BCF Narrative Plan

Bodies involved in the plan

The Better Care Fund (BCF), and those budgets within it, are key elements of discussions across systems in Essex. This is key through all levels of the Essex system. Local alliances/ICPs determine the best approach for investing the BCF budget which has been delegated. There are dedicated local Partnership Boards focused on managing the BCF, developing schemes, evaluating performance and managing the budgets for local delivery. These boards cover the following organisations in Essex:

Essex County Council

5 CCGs through BCF Boards:

- North East Essex CCG
- Mid Essex CCG
- West Essex CCG
- Basildon & Brentwood CCG
- Castlepoint & Rochford CCG

Wider Alliance representatives including:

- Hospital Trusts
- CVS
- District & Borough Councils
- GPs / PCNs / Primary Care
- Community Health Providers
- Ambulance Trust
- Hospices

ICS Partners:

- Herts and West Essex ICS
- Mid and South Essex ICS
- Suffolk & North East ICS

The Delivery Plan for Essex has been co-produced through local Partnership meetings that sit outside of the formal BCF boards, where priorities for local alliances form the basis of decisions to invest.

Executive Summary

Essex is one of the largest and most complex health and care systems in the country. The Essex Health and Wellbeing Board area comprises five CCGs, three acute trusts (across 5 sites), and links to three integrated care partnerships and to an additional 4 local authorities (Southend, Thurrock, Suffolk and Hertfordshire) and additional 6 CCGs that sit outside these BCF arrangements but are part of the STP footprints.

Our vision for health and wellbeing is to be more place-based, more preventative and more joined-up in order to improve population health outcomes, and to reduce health inequalities, for people of all ages across Essex. The Essex system is committed to building inclusive place-based partnerships as the bedrock of how it works to improve health and care outcomes in a local place and to achieve this through working with local ICSs on transition planning. Fundamentally, we want to see improved health outcomes, and reduced health inequalities, across the whole Essex population of all ages from the cradle to the grave as we deliver our duties set out in the Care Act.

The **Essex Joint Health and Wellbeing Strategy** sets out a vision that:
We want everybody in Essex to live well together.

- We want all people in Essex to live healthy, happy and full lives and to be able to fulfil their potential, including those who might be vulnerable.
- We want every child to get a great start in life.
- We want everybody to live in a strong, sustainable and supportive community with good opportunities for work and other meaningful activity and a healthy standard of living.
- We want everybody to be able to maximise their capabilities with control over their own lives, including the ability to make healthy lifestyle choices for themselves and their families.
- We want to ensure that everyone has the opportunity to enjoy life long into old age. We want everyone to have access to high quality health services delivered in the right way at the right time when they need specialist help and support.

This Strategy, along with the Essex Joint Strategic Needs Assessment, is due to be renewed by March 2022 to ensure that changes because of Covid and the Health and Care Bill are taken into consideration.

To achieve this, we recognise the need for a more integrated health and social care system and our priorities for 2021/22 are:

- Prevention and promoting self-care
- Enabling people to live independently and to access support in their community
- Working in more integrated and joined-up ways to improve patient pathways and transfers of care
- Improving information sharing
- Ensuring that health and social care are financially sustainable
- Improving patient experiences

	Scheme	2021/22 £'000
1	Provision of Social Care	33,377
2	Care Act	4,167
3	Reablement	4,838
4	Community Services/ Mental Health Services/Carers Support / Carers Breaks	65,972
5	Disabled Facilities Grant	11,885
6	Improved Better Care Fund	45,017
Total		165,257

To meet future challenges Adult Social Care needs to change, moving to a place-based model that is more local, more preventative, and more integrated, with citizens, communities, partners and providers working together to ensure that people can get the right support at the right time to maintain their independence and quality of life. The vision that underpins this strategy is shared with partners and sets an ambition to put communities at the heart of Adult Social Care: enabling people to live their lives to the fullest.

Our Adult Social Care Strategy defines key areas of focus through to 2025 to progress the Council's strategic ambitions and has been developed in the context of the Government's Health and Care Bill. We have identified 7 immediate, mission-critical areas that we must address in the next 4 years:

1. Develop a prevention and early intervention offer - to reduce or delay the onset of health and care needs;
2. Improve our support offer to carers – to ensure that people get the support they need in their caring roles, while enabling them to enjoy a good quality of life;
3. Improve access to housing, employment, and meaningful opportunities – ensuring we promote an inclusive society that addresses inequalities in access that have an adverse impact on quality of life, independence and health outcomes;
4. Implement place-based working and integration – working in multi-disciplinary teams with partners to improve people's experience of the health and care system;
5. Support and shape the care market – so that care provision is viable and sustainable going forward;
6. Improve quality of practice – to fully embed a strengths-based approach that promotes independence, choice and control and dignity;
7. Improve digital and technology infrastructure – to ensure we have the right support for people with care needs to live independently, to support the workforce to work as efficiently as possible, and to support the care market.

