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

Health and Wellbeing Board

The meeting will be held at **11.00am – 1:00pm** on **31 August 2023**

Council Chamber, CO3 Building, Civic Offices, New Road, Grays, Essex, RM17 6SL.

This is an in-person meeting only.

Membership:

Councillors George Coxshall (Chair), Barry Johnson, Elizabeth Rigby and Sue Shinnick

Ian Wake, Corporate Dirctor of Adults, Housing and Health
Jo Broadbent, Director of Public Health
Rita Thakaria, Partnership Director (NELFT / EPUT / Thurrock Council)
Sheila Murphy, Corporate Director of Children's Services
Michael Dineen
Anthony McKeever, Executive Lead Mid and South Essex Health and Care Partnership & Joint Accountable Officer for its 5 CCGs
Aleksandra Mecan, NHS MID AND SOUTH ESSEX IC
Margaret Allen, MSE
Jeff Banks, Director of Strategic Partnerships
Michelle Stapleton, Executive Member, Basildon and Thurrock Hospitals University Foundation Trust
Fiona Ryan
Hannah Coffey, Deputy Chief Executive, Mid and South Essex NHS Foundation Trust
Kim James, Chief Operating Officer, Healthwatch Thurrock
Mark Tebbs, Thurrock CVS
Jim Nicholson, Chair of the Adult Safeguarding Partnership or their senior representative
Chair of the Adult Safeguarding Partnership or Senior Representative, Thurrock Local Safeguarding Children's Partnership or their Senior Representative
Gill Burns, Director level representation of Thurrock, North East London Foundation Trust (NELFT)
Alexandra Green, Executive Director of Community Services and Partnerships, Essex Partnership University Trust (EPUT)
B J Harrington, Essex Police

Agenda

Open to Public and Press

Page

1 Apologies for Absence

2 Minutes of 27 July meeting and Action and Decision Log **5 - 8**

To approve as a correct record the minutes of the Health and Wellbeing Board meeting held on 27 July 2023, which are included in member's papers.

To review action and decision log which will be shared on screen.

3 Urgent Items

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

4 Declaration of Interests

5 Virtual Items for consideration

1. As part of managing and prioritising Health and Wellbeing Board time we consider items for Board's information virtually.
2. Secretariat have not been notified of any items to be circulated and considered virtually following today's meeting.

3. Members are asked to highlight any reports that they would like the Board to be aware of and these can be circulated outside of the meeting.

6 Action log follow up. NHS Weight Management Services **9 - 22**

1. A PowerPoint presentation is available within member's papers.

7 SET Mental Health Strategy **23 - 56**

A covering report and copy of the Strategy is included within member's papers.

8	**Initial Health Assessments**	**57 - 68**
	A report is provided in member's papers	
9	**Thurrock Tobacco Control Strategy**	**69 - 96**
	A covering report and copy of the Thurrock Tobacco Control Strategy is provided within member's papers	
10	**Health and Wellbeing Strategy in focus Domain 3 - Person Led Health and Care**	**97 - 118**

Queries regarding this Agenda or notification of apologies:

Please contact Darren Kristiansen, Business Manager - AHH and Claire Dixon Business Support Officer AHH by sending an email to DKristiansen@thurrock.gov.uk or Claire.Dixon@Thurrock.gov.uk

Agenda published on: **23 August 2023**

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DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF

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

<u>Helpful Reminders for Members</u>

- *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?*

<u>When should you declare an interest *at a meeting?*</u>

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

Does the business to be transacted at the meeting
- **relate to; or**
- **likely to affect**

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

Disclosable Pecuniary Interests shall include your interests or those of:

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

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

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

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

Pecuniary

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

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

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

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

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

Non- pecuniary

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

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

Our Vision and Priorities for Thurrock

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

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

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

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

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

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

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

PUBLIC Minutes of the meeting of the Health and Wellbeing Board held on 27 July 2023 11.00am-12.00pm

Present:
Councillor G Coxshall (Chair)
Councillor Rigby
Ian Wake, Corporate Director for Adults, Housing and Health
Jo Broadbent, Director of Public Health
Margaret Allen, Deputy Thurrock Alliance Director
Rita Thakaria, Partnership Director, Thurrock Council, EPUT and NELFT
Michele Lucas, Assistant Director for Education and Learning
Mark Tebbs, Chief Executive, CVS
Jim Nicolson, Adult Safeguarding Board
Michelle Stapleton, Integrated Care Pathway Director, Mid and South Essex NHS Foundation Trust
Robert Thompson, Essex Police
Sharon Hall, Northeast London Foundation Trust (NELFT)

Apologies:
Councillor Johnson
Councillor Shinnick
Sheila Murphy, Corporate Director for Children's Services
Michael Dineen, Assistant Director for Counter Fraud and Community Safety
Aleksandra Mecan, Thurrock Alliance Director
Jeff Banks, Mid and South Essex Integrated Care System
Fiona Ryan, Managing Director, Mid and South Essex NHS Foundation Trust
Kim James, Chief Operating Officer, Healthwatch Thurrock
Gill Burns, Director of Children's Services, Northeast London Foundation Trust (NELFT)
Alex Green, Executive Director of Community Services and Partnerships, Essex Partnership University Trust (EPUT)
Hannah Coffey, Acting Chief Executive, Mid and South Essex NHS Foundation Trust
BJ Harrington, Chief Constable, Essex Police

Guests:
Christopher Smith, Thurrock Council

1. Welcome, Introduction and Apologies

Colleagues were welcomed and apologies were noted. Michele Lucas attended on behalf of Sheila Murphy, Margaret Allen provided representation from the Thurrock Alliance and Sharon Hall attended on behalf of Gill Burns.

2. Minutes / Action Log

The minutes of the Health and Wellbeing Board meeting held on 23 June 2023 were approved as a correct record.

The action and decision log will be considered at the next meeting (31 August 2023).

3. Urgent Items

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

4. Declaration of Interests

There were no declarations of interest.

5. Year End Report for the Better Care Fund (BCF)

This item was introduced by Christopher Smith, Thurrock Council. Key points included:

- Thurrock's initial Better Care Fund Plan, and Better Care Fund Section 75 Agreement between the Council and NHS, was approved in 2015. The arrangement has allowed the creation of a pooled fund, which is overseen by the Thurrock Integrated Care Alliance made up of officers from the Council and NHS Mid and South Essex Integrated Care Board (NHS MSE ICB).
- The Better Care Fund Policy framework for this year and next, published on 4 April 2023, sets out the Government's priorities for 2023-25, including improving discharge, reducing the pressure on Urgent and Emergency Care and social care, supporting intermediate care, unpaid carers, and housing adaptations.
- The vision for the BCF over 2023-25 is to support people to live healthy, independent, and dignified lives, through joining up health, social care and housing services seamlessly around the person. A detailed breakdown for funding for specific workstreams such as hospital discharge has been provided.
- The Plan has been submitted to meet the timescales outlined by NHS England and at present it is undergoing scrutiny via an assurance process with approval letters anticipated week commencing 8 September 2023.
- A local review of the BCF commenced in July 2023, with the aid of the Better Care Fund Support Programme which is delivered through the LGA.

During discussions, the following points were made:

- Following publication of the Health and Wellbeing Board papers, the legal implications were verified by Daniel Longe, Principal Solicitor as follows:
    - Section 75 of the NHS Act 2006 makes provision for joint partnerships between NHS and Local authorities for the purpose of discharging prescribed functions of both statutory bodies. Particularly s75(2) makes provision for the establishment and maintenance of a fund which can be disbursed for the purposes of those prescribed functions;
    - Pursuant to s75 of the NHS Act 2006, and the Health and Social Care Act 2012 HWBs, one of the functions of the HWB is to set strategic direction to improve health and wellbeing;
    - The report sets out the work undertaken pursuant to the abovementioned legislative framework and is within the powers of the HWB and the Council to approve.
- Members welcomed the two year plan BCF submission and thanked Christopher Smith and partners for their contributions, collective partnership, and ambition in taking this forward.
- The strong narrative of the submission was highlighted and the clear alignment between the BCF and the Better Care Together Thurrock (BCTT): The Case for Further Change.
- Colleagues noted the metrics relating to hospital admission and discharge are positive and recognise the importance of preventing failure demand as part of supporting better outcomes for residents.
- Members recognised that the BCF plan could evolve further following consultation and support by the LGA therefore the Board will be provided with further updates in due course.

Decision: Members of the Board approved the Better Care Fund Plan for 2023 to 2025.

Prior to closing the meeting, the Chair advised colleagues that Jeff Banks (Mid and South Essex Integrated Care System) had received the endorsement letter of the Mid and South Essex Joint Forward Plan and members were thanked for their endorsement.

The meeting finished at 11:15am.

CHAIR………………………………..

DATE…………………………………

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Mid and South Essex

Thurrock Alliance
Weight Management Provision in Thurrock

Thurrock Health and Wellbeing Board
31st August 2023

Updated 14-08-2023

www.midandsouthessex.ics.nhs.uk

Tier 2 Weight Management

- Tier 2 weight management provision takes the form of a 12 week programme which includes an exercise programme, healthy eating guidance, portion control and healthy lifestyle support.
- The SLH/ASOP Initiative is broadly based on tier 2 provision.
- Usually, to access tier 2 provision, the person would be referred by their GP. However, the programme is open to people who may self-refer
- The tier 2 provision is commissioned by the council's Public Health team in conjunction with partners across the borough and is delivered locally
- The rate of uptake (referrals that convert into a person on the programme) has seen an increase for men, up from 10% in 2022/23 to 14% in the first quarter of 2023/24

Tier 3 weight management

Tier 3 weight management is a more complex service. A person is referred by their GP and must have completed a tier 2 programme to be eligible.

The Tier 3 service incorporates psychological support for people and lasts for 12 months. The first 12 weeks is a curriculum-based programme of classes dealing with a wide range of weight-related issues (healthy cooking advice, portion control, etc) and is based on Cognitive Behavioural Therapy

The following 9 months are focussed on maintenance of healthy eating choices and monitored weight loss.

NICE has guidance and requirements set on weight management provision and the service in Thurrock fully meets these requirements.

Tier 3 provision is commissioned by health (previously CPR CCG on behalf of Thurrock, CPR, Basildon & Brentwood and Southend, now by a central ICB team).

Evidence of Benefits 1

2022/23 outturn figures.
Provided by MoreLife, the South Essex Tier 3 provider.
Target 75-100 completers. Outturn 111 completers

Group Data in Thurrock from April 2022 - March 2023	
Total number of referrals received	688
Total number of clients booked onto groups	219
Number of clients dropped out before starting group	28
Number of clients that started group and attended 1 or more out of 12 sessions	191
Number of clients that dropped out before completing 10 out of 12 sessions	80
Number of completers - clients that have attended 10 or more out of 12 sessions	101
Potential completers - clients that are still on programme	10
The number of completers who achieved a 5% weight loss during the programme	34
The number of completers who achieved a 3% weight loss during the programme	60

Evidence of Benefits 2.

	Score Values	Percentage Achieved	KPI Target
Percentage of completers achieving 5% weight loss at 12 weeks	34 out of 93 completers*	37%	30%
Percentage of completers achieving 3% weight loss at 12 weeks	60 out of 93 completers*	65%	60%
Percentage of clients that completed group including potential completers	111 out of 191	58%	60%

Other Weight management services in Thurrock 1.

Binge Eating Behaviour service

- In September 2021 an additional service was commissioned for South Essex (including Thurrock). This took the form of a binge eating behaviour (BEB) service.
- BEB has been identified as one of the main causes of people dropping out of weight management provision, with up to 30% of attendees not completing the courses on offer.
- The Tier 3 provider in Thurrock is accredited to provide this service by NHSE. The programme consists of a 12 week 'pre-tier 3' programme which addresses the underlying causes of the BEB.
- On completion of the BEB 12 week course the person is immediately enrolled on the Tier 3 programme. Evidence has shown that the drop out rate from tier 3 is significantly reduced and the weight loss experienced by people is proportionately greater and is maintained for longer
- This service remains in place in South Essex

Other weight management services in Thurrock 2.

Digital Weight Management

- NHS England has a national weight management programme which is a digital offer, using smart phones and PCs.

- It is a 12 week programme based on supported self-directed care. A person's GP may refer to this programme.

- It should be noted that there a limitations to this offer in that it is reliant on access to digital platforms. Whilst there has been a small percentage of uptake for this programme across MSE, the digital deprivation (for a number of reasons) has limited its effectiveness for residents in this part of greater Essex.

Other Weight Management services in Thurrock

Drug Therapies

- There is a drug therapy option for people who meet the eligibility criteria for tier 3 weight management provision.
- The drug is called Saxenda and is usually appropriate for iro 20% of people who meet the criteria for tier 3 services.
- A person who is eligible for Saxenda must be on a tier 3 programme and under the care of a consultant endocrinologist.
- The drug therapy programme is 2 years and is offered as an alternative to tier 4 bariatric surgery.
- NHS England is awaiting delivery into the UK of a later version of the drug therapy called Wegovy. It is estimated that approximately 80% of people eligible for tier 3 provision will be suitable for this drug.

Stanford le Hope PCN Weight Management Initiative

- The Thurrock Healthier Futures Clinic began seeing obese patients in June 2023 and has offered this extensive "health MOT around weight management and lifestyle " service to 2750 people from both SLH and ASOP PCNs.
- These are 2750 additional appointments focused on weight and lifestyle to reduce the personal and societal burden of obesity.
- Evaluation is underway, supported by Thurrock Population Health team, which started in June 2023 and will report after 6 months (November) and then a year (June 24) - it's too early to measure outcomes yet.
- The Obesity project in ASOP PCN has been paused temporarily to identify suitable venues in which to see patients.
- This is a supplementary primary care service which offers a holistic service that looks at all aspects of a person's medical health and lifestyle.

- The health aspects including fully explaining all aspects of blood pressure management and issues if these aspects are not followed,. A full explanation of cardiac and diabetes risk and ways to minimise this. Also, a medication review if required etc.

- These appointments are longer and more in-depth than primary care has time for, which is a big difference.

- It then offers (with agreement of the patient) referral to the best existing services for them. The Health and Wellbeing coach follows the patient up regularly to encourage participation and completion of the interventions. As we move forward, we will adapt this based on the evaluation findings.

Evidence of benefits 1.

Cohort 1

Seen Care Coordinator 3 patients

Seen by Advanced Nurse Practitioner 3 patients +one of these were further followed up

Health and Wellbeing coach saw all three patients and then followed them up twice.

Referred to:

Exercise 1

WM 1

Cohort 2

Seen Care Coordinator - 9 patients - further 2 patients did not attend offered appointment

Seen by Advanced Nurse Practitioner 3 patients who also saw them for two further follow-ups and 2 did not attend (DNA)

Health and Wellbeing coach saw 5 patients, and followed up with six appointments - 2 patients did not attend offered appointment

Referred to:

ECG 1

24hr BP 1

Morelife 1

Digital Weight Managment 1

Evidence of benefits 2.

Cohort 3

Seen Care Coordinator 114 patients (with 15DNAs)

Seen by Advanced Nurse Practitioner 19 patients and he followed up 10 of these

Health and Wellbeing coach saw 68patients with 15 followed up further and 2 DNA

Referred to:

Gynae 1

Digital Weight Management 5

24hr BP monitoring 5

Started HTN treatment 3

Bloods requested 13

Exercise 11

Social prescriber 1

Weight management 18

Holter monitor (cardiac monitor) 1

We have recently started to trial calorie counting apps with some patients. They will send the diary at the end of the week so we can support them making better choices

Any questions?

Margaret Allen
Deputy Director, Thurrock Alliance

www.midandsouthessex.ics.nhs.uk

Date of Meeting: 31st August 2023	ITEM: 7
Thurrock Health and Wellbeing Board	
Southend, Essex and Thurrock All-Age Mental Health Strategy 2023-2028	
Wards and communities affected: All	**Key Decision:** N/A
Report of: Maria Payne, Strategic Lead – Public Health	
Accountable Assistant Director: Andrea Clement, Assistant Director & Consultant in Public Health	
Accountable Director: Dr Jo Broadbent, Director of Public Health	
This report is Public	

Executive Summary

Partners across Southend, Essex and Thurrock have come together to align existing priorities and develop an All-Age Mental Health Strategy. It is underpinned by population need and also incorporates existing national guidance. The work on this strategy has been ongoing through the last year, led by an external consultancy company (Tricordant), and is now being presented for endorsement and approval at the Boards of all key partners.

It is also proposed for there to be a Strategy Implementation Group established to support the delivery of the ambitions in the strategy.

Commissioner Commentary

Not applicable

1. Recommendation(s)

1.1 Adopt the draft Southend, Essex, and Thurrock Mental Health strategy in the appendix, which has been developed jointly with health and care partners across the geography of greater Essex.

1.2 Agree for Thurrock to be part of a Southend, Essex and Thurrock (SET)-wide Strategy Implementation Group to support and coordinate collaborative working across partners to implement the strategy.

2. Introduction and Background

2.1 Support for people with mental health needs is provided by a range of different organisations, some of which are Thurrock-specific, and others span wider geographies, including the Mid and South Essex Integrated Care Board and SET footprints.

