Public Document Pack

SOUTHEND-ON-SEA BOROUGH COUNCIL

Health & Wellbeing Board

Date: Wednesday, 5th December, 2018
Time: 5.00 pm
Place: Darwin Room - Tickfield Centre
Contact: Robert Harris

Email: committeesection@southend.gov.uk

A G E N D A

1 **Apologies for Absence**

2 **Declarations of Interest**

3 **Questions from Members of the Public**

4 **Minutes of the Meeting held on Wednesday 19th September 2018** (Pages 1 - 4)
Minutes attached.

5 **Violence and Vulnerability Update**
Verbal report from the Corporate Director for Public Protection (no papers)

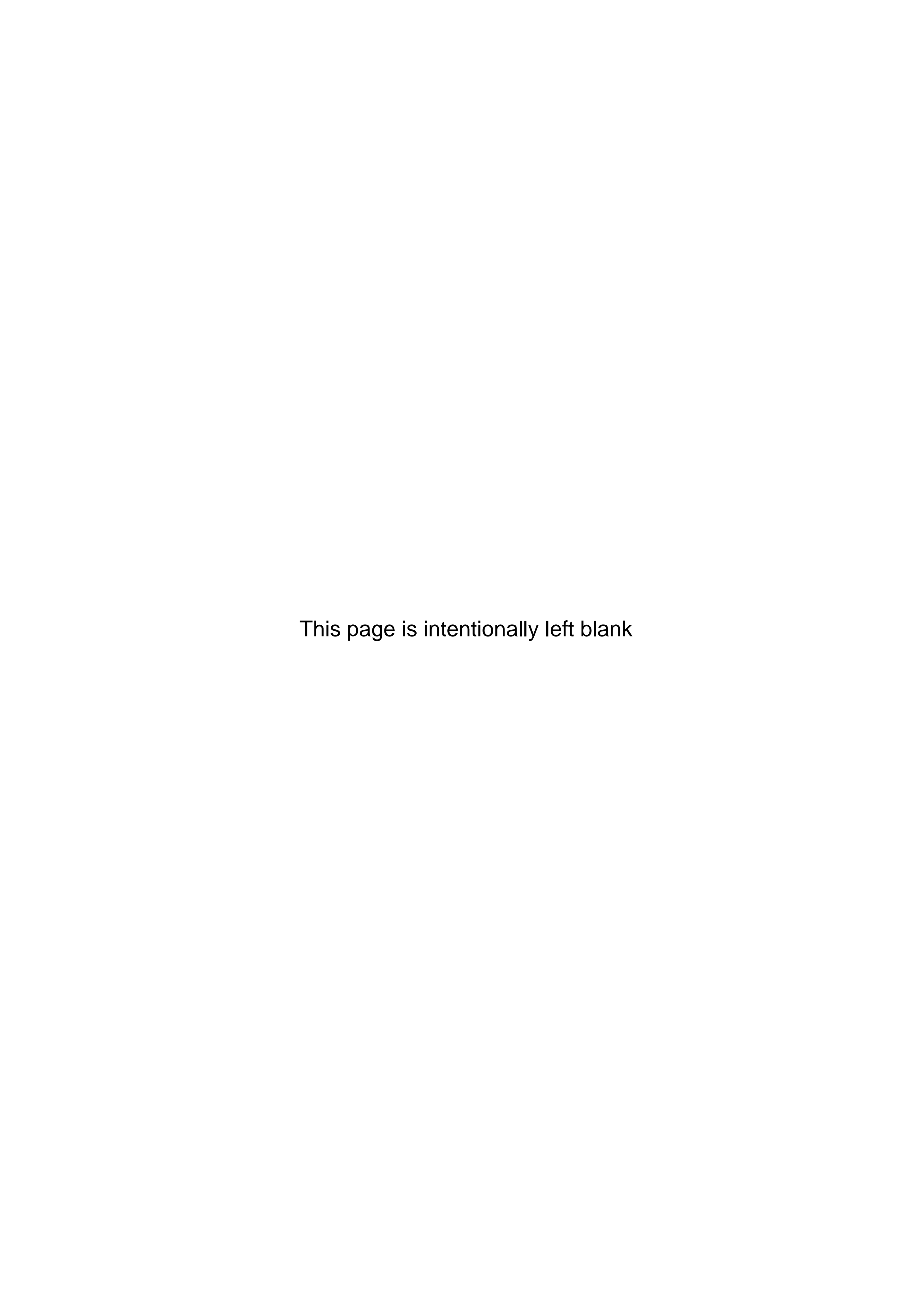
6 **A Better Start Update** (Pages 5 - 16)
Report from ABSS Director attached

7 **Locality Strategy** (Pages 17 - 60)
Joint Report from Deputy Chief Executive (People) and Interim Accountable Officer attached

8 **Southend-on-Sea Borough Council STP Referral Letter** (Pages 61 - 76)
Referral letter attached for information

Members:

J Garcia-Lobera (Deputy Chair), J Gardner, Y Blucher, Mr A Khaldi, C Gritzner, Cllr L Salter (Chair), Cllr M Davidson, Cllr F Evans, Cllr J Lamb, Cllr C Willis, Cllr R Woodley, Pike, S Leftley, A Atherton, K Jackson, Morris, Chaturvedi, M Freeston, A Griffin, S Dolling, Ms J Cripps, C Panniker and J Broadbent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SOUTHEND-ON-SEA BOROUGH COUNCIL

Meeting of Health & Wellbeing Board

Date: Wednesday, 19th September, 2018

Place: Johnson Room - Tickfield Centre

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Present: Councillor L Salter (Chair)
Dr K Chaturvedi (SCCG), Ms C Gritzner (SCCG), Councillor M Davidson (SBC), Councillor R Woodley (SBC), Ms A Griffin (SBC), Mr S Leftley (SBC) and Mr K Ramkhelawon (SBC)
Mr A Brogan (EPUT – non-voting), Ms J Broadbent (Healthwatch Southend – non-voting) Mr A Khaldi (ABSS – non-voting), Ms Y Blucher (SUFHT – non-voting) and Mr S Dolling (SBC – non-voting)

In Attendance: Councillors A Chalk and J McMahon
N Faint, F Abbott, L Watson, R Baker, S Rollason, J Banks and R Walters

Start/End Time: 5.00 - 5.45 pm

287 Apologies for Absence

Apologies for absence were received from Councillor F Evans, Councillor J Lamb, Councillor C Willis, Dr J Garcia, C Panniker, J Cripps, J Gardner, A Semmence, S Morris, J O'Loughlin, B Martin, J Lansley, S Houlden and E Chidgey.

288 Declarations of Interest

The following declarations of interest were made at the meeting:-

(a) Councillor Salter – agenda items relating to – Minutes re STP; Localities update; Physical Activity Strategy - non-pecuniary interest – husband is Consultant Surgeon at Southend Hospital; daughter is a Doctor at Basildon Hospital; son-in-law is a GP in the Borough;
(b) C Gritzner – agenda item relating to Minutes re STP – daughter is a Doctor at Basildon Hospital;
(c) Councillor McMahon – agenda relating to A Better Start Southend update – non-pecuniary interest - member of the Better Start Ward Panel.

289 Minutes of the Meeting held on Wednesday 20th June 2018

Resolved:-

That the Minutes of the Meeting held on Wednesday, 20th June, 2018 be confirmed as a correct record and signed.

290 Questions from members of the public

There were no questions from members of the public.

291 Southend 2050 Progress, Emerging themes and next steps

The Board received a detailed update from Rob Walters on the 'Southend 2050' conversations that have taken place over recent months and outlined the emerging themes and next steps. The borough wide conversation is about the future of the borough and how it affects the everyday lives of the people that live, work and visit. The role of the Board is crucial in the discussions going forward and Board members will be invited to events in coming weeks which will provide further information on emerging messages.

By the end of the year there will be a shared ambition which people can recognise and get behind.

Resolved:-

The Board welcomed the update and asked to receive regular updates.

292 A Better Start Southend (ABSS) programme update

The Board considered a report from the A Better Start Southend (ABSS) Programme Board Project Director which provided an update on the progress with the programme. The following areas were highlighted:-

- Social and Emotional Strategy - this final strand of activity was now agreed by the Partnership Board and ABSS will, in the coming months, be delivering on all funded programme themes
- National Evaluation - The national cohort study led by Professor Jane Barlow of Warwick University will commence in 2019 and ABSS will join when ready
- Children Centres - ABSS has responded positively to a request from council to support the Children's Centres and will be bringing forward proposals for a multi-agency pilot project, testing new models for managing and delivering integrated services at the centres
- Governance Review - a new governance structure has been agreed by Partners and will ensure effective oversight as the work ramps up

The Chair commended ABSS for the excellent progress being made and Members welcomed proposals for supporting the development of Children's Centres.

Resolved:-

That the update report be welcomed.

293 Special Educational Needs and Disability (SEND) Update

The Board considered a report by the Deputy Chief Executive (People) which provided an update on the progress made in the SEND Three Year Journey and

provided information on the SEND area Inspection. The report also advised the Board about the Strategy refresh which will be brought to the December meeting of the Board.

Resolved:-

That the report and actions outlined be noted.

294 Localities - Living Well in Thriving Communities

The Board considered a joint report by the Deputy Chief Executive (People) and Interim AO, Southend & Castle Point & Rochford CCGs which provided an update on the formation of localities for health and social care in Southend.

Resolved:-

1. That the principles of the Locality Strategy (Living Well in Thriving Communities) developed across South East Essex (SEE) be endorsed.
2. That the principles of collaborative working as described within the paper particularly the continued evolution of the SEE Locality Partnership be agreed.
3. That the principles of shared resource to ensure the successful delivery of integrated models of care that have been developed through a Locality approach be agreed.
4. That the strong focus of this work on Southend Localities and alignment with Southend 2050 be noted.
5. That the SEE Locality Partnership sign off the final amendments of the Living Well in Thriving Communities.

295 Physical Activity Strategy - Implementation plan reporting

The Board considered a report by the Deputy Chief Executive (People) which provided an update on the progress to date with the implementation of the Southend-on-Sea Physical Activity Strategy 2016-2021 refreshed action plan, including successes, challenges and future opportunities.

Councillor Davidson is the Chair of the Active Southend multi agency group which is overseeing the delivery of the Strategy.

Resolved:-

1. That the update be noted and that representative organisations promote the South Essex-wide Active 10 campaign within their respective organisations and to wider partners.
2. That regular updates be brought to future Board meetings.

296 Date and time of future meetings

The Board noted the dates and times of future meetings:-

Wednesday 5th December 2018 @ 5 pm Darwin Room, Tickfield Centre
Wednesday 23rd January 2019 @ 5 pm Darwin Room, Tickfield Centre

Chairman: ________________________

Agenda

Item No.

6

Southend Health & Wellbeing Board

Report by
Alex Khaldi, Chair, A Better Start Southend

to

Health & Wellbeing Board

on

5th December 2018

Report prepared by:
Jeff Banks, Director, A Better Start Southend

X	For discussion		For information only		Approval required

A Better Start Southend - update

Part 1 (Public Agenda Item)

1 Purpose of Report

The purpose of this report is to:

1.1 Provide an update from the Chair of A Better Start Southend (ABSS) on key developments since the last meeting.

2 Recommendations

HWB are asked to:

2.1 Note the contents of the report and raise issues and opportunities with the Chair of the ABSS Partnership Board, Alex Khaldi.

2.2 Agree that ABSS present to the Board meeting in March 2019.

2.3 Consider attendance at training opportunity *'Strategic Approaches to Father Inclusive Practice'* on 15th January 2019.

2.4 Consider attendance at the ABSS Conference *'Who's the Expert? Innovation in Co-production and Service Design'* on 11th April 2019.

3 Background

3.1 GOVERNANCE

a) Partnership

The Chair and Director of ABSS has been undertaking further meetings with strategic partners, including Malcolm McCann, Executive Director of Community Services & Partnerships at EPUT; Professor Vasilios Ioakimidis, Director of Centre for Social Work & Social Justice, School of Health and Human Sciences at the University of Essex; Clare Burns, Director of Operations for Planned and Scheduled Care at Southend University Hospital NHS Foundation Trust; among others. There has been a particular focus on strengthening engagement with NHS partners.

It is intended to hold an event with partners and the Director of ABSS will liaise with Alison Griffin, the Chief Executive of Southend-on-Sea Borough Council, to develop proposals further. It is anticipated that this event will be held in the new year.

b) Big Lottery Fund

ABSS participate in a number of regular Programme feedback sessions with the Big Lottery Fund, at a Directorial and Programme Management level and the formal Quarterly Grant Management Meeting took place on 17th September. In addition to regular update items, ABSS shared work relating to Adverse Childhood Experiences and initiatives focussed on engaging Fathers. The next review is scheduled for January 2019 and will focus on review of the risk register along with the programme implementation plan and communications plan.

The Director participated in a meeting of the A Better Start National Advisory Group on 18th October at the ABS Lambeth site, LEAP. This was a useful opportunity to share insights across the wider national programme and meet national experts who support the programme and local stakeholders. The next meeting of the National Advisory Group will take place on 29th January 2019 and will be in Southend-on-Sea. The Advisory Group routinely receive a presentation from parents and it is suggested ABSS Partners save the date, as there may be benefit in key stakeholders attending the event to share practice, etc.

ABSS continues to be involved in a number of cross site / national initiatives, including:

- Development of Improvement Science techniques;
- Warwick Consortium national cohort study;
- 23Red joint national Communications Campaign;
- Flying Binary, national data dashboard;
- Various 'Communities of Practice' shared learning and development platforms.

c) Governance

Following the adoption of the new Governance structure, the first four Group meetings have taken place: Parents' Group, Programme Group, Finance and Risk Group and Insights and Analysis Group. Reports from these groups will be shared with the Partnership Board. The decision to engage parents in all governance meetings has been welcomed and there has been parent representation at all meetings. Terms of Reference for Groups establish that the meetings will be quorate when there are two or more partners represented and two or more parents. Three of the four meetings have been quorate and partners are working hard to strengthen representation at all meetings.

There have been two meetings of the 'Think Tank' working on strategic System Change and Community Resilience and the group is finalising the commissioning, with support from SBC,

of a system map and mapping tool which will help inform discussion around system effectiveness and opportunities.

The Finance and Risk Group and the Partnership Board reviewed and approved the Quarter Two Summary Management Accounts submission to Big Lottery. The summary is attached as Appendix One.

The Chair, Director and team remain grateful to the many partners and stakeholders who contribute so positively to the various governance processes at ABSS.

3.2 PROGRAMME MANAGEMENT UPDATE

a) Programme Management Office Capacity

The capacity of the core team has been enhanced with a number of recent appointments and new staff are now inducted and working well. A number of administrative roles are being recruited including two new posts and one to fill an existing vacancies. A further full time Project Manager is also being recruited as previously agreed and additional capacity will be established during the commissioning of the Social & Emotional work stream.

A Memorandum of Understanding has been agreed between SBC Public Health and ABSS, facilitating the continued deployment of one Health Improvement Practitioner Advanced to offer strategic support for the ABSS Diet and Nutrition work stream, and establishing a further arrangement for a Senior Public Health Principal to support strategically with Social and Emotional programme development. These arrangements contribute significantly to core expertise/capacity and strengthen the ability of the partnership to respond to key strategic objectives of mutual benefit. The programme is extremely grateful for this support and looks forward to further developing the strategic relationship with Public Health, working with these much valued colleagues. Arrangements are being finalised to continue the current deployment of a 0.6 f/t/e Programme Manager from EPUT.

As reported previously, the Programme Management Office is looking at additional office accommodation, to complement the Alexandra Street office and options are being finalised.

The Director has been working with the team to establish a new operational management structure for ABSS.

b) Programme Activity

ABSS continues to make significant progress with implementing projects and programmes across the three key areas of focus: Diet and Nutrition, Communication & Language and Social & Emotional Development. A service delivery contract is currently being finalised with Family Action for delivery of a range of new programmes in Children's Centres including:

End of Winter Term

- Father Reading Every Day (FRED)
- Starting Solids Workshops

Spring Term

- Food for Life
- Basic Cooking Skills

- FRED
- Starting Solids

The Programme Management Office are finalising commissioning timescales for Social & Emotional work stream and a Preparation for Parenthood Programme supplier engagement event has been planned for 11th December. Through a task and finish workgroup, the detailed specification for the Family Support Project is being developed alongside key stakeholders, for presentation to the Programme Group on 9th January 2019. The universal offer for parenting, Empowering Parents, Empowering Communities (EPEC), is now in delivery with a further 6 programmes planned for the spring term.

The Programme Management Office are undertaking a review of the current suite of Communication & Language programmes undertaken through 'Let's Talk' and have met with the EPUT Principal Paediatric Speech and Language Therapist in order to differentiate, define and quantify each of the individual offers. The Speech, Communication & Language Family Support Workers are now in role within the SBC Special Educational Needs team and started supporting parents on the 5th November.

Pre-School Learning Alliance have been successful in gaining funding from the DfE to roll out elements of the ABSS Speech and Language work to five new areas – Leeds, Birmingham, North Yorks, Portsmouth and Lincolnshire. As part of this we have the opportunity of extending Let's Talk activity to the other non-ABSS wards in Southend. We are delighted with this success and Michael Freeston from the Pre-school Learning Alliance has worked closely with the ABSS lead Speech and Language Therapist on this.

The quarter 2 service reviews with current providers are currently being undertaken.

A training opportunity *'Strategic Approaches to Father Inclusive Practice'* is being offered to the Partner 0-3 workforce on 15th January 2019. Details have been shared with Board members and they are requested to encourage attendance from their agency.

An ABSS Conference entitled *'Who's the Expert? Innovation in Co-production and Service Design'* is scheduled for 11th April 2019 and Board members are asked to 'save the date'. Further information is provided at Appendix Two.

A Case Study is included at Appendix Three

c) System Change and Community Resilience

ABSS is continuing to develop work exploring the GP Family Friendly approach and is currently working with partners to explore how to bring paediatrics into local primary care delivery models. On 8th November a co-production event was held with GP practices from the East Central locality to explore opportunities and secure 'buy in' for the proposed model of delivery, with the objective being to reduce A&E attendance for gastrointestinal disorders and respiratory illness. It is hoped that these approaches may be able to contribute to the reduction of winter pressures over the 2018/19 season.

ABSS has responded positively to a request from SBC to support the Children's Centres and has offered a proposal for a multi-agency pilot project, testing new models for managing and delivering integrated services at the centres.

Following the decision of the Partnership Board to undertake a review of the Engagement programme, the Programme Management Office have been exploring options through co-production and benefiting from formative evaluations. Colleagues have also engaged with SBC and partners to explore opportunities for using principles of Asset Based Community Development and Restorative Practice, to reinforce the value of this work in building community resilience and sustainability. Proposals were considered and approved by the Partnership Board on 12th November and an implementation plan will be discussed with the ABSS Programme Group on 3rd December.

ABSS has continued to be heavily involved in the development of 0-19 Children Young People and Families Services and staff are supporting a number of working groups in addition to the main Steering Group, looking to develop a new 0-19 model.

The 'Think Tank' continue to meet to support the work of ABSS as a catalyst for system change and community resilience.

d) Local evaluations

The Partnership Board have agreed to support the allocation of resources to undertake formative evaluations of key programmes of activity, and draft reports for the first three areas examined have been presented to the Insights and Analysis Group for review. These will be refined prior to circulation to providers for fact checking before publication. In line with the ABSS bid the decision to undertake these formative evaluation in-house has seen *"our local workforce further developing their research skills as an element of continuous professional development and reflective practice"*. Three further formative evaluation reports are currently in production.

On 5th November, the Insights and Analysis Group considered a proposal to replace two temporary Research and Evaluation Officers with a permanent team – building evaluation capacity as detailed in the original ABSS bid. The Insights and Analysis Group also reviewed options for the commissioning of the programme-wide local evaluation and proposals will be brought to the Partnership Board on 21st January 2019.

e) National Cohort Study

Further discussions have taken place with the Big Lottery Fund and the Warwick Consortium regarding the implementation of the Cohort Study. It is now anticipated that the Cohort Study will commence later in 2019. The Partnership Board has expressed strong support for the Cohort Study and, operationally, staff continue to provide all necessary resource and information, as required.

4 Reasons for Recommendations

4.1 ABSS Governance have reviewed and approved activities at the appropriate level.

5 Financial / Resource Implications

5.1 None at this stage outside permitted programme projections.

6 Legal Implications

6.1 None at this stage

7 Equality & Diversity

7.1 None at this stage.

8 Appendices

8.1 Appendix One – Quarter Two Summary Management Accounts

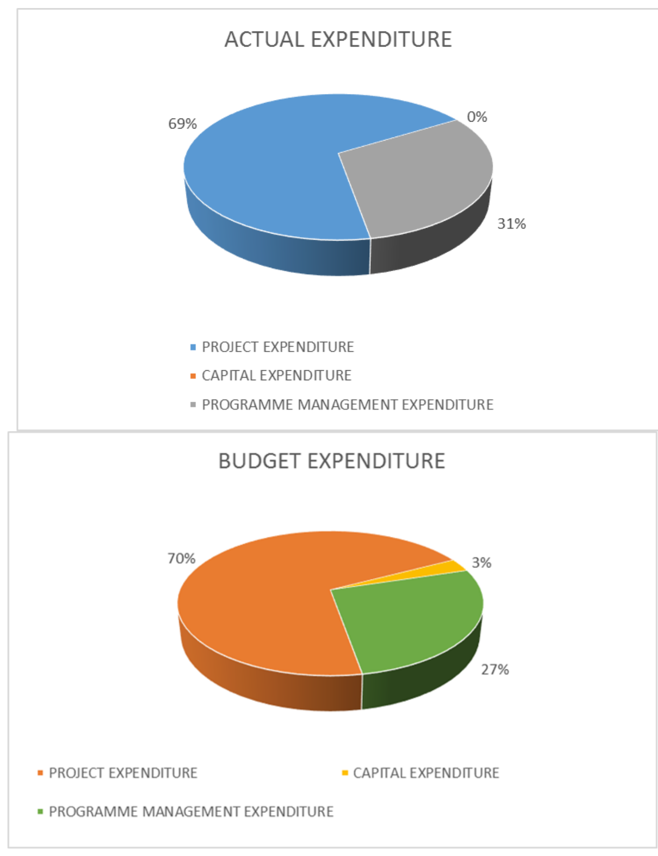
8.2 Appendix Two – Conference ‘Save the Date’ flyer

8.3 Appendix Three - Case Study

8.1 **APPENDIX ONE – Quarter Two Summary Management Accounts**

CONFIDENTIAL SIX MONTHS TO 30 SEPTEMBER 2018

The management accounts for the A Better Start Southend (ABSS) programme show income received and expenditure incurred during this financial year. Management accounts are presented to the ABSS Partnership Board quarterly, coinciding with the submission of returns to the Big Lottery Fund. More detailed monthly accounts are reviewed by the ABSS Finance and Risk Board.
The accounts for the financial period from 1 April 2018 to 30 September 2018 show project expenditure of £837,000, capital expenditure of £nil and programme management (PMO) expenditure of £375,000. These are represented as a percentage of total spend in the first chart.



