Mid and South Essex Integrated Care System

NHS Mid and South Essex

NHS Mid and South Essex

Joint Forward Plan 2023-2028

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Foreword from our Chair

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

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

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

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

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

About this Document

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

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

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

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

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

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

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

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

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

Health & Wellbeing Boards Statements

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

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

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

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

Essex Health & Wellbeing Board:

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

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

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

Opinion of Essex Health and Wellbeing Board

Southend Health & Wellbeing Board:

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

Opinion of Southend Health and Wellbeing Board

Thurrock Health & Wellbeing Board:

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

Opinion of Thurrock Health and Wellbeing Board

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

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

Mid and South Essex Integrated Care Partnership

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

Engagement with Partners and Residents

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

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

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

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

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

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

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

Part 1: The Collective Ambition of NHS Partners

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

Introduction

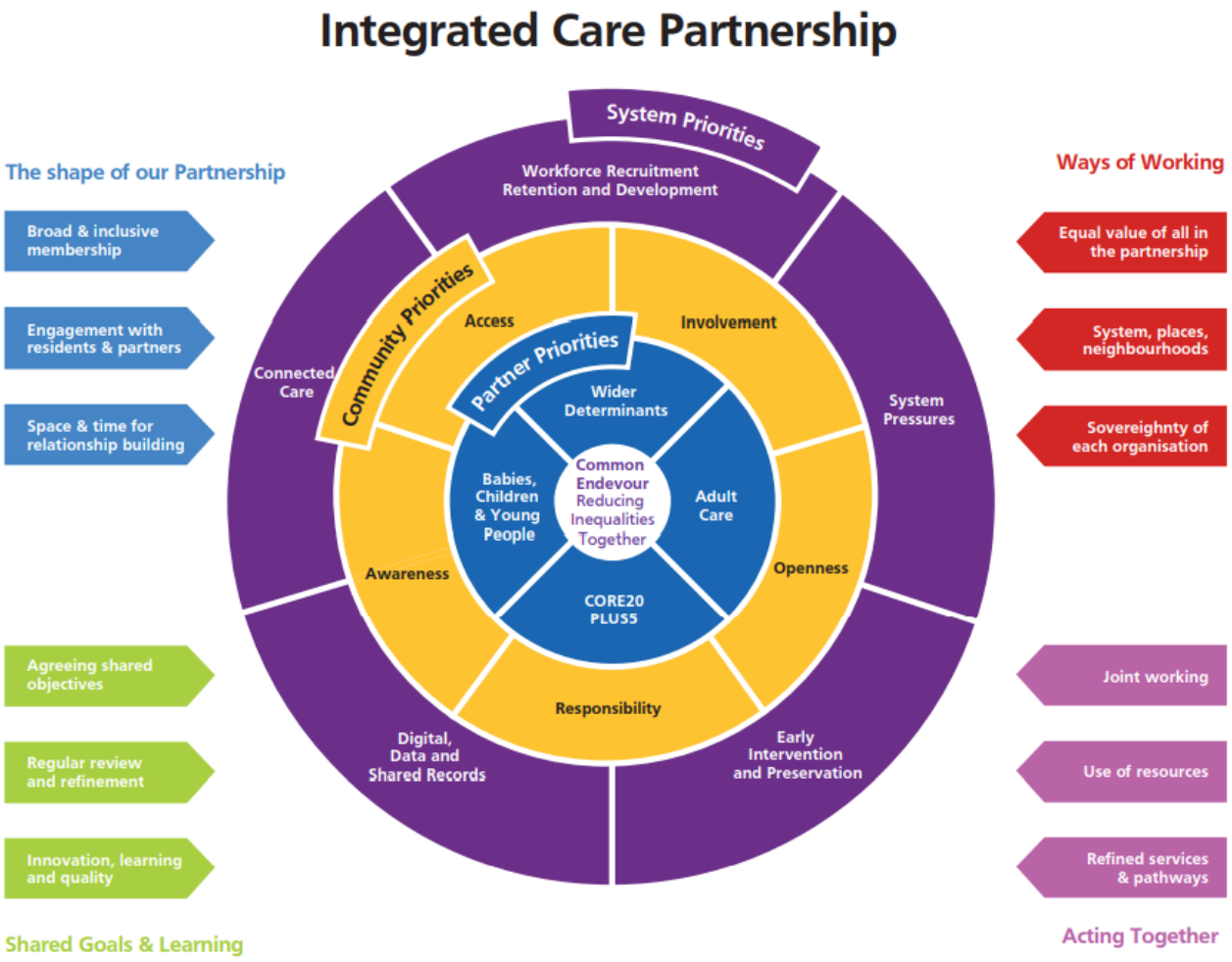
At the time of inception of our Integrated Care System, all partners agreed that our main objective should be to 'up our game'. Consequently, NHS partners have agreed that, in this Part 1 document, we should set out our collective ambitions to both address the significant challenges we face and set a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

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

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

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

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



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

Our Vision

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

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

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

The Scale of the Challenge

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

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

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

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

Commitments

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

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

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

Ground Rules

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

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

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

Our Key Strategic Ambitions

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

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

Improving Quality

Access, Experience and Outcomes

Why is this important

Our residents describe difficulties in accessing healthcare services.

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

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

How will we do it

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

Health Inequalities

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

Why is this important

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

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

How will we do it

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

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

Financial Sustainability

A collective commitment to live within our means.

Why is this important

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

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

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

How will we do it

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

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

Operational Delivery

A commitment to improving our operational planning and delivery functions

Why is this important

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

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

How will we do it

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

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

Supporting our Workforce

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

Why is this important

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

How will we do it

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

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

Let staff lead

Growing our stewards for the future

Widespread development of quality improvement and leadership skills

Why is this important

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

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

How will we do it

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

Population health improvement

Focus on prevention, early intervention and targeted approaches.

Providing more personalised care that addresses existing health inequalities.

Measure what matters to our residents.

Why is this important

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

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

How will we do it

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

Digital, Data and Technology

Gearing up our system to become more digitally enabled

Supporting our residents to use digital tools

Why is this important

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

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

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

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

How will we do it

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

Mobilising and Supporting Communities

The assets in our communities and supporting them to flourish

Why is this important

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

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

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

How will we do it

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

Improving our System Oversight Framework rating

Why is this important

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

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

How will we do it

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

Research and Innovation

Bringing benefits for residents, staff and the local economy.

Why is this important

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

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

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

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

How will we do it

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

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

Further developing our system

Why is this important

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

How will we do it

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

Part 2 – Improving population health and reducing health inequalities

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

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

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

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

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

Integrated Care

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

Our partnership comprises the following partners:

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

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

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

Nine voluntary and community sector associations

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

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

One ambulance trust

Three Healthwatch organisations

Our priority is to integrate services at every level:

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

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

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

The Importance of Local Delivery

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

Appendix 1 describes our local approach.

Stewardship

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

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

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

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

Selected highlights:

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

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

Challenges and areas for development

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

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

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

Opportunities:

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

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

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

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

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

Improving Population Health

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

- Population Health Management
- Inequalities

- Prevention and early intervention
- Personalised care
- Anchor institutions

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

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

Reducing Health Inequalities – the Core20Plus5 Frameworks

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

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

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

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

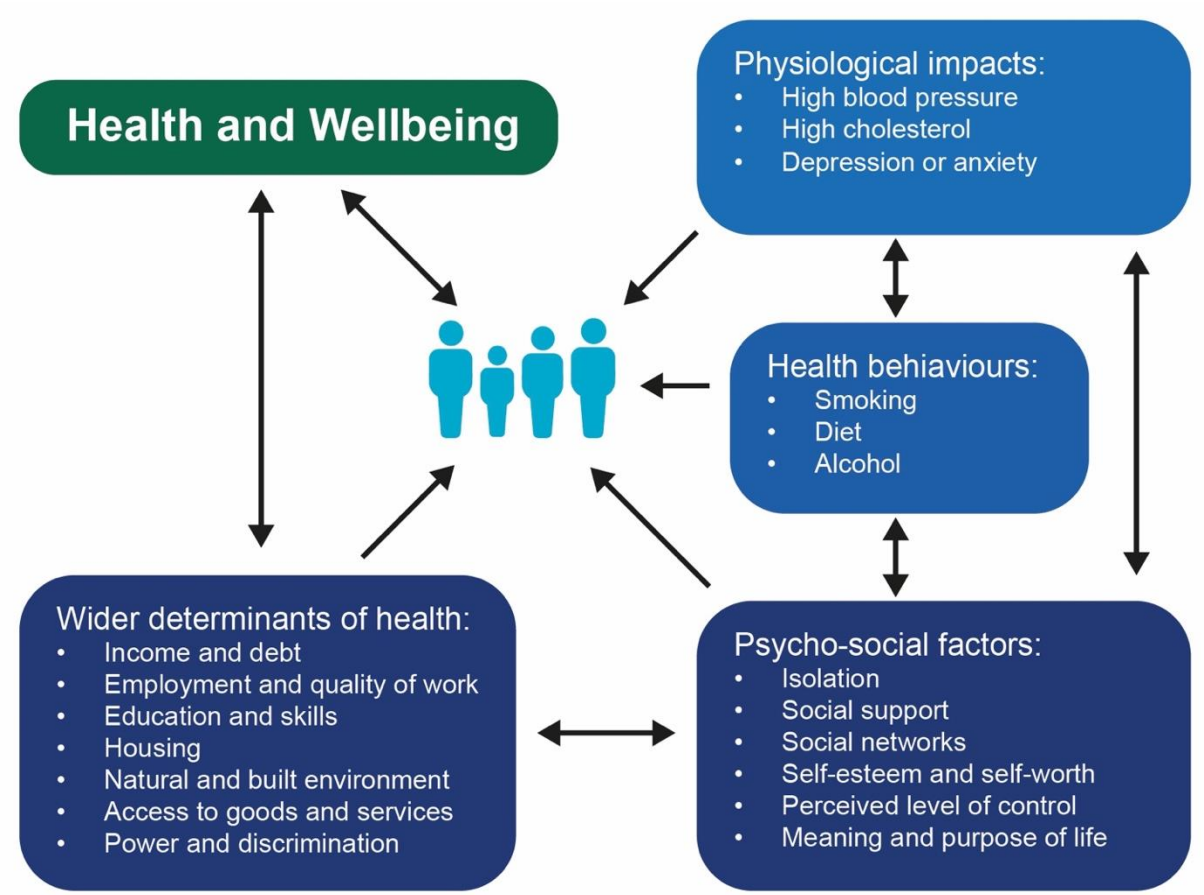
Children and Young People
Asthma
Diabetes
Epilepsy
Oral Health
Mental health

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

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

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

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



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

Through the Population Health Improvement Board, we will:

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

Case Studies

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

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

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

Case Study – Children's Oral Health

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

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

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

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

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

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

Case Study:

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

Health Inequalities Funding

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

Basildon and Brentwood Alliance

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

Mid Essex Alliance

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

South East Essex Alliance

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

Thurrock Alliance

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

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

Health Inequalities research

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

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

A focus on Prevention

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

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

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

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

Our Initial Prevention Priorities

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

Cardiovascular Disease

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

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

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

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

Healthy Weight

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

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

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

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

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

Tobacco Dependency

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

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

Innovative partnerships with industry

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

Future areas of focus

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

Enabling Improvements in Population Health

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

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

Improving Operational Performance

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

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

Supporting System Development

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

Part 3 – Delivery Plans

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

Appendix 1 – Local Delivery

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

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

Basildon and Brentwood Alliance

What have our residents told us?

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

Current Conditions

Population size and demographics

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

Health Inequalities

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

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

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

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

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

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

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

Workforce:

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

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

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

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

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

Estate:

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

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

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

What is the requirement from the NHS?

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

Our Ambition

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

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

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

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

Delivery priorities:

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

Ensuring Delivery:

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

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

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

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

Delivery Plan

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

Thurrock Alliance

What have our residents told us?

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

Current conditions:

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

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

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

Workforce

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

Data quality and lack of effective business intelligence

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

Estates

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

What is the requirement from the NHS?

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

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

Our ambitions:

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

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

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

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

Delivery Priorities

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

- Urgent and episodic care
- Complex care
- Prevention

Developing Primary Care

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

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

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

Supporting Urgent and Episodic Care

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

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

Developing relationships between Primary and Secondary Care

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

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

Ensuring Delivery

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

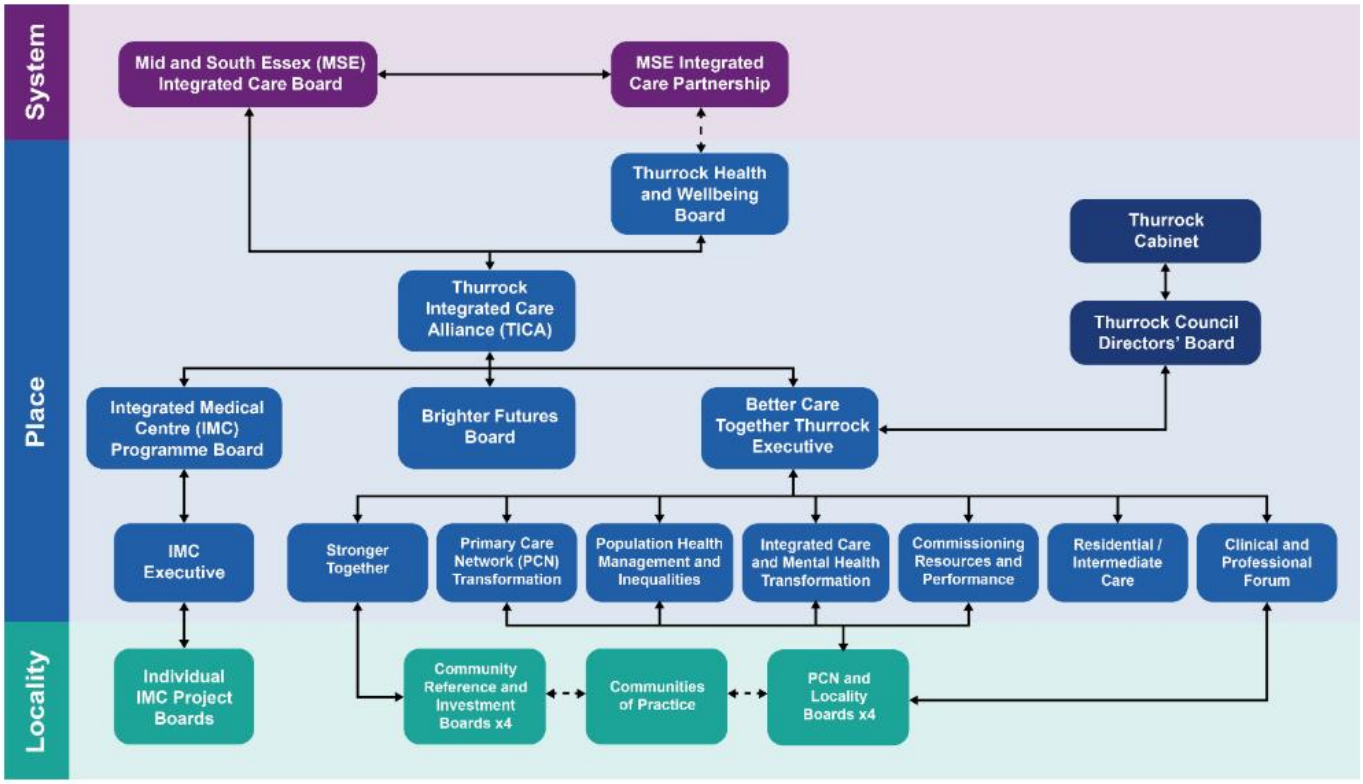
The Thurrock Alliance has spent much of 2022 on a development journey, with the explicit aim to build a clear purpose and a sense of trust. The governance structure is now signed off, but in the interim significant amounts of work have been done to deliver the Better Care Together Thurrock Implementation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

Local Governance architecture in Thurrock

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

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

The below shows the System governance structure.



Delivery Plan

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

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

South-East Essex Alliance

What have our residents told us?

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

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

Co-production of solutions in our neighbourhoods

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

This will be achieved by:

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

Current Conditions

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

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

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

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

Workforce:

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

Data quality and lack of effective business intelligence:

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

Estate:

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

What is the requirement from the NHS?

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

Our Ambitions

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

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

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

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

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

Delivery Priorities

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

- Urgent and episodic care
- Complex care
- Prevention

Developing Primary Care

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

Supporting Urgent and Episodic Care

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

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

Developing relationships between Primary and Secondary Care

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

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

Delivery Plan

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

Mid Essex Alliance

What have our residents told us?

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

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

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

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

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

Current Conditions

Population size and demographics:

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

Health inequalities:

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

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

Workforce:

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

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

Data and Information:

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

Geography and Estate:

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

What is the requirement from the NHS?

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

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

Our ambitions

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

Delivery Priorities

Health Inequalities:

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

Asset Based Community Development:

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

Develop primary care and build Integrated Neighbourhood Teams:

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

Support Integrated Care System and national priorities:

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

Ensuring Delivery

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

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

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

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

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

Delivery Plan

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

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

Transforming Primary Care

What have our residents told us?

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

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

Current Conditions

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

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

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

What is the requirement from the NHS?

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

Our Ambitions

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

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

Delivery Priorities

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

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

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

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

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

Ensuring Delivery

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

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

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

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

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

Delivery Plan

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

Digital Access to Primary Care

What have our residents told us?

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

Current Conditions

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

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

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

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

What is the requirement from the NHS?

NHS Long Term Plan:

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

Fuller Stocktake:

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

Our Ambitions

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

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

Delivery Priorities

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

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

Ensuring Delivery

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

Delivery Plan

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

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

Developing our Community Services

What have our residents told us?

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

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

Current Challenges

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

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

What is the requirement from the NHS?

National NHS planning objectives 2023/24

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

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

Our Ambitions

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

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

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

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

Delivery Priorities

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

Integrate

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

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

Innovate

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

Improve

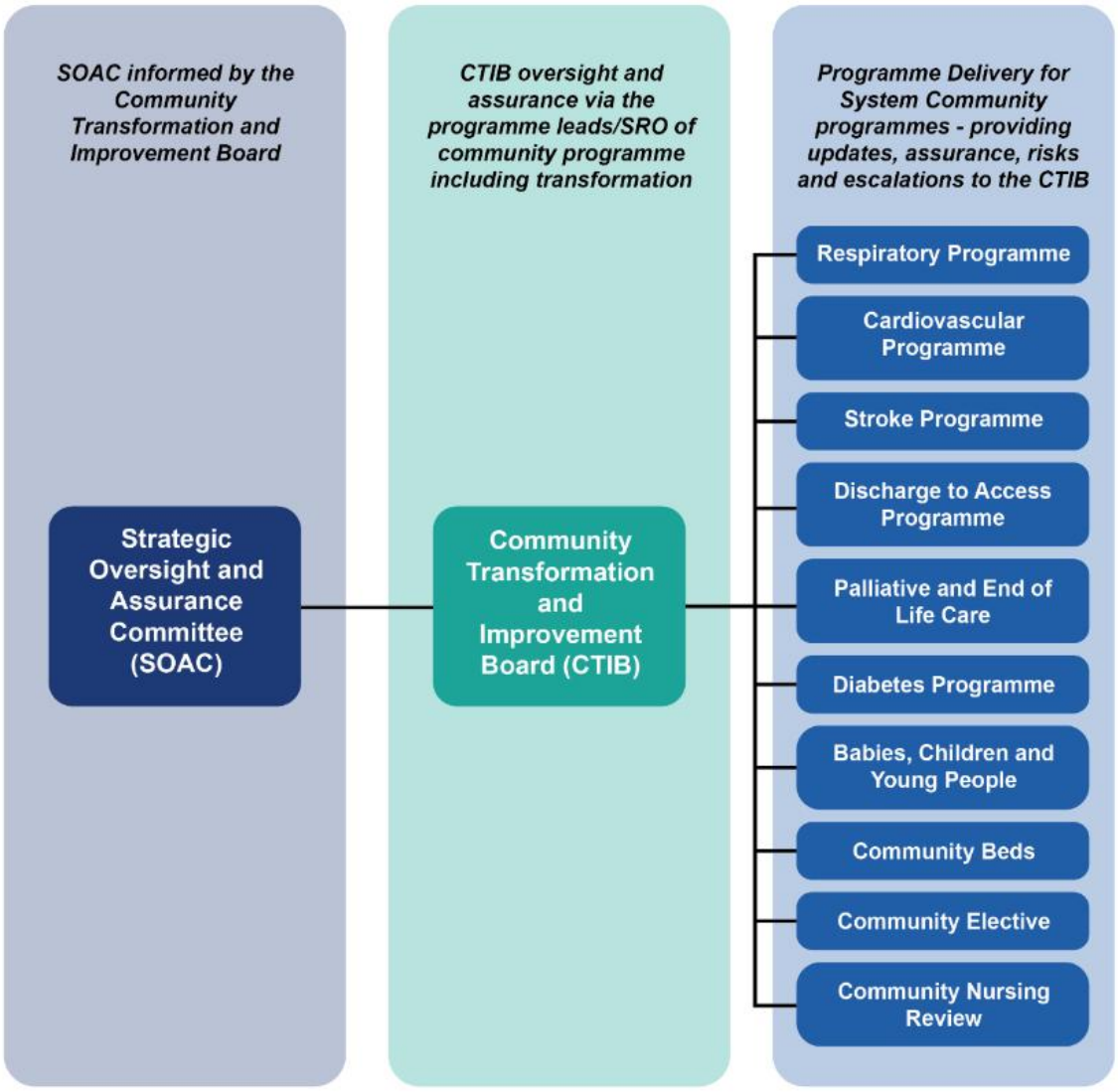
- Optimise efficiency and effectiveness of Virtual wards
- Ensure compliance with zero 65 week waits for community services by March 2024
- Introduce self-referral to falls response services, musculoskeletal services, audiology-including hearing aid provision, weight management services, community podiatry,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

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

Ensuring Delivery

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

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



Delivery Plan

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

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

Appendix 2 – Improving Population Health

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

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

Population Health Improvement Board

What have our residents told us?

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

Current conditions

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

What is the requirement from the NHS?

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

Our ambitions

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

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

Delivery Priorities

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

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

Adults focus

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

Children and young people focus

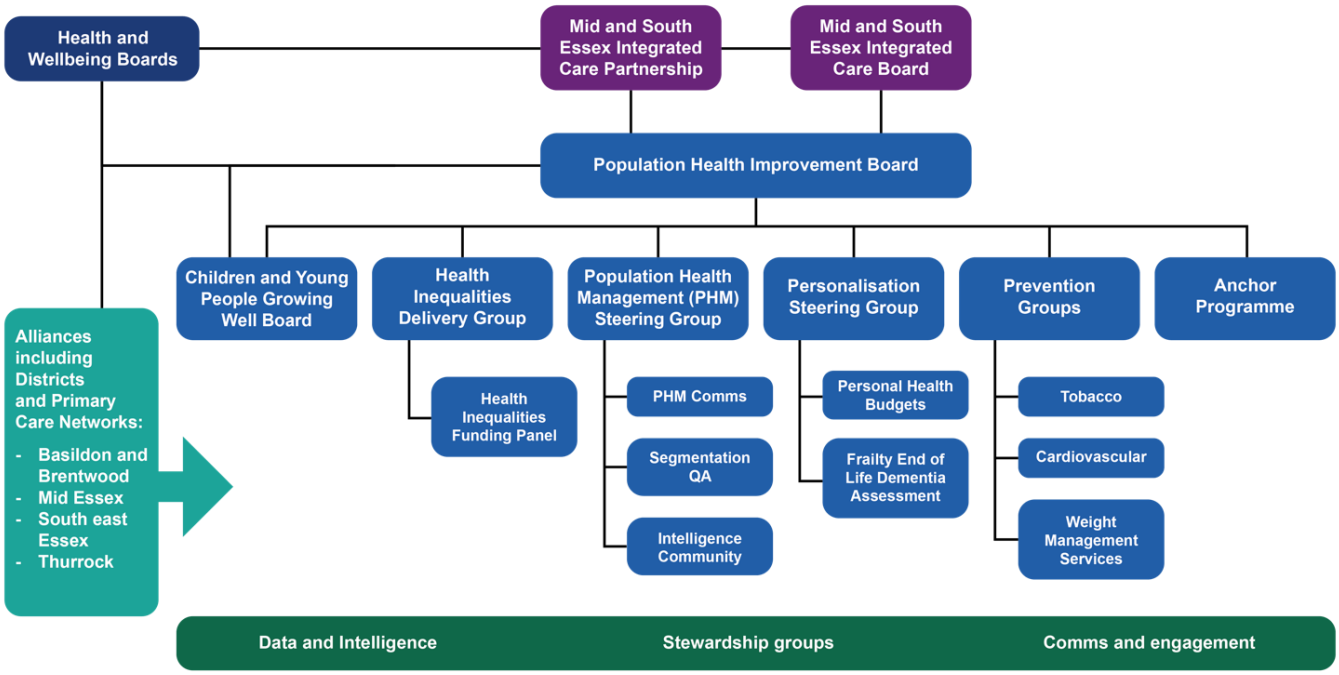
Asthma
Diabetes
Epilepsy
Oral Health
Mental Health

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

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

Ensuring Delivery

Senior Responsible Owner: Jo Cripps



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

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

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

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

Delivery Plan

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

Personalised Care

What have residents told us?

