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**SOUTHEND-ON-SEA BOROUGH COUNCIL**

# People Scrutiny Committee

**Date: Tuesday, 8th October, 2019 @ 18.30**
**Place: Committee Room 1 - Civic Suite**
**Contact: Fiona Abbott, Principal Democratic Services Officer**
**Email: committeesection@southend.gov.uk**

## AGENDA

******** **Part 1**

**1** **Apologies for Absence**

**2** **Declarations of Interest**

**3** **Questions from Members of the Public**

**4** **Minutes of the Meeting held on Tuesday, 9th July, 2019** (Pages 1 - 8)

******** **OTHER SCRUTINY MATTERS**

**5** **The Proposed Implementation of a Dementia Community Support Model** (Pages 9 - 98)
Report and presentation from Dr Jose Garcia (NHS Southend CCG Chair), Jo Dickinson (Locality Development Manager) and S Dinnage (Community Mental Manager, EPUT).

******** **ITEMS CALLED IN / REFERRED DIRECT FROM CABINET - TUESDAY, 17th SEPTEMBER, 2019**

**6** **Ofsted Inspection of Children's Services** (Pages 99 - 114)
**Minute 326** (Cabinet Book 1, Agenda Item No. 17 refers)
Called in by Councillors Cox and Davidson

**7** **Southend 2050 Outcomes Success Measures Report - Quarter 1 2019/20** (Pages 115 - 132)
**Minute 333** (Cabinet Book 3, Agenda Item No. 24 refers)
Called in to all three Scrutiny Committees by Councillors Cox and Davidson

**ITEMS CALLED-IN FROM FORWARD PLAN**
NONE

**PRE-CABINET SCRUTINY ITEMS**
NONE

******** **OTHER SCRUTINY MATTERS**

**8** **Schools Progress Report** (Pages 133 - 136)
Report of Deputy Chief Executive (People)

**9 Scrutiny Committee - updates** (Pages 137 - 168)
Report of Executive Director (Legal & Democratic Services)

**TO: The Chair & Members of the People Scrutiny Committee:**

Councillor L Salter (Chair), Councillor N Folkard (Vice-Chair)
Councillors M Borton, H Boyd, A Chalk, A Dear, M Dent, F Evans, D Garne, B Hooper, M Kelly, C Nevin, K Mitchell, I Shead, M Stafford, A Thompson and C Willis

Co-opted members
Church of England Diocese –
Fr Jonathan Collis (Voting on Education matters only)

Roman Catholic Diocese –
VACANT (Voting on Education matters only)

Parent Governors
(i) VACANT (Voting on Education matters only)
(ii) VACANT (Voting on Education matters only)

SAVS – K Jackson (Non-Voting) *)*
Healthwatch Southend – J Broadbent (Non-Voting)
Southend Carers Forum – T Watts (Non-Voting)

Observers

Youth Council
(i) N Whitehouse (Non-voting)
(ii) S Kebbell (Non-Voting)

**SOUTHEND-ON-SEA BOROUGH COUNCIL**

**Meeting of People Scrutiny Committee**

**Date: Tuesday, 9th July, 2019**
**Place: Committee Room 1 - Civic Suite**

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**Present:** Councillor L Salter (Chair)
Councillors N Folkard (Vice-Chair), H Boyd, A Chalk, D Cowan*, A Dear, M Dent, F Evans, D Garne, B Hooper, M Kelly, K Mitchell, C Nevin, I Shead, M Stafford, A Thompson and C Willis
Mr T Watts – co-opted member
*Substitute in accordance with Council Procedure Rule 31.

**In Attendance:** Councillors I Gilbert, T Harp, A Jones and C Mulroney (Cabinet Members)
Councillors K Evans, K Buck and S George
S Leftley, D Simon, F Abbott, S Baker, A Keating, B Martin, J O'Loughlin and K Ramkhelawon

**Start/End Time:** 6.30 p.m. - 8.55 p.m.

## 156 Apologies for Absence

Apologies for absence were received from Councillor M Borton (substitute Cllr D Cowan) and K Jackson, J Collis and J Broadbent (co-opted members).

## 157 Declarations of Interest

The following interests were declared at the meeting:-

(a) Councillors Gilbert, Jones, Harp and Mulroney (Cabinet Members) – interest in the referred items; attended pursuant to the dispensation agreed at Council on 19th July 2012, under S.33 of the Localism Act 2011;
(b) Councillor Salter – agenda item relating to Scrutiny Committee - updates – non-pecuniary - husband is consultant Surgeon at Southend Hospital; daughter is a consultant at Basildon Hospital; son-in-law is GP in the Borough;
(c) Councillor Nevin - agenda items relating to – Annual Public Health Report; Scrutiny Committee updates - non-pecuniary – NHS employee at external Trust; previous association at Southend & MEHT Hospitals; sons work at MEHT; sister works at Basildon Hospital; niece works for Public Health England;
(d) Councillor Folkard – agenda item relating to Scrutiny Committee - updates – non-pecuniary – Ambassador for Fund Raising Team at Southend Hospital; relative works at Broomfield Hospital; on the reading panel at Southend Hospital;
(e) Councillor Kelly - agenda item relating to Scrutiny Committee - updates – non-pecuniary – employer is EPUT, mentioned in report;
(f) Councillor Mitchell - agenda item relating to Southend Safeguarding Partnership – non-pecuniary – employer is Essex County Council, in Children & Families Directorate; adult child in supported living in receipt of continuing health care / social care funding;

(g) Councillor Hooper - agenda item relating to Schools Progress Report – non-pecuniary – son attends secondary school in Borough; Director of Blade Education (a not-for-profit company);
(h) Councillor Mulroney - agenda item relating to Scrutiny Committee - updates – non-pecuniary – relative works at Broomfield Hospital.

**158 Questions from Members of the Public**

The responses to the questions submitted by Mr Webb to the Cabinet Member for Health and Adult Social Care and the Cabinet Member for Children & Learning will be forwarded to him as he was not present at the meeting.

**159 Minutes of the Meeting held on Tuesday, 9th April, 2019**

Resolved:

That the Minutes of the Meeting held on Tuesday, 9th April, 2019 be confirmed as a correct record and signed.

**160 Revised Southend 2050 - Five Year Road Map**

The Committee considered Minute 71 of Cabinet held on 25th June 2019, which had been referred direct by Cabinet to all three Scrutiny Committees together with a report of the Chief Executive setting out the content of the revised Southend 2050 Five Year Road Map timeline, following the formation of the Joint Administration at Council on 3 June 2019.

In response to a question regarding the aim to become a living wage employer, the Leader said that he would be happy to provide more information / detail on this.

Resolved:

That the following recommendation of Cabinet be noted:

"That the revised Southend 2050 Road Map time-line as set out in Appendix 1 to the submitted report be agreed, reflecting the policy objectives of the new Joint Administration."

Note: This is a Council Function
Cabinet Member: Cllr Gilbert

**161 In the context of the vision for Southend 2050, what is the vision of young people which improves their lives, and what are the pathways to achieve this**

The Committee considered Minute 72 of Cabinet held on 25th June 2019, which had been referred direct by Cabinet to Scrutiny together with a report of the Strategic Director (Legal & Democratic Services). This presented the recommendations of the 2018/19 scrutiny project '*In the context of the vision for Southend 2050, what is the vision of young people which improves their lives and what are the pathways to achieve this ambition'.*

Resolved:

That the following decisions of Cabinet be noted:

"1. That the report and conclusions from the in depth scrutiny project set out at Appendix 1 to the submitted report, be endorsed.

2. That it be noted that approval of any recommendations with budget implications will require consideration as part of future years' budget processes prior to implementation."

Note: This is an Executive Function
Cabinet Member: Cllr Jones

**162 Southend Safeguarding Partnership**

The Committee considered Minute 77 of Cabinet held on 25th June 2019, which had been referred direct by Cabinet to Scrutiny together with a report of the Deputy Chief Executive (People). This gave an overview of Southend Safeguarding Partners response to the changes in governance required by the "Working Together to Safeguard Children - A guide to inter-agency working to safeguard and promote the welfare of children – July 2018".

Resolved:

That the following decision of Cabinet be noted:

"That the report be noted and approved."

Note: This is an Executive Function
Cabinet Members: Cllr Harp and Cllr Jones

**163 Annual Public Health Report**

The Committee considered Minute 79 of Cabinet held on 25th June 2019, which had been referred direct by Cabinet to Scrutiny together with a report of the Deputy Chief Executive (People), which presented the 2018-19 Annual Report of the Director of Public Health.

In response to questions regarding the mental health statistics, the Interim Director of Public Health said that he would provide a written response about the pathways from 'Therapy for You' services to intensive therapeutic support.

Resolved:

That the following decision of Cabinet be noted:

"That the content and recommendations of the 2018-19 Annual Report of the Director of Public Health, be noted."

Note: This is an Executive Function
Cabinet Member: Cllr Harp

## 164 Year End Performance Report 2018/19

The Committee considered Minute 86 of Cabinet held on 25th June 2019, which had been referred direct by Cabinet to all three Scrutiny Committees together with a report of the Strategic Director (Transformation) that outlined the end of year position of the Council's corporate performance for 2018/19.

Resolved:

That the following decision of Cabinet be noted:

"That the 2018/19 end of year position and accompanying analysis, be noted."

Note: This is an Executive Function
Cabinet Member: Councillor Gilbert

## 165 Southend 2050 Corporate Performance Framework for 2019/20 Onwards

The Committee considered Minute 87 of Cabinet held on 25th June 2019, which had been referred direct by Cabinet to all three Scrutiny Committees together with a report of the Strategic Director (Transformation) which outlined the new Southend 2050 Corporate Performance Framework for 2019/20 onwards.

In response to questions about the content of the measures to be included in the quarterly Corporate Performance report, the Leader said that he would be happy to consult the Scrutiny Committee Chairs on the proposed content. He also confirmed that Cabinet will continue to refer the report to Scrutiny to consider.

Resolved:

That the following decision of Cabinet be noted:

"That the proposed Corporate Performance Framework for 2019/20 onwards, as set out in appendix 1 to the submitted report, be adopted."

Note: This is an Executive Function
Cabinet Member: Cllr Gilbert

## 166 Corporate Risk Register

The Committee considered Minute 88 of Cabinet held on 25th June 2019, which had been referred direct by Cabinet to all three Scrutiny Committees together with a report of the Strategic Director (Finance and Resources) setting out the 2018/19 Corporate Risk Register year end update together with the proposed approach to refreshing the Corporate Risk Framework.

Resolved:

That the following decisions of Cabinet be noted:

"1. That the 2018/19 Corporate Risk Register and the year end updates, set out in appendix 2 to the submitted report, be noted.

2. That the proposed approach to refreshing the Corporate Risk Management Framework, be endorsed."

Note: This is an Executive Function
Cabinet Member: Cllr Woodley

**167 Capital Outturn Report 2018/19**

The Committee considered Minute 90 of Cabinet held on 25th June 2019, which had been referred direct by Cabinet to all three Scrutiny Committees together with a report of the Strategic Director (Finance and Resources). This concerned the capital investment programme outturn for 2018/19, which sought approval of the relevant budget carry forwards and accelerated delivery requests and in year amendments for the current approved programme.

Resolved:

That the following recommendations of Cabinet be noted:

"1. That the expenditure on the capital programme for 2018/19 totalling £50.899m against a revised budget of £52.648m, a delivery of 96.7%, be noted.

2. That the relevant budget carry forwards and accelerated delivery requests totalling a net £3.059m moving into 2019/20, as set out in Appendices 1 and 2 to the submitted report, be approved.

3. That the virements, reprofiles and amendments and new external funding for schemes, as detailed in Appendices 3, 4 and 5 to the report, be noted.

4. That in respect of the A127 Kent Elms Junction Improvements project:

(i) That it be noted that the delays to the project have led to an overspend against the scheme budget of £2.446m with £1.075m of this incurred in 2018/19.
(ii) That a further budget of £1.371m be added to the capital investment programme to deliver the scheme over the following years, 2019/20 £1.331m and 2020/21 £0.040m, to be financed by borrowing.

5. That in respect of the Priory, Delaware and Viking new build project:

(i) That the updated financial business case position, be noted.
(ii) That this project be moved from the 'Schemes subject to viable business cases' section into the main capital investment programme.
(iii) That the procurement exercise undertaken which has resulted in an additional budget requirement, be noted.
(iv) That a further budget of £1.519m is added to the capital investment programme in 2020/21 to be financed by borrowing, to enable the scheme to be delivered.

6. That a budget of £4.3m to be added to the Housing Revenue Account (HRA) capital investment programme in 2019/20 to facilitate the HRA Affordable Housing Acquisitions Programme, funded 30% from retained Right to Buy capital receipts and 70% from the HRA Capital Investment Reserve, be approved.

7. That a budget of £0.250m be added to the capital investment programme, £0.125m in 2019/20 and £0.125m in 2020/21, to undertake a two year programme of street lighting infill, to be financed by borrowing.

8. That the relevant changes to the budget identified since the approved capital investment programme was set at Council on 21 February 2019, as detailed in Appendix 6 to the report, be approved.

9. That it be noted that the above changes will result in an amended Capital Investment Programme of £233.166m for the period 2019/20 to 2023/24, as detailed in Appendix 7 to the report.

10. That the schemes subject to viable business cases for the period 2019/20 to 2021/22 totalling £37m be noted.

11. That the content of the Community Infrastructure Levy (CIL) Annual Financial Report 2018/19 be noted and that the CIL Main Fund receipts from 2018/19 and previous financial years be carried forward until spending plans are reviewed in early 2020/21.

12. That authority be delegated to the Director for Planning and Transport (in consultation with Ward Members and the Executive Councillor for Environment and Planning) to agree how the Ward Neighbourhood Allocations received up until 31st March 2019 (excluding allocation to Leigh Town Council) are to be spent."

Note: This is a Council Function
Cabinet Member: Cllr Woodley

**168 Council Procedure Rule 46**

The Committee considered Minute 93 of Cabinet held on 25th June 2019, which had been referred direct by Cabinet to Scrutiny, concerning action taken under Standing Order 46.

Resolved:

That the following decision of Cabinet be noted:

"That the submitted report be noted".

Note: This is an Executive Function
Cabinet Member: Cllr Harp

**169 Schools Progress Report**

The Committee received a report of the Deputy Chief Executive (People) setting out details of the current position with regard to the performance of all schools, including those causing concern and updated on known Academy developments.

It was noted that several of the initiatives outlined in the report are a direct implementation of the 2019-20 2050 Outcome Delivery Plan for Opportunity and Prosperity - readiness for school and work.

The Director of Learning provided a verbal update on the outcome of the recent OFSTED Inspections and the published MPR % pupils attending Good or Outstanding schools.

In response to questions about the work being undertaken by ISOS, the Director of Learning said that he will circulate the research methods being used.

Resolved:

That the report be noted.

Note: This is an Executive Function.
Cabinet Member: Cllr Jones

**170 Scrutiny Committee - updates**

The Committee considered a report by the Strategic Director (Legal & Democratic Services) which updated the Committee on a number of Scrutiny matters.

With reference to section 5 of the report, which updated the Committee on the Mid and South Essex STP referral to the Secretary of State, the Chair referred to the stakeholder letter received from Clare Panniker, Chief Executive of Mid and South Essex University Hospitals Group (MSG), attached at Appendix 2, which had caused a significant amount of disquiet. The Chair advised the Committee that a meeting had taken place with Ms Panniker, at which the contents of the letter had been discussed and explored the implications. The Chair also read out a statement position and a copy was circulated at the meeting which explained and clarified the process being followed. Further discussions with the MSG are planned.

Resolved:

That the report and actions taken be noted.

Note: This is a Scrutiny Function.

**171 Statutory Scrutiny Guidance**

The Committee considered a report by the Strategic Director (Legal & Democratic Services) which advised about the publication of the Statutory Scrutiny Guidance on 7th May 2019 ('the 2019 Guidance'). The 2019 Guidance was produced following a commitment that Government made in early 2018 following on from the Communities & Local Government Select Committees' inquiry into overview and scrutiny and supersedes guidance published in 2006.

The 2019 Guidance, a copy of which was attached at Appendix 1 to the report, does not require the Council to change any of its scrutiny arrangements but does provide the opportunity to enhance the scrutiny processes. Section 4.5 of the report set out some areas to be explored further – namely around greater use of local experts, developing an Executive / Scrutiny Protocol and encouraging great use of 'information bulletin's / briefings' to reduce pressure of items on Committee agendas.

Resolved:

That the approach, set out in paragraph 4.5 of the report, be agreed.

Note: This is a Scrutiny Function.

**172 In depth Scrutiny Projects and Summary of Work**

The Committee considered a report by the Strategic Director (Legal & Democratic Services) concerning the possible in depth scrutiny project to be undertaken by the Scrutiny Committee in 2019/20. The report also attached some information about the work carried out by the Committee in the 2018/19 Municipal year.

Resolved:

1. That the in depth project for 2019/20 will be on the appropriate use of reablement for older people (65 and over) when discharged from hospital, to maximize the number of people at home after period of 91 days ('Home First' approach).
2. To note that the following Councillors have been appointed to the Project Team which will manage the in depth project – Councillors A Dear, D Garne, F Evans, M Borton, C Nevin, A Chalk, I Shead and A Thompson.
3. That the information attached at Appendix 3 to the report, the summary of work of the three Scrutiny Committees during 2018/19, be noted.
4. That a briefing note be circulated to the Committee about domestic abuse and the multi agency work taking place to address this issue.

Note: This is a Scrutiny Function.

**173 Minutes of the Meeting of Chair's Scrutiny Forum held on, Tuesday, 18th June, 2019**

Resolved:

That the Minutes of the meeting on the Chair's Scrutiny Forum held on Tuesday, 18th June, 2019 be received and noted.

Note: This is a Scrutiny Function.

**Chair:** _____

# Southend-on-Sea Borough Council

**Agenda Item No.**

**5**

**Report of Deputy Chief Executive (People)**

**To**
**People Scrutiny Committee**
**on**
**8 October 2019**

Report prepared by:
Jo Dickinson, Locality Development Manager (Dementia lead SEE CCGs), Southend Borough Council

| For discussion | X | For information only | | Approval required | |
|---|---|---|---|---|---|

## The Proposed Implementation of a Dementia Community Support Model

## Part 1 (Public Agenda Item)

### 1 Purpose of Report

The purpose of the report is to provide the Scrutiny Committee with:

1.1 An update on the issues and paper submitted to the People Scrutiny Committee on 9th October 2018 and Council on 18th October 2018, proposing the closure of Maple ward; and

1.2 Share details of the newly approved Demetia Community Support Model in the south east.

### 2 Recommendations

2.1 To note the update and share their views on the newly approved Dementia Community Support model.

2.2 To note the details of the dementia community model which is a permanent move and aims to go live April 2020;

2.3 To note the reduction in the **ring fenced** step up and step down beds in Clifton Lodge and Rawreth Court from ten to four. The number of beds available across both facilities remains the same; there is no overall reduction.

2.4 To note the CCG commitment to regular review of the bed base to see if there is further scope for reduction or increase due to work with community providers to offer a clinically suitable alternative.

### 3 Background & Context

3.1 In October 2018, the Council resolved the following (Minute 394 refers):

*"1. That the investment of £1.5m into a new primary care centre in the St Luke's ward, be supported.*

*2. That the creation of an additional 15-20 adult inpatient beds, to reduce the need for Southend residents having to be placed out of area, be supported.*

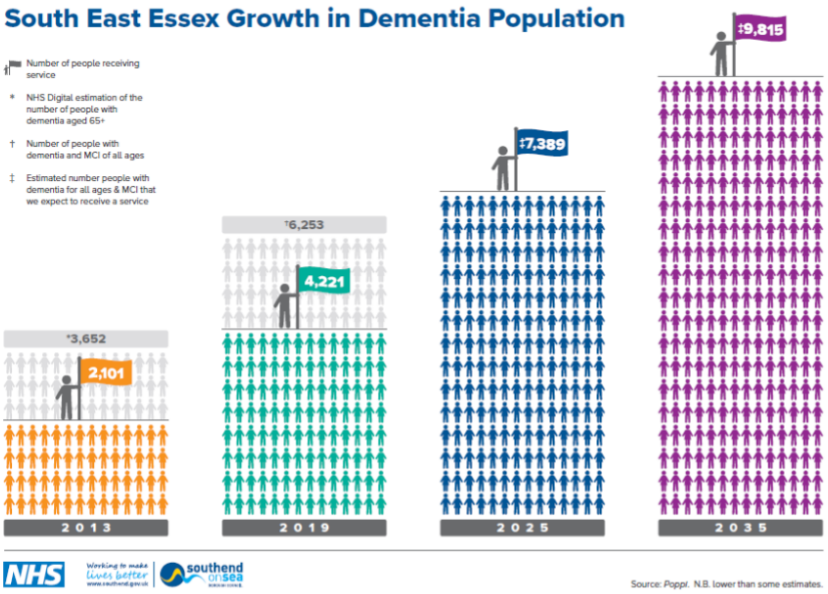
*3. That the request from Southend Clinical Commissioning Group (SCCG) and Essex Partnership University NHS Foundation Trust (EPUT) to defer consultation due to patient and staff safety issues, until the point of determining permanent moves, be supported.*

*4. That the establishment of a clinical group with the appropriate staff side representation to review and lead changes to enhance inpatient and community treatment, care and support going forward, be supported. This will include reviewing the options to bringing the Older People Organic Assessment beds back into South East Essex, with recommendations being completed by August 2019."*

3.2 The decision was therefore that Maple Ward would be closed - a 24 bedded organic assessment unit in Southend that was running at half occupancy. Dr Jose Garcia was asked to chair a clinical group to look at: the current dementia offer; identify the requirements of a new wraparound model to ensure robust community support to the person with dementia and their carer and to identify any gaps in knowledge and data.

3.3 As well as a commitment to develop a robust community model there was also a commitment to offer 10 beds (from the totality of 70 across Clifton and Rawreth) in Clifton and Rawreth (five in each) exclusively to the south east as step up/step down beds. The aim being to prevent as many people from the south east as possible being detained in Thurrock Meadowview ward. The beds have had a low occupancy rate overall since Maple Ward closed; one person has moved to Meadowview at the family's request because of their local connection to Thurrock and twelve other people have not needed to be assessed and detained in Meadowview due to the use of the step up beds.

3.4 The infographic below shows the rise in people with Dementia in South East Essex over the next 15 years. The person standing on top represents the current service. As shown, if the number of people with dementia rises as expected, the current service will not be able to safely manage and support the number of people with dementia. The growth numbers indicate that the number of people with dementia is likely to increase up to 4 times the current rate. The business case introduces a smarter model with a more diverse range of skilled staff which will enable the service to safely support the increase in demand for the service at a lower cost.




3.5 The above is also inextricably linked to two other pieces of work:

- The requirement to develop St Luke's primary care centre through NHS England capital funding (circa 1.5m).

- The requirement to address pressures on adult mental health beds across south Essex and the impact this is having on both their treatment and wellbeing.

- Updates on all can be found in section 4.

## 4 Update

| Detail from paper to Scrutiny & Council in October 2018 | Update |
|---|---|
| Facilitate the improvement of St Luke's Primary Care Centre. Thus enhancing facilities and access to primary care in Southend. Opportunity to increase the current list size by approx. 4,000 patients from its current 6000 to 10000. | All is going ahead and work currently taking place. Plan for a new GP surgery to be operating from the new site in Feb 2020. |
| Move intermediate care beds from CICC to Maple ward at Rochford hospital. This will increase the capacity for intermediate care provision from 16-22 beds across south east Essex. | Increased capacity is very helpful and being utilised. Facility is modern, bigger and can accommodate bariatric patients (the former CICC site could not do this). |
| Move existing south east Essex dementia care assessment beds from Maple ward to Meadowview Ward at Thurrock Community Hospital in Grays. As these patients have an urgent need for specialist assessment and treatment they need to be formally detained under the Mental Health Act, and that means they need to be Admitted to hospital (and not any other such facility such as nursing or care home). | There has been a considerable reduction in the numbers of people that have needed to access dementia assessment beds over the previous eleven months compared to numbers that were detained on Maple ward.<br><br>The numbers that have been prevented using the beds across the south east in Meadowview is 19 over the 11 month period. This has been due to the use of the step up beds available in Clifton and Rawreth and gatekeeping by the Dementia Intensive Support Team.<br><br>Further information about the proposed Dementia Community Support model can be found in section 5 of the report. |
| Through consolidating Maple and Meadowview wards funding will be released from the existing financial envelope to allow for the creation of an additional 16-20 adult mental health inpatient beds at Gloucester Ward Basildon. | The 20 adult beds remain open and will continue to remain open until the demand has reduced. EPUT at the present time do not have a clear account of what impact the Personality Disorder pathway will have on inpatient beds; although anticipate that it will have.<br><br>EPUT are aiming to have the PD pathway up and running by 1st April depending on ability to recruit. |

## 5 Proposed Dementia Community Support Model:

5.1 As a system we are driving through changes that put the person and their families at the centre of their care. The premise is wellbeing and living longer and more fulfilling lives in the community for as long as possible. We want to manage rising risk, take a preventative approach and avoid crisis by deploying resources pro-actively. 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.

5.2 The opportunity to test in the south east arose in November 2018 due to a requirement to reconfigure dementia inpatient beds in order to provide additional mental health beds. A small augmentation to the South East Essex Dementia Intensive Support Service, alongside operationalising the proposed integrated model and new ways of working resulted in significant reduction in admission to dementia beds.

5.3 The new model is a culmination of work that has been taking place in the south east as well as the clinical group chaired by Dr Garcia. The south east has a good reputation for dementia services. This began with a series of public and stakeholder consultation engagement events; followed by system checks such as EQUIP, clinical tasking of diagnosis, running the Dementia Quality Toolkit (DQT) in practices; plus a number of test and learns of different scale and magnitude. Examples can be found on page 7 of the business case.

5.4 During the last nine months the Dementia Intensive Support Team (DIST) have developed a strong working relationship with Day Assessment Unit (DAU) and SWIFT (physical health community support team) to help support the admission avoidance process.

5.5 The new model in the south east comprises of the following principles:

5.5.1 Easy access, no wrong door approach to our service, pre, peri and post diagnosis through to end of life.

5.5.2 The service wraps around people living with dementia and their carers, empowering and enabling them to live the life they would like with their diagnosis.

5.5.3 The service is driven by and directly influenced by the voices, experiences and opinions of people with dementia and their carers.

5.5.4 The emphasis is on identifying rising risk and enhancing positive risk taking rather than reacting to a crisis response. This compliments the strength based approach that we promote as a team.

5.5.5 Services are responsive, appropriate, integrated with whole locality systems and provide right care, right place and right time interventions and support.

5.5.6 Where inpatient care is required that it is planned, purposeful of optimal length and has clear value to the person admitted.

The Dementia Community Support Model:

5.5.7 **The Locality Teams** are aligned with each of the eight localities and nine Primary Care Networks. The locality team are the point of contact for the GP's, Practice staff and patients. All members of the locality team will have access to the same patient record system as GP's and the other services that wraparound the patient, and all will be able to input into and update the dementia care plan. We aspire to work with PCN's as they develop to explore how they can complement the dementia locality offer. It is envisaged both will work closely

together. On completion of a home assessment the locality team will bring the patient to MDT where further assessments and tests can be undertaken. After this the opportunity to discuss the diagnosis will be offered.

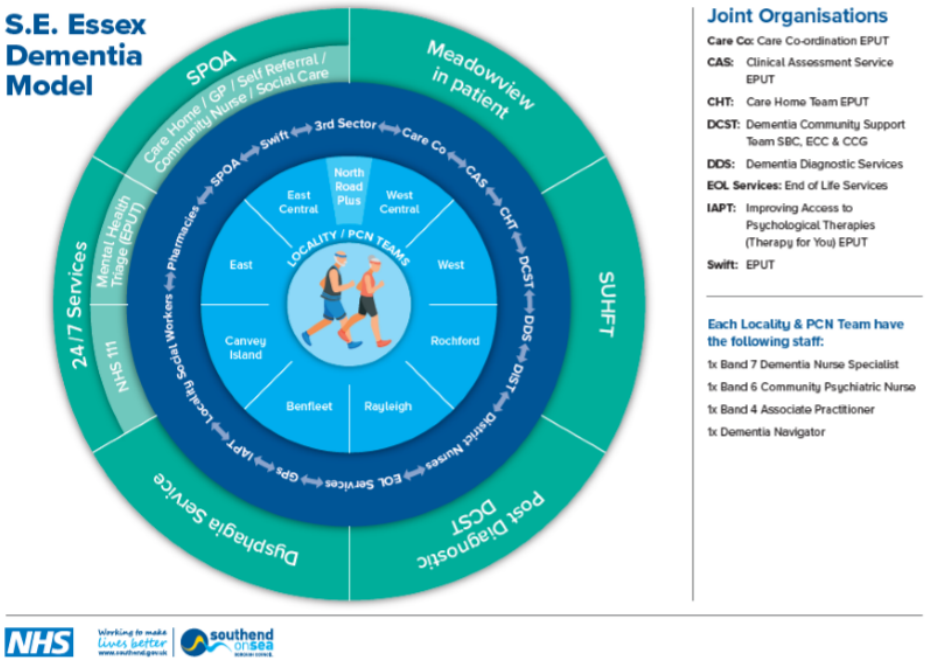
5.5.8 **Care Home Team** A Dementia Nurse Specialist leads in the care home team offering expert advice and supports the GP when diagnosing. Registered nurses can offer training and support to care home staff on site which will enable understanding of their clients; understand a response appropriately that can be challenging and identify rising risk. This will help reduce A&E visits and support the movement between care homes to enable people with dementia to have the best and most appropriate care. They will help develop care home multi-disciplinary team meetings with their dementia expertise and pick up a diagnosis of Mild Cognitive Impairment (this converts to a dementia diagnose in 1 in 3 cases). The Speech and Language Therapist supports care home staff with training on Dysphagia and practical help to improve the care for residents who need support and a swallowing/dysphagia plan to help them to live independently for longer. Locality Dementia Navigators also support the home to achieve dementia friendly accreditation and continue to support the care home staff with basic dementia training and education around environments and offering peer support for resident's families.

5.5.9 **Clinical Assessment Service** Offering a specialist assessment service for older adults not previously known to Mental Health services. It is an intermediate service that gives a greater level of clinical expertise in assessing a patient. This expertise ensures that individuals are referred efficiently and effectively into the most appropriate onward care pathway, including consultant lead secondary care services. The service consists of a Mental Health Nurse Practitioner, Community Mental Health Nurse and Community Support Workers to support comprehensive assessment and appropriate support in completing actions identified in assessment.

5.5.10 **SPOA (Single Point of Access)** Staffed with a Dementia (Mental Health) Nurse Specialist and an Associate Practitioner, this will provide a single access point to community dementia and older adult mental health services, triaging and passing to the appropriate team/team member. They will also offer advice and support to other professionals in SPOA in providing appropriate MDT responses to referrals.

5.5.11 **The Dementia Intensive Support Team (DIST)** work jointly with community health services, mental health, primary care, the acute trust and other agencies (including social services and ambulance services) to reduce unplanned emergency admissions to acute hospitals. The service operates from a community base but link directly with Southend University Hospital (SUHFT) A&E Department, DAU (Day Assessment Unit) and SPOA (Single Point of Access). The interventions offered by the Service are aimed at managing pre crisis and enabling people with dementia and their carers to be supported in the community to avoid an unnecessary admission. Should people with dementia be admitted to SUHFT the service will support/facilitate early than usual discharge where able. The Dementia Navigator is also a part of the team, within SUHFT, attending board rounds and ensuring carer / family support is place where requested and onward referrals to the community Dementia Navigators are completed, ensuring a smooth transition between inpatient stay and community residence.

5.5.12 The visual below shows the narrative of the new model in an easy to understand diagram.




## 6 Financial

6.1 The funding for the new Dementia Community Model has been clinically approved at the CCG's Joint Clinical Executive Committee and at both Southend and Castle Point and Rochford Governing Body meetings. The model will be implemented from April 2020.

6.2 Pooled funding will also be explored with system partners

6.3 There is an expectation that the model will save costs across the system and over the next six months, before implementation, we will identify practice level activity and associated costs to baseline these figures. Numbers will be baselined across localities/Primary Care Networks.

## 7 Clifton and Rawreth Lodge Beds

7.1 Five beds have been made available at Clifton Lodge (and the same at Rawreth Court). This was an assurance given to Full council in Southend in November 2018. These beds have been ring fenced for south east patients as long as they are needed. They were intended to have two different uses:

**Step Up** - ability for people to use the Clifton/Rawreth beds as an opportunity to avoid assessment at Meadowview. A short stay that can monitor/treat behaviour that challenges/ meds review and carer respite. Plus assess if a longer stay is needed in a regular bed.

**Step down** - at the point at which patients can appropriately have their mental health act section removed they can be transferred to Clifton Lodge/Rawreth Court for any on-going treatment, monitoring and discharge planning.

7.2 The beds in Clifton and Rawreth have been very helpful as they have supported patients to have short term interventions that have enabled them to step up so they do not require use of the detention beds in Meadowview.

7.3 The number of ring fenced beds required in the south east moving forward can be reduced from ten to four. There have been, on average, 2, 3 or 4 used in any given month. This number will be reviewed on a regular basis to ensure the bed numbers meet the needs of the population. The first review will take place in six months and then regular quartlery reviews will take place from April 2020 when the new community model is introduced within the system.

7.4 The introduction of the new community model will enable people to have the right care and support in the community and the care home team will ensure that the person is getting the right level of support in their care home and are appropriately placed.

## 8 Reasons for Recommendations

8.1 There are many reasons why an enhanced community model is paramount, which include:

- Being able to pro-actively review patients so people with rising risk are monitored and not just those with the highest need.
- Growth of number of people likely to have a dementia diagnosis in the south east over the next 15 years.
- Supporting the integrated care plan; Co-ordinator of care role and regular dementia reviews.
- Increased risk of crisis, hospital admission (both acute and mental health) increased CHC funding, increased care home and care package usage.
- Increased carer stress due to reduced support and understanding of their unique role.

## 9 Workforce - Dementia Community Support Model

9.1 The south east Essex dementia teams have always had passionate and committed staff who are loyal. The team has consistently been fully staffed and whenever vacancies are advertised strong applications are received. The model we are planning to implement is innovative and cutting edge and national award finalists. Staff will be working with people in a preventative way which affords people a better quality of life in their community. We are assured that workforce will not be a risk that will prevent the new model being implemented and delivering the benefits as planned.

## 10 Consultation

10.1 There has been consultation over the last few years with public, patients and stakeholders regarding clinical and community services. Full details can be found on page 11 of the business case.

## 11 Outcomes/Benefits

11.1 The expected benefits of the new model are as follows:

- Introduction of an integrated care plan, incorporating both dementia and frailty that can be viewed and used across services and systems on SystmOne.
- Locality teams that align to Primary Care Network's to offer bespoke support to primary care.
- Locality teams will support rising risk and have integrated pathways with DAU, SWIFT and Complex Care Coordination.
- Locality teams will offer 'lifelong' support, advice and review; and are able to take the care coordination role.
- Reduced GP workload as less appointments are taken up by people living with dementia and their carers in GP surgeries and more people are seen by the dementia locality team.
- Better links to social care and ability for dementia nurses to implement packages of care.
- A better quality service for people with dementia that ensures they do not have to repeatedly tell their story and that there are fewer hand offs.
- Greater level of personalised support, advice and health promotion to carers.
- More support to care homes and GPs via a care home team.
- Reduced memory assessment pathway by introducing diagnostic phasing over a range of entry points to enable a better fast track diagnostic offer that enables quicker access to post diagnostic support.
- Established links to frailty.
- Delirium recognised, identified and treated faster.
- A 'watch and see' approach to Mild Cognitive Impairment (one third of cases converts to dementia) that ensures no one falls through the net.

## 12 Test and Learns

12.1 A number of test and learns have been tried across the system to test the new model and ways of working. They have proved successful and have been scaled up. Details of the test and learns can be found on page 7 of the business case.

## 13 Testimonial

13.1 *'We as a family have found the DIST team to be a amazing help to us, before they were involved in the care of my mum we were struggling to know what way to turn we had been to many appointments at the doctors and Private hospital appointments to try and get some help and get our foot on the ladder so to speak but had had no luck it was just taking so long and to be honest they won't very helpful.*
*My mum had been confused and very aggressive for quite some time but we felt like it was getting worse and something needed to be done .*
*We've never had to deal with I'll health or doctors in the past so this was all new to us and very daunting.*
*Out of desperation and a last resort I ask for help on our local Facebook page as the situation was getting worse , and straight away Diane's name was being put forward. I texted her that evening and within minutes she was in contact with me and the ball was rolling.*
*Within days she was at my parents house having a meeting and sorting out a bad situation, and from that point on we've had so much help and support mum is on mediation now and although the situation will never get any better it's under control with the help of the DIST team ( Tony and Diane ).*
*I fill that they have become friends and I fill that I could call them at any time day or night and they would be there for my me , my mum or my family.*
*My mum was very nervous about seeing someone and facing the problems she has but she is so at ease with Tony and Diane especially Tony she has taken a liking to him and trusts what he tells her.*
*The DIST team have become a very important part of our life and we don't know where we would be without there care and support we are eternally grateful they go above and beyond and really do actually care.*
*Thank you so much.'*

## 14 Legal Implications

14.1 None at this stage.

## 15 Equality & Diversity

15.1 An Equality Impact and Quality Impact assessment have been carried out and are embedded in Appendix E

## 16 Background Papers

The following papers are included in the business case:

- Essex County Council Public Consultation
- South East Essex Locality Strategy
- 2050 and Transforming Together (one sider)

- Southend 2050 Roadmap summary
- Southend 2050 Five Year Road Map to 2023
- Wraparound Support Scenarios
- SEEMS slides
- Care Home Toolkit
- Dementia Friendly Primary Care Practice
- Domiciliary Care Food and Fluid Flow Chart
- Domiciliary Care Personal Care Flow Chart
- Domiciliary Care Toolkit
- Dementia Integrated Care Plan

## 17 Appendices

| | |
|---|---|
| Appendix A – The Dementia Business case | Dementia Services Transformation Mode |
| Appendix B – Equality Impact Assessment and Quality Impact Assessment | QIA - Final.xlsx<br>EIA - Dementia Business Case FINAL.c |

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# APPENDIX A

THE DEMENTIA BUSINESS CASE (52 pages)

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Dementia Business Case

Dementia Services Transformation Model South East Essex

| Document Control Information | |
|---|---|
| Version Number | 19 |
| Authors | Jo Dickinson, Nancy Smith, Emily Francis |
| Date | 22nd August 2019 |

## Contents

# Executive Summary

The full business case makes a case for an enhanced community model that ensures early diagnosis and good post-diagnostic support. A community model is optimally provided with system partners in primary care and is able to respond proactively to those with dementia or suspected dementia and their carers in their own homes and community settings.

