Locality Approach for Southend

Report of

Sadie Parker (Associate Director Primary Care & Engagement, SCCG)
Jacqui Lansley (Joint Associate Director for Integrated Care Commissioning)

to

Locality Transformation Group

on

3rd May 2016

Report prepared by:
Paul Taylor, SBC
Andrea Bann, SCCG

For discussion	X	For information only		Approval / Action required	X

Date of the meeting	3rd May 2016
Sponsoring LTG Member	Jacqui Lansley
Purpose of Report	To approve the options appraisal and agree a number of localities for Southend
Recommendation	The Senior Officer Transformation Oversight Group is asked to Approve the recommendations
Previous LTG Dates	6th April 2016
Other committees / executive that this paper has gone to	n/a
Other committee / executives that this paper will go to	Clinical Executive 12th May 2016

1 Purpose of Report

The purpose of this report is as follows;

1.1 to provide LTG with an update to the development of the Locality Approach for Southend.

1.2 to provide LTG with an opportunity to discuss, feedback and agree the proposal for Locality Approach.

2 Recommendations

LTG are asked to;

2.1 sign off the recommendations; and

2.2 recommend that the paper (with any amendments) is presented to Clinical Executive Committee on 12th May 2016.

3 Background & Context

3.1 Introduction

This report is to provide the Senior Officer Transformation Oversight group with an options appraisal around how the commissioning localities will be formed for health & social care and a recommendation on the number of localities that would be suitable for Southend.

3.2 Background

The vision for the locality approach is that a locality is the central place where integrated health and social care interventions are co-ordinated, this represents a shift away from the hospital and into the community.

Each locality will utilise existing (or new) NHS / SBC estate to provide a complex care service for a risk stratified cohort of patients and carers. The locality (aligned to the redesign of adult social care) would also provide primary care services working in a multi-disciplinary team environment. Further, the locality approach is aligned to the Essex Success Regime.

In support of the work we are partnered as a system to deliver Better Start, a BIG Lottery funded programme working to enhance universal preventative services for Early Years and Early Years Public Health, to improve the life chances of Southend's children. A workstream within Better Start is focused on providing a 'family friendly' GP service based at practices. The service will look to build on existing and develop community relationships to provide integrated services in response to the health and care needs of the locality populations.

3.3 Report

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. One of these models outlines the need for multi-specialty community providers (MCPs). To further help support the transition towards commissioning integrated care,

this report is to identify the number of localities within Southend which work around 50,000 residents or patients.

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 would shift a majority of outpatient consultations and ambulatory care 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. Monitor (2015) states:

The health economy faces quality, financial and operational challenges which put the sustainability of health and care services at risk. As well as the financial situation across the whole health and care economy, it will also look at governance and other issues. Across Essex in particular there are workforce challenges across primary and secondary care in the local health economy. The Success Regime will aim to produce a single strategic plan for the local health and care system, shared by all local stakeholders.

The drive for matrix working between health and care services has given rise to the opportunity to develop localities, where a combination of social work, primary and secondary care services can co-locate or integrate. Southend Clinical Commissioning Group (SCCG) have identified potential asset based sites across West, Central and East Southend. Clinical commissioning and Adult Social Care are currently undergoing transformational change and so it is now timely to consider the options for social work staff to be co-located or integrated with these sites, which will have the potential to:

- Increasing efficiencies across the health and care economies;
- Coordinate the commissioning of services to support the demographic changes, increased multi-morbidity, clusters of risk factors and the rising needs of frail older people;
- Facilitate the development of high standard out-of-hospital services;
- Improve outcomes for adults who use services;
- Support the prevention agenda with communities;
- Develop integrated assessment, care planning and joint approaches to health and social care practice;
- Align, where possible, to children services, schools and other health services *e.g.* mental health to drive towards a position of working with families and communities, rather than discrete sets of individuals.

Primary Care services in Southend are currently delivered by 35 GP practices spread over 30 locations; 38 Pharmacies, of which 7 open for extended hours; 22 dental practices and 22 Ophthalmologists. SCCG commissions community and Mental Health services (MH) from South Essex Partnership Trust (SEPT). These services include Adult Intermediate Care, Rapid Response Service, Continence Services, Podiatry Services, Occupational Therapy (OT), Mental Health (MH) and District Nursing (DN).

