



Mid and South Essex
Health and Care
Partnership

Our 5 Year Strategy & Delivery Plan



Working together for better lives



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Welcome from the Independent Chair of the Mid & South Essex Health & Care Partnership

As the newly appointed Independent Chair of the Mid & South Essex Health & Care Partnership, I am delighted to present this strategy to you. Over the past three years, the Partnership has had many successes. I hope you will see from our strategy that we plan for our Partnership to go from strength to strength.

We recognise that an individual's ability to live a happy and healthy life is heavily impacted by factors such as housing, education and employment. We want our communities to thrive, for our residents to manage their own lives and to help each other. That's why we are changing the way we work to address these wider determinants and to support people to live well.

Of course, we still must make sure that our health and care services are there for people when needed and offer a high quality, easily accessible route to getting help.

We have already started to reform and improve our acute hospital services. We have bold plans for redesigning the rest of the health and care system through our four places, with primary care networks as the bedrock of person-centred care and support.

An important part of our development will be to achieve Integrated Care System status – and we are working to achieve this by April 2021.

I commend this strategy to you and I look forward to working with our partner organisations to deliver our ambitious programme of improvement.

Professor Michael Thorne
Independent Chair
Mid & South Essex Health & Care Partnership

About this Document

This document is in two parts;

Part 1 describes our vision and objectives for the further development of our Health and Care Partnership; it sets out how, by working together, we expect to improve the health and wellbeing of our 1.2m residents.

It also provides detail on our operating model, and the role of our four places and primary care networks.

Part 2 provides a more detailed delivery plan, outlining how the Partnership will work to deliver the commitments in the NHS Long Term Plan. It also describes the work we will undertake to achieve Integrated Care System designation, in order to bring further benefits for our residents and staff.

DRAFT



Mid & South Essex Health & Care Partnership – who we are

The Mid and South Essex Health and Care Partnership serves a population of 1.2 million people, living across Braintree, Maldon, Chelmsford, Castle Point, Rochford, Southend, Thurrock, Basildon and Brentwood.

Our Partnership comprises the following partners:

Over **150** GP practices, operating from over **200** sites, forming **28** Primary Care Networks.




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

Mid Essex
390k population

9 Primary Care Networks:
3 - Chelmsford
2 - Braintree
2 - Maldon/Chelmsford
1 - Maldon/Braintree
1 - Braintree/Chelmsford



3 top tier local authorities
and **7** district and borough councils



3 Healthwatch organisations



Nine voluntary and community sector associations



Five clinical commissioning groups

Three main community and mental health service providers



Basildon & Brentwood
276k Population

6 Primary Care Networks:
5 - Basildon
1 - Brentwood



One ambulance trust

Thurrock
176k Population

4 Primary Care Networks:
Tilbury & Chadwell
Grays
Purfleet
Corringham

South East Essex
370k Population

9 Primary Care Networks:
2 - Castle Point
2 - Rochford
5 - Southend

Our Population

Our public health teams have created a Mid & South Essex Population Profile (see appendix 1) to describe our population in detail. The following headlines provide an overview for our area - but mask sometimes significant differences across the areas. The details contained within the profile pack, along with the Joint Strategic Needs Assessments and strategies of our three top tier Health & Wellbeing Boards, has helped to define our priorities.

Demography

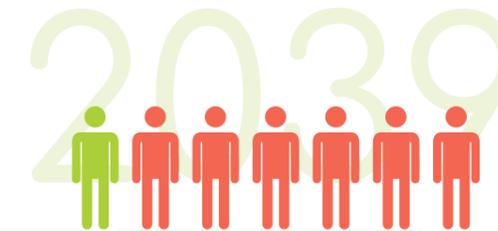
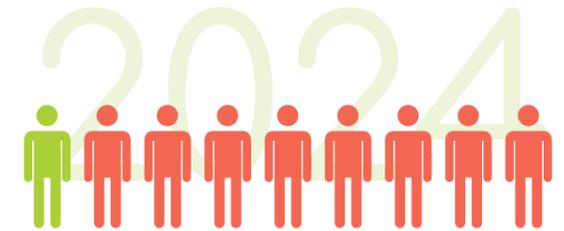
5.22%

// The total population size of Mid and South Essex is projected to increase by 5.22% over the next 5 years and 14.70% over the next 20 years.

14.70%



// In 2017 1 in 12 people were aged over 75; this is estimated to increase to 1 in 9 by 2024 and to 1 in 7 by 2039.



// Over the next 5 years the largest increase is forecast among 75 – 79 year olds. By 2034 the largest increases are forecast for the 90+ years population.

90+

0.59 YEARS

// The life expectancy gap between local authorities has decreased by up to 0.59 years among males and 0.35 years among females, but there is still variation even within boroughs/districts.

0.35 YEARS

Education, Employment & Prosperity

- // Deprivation has increased across the 1.2m population
- // Overall Essex is performing worse than national comparisons for reading and maths scores creating a disadvantage for future schooling and ultimately skills for work
- // The productivity gap is increasing between mid and south Essex and national comparators.
- // Homes have become up to 58% less affordable over the last decade.

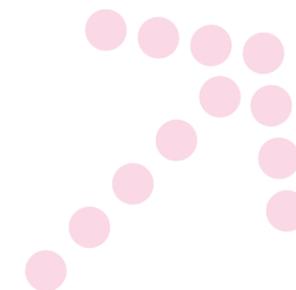


58%



Health Behaviours & Outcomes

- // There are high and increasing proportions of overweight or obese adults.
- // There are increasing numbers of overweight or obese children in early years schooling
- // Some areas have high and increasing rates of Coronary Heart Disease, Hypertension, Stroke, Diabetes and Chronic Obstructive Pulmonary Disease
- // More people in this area die from cancer, heart disease and liver disease than expected
- // More people are being diagnosed with dementia
- // Mental health conditions are increasing in adults and children and in some areas suicide rates are increasing



Health and Wellbeing Board Strategies

Our Health and Wellbeing Boards are important partners and their agreed priorities are aligned with this strategy.



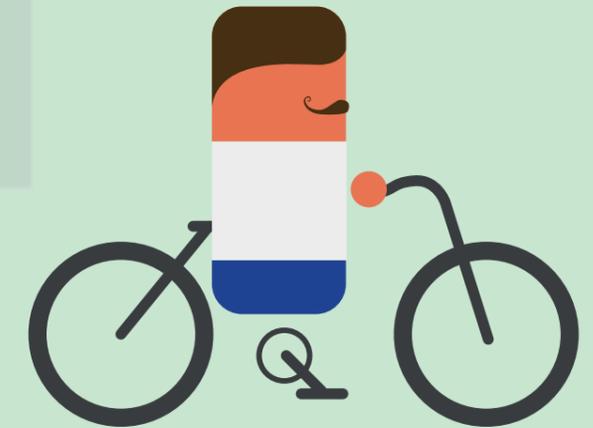
Thurrock HWBB Priorities

- // Opportunity for all
- // Healthier environment
- // Better emotional health and wellbeing
- // Quality care, around the person
- // Healthier for longer



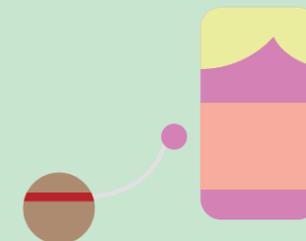
Essex HWBB Priorities

- // Improving mental health and wellbeing
- // Addressing obesity, improving diet and increasing physical activity
- // Influencing conditions and behaviours linked to health inequalities
- // Enabling and supporting people with long term conditions and learning disabilities



Southend HWBB Priorities

- // Increasing physical activity
- // Increasing aspiration and opportunity
- // Increasing personal responsibility and participation



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

This means:

Healthy Start – helping every child to have the best start in life

// supporting parents and carers, early years settings and schools, tackling inequality and raising educational attainment.

Healthy Minds – reducing mental health stigma and suicide.

// supporting people to feel comfortable talking about mental health, reducing stigma and encouraging communities to work together to reduce suicide

Healthy Places – creating environments that support healthy lives.

// creating healthy workplaces and a healthy environment, tackling worklessness, income inequality and poverty, improving housing availability, quality and affordability, and addressing homelessness and rough sleeping.

Healthy Communities – which spring from participation

// making sure everyone can participate in community life, empowering people to improve their own and their communities' health and wellbeing, and to tackle loneliness and social isolation

Healthy Living – supporting better lifestyle choices to improve wellbeing and independent lives

// helping everyone to be physically active, making sure they have access to healthy food, and reducing the use of tobacco, illicit drugs, alcohol and gambling.

Healthy Care – joining up our services to deliver the right care, when you need it, closer to home

// from advice and support to keep well, through to life saving treatment, we will provide access to the right care in the best place whether at home, in your community, GP practice, online or in our hospitals.

Delivering Our Vision

The health and wellbeing of people in some of our areas is much poorer and on average people die younger there than in other areas. As a Partnership our overriding aim is to change this.

We have set four ambitions to help us achieve this aim:

1. Creating Opportunities

For our communities to thrive we need good education, opportunities for employment, decent housing and a vibrant local economy. Our Partnership represents some of the largest employers and purchasers of goods and services locally, so we have an important role to play. By working together, we can harness these opportunities for the benefit of local residents.

2. Supporting Health and Wellbeing

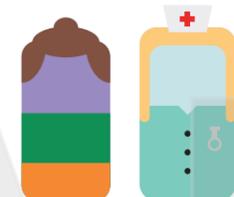
By working in different ways and in closer partnership with our communities we can do more to prevent the things that cause poor health and mental illness. Up to 40 per cent of ill health can be avoided so by getting a grip on issues sooner we can stop them becoming bigger problems in the future.

3. Bringing Care Closer to Home

Joining up our different health, care and voluntary sector 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.

4. Improving and Transforming Our Services

We want to make sure our residents have the highest chances of recovery from their illness or condition, and to give them the best treatment we 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 and avoid more serious illness.



Executive Summary

The way we live and the lifestyles we lead have changed a great deal over the years.

Our population is growing, new technology is being developed and research into the things that can affect our wellbeing is providing new answers.

We are living longer, but not all of those extra years are spent in good health and some of our communities experience significantly poorer health than others. Our health and care staff are also under a great deal of pressure, coping with increased demand for our services.

All of this means the support and help we sometimes need to lead a happy and healthy life must change and adapt too.

We want our residents to have a good quality of life, from education and employment opportunities, to making better choices about being active and what they eat.

We are changing the way we work together as organisations to harness the power our communities and residents have to take more control of their lives and wellbeing.

Part 1 of our five year plan sets out our goals, priorities and the actions we want to take to play our part in improving the health and wellbeing of people living in our cities, towns and villages right across mid and south Essex.

Starting with you, your family and social networks, the first section of our plan describes how we will make it easier to find out about ways to prevent you from becoming unwell and where you can get support to make the changes you need to improve your health

If you have a long term condition such as diabetes or breathing problems, you will be able to work together with range of health and care professionals to explore the support you need to manage your health and prevent more serious illness developing.

To do this we are setting-up teams comprising different health and care professionals to provide joined up care. These teams will include GPs, social workers, pharmacists, district nurses, mental health workers, physiotherapists and colleagues from the voluntary sector, working together in Primary Care Networks.

Supporting Primary Care Networks will be four "Place", partnerships covering South East Essex, Thurrock, Basildon and Brentwood and Mid Essex. These will bring together groups of Primary Care Networks, with local council teams, community and mental health service providers, the hospital teams serving that location and voluntary sector partners to ensure the health and care needs of their local population are met.

In Part 2, we explain how we will deliver the commitments set out in the national NHS Long Term Plan (LTP) for improving care for major health conditions (www.longtermplan.nhs.uk)

We set out the actions we're taking to improve care for conditions such as cancer, mental health conditions, cardio vascular disease, diabetes and for people at key points in their lives, for example having a baby or at the end of life. These include:



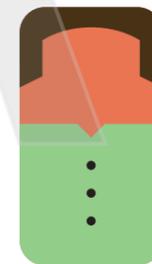
Prevention – see section 9

- // our work on prevention for major health conditions including cancer, diabetes, and cardiovascular disease
- // work on reducing childhood obesity through the adoption of the Daily Mile across our schools
- // increasing physical activity in adults, linking with Sport England and Active Essex



Cancer - see section 14

- // introducing a new test to help detect and diagnose bowel cancer earlier, so we can treat people quicker and improve their health outcomes
- // setting up a Rapid Diagnostic Centre for patients with non-specific symptoms which could indicate cancer
- // becoming a pilot area for the National Targeted Lung Health Check to support earlier diagnosis of lung cancer



Mental Health – see section 15

- // creating safe places for people to walk-in such as community cafés, where they can find emotional support when they feel their anxieties or other mental health problems are escalating
- // setting-up mental health support teams in schools to provide therapy and support to children and younger people
- // improving how we support people with a personality disorder at an early stage, so that they can manage their condition and are less likely to need to go to hospital



Cardiovascular disease – see section 19

- // focusing on atrial fibrillation (irregular and often abnormally fast heart beat) to improve earlier detection and treatment to prevent stroke
- // reviewing existing patients to ensure their medication is appropriate
- // improving access to specialist care at the Essex wide Cardiothoracic Centre, with more patients requiring an angiography being seen within 72 hours.

**Diabetes** – see section 22

- // rolling-out the NHS Diabetes Prevention Programme to provide personalised support to people to reduce their risk of developing diabetes
- // reducing the impact of diabetes among harder to reach/less engaged groups
- // piloting the MyDiabetes app with 500 newly diagnosed Type 2 diabetics to support them to understand and better manage their condition and reduce the risk of more serious complications developing

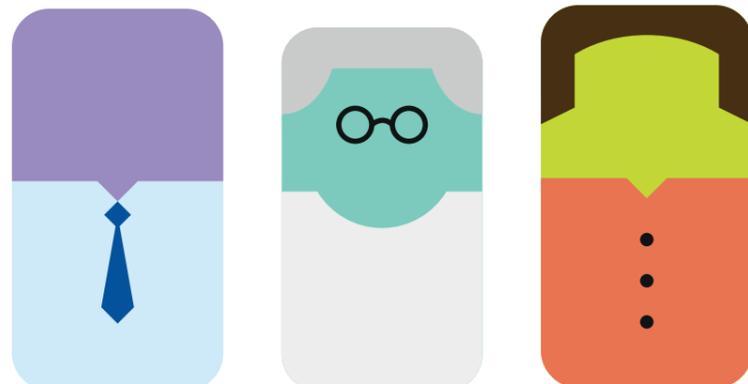
**Maternity** – see section 25

- // launching the Maternity Direct App to allow mums-to-be to speak online with an NHS midwife about non-urgent concerns at anytime
- // creating personalised care plans to support women to have choice and opinions about the care they receive
- // reviewing our current perinatal mental health services to make it easier for those in need to access support and care.

We have also set out our ambition to become a fully Integrated Care System for our 1.2 million residents, by 2021 as set out in the NHS Long Term Plan. This will bring significant benefits to our area through more funding and joined up planning to avoid wasteful duplication.

Overall though, our plan isn't just about the NHS because we need to think wider than that. By linking up with our local councils, social care teams and voluntary sector organisations, we can look at the impact housing, our environment and air quality have as well as how we can prevent ill health in the first place by identifying earlier those people at risk, and also provide support for those who have a long-term illness.

We all have a role to play – as public services, as individuals, families and communities - all taking responsibility to think differently about our health and wellbeing and working together for better lives in mid and south Essex.



Part 1: Our Strategy

1. Foreword and Introduction

The Mid and South Essex Health and Care Partnership (the Partnership) comprises the key NHS and Local Authority organisations covering the mid and south Essex area. Our ultimate aim is to reduce the inequalities that our residents face.

Through working in partnership over recent years, we have made good progress – for example:

In primary care:

- // We are investing in primary care to address the significant challenges faced relating to demand for services, the availability of professionals to support patients and updating our buildings and infrastructure. Additional monies will be invested in primary care over five years to enhance the primary care workforce with new roles and enable patients to access a wider range of services locally. Patients will have full digital access to primary care through on-line consultations, appointment booking and prescription ordering.
- // We have established 28 Primary Care Networks (PCNs), which are groups of general practices working together across populations of 30-50,000 patients. These networks form the basis for local collaboration and integration of services. Clinical Directors for each network have been appointed.

In our community & mental health services

- // We have a pan-Essex Mental Health and Wellbeing Strategy, which puts mental health at the heart of all policy and services in Greater Essex, outlining work with our communities to build resilience and emotional well-being, and ensuring that anyone with a mental health need can access the right service at the right time. We have strong plans in place to improve urgent and crisis mental health services.
- // Our emotional health and wellbeing service for children and young people is well established and using innovative ways of delivering services, including mental health teams working across schools.
- // Our community physical and mental health teams are working closely with primary care and voluntary sector organisations to collaborate and join services around the needs of the local population.
- // Our community teams are working in an integrated way to support keeping people at home, and ensuring timely, safe discharge from hospital.
- // There is already significant integration between health and social care services at place level and we will develop this further over time.

In our hospitals:

- // Our consolidated clinical strategy across the three acute hospitals is reducing unwarranted variation in access and service quality, improving our specialist services and addressing significant workforce challenges.
- // Our plans for improving services have been approved by the Secretary of State for Health and Social Care and we have commenced a programme of service redesign to improve services for our patients.
- // We secured £118m capital funding to support improvements to our estates and infrastructure across the hospitals to enable these changes to take place.
- // Work with our Cancer Alliance has seen significant investment in transforming our cancer services and supporting early detection – with a pilot Lung Health Check programme in Thurrock.
- // We have also been selected as a Rapid Diagnostic Centre pilot, bringing faster diagnosis and treatment of cancers for our residents.

In clinical & professional leadership

- // We have strong clinical engagement and leadership in developing our plans and ensuring the quality and safety of services.
- // Clinical leaders have been identified for all of our transformation programmes.
- // Our clinical leaders have opportunities for development through quality improvement and leadership fellowships.
- // Our Primary Care Network Clinical Directors are benefitting from specific development targeted to their new roles as system leaders.

In engagement with our residents:

- // We have strong engagement with our communities through all of our organisations and ensure that insight gathered through engagement is used to full effect
- // We work closely with our Healthwatch organisations.
- // We link closely with community groups and voluntary sector organisations at local level. Our CCGs have strong patient participation forums to bring the local voice to primary care development.

In supporting our workforce:

- // We have built strong foundations for ensuring effective recruitment and retention across our health and care services, including the development of new roles, a preceptorship programme for newly qualified nurses, and opportunities for staff development.
- // Our local medical school at Anglia Ruskin University will support our ambitions to grow a local medical workforce.
- // We have implemented a range of innovative solutions to meet our workforce challenges – this includes the introduction of trainee nurse associates, physician assistants, and apprentices.

In using our estate effectively

- // We have developed a system-wide estates strategy that ensures we are working together to make best use of our buildings and infrastructure, and ensures that we are planning for housing growth in a strategic way and utilising available development funding to support our communities.

In digital transformation

- // Our digital plans include the development of an Integrated Shared Care Record, so that all health and care professionals working with residents will be able to see their records. This will support more coordinated care and enable our health and care professionals to do their jobs better.

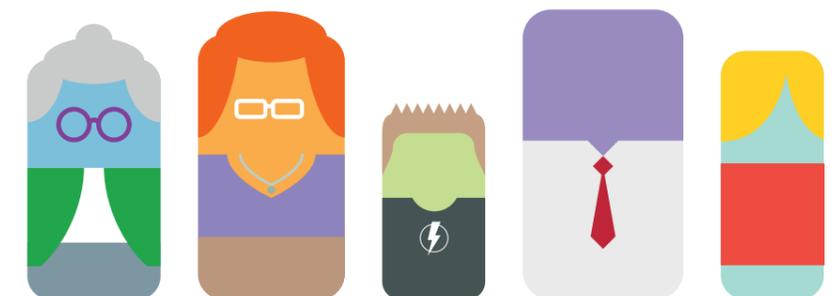
In research & Innovation:

- // Our strong work on innovation has enabled us to develop and support our staff to introduce new techniques, products and services that benefit our residents.
- // We have agreed a way of working with industry partners to ensure our residents can benefit from cutting edge technologies and innovations.
- // We have excellent links with our academic partners, including UCL Partners and the Eastern Academic Health Science Network, bringing new ideas and innovations to improve services for our residents.

While we have had many successes, we know that there is much more to do. Traditionally, we have provided services in relative isolation, focussed on specific organisations and resulting in fragmentation and a variable experience for our population. We have also not always fully considered the impact of the wider determinants of health (such as housing, education, employment), and how, by working together, we can impact on these issues in a positive way.

The challenge, and therefore the opportunity, is to support individuals and communities to proactively use their strengths and assets. By working together, we can plan for our workforce, enhance our digital capabilities and take advantage of opportunities for research and innovation, using the wealth of data we collect to maximum effect, and ensure that we are making best use of our resources, delivering efficient and effective services.

We believe that coming together as an integrated care system will enable us to deliver for our residents.



2. What have our communities told us?

There are 17 organisations in our Partnership, which together link with and represent a vast range of organisations and networks.

Each of those organisations engage regularly with local residents or citizens, including those who use local health and care services in a variety of different ways and we are committed to ensuring those voices are reflected in the programmes of work we undertake together.

Since the start of our Partnership, we have undertaken a wide ranging programme of engagement as well as a recent full-scale public consultation. As a collective, we engage regularly with thousands of people across the local area, so it is important to note we are not starting our engagement with residents from scratch and we have a wealth of expertise via local place engagement networks, patient reference groups, and community forums which has helped us to maximise our existing engagement mechanisms without duplication of effort and cost.

The bespoke engagement around the NHS Long Term Plan, provided for us through our local Healthwatch organisations, gave the opportunity to continue conversations on the future of health and care in our area and is to be welcomed alongside the willingness of the community to seek greater understanding and become more informed. The report from this engagement is provided at Appendix 2.

What we have heard

We've heard from and spoken to lots of local people, organisations and health and care professionals to help develop our plan over a number of months. Here is a summary of what we have heard and how we are responding.

We should do more to support people to stay healthy and well, and prevent people from getting ill.

Our approach to prevention will have a focus on children and young people, together with support for parents and carers, and on building active and involved communities.

We have committed to addressing the wider determinants of health, such as housing, education and income through our Partnership, recognising it takes everyone to join forces and tackle inequalities if we are going to make a real difference.

People don't want to have to repeatedly tell their story to different health and care professionals.

Our plan describes how we will better coordinate the different professionals and services supporting individuals, working with them to shape their care, in locally-based teams to deliver personalised care. We are also developing a shared care record which will enable all professionals to access to vital information when they need it, to improve how we join up the care we provide.

We aren't making the most of the opportunities that new technology offers to improve people's care.

From the success we have already seen in projects across mid and south Essex we know that investing in technology will help to put people in control of their health and care, while also providing the opportunity to reduce the pressure on our services. We are committed to focusing on digital transformation across health and social care to benefit both our residents and staff.

Recruiting more people to work in health and care, and supporting our workforce must be a priority.

Our plans mean nothing if we do not have a highly skilled workforce, working in dedicated teams to deliver high quality, person-centred care. Our plans set out how we will recruit new people to work in the health and care sector, as well as do much more to retain and develop our existing NHS and social care workforce through the development of new roles and career development.

People have difficulty in being able to get an appointment at their GP surgery.

We have and are continuing to invest in primary and community care so that different health and care professionals work together in teams based around groups of GP practices. This will make gaining access to care and support easier for our residents and presents a real opportunity to make sure our residents get the care they need, delivered by the most appropriate professional; at the time they need it.

Improving mental health care needs to be a priority area.

We want people of all ages to be able to get the help and support they need quickly and easily, so that mental health needs are identified and treated early. We are increasing our focus on prevention and wellbeing, as well as providing enhanced support for people in crisis and providing effective inpatient care.

We should work more closely with local community groups and voluntary organisations.

Our plan is centred on linking everybody in our communities together to help keep people healthy, well and active, to support people when they are ill and care for people when they need help.

It's important we consider travel and transport to and from health services and activities which keep people healthy and well.

We recognise transport can be a barrier to people accessing the care they may need. Our plan aims to ensure our services join-up in the very heart of our communities, to make more support available closer to where people live. And if they need to travel for very specialist care, support is in place for those who need it.

Next steps

The Partnership is committed to do all it can to make sure people's voices remain at the heart of our development and we will continue to build on the excellent work Healthwatch partners and engagement colleagues have done to date.

We are developing a citizens' panel – called Virtual Views, to support us to research and understand the views of a demographically representative sample of our population.

We will also continue to draw on insight, both quantitative and qualitative, gathered within our Partnership member organisations.

Given their multi-agency membership, the Health and Wellbeing Boards across Essex, Southend and Thurrock, both upper tier, and at district level, continue to provide an effective public forum for discussions on local plans and wider challenges.

We have already begun a series of conversations with our community, voluntary sector and service user groups with the aim of co-producing a refreshed engagement framework. This will be an important foundation to deliver the ambition outlined in this strategy to become a fully integrated care system by April 2021.



3. Delivering Our Vision – Our Ambitions



3.1 Ensuring Equality: Addressing Inequality & Reducing Unwarranted Variation

Reducing inequalities is a complex challenge and we are committed to working with our partners to address this. We aim to do this by:



3.2 Creating Opportunities: Education, Employment, Housing & Growth

Tackling wider determinates ~ a system of anchors

As key employers and commissioners of services, partnership organisations are well placed to impact on local economic opportunities and to focus on addressing inequalities. Major areas of opportunity include employment and recruitment practice, local procurement targeted at small and medium sized business, and work with schools and other education providers to encourage educational attainment and aspiration.

Employment and Recruitment.

Basildon Hospital is leading work in this area and is seen as a national lead with a focus on understanding the local job market. The hospital is also working with Essex County Council to support people with learning difficulties to enter the workplace.

Thurrock Council have worked with NELFT to develop a new shared vision of an integrated front line health and care worker, with a defined career pathway. These posts are being recruited to and have proved very popular in offering a new career choice where carer jobs were seen as unpopular. Essex County Council is starting work on how to explicitly recruit from more deprived areas, recognising that there are barriers to accessing work that will need to be addressed.



Working with schools

As large employing organisations with significant workforce challenges, partners are recognising the importance of working with our schools to address aspiration and employment issues, particularly in more deprived areas. The Essex Children's Partnership Board, including head teachers, has endorsed this approach. With support from a public health grant, Basildon Hospital is embarking on an outreach programme to local schools to help improve interest and recruitment to NHS roles.

DRAFT

Case Study:**Enabling Carers to Care – Essex County Council**

Under the Care Act, local authorities have a statutory duty to offer carers assessments and to provide appropriate information, advice and guidance on other forms of support available to promote wellbeing.

Care givers contribute to enabling and empowering their loved ones to stay healthy and live meaningful lives. In Essex, it is estimated over 145,000 people provide care to their loved ones at an estimated value of £822,300,544 per annum.

The commissioning approach for care givers is fragmented across the system. Our research and engagement has identified areas for improvement where we can make a genuine impact on carers' lives and the lives of those they care for. To support this, we designed a strategic framework to underpin how, as organisations and systems, we can support and improve the lives of all care givers, structured around the five A's:

- // Becoming a care giver – 'adopting' the role of a care giver
- // Identifying as a care giver – 'accepting' life as a care giver
- // Living well – 'adapting' to life as a care giver
- // Responding to change - remaining 'alert' to the changing demands of being a care giver
- // Life after caring – 'adjusting' to life after being a care giver

Our plan for the coming months we will see us work with partners to design and implement a Care Giver's Charter to establish commitment across communities to better support people in a care-giving role and implement a cultural change programme to support individual resilience.

We will work with newly formed Primary Care Networks to re-design the community offer for care givers and help develop networks of support around them, including supporting the increased take up of care technology, and developing a digital tool to support carer networks.

**Procurement**

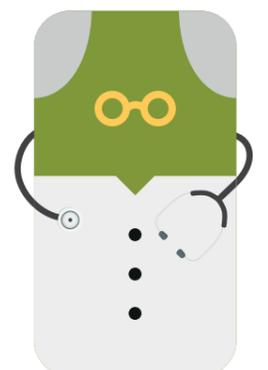
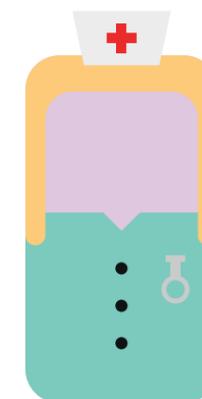
Partners are committed to supporting the local economy and commissioning services locally where possible. Essex County Council perform well compared to other counties with over two thirds of commissioned spend occurring within Essex, and one third with small and medium sized enterprises. As a system we will consider how best we can work within existing procurement regulations to support the local economy and will also consider how to ensure local social value is in contracts, including, for example, the number care leavers or people with physical and learning difficulties employed.

