APPENDIX 1

Hertfordshire & West Essex STP briefing for Essex HOSC committee – 15th January 2020

Introduction:

This briefing paper is divided into two sections. Section one is a brief summary of the key elements of the Herts & W Essex NHS Long Term Plan and section two is the specific responses to the HOSC questions from the West Essex Integrated Care Partnership (ICP) called One Health & Care Partnership.

Unfortunately due to the recent National election, the final approved version of the HWE STP LTP is still not cleared for formal publication. This should be public in early February as we are awaiting new National guidance and possibly further clarity on priorities from the new government.

HWE STP is in the process of appointing a single Chief Executive and Accountable Officer for the STP and three Clinical Commissioning Groups with interviews on the 20th January 2020.

HWE STP is working closely with NHSE/I as part of an Integrated Care System (ICS) accelerator site on the system and Integrated Care Partnership (ICP) architecture for the future. This process should be concluded by March 2020 and it has already been agreed that the proposed Mental Health ICP, which is still being developed, will only cover Hertfordshire. West Essex ICP will be a core part of the Essex wide approach to mental health for the residents of the three District Councils in West Essex.

Below is a summary of the HWE STP NHS LTP covering the overall approach, priority areas and how we intend to work together.

Section one:

Executive summary of Hertfordshire and West Essex STP NHS Long Term Plan 2019-2024

1. The NHS Long Term Plan (LTP), published in January 2019, sets the direction for NHS organisations delivering care to patients across the country over the next 10 years. The plan identifies five priorities and specifies in detail the action to be taken to meet these:

- Targeted care built around the patient
- Preventing illness and tackling health inequalities
- Boosting recruitment and retention of a highly skilled workforce
- Making better use of data and digital technology
- Maximising value for the taxpayer

2. Commissioners of health and social care services in Hertfordshire and West Essex were required to respond to the LTP, setting out how they will deliver on national priorities locally.

3. The Hertfordshire and West Essex Sustainability and Transformation Partnership (STP) is responsible for the health and care of approximately one and a half million people across Hertfordshire and West Essex. Our population is growing and ageing rapidly: the number of people aged over 75 in our area is expected to increase by 37% over the next ten years. We are seeing an increasing number of elderly patients with complex health needs.

4. While most of our population enjoy good health, significant health inequalities exist across the area and some of our residents are dying from illnesses such as circulatory diseases, cancer and respiratory diseases at a younger age than we would expect.

5. Health and care services across our STP are commissioned and provided by a large number of public, private and 'third' sector organisations and collectively we face significant challenges: our services can sometimes be fragmented, we are struggling to meet demand, we don't always make the best use of technology, and we are finding it difficult to recruit and retain the workforce we need.

6. Despite this, we know that if we work together effectively, there are huge opportunities to improve the health and care of our population and to make better use of our resources. Our leading approach to health and social care collaboration and integration will continue to be a key driver for improvements and we have ambitious plans to provide more holistic, personalised care supported by improved digital technology. The government has recently made a significant financial commitment that will enable us to make much needed improvements to our hospitals.

7. Our plans are built on the priorities we set out in the Hertfordshire and West Essex STP plan (2016) and further developed through the Hertfordshire and West Essex Integrated Health and Care Strategy (2018). The local strategy follows the 'life course' approach used by the Hertfordshire and Essex Health and Wellbeing Boards to tackling health inequalities and people whose health is frail, which can include adults and children as well as older people. This document represents the next step in development of the strategy.

8. **We have three strategic clinical and care priorities: frailty, maternity and children's services and transformation of planned care services.** These areas have been selected because:

- there is close alignment of national commitments and local priorities
- there are significant opportunities to deliver improvements to care and maximise value based on comparison with peers and best practice.

The emerging science of population health management has played a key role in identifying opportunities to improve the wellbeing of our residents. A focus on taking a proactive approach to preventing the onset of avoidable ill-health is central to our plans.

9. **Tackling health inequalities for people of all ages, or 'life stages', is a key local ambition**. We know that lifestyle factors can be a contributing factor to frailty, particularly in older people, and we are seeking to improve outcomes for all through focused work in this area.

10. There are also huge opportunities to make improvements to our maternity and children's services: reducing avoidable variability in outcomes and doing everything we can to ensure that all our children and young people have a strong start in life – setting them on a path to a healthier future and reducing the impact on the health and care system later in life. Improvement of maternity and children's services is a national priority for the NHS.

11. Similarly, planned care is a priority area for improvement nationally and we know by comparing our performance with others that we could deliver better care and better value.