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

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

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

Current Conditions

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

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

What is the requirement from the NHS?

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

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

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

Our Ambitions

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

Delivery Priorities

Leadership

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

Culture Development

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

Supporting Strategy

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

Quality Improvement

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

Ensuring Delivery

Senior Responsible Owner: Emma Timpson,

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

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

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

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

Delivery Plan

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

Population Health Management

What have our residents told us?

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

What is the current state of play/local challenges?

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

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

What is the requirement from NHS?

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

What is the ambition?

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

These interventions will contribute towards the Integrated Care System Core Outcomes

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

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

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

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

What are the delivery priorities?

Population Health Management specific priorities include:

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

Governance

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

How will we ensure delivery?

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

The Population Health Management steering group also has subgroups including:

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

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

Delivery Plan

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

Stewardship

What have our residents told us?

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

Current conditions

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

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

What is the requirement from the NHS?

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

Our Ambitions

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

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

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

Delivery Priorities

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

Our duty to seek advice

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

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

Ensuring Delivery

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

How will we ensure delivery

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

Delivery Plan

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

Innovation

What have our residents told us?

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

Current conditions

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

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

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

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

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

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

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

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

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

What is the requirement from the NHS?

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

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

Our Ambitions

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

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

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

Delivery Priorities

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

mid and south Essex innovation delivery priorities include

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

Ensuring Delivery

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

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

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

Delivery Plan

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

Appendix 3 - Workforce

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

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

Workforce

What have our residents told us?

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

Current Conditions

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

What is the requirement from the NHS?

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

What is the ambition

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

Delivery Priorities

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

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

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

Ensuring Delivery

Senior Responsible Owner: Chief People Officer

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

Delivery Plan

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

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

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

Clinical and Care Professional Leadership

What have our residents told us?

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

Current Conditions

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

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

What is the requirement from the NHS?

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

Our Ambitions

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

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

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

Delivery Priorities

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

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

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

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

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

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

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

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

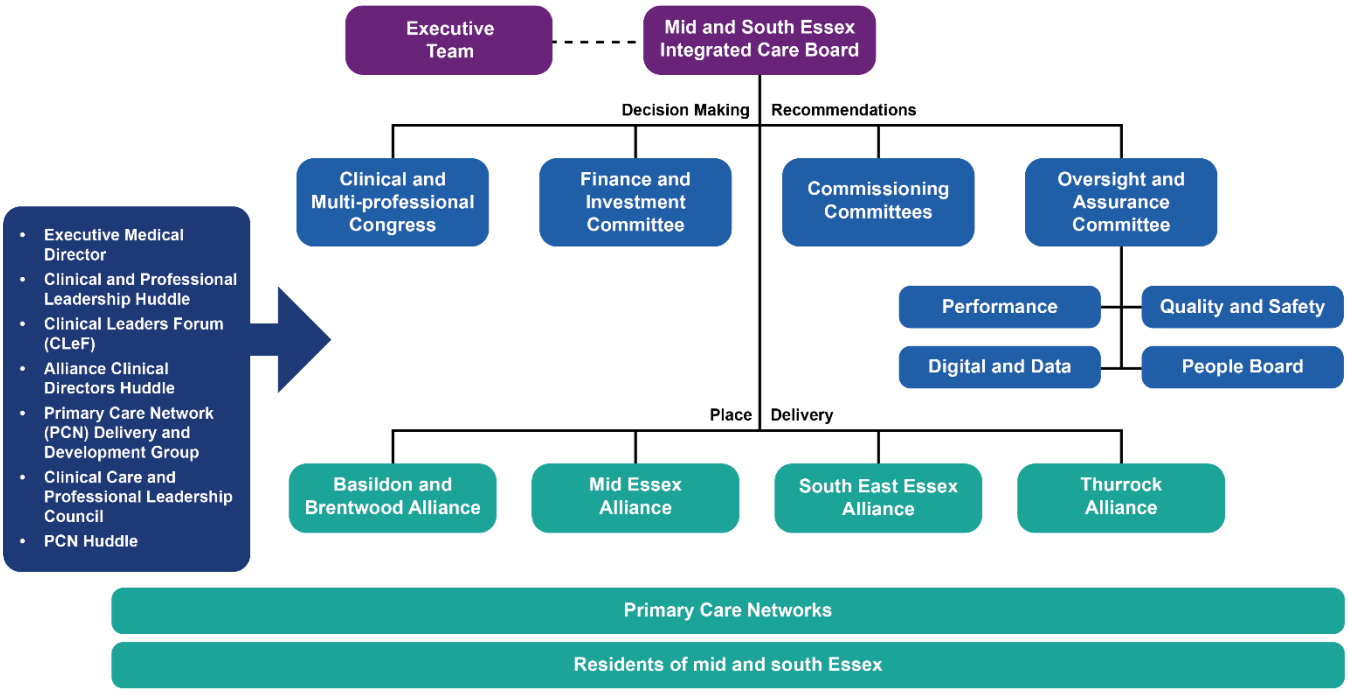
- Engage with Anglia Ruskin University / University of Essex on collaborative apprenticeships and Health and Care Academy formation
- Continue to run an annual Leading within Mid and South Essex Integrated System leadership development programme

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

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

Ensuring Delivery

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



The above shows the System governance structure.

Delivery Plan

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

Nursing Quality and Safety

What have our residents told us?

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

- feel safe
- feel listened to
- be respected

Current conditions

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

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

What is the requirement from the NHS?

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

Our ambitions

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

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

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

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

Delivery Priorities

A shared commitment to quality:

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

Population focussed:

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

Coproduction with the people using the services:

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

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

Clear and transparent decision making:

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

Timely and transparent information sharing:

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

Subsidiarity:

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

Ensuring Delivery

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

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

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

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

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

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

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

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

Delivery Plan

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

Appendix 4 – Infrastructure

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

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

Estates

What is the current state of play/local challenges

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

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

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

What is the requirement from NHS

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

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

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

What is the ambition

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

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

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

What are the delivery priorities

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

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

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

Governance

Senior Responsible Owner: Jen Kearton

How will we ensure delivery

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

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

Delivery Plan

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

Capital Estates

What have we heard from residents/patients

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

What is the current state of play/local challenges

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

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

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

What is the requirement from NHS

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

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

What is the ambition

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

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

What are delivery priorities

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

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

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

Governance

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

How will we ensure delivery

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

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

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

Delivery Plan

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

Sustainability

What have we heard from residents/patients

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

What is the current state of play/local challenges

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

What is the requirement from NHS

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

What is the ambition

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

What are delivery priorities

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

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

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

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

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

Governance

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

How will we ensure delivery

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

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

Delivery Plan

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

Appendix 5 - Finance

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

- Finance
- Procurement and Supply Chain
- Specialised Commissioning

Finance

What is the current state of play/local challenges

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

What is the requirement from NHS

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

What is the ambition

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

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

What are the delivery priorities

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

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

Governance

Senior Responsible Owner: Jen Kearton

How will we ensure delivery

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

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

Delivery Plan

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

Procurement

What have we heard from residents/patients

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

What is the current state of play/local challenges

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

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

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

What is the requirement from NHS

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

What is the ambition

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

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

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

What are delivery priorities

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

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

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

Governance

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

How will we ensure delivery

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

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

Delivery Plan

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

Specialised Commissioning Services

Current Issues

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

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

What is the requirement from the NHS?

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

Our ambition

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

What are the delivery priorities

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

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

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

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

Ensuring Delivery

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

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

Delivery Plan

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

Appendix 6 – Digital, Data and Technology

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

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

Patients Know Best

What have heard from our residents

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

Current Conditions

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

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

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

What is the requirement from the NHS?

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

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

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

Our Ambitions

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

Delivery Priorities

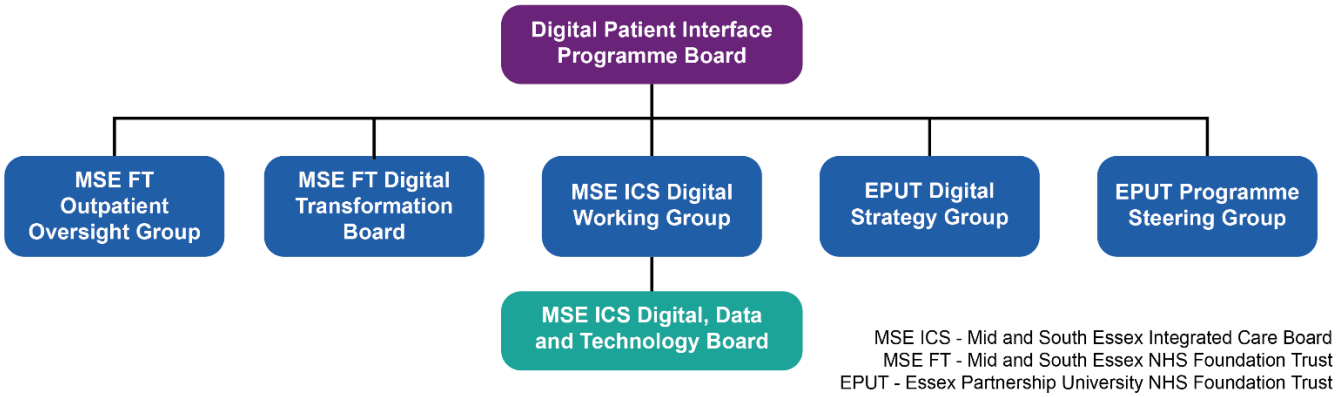
- Reduction in administrative burden: using pre-assessment questionnaires saving care team time
- Reduction in Did not Attend and slot utilisation: greater visibility of appointment information and easier access to information on changing appointments will reduce Did not Attends.
- Deliver cost savings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

Ensuring Delivery

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

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

Below delivery governance structure.



Delivery Plan

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

Shared Care Record

What have we heard from our residents?

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

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

Current Conditions

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

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

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

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

What is the requirement from the NHS?

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

Our Ambitions

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

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

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

Delivery priorities

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

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

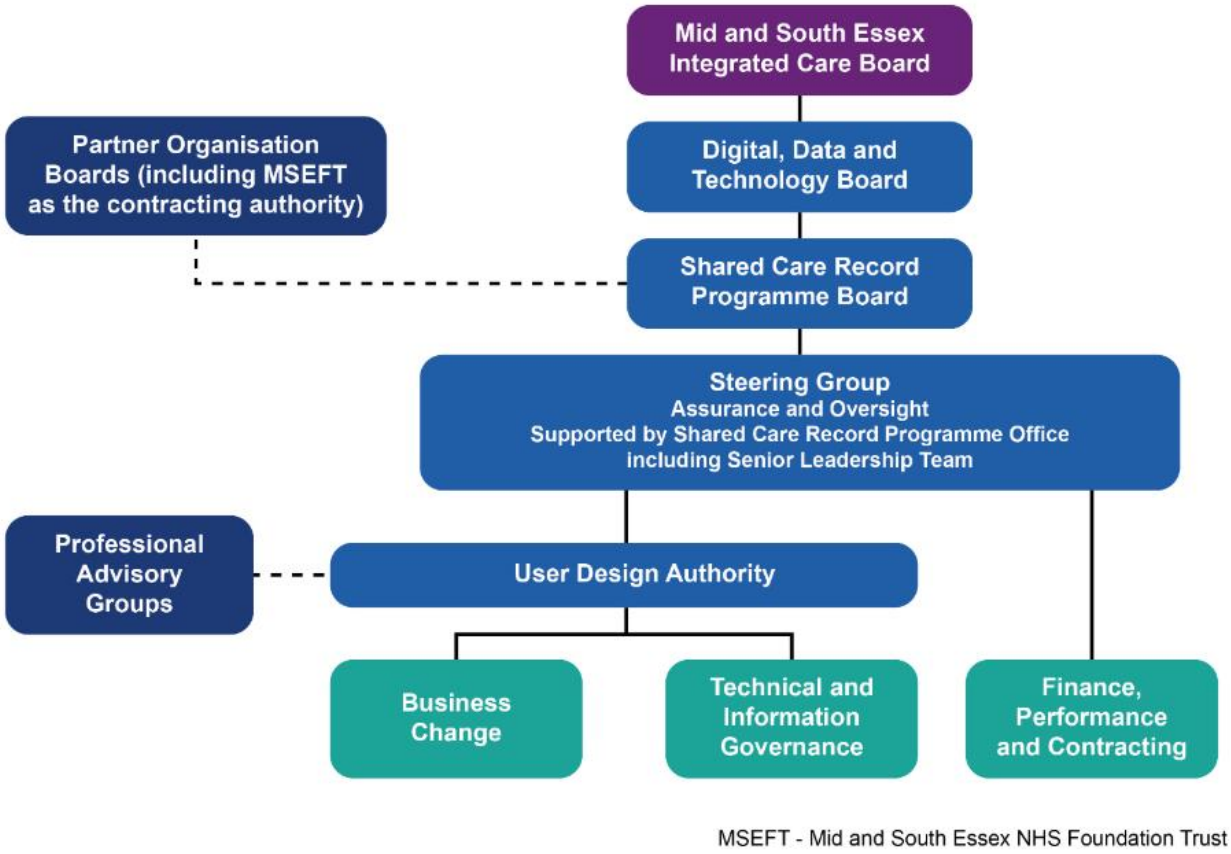
Through our Business workstream we will work with front line teams to maximise the benefits and positive impact of having integrated patient records and workflow across our system.

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

Ensuring Delivery

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

Below diagram of governance arrangements.



Delivery Plan

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

Digital – Data Quality

Current Condition

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

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

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

What is the requirement from the NHS?

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

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

Our ambitions

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

Deliver Priorities

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

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

Ensuring Delivery

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

Delivery Plan

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

Electronic Patient Record

What have our residents told us?

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

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

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

Current Conditions

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

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

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

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

What is the requirement from the NHS?

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

All providers, across acute, community and mental

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

Our Ambitions

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

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

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

Delivery Priorities

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

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

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

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

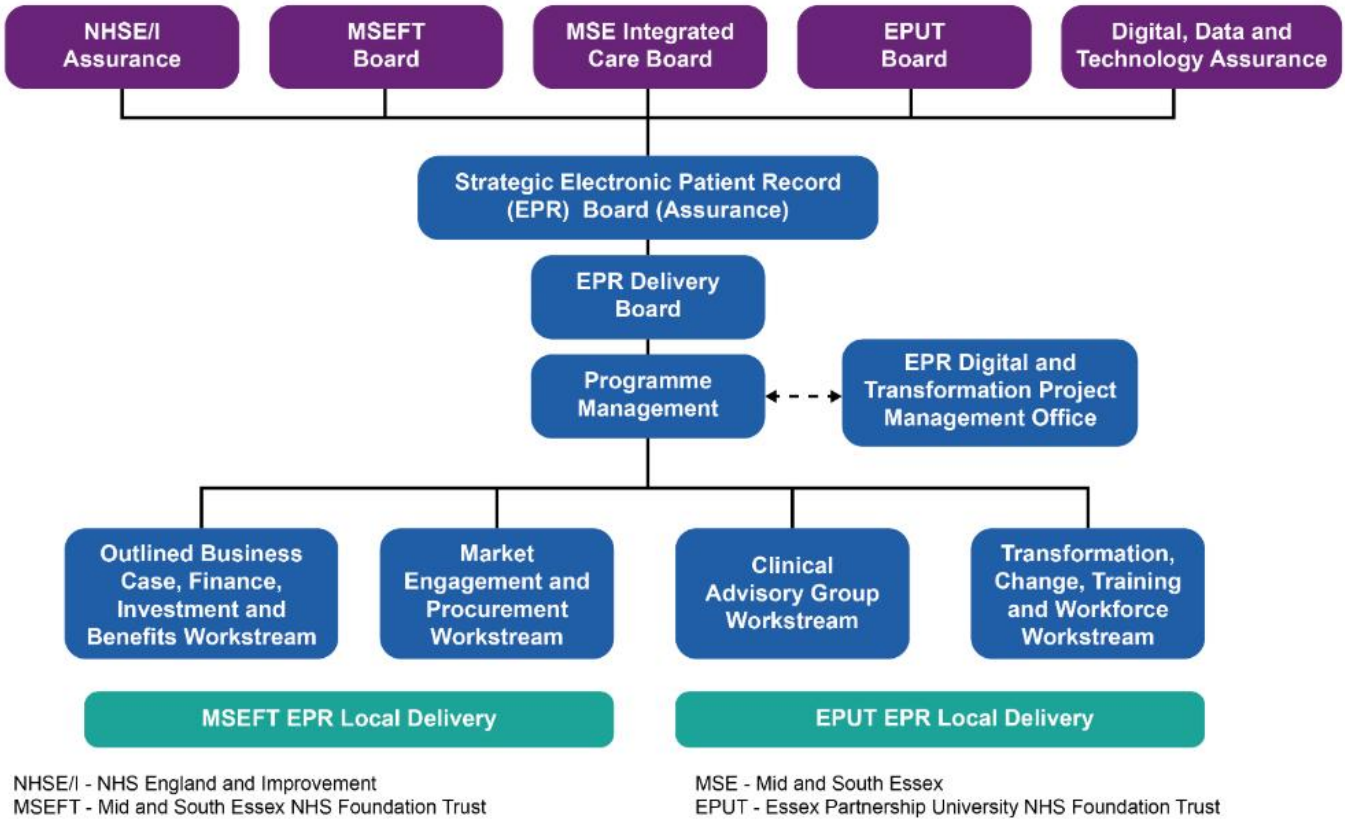
Ensuring Delivery

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

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

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

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



Delivery Plan

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

Digital – Strategic Data Platform

What have we heard from our residents

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

Current Conditions

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

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

What is the requirement from the NHS?

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

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

Our Ambitions

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

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

Delivery priorities

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

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

Ensuring Delivery

Senior Responsible Owner: Steve Gallagher

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

Delivery Plan

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

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

Digital – Digitising Social Care Record

What have our residents told us?

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

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

Current Conditions

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

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

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

What is the requirement from the NHS?

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

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

Our Ambitions

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

Delivery Priorities

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

Ensuring Delivery

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

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

Delivery Plan

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

Appendix 7 – Improving Operational Performance

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

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

Maternity

What have our residents told us?

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

Current conditions

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

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

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

What is the requirement from the NHS?

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

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

Our Ambitions

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

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

Delivery Priorities

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

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

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

MSE Long Term Plan stillbirth rate ambition

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

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

MSE Long Term Plan neonatal mortality rate ambition

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

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

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

Ensuring Delivery

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

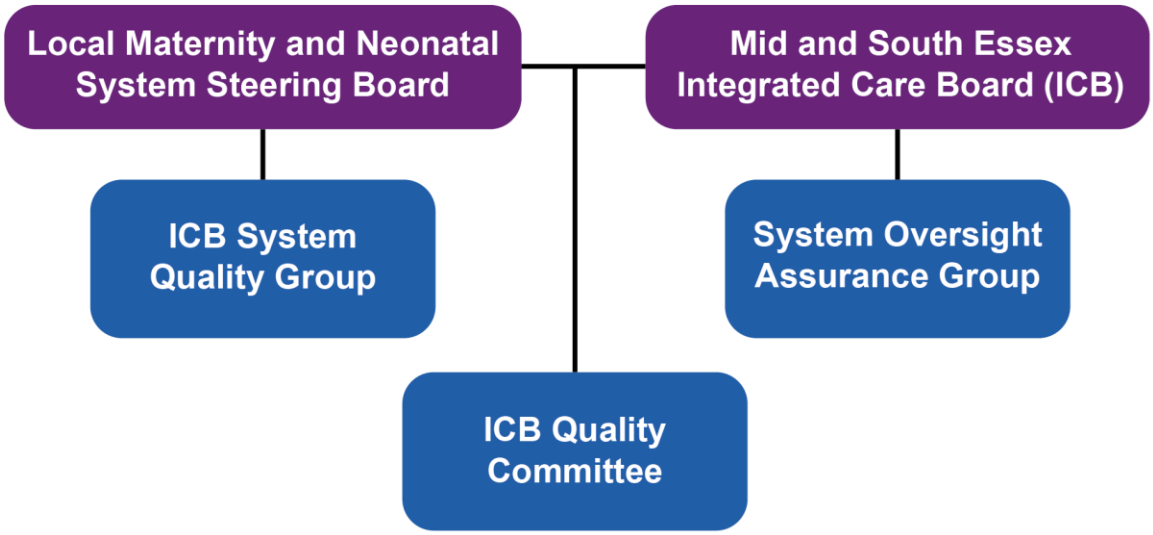
The Local Maternity and Neonatal System has clear governance processes in place that ensures oversight is provided by the Local Maternity and Neonatal System Steering Board, which is chaired by the Maternity Senior Responsible Owner and Chief Nurse for the Integrated Care Board. In line with NHS England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

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

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

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

The below shows the System governance structure.



Delivery Plan

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

Women's Health Hubs

What is the requirement from the NHS?

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

Our Ambition

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

Delivery Priorities

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

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

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

Elective Care (Including Choice)

What have our residents told us?

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

Current Conditions

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

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

What is the requirement from the NHS?

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

Our Ambition

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

Bringing Care Closer to Home:

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

Improving and Transforming Our Services:

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

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

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

Delivery Priorities

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

The below table shows the mid and south Essex system planned Referral to Treatment 65+ week backlog trajectory to a zero position from March 2024.

Date	April 2023	May 2023	June 2023	July 2023	August 2023	September 2023	October 2023
No.	4,383	3,985	3,585	3,187	2,791	2,391	1,994

Date	November 2023	December 2023	January 2024	February 2024	March 2024
No.	1,596	1,196	799	402	0

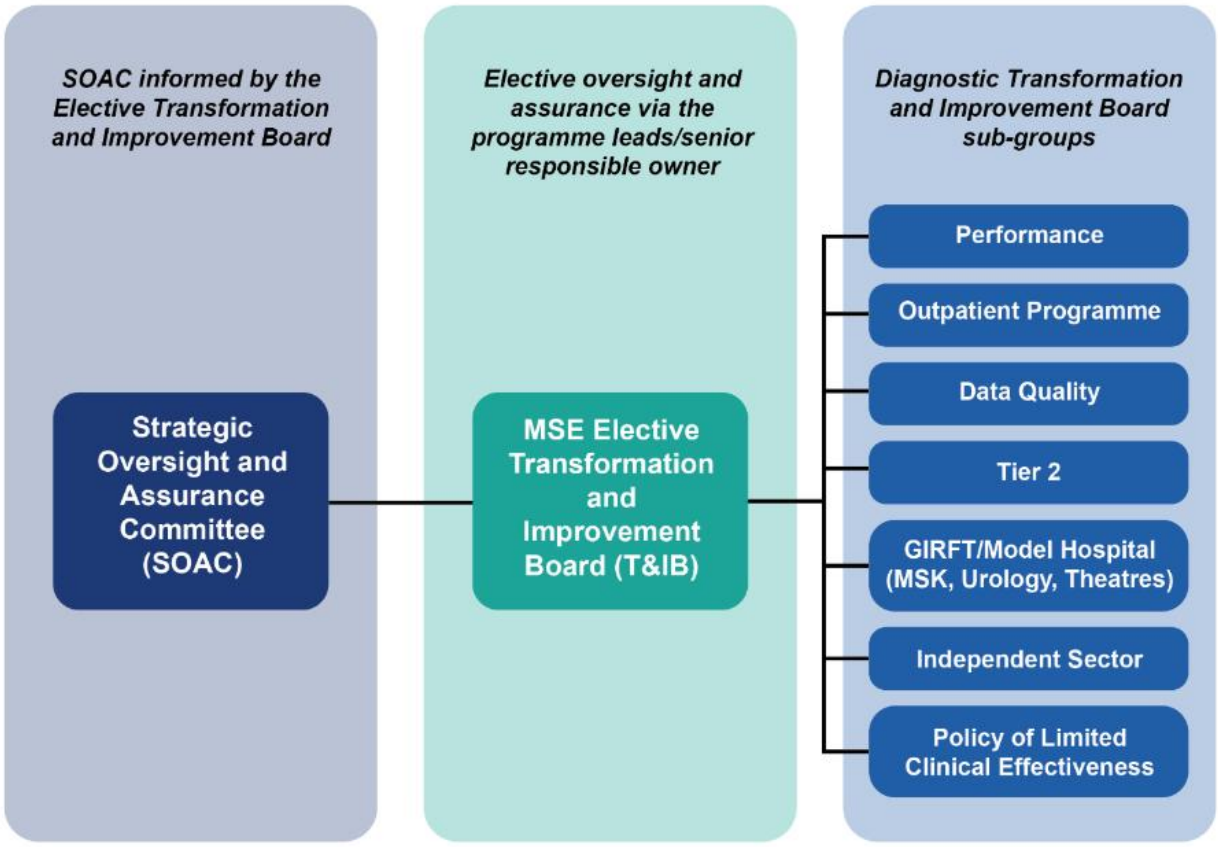
Ensuring Delivery

Senior Responsible Owner: Andrew Pike
Clinical Lead: Ronan Fenton

The Mid and South Essex Transformation and Improvement Board for Elective Care oversees all aspects of elective (referral to treatment). The National Planning asks, and delivery, recovery or mitigation plans are presented here for assurance.