South Essex 2050

The councils of Basildon, Brentwood, Castle Point, Rochford, Southend-on-Sea, Thurrock and Essex County are working together to develop a long-term growth ambition to underpin strategic priorities across the region. The 'South Essex 2050 Ambition' aims to ensure that the local authorities retain control of South Essex as a place, putting them in a strong position to shape and influence wider plans and strategies from government and other investment priorities.

In January 2018 the local authorities formed the Association of South Essex Local Authorities (ASELA) to ensure implementation of the ambition. The association will focus on the strategic opportunities for the south Essex economic corridor to influence and secure the strategic infrastructure that will help our communities to flourish and realise their full economic and social potential. The aims of the association are to:

- // Develop a strategy to open up spaces for housing, business and leisure development;
- // Transform transport connectivity;
- // Support industrial opportunity;
- // Shape local labour and skill markets;
- // Create fully digitally-enabled places;
- // Secure a sustainable energy supply;
- // Influence and secure funding for necessary strategic infrastructure; and
- // Enhance health and social care through co-ordinated planning.





3.3 Health & Wellbeing: Healthy Lives & Healthy Behaviours

Through partners working together, we aim to support individuals to live healthy lives through:

- // Providing information and support for people to self-care including through on-line and digital options.
- // Focusing on prevention of ill-health by:
 - // Providing good housing through the Local Plan of each local authority, with a particular focus on the quality of housing
 - // Improving diet and increasing physical activity by building on the "Livewell" and "Active Essex" initiatives, and targeted investment from Sport England.
 - // Weight management services supported by a range of community-led delivery partners.
 - // Ensuring good air quality
 - // Offering smoking cessation services and smoke free environments
 - // Working to improve alcohol treatment services across our three hospitals, ensuring links to wider mental health and community drug and alcohol support services.
- // Identifying and supporting individuals at risk of developing ill health, for example through the National Diabetes Prevention Programme.
- // Providing people with long-term conditions access to talking therapies to prevent the onset of anxiety and depression as a result of their condition,
- // Using social prescribing to provide help to people who have "social" needs, for example, through provision of information and guidance on housing or welfare issues.
- // Signposting people to local support mechanisms in their communities that help to address issues of social isolation and loneliness.



3.4 Moving more care closer to home

We are committed to bringing as many services as possible closer to people's homes – whether that is through digital channels, where residents can access support on-line or through designated apps, or by bringing a range of physical, mental health and social care services into the community.

It is our intention that the vast majority of services will be delivered locally – including lifestyle support services, outpatient appointments, some diagnostic tests and long-term condition support. We will also ensure swift and safe return to home for our residents after a period of hospitalisation.

Part two of this document describes, for some major health conditions, how we will be bringing care closer to home, through our primary care networks and places.

3.5 Transform & Improve Health and Care Services

While the standard of care offered through our health and care services is generally good, we know that we need to make improvements. We have established programmes to improve and transform:

- // Primary and community care
- // Cancer services
- // Mental health services
- // Cardiovascular disease
- // Elective care
- // Care for older people
- // Respiratory services
- // Maternity services
- // Care for people with learning disability and autism

Part two of this document provides further detail on each of these areas.



4. How will we know if we've made a difference?

4.1 Our Outcomes Framework

Our Directors of Public Health have developed a Partnership-wide outcomes framework (see Appendix 3) to help us to track our progress in the key areas where we believe, by working together in partnership, we can make a difference.

Linked to our five ambitions described above, table 1 illustrates a selection of indicators that we will use to monitor our progress. Over the coming months, we will work to develop stretching ambitions over the 5 year period of this strategy for each of the indicators given below.

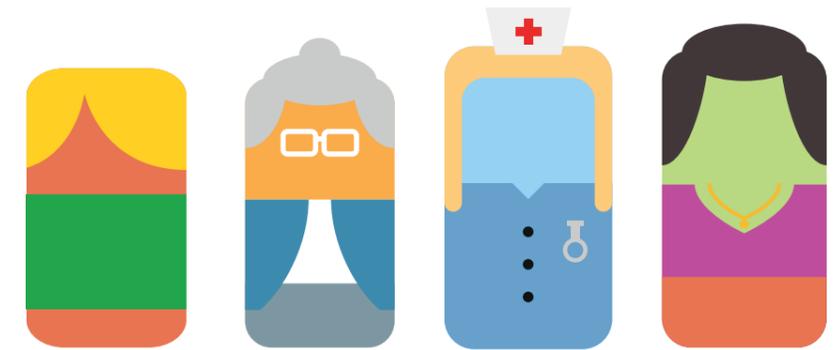
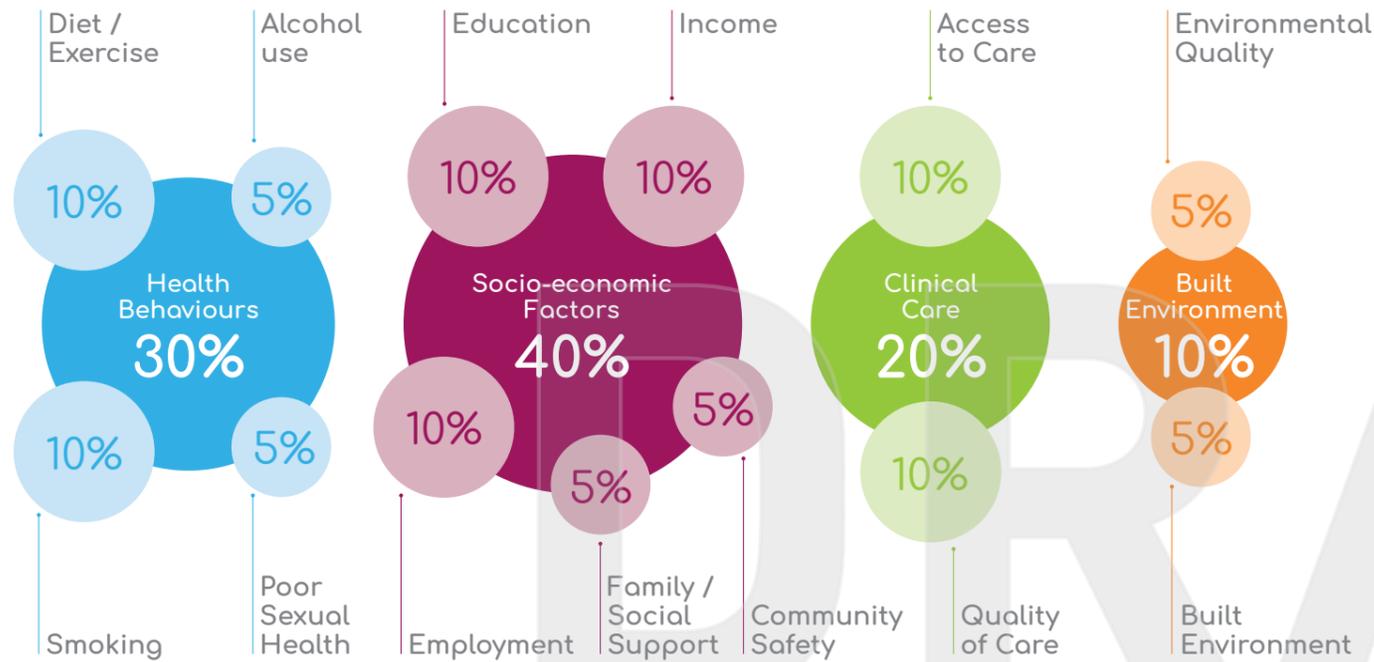


Table 1: Outcomes framework

	How will we know we've made a difference?	What metrics will we use to track progress?		How will we know we've made a difference?	What metrics will we use to track progress?
Reducing Inequalities	Inequality will reduce and our residents will enjoy longer, healthier lives.	<ul style="list-style-type: none"> // Slope Index of Inequality // Healthy Life Expectancy measures 	Moving care closer to home	Our residents report good access to and experience of primary and community services.	<ul style="list-style-type: none"> // Patients reporting good overall experience with practice appointment times and good experience of making an appointment. // Patients reporting a positive experience of their GP practice. // Delayed transfer of care // A&E attendances conveyed by ambulance
Creating Opportunity	<p>Our children achieve good development and educational attainment.</p> <p>Employment will rise.</p> <p>Homelessness will reduce and we will have good housing stock.</p>	<ul style="list-style-type: none"> // School Readiness // Percentage of people in employment // Educational attainment // Statutory homelessness // Number of non-decent dwellings // Air quality 	Transforming our services	<p>Our residents have consistent, timely access to safe, high quality health and care services.</p> <p>The outcomes from our services are improved.</p>	<ul style="list-style-type: none"> // Breast and bowel screening uptake // Cancer waiting times // Elective waiting times // % of residents with high self-reported happiness // Reduction in depression cases // Reduction in self-harm // Reduction in suicide // Treatment and recovery rates for IAPT services // Physical health checks for patients with serious mental illness // Mental health admissions to hospital
Health & Wellbeing	Our residents live long, healthy lives, and are supported to make good decisions on their own health and wellbeing.	<ul style="list-style-type: none"> // % of adults classified as overweight or obese. // Reception and year 6 prevalence of overweight children // % of adults physically active // Smoking prevalence // Admissions for alcohol related conditions // QOF prevalence for diabetes, AF, CHD, hypertension, cholesterol. // % of people self-caring after reablement // Patient Activation Measures 			

5. Addressing the Wider Determinants of Health

It is well known that socio-economic factors and behavioural aspects have a significant impact on individual health and well-being; the provision of clinical care provides a relatively small impact as illustrated below.



SOURCE: Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute in US to rank countries by health status

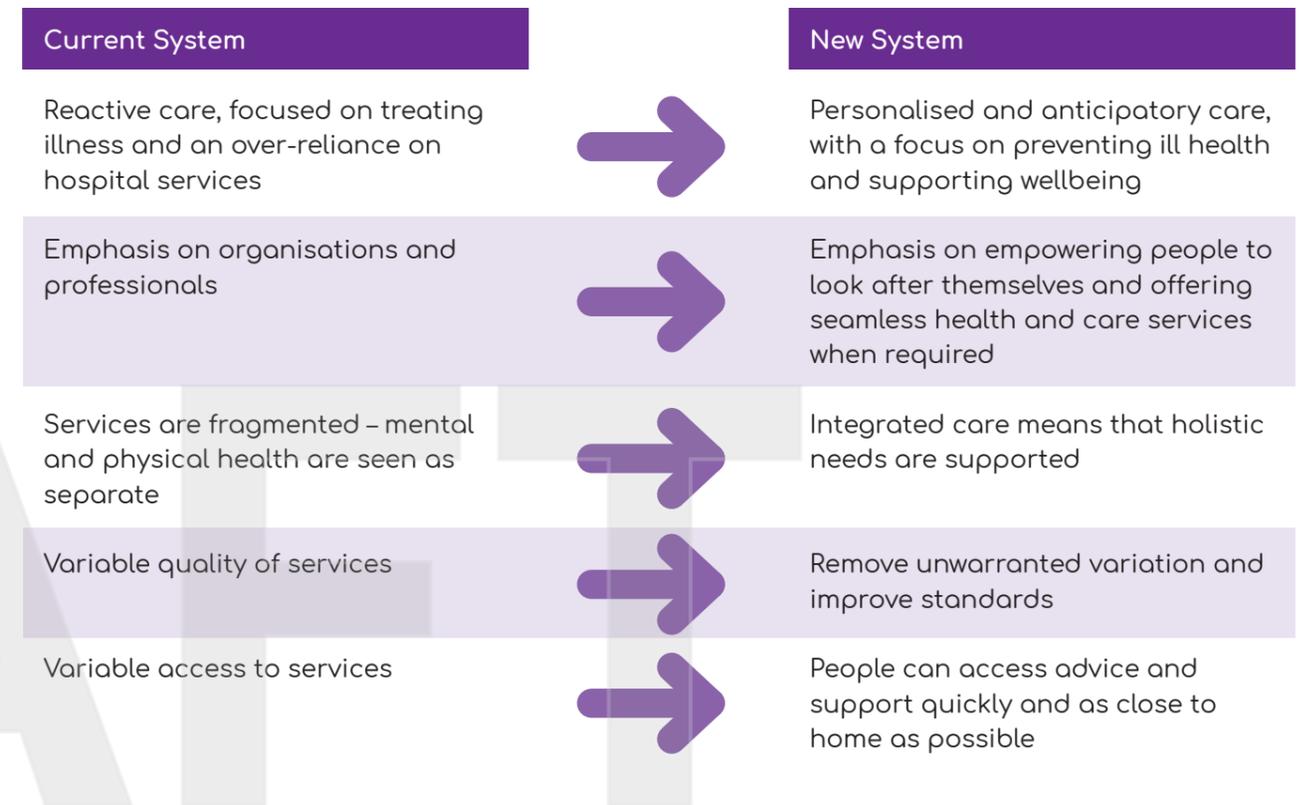
To ensure sustainability of our health and care system in the future, far more emphasis must be placed on the wider determinants of health.

The vast majority of interactions with residents take place locally – and this is where we can have most impact on supporting health and wellbeing. The focus of this strategy is on those local plans that are owned by local people and local partnerships, aligned to the relevant Health and Wellbeing Board. The concept of subsidiarity (to deal with issues at the closest level) is key to the success of this strategy.

While partners operate at a number of different levels, we have sought to ensure that there is no hierarchy attached to these levels.

5.1 What will be different?

We are changing the model of care in mid and south Essex, from one which is reactive and heavily reliant on acute hospital services, to one which is focused on empowering people to stay well and look after themselves, ensuring local access to care and support when required.



5.2 Our design principles

In line with this shift in care model, we have started to develop a new collaborative operating model to describe our approach. The design principles of this operating model can be summarised as:

Design Principle	Description
<p>We will co-design with insights and intelligence, putting residents at the centre</p> 	<ul style="list-style-type: none"> // We will work with our residents and staff to shape services that are focussed on better outcomes, long-term sustainability and continuous improvement, driven by a feedback culture. // We will use data that is connected and evidence to ensure we understand fully the challenge and opportunity. // We will ensure we have the right resources to enable us to get an accurate view from shared and collective knowledge, insight and data, which will inform our plans and actions.
<p>We will connect people together, delivering integrated care in the community</p> 	<ul style="list-style-type: none"> // Services are designed to put residents in control – providing high quality information that is accessible online at any time and supporting them to make informed decisions. // We will ensure different organisations work together, meaning people get the right care more quickly and easily.
<p>We will support people to stay well through prevention, self-care and independence thus building resilient communities</p> 	<ul style="list-style-type: none"> // We will shift from the reactive transactional model currently in place, to a responsive, proactive and sustainable system that focuses on keeping residents well and supports them through all stages of their life. // We will reduce inequalities by acknowledging and investing in the wider determinants of health and ensuring pathway design begins with prevention.
<p>We will adopt digital and technology by default</p> 	<ul style="list-style-type: none"> // Services will seek to optimise the use of technology consistently e.g. digital channels will be adopted as the primary and preferred method for communication and patient interactions. // Other channels will remain available but used only when most appropriate. // Staff and residents are supported to adapt to new ways of working and champion innovation.
<p>We will enhance local care teams, led by multidisciplinary teams, that optimise the skills of a diverse workforce</p> 	<ul style="list-style-type: none"> // Partners adopt a system-wide view and approach to delivering high quality, integrated services that are multidisciplinary team led. We will adopt best practice across the system, supporting all professionals to work at the top of their skillset. // Local teams will have ownership for helping deliver clinically, operationally and financially sustainable services. // We will support GP practices to work more closely together and to work with other care providers, sharing skills and resources.
<p>We will deliver services as close to home as possible</p> 	<ul style="list-style-type: none"> // Community based provision of services is the default position, unless necessitated by clinical need. This ensures residents are able to access health, care and wellbeing services in the most appropriate setting for their needs, including online.

5.3 Defining our Future Operating Model

Our operating model is based around the following anchor points:



5.3.1 You

Our model of delivery starts with the individual, their family, friends and social networks. We want to support people to live healthy lives, to make good decisions and to look after themselves.

We will ensure that as individuals and communities people have the right information and support to stay as well as possible for as long as possible. This information and support will be developed in partnership with individuals and communities so that it meets their needs, and it will take advantage of the growing number of channels available to people to consume information in a format and at a time that suits them. We acknowledge that a “one size fits all” approach to care and support will not work across 1.2m people.

When individuals are unwell, or are living with a long-term condition, we are committed to adopting the key principles of the personalisation agenda to support them to be part of their care planning, and where appropriate to tailor the support that they receive to meet their individual needs.



5.3.2 Your Neighbourhood

People are embedded in their local community and this is where good support for health and care is most impactful. Evidence suggests that “natural communities” comprise around 30-50,000 residents and, across mid and south Essex, we are using this footprint as a means of ensuring that social care, welfare, advice, physical and mental health services collaborate to provide seamless care and support to residents. To support this approach, 28 Primary Care Networks (PCN) have been formed; these are groups of practices collaborating around populations of 30-50,000 residents to provide better access and more streamlined services. Practices will work together to deliver some specialist services closer to home, and also provide services such as home visiting, extended hours access, and same-day appointments. With a focus on prevention and personal empowerment, PCNs will over time become the key operational delivery units for local and national transformation programmes, for example health screening and vaccinations, personalisation and ensuring people age well. PCNs are newly established and these deliverables will emerge over time.

Through PCNs we will deliver the ‘triple integration’ of primary and specialist care, physical and mental health services, and health with social care, consistent with what doctors report is needed. We will move to a GP-led system of care that focuses on improving population health and wellbeing, and supporting the sustainability of primary care and supporting services. The PCNs are developing their plans to open up new methods of accessing care and support, and expanding the workforce to incorporate new roles that will support people in different ways. These new roles in primary care include social prescribers, who can signpost individuals to different means of advice and support, and pharmacists working alongside GPs to manage medicines reviews and provide advice to patients.

5.3.3 Your Place

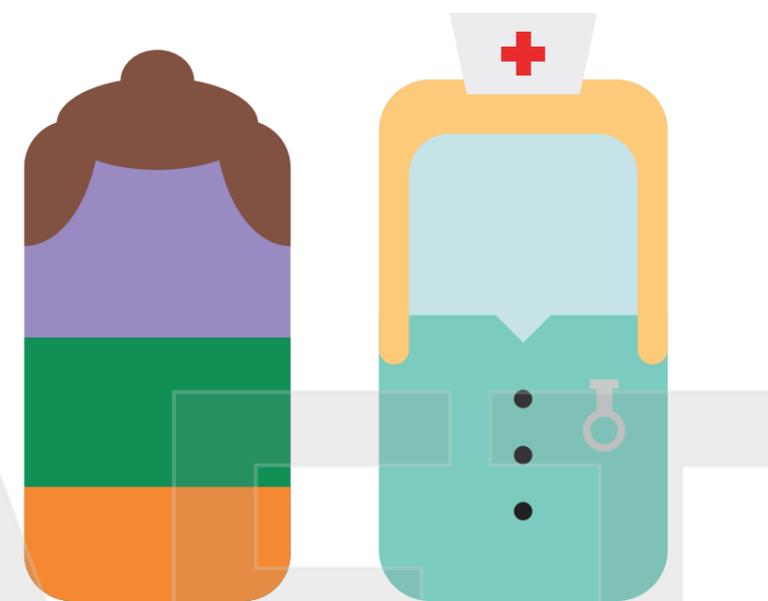
For mid and South Essex, “place based” systems involve multiple partnerships operating around populations of c170,000 - 400,000 residents. These Places provide a meaningful footprint within which to plan, design and deliver health and care services for and with the local community.

In mid and south Essex we have defined four Places:

- // Thurrock
- // Basildon & Brentwood
- // Mid-Essex (comprising three district council areas – Maldon, Braintree and Chelmsford)
- // South East Essex (comprising Southend, Castle Point, and Rochford).

Over time we expect that the four places become **Integrated Care Partnerships** – an alliance of local authority, NHS, community and voluntary sector organisations coming together to build and support resilient communities.

Each of our Places have defined local plans for and with local communities – these plans are described later in this strategy.



5.3.4 Our System

Some services and activities are best undertaken at system level (across the 1.2m population of mid and south Essex). We are working together on plans focusing on:

- // The provision of acute hospital and acute mental health services
- // Planning and development for our workforce
- // System-wide estates and capital planning
- // System-wide digital transformation
- // Data and analytics to support population health
- // Clinical leadership
- // Opportunities for research and innovation

We are committed as a partnership to meet the ambition set out in the NHS Long-Term Plan to become an integrated care system by 2021. This means that we will put our partnership working on a more formal footing, enabling better collaboration to help us to support the health and wellbeing of our population.

Part two of this document describes the work we will undertake to achieve this designation.

6. Place – Based Plans

Our “place based” systems involve multiple partnerships operating around populations of c170,000 - 400,000 residents. These Places provide a meaningful footprint within which to plan, design and deliver health and care services for and with the local community.

The following sections provide detailed information on our four places.

PRIORITIES:

- 1 Implementation of the aligned team model
- 2 Support patients and carers to better manage their own health and wellbeing
- 3 Support residents to access alternative services



PRIORITIES:

- 1 Transform community and primary care services
- 2 Develop strong and resilient communities
- 3 Transform how residents with long-term conditions are managed in the community
- 4 Reconfigure the out of hospital estate

PARTNERSHIP:

Basildon & Thurrock University Hospitals NHSFT
 North East London NHSFT
 Thurrock CCG
 Essex Partnership University NHSFT
 Thurrock Council
 Community Voluntary Sector
 Primary Care Networks – 4

Basildon & Brentwood

Predicted population growth

Age Band	2020	2041
0-14	19.23%	20.82%
15-24	16.48%	19.30%
30-64	46.03%	49.81%
65-89	17.30%	23.83%
90+	0.97%	2.12%
Total	269.4	312.2

PARTNERSHIP:

Basildon & Thurrock University Hospitals NHSFT
 North East London NHSFT
 Basildon & Brentwood CCG
 Essex Partnership University NHSFT
 Essex County Council
 Brentwood Borough Council
 Basildon Council
 Community Voluntary Sector
 Primary Care Networks – 6

Thurrock

Predicted population growth

Age Band	2020	2041
0-14	14.29%	15.14%
15-24	11.28%	14.03%
30-64	30.59%	34.26%
65-89	8.87%	13.40%
90+	0.37%	0.85%
Total	176.2	209.3



Mid Essex

Predicted population growth

Age Band	2020	2041
0-14	25.72%	25.45%
15-24	22.94%	24.72%
30-64	67.67%	67.41%
65-89	29.66%	40.91%
90+	1.52%	4.01%
Total	397.4	437.8

PRIORITIES:

- 1 Ensure every child can have a good start in life
- 2 Wider primary care network development, including a focus on prevention and population health
- 3 Attracting staff to want to work and live in mid Essex



PARTNERSHIP:

Mid Essex CCG
 Essex County Council
 Chelmsford City Council
 Braintree & Witham District Councils
 Maldon District Council
 Provide CIC
 Mid Essex Hospital
 Farleigh Hospice
 Community Voluntary Sector
 Anglia Ruskin University
 Essex Partnerships University NHSFT
 Primary Care Networks - 9



PRIORITIES:

- 1 Strengthened GP services
- 2 Appropriate access to secondary care
- 3 Improve outcomes for all-age mental health
- 4 Support self-care and prevention for all

PARTNERSHIP:

Southend CCG
 Castle Point & Rochford CCG
 Southend Borough Council
 Essex County Council
 Castle Point Borough Council
 Rochford District Council
 Essex Partnerships University NHSFT
 Southend University Hospital NHSFT
 Community Voluntary Sector
 North East London NHSFT
 Primary Care Networks - 9

South East Essex

Predicted population growth

Age Band	2020	2041
0-14	23.31%	23.90%
15-24	21.12%	23.42%
30-64	61.02%	62.40%
65-89	28.43%	38.90%
90+	1.52%	3.60%
Total	364.8	410.1



6.1 Thurrock

Better Care Together Thurrock sets out our plans for delivering a fundamental change in how health and care services are delivered in Thurrock, recognising the importance of addressing the wider determinants of health and wellbeing. Our statutory Health and Wellbeing Strategy, overseen by Thurrock Health and Wellbeing Board, considers and stimulates action on those wider determinants.

Our vision

The Health and Wellbeing Board's vision is to 'add years to life and add life to years'. The Thurrock Health & Wellbeing Board strategy focuses on five key goals, each with a number of aligned objectives.

1. Creating opportunity for all, including objectives on educational progress, employment and training and prosperity
2. A healthier, safer and accessible environment, including objectives on outdoor spaces, good homes, air quality and connected communities
3. Better emotional health and wellbeing including objectives on supporting parents, reducing social isolation and supporting children and young people's mental health
4. Quality care, centred around the person, including objectives on the creation of four integrated medical centres (IMCs) in communities across Thurrock, improving GP services and supporting people to take control of their own healthcare
5. Healthier for longer including objectives on reducing obesity, increasing early identification of long term conditions, supporting smoking cessation and improving prevention and treatment for cancer

Our Population:

As of 2019, the Borough of Thurrock is home to an estimated 172,500 people. By 2041 this population is projected to grow to over 209,000 residents, an increase of approximately 21%.

Thurrock is a culturally and linguistically diverse borough. An estimated 25% of the population are 'non-white British', with this figure rising to around 30% amongst school-aged children. The population speaks over 70 distinct languages.

Thurrock has a relatively young population, with an average age of 36.9 years (lower than both the East of England average (41.6 years) and the England figure (39.9 years). This is directly comparable to the age profile seen in most London boroughs. The average age in Thurrock has been increasing over recent years however and this trend is expected to continue over the next 20 years, leading in time to a fundamentally different population structure - by 2041 Thurrock is projected to see a more evenly distributed age profile, with an increased proportion of residents in the 65+ and 90+ age groups in particular. This will mean an additional 14,000 residents aged 65+ years and 1,300 aged 90+ years respectively.

Thurrock's overall level of deprivation is lower than the national average, however some Thurrock neighbourhoods (predominantly in the southern and western parts of the borough) are within the most deprived 20% nationally. These areas also experience the highest levels of worklessness and benefit claimant rates.

Health outcomes within Thurrock vary by geography with a life expectancy gap between the best and worst performing wards of 9.7 years for males and 10.2 years for females.

In recent years healthy life expectancy has fallen from 65.7 years (males) and 64.5 years (females), to 62.6 years and 61 years respectively. This suggests that whilst individuals in Thurrock are living longer, they are doing so whilst experiencing more chronic, long term conditions, such as cancer, cardiovascular disease (CVD), diabetes and respiratory disorders.

Our Challenges

Thurrock experiences a number of challenges, these include:

- // Staff recruitment and retention, particularly when competing with inner London allowances.
- // Travel and access to services - the area comprises urban, rural and industrial areas
- // Regeneration - costs are consistent with London boroughs but land values are lower than in neighbouring authorities.

Our Partnership

The Thurrock Integrated Care Alliance, jointly chaired by Mandy Ansell, Accountable Officer for Thurrock CCG and Roger Harris, Director of Adults, Housing and Health for Thurrock Council, oversees the local plan for health and care.

The Alliance is the result of strong historical collaboration between organisations. The Alliance comprises the following partners:

- // Basildon & Thurrock University Hospitals NHS Foundation Trust (BTUH)
- // North East London NHS Foundation Trust (NELFT)
- // Thurrock CCG
- // Essex Partnership University NHS Foundation Trust (EPUT)
- // Thurrock Council
- // Community & Voluntary Sector partners
- // Primary Care Network Leads

"The local authority recognises it is essential to work with the NHS to deliver services that are more joined up, more community based and reflect local community needs and aspirations. Place is important because all the evidence suggests that transformational change and genuine community engagement happens at a local level. That is why we are passionate about supporting our local agenda without forcing people into a 'one size fits all' arrangement, across unrecognisable bureaucratic boundaries"

Roger Harris, Corporate Director Adults, Housing and Health, Thurrock Council

The Thurrock Health and Wellbeing Board oversees the programme and is closely aligned with its delivery.

Thurrock has four primary care networks:

- // Tilbury & Chadwell
- // Corringham
- // Grays
- // Purfleet

Partnership working in Thurrock has been driven by a comprehensive Case for Change, which proposed using one locality (Tilbury & Chadwell) as an innovation site. This is acting as the 'route map', setting the direction of travel for the locality and enabling the alliance to test and learn how best to enable residents to stay well and independent. Shifting the system towards early intervention and prevention was a significant part of the work.

