Thurrock - An ambitious and collaborative community which is proud of its heritage and excited by its diverse opportunities and future

# Health and Wellbeing Overview and Scrutiny Committee

The meeting will be held at **7.00 pm** on **14 June 2018**

**Committee Room 1, Civic Offices, New Road, Grays, Essex, RM17 6SL**

**Membership:**

Councillors Victoria Holloway (Chair), John Allen (Vice-Chair), Abbie Akinbohun, Ben Maney and Elizabeth Rigby

Ian Evans (Thurrock Coalition Representative) and Kim James (Healthwatch Thurrock Representative)

**Substitutes:**

Councillors Alex Anderson, Cathy Kent, Sue Sammons and Sue Shinnick

## Agenda

Open to Public and Press

**Page**

**1. Apologies for Absence**

**2. Minutes** **5 - 12**

To approve as a correct record the minutes of the Health and Wellbeing Overview and Scrutiny Committee meeting held on 12 March 2018.

**3. Urgent Items**

To receive additional items that the Chair is of the opinion should be considered as a matter of urgency, in accordance with Section 100B (4) (b) of the Local Government Act 1972.

**4. Declarations of Interests**

**5. HealthWatch**

**6. For Thurrock in Thurrock - New Models of Care across health and social care** **13 - 34**

**7. Verbal Update on Learning Disability Health Checks**

**8. Verbal Update Sustainability and Transformation Partnership (STP) Consultation**

**9. Essex, Southend and Thurrock Joint Health Scrutiny Committee on the Sustainability and Transformation Partnership (STP) for Mid and South Essex** **35 - 60**

**10. Work Programme** **61 - 64**

**Queries regarding this Agenda or notification of apologies:**

Please contact Jenny Shade, Senior Democratic Services Officer by sending an email to Direct.Democracy@thurrock.gov.uk

Agenda published on: **6 June 2018**

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## DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF

**Breaching those parts identified as a pecuniary interest is potentially a criminal offence**

**Helpful Reminders for Members**

- *Is your register of interests up to date?*
- *In particular have you declared to the Monitoring Officer all disclosable pecuniary interests?*
- *Have you checked the register to ensure that they have been recorded correctly?*

**When should you declare an interest *at a meeting?***

- **What matters are being discussed at the meeting?** (including Council, Cabinet, Committees, Subs, Joint Committees and Joint Subs); or
- If you are a Cabinet Member making decisions other than in Cabinet **what matter is before you for single member decision?**

**Does the business to be transacted at the meeting**

- **relate to; or**
- **likely to affect**

**any of your registered interests and in particular any of your Disclosable Pecuniary Interests?**

Disclosable Pecuniary Interests shall include your interests or those of:

- your spouse or civil partner's
- a person you are living with as husband/ wife
- a person you are living with as if you were civil partners

where you are aware that this other person has the interest.

A detailed description of a disclosable pecuniary interest is included in the Members Code of Conduct at Chapter 7 of the Constitution. **Please seek advice from the Monitoring Officer about disclosable pecuniary interests.**

**What is a Non-Pecuniary interest?** – this is an interest which is not pecuniary (as defined) but is nonetheless so significant that a member of the public with knowledge of the relevant facts, would reasonably regard to be so significant that it would materially impact upon your judgement of the public interest.

### Pecuniary

If the interest is not already in the register you must (unless the interest has been agreed by the Monitoring Officer to be sensitive) disclose the existence and nature of the interest to the meeting

If the Interest is not entered in the register and is not the subject of a pending notification you must within 28 days notify the Monitoring Officer of the interest for inclusion in the register

**Unless you have received dispensation upon previous application from the Monitoring Officer, you must:**

- **Not participate or participate further in any discussion of the matter at a meeting;**
- **Not participate in any vote or further vote taken at the meeting; and**
- **leave the room while the item is being considered/voted upon**

**If you are a Cabinet Member you may make arrangements for the matter to be dealt with by a third person but take no further steps**

### Non- pecuniary

Declare the nature and extent of your interest including enough detail to allow a member of the public to understand its nature

**You may participate and vote in the usual way but you should seek advice on Predetermination and Bias from the Monitoring Officer.**

## Our Vision and Priorities for Thurrock

An ambitious and collaborative community which is proud of its heritage and excited by its diverse opportunities and future.

1. **People** – a borough where people of all ages are proud to work and play, live and stay

   - High quality, consistent and accessible public services which are right first time
   - Build on our partnerships with statutory, community, voluntary and faith groups to work together to improve health and wellbeing
   - Communities are empowered to make choices and be safer and stronger together

2. **Place** – a heritage-rich borough which is ambitious for its future

   - Roads, houses and public spaces that connect people and places
   - Clean environments that everyone has reason to take pride in
   - Fewer public buildings with better services

3. **Prosperity** – a borough which enables everyone to achieve their aspirations

   - Attractive opportunities for businesses and investors to enhance the local economy
   - Vocational and academic education, skills and job opportunities for all
   - Commercial, entrepreneurial and connected public services

**Minutes of the Meeting of the Health and Wellbeing Overview and Scrutiny Committee held on 12 March 2018 at 7.00 pm**

| | |
|---|---|
| **Present:** | Councillors Graham Snell (Chair), Victoria Holloway (Vice-Chair), Gary Collins, Joycelyn Redsell and Gerard Rice<br><br>Ian Evans, Thurrock Coalition Representative<br>Kim James, Healthwatch Thurrock Representative |
| **Apologies:** | Councillor Jack Duffin |
| **In attendance:** | Roger Harris, Corporate Director of Adults, Housing and Health<br>Les Billingham, Assistant Director of Adult Social Care and Community Development<br>Frances Leddra, Principal Social Worker and Strategic Lead, Safeguarding and Complex Care<br>Tania Sitch, Integrated Care Director for Thurrock, Thurrock Council and North East London Foundation Trust<br>Catherine Wilson, Strategic Lead Commissioning and Procurement<br>Geraldine Rogers, Nurse, North East London Foundation Trust<br>Jenny Shade, Senior Democratic Services Officer |

Before the start of the Meeting, all present were advised that the meeting may be filmed and was being recorded, with the audio recording to be made available on the Council's website.

**40. Minutes**

The Minutes of the Health and Wellbeing Overview and Scrutiny Committee held on the 18 January 2018 were approved as a correct record.

**41. Urgent Items**

There were no items of urgent business.

**42. Declarations of Interests**

No interests were declared.

**43. Healthwatch**

The Chair asked Kim James how the Sustainability and Transformation Plan consultation had progressed locally. Kim James stated that HealthWatch had attended many consultation events, listened to residents' concerns and had distributed over 5000 hard copies of the consultation documentation. The

general concern was that the voice of residents was not being heard with many questions being unanswered.

**44. Thurrock First - Health and Social Care Single Point of Access**

Tania Sitch, Integrated Care Director of Thurrock Council and North East London Foundation Trust, updated Members on the Thurrock First Service which had been launched in November 2017. That collaboration had taken place between health and social care partners and provided a single access point for information, professional advice, referral, assessment and had access to services across the health and social care for Thurrock residents. With Thurrock First aiming to reduce duplication and bring together the previous separate initial points of contact.

Councillor Redsell thanked Tania Sitch for the report and asked whether the service would be extended to children's services and whether residents might be reluctant to use the service as calls may trigger safeguarding issues. Tania Sitch stated that future efficiencies of the service would include links to children's services and that the Council would have a duty to respond to all calls.

Councillor Collins thanked Tania Sitch for the report and appreciated the evidence based outcomes and questioned how long before the IT was fully up and running. Tania Sitch stated that IT programmes were being devised to talk to each other and this may take some time. Roger Harris stated that multiple systems were being developed so that data sharing could be accessed but could potentially take time to achieve but this should not been seen as a shortcoming of the service.

The Chair stated that examples of improved outcomes for residents showed that conversations were being undertaken and that residents were able to access the services and assets available in the community so that complex health issues could be addressed.

Councillor Redsell asked how accessible the contact number was. Tania Sitch stated that the number had been publicised at the launch and continued to be advertised in general practitioner surgeries, by the ambulance service, in health hubs and libraries and by HealthWatch. All telephone calls made to the old numbers would automatically be diverted to the new service number.

**RESOLVED**

**That the Health and Wellbeing Overview and Scrutiny Committee noted and commented on the progress in the development of Thurrock First.**

**45. Living Well in Thurrock: Adult Social Care Transformation Programme Update**

Les Billingham, Assistant Director for Adult Social Care and Community Development, presented the report that reflected on what had been achieved

through the delivery of the Living Well in Thurrock Programme and set out the next steps and future plans.

The Chair thanked Les Billingham for the very comprehensive report.

Councillor G Rice stated that the Adult Social Care Department should be congratulated on the positive feedback received and the work being recognised on the transformation work being undertaken within Thurrock.

Councillor Collins echoed Councillor G Rice comments and stated what a great achievement this was.

Ian Evans asked what the planning timescales would be on the 21st Century Care Home on the Whiteacre and Dilkes Wood sites. Les Billingham stated that this development had some complications as the health centre was also in need of repair and proposals to rebuild this as part of the primary care estate development may form part of the planning application. Les Billingham stated that if a decision was made not to rebuild the health centre a business case would be presented to Cabinet in late summer 2018 with the residential home possibly ready by 2020.

Councillor Redsell stated that consideration should also be given to those residents that wished to stay at home and integrate their help into the community. That different forms of care home developments would be required in Thurrock to ensure that loneliness would be addressed. Les Billingham stated that this was the objective of Positive Futures and that Thurrock should build new residential homes so that they are as good as they can be. Les Billingham stated that Thurrock was an incredible place that had an amazing community spirit with the good will and intent of residents being demonstrated.

Councillor Redsell stated that Thurrock should be building good aspirational homes that residents want to live in.

Councillor G Rice stated that it was exciting news that Thurrock were to build 32,000 new homes and that Thurrock Council should take this forefront opportunity to say that Thurrock's residents need the right type of homes, a variety of designs that had facilities nearby.

Councillor Redsell stated that help should also be given to the private sector housing market to ensure that properties could be freed up as required.

Roger Harris suggested that a Joint Health and Housing Initiative Report be added to the work programme for the next municipal year.

The Chair questioned how long before further wellbeing teams could be introduced. Les Billingham stated that the pilot would run for 12 months which would be sufficient time to evaluate the concept and provide proper evaluation data. Les Billingham stated the roll out of this delivery model would be the way Thurrock would continue to work into the future.

The Chair thanked Officers for the report and that it was good news that it focused on serving the people of Thurrock.

**RESOLVED**

1. **That the Health and Wellbeing Overview and Scrutiny Committee noted and commented on the Adult Social Care Transformation Programme, Living Well in Thurrock.**

2. **That the Joint Health and Housing Initiative Report be added to the 2018/19 work programme.**

## 46. Dementia Strategy - Implementation Progress

Catherine Wilson, Strategic Lead Commissioning and Procurement, updated Members on the progress made within Thurrock of the implementation of the Southend, Essex and Thurrock Dementia Strategy 2017-2021 and informed Members of future events to ensure that an inclusive approach of the strategy implementation in Thurrock.

Councillor Redsell stated that help should be available for all adults in the community to ensure they are aware of the services and still feel needed in the community. Catherine Wilson stated that the wellbeing teams focused on those residents and offered close support and would react as required. Roger Harris stated that these were not just specialist services but for wider community responses and awareness to ensure that residents did not feel isolated.

Councillor Collins asked if there would be any buddy-up mentoring schemes for supporting carers to support each other so that they do not feel isolated. Catherine Wilson stated that the Cariads service was available and that more work would need to be done as part of the consultation process.

Councillor Collins questioned whether the Living Well in long term care was adequately resourced. Catherine Wilson stated that a lot of work was being undertaken with residential and care homes and training would be on-going.

Councillor G Rice agreed with Councillor Collins that social integration was vital but stated that under-doctoring in Thurrock should be addressed as a priority.

Councillor V Holloway stated that consideration should also be given to the support of couples when one of them may be the carer who may become ill. Catherine Wilson stated that the social care assessment would be undertaken to future proof all circumstances and prioritise what residents want.

The Chair stated that this could be a difficult and complex situation and that education was vital and maybe look at other local authorities on what they have undertaken on their dementia strategy.

Councillor Redsell asked whether the Police had information on dementia patients. Catherine Wilson stated that it was important on how this can be undertaken with the Police and that further work would continue to address this.

Members requested that the Dementia Strategy be added to the 2018/19 work programme to be presented in 12 months' time.

**RESOLVED**

1. **That the Health and Wellbeing Overview and Scrutiny Committee commented on the current position regarding the Southend, Essex and Thurrock Dementia Strategy in Thurrock.**

2. **That the Dementia Strategy be added to the 2018/19 work programme.**

**47. Supporting People with Personality Disorders and Behaviours that Challenge**

Fran Leddra, Principal Social Worker and Strategic Lead Safeguarding and Complex Care, informed Members on the position to supporting people with Personality Disorders and Behaviours that challenge.

Kim James thanked Officers for the report and that the Committee had listened to HealthWatch's concerns and had reacted quickly and results had been achieved already. Those areas of concern were with those individuals that did not engage with services available but knew the services would be there when required. The objective would be to make residents feel safe and have services in place in times of crisis. Kim James stated that training had also been offered to the voluntary sector.

Councillor Collins questioned whether there was any particular common reason to cause challenging behaviour. Fran Leddra stated that this could be due to a wide variety and spectrum of reasons and issues.

Councillor Redsell questioned how Members should deal with those residents who request confidentiality on issues such as hoarding. Fran Leddra stated that adult safeguarding could come into place where self-neglect or harm was evident.