12. In addition to our priority areas we are working hard on improvements across a huge number of health and care services in Hertfordshire and West Essex.

13. Our integrated health and care strategy has been developed and refined through meaningful engagement with local people including patients, clinicians, care professionals and carers – all of whom have played a key role in shaping local plans that deliver on national priorities and reflect variations in local need. **The strategy is guided fundamentally by the Essex and Hertfordshire Health and Wellbeing Boards.**

14. **To support delivery of more holistic health and care provision, we are redesigning the way services are commissioned and delivered across the STP, developing an Integrated Care System (ICS), comprising three Integrated Care Partnerships (ICPs) and 34 Primary Care Networks (PCNs – clusters of GPs, nurses, and other key health and care professionals typically serving up to 50,000 patients). Our two county councils will play an active role in the development, leadership strategy and joint commissioning of these partnerships**.

- The ICS will have over-arching responsibility for ensuring that we get the most for our population from our £3.2bn health and care budget and 56,000-strong workforce and will provide clinical and professional leadership for Hertfordshire and West Essex.

- Our three ICPs will be responsible for delivering services in Herts Valleys, East and North of Hertfordshire and West Essex – following strategic direction from the ICS and responding to local needs.

- Primary Care Networks will have a central role to play in the transformation of out of hospital care delivery on the ground.

15. **Population health management is at the heart of our plans to deliver improved outcomes and a better quality of life for all our residents.** Increasingly, a population health management approach will enable us to provide care that is more targeted and proactive – designed around the unique needs of our citizens. Collectively, our health and care organisations hold a wealth of information about our population. Developments in digital technology are enabling us to combine and analyse this data in new ways to provide invaluable insight and intelligence: enabling us to take a more proactive approach to preventing ill-health.

16. **We have a strong focus on prevention (preventing people from falling into avoidable ill-health).** We know that, locally, children and adults experiencing the biggest health inequalities can typically live between 10 and 20 years less than the local average life expectancy. This is a diverse group which includes people with learning disabilities, children in the care of local authorities, people living in poverty, those who are socially isolated, armed forces veterans and other groups including travellers and black, Asian and minority ethnic residents. We are:

- improving mental health and wellbeing
- addressing obesity, improving diet and increasing physical activity
- influencing the conditions and behaviours linked to health inequalities
- enabling and supporting people with long-term conditions and disabilities and their families and carers

17. **A new approach to out of hospital care, provided in local communities, will be core to our transformation**. We are investing over £50m to provide more care closer to where people live. We recognise that General Practice is part of a much wider local care system – providing effective, person-centred care and support. This should involve close integration with a wide range of other services including social care, housing, mental health, community nursing, 'third' or voluntary sector organisations and hospital services. Primary Care Networks will drive this transformation.

18. Health and social care partners have worked together with the third sector to develop a comprehensive frailty programme. This includes the transformation of hospital frailty care, full integration of community-based care and enabling people to have more control over their own health and wellbeing. These changes will enable us to provide care that is more proactive and designed around the patient.

19. We are developing a whole STP urgent care strategy with a strong focus on reducing avoidable hospital admissions and reducing delays and variation in care through the delivery of system-wide outcome measures. We are also ensuring that we meet national improvement targets and that we take every opportunity to implement innovative models of care, learning from other successful health systems.

20. Local urgent and emergency care services will continue to develop to provide an integrated network of community and hospital-based care, built around the needs of the population. This will ensure that, for example, those with complex needs receive extra support and alternative ways to interact with the system. With a flexible approach we can more effectively manage resources to ensure that we can provide the right care in the right place at the right time. Where we are able to reduce the pressure on emergency services, we will be able to target resources elsewhere.

21. We are working hard to enable people to take a more active role in managing their own health and wellbeing. By adopting a more personalised approach and acknowledging the priorities of patients, service users, and the friend and family carers that support them, we are improving the quality and effectiveness of the care we provide. Importantly, we are encouraging more people to take control and responsibility for their own health and wellbeing and ensuring that services are more sustainable.