Governance

The Health & Wellbeing Board provides strategic leadership and direction for decision-making and joint commissioning across Essex covering all relevant CCGs and ECC. In this capacity it also acts as the final point of governance for BCF. The HWB receives quarterly reports on progress, spending and impact of the BCF. It reviews these in the context of reports on the broader integration agenda.

The BCF is governed at a local BCF pool level for the ongoing monitoring of schemes, metrics and financial performance through locality BCF Partnership Management Boards (CCG Accountable Officers and Finance Officers /

ECC Heads of Commissioning, reporting to Directors for Local Delivery, and Finance Officers). In some localities these Partnership Management Boards are free standing Boards and in others they have been incorporated in alliance/ICP discussions. Transformational plans and programmes are formally discussed and approved by existing local authority Governance processes and within each CCG's governing bodies.

Within Essex the Better Care Fund has one overarching S75 that incorporates all agreements for delegating BCF locally. ECC and the CCGs have agreed use of all pooled budgets in a joint and transparent manner, through jointly agreed governance routes. Decisions about use of funding are based on a clear and shared understanding of the allocation of resources across different areas of Essex, how this relates to population need, the services that will be supported and the outcomes that will be delivered.

In addition to the locality management and monitoring of the BCF, ECC is providing Programme Management and PMO resource to support the Health and Wellbeing Board with its responsibilities to agree and submit plans and quarterly reports to NHS England.

Overall approach to integration

We recognise that there is no one size fits all model that will be appropriate across the whole of Essex, which is why our focus has been on local collaboration. However, the approach to integration set out in this plan outlines our desire to move towards:

- building inclusive place-based partnerships as the bedrock of how we work to improve health and care outcomes in a local place.
- A greater focus on prevention and maintaining independence
- A common commitment to Discharge to improve the timeliness of transfers of care but also the quality of service received – with a focus on Home First
- Creating closer working between all partners to improve outcomes for the population of Essex.
- Taking forward new ambitions set out in the Health and Care Bill in how Health and Care systems work together
- Population Health Management approaches to support better risk stratification and preventative work
- Addressing and reducing Health inequalities

Ultimately our long-term ambition is to take collective responsibility for resources and population health and to provide joined up, better coordinated care for the benefit of the Essex population.

While all areas in Essex are committed to progressing the integration agenda, and implementing requirements set out in the Health and Care Bill by April 2022 through a shared strategic vision, it remains vital that local needs, opportunities, and challenges are considered in the models we take forward. The complex geography of Essex and the various organisational and strategic footprints mean that while the overarching vision, and ICSs, will guide our work on integration, how this looks locally will take different forms and progress at differing rates. We will also look to advance integration on the ground where it can be done quickly and beneficially without the need for complex new organisational structures and / or commissioning and contractual arrangements.

North East Essex

The aim of the NEE Alliance is to transform the health and wellbeing of the population of North East Essex by creating a sustainable system of health and wellbeing services that meet the immediate and longer-term needs of our population. This will be achieved through integrated commissioning and integrated delivery of health and wellbeing services. The Alliance will work collaboratively to achieve the best possible health and wellbeing outcomes for the people of North East Essex. It is committed to preventing and tackling the causes of ill health and reducing health inequalities, as well as improving the services and support we already provide. The Alliance will listen to the voice of local people in order to truly understand their needs, and address these by working alongside communities, and building on community assets.

The NEE Health and Wellbeing Alliance has recently undertaken a 16 week period of reflection on its maturity, focus and next steps of integration and work together, whilst acknowledging future potential changes linked to the NHS

white paper on ICS development as an organisational body. The goal is to keep moving towards a unified capability and capacity to achieve the triple aim and to provide a fair, honest, transparent and timely account of "place-based" performance to the communities served.

This ambition is supported through the local NE Essex iBCF Schemes where additional contributions have been made by the wider system into the iBCF pool to drive this agenda forward. NEE is perusing a Home First agenda to support admission avoidance and safe timely discharge back to the community. Some of the key activity supported through the iBCF includes:

NE Locality Initiatives	Description
Additional Swan UCRS Hours	To fund extra contractual hours with Swan for adults requiring reablement as admission avoidance to support the UCRS transition with ECL.
The Sound Doctor	An audio-visual learning programme aimed at encouraging effective self-management.
NEE Alliance Integration	To support place-based integration approach (as outlined in the above NE Essex Case for Change).
NEE Neighbourhoods	To realise the Alliance Neighbourhood ambition, costs will be attached to test and learn activity, the development of community hubs and employment of external project support.
Change and Domain Delivery	Alliance Delivery Lead roles (4) to support CMO and Live Well Domains.
Community Micro Enterprises (CMEs)	Using an Asset Based approach to the provision of care and support services in the local area.
System Resilience	Supporting Winter and system pressures
Active Environment Officer	Match funding for post to support the Alliance roll out of the LDP – it will report into the CMO and Be Well domain Leads
OT services for the Early Intervention Vehicle	Supporting Fallers to remain at home and prevent conveyance to hospital and hospital stays for OT support to be provided at home
Reablement Support	Admission Avoidance Social Workers ro support people to remain at home where possible.