There are many reasons why the dementia community offer needs to be transformed. There is an increasing older age population which unfortunately has a direct increase on the numbers of people that will be diagnosed with dementia in the coming years. A diagram on page 16 of the business case outlines this increase and impact visually.

There is an expectation that 85% of people with suspected dementia will be diagnosed within six weeks from April 2021. The post diagnostic support offer will comprise of a fully comprehensive shared care plan, available on S1, for all professionals to view.

As a system we are seeking to drive through changes that put the person and their families at the centre of their care. The premise is wellbeing and living longer, fulfilling lives in the community for as long as possible. We want to manage rising risk take a preventative approach and avoid crisis by deploying resources pro-actively. 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.

The opportunity to test in the south east arose in November 2018 due to a requirement to reconfigure dementia inpatient beds in order to provide additional mental health beds. A small augmentation to the South Essex Dementia Intensive Support Service (DISS) service, alongside operationalising the proposed integrated model and new ways of working resulted in a significant reduction in admission to dementia beds.

The key to the success of this trial in South East Essex was the implementation of the new ways of integrated working. Those with a diagnosis of dementia go into hospital as a consequence of a range of issues but rarely as a consequence of dementia. It is usually the system around the person with dementia that fails: e.g. an inability to recognise and treat infections appropriately, a break down in care arrangements, inability to recognise environmental triggers or non-recognition of end of life indicators.

Care at home supports the mantainance of independence and function and further maintains significant family and community relationships. Suppoort for carers is central to the community dementia model of care. The model identifies carers support as a system wide responsibility. Support will be reviewed by health, social care and third sector practitioners whenever there are touch points with their services. It is important to emphasise this component of the model.

The options appraisal describes a range of options and the recommends the GOLD option. This option comprises of the following components:

- Care Home including Speech and Language Therapy
- Locality Teams providing dementia diagnostic phasing
- Clinical assessment services
- Single Point of Access
- Dementia Intensive Support Team

## Introduction and Background

The transformation journey began five years ago with the initial consideration of remodelling. i.e. South East Essex Memory Service (SEEMS) model (see appendix I). Essex Partnership University Trust (EPUT) have also committed to transforming dementia community services a diagram of their model can be found on page 20

The model has been developed with clinical and non-clinical colleagues along with consultation and engagement with people living with dementia and those who care for them. Development was undertaken collaboratively with a range of EPUT clinical and professional staff, Southend, ESSEX and Thurrock CCG commissioners, local authority commissioners, third sector and patient carer representatives.

The model was informed by the Five Year Forward View and the integration ambitions of the STP, the Southend, Essex and Thurrock Dementia Strategy and the clinical model for mental health in Essex, the mid and South Essex STP transformation plan. The overarching principles of the model were guided by the NHSE 5 Well Pathway, The Prime Ministers Challenge 2020, NICE Guidance and associated research and guidance documents published by the Department of Health and special interest groups such as the Alzheimer's Society

In November 2018, following discussion of the closure of Maple Ward, Dr Jose Garcia was asked to chair a clinical group to look at; the current offer, what the new wraparound model would need to look like to ensure minimal disruption to the patient and to identify any gaps in knowledge and data

The group membership was broad and included GP's and CCG Clinical Leads, Southend Hospital Geriatricians, Southend Borough Council Commissioners, Multiple professionals from EPUT, Colleagues from Primary Care. (see appendix J for full invite list)

The group met eight times over eight months to understand and support Dementia Community Services address the needs of those patients who would have previously been detained to Maple Ward after the planned closure. The discussion, planning and projects enabled the dementia teams to develop best practice and essential learning by making small changes to the way the current staff and teams work together.

The creation and delivery of a number of test and learn and pilot projects are listed below along with other factors that influenced and help develop the new model and the move to change the way we support those with a concern about their cognitive function and those who care for them.

The numbers of people that will be diagnosed with dementia over the next 5, 10, 20 years will continue to increase and we have been working over the last four years to look to 'future proof' our dementia offer. During this time we have identified gaps, barriers and broken parts of the system.

These include inappropriate care home placements (resulting in higher cost placements; high admission/re-admission to SUHFT; carer breakdown and escalating Continuing Health Care costs,) lack of care home training and support plus the ability for clinical services to access care packages and advise on care packages in the community. An important feature of support and training to the care homes staff has been around swallowing and Dysphagia in people with dementia. This is also a need for those living in their own homes where without a considered plan can result in unnecessary

hospital admissions and consequently someone being discharged from hospital to a care home. Care homes have identified 265 individuals who they believe need a review by the Speech and Language Therapist for swallowing issues. The roles within the new model have been identified to enable a more preventative strengths based approach to be applied to dementia practice.

People with dementia can be described as the most vulnerable in the community and should expect to live well with their diagnosis. We know that as well as a diagnosis other factors contribute to the dementia experience such as social isolation, stigma, depression and anxiety, housing and feeling safe and understood in your surroundings.

This model enables carers and people with dementia to have a better quality of life wherever the live in the community. They should be able to benefit from assets enabling a preventative and inclusive approach that challenges stigma and discrimination. This serves as a reminder of the national dementia statements, such as, 'We have the right to continue the day to day and family life without discrimination or unfair cost to be accepted and included in our communities and not to live in isolation or loneliness'.

This knowledge and understanding of the dementia experience for the person seeking diagnosis and those around them enabled us to develop the Principles of the new model. There can be summarised as:

- Easy access, no wrong door approach to our service, pre, peri, post diagnosis through to end of life. Not only for people with dementia and their carers but for our partners throughout health, social care and the community. This provides seamless care with no visible hand offs to the people we support.
- The service wraps around people living with dementia and their carers, empowering and enabling them to live the life they would like with their diagnosis.
- The service is driven by and directly influenced by the voices, experiences and opinions of people with dementia and their carers
- We pride ourselves on supporting all those involved in a diagnosis and work with both the person and their families to identify rising risk and enhancing positive risk taking rather than reacting to a crisis response. This compliments the strength based approach that we promote as a team.
- Services are responsive, appropriate, integrated with whole locality systems and provide right care, right place and right time interventions and support.
- Provide bespoke training packages which are used to enhance knowledge, skills and understanding in how to support a person with dementia across the systems. E.g. hospital, care home, community, family carers. Support and care wherever possible is provided in the persons home community whatever that home setting may be.
- Where inpatient care is required that is planned, purposeful of optimal length and has clear value to the person admitted.

## Wraparound outcomes

**Listening exercises and consultation as outlined later in this document**.

Attendance at and presenting to **NHS Clinical Network** and acting on **NHS Improvement** recommendations to increase the Dementia Diagnosis Rate and post diagnostic support offer.

**Risk Stratification:** Potential use of the Risk Stratification tool by the Arden and GEM to identify people who have not been to their GP practice for some time but are at risk of being a high frequency user. As such this could be an important tool in supporting us to identify those people with dementia, mild cognitive impairment or a dual diagnosis such as dementia and a learning disability who are at risk of being in crisis. This tool could also support delivery of existing services and the development of PCNs

**Test and learn projects:**

- **Dementia Friendly GP's** - Encouraging GP Practices across Castle Point and Rochford to become Dementia Friendly to support the increase in the Dementia Diagnosis Rate (DDR). This has resulted in 17 out of 23 GP Practices achieving iSPACE accreditation in 12 months.
- **Floating Consultant** funded to explore various primary care and novel diagnostic pathways. E.g. Complex diagnosis in care homes, acute diagnostic work in SUFHT and mild Cognitive Impairment (MCI) review.
- **Dementia Pathways – Scenarios**. Looked at the journey of the five most common reasons most people living with dementia and/or their carers will find themselves in a crisis type situation. The scenarios were, Carer Unwell, Carer unable to cope, Person with dementia has other physical health needs, Behaviour that is seen as challenging and a Person with dementia living in a care home. All are real life situations faced by the Dementia Services staff and the responses given at that time with the addition of what could be achieved with further service developments.
- **Workforce support and medication risks to people with dementia living at home**. Discussion between clinical professionals in the group about medication changes of prescribing professional completing a welfare check or a GP home visit and how this is then acted upon by care agency workers without instruction in the person's care plan. This coincided with concerns raised from a Domiciliary Care Provider that there is an increase in care staff sickness. The result was the creation of the Dementia Friendly Domiciliary Care Toolkit with pathways for staff to follow to support learning and create robust relationships with other professionals. The pathways included Medication, Personal Care and Nutrition & Hydration.
- **EQUIP** – GP Practice Dementia validation Exercise, completing an audit before and after initial changes to establish impact and demonstrated good practice within the service.
- **SystmOne and Clinical tasking**. Ensuring patients go on QOF by using SystmOne. Benefits in terms of DDR and post diagnostic support.
- **DQT** – also identified good practice and allows GP practice to check on outcomes of referrals.
- **MCI – review project**. Historically patients with a diagnosis of MCI were discharged on diagnosis. New model offers psychological support and psycho education and delays further cognitive decline.
- **SPOA**: Team able to assess and access packages social care
- **Care Home MDT** being trailed at Rose Martha Court. Fortnightly meeting with Dementia Nurse Specialist, Speech and Language Therapist, Care Home Manager and Senior Staff member, Social Worker and Adult Social Care Occupational Therapist. The MDT identifies

rising risk, avoiding escalation of safeguarding referrals, maximising staff support and training and increasing resident quality of life.

- **Board Round at Southend Hospital**: Windsor Ward attend on Monday, either Dementia Navigator or DIST. Princess Anne Ward attend daily. Usually a quick discussion about the patients on the ward to ascertain if they are ready for discharge, what care is needed on discharge, equipment and if any referrals need to be completed. Dementia Navigator receives a list of the patients on both wards in the morning from the ward clerk so they can check if they are known to the team and have a diagnosis of dementia. Any referrals for the team are then taken.
- **Hospital MDT –** attend on a Wednesday. Southend and Essex Social workers attend; the ward physio, nurses and doctors attend. The MDT is more in depth discussion of the patients on the ward but do cover the same things.
- **Dementia Care Plan** which includes Mild Cognitive Impairment (MCI) and Frailty and continued roll out across South East Essex
- **Dementia Navigators access to SystmOne.** As part of an integrated service Southend Borough Council Dementia Navigators will have access to and training on the same patient record system as EPUT health colleagues.
- **Outcome Delivery Plans** - Member of the team based in SPOA at Southend-on-Sea Borough Council
- **Family carers** - 6 week family carers training and support in partnership with Improving Access to Psychological Therapy (IAPT).

**The integration between Dementia and Older Adults Community Mental Health Service and the Dementia Community Support Team:**

- Offering bespoke support pre-diagnosis through to end of live for people living with dementia and their carers.
- The use of the same electronic patient record system for both teams to align health and social care and unify patient support.
- Locality hubs and community spaces housing team members.
- Incorporating primary and secondary care along with gatekeeping the Mental Health Wards,

The vision for the south east is underpinned by the Essex Dementia System that has a shared vision for the future where 'people living with dementia are recognised as unique individuals who are actively shaping their lives and their care whilst being able to remain as physically and emotionally healthy for as long as possible.' Key to meeting this vision is integrated and collaborative working across all health, social care and community settings.

## Strategic Context

Dementia is a growing challenge. As the population ages and people live for longer it has become one of the most important health and care issues facing the world. In England it is estimated that around 676,000 people have dementia. In the whole of the UK, the number of people with dementia is estimated at 850,000.

Dementia mainly affects older people, after the age of 65; the likelihood of developing dementia roughly doubles every five years. However, for some, dementia can develop earlier presenting different issues for the person affected, their carer and their family.

There are around 540,000 carers of people with dementia in England. It is estimated that one in three people will care for a person with dementia in their lifetime. Half of them are employed and it's thought that some 66,000 people have already cut their working hours to care for a family member, whilst 50,000 people have left work altogether.

There is a considerable economic cost associated with the disease estimated at £23 billion a year, which is predicted to triple by 2040. This is more than the cost of cancer, heart disease and stroke.

- Dementia is a key priority for both NHS England and the Government. In February 2015 the Prime Minister launched his Challenge on Dementia 2020, which set out to build on the achievements of the Prime Minister's Challenge on Dementia 2012-2015.

It sets out NHS England's aim that by 2020 we are:

- the best country in the world for dementia care and support for individuals with dementia, their carers and families to live; and
- The best place in the world to undertake research into dementia and other neurodegenerative diseases.
- Some of the key aspirations of this vision are:
- Equal access to diagnosis for everyone
- GPs playing a lead role in ensuring coordination and continuity of care for people with dementia
- Every person diagnosed with dementia having meaningful care following their diagnosis
- All NHS staff having received training on dementia appropriate to their role.

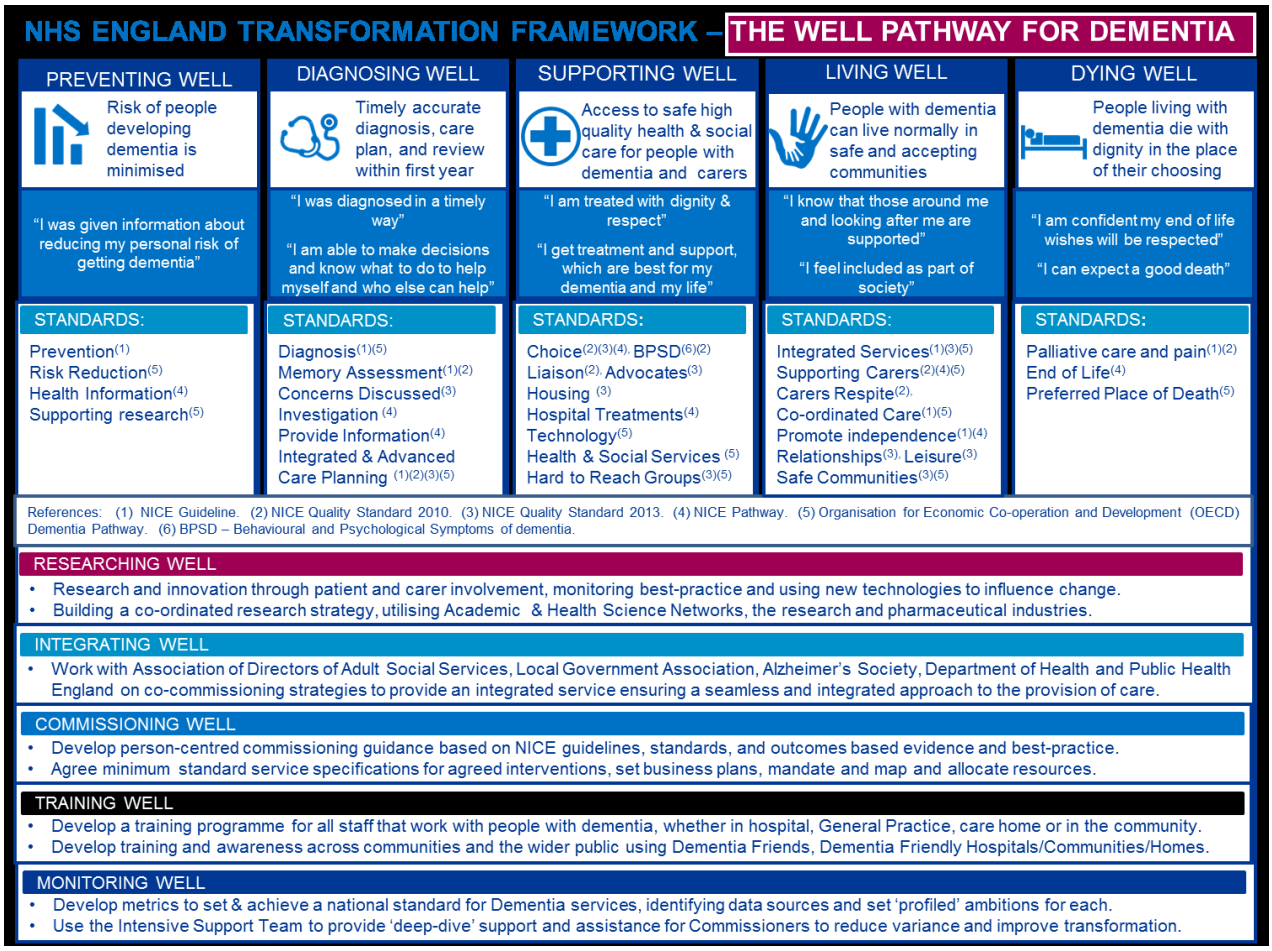
The implementation plan (Prime Minister's Challenge on Dementia 2020 Implementation Plan Implementation Plan Annex 2: Roadmaps to 2020 delivery) outlines how the 50 commitments set out within the challenge will be met, these plans are set out across 4 key themes, risk reduction, health and care, awareness and social action. The implementation plan recognizes that many of these commitments can only be met through the joint efforts of multi-organisations.

**Key deliverables for 2020** are the provision of a 0-6 week referral to diagnosis pathway for 85% of those referred. All those diagnosed will have a care coordinator the majority of which will be provided from primary care community or third sector services. All those with dementia will have a dementia care plan which is reviewed annually. By adopting the new model we think this will be achievable as care planning will be initiated on referral and the new diagnostic phasing will create more options and greater chance of achieving the 0-6 week pathway as suggested in NHSE & NICE guidance.

In 2018 an update on The Prime Minister's Challenge on Dementia 2020 was initiated to review progress against the key commitments, the report on the phase 1 of the review was published in February 2019. Phase 2 of the plan is to be delivered over 2018-2020 and builds on the outcomes of the review.

## Five Well Pathway

NHSE have designed the transformation of dementia care as a "Five Well Pathway" (see below).




This pathway frames the commissioning and delivery intentions for the achievement of the ambitions as set out in the Prime Ministers Challenge.

## NHS Five Year Forward View (October 2014)

The Five Year Forward View states the requirement to distinguish means from ends, so that systems flex in pragmatic ways to support the work that needs doing, that out-of-hospital care needs to become a much larger part of what the NHS does and services need to be integrated around the patient. It states that across England, commissioners and providers across the NHS and local government need to work closely together to improve the health and wellbeing of their local population and make best use of available funding.

As people live longer the NHS needs to adapt to their needs, helping frail and older people stay healthy and independent, avoiding hospital stays where possible. To improve prevention and care for patients, as well as to place the NHS on a more sustainable footing, the NHS Five Year Forward View called for better integration of GP, community health, mental health and hospital services, as well as more joined up working with home care and care homes.

## Next Steps Five Year Forward View (March 2017)

This reports that early results from parts of the country that have begun to implement the Five year Forward recommendations are seeing slower growth in emergency hospitalisations and less time spent in hospital compared to the rest of the country. The difference has been particularly

noticeable for people over 75 who often face a revolving door of emergency admission, delayed discharge and then hospital re-admission. These partnerships are described as more than just the 'wiring' behind the scenes, they are a way of bringing together GPs, hospitals, mental health services and social care to keep people healthier for longer and integrate services around the patients who need it most. The partnerships are further described as a forum in which health leaders can plan services that are safer and more effective because they link together hospitals so that staff and expertise are shared between them. At their best, they engage front-line clinicians in all settings to drive the real changes to the way care is delivered that they can see are needed and beneficial and they are vehicles for making the most of each pound of public spending.

## NHS Long Term Plan (January 2019)

NHS 10 year plan www.longtermplan.nhs.uk was published. The plan sets out an NHS model of delivery which builds on the Five year Forward View commitments with the ambition of patients receiving better support, and properly joined-up care at the right time in the optimal care setting. To achieve this ambition the plan sets out the creation of multidisciplinary teams aligned with new primary care networks (PCNs). PCNs are based on neighbouring GP practices that work together typically covering 30-50,000. Implementation of the plan will result in fully integrated community-based health care.

The NHS and partners will move to create Integrated Care Systems everywhere by April 2021, building on the progress already made. ICS's bring together local organisations in a pragmatic and practical way to deliver the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care. They will have a key role in working with Local Authorities at 'place' level, and through ICSs, commissioners will make shared decisions with providers on population health, service redesign and Long Term Plan implementation.

## The Care Act (2014)

The 6 principles of the Care Act are;

- Empowerment, Protection, Prevention, Proportionality, Partnership and Accountability.

The Act places significant emphasis on prevention through local authorities integrating care and support with other local services, it requires local authorities to carry out their care and support responsibilities with the aim of joining-up the services provided. This general requirement applies to all the local authority's care and support functions for adults with needs for care and support and for carers.

The duty applies where the local authority considers that the integration of services will promote the wellbeing of adults with care and support needs or of carers in its area, contribute to the prevention or delay of the development of needs of people, improve the quality of care and support in the local authority's area, including the outcomes that are achieved for local people.

# Consultation & Engagement

From the 11th to the 22nd March 2019, the Dementia Intensive Support Team (DIST), Dementia Community Support Team (DCST) & Care Coordination undertook consultation and engagement work with the public regarding dementia services that they had received.

In total 22 people with dementia and their carers were consulted.

Of the 22; 10 accessed DAU, 12 accessed A&E and in 3 cases detention was considered.

The Carer's were asked whether anyone had spoken to them to find out about their needs as a carer. 16 said that either DIST, ward staff, the Dementia Navigators or OPCMT had asked about their needs as a carer. The 6 that said they weren't asked had accessed A&E rather than DAU.

14 of the carers said they had been kept up to date with what is happening with the person they care for. The 8 that said they hadn't been kept up to date had accessed A&E rather than DAU.

When asked if they thought there was any overlap between the people involved with the carer or person with dementia, 4 said yes but in a positive way. 15 of the people said there was no overlap and 3 either did not know or said there was no one involved with their care.

The carers that were seen in DAU were asked to comment on their experience. All that attended gave positive feedback which included: "Professional, friendly, caring", "DAU was fantastic, staff very understanding and caring" and "Very pleased. Whole family were able to attend. Nothing was too much trouble"

The carers that were seen in A&E were also asked to comment on their experience. Apart from one comment all gave negative feedback of the experience; "busy and distressing for my mum. No quiet place, too much noise", "horrible, could not understand what was going on, no one spoke to me" and "to make a person with dementia sit in A&E for 5 hours is not right. So stressful for family".

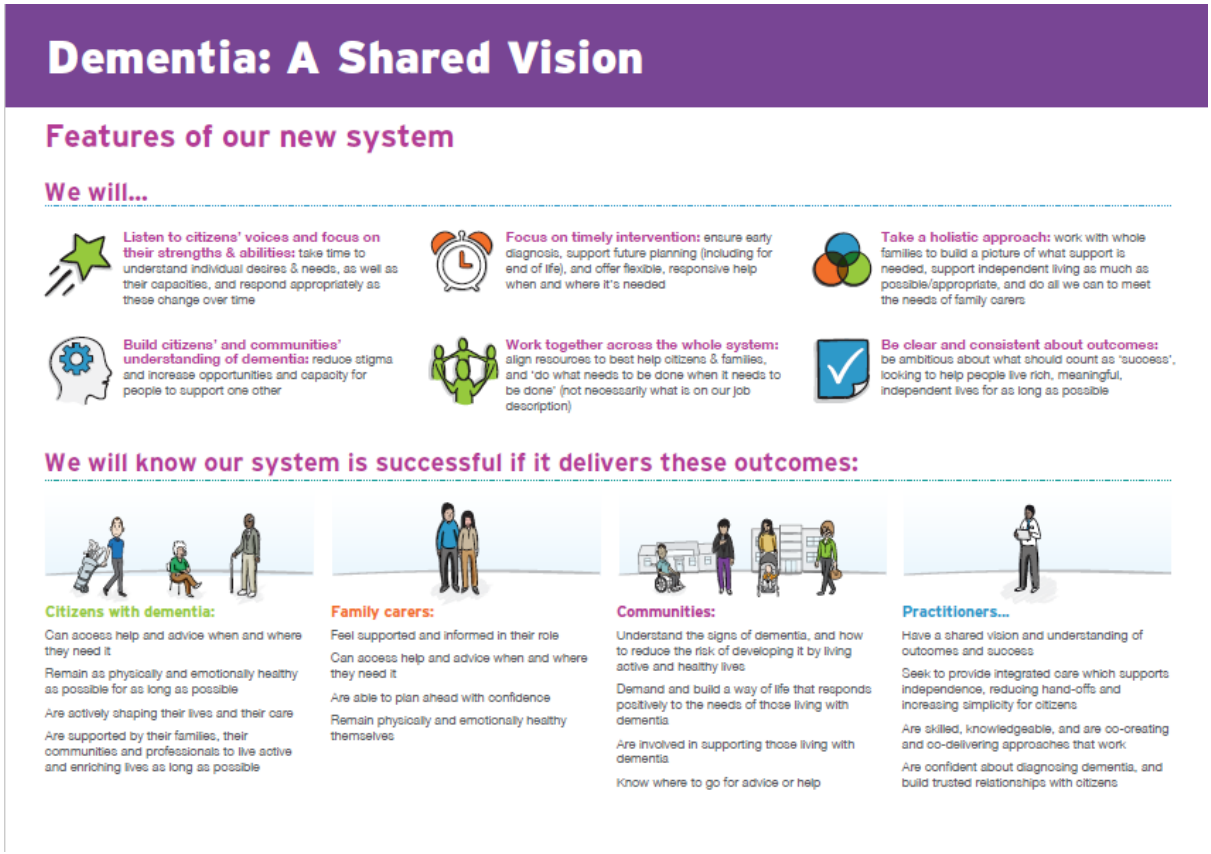
**Consultation:**
Throughout 2016 extensive consultation and engagement was facilitated with people living with dementia, carers, general public, stakeholders and provider organisations, Adult Social Care, Care Homes and Domiciliary Care Providers.

**The following main points came from the consultations**

- Information available and accessible when and how you want and need it
- Having one point of contact from the first sign of possible symptoms through to End of Life care, who will navigate the service pathway and support the person diagnosed and their carer. This same person to be the link and liaison between the person with dementia and health, social care and third sector providers.
- Improved coordination and integration between health and social care services to enable smooth transition through the dementia pathway for patients and carers.
- Being able to take part in community life

The results of the consultations are reflected in the new Dementia Community Model and offers residents of Southend and CP&R holistic support concentrating on wellbeing and living well with dementia.

In 2015 Essex County Council (ECC) carried out an extensive consultation with the Public Office to establish community views and priorities for future dementia support. The diagram below is a summary of the findings. The main report can be found in Appendix C.




*Extract from Essex County Council Public Office Consultation; Rethink Dementia 2015 – a Collaborative Enquiry. Please see Appendix C for full document*

## Local Context

### The Southend, Essex and Thurrock Dementia Strategy 2017-2021

The strategy is for everybody in Southend, Essex and Thurrock, (Greater Essex), who is living with dementia or supporting someone who is. It describes what support for people with dementia will look like in the future. The principles of which are summarized as; intervening early to prevent needs from increasing and help people to continue to live independent lives, building on their strengths and the resources available to them within their personal network and the wider community

For those people who need ongoing support, the aim is to ensure that this support responds to the needs of individuals and supports the wider family network. The Strategy identifies 9 key priorities:

- Prevention
- Finding Information & Advice
- Diagnosis & Support
- Living well with Dementia in the Community
- Supporting Carers
- Reducing the Risk of Crisis
- Living well In Long Term Care
- End of Life
- A Knowledgeable and Skilled Workforce

## Mid and South STP - The STP Plan updated and published in further detail in October 2016

The plan describes the STP vision as "to unite our different health and care services around you and all of your potential needs" with physical, mental health and social care working together. The principles of the plan are based on prevention and early treatment, early response and ease of access to emerging difficulties via a range of access options optimising technological opportunities.


## Integration and Place based Models of Service Delivery

Each of the 5 CCGs within the Mid and South Essex STP are developing or implementing place based, integration models which reflect the STP ambition and accord with the 5 year forward view and NHS 10 year plan. Each CCG area is at varying stages of development of place based integrated services. The NHS 10 year plan has provided a further driver for delivery with the requirement for surgeries to have committed to local Primary care networks (PCNs) by July 2019 (though not compulsory will have financial implication for those surgeries that do not sign-up). The Primary Care Networks of circa 30-50,000 population size will become the key vehicle for delivering many of the commitments in the long-term plan and providing a wider range of services to patients. They will become the footprint around which integrated community-based teams will develop building on exiting hub and neighbourhood configurations. Community and mental health services will be expected to configure their services around these Primary Care Network boundaries. These teams will provide services to people with more complex needs, providing proactive and anticipatory care.

## Southend Essex and Thurrock local Authority Priorities

Adult Social Care models across each local authority embrace the strengths/prevention imperatives of the Social Care Act 2014 and the ambitions of the NHS FYFV and the NHS long term plan. Recognise that current service remains primarily a crisis model of delivery and that a whole-system

approach is required which will require partnership working with communities, locality partner organisations and the private sector to shift resources towards preventative well-being services and community solutions. Each local authority has a range of initiatives to meet these ambitions, examples of which are; Thurrock First which is a single point of contact for Adult Social Care, Health and Mental Health and the initiation of four Integrated Medical Centres across Thurrock. Similar integrations initiatives are underway in both Southend and Essex, with local authority services aligning with locality hubs and the development of a single point of access. In Southend and CPR social care workers have aligned with the rapid response health and dementia services to provide out of hospital options.

### Essex Partnership University Trust Transformation Priorities

The merger of North Essex Partnership Trust (NEP) and South Essex Partnership Trust (SEPT) into the Essex Partnership University Trust (EPUT) in April 2017 brought with it an explicit requirement to transform operational mental health services to deliver both increased effectiveness and outcomes for those using EPUT services and deliver financial efficiencies to the health economy.

The transformation programme which was initiated prior to the merger reflected the Southend Essex and Thurrock Mental Health and Dementia strategic plans and National guidance primarily the FYFV. The vision of EPUT was through transformation to achieve;

"By 2020/21, adult community mental health services will provide timely access to evidence-based, person-centred care, which is focused on recovery and integrated with primary and social care and other sectors…… best utilising workforce by engaging with national initiatives re training upskilling and collaborative working"

The commitment is therefore to develop accessible and responsive services which meet the needs of local populations whilst delivering consistent and highest quality services wherever they are accessed across the Trust, are Primary Care facing, evidence a needs led rather than process led approach to care delivery and work in partnership with all partners to deliver on the ambitions and intentions of local CCGs STP local authorities and National requirements.

## South East Essex Population – Dementia Growth

NOMIS is a service provided by the Office of National Statistics (ONS), and provides the most detailed and up to date UK labour market statistics - for example population figures and economic activity such as employment. The mid-year population is published at the end of June for each year. This figure gives us our population estimates for the UK and breaks down for Local Authorities. The mid-year population figure for Southend-on-Sea in 2017 was 181,800; and this figure has now changed to **182,500** for 2018. Southend has 35 GP practices and works within four localities. In terms of PCN's Southend is split five ways. East and West mirror the locality footprint but East and West Central share a fifth PCN called North Road Plus.

Population for CPR is currently recorded at 182,000 over 27 GP practices spread over four localities. CPR's four PCN's mirror the four localities.

POPPI has recently updated it dementia rate predictions using the most up to date data from the Dementia UK: Update (2014).

The data is extrapolated from a figure produced by the JSNA in 2008, where the diagnosis figure for Essex would rise from 22,300 to 35,500 by 2025.

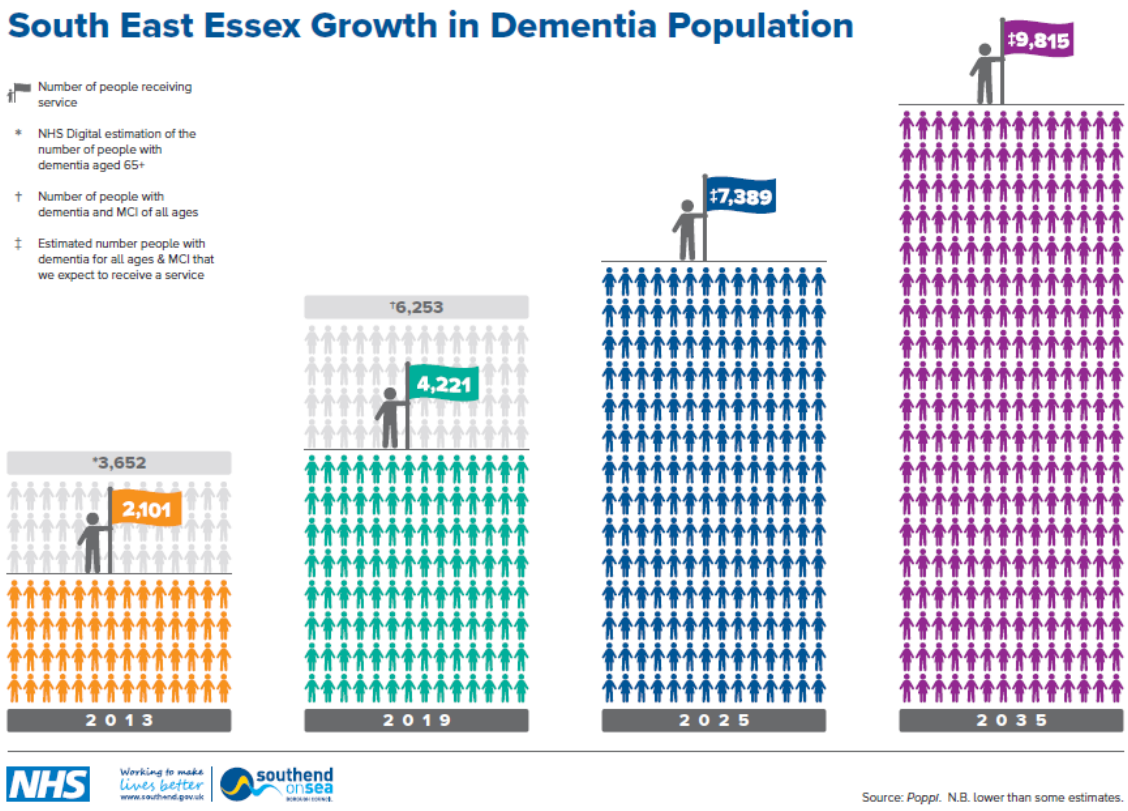
It was recognised at the time that this was substantially lower than Alzheimer Society research, which suggested a figure of 40,750 by 2025 for Essex (14% more than the JSNA estimation).

This 2008 JSNA figure is calculated from POPPI (Projecting Older People Population Information) predictions and uses the MRC CFAS II prevalence figures.

There are a number of published rate estimation percentages and the 2007 Dementia UK prevalence estimates were increased in 2014. Which is contrary to the thinking that prevalence is reducing. These in turn are both lower than those estimated in the World Alzheimer's report for Western Europe.

All of these have higher estimation percentage rates than the Medical research Council (MRC) Cognitive Function and Ageing Study II (CFAS II), which is employed in the National NHS DDR calculation. Therefore this is probably a pretty safe estimation for future planning. The CFAS II estimated percentages appear to be the lowest of any data set.

Population growth from POPPI. Extracting local data for our three LA areas Southend, Castle Point and Rochford, calculated estimated DDR using MRC CFAS II and The World Alzheimer's Report for Western Europe percentages to show the possible level of increase.

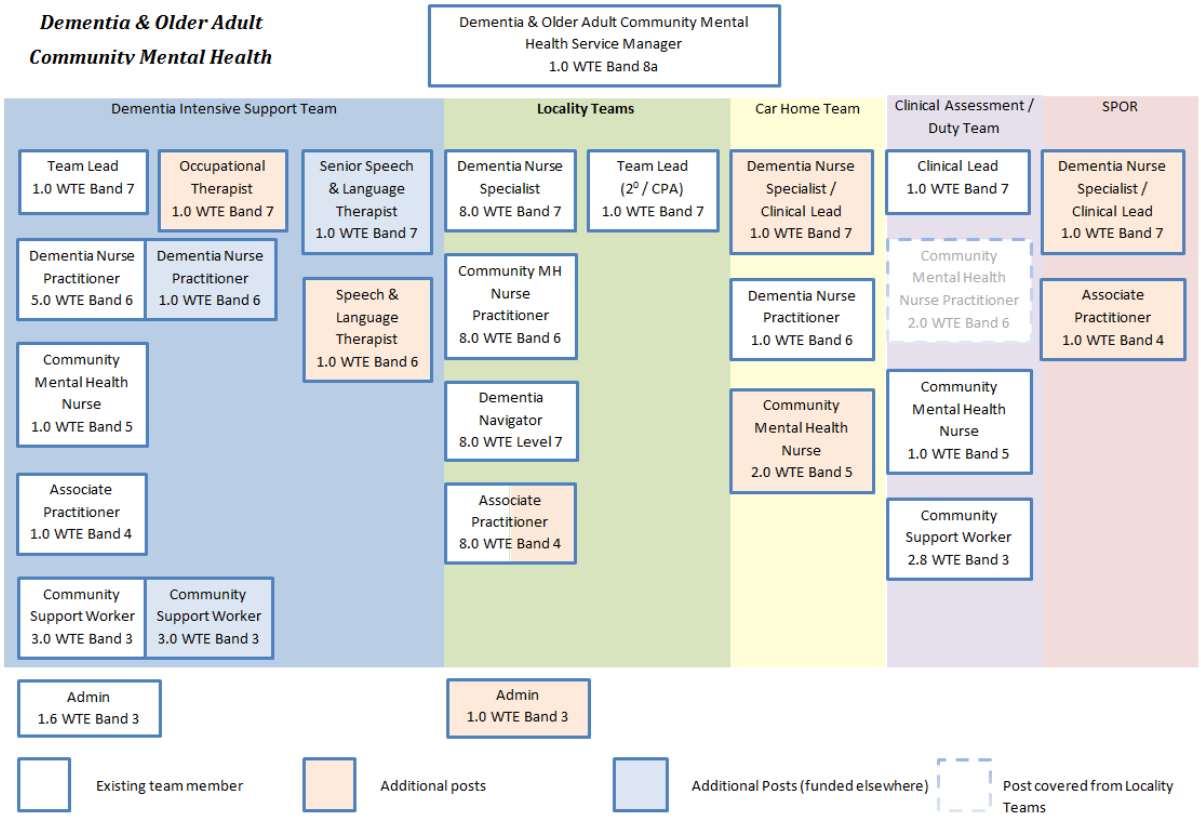



The infographic shows the rise in people with Dementia in South East Essex over the next 15 years. The person standing on top represents the current service. As shown if the number of people with dementia rises as expected the current service will not be able to safely manage and support the number of people required.

The growth numbers indicate that the number of people with dementia is likely to increase up to 4 times the current rate. However, rather than simply quadrupling the staffing numbers the business

case introduces a smarter model with a more diverse range of skilled staff which will enable the service to safely support the increase in demand for the service at a lower cost.

