.

2.8 When this power is exercised the Local Authority must publish in at least one local newspaper circulating in the district a notice setting out the table of fares allowing not less than 14 days for objection to be made. The Local Authority must make available at their offices a copy of said notice.

2.9 If after the 14 days no objection has been received or received and withdrawn, then the new fare takes effect from the date published in the notice

2.10 If objection has been received and not withdrawn the Local Authority must consider the objection and may make changes to the proposed table of fares as it feels necessary, or it may choose to not make any changes to the proposal.

2.11 If objection is received a report will be brought back to Cabinet for consideration. The new fare will then come into effect within two months of the original date.

3. Issues, Options and Analysis of Options

3.1 A request from representatives of the hackney carriage trade has been received for an increase in the Taxi Fare.

3.2 The proposes table of fares are detailed in **Appendix A**, along with a comparison on the difference in cost for a journey of varying distance.

3.3 It is intended that the new table of fares will come into effect from 5 August 2022.

4. Reasons for Recommendation

4.1 The process of setting Hackney carriage Fares is prescribed by the legislation; this recommendation is compliant with the procedure to be followed.

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

5.1 Following agreement by this committee the public consultation will be carried out in accordance with the requirements contained within Section 65, Local Government (Miscellaneous Provisions) Act 1976.

5.2 A notice will be published in a local paper the week beginning the 18 July 2022 and will be posted on Thurrock Councils Website and on the public notice board at the front of the Civic Offices, giving 14 days for representations to be made.

5.3 If no representations are received, then the proposed table of fares will come into effect on the 5 August 2022.

5.4 If representation is received, then that representation will be presented to Cabinet for consideration.

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

6.1 None.

7. Implications

7.1 Financial

Implications verified by: **Laura Last**
Senior Management Accountant

There are no direct financial implications for Thurrock Council arising from this report.

7.2 Legal

Implications verified by: **Simon Scrowther**
Litigation Lawyer

(1) A district council may fix the rates or fares within the district as well for time as distance, and all other charges in connection with the hire of a vehicle or with the arrangements for the hire of a vehicle, to be paid in respect of the hire of hackney carriages by means of a table (hereafter

in this section referred to as a “table of fares”) made or varied in accordance with the provisions of this section.

(2) (a) When a district council make or vary a table of fares they shall publish in at least one local newspaper circulating in the district a notice setting out the table of fares or the variation thereof and specifying the period, which shall not be less than fourteen days from the date of the first publication of the notice, within which and the manner in which objections to the table of fares or variation can be made.

(3) A copy of the notice referred to in paragraph (a) of this subsection shall for the period of fourteen days from the date of the first publication thereof be deposited at the offices of the council which published the notice, and shall at all reasonable hours be open to public inspection without payment.

7.3 **Diversity and Equality**

Implications verified by: **Rebecca Lee**

Team Manager, Community Development

A Community Equality Impact Assessment will be completed for the proposed revised Hackney Carriage Fares informed by the consultation process. The table of fares does not allow additional charges to be made for passengers accompanied by guide dogs or wheelchair users. This recognises the relevant duty set out in legislation to make reasonable adjustments for disabled users of Hackney Carriages.

7.4 **Other implications** (where significant) – i.e. Staff, Health Inequalities, Sustainability, Crime and Disorder, and Impact on Looked After Children

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 A** – Details of Current Table of Fares and Proposed Table of Fares.

Report Author:

Paul Adams

Licensing Manager, Public Protection

Appendix A –

Fare Comparison
EXISTING FARES

Distance (miles)	Tariff 1 Rate 1	Tariff 1 Rate 2	Tariff 1 Rate 3	Tariff 2 Rate 1	Tariff 2 Rate 2	Tariff 2 Rate 3
1	4.31	6.07	7.53	6.47	8.73	11.34
2	5.94	8.51	10.78	8.91	11.95	16.23
3	7.57	10.96	14.04	11.36	15.24	21.12
4	9.20	13.40	17.03	13.80	18.50	26.01
5	10.83	15.84	20.56	16.24	21.76	30.89
10	21.77	28.46	39.44	28.86	40.64	56.12

PROPOSED FARES

Distance (miles)	Tariff 1 Rate 1	Tariff 1 Rate 2	Tariff 1 Rate 3	Tariff 2 Rate 1	Tariff 2 Rate 2	Tariff 2 Rate 3
1	5.08	7.44	9.80	7.44	10.59	14.51
2	7.10	10.28	13.46	10.28	14.24	19.80
3	9.12	13.12	17.12	13.12	17.89	25.09
4	11.14	15.96	20.78	15.96	21.54	30.39
5	13.16	18.80	24.44	18.80	25.19	35.68
10	24.25	33.04	44.97	33.04	45.72	62.15

Current and Proposed Table of Fares.

	PROPOSED TARIFF 1 Up to 4 Persons	**PROPOSED TARIFF 2 Over 4 Persons**	**CURRENT TARIFF 1 Up to 4 Persons**	**CURRENT TARIFF 2 Over 4 Persons**
RATE 1: For all hiring's except those occurring on the days and times defined in Rate 2 & 3				
For the first 114.95 metres (approx 125.71 yards) or the first 48 seconds (or a combination of parts of such distance or time)	£3.20		£2.80	
For the first 114.95 metres (approx 125.71 yards) or the first 36 seconds (or a combination of parts of such distance or time)		£4.80		£4.20
For each additional 159.3 metres (approx. 174.2 yards) or 48 seconds (or a combination of parts of such distance or time) or until a distance of 9.65 kilometres (approx. 6 miles) travelled	£0.20		£0.20	
For each additional 170 metres (approx. 185.91 yards) or 36 seconds (or a combination of parts of such distance or time) or until a distance of 9.65 kilometres		£0.30		£0.30