This Board then collates headline risks, actions and escalation items which are presented to the Mid and South Essex Integrated Care System's Oversight and Assurance Committee.

The below shows the System governance structure.



GIRFT - Getting it right first time
MSK - musculoskeletal

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Detailed plans for 23/24 are set out within the operational planning submission	From quarter one to quarter four 2023/24
Achievement of zero patients waiting over 65 weeks for their procedure	Quarter four 2023/24
Continue to increase number of patients receiving virtual outpatient appointment	From quarter one to quarter four 2023/24
Continue to increase number of patients receiving their follow up appointment as patient initiated as opposed to a pre-booked appointment (empowering the patient)	From quarter one to quarter four 2023/24
Continue to reduce patients waiting over 52 weeks for their procedure	From quarter one 2023/24 to second half of 2025/28

Cancer Services

What have our residents told us?

Currently our patients are waiting too long to find out if they have a cancer diagnosis, or for their treatment.

Cancer Stewards to continue to lead the Cancer transformation programme across mid and south Essex including involvement in best practice pathway review and sustainability, allocation of Cancer Alliance resources for the optimum outcome that supports the short-, medium- and long-term System ambition for cancer services and population health.

Ensuring our residents have the highest chances of recovery from their illness or condition, and to give them the best treatment we can, through implementation of best practice pathways. Demand for services is changing, we will use technology to implement new ways of providing care.

Personalisation is paramount to how we engage with our population and underpinned by leadership and a skilled workforce who can respond to population needs, this includes use of shared decision making to ensure that the patient pathway is right for them.

To achieve our ambition, we need to understand what our population want from us and ensure that any change is underpinned by experience, feedback and engagement from service users, ensuring use of co-production in future pathway redesign.

Recognising the importance of pre-habilitation and rehabilitation and improving post treatment care for those individuals, their families and carers. Empowering people to re-engage with services as part of their self-management plan.

Current Conditions

To effectively deliver best practice pathways and develop cancer services we need the right workforce across all specialties. Succession planning, recruitment and retention of workforce is essential to service delivery. The right staff and ongoing training must be part of our workforce plans. Workforce considerations for effective and safe cancer services need to include diagnostics and pathology because without capacity here the ability to recover cancer services will be impacted.

Across Cancer services working with all partners including primary care networks is critical, work with the Primary Care Networks is essential to improving information shared with referrals to enable patients to be actively triaged to the right pathway for them.

The System is moving services closer to home, particularly for diagnostics and chemotherapy.

What is the requirement from the NHS?

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

Our Ambitions

As outlined in the Mid and South Essex Long Term Plan our focus for Cancer remains:

- Promoting use of screening and tests to enable early diagnosis across cancer services including access for marginalised groups. This promotion extends to non-invasive tests to support early diagnosis.
- Consolidation of the Rapid Diagnostic Service for patients to incorporate a consistent offer across our population this will include non-site specific symptoms which could indicate cancer and ensure people are on the correct pathway.
- Implementation of a range of Targeted Interventions to enable case finding and active promotion and prevention for individuals
- Continuing National Targeted Lung Health Checks to support earlier diagnosis of lung cancer as per National requirement.

Delivery Priorities

To enable safe care our patient pathways, need to be supported by enablers including the shared patient record, so that wherever the patient attends for their care, their clinical team can see their records to reduce delays.

Joining up our different health, care and voluntary services means we can bring services closer to people's homes. Opportunities for care closer to home include chemotherapy, infusions, surveillance diagnostics, local tests and access to medication.

We will develop a System wide approach for cancer patients ensuring effective pathways and partnership working and following Nationally agreed best practice pathways.

We will continue to work with our patient population. The two pilots in development:

1. Virtual Group Cancer Care Review
2. Prostate Case Finding pilot

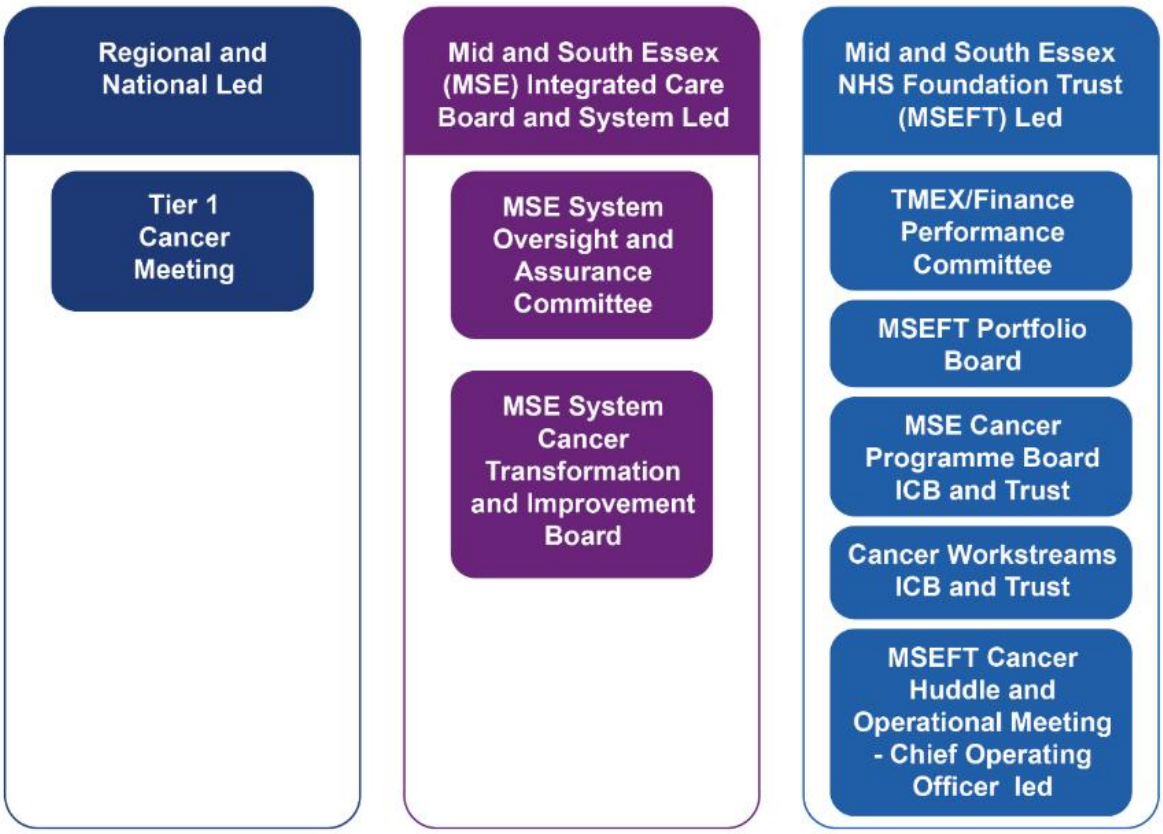
are two examples of co-production that have involved patients from the very start, and we are committed to build on co-production work.

We will continue to involve and listen to our Mid and South Essex Patient Champion Engagement Committee.

Ensuring Delivery

Senior Responsible Owner: Karen Wesson
Clinical Lead: Liz Towers

The Mid and South Essex Transformation and Improvement Board for Cancer oversees all aspects of cancer care. The National Planning asks, and delivery, recovery or mitigation plans are presented here for assurance. This Board then collates headline risks, actions and escalation items which are presented to the Mid and South Essex Integrated Care System's Oversight and Assurance Committee.



The above shows the System and internal Trust governance structure.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
The priority pathways with continued initial focus for 2023/24 to reduce patients waiting over 62 days are: • Skin • Colorectal • Prostate • Gynaecology • Breast	From quarter one to quarter four 2023/24
Trust tracking of tumour site trajectories for Haematology, Head & Neck, Lung and Upper Gastrointestinal Intestinal during 23/24	Quarter two 2023/24
28-day Cancer faster diagnosis standard (67.5% - June 23 / 70% - Sept 23 / 72.5% - Dec 23 / 75% - March 24)	Quarter four 2023/24
Targeted improvement and recovery plans for increasing % of cancers diagnosed at states 1 & 2 *(See 23/24 operational plan for further details relating to –* • Lynch Testing • Prostate Case Finding • Cervical Screening • IT system improvement • Pathology systems improvements • Bowel Screening • Non-specific Symptoms pathways • Targeted Lung Health Checks	From quarter one to quarter four 2023/24

Adult Mental Health Services

What have our residents told us?

Working with our communities and against national guidance has been key to how we transform mental health services. The message from our local population has been an ask for services to be more joined up, ensuring users and communities are part of co-producing services, making care individualised and responsive with prevention and early intervention to support them live well in their communities.

We continue to hear from local residents, staff working within the Integrated Care System and in the Integrated Care Board about the challenges of joined up working. This spans across the acute, secondary, and primary care space and across physical and mental health care and social arenas. This means a change in language, physical and digital space and building confidence in the workforce to be able to hold the whole person in mind and make sure that we optimise every contact.

Current Conditions

Our Mental Health Partnership Board through the Whole System Transformation Group has overseen the development of the transformation to enhance effective delivery on the Long-Term Plan commitments through the Mental Health Investment Standard. The current transformation of community mental health services whilst ongoing has highlights of a system with significant reliance on inpatient services, a workforce challenge and sometimes a lack of defined structure between system and place.

Through our focus on the wider determinants of health, our primary care networks, and place-based plans, we want to ensure the system rebalances in favour of prevention, early intervention, resilience, and recovery.

What is the requirement from the NHS?

Mental health transformation continues to take place in Mid & South Essex, aligned with the calls to improve and widen access to mental health support outlined in the 2021 report from the independent Mental Health Taskforce review, the Five Year Forward View for Mental Health1 and the NHS Long Term Plan.

Our Ambitions

The Southend, Essex and Thurrock Mental Health and Wellbeing Strategy 2017-2021, (being refreshed 2022) articulated a common vision and ambition for the development of high-quality mental health care, around the commitment to “ensure that everyone needing support in Southend, Essex and Thurrock–including families and carers –get the right service at the right time from the right people in the right

way”2. The Strategy explicitly acknowledged the 8 principles set out in the NHS Five Year Forward View for Mental Health.

Our vision for mental health in Mid & South Essex Integrated Care System is to:

- Improve urgent and emergency care mental health – crisis response and care.
- Integrate social care, mental health and physical health – parity of esteem and care closer to home.
- Promote good mental health and preventing poor mental health – early intervention and prevention.
- Moving the narrative to a ‘we/our’ shared language rather than ‘them/us’ language, to support understanding and confidence in the system about the person’s journey through services.
- Collocating services either physically or virtually so that every contact can be maximise and skills can be shared.
- Commitment to all age Mental Health strategy and delivery through a collaborative as part of the strategy implementation

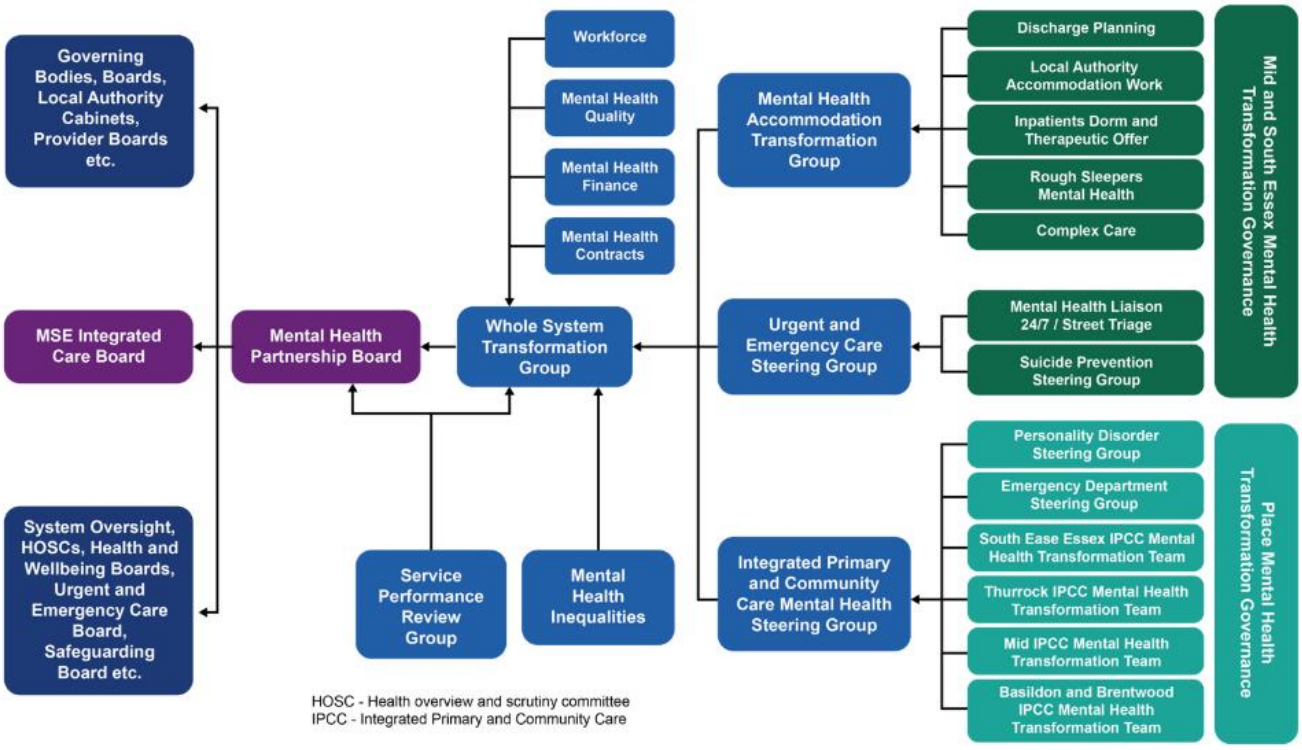
Delivery Priorities

1. Urgent and Emergency Care Mental Health
2. Liaison Mental Health
3. Adult and Older Adult Crisis
4. Acute Care (including Out of Area Placements)
5. Community Serious Mental Illness services for Adults and Older Adults
6. Early Intervention in Psychosis
7. Individual placement services
8. Serious Mental Illness – Physical Health Checks
9. Advancing Inequalities in Mental Health
10. Integrated Primary and Community Care Mental Health
11. Community Chronic Mental Illness for Adults and Older Adults
12. Improving Access to Psychological Therapies
13. Perinatal
14. Integrated model
15. Dementia
16. Functional Older Adults
17. Suicide Reduction & Bereavement
18. Bereavement
19. Complex Care & and move from Care Programme Approach

Ensuring Delivery

Senior Responsible Owner: Maria Crowley
Clinical Lead: Amy Bartlett

Below organogram of system governance arrangements.



Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
A range of complementary and alternative crisis services to Accident & Emergency and admission (including in voluntary and community, faith and social enterprise/ local authority-provided services) within all local mental health crisis pathways;	Quarter three 2023/24
Deliver against Integrated Care Board level plans to eliminate inappropriate adult acute out of area placements as against planned trajectory	Quarter four 2023/24
The therapeutic offer from inpatient mental health services will be improved by increased investment in interventions and activities, resulting in better patient outcomes and experience in hospital. This will contribute to a reduction in length of stay for all services to the current national average of 32 days (or fewer) in adult acute inpatient mental health settings (“Time to Care”)	First half of 2024/25
Established new specialist mental health provision for rough sleepers	Quarter two 2023/24
Deliver against multi-agency suicide prevention plans, working towards a national 10% reduction	Quarter one 2023/24

Delivery Plan objectives	Timespan for implementation of objectives
in suicides with a suicide bereavement plan in place	
All areas within Mid and South Essex Integrated Care Board will maintain the existing Talking Therapies referral to treatment time and recovery standards	Quarter three 2023/24
Supporting women to access evidence-based specialist mental health care during the perinatal period. This will include access to psychological therapies and the right range of specialist community	First half of 2024/25
Provision of NHS specialist treatment for people with serious gambling problems.	Quarter four 2023/24
Mental health professionals working in ambulance control rooms, Integrated Urgent Care services, and providing on-the-scene response via a Mental Health ambulance car in line with clinical quality indicators	Quarter two 2023/24
Continuation of the new integrated community models for adults with Serious Mental Illness (including care for people with eating disorders, mental health rehabilitation needs and a 'personality disorder' diagnosis) spanning both core community provision and implementation of the complex care pathway with a move to "personalised Care "for greater choice and control, moving away from the care programme approach	Quarter three 2023/24
Implementation of recovery colleges and improving access to Individual Placement and Support to be doubled, enabling people with severe mental illnesses to find and retain employment. Ensuring over 60% of people experiencing a first episode of psychosis will have access to a National Institute for Health and Care Excellence - approved care package within two weeks of referral. 60% of services will achieve Level 3 National Institute of Health and Care Excellence concordance by end 2023/24	Quarter four 2023/24

Children and Young People Mental Health

What have we heard from residents/patients

The evidence tells us that Children and Young People are continuing to recover from the impact of the pandemic which for some has had a negative effect on their development, emotional wellbeing, and mental health.

Families tell us it remains difficult to access specialist mental health services in a timely way and that the wide variety of services on offer are challenging to navigate.

What is the current state of play/local challenges

The demand has risen for services with the number of children who have concerns with their mental health increasing to 1 in 6 in comparison to 1 in 9 only 5 years ago (Young MINDs).

What is the requirement from NHS

The NHS Long Term Plan sets out the ambition to expand Children and Young Peoples Mental Health Services widening the access to services closer to home, reduce unnecessary delays and deliver specialist mental health care in ways which work better for families. This builds on the commitment from the Children and Young Peoples mental health green paper which brings together the Department for Education and Department of Health in a programme of work to strengthen the support and offer in educational settings. Working in partnership we will continue to educate families and young people in managing and preventing the potential risks of online harm and high-risk behaviours.

What is the ambition?

The Southend, Essex and Thurrock Mental Health and Wellbeing Strategy is an all-age strategy which identified specific areas for focus including Eating Disorders, Crisis services, integrated care within local acute trusts, improving access and ability to measure outcomes and use of digital technology to support care.

We know the support young people require as they move into adulthood often needs to be bespoke and holistic to this age group and will be working across the sectors to develop this further.

What are the delivery priorities?

1. To continue with the expansion and transformation of mental health services, as set out in the NHS Mental health Implementation Plan and improve the quality of Mental Health care across all ages.

2. There are clear pressures in relation to Children and Young People referrals (demand), acuity and severity of needs. A whole system approach is needed to harness effective prevention and early intervention initiatives. This acknowledges the health inequalities which are influenced by economic factors, relational influences, individual and family health and wellbeing and environment in which we live.
3. To increase access and equality, build capacity and capability in the system and build resilience in the community.
4. Priorities prevention and early intervention across education, health and care and voluntary and community, faith and social enterprise pathways and continue to transform services to deliver better outcomes and more resilient Children and Young People

Governance

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

Delivery of the strategic ambitions and programme will be overseen by the Children's Commissioning Collaborative for Southend, Essex and Thurrock with the development of the Mental health Strategy Implementation Group which will provide the oversight for both adults and children mental health programmes of work. mid and south Essex publish our Open Up Reach Out Local Transformation Plan annually which identifies areas of investment and progress on delivery.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Transformation of the Children and Young People Eating Disorder Pathways to include Specialist Treatment and Recovery Service roles	From quarter three to quarter four 2023/24
To use feedback tools and routine outcome measures to ensure the voice of the Children and Young People is centre and care is person centred.	Quarter four 2023/24
Develop the service offer for 18–25-year-olds to support transition to adulthood.	From quarter one to quarter four 2023/24
Expansion of Mental health Support Teams in Schools waves 7 & 9	From quarter three 2023/24 to first half of 2024/25
Embedding Children and Young People Mental Health practitioners in a phased approach with Primary Care.	From quarter three 2023/24 to second half of 2024/25
Expansion of Learning Disability /Neuro Diversity Child and Adolescent Mental Health Team	From quarter four 2023/24 to second half of 2024/25
Capital development programme for Children and Young People Eating Disorder Service	From quarter four 2023/24 to first half of 2024/25
Review and design a model of care with voluntary and community, faith and social enterprise providers for mid and south Essex .	From quarter two 2023/24 to first half of 2024/25

Neurodiversity

What have our residents told us?

The current challenge is to fully understand the models of provision and identify the gaps and variations across mid and south Essex and (where appropriate) on the greater Essex landscape. This includes working with a wider set of partners, stakeholders and communities, experts by experience and their families to obtaining feedback to help shape and deliver modern fit for purpose models of neurodiversity provision.

Current Conditions

Currently neurodiversity services are delivered by a range of statutory and voluntary agencies which are not aligned or delivered within an agreed strategic approach. This presents with challenges of inequitable access, variation in provision, fragmented delivery which is not maximising the opportunities of working collaboratively within an all-age approach to provide the best and most efficient models of care for people requiring support with neurodiversity presentations.

What is the requirement from the NHS?

We need to ensure the provision and commissioning of models of care meet the statutory requirements.

To ensure local provision reflects the needs and requirements of the standards or codes of conduct to addresses inequalities in access, variations in provision.

To ensure appropriate governance and oversight of the provision of services, to continuously review and evaluate the models of provision to reflect the changing socio-economic situations impacting on local populations.

Our Ambitions

For NHS, Local Authorities, voluntary services and others to work collaboratively to co-produce services that are equipped and designed to around family health models.

To deliver models of care that maximise resource allocation within a whole system, all age pathways.

To develop new and innovative ways of partnership working that focus on family health models (all age models) with better alignment between the NHS, local authority and associated partners.

To address the growing demand for access and whole system models of provision that maximise resources.

Delivery Priorities

2023/24 we will undertake a comprehensive mapping of current service provision and identify the gaps to inform an all age, whole systems joined up approach to deliver fit for purpose Neurodiversity programmes.

The Integrated Care Board has approved the appointment of a dedicated project lead post on a fixed term basis to undertake this mapping work.

We will develop new partnership models for delivery of our Neurodiversity programmes which aligns to the babies, children and young people's programme, and in line with the spirit of the Integrated Care Strategy. This will complement existing work underway to develop and all age, mental health strategy pan Essex.

Ensuring Delivery

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

The delivery of programme of work for Neurodiversity will be set out in 2023/4 and remain accountable to the Integrated Care Board on deliverables. The Integrated Care Board will provider oversight and governance on the programme and will want to ensure alignment to the Children and Young People and mental health programmes of work.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Integrated Care Board in consultation with partners and providers undertake an all-age review of the current provision of services across Essex, identifying the current pathway and provision, identify gaps in provision.	Quarter one 2023/24
Develop new partnership models for delivery of the Neurodiversity programmes which aligns to the babies, children and young people programme and is in line with the Integrated Care Strategy.	Quarter two 2023/24
Ensure appropriate procurement and commissioning of fit for purpose, evidence based modern models of care for Neurodiversity that is aligned to Children and Young People and mental health commissioned services.	Quarter three 2023/24
Review and evaluation of the commissioned models of provision to inform ongoing service developments in consultation with stakeholders which takes into account research findings, new and emerging policy changes.	From quarter four 2023/24 to first half of 2024/25

Babies, Children and Young Peoples Services

What have our residents told us?

Co-production with Children and Young People and families is central to the development of our strategic direction and is reflected in the development of agreed values and principles.

Current Conditions

mid and south Essex has a children population of circa 270k and although there are similarities in health needs there are also significant variations associated with demographics and wider determinants of health.

mid and south Essex will have a Children and Young People Panel to support the strategic work of the Integrated Care Board which will be further developed with children and young people in parallel with the Children's Partnership Framework.

We continue to shape services adopting the principles of a person-centred approach to care and preparing Children and Young People and their families for effective transition to adulthood.

What is the requirement from the NHS?

The Integrated Care System will deliver the ambitions of the NHS Long Term Plan supported by the partnerships and identifying synergies with wider Government Strategies including Levelling Up and Regeneration, Social Care reforms, Schools white paper opportunity for all and Family Hubs and Start for Life programme.

The NHS has specific statutory requirements under the Children's and Family Act and Special Education Needs and Disabilities Code of Practice in relation to Special Educational Needs and Disabilities and will continue to work in partnership with the Local Areas Special Education Needs and Disabilities Boards in delivery of the respective Special Education Needs and Disabilities Strategies and Inclusion Plans.

The Core 20+5 Framework for Children and Young People has identified areas for focus including Diabetes, Epilepsy, Asthma, Oral Health and Mental Health. There will be a continuous focus on improving the outcomes for those in our most deprived areas and cohorts of Children and Young People where the outcomes are not comparable with their peers such as children who are in care, Special Education Needs and Disabilities and those involved in the youth justice system.

The Children and Young People ambitions will be the responsibility of the Growing Well Programme Board led by the Director for Children and Young People and clinical lead. The Growing Well Programme Board will align and connect with the

Essex, Southend and Thurrock Children and Young People partnership forums and the four alliances.

