

South East Essex Locality Partnership

Locality Strategy

Living Well in Thriving Communities



Contents

1. Introduction, Purpose and Audience	2
2. Context and Case for Change.....	3
Case for Change	4
The Financial Case and Logic Model	6
The Public Health Case.....	8
Disease and harm prevention at a population level.....	8
Population Health Management	9
3. Our vision for the future	10
Locality Working - A Place-Based Approach	10
System Ambitions	11
Development Process	13
Principles behind the Model of Care	14
The Model of Care	16
The Role of the Hospital.....	17
Principles of Collaboration.....	17
Ambition for the System	17
The local landscape.....	17
Memorandum of Understanding.....	18
Features of integration	18
4. How we will implement our vision	19
What are we going to do once?.....	19
Current status of Localities	20
Locality Variation	20
Locality Implementation Plans.....	21
Transformation Oversight.....	21
5. Enablers.....	23
Engagement, Communications and Co-design.....	23
Workforce	23
Estates.....	25
IT Systems	26
Digital Innovation.....	26
Digital as an enabler.....	27
6. Next steps/timeline	28
7. Appendices.....	29

1. Introduction, Purpose and Audience

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

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

The purpose of this document is to;

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

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

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

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

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

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

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

This document is structured to enable the reader to understand the

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

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

2. Context and Case for Change

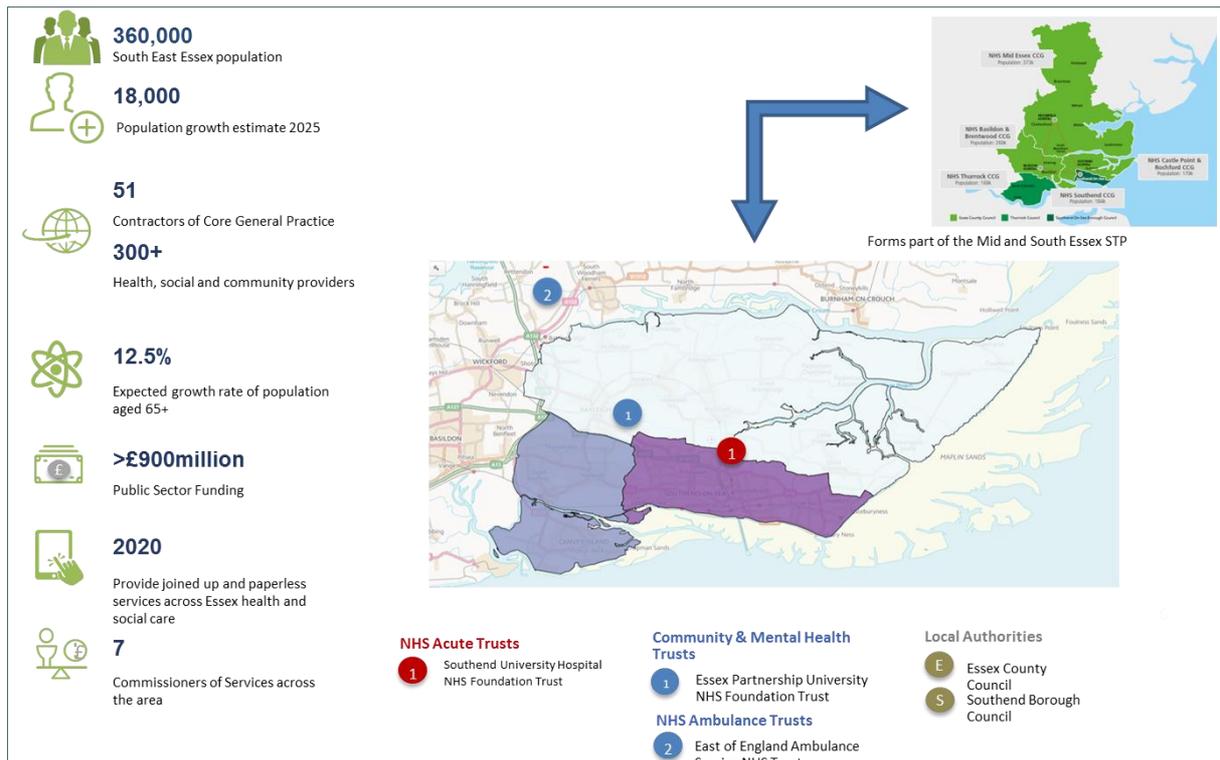
A quick portrait of the patch and the organisations within it