2.2 Over the last year, colleagues from Thurrock have worked with partners across Southend and Essex, alongside an external consultancy (Tricordant) to:

- Understand our population needs around mental health, which have been articulated in a separate SET-wide needs assessment document. *(Thurrock Public Health colleagues were key to the shaping of this)*
- Respond to the identified needs within the context of national policy and local ICP and organisational strategies
- Develop a revised 'all age' strategy building on the last SET-wide strategy (2017-21) *(see link to previous Health and Wellbeing Board cover paper for this in section 8 of this report.)*
- Explore options for working together to support implementation of the strategy
- Develop supporting enabler and implementation plans

2.3 The core partners on this group have included:

- North East Essex (part of Suffolk and North East Essex ICS) (NEE)
- West Essex (part of Hertfordshire and West Essex ICS) (WE)
- Mid and South Essex ICB (MSE)
- Southend City Council (SCC)
- Essex County Council (ECC)
- Thurrock Council (TC)
- Essex Partnership University NHS Foundation Trust (EPUT) – provider of adult services
- North East London NHS Foundation Trust (NELFT) – provider of children and young people's services

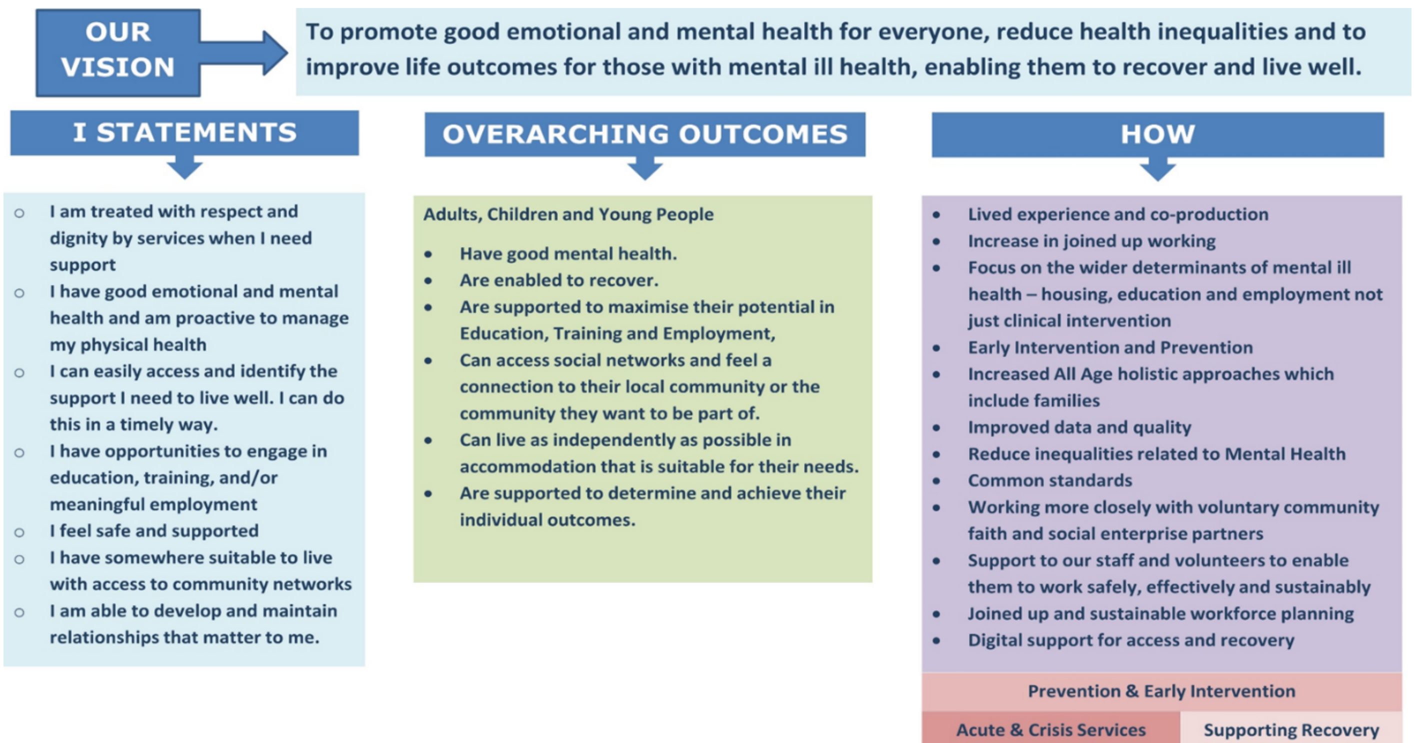
In addition, Essex Police have been engaged and are keen to be part of the arrangements established. Voluntary, Community, Faith, and Social Enterprise sector organisations have also been engaged in developing the strategy and will continue to be key partners in the next phase of implementation.

2.4 The Thurrock Council input has largely been provided by Adult Social Care Commissioning and Public Health; with oversight from the Mental Health Transformation Board and Mental Health Operational Group meetings, and Children's colleagues.

2.5 The strategy document contains details on how it has aimed to coordinate and align with priorities from a range of organisational strategies, with those of

particular note to Thurrock including the Thurrock Health and Wellbeing Strategy, the Mid and South Essex Integrated Care Strategy and the Better Care Together Thurrock Strategy.

2.6 The strategy is intentionally brief for reasons of clarity and deliverability and lays out the 'all age' vision and principles we will work to and the outcomes to be achieved over the next five years, guided by a set of I-Statements. It is shown in summary form below:



2.7 A significant challenge of the previous 2017 Strategy was not its content, (much is still relevant) but its implementation. System partners are therefore determined to develop effective mechanisms for ensuring implementation of the strategy whilst recognising most of the delivery will continue to be at local Place level with ICBs, Local authorities, care providers, VCFSE and other partners working together with people with lived experience, typically in local Alliances. In Thurrock, we anticipate our local Mental Health Transformation Board and Integrated Emotional Wellbeing Partnership will be pivotal mechanisms for ensuring local delivery, alongside the clinical strategies developed by our PCNs.

2.8 Partners have developed proposals for a '**Southend, Essex and Thurrock All-Age MH Strategy Implementation Group**' (SIG) focussed on overseeing a limited range of key strategic issues around overall strategy delivery and SET system development with partners sharing leadership of individual workstreams as appropriate. It will build on the existing informal working arrangements established for oversight of the strategy development itself.

2.9 The SIG will have oversight and monitoring of the overall SET Mental Health Strategy, including the delivery of SET-level outcomes for specialist services (Eating Disorders, Perinatal Mental Health, Personality disorder, and inpatient and community bed-based care). The membership will include senior representatives from the core partners listed in 2.3 above, Essex Police, and have input from people with lived experience.

2.10 The SIG will be a collective 'decision recommending body'. Formal decision making will continue in line with individual organisation's internal governance approvals. The SIG will work with a range of supporting groups, including many which exist already:

- The existing Collaborative Children's Forum which oversees a single contract for the commissioning of Children and Young People's mental health services
- Existing mental health Taskforce groups adapted as required following a current external review process.
- New supporting groups, only where needed, which are likely to include:
  - Co-production – challenging and supporting the system to ensure co-production is embedded.
  - Development of joined up approaches to key enablers such as finance, outcome and performance reporting, workforce and digital.
  - Key areas where enhanced focus is needed such as embedding a holistic approach around transition.

3. Issues, Options and Analysis of Options

3.1 Option 1 is to do nothing, and not endorse either the strategy or the participation in the Strategy Implementation Group. This means that the SET-wide mental health strategy that has been approved across the rest of the geography and across partner agencies that operate in Thurrock, would not include Thurrock. This would add complexity to existing partnership working arrangements, and mean Thurrock does not have a 'voice' in some of the system-wide transformation programmes that span beyond our sphere of influence. Not approving the strategy risks missing out on an opportunity to lead change alongside partners and ensure that those changes align with existing Thurrock strategic ambitions.

3.2 Option 2 is to approve the strategy and participation in the Strategy Implementation Group. This option means that there is a clear, united direction for partners across SET, and is aligned to national policy and all local strategies.

4. Reasons for Recommendation

4.1 Option 2 is recommended – to approve both recommendations 1.1 and 1.2 listed above. In addition to having a SET-wide agreed strategic direction for mental health which spans an all-age approach, having Thurrock participation in the Implementation Group means that we can continue to advocate for Thurrock and align with our existing strategic ambitions.

4.2 Some individual partners on the Thurrock Health and Wellbeing Board have already approved this strategy and participation in the Strategy Implementation Group. For example, it has already been endorsed by EPUT and MSE ICB Executive Boards, as well as the other two ICBs in Essex and the Essex Health and Wellbeing Board.

4.3 The Board are asked to note it will receive regular updates on progress with implementation of the strategy and development of collaborative working arrangements.

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

5.1 An external agency, Tricordant, were commissioned by Essex County Council to deliver the Mental Health strategy, development of which included gathering inputs from the community and specifically those with lived experience of mental ill-health. They held conversations with over 100 individuals, groups or organisations across Essex.

5.2 It is intended that there will be a lived experience group to inform the delivery of the strategy on an ongoing basis with appropriate Thurrock representation on that forum.

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

6.1 This strategy aligns most closely to Thurrock Council's People Priority:

***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*

6.2 It also aligns with the Thurrock Health and Wellbeing Strategy, in particular the objectives within domains 1 (Staying Healthier for Longer) and 3 (Person-Led Health and Care).

7. Implications

7.1 **Financial**

Implications verified by: **Not applicable – external partner report**

There are no direct financial implications from implementing this strategy or participating in the Strategy Implementation Group. The aims within the strategy include a focus on early intervention and prevention of costs in the long term.

7.2 **Legal**

Implications verified by: **Not applicable – external partner report**

There are no direct legal implications from implementing this strategy or participating in the Strategy Implementation Group. It is not a statutory requirement to have a mental health strategy in place. Approval of the strategy does not commit any Thurrock partner to any future commissioning or spending decision.

7.3 **Diversity and Equality**

Implications verified by: **Not applicable – external partner report**

A Community Equality Impact Assessment has been completed on this strategy by Thurrock Council, and the summary text included below:

The SET Mental Health Strategy outlines a number of commitments and priorities for system partners, including Thurrock Council, which aim to promote good emotional and mental health for everyone, reduce health inequalities and to improve life outcomes for those with mental ill-health, enabling them to recover and live well.

Data analysis undertaken to inform the strategy has identified that there are certain population groups that may be at higher risk of poorer mental health outcomes. We will ensure that the delivery plan underpinning the SET Mental Health Strategy prioritises action for these groups and aligns to other existing strategic commitments within Thurrock to improve community cohesion and reduce health inequalities.

The assessment highlighted that implementation of this strategy will not have an adverse impact on any individuals with a protected characteristic.

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

A focus on reducing health inequalities and on prevention and early intervention are listed in the guiding principles of this strategy; therefore this

approach should mitigating existing inequalities in experience of accessing mental health support.

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):

- Health and Wellbeing Board paper for SET Mental Health and Wellbeing Strategy 2017-21: https://democracy.thurrock.gov.uk/documents/s11028/Essex%20Southend%20and%20Thurrock%20Mental%20Health%20and%20Wellbeing%20Strategy.pdf

9. **Appendices to the report**

- Draft strategy for approval

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Southend Essex and Thurrock

Mental Health Strategy

Suffolk and North East Essex Integrated Care Partnership

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Introduction

Health and care leaders across Southend, Essex, and Thurrock (SET) are working to further improve the lives of those who live with mental ill health. This brief and practical all-age strategy sets out the vision and principles we will work to and the outcomes to be achieved over the next five years.

Our vision is to promote good emotional and mental health for everyone, reduce health inequalities and to improve life outcomes for those with mental ill health, enabling them to recover and live well.

This strategy builds on previous work and aligns with the local strategies produced by the three Integrated Care Partnerships[1], covering:

- Mid and South Essex
- North East Essex (part of the Suffolk and NEE ICS[2])
- West Essex (part of the Hertfordshire and West Essex ICS).

Southend, Essex, and Thurrock System Partners

Organisations from across a complex geography are working together in partnership and are committed to ongoing learning as part of the delivery of the strategy:

- North East Essex (NEE)
- West Essex (WE)
- Mid and South Essex ICS (MSE)
- Southend City Council (SCC)
- Essex County Council (ECC)
- Thurrock Council (TC)
- Essex Police (EP)
- Essex Partnership University NHS Foundation Trust (EPUT) – provider of adult services
- North East London NHS Foundation Trust (NELFT) – provider of children and young people's services

People who use mental health services, families, and carers with lived experience, and Voluntary, Community, and Social Enterprise (VCSE) sector organisations have also been engaged in developing the strategy and will continue to be key partners in delivering it.

Appendix 1 contains further detail of each of the individual geographies covering the Place based partnerships.

The vision and deliverables of this strategy

We have a clear vision for this strategy, and from working with groups of people with lived experience of mental ill health we have co-produced a list of ''What Matters to People' which informs the outcomes to be delivered through the strategy.

[1] Integrated Care Partnerships (ICP) are a statutory committee jointly formed between the NHS Integrated Care Board (ICB) and all upper tier local authorities that fall within the Integrated Care Systems (ICS) area.

[2] Integrated Care Systems (ICS) are partnerships of organisations that come together to plan and deliver joined up health and care services to improve the lives of people who live and work in the area.

Southend, Essex, and Thurrock Mental Health Strategy on a Page 2023-28

OUR VISION

To promote good emotional and mental health for everyone, reduce health inequalities and to improve life outcomes for those with mental ill health, enabling them to recover and live well.

KEY OUTCOMES

- Improved wellbeing levels across Southend, Essex and Thurrock population
- Reduced health inequalities
- Reduced premature mortality for people with serious mental illness

WHAT MATTERS TO PEOPLE

- I am treated with respect and dignity by services when I need support
- I have good emotional and mental health and am proactive in managing my physical and mental health
- I can easily access and identify the support I need to live well. I can do this in a timely way
- I have opportunities to engage in education, training, and/or meaningful employment
- I feel safe and supported
- I have somewhere suitable to live with access to community networks
- I am able to develop and maintain relationships that matter to me.

WHAT IS NEEDED

Adults, Children and Young People

- Have good mental health
- Are enabled to recover
- Are supported to maximise their potential in Education, Training and Employment,
- Can access social networks and feel a connection to their local community or the community they want to be part of
- Can live as independently as possible in accommodation that is suitable for their needs
- Are supported to determine and achieve their individual outcomes.

WHAT WE WILL ACTION

- Co-producing plans and services with people with lived experience
- Increasing joined up working
- Focus on the wider determinants of mental ill health – housing, education and employment not just clinical intervention
- Increasing all age holistic approaches including families
- Improving data and quality
- Reducing inequalities related to mental health
- Embedding trauma informed care
- Ensuring common standards across services
- Working more closely with voluntary, community, faith and social enterprise partners
- Supporting our staff and volunteers to work safely, effectively and sustainably
- Joined up and sustainable workforce planning
- Digital support to access services and for help with recovery

Prevention & Early Intervention

Acute & Crisis Services | Supporting Recovery

[Type text]

PRIORITIES FOR THIS STRATEGY – Adults

Prevention & Early intervention

- Provide information and support on wellbeing and managing risks to mental health to help people to maintain good mental and physical health. This could be from non-clinical voluntary services as well as formal services.
- Ensure people have access to local community-based support for their mental health throughout their lives. This should include integrated therapies, especially for people who have complex needs and/ or are particularly vulnerable.
- Ensure people with severe mental illness receive a full annual health check and follow-up interventions
- Improve access to adult eating disorder services
- Increase access to specialist perinatal mental health care for all new and expectant mothers
- Review mental health support for older people recognising the need to support carers, and the impact of social isolation and loneliness
- Improve coordination of support for people through key life transitions especially for 18-25 year olds.
- Embed a 'think family' approach to consider and support the needs of a whole family around a person

Acute and Crisis Services

- Improve pathways and access to community-based support during a mental health crisis to avoid escalation and/ or inpatient admission.
- Ensure prompt access to good quality first response care in an emergency that includes mental health assessment and support
- Improve safety of mental health inpatient environments
- Reduce hospital admissions for mental health conditions, including emergency admissions for self-harm, through improved community support
- Reduce time spent in inappropriate out of area placements by adults needing non-specialist mental health inpatient care

Supporting recovery

- Improve access to effective Talking Therapies for everyone who needs support
- Improve access to integrated, holistic and recovery-focused mental health support for adults with severe mental illness
- Develop supported accommodation in the community to support timely discharge from hospital settings
- Improve and embed integrated pathways to access housing, education, employment, self directed support and skills, particularly for people severe mental illness
- Work with local employers and partners to develop suitable opportunities and roles for people with severe mental illness

Priorities for this Strategy – Children and Young People

Prevention & Early intervention

- Improve access to wellbeing advice and support in communities and schools
- Improve access to FREED (first episode rapid early intervention for eating disorders) and for ARFID (Avoidant restrictive food intake disorder)
- Improve access to trauma informed services through communities or schools
- Improve access to infant mental health services
- Increase access to CAMHS (Children and Adolescent Mental Health Services).
- Increase access to health and justice mental health provision
- Increase provision of mental health in schools teams across Essex
- Continue expansion of non-clinical services to support prevention and a wider determinant of health approach to children, young people, and their families/carers
- Embed a 'think family' approach to consider and support the needs of a whole family around a child
- Develop digital support for children and young people's mental health
- Develop mental health workers in primary care

Acute and Crisis Services

- Improve access to intensive support in the community
- Improve access to the crisis team from hospital or home
- Ensure 24/7 access to crisis care and support and continue to develop these services
- Reduce hospital admissions, especially for those with mental health and learning disabilities/autism
- Reduce length of stays (where appropriate) for inpatients
- Integrate mental health services for children and young people with acute trusts
- Reduce hospital admissions for self-harm by rolling out the self-harm tool kit to schools and other settings
- Expand of the community mental health and CYP learning disability and neurodevelopment team
- Mobilise at risk mental health state (ARMS) teams

Supporting recovery

- Increase access and choice of support and treatment options for young people
- Increase pathways to support the Young Adults 18-25 Transition
- Increase 'step down' services from more intensive to less intensive support
- Improve access to home feeding support teams for eating disorders
- Improve integrated pathways to access education, training, and employment
- Increase access to digital support
- Increase non-clinical support for recovery programmes
- Support children to stay with their families whilst receiving services so that less children with mental health needs entering the care system

How we have developed this strategy

To develop the strategy, we commissioned external consultants (Tricordant) who worked with a steering group of system leaders. Tricordant interviewed the leaders and held two system-wide workshops to obtain a clear sense of direction for the strategy.

Conversations were held with over 100 individuals, groups or organisations representing those with lived experience. This included Mind and Healthwatch, as well as smaller and more locally based organisations such as Trustlinks and Southend Association of Voluntary Services (SAVS) through to very specific groups such as those representing Bangladeshi women and African men.

The Tricordant team included experts by experience. A consultant psychiatrist and an executive mental health nurse carried out research into the specific population needs by working with public health colleagues and local clinicians and professionals and by using data from the local Mental Health Joint Strategic Needs Assessment (JSNA) and key national and local data sources.

Why do we need this strategy?

Societal and Economic cost of mental illness

Poor mental health has a huge impact on the overall health and wellbeing of people and is increasing. Suicide is the leading cause of death for men under 50 with 75% of all suicides being men[3]. Suicide in women aged 24 or under in 2021 saw the largest increase since ONS began recording them in 1981[4]. Depression is now the third most common cause of disability[5]. 1 in 4 people will have mental health challenges at some point in their lives[6].

Poor mental health can impact on schooling and educational attainment, ability to work and stay in work, quality of relationships and experiences of ageing. Half of mental ill health starts by age 15 and 75% develops by age 18[7].

The economic cost of mental ill health is estimated to be approximately £100 billion for the UK [8] which suggests it is around £3.2 billion for Southend, Essex, and Thurrock. 72% of the economic cost is considered to be from lost productivity due to absence from work. The 15-49 age group accounts for 56% of the economic cost and the 50-69 group at 27%. Within Southend, Essex, and Thurrock approximately £400

[3] NHSE Tackling the root cause of suicide https://www.england.nhs.uk/blog/tackling-the-root-causes-of-suicide/

[4] https://mentalhealthinnovations.org/news-and-information/latest-news/ons-report-shows-alarming-rise-in-suicide-rates-among-young-women.

[5] https://www.who.int/news-room/fact-sheets/detail/depression

[6] https://www.mind.org.uk/information-support/types-of-mental-health-problems/statistics-and-facts-about-mental-health/how-common-are-mental-health-problems/

[7] https://mhfaengland.org/mhfa-centre/research-and-evaluation/mental-health-statistics/

[8] https://www.lse.ac.uk/News/Latest-news-from-LSE/2022/c-Mar-22/

million is spent each year by the NHS, Local Authorities, and Police on emotional wellbeing and mental health.

Population needs

Our engagement and research has identified the following key challenges for Southend, Essex, and Thurrock.[9] ICP strategies include more detailed information for their local populations. Many of these facts are not unique to this area and impact much of the UK.