Our Ambitions

As a partnership, we are committed to improving the lives of Children and Young People and it stands as a top priority for us as a system. To support this ambition, we have developed a Partnership Framework which recognised the strategies and priorities held by many organisations and is designed as an enabler recognising that we can have a bigger impact by working on factors that influence health and wellbeing, not just at the point of illness or crisis.

In 2023/24 we will develop new partnership models for delivery of our Children and Young People and Neurodiversity programmes, working with a wider set of partners and stakeholders and communities, in line with the spirit of the Integrated Care Strategy. It is anticipated this will see us securing additional resources to bring this work forwards. This will complement existing work underway to develop and all age, mental health strategy pan Essex.

Delivery Priorities

We have 6 priority areas of work with associated programmes. These include Children and Young People Mental health, Special Education Needs and Disability, Neurodiversity, Palliative and End of Life, Transformation of Community Services and Urgent and Emergency pathways.

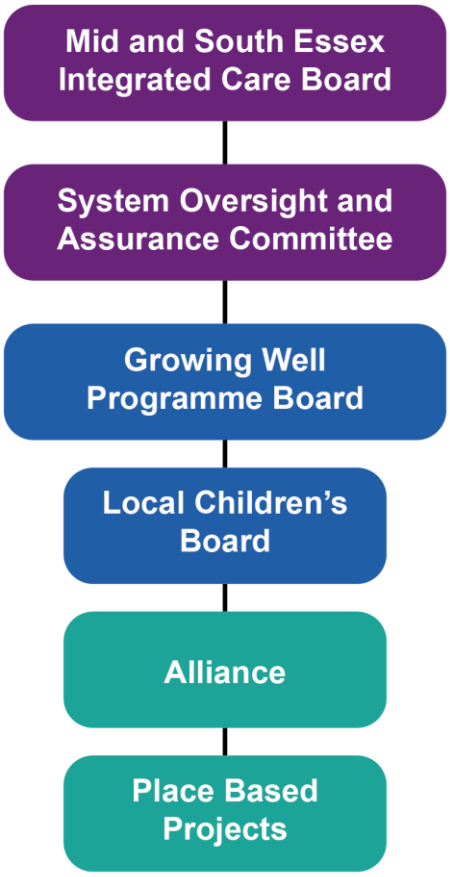
There is an opportunity with existing partnerships to secure development resources to form a new integrated Babies, Children and Young People approach, starting with early years health and care and then extending into all Children and Young People.

Ensuring delivery

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

The Children and Young People ambitions for the NHS Long Term Plan will be the responsibility of the Growing Well Programme Board led by the Director for Children and Young People and clinical lead. The Growing Well Programme Board will align and connect with the Essex, Southend and Thurrock Children and Young People partnership forums and the four alliances.

Below organogram of system governance arrangements.



Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Asthma: Children and Young People Community Asthma team aligned to 8 PCNs in South East Essex by March 2024	Quarter four 2023/24
Children and Young People End of Life: Agreed Children and Young People End of Life Ambitions Framework Implementation Plan by December 2023	First half 2024/25
Children and Young People End of Life: 24/7 Palliative and End of Life Care service in place by March 2025	Second half 2024/25
Diabetes: Agreed Improvement Plan developed by March 2024	Quarter four 2023/24

Delivery Plan objectives	Timespan for implementation of objectives
Diabetes: Increase access to Continuous Glucose Monitoring and insulin pumps within agreed protocols and National Institute of Health and Care Excellence Guidance by 25/26	2025/28
Epilepsy: Agreed Improvement Plan developed by March 2024	Quarter four 2023/24
Urgent & Emergency Care: Hospital@Home pilot in place by September 2023	First half of 2024/25
Urgent and Emergency Care: Long-term Paediatric Acute Respiratory Infection Model in place by December 2023	Quarter two 2023/24
To reduce the number of children requiring higher levels of mental health services by strengthening early intervention, support and education for Schools and Colleges.	Quarter one 2023/24
To improve access to specialist Children and Young People Mental Health Services	Quarter one 2023/24
To improve the outcomes and experience of children and young people with Special Educational Needs and Disabilities and ensure the Integrated Care Board meets it statutory requirements.	Second half of 2024/25

Reducing Pressure on Urgent and Emergency Care Services

What have our residents told us?

Co-production with patients and families and system partners is central to the development of our strategic direction for Urgent and Emergency Care services.

Current Conditions

The urgent care system is under significant pressure and this impacts on our responsiveness to sustain delivery to elective and cancer services. All partners are working hard to address urgent care pressures and ensure service provision for people alternative to Emergency Department that meet their needs and requirements.

We have three established sub-systems for urgent and emergency care (southeast, southwest, and mid Essex). These sub-systems currently have their own delivery boards, where partners work together to deliver improved urgent and emergency care services, which feed into the Mid & South Essex Urgent and Emergency Care Transformation & Improvement Board

111 Service:

We have a comprehensive NHS 111 service covering the entire mid and south Essex population. This includes a single multidisciplinary Clinical Assessment Service within integrated NHS 111, ambulance dispatch and General Practitioner out of hours services. NHS111 provision from Mid & South Essex is provided by IC24, who went live with the online NHS111 in December 2022, as well as the continuation of the telephony service.

As part of the national Pathways Light programme, from April 2023 our IC24 Provider will be increasing service provision to incorporate access to Dental Service Advisor, urgent repeat prescriptions and Minor Injuries Service Advisor.

Same Day Emergency Services:

All three hospitals offer a same day emergency service for 12 hours/day, 7 days/week. These services provide fast access for patients to diagnostics and treatment and reduce hospital admissions.

The Same day emergency service models are currently under review to ensure maximise service provision opportunity to ensure same day treatment.

Alternative to Emergency Department:

Mid & South Essex will be an early adopter, commencing in Quarter 1 2023/23 for Alternative to Emergency Department to support the delivery of a roadmap for individuals to be aware of service existence, and how to access the service. As well as overview of gaps in the roadmap for further interventions/investment.

Older People's Service:

Our three hospitals have worked to develop assessment and treatment units specifically to meet the needs of older people.

At Broomfield, the operating hours of the Frailty Ambulatory Service is 08.00-20.00 Mon-Sun.

At Southend the Frailty Service currently operates Monday-Friday 09:00 to 17:00.

Basildon offers a full 7-day frailty service.

Virtual Wards:

The current baseline of virtual ward capacity for mid and south Essex is 175 virtual ward beds. The virtual ward baseline as at 31.03.23 is as follows:

- Respiratory Virtual Ward: 45 beds
- Frailty Virtual Ward: 60 beds
- Hospital@Home Virtual Ward: 55 beds
- Heart Failure Virtual Ward pilot: 15 beds

We continue to work towards the national ambition of 480 virtual ward beds operational by December 2023. Our current plans include a revision of our Respiratory virtual ward based on recent occupancy from 45 to 15 virtual wards beds; plus inclusion of our virtual Emergency Department of 42 VW beds delivered via our Urgent Community Response Teams.

The Frailty Virtual Ward will soon incorporate an additional 15 unplanned out of hours response Virtual Webs beds, and 60 further VW beds delivered via the complex wound care team. We intend to include these within our Virtual Wards from the end of May following completion of our governance processes.

The ongoing efficiency programme including a focus on digital, workforce and communications enablers will be a key ongoing element of developing our capacity and occupancy – particularly within the Frailty virtual ward where we know the biggest opportunity lies.

In addition, our Stroke Earlier Supported Discharge pathway will deliver 60 Virtual Ward beds and the Mental Health Crisis Response Teams and Dementia Services a further 30 Virtual Ward beds.

All of the above equates to an assumption for September 2023 that 370 Virtual Ward beds will be available within our system with further pathways are being developed including Children's Hospital at Home, Musculoskeletal Post-surgical, and further expansion of Frailty Virtual Ward to include Acute Kidney Infection.

Urgent Community Response Team:

Full geographic coverage from 8am-10pm 7 days a week is in place across mid and south Essex. The service provision covers the nine clinical conditions or needs, including level 2 falls, in line with the national 2-hour guidance. Scoping has commenced to identify potential demand outside of operational hours and considerations of extending beyond core hours underway.

Newly enhanced service whereby Urgent Community Response Teamwork in collaboration with East of England Ambulance Trust to support in clinically appropriate referrals being shared with Urgent and Community Response Team to support visits and care to patients requiring urgent care, enabling the ambulances to be released to support those individuals requiring emergency care. mid and south Essex are consistently exceeding the minimum threshold of reaching 70% of 2-hour crisis response demand within 2 hours.

Further exploration in progress in implementation of 'call before you convey', working with System partners and East of England Ambulance Trust to support ambulances with alternative options to Emergency Department, and all crews will dial one number whereby they will have a Multi-Disciplinary Team to support patients into alternative pathways, excluding priority and Category 1 calls. Rollout anticipated for Quarter 3 in 2023/34

Improving Discharge:

Implementation of data platform systems to support with real-time decision making to support patient flow and discharge throughout the System. Shrewd Resilience and Teletracking systems will be utilised to daily monitor the discharges identified against the requirement to ensure patients flow from front to back door, and early intervention implemented where there a deficit is identified.

By the end of June 2023 Criteria Led Discharge will be implemented across the hospital sites, which will provide a framework to facilitate 'home for lunch' discharges as well as increasing weekend discharge rates.

What is the requirement from the NHS?

The Integrated Care System acknowledges the requirements within the NHS England published national delivery plan for recovering urgent emergency services.

Date published: 30 January 2023

Our Ambitions

A system that provides more, and better care in people's homes, gets ambulances to people more quickly when they need them, sees people faster when they go to hospital and helps people safely leave hospital having received the care they need.

Everyone to receive the very best urgent and emergency care, raising standards of quality and safety patients and their families:

We will work to expand and better joining up health and care outside hospital: stepping up capacity in out-of-hospital care, including virtual wards, so that people can be better supported at home for their physical and mental health needs, including to avoid unnecessary admissions to hospital.

We will make it easier to access the right care: ensuring healthcare works more effectively for the public, so people can more easily access the care they need, when they need it.

Delivery Priorities

- Expand 111 service offer in accordance with pathways light programme.
- 111, Primary Care and East of England Ambulance Trust Ambulance to directly book Same Day Emergency Care slots into the service in Quarter 2 of 2023/24.
- Improve awareness and access to alternative services avoiding emergency departments.
- Expansion of virtual ward capacity increasing referrals and utilisation of the virtual ward capacity.
- Identify potential Urgent Community Response Team demand outside of operational hours and considerations of extending beyond core hours.
- Implement Multi-Disciplinary Team support number for ambulance crew support to ensure alternatives to Emergency Department fully optimised.
- Increase 'home for lunch' discharges through criteria led discharge initiatives.

Ensuring delivery

Whole pathway responsibility:

Clinical Lead: Dr Eddie Lamuren, Clinical Director (Emergency Care), Mid and South Essex NHS Foundation Trust, supported by Hospital Site Emergency Department Clinical Leads

Senior Responsible Owner: Hospital Site Managing Directors, Mid and South Essex NHS Foundation Trust

111 Governance:

Senior Responsible Owner: Samantha Goldberg

Clinical Lead: Dr Sanjeev Rana

Delivery will be monitored via the daily and monthly NHS111 volumes and performance metrics, as well as increase in alternative to Emergency Department dispositions.

Same Day Emergency Care Governance:

Senior Responsible Owner: Samantha Goldberg
Clinical Lead: Eddie Lamuren

Delivery will be monitored through the monitoring of referrals received and accepted into the service and reduction in admission into acute hospital beds

Alternatives to Emergency Department Governance:

Senior Responsible Owner: Samantha Goldberg
Clinical Lead: Sarah Zaidi / Matt Sweeting

Delivery will be monitored through the volume of ambulance conveyed to the hospital, ambulance offload times, and increase in referrals to alternative services.

Older People Services Governance:

Senior Responsible Owner: Samantha Goldberg
Clinical Lead: Eddie Lamuren

Virtual ward Governance:

Senior Responsible Owner: Gerdi Du Toit
Clinical Lead: Sarah Zaidi / Matt Sweeting

UCRT Governance:

Senior Responsible Owner: Samantha Goldberg
Clinical Lead: Yvonne Mubu

Monitored through the increase in referrals from East of England Ambulance Trust to Urgent Community Response Team and reduction in Category 3 ambulances conveyed to the hospital

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
111 dental advisors, urgent repeat prescriptions and minor injuries advisor go live	Quarter one 2023/24
Same Day Emergency Care direct booking slots available (111, Primary Care, Ambulance Services)	Quarter two 2023/24

Delivery Plan objectives	Timespan for implementation of objectives
Commence early adoption of alternative to Emergency Department roadmap	Quarter one 2023/24
480 virtual ward beds operational by December 2023.	Quarter three 2023/24
Multi-Disciplinary Team East of Essex Ambulance Trust alternative to Emergency Department contact system rolled out	Quarter three 2023/24
Criteria led discharge fully implemented across hospital sites	Quarter two 2023/24

Respiratory Services

What have our residents told us?

Our residents have fed back to our respiratory services the importance of knowing more about their respiratory health, knowing how to self-manage their health conditions and having access to environments where they can share their experiences with others in similar situations (eg pulmonary rehabilitation).

They want to be involved not only in the management of their own health but also in the co-production of the healthcare services they use, ensuring that the patient voice is heard, and the services meet the needs of the residents who use them.

Current Conditions

There are estimated to be approximately 170,000 people with a respiratory condition in mid and south Essex. This is likely to be an underestimate of true numbers. Prior to the covid pandemic, estimates based on expected prevalence of Chronic Obstructive Pulmonary Disease suggest that within mid and south Essex we have 7000 to 13000 people with Chronic Obstructive Pulmonary Disease who are as yet undiagnosed. This has been further exacerbated by pauses in respiratory diagnostics, such as spirometry, during the covid pandemic.

Patients with respiratory conditions often have co-morbidities with approximately 40% having co-morbidities, 29% having co-existent frailty and 36% being in the last year of life. Our respiratory patients also have a significantly higher rate of co-existent mental health conditions with 14% having depression ad 10% having anxiety compared to 5% having depression or anxiety in the overall mid and south Essex population.

Our patients have high utilization of emergency care with high rates of hospital readmission, respiratory readmissions accounting for nearly 15,000 bed days, the most common reason being Chronic Obstructive Pulmonary Disease. This is exacerbated by the backlog in diagnostic services with patients on average having 3 emergency care utilizations for respiratory disease in the year prior to a diagnosis of Chronic Obstructive Pulmonary Disease.

Long covid can be a debilitating multi-system condition affecting an individual's physical, psychological and cognitive health, their daily life and ability to work or attend education. The Office of National Statistics Coronavirus Infection Survey in March 2023 estimated that there are around 1.9 million people in England experiencing symptoms following COVID-19 for more than four weeks: 1.3 million of whom for over 12 months. An estimated 381,000 people in England report that long COVID is significantly impacting on their day-to-day activities. Applying these figures to mid and south Essex 24,000 people will have Long COVID symptoms after a year and 14,261 after two years.

What is the requirement from the NHS?

The NHS long term plan highlights key areas of focus as:

- Ensuring more patients have access to testing such as spirometry testing so respiratory diseases are diagnosed and treated earlier
- Ensuring patients with respiratory disease receive and use the right medication including educating patients on the correct use of inhalers
- Expanding rehabilitations services including Pulmonary Rehabilitation services so patients can better self-manage and live as independently as possible.

NHS England also have a requirement for respiratory virtual wards to support the care of acutely unwell respiratory patients in their own homes.

We are working towards meeting the requirements of the long-term plan with a number of pieces of work in these areas.

Spirometry and fractional exhaled nitric oxide tests are available for the entire mid and south Essex population and all patients receive a full clinical assessment as well as diagnostic tests. The holistic service offered is able to guide on treatment as well as referral to supporting services such as smoking cessation and pulmonary rehabilitation, so patients have access to timely and high-quality input for their respiratory disease. Within mid and south Essex we have worked with our cardiology and mental health services to design pathways for cough and breathlessness which ensure patients have early access to the right diagnostic tests and treatment and are seen by the right services in a more timely manner. Patients also have access to support for their psychological well-being through NHS talking therapies and dedicated clinical psychologists who focus on breathlessness management

Pulmonary rehabilitation is one of the most evidence based and high value treatments for Chronic Obstructive Pulmonary Disease. It reduces hospital admissions and improves quality of life and exercise capacity of patients as well as supporting in patient self-management. Pulmonary Rehabilitation is provided to all of the residents in mid and south Essex with chronic respiratory disease. All providers are undergoing accreditation and innovative work is being done including “pop-up” Pulmonary Rehabilitation sessions being delivered in areas of either higher socioeconomic deprivation or areas in which patients can’t access standard Pulmonary Rehabilitation settings and a Chronic Obstructive Pulmonary Disease patient education programme being delivered to those patients in the most socioeconomically deprived Primary Care Networks. This currently being piloted in Mid Essex with the aim to expand across mid and south Essex.

Pneumonia is a key focus of the respiratory programme. Pneumococcal vaccination rates within mid and south Essex have historically been some of the lowest within East of England and the programme is committed to ensuring pneumococcal vaccination rates improve, including focusing on the Core20PLUS5priority of

pneumococcal vaccination in patients with Chronic Obstructive Pulmonary Disease. Within mid and south Essex, LEADER reports have highlighted higher rates of death than some other areas from pneumonia or respiratory causes in our population with learning disabilities. We are passionate about addressing this and are working with partners to explore this further and address any inequalities.

mid and south Essex has three respiratory virtual wards, covering all areas of the population and supporting in caring for patients with respiratory disease in their own home rather than the hospital setting. The services can offer oxygen therapy, vital observations, IV antibiotics, nebulizer therapy and oxygen and are supported with digital technology.

Throughout winter 22/23 all of our residents had access to Acute Respiratory Infection Hubs. These are currently undergoing evaluation with Mid Essex being a pilot sire for national evaluation and a sustainable model is being explored to ensure our patients with Acute Respiratory Infections can receive timely treatment closer to home during times of winter pressures.

The long covid commissioning guidance published in July 2022 sets out requirements, including there should be a coordinated whole pathway of assessment, treatment and multifaceted rehabilitation and psychology support with direct access to required diagnostics. Also post COVID services are accessible to people from communities and sub-populations who experience health inequalities.

Our Ambitions

Our ambition is to work with our residents to design and deliver high quality patient centred services that allow earlier diagnosis of respiratory disease, better management of respiratory symptoms, and enable greater self-management of respiratory conditions.

What are our delivery priorities?

1. **Early and Accurate diagnosis:** Through increased capacity of spirometry and fractional exhaled nitric oxide tests and collaboration with Community Diagnostic Centres.
2. **Pulmonary Rehabilitation:** Delivered by Pulmonary Rehabilitation accredited services, ensuring both virtual and face to access and focussing on lesser accessed populations.
3. **Pneumonia:** To increase uptake of pneumococcal vaccination in our population and to reduce preventable pneumonia deaths in those with learning disabilities.
4. **Respiratory Virtual Ward:** To increase the number of appropriate patients being treated in their own homes on the respiratory virtual ward rather than in hospital.

5. **Acute Respiratory Infection Hub:** To evaluate our previous Acute Respiratory Infection hub models and build a sustainable approach for the future to help manage increased rates of respiratory infection in the winter.
6. **Long covid:** To continue to deliver a holistic pathway of assessment, treatment and multifaceted rehabilitation. To reduce health inequalities by having a focused plan which includes the use of the repurposed 'vax van'. To offer 100% of people assessments within 6 weeks of referral. To expand our co-production group

Governance

Senior Responsible Owner: Selina Douglas
Clinical Lead: Dr Abi Moore (respiratory)
Mid and South Essex Integrated Care System

Ensuring delivery

The Respiratory Programme is one of our key priority areas and transformation of services is supported by a formal governance structure. The programme reports into our community transformation board and works closely with the urgent emergency care board. There is dedicated programme support and a clinical lead.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Increase diagnostic provision to include cardiac and respiratory diagnostics for breathlessness by Oct 2023	Quarter three 2023/24
Recruit additional psychologists to provide support for breathless patients across both Respiratory and Cardiology pathways by September 2023.	Quarter two 2023/24
Work with Healthwatch to develop Pulmonary Rehabilitation co-production model and then extend out across respiratory services by October 23	Quarter three and four 2023/24
Ensure Mid and South Essex Integrated Care System is compliant with National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme by March 2024.	Quarter four 2023/24
All staff to be fully accredited or underway in the pathway of accreditation by the Royal College of Physicians Pulmonary Rehabilitation Services Accreditation Scheme by March 2025.	First half of 2024/25

Delivery Plan objectives	Timespan for implementation of objectives
To hold awareness raising events re the signs of pneumonia and preventative action that can be taken, which will include dedicated events for Learning Disability and neuro disability patients / carers / next of kin by December 2023.	Quarter three 2023/24
Undertake Evaluation and submit business case for sustainable Acute Respiratory Infection Hub model by September 2023 and align to respiratory virtual wards by Dec 23.	Quarter two 2023/24
Increase the numbers of people with health inequalities referred to the long covid team. By continuing to raise awareness with local health professionals and harnessing partnerships to deliver innovative health solutions	First half of 2024/25

Outpatient Programme

What have our residents told us?

A patient engagement session is planned for end of March ’23 to support the new workstreams supporting the move to a single integrated access service.

Feedback from patients regarding issues affecting their ability to attend planned appointments is currently being gathered within work to better understand Did Not Attends.

What is the current state of play/local challenges

The Programme has improved visibility of the key performance indicators for the operational teams using Power Business Intelligence, so these metrics are now able to be reviewed weekly by the care groups to ensure continued focus and improvement. The project team will be conducting ‘health checks’ with each operational specialty before rolling improvement initiatives out to further improve performance in identified areas.

During the next year, teams will be working to improve the central access function which will deliver an improved service for patients and a better experience for our staff through enhanced training and improved technology solutions.

The programme will continue the roll out of eConsult to all specialities and introduce phase 2 of the Programme during the year.

What is the requirement from the NHS?

Key Performance Indicators for 2023/24 is to reduce Follow-up activity by 25% (of baseline 2019/20 activity) by March 2024.

Our Ambitions

WS1 - Operational Excellence: We will equip managers with the right tools and skills to make data driven decisions to help achieve key national performance Key Performance Indicator's across all specialties by end March 2024

WS2 - Reshaping Access: By end of March 2026, we will deliver better patient and staff experience through implementation of consistent streamlined booking processes which will enable better management of referrals and new demand.

WS3 - Virtual Outpatients: We will adopt and implement new digital technologies and approaches that will deliver care in an innovative, efficient, and patient centric way by end of March 2024

WS4 - System Pathway redesign: We will deliver new models of care across Mid and South Essex Integrated Care System, giving patients seamless experience and right care at the right time by the end of March 2024

Delivery Priority

- Better experience for patients
- £42m of improved value through reducing waste and using technology
- 2% reduction in Did Not Attends, from current c8% to 6%
- Enhanced capacity (increase in Advice and guidance utilisation, Patient-initiated follow-up
- 25% reduction in follow ups (2019/20 baseline)
- New single integrated access team

Ensuring Delivery

Senior Responsible Owner: Andrew Pike
Clinical Lead: Professor Tony Young

The programme team will deliver using detailed project plans for each workstream on the Smartsheet system. Reporting dashboards will be used to inform sponsors, programme boards and executive groups.

Delivery Plan

Delivery Plan objectives	Quarter one 2023/24	Quarter two 2023/24	Quarter three 2023/24	Quarter four 2023/24	First half of 2024/25	Second half of 2024/25	2025 to 2028
Reduce follow up activity by 25% by end of March 2024	5%	12%	20%	25%			
Reduce Did Not Attends from 8% to 6% by end of March 2024	8%	8%	7%	6%			
WS1: Operational Excellence	£1.1m	£1.3m	£1.4m	£1.5m	£5.8m	£5.8m	
WS2: Reshaping Access	£0.3m	£0.3m	£0.3m	£0.3m			
WS3: Virtual Outpatients – to be modelled							
WS4: System Pathway Redesign	£0.9m	£0.9m	£0.9m	£1.0m			

Delivery Plan objectives	Quarter one 2023/24	Quarter two 2023/24	Quarter three 2023/24	Quarter four 2023/24	First half of 2024/25	Second half of 2024/25	2025 to 2028
Total of WS1 to WS4	£2.3m	£2.5m	£2.6m	£2.8m	£5.8m	£5.8m	

Diagnostics

What have our residents told us?

Our residents want the ability to access tests to diagnose their condition close to home, they want to access diagnostics once and not have them repeated unnecessarily.

Our residents want timely results and the least invasive test to enable them to receive a diagnosis or treatment plan.

Current Conditions

The key challenge for diagnostic recovery is the ability to provide continued service when capacity for delivery is impacted by wider pressures within the system. We continue to work with other System partners (Independent Sector and Community Providers) so we can maximise diagnostic capacity to support, people to access the most appropriate diagnostic test for their condition.

We are working to increase early diagnosis and the turnaround time for results of diagnostic tests across all our providers.

We have been working with our primary care practices to increase the use of Faecal Immunochemical Test tests, a non-invasive test that supports diagnosis for bowel conditions; the use of this test reduces the need for more invasive diagnostic tests whilst providing results to the patient in a timely manner.