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

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

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

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



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

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

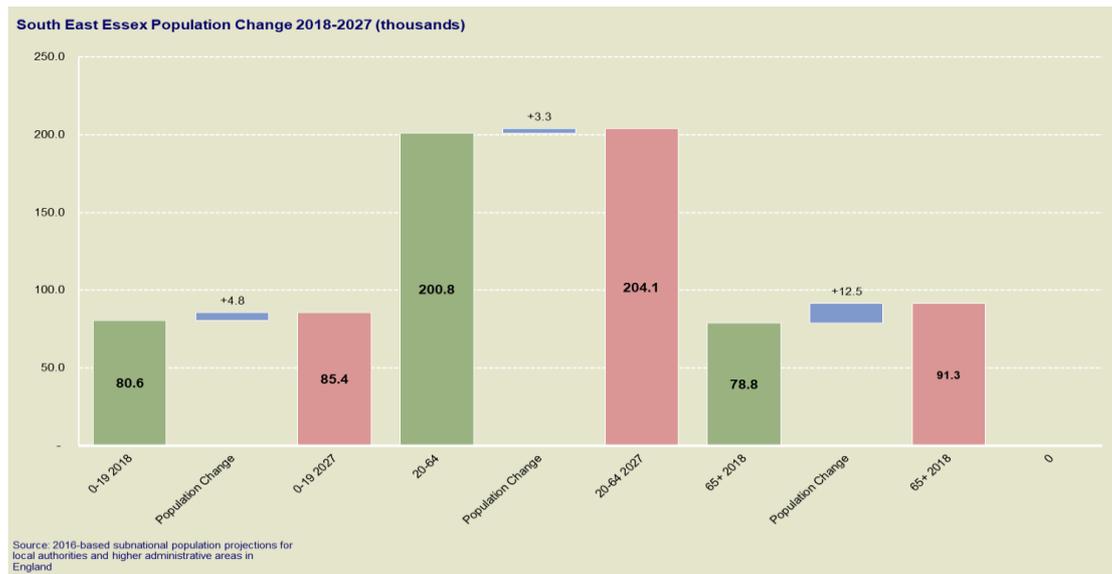
Case for Change

A short narrative on the challenges faced locally

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

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

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



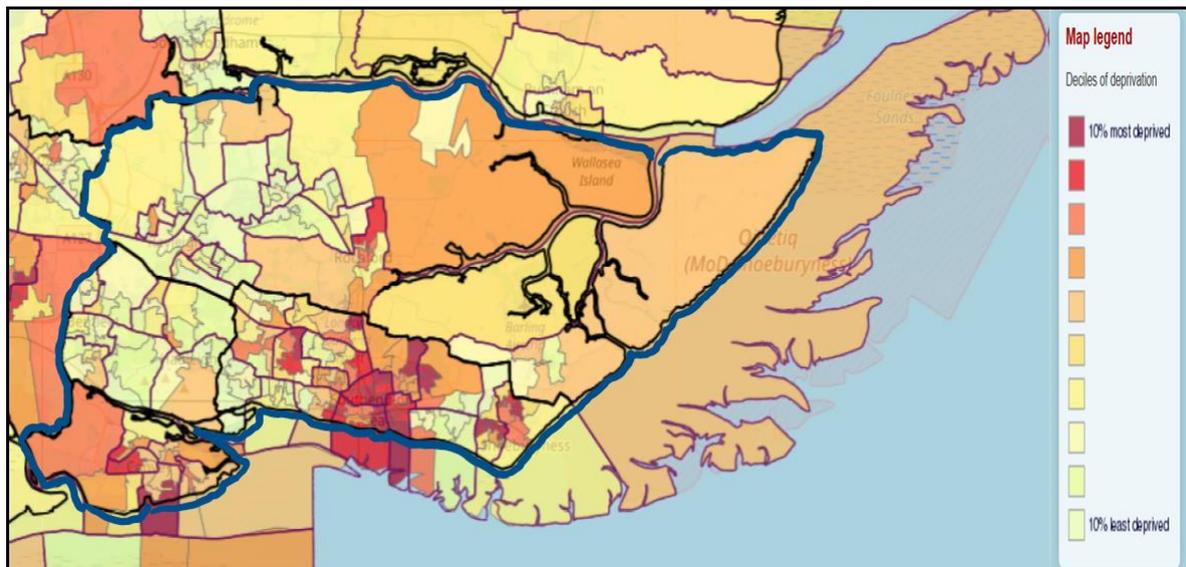
South East Essex as an area is one that contains within it a collection of smaller communities, each with their own specific care needs based upon the demographic of the population living there.