Mid Essex

The Mid Essex Alliance has set out high level ambitions aligned to the requirements of each ***neighbourhood*** for 2021-22:

- COVID recovery
- Integrated health and social care (including the development of PCNs), and
- A renewed focus on prevention and reduction of health inequalities.
- Reduced social isolation/Suicide prevention

- ABCD/strengthening communities
- Frailty elderly
- Drugs/Alcohol/County Lines/violent crime
- High street recovery/Night-time economy / homelessness (rough sleepers)
- Promote physical wellbeing
- Promoting mental wellbeing
- Reducing obesity
- Primary Care sustainability and development

The Mid Essex Alliance is fully committed to putting its citizens at the heart of its decision making at all times. Our strength lies within the strength of our communities. A place plan has been developed to include this approach.

Some of the guiding principles for delivering this include:

- Support the Live Well ethos, Asset Based Community Development principles, and embed social value in all that we do.
- Demonstrate that the citizen's, service users' and patients' best interests and safety are at the heart of planning, development, oversight and accountability activities.
- Transparency for information sharing, skills and experience and encourage Co-Production in designing and delivering integrated services.
- Collaborative governance to support open and transparent decision making. Decisions will be on a "Best for Service/Place" basis, evidencing population outcomes.
- Conduct timely and efficient organisational decision-making to support the work programme envisaged under the Mid Essex Alliance, adhering to statutory requirements and best practice by complying with applicable laws and standards, including EU procurement rules, EU and UK competition rules, data protection and freedom of information legislation.

Some of the key activity supported through the iBCF includes:

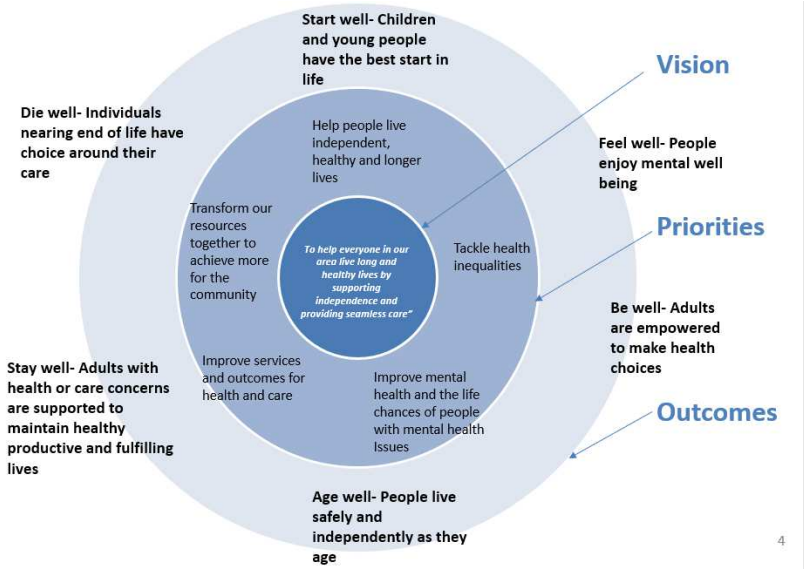
Mid Locality Initiatives	Description
Trusted Assessors	Trusted Assessor posts at Broomfield Hospital to support with increased discharge time of Adults into ECL reablement.
CHC Social Worker	Social worker post to support with leading on continuing healthcare assessments in Mid Essex, supporting with decreased discharge times, access to CHC funding and integration with health partners involved with continuing healthcare.
DISS	Contribution towards the Dementia Intensive Support Service (DISS) to provide link social worker posts within the neighbourhood teams and overall senior social worker coordination.
EOL	ASC contribution towards the overall End of Life service in Mid Essex provided through Farleigh Hospice.

