17 November 2016	ITEM: 6 (additional paper)

Health and Wellbeing Board

Principles for the forward work of the STP / ESR – Joint agreement between Thurrock, Southend and Essex

Report of: Councillor J Halden Portfolio Holder for Education and Health and Chair of Thurrock Health and Wellbeing Board

This report is public.

Executive summary

The work to make the local NHS more sustainable requires full partnership buy in from a range of stakeholders. Following the establishment of strong working relationships between the 3 Chairs and Cabinet Members for Health in Thurrock, Southend and Essex, as well as lead officers, these principles have been drafted to fully articulate the conversations of the last few months in regards to the STP.

This approach has been fully endorsed by the three local authorities; if these principles are accepted then it will be the basis of a truly united approach to make the STP the massive success we know that it can be.

The following principles will be submitted to the Independent STP Chair from the three local authorities.

1.1 It is important that **any proposals are reported to the appropriate Health and Wellbeing Board**, particularly those that directly affect the planning, commissioning and provision of health and social care services.

This approach will help to make sure that the STP can continue to be informed by relevant Councils, Clinical Commissioning Groups and NHS providers. It will also reduce the risk of the STP growing outside its parameters and halting other work that is in progress because partners lose sight of who and what the correct driving force is. The vital role of independent and separate CCG' and Health and Wellbeing Boards (and their associated Heathwatches) must be definitive.

1.2 There should be **clear acknowledgement that the STP cannot be a success without local authority and CCG buy in** – for example, both Southend and Thurrock have coterminous councils and CCG's meaning that the health agenda can be fully integrated and supported with the place making agenda. A weakening of the Council/CCG link via an overly executive structure would be massively detrimental.

1.3 There will be some occasions when it makes financial and clinical sense to operate on a larger footprint – e.g. south west Essex for urgent care, south Essex for acute mental health and the whole of Essex where it is in the best interest of all residents, regardless of local authority boundaries.

We will aggregate up where it makes sense not the other way round. Pan STP working should be on clearly defined principles and certainly not the default position.

1.4 It is **vital that close links are retained with our own patients, carers and service users** and the links to Healthwatch are vital to get that service user experience.

For example, local authorities will know their own populations more intimately than the STP board due to the sheer range of services that are delivered at close quarters. The STP must be very clear that engagement etc is best placed to be delivered via local authorities and via Healthwatch.

1.5 We want to **ensure that there is a democratic input and voice into the process through Health and Wellbeing Overview and Scrutiny Committee, Cabinet and the Health and Wellbeing Boards**.

It is important that elected members can provide input into the key decisions that are taken through these mechanisms and that the system remains 'democratically accountable' to Thurrock residents. This political and clinical input must be an integral part of the STP structure and should not sit as some type of external or limited body which would have an arms distant input.

1.6 There are some **very significant savings that will be needed and some radical transformation in the way that services are delivered locally**. This will need more than just superficial reorganisation but fundamental change. This will include a much better understanding of patient/client flows through the system, integration of health and social care data sets and use of evidence based solutions.

This also requires vital linkages with the planning agenda, housing, regeneration and so on. The STP must be clear that it is a structure and not a way of working in itself.

1.7 The **priority has to be strengthening and improvement in the quality and capacity of primary care**. This is the single biggest reason that is holding back health advances and leading to greater inequalities in the provision of health care.

While the big financial challenges are very apparent at the Hospital stage, we must be clear that primary care insufficiencies are driving much of this. Hospital deficits must be seen, in part, as a symptom of poor primary care and the STP must support local work on primary care improvements, not the other way around.

1.8 Across the board we want to **see an investment shift towards early intervention and prevention**. This will require systematic embedding of prevention programmes within the day to day practice of the NHS in line with "The NHS Five Year Forward View" and use of NHS resources to deliver

prevention. The Public Health Grant alone is insufficient to deliver prevention at the scale required to make the system sustainable.

The **work of the STP must be given time to bed in and be correctly tested** i.e. we cannot look to continuing a conversation about structures while we have the more pressing issue of paying for intervention. It is for this reason that we will not be looking towards any pan-Essex commission for social care and health and instead will work to ensure that collaborative but not restrictive working, via the STP, is a success.

1.9 We need to be **clear in regards to forward planning and delivery** i.e. making sure we compliment the working between health providers and councils to rationalise old estate and build integrated services that are fit for a long term future. The STP cannot just consider health structures and not consider concrete delivery. This needs the fullest political buy-in to realise ambitions.

1.10 **Social care needs strengthening**. The NHS has seen significant increase in resources not matched in social care. This needs to be rebalanced and local authorities have recently submitted a joint paper to the DCLG Select Committee which is reviewing the funding of adult social care.