Essex County Council

Essex Health and Wellbeing Board

09:30	**Wednesday, 19 July 2023**	**Committee Room 1 County Hall, Chelmsford, CM1 1QH**

For information about the meeting please contact: Essex Health and Wellbeing Board Secretariat
Telephone: 033301 31307
Email: essex.partners@essex.gov.uk

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		Pages
1	**Membership, Apologies, Substitutions and Declarations** To include nomination of the Vice-Chairman.	6 - 8
2	**Minutes and Actions of the meeting of the Essex Health and Wellbeing Board held on 17 May 2023** To agree the minutes as an accurate record and review outstanding actions	9 - 14
3	**Questions From The Public** The Chairman to respond to any questions from members of the public which are relevant to the business of the Board of which advanced notice has been given. Questions must be notified to the Board Secretariat at essex.partners@essex.gov.uk Further information is available the Council's website.	
4	**Mid and South Essex ICS** 09:35 – 10:00	

4a	**Mid and South Essex Joint Forward Plan (HWB/12/23a)** Jeff Banks To confirm receipt and endorse the Mid and South Essex Joint forward plan.	**15 - 262**
4b	**Update on Mid and South Essex NHS Foundation Trust Hospital Performance and CQC Action Plan (HWB/12/23b)** • A verbal update from Mid and South Essex NHS Foundation Trust (MSEFT) rep following the report by the Care Quality Commission (CQC) • A verbal update from Cllr Jeff Henry, Chair of Essex County Council's Health Overview and Scrutiny Committee on the Committee's response to the report.	**263 - 270**
5	**Better Care Fund (HWB/13/23)** 10:00 - 10:15 Peter Fairley, Will Herbert and Emma Richardson To share the latest version of the Better Care Fund Plan 2023/24 and for the Board to endorse.	**271 - 327**
6	**Mental Health Strategy (HWB/14/23)** 10:15 - 10:25 Moira McGrath and Emily Oliver • To receive briefing on changes from draft considered by board in January 2023 • To receive feedback on these changes and any other points • To provide endorsement subject to formal governance elsewhere	**328 - 358**
7	**Suicide Prevention (HWB/15/23)** 10:25 - 10:40 Jane Gardner and Gemma Andrews • To receive a report on real-time suicide data for 2022 • To receive a progress report from the Suicide Prevention Partnership Board on work to build a strategic commitment and inform and direct operational activity	**359 - 369**

8 **Data Declaration (HWB/16/23)** **370 - 383**
10:40 - 11:00

Chief Constable BJ Harrington and Assistant Chief Constable Fiona Henderson

To raise awareness of the 'data declaration' which has been developed between Essex Police, Essex County Council and the University of Essex to facilitate better sharing of information for understanding and addressing system-wide problems effectively.

9 **Introduction to workshop**
11:00 - 11:10

Adrian Coggins

10 **Essex Health and Wellbeing Board Forward plan** **384 - 386**
For noting / suggestions.

11 **Date of Next Meeting**
To note that the next meeting will be held on Wednesday 20th September 2023, at a venue to be confirmed.

12 **Dates of future meetings**
To propose the dates for meetings taking place in 2024 - all 09:30 - 14:00:

- 24th January
- 20th March
- 15th May
- 17th July
- 18th September
- 20th November

13 **Urgent Business**
To consider any matter which in the opinion of the Chairman should be considered in public by reason of special circumstances (to be specified) as a matter of urgency.

14 **Urgent Exempt Business**
To consider in private any other matter which in the opinion of the Chairman should be considered by reason of special circumstances (to be specified) as a matter of urgency.

Exempt Items

(During consideration of these items the meeting is not likely to be open to the press and public)

The following items of business have not been published on the grounds that they involve the likely disclosure of exempt information falling within Part I of Schedule 12A of the Local Government Act 1972. Members are asked to consider whether or not the press and public should be excluded during the consideration of these items. If so it will be necessary for the meeting to pass a formal resolution:

That the press and public are excluded from the meeting during the consideration of the remaining items of business on the grounds that they involve the likely disclosure of exempt information falling within Schedule 12A to the Local Government Act 1972, the specific paragraph(s) of Schedule 12A engaged being set out in the report or appendix relating to that item of business.

Agenda item 1

Committee: Essex Health and Wellbeing Board (EHWB)

Enquiries to: Essex Health and Wellbeing Board Secretariat
Essex.partners@essex.gov.uk

Membership, Apologies, Substitutions and Declarations of Interest

Recommendations:

To note:

1. Membership as set out below.

2. Apologies and substitutions

3. Declarations of interest to be made by Members in accordance with the Members' Code of Conduct

Membership
Quorum:
One quarter of the membership and will include:

- At least one Essex County Council Elected Member
- At least one ICB (Integrated Care Board) Representative
- Essex County Council either Director of Adult Social Care, Director of Children's Services or Director for Public Health.

Statutory Members	
Cllr John Spence (Chairman)	Essex County Council
Cllr Beverley Egan	Essex County Council
Cllr Mike Steel	Essex County Council
Gavin Jones	Chief Executive, Essex County Council
Nick Presmeg	Executive Director of Adult Social Care, ECC
Helen Lincoln	Executive Director of Children's Services, ECC
Lucy Wightman	Director, Wellbeing, Public Health, and Communities, ECC
Paul Burstow	ICS chair / ICB chair, NHS Hertfordshire and West Essex
Dr Jane Halpin	ICS lead and ICB CEO, NHS Hertfordshire and West Essex
Michael Thorne	ICS chair / ICB chair, NHS Mid and South Essex,

Anthony McKeever	ICS lead and ICB CEO, NHS Mid and South Essex
William Pope	ICS chair, NHS Suffolk and North East Essex
Ed Garratt	ICS lead and ICB CEO, NHS Suffolk and North East Essex
Cllr Peter Davey	Essex Association of Local Councils
Sam Glover	Chief Executive Officer, Healthwatch Essex
Ian Davidson	Chair of Essex Partnership Strategic Coordination Group
Dr Freda Bhatti	GP representative for North East Essex
Dr Ian Perry	GP representative for Hertfordshire and West Essex
Dr Anna Davey	GP representative for Mid Essex
Daniel Doherty	Mid Essex Alliance - Officer
Cllr Graham Butland	Mid Essex Alliance - Elected Member (Leader of Braintree District Council)
Ruth Hallett	South East Essex Alliance - Officer
TBC	South East Essex Alliance - Elected Member
Laura Taylor Green	North East Essex Alliance - Officer
TBC	North East Essex Alliance -Elected Member
Toni Coles	West Essex Alliance (Health and Care Partnership) - Officer
TBC	West Essex Alliance (Health and Care Partnership) – Elected Member
Simon Williams	South West (Basildon and Brentwood) Alliance - Officer
TBC	South West (Basildon and Brentwood) Alliance – Elected Member
Alison Wilson	Mind in West Essex (Voluntary Sector)
Lorraine Jarvis	Chelmsford CVS (Community and Voluntary Sector) (Voluntary Sector)

Lance McCarthy	Acute Hospital Representative (to be co-opted by the board after consulting organisations or their representatives)
Paul Scott	Chief Executive Officer at Essex Partnership University NHS Foundation Trust (Mental Health)
Jacqui Van Rossum	North East London Foundation Trust (Community Provider)
Simon Wootton	Leader of Rochford District Council
Georgia Blakemore	Chief Executive of Epping Forest District Council
TBC	Representative nominated by NHS England
TBC	Business sector representative

Non-voting Members	
Roger Hirst	Essex Police, Fire and Crime Commissioner
B J Harrington	Essex Police Chief Constable
Deborah Stuart-Angus	Independent Chair of the Essex Safeguarding Adults Board
David Archibald	Independent Chair/Facilitator of the Essex Safeguarding Children Board
Cllr Kay Mitchell	Chair of the Southend HWB
Cllr James Halden	Chair of the Thurrock HWB
Richard Comerford	HCRG group (Childrens Mental Health)
Sanjiv Ahluwalia	Head of School of Medicine, Anglia Ruskin University
Nicola Mallett	Data Analytics practitioner

Minutes of the meeting of the Essex Health and Wellbeing Board held at 09:30am on Wednesday 17 May 2023 in Committee Room 1, County Hall, Chelmsford

1. Membership, apologies, substitutions, and declarations of interest

Present:

Councillor John Spence	Essex County Council (Chairman)
Jeff Banks	Mid and South Essex ICS
Georgina Blakemore	Chief Executive of Epping Forest District Council
Paul Burstow	ICB chair designate, NHS Hertfordshire and West Essex
Toni Coles	Herts and West Essex ICB
Kate Crofts	Senior Equality and Partnerships Adviser, ECC
Peter Davey	Essex Association of Local Councils
Dr Anna Davey	Primary Care Partner Member on MSE ICB
Ian Davidson	Vice-Chair and Chair of Essex Partnership Strategic Coordination Group
Dan Doherty	Mid Essex Alliance
Councillor Beverley Egan	Essex County Council
Dr Jane Halpin	ICS lead and ICB CEO, NHS Hertfordshire and West Essex
Leighton Hammett	Detective Superintendent, Essex Police
Will Herbert	Head of Integration Partnerships, ECC
Roger Hirst	Essex Police, Fire and Crime Commissioner
Will Hooper	Senior Strategy Advisor, ECC
Susannah Howard	ICS Programme Director, Suffolk, and Northeast Essex ICS
Shammi Jalota	Head of Profession Equalities and Partnerships, ECC
Lorraine Jarvis	Chelmsford CVS (Voluntary Sector)
Helen Lincoln	Executive Director for Children, Families & Education
Dr Kate Mahoney	Healthwatch Essex
Chris Martin	Executive Director for Children, Families & Education
Anthony McKeever	ICS lead and ICB CEO, NHS Mid and South Essex
Will Pope	ICS chair / ICB chair, NHS Suffolk, and North East Essex
Nick Presmeg	Executive Director for Adult Social Care, ECC
Nathan Rowland	Stakeholder Engagement Manager, ECC
Dr Danny Showell	Public Health Consultant, ECC
Catherine Smith	Mid and South Essex ICS
Laura Taylor-Green	Director, NEE Alliance
Mike Thorne	ICS chair / ICB chair, NHS Mid and South Essex,
Ian Tompkins	Herts and West Essex ICB
Richard Watson	Deputy Chief Executive and Director of Strategy and Transformation, SNEE Integrated Care Board
Freddey Ayres	Democratic Services Officer, ECC
Richard Buttress	Democratic Services Manager, ECC
Jasmine Langley	Democratic Services Officer, ECC

Apologies for absence were received, as set out below:

Councillor Tony Ball	Essex County Council
Dr Freda Bhatti	GP Representative for North East Essex
Peter Fairley	Director for Integration and Partnerships, ECC
Ed Garrett	ICS lead and ICB CEO, NHS Suffolk and North East Essex
Sam Glover	Chief Executive, Healthwatch
Pam Green	Basildon & Brentwood Alliance
B J Harrington	Essex Police Chief Constable
Gavin Jones	Chief Executive, ECC
Clare Kershaw	Director, Education, ECC
Lance McCarthy	CEO, The Princess Alexandra Hospital, NHS
Councillor Lynda McWilliams	North Alliance Political Representative
Councillor Kay Mitchell	Chair of Southend HWB, Southend City Council
Paul Scott	
Councillor Mike Steel	Essex County Council
Deborah Stuart-Angus	Independent Chair, Essex Safeguarding Adult Boards
Lucy Wightman	Director, Wellbeing, Public Health, and Communities, ECC
Simon Williams	Basildon & Brentwood Alliance
Alison Wilson	Mind in West Essex (Voluntary Sector)

Attendees joining online:

Sanjiv Ahluwalia	Anglia Ruskin University
William Guy	NHS Mid and South Essex ICB

There were no declarations of interest.

2. Minutes of the meeting and progress report on actions arising

It was **RESOLVED** that the Board agreed that the minutes were a correct record of the meeting and noted the updated progress report on the outstanding actions.

3. Questions from the public

There were no public questions.

4. New Delegations to Integrated Care Boards (ICBs) (HWB/07/23): William Guy, Laura Taylor-Green and Avni Shah.

The Board received an update and presentation regarding the new delegations to ICBs that came into effect on the 1st April 2023 including: Pharmacy Commissioning, Optometry and Dentistry.

- From 1st April 2023 all ICB received delegation of Pharmacy, Optometry and Dentistry services commissioning responsibility.
- Key Functions included:
    - Contract management and oversight
    - Oversight of regulations (pharmacy)
    - Commissioning of a full range of dental
    - Development of community pharmacy and optometry services
    - Quality assurance and oversight
    - Market Management and Management

The Board emphasised the importance of the work on engagement that would be needed between the ICB's and the various Health and Wellbeing Boards covering the three systems and the desire for regular updates to be brought before the board with a progress report to address the challenges and opportunities raised.

The Board discussed the need to develop further collaboration with the external partners specifically between the three PODs to move away from the current situation of competitiveness and aim towards a common goal.

The board stated that the greatest issue was with dentistry as it was said to be more commercially motivated. It was expressed that there was a need for early intervention, and it was queried if services could be provided by other means with emphasis on areas of deprivation. The board was advised that that there was a toothbrush scheme in Essex and Suffolk and that work was being undertaken with Universities in Essex and Suffolk for training of dentists at a local level.

It was **RESOLVED** that Board members noted the delegation of the POD's to the three ICBs

Action:
To check in with other Primary Care Partner Members for an overview of their positions in relation to POD's.
Action:
To decide how often a full update on the Essex footprint should be brought to the Health and Wellbeing Board.

5. Suffolk and North East Essex (SNEE) and Hertfordshire and West Essex (HWE) Joint Forward Plans 2023-2028 (HWB/08/23): Richard Watson, Beverley Flowers, Jo Cripps and Stephen Madden

The Board received and discussed the progress of the ICB Joint Forward Plans and Suffolk and North East Essex ICB Plan.

The Board made an observation that there was no reference to town and parish councils as a third tier as implementors of these strategies.

The Board expressed the importance of the work that could be undertaken to ensure the provision of enough physical facilities for primary care and that that it should be cognisant of general growing population trends, and demographies in particular growth areas.

The Board shared that they would commit to working together on the actions that emerge from the action plans that had been developed at a system and alliance level

It was **RESOLVED** that the Board endorsed and supported the SNEE ICB and HWE ICB Joint Forward Plans.

Action:
The MSE Forward Plan to be circulated once published, and, if needed, a special, virtual meeting will be arranged in June to enable HWB members who would like to, to discuss.

6. Essex Partnership Data Declaration (HWB/09/23): Leighton Hammett

The Board agreed that substantive discussion on this item was to be deferred to a later date.

It was **RESOLVED** that this item was to be added to the forward plan to be considered by the Board at the meeting held in July 2023.

Action:
The police to further engage with partner organisations to increase data declaration sign-up.

Action:
That this item is to be added to the forward plan for the meeting of the Health and Wellbeing Board to be held in July 2023.

7. Better Care Fund (BCF) Plan 2022/23 End of Year Report (HWB/10/23): Emma Richardson

The Board received an update on of the performance of the BCF for 2022/23 the key points were as below:

- On track to meet all targets; this was an improvement from the previous year.
- Outperforming targets around long-term supportive needs being met by residential care.
- Officers expressed gratitude to partners for support through BCF in particular the alliances and their work around local 'The improved Better Care Fund' (iBCF) scheme.

The Board acknowledged and commended the update as an improvement from the previous year.

It was **RESOLVED** that the Board endorsed the BCF 2022/23 End of Year Report.

8. Introduction to the Fuller Stocktake Report: Dr Anna Davey

The Board received an introduction of the Fuller Stocktake Report setting out the formation, key themes, key findings, and the vision of primary care in the future.

It was **RESOLVED** that the Board noted the introduction to the Fuller Stocktake Report.

9. Essex Health and Wellbeing Board - Forward plan

It was **RESOLVED** that members noted the forward plan. If members wish to add anything to the forward plan to contact HWB secretariat

10. Date of future meetings

The Board noted that the next meeting will take place at 9:30am on Wednesday 19 July 2023 in the Committee Room 1 at County Hall, Chelmsford, CM1 1QH.

11. Any other business

The Chairman shared that there had been a motion brough to full council in relation to Health and GP Services in Essex prior to this meeting.

Action
That the motion that was heard at the meeting of full council proposed, amended and implemented, be sent to members of the Board.

There being no further business the meeting concluded at 11:45.

ESSEX HEALTH AND WELLBEING BOARD

Actions as of 10 July 2023

Action	Action By	Deadline	Update
New Delegations to Integrated Care Boards (ICBs)			
To check in with other Primary Care Partner Members for an overview of their positions in relation to Pharmacy, Optometry and Dental (POD) Services and to decide how often a full update on the Essex footprint should be brought to the Health and Wellbeing Board.	Jeff Banks / Will Guy	Update requested by 5th July 2023.	In progress – Update requested by September HWB Meeting
Suffolk & North-East Essex and Hertfordshire & West Essex Joint Forward Plans 2023-2028			
This item to be brought back to the board at a future date to be confirmed at the next agenda setting meeting. The Mid & South Essex Forward Plan to be circulated once published, and, if needed, a special, virtual meeting will be arranged in June to enable HWB members who would like to, to discuss.	Health and Wellbeing Secretariat	7th June 2023	Completed – Coming to 19 July EHWB meeting
Data Declaration			
The board recommended that the police further engage with partner organisations to increase data declaration sign-up. The item will then be added to the forward plan for the July meeting of the Health and Wellbeing Board.	B J Harrington	5th July 2023.	Completed - Coming to 19 July EHWB meeting

Agenda Item 4a
HWB/12/23a

Report title: Mid and South Essex Joint Forward Plan 2023-2028	
Report to: Essex Health and Wellbeing Board	
Report author: Jeff Banks, Director of Strategic Partnerships, NHS Mid and South Essex ICB	
Date: 19 July 2023	**For:** Confirmation
Enquiries to: Jeff Banks jeff.banks2@nhs.net	
County Divisions affected: *Mid and South Essex*	

1 Purpose of Report

1.1 The Health and Care Act 2022 ("The Act") establishes Integrated Care Boards (ICBs) as the statutory body responsible for NHS services in each locality, and Integrated Care Partnerships which draw together wider partners concerned with improving health and wellbeing outcomes for residents. Each ICB, along with its partner NHS Trusts/Foundation Trusts must prepare a five-year Joint Forward Plan (JFP), working with local Health and Wellbeing Boards (HWBs) to ensure that the joint local health and wellbeing strategy and relevant joint strategic needs assessments are reflected in the JFP.

1.2 As MSE's JFP was not available for discussion at the last meeting of the HWB, it was agreed that it would be circulated by e-mail to Board members (13th June), to enable the HWB Chairman then to write back to MSE with any comments ahead of the 30th June deadline. It was further agreed that it would then be brought back to July's HWB meeting for formal acknowledgement.

1.3 The Chairman's letter of opinion is attached as ***Appendix One***

1.4 The Mid and South Essex JFP is included as ***Appendix Two***

2 Recommendations

2.1 Members are asked to confirm the Chairman's endorsement of the MSE JFP and its alignment with the Essex Health and Wellbeing Strategy, having been given the opportunity to respond to the draft JFP.

3 Background

3.1 The 2022 Act established 42 Integrated Care Systems (ICSs), which are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area.

3.2 Each ICS is made up of two main committees:

- ***Integrated Care Board (ICB)***: A statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget, and arranging for the provision of health services in the Integrated Care System area. The establishment of ICBs resulted in Clinical Commissioning Groups being closed.

- ***Integrated Care Partnership (ICP)***: A statutory committee jointly formed between the NHS ICB and all upper-tier local authorities that fall within the ICSs area (councils with responsibility for children's and adult social care and public health). The ICP will bring together a broad alliance of partners concerned with improving the care, health, and wellbeing of the population, with membership determined locally. The ICP is responsible for producing an Integrated Care Strategy on how to meet the health and wellbeing needs of the population in the Integrated Care System area.

3.3 The Act requires each ICB to prepare a JFP and national Guidance on the development of JFPs, which NHS England shared with ICBs on 24th December 2022, establishes JFPs must be reviewed and updated or confirmed annually before the start of each financial year. The draft JFP for Mid and South Essex covers the key areas identified in the Guidance and other relevant local priorities.

3.4 The Guidance states that, as part of the process of developing JFPs, ICBs must come to the HWB(s) which are within the geographic area the JFP covers for discussion and approval. The guidance states engagement with HWBs should be as follows:

> *"ICBs and their partner trusts have a duty to prepare a first JFP before the start of the financial year 2023/23 – i.e. by 1 April. For this first year, however, NHS England is to specify that the date for publishing and sharing the final plan with NHS England, their integrated care partnerships (ICPs) and Health and Well-being Boards (HWBs), is 30 June 2023. We therefore expect that the process for consulting on a draft (or drafts) of the plan, should be commenced with a view to producing a version by 31 March, but recognise that consultation on further iterations may continue after that date, prior to the plan being finalised in time for*
>
> *publication and sharing by 30 June".*

[…]

> *"ICBs and their partner trusts must send a draft of the JFP to each relevant HWB when initially developing it or undertaking significant revisions or updates. They must consult those HWBs on whether the draft takes proper account of each JLHWS [Joint Local Health and Wellbeing Strategy] published by the HWB that relates to any part of the period to which the JFP relates. A HWB must respond with its opinion and may also send that opinion to us, telling the ICB and its partner trusts it has done so (unless it informed them in advance that it was planning to do so)"*
>
> *[…]*
>
> *"The JFP must include a statement of the final opinion of each HWB consulted."*
>
> *(NHS England, Guidance on developing the joint forward plan 23 December 2022)*

4. Approach to developing the JFP

4.1 The JFP has been developed taking the Integrated Care Strategy for Mid and South Essex ICS, also previously approved by this Board, as its starting point. In this regard, they key priorities will be familiar to the HWB.

4.2 There has been a shared desire to ensure that, alongside the varied NHS commitments, the JFP is able to pinpoint the most impactful issues that NHS partners should work together on. The draft JFP is therefore presented as a 3-part document:

- Part 1 – provides some background to the current challenges the NHS is facing in Mid and South Essex, and identifies a number of areas where, as NHS partners, we will work together to make an impactful change. Detailed plans will be developed to ensure that we deliver on these commitments, together.

- Part 2 – provides the underpinning aspects of our approach, describing our work on population health improvement, health inequalities and prevention, and also describes our approach to local delivery – through our Alliances.

- Part 3 – contains a number of appendices which describe our approach to delivering on NHS Long Term Plan commitments and other statutory duties placed upon the NHS. These commitments are delivered by various partners across our system, working in provider organisations and the ICB – each appendix describes the governance arrangements for ensuring delivery, including oversight and assurance arrangements through our relevant system governance mechanisms.

4.3 The operational approaches identified in Part 3 will of course develop over time, taking into account existing and future local and national NHS priorities and system pressures. Members were asked to place particular focus on Part

1 and Part 2, to ensure there is clear understanding of how we proposed to prioritise our work and approaches to partnership working across the wider system.

5 Engagement with partners and residents

5.1 The Integrated Care Strategy outlines a system-wide ambition to move from occasional engagement initiatives to a model of continued engagement with partners and residents, building relationships and trust, and ensuring there are regular opportunities throughout the year where residents can meet with health and social care services and influence the work directly.

5.2 In May 2023, the ICB commenced an annual programme of *'Spring Conversations'* to engage with partners and residents directly on the priorities included the JFP. Over a series of ten workshops, and in two online sessions, over 140 local residents, system leaders and staff working across health and social care, and representatives of voluntary and community sector organisations, came together to look at specific lines of enquiry directly relating to this JFP.

5.3 In addition to the open access 'Spring Conversations', a series of sessions with residents who come from more marginalised groups who are less often heard, often referred to as *'Inclusion Health Groups'* were also held. These targeted workshops and drop-in sessions engaged 460 residents, including members of the traveller community, parenting groups, older peoples' groups, young people (via Essex Council for Voluntary Youth Service), carers support groups and with groups supporting people with Learning Disabilities and Autism.

5.4 Each session was co-hosted by a member of the Integrated Care Partnership, or a local community leader, and was based on the principles of 'appreciative enquiry' - a strengths-based, positive approach, opening up conversations about what is working well, and how participants can support and contribute to the change they wish to see. In addition to specific the lines of enquiry relating to the JFP, participants explored the part they can play across four domains: as individuals and in our families; in the neighbourhood where we live; the organisations we work or volunteer in; and as leaders. Engagement activities took place in community hubs, village halls, and in local pubs and at a comedy club.

5.5 In addition, the 'Essex is United – Your Questions Answered' Facebook group and the associated private Facebook Messenger group, was used to ask a series of questions of residents. These engagements collectively reached over 35,000 residents, with 218 specific comments or questions, each of which was responded to directly by the group admins. A total of 732 social media group 'admins' were contacted for support, represent a wide range of communities of interest, need or geography.

5.6 Running alongside the engagement work, was a more detailed online questionnaire, which was completed by individuals wanting to respond in a more detailed way to the sections included with the JFP.

5.7 The outcome of this engagement work has significantly influenced the shape of this JFP and will continue to influence how we deliver on the priorities we have identified together. A summary of these conversations will be summarised in the developing 'Insight Bank', an open access, searchable database of insights about the experiences gathered across the partnership, both from those delivering and receiving health and care services.

6 Governance

6.1 The Integrated Care Board approved the draft JFP at its meeting on 18th May 2023. Mid and South Essex Foundation Trust approved the draft at its meeting on 25th May 2023. Remaining provider Boards are being asked to approve the plan over the course of June. There will be ongoing opportunities for partners to receive feedback and influence the delivery of the JFP, through the commitment to review and update or confirm the JFP annually before the start of each financial year.

6.2 The ICB determined that it needed to work through its internal governance process at the appropriate pace (ensuring proper review by the ICB and NHS provider boards, etc.). Also, the ICB wanted to ensure all three HWBs in Mid and South Essex had equal opportunity to be informed of and influence the JFP. With two of the three HWBs not sitting at key milestones in the development of the JFPs (due to local elections) the ICB sought advice, and it was agreed it could wait and bring forward the draft JFP when all three HWBs were sitting and therefore able to consider them concurrently.

7 Options

7.1 MSE JFP needed to be approved and published by 30 June 2023.

7.2 Councillor John Spence, as Chairman of the Essex Health and Wellbeing Board, submitted a letter on behalf of the board, please see ***Appendix One***, feeding back comments and confirming that it aligns with the Essex Health and Wellbeing Strategy.

7.3 It therefore has now been submitted, but it was agreed to bring back to the Board to ensure formal confirmation.

7.4 Members are asked to confirm the Chairman's endorsement of the MSE JFP and its alignment with the Essex Health and Wellbeing Strategy, having been given the opportunity to respond to the draft JFP.

8 Financial implications

8.1 MSE JFP set out the respective ICB's five-year plan and includes a section on Finances. The paper itself though is not asking for financial investment.

9 Legal implications

9.1 None

10 Equality and Diversity implications

10.1 The Public Sector Equality Duty applies to the Council when it makes decisions. The duty requires us to have regard to the need to:

(a) Eliminate unlawful discrimination, harassment and victimisation and other behaviour prohibited by the Act. In summary, the Act makes discrimination etc. on the grounds of a protected characteristic unlawful

(b) Advance equality of opportunity between people who share a protected characteristic and those who do not.

(c) Foster good relations between people who share a protected characteristic and those who do not including tackling prejudice and promoting understanding.

10.2 The protected characteristics are age, disability, gender reassignment, pregnancy and maternity, marriage and civil partnership, race, religion or belief, gender, and sexual orientation. The Act states that 'marriage and civil partnership' is not a relevant protected characteristic for (b) or (c) although it is relevant for (a).

10.3 The Equality Comprehensive Impact Assessment indicates that the proposals in this report will/will not have a disproportionately adverse impact on any people with a particular characteristic. *(Describe the specific equality and diversity implications of the proposal, any adverse findings from the Equality Comprehensive Impact Assessment and your proposed mitigation measures)*

11 List of appendices

- ***Appendix One****:* Chairman's letter of opinion
- ***Appendix One****:* NHS Joint Forward Plan for Mid and South Essex.

12 List of Background papers

Members may wish to consider the NHSE's Guidance on developing the joint forward plan Version 1.0, published 23 December 2022, which is available at this link https://www.england.nhs.uk/wp-content/uploads/2022/12/B1940-guidance-on-developing-the-joint-forward-plan-december-2022.pdf

Mid and South Essex Integrated Care System

NHS Mid and South Essex

NHS Mid and South Essex

Joint Forward Plan 2023-2028

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Foreword from our Chair

I'm delighted to present this, our first Joint Forward Plan, as the Mid and South Essex Integrated Care System. This plan outlines the joint ambitions of NHS partners in mid and south Essex, which both respond to and support the joint health and wellbeing strategies of our three upper tier local authority partners (Essex County Council, Southend City Council and Thurrock Council), and the Integrated Care Strategy that we have jointly developed, under the auspices of the Integrated Care Partnership.

As is the case for many newly established Integrated Care Systems, we face a number of challenges. The Covid pandemic has exacerbated health inequalities in our population, our primary care services are under extreme pressure. Demand on our mental health, urgent and emergency services are significant, we have long waits for planned treatments, and we are not meeting nationally set standards in relation to cancer care. Collectively, our providers are carrying significant vacancies and we over-rely on bank and agency staff to fill rotas – as a result the quality of care we offer can sometimes suffer. We have a significant underlying structural deficit, and we are not meeting our planned financial position.

Within these many challenges, we are also a system that has high ambitions to improve the health and wellbeing of the population that we serve. We have delivered a number of impressive and long-lasting improvements and have had many successes. This plan will look to continue to build on those positives. It incorporates detailed operational and financial plans for the first year, 2023/24, in line with NHS England guidance, and outlines the ambitions and plans of NHS partners over the coming five years in key areas.

We are committed to continuing to work together to do all that we can to improve outcomes for our local population.

Professor Michael Thorne CBE
Chair
NHS Mid and South Essex Integrated Care Board

About this Document

This document is the first Joint Forward Plan for NHS partners since the inception of the statutory Integrated Care System in mid and south Essex.

The production of this plan has followed guidance issued by NHS England and the detailed operational planning and financial framework issued to NHS organisations for 2023/24.

We have split the Joint Forward Plan into three distinct parts:

This first section (**part 1**) provides an overview of our collective view of the NHS system over the next five years. This describes how the NHS will take forward the Integrated Care Strategy, taking into account the Joint Local Health and Wellbeing Strategies of our upper tier local authorities, along with the strategic ambitions of NHS and wider partners. Part 1 can be considered the executive summary for the Joint Forward Plan.

Part 2 of this plan describes the underpinning approach we will take to deliver on our collective ambition to improve population health and reduce health inequalities.

We will seek feedback from partners on this first part as to how well they consider the plan reflects the current challenges and ambitions of partner organisations and strategies.

Part 3 of the plan is a series of appendices which describe how we will meet the statutory requirements placed upon the NHS – offering an overview and a high-level delivery plan for each Long-Term Plan commitment and statutory function for the NHS. This section of the plan has been produced by subject matter experts, working across NHS partners, to reflect on delivery of the NHS Long Term Plan.

The NHS operational planning guidance for 2023/24 has set out clear expectations for delivery and our collective submissions to NHS England aggregate our shared ambitions and commitments for 2023/24 – this is year one of the Joint Forward Plan.

We will share the appendices in Part 3 with partners, who may wish to review some or all of the sections. However, through the usual course of our work, it is our expectation that residents, patients, and partners, will be fully involved in defining and supporting delivery of these priorities.

Health & Wellbeing Boards Statements

The Integrated Care Board has worked closely with its three Upper Tier Local Authorities, Essex County Council, Southend-on-Sea City Council and Thurrock Council, in developing the Joint Forward Plan and is mindful of the importance of engaging positively with partners to ensure the Joint Forward Plan is understood and supported. The Guidance states engagement with Health and Wellbeing Boards should be as follows:

"Integrated Care Boards and their partner trusts must send a draft of the Joint Forward Plan to each relevant Health and Wellbeing Board when initially developing it or undertaking significant revisions or updates. They must consult those Health and Wellbeing Boards on whether the draft takes proper account of each Joint Local Health and Wellbeing Strategy published by the Health and Wellbeing Board that relates to any part of the period to which the Joint Forward Plan relates. A Health and Wellbeing Board must respond with its opinion and may also send that opinion to us, telling the Integrated Care Board and its partner trusts it has done so (unless it informed them in advance that it was planning to do so)"

NHS England, Guidance on developing the joint forward plan 23 December 2022

The Joint Forward Plan was formally submitted to each Upper Tier Local Authority in accordance with the Guidance and was considered by the Southend Health and Wellbeing Board on 15th June 2023 and by Thurrock Health and Wellbeing Board on 23rd June 2023. As the meeting schedule did not allow for a draft Joint Forward Plan to go to the full Essex Health and Wellbeing Board, the draft was formally received by the Chair and an opinion provided on behalf of the Board on 27th June 2023. The Joint Forward Plan has been very well received by all three Upper Tier Local Authorities who have endorsed the plan, whilst acknowledging the challenges public sector authorities face.

Essex Health & Wellbeing Board:

"The Essex Health and Wellbeing Board is supportive of the Mid and South Essex Joint Forward Plan and the actions it sets out. It has taken into consideration both the Joint Strategic Needs Assessment and the Joint

Health and Wellbeing Strategy for Essex and there are clear links to the priorities in these Documents. We welcome the commitment the Joint Forward Plan sets out to

place-based working through the alliances and the development of neighbourhood teams and the ambition to explore integration of services at every level, taking joined up health and care decisions closer to the resident."

Opinion of Essex Health and Wellbeing Board

Southend Health & Wellbeing Board:

"This Joint Forward Plan has been collated following the Southend Health and Wellbeing Board's endorsement of the Integrated Care Strategy's Integrated Care Strategy (March 2023) and having due regards to the priorities set out in our Health and Wellbeing Strategy (2021-24). The Joint Forward Plan will further support and drive our collective endeavours in reducing health inequalities in our population, exacerbated by the Covid pandemic."

Opinion of Southend Health and Wellbeing Board

Thurrock Health & Wellbeing Board:

"Board members endorsed the plan and its strong commitment to tackling inequalities, reflecting Thurrock's Health and Wellbeing Strategy's ambitions of levelling the playing field across Thurrock. The Joint Forward Plan will further support and drive our joint endeavours in reducing health inequalities in our population and Thurrock Health and Wellbeing Board acknowledged the importance of maintaining the Better Care Fund as one of the key delivery mechanisms for ensuring our collective ambitions can be achieved".

Opinion of Thurrock Health and Wellbeing Board

The response has been exceptionally positive, and the Integrated Care Board is grateful to the Upper Tier Local Authorities for their support. The Integrated Care Board and its partner trusts are committed to working closely with Upper Tier Local Authority partners in delivering the ambitions outlined in the Mid and South Essex Integrated Care Strategy and will work closely with partners to deliver the NHS priorities outlined in the Joint Forward Plan.

The full responses received from each Upper Tier Local Authorities are included as Appendix 9 (pages 233)

Mid and South Essex Integrated Care Partnership

On 28th June 2023, the draft Joint Forward Plan was received and endorsed by the Mid and South Essex Integrated Care Partnership.

Engagement with Partners and Residents

The Integrated Care Strategy outlines a system-wide ambition to move from occasional engagement initiatives to a model of continued engagement with partners and residents, building relationships and trust, and ensuring there are regular opportunities throughout the year where residents can meet with health and social care services and influence the work directly.

In May 2023, the Integrated Care Board commenced an annual programme of *'Spring Conversations'* to engage with partners and residents directly on the priorities included within the Joint Forward Plan. Over a series of ten workshops, and in two online sessions, over 140 local residents, representatives of voluntary and community sector organisations, system leaders and staff working across health and social care, came together to look at specific lines of enquiry directly relating to this Joint Forward Plan.

In addition to the open access 'Spring Conversations', a series of sessions with residents who come from more marginalised groups who are less often heard, often referred to as *'Inclusion Health Groups'* were also held over a six-week period. These targeted workshops and drop-in sessions engaged 460 residents, including members of the traveller community, parenting groups, older peoples' groups, young people (via Essex Council for Voluntary Youth Service), carers support groups and with groups supporting people with Learning Disabilities and Autism.

Each session was co-hosted by a member of the Integrated Care Partnership, or a local community leader, and was based on the principles of 'appreciative enquiry' - a strengths-based, positive approach, opening up conversations about what is working well, and how participants can support and contribute to the change they wish to see. In addition to specific lines of enquiry relating to the Joint Forward Plan, participants explored the part they can play across four domains: as individuals and in our families; in the neighbourhood where we live; the organisations we work or volunteer in; and as leaders. Engagement activities took place in community hubs, village halls, and in local pubs and at a comedy club.

In addition, the 'Essex is United – Your Questions Answered' Facebook group and the associated private Facebook Messenger group, was used to ask a series of questions of residents. These engagements collectively reached over 35,000 residents, with 218 specific comments or questions, each of which was responded to directly by the group admins. A total of 732 social media group administrators were contacted for support, representing a wide range of communities of interest, need or geography.

Running alongside the engagement work, was a more detailed online questionnaire, which was completed by individuals wanting to respond in a more detailed way to the sections included with the Joint Forward Plan.

The outcome of this engagement work has significantly influenced the shape of this Joint Forward Plan and will continue to influence how we deliver on the priorities we have identified together. A summary of these conversations will be available for residents and partners to see on the developing ‘Insight Bank’, an open access, searchable database of insights about the experiences gathered across the partnership, both from those delivering and receiving health and care services.

Part 1: The Collective Ambition of NHS Partners

Upping our game: in it together for long healthy lives and the best of care, clinical outcomes and careers.

Introduction

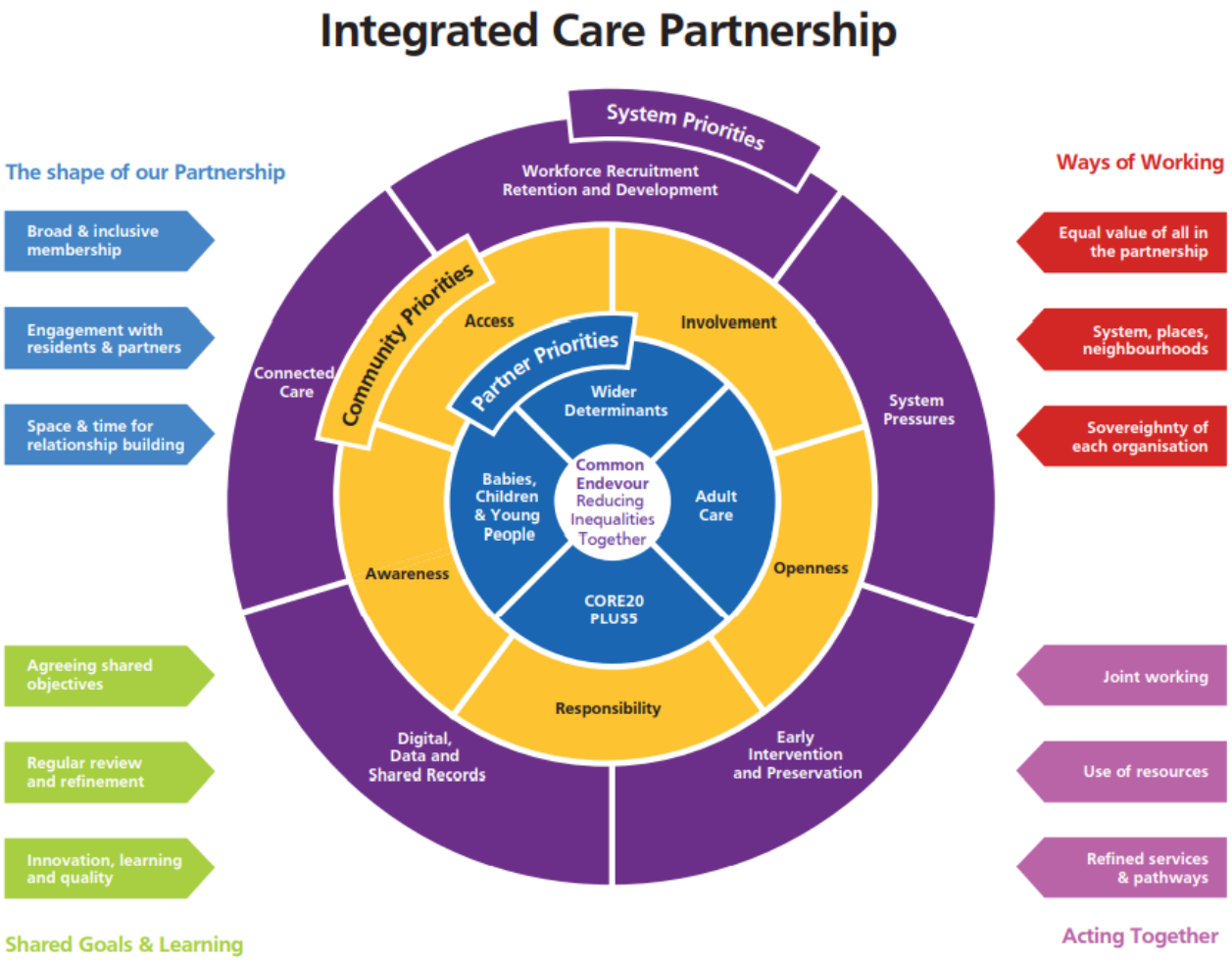
At the time of inception of our Integrated Care System, all partners agreed that our main objective should be to 'up our game'. Consequently, NHS partners have agreed that, in this Part 1 document, we should set out our collective ambitions to both address the significant challenges we face and set a strategic ambition for the NHS we want our residents to experience.

NHS partners agree that 'warm words' will not deliver this ambition – our leaders and organisations are committed to working together and with local authority partners in a way not seen previously, with concrete agreements and actions, to deliver for our population. We realise that improvement across the board means opening up our individual organisations so that they can benefit from our collective ideas and experience while respecting our statutory independence.

We want people to live longer, healthy lives, to be able to access the best of care and to experience the best clinical outcomes, and for us to be exceptionally able to attract good people to work with us, recognising we offer meaningful careers. We are clear that delivering this ambition must start now and reflect our challenging starting position.

We are committed to delivery of the Integrated Care Strategy, recently co-developed with partners through our Integrated Care Partnership. The Integrated Care Strategy draws heavily upon the joint health and wellbeing strategies of our upper tier local authorities, and so we expect that our plans will contribute to the delivery of those strategies through our Primary Care Networks and neighbourhoods, the alliances and (where appropriate) across the mid & south Essex system.

Central to our Integrated Care Strategy is our desire to see residents united with health and social care services around the single '**Common Endeavour**' of **reducing inequalities together**.



The Mid and South Essex ICS Integrated Care Strategy, plan on a page, March 2023.

Our Vision

A health and care partnership working for a better quality of life in a thriving mid and south Essex, with every resident making informed choices in a strengthened health and care system.

As NHS partners in the Integrated Care Partnership, the Common Endeavour expresses our collective desire to work to eliminate avoidable health and care inequalities by creating a broad and equal partnership of individuals, organisations, and agencies, focussing on prevention, early intervention and providing high-quality, joined-up health and social care services, when and where people need them.

Our Integrated Care Strategy (Integrated Care Strategy link) states that this cannot be achieved by statutory partners alone – and we are committed to ensuring voluntary, community, faith and social enterprise organisations, residents, and others are invited to join us in our Common Endeavour. Together we will significantly increase focus on individual and community engagement, wider determinants, early intervention, and prevention.

The Scale of the Challenge

We must be honest about the challenges faced by the NHS locally.

- Demand for complex care across all services is rising as our population ages; we often duplicate service offerings or fail to deliver the joined-up, personalised care.
- We are not well resourced in terms of workforce – with particular shortfalls in primary care, and significant nurse, support worker, allied health professionals and in some clinical specialities, medicine vacancy rates. Both recruiting and retaining staff has been problematic in recent years.
- We are challenged operationally – struggling to maintain standards in some areas whilst escalation capacity usually reserved for winter is often required year-round. Length of stay in our services has increased significantly.
- We have a substantial historical structural deficit and we have failed to deliver our financial improvement plans. We have posted a system financial deficit for 2022/23, driven largely by a failure to deliver efficiencies and an over-reliance on bank and agency staffing – underpinned by rising demand in certain areas of care, more complex treatment regimes in some specialities and a failure to prevent chronic disease exacerbation. A key consequence of our deficit is that we have been limited in the investment we have been able to make in transforming health and care. We do not wish to cede control over our operations that is a likely consequence of not resolving our deficit. We wish to retain our autonomy within the agreed NHS framework.

- Our patients have not received the highest quality care in some cases – we have quality and safety challenges across many services.
- We are failing to meet many of the statutory requirements set out in the NHS Constitution.
- Constrained capital is now creating pressures and limiting our ability to transform due to irretrievable equipment/infrastructure breakdown.

In order to turn this set of circumstances around, we need not only to do things differently, but to do different things. As NHS partners, we are making a set of commitments in this joint forward plan that we must take forward together.

Commitments

Over the course of this Joint Forward Plan, NHS partners are committed to the following actions (further detail can be found below and, in the appendices,):

- A focus on **reducing health inequalities** experienced throughout our population. We will focus our work on delivering against the **Core20PLUS5 frameworks** for adults and children at neighbourhood, alliance and system level, using a population health improvement approach.
- The delivery of **local, personalised, coordinated services**, delivered through **integrated neighbourhood teams**, managed through our four alliances.
- Making significant progress on **reducing avoidable mortality** in the following areas:
  - Cancer
  - Cardiovascular disease
  - Respiratory conditions
- Increasing our work, in partnership, on the following **preventative activities**:
  - Tobacco cessation
  - Healthy weight
  - Physical activity
- Continuing our work to **amplify clinical and professional leadership** in our system – using our **Stewardship programme** and leadership development opportunities to develop a future view of services that enable the highest professional standards, and a multi-professional approach.
- Increasing the amount we **invest 'up-stream' in evidence-based interventions and preventative activities that take place closer to the resident** – underpinned by a commitment to understanding the impact of our work on health inequalities and ensuring we have explored the prevention aspect of all investments.

- Using **population health management** to support us in setting ambitious targets for prevention investment annually. Our ability to do so will require a concomitant reduction in crisis/acute sector spend and a commitment to use available transformational funding differently, evaluating and embedding embed what works.
- Developing a clear demand and capacity model for the system that is used to underpin **integrated operational decision-making that is organisationally agnostic** and focussed on how best to meet the needs of the population.
- **Investing strategically in our voluntary and community, faith and social enterprise** to support wellbeing, prevention and early intervention,
- Continuing to **evolve our relationship with communities** – involving them in designing service offers and being open with them about the limitations and challenges we face.
- Placing an emphasis on **equality, diversity and inclusion** – for our workforce and our patients.
- Learning from and building upon existing and future **innovative practice**.
- Considering social value in our approach, linking to our **Anchor Charter**.

Ground Rules

A number of 'ground rules' have been agreed, either through national directives applied to all Integrated Care Systems, or through local agreement. These are summarised below:

- As a system in deficit, a 'triple lock' lock is applied to any new investment across revenue and capital monies. This means that investments above a certain value or those which are unbudgeted will be scrutinised by NHS England as well as by the Integrated Care Board and provider Boards.
- Resources are allocated in line with national directions where they apply.
- Growth funding will flow to providers where growth in activity is demonstrated.
- A joint commitment to deliver against a trajectory for vacancy reduction (and concomitant reduction in bank and agency which will be stratified by speciality) along with targeted actions on recruitment, retention, adoption and spread of new roles and securing a sustainable future pipeline of staff.
- A programme to rationalise estate and backlog maintenance bills is agreed and delivered.
- Demand and capacity are clearly understood and underpins decisions on investment, delivery and operational performance.

- Access to elective care will be based on clinical prioritisation, health inequalities, and a commitment to reducing the longest waiting times within core levels of activity agreed across NHS and independent providers.
- The Integrated Care Board will reduce its running costs from £22m to £17.2m by 1st April 2025.
- Collective prioritisation and deployment of transformation funds (subject to the triple lock described above) will be targeted towards those areas that support the reduction of health inequalities, focus on prevention and generate a system return on investment that is impactful for our population.
- The primary care 'working together' framework is implemented to incentivise proactive care.
- Evidence based efficiency programmes will be delivered, underpinned by equality and health inequality impact assessments for all programmes.

Our Key Strategic Ambitions

We have established a Chief Executive Forum spanning the Integrated Care Board, Mid and South Essex NHS Foundation Trust, Essex Partnership University NHS Foundation Trust, North-East London Foundation NHS Trust and Provide Community Interest Company. The commitments outlined above have thus been agreed and recommended by the partner organisation's respective Chief Executive Officers before being adopted by the Integrated Care Board and provider Boards.

Over and above the commitments in the 2023/24 operational plan, and the delivery plans outlined in the appendices of this Joint Forward Plan, the Chief Executive Officers / Boards have committed to:

Improving Quality

Access, Experience and Outcomes

Why is this important

Our residents describe difficulties in accessing healthcare services.

Our regulators have placed enforcement and improvement actions on some of our providers.

Our clinical and professional leaders have a pivotal role in ensuring quality and we must support them to deliver the best quality services they can.

How will we do it

What we will do	When we will do it by
Use continuous improvement approaches within an overall quality management framework for all aspects of the system.	Ongoing
Deliver and sustain the 'must' and 'should do' actions, as identified by the Care Quality Commission regarding Mid and South Essex NHS Foundation Trust and Essex Partnership University NHS Foundation Trust, to improve quality of services for our population.	March 2024
Make required improvements to Maternity, Referral to Treatment and Cancer performance so that Undertakings are removed (Mid and South Essex NHS Foundation Trust)	September 2023
Improve in patient experience of primary care through integrated neighbourhood teams. Process evidenced by an improvement in National patient satisfaction survey outcomes by 15% (to 80%) by 2025 and 25% (to 90%) by 2027 from current values of median satisfaction scores of 65%.	2025 onwards

Health Inequalities

Our Common Endeavour – the NHS must play its part in reducing health inequalities

Why is this important

We know that existing health inequalities have been exacerbated by Covid, our integrated care strategy, adopted by all partners, has reducing health inequality as the unifying 'common endeavour'.

We must listen to the experience of individuals and communities regarding their experiences, and work with them to help us design support, together.

How will we do it

What we will do	When we will do it by
Working together with partners on the wider determinants of health, raising awareness of the important role that local authorities, voluntary and community, faith and social enterprise and communities play in prevention and early intervention and supporting new partnership approaches.	March 2024

Deliver our agreed plans in relation to Core20PLUS5 frameworks for adults and children with defined programmes for the most deprived populations, our plus groups (at local and system level) and the prescribed clinical areas.	March 2024
Further development of the Anchor Charter, and through the Integrated Care Partnership Outcomes Framework, demonstrate impact for our local population.	September 2023
Use experience-based co-design, learning from innovation, coproduction and data to understand frequent users of our services (health and care) – developing mechanisms to gather insights, through lived experience, to better understand and implement support needs	September 2023

Financial Sustainability

A collective commitment to live within our means.

Why is this important

As a system, we ended the 2022/23 financial year with a deficit of £46.4m. We worked collectively to deliver in-year financial improvement and we will continue to develop our plans as a system to deliver financial stability.

We are subject to increased regulatory financial scrutiny from our NHS England national and regional offices because of our position.

We must balance the need for financial sustainability with the need to innovate and invest in areas that require improvement and can demonstrate benefit for patients.

How will we do it

What we will do	When we will do it by
Commit to delivering improvements in productivity by understanding our system cost base and developing our clinical stewardship approach to support collective value-based decision-making.	April 2023 and ongoing
Deliver the action required to remove costs and increase efficiencies as a system, using benchmarking and local intelligence, acknowledging that efforts in one space may create benefit in another but as a system the ultimate benefit is to our residents.	April 2023 and ongoing

What we will do	When we will do it by
Agree and deliver a programme of corporate function consolidation across co-terminus partners, to offer best value to our population.	April 2023 and ongoing
Agree and deliver against trajectory for vacancy reduction (and concomitant reduction in bank and agency which will be stratified by speciality) through a dedicated programme of system-wide recruitment, retention and new role development.	April 2023 and ongoing
Accelerate our joined-up approach to Estates, as part of a system-wide Infrastructure Strategy, which will support efficient use of resources across the system.	April 2023 and ongoing
Consider opportunities presented through delegation of specialised commissioning including the exploration of more affordable care models, to offer best value to our population.	April 2023 and ongoing
Reduce the Integrated Care Boards running costs from £22m to £17.2m by April '25	1 April 2025

Operational Delivery

A commitment to improving our operational planning and delivery functions

Why is this important

Competing organisational needs and priorities, and differing levels of capacity and capability can distort operational delivery that is focussed on offering the best care to our patients.

Through benchmarking, we know that we can make improvements in productivity and access to services.

How will we do it

What we will do	When we will do it by
Initial demand and capacity model including whole system data (beds) developed to enable organisationally diagnostic decision-making.	April 2023 (initial)
Further enable demand and capacity modelling to support decisions on future community capacity (virtual and bedded) and operational / clinical interfaces.	May 2023

Consider, with partners, longer-term capacity requirements for care settings, to include health and social care settings.	July 2023
Identify a rolling programme of productivity improvements, including future service delivery models, aligned with tools such as Getting It Right First Time, Model Hospital.	April 2023 onwards

Supporting our Workforce

Recruit and retain the best staff, give local people opportunities to work across health and care services.

Why is this important

Current pipelines for professional staff across health and social care will not meet demand trajectories. We must commit to new roles and ways of working now, in order to see a difference by the end of this Joint Forward Plan period.

How will we do it

What we will do	When we will do it by
Develop a system-wide approach to workforce planning that is closely aligned to finance and activity planning.	March 2023
Through the planning round quantify the volume of enduring vacancies based upon the metrics of provider performance and the known opportunity within our undergraduate pipeline.	March 2023
Agree the volume of enduring vacancies that will be replaced with new roles in each organisation to include Training Nurse Associates, Advanced Clinical Practitioners, Physician Associate, enhanced Healthcare Support Workers roles and apprenticeships.	April 2023 onwards
Stratify our workforce hotspots by speciality and undertake focused intervention on recruitment, retention, transformation and staff wellbeing.	June 2023
Launch our Healthcare Support Worker academy as a ‘one workforce’ initiative which champions the recruitment, on boarding and education of new entrants to health and care. In addition, the academy will provide educational and Continued Professional Development opportunities, career coaching and mentorship to	June 2023

support, value and retain Healthcare Support Worker and map out career pathways into apprenticeship pathways across a range of professional groups including nursing, Advanced Health Practitioners and medicine.	

Let staff lead

Growing our stewards for the future

Widespread development of quality improvement and leadership skills

Why is this important

We know that we must enhance the capability and capacity of our clinical and professional staff to lead and engage with transformation activities across the Integrated Care System.

Not only will this ensure that services are forward focused and use the range of skills available to us, but it can also contribute to better satisfaction at work and enhance retention.

How will we do it

What we will do	When we will do it by
Delivery of agreed clinical stewardship training and development modules to enable formation of stewardship groups for all agreed care areas.	April 2023 and ongoing
Launch hosting arrangements to enable testing and implementation of stewardship of resources at the level of a whole care area level – with stroke care as the first pilot. Stewards and host organisation to work together on care area.	September 2023
Create the environment to support integrated, multi-organisational, multi-disciplinary working; Removing silo working and enabling person-focussed, asset-based thinking in the delivery of services.	Ongoing

Population health improvement

Focus on prevention, early intervention and targeted approaches.

Providing more personalised care that addresses existing health inequalities.

Measure what matters to our residents.

Why is this important

Traditionally the NHS has focused on treatment and curative activities. While we have, more recently concentrated on early identification and intervention, we recognise that we must play a full part, with our public health teams and wider partners, on prevention. Our Population Health Improvement Board will support both the Integrated Care Board and the Integrated Care Partnership to realise these ambitions.

Our Integrated Care Strategy outlined commitments, encapsulated in a series of “I” and “We” statements, which we fully adopt.

How will we do it

What we will do	When we will do it by
Over the course of this Joint Forward Plan, we commit to shifting resources to evidence-based upstream and preventative activities (described in detail in the appendices) using population health management information and benchmarking to determine the ambition.	March 2028
Full implementation of the personalised care framework.	March 2024
Refresh the Integrated Care Strategy Outcomes Framework and set medium and long-term ambitions for specific work programmes.	May 2023
Develop baseline and measures for the ‘I’ and ‘We’ statements from the Integrated Care Strategy and report these via the Integrated Care Partnership.	April 2023 onwards

Digital, Data and Technology

Gearing up our system to become more digitally enabled

Supporting our residents to use digital tools

Why is this important

We have historically struggled to join up our digital offer. We are making great progress in this area and recognise that we must involve patients and professionals in our future plans.

We have a poor data/business intelligence infrastructure and recognise the need to enable staff with these specialist skills to work together to join up our approach and ensure best data quality.

We will look to exploit opportunities to ensure health and care data is shared amongst professionals to enable improved decision-making and care provision for our residents.

We will look to empower residents to have better control and access to their own records.

How will we do it

What we will do	When we will do it by
Procure and install a single Electronic Patient Record across our main providers.	March 2025
Implement the Shared Care Record which is accessible to health and care partners.	June 2024
Continue to build our strategic data platform (Athena) to enable sharing of data to enhance population health improvement, planning and operational delivery.	Rolling programme
Work to create a virtual data/business intelligence team to enable resilience, learning and improve data quality and literacy.	March 2024
Implement an integrated digital patient interface for our residents.	March 2024
Through our local authority partners, increase the use of digital social care records.	Rolling programme
Improve our core infrastructure and access to services across partner organisations...	Rolling programme
Create a digital capability approach to support our professional workforce.	Rolling programme
Drive efficiencies and improved workflow through Robot Process Automation.	Rolling programme

Mobilising and Supporting Communities

The assets in our communities and supporting them to flourish

Why is this important

People/residents have told us, through the development of the Integrated Care Strategy, that they want to be involved, informed and supported to take responsibility for their own health and wellbeing and that of their loved ones. In return they want us

to be open and honest about the challenges we face, and enable them access to personalised, integrated services, close to where they live.

We recognise and appreciate that as NHS partners we need to improve our interaction with individuals and communities, building trust in our services and enabling people to self-care, support one another.

How will we do it

What we will do	When we will do it by
Develop a model/blueprint for Integrated neighbourhood teams categorising the service offer, staff model and interaction with our voluntary and community, faith and social enterprise against population need.	September 2023
Working with partners, develop an asset-based community development approach.	September 2023
Fully establish our Community and Voluntary Sector Assembly aligned to system and place through our alliances.	June 2023
Establish a partnership-based Co-Production and Engagement Steering Group to ensure effective planning, accountability and inclusion.	June 2023
Establish an influencer network to ensure we can diversify our approach to community building and engagement.	June 2023
Develop and implement an engagement impact framework to ensure efficacy and inclusion in our engagement approaches.	September 2023
Deliver an ongoing series of community conversations, workshops, seminars, and engagement activities, which draw together a much wider set of contributors into the work of our Integrated Care System.	June 2023 onwards
Grow our community campaign approach, develop a Human Library and Lived Experience network, which will ensure a better approach to immersive practice as a system.	June 2023
Develop a paired learning Leadership Programme with and for the voluntary and community, faith and social enterprise and our workforce.	December 2023

Improving our System Oversight Framework rating

Why is this important

Providers are subject to a range of interventions (from national and regional and the Care Quality Commission) – there is a risk this will impact provider, and potentially Integrated Care Board, System Oversight Framework ratings.

We are agreed as NHS partners that we would wish to remain within current System Oversight Framework ratings and be enabled to deliver our improvement plans.

How will we do it

What we will do	When we will do it by
Work with our regulators to ensure effective oversight and assurance of our collective activities.	March 2023 and ongoing

Research and Innovation

Bringing benefits for residents, staff and the local economy.

Why is this important

Research and innovation are integral parts of the NHS constitution and key enablers in driving improvements in clinical care.

We have an established track record of innovation – Mid and South Essex NHS Foundation Trust host national innovation schemes, and we have an Integrated Care System innovation fellowship programme. There are opportunities to build on this.

Research active organisations are beneficial for residents and staff alike – and have important benefits for the economy. We have the scale and scope to generate opportunities and maximise our research activity.

We should link these activities to a wider commercial strategy for the system.

How will we do it

What we will do	When we will do it by
Develop a system-wide research and innovation strategy that supports a culture of research and sets our ambition for research infrastructure, income and participation.	October 2023
Develop a commercial strategy for the system that enables us to build our approach to working with	Autumn 2023

industry partners, universities, University College London Partners (as our Academic Health Science Network partner) and research organisations.	

Further developing our system

Why is this important

We are committed to on-going development of our integrated care system.

How will we do it

What we will do	When we will do it by
The Community Collaborative will operate under a single contract (commencing in shadow form for 2023/24).	April 2023
The Community Collaborative will be part of the NHS England accelerator collaborative programme.	April 2023 – March 2024
Our mental health provider continues to operate as part of the specialist provider mental health collaborative.	April 2023 and ongoing
We are exploring a mental health collaborative approach across mid and south Essex.	September 2023
The Integrated Care Board will assume delegated pharmacy, optometry and dentistry commissioning responsibilities.	April 2023
Play a full part in delegation of specialist commissioning functions as defined by NHS England.	April 2024

Part 2 – Improving population health and reducing health inequalities

This is our first Joint Forward Plan. We have taken the approach of splitting our plan into our high level, collective ambitions (see Part 1) and in this Part 2 document, we have outlined the key enablers to deliver the NHS' contribution to the common endeavour outlined in our Integrated Care Strategy – to reduce health inequalities, together.

In preparing this Joint Forward Plan, we have had regard for the regulatory and statutory requirements, particularly the 2023/34 planning guidance, and the four key aims established for Integrated Care Systems:

- Improving outcomes in population health and health care.
- Tackling inequalities in outcomes, experience, and access.
- Enhancing productivity and value for money.
- Supporting broader social and economic development.

We have also had regard for the 'Triple Aim' established for NHS bodies that plan and commission services, requiring them to consider the effects of decisions on:

- The health and wellbeing of the people of England (including inequalities in that health and wellbeing).
- The quality of services provided or arranged by both themselves and other relevant bodies (including inequalities in benefits from those services).
- The sustainable and efficient use of resources by both themselves and other relevant bodies

Integrated Care

Although this is a plan for NHS organisations, we work closely with wider partners across the integrated care system.

Our partnership comprises the following partners:

Three top tier local authorities and **seven** district, borough and city councils

Over **149** GP practices, operating from over **200** sites, forming **27** Primary Care Networks

Three community and mental health service providers working as a community collaborative

Nine voluntary and community sector associations

One hospital trust with main sites in Southend, Basildon and Chelmsford

A range of other partners, including Essex Police, Fire and our three local universities

One ambulance trust

Three Healthwatch organisations

Our priority is to integrate services at every level:

Neighbourhoods - based around our primary care networks, we are working to develop **integrated neighbourhood teams** as the footprint for people to access support and care locally, be that through their own networks and communities, through contact with community and voluntary sector services, or statutory health and care services.

Alliances - where statutory and non-statutory partners are coming together in geographical areas to support asset-based approaches. Our four alliances are progressing in building relationships and partnerships locally and further detail can be found at **Appendix 1**.

System – working together through our Integrated Care Partnership, comprising partners including our upper tier local authorities, our district, borough and city Councils, community and voluntary sector organisations, universities and NHS partners.

The Importance of Local Delivery

The golden thread to our approach is to work with our local communities. Our alliances have made positive developments to link with residents and the voluntary and community, faith and social enterprise locally. Alliances take a lead role in delivering and coordinating work on health inequalities and prevention, using data to make evidence-based interventions, with a clear focus on the wider determinants of health. From an NHS perspective, a key deliverable is to make improvements in primary care and ensure local health services meet the needs of the local population.

Appendix 1 describes our local approach.

Stewardship

Stewardship is our vehicle for achieving the triple aim in mid and south Essex: improving the health and wellbeing of our population, improving the quality of our services, and using our resources efficiently and sustainably, whilst addressing existing inequalities within each of these.

The programme is based upon the work of Nobel Prize winner Elinor Ostrom, who studied the sustainable, equitable management of shared resources by the resource users. It applies her ground-breaking work to our health and care settings.

***Stewardship in mid and south Essex**: bringing 'resource-users' (frontline and back-office staff and residents) together within care areas to act as stewards – delivering the greatest value for residents from our pooled resources.*

Over the past two years we have developed significant, unique capacity via our cohort 1 stewardship groups (Ageing Well, Cancer, Cardiac care, Respiratory, Stroke and Urgent and Emergency Care). These groups have now begun to provide important leadership within their care areas, resulting in both tangible and intangible changes and improvements.

Selected highlights:

Cancer: With active support and encouragement from the Cancer Stewards, a new day zero Patient Tracker List approach was launched in November 2022. At that point there were around 1,000 patients waiting 62 days for a diagnosis after a General Practitioner referral. This has subsequently been reduced to 595 and is expected to be under 100 by March 2023. The day zero Patient Tracker List is a real game changer. The action-oriented strategy ensures patients who don't have cancer are appropriately and speedily informed and taken off cancer pathways, meaning those with cancer are quickly and appropriately directed to the correct service. The team's next focus is on prostate cancer pathways.

Ageing Well: Through the guidance and efforts of the Ageing Well Stewards, the mid and south Essex electronic frailty care coordination system register was designed, built and launched in April 2022. It now has more than 8,000 people with frailty and dementia added. This resource enables prioritisation and increased visibility of residents with frailty and complex needs for more seamless, proactive and effective care coordination between providers. The team have also championed the Frailty Consultant hotline, which now takes over 350 calls / month, and is associated with admission avoidance rates at 80%.

Challenges and areas for development

Role: Different groups have engaged in different mixes of strategic and operational work, influenced by group membership and care area needs. Awareness of stewardship and the groups is not currently widespread across the system at all levels.

Relationships: Tensions have occurred over relationships with existing transformational capacity, or where such capacity is lacking.

Resources: Whilst stewardship teams have been developed at a care area level, care area budgets remain unclear and accountability for resource management remains distributed by organisation. This has restricted stewards' opportunities, leading to a focus on service improvement within existing siloed budgets, rather than being able to meaningfully steward and help flex resources across settings for greater population benefit within their care area.

Opportunities:

- Stewardship positioned as a key enabler to achieve the triple aim, with hosting of whole care areas necessary to unlock further potential.
- System-wide communication of the vision of stewardship for whole system transformation rather than incremental improvement.
- Empowerment of stewardship groups to influence long term plans.

Through one of our own clinicians and National Clinical Lead for Innovation, Professor Tony Young, we continue to support in partnership Anglia Ruskin University deliver the world's largest and most successful workforce development programme focussing on clinical innovation. The NHS Clinical Entrepreneurship programme is now entering its 7th cohort with many of those successfully applying working within Mid and South Essex NHS Foundation Trust, and equally we have seen innovation adopted into our Trust because of connections made through NHS Clinical Entrepreneurship Programme.

Mid and South Essex innovation works closely with our local Academic Health Science Network University College London Partners, HealthTech Enterprise, Health Education England, and Accelerated Access Collaborative, local universities, as part of partnership working. Mid and South Essex Integrated Care System has achieved great successes with partners including Ford Motor Group for the Essex Covid Vax/Respiratory Van and British Heart Foundation for the BP@Home solutions.

One example of this that we have heard from local development strategies and health and wellbeing plans, "Mid and South Essex NHS Foundation Trust is a lead steering partner with Essex County Council and Basildon District Council to consider the feasibility of a Health and Social Care Innovation Incubator in the Basildon area. Citizens with innovative ideas would be supported to develop and grow, building on existing relationships with our universities, enterprise hubs, and local Industry partners to address the wider determinants of health through grass-roots innovation".

Further information on stewardship can be found at **Appendix 2**.

Improving Population Health

At the heart of our work is a desire to improve population health. We know that we can only do this by working in partnership with our local authority colleagues, with public health teams, professionals and residents themselves. To help guide our efforts and maintain accountability, we have established a **Mid and South Essex Population Health Improvement Board**. This brings together our partners to align our work on:

- Population Health Management
- Inequalities

- Prevention and early intervention
- Personalised care
- Anchor institutions

The Population Health Improvement Board has a dual line of reporting – to both the Mid and South Essex Integrated Care Partnership, to bring together the work around wider determinants of health; and to the Integrated Care Board, to drive improvements around specific healthcare priorities. The Population Health Improvement Board's programme has a broad remit which is summarised below.

To deliver our ambition the Population Heath Improvement Board will ensure that the needs of our population and existing health inequalities are understood and areas for intervention prioritised with an emphasis on moving prevention work upstream.

Reducing Health Inequalities – the Core20Plus5 Frameworks

Reducing health inequalities reflects both a core statutory duty that we share as NHS organisations, and also the central '**common endeavour'** from our integrated care strategy (Integrated Care Strategy link).

Within the NHS, we have prioritised our work around the Core20PLUS5framework for adults and children. This enables us to:

- Concentrate efforts on the **20% most deprived communities** within our ICS, as identified by the national Index of Multiple Deprivation.
- Identify and work with **'plus groups'**– communities that may experience poorer access to good health outcomes as a result of their characteristics – this includes, but is not limited to, black and minority ethnic residents, carers, people with living with a learning disability or some neurodiverse residents, people at risk of homelessness, veterans, gypsy, Roma and traveller groups, refugees, asylum seekers and migrants. We have identified these groups at both system and alliance level and targeted our engagement resources towards working with communities directly to understand their experiences and see how best we can support their health and care needs. Focus on a small number of **clinical conditions** –

Adults
Maternity
Severe Mental Illness
Chronic respiratory disease
Early cancer diagnosis
Hypertension case finding and lipid optimal management

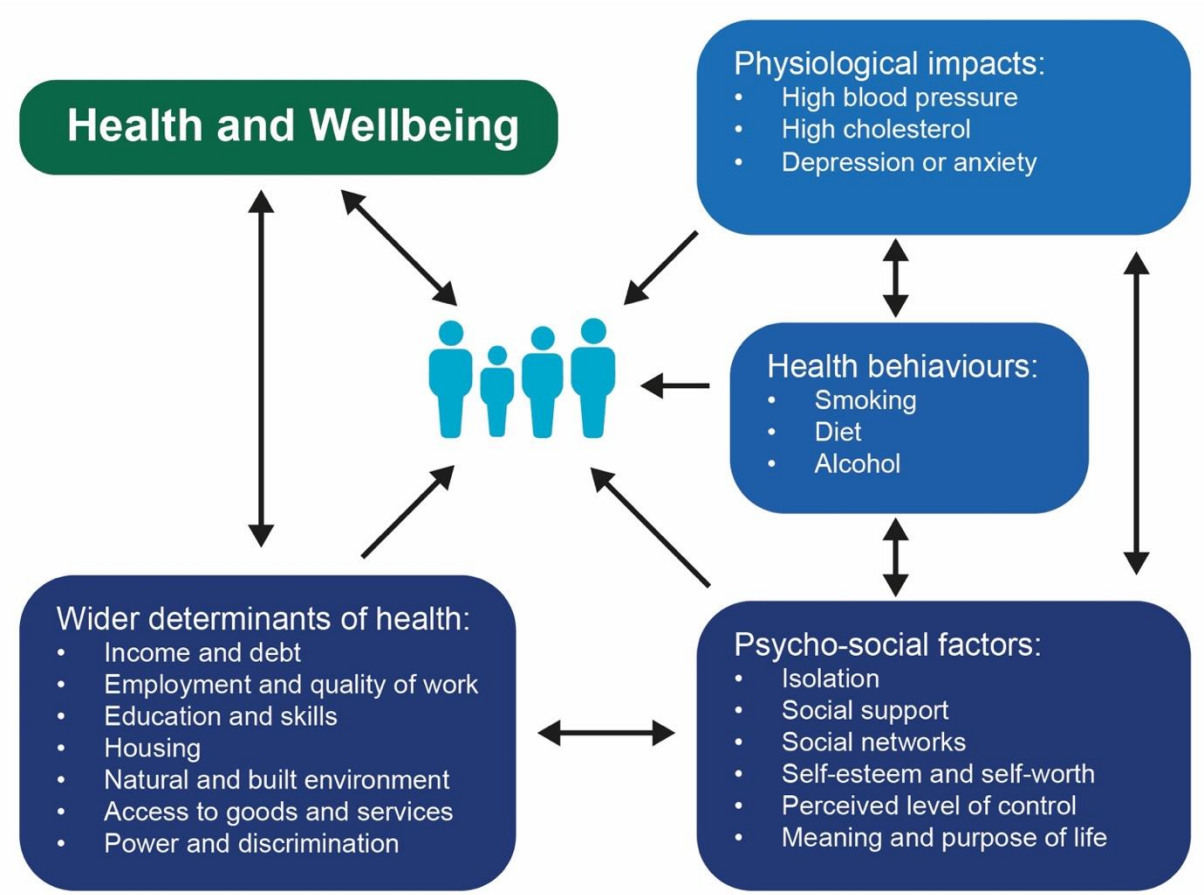
Children and Young People
Asthma
Diabetes
Epilepsy
Oral Health
Mental health

We recognise the need to embed a health inequalities approach to all of our work so that we think about this as a first principle in all that we do. We must therefore:

- Improve **data collection and reporting** to ensure improved completeness of recording regarding ethnicity, inclusion groups and other plus group status such carers to enable us to support these residents better.
- Continually review the **restoration and delivery of services** to ensure that at risk groups are not further disadvantaged.
- **Mitigate digital exclusion**, through adoption of our agreed digital exclusion principles, to support residents in accessing digital services through skills development.
- Embed the comprehensive use of **Health Inequalities Impact Assessments** with identified actions delivered.

The Mid and South Essex Integrated Care Strategy common endeavour of **Reducing inequalities** requires us to work together to create a broad and equal partnership of individuals, organisations and agencies, focussed on prevention and early intervention, to provide high-quality, joined-up health and care services, when and where people need them.

Reducing inequalities is a complex picture with no single action or single organisation able to have impact alone, it requires a sustained organised collaborative focus. The adapted Labonte model summarises the complex system that causes inequalities to thrive. It encapsulates the different factors that impact our health, where they stem from (the wider determinants of health), how they interact, multiply, reinforce and act both in sequence and simultaneously.



Our approach builds on the adapted Labonte model and reflects that interventions must focus on 'treating' the environment and place and not just people, as acting on only one factor is likely to provide a partial and incomplete response to the situation.

Through the Population Health Improvement Board, we will:

- Deliver a series of deep dives bringing together partners to take a holistic view of need and provision for specific Plus groups.
- Improve the identification and data recording for Plus groups to take a data driven approach to identify current gaps and inequalities.
- Collaborate with partners to map community assets

Case Studies

There are already examples of good practice within the system which we learn and build upon including:

- 'Southend the Southend Integrated care for Homeless' programme link
- 'Understanding Inequality project', run in partnership by Mid and South Essex NHS Foundation Trust and Healthwatch Essex involving people with learning disabilities to improve to access and experiences of hospital services (Understanding Inequality Project link)https://www.understanding-inequalities.ac.uk/
- Building on the success of the COVID vaccination and testing sessions arranged during the pandemic, a programme of health outreach sessions is underway for Gypsies, Roma, Travellers and Showmen who are in Thurrock. This has involved partners such as Thurrock Council, Essex Partnership University NHS Foundation Trust, North-East London NHS Foundation Trust, Inclusion Visions, one local General Practitioner practice and Thurrock CVS. It is known that there are many people living on the sites with a range of health conditions, including: people who fell under the definition of Clinically Extremely Vulnerable during the COVID-19 pandemic; older persons with mobility issues; individuals registered with Long Term Conditions; and a likely greater number whose health conditions are not registered
- Mid and South Essex Anchor programme supporting people living in some of the most deprived areas of Southend to secure quality work at Southend Hospital or in another local health or care organisations (MSE Anchor programme link)
- 'Core20plus Connectors programme' focusing on chronic obstructive pulmonary disease and working within the six most deprived wards in Southend. (Southend Core20plus Connectors Programme link)
- Improving health and digital literacy for those in most deprived wards in Thurrock by working with library teams who already support volunteers to deliver digital skills training to residents. (Improving Health and Digital Literacy in Thurrock link)
- Utilising the 'Outreach bus' 'to visit deprived areas in Canvey to increase hypertension case finding, cancer screening and vaccination uptake, health and wellbeing advice and onward referral thus increasing contact with appropriate services and alleviating loneliness and increasing wellbeing.

- The Mid and South Essex Integrated Care System has been successful in becoming one of seven Integrated Care System Core20PLUS accelerator sites and a Core20PLUS Connectors site.
- Through our community engagement programme, we will listen, engage and co-produce future interventions.

Case Study – Children's Oral Health

This group is overseen by the Children and Young People Growing Well Board and has representation from key partner organisations across the Integrated Care System.

The Child Oral Health Inequalities Steering Group has sent out key objectives to drive collaborative action to toward reducing Children and Young People oral health inequalities. The identified principles of these actions will be:

- Identify areas for improvement in reducing oral health inequalities across mid and south Essex
- Inform and influence wider system Children and Young People policies and programs which would improve child oral health
- Identify opportunities to implement oral health prevention strategies into current children and young people workstreams
- Mapping of current child oral health prevention activities across mid and south Essex and identify gaps for improvement
- Use a data informed approach to drive preventative activities in those areas of highest need
- Inform the wider system on sustainable action to reduce oral health inequalities

Using the Core20PLUS5 we have identified our priority PLUS groups as Special Educational Needs and Disability, Looked After Children, Deprivation, Refugees, Asylum Seekers and Migrants; to deliver targeted preventative actions. In addition to preventative actions, we are working with commissioners to increase access to dental services. This has included identification of dentists prioritising access for Looked After Children.

Waiting list analysis has been undertaken for those children under 10 currently on elective general anaesthetic waiting lists within Mid and South Essex NHS Foundation Trust. Complete analysis will be extended to included waiting list data from Community Dental Services. Trends identified will inform an action plan to mitigate disparities identified.

Implementation of a supervised toothbrushing program in partnership with Community Dental Services is being rolled out to 20 pilot sites in areas of deprivation within Southend and Basildon. It is expected that on evaluation this will be scaled up to further sites across mid and south Essex. Further planning is in progress to increase the delivery of targeted interventions which support families and children to adopt positive oral health behaviours.

Case Study:

The approach undertaken by Mid and South Essex Foundation NHS Trust to review and deliver action plans that begin to address inequalities seen in their waiting list when viewed by ethnicity, age, area of deprivation is being adopted more widely by community services. This will become a rolling programme of work.

Health Inequalities Funding

As part of our commitment to health inequalities, the Health Inequalities Funding is committed recurrently to deliver improved outcomes for the population of mid and south Essex. In 2022/23 the NHS invested £3.9m to support innovative partnership solutions around the Core20PLUS5 priorities that were identified as meeting local needs by our four alliances. The range of projects that were supported include:

Basildon and Brentwood Alliance

- Child oral health
- Transition from primary to secondary schools in deprived areas
- Physical activity schemes supporting Core20 and specific plus groups
- Social prescriber for children and families in areas of high deprivation
- Young people employment opportunities from most deprived areas
- Supporting those affected by dementia

Mid Essex Alliance

- Young Carer support and their family members
- Pilot Chronic Obstructive Pulmonary Disease patient education
- Outreach within traveller communities and Severe Mental Illness health checks
- Extending transport services for those unable to attend clinic appointments
- Men's Mental health
- Outreach clinics in warm spaces
- Sensory inequalities ambassador

South East Essex Alliance

- Cardiovascular disease case finding and alleviating system flow pressures
- Loneliness and improving access to service
- Suicide prevention
- Veterans' mental health and access to services
- Family and childhood mental health and resilience
- Focus on mental health through the green agenda
- Dental access for deprived and the young

Thurrock Alliance

- Obesity transformation
- Lifestyle risk management through motivational interviewing
- Workplace Health Champions to provide smoking cessation
- Gypsy, Roma, Traveller and Showman communities improving access to health services
- Thurrock's homeless communities improving access to health services
- Health and digital literacy
- Enhancing safeguarding, health and mental wellbeing for vulnerable young people and young parents

The Integrated Care System has commissioned the University of Essex as an evaluation partner to provide a framework and evaluation tools to assess outcomes from these investments. The Framework with the tools will be available Quarter 1 2023/24 and we are expecting evaluation of the projects to be completed by the end March 2024. A lesson learnt exercise will inform the future approach to the deployment of the funding to ensure that it supports addressing those with the greatest need.

Health Inequalities research

We will work with our university partners to ensure that we are developing our health inequalities approach based on the latest research evidence. There are two specific multi-disciplinary and multi-stakeholder partnership projects that are forthcoming in 2023/24:

- 'Innovate' a project to improve mental health and wellbeing by mobilising community assets to tackle health inequalities
- Building a community of practice to identify barriers and priorities and solutions to the right of access to healthcare for travelling communities.

A focus on Prevention

The NHS Long Term Plan has a strong focus on the treatment and prevention of illness by supporting patients to adopt improved healthy behaviours. We are taking forward the specific commitments set out in the NHS Long Term Plan whilst, through the work of the Integrated Care System Stewardship groups, ensuring a focus on prevention across broader NHS activities.

We continue to work in collaboration with our local authority partners and their funded services to deliver joined up and seamless approaches to prevention.

We will adopt a framework for the clinical priority area that considers the upstream pathway interventions to reduce risky lifestyle behaviours and the contribution that the wider determinants of health have on preventing ill health.

The work of Population Health Improvement Board recognises that the frameworks under development as part of the community strategy and stewardship programmes will feed into the alliance-based approach.

Our Initial Prevention Priorities

In 2023/24 we are focusing on a prevention work programme, through interim financial support from NHS England. This has enabled focus on three areas which are proven to be most impactful to prevent a variety of conditions and ill health.