West Essex

In the West Essex One Health and Care Partnership the vision is to help everyone in our area live long and healthy lives by supporting independence and providing seamless care. This will be delivered through the following priorities:

- Help people live independent, healthy and longer lives
- Tackle health inequalities
- Improve mental health and the life chances of people with mental health Issues

- Improve services and outcomes for health and care
- Transform our resources together to achieve more for the community



Models of Care to achieve the above include:

- Greater focus on preventing disease and managing existing long term conditions in the community
- Fundamentally shift more care from the hospital to the community, treating people closer to home without the need to go into hospital – home first
- Enable fluidity of resources across organisational boundaries to dissolve the historic divide between primary care, secondary care and community health and care services.
- Further integration across health and social care pathways designed on the principles of multi-disciplinary team (MDT) working.
- Majority of our provision will be deployed by providers at geographical PCN level, resourced based on the population health needs of those populations.
- Patients will be supported to have more control over their own health and wellbeing supported by personalised care & guided through digital tools.
- More outreach from acute hospital consultants and specialist teams to work alongside community health and social to support admission avoidance, management of long-term conditions and post-hospital discharge.
- Access to emergency care services will be expanded and reformed to provide alternatives to Emergency Departments that offer timely access for urgent care closer to people's homes, and to shift towards "managed urgent care" through effective clinical triage and a digitally enabled NHS 'front door'.

Some of the key activity supported through the iBCF include:

West Locality Initiatives	Description
Admission Avoidance	To support the adult to remain in the community and their own home during a period of crisis. This supports adult who may have turned up at Emergency Departments and without this service it would have led to the adult having a 24hrs – 48hrs assessment period or admission within an acute setting
Impartial Assessor	This service acts as an intermediary between the care home and acute hospital and will support the adults the discharge back to the care home including undertaking nursing needs assessment on behalf of the care.
Care Home Facilitator	This service supports the adult and carer find a suitable care service that meets those needs and is targeted at those who are self-funded and without this support would have longer stays in hospital
Care Home Hub Operation and transformation	To support the care homes and implement new initiatives that include the management of discharges and readmission to hospital.
Therapy Review	To undertake a review of all therapy services across acute, community and social care to redesign the service to support better outcomes for the adult and better integrated OT interventions

Care Co-ordination Centre Development	Support the development a co-ordination centre that will manage all discharges from the hospital and priorities system capacity to meet the demands on the system and proactive management of the adult through their pathway
PACTs / Care Co-ordination Centre implementation	To support the implementation of the co-ordination centre by ensure appropriate resource available
Falls in Care Homes	To supply equipment and the training of care home staff to avoid unnecessary ambulance call out and conveyances to hospital

South East Essex

South East Essex Alliance's ambition is to enable smooth and easy access to integrated health and care provision, that is delivered by a happy and motivated workforce; working together to reduce health inequalities. By

- Working towards outcome-based commissioning
- Empowering clinicals at the heart of change
- Addressing health inequalities
- Collaborative working across system and place
- Utilising Population Health Management data and methodologies.

South East Essex has developed a place plan divided into themes: Healthy Living, Healthy Places, Healthy Communities, Healthy Care, Healthy Start and Minds. Overarching themes are:

- Locality working
- Development of PCN footprints
- Co-production
- Tackling Health Inequalities
- Prevention and Early Intervention

There is a notable complexity with this Alliance as it encompasses Southend Borough Council / unitary authority who of course have their own BCF, Social Care and Commissioning functions.

South East Locality Initiatives	Description
Neighbourhood Teams	The Locality Development Managers will take an operational and strategic lead on the development of a population health focused system that will improve well-being and outcomes for the locality populations working across health, social-care, housing and non-paid services.
Dementia Support	Bespoke support pre-diagnosis through to end of life for people living with dementia and their carers. Forming part of an integrated service that wraps around people, enabling them to live the life they would like with their diagnosis, including hospital inpatient stays and residential care. It is also the crucial link to all health, social care and community support in the area. The Team also includes support for Older People's Mental Health and Frailty.
Bridging Service	'Bridges the gap' between hospital discharge and reablement or domiciliary care support in people's homes. Coverage includes 17 starts flexed across the area. Commissioned by the CCG (delivered by the Acute Trust) this has proved to be highly effective in South Essex providing vital link and enabling smooth discharge to a home setting.
Care Coordination	Enhance the offer of the existing EPUT 'Care Coordination service' to undertake gait and balance assessments for patients on their caseload through the employment of Physio Therapists to undertake this role. Due to come to an end Dec 21.

South West Essex

The primary ambition of the Basildon and Brentwood Alliance is to reduce inequality, placing this at the centre of all decision making. This ambition is directly shared by the Health and Care Partnership Board. The local place plan is focused on implementing transformation across four domains and enablers to address inequality:

- Access – understand the communities that are underserved by current approaches to access. This will be considered at a PCN level due to the need for a hyper local understanding of the communities served.