- **Large and growing demand**
    - The number of adults with common (mild and moderate) mental health problems in the population is approximately 1 in 6
    - 1 in 6 children and young people (CYP) also have mental health problems, an increase from 1 in 9 only 5 years ago[10]
    - There is a smaller, but growing, number of people with severe mental ill health causing significant ongoing impact on their daily lives
    - Current services, particularly for adults, do not appear to match population needs and current or predicted demand
    - There has been a significant deterioration in mental health and wellbeing through Covid 19 and the impact is anticipated to be ongoing
    - Mental health services are experiencing unprecedented demand with a 76% increase in new referrals in February 2022 compared to the same month in 2020, which led to approximately 5% more total mental health contacts in that same period. Children and young people contacts increased by 16% during the same period
    - Mental ill health has a strong correlation with deprivation and the cost-of-living pressure is expected to add to challenges for those living in deprivation and increase the number who will suffer anxiety and depression.
    - The older population in Southend, Essex and Thurrock is expected to increase by 32,000 people by 2027. National data indicates that 1 in 4 are likely to be affected by depression and only an estimated 15% will receive NHS help[11]
- **Demand presents across the whole system,** not just specialist mental health providers. It significantly impacts Primary Care, A&E departments, and the Police amongst others

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[9] Unless stated data is drawn from the accompanying document 'Mental Health– Population Health Needs in Southend, Essex and Thurrock' or from https://mhfaengland.org/mhfa-centre/research-and-evaluation/mental-health-statistics/.

[10] https://www.youngminds.org.uk/about-us/media-centre/mental-health-statistics

[11] https://www.mentalhealth.org.uk/explore-mental-health/mental-health-statistics/older-people-statistics

- It is estimated nationally that 40% of GP appointments are for mental health related issues
- 15-25% of all incidents Essex Police responds to involve mental health[12]

- **Physical and mental health challenges** are often linked with both experienced by many people
- **Complexity through multiple conditions is common** among individuals with mental illness including links with learning disabilities, substance misuse, offending and social exclusion
- **Certain groups are disproportionately affected** by mental health issues as these can be made more complex by the interaction of different categories of social identity. For example, people from different genders or ethnic groups, LGBTQ+ people, travellers, young adults, older people, and people living in poverty, may receive **inequitable service provision and care.** This can be perpetuated by the inaccessibility of services e.g., for people with low levels of literacy or where English is not the first language or for other cultural reasons
  - Many people find it difficult to access mental health services via their GP
- **Inequality and service variation**
  - The prevalence of common mental health problems varies across Southend, Essex, and Thurrock
  - There is also significant variation in premature mortality in people with severe mental illness
  - Provision varies across areas even when levels of deprivation and resources are accounted for
  - Many people with mental health needs from London Boroughs are placed in Southend, which increases demand.
- Between a quarter to a half of adult mental illness may be **preventable with appropriate interventions in childhood and adolescence**
- Only half of adults in contact with specialist mental health services are in stable and **appropriate accommodation**.
- People in contact with specialist mental health services have a 73% lower **employment** rate than the general population. T

Across Southend, Essex, and Thurrock there are significant local mental health challenges, for example[13]:

- Southend has high rates of common and severe mental health
- Tendring has challenges around mental and behavioural disorders, admissions for self-harm, and suicide
- Thurrock has increasing numbers of children with social, emotional, and mental health needs, and high

[12] Mental Ill Health Problem Profile 2022, Essex Police

[13] Based on various sources quoted in the Joint Strategic Needs Analysis

premature mortality for people with severe mental illness

Taking these community needs into consideration is key. This strategy aims to ensure that need drives provision and provision meets need. We want to have the right provision in the right place for every citizen across Southend, Essex, and Thurrock who requires support and care for their mental health.

National Policy Drivers

In implementing this strategy, we will ensure we meet the specific requirements of relevant national strategies whilst delivering the needs of the local population.

The government Department of Health and Social Care are due to publish a Major Conditions Strategy during 2023. This strategy will tackle the conditions that contribute most to the burden of disease in England, including mental ill health, and the increasing number of people living with multiple conditions. This joined-up strategy will ensure that mental ill health is considered alongside physical health conditions. A separate national suicide prevention strategy will also be produced during 2023.

Several other national initiatives are under way such as:

- reform of the Mental Health Act
- reform of Care Programme Approach (CPA), a package of care for people with mental health problems
- Adult Social Care reform, including charging reform
- refresh of the Triangle of Care, a best practice guide that includes and recognises carers as partners in care
- Levelling Up, the government agenda to improve opportunities for everyone across the UK

All of these initiatives will help contribute to the success of this strategy.

Views from Lived Experience

To develop this strategy, we have listened to individuals and groups with lived experience. We have heard some consistent key themes about what people want:

Availability of services

- More clarity and consistency regarding referral pathways to avoid re-referrals or people falling through the gaps
- Shorter waiting lists, especially for children and young people
- Increased provision of personality disorder services
- More resources directed to early intervention and prevention services
- Improved access to primary care services, including in-person GP appointments

Person centred care

- Less need for people to repeat their stories

- More continuity of care and improved communication, especially for those on waiting lists
- Better care coordination and sharing of information, particularly across organisational boundaries and fragmented services
- More choice regarding therapy and treatments, for example where people would prefer to be referred to voluntary, community, and social enterprise providers (VCSE)
- Better listening to understand and tailor care to meet individual need
- Greater engagement with families and carers as partners in care.

Inequalities and inequities

- More accessible and inclusive services that can meet a range of needs
- Less stigma around mental illness across health, care, and public services
- A more consistent base level-standard to reduce disparities between services across Southend, Essex, and Thurrock.
- Greater engagement with people from ethnic and minority communities
- More meaningful involvement and co-production opportunities to strengthen the voice of lived experience
- Better support for transitions of care, particularly between young people and adult services, and inpatient and community services.

Stories of improvement

Whilst we heard many concerns from those with lived experience we did also hear about good experiences, services, and initiatives that we can continue to build on. A few examples of these are:

- Social prescribing link workers in Southend and the Friends for Lives suicide intervention and prevention service
- The children and young people mental health support team in schools in West Essex and the partnership with EPUT to provide seven mental health coaches integrated with Primary Care Networks (PCNs)
- Projects such as the Trust Links Growing Together project, the Colchester based Bangladeshi Women's Association and the Crisis Café in North East Essex, which all provide additional mental health support including out of hours
- Initiatives by Mind in Mid and South East Essex, such as 'Somewhere to Turn' and their supported housing solutions that give people greater independence
- Integrated PCN mental health teams in Thurrock that have multidisciplinary working and psychiatrists running

clinics within surgeries. They are also changing their use of language, such as using the term ‘transfers’ instead of ‘discharge’ to reduce people’s fear of losing a service.

Moving forward from previous strategy

Many aspects of the previous 2017-21 SET mental health strategy are still relevant, and implementation continues. Despite some of the great work that has happened across the system during challenging times, many people's interactions with, or ability to access health and care services can still be difficult. Many people report that they are not seeing benefits from the changes and investment in services.

Whilst recognising the difficulties of the previous few years it is important to also acknowledge the areas of success. Examples include:

- An enhanced emotional wellbeing offer for children and young people
- New adult urgent care pathways including mental health facilities at emergency departments
- An improved community offer for adults, including support to primary care
- Enhanced community support for people with personality disorders
- Extended employment support to prevent people losing their jobs
- Integration of physical and mental health community services in West Essex to better meet the needs of older people, in particular those with multiple long-term conditions
- Improved culture of learning and improvement within mental health services

Specific focus on Children and Young People

This is an all-age strategy which also covers children and young people; however, it is important to stress our specific areas of focus for this important group. These are:

- Eating Disorder Services
- Crisis Services
- MH Services and Acute Trusts- improving integration
- Mental Health Support Teams working with Education
- Access and Outcomes
- Use of digital technology
- Young Adults 18-25 transition
- CYP specialist workforce

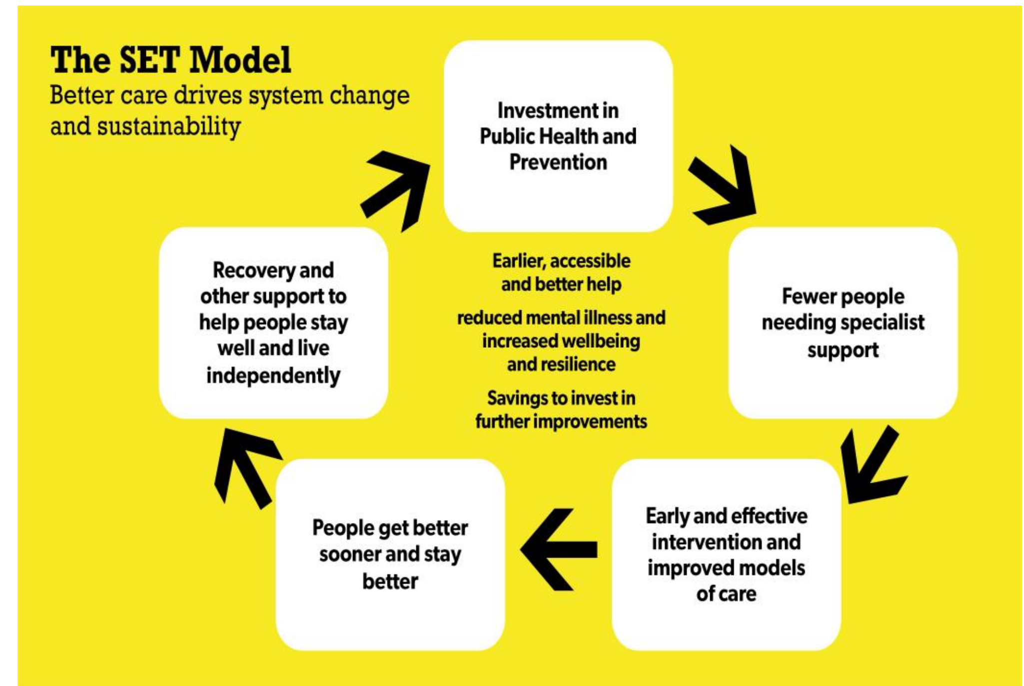
Across Southend, Essex, and Thurrock we will also be working together to support children and young people to manage risks such as the potential for online harm and use of harmful behaviours. This helps enable them to be supported

in the community by preventing need for admission into care or hospital.

There is an annually updated local transformation plan for Children and Young People in place which supports this strategy.

Developing our local model: better care drives system change and sustainability

The diagram below summarises the strategic approach for Southend, Essex, and Thurrock which seeks to further improve our approach to prevention, early intervention, and community support within the context of the wider determinants of mental health, to reduce the need for hospitalised care.



Focussing on the wider determinants of mental health

Wellbeing and mental health challenges affect all of us. Everyone seeks to maintain their own emotional and mental health and support those around us. This is not always easy or possible, especially if there is a background of trauma. When people experience deterioration in their emotional and mental health, this causes distress and can lead to crisis. In our services we want to work with people to understand and address the root of the 'triggers' for deterioration in their

emotional and mental health as well as helping them respond to the symptoms.

It is widely accepted that clinical care only contributes to 20% of the impact on people's general health outcomes. Social and economic factors have double that impact, and in mental health we know that disadvantage and discrimination have a disproportionate impact. We want to work together with communities to develop their capacity to be supportive, inclusive, resilient, and emotionally healthy places for children, young people, and adults.

Whilst the clinical services provided by the NHS have a vital part to play, the role of local authorities and local VCSE organisations and networks is also critical for influencing the factors which support people's mental health.

Local authorities have duties under the Care Act and Children's' Act to promote the wellbeing of individuals and to provide services which help to prevent, reduce, or delay peoples' needs developing, including the impacts on children of adverse childhood experiences. We plan to strengthen our work with families, carers, and schools to improve emotional wellbeing and prevent long term mental ill health in children and young people. Through this strategy we are also committed to further strengthening support for older people.

We are focused on ensuring equity of service provision across the Southend, Essex, and Thurrock geography to improve outcomes for people of all ages in all our communities. We are working together at both the larger geography and local levels to plan and further improve services at the right population level.

Each of the three ICPs have been developing their strategies, with a key leadership role for local authorities in leading, commissioning and coordinating wellbeing, prevention, and community mental health services. There is an active programme of public mental health across SET which aims to develop a prevention strategy to reduce the risk of mental ill health and the need for specialist support. This also links to local approaches to service transformation, Levelling Up and improving Population Health.

Early and effective help and support

Where people do become unwell and need support, this model and the priority areas we have outlined in the strategy will help ensure people can easily access the treatment they need when and where they need it.

Focusing on recovery

Local Authorities have a role in empowering people who have mental illness, as well as their unpaid carers, and wider communities. They enable people to lead fulfilling and independent lives by providing information, advice, advocacy and offering practical support with everyday activities including for example housing, employment, finance and debt advice, direct payments, and technology. We recognise that recovery is enabled as people grow their ability to access a

life with purpose, meaning and a voice. It is more than just the absence of symptoms.

We want to make sure people have the right place to live and can access meaningful activity such as education and employment whilst they are in recovery. A new supported accommodation model is working to help ensure more people live in stable and appropriate accommodation, and there is also work underway to improve support to enter and stay in employment.

Suicide Prevention

The Southend, Essex and Thurrock Suicide Prevention Board strategy and delivery plans will align to support the ambition of this Mental Health strategy and associated plans. The Board has an all-age approach to preventing suicide which is underpinned by the priorities agreed within the national suicide prevention strategy.

Workforce

The organisations working in the SET mental health system face significant workforce pressures. Recruitment and retention are difficult and there are high vacancy and turnover rates; this is a national situation and not just local to Southend, Essex, and Thurrock. The shortage of staff places pressure on our workforce and could limit achievement of our strategic objectives if not quickly addressed.
To overcome this, we are working to reimagine what the workforce could look like and implement new workforce models. Our desire to move care into the community where appropriate, rather than using inpatient facilities, will ease pressure on the inpatient workforce and create the opportunity for different job roles in the community.

We want to create exciting employment opportunities for the workforce to develop new or existing careers within the Southend, Essex, and Thurrock geography. This will include improving support for the wider social care and VCSE workforce within the mental health system and creating positive cultures and working experiences for all of our workforce.

Digital Technology

Digital technology is a key enabler to support people within a joined up mental health care system. During the life of this strategy, we will develop digital technology for staff to share information more easily and for people with mental health needs to access more services online.

We are aware that digital technology is not easy to use for everyone and will work to support digital inclusion and provide alternative options for people using services.

Implementation and monitoring achievement

A plan is being developed to implement the strategy, which will be overseen by a Strategy Implementation Group of senior leaders across the SET mental health and care system. Most of the implementation will be led by partners working in their local places.

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There will be clear responsibility and accountability across the system for improving individual outcomes, creating the conditions for promoting good mental health, and delivering services where needed. We will publish information on how partners will work together across the system and the governance arrangements through which decisions will be made. This will include links to other key workstreams such as suicide prevention, and overarching governance boards at Alliances[14], Local Authorities, ICSs and Health and Wellbeing Boards.

An outcomes framework and key performance indicators (KPIs) will be made available with regular ongoing reporting to demonstrate the status of the work and progress achieved to implement the strategy. Measures will include the reported experiences and perceptions from those with lived experience and will be made publicly available.

To measure performance improvement, we will use the financial year 2020-2021 as our baseline, except for where a specific national or local target is already in place.

A key challenge is to ensure that the work to implement this strategy is coproduced with support and input from those with lived experience. This involvement should be genuine and give equal voice to people who traditionally may not have been involved, especially those from ethnic and minority communities. System leaders are working with local lived experience networks to agree the best ways to ensure their meaningful involvement to develop new collaborative decision-making arrangements.

This is an important strategy for the people of Southend, Essex, and Thurrock. The leaders of the local authorities and NHS are determined to make it work and deliver improved prevention and early intervention, as well as high quality care, support, and treatment for those living with mental ill health. Success will come from working together to address the wider determinants of emotional and mental health and reduce the impact of mental ill health.

[14] See appendix 9. There are 6 Alliances across SET, made up of NHS, Local Authority and VCFSE partners focussed on a place covered by a unitary authority and/or district council. These are Thurrock, South East Essex which includes Southend City, Basildon & Brentwood, Mid Essex, West Essex and North East Essex.

Appendix

Local Geographies

West Essex: Population 319,000
Hertfordshire and West Essex ICB works with Essex County Council (ECC) and the 3 District Councils of Epping Forrest, Harlow and Uttlesford, in the West Essex Health and Care Partnership. The partnership has focussed on joining up community mental health services with physical community health services, integrated around primary care.

North East Essex: Population 341,000
Suffolk and North East Essex ICB works with ECC and the 2 Borough/District Councils of Colchester and Tendring in the North East Essex Health and Wellbeing Alliance which is a collaboration of commissioners, providers and other system partners working together to transform the health and wellbeing of the population of North East Essex as an integrated system. Their approach is for everyone at all stages of their life to be able to Live Well, so they work towards outcomes using the 6 domains of the Live Well mode including ‘Feel Well; Supporting mental wellbeing’ and ‘Be Well; Empowering adults to make healthy lifestyle choices.’

Mid Essex: Population 402,000
Mid and South Essex ICB also work with ECC and the 3 Borough/District Councils of Chelmsford, Braintree, and Maldon, in the local NHS Alliance which covers Mid Essex. Existing areas of focus for the Mid Essex Alliance includes suicide prevention.

Southend City Council: Population 183,000
Southend City Council, and Mid and South Essex ICB are the statutory commissioners of mental health services for Southend. The Council’s social care vision is to work collaboratively with people to enable them to live safe, well and independently in the community, connected to the people and things they love. This is outlined in **3 key strategies around Living Well, Caring Well and Ageing Well**. Through a strengths-based focus, there is a drive to transform care and support to ensure that there are flexible options that enable independence. In particular, local partners are working together to address the disproportionate number of people in residential care, often placed by London Boroughs.

Thurrock: Population 178,000
Thurrock is a unitary authority area with borough status. It is part of the London commuter belt and an area of regeneration within the Thames Gateway redevelopment zone. The local authority, Thurrock Council, and Mid and South Essex ICB are the statutory commissioners of mental health services and are implementing an ambitious local strategy, Better Care Together Thurrock, developed by local partners through the Thurrock Integrated Care Alliance (TICA). The strategy sets out Thurrock's collective plans to transform, improve and integrate health, care and third sector services for adults and older people, to improve their wellbeing.

Key aspects relevant to this strategy include:

- Human learning Systems as the core guiding approach
- Strengths and assets-based approach to community engagement and development,
- Co-production with residents and communities to develop radically new models of care
- Integrating and transforming community mental health services with General Practice in the context of Primary Care Networks and a wider integrated housing, care and wellbeing workforce
- Transformation in local community mental health services has already begun to see significant reductions in access times and improved quality, and an enhanced focus on recovery
- Focusing on proactive and preventative care using Population Health Management.