Our Priorities – Better Care Together Thurrock

Our Vision

To provide better outcomes for individuals that are closer to home, holistic and that create efficiencies (by shifting resources to deliver a better impact) within the health and care system

Our Aims

The alliance has five key aims:

1. Reduce the number of unplanned hospital and residential admissions
2. Reduce the number of A&E attendances for conditions that could have been treated elsewhere within the community
3. Reduce the number of delayed transfers of care
4. Keep people as independent as possible for as long as possible, and reduce/prevent/delay entry into care and support services
5. Move more services out of hospital/acute care into the community

To deliver this a programme of transformation has been taking place across Thurrock that radically changes how services are accessed and delivered for residents. This programme has five main priorities:

Priority 1: To transform community and primary care services; this includes:

1. Improved access to primary care and an enhanced range of services available
2. Streamlining how primary care and community services work together in local teams
3. Greater emphasis on prevention and early treatment and support

Case Study:

Extended Primary Care Teams

In Tilbury and Grays the following professionals are working as an extended primary care team across all practices in the primary care network; paramedic, practice based pharmacist, physician associate, physiotherapists, advanced nurse practitioners and social prescribers. A process is underway to recruit mental health practitioners to join this enhanced team.

In addition existing health and social care services, community and voluntary services and assets, also work together to build a seamless service for residents.

Priority 2: To develop strong and resilient communities, this includes:

- // Improved access to health and care solutions within the community, with a focus on prevention and early intervention
- // Personalised care that focuses on 'what's strong' rather than 'what's wrong'
- // Care solutions that incorporate a greater use of technology and of community assets

The approach looks at what is available within the community, how technology can help, and what friends and family can do before looking at a service option. A number of initiatives have been introduced to test and develop the approach, including:

Community-Led Support – One team has been introduced in Tilbury and Chadwell to give local people immediate access to social work and enable social workers to support and advise people at the earliest opportunity. The team has focused on reducing bureaucracy so that it can spend a greater amount of time face-to-face, and uses a strength-based assessment approach.

Wellbeing Teams – two Wellbeing Teams have been introduced in Tilbury and Chadwell. The teams focus on helping people to achieve what matters to them. The Wellbeing Teams will be working alongside enhanced primary care teams and will play a proactive role in helping others in the community to remain independent.

Local Area Coordinators (LACs) – Running successfully since 2013, there are 14 LACs in place to support people who are on the cusp of a crisis and work alongside them to enable them to articulate and achieve what a good life looks like to them. The approach increases individual resilience and reduces the need for formal service solutions.

Priority 3: To transform how residents with Long Term Conditions are managed in the community, this includes:

- // Earlier identification of long term conditions (LTC)
- // Emphasis on self-care and assistive technology
- // Redesign of pathways of care to support people with LTCs

To support this priority we have implemented thirteen long term condition projects to improve outcomes, including:

- // Increasing the uptake of NHS Health Checks, targeting high risk cardiovascular disease patients
- // Increasing detection, diagnosis and treatment of hypertension and atrial fibrillation to prevent emergency admissions and strokes
- // Improving diabetes and pre-diabetes detection
- // Increasing depression and anxiety screening and treatment for patients with LTCs
- // Improving smoking cessation services
- // Improving uptake of flu vaccinations amongst high risk patient groups
- // Improved support for patients with respiratory conditions

Priority 4: To reconfigure the out of hospital estate

Over the coming three years, we will open an integrated medical centre (IMC) in each of our four localities. In addition to improving the provision of primary care services, following public consultation in 2018, the outpatient and diagnostic services currently delivered from Orsett Hospital will be redistributed to these local centres, enabling Orsett Hospital to close.

The IMCs will provide a range of services traditionally delivered from a hospital setting, including cardiology, haematology, and dermatology, ear, nose and throat, pain management, respiratory services and rheumatology. Thurrock has established a Peoples' Panel to support the transformation work required to re-provide services currently delivered in Orsett Hospital to the four new IMCs.

“Thurrock has always seen the value of working in partnership to develop solutions that meet the needs of our community. We are very lucky to be co-terminus with our Council and we work closely across many streams of work, sharing information and developing our system for the benefits of Thurrock residents.”

Mandy Ansell, Accountable Officer,
Thurrock CCG Officer

Thurrock Council also encourages feedback in its Your Place Your Voice community engagement work, where residents are asked about their priorities for health and care.

As our alliance develops further, there will be further opportunities for our residents to engage with our plans.

Engaging with our Community

Thurrock has a strong history of engaging with its community. The CCG has engaged on the changes to health and care in Thurrock through consultation, local engagement and through working closely with our Healthwatch. The initial conversations around doing things differently were taken out to the public in April – September 2016 through For Thurrock in Thurrock, the council further consulted in the summer 2017 with the 21st Century Health and Care consultation. The CCG has a number of avenues to gain information. This includes our patient group, the Commissioning Reference Group and through visiting local community hubs and support groups including the Thurrock Over Fifties Forum, stroke group and diabetes groups.

6.2 Mid-Essex

Our Population:

With a population of circa 392k, Mid Essex is the largest place in the mid and south Essex system. Estimated population increases to 2039 suggest there will be a 10.8% increase; in line with England averages.

Within mid Essex there are three district authority areas: Braintree, Chelmsford and Maldon, which have distinct population profiles. The Maldon population profile is significantly different to the other districts especially in the 20-40 year age categories.

The future increases in the 75-year plus categories across all districts is significant, while the population for under 75s on the whole reduces. This is likely to have a significant impact on our ability to support the more elderly population.

All local authorities in mid and south Essex have seen an increase in average Indices of Multiple Deprivation (IMD) scores, indicating increasing levels of deprivation between 2010 to 2015. The largest increases in deprivation were seen in Basildon and Chelmsford, although on the whole, the deprivation across mid Essex is lower than most other areas in Mid and South Essex.

Our key health challenges in mid-Essex relate to poor management of diabetes, a growing level of poor mental health, particularly for young men, and a growing homelessness problem.

Our Partnership

The Mid-Essex Live Well Partnership brings together partners enabling them to work together to understand the local social determinants of health and working with our wider population to implement changes. The Partnership is chaired by the CCG Director of Clinical Transformation, and is a collaboration between organisations working to support the population in mid-Essex. The Partnership comprises the following:

- // Mid Essex CCG
- // Essex County Council (Adult social care, Education, Children)
- // Chelmsford City Council
- // Braintree & Witham District Council
- // Maldon District Council
- // Provide CIC
- // Mid Essex Hospitals
- // Farleigh Hospice
- // Chelmsford CVS
- // Maldon CVS
- // Community 360 (Braintree CVS area)
- // Anglia Ruskin University
- // Essex Partnership University NHS Foundation Trust (EPUT)
- // Clinical Directors for each of the Primary Care Networks



Over time it is possible that further links will be made with statutory authorities and other key providers.

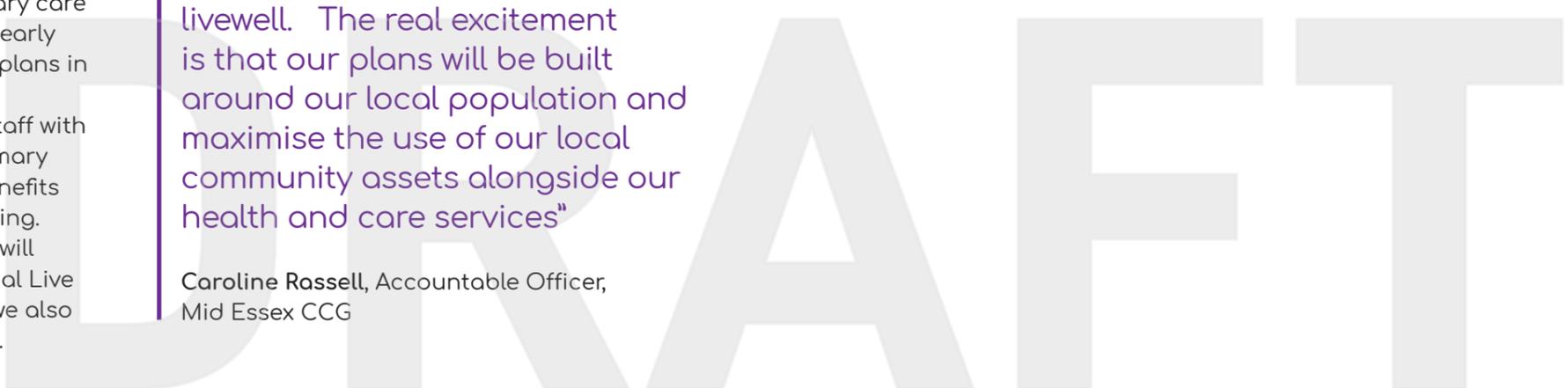
At partnership level, we interact with Broomfield Hospital, our community and mental health service providers primary care, and our local hospice to oversee integration and ensure consistent pathways of care. We can look at pooling or sourcing funding and joining up resources to support local service sustainability. The partnership links closely with the Essex County Council Health and Wellbeing Board.

We recognise, however, that for many areas of concern we can have most impact by working at the local level. To this end, we also work closely with our district authority partners on issues such as housing and leisure, as well as with voluntary sector partners to deliver support at the local level.

Across Mid Essex there are nine primary care networks. These are very much at an early stage of development. We have clear plans in place to support their development. Over time, the CCG expects to align staff with partners at district authority and primary care network level to maximise the benefits that local partnership working can bring. District Health and Wellbeing Groups will oversee the implementation of the local Live Well agenda. At this very local level, we also work to engage with our communities.

“Our place based plans in Mid Essex will provide us with the opportunity to work with our local stakeholders around our common goal of ensuring that everyone in Mid Essex can livewell. The real excitement is that our plans will be built around our local population and maximise the use of our local community assets alongside our health and care services”

Caroline Russell, Accountable Officer, Mid Essex CCG



Workforce/Education

// Doing more to attract staff to want to work and live in Mid Essex. This will include being more proactive with schools to highlight the career opportunities within the public sector.

These priorities reflect the findings of the Joint Strategic Needs Assessment and align with the Joint Essex Health & Wellbeing Strategy. Over the coming months the Partnership will agree some outcome measures to track the success of these priority programmes.

Engaging with our Community

There is strong community engagement through individual organisations within the Partnership. Over the coming months, the Partnership will develop its plans on continuing community engagement.

Our Priorities

The vision for the Mid Essex Live Well Partnership is “Creating Opportunities to Live Well”.

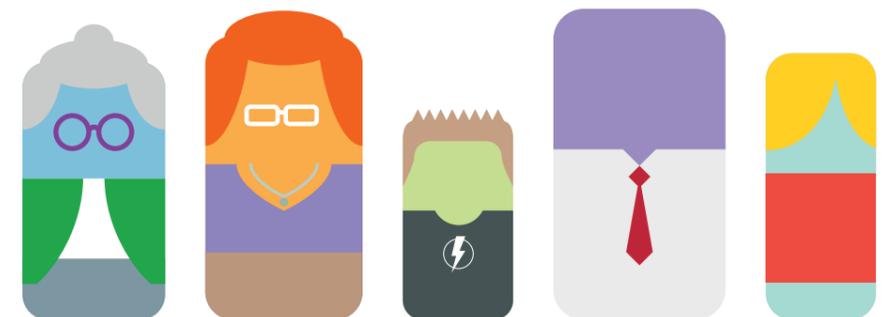
By working together, we will jointly own issues and seek to act in a proactive way to support our residents. The Partnership has decided that its initial priorities will be focused in three areas:

Start Well

// Working together to ensure every child can have a good start in life and the education to ensure they can live well.

Wider Primary Care Network Development

// Development of the PCNs with support from system partners to align services so that there is greater sustainability across both health and care services. This will also focus on the preventative and population health agenda to mitigate demand on public services.



6.3 Basildon & Brentwood

Our Population:

Basildon and Brentwood is coterminous with the boroughs of Basildon (population 185,000) and Brentwood (population 78,000) and has a GP-registered population of 279,000. There are 35 GP practices working across six primary care networks. The area has a mixed demography with some very affluent wards, and some of the more deprived wards in the country, pockets of high density housing to low density rural communities.

Pitsea and Laindon are more deprived areas with a significant regeneration planned which can support health and care integration. It is anticipated that by 2037, the overall population will have grown by 18%, with those aged over 65 years growing by 61%. The working age population (<45 years), will shrink whilst there will be a sizeable increase in the younger age group (0-14 years). The birth rate has remained fairly constant in recent years, although risk in maternal health must be addressed to reduce perinatal mortality and teenage pregnancies.

Brentwood is relatively more affluent whilst Basildon has very large disadvantaged communities. There is at least a seven year difference in life expectancy across the boroughs. There is a pronounced level of premature mortality, with cancer (134 per 100,000) and circulatory diseases (60 per 100,000) being the greatest burden. The inequality in health is highlighted by the difference in mortality rate in cancer between Pitsea North West in Basildon (140 per 100,000) and Tipp Cross in Brentwood (64 per 100,000).

While there has been progress in some quality measures, compared to the CCG's peer group (ONS Cluster of similar CCGs), the performance against metrics such as potential years of life lost from causes amenable to healthcare, health-related quality of life for people with long term conditions and those with long term mental health conditions are amongst the lowest recorded. Basildon has a significant proportion of excess deaths in winter especially in the older age group. The CCG has the highest proportion of people living with a common mental health condition compared to its peers.

It is estimated that 10% of local residents are acting as unpaid carers and many will experience changing health and housing needs. Around 6% of older people live alone in Essex and it is now estimated that 60% of them could develop dementia and therefore be more likely to enter residential/nursing care.

Our Partnership

Partners working across local health and care come together in the Basildon and Brentwood Alliance Forum. The Alliance Forum is chaired by Dr Boye Tayo, chair of Basildon & Brentwood CCG, and oversees planning and delivery of local health and care transformation. The Alliance is a collaboration between organisations working to support the population in Basildon & Brentwood and comprising the following partners:

- // Basildon & Thurrock University Hospitals NHS Foundation Trust (BTUH)
- // North East London NHS Foundation Trust (NELFT)
- // Essex Partnership University NHS Foundation Trust (EPUT)
- // Primary Care Networks Clinical Directors (x6)
- // Essex County Council
- // Brentwood Borough Council
- // Basildon Borough Council
- // Basildon and Brentwood CCG
- // Voluntary Sector organisations (via the CVS)

Basildon and Brentwood has six Primary Care Networks (PCNs) around the neighbourhoods of Billericay, Brentwood, Central Basildon, East Basildon, West Basildon and Wickford. The PCNs were formed this year to bring together general practices to form a strong foundation for the local integration of community based teams with primary care.

Basildon and Brentwood CCG is an active participant in three Health and Wellbeing Boards – Essex County Council, Basildon and Brentwood. The work of the Alliance aligns closely with the priorities of these three Health and Wellbeing Boards.

Our Priorities

The Basildon and Brentwood Alliance have agreed the following priorities:

- // Support local people to improve their health and wellbeing and stay independent for longer
- // Reduce health and wellbeing inequalities for people of all ages
- // Integrate health and care services
- // Deliver safe and sustainable services
- // Progress towards becoming an Integrated Care Partnership.

By working together around four initial priority areas we will strengthen our local partnerships and build a culture of integrated working that delivers improved outcomes of our population.



Aligned Teams

Improve integration of health and social care services around PCN footprints.



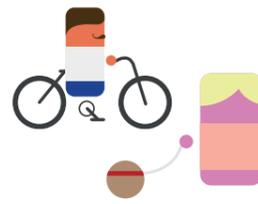
Dementia

Improve diagnosis and subsequent support for patients with dementia.



Intermediate Care

Review patient flows across health and social care and develop pathways to support optimal independence.



Reducing inactivity

Reduce levels of inactivity across Basildon as part of a Sports England pilot.



These priorities reflect the findings of the Joint Strategic Needs Assessment and align with the Joint Essex Health and Wellbeing Strategy.

Implementation of the **Aligned Team** model will transform the way services are integrated to better support the populations they serve. The Aligned Teams will operate on a Primary Care Network footprint and cover community health, mental health, primary care, social care and third sector provision with in-reach from secondary care services where appropriate. This model requires significant cultural change in the way services are delivered in order to risk stratify the population, proactively care plan and support patients and carers to better manage their own health and wellbeing.

The integration of services at a neighbourhood level incorporates a model for social prescribing that has been implemented across the Basildon and Brentwood footprint which has helped to provide signposting and support to patients on how to access alternative services.

Dementia has been recognised as a priority where each partner within the Alliance has a role to play in improving the initial diagnosis for patients with dementia and then the subsequent care and support provided to enable individuals to remain as physically and emotionally health for as long as possible.

Partners within the Alliance have commissioned an external review of **Intermediate Care Services**. The aim is to understand where our intermediate care offer can give people better outcomes and help more people stay at home. A case review and patient flow review is underway to establish the difference between one 'ideal' pathway for patients and the current provision. Through the Alliance partners will work together to redesign and integrate services so that care provided is seamless and people receive effective short term care in the community leading to the most independent long term outcome.

Essex is one of 12 pilot areas selected by Sport England with Basildon being targeted as an area with a high level of physical inactivity and higher levels of poverty and social immobility. **Reducing inactivity** will be a whole system approach focused on an asset based community development approach which is working with communities to harness their strengths, capacity and knowledge.

Outcomes:

By working together, we want to make a difference to the way in which services are planned, purchased and delivered. We have defined a small number of indicators to help illustrate that our new ways of working are having impact, these are:

- // A reduction in non-elective readmissions for patients aged 75+ for medical reasons
- // A reduction in falls-related admissions
- // A reduction in the rates of physical inactivity

Whilst the initial priorities are focused around our elderly population, the Alliance Forum will be considering the needs of all age groups including children and young people.

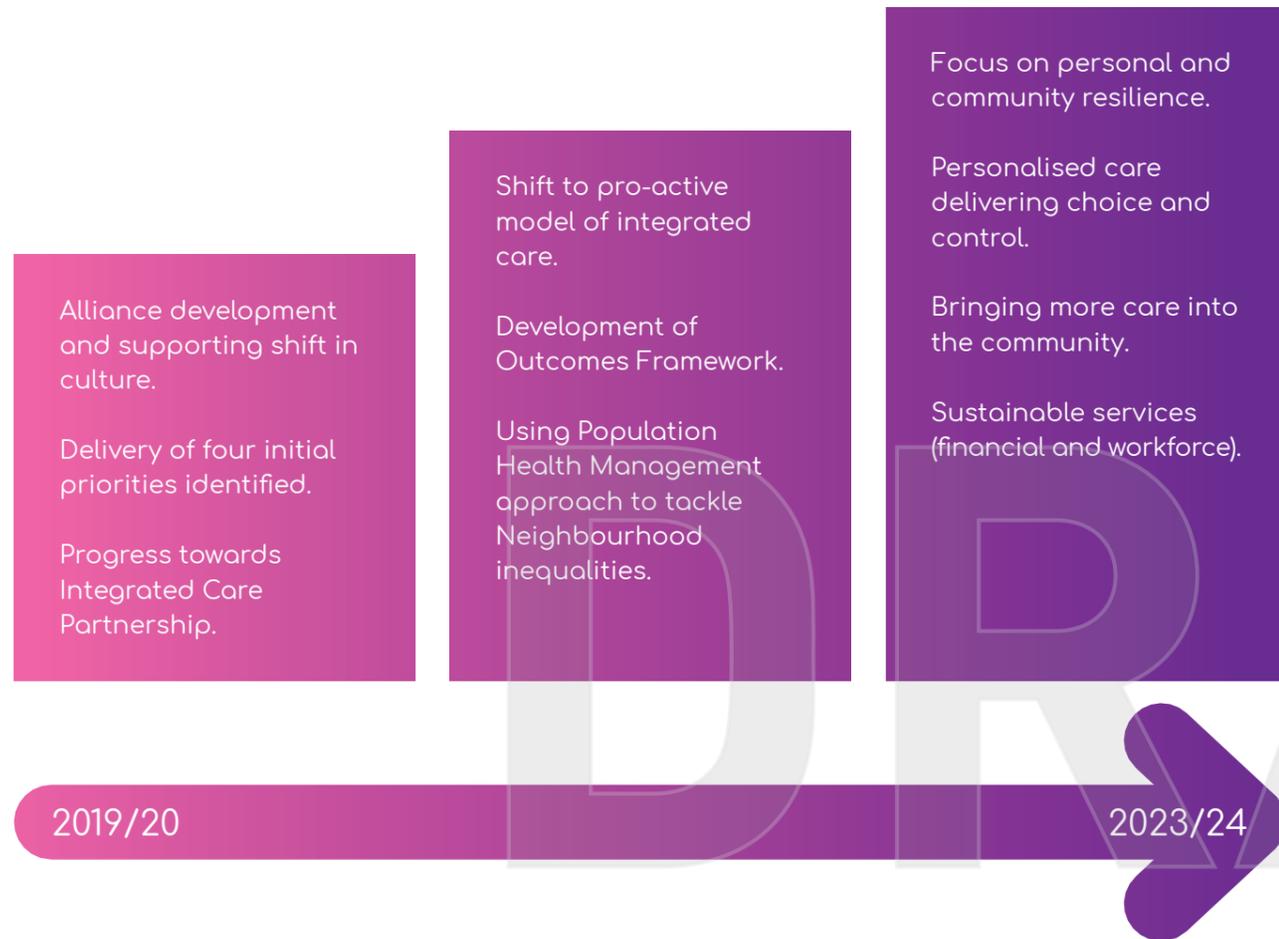
Our 5-Year Plan

Over the next five years the Alliance Forum will transition into an Integrated Care Partnership that will support the delivery of the ambitions set out in this strategy. In the first years the focus will be on delivering the agreed priorities outlined above. It is recognised that a significant change in culture is required to deliver the transformation programme and that will not happen overnight.

The next step change will be as we mature as an Integrated Care Partnership and move towards the development of an outcomes framework that measures how we are performing and improving the health and wellbeing of our population. The Alliance Forum will adopt a Population Health Management approach using health and social care data to have a greater understanding of people's needs to target interventions and deliver care to achieve maximum impact.

Towards the later years the Integrated Care Partnership will establish a comprehensive model of personalised care that supports people of all ages and their carers to manage their physical and mental health and wellbeing. This will build upon community resilience and the asset based development approach that has been adopted in the earlier years.

The Integrated Care Partnership will work with the ICS to ensure that the investment in system wide estate and digital technologies will enable more care to be brought into the community and integrated with the established teams. The workforce expansion and development to support the new models of care will accelerate throughout the five year period.



How we will deliver this

The Alliance Forum will have clear oversight of the delivery of our agreed priorities through a shared work plan, with each scheme being led by the most appropriate organisation. The focus will be on the integration of health and social care services to support a shift away from reactive to pro-active care. Combined with the development of the asset-based management approach that build individuals and community resilience, the transformation in culture will start to impact.

The Alliance recognises that the traditional approaches to contracting and commissioning and individual organisational accountability will not deliver the change required. Over time the Alliance will adopt a collective approach that is outcome driven for both operational staff and senior leaders.

The Alliance Forum supports 'doing things once' where it makes sense to do so. This would include the development of a service operating model that would define standards and outcomes. Nonetheless, there are likely to be some specific nuances in the delivery of the service offer as a result of taking a targeted Population Health Management approach to reducing inequalities in certain wards within the population of Basildon and Brentwood.

Engaging with our Community

The priorities and approach the Alliance is seeking to take is driven by significant engagement with communities and stakeholders undertaken by the CCG, Essex County Council, Basildon Council and Brentwood Council. There are very active patient participation groups, residents groups and service user groups in existence and the Alliance will ensure these are part of the design and implementation of service change locally.

Our Work with the System

The organisations represented within Basildon and Brentwood Alliance Forum work at a system level on cross-cutting issues such as developing our approach to population health management and prevention, digital transformation, ensuring best use of resources, workforce planning and transformation.



6.4 South East Essex

Our Population:

South East Essex (SEE) comprises three main areas – Southend, Castle Point and Rochford with a combined population of c370,000.

The SEE local system is under intense pressure as a result of a multitude of issues including but not limited to a growing population, reduced funding for adult social care, a plateauing of funding for the NHS, an increase in individuals experiencing problems with their mental health, multiple long-term conditions, social circumstances (eg. housing, employment etc) and an increase and variable ask of public services. These are challenges that are faced all across the country and, in South East Essex, the circumstances are no different.

Moving forward SEE will see a growth in population of 6%, or 20,000 people, over the next 10 years (2018-2027); this coupled with funding pressures and lifestyle choices, will under the current model of care and support, lead to an exponential and unmanageable demand for public services.

SEE as an area is one that contains a collection of smaller communities, each with their own specific care needs based upon the demographic of the population.

It also has a complex and varied health profile as summarised within Public Health England’s Local Authority Health Profiles 2018.

Castle Point	Rochford	Southend-on-Sea
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Health in summary

The health of people in Castle Point is varied with the England average. About 15% (2,100) of children live in low income families. Life expectancy for both men and women is similar to the England average.

The health of people in Rochford is generally better than the England average. Rochford is one of the 20% least deprived district/unitary authorities in England, however about 10% (1,300) of children live in low income families. Life expectancy for both men and women is higher than the England average.

The health of people in Southend-on-Sea is varied with the England average. About 19% (6,300) of children live in low income families. Life expectancy for men is lower than the England average.

Health inequalities

Life expectancy is 6.6 years lower for men and 3.6 years lower for women in the most deprived areas of Castle Point than in the least deprived areas.

Life expectancy is 3.9 years lower for men and 5.4 years lower for women in the most deprived areas of Rochford than in the least deprived areas.

Life expectancy is 11.1 years lower for men and 9.7 years lower for women in the most deprived areas of Southend-on-Sea than in the least deprived areas.

SEE, like many other areas, is a complex landscape of health and social care commissioners, providers and third sector organisations. SEE is rich in community assets which currently work, some through partnership, some through silos, in support of communities and individuals. The area is diverse on many fronts: poverty, affluence, ethnicity and age but is rich in terms of its physical assets. The challenge for SEE is to ensure that these are used to support the health and wellbeing of our residents. The SEE area also forms part of the Mid and South Essex Health & Care Partnership planning footprint.

The complex nature of SEE aligned with increasing demand for services, unaligned workforce cultures, reducing community resilience and decreasing resource means that we have to deliver support, preventative interventions and integrated services on a population needs basis.

Our Partnership

The local health and care work is overseen by the South East Essex Partnership Group, chaired in rotation by a senior executive from either Southend on Sea Borough Council, Essex County Council or either of the two CCGs. The Partnership Group is a collaboration between organisations working to support the population in SEE and comprising the following partners:

- // Southend CCG
- // Castle Point & Rochford CCG
- // Southend Borough Council
- // Essex County Council
- // Castle Point Borough Council
- // Rochford District Council
- // Essex Partnership University Hospitals NHS Foundation Trust (EPUT)
- // Southend University Hospital NHS Foundation Trust (SUHFT)
- // Southend Association of Voluntary Services (SAVS)
- // Castle Point Association of Voluntary Services (CAVS)
- // North East London NHS Foundation Trust (NELFT)

The area is covered by nine primary care networks (PCNs), which have formed this year with the aim of building on the strong foundations built informally between locally

“The development of a long-term plan for mid & south Essex represents a significant opportunity for the south east Essex system.

With the plan focused on prevention, health inequalities and local people managing their health, there is a clear link with the strength and community based approach we are collectively delivering in south east Essex.

We are very excited for the future and keen to explore the benefits from the close working relationships we have invested and built over the course of the past few years. The engagement across south east Essex to develop the ‘Living Well in Thriving Communities’ strategy was substantial and we are now beginning to see the benefits of this work.”

Simon Leftley, Deputy Chief Executive (People), Southend-on-Sea Borough Council and Chair of the South East Essex Group Partnership.

integrated teams and primary care providers. The PCNs in SEE represent a significant opportunity to further integrate local teams with primary care, to respond to the local needs of our populations and build upon the community assets within our localities.

There is a direct line between both the Southend Health and Wellbeing Board, the Essex Health and Wellbeing Board and the partnership group. The group is mandated on behalf of both Boards to develop, evolve and implement the agreed locality strategy.

The implementation of the locality strategy operates through an approach of partnership working, integration and collaboration. The arrangements that are evolving are built on this principle and it is clear that it will require organisations and interests, to be represented in multiple forums. The group has the task of oversight and ensuring that the key challenges to implementation of the locality strategy are addressed. Co-design and co-production are principles that run throughout and the group supports each individual organisation represented to report separately into governance channels.