(approx. 6 miles) travelled				
Then for each additional 178.75 metres (approx. 195.48 yards) or 48 seconds (or a combination of parts such distance or time)	£0.30		£0.30	
Then for each additional 186 metres (approx. 203.41 yards) or 36 seconds (or a combination of parts such distance or time)		£0.40		£0.40
RATE 2: For all hiring's begun between 22:00 hours and 06:00 hours Mondays to Saturday inclusive; all day Sunday; all day Bank Holiday (except where Rate 3 applies)				
For the first 114.95 metres (approx 125.71 yards) or the first 36 seconds (or a combination of parts of such distance or time)	£4.80		£3.80	
For the first 114.95 metres (approx 125.71 yards) or the first 24 seconds (or a combination of parts of such distance or time)		£7.20		£5.70
For each additional 170 metres (approx 185.91 yards) or 36 seconds (or a combination of parts of such distance or time) or until a distance of 9.65 kilometres (approx 6 miles) travelled	£0.30		£0.30	
For each additional 176.36 metres (approx 192.87 yards) or 24 seconds (or a combination of parts of such distance or time) or until a distance of 9.65 kilometres (approx 6 miles) travelled		£0.40		£0.40
Then for each additional 186 metres (approx 203.41 yards) or 36 seconds (or a combination of parts such distance or time)	£0.40		£0.40	
Then for each additional 193.1 metres (approx 211.17 yards) or 24 seconds (or a combination of parts such distance or time)		£0.60		£0.60
RATE 3: For hiring's begun between 18:00 hours on 24th December until 06:00 hours on 27th December and those begun between 18:00 hours on 31st December and 06:00 hours on 2nd January				
For the first 114.95 metres	£6.40		£4.50	

(approx 125.71 yards) or the first 24 seconds (or a combination of parts of such distance or time)				
For the first 114.95 metres (approx 125.71 yards) or the first 18 seconds (or a combination of parts of such distance or time)		£9.60		£6.80
For each additional 175.85 metres (approx 192.31 yards) or 24 seconds (or a combination of parts of such distance or time) or until a distance of 9.65 kilometres (approx 6 miles) travelled	£0.40		£0.40	
For each additional 182.5 metres (approx 199.58 yards) or 18 seconds (or a combination of parts of such distance or time) or until a distance of 9.65 kilometres (approx 6 miles) travelled		£0.60		£0.60
Then for each additional 193.1 metres (approx 211.17 yards) or 24 seconds (or a combination of parts such distance or time)	£0.60		£0.60	
Then for each additional 200.22 metres (approx 218.96 yards) or 18 seconds (or a combination of parts such distance or time)		£0.80		£0.80
Extra Charges (applicable to Rates 1,2 & 3)				
For each dog carried (except assistance dogs, for which no charge will be added)	£0.50	£0.50	£0.50	£0.50
All road toll and congestion charges where applicable				

PLEASE NOTE:

- Dogs are carried at the driver's discretion, except assistance dogs
- All fares and charges are inclusive of VAT
- A charge can be made if a passenger soils a vehicle

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13 July 2022	Item: 18
Cabinet	
End of Year (April 2021 to March 2022) Corporate Performance Report 2021/22	
Wards and communities affected: All	**Key Decision:** Non-key
Report of: Councillor Shane Hebb, Cabinet Member for Transformation and Performance	
Accountable Assistant Director: n/a	
Accountable Director: Karen Wheeler, Director of Strategy, Engagement and Growth	
This report is public	

Executive Summary

This report provides a final position in relation to the performance of key indicators during the 2021/22 council year.

Despite the varying longer-term impact of COVID, the report shows that 67.5% of indicators are currently achieving target and 69% are better than or the same as the previous year.

To recap, during the first three months of the financial year (April to June), the country was preparing to open up slowly in line with the government's roadmap, but there were still a number of restrictions in place. In quarter 2 (July to September), some indicators were still being directly or indirectly impacted by the coronavirus pandemic although national restrictions had significantly reduced. During quarter 3 (October to December), rates of infection and restrictions increased again. In the final quarter (January to March) restrictions were lifted, however there were still some residual knock-on impacts to some services.

The report highlights if, where and how COVID-19 disrupted or changed performance and/or priorities and demand levels across a number of services during the year and in some cases continues to have a lasting effect.

It is anticipated that this will be the final corporate performance report which will include a specific section focused on COVID impact.

The future landscape of Thurrock is changing, across the whole borough with the Thames Freeport and Towns Funds awards being key place-changing initiatives, designed to help level-up Thurrock and create a borough where everyone can proudly live, work and play. As such, the Portfolio Holder for Transformation and Performance

has given direction that Thurrock Council will refresh the borough 'vision' (last reviewed in 2016) to ensure these initiatives feature in the forward plan and priorities for Thurrock. This will also lead to an associated refresh of the corporate performance framework – meaning that a modern set of key priorities and key performance indicators will be introduced so that the council is targeted toward the delivery of a new purpose and vision.

The report also highlights other achievements of the council during the year. This report was considered at Corporate Overview and Scrutiny Committee on 12 July 2022.

1. Recommendation(s):

1.1 To note and comment upon the performance of the key corporate performance indicators in particular those areas which did not reach their target and the impact of COVID-19.

1.2 To identify any areas which require additional consideration in 2022/23 as part of the refresh of the council's corporate performance framework.

1.3 To agree to commencing a refresh of the borough forward vision, and underlying key priorities and key performance indicators, reflecting a modern Thurrock (inclusive of major infrastructure investment through the Towns Funds and Thames Freeport).

2. Introduction and Background

2.1 The performance of the priority activities of the council is monitored through the Corporate Key Performance Indicator (KPI) framework. This provides a mixture of strategic and operational indicators. The indicators have been chosen to be as clear and simple to understand as possible, whilst balancing the need to ensure the council is monitoring those things which are of most importance, both operationally and strategically.

2.2 This reflects the demand for council services increasing and being ever more complex, not least due to the impact of the coronavirus pandemic, and the need for a holistic approach to monitoring data and intelligence. Analysis of performance and internal processes at service level by Directors continued monthly throughout 2020/21 and continued throughout 2021/22.

2.3 These corporate indicators were reported to both Corporate Overview and Scrutiny Committee and Cabinet on a quarterly basis throughout 2021/22.

2.4 Since June 2019, where performance is below target, commentary has been included to show the intended improvement plan. This is included in Section 3.6 as the "Route to Green".

3. Issues, Options and Analysis of Options

This report is a monitoring and update report, therefore there is no options analysis.

3.1 **Summary of Corporate KPI Performance**

End of Year 2021/22 Performance against target			
Achieved	67.5% (27)	↑ BETTER	63%
		→ STATIC	18.5%
		↓ WORSE	18.5%
Failed	32.5% (13)	↑ BETTER	41.7%
		→ STATIC	0%
		↓ WORSE	58.3%

Direction of Travel compared to 2020/21	
↑ **BETTER**	56.4% (22)
→ **STATIC**	12.8% (5)
↓ **WORSE**	30.8% (12)

3.2 **Impact of Covid-19**

3.2.1 The final End of Year overall outturn is 67.5% of indicators achieving their target which is higher than the outturn for 2020/21 of 63%, but below the largely pre-COVID outturn in 2019/20 of 74%. However, given the significant impact and disruption over the last two years due to COVID-19, it is difficult to make a like-for-like comparison. During the period which this report covers, the first quarter plus December saw the country still in various phases of lockdown. Whilst restrictions have now ceased, the council has continued to see residual impacts to some services.

