Expression of Interest - Health and Social Care Integration Pioneer

Southend on Sea

1. Introduction

This expression of interest outlines Southend's case for becoming a Health and Social Care Integration Pioneer and covers the geographical area served by Southend-on-Sea Borough Council. It has been jointly prepared by Southend Borough Council and Southend Clinical Commissioning Group and is endorsed by key local stakeholders, including South Essex Partnership University NHS Foundation Trust (SEPT)*. **Southend's Health and Well Being Board is fully committed to, and has authorised, this bid.**

Southend's well established culture of responsive partnership working forms a vital backdrop to this expression of interest. Local public, private and voluntary sector partners collaborate frequently and successfully, jointly investing in the borough and making sustained improvements to services. Health and social care partners in particular have an enviable record of innovation and service integration. This means that we are perfectly positioned to make changes at the scale and pace required of a pioneer. We also know that Southend's densely populated and compact size lends itself to a localised, issues-focussed approach to integration work whilst at a scale that can make a real difference. In particular Southend has a number of characteristics that are particularly relevant to the pioneer role. We have;

- an impressive and demonstrable track record of delivery
- a history of innovation and sharing of good practice, both at a local and national level
- strong, well developed and sustainable local partnership working
- the ability to move at scale and pace
- affiliation with the Whole Essex Community Budget.

2. Background

Meeting local need is increasingly challenging

Southend on Sea has significant health and social care challenges. Compared with the England average the health of the 174,000 people that live in the borough is mixed. Deprivation is higher than average, resulting in 7,900 children living in poverty. The rates of violent crime, long term unemployment and drug misuse are higher than the national average. Life expectancy is around 9 years lower in the most deprived areas when compared with the least deprived areas. Around 18% of our year 6 children are obese, as is nearly a quarter of the adult population. The rate of hospital stays for alcohol related harm is worse than the England average and currently 5.3% of adults require and receive support from social services.

Local demographics and old ways of working are adding pressure

Perhaps the most significant challenge is our ageing population. Frail elderly people over 80 make up 9.8% of the population, far higher than the regional average of 7%. There are over 9,000 patients in the CCG area over the age of 75 whilst 18% of the population are over 65. There is a predicted increase of 5% for those aged over the age of 85 by 2020. A high number of these patients are burdened with long term conditions and social issues which require support. By 2015 we forecast increases in the numbers of people suffering from stroke (9.46%), diabetes (12.46%), CHD (9.1%), hypertension (4.5%, but already at 29% of the patient population) and COPD (11%). The number of people with Dementia is predicted to rise from 3,300 people to 5,098 by 2017.

The demographic data paints a stark picture of need, dependency and service utilisation. It is clear that without proactive needs based planning centred around case finding, prevention, crisis

response and rehabilitation, Southend is facing a demographic time bomb over the next 5 years. Against this backdrop we have the challenges of drastically reduced public sector funding. For example Southend Council is in the third year of a four year programme to reduce spending by £59.9m whilst seeing a growing demand for mental health, learning and physical disability and children's services. Other partners face similarly bleak financial pressures.

In response to this we have made real progress in stripping out waste and duplication from the local health and wellbeing infrastructure over recent times. Our interventions have yielded better outcomes and efficiencies for local people. But partners are agreed that there is scope for more change and are determined to see through the next stage of our reforms. We are unanimous that an integrated partnership approach is crucial if we are to manage the financial & demographic challenges in Southend.

So, we are on a journey of integration

Improving collaboration and integration of health and social care has been a driving strategic imperative for Southend's partners for some time. Our primary focus is very much on personalised care, something we are aware many CCGs and health partners have not prioritised as highly. For us personalisation is imperative. By giving people control over their lives, through the ability to decide how their support needs are met, we allow them to gain independence and exercise as much real decision making as possible. Evidence shows outcomes are improved when people have been actively involved in decisions about their care. And we know that individuals are often better equipped than the public sector to use resources in creative ways to achieve results. We do not see conflict between personalising care and driving up outcomes – in Southend we aim to deliver both.

3. Our journey so far

Innovative health and social care integration is not new in Southend

In 2009 Southend Council set out, and broadly delivered, an ambitious blueprint for transforming social care. It defined a structure and model of the future state of social services, the key drivers for change and what this change would look like. A focus on innovative and collaborative working with health partners was a central plank in this and since then the Council has worked with determined partners to bring about the blueprint. Southend CCG has, alongside its own ambitions, developed a linked integration strategy to help drive this work ahead. GP's and local people have been actively involved in the process of shaping the CCGs three key priorities of integration, personalization and quality care first time.

