Essex Better Care Fund 2022-23 narrative plan

Essex Health and Wellbeing Board

Bodies involved in preparing the plan:

Local authority:	**Integrated care boards (ICBs):**	**Five 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 • Castle Point & 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 Greater Essex Operational Tactical Co-ordination Group, 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 have considered and been asked to endorse the plan.

Executive summary

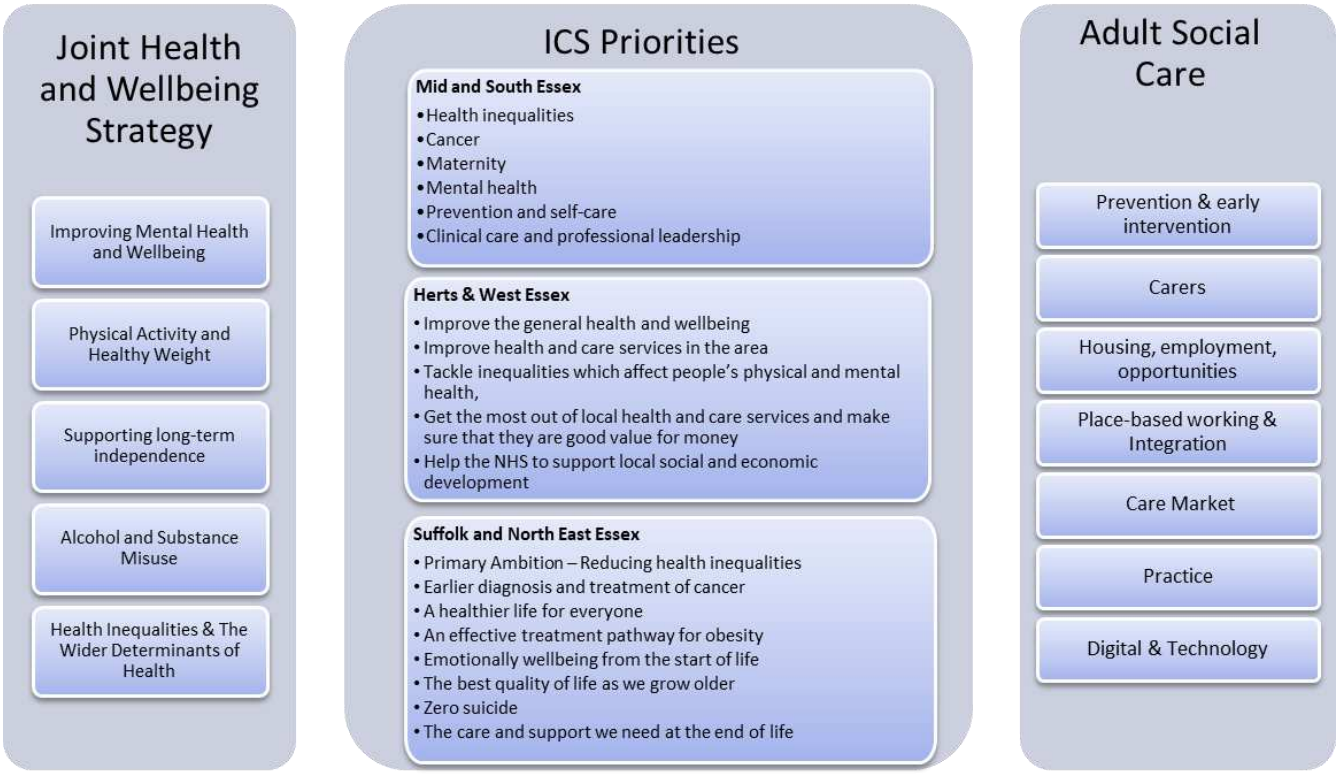
Essex is one of the largest and most complex health and care systems in the country. This year has seen the introduction of Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs), with Essex part of three Integrated Care Systems (ICSs) which overlap with other local authority boundaries (Southend, Thurrock, Suffolk and Hertfordshire).

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.

Since the 2021/22 plan, Essex have updated our Joint Health and Wellbeing Strategy (JHWS) which sets out refreshed priorities and an increased 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.

Priorities for 2022-23



The diagram above 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).