- **Integrated Working** –new approaches to proactive care planning that enable patients that often present late in disease progression due to socio economic factors to be identified and supported at an earlier stage
- **Community Development** – focus our community development approach on the three PCNs in Basildon using social prescribing, asset-based community development and other approaches to build stronger resilience
- **Operational Delivery** – continuously learn and refine approaches based on the experience of delivery in Basildon and Brentwood. Share learning on hard-to-reach communities that has been at the forefront of the Covid Vaccination approach and apply this to other interventions

Some of the key activity supported through the iBCF includes:

South West Locality Initiatives	Description
Alliance Development Diagnostic	This will be completed by Collaborate
Neighbourhood Teams	Neighbourhood Co-ordinators to strengthen the contribution of neighbourhood teams and improve care coordination for people with different levels of need in that neighbourhood. Key activities: • Develop a locality workforce identity. • Pilot a new model of care. • Map assets and review commissioning arrangements. • Cultivate inclusive locality leadership. • Revised activity post covid restrictions
Bridging - existing runs till end of April	17 starts flexed across South Essex to 'Bridge the Gap' between hospital discharge and care support in people's homes.
Associate Director	Funding for Joint role of NELFT and Health and Social Care to deliver a locality, neighbourhood plan. With the view for integrated delivery and building collaboration to support system needs.
Trust Links	A charity running a garden scheme in the area has requested support for a site in Vange, Basildon. Funding has been secured from the CCG, Sport England LDP, Basildon Health and Wellbeing Board, 'ECC Strengthening Communities' budget and a few smaller sources of money.

We have a robust approach to constructive collaborative commissioning across Essex. A joint bi-monthly meeting of CCG Accountable Officers and Directors of Adults Services provides Essex-wide coordination. Some of the key work areas and programmes include:

- Joint county-wide commissioning arrangements for Transforming Care led by Essex County Council.
- Joint county-wide children's mental health commissioning led by West Essex One Health & Care Partnership (West Essex CCG)
- Mental Health Programme Boards to oversee mental health commissioning and delivery in North East Essex, West Essex and for Mid & South Essex
- Local alliance based collaborative planning for intermediate care (North East Essex, West Essex, Mid Essex, South East Essex & South West Essex)
- County-wide joint finance meetings to discuss financial planning and alignment

- County-wide planning group for continuing care and a joint transformation programme in Mid & South Essex
- Joint commissioning of the North East Essex Integrated Community Service Alliance led by North East Essex CCG
- Joint commissioning of the Essex Equipment Service led by Essex County Council for Mid & South Essex and North East Essex
- Joint planning and development work with District and Borough Councils on use of the Disabled Facilities Grant
- Joint planning groups with District and Borough Councils on independent living and move on from supported accommodation
- Joint strategies for Autism, Mental Health, Suicide Prevention, Carers and Dementia
- Joint dementia commissioning team employed through Essex County Council covering North East Essex, West Essex, Mid Essex, Castle Point & Rochford and Basildon & Brentwood
- Joint suicide prevention - planning and oversight group for Southend, Essex & Thurrock

As part of the new ICS arrangements, we will be reviewing the current governance, commissioning and financial alignment.

Supporting Discharge (national condition 4)

The Connect Programme

The Connect Programme brings together ECC, NHS and Newton Europe and comprises 5 workstreams, 4 of which directly relate to hospital flow. The programme will improve system flow, prevent avoidable admissions into hospital, reduce admissions into residential care, and improve the efficiency and effectiveness of reablement services.

The programme is introducing new processes to improve flow and effectiveness within ECL's Reablement service, supporting 1200 more people to use a more effective service each year. It is embedding more independent decisions on discharge from hospital and short-term beds to enable 240 more people home every year and reduce length of stay in interim beds for adults.

It includes an acute-based trial to reduce inappropriate use of interim bed pathways when home is a suitable and safe alternative through:

- Advanced planning in the acute to ensure that ideal outcomes can be realised as often as possible, by removal of blockers and targeted actions during a patient's stay.
- MDT meetings across Health & Social care to agree the ideal pathway on discharge. Multidisciplinary working to maximise a strengths-based approach throughout. Patients going home when deemed appropriate by teams sharing knowledge and expertise.

These are now live across all 5 acute hospitals in Essex, underpinned by an improvement cycle ethos.

The Programme is also working with ASC Discharge to Assess (D2A) Teams to reduce Length of Stay and improve outcomes from interim beds through:

- Live Allocation of Social Worker upon discharge and first contact with family/individual within 48 hours.
- Working with health therapy and community nursing provision, to ensure adults' goals and needs are understood and met whilst in interim bedded care.
- Weekly review meetings with ASC, Community Therapy (currently in some areas but not all) and Provider where plans for every adult are discussed with a clear understanding of aims and progress.
- Making sure every adult is progressing to their most independent outcome, at a time that is right for them.

This activity is live in all quadrants of Essex, underpinned by an improvement cycle ethos.

Working with ECL, our Reablement Provider, to improve flow and effectiveness within the service by:

- Supporting ECL to be more focussed on identifying and meeting the outcomes of adults in their service.
- Introducing new methods to identify, meet and track the therapy needs of adults in their service.

- Introducing new processes to recognise when an adult is ready to exit Reablement, and to support a timelier and more seamless exit into the Care Market.
- New 'Early MDTs' to identify and agree actions to support adults with complex health, care or social needs.