Commentary regarding underspend

- Co-production – an element was returned due to non-delivery of part of the contract relating to cross-borough co-production strategy embedding
- Crèches – saving made due to employing directly and less reliance on agency staff
- Projects – delayed start to some project-linked staff roles
- Programme Office – delayed appointment to some PMO staff roles whilst the new team is embedded

Summary Management Accounts - Confidential
Period: QUARTER TWO 2018-19

	Period: APRIL to SEPTEMBER 2018		
	Actual	**Budget**	**Variance (adverse) or favourable**
INCOME	£	£	£
REVENUE FUNDING RECEIVED FROM BIG LOTTERY FUND	1,288,000	1,445,000	(157,000)
CAPITAL FUNDING RECEIVED FROM BIG LOTTERY FUND	13,000	44,000	(31,000)
LEVERAGED INCOME	130,000	-	130,000
TOTAL INCOME	**1,431,000**	**1,489,000**	**(58,000)**
EXPENDITURE			
PROJECTS			
SOCIAL AND EMOTIONAL	221,000	262,000	41,000
COMMUNICATION AND LANGUAGE	250,000	267,000	17,000
DIET AND NUTRITION	166,000	167,000	1,000
SYSTEM CHANGE	139,000	243,000	104,000
CRECHE SERVICES	26,000	55,000	29,000
MONITORING & EVALUATION	7,000	23,000	16,000
DATA ANALYSIS	28,000	26,000	(2,000)
PROJECT EXPENDITURE	**837,000**	**1,043,000**	**206,000**
SALARIES AND SECONDMENTS	230,000	273,000	43,000
OTHER PMO COSTS	145,000	128,000	(17,000)
PROGRAMME MANAGEMENT EXPENDITURE	**375,000**	**401,000**	**26,000**
TOTAL REVENUE EXPENDITURE	**1,212,000**	**1,444,000**	**232,000**
CAPITAL EXPENDITURE	-	44,000	44,000
LEVERAGED COSTS	130,000	-	(130,000)
TOTAL EXPENDITURE	**1,342,000**	**1,488,000**	**146,000**
NET FUNDING IN ADVANCE/(OWED)	**89,000**	**1,000**	**88,000**

CUMULATIVE FIGURES FROM START UP TO DATE	£
INCOME	**7,898,000**
PROJECT EXPENDITURE	3,497,000
PROGRAMME MANAGEMENT EXPENDITURE	3,686,000
CAPITAL EXPENDITURE	570,000
LEVERAGED	130,000
TOTAL EXPENDITURE	**7,883,000**
NET FUNDING IN ADVANCE/(OWED)	**15,000**

CONVENTION: Brackets around a number signify either an amount owed by the Big Lottery or an adverse variance (ie income less than budget or expenditure greater than budget)

8.2 **APPENDIX TWO – ABSS Conference – Who's the Expert? Innovation in Co-production and Service Design**

8.3 **APPENDIX THREE – Case Study**

Ileana

Ileana has been A Better Start Southend Parent Champion for over 16 months now, spreading the word about A Better Start and encouraging new parents to take part in the programme.

She describes herself as a stay-at-home mum with 3 children - twin boys 2.5 years of age and a daughter aged 5. She was attending play groups with the boys and starting to venture out more and as her life was full on with childcare she was not really thinking about work/volunteering etc.

Ileana met an SAVS Better Start Engagement Officer promoting opportunities to get involved in the A Better Start Programme in at her local primary school playground one day when collecting her daughter. This interested her and she provided her contact details so a follow up contact could be made. During a home visit she was informed about the Parent Champion Training course that was coming up. She was a bit hesitant at first as she likes to ensure she can see things through and knew there would be a level of commitment.

As the twin boys had never been away from her or looked after by anyone other than herself and her husband, Ileana was apprehensive about the crèche situation as she had previously tried a crèche but this was too challenging for the boys.

With the Parent Champion training, the team, together with the crèche workers and Ileana tested and learnt what works and what didn't with regards to settling the boys in crèche. She was able to stay in the training with the group and a volunteer was provided to engage the boys if they came out of the crèche and into the training room. This was a key fact that kept her engaged on the course.

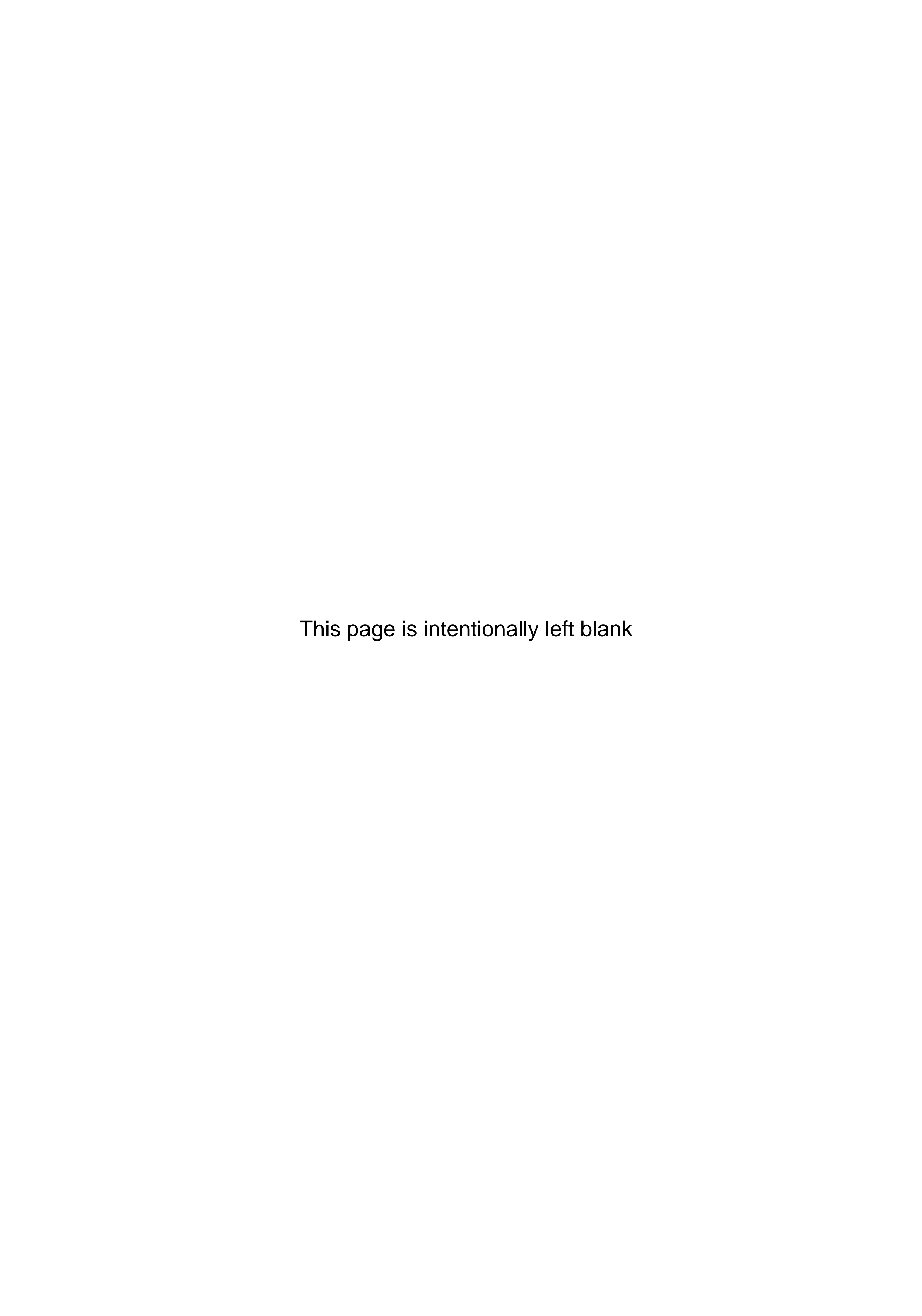
Ileana's main aim and motivation to get involved related to her children and to help improve the lives of under 4s and their families. Ileana says: "The Parent Champion role has given me the opportunity to be involved so many different elements. I feel part of the decision making process and enjoy the experience of co-production meetings."

Ileana's role has included Partnership Board Meetings, Breastfeeding service design, Milton Gardens Focus Group, attending Parent Forums, Communications Group and community events. The impact on Ileana personally has been positive she is more confident, has built up a strong social network and continues to improving her IT/data entry skills.

Ileana feels volunteering is helping her with future goals as she will soon begin to think about returning to work. Being a Parent Champion has given her ideas for the type of work she wants to, and she has also now attended events with the Work Skills project.

Ileana adds: "The entire experience has been so enjoyable and feels like a meaningful use of my time and well worth doing it has changed my life".

Update November 2018: Ileana has recently found employment.



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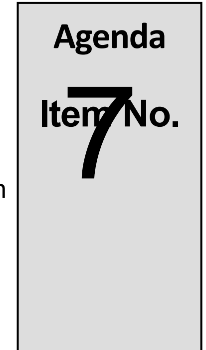


Southend Health & Wellbeing Board

Joint Report of
Simon Leftley, Deputy Chief Executive (People), Southend on Sea Borough Council
Cathy Gritzner, Interim Accountable Officer, Southend and Castle Point & Rochford CCGs

to

Health & Wellbeing Board

on

05 December 2018

Report prepared by:
Nick Faint, Integration Programme Manager, SBC
Ashley King, Interim Programme Director, Southend and Castle Point & Rochford CCGs

	For discussion		For information only	X	Approval required

Locality Strategy
Living Well in Thriving Communities

Part 1 (Public Agenda Item)

1 Purpose of Report

The purpose of this report is to;

1.1 Provide Health & Wellbeing Board (HWB) with a briefing and update regarding the development of a Locality Strategy - Living Well in Thriving Communities, **Appendix A**, for health and care in Southend on Sea (Southend).

2 Recommendations

HWB are asked to;

2.1 Note that the Locality Strategy has been endorsed by the South East Essex Partnership Group (the Partnership);

2.2 Endorse the Locality Strategy developed across South East Essex (SEE); and

2.3 Recommend that the Locality Strategy is submitted to the relevant organisation governance as appropriate.

3 Background

3.1 The vision for the Locality is that it is the central place where integrated health and social care interventions are delivered and co-ordinated.

3.2 Each Locality will utilise locally based assets to support residents and patients whilst integrated primary, community and social care services work in a multi-disciplinary team environment.

3.3 The Mid and South Essex Sustainability and Transformation Partnership (STP) have consulted on plans to reconfigure the acute health service provision across the mid and south Essex geography. The reconfiguration of the acute services assumes that the community infrastructure (Localities) is in place to deliver a strength based that supports both local residents, communities and services.

3.4 The development of Localities and integrated services are aligned to other transformational activities within both Southend, SEE and the wider Essex systems. For example; the commissioning of an integrated care co-ordination service and a dementia navigator service; the children's community paediatrics service and an Essex wide mental health service.

3.5 Following an update provided to HWB on 18 Sep 2018 regarding the development of Localities and a Locality Strategy the Partnership agreed the Strategy (16 Nov 2018) for endorsement at HWB.

Principles

3.6 The principles of the Locality Strategy are to;

3.6.1 Provide a central point of reference that for all key stakeholders, binds them together through a joint ambition that demonstrates the strength of the SEE partnership;

3.6.2 Outline the approach that we will adopt across SEE to deliver new models of integrated care, with a focus on individuals, prevention, strength based approaches and community resilience;

3.6.3 To provide a framework for the creation of a business plan for each of the SEE Localities that will support not only the operational development but the strategic development of Localities

3.7 In the strategy, a clear and bold vision is set out that includes:

- A focus on the **importance of place/localities** as a unit of planning
- A **commitment to integrating services** around the needs of individuals and communities
- Placing a strong **emphasis on prevention**
- Collectively defining and agreeing a single set of **outcomes**
- An expectation that **collaboration** (rather than competition) will be the norm
- Enabling and encouraging **local teams and professionals to have greater flexibility** so that they can be driven by people's needs, not organisational or professional silos, and
- An explicit requirement to **look closer at formalising the working arrangements** in place across the south east Essex system

Next Steps

3.8 The development of the Locality Strategy has been a significant period in time for the forming of partnerships. It has challenged system thinking and encouraged organisations to work better together.

3.9 Cultural change will underpin the successful implementation of the Locality Strategy and the approach for implementation will need to be iterative in its nature and flexible to the changing requirements of the system.

3.10 It is proposed that the priorities for the SEE Locality Partnership over the next six months are;

3.10.1 Develop a Memorandum of Understanding that underpins the collaborative approach described, and

3.10.2 Explore the ambition of each partner in regards to the continued evolution of the SEE Locality Partnership

3.11 At **Appendix B** are one page plans for each of the Southend Localities. It should be noted that these have been formed following engagement with communities, operational teams and senior managers. The Partnership have overseen this approach and it should be further noted that the one page plans will be reviewed and updated on a regular basis.

4 Financial / Resource Implications

4.1 None at this stage

5 Legal Implications

5.1 None at this stage

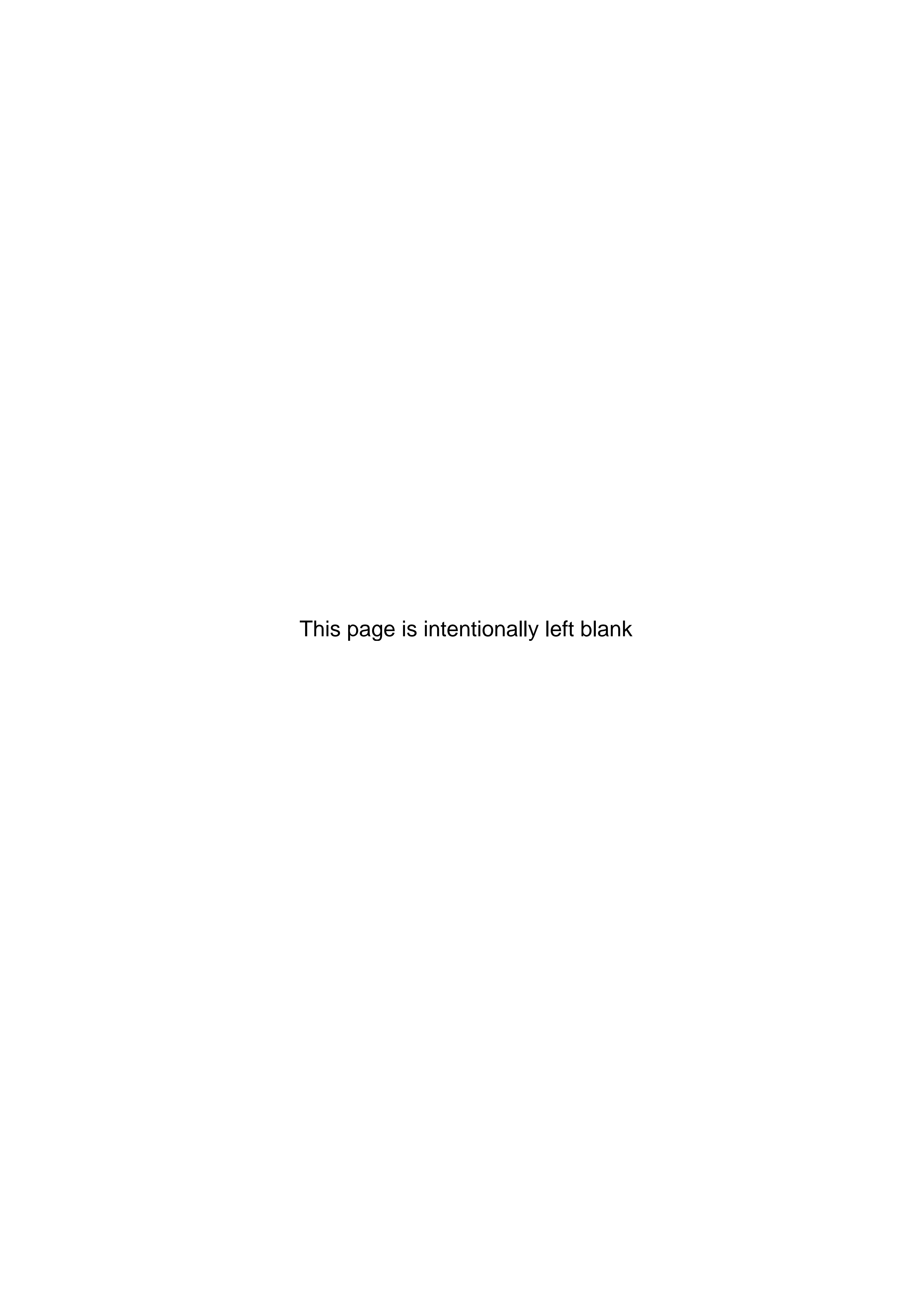
6 Equality & Diversity

6.1 The Locality approach should result in more efficient and effective provision for vulnerable people of all ages.

7 Appendices

7.1 **Appendix A** – Locality Strategy – Living Well in Thriving Communities.

7.2 **Appendix B** – East, East Central, West Central and West one page plans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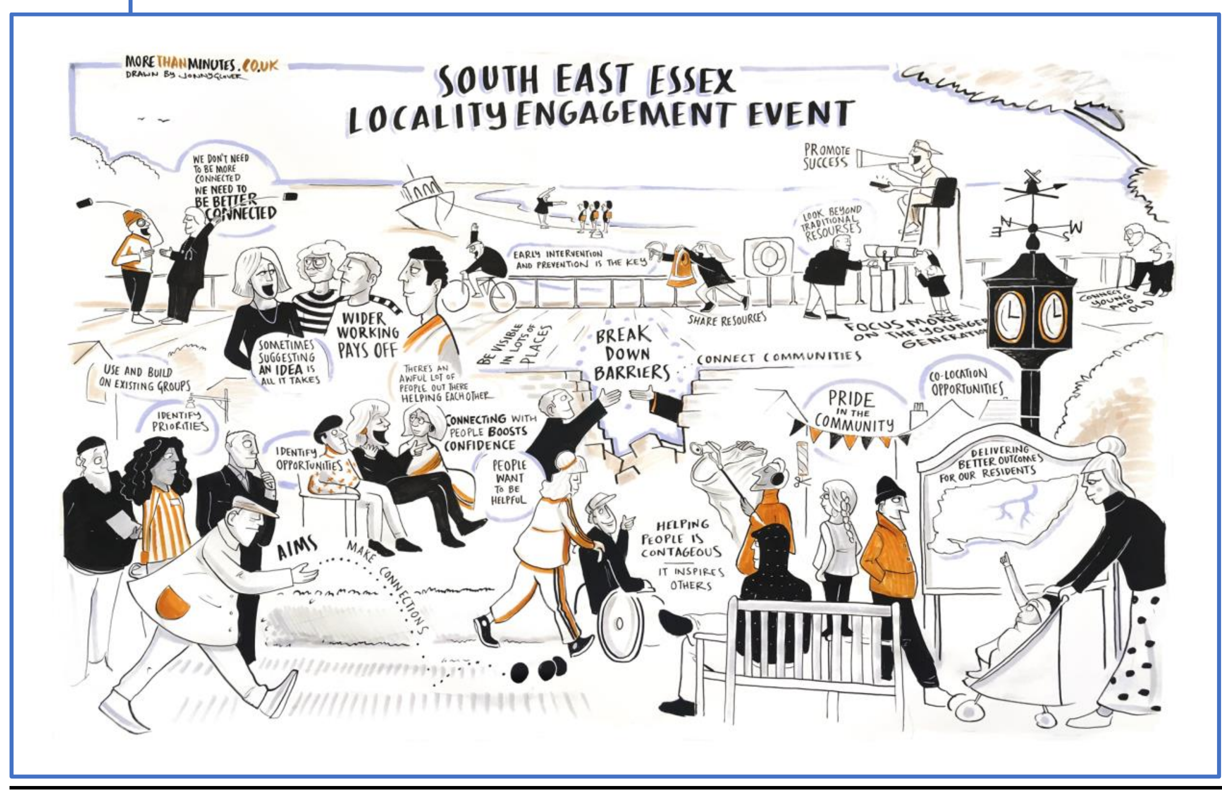
South East Essex Locality Partnership

Locality Strategy

Living Well in Thriving Communities



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1. Introduction, Purpose and Audience

Why do we need this document and who it is aimed at?

Health and Social Care organisations in South East Essex (SEE) share an ambition to **improve the wellbeing and lives of the people they serve**. They will work with each other and with the local populations to **organise services and mobilise resources within the communities.** The approach will be based **around the needs and locations of people, rather than boundaries of organisations** and will focus on prevention and supporting the strengths of communities and individuals.