Our Priorities

There is a desire from all partners to invert our existing model of care, for future solutions to be driven by the lived experiences of the residents within an area. The desire includes the mobilisation of all the assets at our disposal (within local authorities, health and third Sector) which can be used to engage communities and empower a supportive functionality and ensure public services are designed to support this approach.

It is the ambition for the system to move from a reactive model of care and enable an improved focus on prevention, self-care, personal responsibility, empowerment and wider community resilience. The model will articulate how the support individuals require can be delivered against this backdrop that is person centred, outcome focused, integrated and that provides the best possible outcomes for the individual.

Traditional top-down approaches to change, or transformation, that rely on an overarching system (or national) view that is then broken down into sub-systems (local views) are not considered as the best option for maximising the collective power of individuals, communities and the third

“Health and care partners across south east Essex are collaborating across organisational boundaries to unlock the potential within the community and better understand how local residents can be supported to keep safe, well and happy in their own homes.

The development of our local Primary Care Networks offer a positive foundation for strengthening and re-designing community services to meet local needs. We want to proactively support people at risk of deteriorating ill health, focus on what individuals can do and support them to achieve their goals while supporting local staff to work in partnership with shared information to provide joined up care.”

Dr Sunil Gupta, Chair, Castle Point & Rochford Clinical Commissioning Group

and statutory sectors. By focusing on the deficits, rather than the assets, top-down approaches can sometimes be criticised for undervaluing the importance of local knowledge and assets and, as a result, the differentiation between local and systemic/national issues becomes misunderstood. This can be problematic, particularly when thinking about improving health and wellbeing, as it can cause us to think that the wider perspective is all that matters and prevent us from understanding local needs. Place-based working is a grass roots, person-centred, approach used to meet the unique needs of people in one given location by working together to use the best available resources and collaborate to gain local knowledge and insight.

By working collaboratively with the people who live and work locally, it aims to build a picture of the system from a local perspective, taking an asset-based approach that seeks to highlight the strengths, capacity and knowledge of all those involved. Through the above approach and by strengthening our local partnership the following priorities have been agreed;

- // **Strengthened GP services.** The provision of primary care services is diverse and varied. With the involvement of the PCNs and locality working our plan is to invest in and improve GP services so that outcomes are improved for residents and patients. Patients, in the first instance will be encouraged to take responsibility for themselves and access GP services only when needed. GPs will work in partnership with partners to ensure access to front line services will be dictated by need rather than availability. An outcome for patients will be that they are able to access the right care at the right place at the right time.
- // **Appropriate access to secondary care.** We will invest in the community, in primary care, in social care so that our residents will only need access to secondary care services when it is absolutely necessary.
- // **All age mental health** is an increasing issue for the SEE population. We will invest in mental health services, build partnerships across organisation so that patients who have a need for mental health interventions receive the best possible outcomes.
- // **Supporting self-care & prevention** through Population Health Management. By understanding further the needs of our local population, integration and local working can be tailored. Through sharing data and working in partnership we can further understand the impact of the wider social determinants (eg poor housing, income, diet, environment etc) on an individuals' health and wellbeing. The impact of living close to or having better access to parks or open spaces can be better understood. This understanding (as examples) will influence who and what we invest our limited resources in.

Our 5-Year Plan

It is collectively agreed that the current approach to commissioning, delivery and the subsequent monitoring of success is not conducive to supporting the development of a locality approach. Providers often have conflicting priorities as a result of different approaches to commissioning, and no ability to obtain a system view of current and future priorities.

It is considered that a move to measuring outcomes will address the first issue – and the system is in the process of identifying how an outcomes framework may be structured.

For this to be successful all parties need to agree the key outcomes the system wishes to achieve, and commission and provide services that ultimately contribute to the delivery of these.

The SEE plan to deliver our agreed strategy is across two levels:

Firstly, we will work at a locality level supporting the development of locality teams. We will support the development of a culture built through partnerships and relationships. Integrated working will be actively encouraged, safe spaces will be created through which operational staff will be able to try different initiatives, learn and evolve. The community and community assets are at the centre of this plan as is a strength based approach. The initiatives developed will be in partnership with our communities, they will directly respond to a need and will place the person at the centre. Operational relationships across the entire system will be challenged, the wider determinants of health and wellbeing will be a major consideration. Most importantly, the learning from each initiative will be understood and used to evolve the next steps.

Examples within this first level that have already been delivered are: the development of a community group to address social isolation and loneliness (West Central Locality); regular multi-disciplinary team working (all localities); the development of the 'hub' concept (East Central and East Localities); assistive technology and care homes (West Central Locality); dementia navigators (all localities).

Future examples include the development of a community based asset around the new St Luke's Primary Care Centre (East Central Locality).

Secondly, our senior leaders will be challenged to work in partnership at both an individual and organisational level. This will be achieved through the development of outcomes, a plan to further pool budgets, work in true partnership with providers and strengthen relationships with the community and voluntary sector. Our leaders will listen to communities, residents, patients and operational staff. Outcomes will be 'made real' for our leaders so that they can understand the impact of their collective decision making. However, a risk has been identified with the merging of the CCG and the engagement of senior leaders within the SEE system.

How we will deliver this

The model of care designed for SEE is one that focusses on enabling people to remain independent. It is a model that moves the focus to pre-emptive and pro-active care and ensuring communities and individuals have access to the necessary assets to enable this to happen.

In addition to this ambition for the whole population it fundamentally focuses on the community as consisting of four distinct cohorts

1. Those that do not require care or support at this point in time, nor are they expected to require care or support over the next five years
2. Those that, based on a variety of factors are likely to require care and support within the next five years, and the expectation that they are identified and provided access to solutions that either defer or delay the requirement for care
3. Those that, despite of the best intentions of the individual, their community and support network do require the support of formal services – in this instance the system collectively works to ensure they continue to live well with care and/or support in place and return to living an unsupported healthy and active life in a safe and timely manner, and
4. Those that will always need care and support who will receive services that enable them to live well regardless of the complexity of need

Whilst the 'Living Well in Thriving Communities' model has a focus on personal and community resilience and the strengthening of support available within the community (primary, community and through social care), there is no denying that people will continue to need a level of care and support that is either best provided, or overseen, by the clinical/medical expertise available through an acute provider. The model of care however places an emphasis on both timely – and where possible pre-emptive - intervention and the pro-active return of individuals to their normal place of residence with any required on-going care and support delivered outside of a hospital ward.

For this to be successful there would be an expectation that those responsible for delivering support within the locality setting link with acute colleagues to ensure the care provided is seamless, and the drive is to ensure the individual returns to their normal place of residence in a safe and timely manner.

As individual organisations each partner has already stated their own vision and values. Whilst these are specific to each individual organisation and would have been developed through wide organisational and stakeholder engagement, all organisations have common themes running through their values. Using these individual organisational values it is possible to extract a number of key principles that the system wishes to work to:

- // It is accepted that the combined strength of the system is greater than the individual strengths of the organisations that make it. As such a principle of collaboration shall be adhered to across SEE to address the challenges and deliver the model as described in this document

- // Previous attempts to redesign the system have failed in part as a result of what is sometimes referred to as the 'fortress mentality' – in order to overcome this the partners will be open and honest in the interactions with each other and the populations which they serve
- // Underpinning both of these is a need to be compassionate and supportive – not only towards the populations that they serve, but also to individual organisations' positions. The system has a greater chance of overcoming challenges together by accepting them as system challenges, as opposed to separate organisational ones

We will ensure that where it makes sense to 'do things once' the system will support this. The expectation is that strategic direction will be defined once across the system ensuring that there is a single approach to: (a) defining the model and ensuring consistency in model development where this makes sense; (b) where gaps in interventions or functions are identified within localities and where this gap exists across multiple localities a single approach will be strived for; (c) standard operating procedures for functions such as MDT's or social prescribing; (d) agreeing locality population health and wellbeing outcomes; and (e) developing and delivering an approach for the definition, extraction and analysis of information needed to support locality development.

It is acknowledged that whilst we can simplify need and challenges across the wider footprint each locality will have its own specific nuances based upon the local population. These include;

- // Health behaviours such as tobacco use, diet and exercise and alcohol and drug use
- // Physical environment such as air and water quality, housing and transport
- // Social and economic factors such as education standards, employment levels and income
- // Access to and quality of clinical care

Collectively, whilst these contribute to the length and quality of life of an individual they also contribute to an individuals' ability and appetite to engage with their own health and wellbeing and take responsibility for their own independence.

Engaging with our Community

The development of Locality based models of care, which focus on prevention, personal empowerment, community resilience and the underlying principle of services and interventions being developed around the needs of the population, relies heavily on the assumption that local people will be involved in all levels of developing, implementing, reviewing and assessing the new models of care.

To support the development of localities the system needs appropriate resource from all organisations working to implement an engagement strategy built on:

- // The principles of co-design and co-production - involving, collaborating and devolving – and evolution from current approaches to engagement, and
- // A whole system approach, across locality, communications and engagement to offer a place based offer for the locality and where appropriate and specific locality focus to meet separate needs and requirements.
- // Working in partnership with voluntary sector and communities to build upon what is already strong within localities.
- // Working with residents on a good life model, helping people to stay strong, preventing the need for a service in their lives.

It is anticipated that shared resources are identified to address and manage these requirements and that a joint plan is developed and implemented to support the wider transformation of the system

Our Work with the System

The organisations represented within SEE work at system level on cross-cutting issues such as developing our approach to population health management and prevention, digital transformation, ensuring best use of resources, workforce planning and transformation. We need to keep building and working on a shared purpose ensuring that behaviours and values are consistent across the system.



7. Our Current Challenges

Organisations within the Mid and South Essex Health and Care Partnership are facing significant pressures, both in terms of rising demand for services, shortages in staff and financial challenges.

Workforce

Securing a sufficiently skilled workforce is a challenge for all partners in our system. In the NHS, vacancy rates are high, and this is creating pressures both in relation to service provision and finance (the locum /agency staff rate of 14% is higher than the average across the East of England). We are in close proximity to London, and trained, experienced staff are often attracted to work there; this is exacerbating our workforce pressures.

In social care, there are significant workforce challenges, particularly within the domiciliary care market, where there is a high turnover of staff and a number of provider failures. Attracting nursing staff and managers to work in care homes is also very challenging. It is often difficult to attract younger workers into the care market when they can obtain similar or higher salaries in the private sector.

See section 28 and Appendix 4 for further detail.

Performance & outcomes

We face significant challenges in performance against NHS Constitutional Standards, in particular, demand for urgent and emergency care which impacts significantly on waiting times for cancer and elective care,

It is of concern to us that our cancer outcomes are not where we would want them to be and this will be a major area of focus for us in the coming months.

In general our performance against mental health standards – including access to talking therapies, early intervention for first episode psychosis and children and young people's mental health – are in line with constitutional standards requirements, but we know that we have further to go to improve services for residents experiencing mental health conditions.

Part two of this document describes our work to improve performance and outcomes in more detail.

Demand

Demand for our services is rising – our primary care strategy (June 2018) identified that as a combination of increasing demand and a lack of primary care capacity we are approximately 20,000 GP appointments short per week. As well as impacting patients who may not be able to access the support they need, this lack of capacity undoubtedly places additional demand on other services within the system, as a significant proportion of patients looking for a GP appointment will attend A&E. We estimate that if we do nothing to address capacity issues in primary care, the gap could grow to 60,000 appointments per week, with the attendant impact on patients, carers and services. Our work through Primary Care Networks and developing our place-based plans are geared towards addressing these challenges.

Local authorities

The scale of the challenge facing social care is creating an uncertain service and financial environment within local authorities. Demographic pressures, growing public concern and a system at 'tipping point' contribute to this uncertainty whilst increasing financial pressures solidify the issue.

Council funding for social care is derived from the remaining revenue support grant received from central government, from locally generated incomes such as council tax and business rates, and from user charges. Current national policy is to end the revenue support grant over the next few years and for Local authorities to retain 75% of business rates raised. In addition, with the Government only recently announcing a one year spending review for 2020/21 there remains continued uncertainty with Government funding for social care. This policy presents a risk to local authorities as they may find themselves with revenues that differ significantly from the social care spending needs.

Additional funding has been available via the Better Care Fund, an Improved Better Care Fund grant, winter pressures money and the ability to supplement council tax with a social care precept alongside recent one-off social care grants. However, the difficulties facing social care remain and the Government has yet to provide the full funding and certainty of funding requirements. In addition, the thrust of Government policy for local authority funding is for local authorities to enter an era of financial self-sustainability, which will bring imminent challenges given the demands and cost pressures of social care.

Challenges around the increasing demands of workforce, provider stability, recruitment and retention remain despite proactive work by the local authorities to address concerns.

The task set by national policy is to consolidate and integrate services across health and social care. With no certainty around the future funding for social care local authorities have identified high risk to committing funding over the long term.

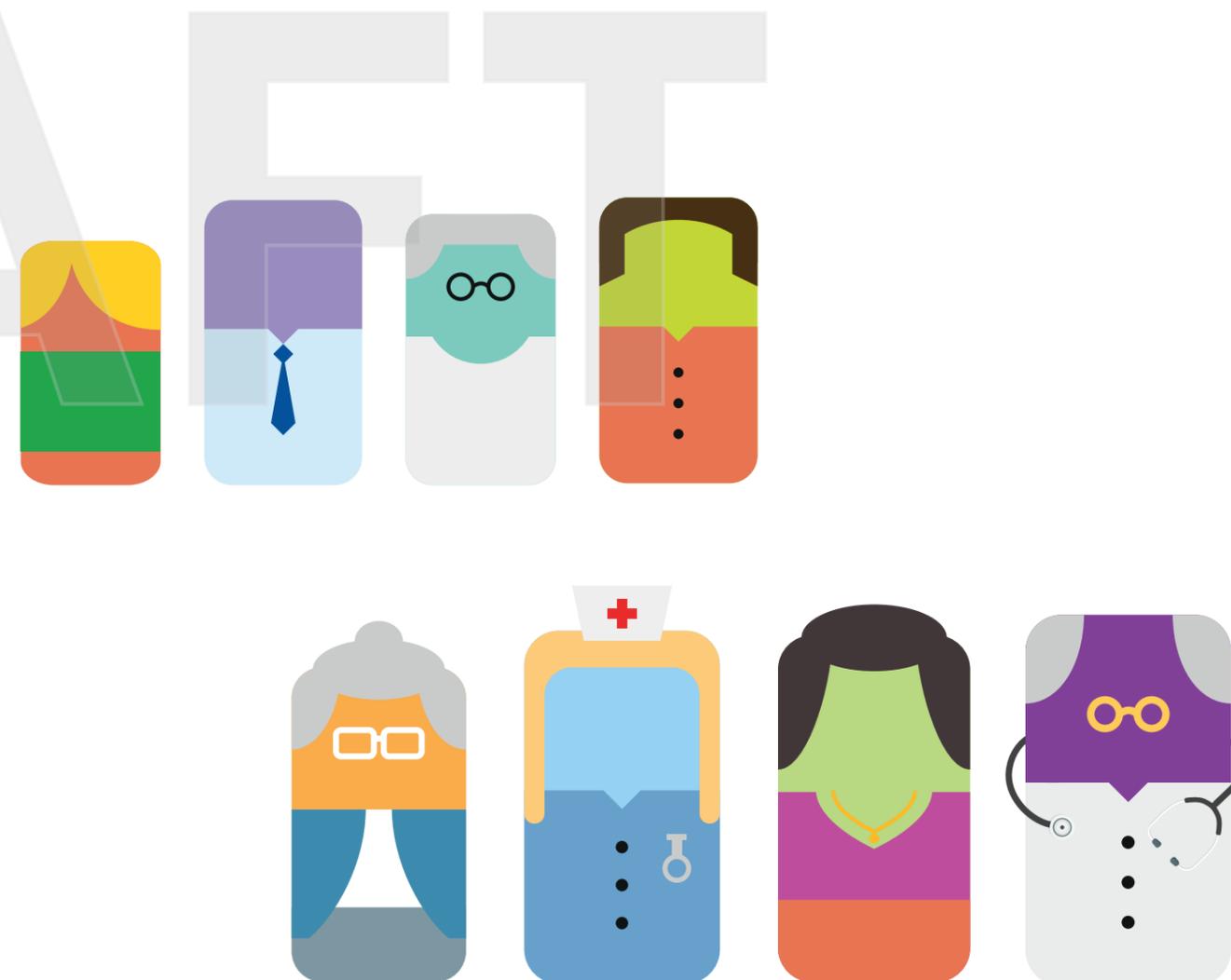
NHS Finance

The NHS in mid and south Essex has traditionally been a financially challenged system and this has impacted on our ability to provide investments into delivering high quality healthcare for our population. We have agreed a delivery plan to meet allocated system control totals over the next five years. These plans are not without challenge, however, it is only by working together, and making best use of the wealth of data we collect, can we reduce duplication and drive efficiencies in the system. Part 2 of this document and Appendix 5 provides further detail on NHS financial plans.

Addressing challenges together

Through the Better Care Fund (BCF) NHS and local authority partners are working together to address the challenges on each sector:

- // Thurrock's Better Care Fund Plan reflects the vision for and progress made on delivering a redesigned place-based health and care system. The pooled fund now totals £48m of joint health and care funding, with the plan's schemes designed to shift activity away from the acute sector. This includes a strong focus on prevention and early intervention as well as ensuring, as far as is possible, that the current adult social care market can be stabilised. Governance arrangements for the BCF Plan are through Thurrock's Integrated Care Partnership and ultimately through the Health and Wellbeing Board.
- // The challenges in Southend are significant and demand for services continues to increase. The Southend BCF plan continues the work of integration, community asset building and locality development and builds on all the successes and learning from previous years. There is a strong focus for the Southend BCF on strengthening primary care through the development of Primary Care Networks, investing in the community and alleviating pressures within the acute environment. As noted elsewhere in this strategy, Local Authority finance is uncertain so the challenge for the BCF has been to find balance between sustainability and investment at pace. The Southend BCF plan is further underpinned by the close partnership held with partners across mid and south Essex.
- // The Essex BCF plan is worth a total of £154 million in 2019/20 and aligns to the wider integration landscape across Essex. The Essex health and social care landscape is particularly complex, with five CCGs and three Health and Care Partnerships that overlap Essex borders. The BCF supports local delivery of Long Term Plan aspirations and forms the foundations for integrated working. At a pan-Essex level the focus is on prevention; early intervention and enablement, safeguarding, and care market quality and sustainability. Individual CCG locality-based pooled funds channel funding according to local priorities. The Essex Health & Wellbeing Board provides strategic leadership and direction for decision-making and joint commissioning and acts as the final point of governance for the Better Care Fund.



Part Two: Our Delivery Plan

8. Delivering on NHS Long Term Plan Commitments - Introduction

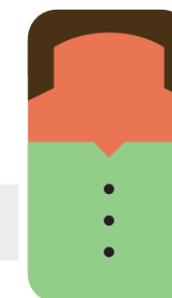
This part of the strategy outlines how the Partnership will deliver on the foundational commitments in the NHS Long Term Plan (LTP).

The LTP set out a number of criteria against which plans would need to align.

Our plans are:

- // **Clinically-led** – senior clinicians are involved in leading the development of all of our plans – through individual clinical transformations programmes, PCN Clinical Directors, provider and commissioner clinical leads and, at system level, through the Clinical Cabinet. All of our change programmes have clear quality impact assessments and “check and challenge” through the various clinical fora. Further information on our Clinical Cabinet and plans for future clinical leadership arrangements can be found in section 33.
- // **Locally-owned** – we have engaged with our communities over a long period of time and this engagement continues through individual statutory organisations, through pathway and programme groups, and via the system-wide Service User Advisory Group. The feedback received from all these sources has helped to shape our plans (see section 2)
- // **Realistic workforce planning** – within the current workforce restraints, individual organisations have set realistic workforce plans to enable the safe delivery of current and transformed services. Our workforce plans have been triangulated with finance and activity plans, and we have placed great focus on retaining and developing our existing staff alongside the development of new roles to meet the changing needs of our population. See section 28.
- // **Financial balance** – our plans observe the business rule set out in the NHS LTP Implementation Framework. As part of our plans to achieve Integrated Care System designation, we recognise that we have further to go in relation to maturing our financial management across the system and this work is underway.
- // **National standards and LTP commitments** – as a system we are committed to delivering the requirements of the LTP – and we set out below how we will do this.

- // A focus on **reducing inequality and unwarranted variation** – as a partnership we are committed to reducing health inequalities. Our strategy has described how we will do this through our focus on creating opportunities, supporting healthy lifestyles, bringing care closer to home and transforming our services.
- // **Engaging partners** – our plans are a collaboration of partners involved in delivering health and care services in mid and south Essex,
- // **Focused on innovation** – we place great emphasis on innovation in our system. Our work on innovation is summarised in section 31.



9. Prevention and addressing health inequalities

Clinical Lead: Mike Gogarty (ECC), Ian Wake (Thurrock), Krishna Ramkhelawon (Southend), Directors for Public Health
Senior Responsible Owners: CCG Accountable Officers

Prevention is about transforming life outcomes, and not simply about stopping bad things from happening. An estimated 40% of all ill health is preventable. By reducing the prevalence of the risk factors, we will reduce the burden of ill health. We know that prevention is best achieved through improving material wealth with a focus on employment and education, addressing social isolation and tackling unhealthy lifestyle choices. We are committed to using evidenced based clinical and non-clinical interventions and planning and infrastructure that influence life outcomes from birth.

Our Commitments

With an ageing and growing population, it is imperative that we find ways to reduce avoidable demand on our statutory services. Prevention requires actions across the Partnership. It cannot be done by any single organisation. The aims of our prevention programmes are to:

- // Improve the health and wellbeing of our population
- // Support people to be in good health for longer (improving healthy life expectancy)
- // Target interventions to improve self-management for people with long-term conditions
- // Develop our staff to work in different ways – promoting wellness
- // Develop our digital capability to support residents to live well

9.1 Giving children and young people the best start in life

Every child and young person, regardless of the circumstances into which they are born, should have the opportunity to maximise their potential and future life chances.

Our Commitments

We are focussed on ensuring that mid and south Essex is a place where children can flourish and achieve their full potential in life.

We know it makes strong sense to invest in the early years from an economic perspective as the long-term savings that can be generated are considerable.

Current Work & Future Plans

Thurrock

Brighter Futures Thurrock represents an integrated children's partnership which brings together – Healthy Families, the Prevention and Support Team and Children's Centres. The ambition for Brighter Futures is to ensure children and families achieve good outcomes through universal provision and when needed through effective early help. This model will be underpinned by a Children's Prospectus from 2020/21. This high level strategic document will seek to clearly articulate Thurrock's vision for the health of its young people.

Local evidence points to key challenges for the under 5's - these include immunisation, obesity, breastfeeding initiation and maintenance, communication and language, outcomes at the two to two and half year child development check within health visiting and early years, oral health and accident and minor illnesses. A wellbeing offer for the 0- fives is being co-produced in Thurrock to address these needs, thereby providing an equitable evidenced offer to residents based on need.

Childhood immunisations trends in Thurrock have experienced a downward trend since 2010, specifically MMR1, MMR2 and PCV. In response the public health team have developed a child immunisations recovery plan, 2019 -21. This was prepared in partnership with NHSE and overseen by the Essex Vaccination Committee. Implementation commenced in June 2019. The plan aims to

- // Improve understanding of performance at a smaller area level
- // Understand the barriers and opportunities underpinning vaccine uptake.
- // Improve access to vaccinations for children
- // Ensure proactive messages about childhood vaccination are promoted in line with local social research and national evidence



A Better Start Southend is a 10-year test and learn programme funded by The National Lottery Community Fund, awarded £40m in 2015 to transform children's lives in Southend-on-Sea. Working with key Partner organisations across health, social care and education, and with local people - parents, carers and volunteers - engaged at every stage, ABSS is helping shape innovative services for young children and families for years to come. With a focus on **diet and nutrition, communication and language and social and emotional development** as well as cross cutting themes of **system change and community resilience**, ABSS is piloting inventive projects including breastfeeding support groups and 1:1 advice, healthy eating programmes (HENRY), maternal mental health initiatives and family support workers - as well as projects supporting speech and language development and building economic independence of families through work skills programmes.

Focussing initial 'test and learn' projects in six of Southend's most deprived wards, the programme aims to share the learning across a wider geographical footprint and will work with partners to that end. Data analysis, research and evaluation is undertaken by specialist data teams and higher education partners.

For more information visit
www.abetterstartsouthend.co.uk

Essex County Council

ECC has commissioned a partnership of Virgin Health and Barnado's to deliver a focussed, evidence-based and needs-driven approach to the Best Start in Life. This was informed by ethnographic research into the needs of local young people and families.

The council and partners recognise the central importance of evidence-based parenting support in ensuring school readiness especially within deprived populations and high risk groups and a set of outcome based KPIs have been agreed to ensure progress in this area.

In some areas there are unacceptable levels of child poverty and the system is adapting the Healthier Wealthier Child model from Glasgow using links between midwives and health visitors and local Citizens' Advice Bureau (CAB) to ensure young families can access all the support, advice and benefits they need.

Southend

Childhood immunisation in Southend is generally improving with the transfer of the Health Visiting service in-house. The council is closely aligned with the A Better Start Southend (ABSS) programme, and is developing a new framework for the commissioning of the 0-19yrs service with a focus on serving the most disadvantaged communities better and to bring about incremental behaviour change through engagement and co-design of support services.

ABSS's mission is to achieve system change such that by the conclusion of Lottery Funding, local partners have embedded a sustainable system. The aim is to shift the focus away from traditional service commissioning towards greater levels of community and practitioner ownership, recognising the social capital we can build will be key to sustainability of services and the local approach.

9.2 Flu Immunisation

An effective flu immunisation programme will prevent vulnerable people from becoming unwell.

Our Commitments

We commit to working with existing networks to:

- // To increase public awareness of the need for the vaccine, its benefits and to dispel myths
- // Support primary care networks to offer the vaccine – eg. offering flu clinics outside normal hours, using GP-online to book appointments etc.
- // Regularly monitor uptake data, to have a better understanding of practice/ group variation etc. in order to give support.

Current Work & Future Plans

Essex

Supports public awareness of winter health through its public facing website that signposts to NHS information on seasonal flu immunisation and other ways to stay healthy. In addition the council is promoting the uptake of seasonal flu immunisation among public facing social care staff.

Southend

The 2019/20 Flu plan for Southend-on-Sea aims to increase the uptake of the vaccination in key vulnerable groups through collaboration across healthcare and public sector organisations in the borough to optimise resources and increase public awareness. The key aspiration of the plan is to achieve 75%+ uptake in adult vaccinations, 48%+ uptake in pre-school children, and 65%+ in school age children. Additionally, key vulnerable groups such as homeless/rough sleepers are being prioritised for service outreach and the LeDeR Programme has identified people with learning disabilities as a key group to prioritise.

A key component of the flu vaccination plan is the vaccination of healthcare staff and of public-facing staff in the local authority and partner organisations. The plan has widened access to the staff vaccination programme to key staff members in, for example, housing services and the voluntary sector.

Thurrock

The overarching strategy of the 2019/20 Thurrock Flu action plan is to work with existing networks including GP surgeries, extended access health hubs, pharmacies and community nursing, to offer the flu vaccination to a wide range of our population, particularly those aged 65+ and our 'at risk' population aged 64 years old and under. The work involves collaboration with staff working in care homes, healthcare workers, carers, and those who come into contact with vulnerable groups.





9.3 Cardiovascular Disease (CVD) Prevention

The most recent modelled prevalence of cardiovascular disease published by Public Health England highlighted a gap between the registered prevalence in the area for hypertension, atrial fibrillation and diabetes. These are major risk factors for premature death and disability and yet are relatively simple to address to enhance prevention. However, there is still a substantial variation in rates of early diagnosis and optimal treatment.

High quality primary care is central to improving outcomes in CVD because this is where much prevention, diagnosis and treatment is delivered. Improving primary care management of cardiovascular and cardiovascular-related conditions can prevent both adverse health events and costs. This underpins the need for the development of programmes that can identify patients suffering from long-term conditions at the earliest onset.

Long term conditions disproportionately affect certain groups of people such as, vulnerable individuals, those in the BME groups, areas of high deprivation or those with a disability. One of the factors identified to contributing to the highest level of inequality is due to low capacity in primary care. To tackle this unfairness, public health is looking at bringing screening services closer to the community and contributing to creating more efficient screening and diagnosis pathways in primary care.