Basildon & Brentwood: Population 264,000
Mid and South Essex ICB also work with ECC and the 2 District Councils of Basildon Point and Brentwood in the local NHS Alliance which covers Basildon & Brentwood. The Basildon and Brentwood Alliance is committed to:

- Understanding and working with communities
- Joining up and co-ordinating services around people’s needs
- Addressing non-medical factors that affect the health and wellbeing of local people
- Supporting quality and sustainability of local services

Thurrock Council

Community Equality Impact Assessment

Service area and lead officer

Name of service	Public Health / Adult Social Care
Lead officer name	Maria Payne
Lead officer job title	Strategic Lead – Public Health
Lead officer email address	mpayne@thurrock.gov.uk

Subject of this assessment

What specific policy, strategy, function or service is the subject of this assessment?
Southend, Essex and Thurrock Mental Health Strategy 2023-28
Borough-wide or location-specific?
☒ Borough-wide ☐ Location-specific – please state locations below. Click or tap here to enter text.
Why is this policy, strategy, function or service development or review needed?
Thurrock undertake a lot of work to address mental health needs in partnership with other organisations, many of whom span across Essex. On a strategic level, we sit on numerous ICB-level and SET-level forums for both children's and adults mental health transformation. Before now, there have been two separate pan-Essex mental health strategies – one for adults and one for children's – both of which Thurrock has previously been part of. This supersedes both documents as they have both expired, and provides a current collective agreed picture of priorities across the SET geography, whilst simultaneously recognising existing priorities and needs in local areas.

1. Consultation and supporting information

1.1. What steps you have taken, or do you plan to take, to consult or engage the whole community or specific groups affected by this development or review? **This is a vital step.**

Steps you have taken, or plan to take, to consult or engage
An external agency, Tricordant, were commissioned by Essex County Council to deliver the Mental Health strategy, development of which included gathering inputs from the community and specifically those with lived experience of mental ill-health. They held conversations with over 100 individuals, groups or organisations across Essex. It is intended that there will be a lived experience group to continuously inform the delivery of the strategy, and we will ensure there is appropriate Thurrock representation on that forum.

1.2. What data or intelligence sources have you used to inform your assessment of the impact? How have these helped you understand who will be affected by the development or review?

Sources of data or intelligence, and how they have been used
A number of data sources have been used in both the development of the strategy and consideration of its impact, including the Census 2021 showing our local demographic profile, local research undertaken to identify groups at risk of experiencing inequalities in mental health condition prevalence and service access, and data on those currently known to mental health services to consider where we might need to focus.

2. Community and workforce impact

2.1. What impacts will this development or review have on communities, workforce and the health and wellbeing of local residents?

Communities and groups	Positive	Neutral	Negative	Summary of positive and negative impacts	How will positives be maximised, and negatives minimised or eliminated?
Local communities in general	☒	☐	☐	Commitments made in this strategy span across the spectrum of mental health, with the vision to promote good emotional and mental health for everyone, reduce health inequalities and to improve life outcomes for those with mental ill-health, enabling them to recover and live well.	The pan-Essex Strategy Implementation Group will have Thurrock representation which in turn will feed into our local Mental Health Partnership Forum arrangements in order to ensure relevant work benefits our Thurrock residents.
Age	☒	☐	☐	A number of commitments in this strategy focus on the 'all age' approach, or the 'think family' approach, meaning that a greater level of consideration will be given across age groups rather than to consider them in silo and risk people 'falling through gaps'. Certain age groups are also mentioned specifically in this strategy, including 18-25 year olds and older people, as local data on inequalities in mental health has identified them to be at risk of poorer mental health outcomes.	Locally we will ensure these elements are joined up with relevant Thurrock forums and partners.

Communities and groups	Positive	Neutral	Negative	Summary of positive and negative impacts	How will positives be maximised, and negatives minimised or eliminated?
Disability	☒	☐	☐	A strong focus of this strategy is to improve outcomes of those with existing poorer mental health, with SMI and Eating Disorders explicitly mentioned. In Thurrock we are particularly aware of our higher than average premature mortality rate for those with SMI so we welcome inclusion of this group as a priority focus.	We will coordinate work with our physical health and social care colleagues to ensure holistic offers of support are in place as per strategic commitments.
Gender reassignment	☐	☒	☐	No particular impact has been identified from this strategy.	Click or tap here to enter text.
Marriage and civil partnership	☐	☒	☐	No particular impact has been identified from this strategy.	Click or tap here to enter text.
Pregnancy and maternity	☒	☐	☐	One of the commitments in the strategy is to improve access to perinatal and specialist mental health care for all new and expectant mothers. We know this access is particularly challenged in Thurrock.	In Thurrock we are particularly delivering on this via our Family Hubs Transformation Programme and the investment into the perinatal mental health / parent-infant relationship aspects, which adds capacity and strengthens inter-agency pathways so that perinatal mental health issues can be met at an earlier stage.

Communities and groups	Positive	Neutral	Negative	Summary of positive and negative impacts	How will positives be maximised, and negatives minimised or eliminated?
Race	☒	☐	☐	Whilst not explicitly prioritised in this strategy, it is mentioned that individuals from certain ethnic minority groups are at higher risk of poorer mental health or are disproportionately seen in certain services (e.g. secondary care). The commitments in this strategy to reduce health inequalities and focus on the wider determinants of health should particularly address some areas of racial inequality.	We will ensure that the lived experience group that work alongside the professionally-led Strategy Implementation Group incorporate views from a range of backgrounds, to ensure that opportunities to target delivery against certain commitments are not missed.
Religion or belief	☐	☒	☐	No particular impact has been identified from this strategy.	Click or tap here to enter text.
Sex	☐	☒	☐	No particular impact has been identified from this strategy.	Click or tap here to enter text.
Sexual orientation	☐	☒	☐	No particular impact has been identified from this strategy.	Click or tap here to enter text.
Location-specific impact, if any	☐	☒	☐	No particular impact has been identified from this strategy.	Click or tap here to enter text.
Workforce	☐	☒	☐	No particular impact has been identified from this strategy.	Click or tap here to enter text.

Communities and groups	Positive	Neutral	Negative	Summary of positive and negative impacts	How will positives be maximised, and negatives minimised or eliminated?
Health and wellbeing of residents	☒	☐	☐	The overarching vision of this strategy is to promote good emotional and mental health for everyone, reduce health inequalities and to improve life outcomes for those with mental ill-health, enabling them to recover and live well. This also includes support for residents to support their own mental health and wellbeing where appropriate.	Via the partnership delivery plan owned by the Strategy Implementation Group.
Socio-economic outcomes	☐	☒	☐	No particular impact has been identified from this strategy.	Click or tap here to enter text.
Veterans and serving members of the armed forces	☒	☐	☐	Whilst not explicitly prioritised in this strategy, it is known that veterans and armed forces personnel are at risk of experiencing poorer mental health / developing post-traumatic stress disorder. Commitments are made within the strategy to reduce health inequalities within services.	We will ensure that the lived experience group that work alongside the professionally-led Strategy Implementation Group incorporate views from a range of backgrounds, to ensure that opportunities to target delivery against certain commitments are not missed. We will also connect this to local work around promoting support available to veterans on an ongoing basis.

3. Monitoring and review

3.1. How will you review community and equality impact once the policy, strategy, function or service has been implemented? These actions should be developed using the information gathered in sections 1 and 2 and included in your service area's business plans.

Action	By when	By who
To ensure appropriate representation from Thurrock on both the Strategy Implementation Group and the lived experience group.	September 2023	Maria Payne / SET Strategy Implementation Group
To ensure the monitoring mechanism for the Strategy includes adequate mechanisms to capture community feedback / impact on an ongoing basis.	September 2023	Maria Payne / SET Strategy Implementation Group
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Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

4. Next steps

4.1. The information gathered must be used to inform reports presented to Cabinet or overview and scrutiny committees. This will give members a necessary understanding of the impact their decisions will have on different groups and the whole community.

Summarise the implications and customer impact below. This summary should be added to the committee reports template in the Diversity and Equality Implications section for review and sign-off at the consultation stage of the report preparation cycle.

Summary of implications and customer impact

The SET Mental Health Strategy outlines a number of commitments and priorities for system partners, including Thurrock Council, which aim to promote good emotional and mental health for everyone, reduce health inequalities and to improve life outcomes for those with mental ill-health, enabling them to recover and live well.

Data analysis undertaken to inform the strategy has identified that there are certain population groups that may be at higher risk of poorer mental health outcomes. We will ensure that the delivery plan underpinning the SET Mental Health Strategy prioritises action for these groups and aligns to other existing strategic commitments within Thurrock to improve community cohesion and reduce health inequalities.

5. Sign off

5.1. This Community Equality Impact Assessment must be authorised by the relevant project sponsor, strategic lead, or assistant director. Officers authorising this assessment are responsible for:

- the accuracy of the information
- making sure actions are undertaken

Name	Role	Date
Maria Payne	Strategic Lead – Public Health	11/07/23
Ceri Armstrong	Strategic Lead – Commissioning & Procurement	Click or tap here to enter text.
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31 August 2023	ITEM: 8
Health and Well Being Board	
Joint Report on Initial Health Assessments for Looked After Children (Update)	
Wards and communities affected: All	**Key Decision:** None
Joint Report of: Dan Jones – Strategic Lead CLA (Child Looked After) Sharon Hall - Assistant Director, SET CAMHS and Children's South Essex & Thurrock (NELFT) Ines Paris - Designated Lead Safeguarding Nurse – Mid and South Essex Integrated Care Board	
Accountable Assistant Director: Janet Simon – Assistant Director, Children's Social Care and Early Help	
Accountable Director: Sheila Murphy – Corporate Director of Children's Services	
This report is Public	

Executive Summary

This report provides an update on Initial Health Assessment performance. Our target is that 90% of children entering care receive their IHA appointment within 20 working days of entering care. This target is not currently met. Additional capacity has been helpful in improving performance where children are placed within the NELFT area. Whilst this has assisted, it has not addressed the issues which are also faced in other areas of the country. The service and the ICB plan to link with other local authorities who perform well to identify any changes we can make to local practice.

When a child becomes looked after by Thurrock Council, it is a statutory requirement that they receive an assessment of their health within 20 working days; this is known as an Initial Health Assessment (IHA). The IHA must be completed by a medical practitioner and is coordinated jointly between Thurrock Council and the NHS.
Our target is that 90% of children entering care receive their IHA appointment within 20 working days of entering care.

- In the third quarter of 2022-23; 29% of children received an IHA within 20 working days of becoming looked after. This was well below our target.

- In the fourth and final Quarter of 2022-23, 15% of children received an IHA within 20 working days of becoming looked after
- In the first quarter of 2023-23 51% of children requiring IHA's received IHAs in time

The report **highlights further areas for improvement to achieve our target of 90% of all children entering care in Thurrock achieving an IHA within 20 working days. Given the performance issues, incremental targets may be useful in the region of 60-70% and then 80-90%** These figures are for all Thurrock looked after children, irrespective of Placement area, and therefore relate to a number of different Health Providers.

Compliance with statutory timeframes for initial health assessments are important, it is important to note that:

- Even when delayed, most looked after children will have an Initial health Assessment completed. Reasons for a small number of young person not having an assessment includes young people leaving care before an assessment takes place and young people who have refused or failed to attend their appointment. Where this happens, young people are spoken to and encouraged to attend with support.
- Initial Health Assessments tell us about our looked after children's health, and actions that are required to meet their health needs accordingly.

1. Recommendation(s)

1.1 Members note the positive impact of the additional capacity provided by the ICB to NELFT

1.2 Members are aware of the further steps being taken to improve performance.

1.3 The target is adjusted to 70% IHA referrals on time with a stretch target of 90%

2. Introduction and Background

2.1 When a child becomes looked after by Thurrock Council there is a duty under the *Care Planning, Placement and Case Review (England) Regulations 2010* to undertake an assessment of their health needs within 20 working days of accommodation. This is referred to as the Initial Health Assessment. There are two steps to the completion of an IHA:

- Social Care refer the child within 5 days of becoming looked after.
- The child is provided with and attends the Initial Health Assessment appointment within 20 working days of becoming looked after.

Following the appointment, a report is sent to the Social Worker and ensures those caring for the child understand their health needs.

2.2 The Health Service local to where the child is living in care is responsible for the IHA appointment. For Thurrock children placed in Basildon, Brentwood and Thurrock, this Provider is NELFT. It is not permissible for Health Services to prioritise children from their own area. This means that Thurrock based health services have to offer Paediatric IHA appointments to all children who are newly placed in Thurrock whether they are in the care of Thurrock Council or the care of another local authority. This is in accordance with NHS England guidance (2022)

2.3 Almost all children receive an IHA but there has been a fluctuation in the ability to deliver this within the statutory timeframe. This has been a persistent issue and was raised in the 2019 Ofsted Inspection of Children's Services.

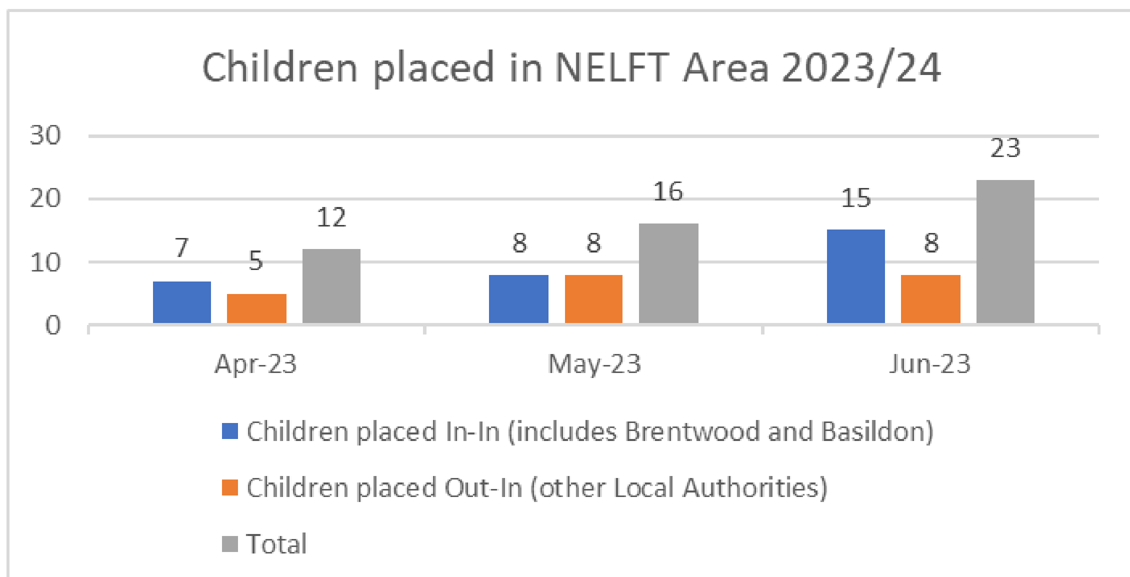
2.4 When considering IHA data it is important to acknowledge that Thurrock Children's Social Care work with different health areas:

- Thurrock Children placed in Thurrock, Basildon & Brentwood – IHA completed by NELFT
- Thurrock Children placed outside of Thurrock, Basildon & Brentwood – IHA completed by local Health Providers

Children are also placed in Thurrock, Basildon & Brentwood by other local authorities - IHA completed by NELFT which impacts local capacity.

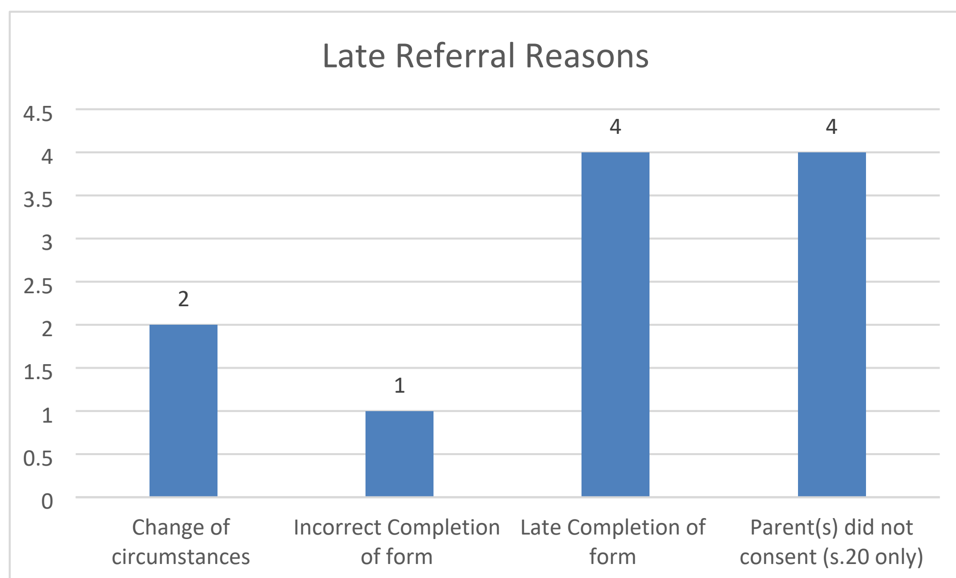
2.5 **NELFT Data**

The chart below shows the total number of children placed in the NELFT area during this period (IHA's completed by NELFT and Provide Wellbeing) – this includes all Children Placed by Thurrock in the NELFT area and Children placed by other Local Authorities cases.



2.6 **Referral Performance Quarter 1 2023/24**

Thurrock Children's Social Care are required to send a referral to Health within 5 working days of becoming looked after. 79% of referrals are made on time. Delay reasons are monitored and the reasons this target is missed are:



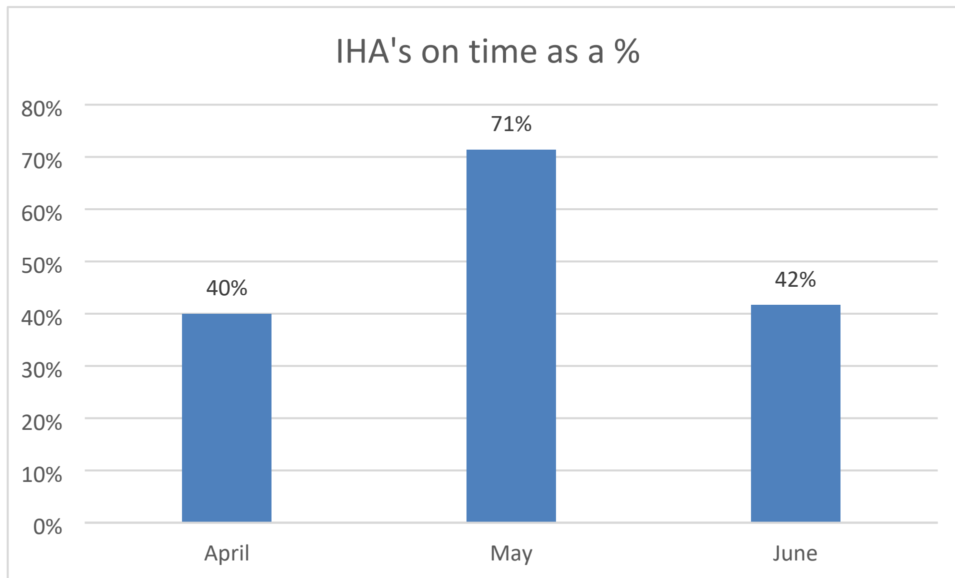
2.7 Where children aged 0-15 years become looked after at their parent's request (s.20); if the parent does not agree to the IHA then this can cause delay in referral as above. These instances of delay fall outside of the local authority's direct control.

2.8 Where the form is completed incorrectly or late, the relevant Service managers are tasked with ensuring this is addressed and that there is appropriate follow up so this is not repeated.