Councillor G Rice questioned whether the Outreach Team had sufficient support from both social workers and psychiatrics. Fran Leddra stated that the Outreach Team were fully staffed and were succeeding with the pressure and demands of the services.

The Chair questioned what interventions would be in place for those residents that had not engaged. Fran Leddra stated that a "safety net" would be put in place with all multi agencies being aware of all issues and that professional

help would be available when those residents required it the most. Residents may also indicate that help was required by gravitating to one area out of pattern.

Kim James stated that agencies were aware of those residents in crisis and liaised and coordinated with them until they were ready to engage.

Councillor V Holloway questioned whether the training had been extended to the Police. Fran Leddra stated that training had been extended to all key parties that were actively engaging.

The Chair thanked HealthWatch for raising this issue and that it proved that the Health and Wellbeing Overview and Scrutiny Committee addressed and responded to issues as they arose.

**RESOLVED**

**That the Health and Wellbeing Overview and Scrutiny Committee commented on the current position regarding services for people who have a personality disorder.**

**48. Joint STP / Orsett Hospital Consultation - Verbal Update**

Roger Harris stated that following the decision made by the Health and Wellbeing Overview and Scrutiny Committee to join the Joint Committee with Essex and Southend he and Members had attended informal and formal meetings. That Councillor Snell had been made Vice-Chair of the Joint Committee and that the Consultation had been extended to the 23 March 2018. Roger Harris stated that the response would be a joint response but reserve the right to submit responses once further information was available. There had been particular concerns on unanswered questions on transport, the service plan, finances, Orsett hospital and the integrated medical centres. It was envisaged that following the end of the consultation period, the Joint Committee will continue to meet, consider and address issues.

Councillor Snell stated that the result of the consultation so far were not surprising. With no clinical evidence as to why the consultation was being undertaken. Councillor Snell stated that there were so many unanswered questions and residents were not exactly sure what was being proposed. That no definitive answers had been given on when Orsett hospital would close and where services would be situated.

Councillor Redsell stated that having attended public consultations it was evident that residents did not have the right information and understanding and would like to see some positivity come out of these consultation events.

Roger Harris stated that this was down to the element of trust with the consultation process and that residents were not convinced on the proposed plans and how these services would be delivered.

Councillor G Rice stated that it was down to distrust and had concerns that the integrated medical centres might not be able to pick up all the services such as dialysis. Kim James stated that HealthWatch had spoken to users and carers at dialysis units and as patients were transported by ambulance there was no real concern as to where the treatments would be undertaken, just that importance of these treatments being received.

The Chair stated that Members should be sceptical on what services would remain in Thurrock and that different responses were being given depending on who you spoke to.

Councillor Collins stated that he would like to see a business model and see something in writing that no services would be moved out of Thurrock.

The Chair stated that the consultation was being clinically driven but had not seen any evidence of this as yet.

Kim James stated that HealthWatch had invited representatives from the Sustainability and Transformation Plan to meet residents so that real time issues and views could be discussed and picked up.

Kim James stated that dates had been cancelled for the Sustainability and Transformation Plan Programme Board and had been informed that HealthWatch should join the Chairs Group. Kim James had concerns that the Sustainability and Transformation Plan was losing the capacity to have real independent voices heard. Councillor Snell agreed to raise this issue at the formal Joint Health and Wellbeing Overview and Scrutiny Committee this week.

**49. Work Programme**

The Chair stated that this was the last Health and Wellbeing Overview and Scrutiny Committee for this municipal year and that the work programme was now complete.

The Chair asked Members if there were any items to be added or discussed for the work programme for the next municipal year.

Members agreed that the Dementia Strategy be added to the next municipal year work programme to be presented in 12 months' time.

Members agreed that a Joint Health and Housing Initiative Report be added to the next municipal year work programme.

**RESOLVED**

1. **That the item Dementia Strategy be added to the 2018/19 work programme.**

**2. That the item Joint Health and Housing Initiative Report be added to the 2018/19 work programme.**

The Chair thanked Members and Officers for their contribution and their continued support to the Health and Wellbeing Overview and Scrutiny Committee.

**The meeting finished at 9.00 pm**

Approved as a true and correct record

**CHAIR**

**DATE**

**Any queries regarding these Minutes, please contact Democratic Services at Direct.Democracy@thurrock.gov.uk**

| 14 June 2018 | | ITEM: 6 |
|---|---|---|
| **Health and Wellbeing Overview and Scrutiny Committee** | | |
| **For Thurrock in Thurrock – New Models of Care across health and social care** | | |
| **Wards and communities affected:**<br>All | **Key Decision:**<br>Non-Key | |
| **Report of:** Roger Harris, Corporate Director of Adults, Housing and Health | | |
| **Accountable Assistant Director:** Tania Sitch (Integrated Care Director) and Les Billingham, Assistant Director for Adult Social Care and Community Development | | |
| **Accountable Director:** Roger Harris, Corporate Director of Adults, Housing and Health | | |
| **This report is** public | | |

**Executive Summary**


Transformation of the existing health and social care system is a must in order to ensure sustainability and ensure all available resources are used to greatest effect. Last year HOSC received a report from the Director of Public Health entitled “The Case for Change” – this report demonstrates the work undertaken to date.

The New Models of Care innovation site in Tilbury and Chadwell was launched as part of phase 2 of Thurrock’s transformation programme in collaboration with local health partners and the voluntary and community sector. The new programme has been named Better Care Together Thurrock. The programme focuses on four interlinked areas:

- The development of a new Primary Care Workforce – to address the shortages of GP’s and improve the Primary Care offer.
- Improved identification and early treatment of people with Long Term Conditions.
- The redesign of the health and social care workforce and all community based solutions.
- The development of four Integrated Medical Centres to ensure that we have 21st Century local facilities.

The outcomes built into the project are improved access to services, a single point of contact, earlier identification of long term conditions such as COPD and improved health outcomes across a range of measures.

Finally, to oversee all of our integration plans the partners have formed “Thurrock Integrated Care Alliance (TICA)” to act as the umbrella body to take our integration plans forward.

## 1. Recommendation:

**1.1 For the Health and Wellbeing Overview and Scrutiny Committee to comment on progress with delivering the New Models of Care programme.**

## 2. Introduction and Background

2.1 Ian Wake, Thurrock's Director of Public Health, presented a very compelling case for change to HOSC in September 2017. The case for change set out a new model of care for Tilbury and Chadwell. The document followed on from a detailed needs assessment for the area and stemmed from the publication of the 'Annual report of the Director of Public Health' (2016). The document set out the financial challenges faced in the future for the health and social care system and for the health challenges facing the population of Tilbury and Chadwell. The case for change demonstrated a key issue is the rising and unsustainable demand for emergency care within the most expensive part of the system ie. acute hospitals. The paper sets out that investment in the quality and capacity of Primary, Community and Mental Health care will have a positive impact on reducing demand and improving the outcomes for people. This paper sets out the way forward and is the driver for the New Models of care Programme.

2.2 The "New Models of Care" programme established a steering group to oversee the design of the transformation and develop of the new offer and has had continuous and positive representation from:

a. Thurrock Council Adult Social Care;
b. Essex Partnership University Trust (EPUT);
c. North East London NHS Foundation Trust (NELFT);
d. Basildon and Thurrock University Hospital (BTUH);
e. Thurrock Clinical Commissioning Group (CCG);
f. GPs and Practice managers representing the 8 current practices in Tilbury; and
g. Community and voluntary sector – Thurrock CVS, Healthwatch and the Thurrock Coalition

2.3 The steering group reports to the Thurrock Integrated Care Alliance (TICA). This has senior representation from all partners listed in 2.2 above. The Alliance aims to bring together all partners and agree how we will work together in a meaningful way to deliver improved outcomes for the people of Thurrock, overseeing all the various transformation programmes.

2.4 The main work streams the steering group are working to are

- **Engagement and communication**: including Public, Staff and stakeholders. This is key to ensure this transformation is a success. An engagement officer is being recruited to ensure engagement takes place with the people of Tilbury and Chadwell as co-production and engagement is paramount.

- **Outcome based commissioning and reporting**: this will challenge the current commissioning and contracting arrangements to make them fit for purpose and will review the number of contracts and total value/where the money goes. This group includes all commissioners of health, social care and the voluntary sector. Changing the way we manage contracts will be essential to enable partners to work together and focus on the right things.
- **Development of a new workforce in primary care** – to support the 8 practices in Tilbury and Chadwell a team is being recruited to and will be hosted by NELFT. The team will include new roles including a Paramedic Practitioner, Physician's Assistant, Pharmacist and Physiotherapists etc. this team will support practices to ensure GP's are used where most needed and will lead to reduced waiting times and people seeing the right person first time.
- **Implement an integrated workforce** – following a Theory of Change methodology being used, this workstream will bring together the health, mental health, social care and voluntary sector workforce together to ensure residents receive more coordinated care and a more personal response. This includes:
    - Well-being teams development – including health teams (NELFT/EPUT).
      These are staff-led teams providing an alternative delivery model and includes a new approach to domiciliary care. This will lead to more time with people and more flexibility in the way care is delivered and a much improved coordinated response.
    - Community led social work support – this team will carry out social work functions in the community and is a staff led approach which will improve ways of working. As with the above it reduces bureaucracy, increases time spent with people and improves the person's experience.
    - Review of roles will reduce duplication of care across health and social care teams and will look at HR, Estates, Information Governance and many other aspects.
- **Improving the diagnosis and treatment of people with Long Term Conditions** – The New Model of Care Strategy identified

that there were thousands of patients in Tilbury and Chadwell with existing long term conditions including high blood pressure, diabetes, coronary heart disease, depression and stroke who had not been diagnosed and were not, therefore, having their conditions treated or managed effectively. Both inadequate diagnosis and management was leading to preventable serious health events such as heart attacks and strokes placing avoidable demands on the health and social care system. A series of 13 programmes have been devised to improve the identification and treatment including a stretched Quality and Outcome Framework (QOF); using IT systems to improve the call and re-call arrangements; a pro-active hypertension case-finding programme and better targeting of NHS Health Check programmes.

- **Evaluation** – Public Health England and the University of Birmingham are working jointly to ensure any evaluation is robust and focuses on outcomes for the people of Tilbury and Chadwell and the benefits and impacts to the system.
- **TEC Technology Enabled Care** - this programme looks at how technology can enrich the lives of residents and improve efficiencies to the system so resources are used where they have the best impact.

2.5 The New Models of Care Programme is starting to get recognition nationally and being seen as an exemplar of good practice. The programme recently won two highly commended awards from LARIA – Local Area Research & Intelligence Association, award. These awards are national and recognise organisations which have undertaken pieces of research/intelligence that have really driven decision-making and led to better population outcomes.

2.6 The steering group continues to work on all the above work streams with robust project management. There are differing timeframes for each of the work streams depending on the level of change needed but people will start to see changes from now.

## 3. Issues, Options and Analysis of Options

**Why do we need to transform?**

3.1 There are a number of factors driving the need for transformation across the health and care system. These include:

- An ageing population – with people living for more years but with a greater number of years in poorer health;
- Increased complexity of cases for both older people and working age adults – in the recent ADASS financial survey over 90% of authorities reported that costs and demand pressures in Learning Disabilities was putting considerable strain on their budgets;
- Insufficient capacity across the system – the figures in Appendix 1 show the shortfall in GPs but this is becoming an increasing problem in the care sectors;
- In extremely fragile provider market – particularly domiciliary care. Three domiciliary care providers have handed back contracts or had their contracts terminated in the past three years in Thurrock;
- A health and care system designed to react to rather than prevent ill-health; and
- Difficulty retaining and recruiting social care staff – carers in particular and for Thurrock we have such a diverse and dynamic local economy this is a particular problem.

3.2 The factors driving the need for health and social care transformation require a very different approach to be taken – one that focuses on prevention and early intervention and more generally on promoting wellbeing. The current system has predominantly focused on responding to need and waiting until individuals reach crisis point. To successfully overcome current challenges, transformation must redesign the foundations upon which the health and care system is based – for example:

- A focus on strengths not on need – reducing dependency;
- Empowering individuals to take control of their own lives;
- Targeting interventions so that they prevent crisis;
- The importance of outcomes as opposed to process;
- The need to reduce duplication, bureaucracy and process to ensure the majority of resource is focused on providing support;

- The importance of technology to enable improved outcomes; and
- The importance of a solution and outcome focus not of a service and prescription model.

3.3 Whilst the transformation of the health and care system is extremely complex and constantly evolving, there is already evidence that the approach being taken in Thurrock is having an impact. In addition to a number of case studies captured to demonstrate impact, the 2016 Annual Director of Public Health report stated that data *'suggests prevention and early intervention programmes such as Local Area Coordination, Stronger Together and Living Well in Thurrock are having a positive impact on reducing demand for statutory care packages….'* Whilst this is positive and evidence that the Transformation Programme is shifting the system towards prevention and early intervention, there is a need to acknowledge that when individuals do enter the system, they often have a greater degree of complexity and therefore cost.

3.4 The New Models of Care is building on the achievements to date including the following innovation. These were detailed in a report to HOSC presented in March 2018 :

- **Local Area Coordination** - a borough wide team supporting people in their local communities.
- **Social Prescribing** - working in GP practices to address non-medical presentations.
- **Thurrock First –** launched in October 2017 an integrated single point of access across health and social care.
- **Micro-Enterprises –** over 30 small, local business established to support the care system.
- **Chichester Close –** opened in autumn 2017, supported living units for adults with Learning Disabilities.
- **21st Century Care Home –** a new facility in South Ockendon designed to offer a new model of residential care.