Our Commitments

- // Bring screening services closer to the community.
- // Target groups of vulnerable people to decrease existing inequities.
- // Create efficient, evidenced based pathways for screening, referral and diagnosis.
- // Educate on and promote high quality management of cardiovascular disease.
- // Work collaboratively with the voluntary sector to better understand the needs of the population and create programmes and interventions that are tailored to specific population groups.

Current Work & Future Plans

Thurrock

- // NHS Health Checks provide a systematic way of identifying patients either at high risk of, or with undiagnosed cardio-vascular disease and then providing referral to lifestyle modification programmes or where necessary clinical management. NHS Health Checks in Thurrock are provided either by the GP practice or by the Thurrock Healthy Lifestyle Service. There is an ambition to reach a 60% conversion from invites to completed checks. Last year the service achieved 48%. Improvements have been made through new software that enables consistent delivery of the health check and ensures data is transmitted back onto the clinical systems. In 2018 a localised best practice guide was produced to help GP practices deliver the NHS Health Check programme to a high standard.
- // The Thurrock the Hypertension Detection project commenced in April 2017, as a 3 year programme to address the high level of under-detection of hypertension. The overarching outcome of the project is to achieve a 10% increase in hypertension register completeness in Thurrock by 31st March 2020 compared to the 31st March 2017 baseline. The series of detection streams being implemented as part of the overall project includes;
 - // Community Pharmacy detection (Jun. 2017 – Mar. 2018)
 - // GP waiting area detection (Since Feb. 2018)
 - // Smoking Cessation clinic detection (Since Jul. 2018)
 - // Community hub detection (Since Aug. 2018)
 The programme has been highly successful, delivering a 6% increase in register size in its first year.
- // **Diabetes Detection Programme** – a series of pilot projects which commenced with a Diabetes Detection in Dentistry is underway. The purpose of Thurrock Diabetes Community Detection is to develop work streams to act on the low case finding rates for diabetes mellitus (type 2), aiming to increase the detection rate of people living with diabetes who are asymptomatic and are at risk of serious health implications if undiagnosed. Additional to early diagnosis, pre-diabetic range is also being considered, with high risk patients being referred into the National Diabetes Programme for healthy lifestyle education. It is intended that the projects will also increase the number of people receiving appropriate care and treatment to prevent disease onset.
- // **CVD Upskilling** - Public health have developed and implemented a number of work streams focused on the improvement in detection and management of patients with long term conditions. These work streams also carry with them a significant financial investment. To ensure the effectiveness of the initiatives and achievement of outcomes it is acknowledged there is a need to upskill the practices and clinicians who will be delivering the required activity. A focused training programme incorporating up to date guidelines and evidence-base, aimed specifically to address the needs of front line primary care was procured. The CVD Upskilling programme encompasses six Modules of training, with the aim of supporting primary care services to achieve the stated outcomes of ensuring appropriate practice based investigations and diagnosis, on-going CVD management and onwards referrals. The first round of training was completed in March 2019 with resoundingly positive feedback. The second cohort of clinicians commenced in October 2019.

// **Stretched QOF** – this contract with primary care commenced in July 2018 to incentivise GP practices to achieve above the maximum Quality and Outcomes Framework threshold for selected CVD, mental health and respiratory indicators. In doing so, this seeks to provide interventions to an increased number of patients eligible, improving the management of long term conditions in primary care leading to the following outcomes:

- // Reduction of non-elective hospital activity from patients with long term conditions.
- // Reduction in the number of patients having a major health event that results in a new or increased need of adult social care packages (e.g. stroke)
- // Improvement in the health and wellbeing of patients with a long term condition (LTC).

In 2018/19 the programme delivered a significant increase in performance across 18 of the 19 QOF indicators selected, with performance in CVD indicators in Thurrock now significantly better than the England mean. In 2019, the contract was updated to reflect the new QOF indicators and clinical threshold targets as indicated in the Long Term Plan.

Essex

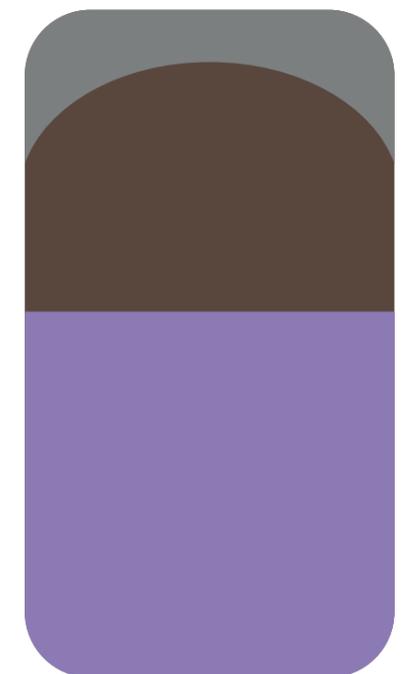
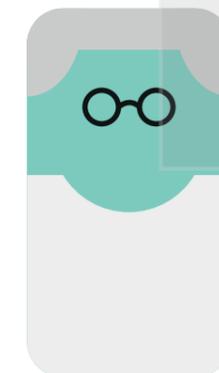
- // **Health Checks:** Essex County Council remain one of the top performing county councils for health checks and have an ambition to increase uptake in the most deprived groups such that 25% of checks are within the most deprived quintile. Additionally the Council continue to commissioning senior health checks, recognising the higher absolute risk and lower numbers needed to treat in the 75 to 84 age group.
- // **Hypertension:** Essex completed a hypertension detection and management project in 2018. Our consideration of published evidence and local data suggest further specific initiatives in this area in Essex are not currently a priority although we would still expect primary care to identify and manage people with high blood pressure and wider cardiac risk in line with national guidelines.
- // **Diabetes prevention** - Essex are keen to work with primary care colleagues to ensure people who may be at risk of diabetes are referred for lifestyle advice including weight loss. Local review of literature and a desire to simplify systems suggests a model simply based on weight is best to identify the most people at risk of type 2 diabetes and there is ample capacity in lifestyle and weight loss support services to support referrals.
- // **Atrial fibrillation** - Essex have run several initiatives over recent years to work with practices to ensure people with AF receive optimal stroke prevention management. There is however further scope for improvement in this area and therefore the AF work highlighted in section 21 is welcomed.

Southend

Southend-on-Sea met its targets for provision of NHS Adult Health Checks in 2018/19 and has sought to build on this for 2019/20, working with the new PCNs to better target people in areas of higher deprivation and provide more flexible access out of hours service through community hubs. In addition, a plan has been developed for provision of a dedicated service to increase access to physical health checks for people with significant mental illness.

A local incentivised scheme for PCNs has been developed to support prevention interventions across the life course. This provides an extended QOF for a set of prevention areas to be prioritised according to key areas of PCN need from childhood through to older age populations. This extended QOF service includes work to reduce risk factors for CVD through identification and optimised management of atrial fibrillation (AF) and hypertension. This will be in place from January 2020.

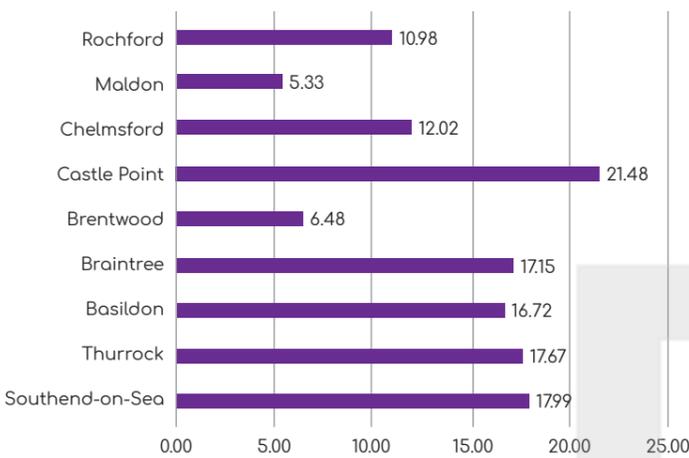
Additionally, surgery pods are in place in a number of GP practices in Southend with a plan agreed to roll this out across all practices. These pods are also in place in care homes across the borough. There is scope to enhance these pods to enable further identification of AF through additional software.



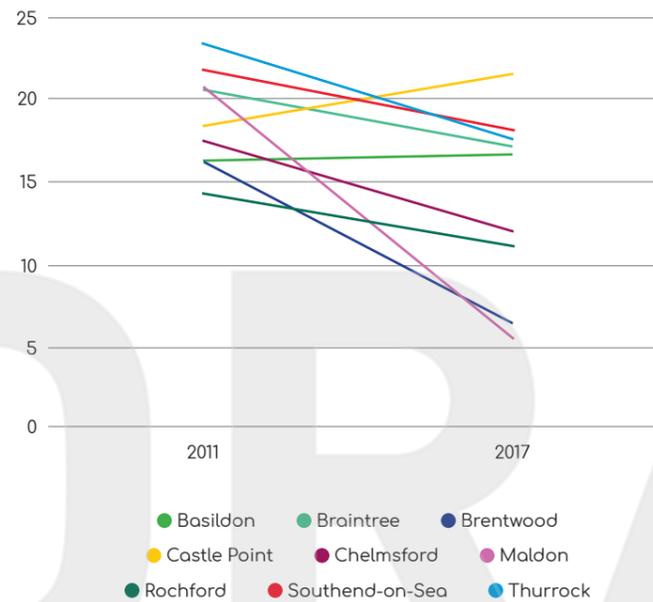
9.4 Tobacco Control

The proportion of current smokers among residents aged over 18 has mostly decreased across mid and south Essex since 2011. Helping people to stop smoking remains a key way to prevent avoidable early ill health.

Proportion of current smokers, 2017



Trend in proportion of current smokers 2001-2017



Our Commitments:

All partners are committed to working together to take a more proactive approach around smoking cessation for staff, patients and visitors. We will achieve this by preventing people from starting to smoke, supporting more people to quit and tackling health inequalities by targeting key groups. Specific points of action will be:

- // To ensure smoke free environments within our own institutions and focus more on identifying smokers and supporting them to quit.
- // Using the Anchor Institution programme to support the smoke free agenda, particularly through work with hospitals as major employers.
- // Through our Places we will target interventions in particular areas of high smoking prevalence
- // Through our maternity services transformation work, ensuring additional support is available for pregnant women to quit smoking, both in order to reduce health inequalities and the adverse impacts on the health and development of foetuses and infants.

Current provision & future plans

Community smoking cessation services exist across our three local authority areas. These services offer lifestyle advice and support for stopping smoking:

Southend

Has launched a new Harm Reduction Strategy which will tackle the issues intertwined with gambling, tobacco control and smoking and drug and alcohol misuse. This will drive the smoke-free work across a number of partnerships. The council is actively working with local vaping shops to support smokers to quit tobacco smoking, as well as moving to appoint a dedicated public health midwife to better support pregnant smokers. The Smoke-free School Gates campaign is working with primary schoolchildren to encourage their grown-ups to stop smoking at the school gates.

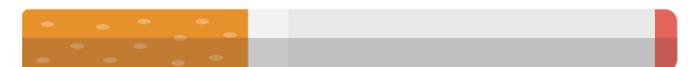
Thurrock

Public health officers have been working with EPUT, BTUH and secondary care datasets to support the implementation of smoke free sites set out in the Tobacco Control Plan for England (2017-2022) and the NHS Long Term Plan's Ottawa/CURE model in acute settings. This includes brief advice, screening and referral to community smoking cessation services but also smoking cessation support for inpatients.

Collaborative working with Trading Standards is restricting the supply of 'pocket-money-priced' illicit and counterfeit tobacco. Test purchases and tobacco detection dogs are just two of the enforcement measures implemented. Since 2017, the council's Trading Standards Team has conducted numerous covert operations across the borough, seizing tens of thousands of counterfeit and smuggled cigarettes and numerous kilos of hand rolling tobacco. The Council has taken enforcement and legal action against all itinerant traders.

Essex

Alongside more traditional interventions, piloted the use of vape vendors in supporting complete switch from tobacco to ecigs. This followed recognition that many people chose to try and substitute tobacco with vaping rather than approach traditional smoking support services. The approach has been recognised by Public Health England and shared as good practice. Trading Standards, part of the Public Health team in Essex, have too made considerable inroads into tackling illicit tobacco.

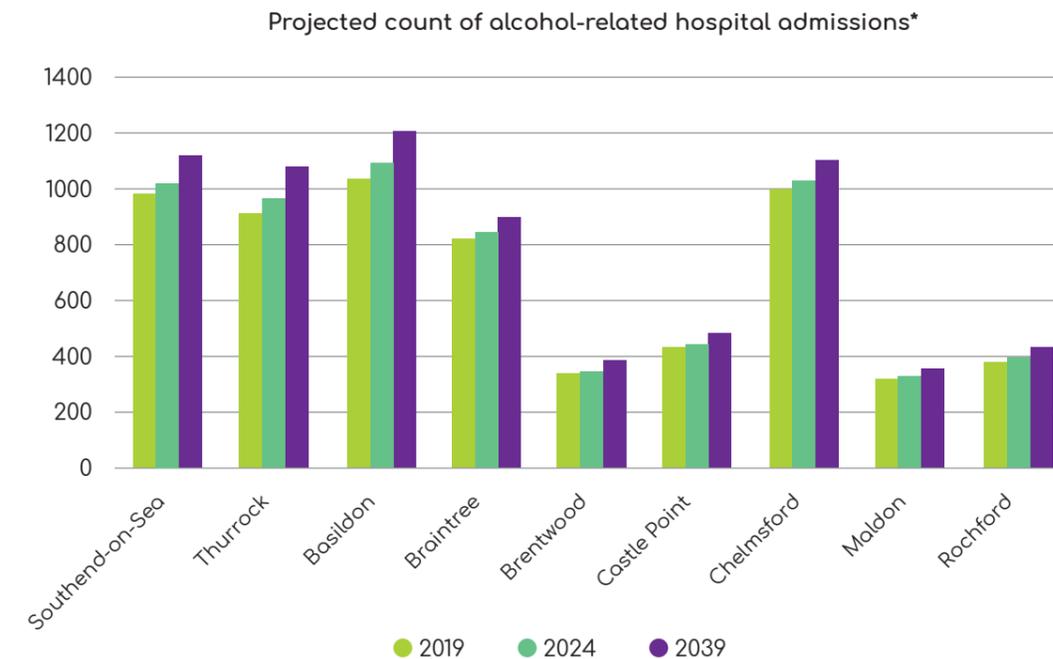
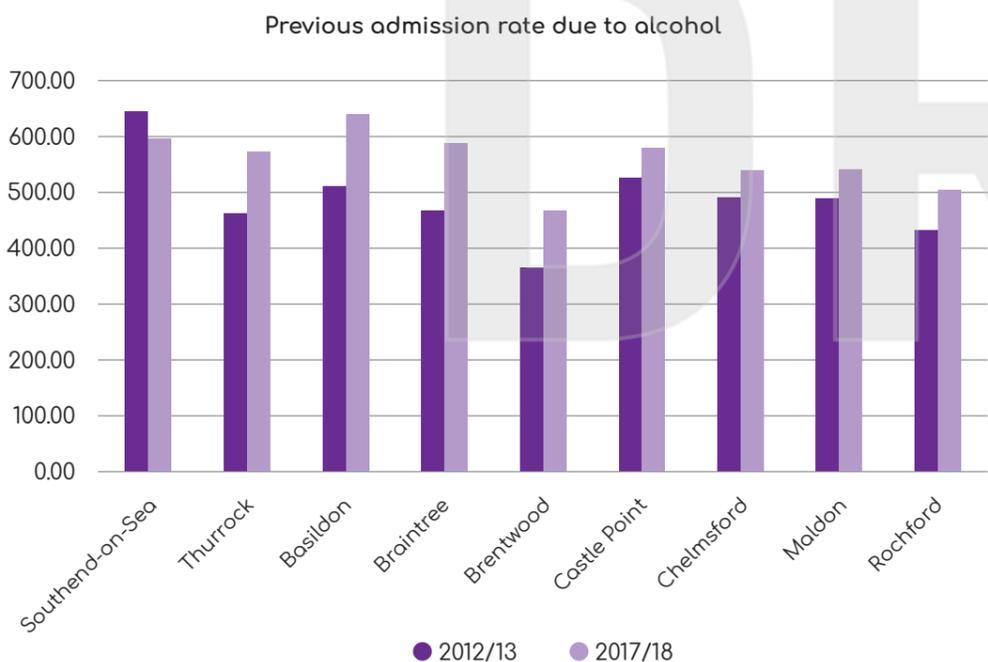


9.5 Alcohol Use

Alcohol is a significant cause of harm across mid and south Essex, resulting in high numbers of hospital admissions, ambulance call outs and GP attendances.

Through the narrow measure of alcohol related hospital admissions per 100,000 population (which includes only those admissions where alcohol is directly attributable), Basildon had the highest rate of all local authorities across mid and south Essex and the largest increase over the previous five years. This contrasts with Southend-on-Sea which had the second largest rate for 2017 but was the only local authority to show a decline (-47) in hospital admission rates since 2012/13.

Based on population estimates, the number of alcohol-related hospital admissions is likely to increase, with Basildon and Thurrock forecast to have the largest percentage increase over the next five-20 years.



Our Commitments:

- // We will take a more proactive approach to alcohol management including identification of individuals with alcohol dependency, and support for people to reduce/abstain to prevent ill-health.
- // All organisations will take action to minimise the impact of alcohol on the most vulnerable including the children of dependent and harmful drinkers.
- // All local authorities seek to increase the number of dependent drinkers receiving treatment.
- // Specific actions will target areas with high prevalence of alcohol related harm through place-based plans.

Current provision and future plans:

- // Across the system we have some excellent community alcohol support services including preventative and treatment services being provided across community, primary and secondary care, but the service offer is not consistent and funding arrangements require review. Better alignment across the partnership footprint between service providers could ensure we manage differential access and share learning and good practice.
- // The LTP highlighted alcohol treatment teams (ACTs) as being an effective approach to preventing alcohol-related harm. Currently the local authority Public Health teams fund two roles in each hospital – an Alcohol Liaison (nurse) Service and an A&E Liaison Service. Discussions are ongoing about how to enhance the hospital-based services, focused on linking with mental health workers and improving links to community drug and alcohol services and having more liaison support workers covering longer hours, including events and weekends
- // The charity Open Road provide weekend support in the city centre in Chelmsford to keep those affected by alcohol safe and away from A&E services, this model is being reviewed across the footprint. Southend has started this review, following the decommissioning of a similar service in 2017-18.

9.6 Obesity

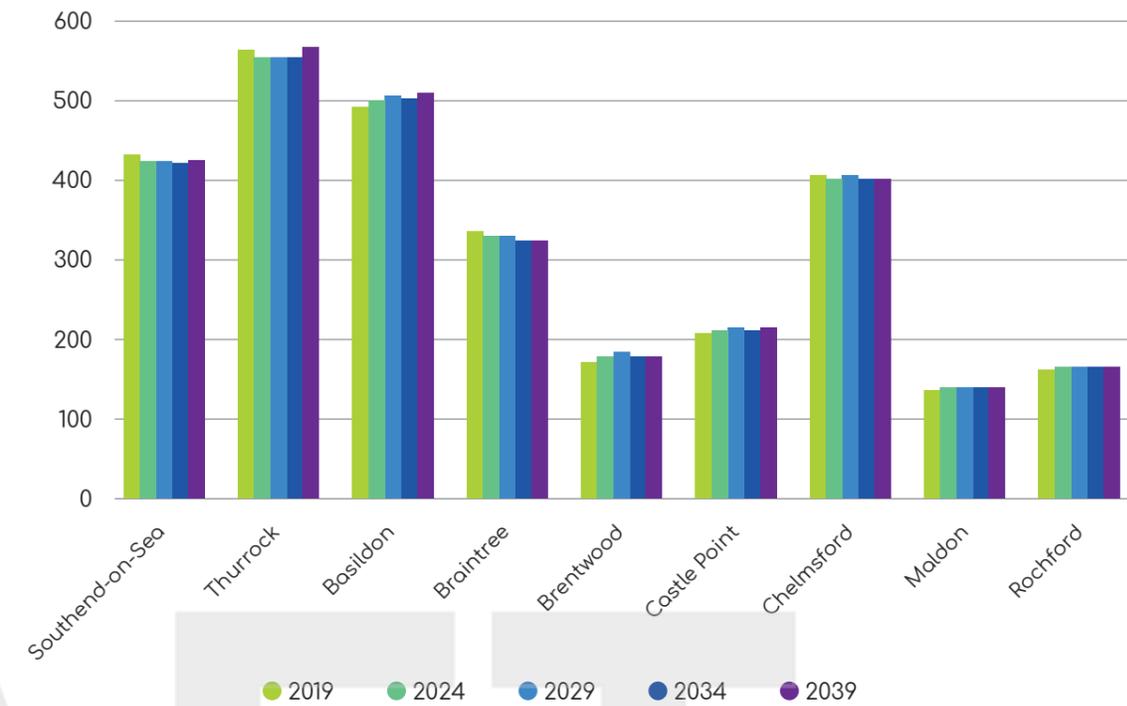
Children

Being overweight is partly responsible for more than a third of all long term health conditions.

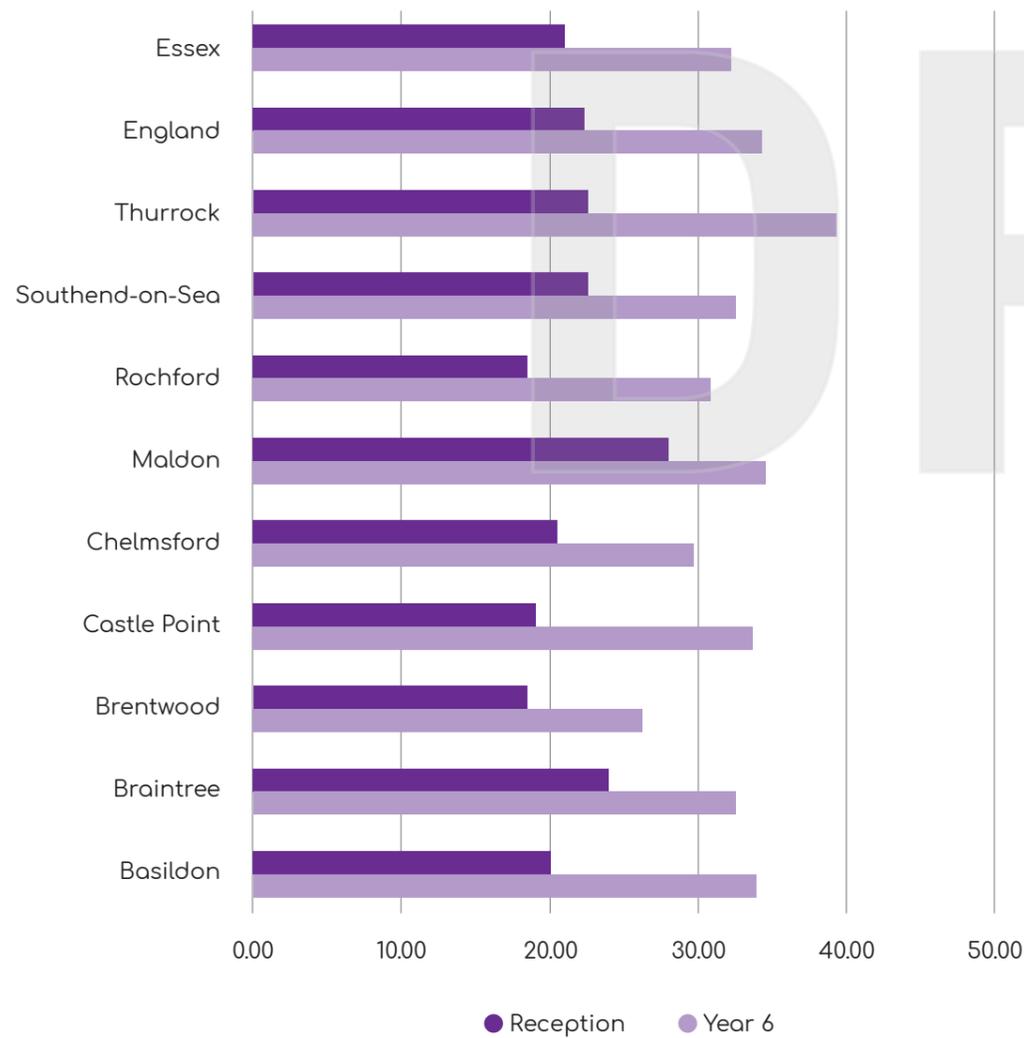
If the proportion of overweight or obese children remains the same, due to projected population increases, the total number is likely to increase across the footprint. It is forecast that Southend, Thurrock and Basildon will consistently have the highest count of overweight or obese children in reception.



Projected count of children overweight or obese in Reception*

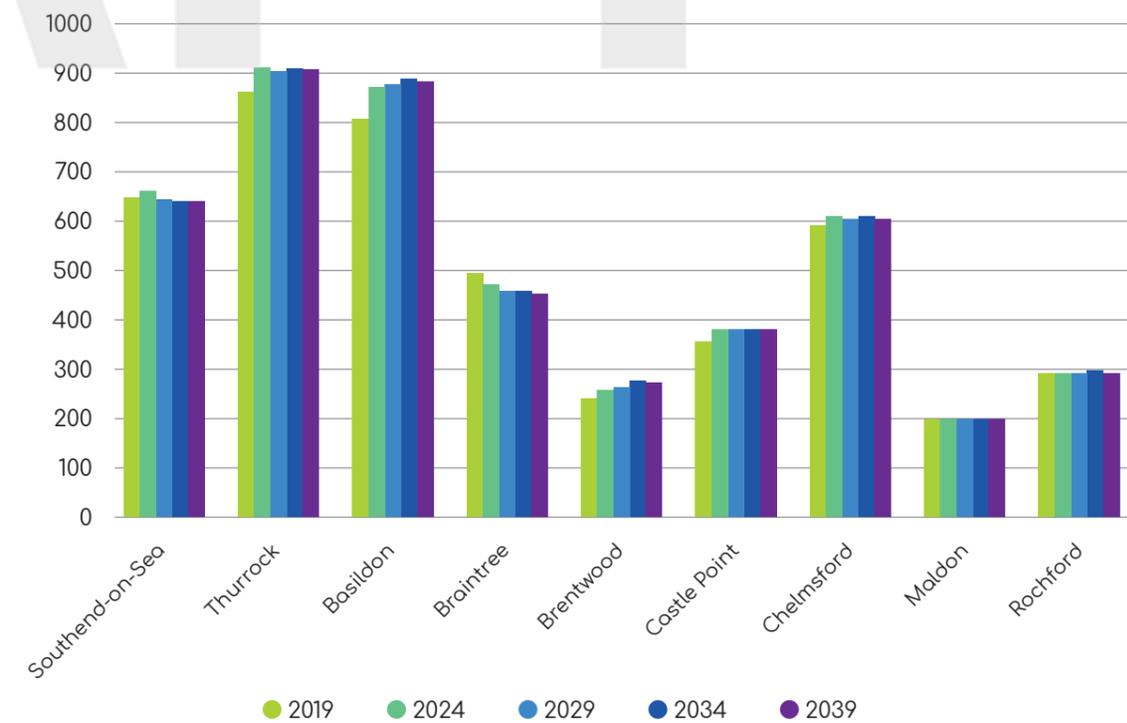


Proportion of children overweight or obese in Reception and Year 6 (2017/18)



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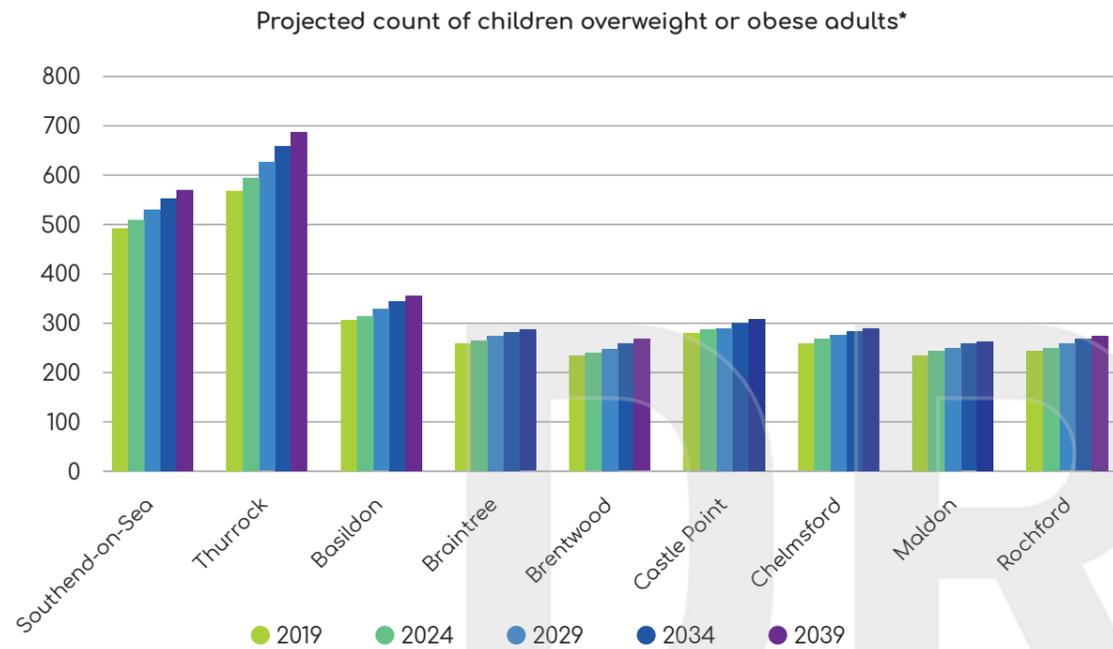
Projected count of children overweight or obese in Year 6*



Adults

The proportion of overweight or obese adults was the highest in the Basildon district, however, the proportion in all but three local authorities was higher than across England.