3.2.2 In most cases the targets for 2021/22 were decided to be based on "normal" circumstances to more clearly analyse the impact of the disruption caused by the pandemic. Where an indicator has failed to reach its end of year target, the commentary provided will identify clearly whether this is related to COVID-19 impacts or other factors impacting on performance.

3.2.3 There were some 'People'-orientated KPIs in the scorecard which have not been able to be reported at all during 2021/22 data due to COVID-19 disruption. These are as follows:

Number of delayed transfers of care (DTOC) - days from hospital (attrib. to NHS, ASC & Joint)	Collection of official DToC figures was suspended by NHS England for 2021/22.
Number of GP practices with automated screening protocol in place for depression and anxiety amongst LTC (long-term conditions) patients	Data has not been available from GP practices throughout 2021/22.
% of GP practices who have received a) 1 visit to discuss COVID recovery in relation to Quality Outcomes Framework (QOF) b) second visit to review outcomes of first and discuss the cancer quality improvement work	Due to prioritising primary care on the booster vaccine campaign in response to the pandemic recovery, visits were suspended and data ceased in relation to these QOF indicators.
KS2 Attainment - % Achieving Expected or Better Progress in a) Reading b) Writing c) Maths	Government is not publishing annual attainment data for schools for last year.
KS4 Attainment 8 score	
KS4 Progress 8 score	
KS4 % English / maths combined GCSE grade 5+	
Achievement of Level 2 qualification at 19 years old	
Achievement of Level 3 qualification at 19 years old	
Children Looked After KS2 – % Achieving the National Standard in Reading, Writing & Maths	
Children Looked After KS4 – Progress 8 score	

3.3 **Highlights of 2021/22**

Despite the challenges that 2021/22 has created there are many highlights and achievements to share, including:

- Thurrock received £42.7million as part of the Towns Fund with Tilbury receiving £22.8million and Grays being awarded £19.9 million
- co-production with private sector partners of the Thames Freeport Full Business Case for government
- delivery of approximately 2,000 Christmas presents to children and young people known to social care teams donated by Thurrock residents and businesses for Give a Gift
- 30 family-run and small independent businesses taking part in the Shop Safe Shop Local campaign in support of Small Business Saturday and over the festive period
- support offered to small businesses across the borough as part of the council's Welcome Back Fund programme
- new Vaccine Champions recruited to make sure more of the borough's residents get the protection the COVID-19 vaccines offer thanks to £485,000 of government funding awarded to the borough
- Mayor's COVID stars – special recognition certificates were given to around 450 people in the borough who were nominated for having gone above and beyond to help their community during the COVID-19 pandemic
- partnership working to refresh the Health and Wellbeing Strategy
- support to Office of National Statistics to deliver the Census 2021 survey
- Beaconsfield Place opened in Tilbury - a new build affordable and accessible development comprising of 31 one-bedroom flats and four two-bedroom duplexes, plus derelict garages in Chadwell St Mary were transformed into two habitable residential bungalows benefiting Thurrock families who have health or mobility problems
- several joint operations started with Essex Police targeting nuisance bikers, with expanding initiatives starting through 2022.
- first-ever Thurrock Enterprise Week (#TEW) promoted business growth, entrepreneurship and connected local businesses to major strategic investment projects across the borough
- Stanford-le-Hope railway station gained planning approval after delays at the Planning Committee
- Grays Beach Riverside Park received new play equipment, including a new ship and castle, Parkour outdoor sports, health and fitness area and improved accessibility
- The Highway Maintenance Team have performed well with their management of pothole repairs – in ten out of the 12 months 100% of potholes were repaired within policy and agreed timeframe and a final outturn of 99.87%

3.4 On target performance

67.5% of available corporate KPIs achieved their targets. (Brackets show actuals where appropriate).

Indicator Definition	Portfolio Holder 2021/22	*2020/21 Outturn*	Quarter 1 Year to Date	Quarter 2 Year to Date	Quarter 3 Year to Date	In Month Jan	In month Feb	In month March	End of Year Outturn	Target Status	Direction of Travel since 2020/21	2021/22 Target
% of Major planning applications processed in 13 weeks	Cllr Maney	*97%*	100%	100%	100%	100%	100%	100%	100.00% (29)	ACHIEVED	BETTER	90%
Forecast Council Tax collected	Cllr Hebb	97.96%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.2%	ACHIEVED	BETTER	98%
% of refuse bins emptied on correct day	Cllr Jefferies	*97.31%*	99.87%	99.96%	99.95%	99.96%	99.94%	99.96%	99.95%	ACHIEVED	BETTER	98.5%
% of potholes repaired within policy and agreed timeframe	Cllr Maney	*98%*	99%	100%	100%	100%	100%	100%	99.87% (3,888)	ACHIEVED	BETTER	98%
Forecast National Non-Domestic Rates (NNDR) collected	Cllr Hebb	96.8%	96.8%	96.8%	96.8%	96.8%	96.8%	96.8%	98.4%	ACHIEVED	BETTER	96.8%
Tenant satisfaction with Transforming Homes	Cllr Spillman	86.5%	90.3%	88.4%	89.9%	75.0%	100%	92.9%	90.3% (102)	ACHIEVED	BETTER	85%
Number of health hazards removed as a direct result of private sector housing team intervention	Cllr Spillman	746	212	455	724	154	57	73	1,008	ACHIEVED	BETTER	1,000
Number of hubs/libraries events/activities supporting engagement in cultural /social/learning opportunities for well-being/strengthen community connections	Cllr Huelin	*437*	99	290	602				1,261	ACHIEVED	BETTER	360
Value of council owned property disposals	Cllr Coxshall	*£460k*	£537k	£2,797k	£2,797k				£9,276k	ACHIEVED	BETTER	£3m
% occupancy of council-owned business centres	Cllr Coxshall	*71%*	75%	75%	86.67%				87%	ACHIEVED	BETTER	80%
Proportion of older people (65+) still at home 91 days after discharge from hospital into reablement/ rehabilitation	Cllr Huelin	*86.40%*	91.9%	84.0%	94.4%				91.1% (82)	ACHIEVED	BETTER	86.3%
Number of new Micro Enterprises started since 1 April 2021	Cllr Huelin	*20*	4	16	21				29	ACHIEVED	BETTER	20
% of places accessed for two year olds for early years education in the borough	Cllr Johnson	*70%*	71.6%	82.3%	77.27%				77%	ACHIEVED	BETTER	73%
Value of business rate base	Cllr Hebb	*£283m*							£289m (1/4/22)	ACHIEVED	BETTER	£277.5m
Total number of employee jobs in Thurrock (data from ONS/NOMIS)	Cllr Coxshall	*66,000*							73,000	ACHIEVED	BETTER	66,000
% of secondary schools judged "good" or better	Cllr Johnson	*60%*							70%	ACHIEVED	BETTER	63%