The purpose of this document is to;

- Provide a central point of reference that for all key stakeholders, binding them together through a joint ambition that demonstrates the strength of the SEE partnership that exists;
- Outline the approach that we will adopt across SEE to deliver new models of integrated care, with a focus on individuals, prevention, strength based approaches and community resilience;
- To provide a framework for the creation of a business plan for each of the SEE Localities that will support not only the operational development but the strategic development of Localities

Across SEE all statutory organisations have been working towards implementing new models of integrated care, bringing together traditional siloed services such as community physical and mental health services, adult social care and the third sector, to operate in a way that meets the needs of individuals and communities in a different, more holistic way.

Good progress has been made, however this approach has generally been driven by individual organisations, and their own priorities. It is considered that the greatest opportunity will be achieved by working strategically across a SEE footprint, but enabling local level design and implementation of changes to meet specific needs of the local population.

The decision to work across SEE's multiple health and care commissioning boundaries has resulted in a need to re-articulate the vision, core objectives and principles to ensure all partners are using the same language, with the same interpretation, and towards the same end point.

As such key system leaders have collectively defined the model of care that we aspire to and agreed an approach to implementation that focuses on bottom-up design principles and the empowerment of the public and frontline staff.

This document describes the principles that the system wishes to work under, defining how it will enable new ways of working to take hold, and how this aligns with complimentary strategies under development and already in existence, such as;

- Mid and South Essex Primary Care Strategy;
- Southend, Essex and Thurrock Mental Health and Wellbeing Strategy 2017-2021;
- Southend 2050;
- Southend Adult Social Care Transformation;
- Digital Essex 2020;
- The strategy for Acute Service reconfiguration;
- Essex County Council Organisation Strategy 2017-2021

This document is structured to enable the reader to understand the

- the problem we are trying to solve;
- the SEE vision for the future, and
- how we will implement this vision and the next steps that are required.

Once agreed this document will be used as the foundation to enable development of Locality diagnostics and implementation plans which will describe current population needs and solutions in place within each area, and a plan for moving towards the new model of care – this will include current utilisation of workforce and health and social care resources.

2. Context and Case for Change

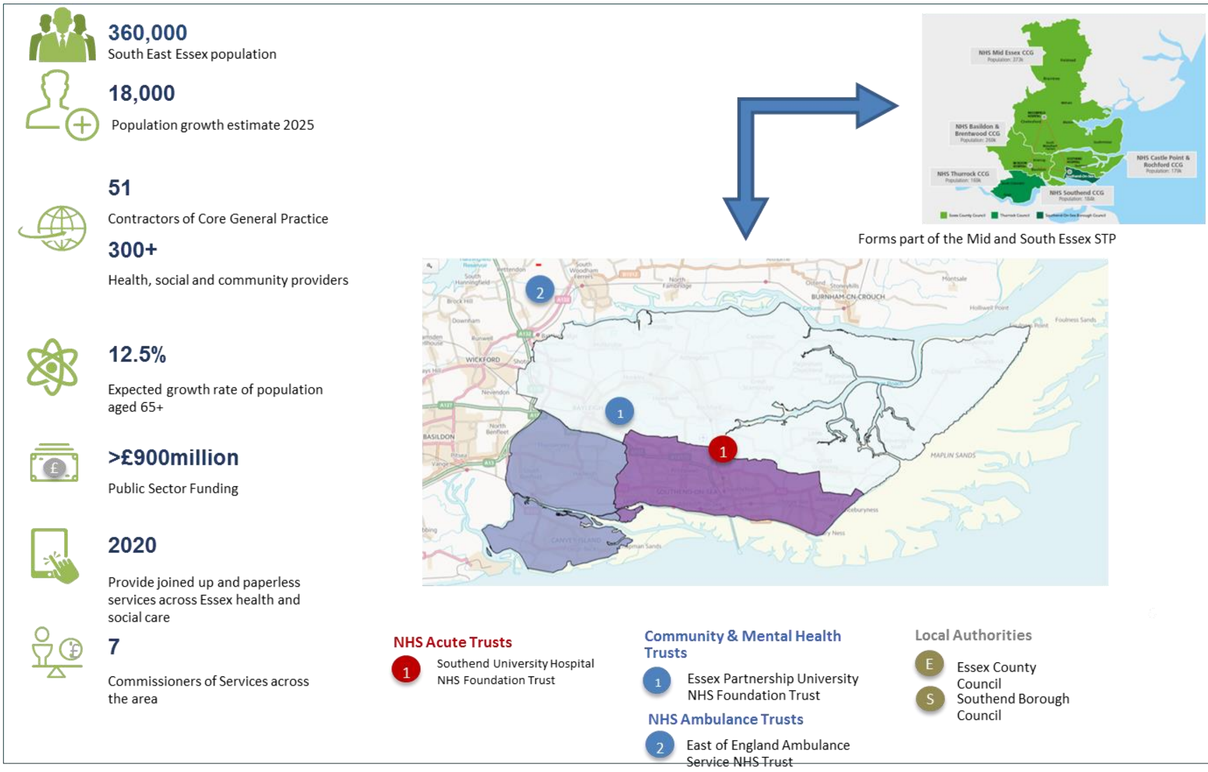
A quick portrait of the patch and the organisations within it

South East Essex, like many other areas, is a complex landscape of health and social care commissioners and providers and third sector organisations. SEE is rich in community assets which currently work, some through partnership, some through silo's, in support of communities and individuals. The area is diverse on many fronts; poverty, affluence, ethnicity and age. The SEE area also forms part of the Mid and South Essex Sustainability and Transformation Partnership (STP) planning footprint.

The complex nature of SEE aligned with increasing demand for services, unaligned workforce cultures, reducing community resilience and decreasing resource means that we have to find our way through and deliver support, preventative interventions and integrated services on a population needs basis.

To navigate our way through this complexity a strategic programme of transformation is required. It is intended that this transformation programme seeks input and oversight from all key organisations and sectors. Whilst this is summarised in the diagram below the discussions to date informing this vision have included

- Castle Point Association of Voluntary Services (CAVs)
- Essex County Council (ECC)
    - Commissioners
    - Social Care
    - Public Health
- Essex Partnership NHS Foundation Trust (EPUT)
- General Practice (GPs)
- NHS Castle Point and Rochford Clinical Commissioning Group (CPRCCG)
- NHS Southend Clinical Commissioning Group (Southend CCG)
- Southend Association of Voluntary Services SAVs)
- Southend Borough Council (SBC)
    - People Commissioners
    - Place
    - Social Care
    - Public Health
- Southend University NHS Foundation (SUHFT)



The individuals present have been representing the views of their individual organisations, the patients and public that they serve and represent, and the alignment with the ambitions of the wider system.

All partners want to move to a model of care that is no longer re-active, and places greater emphasis on keeping people well, and within their own community.

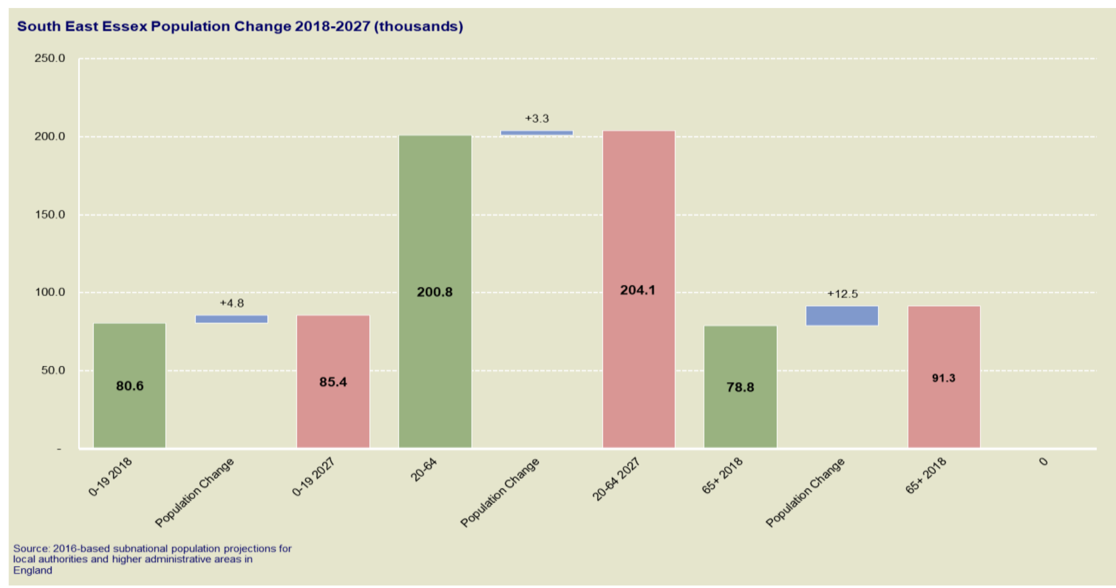
Case for Change

A short narrative on the challenges faced locally

The local system is under intense pressure as a result of a multitude of issues including but not limited to a growing population, reduced funding for adult social care and a plateauing of funding for the NHS, an increase in individuals experiencing problems with their mental health, multiple long-term conditions, social circumstances and an increase and variable ask of statutory services. These are challenges that are faced all across the country, and have been articulated many times.

In simple terms the system as it is currently operating is no longer fit for purpose. It does not work collaboratively across itself, or with the public it serves, to make best use of the assets that is has at its disposal. The way it currently operates is not operationally or financially sustainable now, and simple projections of population growth compared to statutory funding increases shows that this challenge is only going to grow.

Moving forward SEE will see a growth in population of 6%, or 20,000 people, over the next 10 years (2018-2027, ONS 2016-based subnational population projections) – this coupled with funding pressures, and lifestyle choices, will under the current model of care and support lead to an exponential, and unmanageable demand for public services.



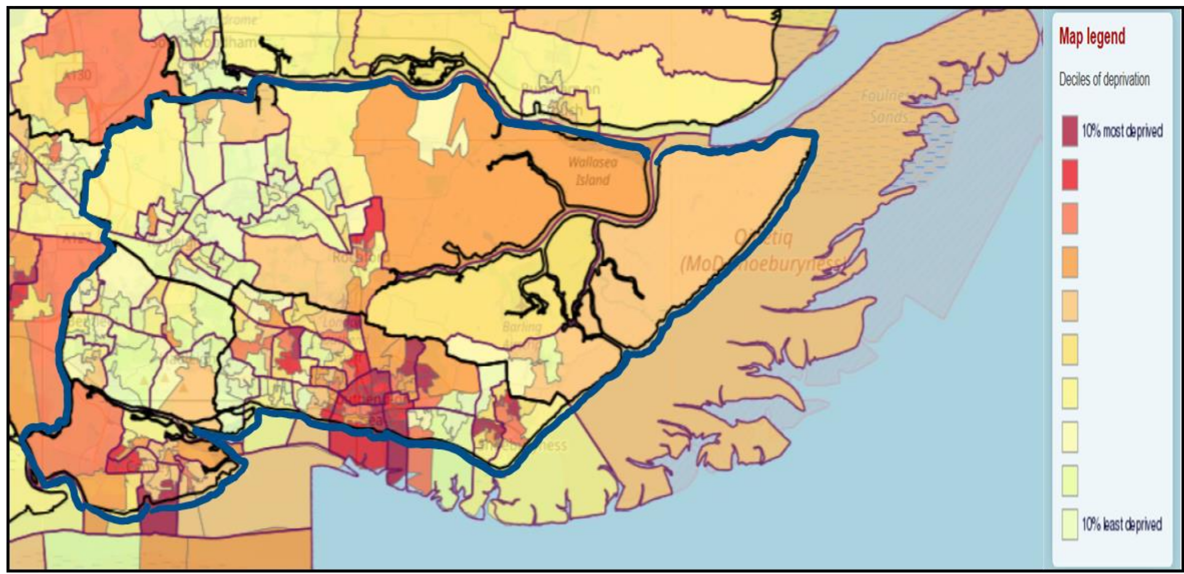
South East Essex as an area is one that contains within it a collection of smaller communities, each with their own specific care needs based upon the demographic of the population living there.

It also has a complex and varied health profile as summarised within Public Health Englands Local Authority Health Profiles 2018[1]

	Caste Point	Rochford	Southend-on-Sea
Health in summary	The health of people in Castle Point is varied with the England average. About 15% (2,100) of children live in low income families. Life expectancy for both men and women is similar than the England average	The health of people in Rochford is generally better than the England average. Rochford is one of the 20% least deprived district/unitary authorities in England, however about 10% (1,300) of children live in low income families. Life expectancy for both men and women is higher than the England average	The health of people in Southend-on-Sea is varied with the England average. About 19% (6,300) of children live in low income families. Life expectancy for men is lower than the England average
Health Inequalities	Life expectancy is 6.6 years lower for men and 3.6 years lower for women in the most deprived areas of Castle Point than in the least deprived areas	Life expectancy is 3.9 years lower for men and 5.4 years lower for women in the most deprived areas of Rochford than in the least deprived areas	Life expectancy is 11.1 years lower for men and 9.7 years lower for women in the most deprived areas of Southend-on-Sea than in the least deprived areas

As is illustrated below, the footprint has areas that sit across the national Index of Multiple Deprivation, meaning that what is suitable in terms of support, service offer, and system expectation in one area, is not necessarily suitable within another.

[1] https://fingertips.phe.org.uk/profile/health-profiles/area-search-results/E12000006?search_type=list-child-areas&place_name=East%20of%20England



Traditional approaches to commissioning and service provision have looked at the footprint as a whole – however with this change in demand and variability of need it is apparent that it is not appropriate to look at need at this macro level. It is also not appropriate to separately look at needs and symptoms, isolate the relationship between child health and future adult health, mental health and physical health, or an individuals health and care needs and the environment that they live and work in.

The system also lacks the resources – both people and financial - to continue to provide services in traditional ways, either for the current needs of the population, or projected needs based on demographic changes and population increases.

Top down direction and service development has resulted in fragmented and isolated services, with individuals and groups falling through gaps in services and interventions – designed to meet the needs of groups of individuals identified by high-level system analysis, resulting in duplication of effort and time, and suboptimal outcomes and experiences.

The Financial Case and Logic Model

Analysing the available Health and Social Care funding in south east Essex is as equally complex as the commissioning landscape. Whilst it is easily identifiable at organisational level it is not easily analysed at locality or function level.

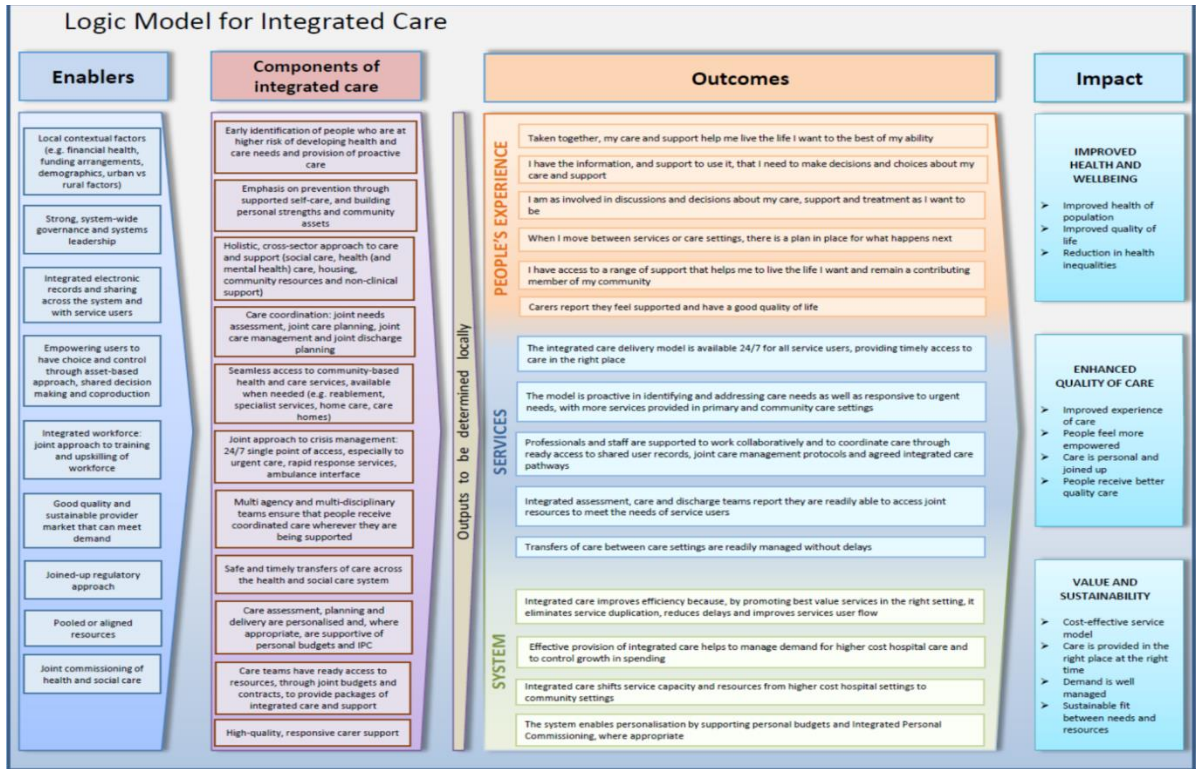
Further complexity exists with Local Authority arrangements such as the differences in scope between Essex County Council and Southend Borough Council and the role of District Councils within Essex County Council boundaries.

Most organisations also report spend against contracts or providers and not against patient cohorts, and performance is measured by outputs as opposed to outcomes.

The financial/economic case supporting the implementation of new models of care as described within this document is based on emerging evidence and a strong logic model as illustrated below. Whilst this is not ideal in terms of confidence of success, what is absolutely clear, and well-articulated in other system and organisations documents, is that the status quo – continuing to deliver services in a reactive, un-coordinated and personal deficit focused way – is unsustainable from a resource perspective, be that financial, workforce, time or any other that is able to be measured.

The Social Care Institute for Excellence have developed a Logic Model for Integrated Care which goes some way to supporting the thinking behind the financial and economic case – particularly when it comes to ensuring that

the system makes best use of its available resource, and the reasonable assumption that improved quality in itself reduces costs incurred.

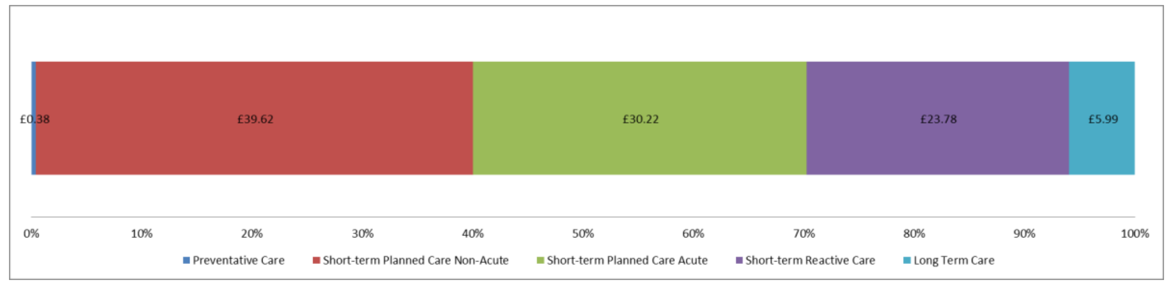


What is apparent through a simplistic analysis of CCG spend incurred within the system is that the majority of current health commissioner resource is utilised either on on-going care, or re-actively responding to rapid deterioration in need – as opposed to investing in preventative care. Whilst not easily analysed anecdote suggests that a similar review of Local Authority spends would see a similar focus on residents with current needs as opposed to investments on keeping people well.

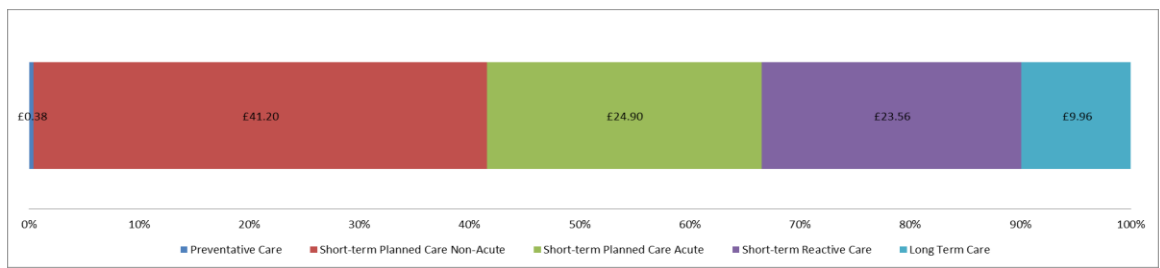
Both CCG's generally report spend against provider sectors, or commissioning programmes. The vast majority of the CCG spend will be on meeting the identified health needs of the population, with very little committed towards the fit and healthy population – this has been further influenced by the removal of Public Health funding from CCG budgets when they were formed, with this money being realigned to local authorities.

The graph below illustrates that for every £100 spent by the Castle Point and Rochford CCG

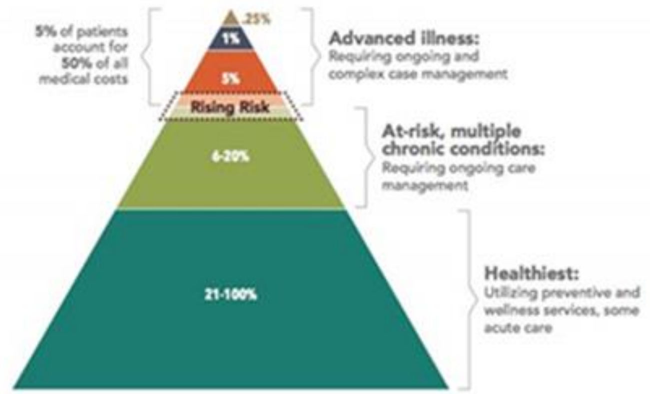
- £39.62 is committed to meeting short-term (non-permanent) health needs in a planned manner, assuming patients do not remain on caseloads in perpetuity. This covers nearly all spend areas of primary and community care
- £30.22 on planned acute services such as Out-patient appointments and Elective inpatient and daycases
- £23.78 is spent on reactive care covering Accident and Emergency and Non-Elective admissions
- £5.99 is spent on meeting the on-going needs of patients receiving Continuing Healthcare, and
- 38p is spent on services commissioned to proactively support individuals, the majority of whom have been identified as already having a health or care need



Whilst the numbers are slightly different for Southend the overall picture of how resource is utilised is not materially different.