Connect has provided a *single version of the truth* in terms of discharge outcomes by pulling together multiple data sources. This creates a positive culture through measuring the percentage of people returning home from an interim setting. Our data already shows us that:

- 1 in 5 people previously discharged to an out-of-hospital bed in MSE now go home instead.
- 55% of people plan to go home from an interim placement with the support of our D2A pilot (previously 25%).

As well as the Connect Programme our approach to improve outcomes for people discharged from Hospital includes the following components:

Investment in bridging, ILOR and reablement surge capacity	We are working on our reablement offer to improve the efficiency of reablement services (by reducing length of stay in the service) and improve the effectiveness of the service (by reducing ongoing care needs for people leaving the service), with an ambition of creating capacity for an extra 1,100 people to benefit from reablement per year. We are also increasing Reablement surge capacity through further contracts across the county with 'in lieu of reablement providers' as well as bridging services in each area, to reorientate people in their own homes while they wait for reablement support to commence.
Designated settings	We are working with a care home to provide a Covid Positive Designated setting within the administrative boundaries of Essex. This setting is to support the safe discharge of Covid Positive adults from hospitals who are medically optimised yet testing Covid positive which is preventing them from returning home until their isolation period is completed. The designated setting is ensuring strong infection prevention, protecting care homes and communities and allowing the necessary flow within the acute and community hospital sector. Capacity is currently being maintained with options of increasing if required.
Care Provider Hubs	Care provider hubs have been developed to support Care Homes to be in the best position to accept admissions from hospital. This was implemented across Essex in response to the pandemic, changing guidance, infections control procedures etc. but will continue to deliver going forward to provide ongoing support to the Market.
LAPEL	We have developed a LAPEL system to support our ability to respond to and communicate the level of pressure within the system. In Essex we are operating at LAPEL 3. This is mainly due to pressures in the domiciliary care market. A variety of different intelligence is triangulated to support decisions on LAPEL level. Escalation on LAPEL triggers a different pace and focus to our response as well as supporting prioritisation of capacity within ECC.
Care home vaccinations	Vaccinations will also support improved discharge in Essex. By combining this requirement with annual flu vaccinations, care staff should be in the most protected position possible to support vulnerable people, including those being admitted from hospital. Current rates of vaccinations are at 95%.

We also have plans in place to review bottlenecks and challenges in the system and a review of how the D2A process is working throughout winter 2021. This will determine recommendations going into 2022/23 to improve pathways even further. Other Initiatives to support discharge include:

- Growing provider of last resort capability
- Collaboration across the system via escalation meetings
- Work to coordinate voluntary sector offer across health and social care
- Interim placement beds – mini competition under IRN to secure capacity. Work underway to ensure wrap-round support to maximise independence and move people back home.
- Prioritisation of placements for domiciliary market
- PPE and infection control processes in place and supported through care hubs

- Workforce initiatives – link to ECC economic growth, summit with Essex Carers Association to explore most effective means of incentivising people to take up a career in health and/or care.
- DFG housing OTs - Timely discharges from hospital are made possible through the DFG, shortening the amount of time people remain in hospital. Progress is monitored through these early returns to home.

These countywide initiatives are also supported by more focused ambitions to improve discharges at local level:

North East Essex

The ambition is for local community health and care services to work together, to care for people in their own home wherever possible. This is essential if everyone in Suffolk and North East Essex is to live well and age well. They commit to ensuring that:

- People in health crisis or recovering from ill-health have the health and care support they need, within their own homes wherever possible
- Care and support is provided in the local community and by integrated services
- People living in care homes have access to healthcare support when they need it

Mid Essex

The following iBCF schemes directly contribute to improving discharges:

- Trusted Assessor – Trusted Assessor posts based at Broomfield Hospital to support with increased discharge time of Adults into ECL reablement.
- Continuing Health Care Dedicated Social Worker - Social worker post to support with leading on continuing healthcare assessments, supporting with decreased discharge times, access to CHC funding and integration with health partners involved with continuing healthcare.
- Admission Avoidance supported by the UCRT initiative
- Community Hospital Flow

West Essex

The Vision of an out of hospital strategy and model is for a Health and Care system that helps people to stay well. When patients need health and social care, we meet that need together to provide the most effective care in the best setting. Specific initiatives funded through the iBCF focused on Discharge:

- Admission Avoidance - To support the adult to remain in the community and their own home during a period of crisis. This supports adults who may have turned up at Emergency Departments and without this service it would have led to the adult having a 24hrs – 48hrs assessment period or admission within an acute setting
- Impartial Assessor - an intermediary between the care home and acute hospital and will support the adult's discharge back to the care home including undertaking nursing needs assessment on behalf of the home.
- Care Home Facilitator - supports the adult and carer to find a suitable care service that meets those needs and is targeted at those who are self-funded and who without this support would have longer stays in hospital
- Care Home Hub Operation and transformation - To support the care homes and implement new initiatives that include the management of discharges and readmission to hospital.
- Development of a Care Co-ordination Centre Development – to manage all discharges from the hospital; prioritise system capacity to meet demand and proactively manage the adult through their pathway. This is being explored with support from ECIST/LGA to work with PAH to embed criteria to discharge and monitor impact of any changes.