Cardiovascular Disease

Cardiovascular disease is one of the leading causes of premature death. Hypertension is the biggest risk factor for cardiovascular disease and is the second top risk factor for all premature death and disability in mid and south Essex. Through the establishment of the Cardiology Programme Board there will be a focus on delivering the following prevention activities in relation to cardiovascular disease:

- **BP@home** – continue with the successful roll out of the national pilot of recruiting over 59,000 residents to test out how residents can improve their health outcomes through the self-monitoring, by expanding the scheme working alongside our community pharmacists and through integration into relevant clinical pathways such as renal. The ambition is to have over 75,000 residents monitoring their blood pressure by end of March 2024 with community schemes in place in areas where health inequalities are most prevalent.
- K**ardia AliveCor** – maximise the use of these mobile heart monitors that allows individuals to detect, monitor and manage heart arrhythmias with automatic analysis, located in General Practitioner surgeries, community centres and on our outreach bus. We are anticipating that the National Institute for Health and Care Excellence will publish guidance during 2023/24, following completion of the Digital Technology Assessment Criteria, that supports the use of Kardia AliveCor mobile device for detecting atrial fibrillation. We will therefore look to further adopt this technology as part of an integrated prevention approach during 2024/25.
- **Innovation for Health Inequalities Programme** - expand the mobile unit (outreach bus) to a targeted core20PLUS5 population, to include broader cardiovascular disease risk assessment and management (including arterial fibrillation, blood pressure, cholesterol, smoking) by developing trusted communication to reduce inequality of healthcare provision to this group. This programme will commence in Quarter 1 2023/24 with an outcome assessment completed by the end of the 2023/24 financial year.
- **Community Pharmacy Hypertension Case finding** – increase identification and diagnosis of hypertension by Community Pharmacy to improve outcomes and reach people who may not attend general practice, by doubling the number of individuals that have a blood pressure check at their Community Pharmacy by 2024/25.
- **University College London Partners Proactive care framework** – roll out the adoption of the framework following the Primary Care Network pilot based on risk stratification and prioritisation of atrial fibrillation, blood pressure, cholesterol and type 2 diabetes to optimise treatment early in those with greatest need. During Quarter 1 2023/24 we will review the outcomes from

Phase 1 pilot, phase 2 roll out will commence Quarter 2 with the scheme being available to all Primary Care Networks by the end of 2023/24.

- **Financial framework** – implementation of a primary care transformation support scheme to support a holistic approach to implementation of a cardiovascular disease prevention scheme in 2023/24.

Healthy Weight

In 2020/21 nearly two thirds of adults in mid and south Essex were overweight or obese and are at increased risk of heart and circulatory diseases like heart attacks, strokes and vascular dementia.

Together with our local authority partners, we are working with an industry partner to transform and integrate Tier 2 and Tier 3 weight management services. We aim over the next two years to:

- Commission a smoother, more personalised patient experience of weight management services, accessible to an increased proportion of the eligible population, with reduced hurdles and barriers to accessing support and treatment
- Deliver a clearer, more outcomes-focused evaluation framework, to understand impact on individual, population and system outcomes, including impact on inequalities.

Adopt shared accountability across the health and care system for weight management outcomes

We will continue to promote and ensure that the ***Digital weight management service*** is offered to those adults living with obesity who also have a diagnosis of diabetes, hypertension or both. Alongside encouraging the uptake of ***the Enhanced service specification for weight management*** by primary care.

Tobacco Dependency

Treating tobacco dependence is specifically identified as a key service that can improve the prevention of avoidable illness. The NHS long term plan commits to providing NHS-funded tobacco treatment to all patients admitted to hospital and pregnant women by 2023/24.

We have already commenced recruitment of Healthy Hospital Managers and Smoking Cessation Support works to support the new smoke-free pregnancy pathway. In 2023/24 additional workforce will be recruited to enable all those admitted to our hospitals or specialist mental health services will be offered NHS funded tobacco treatment services. Along with developing further integration with Community Pharmacy providers as part of the delivery of the ***Community Pharmacy Advanced Service*** Specification - NHS Smoking Cessation Service.

Innovative partnerships with industry

We will continue to explore industry partnerships, focused on providing care for patients with type II diabetes within mid and south Essex, enabling a financial model which will immediately allow type 2 diabetes patients to access the proven outcomes of Diabetes Digital Media's Health's low carb diet diabetes management programme.

Future areas of focus

- We will look to undertake focused work to support improved pathways and service models in:
- ***Antimicrobial resistance*** - support implementation and delivery of the NHS plan's five-year action plan (March 24)
- ***Alcohol*** – explore the learnings from those Integrated Care Systems with Specialist Alcohol Care Teams and work in partnership with our local authorities to improve access and outcomes (April-Sept 24)
- ***Making Every Contact Count*** – building on the lessons learnt from the Covid vaccination programme and the subsequent use of the mobile unit to outreach into seldom heard communities we will expand the approach across the four alliance areas (23/24)
- ***Children and Young People*** – within the Growing Well Board agenda there is a significant focus upon prevention programmes of work, we will look to ensure that an all age and family holistic approach can be taken to preventing ill health (23/24)

Enabling Improvements in Population Health

Our clinical and professional teams work across the system to transform and improve health services every day. There are a number of critical enabling activities that support their work:

- Population Health Management – *see* ***Appendix 2***
- Workforce and Clinical Leadership – *see* ***Appendix 3***
- Estates – *see* ***Appendix 4***
- Finance – *see* ***Appendix 5***
- Digital and data – *see* ***Appendix 6***

Improving Operational Performance

Our teams work incredibly hard to deliver safe and effective care, every day. We know, however, that many of our services are not currently meeting the requirements of the NHS Constitution, and we experience challenges in delivering high quality care consistently.

Our plans to improve services can be found at **Appendix 7**.

Supporting System Development

Our statutory arrangements under the Health and Care Act 2022 are new and developing. **Appendix 8** of this plan describes our governance arrangements and the steps we are taking on new duties such as the Integrated Care Strategy Green Plan, duties in relation to Violence and Aggression against Women and Girls.

Part 3 – Delivery Plans

In a series of appendices, this part of the Joint Forward Plan provides our plans to deliver on NHS Long Term Plan commitments and statutory duties placed on the NHS.

Appendix 1 – Local Delivery

Within this section you will find long term plans relating to our alliances, Primary Care and the development of Integrated Neighbourhood Teams:

- Basildon and Brentwood Alliance
- Thurrock Alliance
- South-East Essex Alliance
- Mid Essex Alliance
- Primary care and integrated neighbourhood teams
- Primary care digital access
- Developing our community services

Basildon and Brentwood Alliance

What have our residents told us?

Our partners from Healthwatch and Achieve, Thrive, Flourish have provided valuable insights into the views of our residents. There is currently an Asset Mapping exercise being undertaken which will provide further insight and it is imperative that we use the information gathered and ensure there is increased engagement going forward.

Current Conditions

Population size and demographics

Basildon and Brentwood have a General Practitioner registered population of 279,000 and a very mixed demography of very affluent areas alongside some of the most deprived wards in the country. There are areas of high-density housing as well as low density rural communities. It is anticipated that by 2037 the overall population will have grown by 18% with those aged over 65 growing by 61%.

Health Inequalities

Across the Basildon and Brentwood area there are 48,217 people living in the 20% most deprived areas in England, which amounts to 17% of our total population, the highest across mid and south Essex. Life expectancy for males and females is higher than the national average in Brentwood but lower in Basildon. Additionally, in Basildon there is a 10-year difference in life expectancy between the least and most deprived areas.

Using the Core20Plus5 framework has helped to understand our local challenges and aligned to our Live Well strategy will help to address these health inequalities.

Local population health data indicates that cancer, circulatory disease, and respiratory disease prevention should be our areas of focus.

Smoking prevalence among people with a long-term mental health condition is relatively high amongst comparators and increasing in both Basildon and Brentwood.

Physical activity amongst children and young people is relatively high but low for adults in Basildon.

The suicide rate and emergency hospital admissions for intentional self-harm has been increasing in Basildon and Brentwood overall with relative rates in Brentwood the highest in Essex.

Obesity in children in Basildon is relatively high and continues to increase, whilst levels of obesity in adults across both Basildon and Brentwood are high and increasing.

Workforce:

The average number of patients per General Practitioner is high in the area.

There are high numbers of vacancies across all sectors of health and social care.

Whilst additional staff have been recruited through the Additional Roles Reimbursement Scheme, recruitment and retention is an ongoing issue.

Similarly, recruitment and retention issues exist in the care sector.

As an alliance there is a great opportunity to work together, promote our assets such as jointly appointed posts, training and development and make this an area where staff want to come and work.

Estate:

Many of our surgeries are now struggling to accommodate additional staff because of lack of space.

Our current estate across health and care is generally old and does not support our ambition to integrate health and care.

As an alliance we are investigating the potential to share space and progress innovative solutions to overcome current constraints as well as pursuing opportunities for new builds.

What is the requirement from the NHS?

Over the next five years the Basildon and Brentwood Alliance will lead on a significant transformation journey, reducing health inequalities and addressing the wider determinants of health, underpinned by an ethos of partnership working and cultural change. We will focus on proactive care and prevention so that our residents live longer healthier lives.

Our Ambition

Basildon and Brentwood Alliance have recently been re-established with a wide range of partner organisations committed to working together to tackle health inequalities and the wider determinants of health. To achieve this, partners have signed up to a Live Well strategy that comprises of six domains (Start Well, Feel Well, Be Well, Stay Well, Age Well and Die Well) that cover the entire life course of our residents. This will be the key strategy over the next five years with a distributed leadership model supporting domain leads from all partner organisations. We will use an Outcome Based Accountability process to design and monitor strategies relating to this work and ensure common language and understanding between partners.

The development of integrated neighbourhood teams will be the foundation of our work, and these will enable health, social care, and voluntary sector organisations to work collaboratively at local level using an asset-based approach to deliver the strategy. Our voluntary sector and its continued growth is key to our ambition and it is therefore essential that as an alliance we support and strengthen this asset.

We will be outcomes driven and prioritise our combined efforts by using reliable population data, shared across all sectors as well as the local intelligence of our workforce and residents. We will develop, shared training and development, joint posts across sectors and will also share estate to improve efficiency and further cement relationships and a collaborative culture with partners. Existing funding mechanisms such as the Better Care Fund will be used effectively and strategically in areas where there is the greatest level of inequality, and we will build upon this to develop additional areas of pooled resource.

The alliance will build upon the legacy of the 2012 London Olympics, funding through Sport England local delivery pilot via Active Essex and the subsequent Find Your Active Basildon and Brentwood, initiatives to give our residents and workforce multiple opportunities to increase the amount of physical activity they undertake. Sport is a non-judgemental medium and that has enabled communities to think differently about their wellbeing and embedded a culture change within the local system leadership that supports the wider alliance ambitions. All our General Practitioner practices will be Active Practices and all our residents will be able to access an activity that suits their ability, preference and circumstances.

Delivery priorities:

- Stabilising and developing primary care
- Developing integrated neighbourhood teams
- Supporting urgent and episodic care
- Prevention
- Communication with residents
- All of the above to be underpinned by Live Well strategy

Ensuring Delivery:

Senior Responsible Owner: Pam Green
Clinical Lead: Dr Boye Tayo

The Alliance Committee was re-established in 2022 and is Chaired by the Alliance Director. The delivery priorities listed were agreed through this committee, and sub committees are in place or being developed to support delivery. These include Alliance Executive, Clinical and Professional, Health Inequalities, Voluntary Sector, Operations and Resilience, Domains, and Integrated Teams. Membership is broad

and committees will be led by the most appropriate organisations. Each subgroup will feed back into the Alliance Committee to ensure delivery.

The Committee has approved an Asset Mapping commission that will focus the alliance on available resource as well as highlight gaps that will need to be addressed if we are to make positive change

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Provide Outcome Based Accountability training for Domain Leads and other key stakeholders	Quarter 1 2023/24
Embed the Live Well Strategy and six domains across the alliance through workshops and domain lead meetings	From Quarter 1 – Quarter 4 2023/24
Six Integrated Neighbourhood Teams established	1st INT live in Quarter 1 2023-24 Roll out plan for all 6 to be established by Quarter 1 2024/25
Each Primary Care Network to have established Active Practices	Quarter 4 2023/24
Health Inequalities plan developed, and key priorities approved by Alliance Committee	Quarter four 2023/24
Maximise resources to increase sustainability of primary care in line with Fuller report	Quarter three 2023/24
Create a shared Estate plan between partners and maximise resources	Quarter 4 2023/24
Create best practice guides for new practice roles (using First Contact Practitioners as start point) to promote communities of practice and improved understanding	Quarter 3 2023/24
Alliance Plan to be discussed, developed and finalised at Alliance Committee	Quarter 3 2023/24

Thurrock Alliance

What have our residents told us?

Residents have told us that access to General Practitioner services in Thurrock is 'patchy', and in some instances very difficult. Travel around the borough is not easy, especially for older and disabled residents which makes getting to appointments a challenge.

Current conditions:

Within the borough of Thurrock there are 27 General Practitioner practices comprising 4 Primary Care Networks. The population of Thurrock (2021 Census) is 178,000. Key facts:

- Thurrock is the second most under-doctored area in England
- 40% of children at year 6 are overweight in Thurrock
- 21,271 Thurrock residents are in the core 20 Plus 5 categories (11%)
- Overweight or obesity in adults sits at 70%
- The deaths of 2,522 Thurrock residents were directly attributable to socioeconomic inequality Between 2003 and 2018

As well as demographic and health inequality challenges, there are some key problems which are limiting quality improvement efforts:

Workforce

Nursing vacancies in two of our key local providers – Mid and South Essex NHS Foundation Trust and Essex Partnership University NHS Foundation Trust – stand at 12 – 13%, and retention of Additional Roles Reimbursement Scheme roles in primary care is becoming an increasing challenge due to a lack of career progression opportunities.

Data quality and lack of effective business intelligence

This prevents us driving quality improvement and targeting resources in the most effective way.

Estates

The general state of the estate in Thurrock is poor, with a large number of primary care sites in need of significant modernisation/upgrade.

What is the requirement from the NHS?

Health, social care, and voluntary sector will be organised so operational delivery will happen collaboratively at neighbourhood level. Connected, integrated

neighbourhood models will be the mechanism for ensuring support is coordinated, anticipatory, and personalised to the needs of the individual. Using the Human Learning System model of personalisation and change management.

Our ambitions:

By 2025, the Thurrock Alliance aims to have fully delivered the implementation plan from the Better Care Together Thurrock Strategy for all residents in the borough.

The Better Care Fund, and any other delegated finances, will be used strategically to ensure resources are targeted to those areas where they can be most impactful in addressing health inequalities. The Thurrock Better Care Fund will be reviewed during the latter part of the 2023/24 financial year, working with Thurrock Council and the Local Government Association, delivering an agreed focus of expenditure to tackle the common areas of the Mid and South Essex Integrated Care Strategy, the Thurrock Health and Wellbeing Board Strategy and the Better Care Together Thurrock Implementation plan.

Our work will be underpinned by reliable and timely data, competently triangulated with local intelligence from our residents and workforce. Key priorities will be identified through targeted discovery phases focused on enquiry questions, for example, how does poor housing impact on the respiratory health of residents in our Core20 wards?

The alliance is currently developing its five-year strategy, with a 2023/24 action plan to drive and monitor progress.

Delivery Priorities

A focus on health inequalities delivered through neighbourhood models. The opportunities to respond to these challenges must focus on the Fuller Stocktake framework of addressing:

- Urgent and episodic care
- Complex care
- Prevention

Developing Primary Care

The alliance is driving forward the Primary Care Network Accelerator Programme to support the development of Clinical Strategies and the creation of Multi-Morbidity Hubs across the borough.

The General Practitioner Fellowship Scheme has been established to support development within the body of doctors in the borough.

Clinical Leads have been recruited to support the Alliance Clinical Director in delivering targeted support to primary care for specific condition management.

Supporting Urgent and Episodic Care

We are working with local providers on a number of initiatives which will address increased demand over the winter months, whilst embedding sustainable improvements, including

- Targeting improvements in vaccination uptake for both Covid and Flu
- Targeted prevention to reduce falls is being explored with the falls provider (North-East London NHS Foundation Trust)
- Understanding the needs of High Intensity Users and developing alternative support mechanisms
- Social Prescribing Review to begin in Quarter 4 (2022/23) to develop learning networks
- Continuance of the Acute Respiratory Hub to June 2023 to reduce Emergency Department attendances

Developing relationships between Primary and Secondary Care

Deep dives to gather intelligence are underway with practices with higher Emergency Department attendances to strengthen relationships between primary and secondary care. Open dialogue between clinicians across both settings to explore alternative solutions to support their population out of hospital.

In future, where appropriate and in line with the local population's digital literacy, there will be a suite of digital offers to support people to manage their own health and wellbeing. We will adopt system-wide technology, and work with our residents to test and implement in ways that meet their needs. This has already begun in relation to weight management.

Ensuring Delivery

Senior Responsible Owner: Aleksandra Mecan
Clinical Lead: Dr Manjeet Sharma

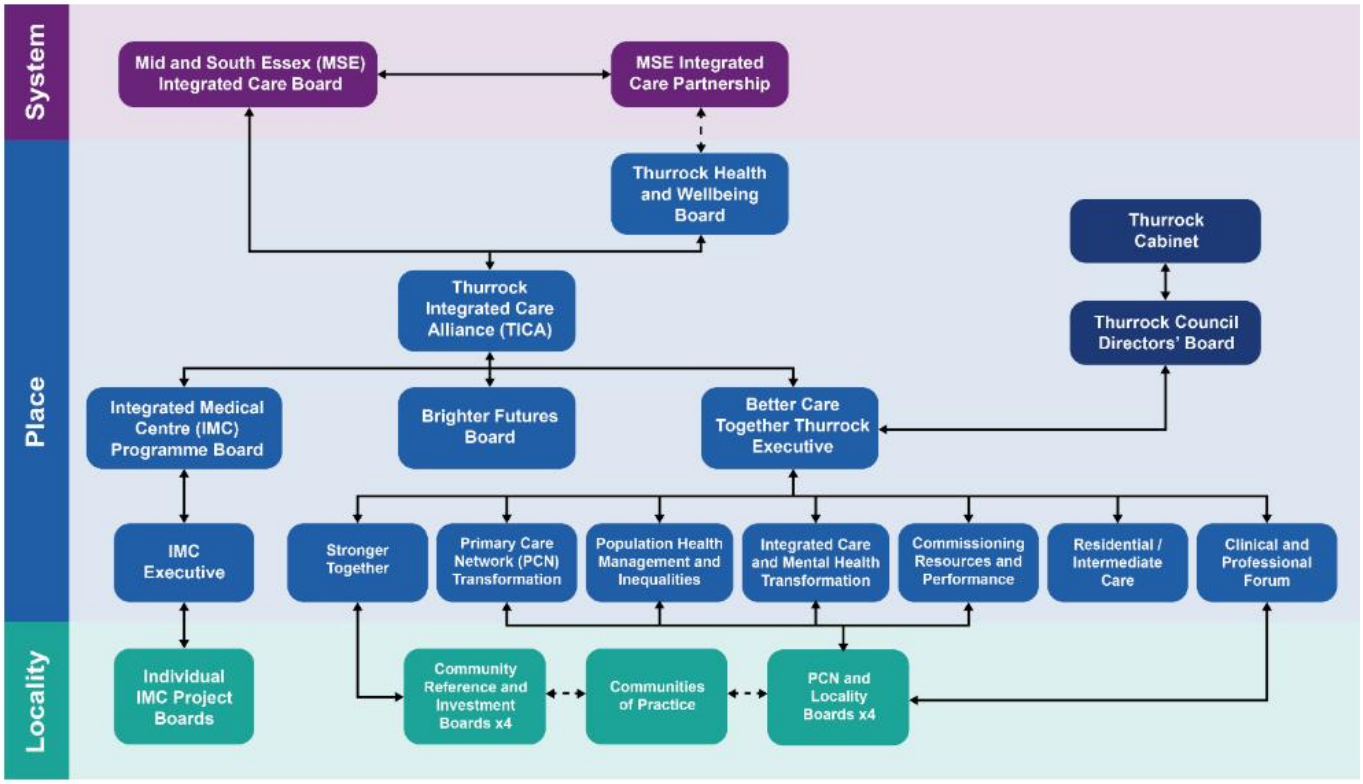
The Thurrock Alliance has spent much of 2022 on a development journey, with the explicit aim to build a clear purpose and a sense of trust. The governance structure is now signed off, but in the interim significant amounts of work have been done to deliver the Better Care Together Thurrock Implementation plan. Alliance team members are now identified to lead or contribute to local working groups that report to the Thurrock Integrated Care Alliance Board, which is directly linked to Thurrock Health and Well Being Board and the Integrated Care Board Board.

Local Governance architecture in Thurrock

Through the Health Overview and Scrutiny Committee, and the Better Care Together Thurrock Executive/Thurrock Integrated Care Board, the alliance achieves a degree of public and political scrutiny, and we are committed to building a strong and meaningful rapport with our residents. Through the use of the Human Learning System (personalisation) model, we are working with residents and partner organisations to deliver a radical change to service provision. This will become the basis of all work with residents as we move forward.

Our residents and voluntary sector are valuable assets and as an alliance we are committed to meeting them where they are – in their neighbourhoods. This outreach approach aims to deepen our understanding of the lived experience of people in Thurrock.

The below shows the System governance structure.



Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Fuller stocktake supporting and developing primary care	From quarter one to quarter four 2023/24

Delivery Plan objectives	Timespan for implementation of objectives
Standardising access to primary care across borough for all residents	From quarter one to quarter four 2023/24
Increase covid vaccinations rates and flu immunisation	From quarter one to quarter four 2023/24
Increase targeted prevention to reduce falls increasing effectiveness of strength and balance programme	From quarter one to quarter four 2023/24
Assess and identify alternatives for high intensity users	From quarter one to quarter four 2023/24
Provide alternatives for frequent General Practitioner attenders, this is the subject of a Human Learning System experiment (this work will continue throughout 2023/24)	From quarter one to quarter four 2023/24
Create social prescribing learning networks and new social prescriber opportunities	From quarter one to quarter four 2023/24
Ongoing resident engagement across borough based on the Human Learning System approach which test assumptions. The approach is refined based on engagement with residents (these activities will continue throughout the year)	From quarter one to quarter two 2023/24
Supporting General Practitioner fellowship enhanced service increasing numbers of specialist General Practitioners	From quarter one to quarter four 2023/24. Achieve four of 12 by Quarter four.
Deliver carers matrix across Thurrock with targeted actions throughout the year	From quarter one to quarter four 2023/24
Build on Serious Mental Illness/Learning Disability health checks ensuring residents equitably supported (target improvement rates for Serious Mental Illness/Learning Disability cumulative totals)	From quarter one to quarter four 2023/24

South-East Essex Alliance

What have our residents told us?

At recent conversations with residents at the Healthwatch community assembly we heard that residents are frustrated with the pace of change and that they would like to feel improvements. There was appreciation for the comprehensive, unbiased, and inclusive community and resident engagement we led in Shoebury to identify the preferred site for the new Health and Wellbeing Hub.

From May 2023, we will be strengthening relationships through neighbourhood-level conversations. Initially, these will be led by the alliance team, but we will be supporting them to become self-governing in 18-24 months. Insights from these conversations will inform further iterations of the Alliance Plan, and we will collectively develop improvement projects with residents.

Co-production of solutions in our neighbourhoods

We will ensure the voice of residents is heard by spending time with local people to listen to their valued experiences, creating a feedback loop that is neighbourhood based.

This will be achieved by:

- A regular meeting held in each neighbourhood which will create a space to listen and work in collaboration.
- Community conversations with "experts by experience voice"(i.e. people who have lived experience of conditions and services).
- Co-produced solutions, story-telling and inviting feedback and opportunities to collaborate
- Utilising data and insights to strengthen the story
- Ensuring work is fed back through the neighbourhood meetings and the alliance.

Current Conditions

Across South-East Essex there are 58,818 people living in the 20% most deprived areas in England, which amounts to 15% of our total population. With this level of deprivation, in combination with an ageing population, we are experiencing greater numbers of people presenting with complex long-term needs, poor mental health, leading to a population with poorer disability-free life expectancy.

In order to understand our local challenges, the South East Essex Alliance adopts the CORE20plus5 framework. Local population need analysis suggests that frailty, mental health and obesity are driving demand for services. In addition, our local community engagement work, has shown there are low levels of awareness of self-

awareness of self-care tools and pharmacies which can provide an alternative to GP or hospital services.

As well as demographic and health inequality challenges, there are some key problems which are limiting quality improvement efforts:

Workforce:

Nursing vacancies in two of our key local providers – Mid and South Essex NHS Foundation Trust and Essex Partnership University NHS Foundation Trust – stand at 12 – 13%, and retention of Additional Roles Reimbursement Scheme roles in primary care is becoming an increasing challenge due to a lack of career progression opportunities.

Data quality and lack of effective business intelligence:

This prevents us driving quality improvement and targeting resources in the most effective way.

Estate:

We currently do not have the right size or type of space both within the hospital or to support the development of our integrated neighbourhood teams or other primary and community services. In addition, significant areas of South East Essex are at serious risk of flooding due to climate change.

What is the requirement from the NHS?

By 2028, the South East Essex Alliance aims to have fully aligned its committee and partnership members, and member organisations, in the common endeavour of tackling health inequalities across the entire life course of our residents, pre-birth to death.

Our Ambitions

Health, social care, and voluntary sector will be organised so operational delivery will happen collaboratively at neighbourhood level. Connected, integrated neighbourhood models – such as Primary Care Network-aligned community teams – will be the mechanism for ensuring support is coordinated, anticipatory, and personalised to the needs of the individual.

The Better Care Fund, and any other delegated finances, will be used strategically to ensure resources are targeted across South East Essex to those areas where they can be most impactful in addressing health inequalities.

Our work will be underpinned by reliable and timely data, competently triangulated with local intelligence from our residents and workforce. Key priorities will be identified through targeted discovery phases focused on enquiry questions, for example, how does poor housing impact on the respiratory health of residents in our Core20 wards.

The alliance is currently developing its five-year strategy, with a 2023/24 action plan to drive and monitor progress. As the South East Essex Alliance spans two Local Authorities, we have a particular challenge to blend existing health and wellbeing

frameworks into consistent and meaningful strategic architecture within which the alliance can operate successfully. It is a testament to our alliance members that we already have initiatives in place that span these boundaries and deliver benefit to our collective population.

Delivery Priorities

A focus on health inequalities delivered through neighbourhood models. The opportunities to respond to these challenges must focus on the Fuller Stocktake framework of addressing:

- Urgent and episodic care
- Complex care
- Prevention

Developing Primary Care

The mechanism for delivery is through neighbourhood models. Primary care is already beginning to work in an integrated way with community health, mental health, social care, and the voluntary sector. We are working with all partners to develop Primary Care Network clinical strategies to further embed integrated ways of working. The Primary Care Network Aligned Community Team model lends itself to supporting any cohort of a Primary Care Network population which presents with complex needs where multi-agency support can be coordinated to effectively safety-net the individual to stay safely in their home.

Supporting Urgent and Episodic Care

We are working with local providers on a number of initiatives which will address increased demand over the winter months, whilst embedding sustainable improvements, including

- Improving vaccination uptake
- Targeted prevention to reduce falls
- Understanding the needs of High Intensity Users and developing alternative support mechanisms
- Supported and informed the development of a framework to optimise deployment of volunteers in the emergency department
- Social Prescribing in our local Urgent Treatment centre

Developing relationships between Primary and Secondary Care

- Deep dives to gather intelligence are underway with practices with higher Emergency Department attendances to strengthen relationships between primary and secondary care. Open dialogue between clinicians across both settings to explore alternative solutions to support their population out of hospital.
- Exchanges - Clinicians from primary care and the acute shadowing each other to deepen understanding of respective knowledge and pressures.

In future, where appropriate and in line with the local population's digital literacy, there will be a suite of digital offers to support people to manage their own health and wellbeing. We will adopt system-wide technology, and work with our residents to test and implement in ways that meet their needs.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Establish eight Primary Care Network-aligned community teams models as part of the development of integrated neighbourhood teams in South-East Essex	First half of 2024/25
Apply evaluation framework based on the triple value ethos and apply to at least two workstreams	Quarter four 2023/24
Develop a South-East Essex communication network - led by community partners Southend Association of Voluntary Services	Quarter one 2023/24
Moving mental health First Response provision into the neighbourhood delivery model - phased implementation with delivery in one Primary Care Network, but scoped for all	Quarter three 2023/24
Develop a change model for implementing Frailty End-of-Life Dementia Assessment (FrEDA) tool - place-based adoption of the system-wide anticipatory and personalisation approach	Quarter four 2023/24
Develop a coordinated approach to tackling obesity in South East Essex, taking an asset-based approach	First half of 2024/25
Implement integrated primary care paediatric asthma nurses, with the asthma team aligned to all 8 South East-Essex Primary Care Networks	Quarter three 2023/24

Mid Essex Alliance

What have our residents told us?

Listening to our residents is at the heart of all we do within the mid Essex alliance. We have worked with Healthwatch Essex to engage residents across a wide range of geographies, demographic characteristics and seldom heard communities. Healthwatch have helped us hear from communities such as veterans, those with sensory impairment, lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual as well as other minority communities.

The overwhelming message from our communities is to 'Build on what's strong, not what's wrong' and this has become something of a mantra for the mid Essex Alliance. It drives our approach to Asset Based Community Development or Asset Based Community Development.

Our populations have informed a number of our key priorities. In terms of our NHS, we know that access to services, especially primary care, is at the forefront of resident concerns. Likewise, diagnosis rates of dementia and support to those with autism spectrum disorder and learning disabilities are also of concern to our public.

Wider afield, our public tell us they are concerned over the well-being of children and young people, more so since the pandemic. Childhood obesity rates, the mental health of children and young people and managing childhood illness all feature prominently in conversations with our public.

Finally, tackling the high suicide rates amongst our population is a significant priority for us. Many of our communities have been sadly impacted by suicide so it remains a common theme we hear

Current Conditions

Population size and demographics:

Today's population size of nearly 403,000 people in mid Essex is projected to increase to almost 418,000 by 2030, and almost 440,000 by 2043. Within this, the over 70 age group will see the largest increase – 14% by 2030 and 40% over the next twenty years. With female and male life expectancy in mid Essex higher compared to the England average, this large increase in population size and ageing demographic will see an increase in demand for health and care services. This will be further compounded by an increase in the complexity of care required, a high prevalence of ill health and lifestyle factors that negatively impact on overall health and wellbeing.

Health inequalities:

There are 5,236 people in mid Essex live in the lowest deprivation decile – 1% of the total population. Within this, there are clear challenges, e.g., high smoking rates in the most deprived areas of Braintree and Maldon, and poorer uptake of flu vaccinations.

By more broadly applying the national CORE20PLUS5 framework to support understanding and management of health inequalities, data indicates that the greatest impact in mid Essex could be achieved by focusing on cardiovascular disease, cancer and respiratory prevention.

Workforce:

Whilst there has been very good progress in recruitment to roles within primary care, it should be noted that we now have 35 (25 Full Time Equivalents) fewer General Practitioner Partners working in Mid Essex than in 2015. The loss of General Practitioner Partners has mainly been offset by a rise in salaried General Practitioners and more General Practitioner trainees entering the system. However, around one third of General Practitioners, nursing and administrative staff in primary care are over 55 years, a figure that is above the national average, presenting a risk for a surge in retirement from those staff groups.

Furthermore, a fragmented approach to employment across health and social care increases artificial competition, reduces flexibility and limits opportunities for career progression, impacting on recruitment and retention.

Data and Information:

Limitations around data sharing provides a challenge to meaningful integration of partners to deliver care differently. Poor data quality inhibits ability to inform decision making and understand impact.

Geography and Estate:

Mid Essex has large areas of rurality, making efficient service delivery and access to care more challenging. Clinical estate is limited and, in order to manage immediate demands, may not be prioritised for the development of integrated neighbourhood teams. Even though a more flexible approach that considers alternative settings for care and the use of technology may alleviate some pressures, there is a need for a comprehensive, all-partner plan for ensuring the right type of estate to deliver agreed priorities.

What is the requirement from the NHS?

Over the next five years, the Mid Essex Alliance will further strengthen and develop its partnership approach to jointly understand and address wider determinants of

health, enabling a shift in focus from reactive care to proactive and preventative early intervention.

Our ambitions

There will be an emphasis on enabling the wider community to maximise local knowledge through active participation in the design and delivery of sustainable health and wellbeing interventions. Health inequalities will be better understood, and services will be developed to effectively address inequity, supporting the most disadvantaged in our communities to improve their quality of life. Integrated neighbourhood teams (consisting of health, social care and voluntary sector partners) will provide a bespoke, flexible vehicle for delivery, removing artificial divides between organisations and instilling a united 'one team' approach that considers each individual and their unique needs.

Delivery Priorities

Health Inequalities:

Utilise data and 'soft intelligence' to work with partners to shape priorities and design interventions that will see a reduction in health inequalities. Jointly design an outcomes-based framework that will articulate a common vision and ensure efforts are focused on the most in need.

Asset Based Community Development:

Embedding Asset Based Community Development will be the standard approach across the alliance, building on assets that are found in the community and mobilising individuals, associations, and institutions to come together to realise and develop their strengths, ensuring widespread community awareness of all assets and building support networks from the ground up.

Develop primary care and build Integrated Neighbourhood Teams:

Implement recommendations from the Fuller report to effectively deliver urgent/episodic and complex care, and support prevention. Enable development of Primary Care Networks as the preferred primary care delivery model, supporting sustainability and providing the basis for integration with community health, mental health, social care and the voluntary sector as a cohesive, fully functioning integrated team that designs and delivers local population health management through Integrated Neighbourhood Teams.

Support Integrated Care System and national priorities:

Utilise local knowledge and networks to support delivery of broader priorities such as cancer screening, referral to treatment times and winter resilience.

Ensuring Delivery

Senior Responsible Owner: Dan Doherty
Clinical Lead: Dr Matthew Sweeting

The alliance membership currently meets as a formally recognised group, Chaired by the Integrated Care Board Alliance Director. Membership extends beyond traditional boundaries of health and social care, including wider system partners. To date, key achievements through this partnership include successful distribution of funding to support health inequalities schemes, and a collaborative approach to producing a single outcomes framework with shared deliverables and accountability. The alliance also participated in the Place Development Programme in 2022, lessons from which will inform further thinking around the alliance approach, alliance development and governance arrangements.

Early in 2023, members will consider ongoing governance options. This is likely to include the introduction of additional sub-groups, each focussing on defined alliance priorities that drive forward the overall strategic vision. Two further sub-groups – finance and data/Business Intelligence – will hold responsibility as enabling functions. Membership of all groups will be broad but determined by the area of focus, with 'leadership' of each group assigned to the most appropriate partner organisation, reflecting the equitable nature of an integrated care system approach. Careful consideration will be given as to how the 'citizen voice' will be meaningfully included across all tiers of governance.

The aforementioned Alliance Outcomes Framework will shape alliance priorities and governance structures, and, through ongoing reporting of progress, will provide a key indicator of delivery towards the long-term vision. This will be complemented by an appropriate level of programme management oversight.

District Health and Wellbeing Boards feed into the alliance, ensuring a two-way communication channel that values local insight and influence.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Review alliance governance arrangements and establish model able to provide strategic direction/oversight as well as operational delivery	Quarter two 2023/24
Agree approach to ensuring 'citizen voice' is heard and able to contribute to alliance priorities and plans	From quarter one to quarter two 2023/24
Partners design a joint outcomes-based framework, building on population health data, alliance priorities and emphasising collective responsibility for delivery	From quarter one to quarter two 2023/24

Delivery Plan objectives	Timespan for implementation of objectives
Establish mechanism for reporting against agreed outcomes and commence monitoring	Quarter two 2023/24
Promote Asset Based Community Development training across partners, identifying local 'champions' to ensure wider buy-in and cultural change	From quarter two to quarter three 2023/24
Develop Integrated Neighbourhood Teams: project governance established. Alliance partners jointly determine geographical footprint, model, strategy and timeline for roll out.	Quarter two 2023/24
Pilot Integrated Neighbourhood Teams commence	From quarter two to quarter four 2023/24
Evaluation of pilot Integrated Neighbourhood Team sites	From quarter four 2023/24 to first half of 2024/25
Wider roll out of additional Integrated Neighbourhood Team sites	From quarter four 2023/24 to first half of 2024/25
Local networks and knowledge deployed to support delivery of Integrated Care System and national priorities (e.g., screening uptake, Learning Disability health checks and dementia diagnosis), with clear support plan developed	From quarter one 2023/24 to 2025/28

Transforming Primary Care

What have our residents told us?

Patients value primary care services and primary care delivers in excess of 80% of all patient interactions with the NHS.

Patient experience of primary care services has fallen following the Covid pandemic. mid and south Essex has amongst the lowest overall satisfaction with primary care services in our region and nationally.

Current Conditions

Primary Care is currently experiencing significant challenges on a number of fronts.

Workforce - Nationally and locally, there is a reducing number of General Practitioners working within primary care. This issue is further compounded by existing low levels of General Practitioners compared to peer systems. We have an ageing profile of General Practitioners and practice nurses within mid and south Essex.

Demand – Demand upon primary care services has increased over recent years and whilst overall capacity has increased, demand often outstrips available capacity. Unmet demand in other parts of the system e.g., acute long-term follow-ups have an inevitable impact on primary care as patients seek alternative clinical input. The result is that satisfaction with primary care access has fallen.

What is the requirement from the NHS?

Primary care is required to work with local partners in integrated neighbourhood teams, delivering the three types of care set out in the Fuller Stocktake.

Our Ambitions

To align the collective workforce and assets around the needs of our local populations to provide:

- A system wide approach to Urgent and Episodic Care to improve same day care for patients and ensure sustainability for practices
- An integrated neighbourhood team approach to Complex Care Management which is more psychosocial in its approach to supporting holistic health and wellbeing
- Interventions to improve Preventative Care on a primary and secondary prevention basis using analytics and population health approaches.
- prevention basis using analytics and population health approaches.

Delivery Priorities

Strategically, Mid and South Essex Integrated Care Board will implement a transformation programme that will, over 3-5 years, enable Integrated Neighbourhood Teams across our system to deliver Urgent and Episodic Care, Complex Care and Preventative Care.

This will be delivered through bottom-up transformation led by our alliances, supported by system enablers.

There are two national specific requirements within the national planning guidance for 2023/24;

- Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024
- Continue to recruit 26,000 Additional Roles Reimbursement Scheme roles by the end of March 2024
- In addition, there is a requirement to “Make it easier for people to contact a General Practitioner practice, including by supporting general practice to ensure that everyone who needs an appointment with their General Practitioner practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need”

We are anticipating further guidance (due March 23) from NHS England that sets out requirements from Integrated Care Boards in regard to the Recovery of Access to Primary Care Services.

Ensuring Delivery

Senior Responsible Owner: Dr Anna Davey
Clinical Lead: Dr Anna Davey

Primary Care reports through to the Integrated Care Board via the Primary Care Commissioning Committee (a formal subgroup of the Integrated Care Board). This meets on a monthly basis and receives regular reports on Quality, Workforce, Finance, Estates, and Digital. In addition, the Primary Care Commissioning Committee makes decisions on key contractual matters and where required the operational implementation of primary care transformation.

To support the delivery of our Integrated Neighbourhood Team Vision, we will establish a new Oversight Group and refocus our existing Development and Delivery Group. A standard set of Integrated Neighbourhood Team principles and a delivery framework will be co-developed alongside the alliances. This will provide the standardised vision and expectations. More locally alliances will work alongside their

forming Integrated Neighbourhood Team colleagues to localise the delivery from the bottom up to ensure initial priorities are formed around their neighbourhood needs.

The programme is likely to require additional transformation resource in order to deliver within the expected timeframe.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Agreeing Vision for Integrated Neighbourhood Teams	Quarter one 2023/24
Implementing Phase One of our Integrated Neighbourhood Team Working Together Scheme	Quarter one 2023/24
Primary Care Networks mobilising priorities within their Clinical Models e.g., Primary Care Network Aligned Community Team approach	From quarter one to quarter four 2023/24
Development of Model for Urgent and Episodic Care	From quarter one to quarter two 2023/24
Development of Road Map for long term Integrated Neighbourhood Teams	From quarter two to quarter three 2023/24
Review and align our strategic and operational approach to estates, data and workforce to underpin implementation of our Integrated Neighbourhood Teams	From quarter one to quarter two 2023/24
Design and deliver engagement programme with providers to prepare for delivery of 2024/25 national contract changes	From quarter three 2023/24 to first half of 2024/25

Digital Access to Primary Care

What have our residents told us?

Residents tell us that access to primary care is challenging in part driven by increased demand and in part by the traditional model for accessing primary care services which centres on calling practices first thing in the morning.

Current Conditions

Different digital services are offered to and by General Practitioner practices and other avenues of care are not socialised or properly developed.

Pathways are not efficient as information is not shared across care settings often resulting in additional contacts with primary care clinicians to enable completion of tasks.

The full capabilities of the existing technology are not fully exploited, and many applications and systems have been deployed to primary care with little business change, implementation or training. The use of technology varies by service and is often dependant on costs or clinical perception.

Nationally, the new General Practitioner contract settlement (23/24) and the as yet to be published Access plan place significant onus on improving the use of digital technologies to improve the user and workforce experience.

What is the requirement from the NHS?

NHS Long Term Plan:

- By 2023/24 every patient in England will be able to access a digital first primary care offer Section 1.43. Digital technology will provide convenient ways for patients to access advice and care.
- Digital NHS ‘front door ‘including advice, symptom checking, telephone and video consultations. Supporting remote monitoring of conditions. Online resources to support Mental Health and recovery.

Fuller Stocktake:

- Better align Demand with Capacity
- Improve the telephone journey,
- Improve the online journey
- Enhance triage and care navigation
- Better manage practice workload

Our Ambitions

To provide a digital environment that delivers the flexibility demanded by a modern multi agency service. The formation of Locality services will see a range of clinical services offered by many different providers from the same location.

The digital environment should be an enabler to optimise the quality of care provided. There should be a consistent access model across modes of entry to ensure the right care at the right time at the right place.

Delivery Priorities

We will look to deliver improvements in access and drive efficiencies working with our Integrated Care System partners and wider regional organisations, focusing on a number of key areas:

- Providing applications and digital services to support the following:
    - Expanding the role of community pharmacy and making patient records available to be both read and written to.
    - Making it easier for patients to contact their practice to make an appointment and access other services via Telephone, Web, App and other routes
    - Cutting bureaucracy and unnecessary workload within a practice such as delivering the on-line registration of new patients
    - Building Capacity where most needed by the use of business intelligence

Ensuring Delivery

Integrated Care System Senior Responsible Owner: William Guy
Integrated Care System Programme Lead: Alex Hemming
Chief Clinical Information Officer: Dr Taz Syed

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
NHS App integration with People Know Best	Quarter two 2023/24
Prospective record access for all patients by 31/10/23	Quarter three 2023/24
Successful implementation of access improvement plans by 31/03/24	Quarter four 2023/24
General Practitioner Online registrations in all practices	Quarter four 2023/24
General Practitioner practice website procurement and rollout	Quarter four 2023/24

Delivery Plan objectives	Timespan for implementation of objectives
Development of Primary Care Network System1 hubs and their interaction with integrated neighbourhood teams	Quarter four 2023/24
Digital champion programme to support residents in the use of digital tools to interact with primary care	Quarter four 2023/24
Digitisation of all Lloyd George records in primary care	First half of 2024/25
All practices to be on cloud-based telephony system by end of 2025 (Note: this deadline may be brought forward)	Second half of 2024/25

Developing our Community Services

What have our residents told us?

Residents/Patients have been engaged in the redesign of Community services and the following themes have been consistent:

- Community services should be delivered locally as possible
- Teams should work together to offer seamless provision without the need for people to tell story multiple times.
- To be supported in their own home where possible
- Consistent service offer removing any postcode lottery

Current Challenges

Community services act as the glue between primary and acute care, so pressure experienced in either sector has an effect on community services. In recent times there have been 3 significant challenges for Community services to contend with

- **COVID-19** - With staff having to work in very different ways or being redeployed from their usual services (and those temporarily suspended) and directed to support the response to the pandemic. This has taken a toll on staff but has also created increased waiting times to access community services.
- **Urgent and Emergency Care** - Community services play a significant part in providing urgent and emergency care with a focus on admission avoidance and ensuring people receive high quality urgent care at home where clinically safe and appropriate. Community services are also instrumental in supporting discharge. Urgent and emergency care in mid and south Essex has been under incredible sustained pressure which has directed capacity and focus away from preventative and routine work with the subsequent impact on service provision.
- **Workforce** - As alluded to in the sections above the workforce toll due to the Covid-19 pandemic and the sustained pressure from urgent and emergency care cannot be underestimated.

What is the requirement from the NHS?

National NHS planning objectives 2023/24

- Consistently meet or exceed the 70% 2-hour urgent community response standard

- Reduce unnecessary General Practitioner appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals

Our Ambitions

To deliver best in class community health and care services to the residents of mid and south Essex.

Community health teams play a vital role in supporting people with complex health and care needs to live independently in their own home for as long as possible. Many services involve partnership working across health and social care teams, made up of a wide variety of professionals including General Practitioners, community nurses, allied health professionals, district nurses, mental health nurses, therapists and social care workers

in line with the NHS Long Term Plan our ambitions are to:

- shift more care from hospital to the community
- bring together different professionals to coordinate care
- help more people to live independently at home for longer
- develop more rapid community response teams to prevent unnecessary hospital spells and speed up discharges home
- upgrade NHS staff support to people living in care homes
- improve the recognition of carers and support they receive
- make further progress on care for people with dementia
- give more people more say about the care they receive and where they receive it, particularly towards the end of their lives

Delivery Priorities

We will build on the established Mid and South Essex Community Collaborative as the main delivery vehicle to drive the improvements in community service provision. We have aligned the delivery priorities for Community services with the vision to integrate, innovate and improve

Integrate

- Through alliances we will transform community health services so that services are aligned with neighbourhoods that make sense to communities, and we will ensure that our local community health service workforce forms an integral part of each integrated neighbourhood team.
- Work with system partners, residents and patients to design, produce and implement integrated intermediate care services that optimise independence

- Standardise delivery of community services where it makes sense to do so. Service areas include:
  - Adult Speech and Language Services
  - Diabetes
  - Children and Young People (Autism Spectrum Disorder)
  - Virtual Wards (Respiratory and Frailty) and Community Beds
  - Urgent Care Response Team
  - Stroke
  - Wheelchairs

Innovate

- Introduce and optimise technologies and innovations to drive efficiency and productivity and release clinical time to be patient facing – introduce dictation software, route planning and optimise the use of Whzan and raiser chairs in care settings and virtual wards including remote monitoring

Improve

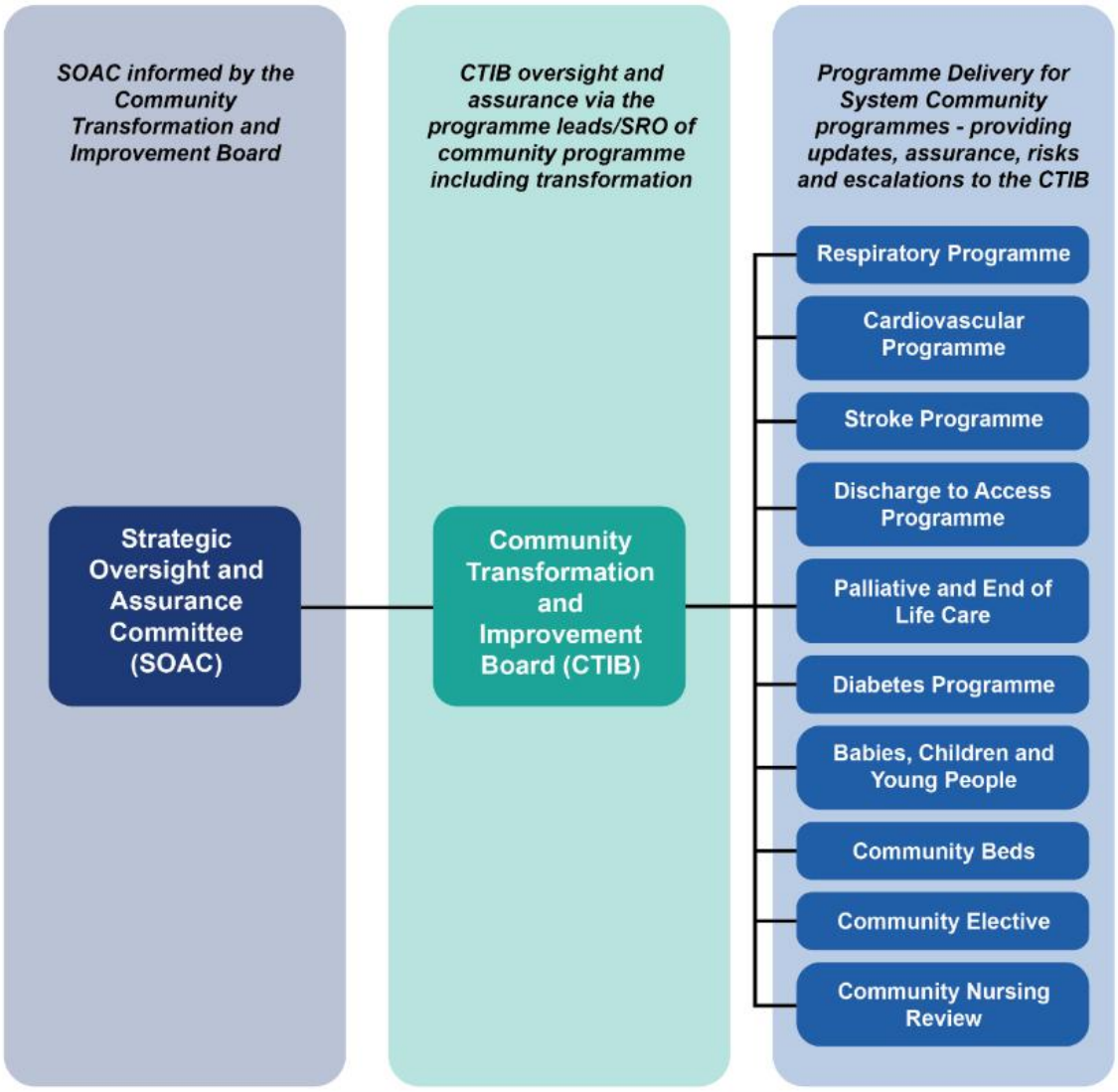
- Optimise efficiency and effectiveness of Virtual wards
- Ensure compliance with zero 65 week waits for community services by March 2024
- Introduce self-referral to falls response services, musculoskeletal services, audiology-including hearing aid provision, weight management services, community podiatry, and wheelchair and community equipment services.
- Continue to improve the offer and identification for carers through 6 monthly coordination of place and system carers maturity matrix

As part of forming the architecture for the future we will recontract the community collaborative to create the conditions for improving, integrating and innovating community services, together

Ensuring Delivery

Senior Responsible Owner: Gerdalize du Toit
Clinical Lead: Dr Sarah Zaidi

The Community Transformation and Improvement Board will oversee the transformation, recovery, and performance of the community workstreams and is a subcommittee of the System Oversight and Assurance Committee.



Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
480 virtual hospital beds in place by Dec 23	Quarter three 2023/24
Reduce long waits to less than 65wks	Quarter four 2023/24
Reduce long waits to less than 52wks	Second half of 2024/25
Design and implement new integrated intermediate service	Quarter three 2023/24
Standardise delivery of community Services	Quarter four 2023/24
Support the design, deployment, and delivery of Integrated Neighbourhood teams	From quarter one 2023/24 to the first half of 2024/25
Introduce and optimise technologies and innovations to release clinical time	Quarter four 2023/24

Delivery Plan objectives	Timespan for implementation of objectives
Reach mature on all eight domains of the Carers Maturity matrix	2025/2028
Establish longer term commissioning arrangements for the Community collaborative	From quarter three to quarter four 2023/24

Appendix 2 – Improving Population Health

Within this section you will find long term plans relating to:

- Population Health Improvement Board
- Personalised Care
- Population Health Management
- Stewardship
- Innovation

Population Health Improvement Board

What have our residents told us?

From extensive engagement with residents across the system and more locally through our alliances, we hear that residents feel that things need to change. All understand that improving the health and care of people in mid and south Essex requires a re-balancing of our activities towards prevention, early intervention and anticipatory care.

Current conditions

Reducing inequalities is a complex picture with no single action or single organisation able to achieve this in isolation. Reducing inequalities requires a sustained, organised, collaborative focus. The adapted Labonte model summarises the complex system that causes inequalities to thrive. It encapsulates the different factors that impact our health, where they stem from (the wider determinants of health), how they interact, multiply, reinforce and act both in sequence and simultaneously.

What is the requirement from the NHS?

Our Integrated Care Strategy has a shared common endeavour of **reducing inequalities** which reflects our desire to work together to eliminate avoidable health and care inequalities by creating a broad and equal partnership of individuals, organisations and agencies, focussing on prevention and early intervention and providing high-quality, joined-up health and care services, when and where people need them.

Our ambitions

Our ambition is to eliminate avoidable health and care inequalities by focusing on prevention, early intervention and providing high-quality, joined-up health and social care services, when and where people need them.

We have established a Mid and South Essex Integrated Care Strategy Population Health Improvement Board to drive an integrated approach to inequalities improvement. This board brings together the programmes of work across the Integrated Care System on Health Inequalities, Population Health Management, Prevention, Personalised Care and the Anchor Programme and the work of the Children and Young People's Growing Well Board.

Delivery Priorities

We have adopted the national NHS 'Core20PLUS5' framework to prioritise work on reducing health inequalities, focusing on:

- Most deprived 20% of the national population
- Plus groups those that experience poorer health outcomes. We have thus far identified Black and Minority Ethnic groups, Carers, People with Learning Disabilities, people experiencing Homelessness, Gypsy, Roma and Traveller and Showmen communities, veterans.
- Five clinical areas of focus:

Adults focus

Maternity
People with Serious Mental Illness
Early Cancer diagnosis
Chronic Respiratory Disease
Cardiovascular disease with focus on Hypertension

Children and young people focus

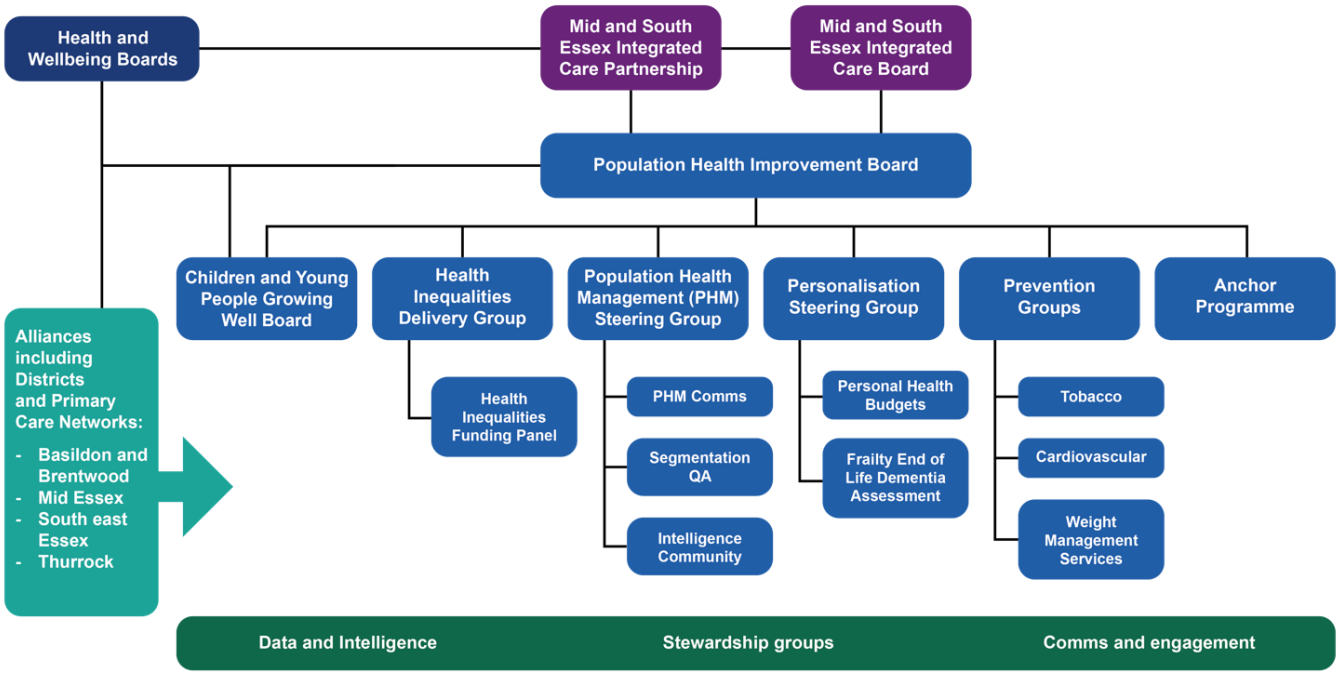
Asthma
Diabetes
Epilepsy
Oral Health
Mental Health

- The delivery priorities are to ensure equitable access by:
- Embedding system wide adoption of Health Inequalities Impact Assessments utilising a digital tool, together with system development approach of co-designing of services with residents, engaging with those from vulnerable groups.
- Improved data collection and reporting to ensure improved completeness of recording regarding ethnicity, inclusion groups and other groups such as carers
- Continually reviewing the restoration and delivery of services to ensure that at risk groups are not further disadvantaged. A rolling programme will address inequalities seen in waiting lists when viewed by ethnicity, age, area of deprivation.

- Working with system partners to mitigate digital exclusion, through adoption of our agreed digital exclusion principles, to support residents in accessing digital services through skills development.
- Development of a financial framework that adopts principle of proportionate universalism to deliver at scale services that are proportionate to the needs of our population

Ensuring Delivery

Senior Responsible Owner: Jo Cripps



Clinical Leads: Dr Sophia Morris (Health inequalities), Luke Tandy (Population Health Management), Dr Anita Pereira (Personalised Care) and Dr Peter Scolding (Prevention)

The Population Health Improvement Board will develop an outcomes framework linked to the integrated care strategy that will track whether we are making a difference. The key outcomes will include:

- improving healthy life expectancy
- narrowing the gap between the most and least deprived areas
- reducing the proportion of our population that are obese and the number that smoke
- increasing healthy lifestyle behaviours such as physical activity
- diagnosing cancers at an earlier stage

- equitable access to services measured across waiting lists, health checks, screening and vaccination uptake

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Deliver Population Health Improvement Board and Health inequalities dashboard to monitor outcomes and impact that reflects Integrated Care Partnership Strategy	Quarter two 2023/24
Health inequalities funding for 2023/24 prioritised and implementation commenced	Quarter three 2023/24
Evaluate the outcomes from 2022/23 Health Inequalities Funding	Quarter three 2023/24
Financial strategy development to support Population Health Improvement Board priorities around health inequalities and prevention investment including confirming partner contributions	First half of 2024/25
Organisational development support to embedding equality mindset including development and delivery of Integrated Care Strategy Wide Health Inequalities Impact Assessment Digital Tool and Equality Delivery System	Quarter four 2023/24

Personalised Care

What have residents told us?

Shared Decision making is a key component of the comprehensive model of personalised care and brings together residents and clinicians in equal partnership to make decisions. Many of our residents want to be involved in shared decision-making conversations to have more choice and control over their care.

As part of a co-production empowerment campaign a baseline survey of over 600 residents concluded that:

- 70% of people understand what is meant by Shared Decision Making
- 80% of residents stated they want to participate and would find handy prompt questions useful

Current Conditions

Working with the National Institute of Health Research, a behavioural science research study has been conducted, that tells us the prevalence, enablers, and challenges for practitioners to adopt Shared Decision Making in routine practice. The study reveals that:

- > 40% of professionals incorporate Shared Decision Making in over 75% of their conversations with people
- 45% of professionals are confident in holding Shared Decision-Making conversations
- 40% of professionals stated that time is a constraint to undertaking good Shared Decision-Making conversations and to do more in practice
- 75% of professionals agreed that focussed training in Shared Decision-Making skills will help improve conversations.

What is the requirement from the NHS?

The NHS Long Term Plan commits to making Personalised Care business as usual reaching 2.5 million people by March 2024.

The comprehensive model for personalised care comprises of six components that provides a framework of evidence-based principles, tools and resources for whole population, universal and targeted interventions.

The model provides the conditions for relationships between residents and professionals to respond to population health management intelligence of the rising complexity of needs and wider determinants of health by starting with a collaborative Shared Decision-Making process to address disparities in outcomes, access, and experience.

Our Ambitions

The ambition is to reduce the prevalence of health inequalities by adopting a culture of personalised care, focusing on those at greatest risk of poor health identified within the Core20Plus5 Framework for mid and south Essex.

Delivery Priorities

Leadership

- Develop clinical and peer leaders, champions and sponsors in personalised care implementation and innovation in delivery.

Culture Development

- Build upon good practice and foster a continuous learning culture through a ‘community of practice’ and by offering innovative training programmes such as Immersive Simulation training embedding health coaching skills across the system.
- Empower people to exercise choice and control meaningfully for them, their families, and communities by producing tools, resources, and policy to encourage innovation in delivery through shared decision making and supported self-management, personalised care and support planning, and personal health budgets as solutions to reflect diversity.

Supporting Strategy

- Produce qualitative evidence of the impact personalised care has on improving outcomes, access, and experience aligned with the priorities of the Integrated Care System Strategy.
- Work collaboratively with partners across the system including the voluntary sector to generate capacity for non-medical interventions through personalised care models.

Quality Improvement

- Support implementation of Personalised Care and Support Planning practices for managing e.g., frailty and End of Life care.
- Scope the potential for digitisation of Personal Health Budgets tools and resources to support development and enable growth in the legal right to have cohorts such as Personal Health Budgets in Section 117 aftercare pathways.

Ensuring Delivery

Senior Responsible Owner: Emma Timpson,

Associate Director, Health Inequalities and Prevention
Clinical Lead: Clinical Leads for Health Inequalities and Personalised Care

Reducing health inequalities is at the heart of the Integrated Care System strategy. Personalised care is a key strand of work overseen by the Population Health Improvement Board.

To co-ordinate the programme we have established a system wide Personalised Care Steering Group accountable to the Population Health Improvement Board.

Working in partnership through the Personalised Care Steering Group, we will design a local appropriate outcomes approach including national requirements.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
3,630 Personal Health Budgets in Place	Quarter one, two and four 2023/24
24,534 Personalised Care and Support Plans in Place	Quarter one, two and four 2023/24
10 professionals per month trained in coaching skills	From quarter one to four 2023/24
300 Professionals trained in Personalised care skills for managing frailty by virtual reality	From quarter one to four 2023/24
Develop connectivity between Personalised Care Steering Group and Community Assembly, strategic co-production to develop clinical championship and peer leadership for personalised care.	Quarter one, two and four 2023/24
Continue to deliver Adopting Coaching Skills Approach Course	From quarter one to quarter two 2023/24
Establish and Launch Coaching Supervision Framework	Quarter two 2023/24

Population Health Management

What have our residents told us?

The NHS Long Term Plan defines a mature as Integrated Care System as one with Population Health Management capabilities which support the design of new integrated care models for different patient groups, with strong Primary Care Networks and integrated teams and clear plans to deliver the service changes set out in the Long-Term Plan; improving patient experience, outcomes and addressing health inequalities.

What is the current state of play/local challenges?

Progress has been made recently in the underpinning infrastructure for Population Health Management and the sharing of insights, for example through Population Health Management Health Inequalities Data Packs. Ongoing challenges include:

1. Ensuring system-wide access to Population Health Management integrated dataset and segmentation model
2. Culture change, including confidence to engage with data-based insight and to build interventions through co-production
3. Enhancing system-wide understanding of Population Health Management and building the skills to maximise its potential
4. Ensuring complete Adult Social Care data integration from all Local Authorities, and working towards broader public sector and VCFSE data

What is the requirement from NHS?

To facilitate access to, and promote the practical utilisation of, a PHM integrated dataset across the system. Align PHM approaches with the PHIB (and eventually wider ICB) financial strategy to support priorities around health inequalities and prevention.

What is the ambition?

By 2028, multiple cohorts of residents will be identified annually for focused projects that design, implement and evaluate (and scale where appropriate) evidence-based interventions. These will focus on prevention and early intervention to deliver the greatest impact on population health from available resources.

These interventions will contribute towards the Integrated Care System Core Outcomes

- Improving outcomes in population health and healthcare systems
- Tackling inequalities in outcomes, experience, and access
- Enhancing productivity and value for money

It is also envisaged that more work will be done with all system partners, including NHS and Local Authorities as well as providers, residents, and the Voluntary Sector. The aim of this will be to tackle wider determinants of health including (but not limited to):

- The built environment (e.g. housing quality, planning, transport infrastructure and active travel)
- Reducing lifestyle risk factors (e.g. tackling obesity through whole system approaches)
- Support for residents in the lowest socioeconomic groups (e.g., reducing or mitigating the impacts of poverty and fuel poverty, considering the role of Anchor institutions as local employers)
- Giving children the best chance at success in life (e.g., education, healthy diet, exercise)

Working together on these wider determinants would contribute towards the Integrated Care System Core Outcome of supporting broader social and economic development.

What are the delivery priorities?

Population Health Management specific priorities include:

- Supporting alliances, Primary Care Networks and Stewardship programmes to deliver their outcomes, embedding a Population Health Management approach.
- Using the segmentation model to identify cohorts of individuals who are progressing too quickly or undetected towards ill health and co-designing interventions which will address that.
- Delivering on the system priority of early intervention and prevention

Governance

Senior Responsible Owner: Jo Broadbent,
Director of Public Health, Thurrock Council
Clinical Lead: Luke Tandy, PROVIDE

How will we ensure delivery?

The Population Health Management steering group is a sub-group of and is overseen by the Population Health Improvement Board. It is very closely linked in terms of content and priorities to the Health Inequalities Delivery Group, Personalisation of Care Delivery Group, and Prevention Delivery Group.

The Population Health Management steering group also has subgroups including:

1. The segmentation model quality assurance sub-group
2. Communications sub-group
3. Various project delivery groups

Population Health Management also has a very close relationship with, and dependency on Business Intelligence including the infrastructure they provide for access to data, and with Local Authority Public Health teams.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Population Health Management Governance in place for all Population Health Management related projects	Quarter one 2023/24
Expand Population Health Management support to all areas including prevention, inequalities, personalised care, stewardship	Second half of 2024/25
Slowing progression to ill health through segmentation model	2025-28

Stewardship

What have our residents told us?

mid and south Essex residents have engaged positively with the model of community mobilisation via social media piloted with our Ageing Well stewardship group. They will also play a significant and increasing role in working with our stewardship groups to and identify and elucidate strategic priorities as part of their annual reporting.

Current conditions

The current systems, incentives and culture are not conducive to delivering value for the population in an optimal way. Health and care resources are therefore not always directed to where they are needed most. There is a general trend towards increasing levels of clinical intervention, particularly in the acute sector; whilst this may represent a better outcome or experience for an individual, at a population level this trend poses a challenge.

An opportunity cost exists, relating to the missed opportunity for investing progressively further in activity which would deliver higher value to our residents, including both up-stream and downstream care. Stewardship is therefore our radical approach to redressing this, and ensuring that care pathways are viewed holistically, with resources targeted towards those activities that represent high value to our citizens, including addressing the wider determinants of health, and away from those that represent low value.

What is the requirement from the NHS?

The Integrated Care System needs to work collaboratively to use allocated resources to optimally, and equitably, improve the health and wellbeing of the 1.2 million people we serve.

Our Ambitions

We will adopt a culture of stewardship. This means using common resources wisely for population segments for the good of all in that care area - not for the good of our own organisation or team.

We will equip and support resource users (notably clinicians, patients and residents) with the skills and wherewithal to make decisions about how resources should best be used, giving them responsibility for doing so and enabling clear accountability.

This programme therefore defines both how we make decisions about particular care areas, but also aims to shift the culture within the whole integrated care system accordingly.

Delivery Priorities

- Stewardship groups formed for 25 care areas by 2025
- Personal development programme rolled out for each cohort
- Mechanisms for shifting resources (e.g., Hosting) implemented
- Stewardship Business Intelligence dashboards developed and implemented
- Organisational development for Integrated Care System to embed culture of stewardship across organisations

Our duty to seek advice

Our system Clinical and Multi-Professional Congress, chaired by the Integrated Care Board Medical Director, brings together frontline staff from community, primary, secondary, social, and urgent and emergency care, mental and public health, pharmacy, and patient engagement sectors.

They provide support to the Integrated Care Board where requested in developing and delivering clinical and care strategy, effective use of resources, innovation and horizon scanning, enabling and engaging clinical and care leadership, changing clinical and care mindsets and supporting assurance and statutory adherence.

Ensuring Delivery

Senior Responsible Owner: Dr Ronan Fenton
Clinical Lead: Dr Peter Scolding

How will we ensure delivery

- The programme is overseen by the Stewardship Programme Board
- Assurance of the Stewardship Programme will take place the Integrated Care Board System Oversight and Assurance Committee.
- From 2023 we will also publish an annual report based on both care areas and population segments, demonstrating progress against our aims and comparing our performance with others.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
25 stewardship groups functioning by 2025	Second half of 2024/25

Innovation

What have our residents told us?

We continue to work with service users and those within our communities to understand barriers to uptake of innovation, inequality and how we can address areas of exclusion, through effective partnership and strengthening of local networks, assets, and relationships. As a system of Anchor organisations, we need also to consider ways to build social value and address social determinants of health in doing this as we have heard the value of local assets and the power of innovation in doing this.

Current conditions

Innovation has been subject to the same challenges seen across the NHS and social care, resulting in lack of capacity within organisations to implement new innovations.

The Integrated Care System landscape is new and fertile, and whilst formal structures are established, mid and south Essex innovation has continued to work in collaboration and partnership.

In 2019, a collaboration between Mid and South Essex NHS Foundation Trust and the Innovation Unit saw the development of Mid and South Essex NHS Foundation Trust's 5 Stage Model to Create an Innovation Culture. The stages are:

- Developing a vision and strategy
- Developing a case for change
- Establishing key priorities
- Run a staged selection process
- Build an innovation function.

We continue to have a joint programme and jointly chaired Innovation Advisory Group.

Developments such as digital care models and ongoing Outpatient transformation present additional opportunities for innovation but also the need to be mindful of pace required to deliver recovery trajectories.

System digital maturity, appetite and strategy needs to be considered for innovation choices and readiness.

Through one of our own clinicians and National Clinical Lead for Innovation, Professor Tony Young, we continue to support in partnership Anglia Ruskin University deliver the world's largest and most successful workforce development programme focussing on clinical innovation. The NHS Clinical Entrepreneurship

programme is now entering its 7th cohort with many of those successfully applying working within Mid and South Essex NHS Foundation Trust, and equally we have seen innovation adopted into our Trust because of connections made through NHS Clinical Entrepreneurship programme. Further to this, Mid and South Essex NHS Foundation Trust hosts the NHS Clinical Entrepreneurship programme InSites Programme which is seeing Clinical Entrepreneurship Programme innovation being scaled across a network of NHS Provider Trusts. This programme is actively demonstrating the benefits of a learning culture framework approach to streamlining NHS innovation adoption. mid and south Essex innovation works closely with our local Academic Health Science Network (University College London Partners), HealthTech Enterprise, Health Education England, and Accelerated Access Collaborative, local universities, as part of partnership working. Mid and South Essex Integrated Care System has achieved great successes with partners including Ford Motor Group for the Essex Covid Vax/Respiratory Van and British Heart Foundation for the BP@Home solutions.

What is the requirement from the NHS?

The NHS Long Term Plan commitments include accelerating uptake of selected innovative medical devices, diagnostics, and digital products to patients faster, through existing MedTech Funding Mandate policies, or similar programmes.

In line with the 2023/4 Planning Guidance, the innovation programme will continue to progress use of machine learning, Artificial Intelligence, and new ways of organising and providing care for example, using innovations such as Deep Medical that increase efficiency in our outpatient recovery programme around driving down avoidable appointment Did Not Attends; and ‘C the Signs’, supporting with earlier cancer diagnosis opportunities.

Our Ambitions

The Mid and South Essex Innovation Programme has been operating at a system level, since 2019. The programme aims to build a culture of innovation to help deliver our Common Endeavour of reducing inequalities together. Over the next five years Mid and South Essex Integrated Care System will build on its already nationally recognised pedigree as an innovative system by seeing increasing numbers of residents, students, staff and partner organisations being involved in innovating for the benefit of our patients, residents and staff. This will be done by:

- Increasing adoption of innovation, developing Anchor innovation and innovations that support these goals in practice,
- Increased participation of student, staff, and residents/carers in formal innovation development activity, positively increasing home-grown innovation.
- Inward investment to mid and south Essex through grants and awards, including self-sufficiency to pump-prime innovation investment
- Evolution of innovation policies; including Intellectual Property

- Using innovation as an enabler to address health inequalities
- Enhancing innovation culture and readiness, cross-system
- Collaborating with industry to boost partnership working
- Use collaborative innovations to improve working practices and person-centre outcomes

Delivery Priorities

The themes for Mid and South Essex Innovation Fellows continue to be aligned to the key national, regional, and local objectives e.g., workforce, reducing health inequalities (in line with CORE20PLUS5 Adults), Children and Young People's Mental Health (in line with CORE20PLUS5 Children and Young People) and Covid-19 recovery. This intentional alignment will continue for the next five years linking local innovation with planning guidance and Long-Term Plan goals, while supporting our common endeavour in Mid and South Essex Integrated Care System.

mid and south Essex innovation delivery priorities include

- Increased adoption of innovations in line with Integrated Care System objectives year on year from 2022/23 baseline.
- Develop Anchor Innovation - social value incubator
- Develop innovations that progress Anchor goals in practice
- Students and staff members participating in formal innovation development activity
- Increase in industry partnerships or innovation
- Inward investment to mid and south Essex through grants and awards
- Agree Intellectual Property Policy across Integrated Care System
- Progress innovation as an enabler of addressing health inequalities
- Use collaborative innovations to improve working practices and person-centre outcomes

Ensuring Delivery

Senior Responsible Owner: Charlotte Williams
Clinical Lead: Professor Tony Young

mid and south Essex innovation is monitored through a monthly Mid and South Essex NHS Foundation Trust Innovation Working Group and a quarterly system-wide Innovation Advisory Group.

The mapping of each provider organisation's focus areas is underway to ensure a joined up collaborative approach.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Develop Anchor Innovation - social value incubator	From quarter one 2023/24 to first half of 2024/25
Students and staff members participating in formal innovation development activity 1. Monitored via use of MediShout QI 2. Identifying new staff innovations each month via the working and advisory group	From quarter one to 2025/28
Increased adoption of innovations in line with Integrated Care System objectives year on year from 2022/23 baseline.	From quarter one to quarter two 2023/24
Increasing of Mid and South Essex Innovation Fellows year on year	Quarter three 2023/24
Inward investment to mid and south Essex through grants and awards	From quarter one to 2025/28
Increase in industry partnerships or innovation	From quarter one to 2025/28

Appendix 3 - Workforce

Within this section you will find long term plans relating to:

- Workforce
- Clinical Care and Professional Leadership
- Nursing and Quality

Workforce

What have our residents told us?

The Mid and South Essex Integrated Care System continues to reset activity following substantial winter pressures overlaid by Covid and elective recovery. The system has high vacancy levels across core services and an unsustainable dependency on bank and agency staffing. There is a requirement for the consistent review workforce data quality and reporting to ensure that there is robust oversight of workforce trends.

Current Conditions

- Complexity of the system geography including proximity to London and providers delivering across multiple Integrated Care System's
- High levels of vacancy impacting staff morale, retention, absence, and turnover
- High dependency on temporary staffing with usage increasing (6.6% of pay bill)
- Workforce data anomalies

What is the requirement from the NHS?

The aim is to implement robust, integrated workforce planning, reduce temporary staffing usage and adopt and embrace new roles and ways of working.

What is the ambition

To meet the needs of our local communities there is a requirement to increase focus on recruitment and retention of staff, with particular emphasis on registered nurses, medical staff and support to clinical roles.

Delivery Priorities

Our new people strategy sets out the following priorities designed to address these areas of concern across our Integrated Care System workforce:

- Recruit at scale and across the system via a centralised programme. 'One workforce' approach, streamlining the recruitment process to enhance applicant experience.
- Use branding of mid and south Essex as the recruiter for the system for health and care – 'great place to work, develop and live'.

- Agree percentage of current vacancies to support joint recruitment initiatives to substantially grow assistant/associate roles which will form our workforce pipeline leading to a suite of apprenticeship roles.
- Active, consistent engagement with schools and colleges – influencing and supporting younger ages e.g., from Cadets 12 years plus. Creating local pipelines for future workforce supply
- Registrant roles involved in shaping future workforce models – adopting new skill mix and use of digital/technology e.g., learning from Virtual Hospitals.
- Blended education and training to support the skill gaps of current and future workforce utilising our Academy and local Health Information Exchanges
- Strategic workforce planning at Integrated Care System level linking with the Framework 15 programme- embed new roles and workforce transformation in this process.
- Implement flexible working initiatives to support retention and growth in all areas and target workforce hotspots.
- People Board to form a workforce planning steering group to sequence the activities in this refresh and start to build more granular workforce plans, starting at system level and filtering down

Ensuring Delivery

Senior Responsible Owner: Chief People Officer

- Strategy and operational plans enacted via the People Board
- Workforce metrics monitored monthly at System Oversight and Assurance Committee

Delivery Plan

For detailed delivery plans for 23/24 please see operational planning submission

Delivery Plan objectives	Timespan for implementation of objectives
Convene System workforce summit to agree operational workstreams aligned to system workforce challenges and opportunities.	7/6/2023
Establish system workforce operational control workstream as an integral component of the System Project Management Office with oversight by System Oversight and Assurance Committee.	1/8/2023

Launch the Healthcare Support Worker academy and align it to the System Academy function recruiting, onboarding & educating the prescribed volume of entry level staff to fill Trainee Nurse Associates /Registered Nurse Associate and Apprenticeship Targets	1/6/2023- 1/4/2024
Recruit the prescribed number of new roles as per the June 2023 workforce summit to include but not restricted to Physician Associates, Advanced Care Practitioners, Registered Nurse Associates and Anaesthetic Associates Recruit 85% Undergraduate output	1/6/23-1/4/2024 10/2023
Coordinate and co-produce a system workforce plan Years 2-5 aligned to the national workforce plan and local system priorities	4/2024 – 4/2028

Clinical and Care Professional Leadership

What have our residents told us?

There is variation across our alliance areas in care received and while work has been undertaken to ensure consistency, it is Clinical and Care Professional Leadership that will make a difference to our population.

Current Conditions

This workstream both supports and is challenged by our workforce issues and huge demand and capacity mismatch.

However, the aim of this work is to assist with the recruitment and retention of clinical and professional staff groups. The insights and actions of our Clinical and Care Professional Leadership's will address and improve the effectiveness of our efforts to address our operational delivery pressures in all areas.

What is the requirement from the NHS?

- Improving outcomes in population health and healthcare – establish and maintain a pipeline of trained and supported leaders to lead at system, alliance, and place level.
- Tackling inequalities in outcomes, experience, and access – Support the work of the System clinical Leads for Inequalities by the incorporation of managing inequalities in all System and alliance work.
- Enhancing productivity and value for money – by ensuring Clinical Care Professional Leadership leaders are included in the design and decisions within our system's services.
- Helping the NHS support broader social and economic development – through our partnership within and outside health and social care including engagement in the education and private sectors.

Our Ambitions

To put clinical and multi-professional leadership at the heart of our system by creating a distinctive and attractive offer to support the active participation of staff within mid and south Essex to lead as part of their day-to-day work.

- To fulfil the requirements and work within the 5 principles set out within the white paper Building strong integrated care systems everywhere paper link.
- To reflect this commitment in our governance structure and leadership arrangements.

- To strengthen and further develop our Clinical Care Professional Leadership arrangements for current and future leaders.
- To ensure that Clinical Care Professional Leadership leaders are empowered and accountable for the delivery of high-quality care and to exercise effective clinical advocacy for individuals and groups who are the most unequal or excluded in its communities.
- To develop and maintain a framework document that sets out the ambitions and strategy of this programme of work.

Delivery Priorities

There are effective structures and communication mechanisms to connect Clinical Care Professional Leaderships at each level of the system:

- A strategic framework and offer that identifies, recruits, and retains an inclusive group of motivated clinical leaders
- Complete and refresh Clinical Care Professional Leadership framework

Clinical and Care Professional Leads working within Integrated Care System governance to support collective accountability for whole-system delivery:

- System Clinical Leads supported re-appointed/refreshed
- Alliance Clinical Directors supported and re-appointed/refreshed
- Alliance Clinical Leads supported and re-appointed/refreshed

A culture of shared learning to collaborate and innovate with a wide range of partners, including patients and local communities e.g., through engagement events, surveys and annual check-ins

Clinical Care Professional Leaderships are given protected time, support, and infrastructure to carry out their system leadership roles.

- Clinical Care Professional Leadership Council Monthly meetings
- Establish Clinical Care Professional Leadership Faculty and Special Interest Groups
- Establish and Support Special Interest Groups

Clearly defined and visible support to develop the leadership skills to work effectively across organisational and professional boundaries.