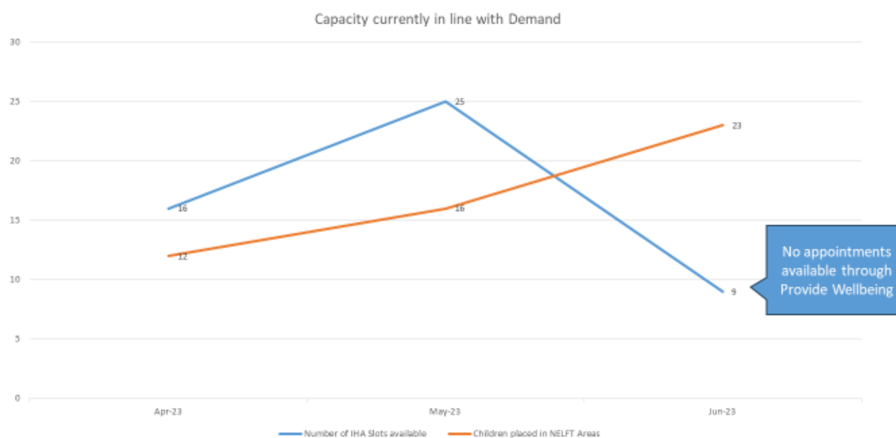
2.9 If there is a delay in receiving the referrals impacts on the ability for NHS providers to accommodate IHA within the 20 days. On occasions where referrals have been received late, NELFT make every effort to arrange an IHA at the earliest possible opportunity, on occasion this has been within 4 days of receipt of referral.

2.10 **IHA Performance**

The additional IHA capacity came online in early 2023, it was anticipated that this would take some time for the impact of the additional appointments provided to show in the performance data. The following graph sets out IHA performance by the month children entered care:



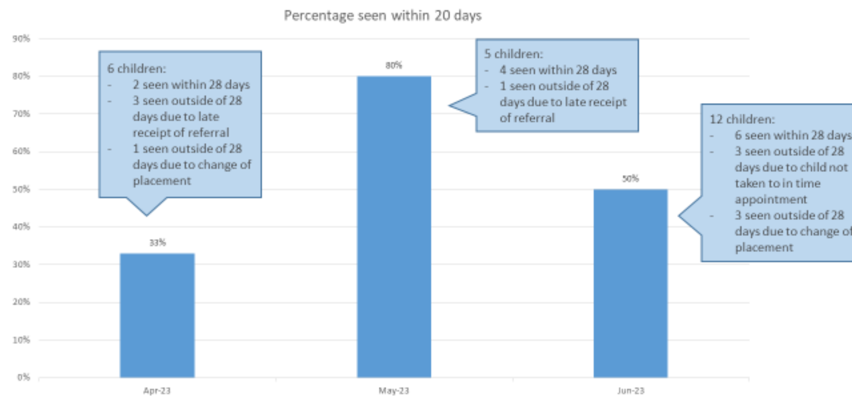
IHA Availability vs Demand



The above chart shows the local appointment availability (blue line) verses the demand for appointments. It is clear that where additional appointments funded by the ICB are available performance improves. Where these additional appointments are not available demand exceeds supply. Demand can be variable and for this quarter the demand for IHA's for Thurrock Children was exceptionally high as 30 children entered care that month, 22 of whom required an IHA. They were placed both in and out of area.

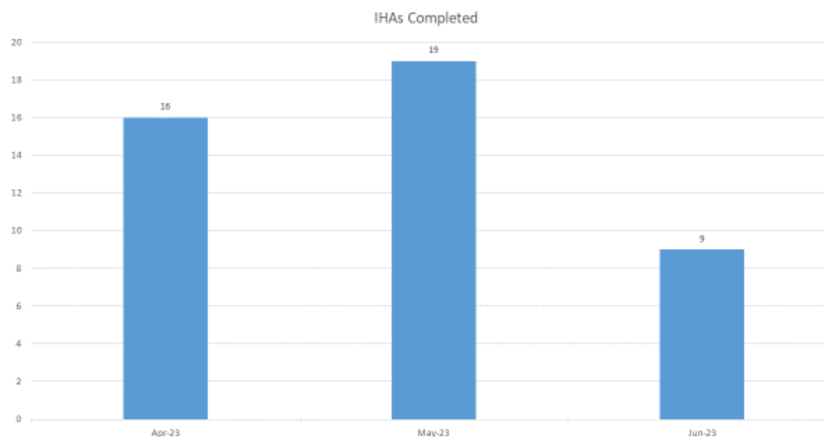
2.11 When children are placed within the NELFT area (Thurrock, Basildon and Brentwood) performance is as follows:

Percentage Seen within 28 days – based on Thurrock In-In Children becoming looked after in every given month (excludes BB In-In children)

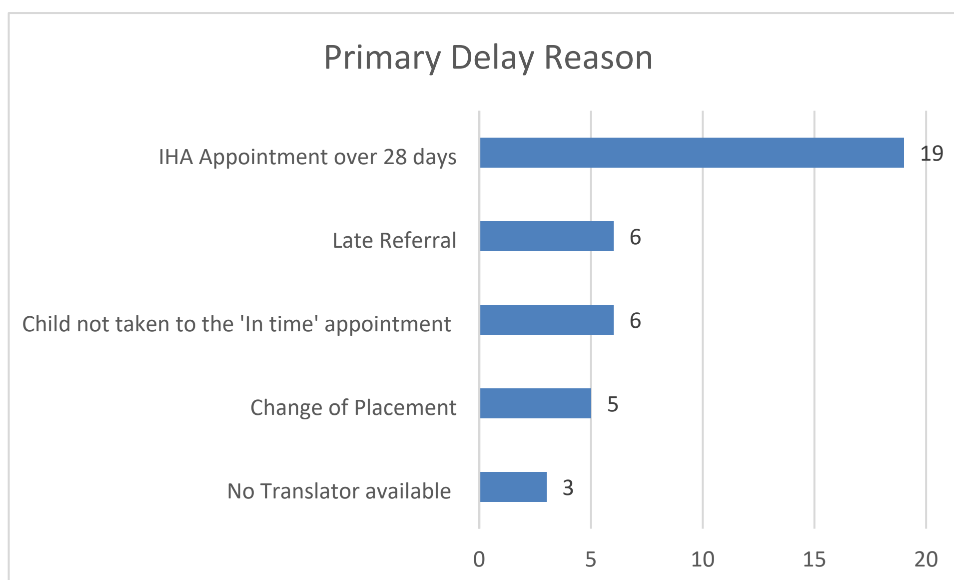


The following graph demonstrates the total number of IHA delivered across Basildon Brentwood and Thurrock for all looked after children placed in that area by all authorities. This demonstrates the high level of demand faced by Health partners.

IHA Completed – Quarter 1 2023/24



Delay reasons are tracked and reasons for delay in IHA are as follows for all Thurrock children (in & out of area)



The above graph reflects delay reasons since 01 April 2023 to 31 July 2023. Key themes and responses are:

- **IHA Appointment over 28 days.** This means that demand outstripped capacity for IHA's to be delivered and an appointment was not available when required. For children placed in the NELFT area the additional appointments have been effective but for those placed outside of area there is no additional capacity.
- **Late Referrals** – This has impacted six children. Late referrals can be due corrections required on the originally submitted form or consent issues.
- **No Translator** – Translation services are commissioned by Thurrock Council; we are able to arrange translators for planned appointments through our contracted translation service. Some Paediatricians require an in person rather than telephone translator which can cause delay due to availability to travel. On occasion translators are not available on the appointment date and a wider range of suppliers is being sought by spot purchase to increase availability
- **Child not taken to the Appointment:** On occasion children have not been take to the appointment, this has been due to the child being ill and issues for the carers. If the carer is not available, then the allocated should take the child to the appointment
- **Change of Placement**: On occasion a child will change both placement and health area which can cause delay as a new appointment needs to be found. This can happen before an IHA appointment has been allocated so it cannot be retained.

3. Issues, Options and Analysis of Options

3.1 It is important to note that the NELFT and the Council Officers work collaboratively to track and monitor all Thurrock children on a weekly basis. The ICB is also invited and will attend these meetings, when required. All children

and young people are seen at the earliest opportunity. Regular exception reports capture the reasons for any breaches. The additional capacity has been effective, and this started to show impact in the early data. These meetings have been established for some time and continue to work to address the issues.

3.2 Nationally there is a shortage of Paediatricians and no clear National workforce plan. Within NELFT, there is a clear recruitment plan in place to fill the vacant posts. For children placed outside of Thurrock, officers and NELFT LAC team proactively engage with NHS providers in their area to support transfer of care and track delivery of IHAs but have little influence on pressures on their local services. The escalation pathways from NELFT to ICB are currently being reviewed to ensure timely ICB to ICB liaison takes place when required.

3.3 The availability of in person translators is impacting in some cases on the timely completion of IHA's. Whether translation is in person or virtual is a clinical decision and on a case by case basis. We continue to review this and look at best options to ensure this does not delay the IHA.

3.4 IHAs are recognised as a national and local priority, as per the Southend, Essex and Thurrock (SET) Looked After Children Health Strategy 2022-24. Across SET, and IHA video is being commissioned to inform CYP and carers of the IHA process and increase uptake and attendance and reassure children and young people and foster carers about the process. An Essex wide digital solution is being progressed so the referrals are collated and can be passed between health areas when needed. This should enable areas of high demand to be identified as well as areas with capacity.

3.5. Designated Nurses across SET are currently completing a SET options paper considering a service for Separate Migrant Children. This will assist in managing demand and ensure tailored services. Thurrock Health and Wellbeing Board will be kept updated on progress.

3.6 The additional IHA capacity funded by the ICB has proven to improve the timeliness of local IHAs, however challenges remain. The ICB is reviewing medium and long term plans to ensure sustainability. The new ICB landscape and the development of the Community Provider Collaborative across Mid and South Essex provides the opportunity to design a sustainable longer-term solution.

3.7 NHS England have launched a new Assurance of Statutory Health Assessments for Looked After Children. This is a national health data collection designed to provide assurance that children are receiving their statutory health assessments in the statutory timescales. It has been launched in July 2023 and will look to:

- reduce the proportion of Looked After Children who do not receive their health assessments within the statutory timescales and to improve the notification of placements.

- provide continuity of healthcare to children placed in a new area with an identified health need in a timely manner
- provide assurance however there may be an opportunity to explore quality aspects at a later date.

3.8 **Improvement Routes**

Actions	Lead
Development of SET wide IHA tracking – this will ensure performance and progress sis tracked across the wider Essex area and will ensure best use of resources.	NELFT
Joint Visit to an authority which is performing well to identify learning and what enables good performance	Children's Services and ICB
National NHS audit of IHA's to identify national solutions to improve performance	ICB/NHS England
Review of additional capacity provided to NELFT to provided a sustainable longer term solution	ICB
Review of IHA services for Separated Migrant Children (UASC) to ensure that there is tailored service that can meet demand	ICB

4. Reasons for Recommendation

4.1 The Health and Well Being Board are updated on the improved performance in relation to Initial Health Assessments performance in this area has remained inconsistent since 2019. Additional funding from the ICB has been significant in improving outcomes for children placed in the NELFT area.

4.2 The Health and Well Being Board are informed of the further steps being taken to improve this.

4.3 Health and Wellbeing Board and Corporate Parenting Committee have a further understanding of the health needs for Thurrock Looked After Children.

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

5.1 Our Corporate target is for 90% of Initial Health Assessments to be completed in 20 working days of entering care

6. Implications

6.1 **Financial**

Implications verified by: David May Strategic Lead Finance

The are no financial implications for this report

6.2 **Legal**

Implications verified by: Petrena Sharpe

Safeguarding Lawyer (Team Leader)

The Council has general duty to safeguard and promote the welfare of any child that its looks after under Section 22(3) of the Children Act 1989 and it must have regard to the Corporate Parenting Principles in Section 1(1) of the Children and Social Work Act 2017.

The Care Planning, Placement and Case Review (England) Regulations 2010 set out the detailed legal requirements in caring for Looked after Children. The timescales for health are set in regulation 7 which provides for the Council to make arrangements for the health assessment by the child's first review, and for a written report of the health assessment to be provided as soon as soon as reasonably practicable.

6.3 **Diversity and Equality**

Implications verified by: Roxanne Scanlon

Community Engagement and Project Monitoring Officer

The Service is committed to practice, which promotes equality, diversity and inclusion, and will carry out its duties in accordance with the Equality Act 2010, Public Sector Equality Duty and related Codes of Practice and Anti-discriminatory policy. The service recognises that a range of communities and groups of people may have experienced obstruction or the impact of prejudice when accessing services including Social Care and Health services. Both Services are committed to support all children in the care of Thurrock Council to access Initial Health assessments, individual arrangements are made where required to meet needs and address individual concerns

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

- Impact on looked after children

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

- None

8. Appendices to the report

- None

9. Key points of interest within appendices

- None

Report Author:

Dan Jones – Strategic Lead CLA

Sharon Hall - Assistant Director, SET CAMHS and Children's South Essex & Thurrock (NELFT)

Ines Paris - Designated Lead Safeguarding Nurse – Mid and South Essex Integrated Care Board

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31 August 2023		ITEM: 9
Health and Wellbeing Board		
Thurrock Tobacco Control Strategy 2023-2028		
Wards and communities affected: All	**Key Decision:** Non-key	
Report of: Dr Jo Broadbent, Director of Public Health		
Accountable Assistant Director: Andrea Clement, Assistant Director of Public Health		
Accountable Director: Dr Jo Broadbent, Director of Public Health		
This report is Public		

Executive Summary

The previous Tobacco Control Strategy for Thurrock expired in 2021 and following this, a Joint Strategic Needs Assessment (JSNA) was conducted. A JSNA assesses the current and future health and care needs of the local population and is used to inform and guide the planning and commissioning of health and wellbeing services. The Tobacco Control JSNA made recommendations for reducing smoking and smoking related harm in the borough. The recommendations from this JSNA have been reflected in the current strategy document, which aims to provide strategic direction for the continuing work to reduce smoking and tobacco related harm in Thurrock.

This strategy takes an inequalities approach, in line with the findings of the JSNA and Goal 1A of the Health and Wellbeing Strategy 2022-2026. Actions will be focussed on reducing smoking within the eight most deprived wards as well as among Routine & Manual workers, those with long-term mental health conditions, those with substance misuse, and parents-to-be. This strategy will be supported by a delivery plan detailing specific actions that will help to achieve the ambitions and overall goal of reducing smoking prevalence in Thurrock.

1. Recommendation(s)

1.1 That Health and Wellbeing Board note the contents of and agree to the publication of the Tobacco Control Strategy 2023-2028 on the Council website.

2. Introduction and Background

2.1 This strategy has been brought to Health and Wellbeing Board at the request of the Director of Public Health to obtain approval of the strategy and assent to publish on the Council website.

2.2 This strategy builds on the work of the previous Tobacco Control Strategy for 2016-2021 and takes into account the recommendations made in the Thurrock Whole System Tobacco Control JSNA 2021, which was brought to the board on 18 March 2022.

2.3 The most recent smoking prevalence data shows Thurrock has an overall prevalence of 12.6%, which is similar to England and the East of England.

2.4 Smoking accounts for half of the difference in life expectancy between the most and least deprived wards and 63% of smokers are from the 8 most deprived wards.

2.5 High smoking rates continue to persist among Routine & Manual workers, those with long-term mental health conditions, those with substance misuse, and parents-to-be.

2.6 This strategy takes an inequalities approach to tackling smoking in Thurrock by targeting activity where there is the greatest need (the areas and groups listed in 2.4 and 2.5)

2.7 The strategy is organised into four priority areas: Prevention, Smoke-free Environments, Helping Smokers to Quit, and Communication, Evaluation, and Adaptation. Each priority contains ambitions that we aim to achieve and together, they will help us to reduce smoking prevalence in Thurrock. These ambitions are laid out in the full strategy document, attached as **Appendix 1** to this report.

2.8 Following the publication of this strategy, a delivery plan will be completed detailing the actions that will be taken to achieve the ambitions of the strategy.

2.9 Progress on the strategy will be monitored and will be reported to Better Care Together Thurrock via the Population Health and Inequalities Working Group.

3. Issues, Options and Analysis of Options

3.1 The final draft version of the strategy was completed in June 2023 and was subsequently approved by the Public Health Leadership Team, the Adults, Housing and Health Directorate Management Team, and Thurrock Integrated Care Alliance.

3.2 The board will note the contents of the Tobacco Control Strategy 2023-2028 and provide their signoff for publication of this strategy on the Council website. The strategy will provide direction for a delivery plan, comprised of detailed

actions that the Council and Partners will take to achieve a reduction in smoking prevalence focussed on the groups of greatest need.

4. Reasons for Recommendation

4.1 It is recommended that the Board approve the strategy document. In providing final signoff on the strategy the public health team and partners will be able to complete the delivery plan and actions towards the strategic ambitions can begin.

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

5.1 This strategy has been reviewed and approved in its final form by Public Health Leadership Team, Adults Health and Housing DMT, and Thurrock Integrated Care Alliance.

5.2 In addition, a representative from all named stakeholder groups reviewed and commented on an earlier draft; this feedback was worked into the final version.

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

6.1 The Thurrock Health and Wellbeing Strategy 2022-26 contains a goal to reduce smoking in Thurrock. It commits to doing so by developing a Tobacco Control Strategy that focusses on areas of high deprivation and disproportionately affected groups.

7. Implications

7.1 **Financial**

Implications verified by: **Bradley Herbert**
Senior Management Accountant

There are no direct financial implications of noting the content of the strategy and providing approval for its publication on the Council website. More specific financial implications would be likely to follow from any subsequent delivery plan.

7.2 **Legal**

Implications verified by: **Kevin Molloy**
Principal Solicitor Contracts Team

Section 2B of the National Health Service Act 2006 requires each local authority to take such steps as it considers appropriate for improving the health of the people in its area. Approval and implementation of the Tobacco

Control Strategy will continue to allow the appropriate steps to be taken to improve the health of people in the area. The Council has a duty under section 149 of the Equality Act 2010 (the public sector equality duty) in the exercise of its functions to have regard to the need to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- advance equality of opportunity between persons who share a relevant protected characteristics and persons who do not share it;
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Under Section 111 of the Local Government Act 1972, local authorities have the power to do anything (whether or not involving the expenditure, borrowing or lending of money or the acquisition or disposal of any property or rights) which is calculated to facilitate, or is conducive or incidental to, the discharge of any of their functions. The procurement of any goods, works or services by the Council which will flow from this strategic decision must be undertaken in accordance with all relevant provisions of the Council's Constitution including Contracts Standing Orders and all applicable procurement rules, including where applicable the Public Contracts Regulations 2105.

7.3 **Diversity and Equality**

Implications verified by: **Roxanne Scanlon**

Community Engagement and Project Monitoring Officer

The Tobacco Control Strategy aims to reduce smoking and tobacco related harm in Thurrock which will be of benefit to all longer term, regardless of protected characteristics. Details of the inequalities approach used in updating this strategy are included within this report. A full Community Equality Impact Assessment will be completed ahead of the subsequent delivery plan creation.

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

The Tobacco Control Strategy 2023-2028 will focus on reducing health inequality caused by smoking. By virtue of this approach, higher risk groups that are most affected by smoking will be targeted for support.