To deliver against these shared priorities we will focus our work through the Better Care Fund 2022/23 on:

- Intermediate Care
- Care Market Development
- Communities and Early Help
- Discharge to Assess
- Alliance Development
- Neighbourhood teams and PACTs (PCN-aligned community teams)
- Carers

Summary of Finances:

Funding Source	**HWE** **£m**	**MSE** **£m**	**SNEE** **£m**	**DLUHC** **£m**	**Total** **£m**
NHS Contribution	23.8	64.3	26.5		114.5
iBCF				46.4	46.4
DFG				11.9	11.9
Total BCF Pooled Budget	**23.8**	**64.3**	**26.5**	**58.3**	**172.8**

Expenditure Plan	**HWE** **£m**	**MSE** **£m**	**SNEE** **£m**	**County-wide** **£m**	**Total** **£m**
Social Care (min NHS contribution)	9.3	26.0	10.3		45.6
Community Services	14.4	38.3	16.1		68.9
iBCF Meeting Social Care Needs				36.1	36.1
iBCF Countywide & Locality Schemes	0.2	0.4	0.1	9.6	10.3
DFG funded	2.1	6.0	3.8		11.9
Total BCF Plan	**26.0**	**70.7**	**30.4**	**45.7**	**172.8**

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 quarterly reports on progress.

Sitting beneath the Health and Wellbeing Board, the Greater Essex Integrated Health and Care Liaison Group (IHC Liaison Group) 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 ICS chief executives, and the Director of Public Health for Essex. The group also includes representatives from Southend and Thurrock, but does not act as the BCF partnership board for those unitary local authorities.

The Essex BCF is governed by a section 75 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.

Overall BCF plan and approach to integration

Context

Essex has an ageing and growing population and has a higher proportion of the population aged over 65 than the England average. The recent census showed that Essex has seen a 44% increase in the population aged 70-74 over the last decade, compared with 37% 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, this 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 almost doubled between 2007 and 2017.

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.

Alongside this, Essex operates in arguably the most complex health and care system 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 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.

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.

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.

Joint Integration & BCF Priorities:

I. Intermediate 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. It 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. Service contracts are in place providing block capacity of over 13,000 hours per week of reablement with an average of 80 adults supported each week through reablement contracts, and a further 30 per week supported by our In Lieu of Reablement (ILOR) 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.

Below is a summary of forecast expenditure and funding streams for the areas of intermediate care managed by ECC.

Forecast Expenditure	**2022/23 £m**
Reablement at Home	18.3
Additional Reablement Capacity / In Lieu of Reablement	4.9
Spot Purchased Reablement	5.9
Bridging	3.6
Total Intermediate Care (ECC managed)	**32.8**

Funding Source	**2022/23 £m**
BCF 2022/23	12.0
iBCF 2022/23	7.3
Other sources (recurrent)	6.3
Other sources (non-recurrent)	7.2
Total Intermediate Care (ECC managed)	**32.8**

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 and 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.

In the short-term this requires an interim step to secure additional reablement provision to replace in-lieu-of-reablement (ILOR) services across the county and to procure bridging services. This will drive consistency and improvements in our reablement and bridging capacity, aimed at driving the cross-system collaboration needed as we move toward an integrated model for intermediate care services. To support with this, the Council has created the Connect programme which is refining the process flows and system intelligence to support better delivery of reablement outcomes.

II. Care Market Development – the BCF and iBCF is utilised to support the care market. For example, it funds 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 have been high for the past 12 months, as the

domiciliary care sector has struggled to compete with other sectors of the economy for workforce. From engagement we know that the key challenge is workforce, so we have several initiatives in place to help providers retain and recruit staff. Essex is currently refreshing its market shaping strategy.

III. **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.

IV. **Discharge to Assess** – a review has shown there are 5 different approaches across Essex and identified four areas of focus that would benefit from being addressed in terms of the D2A guidance; Leadership, Transfer of Care Hubs, Community pathways and Post Discharge community reviews. Improving hospital discharges is a priority for addressing through 2022-23.

V. **Alliance Development** - At a local level, there is some 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.

Alliance Development is also a common theme across many parts of the Essex system with several alliances looking to strengthen change management and programme delivery capacity at place level to focus on integrated projects such as "**Connected Places**".

VI. **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.

VII. **Unpaid Carers –** Essex has developed and launched a new carers strategy which sets out 6 commitments to support unpaid carers. This is set out in more detail later in the plan.

The diagram below provides an overview of our shared priorities at county and place level.