3.5 Integrated Medical Centres – The Council, along with its health

partners, signed a “Memorandum of Understanding” in 2017 which committed all partners to the development of four Integrated Medical Centres in Thurrock. The original idea behind the IMC’s was to strengthen the capacity and capability of primary care in Thurrock. With the proposed transfer of services from Orsett Hospital (which is still subject to a final decision following the public consultation) this provided an opportunity to expand their remit and offer a wider range of services to local people. The planning for all four IMC’s is well underway. Tilbury / Chadwell IMC is most advanced and a design team are working on detailed drawings with a view to submitting planning permission later this year and a joint Business Case being submitted to various NHS bodies and the Council at the same time. Subject to receiving the required approvals, work on site should start in the Spring of 2019 with building works taking 18 months.

**4. Reasons for Recommendation**

4.1 To update the Committee and ensure its input on progress made to date and on future system wide transformation under the New Models of Care (Better care Together Thurrock) Programme.

**5. Consultation (including Overview and Scrutiny, if applicable)**

5.1 Thurrock residents were consulted on and informed a set of principles that underpin any health and care transformation activity. Additionally, Thurrock residents – including users of services, carers, and representative organisations – are involved in shaping many of the pieces of work incorporated within the transformation programme. As part of this, the Council works with user-led organisation Thurrock Coalition to ensure plans are developed in conjunction with users of services and their representatives.

Furthermore a resource has been made available and is funded by all partners involved, to employ an engagement worker/sin Tilbury and Chadwell to ensure services and other solutions are co designed and owned by citizens.

**6. Impact on corporate policies, priorities, performance and community impact**

6.1 The New Models of Care transformation programme will contribute to the delivery of the Council's vision and priorities in particular:

**People** – a borough where people of all ages are proud to work and play, live and stay

- High quality, consistent and accessible public services which are right first time
- Build on our partnerships with statutory, community, voluntary and faith groups to work together to improve health and wellbeing
- Communities are empowered to make choices and be safer and stronger together

**7. Implications**

7.1 **Financial**

Implications verified by: **Jo Freeman**

**Management Accountant Social Care & Commissioning**

The new Models of Care Transformation Programme is delivered within existing budgets and through the successful bidding of government funding grants. The Programme is designed to help to meet the challenges faced by Adult Social Care and to therefore ensure as best as possible that the Department is able to meet demand and operate within its budget.

7.2 **Legal**

Implications verified by: **Sarah Okafor**
**Barrister (Consultant)**

On behalf of the AD of Law I have read in full the contents of this report, and there appears to be no external legal implications arising from it. The aims and objectives of the programme will operate within the range of legislative statutory frameworks that govern ASC and Local Government functions.

7.3 **Diversity and Equality**

Implications verified by: **Becky Price**
**Community Development Officer**

Service users and residents across all protected groups may be impacted by the new Models of Care Programme. The most positive implication increases choice and control over the type of solution individuals receive Positive implications also relate to preventing and delaying service need and a focus on delivering outcomes. Failure to fully implement the programme could have negative impacts – for example a reduction in services offered or how they are offered and restrictions about the type and accessibility of services available. This could lead to higher levels of dependency and complexity of cases. Implementation of the Living Well in Thurrock Programme aims to address inequality in service provision and increase the scale and the scope of the positive benefits outlined.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder) : None

**8. Background papers used in preparing the report** (including their location on the Council's website or identification whether any are exempt or protected by copyright):

- Living Well in Thurrock: Adult Social Care Transformation Programme, Health and Wellbeing Overview and Scrutiny Committee, 17 January 2018

- New Model of Care for Tilbury and Chadwell, Health and Wellbeing Overview and Scrutiny Committee, 16 November 2017

## 9. Appendices to the report

Appendix 1 – Extract from Case for Change showing Primary Care Shortfall and Capacity challenges.

**Report Author**

Tania Sitch
Integrated Care Director

Adults, Housing and Health / NELFT

APPENDIX 1

# The Case for Change: A New Model of Care for Tilbury and Chadwell

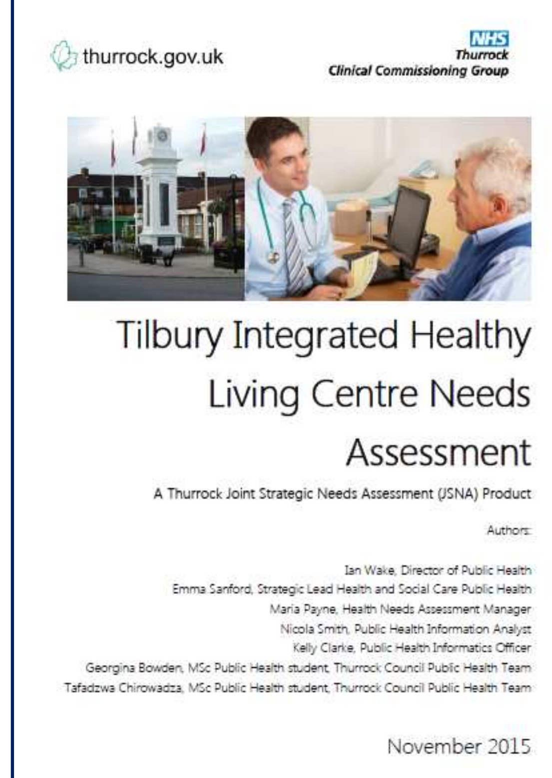


**Ian Wake**
**Director of Public Health**

September 2017

# A whole system's understanding, a whole system's approach




thurrock.gov.uk

NHS
Thurrock
Clinical Commissioning Group

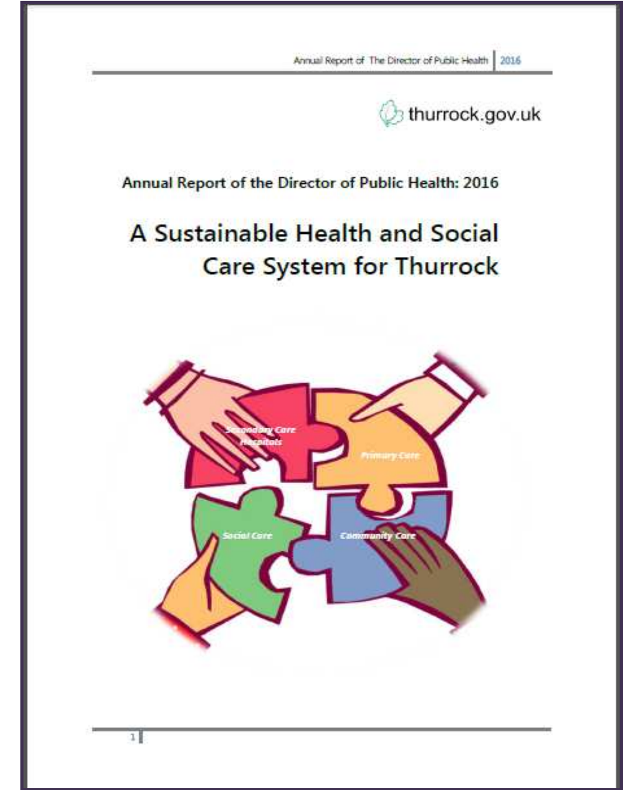
Tilbury Integrated Healthy Living Centre Needs Assessment

A Thurrock Joint Strategic Needs Assessment (JSNA) Product

Authors:

Ian Wake, Director of Public Health
Emma Sanford, Strategic Lead Health and Social Care Public Health
Maria Payne, Health Needs Assessment Manager
Nicola Smith, Public Health Information Analyst
Kelly Clarke, Public Health Informatics Officer
Georgina Bowden, MSc Public Health student, Thurrock Council Public Health Team
Tafadzwa Chirowadza, MSc Public Health student, Thurrock Council Public Health Team

November 2015


Annual Report of The Director of Public Health | 2016

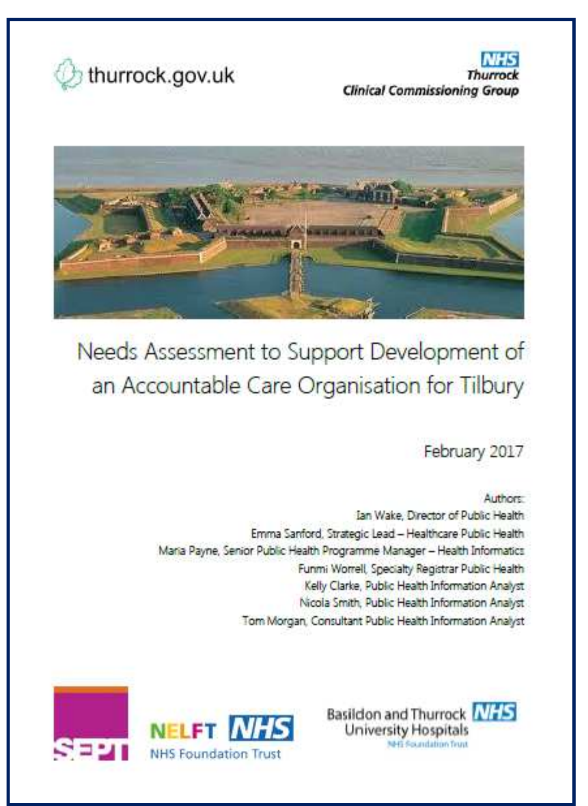
thurrock.gov.uk

Annual Report of the Director of Public Health: 2016

A Sustainable Health and Social Care System for Thurrock



1


thurrock.gov.uk

NHS
Thurrock
Clinical Commissioning Group

Needs Assessment to Support Development of an Accountable Care Organisation for Tilbury

February 2017

Authors:
Ian Wake, Director of Public Health
Emma Sanford, Strategic Lead – Healthcare Public Health
Maria Payne, Senior Public Health Programme Manager – Health Informatics
Funmi Worrell, Specialty Registrar Public Health
Kelly Clarke, Public Health Information Analyst
Nicola Smith, Public Health Information Analyst
Tom Morgan, Consultant Public Health Information Analyst



https://www.thurrock.gov.uk/healthy-living/health-statistics-and-information

# A whole system's understanding, a whole system's approach

Accountable Care Partnership

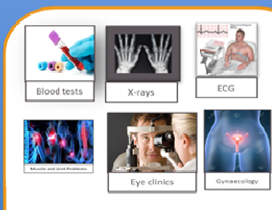
..improve your social and mental wellbeing

..help you stay healthy

..address the root causes of bad health and well-being

..deliver a world class GP surgery

...diagnose and manage LTCs




...bring the hospital into the community

Flexible Community based ASC

1. **Inadequate understanding of patient/client flow between constituent parts of the system. STP has the wrong approach**

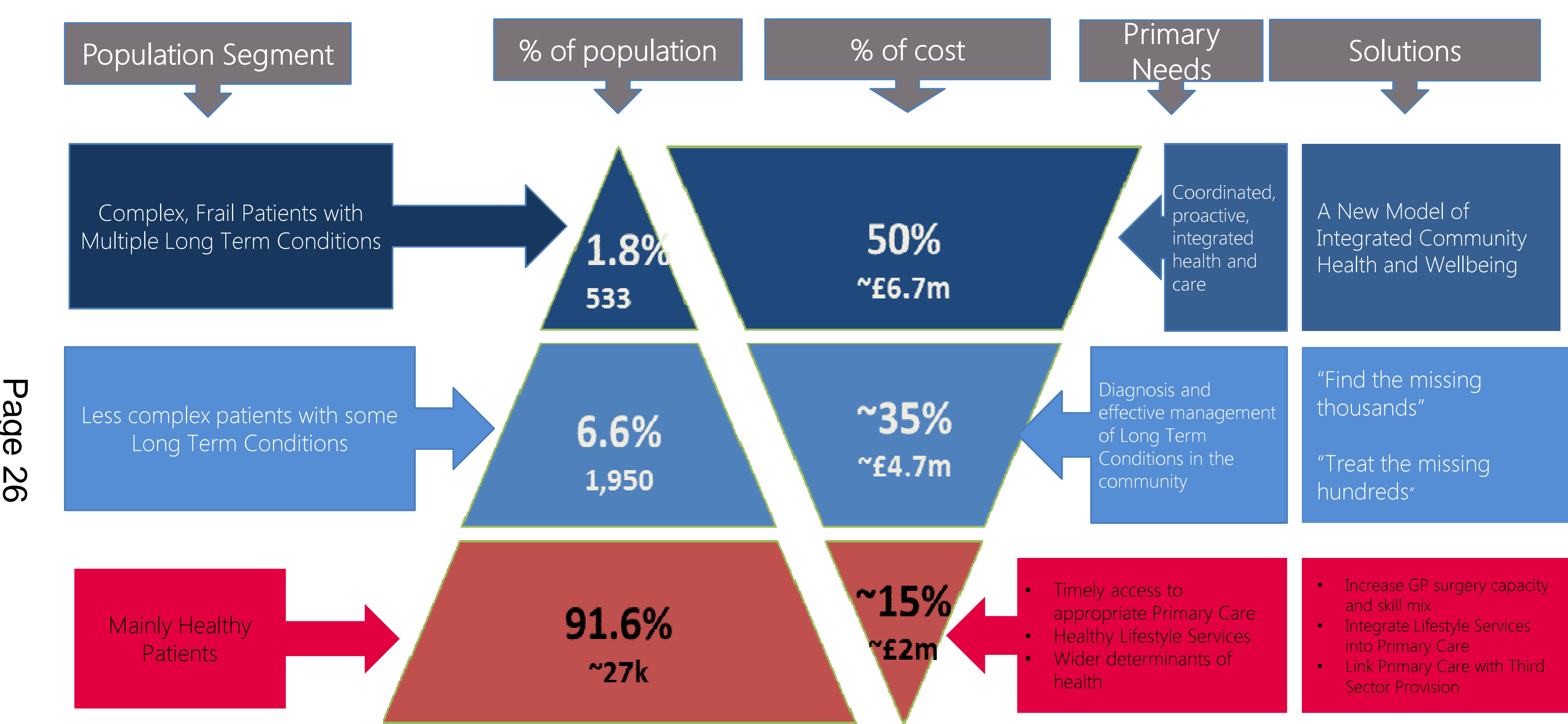
**The money and the patients are in the wrong place**
- Avoidable hospital admissions
- Avoidable delays in hospital discharges
- A&E and ambulance "misuse"