What this shows is that the majority of CCG spend is utilised on the estimated 20% of patients that have a care need now, with very little committed towards maintaining the health of the population. This approach to funding care is unlikely to be sustainable in the future as the projected gap between available resources and population demand increases.



The Public Health Case

Disease and harm prevention at a population level

The rationale and benefits for individuals where disease prevention interventions are implemented are recognised and well known. The impact on individual diseases of immunisation programmes, screening programmes, and health promotion programmes, for instance, can be clear and has been analysed and demonstrated through clinical research and evaluation over the past century. However the benefits for health and social care systems from population level prevention programmes are only recently being quantified through an emerging research evidence base.

It is important to note that investing in population level disease prevention is primarily about improving lives rather than producing financial savings or reducing healthcare demand. Successful prevention at population level can increase life expectancy and consequently increase care needs in the future. However, ambitions for prevention interventions may include reduction in demand pressures for key services such as urgent and

emergency care and re-allocation of resource to facilitate improved efficacy, efficiency, and equity in health and social care services.

Health promotion and disease prevention must take account of a complex system of determinants. These familial, social, and economic determinants may require different specific interventions and these interventions may impact on multiple disease areas. With multiple interventions impacting on multiple conditions, it has traditionally proved difficult to definitively link specific population-level interventions with specific outcomes. We do know that the potential positive health impact accrued from successful population-level interventions is greater than that for interventions targeted at high-risk groups. However, these interventions require more resource, and buy-in from the wider population and policy makers where interventions impact upon individuals who are unlikely to benefit personally. This is known as the prevention paradox where large proportions of a population who are at low risk receive no immediately discernible individual health benefit from a population-level intervention.

Celebrated Public Health case studies such as the North Karelia Project in Finland showed that population level interventions with buy-in from healthcare services, social care services, industry, regional government and local communities could reduce levels of coronary heart disease from global high levels to rates comparable with European neighbours. This was through changing health-impacting behaviours across the whole population, not just those who were identified as being at high risk. The British Family Heart Study intervention and the German Cardiovascular Prevention Project are both examples of large-scale population-level prevention programmes that showed a significant decrease in the prevalence of cardiovascular disease risk factors for the population participating. The evidence base has led to NICE recommending cross-sector population-level programmes within its Cardiovascular Disease Prevention Guideline (PH25)[2].

Population Health Management

It is clear that there is a strong rationale for matching evidence-based intervention and resource to identified population health need. A robust, effective, and equitable healthcare system requires effective systems for identifying and quantifying need. The population health management (PHM) approach encompasses a range of models which attempt to quantify levels of need through aggregation and triangulation of patient and population health data and effectively managing that identified need. A successful PHM model starts from the perspective of understanding people's lives and the impact that disease has upon them and modelling pathways of care around this rather than treating isolated episodes of illness. This means that systems must take account of social factors in designing service access and demand parameters. Healthcare providers such as Kaiser Permanente in the United States have suggested from their activity data that around four fifths of patients identified as being at highest risk of being the highest users of their services have at least one unmet social need[3].

This approach seeks to group patients with similar health needs. The population segmentation that PHM brings aims to quantify the multi-factorial increase in cost to health and social care systems of multi-morbidity and the impact of deprivation on health outcomes in specific health systems. The evidence base for PHM is, however, slim as the approach has only recently been taken up.

Examples of the successful impact of PHM on health systems and health outcomes are emerging, with case studies in the London Borough of Camden showing initial reductions in emergency admissions, emergency bed days, and overall secondary care financial savings. For diabetes, identification of untreated diabetes patients and consequent reductions in amputations and unplanned admissions was seen, leading to the borough achieving nationally-rates outstanding outcomes[4]. Imperial College has also undertaken early evaluation of five

[2] Cardiovascular disease prevention: Public health guideline [PH25]. 2010. Available at: https://www.nice.org.uk/guidance/ph25/chapter/1-Recommendations
[3] Shah N et al. 2016. Health care that targets unmet social needs. New England Journal of Medicine Catalyst (Note: this is a journal article rather than a peer reviewed paper where data would be available for scrutiny.)
[4] Sayer C et al. 2017. Toward accountable care: achieving value and integration via population health management. New England Journal of Medicine Catalyst.
(Same note as above.)

vanguard sites for risk stratification in England and published their report in 2017. While there is minimal robust evidence at this early stage in the vanguard sites' operations, it found early anecdotal evidence of improvements to tailored care for patients by paramedics and reductions in lengths of stay and delayed transfers of care (which are potentially linked to the programme). However, more time is required before the evaluation would be able to fully determine whether there is stronger quantifiable and attributable evidence for the efficacy of the programmes.

It may be the case that population health management will produce most benefit from triangulating and cross-referencing health-impacting data to identify where individuals are not accessing evidence-based healthcare or social support where the need is identified. Linking data sets may enable us to better assess whether the systems we have in place are working and where improvements can be made.

3. Our vision for the future

'what' is it that we wish to achieve across south east Essex

There is a desire from all partners to invert our existing model of care, for future solutions to be driven by the lived experiences of the public and staff within an area – for they know and appreciate the challenges faced within communities. The desire includes the mobilisation of all the assets at our disposal (within Local Authorities, Health and 3rd Sector) which can be used to engage communities and empower a supportive functionality.

It is the ambition for the system to move from a reactive model of care and enable an improved focus on prevention, self-care, personal responsibility, empowerment and wider community resilience. The model will articulate how support individuals require can be delivered against this backdrop that is person centred, integrated and that provide the best possible outcomes for the individual.

Locality Working - A Place-Based Approach

Traditional models of commissioning and provision have failed to deliver sufficient benefit to local communities. In line with national direction there is local move to adopt a place based approach, focusing on the needs of local communities as opposed to the amalgamated needs within traditional organisational boundaries.

The national agenda of public service reform and the integration of health and social care emphasise the growing requirement for localised responses to the demands and challenges facing health and social care in particular, and the public sector more generally. However, the perceived failure of conventional approaches to reduce inequalities and prevent problems is still leading to poorer outcomes for people despite local services responding to the complex needs of individuals, families and communities.

In response, policy and legislative developments are increasingly placing priority on collaborative working between people who provide services and those who use them. This aims to enable people to exercise choice and exert greater control over the types of support needed for better personal health and wellbeing outcomes by engaging partners with the flexibility and scope for innovation.

Place-based approaches may be one way of encouraging this way of working and may help to generate innovative ways to tackle some of these issues. This is explored in the examples that follow.

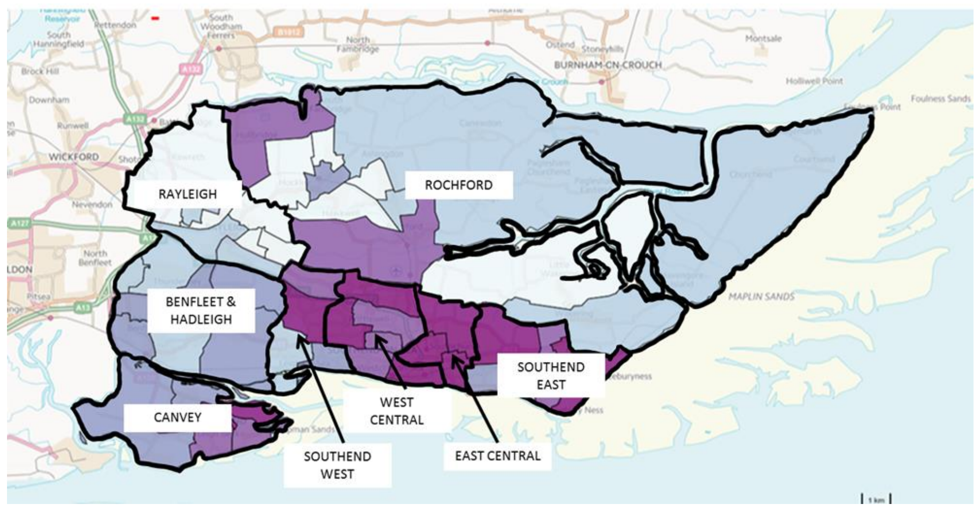
Traditional top-down approaches to change, or transformation, that rely on an overarching system (or national) view that is then broken down into sub-systems (local views) are not considered as the best option for maximising the collective power of individuals, communities and the third and statutory sectors. By focusing on the deficits, rather than the assets, top-down approaches can sometimes be criticised for undervaluing the importance of local knowledge and assets and, as a result, the differentiation between local and systemic/national issues becomes misunderstood. This can be problematic, particularly when thinking about

improving health and wellbeing, as it can cause us to think that the wider perspective is all that matters and prevent us from understanding local needs.

Place-based working is a grass roots, person-centred, approach used to meet the unique needs of people in one given location by working together to use the best available resources and collaborate to gain local knowledge and insight. By working collaboratively with the people who live and work locally, it aims to build a picture of the system from a local perspective, taking an asset-based approach that seeks to highlight the strengths, capacity and knowledge of all those involved.

There are a number of issues with the precursors to place-based approaches (e.g. active regional development, place-blind methods or community planning) such as a misdiagnosis of issues, lack of an asset-based approach, tokenistic community engagement and short-term horizons. Together, these have led to an increased demand for approaches that value the importance of place, while also understanding the need for embedded, person-centred ways of working. While these approaches sought to improve local resources, they didn't have any specific place-based considerations and therefore could be considered 'top-down' as opposed to community focused 'bottom-up' approaches. A place-based approach, on the other hand, acknowledges the complexity of people's lives by working in direct partnership with a range of people and provides one way of uncovering the needs and strengths of local communities.

Within SEE we have identified 8 Localities to work across in terms of a place-based approach, 4 in Southend and 4 across Castle Point and Rochford. These are as identified below, and illustrated on the map



System Ambitions

Improving Outcomes and a move to a sustainable, prevention and empowerment focused health and care system

It is collectively agreed that the current approach to commissioning, delivery and the subsequent monitoring of success is not conducive to supporting the development of a locality approach. Providers often have conflicting priorities as a result of different approaches to commissioning, and no ability to obtain a system view of current and future priorities.

It is considered that a move to measuring outcomes will address the first issue – and the system is in the process of identifying how an Outcomes Framework may be structured.

For this to be successful all parties need to agree the key outcomes the system wishes to achieve, and commission and provide services that ultimately contribute to the delivery of these

It has been agreed that outcomes should be relevant to an all age, all need population, and by definition is something that matters to

- The person
- The community
- The population as a whole

The outcomes need to reflect clinical quality, quality of service provision and ensure the right balance between this and personal experience/satisfaction and the need to assess outcomes for the whole population, as opposed to separating different population groups.

Current thoughts are built around the development of a three tiered approach to the framework

- Domains – what is important and SEE is intending to improve
  - Draft wording agreed and included in the slide deck for comment
- Outcome – outward facing narrative of what is to be achieved
  - Wording still requires agreement
- Indicators – how the outcomes are to be measured at a locality level
  - Agreed that whilst there is a likely to be a core set of indicators that are consistent across all localities, there is a desire to have locality specific indicators that reflect the needs of the specific population
  - As a principle utilise existing indicators if appropriate
  - Current localities not sufficiently mature to define their own indicators

Where appropriate these will need to be aligned with contracted KPI's

Commissioning partners across south east Essex came together and have agreed that the four domains that they wish to focus on are as follows

1. Health and Wellbeing: Indicators linked to population health outcomes, prevention, independence and lifestyle factors;
2. Care Quality and Experience: Indicators linked to positive personal experience, safe and effective care, and partnership development between people and community assets;
3. Sustainability: Indicators focusing on the impact of the integrated and collaborative working on financial and clinical sustainability of the community and the system; and
4. Transformation Drivers: This category includes measures that will help to drive improvements and change in the other outcome areas, in particular changing clinical and people culture.

Stating an ambition to work towards outcomes, instead of outputs, is not a new concept but one that has been voiced in a multitude of forums over recent years. It is also sometimes difficult to translate this ambition into reality. Whilst work is required to agree the set of indicators that will measure achievement of this it is not unreasonable to assume during the early stages of development the system will use existing measures to underpin and assess the approach.

As such the system should collectively work towards improve the following, existing, measures;

Health and Wellbeing		
Goal	Indicator	Source
Reducing inequality in life expectancy at birth	Slope index of inequality in life expectancy at birth within English local authorities	PHOF
Improving quality of life	Social care-related quality of life Health related quality of life for people with long-term conditions Quality of life for carers	ASCOF CCCG IAF ASCOF & CCG IAF
Improvements in the number of people physically active	Percentage of physically active and inactive adults	PHOF
Reducing childhood obesity	Child excess weight in 4-5 and 10-11 year olds	PHOF
Reducing Social Isolation	Proportion of people who use services, and their carers, who reported that they had as much social contact as they would like	ASCOF

Ensuring people have access to necessary information and advice	The proportion of people who use services and carers who find it easy to find information about services	ASCOF
Increase the number of people accessing therapies for common mental health conditions	Increase the proportion of people with a common mental health problem accessing Improving Access to Psychological Therapies (IAPT) treatment	IAPT data set
Care Quality and Experience		
Goal	Indicator	Source
Increase the number of people who are able to manage	People with a long-term condition feeling supported to manage their condition	CCG IAF
Reduce the number of premature deaths that should not occur in the presence of timely and effective healthcare	Potential years of life lost (PYLL) from causes considered amenable to healthcare	PHOF
Reducing the number of people attending A&E with mental health needs, who could have these met more effectively	Number/proportion of people attending A&E with mental health needs	To be identified
Improving staff health and wellbeing	Staff satisfaction, and reporting of 'I' statements	To be identified
Delaying and reducing the need for care	Proportion of people still at home 91 days after discharge	ASCOF
Overall satisfaction with services	Overall satisfaction of people who use services with their care and support Overall satisfaction of carers	ASCOF ASCOF
Increase the number of people who die in their preferred place/experience a good death	Percentage of deaths which take place in hospital	CCG IAF
Sustainability		
Goal	Indicator	Source
Measure the levels of co-ordination between hospitals, community and social care services	Delayed Transfers of Care attributable to the NHS and Social Care per 100,000 population	CCG IAF & ASCOF
Reducing the utilisation of hospital beds following emergency admission	Population use of hospital beds following emergency admission	CCG IAF
Reducing the utilisation of long-term residential/domiciliary care provision	Average age of patients starting long-term packages of care (residential or domiciliary)	To be identified

Development Process

Significant work has been undertaken during 2018 to develop and articulate the local model of care with key stakeholders.

It is anticipated that the interpretation of this model will be consistent across the eight locality areas that form the basis of the transformation programme, but with local variation for implementation where population needs, partnership offers and available 'assets' dictate.

At the heart of the Locality Model are the following principles

- Move from an acute-centric model of care to one that focuses on
  - Independence / self-responsibility adopting the principle of focusing on peoples strengths
  - Utilisation of community assets
  - Promotion of preventative activity and utilisation of the principle of making every contact count
  - Integrated working
  - Outcomes driven

- Move to a system of GP led care
- Enable locality models to develop utilising the collective opportunity of statutory, third sector, community and personal assets to meet the needs of the person and the population
- Enable cross organisational working to support the delivery of the collective outcomes
- This has resulted in the model as illustrated on the following page

The model is in full alignment with the STP Primary Care Strategy which has two key proposals at the heart of its model

- Moving away from a system in which services are principally GP delivered to one where services are GP led
- Encouraging and enabling practices to come together to form and lead localities serving populations of approximately 30 - 40,000 people

Principles behind the Model of Care

A strengths-based approach to care, support and inclusion says let's look first at what people can do with their skills and their resources and what can the people around them do in their relationships and their communities. People need to be seen as more than just their care needs – they need to be experts and in charge of their own lives.
Alex Fox, chief executive of the charity Shared Lives

The phrases 'strengths-based approach' and 'asset-based approach' are often used interchangeably. The term 'strength' refers to different elements that help or enable the individual to deal with challenges in life in general and in meeting their needs and achieving their desired outcomes in particular. These elements include:

- their personal resources, abilities, skills, knowledge, potential, etc.
- their social network and its resources, abilities, skills, etc.
- community resources, also known as 'social capital' and/or 'universal resources'.

Strengths-based practice is a collaborative process between the person and those supporting them, allowing them to work together to determine an outcome that draws on the person's strengths and assets. As such, it concerns itself principally with the quality of the relationship that develops between those providing and those being supported, as well as the elements that the person seeking support brings to the process.

The vision for south east Essex is the development of new models of care that align with the narrative above and are robust, resilient and sustainable while encompassing health, social care and third sector as well as the wider health and wellbeing of the individual. We want to work with the population as a whole on geographical footprints at sub CCG/LA level – these footprints are known as Localities – with populations between 30-50,000 people, enabling greater community design, and variability in approach and types/ways of service provision to meet the specific community needs.

It is essential that the Locality approach is built alongside resilient and sustainable General Practice and align with the movement to locality based primary care as described in the Mid and South Essex Primary Care Strategy. The success of the system is reliant on closer partnership working, and the collaboration of expertise and resources, by those working within localities.

The arrangement into Localities and the transition to a new model of care will also need to reflect the differing offers of partnership from the two Local Authorities within SEE.

The development of Localities is at the very core of and underpins the priorities for for Southend Borough Council (SBC). The Locality approach is pivotal to the Southend2050 visioning work and is supported by the closer matrix working across SBC.

During the course of 2018 SBC led the development of a resident and stakeholder ambition for the future of the Borough. The work has identified the sort of place residents and stakeholders want Southend to be. As a result

of this work 5 key themes / outcomes have been agreed which will be the drivers for how SBC engage with the development of Localities. The themes are;

- Pride and Joy;
- Safe and Well;
- Active and Involved;
- Opportunity and Prosperity; and
- Connected and Smart.

By 2050, Southenders are proud of what Southend has to offer, they feel safe in all aspects of their lives and are well enough to live fulfilling lives. By 2050 our communities are active and involved and feel invested, Southend is a successful place and our prosperity is shared amongst all people and the people can easily get in, out and around the borough, all supported by a world class digital infrastructure.

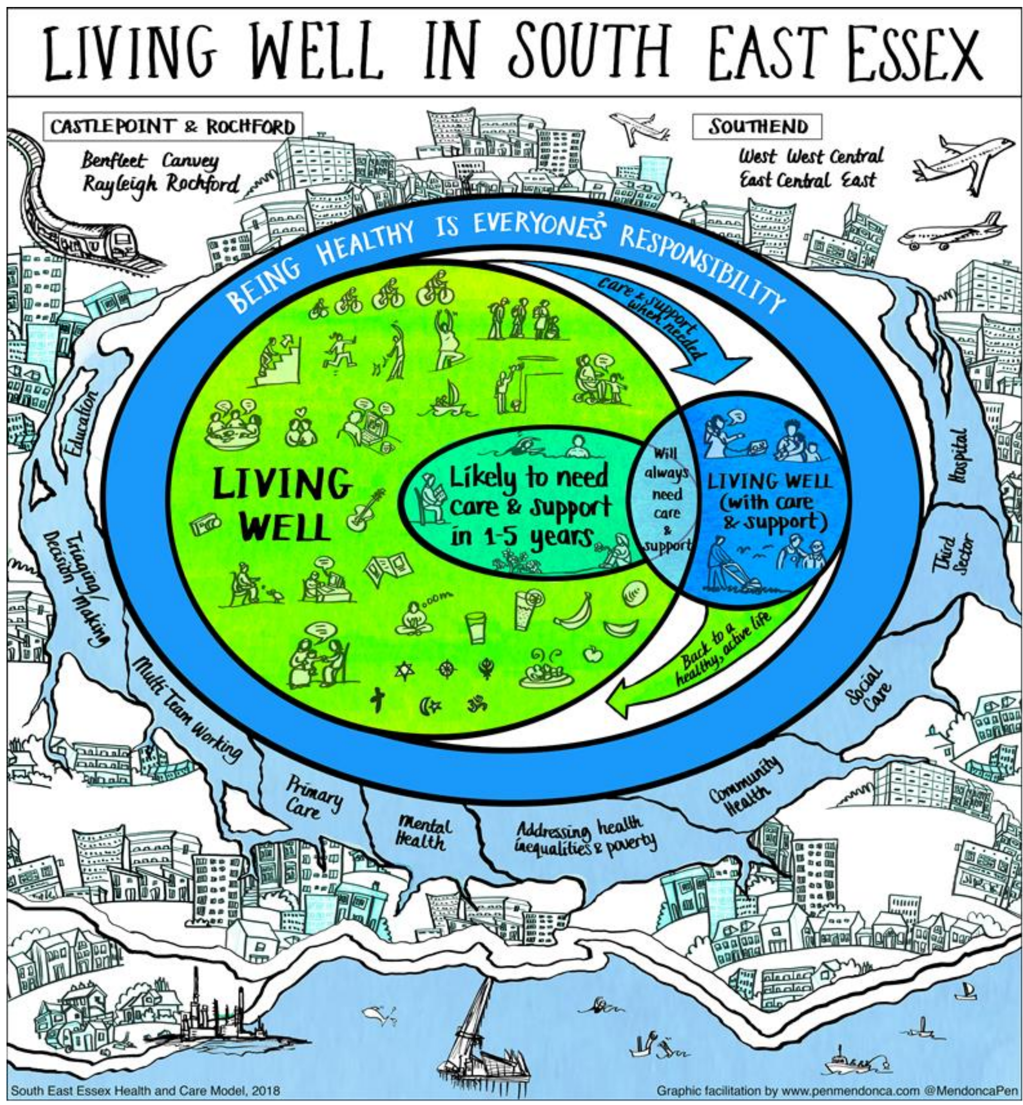
To deliver the themes and outcomes a roadmap has been developed which describes the journey from now to 2050. The roadmap focuses on the next 5 years and sets out clear actions that will be taken during this time.