It also has a complex and varied health profile as summarised within Public Health England's Local Authority Health Profiles 2018¹

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

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

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



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

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

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

The Financial Case and Logic Model

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

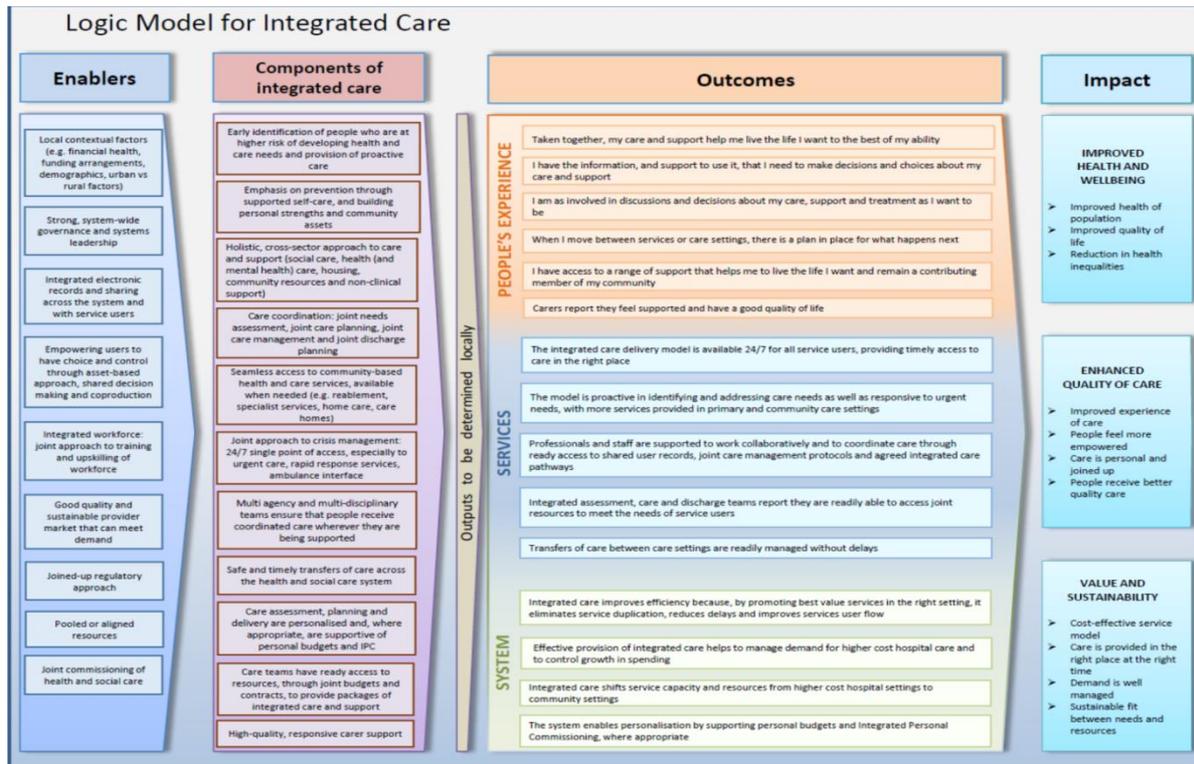
Further complexity exists with Local Authority arrangements such as the differences in scope between Essex County Council and Southend Borough Council and the role of District Councils within Essex County Council boundaries.