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 a number of 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. The countywide fund has also funded incentive payments to facilitate fast-track discharges and to reduce unmet need in the community. 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	To realise the **Alliance Neighbourhood** ambition in North East Essex the BCF will support **test and learn activity** and the development of **community hubs and community models of working as part of the Neighbourhood teams project**. It will also support the continuation of work on **Community Micro Enterprises** (CMEs) and using an Asset Based approach to the provision of care and support services in the local area. Providing greater choice and control for local residents. The partnership is investing in **Alliance Delivery Leads** connecting these leads to key alliance programmes, to create additional delivery capacity. The partnership is also investing in **discharge support programmes** aimed to improve a residents opportunities to access reablement care via a trial to support on a ward pre discharge and a project to ensure 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.
Mid and South Essex ICS	
Mid Essex	In addition to the continuation of several existing programmes funded through the BCF this year partners in Mid Essex have agreed to take forward the **Supporting Wellbeing Outreach Team**. Provided by Chelmsford CVS, this service supports Adults returning home from hospital with low-level issues such as equipment, house clearing, shopping etc to ensure successful hospital discharge and avoid unnecessary readmission. The partnership is investing in **Alliance Delivery Leads** – learning from North Essex and connecting these leads to key alliance programmes, to create additional delivery capacity. **Virtual ward link workers,** to provide focussed support with each frailty virtual ward from social care to support Adults moving through the model and ensuring that they receive the most appropriate input from social care to maximise opportunities for independence.
South East Essex	In South East Essex the BCF has supported programmes including the **Aging Well Intensive Carers,** an integrated programme with health and community teams to aid discharge from hospital to own home or most appropriate care facility. It will also continue to support **Research into Readmissions & Avoidable Admissions** - commission deep dive analysis to offer clear reasons for readmission. As a result of the BCF we have also been able to extend **Dementia support (Dementia Community Support Team)** working in partnership with Southend.

South West Essex	We are working to further strengthen our alliance working and, building on learning from North Essex, we are creating **Alliance Delivery Leads** tasked with taking forward priority programmes of work for the alliance and supporting local system transformation. We are also exploring the use of the **Gemima Risk Stratification Tool** - Implementing a Risk Stratification Tool for primary care to inform care plan discussions at MDT across health and social care and to identify service users with high/multi complex needs At a neighbourhood level the BCF has is supporting **Neighbourhood Co-ordinators** to strengthen the contribution of neighbourhood teams and improve care coordination for people with different levels of need in that neighbourhood.
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 priorities 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

Implementing the BCF Policy Objectives (national condition four)

Approach to enabling people to stay well, safe and independent at home for longer

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 partners across the alliance have undertaken Asset Based Community Development (ABCD) training and embedded those principles in how they work. We are also continuing our work on Community Micro Enterprises (CMEs) to help provide greater choice and control for people in ow their needs are meet local through the assets that exist in their local area.

In South Essex, in Basildon and Brentwood and Castle Point and Rochford we are exploring how social prescribing can help build stronger resilience and enable people and their families to maintain their independence. The social prescribers work to link individuals with early interventions and prevention support within the community.

In Mid Essex 'Connected Places' is a joint pilot project between Mid Essex Community Health and ASC exploring ways to integrate personalised health and social care services and drive outcomes for people living in the Dengie peninsular, a rural area of Essex. This is providing a more joined-up localised response with community nursing, ASC and domiciliary care working as a neighbourhood team together with a network of other professionals wrapped around them. We are now looking at how we can take the learning from this pilot and extend it to other communities in Mid Essex supported by Alliance Delivery Leads

II. Joined-up approaches to population health management

Work is ongoing as a part of the development of each of our 3 ICS systems to embed population health management and the use of data and intelligence to support commissioning, planning and strategic decision-making. Approaches are being developed in each ICS system.

Mid and West Essex were both 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 and South Essex, ECC and the NHS are currently embedded in some key **PHM test projects including a PCN focussed frailty trial** involving the use of linked data to drive machine learning models in the identification of those at risk of hospital admission. Through improved insight individuals can be targeted for evidence-based interventions to prevent, reduce or delay health deterioration and improve outcomes. Other projects include the linking of adult social care data and hospital waiting lists to improve prioritisation and address health inequalities, this also involves the testing of data platforms for future data sharing opportunities. ECC is also **implementing new digital infrastructure to enable modern data architecture and analytics**, paving the way for ECC to utilise linked NHSD commissioning datasets for the developing PHM programme.

Across our 3 ICSs we are working in partnership on several PHM projects including:

Suffolk and North East Essex ICS

Vulnerability Index
- Working with partners and their multiple data inputs to develop an index of vulnerability (physical, social, financial) to support targeted interventions.