The ambition for 2050 is at the very core of developing Localities in the Borough. Southend are committed to implementing this strategy and using all available resources innovatively to contribute to the delivery of the agreed outcomes.

The partnership working offer from Southend is mature enough to be able to mobilise resource and assets across the entire Local Authority spectrum.

The offer from Essex County Council (ECC) is as equally detailed as SBC but different. ECC want to see a transformational shift from a focus on long-term care and support to those in crisis to early intervention and enabling people to live independently for as long as possible, by making the best and most sustainable use of all available resources. ECC is committed to working with partners as part of multi-disciplinary teams and delivery of the locality model built on a foundation of integrated working.

The Model of Care



The model of care designed for south east Essex is one that focusses on enabling people to remain independent. It is a model that moves the focus to pre-emptive and pro-active care and ensuring communities and individuals have access to the necessary assets to enable this to happen.

In addition to this ambition for the whole population it fundamentally focuses on the community as consisting of four distinct cohorts

1. Those that do not require care or support at this point in time, nor are they expected to require care or support over the next five years
2. Those that, based on a variety of factors are likely to require care and support within the next five years, and the expectation that they are identified and provided able to access solutions that either defer or delay the requirement for care
3. Those that, despite of the best intentions of the individual, their community and support network do require the support of formal services – in this instance the system collectively works to ensure they continue to live well with care and/or support in place and return to living an unsupported healthy and active life in a safe and timely manner, and
4. Those that will always need care and support who will receive services that enable them to live well regardless of the complexity of need

The Role of the Hospital

In any health and care economy the physical status of the local acute trust gives the public the impression that this is the default place to get their needs met – be it through the clinical advice of a consultant for on-going management of a long-term condition, or through the 'easy' access to medical support through the front door of the Accident and Emergency department. South East Essex is no exception with the model of care that has evolved, certainly in terms of current spend, being particularly acute centric – this is despite the fact that 90% of health contacts are undertaken across both primary and community care providers and outside the walls and responsibilities of the local acute provider.

Whilst the 'Living Well in Thriving Communities' model has a focus on personal and community resilience and the strengthening of support available within the community (primary, community and through social care), there is no denying that people will continue to need a level of care and support that is either best provided, or overseen, by the clinical/medical expertise available through an acute provider. The model of care however places an emphasis on both timely – and where possible pre-emptive - intervention and the pro-active return of individuals to their normal place of residence with any required on-going care and support delivered outside of a hospital ward.

For this to be successful there would be an expectation that those responsible for delivering support within the locality setting link with acute colleagues to ensure the care provided is seamless, and the drive is to ensure the individual returns to their normal place of residence in a safe and timely manner.

Principles of Collaboration

As individual organisations each partner has already stated their own vision and values. Whilst these are specific to each individual organisation, and would have been developed through wide organisational and stakeholder engagement, all organisations have common themes running through their values. Using these individual organisational values it is possible to extract a number of key principles that the system wishes to work to

- It is accepted that the combined strength of the system is greater than the individual strengths of the organisations that make it. As such a principle of **collaboration** shall be adhered to across south east Essex to address the challenges, and deliver the model as described in this document
- Previous attempts to redesign the system have failed in part as a result of what it sometimes referred to as the 'fortress mentality' – in order to overcome this the partners will be **open and honest** in the interactions with each other and the populations which they serve
- Underpinning both of these is need to be **compassionate and supportive** – not only towards the populations that they serve, but also to individual organisations positions. The system has a greater chance of overcoming challenges together, and accepting them as system challenges, as opposed to separate organisational ones

Ambition for the System

The local landscape

In this section we have set out our vision and described a number of the changes we want to make. These include:

- A focus on the importance of place/localities as a unit of planning
- A commitment to integrating services around the needs of individuals and communities
- Placing a strong emphasis on prevention
- Collectively defining and agreeing a single set of outcomes
- An expectation that collaboration will be the norm
- Enabling and encouraging local teams and professionals to have greater flexibility so that they can be driven by people's needs, not organisational or professional silos

We know that a key factor that will influence how rapidly we are able to make progress in delivering this plan is how effectively we, as a set of organisations, work together. If we work well, we will create an environment which supports and accelerates change; if we do not, there will be frequent obstacles and change will be slow.

We recognise that our local landscape is complex, with a large number of statutory and non-statutory bodies involved in the planning, funding and provision of services. In addition, not many of our organisations share a common geographic footprint, and most are simultaneously members of multiple 'systems' – sometimes very local, such as at neighbourhood or ward level, sometimes at all Southend or Castle Point or Rochford level; sometimes all of Essex or a sub-set of it; and sometimes at a regional or even national level.

There is no simple structural or organisational way of cutting through this complexity, and we are concerned that a focus on organisational form will be distracting. Therefore, our approach is to focus on two elements that we think will enable us to make the quickest progress in implementing our strategy: developing a Memorandum of Understanding; and taking a pragmatic approach to integration.

Memorandum of Understanding

While we have worked well as a set of organisations to develop this strategy, we know that delivering the changes we have set out will require us to go further and deepen our partnership.

Therefore, we have committed to developing a Memorandum of Understanding (MoU) that will set out in clear language how we will work together, what principles we will follow and how we will behave. Whilst not legally binding, the MoU will clarify and codify the commitments we are making to one another and to local people.

We will develop this agreement over the coming months, and will ask all of our Boards and equivalent decision-making fora to formally sign up to this MoU. We aim to complete this work by the end of March 2019.

Features of integration

We know from other systems that there are a number of aspects or features that can help partnerships such as ours to successfully deliver ambitious plans like ours.

These span a spectrum from systems that have very limited integration to those that are highly integrated, with each displaying different features:

Our guiding principle in deciding where to place ourselves on this spectrum is to be pragmatic, and take decisions on an issue by issue basis. For example, if a particular aspect of our plan would best be delivered by a single organisation taking the lead on behalf of the wider system, then that is what we will do. Conversely, if we

consider that progress will be quicker by being much more integrated – for example by having delegated decision making, single teams and pooled budgets - then this is what we will do. Our over-riding principle is one of pragmatism – what matters is what works.

4. How we will implement our vision

How we plan to bring all of this together, including those things that are 'do once' either south east Essex wide or wider and the Development of the eight localities

Previous change programmes have generally operated in a way that separated commissioner and provider discussions. This has resulted in less than optimal implementation of solutions as there are often differences in interpretation of message when discussions are undertaken in separate rooms

Delivery of the ambitions stated in this document are reliant on system-wide transformation. It is reliant on clarity of message, consistent interpretation of asks and consistent understanding of answers. It will fail if organisational interests, or commissioner and provider separation, drives the discussions.

The success is reliant on strong partnerships across the system, between organisations, between staff and between the communities and individuals which they serve.

What are we going to do once?

We will ensure that where it makes sense to 'do things once' that the system will support this. This document clarifies the expectation that strategic direction will be defined once across the system, with this supported by a single approach to

- Defining the Model and ensuring consistency in model development where this makes sense. This includes
  - Where gaps in interventions or functions are identified within localities where this gap exists across multiple localities a single approach will be strived for – an example may include self-care and support resources for carers or those with on-going care and support needs
  - Standard operating procedures for functions such as MDT's or social prescribing
- Agreeing locality population health and wellbeing outcomes
- Developing and delivering an approach for the definition, extraction and analysis of information needed to support locality development
- Engagement and co-production with individuals, communities and organisations in south east Essex for development of localities and new operational service models

Current status of Localities

Discussions to date have identified a number of key elements that contribute to a strong locality model. A desk top assessment has been undertaken across these areas for the eight localities to develop a baseline of maturity as summarised below

	Benfleet & Hadleigh	Canvey	East	East Central	Rayleigh	Rochford	West	West Central
Primary Care Collaboration	◕	◑	◔	◑	◔	◑	◑	◔
Locality MDT's	◕	◕	◕	◕	◕	◕	◕	◕
Locality Design Teams	◑	◑	◑	◑	◑	◑	◑	◑
Social Prescribing	◔	◔	○	○	◔	◔	○	○
Locality Co-ordinators	◔	◔	○	○	◔	◔	○	○
Community Mental Health	○	○	○	○	○	○	○	○
Locality Health Needs Assessments	○	○	●	●	○	○	●	●
Suitable Estate Solution	◔	●	○	◑	◔	◔	◑	◑
Shared Data Solutions	◑	◑	◑	◑	◑	◑	◑	◑
Use of data to deliver Care	○	○	○	○	○	○	○	○

As part of the development of individual Locality Implementation Plans (see below) this desk top evaluation will be repeated with frontline staff and communities to get a consistent view of current provision and identify both locality and system areas of priority for development.

Locality Variation

It is acknowledged that whilst we can simplify need and challenges across the wider footprint each locality will have its own specific nuances based upon the key determinants of health

- Health behaviours such as tobacco use, Diet and Exercise and Alcohol and Drug use
- Access to and quality of clinical care
- Social and Economic factors such as Education standards, Employment levels and Income
- Physical Environment such as Air and Water quality and housing and transport

Collectively these contribute to the length and quality of life of an individual

Whilst further work is required in understanding the nuances between localities using the proxy measure of Life Expectancy and Health Life Expectancy it is undeniable that the variation across the footprint is unacceptable.

As of the 2011 census there is a 20 year gap between the areas with the highest and lowest expectancy levels across south east Essex

Life Expectancy

- Men born within the Kursaal Ward of Southend, and within Southend East Central Locality, has a Life Expectancy of 73.58 years compared to
- Women born in Hockley West, and within the Rochford Locality, has a Life Expectancy of 94.92 years

The variation in Health Life Expectancy is just as stark

- Men born within the Victoria Ward of Southend, and within Southend East Central Locality, has a Health Life Expectancy of 55.62 years compared to
- Women born in Hockley West, and within the Rochford Locality, has a Healthy Life Expectancy of 76.08 years

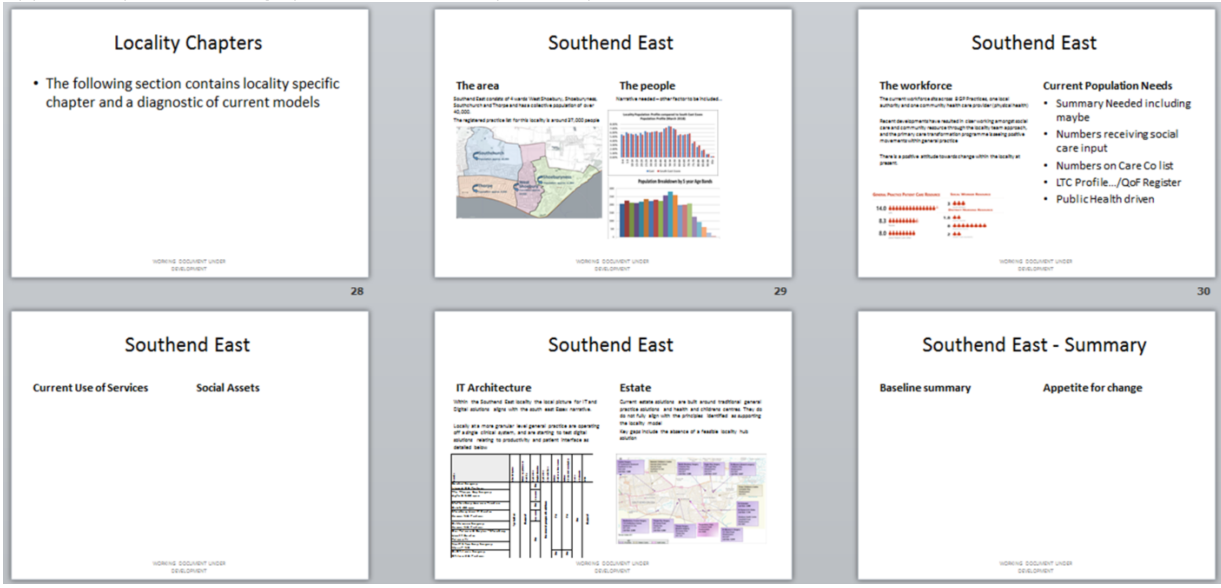
Detailed, and summary, locality needs assessments are being developed for each area, examples for the four Southend Localities can be seen in Appendix 1.

Locality Implementation Plans

In order to progress each locality will need to undertake a diagnostic that looks into the current situation in that area, assessing current and future needs of the population against the assets available to them. An example of what this may look like is included below. Following approval of 'Living Well in Thriving Communities' work will progress at pace to complete these, and develop locality level development plans that aim to address the gaps identified. These are likely to cover

- The need/service offer gap
- The numbers and skill mix required to close this gap, after any productivity opportunities
- Any estate implications
- An approach to innovation and digital

It is expected that the system look at innovative ways to address these gaps, including through alternative utilisation of available resource, and the refocusing of assets towards areas identified as providing the biggest opportunity to delivering system sustainability and improved outcomes.



Transformation Oversight

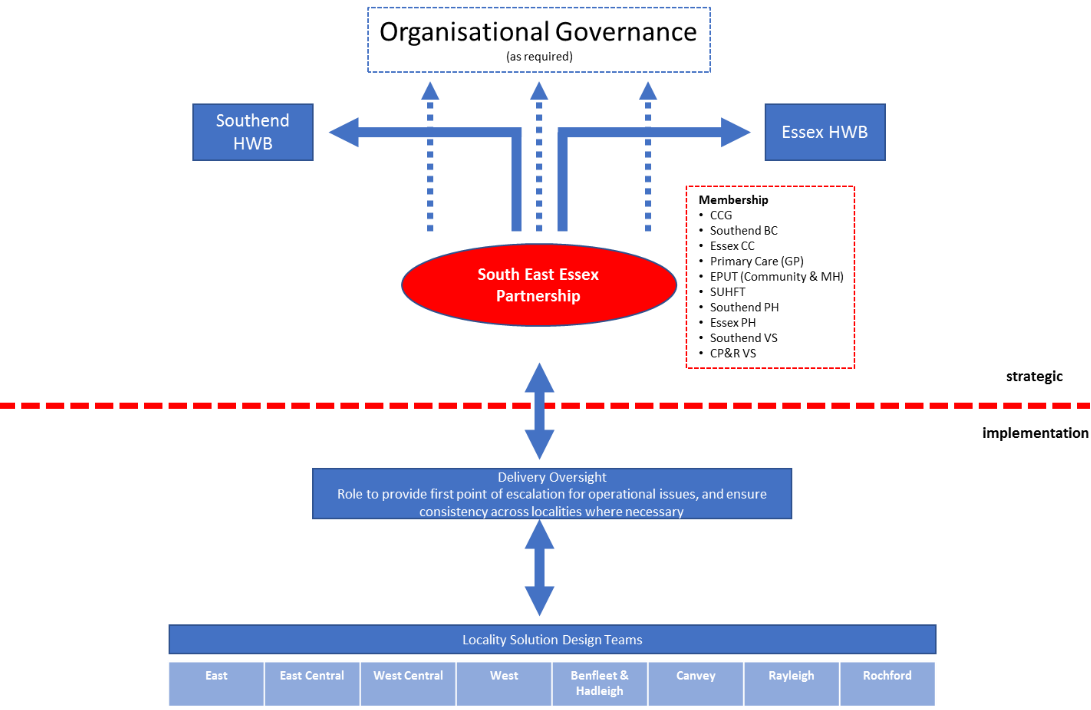
Programme oversight will operate through an approach of integration and collaboration – not one of separation. The arrangements that are evolving, and summarised below, are built on this principle and it is clear that it will require organisations, and interests, to be represented in multiple forums.

In regards to provide leadership and programme oversight the approach as described below shall be followed

1. The South East Essex Partnership will take on the role of Programme Board, providing system leadership and oversight to ensure delivery of the model, and any key challenges and risks to implementation are resolved

2. Operational design will be through both co-design and co-production at locality level, utilising where appropriate existing design teams that have been so effective to date in implementing practical on-the-ground changes to service provision
3. A forum will be developed that bridges the gap between these tiers to ensure operational challenges are addressed in a timely manner, there is a consistency of solution design where this is necessary, and there is strong cross learning arrangements in place between the eight localities to ensure best practice is implemented across the wider patch

The SEE Locality Partnership, launched in May 2018, will report into organisations governance channels where necessary, and into both Southend and Essex Health and Wellbeing Boards. Representation at this forum will be through senior executives of represented organisations to ensure the Partnership can effectively deliver against its objectives.



We will use this structure to programme manage the system transformation, including identifying available resource, system priorities and unblock issues that are impacting on delivery. We will ensure that there is cross fertilisation of all elements to ensure all stakeholders are involved in appropriate discussions, and that work is not undertaken in areas that do not align with the wider strategic vision.

The implementation will include the development of individual Locality Diagnostics and Implementation Plans, identifying the assets and deficits of the local areas, and developing plans to address these at a local level with the support of the wider system.

5. Enablers

Delivery of this model is reliant on many factors, a number of which cut across this ambition and others already in place.

It is not the desire to duplicate work, or further separate workstreams depending on strategic driver, but to bring together and align approaches to deliver the best possible outcomes.

As such a number of key enabler programmes of work will be needed to support the transformation to a new model, and where possible these will align with principles already agreed.

These principles are as outlined over the following sections

Engagement, Communications and Co-design

The development of Locality based models of care, which focus on prevention, personal empowerment and community resilience and the underlying principle of services and interventions being developed around the needs of the population, relies heavily on the assumption that local people will be involved in all levels of developing, implementing, reviewing and assessing the new models of care.

To support the development of localities the system needs appropriate resource from all organisations working to implement an engagement strategy built on

- the principles of involving, collaborating and devolving as described in the ladder of engagement – and evolution from current approaches to engagement, and
- an approach that enables system wide, and cross locality, communications and engagement where appropriate and specific locality focus to meet separate needs and requirements

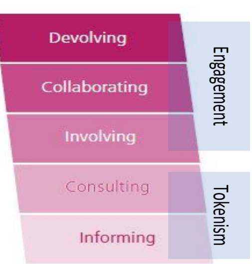
It is anticipated that shared resources are identified to address and manage these requirements and that a joint plan is developed and implemented to support the wider transformation of the system

This has been identified as a key risk to delivering any new model of care.

The 'Ladder of Engagement and Participation'

There are many different ways in which people might participate in health depending upon their personal circumstances and interest. The 'Ladder of Engagement and Participation' is a widely recognised model for understanding different forms and degrees of patient and public involvement, (based on the work of Sherry Arnstein[7]). Patient and public voice activity on every step of the ladder is valuable, although participation becomes more meaningful at the top of the ladder.

Devolving	Placing decision-making in the hands of the community and individuals. For example, Personal Health Budgets or a community development approach.
Collaborating	Working in partnership with communities and patients in each aspect of the decision, including the development of alternatives and the identification of the preferred solution.
Involving	Working directly with communities and patients to ensure that concerns and aspirations are consistently understood and considered. For example, partnership boards, reference groups and service users participating in policy groups.
Consulting	Obtaining community and individual feedback on analysis, alternatives and / or decisions. For example, surveys, door knocking, citizens' panels and focus groups.
Informing	Providing communities and individuals with balanced and objective information to assist them in understanding problems, alternatives, opportunities, solutions. For example, websites, newsletters and press releases.



Workforce

The Primary Care Strategy articulates the challenges faced within General Practice. It describes how a mix of rising demand, and an aging workforce, is leading to a situation where the capacity will not exist to meet the needs of the population under the current model of General Practice.

This is the same situation faced by social care and community health services. Continuing to operate within the boundaries of traditional roles and responsibilities will not enable the system to improve outcomes for patients

– and there is a real possibility that continuing in the same manner will not even enable the system to maintain the outcomes that it currently achieves.

Where care is needed it is important that the workforce is developed in a way where duplication is minimised – the anecdotal stories of multiple professionals visiting a patient in one day due to service 'specialisms' need to become a thing of the past.

In order to address this the system needs to move towards new roles, combining competencies so staff can address a more comprehensive range of needs, and enable best use of the resources available in the system.

This movement to new roles and ways of working will be driven from the ground up – as teams working in localities identify skills and knowledge gaps the system will work to address these rapidly through continuous training, shared across partners. Where the views from the public and frontline staff need to result in a strategic change across a wider system – for example educational bodies – this will be linked through workforce forums, such as the Local Workforce Action Board (LWAB) which has, according to Health Education England (HEE), two areas of responsibility; supporting STPs across a broad range of workforce and HR activity, and the local delivery of the HEE Mandate from the Department of Health and other key workforce priorities in line with national policies.
Its core functions form the pillars of the HEE offer to STPs and include:

- developing a clear understanding of the current and currently foreseeable future workforce – through robust workforce intelligence,
- a robust workforce strategy,
- a workforce transformation plan, and
- leadership and OD support to enable staff, patients and carers to confidently and competently lead change across pathways, organisations and systems.

The work of this strategic forum needs to be influenced by the on-the-ground learning that will come from local implementation.