The separately realised, but consciously linked, ambitions of local partner organisations are brought together in Southend's Joint Health and Wellbeing Strategy which majors on integration as a key cross-cutting principle. The strategy, and resulting action plan, is owned and driven forward by a committed and highly engaged Health and Well Being Board. In developing a joint approach to integration, local partners have aligned their separate organizational strategies so that they;

- listen to the voice of people who use our services
- share a vision about the priorities for local services
- commit to continuing development of integrated work
- reflect the Joint Strategic Needs Assessment (JSNA) for the population of Southend
- contribute to the wider vision for communities shared with partner commissioners
- shape other local commissioning plans to enable integration of services and pathways
- integrate planning so that local resources are used to better effect.

Southend's major health and social care players agree that further integration is crucial. Perhaps the most compelling and tangible evidence of this joint belief are the many initiatives that we have conceived and driven forward together over several years. In short we have rolled up our sleeves

and are already delivering on our long term plans.

We have a track record of effective, practical and respected integration work

A strategic programme of joint work, combining focus, resource and thinking across key partners, has allowed partners to drive forward a range of integration initiatives. These include;

Community level multi-disciplinary teams – that bring together dementia nurse, CCG clinical leads, ambulance service, admission avoidance, consultant geriatrician, therapists and our single point of referral team to co-manage local delivery.

General Practice level multi-disciplinary teams – which allows GPs, district nurses, community matrons, social workers and community healthcare specialists to meet regularly to focus on case management and risk stratification. They collaborate with the acute and community trusts and develop pathways to manage patients with chronic long term conditions. Unlike other models there is an overarching specialist clinical model through links with Southend hospital.

Integrated Locality Teams – that align community nursing services to social care teams.

Integrated services and pathways – that streamline and ease patient and user journeys in areas such as chronic obstructive pulmonary disease (COPD), MSK and Diabetes.

Single Point of Referral – A SPOR for professionals has been established with the aim of reducing avoidable admissions to hospital and reductions in the delayed transfers of care, increasing the numbers of people being referred for and accessing re-ablement services. Since the SPOR became operational, and functioned as the referral point we have seen a continued improvement in the outcomes of those people who undergo re-ablement in an increase in their independence. This is reflected in a reduction in the size of care packages.

Joint work on preventing delayed discharge – partners have worked fruitfully together in this area against a challenging background. Statistics show major improvements. We are held up as best practice national and team have been asked to share learning.

Collaborative Care – a service where social care and community healthcare services work together to deliver intensive re-ablement services. It has significantly reduced admissions to hospital, long term residential care and the need for large care packages.

Streets Ahead – The national Troubled Families programme, has been radically re-engineered in Southend to allow agencies, voluntary sector and communities to work collaboratively to support families with complex needs. Partners have re-evaluated their service delivery to deliver better and more cost effective outcomes. So far we have successfully engaged with over 170 families, most of whom are working to address inter-generational health and social challenges for the first time.

Connected Care – a behavioural change programme that assists the ageing population to manage their long term conditions. It promotes patient self-management and has reduced urgent care admissions.

We have listened, engaged and brought local people with us on the journey

We are clear that listening to what users want from us is crucial if services are to be fit for purpose. We view the people of Southend as essential co-producers in the development of new ways of working. Use of National Voices 'I' statements has been central to this thinking and this has allowed us to engage with people in a new and refreshing way. Patients and service users have comprehensively used 'I' statements to articulate their expectations and this information is now fundamentally influencing our service redesign intentions. We recognise the intrinsic value of this approach and will seek to further embed the Narrative into our daily approaches. So far people have told us that they like what we have done to create more seamless services. Naturally we understand that their focus is on the immediate quality and ease of support rather than the infrastructure that sits behind it.

Partners, communities, public and patients regularly come together to set and develop priorities and

influence processes. In doing so, we continue to develop a clear picture of local need and the desired future state. VCS organisations are key partners and also play an important role in providing access routes to opinion and feedback. Recent examples of successful engagement methods include;

Deliberative sessions– set up to focus on hot topics, such as preparation for Healthwatch, joint provision of mental health services, new pathways of care and holistic approaches to supporting carers.