**Inadequate capacity leads to inadequate quality in Primary Care, Community Care and ASC and keeps the money and the people in the wrong place**
- Find the missing thousands
- Treat the missing hundreds
- Increase Primary, Community and ASC capacity

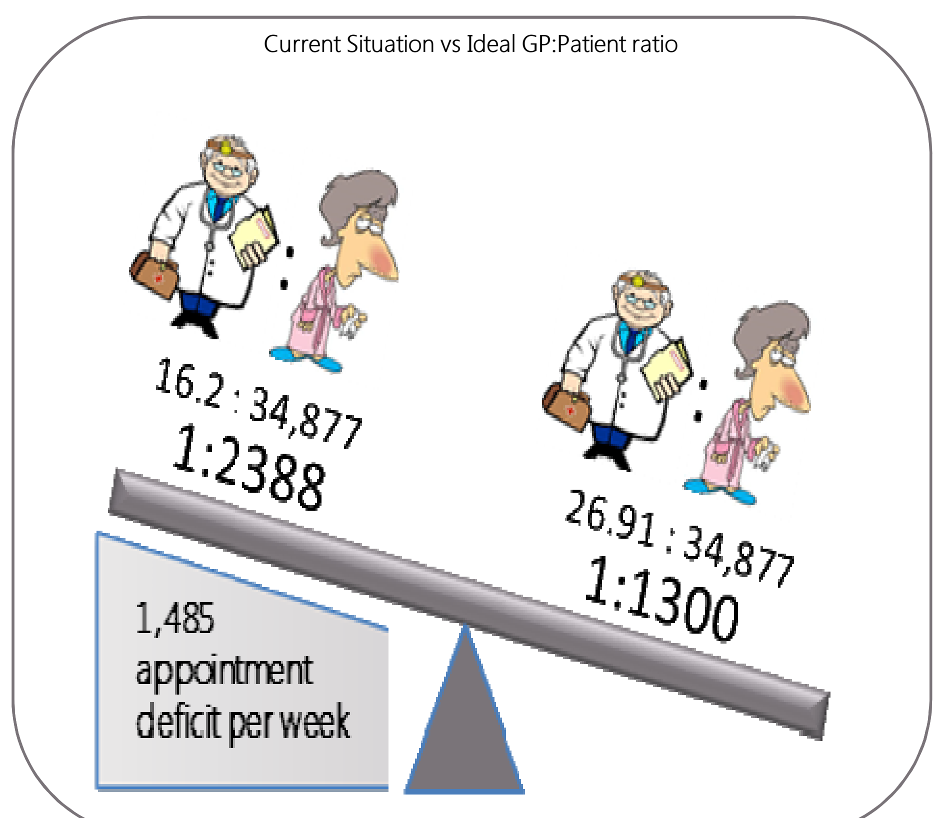
**Solve the capacity/quality issue and the money will follow**

**Solving the quality issue requires integrating the system (and the money)**
- Integrate ASC and Health
- Interface between GP surgeries and Community Services needs to be improved
- Interface between GP surgeries and Mental Health needs to improve
- Integrate Public Health Services
- Integrate self care and community capacity

6. **We require a period of double running to solve the problem**


Population segmentation and new care models
Population Segment
% of population
% of cost
Primary Needs
Solutions
Complex, Frail Patients with Multiple Long Term Conditions
1.8%
533
50%
~£6.7m
Coordinated, proactive, integrated health and care
A New Model of Integrated Community Health and Wellbeing
Less complex patients with some Long Term Conditions
6.6%
1,950
~35%
~£4.7m
Diagnosis and effective management of Long Term Conditions in the community
"Find the missing thousands"
"Treat the missing hundreds"
Mainly Healthy Patients
91.6%
~27k
~15%
~£2m
Timely access to appropriate Primary Care
Healthy Lifestyle Services
Wider determinants of health
Increase GP surgery capacity and skill mix
Integrate Lifestyle Services into Primary Care
Link Primary Care with Third Sector Provision

# 5. Enhancing the capacity and capability of Primary Care



Financial Impact of Inadequate Primary Care Access

In 2015/16:

- 77% of A&E attendances from Tilbury and Chadwell residents were for clinical issues that could have been dealt with in the community
- This resulted in £950,000 of net excess cost to our local health system



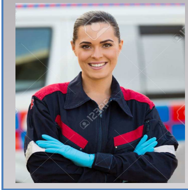
[2] Primary Care Foundation and NHS Alliance, Making Time in General Practice, October 2015

# 5. Enhancing the capacity and capability of Primary Care

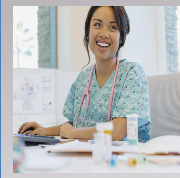
Nurse Practitioner

Practice Based Pharmacist

Physiotherapist

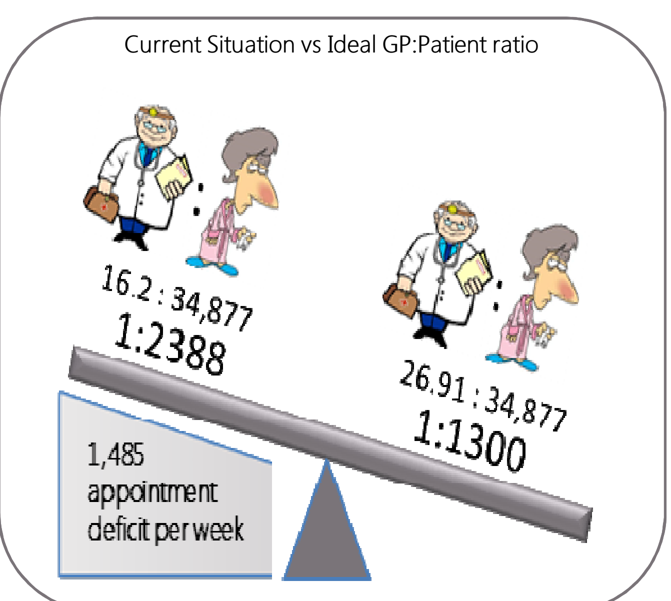


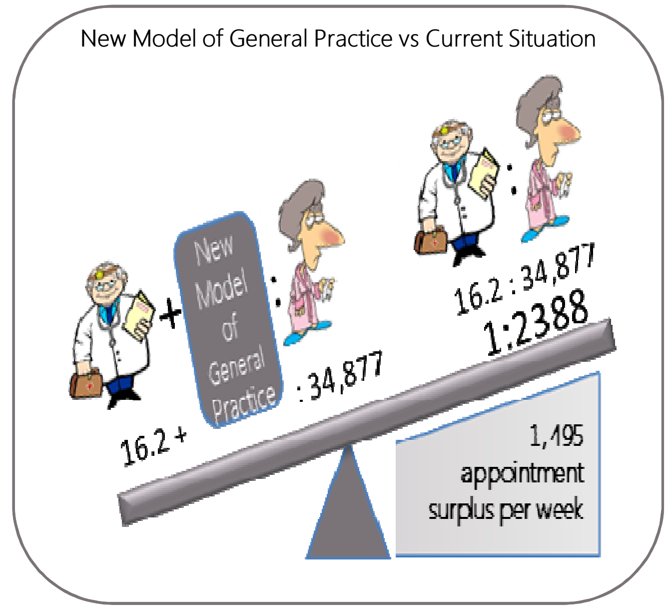
Paramedic



Physicians Assistant

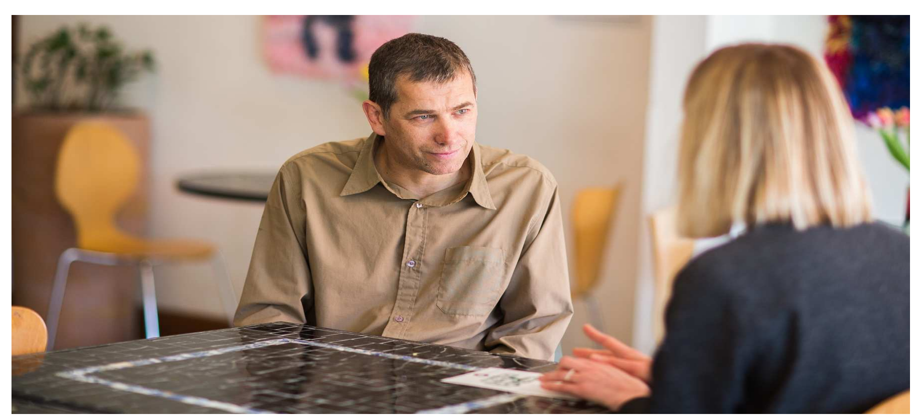
Wellbeing Worker

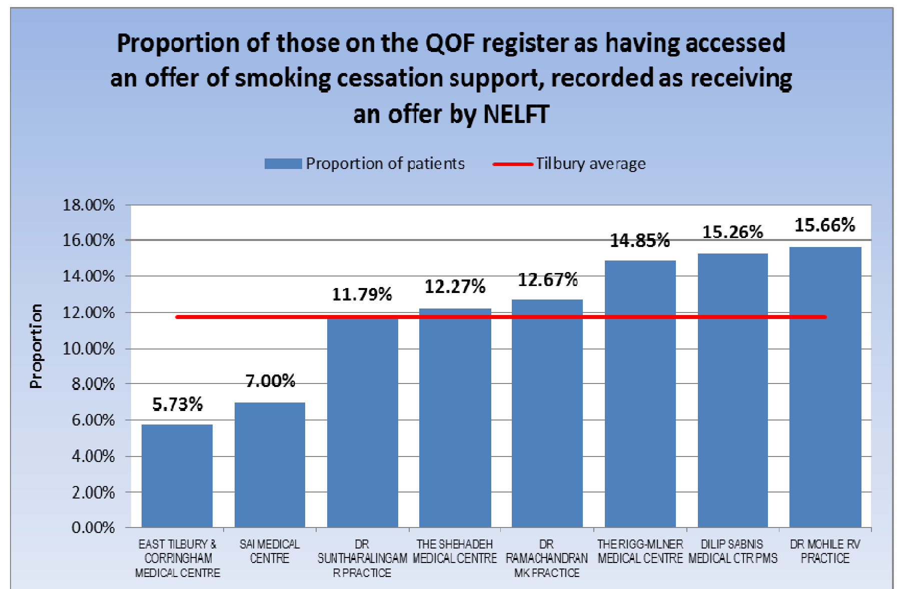


# Enhancing the capability and capacity of Primary Care

- Social Prescribing
- Strengthen Patient Participation Groups
- Increase coverage of the GP Satisfaction Survey
- Integrate Public Health Wellbeing Services





# 5. Enhancing the capacity and capability of Primary Care

## Effective Front Door Triage



### Telephone Triage and Consultation by a GP

- Most experienced clinician is triaging
- Up to 70% of consultations handled by phone in 4-6 minutes
- Need for face to face consultation determined within 2 minutes
- Improved access and reduced DNAs by up to 80%

### Highly trained reception staff

- Reduced GP appointment demand by 10%
- Improved patient and staff satisfaction

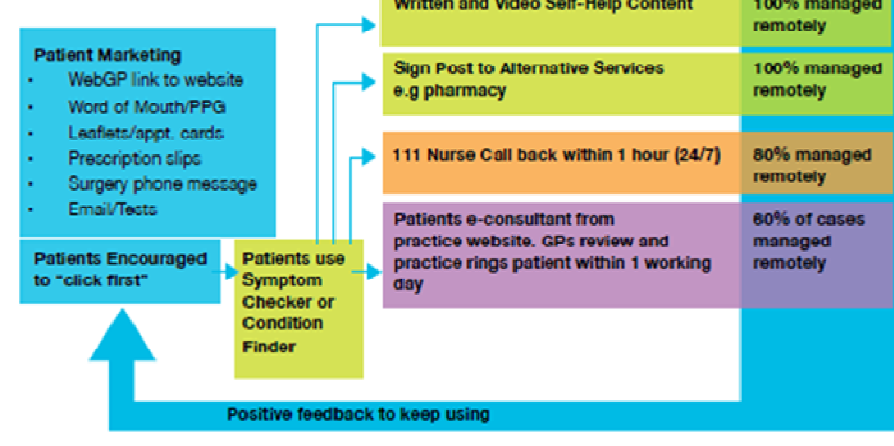
### Web-GP

- 90% of users don't contact the practice
    - 60% use symptom checker
    - 20% visit pharmacy
    - 10% request a 111 nurse call back

- 10% of users have an online consultation
    - 40% are dealt with by a GP remotely – average of 2.9 minutes
    - 20% receive a telephone consultation
    - 40% have a face to face appointment with a member of the surgery's clinical team

- 14% stated that they would have gone to A&E

**Web GP Patient Flows**



# 6. Find the missing thousands, treat the missing hundreds

Less complex patients with some Long Term Conditions

6.6%
1,950

~35%
~£4.7m

Diagnosis and effective management of Long Term Conditions in the community

- Systematically diagnose undiagnosed LTCs ("Find the missing thousands")
- Effective, integrated management of LTCs in Primary and Community Care ("Treat the missing hundreds")