22. **We will ensure people who are most "at risk" – due to social vulnerabilities and their clinical needs – are prioritised for integrated care plans that are person, carer and whole-system owned. This will include groups of people who have the biggest inequalities in health such as looked after children, those with serious mental illness and people with learning disabilities, as well as those with a high frailty score. We are also seeking to develop personalised plans around people who have had multiple A&E attendances, multiple emergency admissions and those who have used 999 or 111 multiple times. T**he following will support this:

- We're prioritising the introduction of personal health budgets for more of our residents with complex health needs
- We're trialling a patient-held booklet, 'My Plan', developed by people with long-term conditions and their carers, to enable people to capture what's important to them, their future wishes and the steps they need to take in a medical emergency
- Every PCN will employ a social prescribing 'link worker' – focused on ensuring that people with non-medical issues that are making them ill, like loneliness, physical inactivity or debt, are supported to build their personal resilience by putting them in touch with community organisations that can help.

23. We are prioritising transformation of maternity services and children's health and social care across Hertfordshire and West Essex. By working together across STP organisations to offer continuity of care to expectant mothers throughout their pregnancy, birth and post-natal care and through sharing expertise and information, we have a significant opportunity to improve the health and wellbeing of some our area's most vulnerable residents.

24. **We are committed to ensuring that the emotional and mental wellbeing of our children and young people is a priority and a responsibility for all our area's partner organisations.** During 2019 there has been significant work and financial investment in increasing access to timely, evidence-based mental health

interventions to ensure that we are providing support to children and young people at the earliest opportunity – often in a school or college setting. We are also improving support for parents and carers, children and young people experiencing crisis or trauma, and those engaging in sexually harmful behaviours.

25. **We are redesigning outpatient services, with three outpatient redesign programmes underway which include digitally innovative solutions**. These will increase patient knowledge, provide improved access to advice and guidance, and reduce unnecessary face-to-face attendances over the next five years. Key priorities:

- deliver planned care interventions in the most cost-effective setting and use our highly skilled workforce in a way which delivers the most value to the population and the system
- redesign and standardise planned care services using evidence-based improvement methodologies and scale up best practice across the system
- manage demand by reducing referrals through the application of evidence-based thresholds and maximise the use of technology to provide convenient alternatives to face-to-face appointments.
- improve productivity by streamlining services
- secure sustainable services by systematically identifying services across the STP that can be improved through greater collaboration and implementation of new models of care

26. We have made good progress by using digital technology to support the delivery of health and care services, including roll out of the 'My Care Record' platform and supporting data-sharing agreement across the STP and developing and deploying a single information-sharing agreement across the system. A live information 'dashboard' showing real-time pressures acting on our urgent and emergency care system is improving our ability to anticipate and respond to demand and we have defined standard approaches to coding information within clinical systems for frailty, falls and end of life.

27. There is much more we can do with digital and STP partners have recently committed to invest in development and delivery of a digital strategy covering the whole of Hertfordshire and West Essex that will enable us to focus on optimising current systems, and development and implementation of new systems to support transformation and new ways of working.

28. **We are investing £10.4m over the next five years specifically targeted at improvements in early cancer diagnosis and improving cancer survival rates.** All types of cancer are included in our improvement work, with a particular focus on breast, bladder, lung and colorectal cancer. Our early stage diagnosis ranges between 50.5% and 54.6% against an England average of 51.9% and has remained constant between 2012 and 2018.

29. **We are investing £30m in mental health, autism and learning disabilities services over the next five years.** Investment will be focused on, amongst other areas, locally delivered care linking with PCNs, more joined- up provision across the STP and closer integration of mental and physical healthcare. Improved mental health support will be key to delivery of priority and other areas – such as maternity and children and frailty – and there are plans in place to support these.

30. We are targeting big improvements in the treatment of cardiovascular disease, stroke, diabetes and respiratory disease and have identified a number of opportunities to reduce variation, improve quality and deliver better value through national programmes such as RightCare (though the scale of opportunity is variable across the STP). This work includes a move towards digitally-supported, co-delivered models and further integration of hospital based and community services to enable more seamless care.

31. **Our workforce will be key to supporting change and in particular enabling delivery of more patient-centred care via PCNs**. The workforce programme covers recruitment and retention, education and development, innovation and technology, leadership and organisational development and enabling a 'one workforce' approach. Key priorities:

- making the NHS and social care sector the best place to work
- improving the leadership culture
- addressing urgent workforce shortages
- transforming how we work
- a new operating model

32. Modernisation of our hospital estate is critical to delivery of our strategy and will provide us with an opportunity to improve access and deliver efficiencies across our health and care system. As noted above, two of our area's acute hospital trusts were included in a significant national NHS investment programme announced in September 2019. Our estate strategy also includes additional and flexible capacity in primary care and the development of integrated neighbourhood care hubs. **We are working on a single Public Estate Plan to be developed and agreed by April 2020, building on existing organisational and system estate plans.** This will support hospital transformation enabled by the recent capital commitment from the Government.