Direct engagement - with specific groups, such as the Older People's Assembly, to discuss the future of services that support people over 50 maintain health and independence; with people with learning disabilities; with carers/family, advocacy groups and other partner organisations about the choices people have over their daily lives.

'Come and tell us' events – high profile events in our major shopping centres using creative methods, such as drama, dances and personal challenges.

Consultation and focus groups – service users are engaged on a wide range of topics, ranging from their experience of services to specific discussions, such as the content of the Local Account. Our most recent consultation focussed on supporting people with physical or sensory impairments get the most out of life.

And we have backed up this work with sustainable and effective systems of information and finance management

We know that successful delivery on the ground is not enough. Governance is important in allowing us to baseline, evaluate and understand the impact of our efforts and to control and develop our work. Here are some key examples of our governance arrangements.

Year of Care Pilot - In 2011 Southend successfully secured one of 7 national pilots to support health and social care teams to integrate care in a more sustainable way by better aligning the funding flows and incentives with peoples' needs. The aim of our funding model is to improve outcomes and deliver a more effective use of resources by shifting the focus away from episodic, activity driven funding flows towards person centred care, irrespective of organisational boundaries.

Caretrak – a jointly commissioned health and social care information system that integrates health and social data care which maps individual patient's journey and spend. Southend was the first area nationally to launch such a system. It provides accurate information for caseload risk stratification to multi-disciplinary teams and at a strategic level assesses the impact of collective commissioning decisions, enabling decision makers to identify the evidence in support of transformation of social care. This includes the impact of personal budgets in social care and average spend per patient. Caretrak has proved to be a robust, timely and cutting edge data management tool. Phase 2 of implementation will see the inclusion of community services data.

Personal budgets - Personal budgets have been the focus of significant resource over the last few years. We have adopted this method of providing support to all community based service users as a means of giving the individual the choice and control over what and how support is obtained. We are seeing service users make good use of the resources to hand and are looking to maximise the benefits to them. For example, over 2012/13 we have had a number of MH service users take a one-off payment in order to buy a bicycle or gym membership. Getting out and about and taking physical activity have positive benefits on many mental health conditions.

Southend's Health & Wellbeing Information Point (SHIP) website – Launched in February 2012, SHIP provides information about health and social care services in an easy-to-search on-line directory: www.southendinfopoint.org The site includes information about a range of services and opportunities that help people enjoy independence at home and in their community. So far 700 local services are listed, service providers can manage their own records, visitors can 'rate and review' a service. Staff regularly use SHIP as a tool to signpost people to community services. In May 2013 the council launched a local PA (Personal Assistant) Register which

connects those needing support with people who provide services.

Partners have also been carrying out far-sighted organisational restructuring. The Council has reorganised its directorates for improved efficiency and better cross-service working whilst absorbing public health responsibilities. The Council and NHS have also implemented locality working with the NHS for services for older people and people with a physical and sensory impairment. Phase 1 in July 2012 saw the restructure of care management teams into generic locality teams that are co-terminus with CCG boundaries. Phase 2 will explore opportunities for close alignment/integration with CCG. Southend CCG has a carefully designed operational structure which makes best use of local expertise and knowledge whilst ensuring a clear route for people's voice.

Our successes have been built on solid and sustainable foundations

Genuine and productive working relationships A culture of mutual respect and understanding of each other's viewpoints has been built over many years. This allows for candid, challenging but always constructive conversations. In this atmosphere partners are often able to find consensus on seemingly intractable and long standing issues. The agreement of a Joint Mental Health Strategy across Southend, Thurrock and Essex County Councils plus 4 separate CCGs, for example, is testament to our determination to leverage the maximum benefits from joint working. Already, these partners are actively exploring pooled budgets and integrated commissioning.

A track record of pathfinding and innovation Partners in Southend have an appetite for thinking big and taking carefully calculated risks. This has seen us lead the country in many aspects of integration work. For example;

- Our Multi Disciplinary Teams were established before most parts of the country.
- We were first in the country to develop an integrated information system (Caretrak) and are pioneering high quality data management.
- We were one of only 6 national pilots for the Department of Health Year of Care Pilot.
- We are considered national best practice for managing discharge.
- We are a regional award winning pathfinder for a range of commissioning schemes and service developments such as SPOR and Admission Avoidance Cars.
- We are a National Pathfinder for patient Public Involvement.
- We have a notable national profile, for example recent coverage in the HSJ and the Guardian profiled our work on integration and the unplanned care agenda
- We participated in the Kings Fund desktop review for Integrated Working .
- We are East of England leads on integrated locality working.
- Southend Council was awarded LGC Council of the Year 2012, in part due to a track record of excellent partnership working.
- We are joint partners with Essex County Council and Thurrock Council in the Whole Essex Community Budget and have played an active part in the development of the Integrated Commissioning workstrand.