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

- Thurrock Whole System Tobacco Control JSNA 2021 (link: Thurrock Council - Joint Strategic Needs Assessment: Whole systems tobacco control, 2021)

9. Appendices to the report

- Appendix 1: Tobacco Control Strategy 2023-2028

Report Author:

Katie Powers
Health Improvement Officer
Public Health

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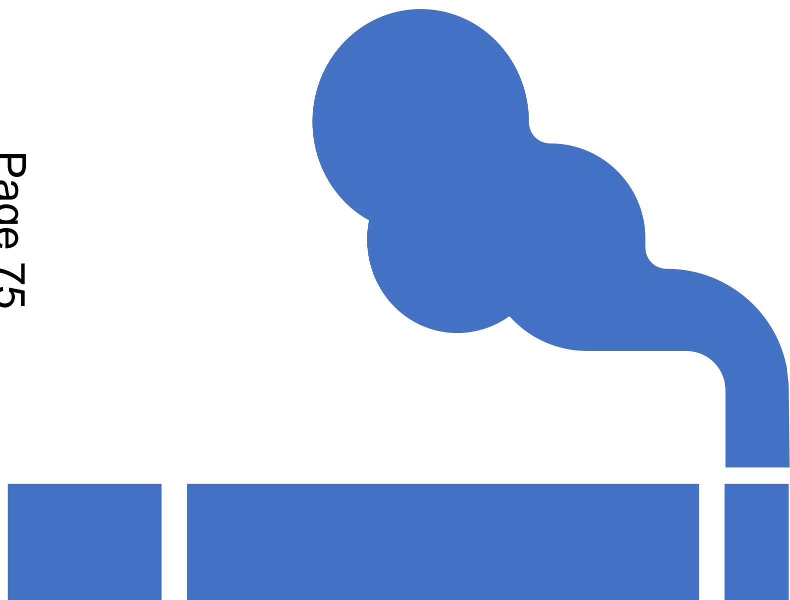

2023 – 2028

Thurrock Tobacco Control Strategy

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Introduction

Smoking is widely accepted as one of the most detrimental behaviours that can affect the health of our communities and increase the risk of suffering serious illness and premature death.

Cigarettes are the main cause of death for about half of all long-term smokers and are a significant contributor to increased morbidity in others.[1] Smoking causes conditions ranging from cancers, vascular disease, respiratory diseases, dementia, rheumatoid arthritis, sight loss, and events such as heart attacks and strokes. It is the 4000 chemicals in tobacco which cause the harm to health, over 50 of which can cause cancer.[2]

In England there have been concerted efforts to reduce the number of smokers in the population and to increase education about the health harms of smoking as well as the wider societal impacts. While there have been considerable reductions in the smoking population of England from 45% 1974, the Annual Population Survey from 2021 indicates that 13% of adults in England and 12.6% in Thurrock still smoke.[3]

While the significant reduction in smoking both nationally and locally is welcome, these reductions and the harms that tobacco causes on those in the community who smoke is not equally distributed. There are deep inequalities related to tobacco use. The use of tobacco and its associated harms continue to fall hardest on some of the poorest and most vulnerable people in our communities.

[1,2] Cancer Research UK. [3] NHS Digital Fingertips

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Smoking and Inequalities

Smoking is the single largest driver of health inequalities in England, accounting for half the difference in life expectancy between those living in the most and least deprived communities. Smoking is much more common among people with lower incomes. The more disadvantaged a person is, the more likely they are to smoke and to suffer from smoking related illness and early death related to smoking.

As spending on tobacco consumes a relatively high proportion of the household income for people with low incomes who smoke, smoking can lock people into poverty. In addition to its impact on health inequalities, smoking also brings a huge financial cost to wider society. Action on Smoking and Health (ASH) estimates the cost of smoking to England's economy to be £12.6 billion each year.

Nearly all of those who start smoking do so as young people in their teens or early twenties. Where smoking is more visible in homes, communities and workplaces, there is higher likelihood that smoking will be taken up by the next generation. Children and young people who live with parents who smoke are nearly three times more likely to become smokers themselves than their peers who do not live with smokers. If smoking is more visible and perceived to be socially normal behaviour, there is a higher likelihood to experiment with tobacco. The "de-normalising" of smoking is important in changing attitudes in children and young people to the use of tobacco.

There has traditionally been a focus on the provision of universal Stop Smoking Services to address the reduction in the prevalence of smoking in our communities. This was the best approach when the numbers of smokers in society were much higher. Since there are fewer smokers generally, smoking has become an issue of inequality and therefore, an approach needs to be taken in order to specifically target groups where rates remain high.

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Reducing Tobacco-Related Harm

The likelihood of successfully quitting in the long term is increased by three times through the use of Local Stop Smoking Services, which provide behavioural support to aid quitting.[4] While about half of attempted quits are made without the use of Nicotine Replacement Therapy (NRT) or other aids,[3] the use of NRT and licensed pharmacotherapy helps reduce the nicotine cravings that arise with stopping smoking.

There are six internationally recognised strands of tobacco control[4] which have become the core of tobacco control policies across the world. The six strands are:

1. Making smoking less affordable
2. Regulating tobacco products more effectively
3. Reducing exposure to second hand smoke
4. Stopping the promotion of tobacco products
5. Helping smokers to quit
6. Effective communications for tobacco control

To achieve a smoke-free Thurrock, there is a need to continue to prevent the uptake among young people, reduce the supply and demand of illicit tobacco through regulation and enforcement, reduce exposure to second hand smoke through creating smoke-free environments, and focus efforts to support people to stop smoking in communities where smoking rates are still higher than the wider population.

This strategy will take an inequalities approach to tobacco control, ensuring that action is targeted where it will have the greatest impact for the groups of greatest need within Thurrock. Due to the wide range of areas impacted by smoking, and the variety of interventions required to address it, a comprehensive and strategic approach to tobacco control is needed. To achieve this, all parts of our system will have their part to play.

This strategy is based on the detailed analysis in the Thurrock Whole System Tobacco Control JSNA 2021

[4] Healthy Lives, Healthy People: a tobacco control plan for England

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National Context Summary

- The main form of tobacco used in the United Kingdom (UK) is cigarettes.
- While the proportion of people in England who smoke has reduced, smoking cigarettes continues to be the main cause of premature and preventable death in England. It is also the largest single contributor to health inequalities, accounting for half the difference in life expectancy between those living in the most and least deprived communities.
- Smoking impacts health across peoples lives; it causes permanent lung damage to children exposed to second hand smoke; it is a common cause of sickness absence; it increases the risk and severity of long-term conditions and infectious diseases; it reduces the effectiveness of many medicines and treatments, shortens healthy life expectancy and increases mortality.
- Smoking is not a lifestyle choice; evidence has demonstrated that it is an addiction. Most smokers want to quit (recent data suggests about 58%) and many try each year, mostly on their own and increasingly with the support of e-cigarettes; however, the most effective method of stopping smoking is through evidence-based stop smoking services.
- Thurrock has reached a similar smoking prevalence rate than the England average, however people from poorer socio-economic groups and people living with mental ill health continue to be more likely to smoke than the general population. This has far reaching consequences on the health of residents, household budgets, health and care services, the economy, and the environment.
- Full national context can be found in the Thurrock Whole System Tobacco Control JSNA 2021

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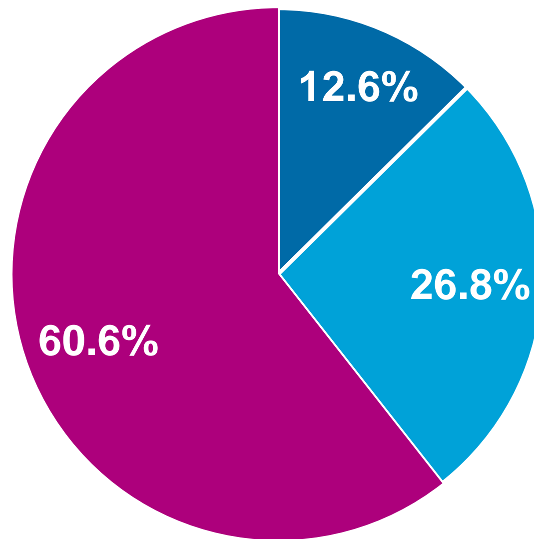
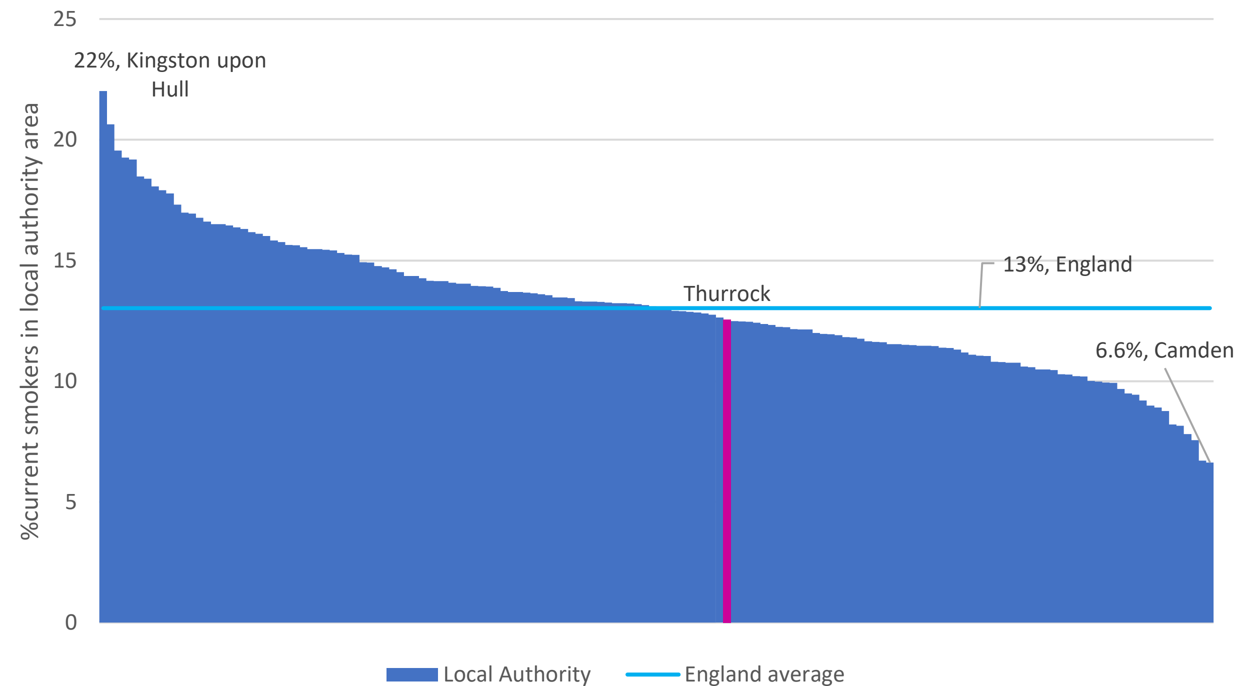
Local Context

There is a continuing decline in the proportion of people who smoke in the Thurrock. As of 2021, the annual Population Survey (APS) indicates that 12.6% of people in Thurrock smoke; this is similar to the estimated rate of smoking in England (13%) and in the East of England region (12.9%). However, there has been a change in the method of collecting these data due to the Covid-19 pandemic, which appeared to show a large and unexplained decrease in smoking prevalence nationwide; it is therefore recommended to interpret these prevalence numbers with caution. The true prevalence of smoking in Thurrock could be as high as 15.6%.* Thurrock still has a long way to go to reach the UK government's ambition to be 'smokefree' by 2030, meaning only 5% or less of the population smoke. Data from Camden shows it is possible to get close to that ambition; their 2021 smoking rate was 6.6%.

* 95% confidence interval: 9.5%-15.6%



Source: NHS Digital Fingertips (2021)



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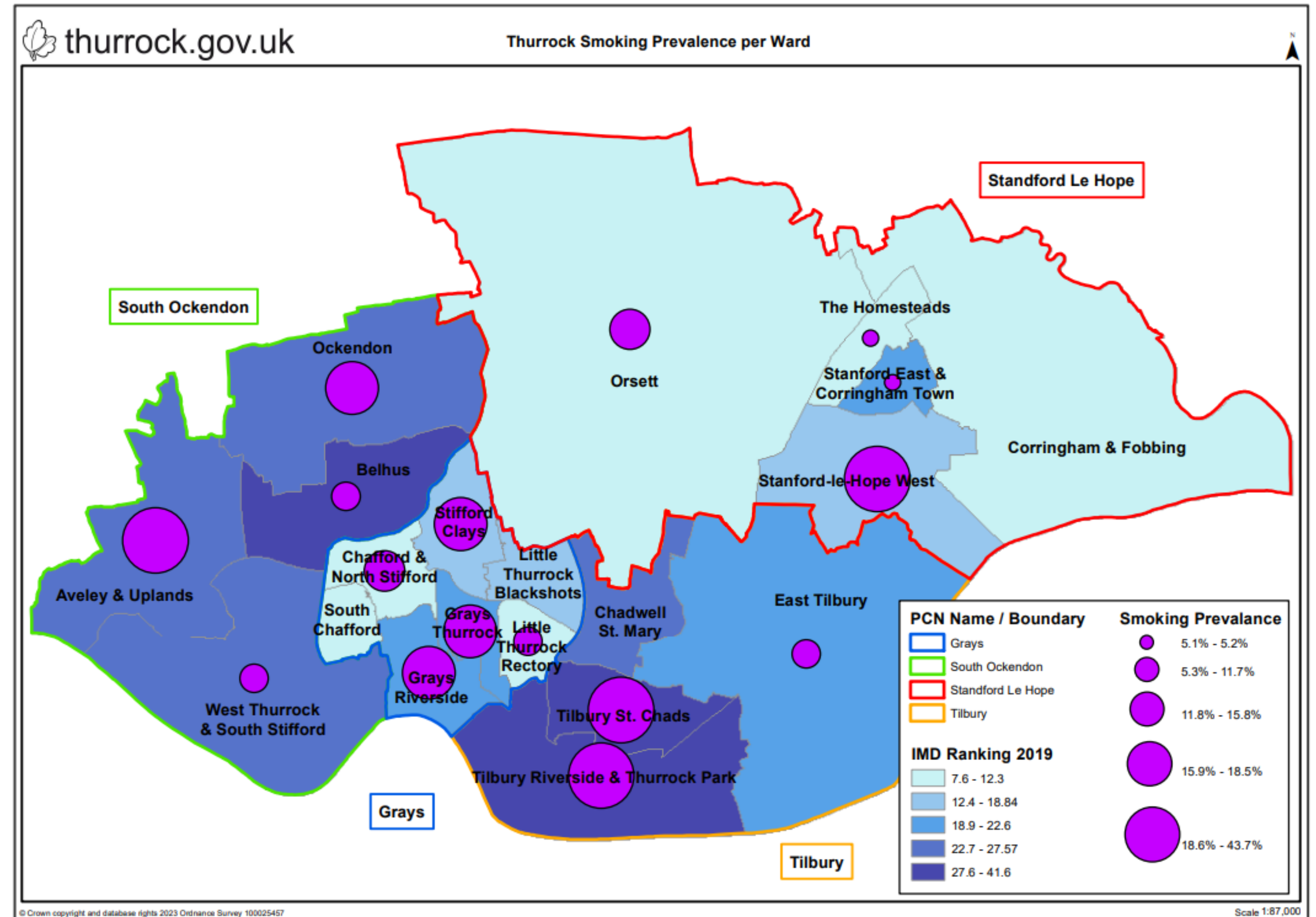
Source: NHS Digital Fingertips (2021)

Inequality

The decrease in smoking rates across Thurrock has not been evenly distributed. Areas of higher deprivation have seen slower progress than their more affluent neighbours. The difference in life expectancy between the most and least deprived wards is 9 years for men and 7 years for women, and half of this can be attributed to smoking. It is vital that the eight most deprived wards in Thurrock, which account for 63%* of smokers, receive targeted attention across all areas of this strategy to make the largest possible difference to the equity of health across the borough. NICE recommends that an effective stop smoking service reach 5% of the smoking population; in 2021/22, the Thurrock SSS reached slightly below that target (4.5%) across the borough. In individual wards, 10 were below the 5% target, half of those were among the 8 most deprived areas.

Thurrock Ward-Level Smoking Prevalence (QOF 2021/22)



*not counting Chadwell St Mary- GPs now part of college health and no longer reporting QOF separately

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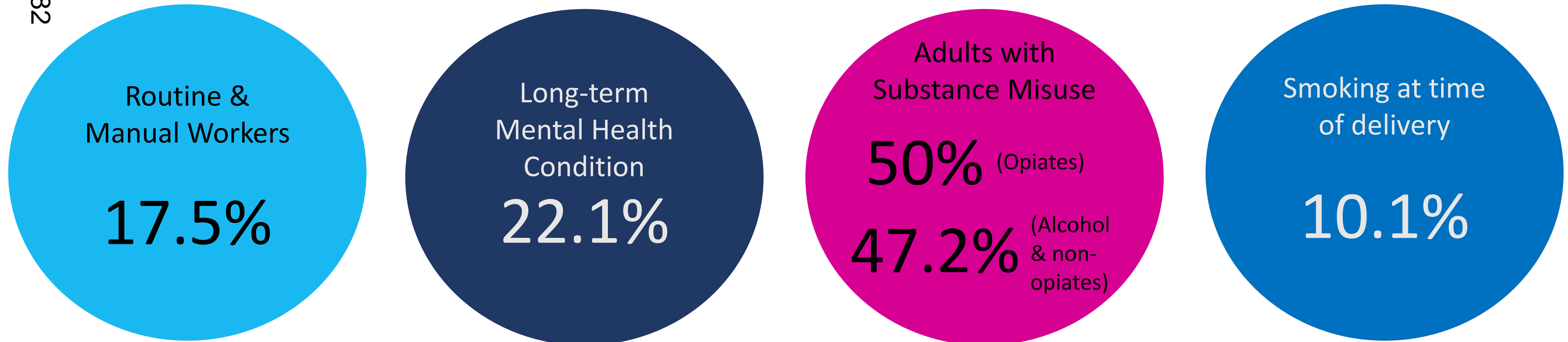
High Risk Groups

While the overall smoking prevalence has been decreasing in Thurrock, there are still some groups that are disproportionately affected by smoking, which contributes significantly to health inequality in the borough. The below shows that the rates of smoking among Routine & Manual workers, those with mental health conditions, and adults with substance misuse are all much higher than the 12.6% Thurrock average. This means that these groups are disproportionately affected by the harms of smoking compared to the overall population. Smoking at the time of delivery is higher than the regional (8.5%) and national (9.1%) averages and due to the unique harms caused by smoking during pregnancy, targeted reduction is required.



Source for all: NHS Digital Fingertips (2021)

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Support to Stop Smoking: current service provision

The primary stop smoking service in Thurrock is provided by Thurrock Healthy Lifestyles Service (THLS). The offer supports residents to quit using a variety of Nicotine Replacement Therapy (NRT) products and weekly telephone sessions with a Health Improvement Practitioner. NICE guidance cites a 35% quit rate at 4 weeks as the benchmark for an effective stop smoking service, the THLS service supports quits for 12 weeks, so we hold the Thurrock service to a higher standard than the NICE recommendations mandate.