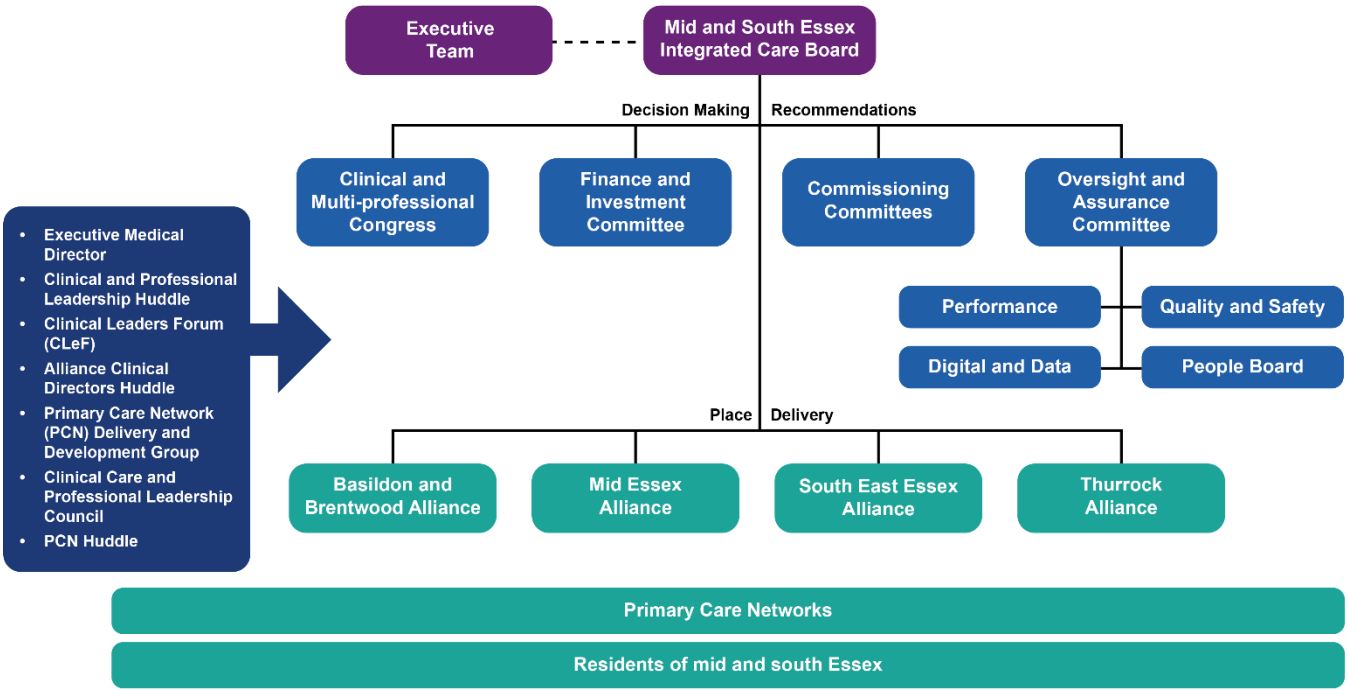
- Engage with Anglia Ruskin University / University of Essex on collaborative apprenticeships and Health and Care Academy formation
- Continue to run an annual Leading within Mid and South Essex Integrated System leadership development programme

Stewardship is an approach to health and care services that we are developing across the Mid and South Essex Integrated Care System. It is about bringing together teams of health and care staff and managers within a care area, to get the best value from our shared health and care resources. Stewardship groups providing health services within allocated resources; advising convening and supporting across system services

- Establish and support 25 stewardship groups by 2025
- Recruit System Medical Director Team
- Recruit Two clinical fellows annually
- Clinical Transformation/Veterans Lead
- Two DSMDs

Ensuring Delivery

Senior Responsible Owner: Dr Ronan Fenton
Clinical Lead: Sarah Crane



The above shows the System governance structure.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
4 x alliance clinical directors recruited supported and refreshed	Quarter one 2023/24 and first half of 2024/25
22 system clinical leads recruited supported and refreshed	Quarter one 2023/24 and first half of 2024/25
Alliance clinical leads recruited supported and refreshed	Quarter two 2023/24, first half of 2024/25 and 2025/28
Clinical Care Professional leadership council developed and maintained	Quarter one 2023/24, first half of 2024/25 and 2025/28
Clinical Care Professional leadership engagement events developed and delivered	Quarter three 2023/24
Clinical Care Professional leadership faculty developed and maintained	Quarter three 2023/24

Nursing Quality and Safety

What have our residents told us?

Overwhelmingly through engagement with our residents, three key themes arise. They want to:

- feel safe
- feel listened to
- be respected

Current conditions

Teams within Mid and South Essex Integrated Care System already perform an outstanding job every day to deliver healthcare services. However, they are facing multiple challenges which impacts on their ability to achieve the quality of service they would like to provide including challenges in recruitment and retention, financial pressures, relentless and growing pressure from infectious diseases as well as long-term conditions, coupled with an ageing population.

Despite the processes in place for monitoring the safety of services, patients sometimes suffer harm. Consequently, health and care teams need robust systems and processes to ensure care provided is of high quality and safe. To support us to achieve this aim, we have developed six key principles that underpin decisions around quality.

What is the requirement from the NHS?

The programme of transformation across mid and south Essex presents clear opportunities for health and social care organisations, education, and police partners to work together to address current quality and inequality challenges. We recognise that each organisation has its own statutory duties in relation to ensuring the quality and safety of services.

Our ambitions

Our approach does not seek to replace these duties, rather it aims to deliver:

- A streamlined and efficient approach to quality measurement and monitoring
- Opportunities to increase the voice of patients/residents
- A better understanding of health quality and wider system inequality variation across integrated pathways, rather than looking at quality in silos
- The structure, process and guidance needed by teams to ensure regulatory compliance
- Better use of data, including the effective triangulation of multiple sources of data and quality surveillance to enable early warning and prevention

- Agreement on the approach to defining, measuring and monitoring quality under new contractual arrangements.

Clear quality and health inequality impact assessments are undertaken for all change and transformation programmes.

Delivery Priorities

A shared commitment to quality:

- By end of 2023, we will have an agreed suite of documents that describe our committees and information flows
- By 2024, we will collectively support services to improve by undertaking a programme of peer reviews to assess the quality provided. Findings from the reviews will feed the provider of care and our Quality Committee
- By 2025, there will be a series of learning events to educate us on what good looks like and to drive innovation. **The aim will be for Care Quality Commission to rate our services as 'good' and 'outstanding' by 2028**.
- Establish a system-wide quality improvement approach by end of 2027.

Population focussed:

- By 2024, we will develop a suite of quality measures that will help us to identify those most at need of high-quality care, and to improve their ability to access these services.
- We will have a good understanding of our most vulnerable neighbourhoods.
- The Local Maternity and Neonatal Strategic Board will continue to strive to provide services that mothers and family's desire and to ensure services are safe by implementing the three-year Single Delivery Plan for maternity and neonatal services which was published in March 2023.
- We will continue to embed and strengthen the delivery of Personalised Care throughout our healthcare services.
- We will continue to work towards our ambition of delivering care closer to home.

Coproduction with the people using the services:

- By 2025, we want to have established a culture where coproduction and listening to people is part of the way we do things. We will learn from our complaints and enhance skills through training and education to truly coproduce care.

- By end of 2023 we will have appointed our Patient Safety Partners

Clear and transparent decision making:

- We will work collectively together to create a culture of transparency and trust within the Integrated Care System.
- By 2027, our workforce will feel able to speak out about safety concerns without fear and we will measure progress via our NHS Staff Survey.

Timely and transparent information sharing:

- By end of 2023, we will have a robust framework for safeguarding assurance
- By 2024 we will have developed a clinical quality dashboard to review our performance
- By 2026, we will produce a collaborative system learning programme to support sharing, training, innovation and effectiveness.

Subsidiarity:

- By end of 2023, we will have embedded processes to support our General Practitioner practices, optometrists, community pharmacies and dental surgeries to improve their safety.

Ensuring Delivery

Senior Responsible Owner: Dr Giles Thorpe, Chief Nurse
Clinical Lead: Dr Giles Thorpe, Chief Nurse

The National Quality Board outlined two key requirements for quality oversight in an Integrated Care System:

1. To ensure fundamental standards of quality are delivered thus managing patient safety risks and addressing inequalities and variations in care.
2. To continually improve the quality of services, in a way that makes a real difference to the people using them.

Our unitary board members have collective and corporate accountability for the performance of our organisation and will be responsible for ensuring its functions are discharged.

Providers of NHS services will continue to be individually accountable for:

- Quality, safety, use of resources and compliance with standards through the provider licence (or equivalent conditions in the case of NHS trusts) and Care Quality Commission registration requirements

- Delivery of any services or functions commissioned from or delegated to them, including by our NHS Integrated Care System body, under the terms of an agreed contract and/or scheme of delegation.
- Participation in system working with other statutory partners

As an Integrated Care System, we will collectively oversee and improve the safety and quality of services through the development of a system wide quality dashboard which captures health inequalities, multi- organisation membership on the Integrated Care Board Quality Committee and strengthening our patient voice.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Set up task and finish groups to develop outcome metrics for dashboard and complete build of dashboard by June 2024 to strengthen system oversight and assurance for the delivery of safe care. Strengthen to citizen feedback of services to drive improvement and reduce variation of care across the Integrated Care System.	First half of 2024/25
To enhance the quality and safety of care by continued implementation of the Patient Safety Strategy and the Patient Safety Incident Framework by end of December 2023	Quarter four 2023/24
Establish a revised safeguarding structure across the Integrated Care System that provides safeguarding expertise at a strategic, Place and provider level. Develop a 2-year work programme, which will include provisions of the Domestic Abuse Act 2021 and other statutory guidance.	Quarter two 2023/24

Appendix 4 – Infrastructure

Within this section you will find long term plans relating to:

- Estates
- Capital Estates Planning
- Sustainability and Net Zero Climate Commitments

Estates

What is the current state of play/local challenges

Like many systems mid and south Essex faces challenges from aging Estate that has not received the necessary investment to maintain its condition or appropriate functionality, to keep up with the growing populations and the objective to deliver services closer to people's homes.

The Naylor review identified "NHS England has a small programme of capital grants to build or expand primary care premises, but this will be inadequate to facilitate the vision of the 5 Year Forward View". No changes have been made to address this issue as capital investment for the system is constrained by both the national limits and direct award to the foundation trust.

This converts the risk for Primary Care into an issue that it cannot deliver against the existing demands, let alone the growing one. This will start building a risk in relation to maintenance and both building and patient safety.

What is the requirement from NHS

Recognition of investment best practice and benchmarking from other large complex estates, where expenditure is not prescriptive between capital and revenue. The Naylor report concluded that major investment is required to develop new models of primary care. Analysis and evaluation of the different estate models to deliver the new models of care is required, to best develop the case for new capital investment in the estate.

Commitment to the new Government Property Standard and the requirement to monitor and report on the performance across all aspects of the estate using the metrics specified for use across government.

Along with the adoption of the Government Property Data Standard to improve data quality, consistency, and interoperability throughout the public sector estate. Adoption of this common approach to collecting, referencing and reporting all property usages, including land and buildings will help drive Value for Money across the One Public Estate.

What is the ambition

Create new models of care delivers the Long-Term Plan by leveraging best practice, data, and targeted investment to offer our residents a range of services in an easily accessible way, making the best use of one public estate and the opportunities to consolidate resources.

We would then be able to make better, outcome focussed decisions about how to optimise our infrastructure across the system. Enabling us to deliver estate

improvements within the financial challenges we face as we recognise the impact of the built environment to improve the wellbeing and health outcomes of staff and residents and address health inequalities within our system.

What are the delivery priorities

Embracing the opportunity to work together to identify and acquire appropriate sources data, to build a collective understanding of our Estate, its condition and use to help inform decision making on how to optimise the estate through a coherent System Infrastructure Strategy.

Our alliances are fundamental in bringing all voices together around the local needs and requirements to ensure our physical estates supports us to deliver the services when and where we need them to be.

We must prioritise appropriate planning across all areas of estate to ensure we deliver value for money and efficient use of resources.

Governance

Senior Responsible Owner: Jen Kearton

How will we ensure delivery

The Systems property and digital function's governance and strategy will promote appropriate, proportionate, and consistent ways of managing and investing in its infrastructure.

The governance and management framework will be documented, showing system overview, structures, decision making processes, terms of reference job roles, and defines remits and authority limits for decision-making. It will include systems for agile responses or adjustments to change, incorporating improvement opportunities.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Data and Management Information	Quarter one 2023/24
Stocktake of all current Estate across the System	Quarter one 2023/24
Evaluation of strategic themes and priorities	Quarter two 2023/24
Building Capability and Capacity	Quarter two 2023/24
Design a Target Operating Model	Quarter two 2023/24
Recruit, train and retain a high performing team	From quarter two to quarter three 2023/24
Estate and Capital Planning and Decision Making	From quarter one to 2025/28

Capital Estates

What have we heard from residents/patients

We take on board patient feedback as part of the request process for projects. For material programmes there is a project and steering group structure which includes patient and carer stakeholders.

What is the current state of play/local challenges

The Integrated Care Board is in the second year of an agreed three-year capital funding envelope.

The Integrated Care Board manages a system allocation of capital and continuously explores further additional opportunities in respect of the development of:

- Electronic Patient Record
- Community Diagnostic Centres at Mid and South Essex NHS Foundation Trust
- Funding for International Financial Reporting Standard 16 leases

What is the requirement from NHS

mid and south Essex is committed to working together, to make best use of the resources we have available.

Although the Integrated Care Board has submitted a capital expenditure plan in line with funding, the system as a whole remains overcommitted.

What is the ambition

We want high quality, facilities and equipment to deliver digitally enabled services in an efficient and effective way.

We hope to plan and prioritise all developments for the system to enable us to deliver a pipeline of improvements within the financial challenges we face as we recognise the ability of long-term investments to drive wellbeing of staff and residents as well as efficiencies for our population.

What are delivery priorities

The plan includes spend on the procurement and development of a joint Electronic Patient Record, this will support the integration of services and the deliver efficiencies for our patient population and clinical workforce.

Backlog maintenance, ward refurbishments and equipment replacement make up the majority of the rest of the programme.

We have prioritised our primary care developments within the capital and revenue funding we have and we continue progress all opportunities to work across system partners to improve and realise estate where possible.

Governance

Senior Responsible Owner: Trevor Smith, Essex Partnership University NHS Foundation Trust

How will we ensure delivery

The system has operated a System Investment Group, chaired by Essex Partnership University NHS Foundation Trust since October 2021. This forum has been used to discuss and recommend major investment cases to the Senior Financial Leaders Group, and more recently the Finance Investment Committee, since the creation of the Integrated Care Board.

The System Investment Group has also been the forum at which capital allocations and plans are reviewed and agreed.

In addition, the capital teams work closely together on a less formal basis and meet weekly for the last two months of the year to ensure the maximum deployment of the system capital allocation and manage within the Integrated Care Board envelope. The Integrated Care Board delivered the capital plan with a small overspend of £43k.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Capital Planning	Quarter one 2023/24
National review of the Electronic Patient Record business case	From quarter one to quarter three 2023/24
Development of Essex Partnership University NHS Foundation Trust, Mid and South Essex Integrated Care Board Estates Strategies	From quarter one to quarter three 2023/24
NHS Infrastructure Strategy	From quarter two to quarter three 2023/24

Sustainability

What have we heard from residents/patients

This is an area that has lots of public support and will require their co-operation as we change the way services are delivered – for example through the virtual wards, reduced car travel, changing inhaler type etc.

What is the current state of play/local challenges

mid and south Essex has its Green Plan in place, which has a clear set of actions to deliver on the 9 areas of focus included in the Greener NHS Programme. The challenge is in managing competing expectations to enable sustainability to be taken seriously and prioritised amongst a multitude of other priorities.

What is the requirement from NHS

The Greener NHS Programme has committed the NHS to being the first health service, in the world, to be net carbon zero. This is by 2040 for scopes 1 and 2, and 2045, for scope 3.

What is the ambition

To embed sustainable thinking into all the different work programmes that mid and south Essex has, the ambition is to ensure existing work is effectively captured to prevent duplication and ensure we embed sustainable practices and processes in all we do.

What are delivery priorities

The Mid and South Essex Green Plan has a set of priorities to deliver on the 9 areas of focus as set out by the Greener NHS Programme. These are designed to align with existing work programmes, to prevent duplication, but also to provide a clear link to the sustainability work so we can report on progress through the sustainability governance channels.

The main focus for 2023-24, to ensure we align with the regional focus, will be on:

1. Reducing the reliance on fossil fuels and minimising energy consumption
2. Avoiding single-use items
3. Recycling items instead of disposing of them
4. Increasing the social value delivered by the Trust

This process will enable mid and south Essex to reposition its delivery aims to they are in line with regional priorities, enabling more flex in priorities. As a part of this

reshaping work, mid and south Essex is also aligning the Trust and Integrated Care System Green Plans to allow a more consistent and symbiotic approach.

Governance

Senior Responsible Owner: Jonathan Dunk
Clinical Lead: Ronan Fenton/Paula Wilkinson

How will we ensure delivery

The Integrated Care System has a Sustainability Board that is chaired by the Executive Senior Responsible Owner lead. This Board feeds into wider Integrated Care Board and Provider Boards.

There is an exec lead in place for the majority of the areas of focus, and quarterly meetings take place with them and the Head of Sustainability to measure progress. For areas of focus that are linked to numerous elements – such as Adaptation and Sustainable Models of Care, mid and south Essex is developing sophisticated measurement tools and Key Performance Indicator's These conversations are taking place with the Executive Lead, as a part of the wider governance development processes.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Governance processes redefined and embedded	From quarter one to quarter two 2023/24
Carbon footprint of the Trust baselined and clear actions for reducing	Quarter two 2023/24
Air pollution pilot completed and Trust has clear actions for reducing air pollution in the supply chain at Southend	From quarter four 2023/24 to first half of 2024/25
Project to highlight the importance of reusing materials, and reducing energy to take place	From quarter three to quarter four 2023/24
Focused approach to increasing the social value delivered by the Trust	From quarter four 2023/24 to first half of 2024/25
Energy project with NHS England to have identified alternative energy options for the Trust	From quarter three to quarter four 2023/24
Alignment of priorities to existing work programmes – i.e., digital, workforce etc.	From quarter one 2023/24 to first half of 2024/25
Funding opportunities identified to bring in organisations such as Jump, to raise awareness	From quarter two to quarter four 2023/24

Appendix 5 - Finance

Within this section you will find long term plans relating to:

- Finance
- Procurement and Supply Chain
- Specialised Commissioning

Finance

What is the current state of play/local challenges

Our system has faced increased and sustained operational challenges which have frustrated our ability to address our underlying deficit position. We have a good collective understanding of our cost drivers, and we are focusing our efforts to specifically address areas where we know we need to do something differently so we can continue to support everyone we need to.

What is the requirement from NHS

NHS organisations are required to operate within the resources they available to them. As a system of NHS organisations, they have a duty to corporate together to deliver breakeven and as part of the wider health and care system we are committed to delivering sustainable services for our population.

What is the ambition

As a system we have the ambition to develop systems and resources to support people to take proactive control of their health. Our aim is to ensure we make evidence-based investments to ensure stable sustainable services and support prevention of ill-health. We must ensure we only invest where there is no resource improvement potential, ensuring we prioritise value for money and maximise our system pound.

We must bring our system back to balance through productivity and cash releasing efficiencies savings in the fastest most sustainable, following our clinical leads to deliver change.

What are the delivery priorities

We continue to pursue our core principles. Working collectively as a system we intend to drive up our reporting, costing and intelligence sharing so we can empower our clinicians and stewards to drive evidence-based resource allocation.

We are working together to support the efficiency programme, benchmarking, and monitoring to ensure we understand where we are making a difference. We must continue to reduce waste and duplication wherever it manifests to ensure we deliver the best for our residents.

Governance

Senior Responsible Owner: Jen Kearton

How will we ensure delivery

We have an established System Finance Leadership Group and System Investment Group which is supported by deputies across all our organisations in health and social care.

Our Finance leads are embedded into our programme groups to ensure we bring together our governance streams.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Annual Planning 23/24	Quarter one 2023/24
Medium Term Financial Planning/Recovery and Efficiency and Capital	From quarter one to quarter two 2023/24
Continued development of costing and service line approach to resource management	From quarter two to quarter four 2023/24

Procurement

What have we heard from residents/patients

We have heard from our residents and patients, that they want high quality care that is safe and effective. We know that our patients want care that is delivered and enabled close to home. Procurement plays a key part in enabling clinical services to deliver care to our patients safely and effectively, ensuring that we purchase high quality products and services affordably, and deliver the best value for every pound spent from the public purse.

What is the current state of play/local challenges

Mid and South Essex Procurement teams have been collaborating for over 2 years, with the introduction NHS England's 34 step plan which is supporting the alignment of how we manage and govern procurement services across the Mid and South Essex Integrated Care System.

There are a number of joint procurements now in place across the Integrated Care System. There are challenges across teams with different systems, making data comparison sometimes challenging.

mid and south Essex are working collaboratively on the current supply chain issues to ensure resilience on product shortages.

What is the requirement from NHS

mid and south Essex is committed to working together, utilising the NHS England 34 step plan, to make best use of the resources we have available. We must make efficient use of budgets to procure high quality products and services whilst delivering cost efficiency programmes.

What is the ambition

A unified procurement service across the Integrated Care System, that enables standardisation of products, whilst delivering economies of scale. We know that helping clinicians to standardise products, leads to reductions in variations of care, and better outcomes for our patients.

mid and south Essex will be working collaboratively with our suppliers to ensure that there is social value contribution including net zero in all tenders and contracts for our system.

mid and south Essex will also look at how it can better manage inventory to reduce waste and increase Just In Time procurement opportunities.

What are delivery priorities

Mid and South Essex procurement teams will continue to build relationships and collaboration across procurement teams in the Mid and South Essex. Sharing of current practice, processes and data, to look for areas of opportunity for alignment.

Review of existing resources across the Mid and South Essex to look at how we best utilise our expertise to deliver savings, but also at how we retain and develop our staff.

The review of how we currently work will form the baseline of service understanding that then will support us to design and develop our Integrated Care System strategy for procurement, and to build a unified procurement function across Mid and South Essex.

Governance

Senior Responsible Owner: Jonathan Dunk
Clinical Lead: To be confirmed

How will we ensure delivery

This forms part of the Mid and South Essex Corporate Services reconfiguration group, which is overseeing opportunities for the alignment across Organisations. Progress on the design of the future unified mid and south Essex procurement service will be reported and governed through this group.

The workstream Integrated Care System procurement group is already established, and ongoing progress is monitored through the NHS England 34 steps plan.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Development of the Integrated Care System strategy for procurement	From quarter two to quarter three 2023/24
Review of existing resources across mid and south Essex	From quarter one to quarter two 2023/24
Review of current systems and data across mid and south Essex	From quarter one to quarter two 2023/24
Shared training and development plan across	Quarter two 2023/24
Ongoing opportunities for collaboration across contracts	From quarter one to quarter two 2023/24
Development of an aligned process for managing social value and net zero commitments	From quarter two to quarter three 2023/24
Design and implementation of a unified procurement service across Integrated Care System	From quarter three 2023/24 to first half of 2024/25

Specialised Commissioning Services

Current Issues

Full delegation of specialised services will occur in April 2024. Therefore, 2023/24, will be preparatory 'shadow' year, where NHS England will set up a statutory Joint Commissioning Committee for Specialised Services, which will require Integrated Care Board leadership, engagement and representation in the Committee. Through 2023/24, the statutory Joint Commissioning Committee will manage the full portfolio of specialised services.

The 'shadow' year will enable Integrated Care Boards and NHS England regional office to test the arrangements for full delegation in April 2024. This includes the proposed hosting arrangements for the Specialised Commissioning team in Bedfordshire, Luton and Milton Keynes Integrated Care Board.

What is the requirement from the NHS?

From April 2023, Integrated Care Boards entering Joint Working Agreements with NHS England will become jointly responsible, with NHS England, for commissioning the Joint Specialised Services and for any associated Joint Functions.

Our ambition

NHS England and Integrated Care Boards will form a statutory Joint Committees that collaboratively make decisions on the planning and delivery of the Joint Specialised Services, to improve health and care outcomes and reduce health inequalities. Joint Committees are intended as a transition mechanism for Integrated Care Boards that require additional support before they are ready to take on full delegated commissioning responsibility

What are the delivery priorities

The 23/24 priorities for Integrated Care Boards are to:

1. Establish the Joint Committee and associated delegation framework and agreement.
2. Implement a joint work programme reflecting the clinical and service priorities for 23/24 and beyond and building on the prioritisation process established in autumn '22.
3. Commence transformation of three priority pathways, these being specialist cancer services, neonatal services and specialist mental health services.
4. Develop the governance, capacity and capability associated with full delegation using the Pre-Delegation Assessment Framework and safe

delegation checklist to create and embed the local management arrangements required to deliver effective commissioning.

The deliverable and success criteria will be the transfer of full delegated responsibilities on 1st April 2024.

Ensuring Delivery

Senior Responsible Owner: Karen Wesson
Clinical: Not applicable until after Delegation

Delivery of the joint work programme will be overseen by the Joint Commissioning Committee for Specialised Services, with regular updates submitted to the Board of the Integrated Care Board.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Implementation of Medical Thrombectomy	First half of 2024/25
Cardiac Transformation	Quarter four 2023/24
Knee Revisions Project Phase 2	Quarter three 2023/24
Mount Vernon Cancer Centre Review	Quarter three 2023/24
Set up working group to devise interim planning and prioritisation process for 2024/25 and beyond.	Quarter two 2023/24
Children and Young People Professional Support Gender Identity Development Services	Quarter four 2023/24
Full delegation of specialist commissioning responsibilities to Integrated Care Boards	First half of 2024/25
East of England Region Mental Health Provider Collaborative, Phase 2 Devolving of Services	2025/28

Appendix 6 – Digital, Data and Technology

Within this section you will find long term plans relating to:

- Patients Know Best
- Shared Care Records
- Data Quality
- Electronic Patient Record
- Strategic Data Platform
- Digitising Social Care Records

Patients Know Best

What have heard from our residents

“The ability to see my appointments and information online has saved me missed appointments due to letters not turning up in the post. If I wanted to, I can share my records with family to support my care needs.”

Current Conditions

The Digital Patient Interface is a collaborative approach being implemented with support from the Integrated Care Board into two trusts to enable more effective use of resources.

The NHS App, delivered by NHS Digital, is a simple and secure way to access a range of NHS services on a smartphone or tablet and is available to all patients aged 13 and over who are registered with a General Practitioners practice in England. This first of its kind national integration allows patients with a Patients Know Best personal health record to directly access their combined dataset from Patients Know Best within the NHS App interface.

Patients Know Best is contracted for more than 12 million people to use the service across the United Kingdom. The Patients Know Best platform includes health information generated from General Practitioners as well as hospitals, community and mental health services and the patient’s own contributed data, for example from monitoring devices or questionnaires.

What is the requirement from the NHS?

The NHS Long Term Plan sets out the vision of empowering people through their ability to access, manage and contribute to their health and care record through digital tools. It calls out the need to create straightforward digital access to NHS services, for both patients/residents and carers. It sets out a new service model for the 21st century with out of hospital care boosted, dissolution of the historic barrier between primary and secondary care, people empowered with more control over their health and mainstreaming digitally enabled primary and out-patient care.

NHS Long Term Plan: In 2020/21, people will have access to their care plan and communications from their care professionals via the NHS App.

By March 2024 Acute Hospitals will have Patient Engagement Portal supporting outpatient management.

Our Ambitions

Our ambition is to put patients in charge of their health and care records enabling them to manage their own information digitally.

Delivery Priorities

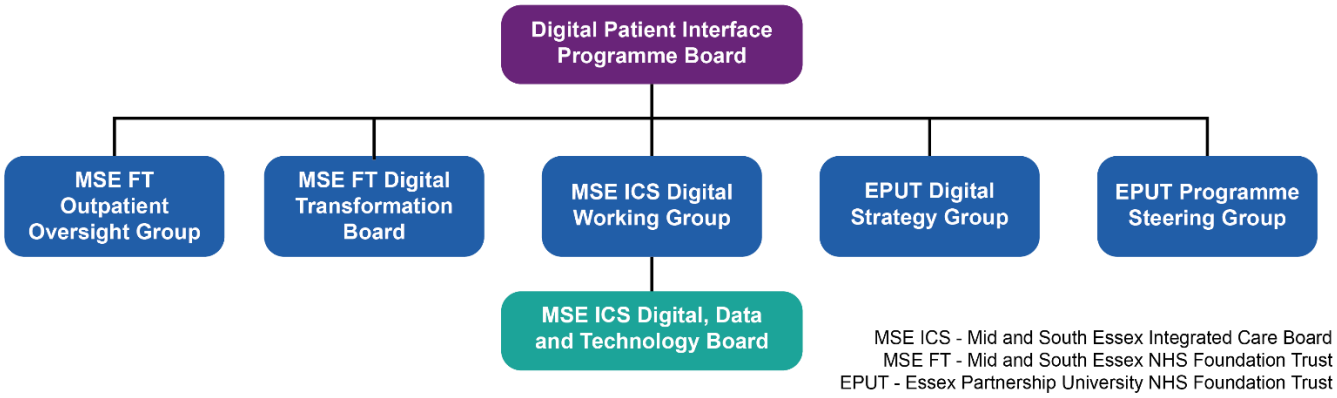
- Reduction in administrative burden: using pre-assessment questionnaires saving care team time
- Reduction in Did not Attend and slot utilisation: greater visibility of appointment information and easier access to information on changing appointments will reduce Did not Attends.
- Deliver cost savings through Digital rather than paper communication: reduction in the number of letters sent via post as patients with access to the portal can opt out of paper communication. Information previously shared as paper leaflets can also be shared via the portal.
- Improve patient experience: patients are empowered with control over their own health record
- Supports improved outcomes: patients can track and monitor their own health and be supported via digital guidance.

Ensuring Delivery

Senior Responsible Owner: Barry Frostick
Clinical Lead: Sam Neville Clinical Nursing Information Officer

Project resources have been provided across the partner organisations and governance is delivered by way of an Integrated Care System programme board. The Digital Patient Interface Programme Board is a decision-making board made up of each of the partners involved in the delivery of the digital patient interface.

Below delivery governance structure.



Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Implementation commences	Quarter one 2023/24
Implementation complete with Mid and South Essex NHS Foundation Trust and Essex Partnership University NHS Foundation Trust	Quarter four 2023/24

Shared Care Record

What have we heard from our residents?

Our residents and clinical workforce are dealing with fragmented care records resulting in decisions and actions being taken without always the full knowledge of the care record to hand.

“I am going through all sorts of tests again because the trust can’t access my records, which I am really mad about. I wish it was all one system and I wouldn’t have to go through all of this all over again.” (Female Patient)

Current Conditions

In 2019 a short-term tactical information sharing solution (Cerner Health Information Exchange was put in place with the contract due to end in July 2024.

This solution was part of much wider regional programme under ‘My Care Record’ banner. Health Information Exchange was selected as an approach to create sharing capabilities for some of our partners across the Integrated Care System. Whilst this has provided some immediate benefits on viewing data it is recognized that the current solution does not support the ambition set out in the NHS Long Term Plan and therefore does not meet the full Integrated Care System Digital Strategy priorities.

There will be a significant transformation programme required to maximise the opportunities a shared care record will bring.

The programme is in an advanced procurement state – aiming to award contracts Q1 23/24 and start planning and implementation immediately following.

What is the requirement from the NHS?

NHS Long Term Plan: By 2024, secondary care providers in England, including acute, community and mental health care settings, will be fully digitised, including clinical and operational processes across all settings, locations and departments. Data will be captured, stored and transmitted electronically, supported by robust IT infrastructure and cyber security, and Local Health and Care Records will cover the whole country.

Our Ambitions

To procure and implement a System - wide Shared Care Record which meets the diverse needs of end users and therefore can make a difference to improving resident and patient care across different care settings within mid and south Essex.

The Shared Care Record ambition has been set against the following success factors:

- A shared care record which takes information from each of the in-scope service providers
- Interoperability across systems, such that each team works primarily from host/local single front-end, whilst still accessing the shared care record
- As near to real-time data to support crisis management and multiple same-day interactions in the integrated care team for patients
- Move towards bi-directional integration to ensure that accurate, timely and appropriate information is captured in each service providers system (avoiding additional double-keying)
- Reporting and analytics capability aligning to data platform strategy to support benefits tracking, identifying service usage patterns, prioritisation of spend and commissioning planning
- Reporting and analytics capability aligning to data platform strategy to support benefits tracking, identifying service usage patterns, prioritisation of spend and commissioning planning

Delivery priorities

The Shared Care Record Programme has been keen to ensure that there is strong representation from various professional groups (clinical, operational, technical, procurement and finance) across all System partner organisations. The Programme has striven to promote the ethos of co-production throughout the procurement process to ensure that there is maximum buy-in from organisations in the implementation phase.

We will work with our partners to create the technical supporting infrastructure and functions to support new integrated ways of working.

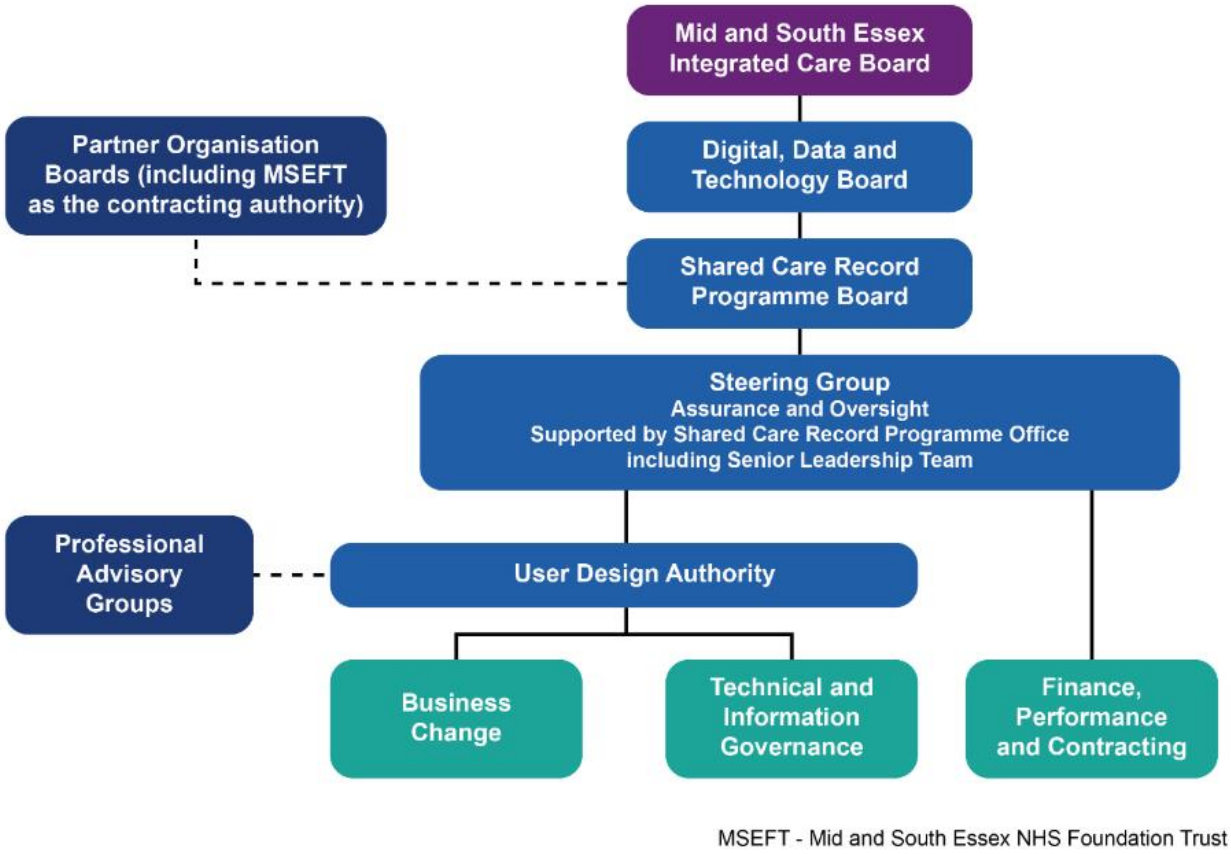
Through our Business workstream we will work with front line teams to maximise the benefits and positive impact of having integrated patient records and workflow across our system.

We will partner with Integrated Care Systems who are already implementing Shared Care Records to learn and accelerate our delivery.

Ensuring Delivery

Integrated Care System Senior Responsible Owner: Barry Frostick
Integrated Care System Clinical System Programme Director: Clare Steward
Chief Clinical Information Officer: Dr Taz Syed

Below diagram of governance arrangements.



Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Contract Award to Preferred supplier to provide Shared Care Record	Quarter one 2023/24
Implementation (Phasing to be confirmed as part of contract signature)	Second half of 2024/25

Digital – Data Quality

Current Condition

Recurrent issues with data quality mean that, as a system, we struggle to make operational and strategic decisions using a data-driven approach.

We need to adopt the Mid and South Essex NHS Foundation Trust data quality framework and vision, which is in line with our organisational strategy and the wider Integrated Care System digital strategy. This outlines the importance of:

- Capturing and maintaining patient information accurately to support excellent clinical care.
- Ensuring accurate corporate data to provide more efficient processing of staffing, finance and corporate information.
- Greater integration between systems and providers.
- Fostering an organisational culture that is committed to high quality data
- A need to increase operational ownership for resolution of data quality issues because of poor data entry by operational users.

What is the requirement from the NHS?

A need to provide accurate and reliable performance and management information for services.

Better alignment and coaching from NHS England on the use of the Data Quality Maturity Index.

Our ambitions

- To embed high quality data into the everyday working of staff throughout the organisation, ensuring it is a central theme of a wider business management approach reinforcing right data, first time, every time.
- To have a published Data Quality Maturity Index that is delivered to the Integrated Care System board
- To create a consistent approach in managing data quality concerns which are raised with clear operational ownership for resolution.

Deliver Priorities

- Recruitment of a Data Quality Lead to deliver on the Data Quality Framework
- Assessment of the current state of Data Quality across Integrated Care System
- Rollout of the Data Quality Framework across the Integrated Care System.

- Resolution of highlighted data quality issues including Referral To Treatment and Discharge (No Criteria To Reside)
- Integration of Data Quality into operational governance for assurance and agreement on resolution paths.

Ensuring Delivery

- All developments are run through a business intelligence governance board and where appropriate we request clinical and business leads to own future data quality, by each relevant system.
- Data quality items will feed through existing operational meetings and report to the System Oversight and Assurance Committee.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Recruitment of a Data Quality Lead	Quarter two 2023/24
Assessment of the current state of Data Quality across Integrated Care System	Quarter three 2023/24
Rollout of the Data Quality Framework	Quarter four 2023/24

Electronic Patient Record

What have our residents told us?

There are many areas across the Mid and South Essex Integrated Care System where our residents have overlapping needs across acute, mental health and community care – yet our systems are not setup to manage this effectively as evidenced by:

Our Electronic Patient Record approach offers a solution to this by:

- Building an integrated health care solution infrastructure for the first time in the United Kingdom.
- Providing clear data across shared pathways allowing a view of the whole person when providing care – regardless of their point of access to the system and regardless of their needs.

Current Conditions

Our system currently relies on an “unintegrated” digital health infrastructure with over 10 siloed clinical systems.

Lack of Electronic Patient Record integration prevents staff from having an overall picture of the patient’s clinical journey and consistent access to viewing patient records and notes. This leads to gaps in the patient’s clinical pathway and poses risks.

Mid and South Essex NHS Foundation Trust have 3 Electronic Patient Record’s and Essex Partnership Trust have 7 Electronic Patient Record’s. In Mid and South Essex NHS Foundation Trust they have multiple patient indexes in use meaning a patient could have three records if they are seen at more than one hospital site. Resolving this level of fragmentation and complexity will underpin a number of resolutions for Data Quality issues, unwarranted variation of clinical care and a reduction of integration requirements.

There is no system in the UK market that currently delivers the functionality required across all care settings. Mid and South Essex NHS Foundation Trust and Essex Partnership University NHS Foundation Trust would be 'first movers' in this space. The collaboration is strengthened by a clear vision and history of delivering complex programmes together. Essex Partnership University NHS Foundation Trust and Mid and South Essex NHS Foundation Trust are actively collaborating on various programmes of work to integrate digital and data systems, e.g., the Shared Data Platform.

What is the requirement from the NHS?

All Integrated Care Systems and their NHS Trusts are aiming to have core digital capabilities, including electronic health records, in place by April 2026.

All providers, across acute, community and mental

health settings, will be expected to advance to a core level of digitisation by 2024.

Our Ambitions

The objective of this programme is to procure and implement a new unified Integrated Care System enterprise-wide electronic patient record system for mental health, community, acute services with an integrated electronic prescribing and medicines administration functionality.

The scope is for functionality provided by an Electronic Patient Record system to support the clinical and administrative processes, improve the safety and delivery of patient care, patient experience and outcomes.

It supports the NHS England national ambitions by entering Essex Partnership University NHS Foundation Trust and Mid and South Essex NHS Foundation Trust into a partnership to procure a unified Electronic Patient Record solution. Investment in a unified Electronic Patient Record solution also supports the strategic, digital, and system visions and priorities for both Trusts and enables the Trust and Integrated Care System Digital Strategies to work as an integrated system.

Delivery Priorities

Delivery of NHS England priorities including ‘a wide-ranging and funded programme to upgrade technology and digitally enabled care across the NHS’, recognising that ‘digital services and data interoperability give us [the NHS] the opportunity to free up time and resources to focus on clinical care and staying healthy.’ It sets the expectation that ‘all providers, across acute, community and mental health settings, will be expected to advance to a core level of digitisation by 2024.’

NHS England aims to support healthcare providers by accelerating the rollout of Electronic Patient Record systems, aiming for 90% of NHS trusts to have an electronic patient record in place by December 2023.

The Trusts do not currently have a single electronic patient record. There is a clear mandate from NHS England to improve their current level of digitisation to a core level.

We are working in partnership with our providers to deliver this ambitious and challenging programme.

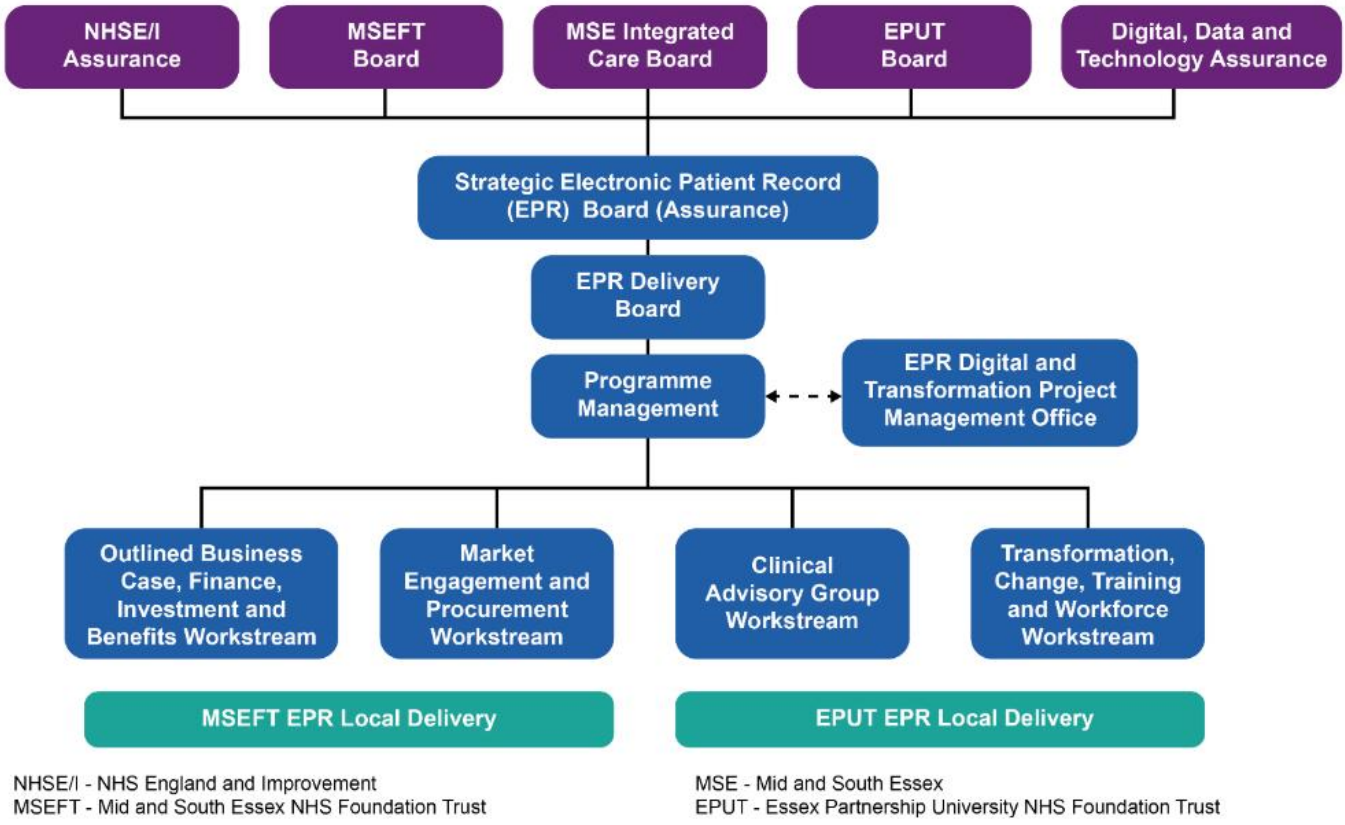
Ensuring Delivery

Integrated Care System Senior Responsible Owner: Anthony McKeever
Barry Frostick
Integrated Care System Programme Director: Clare Steward
Essex Partnership University NHS Foundation Trust Lead Senior Responsible Owner:
Paul Scott
Zephan Trent
Mid and South Essex NHS Foundation Trust Lead Senior Responsible Owner:
Hannah Coffey
Charlotte Williams
Essex Partnership University NHS Foundation Trust Delivery Lead: Adam Whiting
Mid and South Essex NHS Foundation Trust Delivery Lead: Gemma Lawrence

There is an existing Digital, Data and Technology Board in place.

There are Trust level programme teams in place at both Essex Partnership University NHS Foundation Trust and Mid and South Essex NHS Foundation Trust and workstreams are aligned and established.

The organogram below shows the feed of work streams into the Programme Board, Delivery Board and ultimately the Strategic Board. The Strategic Board membership includes Mid and South Essex Integrated Care Board and Essex Partnership University NHS Foundation Trust Chief Executive Officer's, Senior Responsible Officer's and the Integrated Care System Chief Digital Information Officer, providing the appropriate governance, oversight and empowerment to action recommendations and resolve escalations.



Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Outline Business Case Approved	Quarter one 2023/24
Invitation To Tender and Specification published	Quarter two 2023/24
Intent to award published	Quarter three 2023/24
Full Business Case Approved	Quarter four 2023/24
Contract Signature	Quarter four 2023/24
Deployment to be confirmed – subject to supplier choice and full business case approval	To be confirmed

Digital – Strategic Data Platform

What have we heard from our residents

Whilst impactful to residents this is not a resident facing product/programme of work

Current Conditions

In April 2021, Mid and South Essex Integrated Care System approved our Business Intelligence Strategy. This set out a number of recommendations around people, processes, information, and technology, to deliver on the key messages of improving the lives of our residents. Central to this was the creation of a Strategic Data Platform (now known as Athena) where data can be manipulated and collated to provide a single source of truth.

This will enable better planning at an Integrated Care System level, to provide evidence-based decision making and the ability to focus on improving services and the health and wellbeing needs for the 1.2m population in mid and south Essex.

What is the requirement from the NHS?

National guidance outlines that Integrated Care System' must "develop shared cross-system intelligence and analytical functions that use information to improve decision-making at every level, including:

- actionable insight for frontline teams.
- near-real time actionable intelligence and robust data (financial, performance, quality, outcomes).
- system-wide workforce, finance, quality and performance planning; and
- the capacity and skills needed for population health management.

Our Ambitions

The implementation of a strategic data platform is one of the main foundations to:

- unlock the full potential of our vast data sets
- improve operational planning and more effectively target our finite resources
- empower our Stewardship programme
- improve the health of our residents through the proactive targeting of services
- provide a single source of data for our system partners

Delivery priorities

- To give all mid and south Essex partners access to platforms a single view of data.

- Integration of data into population health systems
- Creation of virtual analytics team
- Data alignment
- Future data resilience

Ensuring Delivery

Senior Responsible Owner: Steve Gallagher

All developments are run through a business intelligence governance board and where appropriate we request clinical leads to own future dashboards

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Data sharing and sub license agreements that will enable all Integrated Care System partners access to the data	Quarter two 2023/24
Create a more enriched view of our residents including non-health data, such as housing, education etc	Quarter two 2023/24
Single Data Services for Commissioners Regional Office feed ideally via Arden and Gem for all Essex residents, including neighbouring Integrated Care Boards (Suffolk and North Essex and Herts and West Essex) data too	Quarter two 2023/24
To build a virtual advanced analytics team in conjunction with Arden and Gem and Essex County Council, to support future requirements around predictive analytics and demand and capacity	Quarter three 2023/24
Create a single view of the data architecture across mid and south Essex, to enable a better understanding of how data flows across the organisation, to identify bottlenecks, data quality issues, migration concerns	Quarter three 2023/24
Create a data quality framework, that includes an assessment, programme, education and metrics, to improve the quality of data across the Integrated Care System and keep at a more consistently high level	Quarter three 2023/24
To migrate all necessary GEMIMA reports to the Athena platform	Quarter one 2023/24
Ensure all General Practitioners have signed data sharing agreements allowing access to patient held data	Quarter one 2023/24

Delivery Plan objectives	Timespan for implementation of objectives
To move towards the creation of a single virtual (or physical) data and analytics team for the Integrated Care System, teaming or sharing resources, technologies, methods of delivery etc.	Quarter four 2023/24
Alignment with the Federated Data Platform and Secure Data Environment strategies with NHS England	First half of 2024/25
Implementation of a consistent methodology for the development, testing and release of future dashboards, including upskilling the workforce, as and where appropriate	Quarter two 2023/24
The inclusion of additional data flows to Athena, including non-health data, workforce etc	Quarter two 2023/24
Development of the Integrated Care System Development Plan Business Case to secure funding and ensure the platform can be sustained in the next 3-5 years	Quarter one 2023/24

Digital – Digitising Social Care Record

What have our residents told us?

NHS England is running a programme to help Care Quality Commission registered care providers to adopt a digital social care record system. They will fund 50% of providers first year implementation costs. In mid and south Essex, providers can claim up to a maximum of £10,000.

Over 87% of care providers who do not have a Digital Social Care Record system have said they would be interested in acquiring a system to enable them to spend less time on paperwork and more time delivering care, leading to better and quicker care plan creation and an overall increase in the quality of care they deliver.

Current Conditions

At the current time the care market is challenged by way of capacity to respond and draw down resources even when they may be of benefit. Our priority is to look at how the Integrated Care System invests further in resource to support the engagement of the care market as part of a match funding arrangement over the remaining two years of the national programme.

Working in partnership the Mid and South Essex Integrated Care System Digital Social Care Record team resource have run a baselining exercise with neighbouring Integrated Care Systems to establish how prevalent the use of Digital Social Care Record systems are across our market. So far, this has indicated 37% of the market use a Digital Social Care Record system, which is significantly below what Care Quality Commission have stated, however, we have had difficulty in engaging with the market to the extent we have hoped (18% of mid and south Essex based providers (111/619) have responded to our baselining survey to date) and we are working to increase the response rate.

Locally across the Mid and South Essex Integrated Care System three local authority footprints, there is an issue with the systems available to our care providers. The systems eligible for funding must come from the NHS assured supplier list. For example, in Essex, the Access Group have a high share of the market, but they are not on this list. This has led to some providers not wanting to pursue funding.

What is the requirement from the NHS?

NHS England and NHS Improvement have set a target of 60% of care providers to have a Digital Social Care Record system by 31st March 2023, and 80% by 31st March 2024.

From April 2023, the project will also include funding for falls technology, and a wider scope for what providers can claim for in regard to digital social care records. For example, they will be able to apply for funding for rostering systems.

Our Ambitions

- Ensure that all Care Quality Commission registered care providers have a digital social care record system.
- To create a locally led falls programme and reduce the risk of and occurrence of falls within our health and care system. The 10% of residents most at risk of falls will have sensor-based falls technology in place by the end of the programme.

Delivery Priorities

mid and south Essex to achieve 60% of the market having an “NHS assured supplier” Digital Social Care Record system in place by 31st March 2023, and 80% having one by 31st March 2024.

Ensuring Delivery

Integrated Care System Senior Responsible Owner: Barry Frostick
Integrated Care System Programme Director: Clare Steward

The Digital Social Care Record programme reports to the Mid and South Essex Integrated Care System Digital, Data and Technology Board. The work is being led by Essex County Council on behalf of Thurrock and Southend local authorities.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
60% Care Quality Commission registered care providers to have a Digital Social Care Record	Quarter one 2023/24
80% Care Quality Commission registered care providers to have a Digital Social Care Record	Quarter four 2023/24

Appendix 7 – Improving Operational Performance

Within this section you will find long term plans relating to:

- Maternity Services
- Women's Health Hubs
- Elective Care (including Patient Choice)
- Cancer Services
- Primary Care
- Adult Mental Health Services
- Babies, Children and Young People Mental Health Services
- Neurodiversity Services
- Babies, Children and Young People Services
- Urgent & Emergency Care Services
- Respiratory Breathlessness Services
- Outpatients Services
- Diagnostic Services
- Stroke Services
- Cardiac Services
- Cardiovascular Services
- Palliative and End of Life Care Services
- Diabetes Services
- Dermatology Services
- Eye Care Services
- Pharmacy and Medicines Optimisation
- Musculoskeletal and Pain Services

Maternity

What have our residents told us?

Listening to women, people, and their families, is fundamental to improving maternity and neonatal services. The Maternity Improvement Programme brings together all associated activity needed to address regulatory, national, and local requirements led by defined workstreams. Its progress is supported by representatives from the Local Maternity and Neonatal System and the Maternity and Neonatal Voices Partnership (a service user representative group), demonstrating the collaborative nature of this approach. This ensures maternity and neonatal services are coproduced and developed in conjunction with those using them.

Current conditions

Currently, local maternity services in mid and south Essex, are challenged by significant midwifery vacancies. To overcome this, the Local Maternity and Neonatal System, Mid and South Essex NHS Foundation Trust and the Integrated Care System are working collaboratively to ensure all avenues for both recruitment and retention are pursued, with both a short-term and long-term view.

Maternity services at Mid and South Essex NHS Foundation Trust are currently rated as ‘’Requires Improvement’’ by the Care Quality Commission, following their inspection in 2022. The maternity service at Basildon has a Section 31 Care Quality Commission Warning Notice in place and associated legal undertakings which are monitored and supported by the Local Maternity and Neonatal System, Integrated Care Board and NHS England.

Another important area of focus for local maternity services is their maternity governance team, who following recent re-organisation, are working to embed their work. Mid and South Essex NHS Foundation Trust is working closely with their NHS England Maternity Improvement Advisor to review governance processes, ensuring they are effective and robust to underpin the safety of the service.

What is the requirement from the NHS?

The NHS Maternity and Neonatal Long-Term Plan commits to achieve 50% reductions in stillbirth, maternal mortality, neonatal mortality, and serious brain injury by 2025.

It also seeks to reduce pre-term births by 25%, with a reduction in the preterm birth rate from 8% to 6%. In conjunction with this over the next five years (2023-2028), maternity and neonatal services will focus on delivery of the Maternity Transformation Programme priorities and improving the quality of maternity and neonatal care to enable the movement of the Care Quality Commission’s maternity services rating from ‘’Requires Improvement’’ to ‘’Good’’.

Our Ambitions

The Mid and South Essex Local Maternity and Neonatal System comprises a wide variety of individuals and organisations involved in maternity and neonatal services, including representatives for those who use them. It is committed to improving both the quality of care and the experience of those using maternity services, ensuring it reflects a safe, personalised, and equitable service, based around the needs of a woman or person, and her family. We are working to implement the vision set out in Better Births (2016) through delivery of the national Maternity Transformation Programme.

Alongside this, the Local Maternity and Neonatal System will continue to have oversight of the Immediate and Essential Actions identified within the final Ockenden report as well as the recommendations from the independent investigation into East Kent's maternity services. These will continue to inform maternity services organisation and care delivery, which is key to the ongoing improvement and learning needed by our services.

Delivery Priorities

The key priorities for the Local Maternity and Neonatal System and maternity services provided in mid and south Essex include:

- Supporting the provision of midwifery continuity of carer, as the default model of care by ensuring the building blocks are in place for continued safe rollout.
- Ensuring the implementation of the five elements of the Saving Babies Lives care bundle v2, including any future iterations of it.
- Ensuring ongoing participation in the national Maternity and Neonatal Safety Improvement Programme.
- The establishment of Maternal Medicine Networks, so that women with significant medical problems have timely access to specialist advice and care at any stage of pregnancy. Maternity Medicine pathways will seek to establish referral processes between primary care providers and local maternity services, in order to achieve this.
- The Local Maternity and Neonatal System will support the delivery of the Equity and Equality action plan, to reduce health inequalities in maternity and neonatal care.
- The development of smoke free pregnancy pathways, reflecting the NHS Long Term Plan ambition.
- Implementation of Maternal Mental Health Services, initially for those who have experienced the loss of a baby, as part of a collaboration between perinatal mental health and maternity services.

- The development of local Perinatal Pelvic Health Services in conjunction with specialist midwives and physiotherapists.
- Ensuring all women are offered a personalised care and support plan underpinned by a risk assessment and in line with national guidance. These will be developed in collaboration with Maternity and Neonatal Voices Partnerships.
- Supporting the ongoing implementation of the Trust's Digital Maternity Strategy and digital roadmap, to improve women's access to their records and plans, clinicians use of digital technology and the organisations access to key information.

MSE Long Term Plan stillbirth rate ambition

Rates and numbers of live and stillbirths	Baseline 2016	2019/20	2020/21	2021/22	2022/23	2023/24
Ambition rate per 1,000 live births and stillbirths	4.3	3.6	3.5	3.3	3.1	2.9
Actual rate per 1,000 live births and stillbirths	4.3	2019 - 3.12	2020 - 3.24	2021 - 3.15		

*Data source Perinatal mortality by organisation | MBRRACE-UK (le.ac.uk)

MSE Long Term Plan neonatal mortality rate ambition

Rates and numbers of neonatal mortality	Baseline 2016	2019/20	2020/21	2021/22	2022/23	2023/24
Ambition rate per 1,000 live births and stillbirths	1.0	0.9	0.8	0.8	0.7	0.6
Actual rate per 1,000 live births and stillbirths	1.0	2019 1.27	2020 1.06	2021 – 0.84		

*Data source Perinatal mortality by organisation | MBRRACE-UK (le.ac.uk)

Note: National data reported by calendar year with availability to 2021 currently. Itis acknowledged that the pandemic has had an impact on rates of stillbirth and preterm birth (which may in turn impact rates of neonatal death), and this should be taken into consideration.

Ensuring Delivery

Senior Responsible Owner: Dr Giles Thorpe, Chief Nurse
Clinical Lead: Gemma Hickford

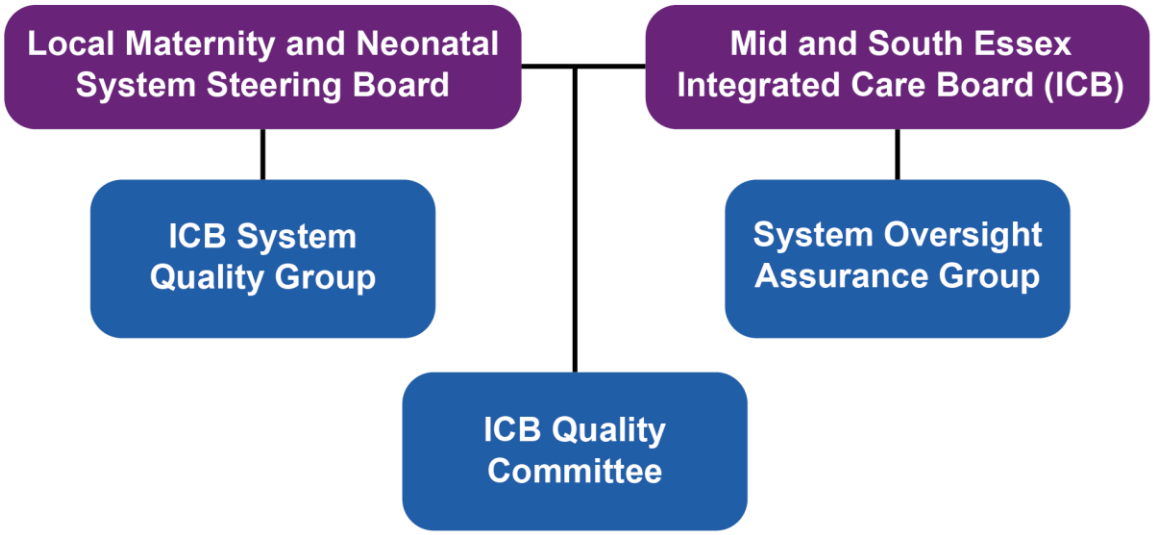
The Local Maternity and Neonatal System has clear governance processes in place that ensures oversight is provided by the Local Maternity and Neonatal System Steering Board, which is chaired by the Maternity Senior Responsible Owner and Chief Nurse for the Integrated Care Board. In line with NHS England guidance, the Local Maternity and Neonatal System is responsible for full and ongoing oversight of quality, and this understanding of the quality of local maternity and neonatal services informs transformation.

In conjunction with this, the revised Perinatal Quality Surveillance Model has been implemented, detailing the clear lines of responsibility and accountability held by the trust, Local Maternity and Neonatal System/Integrated Care System, regional and national NHS England teams, in terms of addressing quality concerns at each level of the system.

Several of the priorities identified are operationally overseen by Trust based workstreams, organisational escalation at Trust level is then expected to be through the Maternity Improvement Programme Committee.

The Local Maternity and Neonatal System Steering Board will also receive escalations and maintains system oversight of progress against priorities for transformation.

The below shows the System governance structure.



Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Reduce rates of maternal, neonatal deaths stillbirths and brain injury by 50%	Second half of 2024/25
Increase proportion of smoke free pregnancies to 94% or greater	Quarter two 2023/24
Improve access to perinatal mental health care	Quarter three 2023/24
Provide improved access to specialist pelvic health services	Quarter three 2023/24
Ensure all women and pregnant people are offered a personalised care and support plan during pregnancy	Quarter three 2023/24
Reduce preterm birth rates by 25%, from 8% to 6%	Second half of 2024/25

Women's Health Hubs

What is the requirement from the NHS?

The Government has identified the opportunity to integrate women's health services more effectively, with a more woman-centred, life course approach, reflected in the new Women's Health Strategy. The Women's Health Strategy for England, which was published in July 2022, sets out a ten-year plan for each Integrated Care Board to boost health outcomes for all women and girls and radically improve the way in which the health and care system engages and listens to all women and girls. The strategy encourages the expansion of Women's Health Hubs and other models of one stop clinics across the country. The overarching ambition of the Women's Health Hub model is to improve women's access and experiences of care by better integrating the services and support they require throughout their life.

Our Ambition

Mid and South Essex Integrated Care System has an opportunity to improve the way care pathways work for women living in our footprint, determining priorities based on local need, identifying and addressing barriers in commissioning and funding to improve Women's health and wellbeing through the development of a Women's Health Hub. The Women's Health Hub model brings together a range of women's health services including contraception, menstrual health, menopause, abortion and screening, tailored to the needs of the region. Hubs are not necessarily a 'place' but a 'concept' where healthcare professionals with enhanced skills bring together their expertise. It enables these healthcare professionals to offer a wide range of women's health services in an easy to access location. It uses the right healthcare professional at the right time, in the right place to ensure a sustainable approach.

Delivery Priorities

The key project milestones for the development of a Women's Health Hub in mid and south Essex include:

Delivery Plan objectives	Timespan for implementation of objectives
Mapping of Women's services available in mid and south Essex	June 2023
Development of a Women's Health Strategy for Mid and South Essex Integrated Care Board outlining the concept for the Women's Health Hub	June 2023
Project initiation, development of key stakeholder groups, robust project planning to deliver the priorities of the Women's Health Strategy for mid and south Essex	June 2023 onwards

Go live with mid and south Essex Women's Health Hub	April 2024

Elective Care (Including Choice)

What have our residents told us?

Our residents want the ability to choose provider, they want to be able to receive care close to home and in a timely manner.

Current Conditions

The key challenge for elective recovery is the ability to provide continued service when capacity for delivery is impacted by wider non-elective pressures within the system. We continue to work with other System partners (Independent Sector and Community Providers) so we can maximise capacity to support, manage and treat people awaiting elective care. Sustaining focus on other key areas for example virtual clinic appointments and patient initiated follow ups will be the key to releasing capacity both now and for the future.

Enabling people to be well and as fit as possible whilst waiting for care is critical to ensuring we can deliver treatments / procedures as quickly as possible. Information and communication for people waiting has been developed – this is promoted via the MyPlannedCare website. This is a national platform for the public to access information about local services, including provider waiting times so that patients can exercise choice as per the national Choice Framework.

What is the requirement from the NHS?

Mid and South Essex Integrated Care System is required to respond to the national planning asks for elective operating priorities, which are supplemented with asks from national team throughout the year.

Our Ambition

As outlined in the Long Term Plan our focus for Elective care remains:

Bringing Care Closer to Home:

- Joining up our different health, care and voluntary services means we can bring services closer people's homes –whether that is through support on-line, or by bringing health and care services into the community such as some hospital outpatient appointments, tests like x-rays and blood tests and support for people living with long term conditions like diabetes or breathing problems.

Improving and Transforming Our Services:

Ensuring our residents have the highest chances of recovery from their illness or condition, and to give them the best treatment we can, to live as well as they can.

Demand for services is changing as people grow older and live with more long-term conditions and there is much more we could do with technology, medical

advances and new ways of working to treat people at an earlier stage, avoid more serious illness, and to live as well as they can for longer.

Delivery Priorities

- Having clear recovery trajectories and plans for the key asks as per the 2023/24 National Planning Guidance. Operating priorities will be subject to change as Planning Guidance is released and refreshed annually.
- There were additional elective recovery asks sent to each System within the National Tier 1 and Tier 2 letter. The Mid and South Essex NHS Foundation Trust board completed its assessment against these – these are overseen via the Elective Board.
- The key Referral to Treatment deliverable is to have zero patients waiting 65+ weeks from March 2024 onwards.

The below table shows the mid and south Essex system planned Referral to Treatment 65+ week backlog trajectory to a zero position from March 2024.

Date	April 2023	May 2023	June 2023	July 2023	August 2023	September 2023	October 2023
No.	4,383	3,985	3,585	3,187	2,791	2,391	1,994

Date	November 2023	December 2023	January 2024	February 2024	March 2024
No.	1,596	1,196	799	402	0

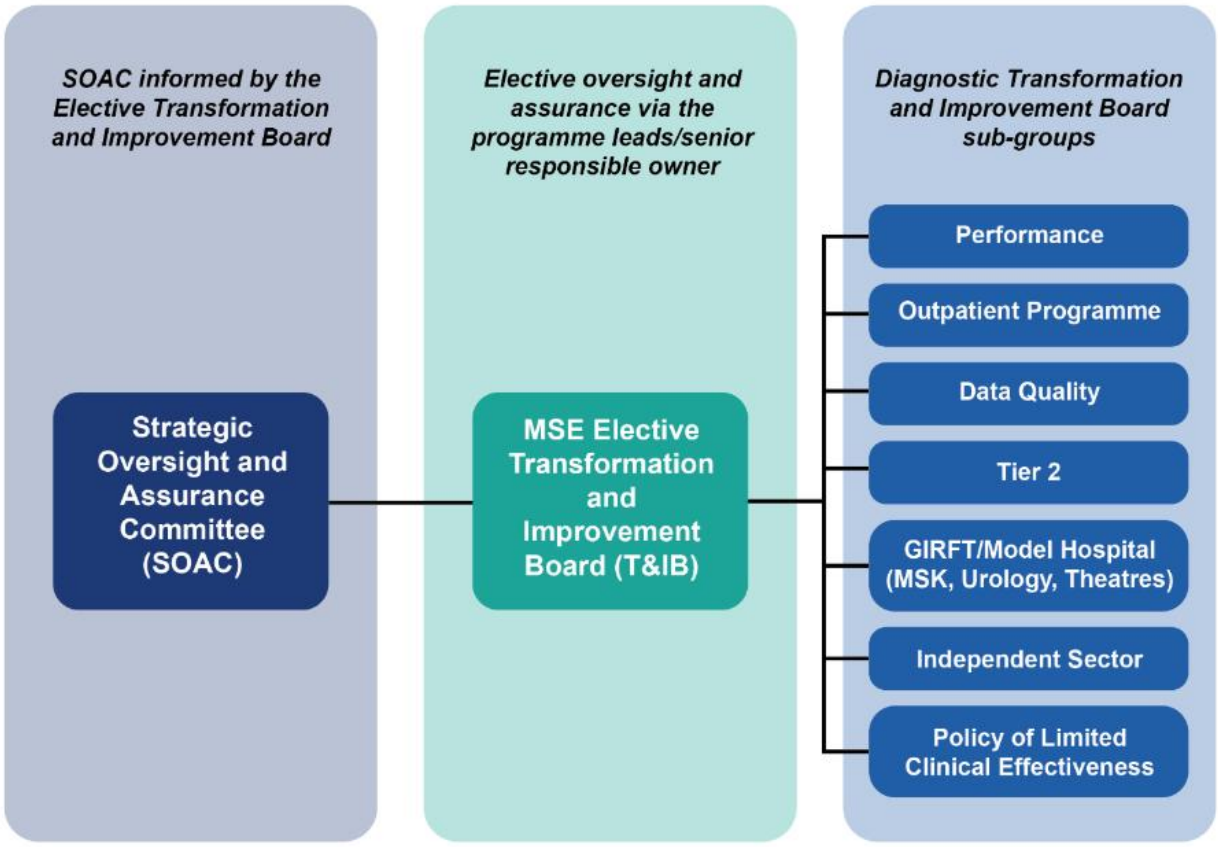
Ensuring Delivery

Senior Responsible Owner: Andrew Pike
Clinical Lead: Ronan Fenton

The Mid and South Essex Transformation and Improvement Board for Elective Care oversees all aspects of elective (referral to treatment). The National Planning asks, and delivery, recovery or mitigation plans are presented here for assurance.

This Board then collates headline risks, actions and escalation items which are presented to the Mid and South Essex Integrated Care System's Oversight and Assurance Committee.

The below shows the System governance structure.



GIRFT - Getting it right first time
MSK - musculoskeletal

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Detailed plans for 23/24 are set out within the operational planning submission	From quarter one to quarter four 2023/24
Achievement of zero patients waiting over 65 weeks for their procedure	Quarter four 2023/24
Continue to increase number of patients receiving virtual outpatient appointment	From quarter one to quarter four 2023/24
Continue to increase number of patients receiving their follow up appointment as patient initiated as opposed to a pre-booked appointment (empowering the patient)	From quarter one to quarter four 2023/24
Continue to reduce patients waiting over 52 weeks for their procedure	From quarter one 2023/24 to second half of 2025/28

Cancer Services

What have our residents told us?

Currently our patients are waiting too long to find out if they have a cancer diagnosis, or for their treatment.

Cancer Stewards to continue to lead the Cancer transformation programme across mid and south Essex including involvement in best practice pathway review and sustainability, allocation of Cancer Alliance resources for the optimum outcome that supports the short-, medium- and long-term System ambition for cancer services and population health.

Ensuring our residents have the highest chances of recovery from their illness or condition, and to give them the best treatment we can, through implementation of best practice pathways. Demand for services is changing, we will use technology to implement new ways of providing care.

Personalisation is paramount to how we engage with our population and underpinned by leadership and a skilled workforce who can respond to population needs, this includes use of shared decision making to ensure that the patient pathway is right for them.

To achieve our ambition, we need to understand what our population want from us and ensure that any change is underpinned by experience, feedback and engagement from service users, ensuring use of co-production in future pathway redesign.

Recognising the importance of pre-habilitation and rehabilitation and improving post treatment care for those individuals, their families and carers. Empowering people to re-engage with services as part of their self-management plan.

Current Conditions

To effectively deliver best practice pathways and develop cancer services we need the right workforce across all specialties. Succession planning, recruitment and retention of workforce is essential to service delivery. The right staff and ongoing training must be part of our workforce plans. Workforce considerations for effective and safe cancer services need to include diagnostics and pathology because without capacity here the ability to recover cancer services will be impacted.

Across Cancer services working with all partners including primary care networks is critical, work with the Primary Care Networks is essential to improving information shared with referrals to enable patients to be actively triaged to the right pathway for them.

The System is moving services closer to home, particularly for diagnostics and chemotherapy.

What is the requirement from the NHS?

Mid and South Essex Integrated Care System is required to respond to the national planning asks for cancer, these are supplemented with asks from national team throughout the year.

Our Ambitions

As outlined in the Mid and South Essex Long Term Plan our focus for Cancer remains:

- Promoting use of screening and tests to enable early diagnosis across cancer services including access for marginalised groups. This promotion extends to non-invasive tests to support early diagnosis.
- Consolidation of the Rapid Diagnostic Service for patients to incorporate a consistent offer across our population this will include non-site specific symptoms which could indicate cancer and ensure people are on the correct pathway.
- Implementation of a range of Targeted Interventions to enable case finding and active promotion and prevention for individuals
- Continuing National Targeted Lung Health Checks to support earlier diagnosis of lung cancer as per National requirement.

Delivery Priorities

To enable safe care our patient pathways, need to be supported by enablers including the shared patient record, so that wherever the patient attends for their care, their clinical team can see their records to reduce delays.

Joining up our different health, care and voluntary services means we can bring services closer to people's homes. Opportunities for care closer to home include chemotherapy, infusions, surveillance diagnostics, local tests and access to medication.

We will develop a System wide approach for cancer patients ensuring effective pathways and partnership working and following Nationally agreed best practice pathways.

We will continue to work with our patient population. The two pilots in development:

1. Virtual Group Cancer Care Review
2. Prostate Case Finding pilot

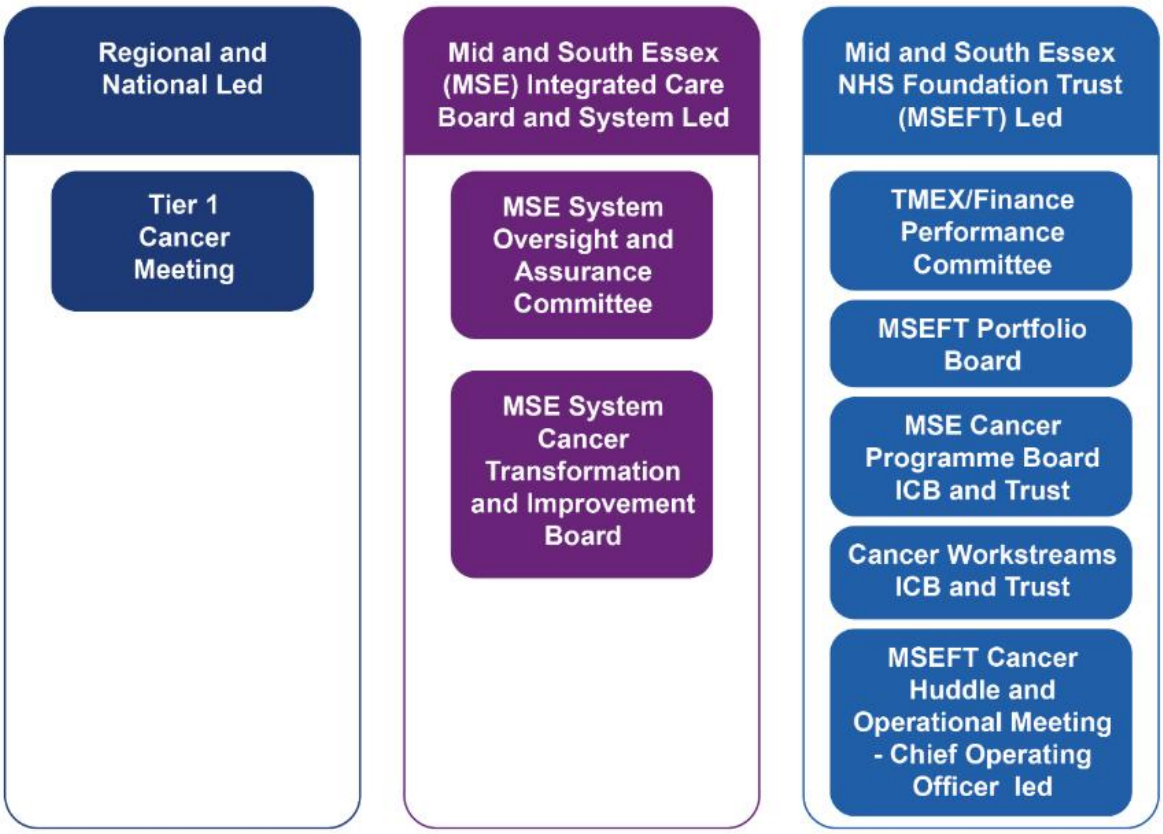
are two examples of co-production that have involved patients from the very start, and we are committed to build on co-production work.

We will continue to involve and listen to our Mid and South Essex Patient Champion Engagement Committee.

Ensuring Delivery

Senior Responsible Owner: Karen Wesson
Clinical Lead: Liz Towers

The Mid and South Essex Transformation and Improvement Board for Cancer oversees all aspects of cancer care. The National Planning asks, and delivery, recovery or mitigation plans are presented here for assurance. This Board then collates headline risks, actions and escalation items which are presented to the Mid and South Essex Integrated Care System's Oversight and Assurance Committee.



The above shows the System and internal Trust governance structure.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
The priority pathways with continued initial focus for 2023/24 to reduce patients waiting over 62 days are: • Skin • Colorectal • Prostate • Gynaecology • Breast	From quarter one to quarter four 2023/24
Trust tracking of tumour site trajectories for Haematology, Head & Neck, Lung and Upper Gastrointestinal Intestinal during 23/24	Quarter two 2023/24
28-day Cancer faster diagnosis standard (67.5% - June 23 / 70% - Sept 23 / 72.5% - Dec 23 / 75% - March 24)	Quarter four 2023/24
Targeted improvement and recovery plans for increasing % of cancers diagnosed at states 1 & 2 *(See 23/24 operational plan for further details relating to –* • Lynch Testing • Prostate Case Finding • Cervical Screening • IT system improvement • Pathology systems improvements • Bowel Screening • Non-specific Symptoms pathways • Targeted Lung Health Checks	From quarter one to quarter four 2023/24

Adult Mental Health Services

What have our residents told us?

Working with our communities and against national guidance has been key to how we transform mental health services. The message from our local population has been an ask for services to be more joined up, ensuring users and communities are part of co-producing services, making care individualised and responsive with prevention and early intervention to support them live well in their communities.

We continue to hear from local residents, staff working within the Integrated Care System and in the Integrated Care Board about the challenges of joined up working. This spans across the acute, secondary, and primary care space and across physical and mental health care and social arenas. This means a change in language, physical and digital space and building confidence in the workforce to be able to hold the whole person in mind and make sure that we optimise every contact.

Current Conditions

Our Mental Health Partnership Board through the Whole System Transformation Group has overseen the development of the transformation to enhance effective delivery on the Long-Term Plan commitments through the Mental Health Investment Standard. The current transformation of community mental health services whilst ongoing has highlights of a system with significant reliance on inpatient services, a workforce challenge and sometimes a lack of defined structure between system and place.

Through our focus on the wider determinants of health, our primary care networks, and place-based plans, we want to ensure the system rebalances in favour of prevention, early intervention, resilience, and recovery.

What is the requirement from the NHS?

Mental health transformation continues to take place in Mid & South Essex, aligned with the calls to improve and widen access to mental health support outlined in the 2021 report from the independent Mental Health Taskforce review, the Five Year Forward View for Mental Health1 and the NHS Long Term Plan.

Our Ambitions

The Southend, Essex and Thurrock Mental Health and Wellbeing Strategy 2017-2021, (being refreshed 2022) articulated a common vision and ambition for the development of high-quality mental health care, around the commitment to “ensure that everyone needing support in Southend, Essex and Thurrock–including families and carers –get the right service at the right time from the right people in the right

way”2. The Strategy explicitly acknowledged the 8 principles set out in the NHS Five Year Forward View for Mental Health.

Our vision for mental health in Mid & South Essex Integrated Care System is to:

- Improve urgent and emergency care mental health – crisis response and care.
- Integrate social care, mental health and physical health – parity of esteem and care closer to home.
- Promote good mental health and preventing poor mental health – early intervention and prevention.
- Moving the narrative to a ‘we/our’ shared language rather than ‘them/us’ language, to support understanding and confidence in the system about the person’s journey through services.
- Collocating services either physically or virtually so that every contact can be maximise and skills can be shared.
- Commitment to all age Mental Health strategy and delivery through a collaborative as part of the strategy implementation

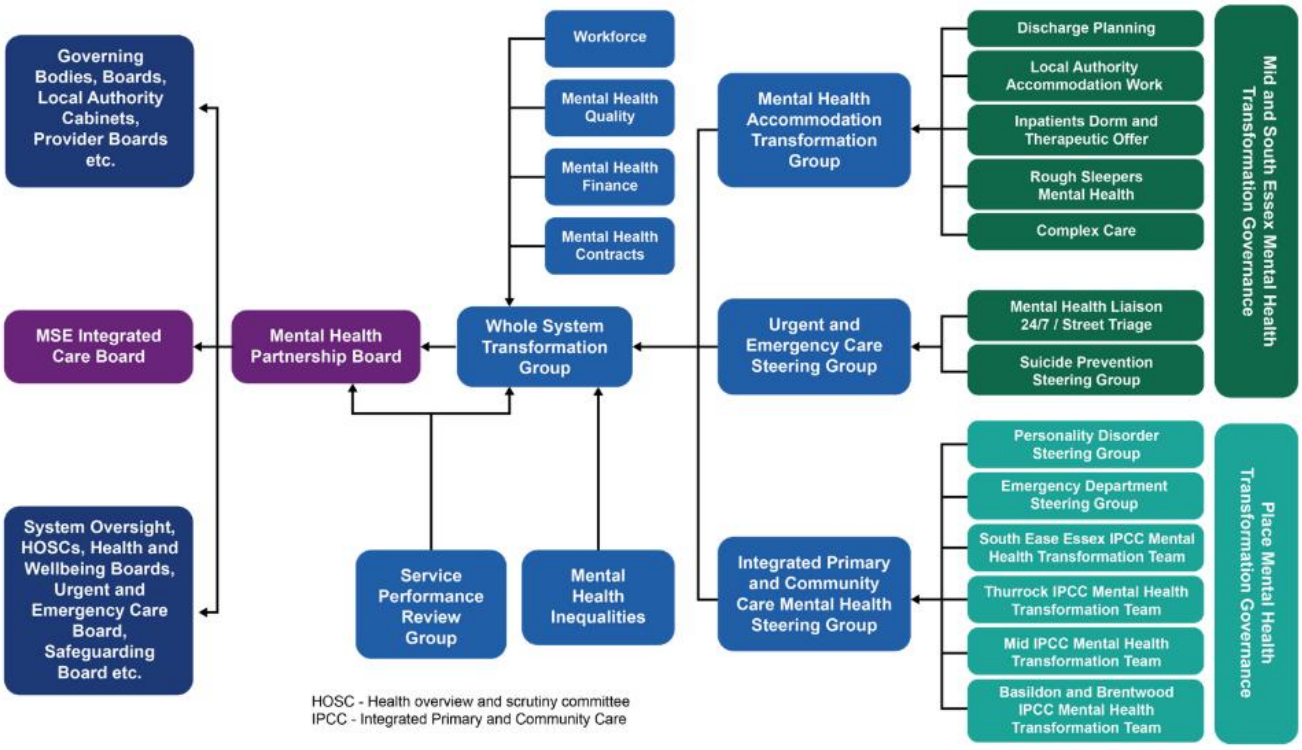
Delivery Priorities

1. Urgent and Emergency Care Mental Health
2. Liaison Mental Health
3. Adult and Older Adult Crisis
4. Acute Care (including Out of Area Placements)
5. Community Serious Mental Illness services for Adults and Older Adults
6. Early Intervention in Psychosis
7. Individual placement services
8. Serious Mental Illness – Physical Health Checks
9. Advancing Inequalities in Mental Health
10. Integrated Primary and Community Care Mental Health
11. Community Chronic Mental Illness for Adults and Older Adults
12. Improving Access to Psychological Therapies
13. Perinatal
14. Integrated model
15. Dementia
16. Functional Older Adults
17. Suicide Reduction & Bereavement
18. Bereavement
19. Complex Care & and move from Care Programme Approach

Ensuring Delivery

Senior Responsible Owner: Maria Crowley
Clinical Lead: Amy Bartlett

Below organogram of system governance arrangements.



Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
A range of complementary and alternative crisis services to Accident & Emergency and admission (including in voluntary and community, faith and social enterprise/ local authority-provided services) within all local mental health crisis pathways;	Quarter three 2023/24
Deliver against Integrated Care Board level plans to eliminate inappropriate adult acute out of area placements as against planned trajectory	Quarter four 2023/24
The therapeutic offer from inpatient mental health services will be improved by increased investment in interventions and activities, resulting in better patient outcomes and experience in hospital. This will contribute to a reduction in length of stay for all services to the current national average of 32 days (or fewer) in adult acute inpatient mental health settings (“Time to Care”)	First half of 2024/25
Established new specialist mental health provision for rough sleepers	Quarter two 2023/24
Deliver against multi-agency suicide prevention plans, working towards a national 10% reduction	Quarter one 2023/24

Delivery Plan objectives	Timespan for implementation of objectives
in suicides with a suicide bereavement plan in place	
All areas within Mid and South Essex Integrated Care Board will maintain the existing Talking Therapies referral to treatment time and recovery standards	Quarter three 2023/24
Supporting women to access evidence-based specialist mental health care during the perinatal period. This will include access to psychological therapies and the right range of specialist community	First half of 2024/25
Provision of NHS specialist treatment for people with serious gambling problems.	Quarter four 2023/24
Mental health professionals working in ambulance control rooms, Integrated Urgent Care services, and providing on-the-scene response via a Mental Health ambulance car in line with clinical quality indicators	Quarter two 2023/24
Continuation of the new integrated community models for adults with Serious Mental Illness (including care for people with eating disorders, mental health rehabilitation needs and a 'personality disorder' diagnosis) spanning both core community provision and implementation of the complex care pathway with a move to "personalised Care "for greater choice and control, moving away from the care programme approach	Quarter three 2023/24
Implementation of recovery colleges and improving access to Individual Placement and Support to be doubled, enabling people with severe mental illnesses to find and retain employment. Ensuring over 60% of people experiencing a first episode of psychosis will have access to a National Institute for Health and Care Excellence - approved care package within two weeks of referral. 60% of services will achieve Level 3 National Institute of Health and Care Excellence concordance by end 2023/24	Quarter four 2023/24

Children and Young People Mental Health

What have we heard from residents/patients

The evidence tells us that Children and Young People are continuing to recover from the impact of the pandemic which for some has had a negative effect on their development, emotional wellbeing, and mental health.

Families tell us it remains difficult to access specialist mental health services in a timely way and that the wide variety of services on offer are challenging to navigate.

What is the current state of play/local challenges

The demand has risen for services with the number of children who have concerns with their mental health increasing to 1 in 6 in comparison to 1 in 9 only 5 years ago (Young MINDs).

What is the requirement from NHS

The NHS Long Term Plan sets out the ambition to expand Children and Young Peoples Mental Health Services widening the access to services closer to home, reduce unnecessary delays and deliver specialist mental health care in ways which work better for families. This builds on the commitment from the Children and Young Peoples mental health green paper which brings together the Department for Education and Department of Health in a programme of work to strengthen the support and offer in educational settings. Working in partnership we will continue to educate families and young people in managing and preventing the potential risks of online harm and high-risk behaviours.

What is the ambition?

The Southend, Essex and Thurrock Mental Health and Wellbeing Strategy is an all-age strategy which identified specific areas for focus including Eating Disorders, Crisis services, integrated care within local acute trusts, improving access and ability to measure outcomes and use of digital technology to support care.

We know the support young people require as they move into adulthood often needs to be bespoke and holistic to this age group and will be working across the sectors to develop this further.

What are the delivery priorities?

1. To continue with the expansion and transformation of mental health services, as set out in the NHS Mental health Implementation Plan and improve the quality of Mental Health care across all ages.

2. There are clear pressures in relation to Children and Young People referrals (demand), acuity and severity of needs. A whole system approach is needed to harness effective prevention and early intervention initiatives. This acknowledges the health inequalities which are influenced by economic factors, relational influences, individual and family health and wellbeing and environment in which we live.
3. To increase access and equality, build capacity and capability in the system and build resilience in the community.
4. Priorities prevention and early intervention across education, health and care and voluntary and community, faith and social enterprise pathways and continue to transform services to deliver better outcomes and more resilient Children and Young People

Governance

Senior Responsible Owner: Dr Giles Thorpe, Chief Nurse
Clinical Lead: Amy Bartlett

Delivery of the strategic ambitions and programme will be overseen by the Children's Commissioning Collaborative for Southend, Essex and Thurrock with the development of the Mental health Strategy Implementation Group which will provide the oversight for both adults and children mental health programmes of work. mid and south Essex publish our Open Up Reach Out Local Transformation Plan annually which identifies areas of investment and progress on delivery.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Transformation of the Children and Young People Eating Disorder Pathways to include Specialist Treatment and Recovery Service roles	From quarter three to quarter four 2023/24
To use feedback tools and routine outcome measures to ensure the voice of the Children and Young People is centre and care is person centred.	Quarter four 2023/24
Develop the service offer for 18–25-year-olds to support transition to adulthood.	From quarter one to quarter four 2023/24
Expansion of Mental health Support Teams in Schools waves 7 & 9	From quarter three 2023/24 to first half of 2024/25
Embedding Children and Young People Mental Health practitioners in a phased approach with Primary Care.	From quarter three 2023/24 to second half of 2024/25
Expansion of Learning Disability /Neuro Diversity Child and Adolescent Mental Health Team	From quarter four 2023/24 to second half of 2024/25
Capital development programme for Children and Young People Eating Disorder Service	From quarter four 2023/24 to first half of 2024/25
Review and design a model of care with voluntary and community, faith and social enterprise providers for mid and south Essex .	From quarter two 2023/24 to first half of 2024/25

Neurodiversity

What have our residents told us?

The current challenge is to fully understand the models of provision and identify the gaps and variations across mid and south Essex and (where appropriate) on the greater Essex landscape. This includes working with a wider set of partners, stakeholders and communities, experts by experience and their families to obtaining feedback to help shape and deliver modern fit for purpose models of neurodiversity provision.

Current Conditions

Currently neurodiversity services are delivered by a range of statutory and voluntary agencies which are not aligned or delivered within an agreed strategic approach. This presents with challenges of inequitable access, variation in provision, fragmented delivery which is not maximising the opportunities of working collaboratively within an all-age approach to provide the best and most efficient models of care for people requiring support with neurodiversity presentations.

What is the requirement from the NHS?

We need to ensure the provision and commissioning of models of care meet the statutory requirements.

To ensure local provision reflects the needs and requirements of the standards or codes of conduct to addresses inequalities in access, variations in provision.

To ensure appropriate governance and oversight of the provision of services, to continuously review and evaluate the models of provision to reflect the changing socio-economic situations impacting on local populations.

Our Ambitions

For NHS, Local Authorities, voluntary services and others to work collaboratively to co-produce services that are equipped and designed to around family health models.

To deliver models of care that maximise resource allocation within a whole system, all age pathways.

To develop new and innovative ways of partnership working that focus on family health models (all age models) with better alignment between the NHS, local authority and associated partners.

To address the growing demand for access and whole system models of provision that maximise resources.

Delivery Priorities

2023/24 we will undertake a comprehensive mapping of current service provision and identify the gaps to inform an all age, whole systems joined up approach to deliver fit for purpose Neurodiversity programmes.

The Integrated Care Board has approved the appointment of a dedicated project lead post on a fixed term basis to undertake this mapping work.

We will develop new partnership models for delivery of our Neurodiversity programmes which aligns to the babies, children and young people's programme, and in line with the spirit of the Integrated Care Strategy. This will complement existing work underway to develop and all age, mental health strategy pan Essex.

Ensuring Delivery

Senior Responsible Owner: Dr Giles Thorpe, Chief Nurse
Clinical Lead: Maria Crowley

The delivery of programme of work for Neurodiversity will be set out in 2023/4 and remain accountable to the Integrated Care Board on deliverables. The Integrated Care Board will provider oversight and governance on the programme and will want to ensure alignment to the Children and Young People and mental health programmes of work.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Integrated Care Board in consultation with partners and providers undertake an all-age review of the current provision of services across Essex, identifying the current pathway and provision, identify gaps in provision.	Quarter one 2023/24
Develop new partnership models for delivery of the Neurodiversity programmes which aligns to the babies, children and young people programme and is in line with the Integrated Care Strategy.	Quarter two 2023/24
Ensure appropriate procurement and commissioning of fit for purpose, evidence based modern models of care for Neurodiversity that is aligned to Children and Young People and mental health commissioned services.	Quarter three 2023/24
Review and evaluation of the commissioned models of provision to inform ongoing service developments in consultation with stakeholders which takes into account research findings, new and emerging policy changes.	From quarter four 2023/24 to first half of 2024/25

Babies, Children and Young Peoples Services

What have our residents told us?

Co-production with Children and Young People and families is central to the development of our strategic direction and is reflected in the development of agreed values and principles.

Current Conditions

mid and south Essex has a children population of circa 270k and although there are similarities in health needs there are also significant variations associated with demographics and wider determinants of health.

mid and south Essex will have a Children and Young People Panel to support the strategic work of the Integrated Care Board which will be further developed with children and young people in parallel with the Children's Partnership Framework.

We continue to shape services adopting the principles of a person-centred approach to care and preparing Children and Young People and their families for effective transition to adulthood.

What is the requirement from the NHS?

The Integrated Care System will deliver the ambitions of the NHS Long Term Plan supported by the partnerships and identifying synergies with wider Government Strategies including Levelling Up and Regeneration, Social Care reforms, Schools white paper opportunity for all and Family Hubs and Start for Life programme.

The NHS has specific statutory requirements under the Children's and Family Act and Special Education Needs and Disabilities Code of Practice in relation to Special Educational Needs and Disabilities and will continue to work in partnership with the Local Areas Special Education Needs and Disabilities Boards in delivery of the respective Special Education Needs and Disabilities Strategies and Inclusion Plans.

The Core 20+5 Framework for Children and Young People has identified areas for focus including Diabetes, Epilepsy, Asthma, Oral Health and Mental Health. There will be a continuous focus on improving the outcomes for those in our most deprived areas and cohorts of Children and Young People where the outcomes are not comparable with their peers such as children who are in care, Special Education Needs and Disabilities and those involved in the youth justice system.

The Children and Young People ambitions will be the responsibility of the Growing Well Programme Board led by the Director for Children and Young People and clinical lead. The Growing Well Programme Board will align and connect with the

Essex, Southend and Thurrock Children and Young People partnership forums and the four alliances.

Our Ambitions

As a partnership, we are committed to improving the lives of Children and Young People and it stands as a top priority for us as a system. To support this ambition, we have developed a Partnership Framework which recognised the strategies and priorities held by many organisations and is designed as an enabler recognising that we can have a bigger impact by working on factors that influence health and wellbeing, not just at the point of illness or crisis.

In 2023/24 we will develop new partnership models for delivery of our Children and Young People and Neurodiversity programmes, working with a wider set of partners and stakeholders and communities, in line with the spirit of the Integrated Care Strategy. It is anticipated this will see us securing additional resources to bring this work forwards. This will complement existing work underway to develop and all age, mental health strategy pan Essex.

Delivery Priorities

We have 6 priority areas of work with associated programmes. These include Children and Young People Mental health, Special Education Needs and Disability, Neurodiversity, Palliative and End of Life, Transformation of Community Services and Urgent and Emergency pathways.

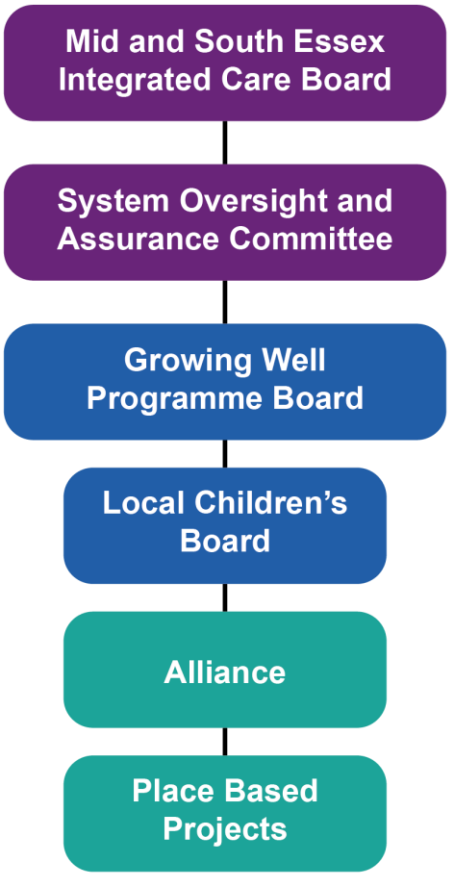
There is an opportunity with existing partnerships to secure development resources to form a new integrated Babies, Children and Young People approach, starting with early years health and care and then extending into all Children and Young People.

Ensuring delivery

Senior Responsible Owner: Dr Giles Thorpe, Chief Nurse
Clinical Lead: Dr Sooraj Natarajan

The Children and Young People ambitions for the NHS Long Term Plan will be the responsibility of the Growing Well Programme Board led by the Director for Children and Young People and clinical lead. The Growing Well Programme Board will align and connect with the Essex, Southend and Thurrock Children and Young People partnership forums and the four alliances.

Below organogram of system governance arrangements.



Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Asthma: Children and Young People Community Asthma team aligned to 8 PCNs in South East Essex by March 2024	Quarter four 2023/24
Children and Young People End of Life: Agreed Children and Young People End of Life Ambitions Framework Implementation Plan by December 2023	First half 2024/25
Children and Young People End of Life: 24/7 Palliative and End of Life Care service in place by March 2025	Second half 2024/25
Diabetes: Agreed Improvement Plan developed by March 2024	Quarter four 2023/24

Delivery Plan objectives	Timespan for implementation of objectives
Diabetes: Increase access to Continuous Glucose Monitoring and insulin pumps within agreed protocols and National Institute of Health and Care Excellence Guidance by 25/26	2025/28
Epilepsy: Agreed Improvement Plan developed by March 2024	Quarter four 2023/24
Urgent & Emergency Care: Hospital@Home pilot in place by September 2023	First half of 2024/25
Urgent and Emergency Care: Long-term Paediatric Acute Respiratory Infection Model in place by December 2023	Quarter two 2023/24
To reduce the number of children requiring higher levels of mental health services by strengthening early intervention, support and education for Schools and Colleges.	Quarter one 2023/24
To improve access to specialist Children and Young People Mental Health Services	Quarter one 2023/24
To improve the outcomes and experience of children and young people with Special Educational Needs and Disabilities and ensure the Integrated Care Board meets it statutory requirements.	Second half of 2024/25

Reducing Pressure on Urgent and Emergency Care Services

What have our residents told us?

Co-production with patients and families and system partners is central to the development of our strategic direction for Urgent and Emergency Care services.

Current Conditions

The urgent care system is under significant pressure and this impacts on our responsiveness to sustain delivery to elective and cancer services. All partners are working hard to address urgent care pressures and ensure service provision for people alternative to Emergency Department that meet their needs and requirements.

We have three established sub-systems for urgent and emergency care (southeast, southwest, and mid Essex). These sub-systems currently have their own delivery boards, where partners work together to deliver improved urgent and emergency care services, which feed into the Mid & South Essex Urgent and Emergency Care Transformation & Improvement Board

111 Service:

We have a comprehensive NHS 111 service covering the entire mid and south Essex population. This includes a single multidisciplinary Clinical Assessment Service within integrated NHS 111, ambulance dispatch and General Practitioner out of hours services. NHS111 provision from Mid & South Essex is provided by IC24, who went live with the online NHS111 in December 2022, as well as the continuation of the telephony service.

As part of the national Pathways Light programme, from April 2023 our IC24 Provider will be increasing service provision to incorporate access to Dental Service Advisor, urgent repeat prescriptions and Minor Injuries Service Advisor.

Same Day Emergency Services:

All three hospitals offer a same day emergency service for 12 hours/day, 7 days/week. These services provide fast access for patients to diagnostics and treatment and reduce hospital admissions.

The Same day emergency service models are currently under review to ensure maximise service provision opportunity to ensure same day treatment.

Alternative to Emergency Department:

Mid & South Essex will be an early adopter, commencing in Quarter 1 2023/23 for Alternative to Emergency Department to support the delivery of a roadmap for individuals to be aware of service existence, and how to access the service. As well as overview of gaps in the roadmap for further interventions/investment.

Older People's Service:

Our three hospitals have worked to develop assessment and treatment units specifically to meet the needs of older people.

At Broomfield, the operating hours of the Frailty Ambulatory Service is 08.00-20.00 Mon-Sun.

At Southend the Frailty Service currently operates Monday-Friday 09:00 to 17:00.

Basildon offers a full 7-day frailty service.

Virtual Wards:

The current baseline of virtual ward capacity for mid and south Essex is 175 virtual ward beds. The virtual ward baseline as at 31.03.23 is as follows:

- Respiratory Virtual Ward: 45 beds
- Frailty Virtual Ward: 60 beds
- Hospital@Home Virtual Ward: 55 beds
- Heart Failure Virtual Ward pilot: 15 beds

We continue to work towards the national ambition of 480 virtual ward beds operational by December 2023. Our current plans include a revision of our Respiratory virtual ward based on recent occupancy from 45 to 15 virtual wards beds; plus inclusion of our virtual Emergency Department of 42 VW beds delivered via our Urgent Community Response Teams.

The Frailty Virtual Ward will soon incorporate an additional 15 unplanned out of hours response Virtual Webs beds, and 60 further VW beds delivered via the complex wound care team. We intend to include these within our Virtual Wards from the end of May following completion of our governance processes.

The ongoing efficiency programme including a focus on digital, workforce and communications enablers will be a key ongoing element of developing our capacity and occupancy – particularly within the Frailty virtual ward where we know the biggest opportunity lies.

In addition, our Stroke Earlier Supported Discharge pathway will deliver 60 Virtual Ward beds and the Mental Health Crisis Response Teams and Dementia Services a further 30 Virtual Ward beds.

All of the above equates to an assumption for September 2023 that 370 Virtual Ward beds will be available within our system with further pathways are being developed including Children's Hospital at Home, Musculoskeletal Post-surgical, and further expansion of Frailty Virtual Ward to include Acute Kidney Infection.

Urgent Community Response Team:

Full geographic coverage from 8am-10pm 7 days a week is in place across mid and south Essex. The service provision covers the nine clinical conditions or needs, including level 2 falls, in line with the national 2-hour guidance. Scoping has commenced to identify potential demand outside of operational hours and considerations of extending beyond core hours underway.

Newly enhanced service whereby Urgent Community Response Teamwork in collaboration with East of England Ambulance Trust to support in clinically appropriate referrals being shared with Urgent and Community Response Team to support visits and care to patients requiring urgent care, enabling the ambulances to be released to support those individuals requiring emergency care. mid and south Essex are consistently exceeding the minimum threshold of reaching 70% of 2-hour crisis response demand within 2 hours.

Further exploration in progress in implementation of 'call before you convey', working with System partners and East of England Ambulance Trust to support ambulances with alternative options to Emergency Department, and all crews will dial one number whereby they will have a Multi-Disciplinary Team to support patients into alternative pathways, excluding priority and Category 1 calls. Rollout anticipated for Quarter 3 in 2023/34

Improving Discharge:

Implementation of data platform systems to support with real-time decision making to support patient flow and discharge throughout the System. Shrewd Resilience and Teletracking systems will be utilised to daily monitor the discharges identified against the requirement to ensure patients flow from front to back door, and early intervention implemented where there a deficit is identified.

By the end of June 2023 Criteria Led Discharge will be implemented across the hospital sites, which will provide a framework to facilitate 'home for lunch' discharges as well as increasing weekend discharge rates.

What is the requirement from the NHS?

The Integrated Care System acknowledges the requirements within the NHS England published national delivery plan for recovering urgent emergency services.

Date published: 30 January 2023

Our Ambitions

A system that provides more, and better care in people's homes, gets ambulances to people more quickly when they need them, sees people faster when they go to hospital and helps people safely leave hospital having received the care they need.

Everyone to receive the very best urgent and emergency care, raising standards of quality and safety patients and their families:

We will work to expand and better joining up health and care outside hospital: stepping up capacity in out-of-hospital care, including virtual wards, so that people can be better supported at home for their physical and mental health needs, including to avoid unnecessary admissions to hospital.

We will make it easier to access the right care: ensuring healthcare works more effectively for the public, so people can more easily access the care they need, when they need it.

Delivery Priorities

- Expand 111 service offer in accordance with pathways light programme.
- 111, Primary Care and East of England Ambulance Trust Ambulance to directly book Same Day Emergency Care slots into the service in Quarter 2 of 2023/24.
- Improve awareness and access to alternative services avoiding emergency departments.
- Expansion of virtual ward capacity increasing referrals and utilisation of the virtual ward capacity.
- Identify potential Urgent Community Response Team demand outside of operational hours and considerations of extending beyond core hours.
- Implement Multi-Disciplinary Team support number for ambulance crew support to ensure alternatives to Emergency Department fully optimised.
- Increase 'home for lunch' discharges through criteria led discharge initiatives.

Ensuring delivery

Whole pathway responsibility:

Clinical Lead: Dr Eddie Lamuren, Clinical Director (Emergency Care), Mid and South Essex NHS Foundation Trust, supported by Hospital Site Emergency Department Clinical Leads

Senior Responsible Owner: Hospital Site Managing Directors, Mid and South Essex NHS Foundation Trust

111 Governance:

Senior Responsible Owner: Samantha Goldberg

Clinical Lead: Dr Sanjeev Rana

Delivery will be monitored via the daily and monthly NHS111 volumes and performance metrics, as well as increase in alternative to Emergency Department dispositions.

Same Day Emergency Care Governance:

Senior Responsible Owner: Samantha Goldberg
Clinical Lead: Eddie Lamuren

Delivery will be monitored through the monitoring of referrals received and accepted into the service and reduction in admission into acute hospital beds

Alternatives to Emergency Department Governance:

Senior Responsible Owner: Samantha Goldberg
Clinical Lead: Sarah Zaidi / Matt Sweeting

Delivery will be monitored through the volume of ambulance conveyed to the hospital, ambulance offload times, and increase in referrals to alternative services.

Older People Services Governance:

Senior Responsible Owner: Samantha Goldberg
Clinical Lead: Eddie Lamuren

Virtual ward Governance:

Senior Responsible Owner: Gerdi Du Toit
Clinical Lead: Sarah Zaidi / Matt Sweeting

UCRT Governance:

Senior Responsible Owner: Samantha Goldberg
Clinical Lead: Yvonne Mubu

Monitored through the increase in referrals from East of England Ambulance Trust to Urgent Community Response Team and reduction in Category 3 ambulances conveyed to the hospital

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
111 dental advisors, urgent repeat prescriptions and minor injuries advisor go live	Quarter one 2023/24
Same Day Emergency Care direct booking slots available (111, Primary Care, Ambulance Services)	Quarter two 2023/24

Delivery Plan objectives	Timespan for implementation of objectives
Commence early adoption of alternative to Emergency Department roadmap	Quarter one 2023/24
480 virtual ward beds operational by December 2023.	Quarter three 2023/24
Multi-Disciplinary Team East of Essex Ambulance Trust alternative to Emergency Department contact system rolled out	Quarter three 2023/24
Criteria led discharge fully implemented across hospital sites	Quarter two 2023/24

Respiratory Services

What have our residents told us?

Our residents have fed back to our respiratory services the importance of knowing more about their respiratory health, knowing how to self-manage their health conditions and having access to environments where they can share their experiences with others in similar situations (eg pulmonary rehabilitation).

They want to be involved not only in the management of their own health but also in the co-production of the healthcare services they use, ensuring that the patient voice is heard, and the services meet the needs of the residents who use them.

Current Conditions

There are estimated to be approximately 170,000 people with a respiratory condition in mid and south Essex. This is likely to be an underestimate of true numbers. Prior to the covid pandemic, estimates based on expected prevalence of Chronic Obstructive Pulmonary Disease suggest that within mid and south Essex we have 7000 to 13000 people with Chronic Obstructive Pulmonary Disease who are as yet undiagnosed. This has been further exacerbated by pauses in respiratory diagnostics, such as spirometry, during the covid pandemic.

Patients with respiratory conditions often have co-morbidities with approximately 40% having co-morbidities, 29% having co-existent frailty and 36% being in the last year of life. Our respiratory patients also have a significantly higher rate of co-existent mental health conditions with 14% having depression ad 10% having anxiety compared to 5% having depression or anxiety in the overall mid and south Essex population.

Our patients have high utilization of emergency care with high rates of hospital readmission, respiratory readmissions accounting for nearly 15,000 bed days, the most common reason being Chronic Obstructive Pulmonary Disease. This is exacerbated by the backlog in diagnostic services with patients on average having 3 emergency care utilizations for respiratory disease in the year prior to a diagnosis of Chronic Obstructive Pulmonary Disease.

Long covid can be a debilitating multi-system condition affecting an individual's physical, psychological and cognitive health, their daily life and ability to work or attend education. The Office of National Statistics Coronavirus Infection Survey in March 2023 estimated that there are around 1.9 million people in England experiencing symptoms following COVID-19 for more than four weeks: 1.3 million of whom for over 12 months. An estimated 381,000 people in England report that long COVID is significantly impacting on their day-to-day activities. Applying these figures to mid and south Essex 24,000 people will have Long COVID symptoms after a year and 14,261 after two years.

What is the requirement from the NHS?

The NHS long term plan highlights key areas of focus as:

- Ensuring more patients have access to testing such as spirometry testing so respiratory diseases are diagnosed and treated earlier
- Ensuring patients with respiratory disease receive and use the right medication including educating patients on the correct use of inhalers
- Expanding rehabilitations services including Pulmonary Rehabilitation services so patients can better self-manage and live as independently as possible.

NHS England also have a requirement for respiratory virtual wards to support the care of acutely unwell respiratory patients in their own homes.

We are working towards meeting the requirements of the long-term plan with a number of pieces of work in these areas.

Spirometry and fractional exhaled nitric oxide tests are available for the entire mid and south Essex population and all patients receive a full clinical assessment as well as diagnostic tests. The holistic service offered is able to guide on treatment as well as referral to supporting services such as smoking cessation and pulmonary rehabilitation, so patients have access to timely and high-quality input for their respiratory disease. Within mid and south Essex we have worked with our cardiology and mental health services to design pathways for cough and breathlessness which ensure patients have early access to the right diagnostic tests and treatment and are seen by the right services in a more timely manner. Patients also have access to support for their psychological well-being through NHS talking therapies and dedicated clinical psychologists who focus on breathlessness management

Pulmonary rehabilitation is one of the most evidence based and high value treatments for Chronic Obstructive Pulmonary Disease. It reduces hospital admissions and improves quality of life and exercise capacity of patients as well as supporting in patient self-management. Pulmonary Rehabilitation is provided to all of the residents in mid and south Essex with chronic respiratory disease. All providers are undergoing accreditation and innovative work is being done including “pop-up” Pulmonary Rehabilitation sessions being delivered in areas of either higher socioeconomic deprivation or areas in which patients can’t access standard Pulmonary Rehabilitation settings and a Chronic Obstructive Pulmonary Disease patient education programme being delivered to those patients in the most socioeconomically deprived Primary Care Networks. This currently being piloted in Mid Essex with the aim to expand across mid and south Essex.

Pneumonia is a key focus of the respiratory programme. Pneumococcal vaccination rates within mid and south Essex have historically been some of the lowest within East of England and the programme is committed to ensuring pneumococcal vaccination rates improve, including focusing on the Core20PLUS5priority of

pneumococcal vaccination in patients with Chronic Obstructive Pulmonary Disease. Within mid and south Essex, LEADER reports have highlighted higher rates of death than some other areas from pneumonia or respiratory causes in our population with learning disabilities. We are passionate about addressing this and are working with partners to explore this further and address any inequalities.

mid and south Essex has three respiratory virtual wards, covering all areas of the population and supporting in caring for patients with respiratory disease in their own home rather than the hospital setting. The services can offer oxygen therapy, vital observations, IV antibiotics, nebulizer therapy and oxygen and are supported with digital technology.

Throughout winter 22/23 all of our residents had access to Acute Respiratory Infection Hubs. These are currently undergoing evaluation with Mid Essex being a pilot sire for national evaluation and a sustainable model is being explored to ensure our patients with Acute Respiratory Infections can receive timely treatment closer to home during times of winter pressures.

The long covid commissioning guidance published in July 2022 sets out requirements, including there should be a coordinated whole pathway of assessment, treatment and multifaceted rehabilitation and psychology support with direct access to required diagnostics. Also post COVID services are accessible to people from communities and sub-populations who experience health inequalities.

Our Ambitions

Our ambition is to work with our residents to design and deliver high quality patient centred services that allow earlier diagnosis of respiratory disease, better management of respiratory symptoms, and enable greater self-management of respiratory conditions.

What are our delivery priorities?

1. **Early and Accurate diagnosis:** Through increased capacity of spirometry and fractional exhaled nitric oxide tests and collaboration with Community Diagnostic Centres.
2. **Pulmonary Rehabilitation:** Delivered by Pulmonary Rehabilitation accredited services, ensuring both virtual and face to access and focussing on lesser accessed populations.
3. **Pneumonia:** To increase uptake of pneumococcal vaccination in our population and to reduce preventable pneumonia deaths in those with learning disabilities.
4. **Respiratory Virtual Ward:** To increase the number of appropriate patients being treated in their own homes on the respiratory virtual ward rather than in hospital.

5. **Acute Respiratory Infection Hub:** To evaluate our previous Acute Respiratory Infection hub models and build a sustainable approach for the future to help manage increased rates of respiratory infection in the winter.
6. **Long covid:** To continue to deliver a holistic pathway of assessment, treatment and multifaceted rehabilitation. To reduce health inequalities by having a focused plan which includes the use of the repurposed 'vax van'. To offer 100% of people assessments within 6 weeks of referral. To expand our co-production group

Governance

Senior Responsible Owner: Selina Douglas
Clinical Lead: Dr Abi Moore (respiratory)
Mid and South Essex Integrated Care System

Ensuring delivery

The Respiratory Programme is one of our key priority areas and transformation of services is supported by a formal governance structure. The programme reports into our community transformation board and works closely with the urgent emergency care board. There is dedicated programme support and a clinical lead.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Increase diagnostic provision to include cardiac and respiratory diagnostics for breathlessness by Oct 2023	Quarter three 2023/24
Recruit additional psychologists to provide support for breathless patients across both Respiratory and Cardiology pathways by September 2023.	Quarter two 2023/24
Work with Healthwatch to develop Pulmonary Rehabilitation co-production model and then extend out across respiratory services by October 23	Quarter three and four 2023/24
Ensure Mid and South Essex Integrated Care System is compliant with National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme by March 2024.	Quarter four 2023/24
All staff to be fully accredited or underway in the pathway of accreditation by the Royal College of Physicians Pulmonary Rehabilitation Services Accreditation Scheme by March 2025.	First half of 2024/25

Delivery Plan objectives	Timespan for implementation of objectives
To hold awareness raising events re the signs of pneumonia and preventative action that can be taken, which will include dedicated events for Learning Disability and neuro disability patients / carers / next of kin by December 2023.	Quarter three 2023/24
Undertake Evaluation and submit business case for sustainable Acute Respiratory Infection Hub model by September 2023 and align to respiratory virtual wards by Dec 23.	Quarter two 2023/24
Increase the numbers of people with health inequalities referred to the long covid team. By continuing to raise awareness with local health professionals and harnessing partnerships to deliver innovative health solutions	First half of 2024/25

Outpatient Programme

What have our residents told us?

A patient engagement session is planned for end of March ’23 to support the new workstreams supporting the move to a single integrated access service.

Feedback from patients regarding issues affecting their ability to attend planned appointments is currently being gathered within work to better understand Did Not Attends.

What is the current state of play/local challenges

The Programme has improved visibility of the key performance indicators for the operational teams using Power Business Intelligence, so these metrics are now able to be reviewed weekly by the care groups to ensure continued focus and improvement. The project team will be conducting ‘health checks’ with each operational specialty before rolling improvement initiatives out to further improve performance in identified areas.

During the next year, teams will be working to improve the central access function which will deliver an improved service for patients and a better experience for our staff through enhanced training and improved technology solutions.

The programme will continue the roll out of eConsult to all specialities and introduce phase 2 of the Programme during the year.

What is the requirement from the NHS?

Key Performance Indicators for 2023/24 is to reduce Follow-up activity by 25% (of baseline 2019/20 activity) by March 2024.

Our Ambitions

WS1 - Operational Excellence: We will equip managers with the right tools and skills to make data driven decisions to help achieve key national performance Key Performance Indicator's across all specialties by end March 2024

WS2 - Reshaping Access: By end of March 2026, we will deliver better patient and staff experience through implementation of consistent streamlined booking processes which will enable better management of referrals and new demand.

WS3 - Virtual Outpatients: We will adopt and implement new digital technologies and approaches that will deliver care in an innovative, efficient, and patient centric way by end of March 2024

WS4 - System Pathway redesign: We will deliver new models of care across Mid and South Essex Integrated Care System, giving patients seamless experience and right care at the right time by the end of March 2024

Delivery Priority

- Better experience for patients
- £42m of improved value through reducing waste and using technology
- 2% reduction in Did Not Attends, from current c8% to 6%
- Enhanced capacity (increase in Advice and guidance utilisation, Patient-initiated follow-up
- 25% reduction in follow ups (2019/20 baseline)
- New single integrated access team

Ensuring Delivery

Senior Responsible Owner: Andrew Pike
Clinical Lead: Professor Tony Young

The programme team will deliver using detailed project plans for each workstream on the Smartsheet system. Reporting dashboards will be used to inform sponsors, programme boards and executive groups.

Delivery Plan

Delivery Plan objectives	Quarter one 2023/24	Quarter two 2023/24	Quarter three 2023/24	Quarter four 2023/24	First half of 2024/25	Second half of 2024/25	2025 to 2028
Reduce follow up activity by 25% by end of March 2024	5%	12%	20%	25%			
Reduce Did Not Attends from 8% to 6% by end of March 2024	8%	8%	7%	6%			
WS1: Operational Excellence	£1.1m	£1.3m	£1.4m	£1.5m	£5.8m	£5.8m	
WS2: Reshaping Access	£0.3m	£0.3m	£0.3m	£0.3m			
WS3: Virtual Outpatients – to be modelled							
WS4: System Pathway Redesign	£0.9m	£0.9m	£0.9m	£1.0m			

Delivery Plan objectives	Quarter one 2023/24	Quarter two 2023/24	Quarter three 2023/24	Quarter four 2023/24	First half of 2024/25	Second half of 2024/25	2025 to 2028
Total of WS1 to WS4	£2.3m	£2.5m	£2.6m	£2.8m	£5.8m	£5.8m	

Diagnostics

What have our residents told us?

Our residents want the ability to access tests to diagnose their condition close to home, they want to access diagnostics once and not have them repeated unnecessarily.

Our residents want timely results and the least invasive test to enable them to receive a diagnosis or treatment plan.

Current Conditions

The key challenge for diagnostic recovery is the ability to provide continued service when capacity for delivery is impacted by wider pressures within the system. We continue to work with other System partners (Independent Sector and Community Providers) so we can maximise diagnostic capacity to support, people to access the most appropriate diagnostic test for their condition.

We are working to increase early diagnosis and the turnaround time for results of diagnostic tests across all our providers.

We have been working with our primary care practices to increase the use of Faecal Immunochemical Test tests, a non-invasive test that supports diagnosis for bowel conditions; the use of this test reduces the need for more invasive diagnostic tests whilst providing results to the patient in a timely manner.

We continue to progress the two key national requirements of Systems for diagnostics:

- Community Diagnostic Service/Centres and
- Rapid Diagnostic Service

Both of these will increase capacity and support the ambition of care closer to home and easier access locally for our residents.

What is the requirement from the NHS?

Mid and South Essex Integrated Care System is required to respond to the national planning asks for diagnostics, which are supplemented with asks from NHS England national team throughout the year.

Our Ambitions

As outlined in the Long Term Plan our focus for Diagnostics remains:

Bringing Care Closer to Home:

Joining up our different health, care and voluntary services means we can bring services closer people's homes – whether that is through support on-line, or by bringing health and care services into the community such as some hospital tests like x-rays and blood tests and support for people living with long term conditions like diabetes or breathing problems.

Ensuring that every Place has adequate and appropriate provision, based on its demographic and need, of both Screening and diagnostic services

Improving and Transforming Our Services - Ensuring our residents have the highest chances of recovery from their illness or condition, and to give them the best treatment we can, to live as well as they can.

Demand for services is changing as people grow older and live with more long-term conditions and there is much more we could do with technology, medical advances and new ways of working to treat people at an earlier stage, avoid more serious illness, and to live as well as they can for longer.

Delivery Priorities

- Mid and South Essex NHS Foundation Trust and Integrated Care Board Partners are working to ensure clear recovery trajectories and plans for the key asks as per the 2023/24 National Planning Guidance. Operating priorities will be subject to change as Planning Guidance is released and refreshed annually.
- The key diagnostic deliverable is to:
    - Have increased number of patients receiving diagnostic tests within six weeks - the March 2025 ambition of 95%
    - Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their General Practitioner for suspected cancer are diagnosed or have cancer ruled out within 28 days.
    - Increase the percentage of cancers diagnosed at stages 1 & 2 in line with the 75% early diagnosis ambition by 2028

The below table shows the Mid and South Essex Integrated Care System planned diagnostic trajectory for 2023/24 as the first year to achieve the planning ask.

Ensuring Delivery

Senior Responsible Owner: Dr Ronan Fenton
Clinical Lead: Dr Ronan Fenton/Dr Qaiser Malik

The Mid and South Essex Transformation and Improvement Board for Diagnostics oversees all aspects of diagnostics including performance (escalation from sub-group – see below), Community Diagnostic Service/Centre implementation and Rapid Diagnostic Service to support early cancer diagnosis.

The Board receives performance information from its diagnostic performance sub-group. This group focuses on the referral to diagnostic test, turnaround time for results across acute, community and independent sector providers. The National Planning asks, and delivery, recovery or mitigation plans are presented here for assurance.

The performance sub-group escalates the key risks to the Board which are presented to the Mid and South Essex Integrated Care System's Oversight and Assurance Committee.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Recovery of the referral to diagnostic test standard (6 weeks) so 95% of patients receive their test in six weeks	March 2025

Stroke Services

What have our residents told us?

There is variation across alliance areas in care received, particularly with reduced level of support for patients after stroke across alliance areas. Stroke Stewards are focussing on a number of projects to improve access to post stroke care and access to local voluntary support groups.

Current conditions

Across mid and south Essex:

- Not all stroke patients are being admitted to stroke wards due to bed pressures within the acute resulting in a number of medical outliers on stroke wards. Two acute sites in mid and south Essex have an E rating on Sentinel Stroke National Audit Programme for this indicator.
- Delays in scanning at arrival to hospital due to front door acute pressures thus reducing the number of patients eligible for thrombectomy.
- No community bed pathway for Covid positive patients resulting in discharge delays until patients test negative or are out of isolation period.
- Community Early Supported Discharge services are under pressure, intensity of rehabilitation has been reduced due to the number of referrals and rehabilitation requirements, Mid Essex service is currently holding a waiting list.
- There is differential access to community services across the system
- Workforce is an issue across acute and community stroke services.

Partnership working:

- Both community bed sites, Cumberledge Intermediate Care Centre and St Peter's are working in collaboration and now have a single acceptance criterion.
- Therapists across acute and community have worked in partnership to align patient assessments and reviews by all using the EQ-5D tool.
- Mid and South Essex Integrated Care System is part of the South East of England Integrated Stroke Delivery Network to support and align work plans across the region. The Integrated Care System has successfully bid for numerous funding to support different ways of working such as the mid and south Essex catalyst funding project, focussing on growing our own Stroke

Multi-Disciplinary Team workforce using band 4 Rehabilitation Assistants to enhance the Community Stroke pathway across mid and south Essex.

- Stroke Programme Board and Stroke Stewardship in place with representation across primary care, community, acute and voluntary sectors.

What is the requirement from the NHS?

This below system vision links to the NHS Long-Term Plan which highlights both increased thrombectomy and improved post hospital stroke rehabilitation models.

Our Ambitions

The stroke stewardship team are reviewing the end-to-end pathway to ensure that all elements are delivered in line with the National Stroke Service Model and the Integrated Community Stroke Service. A recent review of quality adjusted life years data demonstrated that mid and south Essex should invest less into acute services and more into community services and Thrombectomy to provide better outcomes for stroke survivors.

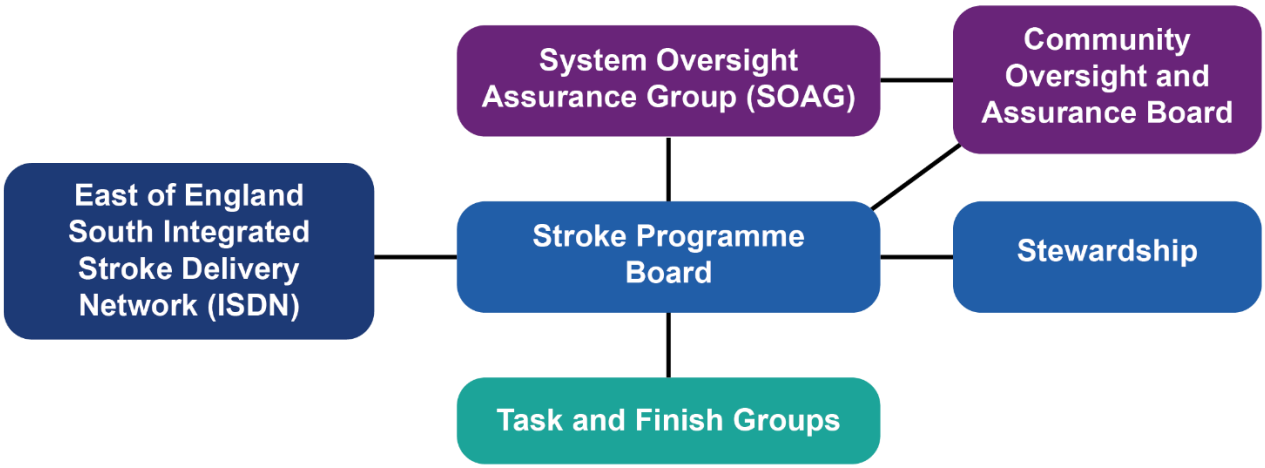
Delivery Priorities

- Acute action plans to improve Sentinel Stroke National Audit Programme rating at all three sites by June 2023.
- Acute audit to be undertaken to identify delays in the system by March 2023.
- Community bed reconfiguration by September 2023 (subject to public consultation).
- Implement the Integrated Community Stroke Service model by April 2024. Implement the Integrated Community Stroke Service model by April 2024. The Integrated Community Stroke Service model has nine key components; integration, responsive and intensive, needs based, pathways of care, seven day working, team composition, specialist service, education and training and tailored goals and outcomes.

Ensuring Delivery

Senior Responsible Owner: Charlotte Dillaway
General Practitioner Lead: Dr Deepa Shanmugasundaram
Consultant Lead: Dr Ramanathan Kirthivasan

The table below shows the System governance structure.



Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Acute Sentinel Stroke National Audit Programme rating to improve to an A rating by June 23	Quarter one 2023/24
Reconfigure community stroke beds (42-48) (subject to public consultation)	From quarter two to quarter three 2023/24
Implement Integrated Community Stroke Service specification ensuring all stroke survivors access to community support / rehab	First half of 2024/25

Cardiac Services

What have our residents told us?

Local residents and patients want to be able to access services closer to home. Patients also want and need all parts of the health system to communicate all of their information when they are being referred on from primary care to community, secondary or tertiary settings. This includes avoiding repeating tests or investigations when moving between care providers and levels of care.

Our approach is to provide local access to services where possible and centralise services where necessary to achieve true clinical excellence.

We aim to increase the provision of tertiary and quaternary services in the Essex Cardiothoracic Centre so fewer patients need to travel out of area for specialist care.

Current Conditions

We have a significant deficit in cardiac diagnostic capacity which needs to be addressed through medium- and long-term actions. Echocardiography is a key diagnostic for many cardiac conditions in both elective and acute presentation. Demand for echocardiography will continue to grow and we will need a growing cardiac physiology workforce to meet this demand. System partners will work in collaboration to implement a strategic workforce plan and career pathway for cardiac physiology to locally develop specialist staff to deliver an integrated service in hospital, in community diagnostic hubs and in other community settings.

Cardiac CT is increasingly important as a first line diagnostic test in cardiac presentations. Availability is highly variable across the system and overall, less than half the capacity recommended for our population. The new community diagnostic hubs will accommodate low risk CT activity freeing capacity in hospitals for these specialist Cardiac CT scans. This will allow us to meet overall demand and ensure equitable access to these specialist diagnostics.

Cardiac MRI is a highly specialist diagnostic currently operated from the tertiary Essex Cardiothoracic Centre. We have developed a regional hub and spoke model to improve equity of access for patients across the region. The first spoke site is Ipswich hospital. With the introduction of community diagnostic hubs freeing MRI capacity in hospitals we aim to expand this model so that patients can access this tertiary diagnostic service in their local hospital with expert oversight and support clinically from the Essex Cardiothoracic Centre.

The Heart Failure team in Basildon have an excellent service for local patients with seamless integration of community, hospital and tertiary clinical teams. This service has published national findings in optimal management of heart failure including the development of the new “Quad Score” to avoid treatment inertia and maintain focus on optimisation of heart failure medications. We will continue to roll out these clinical

models across the system to ensure that patients receive the best care. Heart failure patients require intense monitoring in the first 12 weeks to optimise management and avoid more invasive and expensive interventions. We have a significant shortfall in our specialist HF nursing workforce required to meet this need. We will be developing a workforce plan to include nursing and other roles within the multi-disciplinary team to ensure that all patients are optimally supported delivering better care and better value care overall.

Inherited Cardiac Conditions, including heart muscle disease (cardiomyopathy) and sudden arrhythmic death syndrome, affects 1 in 250 people worldwide and thorough family screening is needed to identify relatives at risk of potentially life-threatening heart disease. NHS England document A09/S/c 2013/14 “Inherited cardiac conditions” states that anyone with Inherited Cardiac Conditions, and their first-degree relatives, should have access to specialist Inherited Cardiovascular Conditions services within the catchment area. Genetic testing is centrally funded from April 2020, at no cost to the Trust.

All of our planned improvements in cardiac services require greater digital integration across the system, between sites and providers. Failure to achieve risks creating duplication and clinical risk.

What is the requirement from the NHS?

Heart and circulatory disease, also known as cardiovascular disease, causes a quarter of all deaths in the United Kingdom. Cardiovascular disease is the single biggest condition where lives can be saved by the NHS over the next 10 years. The Long-Term Plan describes a number of improvement actions required.

Our Ambition

We plan to support the these aims for cardiac services through 6 key improvements:

- **Earlier diagnosis** of more people with heart conditions through increased access to specialist cardiac diagnostics including echo, CT, MRI via community diagnostic hubs and specialist hospital-based services
- Better support for patients with chronic **cardiac conditions** including heart failure and heart valve disease including access to nurse specialists working seamlessly with specialist consultants through Multi-Disciplinary Team and virtual ward models
- Increased use of **genetic testing** enabling early diagnosis and treatment including development of the inherited cardiac conditions service.
- Access to life-saving **emergency and acute** diagnosis and treatment with further improvements in rapid access to tertiary treatment for Percutaneous Coronary Intervention, Coronary Artery Bypass Graft and Cardiogenic shock

- Continued development of local access to **specialist tertiary services** at the Essex Cardiothoracic Centre so that patients can access the latest advances in cardiac care locally within mid and south Essex such as minimally invasive cardiac surgery, specialist aortic surgery, percutaneous valve repair / replacement and Electrophysiology
- Expanding access to **cardiac rehabilitation** services to help people recover after treatment including diverse offers for community access and virtual support

Delivery Priorities

The recovery of access standards in cardiac services is a significant priority. Timely access to cardiac diagnostics, in particular echocardiography and CT, will be linked to collaborative system delivery of community diagnostic hubs and specialist workforce planning in cardiac physiology.

Through the Covid-19 pandemic cardiac services have unfortunately been impacted through periods of reduced activity and resultant increase in waiting lists. Increased waiting times have also led to higher clinical acuity of patients in both emergency and elective pathways. Hospital Cardiology services are working to reduce waiting times for outpatient and elective care in line with national Referral to Treatment recovery trajectories. Effective use of clinical triage and of improved technologies has reduced delays in outpatient pathways. Patients now have access to virtual appointments in many cases when in person appointments are not required (for example for physical examination).

In the tertiary setting the greatest impact of the pandemic on waiting times has been for cardiac surgery. A cardiothoracic surgery recovery plan is in place and has seen good delivery through 2022. This work will continue and is reliant upon a large specialist clinical workforce and balancing the demands of elective and emergency surgery. We have invested in additional facilities within the Essex Cardiothoracic Centre to create additional capacity. Cardiac Intensive Care Unit capacity is key to supporting the surgical recovery and we will be continuing to invest in Intensive Treatment Unit clinical workforce to meet this need.

We have an excellent emergency service for primary Percutaneous Coronary Intervention based at the Essex Cardiothoracic Centre and have made good progress with improvements in the Non-ST-Elevation Myocardial Infarction pathways. We aim to further improve the Non-ST-Elevation Myocardial Infarction service to reduce time to treatment in line with the national standards. This will be through extended weekend working and through earlier transfer of patients to the specialist centre by increasing capacity. We will continue to focus on clinical efficiency and value by extending our nurse-led discharge pathway.

Our ability to rapidly transfer inpatients to the tertiary centre is an important enabler for effective acute inpatient care, ensuring that we avoid delays and also supporting

efficient scheduling. Current pressure on the ambulance service have impacted on cardiac transfers. We will work with the ambulance Trust to develop innovative new models and modes for patient transfer.

Ensuring Delivery

Senior Responsible Owner: Dr Ronan Fenton
Clinical Lead: Dr Sunil Gupta

Our overall programme of work to achieve our ambition will be overseen through the Mid and South Essex Integrated Care System Cardiovascular Disease Programme Board. There will also be specific working groups leading on specialist pathways and projects including the Cardiogenic Shock Working Group and Cardiology stewardship group.

We aim to ensure delivery through excellent multi-disciplinary and inter-sector engagement, collaboration and commitment to delivering improvements for patients that also present a more clinical effective and resource-efficient whole system approach to cardiac care.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Comprehensive Cardiac Cardio Thoracic service in plan in all acute hospital settings (1) developing capacity alongside Congenital Diaphragmatic Hernia models sufficient to meet local population need (2)	(1) quarter three 2023/24 (2) 2025/28
Cardiac Physiology workforce strategy implemented (1) and delivering improved retention, development of teams to fill vacancies and meet clinical service need (2)	(1) quarter two 2023/24 (2) 2025/28
Standardised integrated model of care for Heart Failure patients underpinned by Multi-Disciplinary Team working and collaboration to ensure that Heart Failure patients receive the care they need with no barrier to movement between providers and levels of care.	Second half of 2024/25
Rapid Non-ST-Elevation Myocardial Infarction service in place across system with early inter-hospital transfer and weekend working	First half of 2024/25
Recovery of waiting times for elective cardiac surgery	First half of 2024/25

Delivery Plan objectives	Timespan for implementation of objectives
Commence Mitral Transcatheter Edge to Edge Repair service (1) and develop to full population roll out as high-volume centre (2)	(1) quarter two 2023/24 (2) 2025/28

Cardiovascular Services

What have our residents told us?

We have conducted a survey, including interviews as well as shorter form questions, of people accessing our BP@Home programme. The results are being analysed at present.

Current Conditions

In parallel with activity nationally, our cardiovascular disease detection and treatment activity dipped during the Covid-19 pandemic. We are working to restore and expand previous detection and management levels.

Whilst our Alivecor and BP@Home programmes have accelerated progress relating to Atrial Fibrillation and Blood Pressure, we will need to expand capacity within the lipid management pathway to increase diagnosis and treatment levels.

Our baseline data shows the following trends in hypertension and cholesterol:

- Below national average (57%) of patients aged 18 or over with no GP-recorded cardiovascular disease and a General Practitioner recorded QRISK score of 20% or more, on lipid lowering therapy.
- Below national average, and lowest in East of England Region percentage of patients aged 18 and over, with General Practitioner recorded Cardiovascular Disease (narrow definition), in whom the most recent blood cholesterol level (measured in the preceding 12 months) is non-HDL cholesterol less than 2.5mmol/l or LDL-cholesterol less than 1.8mmol/l.

What is the requirement from the NHS?

Increase percentage of patients with hypertension treated to National Institute for Health and Care Excellence guidance to 77% by March 2024.

Increase the percentage of patients aged between 25 and 84 years with a cardiovascular disease risk score greater than 20 percent on lipid lowering therapies to 60%.

The NHS is working collaboratively across primary, secondary and community care settings to improve and integrate cardiovascular disease pathways and workstreams into normal working practices.

Our Ambition

Our long-term vision is to continue moving upstream in our approach to cardiovascular disease, including prevention and early detection of atrial fibrillation,

hypertension and high lipids, so that our residents are able to enjoy more years of healthy life, with lower rates of heart attacks and strokes.

We will do this by focusing on:

- **Primary prevention:** working in partnership with communities and place-based teams on primary prevention, including links with our partnership approach to healthy weight and smoking.
- **Detection and 'datafication':** identifying residents with risk factors or established disease, using risk stratification approaches, and generating valuable data to drive proactive and, where possible, predictive, activity
- **Early intervention:** providing holistic, personalised support and treatment to residents with identified risk factors or early-stage cardiovascular disease.
- **Treatment:** providing holistic, personalised support and treatment to those with more established cardiovascular disease.

At system level, system programmes drawn together in alignment, with Population Health Management, personalised care, inequalities etc running through.

Delivery Priorities

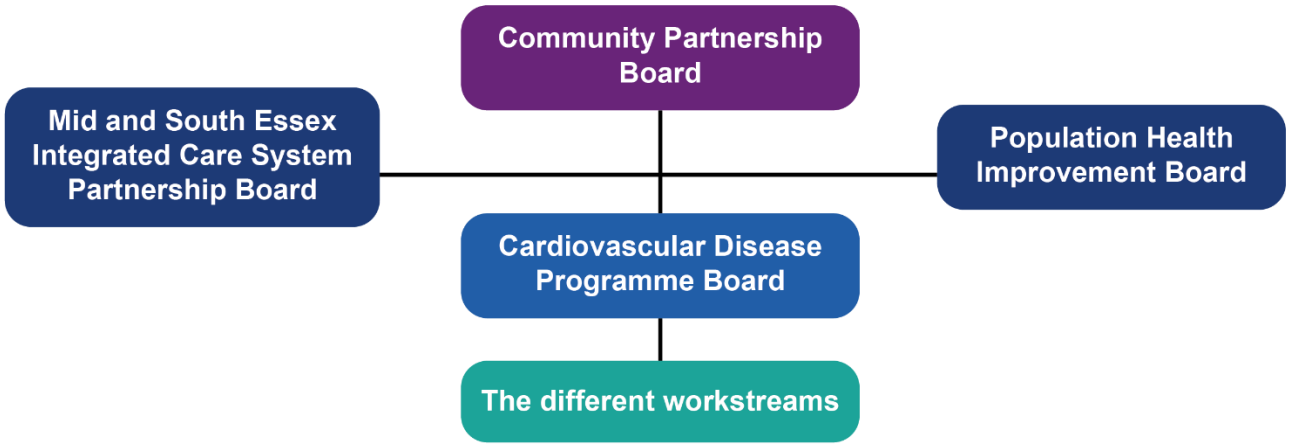
Different Cardiovascular Disease prevention-focused workstreams will align with our system prevention approach:

- Primary prevention: linking with healthy weight and tobacco dependency support to reduce cardiovascular disease related risk factors.
- Detection
  - NHS Health checks
  - BP@Home programme
  - Breathlessness van (with mobile Blood Pressure devices)
  - Exploring potential to expand use of Fibricheck whilst Alivecor use is reviewed nationally.
- Datafication, early intervention and treatment
  - Proactive care framework
  - Lipid management pathway – expanding access to genetic testing for familial hypercholesterolaemia, as well as to first- and second-line therapy.

Ensuring Delivery

Senior Responsible Owner: Dr Ronan Fenton
Clinical Lead: Dr Pete Scolding

The different workstreams (Atrial Fibrillation, Blood Pressure and lipids) will report into a system Cardiovascular Board (established Feb 23). This board will be accountable to the Community Partnership Board. See below organogram.



Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Expand BP@Home scheme by working alongside our community pharmacists and further integration into relevant clinical pathways such as Renal	Quarter four 2023/24
Monitor National review of Kardia Alivecor mobile heart monitors, and if re-approved expand use in General Practitioner surgeries, community centres and on our outreach bus. Scope potential to expand use of fibricheck app as alternative.	Quarter four 2023/24
Participate in Innovations for Health Inequalities Programme to expand the mobile unit (outreach bus) to a targeted core20Plus population, to include broader cardiovascular disease risk assessment and management (including Atrial Fibrillation, blood pressure, cholesterol, smoking)	Quarter four 2023/24
Maximise Community Pharmacy Hypertension case finding	Quarter four 2023/24
Implement University College London Partners Proactive care framework for risk stratification and	Quarter four 2023/24

Delivery Plan objectives	Timespan for implementation of objectives
prioritisation of atrial fibrillation, blood pressure, cholesterol, and type 2 diabetes	
Scope and agree approach to improving lipid outcomes.	Quarter four 2023/24

Palliative and End of Life Care

What have our residents told us?

A Health Needs Assessment was undertaken in 2022 by Healthwatch Essex with the oversight of the Hospice Collaborative. Three key themes emerged:

- Improvement to accessing services: including 24/7; bereavement support; access to medication and pain relief
- Improved communication: between professionals; ease of contact for information and advice
- Clearer information: clear pathways for care, to preserve independence including sign posting and earlier referrals between services and hospices

Current Conditions

Across the Integrated Care System there are multiple organisations providing Palliative and End of Life Care with varying service models between alliance with different population health needs. A gap analysis benchmarked against the National Ambitions Framework identified the following challenges:

Lack of Co-ordinated, consistent access to care:

To achieve our ambitions for Palliative and End of Life Care, collaboration across the full spectrum of health and social care, voluntary and third sector organisations, and local communities will be essential. The recent establishment of the hospice collaborative and the community collaborative will have a key influence. The challenge is developing 24/7 models of care that address the population needs of each alliance in a co-ordinated, equitable, and consistent way. Lack of digital solutions to support shared care records and Electronic Palliative Care Coordination System are negatively impacting on delivering co-ordinated care. Inequities in access to high quality bereavement services also affects the wellbeing of families and carers long term.

Reactive rather than proactive care:

Patient experience and outcomes that matter most are improved through early recognition of the End of Life and personalised care planning for the future. To move to a proactive approach to care will require a significant cultural shift within the Integrated Care System, but one that is necessary to reduce unnecessary hospital admissions and therefore, system pressures. There is a need to empower our patients and families through practical support, information, and training in the End of Life care.

Skilled workforce:

Nationally, there is known shortage of multi-professional specialists in Palliative and End of Life Care which is affecting recruitment and retention of staff within our Integrated Care System. Without the right workforce, the ambition to enable people and their families/carers to have the best support and outcome at the End of Life will not be achieved. In addition, a recent mid and south Essex wide education gap analysis identified that our current healthcare workforce would benefit from blended education and training programmes to increase their confidence and skills in the delivery of Palliative and End of Life Care.

What is the requirement from the NHS?

We are committed to the standards required to deliver high quality Palliative and End of Life Care services within the Integrated Care System. These include:

- Ambitions for Palliative and End of Life Care: a National Framework for Local Action 2021 – 26
- NHS Long Term Plan
- NHS Palliative and End of Life Care Statutory Guidance for Integrated Care Boards, September 2022

Our Ambitions

Working in partnership across health and social care, including the voluntary sector and local communities, we will ensure that the palliative and end of life care needs of people of all ages with life-limiting illness, and their families/carers, are met so that they receive the care and support they need to live and die well. This is irrespective of diagnosis or condition, and especially in the last year of life. We will focus on the "outcomes that matter most" to those we care for.

Delivery Priorities

The Palliative and End of Life Care Programme Board will be responsible for delivering a robust Palliative and End of Life Care workplan through 6 workstreams (as detailed below) whose focus will be to:

- Improve the recognition of people in the last year of life to focus on early personalised care planning and proactive anticipatory care
- Ensure that people are cared for and die in their preferred place of care, and to avoid unnecessary hospital admissions
- Ensure equity of access for our population to 24/7 co-ordinated care, information and advice, including access to anticipatory medication
- Complete the System-wide roll out of an Electronic Palliative Care Coordination System to improve co-ordinated and informed care. This will

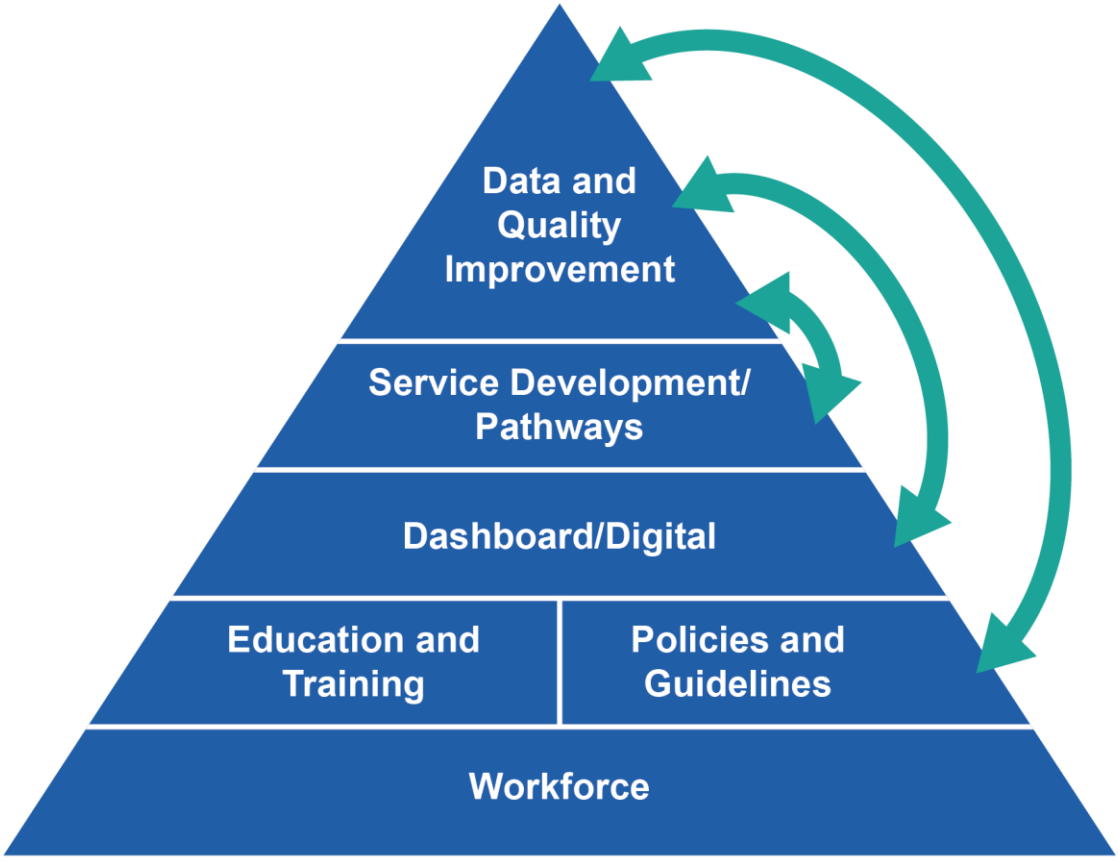
support the development of a Palliative and End of Life Care dashboard and its link to Population Health Management

- Support development of a single shared care record to ensure care is delivered at the right time by the right person with the right information
- Develop models of care to support the needs of families and carers
- Improve the quality of Palliative and End of Life Care through training and education to ensure a skilled, and confident workforce. This includes sustainability and innovation through workforce planning
- Improve the reach of Palliative and End of Life Care through mobilising community focussed approaches to palliative and end of life care, such as compassionate communities and integrated neighbourhood teams
- Increase equity of access to high quality all age bereavement services
- Improve the quality of Palliative and End of Life Care through training and education to ensure a skilled, and confident workforce. This includes sustainability and innovation through workforce planning
- Improve the reach of Palliative and End of Life Care through mobilising community focussed approaches to palliative and end of life care, such as compassionate communities and integrated neighbourhood teams
- Increase equity of access to high quality all age bereavement services

Ensuring Delivery

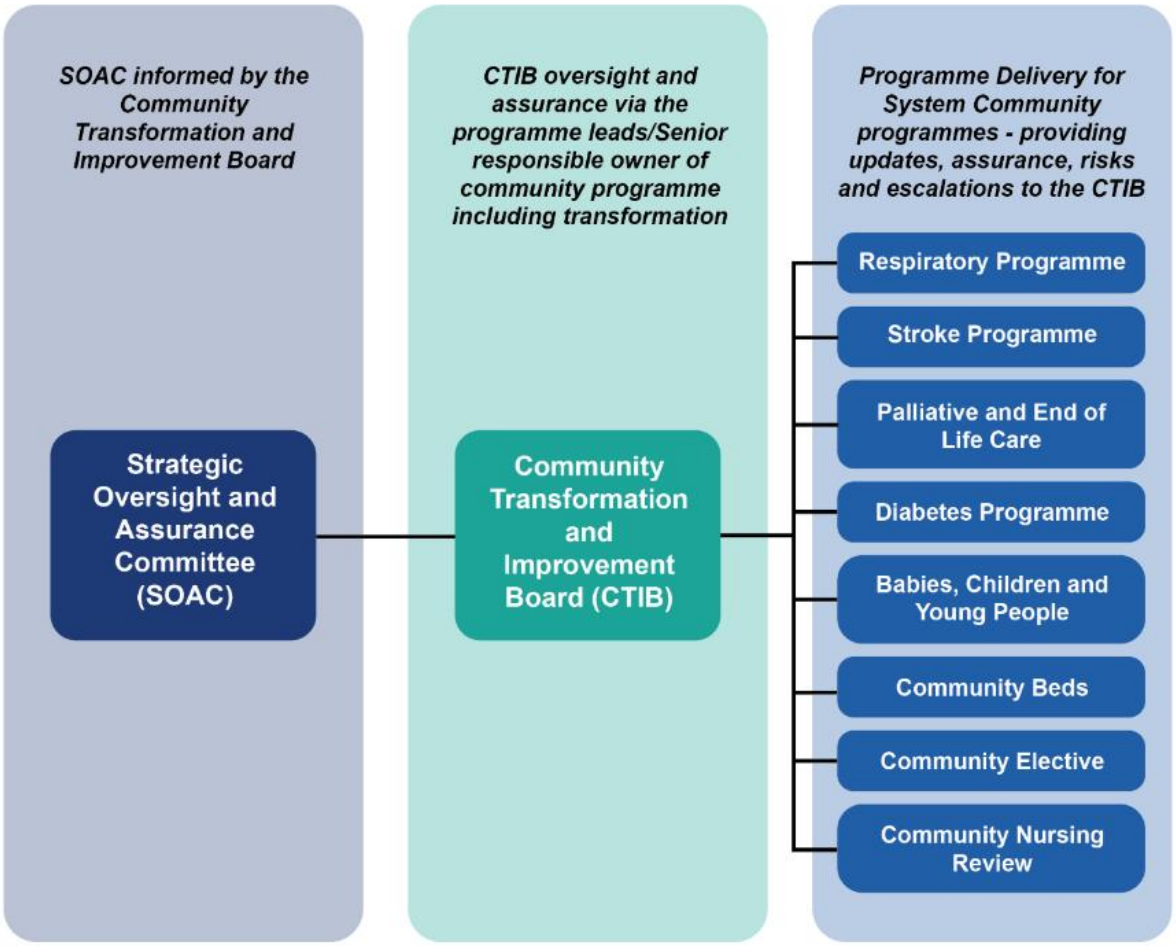
Senior Responsible Owner: Karen Wesson
Clinical Lead: Dr Eva Lew

The Palliative and End of Life Care Programme Board will be responsible for delivering a robust Palliative and End of Life Care workplan through 6 workstreams



The Palliative and End of Life Care Programme Board reports to the Community Transformation and Improvement Board which is then overseen by the Strategic Oversight and Assurance Committee. It is expected that the four mid and south Essex alliance End of Life Network Groups will have representation on the Palliative and End of Life Care Programme Board and be active members on the Palliative and End of Life Care Palliative and End of Life Care workstreams.

Below organogram of system governance arrangements.



Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Increase recognition of population last 12 months of life achieving 1% by 2028	Quarter three 2023/24
Increase proportion of people offered personalised care support	Quarter four 2023/24
Deliver 24/7 coordinated care, information and advice including access to anticipatory medicine	First half of 2024/25
Deliver sustainable end of life care workforce	Second half of 2024/25

Diabetes Services

What have our residents told us?

There is variation across alliance areas in care received, for example, there is reduced uptake or completion of annual health checks in South-East Essex area in comparison to others and we see increased amputation rate for diabetic foot disease in parts of this area. The Integrated Care Board has led projects to improve uptake of checks and develop pathways centrally with varied results.

Current Conditions

There are approximately 69,000 (5.7% population) people living with Diabetes across MSE who could be at risk from diabetes complications, and additionally 28,705 people with Non-Diabetic Hyperglycaemia at risk of developing Type 2 Diabetes within 3 years. Effective management of Diabetes is vital for people to avoid complications that are a detriment to quality of life and require health care interventions. An increase of preventable Type 2 diabetes could pose a significant strain onto the Integrated Care Board in the medium term if preventative interventions are not made.

Challenges in community/integrated Diabetes services and hospital trusts as they work together to develop a joined up and equitable approach, aligning policy and pathways between 3 hospital sites and 3 community providers with varied models of delivery. In addition, there are increased caseloads of people presenting with complications arising after the covid-19 pandemic.

The Integrated Care Board is currently going through formulation of leadership via recent recruitment of a System Diabetes Clinical Lead and the development of stewardship programme therefore these should be supportive in achieving objectives.

Need to deliver at lower cost to ensure sustainability in the system whilst meeting an increased population demand. Future investment amounts from NHS England Cardiovascular Disease and Respiratory network are currently unknown therefore planning for future quality improvement projects is challenging.

What is the requirement from the NHS?

In line with the NHS Long Term Plan, the Diabetes team are undertaking several quality improvements pilots and projects, some transformational and funded by NHS England and some now business as usual programmes that will impact prevention, patient understanding, knowledge and management of diabetes and improve pathways with aim of reducing long-term complications and health care interventions. OBJ

Our Ambitions

In line with the NHS long term plan the Integrated Care Board aims to;

- Develop data sources and use of data and information to have better overview of population needs and health inequities with the aim of sharing data and working more collaboratively with services.
- Have a heavy focus on prevention, particularly on the significant population size at risk through preventative and educational programmes.
- Increase number of those attending structured education or using digital tools to support.
- Significant increase in completion of diabetes annual health checks and recovery of treatment targets to pre pandemic levels and above.
- Improve pathways for diabetic foot management and preventative interventions to reduce amputation rates and improve quality of life for people with a Diabetic foot condition.
- Support nursing teams to be fully staffed delivering 6-7 days services across Integrated Care System.
- Increased use of technology such as Glucose monitoring delivered to all Type 1 diabetes patients and many Type 2 multiple daily injections.

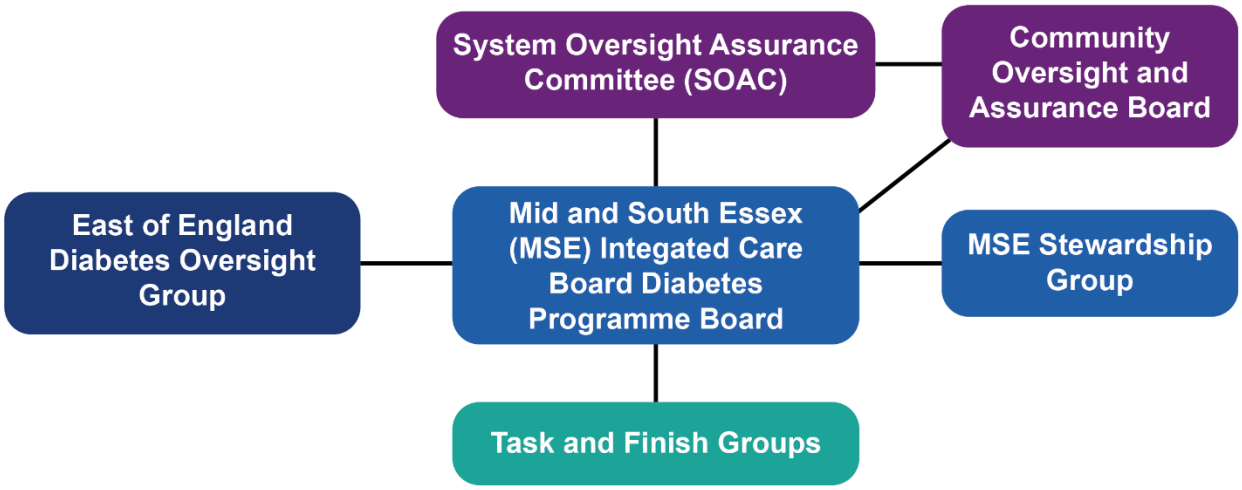
Delivery Priorities

- Diabetes dashboard to be finalised ready for analysis and identification of health inequalities, informing strategic planning by the Diabetes programme board.
- Maintain and increase referrals into services such as diabetes prevention programme, Low Calorie Diet Programme, structured education or digital tools.
- Significant increase in completion of all 8 key diabetes care processes/annual health checks to be at 34% of the diabetes population (currently 27.6%) and recovery of treatment targets to pre-pandemic levels to be at 33% (currently 27.1%) by March 2024.
- Ensure an effective and clear pathway for the Diabetic Foot in mid and south Essex with relevant preventative steps and being used effectively
- Support nursing teams to be fully staffed delivering 6-7 days services by 2024-25.
- Increased use of technology such as Glucose monitoring delivered to all T1 diabetes patients (70% by 2024 and 95% by 2025-26)

Ensuring Delivery

Senior Responsible Owner: Dr Ronan Fenton
Clinical Lead: Deepa Shanmugasundaram

The above shows the System governance structure.



Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Self-management digital and education support tools to newly diagnosed patients	From quarter one to quarter two 2023/24
Improved care processes uptake from ~27% to ~34% across 8 rolling care processes	Quarter three 2023/24
Target improvements across 3 x treatments from ~27% to ~ 33%	Quarter four 2023/24
Power Business Intelligence dashboard finalised and in use across Integrated Care System	Quarter four 2023/24

Dermatology Services

What have our residents told us?

The Dermatology patient survey in February 2023 found that:

- 59% of respondents had accessed care from their General Practitioner for their skin condition with 62% of patients regularly managing their skin conditions at home. Only 23% had a tele dermatology assessment.
- 44% of respondents had accessed skin treatment via a community or hospital service with mixed outcomes, the common trend being that the clinical care received by hospitals was good but often experienced long waiting times and thought the service was not patient focussed.
- 45% stated that their skin condition has impacted on their mental health and wellbeing with common themes being that skin conditions are leading to lack of sleep, increased anxiety of visual appearance.

Current Conditions

Challenges driving dermatology pressures include a shortage of consultant dermatologists and an ageing workforce, variation in diagnosis and management in primary care due to a lack of dermatological training for General Practitioners; limited or fragmented use of available technology; inadequate triage in both primary and secondary care, limited and inconsistent coding of outpatient activity (NHS England Transforming Elective Care Services - Dermatology).

Local pressures resemble the national picture for Dermatology with increased patient waiting lists: dermatology is one of three priority areas due to significantly increasing demand for Dermatology services. The Integrated Care System has formed a Dermatology Board with representation across primary care, community and acute services. The Dermatology Board has overseen development of joint pathways with community and acute services to improve care for service users.

The Dermatology Programme Board alongside Dermatology Stewards have committed to implementing a single Community Dermatology Service across the Integrated Care System to support improvement in Dermatology services, reducing health inequalities, improving patient experience and patient outcomes, communication, and waiting times for patients.

What is the requirement from the NHS?

The Dermatology Programme Board are implementing an Integrated Community Dermatology Service, acting as a single point of access into community and secondary care services in line with national guidance. The service will be innovative and improve outcomes for service users.

Our Ambitions

Through use of teledermatology the service will ensure that service users are seen in the right setting, first time, subsequently improving the early diagnosis of Skin Cancer and reducing hospital waiting times through triage. This links to the NHS Long Term Plan to boost out of hospital care and use technology to redesign clinical pathways.

In addition, Dermatology Stewards have identified key improvement areas. These include:

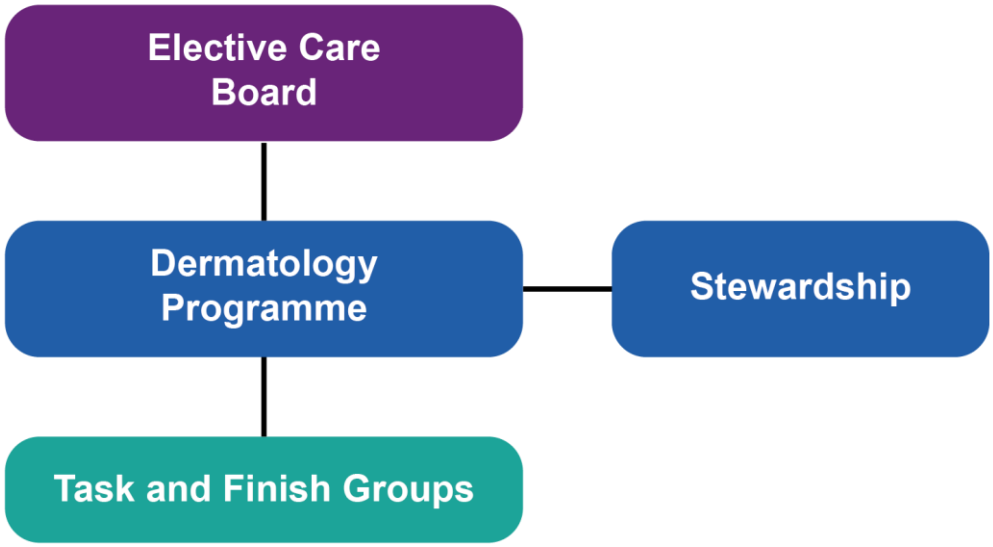
- Public health promotion of Dermatology conditions
- Continued engagement and training with General Practitioners and Health Care Professionals
- Initiatives to support the retention and training of workforce

Delivery Priorities

- Improve Skin Cancer 2 week wait and Referral to Treatment waiting times
- Achieve the faster diagnostic standard for skin cancer
- Implement the Integrated Community Dermatology Service by April 2024
- Deliver a seamless care pathway for our residents from point of prevention onwards

Ensuring Delivery

Senior Responsible Owner: Emily Hughes
Clinical Lead: Rachel Wiltshire
Below organogram of system governance arrangements.



Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Implement a single Integrated Community Dermatology service across mid and south Essex by April 2024	Quarter three 2024/25

Eye Care

What have our residents told us?

The common theme in feedback from residents is that the quality of care given during attendances is good, however the waiting time for appointments (particularly follow up care), delays for surgery and telephone access to the service require improvement. Care closer to home and easier to access is well received, this is supported by Friends and Family Test responses that are more positive for satellite/community locations than for attendances at the large Trust sites.

Current Conditions

Eye care services across mid and south Essex are significantly challenged as a result of year-on-year growth in demand and the added impact of the COVID-19 pandemic. The number of people waiting for appointments at hospital is at a record high particularly for those with developing or chronic conditions. This has an impact on the avoidable deterioration of vision and long-term outcomes for our population.

What is the requirement from the NHS?

By understanding our current demand and future growth in demand for eye care services we will target pathway transformation to maximise capacity to ensure patients are treated in a timely manner and as close to home as possible.

The Planning Guidance for 23/24 identifies the requirement to ensure direct referral routes from community optometrists to ophthalmology for all urgent and elective eye consultations.

Our Ambitions

The aim of the Mid and South Essex Eyecare Transformation Programme is to ‘improve and preserve the vision of our residents now and in the future by achieving a system-wide sustainable and integrated eye care service across mid and south Essex’

We intend to reduce the non-admitted waiting list and improve Referral to Treatment performance, significantly reduce the overdue follow up waiting list and improve patient outcomes, particularly relating to avoidable deterioration of vision whilst waiting for treatment).