Average gross full-time weekly wage in Thurrock for those living in Thurrock	Cllr Coxshall	*£630.60*							£670.60	ACHIEVED	BETTER	£631.70

Indicator Definition	**Portfolio Holder 2021/22**	***2020/21 Outturn***	**Quarter 1 Year to Date**	**Quarter 2 Year to Date**	**Quarter 3 Year to Date**	**In Month Jan**	**In month Feb**	**In month March**	**End of Year Outturn**	**Target Status**	**Direction of Travel since 2020/21**	**2021/22 Target**
Number of applicants with family commitments in Bed & Breakfast for six weeks or more (ie presenting as homeless with dependent child(ren) or are pregnant)	Cllr Spillman	*0*	0	0	0	0	0	0	0	ACHIEVED	STATIC	0
Overall spend to budget on HRA (£K variance against forecast)	Cllr Spillman	*£0*	£0	£0	£0	£0	£0	£0	£0	ACHIEVED	STATIC	£0
% of volunteer placements filled within council	Cllr Huelin	*96%*	90%	93%	94%				96% (185)	ACHIEVED	STATIC	96%
Successful completion of treatment in Young People's Drug & Alcohol service (YTD)	Cllr Mayes	*90%*	100%	95%	96%				89%	ACHIEVED	STATIC	70%
Overall spend to budget on General Fund (% variance against forecast)	Cllr Hebb	*0*	0	0	0				0	ACHIEVED	STATIC	0
% of Minor planning applications processed in 8 weeks	Cllr Maney	*100%*	100%	100%	100%	100%	100%	90%	99.46% (184)	ACHIEVED	WORSE	90%
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	Cllr Huelin	*618.3 per 100k pop*	178.4 (43)	336.1 (81)	493.8 (119)	539.5 (130)	614.2 (148)	651.5 (157)	651.5 (157)	ACHIEVED	WORSE	738.7 (178)
% of repairs completed within target	Cllr Spillman	*98.3%*	97.2%	95.4%	95.9%	97.0%	97.0%	95.9%	96.0% (33,423)	ACHIEVED	WORSE	95%
No of placements available within council for volunteers	Cllr Huelin	*224*	150	194	177				192	ACHIEVED	WORSE	190
Street Cleanliness - a) Litter	Cllr Jefferies	*4.61%*	6.17%	7.83%	9.50%				7.83%	ACHIEVED	WORSE	9%
3&4 year olds accessing a funded nursery place (ANNUAL)	Cllr Johnson	*new KPI*	This indicator relies on data published by the Department for Education, which at the point of writing the report was not yet available.									90% 2021 National Average

3.5 **Off target indicators**

At year end, thirteen (13) of the available indicators failed to meet their target.

Indicator Definition	Portfolio Holder 2021/22	*2020/21 Outturn*	Quarter 1 Year to Date	Quarter 2 Year to Date	Quarter 3 Year to Date	In Month Jan	In month Feb	In month March	End of Year Outturn	Target Status	Direction of Travel since 2020/21	2021/22 Target
Payment rate of Fixed Penalty Notices (FPNs)	Cllr Gledhill	*49%*	60.6%	58.9%	46.9%	41.5%	59.6%	44%	54%	FAILED	BETTER	70%
The payment rate of FPNs has been below target throughout 2021/22 however at year end has achieved an improved outcome to 2019/20. This is due to factors that are outside of the control of the service, including the knock-on financial and emotional impact of COVID-19 on residents who are fined. The service has received a high level of representations and appeals over the last 12 months with requests for extended payment periods. The service continues to adopt a supportive approach agreeing payment plans on a case by case basis.												
ROUTE TO GREEN IN 2022/23												
We have been offering extended periods to pay fines to increase payment compliance as residents emerge from the pandemic and the assisted supported benefits offered by the government. We are increasing revisits to offending residents in order to assist in payment compliance. Kingdom Services are now using software to confirm the recipient's' details at the point of issuing fixed penalty notices. At the previous meeting the Corporate Overview and Scrutiny Committee asked for more details about the process for following up non-payment of fines. The Environmental Enforcement team are responsible for encouraging FPNs payments to be made. If a recipient fails to pay an FPN in the required 14 days an officer will attempt to contact the resident by phone call and/or sending a reminder letter. If a recipient still fails to pay the FPN the officer will conduct the necessary checks and complete a prosecution case file. This will then be submitted to the council's legal team to follow the prosecution process. It is important to note that recipients of an FPN are at liberty to NOT pay the FPN and attend court where they can submit a not guilty plea.												

Indicator Definition	Portfolio Holder 2021/22	*2020/21 Outturn*	Quarter 1 Year to Date	Quarter 2 Year to Date	Quarter 3 Year to Date	In Month Jan	In month Feb	In month March	End of Year Outturn	Target Status	Direction of Travel since 2020/21	2021/22 Target
Of the children who reached their 28th day in care within the reporting period; % that had an Initial Health Assessment (IHA) within 20 working days (28 calendar days)	Cllr Johnson	*57%* *KPI definition amended*	85.2%	61.2%	58%				*58.8%*	FAILED	BETTER	80%
Delays to appointments have been due to a number of different factors including from health colleagues, placement changes, capacity issues, family having cancelled appointment or not attending scheduled meetings. The capacity of health colleagues has been an issue and this has been escalated to enable a joint solution to be found. Small numbers involved also impacts significantly on the percentage change. The service continues to work with new team managers and social workers to ensure they understand the paperwork and reduce delays.												
ROUTE TO GREEN IN 2022/23												
Ensuring that the paperwork (where there is consent) is sent within 5 days to health colleagues is key. The initial appointments for children within Thurrock are usually within the 20 days. However, there are capacity issues for all health authorities in England for IHAs. Delays are addressed through the weekly IHA meeting and escalated where necessary. There is regular consultation with the Clinical Commissioning Group (CCG) and regular reviewing of the data. This is ongoing. 2022/23 will see a renewed focus on the IHA and seeking consent from parents as well as agreeing with foster carers that they cannot re-arrange appointments and arranging for social workers to attend with the carers. Health colleagues have indicated that there is agreement for additional resource to ensure appointments within Thurrock can be more effectively supported but the national picture remains the same and we continue to meet weekly with health colleagues to ensure that there is liaison and escalation with other LAs where they are responsible for IHA appointments.											