Mirroring the approach of the Primary Care Strategy we have also identified a number of areas where, working as a system, we need to do more. We will need to agree how the work is co-ordinated but the local system needs to focus on

- Recruitment - we will develop system wide recruitment campaigns, including holding information evenings and running regular assessment centres for cohorts of staff. In this way, we think we will achieve a higher profile for the local system, our STP, encourage more applicants for local roles and be able to establish and 'at scale' approach to recruitment.
- Retention - we will explore the further steps we can take to encourage and enable existing staff to continue to work and contribute locally. This will include looking at incentives for key groups, better meeting development needs and identifying clearer opportunities for career progression.
- Workforce intelligence - we recognise that having clear, timely and accurate local workforce data is key if we are to plan effectively at CCG and higher at a STP level. We will work more closely with HEE, the Local Workforce Action Board and front-line staff to develop our workforce intelligence.
- New roles and job design - our new model of care relies on recruiting a wider range of staff, but also on developing new roles. In order to minimise duplication, we plan to work as a system to develop a common approach to these roles, such as standardised job descriptions, person specifications and competency frameworks.
- Role rotation - we are keen to explore how we can make all roles more attractive and rewarding. One aspect we will look at is designing roles that enable staff to move across localities and care settings. We think that such a development will lead to higher job satisfaction, improved professional development and better recruitment and retention.
- Training and development - our new model of care places considerable emphasis on all staff working to the top of their skill set. As a result, having comprehensive, ongoing training and development programmes for all staff groups will be vital.

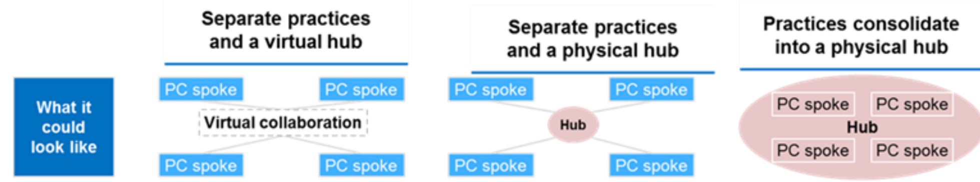
Estates

The principles of local health and care estates is consistent with the principles included in the STP Primary Care Strategy, and aligns with the recently drafted STP estates strategy.

Whilst it is anticipated that new ways of working will result in a likely change of setting for health and care interventions – ranging from self-care at home and community support, to provision of statutory services in fit for purpose estate – it is acknowledged that a significant amount of interventions will fall into the latter category.

As a starting point, all services should be provided in premises that are accessible, attractive and of high quality. But to fully deliver our new model of care we need to go further, by developing physical or virtual hubs that support locality working, provide accommodation for the staff we anticipate will deliver the model of care, enable services to be integrated and - where possible - co-located and be available for wider community level utilisation.

The Primary Care estates solution for service provision will be built around a hub and spoke model, with there being a number of possible interpretations, and it is expected that this aligns with the wider estates solutions for the local model of care.



There are a number of principles the system will work towards when developing future estates plans

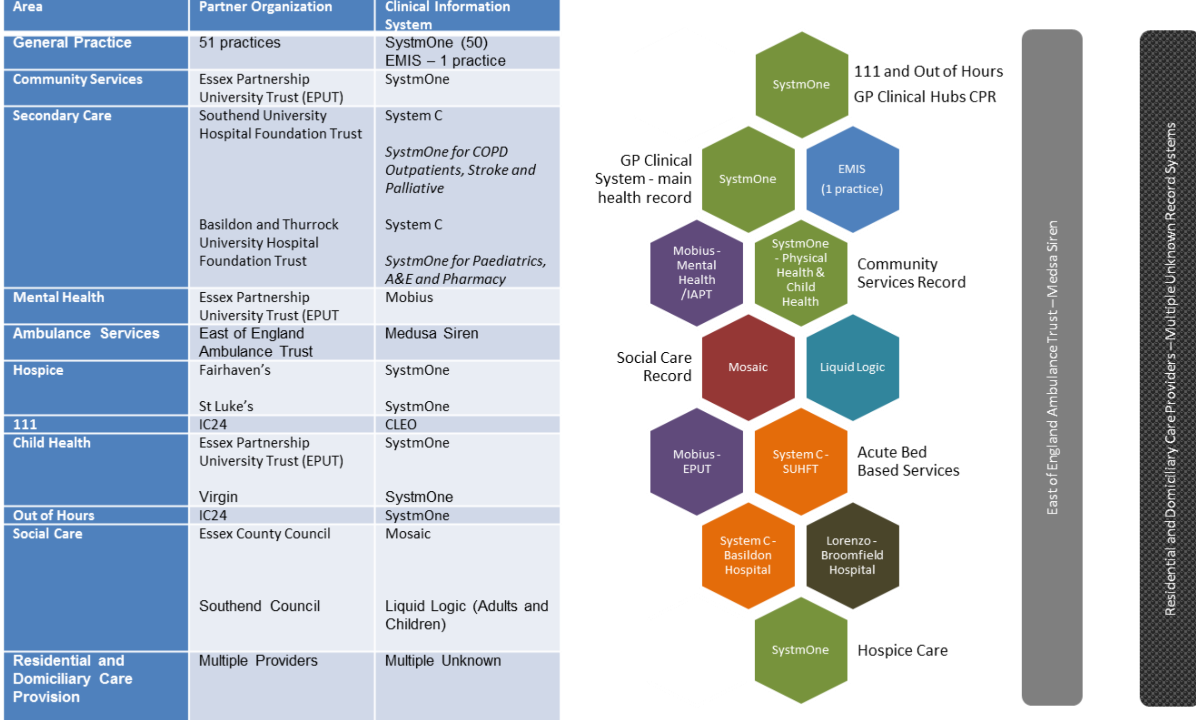
- Each locality will have a Health & Social Community Care "Hub" providing integrated services including primary care, out of hospital, community, and third sector services;
- The Hub will provide services to at least 30,000 residents and must have the ability to operate 24 hours a day, seven days a week;
- The accommodation will be as flexible and generic as possible to allow an entire range of services to be delivered from it. There will be as little specialised clinical space as possible and dedicated space will be kept at a minimum;
- The precise services that are to be delivered from each Hub has yet to be defined and so, where a new facility may be required, the size of this cannot yet be determined. However, where a suitable Hub already exits, the service model may be influenced by the existing accommodation;
- If a suitable building already exists in a Locality that could be used as a Hub it must be identified as such providing it:
- Has the capacity to accommodate existing services plus a range of integrated care services;
- Is fit-for-purpose or could be made fit-for-purpose.
- Any LIFT building i.e. Canvey PCC that has a long-term lease commitment must be identified as the Locality Hub.
- Each Hub will have a number of spokes, dependant on the requirements of that locality;
- We will make best use of the available estate, such as Childrens Centres, in designing how the model will be implemented locally

IT Systems

It is an undeniable fact that health and social care decision making is at its optimum when the professional has access to the most complete set of person specific information.

Unfortunately historic and current arrangements for commissioning and providing services have not encouraged collaboration across health and social care organisations when making decisions around IT architecture.

This has resulted in a fragmented arrangement of clinical and social care record systems, which in the main do not have the ability to interact with each other – the diagram and table below illustrates current arrangements



Area	Partner Organization	Clinical Information System
General Practice	51 practices	SystmOne (50) EMIS – 1 practice
Community Services	Essex Partnership University Trust (EPUT)	SystmOne
Secondary Care	Southend University Hospital Foundation Trust	System C *SystmOne for COPD Outpatients, Stroke and Palliative*
	Basildon and Thurrock University Hospital Foundation Trust	System C *SystmOne for Paediatrics, A&E and Pharmacy*
Mental Health	Essex Partnership University Trust (EPUT	Mobius
Ambulance Services	East of England Ambulance Trust	Medusa Siren
Hospice	Fairhaven's St Luke's	SystmOne SystmOne
111	IC24	CLEO
Child Health	Essex Partnership University Trust (EPUT) Virgin	SystmOne SystmOne
Out of Hours	IC24	SystmOne
Social Care	Essex County Council Southend Council	Mosaic Liquid Logic (Adults and Children)
Residential and Domiciliary Care Provision	Multiple Providers	Multiple Unknown

It is essential that the system collectively identifies a way to overcome the challenges this creates. In order to do so the following principles are proposed in regards to IM&T infrastructure changes.

- IM&T changes will be driven by business or clinical need.
- New technologies may stimulate business or clinical change but will not drive it.
- Systems installed will be exploited to provide maximum benefits.
- Choice of systems will include requirements for interoperability.
- Choice of providers will include understanding their own development plans to ensure they are innovative, pro-active and in-keeping with the direction of the local system.

Digital Innovation

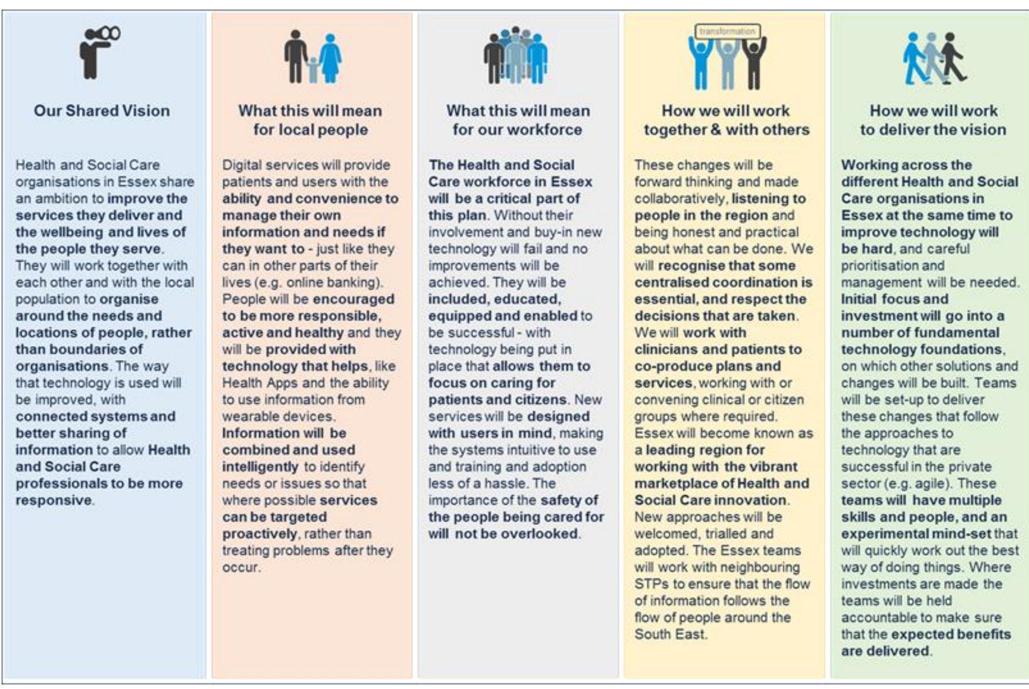
We know that the use of digital and other technologies across health and care settings as drivers for change is generally poor. In a world where people can bank, shop, arrange travel and 'socialise' through technology the offer locally to people for digital solutions to health and care needs is lacking.

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

We know that the use of digital and other technologies will be a key enabler for our future model of care. Digital and other technologies have the potential to help with the better management of demand, create capacity

within services, reduce bureaucracy and support localities to operate at scale. We also know that to date we have made limited progress in this key area; work has been somewhat fragmented and we lack a unifying vision and architecture.

The Mid and South Essex STP Digital Strategy 2018 includes the following Digital Vision statement. This has been developed in collaboration across the whole of Mid and South Essex and all key stakeholders within south east Essex.



The Primary Care Strategy also states that there are considerable opportunities to improve efficiency by taking a more systematic approach to the adoption and spread of digital technology. Without repeating the contents of this paper the following should be noted within this strategy

Digital as an enabler

It is anticipated that a number of potential solutions which, taken together, could help the system close the gap between demand and capacity. Several of these solutions are dependent upon, or would be significantly enhanced by, the systematic deployment of digital solutions. Examples include:

Managing demand

- *Self-care and community support*. These tools are well developed and have a range of applications, including apps and software that support behaviour change (for example people with diabetes) as well as providing online support for people with a wide range of conditions including anxiety and depression
- *Prediction and risk stratification*. There are a number of established tools that can support practices to risk stratify patients on their list and identify those patients that have 'rising risk'. This enables comprehensive care plans to be put in place for these individuals, enabling them to stay well for longer

Creating capacity

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

Operating at scale

- *Communication across settings*. Having access to patient level information across a range of care settings is vital, especially as patients are frequently in contact with multiple services. As well as

a core shared core record, further digital solutions now enable summary records to be held on smartphones, and for automatic communication with patients (such as appointment reminders, medication alerts etc.)

It is intended that local transformation aligns to the wider strategic intent included within the pan Essex document 'Digital Essex 2020' and the Primary Care Strategy, and that we utilise the collective voice of the South East Essex Partnership to influence these other programmes of work.

6. Next steps/timeline

As is the case with any proposed transformation stating the ambition and vision is only the first step. As has been articulated throughout this document work has been progressing locally in the absence of this single narrative.

Whole scale system change – and particularly the cultural change that is required to successfully deliver the ambition in this document – takes time, and needs to be supported by a methodical approach to delivery.

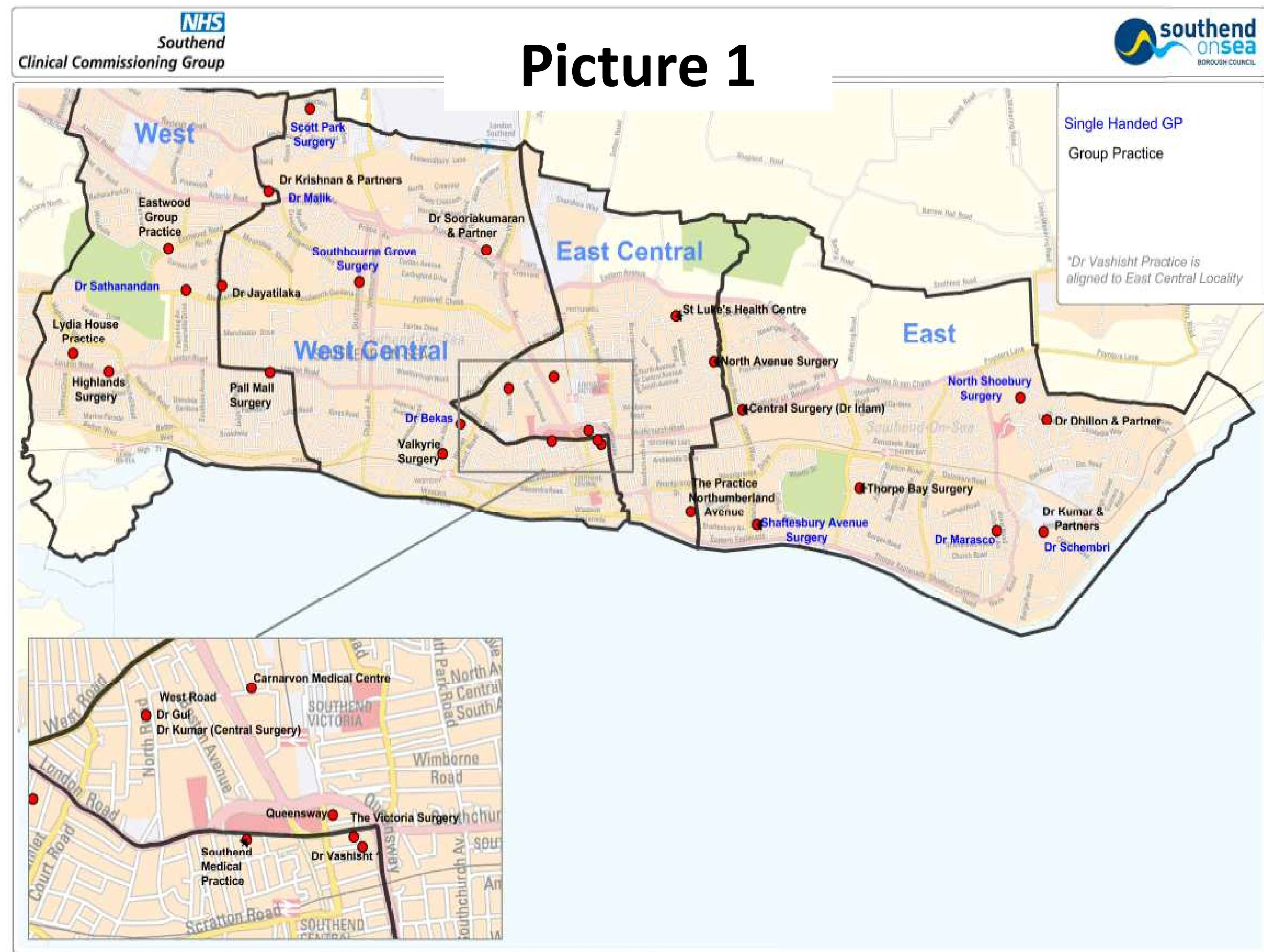
This approach will need to be organic in its nature to adapt to the changing requirements of the system, and the learning that will be developed through closer working with the populations served.

In order to ensure the programme receives the impetus required the following has been identified as key steps to be taken before the end of the current financial year, at the end of which more detailed locality specific plans are intended to be in place, and final arrangements for the necessary governance between the South East Essex Locality Partnership and front line staff are agreed

		Next Steps			
October	November	December	January	February	March
Develop two (1 ECC & 1 SBC) Locality Diagnostics & Implementation Plans			Develop final six (3 ECC & 3 SBC) Locality Diagnostics & Implementation Plans		
Working Group Implementation Plan Dev't	Roll-out of Implementation plan for creation of multi-agency teams				
Development of Multi-Agency approach to Communications, Engagement and Co-Production					
Stakeholder Engagement Event					
Finalise South East Essex Outcomes Framework					
Progress development of Memorandum of Understanding and Ambition for SEE Locality Partnership					

7. Appendices

Appendix 1 – Locality Needs Assessments



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Southend East Locality

Introduction

East comprises a number of distinct areas within the Borough of Southend. Firstly, four wards make up the East Locality; Shoebury, Southchurch, Thorpe and West Shoebury. Picture 1 shows the boundaries for East. There are circa 36,000 people registered to GP practices in East as compared to the Ward population of circa 41,500. The difference is attributed to patients being registered to GP practices outside of East.

The split of male to female is equal. East has a smaller proportion of male adults of working age, particularly between 30 and 44 and a higher population of people aged between 65 and 69.

The population is set to increase in coming years. Projections show that East will increase by a further 4,036 residents by 2029 and a further 1,000 residents over the age of 75 by 2029. These projections do not include any housing developments.

Key Challenges

Deprivation & Wider determinants of health – There are 107 Lower Super Output Areas (average 1,500 residents) in Southend of which 26 are in East. 5 of these are in the 10% most deprived areas in England. Deprivation, employment, housing and education is directly linked to life expectancy and length of disability free life. Residents in East are statistically more likely to have higher levels of **mental illness**, increased likelihood of developing **a long-term illness** (respiratory, cardiovascular disease) and a higher prevalence of **unhealthy lifestyle behaviours** (obesity, physical activity and smoking). Children from East are more likely to experience an acute illness leading to a hospital admission, are less likely to maintain a healthy weight and more likely to experience emotional and behavioural problems.

Wider determinants of health and wellbeing – Data in East suggests that residents face challenges around housing, education, employment, air quality and crime. These wider determinants all contribute to a residents health and wellbeing and their likely need to interact with services.

Long Term Conditions – East has a greater percentage of patients diagnosed with respiratory illness, heart disease and hypertension compared to Southend.

Long Term priorities

1. **Improve Health and Wellbeing (Safe & Well)** – measured through people feeling safe and secure at all times; people are remaining well enough to enjoy fulfilling lives; and the most vulnerable in our community are effectively protected and have their quality of lives improved;
2. **Improve Care Quality and Experience** – measured through positive personal experiences, safe and effective care and partnership development between people and community assets;
3. **Sustainability** – sustainable impact of the integrated and collaborative working on financial and clinical sustainability of the community and the system;
4. **Channel Shift (Active & Involved)** – we have a thriving, active and involved community that feel invested East; the benefits of community connection are evident as more people come together to help, support and spend time with each other; a range of initiatives help communities come together to enhance their Locality and environment.

12 month plan

1. **Improving access & reducing the impact of the wider determinants of health;** for the moderate needs individual via the Multi Disciplinary Team function currently in operation (addresses all four challenges) and closer collaboration between organisations in East Central;
2. **Improving access** to preventative support via pharmacy hubs and the development of hubs in East (addresses three challenges);
3. **Enabling the integration and the development of the hub model to encourage use** of voluntary sector assets in health and care models with a focus on prevention (addresses three challenge);
4. **Creating an environment** through which people are empowered to make decisions about themselves and their own lives (addresses three challenges).

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Southend East Central Locality

Introduction

East Central comprises a number of distinct areas within the Borough of Southend. Firstly, three wards make up the East Central Locality; Kursaal, St Luke's and Victoria. Picture 1 shows the boundaries for East Central. There are circa 60,000 people registered to GP practices in East Central as compared to the Ward population of circa 35,000. The difference is attributed to patients living in a different Locality and GP practices being located on the Locality border.

The split of male to female is equal. East Central has a larger proportion of children and young people under 25 years, and a larger proportion of adults of working age, particularly males between 25 and 39. The population of people aged over 65 is lower than Southend average.

The population is set to increase in coming years. Projections show that East Central will increase by a further 3,800 residents by 2029. This doesn't include regeneration developments, Queensway for example.

Key Challenges

Deprivation & Wider determinants of health – There are 107 Lower Super Output Areas (average 1,500 residents) in Southend of which 19 are in East Central. 5 of these are in the 10% most deprived areas in England. Deprivation, employment, housing and education is directly linked to life expectancy and length of disability free life. Residents in East Central are statistically more likely to have higher levels of **mental illness**, increased likelihood of developing **a long-term illness** (respiratory, cardiovascular disease) and a higher prevalence of **unhealthy lifestyle behaviours** (obesity, physical activity and smoking). Children from East Central are more likely to experience an acute illness leading to a hospital admission, are less likely to maintain a healthy weight and more likely to experience emotional and behavioural problems.