Table below shows the variation of spend on community dementia services across the STP. This does not include any spend on crisis teams. For the South East this is the totality of the health spend




## Dementia Spend £000

| CCG | CPR | SND | BB | THU | MID |
|---|---|---|---|---|---|
| Memory Assessment Service | 714 | 993 | 1,199 | 392 | -* |
| DIST | 192 | 197 | 813 | 397 | 465 |
| Community Dementia Nurses | 129 | 134 | 173 | 105 | -* |
| BCF Dementia Nurses | - | - | - | 114 | - |
| | 1,035 | 1,324 | 2,185 | 1,008 | 465 |

| | | | | | |
|---|---|---|---|---|---|
| **Estimated prevelance** | **2803** | **2420** | **3306** | **1512** | **5021** |

## Dementia Diagnosis Rates (DDR)

All CCG's are required to meet the constitutional target of 66.7% diagnosis rate against the estimated prevalence of those calculated to be living with dementia. Southend continues to reach and exceed the target. The most recent (July 2019) diagnosis rate was 79.4% which meant that a total of 1,922 people with dementia had a diagnosis compared to 2,420 who are thought to be living with the condition.

In Castle Point and Rochford there has been an ongoing struggle to meet the DDR. CPR met DDR in October 2018 and has teetered around the 66.7% mark for approximately 6 months. There was a slight dip in February and then the DDR slipped in May to 65.2% and increased slightly in July 2019 to 65.6%. July statistics portray that out of a possible 2,803 people with dementia 1,839 have a diagnosis.

## Costed MH Delivery Plan

Following the increase in funding to DIST to improve admission avoidance to SUHFT, there was a knock on effect in the usage of the Organic MH bed base in SEE. With occupancy reduced for an extended period to 50% (approximately). This low level of occupancy allowed a transfer of funds to increase the provision of acute adult MH beds in SEE where there were high levels of demand and consolidate Organic MH beds in Meadowview.

To ensure Southend and CP&R patients are not admitted to Meadowview (in Thurrock) an investment has been made in DIST of 1.0 WTE band 6 Nurse and 3.0 WTE band 3 support workers, to support alternatives to admission. In addition 10 beds have been identified in Rawreth Court and Clifton Lodge (5 in each) to support step-down for patients admitted to Meadowview, when assessment is completed, and step-up for short-term enhanced support, while appropriate care-package is arranged. The DIST have developed a strong working relationship with DAU and SWIFT to help support the admission avoidance process.

The investment in urgent response (DIST) is currently able to meet the current need in SEE and have kept admission numbers very low. However, it is noted that between 2019 and 2025 there will be an estimated increase in population of 28% in the 75 to 84 years age group and 17% in the over 84 age group (with a reduction in the 18 to 54 population), with an estimated increase in people with Dementia in the area to a little under 7,000. This figure does not include those diagnosed with dementia who are under 65 years of age or those diagnosed with Mild Cognitive Impairment. It is realised to support this increasing older population and numbers of individuals with Dementia, and those supporting them, an investment in wrap-around integrated community services is required, to avoid an overload of the urgent response teams and the knock on admissions to SUHFT and Organic MH beds.

## Southend's 2050 vision

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.

Our shared ambition has five themes; Pride & Joy, Safe & Well, Active & Involved, Opportunity & Prosperity and Connected & Smart.

Each theme has a number of outcomes and dementia services and support are directly influenced by a number of these such as;
Safe & Well:

- We are all effective at protecting and improving the quality of life for the most vulnerable in our community.
- Southenders are remaining well enough to enjoy fulfilling lives, throughout their lives.

Active & Involved:

- The benefits of community connection are evident as more people come together to help, support and spend time with other.
- A range of initiatives help communities come together to enhance their neighbourhood and environment
- More people have active lifestyles and there are significantly fewer people who do not engage in any physical activity

Connected & Smart:

- People have a wider choice of transport options.
- Southend is a leading digital city with world class infrastructure, that enables the whole population

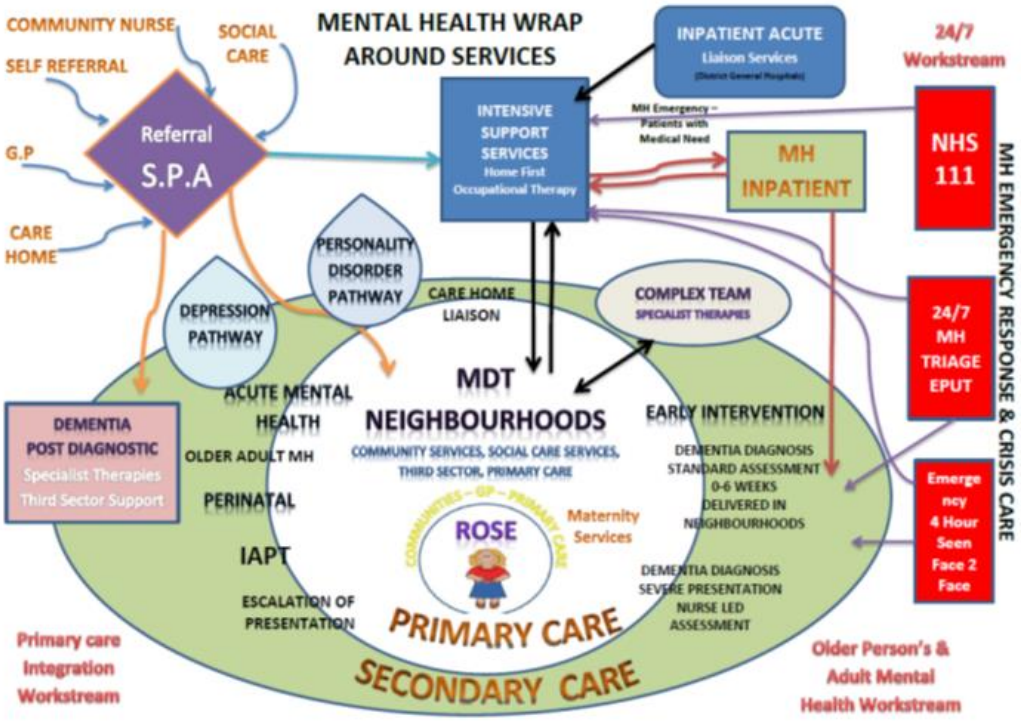
**The Five Year Roadmap timeline to 2023.**
We are already responding to some of the milestones for 2019, such as; ***Increased numbers of active people*** and ***community based social work practice embedded***. We are aligned with localities and Primary Care Networks to help us meet the 2020 milestones ***Localities – integrated health and social care services provided locally*** and are working with colleagues to be integrated with the ***New social care home operational*** and ***More integrated transport provision*** and ***Campaign for a new hospital for Southend.***

**Locality Working - A Place-Based Approach**
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.
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.
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.
Within South East Essex 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.

Essex Partnership University Trust (EPUT) have also commited to transforming dementia community services.An infographic of the model canbe found below.

## EPUT transformation drawing and community model.




## Intermediate Care Beds:

There are many different intermediate care beds available across the system as described below. The CCG is going to start a review of all intermediate care beds in order to ascertain the provision that is available across the south east. As it stands there is generally confusion and lack of clarity in terms of purpose, usage and referral pathway to the different resources. At this point it is difficult to say whether any of the facilities listed below could offer a reliable alternative to the ring fenced beds at Clifton and Rawreth.

Intermediate Care units commissioned by the CCG:

| | |
|---|---|
| CICC | 22 |
| Rosedale | 10 |
| Clifton | 35 |
| Rawreth | 35 |
| Uplands | Up to 10 on a spot purchase framework |
| Total | **108 to 118** |

The majority of referrals into the community beds come from Southend Hospital for a variety of reasons, most commonly; Rehabilitation, Community Health Care (CHC) funding, and Discharge to Asses (D2A).

CICC: Primarily a Southend resource. Rehabilitation Beds up to six weeks with a view to discharge to own home or residential placement as an interim or long term.

Rosedale: Primarily an Essex resource. Rehabilitation Beds up to six weeks with a view to discharge to own home or residential placement as an interim or long term.

Clifton: Primarily a health resource. (Southend) Discharge from hospital most likely triggering a CHC assessment.

Rawreth: Primarily a health resource. (Essex) Discharge from hospital most likely triggering a CHC assessment.

Uplands: Primarily a Southend resource. Rehabilitation Beds up to six weeks with a view to discharge to own home or residential placement as an interim or long term.

Southend Borough Council has 20 discharge to assess beds in total:

| | |
|---|---|
| Astral Lodge | 4 |
| Delaware | 8 |
| Priory House | 8 |
| Total | **20** |

Astral Lodge: D2A from hospital, medically fit patients who trigger a Social Care or CHC assessment

Delaware: D2A from hospital, medically fit patients who trigger a Social Care or CHC assessment

Priory: D2A from hospital, medically fit patients who trigger a Social Care or CHC assessment

## Dementia Community Support Team Offer:

The Dementia Community Support team are a unique dementia community team offering bespoke support pre-diagnosis through to end of live for people living with dementia and their carers.

The team is made up of:

- Dementia Navigators
- Dementia Network Coordinator
- Dementia Action Alliance Coordinator
- Peer Support Group Facilitators
- Community Engagement Worker
- Team Manager

The Dementia Community Support Team is part of an integrated service that supports people with dementia and their carers pre, peri and post diagnosis through to end of life.

The service wraps around people living with dementia and their carers, empowering and enabling them to live the life they would like with their diagnosis.

We provide an easy access, no wrong door approach to our service. Not only for people with dementia and their carers but for our partners throughout health, social care and the community. This provides seamless care with no visible hand offs to the people we support.

Our work is driven by and directly influenced by the voices, experiences and opinions of people with dementia and their carers which in turn drives the work streams of our dementia steering group.

We believe that dementia is everybody's business and therefore develop bespoke training packages which we use to enhance knowledge, skills and understanding in how to support a person with dementia across the systems. E.g. hospital, care home, community, family carers.

We are passionate that all environments and services should be dementia friendly and have created dementia friendly toolkits and resources for a variety of settings and services, such as; GP practices, care homes, domiciliary care, sheltered accommodation, dentists and funeral directors.

We pride ourselves on supporting all those involved in a diagnosis and work with both the person and their families to identify rising risk and enhancing positive risk taking rather than reacting to a crisis response. This compliments the strength based approach that we promote as a team.

We offer information, practical advice and support to understand dementia and the day to day challenges it may bring enabling independence, choice and control. Our services offer support and guidance through every step of the dementia experience, including hospital inpatient stays and residential care. We are also the crucial link to all health, social care and community support in our area.

Our aim is to help people living with dementia and those who care for them to live well by promoting health, happiness and wellbeing through a variety of ways such as:

- Promote understanding of dementia and the ways in which people can be affected, through information and education.
- Support community services to include people living with dementia in all aspects of community life by creating better access to social opportunities
- Work with all our community partners to build peer led social opportunities which are age appropriate and reflect individual interests and hobbies.

## Dementia Pathways – Scenarios.

The following scenarios looked at the journey of the five most common reasons most people living with dementia and/or their carers will find themselves in a crisis type situation. (see appendix E for scenarios)

In the table below we have described real life situations faced by the Dementia Services staff and have given examples of the added response and service (in bold) we will provide with the Silver Model and ongoing development of services.

| Scenarios | Model Silver |
|---|---|
| Carer unwell | Ambulance called by Mr A exacerbation of a chest infection. Ambulance came and took Mr A to Hospital ED and left Mrs A at home. The Ambulance service did not know Mrs A's diagnosis of dementia. Daughter alerted by hospital that dad was there and she made her way to the house. Daughter told by neighbour that mum had been seen walking along the street looking for her husband. Daughter did not know mum was home alone. Daughter went looking for mum and found her, brought her home and called DIST. DIST visited, alerted SPOR and an interim care package was implemented for mum to stay at home with regular updates on Fred's care from DIST which reassured her.<br>Mr B suffering acute issues with prostate but was refusing to attend hospital appointments due to leaving his wife who has dementia. SWIFT alerted DIST to concerns and DIST arranged with daughter that she would bring both Mr and Mrs B to DAU for the day to undergo all tests. This worked extremely well for the couple who were always together and reassured the daughter too.<br><br>**Further developments within the service:**<br>• Will ensure the dementia care plan will be available to all to ensure updated info on both patient and carer.<br>• Training and awareness to 999 / 111 services to understand care plan / dementia needs and who to go to.<br>• Tweak the alignment in terms of Social Care packages and speed of the response to requests. |
| **Carer unable to cope** | Mrs C rang GP about mum, saying Mum unable to cope at home, wandering, delusional, and psychotic. GP contacted DIST for a Mental Health Assessment for possible detention. DIST visited immediately. Due to DIST concerns SWIFT visited and took physical health tests. From these results she came into DAU for a treatment plan. Stepped up into a DIST bed at Clifton due to delirium and behaviours. She remained on Clifton for 3 weeks then returned home with a small care package.<br>Daughter of couple is a health professional. Dad has Lewy Body dementia and mum finds it difficult to understand the illness and behaviour. Daughter visited parents and due to the difficulties at home including behaviour and carer stress and breakdown, took dad to A&E with the view to detention. Dad was assessed in A&E as DAU was closed and Dr W assessed him in AMU where EOL was identified. He was eventually was |

| | |
|---|---|
| | admitted to a bed in Rawreth, where he stayed for 2 weeks and was then moved to residential care where he settled and recently died.<br><br>**Further developments within the service:**<br>• DAU being open would have been less stressful for dad and the family and this would have reduced the length of stay in hospital as he would have been assessed quicker.<br>• Ensure departments are better informed of DIST services and build on relationships**.** |
| **PWD -** Physical Health needs | 83 year old Female with Alzheimer's. Husband referred to DIST due to carer stress and felt he could not cope and wanted his wife in hospital. He was presenting with:<br>Rapid acute confusion<br>Behaviour and Systemic symptoms of infection,<br>Agitation,<br>Aggression,<br>Repeat falls / Reduced mobility.<br><br>DIST received referral and completed the initial visit. Assessment of the patient for deterioration of their organic condition completed and support offered to her husband.<br>During visit potential signs of infection noted - Referral to SWIFT made over phone whilst with the husband. SWIFT on request of referring professional attended to the patient. Physical assessment was completed including bloods within 30 minutes.<br>Mr D - PWD brought into hospital and seen by DIST in AMU as family could no longer cope Mr D had severe COPD and cardiac failure. Behaviour became increasingly difficult when feeling physical unwell. Due to DIST knowledge of the patient from community dwelling, they were able to speak to an appropriate care home who they knew would be able to meet the needs of Mr D. Called the care home and arranged for assessment. Was discharged to their care. Negated the need for CHC funding, which was the only option according to AMU.<br><br>**Further developments within the service**:<br>• Parity of services across the 2 boroughs<br>• Access to the Care Plan for all<br>• Education and constant reminders to contact services as early as possible.<br>• Ascertain whether DIST or DCST know the patient in community |
| Behaviour that challenges | PWD Mrs E contacted 999 for ambulance every day. She lived in sheltered accommodation. Sheltered accommodation wanted her to leave, hospital unhappy with repeat attending, DIST did a joint assessment on DAU with Geriatrician. Identified that admissions were cause by her forgetting she had COPD and not taking her AM meds. This resulted in multiple |

| | |
|---|---|
| | attendance from paramedics and A&E. DIST visited at home with signs to instruct her to take her medication and reminding her that she had COPD, which gave reassurance and to only call 99 if her meds were not working,. She has attended A&E once in 9 months following a fall in the street.<br>Care Home over the course of 9 months requested multiple requests for resident Mrs E to be detained due to behaviour supported by ASC. DIST identified it was environment placement issues and following a discussion with the Senior Social Worker over the course of a day at the home observing it was recommended that MRS E was moved to more appropriate care home where she still happily lives privately funded without incident.<br>Mr F was wandering. DIST staff visited and was clearly not engaging with staff. Staff stopped her from getting run over. Staff contacted police to attend for her safety. Contacted manager who alerted 136 suite. Police attended and hospital admitted her Beech Ward overnight and moved into a care home the next day where she has remained without incident.<br><br>**Further developments within the service**:<br>• Quick access to appropriate therapies<br>• Increased access to community beds<br>• Increased Police awareness and training |
| **PWD In care home:** | Toolkit & support from DIST and DCST to enhance understanding and support available including training for Care Home staff. MDT pilot to begin soon in Rose Martha Lodge. Ashley SLT supporting homes with dysphagia. Involving DIST in pre placement discussions.<br><br>**Further developments within the service**:<br>• Able to access the same services in a residential home that you would in your own home.<br>• Reduce inappropriate A&E visits direct from care home environmental issues.<br>• Care Plan for all.<br>• MDT approach for care home placement. |

## Options Appraisal

The tables below outline the options to be considered. The following outcomes, taken from Dementia Action Alliance – National Dementia Declaration have been included in each option where they are deemed to have been appropriately impacted:

Desired outcomes for people with dementia and their carers

The Dementia Statements

'*We have the right to be recognised as who we are, to make choices about our lives including taking risks, and to contribute to society. Our diagnosis should not define us, nor should we be ashamed of it.'*

*'We have the right to continue with day-to-day and family life, without discrimination or unfair cost, to be accepted and included in our communities and not live in isolation or loneliness.'*

*'We have the right to an early and accurate diagnosis, and to receive evidence based, appropriate, compassionate and properly funded care and treatment, from trained people who understand us and how dementia affects us. This must meet our needs, wherever we live.'*

*'We have the right to be respected, and recognised as partners in care, provided with education, support, services, and training which enables us to plan and make decisions about the future.'*

*'We have the right to know about and decide if we want to be involved in research that looks at cause, cure and care for dementia and be supported to take part.'*

<table>
<tr><td colspan="2">OPTIONS</td></tr>
<tr><td colspan="2">Option 1<br>Do Nothing</td></tr>
<tr><td colspan="2">Description:</td></tr>
<tr><td colspan="2">This option would mean that we continue to offer the same existing service.</td></tr>
<tr><td>Benefits:</td><td>Outcomes:</td></tr>
<tr><td>No upfront investment required but lack of community/prevention interventions would mean that other statutory services continue to increase their expenditure due to lack of preventative/community model.</td><td>Positive outcomes would be limited as services become overburdened and resources stretched to beyond capacity.</td></tr>
<tr><td colspan="2">Risks:</td></tr>
<tr><td colspan="2">Increased risk to patients due to lack of post diagnostic support options available for people with dementia and their carers.<br>Lack of quality support due to staff stress and burn out.<br>Increased costs to the system due to the increase in predicted numbers of people predicted to have dementia in the south east over the next X years.<br>More crisis support needed.<br>Increased admissions to SUHFT.<br>Increased CHC spend.<br>Increased residential care packages and social care spend.<br>More detentions under the mental health act.</td></tr>
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<table>
<tr><td>OPTIONS</td></tr>
<tr><td>Option 2:<br>Bronze standard</td></tr>
<tr><td>Description:</td></tr>
<tr><td>Bronze standard is a lower cost higher risk option that offers some increased capacity as per Silver/Silver</td></tr>
</table>

Plus option but is unable to infiltrate the system in a way that more resourced model can. The community support would be more limited and rather than offer preventative and rising risk support across all areas, the system would have to focus on particular areas.

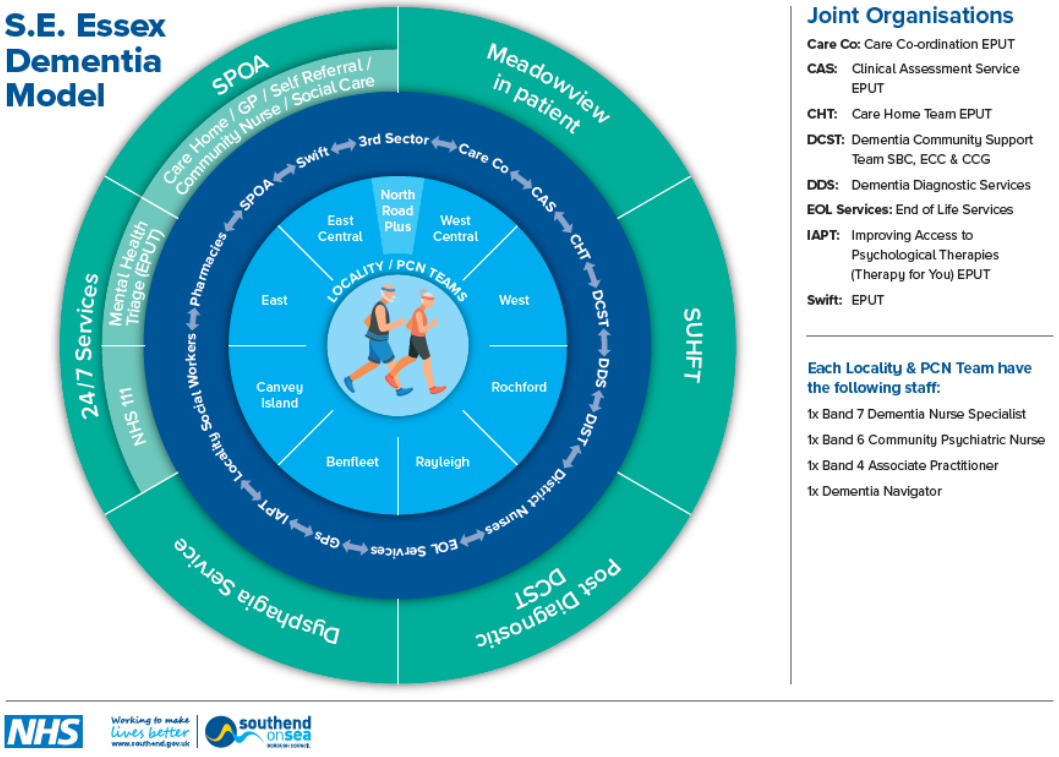
The numbers of people that will be diagnosed with dementia over the next 5, 10, 20 years will continue to increase. Work is being carried out to look to 'future proof' our dementia offer and during this process gaps and barriers/broken parts of the system have been identified.

These include inappropriate care home placements (resulting in higher cost placements; high admission/re-admission to SUHFT; carer breakdown and escalating CHC costs), lack of care home training and support plus ability for clinical services to access care packages and advise on care packages in the community. Swallowing and Dysphagia in people with dementia is also a need within care homes/community; without a plan this can result in unnecessary hospital admissions and consequently someone being discharged from SUHFT into a care home. Care homes have identified 265 individuals who they believe need a review by SLT for swallowing issues. The roles below have been identified to enable a more preventative strengths based approach to be applied to dementia practice.
People with dementia can be described as the most vulnerable in the community and should expect a decent quality of life. The plan to resource the roles below enables carers and people with dementia to have a better quality of life. This is in both their own homes and care homes, and use of community assets enables a preventative and inclusive approach that challenges stigma and discrimination. This also chimes with the national dementia statements, such as, 'We have the right to continue the day to day and family life without discrimination or unfair cost to be accepted and included in our communities and not to live in isolation or loneliness'.
**2 x band 5 Nurses:** can offer training and support to care homes on site which will enable staff to develop their understanding of clients; understand challenging behaviour; less A&E 'dumping' and to support the movement between care homes to enable people worth dementia to have the best and most appropriate care. They can help develop care home multi disciplinary team meetings with their dementia expertise and pick up a diagnosis of Mild Cognitive Impairment (this converts to a dementia diagnose in 1 in 3 cases).
**1 x Band 4 worker or equivalent to have a triage role in SPOA:** to work in SPOA to triage and allocate referrals and offer advice and support to other professionals in SPOA and hubs as needed. This is to avoid people coming to the memory services via multiple routes and being inappropriately referred. With this role all referrals could come through one point and allow them to be appropriately triaged to the right service in a timely manner. Help to act as a gatekeeper to inappropriate placements. These roles can offer a preventative element as they will be able to ensure the best use is made of community assets to support people to remain independent of services for longer.
**1 x band 6 nurse Speech and Language Therapist role:** This role will support the band 7 SLT nurse role due to the high numbers of people both in care homes and community who need support and a swallowing/dysphagia plan to help them to live independently for longer.
**1 x band 7 Dementia Specialist Nurse:** All these roles will require clinical supervision and generate work for community dementia services in terms of increased diagnosis and increased follow up care.

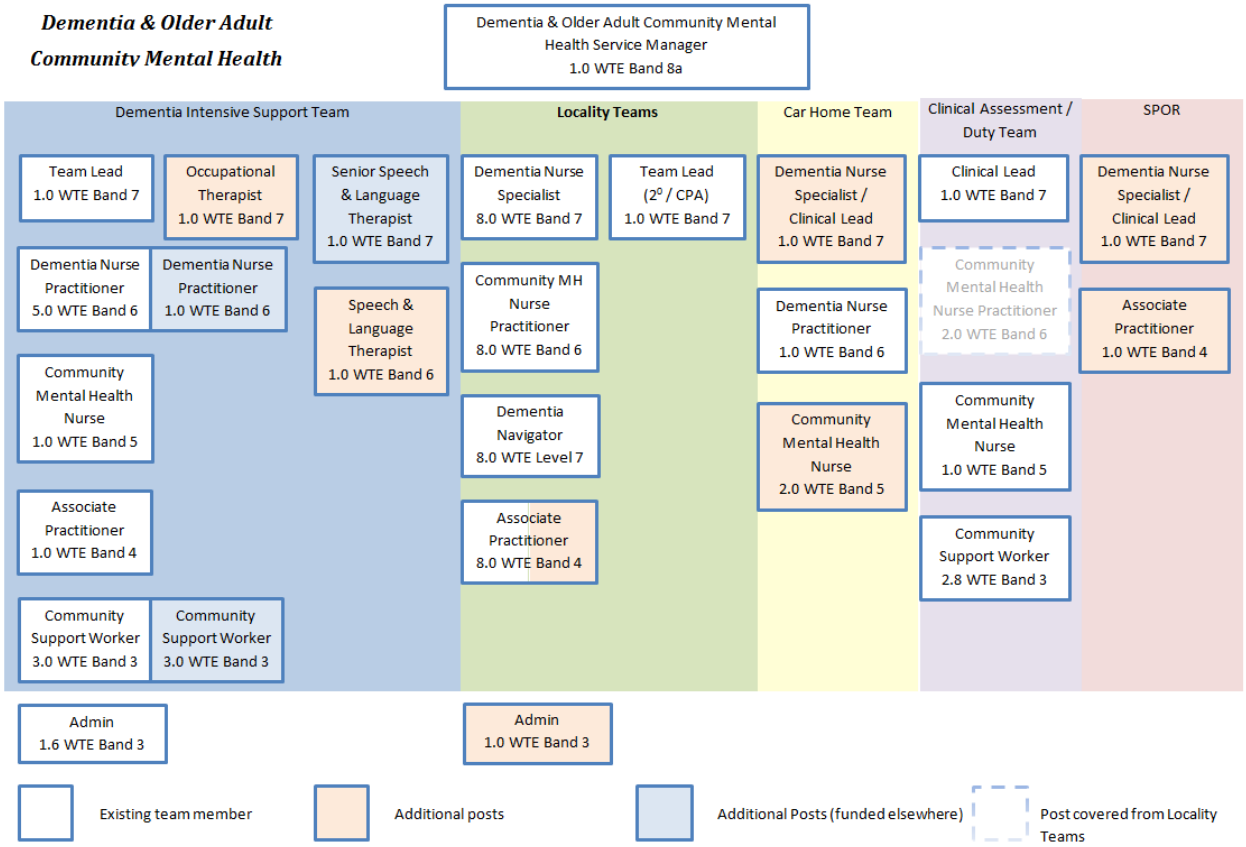
| Benefits: | Outcomes: |
|---|---|
| Lower costs<br>Care home staff training and support increased<br>Support for SPOA to triage and allocate<br>Less hand offs as dementia staff will be located with SPOA<br>Increased support for Speech and Language / Dsyphasia and swallowing problems<br>Identify rising risk to prevent escalating care home costs | ***We have the right to be recognised as who we are, to make choices about our lives including taking risks, and to contribute to society. Our diagnosis should not define us, nor should we be ashamed of it.***<br><br>***We have the right to continue with day-to-day and family life, without discrimination or unfair cost, to be accepted and included in our communities and not live in isolation or loneliness.*** |

| | |
|---|---|
| Better quality of life for people with dementia and their carers<br>Support to discharge back to own home from hospital setting with a bespoke care plan | ***We have the right to an early and accurate diagnosis, and to receive evidence based, appropriate, compassionate and properly funded care and treatment, from trained people who understand us and how dementia affects us. This must meet our needs, wherever we live.***<br><br>***We have the right to be respected, and recognised as partners in care, provided with education, support, services, and training which enables us to plan and make decisions about the future.*** |
| | |
| Risks: Using the forecasted growth for increasing dementia cases this level of resourcing is not considered to be a sustainable solution and reflects the short term picture | |

| OPTIONS |
|---|
| Option 3<br>Silver Standard |
| Description: |
| Silver standard is about introducing an effective system solution that encourages a preventative offer for people with dementia, their carers and families as well as the capacity to manage rising risk by wrapping the community offer around the person so they are considered as individuals. Based on the principles on page 2. |



## EPUT Staffing structure chart




**Team narrative:**

**Care Home Team including SLT**

A Dementia Nurse Specialist leads the Care Home Team offering expert advice and supports GP's when diagnosing. Registered Nurses can offer training and support to care homes staff on site which will enable development and understanding of their clients; understand and respond appropriately to behaviour that can be challenging and identify rising risk; This will help to reduce A&E visits and support the movement between care homes to enable people with dementia to have the best and most appropriate care. They will help develop care home multi-disciplinary team meetings with their dementia expertise and pick up a diagnosis of Mild Cognitive Impairment (this converts to a dementia diagnose in 1 in 3 cases).

The Speech and Language Therapist supports care home staff with training on Dysphagia and practical help to improve the care for residents who need support and a swallowing/dysphagia plan to help them to live independently for longer.

Locality Dementia Navigators also support the home to achieve dementia friendly accrediatation and continue to support the care home staff with basic dementia training and education around environments and offering peer support for residents families

**Locality Team providing Dementia Diagnostic Pathway**

The Locality Team are aligned with each of the eight localities and nine Primary Care Networks. The locality team are the point of contact for the GP's, Practice staff and patients. All members of the locality team will have access to the same patient record system as GP's and the other services that wraparound the patient, and all will be able to input into and update the dementia care plan. We aspire to work with

PCN's as they develop to explore how they can compliment the dementia locality offer. It is envsiaged both will work closely together.

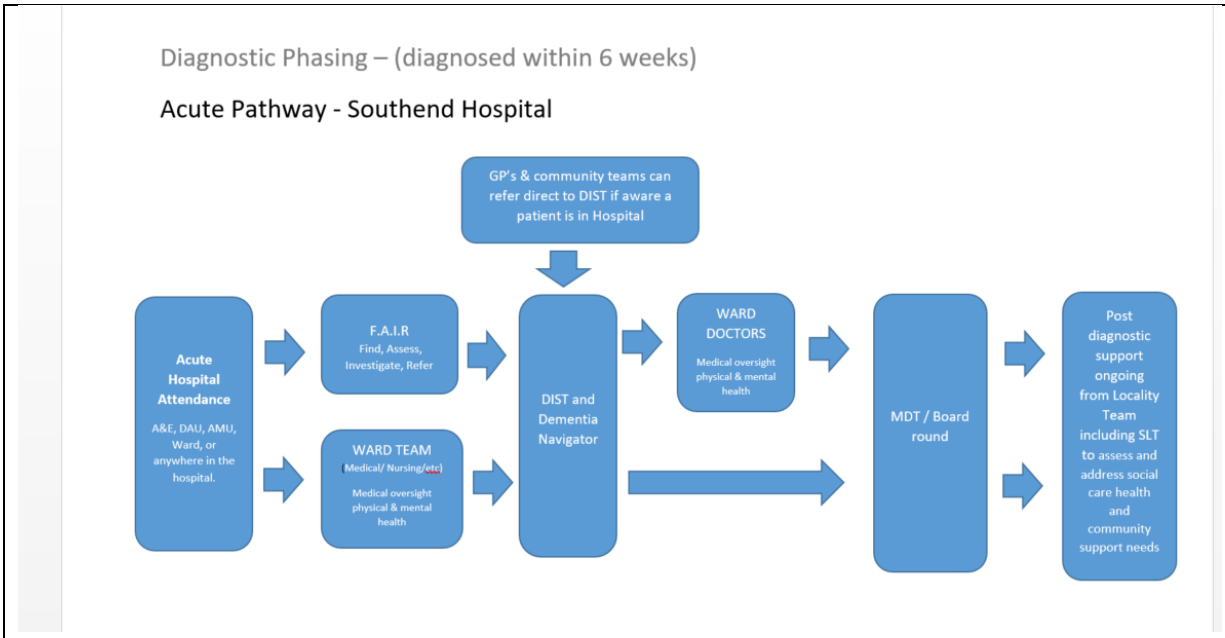
The communication between the integrated services and GP's will be greatly enhanced by the care plan and gives all professionals the opportunity to have the most up to date information on intercations with patients.

On completion of a home assessment the locality team will bring the patient to MDT where further assessments and tests can be undertaken. After this the opportunity to discuss the diagnosis will be offered.

**Clinical Assessment Service**
Offering a specialist assessment service for older adults not previously known to Mental Health services. It is an intermediate service that gives a greater level of clinical expertise in assessing a patient. This expertise ensures that individuals are referred efficiently and effectively into the most appropriate onward care pathway, including consultant lead secondary care services**.**
The service consists of a Mental Health Nurse Practitioner, Community Mental Health nurse and Community Support Workers to support comprehensive assessment and appropriate support in completing actions identified in assessment.

**SPOA**
Staffed with a Dementia (Mental Health) Nurse Specialist and an associate practitioner, this will provide a single access point to community Dementia and older adult mental health services, triaging and passing to the appropriate team/team member. They will also offer advice and support to other professionals in SPOA in providing appropriate MDT responses to referrals.
**DIST**
The Dementia Intensive Support Team work jointly with community health services, mental health, primary care, the acute trust and other agencies (including social services and ambulance services) to reduce unplanned emergency admissions to acute hospitals. The service operates from a community base but link directly with Southend General Hospitals A+E Department, DAU (Day Assessment Unit) and SPOR (Single Point of Referral). The interventions offered by the Service are aimed at managing the crisis that led to the potential need for hospital attendance and enabling people with dementia and their carers to be supported in the community to avoid an unnecessary admission. Should people with dementia be admitted to Southend University Hospital the service will support/facilitate early than usual discharge where able. The Dementia Navigator is also a part of the team, within SUHFT, attending board rounds and ensuring carer / family support is place where requested and onward referrals to the community Dementia Navigators are completed, ensuring a smooth transition between inpatient stay and community residence.

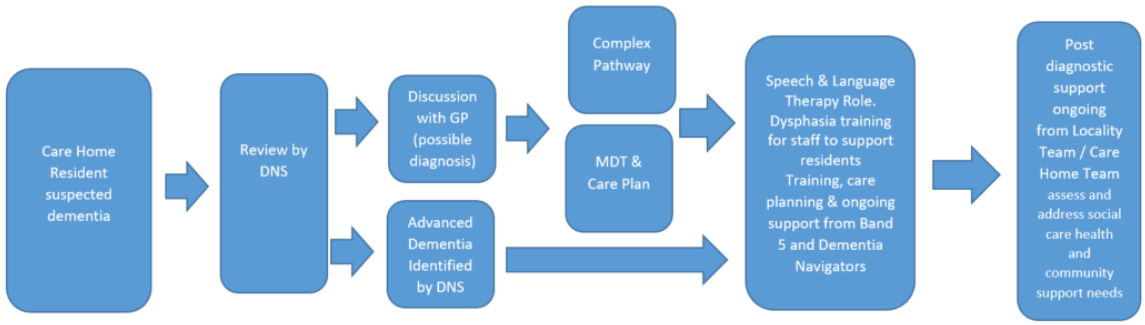
## Diagnostic Phasing




**Completed by DIST staff**
Team Lead
Dementia Nurse Practitioners
Community Mental Health Nurse
Associate Practitioner
Community Support Workers
Dementia Navigator
Admin

The Dementia Intensive Support Team work jointly with community health services, mental health, primary care, the acute trust and other agencies (including social services and ambulance services) to reduce unplanned emergency admissions to acute hospitals. The service operates from a community base but link directly with Southend General Hospitals A+E Department, DAU (Day Assessment Unit) and SPOR (Single Point of Referral). The interventions offered by the Service are aimed at managing the crisis that led to the potential need for hospital attendance and enabling people with dementia and their carers to be supported in the community to avoid an unnecessary admission. Should people with dementia be admitted to Southend University Hospital the service will support/facilitate early than usual discharge where able. The Dementia Navigator is also a part of the team, within SUHFT, attending board rounds and ensuring carer / family support is place where requested and onward referrals to the community Dementia Navigators are completed, ensuring a smooth transition between inpatient stay and community residence.