It is forecast that Basildon, Southend and Thurrock will consistently have the three highest counts of overweight or obese adults and the largest percentage increase in count from 2019 to 2024 and 2039.



Basildon and Thurrock had the lowest proportion of adults that were physically active, lower than the Essex and England average. Basildon also had the lowest proportion of adults meeting the recommended “five a day” fruit and vegetable target, lower than the Essex and England average.

Our Commitments

- // We recognise that active and health lifestyles contribute to improve physical and mental health. We commit to supporting our residents to make the best choices about their diet and physical activity levels.
- // Our local authorities have committed to a “health in all policies” approach.
- // We will ensure access to commissioned weight management services across the footprint for both adults and children, in accordance with NICE guidance.
- // Increase uptake of the Diabetes Prevention Programme and target groups that are at higher risk.
- // Work together on whole system approaches to encourage healthy lifestyles and weight management.
- // Use the Anchor Institution approach to create healthier working environments, particularly active travel, physical activity opportunities and reduced access to high sugar food and drinks.

Current Provision & Future Plans

Currently it is estimated that 22% of the population of Essex is classified as inactive.

Southend

A new wellbeing service was commissioned in 2019 in Southend. The main remit is to enable community-led Tier 1 service development, building on some existing initiatives and more collaboration with other existing ‘Tier 2’ providers locally. The services work with the PCNs to develop a wider offer for the Exercise Referral Programme, which currently only offers gym-based sessions. PCNs would like a mix of community-led initiatives as well as dedicated low to moderate impact activities – such as yoga, Pilates, TaiChi, swimming, etc. Southend plans to launch this new service in 2020. The council is reviewing their offer for Strength and Balance exercise programmes, expanding from fall prevention to healthy ageing.

Southend Council is also promoting the Daily Mile in schools and will shortly add this to the menu of interventions as part of the Enhanced Healthy School programme. The dedicated investment through A Better Start Southend programme, is enabling more alignment between physical wellbeing activities and the diet and nutrition component in looking at obesity.

The Southend Physical Activity Implementation strategy is entering its final year, and most of the key actions are already in place or in development including tackling obesity through planning and development and adopting Sport England’s “10 Principles of Active Design”.

THE DAILY MILE

65,000 primary school children across Essex & Southend are participating in the Daily Mile programme. Active Essex is one of ten partnerships to receive funding to employ a Daily Mile coordinator to embed the programme across our schools.

Essex

The limited range and impact of traditionally commissioned tier 2 services led to a service redesign, led by the tier 2 provider, to transform the service to be one of community- led peer support weight loss groups. These have delivered a 30% increase in activity in the first year at half the cost, with weight loss levels in individuals comparable with the National Diabetes Prevention Programme. This work has led Essex to rethink how best to prevent diabetes locally, including an approach to optimising referral of anyone who is overweight into the service.

A second approach, highlighted as best practice in the NHS Green paper , is a whole system approach to childhood obesity developed on the evidence based EPODE model piloted in a local authority. The schools benefitting from the whole system interventions showed weight loss over the pilot while control areas saw a gain. The model will be rolled out subject to continued gains in the upcoming NCMP results.



Essex has been awarded a £10.68m National Lottery grant from Sport England to increase physical activity and tackle the inequalities that prevent nearly 400,000 people from enjoying the benefits of an active lifestyle. The programme has seen 20 action research projects across the county and involves almost 1500 stakeholders and community groups. The plans include:

- // Getting local people involved, who want to create activities in their areas
- // Creating active parks, coastal paths and new walking and cycling routes
- // Easy access to small grants and support for community projects
- // Investing in successful voluntary groups and charities to scale up their activities
- // Training people in voluntary as well as paid roles, creating thousands of new volunteers, leaders and coaches
- // Brightening up buildings, streets and parks to make them attractive places to be active
- // World class measurement and evaluation which will be shared UK-wide

Thurrock

Whole Systems Obesity Strategy

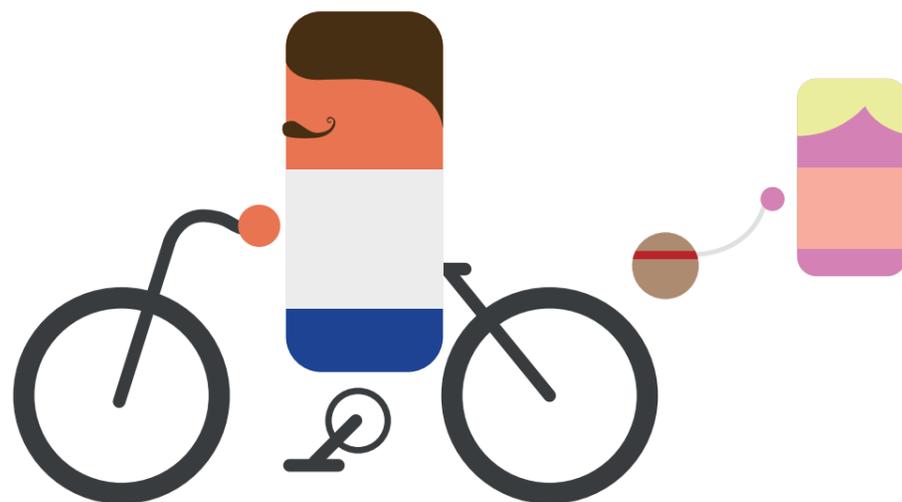
In 2017/18, 69% of the adult population were overweight and obese in Thurrock. This prevalence is statistically significantly greater compared to England (62%) and is the highest in the East of England. Prevalence of childhood obesity in Thurrock at reception and year six are 10.7% and 25.3% respectively (2017/18). The year six prevalence is also statistically significantly greater than England's prevalence.

In 2019/20, a Whole Systems Obesity Strategy has been developed as the strategic driver for preventing and reducing obesity in Thurrock. There are five goals within the strategy:

- // Enabling settings, schools and services to contribute to children and young people achieving a healthy weight
- // Increasing positive community influences
- // Improving the food environment and making healthier choices easier
- // Improving the built environment and getting the physically inactive active
- // Improving the identification and management of obesity

Thurrock Exercise on Referral (EOR)

EOR is a prescribed exercise programme offering specific programmes for people with long term conditions including obesity, COPD, Parkinson's, low level mental health, diabetes, back pain, cardiovascular conditions (e.g. high blood pressure), stroke and cancer. The programme is 12 weeks long and includes twice weekly sessions. Impulse Leisure is the provider of the service and it is offered at the three leisure centre sites across Thurrock. The programme has physical, mental and social benefits. Being in the group provides a social opportunity useful for sharing ideas and tips around self-management.



9.7 Air quality

Air pollution contributes to a number of conditions, including lung cancer, heart disease, stroke and lung diseases, such as asthma and is a significant contributor to health inequalities.

Our Commitments

- // Work in partnership to encourage and support staff to use travel modes such as cycling, public transport or walking. Some organisations already offer incentives and subsidies for using public transport (eg, the acute hospitals offer discounts on bus travel) and we will seek to map what is on offer and share good practice.
- // Support and encourage service users to use sustainable travel methods.
- // Reduce business mileage through increased use of video- and tele-conferencing, Webex and other on-line means.
- // Use of low emission vehicles for business wherever possible. Southend boasts the only electric car-club scheme in this area for use by council employees and other local residents/businesses.

Future Plans

Southend

Will be looking to explore opportunities in the creation of Park & Ride schemes that could better serve the airport and encourage the use of the excellent train service to access its beaches.

Southend recognises the need to invest in new technology to help better measure peaks of poor air quality and is looking to pilot an Internet of Things project with the support of Public Health England. Southend will also be exploring policy options to help alleviate high air pollution in its Green City policy development.

Essex

Through its [Essex Design guide](#), Essex County Council is setting the expectation that the substantial new development that is taking place in Essex supports active transport and access to the natural environment.

[Essex Air](#), a collaboration of all upper and lower tier local authorities in Greater Essex, is developing its public facing website to improve the information to the public to provide clear information on air quality in their local area.

9.8 Anti-microbial resistance

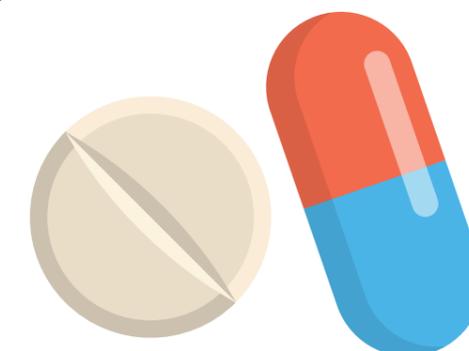
The NHS Long Term Plan sets out an ambition to drive progress in implementing the Government's five-year national action plan, Tackling Antimicrobial Resistance, to reduce overall antibiotic use and drug-resistant infections.

Our Commitments

- // To achieve the measures of success within our remit as set out in the Tackling Antimicrobial Resistance 2019-2024; the UK's five-year national action plan
- // To optimise system wide use of antimicrobials
- // To establish a:
 1. single system-wide antimicrobial stewardship committee
 2. system wide antimicrobial stewardship strategy
 3. surveillance system for data review and analysis
 4. system to promote the antibiotic guardian pledge
- // Provide system wide leadership to providers on the delivery of national Commissioning for Quality and Innovation (CQUIN) indicators.

Current Work & Future Plans

- // There is a newly appointed senior responsible officer for AMR, who will provide system leadership to ensure the delivery of the 5-year national action plan.
- // Focus to date includes;
 - // Establishment of system- wide governance structure with a single overarching Antimicrobial Stewardship Committee to provide system leadership for preventing and reducing rates of healthcare associated infections (HCAI) and the AMR agenda.
 - // Provision of system wide leadership to:
 1. Reduce total antibiotic consumption by 1% from the 2018 baseline by the end of Q4 2019/20
 2. Deliver the two NHS Improvement Commissioning for Quality and Innovation (CQUIN) indicators:
 - // Improving the management of lower urinary tract infections in older people
 - // Improving appropriate use of antibiotic surgical prophylaxis in elective colorectal surgery



Our work plan for the coming two years is to:

- // Establish a single Primary care antimicrobial prescribing formulary across mid and south Essex
- // Establish a single secondary care antimicrobial prescribing formulary across mid and south Essex hospitals
- // Standardise the implementation of the national PHE target antibiotic campaign on an ongoing basis
- // Monitor antimicrobial prescribing data and local antibiotic key performance indicators (KPIs) eg. Prescribing of broad spectrum antibiotics. to address areas of improvement by educating and training all prescribers on appropriate use of antibiotics by promoting use of the target antibiotic toolkits

9.9 Public Mental Health

Essex County Council

It is recognised that, regardless how much the system invests in mental health services, it will be impossible for funded services to identify and intervene with all people who may be at risk of mental health issues. One of the solutions includes developing local social media Facebook groups to enable people to be able to identify and the address the issues that are important to them within their own communities. The system will support them with training and with small microgrants.

The system is growing in coverage with Facebook groups being identified and supported by an independent social media expert. Work to date includes widespread community based mental health first aid training, online suicide training and domestic abuse training as well as action around social isolation, weight loss support and physical activity.

A second key route to communities in many parts of Essex is via the parish councils. A dedicated public health practitioner post has been employed by the Association of Local Councils and charged with engaging parishes in the work described above.

The system is also working with employers to ensure a strong workplace health approach. The Joint Health & Wellbeing Strategy for Essex has specific targets on helping people with mental health issues to be employed and retained in the workplace.

Essex has seen a rise in suicides and specific action has been initiated to tackle this including widespread roll-out of training to communities, with particular focus on those who may be in contact with those at higher risk. This has led to work through local districts with barbers, taxi drivers and pubs who are most likely to see people who may be less likely to recognise their own risk. There is also work with debt agencies, housing and Job Centres to ensure those at risk through debt and lack of employment can best be identified. This is being supported by a social media campaign "It's never too late, Mate".

Loneliness is a key challenge and the system is developing a series of local and system-wide approaches to tackle this. This has included the launch of the

United in Kind social movement and the development of a systematic approach to identify and tackle loneliness across Essex. This requires active (but very limited) intervention through primary care and is built around a care navigator model embedded in a large local community organisation. The new opportunity open to PCNs through social prescribers will be aligned with existing related systems to ensure the optimal gain to local people from these new roles.

In addition to issues around access to work and the impact of this on health and life expectancy, people with mental health issues often suffer poor lifestyle choices. Improved physical activity will both help address mental health issues and improve wider health outcomes. As a national Sport England LDP pilot one area of specific focus is improving physical activity in people with mental health issues using a whole system approach.

The system is also working with employers to ensure a strong workplace health approach. Working Well provides targeted and tailored interventions within the workplace to support employers to improve and maintain the mental and physical health of their employees. The programme offers a broad range of approaches including Mental Health First Aid training, smoking cessation, stress awareness training, as well as increased physical activity.

This is now also supported by the Working Well Accreditation programme, and a monthly newsletter is provided to organisations which gathers feedback on mental health first aid interventions carried out by the Mental Health First Aiders. This programme is currently working with 165 businesses county-wide and has partnered with the Chambers of Commerce and the Federation of Small Businesses to increase reach.

Southend

The Southend 2050 vision places health and wellbeing at the heart of planning across all areas of local authority business, and recognises the benefits of a "health in all policies" approach to addressing the wider determinants of mental health. The vision and strategy seeks to develop systems and a planned environment within the borough that enables residents and communities to optimise their life opportunities and resilience and improve their wellbeing.

Priority areas of work for promoting wellbeing and preventing mental ill health are the development of a multi-partner social prescribing system across the borough, development of population health management approaches to identify optimal use of mental health resources, and a new system for increasing access to physical health checks for people with significant mental illness. The Public Health team manage and deliver/commission a significant programme of interventions and systems for children and young people to build personal resilience and support them in times of emotional wellbeing need, both inside and outside school. The A Better Start Southend programme supports parents in areas of high deprivation with developing healthy relationships with their young children, recognising the importance of this for the rest of the life course.

The council is also reviewing its offer to local businesses in regards to mental health and wellbeing as part of a refresh of the Public Health Responsibility Deal, with a focus on micro-businesses which make up 86% of all local enterprises.

Thurrock

Adults and Older People

- // Thurrock is involved in a number of initiatives around improving the mental health and wellbeing of its population and preventing onward service use. Thurrock's overall commitment to this approach can be seen in the recent signing of the Prevention Concordat for Better Mental Health, which was submitted in July 2019 by Thurrock's Health and Wellbeing Board – demonstrating the extent of partnership agreement towards this aim. Some examples of specific work programmes currently underway or planned to commence include:
 - // Mapping where residents with poor mental health are currently being seen by non-specialist services, in order to roll out improved opportunities for case finding/early identification and better pathways to support options such as the Recovery College
 - // The housing service have recently employed a mental health practitioner to improve staff skills around identifying and supporting those with mental ill-health, and to increase awareness of wider support options available
 - // We are supporting national initiatives, such as promoting Every Mind Matters, but have also invested in Mental Health First Aiders across the borough. We plan to evaluate the success of this in 2020.
 - // We will complete a worklessness and health Joint Strategic Needs Assessment which will include recommendations on ensuring the mental health needs of those in employment are met, and also that those with poor mental health who are out of employment can be supported.
 - // Several organisations are screening their patients for likely anxiety or depression, with an onward referral pathway to the local IAPT service if required. This is underway in a handful of GP practices for diabetes patients in the first phase, and will be further rolled out to more practices during 2019/20. It is also being undertaken in the Healthy Lifestyles Service and the community diabetes team.
- // Thurrock is also undertaking a number of initiatives which will aim to reduce inequalities in those groups identified to have poorer mental health. The Public Health team undertook Joint Strategic Needs Assessments for Adult Common Mental Health Disorders and for Children's Mental Health and Wellbeing in 2017. Both documents profiled key groups at high risk of poorer mental health. Public Health intelligence has informed the way data is being collected for several clinical services – such as EIP, IAPT and Recovery College, as the services are now monitoring more information on different population groups. This is monitored as part of monthly contract review meetings – particularly for BAME and older people's referrals.
- // As part of the work to transform the mental health of those with serious mental illness, Thurrock is developing a new model of care at locality level – piloting in Tilbury. Fundamental to this is the mapping of all services and organisations which might support those with poor mental health – even if that is not their primary remit; understanding current demand, capacity and service interfaces. This will aim to improve the future offer of support and ensure services that support employment, housing, social care and other wider determinants of health are aligned appropriately with clinical treatment models – recognising that aspects such as homelessness and unemployment are key drivers of poor mental health.

- // To improve the mental health of those with physical LTCs, Thurrock is rolling out a new programme of serious mental illness Physical Health Checks for 2019/20, with the ambition for 60% to have had this by March 2020. The other programme of work for those with LTCs relates to depression screening – completion of the PHQ9 and GAD7 screening tool is being trialled in a handful of GP practices for Diabetes patients, and will be further rolled out to more practices during 2019/20 and evaluated for impact. Depression screening will also shortly begin in the Council's Sheltered Housing tenancy reviews – this will aim to improve identification and referrals from older people. If successful, this approach will be further rolled out to more front line staff.

Thurrock's Mental Health Transformation Board agreed the need to have an Outcomes Framework for Mental Health, which focussed on system-wide outcomes rather than service-specific targets and will incorporate information around inequalities.

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10. Giving People Control – Personalised Care

Underpinning all of our work is the commitment to give our residents control of their lives and, if health and care services are required, to ensure these are personalised and support the principles of the comprehensive model for personalisation. We acknowledge that the move to a system built on principles of proactive and personal care requires a shift in the cultural mind-set of all those that play a part. Personalisation will not be seen as a “nice to do”, but as a fundamental element of our new operational model, irrespective of the age or need of the individual. As a system we will ensure that the flexibility in service provision is available for those groups of patients who may need adjustments to the universal offer, groups like people with a mental health need, children and those approaching the end of their life.

All transformation will be measured against the nationally defined comprehensive model for personalisation, from the simplest level of personalised care – choice – through to the ability to implement personal budgets where these are appropriate to meet the needs of individuals not met through universal service offerings. Achieving this requires a level of cultural change across the system that has not been previously delivered.

Through a programme of organisational and cultural change over the next four years, we commit to supporting:

- // the public to understand the personalisation agenda
- // providers of health and care to become flexible in service provision, enabling shared decision-making at all points in a patient journey, and promoting the self-care agenda through enabling both individual and community resilience
- // commissioners of services to ensure that services are contracted in a way that enables the delivery of the personalisation agenda, including a movement to commissioning for outcomes that matter to the individual, and does not discourage local innovation amongst providers to flex services to better meet the needs of residents.

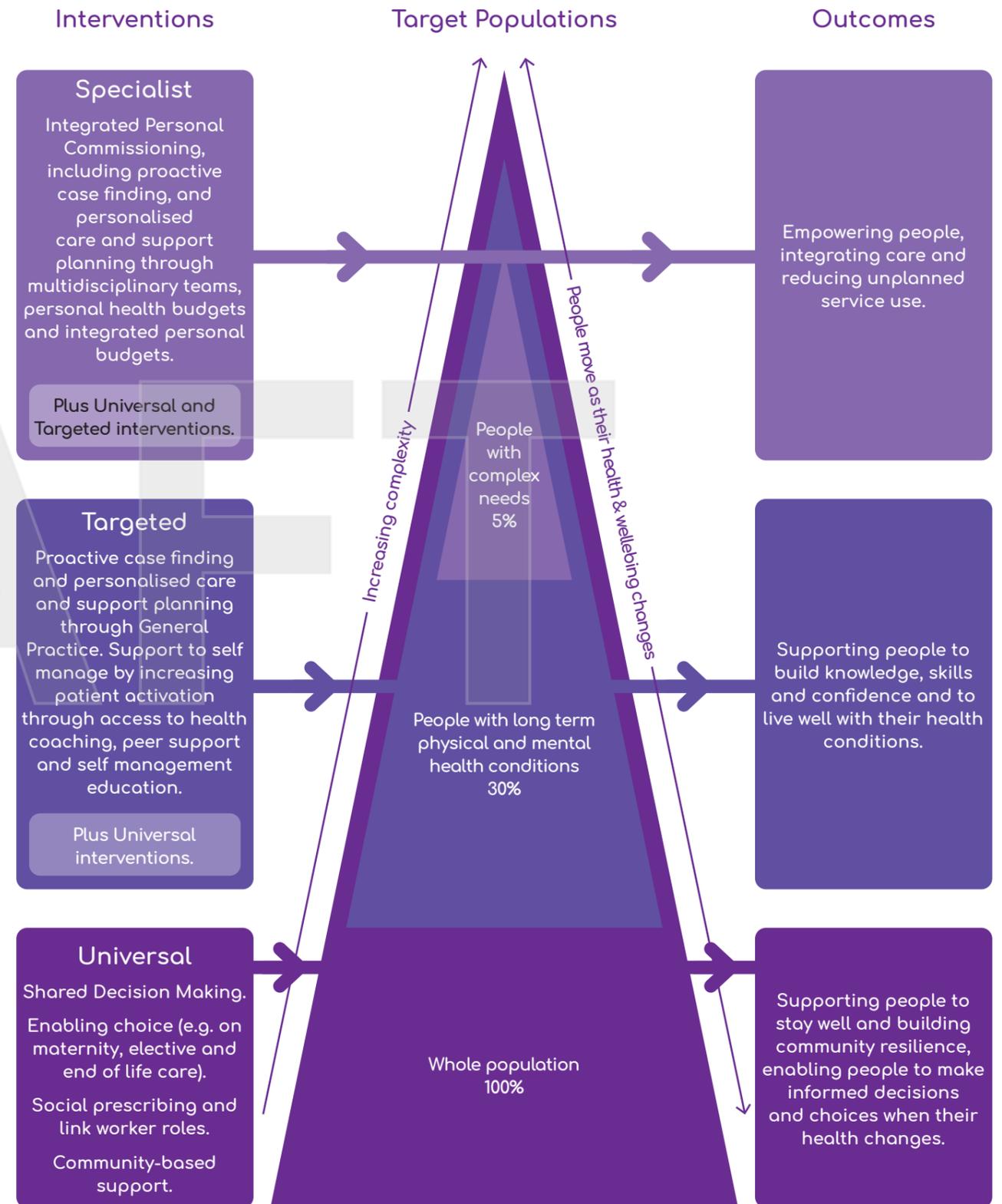
Our commitments

In order to ensure we embed personalised care across the Partnership, we will:

- // By April 2020 create a Partnership-wide Personalised Care Pledge; underpinning a cultural transformation programme across all key partners
- // Ensure the six components of personalisation become “business as usual” for all partners within the system, underpinning both the approach to commissioning and provision and the messages shared with the local population
- // Identify personalisation champions within the system
- // Develop the infrastructure across the system to ensure personal health budgets are available for those individuals that would benefit from them

Comprehensive Model for Personalised Care

All age, whole population approach to Personalised Care

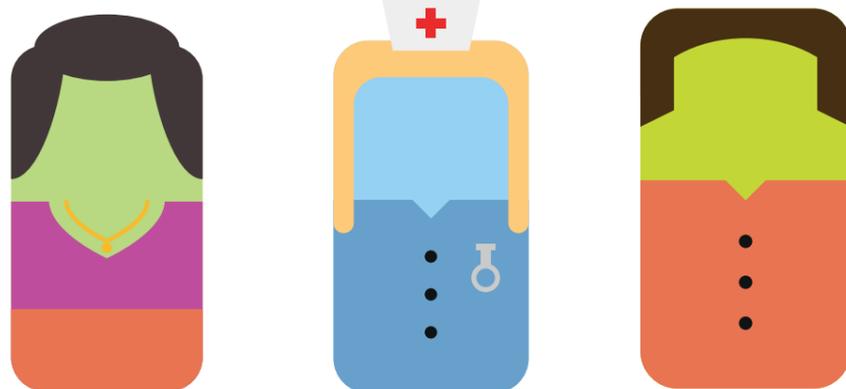


Personal Health Budgets and Integrated Personal Budgets

The CCGs are active in ensuring the roll out of Personal Health Budgets (PHBs) across their areas. This includes Personal Wheelchair Budgets, Continuing Healthcare (CHC) and Children’s Continuing Care on a ‘right to have’ basis. Whilst we accept the PHB target the local view is that PHBs should be utilised, not to hit a specific target, but to improve patient outcomes where an individual’s needs are either uniquely different, or not being met through the universal service offer to the whole population.

In accordance with NHS England’s PHB work programme, the CCGs have developed clear activity improvement trajectories to meet the national target of 200,000 by 2023/24. The development of a system-wide pledge for personalised care will facilitate standardisation of good practice across the region.

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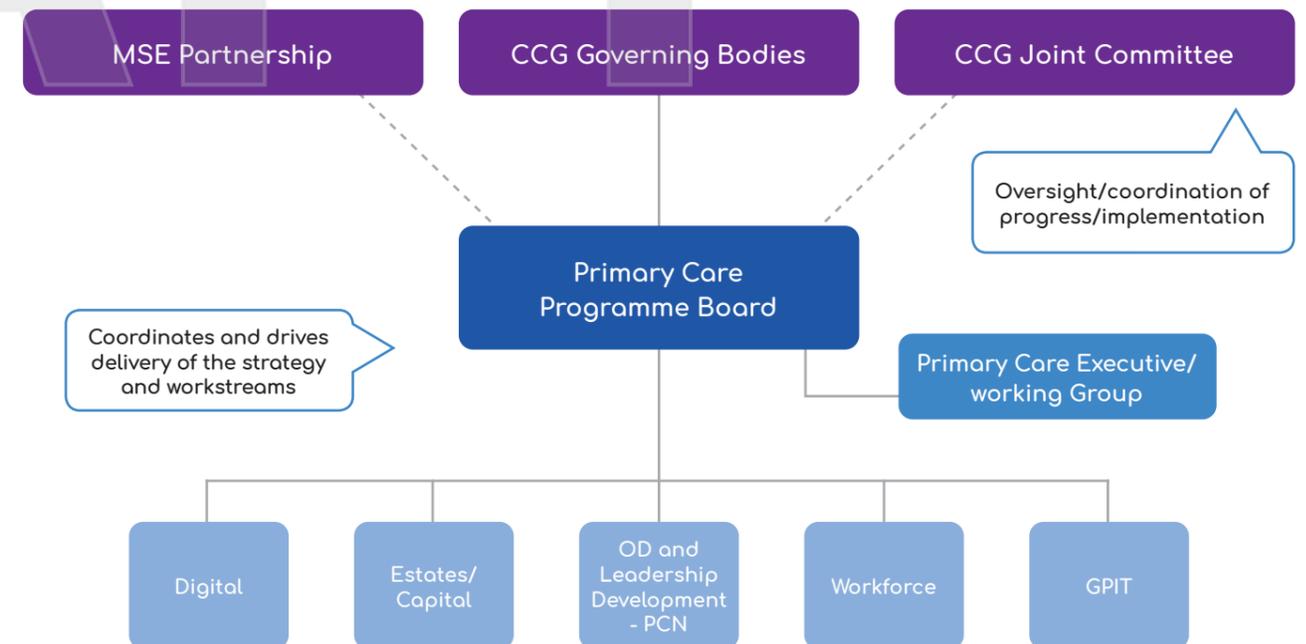
11. Transforming “Out of Hospital” care

Clinical Lead: Dr Jose Garcia, Chair, Southend CCG & Chair of the Primary Care Programme Board
 Senior Responsible Owner: Caroline Russell, Accountable Officer, Mid Essex CCG and Lead Accountable Officer for Out of Hospital Care

We developed our single Primary Care Strategy in June 2018, focusing on ensuring general practice is sustainable and able to fulfil its role as a foundation for future models of care. The strategy recognised that the ‘full population’ registered list of general practice makes them an essential partner in any move to population health and population health management.