A number of Southend GP practices are based in converted residential properties. There are modern primary care centre facilities in North Road, Valkyrie Road and in Leigh, with additional investment from NHS England being used to develop two new primary care centres in Shoebury and St Luke's and to refurbish the Kent Elms Health Centre. These primary care centres will be a focus for our locality approach to integrated service provision in the borough.

The national average list size of a GP practice is around 7000 patients. In Southend, two thirds of our practices are smaller than this with 10 practices being operated by a single GP. Many of our GPs in these smaller practices are approaching or at retirement age and some operate with high ratios of patients, using locum GPs on a sessional basis to add capacity. This leads to concern about the stability and sustainability of local general practice and its ability to respond to changing policy for general practice, such as providing wider primary care at scale, moving more services into the community and providing services across seven days. The size of our practices range from Dr Velmurugan's surgery at 995 patients to the Queensway Medical Practice at 22,004 patients.

There is wide variety in the quality of and access to general practice in the local area. We look at referral rates, emergency admissions, A&E minors attendance, GP out of hours services usage, dementia diagnosis rates, prescribing and many other sources of information to triangulate data on practices. As we move to co-commissioning over the next few months, this data will inform our approach to monitoring GP practices and managing the implementation of our locality approach. One area we identified as a priority was the longstanding problems in accessing quality primary medical services for residents of care homes.

Southend on Sea has a higher than average density of care home provision and practices, particularly in the Westcliff area, and are struggling to provide the level of care needed by residents of care homes. We have procured and are currently mobilising a new pilot for a dedicated GP practice for residents of care homes across the borough. This practice will provide an enhanced level of coordinated and proactive care to its patients with a view to improving the quality of their care, reducing health crises through the implementation and regular monitoring of personal care plans, thus reducing the number of emergency admissions, A&E attendances and ambulance attendances for this group of patients.

There is currently some joined up practice with DN, OT (and other allied health professionals) and MH community services. Social workers are also attached to GP surgeries and attend Multi-Disciplinary Team (MDT) meetings once a month. However, there is more that can be done to prevent, reduce and delay the long term care needs.

Part of the solution could be the requirement to explicitly integrate community health services (GPs, DNs, MH and so on) rather than continue with a model which is largely fragmented and lacks the consistency of a health and social care approach.

Nationally, people with long-term conditions account for 50% of all GP appointments and 70% of hospital bed days, but there is mounting evidence that this heavy reliance on acute and long-term care is not the best way to manage patients with more complex need and is poor value for money. This is where social work can contribute: whereas historically the medical care model may have tended to arguably foster dependency, the social work model aims to promote independence. Early indications are that reductions of 15 – 20% of adults in residential/nursing home placements and 20 – 30% of patients in A&E attendance and hospital bed occupancy are achievable among people deemed to be at "high risk".

These figures are borne out by five case studies presented in the background papers of this joint report where GP-social worker partnerships have started to save money desperately needed elsewhere by listening to what outcomes people want.

There are three options highlighted below which identify the advantages and disadvantages to both the heath and care economies, taking into consideration the following factors:

- Demographics currently & projected
- Deprivation across each ward
- The current organization of children's teams within social care
- Current and likely future staffing numbers across East/West localities for social care
- Geographical size of each locality
- The potential rationalization of GP surgeries within each locality
- Number of residents attached to each GP surgery in each locality
- Adult social care activity data including number of assessments, safeguarding adults/children,
- SUHFT Hospital data (non-elective rates in each area/A&E attendance)
- Community Health services are co-hosted by Southend CCG and Castle Point and Rochford CCG.

There is potential to develop a commissioning model based on ward population as opposed to registered patient population. By aligning our clinical commissioning needs with the Southend Borough Council and other community providers we can work collaboratively to develop care models which will have a direct impact on the ward population taking into account the complexity of needs arising from poverty, housing and social care needs. This integrated approach will in turn help to facilitate the development of systemic change with other system stakeholders.

4 Options

4.1 Option 1: Remain the same

Adult social care is currently divided into two localities with a separate review team, hospital team and two entry points (Access & SPoR). Resultantly, there is limited preventative practice with most of social work time reacting to referrals with most time spent completing assessments, safeguarding enquiries, Mental Capacity Act (2005) assessments and Best Interest Assessments.

There are currently no primary care localities across Southend. All Primary Care providers operate in isolation of one another; this includes GP, Pharmacies, Dentist and Ophthalmologists, by way of independent contracts or NHS Regulations.