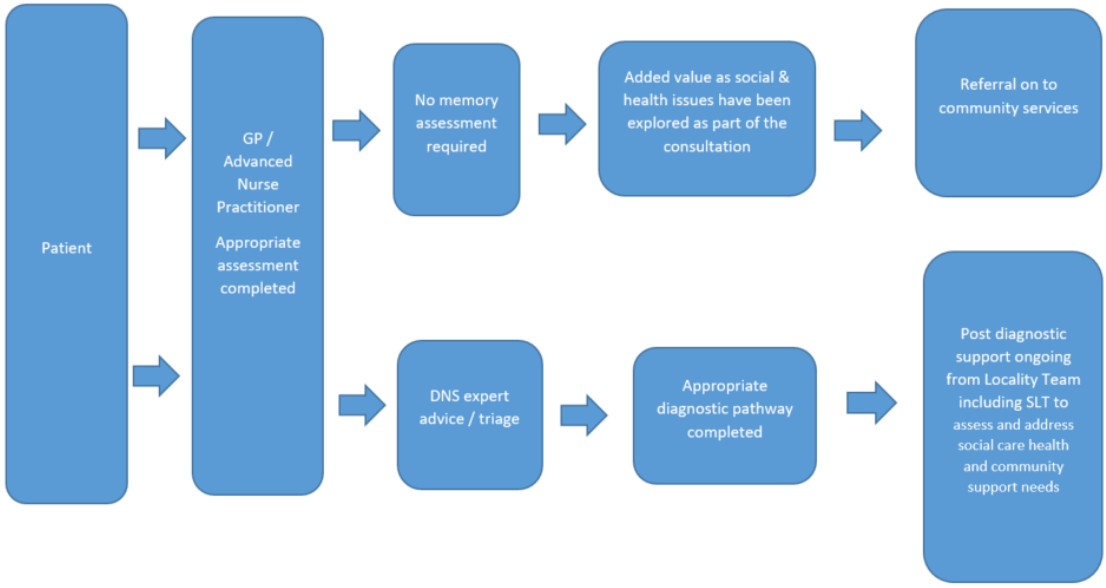
Care Home Pathway (Locality / Care Home Teams)




**Completed by Care Home Team staff**
Dementia Nurse Specialist
Dementia Nurse Practitioner
Community Mental Health Nurses

Dementia Nurse Specialist leads the Care Home Team offering expert advice and supports GP's when diagnosing. Registered Nurses can offer training and support to care homes staff on site which will enable development and understanding of their clients; understand and respond appropriately to behaviour that can be challenging and identify rising risk; This will help to reduce A&E visits and support the movement between care homes to enable people with dementia to have the best and most appropriate care. They can help develop care home multi-disciplinary team meetings with their dementia expertise and pick up a diagnosis of Mild Cognitive Impairment (this converts to a dementia diagnose in 1 in 3 cases).
The Speech and Language Therapist supports care home staff with training on Dysphagia and practical help to improve the care for residents who need support and a swallowing/dysphagia plan to help them to live independently for longer.
Locality Dementia Navigators also support the home to achieve dementia friendly accreditation and continue to support the care home staff with basic dementia training and education around environments and offering peer support for residents families

GP Pathway

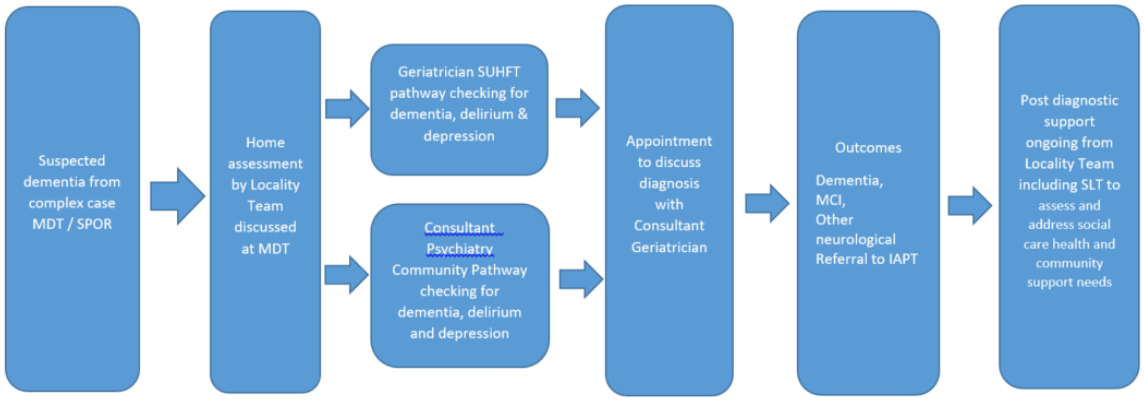


**Completed by Locality Team staff**
Dementia Nurse Specialist (DNS)
Community Mental Health Nurse Practitioner
Dementia Navigator
Associate Practitioner

The locality team are aligned with each of the eight localities and nine Primary Care Networks. The locality team are the point of contact for the GP's, Practice staff and patients. All members of the locality team will have access to the same patient record system as GP's and the other services that wraparound the patient, and all will be able to input into and update the dementia care plan.

The communication between the integrated services and GP's will be greatly enhanced by the care plan and gives all professionals the opportunity to have the most up to date information on interactions with patients.

Complex Dementia Diagnostic Pathway.




**Completed by Locality Team**
Dementia Nurse Specialist
Associate Practitioner
Consultant Psychiatrist / Consultant Geriatrician

On completion of a home assessment the locality team will bring the patient to MDT where further assessments and tests can be undertaken. After this the opportunity to discuss the diagnosis will be offered.

| Benefits: | Outcomes: |
|---|---|
| Better patient outcomes.<br>Resilience building for both the person with dementia and their carer.<br>Expert support available in the person's locality and PCN.<br>Free up primary care resources.<br>Reduction of reliance on social care.<br>Locality working which will better utilise community assets and a strength based approach.<br>Appropriate placements for care homes. | ***We have the right to be recognised as who we are, to make choices about our lives including taking risks, and to contribute to society. Our diagnosis should not define us, nor should we be ashamed of it.***<br><br>***We have the right to continue with day-to-day and family life, without discrimination or unfair cost, to be accepted and included in our communities and not live in isolation or*** |

| | |
|---|---|
| Close working with GPs and PCNs | ***loneliness.***<br><br>***We have the right to an early and accurate diagnosis, and to receive evidence based, appropriate, compassionate and properly funded care and treatment, from trained people who understand us and how dementia affects us. This must meet our needs, wherever we live.***<br><br>***We have the right to be respected, and recognised as partners in care, provided with education, support, services, and training which enables us to plan and make decisions about the future.*** |
| Risks: | |
| Using the forecasted growth for increasing dementia cases this level of resourcing is not considered to be a sustainable solution in the long term.<br>Recruitment<br>Procurement<br>Funding | |
| | |

| OPTIONS | |
|---|---|
| Option 4:<br>Silver Standard Plus | |
| Description: | |
| Silver standard is about introducing an effective system solution that encourages a preventative offer for people with dementia, their carers and families as well as the capacity to manage rising risk by wrapping the community offer around the person so they are considered as individuals. Based on the principles on page 2. The difference between Silver and Silver Plus is that Silver Plus reviews on a yearly basis and adds costs in real terms year on year to account for growth in numbers of people with dementia.<br><br>The transformation model uses team members in support worker, associate practitioner and qualified roles, in bands 3, 4, 5, 6 and 7, allowing a carer pathway and personal development within the service, while still gaining a broad range of experience, across the service functions and will allow support staff to train in service to become registered nurses over time. This 'grow your own' model also increases staff retention and job satisfaction | |
| Benefits: | Outcomes: |
| Better patient outcomes.<br>Resilience building for both the person with dementia and their carer.<br>Expert support available in the person's locality and PCN.<br>Free up primary care resources.<br>Reduction of reliance on social care.<br>Locality working which will better utilise community assets and a strength based approach.<br>Appropriate placements for care homes. | ***We have the right to be recognised as who we are, to make choices about our lives including taking risks, and to contribute to society. Our diagnosis should not define us, nor should we be ashamed of it.***<br><br>***We have the right to continue with day-to-day and family life, without discrimination or unfair cost, to be accepted and included in our communities and not live in isolation or loneliness.***<br><br>***We have the right to an early and accurate diagnosis,*** |

| | |
|---|---|
| | ***and to receive evidence based, appropriate, compassionate and properly funded care and treatment, from trained people who understand us and how dementia affects us. This must meet our needs, wherever we live.***<br><br>***We have the right to be respected, and recognised as partners in care, provided with education, support, services, and training which enables us to plan and make decisions about the future.*** |
| Risks: | |
| Using the forecasted growth for increasing dementia cases this level of resourcing is not considered to be a sustainable solution in the long term although this model is closer to reflecting the short to medium term growth by looking at additional resources required year on year.<br>Close working with GPs and PCNs. | |
| | |

| OPTIONS | |
|---|---|
| Option 5:<br>Gold Standard | |
| Description: | |
| Gold standard offers all that is available in Silver Plus but does takes a longer term view of services by using the Silver Plus short to medium term model but also commits to modelling a longer terms solution once Silver Plus has been in operation for three plus years. The thinking behind this is that this enables the community model to embed and integrate with other parts of the system plus explore cost effective ways to develop an offer for the future. The aim is to offer digital solutions and interventions too which may be in their infancy at this point in time. | |
| Benefits: | Outcomes: |
| Better patient outcomes.<br>Resilience building for both the person with dementia and their carer.<br>Expert support available in the person's locality and PCN.<br>Free up primary care resources.<br>Reduction of reliance on social care.<br>Locality working which will better utilise community assets and a strength based approach...<br>Appropriate placements for care homes.<br>Allows the system to grow and evolve organically to enhance integration and maximise community assets plus the best digital technology. | ***We have the right to be recognised as who we are, to make choices about our lives including taking risks, and to contribute to society. Our diagnosis should not define us, nor should we be ashamed of it.***<br><br>***We have the right to continue with day-to-day and family life, without discrimination or unfair cost, to be accepted and included in our communities and not live in isolation or loneliness.***<br><br>***We have the right to an early and accurate diagnosis, and to receive evidence based, appropriate, compassionate and properly funded care and treatment, from trained people who understand us and how dementia affects us. This must meet our needs, wherever we live.***<br><br>***We have the right to be respected, and recognised as partners in care, provided with education, support, services, and training which enables us to plan and*** |

| | |
|---|---|
| | ***make decisions about the future.*** |
| Risks: | |
| Using the forecasted growth for increasing dementia cases this level of resourcing is not considered to be a sustainable solution in the long term although this model is closer to reflecting the short to medium term growth by looking at additional resources required year on year.<br>Close working with GPs and PCNs.<br>XXXX | |
| | |

## Finance:

Table below shows the financial resource required for each option. A breakdown can be found in Appendix H.

| OPTION WITH COSTS | |
|---|---|
| Option 1 | £0 |
| Option 2 Bronze. 1 x Band 7. 2 x Band 5, 1 x Band 4 | £188,000 |
| Option 3 Silver. | £569, 945 |
| Option 4 Silver + | £569, 945 (plus year on year growth costs) |
| Option 5 Gold | £569, 945 (plus year on year growth costs) and commitment to review long term sustainability once Silver Plus been operational for a few years to look to cost effective longer term solutions. |

## Preferred Option

The preferred option is option 5, Gold because as well as bringing in short to medium term solutions it takes a wider, longer term view that aims to secure person centred community focussed dementia interventions, to people with dementia and their carers, that aligns to both the ageing population and forecast of increased diagnoses. This option will cost £569,945 in 2020/21 and will need the following roles to be funded:

- 2 x Band 7
- 1 x Band 6
- 2 x Band 5
- 5 x Band 4
- 1 x Band 3

The final destination for the business case and cover paper is People Scrutiny on 8 October. Once this approach has been endorsed through both CCG and SBC/ECC Governance during August and September.

## Workforce

The workforce challenges to health and social care are well known, with a 9% vacancy rate across the NHS currently reported by NHS Improvements. In developing the future model of

dementia/older adult community mental health care we have tried to manage a number of workforce challenges.

Without workforce planning being deeply imbedded in the new model the situation would only worsen. The reduction in Organic bed base in itself brings challenges to workforce development as staff progression was traditionally based on a ward to community model. Where post-registration nurses underwent preceptorship and developed the specialist dementia skills needed, then transferring to community with a good grounding in dementia care. In the future this pool will be greatly reduced, with the majority of dementia specialist roles in the community to support care at home away from acute settings both physical and mental health.

The challenge is heightened by the increasing numbers of residents over 65 and a reduction in those of working age in South East Essex over the coming years. Any model without future investment is unsustainable will eventually become overloaded, by new ways of working and upskilling the workforce we have built in a level of sustainability in the model as efficiencies should develop in the system as the model matures and workforce development takes place and is embedded in practice.

The transformation model uses team members in support worker, associate practitioner and qualified roles, in bands 3, 4, 5, 6 and 7, allowing a career pathway and personal development within the service, while still gaining a broad range of experience, across the service functions and will allow support staff to train in service to become registered nurses over time. This 'grow your own' model also increases staff retention and job satisfaction.

By integrated locality working skill-sets can be maximised, but still ensuring the highest quality of care. The service model allows the flexibility to have team members who are mental health and general nurse, looking to have duel competent/qualified nurses.

With further integration, and possible colocation, with non-mental health community services, building on the current work with teams such as SWIFT, Care Co-ordination Team, SUHFT Frailty Team amongst others, team members skills can be maximised with increased opportunity to develop a broad skill base in all practitioners, while maintaining specialist roles.

The nurse specialist in taking the role of the coordinator of care will work with a locality team including a band 6 CPN (secondary care mental health), band 4 Associate Practitioner and Dementia Navigator, with the GP and other community and primary care services in their support of those with dementia and their carers. The specialist nurse would give clinical over-sight, but others would be delegated to complete elements of review, care planning and support according to individual need, clinical indication and individual competence.

By using this model the nurse specialist (a number are non-medical prescribers and we are training more) will free time for the GP by seeing individuals for dementia related issues, hopefully within practices or at home, the associate practitioners will free time from other professionals, including the nurse specialists, GPs and consultants, by undertaking medical and physical health reviews, but having clear access to clinical support and escalation pathways for identified issues.

By using a shared electronic patient record and a shared care plan it is hoped that there will be a significant reduction in duplication and an increase in patient satisfaction (and outcome) by reducing repetition. This single care plan will also support all professionals involved in care as a single point to communicate changing needs, interventions and patient wishes for future care.

With roles also in SPOA, care home support, clinical assessment service, etc. team members in the service can develop a wide range of skills while receiving support from experienced practitioners.

## Recommendations

The recommendation is for Option 5 Gold standard as it takes a longer term view of services. This time will give us the ability to roll out current pilot projects and better understand the needs of our growing population. This will also enable the new community model to embed and integrate with other parts of the system providing high quality support, care and treatment.

## Implementation Plan

| Objective | Milestone |
|---|---|
| Business Case Agreement | October 2019 |
| Transformation oversite group | November 2019 |
| Consultation with Primary Care & other Stakeholders | November 2019 |
| Consultation with staff & Restructure | November 2019 |
| Press release | November 2019 |
| Recruitment | November 2019 |
| Stabilizing posts and use temporary staff while recruitment underway. | January / February 2020 |
| 3all posts recruited to | February – March 2020 |
| New service up and running. | April 2020 |

## Benefits Realisation

| **Desired benefit** | **Stakeholders Impacted** | **Enablers required to realise benefit** | **Outcomes displayed if benefit realised** | **Current Baseline measure** | **Who is responsible?** | **Target date** |
|---|---|---|---|---|---|---|
| Increase dementia Diagnosis | All residents of South East Essex and its health and social care economy. | Public health awareness, Dementia series embedded within primary care, improved electronic referral tools. | More people with dementia have a formal diagnosis and receive appropriate diagnostic tools. | DDR June 2019 Southend 79.4% Castle Point & Rochford 65.6% | Primary Care in collaboration with EPUT dementia services | Both areas to reach and maintain target by September 2019. All areas continue to sustain and |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | improve as o going measure. |
| Increase crisis prevention | All residents of South East Essex and its health and social care economy. | All those with a dementia diagnosis have a comprehensive dementia primary care care plan.<br><br>All Primary Care networks have aligned dementia practitioners who actively participate in dementia and frailty MDTs. | Those with a diagnosis of dementia have their care provided in the community with<br><br>Primary care. | TBC –System data required | Primary Care in collaboration with EPUT dementia services | Increase in recorded number of primary care dementia car plans by January 2020 |
| Increase crisis prevention response for people who live in the community | All residents of South East Essex and its health and social care economy | Full implementation of the community dementia model with associated additional staffing. Formal collaborative working arrangements with health and social care systems partners | Reduced number of in-patient admissions. | In-patient numbers fluctuate current numbers average 3 | Primary Care in collaboration with EPUT dementia services, social care, community and acute services. | Reduction in admissions to benchmarked figure of 20-2 beds by 31.03.2020. |
| Increase the numbers of those with dementia to die in their preferred place of | All those with a dementia diagnosis their carers and the health and social care economy | All those with a diagnosis have shared end of life care plans inclusive of preferred place of care and | Those with dementia to die in their preferred place of death | TBC – Primary Care data | Primary Care in collaboration with EPUT dementia services, social care, community | TBC –<br><br>Primary Care data |

| | | | | | | |
|---|---|---|---|---|---|---|
| death | South East Essex | death | | | and acute services. | |
| Increase the number of carers receiving appropriate support and advice | Carers of those with dementia and the health and social care economy of South East Essex | Increase in the number of recorded carers assessments | Carers receiving appropriate support and advice | Primary care data. | Primary Care in collaboration with EPUT dementia services, social care, community and acute services. | Primary Care recorded carers care plan in line with national target. |

## Risk Log

| Risk | Likelihood | Impact | Mitigation |
|---|---|---|---|
| **Clinical** | | | |
| Model is dependent on collaborative systems working | | | Robust implementation plan with options being developed |
| Recruitment – inadequate staff to deliver the new model | | | Development of a robust workforce recruitment collaborative working with system partners |
| **Financial** | | | |
| CCGs agreement to the investment and savings model | | | CCGs cognisant of the benefits to the whole health economy |
| Cost benefits of investments are not realised | | | Local and National modelling support a robust implementation plan to offset this risk |
| **Quality** | | | |
| Appropriate physical access to Primary Care Settings (GP practices / hubs) | | | Extensive engagement with GPs and pilot projects such as ISPACE and care plan pilot have previously been carried out successfully. Both CCG clinical chairs have endorsed this approach. |

# Appendices

## Appendix A: References

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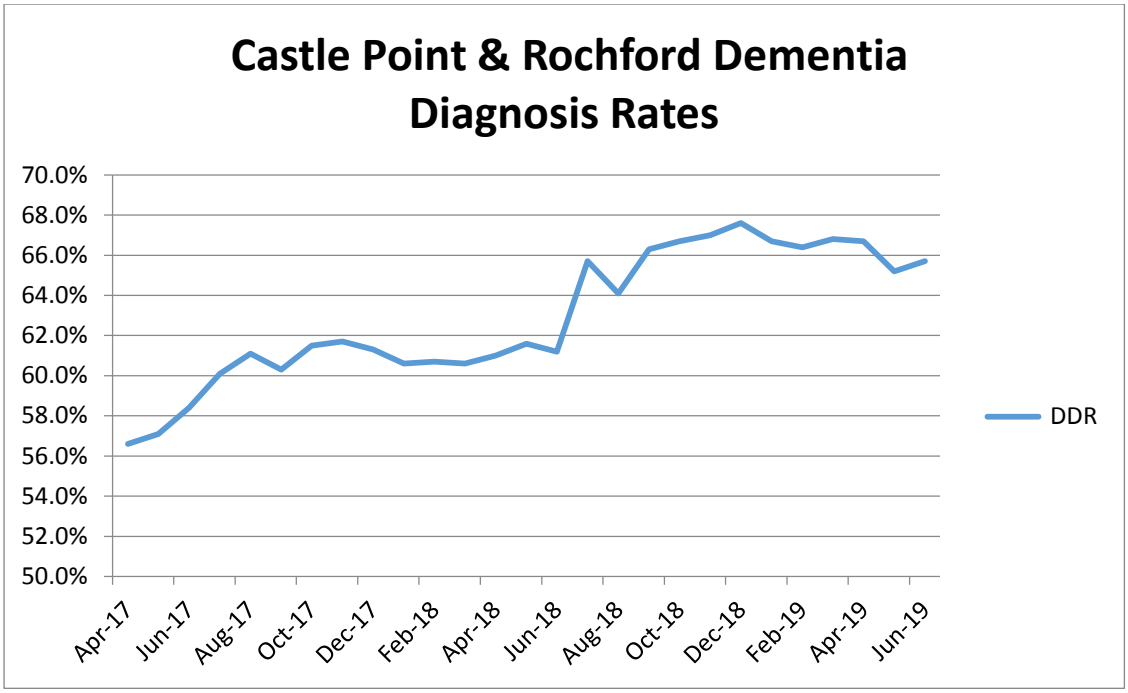
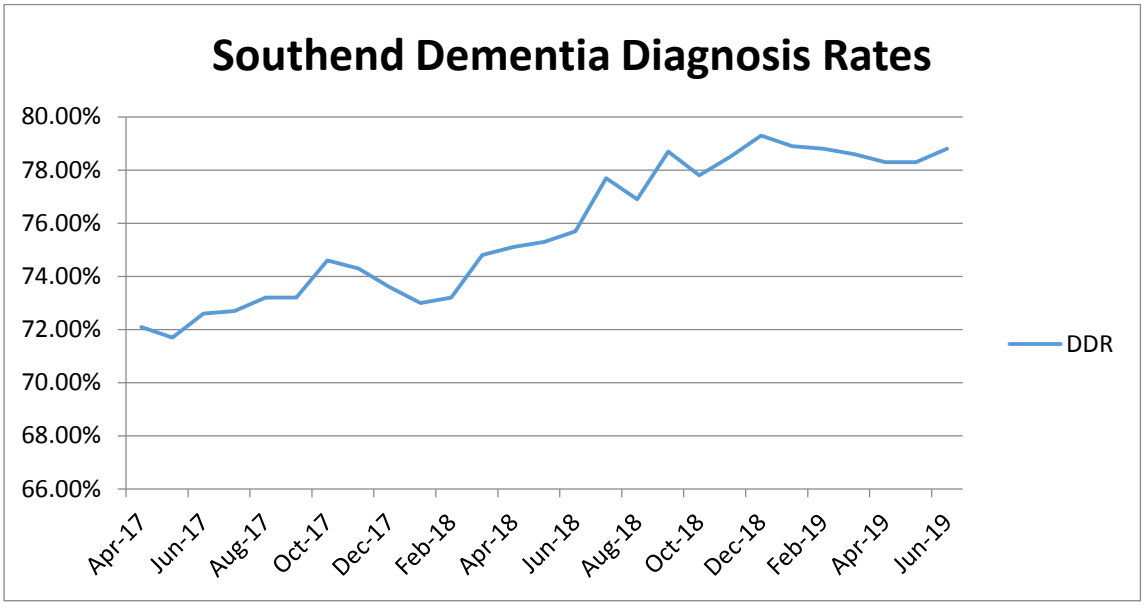
Appendix B: Dementia Diagnosis Rates

| Number of Patients with Dementia aged 65+ | Recorded | Estimated | Diagnosis rate % | Prevalence Rate Gap to meet 66.7% |
|---|---|---|---|---|
| **Jun-18** | | | | |
| Castle Point and Rochford | 1835.0 | 2794.3 | 65.7 | 28.8 |
| Southend CCG | 1902.0 | 2413.1 | 78.8 | |




Appendix C: Essex County Council Public Consultation:

RethinkingDementia_10Jan_FINAL.pdf

Appendix D: Southend 2050 vision and Locality Strategy

Appendix A_Locality Strategy Final.pdf

2050 and TT summary - one sider.p

Southend 2050 roadmap summary.pc

Southend 2050 Five Year Road Map to 202

## Appendix E: Scenarios

Wraparound support scenarios.xlsx

## Appendix F: The Dementia Statements

https://www.dementiaaction.org.uk/nationaldementiadeclaration

## Appendix G: Population growth

POPPI - Predicted To Have Dementia

| **Dementia - Southend** Bottom of Form | **2019** | **2020** | **2021** | **2025** | **2030** | **2035** |
|---|---|---|---|---|---|---|
| People aged 65-69 | 114 | 115 | 115 | 126 | 149 | 155 |
| People aged 70-74 | 268 | 265 | 265 | 244 | 269 | 318 |
| People aged 75-79 | 387 | 410 | 445 | 520 | 478 | 530 |
| People aged 80-84 | 597 | 607 | 607 | 714 | 926 | 852 |
| People aged 85-89 | 678 | 700 | 695 | 772 | 950 | 1,222 |
| People aged 90 and over | 687 | 687 | 687 | 804 | 980 | 1,275 |
| Total | 2,731 | 2,784 | 2,814 | 3,180 | 3,752 | 4,352 |

| Top of Form | **2019** | **2020** | **2021** | **2025** | **2030** | **2035** |
|---|---|---|---|---|---|---|

**Dementia - Rochford**

Bottom of Form

| | | | | | | |
|---|---|---|---|---|---|---|
| People aged 65-69 | 73 | 72 | 71 | 75 | 86 | 88 |
| People aged 70-74 | 183 | 183 | 179 | 153 | 161 | 186 |
| People aged 75-79 | 270 | 286 | 304 | 362 | 311 | 326 |
| People aged 80-84 | 406 | 416 | 416 | 486 | 617 | 547 |
| People aged 85-89 | 378 | 378 | 417 | 478 | 595 | 772 |
| People aged 90 and over | 299 | 327 | 357 | 416 | 564 | 740 |
| Total | 1,609 | 1,662 | 1,744 | 1,970 | 2,334 | 2,659 |

Top of Form

| **Dementia - Castle Point** | **2019** | **2020** | **2021** | **2025** | **2030** | **2035** |
|---|---|---|---|---|---|---|

Bottom of Form

| | | | | | | |
|---|---|---|---|---|---|---|
| People aged 65-69 | 65 | 65 | 64 | 69 | 80 | 81 |
| People aged 70-74 | 156 | 156 | 156 | 137 | 151 | 170 |
| People aged 75-79 | 228 | 240 | 263 | 316 | 275 | 303 |
| People aged 80-84 | 359 | 369 | 356 | 416 | 547 | 486 |
| People aged 85-89 | 356 | 378 | 378 | 439 | 517 | 672 |
| People aged 90 and over | 268 | 299 | 299 | 357 | 474 | 592 |
| Total | 1,432 | 1,507 | 1,516 | 1,734 | 2,044 | 2,304 |
| CP&R Total | 3,041 | 3,169 | 3,260 | 3,704 | 4,378 | 4,963 |
| Grand Total | 5,772 | 5,953 | 6,074 | 6,884 | 8,130 | 9,315 |

## Appendix H: Staff costs

| South East Essex Additional DISS Staffing Model 19/20 - Occupational Therapist | | | | | |
|---|---|---|---|---|---|
| **Pay Cost** | | | | | |
| **Roles** | **Service Description** | **Rota Type** | **Band** | **WTE** | **GBP £** |
| Occupational Therapist | Assessment for equipment in an emergency situation. Provide anxiety management and other urgent responses. | Mon-Fri 9-5 No AL,Sickness,Training cover | 7 | 1.00 | 50,400 |
| **Total Pay Cost** | | | | **1.00** | **50,400** |
| **Non Pay Cost** | | | | | |
| Travel | | | | | 1,400 |
| Mobile Phones | | | | | 450 |
| Training | | | | | 250 |
| Stationery | | | | | 220 |
| Laptops , PC & Connectivity | | | | | 851 |
| Miscellaneous | | | | | 252 |
| **Total Non-Pay** | | | | | **3,423** |
| **Total Pay & Non Pay Cost** | | | | **1.00** | **53,823** |
| Management Overhead | | | | | 5,382 |
| **Grand Total** | | | | | **59,205** |

| South East Essex Additional DISS Staffing Model 19/20 - Associate Practitioner (Triage) | | | | | |
|---|---|---|---|---|---|
| **Pay Cost** | | | | | |
| **Roles** | **Service Description** | **Rota Type** | **Band** | **WTE** | **GBP £** |
| Associate practitioner (Triage) | Integrated role within the Single point of referral supports right time right place referral pathways - improves efficiencies across the | Mon-Fri 9-5 No AL,Sickness,Training cover | 4 | 1.00 | 27,739 |
| **Total Pay Cost** | | | | **1.00** | **27,739** |
| **Non Pay Cost** | | | | | |
| Travel | | | | | 1,400 |
| Mobile Phones | | | | | 450 |
| Training | | | | | 250 |
| Stationery | | | | | 220 |
| Laptops , PC & Connectivity | | | | | 851 |
| Miscellaneous | | | | | 139 |
| **Total Non-Pay** | | | | | **3,310** |
| **Total Pay & Non Pay Cost** | | | | **1.00** | **31,049** |
| Management Overhead | | | | | 3,105 |
| **Grand Total** | | | | | **34,154** |

| South East Essex Additional DISS Staffing Model 19/20 - Dementia Specialist Nurses | | | | | |
|---|---|---|---|---|---|
| **Pay Cost** | | | | | |
| **Role** | **Service Description** | **Rota Type** | **Band** | **WTE** | **GBP £** |
| Dementia Specialist Nurses | To support increase in diagnostic and support pathways and achieving of the 0-6 week pathway | Mon-Fri 9-5 No AL,Sickness,Training cover | 7 | 2.00 | 100,799 |
| **Total Pay Cost** | | | | **2.00** | **100,799** |
| **Non Pay Cost** | | | | | |
| Travel | | | | | 2,800 |
| Mobile Phones | | | | | 900 |
| Training | | | | | 500 |
| Stationery | | | | | 440 |
| Laptops , PC & Connectivity | | | | | 1,702 |
| Miscellaneous | | | | | 504 |
| **Total Non-Pay** | | | | | **6,846** |
| **Total Pay & Non Pay Cost** | | | | **2.00** | **107,645** |
| Management Overhead | | | | | 10,765 |
| **Grand Total** | | | | | **118,410** |

| South East Essex Additional DISS Staffing Model 19/20 - Associate Practitioners | | | | | |
|---|---|---|---|---|---|
| **Pay Cost** | | | | | |
| **Role** | **Service Description** | **Rota Type** | **Band** | **WTE** | **GBP £** |
| Associate practitioners | Align to hubs support primary care in post diagnostic pathway | Mon-Fri 9-5 No AL,Sickness,Training cover | 4 | 4.00 | 110,955 |
| **Total Pay Cost** | | | | **4.00** | **110,955** |
| **Non Pay Cost** | | | | | |
| Travel | | | | | 5,600 |
| Mobile Phones | | | | | 1,800 |
| Training | | | | | 1,000 |
| Stationery | | | | | 880 |
| Laptops , PC & Connectivity | | | | | 3,404 |
| Miscellaneous | | | | | 555 |
| **Total Non-Pay** | | | | | **13,239** |
| **Total Pay & Non Pay Cost** | | | | **4.00** | **124,194** |
| Management Overhead | | | | | 12,419 |
| **Grand Total** | | | | | **136,613** |

| South East Essex Additional DISS Staffing Model 19/20 - Qualified Nurse | | | | | |
|---|---|---|---|---|---|
| **Pay Cost** | | | | | |
| **Role** | **Service Description** | **Rota Type** | **Band** | **WTE** | **GBP £** |
| Qualified Nurse | Provide Care home support/assessment review for non-complex prevent crisis | Mon-Fri 9-5 No AL,Sickness,Training cover | 5 | 2.00 | 67,774 |
| **Total Pay Cost** | | | | **2.00** | **67,774** |
| **Non Pay Cost** | | | | | |
| Travel | | | | | 2,800 |
| Mobile Phones | | | | | 900 |
| Training | | | | | 500 |
| Stationery | | | | | 440 |
| Laptops , PC & Connectivity | | | | | 1,702 |
| Miscellaneous | | | | | 339 |
| **Total Non-Pay** | | | | | **6,681** |
| **Total Pay & Non Pay Cost** | | | | **2.00** | **74,455** |
| Management Overhead | | | | | 7,446 |
| **Grand Total** | | | | | **81,901** |

| South East Essex Additional DISS Staffing Model 19/20 - Speech & Language Therapist | | | | | |
|---|---|---|---|---|---|
| **Pay Cost** | | | | | |
| **Role** | **Service Description** | **Rota Type** | **Band** | **WTE** | **GBP £** |
| Speech and Language Therapist | Support admission avoidance, care home training, support to primart and community care with dementia | Mon-Fri 9-5 No AL,Sickness,Training cover | 7 | 1.00 | 50,400 |
| Speech and Language Therapist | Support admission avoidance, care home training, support to primart and community care with dementia | Mon-Fri 9-5 No AL,Sickness,Training cover | 6 | 1.00 | 42,029 |
| **Total Pay Cost** | | | | **2.00** | **92,429** |
| **Non Pay Cost** | | | | | |
| Travel | | | | | 2,800 |
| Mobile Phones | | | | | 900 |
| Training | | | | | 500 |
| Stationery | | | | | 440 |
| Laptops , PC & Connectivity | | | | | 1,702 |
| Miscellaneous | | | | | 463 |
| **Total Non-Pay** | | | | | **6,805** |
| **Total Pay & Non Pay Cost** | | | | **2.00** | **99,234** |
| Management Overhead | | | | | 9,923 |
| **Grand Total** | | | | | **109,157** |

| South East Essex Additional DISS Staffing Model 19/20 - Admin Staff | | | | | |
|---|---|---|---|---|---|
| **Pay Cost** | | | | | |
| **Roles** | **Service Description** | **Rota Type** | **Band** | **WTE** | **GBP £** |
| PA / Admin | | Mon-Fri 9-5 No AL,Sickness,Training cover | 3 | 1.00 | 24,438 |
| **Total Pay Cost** | | | | **1.00** | **24,438** |
| **Non Pay Cost** | | | | | |
| Travel | | | | | 1,400 |
| Mobile Phones | | | | | 450 |
| Training | | | | | 250 |
| Stationery | | | | | 220 |
| Laptops , PC & Connectivity | | | | | 851 |
| Miscellaneous | | | | | 123 |
| **Total Non-Pay** | | | | | **3,294** |
| **Total Pay & Non Pay Cost** | | | | **1.00** | **27,732** |
| Management Overhead | | | | | 2,773 |
| **Grand Total** | | | | | **30,505** |

## Appendix I: SEEMS Model

SEEMS slides 051118.pptx

## Appendix J: Wraparound meeting attendees

| **Integrated Commissioning** | **(including CP&R and Southend CCG)** |
|---|---|
| Alison Birch | Head of Primary Care Development |
| Emily Francis | Integration Support Officer |
| Jose Garcia | GP/ Southend CCG Chair and Clinical Lead for Mental Health |
| Sunil Gupta | GP / Castle Point & Rochford CCG Chair and Clinical Lead for Dementia (CP&R CCG) |
| Jo Dickinson | Locality Development Manager (Dementia Lead Southend and CP&R CCG) |

| | |
|---|---|
| Hugh Johnston | Associate Director of Integrated Commissioning – Mental Health, Learning Disability and Dementia |
| Nancy Smith | Strategy and Commissioning Officer for Dementia & Dementia Community Support Team Manager |
| Paul Taylor | Associate Director of Integration and partnerships Southend and Castle Point and Rochford CCG |
| Jennifer Speller | Associate Director Primary Care |

**Southend Borough Council**

| | |
|---|---|
| Amanda Blake | Community Development Manager |
| Gemma Czerwinke | Integrated Discharge Manager |
| Jeremy Dorne | SPOA Team Manager |
| Lynn Scott | Head of Adult Social Care |
| Paul Mavin | Head of Service Business Support |
| Sarah Range | Head of Adult Mental Health and principle social worker - Adults |

**Essex County Council**

| | |
|---|---|
| Melanie Williamson | Integration & Partnership Delivery Lead - Essex County Council |
| Lorraine Mott | Dementia Commissioner Essex County Council |

**SUHFT**

| | |
|---|---|
| John Whitear | Associate Specialist in Medicine for the Elderly |
| Lindsay Popham | Dementia Nurse Specialist (Southend University Hospital) |

**EPUT**

| | |
|---|---|
| Flora Baafuo-Awuah | Team Leader, Care Co-ordination Team (Southend) |
| Subbalekshmi Reddy | Consultant in Old Age Psychiatry |
| Juliette Glackin-Fuller | Team Leader, Care Co-ordination Team (CP&R) |
| Rachel Lofthouse | Service Manager Dementia & Frailty |
| Nyssa Paige | Transformation Programme Manager |
| Kevin Mckenny | Deputy Director Integrated Care |
| Amanda Yeates | Matron Intermediate Care and Single Point of Referral Co-ordinator |
| Spencer Dinnage | Dementia & Older People's Community Mental Health (South East Essex) Team Manager |
| Stephanie Rea | Associate Director: Dementia and Older People Services |

**Other**

| | |
|---|---|
| Jacqueline Smith | Dementia Nurse Specialist & Frailty Nurse (Pall Mall Surgery) |

## Appendix K: Equality Impact Assessment

EIA - Dementia Business Case 19.08.

## Appendix L: Quality Impact Assessment:

QIA - Final.xlsx

## Appendix M: Dementia Friendly Toolkits

Care Home Toolkit.docx

Dementia Friendly Primary Care Practice

Dom Care F&F Flow Chart.docx

Dom Care P.Care Flow Chart.docx

Domiciliary Care Toolkit.docx

## Appendix N: Dementia Care Plan

Care Plan - SystmOne

# APPENDIX B

QUALITY IMPACT ASSESSMENT (6 pages)

EQUALITY IMPACT ASSESSMENT – DEMENTIA BUSINESS CASE (15 pages)

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## Instructions

This QIA process contains two stages:

1. QIA Checklist
2. QIA Tracker

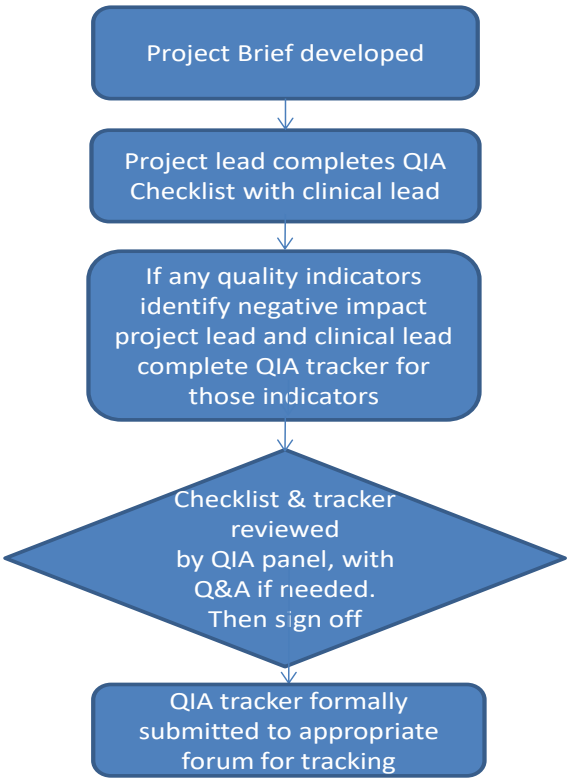
The Checklist is to be completed first by the project lead and clinical teams, using information from the project brief, and/or business case. This is to screen out whether the full tracker is required.

If potential for a negative impact is identified, that quality indicator should be pulled through to the QIA Tracker and explored in detail.

If no negative impacts are expected then it is not necessary to complete the QIA Tracker section.

Once completed QIAs should be sent to the Quality Team, copying in the PMO Transformation Lead.

Ongoing management of KPIs and risks should be managed through existing mechanisms, (e.g. risk logs, KPI monitoring processes, financial tracking processes etc), this is not designed to replace regular monitoring.



## Quality Impact Assessment Checklist

| | |
|---|---|
| **Project Name** | Transformation of Dementia Community Services |
| **Portfolio (bucket)** | Integrated Commissioning |
| **People completing the QIA** | Emily Francis, Jo Dickinson, Nancy Smith |
| **Date** | 15/08/19 |

| | RAG RATING | QIA Panel Comments |
|---|---|---|
| PATIENT SAFETY | | |
| CLINICAL EFFECTIVENESS | | |
| PATIENT EXPERIENCE | | |
| INEQUALITIES OF CARE | | |
| STAFF EXPERIENCE | | |
| TARGETS / PERFORMANCE | | |
| PROMOTING WELLBEING | | |

| | |
|---|---|
| **QIA Panel names:** | |

# Quality Impact Assessment Checklist

To be completed by the Clinical Lead and Project Manager

Please complete this tracker for all projects, to identify whether there could be a potential impact on the quality indicators shown.