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

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

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

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

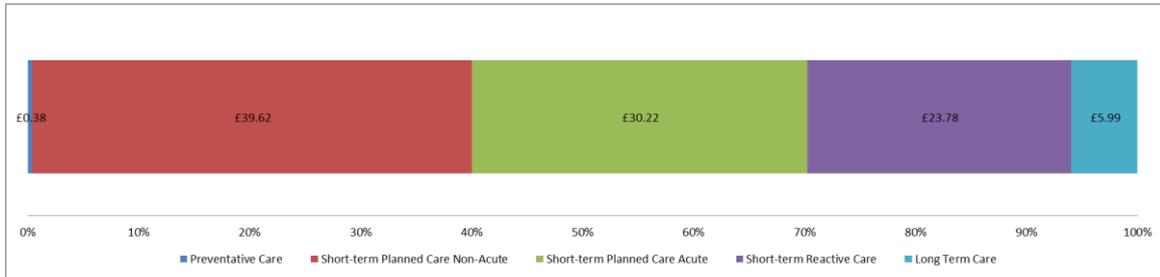


What is apparent through a simplistic analysis of CCG spend incurred within the system is that the majority of current health commissioner resource is utilised either on on-going care, or re-actively responding to rapid deterioration in need – as opposed to investing in preventative care. Whilst not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

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

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

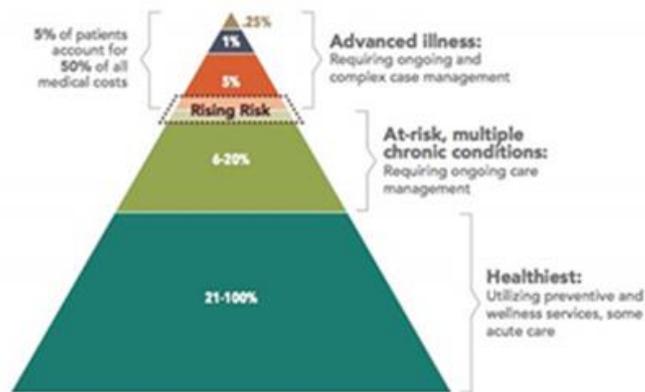
- £39.62 is committed to meeting short-term (non-permanent) health needs in a planned manner, assuming patients do not remain on caseloads in perpetuity. This covers nearly all spend areas of primary and community care
- £30.22 on planned acute services such as Out-patient appointments and Elective inpatient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



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



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



The Public Health Case

Disease and harm prevention at a population level

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

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

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

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

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

Population Health Management

It is clear that there is a strong rationale for matching evidence-based intervention and resource to identified population health need. A robust, effective, and equitable healthcare system requires effective systems for identifying and quantifying need. The population health management (PHM) approach encompasses a range of models which attempt to quantify levels of need through aggregation and triangulation of patient and population health data and effectively managing that identified need. A successful PHM model starts from the perspective of understanding people's lives and the impact that disease has upon them and modelling pathways of care around this rather than treating isolated episodes of illness. This means that systems must take account of social factors in designing service access and demand parameters. Healthcare providers such as Kaiser Permanente in the United States have suggested from their activity data that around four fifths of patients identified as being at highest risk of being the highest users of their services have at least one unmet social need³.

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

Examples of the successful impact of PHM on health systems and health outcomes are emerging, with case studies in the London Borough of Camden showing initial reductions in emergency admissions, emergency bed days, and overall secondary care financial savings. For diabetes, identification of untreated diabetes patients and consequent reductions in amputations and unplanned admissions was seen, leading to the borough achieving nationally-rates outstanding outcomes⁴. Imperial College has also undertaken early evaluation of five

² Cardiovascular disease prevention: Public health guideline [PH25]. 2010. Available at: <https://www.nice.org.uk/guidance/ph25/chapter/1-Recommendations>

³ Shah N et al. 2016. Health care that targets unmet social needs. *New England Journal of Medicine Catalyst* (Note: this is a journal article rather than a peer reviewed paper where data would be available for scrutiny.)

⁴ Sayer C et al. 2017. Toward accountable care: achieving value and integration via population health management. *New England Journal of Medicine Catalyst*. (Same note as above.)