33. Estate transformation and modernisation is a critical enabler of our strategy and provides an opportunity to improve access and deliver efficiencies across our health and care system. The government recently committed two of the largest financial investments in the country to our STP and this money will enable us to make much needed improvements. Our estate strategy also includes additional and flexible capacity in primary care, development of integrated neighbourhood care hubs as well as our acute hospital

estate redevelopments. This will support hospital transformation enabled by the recent capital commitment from the government.

34. Our STP has co-ordinated its approach to the financial planning element of the NHS Long Term Plan via the STP Finance Directors' Group and a task and finish group led by deputy finance directors, with each of the three CCG area's economies working together to that our activity and expenditure are aligned. We will develop and agree a three to five-year public sector investment and efficiency programme with Local Authorities and Local Enterprise Partnerships by September 2020.

35. We have agreed a medium-term financial plan which returns the STP to financial balance in the medium term, through efficiencies identified by RightCare and Model Hospital, system transformation and assumptions in respect of recurrent STF funding. Oversight of the plan is provided by the established Finance Directors Group which includes representation from Essex and Hertfordshire County Councils.

36. **We are ambitious for a healthier future for the residents of Hertfordshire and West Essex. Our partnerships are strong and we have a plan that will deliver our ambitions.**

Section two:

Response from One Health & Care Partnership to HOSC questions

Health & Care Partnership

West Essex One Health and Care Partnership

Update for Essex County Council Health Overview and Scrutiny Committee

Section 1- Mission of The One Health and Care Partnership (OHCP)

The West Essex One Health and Care Partnership is a collection or organisations delivering care for our population including

- West Essex CCG
- Princess Alexander Hospital Harlow
- Essex Partnership University Trust
- Essex County Council
- 3 District Councils
- Primary Care Networks and individual GP Practices
- GP Federations
- Voluntary sector

The One Health and Care Partnership's mission/ambition is to work together to provide the best possible care and support for people when they need it.

Bringing together NHS organisations, local hospitals, GPs, social care and the charity and voluntary sector we put local people, and the quality of health and care services, at the centre of all we do.

Our aim is to put an end to things that can delay action, be it appointments, treatment or access to support. We want to stop people being passed around different organisations, on different sites, seeing different people.

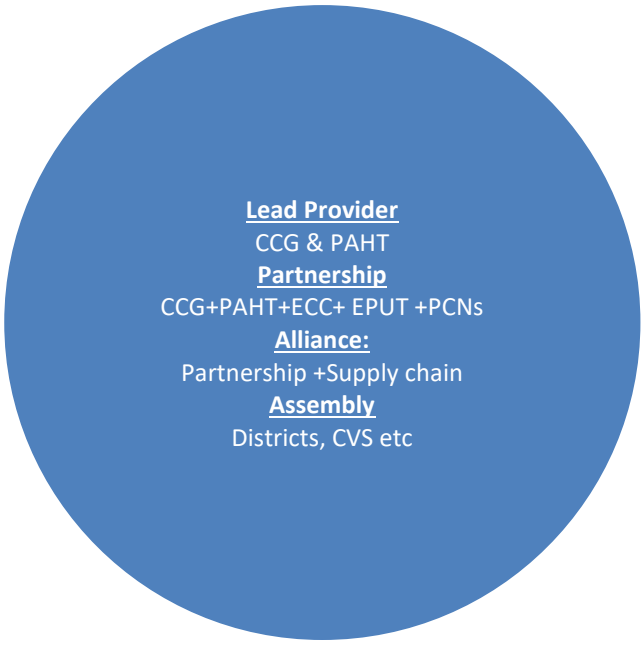
Instead we want to see care that is more joined up and more personal, closer to people's lives and location and more consistent.

The West Essex One Health and Care Partnership is a series of partnerships

Section 2 - Working in Partnership to deliver the West Essex One Health and Care Partnership Vision

The Tiers of Membership:

A) Lead Provider- contractual partnership PAH/CCG plus sub-contracts
B) OHCP Partnership- Partnership Agreement/Statement of Intent
C) OHCP Alliance – MOU
D) OHCP Assembly- Compact



The Core Partners (Tier 1 and Tier 2) within the One Health and Care Partnership are

- West Essex CCG
- Princess Alexander Hospital
- Essex Partnership University Trust
- Essex County Council.