If no negative impacts are identified then it is not necessary to complete the next tab - QIA Tracker

| | |
|---|---|
| **Project Name** | Transformation of Dementia Community Services |
| **Portfolio (bucket)** | Integrated Commissioning |
| **Date** | 15th August 2019 |

QIA APPROVED:

| | |
|---|---|
| Signature: Quality Lead Nurse: | |
| Date: | |

## Quality indicators to be risk assessed

| | | Quality Impact Assessment | | | Project Manager Comments | QIA Panel Comments |
|---|---|---|---|---|---|---|
| | | Please 'X' ONE for each | | | Name: Emily Francis | Name: |
| | | Chance of Impact on Indicator | | | Date: 15/08/19 | Date: |
| **Risk to** | **Quality Indicator** | **Positive Impact** | **No Impact** | **Negative Impact** | **Comments (if required) from the person completing the QIA assessment** | **Comments by the Quality Team or QIA panel approving the QIA** |
| PATIENT SAFETY | Patient safety adverse events including avoidable harm and Patient Safety Alert Services (PSAS) | x | | | The model will work to prevent patients and their carers going into crisis. | |
| | Medicine management and safe administration | x | | | Increased capacity to the service will enable the team to continue this. | |
| | Mortality HSMR/SHMI | | x | | | |
| | Any Infection control issues including MRSA/C*diff* | | x | | | |
| | CQC: Visits and Registration | | x | | | |
| | NHSLA / CNST | | x | | | |
| | Essential training | x | | | The team will deliver bespoke dementia training courses which will significantly improve the existing dementia offer in South East Essex care homes, hospitals, domiciliary care agencies, etc. | |
| | Workforce (vacancy turnover absence and revalidation) | x | | | More capacity to the service will relieve existing pressures in the system | |
| | Safe, clean, comfortable and well maintained environments/equipment | | x | | | |
| | NICE Guidance and Quality Standards, VTE, Stroke, Dementia | x | | | The model has been created according to several different guidance's and frameworks listed in the business case | |
| | Helping people recover from ill health/ injury and preventing people from dying prematurely | x | | | The service will support individuals pre, peri & post diagnosis and so identifying dementia earlier will achieve this. | |
| | Other Outcome Guidance e.g. PROMs | | x | | | |
| | Other external accreditation e.g. RCN | | x | | | |
| | National clinical audit/research and development | | x | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| CLINICAL EFFECTIVENESS | Clinical outcomes | x | | | The service will improve clinical outcomes for patients. | |
| | Breastfeeding rates | | x | | | |
| | Emergency bed days | x | | | The service will work on admission avoidance and so will be reducing the risk of crisis and therefore emergency bed days, length of stay and readmission. | |
| | Length of stay | x | | | As above | |
| | Emergency re-admissions (30 day) | x | | | As above | |
| | Minor Injuries Standards | | x | | | |
| | Day case rates | | x | | | |
| PATIENT EXPERIENCE | Patient feedback (e.g. FFT, NHS Choices, comments, compliments concerns, complaints, national and local surveys) | x | | | Extensive public consultation has taken place and this feed into the creation of the new model. | |
| | Patients, Carers and Public engagement | x | | | As above | |
| | Waits for admission / Treatment | x | | | Increased capacity to the service will enable this. | |
| | Mixed Sex breaches | | x | | | |
| | Delayed Discharge | x | | | The team will work with care homes & care providers | |
| | End of Life pathway | x | | | | |
| | Cancelled day case operations | | x | | | |
| | Waiting times for therapy services | x | | | Increased capacity | |
| | Making every contact count | X | | | This always has to be considered. he service we are moving to will have much fewer hand offs. | |
| INEQUALITIES OF CARE | Access to services - equality impact | x | | | This always has to be considered. he service we are moving to will have much fewer hand offs. | |
| | Variation in care provision | x | | | Increased capacity and range of different staffing | |
| STAFF EXPERIENCE | Workforce capability care and skills | x | | | Bespoke dementia training. The transformation model uses team members in support worker, associate practitioner and qualified roles, in bands 3, 4, 5, 6 and 7, allowing a carer pathway and personal development within the service, while still gaining a broad range of experience, across the service functions and will allow support staff to train in service to become registered nurses over time. This 'grow your own' model also increases staff retention and job satisfaction. | |
| | Working practice | x | | | | |
| | Staff satisfaction (e.g. FFT, annual staff survey / local surveys) | x | | | Increased capacity to the service will relieve existing pressures. | |
| | Mandatory Training compliance | x | | | | |
| TARGETS / PERFORMANCE | Performance | x | | | increased capacity will allow more efficient diagnoses | |
| | Achievement of local, regional, national targets | x | | | Increase in dementia diagnosis rates in Southend, Castle Point & Rochford | |

| | | | | | | |
|---|---|---|---|---|---|---|
| PROMOTING WELLBEING (in the provision of care and support) | Persons sense of personal dignity (including treatment of the individual with respect) | x | | | The service offers bespoke support to each individual i.e. will see them in a place of their own choosing. | |
| | Persons physical and mental health and emotional wellbeing | x | | | The service will also support the carers of individuals with dementia. The new service will also link in with IAPT and so will better support older people with depression. | |
| | Abuse and neglect (safeguarding) | x | | | robust safeguarding policy | |
| | Personal control over day-to-day life (including over care and support provided and the way it is provided) | x | | | Service will support person with dementia and their carers to access Adult social care if required | |
| | Opportunities for participation in work, education, training or recreation | x | | | | |
| | Social and economic wellbeing | x | | | | |
| | Domestic, family and personal relationships | x | | | | |
| | Suitability of living accommodation | x | | | The service will assess this and make recommendations. | |
| | Personal contribution to society including sustainability | | x | | | |

## pact Assessment - Tracker

ed by the Clinical Lead and the Project Manager.  Please complete this tracker for all quality indicators that have identified a negative impact, just for that line. impact has been identified it is not necessary to complete this tracker.

ed the risks from this section should be included in the individual project risk log to ensure they are monitored and mitigated appropriately.  In addition they ied and pasted into the overall QIA risk tracker to ensure they are reported and tracked by the Transformation PMO Team.

### sment Matrix

| | Risk matrix | | Severity / Impact / Consequence | | | | |
|---|---|---|---|---|---|---|---|
| Likelihood of recurrence | | | None/Near Miss | Low | Moderate | Severe | Catastrophic |
| | | SCORES | 1 | 2 | 3 | 4 | 5 |
| | Rare | 1 | 1 | 2 | 3 | 4 | 5 |
| | Unlikely | 2 | 2 | 4 | 6 | 8 | 10 |
| | Possible | 3 | 3 | 6 | 9 | 12 | 15 |
| | Likely | 4 | 4 | 8 | 12 | 16 | 20 |
| | Certain | 5 | 5 | 10 | 15 | 20 | 25 |

| | Risk Scores |
|---|---|
| Very Low Risk | 1-3 |
| Low Risk | 4-6 |
| Moderate Risk | 8-12 |
| High Risk | 15-25 |

## cker

| Negative Impact area | Description of negative impact and or risk | Likelihood | Impact | Risk Rating | Mitigating actions/controls | Residual Risk Rating | Escalation & risk tracking | Corresponding metric(s) | Tracking / monitoring forum | Risk owner |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |
| | | | | | | | | | | |
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| | | | | | | | | | | |

Castle Point and Rochford Clinical Commissioning Group
Southend Clinical Commissioning Group

# APPENDIX B EIA – DEMENTIA BUSINESS CASE
# EQUALITY IMPACT ASSESSMENT
# (ANALYSIS OF THE EFFECTS ON EQUALITY)

NAME OF PROJECT: Transformation of Dementia Community Services

DATE EIA COMPLETED: 15th August 2019

ASSESSING MANAGER:

*Please refer to the Equality Impact Assessment Guidelines at each stage when completing this template.*

## Step 1: About your piece of work

| | |
|---|---|
| Directorate | Integrated Commissioning – Partnerships and Integration |
| Lead Manager | Jo Dickinson |
| Piece of Work (hereafter referred to as "project" to be assessed | Transformation of Dementia Community Services – Business Case |
| Main purpose and intended outcomes of project | The purpose is to enhance the dementia community offer for patient's pre, peri and post diagnosis. This will be achieved by increasing staffing resources in the existing team.<br><br>By enhancing the service we will achieve the outcomes identified in the below dementia statements which were developed by the Dementia Action Alliance:<br><br>'*We have the right to be recognised as who we are, to make choices about our lives including taking risks, and to contribute to society. Our diagnosis should not define us, nor should we be ashamed of it.'*<br><br>*'We have the right to continue with day-to-day and family life, without discrimination or unfair cost, to be accepted and included in our communities and not live in isolation or loneliness.'*<br><br>*'We have the right to an early and accurate diagnosis, and to* |

| | |
|---|---|
| | *receive evidence based, appropriate, compassionate and properly funded care and treatment, from trained people who understand us and how dementia affects us. This must meet our needs, wherever we live.'*<br><br>*'We have the right to be respected, and recognised as partners in care, provided with education, support, services, and training which enables us to plan and make decisions about the future.'*<br><br>*'We have the right to know about and decide if we want to be involved in research that looks at cause, cure and care for dementia and be supported to take part.'* |
| Groups whom the project should benefit or apply to, e.g., service users, CCG staff | Any resident of South East Essex who is pre, peri or post dementia diagnosis and their carers.<br><br>Existing staff in the EPUT & SBC, ECC & CCG Dementia community support team. |
| Any associated strategies, policies, guidelines, frameworks | • Prime Minister Challenge on Dementia 2020<br>• NHS 5 Well Pathway |

| | |
|---|---|
| 86 | • NHS 5 year forward plan<br>• Next steps 5 year forward view<br>• NHS Long term plan<br>• The Care Act<br>• Mid and South STP - The STP Plan updated and published in further detail in October 2016<br>• Integration and Place based Models of Service Delivery<br>• Southend Essex and Thurrock local Authority Priorities<br>• Essex Partnership University Trust Transformation Priorities<br>• NICE, 2018. Dementia: assessment, management and support for people living with dementia and their carers. London: NICE.<br>• NICE, 2019. Dementia, disability and frailty in later life: midlife approaches to delay or prevent onset overview. London: NICE.<br>• NICE, 2019. Dementia: Quality standard [QS184]. London: NICE. |
| List any research or literature review evidencing that people with protected characteristics are specifically affected by this policy/process | As above. |

## Step 2: Initial Screening

*This section assesses whether your project has any relevance to equalities.*
You should score each element as follows:
3 – this area has a high relevance to equalities
2 – this area has a medium relevance to equalities
1 – this area has a low relevance to equalities
0 – this area has no relevance to equalities

Overall Impact Score :

| | | | |
|---|---|---|---|
| **0 points** | No or Relevance | **1 – 9 points** | Low Relevance |
| **10 – 18 points** | Medium Relevance | **19 - 27 points** | High Relevance |

**Irrespective of the total score calculated above, the overall impact is affected by the following:**
**If any one or more of the equality groups has scored 2 then the overall impact is MEDIUM**
**If any one or more of the equality groups has scored 3 then the overall impact is HIGH.**

| Project (or aspect of project) | Age | Disability | Gender | Pregnancy | Marital status | Race | Sexual Orientation | Religion | Human Rights | Total Points | Overall Impact (High, Medium Low) |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Project | 3 | 3 | 3 | 0 | 3 | 3 | 3 | 3 | 3 | 24 | High |
| | | | | | | | | | | | |
| | | | | | | | | | | | |

Please identify the main issues relating to equality and diversity within your project and explain the rationale for your equality scoring:

Have you identified any positive impacts upon any of the equality groups ?  If so, please outline.

The transformation of community dementia services will result in a positive impact to any resident of South East Essex with dementia and their carers.

The service will support any individual pre, peri and post a dementia diagnosis. There is no upper or lower age limit to the service.

With the increase in resource there will be increased capacity to the service to assess, diagnose and support people with dementia and their carers.

The increased capacity will also have a positive impact to those living in care homes as the team will be able to specifically support care homes as well as people living in the community.

Mitigations have also been put in place to prevent patients being admitted into Meadowview following the closure of Maple Ward. To ensure Southend and CP&R patients are not admitted to Meadowview (in Thurrock) an investment has been made in DIST of 1.0 WTE band 6 Nurse and 3.0 WTE band 3 support workers, to support alternatives to admission. In addition  beds have been identified in Rawreth Court and Clifton Lodge to support step-down for patients admitted to Meadowview, when assessment is completed, and step-up for short-term enhanced support, while appropriate care-package is arranged. The DIST have developed a strong working relationship with DAU and SWIFT to help support the admission avoidance process.

Since the closure of Maple Ward only one patient has been transferred to Meadowview but this was at the request of the patient's family as they live closer to Meadowview hospital.

If your overall score is **"none",** your EIA ends here. Please send this form to PMO Team for onward approval to the relevant Quality Team.

If your score is **"low",** have you identified any negative impacts of your project upon equalities? Yes / No

If Yes, please outline potential impacts and changes (however small) that can be made to tackle this impact. Please record this in Section 6. Please send this form to PMO Team for onward approval to the relevant Quality Team.

Please conduct the EIA again when you next review or change your project and please provide updates every 3 months on any remedial actions you have identified on page 4.

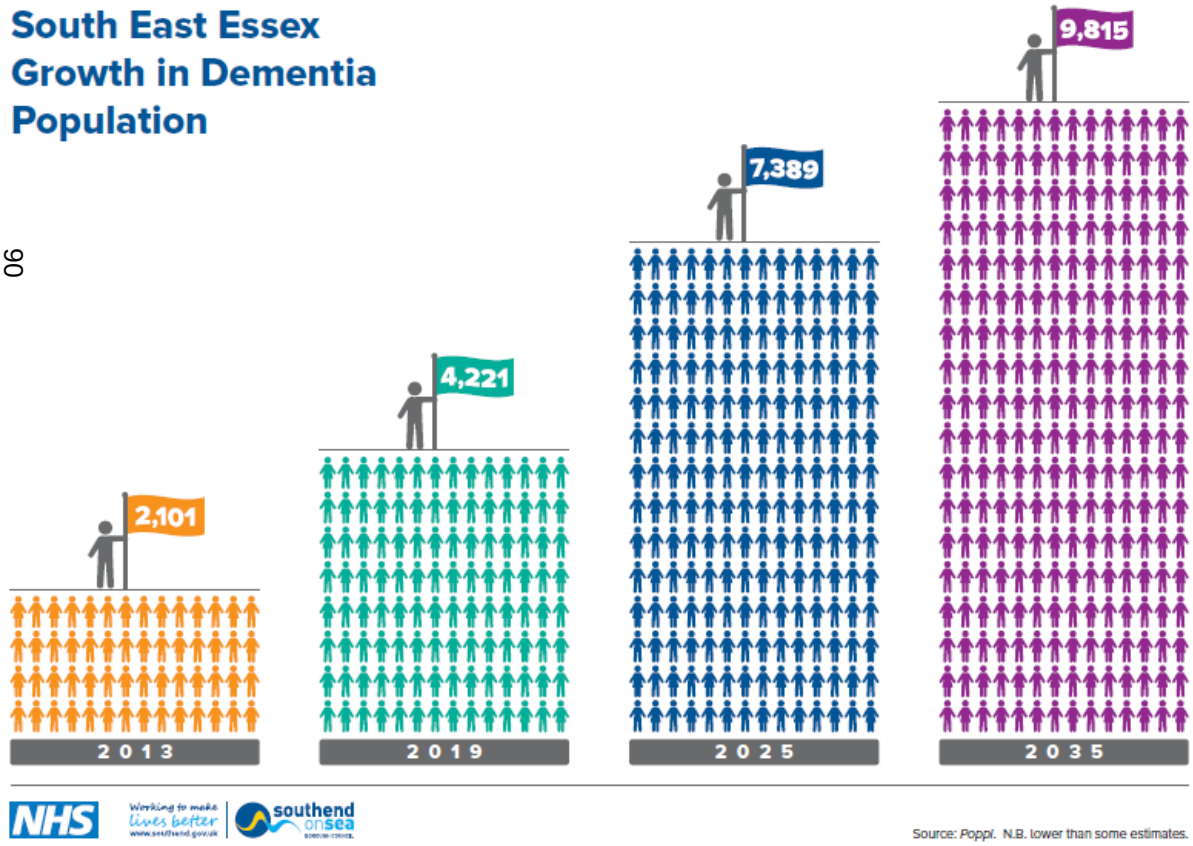


If the overall score is **"Medium or High",** please turn over to complete your EIA.

## Step 3: Scoping

*You will need to refer to the information you provided in the initial screening in step 2, and key facts and figures about the local population to complete this section. You may find it helpful to refer in detail to the questions included in the EIA Guidelines for this section*

The below Infographic shows the forecasted rise in the dementia population in South East Essex:



## Step 4: Identifying Positive and Negative Impacts

Based on the evidence you have gathered in Section 3, have you identified any potential differential impact (positive or negative) for any of the equality groups?

| | Positive | Negative |
|---|---|---|
| Age<br><br>91 | The service will support any individual living in South East Essex who is pre, peri or post dementia diagnosis and their carer. The service does not have an upper or lower age criteria. | |
| Disability | The service works in partnership with other services such as Care Coordination, Swift and IAPT. | |
| Gender | The service will support any individual living in South East Essex who is pre, peri or post dementia diagnosis and their carer. | |
| Pregnancy | N/A | |
| Race | The service will support any individual living in South East Essex who is pre, peri or post dementia diagnosis and their carer.<br>The community arm of the service will | |

| | | |
|---|---|---|
| | actively try to reach out to the BAME community as well as traditionally hard to reach groups. | |
| Sexual Orientation | The team will support carers as well as care home & sheltered accommodation staff in sensitivities and complexities around people with dementia and their sexual orientation. | |
| Marital status | The service supports carers as well as the person with dementia. There are peer support groups and one to one support to prevent the carer going into crisis which in many cases is the spouse of the person with dementia. | |
| Religion<br>92 | The community arm of the service will seek to reach out to traditionally hard to reach communities. | |
| Human Rights | | The inpatient service at Maple Ward has now closed. The closest alterative for patients is Meadowview in Thurrock. Mitigations have been put in place to prevent patients being admitted into Meadowview following the closure of Maple Ward.<br>To ensure Southend and CP&R patients are not admitted to Meadowview (in Thurrock) an investment has been made in DIST of 1.0 WTE band 6 Nurse and 3.0 WTE band 3 support workers, to support |

| | | |
|---|---|---|
| 93 | | alternatives to admission. In addition beds have been identified in Rawreth Court and Clifton Lodge to support step-down for patients admitted to Meadowview, when assessment is completed, and step-up for short-term enhanced support, while appropriate care-package is arranged. The DIST have developed a strong working relationship with DAU and SWIFT to help support the admission avoidance process.<br><br>This has been listed as a possible negative impact because of the small risk of patients being admitted to a ward in Thurrock rather than in South East Essex. However, to date only one patient has been admitted to Meadowview and this was at the request of the patient's family who lived closer to that area.<br><br>It is envisaged that the expansion to the team will strengthen and enhance the exiting community offer meaning that no patients will be admitted to Meadowview unless absolutely necessary. |

Is the impact as a result of direct or indirect discrimination? (*refer to Guidelines for definitions of these terms)* No (delete as applicable)

If the impact is as a result of indirect discrimination, please explain how this might be justifiable in meeting a particular aim of the project?

N/A

Who have you consulted about the positive and negative impact of the project on equality and what were their views?

From the 11th to the 22nd March 2019, the DIST, DCST & Care Coordination undertook consultation and engagement work with the public regarding dementia services that they had received.
In total 22 people with dementia and their carers were consulted.
Of the 22; 10 accessed DAU, 12 accessed A&E and in 3 cases detention was considered.
The Carer's were asked whether anyone had spoken to them to find out about their needs as a carer. 16 said that either DIST, ward staff, the Dementia Navigators or OPCMT had asked about their needs as a carer. The 6 that said they weren't asked had accessed A&E rather than DAU.
14 of the carers said they had been kept up to date with what is happening with the person they care for. The 8 that said they hadn't been kept up to date had accessed A&E rather than DAU.
When asked if they thought there was any overlap between the people involved with the carer or person with dementia, 4 said yes but in a positive way. 15 of the people said there was no overlap and 3 either did not know or said there was no one involved with their care.
The carers that were seen in DAU were asked to comment on their experience. All that attended gave positive feedback which included: "Professional, friendly, caring", "DAU was fantastic, staff very understanding and caring" and "Very pleased. Whole family were able to attend. Nothing was too much trouble"
The carers that were seen in A&E were also asked to comment on their experience. Apart from one comment all gave negative feedback of the experience; "busy and distressing for my mum. No quiet place, too much noise", "horrible, could not understand what was going on, no one spoke to me" and "to make a person with dementia sit in A&E for 5 hours is not right. So stressful for family".

**Consultation:**
Throughout 2016 we facilitated extensive consultation and engagement with people living with dementia, carers, general public, stakeholders and provider organisations, Adult Social Care, Care Homes and Domiciliary Care Providers.

**The following main points came from the consultations**

- Information available and accessible when and how you want and need it
- Having one point of contact from the first sign of possible symptoms through to End of Life care, who will navigate the service pathway and support the person diagnosed and their carer. This same person to be the link and liaison between the person with dementia and health, social care and third sector providers.
- Improved coordination and integration between health and social care services to enable smooth transition through the dementia pathway for patients and carers.
- Being able to take part in community life

## Step 5: What has been done to promote equality in your project and how will you evaluate how effective this has been?

The service will support any individual living in South East Essex who is pre, peri or post dementia diagnosis and their carer irrespective of any protected characteristic

The service will submit a performance monitoring framework and so Integrated Commissioning and monitor the progress of the service.

There is a well-established working relationship between EPUT and SBC/S/CPR CCG. The team meet on a regular basis to discuss any matters arising, including dementia diagnosis rates, joined up working, weekly figures.

An Integrated Care Plan template for dementia and frailty has been created and will be used on SystmOne. This will be used by all professionals involved in the care of the individual. The Care Plan will be able to be viewed and coproduced by professionals such as GPs, all staff in the dementia team, Care Coordination, etc. This will ensure professionals are working together to generate the best possible outcomes for the individual and their carer.

The Service Specification has been rewritten to ensure that the key performance indicators reflect equality monitoring and outcome focused commissioning.

**Step 6: What practical actions would help reduce any negative impact on the equality groups you have identified?**

| Issue identified | Action to be taken | Lead | Timescale |
|---|---|---|---|
| In very rare circumstances there is a chance that a patient could be transferred to Meadowview in Thurrock | Team to continue the admission avoidance work that has so far resulted in no unwanted admissions. Expansion of the team will also result it more resources to the team. | Jo Dickinson, Nancy Smith, Spencer Dinnage | Ongoing |
| | | | |
| 96 | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**You have now completed your Equality Impact Assessment**

**Please submit to PMO Team for onward approval and sign off by Quality Team.**

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# Southend-on-Sea Borough Council

**Agenda Item No.**

**6**

**Report of Deputy Chief Executive (People)**
**to**
**Cabinet**
**on**
**17th September 2019**

Report prepared by: Ruth Baker, Head of Children's Service Transformation

## Ofsted Inspection of Local Authority Children's Services

**People Scrutiny Committee**
**Cabinet Member: Councillor Anne Jones**
**Part 1 (Public Agenda Item)**

### 1. Purpose of Report

1.1 To advise Cabinet of the outcome of the Inspection of Local Authority Children's Services

### 2. Recommendations

2.1 That the report is noted

2.2 That the action plan and revised Strategic Children's Services Improvement Plan is brought to Cabinet in January 2020 to enable Cabinet to provide scrutiny and challenge of, and support for, progress

### 3. Background

3.1 Ofsted undertook an ILACS full inspection of Children's Services between 15 and 26 July. An inspection team of 4 inspectors, with 2 additional inspectors for education, fostering and adoption being present for 3 days in total, were on site for 8 days across the 10 day inspection period.

3.2 The inspection focused all areas of statutory children's social work services and early help services delivered by the Council. It did not inspect the work of partners.

3.3 During the week before the inspection team arrived on site they accessed a large of amount of performance and child level data, documents describing the work we do and reports to corporate parenting group, children's services improvement board, success for all children group, annual reports and report to LSCB.

3.4 The inspection team spoke to a number of schools attended looked after children and to 8 foster carers and adoptive parents. In addition they met with

the Young Experts Group (children in care council) and a group of 20 young people aged 16 to 25 years who are in or have left care.

3.5 For the majority of the time spent on site inspectors sat with social workers in all teams, and with their team managers, looking at the records of children. The inspectors also spent time accessing children's records on our electronic case management system alone.

3.6 Each day the lead inspector met with the Deputy Chief Executive, Director of Children's Services and some Heads of Service to give feedback on what they had seen during their previous day's activity.

3.7 ILACS result in graded judgements, an overall judgement for effectives and sub-judgements for the impact of leaders on social work practice for children, the experiences and progress who need help and protection and the experiences and progress of children in care and care leavers. The inspectors stated that services for children in Southend require improvement to be good across all areas.

3.8 The inspectors highlighted areas of significant improvement and many areas which they describe as excellent, effective and highly effective. This is contained in the opening statement within their report which says:

"*Services for children in Southend-on-Sea require improvement to be good, as was the case at the last inspection in 2016. While senior leaders have made significant progress in some areas in improving the quality of practice, despite a challenging local context, there is more work to do. Leaders have concentrated heavily on strengthening the 'front door' multi-agency response to contacts and referrals, planning for children in need and services for vulnerable adolescents, following learning from a joint inspection. These services are now highly effective".*

3.9 Other areas which were described as very strong include the work of the virtual school, planning for children in need, using the voice of children in assessments, the quality of evidence presented before the courts when we make applications to remove children from their parents care and the work of our adoption team.

3.10 The cross party political commitment, and the role of the lead member for children and learning, were identified as an area of strength within the inspection report.

3.11 The inspection report details main areas for improvement. This compares with 12 areas for improvement following the inspection in 2016. The areas for improvement are:

- Managers' and leaders' oversight, and evaluation, of the quality of frontline practice, and translating this into timely planning for improvements for children within their timeframe.
- The quality of planning for children in need of protection.
- The oversight and challenge from independent chairs of children's child protection conferences and children's care reviews.
- The timeliness and effectiveness of pre-proceedings under the public law outline (PLO) arrangements.

3.12 We are required to produce an action plan based on the four areas to improve within 60 days. The action plan will be included in a revised children's services improvement plan. It is of note that the areas identified are areas that we had been working to improve prior to the inspection within the improvement plan, at Children's Services Performance Board and in individual service plans.

3.13 The progress of our improvement plan will continue to be challenged, monitored and scrutinised by the Children's Services Improvement Board, Improvement Board Scrutiny Panel and People Scrutiny Committee.

## 4. Other Options

4.1 No other options are available

## 5. Reasons for Recommendations

None

## 6. Corporate Implications

6.1 Contribution to the Southend 2050 Road Map

Improved outcomes for the most vulnerable children in Southend contributes to all Southend 2050 ambitions and outcomes as these are children who will be the leaders, workers, business owners, citizens and users of services in 2050. The outcomes of Safe and Well, Active and Involved and Opportunity and Prosperity are those which have the strongest link to the work we are undertaking to improve outcomes for children.

6.2 Financial Implications

None identified at present

6.3 Legal Implications

None identified at present

6.4 People Implications

None identified at present

6.5 Property Implications

None identified at present

6.6 Consultation

Not required

6.7 Equalities and Diversity Implications

No implications relating to equalities and diversity were identified during the inspection

6.8 Risk Assessment

Not required at this time

6.9 Value for Money

Not identified at present

6.10 Community Safety Implications

No specific Community Safety Implications were identified as part of the inspection. The work with vulnerable adolescents, which relates to criminal and child sexual exploitation, was identified as an area of strong practice

6.11 Environmental Impact

None identified.

## 7. Background Papers

None

## 8. Appendices

Appendix 1 - Final report, ILACS inspection of Southend on Sea Borough Council

# Southend-on-Sea Borough Council

## Inspection of children's social care services

**Inspection dates: 15 July 2019 to 26 July 2019**

**Lead inspector: Brenda McInerney**
**Her Majesty's Inspector**

| Judgement | Grade |
|---|---|
| The impact of leaders on social work practice with children and families | Requires improvement to be good |
| The experiences and progress of children who need help and protection | Requires improvement to be good |
| The experiences and progress of children in care and care leavers | Requires improvement to be good |
| Overall effectiveness | Requires improvement to be good |

Services for children in Southend-on-Sea require improvement to be good, as was the case at the last inspection in 2016. While senior leaders have made significant progress in some areas in improving the quality of practice, despite a challenging local context, there is more work to do. Leaders have concentrated heavily on strengthening the 'front door' multi-agency response to contacts and referrals, planning for children in need and services for vulnerable adolescents, following learning from a joint inspection. These services are now highly effective.

However, progress has been uneven, and some improvements are not yet making enough difference for children. Senior leaders had recognised many of the weaknesses found during the inspection, but action plans are not driving improvements at a sufficient pace. While initial work to protect children at risk of harm is prompt and of a consistently good quality, too many children with longer-term plans are not made safe quickly enough. Progress in improving permanence planning for children with a plan of long-term fostering has been slow. Support and training for foster carers is starting to improve following significant challenges within the service.

Although leaders have increased management capacity, the quality of oversight and decision-making that managers provide is not yet consistently effective. As a result, weaker practice is not always recognised or challenged, and delays in making changes for children are not always addressed decisively.

A well-embedded performance management system has helped to sustain improvements in the timeliness of core social work practice, most of which is well matched to the needs of children. Senior leaders recognise that the quality assurance framework they have recently put in place is not yet providing them with a wholly accurate understanding of the quality of front-line practice or of whether children have better outcomes because of the help and support they receive.

## What needs to improve

- Managers' and leaders' oversight, and evaluation, of the quality of frontline practice, and translating this into timely planning for improvements for children within their timeframe.
- The quality of planning for children in need of protection.
- The oversight and challenge from independent chairs of children's child protection conferences and children's care reviews.
- The timeliness and effectiveness of pre-proceedings under the public law outline (PLO) arrangements.

## The experiences and progress of children who need help and protection: requires improvement to be good

1. While many of the services that keep children safe are effective, the inconsistent management oversight and grip on some key child protection processes mean that change for children is not always timely or sustained. Too many families experience repeated assessments. When risks do not reduce for children, ineffective monitoring means that there can be delay in children's cases being brought before the court.

2. Children and their families benefit from a wide range of early help services in Southend which work effectively with families to promote children's welfare and reduce risk. Partners take the lead in completing early help assessments and play an active role in planning and reviewing early help services for families. Families are involved in evaluating the help they receive; they report that things are better following intervention.

3. Initial responses to concerns about children at risk are prompt and thorough, and thresholds applied within the multi-agency safeguarding hub plus (MASH+) are proportionate and consistent. Well-considered initial decisions are made, including out of hours, about the help and protection that children need. Partners make timely and detailed referrals when they are concerned about children. Decisions and discussions about risks to children are well informed by the history of previous interventions and a wide range of partner information, including from health providers and GPs.

4. The practice of undertaking statutory visits by MASH+ social workers to establish the need for an assessment in a small number of cases means that some children and their families are having to tell their stories more than once. In other examples, duty visits delay the start of meaningful work by the allocated social worker. Leaders do not have a clear understanding of the experiences of children and families subject to this practice.

5. The risks to victims and children affected by domestic abuse are well understood. The dedicated multi-agency risk assessment team (MARAT) supports effective information-sharing on high-risk incidents and ensures that safety planning results in children's situations improving. Where risks are less acute, children and families are identified and connected to targeted support, such as groups for parents and children.

6. Assessments are timely, and children and families are connected to targeted help and support during the assessment process. This is making a difference for parents, who are being helped to address mental health or substance misuse difficulties. Children's views inform assessments through sensitive direct work with their social workers. This is supported by a flexible needs-led approach to the number of assessment visits by social workers. There is particularly strong practice in pre-birth assessment and early permanence planning. However, chronologies are not used to understand the patterns of neglect experienced by a high number of children in Southend-on-Sea.

7. The process of automatically re-assessing any family referred to the MASH+ within six months of social care involvement ending is not always proportionate to the presenting risk. Some families are subjected to unnecessary social care intervention when initial enquiries could have better established risks and informed a more appropriate response.

8. The majority of child in need planning is helping to improve children's circumstances. Social workers have time to spend with children, visits are purposeful and capture children's views, and workers build trusting relationships with children and parents. Families are given enough time and support to make and sustain changes in their parenting, an improvement since the previous inspection. Social workers plan carefully for children and families in order to ensure that they continue to receive help after their involvement comes to an end. For a small number of children, there is delay in escalating to

child protection planning where child in need work is not reducing risks quickly enough.

9. A wide range of partners participate in well-chaired and well-recorded strategy meetings, ensuring that child protection enquiries are child-centred and identify the risks to children and result in immediate safety planning. Decisions to progress to initial child protection conferences are proportionate and these meetings are now consistently timely for children and families.

10. Some child protection plans are not of a good quality. In these cases, children experience delays before receiving the level of help and intervention they need. When children are not being made safer, there is a lack of direction by managers, and limited challenge by child protection conference chairs. This means that some children are remaining in neglectful circumstances for too long, exposed to cumulative risk of harm from domestic abuse and parental ill-health and/or substance misuse. In better practice, child protection planning is more effective and helps produce positive change. Skilled social workers are able to forge working relationships with families, even where there have been high levels of resistance.

11. Practice in pre-proceedings under Public Law Outline (PLO) work is inconsistent. Poor tracking by managers and delays in commissioning assessments hamper timely decision-making about applications for court orders. At times, urgent legal planning is being delayed because of a lack of clarity about which meetings and panels make decisions. This means that some children are left in situations of risk for too long. In better managed cases, assessments are timely, and progress is closely monitored by managers. Letters to parents at the start of pre-proceedings work are too long and do not clearly explain the change required from parents to care for their children successfully.

12. Most children with disabilities are well supported by their social workers, who understand their needs well. Social work visits are purposeful and well recorded. However, inconsistent practice means that, for a very small number of children subject to a child protection plans, risks are not identified and responded to soon enough.

13. Children at risk of exploitation experience highly effective help and support from a range of skilled practitioners within the Adolescent Intervention and Prevention Team (AIPT). Children and young people benefit from persistent efforts to engage them. Risk is assessed well, and effective support services contribute to multi-agency planning. In most cases, this significantly reduces the risk of harm, and children's situations improve.

14. When children go missing from home or care, they are consistently offered return home interviews. Although these are not always completed within the required statutory timescales, they are prioritised in line with the level of risk

being presented. However, children's records do not always demonstrate that intelligence from these interviews is being shared with key professionals to inform work to prevent further missing episodes.

15. Referral pathways for homeless 16- and 17-year-olds are under-developed, resulting in an inconsistent level of response. While the number of young people presenting as homeless is small, they do not all have their needs formally assessed. Homeless young people are not always informed of their rights to become accommodated where appropriate and in line with their wishes.

16. Robust systems are in place to safeguard children who are home educated or missing from education. The work of the Fair Access Panel is ensuring that pupils do not change schools unless this in their best interests and there is sufficient support to meet their needs.

17. Arrangements to ensure the suitability of care for privately fostered children are well established. Children's welfare is monitored, and support is provided when required.

18. There is an effective system in place for the management of allegations against adults working with children. Individual risks to children are identified and responded to swiftly.

## The experiences and progress of children in care and care leavers: requires improvement to be good

19. Most children live in placements that meet their needs. When care proceedings are issued, they are concluded within recommended timescales, and timely legal permanence is secured for children. The local judiciary and CAFCASS spoke positively about the quality of evidence and care plans put before the court.

20. Wherever possible, children are matched appropriately to carers. Most children receive high-quality care in stable placements. However, when this is not the case, independent reviewing officers are not always effective in recognising and challenging children's experiences. While some children benefit from timely matching with permanent carers, delays for children in achieving permanence through long-term fostering are not being picked up and addressed effectively.

21. The overall quality of care planning is not yet good. While plans are comprehensive, too many actions are too broad and have no date for completion. Social workers' reports to children's reviews are too limited. Records of reviews are frequently missing from or are added very late to children's records. As a result, key decisions for children are not well informed by their current circumstances and delays are not always followed up by their social workers and reviewing officers. There has been little progress in

addressing these weaknesses, which were already identified at the last inspection.

22. Only a small number of children live a long way from Southend-on-Sea and for those that do there is no detriment in the quality of care and support they receive. Children in care are helped to stay in touch with family and friends; planning is sensitive and regularly reviewed to ensure that contact is a positive and fun experience for children.

23. A small number of children have experienced a high number of changes of care placements without there being any learning from disruption meetings or any pause to improve the quality of matching children to the right carers. This means that there is limited planning to reduce the risks of future placements breaking down. Very few children benefit from an up-to-date holistic social work assessment to inform their care planning reviews, even when their care plans or circumstances change.

24. The quality of the fostering service is improving, from a low base, following recent action taken by leaders. Assessments and reports to the fostering panel do not always consider foster carers' abilities to care for two or three children. As a result, decisions to place children in foster placements with other children are not always informed by current knowledge of the carer's capacity. A small number of children experience unplanned moves because, as one of several children in placement, their needs are not being met.

25. Annual reviews of foster carers have not all been completed in time or to required standards. As a result, opportunities are missed to identify how carers will be supported to undertake ongoing training and development appropriate to their experience. Not all foster carers receive regular supervision from their supervising social worker. Inspectors saw a very small number of examples of children's placements ending in an unplanned way due, in part, to a lack of earlier intervention for children and focused support for carers.

26. Children in care and care leavers get good support to keep themselves safe. This includes, where appropriate, the provision of specialist placements to address risks from exploitation. Children at risk from misusing substances get prompt support from the co-located youth drug and alcohol team (YDAT).

27. Assertive action is improving educational outcomes for children in care. The virtual school is effective and works in close partnership with social workers and carers to ensure that each child's educational needs are met and prioritised. This is an area of significant progress since the last inspection. There is challenge as well as support to schools to promote children's success, and personal education plans are of a good quality and include children's views. A specialist worker within the virtual school is helping to reduce school exclusions for children in care.

28. Inspectors saw many examples of children in care not having timely access to mental health and therapeutic support. In some instances, there were unacceptable waiting times of up to 30 weeks from referral to receiving a service. There is no dedicated pathway for children in care to access the locally commissioned mental health service for children. This causes significant problems as children already enter care with a high degree of trauma and attachment difficulties. To address this gap, senior leaders have funded a mental health practitioner who provides valuable interventions to children and their carers. Leaders recognise that they need to do more to improve children's access to therapeutic support and its impact for children and their carers.