The Stop Smoking Service is one of the main tools Thurrock has to tackle inequality in smoking rates. Targeted outreach to high-prevalence areas, and tailored interventions for high-risk groups will help to increase service impact within hard to reach communities. Based on performance data, the service is generally an effective one, but it is not achieving equally across all ethnic groups and we do not currently know success rates for all high-risk groups.

Routine & Manual workers are 30% of referrals and 34% have successfully quit at 12-weeks. The service appears to work well for this group, and the focus should be on increasing referrals.

Clients with recorded **mental health conditions** are 13% of referrals and 28% of these achieved a 12-week quit. Ways to increase both referrals and effectiveness for this group should be explored and implemented.

We don't have robust data for service users with **substance misuse**. A solution should be explored to ensure we can monitor equity of service for this group.

Pregnant women who are referred to the service are a minority, but 33% of them successfully quit after 12-weeks. The THLS service is effective for this group, so an effort should be made to increase referrals. We will also look to adopt a whole family approach to support the wider household.

Referrals into the service do not reflect the ethnic makeup of the Thurrock population and successful quit rates vary between groups. More outreach is needed within **minority ethnic groups**, and adjustments to make the service more effective for Black and mixed race service users should be explored and implemented.

Ethnic Group	Pop %	Referrals %	Quit rate %
White	76.7	92.7	33.5
Asian	6.9	2.6	35.6
Black	11.9	1.9	22.2
Mixed	3.0	1.5	27.8

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Previous Work

Thurrock's previous Tobacco Control Strategy for 2016-2021 included three strategic themes:

- **Prevention**: interventions that aim to reduce the visibility of smoking, normalise quitting and inform the public about the risks of smoking and how to get support.

- **Enforcement**: interventions that deliver against legal obligations concerning tobacco and mainly aim to reduce exposure to second hand smoke and the impact of illicit tobacco.

- **Treatment**: includes brief interventions advice, referrals and stop smoking services. For people who are not yet ready to quit, treatment also includes harm reduction approaches.

Alongside a universal stop smoking offer, the strategy proposed targeted support to people living in more socio-economically deprived areas, people with long term conditions, mental ill health, and pregnant women. Delivery of this was supported by strong leadership and governance through its Tobacco Control Alliance. Also, Thurrock was awarded with CLeaR accreditation (in 2015), which assesses the extent to which local authorities deliver their tobacco control programmes against best practice principles.

Due to a number of factors, including the COVID-19 pandemic, the Tobacco Control Alliance is no longer in place, therefore it will be necessary to find a new home for leadership of this current strategy if success is to be driven forward.

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Priorities

The overarching goal of this Tobacco Control Strategy is to reduce overall smoking prevalence in Thurrock to 7.1% by 2027/28, with a view to achieve the UK Government's ambition of ≤5% by 2030. This goal will be supported by four priority workstreams that will ensure activity is focussed on areas of greatest impact as identified by the 2021 Tobacco Control JSNA

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Principles

Due to the potential volume of priorities, we have sought to prioritise delivery options against the JSNA recommendations based on the following underpinning principles:

- **Strategic alignment:** there are a number of innovations in the local system that could support delivery of the whole systems tobacco control approach. We will prioritise capitalising on such innovations to make most efficient use of local resources and to support a holistic approach to tobacco control.
- **Inequalities:** where research evidence indicates an intervention is more likely to impact on inequalities in smoking prevalence.
- **Evidence strongest:** where evidence is available, interventions that have the strongest research evidence have been chosen.
- **Co-Production:** where research evidence is weak / unavailable but there is an inequality, we will prioritise co-producing solutions with local population groups.
- **Evaluation and monitoring:** where research evidence is weak / unavailable but there is a need to innovate, we commit to undertaking timely and good quality evaluation to enable the strategy to have the agility to adapt as we learn what works bets locally.

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Prevention

This priority will focus on stopping smoking before it starts. This will be achieved through working with young people, expectant parents, and education settings.

What we will do:

1. Reduce access to illicit tobacco
2. Continue enforcement against illegal sales of tobacco products to children
3. Increase screening for smoking/vaping among young people
4. Reduce smoking among pregnant women and their partners/households

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Prevention

Ambition	Reason	Principle	Evidence Base	Responsibility
1a: Reduce access to illicit tobacco	Illicit tobacco undermines national initiatives to reduce the affordability of smoking.	Strategic alignment	Action on Smoking and Health (ASH) 10 high impact actions for local authorities and their partners	Trading Standards
1b: Continue enforcement against illegal sales of tobacco products to CYP	The majority of smokers start before the age of 21.	Strategic alignment	Action on Smoking and Health (ASH) 10 high impact actions for local authorities and their partners	Trading Standards
1c: Work with schools and other education settings to co-design and deliver relevant tobacco and vaping messaging.	The majority of smokers start before the age of 21, and vaping amongst young people is increasing.	Co-production	NICE guidance. Tobacco: preventing uptake, promoting quitting and treating dependence	Schools Children's and Education Brighter Futures Board Trading Standards
1d: Increase screening for smoking/vaping among young people	The majority of smokers start before the age of 21.	Evidence strongest	Thurrock Whole System Tobacco Control JSNA 2021	Schools Young people's services (YOS, substance misuse, etc.) Brighter Futures
1e: Tackle smoking among pregnant women and their partners/ households	Smoking in pregnancy has reduced at a slower rate than the general population and poses unique risks to child development.	Strategic alignment Inequalities Evidence strongest	NHS long-term plan	THLS BTUH Tobacco Dependency prevention sub-group (MSE ICS)

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Smoke-free Environments

This priority will focus on reducing the harm caused by second-hand smoke by restricting smoking in public spaces and de-normalizing smoking, as well as increased enforcement of national smoke-free initiatives.

What we will do:

1. Explore enforcement strategies for smoke-free healthcare settings
2. Smoke-free pledge across the council estate
3. Smoke-free homes approach for expectant parents
4. Smoke-free settings for children and young people

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Smoke-free Environments

Ambition	Reason	Principle	Evidence Base	Responsibility
2a: Explore enforcement strategies for smoke-free hospitals/healthcare settings and NHS smoke-free pledge	A clear and visible way for NHS organisations to show their commitment to helping smokers to quit and to providing smokefree environments which support them.	Strategic alignment	Smoke-free NHS pledge	BTUH Tobacco Dependency Prevention Sub-Group (MSE ICS)
2b: Smoke-free pledge across the council estate	The council should lead this strategy by example and ensure that smoke-free pledge commitment is visible and enforced	Strategic alignment	Action on Smoking and Health (ASH) 10 high impact actions for local authorities and their partners	Human Resources Estates Security
2c: Smoke-free homes approach, particularly for expectant parents	Promotion and support for smoke-free homes, particularly council housing, will align with NHS LTP smoke-free pregnancy pathway	Strategic alignment Inequalities	Action on Smoking and Health (ASH) 10 high impact actions for local authorities and their partners	NHS Housing Team Community Teams Mental Health Providers
2d: Smoke-free settings for children and young people	Protect the public, especially young children, from secondhanded smoke and de-normalize smoking more broadly	Inequalities	Action on Smoking and Health (ASH) 10 high impact actions for local authorities and their partners	Parks Team Public Health Schools

Help Smokers to Quit

This priority will focus on getting more Thurrock smokers to quit. There will be a particular focus on reducing health inequalities by targeting smokers from groups that are disproportionately affected by smoking.

What we will do:

1. Increase quitters from the 8 most deprived wards
2. Increase quitters from high risk groups
3. Work with NHS partners to build smoking cessation into all clinical pathways and strengthen existing pathways into the Stop Smoking Service
4. Increase accessibility of Stop Smoking Service
5. Improve and expand vape offer

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Help Smokers to Quit

Ambition	Reason	Principle	Evidence Base	Responsibility
3a: Increase quitters from the 8 most deprived wards-	63% of smokers in Thurrock live in the 8 areas with highest deprivation	Inequalities Evidence strongest	Thurrock Whole System Tobacco Control JSNA 2021	Primary Care THLS
3b: Increase quitters from high-risk groups	Smoking amongst those with long-term mental health conditions, substance misuse, those working in routine & manual jobs, and pregnant women remains high, despite an overall decrease in rates.	Inequalities Evidence strongest	Thurrock Whole System Tobacco Control JSNA 2021	Primary Care EPUT Inclusion CGL THLS
3c: Work with NHS partners to build smoking cessation into all clinical pathways and strengthen existing pathways into the Stop Smoking Service	Referrals into the SSS have fallen in recent years, pathways need to be reviewed.	Strategic alignment Evidence strongest	Thurrock Whole System Tobacco Control JSNA 2021 Case for Further Change	Primary Care EPUT Inclusion CGL THLS Tobacco Dependency Prevention Sub-Group (MSE ICS) BTUH
3d: Increase accessibility of Stop Smoking Service (apply learning from ambition 4c)	Adjustments need to be made to achieve more successful quits from Black and mixed ethnic groups as well as those with long-term mental health conditions and substance misuse	Inequalities Co-production	Thurrock Whole System Tobacco Control JSNA 2021	Public Health THLS EPUT Inclusion
3e: Improve and expand vape offer	Vapes are an effective harm-reduction tool that help smokers to quit.	Evidence strongest	Khan Review: making smoking obsolete	Public Health THLS

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Communication, Evaluation, Adaptation

This priority will focus on targeted marketing of smoking cessation support, evaluating initiatives to understand what works, and ensuring the delivery of this strategy is dynamic, responsive to change, and open to innovation.

What we will do:

1. Develop a targeted communication plan
2. Re-establish a monitoring framework to track and ensure strategy delivery
3. Conduct research and engagement to understand the needs of groups that are underrepresented in the Stop Smoking Service
4. Collect feedback to inform evaluation

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Communication, Evaluation, Adaptation

Ambition	Reason	Principle	Evidence Base	Responsibility
4a: Develop a targeted communication plan	Mass media campaigns are effective at increasing quit attempts	Evidence strongest	Action on Smoking and Health (ASH) 10 high impact actions for local authorities and their partners	Communications Team Public Health
4b: Re-establish a monitoring framework to track and ensure strategy delivery	Tobacco Control Alliance was successful in driving forward previous strategy aims	Evaluation and monitoring	Thurrock Whole System Tobacco Control JSNA 2021	All stakeholders
4c: Conduct research and engagement to understand the needs of groups that are underrepresented in the Stop Smoking Service (inform delivery of ambition 3d)	The SSS in Thurrock is not equally accessible to and effective for all groups.	Inequalities Co-production	Thurrock Whole System Tobacco Control JSNA 2021	Public Health
4d: Collect feedback to inform evaluation	Interventions should be evaluated, especially areas for innovation to assess their effectiveness and equity impact	Evaluation and monitoring	Thurrock Whole System Tobacco Control JSNA 2021	Monitoring group

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Next Steps

Sign-off from Thurrock Integrated Care Alliance (TICA) and Health and Wellbeing Board (HWB) will be sought prior to publication.

This strategy will be supported by a delivery plan detailing specific actions to achieve the aims across each priority area.

Progress will be monitored against the delivery plan with regular updates on agreed actions from accountable stakeholders reported to strategy coordinator.

The strategy group will report to: Better Care Together Thurrock via the Population Health & Inequalities Working Group

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31st August 2023	ITEM: 10
Health and Wellbeing Board	
Strategy in Focus – Domain 3: Person-Led Health and Care	
Wards and communities affected: All	**Key** N/A
Report of: Ceri Armstrong, Strategic Lead of Transformation and Commissioning (Adult Social Care)	
Accountable Assistant Director: Les Billingham, Assistant Director of Adult Social Care and Community Development	
Accountable Director: Ian Wake, Corporate Director of Adults, Housing and Health	
This report is Public	

Executive Summary

This purpose of this report is to reflect on achievements against year one commitments 'we said' and 'we did', and to identify year two commitments. This is in relation to the strategic goal 'Person-Led Health and Care'.

Person-Led Health and Care links directly to the delivery of Thurrock's Integrated Care Strategy 'The Case for Further Change' (in particular chapters 5, 7 and 8) and is a key part of the Better Care Together Thurrock Programme.

The Case for Further Change is a significant transformation programme – delivering both system and culture change.

1. Recommendations

1.1 That Health and Wellbeing Board note year one achievements.

1.2 That Health and Wellbeing Board agree year two commitments.

2. Introduction and Background

2.1 The Case for Further Change, Thurrock's Integrated Care Strategy, is one of the key strategies responsible for delivering the commitments set out in Thurrock's Health and Wellbeing Strategy. The other strategy is the Brighter Future's Strategy.

2.2 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 (Human Learning Systems).

2.3 The Strategy sets out how it intends to transform the health and care system through a number of themed chapters (chapters 4-9). Domain 3 of the Health and Wellbeing Strategy (Person-Centred Health and Care) reflects the strategic commitments set out in chapters 6, 7 and 8 of the The Case for Further Change.

2.4 The attached presentation demonstrates what has been achieved against year one commitments, and the commitments set for year two. Given the significance of the change being undertaken and given that much of what is being delivered is through ongoing experimentation and learning, some of what is set out at this point in time may need to be refreshed or reviewed during the year. If this is the case, and explanation will be given as to why any change has occurred.

3. Issues, Options and Analysis of Options

3.1 N/A

4. Reasons for Recommendation

4.1 Recommendations reflect what is required for the Health and Wellbeing Strategy to be delivered – e.g. achievements against year one commitments and recommended year two commitments.

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

5.1 On-going engagement is a key theme of The Case for Further Change and informs how the Strategy is developed and delivered.

5.2 The Health and Wellbeing Strategy was developed following consultation with residents and stakeholders.

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

6.1 Domain 3 of the Health and Wellbeing Strategy has a significant impact on the overall delivery of the Strategy.

6.2 Domain 3 impacts on the Community in terms of enabling a system that is, where appropriate, place-based, easy to access, and designed around the people that need it – with a focus on preventing, reducing and delaying the

need for care and support. Domain 3 impacts on reducing health inequalities and inequity across the system.

7. Implications

7.1 Financial

Implications verified by: **Not provided as this is an ongoing progress report reflecting implementation of the Strategy**

Domain 3 of the Strategy is and will continue to be delivered within existing budgets.

7.2 Legal

Implications verified by: **Not provided as this is an ongoing progress report reflecting implementation of the Strategy**

All existing and future legal frameworks are and will continue to be adhered to in the development and delivery of person-led health and care.

7.3 Diversity and Equality

Implications verified by: **Not provided as this is an ongoing progress report reflecting implementation of the Strategy**

A Community Equality Impact Assessment was carried out against The Case for Further Change. The Case for Further Change, and chapters 5, 7 and 8 aim to ensure equity across the system by developing a system that is designed around people and their individual requirements.

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

Commitments and activity delivered as part of domain 3 contribute to the reduction in health inequalities.

8. Background papers used in preparing the report

- The Case for Further Change – Thurrock Integrated Care Strategy https://democracy.thurrock.gov.uk/documents/s34501/Appendix%20B%20-%20Better%20Care%20Together%20Thurrock%20-%20Further%20Case%20for%20Change%20-%20Full%20Version.pdf

9. Appendices to the report

- Domain 3 Achievements and Commitments Presentation

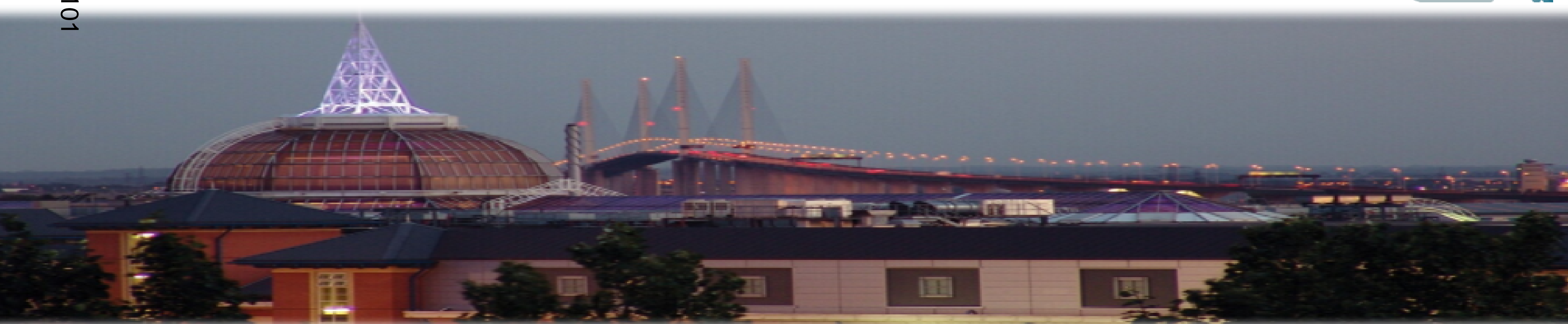
Report Author:

Ceri Armstrong
Strategic Lead of Transformation and Commissioning (ASC)
Adult Social Care and Community Development

Thurrock Health And Wellbeing Strategy 2022-2026

Levelling the Playing Field in Thurrock

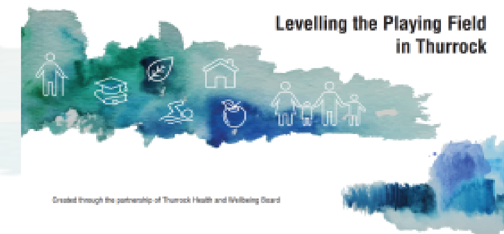
Created through the partnership of Thurrock Health and Wellbeing Board



Year 2 Report to Thurrock Health and Wellbeing Board

Domain 3 – Person Led Health and Care

Domain 3 Person Led Health and Care



Domain Aims and Ambitions

Better outcomes for individuals, that take place close to home and make the best use of health and care resources

What we want to achieve

We want to create healthy systems to deliver healthy outcomes - underpinned by strong relationships between all system actors based on respect and trust and a shared vision and understanding of the system. We believe that this will mean:

Residents being able to achieve more of what matters to them; support provided in collaboration with the community and focusing first and foremost on what the community can offer; residents maximising opportunities to stay as healthy as possible and requiring fewer interventions from services; residents being able to find the right solution for them first time and in the right place; residents being empowered to achieve their version of a good life; and our alliance and system resources achieving better outcomes through earlier intervention and preventative and integrated solutions that reduce 'failure demand'.