Importantly we can evidence how we have shared all of this learning with peers and stakeholders. Our doors have been, and will continue to be, firmly open to those that we can help and innovate with.

A grounded approach We have consciously taken a bottom up approach to the development of our integration work. Front line staff, operational managers, GPs and communities have all played a crucial part in designing and shaping new approaches. This means we know that our new ways of working are eminently workable, pragmatic and sustainable. And, perhaps more importantly, we know that the staff that make them work from day to day are committed to them.

4. But we know there is more to do

We have a clear vision of our where our integration work will take us.

Over the next few years we will continue to transform the local health and social care landscape in Southend . In doing so we will be guided by two main principles;

- **we will place the needs of people, and their carers, at the centre of our thinking, by truly understanding what integrated care and support looks like from an individual's perspective (through use of National Voices narrative)**
- **we will take a 'whole age' perspective so that the people's needs, from child to old age, lead our planning.**

So far we have made real and sustainable progress on improving care pathways, developing the way that we collectively use information, shifting our focus to preventing high cost care and better husbanding our resources. Therefore we will sustain momentum and **accelerate our integration journey** by playing to these strengths. Our combined vision is to deliver fundamental and far reaching changes, by 2018 or earlier. The tables below summarise our ambition.

What	By when
Better integrated services and better access to them • Services will be co-designed with patients and users to be more flexible and resilient • A wider range of providers, including those in housing and children's services, will be involved in delivering integrated services • Integrated health and social care teams will be wrapped around the individual and their family • There will be choice at every stage of the pathway • Wherever possible primary, social and community staff will work in integrated teams • Services will be responsive and able to flex to meet, and where appropriate, reduce the demand for urgent care at our local hospital • More specialist teams will be based in the community • A Single Point Of Referral will be the norm • There will be one route of route of access for all unplanned care	2013 ↓ 2016

What	By when
Better integrated information and knowledge • Multi-disciplinary teams will routinely use data to proactively manage the highest risk people • There will be universal joined up information and advice available for all individuals, including those that self assess or self fund. This includes a single, accessible directory of services • We will have uncomplicated pathways that are easy to understand and access • We will routinely risk-profile patient and service users across health and social care • We will have more effective business processes and systems that support mobile working, electronic care records, and common assessments • We will have comprehensive real time financial and performance information about health and social care so that we can monitor the financial impact of people's journeys through our systems • There will be a single integrated set of data across health and social care	2013 ↓ 2018

What	By when
A renewed focus on prevention and individual responsibility • There will be an increased emphasis on people that are able to take more responsibility for their health and wellbeing • Hospital specialists will proactively manage the highest risk patients • Prevention programmes will increase significantly. For example telecare and telehealth will be rolled out so that people are better supported to live in their own homes with less risk • Housing, with appropriate care and support will be an integral part of the care package available to users • Individualised budgets and direct payments will be widespread • Services will be able to be purchased and controlled directly by the individual to meet their need	2013 2016

What	By when
Better use of resources through joint planning and commissioning • We will have joint commissioning strategies that balance investment in prevention, early intervention and re-ablement with intensive care and support for those with high levels of need • Partners will have agreed the respective investments needed to get the best value for money from the local health and social care economy • Resources and buildings will not serve as a constraint on the provision of individual services • Staff will be able to access systems, resource and information from any partners building (data protection withstanding) • Staff will be co-located and will work in fit for purpose buildings	2013 2018

What	By when
Better understanding of local people and their experiences • New ways of measuring people's experiences of integrated care and support will have been developed, tested and adopted • A comprehensive and collaborative public mobilisation and community development campaign will promote concepts of self responsibility and prevention • People and communities in Southend will feel an increased level of community cohesion and pride of place • People will be better equipped and motivated to help themselves (through a range of asset based community development interventions) • The social and physical capacity of the community and voluntary sector will have been significantly increased. This will be sustainable • Partners will have significantly reduced cost to the public purse and redeployed resources	2013 2016

We recognise that we must take a whole-systems, big picture approach to bring about our vision. This means identifying, and convincing a wider range of partners to join us. And then helping them to realise that, in principle, no silo is protected, no budget ringfenced and no structure out of scope.

