

# Southend Health & Wellbeing Board

Agenda  
Item No.

**Joint Report of**  
Simon Leftley, Corporate Director for People, SBC  
Melanie Craig, Chief Officer, Southend CCG

**to**  
**Health & Wellbeing Board**  
**on**  
**01 August 2016**

Report prepared by:  
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For discussion	X	For information only	X	Approval required
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## Locality Approach for Southend

Part 1 (Public Agenda Item)

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### 1 Purpose of Report

The purpose of this report is to;

- 1.1 Provide Health & Wellbeing Board (HWB) with a briefing and update regarding the formation of commissioning Localities for health & social care in Southend on Sea; and
- 1.2 Demonstrate how an integrated complex care co-ordination service might fit with the Locality approach;

### 2 Recommendations

HWB are asked to;

- 2.1 Discuss and note the locality approach to be adopted and that it will be based on 4 Localities in Southend on Sea.

### 3 Background

- 3.1 The vision for the Locality approach is that a Locality is the central place where integrated health and social care interventions are delivered and co-ordinated, this represents a shift away from the hospital and into the community.
- 3.2 Each Locality will utilise existing (or new) NHS / Council estate to provide primary, community and social care services working in a multi-disciplinary team environment and a complex care service for a risk stratified cohort of

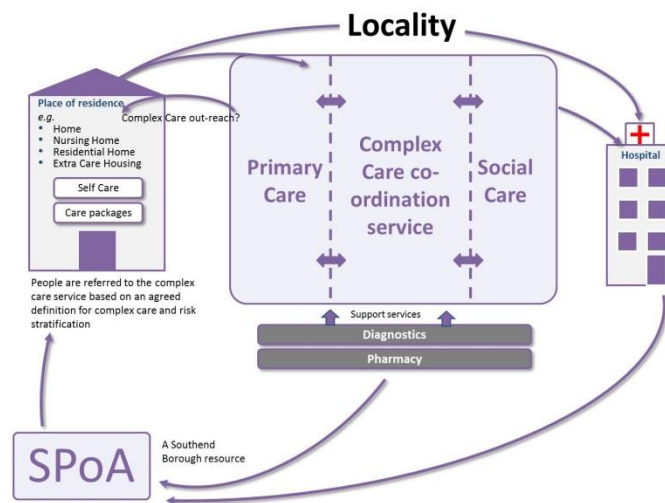
patients and carers. Further, the locality approach is aligned to the Essex Success Regime.

- 3.3 A complex care co-ordination service has been developed and is currently subject to approval. The service has been developed so that it is aligned to the Locality approach. It will support primary care and community services in ensuring patients receive the right care at the right time and in the right place.
- 3.4 The Locality approach and integrated services that exist within are aligned to the actions from the pre board discussion items held by HWB regarding Mental Health, Community Recovery Pathway and Integrated Childrens service.
- 3.5 During the course of quarter 1 2016 / 2017 the Joint Associate Director of Integrated Care Commissioning led an engagement process with the members of the Clinical Executive Committee SCCG to introduce the detail behind the Locality approach and the complex care service. The team has also engaged with system leaders from both commissioners (SCCG and the Council) and providers (SBC, SUHFT and SBC) in developing the Locality approach.