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

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

3. Our vision for the future

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

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

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

Locality Working - A Place-Based Approach

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

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

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

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

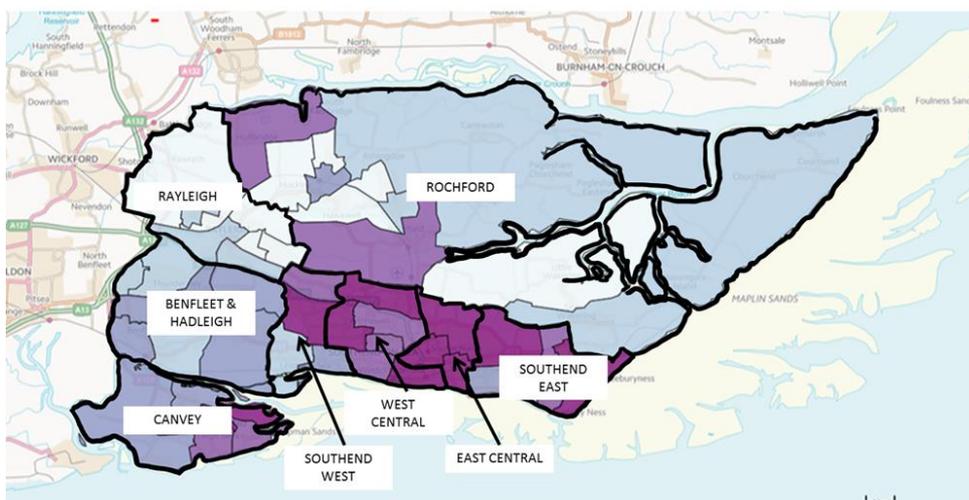
Traditional top-down approaches to change, or transformation, that rely on an overarching system (or national) view that is then broken down into sub-systems (local views) are not considered as the best option for maximising the collective power of individuals, communities and the third and statutory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

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

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

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

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



System Ambitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Development Process

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

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

At the heart of the Locality Model are the following principles

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

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

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

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

Principles behind the Model of Care

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

Alex Fox, chief executive of the charity Shared Lives

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

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

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

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

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

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

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

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

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

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

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

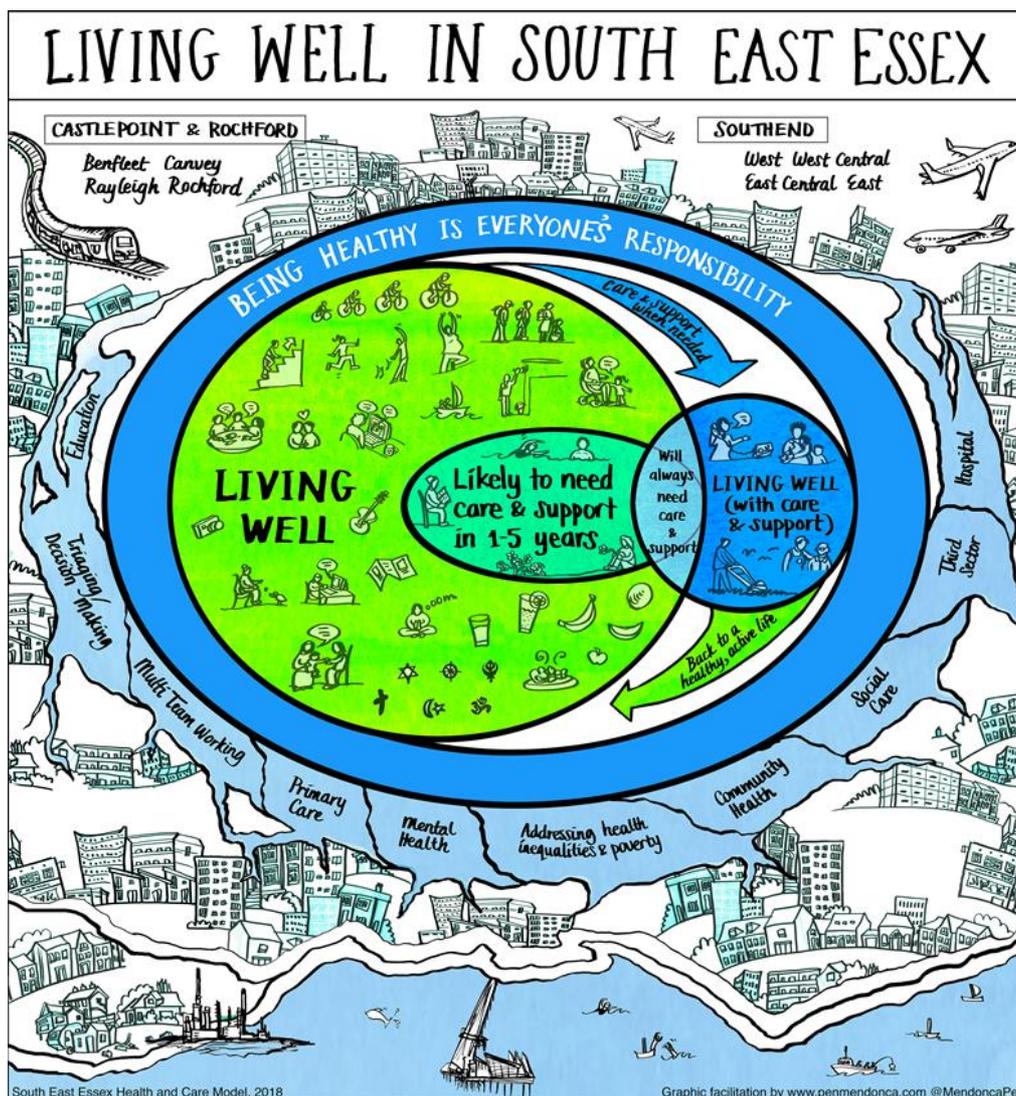
To deliver the themes and outcomes a roadmap has been developed which describes the journey from now to 2050. The roadmap focuses on the next 5 years and sets out clear actions that will be taken during this time.

