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.

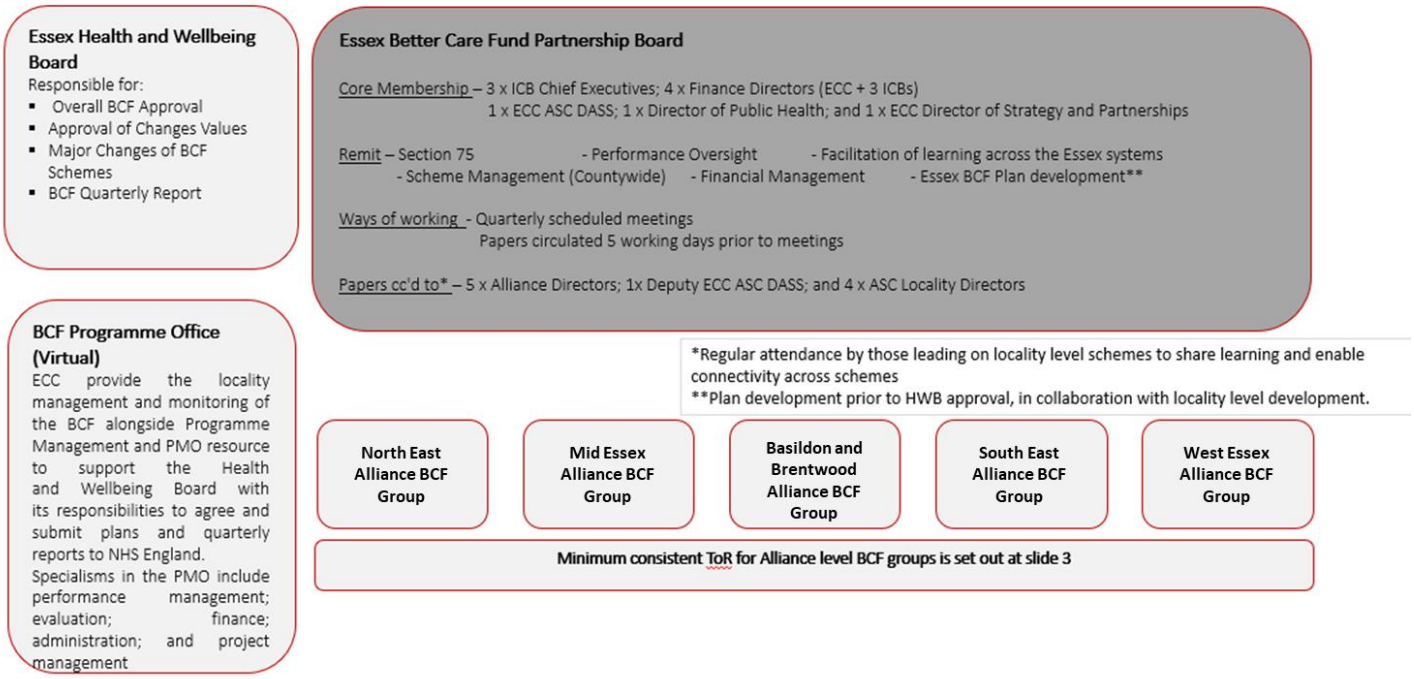
At a place level, our BCF Plan is co-produced through local Partnership meetings, where priorities for local alliances form the basis of decisions to invest. Local alliances / ICPs determine the best approach for investing the delegated BCF Budget in their area.

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

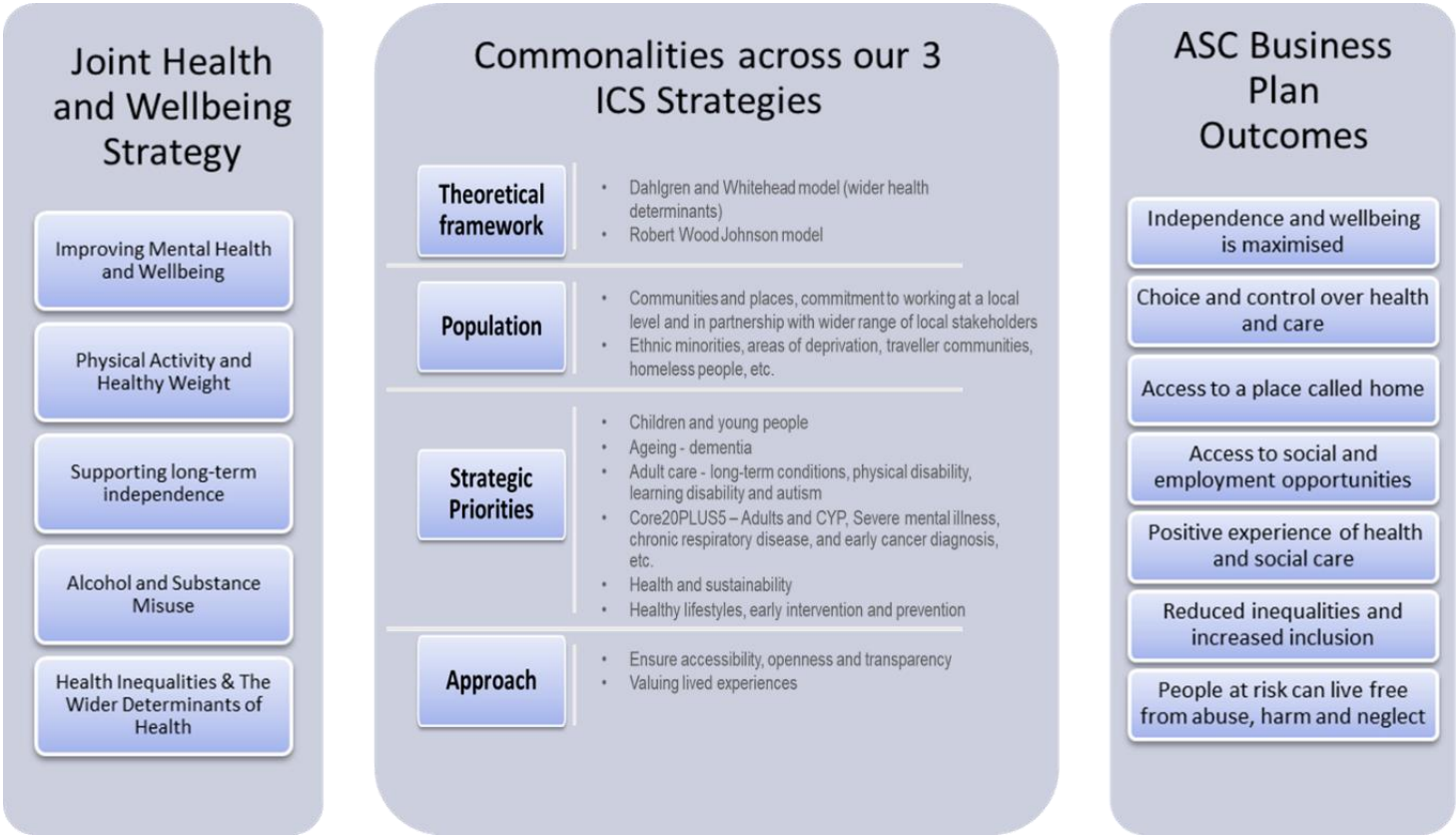
Please outline your approach to embedding integrated, person-centred health, social care and housing services including:

- 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.