### **The proposed model**

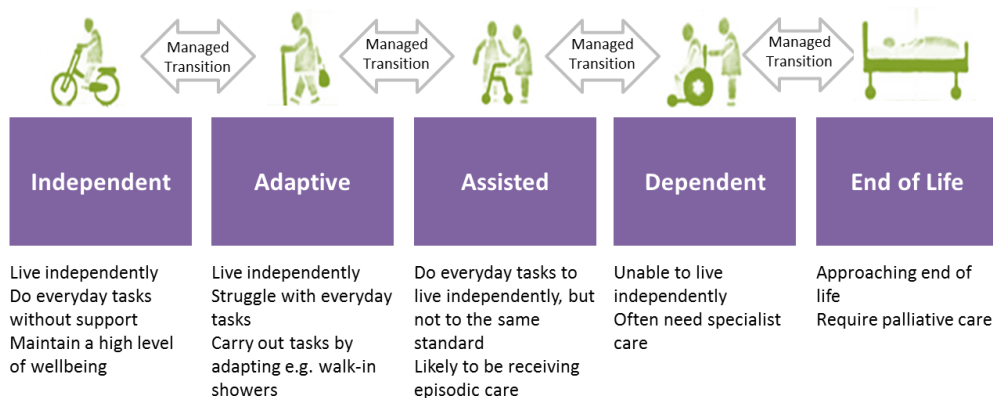
- 3.6 A number of factors have driven the move towards integrated care provision across Southend-on-Sea. Published in October 2014 by NHS England, The NHS five Year forward view (5YFV) sets out a positive vision for the future based around seven models of care.
- 3.7 To further help support the transition towards commissioning integrated care, it was agreed in May 2016 (see Appendix 1a & b) that the number of localities within Southend is 4 (four) which work around circa 50,000 residents or patients, as recognised as best practice by the Essex Success Regime.
- 3.8 Under this new care model outlined in the 5YFW, GP group practices will expand bringing nurses and community services, hospital specialists and others to provide integrated out-of-hospital care. These practices will shift a majority of outpatient consultations and ambulatory care to out-of-hospital settings. To support the 5YFV approach, most recently, the Essex Success Regime has highlighted the requirement for health and care economies to join-up and address problems systematically, rather than in isolation.
- 3.9 The drive for matrix working between health and care services has given rise to the opportunity to develop Localities (as demonstrated in the diagram below), where a combination of primary, community and social care can co-locate or integrate.