Through previous work on Total Place and Community Budgets we know that full organisational and financial integration is the pure and logical final stage of this process. But this may take many years, if at all, to come about. For us the real value is in the immediate benefits derived from the outcomes achieved during the journey. And this is where we will deliver both short and medium term learning for pioneers, national partners and wider stakeholders.

We have learned from, and will continue to work with, partners on the Whole Essex Community Budget

As a Unitary authority situated within the Greater Essex boundary, we are currently working with Essex County Council, Thurrock Council and Essex wide partners in health, public safety, VCS and probation, on aspects of the Whole Essex Community Budget (WECB). Because of this there is tangible commitment to better integration and service redesign in health, social care and many other areas. Positive outcomes are already beginning to emerge. As a committed signatory to the WECB we are clear that valuable innovation may come from this project. Indeed, most key partners have already invested resource, time and thinking into the community budget initiative.

We are fully committed to commissioning and delivering integrated care solutions beyond Southend's boundaries where it is demonstrated that this is the most effective approach. However, local partners in Southend are clear that any proposed changes to existing services resulting from WECB must first satisfy a simple question; 'Is this change in the best interests of Southend citizens?' For example Southend's GPs tell us that a very convincing business case would need to be made to demonstrate that our local communities would not be disadvantaged before any Essex-wide 'one size fits all' model of primary care were adopted locally. This stance is generally replicated throughout our local partnerships. Should Southend become a Health and Social Care Integration Pioneer we would be able to offer national partners and Pioneers an insight into this fascinating dynamic as a valuable source of learning.

Achieving the best outcomes for individuals, and ensuring the best use of resources, requires models and solutions of integrated care that demonstrate flexibility. This means identifying what elements of the system are best managed and delivered beyond administrative boundaries and what elements are best managed and delivered locally. We have continuous discussions with our partners across the South Essex health and social care economy to identify what parts of the system may require a broader geographical approach – e.g. South Essex or Whole Essex – and how this might best be facilitated.

5. What we will do next

Pioneer status will allow us to accelerate our journey.

We will take forward both our legacy projects and new projects with energy and focus. Firstly we will build on the successes of our existing work, by;

- Reaping further benefits from SPOR by further simplification of access and establishing a single route of referral
- Rolling out further multi-disciplinary teams – for example by developing practice level MDTs to single-handed-GP population (50% of population) and targeting re-admissions
- Leveraging even more benefits from Caretrak by enhancing its strategic analysis functions
- Taking forward the Year of Care pilot work by focussing on two areas, the development of shadow currencies for an LTC Year of Care and the testing of a concept that considers post acute Recovery, Rehabilitation and Reablement. We will develop, shadow and monitor a currency for patients with long-term conditions and develop a contracting and commissioning framework for local use in 2013/14. We will also test the RRR concept to establish whether funds can be liberated from within national tariffs (HRGs) to support rehabilitation and re-ablement services.
- Developing integrated locality teams and pathways – through joining existing health and social care teams and piloting new pathways for stroke rehab and intermediate care beds.
- Developing further community based specialist services that avoid the need for a hospital referral or more expensive forms of care.

However we will also open up major new areas of exploration. These will include;

- Developing a broader 'all ages approach' to integration work, thereby engaging and mobilising a wider range of partners in our work. Key partners will include children's services (particularly aspects of SEN, CAMHS and Troubled Families) and housing (particularly around home from hospital services, enhanced adaptations and home settings)
- Stepping up our ambition for service integration. In particular we are exploring options to leverage improved joint working from Learning Disabilities and services working with Frail Elderly. These areas are relatively untapped at present and we know we will be able to yield a number of quick integration wins.
- Improving the engagement of the third sector in our integration work
- Deepening our understanding of individuals perspectives through use of 'I' statements and truly effective engagement techniques.
- Additional work to ensure individuals feel empowered to take control of their own lives, treatment and care.
- Further, and more radical, collaborative commissioning for best value.

With Pioneer support we will accelerate at scale and pace

As well as contributing to the national knowledge base we also anticipate that national partners, experts and fellow pioneers will be able to help us explore the potential for specific pieces of work. These include development of our information sharing and data systems, broadening our stakeholder base and meeting the challenge of shifting the focus from an over reliance on acute care.