Delivery Priorities

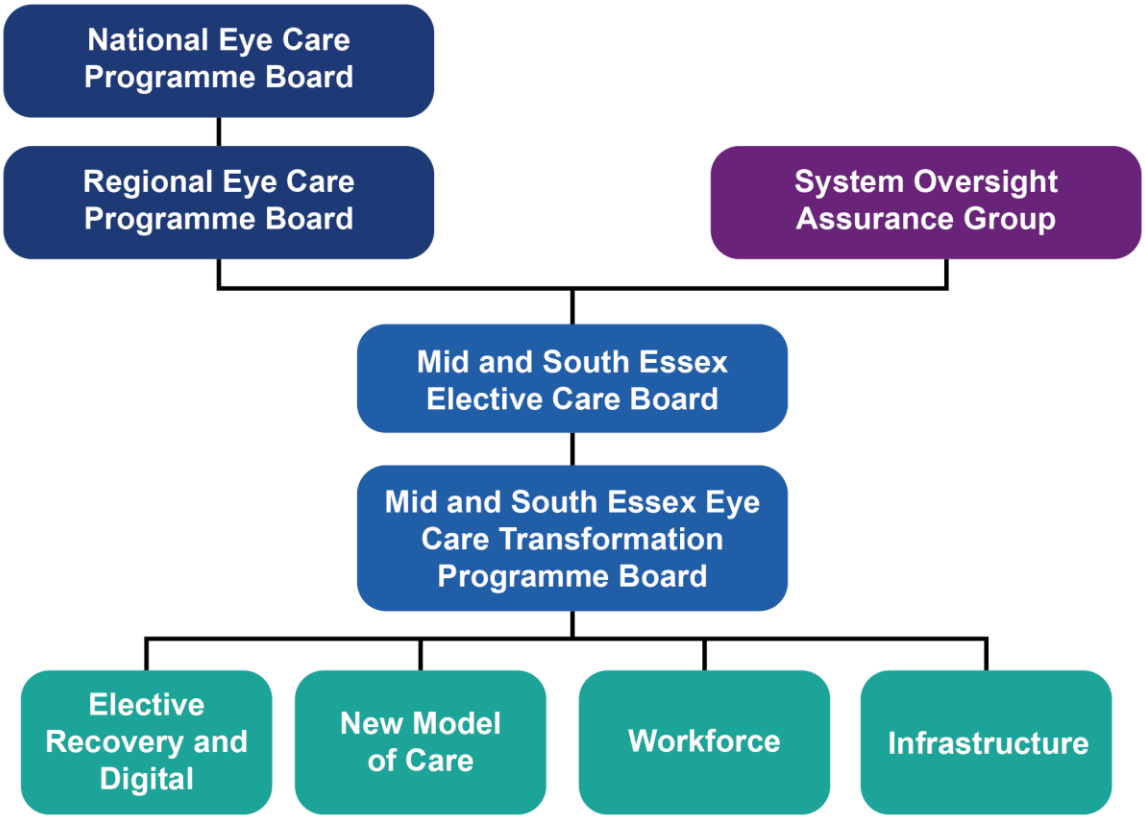
Led by the Eyecare Transformation Programme Board, improving outcomes for patients and their experience of care will be achieved through:

- Developing new pathways and increasing capacity and efficiency of services to meet growing demand
- Reducing waiting times for care
- Maximising the clinical capabilities of the ophthalmic workforce and developing new roles
- Improving estates and digital infrastructure to support the future delivery model

Ensuring Delivery

Senior Responsible Owner: Andrew Pike
Clinical Lead: Dr Boye Tayo

Below organogram of system governance arrangements.



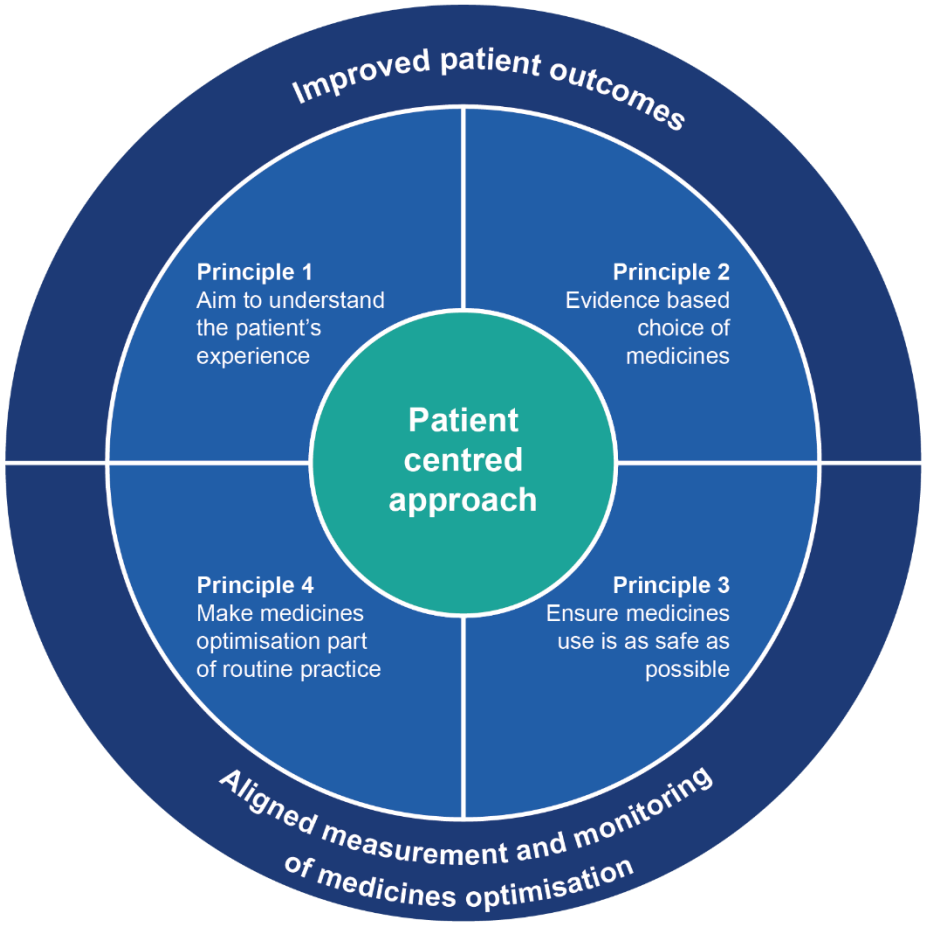
Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Complete review of 8,000 glaucoma patients	Quarter one 2023/24

Delivery Plan objectives	Timespan for implementation of objectives
Full implementation of Referral Hub with clinical triage	Quarter one 2023/24
Implement one diagnostic hub and develop specification for spokes (subject to business case)	Quarter three 2023/24
Expand use of Eyecare electronic Referral System and implement Advice & Guidance functionality	Quarter two 2023/24
Develop and implement pre-op cataract pathway and glaucoma case finding	From quarter three to quarter four 2023/24
Review and develop end to end pathways for medical retina	First half of 2024/25
Implement diagnostic pathway with associated capacity across all mid and south Essex	Second half of 2024/25
Development and mobilisation of long-term estates and infrastructure solutions for acute ophthalmic care as per the new model and pathways	2025/28

Pharmacy and Medicines Optimisation

What have our residents told us?



Current Conditions

Antimicrobial Stewardship: National target has not been achieved since November 2021, some of this increase is attributed to surge in demand for management of Group A Strep and prevention of Diphtheria and in line with increase in antibiotic prescribing seen nationally. There is steady decrease in the use of broad-spectrum antibiotics.

Patient Safety: Reduction of dependence forming medicines is a priority. mid and south Essex currently has over 1000 patients prescribed >120mg morphine daily. New guidance and implementation documents in place to support patient and prescribers.

Resources: Cost pressures arising from increasing demand for medication, increase in price due to shortages leading to price inflation and Department of Health price concessions.

Over-prescribing: Overprescribing directly affects some groups with protected characteristics. In Oct 2022 there were 111,458 (10.87% c.f. 10.79% national average) people taking 8 or more unique medications (range across alliances 8.33% to 11.04%) and the average number of unique medicines prescribed for all patients in MSE was 3.66 compared with 3.53 nationally.

Community pharmacy integration: Slow uptake of community pharmacy consultation service and under-utilisation of community pharmacy clinical services (both nationally and locally commissioned) by General Practitioner practices.

The Essex Pharmacy Leads network was re-invigorated during the pandemic and continues to support system wide working.

What is the requirement from the NHS?

- A whole system approach to medicines optimisation to improve population health.
- Improve access to medicines.
- Improve health outcomes from medicines.
- Reduce inappropriate prescribing.
- Deliver value from medicines.
- Reduce waste.
- Promote self-care.

Our Ambitions

To ensure that people living in mid and south Essex have access to the medicines they need, in the right place and at the right time; to achieve the greatest health outcomes for themselves and the local community, within the resources available.

Delivery Priorities

- Achieve the antimicrobial prescribing metrics year on year by implementation of National Institute for Health and Care Excellence guidance and cross-sector guidance on common infections in line with Integrated Care Board Antimicrobial Resistance Workplan 2023-2026
- Patient Safety - Patient Safety- reduce the risk of medicines-related harm from high-risk drugs - Valproate Prescribing in people under 55 and other Patient Safety Incident Response Framework priorities; improved monitoring to reduce risk of harm Eclipse Patient Safety indicators
- Reduce number of patients on high dose opioids to Integrated Care Board average.
- Resources - make best use of NHS funding by managing cost pressures arising from increasing demand for medication and reduce variance in

prescribing spend £per ASTRO-PU electronic between mid and south Essex practices to drive equity, appropriate distribution and best use of resources and make best use of existing pharmacy workforce and developing a pharmacy workforce pipeline strategy.

- Reducing over - prescribing and over supply - reducing carbon burden of medication. Polypharmacy - reduce inappropriate polypharmacy - reduce variation across mid and south Essex electronic Patient Aligned Care Team 2 Polypharmacy Prescribing Comparators

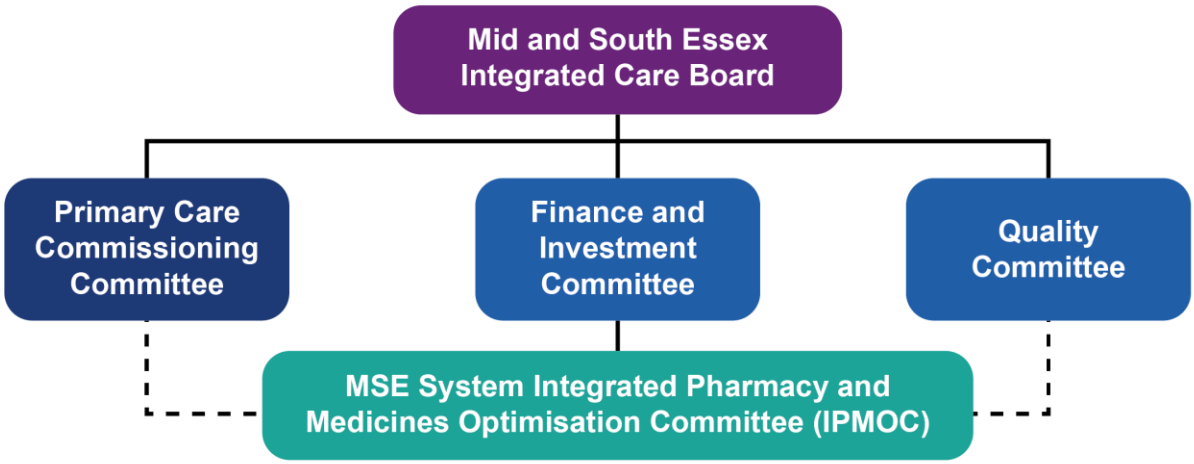
- Integration of community pharmacists and community pharmacies into ICB pathways; optimising the use of nationally commissioned services Community Pharmacy Consultation Service Discharge Medicines Service, Blood Pressure Check Service and Oral Contraceptive Service; development of clinical services delivered including Independent Prescribing by Community Pharmacists.

Ensuring Delivery

Senior Responsible Owner: Paula Wilkinson
Clinical Lead: Dr Aravinda Guniyangodage

The Mid and South Essex Medicines Optimisation Committee is in place and working towards single formulary and prescribing guidance for the Integrated Care System. The Medicines Optimisation Committee will operate within delegated authority and be accountable to the Mid and South Essex Integrated Pharmacy and Medicines Optimisation Committee, which working through system/alliance medicines optimisation groups, will drive systemisation of medicines optimisation and pharmacy integration

The below shows the proposed governance structure.



Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Establish Mid and South Essex Antimicrobial Resistance Network of Primary Care Network lead pharmacists and train the trainer programme; and audit programme to drive change	Quarter one to quarter three 2023/24
Implement and embed Patient Safety Incident Response Framework, patient safety audit programme	From quarter two to quarter three 2023/24
Undertaken pharmacy workforce gap analysis and develop a pharmacy workforce strategy for mid and south Essex.	From quarter two to quarter three 2023/24
Optimise use of High-Cost Drugs- use of biosimilars	From quarter three 2023/24 to second half of 2024/25
Implement annual system wide Medicines Optimisation Locally Enhanced Scheme to drive quality, equitable and cost-effective prescribing and reduce variance MOLES 23-24	From quarter one to quarter three 2023/24
Increase delivery of high-quality structured medication reviews to improve outcomes and reduce medicines-related problems for patients ensuring equity in access and focus on people with Serious Mental Illness and those with Learning Disabilities.	From quarter two to quarter three 2023/24
Develop and implement action to address the carbon impact of unnecessary prescribing and medicines waste in areas other than inhalers.	From quarter two to quarter three 2023/24
Implement and evaluate Independent Prescribing Pathfinder within community pharmacy with focus on extension of Community Pharmacy Consultation Service initially.	From quarter one to quarter four 2023/24

Musculoskeletal and Pain Service

What have our residents told us?

A small-scale survey was undertaken in 2023, 108 people responded in total with 46 expressing an interest in being involved in future discussions. An online event was held 11th May 2023 targeting the people who responded to the survey. In addition, face to face survey engagement will be undertaken at Musculoskeletal, Pain and Rheumatology outpatient clinics during May.

Current Conditions

Current challenges and pressures:

- Differential access to services across the system in community and secondary care.
- Waiting list pressures in secondary care, admitted and non-admitted.
- Workforce pressures.

Partnership working:

- Musculoskeletal Delivery Group in place with speciality specific task and finish groups. All groups have representation from all providers currently offering Musculoskeletal care across the system including primary, community and secondary care.

What is the requirement from the NHS?

Musculoskeletal is one of the three speciality priorities described in the NHS Planning Guidance 2021/22 to support a reduction in variation in access and outcomes. Within the Mid and South Essex Integrated Care System there are six providers providing Musculoskeletal services across community and multiple NHS and Independent Sector delivering secondary care, which creates a variation in both access to services and pathways being delivered across the population.

Our Ambitions

Musculoskeletal transformation includes trauma and orthopaedics, rheumatology, pain management and therapies. Working with stakeholders since Autumn 2021, the Musculoskeletal System Delivery Group have developed a new community pathway, for people aged 16 years and over, based on the East of England Musculoskeletal Pathway Improvement Framework, the Best Musculoskeletal high impact recommendations and adhering to the Getting It Right First-Time pathway.

The proposal is to commission a single Community Musculoskeletal and Pain Service for mid and south Essex which aims to triage, assess, and treat more patients outside of acute services and improve outcomes, quality and patient

experience of care. Residents that cannot be managed in primary care will be referred to the community service via a Single Point of Access for assessment, diagnostics, diagnosis, and treatment. Patients who require surgery or specialist assessment and/or treatment will follow a pathway through the community service into an acute service of their choice.

Delivery Priorities

- System wide community Musculoskeletal and pain service to be implemented by Quarter 4 23/24
- 80% conversion rate to surgery
- <20% discharged at first appointment.
- Support waiting list reduction.

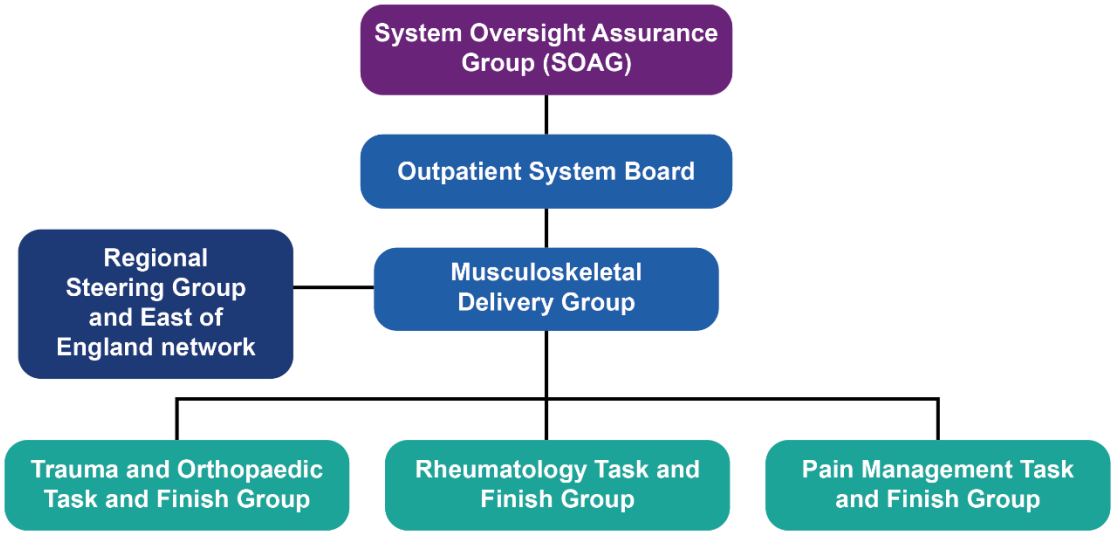
The new service will deliver high quality, patient focussed care that is innovative, improves outcomes and reduces health inequalities for patients. Expected outcomes will include:

- Delivering a population health approach focused on optimising outcomes, including reducing health inequalities
- Providing a service that delivers equitable outcomes and experience
- Improving life-long best Musculoskeletal health for the population of mid and south Essex using preventative and anticipatory care approaches
- Delivering a seamless integrated pathway
- Adherence to Referral to Treatment standards and more efficient recovery of waiting lists.

Ensuring Delivery

Senior Responsible Owner: Gerdalize du Toit
Clinical Lead: Gurvinder Saluja
Clinical Lead: Mr Sean Symons Mid and South Essex NHS Foundation Trust

The table below shows the System governance structure.



Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Specification to be signed off by the Delivery Group	Quarter one 2023/24
Further resident engagement event	Quarter one 2023/24
Scoping exercise around paediatric orthopaedic pathways	Quarter three 2023/24
System wide Musculoskeletal and Pain Community Service to be in place in 23/24 Quarter 4	Quarter four 2023/24
Identification and prioritisation of further initiatives to improve pathways and outcomes	First half of 2024/25

Appendix 8 – Supporting System Development

Within this section you will find long term plans relating to:

- System Governance
- Serious Violence (including Violence Against Women and Girls, Domestic Abuse, Sexual Violence, Knife & Gang related violence)
- Research Studies
- Delegation of Services (Pharmacy, Optometry and Dental Services)
- Specialised Commissioning
- Community Mobilisation, Transformation & Resilience

Building our Integrated Care System Governance

Governance arrangements to establish the Integrated Care Board are sound, meet the requirements of the Act and were seen as good practice by NHS England. As the Integrated Care Board matures to meet its objectives of subsidiarity and integration, governance must evolve to enable this maturity.

Residents/patients have asked the Board for more focussed engagement on decision making and expect standards of business conduct / transparency of decision making in line with our goals to be robust, demonstrating our accountability and influence over the performance of the system.

Governance is an enabling function and so must work closely with all directorates to achieve its objectives and the Integrated Care Board ambition.

What is the requirement from NHS

The Integrated Care Board must ensure that systems of internal control are robust to manage system and local Integrated Care Board risks that threaten the achievement of Integrated Care Board objectives and maintain and strengthen compliance with legislation and codes of governance.

This includes the approval of plans, strategies, and business cases as well as scrutiny of decisions and seeking assurances and legal advice that Integrated Care Board functions are delivered appropriately. As the Integrated Care Board develops, taking on delegated functions from NHS England, strengthening subsidiarity and integrating with our partners, governance will need to evolve to enable these functions to be delivered.

What is the ambition

To maintain compliance with statutory duties and good governance practices. In line with the NHS Long Term Plan and Integrated Care Partnership Strategy:

- Support integration with partner organisations – strong system decision making and risk management
- Establish governance to support Subsidiarity – fully integrated and streamlined Provider Collaboratives / lead provider model

Satisfactory outcome to Care Quality Commission inspection of Integrated Care Systems

What are the delivery priorities?

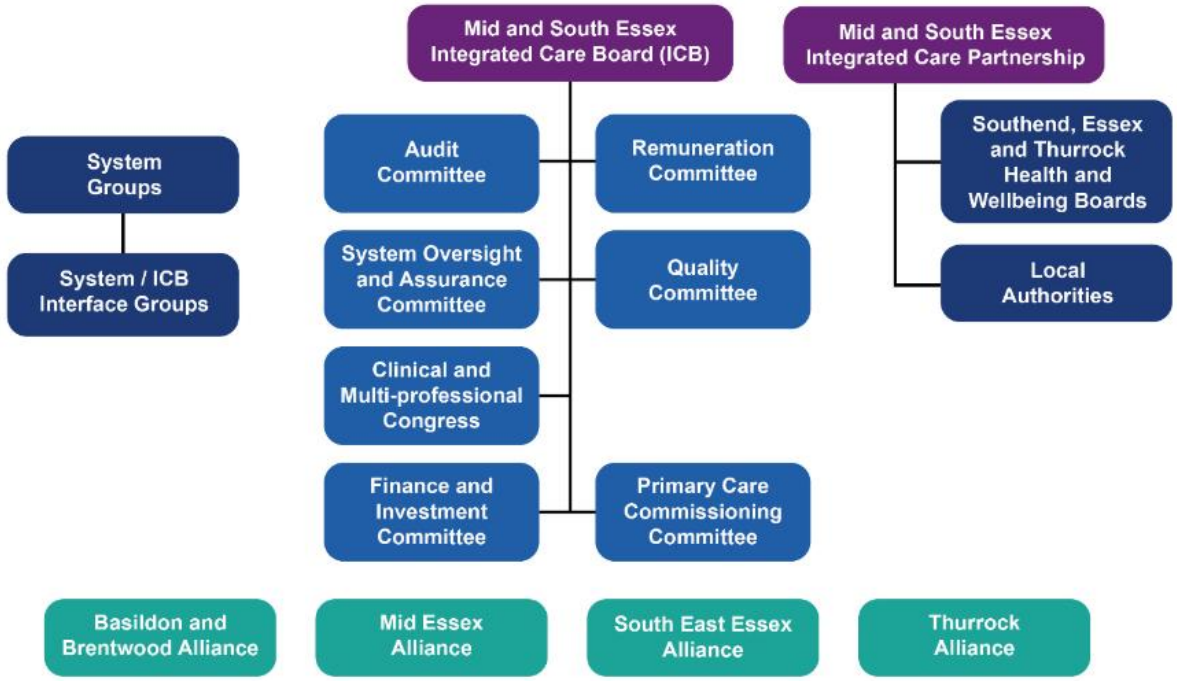
- Maintain good governance and compliance with statutory duties for example the duty to obtain appropriate advice.
- Enhance reporting and information flows to the Board and committees using synthesised 'highlights and exception' approach for escalation of performance (incl. constitutional standards, quality, and finance) risk and assurance as the key components of core reporting.
- Embed and enhance robust governance and the Integrated Care Boards standards of business conduct at all relevant levels including arrangements for effective decision making, management of conflicts of interest and ensuring all aspects of the Integrated Care System uphold the Nolan Principles of conduct in public life
- Utilise data and dashboards to ensure that assurance of performance to Board and committees is high quality, contemporary and serves the need of the organisation's governance.
- Create the appropriate governance functions in support of the delegation of NHS England commissioning functions for podiatry, optometry and dentistry and shadow arrangements for specialised commissioning, as well as delegation to place, collaboratives, the role of stewardship groups etc.
- Create more effective and agile decision making that aligns, where appropriate, organisational governance processes to support delivery of system priorities e.g., business cases for transformational investment, financial recovery programme(s).
- Develop collaboration with partners to support Integrated Care System integration and the management of risk across the system that enables individual accountability and collective responsibility.

Governance

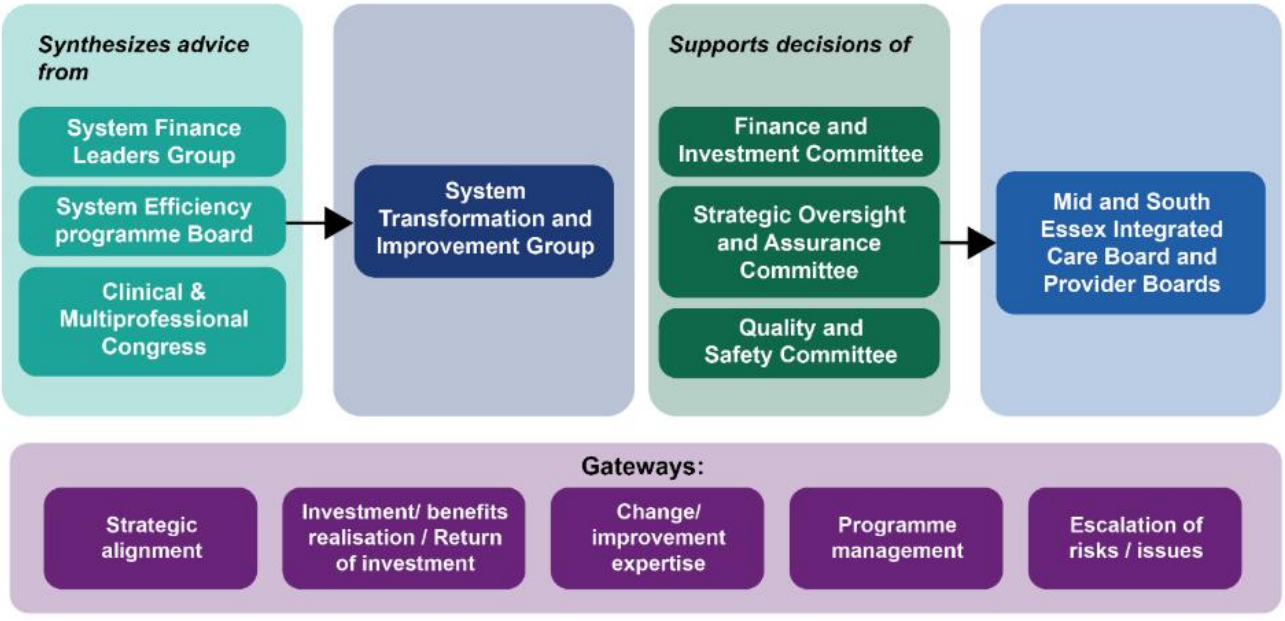
Senior Responsible Owner: Anthony McKeever
Lead: Mike Thompson

How will we ensure delivery

The below diagram shows the Integrated Care Board accountability structure



The below shows the System governance structure.



Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Maintaining robust governance to keep the Integrated Care Board safe / meet statutory requirements e.g., annual report, duty to obtain appropriate advice.	From quarter one 2023/24 to 2025/28
Enhance performance quality and finance reporting to Integrated Care Board and assurance through committees	Quarter one 2023/24
Revise and update business case process	From quarter one to quarter two 2023/24
Review and update Scheme of Delegation for decision making and onward delegation	Quarter two 2023/24
Support effective use of system transformation and investment group	From quarter one to quarter two 2023/24
Guidance and training for staff on effective decision making	Quarter two 2023/24
Support the delivery of the governance peer review	Quarter one 2023/24
Implement strengthened governance outcomes from the peer review	From quarter two to quarter three 2023/24
Establish governance for Specialised Commissioning	Quarter four 2023/24
Work with system partners and place to fully understand what governance structure is required.	From quarter one to quarter two 2023/24
Support the development of delegation to place, collaboratives	From first half 2024/25 to 2025/28
Develop integration of governance with partners and system risk management	From quarter two to quarter four 2023/24
Co-ordinate the preparation for and response to Care Quality Commission inspection of the integrated care system	From quarter two 2023/24 to second half of 2024/25

Serious Violence (including Violence Against Women and Girls, Domestic Abuse, Sexual Violence, Knife & Gang related violence)

What have our residents told us

Everyone has the right to live safely, free from abuse and neglect. Abuse and neglect can occur anywhere; at home, public place or whilst receiving services such as health care, education, or in social care setting. There are many forms of abuse; sexual, physical, psychological, domestic, discriminatory, financial and neglect.

What is the current state of play/local challenges

Victims of abuse are also more likely to develop a dependency to or misuse alcohol and/or drugs and domestic abuse and serious sexual violence has been strongly associated with sleep and eating disorders and exacerbation of psychotic symptoms. Individuals with mental health problems may also be more vulnerable to domestic abuse.

Any form of abuse can result in a wide range of significant impacts on the health of an individual ranging from physical to mental health concerns. Prolonged exposure to physical abuse can lead to significant long-term health problems or death. Domestic abuse can have a widespread and significant impact on mental health and can lead to conditions such as anxiety, depression, suicidal behaviour, and post-traumatic stress disorder.

Integrated Care Board statutory duties within the Domestic Abuse Act 2021

Integrated Care Board statutory duties within the Serious Violence Duty 2022

What is the requirement from the NHS

The ‘Serious Violence Duty’ is a legal duty on the ICB to collaborate locally to work together to prevent and reduce ‘serious violence’. The definition of ‘serious violence’ now includes domestic abuse and sexual offences.

Within the NHS, the impacts of domestic abuse and sexual violence are felt in every area of our health care system, from emergency departments to ambulance call outs to our maternity wards.

Breaking the cycle of Serious Violence (domestic abuse and sexual violence) is one of the priorities in the Police and Crime Plan for Essex. The Government’s Violence Against Women and Girls Strategy 2016-20 follows a framework that includes:

provision of services, partnership working and pursuing perpetrators. It has a focus on the need to transform service delivery, have a change in social action to achieve a sustainable long-term reduction in the prevalence of abuse and to break the inter-generational consequences of abuse.

Reducing violence in in our communities and the impact of drug driven violence, is the key priority for the Essex Violence and Vulnerability Partnership.

What is Our Ambition

The Integrated Care Board has committed to work in partnership with Police, Social Care and many of our local charities and voluntary organisations to address the many forms of abuse and violence our residents are experiencing.

- Partners in the Southend, Essex and Thurrock Domestic Abuse Board working together to commission a range of specialist victim and perpetrator services and raising awareness and recognition of abuse.
- Partners in the Essex Violence and Vulnerability Partnership commissioning a joint strategic approach in preventing violence and protecting the vulnerable in our communities
- Partners with the Community Safety Partnership teams which bring together organisations and groups that share responsibility of tackling crime and disorder, anti-social behaviour plus drug and alcohol related offending

What are the delivery priorities?

Domestic Abuse Strategy five key outcomes:

- Children & young people can recognise and form healthy relationships;
- People experiencing and at risk of experiencing domestic abuse are supported to be and feel safe;
- Everyone can rebuild their lives and live free from domestic abuse;
- Supporting and disrupting perpetrators to change their behaviour and break the cycle of domestic abuse;
- Communities, professionals, and employers can recognise domestic abuse at the earliest opportunity and have the confidence to act.

Violence and Vulnerability Strategic Objectives

- Voice of our communities
- Targeting interventions
- Developing the workforce
- Communications – raising awareness
- Improving understanding

Community Safety Partnership Objectives

- Tackling violence against women and girls
- Tackling community based antisocial behaviour and safeguarding victims
- Safer communities
- Human trafficking, modern day slavery and organised immigration crime

Sexual Safety of NHS Staff and Patients

In recent times there have been reports of sexual assault, harassment, and abuse in the NHS. It is right that we collectively shine a spotlight on this important issue. Any abuse is unacceptable, and our number one priority must be to keep staff and patients safe. In achieving this it is important that every part of the NHS takes a systematic zero-tolerance approach to tackle this issue which encompasses prevention, support and decisive action against perpetrators. With over 1.3m people employed in the NHS, and with about 2 million contacts with patients every working day, the NHS has a responsibility to protect staff and patients and offer safe spaces and routes for support. In July 2022 NHS England established a Domestic Abuse and Sexual Violence Programme to build on our robust safeguarding processes for protecting patients, improve victim support, and focus on early intervention and prevention. This will form a key piece of the work within the Integrated Care Board's programme of work in delivering the Serious Violence Duty which, requires organisations including Integrated Care Boards, to collaborate locally to prevent and reduce 'serious violence', which includes domestic abuse and sexual offences.

The Integrated Care Board Safeguarding team will work jointly with workforce leads and analytical colleagues and prioritise 3 areas of work:

1. Supporting our staff - A review of NHS staff policies, and include a dedicated sexual safety policy, to provide support and training on domestic abuse and sexual violence, with best practice shared across the system.

2. Executive leadership – The Executive team within the Integrated Care Board with senior leaders across the healthcare system will work collectively to tackle sexual assault and harassment of staff in the NHS.

3. Improving data collection – it is important that data can be collected and is meaningful to help inform what needs to be done

Governance

Senior Responsible Owner: Jeff Banks
Clinical Lead: Linda Moncur Director of Nursing for Safeguarding

How will we ensure delivery

Through partnership working across the Integrated Care Partnership the Integrated Care Board will deliver its statutory duties and realise the outcomes identified in the Domestic Abuse Strategy, the Violence and Vulnerability Strategy and the Community Safety Partnership Priorities.

The strategic working of the alliance groups is inclusive of the need to address the social determinants of healthcare and health related behaviours between areas and communities and the need to address inequalities particularly through the work on Core20PLUS5 Framework.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Existing or new partnership established for joint decision making with partners	Quarter one 2023/24
Evidence based analysis completed identifying local serious violence issues	Quarter three 2023/24
Prepared local strategy to contain prevention and reduction initiatives	Quarter four 2023/24
Review and refresh of needs analysis and strategy	First half of 2024/25

Research in Primary Care and Community

What have we heard from residents/patients

This is an internal organisational requirement only

What is the current state of play/local challenges

Relatively little health-related research has been conducted in mid and south Essex compared to other areas of England. This is partly due to the absence of large research-based academic institutions and medical schools in the area. This may be having a damaging effect on the local health care economy by reducing opportunities for innovation and research available to local patients, reducing the attractiveness of the area to high performing health care professionals and reducing the investment that is associated with research centres.

In addition, all community services are suffering with workforce shortages, increased clinical needs and backlogs caused in part by the Covid pandemic. Primary care in particular is fragile with its highly fragmented structures, limited and variable management capacity and poor morale and retention.

Increasing research activity and collaboration between partners may achieve economies of scale, mutual support and better outcomes. In addition, it may help attract and retain highly skilled staff and create a virtuous circle of more sustainable health care systems.

What is the requirement from NHS

Community, Primary Care and other out of hospital Health Services in Mid & South Essex include

1. 150 General Practitioner practices organised into 27 Primary Care Networks
2. 3 Community and Mental Health Providers
3. approx. 550 schools
4. >69 care homes
5. 3 hospices
6. 1 prison

Plus, many more community dentists, pharmacists and optometrists.

Currently each community provider is conducting research supported through its own research office which provide varying levels of support to researchers.

In addition, the North Thames Clinical Research Network, which currently covers mid and south Essex, supports the implementation of research in partner organisations including primary care and agile settings such as those above. Funding is from the National Institute of Health Research via the local primary care office based in Broomfield Hospital. This covers Mid & South Essex, West Essex, Luton and Herts

Valleys. In April 2024 the footprint will alter so that mid and south Essex will become part of the East of England Local Clinical Research Network. Although the footprint and relationships will change the underlying NIHR priorities and funding should remain similar.

What is the ambition

As a system, Mid & South Essex aims to increase the number of research studies conducted in the community and to increase the number of research-active primary care networks.

It will help achieve this in partnership with the Local Clinical Research Network by promoting research activities through its publications and website, through incorporating research activity in its commissioning activities and supporting Research Champions in primary care.

There are four themes to the Vision:

1. Research is available and responsive to the health and care needs of our population
2. Adaptive connection of research systems and processes to Primary Care systems
3. Strategic engagement and incentivisation in Primary Care
4. Strategic development of the Primary Care Research Workforce

The longer-term vision is to partner with local academic institutions to increase the local base of academic expertise to lead more locally designed and locally relevant research studies. The Anglia Ruskin University Medical School is developing its long-term strategy in partnership with the Integrated Care Board to deliver this. Ultimate goal to establish a Centre for Advancing Primary & Integrated Care.

What are the delivery priorities

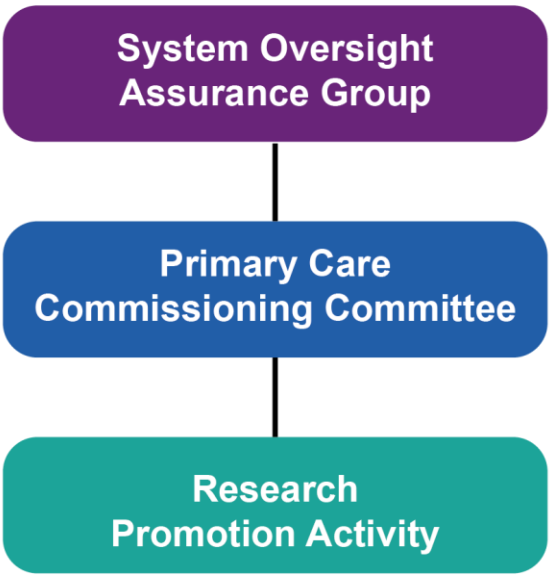
- Develop community of practice in out of hospital research between providers: North-East London Foundation Trust, Essex Partnership University NHS Foundation Trust, Provide, Primary Care. Initial meetings commenced Nov 2022 and planned quarterly contact meetings to explore and support options for collaboration and mutual support and development. To initiate by April 2023.
- Identify options to increase capacity to support and develop research through funding applications to employ a coordinator for primary and community care research. Sept 2023

- Support collaborative links with local universities to develop and champion primary care and community research within mid and south Essex. Agree joint strategy. Sept 2023
- Recruit and support research champions in primary and community care across mid and south Essex. Sept 2023 and ongoing.

Governance

Senior Responsible Owner: Ronan Fenton
Clinical Lead: James Hickling

How will we ensure delivery



Above organogram of system governance arrangements.

Currently the research workstream in Mid and South Essex Integrated Care Board has no budget allocation. It relies on soft leadership, networking and influence to work with partners to meet its objectives. Reporting is proposed to be via the Primary Care Commissioning Committee.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Establish community of practice	Quarter one 2023/24
Agree options to support and develop activity	Quarter two 2023/24
Links with academic institutions	Quarter two 2023/24

Delivery Plan objectives	Timespan for implementation of objectives
Research Champions	Quarter three 2023/24
Increase collaboration across community-based research active organisations	Second half of 2024/25
Increase quantity, quality and proportion of locally led research through Centre for Advancing Primary & Integrated Care	2025/28

Research in Acute Setting

What have we heard from residents/patients

This is an internal organisational requirement only

What is the current state of play/local challenges

Mid and South Essex NHS Foundation Trust has a proud and growing reputation as a centre of innovation and research but only 33 of >700 consultants are research-active, and we are unsure of other healthcare professional involvement. However, our geography means we compete with larger London research institutions. We should look to work with partners to define the unique offer that Mid and South Essex NHS Foundation Trust has and to develop a long-term system wide research strategy.

In addition to this, we must consider how we improve training provision to increase the overall satisfaction of staff with their onsite training. Our General Medical Council National Teaching Survey scores continue to be lower than our peers. Continuing to grow our partnership with the medical school at Anglia Ruskin University and with the University of Essex will help to build our teaching capability.

What is the requirement from NHS

The Health and Care Act 2022 (the 2022 Act) sets new legal duties on Integrated Care Boards around the facilitation and promotion of research in matters relevant to the health service, and the use in the health service of evidence obtained from research.

What is the ambition

Key points in the draft Research & Development strategy document:

1. Establish a culture where research is appreciated across all staff groups and embedded into routine practice
2. Develop a High-Quality Research Portfolio offering access to patients across all specialties and sites
3. Increase quantity of research
4. Patients and public are engaged with, participate in and benefit from research
5. Research is adequately funded via National Institute of Health Research funding, external grant applications, commercial research income and charity funding
6. Research is well governed, managed, supported and delivered and studies are delivered as agreed

What are the delivery priorities

The immediate plan is to develop a system-wide research strategy that incorporates research in acute settings with research in community and primary care (see separate Joint Forward Plan). This will cover People, Partnerships, Portfolio of assets, and Patients/Populations.

Joint funding from the Anglia Ruskin University, Integrated Care Board and Mid and South Essex NHS Foundation Trust has allowed recruitment to two posts to create a research strategy team.

They are currently involved in a stakeholder engagement exercise to draw up the priorities for a strategy, which is due to be published in June 2023.

Engagement will take place in the summer of 2023. Draft objectives are stated above.

Governance

Senior Responsible Owner: Ronan Fenton
Clinical Lead: James Hickling

How will we ensure delivery

Short term collaborative funding has supported the establishment of a small research strategy group. Delivery of the strategy will depend on system-wide partners including NHS providers, academic institutions and the Integrated Care Board.

National support through National Institute of Health Research and other funding sources. Oversight will be through the Clinical & Professional Leadership Directorate. Overall governance to be agreed.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Conduct initial stakeholder engagement	Quarter one 2023/24
Publish System-Wide Research Strategy	Quarter two 2023/24
Further engagement and final strategy production	Quarter three 2023/24
Implement Research Strategy	From quarter four 2023/24 to 2025/28

Pharmacy, Optometry and Dental Services Delegation

What have our residents told us?

Access to all primary services (including Pharmacy, Optometry and Dental services) is a priority for our local population. Many residents see accessing these services as both an alternative to hospital-based care and as the gatekeeper to hospital-based services where required.

Residents are struggling to access dental services particularly in some more deprived areas of the Integrated Care Board. Many residents access private dental services due to a lack of NHS provision.

Current Conditions

Pharmacy optometry and dentistry services will be delegated to Integrated Care Boards as of 1 April 2023. Transition plans are underway, but there are significant challenges in taking on these responsibilities including access to care, quality and finance.

Access to dental services nationally is a significant challenge. This is in part due to workforce constraints but also is attributed to the existing contractual settlement with dentists. The contract framework is currently under review nationally.

Nationally, there are also challenges within the community pharmacy workforce. There is concern that the planned expansion of community pharmacy services as an alternative to general practice cannot be supported within the current resource constraints.

What is the requirement from the NHS?

The Planning Guidance for 23/24 identifies the following requirements that impact on Pharmacy, Optometry and Dental services.

- Recover dental activity, improving units of dental activity towards pre-pandemic levels
- Increase the use of Community Pharmacy Services as an alternative to general practice
- Ensure direct referral routes from community optometrists to ophthalmology for all urgent and elective eye consultations
- Recovery of secondary care dental service waiting lists as part of overall waiting list recovery

Our Ambitions

The Integrated Care Board seeks to ensure that Pharmacy, Optometry and Dental services form a key part of our Integrated Neighbourhood Team model for urgent and episodic care, complex care and prevention.

Delivery Priorities

Pharmacy, Optometry and Dental Services will be delegated to Integrated Care Boards from 1st April 2023. As such, our initial priority is to stabilise arrangements and ensure we are delivering our business-as-usual functions effectively. From this foundation we will then undertake a process of strategy development over a six-month period. We will engage with stakeholders throughout this process.

From the end of 23/24, we will seek to deliver upon our strategic ambitions.

Ensuring Delivery

Senior Responsible Owner: Dr Ronan Fenton,
Medical Director Integrated Care Board
Clinical Lead: Dr James Hickling

A number of subgroups of the Primary Care Commissioning Committee will oversee the effective commissioning of Pharmacy, Optometry and Dental services. In addition, the Primary Care Commissioning Committee will oversee the development of clear local strategies that link in with our Integrated Neighbourhood Team ambitions.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Transfer and stabilise services following delegation from NHS England	Quarter one 2023/24
Ensure Business as Usual functions are undertaken effectively	Quarter two 2023/24
Develop Community Pharmacy and Dental Strategies (and continue Ophthalmology Stewardship programme)	From quarter three to quarter four 2023/24
Implement Strategies	From first half on 2024/25 to 2025/28

Community Resilience and Engagement

What have our residents told us?

We knew it was essential that the building-blocks of our strategy and the ambitions of the Joint Forward Plan were informed by a range of conversations with residents, community organisations, clinicians, care professionals and leaders in the NHS, plus our local authorities.

In developing the integrated care strategy, we held eight workshops based in community venues, collectively engaging over 170 people from all parts of our system, including elected councillors, system leaders, staff and, most importantly, members of our community. We also used the 'Essex is United – Your Questions Answered' Facebook group to ask a series of questions of the general public. Each was viewed on average 1,700 times, with an average of 280 comments and votes on each question.

We use our Community Campaign Model and our emergent Community Assembly to convene and engage with our communities iteratively, we have a network of 10,200 Community Groups. We have engaged digitally with 3000 members of the public to support the development of the Assembly. This is an approach we intend to continue to evolve to support the delivery of the Joint Forward Plan.

We have adopted a convening, iterative engagement approach that; meets people where they are and focuses on appreciative enquiry.

We have asked people what is working well and what could we do more of. The emergent themes from our community conversations are:

- **Access:** Personalisation and complexity remain a challenge both physically and digitally for our communities. We must make our offer obvious and our systems intuitive with a focus on primary care, urgent care and care closer to home
- **Equitable and Honest:** More work is required to meet inclusion health groups where they are, whilst being open on what is possible. This will become an ongoing feature of the work of the Integrated Care Partnership as it moves forward. Additionally, a commitment to learning from issues and sharing this openly.
- **Awareness:** Further development of behaviour change support to address the wider determinants of health through collaboration around early intervention and prevention
- **Building Responsible Community Together:** Active listening and development of equitable mechanisms that offer a proportionate way for communities to work with us to solve the societal challenges we all face.

Current Conditions

We cannot service our way out of the current service and societal challenges we face. Communities are our greatest asset in driving behaviour change to empower people to Live Well - this requires a new model of civic infrastructure. This means we will need to meet people where they are and work shoulder to shoulder with our people to leverage the best outcomes for our communities.

What is the requirement from the NHS?

As articulated in the Mid and South Essex Integrated Care Strategy, "Engagement of partners and stakeholders will not be an occasional duty but will be a permanent feature of the work of our Partnership"

Our Ambition

We will create a whole system, asset-based approach to working with communities. We will empower people to connect face to face and virtually around societal, system and neighbourhood-based challenges, that are important not only to communities of place, purpose and interest but also supports driving social movements that ensure better system outcomes, that are relevant to the communities mid and south Essex serves, this will create the foundations of resilient, citizen-led communities that can truly level up and reduce health inequalities.

We believe that engagement with our communities should be:

Organisation:

1. Supported by those with the power to change things
2. In an inclusive society, public engagement should be built into the decision-making.
3. Processes of systems, funding bodies, innovators and communities themselves to drive a series of common endeavours

Open to Experimentation:

4. Supportive of a focus on Citizen-led approaches from arts-based engagement to the use of social media that can highlight concerns that can be missed in institutional engagement.

Purposeful:

5. Engagement should be about shaping priorities and decisions rather than simply a consultation to gain acceptance of the public for a new policy or strategy

Sensible about measures of success:

6. A report is often the outcome of engagement activity. However, public engagement can do much more than this. Just as important as the formal, documented outcomes should be how the process itself influences participants and leads to open and surprising discussions about societal issues that matter to our communities

Participants - Targeted at Specific and Universal Audiences:

7. A sensitively focussed approach that includes but is not dominated by an interested and motivated group only. Our thoughtful engagement approach seeks to consider how we meet diverse communities and those with protected characteristics on their terms

Beneficial for Participants:

8. Crafting an engaging experience for participants, or offering support, skills and training that empowers participants to act as community organisers and intermediaries between the statutory and community sector.

Methods Informed and Facilitated:

9. Ensuring our teams have skills in engagement that enable them to explore different views, to provide information where necessary and then to use judgement to interpret findings.

Delivery Priorities

- **We** will establish a Community Assembly model that aligns to system and place through our alliances, an Independent and Private Providers Network, and a Community Voices Network to ensure a wider range of partners are able to influence and contribute to achieving our shared objectives.
- **We** will establish a partnership-based Co-Production and Engagement Steering Group to ensure effective planning, accountability and inclusion.
- **We** will create a paired leadership and learning programme for Voluntary and Community and Social Enterprise and Clinical Leaders to support better collaboration and growth for our people
- **We** will establish an influencer network to ensure we can diversify our approach to community building and engagement.
- **We** will further develop our approach to Volunteerism to support system pressures and communities themselves
- **We** will establish an engagement impact framework to ensure efficacy and inclusion of our engagement approaches

- **We** will develop an ongoing series of community conversations, workshops, seminars, and engagement activities, which draw together a much wider set of contributors into the work of our Integrated Care Partnership.
- **We** will grow our Community Campaign approach, to consider a digital first approach to engagement and peer support, we will develop a Human Library and Lived Experience network, which will ensure a better approach to immersive practice as a system
- **We** will co-produce a Community Engagement Benefits framework with our Communities to ensure equity and reciprocity for participation in our engagement approaches.
- **We** will deliver a mid-point review on our Year 1 and 2 approaches to confirm and challenge impact and efficacy.

Year 4 and 5 to be determined by Year 3

Ensuring Delivery

Senior Responsible Owner: Kirsty O'Callaghan
Clinical Lead: To be established after approval at Steering Group

The governance routes are being established re engagement steering group and assembly - both of which are in co-production phase now. There is a draft and not yet agreed model for the engagement steering group in development and approval of this will be an action for completion in due course.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Community Assembly Model Agreed and Established	From quarter one to quarter four 2023/24
Co-Production and Engagement Steering Group Operational	Quarter one 2023/24
Influencer Community Builder Enabling Network Established	Quarter two 2023/24
Voluntary, Community and Social Enterprise Partnership and Engagement Framework Agreed	Quarter three 2023/24
Community Conversation Cycle	From quarter two 2023/24 to second half of 2024/25
Expansion of Community Campaign Digital First Programme	From quarter one 2023/24 to second half of 2024/25

Delivery Plan objectives	Timespan for implementation of objectives
Community Engagement Benefits Framework	From quarter three 2023/24 to second half of 2024/25
Voluntary, Community and Social Enterprise and Clinical Paired Leadership Programme	From first half 2024/25 to second half of 2024/25
Voluntary, Community and Social Enterprise Referral Tool delivered	From quarter two 2023/24 to second half of 2024/25
Efficacy Review Interdependent	2025/28

Appendix 9 - Health and Wellbeing Board endorsement letters

Essex County Council endorsement letter

Essex County Council

Mr Anthony McKeever
Mid and South Essex Integrated Care Board Phoenix Court
Christopher Martin Road Basildon
Essex SS14 3HG

27th July 2023

Dear Anthony,

The Essex Health and Wellbeing Board is supportive of the MSE JFP and the actions it sets out. It has taken into consideration both the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy for Essex and there are clear links to the priorities in these documents.

We welcome the commitment the JFP sets out to place-based working through the alliances and the development of neighbourhood teams and the ambition to explore integration of services at every level, taking joined up health and care decisions closer to the resident.

We are also pleased with the emphasis the JFP places on investing upstream in evidence- based interventions and preventative activities. This aligns well with the Health and Wellbeing Strategy that identified 'Focusing on prevention and early intervention' as a cornerstone to long term sustainability and one of the foundations of collective success for the system.

It is important that the JFP is all-age and, although the document signals this by recognising important issues such as the need for the system to collaborate on issues such as transitions to adulthood and the expansion of support for children and young people's mental health, we feel the emphasis on pre-birth, children and young people's outcomes could be strengthened. This is essential if we are to address the increase in caseload numbers and complexity following the pandemic.

Most importantly the JFP recognises that being successful in reducing health inequalities requires us to work together and that no single action or single organisation is able to have impact alone, it demands a sustained organised collaborative focus. We look forward to working in an equal partnership with our NHS

colleagues through the ICB, ICP and HWB to provide joined-up health and care services to the people of Mid and South Essex and tackle the causes of ill health.

We recognise that each ICB has been given a very challenging task of reducing its running costs by 20% from April 2024 and by a further 10% from April 2025. Essex County Council encourages MSE to work collaboratively with the other Essex ICBs, and ECC itself, to ensure it explores opportunities for joint working and efficiencies in a way that avoids or minimises

adverse impacts on Essex residents. Two areas identified in conversations so far between ICBs and ECC have been around mental health and children's services. We are keen to support those conversations to ensure we improve services in these areas and achieve potential economies of scale.

Yours sincerely,

Cllr John Spence

Chairman, Essex Health and Wellbeing Board

Southend-on-Sea City Council endorsement letter.

To: SEE Alliance
C. McCarron.
Our ref: RH/HWB Your ref:
Date: 19 June 2023
Telephone: 01702 215106
Email: robertharris@southend.gov.uk

Dear Caroline,

RE: Health and Wellbeing Board held 15th June 2023: Endorsement of NHS Mid and South Essex Joint Forward Plan

The Mid and South Essex ICS's Joint Forward Plan (JFP) was developed following guidance issued by NHS England and the detailed operational planning and financial framework issued to NHS organisations for 2023/24. This JFP has been collated following the Southend Health and Wellbeing Board's endorsement of the ICS's Integrated Care Strategy (March 2023) and having due regards to the priorities set out in our Health and Wellbeing Strategy (2021-24).

The JFP will further support and drive our collective endeavours in reducing health inequalities in our population, exacerbated by the Covid pandemic. The local health and care system is facing a plethora of challenges and our primary care services are under extreme pressure. There are increasing demands on our mental health services, urgent and emergency services, and we have long waits for planned treatments, as well as not meeting nationally set standards in relation to cancer care.

The Southend Health and Wellbeing Board welcomes this plan and the area of priorities set out to address the challenges highlighted above as well as tackling the growing financial deficit that the system continues to experience.

Yours sincerely

Cllr J. Moyies

Chair, Health and Wellbeing Board

Thurrock Council endorsement letter

Thurrock Council, Civic Offices, New Road, Grays Thurrock, Essex RM17 6SL
www.thurrock.gov.uk

Councillor George Coxshall

Chair of Thurrock Health and Wellbeing Board

26 June 2023

Dear Jeff

Thurrock Health and Wellbeing Board's endorsement of the NHS Mid and South Essex Joint Forward Plan

The Mid and South Essex ICS's Joint Forward Plan (JFP) was developed following guidance issued by NHS England and the detailed operational planning and financial framework issued to NHS organisations for 2023/24. The JFP was considered by Thurrock Health and Wellbeing Board on Friday 23 June 2023.

Board members welcomed the plan reinforcing commitments to transforming the way in which health and care services are provided to residents, its commitment to subsidiarity and putting patients at the heart of decision making, reflecting Thurrock's Integrated Care Alliance strategy - Better Care Together- Case for Further Change.

Board members endorsed the plan and its strong commitment to tackling inequalities, reflecting Thurrock's Health and Wellbeing Strategy's ambitions of levelling the playing field across Thurrock.

The JFP will further support and drive our joint endeavours in reducing health inequalities in our population and Thurrock Health and Wellbeing Board acknowledged the importance of maintaining the Better Care Fund as one of the key delivery mechanisms for ensuring our collective ambitions can be achieved.

Yours sincerely

Councillor George Coxshall

Cabinet Member for Health, Adult's Health, Community & Public Protection Chair, Thurrock Health and Wellbeing Board

Essex County Council
Cabinet Office
County Hall
Chelmsford
Essex CM1 1QH

Essex County Council

Mr Anthony McKeever
Mid and South Essex Integrated Care Board
Phoenix Court
Christopher Martin Road
Basildon
Essex
SS14 3HG

27th July 2023

Dear Anthony,

The Essex Health and Wellbeing Board is supportive of the MSE JFP and the actions it sets out. It has taken into consideration both the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy for Essex and there are clear links to the priorities in these documents.

We welcome the commitment the JFP sets out to place-based working through the alliances and the development of neighbourhood teams and the ambition to explore integration of services at every level, taking joined up health and care decisions closer to the resident.

We are also pleased with the emphasis the JFP places on investing upstream in evidence-based interventions and preventative activities. This aligns well with the Health and Wellbeing Strategy that identified 'Focusing on prevention and early intervention' as a cornerstone to long term sustainability and one of the foundations of collective success for the system.

It is important that the JFP is all-age and, although the document signals this by recognising important issues such as the need for the system to collaborate on issues such as transitions to adulthood and the expansion of support for children and young people's mental health, we feel the emphasis on pre-birth, children and young people's outcomes could be strengthened. This is essential if we are to address the increase in caseload numbers and complexity following the pandemic.

Most importantly the JFP recognises that being successful in reducing health inequalities requires us to work together and that no single action or single organisation is able to have impact alone, it demands a sustained organised collaborative focus. We look forward to working in an equal partnership with our NHS colleagues through the ICB, ICP and HWB to provide joined-up health and care services to the people of Mid and South Essex and tackle the causes of ill health.

We recognise that each ICB has been given a very challenging task of reducing its running costs by 20% from April 2024 and by a further 10% from April 2025. Essex County Council encourages MSE to work collaboratively with the other Essex ICBs, and ECC itself, to ensure it explores opportunities for joint working and efficiencies in a way that avoids or minimises

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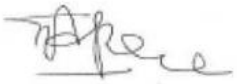
adverse impacts on Essex residents. Two areas identified in conversations so far between ICBs and ECC have been around mental health and children's services. We are keen to support those conversations to ensure we improve services in these areas and achieve potential economies of scale.

Yours sincerely,



Cllr John Spence
Chairman, Essex Health and Wellbeing Board

Agenda Item 4b
HWB/12/23b

Report title: Update on Mid and South Essex NHS Foundation Trust Hospital Performance and CQC Action Plan	
Report to: Essex Health and Wellbeing Board	
Report author: Mid & South Essex NHS Foundation Trust	
Date: 19 July 2023	**For:** Discussion
Enquiries to: Health and Wellbeing Board Secretariat, essex.parnters@essex.gov.uk	

1 Purpose of Agenda Item

1.1 For the Board to receive:

i. A verbal update from Mid & South Essex NHS Foundation Trust (MSEFT) following the report by the Care Quality Commission (CQC);

ii. A verbal update from Cllr Jeff Henry, Chair of Essex County Council's Health Overview and Scrutiny Committee on the Committee's response to the report.

Reference Number: HOSC/19/23

Report title: Updates on hospital performance, Community Diagnostic Centres, urology reconfiguration, and the CQC action plan from Mid and South Essex NHS Foundation Trust	
Report to: Health Overview Policy and Scrutiny Committee	
Report author: Mid and South Essex NHS Foundation Trust	
Date: 1 June 2023	**For:** Discussion
Enquiries to: Richard Buttress, Democratic Services Manager (richard.buttress3@essex.gov.uk) or Freddey Ayres, Democratic Services Officer (freddey.ayres2@essex.gov.uk)	
County Divisions affected: Not applicable	

1. Introduction

1.1 This report includes updates from Mid and South Essex NHS Foundation Trust (the Trust) on operational performance, the Community Diagnostic Centre programme, urology reconfiguration, and progress on actions from recent CQC visits and feedback.

2. Action required

2.1 The Committee is asked to consider this report and identify any issues arising.

3. Background

3.1 Trust performance – Foundations for the Future

As part of our Foundations for the Future improvement programme, the Trust is continuing its work to improve the basics in the care provided to its patients.

This is taking place through a series of 'sprints' where teams work together in targeted and rapid ways to support improvement in core areas, which are outlined below, in urgent and emergency care, cancer, falls and recruitment, among others.

Recent actions that have been taken include the use of the Malnutrition Universal Screening Tool across all the Trust's hospitals. This provides a single, standard process for how inpatients' risk of being malnourished is assessed and helps clinical staff to intervene. The Trust has also rolled out protected mealtimes, started to recruit volunteer feeding buddies to support inpatients, and brought in new ways to measure how well staff are keeping patients hydrated. There are plans to bring in additional training to improve paediatric nutrition.

The Trust has introduced a pilot which is providing bigger and easier-to-grip cutlery for patients who find it difficult to use ordinary knives and forks. Four wards across the Trust are trying this new cutlery and it is being received well by patients, who can eat more independently and enjoy their food.

The Trust is making the greatest possible use of its Hospital@Home service. This has helped patients to leave hospital and continue treatment in the comfort of their own home, while avoiding admissions. Staff have more access to information to make it easier for them to use the service.

Under Financial Foundations, the Trust is identifying schemes where efficiencies can be found and so releasing funding for other projects. This is alongside refreshed training for staff on improving value. There is a focussed drive to reduce the number of Bank staff used, following a higher than expected uptick in the costs for staff during month one. We are also focussing on improving quality and safety as key cornerstones for improving financial efficiency.

As part of the next sprint, plans include speeding up the process for hiring new staff, making it easier for the Trust to listen to its staff, and further improving patient communication.

3.2 Trust performance – Urgent and emergency care

The Trust remains very busy in emergency departments, with some performance indicators improving and some declining.

Four-hour performance

All three hospital sites have shown a slight decrease in performance against the four-hour standard (where patients are admitted, transferred or discharged within four hours). From February to March, Southend fell by 0.9%, Basildon fell by 1.2%, and Broomfield fell by 1.3%. This can be explained by the impact of the bank holidays and strike days creating surge pressure following these events.

Time to initial assessment

The average time taken for patients to receive an initial assessment in mid-May was 15 minutes or less in all our hospitals:

- Basildon Hospital: 11 minutes
- Broomfield Hospital: 9 minutes
- Southend Hospital: 12 minutes

The Trust has introduced specific events to focus on discharge at Basildon and increase patient flow through our emergency departments. Initial work to reconfigure the emergency department at Southend was completed, adding seven additional majors cubicles earlier in the year while a new ward has been opened for admitted patients in the Emergency Department.

Ambulance handovers

This continues to improve, with an average handover time across the Trust of 28 minutes in April, down from 35 minutes in March. More than 33% of ambulances handed over in under 15 minutes.

Same Day Emergency Care (SDEC)

The Trust is resetting the use of its SDEC units. During the busy winter months these SDEC areas have been used as overflow bed capacity, but they can now

be used for the purpose they were set up for and very few people need to be kept in overnight using this extra capacity.

These units at the three hospitals support patients to receive assessments, tests and treatment and be discharged on the same day. This helps to improve patient experience and ease congestion in the hospitals by avoiding unnecessary admittance.

3.3 Trust performance – Cancer

The Trust continues to work on reducing the time it takes for patients to find out if they are diagnosed with cancer, or to begin treatment.

In early May, the Trust had 788 patients waiting over 62 days on GP-referred pathways to rule out or treat cancer. While this was a significant reduction from 1,500 at the start of the year, there has been a slight decline in predicted performance. The two-week wait performance in April was 50%.

The Trust is focusing on areas which will have the biggest impact in reducing waiting times, including skin, colorectal and urology cancers. In colorectal, for example, clinicians are engaging more with GPs to improve referrals and endoscopy waiting times have been reduced, while the Trust has developed draft improvement plans for chemotherapy and radiotherapy.

Faster Diagnosis Standard

This standard ensures patients will be diagnosed or have cancer ruled out within 28 days of being referred urgently by their GP for suspected cancer. The Trust is currently underperforming in this standard with its performance of 64% but has made improvements to achieve the target of 75%.

Action to date has seen a focus on skin cancers, with a reduction in the 62-day backlog from over 1,000 in October 2022 to 168 patients in late April. The Trust reached 82% on the Faster Diagnosis Standard, from 25% in October 2022. A tele-dermatology pathway has been launched, reducing unnecessary skin-cancer referrals to hospital, helping to reduce waiting lists.

The Trust plans to focus activities on cancer pathways including; colorectal (recruitment programme), skin (quality improvement programme), urology (better understand demand and capacity), gynaecology (provide Trust-wide ultrasound reporting), and to develop a workforce strategy for cancer diagnosis and treatment pathways.

3.4 Trust performance – Elective recovery

Referral to Treatment (RTT) – Long-waiting patients

The Trust has reduced the number of patients waiting 78 weeks for treatment or alternative care, from around 1,800 patients in November 2022 to 20 at the end of March. This then rose slightly to 89 at the end of April, because of the impact of the Easter holidays and strikes.

The Trust has been recognised as top in the East region and among the best in the country for reducing our 78-week wait time.

The focus now is on the 65-week and 52-week waits, by expanding surgical capacity to treat patients. Plans are to have no patients waiting more than 65 weeks by December 2023 (for non-admitted) and March 2024 (for admitted).

3.5 Trust performance – Diagnostics

Diagnostics recovery will be a key focus in 2023/24 to support efforts to reduce cancer waits and improve RTT performance. The target is that patients should not wait more than six weeks for a diagnostic test after it is requested.

Diagnostic performance was 69% in March (target 95% by March 2025) – an improvement from 67% the previous month and the third month consecutively to demonstrate improvement.

The Trust has set up a diagnostics project group to help focus on achieving this standard. Progress is monitored via the Elective Recovery Group.

The building of new Community Diagnostic Centres (CDCs), means that in the year 2024/25 there will be far more permanent capacity to carry out much-needed tests faster and closer to home.

3.6 Trust performance – Staff vacancies and recruitment

The vacancy rate across the Trust, after reducing for seven consecutive months, saw a very small (0.2%) increase to 11.2% in March as the organisation grew. This remains below the target of 11.5%.

The Trust continues to hold large-scale recruitment campaigns in areas that are difficult to recruit to, including healthcare support workers, estates and facilities, nursing, and medical staff. This led in April to 30 job offers for Healthcare Assistants at Broomfield Hospital made, and seven job offers made at an emergency department recruitment open day. The Trust attends university fairs and encourages young people to begin a career in the NHS, and is working with EPUT on joint recruitment days.

Retention has improved over the past eight months, at 13.2% in April, down from 13.6% in March. The Trust has introduced programmes to improve staff wellbeing, which include:

- Sessions informed by NHS England to teach managers how to have wellbeing conversations
- Ongoing recruitment of mental-health first aiders among staff
- Financial support for staff, including a community pantry, tea and coffee for departments, vouchers, and dedicated financial wellbeing information.

The Trust relies far less on agency staff.

3.7 Trust performance – Complaints and PALS

Complaints and Patient Advice and Liaison Service (PALS) response rates remain a key area of pressure. The standard for responses to formal complaints is 40 working days, and five working days for PALS queries.

The Trust is committed to reducing the number of delayed responses. A new governance staffing structure was put in place in January 2023, involving weekly meetings with main divisions to discuss and progress active cases, and reporting of active and overdue cases to improve performance monitoring. This has already started to reduce delayed responses to formal complaints, from 265 in January 2023 to 184 in April.

The number of formal complaints received has remained fairly static over the last two years, averaging 126 per month, with 145 in March 2023. In recent months there has been an increase in PALS enquiries, with 968 in January and 1,061 in March. The main themes are appointments (waiting times and cancellations) and communication.

3.8 Trust performance – Falls

Reducing falls (with or without harm) is a national priority. The Trust continues to review a high number of patients to identify high-risk fallers and ensure that every mitigation is made to prevent further falls. Initiatives include anti-slip socks, individual support for confused patients, and a trial of falls censors and alarms on beds.

There are harm-free falls champions based on wards who support awareness of falls prevention among staff.

3.9 Trust performance – Pressure ulcers

Pressure ulcer prevention is a cornerstone in the Trust's drive to improve quality of care, reduce harm and improve patient experience.

A number of preventative and management strategies within the Trust are being implementing. A Topical Negative Pressure Therapy policy has now been ratified and is being shared across the sites. The Tissue Viability Steering Group is putting quality improvement initiatives in place to reduce the number of ulcers and assess wounds.

3.10 Community Diagnostic Centres

The Trust has been working to ensure it increases diagnostic capacity in mid and south Essex and has been seeking to secure significant funding, through the Government's Community Diagnostic Centre Programme. The centres will offer diagnostics closer to home for residents, and some centres will offer wider tests such as endoscopy and other investigative procedures.

Following approval of submitted business cases, funding has been approved for Thurrock and Braintree CDCs. The Thurrock CDC will be located at Long Lane in Grays and is due to open in Spring 2024. The Braintree CDC will be an extension of the St Michael's building at Braintree Community Hospital site and is due to open in Autumn 2024. Both will offer x-ray, MRI, CT, ultrasound, blood tests and heart and lung tests. Braintree will also offer Echocardiograms. They are in the implementation phase with contractors being appointed and final programmes of work being developed.

The Government has now announced funding for the third Community

Diagnostic Centre (CDC) in mid and south Essex, which is due to be located at a central location in Pitsea.

The Trust has taken action to speed up access and offer more diagnostic tests in the community. It is working closely with Basildon Council and following due process with regards to planning and contracts for the permanent centre. In the meantime, the Trust is keen to provide community diagnostic capacity via a temporary solution in Basildon. This will offer CT scans, MRI scans and endoscopy tests via mobile units which will be placed in a car park, near to Basildon train station. This facility will be provided later this year.

The CDC in Pitsea will support residents from across south Essex, and the first phase will offer all of the above services, as well as heart and lung tests and more endoscopy rooms.

The Trust expects the Pitsea CDC to be open by the end of 2024.

The Trust is leading on the programme with the Mid and South Essex Integrated Care System.

Following each centre receiving funding, the Trust has been engaging with residents to show them the plans and ask what their needs will be and how they would like to access the centres. This information is being used to help develop service models.

The first engagement for Braintree residents was held at the George Yard shopping centre in Braintree on 10 May. The Trust is planning further events in with local staff and residents to engage as many people as possible. A survey is open to residents to allow them to give feedback on their current diagnostic experiences, and the Trust encourages this to be shared: www.mse.nhs.uk/have-your-say

The Trust plans to begin public engagement events for the Pitsea CDC in July, with a further event in September. Alongside this, it will engage with staff about the opportunities at each of the CDCs, as well as colleagues in primary care about how this will support their referrals.

3.11 Urology service reconfiguration in mid and south Essex

Following the public consultation – Your Care in The Best Place – which was agreed by the Secretary of State in 2019, Urology services are being consolidated from three separate services to two services providing Urology care across three sites, with emergency treatment delivered at Broomfield and Southend.

From 15 May, in line with our clinical reconfiguration plans to provide centres of expertise and specialist care, Urology services have changed for patients arriving at Basildon Hospital. The service at the Southend site will remain unchanged.

Basildon patients requiring emergency admission for urology care, who cannot

be treated in the Same Day Emergency Care (SDEC) Unit will be transferred to the Broomfield site. Transport services have been secured for these patients using the current patient transport provider and blue light emergencies will be transferred by EEAST.

Some elements of complex non-cancer surgery will also move from Basildon to Broomfield, with the Basildon site retaining day cases and 23-hour cover as well as Same Day Emergency Care.

Benefits of the change

- It meets all recommendations in the original Decision-Making Business Case – agreed at Clinical and Multi Professional Congress in March 2023
- Improved patient safety for Basildon patients – faster access to specialist care.
- Expected reduction in length of stay by introducing a robust combined on-call and Consultant of the Week model.
- Improved outcomes due to consolidated service at Broomfield for complex elective/planned surgery. Complex elective surgery, with longer length of stay will be at Broomfield. Basildon now only has 23 hour stay and day cases.
- Equity of access for patients – consistency of service.
- Faster access for Renal Colic patients - a hot urology theatre (not available at Basildon) will allow increased primary treatment of ureteric stones (one of the common emergencies) rather than temporising with stents and then a long time on a waiting list. The Trust is a leader in the East of England in offering this.

4. Update and Next Steps

4.1 CQC visits to the Trust

An update on the latest CQC inspections will be provided to the Committee. See above, reference 3.1 on the improvements already made as a result of the inspection feedback.

5. List of Appendices - none

Agenda Item 5
HWB/13/23

Report title: Better Care Fund Plan 2023-25 (including Discharge Fund)	
Report to: Essex Health and Wellbeing Board	
Report author: Peter Fairley	
Date: 19 July 2023	**For:** Decision
Enquiries to: Will Herbert, will.herbert@essex.gov.uk	
County Divisions affected: *All Essex*	

1 Purpose of Report

1.1 This report seeks the formal endorsement of the board of the 2023-25 Better Care Fund Plan. Following its introduction last year, the Discharge Fund Is also included in the 2023-25 plan.

2 Recommendations

2.1 To endorse the Better Care Fund Plan for 2023-25 and note that partners, including Essex County Council, will need to adopt the strategy via their own decision-making processes.

2.2 Note that although the plan covers the period to 31 March 2025, it does not include funding or targets after 31 March 2024. It will therefore be necessary for the HWB to endorse updated funding and targets for 24/25 in spring 2024.

3 Background and Proposal

3.1 Tens of thousands of Essex residents and their carers rely on health and care services to support them. By local authorities and the NHS working closely and integrating our approaches, we can provide services in the most joined-up way. Doing this well can then lead to better outcomes for residents across Essex

3.2 The Better Care Fund (BCF) is a pooled fund between Essex County Council and the three NHS Integrated Care Boards in Essex. The BCF was created by national government in 2013 to promote integration of health and social care services. In 2023/24, the value of the Essex BCF pooled fund is £193.9m, increasing to £209.6m in 2024/25.

3.3 Due to the timescales between the publication of the national planning guidance and the deadlines for submission of the plan, and the engagement required to develop this plan with partners across three Integrated Care Systems, it was not possible to bring the completed plan to HWB ahead of the

due submission date of 28 June 2023. The plan has been submitted subject to endorsement from the board.

3.4 The national guidance and planning framework for the Better Care Fund 2023-25 expects systems to work together to:

a) Reduce the number of permanent admissions into long-term residential and nursing care, in line with the principle of 'Home First'
b) Invest in reablement services with a focus on ensuring people are still at home 91 days after receiving reablement services
c) Reduce the length of time people stay within hospital by reducing the proportion of people who are in hospital over 14 days and over 21 days (this is a change to the previous national condition on delayed transfers of care)
d) Focus on addressing avoidable admissions (this is a change to the previous national condition on reducing non-elective admissions)

3.5 The Essex Better Care Fund (BCF) Plan brings together NHS and local government funding worth £193.9m in 2023/24 to provide vital services that support Essex residents with health and care needs. The Planning Guidance for this fund will run for two years 2023-25 but it is expected that a specific plan for 2024/25 will be developed. The Essex Plan includes expenditure of:

a) £48.1m NHS contribution to adult social care services, including towards the costs of funding care services in a person's home (domiciliary care); reablement services that enable people to recover their strength, confidence and independence; and support to carers.
b) £72.8m on NHS commissioned community services funding a range of health services that support people with complex needs to live as independently as possible and enjoy quality of life.
c) £11.9m via district/borough/city councils on adaptations to homes to meet the needs of people living with disabilities (Disabled Facilities Grant)
d) £25m on schemes that support hospital discharges and help address pressures that typically result from higher demand during winter (such as investment in 'bridging' services that provide interim support for a person between leaving hospital and being able to return home); investment in support to the care market (such as training and quality improvement); and investment in services that support people with sensory impairments (Discharge Funding and iBCF grant).
e) £36.1m contribution to the costs of meeting social care needs arising from higher prices and demand for services, as well as maintaining investment in discretionary services that have a benefit to social care and NHS partners (iBCF grant).

National Conditions:

3.6 As with previous BCF plans there are four national conditions for the funding:

I. **National Condition 1** – The plan must be jointly agreed. The plan must be signed off by ECC and the individual ICBs and endorsed by the Health and Wellbeing Board.

II. **National Condition 2** – NHS contribution to Social Care is maintained in line with inflation. The total amount from the Better Care Fund NHS minimum contribution allocated for supporting social care is £48.1m in 2023/24 and £50.9m in 2024/25. The proposed plan meets that condition.

III. **National Condition 3** – NHS commissioned out of hospital services. The total amount invested in NHS commissioned out of hospital care exceeds the minimum ringfence required. In Essex this is £34.4m in 2023/24 and £36.3m in 2024/25. The proposed plan meets that condition.

IV. **National Condition 4** – Improving outcomes for people being discharged from hospital. From March 2020, the Hospital Discharge Service Requirements replaced previous Delayed Transfer of Care (DtoC) performance standards with revised national processes for hospital discharge. This includes a requirement that people who no longer need to be in hospital should be discharged the same day and a requirement for implementation of 'home first' arrangements. The proposed plan meets that condition.

Metrics and targets

3.7 There are national metrics used to measure progress. These have changed for 2023/24 and 2024/25 and they are published in the Better Care Fund Policy Framework 2023-2025.

I. **Avoidable admissions (specific to Acute) -** This metric measures the number of times people with specific long-term conditions, who should not normally require hospitalisation, are admitted to hospital in an emergency. These conditions include, for example, diabetes, convulsions and epilepsy, and high blood pressure. The metric includes all ages; the rate is standardised to account for differences in the age and sex distribution of the population.

The proposed target in Essex for 2023/24 is a rate of 660 per 100,000.

This is an annual figure and there is no national target. However, based on the data available, the rate for 2022/23 was 660 per 100,000, meaning that if performance is maintained we should maintain this figure.

II. **Permanent admissions to residential and care homes -** This metric remains the same as in previous years – in 2022/23 there were 1,129 older Essex residents admitted to permanent residential or nursing care, corresponding to a rate of 364 per 100,000 residents aged 65 and older. This exceeded the target of 430 per 100,000 residents.

The proposed target in Essex for 2023/24 is a rate of 350 per 100,000 older Essex residents. This aims for a slight improvement compared to 202/23 performance, which was 364 per 100,000 for 2022-23 and already better than the national average.

III. **Effectiveness of reablement -**This metric measures the number of people supported to stay at home after receiving reablement. The metric counts the number of older people discharged from hospital into reablement services between October 1 and December 31, who are still at home when they are followed up between January 1 and March 31.

The proposed target in Essex for 2023/24 is for at least 89% of the people who have received reablement services to remain out of hospital for 91 days following completion of reablement.

This metric will not be measured nationally in 2023/24, but Essex performance will be calculated to measure performance. In 2022/23, the target was 87% based on an average of the previous year's performance. This target was met, with actual performance at 87.2%.

IV. **Hospital Discharge -** The new discharge metric measures the proportion of patients discharged to their usual place of residence. Historically, Essex has performed well on this metric, with a pre-pandemic average of 93.8% of patients discharged to their usual place of residence.

The proposed target in Essex for 2023/24 is 94% of people being discharged into their usual place of residence.

Since January 2021, Essex has seen higher proportions of patients discharged to their usual residence compared to England and similar HWB areas, except for the East of England as a whole – the target looks to improve on this further.

V. **Emergency Hospital Admissions due to Falls in People Over 65 -** This is a new **metric** for the BCF designed to assess health service utilisation rather than need, as many injurious falls will not result in emergency admission. Data for 2021/22 shows that the rate in Essex was 2,063 per 100,000 population, marginally below the national rate of 2,100.

The proposed target in Essex for 2023/24 is 2,000 per 100,000 emergency hospital admissions due to falls in people over 65.

This would represent a slight improvement on the county's 2021/22 performance of 2,063 per 100,000 and remains below the national rate.

VI. **Hospital Discharge Ahead of Winter-** The national guidance for this metric has not yet been released. A separate note will be drafted for approval once this has been clarified. Work is ongoing by DHSC and NHSE to develop this metric on the new discharge ready data. Further engagement and information will be provided over the coming months, ahead of the new metric being required ahead of winter.

VII. **Outcomes** Following **Short-Term Support to Maximise Independence-** This is another new metric being proposed for the 2024/25 BCF plan that is awaiting national guidance on how outcomes will be measured. This will not be monitored for 2023/24.Once the national guidance is published. An update will be shared on the additional metrics.

Options

3.8 Not applicable

Issues for consideration

3.9 iBCF (Improved Better Care Fund)

3.9.1 In the Government's March 2017 Budget additional transitional funding was allocated to social care. The Winter Pressures grant was rolled in to the iBCF in 2020/21. The funding is an annually awarded grant amounting to £46.4m in 2023/24, with planning guidance stating that the same value is assumed for 2024/25. It forms part of the overall £193m BCF allocation. The conditions for use of the iBCF remain the same. That is, it may only be used for:

- Meeting adult social care needs
- Reducing pressure on the NHS (including winter pressures)
- Supporting more people to be discharged from hospital
- Supporting the social care provider market

The iBCF has funded various schemes and initiatives over the course of the allocation and these will need to be afforded within the iBCF envelope in 2023/24 and 2024/25. Management of this has been through locality partnership boards where those schemes that have been shown to add value have been adopted as part of mainstream health or care-based budgets. Scheme level information will be included within the plan (Appendix A).

3.10 Discharge Funding

In September 2022, a new ASC Discharge Fund was announced, and it was a requirement for it to be pooled within local BCF plans as part of the iBCF allocations. It has been confirmed that the Discharge Fund will continue in 2023/24 and 2024/25, with:

- Allocations to Essex County Council worth £6.5m in 2023/24, potentially rising to £10.8m in 2024/25
- Allocations to Integrated Care Boards worth, in 2023/24 and 2024/25 respectively (contribution to Essex BCF in parentheses):
    - For Mid and South Essex: £7.2m and £10m (£5m and £6.9m)
    - For Suffolk and North East Essex: £4.5m and £8.7m (£1.7m and £3.3m)
    - For Hertfordshire and West Essex: £7.2m and £12.2m (£1.5m and £2.5m)

Management of this will be through locality partnership boards where those schemes that have been shown to add value have been adopted as part of mainstream health or care-based budgets. Scheme level information will be included within the plan (Appendix A).

3.11 Disabled Facilities Grant

3.111 Disabled Facilities Grants are provided to all district and borough councils to make adaptations to the home for residents to live as independently as possible. The allocation of funds differs between each authority. The Government, through the BCF, has allocated to Essex for the 2023/24 financial year; £11.9m for DFG, with the same value assumed for 2024/25. The agreed allocations will be passed on to district councils in their totality.

3.1112 Working together, we aim to:

- Establish and support local dialogue, information exchange and decision-making across health, social care and housing sectors
- Enable improved collaboration and integration of healthcare and housing in the planning, commissioning and delivery of homes and services
- Promote the housing sector contribution to addressing the wider determinants of health; health equity; improvements to patient experience and outcomes; ‘making every contact count’; and safeguarding.
- Support more people to live independently, safely and well in their own homes
- Support prevention and early intervention and a reduction in care home placements
- Support timely discharge from hospitals
- Deliver timely, person-centred, flexible services that meet a wider range of needs.

3.113 Oversight and delivery of this agreement is through the Essex Well Homes Group, which will be the operational arm of the action plan, with further oversight by local Health and Wellbeing Boards.

3.12 High Impact Changes

3.121 The High Impact Change Model was developed by the LGA and NHSE as a way to support local care and health systems to manage patient flow and discharge, and implementation of the model has been a requirement of the BCF plan since 2017. For 2023/24 The High Impact Change Model has been updated and remains best practice. The plan outlines all the activity that will contribute to delivery of the High Impact Change model in Essex.