We continue to progress the two key national requirements of Systems for diagnostics:

- Community Diagnostic Service/Centres and
- Rapid Diagnostic Service

Both of these will increase capacity and support the ambition of care closer to home and easier access locally for our residents.

What is the requirement from the NHS?

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

Our Ambitions

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

Bringing Care Closer to Home:

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

Ensuring that every Place has adequate and appropriate provision, based on its demographic and need, of both Screening and diagnostic services

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

Demand for services is changing as people grow older and live with more long-term conditions and there is much more we could do with technology, medical advances and new ways of working to treat people at an earlier stage, avoid more serious illness, and to live as well as they can for longer.

Delivery Priorities

- Mid and South Essex NHS Foundation Trust and Integrated Care Board Partners are working to ensure clear recovery trajectories and plans for the key asks as per the 2023/24 National Planning Guidance. Operating priorities will be subject to change as Planning Guidance is released and refreshed annually.
- The key diagnostic deliverable is to:
    - Have increased number of patients receiving diagnostic tests within six weeks - the March 2025 ambition of 95%
    - Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their General Practitioner for suspected cancer are diagnosed or have cancer ruled out within 28 days.
    - Increase the percentage of cancers diagnosed at stages 1 & 2 in line with the 75% early diagnosis ambition by 2028

The below table shows the Mid and South Essex Integrated Care System planned diagnostic trajectory for 2023/24 as the first year to achieve the planning ask.

Ensuring Delivery

Senior Responsible Owner: Dr Ronan Fenton
Clinical Lead: Dr Ronan Fenton/Dr Qaiser Malik

The Mid and South Essex Transformation and Improvement Board for Diagnostics oversees all aspects of diagnostics including performance (escalation from sub-group – see below), Community Diagnostic Service/Centre implementation and Rapid Diagnostic Service to support early cancer diagnosis.

The Board receives performance information from its diagnostic performance sub-group. This group focuses on the referral to diagnostic test, turnaround time for results across acute, community and independent sector providers. The National Planning asks, and delivery, recovery or mitigation plans are presented here for assurance.

The performance sub-group escalates the key risks to the Board which are presented to the Mid and South Essex Integrated Care System's Oversight and Assurance Committee.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Recovery of the referral to diagnostic test standard (6 weeks) so 95% of patients receive their test in six weeks	March 2025

Stroke Services

What have our residents told us?

There is variation across alliance areas in care received, particularly with reduced level of support for patients after stroke across alliance areas. Stroke Stewards are focussing on a number of projects to improve access to post stroke care and access to local voluntary support groups.

Current conditions

Across mid and south Essex:

- Not all stroke patients are being admitted to stroke wards due to bed pressures within the acute resulting in a number of medical outliers on stroke wards. Two acute sites in mid and south Essex have an E rating on Sentinel Stroke National Audit Programme for this indicator.
- Delays in scanning at arrival to hospital due to front door acute pressures thus reducing the number of patients eligible for thrombectomy.
- No community bed pathway for Covid positive patients resulting in discharge delays until patients test negative or are out of isolation period.
- Community Early Supported Discharge services are under pressure, intensity of rehabilitation has been reduced due to the number of referrals and rehabilitation requirements, Mid Essex service is currently holding a waiting list.
- There is differential access to community services across the system
- Workforce is an issue across acute and community stroke services.

Partnership working:

- Both community bed sites, Cumberledge Intermediate Care Centre and St Peter's are working in collaboration and now have a single acceptance criterion.
- Therapists across acute and community have worked in partnership to align patient assessments and reviews by all using the EQ-5D tool.
- Mid and South Essex Integrated Care System is part of the South East of England Integrated Stroke Delivery Network to support and align work plans across the region. The Integrated Care System has successfully bid for numerous funding to support different ways of working such as the mid and south Essex catalyst funding project, focussing on growing our own Stroke

Multi-Disciplinary Team workforce using band 4 Rehabilitation Assistants to enhance the Community Stroke pathway across mid and south Essex.

- Stroke Programme Board and Stroke Stewardship in place with representation across primary care, community, acute and voluntary sectors.

What is the requirement from the NHS?

This below system vision links to the NHS Long-Term Plan which highlights both increased thrombectomy and improved post hospital stroke rehabilitation models.

Our Ambitions

The stroke stewardship team are reviewing the end-to-end pathway to ensure that all elements are delivered in line with the National Stroke Service Model and the Integrated Community Stroke Service. A recent review of quality adjusted life years data demonstrated that mid and south Essex should invest less into acute services and more into community services and Thrombectomy to provide better outcomes for stroke survivors.

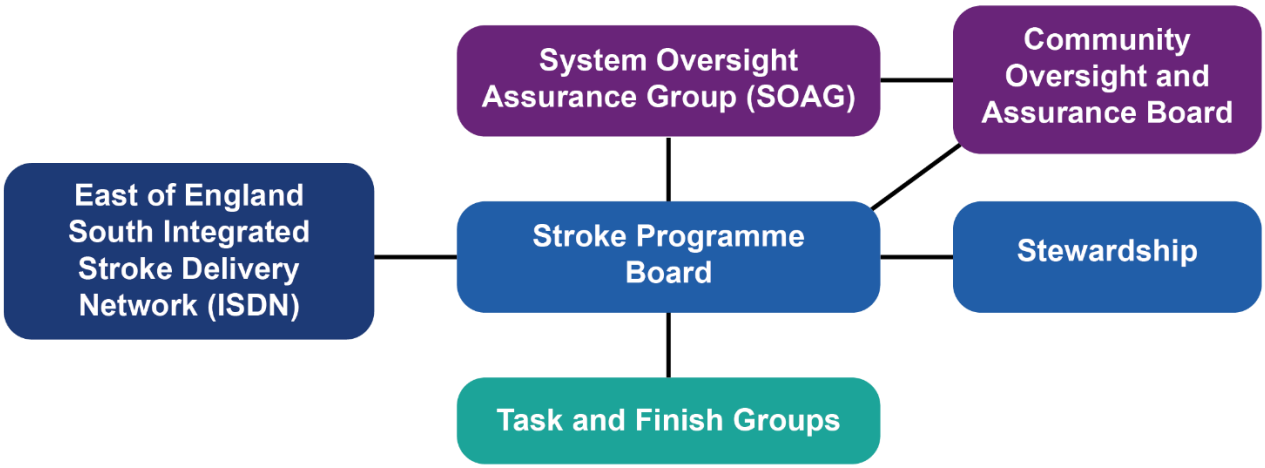
Delivery Priorities

- Acute action plans to improve Sentinel Stroke National Audit Programme rating at all three sites by June 2023.
- Acute audit to be undertaken to identify delays in the system by March 2023.
- Community bed reconfiguration by September 2023 (subject to public consultation).
- Implement the Integrated Community Stroke Service model by April 2024. Implement the Integrated Community Stroke Service model by April 2024. The Integrated Community Stroke Service model has nine key components; integration, responsive and intensive, needs based, pathways of care, seven day working, team composition, specialist service, education and training and tailored goals and outcomes.

Ensuring Delivery

Senior Responsible Owner: Charlotte Dillaway
General Practitioner Lead: Dr Deepa Shanmugasundaram
Consultant Lead: Dr Ramanathan Kirthivasan

The table below shows the System governance structure.



Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Acute Sentinel Stroke National Audit Programme rating to improve to an A rating by June 23	Quarter one 2023/24
Reconfigure community stroke beds (42-48) (subject to public consultation)	From quarter two to quarter three 2023/24
Implement Integrated Community Stroke Service specification ensuring all stroke survivors access to community support / rehab	First half of 2024/25

Cardiac Services

What have our residents told us?

Local residents and patients want to be able to access services closer to home. Patients also want and need all parts of the health system to communicate all of their information when they are being referred on from primary care to community, secondary or tertiary settings. This includes avoiding repeating tests or investigations when moving between care providers and levels of care.

Our approach is to provide local access to services where possible and centralise services where necessary to achieve true clinical excellence.

We aim to increase the provision of tertiary and quaternary services in the Essex Cardiothoracic Centre so fewer patients need to travel out of area for specialist care.

Current Conditions

We have a significant deficit in cardiac diagnostic capacity which needs to be addressed through medium- and long-term actions. Echocardiography is a key diagnostic for many cardiac conditions in both elective and acute presentation. Demand for echocardiography will continue to grow and we will need a growing cardiac physiology workforce to meet this demand. System partners will work in collaboration to implement a strategic workforce plan and career pathway for cardiac physiology to locally develop specialist staff to deliver an integrated service in hospital, in community diagnostic hubs and in other community settings.

Cardiac CT is increasingly important as a first line diagnostic test in cardiac presentations. Availability is highly variable across the system and overall, less than half the capacity recommended for our population. The new community diagnostic hubs will accommodate low risk CT activity freeing capacity in hospitals for these specialist Cardiac CT scans. This will allow us to meet overall demand and ensure equitable access to these specialist diagnostics.

Cardiac MRI is a highly specialist diagnostic currently operated from the tertiary Essex Cardiothoracic Centre. We have developed a regional hub and spoke model to improve equity of access for patients across the region. The first spoke site is Ipswich hospital. With the introduction of community diagnostic hubs freeing MRI capacity in hospitals we aim to expand this model so that patients can access this tertiary diagnostic service in their local hospital with expert oversight and support clinically from the Essex Cardiothoracic Centre.

The Heart Failure team in Basildon have an excellent service for local patients with seamless integration of community, hospital and tertiary clinical teams. This service has published national findings in optimal management of heart failure including the development of the new “Quad Score” to avoid treatment inertia and maintain focus on optimisation of heart failure medications. We will continue to roll out these clinical

models across the system to ensure that patients receive the best care. Heart failure patients require intense monitoring in the first 12 weeks to optimise management and avoid more invasive and expensive interventions. We have a significant shortfall in our specialist HF nursing workforce required to meet this need. We will be developing a workforce plan to include nursing and other roles within the multi-disciplinary team to ensure that all patients are optimally supported delivering better care and better value care overall.

Inherited Cardiac Conditions, including heart muscle disease (cardiomyopathy) and sudden arrhythmic death syndrome, affects 1 in 250 people worldwide and thorough family screening is needed to identify relatives at risk of potentially life-threatening heart disease. NHS England document A09/S/c 2013/14 “Inherited cardiac conditions” states that anyone with Inherited Cardiac Conditions, and their first-degree relatives, should have access to specialist Inherited Cardiovascular Conditions services within the catchment area. Genetic testing is centrally funded from April 2020, at no cost to the Trust.

All of our planned improvements in cardiac services require greater digital integration across the system, between sites and providers. Failure to achieve risks creating duplication and clinical risk.

What is the requirement from the NHS?

Heart and circulatory disease, also known as cardiovascular disease, causes a quarter of all deaths in the United Kingdom. Cardiovascular disease is the single biggest condition where lives can be saved by the NHS over the next 10 years. The Long-Term Plan describes a number of improvement actions required.

Our Ambition

We plan to support the these aims for cardiac services through 6 key improvements:

- **Earlier diagnosis** of more people with heart conditions through increased access to specialist cardiac diagnostics including echo, CT, MRI via community diagnostic hubs and specialist hospital-based services
- Better support for patients with chronic **cardiac conditions** including heart failure and heart valve disease including access to nurse specialists working seamlessly with specialist consultants through Multi-Disciplinary Team and virtual ward models
- Increased use of **genetic testing** enabling early diagnosis and treatment including development of the inherited cardiac conditions service.
- Access to life-saving **emergency and acute** diagnosis and treatment with further improvements in rapid access to tertiary treatment for Percutaneous Coronary Intervention, Coronary Artery Bypass Graft and Cardiogenic shock

- Continued development of local access to **specialist tertiary services** at the Essex Cardiothoracic Centre so that patients can access the latest advances in cardiac care locally within mid and south Essex such as minimally invasive cardiac surgery, specialist aortic surgery, percutaneous valve repair / replacement and Electrophysiology
- Expanding access to **cardiac rehabilitation** services to help people recover after treatment including diverse offers for community access and virtual support

Delivery Priorities

The recovery of access standards in cardiac services is a significant priority. Timely access to cardiac diagnostics, in particular echocardiography and CT, will be linked to collaborative system delivery of community diagnostic hubs and specialist workforce planning in cardiac physiology.

Through the Covid-19 pandemic cardiac services have unfortunately been impacted through periods of reduced activity and resultant increase in waiting lists. Increased waiting times have also led to higher clinical acuity of patients in both emergency and elective pathways. Hospital Cardiology services are working to reduce waiting times for outpatient and elective care in line with national Referral to Treatment recovery trajectories. Effective use of clinical triage and of improved technologies has reduced delays in outpatient pathways. Patients now have access to virtual appointments in many cases when in person appointments are not required (for example for physical examination).

In the tertiary setting the greatest impact of the pandemic on waiting times has been for cardiac surgery. A cardiothoracic surgery recovery plan is in place and has seen good delivery through 2022. This work will continue and is reliant upon a large specialist clinical workforce and balancing the demands of elective and emergency surgery. We have invested in additional facilities within the Essex Cardiothoracic Centre to create additional capacity. Cardiac Intensive Care Unit capacity is key to supporting the surgical recovery and we will be continuing to invest in Intensive Treatment Unit clinical workforce to meet this need.

We have an excellent emergency service for primary Percutaneous Coronary Intervention based at the Essex Cardiothoracic Centre and have made good progress with improvements in the Non-ST-Elevation Myocardial Infarction pathways. We aim to further improve the Non-ST-Elevation Myocardial Infarction service to reduce time to treatment in line with the national standards. This will be through extended weekend working and through earlier transfer of patients to the specialist centre by increasing capacity. We will continue to focus on clinical efficiency and value by extending our nurse-led discharge pathway.

Our ability to rapidly transfer inpatients to the tertiary centre is an important enabler for effective acute inpatient care, ensuring that we avoid delays and also supporting

efficient scheduling. Current pressure on the ambulance service have impacted on cardiac transfers. We will work with the ambulance Trust to develop innovative new models and modes for patient transfer.

Ensuring Delivery

Senior Responsible Owner: Dr Ronan Fenton
Clinical Lead: Dr Sunil Gupta

Our overall programme of work to achieve our ambition will be overseen through the Mid and South Essex Integrated Care System Cardiovascular Disease Programme Board. There will also be specific working groups leading on specialist pathways and projects including the Cardiogenic Shock Working Group and Cardiology stewardship group.

We aim to ensure delivery through excellent multi-disciplinary and inter-sector engagement, collaboration and commitment to delivering improvements for patients that also present a more clinical effective and resource-efficient whole system approach to cardiac care.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Comprehensive Cardiac Cardio Thoracic service in plan in all acute hospital settings (1) developing capacity alongside Congenital Diaphragmatic Hernia models sufficient to meet local population need (2)	(1) quarter three 2023/24 (2) 2025/28
Cardiac Physiology workforce strategy implemented (1) and delivering improved retention, development of teams to fill vacancies and meet clinical service need (2)	(1) quarter two 2023/24 (2) 2025/28
Standardised integrated model of care for Heart Failure patients underpinned by Multi-Disciplinary Team working and collaboration to ensure that Heart Failure patients receive the care they need with no barrier to movement between providers and levels of care.	Second half of 2024/25
Rapid Non-ST-Elevation Myocardial Infarction service in place across system with early inter-hospital transfer and weekend working	First half of 2024/25
Recovery of waiting times for elective cardiac surgery	First half of 2024/25

Delivery Plan objectives	Timespan for implementation of objectives
Commence Mitral Transcatheter Edge to Edge Repair service (1) and develop to full population roll out as high-volume centre (2)	(1) quarter two 2023/24 (2) 2025/28

Cardiovascular Services

What have our residents told us?

We have conducted a survey, including interviews as well as shorter form questions, of people accessing our BP@Home programme. The results are being analysed at present.

Current Conditions

In parallel with activity nationally, our cardiovascular disease detection and treatment activity dipped during the Covid-19 pandemic. We are working to restore and expand previous detection and management levels.

Whilst our Alivecor and BP@Home programmes have accelerated progress relating to Atrial Fibrillation and Blood Pressure, we will need to expand capacity within the lipid management pathway to increase diagnosis and treatment levels.

Our baseline data shows the following trends in hypertension and cholesterol:

- Below national average (57%) of patients aged 18 or over with no GP-recorded cardiovascular disease and a General Practitioner recorded QRISK score of 20% or more, on lipid lowering therapy.
- Below national average, and lowest in East of England Region percentage of patients aged 18 and over, with General Practitioner recorded Cardiovascular Disease (narrow definition), in whom the most recent blood cholesterol level (measured in the preceding 12 months) is non-HDL cholesterol less than 2.5mmol/l or LDL-cholesterol less than 1.8mmol/l.

What is the requirement from the NHS?

Increase percentage of patients with hypertension treated to National Institute for Health and Care Excellence guidance to 77% by March 2024.

Increase the percentage of patients aged between 25 and 84 years with a cardiovascular disease risk score greater than 20 percent on lipid lowering therapies to 60%.

The NHS is working collaboratively across primary, secondary and community care settings to improve and integrate cardiovascular disease pathways and workstreams into normal working practices.

Our Ambition

Our long-term vision is to continue moving upstream in our approach to cardiovascular disease, including prevention and early detection of atrial fibrillation,

hypertension and high lipids, so that our residents are able to enjoy more years of healthy life, with lower rates of heart attacks and strokes.

We will do this by focusing on:

- **Primary prevention:** working in partnership with communities and place-based teams on primary prevention, including links with our partnership approach to healthy weight and smoking.
- **Detection and 'datafication':** identifying residents with risk factors or established disease, using risk stratification approaches, and generating valuable data to drive proactive and, where possible, predictive, activity
- **Early intervention:** providing holistic, personalised support and treatment to residents with identified risk factors or early-stage cardiovascular disease.
- **Treatment:** providing holistic, personalised support and treatment to those with more established cardiovascular disease.

At system level, system programmes drawn together in alignment, with Population Health Management, personalised care, inequalities etc running through.

Delivery Priorities

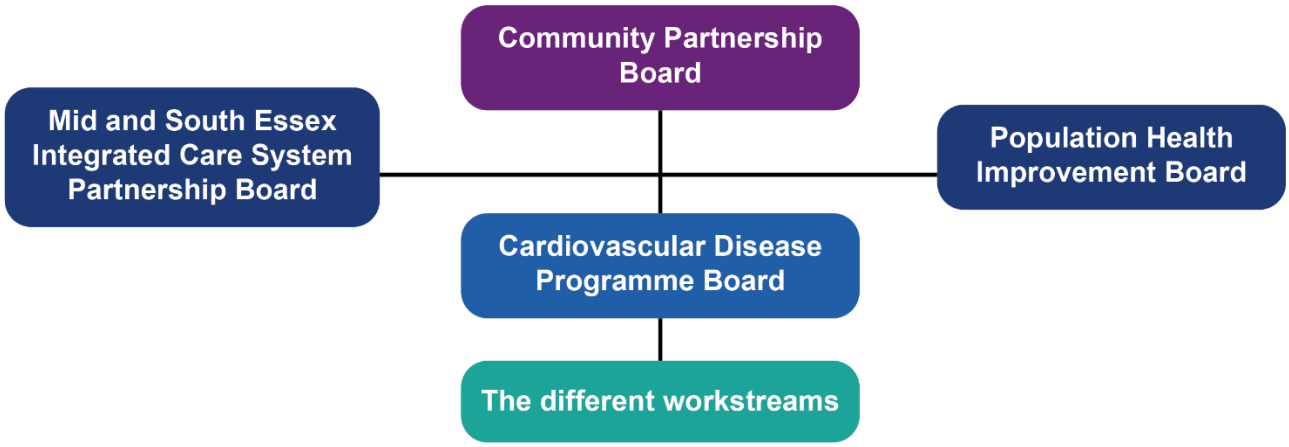
Different Cardiovascular Disease prevention-focused workstreams will align with our system prevention approach:

- Primary prevention: linking with healthy weight and tobacco dependency support to reduce cardiovascular disease related risk factors.
- Detection
  - NHS Health checks
  - BP@Home programme
  - Breathlessness van (with mobile Blood Pressure devices)
  - Exploring potential to expand use of Fibricheck whilst Alivecor use is reviewed nationally.
- Datafication, early intervention and treatment
  - Proactive care framework
  - Lipid management pathway – expanding access to genetic testing for familial hypercholesterolaemia, as well as to first- and second-line therapy.

Ensuring Delivery

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

The different workstreams (Atrial Fibrillation, Blood Pressure and lipids) will report into a system Cardiovascular Board (established Feb 23). This board will be accountable to the Community Partnership Board. See below organogram.



Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Expand BP@Home scheme by working alongside our community pharmacists and further integration into relevant clinical pathways such as Renal	Quarter four 2023/24
Monitor National review of Kardia Alivecor mobile heart monitors, and if re-approved expand use in General Practitioner surgeries, community centres and on our outreach bus. Scope potential to expand use of fibricheck app as alternative.	Quarter four 2023/24
Participate in Innovations for Health Inequalities Programme to expand the mobile unit (outreach bus) to a targeted core20Plus population, to include broader cardiovascular disease risk assessment and management (including Atrial Fibrillation, blood pressure, cholesterol, smoking)	Quarter four 2023/24
Maximise Community Pharmacy Hypertension case finding	Quarter four 2023/24
Implement University College London Partners Proactive care framework for risk stratification and	Quarter four 2023/24

Delivery Plan objectives	Timespan for implementation of objectives
prioritisation of atrial fibrillation, blood pressure, cholesterol, and type 2 diabetes	
Scope and agree approach to improving lipid outcomes.	Quarter four 2023/24

Palliative and End of Life Care

What have our residents told us?

A Health Needs Assessment was undertaken in 2022 by Healthwatch Essex with the oversight of the Hospice Collaborative. Three key themes emerged:

- Improvement to accessing services: including 24/7; bereavement support; access to medication and pain relief
- Improved communication: between professionals; ease of contact for information and advice
- Clearer information: clear pathways for care, to preserve independence including sign posting and earlier referrals between services and hospices

Current Conditions

Across the Integrated Care System there are multiple organisations providing Palliative and End of Life Care with varying service models between alliance with different population health needs. A gap analysis benchmarked against the National Ambitions Framework identified the following challenges:

Lack of Co-ordinated, consistent access to care:

To achieve our ambitions for Palliative and End of Life Care, collaboration across the full spectrum of health and social care, voluntary and third sector organisations, and local communities will be essential. The recent establishment of the hospice collaborative and the community collaborative will have a key influence. The challenge is developing 24/7 models of care that address the population needs of each alliance in a co-ordinated, equitable, and consistent way. Lack of digital solutions to support shared care records and Electronic Palliative Care Coordination System are negatively impacting on delivering co-ordinated care. Inequities in access to high quality bereavement services also affects the wellbeing of families and carers long term.

Reactive rather than proactive care:

Patient experience and outcomes that matter most are improved through early recognition of the End of Life and personalised care planning for the future. To move to a proactive approach to care will require a significant cultural shift within the Integrated Care System, but one that is necessary to reduce unnecessary hospital admissions and therefore, system pressures. There is a need to empower our patients and families through practical support, information, and training in the End of Life care.

Skilled workforce:

Nationally, there is known shortage of multi-professional specialists in Palliative and End of Life Care which is affecting recruitment and retention of staff within our Integrated Care System. Without the right workforce, the ambition to enable people and their families/carers to have the best support and outcome at the End of Life will not be achieved. In addition, a recent mid and south Essex wide education gap analysis identified that our current healthcare workforce would benefit from blended education and training programmes to increase their confidence and skills in the delivery of Palliative and End of Life Care.

What is the requirement from the NHS?

We are committed to the standards required to deliver high quality Palliative and End of Life Care services within the Integrated Care System. These include:

- Ambitions for Palliative and End of Life Care: a National Framework for Local Action 2021 – 26
- NHS Long Term Plan
- NHS Palliative and End of Life Care Statutory Guidance for Integrated Care Boards, September 2022

Our Ambitions

Working in partnership across health and social care, including the voluntary sector and local communities, we will ensure that the palliative and end of life care needs of people of all ages with life-limiting illness, and their families/carers, are met so that they receive the care and support they need to live and die well. This is irrespective of diagnosis or condition, and especially in the last year of life. We will focus on the "outcomes that matter most" to those we care for.