Indicator Definition	Portfolio Holder 2021/22	*2020/21 Outturn*	Tranche 1	Tranche 2	Tranche 3	End of Year Outturn	Target Status	Direction of Travel since 2020/21	2021/22 Target
Street Cleanliness - c) Graffiti % of surveyed areas where there is an unacceptable level of graffiti	Cllr Jefferies	*3.67%*	3.33%	3.83%	3.67%	**3.61%**	FAILED	BETTER	3%

Whilst the target was missed this was an improvement over Tranche 3 from last year and the second best score that we have ever achieved. The team continues to carry out small graffiti clearances on street furniture with all operatives carrying a small graffiti removal kit. The team also carry out large graffiti clearances when needed.

ROUTE TO GREEN IN 2022/23

In addition to ongoing vigilance and cleaning of graffiti by the street cleansing teams, Environmental Enforcement Officers are continuing with Operation Abercrombie and recording graffiti offences. This has seen a reduction in offending and the arrest and prosecution of one offender.

Indicator Definition	Portfolio Holder 2021/22	*2020/21 Outturn*	Quarter 1 Year to Date	Quarter 2 Year to Date	Quarter 3 Year to Date	In Month Jan	In month Feb	In month March	End of Year Outturn	Target Status	Direction of Travel since 2020/21	2021/22 Target
Total gross external income (fees & charges) (based on sales forecast)	Cllr Hebb	*£6.4m*	6.6m	£7.1m	£7.4m				£7.6m	FAILED	BETTER	£8m

The final position was under target and reflects the current level of fees and charges post-pandemic. A proportion of the income loss was announced as being met from Central Government funding and there are some cost reductions associated with specific income losses that further mitigate the overall position.

ROUTE TO GREEN IN 2022/23

This is regularly reported in detail to members as part of the programme of finance and budget reports.

Indicator Definition	Portfolio Holder 2021/22	*2020/21 Outturn*	Quarter 1 Year to Date	Quarter 2 Year to Date	Quarter 3 Year to Date	In Month Jan	In month Feb	In month March	End of Year Outturn	Target Status	Direction of Travel since 2020/21	2021/22 Target
No of new apprenticeships started (inc. existing staff) (exc. LA maintained schools)	Cllr Duffin	*56*	10	23 (33)	6 (39)	4	2	1	46	FAILED	WORSE	62 (2.3% of workforce)

Overall, the council had 46 new apprentice starts in 2021/22 which represents 1.7% of the overall workforce against a public sector target of 2.3%. This ranks us better than the average for local authorities which was 1.2% (as reported by the Local Government Association).

ROUTE TO GREEN IN 2022/23

The government has removed the mandatory targets for each authority for 2022/23. This enables the organisation to focus on how it can offer apprenticeships most effectively rather than focussing on an arbitrary number that does not take into account the local situation. The council will continue to monitor and encourage services to offer apprentices through the Apprentice Champions within each directorate, including the offer of apprenticeships to existing staff as part of their continued professional development.

Indicator Definition	Portfolio Holder 2021/22	*2020/21 Outturn*	End of Year Outturn	Target Status	Direction of Travel since 2020/21	2021/22 Target
% of primary schools judged “good” or better	Cllr Johnson	*92%*	90.0%	FAILED	WORSE	92%

Four primary academy schools had an Ofsted Inspection in the financial year 2021/22. Of those, three retained their “good” outcome and one was downgraded to “requires improvement”.

ROUTE TO GREEN IN 2022/23

The service met with leaders at the Academy which has been rated as “requiring improvement” to identify where support could be provided. The Trust has indicated that they have strong partnerships within their Trust to support the school to improve. There are a number of schools that are due a reinspection. The service meets with all schools annually to identify those at risk of poor Ofsted outcomes and these are discussed where appropriate with the Reginal Schools Commissioners Office as well as with school leaders. The Harris Teaching School Hub Lead and the council’s Strategic Lead meet annually to identify continued professional development and improvement needs within the local authority area.

Indicator Definition	Portfolio Holder 2021/22	*2020/21 Outturn*	Quarter 1	Quarter 2	Quarter 3	At Month end Jan	At Month end Feb	At Month end March	End of Year Outturn	Target Status	Direction of Travel since 2020/21	2021/22 Target
Proportion of people using social care who receive direct payments	Cllr Huelin	*34.4%*	33.1%	31.5%	31.1%	31.1%	31.6%	31.1%	31.1% (450)	FAILED	WORSE	33%

Indicator is 1.9% under target, however, Thurrock is still performing 4.5% above the latest national average (26.6% 20/21) and 6% above the latest regional average (25.1% 20/21). Out of 1,447 long term community services in place at month end, 450 were direct payments.

In order to support hospitals during COVID, new national measures were put in place to provide up to six weeks free care (four weeks from July 2021) to anyone being discharged from hospital, funded under the national Covid Hospital Discharge Policy. As such, individuals leaving hospital are placed in free commissioned services (such as home care). As a consequence, for those individuals who require ongoing care beyond the free period, most are staying with the home care provider they are already receiving support from, rather than moving to a direct payment where they would be required to make their own care arrangements, resulting in a slow uptake of new direct payments.

In addition, the pandemic has resulted in fewer personal assistants and other independent services being available, causing difficulties in individuals sourcing their own care, resulting in more individuals moving from direct payments to council commissioned services. Due to the continuing uncertainty around the pandemic, these individuals are reluctant to move back to a direct payment at this time.

Following the ending of the Section 75 agreement with Essex Partnership University Trust (EPUT), all of the cases transferred back into the Local Authority were reviewed and some cases were identified where the direct payments were no longer current. This has also resulted in a reduction in the overall number of people receiving direct payments.

ROUTE TO GREEN IN 2022/23

Communications have been circulated to practitioners and managers to promote direct payments and ensure that everyone eligible for a direct payment is offered one during the assessment and support planning process. Direct payments will continue to be promoted through communications with practitioners. Manager's authorising the commissioning of new services have also been reminded to ensure that the option of direct payments has been explored with individuals before a commissioned service is authorised.