Wider engagement (Tier 3 and Tier 4) includes

- Primary Care Networks
- GP Federations
- Urgent Care Provider
- 3 District Councils
- Voluntary Sector

Working as the One Health and Care Partnership, they are combining expertise and resources to protect and improve services. The aim is to give people greater control over their own health and care, basing services on the health needs of the local population. There is a united objective to integrate services at the point of need ensuring that patients always receive high quality care in a location that best meets their needs and they see no distinction in the services they are offered.

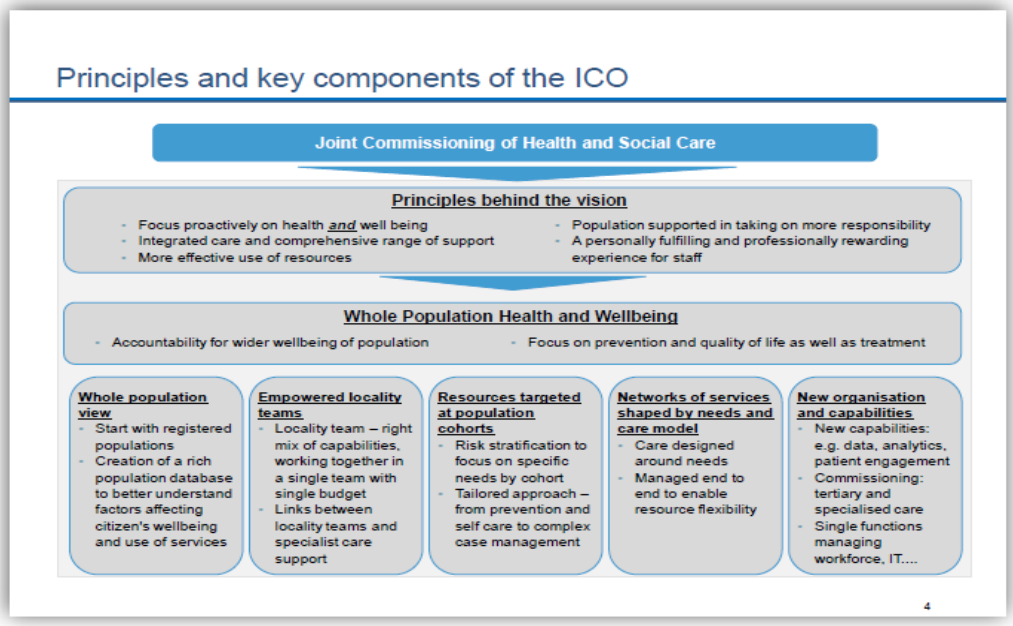
The partnership will focus on closer work involving all partners to ensure information is shared to improve experience and outcomes in health and social care. Communities will gain greater control over their own health and care, knowing that when needed, they can consistently access the right support in the right place at the right time.

This is part of a wider strategy being implemented by the Hertfordshire & West Essex Sustainability and Transformation Partnership (STP), of which many of the partners are members.

For the One Health and Care Partnership (our local ICP) and STP this will require considerable change in the way our organisations work, with calls for greater collaboration and new ways of doing things.

Section 3- Delivering on a consistent ambition

Since 2014, the West Essex Health and Care System has had a clear ambition to deliver an integrated care organisation and the approach take is summarised in the diagram below,



Section 4-.Aligning the ambition

Over the last 3 years the system has established a strong foundation for integration this has included

(1) Governance

- Establishment of the ICP Board
- System leadership provided by the fortnightly Partnership Board
- Launch of the System Transformation Board and System Finance Directors Group
- Clinical engagement, development and strategic planning through the West Essex Professional Leaders Group
- Development of a Single Accountability Framework
- Launch of Clinical Expert Oversight Groups

(2) Alignment of functions

- System analytics and the development of a System Dashboard
- Alignment of PMO
- Joint HR and Comms Delivery Board
- Integrated approach to the delivery of health and social care at neighbourhood level
- My Care My record data integration function.
- System wide actuarial analysis
- Agreement to a single financial control total and suspension of PBR.

(3) Clinical transformation and integration

- Integration of Clinical Expertise through the launch of Expert Oversight Groups. There are 12 in place across a range of clinical specialities and they play a key role in the development of new clinical pathways.
- Launch of the MSK Integrated Care Pathway in July 2019, which is the first of our Lead Provider models with an integrated care pathway, single capitated budget and agreed set of outcomes.
- Development and launch of an integrated system wide COPD Service.
- Range of system wide transformation programmes in place and committed to through the 5-year System Transformation Plan
- Single accountable lead provider in place for Childrens services across Essex.