4. Financial Implications

4.1 Essex County Council is the pooled fund host for the Essex BCF. The tables below summarise the funding sources and planned expenditure at a county-wide and local level for 2023/24 (£193.9m) and provisionally for 2024/25 (£209.6m):

Better Care Fund Summary	2023/24 £m	2024/25 £m
Funding		
NHS Minimum Contribution	121.0	127.8
iBCF	46.4	46.4
DFG	11.9	11.9
Discharge Funding	14.7	23.6
Total BCF Pooled Budget	**193.9**	**209.6**
Expenditure		
NHS Contribution to Adult Social Care	48.1	50.9
Community Services	72.8	76.9
iBCF - Meeting Social Care Needs	36.1	36.1
iBCF – County-wide Schemes	9.6	9.6
iBCF - Local Schemes	0.7	0.7
DFG Related Schemes	11.9	11.9
Discharge Funding – County-wide Schemes	4.0	9.1
Discharge Funding - Local Schemes	10.7	14.4
Total BCF Expenditure Plan	**193.9**	**209.6**

BCF Expenditure 2023/24	BB (MSE) £m	CPR (MSE) £m	ME (MSE) £m	NEE (SNEE) £m	WE (HWE) £m	County-wide £m	Total £m
NHS Contribution to ASC	-	-	-	-	-	48.1	**48.1**
Community Services	13.1	8.5	18.9	17.0	15.3	-	**72.8**
iBCF – Meeting SC Needs	-	-	-	-	-	36.1	**36.1**
iBCF – C'wide Schemes	-	-	-	-	-	9.6	**9.6**
iBCF – Local Schemes	0.1	0.1	0.2	0.1	0.2	-	**0.7**
DFG Related Schemes	1.9	1.4	2.8	3.8	2.1	-	**11.9**
DF – C'wide Schemes	-	-	-	-	-	4.0	**4.0**
DF – Local Schemes*	2.1	1.4	2.9	2.3	2.0	-	**10.7**
Total 2023/24	**17.2**	**11.4**	**24.8**	**23.2**	**19.6**	**97.8**	**193.9**

BCF Expenditure 2024/25 (provisional)	**BB** (MSE) **£m**	**CPR** (MSE) **£m**	**ME** (MSE) **£m**	**NEE** (SNEE) **£m**	**WE** (HWE) **£m**	**County -wide £m**	**Total £m**
NHS Contribution to ASC	-	-	-	-	-	50.9	**50.9**
Community Services	13.9	9.0	19.9	18.0	16.1	-	**76.9**
iBCF – Meeting SC Needs	-	-	-	-	-	36.1	**36.1**
iBCF – C'wide Schemes	-	-	-	-	-	9.6	**9.6**
iBCF – Local Schemes	0.1	0.1	0.2	0.1	0.2	-	**0.7**
DFG Related Schemes	1.9	1.4	2.8	3.8	2.1	-	**11.9**
DF – C'wide Schemes	-	-	-	-	-	9.1	**9.1**
DF – Local Schemes*	2.6	1.8	3.6	3.6	2.9	-	**14.4**
Total 2024/25	**18.4**	**12.2**	**26.5**	**25.6**	**21.3**	**105.7**	**209.6**

* Local schemes are ICS-wide for MSE, notional apportionment is shown.

4.2 Expenditure on all schemes, including those specific to each Alliance area, is detailed in the attached BCF plan documents.

4.3 Grant conditions and local authority funding allocations for the ASC Discharge Fund have been published for the 2023/24 financial year only and include the requirement that all expenditure must be incurred by 31 March 2024. While the methodology for the 2024/25 allocations is not confirmed, the plan assumes (per the guidance) a 66.7% increase in line with national funding.

5 Legal Implications

5.1 The mandate from the Secretary of State to NHS England, which includes requirements as to how NHS money is spent, may include specific requirements relating to the establishment and use of an integration fund. In recent years, the Secretary of State has done this by requiring local NHS organisations, currently ICBs to establish better care funds (BCF).

5.2 The BCF Policy Framework sets out four national conditions that all BCF plans must meet to be approved and for this grant to be allocated and retained by the Council. These are:

- A jointly agreed plan between local health and social care commissioners, signed off by the Health and Wellbeing Board.
- NHS contribution to adult social care to be maintained in line with the uplift to NHS minimum contribution.
- Investment in NHS-commissioned out-of-hospital services.
- Plan for improving outcomes for people being discharged from hospital.

5.3 National condition 1 requires that a plan for spending all funding elements is jointly agreed by local authority and ICB partners and placed into a pooled fund, governed by an agreement under section 75 of the NHS Act 2006.

5.4 Plans will need to confirm that individual elements of the mandatory funding have been used in accordance with their purpose as set out in the BCF Policy Framework, relevant grant conditions and the BCF Planning Requirements for 2023-25.

5.5 Plans must be agreed by the Council and ICBs prior to being endorsed by the Health and Wellbeing Board.

5.6 In Essex, the BCF is established by means of individual agreements under section 75 of the National Health Service Act 2006 between the Council and each of the three ICBs operating within Essex, together with an overarching county-wide s75 agreement which relates to the Improved BCF (iBCF). There are four s75 agreements in total, which are subject to annual variations to reflect the annual mandate and planning requirements. Following approval of the final BCF Plan, the same will be submitted to the Health and Wellbeing Board for endorsement. The Board's role is to consider reports as requested by the Department of Health and to note the proposal with regard to the iBCF. This is part of the Board's role to promote the integration of health and social care.

5.7 Although not a legal requirement, the BCF Plan for 2023/24 'must' be submitted to NHS England by 28 June 2023.

5.8 Targets and funding are not agreed for 2024/25 and a further decision will be required for this period.

6 Equality and Diversity implications

6.1 The Public Sector Equality Duty applies to the Council when it makes decisions. The duty requires us to have regard to the need to:

(a) Eliminate unlawful discrimination, harassment and victimisation and other behaviour prohibited by the Act. In summary, the Act makes discrimination etc. on the grounds of a protected characteristic unlawful

(b) Advance equality of opportunity between people who share a protected characteristic and those who do not.

(c) Foster good relations between people who share a protected characteristic and those who do not including tackling prejudice and promoting understanding.

6.2 The protected characteristics are age, disability, gender reassignment, pregnancy and maternity, marriage and civil partnership, race, religion or belief, gender, and sexual orientation. The Act states that 'marriage and civil partnership' is not a relevant protected characteristic for (b) or (c) although it is relevant for (a).

6.3 The Equality Comprehensive Impact Assessment indicates that the proposals in this report will not have a disproportionately adverse impact on any people with a particular characteristic. (Describe the specific equality and diversity

implications of the proposal, any adverse findings from the Equality Comprehensive Impact Assessment and your proposed mitigation measures)

7 List of appendices

- BCF Narrative Plan
- BCF Planning Template

Essex Better Care Fund 2023-25 narrative plan

Essex Health and Wellbeing Board

Bodies involved in preparing the plan:

Local authority:	Integrated care boards (ICBs):	5 Place Based alliances:	Wider Alliance representatives including:
Essex County Council Essex Health and Wellbeing Board	• Hertfordshire and West Essex ICB • Mid and South Essex ICB • Suffolk & North East Essex ICB	• North East Essex • Mid Essex • West Essex • Basildon & Brentwood • Castlepoint & Rochford	• Hospital Trusts • CVS • District & Borough Councils • GPs / PCNs / Primary Care • Community Health Providers • Ambulance Trust • Hospices

How have you gone about involving these stakeholders?

The plan is developed through a mixture of Essex-wide discussions and local place-based alliance discussions. Essex-wide forums include the Essex Better Care Fund Partnership Board, where system flow and resilience plans are discussed and developed.

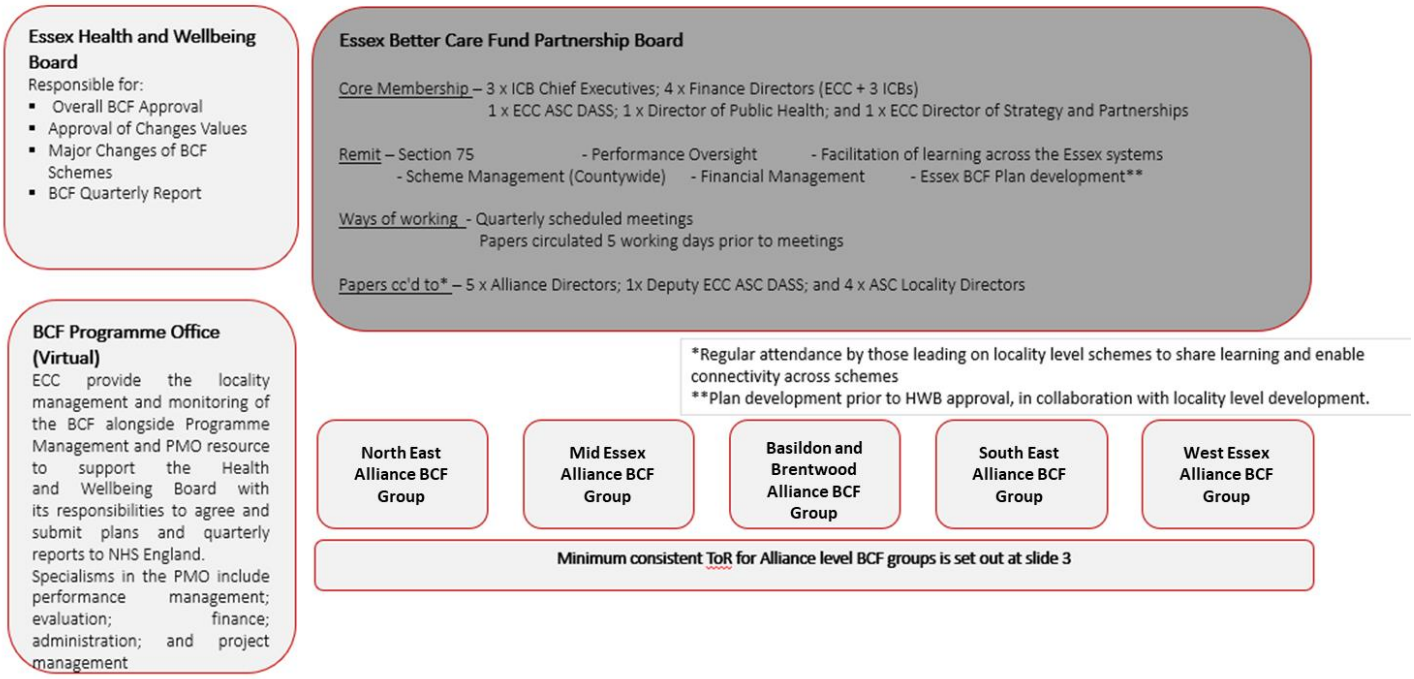
At a place level, our BCF Plan is co-produced through local Partnership meetings, where priorities for local alliances form the basis of decisions to invest. Local alliances / ICPs determine the best approach for investing the delegated BCF Budget in their area.

The Essex Health and Wellbeing Board has considered and been asked to endorse the plan as has Essex County Council Cabinet – approvals from these boards will be complete on 17th July 2023.

Governance

The Essex Health & Wellbeing Board provides strategic leadership and direction for decision-making and joint commissioning across Essex. The Board is consulted and asked to endorse the Essex Better Care Fund Plan. The HWB receives half yearly and end of year reports on progress.

Sitting beneath the Health and Wellbeing Board, the Essex Better Care Fund Partnership Board acts as the lead partnership forum for the development, and management of, the Essex Better Care Fund plan. This group consists of the Director of Adult Social Services for Essex, the ICB chief executives, Finance Directors (Essex and ICBs), Director of Strategy and Partnerships for Essex and the Director of Public Health for Essex. The group link with the both the statutory role of the Health and Wellbeing Board and the place level BCF governance and bring in local representatives regularly to support this. The below structure outlines this board and the governance that sits beneath it.



The Essex BCF is governed by a section 75 agreement (S75) between the County Council and the three integrated care boards. It has 6 pools – a countywide pooled fund, and 5 local pooled funds, one for each place-based alliance.

The BCF is governed at a local level through locality BCF Partnership Management Boards. In some localities these Partnership Management Boards are free standing Boards and in others they have been incorporated into wider alliance/ICP discussions.

Transformational plans and programmes are formally discussed and approved by existing local authority Governance processes and within each ICB's governing bodies. As the ICP arrangements develop locally, the best mechanisms for discussing the BCF and supporting partner engagement in the BCF will be reviewed, to ensure we have open and transparent decision-making processes and that we maximise the opportunities for collaboration.

Within Essex the Better Care Fund has one overarching S75 that incorporates all agreements for delegating BCF locally. ECC and the CCGs (prior to the introduction of ICBs) have agreed use of all pooled budgets in a joint and transparent manner, through jointly agreed governance routes. Decisions about use of funding are based on a clear and shared understanding of the allocation of resources across different areas of Essex, how this relates to population need, the services that will be supported and the outcomes that will be delivered.

In addition to the locality management and monitoring of the BCF, ECC is providing Programme Management and PMO resource to support the Health and Wellbeing Board with its responsibilities to agree and submit plans and quarterly reports to NHS England.

Executive summary

Essex is one of the largest and most complex health and care systems in the country. The county is split across three integrated care systems (Mid and South Essex; Hertfordshire and West Essex; and Suffolk and North East Essex) and works with 12 district/borough/city councils, 5 acute hospital sites. 3 NHS community providers and 2 providers of mental health services (covering childrens and adults).

The Essex system is committed to working through these new arrangements to build and empower strong and inclusive place-partnerships, joining up care and support with local partners, including NHS, local authorities including district councils, schools and communities, and the local voluntary and community sector.

Our Joint Health and Wellbeing Strategy (JHWS) sets out our priorities and a strong focus on addressing the wider determinants of health and health inequalities. It sets a vision to improve the health and wellbeing of all people in Essex by creating a culture and environment that reduces inequalities and enables residents of all ages to live healthier lives.

As partners across the Essex system, we will work together to deliver on this vision, our ambitions for integration and shared priorities, and our duties set out in the Care Act.

Context

Essex has an ageing and growing population and has a higher proportion of the population aged over 65 years than the England average. The recent census data (2021) showed that Essex has seen a 16% increase in the population aged 80 and over during the last decade, compared with 14% increase of the same age group nationally.

Essex is also a diverse county; from rural villages and market towns to urban New Towns and metropolitan centres, to our coastline. While the county is relatively healthy and wealthy, these masks areas of significant deprivation. Essex has the most deprived neighbourhood in the whole of England and the proportion of the Essex population living in the 20% most deprived communities nationally more than doubled between 2007 and 2019, rising from 60,380 to 123,640 people across the county. Accounting for population growth this is equivalent to 4.5% of the population in 2007 versus 8.6% in 2019. Across the different IMD periods the number of residents living in the 20% most deprived areas has more than doubled between 2007 and 2015 rising from 60,380 to 124,984, before reducing slightly to 123,640 in 2019 people across the county. Accounting for population growth this is equivalent 4.5% of the population in 2007 to 8.6% in 2019. Indices of Multiple Deprivation (IMD) 2019 full report | Essex Open Data (Page 11).

Each area within Essex is unique with its own challenges and opportunities. There are significant differences between our communities, their needs and how we work together to address them. For example, the provision of services in rural areas, the deprivation in coastal communities and its impact on health outcomes and tailoring our approaches to the assets in each community.

The complex geography of Essex and the various organisational and strategic footprints mean that while the overarching vision, and ICSs, will guide our work on integration, how this looks locally will take different forms and progress at differing rates.

The role of the Essex Better Care Fund Plan

The Essex BCF Plan promotes and supports collaborative working between Essex County Council, the NHS integrated care boards, the district/borough/city councils and the voluntary and community sector. It supports the achievement of several goals:

1. Enabling people to be as independent as possible
2. Supporting the 'home first' policy
3. Supporting system pressures by facilitating capacity and better 'flow' through the system
4. Supporting care market pressures
5. Improving support to unpaid carers
6. Building inclusive and collaborative place-based partnerships

Key changes since 2022/23 BCF Plan

At a Countywide Level the priorities for 2022/23 were focused on delivering the following:

- **Prevention and Early Intervention** - Our place-based alliances (bringing together local government, the NHS and voluntary and community sector) provide a means for us to engage with and shape our communities. The aspiration at

a local level is to improve our early help and intervention offer to help prevent escalation of need and help prevent demand on acute and social care services. Local updates are given below.

- **Market Development Strategy** – this has been developed and outlines our vision "Enabling people to live their lives to the fullest through a vibrant and sustainable care market, supporting Essex residents to develop their strengths and personal independence". It sets out our strategic priorities to shape the market and address key challenges it faces. It sets out an ambition to grow community-based forms of support such as domiciliary care and supported living; to reduce over-use of, and over-supply of, residential care beds across Essex; and to improve workforce recruitment and retention across the sector.
- **Carers** – our All-Age Carers Strategy outlines how the council and partners will support unpaid carers and sets out 6 commitments for improvement. In line with this we are designing a new **core offer** for services from March 2024. New and existing services will be designed into that new offer. There is also some focused work to increase access to short breaks.
- **Place based working and integration** – every Essex ICS recognises the importance of inclusive place-based partnerships as the bedrock for improving outcomes and services to our populations. Each place-based alliance includes representatives from NHS, the two tiers of local government and the voluntary and community sector. Each alliance has developed governance and a shared plan. By working together with a shared and common goal, identifying small but tangible changes across multi-agency Alliances in every area, Essex has seen tangible improvements in relationships, communication, service delivery and ultimately outcomes for those people accessing services. Colleagues from various organisations come together to share information, ideas, successes and challenges has resulted in solution focused and dynamic conversations.
- **Intermediate Care** - During 2022-23 we replaced our previous In-Lieu-of-Reablement with new *Alternative Reablement Contracts* (ARC). These bring the delivery standards expected via the ARC contracts closer to our core reablement offer (via ECL, the Council's Local Authority Trading Company). We have also emphasised the cross-system collaboration needed via the Connect programme which has refined the process flows and system intelligence to support better delivery of reablement outcomes, across the ARC, ECL and bridging contracts.
- **Housing** – in 2022/23 ECC began trialling the use of BCF-funded *Stepping Stone Home* apartments within Extra Care and Sheltered Housing schemes for adults who need short term help in a safe and secure environment before returning home from hospital or residential care. The aim is to have c. 15 *Stepping Stone Home* apartments in Essex by mid 2024.
- **Digital and Technology** - Our Digital service enables people with care needs to live their lives to the fullest using technology like Alexa's and Oysta devices to compliment traditional care and support. Our offer focuses on early intervention and prevention and considers Technology under Prevent, Reduce, Delay of the Care Act alongside full care act eligibility. The Care Technology service is supporting a proactive and preventative approach to health and social care which is data-led and outcome focused. Care Technology is supporting 6,000 residents and delivering avoidable savings of ~£4.94m. The monitoring and response service has attended 2,098 response visits and picked up 1,053 fallers since go live which has saved an additional £1,474,200 monthly avoidable NHS costs due to ambulance call outs and days in hospital. In February 2023 customer satisfaction survey, 279 people responded, 93% of which were satisfied with the service provided and 96% of respondents would recommend the service to others. 78% of people advised the Technology improved their quality of life and 92% of people advised there was an improvement to feeling safe/secure because of the Technology. Across the contract, we've seen £8.27M return in Social Value across employment, training, green project and reducing public service demand.

In North East Essex the Alliance Neighbourhood programme has moved forward with the development of multi-organisational Live Well Neighbourhood Teams in 3 of the 6 Neighbourhoods. Neighbourhood teams bring together representatives from local organisations, including the voluntary sector, communities, leaders, boroughs and district councils and health and social care, to provide a coordinated approach to population health management.

The Connect programme has supported working in North East Essex to improve system-wide visibility of hospital discharge outcome data. This data has highlighted the benefits of the reduction of residential bed use due to discharge into integrated schemes such as Home to Assess and Stepping Stone Homes. IP and nursing placement trends are much lower than last year, with 35 placements in February 2023 compared to c.150 IP placements in March 2020. This not only reduces cost but enables better outcomes.

The embedding of Shared Care Record and the Health Information Exchange have furthered the sharing of records and data across the system and with service users.

Through the NE Neighbourhood model, an asset-based approach to health and wellbeing is under development. This focuses on prevention through supported self and community-supported care. Co-production with communities will allow for the development of initiatives and the commissioning of services that meet the need communities and individuals in North East Essex.

In Mid Essex there has been positivity in meetings around joint working between partners. The medically optimised situation in Mid shows this, with low numbers delayed leaving and a position we haven't seen for some time. Use of BCF funds e.g. bridging really support with this, and we have seen improvements we hoped to make start to come to reality. Collaboration in BCF plays a part in this. A difference noted in conversations between partners and closer working - sharing issues, having the finances to use more flexibly has benefitted what we need to deliver.

Having the BCF funds focussed in the right way really helps and with iBCF, the chance to do something creative to inform our future decision making. This is a time of transition. Alliance priorities being developed, relations improved, a real desire to continue to work collaboratively for the future.

West Essex is focusing on delivery of an **Out of Hospital Model of Care** which centres upon a **Care Coordination Centre** (BCF-funded) to ensure people navigate to the right service at the right time in the right place. It relies upon an experienced Multi-disciplinary Team supported by technology and a simple trusted referral process to coordinate a person-centred response and provide a real time view of the person from referral to outcome.

Six community-based **Integrated Neighbourhood Teams** (INT) focus on delivery of proactive person-centred care and case management and have a focus on prevention and self care; early identification of rising risk; proactive care planning; preventing escalation of need; and urgent care delivered at local level. The third element of the model is a **Virtual Hospital** which includes community beds; bridging services and reablement; nursing homes; D2A wrap around care; specialist teams and diagnostics.

In South Essex the BCF has supported the deployment of social care staff into neighbourhoods, which fully aligns to health partner strategies. Integrated neighbourhood teams are emerging, providing evidence-based care that is positively impacting on the lived experience of both residents and their families/carers.

The BCF has allowed the South Essex system to increase capacity within the local community and has provided the building blocks to develop this further in 2023/24. Through the BCF we have also been able to support local Voluntary Organisations to provide more sustainable support relating to hospital discharge.

Summary of Finances:

BCF Funding 2023/24	MSE £m	SNEE £m	HWE £m	ECC £m	Total £m
NHS Minimum Contribution	67.9	27.8	25.2	-	**121.0**
iBCF	-	-	-	46.4	**46.4**
DFG	-	-	-	11.9	**11.9**
Discharge Funding	5.0	1.7	1.5	6.5	**14.7**
Total BCF Pooled Budget	**72.9**	**29.5**	**26.7**	**64.8**	**193.9**

BCF Expenditure 2023/24	BB (MSE) £m	CPR (MSE) £m	ME (MSE) £m	NEE (SNEE) £m	WE (HWE) £m	County-wide £m	Total £m
NHS Contribution to Adult Social Care	-	-	-	-	-	48.1	**48.1**
Community Services	13.1	8.5	18.9	17.0	15.3	-	**72.8**
iBCF - Meeting Social Care Needs	-	-	-	-	-	36.1	**36.1**
iBCF - Countywide Schemes	-	-	-	-	-	9.6	**9.6**
iBCF - Local Schemes	0.1	0.1	0.2	0.1	0.2	-	**0.7**
DFG Related Schemes	1.9	1.4	2.8	3.8	2.1	-	**11.9**
DF - Countywide Schemes	-	-	-	-	-	4.0	**4.0**
DF - Local Schemes	2.1	1.4	2.9	2.3	2.0	-	**10.7**
Total BCF Plan	**17.2**	**11.4**	**24.8**	**23.2**	**19.6**	**97.8**	**193.9**

BCF Funding 2024/25 (provisional)	MSE £m	SNEE £m	HWE £m	ECC £m	Total £m
NHS Minimum Contribution	71.8	29.4	26.6	-	**127.8**
iBCF	-	-	-	46.4	**46.4**
DFG	-	-	-	11.9	**11.9**
Discharge Funding	6.9	3.3	2.5	10.8	**23.6**
Total BCF Pooled Budget	**78.7**	**32.7**	**29.2**	**69.1**	**209.6**

BCF Expenditure 2024/25 (provisional)	BB (MSE) £m	CPR (MSE) £m	ME (MSE) £m	NEE (SNEE) £m	WE (HWE) £m	County-wide £m	Total £m
NHS Contribution to Adult Social Care	-	-	-	-	-	50.9	**50.9**
Community Services	13.9	9.0	19.9	18.0	16.1	-	**76.9**
iBCF - Meeting Social Care Needs	-	-	-	-	-	36.1	**36.1**
iBCF - Countywide Schemes	-	-	-	-	-	9.6	**9.6**
iBCF - Local Schemes	0.1	0.1	0.2	0.1	0.2	-	**0.7**
DFG Related Schemes	1.9	1.4	2.8	3.8	2.1	-	**11.9**
DF - Countywide Schemes	-	-	-	-	-	9.1	**9.1**
DF - Local Schemes	2.6	1.8	3.6	3.6	2.9	-	**14.4**
Total BCF Plan	**18.4**	**12.2**	**26.5**	**25.6**	**21.3**	**105.7**	**209.6**

National Condition 1: Overall BCF plan and approach to integration

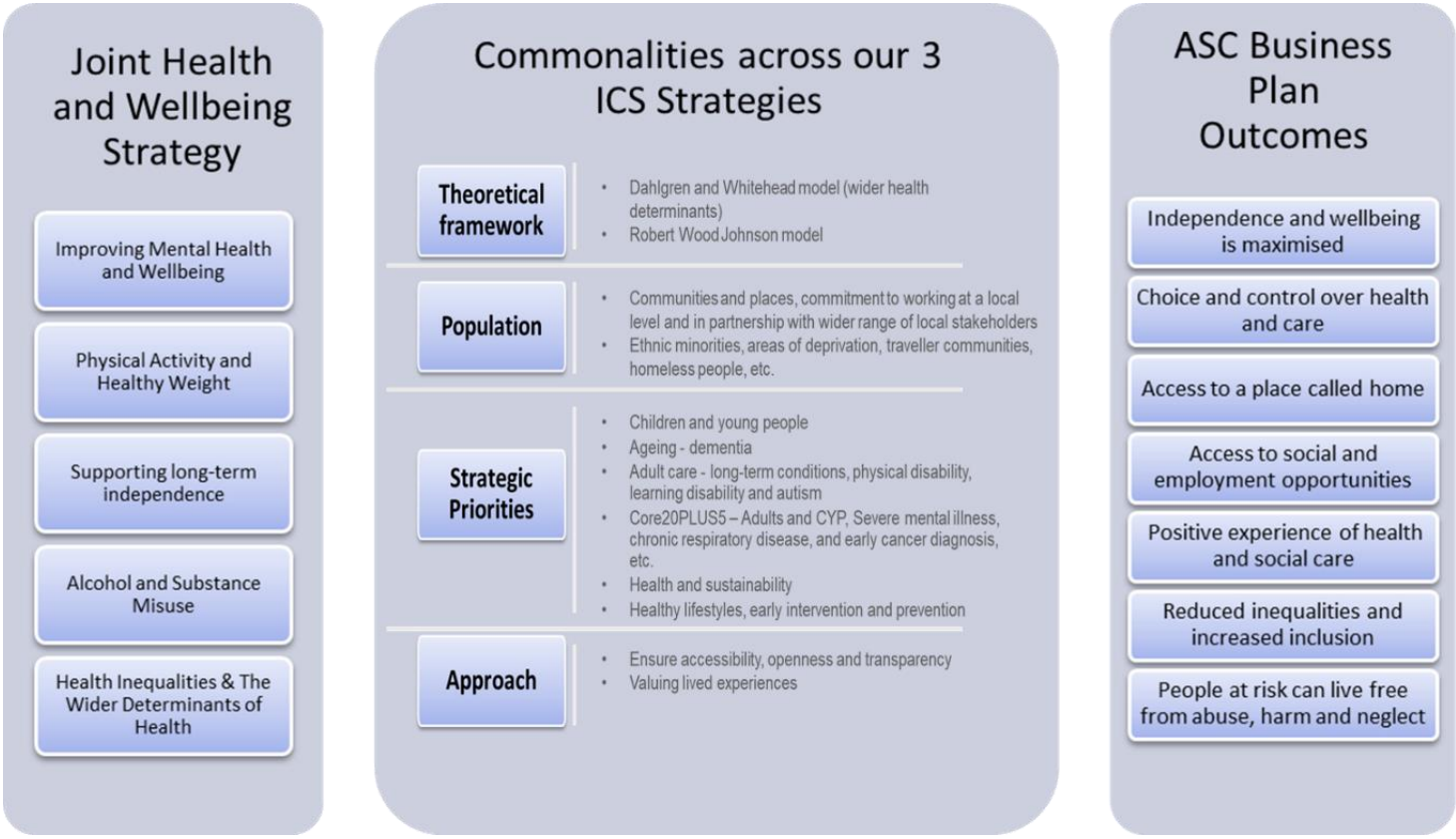
Please outline your approach to embedding integrated, person-centred health, social care and housing services including:

- Joint priorities for 2023-25
- Approaches to joint / collaborative commissioning
- How BCF-funded services are supporting your approach to continued integration of health and social care. Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.

Shared Priorities for 2023-25

The diagram below sets out the priorities of partners within the Essex System. It includes the priorities from:

- Essex County Council Adult Social Care Strategy which defines key areas of focus through to 2025
- Integrated Care System (ICS) priorities
- The priorities from the Essex Joint Health and Wellbeing Strategy (2022-26).



Joint Integration & BCF Priorities for 2023-25:

Across Essex all three of our Integrated Care Systems have a strong focus on place-based working and upon driving delivery of our strategic priorities through the local Alliances. Alliance Development is therefore a key priority and we are committed to strengthening their change management and programme delivery capacity at place level to focus on integrated projects. Alliance Delivery Leads have been recruited in most areas of Essex to ensure this capacity is focused on making this change.

At a local level, there is consistency across our alliances and partnerships in the priorities we are focussing on at place level. Many parts of Essex have adopted the Live Well Framework e.g. Start Well, Be Well, Feel Well, Age Well, Stay Well, Die Well, which provides a flexible framework for developing outcomes across the life spectrum. But all Alliances are focused on

understanding their local areas and neighbourhoods, mapping the assets these areas have and looking to address Health Inequalities through local delivery if integration projects. There is a focus on prevention and early help in every area to ensure that prevent, reduce and delay are at the centre of delivery.

Beyond this there are a number of key priorities for the system that are intended to support our ambition to strengthen support for people within the community and address specific challenges.

Intermediate Care is an essential part of how we deliver on National Condition 4 – Approach to providing the right care in the right place at the right time. We know that most people want to remain in their own homes for as long as possible and long-term care is a last resort. Intermediate care is a fundamental part of how we support our residents to maintain their independence. Each year we are supporting more than 11.6 thousand people through our reablement and bridging services, keeping them out of residential care where it is not needed and reducing their need for ongoing care. The BCF and iBCF is utilised to fund reablement services, as well as a range of bridging and short-term care support to provide intermediate care and support system flow. Service contracts are in place providing block capacity of over 13,000 hours per week of reablement through our Local Authority Trading Company, ECL, with an average of 80 adults supported each week through reablement contracts, and a further 30 per week supported by our Alternative Reablement Capacity (ARC) arrangements totalling over 5500 people each year. In addition, approximately 120 adults are supported in bridging services at any one time. Demand that cannot be met through these contracts is met through spot purchasing of reablement, which is funded by ECC outside of the BCF. There is also capacity for short-term bedded care with in-reach therapy support through community NHS providers.
We are working in partnership with the NHS and with the provider market on a medium to long term approach for re-shaping the intermediate care system, expected to reach conclusions in mid 2023-24, and bringing together reablement services, bridging services, as well as NHS intermediate care services to improve outcomes for people and ensure a joined up and integrated approach to service delivery. The future need and contracting of intermediate care beds is being considered in parallel with this. A project plan and methodology is in place and will be driven via local and countywide oversight groups, including senior directors from across health and social care.

I. **Care Market Development** – the BCF and iBCF is utilised to fund care quality improvement initiatives and training and is also utilised to fund incentive payments to support fast track discharges. Since the pandemic we have seen increased challenges in the care market. The key area of supply difficulty is domiciliary where levels of unsourced care were particularly high during the 2021/22 financial year as the domiciliary care sector struggled to compete with other sectors of the economy for workforce. Levels of unsourced care have steadily decreased since then but remained higher than pre-pandemic levels in the 2022/23 financial year.

Essex has refreshed its **Market Shaping Strategy** to consider these challenges and with a focus on "Enabling people to live their lives to the fullest through a vibrant and sustainable care market, supporting Essex residents to develop their strengths and personal independence". Throughout the delivery of this strategy (2023-2030) we need to support or help shape the care market to:

1. Address care market workforce recruitment and retention challenges
2. Ensure effective management of capacity and demand, both now and for the future
3. Put lived experience of the person at the centre of what we do
4. Ensure delivery of good quality services
5. Improve technological capability and maturity in the care market, to help maximise independence and workforce efficiency
6. Promote the financial sustainability of the sector as a whole

Alongside the six critical themes we have also identified 3 other enabling themes that will need further development, and these are:

- Health & Social Care Integration
- Diversity, Equality & Inclusion
- Climate, Environment & Social Value

Ensuring delivery of good quality services is key to delivery of our Market Shaping Strategy. Currently 80% of providers are rated *Good* or *Outstanding*. We use BCF to fund a range of training and events for residential care homes, nursing homes and domiciliary care providers that are open to all providers and available across the county. Training subjects are requested by providers or identified through safeguarding, quality audits or by health colleagues. As well as care planning and personal care, they cover management of a variety of healthcare issues, including pain management, nutrition and hydrations, and health conditions including mental health, dementia, chronic cardiac, respiratory and musculoskeletal conditions and end of life care.

II. **Communities and Early Help** – Our place-based alliances (bringing together local government, the NHS and voluntary and community sector) provide a means for us to engage with and shape our communities. We are committed to building community assets (based on an understanding of what assets exist and what the gaps are against our priority outcomes) and how we can jointly work together at place level to provide early help and maximise benefits of the local community assets. This is a key part of local approaches to levelling-up, demand management and tackling health inequalities.

III. **Discharge to Assess** – our goal remains Home First for all adults, with the right wrap around services in place to enable this. Following our 2021 Review of Discharge to Assess processes across Essex, each Alliance area is developing a Transfer of Care Hub and a Maturity Matrix (aligned to the High Impact Change model) has been developed to monitor progress.

Neighbourhood teams and PACTs (PCN-aligned community teams) – Across Essex in each locality we are bringing health and social care resources together closer to the community to co-ordinate management of people with complex needs and improve well-being and outcomes for the local populations. These teams working across health, social-care, housing and non-paid services with team members having an understanding of the local assets in the place that can support people. Dedicated roles have been introduced in some areas of Essex (Mid and West) to focus on delivering this agenda within individual neighbourhoods.

IV. **Unpaid Carers –** There are over 146,000 people in Essex providing unpaid care based on the last census. From feedback received when developing our new carers strategy we know that many carers experience challenges adjusting to the role, balancing caring with other responsibilities, and finding information, advice and guidance. Essex has continued to implement its carers strategy which sets out 6 commitments to support unpaid carers to help address these challenges. This is set out in more detail later in the plan.

V. **Mental Health** The Mental Health system in Essex is under considerable strain. Demand has increased over a number of years and has been further accelerated by the Covid pandemic and cost-of-living crisis. System partners acknowledge that change and greater collaboration is required in order to deliver the outcomes the people of Essex tell us they wish to achieve. Health and social care partners across Southend Essex and Thurrock (SET) have produced an All-age Mental Health strategy and developed a programme of work to deliver a shared strategic approach, taking into consideration the following key areas:

- Delivering SET level outcomes for specialist services - Eating Disorders, Peri-natal, Personality Disorder, and Bed based (inpatient beds) and supported accommodation (community beds).
- Coordination and alignment across key pathways including Crisis; admission and discharge planning, and with East of England (EoE) MH Provider Collaborative, and between adult and Children and Young People.
- Information sharing and learning with a focus on equity including reporting on demand, service capacity and performance, locality service models and transformation programmes, outcomes and funding.
- Coordination and alignment across key areas such as quality and safety, workforce, digital, public mental health, population health management, contracting, outcomes and performance metrics.
- Improving system linkages and issues which can impact across SET such as Substance Misuse, Crisis Concordat, Suicide Prevention, Safeguarding and Police MH Risk Assessment Groups and with Regional groups such as EoE Specialist MH Provider Collaborative.
- Facilitating alignment of system governance

VI. **Disabilities –** About 1 in every 6 people in Essex has a long-term health problem or disability and the number of people who have a disability and who may need support is rising. The number of people with sensory impairment is expected to grow by 21% to 410,000 by 2030 and the number of people with learning disabilities who need help from social care is expected to rise by 8% by 2030. To ensure we can meet rising demand for support, Essex has developed a new Disability Strategy, *Meaningful Lives Matter – Our plan for a more inclusive Essex* which launched in May 2023. The strategy sets a clear ambition and commitment for the next 4 years to help improve the lives of people who have a learning disability, a physical disability or a sensory impairment, and adults who have autism or neurodivergence that affects them in a way that they experience to be disabling. It outlines the four things people with disabilities have told us are most important in their lives: good relationships; a place to call home; to be safe and well; and meaningful activity. The strategy identifies where we need to address barriers to these things and will guide our future work with adults with disabilities to help do this.

The diagram below provides an overview of our shared priorities at county and place level.

Approaches to integration & joint/collaborative commissioning

A one size fits all model will not suit the varying needs of our communities across the whole of Essex. We are focussed on building inclusive place-based partnerships as the bedrock of how we work to improve health and care outcomes in a local place. However, through each of these place-based partnerships and at a county and ICS level we will be working towards common commitments:

- A greater focus on prevention and maintaining independence
- A common commitment to Discharge to improve the timeliness of transfers of care but also the quality of service received – with a focus on Home First
- Creating closer working between all partners to improve outcomes for the population of Essex.
- Implementing the changes from the Health and Care Act and the ambitions set out in the integration white paper
- Population Health Management approaches to support better risk stratification and preventative work
- Addressing and reducing Health inequalities
- Improving the support to carers.
- Improving EID for those in our systems living with Disabilities
- A greater focus on improving Mental Health support

Ultimately our long-term ambition is to take collective responsibility for resources and population health and to provide joined up, better coordinated care for the benefit of the Essex population, with a shared understanding of those solutions best created a local level, at Integrated Care System (ICS) level, and at Essex level.

We will also look to advance integration on the ground where it can be done quickly and beneficially without the need for complex new organisational structures and / or commissioning and contractual arrangements.

How BCF funded services are supporting our approach to integration

Area	Activity Summary
Countywide	The BCF and iBCF is continuing to strengthen relationships between partners and support improved outcomes at a county level. It supports several county wide initiatives to address key challenges in the system including securing the provision of reablement services, bridging and in-lieu of reablement services to support system flow. Countywide funding has invested in the award-winning Connect programme which consists of 5 key projects looking at reablement, discharge outcomes, supporting independence, admission avoidance and community hospital bed flow.

	The BCF also continues to support us to increase the quality of services and therefore system capacity by reducing suspended services and those that service users reject through a range of Countywide Care Market Quality Initiatives. It also supports Integrated Dementia Commissioners who have recently produced a new partnership dementia strategy for Southend, Essex and Thurrock. The dementia team have also led on an intergenerational programme connecting young & people living with Dementia to support building a 'Dementia-Friendly Generation'.
Suffolk and North East Essex ICS	
North Essex	In North East Essex, the BCF will support the development of community models of working within the 6 hyperlocal neighbourhood areas. To realise the Neighbourhood ambition, the Alliance will invest in test and learn activity, resourcing to enable additional capacity, and training to support the Asset Based Community Development approach. The partnership will continue to invest in Alliance Delivery Leads, leading on identified priorities within the Live Well Domains and connecting key alliance programmes. The partnership is also investing in discharge support programmes aimed to enable the best outcomes for people receiving care within Nort East Essex. This includes the Ward Enablement project to reduce hospital-acquired deconditioning through the delivery of a reablement-style approach to care on the ward. Stepping Stone Homes enables step down from hospital can be to a supported care facility rather than a care home to increase the changes of returning to independent living for residents. Stroke Pathway-aligned Social Care Workers supports early identification and early involvement within MDT discussions whilst a person is receiving acute care. This enables early discharge planning within the stroke pathway and supports the home first approach.
Mid and South Essex ICS	
Mid Essex	There has been positivity in closer working between partners in Mid Essex and the use of BCF funds has supported collaboration, particularly with low numbers of hospital delays currently evidenced with the support of BCF-funded services in place. Alliance priorities are currently being developed and with improved relationships there is a real desire to continue to work collaboratively in the future using BCF and iBCF funds to drive innovation and service improvement. In Mid Essex we have recently undergone a new bidding process for the use of iBCF funds with a number of new services being proposed. This process has been coordinated jointly between health and social care partners and is a good example of working together to develop new services, and pilot working to inform our future commissioning intentions. It will build on existing initiatives, for example, the therapy provision supplied by Essex Cares Ltd (ECL), our Local Authority Trading Company, to the ARC provider in Mid Essex. New Alliance Programme Leads are now in post in Mid Essex, tasked with building on the previous Dengie Neighbourhood Pilot and develop integrated neighbourhood teams to bring health, social care and community services together on a local level to drive service improvement. This is a good example of collaborative use of BCF funds, and we will continue to explore this model and others as part of a collective effort in the future.
South East Essex	iBCF monies have been agreed to roll out PACT teams across the remaining 3 PCN's in Castle Point & Rochford, so that all four PCN areas will now be following the PACT way of working and should be self-sustaining by the end of March 2024. This integrated model of working closely aligns with the Castle Point and Rayleigh & Rochford social care neighbourhood teams so they will be better aligned in their work and priorities, to support people with more complex needs and prevent deterioration of conditions and unnecessary hospital admissions. This way of working should establish better relationships and links with other sectors and organisations within the community.
South West Essex	We are working to further strengthen and develop our alliance integration into the wider local system. We are building on learning from North Essex, we have created 3x Alliance Delivery Leads roles, tasked with taking forward priority programmes of work for the alliance and supporting local system transformation. This is being

	delivered over a 12 month period via using the Livewell Domains and the Outcome Based Accountability (OBA) framework. We have also commissioned Nesta, Asset Mapping in Brentwood and Basildon. This is to identify with an Asset Based Community Development (ABCD) lens, on what assets our locality already has, what we can expand on and highlight any gaps to support community developments. Furthermore, we are in planning for expansion and revamp of the existing Social Prescribing offer for Basildon and Brentwood. A bidding process for iBCF funds coordinated jointly between health and social care partners, similar to that in Mid Essex, will be undertaken to support innovation within the Alliance linked to our core priority areas as outlined earlier.
Herts and West Essex ICS	
West Essex	In West Essex the BCF continues to provide support for the care co-ordination centre to manage all discharges from the hospital and prioritise system capacity to meet the demands on the system and proactive management of the adult through their pathway. Alongside this our work continues on the implementation of PCN Aligned Community Teams (PACTs) bringing health and social care resources together supported by its own leadership team for co-ordinated management of people with complex needs, improved access to health and care support delivered at home or within local PCN aligned geographies and managing the growth and demand across health and care services.

A full list of current place-based initiatives is available in Annex A

National Condition 2:

Objective 1: Approach to enabling people to stay well, safe and independent at home for longer

Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, community and social care services are being delivered to help people to remain at home. This could include:

- Steps to personalise care and deliver asset-based approaches
- Implementing joined-up approaches to population health management, and proactive care, and how the schemes commissioned through the BCF will support these approaches
- Multidisciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake
- How work to support unpaid carers and deliver housing adaptations will support this objective

I. Personalised care and asset-based approaches

Our approach to personalisation starts within the communities that people live in. At Alliance, County and ICS level we have built excellent partnerships with CVS's to drive our focus and approach to working alongside local and hyper-local communities at 'place' level. This is underpinned by our neighbourhood / PCN aligned model which works closely with system partners to fundamentally know, understand, and support people in the place that they call home.

In the North of the county, Social Prescribers work within PCNs and the acute setting. Community Micro Enterprises (CMEs) continue to provide greater choice and control for people in how their needs are meet local through the assets that exist in their local area. Asset mapping supports the Asset Based Community Development (ABCD) approach embedded across the Alliance, and reflected in the Live Well Neighbourhood Teams approach.

In South Essex, Castle Point and Rochford will be investing in a pilot in care homes, funded by the iBCF, in 2023/24. This will formulate a blueprint for how best to support care home residents and improve medical support, end of life care, reduce falls and admissions and improve use of technology. There will also be a Carers intensive support team funded in this area, recognising that the best personalised support is often delivered by informal carers. This is in addition to the countywide offer. In Basildon and Brentwood Nesta will be commissioned to map the Assets of the area. The focus will be on development of the Alliance Livewell

domains which will test and learn from a wider system perspective at a locality level. Also, the pilot for the Integrated Neighbourhood team (INT) for Central Basildon, will include partners working with the Social Prescriber to fast track support at a grass roots level to prevent escalation to secondary services via MDT meetings.

In Mid Essex, building on the previous work completed in the Dengie Neighbourhood Pilot, Alliance members have commenced with a programme to develop integrated neighbourhood teams aligned to PCN areas. This will bring health, social care and community & voluntary services together to work closely with their communities, improve relationships and develop new ways of working as a collective for the local population.

II. Joined-up approaches to population health management and proactive care

Each of the three ICS areas has an established population health management (PHM) programme that is working towards embedding the approach throughout their systems. ECC is an active member in each of the programmes, supporting the infrastructure development (leadership, digital and data), the generation of intelligence (operational through to strategic) and the move to personalised, proactive, preventative interventions.

- Leadership: ECC is an active member of each ICS PHM Steering Group, driving the strategies to embed PHM within each system's business as usual processes.
- Data platforms: Each ICS has established a new data platform for their system to host a longitudinal, linked health and care record to allow data analytics and insight generation for transformational change.
- Intelligence Functions: To maximise the use of the new data platforms, Intelligence Functions have been set up in each ICS to coordinate work around joint insight and the advancement of quality intelligence to inform ICS transformation work programmes. ECC analysts work alongside ICB colleagues in each intelligence function.

There are a range of projects across the three ICS areas to utilise the linked data, new platforms and Intelligence Function arrangements to generate insight to support evidence-based interventions to prevent, reduce or delay health deterioration and improve outcomes. These include:

- Connected Neighbourhoods – targeting evidence-based advanced care through risk stratification;
- Healthcare Quality – linked data and PHM in support of healthcare quality improvement.
- Equality Impact – dashboard to support Equality Impact Assessments
- Elective Waiting List HIs – linked social care and acute hospital data to explore health inequalities
- Urgent and Emergency Care – aiming to improve insight on drivers and cohorts using U&EC to inform service transformation
- Reablement – insight on rates of reablement across the ICB linked to wider determinants of health
- Safeguarding & Inequalities – links between safeguarding in adult social care and drivers of deprivation.
- Demand and capacity – support to the system on understanding care demand and capacity
- Acute Discharge pathways – build on previous work using dynamic system modelling to understand patient flows
- Neighbourhood teams – linked data to support neighbourhood teams to focus proactive care

West Essex was selected to take part in the ICS Place Development Programme to accelerate and embed adoption of Population Health Management (PHM) and further the development of our alliance, ways of working and approach to neighbourhood teams. Following the completion of the programme we will be taking forward work on developing our roadmap to further embed the PHM approach in these areas creating the mechanisms for effective information and data sharing to help identify and understand local needs and develop effective solutions.

As part of ECC's support of the developing PHM programmes, investment has been made to increase the analytical capacity to generate health and care insight to enable ECC to drive engagement with each system. The increased analytical capacity will enable ECC to help resource PHM projects and embed a PHM approach in the new ICS Intelligence Functions and across the systems.

In Mid Essex, the integrated neighbourhood teams in development across Mid Essex above will also link in with the Thriving Places Index project being developed as part of the Mid Essex Alliance which will allow system partners to better understand the pressure-points in Mid Essex and how we can personalise and prioritise our approach to areas that require faster support from alliance members and in a tailored way.

In North Essex, the developing Alliance Neighbourhood programme aims to create a coordinated approach to Population Health Management. Investment in the ICB Population Health Management Team has furthered the development of an

interorganisational Population Health Management data dashboard. Implementation of the PHM dashboard will enable oversight of the developing PHM approach through the Neighbourhood model.

In South Essex, a PCN Aligned Team approach will be rolled out across Castle Point and Rochford to target preventative actions towards the most at risk / vulnerable groups identified within the PCN with close links with adult social care and other community providers. South Essex has had particular success with its anticipatory end of life care identification, planning and delivery and is a lead in the Ageing Well Stewardship programme. The SEE alliance is ensuring its initiatives and strategies align with better patient outcomes, acknowledging a growing population of frailty with applications such as frEDA. Recent data sharing to inform the SEE Alliance Plan has identified growing areas of concern in mental health and obesity which means a renewed focus on localised drivers of health deterioration and a recognition of key challenges at a ward level. In Basildon and Brentwood the focus will be on development of the MSE Transfer of Care Hub (TOCH). This is to support individuals that are discharged from hospital with a home first approach, with coordination and expansion of holistic services to support the individual to prevent readmission. Basildon & Brentwood is also piloting Integrated Neighbourhood Teams (INT) to provide a quicker response at a place-based level.

III. Multi-disciplinary teams at place or neighbourhood level

Each of our alliances within integrated care systems is working on models of integrated health and care and physical and mental health teams at neighbourhood level.

For example, in North Essex - Live Well Neighbourhood Teams (LNTs) bring together representatives from local organisations (local voluntary sector, communities, leaders, boroughs and district councils and health and social care) to provide a coordinated approach to population health management. This approach is underpinned by prevention, self- care, early intervention, reablement and rehabilitation, including people living in nursing and care homes. People, families and communities that are supported by the LNT will benefit from a broad range of expertise, support and the improved inter organisational relationships that develop through neighbourhood working.

In South West Essex, our neighbourhood teams are led by Locality Development Managers who take an operational and strategic lead on the development of a population health focused system that will improve well-being and outcomes for the locality populations working across health, social-care, housing and non-paid services.

In Mid Essex we have held a series of workshops to further explore the development of Neighbourhood teams as a partnership although linked working at place level is already forming with alignment of ASC and Community Teams within place localities.

In South East Essex the social care team in Castle Point attend MDT's with PCN Aligned Teams (PACTs) and drop-ins at a local caravan park. Over the course of the year there are plans to run social care drops-ins at community locations, which will be summer and winter wellness themed. Virtual wards supporting adults to remain at home will be introduced to focus on, where possible, preventing hospital related deterioration and displacement. There is ongoing work looking at a localised, coproduced Transfer of Care Hub model. At present there is a community coordination centre at Rayleigh hospital which acts as a single point of contact and has recently piloted a paramedic responding to emergency calls and providing local support to prevent people waiting for ambulances / being admitted where they could be supported to stay at home. In Basildon and Brentwood bi-weekly MDT's continue at a neighbourhood level with statutory, clinical and voluntary services working together to support complex cases in the local community. The Integrated Neighbourhood Team pilot is testing whether the process can be smoother for an individual and exploring whether a physician associate can be of support.

In West Essex partners are developing an Out of Hospital Model of Care centred upon a Care Coordination Centre, a Multi- agency team across health and social care providing a single referral hub for partners to access services using Trusted Assessor Assessment and Referral models. The Model also incorporates six Integrated Neighbourhood Teams (INT) that focus on delivery of proactive person-centred care and case management and have a focus on prevention and self care; early identification of rising risk; proactive care planning; preventing escalation of need; and urgent care delivered at local level. The third element of the model is a **Virtual Hospital** which includes community beds; bridging services and reablement; nursing homes; D2A wrap around care; specialist teams and diagnostics.

IV. Housing Adaptations: Disabled Facilities Grant (DFG) and wider services

Disabled Facilities Grants are provided to all District and Borough councils to make adaptations to the home for residents to live as independently as possible. The allocation of funds differ between each authority. The Government, through the BCF, has allocated to Essex for the 2022/2023 financial year; £11,885,443 for DFGs. The allocation for the financial year 2023/24 has not been published but for present purposes, 2022/23 funding levels have been assumed. On that basis the highest allocation amount is

for Tendring with £2,320,471 and the lowest amount is for Uttlesford with £235,576 with an average of £990,454. The agreed allocations will be passed on to district councils in their totality.

An MOU sets out that Essex Districts, County Council, Health and Care partner organisations need to work better together and commits to supporting and delivering housing solutions that have a positive impact on residents and sets out:

- Our shared commitment to joint action across health, social care and housing sectors in Essex;
- Principles for joint working to deliver better health and wellbeing outcomes and to reduce health inequalities;
- The context and framework for cross-sector partnerships, nationally and locally, to design and deliver:
    - healthy homes, communities and neighbourhoods
    - integrated and effective services that meet individuals', carers' and their family's needs
    - A shared action plan to deliver these aims.

Working together, we aim to:

- Establish and support local dialogue, information exchange and decision-making across health, social care and housing sectors
- Enable improved collaboration and integration of healthcare and housing in the planning, commissioning and delivery of homes and services
- Promote the housing sector contribution to addressing the wider determinants of health; health equity; improvements to patient experience and outcomes; 'making every contact count'; and safeguarding.
- To support more people to live independently, safely and well in their own homes
- To support prevention and early intervention and a reduction in care home placements
- To support timely discharge from hospitals
- To deliver timely, person-centred, flexible services that meet a wider range of needs.

Oversight and delivery of this agreement is through the Essex Well Homes Group, which will be the operational arm of the action plan with further oversight by local Health and Wellbeing Boards. The Essex Well Homes Group meets quarterly and has membership from each local authority, including ECC, as well as Housing OTs. In this forum, all DFG matters are discussed, looking at short-, medium- and long-term plans to ensure the DFG funding is being utilised as well as possible.

This year's areas of focus are:

- The new Integrated Care Systems in Essex have created the opportunity to develop relationships across health, social care and housing to focus on the most effective use of the DFG to gain the greatest impact for Essex residents. A planned review of DFGs across Essex is due to take place in this year to make recommendations for system improvements, including sharing of information and intelligence to best use resources, understanding and overcoming the barriers within the local systems and maximising the use of the DFG funds across the three ICS and the whole county.
- Following this review work across the system to ensure that DFG is focused on preventing, reducing and delaying the escalation of need and supporting people to truly live good and independent lives within their own home and communities. This will be through looking at additional discretionary projects and fast-track grants, where appropriate, to ensure that residents across Essex have full access to their own homes and are able to enjoy the benefits of living in their local community. There are also opportunities to link with and refer universal services such as the Essex Wellbeing Service to ensure people get the right support at the right time to prevent their needs from escalating.
- Across the local authorities in Essex we are finalising a better method of reporting to ensure that health, social care and housing partners are better informed of the difference that DFG is making and are able to have clear oversight of the challenges and barriers to ensure the opportunities that DFG creates are maximised.
- Adult Social Care are focussed on providing, support and influence to local authority partners through providing data, evidence, ideas and access to health and social care partnerships to escalate any issues. The aim of this work is to ensure DFG is supporting the implementation of Adult Social Care priorities and drive towards a community model of social care that delivers impact for Essex Residents. This will include options around best use of social care resources to maximise the benefits and looking at how district partners can influence the design of supported living and other social care accommodation to maximise accessibility and reduce the need for adaptations allowing resources to be better spent in other segments of the housing market.

The Independent Living programme is one strand of ECC's work to provide the right housing, at the right time, with the right care and support. Also known as Extra Care, Independent Living provides specialist accommodation for older adults and adults with

disabilities with varying care and support needs. Extra Care housing is recognised as an excellent alternative to residential care, where appropriate, or staying at home in unsuitable accommodation.

Independent living schemes offer contemporary apartments rented or owned by residents, with shared communal areas such as cafés, wellbeing rooms, and lounge / activity areas to socialise and form a welcoming community. There is onsite meal provision for residents and each resident will also have a kitchen within their apartment to make their own meals if they wish. There is a care provider on site 24/7 to give residents and their families peace of mind. Individual care packages are also provided to meet assessed need. This planned care can either be provided by the onsite care team or another care provider as appropriate and in line with the resident's wishes.

Research has shown that independent living schemes provide a significant reduction in isolation, loneliness, anxiety and depression; reduce visits to GPs / hospitals for older residents and can delay or even reverse frailty. Scheme design reduces the risk of falls and provides full wheelchair accessibility. New schemes seek the highest levels of energy efficiency ensuring the homes within them are well insulated. Schemes can also be used as "community assets" where the wider community benefits from the facilities, social activities and support provided.

ECC aims to develop 11 new Independent Living Extra Care schemes, providing 712 apartments with ECC nomination rights into 530 of these. Two of the 11 schemes have been successfully developed to date with one opening in 2020 (in Uttlesford) and another in 2022 (in Braintree). Working with landlords of Extra Care schemes, ECC has successfully embedded flexible referral criteria into schemes, based on extra care suitability to meet need rather than age, care hours or cohort. This has resulted in extra-care communities becoming more inclusive and an increase in the number of adults who have a learning disability or physical and sensory needs moving into Extra Care.

In 2022/23 ECC began to work with system partners to trial the use of Extra Care and sheltered housing as an alternative to temporary residential care home placement where appropriate. Using BCF funding, ECC and partners are in the process of setting up "*Stepping Stone Home*" apartments within Extra Care and Sheltered Housing schemes. *Stepping Stone Home* is for adults who need some extra help and support in alternative accommodation for a short period of time, usually up to six weeks, to optimise independence in a safe and secure home with the right care and support to meet their needs. The aim is to provide a stepping stone

- Before returning home to ensure a timely discharge from hospital or residential care;
- To prevent an admission to hospital or residential care;
- To increase adults' confidence and independence to be able to successfully return home or to other more appropriate housing with or without ongoing care and support.

A *Stepping Stone Home* apartment includes access to any care, support, equipment, and technology needed to optimise independence. A multidisciplinary team (MDT) for each scheme of social care, local housing authority, scheme landlord, community and voluntary sector will work together to identify and consider referrals into *Stepping Stone Home* and to ensure adults are enabled to move on in a timely way to permanent housing with or without ongoing care and support. By mid 2024, ECC aims to have c. 15 *Stepping Stone Home* apartments available in Essex.

Intermediate care to support people in the community – demand and capacity

Set out the **rationale for your estimates of demand and capacity for intermediate care** to support people in the community. This should include:

- Learning from 2022-23 such as
    - **Where number of referrals did and did not meet expectations**
    - **Unmet demand**, ie where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - **Patterns of referrals and impact of work to reduce demand on bedded services** – eg admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- **Approach to estimating demand, assumptions made and gaps in provision identified**
    - Where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?

- How have estimates of capacity and demand (including gaps in capacity) been taken on board and reflected in the wider BCF plans?

Our rationale for estimates of demand and capacity for intermediate care is set out in full below under Intermediate care to support discharge from hospital – demand and capacity. Our commissioning plans for 2023-24 have been informed by this work. In particular we are recommissioning our Intermediate Care bedded offer as the exercise enabled us to separate out the genuine need for overnight intermediate care provision versus where the bed-base has been used due to lack of community-based capacity. We are also able to ramp up or down our Alternative Reablement Contracts to manage flow at periods of high pressure.

We also set out below how our Future of Intermediate Care programme will inform future commissioning of intermediate care to better reflect the scale and pattern of population need, which may impact future utilisation of BCF funding in this area and workforce development.

How BCF funded activity will support delivery of Objective 1

Describe how BCF-funded activity will support delivery of this objective, with particular reference **to changes or new schemes for 2023-25**, and how these services will **impact on the following metrics**:

- **Unplanned admissions** to hospital for chronic ambulatory care sensitive conditions
- **Emergency hospital admissions following a fall** for people over the age of 65
- The number of people aged 65 and over whose long-term support needs were met **by admission to residential and nursing care homes**, per 100,000 population.

This is covered above under Objective 1: Approach to enabling people to stay well, safe and independent at home for longer

National Condition 3: Approach to providing the right care in the right place at the right time

Describe how your area will meet BCF Objective 2: **Provide the right care in the right place at the right time**.

Describe the approach in your area to integrating care to support people to receive the right care at the right time, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support safe and timely discharge, including:

- Ongoing arrangements to embed a **home first approach** and ensure that more people are discharged to their usual place of residence with appropriate support, in line with the Government's hospital discharge and community support guidance.
- How **additional discharge funding is being used** to deliver investment in social care and community capacity to support discharge and free up beds.
- Implementing the ministerial priority **to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow**.

I. Home First

HomeFirst remains a key focus across the five acute systems within Essex, which continues to be monitored through our Discharge Outcomes Steering Group, that has representation from Health and Social Care. Adults PBI data shows ECC Temporary Residential placements down 28% in April 2023 compared with the same period in 2022. During 2022 the Acute elements of the Connect Discharge Outcomes workstream were mature enough to become Business as Usual. This activity was handed over to local Discharge Teams with regular touchpoints / improvement cycles established through the Connect Programme to monitor progress.

Across Mid & South Essex we saw increased bed usage on discharge from December 2022. A continued focus on multi-disciplinary decision-making around an adult's ideal pathway will hopefully ensure this rise is temporary to continue to deliver the best outcomes for adults across Mid & South Essex.

The Connect Programme has delivered several new ways of working within our health & care system. Through our Volumes and Effectiveness work we are looking to support more people directly home through our Reablement providers. We are monitoring the effect of the domiciliary market challenges and taking active steps to mitigate the impact. We have some new Reablement contracts in place and are extending these new ways of working to these providers.

II. How additional discharge funding is being used to deliver social care and community capacity to support discharge

Building on the learning from last year's discharge schemes we will continue the incentive scheme in periods of high demand to care providers to support hospital discharges and address capacity challenges in 'hard-to-source' areas. This will include:

- Pick-up of care packages from the Council's unsourced care list and/or for those operating in the geographical areas where unsourced care is over 200 hours care.
- Same day/next day commencement Saturday and Sunday (and on Bank Holidays).

We will also seek to build on successful schemes which tackled some of our more complex discharges including the provision of bespoke support for people experiencing dementia and their carers at the point of discharge. This will include initiatives such as Dementia Intensive Support Workers in acute settings to support discharge and connect individuals and carers into local support in their communities.

Alongside this we will invest in services to transform intermediate care and improve system flow including:

- Bedfinder teams
- New and Increased Discharge to Assess Provision
- Local initiatives to manage reablement demand above and beyond core contracts

Ward-led enablement will also be continued and expanded providing support for ward staff to enable patients to be as independent as possible during their hospital stay, and become active after an illness or operation reduce their length of stay.

We are committed improving outcomes for people with mental health challenges. As part of this commitment, we will boost capacity to support people with mental health challenges to be discharged from hospital as soon as they are ready by providing additional Approved Mental Health Practitioner capacity over the winter months with a specific focus on triage and signposting to divert the request for a MH Act assessment would have positive impact on potential hospital avoidance.

III. How we are tackling immediate pressures in delayed discharges and improving outcomes for people discharged from hospital and wider system flow

Within reablement the focus has been on exploring how we can make the best use of the reablement service to support adults with reablement potential to achieve their most independent outcomes. This has resulted in the development of a priority matrix that will support the identification of adults to discharge on the right pathway and therefore improve the current process. The Priority Matrix will be trialled in April-July 2023 before wider adoption.

Working with Mid & South Essex data leads, we have been exploring the scope for a Delayed Discharges Tracker to provide a single, consistent position articulating the number of patients whose discharge was delayed from hospital. The report would cover Essex residents discharged across the five acute hospitals and by pathway and whether the responsibility for the delay is attributed to either Health or the Local Authority, so that action can be taken to address this through additional planning / commissioning of solutions. We may decide not to pursue this but have been exploring the difference this might make.

The ultimate goal remains Home First for all adults, with the right wrap around services in place, where needed, to enable this. As systems we recognise this aspiration may not always be possible for all adults and some may require a temporary stay in alternative accommodation with wrap around services prior to a return home. We recognise there is an inconsistent offer across the county for interim placements with multiple homes being utilised, making it harder for Discharge to Assess (D2A) teams to resource, provide consistent wraparound services and delaying outcomes for adults. Through our Intermediate Care Bed new commissioning strategy the aim is to consolidate interim placements across a smaller number of homes in each locality, supported by a multi-disciplinary team from across health, social and voluntary agencies including therapies attached for each bed. Through establishing a therapy-led approach the intention is to

support the transition back to home and continue the rehabilitation of the adult in their own home. The ambition is to see more adults leaving interim placements and returning home with a shorter length of stay. Currently we are scoping the model across partner agencies with the attention of rolling out in Q2 2023/24. Alongside this we are developing the *Stepping Stone Home model* to support hoarders and homeless individuals being discharged from acute hospitals. This follows the successful *Tendring Housing Pilot* and we are developing the model and principles across the rest of the county with the aim to support around 100 people each year.

Through continued investment within our domiciliary care market and provider engagement, unsourced packages of care (including those awaiting hospital discharge) are at record lows, often in single figures. At times during 2022, these could reach 100+ during the crisis in domiciliary care. The aim for 2023-24 is to continue to maintain this improvement.

In North East Essex a Home to Assess service has been developed for adults who have been assessed as requiring an intermediate care service whilst determining their longer-term support needs, but who are not suitable for the Reablement at Home service. This is impacting acute Length of Stay and reducing the number of adults moving to a bedded setting upon discharge.

Initially piloted in North East Essex in late 2022, Ward-led Enablement improves patient experience and outcomes for older people receiving medical treatment in acute hospitals in Essex. It is intensive support that enables adults to begin their Reablement whilst an inpatient, helping the adult to do for themselves rather than having everything done for them, changing the culture of staff and patients. This all contributes to maximising independence, choice and quality of life for inpatients. Mitigating against the patient deconditioning, increasing the patient's confidence in returning to their home environment, resulting in an improved discharge outcome, reducing average length of stay and being ready for their transition home. Ward-led Enablement has now been rolled out across all 5 Essex acute hospitals with plans to expand further into other wards in each acute site.

In Mid Essex BCF money is being utilised to employ a discharge coordinator to help undertake many of the administrative tasks undertaken during the discharge process, freeing up professional time to focus on patients.

In 2022 the Connect Programme was awarded the national MJ Award for *Care & Health Integration* for the work in transforming health and care services in Essex.

We are making improvements to our Information Advice and Guidance so that people better understand the services offered at local level, how these can be accessed at the right time, and the funding options available. We will address this through delivery of All-Age Carers Strategy, Early Help Offer, and Digital and Care Technology Programmes.

Outside of the Better Care Fund, the Care Technology service, which launched in 2021, has now supported more than 6,000 people to improve outcomes and maintain their independence and we have been working to increase the uptake of technology at the points it can have the greatest impact. More details on the successes of this service can be found under Key Changes since 2022/23 BCF Plan above. Going forward we are continuing to grow the service to deliver outcomes in Domiciliary care, Housing, and health where we are building strong foundations for engagement and culture change. In the longer term we are looking to expand further to support our sensory offer, continuing to work with health colleagues to explore opportunities in Discharge to Assess pathways and virtual wards and working with the District Councils across Essex to establish Disabled Facilities Grant alignment and pathways.

Intermediate care to support discharge from hospital – demand and capacity

Set out the rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital. This should include:

- Learning from 2022-23 such as:
  - Where number of referrals did and did not meet expectations
  - Unmet demand, ie where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
  - Patterns of referrals and impact of work to reduce demand on bedded services – eg improved provision of support in a person's own home, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- Approach to estimating demand, assumptions made and gaps in provision identified
- Planned changes to your BCF as a result of this work.
  - Where if anywhere, have you estimated there will be gaps between the capacity and the expected demand?

- How have estimates of capacity and demand (including gaps in capacity) been taken on board and reflected in the wider BCF Plans?

Our demand and capacity estimates are based on a triangulation of different insight and intelligence sources. We track referral volumes into our existing service provision including where those referrals come from (ie hospital or community). We also monitor volumes of people who may be waiting for support or who are accessing short-term alternatives to our core intermediate care contracts, for example short-term domiciliary care or residential placements. Our return on demand has been based on this data work. What we learnt from monitoring these numbers is also informing our commissioning plans for 2023-24. In particular we are recommissioning our Intermediate Care bedded offer, allowing us some clarity on numbers we expect to have in placement for the coming year. The work to inform this was able to separate out the genuine need for overnight intermediate care provision versus where the bed-base has been used due to lack of community-based capacity. We also have the ability to ramp up and down our Alternative Reablement Contracts, which will assist us in managing flow at pressurised times of year. This commonly occurs during the winter period but the surge capacity could be utilised at other points.

Our Future of Intermediate Care programme is evaluating the whole evidence base to inform recommissioning proposals that will come forward in 2023. This intelligence includes some analytical work to bring together fragmented data sets to understand the underpinning level of population need and the number of touchpoints individuals typically have with the system. In due course, this may impact on how we utilise BCF funds for intermediate care (expect in the 2024-25 year). It will also help us to develop the workforce to better focus on meeting need. For example we have used the BCF to support work to add therapy support to one of our ARC contracts – this is driving better collaboration and outcomes for the individual.

Investment in bridging, ILOR and reablement surge capacity continues as we reshape our intermediate care offer to ensure we provide the right care at the right time.

Through our existing arrangements we currently provide 13,000 hours per week of reablement and support over 11,600 individual journeys each year through our reablement, ARC and bridging services. Investment in these services continues to increase as we seek to ensure that people receive the right care in the right place at the right time. We utilised winter discharge fund opportunities to uplift the ARC contracts temporarily by 10%. We have also funded via BCF, collaborative work between ECL and an ARC provider, with ECL supporting ARC cases with a therapy offer.

Expenditure*	**2019/20 Actual £m**	**2020/21 Actual £m**	**2021/22 Actual £m**	**2022/23 Actual £m**	**2023/24 Forecast £m**
Reablement at Home	14.2	17.2	18.4	18.3	19.8
Additional Reablement Capacity / In Lieu of Reablement	3.8	3.5	4.3	5.2	5.4
Reablement contract variations 2023/24					1.7
Spot Purchased 'Domiciliary Care in Lieu of Reablement'	2.0	2.2	3.2	5.7	5.8
Subtotal Reablement	**20.1**	**22.8**	**25.8**	**29.2**	**32.7**
7Bridging			3.1	4.1	3.7
Total Intermediate Care (ECC managed)	**20.1**	**22.8**	**28.9**	**33.2**	**36.4**

* Also includes non-BCF funding sources.

However, we also know that there is scope for improvement in the arrangements and opportunities to maximise the effectiveness and efficiency of our approach through greater collaboration. Over the next year we will continue delivery of a significant programme of work to transform our intermediate care provision across the county bringing together reablement services, bridging services, short-term care home provision, as well as NHS intermediate care services, to improve outcomes for people and ensure a joined up and integrated approach to service delivery. The programme will build on learning from successful initiatives such as the **Connect Programme and the North Essex Integrated Community Services (NICs) arrangements** which have brought together various community health provision such as community beds, UCRT, cardiology, audiology, strength and balance.

Our ambition for the programme is:

- To have a seamless, integrated pathway that gives the best possible experience to individuals, carers and stakeholders (all partners understand each other's involvement with each adult)

- To support people within the community to prevent the need for hospital admissions and refocus delivery towards the areas of greatest need
- Ensure all partners meet their statutory responsibilities, but remain focused on the holistic needs of the individual
- Seek to improve the inclusivity of our provision
- To embed the core principle of 'home first' ensuring that home is the default option for people; this means beds are only considered where the individual's needs or circumstances do not allow them to safely stay at/return home
- Adults accessing the right service at the right time and drawing on services delivered in the community, linking in with system wide services e.g. community health, voluntary sector, primary care.
- To collaborate and use all available resources across the system to best support adults, being flexible as their needs change but always involving them in decision making

2022-23 Demand expectations and learning

Demand has been estimated based on a triangulation of historical data and trends, expected and planned system changes (for example, scheduled recommissioning work on things like Intermediate Care beds) and projected growth in population need. Where there are gaps, we have approached our commissioning and contracting to allow for flexibility. As an example, we have surge capability built into our reablement contract with ECL and are also able to flex, with notice, our ARC contracts.

System demand for intermediate care continued to grow in 2022-23 as the impact of the pandemic and rising needs continues to be felt.

Additional resource was secured for adjacent services, particularly by uplifts, investments and initiatives in domiciliary care which helps ensure timely discharge from reablement once someone is independent as they can be. However our data has indicated that cases entering reablement and ARC are now doing so with a higher level of needs than they may have done in previous years. This has meant that "flow" improvement haven't been at the scale we may have anticipated.

Where it has been necessary to support the system via utilisation of the care home bed base, efforts have been made to ensure stays are only for as long as possible and that a limited number of homes are engaged in this making it more viable to support in-reach via community health therapists and health professional. During 2023-24 we are planning a commissioning exercise to secure Intermediate Care beds which will help ensure the right level of bedded provision to support the system.

Discharge to usual place of residence

Set out how BCF-funded activity will support delivery of Objective 2, with particular reference to **changes or new schemes for 2023-25** and how these services will impact on the following metrics: **Discharge to usual place of residence.**

During 2022 Essex County Council shared the outputs of the Newton Europe Discharge to Assess process report. Although the review was commissioned by ECC it was supported and engaged with by partners from Health, the Voluntary Sector and our provider market. The review was an opportunity to hold a mirror up at the 5 discharge systems across Essex and consider how aligned they are to National policy and best practice, and to the High Impact Change Model. The Review output was shared across Partners and with Place-based Alliances.

Through our Connect D2A Review activity we identified six KPIs that each system should monitor across all pathways. These are:

- Discharge Pathway Split
- Medically-optimised LoS
- Readmission rate
- Recovery effectiveness
- Intermediate care outcomes
- Intermediate care LoS

These are regularly reported in various D2A meetings held across the county with health, social care and voluntary sector partners. The ambition over the next 12 months is for this reporting to lead to more direct action to address challenges that arise and enable us to respond to changing capacity and demand pressures quickly and efficiently.

The development of Virtual Wards and UCRT services allows for more support to be provided for adults within their own home. In Phase 3 of the Connect Programme work we are undertaking a diagnostic to understand how we can further reduce the

numbers of adults readmitted to our acute hospitals through better utilisation of UCRT in both Reablement and Residential provision. The outputs of the diagnostic due in Q2 will determine what further work will be initiated.

High Impact Change Model

Set out progress in implementing the High Impact Change Model for managing transfers of care, any areas for improvement identified and planned work to address these.

The High Impact Change model is a fundamental deliverable of the Better Care Fund in Essex, It provides a framework for many of the schemes to work towards to improve transfers of care. We use the HIC model to both determine where we believe additional investment could make a difference and to assess how existing schemes/approaches are contributing to the wider ambition It covers.

In Essex we review our implementation of the HIC model each year before "closing" the BCF and again as part of the planning process for the year to come. This has been completed informally since Covid but plans are in place to have a more fundamental review – at local level – during the 2023/24 cycle. This aligns with a formal BCF review that has been completed with partners to look for improvements that can be made to how we establish and delivery the BCF going forward. Some of the specific recommendations from this year's review include:

- Long-term strategy – The ambition is to create a 3-5 year plan for the BCF that outlines the approach we will take if funding is as expected. This will allow us to look at more transformational pieces of work that would take several years to deliver, rather than feeling bound by the BCF planning and reporting cycles. It will also increase transparency with all partners having a shared understanding of the long-term view for the BCF.
- Phased approach to broadening the scope to include non-Older Adult schemes – Initial steps are to aligning budgets on specific themes or projects, then explore appetite for pooled funding sourced from the current allocations and/or additional contributions where it's appropriate and advantageous to pool funds/add to the pool. For example, around shared posts such as alliance leads. The long-term strategy should help shape this phased approach.
- Evaluation – Developing a shared approach to evaluating schemes so we can better attribute impact across the HIC model. The current thinking is that this will need to be a framework of evaluation that considers small schemes (under £10k) but that can also be applied to larger schemes. There needs to be consideration for existing decision-making routes both within each organisation but also each system in Essex.
- Governance and Reporting – Looking to drive more consistency within the Essex localities in terms of governance and decision make for the BCF. This will include the implementation of a monthly trackers, common TOR and meetings and approaches to developing new schemes. This will provide a level of consistency and oversight which will reduce the burden of reporting and increase learning/knowledge sharing between systems whilst allowing for local place-based initiatives to be supported.

One particular focus in this year's planning for HIC has been Discharge. It is a key feature of our local, regional and national priorities. A countywide self-assessment identified areas for system improvement and opportunities for learning. The assessment was undertaken with a critical eye with a view to identifying key areas of improvement. Over the next 12 months we expect to complete local self-assessments.

- **Early Discharge Planning.** MDT discharge planning takes place in all areas and work is underway to move this nearer to the point of admission.
- **System Demand and Capacity** information is shared in all acute systems and work is in progress to feed this into strategic commissioning. We describe our efforts to manage demand and capacity above here and how we are taking immediate pressures here.
- **Multi-disciplinary Teams** see above for further details on MDTs in Essex
- **Home First** is a key focus across the 5 Essex acute systems and use of "Step-down" or temporary placements has reduced significantly. However at times of acute system pressure, some adults are still discharged to a bed that could have gone home. See above for further details on our approach to Home First.
- **7 Day Discharge.** All systems discharge 7 days a week. However system capacity issues and lack of decision-makers across some partners mean that weekend discharges continue to be a challenge.
- **Trusted Assessment.** Assessments are undertaken by health assessors on behalf of system partners using single referral forms. We are working to improve consistency of information and assessment.
- **Engagement & Choice.** Our Lived Experience data demonstrates a need to improve discharge planning communication with people and their carers. Improving the support offer for Carers is a priority for 2023-24.

- **Discharge to care homes.** Long term decisions do not take place in hospital. Reductions in temporary placements means more appropriate discharges into 24 hour settings. A new Intermediate Care Strategy will ensure less dispersal of adults with more focused wraparound support.
- **Housing and related services:** The Essex Hospital Discharge Protocol sets out arrangements between the Essex hospitals, local Housing Authorities (including Southend and Thurrock), ECC, Essex ICBs and the Peabody Floating Support Team, to work with patients who are homeless or at risk of homelessness. We describe some of our activity to ensure people are discharged home here. In addition we have described some of our activity relating to DFGs and independent living here, including development of **Stepping Stone Homes** to facilitate discharge from hospital.

In 2021 Newton Europe was commissioned to review the Discharge to Assess process across Essex. The Review identified four areas of focus to address: Leadership, Transfer of Care Hubs, Community Pathways and Post-Discharge community reviews. Each of the five Essex Alliances adopted a high-level roadmap of activity to address these areas.

Transfer of Care Hub (TOCH) development remains a key priority and design is happening across all five localities with each Alliance owning the development of their TOCH. Some challenges remain with respect to ICB geographical footprints and where responsibility is held. A **maturity matrix** has been developed and is used across the County to monitor progress. The Matrix is based upon the Newton Europe Review and aligns to the LGA High Impact Change Model.

The Mid & South Essex Integrated Discharge Team (MSEFT IDT) fulfils the acute elements of a TOCH in that it is a service operated by the Acute Trust within each hospital that conducts the assessment and coordination of complex hospital discharges. The IDT has established processes / procedures / policies and works collaboratively with Mid & South Essex partner organisations across Health, Social Care and VCSE. However the MSEFT IDT does not fulfil the community elements of TOCH (community case management, locality / neighbourhood intervention, coordination and prevention, attendance / admission avoidance etc). The MSEFT IDT will still operate a transfer of care function (thereby covering all acute elements as above that will feed into the place-based MSE TOCHs which can then operate the community elements.

A system-wide workshop was facilitated by *People Too* in March 2023, with a series of engagement events in preparation for the workshop, to understand system baseline and ambition. The long term ambition is that the TOCHs will be aligned to the Alliances to be approved at the ICS Chief Executives Forum.

Discharge data is regularly shared across system partners and the Maturity Matrix is used to monitor progress of D2A development across the county. We are working to bring more Lived Experience into decision making to drive a more person-centred approach. Case Management remains a key area of focus particularly in relating to post-acute discharge. In West Essex we anticipate further developments with the Care Co-ordination Centre. In North East Essex they are looking to pilot a community-based case management approach in Tendring and Colchester.

Care Act Duties

Please describe how you have used BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered.

BCF Funding is used to deliver a range of services to support carers which are described in the next section.

Supporting unpaid carers

Essex's All-Age Carers Strategy 2022-26 outlines how the council and partners will support unpaid carers and sets out six commitments:

- To ensure carers can easily access the information, advice, guidance and support when they need it, early into their caring role;
- To develop professional practice and processes to improve identification and support to carers;
- To improve transitions for carers as they move through specific phases or life events in their caring role;
- To ensure carers have increased opportunity to access good quality support, including opportunities for breaks, to maintain their own wellbeing and those they care for;
- To ensure carers' needs and rights will be understood and recognised across Essex communities;
- To recognise that carers will be the experts that influence, shape and be involved in the decisions that are intended to improve their support and wellbeing.

The BCF is commissioning the Time for You project in which Essex Carers Support works with the carer to develop strategies to reduce the impact of their caring responsibilities. The project was initially funded for 2 years until August 2023 and we plan to extend it until March 2024, when it will be built into the new core offer to be commissioned. Each carer is supported to reflect on their circumstances and ways that they currently achieve a break (or not) and then develop strategies to reduce the impact of their caring role, increase resilience or improve their health and wellbeing. Grants enable carers to arrange activities, breaks or other solutions that reflect their own interests and preferences. The Provider is expected to engage with communities and the wider health and care system to source a broad range of support and activities for carers to access.

Action for Family Carers provide a dedicated, free counselling service for unpaid carers, which is currently funded by the BCF until 2023. We plan to extend this to March 2024 when it will also be built into the new core offer to be commissioned. The service has grown to cover the whole county having started in mid Essex in 2012 and is highly valued by carers with many reporting that it has been a lifeline. Demand for the service rose by 15% during the pandemic and the Service has adapted to provide counselling sessions over the telephone and via Zoom. Carers receive an initial consultation session and six counselling sessions for up to one hour. If required, more than six sessions can be authorised. The service supports carers to maintain their mental and physical health and wellbeing, enabling them to continue caring and reducing demand for GP appointments or social care. It also helps to reduce pressure on statutory mental health services by providing early intervention, delaying need and preventing escalation to more intensive therapeutic services. The service also provides bereavement support for carers.

Mobilise is a "By and For" initiative that is a digital offer to Essex carers. The nature of the offer is that carers are identified early and are enabled to access a range of information, advice and guidance as well as light touch virtual support and access to virtual peer groups. If further expert help is required a carer will be signposted on to the core commissioned services. Mobilise is commissioned to be delivered until March 2024.