Advantages	Disadvantages
Continuity of care and outcomes will be supported in the short-term, minimizing change and distribution to the system currently in place.	The social care locality teams are largely reactive in nature which results in a lack of prevention, reduction in long-term care needs and an inability to forge close working relationships with health colleagues, communities and other assets in their area. The large size of the locality is also obstructive and presents a challenge to connect groups, GPs and other community provision and support.
Patients will remain registered with the same GP and continue to receive the perceived	Patients will continue to face issues accessing Primary Care and other local

same level of care.	community services
Care will continue to be delivered in the same way it always has been.	Systemic change cannot be achieved unless all stakeholders work together to realize the benefits of integrated working and the delivery of sustainable patient care.
Managing patients' needs geographically by locality will ensure you integrate services where they are needed the most.	GPs will continue to face issues in managing patients with complex care needs.

4.2 Option 2: 3 Localities (East, Central and West – Appendix 2)

Historically, South East Essex Primary Care Trust (SEE PCT) split GP provision into three localities. By reintroducing three localities based on the former SEE PCT boundaries it may be easier to win over 'hearts and minds' when working with the practices to support radical system change.

Ward population distribution across the three localities provides a slightly different picture. In terms of population the West locality is 1.7 times larger than the East locality, but the Central locality is just over 1.6 times larger than the East locality.

Locality	Registered Patients	Ward Count
West	62,000	70,000
Central	87,000	66,000
East	36,000	41,000

Areas of Multiple Deprivation Top 10%

Locality	Ward
West	2
Central	8
East	5

Advantages	Disadvantages
Greater economies of scale will allow greater numbers of social workers in each locality to provide the necessary cover (sickness, holiday), relative to option 3 which has more localities.	The central locality presents with high levels of multiple deprivation in comparison to East and West localities and twice the number of adults allocated to GPs (approx. 87,000 people vs. 62,000 and 36,000 people).
Practitioners will need to link more closely with various health clinicians and a variety of GPs because of the larger geographical	High levels of multiple deprivation within the central locality present a challenge to meeting the complexity of needs arising from poverty, housing, health and social care

area relative to option 3	needs and the competing demands from different GP practices.
Already aligns with Early Years teams which are based in 3 localities at present	The concentration on adult health and social care will have less of an advantage in the short-medium term.
By aligning health needs with the ward demographics and deprivation, there is greater opportunity to target the individual needs of the area e.g. respiratory issues, high rates of readmission, housing.	The social care data (appendix 5) highlights that there are 2274 adults open to adult social care teams in the proposed Central locality compared with 1499 (35% less than central) in West and 1164 in East (51% less than central).
	Does not support the development of self-sufficient communities / a community asset based approach.

4.3 Option 3: 4 Localities (Appendix 3a + 3b Locality 1, 2, 3 & 4) aligned with GP centres/surgeries

Locality	Registered Patients	Ward Count
West	53,500	38,500
Central West	52,000	40,000
Central East	55,500	34,000
East	36,000	41,500

Areas of Multiple Deprivation Top 10%

Locality	Wards
West	2
Central West	3
Central East	5
East	5

Advantages	Disadvantages
It will provide health and social workers with greater understanding of the localities, as there will be greater geographical clustering with the communities and services which will benefit patients.	Patients will need to adapt to the changing model of services.
There will also be more equality in terms of need between each of the localities so that patients can receive a more personalised	Aligning with GP surgeries may present as problematic as there will be a proportion of adults who are registered with the GP but

service, rather than having a central locality which is heavily in need of health and social care services and therefore resources will be spread more thinly.	who reside elsewhere in the Borough (figures unknown at present). Although this would be the case with any option
The West of Southend tends to have a high number of care homes, relative to the other parts of the Borough and so this model also supports a better distribution of locality teams.	Having four localities will create a need for an additional senior social worker compared with option 2 as there will be an additional locality.
Organizationally, having four localities is in some respects is easier to manage as each social care team manager would have one senior practitioner supporting one of the localities.	A reduction in numbers of staff per locality will dilute the diversity and specialist knowledge.
At the present time, adult social care is structurally misaligned to the needs of the local population and a lack of operational management across East and West localities are causing problems in managing and leading the service.	It will be more difficult to manage staff sickness/absenteeism although this can be mitigated by having a team manager above two localities so staff can move interchangeably between localities, depending on demand in each locality.