## The Locality approach

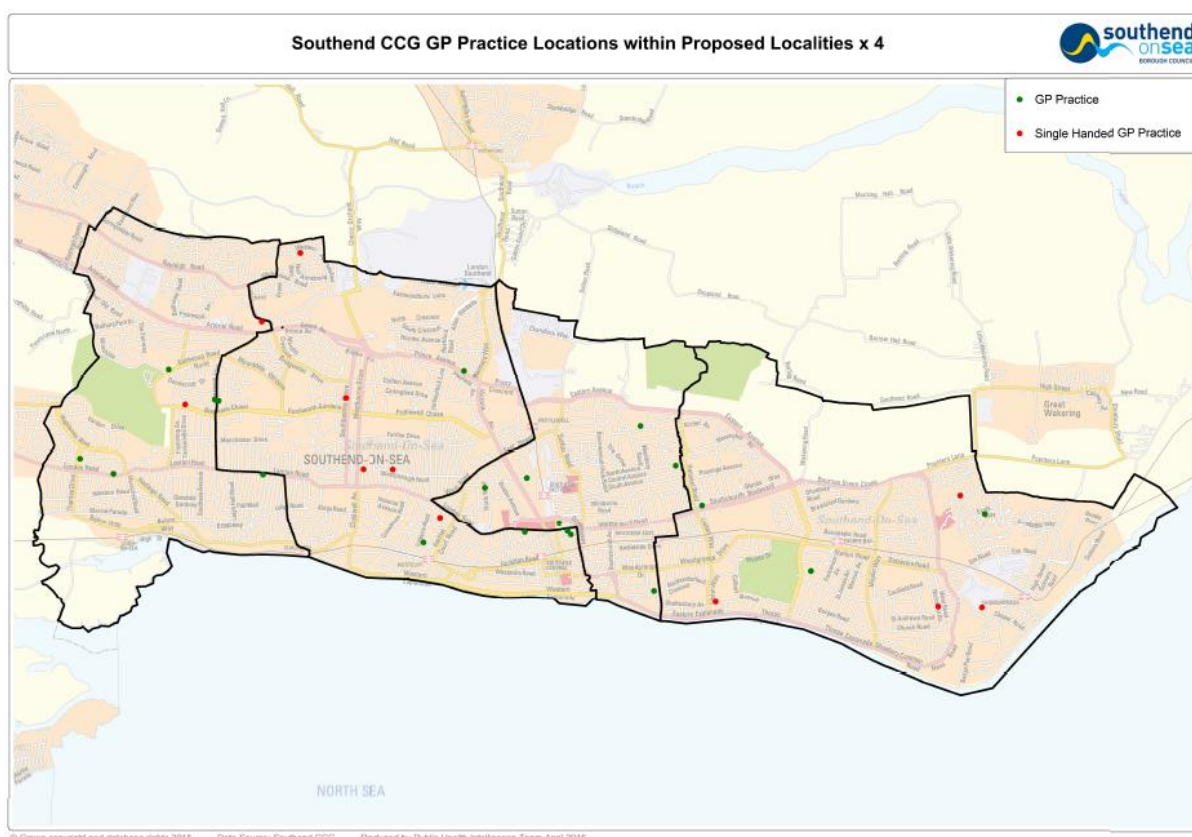


3.10 Closely aligned to a Locality approach is the transitional pathway through which patients will be assessed. Patients with complex care needs – measured through a combination of a frailty index and integrated health and social care data – are those with multiple long term conditions. The best place for the provision of health and social care to these patients should not be the hospital but through the Locality.

## The transitional pathway



3.11 The 4 Localities for Southend are represented below;



### **Timeline for implementation**

3.12 The agreed Locality approach will be implemented across Southend through a staged approach;

3.12.1 There will be a period of testing, which includes; the clustering of GP practices into a Locality framework; the further development of MDTs; the co-location of SPoR and the Access team; and locating a social care worker at a GP practice to embed the way in which health and social care work together.

3.12.2 Implementation of full locality approach, alignment with wider transformation programmes such as Adult Social Care redesign and community health services.

3.13 The four Localities are expected to be fully operational by April 2017.

### **Complex Care Co-ordination service**

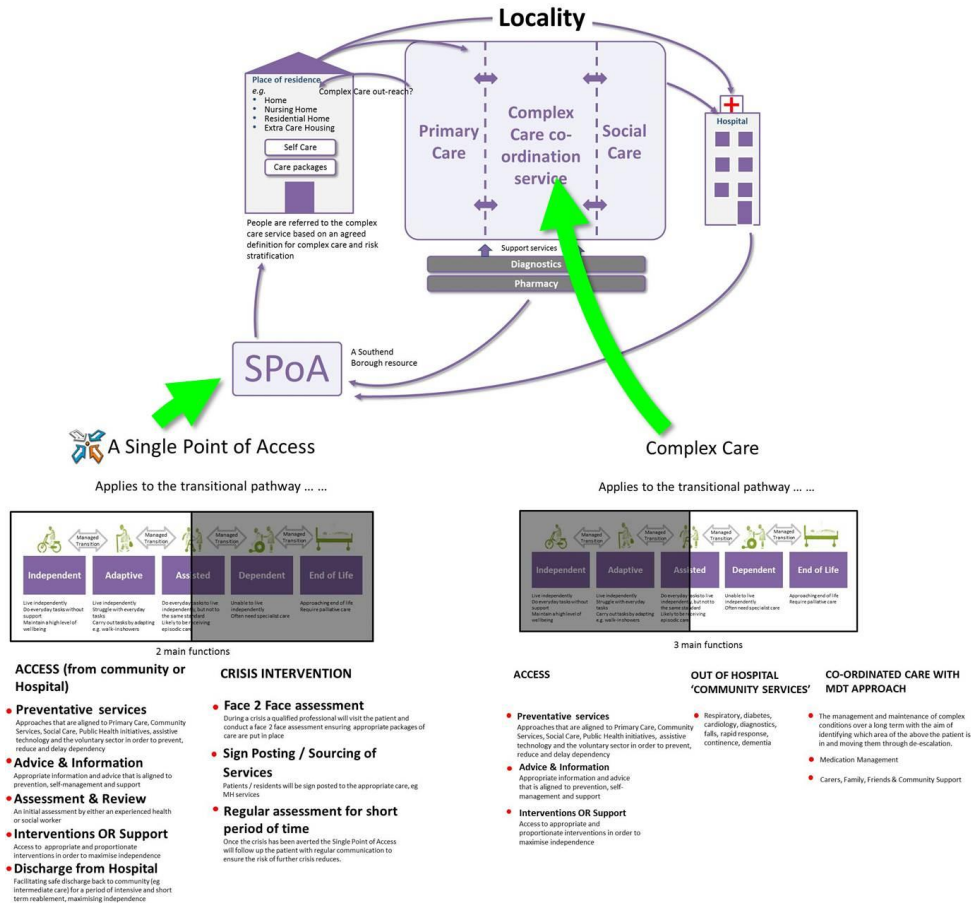
3.14 Within each locality there will be the provision of primary, community and social care. The complex care service will be delivered to support these services ensuring that 'complex care' patients have their care co-ordinated and delivered so as to avoid unnecessary interactions within the system.