Carers early help and access to IAG. ECC commission Carers First to provide a single point of contact for carers for information, advice and support, including support and advice about accessing personalised breaks and about making contingency plans and plans for the future. The service provides proactive support, including "follow up" contact and connects carers to training and appropriate services and networks. It provides face to face support for carers who need this. The Service actively promotes networks of support for carers, including linking carers with similar needs, experiences and interests; supporting existing groups to access expert information and advice and providing expert facilitation if needed. The service also works with employers, providing advice and support about how to support employees with caring responsibilities and how to ensure their services are accessible to carers. The service works with GP practices to identify carers and signpost them to the right support and works with Hospitals to ensure carers are informed about support available when people are discharged and ensure appropriate support is in place for the carer.

All services will come to an end in March 2024 when the learning from the current offers will be designed into the new offer being commissioned for post 2024. During this time there have and will be a series of activities and resources that are being developed and funded by BCF that will support delivery of commitments and underpin the new offer post April 2024 and these are our co-produced Think Carers Toolkit: implementation of our Carers Voices Model and delivering a range of communications campaigns to ensure carers will access the right support at the right time as well as being supported to understand their rights as an unpaid carer. In addition to this there is some focussed work that will result in significantly more carers accessing short breaks to ensure their own health and wellbeing is maintained.

Disabled Facilities Grant (DFG) and wider services

What is your strategic approach to using housing support, including DFG funding, that supports independence at home?

Our strategic approach to using housing support, including DFG funding, that supports independence at home is set out above – link here.

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? If so, what is the amount that is allocated for these discretionary uses and how many districts use this funding?

Nine of Essex's 12 District, Borough and City Councils have made use of the RRO to use DFG funding for discretionary services. The total amount used in this way is £1,987,663. All Essex's district councils have a housing assistance policy which has been submitted with their Delta returns for November 2022.

Equality and health inequalities

How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include

- Changes from previous BCF plan
- How equality impacts of the local BCF plan have been considered
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Changes to local priorities related to health inequality and equality and how activities in the document will address these
- Any actions moving forward that can contribute to reducing these differences in outcomes
- How priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.

A revised Equalities Impact Assessment has been completed for our Better Care Fund Plan:

EQIA BCF 23-24 v2.ECIA521489930 (1).

Our 2023-25 BCF Plan has an increased focus on Carers and in particular we will be seeking to build upon schemes to tackle some of our more complex discharges, including the provision of bespoke support for people experiencing dementia and their carers at the point of discharge.

In line with our responsibilities under the Care Act, adult social care support must be person-centred and specific to that adult. All individuals who are assessed as having eligible needs have the option of a Direct Payment which they can manage via our Direct Payment Support Service; choose to have a Payment Card or have funds deposited in their bank account. ECC has been working with *Think Local Act Personal* to review our Direct Payment Support Service and co-produce a new service that works well for residents. We commissioned *PeopleToo* to do a practice diagnostic in 2021 to evaluate our approach to enablement and the application of strengths-based practice and positive risk-taking with adults with disabilities. This led to a number of practice changes and launch of the Accommodation Hub to support practitioners to look at all options to achieve the right outcomes for individuals.

The importance of tackling the causes of inequality in health outcomes is widely recognised across the system in Essex and reflected in our Joint Health and Wellbeing Strategy where we have committed to creating a culture and environment that reduces inequalities and enables residents of all ages to live healthier lives.

The strategy recognises that tackling health inequalities for any cohort who may experience them from young carers to single person households, to those at risk of or experiencing homelessness requires the support of the wider system, and this is reflected in the membership of our health and wellbeing board and local alliances including local authorities, health, wider public sector and voluntary sector organisations.

It sets out the outcomes we want to achieve for this priority including:

- Worked to ensure that all children have access to quality parenting, early years provision and education that provide the foundations for later in life.
- Helped to address food poverty and ensure that all children can access healthy food.
- Improved access to employment, education and training for adults and young people in our most deprived and disadvantaged communities.
- Embedded the use of health impact assessments in planning practice to ensure new planning proposals do not negatively impact on health, health services or widen health inequalities.
- Supported residents who are digitally excluded, either by lack of equipment, connectivity, skills, cost, or confidence to be able to access services and information to benefit their education, career development, access to clinical services and personal wellbeing.
- Reduced barriers to accessing health and care services for families with low-incomes, children and young people who are in or who have been in care, people with learning disabilities, and other cohorts at greatest risk of poor health outcomes.

Our commitment to tackling inequalities extends beyond the scope of the BCF and we are also working with ICS partners on the use of funding for health inequalities that the ICSs received, linking plans to the Core20plus5 model. In some areas, such as West Essex, a dedicated health inequalities committee has been set-up, which oversees work and reports to the West Essex One Health and Care Partnership. ECC and Herts and West Essex ICB are jointly funding a role at director level on health inequalities and levelling-up.

Another example is the development of the *Thriving Places* Index dataset, being custom-designed by members of the Mid-Essex Alliance, in conjunction with the Centre for Thriving Places to develop a shared place-based dataset and shared priority areas, where a "One Mid Essex Team" approach is being applied to direct effort across organisational boundaries and across the broad determinants of health and wellbeing outcomes.

In addition to our Joint Strategic Needs Assessment and annual Essex Residents Survey, ECC commissioned Oxford Consultants for Social Inclusion (OCSI) to further develop our understanding of Essex communities. The Community Needs Index (CNI) provides a measure of the resilience of communities, capturing the extent to which areas have access to shared spaces and social infrastructure, social and physical connections, a thriving third sector and engaged citizens. The Index allows us to identify areas that suffer the dual disadvantage of high deprivation and high community need and explore some of the factors that drive different levels of community need.

Since our last BCF plan work has also begun on delivering our levelling up programme in Essex. We know that Essex is often seen as prosperous. We have a £40bn economy, support 700,000 jobs, and are home to nearly 75,000 businesses. However, there are gaps in how and where this prosperity is experienced with disparities in opportunity across the county. There are more than 123,000 people in Essex, 40,000 of whom are children, that live in areas that are in the 20% most deprived of the whole UK. This is a figure that has doubled since 2007. There is on average a 12 year life expectancy gap between the most and least deprived areas of the county. Health outcomes among the residents of the most deprived areas of the county are significant worse: 87% higher instance of Respiratory progressive diseases (COPD); 69% increase of mental health conditions; and adult obesity is 53% higher.

The reality is that it does make a difference where you live and who your parents are to the success you enjoy in life. The Councils strategy "Everyone's Essex" sets out an approach to change that.

The Council's Levelling up Essex White Paper explicitly outlines the inequalities experienced in Essex. ECC has funded more than 23 programmes with investment so far focused on interventions that will deliver short to medium term benefits for residents. The Council has also developed a six point plan to support residents with Cost of Living challenges. This includes working with community organisations to target those most at risk from living in a cold home, including vulnerable adults.

Working with partners across the county the council will be focusing on both place-based and cohort inequalities and setting out how they will work together to widen opportunities for left behind areas and disadvantaged communities across the county.

Anchors

For many partners a key component of how they will be levelling up economic outcomes in their local area is through an anchor approach harnessing the potential of large public sector organisations as procurers, employers and local land and asset owners. An Essex Anchor Network is helping to share learning across the system by addressing some of the socio-economic influencing factors. Local Networks have also formed to take forward initiatives in their area. Partners have worked to develop an ideas book to help share good practice across the county and a series of learning events have been held. The ideas book and recordings of the learning events are shared through the Future of Essex website and are available here https://www.essexfuture.org.uk/boards-networks/anchor-institutions/anchor-resources/

In Mid and South Essex, partners have been working together across Essex on anchor-related work including successful partnership work between ECC and MSEFT to bring employment opportunities to local residents, including internships for young people with learning disabilities in Mid and South Essex. All partners have signed up to an ICS Anchor Charter. Similarly, Herts & West Essex has formed a West Essex Anchors Group with local partners, including colleges, and also leads the Essex-wide workstream on Employability in the public sector. Suffolk and North East Essex ICS has brought partners together through an ICS Anchors Programme. The Anchor Programme Board, comprises stakeholders from organisations, Alliances, and a variety of ICS groups and forums to provide strategic oversight and to ensure an effective, joined-up whole system approach aligned to our Primary Ambition of 'enable health equality for everyone'. NHS and wider health and care organisations have signed up to an ICS Anchor Charter that underlines their commitment and a dashboard to monitor progress is being developed.

Public Health

The Council's Wellbeing, Public Health and Communities function brings together a range of services that contribute to improving public health outcomes, protecting our most vulnerable and reducing health inequalities. It also brings together expertise and experience in how, as collective partners, we strategically work together to address health inequalities and recognise their wider determinants. Going forward it is critical that the right approaches, which in many ways are different than those used before, are applied. To make a difference to health inequalities it is critical that the following approaches are employed:

- Shared target geographical places and shared cohorts of people in Essex, based on good quality data and insight, with collective resource allocation, better reflecting where there is most and least need;
- Shared outcomes *and* shared accountability for those outcomes across partners and across organisational boundaries and cultures;
- Understanding the right way to combine multiple different datasets to meaningfully measure our impact on the highly complex problems we are trying to solve.

Functions of Wellbeing, Public Health and Communities include:

- Specialist Public Health Service which commissions drug and alcohol interventions; smoking cessation support; housing-related support; weight management support, NHS Health checks; Healthcare public health advice; Health & Justice services.
- Active Essex is a Sport England designated Active Partnership for Greater Essex. It leads on delivery of a 10 year strategy *Fit for the Future* and delivers multiple programmes to increase physical activity in Essex.
- Strengthening Communities Service works to create conditions to enable communities to respond to societal challenges and commissions community infrastructure development.

The Wellbeing, Public Health and Communities Business Plan 2022-25 is organised around 5 key themes: productive partnerships; place-based public health; prevention; public health priorities and mental wellbeing.

- Prevention. Using population health management approaches to identify people at risk of developing disease or disability and working with partners to reduce the big six lifestyle risk factors to drive down poor health outcomes and loss of independence; and support programmes of work to delay deterioration where people are already unwell.
- Mental Wellbeing. Around 15% of people aged 16-64 and 9.5% of over 65s in Essex have a common mental health disorder and Essex has a higher than average suicide rate. Proposed actions include development of a range of services to promote positive mental wellbeing; increasing the number of Mental Health First Aiders in the community and development of a suicide prevention strategy.

Essex Wellbeing Service

ECC commissions the Essex Wellbeing Service (EWS) in partnership with community organisations, to provide residents with access to health checks; stop smoking services; weight management support and emotional health and wellbeing support. EWS also recruits and connects volunteers with Essex residents in need of support with everyday tasks or who are socially isolated. By combining contracted partners, EWS can carry out one holistic assessment that looks at the whole person rather than individual health behaviours. The service is intended to look outward to other parts of the wider health and wellbeing system and to be a catalyst in joining up care pathways.

BCF Planning Template 2023-25

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.

2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

3. The checklist helps identify the sheets that have not been completed. All fields that appear highlighted in red with the word 'no', should be completed before sending to the Better Care Fund Team.

4. The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'.

5. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.

6. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.

7. Please ensure that all boxes on the checklist are green before submission.

8. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority.

4. Capacity and Demand

Please see the guidance on the Capacity&Demand tab for further information on how to complete this section.

5. Income

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2023-25. It will be pre-populated with the minimum NHS contributions to the BCF, iBCF grant allocations and allocations of ASC Discharge Fund grant to local authorities for 2023-24. The iBCF grant in 2024-25 is expected to remain at the same value nationally as in 2023-24, but local allocations are not published. You should enter the 2023-24 value into the income field for the iBCF in 2024-25 and agree provisional plans for its use as part of your BCF plan

2. The grant determination for the Disabled Facilities Grant (DFG) for 2023-24 will be issued in May. Allocations have not been published so are not pre populated in the template. You will need to manually enter these allocations. Further advice will be provided by the BCF Team.

3. Areas will need to input the amount of ASC Discharge Fund paid to ICBs that will be allocated to the HWB's BCF pool. These will be checked against a separate ICB return to ensure they reconcile. Allocations of the ASC discharge funding grant to local authority will need to be inputted manually for Year 2 as allocations at local level are not confirmed. Areas should input an expected allocation based on the published national allocation (£500m in 2024-25, increased from £300m in 2023-24) and agree provisional plans for 2024-25 based on this.

4. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in ‘yellow’. These will appear as funding sources in sheet 5a when you planning expenditure.

5. Please use the comment boxes alongside to add any specific detail around this additional contribution.

6. If you are pooling any funding carried over from 2022-23 (**i.e. underspends from BCF mandatory contributions**) you should show these as additional contributions, but on a separate line to any other additional contributions. Use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

7. Allocations of the NHS minimum contribution are shown as allocations from each ICB to the HWB area in question. Where more than one ICB contributes to the area's BCF plan, the minimum contribution from each ICB to the local BCF plan will be displayed.

8. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

6. Expenditure

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, units, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Condition 4 and is used by assurers to ensure that these are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:

- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:

- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 6b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose ‘Other’ and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Expected outputs
- You will need to set out the expected number of outputs you expect to be delivered in 2023-24 and 2024-25 for some scheme types. If you select a relevant scheme type, the 'expected outputs' column will unlock and the unit column will pre populate with the unit for that scheme type.
- You will not be able to change the unit and should use an estimate where necessary. The outputs field will only accept numeric characters.
- A table showing the scheme types that require an estimate of outputs and the units that will prepopulate can be found in tab 6b. Expenditure Guidance.

You do not need to fill out these columns for certain scheme types. Where this is the case, the cells will turn blue and the column will remain empty.

6. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where ‘Social Care’ is selected and the source of funding is “NHS minimum” then the planned spend would count towards eligible expenditure on social care under National Condition 4.
- If the scheme is not adequately described by the available options, please choose ‘Other’ and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

7. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend on NHS commissioned out of hospital services under National Condition 4. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select ‘Joint’. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

8. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

9. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

10. Expenditure (£) 2023-24 & 2024-25:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

11. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

12. Percentage of overall spend. This new requirement asks for the percentage of overall spend in the HWB on that scheme type. This is a new collection for 2023-25. This information will help better identify and articulate the contribution of BCF funding to delivering capacity.

You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance. This estimate should be based on expected spend in that category in the BCF over both years of the programme divided by both years total spend in that same category in the system.

7. Metrics

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2023-25. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2023-24.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2023-24. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2021)
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Please use the ISR Tool published on the BCX where you can input your assumptions and simply copy the output ISR:
https://future.nhs.uk/bettercareexchange/view?objectId=143133861
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Falls
- This is a new metric for the BCF and areas should agree ambitions for reducing the rate of emergency admissions to hospital for people aged 65 or over following a fall.
- This is a measure in the Public Health Outcome Framework.
- This requires input for an Indicator value which is directly age standardised rate per 100,000. Emergency hospital admissions due to falls in people aged 65 and over.
- Please enter provisional outturns for 2022-23 based on local data for admissions for falls from April 2022-March 2023.
- For 2023-24 input planned levels of emergency admissions
- In both cases this should consist of:
    - emergency admissions due to falls for the year for people aged 65 and over (count)
    - estimated local population (people aged 65 and over)
    - rate per 100,000 (indicator value) (Count/population x 100,000)

- The latest available data is for 2021-22 which will be refreshed around Q4.
Further information about this measure and methodolgy used can be found here:
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/6/gid/1000042/pat/6/par/E12000004/ati/102/are/E06000015/iid/22401/age/27/sex/4

3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2022-23, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2023-24 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

4. Residential Admissions:
- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

5. Reablement:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

8. Planning Requirements

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Planning Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2023-2025 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select ‘Yes’ or ‘No’ to confirm whether the requirement is met for the BCF Plan.

2. Where the confirmation selected is ‘No’, please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2023-25 Template

2. Cover

Version 1.1.3

Please Note:

- The BCF planning template is categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website and gov.uk. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Essex	
Completed by:	Emma Richardson	
E-mail:	emma.richardson@essex.gov.uk	
Contact number:	07990 518695	
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	No	
If no please indicate when the HWB is expected to sign off the plan:	Mon 17/07/2023	<< Please enter using the format, DD/MM/YYYY

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	John	Spence	john.spence@essex.gov.uk
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off	Mr	Ed	Garratt	ed.garratt@snee.nhs.uk
	Additional ICB(s) contacts if relevant	Mrs	Jane	Halpin	jane.halpin@nhs.net
	Local Authority Chief Executive	Mr	Gavin	Jones	gavin.jones@essex.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)	Mr	Nick	Presmeg	nick.presmeg@essex.gov.uk
	Better Care Fund Lead Official	Ms	Moira	McGrath	moira.mcgrath@essex.gov.uk
	LA Section 151 Officer	Mrs	Nicole	Wood	nicole.wood@essex.gov.uk
*Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->	Additional ICB(s) contacts if relevant	Mr	Anthony	McKeever	ceooffice.mseics@nhs.net

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4. Capacity&Demand	Yes
5. Income	Yes
6a. Expenditure	No
7. Metrics	Yes
8. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: Essex

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£11,885,443	£11,885,443	£11,885,443	£11,885,443	£0
Minimum NHS Contribution	£120,967,970	£127,814,757	£120,967,970	£127,814,757	£0
iBCF	£46,380,576	£46,380,576	£46,380,576	£46,380,576	£0
Additional LA Contribution	£0	£0	£0	£0	£0
Additional ICB Contribution	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£6,502,485	£10,837,475	£6,502,485	£10,837,475	£0
ICB Discharge Funding	£8,192,548	£12,714,434	£8,192,548	£12,714,434	£0
Total	**£193,929,022**	**£209,632,685**	**£193,929,022**	**£209,632,685**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£34,375,666	£36,321,329
Planned spend	£73,374,564	£77,527,564

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£48,146,771	£50,871,878
Planned spend	£48,244,543	£50,975,185

Metrics >>

Avoidable admissions

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	175.0	161.0	168.0	196.0

Falls

		2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,710.4	2,000.0
	Count	5492	6776
	Population	311792	324286

Discharge to normal place of residence

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	93.1%	93.4%	93.7%	94.0%

Residential Admissions

		2021-22 Actual	2023-24 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	368	350

Reablement

		2023-24 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	89.0%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Implementing the BCF policy objectives	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2023-24 Capacity & Demand Template

3. Capacity & Demand

Selected Health and Wellbeing Board: Essex

Guidance on completing this sheet is set out below, but should be read in conjunction with the guidance in the BCF planning requirements

3.1 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.

Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month. The template aligns tothe pathways in the hospital discharge policy, but separates Pathway 1 (discharge home with new or additional support) into separate estimates of reablement, rehabiitation and short term domiciliary care)

If there are any trusts taking a small percentage of local residents who are admitted to hospital, then please consider aggregating these trusts under a single line using the '**Other**' Trust option.

The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.

Estimated levels of discharge should draw on:

- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2023-24
- Data from the NHSE Discharge Pathways Model.
- Management information from discharge hubs and local authority data on requests for care and assessment.

You should enter the estimated number of discharges requiring each type of support for each month.

3.2 Demand - Community

This section collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care or short term care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 2 of the Planning Requirements.

The units can simply be the number of referrals.

3.3 Capacity - Hospital Discharge

This section collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Social support (including VCS)
- Reablement at Home
- Rehabilitation at home
- Short term domiciliary care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting
- Short-term residential/nursing care for someone likely to require a longer-term care home placement

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

3.4 Capacity - Community

This section collects expected capacity for community services. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 7 types of service:

- Social support (including VCS)
- Urgent Community Response
- Reablement at home
- Rehabilitation at home
- Other short-term social care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

Virtual wards should not form part of capacity and demand plans because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, pease select the relevant trust from the list. Further guidance on all sections is available in Appendix 2 of the BCF Planning Requirements.

Any assumptions made. Please include your considerations and assumptions for Length of Stay and average numbers of hours committed to a homecare package that have been used to derive the number of expected packages.	Hospital Discharge Demand data source: ESNEFT - from 2022/23 BCF plan MSEFT - from 2023/24 planning PAH - from 2023/24 planning NHS data only available by pathway. No capacity data available from NHS. Capacity data is ECC only. Community Demand and Capacity only included for pathway 1. Excludes spot purchasing. Based on actual Apr-23 starts and forecast using recent trend, with discharge fund planned capacity added to hospital discharge capacity.

	Complete:
3.1	Yes
3.2	Yes
3.3	Yes
3.4	Yes

3.1 Demand - Hospital Discharge

!!Click on the filter box below to select Trust first!!

Trust Referral Source (Select as many as you need)	Demand - Hospital Discharge Pathway	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	Social support (including VCS) (pathway 0)	1650	1650	1650	1650	1650	1650	1650	1650	1650	1650	1650	1650
MID AND SOUTH ESSEX NHS FOUNDATION TRUST		3615	3615	3615	3615	3615	3635	3649	3663	3677	3684	3663	3615
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST		694	811	698	805	783	789	949	928	978	917	892	1050
EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	Reablement at home (pathway 1)	300	300	300	300	300	300	300	300	300	300	300	300
MID AND SOUTH ESSEX NHS FOUNDATION TRUST		695	695	695	695	695	709	730	744	765	799	765	765
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST		100	101	55	93	93	83	90	95	86	82	60	84
EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	Rehabilitation at home (pathway 1)												
MID AND SOUTH ESSEX NHS FOUNDATION TRUST													
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST													
EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	Short term domiciliary care (pathway 1)												
MID AND SOUTH ESSEX NHS FOUNDATION TRUST													
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST													
EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	Reablement in a bedded setting (pathway 2)	157	157	157	157	157	157	157	157	157	157	157	157
MID AND SOUTH ESSEX NHS FOUNDATION TRUST		243	243	243	243	243	250	254	264	271	278	264	271
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST		33	39	58	62	51	50	46	44	45	38	44	38
EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	Rehabilitation in a bedded setting (pathway 2)												
MID AND SOUTH ESSEX NHS FOUNDATION TRUST													
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST													
EAST SUFFOLK AND NORTH ESSEX NHS FOUNDATION TRUST	Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	15	15	15	15	15	15	15	15	15	15	15	15
MID AND SOUTH ESSEX NHS FOUNDATION TRUST		76	76	76	76	76	80	80	80	83	83	80	76
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST		0	0	0	0	0	0	0	0	0	0	0	0

3.2 Demand - Community

Demand - Intermediate Care Service Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)												
Urgent Community Response												
Reablement at home	412	456	501	478	501	478	501	501	433	501	478	456
Rehabilitation at home												
Reablement in a bedded setting												
Rehabilitation in a bedded setting												
Other short-term social care												

3.3 Capacity - Hospital Discharge

Capacity - Hospital Discharge Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	Monthly capacity. Number of new clients.												
Reablement at Home	Monthly capacity. Number of new clients.	623	649	711	680	711	680	737	737	643	788	757	726
Rehabilitation at home	Monthly capacity. Number of new clients.												
Short term domiciliary care	Monthly capacity. Number of new clients.	313	252	277	264	277	264	277	277	240	277	264	252
Reablement in a bedded setting	Monthly capacity. Number of new clients.	23	23	23	23	23	23	72	72	72	72	72	72
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.												
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.												

Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly		
ICB	LA	Joint
	100%	
	100%	
	100%	

3.4 Capacity - Community

Capacity - Community Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	Monthly capacity. Number of new clients.												
Urgent Community Response	Monthly capacity. Number of new clients.												
Reablement at Home	Monthly capacity. Number of new clients.	193	196	215	205	215	205	215	215	186	215	205	196
Rehabilitation at home	Monthly capacity. Number of new clients.												
Reablement in a bedded setting	Monthly capacity. Number of new clients.												
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.												
Other short-term social care	Monthly capacity. Number of new clients.	153	159	175	167	175	167	175	175	151	175	167	159

Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly		
ICB	LA	Joint
	100%	
	100%	

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: Essex

Local Authority Contribution		
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2
Essex	£11,885,443	£11,885,443
DFG breakdown for two-tier areas only (where applicable)		
Basildon	£1,438,660	£1,438,660
Braintree	£1,056,441	£1,056,441
Brentwood	£420,142	£420,142
Castle Point	£831,407	£831,407
Chelmsford	£1,101,613	£1,101,613
Colchester	£1,452,105	£1,452,105
Epping Forest	£971,213	£971,213
Harlow	£905,627	£905,627
Maldon	£612,132	£612,132
Rochford	£540,059	£540,059
Tendring	£2,320,471	£2,320,471
Uttlesford	£235,576	£235,576
Total Minimum LA Contribution (exc iBCF)	**£11,885,443**	**£11,885,443**

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2
Essex	£6,502,485	£10,837,475

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2
NHS Hertfordshire and West Essex ICB	£1,500,969	£2,528,360
NHS Mid and South Essex ICB	£4,987,365	£6,932,535
NHS Suffolk and North East Essex ICB	£1,704,214	£3,253,539
Total ICB Discharge Fund Contribution	£8,192,548	£12,714,434

iBCF Contribution	Contribution Yr 1	Contribution Yr 2
Essex	£46,380,576	£46,380,576
Total iBCF Contribution	**£46,380,576**	**£46,380,576**

Are any additional LA Contributions being made in 2023-25? If yes, please detail below	No

Local Authority Additional Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box to clarify any specific uses or sources of funding
Total Additional Local Authority Contribution	**£0**	**£0**	

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS Mid and South Essex ICB	£67,923,541	£71,768,013
NHS Suffolk and North East Essex ICB	£27,828,160	£29,403,234
NHS Hertfordshire and West Essex ICB	£25,216,269	£26,643,510
Total NHS Minimum Contribution	**£120,967,970**	**£127,814,757**

Are any additional ICB Contributions being made in 2023-25? If yes, please detail below	No

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional NHS Contribution	**£0**	**£0**	

Total NHS Contribution	**£120,967,970**	**£127,814,757**

	2023-24	2024-25
Total BCF Pooled Budget	**£193,929,022**	**£209,632,685**

Funding Contributions Comments
Optional for any useful detail e.g. Carry over

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: Essex

<< Link to summary sheet

Running Balances	2023-24 Income	2023-24 Expenditure	2023-24 Balance	2024-25 Income	2024-25 Expenditure	2024-25 Balance
DFG	£11,885,443	£11,885,443	£0	£11,885,443	£11,885,443	£0
Minimum NHS Contribution	£120,967,970	£120,967,970	£0	£127,814,757	£127,814,757	£0
iBCF	£46,380,576	£46,380,576	£0	£46,380,576	£46,380,576	£0
Additional LA Contribution	£0	£0	£0	£0	£0	£0
Additional NHS Contribution	£0	£0	£0	£0	£0	£0
Local Authority Discharge Funding	£6,502,485	£6,502,485	£0	£10,837,475	£10,837,475	£0
ICB Discharge Funding	£8,192,548	£8,192,548		£12,714,434	£12,714,434	£0
Total	**£193,929,022**	**£193,929,022**	**£0**	**£209,632,685**	**£209,632,685**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2023-24 Minimum Required Spend	2023-24 Planned Spend	2023-24 Under Spend	2024-25 Minimum Required Spend	2024-25 Planned Spend	2024-25 Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£34,375,666	£73,374,564	£0	£36,321,329	£77,527,564	£0
Adult Social Care services spend from the minimum ICB allocations	£48,146,771	£48,244,543	£0	£50,871,878	£50,975,185	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No

>> Incomplete fields on row number(s):
36, 59, 60,
61, 62, 63,
64, 65, 66,

										Planned Expenditure						
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Expected outputs 2023-24	Expected outputs 2024-25	Units	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding
13001	HWE ICB - West POSC Integrated Stroke Pathway Social Worker	Dedicated and integrated Social Worker for Stroke Pathway	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			Local Authority	Minimum NHS Contribution
13002	HWE ICB - West Programme & Administration Costs (ECC	Administrative support to management of BCF	Enablers for Integration	Programme management					Social Care		LA			Local Authority	Minimum NHS Contribution
13003	HWE ICB - West Integrated Dementia Commissioner (ECC Contribution)	Contribution to integration resource managing pan Essex dementia programme	Enablers for Integration	Integrated models of provision					Social Care		LA			Local Authority	Minimum NHS Contribution
10001	POSC Domiciliary Reablement Main Contract	Reablement contract	Home-based intermediate care services	Reablement at home (accepting step up and step down users)		5950	5950	Packages	Social Care		LA			Local Authority	Minimum NHS Contribution
10002	POSC Live at Home Service	supporting alternatives to residential care	Home Care or Domiciliary Care	Domiciliary care packages		949254	949254	Hours of care	Social Care		LA			Local Authority	Minimum NHS Contribution
10003	Carers Breaks	Respite service for carers to reduce crisis	Carers Services	Respite services		1082	1082	Beneficiaries	Social Care		NHS			Charity / Voluntary Sector	Minimum NHS Contribution
10004	Care Act	Ensuring Care Act compliance for carers	Carers Services	Other	Direct payments	1500	1500	Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution
13004	HWE ICB - West Independent Mental Health Advocacy	Enable every qualifying patient who wants one to have access to an IMHA	Care Act Implementation Related Duties	Independent Mental Health Advocacy					Social Care		LA			Local Authority	Minimum NHS Contribution
13005	HWE ICB - West Community Services	Community provision	Community Based Schemes	Other	Community Health				Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
13006	HWE ICB - West Integrated Dementia Commissioner (CCG Contribution)	Contribution to integration resource managing pan Essex dementia programme	Enablers for Integration	Integrated models of provision					Social Care		LA			Local Authority	Minimum NHS Contribution
13007	HWE ICB - West Programme & Administration Costs (CCG	Administrative support to management of BCF	Enablers for Integration	Programme management					Other	Programme Admin	LA			Local Authority	Minimum NHS Contribution
11001	SNEE ICB - North POSC Integrated Stroke Pathway Social Worker	Dedicated and integrated Social Worker for Stroke Pathway	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			Local Authority	Minimum NHS Contribution
11002	SNEE ICB - North Programme & Administration Costs (ECC	Administrative support to management of BCF	Enablers for Integration	Programme management					Social Care		LA			Local Authority	Minimum NHS Contribution
11003	SNEE ICB - North Integrated Dementia Commissioner (ECC	Contribution to integration resource managing pan Essex dementia programme	Enablers for Integration	Integrated models of provision					Social Care		LA			Local Authority	Minimum NHS Contribution
11004	SNEE ICB - North Independent Mental Health Advocacy	Enable every qualifying patient who wants one to have access to an IMHA	Care Act Implementation Related Duties	Independent Mental Health Advocacy					Social Care		LA			Local Authority	Minimum NHS Contribution
11005	SNEE ICB - North Community Services	Community provision	Community Based Schemes	Other	Community Health				Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
11006	SNEE ICB - North Integrated Dementia Commissioner (CCG	Contribution to integration resource managing pan Essex dementia programme	Enablers for Integration	Integrated models of provision					Social Care		LA			Local Authority	Minimum NHS Contribution
11007	SNEE ICB - North Programme & Administration Costs (CCG	Administrative support to management of BCF	Enablers for Integration	Programme management					Other	Programme Admin	LA			Local Authority	Minimum NHS Contribution
12301	MSE ICB - ME POSC Integrated Stroke Pathway Social Worker	Dedicated and integrated Social Worker for Stroke Pathway	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			Local Authority	Minimum NHS Contribution
12302	MSE ICB - ME Programme & Administration Costs (ECC 50%)	Administrative support to management of BCF	Enablers for Integration	Programme management					Social Care		LA			Local Authority	Minimum NHS Contribution
12303	MSE ICB - ME Integrated Dementia Commissioner (ECC Contribution)	Contribution to integration resource managing pan Essex dementia programme	Enablers for Integration	Integrated models of provision					Social Care		LA			Local Authority	Minimum NHS Contribution
12304	MSE ICB - ME Independent Mental Health Advocacy	Enable every qualifying patient who wants one to have access to an IMHA	Care Act Implementation Related Duties	Independent Mental Health Advocacy					Social Care		LA			Local Authority	Minimum NHS Contribution
12305	MSE ICB - ME Integrated Dementia Commissioner (CCG Contribution)	Contribution to integration resource managing pan Essex dementia programme	Enablers for Integration	Integrated models of provision					Social Care		LA			Local Authority	Minimum NHS Contribution
12306	MSE ICB - ME Programme & Administration Costs (CCG Contribution)	Administrative support to management of BCF	Enablers for Integration	Programme management					Other	Programme Admin	LA			Local Authority	Minimum NHS Contribution
12307	MSE ICB - ME Community Services	Other Community provision, to assist flow and prompt discharge	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
12308	MSE ICB - ME Community Services	Intermediate Care Beds	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation accepting step up and step down users		32	32	Number of Placements	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
12309	MSE ICB - ME Community Services	UCRT Service	Urgent Community Response						Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
12310	MSE ICB - ME Community Services	Virtual Wards	Home-based intermediate care services	Rehabilitation at home (accepting step up and step down users)		60	60	Packages	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
12311	MSE ICB - ME Community Services	Dementia Support Service	Other						Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
12312	MSE ICB - ME Community Services	Farleigh Hospice at Home	Other						Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution
12313	MSE ICB - ME Community Services	Equipment Service Provision - Talley	Other						Community Health		NHS			Private Sector	Minimum NHS Contribution
12314	MSE ICB - ME CHC Admin	Enabling integration of CHC processes	Enablers for Integration	Integrated models of provision					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
12201	MSE ICB - CPR POSC Integrated Stroke Pathway Social Worker	Dedicated and integrated Social Worker for Stroke Pathway	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			Local Authority	Minimum NHS Contribution
12202	MSE ICB - CPR Programme & Administration Costs (ECC 50%)	Administrative support to management of BCF	Enablers for Integration	Programme management					Social Care		LA			Local Authority	Minimum NHS Contribution
12203	MSE ICB - CPR Integrated Dementia Commissioner (ECC Contribution)	Contribution to integration resource managing pan Essex dementia programme	Enablers for Integration	Integrated models of provision					Social Care		LA			Local Authority	Minimum NHS Contribution
12204	MSE ICB - CPR Independent Mental Health Advocacy	Enable every qualifying patient who wants one to have access to an IMHA	Care Act Implementation Related Duties	Independent Mental Health Advocacy					Social Care		LA			Local Authority	Minimum NHS Contribution

12205	MSE ICB - CPR Integrated Dementia Commissioner (CCG Contribution)	Contribution to integration resource managing pan Essex dementia programme	Enablers for Integration	Integrated models of provision					Social Care		LA			Local Authority	Minimum NHS Contribution
12206	MSE ICB - CPR Programme & Administration Costs (CCG Contribution)	Administrative support to management of BCF	Enablers for Integration	Programme management					Other	Programme Admin	LA			Local Authority	Minimum NHS Contribution
12207	MSE ICB - CPR Community Services	Other Community provision, to assist flow and prompt discharge	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
12208	MSE ICB - CPR Community Services	Intermediate Care Beds	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation accepting step up and step down users		17	17	Number of Placements	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
12209	MSE ICB - CPR Community Services	UCRT Service	Urgent Community Response						Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
12210	MSE ICB - CPR Community Services	Virtual Wards	Home-based intermediate care services	Rehabilitation at home (accepting step up and step down users)		28	28	Packages	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
12211	MSE ICB - CPR Community Services	Dementia Support Service	Other						Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
12212	MSE ICB - CPR Community Services	Equipment Service Provision - EPUT	Community Based Schemes	Other	Equipment service Provision				Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
12213	MSE ICB - CPR J Hospice	Hospice	Community Based Schemes	Integrated neighbourhood services					Other	End of Life	NHS			Charity / Voluntary Sector	Minimum NHS Contribution
12214	MSE ICB - CPR CAVS Befriending Service	Befriending	Other						Other	Befriending	NHS			Charity / Voluntary Sector	Minimum NHS Contribution
12215	MSE ICB - CPR Havens Hospice	Havens	Community Based Schemes	Integrated neighbourhood services					Other	End of Life	NHS			Charity / Voluntary Sector	Minimum NHS Contribution
12101	MSE ICB - BB POSC Integrated Stroke Pathway Social Worker	Dedicated and integrated Social Worker for Stroke Pathway	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			Local Authority	Minimum NHS Contribution
12102	MSE ICB - BB Programme & Administration Costs (ECC 50%)	Administrative support to management of BCF	Enablers for Integration	Programme management					Social Care		LA			Local Authority	Minimum NHS Contribution
12103	MSE ICB - BB Integrated Dementia Commissioner (ECC Contribution)	Contribution to integration resource managing pan Essex dementia programme	Enablers for Integration	Integrated models of provision					Social Care		LA			Local Authority	Minimum NHS Contribution
12104	MSE ICB - BB Independent Mental Health Advocacy	Enable every qualifying patient who wants one to have access to an IMHA	Care Act Implementation Related Duties	Independent Mental Health Advocacy					Social Care		LA			Local Authority	Minimum NHS Contribution
12105	MSE ICB - BB Integrated Dementia Commissioner (CCG Contribution)	Contribution to integration resource managing pan Essex dementia programme	Enablers for Integration	Integrated models of provision					Social Care		LA			Local Authority	Minimum NHS Contribution
12106	MSE ICB - BB Programme & Administration Costs (CCG Contribution)	Administrative support to management of BCF	Enablers for Integration	Programme management					Social Care		LA			Local Authority	Minimum NHS Contribution
12107	MSE ICB - BB Community Services	Other Community provision, to assist flow and prompt discharge	Community Based Schemes	Other	Community Health				Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
12108	MSE ICB - BB Community Services	Intermediate Care Beds	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation accepting step up and step down users		19	19	Number of Placements	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
12109	MSE ICB - BB Community Services	UCRT Service	Urgent Community Response						Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
12110	MSE ICB - BB Community Services	Virtual Wards	Home-based intermediate care services	Rehabilitation at home (accepting step up and step down users)		44	44	Packages	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
12111	MSE ICB - BB Community Services	St Lukes - Hospice at Home / One Response	Other						Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution
12112	MSE ICB - BB Community Services	Equipment Service Provision - Talley	Other						Community Health		NHS			Private Sector	Minimum NHS Contribution
12113	MSE ICB - BB Community Services	Dementia Support Service	Community Based Schemes	Other	Dementia Support Service				Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
20001	IBCF meeting social care needs (Care tech)	Telecare and Community based equipment - support for additional pressure in ASC	Assistive Technologies and Equipment	Assistive technologies including telecare		7073	7073	Number of beneficiaries	Social Care		LA			Local Authority	iBCF
20002	IBCF meeting social care needs (D2A team)	Hospital/ discharge to assess team Support for additional pressure in ASC system	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Local Authority	iBCF
20003	IBCF meeting social care needs (Nursing)	Short and long term Nursing Care for over 65s	Residential Placements	Nursing home		660	630	Number of beds/Placements	Social Care		LA			Local Authority	iBCF
20004	IBCF meeting social care needs (Dom Care over 85s)	Support for over 85s - Support for additional pressure in ASC system	Home Care or Domiciliary Care	Domiciliary care packages		291500	277600	Hours of care	Social Care		LA			Local Authority	iBCF
20005	IBCF Countywide Care Market Quality Initiatives	To support dedicated training for care market to improve quality	Enablers for Integration	Workforce development					Social Care		LA			Local Authority	iBCF
20006	IBCF Countywide falls prevention	Dedicated falls prevention provision	Prevention / Early Intervention	Other	Physical health/wellbeing				Social Care		LA			Local Authority	iBCF
20007	IBCF Reablement Flows	To support Reablement	Enablers for Integration	Joint commissioning infrastructure					Social Care		LA			Local Authority	iBCF
20008	IBCF Sensory	Sensory	Other						Social Care		LA			Local Authority	iBCF
20009	IBCF BB Transformation Fund	Allocation of the fund will be determined by the local partnership board and will be	Other						Social Care		LA			Local Authority	iBCF
20010	IBCF CPR Transformation Fund	Allocation of the fund will be determined by the local partnership board and will be	Other						Social Care		LA			Local Authority	iBCF
20011	IBCF ME Transformation Fund	Allocation of the fund will be determined by the local partnership board and will be	Other						Social Care		LA			Local Authority	iBCF
20012	IBCF NE Transformation Fund	Allocation of the fund will be determined by the local partnership board and will be	Other						Social Care		LA			Local Authority	iBCF
20013	IBCF WE Transformation Fund	Allocation of the fund will be determined by the local partnership board and will be	Other						Social Care		LA			Local Authority	iBCF
20014	IBCF - Winter Pressure scheme - Reablement (ARC)	Additional reablement capacity	Home-based intermediate care services	Reablement at home (accepting step up and step down users)		4080	4080	Packages	Social Care		LA			Local Authority	iBCF
20015	IBCF - Winter Pressure scheme - Investment across countywide	Allocation of the fund will be determined by the local partnership board and will be	Other						Social Care		LA			Local Authority	iBCF
40001	ECC discharge - ctywide Incentive Scheme Home Care	One-off payments to incentivise rapid commencement of ongoing	Home Care or Domiciliary Care	Domiciliary care packages		250	250	Hours of care	Social Care		LA			Private Sector	Local Authority Discharge Funding
40002	ECC discharge - ctywide Incentive Scheme Residential	One-off payments to incentivise rapid commencement of ongoing	Residential Placements	Care home		400	400	Number of beds/Placements	Social Care		LA			Private Sector	Local Authority Discharge Funding
40003	ECC discharge - Mental Health Capacity	Additional AMHP resource to focus triage of incoming demand	Workforce recruitment and retention						Mental Health		LA			Local Authority	Local Authority Discharge Funding
40004	ECC discharge - Dementa discharge support	Provide personalised support for patients and carers in planning for discharge from	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge					Social Care		LA			Charity / Voluntary Sector	Local Authority Discharge Funding
40005	ECC discharge - Bedfinder Support	Additional support to improve the visablity of market capacity and management of	High Impact Change Model for Managing Transfer of Care	Monitoring and responding to system demand and capacity					Social Care		LA			Local Authority	Local Authority Discharge Funding
40006	ECC discharge - Recovery to Home beds	Recovery to Home beds - bed capacity with wrap around support for adults requiring	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		429	941	Number of Placements	Social Care		LA			Private Sector	Local Authority Discharge Funding
40007	ECC discharge - IRN Block Beds	Block purchased capacity for short term residential care	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		110	0	Number of Placements	Social Care		LA			Private Sector	Local Authority Discharge Funding
40008	ECC discharge Cedars Block Beds	Block purchased capacity for short term residential care	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		26	0	Number of Placements	Social Care		LA			Private Sector	Local Authority Discharge Funding
40009	ECC discharge - Additional Reablement	Increasing reablement capacity throught existing contractual mechanisms	Home-based intermediate care services	Reablement at home (to support discharge)		550	280	Packages	Social Care		LA			Private Sector	Local Authority Discharge Funding
40010	ECC discharge - Local schemes TBD	Allocation of the fund will be determined by the local partnership board and will be	Other						Social Care		LA			Private Sector	Local Authority Discharge Funding
40011	ECC discharge - Future Intermediate Care model	Recommissioning of existing Intermediate Care offer with a focus on local integration	Home-based intermediate care services	Reablement at home (to support discharge)		0	420	Packages	Social Care		LA			Private Sector	Local Authority Discharge Funding

40012	ECC discharge - Bridging	Implementation of a new model to improve intermediate care response	Home Care or Domiciliary Care	Short term domiciliary care (without reablement input)		0	2610	Packages	Social Care		LA			NHS	Local Authority Discharge Funding
40013	ECC discharge - investment across countywide scheme	Countywide resource to be deployed flexibly to maxmise capacity of planned schemes	Other						Social Care		LA			Private Sector	Local Authority Discharge Funding
40014	ECC discharge - Admin & Evaluation	Administrative cost of payments reporting and implementation	Other						Other	Admin	LA			Local Authority	Local Authority Discharge Funding
30101	DFG Basildon Stairlift Grant	Stairlift grants via DFG	DFG Related Schemes	Adaptations, including statutory DFG grants		50	60	Number of adaptations funded/people	Other	DFG	LA			Local Authority	DFG
30102	DFG Basildon All other mandatory Grants	DFG	DFG Related Schemes	Adaptations, including statutory DFG grants		85	110	Number of adaptations funded/people	Other	DFG	LA			Local Authority	DFG
30103	DFG Basildon Discretionary Grant	Discretionary grant via DFG	DFG Related Schemes	Discretionary use of DFG		8	15	Number of adaptations funded/people	Other	DFG	LA			Local Authority	DFG
30201	DFG Braintree Mandatory DFG	Statutorily obligated-DFG scheme	DFG Related Schemes	Adaptations, including statutory DFG grants		140	140	Number of adaptations funded/people	Other	DFG	LA			Local Authority	DFG
30202	DFG Braintree Discretionary DFG	Top-up funding to Statutorily obligated-DFG scheme	DFG Related Schemes	Discretionary use of DFG		15	15	Number of adaptations funded/people	Other	DFG	LA			Local Authority	DFG
30203	DFG Braintree Handyman Service	Security & Safety works for over 65s or vulnerable people in private rented or owner-	DFG Related Schemes	Handyperson services		120	120	Number of adaptations funded/people	Other	DFG	LA			Local Authority	DFG
30301	DFG Brentwood Disabled Facilities Grants	Statutory DFG grants	DFG Related Schemes	Adaptations, including statutory DFG grants		35	35	Number of adaptations funded/people	Primary Care		LA			Local Authority	DFG
30401	DFG Castle Point DFG related spend	Statutory Spend	DFG Related Schemes	Adaptations, including statutory DFG grants		40	50	Number of adaptations funded/people	Other	DFG	LA			Local Authority	DFG
30402	DFG Castle Point DFG related spend	Discretionary Grants	DFG Related Schemes	Discretionary use of DFG		3	4	Number of adaptations funded/people	Other	DFG	LA			Local Authority	DFG
30501	DFG Chelmsford mandatory assistance	statutory responsibilities for delivering mandatory DFGs - (referred by OT)	DFG Related Schemes	Adaptations, including statutory DFG grants		0	0	Number of adaptations funded/people	Social Care		LA			Local Authority	DFG
30502	DFG Chelmsford Discretionary disabled facilities assistance -	adaptations for children in homes of separated parents - (where home is not main	DFG Related Schemes	Adaptations, including statutory DFG grants		0	0	Number of adaptations funded/people	Social Care		LA			Local Authority	DFG
30503	DFG Chelmsford Discretionary disabled facilities assistance -	access to grounds of a property to enable disabled person to access grounds of	DFG Related Schemes	Adaptations, including statutory DFG grants		0	0	Number of adaptations funded/people	Social Care		LA			Local Authority	DFG
30504	DFG Chelmsford Discretionary disabled facilities assistance -	improvements to help disabled person access the community (referred by OT)	DFG Related Schemes	Adaptations, including statutory DFG grants		0	0	Number of adaptations funded/people	Mental Health		LA			Local Authority	DFG
30505	DFG Chelmsford Discretionary disabled facilities assistance -	providing area for specialist treatment within the home (referred by OT)	DFG Related Schemes	Discretionary use of DFG		0	0	Number of adaptations funded/people	Social Care		LA			Local Authority	DFG
30506	DFG Chelmsford discretionary disabled facilities assistance -	adaptation at home of family member with caring responsibility where home is	DFG Related Schemes	Discretionary use of DFG		0	0	Number of adaptations funded/people	Social Care		LA			Local Authority	DFG
30507	DFG Chelmsford discretionary top-up assistance	where cost of major adaptations and alterations exceed statutury limits for	DFG Related Schemes	Discretionary use of DFG		0	0	Number of adaptations funded/people	Social Care		LA			Local Authority	DFG
30508	DFG Chelmsford discretionary top-up assistance	where individual cannot afford their assessed contribution	DFG Related Schemes	Discretionary use of DFG		0	0	Number of adaptations funded/people	Social Care		LA			Local Authority	DFG
30509	DFG Chelmsford discrectionary remaining independent assistance	urgent and interim solutions to help a vulnerable person to be discharged from hospital	DFG Related Schemes	Discretionary use of DFG		0	0	Number of adaptations funded/people	Social Care		LA			Local Authority	DFG
30510	DFG Chelmsford discrectionary remaining independent assistace	stairlifts - fast track - no means test - grant over £5,000 repayable	DFG Related Schemes	Discretionary use of DFG		0	0	Number of adaptations funded/people	Social Care		LA			Local Authority	DFG
30511	DFG Chelmsford discretionary remaining independent assistance	minor works for elderly residents no means test for residents over 75 years old -	DFG Related Schemes	Other	Choice Policy	0	0	Number of adaptations funded/people	Social Care		LA			Local Authority	DFG
30512	DFG Chelmsford home from hospital key safes	access door key safes - referred through hospital discharge team -	DFG Related Schemes	Handyperson services		0	0	Number of adaptations funded/people	Social Care		LA			Local Authority	DFG
30513	DFG Chelmsford Home from hospital / preventint readmission	Mid - essex OT	DFG Related Schemes	Other	shared funding of ECC apppointed OT	0	0	Number of adaptations funded/people	Social Care		LA			Local Authority	DFG
30601	DFG Colchester Mandatory Disabled Facilities Grant	Mandatory Disabled Facilities Grant	DFG Related Schemes	Adaptations, including statutory DFG grants		60	70	Number of adaptations funded/people	Other	DFG	LA			Local Authority	DFG
30602	DFG Colchester Fast-Track Grant	Non means tested assistance to provide a fast-track adaptations to prevent	DFG Related Schemes	Discretionary use of DFG		20	25	Number of adaptations funded/people	Continuing Care		LA			Local Authority	DFG
30603	DFG Colchester Home Repair Loan	Addressing/removing Category 1 and some Category 2 hazards as	DFG Related Schemes	Discretionary use of DFG		6	8	Number of adaptations funded/people	Community Health		LA			Local Authority	DFG
30604	DFG Colchester Disabled Facilities Assistance	Discretionary DFG to support and top-up eligible works that exceed the mandatory grant.	DFG Related Schemes	Discretionary use of DFG		6	8	Number of adaptations funded/people	Community Health		LA			Local Authority	DFG
30605	DFG Colchester Stairlift Grant	Non means tested grant for stairlift to enable access to essential areas such as	DFG Related Schemes	Discretionary use of DFG		15	25	Number of adaptations funded/people	Community Health		LA			Local Authority	DFG
30701	DFG Epping Forest Stairlift Grants	Grants for stairlifts via DFG (including fast-track discretionary stairlift DFG)	DFG Related Schemes	Discretionary use of DFG		40	50	Number of adaptations funded/people	Other	DFG	LA			Local Authority	DFG
30702	DFG Epping Forest DFG	Bathroom Adaptations, Ramps, steps, Through floor lifts, Step lifts, Kitchens,	DFG Related Schemes	Adaptations, including statutory DFG grants		90	100	Number of adaptations funded/people	Other	DFG	LA			Local Authority	DFG
30703	DFG Epping Forest DFG	Discretionary DFG and Discretionary Top Up	DFG Related Schemes	Discretionary use of DFG		2	2	Number of adaptations funded/people	Other	DFG	LA			Local Authority	DFG
30801	DFG Harlow Fast track Grants	Discretionary grants following a fast track process	DFG Related Schemes	Discretionary use of DFG		65	70	Number of adaptations funded/people	Other	DFG	LA			Private Sector	DFG
30802	DFG Harlow Small Works Grants	Discretionary grants for works < £10K (recipients on income related benefits)	DFG Related Schemes	Discretionary use of DFG		6	6	Number of adaptations funded/people	Other	DFG	LA			Private Sector	DFG
30803	DFG Harlow DFG	Mandatory grants up to £30K	DFG Related Schemes	Adaptations, including statutory DFG grants		45	48	Number of adaptations funded/people	Other	DFG	LA			Private Sector	DFG
30804	DFG Harlow Discretionary DFG	Discretionary grants for works exceeding £30K DFG	DFG Related Schemes	Discretionary use of DFG		4	6	Number of adaptations funded/people	Other	DFG	LA			Private Sector	DFG
30805	DFG Harlow OT Services	Occupational Therapy fees for overseeing grant process	DFG Related Schemes	Other	OT provision to support all Housing teams	1	1	Number of adaptations funded/people	Social Care		LA			Private Sector	DFG
30901	DFG Maldon Mandatory DFG related schemes	Provision of disabled adaptations	DFG Related Schemes	Adaptations, including statutory DFG grants		100	125	Number of adaptations funded/people	Other	DFG	LA			Local Authority	DFG
31001	DFG Rochford Statutory Spend	Mandatory DFG Schemes	DFG Related Schemes	Adaptations, including statutory DFG grants		90	90	Number of adaptations funded/people	Other	DFG	LA			Local Authority	DFG
31101	DFG Tendring DFG	Mandatory Grant	DFG Related Schemes	Adaptations, including statutory DFG grants		175	200	Number of adaptations funded/people	Other	DFG	LA			Local Authority	DFG
31102	DFG Tendring Stairlift Grant	Discretionary grant for stairlifts	DFG Related Schemes	Discretionary use of DFG		40	50	Number of adaptations funded/people	Other	DFG	LA			Local Authority	DFG
31103	DFG Tendring ERG	Disretionary Grant for home repairs to prevent hospital admissions /injury	DFG Related Schemes	Discretionary use of DFG		50	75	Number of adaptations funded/people	Other	DFG	LA			Local Authority	DFG
31104	DFG Tendring DFA	Disabled Facilties Assistance - disretionary for non-mandatory works such as	DFG Related Schemes	Discretionary use of DFG		1	1	Number of adaptations funded/people	Other	DFG	LA			Local Authority	DFG
31105	DFG Tendring DFG Top Up	Top -up assistance for owners needing extensions where moving has been tried	DFG Related Schemes	Discretionary use of DFG		1	1	Number of adaptations funded/people	Other	DFG	LA			Local Authority	DFG
31106	DFG Tendring Senior OT in Housing	Provide in house OT support	DFG Related Schemes	Other	OT provision to support all Housing teams	0	0	Number of adaptations funded/people	Other	DFG	LA			Local Authority	DFG
31107	DFG Tendring Additional Staffing	Additional support beyond mandatory for grants	DFG Related Schemes	Other	Additional support beyond mandatory	0	0	Number of adaptations funded/people	Other	DFG	LA			Local Authority	DFG
31201	DFG Uttlesford DFG	Statutory spend	DFG Related Schemes	Adaptations, including statutory DFG grants		33	35	Number of adaptations funded/people	Other	DFG	LA			Local Authority	DFG
31202	DFG Uttlesford DFG	Discretionary spend	DFG Related Schemes	Discretionary use of DFG		2	4	Number of adaptations funded/people	Other	DFG	LA			Local Authority	DFG
10005	Carers First Contract (Countywide)	the service provides information, advice and guidance for unpaid carers	Carers Services	Carer advice and support related to Care Act duties		5000	5000	Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution

51001	North ICB - Additional Community Therapy	Additional community therapy to support reablement pathway and D2A	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	ICB Discharge Funding
51002	North ICB - Voluntary Sector Discharge Support	Transport, facilitation of patient discharge from hospital and ensuring access	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess					Community Health		NHS			Charity / Voluntary Sector	ICB Discharge Funding
51003	North ICB - Increased acute Therapies to support discharge	Increased weekend cover for acute Therapies to support discharges. Increased staffing,	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		48	48	Number of Placements	Acute		NHS			NHS Acute Provider	ICB Discharge Funding
51004	North ICB - OPAT - Expansion IV in the community (Clacton) x1	OPAT - Expansion IV in the community (Clacton) & Care homes	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	ICB Discharge Funding
51005	North ICB - Additional Case Coordinators	Additional discharge coordinators for the Transfer of Care Hub (TOCH)	Integrated Care Planning and Navigation	Care navigation and planning					Acute		NHS			NHS Acute Provider	ICB Discharge Funding
51006	North ICB Flow Leads	Flow Lead for Colchester Medicine wards	Integrated Care Planning and Navigation	Care navigation and planning					Acute		NHS			NHS Acute Provider	ICB Discharge Funding
51007	North ICB - Ward Led Enablement	Increased the Ward Led Enablement offer onto a second ward. Reducing	Enablers for Integration	Workforce development					Acute		LA			Private Sector	ICB Discharge Funding
51008	North ICB - Trusted Assessors	Trusted Assesors – working within the TOCH in collaboration with partners to	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			Private Sector	ICB Discharge Funding
51009	North ICB - Home to Assess	Home to Assess Service - supporting home first principles	Home-based intermediate care services	Reablement at home (to support discharge)		60	60	Packages	Social Care		LA			Private Sector	ICB Discharge Funding
51010	North ICB - Durban Ward	Durban Ward	Other						Acute		NHS			NHS Acute Provider	ICB Discharge Funding
51011	North Additional discharge support services	Social Prescribing, light touch discharge support and signposting including ED and	Community Based Schemes	Integrated neighbourhood services					Acute		NHS			Charity / Voluntary Sector	ICB Discharge Funding
51012	North Additional Discharge Support - carers	Think carer scheme	Carers Services	Carer advice and support related to Care Act duties		0	30	Beneficiaries	Continuing Care		Joint	50.0%	50.0%	Private Sector	ICB Discharge Funding
51013	North Additional discharge support services	EoL Discharge Support Services	Integrated Care Planning and Navigation	Assessment teams/joint assessment					Acute		NHS			Charity / Voluntary Sector	ICB Discharge Funding
51014	North Additional discharge support services	Clinical Mental Health Discharge Support	Other						Mental Health		NHS			NHS Mental Health Provider	ICB Discharge Funding
51015	North ICB - UCRS Expansion	UCRS Expansion	Urgent Community Response						Community Health		NHS			NHS Acute Provider	ICB Discharge Funding
51016	North DISS	Dementia Discharge Intensive Support	Enablers for Integration	Integrated models of provision					Mental Health		NHS			NHS Mental Health Provider	ICB Discharge Funding
51017	North ICB - Discharge Support	Acute system flow and discharge services	Other						Acute		NHS			NHS Acute Provider	ICB Discharge Funding
51018	North ICB - Technology Enabled Care in the TOCH	Community Support Worker (CSW) to support the use of Care Technology within the	Enablers for Integration	Workforce development					Social Care		LA			Private Sector	ICB Discharge Funding
51019	North ICB - Reablement In Reach Service and Therapy	Upskilling and support to care home providers in enablement practices to	Enablers for Integration	Workforce development					Social Care		LA			Private Sector	ICB Discharge Funding
52001	MSE ICB - Discharge Spend - Ward Based Enablement	Ward Based Enablement	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with reablement (to support discharge)		777	777	Number of Placements	Social Care		NHS			Local Authority	ICB Discharge Funding
52002	MSE ICB - Discharge Spend - Acute Discharge Schemes	Acute Discharge Schemes	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Acute		NHS			NHS Acute Provider	ICB Discharge Funding
52003	MSE ICB - Discharge Spend - Transport	Transport	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess					Community Health		NHS			Private Sector	ICB Discharge Funding
52004	MSE ICB - Discharge Spend - Welfare Support	Welfare Support	Community Based Schemes	Low level support for simple hospital discharges (Discharge to Assess					Community Health		NHS			NHS Community Provider	ICB Discharge Funding
53001	West - D2A Wrap around service	D2A Wrap Around Team to support patients being discharged under the D2A	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Community Health		NHS			NHS Community Provider	ICB Discharge Funding
53002	West - Ward led Enablement	(ECL) in partnership with PAH and ECC on the Ward Enablement programme with	High Impact Change Model for Managing Transfer of Care	Other	ECL in acute hospital setting				Acute		LA			Local Authority	ICB Discharge Funding
53003	West - Tranfer of Care Hub support	4 x TOC CSW roles to suport discharge, based in CCC. Picking up TOC functions	Community Based Schemes	Multidisciplinary teams that are supporting independence, such as					Other	Community, Social care, mental health	Joint	50.0%	50.0%	Local Authority	ICB Discharge Funding
53004	West - Assistive Tech	Assistive technology role within CCC	Assistive Technologies and Equipment	Assistive technologies including telecare		0	0	Number of beneficiaries	Social Care		LA			Local Authority	ICB Discharge Funding
53005	West - Discharge Project Support	Recruitment to schemes supporting the end to end discharge pathway	Workforce recruitment and retention						Other	Community, social care, Primary Care,	Joint	50.0%	50.0%	Local Authority	ICB Discharge Funding
53006	West - Integated Discharge Model	Intergrated Discharge Model - disharge support including support for care homes of 1:1	Integrated Care Planning and Navigation	Care navigation and planning					Other	Community, social care, Primary Care,	Joint	50.0%	50.0%	NHS Community Provider	ICB Discharge Funding
53007	West - Ticket Home	Voluntary sector support based in PAH. Supporting PW0 and PW1 discharges.	Other						Acute		NHS			Charity / Voluntary Sector	ICB Discharge Funding

Further guidance for completing Expenditure sheet

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.

12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care and Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed Based Intermediate Care Services	Number of placements
Home Based Intermeditate Care Services	Packages
Residential Placements	Number of beds/placements
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: Essex

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	173.1	154.9	165.7	190.0	This is an annual figure and there is no national target. However, based on the data available, the rate for 2022/23 was 660 per 100,000, meaning that if performance is maintained we should maintain this figure.	Improved joint working focused on prevention and home first discharge processes.
	Number of Admissions	3,041	2,720	2,911	-		
	Population	1,489,189	1,489,189	1,489,189	1,489,189		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Indicator value	175	161	168	196		

>> link to NHS Digital webpage (for more detailed guidance)

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	2,062.7	1,710.4	2,000.0	Data for 2021/22 shows that the rate in Essex was 2,063 per 100,000 population, marginally below the national rate of 2,100. The proposed target in Essex for 2023/24 is	The Independent Living programme is one strand of ECC's work to provide the right housing, at the right time, with the right care and support and is an example of a funded scheme to address Falls. Also known as Extra Care, Independent Living provides specialist accommodation for older adults and adults with disabilities
	Count	6,635	5492	6776		
	Population	311,792	311792	324286		

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	Quarter (%)	92.8%	93.8%	93.4%	92.8%	Historically, Essex has performed well on this metric, with a pre-pandemic average of 93.8% of patients discharged to their usual place of residence. The proposed target in Essex for 2023/24 is 94% of people being discharged into their usual	HomeFirst remains a key focus across the five acute systems within Essex, which continues to be monitored through our Discharge Outcomes Steering Group, that has representation from Health and Social Care. The Connect Programme has
	Numerator	27,833	28,922	28,439	27,017		
	Denominator	29,978	30,832	30,439	29,113		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		

(SUS data - available on the Better Care Exchange)	Quarter (%)	93.1%	93.4%	93.7%	94.0%	place of residence. Since January 2021,	delivered several new ways of working
	Numerator	27,930	28,020	28,110	28,200	Essex has seen higher proportions of	within our health & care system. Through
	Denominator	30,000	30,000	30,000	30,000	patients discharged to their usual	our Volumes and Effectiveness work we

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	368.2	430.0	363.9	350.0	In 2022/23 there were 1,163 older Essex residents admitted to permanent residential or nursing care, corresponding to a rate of 364 per 100,000 residents aged 65 and older. This exceeded the target of 430 per 100,000 residents. The proposed	Over the next year we will continue delivery of a significant programme of work to transform our intermediate care provision across the county bringing together reablement services, bridging services, short-term care home provision,
	Numerator	1,141	1,374	1,163	1,135		
	Denominator	309,912	319,571	319,571	324,286		

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	85.6%	87.0%	86.1%	89.0%	The proposed target in Essex for 2023/24 is for at least 89% of the people who have received reablement services to remain out of hospital for 91 days following completion of reablement. This metric will not be measured nationally in 2023/24, but	Each year we are supporting more than 11.6 thousand people through our reablement and bridging services, keeping them out of residential care where it is not needed and reducing their need for ongoing care. The BCF and iBCF is utilised
	Numerator	1,258	1,295	1,715	1,780		
	Denominator	1,470	1,488	1,993	2,000		

Please note that due to the demerging of Cumbria information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- Actuals and plans for Cumberland and Westmorland and Furness are using the Cumbria combined figure for all metrics since a split was not available; Please use comments box to advise.
- 2022-23 and 2023-24 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2021-22 estimates.

	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between all partners from ICB(s) in accordance with ICB governance rules, and the LA; been submitted? *Paragraph 11* Has the HWB approved the plan/delegated approval? *Paragraph 11* Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? *Paragraph 11* Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned? Have all elements of the Planning template been completed? *Paragraph 12*	Expenditure plan Expenditure plan Narrative plan Validation of submitted plans Expenditure plan, narrative plan
	PR2	**A clear narrative for the integration of health, social care and housing**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integration of health, social care and housing services including DFG to support further improvement of outcomes for people with care and support needs *Paragraph 13* • The approach to joint commissioning *Paragraph 13* • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered *Paragraph 14* - Changes to local priorities related to health inequality and equality and how activities in the document will address these. *Paragraph 14* The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5. *Paragraph 15*	Narrative plan
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? *Paragraph 33* • Does the narrative set out a strategic approach to using housing support, including DFG funding that supports independence at home? *Paragraph 33* • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils? *Paragraph 34*	Expenditure plan Narrative plan Expenditure plan

NC2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	**PR4**	**A demonstration of how the services the area commissions will support people to remain independent for longer, and where possible support them to remain in their own home**	Does the plan include an approach to support improvement against BCF objective 1? *Paragraph 16* Does the expenditure plan detail how expenditure from BCF sources supports prevention and improvement against this objective? *Paragraph 19* Does the narrative plan provide an overview of how overall spend supports improvement against this objective? *Paragraph 19* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objctive and has the narrative plan incorporated learnings from this exercise? *Paragraph 66*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan
Additional discharge funding	**PR5**	**An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes.**	Have all partners agreed on how all of the additional discharge funding will be allocated to achieve the greatest impact in terms of reducing delayed discharges? *Paragraph 41* Does the plan indicate how the area has used the discharge funding, particularly in the relation to National Condition 3 (see below), and in conjunction with wider funding to build additional social care and community-based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvement for patients? *Paragraph 41* Does the plan take account of the area's capacity and demand work to identify likely variation in levels of demand over the course of the year and build the workforce capacity needed for additional services? *Paragraph 44* Has the area been identified as an area of concern in relation to discharge performance, relating to the 'Delivery plan for recovering urgent and emergency services'? If so, have their plans adhered to the additional conditions placed on them relating to performance improvement? *Paragraph 51* Is the plan for spending the additonal discharge grant in line with grant conditions?	Expenditure plan Narrative and Expenditure plans Narrative plan Narrative and Expenditure plans
NC3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	**PR6**	**A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time**	Does the plan include an approach to how services the area commissions will support people to receive the right care in the right place at the right time? *Paragraph 21* Does the expenditure plan detail how expenditure from BCF sources supports improvement against this objective? *Paragraph 22* Does the narrative plan provide an overview of how overall spend supports improvement against this metric and how estimates of capacity and demand have been taken on board (including gaps) and reflected in the wider BCF plans? *Paragraph 24* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objective and has the narrative plan incorporated learnings from this exercise? *Paragraph 66* Has the area reviewed their assessment of progress against the High Impact Change Model for Managing Transfers of care and summarised progress against areas for improvement identified in 2022-23? *Paragraph 23*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan Expenditure plan Narrative plan
NC4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	**PR7**	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift to the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution? *Paragraphs 52-55*	Auto-validated on the expenditure plan

Agreed expenditure plan for all elements of the BCF	**PR8**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	Do expenditure plans for each element of the BCF pool match the funding inputs? *Paragraph 12* Has the area included estimated amounts of activity that will be delivered, funded through BCF funded schemes, and outlined the metrics that these schemes support? *Paragraph 12* Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend? *Paragraph 73* Is there confirmation that the use of grant funding is in line with the relevant grant conditions? *Paragraphs 25 – 51* Has an agreed amount from the ICB allocation(s) of discharge funding been agreed and entered into the income sheet? *Paragraph 41* Has the area included a description of how they will work with services and use BCF funding to support unpaid carers? *Paragraph 13* Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement? *Paragraph 12*	Auto-validated in the expenditure plan Expenditure plan Expenditure plan Expenditure plan Expenditure plan Narrative plans, expenditure plan Expenditure plan
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Have stretching ambitions been agreed locally for all BCF metrics based on: - current performance (from locally derived and published data) - local priorities, expected demand and capacity - planned (particularly BCF funded) services and changes to locally delivered services based on performance to date? *Paragraph 59* Is there a clear narrative for each metric setting out: - supporting rationales for the ambition set, - plans for achieving these ambitions, and - how BCF funded services will support this? *Paragraph 57*	Expenditure plan Expenditure plan

Agenda Items 6 and 7

Mental Health and Suicide Prevention

At the July Health and Wellbeing Board we have two items which are clearly related and which will be taken consecutively.

The Board is asked to formally endorse the Southend, Essex and Thurrock Mental Health Strategy. In so doing, we will be particularly interested to hear from members and partners:

a) What they believe the highest priorities to be;
b) Their view as to the greatest obstacles and challenges;
c) How we can better evolve governance and collaborative working to optimise implementation.

There will also be the first discussion on the latest report providing information on suicide rates across Essex in 2022. The accompanying paper updates us on work underway and particularly highlights the need to amend our focus and to operationalise. Together they will provoke questions in the minds of members which we believe need to be aired as soon as possible.

There will clearly be more thought and discussion, in this item in particular, than can be accommodated in the available time, so we intend to come back to the topics of mental health and suicide at the next meeting in September. The Board's discussion this time will guide us as to how best we utilise the time available at the next meeting.

Agenda Item 6
HWB/14/23

Report title: Southend Essex and Thurrock Mental Health Strategy	
Report to: Essex Health and Wellbeing Strategy	
Report author: Moira McGrath Director of Commissioning	
Date: 19 July 2023	**For:** Discussion
Enquiries to: Nick Presmeg, Executive Director for Adult Social Care	
County Divisions affected: All Essex	

1. Purpose of the report

To provide an update the to the Essex Health and Wellbeing Board on development of the Southend Essex and Thurrock Mental Health Strategy 2023-2028 which is currently undergoing formal governance processes with statutory partners, and to seek endorsement from the Health and Wellbeing Board subject to formal governance signoff by the individual statutory partners

2. Links to Health and Wellbeing Board Priorities

2.1 When people suffer poor mental health, it is essential that Essex County Council and our partner organisations are able to help ensure they have the support and guidance they need.

2.2 To make sure this happens, Essex County council, along with our partners at Southend City Council, Thurrock Council and the ICB's, have developed an All-Age Mental Health Strategy, which, through our partnership, will cover the entire Greater Essex area.

2.3 It identifies, and provides a response to, the key issues and challenges for those with mental ill health and is closely aligned with existing national guidelines and the strategies of our three local Integrated Care Partnerships (ICPs).

2.4 The draft strategy is currently undergoing review and sign off by individual organisations involved in the development of the strategy and seeking their approval for the establishment of a Strategy Implementation Group to support and co-ordinate collaborative working across partners to implement the strategy.

3 Recommendations

3.1 That the board endorses the draft strategy at appendix 1 subject to formal sign off and adoption by individual partner organisations including Essex County

Council, Southend City Council, Thurrock Council and the three NHS Integrated Care Boards covering the Greater Essex Footprint.

3.2 That the board discuss and agree what the short-term issues and challenges are in achieving the overarching outcomes and where their organisations may be able to contribute to achieving success.

4 Background and Proposal

4.1 Services for people with mental health problems are provided by local authorities, as part of public health and social care functions as well as by the NHS. Essex County Council (the Council) have worked with partners across Southend, Essex, and Thurrock (SET) to:

- Understand our population's needs around mental health informed by the Essex Joint Strategic Needs Assessment (JSNA), national and local data and extensive engagement with local professionals, partners and service users.
- Respond to the identified needs within the context of national policy and local ICP strategies through developing a revised 'all age' strategy building on the 2017 version
- Explore options for working together to support implementation of the strategy
- Develop supporting enabler and implementation plans provides supported accommodation for people with mental health needs.

4.2 The core partners have included:

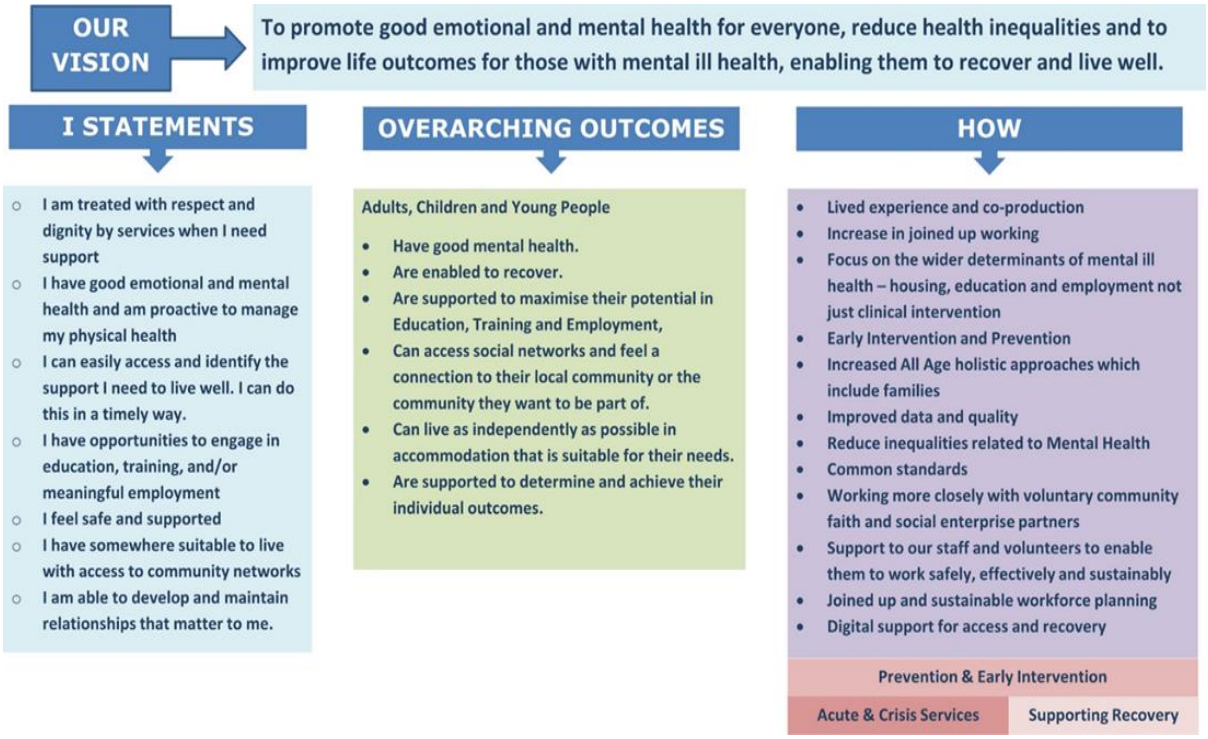
- Suffolk and North East Essex ICB
- Hertfordshire and West Essex ICB
- Mid and South Essex ICB (MSE)
- Southend on Sea City Council (SCC)
- Essex County Council (ECC)
- Thurrock Council (TC)
- Essex Partnership University NHS Foundation Trust (EPUT) – provider of adult services.
- North East London NHS Foundation Trust (NELFT) – provider of children and young people's services.

In addition, Essex Police (EP) have been engaged and are keen to be part of the arrangements established. A range of voluntary, community, faith, and social enterprise (VCFSE) sector organisations have also been engaged in developing the strategy and will continue to be key partners in the next phase of implementation.

4.3 The strategy has been developed based on the population health needs analysis and building on previous work. It aims to co-ordinate the approach across the Southend Essex and Thurrock aligned with the local strategies produced by the three Integrated Care Boards, covering Mid and South Essex, North East Essex

(part of the Suffolk and NEE ICS) and West Essex (part of the Hertfordshire and West Essex ICS). The three NHS Long Term Plans are a framework which set out a list of NHS England priories, predominately for NHS providers, across a range of themes such as crisis and community provision.

4.4 The strategy is deliberately brief and lays out the 'all age' vision and principles we will work to and the outcomes to be achieved over the next five years, guided by a set of I-Statements. It is shown in summary form below.



Implementation

4.5 A significant challenge of the previous 2017 Strategy was not its content - much is still relevant - but its implementation. The complexity of the local socio-political geography and changing NHS landscape made a joined-up approach challenging. In recognition of the complexity the three local Integrated Care Systems have previously commissioned a Mental Health Taskforce Review. This review process has helped to develop a more joined up approach across the three ICBs, which provides a good platform for further collaborative working across partners.

4.6 System partners have therefore been determined to develop effective mechanisms for ensuring implementation of the strategy whilst recognising most of the delivery will continue to be at local Place level with ICBs, Local authorities, providers, voluntary, community, faith and social enterprises and other partners working together with people with lived experience, typically in local Alliances.

4.7 ECC Cabinet is asked to agree that the Council will take part in a proposed 'Southend, Essex and Thurrock All-Age MH Strategy Implementation Group' (SIG) focussed on overseeing a limited range of key strategic issues around overall strategy delivery and SET system development with partners sharing leadership of individual workstreams as appropriate. It will build on the existing informal working arrangements established for oversight of the strategy development itself.

4.8 The scope of the strategy Implementation Group would be to have oversight and monitoring of the overall SET All Age mental Health Strategy, including the delivery of SET level outcomes for specialist services (Eating Disorders, peri-natal, Personality disorder and inpatient and community bed based care), and oversee the development of local strategy delivery plans which wider stakeholders such as the district, city and borough councils and local voluntary sector will be involved in. The membership will include senior representatives from the core partners listed in 3.2, Essex Police, Healthwatch and people with lived experience.

4.9 There has been no public consultation on the draft strategy.

5 Next steps

5.1 Subject to sign off by all Partners:

- The Southend, Essex and Thurrock All-Age MH Strategy will be published and shared with the public and partners.
- The Southend, Essex and Thurrock All-Age MH Strategy Implementation Group' will be formally established and will develop a work programme and supporting working arrangements.
- Regular 6 monthly reports on strategy Implementation progress will be produced by Strategy Implementation Group for each partner.

6 Issues for Consideration

6.1 Equality and Diversity Considerations

6.1.1 The Public Sector Equality Duty applies to the Council when it makes decisions. The duty requires us to have regard to the need to:

(a) Eliminate unlawful discrimination, harassment and victimisation and other behaviour prohibited by the Act. In summary, the Act makes discrimination etc. on the grounds of a protected characteristic unlawful

(b) Advance equality of opportunity between people who share a protected characteristic and those who do not.

(c) Foster good relations between people who share a protected characteristic and those who do not including tackling prejudice and promoting understanding.

6.1.2 The protected characteristics are age, disability, gender reassignment, pregnancy and maternity, marriage and civil partnership, race, religion or belief, gender, and sexual orientation. The Act states that 'marriage and civil partnership' is not a relevant protected characteristic for (b) or (c) although it is relevant for (a).

6.1.3 The equality impact assessment indicates that the proposals in this report will not have a disproportionately adverse impact on any people with a particular characteristic.

6 List of Appendices

Draft Strategy

Southend Essex and Thurrock Mental Heal

Equalities Comprehensive Impact Assessment

ECIA509072287 - Completed ECIA - Sou

7 List of Background Papers

None

Southend Essex and Thurrock

Mental Health Strategy

Contents

Introduction

Health and care leaders across Southend, Essex, and Thurrock (SET) are working to further improve the lives of those who live with mental ill health. This brief and practical all-age strategy sets out the vision and principles we will work to and the outcomes to be achieved over the next five years.

Our vision is to promote good emotional and mental health for everyone, reduce health inequalities and to improve life outcomes for those with mental ill health, enabling them to recover and live well.

This strategy builds on previous work and aligns with the local strategies produced by the three Integrated Care Partnerships[1], covering:

- Mid and South Essex
- North East Essex (part of the Suffolk and NEE ICS[2])
- West Essex (part of the Hertfordshire and West Essex ICS).

Southend, Essex, and Thurrock System Partners

Organisations from across a complex geography are working together in partnership and are committed to ongoing learning as part of the delivery of the strategy:

- North East Essex (NEE)
- West Essex (WE)
- Mid and South Essex ICS (MSE)
- Southend City Council (SCC)
- Essex County Council (ECC)
- Thurrock Council (TC)
- Essex Police (EP)
- Essex Partnership University NHS Foundation Trust (EPUT) – provider of adult services
- North East London NHS Foundation Trust (NELFT) – provider of children and young people's services

People who use mental health services, families, and carers with lived experience, and Voluntary, Community, and Social Enterprise (VCSE) sector organisations have also been engaged in developing the strategy and will continue to be key partners in delivering it.

Appendix 1 contains further detail of each of the individual geographies covering the Place based partnerships.

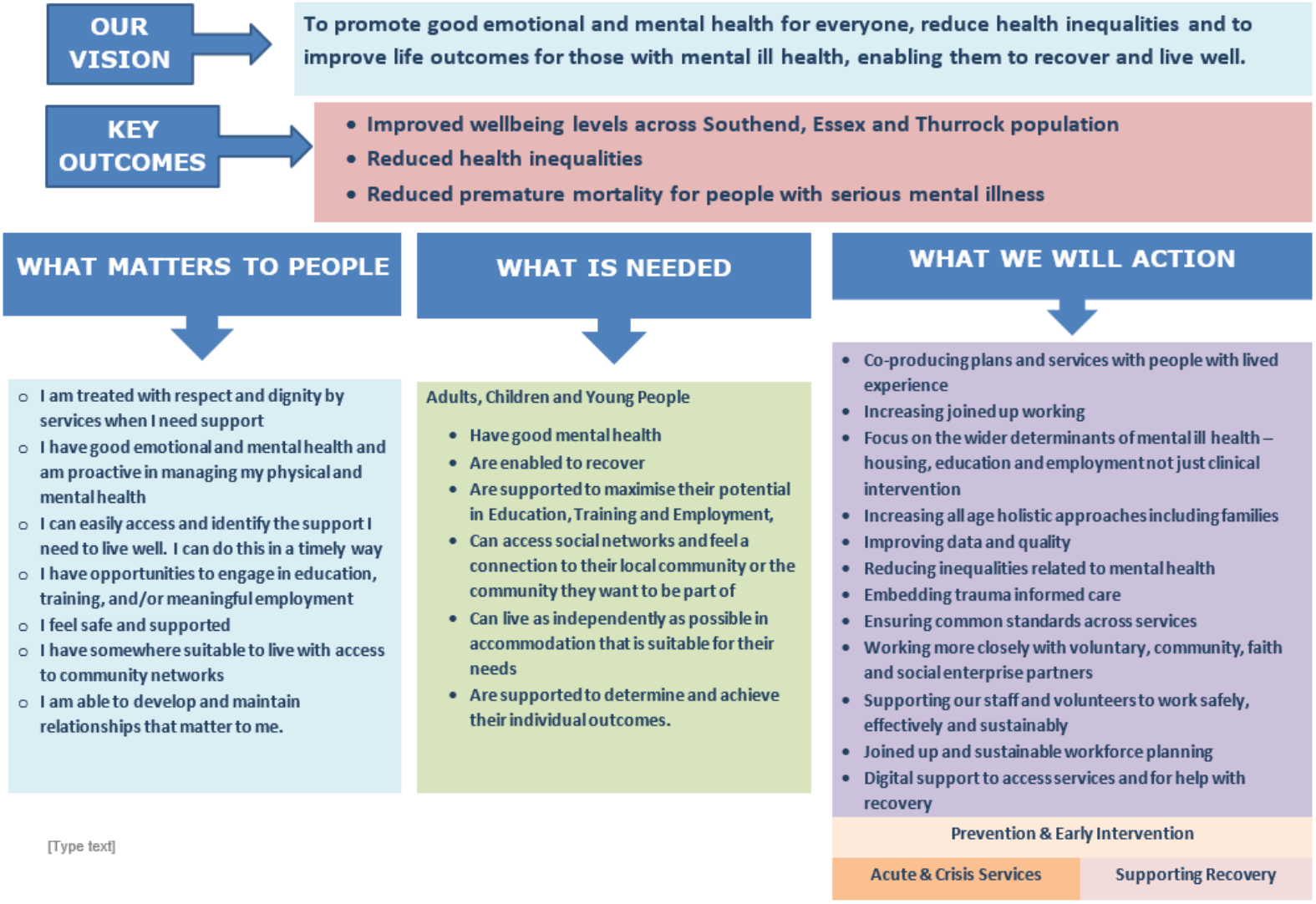
The vision and deliverables of this strategy

We have a clear vision for this strategy, and from working with groups of people with lived experience of mental ill health we have co-produced a list of ''What Matters to People' which informs the outcomes to be delivered through the strategy.