Table 2

| Condition | Observed number of patients | Total estimated number of patients | Additional Number of Undiagnosed Patients based on the estimated prevalence |
|---|---|---|---|
| Stroke (2016) | 650 | 1,398 | 748 |
| Hypertension (2016) | 5,782 | 7,977 | 2,195 |
| CHD (2016) | 1,141 | 2,790 | 1,649 |
| COPD (2016) | 900 | 891 | -9 |
| Depression(2016) | 3,034 | 4,754 | 1,720 |



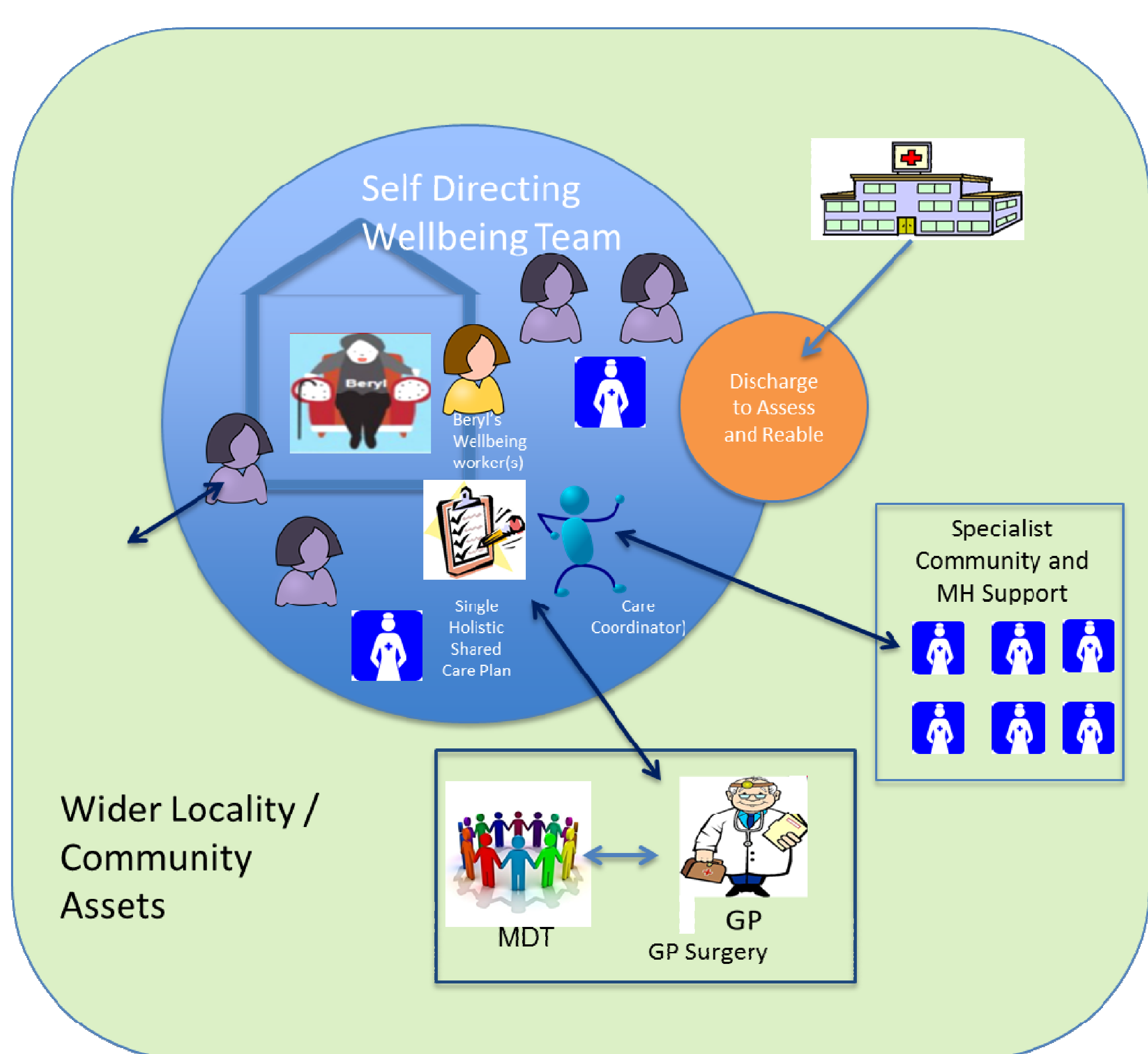
- Finding and treating 100 undiagnosed residents with high blood pressure prevents 10 strokes over three years
- This equates to 270 avoidable strokes in Tilbury every 3 years and a total avoidable cost of £1.8M making identification of hypertension extremely cost effective.

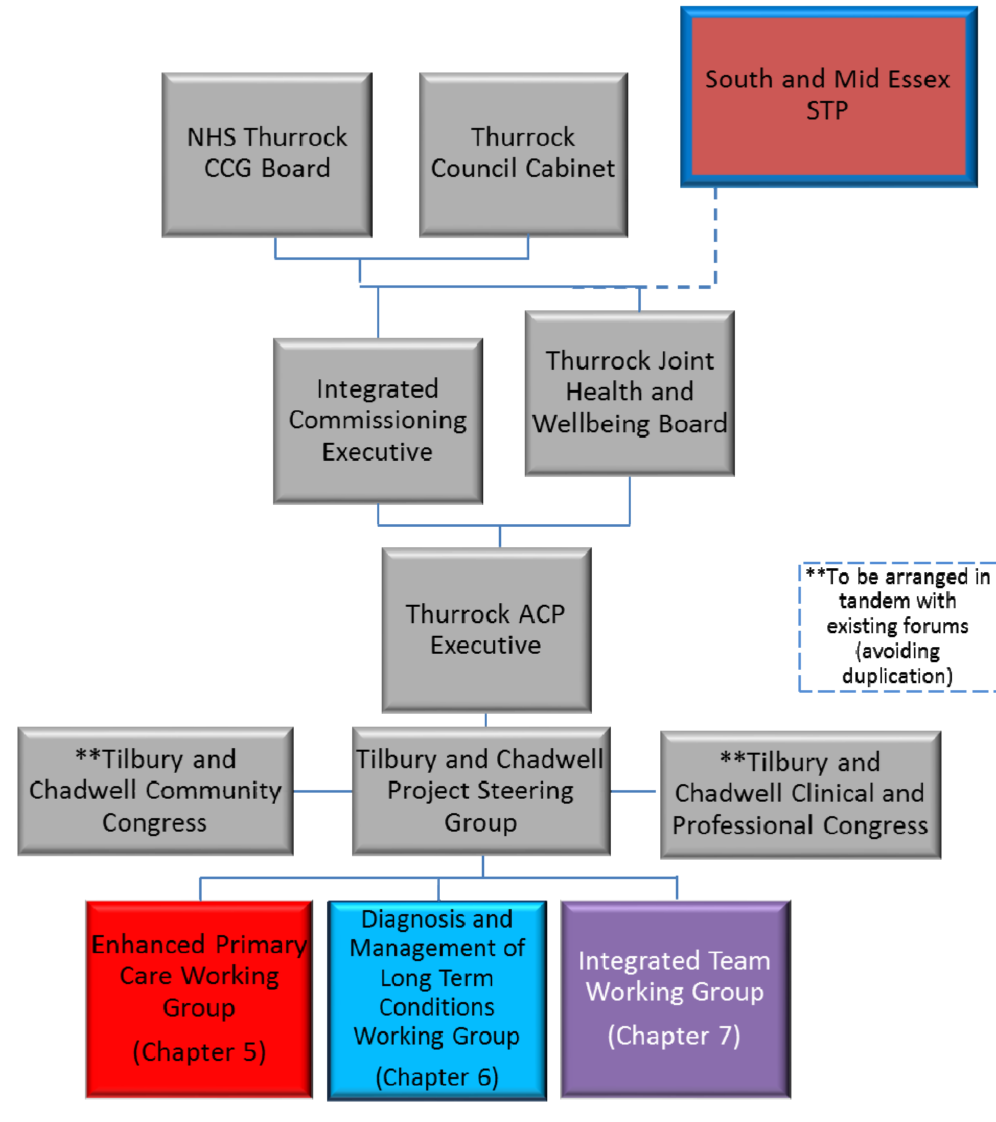
- NHS Health Checks Programme
- Hypertension and AF Screening Programme
- Diabetes case finding through dentist
- Systematic Depression Screening through LTC clinical and ASC staff
- Use of SystmOne/ Mede-analytics

SE2

**SE2** Edited by Emma with Tilbury relevant modelled figures
Sanford, Emma, 18/09/17

# 7. *"What does a good life look like?"* Proactive, Integrated Community Wellbeing






- Implementation Planning
- Evaluation
- Commissioning Arrangements

| 14 June 2018 | ITEM: 9 |
|---|---|
| **Health and Wellbeing Overview and Scrutiny Committee** | |
| **Essex, Southend and Thurrock Joint Health Scrutiny Committee on the Sustainability and Transformation Partnership (STP) for Mid and South Essex** | |
| **Wards and communities affected:** N/A | **Key Decision:** Non Key |
| **Report of:** Roger Harris : Corporate Director of Adults, Housing and Health | |
| **Accountable Assistant Director:** N/A | |
| **Accountable Director:** Roger Harris : Corporate Director Adults, Housing and Health | |
| **This report is** Public | |

**Executive Summary**

At the January 2018 meeting of the Thurrock Health and Well-Being Overview and Scrutiny Committee (HOSC), it was agreed to join with Essex and Southend and participate in the Joint HOSC covering the STP area. The purpose of the Joint HOSC was to respond to the consultation document on acute reconfiguration in Mid and South Essex and to monitor and scrutinise the work of the STP. This report provides an update on the work of the Joint HOSC and seeks confirmation of the Thurrock representation at the Joint HOSC meetings.

**1. Recommendations**

**HOSC are asked to:**

**1.1 Note the terms of reference for the Joint HOSC with Essex and Southend (Appendix 1).**

**1.2 Agree to appoint four members to represent Thurrock HOSC at the joint HOSC.**

**1.3 Agree the approach to the Joint HOSC as outlined in 2.11.**

## 2. Introduction and Background

2.1 The Mid and South Essex STP came out of the former Success Regime established in 2014. STPs exist across the whole country and have been established by NHS England to improve joint working across commissioners and providers and across health and social care. Our STP covers the geographical footprint of Mid and South Essex. This is not a natural, easily recognizable area but was established around the catchment areas of the three acute hospitals at Basildon, Southend and Mid-Essex.

2.2 The STP has an independent chair – Dr Anita Donley and is made up of the 5 CCGs across Mid and South Essex, the acute hospital group, the Mental Health Trust (EPUT), the Community Trust (NELFT), the three local authorities (Thurrock, Essex and Southend), NHS England, the three Healthwatch's and GP's i.e. the five Chairs of the five CCGs in Mid and South Essex.

2.3 Thurrock has expressed its concern over the role and purpose of the STP. Clearly some services do need to be commissioned and provided over a larger footprint than Thurrock and this has been accepted for a long time e.g. some acute specialties such as the various cancer pathways. However,
there is a concern that the STP may undermine the work of the local Health and Well-Being Board and some of our local initiatives e.g. For Thurrock in Thurrock. The Chair of the Health and Well-Being Board has written to NHS England expressing these concerns.

2.4 The STP formally issued its consultation document on the proposed reconfiguration of the services operating from the three acute hospitals in Mid and South Essex in November 2017. This consultation also included the proposals for the future of the services currently on the Orsett Hospital site. The consultation was led by the five Clinical Commissioning Groups in Mid and South Essex and concluded at the end of March 2018. A final report with recommendations will be going to a meeting of the Joint Committee of the 5 CCG's on the 4 July. A summary of the consultation responses received is attached at Appendix 3.

2.5 The purpose of the Joint HOSC is to scrutinise the work of the STP and any consultation exercises it undertakes and how it would meet the needs of the local population in Essex, Southend and Thurrock.

2.6 As reported to the January meeting the Department of Health guidance on Joint Scrutiny Committees is clear - June 2014 regulations: 3.1.7:

*"Regulation 30 also requires local authorities to appoint joint committees where a relevant NHS body or health service provider consults more than one local authority's health scrutiny function about substantial reconfiguration proposals (referred to below as a mandatory joint health scrutiny committee). In such circumstances, Regulation 30 sets out the following requirements:*

- *Only the joint committee may respond to the consultation (i.e. rather than each individual local authority responding separately).*
- *Only the joint committee may exercise the power to require the provision of information by the relevant NHS body or health service provider about the proposal.*
- *Only the joint committee may exercise the power to require members or employees of the relevant NHS body or health service provider to attend before it to answers questions in connection with the consultation."*

3.1.18 further goes on to say *"These restrictions do not apply to referrals to the Secretary of State. Local Authorities may choose to delegate their power of referral to the mandatory joint committee but they need not do so".*

2.7 It is clear from the above that the establishment of the joint HOSC is a requirement but the power of referral is discretionary. Therefore, Thurrock along with Essex and Southend, did not agree to delegate its power of referral to the Secretary of State over "substantial variations in service provision" – that remains the case.

2.8 There have been two formal public meetings of the joint HOSC and two informal meetings and a response on the acute services reconfiguration was submitted on behalf of the Joint HOSC to the STP at the end of March. This is attached at Appendix 2. A series of further meetings are planned including a meeting on 6 June which will be reported back verbally to this meeting. The meetings will rotate across Chelmsford, Southend and Grays and are being held in the evening at the specific request of Thurrock.