29. Children and young people have access to advocates to take forward their concerns and complaints. Senior leaders take these representations seriously and issues are resolved, for example when children wish to change or maintain their care placement. While a small number of children have the benefit of an independent visitor, a much larger number are still waiting for this support.

30. Children's need for life-story work is clearly recognised within their care plans. In practice, however, the arrangements that the local authority has made with a dedicated service for this to be completed can lead to delays for some children whose plan is other than for adoption. Too many young people are being asked to plan for their future beyond care without a clear understanding of their past.

31. There is effective planning for children to return home from care when reunification is in their best interests. Decisions are based on thorough assessments of the needs of the children and carers concerned. This includes effective use and monitoring of planned placements with parents on a care order. After returning home, flexible support, including at evenings and weekends, ensures that children remain appropriately cared for within their families.

32. Practice for children with a plan of adoption and for adoptive parents is an area of excellence. The oversight by the agency decision-maker is thorough and robust. The service is using a virtual reality tool to help prospective adopters to understand typical early childhood experiences of those children being considered for adoption. There has been no disruption to any adoption arrangements in 10 years.

33. Care leavers in Southend benefit from strong relationship-based practice. Services are centred around a drop-in centre from where young people can access a wide range of support. Staying put with foster carers is increasingly available as an option for those care leavers for whom it is relevant. For others, there is a range of good-quality accommodation available with support as needed. Concerted efforts are made to help young people stay and thrive in their education or employment, including going to university or taking up job opportunities provided within the council. While the young people spoken to

were positive about the help they get, they did not all have complete information about their entitlements.

34. Case records for children in care are too variable in quality. Too many records are either incomplete or delayed. This can hamper the ability of a new social worker, auditor or practitioner undertaking life-story work, or even a child accessing their records in later life, to gain a clear overview of the key events in a child's life.

## The impact of leaders on social work practice with children and families: requires improvement to be good

35. There is strong cross-party political and corporate support for children's services. At a time of budget pressures, elected members have agreed additional investment in children's services and have protected non-statutory early help services. The lead member, although new in the role, is already providing effective challenge to the senior leadership team. Strategic planning for children's services is aligned well with wider corporate planning, helping to ensure that children's services are given a high priority.

36. An improvement board has driven some service developments since the last inspection. However, some areas for improvement have not yet been sufficiently addressed. The key strategic priorities and plans for improvement are well focused and emphasise the need for a better understanding of children's experiences and of measuring impact rather than just outputs. However, strategic ambition is not always translating into clear action plans at an operational level and at the pace that children deserve.

37. A case model of restorative practice is being embedded, but is too recently introduced to have positively influenced the inconsistencies in quality of practice. Leaders in Southend-on-Sea work closely with high-performing partners in practice from within the social care sector in order to inform their improvement planning.

38. Governance arrangements are effective, and the chairs of all the key boards meet regularly to plan together. Despite working within a challenging local context, senior leaders have been proactive in building a coherent multi-agency strategic framework to guide efforts to improve outcomes for vulnerable children.

39. Partnerships are a strength in Southend-on-Sea. Arrangements for vulnerable groups, such as children at risk from exploitation or domestic abuse, are highly effective. Leaders work collaboratively with CAFCASS and the family courts, and this is helping to secure early permanence for children. Partners have a high degree of trust in the senior leadership team. However, the multi-agency strategic approach to identifying and responding to neglect is underdeveloped,

despite this being a concern for many children in Southend-on-Sea. While planned initiatives around assessments and tools to measure neglect are appropriate, these are not being implemented quickly enough.

40. Progress in corporate parenting since the last inspection has been uneven. Senior leaders recognise that they need to be more ambitious in their expectations of outcomes for children in care and care leavers. Very few children are engaged in the children in care council or care leavers group, so their views are not routinely used to inform the work of the corporate parenting group. The local authority has clear plans to promote these groups and increase children's participation. The corporate parenting group is providing some successful challenge, for instance by improving timeliness of health assessments. However, it has not sufficiently focused on other key areas, such as the impact for children in care of waiting for mental health and well-being services.

41. Senior leaders understand the needs of the wider community and generally commission resources that are making a positive difference for children and their families. These include, for example, programmes for perpetrators of domestic abuse and responses to child exploitation. However, the current sufficiency strategy is not informed by a needs assessment which analyses the range and complexity of the current and future needs of children in care and care leavers. As a result, the strategy narrowly focuses on increasing the numbers of fostering households rather than on increasing residential care and accommodation for care leavers.

42. Leaders have made considerable progress since the last inspection in developing a reliable performance management framework. First-line managers now have the tools to maintain oversight of performance within teams. This is helping to sustain significant improvements in the timeliness of social work visits, assessments and child protection processes. A suite of reports, including a weekly dashboard for the chief executive and lead member, is helping leaders and managers at all levels to accurately track compliance and activity.

43. A recently revised quality assurance framework is having an impact on improving social work practice from the low base seen at the last inspection. It provides the building blocks towards a better understanding of practice and focuses on outcomes for children, rather than just inputs. However, inconsistencies in auditing have meant that senior leaders have an overly optimistic view of the quality of practice. The low number of case audits of child protection planning has made it harder to recognise weak practice in this area.

44. Senior leaders have increased management capacity since the last inspection. This has resulted in more frequent management oversight and supervision. However, the quality and effectiveness of this oversight is too inconsistent and, where drift and delay are evident in children's planning, decisive action is not

always taken by managers at all levels. As leaders have recognised, not all supervision is yet providing a reflective space. They are currently implementing a new model of 'restorative' supervision in order to secure improvement.

45. The social care workforce in Southend-on-Sea is stable and experienced, with lower than average numbers of temporary staff. While caseloads for social workers are mostly manageable, for a small number of social workers caseload complexity is not always commensurate with their level of experience.

46. Social workers told inspectors that they enjoy working in Southend-on-Sea, that they work in supportive teams and they feel valued by managers and senior leaders. Social workers see themselves as very much part of the community of Southend-on-Sea and are committed and motivated to get the best outcomes for children.

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Piccadilly Gate
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# Southend-on-Sea Borough Council

**Agenda Item No.**

**7**

**Report of Chief Executive**
**to**
**Cabinet**
**on**
**17 September 2019**

Report prepared by:
Nicola Spencer & Louisa Thomas
Data & Insights Analysts

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**Southend 2050 Outcomes Success Measures Report - Quarter 1 2019/20**

**Cabinet Member: Councillor Gilbert**

**All Scrutiny Committees**

**A Part 1 Public Agenda Item**

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## 1. Purpose of Report

1.1 To report on the first quarter of the Southend 2050 Outcomes Success Measures for 2019/20.

## 2. Recommendations

2.1 To note the Quarter 1 performance from 1 April – 30 June 2019.

## 3. Background

3.1 The Council's Corporate Performance Framework has been reviewed to provide robust and transparent performance management to drive the delivery of the five Strategic Delivery Plans. Cabinet agreed that corporate performance for 2019/20 onwards shall consist of three different functions, to enable the Council to robustly monitor and measure the progression of the desired outcomes against the five themes, which are outlined in the 2050 Road Map. The three functions are:

- a Corporate Performance Dashboard (CMT and Cabinet Members)
- a Southend 2050 Outcomes Success Measures Report
- an Annual Place-Based Report.

## 4. Southend 2050 Outcomes Success Measures Report

4.1 The Southend 2050 Outcomes Success Measures Report is a high level summary of the Council's corporate performance and progression over the quarter on the high level strategic priorities. Outcome Delivery Teams provide a strategic narrative once per quarter on the progress made with the delivery of the Southend 2050 outcomes and activity on the Road Map.

The report also contains a snapshot of key place data which will be updated as available throughout the year.

The agreed timetable for reporting is as follows**,** with additional reporting aligned to the scrutiny cycle in January 2020.

| | | To be presented to Cabinet: |
|---|---|---|
| **Quarter 1** | April – June 2019 | September 2019 |
| **Quarter 2** | July – September 2019 | November 2019 |
| **Quarter 3** | October – December | February 2020 |
| **Quarter 4** | January – March 2020 | June 2020 |

4.2 The development of outcomes-focused measures is an iterative process, to enable the measures to be reviewed and developed regularly.

## 5. Further Developments

A number of the measures included in the report have catalysed plans to work collaboratively across the organisation to improve their outcome focus. The development work planned to date is as follows:

### 5.1 Temporary Accommodation

A working group is to be formed to better understand and monitor the outcomes of interventions for those the Council is supporting to access housing.

### 5.2 Child development and Children's Centres

Further collaboration with the Early Years and Health Visitor services will be undertaken, to develop a set of outcome-focused measures regarding the range and success of interventions and services for children aged between two and five, and the use of Children's Centres.

### 5.3 Protecting and nurturing the coastline

Development work is required looking in to litter collections on our beaches especially during the peak months; the protection of nature reserves and sea defences, and educating children on the nurturing and protection of our coastline.

### 5.4 Fibre broadband and WiFi

The data currently received from the Council's WiFi and Fibre broadband suppliers will be developed to better monitor whether the intended benefits to residents and visitors, in terms of service availability, are being realised.

### 5.5 Businesses, skills and employment and high street occupancy

This will be a considerable area for collaboration between the Planning, Economic Growth, Revenues, GIS and Insights teams, with an aim to share and / or integrate the data and systems held and used by the teams to provide a meaningful picture of activity and outcomes in the borough to support and evidence the vision of the Council's Economic Growth Strategy 2017-2022, and to evidence Opportunity and Prosperity outcomes.

5.6 **Independent living and care homes**

Further work will be done to measure the independency of those living in supported living and care homes across the borough.

5.7 **Volunteering**

A mapping exercise will be undertaken to ascertain which parts of the Council uses volunteers and to capture the full breadth of volunteering activity, with further plans to broaden the dataset to include demographic data on volunteers, give insight on the barriers and enablers to volunteering, and the inclusion of SAVS data.

5.8 **Voters**

Development work is planned to map and improve the data and insights available regarding voters' registration rate, turnout, demographic, residential ward, accessibility and other social factors affecting registration.

5.9 **Transport**

The data currently collected annually via the National Highways and Transport Survey will be developed to increase the frequency of data collection regarding smart signalling, traffic flow optimisation, passenger transfer trends and experience, and the experiences of people who use public transport of all kinds in the borough.

5.10 **Air Quality and recycling**

At present, data for air quality is available via a live feed but validated on an annual basis to provide an annual mean. Further work is needed to collect data that can indicate the outcomes for residents resulting from the improvement works being undertaken at various major junctions.

5.11 **Tree planting and removal**

As trees are only planted in the winter months, data is currently reported annually at the end of the planting season. A register of tree removals is maintained on an on-going basis. Further development work will be done with the Parks Management teams to increase the frequency and completeness of data collection on tree planting and removals and to devise meaningful, outcomes-focused measures.

## 6. Reasons for Recommendation

To drive the delivery of the Southend 2050 ambition through robust and strategic performance management arrangements.

## 7. Corporate Implications

Contribution to Council's Ambition and corporate priorities:

To strategically monitor the Council's corporate performance and achievements against the 2050 Road Map and Outcomes.

## 8. Financial Implications

There are no financial implications.

## 9. Legal Implications

There are no legal implications.

## 10. People Implications

People implications are included in the monitoring of performance relating to the Council's resources where these relate to the Council's priorities.

## 11. Consultation

The new performance framework and measures to be included in future performance reporting are included in the Strategic Delivery Plans which were developed through extensive consultation and engagement to articulate the Southend 2050 ambition.

## 12. Equalities Impact Assessment

The priorities and outcomes contained with the 2050 Five Year Road Map are based upon the needs of Southend's communities. This has included feedback from consultation and needs analyses.

## 13. Risk Assessment

The Corporate Risk Management Framework shall be managed alongside the new monitoring for corporate performance. This information shall form part of the new corporate risk register that is managed by the Internal Audit team.

## 14. Value for Money

Value for Money is a key consideration of the Southend 2050 Performance Framework, including the outcome-based investment work, to help assist in identifying Value for Money from services.

## 15. Community Safety Implications

Performance Indicators relating to community safety are included in the Strategic Delivery Plans as well as the Southend 2050 Annual Place-based Report.

## 16. Background Papers

16.1 Monthly Performance Reports (MPRs) from April 2018 to March 2019.

## 17. Appendices:

17.1 Appendix 1: Outcomes Success Measures Report – 1 April–30 June 2019

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BOROUGH COUNCIL

OUR SHARED AMBITION

SOUTHEND 2050
it all starts here

# Outcomes Success Measures Report
# 1 April - 30 June 2019

# Southend 2050: Five Themes and 23 Outcomes for 2023

**Pride & Joy**

**PJ 01** - There is a tangible sense of pride in the place and local people are actively, and knowledgeably, talking up Southend.
**PJ 02** - The variety and quality of our outstanding cultural and leisure offer has increased and we have become the first choice English coastal destination for visitors.
**PJ 03** - We have invested in protecting and nurturing our coastline, which continues to be our much loved and best used asset.
**PJ 04** - Our streets and public spaces are clean and inviting.

**Safe & Well**

**SW 01** - People in all parts of the borough feel safe and secure at all times.
**SW 02 -** Southenders are remaining well enough to enjoy fulfilling lives, throughout their lives.
**SW 03** - We are well on our way to ensuring that everyone has a home that meets their needs.
**SW 04 -** We are all effective at protecting and improving the quality of life for the most vulnerable in our community.
**SW 05** - We act as a Green City with outstanding examples of energy efficient and carbon neutral buildings, streets, transport and recycling.

**Active & Involved**

**AI 01 -** Even more Southenders agree that people from different backgrounds are valued and get on well together.
**AI 02 -** The benefits of community connection are evident as more people come together to help, support and spend time with each other.
**AI 03** - Public services are routinely designed, and sometimes delivered, with their users to best meet their needs.
**AI 04** - A range of initiatives help communities come together to enhance their neighbourhood and environment.
**AI 05** - More people have active lifestyles and there are significantly fewer people who do not engage in any physical activity.



**Opportunity & Prosperity**

**OP 01 -** The Local Plan is setting an exciting planning framework for the Borough.
**OP 02** - We have a fast-evolving, re-imagined and thriving town centre, with an inviting mix of shops, homes, culture and leisure opportunities.
**OP 03** - Our children are school and life ready and our workforce is skilled and job ready. Leads
**OP 04 -** Key regeneration schemes, such as Queensway, seafront developments and the Airport Business Park are underway and bringing prosperity and job opportunities to the Borough.
**OP 05** - Southend is a place that is renowned for its creative industries, where new businesses thrive and where established employers and others invest for the long term.

**Connected & Smart**

**CS 01 -** It is easier for residents, visitors and people who work here to get around the borough.
**CS 02 -** People have a wide choice of transport options.
**CS 03 -** We are leading the way in making public and private travel smart, clean and green.
**CS 04** - Southend is a leading digital city with world class infrastructure.

# Annual Information

Unemployment
3,200 - 3.4%
(April 2018 - March 2019)

4,400 4.6%
(April 2017 - March 2018)

£280,350.00
Average House Price Southend

£245,817.00
Average House Price England
(May 2019)

182,500
Mid-year Population Estimate for Southend
(Nomis July 2018)

1,035
New businesses (2017/18)

1,115
Businesses closed (2017/18)

Teenage conception for under 18's rate of 24.3 per 1,000 (number 70) (2017)

## Transport

75% of people found it easy to get around the borough (2018/19)

63% of people with a disability found it easy to get around the borough (2018/19)

72% of people who do not have a car found it easy to get around the borough (2018/19)

88.1% of children in good or outstanding schools (June 2019)

Early Years Foundation Stage Profile
Achieving a Good Level of Development
74.0%

## Trees

Figures do not include whips

In 2016/17 we planted 322 trees and removed 310

In 2017/18 we planted 279 trees and removed 373

In 2018/19 we planted 384 trees and removed 412

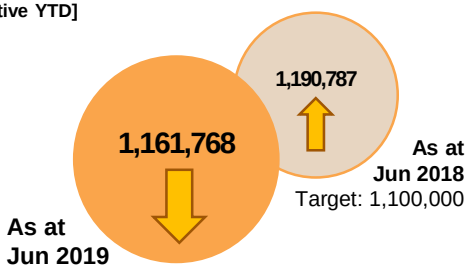
56% Agree people from different backgrounds get on well together*

75% Satisfied with local area as a place to live*

*2018 residents' perception survey, sample 1239 Southend residents

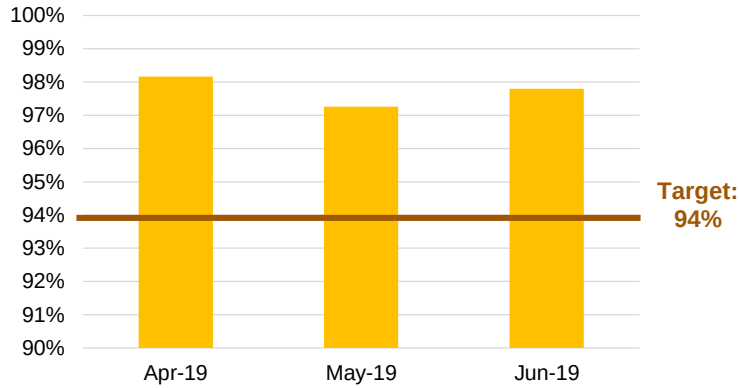
## Participation and attendance at Council owned / affiliated cultural and sporting activities and events and the Pier

**[Cumulative YTD]**

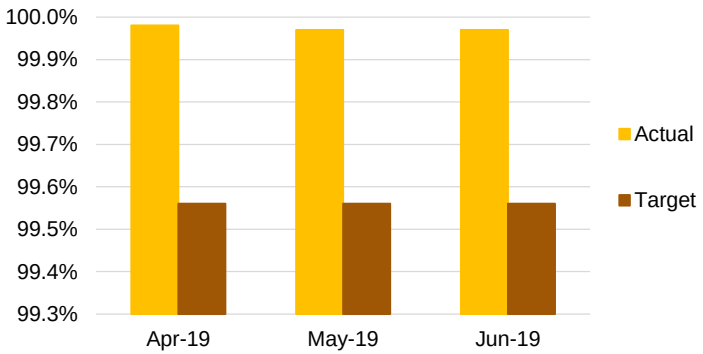



## Acceptable standard of cleanliness: litter

**[Cumulative YTD]**

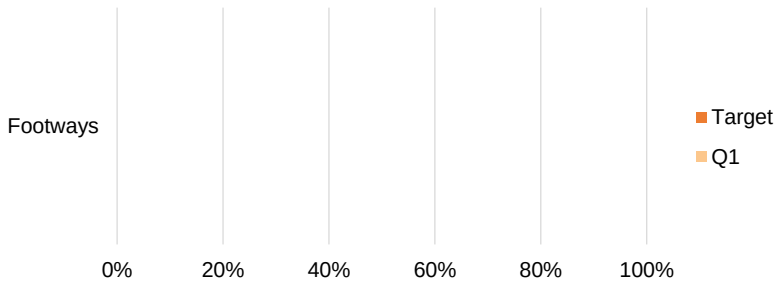



## Waste collections success rate




## Safety Inspections completed on time

**[Awaiting data]**




## Social Media Campaigns

**190**

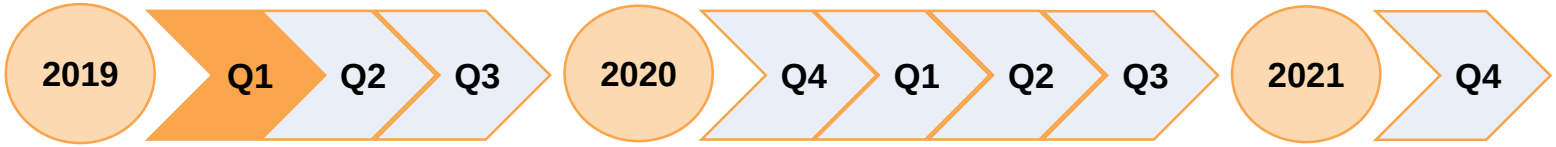
**Number of Instagram photos tagging the Council**
As at June 2019

**1,179**

**Skate park – number of votes on name**
As at June 2019

### Key insights:

- Instagram reach: 9,906. Other social media channels: 72,658 = Total: 82,564
- Pier numbers: 38,370 (June admissions) and 6,853 attended in the last weekend of June alone
- Veolia carry out over 1.8m waste collections across the borough every month, equating to a collections success rate of **99.97%**
- Litter: **97.79%** against the target of 94%


## Quarter 1: Update

The Council and Veolia supported a number of volunteer activities in relation to beach cleaning litter picks, approx. 300 street champions, of which 104 were recruited in this quarter. Additional street washing has taken placed in high footfall areas and, as part of a spring clean campaign in the High Street, a visual media campaign "my street is your street" has continued.

Various amendments on the Seaway Development were agreed at Cabinet in January 2019. The relevant documentation has been completed with Turnstone and the planning application continues to go through the planning process, which will be heard at the Development Control Committee in the autumn.

Discussions have been had with the fund manager and property agent for the Kursaal to understand the issues and their plans for the property.

Work between the property team and Focal Point Gallery in partnership with South Essex College continued to complete the internal layout and finishes of the spaces to complete to RIBA stage 4, ready to be submitted to full planning consent. The development will see Focal Point Gallery expand its offer and launch digital art production spaces and studios to support the creative community. Facilities will include editing and sound recording suites, green screen and photographic studios and significant creative workspace.

The #PrideAndJoy campaign has been very popular on several social media channels. With the objective to flood the internet with positive images of Southend-on-Sea at its best, and to spread the sense of pride and joy in the borough. Through Instagram alone the number of people who have seen the material and photos is 9,906 people; and other social media channels such as Facebook and Twitter was seen by over 72,000 people. In the short time, this campaign is already starting to flood social media with positive images on the borough, enabling and encouraging people to visually 'talk-up' Southend.

The Council also held a competition for naming the new skate park, now named Skatey McSkateface. Various channels of engagement were done through social media, media and PR and new signage in key locations. As a result there was wide spread media coverage from the BBC and local and national newspapers.

## Future milestones

Additional beach litter bins will be placed out to support summer cleaning activities, accompanied by a "my beach is your beach" campaign. Work will also take place to highlight the need to avoid litter and plastics ending up in the marine environment, building a fish sculpture that visitors can fill with litter to publicise the issue. 20 new cigarette bins will be places out in the High Street and Veolia will continue to deploy additional seasonal resources, including putting out a call for more volunteers.

Dialogue is to continue with an open-door for the discussion of options and initiatives with the Council regarding securing a viable future for the Kursaal.

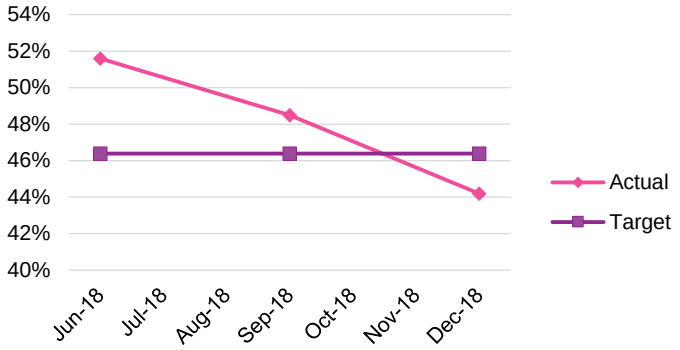
## Key insights:

- A total of **406** street begging / vagrancy / rough sleeping engagements and **179** Anti-Social Behaviour (ASB) Incidents were attended to by the Council's Community Safety Unit team
- Q3 2018/19 household waste and recycling was 43.20% (DEFRA dataset) – this has fallen due to the dry summer last year
- The rate of households per 1000 households in temporary accommodation has increased to 2.51, up 0.78 compared to a rate of 1.78 in June 2018
- 65.8% (132/202) successfully completed Looked After Children health assessments. 7% (15) children refused and 17% (36) were over the age of 15
- 102 new affordable homes added in 2019/20 to Southend, building the new housing supply
- The LAC child's voice case note is now live on Liquid Logic and a survey of LAC and care leavers was carried out in June 2019, with analysis of results being completed
- 318 LAC under 18 years old as at June 2019



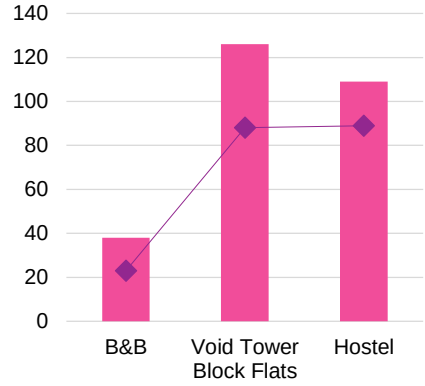
## Percentage of household waste sent for reuse, recycling and composting

**[Cumulative YTD]**




## Temporary Accommodation

**As at June 2019**




**273**
**As at Jun 2019**

Total number of children in TA
(data for 2018 not available)

No. of children
No. of households

## New Education Health Care plans issued within 20 weeks excluding exception cases (SEND)

**Total plans issued: 47**
Period: Q1 2019
Target: 96%

**100%**

## Mental Health

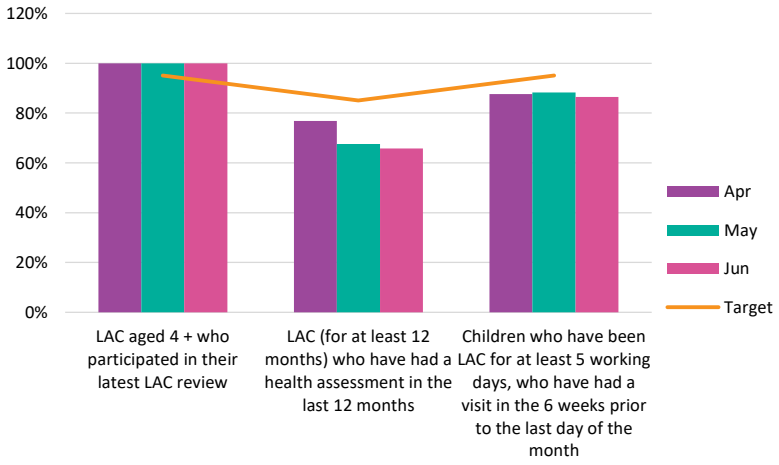
**83.3%**
**May 2018**

**71.9%**
**May 2019**

Proportion of adults in contact with secondary mental health services who live independently with or without support (EPUT)

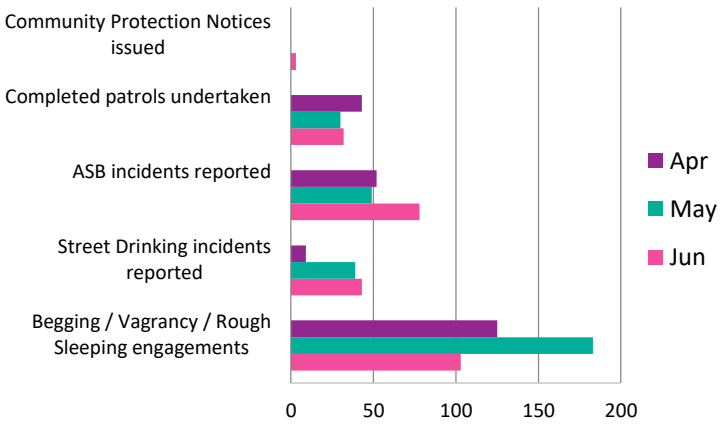
**2019/20 target: 74%**

## Looked After Children (LAC)




## The Council's Community Safety Unit activity

**This dataset does not include data from the Police or other agencies**



SAFE & WELL

2019 Q1 Q2 Q3 2020 Q4 Q1 Q2 Q3 2021 Q4

## Quarter 1: Update

Plans are underway to introduce a specific community hub in York Road and undertake a feasibility study on introducing an intelligence or operation hub within the CCTV centre. Work to embed social work in the community continues, with seventeen GP practices having increased their level of Social Worker presence this quarter. This equates to coverage of approximately 78% of the patient population.

Specialist LD Hubs pilots have started in the Attic Café and Mencap offices, and Trust Links launched their Mental Health and Wellbeing Hub at Growing Together Westcliff.

The Rough Sleeper Initiative secured a second year of Ministry of Housing, Communities & Local Government grant for 2019/20, which will continue to fund various Rough Sleeper-focused services. Newly acquired Rapid Rehousing Pathway funding will be used to develop the Council's tenancy sustainment offer. Recent bimonthly counts of rough sleepers have shown an increase from the winter months, and active partnership with Community Safety teams and others is allowing the Council to develop a more seasonally responsive approach as a result.

A Housing Allocations policy consultation has been undertaken, with changes to the existing approach being accepted by Council in July 2019. The proposed changes are now subject to further consultation and include a proposal to provide enhanced support for young people, up to the age of 25, to whom the Council has acted as a corporate parent. The Homelessness Reduction Act continues to be implemented, with the Housing team working closely with Children's Services to jointly assess and support Looked After Children to access suitable and appropriate accommodation.

A community paediatric transformation programme has begun, made up of eleven interlinked projects. A Joint Paediatric Clinic in East Central locality is being tested, with feedback having been very positive to date. Approval has been received to implement a new Cow's Milk Protein Allergy pathway from September 2019 onwards (subject to governance processes). Two pilots are in train with the voluntary sector to support Family Action at three Children's Centres. Overall, figures show increased use under the current arrangements.

Funding sources have been identified to undertake retro-fitting works to the Council's buildings. The EU-funded "Cool Towns" project aims to manage overheating in urban areas, with pilot sites having been identified in the High Street and the skate park, tree pits and solar water bench.

Southend's reduction in conception rates has plateaued since 2013 and is not falling in comparison with rates for the East of England region and England that are 16 and 17.8 per 1000 respectively. As national teenage pregnancy statistics have a significant lag time and do not reflect the full teenage age group, a local data dashboard is being explored to see how we can look at the local data differently. A Family Nurse Partnership qualitative review of 38 cases was undertaken to understand the lived experience and journey of the teenage parents to date,

## Future milestones:

Begin a consultation that will include local young people on introducing a Cadet Scheme in Southend.

Two further GP surgeries will be approached to increase their social worker presence in Q2, which (if achieved) will increase the percentage of the patient population that can access community-embedded social work practitioners to 86%.

The next phase of the specialist LD Hubs pilots will be a review of the pilots and development of a strategic approach to community hub development.

The Selective Licensing project has started, with a draft position paper being considered by Cabinet in the autumn. A wider report is now being drafted that will incorporate a broader range of other interventions that could be pursued to improve the private rented sector in the borough.

Six paediatric pathway "Task and Finish" groups to be established to focus on asthma, allergies, constipation / incontinence, Down's Syndrome, Cerebral Palsy and Epilepsy.

The "Climate Resilient Urban Nexus Choices" project, exploring how the links between food, water and energy can be exploited to make urban environments more resilient and sustainable in the face of climate change, is focused on "Urban Living Labs" in six cities around the world in Europe, Taiwan, USA and here in Southend-on-Sea.

A new Young Parents pathway is being explored between ABSS and Public Health for the universal health service provision, with a planned stakeholder event in the autumn and a deep dive scheduled for December 2019 to inform the JSNA.

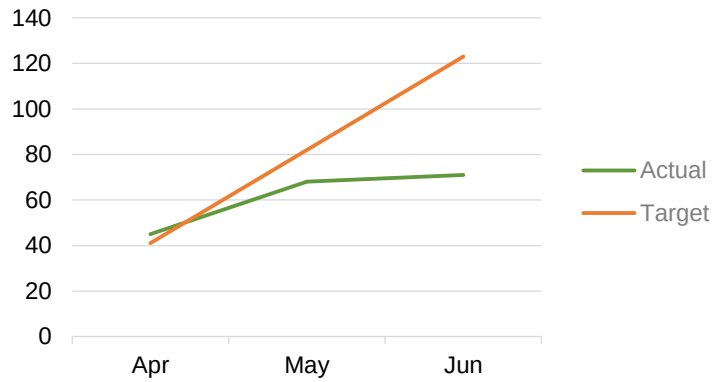
## Organisations signed up to Physical Activity-related pledges of the Public Health Responsibility Deal (PHRD)

Total organisations signed up to PHRD: 16

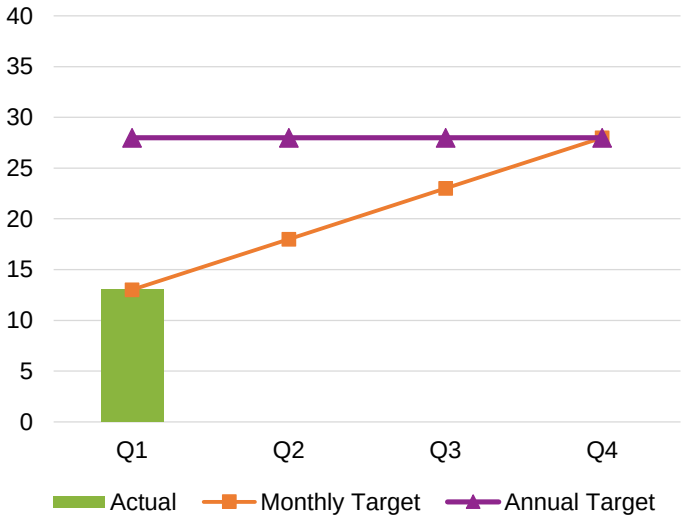
8 Quarter 1 2019/20

-33% vs Quarter 1 2018/19

## Number of individuals completing 12 weeks of the Exercise Referral Programme




## Number of schools signed up for the Daily Mile Programme or equivalent




## Number of hours of volunteering within Culture, Tourism and Property (inc. Pier and Foreshore events)

**[Cumulative YTD]**

Jun 2019
**Actual: 5003**
Target: 4875

Jun 2018
**Actual: 4229**
Target: 4875

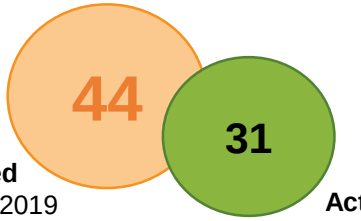
## Falls Prevention activity

~12,520 individuals aged 65+ at risk of falling annually in Southend

151

individuals starting 36 week strength and balance programme to date during 2019/20

## A Better Start Parent Champions

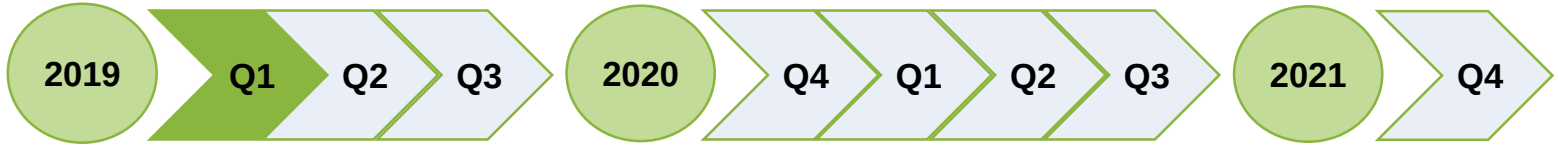



**Trained**
As at Jun 2019

**Active**
As at Jun 2019

## Key insights:

- 5003 volunteering hours (208 days) delivered within Culture. Increase in library, Bookstart and music event volunteers, decrease in Cliff Lift and Focal Point Gallery volunteers.
- Make Southend Sparkle - 96 volunteering hours.
- Average of 260 runners per week participating in Southend Park Runs
- New organisations signing up to the PHRD has reduced as we are now in Year 3 of the programme, meaning that the number of businesses to recruit from in the borough reduces. There is a particular focus on engaging SME businesses for 2019/20
- Not all of the ~12,520 individuals would be appropriate for community based strength and balance programmes but the cohort that could benefit from these programmes is significant. However the Council's programme is running at very close to full capacity with current model / resources.


## Quarter 1: Update

People were asked to put forward their suggestions for names for the new wheeled sports facility in the town centre. “Skatey McSkateface” was completed in time for the summer holidays and opened to the public on 19th July 2019, with an official launch event taking place on 3rd August 2019. The new facility is already encouraging engagement in the area and has received great comments.

Integrated Design Teams continue to meet to develop Locality approaches and integrated working, for example Regular Multi-disciplinary Team working across each Locality (fortnightly), the development of the ‘hub’ concept and closer collaboration with Children’s Centres across the borough.

May 2019 saw the completion of the Council’s affordable housing development in Rochford Road, which comprised of twelve two-bedroom flats and three three-bedroom houses. The ground floor flats were built to wheelchair user dwelling standards and have been allocated via the nominations panel. The Council is pushing ahead with its affordable development programme, which includes two further phases and a Modern Methods of Construction Pilot. Site investigation works have been undertaken, and procurement of the requisite professionals is underway. Estuary Housing Association will be completing their latest affordable housing scheme, Hammond Court in Sutton Road, in August 2019 which will see the provision of 44 dwellings with 26 of these being affordable rent and 18 shared ownership.

Following a major Southend 2050 stakeholder discussion event in February 2019, a follow up session occurred with the business community at the Southend Business Partnership (SBP) briefing in June 2019, resulting in various connections and pledges for participation. A workshop for the West Central locality design took place in June 2019, which involved residents and stakeholders, and a second workshop is being run in August 2019.

Utilising existing data and insight the Council has created a Southend Joint Strategic Needs Assessment product for Physical Activity. 40 physical activity-related projects were run during 2018/19, engaging almost 3000 individuals, 1146 of whom self-assessed as inactive at the start their engagement with a programme. Further development of the Council’s settings-based approaches to increase physical activity include: engaging 11 businesses in physical activity interventions through the Public Health Responsibility Deal, delivery of Early Years workforce training on physical activity in partnership with Active Essex, supporting schools to improve their physical activity offer through the Healthy Schools programme and encouraging schools to deliver the Daily Mile or equivalent activities on a regular basis.

Work undertaken as part of the West Central Locality to develop an Action Plan to support population health and wellbeing has strong features of bringing people of diverse backgrounds together to be involved and valued who would work together on issues of shared importance. Through workshops the Council has brought together staff interested or already working in areas aligned to the outcome; it commenced to reach out to the voluntary and community sector to include them in this important conversation and action around diversity, being valued and getting on well together.

## Future milestones

The SEE Locality Partnership Group is planning the development of the locality plan, starting with West Central, creation of locality dashboards and the development of SEE Dementia Navigators within a Locality setting.

The Council has proposed to bring together key relevant contacts to explore greater co-ordination to the diverse range of community ‘hubs’ across the borough.

In Q2 further workshops to support population health and wellbeing are planned, with the next one in August 2019, working with health and community sector colleagues on joined-up communications regarding Living Well in South Essex.

In Q2 further workshops are planned for developing Asset Based Community Development approaches, with targeted workshops to create a shared narrative around strengths and asset-based approaches. Further drop sessions for staff and partners will be held to keep track of internal and external activity, and to enhance collaboration with SAVS and their networks.