(4) Public Engagement

Since 2014 we have consistently engaged with our citizens in relation to the development of integrated care services and their insight and experience has played a key part in how we deliver our clinical and operational services in the future. Ongoing engagement has been maintained through the launch of the ICP Assembly and the Patients Forum as well as using a range of mediums to share our message across the system.

Section 5 -Development of the West Essex One Health and Care Partnership (Current state)

West Essex CCG, GP Federations, EPUT and PAHT have been working together for a while to work more closely and develop integrated pathways of care for the local population. We have developed well-defined and fully functioning governance and started to recommission some services.

At the OHCP Assembly Launch in June 2019.

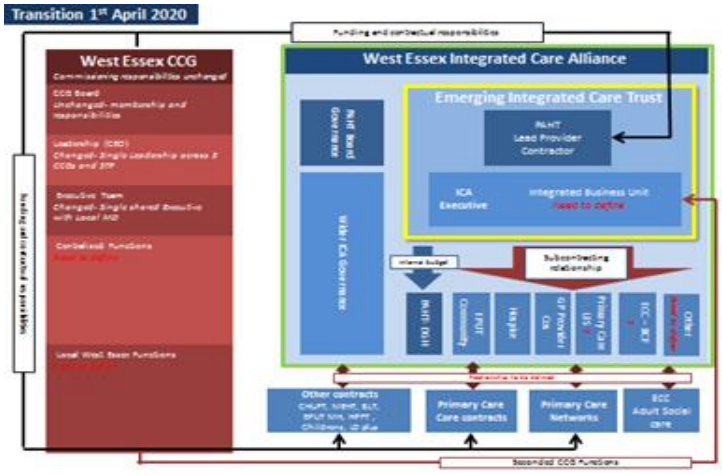
Lance McCarthy (CEO of PAH) said:

"Change must be allowed to happen, and things improved, if we are to protect the health and care services we value so much, not just for now but for future generations.

"There are big opportunities to do this by making common-sense changes to how our health and social care services are run and enable them to work closer together. It's why our local GPs, NHS organisations and local councils are coming together to plan and redesign local health and care for west Essex residents.

In the absence of the ability to significantly change the form of the provider organisations, West Essex ICP is currently a group of providers and commissioners bound together by an MOU and a partnership agreement. The work to date has been the development of integrated governance and some pathway redesign. We are just about to commission integrated services differently (MSK, respiratory / COPD and integrated urgent care) as a lead provider model, with PAHT as the lead, sub-contracting with other providers in the local system for their provision of the relevant part of the service.

Our Key Transition Point Transition 2020-2022- The One Health and Care Partnership



Key delivery points are outlined below

1. Move PAH to Prime Contractor role in a number of identified areas
2. Suspension of PBR and movement towards an Allocative Contract and Single Control Total for the system
3. Change contractual arrangements
4. Fully establish the Joint Business Unit approach to enable a number of shared functions such as business intelligence, PMO, Communications, HR
5. Launch of a System Transformation Plan (2020-2025)
6. Formalise Governance and joint management arrangements
7. Secondment and alignment of staff.

Section 6 -Delivering Sustainable hospital services in West Essex

A key priority of the One Health and Care Partnership will be to ensure sustainable hospital services at Princess Alexander Hospital. The OHCP approach creates significant opportunity for the hospital to not only sustain itself but create new vision and strategic identity for the next ten years through the

- Development of a new hospital
- Increasing of Income and capital to revenue ratio
- Implementation of the clinical strategy for the hospital
- Reduction of fixed costs
- Implementation of model hospital
- Increase of income through repatriation of activity.
- Launch of integrated high-quality clinical pathways
- Delivery of the Medium-Term Financial Plan for the system
- Development of an integrated system workforce plan
- Practical alignment of core functions and back office