2.9 At the January meeting of the Thurrock HOSC it was agreed to appoint the then Chair and Vice- Chair (Cllr G Snell and Cllr V Holloway) plus Cllr T Fish and Cllr G Collins. At the first formal meeting of the Joint HOSC Cllr G Snell was elected as Vice- Chair with Southend taking the Chair and a further Vice-Chair post going to an Essex member. Cllr Snell is no longer a Councillor, Cllr Collins is now a member of Cabinet and we have new members of the Thurrock HOSC, therefore, we need to re-confirm who the members of the Joint HOSC from Thurrock are going to be.

2.10 In the terms of reference attached it is clear that the Joint HOSC will continue whilst the STP continues and so is not just for the purposes of the specific consultation exercise. However, it is important to establish some clear lines of responsibility for what is discussed at the Thurrock HOSC and what is discussed at the Joint HOSC. The suggested position is that those matters that are overwhelmingly the responsibility of one area should be discussed and led by the local HOSC e.g. the future of Orsett Hospital. Whereas those matters that cut across the whole footprint e.g. the future arrangements for cancer services across mid and south Essex should be discussed and led by the Joint HOSC. Clearly there will be some grey areas but this approach is proposed in order to avoid having too many duplicate discussions but most importantly respecting the sovereignty of local areas discussing local matters.

2.11 Finally, it should be noted that the Lead Authority would bear staffing costs of arranging, supporting and hosting the meetings of the Joint Committee but other costs, such as obtaining expert advice, would be apportioned between the three local authorities.

## 3. Issues, Options and Analysis of Options

3.1 There were concerns expressed at the September and January HOSC meeting that this was creating another layer of bureaucracy and potentially taking power and authority away from the Thurrock Scrutiny process.

3.2 As stated above, however, this is not discretionary. To mitigate against the concerns about a loss of local autonomy it was proposed and agreed that we do not delegate our power of referral and that the Thurrock HOSC continues to meet and consider the proposals. This would give a better opportunity to inform the Thurrock representatives at the Joint HOSC meeting and give them confidence they were representing the wider views of the Thurrock scrutiny process.

3.3 The joint committee does have the benefit of potentially a stronger collective voice from the three local authorities in particular on those areas where Thurrock has continually expressed its reservations about the STP process – too much focus on acute hospitals, a lack of focus on out of hospital care, a lack of strategy around primary care and no clear assessment on the impact these proposals will have on adult social care in particular.

## 4. Reasons for Recommendation

4.1 To ensure that Thurrock plays a full and active part in the mandatory joint HOSC but also reserves its right over any potential referrals to the Secretary of State.

## 5. Consultation (including Overview and Scrutiny, if applicable)

5.1 This is covered in the body of the report and the various Appendices.

## 6. Impact on corporate policies, priorities, performance and community impact

6.1 N/A

## 7. Implications

### 7.1 Financial

Implications verified by: **Carl Tomlinson**
**Finance Manager**

None at this stage as the report is largely for noting. Any costs arising from the establishment of the Joint HOSC would have to be contained from within existing resources.

7.2 **Legal**

Implications verified by: **David Lawson**

**Assistant Director of Law & Governance**

The body of the report addresses the relevance of Regulation 30 to participation in a Joint HOSC.

It should also be noted that under the Authority's Constitution the following functions has been determined by Council to the Health and Wellbeing Overview and Scrutiny Committee: Terms of Reference Para 4: "Work in partnership and act as a member of regional, sub-regional and local health scrutiny networks".

Finally the Scrutiny Procedure Rules at Paragraph 6.9 confirm that: "Where the Committee (including any Joint Health Overview and Scrutiny Committee to which the Committee has appointed one or more Members) has been consulted by a local NHS body on any proposal for a substantial variation or development in local NHS services, and the Committee (having considered the evidence) is not satisfied that consultation has been adequate, or considers that the proposal would not be in the interests of the health service in the area, then it may report in writing to the Secretary of State, under section 244, NHS Act 2006."

7.3 **Diversity and Equality**

Implications verified by: **Natalie Warren**

**Community Development and Equalities Manager**

None at this stage as the report is largely for noting.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

N/A

**8. Background papers used in preparing the report** (including their location on the Council's website or identification whether any are exempt or protected by copyright):

See below.

## 9. Appendices to the report

Appendix 1 – Terms of Reference for the Joint HOSC
Appendix 2 – Joint HOSC response to the STP Consultation
Appendix 3 - Summary of consultation responses

**Report Author:**

Roger Harris

Corporate Director of Adults, Housing and Health

# ESSEX, SOUTHEND AND THURROCK JOINT HEALTH SCRUTINY COMMITTEE ON THE SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP / SUCCESS REGIME FOR MID AND SOUTH ESSEX

## TERMS OF REFERENCE

| **1.** | **Legislative basis** |
|---|---|
| 1.1 | The National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Localism Act 2011 sets out the regulation-making powers of the Secretary of State in relation to health scrutiny. The relevant regulations are the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 which came into force on 1st April 2013. |
| 1.2 | Regulation 30 (1) states two or more local authorities may appoint a joint scrutiny committee and arrange for relevant health scrutiny functions in relation to any or all of those authorities to be exercisable by the joint committee, subject to such terms and conditions as the authorities may consider appropriate. |
| 1.3 | Where an NHS body consults more than one local authority on a proposal for a substantial development of the health service or a substantial variation in the provision of such a service, those authorities are required to appoint a joint committee for the purposes of the consultation. Only that Joint Committee may:<br>• make comments on the proposal to the NHS body;<br>• require the provision of information about the proposal;<br>• require an officer of the NHS body to attend before it to answer questions in connection with the proposal. |
| 1.4 | This Joint Committee has been established on a task and finish basis, by Essex Health Overview Policy and Scrutiny Committee (County Council), Southend-on-Sea People Scrutiny Committee (Unitary Council) and Thurrock Health & Wellbeing Overview and Scrutiny Committee (Unitary Council). |
| **2.** | **Purpose** |
| 2.1 | The purpose of the Joint Committee is to scrutinise the implementation of the Mid and South Essex Sustainability and Transformation Partnership (STP) and Success Regime (SR) and how any service changes and proposals arising from them meet the needs of the local populations in Essex, Southend and Thurrock, focussing on those matters which may impact upon services provided to patients in those areas. |
| 2.2 | The Joint Committee will also act as the mandatory Joint Committee in the event that an NHS body is required to consult on a substantial variation or development in service affecting patients in the 3 local authority areas as a result of the implementation of the STP and SR. |
| 2.3 | In receiving formal consultation on a substantial variation or development in service, the Joint Committee will consider:- |

- the extent to which the proposals are in the interests of the health service in Essex, Southend and Thurrock;
- the impact of the proposals on patient and carer experience and outcomes and on their health and well-being;
- the quality of the clinical evidence underlying the proposals;
- the extent to which the proposals are financially sustainable.

and will make a response to relevant NHS body and other appropriate agencies on the proposals, taking into account the date by which the proposal is to be ratified.

2.4 The Joint Committee will consider and comment on the extent to which patients, the public and other key stakeholders have been involved in the development of the proposals and the extent to which their views have been taken into account as well as the adequacy of public and stakeholder engagement in any formal consultation process.

2.5 Notwithstanding any of the above, the relevant parent bodies may still exercise an overview role in relation to STP's, engaging in governance issues / strategic oversight and coordination across the STP footprints.

2.6 It is anticipated that the Joint Committee will continue its deliberations and hold meetings during the consultation and implementation of STP plans. The Joint Committee will review its remit after three years and also at any time at the request of any of the participating authorities.

**3. Membership/chairing**

3.1 The Joint Committee will consist of four members representing Essex, four members representing Southend and four members representing Thurrock, as nominated by the respective health scrutiny committees.

3.2 Each authority may nominate up to two substitute members.

3.3 The proportionality requirement will not apply to the Joint Committee, provided that each authority participating in the Joint Committee agrees to waive that requirement, in accordance with legal requirements and their own constitutional arrangements.

3.4 Individual authorities will decide whether or not to apply political proportionality to their own member nominations.

3.5 The Joint Committee members will elect a Chairman and two Vice-Chairmen at its first meeting, one from each authority, so that each authority is represented in this role.

3.6 The Joint Committee will be asked to agree its Terms of Reference at its first meeting.

3.7 Each member of the Joint Committee will have one vote.

**4. Co-option**

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| 4.1 | By a simple majority vote, the Joint Committee may at any time agree to co-opt representatives of organisations with an interest or expertise in the issue being scrutinised as non-voting members, but with all other member rights. This may be for a specific subject area or specified duration. |
| 4.2 | Any organisation with a co-opted member will be entitled to nominate a substitute member. |
| **5.** | **Supporting the Joint Committee** |
| 5.1 | The lead authority will be decided by negotiation with the participating authorities. The lead authority may be changed at any time with the consent of Essex, Southend and Thurrock. |
| 5.2 | The lead authority will act as secretary to the Joint Committee. This will include:<br>• appointing a lead officer to advise and liaise with the Chairman and Joint Committee members, arrange meeting venues, ensure attendance of witnesses, liaise with the consulting NHS body and other agencies, and produce correspondence and scrutiny reports for submission to the health bodies concerned;<br>• providing administrative support;<br>• organising and minuting meetings. |
| 5.3 | The lead authority's Constitution will apply in any relevant matter not covered in these terms of reference. |
| 5.4 | The lead authority will bear the staffing costs of arranging, supporting and hosting the meetings of the Joint Committee. Other costs will be apportioned between the authorities. If the Joint Committee agrees any action which involves significant additional costs, such as obtaining expert advice or legal action, the expenditure will be apportioned between participating authorities. Such expenditure, and the apportionment thereof, would be agreed with the participating authorities before it was incurred. |
| 5.5 | The non-lead authorities will appoint a link officer to liaise with the lead officer, support liaison back to their respective HOSC and provide support to the members of the Joint Committee. |
| 5.6 | Meetings shall be held at venues, dates and times agreed between the participating authorities. |
| **6.** | **Powers** |
| 6.1 | In carrying out its function the Joint Committee may:<br>• require officers of appropriate local NHS bodies to attend and answer questions;<br>• require appropriate local NHS bodies to provide information about the proposals and to facilitate any site visits requested by the Joint Committee;<br>• obtain and consider information and evidence from other sources, such as |

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| | local Healthwatch organisations, patient groups, members of the public, expert advisers, local authority employees and other agencies. This could include, for example, inviting witnesses to attend a Joint Committee meeting; inviting written evidence; site visits; delegating committee members to attend meetings, or meet with interested parties and report back.<br>• make a report and recommendations to the appropriate NHS bodies and other bodies that it determines, including the local authorities which have appointed the joint committee.<br>• consider the NHS bodies' response to its recommendations; |
| 6.2 | In the event the Joint Committee is formally consulted upon a substantial variation or development in service as a result of the implementation of the STP, and considers:-<br>➢ it is not satisfied that consultation with the Joint Committee has been adequate in relation to content, method or time allowed;<br>➢ it is not satisfied that consultation with public, patients and stakeholders has been adequate in relation to content, method or time allowed;<br>➢ that the proposal would not be in the interests of the health service in its area<br>the Joint Committee will consider the need for further negotiation and discussions with the NHS bodies and any appropriate arbitration. |
| 6.3 | If the Joint Committee then remains dissatisfied on the above three points it may make comments to Essex, Southend and Thurrock Councils. Each Council will then consider individually whether or not they wish to refer this matter to the Secretary of State or take any further action. |
| 6.4 | The power of referral to the Secretary of State is a matter which will not be delegated to the Joint Committee. |
| 6.5 | Each participating local authority will advise the other participating authorities if it is their intention to refer and the date by which it is proposed to do so. |
| **7.** | **Public involvement** |
| 7.1 | The Joint Committee will usually meet in public, and the agenda will be available at least five working days in advance of meetings |
| 7.2 | The participating authorities will arrange for papers relating to the work of the Joint Committee to be published on their websites, or make links to the agenda and reports published on the lead authority's website as appropriate. |
| 7.3 | A press release may be circulated to local media at the start of the process and at other times during the scrutiny process at the discretion and direction of the Chairman and the two Vice Chairmen. |
| 7.4 | Patient and voluntary organisations and individuals will be positively encouraged to submit evidence and to attend. |
| 7.5 | Members of the public attending meetings and who wish to make a statement at the meeting must notify the clerk by close of business on the working day prior to the meeting. Each person will be limited to speaking for a maximum of three |

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| | minutes. If the person speaking is speaking on behalf of a group / body, a spokesperson must be appointed. The period for statements from members of the public at the meeting will be at the Chairman's discretion and normally will not exceed 15 minutes in total. No response will be provided at the meeting. |
| **8.** | **Press strategy** |
| 8.1 | The lead authority will be responsible for issuing press releases on behalf of the Joint Committee and dealing with press enquiries, unless agree otherwise by the Committee. |
| 8.2 | Press releases made on behalf of the Joint Committee will be agreed by the Chairman and Vice-Chairmen of the Joint Committee. |
| 8.3 | Press releases will be circulated to the link officers. |
| 8.4 | These arrangements do not preclude participating local authorities from issuing individual statements to the media provided that it is made clear that these are not made on behalf of the Joint Committee. |
| **9.** | **Report and recommendations** |
| 9.1 | The lead authority will prepare a draft report on the deliberations of the Joint Committee, including comments and recommendations agreed by the Committee. Such report(s) will include whether recommendations are based on a majority decision of the Committee or are unanimous. Draft report(s) will be submitted to the representatives of participating authorities for comment. |
| 9.2 | Final versions of report(s) will be agreed by the Joint Committee Chairman and two Vice Chairmen. |
| 9.3. | In reaching its conclusions and recommendations, the Joint Committee should aim to achieve consensus. If consensus cannot be achieved, minority reports may be attached as an appendix to the main report. The minority report/s shall be drafted by the appropriate member(s) or authority (ies) concerned. |
| 9.4 | Report(s) will include an explanation of the matter reviewed or scrutinised, a summary of the evidence considered, a list of the participants involved in the review or scrutiny; and an explanation of any recommendations on the matter reviewed or scrutinised. |
| 9.5 | In addition, in the event the Joint Committee is formally consulted on a substantial variation or development in service, if the Joint Committee makes recommendations to the NHS body and the NHS body disagrees with these recommendations, such steps will be taken as are "reasonably practicable" to try to reach agreement in relation to the subject of the recommendation. |
| 9.6 | The Joint Committee itself does not have the power to refer the matter to the Secretary of State. |

| 10. | **Quorum for meetings** |
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| 10.1 | The quorum will be a minimum of three members, with at least one from each of the participating authorities. This will should include either the Chairman or one of the Vice Chairmen. Best endeavours will be made in arranging meeting dates to maximise the numbers able to attend from the participating authorities. |

Dr Anita Donley OBE
Mid and South Essex STP
Wren House
Colchester Road
Chelmsford
Essex CM2 5PF

Our ref: Fiona Abbott fionaabbott@southend.gov.uk
Telephone: 01702 215104
Date 22nd March 2018

Dear Dr Donley,

**Joint Health Overview & Scrutiny Committee**
**Formal Response to proposed hospital changes in mid and south Essex**

***Authority***
In accordance with the relevant regulations a Joint Health Scrutiny Committee has been established, comprising Councillors from Essex County Council, Thurrock Council and Southend-on-Sea Borough Council (JHOSC) to review proposals, development and implementation of service changes arising from the Mid and South Essex Sustainability and Transformation Partnership (STP).