Delivery Priorities

The Palliative and End of Life Care Programme Board will be responsible for delivering a robust Palliative and End of Life Care workplan through 6 workstreams (as detailed below) whose focus will be to:

- Improve the recognition of people in the last year of life to focus on early personalised care planning and proactive anticipatory care
- Ensure that people are cared for and die in their preferred place of care, and to avoid unnecessary hospital admissions
- Ensure equity of access for our population to 24/7 co-ordinated care, information and advice, including access to anticipatory medication
- Complete the System-wide roll out of an Electronic Palliative Care Coordination System to improve co-ordinated and informed care. This will

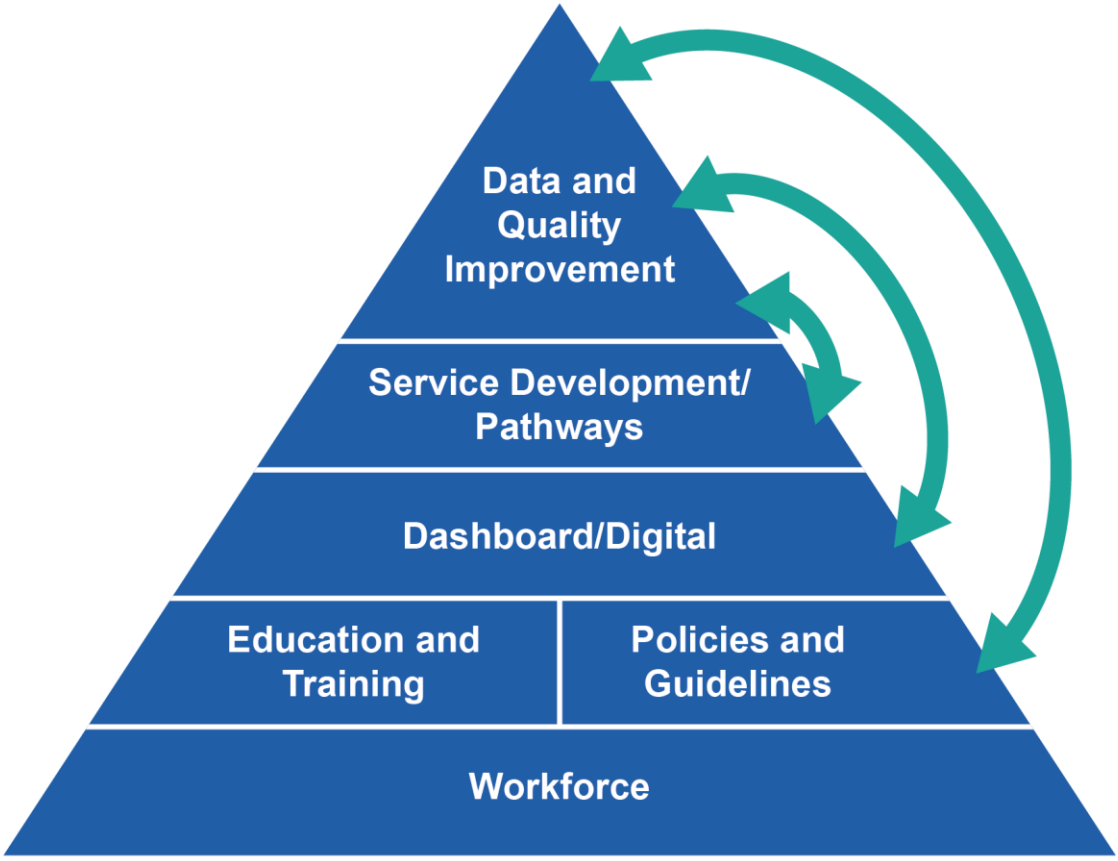
support the development of a Palliative and End of Life Care dashboard and its link to Population Health Management

- Support development of a single shared care record to ensure care is delivered at the right time by the right person with the right information
- Develop models of care to support the needs of families and carers
- Improve the quality of Palliative and End of Life Care through training and education to ensure a skilled, and confident workforce. This includes sustainability and innovation through workforce planning
- Improve the reach of Palliative and End of Life Care through mobilising community focussed approaches to palliative and end of life care, such as compassionate communities and integrated neighbourhood teams
- Increase equity of access to high quality all age bereavement services
- Improve the quality of Palliative and End of Life Care through training and education to ensure a skilled, and confident workforce. This includes sustainability and innovation through workforce planning
- Improve the reach of Palliative and End of Life Care through mobilising community focussed approaches to palliative and end of life care, such as compassionate communities and integrated neighbourhood teams
- Increase equity of access to high quality all age bereavement services

Ensuring Delivery

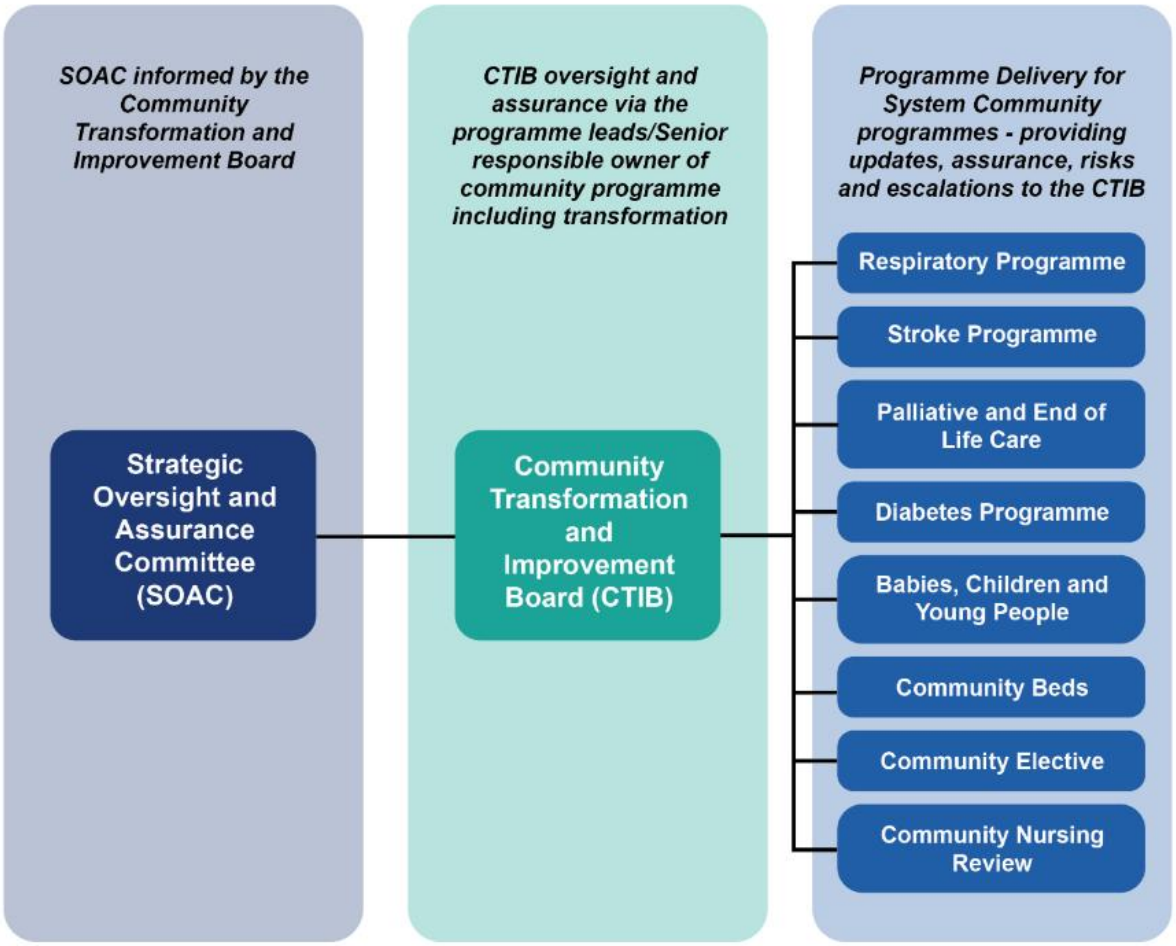
Senior Responsible Owner: Karen Wesson
Clinical Lead: Dr Eva Lew

The Palliative and End of Life Care Programme Board will be responsible for delivering a robust Palliative and End of Life Care workplan through 6 workstreams



The Palliative and End of Life Care Programme Board reports to the Community Transformation and Improvement Board which is then overseen by the Strategic Oversight and Assurance Committee. It is expected that the four mid and south Essex alliance End of Life Network Groups will have representation on the Palliative and End of Life Care Programme Board and be active members on the Palliative and End of Life Care Palliative and End of Life Care workstreams.

Below organogram of system governance arrangements.



Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Increase recognition of population last 12 months of life achieving 1% by 2028	Quarter three 2023/24
Increase proportion of people offered personalised care support	Quarter four 2023/24
Deliver 24/7 coordinated care, information and advice including access to anticipatory medicine	First half of 2024/25
Deliver sustainable end of life care workforce	Second half of 2024/25

Diabetes Services

What have our residents told us?

There is variation across alliance areas in care received, for example, there is reduced uptake or completion of annual health checks in South-East Essex area in comparison to others and we see increased amputation rate for diabetic foot disease in parts of this area. The Integrated Care Board has led projects to improve uptake of checks and develop pathways centrally with varied results.

Current Conditions

There are approximately 69,000 (5.7% population) people living with Diabetes across MSE who could be at risk from diabetes complications, and additionally 28,705 people with Non-Diabetic Hyperglycaemia at risk of developing Type 2 Diabetes within 3 years. Effective management of Diabetes is vital for people to avoid complications that are a detriment to quality of life and require health care interventions. An increase of preventable Type 2 diabetes could pose a significant strain onto the Integrated Care Board in the medium term if preventative interventions are not made.

Challenges in community/integrated Diabetes services and hospital trusts as they work together to develop a joined up and equitable approach, aligning policy and pathways between 3 hospital sites and 3 community providers with varied models of delivery. In addition, there are increased caseloads of people presenting with complications arising after the covid-19 pandemic.

The Integrated Care Board is currently going through formulation of leadership via recent recruitment of a System Diabetes Clinical Lead and the development of stewardship programme therefore these should be supportive in achieving objectives.

Need to deliver at lower cost to ensure sustainability in the system whilst meeting an increased population demand. Future investment amounts from NHS England Cardiovascular Disease and Respiratory network are currently unknown therefore planning for future quality improvement projects is challenging.

What is the requirement from the NHS?

In line with the NHS Long Term Plan, the Diabetes team are undertaking several quality improvements pilots and projects, some transformational and funded by NHS England and some now business as usual programmes that will impact prevention, patient understanding, knowledge and management of diabetes and improve pathways with aim of reducing long-term complications and health care interventions. OBJ

Our Ambitions

In line with the NHS long term plan the Integrated Care Board aims to;

- Develop data sources and use of data and information to have better overview of population needs and health inequities with the aim of sharing data and working more collaboratively with services.
- Have a heavy focus on prevention, particularly on the significant population size at risk through preventative and educational programmes.
- Increase number of those attending structured education or using digital tools to support.
- Significant increase in completion of diabetes annual health checks and recovery of treatment targets to pre pandemic levels and above.
- Improve pathways for diabetic foot management and preventative interventions to reduce amputation rates and improve quality of life for people with a Diabetic foot condition.
- Support nursing teams to be fully staffed delivering 6-7 days services across Integrated Care System.
- Increased use of technology such as Glucose monitoring delivered to all Type 1 diabetes patients and many Type 2 multiple daily injections.

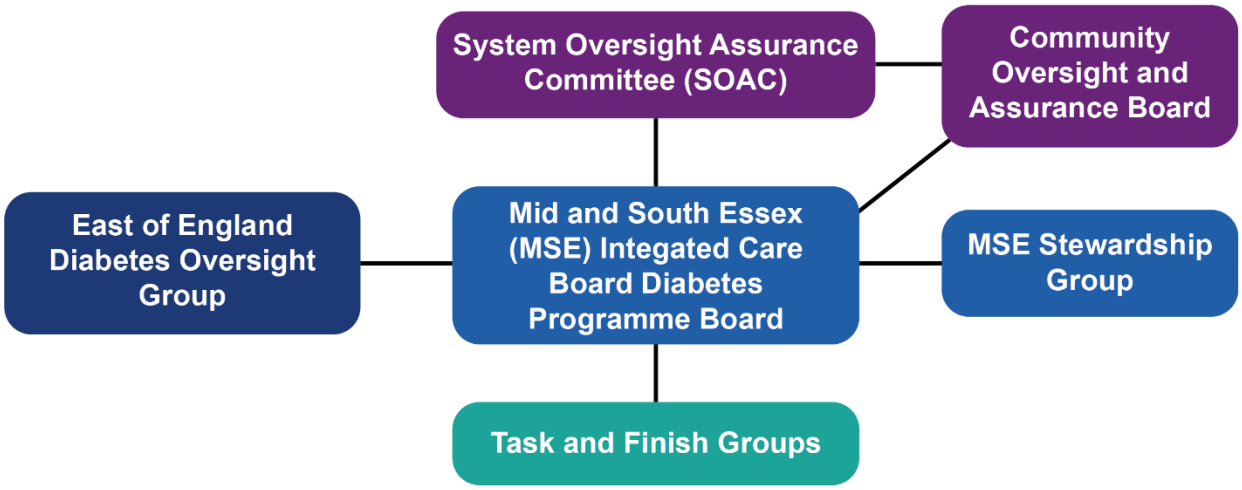
Delivery Priorities

- Diabetes dashboard to be finalised ready for analysis and identification of health inequalities, informing strategic planning by the Diabetes programme board.
- Maintain and increase referrals into services such as diabetes prevention programme, Low Calorie Diet Programme, structured education or digital tools.
- Significant increase in completion of all 8 key diabetes care processes/annual health checks to be at 34% of the diabetes population (currently 27.6%) and recovery of treatment targets to pre-pandemic levels to be at 33% (currently 27.1%) by March 2024.
- Ensure an effective and clear pathway for the Diabetic Foot in mid and south Essex with relevant preventative steps and being used effectively
- Support nursing teams to be fully staffed delivering 6-7 days services by 2024-25.
- Increased use of technology such as Glucose monitoring delivered to all T1 diabetes patients (70% by 2024 and 95% by 2025-26)

Ensuring Delivery

Senior Responsible Owner: Dr Ronan Fenton
Clinical Lead: Deepa Shanmugasundaram

The above shows the System governance structure.



Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Self-management digital and education support tools to newly diagnosed patients	From quarter one to quarter two 2023/24
Improved care processes uptake from ~27% to ~34% across 8 rolling care processes	Quarter three 2023/24
Target improvements across 3 x treatments from ~27% to ~ 33%	Quarter four 2023/24
Power Business Intelligence dashboard finalised and in use across Integrated Care System	Quarter four 2023/24

Dermatology Services

What have our residents told us?

The Dermatology patient survey in February 2023 found that:

- 59% of respondents had accessed care from their General Practitioner for their skin condition with 62% of patients regularly managing their skin conditions at home. Only 23% had a tele dermatology assessment.
- 44% of respondents had accessed skin treatment via a community or hospital service with mixed outcomes, the common trend being that the clinical care received by hospitals was good but often experienced long waiting times and thought the service was not patient focussed.
- 45% stated that their skin condition has impacted on their mental health and wellbeing with common themes being that skin conditions are leading to lack of sleep, increased anxiety of visual appearance.

Current Conditions

Challenges driving dermatology pressures include a shortage of consultant dermatologists and an ageing workforce, variation in diagnosis and management in primary care due to a lack of dermatological training for General Practitioners; limited or fragmented use of available technology; inadequate triage in both primary and secondary care, limited and inconsistent coding of outpatient activity (NHS England Transforming Elective Care Services - Dermatology).

Local pressures resemble the national picture for Dermatology with increased patient waiting lists: dermatology is one of three priority areas due to significantly increasing demand for Dermatology services. The Integrated Care System has formed a Dermatology Board with representation across primary care, community and acute services. The Dermatology Board has overseen development of joint pathways with community and acute services to improve care for service users.

The Dermatology Programme Board alongside Dermatology Stewards have committed to implementing a single Community Dermatology Service across the Integrated Care System to support improvement in Dermatology services, reducing health inequalities, improving patient experience and patient outcomes, communication, and waiting times for patients.

What is the requirement from the NHS?

The Dermatology Programme Board are implementing an Integrated Community Dermatology Service, acting as a single point of access into community and secondary care services in line with national guidance. The service will be innovative and improve outcomes for service users.

Our Ambitions

Through use of teledermatology the service will ensure that service users are seen in the right setting, first time, subsequently improving the early diagnosis of Skin Cancer and reducing hospital waiting times through triage. This links to the NHS Long Term Plan to boost out of hospital care and use technology to redesign clinical pathways.

In addition, Dermatology Stewards have identified key improvement areas. These include:

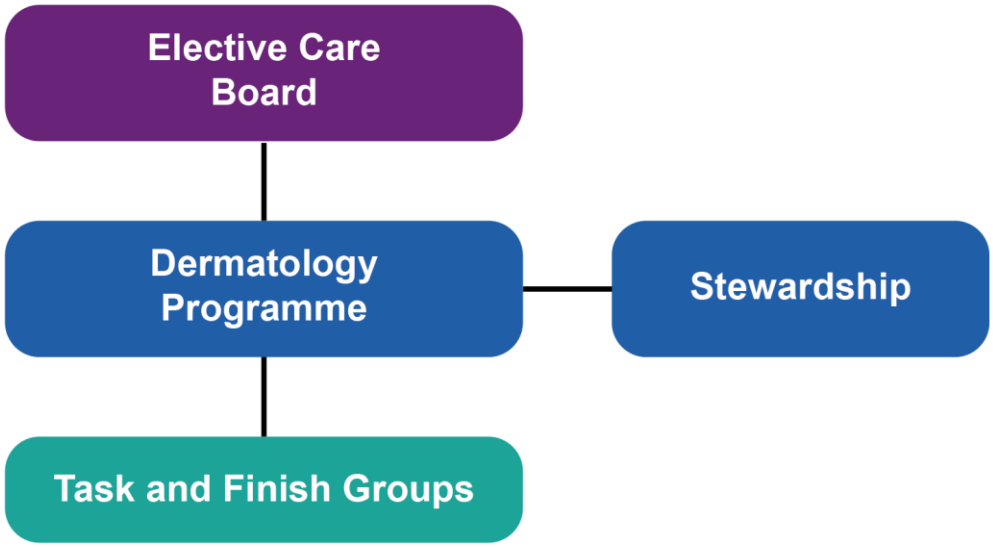
- Public health promotion of Dermatology conditions
- Continued engagement and training with General Practitioners and Health Care Professionals
- Initiatives to support the retention and training of workforce

Delivery Priorities

- Improve Skin Cancer 2 week wait and Referral to Treatment waiting times
- Achieve the faster diagnostic standard for skin cancer
- Implement the Integrated Community Dermatology Service by April 2024
- Deliver a seamless care pathway for our residents from point of prevention onwards

Ensuring Delivery

Senior Responsible Owner: Emily Hughes
Clinical Lead: Rachel Wiltshire
Below organogram of system governance arrangements.



Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Implement a single Integrated Community Dermatology service across mid and south Essex by April 2024	Quarter three 2024/25

Eye Care

What have our residents told us?

The common theme in feedback from residents is that the quality of care given during attendances is good, however the waiting time for appointments (particularly follow up care), delays for surgery and telephone access to the service require improvement. Care closer to home and easier to access is well received, this is supported by Friends and Family Test responses that are more positive for satellite/community locations than for attendances at the large Trust sites.

Current Conditions

Eye care services across mid and south Essex are significantly challenged as a result of year-on-year growth in demand and the added impact of the COVID-19 pandemic. The number of people waiting for appointments at hospital is at a record high particularly for those with developing or chronic conditions. This has an impact on the avoidable deterioration of vision and long-term outcomes for our population.

What is the requirement from the NHS?

By understanding our current demand and future growth in demand for eye care services we will target pathway transformation to maximise capacity to ensure patients are treated in a timely manner and as close to home as possible.

The Planning Guidance for 23/24 identifies the requirement to ensure direct referral routes from community optometrists to ophthalmology for all urgent and elective eye consultations.

Our Ambitions

The aim of the Mid and South Essex Eyecare Transformation Programme is to ‘improve and preserve the vision of our residents now and in the future by achieving a system-wide sustainable and integrated eye care service across mid and south Essex’

We intend to reduce the non-admitted waiting list and improve Referral to Treatment performance, significantly reduce the overdue follow up waiting list and improve patient outcomes, particularly relating to avoidable deterioration of vision whilst waiting for treatment).

Delivery Priorities

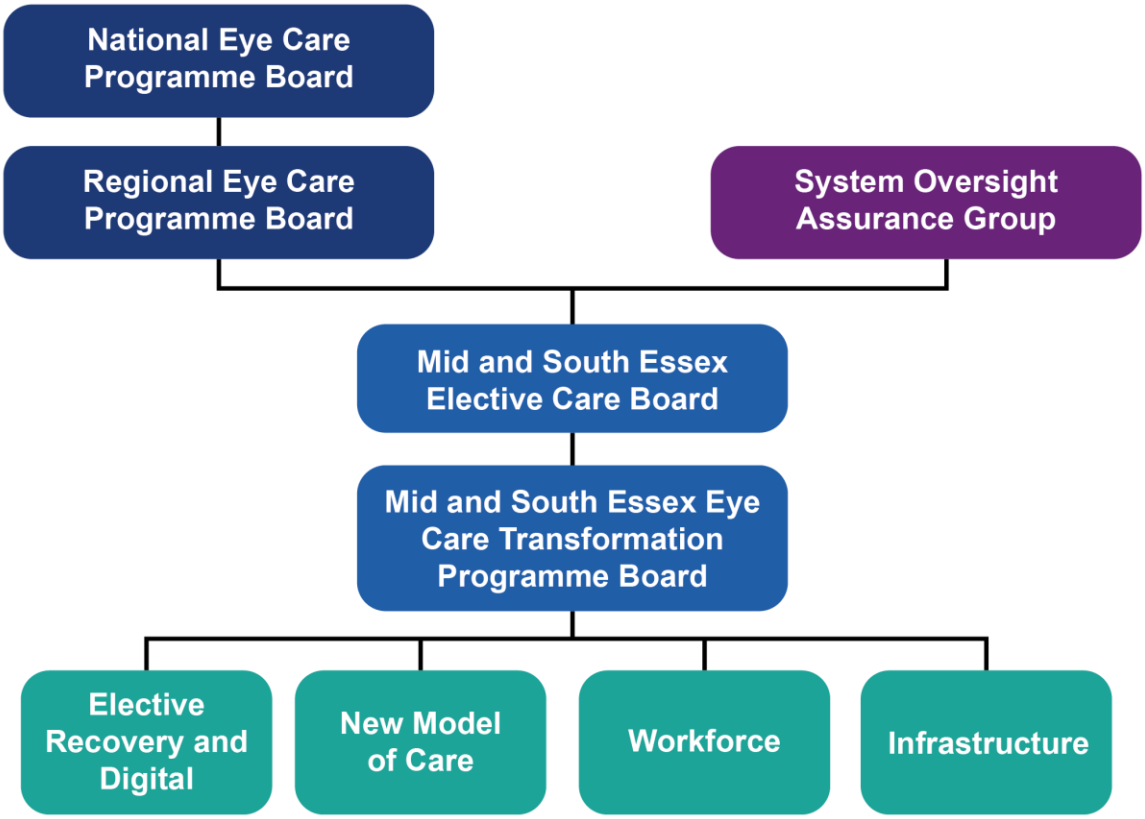
Led by the Eyecare Transformation Programme Board, improving outcomes for patients and their experience of care will be achieved through:

- Developing new pathways and increasing capacity and efficiency of services to meet growing demand
- Reducing waiting times for care
- Maximising the clinical capabilities of the ophthalmic workforce and developing new roles
- Improving estates and digital infrastructure to support the future delivery model

Ensuring Delivery

Senior Responsible Owner: Andrew Pike
Clinical Lead: Dr Boye Tayo

Below organogram of system governance arrangements.



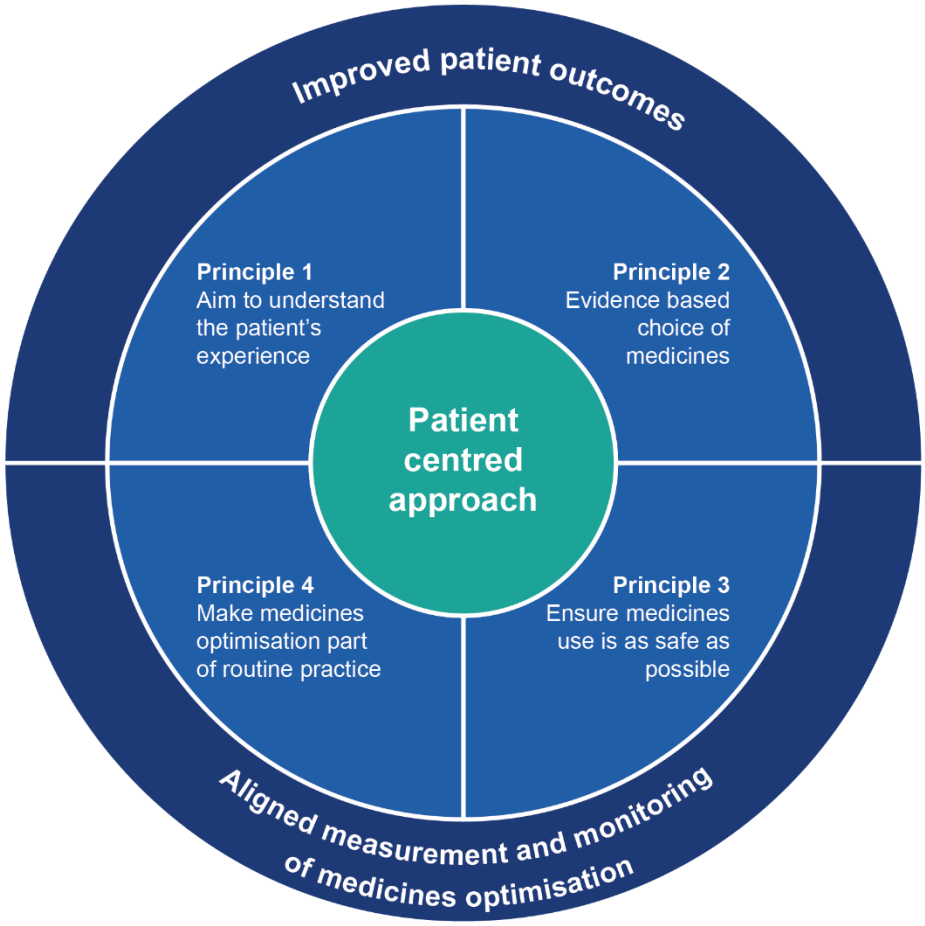
Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Complete review of 8,000 glaucoma patients	Quarter one 2023/24

Delivery Plan objectives	Timespan for implementation of objectives
Full implementation of Referral Hub with clinical triage	Quarter one 2023/24
Implement one diagnostic hub and develop specification for spokes (subject to business case)	Quarter three 2023/24
Expand use of Eyecare electronic Referral System and implement Advice & Guidance functionality	Quarter two 2023/24
Develop and implement pre-op cataract pathway and glaucoma case finding	From quarter three to quarter four 2023/24
Review and develop end to end pathways for medical retina	First half of 2024/25
Implement diagnostic pathway with associated capacity across all mid and south Essex	Second half of 2024/25
Development and mobilisation of long-term estates and infrastructure solutions for acute ophthalmic care as per the new model and pathways	2025/28

Pharmacy and Medicines Optimisation

What have our residents told us?