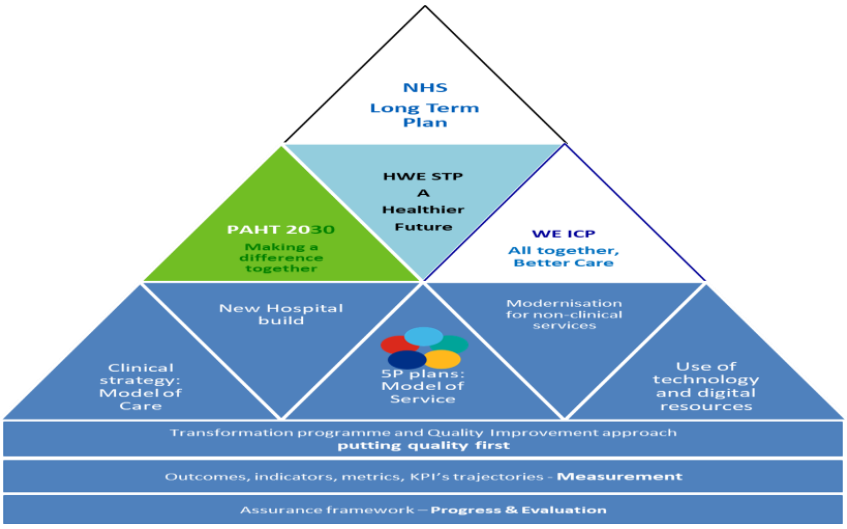
PAH 2030

In June 2019 PAH launched the development of the PAH2030 Strategy. Underpinned by the PAH 1 Vision, 3 Goals and 5 P's framework, PAHT2030 aims to describe the PAHT:

- future model of care in response to the NHS Long Term Plan and our position within the One Health & Care Partnership and HWE STP
- our future estates requirements
- our modernisation plans
- our digital requirements over the next 10 years.

Alignment of the PAH and One Health and Care Partnership Vision

The image below highlights the connection between the NHS Long Term Plan, PAH2030 and the WEOHCP



Section 7- 2 Year Financial Plan- 2020/21and 2021/22 Draft Financial Plans

The CCG and PAH have agreed to suspend Payment by Results (PbR) for the financial years 2019/20 – 2021/22. In addition, discussions are progressing on extending this arrangement to include significantly more of the current service provision in a more comprehensive allocative contractual arrangement.

The new approach with greater income and cost certainty through an 'allocative' contract arrangement linked to the clear direction of travel in the Long-Term Plan, encourages and incentivises both organisations to work collectively to meet the system challenges. This gives far greater emphasis to the system as whole rather than individual organisational sovereignty and financial positions. The prime focus is to improve overall financial sustainability and reduce underlying deficits at greater rate than would be delivered on an individual basis. It promotes a combined and joined up approach to the benefit of patients and financial efficiency and effectiveness.

The key strategy approaches are:

- Collective responsibility for delivery of system control total and securing Financial Recovery Fund
- Joint efficiency planning
- Suspension of PbR to encourage true system working.
- Joint approach to management of financial risk in the system.
- Focus on cost reduction and efficiency as opposed to individual trading positions.
- Realisation of opportunities, including back office integration, estate rationalisation and the acceleration of potential repatriation of activity and model hospital opportunities.

Both organisations have agreed to adopt this approach as the way to address the system issues and challenges. Under the "allocative" approach the partnership will have responsibility for the delivery of care for the "whole" system as opposed to just within the current hospital and service boundaries.

In support of this both organisations have created a system plan and firmly anchored this in the creation locally of the West Essex elements of the Medium-Term Financial Plan (MTFP) across the STP.

Specific Questions from HOSC

1.Do you have any local unique challenges and circumstances that have had to be specifically addressed in your latest updated plan..? with this in mind how are you targeting health inequalities in your area. ?

In West Essex The population is living longer, growing and marked by significant differences in health experience and outcomes between its richest and poorest communities.
The data suggests the system is seeing more complex patients with more complex needs, in a system which can be difficult to navigate, however these people are not always being seen at the right place. The data suggests that outcomes are achieved through an over reliance on acute care, which is unsustainable.

The Needs of our Population: JSNAs
The Joint Strategic Needs Assessment describes the needs of our population. Essex County Council is refreshing this in August 2019, however this is not expected to change significantly. The following has been extracted from the District JSNAs.

Harlow
"Interventions need to reach high risk groups to reduce the number of preventable health conditions" Harlow Well Being Strategy 2018-2028.
Harlow has several wards with high levels of deprivation and health inequalities. Lifestyle challenges include reducing smoking, drinking and obesity levels and increasing physical activity. There is a higher rate of Diabetes than the national average and an increasing number of people with Dementia.
There is a higher than average ratio of jobs per person and an increasing number of jobs, however these jobs are often low paid and potentially zero hours contracts which will impact patient behaviour in accessing services.

Epping
"Our aim is that EFDC residents across all demographics, have the opportunity to lead healthy & fulfilling lives. EFDC Health & Well Being Strategy 2018 – 2018.
Whilst deprivation is lower than average, inequalities exist and there are estimated to be 3,400 children living in poverty.
Lifestyle challenges also exist with 64% of the adult population classified as obese and lower levels of physical activity. 20% of the population smokes and dementia rates are increasing.