How this Domain levels the playing field

This will Level the Playing Field by:

- Improving access to services and solutions;
- Reducing and focusing on areas of health inequality within the Borough – e.g. through prevention and early intervention;
- Better use of available resources – e.g. through the reduction of bureaucracy and silo working;
- Ensuring that the system better reflects what people and communities require – e.g. through developing a new approach to community development
- Improving how the system works together to deliver better outcomes for people requiring more complex solutions – e.g. solutions that span services and organisations

Domain Goals

- **3A – Development of more integrated adult health and care services in Thurrock**
- **3B - Improved Primary Care Response that includes timely access, a reduced variation between practices and access to a range of professionals**
- **3C – Delivery of a Single Workforce Locality Model – a health and care workforce that works across organisational boundaries to be able to provide an integrated and seamless response**
- **3D - Delivery of a new place-based model of commissioning that makes the best use of available resources to focus on delivering outcomes that are unique to the individual**

Goal 3A. Development of more integrated health and care services in Thurrock

What we want to achieve

Address current fragmentation to achieve integrated locality networks that co-design single integrated bespoke solutions with residents

Some key challenges

Organisational culture – the ability to overcome and change existing culture to move from 'transactional' process-led thinking to adopting person-led thinking – including staff who feel empowered to do things differently;

Resource constraints – the ability to deliver transformational change whilst continuing to deliver existing services – which includes the ability to 'double-run' and the ability to manage the fragility of and growing demands facing the current system;

Health landscape – the extent to which the new landscape will be able to align its emerging Strategy with the 'principle of subsidiarity' and Thurrock's Integrated Care Strategy

The outcome of these challenges is:

- The ability of change to embed
- The period of time that it may take to deliver change
- The extent to which our vision can be delivered if resources are not sufficient
- The potential impact on the anticipated impact of delivering Thurrock's Integrated Care Strategy

Goal 3A. Development of more integrated health and care services in Thurrock

How we will achieve this Goal

This priority will primarily be achieved through delivery of Thurrock's Adult Integrated Care Strategy – the Case for Further Change. Oversight of the Strategy will be through the governance arrangements established to ensure the Strategy's delivery. The Strategy will lead to a significant shift in how the health and care system (and services within it) operates and functions.

Delivery of the goal will include:

- Develop and embed Human Learning Systems across the system and within organisations operating within the system – including the 'Commissioning' of a 'learning culture'
- Establish and deliver a programme of work based on the principles of Human Learning Systems and on each specific chapter contained within the Strategy – designed to move away from silos and towards integrated solutions
- Development of 'system stewardship' – moving system leaders and commissioners to focus on ensuring the 'health' of the system as opposed to a role of performance management and contract specification and monitoring.

What will we do differently under this strategy?

- Design systems and solutions that are able to operate around people – rather than expecting individuals to navigate their way around and through numerous 'front doors'
- Empower staff to do things differently – to find the right solutions
- Deliver an integrated system that operates around place and close to where people live
- Focus on delivering wellbeing outcomes rather than solely the delivery of needs or treatment of conditions – holistic approach to the individual

Goal 3A Development of more integrated health and care services in Thurrock

Reporting against our commitments for year 1.

What we said we would do	Progress made
To have delivered four Human Learning Systems ‘learning cycles’ and related ‘experiments’	Four ‘learning cycles’ have been established and are at different stages. A ‘learning’ report has been commissioned to understand the learning that needs to become embedded.
Thurrock Better Care Together Strategy governance (chapter 10) fully established	Governance arrangements are in place through which oversight of BCTT Strategy ‘The Case for Further Change’ will be achieved.
Development and delivery of a ‘devolution agreement’ between the ICB and Thurrock Integrated Care Alliance	This has not been agreed as a result of ongoing restructuring within the ICB, but Thurrock Alliance is a key partner as part of local health and care arrangements in Thurrock and a key signatory of the Integrated Care Strategy for Thurrock.

Our commitments and ambitions for Year Two – 2023/24

- Implement recommendations following the completion of a learning report, and deliver an ongoing series of ‘learning experiments’ – embedding HLS throughout the Directorate as an operating model
- Delivery of an integrated ‘Complex Cases Team’ ‘test and learn’ pilot including Mental Health, Substance Misuse, Adult Social Care, Psychology and Housing – testing the development of an integrated approach to ‘complex’ cases and identifying learning which will result in system change and improved outcomes for the most complex of individuals
- Review of Thurrock Better Care Fund – ensuring that the Fund and Plan mirror Thurrock’s Integrated Care Strategy and support its implementation

Goal 3B. Improved Primary Care Response that includes timely access, a reduced variation between practices and access to a range of professionals

What we want to achieve

We want to deliver Primary Care that is equitable to all .

Some key challenges

Some of the key challenges that may get in the way of us being able to achieve our ambition for goal B are:

- Thurrock is one of the most under-doctored areas of the Country – often exacerbated in the most deprived area of the Borough
- Embedding new ways of working as part of an integrated care system (specifically the end of CCGs and new collaborative requirements under ICBS)
- Core delivery predominantly takes place in silo – rather than sharing of resources across practices or PCN area
- The Pandemic has added greater pressure on an already stretched system

The outcome of these challenges is that:

- Poorer health outcomes for those living in an area under-doctored or where getting an appointment is challenging
- Widening health inequalities – as under doctoring more acute in more deprived areas of the Borough
- Variation in both quality and offer
- Reduced opportunity for prevention and early intervention

Goal 3B. Improved Primary Care Response that includes timely access, a reduced variation between practices and access to a range of professionals

How we will achieve this Goal

Chapter 5 of Thurrock Adult Integrated Care Strategy is focused on 'Transforming Primary Care'

Specific aims for this priority include:

- Improving Primary Care access – including a mixed skill clinical workforce and the delivery of new ways of working;
- Improving quality and addressing variation in outcomes – shifting the balance from reactive to preventative and proactive care and diagnosing and intervening at the earliest opportunity;

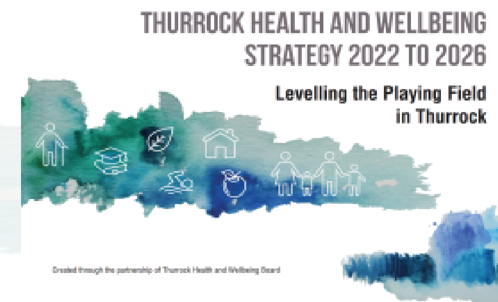
In addition, work will be carried out through the Integrated Medical and Wellbeing Centre programme to improve existing primary care estate and through working with partners to develop collaborative working relationships and solutions focused on 'place' and on PCN areas.

What will we do differently under this strategy?

Wrap around support to GPs by building integrated care teams. In particular:

- Our local Primary Care Strategy has been moving towards GP-led Primary Care rather than solely GP delivered
- Most clinical roles in Primary Care including Physicians Associates are professionally registered and therefore are required to work within the boundaries of their clinical competence. GPs will support the oversight of this within their practices.
- Across NHS Mid and South Essex , 47% of all consultations in Primary Care this year have been provided by GPs. Other provision will be a combination of many different roles – Nurses, Nurse Associates, Pharmacists, Healthcare Assistants, Social Prescribers, Paramedics, First Contact Physios , Local Area Coordinators, Social Workers etc

Goal 3B Improved Primary Care Response that includes timely access, a reduced variation between practices and access to a range of professionals



Reporting against our commitments for year 1.

What we said we would do	Progress made
Increase number of ARRS roles to 80	At end of March 2023, Thurrock has a total of 68.76 full time equivalent ARRS staff in PCNs in 12 different roles. Work continues to increase the ARRS staff numbers.
Recruit 12 additional GP fellows,	Currently (August 2023) 2 GP Fellows working in practices and another 3 to be onboarded in next few months. The revised MSE GP Fellowship Programme will continue to support recruitment into Thurrock.
Deliver a clinical strategy for each of the four PCNS	All PCNs in Thurrock have a clinical strategy. These have been agreed with the ICB Alliance team and have been shared with the ICB central primary care team for approval. Once approved, these will be available for view.

Our commitments and ambitions for Year Two – 2023/24

Development work has started to create Integrated Neighbourhood Teams in each PCN area. This is in response to the Fuller Stocktake and meets a national requirement. Development submissions have been received from the 4 Thurrock PCNs and the Alliance team will be supporting the PCNs to move to the new model over the next 3 years. The INTs will incorporate additional professions and will provide an improved offer to local residents.

Goal 3C. Delivery of a Single Workforce Locality Model – a health and care workforce that works across organisational boundaries to be able to provide an integrated and seamless response

What we want to achieve

To deliver 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

Some key challenges

Similar to Goal 3A, key challenges are:

Organisational culture – in particular the ability to empower and encourage staff to do things differently and to be able to work across organisational and service boundaries – working for place rather than an organisation or service.

Communication and engagement– ensuring that residents and staff are aware of the changes and understand why they are being made but importantly are also able to shape those changes.

Health landscape – the extent to which the new landscape (e.g. end of CCGs and establishment of ICBs) will act as an enabler to required change.

The outcome of these challenges is that:

- Transforming organisational culture against a new set of operating principles can take a significant amount of time;
- Not securing the buy-in of all staff and residents – including the ability to manage the anxiety of extensive change;
- The inability to deliver desired change or achieve desired outcomes (either fully or partially)

Goal 3C. Delivery of a Single Workforce Locality Model – a health and care workforce that works across organisational boundaries to be able to provide an integrated and seamless response

How we will achieve this Goal

Chapter 7 (and aspects of 5 and 8) of Thurrock's Adult Integrated Care Strategy describes in detail the vision for a Single Workforce Locality Model – which is overseen through Integrated Care governance by Thurrock Integrated Locality Working Board.

Due to the complexity of change required, work will be undertaken over a number of phases. Activity will include:

- The development of integrated Community Led Support Teams across adult social care – then developing the Teams further to incorporate functions sitting within other services and organisations;
- The development of blended roles, 'Trusted Assessors' and integrated locality networks;
- Using Better Care Together 'Link Nurses' to understand how Community Health can work as part of a Single Workforce Locality Model;
- Conducting a number of staff-led experiments (against the principles of HLS) to understand what needs to change and how; and
- Mental Health Transformation to enable staff to be locality-based and to build integrated working relationships with other professionals working in the same place.

What will we do differently under this strategy?

- Remove the need for 'onward referrals' – especially within the community;
- Developing solutions that wrap around the individual – rather than expecting the individual to go through different 'front doors';
- Better use of resources – releasing capacity in doing so;
- A greater focus on prevention and early intervention – recognising the signs that people require some support at an earlier stage
- Improved career opportunities across and within the system which are attractive to the workforce

Goal 3C Delivery of a Single Workforce Locality Model – a health and care workforce that works across organisational boundaries to be able to provide an integrated and seamless response

Reporting against our commitments for year 1.

What we said we would do	Progress made
Establish four integrated locality networks	Locality networks have been established in all areas of the Borough and are at different stages of development. The Locality Network in Stanford and Corringham is being used as a test bed for testing new ideas and shaping how networks can and will work.
Deliver a 'blended roles' experiment for Wellbeing Teams – with further 'blending' identified and being tested for other roles	A blended roles experiment has been scoped (Insulin Injections) but has been identified as a year 2 commitment, with the commitment this year being an evaluation of Wellbeing Teams against Wellbeing Team principles and an improvement action plan for those areas seen as not operating as required.
Establish a clear delivery plan for the delivery of a single workforce locality model – with some elements already in place (e.g. integrated social work teams)	Work is ongoing. A number of Housing Teams are now operating at Place level – with test and learn being carried out in Stanford and Corringham. Integrated Social Work Teams are operating in all four areas of the Borough. Community Health ICT Teams are also operating at Place (PCN) level. Further work is being carried out to develop how teams needs to operate differently at locality level – including reviewing roles and processes.

Goal 3C Delivery of a Single Workforce Locality Model – a health and care workforce that works across organisational boundaries to be able to provide an integrated and seamless response

Our commitments and ambitions for Year Two – 2023/24

- Embed locality networks as a way of working - ensuring that they align or integrate with the developing PCN Integrated Neighbourhood Teams and can show evidence of changed ways of working
- Development of an integrated approach to keeping people out of hospital, hospital discharge, and prevention of readmission
- Continue to develop and implement a single workforce locality model – with ongoing experiments via HLS and the implementation of change following learning from those experiments

Goal 3D. Delivery of a new place-based model of commissioning that makes the best use of available resources to focus on delivering outcomes that are unique to the individual

What we want to achieve

A model of commissioning that supports the achievement of the vision as set out within Thurrock's Adult Integrated Care Strategy.

Some key challenges

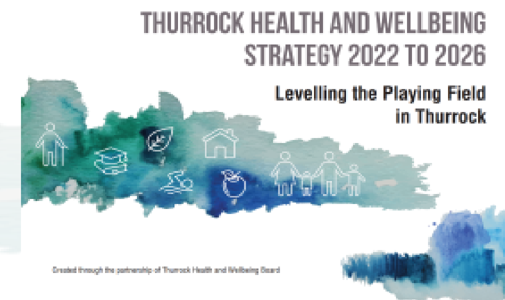
Chapter 10 outlines what an integrated and place-based model of commissioning will look like and how it will be achieved. Key challenges in the delivery of this model are:

- Fragility of the Care Market – the ability for providers to adopt and adapt to a new type of relationship and specification and the ability to encourage new providers that can deliver what is required;
- Culture Change – the ability of commissioners to change their approach and to adopt and adapt to a new commissioning model;
- Trust – the ability for both commissioners and providers to develop a new type of relationship and to develop the trust required in order to do so;
- Resources – achieving the commitment across organisations to place-based and integrated funding; and
- Losing Control – the ability for organisations to shift power (and resource) to communities to test and deliver Community Investment Boards

The outcome of these challenges is that:

- Commissioning stays the same – failing to move away from 'time and task' type models of care, reducing opportunities to commission for learning and to improve the outcomes of individuals and limited the ability to broaden the market place and encourage a greater diversity of providers
- Poor use of resources
- Exacerbated fragility of the market place and failure to limit or reduce market failure

Goal 3D. Delivery of a new place-based model of commissioning that makes the best use of available resources to focus on delivering outcomes that are unique to the individual



How we will achieve this Goal

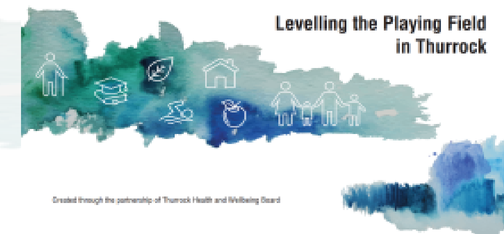
A number of key actions have been identified as part of Chapter 10 of Thurrock's Integrated Care Strategy. This includes:

- Establishing an Integrated Locality Commissioning Board;
- A series of learning experiments designed to shift the working practice of commissioners and providers to one based on HLS principles
- Establishment of a 'learning infrastructure' mechanism to capture and share learning in order to inform commissioning practice
- Implementing 'system steward' training for all commissioners
- Refresh the Market Development Strategy to take into account the principles of HLS and place-based commissioning
- Take steps to shift greater power to communities in relation to commissioning decisions;
- Undertake a full review of the Better Care Fund; and
- Test and evaluate single models of commissioning spanning different service areas across the NHS, Social Care and beyond and bringing together budget and governance arrangements

What will we do differently under this strategy?

- Achieve a different working relationship with providers and other commissioners – one based on co-production, flexibility and learning;
- Enable greater diversification of the market place – particularly by encouraging and enabling grass roots local providers;
- Explore and develop different models of commissioning and provision – e.g. spanning functions, organisations, geographies – as shaped through a Market Development Strategy reflecting integration and place;
- Expand and use integrated commissioning budgets and governance – e.g. via commissioning alliance arrangements

Goal 3D. Delivery of a new place-based model of commissioning that makes the best use of available resources to focus on delivering outcomes that are unique to the individual



Reporting against our commitments for year 1.

What we said we would do	Progress made
Integrated Locality Based Commissioning Board in place	The first step towards this is a grant fund (focused on Health Inequalities) that communities can bid for. This work is being tested initially in Tilbury and Chadwell but there are other grants that other communities in the rest of the Borough can bid for. Grants will be launched in September with the local community voting for them in a participatory budgeting approach.
Action plan for the delivery of integrated and locality based commissioning	A task and finish group has met to identify the outline of a new integrated Commissioning Strategy. This is in the process of being developed. Activity is taking place to adopt a HLS approach to commissioning as contracts reach their end – e.g. Homecare, Substance Misuse
Better Care Fund Plan reviewed with recommendations identified	A review of Thurrock's BCF has been carried out through the offer of support from NHS England. The results of this will be used to develop and improve the BCF.

Our commitments and ambitions for Year Two – 2023/24

- Agreement of a proposed engagement framework, development of actions to inform a community leadership model – which will include the scoping of a Locality Commissioning Board
- Development of an Integrated Commissioning Strategy with year one commitments identified and delivered
- Better Care Fund refreshed to reflect recommendation from the review

Domain 3 – Person-led Health and Care
Key deliverables, commitments and milestones
Year One (July 2022 - June 2023)

Goal 3A - Development of more integrated adult health and care services in Thurrock

- To have delivered four Human Learning Systems 'learning cycles' and related 'experiments'
- Thurrock Better Care Together Strategy governance (chapter 10) fully established
- Development and delivery of a 'devolution agreement' between the ICB and Thurrock Integrated Care Alliance

Goal 3B - Improved Primary Care Response that includes timely access, a reduced variation between practices and access to a range of professionals

- increase number of ARRS roles to 80
- recruit 12 additional GP fellows,
- deliver a clinical strategy for each of the four PCNS

Goal 3C - Delivery of a Single Workforce Locality Model – a health and care workforce that works across organisational boundaries to be able to provide an integrated and seamless response

- Establish four integrated locality networks
- Deliver a 'blended roles' experiment for Wellbeing Teams – with further 'blending' identified and being tested for other roles
- Establish a clear delivery plan for the delivery of a single workforce locality model – with some elements already in place (e.g. integrated social work teams)

Goal 3D - Delivery of a new place-based model of commissioning that makes the best use of available resources to focus on delivering outcomes that are unique to the individual

- Integrated Locality Based Commissioning Board in place
- Action plan for the delivery of integrated and locality based commissioning
- Better Care Fund Plan reviewed with recommendations identified

Domain 3 Monitoring Framework

Indicator	Delivery/Monitoring	Outcome Term	Progress report
Goal 3A: Development of more integrated adult health and care services in Thurrock			
Development of a delivery work plan for chapter 7 and 8 of Thurrock Integrated Health and Care Strategy Delivery and testing of some elements of the Strategy – e.g. extension of Community Led Support remit, extension of Wellbeing Team remit, delivery of Integrated Health and Care Network in one area of Thurrock – Corringham and Stanford	By Thurrock IC Alliance via the Further Case for Change strategy for adult health and care	Short	
Delivery and evaluation of phase I of relevant chapters of Thurrock Integrated Health and Care Strategy		Medium	
Following the delivery and evaluation of phase I of the Strategy, development and implementation of phase II – followed by evaluation/impact assessment.		Long	
Goal 3B: Improved Primary Care response that includes timely access, a reduced variation between practices and access to a range of professionals			
Back office review	By Thurrock IC Alliance via the Further Case for Change strategy for adult health and care	Short	
Implementations of findings from back office review		Medium	
All IMCs in place by 2025		Long	
Goal 3C: Delivery of a Single Workforce Locality Model – a health and care workforce that works across organisational boundaries to be able to produce a seamless and integrated response			
Development of Workforce Locality Model	By Thurrock IC Alliance via the Further Case for Change strategy for adult health and care	Short	
Testing and implementation of place-based care and support model		Medium	
Full implementation of place-based care and support model		Long	
Goal 3D: Delivery of a new place-based model of Commissioning that makes the best use of available resources to focus on delivering outcomes that are unique to the individual			
Pilot and evaluate new approach to deliver care in the home with home care provider by April 2023	By Thurrock IC Alliance via the Further Case for Change strategy for adult health and care	Short	
Implementation of Communities of Practice by 2024		Medium	
Development of four Community Investment Boards and four integrated locality budgets		Long	

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