South East Essex

A renewed focus on discharge has been supported through various workshops to understand where improvements could be made. Potential improvements to the discharge process include:

- Specialist Support for end of life with the aim of reducing admissions and readmissions.
- Integrating Occupational Therapy into D2A Team with a view to reducing readmissions.
- Discharge Link workers to improve and accelerate the discharge process.
- Business brokerage to support the emerging Transfer of Care Hub.
- Additional Support for ageing carers with the aim of reducing readmissions.
- Discharge Guidance for Carers.

- All Family Approach to social prescribing.
- Commission research into reasons for readmission / root cause analysis.
- Transformation Resource to help develop the role of the South East Essex Alliance
- Social care input within Urgent Care response Team.
- Care coordination Centre across partner organisations within the community.

South West Essex

Bridging is a key scheme in Basildon and Brentwood focused on improving discharge pathways. The purpose is to 'Bridge the Gap' between hospital discharge and care support in people's homes. The development of neighbourhood teams aligned to Primary care networks is also a key initiative to provide timely and well-coordinated responses to need. A joint post between the community provider and local authority is in place and team alignment along with multidisciplinary working is taking place within each PCN.

Disabled Facilities Grant (DFG) and wider services

DFGs are grants offered through the Better Care Fund to Essex County Council, who then distribute to all District and Borough councils to make adaptations to the home for residents to live as independently as possible. The allocation of funds differ between each authority. The Government, through the BCF, has allocated to Essex for the 2021/2022 financial year; £11,885,443 for DFGs, which is an increase of nearly £1.5m from last year's allocation. The highest allocation amount is for Tendring with £2,320,471 and the lowest amount is for Uttlesford with £235,576 with an average of £990,454. The agreed allocations have been passed on to district councils in their totality.

An MOU sets out that Essex Districts, County Council, Health and Care partner organisations need to work better together and commits to supporting and delivering housing solutions that have a positive impact on residents.
The MoU sets out:

- Our shared commitment to joint action across health, social care and housing sectors in Essex;
- Principles for joint working to deliver better health and wellbeing outcomes and to reduce health inequalities;
- The context and framework for cross-sector partnerships, nationally and locally, to design and deliver:
    - healthy homes, communities and neighbourhoods
    - integrated and effective services that meet individuals', carers' and their family's needs
- A shared action plan to deliver these aims.

Working together, we aim to:

- Establish and support local dialogue, information exchange and decision-making across health, social care and housing sectors
- Enable improved collaboration and integration of healthcare and housing in the planning, commissioning and delivery of homes and services
- Promote the housing sector contribution to addressing the wider determinants of health; health equity; improvements to patient experience and outcomes; 'making every contact count'; and safeguarding.

Oversight and delivery of this agreement is through the Essex Well Homes Group, which will be the operational arm of the action plan with further oversight by local Health and Wellbeing Boards. The Essex Well Homes Group meets quarterly and has membership from each local authority, including ECC, as well as Housing OTs. In this forum, all DFG matters are discussed, looking at short-, medium- and long-term plans to ensure the DFG funding is being utilised as well as possible.

ECC and Essex district and brough councils have invested in 4 Senior OTs in Housing roles to ensure assessments are made in people's homes and that DFG applications are passed to the relevant local authority in a timely manner. Timely discharges from hospital are made possible through the DFG, shortening the amount of time people remain in hospital. Progress is monitored through these early returns to home.

Keeping residents out of accommodation where they are not having their needs best met is also a priority. An example of this would be residential care, where in some cases residents are not able to maintain independence whilst being 'stuck' in a residential setting. A DFG can allow the resident to return home with the right environment made for them. By investing a DFG through the BCF, Essex health and social care can make a saving by ensuring residents can return home rather than remain in a residential setting.

Equality and health inequalities.

An Equalities Impact Assessment has been completed for the Essex Better Care Fund Plan:

There is a strategic ambition in Essex of Levelling Up. As a system we will seek to reduce health inequalities by bringing together partners and communities to address the socio-economic drivers that underpin poor health outcomes, such as poor housing, poverty, economic insecurity, and low skills. This ambition crosses boundaries between health and care partners and ensures that place-based organisations and communities become the focus.

One area of focus for reducing inequalities and levelling up is Digital Inclusion. We have established a digital inclusion working group to establish what is currently being delivered in this space and identify where opportunities to make a difference may exist. We are focussing our attention in 3 key areas to support the development of our DI Strategy: Digital Skills; Digital Access and Community Mobilisation.