- **Demand and Capacity Model**
  - Supporting a system effort with data and knowledge to model various scenarios on the driving pressures for health and care demand and the required capacity to meet it.
- **Learning Disabilities**
  - The sharing of adult social care data for those supported for learning disabilities needs with ESNEFT*, to link with hospital waiting lists to aid prioritising care and addressing health inequalities. Initial one off data flow with potential for regular provision.

Mid and South Essex ICS

Connected Neighbourhoods (Frailty Segmentation) An embedded ECC analyst in a project with 5 PCNs to accelerate the delivery of anticipatory care for people living with frailty, understanding the factors that drive increased health & care needs, working closely with practitioners to design model of care changes to improve outcomes.
- **Hospital Waiting Lists & Inequity** Linking adult social care data with hospital waiting lists to develop a methodology for priorities care and tackling health care inequity.

Herts and West Essex

Population Segmentation
- Contributing to the development of a population segmentation model and outcomes framework to support population health management methods. Exploring the addition of social care data to advance the model.
- **Health Inequalities programme**
  - Mapping and profile insight provided for the Health Inequalities Committee's work in addressing inequality and inequity around the determinants of health; social, behaviours, environment and service access.

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 bring together representatives from local organisations (local voluntary sector, communities, leaders, boroughs and district councils and health and social care) to provide a single point of contact within a locality to provide a coordinated care response for people, underpinned by prevention, self- care, early intervention, reablement and rehabilitation, (including people living in nursing and care homes). Citizens 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 West Essex partners are working together through the 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. Work is also continuing on developing PCN Aligned Community Teams (PACTs) for co-ordinated management of people with complex needs, improved access to health and care support.

Approach to providing the right care in the right place at the right time

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 5500 people each year through our reablement, ILOR 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.

Expenditure*	**2019/20 Actual £m**	**2020/21 Actual £m**	**2021/22 Actual £m**	**2022/23 Forecast £m**
Reablement at Home	14.2	17.2	18.4	18.3
Additional Reablement Capacity / In Lieu of Reablement	3.8	3.5	4.3	4.9
Spot Purchased Reablement	2.0	2.2	3.2	5.9
Subtotal Reablement	**20.1**	**22.8**	**25.8**	**29.1**
Bridging			3.1	3.6
Total Intermediate Care (ECC managed)	**20.1**	**22.8**	**28.9**	**32.8**

* Also includes non-BCF funding sources such as hospital discharge funding.

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 two years we are undertaking 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.

In the short-term this requires an interim step to secure additional reablement provision to replace in-lieu-of-reablement (ILOR) services across the county and to procure bridging services in North-East Essex and West Essex. This will drive consistency and improvements in our reablement and bridging capacity.

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**

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 council has invested in a new **Care Technology service,** which launched in 2021. This is supporting over 4,700 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. This includes the introduction of early MDTs for adults using our reablement services and strengthening the link and impact of our care technology arrangements by offering training to all reablement assessors and care delivery staff. In addition, pilot studies include trialling a range of technologies such as the use of GPS devices to support falls prevention; Memo Minder; voice-activated sensors for people with memory loss; and using Alexa to support independence. The service has expanded to include prescribers across health including: hospital discharge teams, community health teams, GP care advisors, social prescribers and many more. Our Monitoring and Response provider has a falls pick-up service and is linked into the local Urgent Community Response Teams across Essex, avoiding 67 unnecessary ambulance call-outs in one year, and is working to develop further pathways including virtual wards.

Plans for improving discharge and ensuring people get the right care in the right place

In September 2021 Essex County Council commissioned Newton Europe to undertake a review of the Discharge to Assess processes across the County. Although the review was commissioned by ECC it was supported and engaged with by partners from Health, 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 the High Impact Change Model. The review output was shared

across Partners and with Place based Alliances at the start of 2022. The review highlighted inconsistencies in approach to discharge across the County and identified four areas of focus that would benefit from being addressed in terms of the D2A guidance; Leadership, Transfer of Care Hubs, Community pathways and Post Discharge community reviews. Each of the five Place based Alliances across Essex agreed the gaps were a priority and adopted a high level roadmap of activity to address these gaps.

Each Place is now working at its own pace to deliver against the roadmap. Transfer of Care Hub design is happening across all five localities and the majority have appointed a single system coordinator to drive this work. A maturity matrix has also been developed and in the process of being adopted across the County to monitor progress. The Matrix is based upon the review output and aligns to the LGA High Impact Change Model.