Current Conditions

Antimicrobial Stewardship: National target has not been achieved since November 2021, some of this increase is attributed to surge in demand for management of Group A Strep and prevention of Diphtheria and in line with increase in antibiotic prescribing seen nationally. There is steady decrease in the use of broad-spectrum antibiotics.

Patient Safety: Reduction of dependence forming medicines is a priority. mid and south Essex currently has over 1000 patients prescribed >120mg morphine daily. New guidance and implementation documents in place to support patient and prescribers.

Resources: Cost pressures arising from increasing demand for medication, increase in price due to shortages leading to price inflation and Department of Health price concessions.

Over-prescribing: Overprescribing directly affects some groups with protected characteristics. In Oct 2022 there were 111,458 (10.87% c.f. 10.79% national average) people taking 8 or more unique medications (range across alliances 8.33% to 11.04%) and the average number of unique medicines prescribed for all patients in MSE was 3.66 compared with 3.53 nationally.

Community pharmacy integration: Slow uptake of community pharmacy consultation service and under-utilisation of community pharmacy clinical services (both nationally and locally commissioned) by General Practitioner practices.

The Essex Pharmacy Leads network was re-invigorated during the pandemic and continues to support system wide working.

What is the requirement from the NHS?

- A whole system approach to medicines optimisation to improve population health.
- Improve access to medicines.
- Improve health outcomes from medicines.
- Reduce inappropriate prescribing.
- Deliver value from medicines.
- Reduce waste.
- Promote self-care.

Our Ambitions

To ensure that people living in mid and south Essex have access to the medicines they need, in the right place and at the right time; to achieve the greatest health outcomes for themselves and the local community, within the resources available.

Delivery Priorities

- Achieve the antimicrobial prescribing metrics year on year by implementation of National Institute for Health and Care Excellence guidance and cross-sector guidance on common infections in line with Integrated Care Board Antimicrobial Resistance Workplan 2023-2026
- Patient Safety - Patient Safety- reduce the risk of medicines-related harm from high-risk drugs - Valproate Prescribing in people under 55 and other Patient Safety Incident Response Framework priorities; improved monitoring to reduce risk of harm Eclipse Patient Safety indicators
- Reduce number of patients on high dose opioids to Integrated Care Board average.
- Resources - make best use of NHS funding by managing cost pressures arising from increasing demand for medication and reduce variance in

prescribing spend £per ASTRO-PU electronic between mid and south Essex practices to drive equity, appropriate distribution and best use of resources and make best use of existing pharmacy workforce and developing a pharmacy workforce pipeline strategy.

- Reducing over - prescribing and over supply - reducing carbon burden of medication. Polypharmacy - reduce inappropriate polypharmacy - reduce variation across mid and south Essex electronic Patient Aligned Care Team 2 Polypharmacy Prescribing Comparators

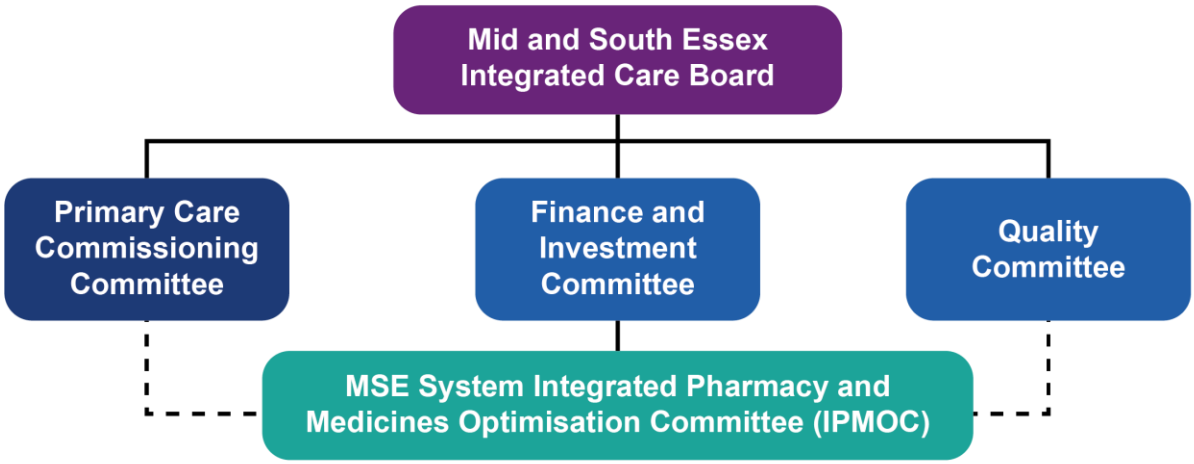
- Integration of community pharmacists and community pharmacies into ICB pathways; optimising the use of nationally commissioned services Community Pharmacy Consultation Service Discharge Medicines Service, Blood Pressure Check Service and Oral Contraceptive Service; development of clinical services delivered including Independent Prescribing by Community Pharmacists.

Ensuring Delivery

Senior Responsible Owner: Paula Wilkinson
Clinical Lead: Dr Aravinda Guniyangodage

The Mid and South Essex Medicines Optimisation Committee is in place and working towards single formulary and prescribing guidance for the Integrated Care System. The Medicines Optimisation Committee will operate within delegated authority and be accountable to the Mid and South Essex Integrated Pharmacy and Medicines Optimisation Committee, which working through system/alliance medicines optimisation groups, will drive systemisation of medicines optimisation and pharmacy integration

The below shows the proposed governance structure.



Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Establish Mid and South Essex Antimicrobial Resistance Network of Primary Care Network lead pharmacists and train the trainer programme; and audit programme to drive change	Quarter one to quarter three 2023/24
Implement and embed Patient Safety Incident Response Framework, patient safety audit programme	From quarter two to quarter three 2023/24
Undertaken pharmacy workforce gap analysis and develop a pharmacy workforce strategy for mid and south Essex.	From quarter two to quarter three 2023/24
Optimise use of High-Cost Drugs- use of biosimilars	From quarter three 2023/24 to second half of 2024/25
Implement annual system wide Medicines Optimisation Locally Enhanced Scheme to drive quality, equitable and cost-effective prescribing and reduce variance MOLES 23-24	From quarter one to quarter three 2023/24
Increase delivery of high-quality structured medication reviews to improve outcomes and reduce medicines-related problems for patients ensuring equity in access and focus on people with Serious Mental Illness and those with Learning Disabilities.	From quarter two to quarter three 2023/24
Develop and implement action to address the carbon impact of unnecessary prescribing and medicines waste in areas other than inhalers.	From quarter two to quarter three 2023/24
Implement and evaluate Independent Prescribing Pathfinder within community pharmacy with focus on extension of Community Pharmacy Consultation Service initially.	From quarter one to quarter four 2023/24

Musculoskeletal and Pain Service

What have our residents told us?

A small-scale survey was undertaken in 2023, 108 people responded in total with 46 expressing an interest in being involved in future discussions. An online event was held 11th May 2023 targeting the people who responded to the survey. In addition, face to face survey engagement will be undertaken at Musculoskeletal, Pain and Rheumatology outpatient clinics during May.

Current Conditions

Current challenges and pressures:

- Differential access to services across the system in community and secondary care.
- Waiting list pressures in secondary care, admitted and non-admitted.
- Workforce pressures.

Partnership working:

- Musculoskeletal Delivery Group in place with speciality specific task and finish groups. All groups have representation from all providers currently offering Musculoskeletal care across the system including primary, community and secondary care.

What is the requirement from the NHS?

Musculoskeletal is one of the three speciality priorities described in the NHS Planning Guidance 2021/22 to support a reduction in variation in access and outcomes. Within the Mid and South Essex Integrated Care System there are six providers providing Musculoskeletal services across community and multiple NHS and Independent Sector delivering secondary care, which creates a variation in both access to services and pathways being delivered across the population.

Our Ambitions

Musculoskeletal transformation includes trauma and orthopaedics, rheumatology, pain management and therapies. Working with stakeholders since Autumn 2021, the Musculoskeletal System Delivery Group have developed a new community pathway, for people aged 16 years and over, based on the East of England Musculoskeletal Pathway Improvement Framework, the Best Musculoskeletal high impact recommendations and adhering to the Getting It Right First-Time pathway.

The proposal is to commission a single Community Musculoskeletal and Pain Service for mid and south Essex which aims to triage, assess, and treat more patients outside of acute services and improve outcomes, quality and patient

experience of care. Residents that cannot be managed in primary care will be referred to the community service via a Single Point of Access for assessment, diagnostics, diagnosis, and treatment. Patients who require surgery or specialist assessment and/or treatment will follow a pathway through the community service into an acute service of their choice.

Delivery Priorities

- System wide community Musculoskeletal and pain service to be implemented by Quarter 4 23/24
- 80% conversion rate to surgery
- <20% discharged at first appointment.
- Support waiting list reduction.

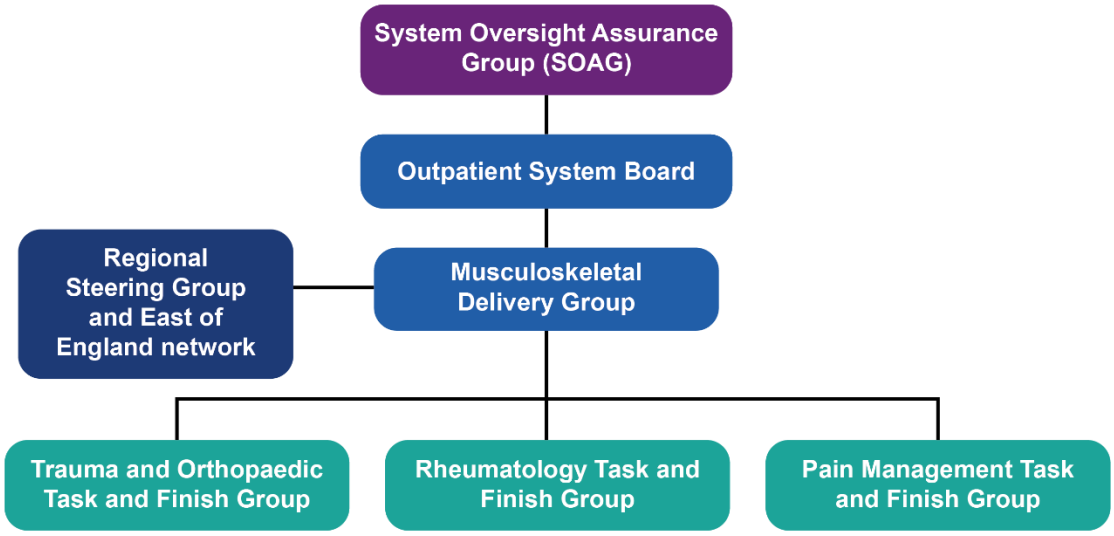
The new service will deliver high quality, patient focussed care that is innovative, improves outcomes and reduces health inequalities for patients. Expected outcomes will include:

- Delivering a population health approach focused on optimising outcomes, including reducing health inequalities
- Providing a service that delivers equitable outcomes and experience
- Improving life-long best Musculoskeletal health for the population of mid and south Essex using preventative and anticipatory care approaches
- Delivering a seamless integrated pathway
- Adherence to Referral to Treatment standards and more efficient recovery of waiting lists.

Ensuring Delivery

Senior Responsible Owner: Gerdalize du Toit
Clinical Lead: Gurvinder Saluja
Clinical Lead: Mr Sean Symons Mid and South Essex NHS Foundation Trust

The table below shows the System governance structure.



Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Specification to be signed off by the Delivery Group	Quarter one 2023/24
Further resident engagement event	Quarter one 2023/24
Scoping exercise around paediatric orthopaedic pathways	Quarter three 2023/24
System wide Musculoskeletal and Pain Community Service to be in place in 23/24 Quarter 4	Quarter four 2023/24
Identification and prioritisation of further initiatives to improve pathways and outcomes	First half of 2024/25

Appendix 8 – Supporting System Development

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

- System Governance
- Serious Violence (including Violence Against Women and Girls, Domestic Abuse, Sexual Violence, Knife & Gang related violence)
- Research Studies
- Delegation of Services (Pharmacy, Optometry and Dental Services)
- Specialised Commissioning
- Community Mobilisation, Transformation & Resilience

Building our Integrated Care System Governance

Governance arrangements to establish the Integrated Care Board are sound, meet the requirements of the Act and were seen as good practice by NHS England. As the Integrated Care Board matures to meet its objectives of subsidiarity and integration, governance must evolve to enable this maturity.

Residents/patients have asked the Board for more focussed engagement on decision making and expect standards of business conduct / transparency of decision making in line with our goals to be robust, demonstrating our accountability and influence over the performance of the system.

Governance is an enabling function and so must work closely with all directorates to achieve its objectives and the Integrated Care Board ambition.

What is the requirement from NHS

The Integrated Care Board must ensure that systems of internal control are robust to manage system and local Integrated Care Board risks that threaten the achievement of Integrated Care Board objectives and maintain and strengthen compliance with legislation and codes of governance.

This includes the approval of plans, strategies, and business cases as well as scrutiny of decisions and seeking assurances and legal advice that Integrated Care Board functions are delivered appropriately. As the Integrated Care Board develops, taking on delegated functions from NHS England, strengthening subsidiarity and integrating with our partners, governance will need to evolve to enable these functions to be delivered.

What is the ambition

To maintain compliance with statutory duties and good governance practices. In line with the NHS Long Term Plan and Integrated Care Partnership Strategy:

- Support integration with partner organisations – strong system decision making and risk management
- Establish governance to support Subsidiarity – fully integrated and streamlined Provider Collaboratives / lead provider model

Satisfactory outcome to Care Quality Commission inspection of Integrated Care Systems

What are the delivery priorities?

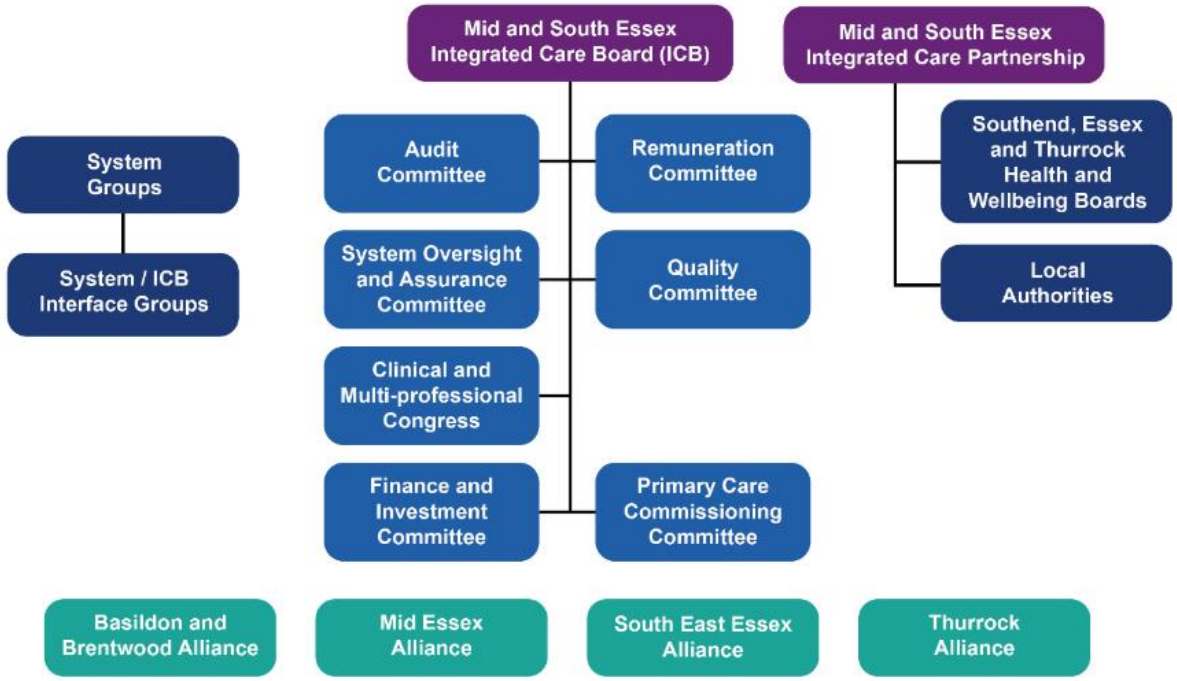
- Maintain good governance and compliance with statutory duties for example the duty to obtain appropriate advice.
- Enhance reporting and information flows to the Board and committees using synthesised 'highlights and exception' approach for escalation of performance (incl. constitutional standards, quality, and finance) risk and assurance as the key components of core reporting.
- Embed and enhance robust governance and the Integrated Care Boards standards of business conduct at all relevant levels including arrangements for effective decision making, management of conflicts of interest and ensuring all aspects of the Integrated Care System uphold the Nolan Principles of conduct in public life
- Utilise data and dashboards to ensure that assurance of performance to Board and committees is high quality, contemporary and serves the need of the organisation's governance.
- Create the appropriate governance functions in support of the delegation of NHS England commissioning functions for podiatry, optometry and dentistry and shadow arrangements for specialised commissioning, as well as delegation to place, collaboratives, the role of stewardship groups etc.
- Create more effective and agile decision making that aligns, where appropriate, organisational governance processes to support delivery of system priorities e.g., business cases for transformational investment, financial recovery programme(s).
- Develop collaboration with partners to support Integrated Care System integration and the management of risk across the system that enables individual accountability and collective responsibility.

Governance

Senior Responsible Owner: Anthony McKeever
Lead: Mike Thompson

How will we ensure delivery

The below diagram shows the Integrated Care Board accountability structure



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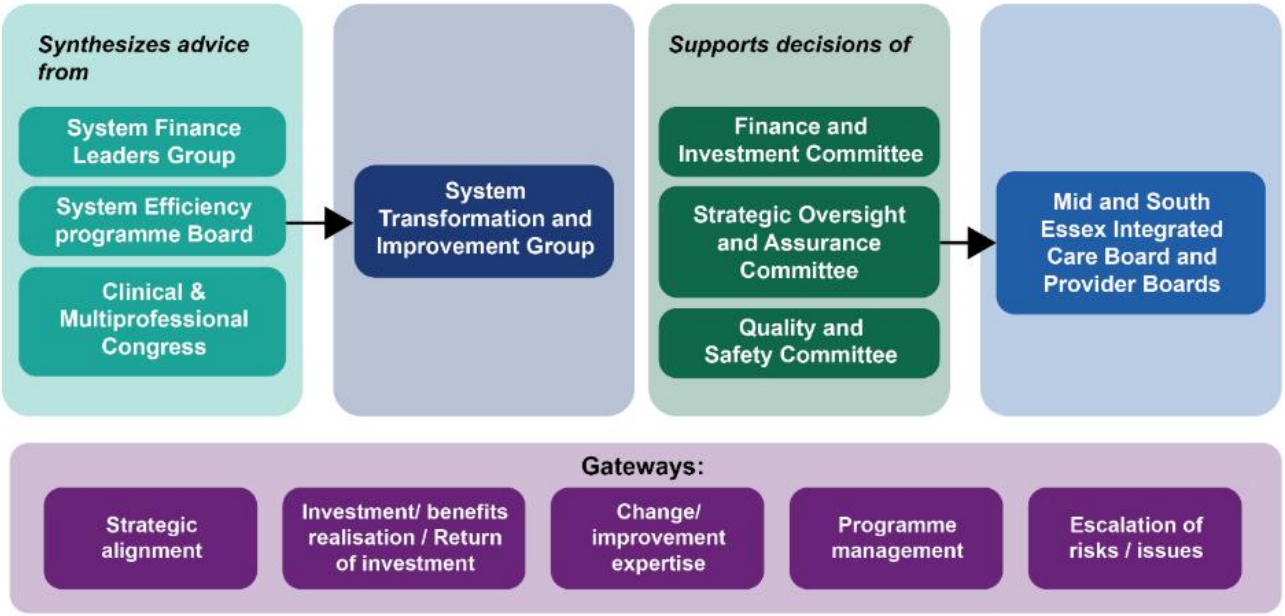


Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Maintaining robust governance to keep the Integrated Care Board safe / meet statutory requirements e.g., annual report, duty to obtain appropriate advice.	From quarter one 2023/24 to 2025/28
Enhance performance quality and finance reporting to Integrated Care Board and assurance through committees	Quarter one 2023/24
Revise and update business case process	From quarter one to quarter two 2023/24
Review and update Scheme of Delegation for decision making and onward delegation	Quarter two 2023/24
Support effective use of system transformation and investment group	From quarter one to quarter two 2023/24
Guidance and training for staff on effective decision making	Quarter two 2023/24
Support the delivery of the governance peer review	Quarter one 2023/24
Implement strengthened governance outcomes from the peer review	From quarter two to quarter three 2023/24
Establish governance for Specialised Commissioning	Quarter four 2023/24
Work with system partners and place to fully understand what governance structure is required.	From quarter one to quarter two 2023/24
Support the development of delegation to place, collaboratives	From first half 2024/25 to 2025/28
Develop integration of governance with partners and system risk management	From quarter two to quarter four 2023/24
Co-ordinate the preparation for and response to Care Quality Commission inspection of the integrated care system	From quarter two 2023/24 to second half of 2024/25

Serious Violence (including Violence Against Women and Girls, Domestic Abuse, Sexual Violence, Knife & Gang related violence)

What have our residents told us

Everyone has the right to live safely, free from abuse and neglect. Abuse and neglect can occur anywhere; at home, public place or whilst receiving services such as health care, education, or in social care setting. There are many forms of abuse; sexual, physical, psychological, domestic, discriminatory, financial and neglect.

What is the current state of play/local challenges

Victims of abuse are also more likely to develop a dependency to or misuse alcohol and/or drugs and domestic abuse and serious sexual violence has been strongly associated with sleep and eating disorders and exacerbation of psychotic symptoms. Individuals with mental health problems may also be more vulnerable to domestic abuse.

Any form of abuse can result in a wide range of significant impacts on the health of an individual ranging from physical to mental health concerns. Prolonged exposure to physical abuse can lead to significant long-term health problems or death. Domestic abuse can have a widespread and significant impact on mental health and can lead to conditions such as anxiety, depression, suicidal behaviour, and post-traumatic stress disorder.

Integrated Care Board statutory duties within the Domestic Abuse Act 2021

Integrated Care Board statutory duties within the Serious Violence Duty 2022

What is the requirement from the NHS

The ‘Serious Violence Duty’ is a legal duty on the ICB to collaborate locally to work together to prevent and reduce ‘serious violence’. The definition of ‘serious violence’ now includes domestic abuse and sexual offences.

Within the NHS, the impacts of domestic abuse and sexual violence are felt in every area of our health care system, from emergency departments to ambulance call outs to our maternity wards.

Breaking the cycle of Serious Violence (domestic abuse and sexual violence) is one of the priorities in the Police and Crime Plan for Essex. The Government’s Violence Against Women and Girls Strategy 2016-20 follows a framework that includes:

provision of services, partnership working and pursuing perpetrators. It has a focus on the need to transform service delivery, have a change in social action to achieve a sustainable long-term reduction in the prevalence of abuse and to break the inter-generational consequences of abuse.

Reducing violence in in our communities and the impact of drug driven violence, is the key priority for the Essex Violence and Vulnerability Partnership.

What is Our Ambition

The Integrated Care Board has committed to work in partnership with Police, Social Care and many of our local charities and voluntary organisations to address the many forms of abuse and violence our residents are experiencing.