Another area of focus has been on Social exclusion to understand those that are "left behind". Through working with Oxford Consultants for Social Exclusion and their community needs index we have a better understanding of the position of our communities. This shows that a significant % of Essex wards score poorly on the community needs index i.e. they struggle for community assets, connectedness to services and civic participation.

In addition, there are some *Left Behind Areas* in Essex. These communities are in the 10% worst nationally for the community needs index and also the 10% worst scores nationally for deprivation. There are 12 wards in Essex classed as left behind: 8 in Tendring and 4 in Basildon. By comparing areas with similar levels of deprivation but different levels of community assets over the last 10 years, it is possible to see the challenges that left behind areas face versus areas of very similar deprivation. For example, left behind areas have almost half the job density as other similarly deprived wards that score better on the community needs index.

The analysis highlights multiple challenges for *Left Behind Areas* all of which need to be addressed to truly address inequalities:

- A lack of local job opportunities and poor access to centres of employment
- Low skills and attainment, leading to relatively high levels of low income and worklessness
- Poor health outcomes
- More vulnerable groups, including households with multiple and complex needs, carers, lone pensioners, lone parents and people with long-term health conditions; as well as those experiencing long term barriers to employment
- Neighbourhood challenges, including higher levels of crime and a lack of affordable housing
- A growing gap between left behind areas and other deprived areas
- A lack of community and civic resources to address and mitigate these issues

Inequalities boards have been created across Essex with a focus on addressing health inequalities and the causes of them. Many factors determine health and care outcomes and about 80% of health outcomes are determined by non-health services. This is often referred to as the 'wider determinants of health' and includes factors such as employment, housing, education, community safety, the built environment and personal lifestyles.

Anchor Institutions. The pandemic has had a significant impact on Essex's economy, particularly those who were already within our most disadvantaged communities, causing widening gaps in inequalities and contributing to poor public health. Anchor Institutions are in a unique and important position to be able to maximise their location, resources and spending power and address these challenges, improving the health of local populations and bringing benefits to all. Anchor Institutions can also develop a strong, local economy that is more self-sustaining, independent, and therefore more resilient to future challenges within the global market.

Anchor Institutions have several levers that they can influence to help shape the local area, these are:

- Workforce development – shaping and developing the skills of the local workforce.
- Employer –employing locally and improving the wellbeing of their employees.
- Local business incubators – supporting SMEs to encourage growth and innovation within them.
- Procurement of goods and services – increasing social value through procurement.
- Estates and environment – ensuring estates include community, health and environmental benefits.

The Essex system is committed to supporting delivery of anchor programmes across Essex. This includes working through Essex Partners Board to establish The Essex Anchor Network co-chaired by Ian Davidson, CEO of Tendring District Council and Ed Garratt, Executive Lead, Suffolk & North East Essex Integrated Care System. The Network provides a platform for members (representing all ICS partners in Essex) to work collaboratively on shared strategic priorities and support each other to unlock their full Anchor potential. This Board provides direction and oversight of local anchor groups and programme boards.

Information, best practices and learning experiences are disseminated into the wider system to facilitate and promote engagement across Essex, thereby extending the impact and outreach of each Anchor's work across different geographical areas and organisation sectors. The network:

- Connects anchors, countywide activity, organisational projects, and local initiatives
- Directly delivers key anchor partnership initiatives and provides support to local anchor projects
- Monitors delivery, utilising the system scorecard
- Develops communications and engagement material to support learning from anchor practice across Essex and the rest of the UK.

Through the anchors network we are also establishing small working groups to take forward priority programmes:

Employability Programmes	Working group chaired by Ian Tompkins, Director of Corporate Services, NHS West Essex Clinical Commissioning Group. Will look at learning from and building on existing employability programmes, promoting the public sector as an employer and supporting people into roles in anchor organisations, whilst developing a workforce that have the transferable skills we require. Initial discussions of the group focused on: • The potential for a shared recruitment campaign promoting the breadth of roles in local anchor organisations and the benefits of these organisations as employers • A public sector employability programme to support people into common roles across our organisations, for example administration or facilities management.
Inclusive Employment	Working group chaired by James Rolfe, Chief Operating Officer, Anglia Ruskin University, will be exploring the practices anchors can adopt to make them more inclusive employers. Two initial areas of work will be: • Reverse Jobs Fair – Increasing inclusive employment across the county through events that highlight the talent within these groups. During Reverse Job Fairs employers circulate the job seekers' stands, giving those individuals (including those with diverse disabilities) the opportunity to demonstrate their skills and abilities in a supported environment. • Inclusive Employment Job Coaches – Providing Employment Practitioner Apprenticeships to organisations so that they may support their own employees to address and overcome obstacles, therefore helping these individuals to secure and maintain employment.