There has been a gradual increase in the number of direct payments over the final quarter of the year, however uptake remains slow owing to the issues described and because the number of people in community council-commissioned services has also increased, there has been little change to the percentage over the year.

Indicator Definition	Portfolio Holder 2021/22	*2020/21 Outturn*	Quarter 1 Year to Date	Quarter 2 Year to Date	Quarter 3 Year to Date	In Month Jan	In month Feb	In month March	End of Year Outturn	Target Status	Direction of Travel since 2020/21	2021/22 Target
% General tenant satisfaction with neighbourhoods/services provided by Housing	Cllr Spillman	*75.5%*	72.8%	73.6%	73.2%	73.9%	80.4%	72.6%	73.8% (1,455)	FAILED	WORSE	75%

During 2021/22 nearly two thousand tenants (circa 20% of all tenants) took part in our perception surveys. Overall, 73.8% of tenants gave a rating of "very satisfied" or "fairly satisfied", 11.5% of tenants gave a neutral rating and 14.7% gave a negative rating of "fairly dissatisfied" or "very dissatisfied".

A key area for dissatisfaction in 2021/22 was due to a significant increase in negative feedback relating to council services not delivered by Housing including refuse collection, street sweeping, housing benefit and abandoned vehicles. These ratings have negatively impacted the 2021/22 satisfaction rate by 1.4%. In terms of Housing related feedback, the clear driver for dissatisfaction with the overall service provided by housing is repairs and maintenance. This accounted for 29.7% of all negative, housing-related feedback.

ROUTE TO GREEN IN 2022/23

The survey has been amended to refocus on services delivered by housing only. Early indications in 2022/23 show that this has positively impacted satisfaction levels. The service is also now making telephone calls to tenants who indicate they are dissatisfied with repairs in order to better understand the drivers of dissatisfaction with repairs and maintenance at a more granular level, to resolve any issues with existing repairs and to progress any outstanding or unreported repairs.

New business intelligence dashboards have been developed which enable a drill down into much greater detail than previously possible to understand the reasons for dissatisfaction with the overall Housing service as well as a range of other measures such as repairs, quality of home and keeping tenants informed amongst others. These dashboards are now operational and will enable the councilto identify issues much quicker. The dashboards will be continuously developed throughout 2022/23.

Indicator Definition	Portfolio Holder 2021/22	*2020/21 Outturn*	Quarter 1 Year to Date	Quarter 2 Year to Date	Quarter 3 Year to Date	In Month Jan	In month Feb	In month March	End of Year Outturn	Target Status	Direction of Travel since 2020/21	2021/22 Target
% Rent collected	Cllr Spillman	*98.3%*	89.5%	93.0%	94.9%	95.7%	96.2%	97.2%	97.2%	FAILED	WORSE	98%

There are many contributory factors for the failure to reach the set target, the majority of which are linked to the effects of the pandemic and the resulting reduction in available income. The number of our tenants claiming benefits during this period increased significantly. Many who had been furloughed for the first year of lockdowns and restrictions stopped working completely and new Universal Credit claims by our tenants increased from 3,094 to 3,706, an increase of 20%. Many of these tenants receive either full or partial housing costs which creates a delay in payment and an accumulation of arrears which is difficult to address. In addition, the migration of tenants across from housing and legacy benefits to Universal Credit continued throughout the year and in some cases resulted in a six week wait for housing costs as opposed to weekly Housing Benefit.

Despite financial inclusion referrals for all tenants making a new claim or transferring as part of the migration process, there are issues - particularly when it comes to Department of Work and Pensions (DWP) involvement - where the council does not have any control. The removal of the Universal Credit uplift occurred in October and many Universal Credit claimants saw this as a reduction in benefit rather than an ending of a temporary support measure and did not budget for this. Over the final quarter of the year the increase in fuel costs, rising food prices and general cost of living increases left many tenants facing a deficit in outgoings versus income. The promotion and take up of the Essential Living Fund (ELF) scheme fuel vouchers helped alleviate this slightly but it has given us some indication of the issues to be faced into 2022/23 as the energy price cap rise starts to affect household finances further.

ROUTE TO GREEN IN 2022/23

2021/22 will be more difficult in many ways than the past year and the measures taken will require careful consideration of resources and utilisation of all funds available. While the council is currently uncertain of how the most recently announced Household Support Fund monies will be distributed, it is to be hoped that Essential Living Fund will be allocated with an amount to assist our most vulnerable tenants with fuel costs. Promotion of the ELF scheme along with enhanced support for our tenants via financial inclusion and possible additional resources within the Financial Inclusion Team, promotion of referrals to Sanctuary Floating Support – aimed at helping people, who might otherwise struggle to cope, to live independently in their own home - to assist tenants with budgeting and debt advice and education by officers on prioritisation of essential outgoings will be at the forefront of the team's efforts in the coming year.

The automation of low stage arrears actions will free up officers' time to take more in-depth action and look at complex cases in a more holistic way. This will alleviate the need for officers to spend time investigating missing payments and concentrate on actual support and collection. Stronger links are being built with DWP to address issues which have arisen in the past year and using the business intelligence reports to identify trends should mean issues are dealt with earlier than would previously have been the case.

Indicator Definition	Portfolio Holder 2021/22	*2020/21 Outturn*	Quarter 1 Year to Date	Quarter 2 Year to Date	Quarter 3 Year to Date	In Month Jan	In month Feb	In month March	End of Year Outturn	Target Status	Direction of Travel since 2020/21	2021/22 Target
Average time to turnaround/re-let voids (in days)	Cllr Spillman	*47.5 days*	30.2 days	31.4 days	32.5 days	42.0 days	33.7 days	26.8 days	34.7 days	FAILED	WORSE	28 days

Average void re-let time performance can be broken down by two void types, general needs and sheltered voids. General needs voids made up the majority of the cohort of voids (71.3%) in 2021/22. The average re-let time for general needs voids was 28.2 days, marginally above the 28 day target.

For sheltered voids, which account for 28.7% of the cohort of voids, the average re-let time in 2021/22 was 50.6 days. However, there is a clear disparity in turnaround performance between sheltered voids with an entrance door on the ground floor and sheltered voids with an entrance door on the first floor or higher. The average re-let time for sheltered voids with an entrance door on the ground floor in 2021/22 was 25 days and on target compared to 73.7 days average for other floors. Sheltered voids with an entrance door on the first floor or higher, which make up a very small proportion of voids overall (15.1%), is the clear driver of void re-let time underperformance and are substantially affecting the overall average re-let time. These voids are generally difficult to let.