ECC and NHS partners are also continuing our Connect programme outlined in our previous BCF Plan. The programme consists of 5 key projects looking at reablement, discharge outcomes, supporting independence, admission avoidance and community hospital bed flow. The programme has been shortlisted for three national awards and improvements include 1 in 5 people previously discharged to an out-of-hospital bed in MSE now go home instead.; and 55% of people plan to go home from an interim placement with the support of our D2A pilot (previously 25%).

Supporting unpaid carers

ECC recently published the All-Age Carers Strategy 2022-26 which 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 is funded for 2 years until August 2023. 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 also funded by the BCF until 2023. 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.

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.

Disabled Facilities Grant (DFG) and wider services

DFGs are grants 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 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 have been 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.

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.

ECC and Essex district and brough councils have invested in 4 Senior OTs in Housing roles to ensure assessments are made in people's homes and that DFG applications are passed to the relevant local authority

in a timely manner. Timely discharges from hospital are made possible through the DFG, shortening the amount of time people remain in hospital. Progress is monitored through these early returns to home.

Housing for older and disabled people

Whilst not funded by BCF, housing and accommodation play a key role in achieving many of our aims and priorities.

Essex Housing, ECC's in-house housing developer was established in 2016 to address housing need by building general, specialist and affordable housing and to provide assets that deliver social value.

To date Essex Housing has delivered 3 schemes (Norton Road, Moulsham Lodge and Goldlay Gardens) that provide apartments for adults with learning disabilities to live independently, delivering 23 units in total. Essex Housing is working on 4 further schemes in Maldon, Epping Forest, Colchester and Castle Point that will deliver a further 28 apartments for adults with learning disabilities, including adults with high needs. There is an ambition to identify and deliver more of these schemes in future to meet identified needs.

The Essex Housing programme is forecast to deliver 420 Independent Living for Older People apartments across Maldon, Rochford, Epping Forest, Tendring, Harlow, Chelmsford and Colchester, with planning secured for 180 of these already (in Rochford, Tendring and Epping Forest).

This programme of specialist housing is designed to promote independence and has a strong focus on accessibility. The design of private sale and affordable homes, as well as new community assets such as libraries, also has a key focus on accessibility, with apartments delivered to date including design considerations such as the inclusion of lifts and double-width corridors.

The next Essex Housing scheme to be delivered is the former Shernbroke Hostel in Waltham Abbey which achieved planning permission earlier in 2022 for 26 flats, including 10 specialist homes for adults with learning disabilities. Essex Housing is now on-site at Shernbroke with development due to be completed in 2023.

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). ECC has worked over the last year

with the landlords of all Extra Care schemes in Essex to which it has nomination rights, to adopt and embed 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 meeting the needs of adults who have a learning disability or physical and sensory needs.

Equality and health inequalities

The importance of tackling the causes of inequality in health outcomes is widely recognised across the system in Essex and reflected in our new 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.

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.

Working with partners across the county the council will be focusing on both place-based and cohort inequalities and developing 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.