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

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

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

The Model of Care



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

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

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

The Role of the Hospital

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

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

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

Principles of Collaboration

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

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

Ambition for the System

The local landscape

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

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

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

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

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

Memorandum of Understanding

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

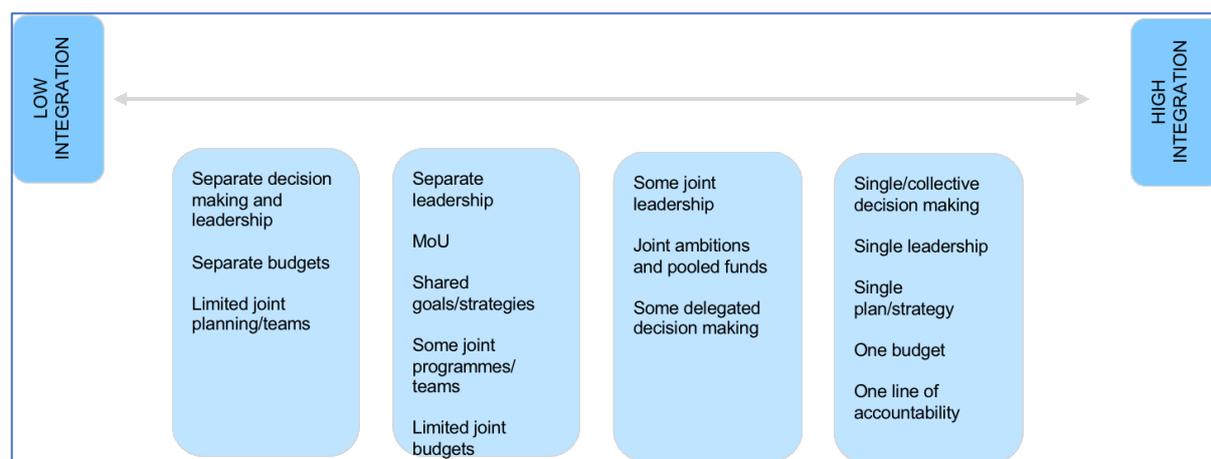
Therefore, we have committed to developing a Memorandum of Understanding (MoU) that will set out in clear language how we will work together, what principles we will follow and how we will behave. Whilst not legally binding, the MoU will clarify and codify the commitments we are making to one another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

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

Features of integration

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

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



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

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

4. How we will implement our vision

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

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

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

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

What are we going to do once?