5 Conclusion / Recommendation

5.1 The recommendation is for option 3 (4 localities) based on the following reasons:

- The data analysis conducted on both health and social care needs supports the transformation into 4 localities, i.e. the services delivered to a patient through their journey support a 4 locality approach;
- The size of the localities highlighted in option 3, social workers will be able to develop stronger relationships with the community and will be able utilize the assets more effectively;
- There is a more even distribution of health, social care, educational and housing needs compared with option 2, which has a densely populated and deprived central locality with high levels of child protection and adult safeguarding issues; both health and social care will struggle to cope the level of demand in that locality.
- Since each area/ward and locality has their own individual challenges, interventions will be more targeted across the four localities – this advantage will be diluted with three localities; particularly a central locality with over 85,000 people registered with GPs. The data suggests the West often has high levels of Mental Capacity Act assessments (especially Chalkwell ward) due to the high numbers of residential/nursing care homes relative to the East of Southend.
- Greater distribution of demographic inequality across four localities is advantageous to option 3 since not all deprivation, poverty and complex need will be the responsibility of one locality to manage (i.e. the Central Locality).
- Physical accessibility will be improved for patients/adults using care services as there will be more locality teams and points of access to GP health centres (4 compared with 3) which will have a geographical advantage for Southend residents.
- Is aligned with the development required for SEPT community services.

The Senior Officer Transformation Oversight (SOTO) group reviews the three options outlined in this report and agree the preferred option.

5.2 Risks

Although option 3 will require one additional supervisory member of social care staff, it is acknowledged that this is needed due to the number of social care staff across all localities and the complexity of casework these teams will be managing. Any locality changes will require a system leadership approach which is developing in some areas of health and social care practice but still distant in others; this presents a challenge to develop enough trust across the systems for effective change.

NB: There are limitations on the quality of data on Carefirst (e.g. GP data on) and with CareTrak.

6 Appendices:

1. Option 1 map for current situation (2 localities);
2. Option 2 map for three localities;
3. Option 3 map for four localities
   3b – GP numbers for each of the 4 localities;
4. Indices of multiple deprivation across Southend-on-Sea (2015);
5. Option 2 data by GP registration:
   (a) Number of MCA2 completed across Southend-on-Sea
   (b) Number of Children known to Southend Borough Council
   (c) Number of open adult clients by area
   (d) Number of other agreements open to social care
   (e) Number of residential agreements by area
   (f) Number of Safeguarding Referrals
   (g) Number of adult clients with at least 3 assessments
6. Option 3 data by GP registration:
   (a) Number of Clients with at least 3 assessments by area
   (b) Number of Mental Capacity Act assessments by area
   (c) Number of children open to social care
   (d) Number of clients by area
   (e) Number of other agreements by area
   (f) Number of residential agreements by area
   (g) Number of adult safeguarding by area
7. Option 2 data by postcode:
   (a) Number of Mental Capacity Act assessments by postcode
   (b) Number of Children known to Southend Borough Council by postcode
   (c) Number of Clients open to adult social care by postcode
   (d) Number of other agreements by postcode
   (e) Number of residential agreements by postcode
   (f) Number of safeguarding referrals by postcode
   (g) Number of adult clients with at least 3 assessments
8. Option 2 data (non-elective admissions into secondary care):
   (a) Non elective admissions into hospital (2013-15) percentage increase;
   (b) Non elective admissions into hospital average
9. Option 3 data by postcode:

(a) Number of Clients with at least 3 assessments by area

(b) Number of Mental Capacity Act assessments by area

(c) Number of children open to social care

(d) Number of clients by area

(e) Number of other agreements by area

(f) Number of residential agreements by area

(g) Number of adult safeguarding by area

10. Option 3 data (non-elective admissions into secondary care):
    (a) Non elective admissions into hospital (2013-15) percentage increase;
    (b) Non elective admissions into hospital average

11. Percentage of people who had a limiting long-term illness/disability 2011 (Public Health)
12. Emergency Admissions into acute care from 2008 – 2013
13. Non-elective admissions, A&E attendances and emergency readmissions by patients MSOA
14. District Nurse allocations across Southend-on-Sea.

1. Background Papers

College of Social Work/Royal College of General Practitioners (2014) GPs and Social Workers: Partners for Better Care Delivering health and social care integration together: A report by The College of Social Work and the Royal College of General Practitioners.

Monitor (2015) *Essex to benefit from Success Regime* (Press Release) [online] Available at: https://www.gov.uk/government/news/essex-to-benefit-from-success-regime Accessed on: 15th January 2016.