- Partners in the Southend, Essex and Thurrock Domestic Abuse Board working together to commission a range of specialist victim and perpetrator services and raising awareness and recognition of abuse.
- Partners in the Essex Violence and Vulnerability Partnership commissioning a joint strategic approach in preventing violence and protecting the vulnerable in our communities
- Partners with the Community Safety Partnership teams which bring together organisations and groups that share responsibility of tackling crime and disorder, anti-social behaviour plus drug and alcohol related offending

What are the delivery priorities?

Domestic Abuse Strategy five key outcomes:

- Children & young people can recognise and form healthy relationships;
- People experiencing and at risk of experiencing domestic abuse are supported to be and feel safe;
- Everyone can rebuild their lives and live free from domestic abuse;
- Supporting and disrupting perpetrators to change their behaviour and break the cycle of domestic abuse;
- Communities, professionals, and employers can recognise domestic abuse at the earliest opportunity and have the confidence to act.

Violence and Vulnerability Strategic Objectives

- Voice of our communities
- Targeting interventions
- Developing the workforce
- Communications – raising awareness
- Improving understanding

Community Safety Partnership Objectives

- Tackling violence against women and girls
- Tackling community based antisocial behaviour and safeguarding victims
- Safer communities
- Human trafficking, modern day slavery and organised immigration crime

Sexual Safety of NHS Staff and Patients

In recent times there have been reports of sexual assault, harassment, and abuse in the NHS. It is right that we collectively shine a spotlight on this important issue. Any abuse is unacceptable, and our number one priority must be to keep staff and patients safe. In achieving this it is important that every part of the NHS takes a systematic zero-tolerance approach to tackle this issue which encompasses prevention, support and decisive action against perpetrators. With over 1.3m people employed in the NHS, and with about 2 million contacts with patients every working day, the NHS has a responsibility to protect staff and patients and offer safe spaces and routes for support. In July 2022 NHS England established a Domestic Abuse and Sexual Violence Programme to build on our robust safeguarding processes for protecting patients, improve victim support, and focus on early intervention and prevention. This will form a key piece of the work within the Integrated Care Board's programme of work in delivering the Serious Violence Duty which, requires organisations including Integrated Care Boards, to collaborate locally to prevent and reduce 'serious violence', which includes domestic abuse and sexual offences.

The Integrated Care Board Safeguarding team will work jointly with workforce leads and analytical colleagues and prioritise 3 areas of work:

1. Supporting our staff - A review of NHS staff policies, and include a dedicated sexual safety policy, to provide support and training on domestic abuse and sexual violence, with best practice shared across the system.

2. Executive leadership – The Executive team within the Integrated Care Board with senior leaders across the healthcare system will work collectively to tackle sexual assault and harassment of staff in the NHS.

3. Improving data collection – it is important that data can be collected and is meaningful to help inform what needs to be done

Governance

Senior Responsible Owner: Jeff Banks
Clinical Lead: Linda Moncur Director of Nursing for Safeguarding

How will we ensure delivery

Through partnership working across the Integrated Care Partnership the Integrated Care Board will deliver its statutory duties and realise the outcomes identified in the Domestic Abuse Strategy, the Violence and Vulnerability Strategy and the Community Safety Partnership Priorities.

The strategic working of the alliance groups is inclusive of the need to address the social determinants of healthcare and health related behaviours between areas and communities and the need to address inequalities particularly through the work on Core20PLUS5 Framework.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Existing or new partnership established for joint decision making with partners	Quarter one 2023/24
Evidence based analysis completed identifying local serious violence issues	Quarter three 2023/24
Prepared local strategy to contain prevention and reduction initiatives	Quarter four 2023/24
Review and refresh of needs analysis and strategy	First half of 2024/25

Research in Primary Care and Community

What have we heard from residents/patients

This is an internal organisational requirement only

What is the current state of play/local challenges

Relatively little health-related research has been conducted in mid and south Essex compared to other areas of England. This is partly due to the absence of large research-based academic institutions and medical schools in the area. This may be having a damaging effect on the local health care economy by reducing opportunities for innovation and research available to local patients, reducing the attractiveness of the area to high performing health care professionals and reducing the investment that is associated with research centres.

In addition, all community services are suffering with workforce shortages, increased clinical needs and backlogs caused in part by the Covid pandemic. Primary care in particular is fragile with its highly fragmented structures, limited and variable management capacity and poor morale and retention.

Increasing research activity and collaboration between partners may achieve economies of scale, mutual support and better outcomes. In addition, it may help attract and retain highly skilled staff and create a virtuous circle of more sustainable health care systems.

What is the requirement from NHS

Community, Primary Care and other out of hospital Health Services in Mid & South Essex include

1. 150 General Practitioner practices organised into 27 Primary Care Networks
2. 3 Community and Mental Health Providers
3. approx. 550 schools
4. >69 care homes
5. 3 hospices
6. 1 prison

Plus, many more community dentists, pharmacists and optometrists.

Currently each community provider is conducting research supported through its own research office which provide varying levels of support to researchers.

In addition, the North Thames Clinical Research Network, which currently covers mid and south Essex, supports the implementation of research in partner organisations including primary care and agile settings such as those above. Funding is from the National Institute of Health Research via the local primary care office based in Broomfield Hospital. This covers Mid & South Essex, West Essex, Luton and Herts

Valleys. In April 2024 the footprint will alter so that mid and south Essex will become part of the East of England Local Clinical Research Network. Although the footprint and relationships will change the underlying NIHR priorities and funding should remain similar.

What is the ambition

As a system, Mid & South Essex aims to increase the number of research studies conducted in the community and to increase the number of research-active primary care networks.

It will help achieve this in partnership with the Local Clinical Research Network by promoting research activities through its publications and website, through incorporating research activity in its commissioning activities and supporting Research Champions in primary care.

There are four themes to the Vision:

1. Research is available and responsive to the health and care needs of our population
2. Adaptive connection of research systems and processes to Primary Care systems
3. Strategic engagement and incentivisation in Primary Care
4. Strategic development of the Primary Care Research Workforce

The longer-term vision is to partner with local academic institutions to increase the local base of academic expertise to lead more locally designed and locally relevant research studies. The Anglia Ruskin University Medical School is developing its long-term strategy in partnership with the Integrated Care Board to deliver this. Ultimate goal to establish a Centre for Advancing Primary & Integrated Care.

What are the delivery priorities

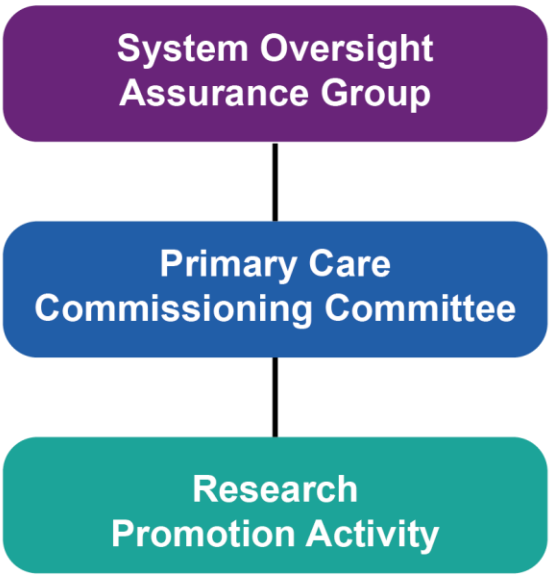
- Develop community of practice in out of hospital research between providers: North-East London Foundation Trust, Essex Partnership University NHS Foundation Trust, Provide, Primary Care. Initial meetings commenced Nov 2022 and planned quarterly contact meetings to explore and support options for collaboration and mutual support and development. To initiate by April 2023.
- Identify options to increase capacity to support and develop research through funding applications to employ a coordinator for primary and community care research. Sept 2023

- Support collaborative links with local universities to develop and champion primary care and community research within mid and south Essex. Agree joint strategy. Sept 2023
- Recruit and support research champions in primary and community care across mid and south Essex. Sept 2023 and ongoing.

Governance

Senior Responsible Owner: Ronan Fenton
Clinical Lead: James Hickling

How will we ensure delivery



Above organogram of system governance arrangements.

Currently the research workstream in Mid and South Essex Integrated Care Board has no budget allocation. It relies on soft leadership, networking and influence to work with partners to meet its objectives. Reporting is proposed to be via the Primary Care Commissioning Committee.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Establish community of practice	Quarter one 2023/24
Agree options to support and develop activity	Quarter two 2023/24
Links with academic institutions	Quarter two 2023/24

Delivery Plan objectives	Timespan for implementation of objectives
Research Champions	Quarter three 2023/24
Increase collaboration across community-based research active organisations	Second half of 2024/25
Increase quantity, quality and proportion of locally led research through Centre for Advancing Primary & Integrated Care	2025/28

Research in Acute Setting

What have we heard from residents/patients

This is an internal organisational requirement only

What is the current state of play/local challenges

Mid and South Essex NHS Foundation Trust has a proud and growing reputation as a centre of innovation and research but only 33 of >700 consultants are research-active, and we are unsure of other healthcare professional involvement. However, our geography means we compete with larger London research institutions. We should look to work with partners to define the unique offer that Mid and South Essex NHS Foundation Trust has and to develop a long-term system wide research strategy.

In addition to this, we must consider how we improve training provision to increase the overall satisfaction of staff with their onsite training. Our General Medical Council National Teaching Survey scores continue to be lower than our peers. Continuing to grow our partnership with the medical school at Anglia Ruskin University and with the University of Essex will help to build our teaching capability.

What is the requirement from NHS

The Health and Care Act 2022 (the 2022 Act) sets new legal duties on Integrated Care Boards around the facilitation and promotion of research in matters relevant to the health service, and the use in the health service of evidence obtained from research.

What is the ambition

Key points in the draft Research & Development strategy document:

1. Establish a culture where research is appreciated across all staff groups and embedded into routine practice
2. Develop a High-Quality Research Portfolio offering access to patients across all specialties and sites
3. Increase quantity of research
4. Patients and public are engaged with, participate in and benefit from research
5. Research is adequately funded via National Institute of Health Research funding, external grant applications, commercial research income and charity funding
6. Research is well governed, managed, supported and delivered and studies are delivered as agreed

What are the delivery priorities

The immediate plan is to develop a system-wide research strategy that incorporates research in acute settings with research in community and primary care (see separate Joint Forward Plan). This will cover People, Partnerships, Portfolio of assets, and Patients/Populations.

Joint funding from the Anglia Ruskin University, Integrated Care Board and Mid and South Essex NHS Foundation Trust has allowed recruitment to two posts to create a research strategy team.

They are currently involved in a stakeholder engagement exercise to draw up the priorities for a strategy, which is due to be published in June 2023.

Engagement will take place in the summer of 2023. Draft objectives are stated above.

Governance

Senior Responsible Owner: Ronan Fenton
Clinical Lead: James Hickling

How will we ensure delivery

Short term collaborative funding has supported the establishment of a small research strategy group. Delivery of the strategy will depend on system-wide partners including NHS providers, academic institutions and the Integrated Care Board.

National support through National Institute of Health Research and other funding sources. Oversight will be through the Clinical & Professional Leadership Directorate. Overall governance to be agreed.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Conduct initial stakeholder engagement	Quarter one 2023/24
Publish System-Wide Research Strategy	Quarter two 2023/24
Further engagement and final strategy production	Quarter three 2023/24
Implement Research Strategy	From quarter four 2023/24 to 2025/28

Pharmacy, Optometry and Dental Services Delegation

What have our residents told us?

Access to all primary services (including Pharmacy, Optometry and Dental services) is a priority for our local population. Many residents see accessing these services as both an alternative to hospital-based care and as the gatekeeper to hospital-based services where required.

Residents are struggling to access dental services particularly in some more deprived areas of the Integrated Care Board. Many residents access private dental services due to a lack of NHS provision.

Current Conditions

Pharmacy optometry and dentistry services will be delegated to Integrated Care Boards as of 1 April 2023. Transition plans are underway, but there are significant challenges in taking on these responsibilities including access to care, quality and finance.

Access to dental services nationally is a significant challenge. This is in part due to workforce constraints but also is attributed to the existing contractual settlement with dentists. The contract framework is currently under review nationally.

Nationally, there are also challenges within the community pharmacy workforce. There is concern that the planned expansion of community pharmacy services as an alternative to general practice cannot be supported within the current resource constraints.

What is the requirement from the NHS?

The Planning Guidance for 23/24 identifies the following requirements that impact on Pharmacy, Optometry and Dental services.

- Recover dental activity, improving units of dental activity towards pre-pandemic levels
- Increase the use of Community Pharmacy Services as an alternative to general practice
- Ensure direct referral routes from community optometrists to ophthalmology for all urgent and elective eye consultations
- Recovery of secondary care dental service waiting lists as part of overall waiting list recovery

Our Ambitions

The Integrated Care Board seeks to ensure that Pharmacy, Optometry and Dental services form a key part of our Integrated Neighbourhood Team model for urgent and episodic care, complex care and prevention.

Delivery Priorities

Pharmacy, Optometry and Dental Services will be delegated to Integrated Care Boards from 1st April 2023. As such, our initial priority is to stabilise arrangements and ensure we are delivering our business-as-usual functions effectively. From this foundation we will then undertake a process of strategy development over a six-month period. We will engage with stakeholders throughout this process.

From the end of 23/24, we will seek to deliver upon our strategic ambitions.

Ensuring Delivery

Senior Responsible Owner: Dr Ronan Fenton,
Medical Director Integrated Care Board
Clinical Lead: Dr James Hickling

A number of subgroups of the Primary Care Commissioning Committee will oversee the effective commissioning of Pharmacy, Optometry and Dental services. In addition, the Primary Care Commissioning Committee will oversee the development of clear local strategies that link in with our Integrated Neighbourhood Team ambitions.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Transfer and stabilise services following delegation from NHS England	Quarter one 2023/24
Ensure Business as Usual functions are undertaken effectively	Quarter two 2023/24
Develop Community Pharmacy and Dental Strategies (and continue Ophthalmology Stewardship programme)	From quarter three to quarter four 2023/24
Implement Strategies	From first half on 2024/25 to 2025/28

Community Resilience and Engagement

What have our residents told us?

We knew it was essential that the building-blocks of our strategy and the ambitions of the Joint Forward Plan were informed by a range of conversations with residents, community organisations, clinicians, care professionals and leaders in the NHS, plus our local authorities.

In developing the integrated care strategy, we held eight workshops based in community venues, collectively engaging over 170 people from all parts of our system, including elected councillors, system leaders, staff and, most importantly, members of our community. We also used the 'Essex is United – Your Questions Answered' Facebook group to ask a series of questions of the general public. Each was viewed on average 1,700 times, with an average of 280 comments and votes on each question.

We use our Community Campaign Model and our emergent Community Assembly to convene and engage with our communities iteratively, we have a network of 10,200 Community Groups. We have engaged digitally with 3000 members of the public to support the development of the Assembly. This is an approach we intend to continue to evolve to support the delivery of the Joint Forward Plan.

We have adopted a convening, iterative engagement approach that; meets people where they are and focuses on appreciative enquiry.

We have asked people what is working well and what could we do more of. The emergent themes from our community conversations are:

- **Access:** Personalisation and complexity remain a challenge both physically and digitally for our communities. We must make our offer obvious and our systems intuitive with a focus on primary care, urgent care and care closer to home
- **Equitable and Honest:** More work is required to meet inclusion health groups where they are, whilst being open on what is possible. This will become an ongoing feature of the work of the Integrated Care Partnership as it moves forward. Additionally, a commitment to learning from issues and sharing this openly.
- **Awareness:** Further development of behaviour change support to address the wider determinants of health through collaboration around early intervention and prevention
- **Building Responsible Community Together:** Active listening and development of equitable mechanisms that offer a proportionate way for communities to work with us to solve the societal challenges we all face.

Current Conditions

We cannot service our way out of the current service and societal challenges we face. Communities are our greatest asset in driving behaviour change to empower people to Live Well - this requires a new model of civic infrastructure. This means we will need to meet people where they are and work shoulder to shoulder with our people to leverage the best outcomes for our communities.

What is the requirement from the NHS?

As articulated in the Mid and South Essex Integrated Care Strategy, "Engagement of partners and stakeholders will not be an occasional duty but will be a permanent feature of the work of our Partnership"

Our Ambition

We will create a whole system, asset-based approach to working with communities. We will empower people to connect face to face and virtually around societal, system and neighbourhood-based challenges, that are important not only to communities of place, purpose and interest but also supports driving social movements that ensure better system outcomes, that are relevant to the communities mid and south Essex serves, this will create the foundations of resilient, citizen-led communities that can truly level up and reduce health inequalities.

We believe that engagement with our communities should be:

Organisation:

1. Supported by those with the power to change things
2. In an inclusive society, public engagement should be built into the decision-making.
3. Processes of systems, funding bodies, innovators and communities themselves to drive a series of common endeavours

Open to Experimentation:

4. Supportive of a focus on Citizen-led approaches from arts-based engagement to the use of social media that can highlight concerns that can be missed in institutional engagement.

Purposeful:

5. Engagement should be about shaping priorities and decisions rather than simply a consultation to gain acceptance of the public for a new policy or strategy

Sensible about measures of success:

6. A report is often the outcome of engagement activity. However, public engagement can do much more than this. Just as important as the formal, documented outcomes should be how the process itself influences participants and leads to open and surprising discussions about societal issues that matter to our communities

Participants - Targeted at Specific and Universal Audiences:

7. A sensitively focussed approach that includes but is not dominated by an interested and motivated group only. Our thoughtful engagement approach seeks to consider how we meet diverse communities and those with protected characteristics on their terms

Beneficial for Participants:

8. Crafting an engaging experience for participants, or offering support, skills and training that empowers participants to act as community organisers and intermediaries between the statutory and community sector.

Methods Informed and Facilitated:

9. Ensuring our teams have skills in engagement that enable them to explore different views, to provide information where necessary and then to use judgement to interpret findings.

Delivery Priorities

- **We** will establish a Community Assembly model that aligns to system and place through our alliances, an Independent and Private Providers Network, and a Community Voices Network to ensure a wider range of partners are able to influence and contribute to achieving our shared objectives.
- **We** will establish a partnership-based Co-Production and Engagement Steering Group to ensure effective planning, accountability and inclusion.
- **We** will create a paired leadership and learning programme for Voluntary and Community and Social Enterprise and Clinical Leaders to support better collaboration and growth for our people
- **We** will establish an influencer network to ensure we can diversify our approach to community building and engagement.
- **We** will further develop our approach to Volunteerism to support system pressures and communities themselves
- **We** will establish an engagement impact framework to ensure efficacy and inclusion of our engagement approaches

- **We** will develop an ongoing series of community conversations, workshops, seminars, and engagement activities, which draw together a much wider set of contributors into the work of our Integrated Care Partnership.
- **We** will grow our Community Campaign approach, to consider a digital first approach to engagement and peer support, we will develop a Human Library and Lived Experience network, which will ensure a better approach to immersive practice as a system
- **We** will co-produce a Community Engagement Benefits framework with our Communities to ensure equity and reciprocity for participation in our engagement approaches.
- **We** will deliver a mid-point review on our Year 1 and 2 approaches to confirm and challenge impact and efficacy.

Year 4 and 5 to be determined by Year 3

Ensuring Delivery

Senior Responsible Owner: Kirsty O'Callaghan
Clinical Lead: To be established after approval at Steering Group

The governance routes are being established re engagement steering group and assembly - both of which are in co-production phase now. There is a draft and not yet agreed model for the engagement steering group in development and approval of this will be an action for completion in due course.

Delivery Plan

Delivery Plan objectives	Timespan for implementation of objectives
Community Assembly Model Agreed and Established	From quarter one to quarter four 2023/24
Co-Production and Engagement Steering Group Operational	Quarter one 2023/24
Influencer Community Builder Enabling Network Established	Quarter two 2023/24
Voluntary, Community and Social Enterprise Partnership and Engagement Framework Agreed	Quarter three 2023/24
Community Conversation Cycle	From quarter two 2023/24 to second half of 2024/25
Expansion of Community Campaign Digital First Programme	From quarter one 2023/24 to second half of 2024/25

Delivery Plan objectives	Timespan for implementation of objectives
Community Engagement Benefits Framework	From quarter three 2023/24 to second half of 2024/25
Voluntary, Community and Social Enterprise and Clinical Paired Leadership Programme	From first half 2024/25 to second half of 2024/25
Voluntary, Community and Social Enterprise Referral Tool delivered	From quarter two 2023/24 to second half of 2024/25
Efficacy Review Interdependent	2025/28

Appendix 9 - Health and Wellbeing Board endorsement letters

Essex County Council endorsement letter

Mr Anthony McKeever
Mid and South Essex Integrated Care Board Phoenix Court
Christopher Martin Road Basildon
Essex SS14 3HG

27th July 2023

Dear Anthony,

The Essex Health and Wellbeing Board is supportive of the MSE JFP and the actions it sets out. It has taken into consideration both the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy for Essex and there are clear links to the priorities in these documents.

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

We are also pleased with the emphasis the JFP places on investing upstream in evidence- based interventions and preventative activities. This aligns well with the Health and Wellbeing Strategy that identified 'Focusing on prevention and early intervention' as a cornerstone to long term sustainability and one of the foundations of collective success for the system.

It is important that the JFP is all-age and, although the document signals this by recognising important issues such as the need for the system to collaborate on issues such as transitions to adulthood and the expansion of support for children and young people's mental health, we feel the emphasis on pre-birth, children and young people's outcomes could be strengthened. This is essential if we are to address the increase in caseload numbers and complexity following the pandemic.

Most importantly the JFP recognises that being successful in reducing health inequalities requires us to work together and that no single action or single organisation is able to have impact alone, it demands a sustained organised collaborative focus. We look forward to working in an equal partnership with our NHS

colleagues through the ICB, ICP and HWB to provide joined-up health and care services to the people of Mid and South Essex and tackle the causes of ill health.

We recognise that each ICB has been given a very challenging task of reducing its running costs by 20% from April 2024 and by a further 10% from April 2025. Essex County Council encourages MSE to work collaboratively with the other Essex ICBs, and ECC itself, to ensure it explores opportunities for joint working and efficiencies in a way that avoids or minimises

adverse impacts on Essex residents. Two areas identified in conversations so far between ICBs and ECC have been around mental health and children's services. We are keen to support those conversations to ensure we improve services in these areas and achieve potential economies of scale.

Yours sincerely,

Cllr John Spence

Chairman, Essex Health and Wellbeing Board

Southend-on-Sea City Council endorsement letter.

To: SEE Alliance
C. McCarron.
Our ref: RH/HWB Your ref:
Date: 19 June 2023
Telephone: 01702 215106
Email: robertharris@southend.gov.uk

Dear Caroline,

RE: Health and Wellbeing Board held 15th June 2023: Endorsement of NHS Mid and South Essex Joint Forward Plan

The Mid and South Essex ICS's Joint Forward Plan (JFP) was developed following guidance issued by NHS England and the detailed operational planning and financial framework issued to NHS organisations for 2023/24. This JFP has been collated following the Southend Health and Wellbeing Board's endorsement of the ICS's Integrated Care Strategy (March 2023) and having due regards to the priorities set out in our Health and Wellbeing Strategy (2021-24).

The JFP will further support and drive our collective endeavours in reducing health inequalities in our population, exacerbated by the Covid pandemic. The local health and care system is facing a plethora of challenges and our primary care services are under extreme pressure. There are increasing demands on our mental health services, urgent and emergency services, and we have long waits for planned treatments, as well as not meeting nationally set standards in relation to cancer care.

The Southend Health and Wellbeing Board welcomes this plan and the area of priorities set out to address the challenges highlighted above as well as tackling the growing financial deficit that the system continues to experience.

Yours sincerely

Cllr J. Moyies

Chair, Health and Wellbeing Board

Thurrock Council endorsement letter

Thurrock Council, Civic Offices, New Road, Grays Thurrock, Essex RM17 6SL
www.thurrock.gov.uk

Councillor George Coxshall

Chair of Thurrock Health and Wellbeing Board

26 June 2023

Dear Jeff

Thurrock Health and Wellbeing Board's endorsement of the NHS Mid and South Essex Joint Forward Plan

The Mid and South Essex ICS's Joint Forward Plan (JFP) was developed following guidance issued by NHS England and the detailed operational planning and financial framework issued to NHS organisations for 2023/24. The JFP was considered by Thurrock Health and Wellbeing Board on Friday 23 June 2023.

Board members welcomed the plan reinforcing commitments to transforming the way in which health and care services are provided to residents, its commitment to subsidiarity and putting patients at the heart of decision making, reflecting Thurrock's Integrated Care Alliance strategy - Better Care Together- Case for Further Change.

Board members endorsed the plan and its strong commitment to tackling inequalities, reflecting Thurrock's Health and Wellbeing Strategy's ambitions of levelling the playing field across Thurrock.

The JFP will further support and drive our joint endeavours in reducing health inequalities in our population and Thurrock Health and Wellbeing Board acknowledged the importance of maintaining the Better Care Fund as one of the key delivery mechanisms for ensuring our collective ambitions can be achieved.

Yours sincerely

Councillor George Coxshall

Cabinet Member for Health, Adult's Health, Community & Public Protection Chair, Thurrock Health and Wellbeing Board