The Primary Care Strategy focused on creating capacity and managing demand through both individual practice support and transformation, as well as collaboration both between practices and between practices and the wider system through our neighbourhoods. This direction of travel was later supported through the NHS Long-Term Plan and nationally negotiated GP Contract Reforms, the latter delivering a contractual vehicle, the Network DES/Primary Care Network Contract, that is being used to accelerate local plans.

Developments in primary care, including the maturity of primary care networks, are overseen by the Primary Care Programme Board:



11.1 Primary Care Networks

Primary care networks (PCNs) will form the vehicle for delivering collaborative working amongst front-line staff. Through PCNs we will deliver the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care. We will move to a GP-led model of care focused on improving population health and wellbeing, and supporting provider sustainability. PCNs will be the foundation stone on which local places will thrive and the key provider vehicle for delivering local services.

We see PCNs as more than just a collaboration amongst practices. At their core they will support collaboration amongst those who positively impact on their population's health and wellbeing. This includes other significant incumbent providers of health and care, education providers, major employers, the third sector and community groups. PCNs are seen as a vehicle to bring together the wider network of primary care providers - community pharmacists, optometrists and dentists.

PCNs are led by clinical directors who will provide leadership for networks' strategic plans, through working with member practices and the wider PCN to improve the quality and effectiveness of network services. We will nurture and support the clinical directors to ensure they are able to fulfil the requirements placed upon them.

With 28 primary care networks it is accepted that they will vary in terms of stability and maturity in the short to medium term. They are however seen as fundamental building blocks in the success of the local health and care system, being the core out of hospital 'delivery units'.

The National Ageing Well agenda, with a focus on anticipatory care and enhanced health in care homes, as well as urgent community response, will only deliver the ambitions where PCNs take a leading role in the care of older people in the community – irrespective of where they live. We envisage, as a minimum that through the national service specifications PCNs will deliver the medical requirements of two of these three programmes of work. This is expected to be implemented through national negotiations from 2020/21.

Through PCNs public health initiatives will be prioritised for their local populations, including maximising uptake of screening and vaccination programmes for people of all ages and all needs.

A move to more person-centred care will see PCNs be the launch pad for whole-system delivery of

- // Shared decision making with anyone who has a health, care or social need including implementing the legal right to choice, and
- // Personalised care and support planning for those living with a long-term condition

Through these two principles PCNs will enable

- // Improvements in self-care and the resources available to support this

- // Links between individuals and other, non-medical, interventions through social prescribing

- // and for those with exceptional needs, pathways into more bespoke support arrangements through enablers such as personal health budgets

PCN Maturity

Following release of the national PCN Development Prospectus and the PCN supporting self-assessment/maturity matrix tool we have worked with the clinical directors to identify their, and their PCNs, short-term development requirements.

As a system we are committed to all PCNs achieving level three maturity by 2023/24.

PCN Development Programme

A comprehensive development plan for each PCN will be in place by the end of 2019/20. This plan is expected to be detailed over the short-term, indicative longer-term and flexible enough to meet changing priorities of the PCN over a longer period. We will use the national tools and support where appropriate, and as a minimum the national allocation - £878k in 2019/20.

PCN development will be evolutionary and take account of both the original position of PCNs, and the desired end state. It is accepted that sustainable change will not be achieved through a short-term, rapid, development programme, but one that supports all partners to embed cultural change, new ways of collaborative working and collective ownership.

Meeting the Funding Guarantee

We commit to meet the local requirements of the real terms increase in funding that covers primary care, community health and continuing health care (CHC) spend by 2023/24.

11.2 PCN Service Developments

We will work with PCNs to ensure they are able to fully deliver services to their population in line with the requirements included within the seven nationally negotiated service specifications.

Service Specifications		
<p>From 2020/21:</p> <ul style="list-style-type: none"> // Structured Medicines Review and Optimisation // Enhanced Health in Care Homes 	<p>From 2020/21 onwards:</p> <ul style="list-style-type: none"> // Anticipatory care requirements (for high need typically multi-morbidity patients, jointly with community care) // Personalised Care // Supporting Early Cancer diagnosis 	<p>From 2021/22 onwards:</p> <ul style="list-style-type: none"> // CVD Prevention and Diagnosis // Tracking Neighbourhood Inequalities

Improving anticipatory care

As part of the Ageing Well programme, anticipatory care will support the move from a reactive, hospital-centric, health and care offer to one of prevention, empowerment and community and personal resilience. The principles of anticipatory care underpin the future models and focus on maintaining wellbeing. This will be underpinned by our Population Health Management work stream.

The expectations of the national service specification are due to be implemented across community providers and general practice from April 2020. The system commits to ensuring the work to date continues, and the national requirements are considered the minimum offer for our population.

We have developed a risk stratification tool to assist PCNs in identifying and managing high risk and rising risk patients in a structured way and this will be rolled out to all PCNs in the coming months to enable a proactive and targeted approach to supporting patients.

Anticipatory care will also encompass supporting maximum coverage of screening opportunities – including supporting early cancer diagnosis –, annual health checks for those who would benefit from it, and ensuring that there is sufficient support for carers, on whom the system relies so much.

Personalised Care

With improvements in anticipatory care, patient identification and holistic care planning driven by a more diverse workforce, PCNs will provide greater emphasis upon personalisation and a move to service delivery in line with the Comprehensive Model for Personalised Care.

Enhanced Health in Care Homes

As part of the Ageing Well programme, the CCGs have been working to improve the offer to residents of care homes. With over 8,000 care home beds a significant proportion of our most vulnerable residents live within a care home setting.

We have prioritised work to implement the Enhanced Health in Care Homes (EHICH) Framework. This is delivered through a partnership approach to co-ordinate the implementation and delivery of a single plan across mid and south Essex. The expectation is to increase the support to care homes through the EHICH model by 2022/23, implementing all elements of the framework across the full footprint.

Good progress has already been made across the seven domains within the EHICH Framework. Local and system level priorities have been identified, with plans being developed to reach full achievement by 2022/23.

Structured Medicines Review and Optimisation

Across the system practices and PCNs have already appointed clinical pharmacists to their primary care teams. The roles and functions of these vary across the patch, but a key commonality is their focus on medicines review.

PCNs will work to ensure that structured medication reviews are provided as a minimum to the defined set of patients as clarified in the specification. The system acknowledges that the introduction of this service coincides with the cessation of Medicines Use Reviews under the Community Pharmacy Contract.

Crisis Response

Across the footprint community-based crisis response has been a key pillar of the evolving models of care, and is seen as an essential component of any future model at place level, providing a safety net for when the proactive and anticipatory models breakdown and ensuring that solutions are not reliant on acute attendance and admission.

Across the footprint we already commission:

- // 100% population coverage for access to community crisis response within 2 hours as part of the commissioned community offer
- // 100% coverage of the population for reablement care within two days of referral

Supporting people to stay at home – Admission Avoidance

We know that our ambulance service is stretched and that people who call for an ambulance who are not suffering a life-threatening condition can experience a significant wait for a response. We also know that, for older patients, waiting a long period of time for an ambulance and then being conveyed to hospital often results in admission. Our community providers are working closely with East of England Ambulance Services Trust to support people who have called an ambulance, where the call has been allocated a category two, three or four response. Where clinically appropriate, community teams are able to intervene and visit these residents to assess their needs and provide any immediate care and support. This scheme is aimed at preventing an ambulance conveyance to hospital. The evaluation of the scheme will be published by the end of 2020; early indications are that the scheme has been successful in supporting people to stay at home and has supported closer collaboration between our community providers and the ambulance trust.

11.3 Digitally Enabled Primary Care

Governance

A primary care specific digital transformation working group has been set up to deliver the digital commitments outlined in the NHS Operational Planning and Contracting Guidance 2019/20, GMS contract for 2019/20 and GMS contract framework.

This group provides a centralised strategic approach to delivering digital transformation in primary care that is clinically-led and locally owned ie. by PCNs, GP practices and patients

This Primary Care Digital Working Group links closely with the Partnership Digital Board to ensure alignment of all digital programmes (see section 29).

As described in the Primary Care Strategy we know that the use of digital and other technologies will be a key enabler for our future model of care. These have the potential to help with the better management of demand, creating capacity in general practice, reducing bureaucracy and supporting practices to operate at scale.

We have identified a number of potential solutions which, taken together, could help practices reduce their workload and close the gap between demand and capacity.

One of the key design principles of our future operating model is to adopt a “digital first” approach. We know that the use of digital and other technologies have the potential to support patients and help with the better management of demand, creating capacity in general practice, reducing bureaucracy and supporting practices to operate at scale. The primary care digital work stream has identified three domains and five local priorities that will start to move primary care towards a new operating model that makes ‘digital first’ a reality. Plans are in place to deliver these priorities:

Manage Demand	// Digital triage - including on-line consultations // On-line patient awareness and education
Create Capacity	// Call-centre/administrative hubs // Supporting isolated individuals
Operate at Scale	// Connectivity - GPs and patients, anywhere

The primary care digital working group will ensure delivery of all national “must do’s” that are primary care specific commitments, as well as identify other local priorities.

11.4 Mid and South Essex - Primary Care Workforce

To drive transformational change in the primary care workforce, a system-wide primary care workforce team has been established along with a dedicated primary care training hub. There have been a number of developments which support the aspirations set out in the Interim NHS People Plan. Examples include:

- // A focus on general practice nursing as a priority and developing new models of working collaboratively with stakeholders locally and nationally towards integrated care.
- // We have increased the wider workforce by almost 12% including the employment of 13 emergency care practitioners, a move designed to reduce the pressure on the GP workforce
- // Information booklets for practices have been developed for new roles including the emergency care practitioner.

As we support the development of PCNs and the full uptake of the additional roles reimbursement scheme we expect to see significant increases in the numbers and types of staff working within primary care.

Whilst PCN's will develop the staffing model that best meets the needs of the local population, assuming PCNs grow the workforce in line with the national assumptions around role types and staff numbers it can be assumed that almost 500 additional posts will be created within primary care as part of the PCN workforce:

WTE - per 50,000 PCN	2019/20	2020/21	2021/22	2022/23	2023/24
Clinical Pharmacist	1	2	2	3	4
Link Worker	1	2	2	3	4
Physiotherapist		1	2	3	4
Physician Associate		1	2	3	4
Paramedic			1	2	3
	2	6	9	14	19

Health and Care Partnership

Clinical Pharmacist	26	52	52	78	104
Link Worker	26	52	52	78	104
Physiotherapist		26	52	78	104
Physician Associate		26	52	78	104
Paramedic			26	52	78
	52	156	234	364	494

Volunteers

The valuable contribution that volunteers make in health and social care sectors is well known. The Kings Fund report, 'Volunteering in General Practice' (2018) identifies specific ways in which volunteers can engage and support general practice. There are over 300 volunteering NHS role - types within our footprint and we have well established volunteering programmes across our provider trusts and partner organisations.

A Digitally-Enabled Workforce

Whilst focus rightly remains on ensuring sufficient numbers of staff are in post, and existing vacancy rates are improved, future models will require a workforce that has enhanced non-clinical competencies, particularly in relation to their use of technology.

We will support, empower and train the workforce to embrace digital tools and innovation as enablers to support them to manage and conduct their roles more efficiently, and with higher level of quality. We will improve the digital capabilities of everyone in the primary care workforce and support positive behaviour change to recognise the potential that digital transformation can bring.



12. Improving our Hospital Services

Clinical Lead: Dr Celia Skinner, Group Medical Director, Mid & South Essex University Hospitals Group
Senior Responsible Owner: Clare Panniker, CEO Mid & South Essex University Hospitals Group

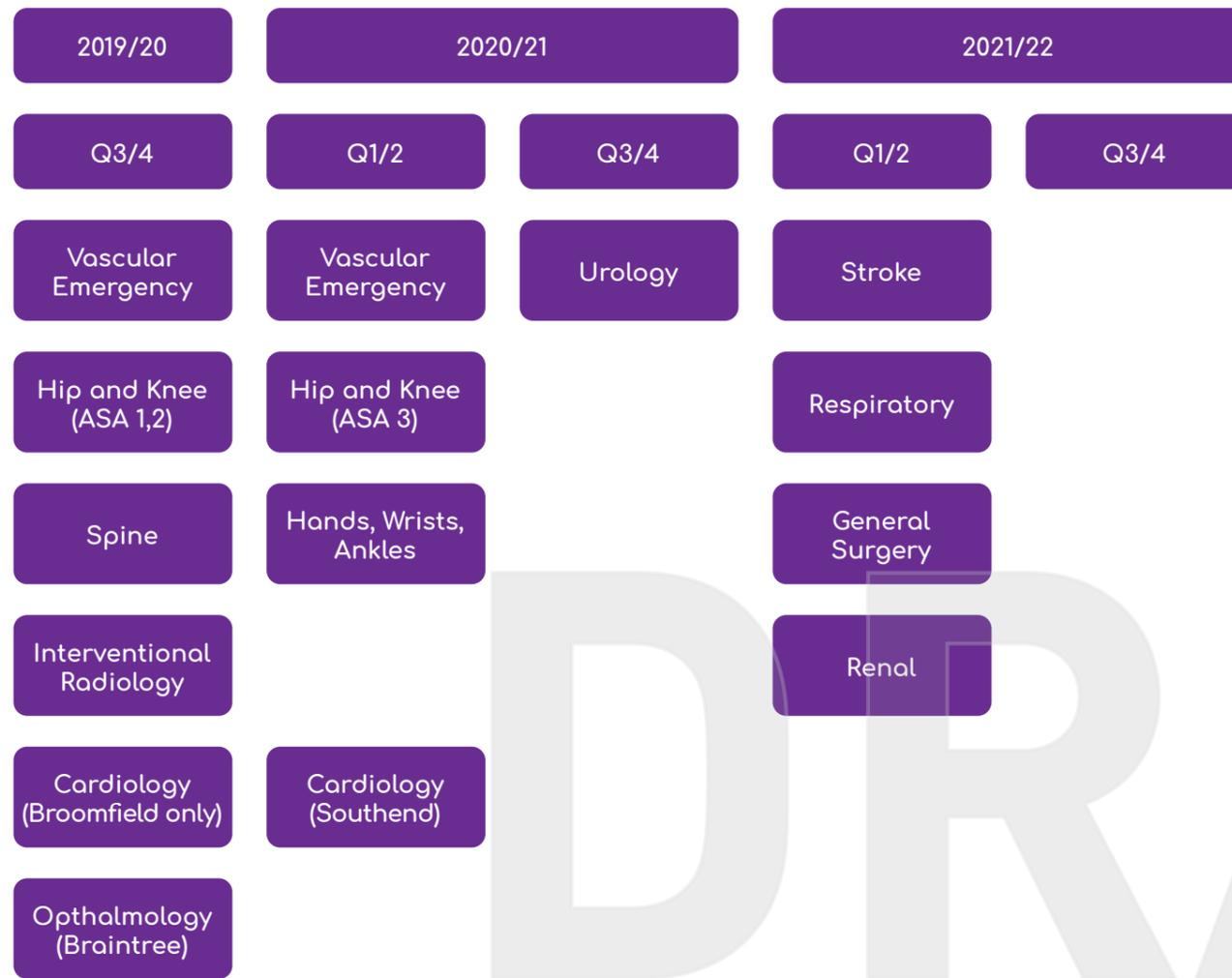
Following a public consultation Your Care in the Best Place, and detailed review of plans by the East of England Clinical Senate, the CCG Joint Committee approved all recommendations relating to the reconfiguration of hospital services in June 2018.

The changes were aimed at improving access to, and quality of, specialist hospital services, and dealing with the significant workforce challenges in the acute sector. The changes were based on five principles:

1. The majority of hospital care remains local (outpatient appointments, diagnostics, day case surgery and maternity), and each hospital will continue to have a 24 hour A&E department that receives ambulances.
2. Certain more specialist inpatient services to be concentrated in one place.
3. Access to specialist emergency services, such as stroke care, will be via the local (or nearest) A&E, where patients will be treated and, if needed, transferred to a specialist team, which may be in a different hospital
4. Elective and emergency care should, where possible, be separated.
5. Some hospital services should be provided closer to home.

The proposals were referred to the Secretary of State for review by the Health Overview and Scrutiny Committees of Southend and Thurrock Councils. Following review by the Independent Reconfiguration Panel, the Secretary of State has advised that the agreed changes can go ahead. Over the coming three years, these plans will be implemented as follows:

Clinical Reconfiguration Programme



Hospital merger

The three acute hospitals in mid and south Essex will merge in April 2020, reflecting significant work over the past three years to consolidate the clinical and corporate strategies, create a single executive team and Chief Executive. The key principles of the three hospitals working together are given below:

Working together as one team means we can do better

- Specialist centres of care leading to faster specialist access, diagnosis and treatment to improve patient outcomes and to attract clinical staff.
- Standardised model and approach to care based on best practice - reducing variation through the use of protocols, again leading to better care and outcomes for patients.
- Standardised model and approach to corporate services based on best practice and using modern technology, better service to the front line and reduced costs.

In turn, these things are enabled by a number of other activities

- Merger - single systems, policies, procedures - clarity of management decision making.
- Infrastructure improvements - particularly in IT, informatics and estates.
- Capacity and capability building - organisational development, strategy unit, change management, communications and engagement.

These changes are supported by the £118m capital award, secured in 2017. This capital funding will support the following schemes:

Basildon Hospital	Broomfield Hospital	Southend Hospital
<ul style="list-style-type: none"> New endoscopy suite Emergency care expansion Critical care expansion Onsite helipad New renal ward New theatres 	<ul style="list-style-type: none"> Critical Care expansion Emergency care expansion 2 new inpatient wards 	<ul style="list-style-type: none"> Purpose built (2 ward) elective surgical care block Emergency care expansion New theatres Creation of new paediatric assessment unit New endoscopy suite 4th LINAC bunker Refurbished ophthalmology unit



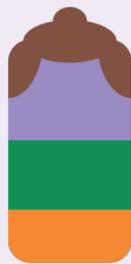
13. Reducing pressure on emergency hospital services

Clinical Lead: Dr Eddie Lamuren, Group Clinical Director (Emergency Care), Mid & South Essex University Hospitals Group
Senior Responsible Owner: Hospital Site Managing Directors, Mid & South Essex University Hospitals Group

We have three established sub-systems for urgent and emergency care (south east, south west and mid Essex). These sub-systems currently have their own delivery boards, where partners work together to deliver improved urgent and emergency care services.

The urgent care system is under significant pressure and this impacts on our responsiveness to deliver elective and cancer services. All partners are working hard to address urgent care pressures.

How will urgent care services be delivered in future?



You

Individuals with an urgent care need can access a range of support including on-line (www.nhs.uk), and through NHS 111, where they can obtain advice, check symptoms and figure out the best course of action.

NHS 111 will provide advice, support and the ability to book appointments with the right professional.

Patients will be able to access on-line advice and consultations with the GP practice.



Neighbourhood

PCNs will be able to offer extended hours appointments in the evenings and at weekends. They may also offer extended home visiting for patients who need it.

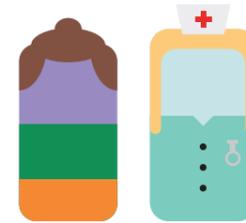
PCNs will use risk stratification tools to proactively identify patients who may be at risk of deterioration or ill health, and intervene early so that they can get the proactive care and support they require, reducing the need for an urgent response.

Community providers and the ambulance service will work together to avoid, wherever possible conveyance to hospital for patients who could be seen within their homes by community teams.



Place

Some urgent care services may be provided at place level, for example, minor injury services.



System

At system level, we will work together to:

- // Reduce the pressure on emergency hospital services.
- // Undertake workforce planning and development to support urgent care services
- // Coproduce communications and engagement with residents about urgent care services, particularly at times of pressure, eg winter
- // Identify and promote on-line and digital channels that will help patients to self-care and find the right support.

13.1 Integrated Urgent Care Service

We have a comprehensive NHS 111 service covering the entire mid and south Essex population. This includes a single multidisciplinary Clinical Assessment Service (CAS) within integrated NHS 111, ambulance dispatch and GP out of hours services.

As part of the national pharmacy contract reforms, from October 2019 NHS 111 will be able to refer minor illness and urgent medical supplies to community pharmacy. The Community Pharmacy Consultation Service provides the opportunity for community pharmacy to play a bigger role and to become an integral part of the NHS urgent care system.

13.2 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 admissions to hospital.

13.3 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-Fri. A move towards a 7 day service will be reviewed in April 2020. The community admission avoidance service operates 7 days per week.

At Southend the Frailty Service currently operates Monday-Friday 09:00 to 17:00 (a total of 40 hours per week). An extension to the operating hours is being overseen by the Frailty Steering Group. A business case is being developed in support of additional staff to facilitate achieving the 70 hours target by December 2019.

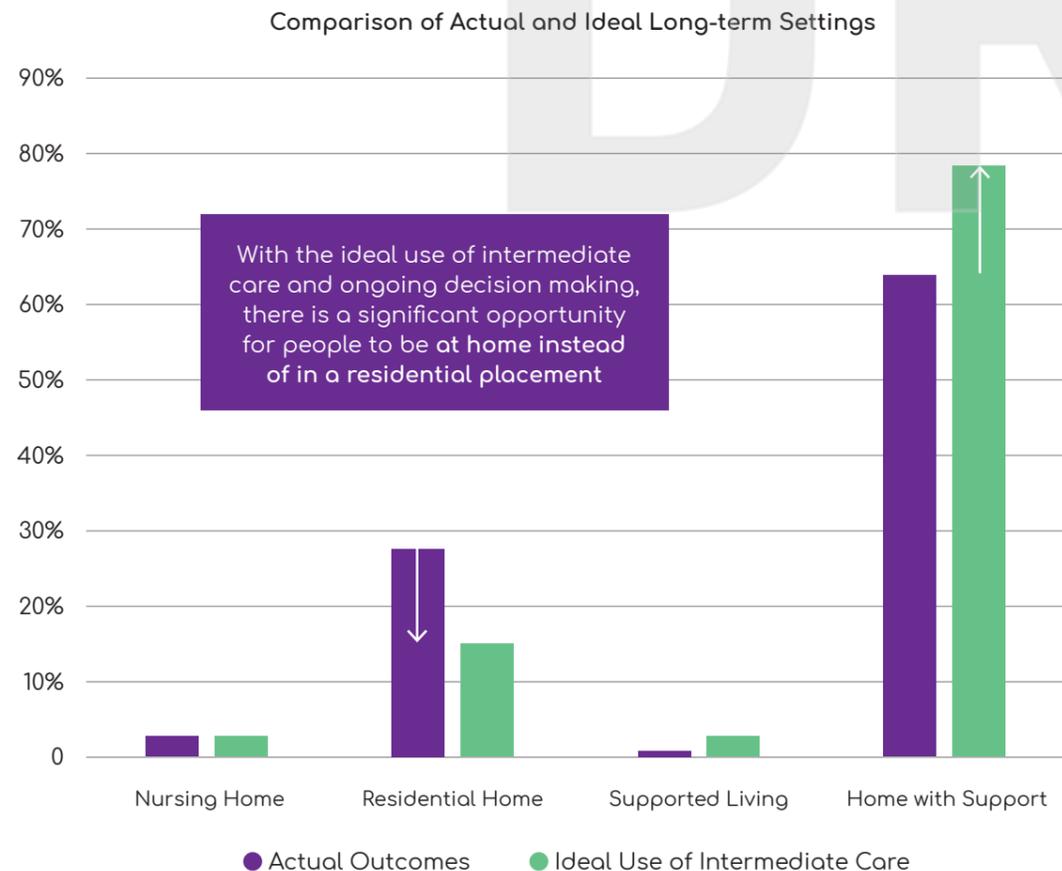
Basildon offers a full 7-day frailty service.

The Ageing Well programme, described above, will see an increased role for primary and community services in identifying and supporting older people to maintain independence and stay at home for longer.

13.4 Discharge Processes

Due to good partnership working between local authority and NHS partners, our Delayed Transfer of Care (DTOC) rate across the three acute hospitals (1.4%) falls well below the target of 3.7%. We expect to maintain this low rate moving forward.

Across Essex, we are working to better understand our reablement and rehabilitation processes and improve on these for our residents. This work has taken an embedded approach to work with discharge teams, patients, families and carers to understand the realities of the discharge process and its outcome. The work is on-going, however, interim findings suggest that if the system could make optimum use of intermediate care and on-going decision-making, there is a significant opportunity to reduce the use of residential placement and for people to be cared for at home (along with their individual wishes).



14. Improving our cancer services

Clinical Lead: Dr Donald McGeachy

Senior Responsible Owners:

Michael Catling, Director of Cancer Services, Mid & South Essex University Hospitals Group

Karen Wesson, Director of Commissioning, Mid & South Essex CCGs Acute Commissioning Team

With almost 7000 new cases of cancer confirmed across mid and south Essex in 2017, our cancer services are under significant pressure. Our screening rates for breast, bowel and cervical cancer are below the required standards which impacts on our early detection and survival rates.

Performance against the 62 day waiting time standard has been challenging for the system. Significant work has been undertaken by the Cancer Alliance and the acute hospitals to improve the situation. We now expect to be compliant with this standard by March 2020.

We recognise that, as well as improving on waiting times for diagnosis and treatment within the hospital setting, the whole system has a responsibility to prioritise prevention, screening early diagnosis and treatment. We are shifting focus to our places, with the intention of improving access, early diagnosis and outcomes for our population – this work will be underpinned by the incorporation of faster translation of innovation and research into practice.

We know that cancer incidence increases with deprivation. Our place-based plans provide a real opportunity to focus on reducing health inequalities and prevention activities, and also to significantly enhance the uptake of screening programmes locally to improve on early diagnosis and treatment. We are also ensuring that:

- // Primary care networks will support practices in using the latest evidence-based guidance to identify people at risk of cancer; recognise cancer symptoms and patterns of presentation; and make appropriate and timely referrals for those with suspected cancer.
- // Our Macmillan GPs work with PCNs to identify and target variation in screening and referrals to promote early diagnosis

We have been successful in our bid to have a Rapid Diagnostic Centre, which is planned to commence in January 2020, as follows:

- // Cohort 1; A&E referrals across all three hospitals
- // Cohort 2 & 3: Upper and lower gastrointestinal referrals
- // Cohort 4: Tele-dermatology (piloted by three Primary Care Networks initially)

Thurrock CCG has been selected to participate in the National Targeted Lung Health Checks programme. This is due to go-live in early 2020. While focussed on the population of Thurrock, we will rapidly take the learning from this programme and seek to embed the improvements across the Partnership.

How will cancer services be delivered in future?



You

Individuals will be supported to maintain healthy lifestyles, with support to reduce the risk factors that can lead to cancer.



Neighbourhood

PCNs will be focussed on prevention and ensuring we meet standards for screening programmes for breast, cervical and bowel cancers.

By working together, practices will be able to offer faster access to appointments ensuring fast onward referral, where required, for tests and treatments.

Patients diagnosed with cancer will receive personalised support throughout their treatment and afterwards

Close work with community and voluntary sector organisations will support patients and their families to access a wider range of services – for example, on welfare advice and support groups

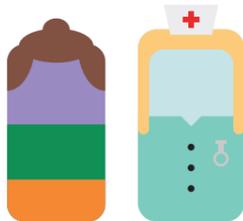


Place

Where safe and possible, a range of outpatient and diagnostic tests will be available closer to home to support patients to access care more locally.

Our places will be focussed on measuring success against activities aimed at improving our cancer offer, for example, monitoring screening uptake, using data to target additional support and interventions where required.

Places will also be focussed on joining up health and care services, reducing fragmentation that patients and their families might encounter.