ROUTE TO GREEN IN 2022/23

An improvement plan is currently in development and a number of actions have been identified in order to improve void re-let time performance, specifically in relation to sheltered voids with entrance doors above the ground floor. A number of the actions within the draft improvement plan have already been implemented with further measures under consideration including:

- implementation of a communications action plan to promote sheltered housing. It is anticipated that this will improve awareness of sheltered housing and reduce number of hard to let voids.
- the sheltered housing web page has been reviewed and updated to ensure information is up to date, clear and concise.
- the sheltered housing team is now in regular contact with a number of other teams across the council in order to identify suitable tenants and are being flexible in relation to the lower age limit for sheltered housing
- a dedicated Sheltered Housing Officer has been assigned to this area to improve performance and is currently pro-actively contacting tenants to support them to move from larger properties, is part of the decommissioning working group, is working closely with the allocations team to identify suitable tenants and is supporting the fast tracking of paperwork.
- contact with other local authorities to share best practice.

Indicator Definition	Portfolio Holder 2021/22	*2020/21 Outturn*	Quarter 1 Year to Date	Quarter 2 Year to Date	Quarter 3 Year to Date	In Month Jan	In month Feb	In month March	End of Year Outturn	Target Status	Direction of Travel since 2020/21	2021/22 Target
% of young people who reoffend after a previously recorded offence	Cllr Johnson	*17.0%*	17.0%	3.0%	26.0%				32.0%	FAILED	WORSE	20%

The final locally produced reoffending rate for 2021/22 is 32%. This figure is based on local data and monitors a smaller and more recent cohort than the national Ministry of Justice (MOJ) figures. This has increased in comparison to the last financial year due to a small cohort containing some prolific offenders. The national Youth Data Summary (110) published by the MOJ highlights the borough's re-offending rate at 36.4% which is slightly above the national average at 33.3%.

ROUTE TO GREEN IN 2022/23

The primary aim of all youth offending teams is to reduce the offending of children in line with the expectations of the Youth Justice Board. Thurrock's current Youth Justice Plan sets the council's strategic direction and highlights six priorities designed to address the offending of local children. Within the plan the council has made a strong commitment to diverting young people away from the criminal justice system by introducing an Out of Court Disposal Panel. The panel is designed to reduce first time entrants and will consequently reduce reoffending.

Indicator Definition	Portfolio Holder 2021/22	*2020/21 Outturn*	End of Year Outturn	Target Status	Direction of Travel since 2020/21	2021/22 Target
Total number of homes permitted through Planning	Cllr Maney	*195*	506	FAILED	BETTER	950

Whilst the target has not been met this figure needs to be looked at in context. In 2021/22, 506 new homes were consented through planning decisions made, though fewer homes were actually built. Whilst the Levelling up and Regeneration Bill hints at providing powers to local authorities to compel developers to complete developments, there is presently very little that local authorities can do to encourage developers to build out planning permissions.

ROUTE TO GREEN IN 2022/23

The service has a low amount of planning permissions and also low recent housing completions figures - in 2021/22 the completions figure was 319. It is not easy to provide comment on how to address this as it is down to private developers to both apply for planning permission and then complete the builds, however the new Local Plan will allocate sites for circa 30,000 new homes, providing competition within the market and an incentive for developers to build more new homes in the borough.

Indicator Definition	Portfolio Holder 2021/22	*2020/21 Outturn*	Quarter 1 Year to Date	Quarter 2 Year to Date	Quarter 3 Year to Date	In Month Jan	In month Feb	In month March	End of Year Outturn	Target Status	Direction of Travel since 2020/21	2021/22 Target
Average time between a child entering care and moving in with its adoptive family adjusted for foster carer adoptions, for children who have been adopted (days) (rolling 12 months)	Cllr Johnson	*amended KPI*	378	375	341				519	FAILED	n/a	426
The reason for the increase in the final quarter was due to just one case which required an extended process.												
ROUTE TO GREEN IN 2022/23												
As the increase in timescale was caused by exceptional circumstances there are no immediate actions planned in this regard.												

3.6 **Other key indicators**

3.6.1 Throughout the year the council also monitors some other indicators as part of the corporate scorecard which, whilst not performance related, are important to keep under review:

Demand Indicator Definition	Portfolio Holder 2021/22	2020/21 Outturn	Q1 Year to Date	Q2 Year to Date	Q3 Year to Date	In Month Jan	In month Feb	In month March	Final Outturn 2021/22	Direction of Travel since 2020/21
No of households at risk of homelessness approaching the Council for assistance	Cllr Spillman	*1,826*	440	909	1,314	167	170	173	1,824	STATIC
No of homeless cases accepted	Cllr Spillman	*211*	35	101	153	9	6	14	182	LOWER

The Homelessness Reduction Act (HRA) 2017 places a duty on local authorities to prevent homelessness or relieve homelessness where this is not possible. The number of approaches include all who have approached the council for housing assistance. A number of these cases were prevented and homelessness has been relieved.

The acceptances are low in comparison to approaches because the service deal with a greater number of cases by preventing and relieving homelessness before they reach the "main duty" stage, which is the stage at which acceptances are recorded.

The council primarily uses the private rented sector to source accommodation for applicants which is secured through regular contact with landlords and estate agents. Tenancy Sustainment Officers and Financial Inclusion Officers then work with the tenant to ensure that the relevant benefits are applied for to enable them to sustain their tenancy. In addition to this, the council also utilises the services of the Community and Employment Support Officer to support applicants into training and employment.

The service also prevents homelessness by negotiating and working with landlords and excluders (someone the applicant currently lives with who has asked the applicant to leave their property) to keep the applicants in the property they are approaching us from or negotiating a planned move into suitable accommodation.

The council did start to see some increases in approaches towards the end of the year – as can be seen above in the monthly data. However, overall 2021/22 was remarkably similar to the outturn seen in 2020/21. The council continue to closely monitor any changes in approaches for homelessness particularly in light of COVID recovery and cost of living pressures throughout 2022/23.

3.7 **Review of the Corporate Performance Framework for 2022/23**

As the council will be refreshing the borough vision and purpose, the underlying corporate performance framework will need to evolve to enable reporting to be better aligned – and be clearer to all audiences - to the council's overall strategic priorities and plans. It is anticipated that a framework for how this will be shared with members as part of the quarter 1 corporate performance reporting cycle later this year.