[1] Integrated Care Partnerships (ICP) are a statutory committee jointly formed between the NHS Integrated Care Board (ICB) and all upper tier local authorities that fall within the Integrated Care Systems (ICS) area.

[2] Integrated Care Systems (ICS) are partnerships of organisations that come together to plan and deliver joined up health and care services to improve the lives of people who live and work in the area.

Southend, Essex, and Thurrock Mental Health Strategy on a Page 2023-28



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PRIORITIES FOR THIS STRATEGY – Adults

Prevention & Early intervention

- Provide information and support on wellbeing and managing risks to mental health to help people to maintain good mental and physical health. This could be from non-clinical voluntary services as well as formal services.
- Ensure people have access to local community-based support for their mental health throughout their lives. This should include integrated therapies, especially for people who have complex needs and/ or are particularly vulnerable.
- Ensure people with severe mental illness receive a full annual health check and follow-up interventions
- Improve access to adult eating disorder services
- Increase access to specialist perinatal mental health care for all new and expectant mothers
- Review mental health support for older people recognising the need to support carers, and the impact of social isolation and loneliness
- Improve coordination of support for people through key life transitions especially for 18-25 year olds.
- Embed a 'think family' approach to consider and support the needs of a whole family around a person

Acute and Crisis Services

- Improve pathways and access to community-based support during a mental health crisis to avoid escalation and/ or inpatient admission.
- Ensure prompt access to good quality first response care in an emergency that includes mental health assessment and support
- Improve safety of mental health inpatient environments
- Reduce hospital admissions for mental health conditions, including emergency admissions for self-harm, through improved community support
- Reduce time spent in inappropriate out of area placements by adults needing non-specialist mental health inpatient care

Supporting recovery

- Improve access to effective Talking Therapies for everyone who needs support
- Improve access to integrated, holistic and recovery-focused mental health support for adults with severe mental illness
- Develop supported accommodation in the community to support timely discharge from hospital settings
- Improve and embed integrated pathways to access housing, education, employment, self directed support and skills, particularly for people severe mental illness
- Work with local employers and partners to develop suitable opportunities and roles for people with severe mental illness

Priorities for this Strategy – Children and Young People

Prevention & Early intervention

- Improve access to wellbeing advice and support in communities and schools
- Improve access to FREED (first episode rapid early intervention for eating disorders) and for ARFID (Avoidant restrictive food intake disorder)
- Improve access to trauma informed services through communities or schools
- Improve access to infant mental health services
- Increase access to CAMHS (Children and Adolescent Mental Health Services).
- Increase access to health and justice mental health provision
- Increase provision of mental health in schools teams across Essex
- Continue expansion of non-clinical services to support prevention and a wider determinant of health approach to children, young people, and their families/carers
- Embed a 'think family' approach to consider and support the needs of a whole family around a child
- Develop digital support for children and young people's mental health
- Develop mental health workers in primary care

Acute and Crisis Services

- Improve access to intensive support in the community
- Improve access to the crisis team from hospital or home
- Ensure 24/7 access to crisis care and support and continue to develop these services
- Reduce hospital admissions, especially for those with mental health and learning disabilities/autism
- Reduce length of stays (where appropriate) for inpatients
- Integrate mental health services for children and young people with acute trusts
- Reduce hospital admissions for self-harm by rolling out the self-harm tool kit to schools and other settings
- Expand of the community mental health and CYP learning disability and neurodevelopment team
- Mobilise at risk mental health state (ARMS) teams

Supporting recovery

- Increase access and choice of support and treatment options for young people
- Increase pathways to support the Young Adults 18-25 Transition
- Increase 'step down' services from more intensive to less intensive support
- Improve access to home feeding support teams for eating disorders
- Improve integrated pathways to access education, training, and employment
- Increase access to digital support
- Increase non-clinical support for recovery programmes
- Support children to stay with their families whilst receiving services so that less children with mental health needs entering the care system

How we have developed this strategy

To develop the strategy, we commissioned external consultants (Tricordant) who worked with a steering group of system leaders. Tricordant interviewed the leaders and held two system-wide workshops to obtain a clear sense of direction for the strategy.

Conversations were held with over 100 individuals, groups or organisations representing those with lived experience. This included Mind and Healthwatch, as well as smaller and more locally based organisations such as Trustlinks and Southend Association of Voluntary Services (SAVS) through to very specific groups such as those representing Bangladeshi women and African men.

The Tricordant team included experts by experience. A consultant psychiatrist and an executive mental health nurse carried out research into the specific population needs by working with public health colleagues and local clinicians and professionals and by using data from the local Mental Health Joint Strategic Needs Assessment (JSNA) and key national and local data sources.

Why do we need this strategy?

Societal and Economic cost of mental illness

Poor mental health has a huge impact on the overall health and wellbeing of people and is increasing. Suicide is the leading cause of death for men under 50 with 75% of all suicides being men[3]. Suicide in women aged 24 or under in 2021 saw the largest increase since ONS began recording them in 1981[4]. Depression is now the third most common cause of disability[5]. 1 in 4 people will have mental health challenges at some point in their lives[6].

Poor mental health can impact on schooling and educational attainment, ability to work and stay in work, quality of relationships and experiences of ageing. Half of mental ill health starts by age 15 and 75% develops by age 18[7].

The economic cost of mental ill health is estimated to be approximately £100 billion for the UK [8] which suggests it is around £3.2 billion for Southend, Essex, and Thurrock. 72% of the economic cost is considered to be from lost productivity due to absence from work. The 15-49 age group accounts for 56% of the economic cost and the 50-69 group at 27%. Within Southend, Essex, and Thurrock approximately £400

[3] NHSE Tackling the root cause of suicide https://www.england.nhs.uk/blog/tackling-the-root-causes-of-suicide/
[4] https://mentalhealthinnovations.org/news-and-information/latest-news/ons-report-shows-alarming-rise-in-suicide-rates-among-young-women.
[5] https://www.who.int/news-room/fact-sheets/detail/depression
[6] https://www.mind.org.uk/information-support/types-of-mental-health-problems/statistics-and-facts-about-mental-health/how-common-are-mental-health-problems/
[7] https://mhfaengland.org/mhfa-centre/research-and-evaluation/mental-health-statistics/
[8] https://www.lse.ac.uk/News/Latest-news-from-LSE/2022/c-Mar-22/

million is spent each year by the NHS, Local Authorities, and Police on emotional wellbeing and mental health.

Population needs

Our engagement and research has identified the following key challenges for Southend, Essex, and Thurrock.[9] ICP strategies include more detailed information for their local populations. Many of these facts are not unique to this area and impact much of the UK.

- **Large and growing demand**
  - The number of adults with common (mild and moderate) mental health problems in the population is approximately 1 in 6
  - 1 in 6 children and young people (CYP) also have mental health problems, an increase from 1 in 9 only 5 years ago[10]
  - There is a smaller, but growing, number of people with severe mental ill health causing significant ongoing impact on their daily lives
  - Current services, particularly for adults, do not appear to match population needs and current or predicted demand
  - There has been a significant deterioration in mental health and wellbeing through Covid 19 and the impact is anticipated to be ongoing
  - Mental health services are experiencing unprecedented demand with a 76% increase in new referrals in February 2022 compared to the same month in 2020, which led to approximately 5% more total mental health contacts in that same period. Children and young people contacts increased by 16% during the same period
  - Mental ill health has a strong correlation with deprivation and the cost-of-living pressure is expected to add to challenges for those living in deprivation and increase the number who will suffer anxiety and depression.
  - The older population in Southend, Essex and Thurrock is expected to increase by 32,000 people by 2027. National data indicates that 1 in 4 are likely to be affected by depression and only an estimated 15% will receive NHS help[11]
- **Demand presents across the whole system,** not just specialist mental health providers. It significantly impacts Primary Care, A&E departments, and the Police amongst others

[9] Unless stated data is drawn from the accompanying document 'Mental Health– Population Health Needs in Southend, Essex and Thurrock' or from https://mhfaengland.org/mhfa-centre/research-and-evaluation/mental-health-statistics/.

[10] https://www.youngminds.org.uk/about-us/media-centre/mental-health-statistics

[11] https://www.mentalhealth.org.uk/explore-mental-health/mental-health-statistics/older-people-statistics

- It is estimated nationally that 40% of GP appointments are for mental health related issues
- 15-25% of all incidents Essex Police responds to involve mental health[12]

- **Physical and mental health challenges** are often linked with both experienced by many people
- **Complexity through multiple conditions is common** among individuals with mental illness including links with learning disabilities, substance misuse, offending and social exclusion
- **Certain groups are disproportionately affected** by mental health issues as these can be made more complex by the interaction of different categories of social identity. For example, people from different genders or ethnic groups, LGBTQ+ people, travellers, young adults, older people, and people living in poverty, may receive **inequitable service provision and care.** This can be perpetuated by the inaccessibility of services e.g., for people with low levels of literacy or where English is not the first language or for other cultural reasons
  - Many people find it difficult to access mental health services via their GP
- **Inequality and service variation**
  - The prevalence of common mental health problems varies across Southend, Essex, and Thurrock
  - There is also significant variation in premature mortality in people with severe mental illness
  - Provision varies across areas even when levels of deprivation and resources are accounted for
  - Many people with mental health needs from London Boroughs are placed in Southend, which increases demand.
- Between a quarter to a half of adult mental illness may be **preventable with appropriate interventions in childhood and adolescence**
- Only half of adults in contact with specialist mental health services are in stable and **appropriate accommodation**.
- People in contact with specialist mental health services have a 73% lower **employment** rate than the general population. T

Across Southend, Essex, and Thurrock there are significant local mental health challenges, for example[13]:

- Southend has high rates of common and severe mental health
- Tendring has challenges around mental and behavioural disorders, admissions for self-harm, and suicide
- Thurrock has increasing numbers of children with social, emotional, and mental health needs, and high

[12] Mental Ill Health Problem Profile 2022, Essex Police

[13] Based on various sources quoted in the Joint Strategic Needs Analysis

premature mortality for people with severe mental illness

Taking these community needs into consideration is key. This strategy aims to ensure that need drives provision and provision meets need. We want to have the right provision in the right place for every citizen across Southend, Essex, and Thurrock who requires support and care for their mental health.

National Policy Drivers

In implementing this strategy, we will ensure we meet the specific requirements of relevant national strategies whilst delivering the needs of the local population.

The government Department of Health and Social Care are due to publish a Major Conditions Strategy during 2023. This strategy will tackle the conditions that contribute most to the burden of disease in England, including mental ill health, and the increasing number of people living with multiple conditions. This joined-up strategy will ensure that mental ill health is considered alongside physical health conditions. A separate national suicide prevention strategy will also be produced during 2023.

Several other national initiatives are under way such as:

- reform of the Mental Health Act
- reform of Care Programme Approach (CPA), a package of care for people with mental health problems
- Adult Social Care reform, including charging reform
- refresh of the Triangle of Care, a best practice guide that includes and recognises carers as partners in care
- Levelling Up, the government agenda to improve opportunities for everyone across the UK

All of these initiatives will help contribute to the success of this strategy.

Views from Lived Experience

To develop this strategy, we have listened to individuals and groups with lived experience. We have heard some consistent key themes about what people want:

Availability of services

- More clarity and consistency regarding referral pathways to avoid re-referrals or people falling through the gaps
- Shorter waiting lists, especially for children and young people
- Increased provision of personality disorder services
- More resources directed to early intervention and prevention services
- Improved access to primary care services, including in-person GP appointments

Person centred care

- Less need for people to repeat their stories

- More continuity of care and improved communication, especially for those on waiting lists
- Better care coordination and sharing of information, particularly across organisational boundaries and fragmented services
- More choice regarding therapy and treatments, for example where people would prefer to be referred to voluntary, community, and social enterprise providers (VCSE)
- Better listening to understand and tailor care to meet individual need
- Greater engagement with families and carers as partners in care.

Inequalities and inequities

- More accessible and inclusive services that can meet a range of needs
- Less stigma around mental illness across health, care, and public services
- A more consistent base level-standard to reduce disparities between services across Southend, Essex, and Thurrock.
- Greater engagement with people from ethnic and minority communities
- More meaningful involvement and co-production opportunities to strengthen the voice of lived experience
- Better support for transitions of care, particularly between young people and adult services, and inpatient and community services.

Stories of improvement

Whilst we heard many concerns from those with lived experience we did also hear about good experiences, services, and initiatives that we can continue to build on. A few examples of these are:

- Social prescribing link workers in Southend and the Friends for Lives suicide intervention and prevention service
- The children and young people mental health support team in schools in West Essex and the partnership with EPUT to provide seven mental health coaches integrated with Primary Care Networks (PCNs)
- Projects such as the Trust Links Growing Together project, the Colchester based Bangladeshi Women's Association and the Crisis Café in North East Essex, which all provide additional mental health support including out of hours
- Initiatives by Mind in Mid and South East Essex, such as 'Somewhere to Turn' and their supported housing solutions that give people greater independence
- Integrated PCN mental health teams in Thurrock that have multidisciplinary working and psychiatrists running

clinics within surgeries. They are also changing their use of language, such as using the term ‘transfers’ instead of ‘discharge’ to reduce people’s fear of losing a service.

Moving forward from previous strategy

Many aspects of the previous 2017-21 SET mental health strategy are still relevant, and implementation continues. Despite some of the great work that has happened across the system during challenging times, many people's interactions with, or ability to access health and care services can still be difficult. Many people report that they are not seeing benefits from the changes and investment in services.

Whilst recognising the difficulties of the previous few years it is important to also acknowledge the areas of success. Examples include:

- An enhanced emotional wellbeing offer for children and young people
- New adult urgent care pathways including mental health facilities at emergency departments
- An improved community offer for adults, including support to primary care
- Enhanced community support for people with personality disorders
- Extended employment support to prevent people losing their jobs
- Integration of physical and mental health community services in West Essex to better meet the needs of older people, in particular those with multiple long-term conditions
- Improved culture of learning and improvement within mental health services

Specific focus on Children and Young People

This is an all-age strategy which also covers children and young people; however, it is important to stress our specific areas of focus for this important group. These are:

- Eating Disorder Services
- Crisis Services
- MH Services and Acute Trusts- improving integration
- Mental Health Support Teams working with Education
- Access and Outcomes
- Use of digital technology
- Young Adults 18-25 transition
- CYP specialist workforce

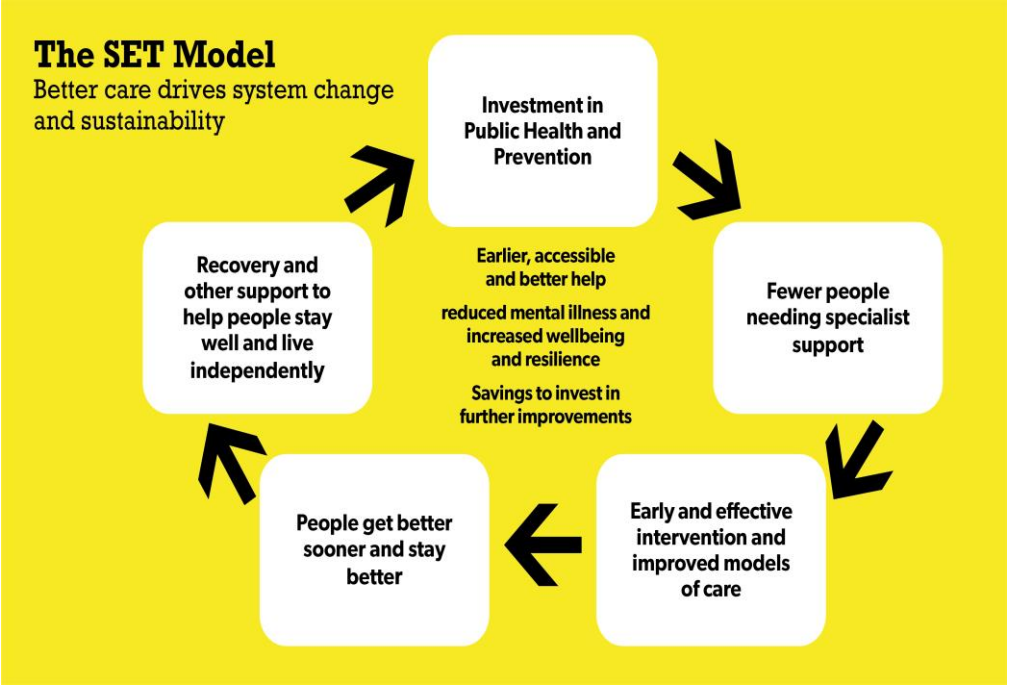
Across Southend, Essex, and Thurrock we will also be working together to support children and young people to manage risks such as the potential for online harm and use of harmful behaviours. This helps enable them to be supported

in the community by preventing need for admission into care or hospital.

There is an annually updated local transformation plan for Children and Young People in place which supports this strategy.

Developing our local model: better care drives system change and sustainability

The diagram below summarises the strategic approach for Southend, Essex, and Thurrock which seeks to further improve our approach to prevention, early intervention, and community support within the context of the wider determinants of mental health, to reduce the need for hospitalised care.



Focussing on the wider determinants of mental health

Wellbeing and mental health challenges affect all of us. Everyone seeks to maintain their own emotional and mental health and support those around us. This is not always easy or possible, especially if there is a background of trauma. When people experience deterioration in their emotional and mental health, this causes distress and can lead to crisis. In our services we want to work with people to understand and address the root of the 'triggers' for deterioration in their

emotional and mental health as well as helping them respond to the symptoms.

It is widely accepted that clinical care only contributes to 20% of the impact on people's general health outcomes. Social and economic factors have double that impact, and in mental health we know that disadvantage and discrimination have a disproportionate impact. We want to work together with communities to develop their capacity to be supportive, inclusive, resilient, and emotionally healthy places for children, young people, and adults.

Whilst the clinical services provided by the NHS have a vital part to play, the role of local authorities and local VCSE organisations and networks is also critical for influencing the factors which support people's mental health.

Local authorities have duties under the Care Act and Children's' Act to promote the wellbeing of individuals and to provide services which help to prevent, reduce, or delay peoples' needs developing, including the impacts on children of adverse childhood experiences. We plan to strengthen our work with families, carers, and schools to improve emotional wellbeing and prevent long term mental ill health in children and young people. Through this strategy we are also committed to further strengthening support for older people.

We are focused on ensuring equity of service provision across the Southend, Essex, and Thurrock geography to improve outcomes for people of all ages in all our communities. We are working together at both the larger geography and local levels to plan and further improve services at the right population level.

Each of the three ICPs have been developing their strategies, with a key leadership role for local authorities in leading, commissioning and coordinating wellbeing, prevention, and community mental health services. There is an active programme of public mental health across SET which aims to develop a prevention strategy to reduce the risk of mental ill health and the need for specialist support. This also links to local approaches to service transformation, Levelling Up and improving Population Health.

Early and effective help and support

Where people do become unwell and need support, this model and the priority areas we have outlined in the strategy will help ensure people can easily access the treatment they need when and where they need it.

Focusing on recovery

Local Authorities have a role in empowering people who have mental illness, as well as their unpaid carers, and wider communities. They enable people to lead fulfilling and independent lives by providing information, advice, advocacy and offering practical support with everyday activities including for example housing, employment, finance and debt advice, direct payments, and technology. We recognise that recovery is enabled as people grow their ability to access a

life with purpose, meaning and a voice. It is more than just the absence of symptoms.

We want to make sure people have the right place to live and can access meaningful activity such as education and employment whilst they are in recovery. A new supported accommodation model is working to help ensure more people live in stable and appropriate accommodation, and there is also work underway to improve support to enter and stay in employment.

Suicide Prevention

The Southend, Essex and Thurrock Suicide Prevention Board strategy and delivery plans will align to support the ambition of this Mental Health strategy and associated plans. The Board has an all-age approach to preventing suicide which is underpinned by the priorities agreed within the national suicide prevention strategy.

Workforce

The organisations working in the SET mental health system face significant workforce pressures. Recruitment and retention are difficult and there are high vacancy and turnover rates; this is a national situation and not just local to Southend, Essex, and Thurrock. The shortage of staff places pressure on our workforce and could limit achievement of our strategic objectives if not quickly addressed.
To overcome this, we are working to reimagine what the workforce could look like and implement new workforce models. Our desire to move care into the community where appropriate, rather than using inpatient facilities, will ease pressure on the inpatient workforce and create the opportunity for different job roles in the community.

We want to create exciting employment opportunities for the workforce to develop new or existing careers within the Southend, Essex, and Thurrock geography. This will include improving support for the wider social care and VCSE workforce within the mental health system and creating positive cultures and working experiences for all of our workforce.

Digital Technology

Digital technology is a key enabler to support people within a joined up mental health care system. During the life of this strategy, we will develop digital technology for staff to share information more easily and for people with mental health needs to access more services online.

We are aware that digital technology is not easy to use for everyone and will work to support digital inclusion and provide alternative options for people using services.

Implementation and monitoring achievement

A plan is being developed to implement the strategy, which will be overseen by a Strategy Implementation Group of senior leaders across the SET mental health and care system. Most of the implementation will be led by partners working in their local places.

There will be clear responsibility and accountability across the system for improving individual outcomes, creating the conditions for promoting good mental health, and delivering services where needed. We will publish information on how partners will work together across the system and the governance arrangements through which decisions will be made. This will include links to other key workstreams such as suicide prevention, and overarching governance boards at Alliances[14], Local Authorities, ICSs and Health and Wellbeing Boards.

An outcomes framework and key performance indicators (KPIs) will be made available with regular ongoing reporting to demonstrate the status of the work and progress achieved to implement the strategy. Measures will include the reported experiences and perceptions from those with lived experience and will be made publicly available.

To measure performance improvement, we will use the financial year 2020-2021 as our baseline, except for where a specific national or local target is already in place.

A key challenge is to ensure that the work to implement this strategy is coproduced with support and input from those with lived experience. This involvement should be genuine and give equal voice to people who traditionally may not have been involved, especially those from ethnic and minority communities. System leaders are working with local lived experience networks to agree the best ways to ensure their meaningful involvement to develop new collaborative decision-making arrangements.

This is an important strategy for the people of Southend, Essex, and Thurrock. The leaders of the local authorities and NHS are determined to make it work and deliver improved prevention and early intervention, as well as high quality care, support, and treatment for those living with mental ill health. Success will come from working together to address the wider determinants of emotional and mental health and reduce the impact of mental ill health.

[14] See appendix 9. There are 6 Alliances across SET, made up of NHS, Local Authority and VCFSE partners focussed on a place covered by a unitary authority and/or district council. These are Thurrock, South East Essex which includes Southend City, Basildon & Brentwood, Mid Essex, West Essex and North East Essex.

Appendix

Local Geographies

West Essex: Population 319,000
Hertfordshire and West Essex ICB works with Essex County Council (ECC) and the 3 District Councils of Epping Forrest, Harlow and Uttlesford, in the West Essex Health and Care Partnership. The partnership has focussed on joining up community mental health services with physical community health services, integrated around primary care.

North East Essex: Population 341,000
Suffolk and North East Essex ICB works with ECC and the 2 Borough/District Councils of Colchester and Tendring in the North East Essex Health and Wellbeing Alliance which is a collaboration of commissioners, providers and other system partners working together to transform the health and wellbeing of the population of North East Essex as an integrated system. Their approach is for everyone at all stages of their life to be able to Live Well, so they work towards outcomes using the 6 domains of the Live Well mode including 'Feel Well; Supporting mental wellbeing' and 'Be Well; Empowering adults to make healthy lifestyle choices.'

Mid Essex: Population 402,000
Mid and South Essex ICB also work with ECC and the 3 Borough/District Councils of Chelmsford, Braintree, and Maldon, in the local NHS Alliance which covers Mid Essex. Existing areas of focus for the Mid Essex Alliance includes suicide prevention.

Southend City Council: Population 183,000
Southend City Council, and Mid and South Essex ICB are the statutory commissioners of mental health services for Southend. The Council's social care vision is to work collaboratively with people to enable them to live safe, well and independently in the community, connected to the people and things they love. This is outlined in **3 key strategies around Living Well, Caring Well and Ageing Well**. Through a strengths-based focus, there is a drive to transform care and support to ensure that there are flexible options that enable independence. In particular, local partners are working together to address the disproportionate number of people in residential care, often placed by London Boroughs.

Thurrock: Population 178,000
Thurrock is a unitary authority area with borough status. It is part of the London commuter belt and an area of regeneration within the Thames Gateway redevelopment zone. The local authority, Thurrock Council, and Mid and South Essex ICB are the statutory commissioners of mental health services and are implementing an ambitious local strategy, Better Care Together Thurrock, developed by local partners through the Thurrock Integrated Care Alliance (TICA). The strategy sets out Thurrock's collective plans to transform, improve and integrate health, care and third sector services for adults and older people, to improve their wellbeing.

Key aspects relevant to this strategy include:

- Human learning Systems as the core guiding approach
- Strengths and assets-based approach to community engagement and development,
- Co-production with residents and communities to develop radically new models of care
- Integrating and transforming community mental health services with General Practice in the context of Primary Care Networks and a wider integrated housing, care and wellbeing workforce
- Transformation in local community mental health services has already begun to see significant reductions in access times and improved quality, and an enhanced focus on recovery
- Focusing on proactive and preventative care using Population Health Management.

Basildon & Brentwood: Population 264,000
Mid and South Essex ICB also work with ECC and the 2 District Councils of Basildon Point and Brentwood in the local NHS Alliance which covers Basildon & Brentwood. The Basildon and Brentwood Alliance is committed to:

- Understanding and working with communities
- Joining up and co-ordinating services around people’s needs
- Addressing non-medical factors that affect the health and wellbeing of local people
- Supporting quality and sustainability of local services

Equalities Comprehensive Impact Assessment v2 - Head of service review

Reference: ECIA509072287

Submitted: 26 May 2023 16:47 PM

Executive summary

Title of policy / decision: Southend Essex and Thurrock Mental Health Strategy

Policy / decision type: Cabinet Decision

Overview of policy / decision: To endorse the draft strategy which has been developed collaboratively with partners and is consistent with our Integrated Care Partnership Strategy and Joint Forward Plan.
To support the establishment of a Strategy Implementation Group to support and coordinate collaborative working across partners to implement the strategy.

What outcome(s) are you hoping to achieve?: Agreement to a strategic approach across the Southend, Essex and Thurrock Mental Health system

Executive Director responsible for policy / decision: Nick Presmeg (Adult Social Care)

Cabinet Member responsible for policy / decision: John Spence (Health and Adult Social Care)

Is this a new policy / decision or a change to an existing one?: New policy / decision

How will the impact of the policy / decision be monitored and evaluated?: Through the strategy implementation group

Will this policy / decision impact on:

Service users: Yes

Employees: Yes

Wider community or groups of people: Yes

If the policy decision impacts on employees, provide details here and include potential impacts on identified groups later in the form: It will involve using available funds in a different way. There will be an implementation plan sitting behind the strategy which will give further information on specific actions. Formal decision making processes will be followed for each decision required as part of this plan.

What strategic priorities will this policy / decision support?: Health, Independence and Wellbeing for All Ages, A good place for Children and Families to Grow

Which strategic priorities does this support? - Health: Healthy lifestyles, Promoting independence, Levelling up health

Which strategic priorities does this support? - Families: Education outcomes, Family resilience and stability, Outcomes for vulnerable children, Levelling up outcomes for families

What geographical areas of Essex will the policy / decision affect?: All Essex

Digital accessibility

Is the new or revised policy linked to a digital service (website, system or application)?: No

Equalities - Groups with protected characteristics

Age

Nature of impact: Positive

Extent of impact: Medium

Disability - learning disability

Nature of impact: Positive

Extent of impact: Low

Disability - mental health issues

Nature of impact: Positive

Extent of impact: High

Disability - physical impairment

Nature of impact: Positive

Extent of impact: Low

Disability - sensory impairment

Nature of impact: Positive

Extent of impact: Low

Sex

Nature of impact: Positive

Extent of impact: Low

Gender reassignment

Nature of impact: Positive

Extent of impact: Low

Marriage / civil partnership

Nature of impact: Positive

Extent of impact: Low

Pregnancy / maternity

Nature of impact: Positive

Extent of impact: Low

Race

Nature of impact: Positive

Extent of impact: Low

Religion / belief

Nature of impact: Positive

Extent of impact: Low

Sexual orientation

Nature of impact: Positive

Extent of impact: Low

Rationale for assessment, including data used to assess the impact: There has been a wide range of engagement work not just from system partners but also from people who use service to inform the strategy. All these exercises tell us that people need and wish to see services which join up across partners, span the all age spectrum, give people meaningful and purposeful activity and support their recovery holistically (rather than just treat symptoms). These are central tenets to the strategy.

What actions have already been taken to mitigate any negative impacts?: There is a commitment to improve our work on equality, diversity and inclusion linked to the known equity issues and over-representation in secondary care services in some groups. These will be addressed by the strategy implementation group.

How could you strengthen any positive impact(s)?: Through partnership working and increasing the level of lived experience influence and co-production with people who use services. As part of the implementation there will be a lived experience group that will be actively involved to inform plans.

Levelling up - Priority areas & cohorts

Children and adults with SEND, learning disabilities or mental health conditions (taking an all-age approach)

Nature of impact: Positive

Extent of impact: High

Children on Free School Meals

Nature of impact: None

Working families

Nature of impact: None

Young adults (16-25 who have not been in education, training or employment for around 6-12 months)

Nature of impact: None

Residents of Harlow

Nature of impact: None

Residents of Jaywick and Clacton

Nature of impact: None

Residents of Harwich

Nature of impact: None

Residents of Basildon (Town) housing estates

Nature of impact: None

Residents of Canvey Island

Nature of impact: None

Residents of Colchester (Town) - Housing Estates

Nature of impact: None

Residents of Rural North of the Braintree District

Nature of impact: None

Rationale for assessment, including data used to assess the impact: Through closer system working and aligned priorities it is expected that people who experience mental ill health will see improvements particularly in relation to transitions.

What actions have already been taken to mitigate any negative impacts?: These will be addressed by the strategy implementation group

How could you strengthen any positive impact(s)?: Through partnership working and increasing the level of lived experience influence and co-production with people who use services.

Equalities - Inclusion health groups and other priority groups

Refugees / asylum seekers

Nature of impact: Positive

Extent of impact: Low

Homeless / rough sleepers

Nature of impact: Positive

Extent of impact: Low

People who experience drug and alcohol dependence

Nature of impact: Positive

Extent of impact: Low

Offenders / ex-offenders

Nature of impact: Positive

Extent of impact: Low

Victims of modern slavery

Nature of impact: Too early for impact to be known

Carers

Nature of impact: Positive

Extent of impact: Low

Looked after children / care leavers

Nature of impact: Positive

Extent of impact: Low

The armed forces community (serving personnel and their families, veterans, reservists and cadets)

Nature of impact: Positive

Extent of impact: Low

People who are unemployed / economically inactive

Nature of impact: Positive

Extent of impact: Medium

People on low income

Nature of impact: Positive

Extent of impact: Low

Sex workers

Nature of impact: Positive

Extent of impact: Low

Ethnic minorities

Nature of impact: Positive

Extent of impact: Low

Gypsy, Roma, and Traveller communities

Nature of impact: Positive

Extent of impact: Low

People with multiple complex needs or multi-morbidities

Nature of impact: Positive

Extent of impact: Low

Rationale for assessment, including data used to assess the impact: There should be little impact

What actions have already been taken to mitigate any negative impacts?:

How could you strengthen any positive impact(s)?:

Equalities - Geographical Groups

People living in areas of high deprivation

Nature of impact: None

People living in rural or isolated areas

Nature of impact: None

People living in coastal areas

Nature of impact: None

People living in urban or over-populated areas

Nature of impact: None

Rationale for assessment, including data used to assess the impact: There should be no specific impact on these groups

What actions have already been taken to mitigate any negative impacts?:

Families

Family formation (e.g. to become or live as a couple, the ability to live with or apart from children)

Nature of impact: None

Families going through key transitions e.g. becoming parents, getting married, fostering or adopting, bereavement, redundancy, new caring responsibilities, onset of a long-term health condition

Nature of impact: None

Family members' ability to play a full role in family life, including with respect to parenting and other caring responsibilities

Nature of impact: None

Families before, during and after couple separation

Nature of impact: None

Families most at risk of deterioration of relationship quality and breakdown

Nature of impact: None

Rationale for assessment, including data used to assess the impact: There should be no impact on these groups

What actions have already been taken to mitigate any negative impacts?:

Climate

Does your decision / policy involve development or re-development of buildings or infrastructure?: No

Does your decision / policy take place in, or make use of, existing buildings or infrastructure?: No

Does your decision / policy involve elements connected to transport, travel or vehicles? This includes travel needs / requirements of both service users and staff (including staff you're planning to recruit): No

Are you undertaking a procurement exercise?: No

Does your decision / policy involve the purchase of goods or materials?: No

Will any waste be generated by this decision? This includes waste from construction, waste generated by service users / staff, and waste generated by replacing existing products / materials with new: No

Action plan to address and monitor adverse impacts

Does your ECIA indicate that the policy or decision would have a medium or high adverse impact on one or more of the groups / areas identified?: No

Details of person completing the form

I confirm that this has been completed based on the best information available and in following ECC guidance: I confirm that this has been completed based on the best information available and in following ECC guidance

Date ECIA completed: 19/04/2023

Name of person completing the ECIA: Emily Oliver

Email address of person completing the ECIA: Emily.Oliver@essex.gov.uk

Your function: Adult Social Care

Your service area: Commissioning

Your team: Commissioning

Are you submitting this ECIA on behalf of another function, service area or team?: No

Email address of Head of Service: Moira.Mcgrath@essex.gov.uk

Agenda Item 7
HWB/15/23

Report title: An update report on intelligence informing action being taken to reduce the rise in suicide rates in Essex	
Report to: Essex Health and Wellbeing Board (EHWB)	
Report author: Jane Gardner, Chair of the SET Suicide Prevention Partnership Board, OPCC/ Lucy Wightman, Director of Wellbeing and Public Health	
Date: 30 June 2023	**For:** Update purposes and discussion
Enquiries to: Gemma Andrews, Health and Wellbeing Manager, gemma.andrews@essex.gov.uk	
County Divisions affected: All Essex	

1. Purpose of Report

1.1 The purpose of this report is to provide the board with updated local and national context for suicide prevention.

1.2 To summarise emerging local trends from the **Real Time Suspected Suicide Surveillance Project (RTSS) Annual report 2022**; the first **complete calendar year** annual data capture of suspected suicides for Southend, Essex and Thurrock (see 3.0).

1.3 To share SET Suicide Prevention Partnership Board progress in: (1) driving strategic commitment to suicide prevention and (2) informing and directing suicide prevention operational activity.

1.4 Ask the board to endorse and support recommendations arising from the report.

2. Recommendations

2.1 EHWB to acknowledge the following recommendations arising from the RTSS 2022 Annual report in relation to suicide prevention approach for Essex:

- Shift from existing recommendation of focusing on 45-64 year old males, to males aged 25 – 44, 45 – 64 and 75+ and females aged 25 – 44 years (i.e., shift to universal response, informed by known drivers, rather than age or sex).

- In response to historically high suicide rates in NEE, NEE to lead the piloting of a locality operating model (SET SP Partnership led Hub and Spoke).

- The **number** of suspected suicides has increased in **all** ICBs in 2022; suicide prevention interventions are needed across all 3 ICBs, rather than just focusing on NEE due to the relatively high rate.

- Acknowledge areas facing resourcing/ capacity challenges impacting operational delivery and associated risks.

- To acknowledge and thank all partner organisations/ individuals contributing to the SET Suicide Prevention Partnership agenda through financial/ staffing sponsorship, championship, and direct work, recognising progress made through these commitments, next steps and the importance of sustainability.

3. Summary of issue

On 26th April 2023 the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) hosted their 9th Annual Conference. Alongside sharing their internationally leading longitudinal research, they communicated early warnings of anticipated national growth, particularly in relation to the predicted 'cohort effect' in reaction to periods of economic stress, modelled on observations from 25 years of patient data and population data since 2010. Locally, since 2010 Essex has shown a trend of worsening and statistically significant higher than national average rates of suicide in NEE, but this NCISH call to action identifies the need to build universal coverage of prevention measures across all geographies in Essex if we are to be stem growth.

3.1 Introducing the RTSS Annual Report 2022

The benefit of RTSS is speed. In 2021 it took 180 days on average for a death by suicide to be registered, compared to the monthly data flows from RTSS. Detailed information from RTSS is used by suicide prevention leads across Greater Essex, and censored bimonthly & annual reports are shared to partners to flag any concerns.

RTSS began in April 2021, and the previous annual report ran between April 2021 to March 2022. Going forward all reports will be based on calendar year instead of financial year. Moving to calendar year analysis is a progression which synchronises our local data discussions with regional and national datasets, as and when new data releases become available. The report looks at all suspected suicides which occurred in 2022 and sets the baseline against which future local trends will be measured year on year.

3.2 RTSS Annual Report 2022 – Findings

Each annual report moving forwards will open with a declaration of the accumulative count of all suspected suicides recorded since the launch of RTSS in April 2021, to enable us to better assess how patterns in Essex compare to national trends.

- Between April 2021 – December 2022 there have been 270 suspected suicides reported to RTSS. 72% (194) of these suspected suicides are male, and many of suspected suicides occur in the middle age (45 - 64) group. This is similar to the national picture.
- There were **178 suspected suicides recorded by RTSS in 2022**. This sets the baseline for calendar year data on which future years will be assessed against.

- In an **average month there are 13 suspected suicides across SET**, and there are **no strong seasonal patterns**

3.3 Age and sex

- There is a very wide range in the age of death by suspected suicide, ranging from 11 to 99 years old. Almost every age & sex has seen an increase in suspected suicides in 2022. Due to relatively small numbers we can't say if these differences are due to chance. We will continue to monitor suspected suicides by age, with a particular focus on any groups which show consistent year on year increases. However, the 2022 data, alongside national modelling, SET SP Board need to bring to the boards attention that prevention activity needs to expand beyond targeting middle aged males. Findings for board attention include:
- There has been a significant increase in the all-age suspected suicide rate (9.6 suspected suicides per 100,000 residents in 2022 compared to 6.6 in 2021). This increase has mostly been driven by a significant increase in male suspected suicides. Some of the largest increases in rates occurred in males, particularly in **males aged 25 – 44, 45 – 64 and 75+**. The NHSE wave kick start funding was costed to target males aged 45-64; this finding evidences a need to support a much larger cohort of residents.
- There has also been a significant increase in the suspected suicide rate in **25 – 44 year olds, driven by an increase in both males and females**. Suspected suicide rates vary year on year, but the increases seen in these three groups are so large that they are unlikely to be due to chance.
- Despite a slight increase in 2022, Greater Essex's suspected suicide rate in the **0 – 24 group continues to be significantly lower than the latest England & Wales 0 – 24 rate.**

3.4 Methods

- Hanging and drug related methods (including poisoning), continue to be the two most common methods used in suspected suicides. Together these two methods account for 77% (137) of all suspected suicides which occurred in 2022. RTSS informs us there are patterns in methods used by males and females, which can inform training and design of community intervention. Drug related deaths include poisonings and overdoses using medication. Information on medications is shared with clinical providers and medicines management in year, to inform discussions around any opportunities for iteratively improving patient safety.

3.5 Locations

- The **majority (72%) of suspected suicides occur in private residences**, most often the persons home. Public places are the next most common location (21%). The proportion of deaths occurring in these two locations hasn't changed since 2021. There are **no common locations for suspected suicides which occur in public.**

3.6 Rates

- The Greater Essex portion of SNEE (Tendring and Colchester) continues to have the highest suspected suicide **rate**, and the Greater Essex portion of HWE (Epping, Harlow, and Uttlesford) continues to have the lowest. These

rates account for the different age and sex structures of the areas, so can be compared across ICBs. However, **due to small numbers, none of these rates are statistically significantly different from each other**.

ICB suspected suicides, 2022

	Number		Rate	
	2021	2022	2021	2022
MSE	49	99	6.5	9.6
SNEE	25	36	11	12.2
HWE	13	23	6.1	8

Note: SNEE & HWE only include the parts inside Greater Essex

3.7 Number

- The **number** of suspected suicides has increased in all ICBs. Partly this is because we have a full year of data for 2022 and only 9 months of data for 2021. As shown below, after adjusting for the incomplete 2021 data, we would expect around 66, 33, and 18 suspected suicides in MSE, SNEE, and HWE respectively – so the increase can't be fully explained by more complete data. The increases suggest that interventions are needed across all 3 ICBs, rather than just focusing on SNEE due to the relatively high rate.

ICB suspected suicides, 2022

	21 RTSS (9 months)	21 RTSS adj. (to estimate 12 months)	22 RTSS (12 months)
MSE	49	66	99
SNEE (NEE only)	25	33	36
HWE (WE only)	13	18	23

3.8 Risk factors

- Risk factors are recorded under five categories within RTSS currently: (i) recent contact with police, or mental health services (within last 6 months), (ii) previous self-harm, ideation or attempt, (iii) domestic abuse (iv) social, housing or financial issues and (v) relationship, employment and living arrangements. Comparisons to 2021 haven't been made. There have been substantial improvements in data quality this year, so it isn't clear if any increases in risk factors is due to improvements in reporting or due to an increase in suspected suicides with those risk factors. This data is utilised in year for both reactive response to incidents and to shape all action directed by the SET SP Partnership Board. Data quality will continue to be iteratively improved under the RTSS project as working relationships with partners mature and RTSS is expanded to include more data sources (for example healthcare data).

3.9 Strategic commitment to suicide prevention

Building a succinct and clear narrative, has enabled the SET Suicide Prevention Partnership to articulate the need for strategic support in the agenda. Since last update to board, the SET Suicide Prevention Partnership have secured strategic commitments to the Suicide Prevention agenda through inclusion in **all three ICB Forward Plan/ ICS Strategies** and formalisation of links between the SET Suicide

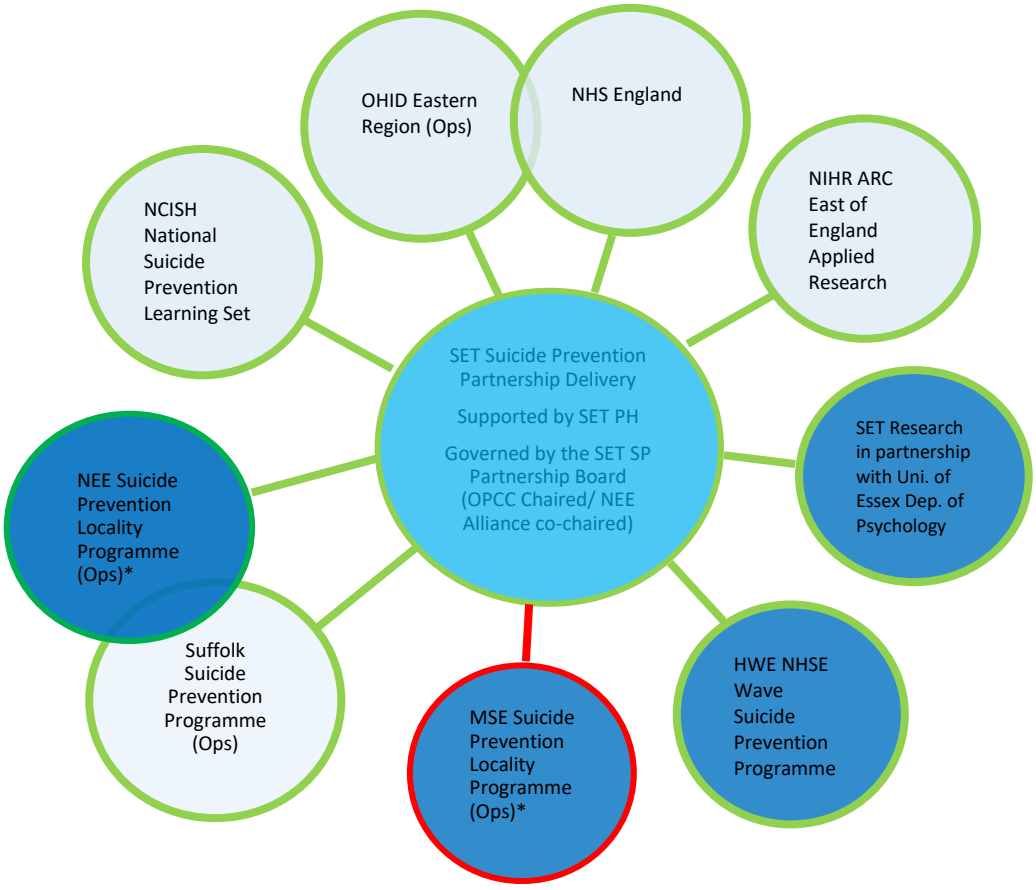
Prevention Partnership Board and **Essex Safeguarding Adults Board** and **Essex Domestic Homicide Review Panel**. Strengthening links between Essex Child Death Overview Panel is also planned later this year. These strategic commitments are essential, since they support the sustained prioritisation of resources required to make an impact and an essential part of the governance of operational delivery.

3.10 Informing and directing suicide prevention operational activity

Information from local and regional RTSS, SET Suicide Prevention Partnership Board members and NCISH is being disseminated through the SET Suicide Prevention Partnership Board. In 2023, the partnership can evidence good practice examples where partners have been able to come together to respond and learn through **incident review**; building our local capability to react, learn and prevent. Although a phased programme of work around improving data quality is ongoing in the background, SET SP Partnership now have sufficient insight to shape support needs which marks considerable progress in moving the agenda from passive observation to positive operational action.

SET Suicide Prevention Partnership Board is supporting the below hub and spoke model of delivery, to improve co-ordination of effort across the partnership.

SET Suicide Prevention Partnership Hub and Spoke Delivery Model



The SET SP Partnership can support all localities in the development of an evidence-based locality action plan, for endorsement by both the respective ICB and Alliance. In April 2024, the HWE NHSE Wave Programme will end; from April 2024 a similar structure to SNEE is planned for HWE; splitting into Hertfordshire Suicide Prevention Programme and a West Essex SP Locality Programme.

	Commitment in ICS Forward Plan	Delivery budget allocated	Workstream identified for ICS to lead on in partnership	Operational capacity status
NEE	Yes	NEE ICS budget for 1 year fixed term post SNEE fair share budget for postholder.	GP training and building of NEE SP operational network	**Green**
WE	Yes	WE is still funded by the NHSE Wave programme and HWE have signalled verbal commitment to sustain existing arrangements beyond this.	Workstreams are still dictated by NHSE at this time	**Green**
MSE	Yes	Verbal commitment to absorb NHSE Wave programme budget into MH Transformation Fund. SET SP Partnership Board seeking confirmation and financial transparency.	Identified by SET SP Partnership Board as an ideal early adopter to pilot an Opiate Weaning workstream in response to local need	**Red** Currently under restructure, evidence of capacity challenges where no dedicated posts are allocated to lead locality operations

3 Next steps

4.1 To build the SET SP Partnership Board's capacity within the hub and spoke operating model. This involves recalling Essex PH resource from ICS operations to support this function.

4 Issues for consideration

a. Financial implications

5.1 Any costs arising from the actions set out in this paper will be accommodated within the Public Health Grant, within funding allocated through the NHSE Suicide Prevention and Reduction programme or from respective ICS budgets.

b. Legal implications

5.2 There are no legal implications. Any decisions relating to the work arising from the SET Suicide Prevention Partnership Board, will be subject to the Council's governance process where applicable.

c. Health/Social implications

5.3 This programme supports the implementation of the wider prevention agenda and Health in All Policies approach.

6 Equality and Diversity implications

6.1 The Public Sector Equality Duty applies to the Council when it makes decisions. The duty requires us to have regard to the need to:

(a) Eliminate unlawful discrimination, harassment and victimisation and other behaviour prohibited by the Act. In summary, the Act makes discrimination etc. on the grounds of a protected characteristic unlawful
(b) Advance equality of opportunity between people who share a protected characteristic and those who do not.
(c) Foster good relations between people who share a protected characteristic and those who do not including tackling prejudice and promoting understanding.

6.2 The protected characteristics are age, disability, gender reassignment, pregnancy and maternity, marriage and civil partnership, race, religion or belief, gender, and sexual orientation. The Act states that marriage and civil partnership is not a relevant protected characteristic for (b) or (c) although it is relevant for (a).

6.3 The equality impact assessment indicates that the proposals in this report will not have a disproportionately adverse impact on any people with a particular characteristic.

Introduction

This is the second annual report using data from Essex Police's Real Time Suicide Surveillance (RTSS) System. Each annual report looks at the cumulative number of suspected suicides reported to RTSS, with an aim of establishing long term trends.

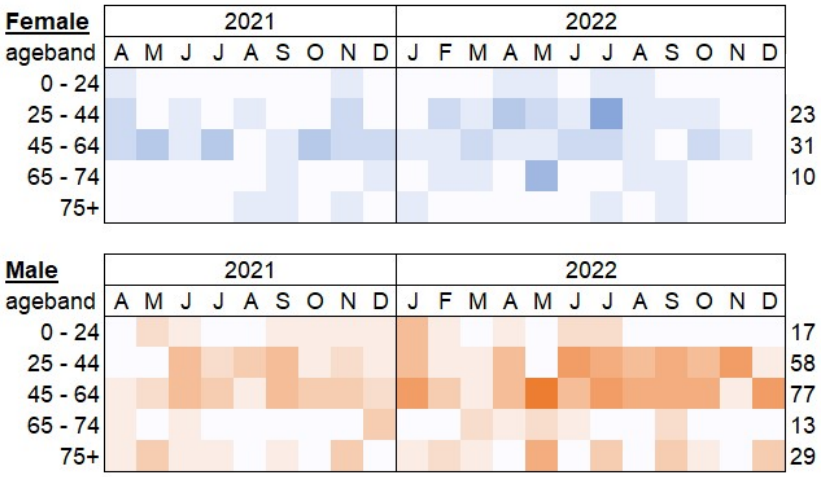
RTSS covers all of Greater Essex, and records suspected suicides which an Essex Police officer responded to. This is different to confirmed suicides, which in most cases need input from the coroner. Some of the suspected suicides in RTSS may be ruled 'not a suicide' once the coroner finished their inquest. RTSS may also miss suspected suicides which occur in some settings – for example if a Greater Essex resident dies by suicide far outside Essex, or if the death occurs in some healthcare settings which would not result in the Police being called.
The benefit of RTSS is speed. In 2021 it took 180 days on average for a death by suicide to be registered, compared to the monthly data flows from RTSS. Detailed information from RTSS is used by suicide prevention leads across Greater Essex, and censored bimonthly & annual reports are shared to partners to flag any concerns.

This report looks at all suspected suicides which occurred in 2022. RTSS began in April 2021, and the previous annual report ran between April 2021 to March 2022. Going forward all reports will be based on calendar year instead of financial year, this ensures RTSS reporting time periods line up with national reporting time periods.

Trends

Between April 2021 – December 2022 there have been 270 suspected suicides reported to RTSS. 178 of those occurred in 2022. 72% (194) of these suspected suicides are male, and the majority of suspected suicides occur in the middle age (45 - 64) group. This is similar to the national picture.

Suspected suicides by month



This chart shows the number of suspected suicides by month, split by age and sex. Darker colours indicate a higher number of suspected suicides. Numbers on the far right of the charts are the total number of suspected suicides since April 2021 to 2022 end.
In an average month there are 13 suspected suicides across SET, and there are no strong seasonal patterns.

There is a very wide range in the age of death by suspected suicide, ranging from 11 to 99 years old. Males make up a much larger proportion of suspected suicides in the 75+ group (83% compared to 72% overall), and there is an almost even gender split in the 65 – 74 group.

The number of suspected suicides is increasing. Between April – December 2021 there were 92 suspected suicides. In 2022 there were 178.
Suspected suicide rates by year, age, and sex are shown in the table.

Suspected suicides have almost doubled in the 25 – 44 group (from an estimated 31 in 2021 to 58 in 2022), with twice as many male and female suspected suicides compared to last year. Males aged 75+ continue to have the highest suspected suicide rates (25.5 per 100k). Suspected suicide rates are consistently higher in males compared to females.

Suspected suicide rates per 100,000 residents

	Total		Female		Male	
	2021	*2022*	*2021*	*2022*	*2021*	*2022*
All ages	**6.6**	↑ **9.6**	**4.2**	**6.4**	**9.1**	↑ **19.4**
0 - 24	2.3	2.7	1.0	1.6	3.4	3.7
25 - 44	6.5	↑ 12.2	3.3	6.9	9.9	18.0
45 - 64	10.9	13.9	9.1	5.6	12.8	22.5
65 - 74	4.8	8.2	2.6	7.8	7.2	8.6
75+	10.0	12.7	4.0	3.0	17.9	25.5

Note: Full year 2021 data estimated based on Apr – Mar.
Arrows show significant increases on last year

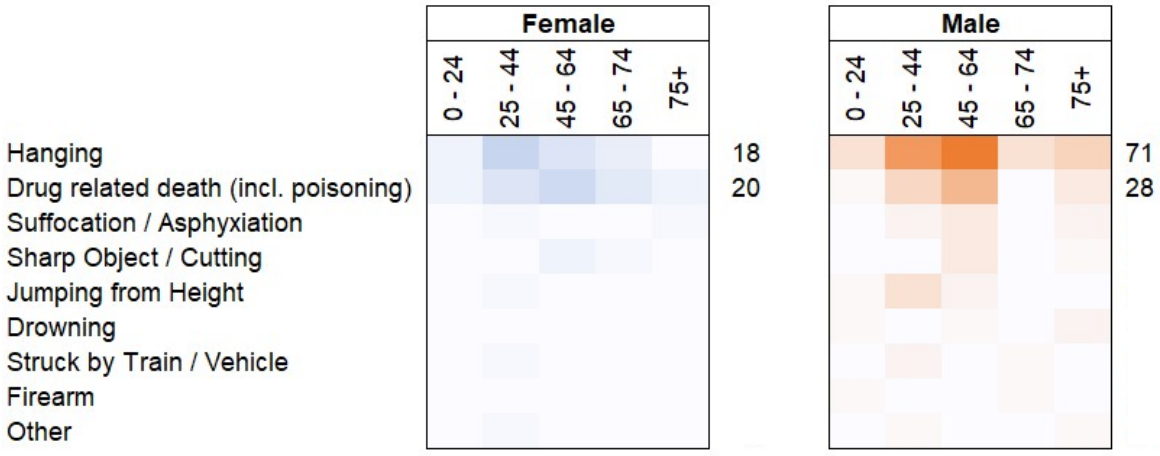
There has been a significant increase in the all-age suspected suicide rate (9.6 suspected suicides per 100,000 residents in 2022 compared to 6.6 in 2021). This increase has mostly been driven by a significant increase in male suspected suicides. Some of the largest increases in rates occurred in males, particularly in males aged 45 – 64, 25 – 44, and 75+. There has also been a significant increase in the suspected suicide rate in 25 – 44 year olds, driven by an increase in both males and females. Suspected suicide rates vary year on year, but the increases seen in these three groups are so large that they are unlikely to be due to chance.

Almost every age & sex has seen an increase in suspected suicides in 2022. Due to relatively small numbers we can't say if these differences are due to chance. We will continue to monitor suspected suicides by age, with a particular focus on any groups which show consistent year on year increases.
Despite a slight increase in 2022, Greater Essex's suspected suicide rate in the 0 – 24 group continues to be significantly lower than the latest England & Wales 0 – 24 rate.

Methods

Hanging and drug related methods (including poisoning), continue to be the two most common methods used in suspected suicides. Together these two methods account for 77% (137) of all suspected suicides which occurred in 2022. The chart below shows methods used, split by sex and age.

Suspected suicide methods, 2022



Drug related deaths are the most common method used in females. The most common method for males is hanging. Males use a wider range of methods compared to females. Hanging and drug related methods account for 83% of all suspected suicides in females, compared to 75% of all male suspected suicides. Jumping for height and suffocation / asphyxiation are the two most common methods after hanging and drug related methods for males, and sharp object / cutting is the next most common method for females.

Drug related deaths include poisonings and overdoses using medication. The most common medication types are pain medication and mental health medication. This data is based on information the officer collected at the scene, it is not based on toxicology reports or medical records and so may undercount the actual number of deaths involving these medicines.

Location (including ICB breakdown)

The majority (72%) of suspected suicides occur in private residences, most often the persons home. Public places are the next most common location (21%). The proportion of deaths occurring in these two locations hasn't changed since 2021. Almost all drug related deaths which involve prescription medication occur at the persons usual place of residence (91%). There is a wider range of methods used in public places, though hanging is the most common. There are no common locations for suspected suicides which occur in public.

The table shows the number of suspected suicides & standardised rates for the three ICBs. Because Essex Police Force Area only covers Greater Essex, parts of Hertfordshire & West Essex and Suffolk & North East Essex ICBs are not included in the data. The number of suspected suicides for these areas will be an undercount of the actual number.
The missing data for these areas is held by Hertfordshire and Suffolk Police respectively.

ICB suspected suicides, 2022

	Number		Rate	
	2021	2022	2021	2022
MSE	49	99	6.5	9.6
SNEE	25	36	11	12.2
HWE	13	23	6.1	8

Note: SNEE & HWE only include the parts inside Greater Essex

The Greater Essex portion of SNEE (Tendring and Colchester) continues to have the highest suspected suicide rate, and the Greater Essex portion of HWE (Epping, Harlow, and Uttlesford) continues to have the lowest. These rates account for the different age and sex structures of the areas, so can be compared across ICBs. Due to small numbers, none of these rates are statistically significantly different from each other.
The number of suspected suicides has increased in all ICBs. Partly this is because we have a full year of data for 2022 and only 9 months of data for 2021. After adjusting for the incomplete 2021 data, we would expect around 66, 33, and 18 suspected suicides in MSE, SNEE, and HWE respectively – so the increase can't be fully explained by more complete data. The increases suggest that interventions are needed across all 3 ICBs, rather than just focusing on SNEE due to the relatively high rate.

For more complete data, please use the public suicide rates. These count all suicides within the ICBs (rather than just the Greater Essex parts), but are based on death registrations so have a lag compared to RTSS.

Risk factors

The table below shows common factors recorded in Police systems for people who died by suspected suicide in 2022. This is based on information available to the Police and information gathered by the officer who responds to the suspected suicide at the scene, so may by an under-report of the actual number. For example, if the next of kin was not aware

that the person had recently been in contact with mental health services, they wouldn't share that information with the officer and it wouldn't be reported to RTSS.
Comparisons to 2021 haven't been made. There have been substantial improvements in data quality this year, so it isn't clear if any increases in risk factors is due to improvements in reporting or due to an increase in suspected suicides with those risk factors.

Factors recorded in police systems for people who die by suspected suicide		Suspected suicides
Recent contact with services (6 months before death)	**Total**	**77**
Note: people can be known to more than 1 service, numbers won't sum to total	Mental health	53
	Police	45
Previous self-harm, suicide ideation, or attempt	**Total**	**69**
Note: people can be in multiple categories, numbers won't sum to total	Suicide attempt	55
	Suicide ideation	16
	Self-harm	<10
Domestic abuse	**Total**	**25**
Note: people can be victims & suspects, numbers won't sum to total	Suspect	17
	Victim	10
Social, housing, or financial issues	**Total**	**38**
Note: people can have multiple issues, numbers won't sum to total	Relationship issues	23
	Financial issues	12
	Housing issues	<10
Relationship, employment, and living arrangements		
	Live alone	67
	Single	52
	In a relationship	55
	Separated	37
	Unemployed	34

Future work

RTSS will be expanded to include more data sources. Two major gaps are attempts data and healthcare data. This work is still in early stages. If you know any potential sources which may be helpful, or want to discuss other potentially useful data sources, please get in touch with Tracey.Allen@essex.police.uk, Gemma.Andrews@essex.gov.uk, mpayne@thurrock.gov.uk, SimonDFord@southend.gov.uk, and Sean.Maguire@essex.gov.uk.

Report title: Essex Partnership Data Declaration	
Report to: Essex Health and Wellbeing Board	
Report author: CC Harrington/ ACO Henderson. Essex Police	
Date: 19 July 2023	**For:** Discussion
Enquiries to: ACO Henderson (fiona.henderson@essex.police.uk \ 07713 095223)	
County Divisions affected: All Essex	

1 Purpose of Report

1.1 The purpose of this report is to raise awareness of the 'data declaration' which has been developed between Essex Police, Essex County Council and the University of Essex to facilitate better sharing of information for understanding and addressing system-wide problems effectively. This is with a view to securing further support from wider board members. The high-level overview in this report will be accompanied by further detail at the meeting itself.

2 Recommendations

2.1 Our primary recommendation will be for Health and Wellbeing Board members to consider signing up to the data declaration so that we can extend the benefits of enhanced data sharing even further across the system.

2.2 Matters for which discussion or decision is required are as follows:

2.3 Agreement in principle, for additional interested parties to support the data declaration and work together to signing a declaration ahead of the next board.

2.4 In due course, committing to sharing assets (knowledge, resource, skills etc.) so that projects supported by the data declaration can be effectively developed and implemented. These skills might include those of information management, information security, analytical, data science or IT personnel.

2.5 There are no anticipated expenditure implications. By signing up to the data declaration, parties are not making a financial commitment.

3 Background and Proposal

3.1 Recently, the ECDA[1] consortium has secured unanimous support from Chief Executives of borough, city and district, and unitary authorities in Essex to improve our use of data and information across the system, formalised through their recognition (via the data declaration) of the growing need to be data driven.

3.2 Without this formalised support we are likely, as a system, to continue to face practical and ethical barriers in our efforts to better understand complex system-wide challenges.

3.3 Already, we have seen the benefits of 'daring to share' through one-off, successful projects. This gives us confidence that by formalising partnership support we will eventually make progress with system-wide challenges.

3.4 Illustrated by the national data and digital strategies, data sharing between public sector agencies is being discussed at a national level with growing vigour, and the progress made by other regions in advanced sharing (West Midlands, for instance) will provide helpful insight we can learn from.

3.5 In addition, the private sector are increasingly choosing to support their public sector colleagues by providing access to skills and expertise which will support this ambition. Already, Essex Police are in a strong collaboration with BT and other private sector companies (an initiative known as the 'Hot House') where much of this activity can be realised.

3.6 Having developed the declaration to its current position within the ECDA consortium, we have been able to address common anticipated challenges and are now at a point where we are clear in the proposal we can extend further to our partners. However, we would welcome further engagement with interested parties before formalising additional support so that we can understand and address any new challenges which might arise.

3.7 With agreement we can develop some pathfinder proposals that can be discussed, agreed and sponsored by the Health and Wellbeing Board.

4 Options

4.1 Option 1: Agree and formalise wider partnership commitment to enhanced data sharing by signing up to the data declaration as new signatories. By increasing the number of signatories there will be a stronger foundation for routinely facilitating better data sharing, and for ensuring the benefits are felt as widely as possible.

4.2 Option 1 is the ECDA preferred option, on the basis that formalising additional support means we can develop working practices which can be implemented

[1] Essex Centre for Data Analytics

widely and avoid the need to generate agreement for each individual work stream. Strategic agreement on any commissioned work would always be sought to ensure suitability and to address any risks or challenges.

4.3 Option 2: Agree to the principle of enhanced data sharing, with the intention of supporting where possible, but without formalising this through the data declaration. Whilst this will still enhance the quality of our capabilities, and our understanding of complex issues, without signing up to the declaration itself we will not benefit from having agreed protocols and practices which are what will ultimately drive our capabilities.

4.4 Option 3: Acknowledge the benefit of enhanced data sharing but consider options on an ad hoc basis when the need arises. Whilst the ECDA consortium will still strive for collaborative sharing across the system in these instances, the practicalities of navigating challenges and barriers on an ad hoc basis is likely to restrict the ease with which we can do so.

5 Issues for consideration

5.1 Financial implications

5.1.1 No financial implications for the board to consider. Any financial impact brought about by specific workstreams will be addressed at the point of strategic agreement. However, the purpose of the data declaration, and ECDA more widely, is to be able to share information *without* financial implication.

5.2 Legal implications

5.2.1 Legal implications are most likely to centre around safe and ethical sharing of information which is what has underpinned the formation of the data declaration and is addressed through its content and ongoing discussion.

6 Equality and Diversity implications

6.1 The Public Sector Equality Duty applies to the Council when it makes decisions. The duty requires us to have regard to the need to:

(a) Eliminate unlawful discrimination, harassment and victimisation and other behaviour prohibited by the Act. In summary, the Act makes discrimination etc. on the grounds of a protected characteristic unlawful

(b) Advance equality of opportunity between people who share a protected characteristic and those who do not.

(c) Foster good relations between people who share a protected characteristic and those who do not including tackling prejudice and promoting understanding.

6.2 The protected characteristics are age, disability, gender reassignment, pregnancy and maternity, marriage and civil partnership, race, religion or belief, gender, and sexual orientation. The Act states that 'marriage and civil partnership' is not a relevant protected characteristic for (b) or (c) although it is relevant for (a).

6.3 The Equality Comprehensive Impact Assessment indicates that the proposals in this report will not have a disproportionately adverse impact on any people with a particular characteristic.

7 List of appendices

Presentation to be distributed in due course, outlining further detail on the above proposal and on possible future work streams.

8 List of Background papers

ECDA data declaration (on request)
National Data Strategy (GOV.UK)
National Digital Strategy (GOV.UK)

essex centre for data analytics

Data declaration
Data masterclass

ESSEX CENTRE FOR DATA ANALYTICS

PARTNERSHIP VENTURE BETWEEN ESSEX COUNTY COUNCIL, ESSEX POLICE AND UNIVERSITY OF ESSEX THAT SEEKS TO PROMOTE THE USE OF DATA SHARING AND ANALYTICS TO IMPROVE OUTCOMES FOR LOCAL PEOPLE

DATA
PEOPLE
ACTION

- **Sharing** data with our partners in safe, secure and ethical ways and deploying best practice analytics and data science that generates new insights to shared challenges
- **Building** capability and capacity, connecting people together, sharing skills, knowledge and expertise, implementing best practice frameworks
- **Fostering** a culture that enables partners to treat data as an asset, prioritising the data literacy learning agenda and creating a positive data ecosystem to support effective evidence-based decision making and published research

Supporting partners to deliver positive impact and outcomes

NEW OPERATING MODEL

MAXIMISING PARTNER OPPORTUNITIES, INTEREST, COMMITMENT AND ASSETS

ACCELERANTS

- Network diversification of BPOTE & Data leads forum
- Data Asset map
- Partnership Analytics projects roadmap
- Data Masterclass for leaders
- Data Declaration signed by all public sector orgs
- Best practice guidance – legal, ethical, robust

ACCELERANTS

- Thematic Data sharing agreements
- Impact framework and KPI's
- Secondment / analyst exchange programme
- Host Innovation labs / hackathons
- Data Ethics Committee
- Data first contracts

Supporting partners to deliver positive impact and outcomes

WHY A DECLARATION

CAN I AND SHOULD MY ORGANISATION SIGN UP?

1

OUR DUTY

- We are committed to delivering the best possible public services to those who live, work and study in the area, supporting the people of Greater Essex in fulfilling their potential and keeping the community safe
- We also have a duty to those who fund public services to provide services that deliver value for money.

2

OUR ROLE

- We recognise that to deliver on these commitments, we must make the best use of all our assets, and this includes data. The data we hold is a key asset, providing essential information about people, communities, businesses, the economy and the environment.
- By treating our data well, ensuring we collect what is of value and using appropriate methods, we can generate “social value” from these data assets. Treating our data as an asset our alongside deploying appropriate analytical methods is key to improving decision making and can help us lead to improved outcomes for the people of Essex.

3

OUR CHALLENGES

- We know that many of the challenges for Greater Essex, including recovering from the Covid-19 pandemic, levelling up our communities, community safety and tackling climate change can only be met by working across organisational boundaries. Sharing data, insight and knowledge is an important part of working across these boundaries, to harness the power of the data held within our organisations.
- But we recognise the importance of using data responsibly, transparently, and securely and in doing so we will maintain the confidence of our residents in our use of their data.

OUR STATEMENTS OF INTENT

THEMES AND COMMITMENTS

Championing the use of data and analytics

We will champion the use of data and analytics that enables better decision making to improve the lives of Essex residents. Role modelling behaviours that support the increased use of data and analytics for decision making by increasing our data literacy, being open minded, curious, and asking good questions.

Building data literacy and Capability

We will support analysts in our organisations to develop analytical skills and knowledge and support all staff in developing their understanding and awareness for data and analytics. Maximize the power data & analytics can bring by embracing a data literacy learning agenda and equipping staff with the skills to create and foster a data culture that drives confidence in how we make evidenced based decisions

Adopting Data Integrity and Data Security standards

We will ensure the data we collect, process and maintain data that is safe and secure at all times and have process that ensure we hold good quality data. This includes working to improve the accuracy, completeness, and consistency of our data. We are GDPR compliant, protecting the data we hold and handling personal data as defined in the law.

Embracing the use of Sharing Data

We will work to make data held within our organisations available to partners for clear purposes and public benefit so that data sharing becomes the norm not the exception. Using Information Governance as an enabler to facilitate the linking of data sets and break down organisational barriers to which allows data to be shared and used in a timely and efficient way.

Acting in Ethical and Transparent ways

We will ensure that all use of data and analytics is within both the law and ethical principles, adopting ethical considerations for the application of analytics & data science, ensuring that it is applied for social good. Being appropriately transparent in our use of this to show we have nothing to hide and build trust. Communicating our commitment to the use of data to our residents and evaluate the difference it has made.

ORGANISATIONS SIGNED UP

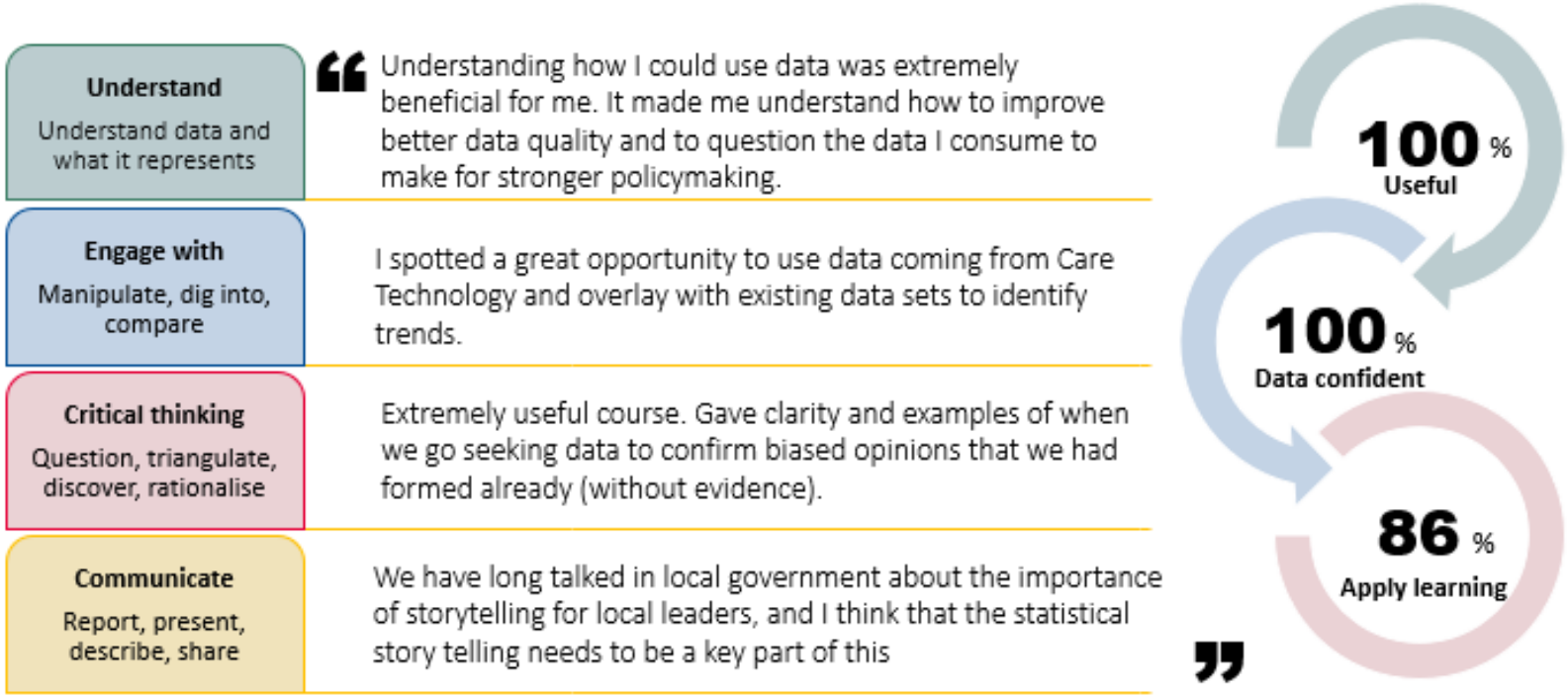
COMMITMENTS

DATA MASTERCLASS

IN PARTNERSHIP WITH ONS DATA SCIENCE CAMPUS

Data Science Campus

- Masterclass created in 2021
- Over 3,000 learners so far
- Senior Civil Servants and leadership programme participants
- Essex first area to engage with the Masterclass as a wider public sector with over 80 leaders completed



WHAT WILL YOU GAIN

IF YOUR INTERESTED AND WANT TO SIGN UP PLEASE CONTACT ECDA ECDA@ESSEX.GOV.UK

WEEK 1 DATA DRIVEN DECISION MAKING

Understand why data matters in government, how it is critical in a diverse range of scenarios and what happens when we get it wrong. Exploring some of the practical considerations of data, and hear invaluable insights from senior leaders and analysts on how they work together to put data at the heart of their decision-making

WEEK 2 COMMUNICATING AND WORKING WITH DATA

Understand how to get to the bottom of the numbers behind the headline, assess the accuracy of claims, and how to demonstrate trustworthiness in communications. Learning from others on why appropriate use and format of data in communications is critical to convey a message with clarity and build trust

WEEK 3 DATA SCIENCE AND NEW FRONTIERS

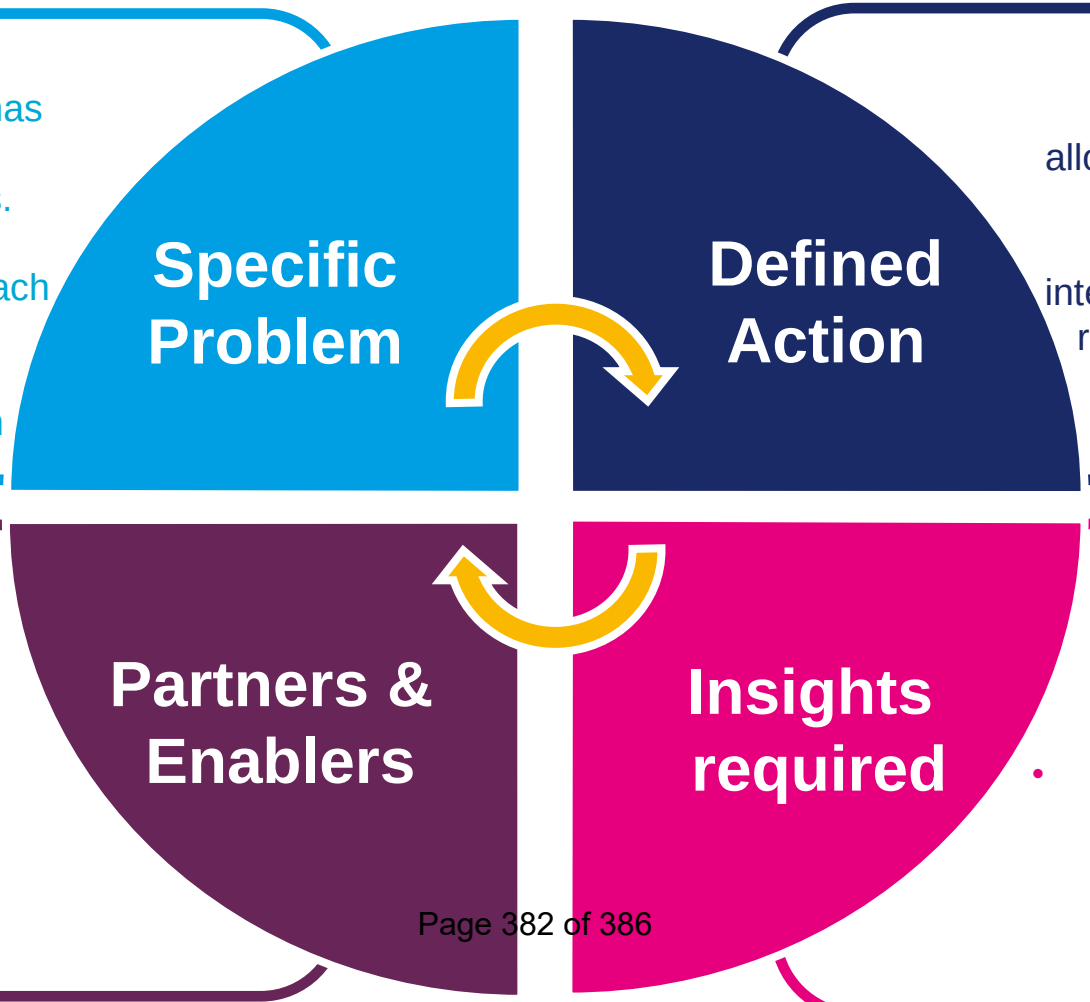
Hear about harnessing the power of data science techniques, how you can spot good opportunities to apply data science techniques to solve real challenges, and how you can be an effective leader when it comes to fostering data science projects within your department, learning from public and private sector companies at the cutting edge of applied analytics

EXPLORATIVE JOINT MENTAL HEALTH INSIGHT

LEAD: ECC & ESSEX POLICE
SPONSOR: LUCY WIGHTMAN, DIRECTOR PH

The impact of the pandemic on people's mental health is well recognised, there has been an increase in demand for support across many public sector organisations.

How can we have an intergraded approach to sharing data and insight in a safe and secure way that helps us understand and address gaps in support & provision



By being better informed of demand and challenges across the system, this could allow us to develop an all age MH approach and better transitional support for young people and those that escalate through intervention intensity. This could allow us to redirect targeted preventative support and help reduce demand on 999 call outs supporting delivery of the MH strategy

- ECC
- MH trusts
- CAMS
- ICSs
- Essex Police
- Ambulance

+Thematic data sharing arrangement
+MH analyst secondment opportunity

- Shared dataset for strategic planning, understanding of demand and impact on services. Using non-personalised data in the first instance.
- District and ward level trends in hot spots and thematic demand profile.
- Flag and trigger pathway analysis to support effective triaging and early identification of appropriate referrals

Essex Centre for Data Analytics: Celebrating a year of collaboration

DATA PEOPLE ACTION ecda

For more information visit the Future of Essex website

http://www.essexfuture.org.uk/innovation/data-and-digital/

Essex Health and Wellbeing Board Forward Plan / Proposed Agendas

Wednesday 20th September 2023
09.30 – 13.30
Venue TBC

	Item and Leads	Leads
1	**Membership, Apologies, Substitutions and Declarations of Interest**	Cllr Spence / Democratic Services
2	**Minutes of the last meeting and matters arising**	
3	**Questions from the Public**	
4	Update from the East of England Ambulance Service Trust	Tom Abell, CEO EEAST
5	**Disability Strategy** - for the board to receive and input into the action plan that will underpin delivery of the new disability strategy	Ruth Harrington and Rachel Williams, ECC
6	**Suicide Prevention & MH**	Gemma Andrews & Jane Gardner
7	**Forward Plan**	Cllr Spence / Democratic Services
8	**Urgent Business**	
9	**Urgent Exempt Business**	
Workshop: TBC		

Wednesday 22nd November 2023
09.30 – 13.30
Venue TBC

	Item and Leads	Leads
1	**Membership, Apologies, Substitutions and Declarations of Interest**	Cllr Spence / Democratic Services
2	**Minutes of the last meeting and matters arising**	
3	**Questions from the Public**	
4	**Forward Plan**	Cllr Spence / Democratic Services
5	**Urgent Business**	
6	**Urgent Exempt Business**	
Workshop: TBC		

Items for which a meeting date has not been identified –		
Agenda Item(s)	**Lead Officer (if known)**	**Notes / Comments**
Suicide Surveillance Figures Update	Jane Gardner & Gemma Andrews	Rolling item to bring back updates at regular intervals
Principles around approaches to finance and the impact on outcomes.	Lead to be identified	Item identified during December 2022 agenda setting meeting discussions.
Items covering: - Community Engagement - Business Engagement - Collaboration	Leads to be identified	ICS leads to work together and advise on how best to cover the topics of Community Engagement, Business Engagement and Collaboration in future Essex HWBB meetings.
Herts and West Essex Virtual Wards Programme	TBA	Suggested following Herts and West Essex Conference. Meeting session to be agreed, suggested for July or September
Eye Health / MSE ICB	Lucy Wightman l Professor Shahina Pardhan	Ophthalmologist and new Non-Exec Director at the MSE ICB – Exploring opportunities and for the HWB to discuss what more we can do to promote eye health across the life course. Opportunity to link with more detailed discussions on the newly delegated primary care commissioning responsibilities in the ICS.