Uttlesford
"Our aim is all children, young people & adults in Uttlesford are able to live healthy, fulfilling & long lives." Uttlesford H&WB Strategy 2019-2022
Uttlesford is a relatively healthy and affluent district however pockets of deprivation do exist within areas.

For the system to be in equilibrium the following need to be addressed;

- **Improve access**
- **Improve prevention and reduce health inequalities**
- **Identify, manage and control those with LTCs outside of the hospital setting, building on the pathway work to date and planned care programme**
- **Manage our Complex and Frail population in a more personalised and co-ordinated way through better identification, proactive community management, rapid response, intermediate care and transfer of care.**

2.Pan Essex Appproach – to what extent can you ensure a pan Essex approach in maintained in the commissioning and delivery of services

Officers from the CCG and the Council work in partnership on the development of core Essex wide services such as Childrens, Mental Health and Childrens Mental Health . From an unplanned care perspective there has been considerable alignment on the delivery of the Better Care Plan Priorities as well as developing a range of innovative based services in partnership to keep people out of hospital and cared for in their own community. More recently there have been a joint procurement and commissioning of intermediate care beds in the West Essex locality and we are through our System Transformation Board committed to deliver the outcomes from the Essex wide Newton review.

3. Children and early years

In line with the delivery of the Essex wide Childrens service there is commitment at county and district level to ensure all our children have the best possible start in life. Similar to Mid Essex there is a focus on pre natal care, maternity and early years health and care support for children and their families.

We are also reacting to what the evidence and data tells us and ensure we put in place integrated care services to address specifics challenges such as increased in childhood obesity in the Harlow Area.

4.How far have you progressed with shared care records ?

The West Essex system has made considerable progress on shared care records through the development of My Care Record. My Care Record is a programme which allows health and care professionals access to view medical records from different organisations for direct care purposes and forms part of the wider Local Health and Care Records (LHCR) programme. In addition to this programme the STP Population Health Management Programme is developing its requirements for a data repository for indirect care purposes. This will enable the system to transition from a reactive system to a proactive model focused on earlier detection and intervention through segmentation and stratification.'

In addition to this we are establishing a system data warehousing approach across the West Essex One Health and Care Partnership and this is being overseen by a System Board.

The key next stage of development is whether to expand the use of My Care Record for direct and indirect care purposes

5. How will you assess the success of your plans? How will you evaluate impact and on what timescale ?

In West Essex we have developed a System Dashboard which is reviewed on a monthly basis.

This has been developed in line with the vision articulated in the NHS 'Long Term Plan and the STP 'A Healthier Future' and will be the overarching tool to monitor improved outcomes as articulated in the OHCP plan.

The tool views the OHCP through three different lenses;

- Our System
- Our Population
- Our Staff (to be developed)

It has been developed using visualisation software with data architecture which enables the user to drill down to different programmes and layers within the system eg the Frail and Complex Programme which can also be viewed by PCN. The outcomes identified are a mixture of Patient Defined outcomes and Clinical Outcomes. The

Patient Defined outcomes have been built using existing outcomes and are planned to be verified via engagement with our Citizen's Panel. These outcomes articulate what is important to our people for example 'spending more time at home' ie less time in hospital or 'feeling supported to manage their long term condition'. Clinical outcomes are discussed at our Expert Oversight Groups.

It is anticipated that as this develops the data will be put to use in our governance including Expert Oversight Groups and our maturing PCN meetings.

The data is pulled from a variety of sources and will be refreshed at different intervals. These overarching outcomes should align with the outcomes detailed in the programmes.

The population section of the dashboard is built on our Population Health Management model which groups our population into three sub groups;

- Generally Healthy
- LTCs
- Complex Patients

The above is broadly based on the 'Bridges to Health' model developed in the US and recognises patients journey through these sub groups as a continuum.

6. Working across Essex : Please provide examples of where you have worked together across Essex ?

We continue to work in partnership with Health and Care colleagues across Essex in a number of areas including

- The delivery and development of integrated childrens services
- Delivery of adult mental health services sharing best practices and approach in relation to the development and modernisation of mental health services
- Joint commissioning and delivery of CAHMS

- Developing a Intermediate care model (bedded and non bedded)
- Implementing the recommendations of the Newton Review

Essex County Council and its lead officers and actively engaged in the development of the One Health and Care Partnership fully represented at the appropriate governance and instrumental in development of services
James Roach

Programme Director West Essex One Health and Care Partnership

January 7th 2020