Living Alone – Recent data indicates that over 40% of the population in East Central aged over 65 years and over are living alone, much higher than the Southend average (34%).

Long Term Conditions – East Central has a greater percentage of patients diagnosed with respiratory illness, heart disease, depression and hypertension compared to Southend.

Long Term priorities

1. **Improve Health and Wellbeing (Safe & Well)** – measured through people feeling safe and secure at all times; people are remaining well enough to enjoy fulfilling lives; and the most vulnerable in our community are effectively protected and have their quality of lives improved;
2. **Improve Care Quality and Experience** – measured through positive personal experiences, safe and effective care and partnership development between people and community assets;
3. **Sustainability** – sustainable impact of the integrated and collaborative working on financial and clinical sustainability of the community and the system;
4. **Channel Shift (Active and Involved)** – we have a thriving, active and involved community that feel invested East Central; the benefits of community connection are evident as more people come together to help, support and spend time with each other; a range of initiatives help communities come together to enhance their Locality and environment.

12 month plan

1. **Improving access** to services for the moderate needs individual via the Multi Disciplinary Team function currently in operation (addresses challenge for Deprivation and Living Alone);
2. **Improving access** to social care through primary care, improving GP knowledge re social care services and improving the relationship between Primary and Social Care (addresses challenge for Deprivation and Living Alone);
3. **Developing greater access** to Mental Health Early intervention services (addresses challenge for Deprivation and Living Alone);
4. **Enabling the integration and encourage use of hub model and engagement with** voluntary sector assets in health and care models with a focus on prevention (addresses challenge for Deprivation and Living Alone);
5. **Creating an environment** through which people are empowered to make decisions about themselves and their own lives (addresses challenge for Deprivation and Living Alone).

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Southend West Central Locality

Introduction

West Central comprises a number of distinct areas within the Borough of Southend. Firstly, six wards make up the West Central Locality; Blenheim Park, Chalkwell, Milton, Prittlewell, St Laurence and Westborough. Picture 1 shows the boundaries for West Central. There are circa 35,000 people registered to GP practices in West Central as compared to the Ward population of circa 64,000. The difference is attributed to two of the largest Southend GP practices being in neighbouring Localities (Pall Mall and Queensway).

The split of male to female is 51.3% Male as compared to 48.7% female. West Central has a smaller proportion of children and young people under 25 years, and a larger proportion of adults of working age, particularly males between 25 and 54. The population of people aged over 65 is similar to the Southend average.

The population is set to increase in coming years. Projections show that West Central will increase by a further 7,125 residents by 2029. It is projected that there will be an additional 1,844 residents in West Central over the age of 75 by 2029.

Key Challenges

Deprivation & Wider determinants of health – There are 107 Lower Super Output Areas (average 1,500 residents) in Southend of which 38 are in West Central. 2 of these are in the 10% most deprived areas in England. Deprivation, employment, housing and education is directly linked to life expectancy and length of disability free life. Residents in West Central (living in deprivation) are statistically more likely to have higher levels of **mental illness**, increased likelihood of developing **a long-term illness** (respiratory, cardiovascular disease) and a higher prevalence of **unhealthy lifestyle behaviours** (obesity, physical activity and smoking).

Wider determinants of health and wellbeing – Data in West Central suggests that residents face challenges around housing, education, employment, air quality and crime. These wider determinants all contribute to a residents health and wellbeing and their likely need to interact with services.

Long Term Conditions – West Central has a greater percentage of patients diagnosed with respiratory illness, asthma, depression and mental health compared to Southend.

Carers – West Central has a greater percentage of care packages than Southend and a significant number of registered carers are caring for a resident of West Central.

Long Term priorities

1. **Improve Health and Wellbeing (Safe & Well)** – measured through people feeling safe and secure at all times; people are remaining well enough to enjoy fulfilling lives; and the most vulnerable in our community are effectively protected and have their quality of lives improved;
2. **Improve Care Quality and Experience** – measured through positive personal experiences, safe and effective care and partnership development between people and community assets;
3. **Sustainability** – sustainable impact of the integrated and collaborative working on financial and clinical sustainability of the community and the system;
4. **Channel Shift (Active & Involved)** – we have a thriving, active and involved community that feel invested West Central; the benefits of community connection are evident as more people come together to help, support and spend time with each other; a range of initiatives help communities come together to enhance their Locality and environment.

12 month plan

1. **Developing a peer support network** to focus on the work of carers and the **implementation and development of a carers consortium** to support the commissioned activity (addresses all four challenges);
2. **Improving access & reducing the impact of the wider determinants of health;** for the moderate needs individual via the Multi Disciplinary Team function currently in operation (addresses all four challenges) and closer collaboration between organisations in West Central;
3. **Enabling the integration** of voluntary sector assets into health and care models with a focus on prevention and wellbeing (addresses all four challenges);
4. **Creating greater use of open spaces and development of hub model** in West Central (addresses all four challenges).
5. **Creative use** of the connection with SUHFT via development of hospital / hub model and a care link worker

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Southend West Locality

Introduction

West comprises a number of distinct areas within the Borough of Southend. Firstly, four wards make up the West Locality; Belfairs, Eastwood Park, Leigh and West Leigh. Picture 1 shows the boundaries for West. There are circa 54,000 people registered to GP practices in West as compared to the Ward population of circa 39,000. The difference is attributed to two of the largest Southend GP practices being in neighbouring Localities (Pall Mall and Queensway).

The split of male to female is 48.6% Male as compared to 51.4% female. West has a smaller proportion of adults of working, particularly between 20 and 34, and a higher proportion of people aged over 65, particularly males between 65 and 79.

The population is set to increase in coming years. Projections show that West will increase by a further 4,309 residents by 2029. It is projected that there will be an additional 1,356 residents in West over the age of 75 by 2029.

Key Challenges

Care Homes – There are a total of 1,299 care home residents registered to GP practices in the Borough of Southend. Of these, 456 are registered with GP practices in West with Pall Mall Surgery having the majority (278). West Locality hosts 9 of the 98 care homes in Southend.

Older people living alone – Data in West suggests that 34% of residents in West over the age of 65 are living alone. In Leigh ward the number is higher at 41%.

Long Term Conditions – West has a greater percentage of patients diagnosed with respiratory illness, heart disease, depression, diabetes, epilepsy and hypertension.

Unplanned admissions – West has a greater proportion of unplanned admissions for Urinary Tract Infections (UTIs), Falls and unspecified chest pain.

Long Term priorities

1. **Improve Health and Wellbeing (Safe & Well)** – measured through people feeling safe and secure at all times; people are remaining well enough to enjoy fulfilling lives; and the most vulnerable in our community are effectively protected and have their quality of lives improved;
2. **Improve Care Quality and Experience** – measured through positive personal experiences, safe and effective care and partnership development between people and community assets;
3. **Sustainability** – sustainable impact of the integrated and collaborative working on financial and clinical sustainability of the community and the system;
4. **Channel Shift (Active & Involved)** – we have a thriving, active and involved community that feel invested West; the benefits of community connection are evident as more people come together to help, support and spend time with each other; a range of initiatives help communities come together to enhance their Locality and environment.

12 month plan

1. **Developing a peer support network** to focus on the working in Hubs and developing Asset Maps for the Locality (addresses challenges for people living alone, people with Long Term Conditions and Unplanned admissions);
2. **Improving access** to services for the moderate needs individual via the Multi Disciplinary Team function currently in operation (addresses all four challenges);
3. **Enabling the integration** of voluntary sector assets into health and care models with a focus on prevention and wellbeing (addresses all four challenges);
4. **Creating greater use of open spaces and encouraging physical activity** in West (addresses all four challenges).

Southend Health & Wellbeing Board

Report of
Simon Leftley, Deputy Chief Executive (People), Southend on Sea Borough Council

to

Health & Wellbeing Board

on

05 December 2018

Report prepared by:
Nick Faint, Integration Programme Manager, SBC
Ashley King, Interim Programme Director, Southend and Castle Point & Rochford CCGs

	For discussion	X	For information only		Approval required

Southend on Sea Borough Council
Mid & South Essex Sustainability and Transformation Plan
Referral to Secretary of State for Health and Social Care

Part 1 (Public Agenda Item)

1 Purpose of Report

The purpose of this report is to;

1.1 Provide Health & Wellbeing Board (HWB) with Southend on Sea Borough Council's referral of the Mid and South Essex Sustainability and Transformation Plan (STP) to the Secretary of State for Health and Social Care.

2 Recommendations

HWB are asked to;

2.1 Note that the referral letter at **Appendix A**;

3 Financial / Resource Implications

3.1 None at this stage

4 Legal Implications

4.1 None at this stage

5 Equality & Diversity

5.1 None at this stage

6 Appendices

6.1 **Appendix A** – Southend on Sea Borough Council letter to Secretary of State for Health and Social Care.

Southend-on-Sea Borough Council

Civic Centre, Victoria Avenue, Southend-on-Sea, Essex SS2 6ER
01702 215000

www.southend.gov.uk

The Rt Hon Matt Hancock MP
Secretary of State for Health and Social Care
39 Victoria Street
London
SW1H 0EU

Our ref:
Your ref:
Date: 23rd November 2018
Telephone: 01702 215000
Email: cllrnevin@southend.gov.uk

Dear Secretary of State,

Referral of Mid and South Essex Sustainability and Transformation Partnership – Your Care in the Best Place Public Consultation by the Mid and South Essex Clinical Commissioning Group's Joint Committee

The Southend-on-Sea Borough Council's People Scrutiny Committee (Scrutiny) writes to advise you that on 9 October 2018 Scrutiny unanimously took the decision to refer the Mid and South Essex Sustainability and Transformation Partnership's (STP) 'Your Care in the Best Place' public consultation and resulting decisions taken by the Mid and South Essex Clinical Commissioning Group's Joint Committee (the CCG Joint Committee) to your office.

In July 2018 the Full Council unanimously agreed a Motion which requested that Scrutiny give due consideration to a referral to the Secretary of State for Health and Social Care. On 18 October 2018 the Council noted Scrutiny's decision to refer to the Secretary of State thereby endorsing the referral.

In June 2014 The Department of Health published 'Guidance to support Local Authorities and their partners to deliver effective health scrutiny'. This guidance stipulated that where scrutiny is required in relation to substantial reconfiguration proposals across local authority boundaries establishment of a Joint Scrutiny Committee (JHOSC) is mandatory. The guidance further allows that Local Authorities may choose to delegate their power of referral to the mandatory JHOSC but need not do so. If they choose to not delegate then the Local Authority may make such referrals.

I can confirm that, as an upper tier Local Authority, Southend-on-Sea Borough Council have formed a JHOSC with both Essex County Council and Thurrock Council. I can also confirm that the power of referral has been retained by each of the Local Authorities.

Southend-on-Sea Borough Council can refer decisions to the Secretary of State under certain prescribed criteria outlined in legislation. Based on these criteria the grounds for this referral are as follows;

i. Scrutiny is not satisfied with the adequacy of the content of the consultation with Southend-on-Sea Borough Council regarding the Mid and South Essex STP – 'Your Care in the Best Place'; and

ii. Scrutiny considers that the CCG Joint Committee decision regarding stroke services (decision #12) is not in the interests of the health service in our area.

Attached to this letter is a detailed supporting document outlining Scrutiny's grounds for this referral, a summary of its reasons and evidence to support this referral.

As Chair of Scrutiny I would ask that you give your full consideration to the issues raised by the Council following its' extensive and thorough work over many years with the STP and previously, the Essex Success Regime.

The detail of our referral is attached to this letter. Should you require any further information, please do not hesitate to contact Fiona Abbott, Statutory Scrutiny Officer, Southend-on-Sea Borough Council, (fionaabbott@southend.gov.uk or 01702 215 104).

Scrutiny looks forward to your reply and we hope that your view on these issues will provide a way forward in support of better outcomes for the residents of Southend-on-Sea.

Yours sincerely,

Councillor Cheryl Nevin
Chair
People Scrutiny Committee
Southend-on-Sea Borough Council
Civic Centre
Victoria Avenue
Southend-on-Sea
Essex SS2 6ER

Referral to the Secretary of State for Health and Social Care

1 Grounds for the referral

1.1 Southend-on-Sea Borough Council (the Council) request that the Secretary of State for Health and Social Care considers our concerns regarding the Mid and South Essex STP (the STP) formal public consultation 'Your Care in the Best Place' and the subsequent decisions taken by the CCG Joint Committee.

1.2 The grounds for this referral are;

- that we consider the content of the formal consultation with the Council to be inadequate; and
- that we consider the proposed changes for stroke services will not be in the interests of health services in our area.

1.3 The reasons and evidence for the referral are laid out in detail below and the structure of this referral paper is as follows;

- Context (section 2)
- Summary of 'Your care in the best place' proposals (section 3)
- CCG Joint Committee decisions (section 4)
- Summary of our reasons for referral (section 5)
- Our evidence (section 6)
- Steps taken to reach agreement with CCG Joint Committee (section 7)

2 Context

2.1 With a population circa 180,000, Southend-on-Sea (Southend) is one of the largest conurbations in the East of England. Southend, however, is changing. The Borough is becoming more ethnically diverse and the number of older people is increasing. The proportion of 65+s is currently higher than the national average and is set to significantly increase by 2025.

2.2 The level of child poverty and deprivation in Southend is worse than the England and Regional averages. In 2015, over a quarter of Southend residents lived within areas classified as being in the 20% most deprived in England.

2.3 Working age adults in Southend are more likely to struggle to find employment and more likely to rely on 'out of work' benefits than an adult in an average family in England. The same Southend adult is slightly more likely to smoke and have a poorer diet than the average person of working age in England.

2.4 Adults, of a working age, in Southend are more likely to suffer from anxiety and depression than the England average. This anxiety and depression is more likely to have an impact on associated children, who will, in turn, be more vulnerable to facing mental health conditions.

2.5 The proportion of people of excess weight is higher in Southend when compared to the England average, whilst levels of physical activity are lower by comparison.

2.6 Older adults, in Southend, are more likely to smoke, have a poorer diet and to suffer from multiple long-term health conditions. As the average older adult ages, they are also more likely to suffer from dementia.

2.7 In Southend, the average life expectancy is close to the England average but the cumulative effect of lifestyle behaviours and socioeconomic background are apparent at the end of life. The difference in longevity is marked between those living in the most and least deprived areas in Southend.

2.8 In the most deprived areas of Southend, life expectancy drops by 11 years for men and 10 years for women. For men and women, over 60% of the deaths which account for the difference in life expectancy between the most and the least deprived wards are lifestyle related death caused by cancers, and circulatory and chronic diseases.

2.9 While the outlook for most families in Southend is good, the health and wellbeing of families from relatively deprived parts of Southend lags behind those from more affluent areas. The gap emerges for those in their school years, widens for those dealing with the realities of adult life and is keenly felt by those in old age.

2.10 In addition to Southend's demographics, visitors to Southend continue to grow at a fast rate, Southend has an international airport and one of the busiest lifeboat stations in the country. The results from the 2017 Economic Impact Assessment have shown that tourism in Southend has rapidly grown. In 2017 more than 7.5million trips were undertaken to Southend. So at various times throughout the year the demands on Southend's health system increases dramatically depending on the mix of visitors and residents.

3 Summary of 'Your Care in the Best Place' proposals

3.1 The proposals led by Mid and South Essex STP, aim to build up GP and community services over the next 5 years and extend the range of professionals and services in local GP practices. At the same time, it is proposed to change and improve the way the three Mid and South Essex hospitals at Southend, Basildon and Broomfield work.

3.2 The flow through hospitals, the wait in A&Es and the wait for discharge from hospital are all at unacceptable levels in Mid and South Essex. The proposals aim to address these challenges.

3.3 Specialist care is also addressed in the proposals with the aim of continuing to provide and improve the levels of specialist care. The proposals aim to create larger specialist teams by bringing together the resource and expertise across the three hospital sites. Through doing this the challenge of workforce development, transport and investment is recognised by the proposals.

3.4 The public consultation took place between November 2017 and March 2018 and the following principles and proposals under each of them were consulted on;

- **Principle 1**. The majority of hospital care will remain local and each hospital will continue to have 24 hour A&E department that receives ambulances;
- **Principle 2**. Certain more specialist services which need a hospital stay should be concentrated in one place, where this would improve care and chances of a good recovery;
- **Principle 3**. Access to specialist emergency services, such as stroke care, should be via the local A&E, where patients would be treated and, if needed, transferred to a specialist team which may be in a different hospital;
- **Principle 4**. Planned operations should, where possible, be separate from patients who are coming into hospital in an emergency; and
- **Principle 5**. Some hospital services should be provided closer to patients either at home or in a local health centre.

3.5 No alternative options were provided by the STP, nor did the STP invite those being consulted with to propose alternative options.

3.6 An independent report looking at responses to the public consultation was published on 22 May 2018. The report produced by specialist consultation analysts, The Campaign Company, provides a breakdown of both the process and responses to proposals aimed at strengthening and improving health and care services in the community and in the three hospitals serving mid and south Essex.

3.7 The analysis indicates there is broad agreement with the overall principles described in the consultation and as per **para 3.4.**

3.8 The analysis identifies some local differences, particularly that there was less general agreement with the proposals from those living in the NHS Southend CCG area.

3.9 The analysis report has also shown key themes of concern particularly in the areas of;

- Transport and accessibility of services;
- Shortages in workforce to deliver a sustainable service; and
- The need for more detailed and costed plans so that stakeholders can better understand how the STP vision will work in practice.

3.10 The 16-week consultation saw 16 large scale public meetings with circa 700 people attending in total, and 40 deliberative workshops and specific events for people who were most likely to be affected by the proposals.

3.11 750 people took part in an independently commissioned telephone survey conducted with a demographically-balanced section of the population across mid and south Essex to ensure that the consultation process accurately captured the views of the wider population. The independent report notes that 15 people (of the 750) had 'heard a lot about the STP' whilst 37 people had 'heard a little'. Of all those who had 'heard about' the STP only 15 people had read the consultation document.

3.12 This suggests that the STP had failed to communicate and consult effectively with the local residents across the STP footprint.

3.13 In total, it is estimated that circa 3,500 (of a total population of circa 1.2M) people took the opportunity to participate. This equates to circa 0.3% of the mid and south Essex population having engaged in the public consultation.

3.14 The independent report outlines the process conducted by the CCG Joint Committee and recognises that the overall response cannot be seen as representative of the population but is representative of interested parties who were made aware of the consultation and were motivated to respond.

4 CCG Joint Committee decision

4.1 On 6 July 2018 a CCG Joint Committee meeting was held resulting in the following decisions;

4.2 **Decision 1** - Consultation process. Decision taken that the Joint Committee and its constituent CCGs have met their statutory duties and ensured an effective and robust public consultation.

4.3 **Decision 2** - Consultation principles CCG Joint Committee noted the five principles for change, upon which the public consultation was based.

4.4 **Decision 3** - A&E departments. Decision taken that the three A&E departments will continue to operate 24 hours a day and receive blue light ambulances. Trained teams will meet the particular care needs of:

- Older and frail people
- Children
- Patients in need of urgent medical treatment
- Patients in need of urgent surgical treatment

4.5 **Decision 4** - Treat and Transfer (clinical transport). Decision taken to approved treat and transfer to specialist services, where appropriate. Changes in specialist services will not begin until a suitable clinical transfer service is in place.

4.6 **Decision 5** - Complex gynaecology (women's services). Decision taken that

- Gynaecological cancer surgery will be located at Southend Hospital
- Complex gynaecological surgery (including uro-gynaecology) will be located at Southend and Broomfield Hospitals.

4.7 **Decision 6** - Complex respiratory services (for complex lung problems). Decision taken that inpatient care for patients with complex respiratory conditions will be located at Basildon Hospital.

4.8 **Decision 7** - Complex kidney disease. Decision taken that inpatient care for patients with complex kidney disease will be located at Basildon Hospital. Very complex care, such as kidney transplants, will continue to be provided in specialised centres in London and elsewhere.

4.9 **Decision 8** - Vascular services (for arteries and veins). Decision taken that a specialist vascular hub will be developed at Basildon Hospital. The abdominal aortic aneurysm (AAA) screening service will remain at Southend Hospital, which already serves the whole of Essex.

4.10 **Decision 9** - Cardiology services (for complex heart problems). Decision taken that quicker access to the range of treatments offered at the existing Essex Cardiothoracic Centre in Basildon.

4.11 **Decision 10** - Gastroenterology services (digestive system). The original proposal for complex gastroenterology was not put forward for a decision at this stage.

4.12 **Decision 11** - Complex general surgery. Decision that;

- Surgery for some complex emergency general surgical conditions, such as upper gastrointestinal procedures will be located at Broomfield Hospital.
- Complex colorectal surgery will be located at Broomfield and Southend Hospitals.

4.13 **Decision 12** – Decision taken that stroke care for patients showing symptoms of a stroke will continue to be via the nearest A&E, where patients will be assessed, stabilised and treated, if clinically appropriate. Patients who have had a stroke will then transfer to Basildon Hospital for a short (approximately 72 hour) period of intensive nursing and therapy support. Should a patient be confirmed as suffering from a bleed on the brain, they will continue to be transferred to a specialised designated centre, as now. This would either be Queen's Hospital, Romford, or Cambridge University NHS Foundation Trust in Cambridge. The CCG Joint Committee strongly supported the ambition to develop a mechanical thrombectomy service. This is a technique that can physically remove a clot from a blood vessel.