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

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

Current status of Localities

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

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

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

Locality Variation

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

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

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

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

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

Life Expectancy

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

The variation in Health Life Expectancy is just as stark

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

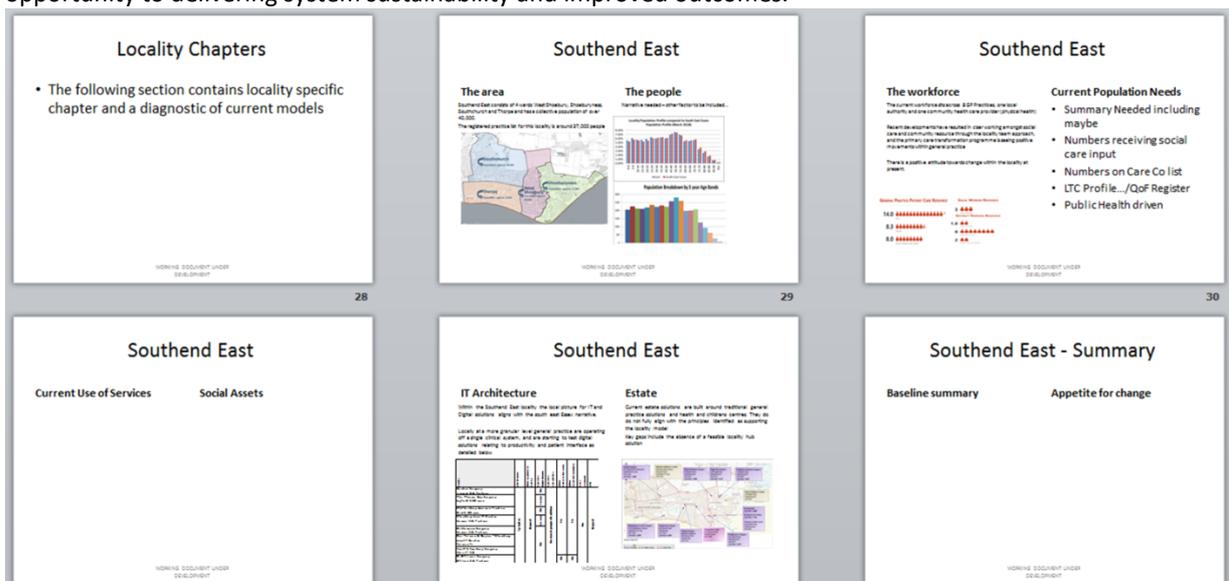
Detailed, and summary, locality needs assessments are being developed for each area, examples for the four Southend Localities can be seen in Appendix 1.

Locality Implementation Plans

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

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

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



Transformation Oversight

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

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

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

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

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



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

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

5. Enablers

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

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

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

These principles are as outlined over the following sections

Engagement, Communications and Co-design

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

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

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

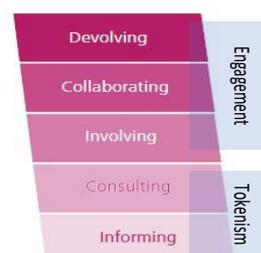
It is anticipated that shared resources are identified to address and manage these requirements and that a joint plan is developed and implemented to support the wider transformation of the system

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

The 'Ladder of Engagement and Participation'

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

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



Workforce

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

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

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

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

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

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

Its core functions form the pillars of the HEE offer to STPs and include:

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

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

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

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

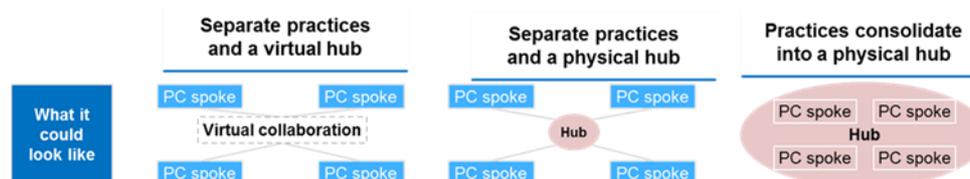
Estates

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

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

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

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



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

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

IT Systems

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

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

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

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



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

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

Digital Innovation

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

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

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

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

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

 <p>Our Shared Vision</p> <p>Health and Social Care organisations in Essex share an ambition to improve the services they deliver and the wellbeing and lives of the people they serve. They will work together with each other and with the local population to organise around the needs and locations of people, rather than boundaries of organisations. The way that technology is used will be improved, with connected systems and better sharing of information to allow Health and Social Care professionals to be more responsive.</p>	 <p>What this will mean for local people</p> <p>Digital services will provide patients and users with the ability and convenience to manage their own information and needs if they want to - just like they can in other parts of their lives (e.g. online banking). People will be encouraged to be more responsible, active and healthy and they will be provided with technology that helps, like Health Apps and the ability to use information from wearable devices. Information will be combined and used intelligently to identify needs or issues so that where possible services can be targeted proactively, rather than treating problems after they occur.</p>	 <p>What this will mean for our workforce</p> <p>The Health and Social Care workforce in Essex will be a critical part of this plan. Without their involvement and buy-in new technology will fail and no improvements will be achieved. They will be included, educated, equipped and enabled to be successful - with technology being put in place that allows them to focus on caring for patients and citizens. New services will be designed with users in mind, making the systems intuitive to use and training and adoption less of a hassle. The importance of the safety of the people being cared for will not be overlooked.</p>	 <p>How we will work together & with others</p> <p>These changes will be forward thinking and made collaboratively, listening to people in the region and being honest and practical about what can be done. We will recognise that some centralised coordination is essential, and respect the decisions that are taken. We will work with clinicians and patients to co-produce plans and services, working with or convening clinical or citizen groups where required. Essex will become known as a leading region for working with the vibrant marketplace of Health and Social Care innovation. New approaches will be welcomed, trialled and adopted. The Essex teams will work with neighbouring STPs to ensure that the flow of information follows the flow of people around the South East.</p>	 <p>How we will work to deliver the vision</p> <p>Working across the different Health and Social Care organisations in Essex at the same time to improve technology will be hard, and careful prioritisation and management will be needed. Initial focus and investment will go into a number of fundamental technology foundations, on which other solutions and changes will be built. Teams will be set-up to deliver these changes that follow the approaches to technology that are successful in the private sector (e.g. agile). These teams will have multiple skills and people, and an experimental mind-set that will quickly work out the best way of doing things. Where investments are made the teams will be held accountable to make sure that the expected benefits are delivered.</p>
--	---	---	---	---

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

Digital as an enabler

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

Managing demand

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

Creating capacity

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

Operating at scale

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

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

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

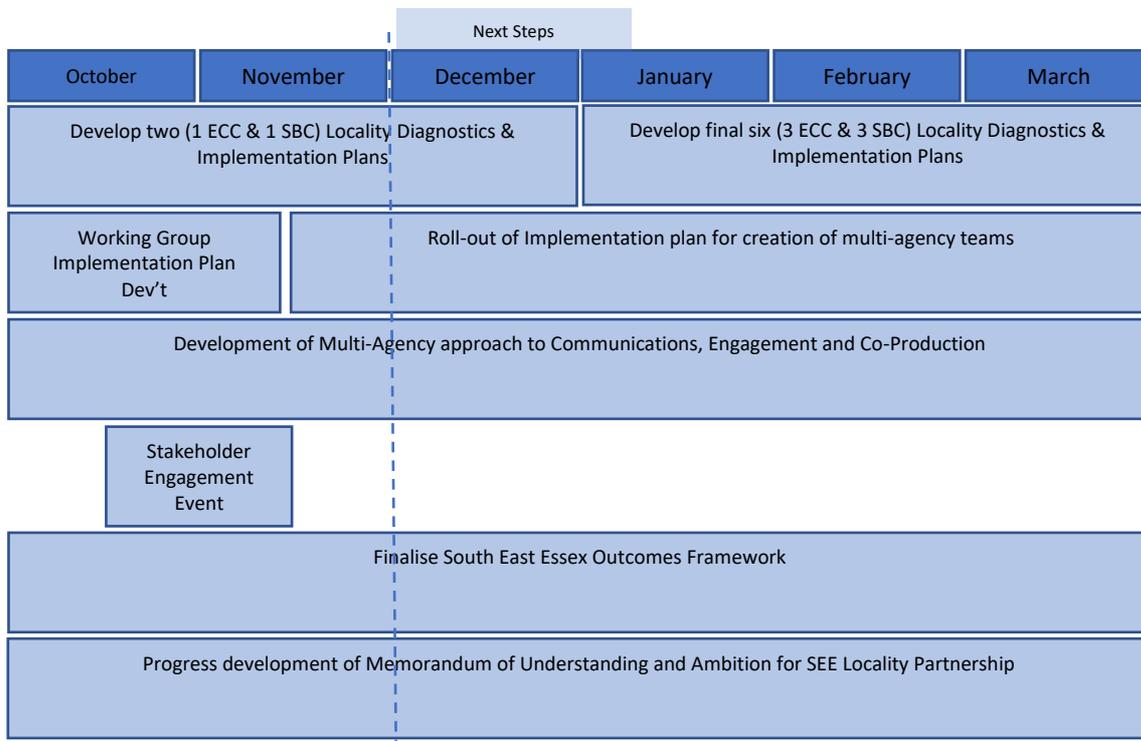
6. Next steps/timeline

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

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

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

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



7. Appendices

Appendix 1 – Locality Needs Assessments