3.15 The aim / vision of the complex care service is to provide those identified with complex care needs with a service that co-ordinates their health and social care provision based upon existing services and need. Their care is currently provided in an uncoordinated and inconsistent manner which is not tailored to

the specific needs of the patients nor is it most efficient use of resources. The aim of the service is to ensure care needs are assessed, care plans are co-designed through an established MDT approach and care is delivered in a co-ordinated way.

## Alignment with the Locality Approach

3.16 The diagram below provides an over view of the complex care co-ordination service and how this interfaces with the Locality Approach and the transitional pathway.



3.17 A complex care co-ordination service will be in operation from 1st October 2016 across the borough of Southend to provide a co-ordination of existing health, social care and community services for an identified and risk stratified complex care cohort.

## The next steps – transformation of Community Services

3.18 Following the implementation of the Locality approach we will undergo a process of consultation and engagement with commissioners, providers and patient groups to redesign community services so that they are fully aligned to the complex care co-ordination service and patient needs.

## 4 Health & Wellbeing Board Priorities / Added Value

The BCF contributes to delivering HWB Strategy Ambitions in the following ways

- 4.1 Ambition 5 – Living Independently; through the promotion of prevention and engagement with residents, patients and staff the BCF will actively support individuals living independently.
- 4.2 Ambition 6 – Active and healthy ageing; through engaging and integrating health and social services within the community the services will be aligned to assisting individuals to age healthily and actively; and
- 4.3 Ambition 9 – Maximising opportunity; Overarching BCF; Southend is the drive to improve and integrate health and social services. Through initiatives within the BCF we will empower staff to personalize the integrated care individuals receive and residents to have a say in the care they receive.

## **5 Reasons for Recommendations**

- 5.1 As part of its governance role, HWB has oversight of the Locality approach.

## **6 Financial / Resource Implications**

- 6.1 None at this stage

## **7 Legal Implications**

- 7.1 None at this stage

## **8 Equality & Diversity**

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

## **9 Appendices**

Appendix 1a & b – Options appraisal for Southend Locality approach	Appended separately
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## HWB Strategy Ambitions

<p><b>Ambition 1. A positive start in life</b></p> <p>A. Children in care   B. Education- Narrow the gap   C. Young carers   D. Children’s mental wellbeing   E. Teen pregnancy   F. Troubled families</p>	<p><b>Ambition 2. Promoting healthy lifestyles</b></p> <p>A. Tobacco – reducing use   B. Healthy weight   C. Substance &amp; Alcohol misuse</p>	<p><b>Ambition 3. Improving mental wellbeing</b></p> <p>A. Holistic: Mental/physical   B. Early intervention   C. Suicide prevention/self-harm   D. Support parents/postnatal</p>
<p><b>Ambition 4. A safer population</b></p> <p>A. Safeguarding children and vulnerable adults   B. Domestic abuse   C. Tackling Unintentional injuries among under 15s</p>	<p><b>Ambition 5. Living independently</b></p> <p>A. Personalised budgets   B. Enabling community living   C. Appropriate accommodation   D. Personal involvement in care   E. Reablement   F. Supported to live independently for longer</p>	<p><b>Ambition 6. Active and healthy ageing</b></p> <p>A. Integrated health &amp; social care services   B. Reducing isolation   C. Physical &amp; mental wellbeing   D. Long Term conditions– support   E. Personalisation/ Empowerment</p>
<p><b>Ambition 7. Protecting health</b></p> <p>A. Increased screening   B. Increased immunisations   C. Infection control   D. Severe weather plans in place   E. Improving food hygiene</p>	<p><b>Ambition 8. Housing</b></p> <p>A. Partnership approach to; Tackle homelessness   B. Deliver health, care &amp; housing in a more joined up way   C. Adequate affordable housing   D. Adequate specialist housing   E. Strategic understanding of stock and distribution</p>	<p><b>Ambition 9. Maximising opportunity</b></p> <p>A. Population vs. Organisational based provision   B. Joint commissioning and Integration   C. Tackling health inequality (improved access to services)   D. Opportunities to thrive; Education, Employment</p>