This last point is a good example. Whilst our work on integration has demonstrated improved outcomes in a number of areas, a particular local challenge is the increasing demands being placed on our local hospital for urgent care. The hospital is seen as a default for health care by the local population and attendances for urgent care continue to rise, resulting in many patients waiting more than 4 hours to be seen. As well as developing robust integrated community services to reduce demand, we will be looking to the pioneer pilot for support to work with our patients and public in making that more difficult cultural shift to reduce urgent care demand.

A dedicated account manager, skills matching and expert analytical work would be much valued and utilised. The kudos of becoming a pioneer, and the uplifting and invigorating positive effect that this would have on our partnership culture and rate of progress, should also not be underestimated.

We will drive out tangible efficiencies.

Our primary focus is on delivering better outcomes and experiences for local people. We will demonstrate that the public are better informed about where they can go to get the best information and advice about their care and support needs. And that they have higher levels of satisfaction with the support they received. But we also have a clear focus on using the public pound to best value. So, as this work progresses, we will regularly show that;

- service performance has improved
- joint planning has been able to apportion costs and benefits across the whole system
- cashable savings have been generated and then released for reinvestment.

Advances in IT will help us make the most of this unprecedented opportunity - we will have the data systems to measure and track our progress. Evidence of the above will be provided to the pioneer network, alongside rationale and analysis of how these results have been achieved.

6. How we'll make it happen

Now is the ideal time for this change

Recent reforms to national health and social care systems provide us with new opportunities to take

forward our local agenda. We are capitalising on these through improving our alignment and working practices wherever possible. We will, of course, continue to engage Government on what freedoms and flexibilities we need to drive forward our integration ambitions. We acknowledge that Government is demonstrating commitment by setting up the £3.8bn integrated care fund (announced on 27 June) and are pleased to see that this effectively increases by a further £2bn the current level of annual NHS resource allocated to social care – a strong sign that Whitehall is serious about integration. We view Southend's Health and Wellbeing Board as the central piece of architecture to influence and rally partners and local people. It is already providing a strong sense of leadership and sense of purpose in Southend.

But we will put in place further robust governance to oversee and scale up our integration work

Pioneer work will form a central strand in the workstreams overseen and driven by Southend's Health and Wellbeing Board. A Pioneer Strategic Group will be established to provide programme direction whilst an operational level Pioneer Delivery Group will meet regularly to establish a costed delivery plan to make day to day, ground level interventions. The Strategic Group will report quarterly on progress to;

- Southend Health and Well Being Board
- Southend CCG Governing Body
- Co-Pioneers and national partners

A particular focus of the Pioneer Strategic Group will be to work with national partners to develop new ways of measuring people's experiences of integrated care and support. Executive sponsors from each organisation will be identified.

7. How we'll help others on their journey

We will work fully, openly, honestly and enthusiastically with national partners, Pioneers and others to develop and share our ways of working and co-produce new approaches to shared challenges.

As we have shown, Southend is considered an integration exemplar in some fields. Our reputation as a go-to area has been established on our willingness and ability to share best practice across partners. We are also visibly committed to a culture of continuous improvement. For example, as national leader on data management, we are already talking to other upper tier authorities about plans to collaboratively develop Caretrak as a powerful diagnostic modelling tool.

We will offer our learning to national systems and processes, using case studies, workshops, peer to peer networking and other methods of dissemination. Areas of innovation continuously arise and we will participate fully in contributing to, and growing, the Integrated Care and Support Exchange (ICASE). We will work closely alongside peers, national partners, training bodies and leadership organisations to promote lessons for wider, rapid adoption. We are particularly keen to work with fellow pioneers to evaluate the medium and long term national impact of integration.

We hope that this Expression of Interest will be received favourably.

For further information, in the first instance, please contact Ade Butteriss, Southend Borough Council adebutteriss@southend.gov.uk **(01702) 215187**

**** Statement from Dr Patrick Geoghegan, Chief Executive, SEPT – June 2013***

I am delighted to support both Southend Borough Council and Southend CCG in the bid to be an Integrated Pioneer Site. As a provider organisation we have excellent relationships with both the Council and the CCG and work very closely together in pooling resources both from a commissioning and provider point of view so that we can enhance the services we provide to our local communities. We have developed a number of initiatives such as single point of referral, integrated teams for care of the elderly and many other projects of which we are seeing real benefits to some of the most vulnerable people who live in our society. We believe that we are in a very strong position to become an Integrated Pioneer Site and SEPT will play its full part in translating this into action.