ANNEX A – Local BCF Projects

NE Locality Initiatives	Description
NEE Neighbourhoods	To realise the Alliance Neighbourhood ambition, costs will be attached to test and learn activity, management roles and external evaluation.
Change and Domain Delivery	Development of data dashboards for each Live Well Domain and Alliance Delivery Lead roles (4) to support the Domain programmes of work.
System Resilience	Supporting Winter and system pressures.
Reablement Support	Admission Avoidance Social Workers to support people to remain at home where possible.
Transfer of Care Hub (TOCH)	Management roles to support the development of the TOCH.
Bridging	The service promotes prompt discharge from hospital where adults are awaiting medically optimised for discharge but awaiting the commencement of an Intermediate Care service.
Stepping Stone Home Flats	Housing provision for adults who want to live independently but need short-term alternative housing and care and support with an enablement focus to achieve this.
West Locality Initiatives	**Description**
Admission Avoidance	To support the adult to remain in the community and their own home during a period of crisis. This supports adults who may have turned up at Emergency Departments or need an intervention in their own home and without this service it would have led to the adult having a 24–48hrs assessment period or admission within an acute setting
Impartial Assessor	This service acts as an intermediary between the care home and acute hospital and will support the adult's discharge back to the care home including undertaking nursing needs assessment on behalf of the care.
Therapy Review	To undertake a review of all therapy services across acute, community and social care to redesign the service to support better outcomes for the adult and better integrated OT interventions
Care Co-ordination Centre Development	Support the development of the workforce in the Care Co-ordination Centre that will 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
PACTs / Care Co-ordination Centre implementation	To support the development of the workforce for the implementation of the PACTs to ensure appropriate skilled workforce available
Intermediate Care Commissioning Strategy Development	To develop future commissioning options for potential adoption by the West Essex system.
Place-based working	Health and Care Partnership Development – to support the continuing development of the Health & Care Partnership.
SW Locality Initiatives	**Description**
Alliance Development	Alliance Delivery Lead roles – building on learning from North Essex and creating Alliance Delivery Leads tasked with taking forward priority programmes of work for the alliance.
Neighbourhood Teams	Neighbourhood Co-ordinators to strengthen the contribution of neighbourhood teams and improve care coordination for people with different levels of need in that neighbourhood. Key activities: Develop a locality workforce identity. • Pilot a new model of care. • Map assets and review commissioning arrangements. • Cultivate inclusive locality leadership. • Revised activity post covid restrictions
Associate Director	Funding for Joint role of NELFT and Health and Social Care to deliver a locality, neighbourhood plan. With the view for integrated delivery and building collaboration to support system needs.
Trust Links	A charity running a garden scheme in the area has requested support for a site in Vange, Basildon. Funding has been secured from the CCG, Sport England LDP, Basildon Health and Wellbeing Board, 'ECC Strengthening Communities' budget and a few smaller sources of money.
Projects in development / discussion	Early Intervention with Families Concept: Social Prescribers to support GPs with signposting on the local, community support that exists for Parents, Children and Families, Young Carers, Parents of SEND children, children of those with mental health issues. Gemima Risk Stratification Tool - Implementing a Risk Stratification Tool for primary care to inform care plan discussions at MDT across health and social care and to identify service users with high/multi complex needs

SE Locality Initiatives	Description
Neighbourhood Teams	The Locality Development Managers will 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.
Dementia Support	Bespoke support pre-diagnosis through to end of life for people living with dementia and their carers. Forming part of an integrated service that wraps around people, enabling them to live the life they would like with their diagnosis, including hospital inpatient stays and residential care. It is also the crucial link to all health, social care and community support in the area. The Team also includes support for Older People's Mental Health and Frailty.
Bridging Service	'Bridges the gap' between hospital discharge and reablement or domiciliary care support in people's homes. Coverage includes 17 starts flexed across the area. Commissioned by the CCG (delivered by the Acute Trust) this has proved to be highly effective in South Essex providing vital link and enabling smooth discharge to a home setting.
Care Coordination	Enhance the offer of the existing EPUT 'Care Coordination service' to undertake gait and balance assessments for patients on their caseload through the employment of Physio Therapists to undertake this role. Due to come to an end Dec 21.
Mid Locality Initiatives	**Description**
Alliance Development	Alliance Delivery Lead roles – building on learning from North Essex and creating Alliance Delivery Leads tasked with taking forward priority programmes of work for the alliance.
Trusted Assessors	Trusted Assessor posts at Broomfield Hospital to support with increased discharge time of Adults into ECL reablement.
CHC Social Worker	Social worker post to support with leading on continuing healthcare assessments in Mid Essex, supporting with decreased discharge times, access to CHC funding and integration with health partners involved with continuing healthcare.
DISS	Contribution towards the Dementia Intensive Support Service (DISS) to provide link social worker posts within the neighbourhood teams and overall senior social worker coordination.
EOL	ASC contribution towards the overall End of Life service in Mid Essex provided through Farleigh Hospice.
SWOT	Supporting Wellbeing Outreach Team. Provided by Chelmsford CVS, this service supports Adults returning home from hospital with low-level issues such as equipment, house clearing, shopping etc to ensure successful hospital discharge and avoid unnecessary readmission.
Projects in development / discussion	• **Therapy support for the new Additional Reablement Capacity (ARC)** contract in Mid Essex, to fully utilise the intermediate care offer in the area and improve Adult outcomes. • **Virtual ward link workers,** to provide focussed support with each frailty virtual ward from social care to support Adults moving through the model and ensuring that they receive the most appropriate input from social care to maximise opportunities for independence. • **Way Back in Extra Care settings**. We have already paid for licences but would want to build into evaluation to determine its value to the residents and whether it is worth rolling out wider. • **Supported living, dementia & modifiable risks factors,** The aim being to increase the numbers of people being able to stay in their homes (supported living) as they age (therefore reducing the costs, improving quality of people's lives)