OPPORTUNITY & PROSPERITY

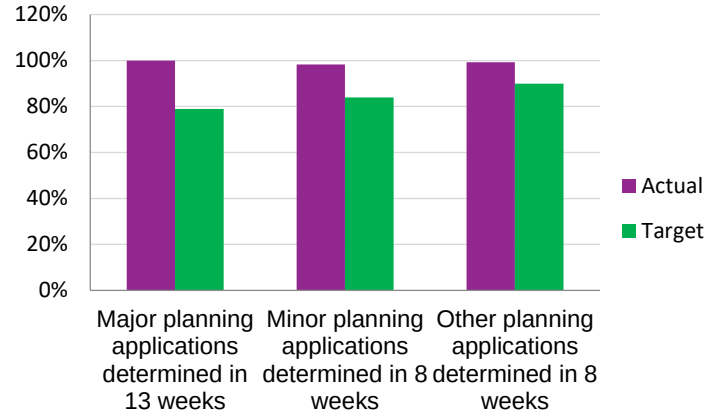
## Key insights:

- In June 2019 **76** new businesses had opened in the borough, and **18** businesses have expanded and/or opened an additional property
- **Six** businesses have relocated within the borough where they required a larger premises or location
- **47** properties transferred into the landlords name as they are now empty
- **96** businesses closed in the borough in June 2019, with an additional **37** properties remaining empty with the landlord liable for the business rates. Nine businesses have relocated within the borough and **six b**usinesses have liquidated
- Housing stock in Southend has seen an increase compared to last year equalling **521** more dwellings (annual info)
- There are 56 post-16 LAC and care leavers, of which 14 are NEET, 36 are in further education and six are in employment.
- 26 LAC and care leavers in Year 11 intended to: go onto apprenticeships or traineeship (2); continue full time education or training (19); or were undecided (5).



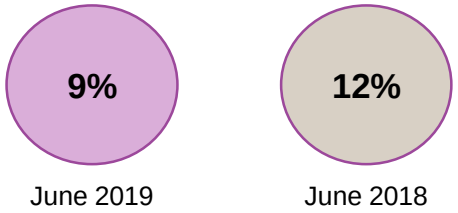
## Determination of Planning Applications

**Number of overall planning applications submitted:** 558
**Success of appeal:** 80 against target of 80




## Delivery of the Capital Programme

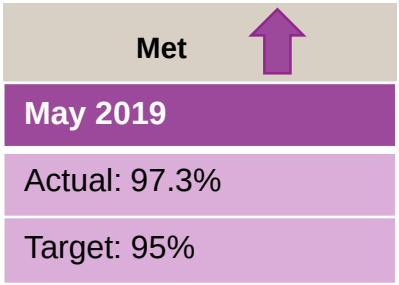
**[Cumulative YTD]**




## Child Development at Two Years Old

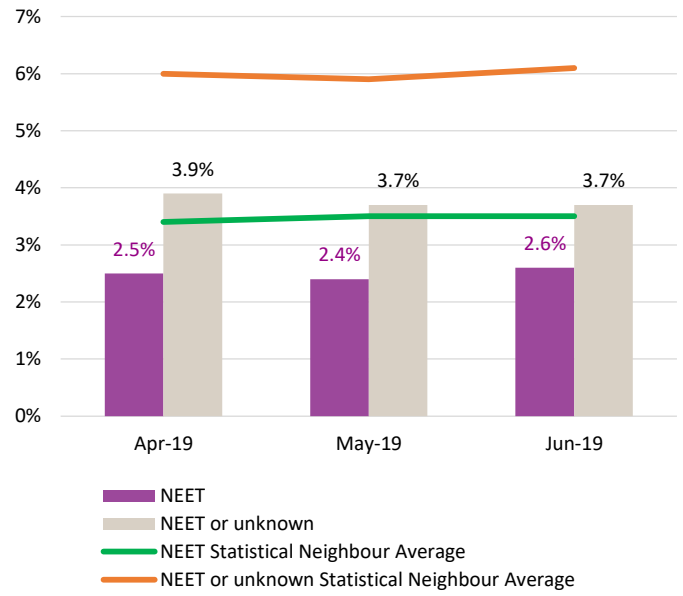
### [Completions of the ASQ at 2 years 9 months]

**To be developed to include referral outcomes**



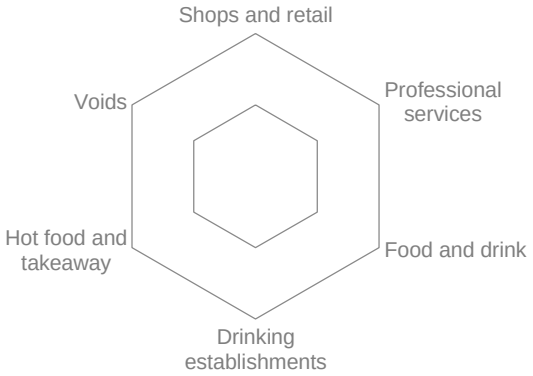

## Percentage of young people Not in Employment, Education or Training (NEET) or whose situation is not known

**Aim to minimise**
**Total number of young people in the borough as at Jun 2019:** 3953




## High street occupancy (BID area only)

**[Data to be available as of Q2 2019/20]**



OPPORTUNITY & PROSPERITY

2019 Q1 Q2 Q3 2020 Q4 Q1 Q2 Q3 2021 Q4

## Quarter 1: Update

The Better Queensway contract and partnership agreement was signed in April 2019, thereby confirming Swan Housing Association as the Council's partner and establishing the Porters Place Southend joint venture LLP that will deliver the regeneration project. Cabinet agreed work to develop a regeneration framework and pipeline of housing and regeneration projects as well as an acquisitions programme in June 2019.

With regards to tenants moving into the Airport Business Park, the relevant contracts have been let and the sale of land has been completed simultaneously with a Development Agreement.

The installation of art work to the Railway Bridge at the Cliff Town Road junction is already in progress.

Discussions regarding refreshed wayfaring and signage are underway. Joint working across several of the Council's teams is starting to look at creating an urban park with outdoor activities and refreshments at either end of the High Street, with shared space for the creative arts and events.

An affordable housing acquisitions programme has been agreed in order to utilise receipts from Right to Buy sales. This programme also includes use of HRA capital. A number of properties of different types and in different parts of the borough have been viewed with the intention of purchase.

Current plans to ensure sufficient school places continues, with sufficient Year 7 school places for 2019 being available as a result of expansion in a number of local secondary schools. Projects to meet this demand are currently on track for delivery. Since 2016/17, an additional ~50 Southend residents applied for, sat and passed entrance exams, and subsequently attended a Grammar School of their choice each year, as a result of awareness raising and support promoting the option of choice. Similar awareness raising activity will proceed ahead of the September 2019 application round for an entry in September 2020.

Specific skills related programmes to support career aspirations continue, including a possible extension to the "60 minute mentor" programme. The Connexions Service has been successful in ensuring that more learners continue in Education, Employment and Training (EET) beyond statutory school age, and our measure of success has been impressive in improving our NEET (Not in EET) figures.

Aligned to the work in narrowing the gap and career aspirations, the Connexions service delivers #kickstartmyfuture activities in Southend schools to raise the aspiration of students to think about higher education and offering further support to students from deprived areas that have the ability to move on to Higher Education but choose not to.

## Future milestones

The Better Queensway business plan will be considered by the relevant Governance Boards in the autumn.

Cabinet will consider the implications and impact of becoming an accredited real living wage employer at their meeting in September 2019.

Construction will continue along with preparations for the relocation of Westcliff Rugby Club to their new facility.

A "sounding board" is being established to include residents, business owners, landlords, councillors, council employees, students, the Bid, the support sector, etc., to consider key areas for improvement in the Town Centre such as empty properties, safety of the community, the cleanliness of the town centre, homelessness and parking.

Future phases of the HRA land review have been agreed and are being progressed. An Employer's Agent is currently being procured for Phases 3 and 4 of the scheme.

A pilot of Modern Methods of Construction is also up and running with an architect now on board and outline planning is due to be submitted in the autumn.

There are new business plans to support additional resource and enhancement to the Community Officers Scheme, to explore moving the presence for the Council into the High Street with a shift in some resource to the High Street in addition to the support sector.

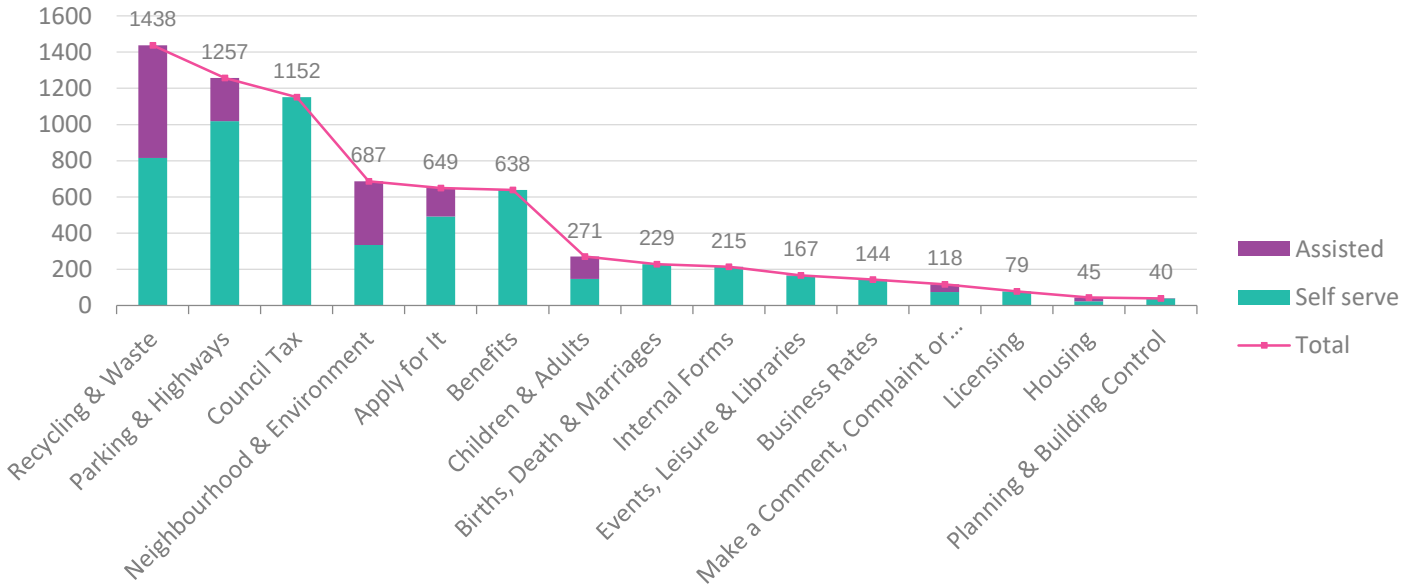
A paper will be going to the new Children and Learning working party proposing options beyond the life of the current expansion programmes. This also includes the possibility of additional funding through a grant by the DfE on top of the basic need allocation.

CONNECTED & SMART

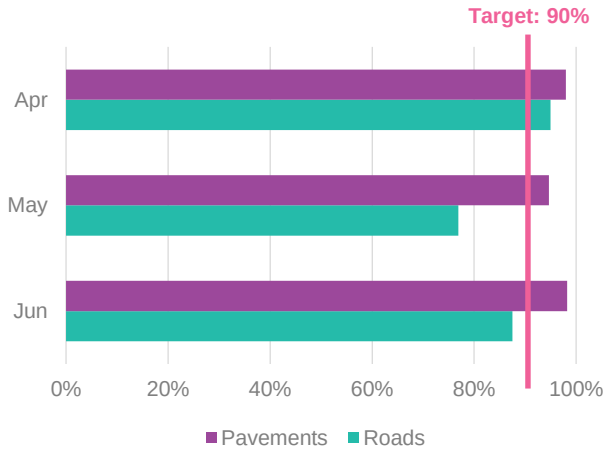
## Key insights:

- Total number of registrations for free Wi-Fi: 91,815
- The High Street is the most popular browsing location for access to free Wi-Fi, followed by Eastern Esplanade, Hamlet Court Road and Leigh Broadway
- Most users are between the ages of **15-24,** with a total of **15,000** people registered
- 1,438 online MySouthend forms regarding Recycling & Waste were completed in June 2019 – and of those, 56.75% were self-serve
- **1,257** online MySouthend forms regarding Parking & Highways were completed in June 2019 and of those **80.99%** were self-serve

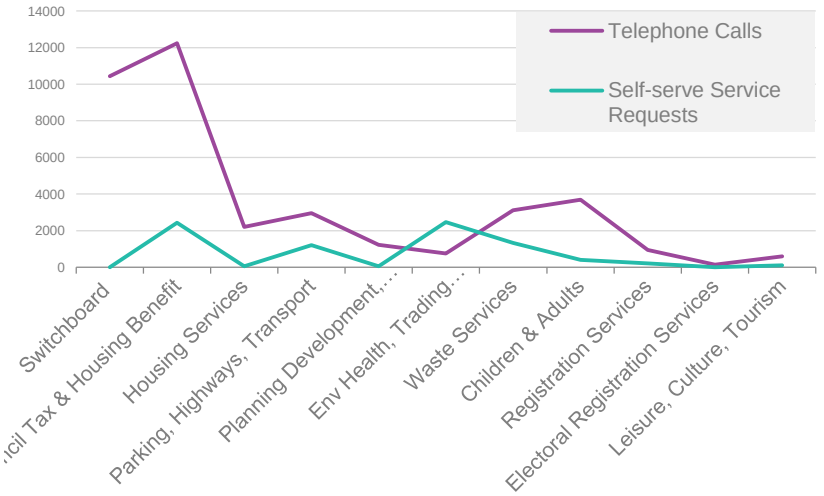
## Service Requests submitted via MySouthend



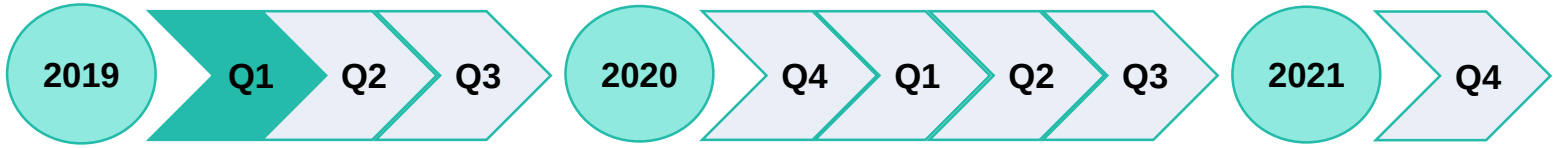

## Percentage of CAT1 defects made safe within response times (roads and pavements)




## Channel Shift - No. of service requests compared to no. of telephone calls



CONNECTED & SMART




## Quarter 1: Update

Installation of the footbridge at A127 Kent Elms commenced under overnight road closures from 7 May 2019 with the main span installed on 11 May 2019. Installation of the handrail and decking continued. The installation of hard landscaping around Kent Elms Health Centre and Library commenced.



Work continues on establishing a simple and effective method of managing the Council's data that complies with data protection and enables the focus of collective efforts on the things that make a positive difference to the people of Southend. Data requirements are being specified over July and August, using the work already done for the Joint Strategic Needs Assessment (JSNA) as a base. Once complete, the technical solution to collect, store and share this data will be developed.

The Council continues to embed an agile working culture, with 30 agile working volunteers in place. We have established a clear definition and standardised ICT equipment has been agreed. There was further rollout of agile working on Floor 8 of Civic 1 to promote cross-organisation collaboration to support the delivery of Southend 2050

The Council already has in operation a full fibre ring, capable of delivering high speed broadband across the borough geographically. In addition, the planned implementation of Fibre to the Home from CityFibre and Vodafone will increase the existing geographical coverage by providing connectivity to an additional sixty four thousand homes by 2021. Free Wi-Fi exists throughout the High Street and along the seafront as far as Old Leigh and Leigh Broadway.

## Future milestones

Project completion of the bridge works and finalisation of the Kent Elms scheme in Q2.

A new project group with a variety of work streams has been established to define and deliver a clear vision of agile working over the coming months.

Work on Floor 10 of Civic 1 to be finished to create an open office environment working area for the Corporate Management Team (CMT). Members of CMT will no longer have individual office spaces.

An innovation area will be created on Floor 2 of Civic 1 to test and design potential agile working solutions, including technology, prior to rollout.

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# Southend-on-Sea Borough Council

**Report of Deputy Chief Executive (People)**
**to**
**People Scrutiny Committee**

**on 8th October 2019**

Report prepared by: Amanda Champ, Head of School Performance & Provision Services

**Agenda Item No.**

8

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Schools Progress Report

**People Scrutiny Committee – Cabinet Member: Councillor Anne Jones**

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## 1. Purpose of Report

To inform Members of the current position with regard to the performance of all schools, including those schools causing concern, and to update on known Academy developments.

## 2. Recommendations

For People Scrutiny to note and approve the information in this report.

It should be noted that several of the initiatives outlined below are a direct implementation of the 2019-20 2050 Outcome Delivery Plan for Opportunity and Prosperity, readiness for school and work.

## 3. Background

There were no inspections over the Summer due to school holidays so, following a significant number of school inspections towards the end of the summer term, the % of pupils attending a good or outstanding school is 88.1% and is now above target.

A new Ofsted inspection framework which has a greater focus on the quality of education, including the curriculum, came into force at the beginning of September. Schools have been fully briefed on the changes to the framework. Training has been offered to Head teachers and Governors.

Two Southend-on-Sea schools have already been inspected under the new framework. Greenways Primary school was inspected 17th September 2019 to 18th September 2019. Bournemouth Park was inspected 24th to 25th September 2019. The outcomes of these reports are not in the public domain at the time of writing this report. We track schools who are potentially due and inspection (according to the Ofsted Inspection guidelines) and offer preparation support should the schools wish to receive it.

**Secondary Schools**
The 'three secondary school project' continues to provide funding for support to Southchurch High, Cecil Jones Academy and Chase High school. Each of the three schools, through their Trusts, have submitted a costed business plan which indicates how the funds will support them in their journey to good, and how the Council will hold them to account for the outcomes achieved in relation to that funding. It should be remembered that neither of the schools is likely to receive an inspection within the academic year.

**Academy conversions**
There have been no Academy conversions since the last People Scrutiny report.

**ISOS**
The Council has commissioned a national research partnership, ISOS, to undertake a major piece of work on inclusion in our schools. ISOS have conducted similar work at national and local level. Isos researchers have already undertaken visits to selected schools and colleges, and have spoken with pupils and parents concerning their experiences of "inclusion", in effect answering the question "are the right children receiving the right education in the right school". This agenda will allow members to consider the degree to which all schools share a collective purpose for the education of all learners in the Borough rather than those only at their own school, and fits well with the new OFSTED framework due to be implemented in September. The full report will be available to members towards the end of the Autumn Term 2019.

**Young people not in employment education or training (NEET) and unknown**
Please see draft figures below for July 2019, these are still draft and subject to change.

**NEET/ Not Known combined**
For July 2019 our **combined NEET and Not Known figure was 4.0%,** this has put the authority into the 2nd quintile for this measurement. When compared to July 2018, our figure was 7.1% and we were in the 5th quintile. The improvement over this past year to this point is significant.

**Not Known**
For July 2019 our NK figure was **1.4%,** this is a noticeable improvement on July 2018 where our figure was **4.1%** putting the Council in the 5th quintile, we are now in the 2nd for this individual measure. This improvement is even more impressive due to the sustained low level of NEETs from July 2019, we would usually expect a rise in NEETs as the NK's decrease.

**Y12/13 Looked after/in care:**
July 18: 28.1% NEET, 3.1% Not Known (out of a cohort of 44)
July 19: 22.2% NEET, 0% Not Known (out of a cohort of 48)

Outcomes for Southend's looked after children have improved since July 2018 when 31.3% were NEET or Not Known ( meaning that 68.7% were in

employment, education or training), compared to 22.2% in July 2019. This means that as of July 2019 we currently have 77.8% of our Y12/13 Looked after or in care young people in employment, education or training. No national LA data is published for this measure so benchmarking is not possible.

## 4. Other Options

N/A

## 5. Reasons for Recommendations

N/A

## 6. Corporate Implications

6.1 Contribution to the Southend 2050 Road Map

The Schools Progress report links directly to the following Southend 2050 ambition themes and outcomes:

**Pride and Joy**

- There is a tangible sense of pride in the place and local people are actively, and knowledgeably, talking up Southend-on-Sea

**Safe and Well**

- People in all parts of the Borough feel safe and secure
- Southenders agree that people from different backgrounds are valued and get on well together
- The benefits of community connection are evident as more people come together to help, support and spend time with each other

**Opportunity and Prosperity**

- Our children are school and life ready and our workforce is skilled and job ready.
- In addition, this report contributes to the Council's stated ambition that all schools will be good or outstanding.

6.2 Financial Implications

The work currently undertaken by school improvement is covered by the core staffing budget and the SLAs with the teaching schools namely the primary teaching school alliance and SETSA

6.3 Legal Implications

none

6.4 People Implications

none

6.5 Property Implications

none

6.6 Consultation
N/A

6.7 Equalities and Diversity Implications
Equality impact assessments have been completed for both major strategies that link to this progress report, namely the grammar school strategy and the pupil premium strategy.

6.8 Risk Assessment
N/A

6.9 Value for Money
N/A

6.10 Community Safety Implications
N/A

6.11 Environmental Impact
N/A

## 7. Background Papers

No additional back ground papers have been used to prepare this document. This report does take account of OFSTED inspection reports published by Ofsted which can be found at
https://www.gov.uk/government/organisations/ofsted

## 8. Appendices

None

# Southend-on-Sea Borough Council

**Report of Executive Director**
**(Legal and Democratic Services)**
**To**

**People Scrutiny Committee**

**On**

**8th October 2019**

Report prepared by: Fiona Abbott

**Agenda Item No.**

**9**

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**Scrutiny Committee - updates**

**Part 1 (Public Agenda Item)**

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## 1. Purpose of Report

To update the Committee on a number of scrutiny matters.

## 2. Recommendations

2.1 That the report and any actions taken be noted.

2.2 That the project plan for the in depth scrutiny review, attached at **Appendix 6** to the report be noted.

## 3. Mid & South Essex Sustainability and Transformation Partnership (STP) - updates

3.1 The Committee will now be aware that the Secretary of State for Health and Social Care wrote to the Chair on 30th July 2019 in response to the letter sent earlier in the year, which referred the proposals resulting from the 'Your Care in the Best Place' public consultation and resulting decisions made by the Mid and South Essex Clinical Commissioning Group's Joint Committee. The letter and advice from the Independent Reconfiguration Panel (IRP) is attached at **Appendices 1 and 2.**[1] The Secretary of State has accepted the advice made by the IRP, which is that, with some further action locally, the proposals should proceed.

3.2 The work of the existing Joint Health Scrutiny Committee, involving Southend, with Essex and Thurrock Councils (JHOSC) has therefore been paused. It will need to restart when any further proposed substantial developments or variations in the provision of health services in the footprint is proposed.

3.3 A further meeting has been held with Clare Panniker, Chief Executive of Mid and South Essex University Hospitals Group (MSE Group) and other representatives and the Chair will provide an update at the Scrutiny Committee meeting. The Chair, Cllr Chalk and Cllr Hooper (as JHOSC Members) also visited Southend Hospital recently. This visit was undertaken with the Chair and Vice Chairs of the

[1] The advice has also been published on the GOV.UK website - IRP: Mid and South Essex advice

Essex Health Scrutiny Committee and the purpose of the visit was to hear from some for the senior management at the Hospital about current issues and challenges and a tour of some of the key areas in the hospital. Visits to the other Hospitals in the Group (i.e. Basildon and Broomfield) will be undertaken in the coming few months. It will also be beneficial for all members of the Scrutiny Committee to undertaken visits to other settings in the community and a programme of visits will be developed and circulated.

3.4 In early September, the STP announced the appointment of Professor Michael Thorne CBE as the new independent Chair. The former Chair, Dr Donley OBE stepped down from the role after over 3 years in post. The press release is attached at **Appendix 3**.

## 4. Scrutiny arrangements for the proposed move of site for Moorfields Eye Hospital

4.1 At the April 2019 meeting of the Committee, members were advised about the scrutiny arrangements for the proposed move of site for Moorfields Hospital and that as the proposals is not contentious, it would be applicable for the Joint Health Overview and Scrutiny Committee (Joint HOSC) for North Central London to manage the scrutiny process on behalf of Southend (Minute 853 refers).

4.2 The proposal is to relocate all the services currently provided at Moorfields' City Road site in Islington, London (along with the UCL Institute of Ophthalmology and Moorfields Eye Charity) to a brand new integrated, purpose-built hospital on land that has become available at the St Pancras Hospital site in Camden, London (subject to public consultation).

4.3 Regular updates / briefing on the proposals has been requested, together with information on the arrangements for public consultation and how local people can respond if they so wish and how respective local Healthwatch bodies will be involved. Further information about the public consultation has recently been circulated to the Committee. The public consultation ran from 24th May 2019 to 16th September 2019[2]. A letter outlining the next steps is attached at **Appendix 4.**

4.4 On behalf of the Chair a comment was sent to the Programme Director on parking and accessibility to the proposed site which will be more problematic than the current Moorfields site. We asked for information on how these issues are being considered and addressed in the co-production work stream. The response from the Chief Operating Officer at Camden CCG is attached at **Appendix 5.**

## 5. Scrutiny project – update

5.1 At the meeting on the 9th July 2019, the Committee agreed that its in depth project for the municipal year would be on the appropriate use of reablement for older people when discharged from hospital, to maximise the number of people at home after period of 91 days (Minute 172 refers).

5.2 The project is led by a project team and the appointments were agreed at Council on 3rd June 2019. The membership for this project is - Councillors Alan Dear,

[2] The consultation website is http://oriel-london.org.uk/consultation-documents/

Denis Garne, Fay Evans, Margaret Borton, Cheryl Nevin, Anne Chalk, Ian Shead and Ashley Thompson and Tim Watts, co-opted member (Southend Carers). Officer support is provided by Sarah Baker, Lynn Scott, Gemma Czerwinkle and Fiona Abbott (project coordinator) with additional support as and when required from other officers.

5.3 A meeting of the project plan was held in early September at which the project plan and scope for the review was considered and agreed. At the meeting, Councillor Evans was appointed as Chair of the project team. A copy of the project plan is attached at **Appendix 6**.

## 6. Other issues

6.1 HIV diagnosis – at the Council meeting on 18th July 2019, Councillor Flewitt asked a question about sexual health data detailed in the Director of Public Health's Annual Report 2018-19. At the meeting the Cabinet Member said that more up to date data would be provided, including information with regards to late diagnosis of HIV. The detailed update provided by the Director of Public Health is attached at **Appendix 7**.

6.2 Centre for Public Scrutiny – the Committee is asked to note that the Centre for Public Scrutiny has recently published the following '10 questions' guide - 'Enhancing the value of sexual health, reproductive health and contraception services through council scrutiny' – which can be accessed via the following link https://www.cfps.org.uk/wp-content/uploads/Enhancing-the-Value-of-Sexual-Health-reproductive-health-and-contraception-services-FINAL-2019.pdf

6.3 Children's Services Improvement Plan Scrutiny Panel – the Committee will recall that the Scrutiny Panel was established in late 2016 to help provide additional challenge to the implementation of the Children's Services action plan. At the Council meeting on 3rd June, the following were appointed to the Panel - Councillors Dear, Walker, Burton, Nevin, Shead and Hooper. The Panel has now met on 12 occasions with the most recent meeting taking place on 14th March 2019. The meeting planned for 22nd July had to be rescheduled due to the Ofsted Inspection and a further meeting now scheduled to be held on 17th October 2019.

## 7. Corporate Implications

7.1 Contribution to the Southend 2050 Road Map - Becoming an excellent and high performing organisation; ensure residents have access to high quality education to enable them to be lifelong learners and have fulfilling employment, aligning to the following 2050 ambitions – active and involved, opportunity and prosperity.

7.2 Financial Implications - there are no financial implications arising from the contents of the report. The cost of any Joint Scrutiny Committee work can be met from existing resources.

7.3 Legal Implications - the Scrutiny Committee exercises the health scrutiny function as set out in relevant legislation. Where an NHS body consults more than one local authority on a proposal for substantial development of the health service or a substantial variation in the provision of such a service, those authorities are required to appoint a Joint Scrutiny Committee for the purposes of the consultation.

7.4 People Implications – none.

7.5 Property Implications – none.
7.6 Consultation – as described in report.
7.7 Equalities and Diversity Implications – none.
7.8 Risk Assessment – none.

## 8. Background Papers

None

## 9. Appendices

**Appendix 1 – letter from Secretary of State**
**Appendix 2 – advice from IRP**
**Appendix 3 – press release**
**Appendix 4 – letter and next steps**
**Appendix 5 – letter from Chief Operating Officer, Camden CCG**
**Appendix 6 – proposed project plan**
**Appendix 7 – update from DPH**

Department of Health & Social Care

*From the Rt Hon Matt Hancock MP*
*Secretary of State for Health and Social Care*

*39 Victoria Street*
*London*
*SW1H 0EU*

*020 7210 4850*

POC_1184725

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

30 July 2019

Dear Cllr Nevin and Cllr Salter,

**Referral to the Secretary of State under Regulation 23(9) of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 of changes to healthcare services in Mid and South Essex proposed by Mid and South Essex STP.**

Thank you for your letter of 15 January 2019 referring to me the above proposals resulting from the 'Your Care in the Best Place' public consultation and resulting decisions made by the Mid and South Essex Clinical Commissioning Group's Joint Committee. As you know, I asked the Independent Reconfiguration Panel (IRP) for their advice. They have now reported to me and I have accepted their advice.

After careful consideration, the IRP has concluded that, with some further action locally, especially in relation to services at Orsett Hospital until new services are in place, the proposals should proceed.

To that end, I would be grateful if you would report back to me in three months on the progress of this case. I enclose a copy of the IRP's advice.

I am copying this letter Suzanne Shale IRP Member and Chair for this sub-group and have written in similar terms to the CCGs and the JHOSC.

Yours ever,

**MATT HANCOCK**

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*157 – 197 Buckingham Palace Road*
*London*
*SW1W 9SP*

Stephen Hammond MP
Secretary of State for Health
39 Victoria Street
London SW1H 0EU

17 July 2019

Dear Minister

**REFERRAL TO SECRETARY OF STATE**
***Mid and South Essex Sustainability and Transformation Partnership***
**Southend-on-Sea Borough Council People Scrutiny Committee**
**Thurrock Council Health & Wellbeing Overview and Scrutiny Committee**

Thank you for forwarding copies of the referral letters and supporting documentation from Cllr Cheryl Nevin, Chair, Southend-on-Sea Borough Council People Scrutiny Committee (PSC) and from Cllr Victoria Holloway, Chair Thurrock Council Health & Wellbeing Overview and Scrutiny Committee (HOSC). NHS England (East of England) provided assessment information. A list of all the documents received is at Appendix One. The IRP provides this advice in accordance with our agreed protocol for handling contested proposals for the reconfiguration of NHS services.

In considering any proposal for a substantial development or variation to health services, the Local Authority (Public Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 require NHS bodies and local authorities to fulfil certain requirements before a report to the Secretary of State may be made. The IRP provides the advice below on the basis that the Department of Health and Social Care is satisfied the referral meets the requirements of the regulations.

The Panel Chairman, Lord Ribeiro, a former consultant surgeon at Basildon University Hospital, declared a conflict of interest and consequently took no part in the consideration and production of this advice. The sub-group leading this work was chaired by Suzanne Shale, IRP member.

**The Panel considers each referral on its merits and concludes that, with some further action locally, the proposals should proceed.**

**Background**
The population of mid and south Essex is around 1.2 million of which around 180,000 live in Southend-on-Sea on the south east coast of the county and around 170,000 in Thurrock on the north bank of the River Thames. Throughout the area - the population of which is projected to grow by some 136,000 by 2031 - there is considerable demographic diversity in terms of overall health and life expectancy, ethnicity and age profile, rural and urban living, affluence and deprivation.

Acute health care is provided by Basildon & Thurrock University NHS Foundation Trust (Basildon Hospital and Orsett Hospital), Southend University Hospital Services NHS Foundation Trust (Southend Hospital) and Mid-Essex Hospital Services NHS Trust (Broomfield Hospital). Services are commissioned by Mid & South Essex Clinical Care Group

(CCG) Joint Committee[1] and NHS Specialised Commissioning. Community and mental health care is provided by Essex Partnership University NHS Foundation Trust, North East London NHS Foundation Trust, and Provide.

In June 2015, health and care organisations in mid and south Essex were selected to enter the NHS Success Regime, a national programme to improve health and social care in locations where there were deep-rooted systemic pressures[2]. With the establishment of Sustainability and Transformation Programmes (STP) in 2016, it was decided to embed the work of the Success Regime into the Mid and South Essex STP with the same footprint and governance processes.

Consideration of possible changes to health services in Thurrock dates back to 2015 leading, in Spring 2016, to the commencement of a local engagement process run jointly by Thurrock Council and Thurrock CCG *For Thurrock in Thurrock* in which residents were asked about their priorities for integrated medical centres (IMC) and services that should be provided locally. In March 2016, a Healthwatch Thurrock report on *For Thurrock in Thurrock* received over 9,000 responses with respondents reporting a strong desire to have care delivered closer to home. Also, in March 2016, an 'acute leaders group' was formed comprising more than 50 local clinicians to develop options for change.

East of England Clinical Senate reports, covering progress in developing the Success Regime, were published in June and October 2016. The Thurrock HOSC received an update on the success regime/STP on 10 November 2016.

An options appraisal workshop, *Mid and South Essex Success Regime – A programme to sustain services and improve care*, was held on 22 February 2017. On 17 May 2017, a 'Memorandum of Understanding' (MOU) for Thurrock was co-signed by relevant partners including Thurrock CCG, Thurrock Council and Basildon Hospital. The MOU stated that *"Provision of services at Orsett Hospital would not cease prior to the construction and opening of the integrated medical centres"* and *"a comprehensive review of health and care services provided at Orsett would be undertaken to inform the appropriate clinical services which may be mitigated to each IMC or other appropriate location, taking account of the specific care needs of the population of each of the four localities in Thurrock".* In August 2017, NHS representatives provided a presentation to the Thurrock HOSC of the action plan for the Thurrock IMCs.

On 20 September 2017, NHS representatives presented a paper to the Southend Health & Wellbeing Board about the STP and detailing progress with a pre-consultation business case, describing the options appraisal process and a change to the clinical service model proposed that would maintain three fully functioning A&E departments at Basildon, Broomfield and Southend. The NHS England National Clinical Director for Stroke emailed NHS officials on 30 September 2017 to offer views on the proposed model for stroke services under the STP. The model differed from the national model of a single hyper-acute stroke unit (HASU) in that people suspected of having a stroke would access care via their nearest A&E department. All three A&E departments would be able to diagnose and initiate treatment if required. The patient would then be transferred to the specialist stroke unit at Basildon Hospital for the first 72 hours post-stroke to receive intensive support and care from a dedicated team before being transferred back home, to their local hospital for ongoing acute care or to a community facility. A third

[1] Comprising Basildon & Brentwood CCG, Castle Point & Rochford CCG, Mid-Essex CCG, Southend CCG and Thurrock CCG

[2] Other success regimes were established in Devon and Cumbria

East of England Clinical Senate report, published in September 2017, questioned whether there was evidence to support the plan to initiate stroke treatment (thrombolysis) on three sites.

The East of England Clinical Senate's fourth report of October 2017 considered further evidence about the proposed model for stroke services and made recommendations, including about additional modelling work required. A meeting of the Southend PSC on 18 October 2017 noted progress on the STP and expressed some reservations about financial modelling and clinical evidence. The need to establish a joint health overview and scrutiny committee with Essex and Thurrock Councils, to be led by Southend-on-Sea Council, was agreed.

The Chancellor of the Exchequer's budget statement of 22 November 2017 announced a capital investment of £118m for the Mid and South Essex STP acute reconfiguration. A pre-consultation business case was published on 23 November 2017. A CCG Joint Committee meeting on 29 November 2017 gave approval to proceed with a public consultation. *Your Care in the Best Place* was launched on 30 November 2017, initially to run to 9 March 2018 and subsequently extended to 23 March 2018. A supplementary document, *The future of locally based health and care services currently provided at Orsett Hospital,* was also produced together with additional materials concerning finance, the clinical transport service, stroke and workforce.

The proposals consulted on outlined a series of changes to acute hospital services aimed at improving access to and the quality of care provided to patients. The proposals focussed on maintaining current centres of excellence across three hospitals:

- Burns and plastic surgery at Broomfield Hospital
- ENT surgery and oral-maxillofacial surgery at Broomfield Hospital
- Specialist cancer care at Southend Hospital
- Specialist cardiothoracic care at Basildon Hospital

GP and community services would be developed to support the changes to acute services. Care for patients showing symptoms of a stroke would continue to be via the nearest A&E and transfer to Basildon Hospital (that is, the model as described above). Services currently provided at Orsett Hospital would be transferred to a range of locations within Thurrock, Basildon and Brentwood delivering care closer to home and allowing stronger integration between primary, community and social care. Orsett Hospital would not be closed before services had been re-provided elsewhere.

Members of the STP team met the Chairs of the Southend, Thurrock and Essex Health & Wellbeing Boards on 16 January 2018 to discuss the consultation. A presentation was provided to the first informal meeting of the Mid and South Essex STP Joint HOSC on 22 January 2018 and again at its first public meeting on 20 February 2018. Clinicians leading the programme attended a Joint HOSC informal meeting on 8 March 2018 and a further presentation on the STP was provided at the Joint HOSC public meeting on 13 March 2018.

The Joint HOSC formally responded to the public consultation on 22 March 2018. It supported the STP in further progressing its proposals whilst expressing concerns about a number of issues and reserving the right to continue its scrutiny of certain aspects of the proposals. The Joint HOSC was content that *"significant consultation work has been undertaken"* and expressed the view that *"the engagement work undertaken has been adequate and in some respects very encouraging"*. It noted that the MOU had been agreed between partners regarding the closure of Orsett Hospital as well as seeking further data on stroke patient numbers. The

public consultation closed on 23 March 2018. Pre-election purdah, prior to local government elections on 3 May 2018, began on 27 March 2018.