The JHOSC has agreed to delegate approval to the Chairman and two Vice Chairmen to approve the response to the current consultation, as set out below. Accordingly, we are writing to you in our respective capacities as Chairman and Vice Chairmen of the JHOSC outlining our views as below.

Notwithstanding the above, the relevant Scrutiny Committees at each constituent authority may continue to scrutinise aspects of the STP separately to the JHOSC where they have a particular localised impact (rather than wider footprint implications) and/or strategic significance, or implications on stakeholder relationships within or across adjoining STP areas. The JHOSC will continue to be the consultative body for significant service variations.

***Background***
The Joint Committee of the CCGs in mid and south Essex launched a public consultation on 30th November 2017. The consultation primarily focuses on proposals to make changes to some specialist hospital services within the acute hospital sector, as well as proposals for the transfer of services from Orsett Hospital in Thurrock to new centres in

the community. The original closing date for the consultation was 9th March 2018. Following our request for an extension, we agreed to your suggestion to extend the deadline for consultation responses to 23rd March 2018.

During the formal consultation period the JHOSC has held two formal meetings, on 20th February 2018 and 13th March 2018 and also held two informal meetings. The papers for the formal meetings are available on each of the participating local authority websites.

***Formal response***

We would like to thank your STP colleagues for their assistance in helping the JHOSC review the current proposals by attending meetings of the JHOSC and providing information as requested. We would particularly like to thank the clinicians who also attended who gave invaluable insights to the clinical considerations behind many of the proposals.

As STPs are developing 5 year plans, the JHOSC will want to have an on-going role in monitoring the STP including any implementation of the current or any subsequent proposals. In submitting this initial response, the JHOSC reserves its right to continue to scrutinise other issues at a later date as it deems fit. This is particularly pertinent for issues the STP continues to develop such as the primary care strategy and transportation strategy (see below).

In formulating this initial response the JHOSC has grouped its comments as follows:-

- Communications and engagement
- Primary Care Strategy
- Community health care
- Workforce plans and impact
- Transport
- Finance
- Stroke services

Communications and engagement

Overall, the JHOSC is content that significant consultation work has been undertaken, and that different methods have been used. However, there seemed to be variations in methods and reach across the footprint and in some cases engagement only gained pace towards the end of the process. The distribution of materials seems to have varied by CCG areas as well.

The Members were concerned that the consultation document itself was lengthy and covered a number of issues which should ideally have been explored separately or in a number of different staggered consultations for example, Orsett Hospital.
**Recommendation**: That the STP should consider in the future whether having so many topics, however linked, in one consultation, is wise.

With regard to the management of the consultation events, some Members expressed concerns about some of the events which had been held, such as the event held in Southend-on-Sea on 8th February 2018 and the subsequent event on 7th March 2018 were both oversubscribed. Another concern was that in some areas consultation events were scheduled for during office hours, meaning it was difficult for residents to attend. The JHOSC suggests that in future, the STP should consider ‘filtering’ attendances to help prevent this and the STP should have had contingencies in place and also have

some flexibility and slack within the timetable to allow for extra events to be scheduled to meet demand.

The JHOSC has been pleased to see the increasing use of social media as a core component of your engagement and makes the following **recommendation**: That the STP continues use of social media in future consultations.

The JHOSC heard about the invaluable work of the local Healthwatch organisations and accordingly makes the following **recommendation: That the CCG Joint Cttee continue to involve the local Healthwatch organisations in its work as they provide a vital independent voice of patients.**

Primary Care Strategy

The JHOSC sees primary care / locality based work as key to the success of the proposals to create a sustainable health and care system in Mid and South Essex. We note that creating sustainable primary care fit for the 21st Century is referenced within the 'Case for Change' document, but that plans remain significantly underdeveloped.

Demand on hospital services both in terms of A&E attendances and unplanned hospital admissions is directly related to the capacity and capability of primary care to offer sufficient appointments to patients, and to diagnose and effectively manage long term health conditions.

The JHOSC recognises that there are systemic problems within primary care in Mid and South Essex including a significant workforce gap leading to unacceptably long waits for appointments, fragmentation of services and an estate that is not fit for purpose. We believe that unless these issues are addressed with a new model of care and significant additional capital and revenue investment in primary and community health care, that avoidable demand on hospital services will continue to increase.

We have concerns that the primary care strategy for the entire footprint has not been prioritised and developed earlier and in conjunction with plans for hospital reconfiguration.

We note that the situation in Thurrock where integrated community medical centres/hubs are more advanced is different to that elsewhere in the footprint and would like to see the learning from Thurrock extended quickly to other parts. We also note that nature of primary care providers and relatively small independent contractors requires that future Primary Care strategy is developed at a locality level, in order to ensure full engagement and clinical leadership of the primary care workforce.

You have advised that a draft Primary Care Strategy will be presented to the Joint Committee of the five CCGs next month before being devolved to the individual CCG Boards for implementation.

Due to the importance of the contribution of primary care to the success of the overall proposals the JHOSC requests early review of the Strategy and will seek assurance that the plans are robust, sustainable and able to achieve the objectives being sought, and most importantly that they are adequately funded in both revenue and capital terms.

**Recommendations:**

1. **The locality based STP Primary Care Strategy is developed, that addresses the systemic issues of lack of capacity, variation in clinical quality and fragmentation of services, and that NHS England provides additional adequate capital and revenue funding for its implementation**

2. **That the JHOSC is able to scrutinise future Primary Care Strategy at the earliest opportunity after the local elections.**

Community health care

The Joint Scrutiny Committee also notes that details relating to community health provision and its integration within the wider STP footprint is currently inadequate. Specifically we would also like to see more details around the proposals relating to the full utilisation of community hospitals in the footprint (with the exception of Orsett – see below).

With regard to the consultation on the closure of Orsett Hospital, we note the assurances given by the current NHS providers and commissioners within a local Memorandum of Understanding, specifically:-

1. That all clinical services provided from Orsett Hospital will continue to be provided within Thurrock, and be migrated to one or more or the four planned Integrated Medical Centres (IMCs).

2. That Orsett Hospital will not close until the IMCs are built and all services have been successfully migrated.

**Recommendation**: That the JHOSC is provided with, and able to scrutinise, further detail on community health care provision to assure it that it is being fully integrated into the STP plans, including a detailed implementation plan for the transfer of services from Orsett.

Workforce plans and impact

We feel that the document needed much clearer statements about how all parties were going to recruit, develop and re-design the workforce of the future. With a rapidly changing workforce, an ageing population and advancing new technologies we do not feel there are anywhere near clear enough plans for the how the aspirations of the STP are going to be developed. In particular:-

- How will it address those key shortages in primary care that will restrict that sector in supporting acute pressures;
- How will shortages in key specialties be addressed;
- How will a new integrated workforce, working across existing traditional boundaries – e.g. primary and acute be developed;
- How will it work with partners in Adult Social Care to support the workforce shortages and challenges they are facing.

We feel that the development of a Joint Workforce Strategy across all sectors of the health and social care economy is an urgent priority. This must include consideration as to how the NHS and LA's can work together to address some of the critical workforce shortages across the whole social care sector – including independent sector providers.

Recruitment issues and delivering the plan depend on resolving these workforce issues. The JHOSC will want to look at this going forward.

Patient transport and workforce transport
The JHOSC recognise that transportation has been a significant issue of concern during the consultation process and notes that a Green paper has recently been published by the STP discussing future principles of providing transport between the hospitals. The JHOSC appreciates that the final solution for such provision cannot be finalised until the outcomes from the formal consultation exercise are decided and commissioning decisions made.

However at this point the JHOSC remains concerned at the logistics of clinical transfers and the issue around clinical supervision of patients. This is an area which the JHOSC will look at going forward. The JHOSC looks forward to discussing the issues further with key staff such as the lead for this work, Dr Ronan Fenton, the Medical Director for the hospital programme of the STP.

The JHOSC is unsure how ‘patient choice’ will feature in the proposals going forward.

**Recommendation**: That the JHOSC is provided with, and able to scrutinise, further detail on patient transport and workforce transport to assure it that it is mitigating the impact of the proposed relocation of certain services.

Finance
The JHOSC is concerned that the STP consultation document did not give a clear financial overview of the challenges facing the health and social care economy. Nor was there are a clear direction of travel for how the mid and south Essex health and care economy would achieve financial balance over the next 5 years.

It is clear from the STP proposals that much of the acute reconfiguration is subject to investment in localities. The JHOSC felt that the proposals are lacking in this regard and was disappointed by lack of financial information and reserves the right to make further comments on this area.

The JHOSC welcomes the proposed capital investment for the acute hospitals but needs to understand further the ‘conditions’ that are attached to the release of the capital from the Treasury, whether the capital is net and so dependent on any land sales for example.

The JHOSC did not think that it was helpful announcing the Trusts merger proposals during the consultation, as this could give the appearance of hiding a very important issue. The JHOSC would want to understand the implications for any future service reconfiguration and has concerns about the impact and timing of the merger.

**Recommendation**: That the JHOSC is provided with detail on finances to facilitate further scrutiny to assure it that plans are financially credible and sustainable.

Stroke services
The JHOSC received some further clarity around the proposals for stroke services however there is still a lack of detail and an understanding of how it will work and therefore reserves its right to scrutinise further the proposals for stroke services
**Recommendation.**

The JHOSC also requested some further information / data and looks forward to receiving this shortly.

***Conclusion***
At this stage, whilst still having concerns about a number of issues, as indicated above (for example the need for the IMCs being open), the JHOSC supports the STP in further progressing its proposals to make changes to some specialist hospital services within the acute sector, as well as proposals for the transfer of services from Orsett Hospital in Thurrock to new centres in the community.

The JHOSC views that the engagement undertaken has been adequate and in some respects very encouraging (e.g. in the use of social media). It still trusts that proposals will be finalised which will be considered to be in the interests of the local health system.

The JHOSC reserves the right to continue its scrutiny of certain aspects of the proposals (as detailed above) to reassure it that the plans being finalised are robust and sustainable, and that sufficient mitigation has been put in place to minimise the impact of some specialist services being relocated (e.g. transportation between hospitals).

Yours sincerely,

Councillor Bernard Arscott
Chairman (JHOSC)
Southend-on-Sea Borough Council

County Councillor Jo Beavis
Vice Chairman (JHOSC)
Essex County Council

Councillor Graham Snell
Vice Chairman (JHOSC)
Thurrock Council

*Correspondence address:-*
*Fiona Abbott*
*Secretary to Joint Scrutiny Committee*
*Southend-on-Sea Borough Council*
*Department of the Chief Executive*
*Civic Centre*
*Victoria Avenue*
*Southend-on-Sea*
*Essex*
*SS2 6ER*

**Mid and South Essex Sustainability and Transformation Partnership**

***Your Care In the Best Place* Consultation Outcome – May 2018**

**Introduction**

Consultation is intended to help NHS organisations make decisions to secure the best possible services that meet the needs of local patients and represent the best possible value for money.

An independent report looking at responses to the *Your Care In the Best Place* consultation on services across Mid and South Essex has been published on 22nd May 2018.

The report, from consultation analysts The Campaign Company, provides an analysis of responses to potential changes to emergency and acute care including stroke services, emergency surgery, trauma and orthopaedic services, and Orsett community hospital. The consultation also sought views on health and care services in the local community.

The report examines the themes and feedback from over 2,700 individual and group responses on the principles for consultation from either completion of online consultation questionnaires, or by filling in a paper survey or by writing in by email or post. It also analyses feedback from hundreds of people who took part in public meetings and other consultation activities.

Following an extensive pre-consultation engagement period over two years, the *Your Care In the Best Place* consultation took place between 30 November 2017 and 23 March 2018. The 16-week consultation saw 16 large scale public meetings with almost 700 people attending in total, and over 40 deliberative workshops and specific events for people who were most likely to be affected by the proposals.