Key changes include a new split between short-term KPIs (activities which occur day-to-day in nature and best measured in timescales of years) and medium/long timescales for strategic objectives (i.e., major projects), which do not fit in within a typical municipal year form of timescale measurement, but typically have 'milestones' during the length of a project. This way, operational matters can be monitored and challenged and strategic delivery will be both more open to all audiences and any pull-forward/slippage of strategic delivery made clear to all elected members.

4. Reasons for Recommendation

4.1 The corporate priorities and associated performance framework are fundamental to articulating what the council is aiming to achieve – both in the short-term and over the long-term. It is best practice to report on the performance of the council. It shows effective levels of governance and transparency and showcases strong performance as well as an acknowledgement of where we need to improve.

4.2 This report also confirms the governance and monitoring mechanisms which were in place.

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

5.1 Performance against the corporate priorities was monitored through Performance Board, a cross-council officer group of performance experts representing each service. Performance Board will continue to consider the corporate KPIs on a monthly basis, highlighting areas of particular focus to Directors Board.

5.2 Each quarter a report is presented to Corporate Overview and Scrutiny Committee, and finally reported to Cabinet. This report was considered at Corporate Overview and Scrutiny Committee on 12 July 2022.

5.3 There were some questions asked at the last O&S Committee in relation to quarter 3 data which required additional clarification. Some of this information has been included in section 3.6 where indicators have not met the end of year target. Other questions are answered below:

5.3.1 The Committee queried the KPI relating to private sector housing health hazards and asked what the difference was between a category 1 and a category 2 health hazard and for examples of each.

The council has powers under the Housing Act 2004 to deal with disrepair issues in privately rented properties where landlords have failed to act and the tenant reports their concerns to the council. Where an inspection is required, an assessment using the Housing Health and Safety Rating System (HHSRS) is carried out.

HHSRS inspections give 'hazard scores' for 29 health and safety areas. The scores are based on the risk of harm to an actual or potential occupier of a dwelling which results from a deficiency in the dwelling and the seriousness of

that harm. Particular vulnerable age groups are those under 5 years old and the elderly.

The government HHSRS guidance describes a category 1 hazard as covering the most extreme harm outcomes with examples including from any cause, lung cancer, mesothelioma (linked to asbestos exposure), permanent paralysis below the neck, permanent loss of consciousness or 80% burn injuries.

Category 2 hazards cover severe harm outcomes, with examples including cardio-respiratory disease/asthma, crytosporidiosis or legionnaires disease (linked to water contamination), regular severe fever, loss of a hand or foot, serious fractures, serious burns, loss of consciousness for days.

5.3.2 In relation to the indicator which shows the percentage of the borough where litter from people discarding or not controlling waste in public areas is at an unacceptable level, which was performing on target, the Committee asked whether it was possible to get more detailed information at a ward level. And also asked for more information about what we are doing to discourage people from littering.

The data from the Keep Britain Tidy (KBT) street cleanliness surveys is provided at a ward level for 2021-22 in the table below. These inspections are a snapshot in time. A grade of A is exceptional, B is considered acceptable with anything below a B requiring intervention.

Ward	Litter Grade					
	A	B+	B	B-	C	D
Aveley and Uplands		10	37	11	2	
Chadwell St Mary	1	19	35	4	1	
Chafford and North Stifford	2	16	36	4		
Corringham and Fobbing	1	21	33	4	1	
Grays Riverside		17	39	3	1	
Grays Thurrock		1	37	5	1	
Little Thurrock Blackshots		10	39	9	1	
Little Thurrock Rectory	1	12	35	2	2	
South Chafford		6	41	13		
Stanford East and Corringham Town		26	29	5		
Stanford-le-Hope West	3	16	32	3	1	
Stifford Clays		6	39	13	1	1
Tilbury Riverside and Thurrock Park	1	10	39	9	1	
Tilbury St Chads		7	33	14	1	
West Thurrock and South Stifford		6	44	7		
Grand Total	9	183	548	106	13	1

With regard to the action taken to prevent littering, there is an active programme of enforcement in place with a high level of fines being issued

each year for across the borough for littering. In addition to this the service supports a number of community litter picks both as organised events and by providing individuals with litter pickers and bags on request. Furthermore, the service is working in partnership with Oceans Together and the Essex Wildlife Trust to ensure that there is an active programme of environmental education within schools.

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

6.1 The vision and priorities cascade into every bit of the council and further to our partners, through key strategies, service plans, team plans and individual objectives.

6.2 This report will help decision makers and other interested parties, form a view of the success of the council's actions in working towards achieving the vision and priority ambitions.

7. Implications

7.1 Financial

Implications verified by: **Laura Last**

Senior Management Accountant

The report provides an update on performance against corporate priorities. There are financial KPIs within the corporate scorecard, the performance of which are included in the report. Where there are issues of underperformance, any recovery planning commissioned by the council may entail future financial implications and will need to be considered as appropriate. The council continues to assess the full financial impact of COVID-19 and this is being regularly reported to members.

7.2 Legal

Implications verified by: **Gina Clarke**

Corporate Governance Lawyer and Deputy Monitoring Officer

There are no direct legal implications arising from the recommendation of this report. However under s3(1) of the Local Government Act 1999, local authorities have general duty to obtain Best Value by making arrangements to secure continuous improvement in the way in which its functions are exercised, having regard to a combination of economy, efficiency and effectiveness.

Effective KPIs are useful in ensuring and monitoring the level of service delivery of the Council's services and activities. Where there are issues of

underperformance, any recovery planning commissioned by the Council or associated individual priority projects may have legal implications, and as such will need to be addressed separately as decisions relating to those specific activities are considered.

7.3 **Diversity and Equality**

Implications verified by: **Rebecca Lee**

Team Manager - Community Development

The Corporate Performance Framework for 2021/22 contains measures that help determine the level of progress with meeting wider diversity and equality ambitions, including attainment, independent living, vulnerable adults, volunteering etc. Individual commentary has been given throughout the year within the regular monitoring reports regarding progress and actions.

7.4 **Other implications** (where significant) – i.e. Staff, Health Inequalities, Sustainability, Crime and Disorder, and Impact on Looked After Children

The Corporate Performance Framework includes areas which affect a wide variety of issues, including those noted above in the body of the report. Where applicable these are covered within the report.

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

N/A

9. Appendices to the report

None

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Strategy, Engagement and Growth

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