A fifth East of England Clinical Senate report was produced in May 2018. On 22 May 2018 an independent analysis of the public consultation was published. Produced by specialist consultation analysts, The Campaign Company, the analysis reported that 16 large scale public meetings had been attended by 700 people, 40 deliberative workshops had been held for people most likely to be directly affected, three meetings had been held specifically about the future of Orsett Hospital and that 750 people had taken part in a telephone survey. It was estimated that 3,500 people had taken part in the consultation. Key findings included:

- Broad agreement with the overall approach to provide care in the best place in the home, in community settings and in hospital
- Concern about access issues, the feasibility of delivering the plan given the resource challenges faced by the NHS and the difficulty of recruiting GPs, community nurses and specialist hospital staff
- Concern amongst patients and residents from Thurrock about the potential impact on the community of the Orsett Hospital proposals and from patients and residents from Southend about possible downgrading of services at Southend Hospital

STP representatives provided a presentation to the Joint HOSC on 6 June 2018 outlining the process so far and high-level findings. At an informal Joint HOSC meeting on 19 June 2018, STP representatives provided draft recommendations to be made in the decision-making business case (DMBC) and a presentation on the clinical transport model. Approval to progress the DMBC was provided by NHS England on 28 June 2018.

The CCG Joint Committee met on 6 July 2018 to consider the DMBC and made 19 decisions. On Decision 12, the CCG Joint Committee approved:

- *"Access to care for patients showing symptoms of a stroke would continue to be via the local A&E department, where patients would be assessed, stabilised and, if indicated, treated with thrombolysis.*
- *After the patient was stabilised, and after discussion between the patient/family and clinicians, the patient would be transferred to Basildon Hospital for a short (approximately 72 hour) period of intensive nursing and therapy support.*

*The CCG Joint Committee also noted that:*

- *Following a stroke and an inpatient stay at Basildon Hospital for a short period of intensive treatment, patients would be transferred home, if their condition had improved sufficiently, or back to their local hospital or community facility for on-going care and treatment. All follow-up outpatient appointments, tests and scans would continue to be offered at all three hospital sites.*
- *Should a patient be confirmed as suffering from a bleed on the brain, they would 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 Joint Committee also strongly supported the ambition to develop a Mechanical Thrombectomy service in mid and south Essex, noting that such a service may be commissioned by NHS England."*

On Decision 15, the CCG Joint Committee approved:

- *"The relocation of services currently provided at Orsett Hospital to a range of locations within Thurrock, Basildon and Brentwood, enabling the closure of Orsett Hospital.*

*The CCG Joint Committee also noted that:*

- *There would be a period of co-production with the local community through the establishment of a "People's Panel" supported by Healthwatch organisations in Thurrock and Essex to determine the best site(s) to relocate these services to.*
- *Alongside the period of co-production, further detailed assessments would be undertaken on equality and health inequality impacts, and the quality impact of proposed service relocations.*
- *Once the period of co-production was completed, and with the detailed work on impact assessment, the CCG Joint Committee would be asked to make a decision on which sites would provide the relocated services, and*
- *In accordance with the agreement between Thurrock CCG, Thurrock Council and the three mid and south Essex hospitals, the Orsett Hospital site would not be closed until the new services were in place at the agreed new locations".*

On 19 July 2018, a meeting of the Southend Council unanimously carried a motion reiterating concerns expressed during the consultation and about the public consultation process itself, including that no other options for the location of the specialist unit had been consulted upon. Amongst its concerns, the Council stated that it could not support the STP without better rationale and evidence for moving stroke services to Basildon Hospital. The motion requested that the Southend PSC give due consideration to a referral to the Secretary of State.

The Joint HOSC met on 30 August 2018 to consider the CCG Joint Committee's decisions. A letter of 25 September 2018 from the Joint HOSC Chair to the CCG Joint Committee Chair confirmed that the Joint HOSC would not be making any further recommendations or comments regarding the decisions made.

The Southend PSC resolved on 9 October 2018 to refer the STP to the Secretary of State.

STP representatives presented a paper to a meeting of the Thurrock HOSC on 5 December 2018. Thurrock Council resolved on 21 December 2018 to refer the decision concerning Orsett Hospital to the Secretary of State.

**Basis for referral**

The Southend-on-Sea Borough Council People Scrutiny Committee's letter of 15 January 2019 states that:

*"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 outlined in para 9(a) and 9(c) (regulation 23) as follows:*

i. *Scrutiny is not satisfied with the adequacy 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 best interests of the health service in the area".*

The Thurrock Council Health & Wellbeing Overview and Scrutiny Committee letter of 8 January 2019 states that:

*"Thurrock HOSC wishes to submit a referral on 2 of the 4 grounds for referral as set out in the Local Authority Health and Scrutiny Regulations: June 2014 and Regulation 23 (Local Authority Public Health, Health and Wellbeing Boards and Health Scrutiny Regulations 2013). The referral is being submitted on the basis of HOSC not being satisfied with the*

*adequacy of the consultation and that the proposal to relocate services currently provided by Orsett Hospital are not in the interest of health services in Thurrock."*

**IRP view**

With regard to the referrals by the Southend-on-Sea Borough Council PSC and Thurrock HOSC, the Panel notes that:

- As a joint health scrutiny committee was formed, the CCGs were not required to provide information to Southend Borough Council or to Thurrock HOSC – only to the Joint HOSC
- The constituent committees of the Joint HOSC retained their own right of referral – two of those constituent committees resolved to refer on grounds of not being satisfied with the consultation
- Southend PSC contends that the CCG Joint Committee decision regarding stroke services (CCG Joint Committee Decision 12) is not in the best interests of the health service in the area
- The Panel has been asked to comment on the sequencing of changes in relation to the closure of Orsett Hospital – Thurrock HOSC contends that the proposal to relocate services currently provided by Orsett Hospital (Decision 15) is not in the interest of health service locally
- Concerns remain locally about specific, practical aspects of the proposals – further work is required to provide necessary reassurance

**Advice**

**The Panel considers each referral on its merits and concludes that, with some further action locally, the proposals should proceed.**

*Consultation issues*

A Joint HOSC was established between Southend-on-Sea, Thurrock and Essex Councils as the health scrutiny body to be consulted on matters relating to the planning, provision and operation of the health services in the area under the Local Authority (Public Health, Health and Well Being Boards) Regulations 2013. The Joint HOSC is the appropriate and only scrutiny body with which the CCGs must consult on any proposals developed in respect of the *Your Care in the Best Place* STP programme. It is also the only body that the NHS is required to provide information to in these circumstances. Nevertheless, the NHS in this instance made additional efforts to engage with the constituent scrutiny committees separately.

The IRP notes that in responding to the consultation the Joint HOSC, of which Southend PSC and Thurrock HOSC formed two thirds of the membership, acknowledged that significant consultation work had been undertaken and that the engagement work undertaken had been adequate and in some respects very encouraging. The Panel finds it difficult to reconcile these statements with the criticisms subsequently made by the scrutiny committees, both of which retained their rights of referral. The Panel understands that DHSC is currently considering revisions to its existing guidance on health scrutiny and may wish to ponder this apparent paradox.

Both referring bodies have declared that they were not satisfied that public consultation on the proposals was adequate. This is addressed by the Panel under Regulation 23(9)(c) as not being in the interests of the health service in the area. As the Independent Chair of the CCG Joint Committee stated in replying to the referring bodies, it was disappointing that greater numbers did not formally respond to the consultation though social media marketing showed a higher 'reach' in excess of 350,000 people. The Panel understands some of the criticisms levelled

about a lack of clarity on detailed planning, for example, on exactly where the services currently provided from Orsett Hospital will be located in the future. There is inevitably something of a 'chicken and egg' situation in that the detailed work relies on a decision first being made. The IRP has yet to advise on a consultation that, with hindsight, could not have been improved upon. Overall, the Panel considers that the consultation with the Joint HOSC and the public consultation were satisfactory.

*Whether the proposals contested are in the interests of local health services*
In considering whether proposals are in the interests of local health services, of the 19 decisions made by the CCG Joint Committee on 6 July 2018 in relation to the STP, the Panel has considered only those raised in the two referrals – namely, Decisions 12 and 15. The Panel was concerned to hear that other proposals that are supported and have benefits for patients are being stalled.

Southend PSC contends that the CCG Joint Committee decision regarding stroke services (Decision 12) is not in the best interests of the health service in the area. It is acknowledged that the model proposed differs from the national model of a single HASU in that people suspected of having a stroke would access care via their nearest A&E department – at Basildon, Broomfield or Southend. Patients requiring intensive support would be transferred to the specialist unit at Basildon for 72 hours before transferring back to an appropriate place for further care. The PSC contends that Southend Hospital would be a more appropriate location for the specialist care provision. The model proposed has been the subject of much consideration by, amongst others, the East of England Clinical Senate, the NHS England National Director for Stroke, UCL Partners, the Stroke Association as well as the PSC and local health and wellbeing board. When implemented, the model will be subject to ongoing assessment by a specially appointed evaluation team from University College London's Department of Applied Health Research. That evaluation will no doubt consider the long-term sustainability of the model. The Panel does not presume to have any greater expertise than those bodies already closely involved. We simply note that, had the national model been adopted - and while evidence of a formal options appraisal for site selection is perhaps a little light - clinical interdependencies and geography suggest that Basildon Hospital would have been the more likely site for a single HASU serving the whole population. Under that model, Southend residents suspected of having a stroke would have been taken to Basildon from the outset rather than transferring after stabilisation for a short period of intensive nursing and therapy support. The proposed model is a variant from what might normally have been expected, affording Southend residents access to stroke care via their own A&E and its ongoing evaluation will no doubt be of interest to other locations.

Thurrock HOSC contends that the proposal to relocate services currently provided by Orsett Hospital (Decision 15) is not in the interest of health services in Thurrock. The Council has been party to the development of these proposals, including the introduction of integrated medical centres and closure of Orsett Hospital, since 2015. The Memorandum of Understanding co-signed by the CCG, Council and Basildon Hospital in 2017 explicitly stated that services at Orsett Hospital would not cease prior to the construction and opening of the IMCs. The CCG Joint Committee decision of 6 July 2018 quoted the agreement and reiterated that services at Orsett Hospital would not be closed until new services were in place in agreed new locations. The Panel expects this undertaking to be honoured. Services to be provided in the new facilities across Thurrock, Basildon and Brentwood are expected to include outpatient clinics, diagnostics and some day-case treatments. The Panel appreciates that more clarity may be required locally on the precise '*how/where/when'* details of the programme – not least on

how the workforce will transfer from the old setting to the new - but that is not a sufficient reason not to proceed. With intelligent dispersing of the new services, that minimises possible travel/transfer disruption for patients who may need to access more than one service, the IMCs should be an improvement on current service provision. They will need to be developed, and the outstanding details agreed, with the collaboration of relevant partners including the proposed People's Panel and local Healthwatch and subject to ongoing consideration by the relevant scrutiny bodies.

In summary, the Panel consider that both Decision 12 and Decision 15 are in the interests of health services locally. If issues around safe transfers and workforce, that were raised in the consultation, are still the cause of concern locally then the opportunity exists to deal with these concerns and provide necessary assurance as the NHS works with its stakeholders towards the implementation phase.

Yours sincerely

Suzanne Shale
IRP Member and Chair for this sub-group

**APPENDIX ONE**

## LIST OF DOCUMENTS RECEIVED

**Southend-on-Sea Borough Council PSC**

1 Referral letter to Secretary of State from Cllr Cheryl Nevin, Chair, Southend-on-Sea Borough Council People Scrutiny Committee, 15 January 2019
Attachment:
2 PSC Chair letter to Chair of CCG Joint Committee, 14 November 2018
3 Draft referral to Secretary of State, 23 November 2018
4 CCG Joint Committee letter to PSC Chair, 21 November 2018
5 Report to Southend-on-Sea Council Cabinet re STP, March 2018
6 paper providing dates of relevant meetings
7 Report of Southend-on-Sea Council chief executive to PSC, 10 October 2017

**Thurrock HOSC**

1 Referral letter to Secretary of state from Cllr Victoria Holloway, Chair, Thurrock HOSC, 8 January 2019 and further letter, xx January 2019

Attachments:

2 DHSC letter to HOSC, 10 January 2019
3 CCG Joint Committee minutes of meeting, 10 January 2019
4 Health and Wellbeing Board minutes of meeting, 30 January 2018
5 Health and Wellbeing Board minutes of meeting, 21 September 2018
6 Joint HOSC minutes of meeting, 6 June 2018
7 Joint HOSC minutes of meeting, 30 August 2018
8 HOSC minutes of meeting, 18 January 2018
9 HOSC minutes of meeting, 12 March 2018
10 HOSC minutes of meeting, 8 November 2018
11 HOSC minutes of meeting, 5 December 2018
12 CCG Joint Committee letter to HOSC Chair, 3 June 2019

**NHS**

1 IRP template for providing assessment information
Attachments:
2 Clinical Senate report, June 2016
3 Clinical Senate report, October 2016
4 Clinical Senate report, September 2017
5 Comments on stroke proposals, NHS England Director for Stroke, September-November 2017
6 UCL partners review of hyperacute stroke care
7 Clinical Senate report, October 2017
8 Clinical Senate report, May 2018
9 Clinical senate report, January 2019
10 Options appraisal process and outcome
11 Pre-consultation business case, November 2017
12 Your Care in the Best place consultation document, 30 November 2017
13 Orsett Hospital specific consultation document, 30 November 2017
14 Independent analysis of consultation responses, The Campaign Company, May 2018
15 Decision-making business case
16 CCG Joint Committee minutes of meeting, 6 July 2018

17 CCG Joint Committee letter to PSC Chair, 21 November 2018
18 CCG Joint Committee letter to HOSC Chair, 3 January 2019
19 Joint HOSC response to consultation, 22 March 2018
20 CCG Joint Committee letter to Joint HOSC, 19 April 2018
21 Mid and South Essex stroke evaluation, 6 July 2018

**News release** **September 2019**

## New independent chair appointed

Professor Michael Thorne CBE has been appointed as the new independent chair of the Mid and South Essex Sustainability and Transformation Partnership (STP).

A former Vice Chancellor and Chief Executive of Anglia Ruskin University, Professor Thorne joins the Partnership this month (September).

Professor Thorne said: “I am delighted to be joining colleagues across the health and care system in mid and south Essex to build on the successes they have already achieved.

“It is an exciting yet challenging time to become involved as the Partnership continues its journey to deliver the ambitions set out in the NHS Long Term Plan over the next five years

“I am committed to ensuring that partnership working continues to be a strong theme and to play my part in the drive to improve the health and care of the communities we service.”

Professor Thorne brings with him a wide range of top level senior leadership experience. He retired as Vice Chancellor of Anglia Ruskin University in March 2016, a post he had served in since 2007.

During his time at Anglia Ruskin University, he founded the Postgraduate Medical Institute which led to the ground breaking and highly successful establishment last year of the Anglia Ruskin University's Medical School at its Chelmsford campus.

Prior to that he was Vice Chancellor at the University of East London for five years and has been a chair and member of a number of government committees.

Professor Thorne's appointment comes as Dr Anita Donley OBE steps down from the role she has held for more than three and a half years.

Dr Donley said: "The time is now right for me to hand the baton over as the Partnership embarks on becoming a fully integrated care system by 2021 and I am delighted someone of Professor Thorne's calibre is taking up the mantle.

"Thanks to considerable commitment from colleagues and stakeholders across the system, I leave as we are seeing the real benefits the significant investment in working together has brought to our area particularly for our hospital, primary care and digital teams."

The Mid and South Essex Sustainability and Transformation Partnership brings together the leaders of 17 health and social care organisations including hospitals, mental health service providers, community service providers, clinical commissioning groups and local authorities.

Professor Sheila Salmon, chair of Essex Partnership University Foundation Trust and chair of the Partnership's chairs' group over saw the appointment of the new independent chair.

She said; "I am delighted that we have secured the appointment of Professor Thorne to head our Partnership board.

"As independent chair, he will bring drive and renewed impetus, working tirelessly across the mid and south Essex patch to continue support and promote partnership working, while also holding us to account to deliver on our aspirations to continually improve the health of the people and communities that we serve".

"We also thank Dr Donley for her tremendous service to this area over the past three and half years, leaving us with a firm legacy on which to continue building lasting improvements to the health and care of our region."

**ENDS**

**For more information contact claire.hankey@southend.nhs.uk**

**Notes to editors**

The role of independent chair of the Mid and South Essex Sustainability and Transformation Partnership is a part-time, non executive position.

It was appointed to following a rigorous open selection process and formal approval from NHS England chief executive Simon Stevens.

**The Mid and South Essex Sustainability and Transformation Partnership comprises:**

**NHS Clinical Commissioning Groups (CCGs), which plan and buy your healthcare with funds from national Government**
Basildon and Brentwood CCG
Castle Point and Rochford CCG
Mid Essex CCG
Southend-on-sea CCG
Thurrock CCG
**CCGs work closely with GPs, pharmacies, dentists, opticians, hospitals, community services, local authorities and voluntary services in your area.**

**Local authorities, which provide social care and plan and buy services from care agencies, care homes and voluntary services**
Essex County Council
Southend-on-sea Borough Council
Thurrock Council
**Organisations that provide health services planned by CCGs**
Mid and South Essex University Hospitals Group
East of England Ambulance Service NHS Trust

**Organisations that provide health and care services planned jointly by CCGs and local authorities**
Essex Partnership University NHS Foundation Trust, which provides community, adult mental health services and children's inpatient mental health services
North East London NHS Foundation Trust (NELFT), which provides community services and children's community mental health services
Provide, which provides community and social care services

**Other main partners**
Your local independent watchdog bodies – Healthwatch Essex, Healthwatch Southend and Healthwatch Thurrock
NHS England Specialised Commissioning, which buys the most specialised services for the whole of the midlands and east region
Health Education England, which is responsible for the development of the NHS workforce.
NHS England and NHS Improvement, the national regulators of the NHS.

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NHS
Camden
Clinical Commissioning Group

***Sent via email***

14th Floor, Euston Tower
286 Euston Road
London
NW1 3DP
www.camdenccg.nhs.uk

Tuesday 17 September 2019

Dear Colleague

**Re: Public consultation on a proposed move of Moorfields Eye Hospital's City Road (London) services has now closed**

I am writing to let you know that the formal public consultation into the proposal to move Moorfields Eye Hospital's City Road, London, services to a new centre bringing together excellent eye care, ground-breaking research and world-leading education in ophthalmology, has now closed.

The consultation, led by NHS Camden Clinical Commissioning Group (CCG) on behalf of all CCGs, together with NHS England Specialised Commissioning, ran from 24 May until 16 September.

Under the proposal eye care services would move to the new centre, along with Moorfields' partner in research and education, the UCL Institute of Ophthalmology and Moorfields Eye Charity. The proposed new centre would be a development on land at the site of St Pancras Hospital, just north of King's Cross and St Pancras stations in central London. If the move were to go ahead, Moorfields and UCL would sell their current land at City Road and all proceeds of the sale would be reinvested in the new centre.

I would like to thank the thousands of service users and families, local people, staff and other stakeholders for taking the time to share their views on the proposal. A draft report into the outcome of the consultation will be available in October.

A decision to proceed to the next planning stages will be made by January 2020. Commissioners will decide whether the proposed move is:

- in the interests of the health of our populations, locally and nationally
- in line with our long-term plans to improve health and care
- an effective use of public money.

We are continuing the discussion and still have a number of events which will focus on some of the main themes which came up during the public consultation. Check the events page for more details and information on how to sign up.

I would encourage you to contact the Oriel team if your group or organisation would like to meet to discuss the proposed move please contact the team by emailing moorfields.oriel@nhs.net or calling 020 7521 4684.

Kind regards

Sarah Mansuralli
**SRO Moorfields Consultation Programme**
**Chief Operating Officer, Camden CCG**
**Working with the people of Camden to achieve the best health for all**

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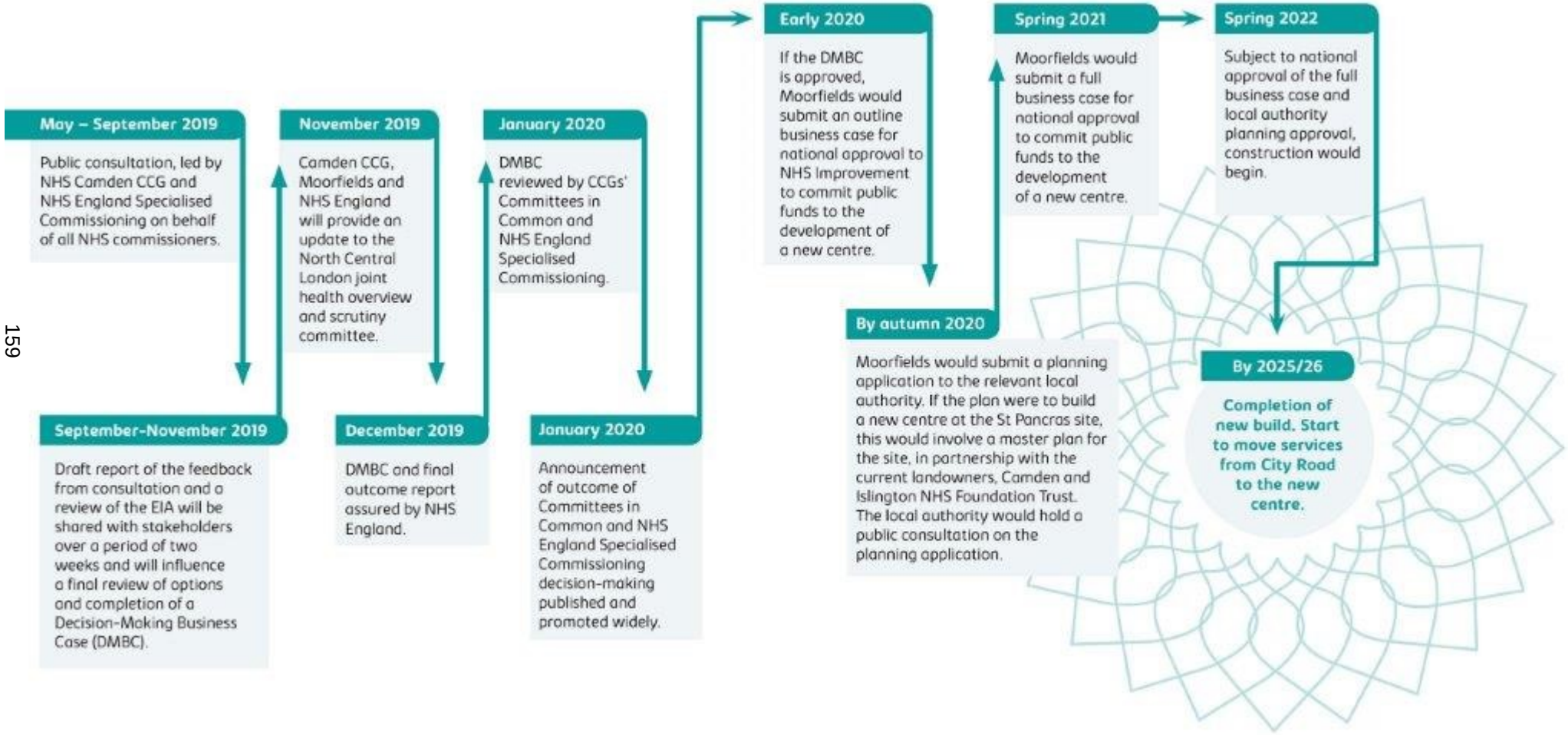
May – September 2019
Public consultation, led by NHS Camden CCG and NHS England Specialised Commissioning on behalf of all NHS commissioners.
September–November 2019
Draft report of the feedback from consultation and a review of the EIA will be shared with stakeholders over a period of two weeks and will influence a final review of options and completion of a Decision-Making Business Case (DMBC).
November 2019
Camden CCG, Moorfields and NHS England will provide an update to the North Central London joint health overview and scrutiny committee.
December 2019
DMBC and final outcome report assured by NHS England.
January 2020
DMBC reviewed by CCGs' Committees in Common and NHS England Specialised Commissioning.
January 2020
Announcement of outcome of Committees in Common and NHS England Specialised Commissioning decision-making published and promoted widely.
Early 2020
If the DMBC is approved, Moorfields would submit an outline business case for national approval to NHS Improvement to commit public funds to the development of a new centre.
By autumn 2020
Moorfields would submit a planning application to the relevant local authority. If the plan were to build a new centre at the St Pancras site, this would involve a master plan for the site, in partnership with the current landowners, Camden and Islington NHS Foundation Trust. The local authority would hold a public consultation on the planning application.
Spring 2021
Moorfields would submit a full business case for national approval to commit public funds to the development of a new centre.
Spring 2022
Subject to national approval of the full business case and local authority planning approval, construction would begin.
By 2025/26
Completion of new build. Start to move services from City Road to the new centre.

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NHS
Camden
Clinical Commissioning Group

***Sent via email*** FionaAbbott@southend.gov.uk
Fiona Abbott
Principal Democratic Services Officer
Legal & Democratic Services
Southend on Sea Borough Council

14th Floor, Euston Tower
286 Euston Road
London
NW1 3DP
www.camdenccg.nhs.uk

Tuesday 17 September 2019

Dear Ms Abbott

Further to your enquiry:

> "The current site at Moorfields is easily accessible by public transport for patients travelling in from the east and there is also good parking nearby, whereas accessibility to the proposed site will be more problematic. Can you let me know how these issues are being considered / addressed in the co-production workstream?"

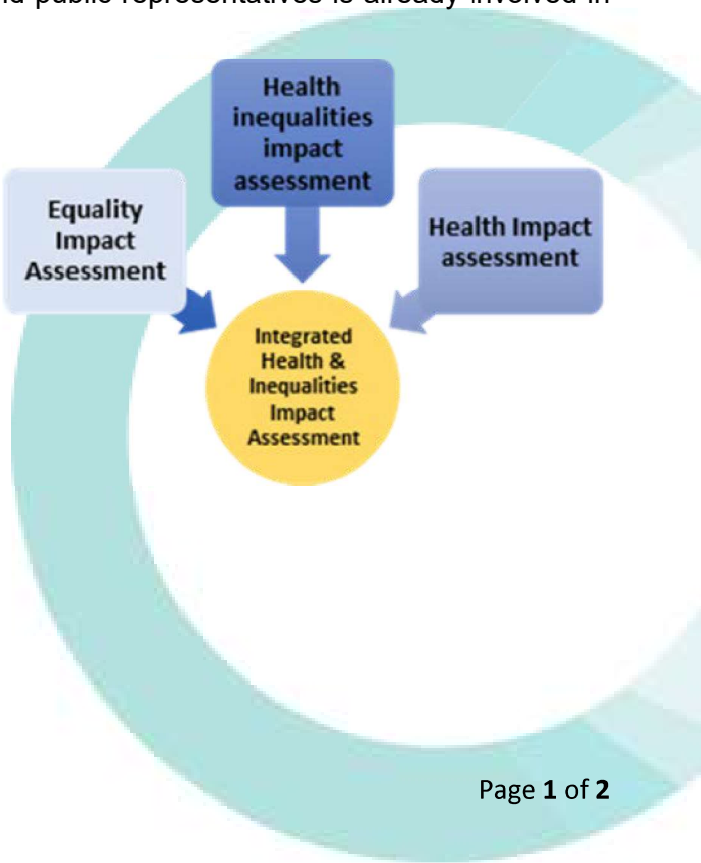
We recognise the need to engage widely with our patient community in respect of patient access and wayfinding to and from the proposed site at St Pancras, and are engaging with patients, carers, Transport for London, Network Rail, the Local Borough of Camden and other stakeholders as we progress designs for the proposed new site.

We have set up six co-production workshops to help coordinate and translate consultation feedback into proposed elements of programme delivery. These six workstreams are as follows:

- Accessibility - getting to the proposed site
- Accessibility - getting around the proposed new centre
- Improving the patient experience
- Managing transition
- Innovation and research
- Options refresh - a task and finish group of patient and public representatives is already involved in the options refresh.

The first **co-production workshop on accessibility** took place on 31 July, and was attended by people with sight loss, carers and members of the Royal National Institute for the Blind (RNIB), Guide Dogs, South East Vision, London Vision, Organisation for Blind African and Caribbean's, Thurrock CCG, Herts Vision and Beyond Sight Loss, as well as building designers AECOM.

The group discussed the current routes to the proposed new site, as well as some of the new technologies that could be used to support people on their journey. Further accessibility workshops will take place in September and October designed to build on these initial discussions with a view to informing future accessibility arrangements, should the proposal to relocate be approved, which is subject to public consultation.



Additionally, we have commissioned a full **integrated health inequalities and equality impact assessment** to understand and assess the consequences of change whilst maximising positive impacts and minimising negative impacts of the proposed change.

| Phase 1 | Phase 2 | Phase 3 |
|---|---|---|
| A rapid scoping report to identify potentially impacted groups to inform pre-engagement activities | A desktop review of "best practice evidence" to identify and develop relevant health outcomes and understand priorities and challenges for key groups. | A revised and final Integrated Health and Inequalities Impact Assessment published to reflect the results of the public consultation. |

We have already completed phases 1 and 2 and this assessment, with phase 3 being scheduled for completion in October 2019, post consultation.

In addition to your query, we have visited Southend and Thurrock to listen to the views of people who would have to travel from outside London.

I hope that this has answered your enquiry but please do not hesitate to contact me should you have further queries.

Yours sincerely

Sarah Mansuralli
**SRO Moorfields Consultation Programme**
**Chief Operating Officer, Camden CCG**

**APPENDIX 6**

# PEOPLE SCRUTINY COMMITTEE
# IN-DEPTH STUDY 2019/20

## *TOPIC:* THE APPROPRIATE USE OF REABLEMENT FOR OLDER PEOPLE (65 AND OVER) WHEN DISCHARGED FROM HOSPITAL, TO MAXIMISE THE NUMBER OF PEOPLE AT HOME AFTER PERIOD OF 91 DAYS

**FRAMEWORK FOR SCRUTINY / SCOPE OF PROJECT:**
Does the current service offer accessible and effective care, delivered to the right people, in the right place and at the right time:-

- How is the service delivered (perform)
- Experience of residents who use service
- Partner agencies view & level of integration
- Comparative information

| | |
|---|---|
| **Method:** Through project team meetings and witness session<br>*(At these sessions, evidence will be taken in public - unless local government access to information rules requires private consideration of information).* | **Target date:** April 2020 |

**MEMBERSHIP**:

Councillor Fay Evans (Chair of Project Team), Councillors Alan Dear, Denis Garne, Margaret Borton, Cheryl Nevin, Anne Chalk, Ian Shead and Ashley Thompson, Tim Watts, co-opted member (Southend Carers)

Officer Core team: Sarah Baker, Lynn Scott, Gemma Czerwinkle and Fiona Abbott (project coordinator)
As and when required: Mike Bennett

**PROPOSED OUTCOMES:**

- Increased awareness of the reablement offer and the intention to promote health, wellbeing, dignity and social inclusion through focused work to maximise independence and reduce the need for longer-term support.
- Assurances that the reablement offer supports the appropriate people to maximise their level of independence and to recommend changes to the offer as appropriate.
- Ensurance that the use of reablement supports the relevant outcomes outlined in the 2050 ambition

**SOURCES OF EVIDENCE**

The main evidence base will be:

- The Care Act 2014

- Adult Social Care Outcomes Framework
- Evidence from key stakeholders

**SUGGESTED STAKEHOLDER/WITNESS GROUPS:**

Hospital Discharge Team
Integrated Commissioning Team
Southend Care
Reablement service
Occupational Health
Southend Carers
Healthwatch Southend
SAVS
Patient participation group / service user

*Project team to identify people to be involved.*

**POSSIBLE ACTIVITY / INDICATIVE PROGRAMME:**

Meeting – 5th September 2019 @ 6 pm
Presentation, context of review & setting scene – local needs and demand; reablement pathways
Open conversation

Site visits – October 2019

1. Community (Sheltered Accommodations / Hubs / Admission Avoidance)
2. Assessment Beds
3. Hospital Team

Meeting – November 2019
Process map for reablement
Updated trends / data
Patient journey – to capture a 'Day in the life of…' and map the patients seen on a normal day in the hospital team.

Meeting
Meet key health partners (commissioners and providers)
Level of integration, gaps etc

Meeting
Review evidence & draft recommendations

# APPENDIX 7

## RESPONSE to Councillors following the Full Council Meeting – 18th July 2019

Thank you Councillor Flewitt for your question regarding access to the new **Southend Sexual Health Service (SSHS)** and your query in regards to late HIV diagnosis as highlighted in the Director of Public Health's Annual Report (2018-2019).

A number of the sexual health indicators benchmark Southend-on-Sea as being better or similar than England, but also recognised that some indicators have less favourable outcomes.

Since April 2019, a new Southend Sexual Health Service has been commissioned to deliver free to access sexual health services to the residents of Southend-on-Sea, this includes the testing, diagnosis, treatment and partner management of sexually transmitted infections (**STI**) and HIV. The service also provides access to a range of contraceptive methods and support in managing conception options.

The sexual health service will offer, from the 1st August 2019, a new digital online offer for STI testing and diagnosis with treatment and partner management being provided through clinical services. This will ensure we can meet our 48-hour urgent access standard to this service which has proven challenging in Southend. This service will complement the already existing HIV Home Sampling offer delivered in conjunction with Public Health England as part of the national service.

The model of the new service did not readily allow for a consistent walk-in facility, as the plan was focused on redirecting users to the online service. Occasional daily slots for a walk-in service has now been made a requirement with a minimum of 10 slots per day. Additionally, based on local utilisation mostly from younger people, the service will provide a Monday afternoon (15:45 to 19:00) walk-in service from the end of August 2019.

From 1st September 2019, the Terrence Higgins Trust (**THT**) will deliver a sexual health promotion and community HIV prevention service and will bring additional resource to deliver community and digital outreach; distributing safer sex and HIV prevention materials; and Point of Care HIV Testing to both the general public and to targeted identified groups.

The new THT's service provision will be using innovative methods of service delivery to further reach out to those groups identified to be at risk for HIV transmission and late diagnosis. By engaging with individuals and groups at Public Sex Environments, digitally through online forums and apps, and by increasing access to safer sexual health resources through local community distributors, THT will ensure an increased access to, and knowledge of, local sexual health support and STI/HIV prevention.

The SSHS and THT, in partnership with the Southend-on-Sea Borough Council Communications Team and Public Health Team will raise awareness of national, regional and local campaigns through joint communication channels including social media.

Primary Care services, delivered by General Practice and Community Pharmacy will also improve access to contraception, particularly Long Acting Reversible Contraception (**LARC**), and Emergency Hormonal Contraception (**EHC**) for those seeking it. We are currently in discussion with the newly formed Primary Care Networks (5 across Southend) to reach an agreement on a formal commissioning of the LARC service, with improved accessibility in the localities, from April 2020.

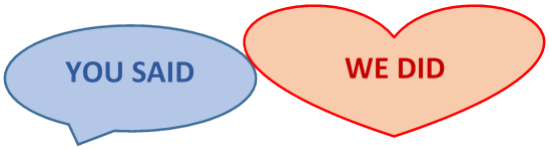
A deep dive exercise is currently underway to review teenage conceptions and pregnancy and to gain better insight into why our rates have plateaued - with the outcomes being presented

to the Health and Wellbeing Board in December 2019. This will inform our renewed approach in working to reduce unwanted and unplanned teenage pregnancies.

The Public Health 0-19 and our Early Help services continue to support young people in school and community settings and supporting young families through Health Visiting and Family Nurse Partnership Services. This offer includes sexual and reproductive health advice and support.

Training is being delivered to support Southend Schools, through the Enhanced Healthy School Project, to implement the statutory Relationships and Sex Education curriculum from September 2020.

The actions above detail access to specialist services as well as a response to a number of complaints (Please review the **You Said – We Did section below**); new technology options for delivering services; improved awareness raising; and direct interventions with young people and targeted groups, these will support an improvement in sexual health outcomes for Southend-on-Sea residents and intend to raise the local indicator outcomes to being better or similar to England.




**Early July - Complaint from SBC's Officer log:**

User's issue is that previously we had sexual health clinics run by "Kingsley Ward Clinic" which they said were very good. However, we now have provision in Thamesgate, which are much less good in terms of availability and access. They said the clinics were open fewer hours with little "drop in" [*walk-in*] function. They said a friend wanted to get the "depo injection" [*LARC*] and was told the next appointment was 23rd of August. They also said that after enquiring they had found that Southend was the only area in Essex where SH24 [*on-line*] services were not available. They asked if the Council were trying to undo all the work done about unwanted teenage pregnancy?

**25th July - Response from the Council following the recent contractual negotiation:**

*The provider of the sexual health service, formerly operating out of the Kingsley Ward Centre, gave Southend-on-Sea Borough Council notice in 2018 of their intention to cease delivering services on 31st March 2019. The Council undertook extensive public and stakeholder consultation during August and September 2018 about the future provision of local sexual health services…. It was agreed that two providers, Provide CIC and Southend Hospital, would deliver the Southend Sexual Health Service from 1st April 2019.*

*The new service operating from Thamesgate House on Victoria Avenue, has been offering access on an appointment only basis. The service continues to assist occasional walk-in patients to access appointments and support, but does not operate dedicated walk-in clinics at present. However, we are mindful that residents value the flexibility of drop-in sessions and we have been in discussions with the providers with the aim of introducing drop-in sessions in September as part of the phased development of the service offer.*

*The clinic offers a range of opening hours throughout the week and provides over 40 hours of access to patients, including late evenings and going forwards a Saturday morning clinic will be available.*

*The Council is working to empower residents to take greater control of their health and wellbeing. The model of service provided by the new Southend Sexual Health service is based on a triaged needs assessment process. This service model already operates successfully across Essex and Thurrock. This ensures that those at greatest risk to their sexual health and wellbeing are prioritised.*

*Without the detail of your friend's circumstances, it is difficult to be specific about the reason why the earliest appointment she was offered for the Depo Provera injection was 23rd August. However the urgency of her need would have been assessed and explained by the Sexual Health Service Intelligence Centre as part of the triage process.*

*Southend has previously only offered targeted online testing for chlamydia and HIV to residents. However as part of the new service, Provide CIC has been doing extensive testing of a more comprehensive online testing service using their own in-house laboratories, rather than SH24. Subject to the satisfactory completion of the test phase they will be launching this in August 2019. This will be accessible through their website.*

*We take our public health responsibilities seriously and, we are keen to help prevent unwanted pregnancies and maintain access to sexual health services. Please be assured that we are working closely with the providers to continue to develop the service.*

*In the event that your friend would like to progress her concerns with the provider, who can provide a more detailed response to her referral and appointment, their contact information is below….*

**29th July - Response from the user:**

*Thank you for your response.*

*I think at home testing is a brilliant idea so I'm happy to hear it will be coming in from August. It's also good to know Thamesgate is considering walk in appointments because having to wait up to two months for an appointment is not practical in this industry.*

*It's good to know Southend also cares about the empowerment of men and women to have control over their sexual health and family planning. Thanks again.*