A further 750 people took part in an independently commissioned telephone survey conducted with a demographically-balanced section of the population across Mid and South Essex.

A separate questionnaire was also made available following feedback to focus specifically on the issues relating to Thurrock residents which was completed by 276 people.

In total it is estimated that more than 4,000 people took the opportunity to participate.

**Background**

The proposals for consultation were influenced very strongly by staff and local people. Between 1 March 2016 and the end of November 2017, there were five phases of engagement, which helped to shape both the decision-making process and the proposals for consultation.

Over the five phases of discussions the options for potential changes in services across the three hospitals in Southend, Chelmsford and Basildon, were narrowed down. From over 100 possibilities five main options for organising services across the three hospitals were reached.

By the end of phase four, the options appraisal phase, two options for more detailed development were identified. Both of these options involved designating Basildon Hospital as a specialist emergency hospital, which would take all patients arriving by "blue light" ambulance.

Following the options appraisal process, there was a strong view from the STP Service Users Advisory Group and others that this approach should be sense checked to address local concerns.

This resulted in announcement in July 2017 of a modification of the outline proposals, which would enable the majority of patients in need of emergency care to continue to receive treatment initially at their local (or nearest) A&E and then, if needed, transferred to a specialist team, which may be in another hospital.

This extended period of engagement and involvement of patients, staff and partner organisations culminated in the development of the five principles upon which the hospital service changes were based and which were the subject of the public consultation .

Following agreement of the Joint Committee of the five Clinical Commissioning Groups on the principles to be consulted upon, the STP public consultation was launched on 30 November 2017. Details of the proposals can be found at www.nhsmidandsouthessex.co.uk

The consultation approach supported the right of patients and the public to information and transparency as a cornerstone of involvement and the principles of the NHS Constitution which commits the NHS "to make decisions in a clear and transparent way, so that patients and the public can understand how services are planned" and "be involved, directly or through representatives, in the planning of services commissioned by NHS bodies".

A suite of materials was produced, including a main consultation document (which benefited from input from all three local authority health overview and scrutiny committees (HOSCs) and Healthwatch partners, a summary document, leaflet, feedback questionnaire and additional information, including a short video animation describing the proposed changes, and further information on key aspects of the changes.

As per the consultation Communications Plan, which was discussed by Health and Wellbeing Boards and the three individual HOSCs, consultation materials were made available in hard copy, as well as via the STP consultation website. Materials were also available in different formats and languages, on request.

**The consultation process**

In line with the relevant regulations a Joint Health and Overview Scrutiny Committee (JHOSC) comprising members from Essex County Council, Southend Council and Thurrock Council was established.

To ensure compliance with the statutory requirement for NHS bodies to consult Local Authorities on proposals under consideration for a variation in the provision of health services, the consultation team attended two formal and one informal meeting with the JHOSC during the consultation period.

Consultation materials were distributed through the networks of the five clinical commissioning groups, the three hospitals and the existing patient representative network associated with all health and care organisations and partners in the voluntary sector and made available in locations such as GP surgeries, libraries, clinics, and community centres.

Activities included email notifications, information in newsletters and on websites, as well as social media platforms of all the health and care organisations and partners.

The consultation was widely publicised through the local media including television, radio and local newspapers in editorial coverage.

Significant use of social media was employed as both a promotion and engagement tool with Facebook and Twitter used as the main platforms. Our use of social media was singled out for praise by the JHOSC in its consultation response.

In terms of promotion, sponsored advertisements on Facebook allowed targeted adverts to be placed on news feeds highlighting “local” opportunities to get involved based on location, for example advertising events in Chelmsford to those who live there and have Facebook accounts.

It has also enabled relevant posts to appear targeting key demographics based on for example age, health workers, religious affiliations and gender.

Information about the consultation thus appeared on the newsfeeds of more than 200,000 people through the combination of paid advertising and via the STP Facebook page and more than 170,000 via their Twitter feed.

Aside from both traditional and social media a cascade approach was adopted through established channels using key communicators across a range of local networks to reach a variety of groups and communities.

Examples of this approach include a focus group session with Thurrock Diversity Network supporting people with physical and or learning disabilities, formal letters to traveller liaison groups, articles run in weekly Council of Voluntary Services updates to their membership and postal mail-louts to patients on CCG engagement databases without email addresses.

Healthwatch Essex, Healthwatch Southend and Healthwatch Thurrock also supported this community cascade approach. The variety of activities included:

- Essex: social media cascade, out and about in the Chatterbox Cab
- Southend: Mailshots and shopping centre promotional stands
- Thurrock: Face to face events, visits to sheltered housing

Participants were encouraged to use an online feedback questionnaire to submit their views, but could also feedback in any of the following ways:

- By letter or email
- Completing a paper questionnaire
- By attending a targeted focus group, where there was structured note taking
- By attending a larger "public" discussion event with structured note taking
- Over the telephone
- Posting and commenting via social media

The consultation team also offered to attend meetings on request from community groups and other organisations.

Letters were also written to an extensive list of stakeholders, community groups, partner organisations, neighbouring STPs and condition specific support groups to ask them to respond formally with their views to the consultation.

As outlined earlier an independent telephone survey was commissioned to a representative sample of 750 of population of mid and south Essex.

In line with the cascade approach the Community and Voluntary Service organisations were asked to write to their member organisations to raise awareness of the consultation and encourage participation. These networks included a wide range of advocates and representatives of minority groups and for example resulted in direct invitation to attend groups such as Southend Ethnic Minority Forum and Transpire (LGBT).

Focussed work was undertaken to ensure those with protected characteristics were able to consider the proposals from the perspective of the relevant characteristics. Letters and consultation materials were sent to groups aligned with the nine protected characteristics set out in the Equality Act 2010 requesting they consider the proposals from the perspective of those they support.

This included groups such as Age UK Essex, Royal Association for Deaf People, Blind Welfare, Stonewall, Traveller Liaison, Roma Support Group, Peaceful Place, YMCA, and Family Action.

A number of focussed group discussions were also undertaken to speak directly to groups likely to be impacted by the proposed changes.

Throughout the consultation the team responded to a number of requests and based on feedback received undertook additional activities. Examples of this include:

- Due to popular demand, additional events were put on in Southend and South Woodham Ferrers
- Produced a video on the Orsett proposals
- Produced summary sheets on stroke, finance and transport and workforce
- Extended the deadline for responding to the consultation to March 23 2018
- Revisited GP practices to ensure materials were on display (and stock replenished)
- Undertook paid advertising in the local media to promote the extended time frame

**Consultation response**

The independent analysis report compiled by The Campaign Company shows broad agreement for the five principles outlined in the consultation report.

However in line with the conversations had during both pre-consultation engagement and the consultation process itself, the analysis identifies some local differences, particularly around the proposals relating to the future of Orsett Hospital from those living in the Thurrock CCG area and less general agreement with the proposals from those living in the Southend CCG area.

The process of informal and formal engagement has been comprehensive and it is clear there has been considerable local discussion about the proposals both prior to and during the consultation. There have been high profile local campaigns around the proposed changes with concern that public and staff will be "put at risk unless the existing resources are left unchanged".

Although there have been genuine concerns raised, it is worth highlighting that for a large number of attendees at the public discussion events and workshops, once the proposed changes had been explored, there was less concern and a greater level of support expressed.

However as previously stated the primary aim of consultation is not to undertake a referendum but to gain better understanding of any potential impact proposed changes may have.

The key question now that the responses to the consultation have been analysed is for the local NHS to consider what has been learned from the consultation and what key feedback from patients and public could affect the proposals to redesign the future services. The analysis of the responses has shown key themes of concern in the areas of:

- Transport and accessibility of services
- Shortages in workforce to deliver a sustainable service
- Financial constraint

The equality and health inequality impact assessment work being undertaken in the post-consultation phase will also assist in identifying any further specific issues to support planning for any subsequent implementation.

**Transport and accessibility of services**

**Patients, Families and Carers**

The numbers of people potentially impacted by the proposed changes are relatively small in comparison with the daily attendances across each hospital site.

However in seeking to address concerns raised, even before the conclusion of consultation, a transport working group chaired by a patient representative was constituted.

The group is supporting on-going work to establish a robust non-emergency transport solution to support those patients and their carers/family members impacted by the proposed change, the recommendations arising from this group on steps that can be taken to help resolve concerns over transport and accessibility will be considered alongside the final proposed service changes.

It also recognises and seeks to address pre-existing accessibility issues identified at all three sites, for example car parking limitations.

**Clinical Transfer**
A small number of patients may be transferred from their local A&E department to receive more specialist care at a different site. We have been developing a detailed service specification for a dedicated emergency transfer service solely to convey these patients identified as benefitting for having on-going inpatient care delivered at specialist unit located at another site. The plans for the transfer service have been considered by the clinical senate and will also be revisited as part of the final decision making on the proposed service changes.

**Workforce**

Gaps in the workforce both in hospitals and community based services are one of the most significant challenges the system in mid and south Essex faces.

A key purpose for the proposed changes is to tackle some of the key workforce gaps that we have across our three hospitals by:

- Expanding the opportunities for training, sub-specialisation and greater experience from the creation of specialist centres across the three hospitals.

- Creating more sustainable rosters for staff working in specialist services to reduce current gaps in rosters or unsustainable working patterns that are currently faced by a number of clinicians within our hospitals.

- Providing a greater range of skills and professions available to patients over an extended seven day period through the creation of single specialist units within mid and south Essex to provide greater support and experience to support staff working in these areas.

We believe that this rationale holds true and as part of the East of England Clinical Senate stage two review, there has been a analysis of the proposed staffing arrangements for the specialist units.

**Finance**

The proposals and financial model underpinning the pre-consultation business case underwent local, regional and national NHS financial assurance approvals prior to the launch of the consultation.

The conclusion reached through this assurance, and through analysis by local NHS leaders is that successful delivery of these proposals will secure a more financially sustainable NHS for the people of mid and south Essex which will also deliver better care.

However, it was also recognised that in order to make these changes work there would need to be investment in our three hospitals in terms of buildings and equipment and as such £118m was allocated to the NHS in mid and south Essex in the 2017 Autumn Budget to support these changes.

**Next Steps**

The opportunity to discuss the issues facing the heath and care system in mid and South Essex is to be welcomed alongside the willingness of the community to seek greater understanding and become more informed in the future of services both in the community and within the three hospitals.

The outcome of the public consultation is an important factor in decision making which needs to be fully taken into account. It is, however, one of a number of important factors for decisions.

The Joint Committee of the five clinical commissioning groups will review the findings of the outcome report as part of its decision making process in the summer, alongside evidence and reports which review clinical, financial and practical considerations.

Following decision making the Joint Committee Chair will formally write to the Joint Overview and Scrutiny Committee to inform them of the decisions made.

The JHOSC will then review and choose whether to provide feedback or make recommendations to the CCG Joint Committee.

Any subsequent implementation programme would be clinically-led and will involve clinical professions from all backgrounds and organisations.

This programme will be built on a principle of co-production. Patients, carers and members of the public will be invited to participate in the transition and implementation planning and will be included as key members of a proposed implementation oversight group

It is likely that a process of learning and review throughout the implementation stage will reduce further the concerns expressed through consultation.

**Health Overview & Scrutiny Committee**
**Work Programme**
**2018/19**

Dates of Meetings: 14 June 2018, 6 September 2018, 8 November 2018, 24 January 2019 and 7 March 2019
Dates of Joint HOSC Meetings: 6 June 2018, 19 June 2018, July (date to be confirmed)

| Topic | Lead Officer | Requested by Officer/Member |
|---|---|---|
| **6 June 2018** | | |
| Joint HOSC - Mid and South Essex STP @ Southend | Thurrock/Southend and Essex | Officers |
| **14 June 2018** | | |
| HealthWatch | Kim James | Officers |
| For Thurrock in Thurrock - New Models of Care across health and social care | Roger Harris / Tania Sitch | Officers |
| Verbal Update on Learning Disability Health Checks | Mandy Ansell / CCG | Officers |
| STP Consultation Verbal Update | Mandy Ansell / CCG | Officers |
| Essex, Southend and Thurrock Joint Health Scrutiny Committee on the Sustainability and Transformation Partnership (STP) for Mid and South Essex | Roger Harris | Officers |
| **19 June 2018** | | |
| Joint HOSC - Mid and South Essex STP @ TBC | Thurrock/Southend and Essex | Officers |
| *** July 2018 (date to be confirmed)** | | |
| Joint HOSC - Mid and South Essex STP @ TBC | Thurrock/Southend and Essex | Officers |

| 8 September 2018 | | |
|---|---|---|
| HealthWatch | Kim James | Officers |
| Integrated Medical Centres Progress Report | Christopher Smith | Officers |
| STP Consultation Outcome | Roger Harris | Officers |
| Thurrock Integrated Care Alliance | Catherine Wilson / Jeanette Hucey | Officers |
| Cancer Wait Times | CCG / Ian Wake | Officers |
| Primary Care Strategy | Andy Vowles | Officers |
| ASC Annual Complaints Report | Tina Martin | Officers |
| **8 November 2018** | | |
| HealthWatch | Kim James | Officers |
| Adult Social Care Funding : Green Paper Proposals | Roger Harris | Officers |
| Fees & Charges Report | Andrew Austin / appropriate finance officer | Officers |
| Safeguarding Annual Report 2017/18 | Roger Harris | Officers |
| Meals on Wheels Provision | Alison Hall | Officers |
| **24 January 2019** | | |
| HealthWatch | Kim James | Officers |
| | | |
| **7 March 2019** | | |
| HealthWatch | Kim James | Officers |
| | | |

Clerk : Jenny Shade   Last Updated : May 2018