4.14 **Decision 13** - Orthopaedic surgery (for bones and joints). Decision taken that;

- Planned orthopaedic surgery, such as hip and knee replacements, will be at Southend Hospital for people in south Essex and at Braintree Community Hospital for people in mid Essex.
- Emergency orthopaedic surgery, such as a serious fracture requiring a hospital stay, will be at Basildon Hospital for south Essex and at Broomfield Hospital for mid Essex.
- Planned complex wrist surgery will be at Southend Hospital and complex emergency wrist surgery will be at Basildon and Broomfield Hospitals.
- Further work will test the viability of planned inpatient spinal surgery at Broomfield and Southend Hospitals.

4.15 **Decision 14** - Urology (e.g. for kidney, bladder and prostate problems). Decision taken that;

- Cancer surgery will be at Southend Hospital

- Complex (non-cancer) emergency urological conditions will be treated at Broomfield Hospital
- Complex uro-gynaecological treatment will be located at both Southend and Broomfield Hospitals.

4.16 **Decision 15** - Orsett Hospital Services currently provided at Orsett Hospital will be transferred to a range of locations within Thurrock, Basildon and Brentwood, enabling the closure of Orsett Hospital. Planning will be in partnership with the local community, including a "People's Panel" supported by Healthwatch organisations in Thurrock and Essex. The Orsett Hospital site will not close until the new services are in place at the agreed new locations.

4.17 **Decision 16** - Family and carer transport. Decision taken that the hospitals will take reasonable steps to support patients, their families and carers, to travel to a more distant hospital, if required. The priorities are to:

- Work with local authority transport planners to enhance existing public transport
- Consider the development of a shuttle bus that could include some of the community hospitals as well as the main hospital sites
- Expand existing community transport and voluntary car schemes
- Provide better information for patients and families on all forms of transport

4.18 **Decision 17** - Capital funding. Decision that £118 million in capital funding is earmarked in central funds to support the hospital changes, plus an additional £12 million being raised locally through the disposal of local assets.

4.19 **Decision 18** - Implementation oversight. Decision that there will be an Implementation Oversight Group, which will include patient and public representatives.

4.20 **Decision 19** - Continued engagement Decision that communication and engagement will continue with patients, public, staff and stakeholder organisations.

5 Summary of reasons for the Referral

The Councils' position;

5.1 Prior to public consultation the Council had proactively engaged with the STP, ensuring that the STP was invited to a number of different meetings and committees. The Council have consistently supported areas of the STP that would improve outcomes for Southend residents and have consistently challenged proposals from the STP that would reduce outcomes, for example, the Council robustly challenged the STP proposals to reconfigure the A&E department at Southend Hospital set out in the original proposals prior to formal public consultation.

5.2 During the process of public consultation the Council formally responded with a report that acknowledged the need for transformation within health services across the STP footprint and offered support for the STP proposals once the proposals had been sufficiently developed. The Council highlighted six areas of concern to the CCG Joint Committee and specifically noted that insufficient information had been made available by that Committee for the Council to take an informed position regarding the STP proposals. Further, the Council welcomed the opportunity to work in partnership with the STP to ensure specific areas of concern were addressed.

5.3 The six areas of concern were;

- stroke services;
- investment in Localities;
- transfers and transport;
- consolidated discharge and repatriation;

- capital investment; and
- workforce.

5.4 On 6 July 2018 the CCG Joint Committee made decisions following recommendations made by the STP programme. These recommendations were made following consideration of the public consultation, clinical senate reports and developed proposals for each of the recommendations.

5.5 Following the CCG Joint Committee decision making process, at the Southend Council meeting on 19 July 2018 a 'motion' was unanimously supported by all Councillors present and carried reiterating the concerns outlined in the Council's response to the STP proposals and further expressing concern at the public consultation process and how it had reached only a small fraction of the population within the STP footprint.

Rationale for referral

5.6 The Council fully recognise that the challenge within mid and south Essex for the provision of health and care services is difficult and extremely complex. The Council further recognise that the current provision of health services within the STP footprint is unsustainable. Reports published by the Council evidence this recognition. Throughout the engagement with the STP, the Council has acknowledged that some of the STP proposals will deliver better outcomes for the residents of Southend. For example, the enhancement of centrally provided specialist services that are not currently provided in Southend Hospital and circa £40M capital investment will, undoubtedly, provide better outcomes.

5.7 Throughout the Councils' engagement with the STP and in the absence of a public consultation regarding a series of options, the Council have continually requested evidence that supports the proposals and evidence that supports the decisions from both a clinical and enabling perspective. The Council's challenge has been 'what are the detailed plans for workforce which will support the delivery of the proposals? What are the detailed plans for transport (patients, family, friends, carers etc.) which will support the delivery of the proposals?'

5.8 The Council believe that the CCG Joint Committee should reconsider their decisions on the following grounds;

Inadequacy of the content of the consultation with the Council

5.9 Insufficient detail to support the decisions made by the CCG Joint Committee regarding **transport** (patients, friends, family and carers), **discharge and repatriation procedure**; **workforce**, **investment** and **implementation** have been provided by the CCG Joint Committee. The Council require this information to reach an informed position on the proposals.

5.10 Despite numerous offers from the Council to support and develop, in partnership, alternative options for consideration the process of public consultation presented the proposals as the only option for consideration. There were **no other options** upon which the CCG Joint Committee consulted.

5.11 There has been a perceived lack of clarity regarding both the decision making process and evidence to support decisions led by the CCG Joint Committee, which has manifested itself through**; inconsistency in accountability**; **disagreement from clinicians** regarding the proposals; and **inconsistent communications** from both the CCG Joint Committee and the Mid, Southend & Basildon Group Hospitals.

Decision #12 (stroke not in the interests of health services in Southend)

5.12 The Borough of Southend has an undeniable challenge regarding strokes. The **demand for stroke services and occurrence of stroke** in Southend does not support the relocation of a specialist stroke rehabilitation service away from Southend Hospital.

Further, evidence to support the co-location of specialist medical services has not been provided by the CCG Joint Committee despite numerous requests from the Council.

5.13 There is an **established stroke service infrastructure in Southend**. The Council is of the opinion that the established infrastructure has not been considered in the development of the STP proposals.

5.14 The plan for the workforce required to deliver decision #12 is not sufficiently developed to support the decision.

5.15 Due to the fact that no options were consulted upon during the public consultation there is **no evidence to suggest that Southend Hospital**, as an option to locate a specialist stroke service, **was considered**.

6 Evidence

Inadequacy of the content of the consultation with the Council;

Transport plans

6.1 The Council acknowledge that the process required to develop plans for transport is complex. Decisions #4 and #16 concern decisions taken by the CCG Joint Committee relating to transport for patients (treat and transfer); family / carer transport.

Treat & Transfer

6.2 The Council recognise that the transport plans for 'treat and transfer' are a continuation of current operational procedures. There are also new plans for reconfigured specialist treatments. The Council further recognise that any STP plans re 'treat and transfer' to accommodate increased volume need to be robust, evidenced, well-resourced and tested.

6.3 Whilst the CCG Joint Committee have provided a broad range of evidence and detailed operational procedures to develop the proposals for 'treat and transfer' the Council have continually requested information to support these plans: specifically, in respect of (1) resourcing plans; (2) finance plans; and (3) implementation plans for the treat and transfer of patients.

6.4 During the course of consultation with the Council the information outlined in **para 6.3** has been requested at a number of both meetings and formal public committees. For example, at the Southend Health and Wellbeing Board in January 2018 representatives of the STP presented the treat and transfer plans and the volume anticipated as a result of the reconfiguration of acute services. When challenged, the evidence to support the plans and the detailed information required to ensure the implementation was not available. In subsequent private and public meetings since January 2018 the required information has still not been made available.

Family / carer transport

6.5 Through the Councils' locally elected Councillors' engagement within local communities concern has been raised by Southend residents regarding the STP plans to transport family and carers to visit patients at either one of the three hospitals. The Council recognise that this would only be in the case of patients who have been subject to the 'treat and transfer' model. The Council anticipate that these proposals will have significant impact on the residents of Southend and have therefore sought detailed assurance from the CCG Joint Committee throughout the process of consultation and engagement. This assurance, despite numerous requests, has not been provided.

6.6 The assurance required focuses on the CCG Joint Committee supplying information and evidence that enables the Council to have a full and detailed understanding of the volume of residents that this will impact on and for the Council to fully understand the STP detailed plan to deliver their proposals. To date and despite numerous requests, none of this information has been provided.

6.7 To help assure the Council a brief study and practical pilot was conducted during 2017; a member of staff was asked to make a number of journeys using public transport from both Southend Central bus station to Basildon Hospital (and return) and from Shoebury Town Centre to Basildon Hospital (and return). The journeys took place mid-morning and mid-afternoon. On both occasions each return journey took in excess of 4hrs.

Workforce proposals

6.8 From the outset of the STP (formerly the Essex Success Regime) the Council have underlined the need to have detailed proposals for workforce. The Council consider that these proposals underpin the entire STP. The proposals must be practical, deliverable and sustainable to ensure the reconfiguration of acute services, the transformation of primary care and the delivery of an out of hospital community model, can be realised.

6.9 Throughout the consultation with the Council workforce evidence has been requested to support the detailed implementation of the STP proposals. The information requested to support the consultation with the Council relates to;

- the plans to recruit and retain the workforce required;
- the plans required to sustain and skill the workforce required; and
- the plans required to operate and manage services.

to deliver the plans for acute reconfiguration; transformation of primary care; and the development of the out of hospital community model.

Investment plan

6.10 The Council have regularly requested information to support decision #17 of the CCG Joint Committee. Specifically, the allocation of the circa £40M of capital investment earmarked for Southend Hospital. The Council have also requested the information regarding the detail of the disposal of assets noted under decision #17. This information has not been provided or made available during the process of consultation with the Council.

Implementation plan

6.11 Throughout the process of consultation both the Council and the CCG Joint Committee have acknowledged the complexity and planning required to implement the STP proposals. Through a number of formal meetings and committees the Council has requested the implementation plan being developed by the CCG Joint Committee. A review of the plan would help the Council to support the CCG Joint Committee decisions. This information has not been provided nor made available during the process of consultation with the Council.

Discharge and repatriation

6.12 The Council has consistently highlighted the challenges for discharge and repatriation to the CCG Joint Committee. For patients to be discharged efficiently a consistent repatriation process needs to be in place. Throughout the consultation with the Council the CCG Joint Committee have not addressed these concerns nor has information addressing these concerns been made available.

Zero options for consideration during public consultation

6.13 Throughout consultation with the Council no options have ever been provided by the CCG Joint Committee upon which the Council could be engaged and consulted with. From the outset the Council have made an offer to work in partnership with the STP to develop alternative options. This has included the Council suggesting a Council investment in a new, modern and fit for purpose facility, providing acute services for Southend which meets the changing and developing needs and aligns with the STP direction of travel. Whilst the Council acknowledges that it is not ‘best placed’ (nor is it our role) to develop alternative options we consider that we have embraced this

opportunity in the interests of delivering better outcomes for our residents. This would have enabled the development of a strong partnership, detailed and robust proposals.

Lack of Clarity

6.14 There has been a perceived lack of clarity regarding both the decision making process and evidence to support decisions led by the CCG Joint Committee, which has manifested itself through**; inconsistency in accountability**; **disagreement from clinicians** regarding the proposals; and **inconsistent communications** from both the CCG Joint Committee and the Mid, Southend & Basildon Group Hospitals. For example;

- the public events planned in Southend appeared to be disorganised and were ticketed which led to the perception that the CCG Joint Committee were not being inclusive throughout the process of public consultation;
- at a public event in Southend the Interim Accountable Officer for Southend CCG made the statement that 'public consultation was not a referendum' leading to the perception by the Council that decisions had already been taken;
- during the process of consultation with the Council the three NHS provider Trusts announced a merger of the three hospital Trusts which led to the perception that the CCG Joint Committee and provider Trusts were aligning themselves to deliver 'already' made decisions;
- since the original inception of the STP (the Essex Success Regime) there have been five Accountable Officers at NHS Southend CCG which has led to the impression that there was inconsistency in accountability and responses to the Council's concerns; and
- prior to public consultation and at a public event in Rochford the Senior Consultant at Southend A&E stated that 'the further patients had to travel, the more likely they would be to die' in reference to the planned reconfiguration of A&E services. Shortly after this statement the STP reversed their proposals to reconfigure the three A&E services. This led to the perception by the Council that other plans for the reconfiguration of acute services were not supported by clinicians and that the CCG Joint Committee were suppressing clinical concerns.

Decision #12 (stroke not in the interests of health services in Southend)

6.15 The decision to locate a specialist stroke service at Basildon Hospital that will provide intensive nursing and therapy is not in the interests of local Southend health services.

Decision #12 - background

6.16 The five principles consulted on included the principle that certain, more specialist, services which require an inpatient stay should be concentrated in one place, where this would improve care and chances of a good recovery.

6.17 This model / principle is supported by the East of England Clinical Senate who confirmed that the proposals for service change would deliver improvements to patient care. The proposals / service model developments for stroke services were developed by leading front-line consultants and have been recognised as improving the quality, outcome and safety of care.

6.18 Whilst it is recognised that specialist services, which require an inpatient stay, would benefit from being concentrated in one place there is no evidence to support the location of a number of the CCG Joint Committee decisions in Basildon. Specifically, decision #12 which refers to …

… 'the care for patients showing symptoms of a stroke continuing to be via the nearest A&E, where patients will be assessed, stabilised and treated, if clinically appropriate. Patients who have had a stroke will then transfer to Basildon Hospital for a short period of intensive nursing and therapy support'…

The decision further recognises that where a patient is confirmed as suffering from a bleed on the brain, they will continue to be transferred to a designated neuro unit, as now. The CCG Joint Committee strongly supported the ambition to develop a mechanical thrombectomy service but makes no recognition that a thrombectomy service (on a best endeavour approach) is currently provided from Southend Hospital.

6.19 The Council has publicly stated support for the clinically developed stroke model but have continually sought evidence to support the location of this model at Basildon Hospital.

6.20 Despite repeated requests from the Council (via Southend Scrutiny, JHOSC and Southend Health and Wellbeing Board) for evidence to support the locating of stroke rehabilitation services at Basildon Hospital no evidence has ever been provided.

6.21 During the course of public consultation locally elected Councillors from all political groups from the Council visited the stroke unit at Southend Hospital to discuss the STP proposals.

6.22 The Councillors left the visit very clear that a model had been developed between the lead consultants for each acute site that places the patient at the centre. The immediate and timely hyperacute clinical intervention is paramount to the delivery of a successful model. The fast reaction of the model to identify patients with strokes (using hyperacute imaging), the ability to quickly identify the cause of the stroke and hyperacute clinical intervention delivered thereafter are all primary considerations of the model.

6.23 The resourcing of the hyperacute clinical intervention model was also a topic of conversation and Dr Guyler (Lead Consultant for Stroke Medicine) outlined the required resource at each site for the model to function effectively. This included a medical hyperacute assessment team 24/7 (incorporating 6 nurses and 6 doctors), a CT scanner 24/7 and an MRI scanner 24/7, all at each hospital site. Clare Panniker (Chief Executive Mid, Southend and Basildon Hospital Group) confirmed to the Councillors and assured the meeting that the STP proposals were committed to resourcing each site appropriately as defined by the model Dr Guyler outlined.

6.24 The decision for the reconfiguration of stroke services and development of a hyperacute clinical intervention model is supported with clinical evidence. However, the rationale to incorporate a specialist stroke unit at Basildon Hospital, where patients will receive a short period of intensive nursing and therapy is unclear and not documented in the CCG Joint Committee Decision Making Business Case.

6.25 The Council acknowledge that The Stroke Association supports the proposals for stroke services as agreed by the CCG Joint Committee. In summary, The Stroke Association specifically supports the development of the model outlined in the CCG Decision Making Business Case. The Stroke Association further supports the development of a specialised stroke service which will provide intensive nursing and therapy. Whilst the report supports the development of the specialist service at Basildon Hospital the Stroke Association were not asked to appraise any alternatives, nor is it clear that any alternatives were appraised by the CCG Joint Committee. For example, the Stroke Association were not requested to comment on whether or not the specialist stroke service should be based at Southend.

Strokes in Southend

6.26 Southend has the highest number of strokes (within the STP footprint) per 1,000 population over the age of 65. The data (17/18) shows that the Southend rate is 7.5 which is significantly higher than Basildon and Mid Essex. Not only does Southend have the highest rate of strokes within the STP, the rate has been steadily increasing (15/16, 16/17 & 17/18) as compared to Basildon and Mid Essex which have been steadily decreasing or remaining constant.

6.27 Stroke admissions for Southend Hospital have been steadily increasing year on year, growing from 694 (14/15) to 734 (16/17). This equates to Southend Hospital admitting

circa 14 stroke cases per week as compared to circa 11 per week each for both Broomfield and Basildon Hospitals, taken from 16/17 data.

Established infrastructure

6.28 Southend Hospital is audited by the Sentinel Stroke National Audit Programme (SSNAP). The most recent audit demonstrates that all three acute hospitals in the Mid and South Essex STP are delivering similar patient outcomes. The evidence and rationale to support the locating of a Specialist Stroke service at Basildon Hospital is not available and raises questions as to why the locating of Specialist Stroke service at Southend Hospital has been overlooked.

6.29 Southend has an international airport and a Medical Technical campus which would allow Southend Hospital to attract research funding. It is unclear whether or not this issue has been considered in the CCG Joint Committee decision making process. In addition, Southend Hospital have consistently demonstrated leadership with regards to the development of stroke services, for example; a mobile stroke unit and a best endeavour thrombectomy service.

Workforce

6.30 Both the CCG Joint Committee and the Council have recognised the significant challenge associated with workforce which will need to be addressed to enable the successful implementation of the STP.

6.31 Despite numerous requests from both JHOSC and the Council the detailed workforce information which is required to provide assurance has not been provided by the CCG Joint Committee. As noted in **para 6.23**, the Chief Executive of Mid, Southend and Basildon Hospital Group confirmed to the Council's locally elected Councillors that resourcing for the clinical hyperacute intervention model (both at local sites and specialist stroke services) would be made available. To date, neither the JHOSC nor the Council have received any information to provide assurance that this commitment is robust.

6.32 By creating a specialist stroke service evidence suggests that lives will be saved and disabilities will be reduced. Access to and availability of a specialist stroke workforce continues to be a problem for delivering high quality evidence based stroke care. The British Association of Stroke Physicians has stated 'Clinical developments in UK stroke services have overtaken the specialist resource needed to support them'. The creation of a specialist stroke service (irrespective of location) will allow for the existing specialist workforce in Mid and South Essex STP to be used more effectively to provide evidence based interventions that save lives and reduce disabilities.

6.33 Additionally, there is no published evidence that addresses the workforce challenges that would be created as a result of the additional transport requirement (patient, friends, family, carer etc.) following the implementation of specialist stroke services at Basildon Hospital.

Southend as an option was not considered

6.34 Throughout the numerous engagement events held between Southend and the STP requests were made for the rationale and evidence base that supported the location of a specialist stroke service, providing intensive nursing and therapy support, at Basildon Hospital. The evidence base that supports the CCG Joint Committee decision has never been made available to either Officers or Councillors at Southend.

6.35 The limited evidence that has been published in the CCG Joint Committee Decision Making Business Case indicates that there are clinical connections between a cardio thoracic centre and stroke services. The clinical evidence to support this has not been made available.

6.36 The CCG Joint Committee Decision Making Business Case also makes reference to the fact that workforce issues will be resolved as a result of locating specialist stroke

services at Basildon Hospital. Both the JHOSC and Southend Scrutiny Committee have requested the evidence to support this rationale. The evidence has not been made available.

7 Steps taken to reach agreement with Mid and South Essex CCG Joint Committee on the proposals

7.1 The Council, across a number of different formal committees and meetings have led a process to meet and engage with representatives from the STP on multiple occasions. From the outset our concerns have been consistent as has our approach to engaging with the STP. The Council has approached engagement with the STP openly and in a transparent manner. The concerns of the Council for workforce, transport, investment, implementation etc. have all been raised by the Council on the basis that evidence is required to support the CCG Joint Committee decision making.

7.2 The Council has invited representatives of the STP to over nineteen formal committee meetings since February 2016 with the objective of understanding the evidence that supports the STP proposals and CCG Joint Committee decisions. It is understandable, therefore, that the Council is frustrated in the lack of evidence and information to support the STP proposals.

Joint Health and Overview Scrutiny Committee

7.3 A Joint Health and Overview Scrutiny Committee (JHOSC) was established in early 2018 to be the consultee for a formal public consultation launched by the Mid and South Essex STP. Southend Council is the lead Local Authority for the JHOSC.

7.4 The JHOSC has held four meetings in public and a number of private briefings with representatives from the STP. At each of the meetings, both formal and informal, detailed information relating to the development and implementation STP has been requested. The responses from representatives of the STP has been difficult to understand and in certain cases; repetitive. This has led the Southend representatives at the JHOSC unclear about the evidence to support the CCG Joint Committee decisions.

Southend People Scrutiny Committee

7.5 Representatives from the STP have attended nine Scrutiny Committees since the announcement of the Essex Success Regime (latterly Mid and South Essex STP). Each meeting has focused on different aspects of the STP proposals although Scrutiny have been consistent in terms of their challenge. Scrutiny, consistent with the Council position, **para 5.3**, have challenged the STP to provide detailed evidence regarding workforce, investment, transportation, discharge and repatriation and primary care investment to support the STP proposals (pre 6 July 2018) and decisions (post 6 July 2018).

7.6 As stated in various Scrutiny Committees the Committee has found the information provided by the STP to be repetitive, unclear and inconsistent with publicly available documents. Further, the committee has found the evidence to support the CCG Joint Committee decisions to be insufficient and not able to address the concerns of the Council.

Southend Health and Wellbeing Board

7.7 Southend Health and Wellbeing Board (HWB) has endeavoured to work in partnership with our health colleagues. Although they have attended many Board meetings both formal and informal, information relating to the STP proposals has been confusing and unclear, often changing from one meeting to the next.