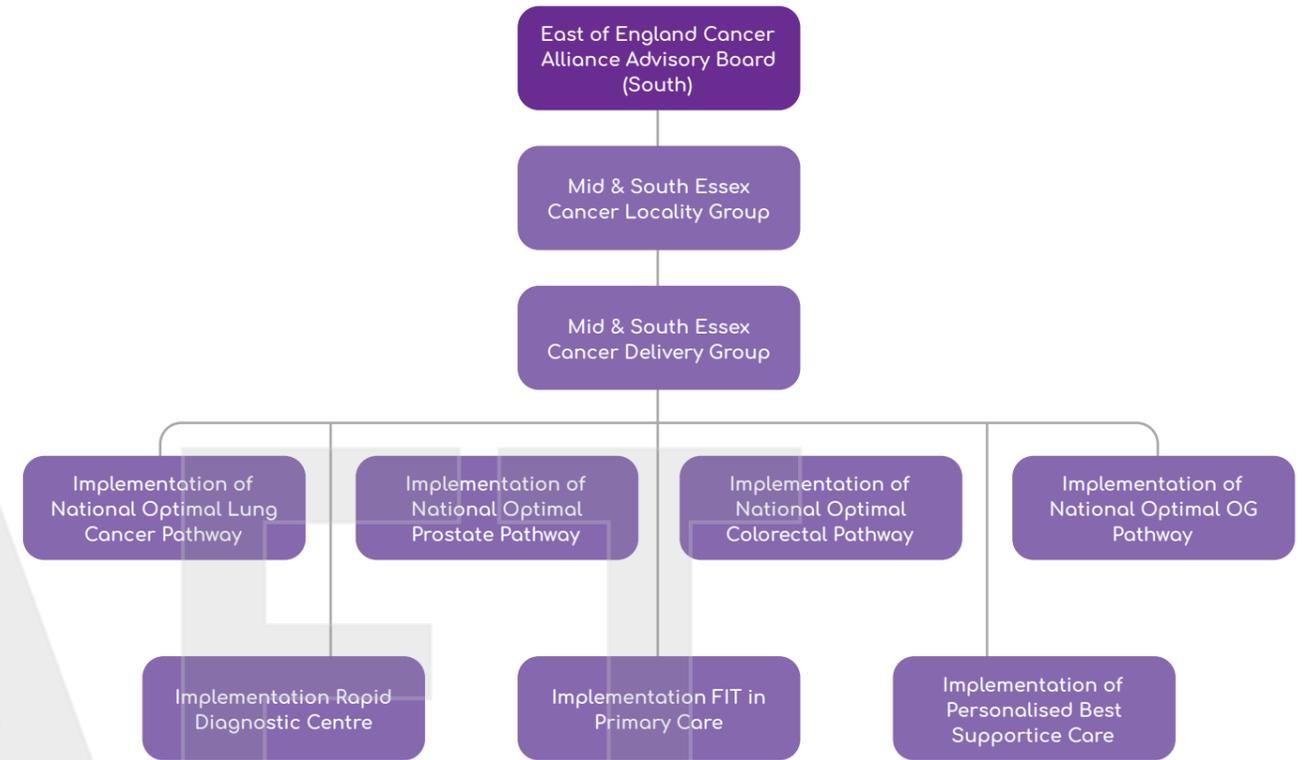
System

At system level, we will work together to:

- // Reduce unwarranted variation in access, quality and outcomes.
- // Undertake workforce planning and development to support cancer services
- // Coordinate communications and engagement, eg through public health messages
- // Coordinate research & innovation opportunities to improve cancer care for our patients
- // Identify appropriate digital solutions that will help patients manage their condition

We have established clinical leadership and a cancer board to oversee the improvement and transformation plans we have in train, working closely with the Cancer Alliance. An overview of the governance and work programmes is as follows:

Mid and South Essex Governance - Cancer Transformation Programme



Our Commitments

We commit to deliver the two national ambitions for cancer to improve the outcomes for our population.

// Survival Rate: Ambition 70% of cancer patients will survive five years or more

The LTP survival ambition aims to place England among the best countries in Europe for cancer survival. The East of England Cancer Alliance five-year survival rate is currently 53.5%, the Partnership's ambition reflects the national plan of achieving 70% survival at 5 years. We are actively pursuing opportunities to improve breast, cervical and bowel screening processes as a means to achieve this ambition as earlier detection improves survival rates.

We have successfully rolled out FIT to our practice population and this will expand to incorporate the national FIT screening programme.

We will also ensure the continued roll out of cancer care reviews and holistic needs assessments for relevant pathways. This enables people with cancer to have a regular review and a personalised care plan ensuring that they are able to access advice and support, or reach back into services without of delay should they identify a concern. We have undertaken this work in partnership with Primary Care, building on the Quality Outcomes Framework to ensure that there is a planned review to support the patient and their wider network following a cancer diagnosis.

// Early stage diagnosis: Ambition to diagnose 75% of cancers at an early stage;

Across England, 53.7% of cancers are diagnosed at stage 1 or 2. Across the East of England Cancer Alliance, 54.6% are diagnosed, with the highest CCG early diagnosis rate at just over 60%. However, currently only three cancers have early diagnosis rates above 75% (breast, melanoma, uterine), with some remaining below 30%.

We will be focussing on the skin pathway (as part of the Rapid Diagnostic Centre work) to incorporate, at primary care network level, the use of Tele-dermatology (based on the Anglian Health Science Network experience). This will improve screening, access and early diagnosis ensuring patients access the right pathway, first time while also releasing capacity within this significantly challenged specialty.

We are working to deliver the national optimal pathways in order to standardise delivery across the system ensuring equity for the population. Interdependency with networked sites (London and East of England) is essential and this is being mapped within each pathway to ensure that delays and flow is understood and risks mitigated.

Our cancer programme is underpinned by a number of key enablers these include:

Cancer Alliance Transformation monies – these monies have supported a number of key programmes and the recruitment of staff to facilitate care and pathway improvements (eg. the cancer care navigator role).

Patient Leadership – from the Cancer Board through to individual pathways, patient representation is paramount. Our patients have supported and driven the focus and direction of our work.

The Thurrock patient group is actively progressing experience and engagement to improve reach and awareness of cancer programmes within the local population, this work will be evaluated, and rolled out across the Partnership.

Workforce:

Workforce is a key challenge for cancer – through work commissioned by HEE and the Cancer Alliance, the three hospitals have undertaken strategic workforce planning. The key findings of the work were that:

- // There is currently a workforce gap, with specific concern in oncology, cancer nurse specialists and chemotherapy.
- // Incident of cancer is likely to grow by 25% over the next decade and will impact on the workforce,
- // There are opportunities to leverage the scale of the hospital reconfiguration and merger to mitigate some future pressures

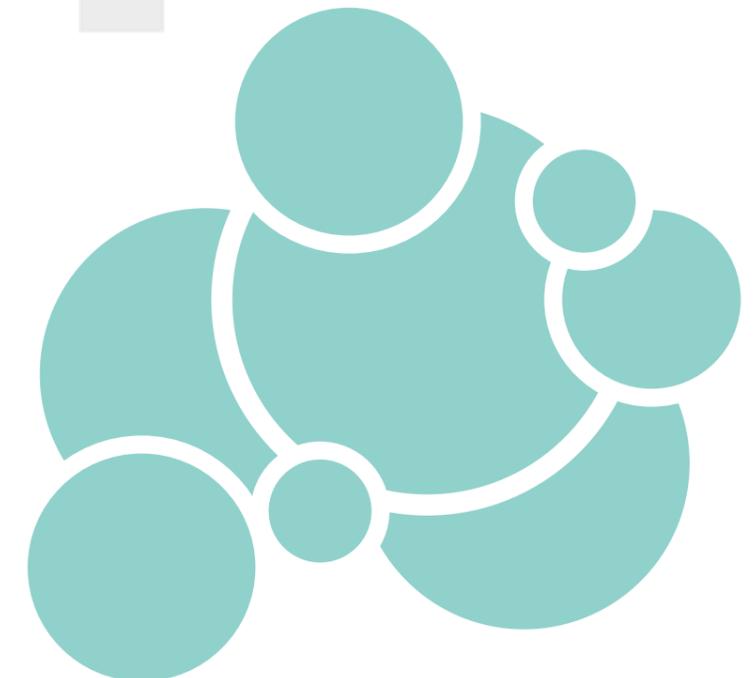
The current priorities for workforce transformation are:

- // Clinical nurse specialists – the scope of CNS roles across the group differs and there is an opportunity to standardise and, in so doing, support CNS to work at the top of their competence, thus increasing capacity in the workforce
- // Oncology and chemotherapy staff require specific focus – services currently rely heavily on locum and agency staff. The hospitals will focus on retention and staff development in the knowledge that there is currently a national shortage in both roles.

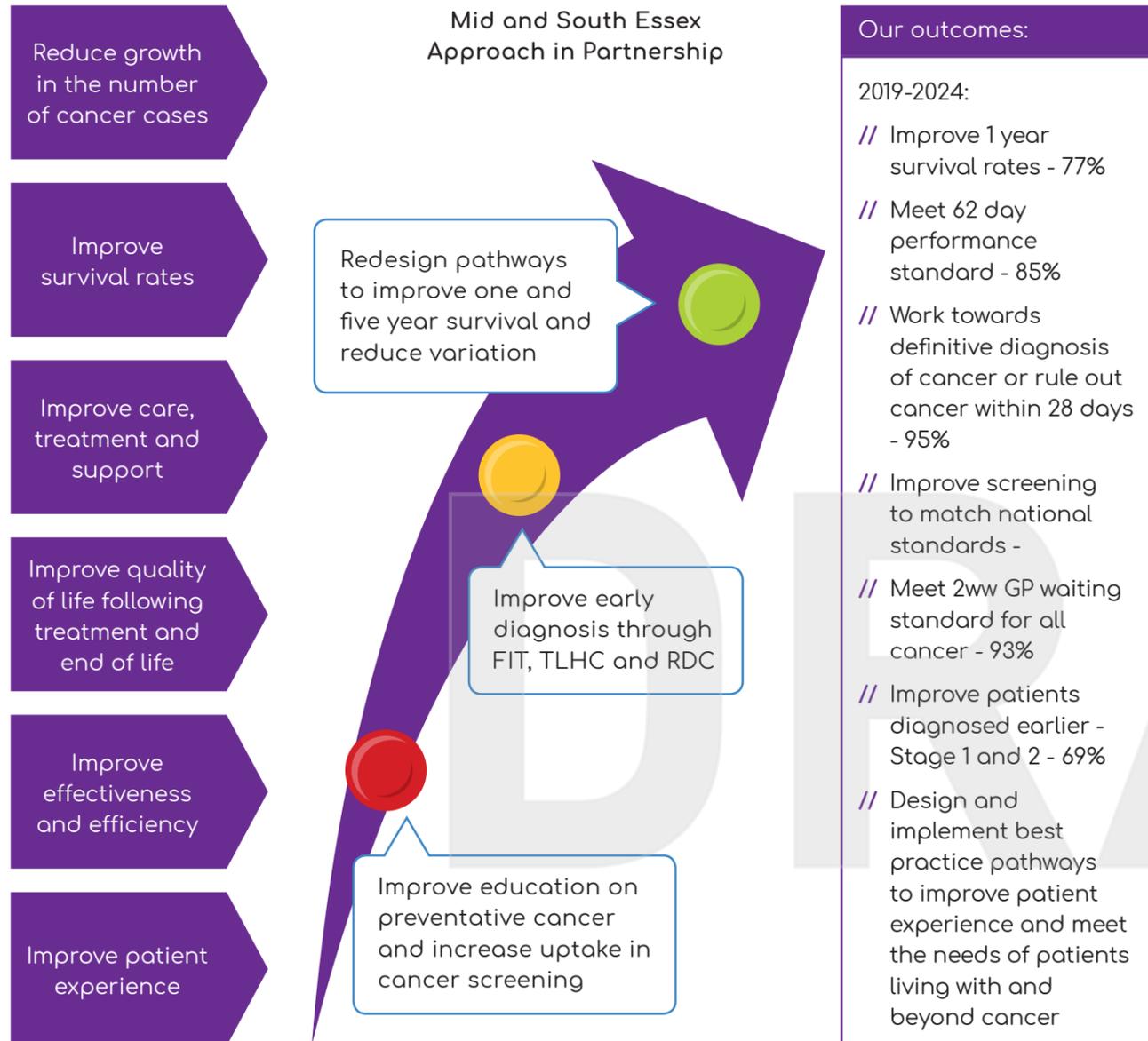
Transparency of system metrics and reporting – we are working with the Cancer Alliance to develop and test a new dashboard enabling the system to understand performance and other measures that reflect the progression of the Cancer Plan, this is supported by sharing of information and data including Right Care/GIRFT. We will develop and roll out a dashboard for the four National Optimal Pathways (breast, lung, urology, and colorectal).

Our cancer transformation plan can be found at Appendix 6

DRAFT



Transforming Cancer Services 2019-2024



15. Improving our mental health services

Clinical Lead: Dr Milind Karale, Medical Director, EPUT
 Senior Responsible Owner: Mark Tebbs, Director of Mental Health Commissioning, Mid & South Essex CCGs

Our vision for mental health 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.

It is clear that in order to deliver on this vision, partners need to work together, focusing on the wider determinants of health to enable the best possible outcomes for our residents. The mental health transformation programme is an extensive undertaking with significant interdependencies and interfaces involving CCGs, local authorities, Essex Police, the ambulance trust, mental health providers, acute hospitals, Healthwatch and many community and voluntary sector partners. A joined up collaborative approach and governance framework has been agreed to enable us to expedite projects at pace and facilitate decision making both as a collective, and through individual governing bodies.

The NHS has made significant additional funding available for mental health services, and has committed that funding will grow faster than the overall NHS budget, creating a new ring-fenced local investment fund worth at least £2.3 billion a year by 2023/24.

Our key transformation programmes are:

- // 24-7 community mental health emergency response and crisis care – assessment and home treatment;
- // Transforming the model of care for dementia;
- // Transforming the model of care for personality disorders;
- // Integrated primary and community care mental health.

The full transformation plan can be found at Appendix 7.

Current Provision

Our Mental Health Partnership Board has overseen the development of a 'Costed Delivery Plan' to help us to understand how we could best use the additional investment to efficiently and effectively deliver on the LTP commitments.

The work highlights a system with lower than average investment in mental health, significant reliance on inpatient services, a workforce challenge and lack of defined structure between system and place.

One-Year Survival from Cancer

East of England has been used as a proxy as data is not available for the new Cancer Alliance boundaries. Cancer Alliance will need to adjust for demographic makeup of the new boundaries.

	Baseline 2016	2019/20	2020/21	2021/22	2022/23	2023/24
One-year cancer survival rate (%)	72.60%	74.1%	74.4%	74.7%	75.1%	75.6%

➔ By 2028 = this should be around 79%

Proportion of cancers diagnosed at stages 1 or 2

East of England South Cancer Alliance

	Baseline 2017	2019/20	2020/21	2021/22	2022/23	2023/24
Numerator	8,592	9,513	10,045	10,428	10,818	11,114
Denominator	15,650	16,679	17,053	17,428	17,803	18,184
Early stage %	54.90%	57.0%	58.9%	59.8%	60.8%	61.1%

➔ By 2028 = this should be 75%

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.

Key issues for mid and south Essex

- // One in five people suffer from a mental health condition, many with depression/anxiety;
- // While depression rates are high, not all patients are diagnosed in primary care and rates of diagnosis vary widely across GP practices and CCGs;
- // The system currently spends £253m on mental health and related services in primary care and social care;
- // Secondary care mental health services represent £103m of overall spend with approximately 17% directed at inpatient mental health support;
- // In 2018/19 we spent c. 12% less per head than national median, though this could be reflective of the relatively lower mental health prevalence in the area;
- // Mental health services are delivered by approximately 2,200 staff across different care settings, with 30% delivering inpatient care;
- // We have proportionately fewer adult consultant psychiatrists and registered nurses as a proportion of inpatient beds;
- // Inpatients are likely to spend longer in hospital than national benchmarks;
- // More patients are likely to be readmitted as an emergency, while patients receive fewer community contacts than the national average.

Our Commitments

15.1 Urgent and Emergency Care (UEC) Mental Health

People facing a mental health crisis should have access to care seven days a week and 24 hours a day in the same way that they are able to get access to urgent physical health care. To deliver responsive options and maximise patient experience and outcomes we are implementing a comprehensive Urgent and Emergency Care Mental Health transformation programme.

Liaison Mental Health

BTUH and SUHFT received UEC wave 1 transformation funding in 2017 to pump prime and accelerate existing plans and expand existing mental health liaison services so that they operate at the 'Core 24' standard. The service commenced mobilisation in April 2017 and formally launched in July 2018. The service which

is delivered by a multi-disciplinary team comprising of medical staff, nurses, psychologists and support workers, aims to see patients in A&E within one hour and to discharge patients from the A&E department to the clinically appropriate pathway within four hours. It provides an assessment, diagnosis, treatment and risk management model.

MEHT has just been successful at the UEC wave 2 transformation bid to enhance the current service. The ambition is the 'Core 24' service will commence mobilisation in December and be fully operational by April 2020.

Investment has been committed as part of MHIS for sustainability of all 3 services.

Adult and Older Adult Crisis

The current CRHT service offer only covers 12 hours a day, seven days and does not support access for self-referrals. Access is purely through health professionals and the home treatment function operates only to 8pm.

To deliver the national mandate and provide a fit for purpose, 24-7 responsive and high standard service, a business case has been developed for additional investment to resource a new service model to meet the needs of people in a mental health crisis by providing a responsive 24-7 community crisis service via NHS 111, offering access via self-referral and promoting intensive home treatment to minimise the need for inpatient services.

We were also successful in receiving national transformation funds to establish three crisis cafes that will be located in the following areas:

- // Thurrock – covering Thurrock, Basildon and Brentwood.
- // Southend – covering Southend, Castlepoint and Rochford
- // Chelmsford – covering Chelmsford, Braintree and Maldon.

The cafes will be operated by the voluntary sector and will provide more suitable alternatives to A&E for many people in a mental health crisis who do not have medical needs. The service specification of the new Mental Health Emergency Response and Crisis Care service is being co-produced with all stakeholders, ensuring users, carers and families play a key role in shaping the model of delivery. The ambition is the new service will be fully operational by April 2020.

Acute Care (including Out of Area Placements (OAPs))

EPUT has undertaken a comprehensive exercise to repatriate patients placed out of area in the last year. Work continues to minimise need for OAPs and eliminating adult OAPs:

- // Assessment Unit opened in the north serving Mid Essex reducing need for OAPs
- // The Assessment Unit has been funded from the reduction in Out of Area Placements
- // On trajectory to deliver against set system level plans

Improving therapeutic offer by:

- // Review of trust's estates to eliminate dormitories and deliver on commitment to provide single bedroom accommodation across by 2020
- // Developing quality improvement programmes of work focusing on workforce, technology, engagement and service user participation and environment.
- // Define the training and pathway requirements to implement the enhanced therapeutic offer inpatient services.

15.2 Community Serious Mental Illness services for Adults and Older Adults

Implementing the Five Year Forward View for Mental Health describes the ambition that by 2020/21, community mental health services for adults of all ages will be better supported to balance demand and capacity, deliver responsive access to evidence-based interventions, integrate with primary care, social care and other local services and contribute towards continued efficiency within the mental health system.

Early Intervention in Psychosis (EIP)

We have 3 EIP teams serving mid Essex, south west Essex and south east Essex. They have all received the 2018-19 national NCAP spotlight audit rating at level 2 (Needs Improvement). The ambition was for all teams to meet level 3 compliance by 2019-20. Action plans are being developed to ensure compliance in the next audit which has now commenced with reports published by summer 2020.

In summary the highlights indicate a system with lower than average investment in mental health, significant reliance on inpatient services, a workforce challenge and lack of defined structure between system and place. Our five-year mental health plan will endeavour to demonstrate how the system rebalances in favour of prevention, early intervention, resilience and recovery through implementation of the MHFYFV and NHS LTP requirements to 2023-24. A robust engagement plan has been developed to run over Q4 2019/20 to ensure the implementation work plan is informed by locality detail.

Individual placement services (IPS)

Rates of employment are lower for people with mental health problems than for any other group of health conditions. IPS is an evidence-based approach to providing employment support for people experiencing serious mental health problems, shown to be twice as effective as vocational rehabilitation, and associated with reduced utilisation of other services, including use of inpatient admissions. IPS is based on eight principles, with increased fidelity to these principles correlated to better outcomes for service users.

We have three IPS services covering Essex, Southend and Thurrock. All services have received transformation funding in the last two years and are on trajectory to deliver the yearly defined targets. The Essex service is classed as a national Centre of Excellence and Southend will be seeking re-accreditation in 2019-20. Thurrock is the youngest service with an ambition to be accredited as a Centre of Excellence by 2022-23.

Serious Mental Illness – Physical Health Checks

People living with severe mental illness (SMI) face one of the greatest health inequality gaps in England. The life expectancy for people with SMI is 15-20 years lower than the general population. This disparity in health outcomes is partly due to physical health needs being overlooked. Every CCG has put in place a plan to ensure people on SMI registers not known to secondary care mental health receive robust physical health checks and follow on interventions. The plans are centred on:

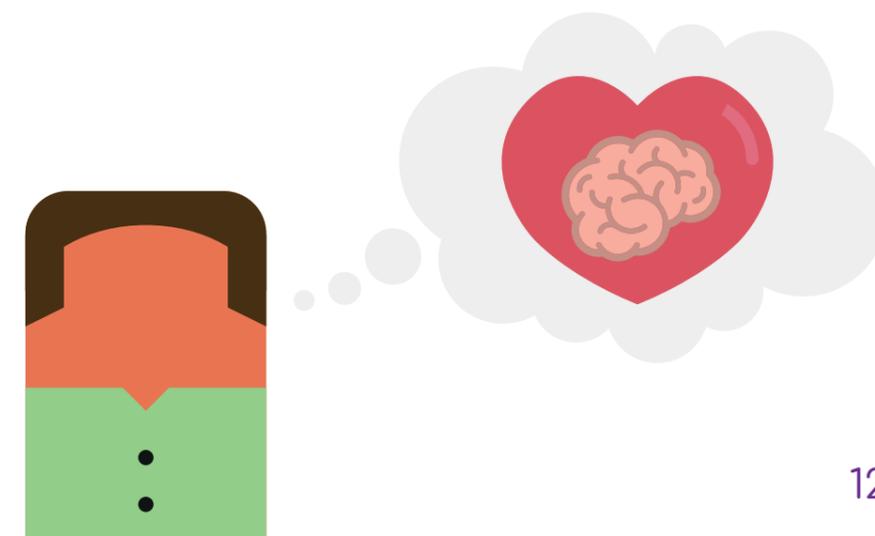
- // Validating registers to enable clarity on performance against trajectories.
- // Promotion campaigns through coproduction and outreach activities
- // Public health programmes e.g. 'Every Contact Counts'
- // Primary care training sessions
- // Monitoring and contract arrangements

There is a system wide steering group in place to facilitate interface with EPUT, standardise processes between secondary and primary care and share good practice.

We currently average 25-30% of people with SMI accessing physical health checks and our ambition is to meet 60% by end Q4 2019/20. The validation of registers alone is likely to give an improved status. All CCGs have committed funds through Locally Enhanced Services initiatives to ensure both the validation is completed and checks are undertaken. We are working to embed SMI-PHCs as a function of the integrated primary and community care mental health teams.

Integrated Primary and Community Care Mental Health

Work is in progress through co-production in all CCGs to define and implement an integrated primary and community care mental health offer for the PCNs. This will provide additional mental health workforce integrated in primary care to deliver a wrap-around mental health service that supports primary care to respond to mental health needs at the earliest presentation, manage need in the least restrictive environment and provide a seamless interface with crisis response and secondary care mental health. The ambition is for the 28 PCNs to have a mental health service offer by 2023-24.



15.3 Community CMI for Adults and Older Adults

IAPT

Nine out of ten adults with mental health problems are supported in primary care. IAPT services across mid and south Essex are commissioned on CCG footprints. The ambition is that all services will continue to deliver against the access, recovery and waiting time's targets. To achieve these the focus is on building workforce capacity through training. Health Education England will fund places and 60% salary support over the next two years whilst CCGs meet the remaining 40%; CCGs will pick up the total responsibility from 2021-22.

Thurrock has embedded therapists in primary care and fully commissioned a bespoke IAPT/long-term condition pathway. The other areas are at different stages of fully operationalising these two requirements. The expectation is that CCGs will be largely compliant in 2020-21. All services are working closely with PCNs to maximise case finding to ensure unmet demand is identified and supported e.g. through social prescribing to access services.

15.4 Perinatal

Integrated model

Mental health and maternity executive leads have identified dedicated resources to lead the further development and expansion of the Specialist Community Specialist Perinatal Mental Health Service in line with increased investment to deliver the ambitions of the LTP. As an aligned resource with the LMS; the scope of work includes the requirements of Better Births implementation in regards to supporting emotional wellbeing and identifying mental health concerns at an early stage, ensuring that wellbeing and mental health is a golden thread running through all services involved in providing care for women and their partners through preconception, antenatal and post-natal care.

High level implementation plans which describe the anticipated phases the have been approved through Mental Health and LMS Governance structures. Firstly, we have committed to using a co-production approach to underpin and inform future investment and design. This will be completed in collaboration with the Maternity Voices Partnership and patient representative groups through commissioning a series of events reflecting both the localities and three acute maternity interfaces. The engagement events will form part of a wider needs analysis to understand demographic variations and features, current referrals and access to specialist services. The access target of 4.5% is being achieved; however there are current variations across localities to address to ensure equity and reduce any resulting health inequalities. Workforce will be considered as part of the Workforce Action Board and LMS Group and include a training needs analysis.

The access target of 10% by 2023/24 will be delivered with further investment to the specialist service expanding and remodeling to align with maternity and locality systems. The phasing of performance against the access targets will be achieved through the development of key areas including:

- // Enhancing the evidenced based psychological offer whilst strengthening the multidisciplinary approach of the specialist team.
- // Expanding the model from the current pre conception advice offer working closely with primary care networks.
- // Extending the service offer for women to 24 months and including assessment/signposting for partners.
- // Developing maternity outreach clinics, through coproduction; these are anticipated to be delivered in pilot sites and rolled out across the system as a test and learn approach. The area would be interested in becoming a pilot site for targeted maternity outreach clinics.

A wider system audit will evaluate key touch points across services including Maternity, IAPT, Health Visiting, Children's Prevention and Support Services and GPs. The aim is to understand unwarranted variation to enable development of a system wide action plan to deliver quality and effective care for women, partners and their families. Key partners will include the voluntary sector to understand the offer across localities and explore opportunities such as prevention of social isolation and peer/support networks for partners.

15.5 Dementia

We know that the population is growing but also ageing rapidly with projection that people aged 75-84 will increase by 28% over the next five years. As of September 2019 the system was achieving a dementia diagnosis rate of 66.2% (range 59.6% Mid – 71.9% SE) against the 67% target.

A transformation programme is currently being implemented to invest more in a community based Dementia model with a focus on early diagnosis. The programme will comprise:

- // **A community model** that is optimally provided with system partners in primary care, to respond proactively to those with dementia or suspected dementia and their carers in their own homes and community settings.
- // **A dementia in-patient model** for those with the most complex needs whose care and treatment cannot be safely provided within the community. In-patient stays for assessment and treatment will be planned, purposeful and time limited with the outcomes of the admission agreed with patients and carers at the point of admission.

The model has been collaboratively developed with EPUT clinical leads and frontline staff, carers by experience, CCGs, local authority commissioning colleagues and third sector partners. Model testing has been undertaken in each CCG as opportunities have arisen. A full test of the model has been undertaken in south east Essex, arising from a requirement to reconfigure dementia inpatient beds in order to provide preparation for winter pressures.

A small augmentation to the South Essex Dementia Intensive Support Service, alongside operationalising the proposed integrated model and new ways of working resulted in a significant reduction in admission to dementia beds. The reduction in admission to inpatient dementia beds has been sustained and provides evidence for the effectiveness of the model. This has enabled reaching and maintaining diagnosis rates above 70%.

The plan is for the model to be rolled out fully across the system with any efficiencies realised through a reduction in inpatient use being re-invested into the community services

15.6 Suicide Reduction & Bereavement

Suicide is rising, after many years of decline. We have identified reducing suicide and self-harm as one of three key priorities for mental health. Suicide is a significant inequality issue. People in the lowest socioeconomic group and living in the most deprived areas are ten times more at risk of suicide than those living in the most affluent group living in the most affluent areas. Suicide is the leading cause of death in males between the age of five and 49.

Suicide Reduction

Southend, Essex and Thurrock have a suicide prevention strategy overseen by a steering board comprised of local authority and NHS senior responsible officers; the board will be listening to the voice of people with lived experience of a death by suicide and linking into organisations such as the Samaritans and SOBS to further enable this.

Organisations across Essex have invested in both suicide awareness and Mental Health First Aid training establishing nominated first aiders. EPUT has a suicide reduction strategy in place.

We are not in receipt of current waves of transformation funding from the Suicide Reduction Programme or suicide bereavement support. (See also section 9).

Bereavement

Under the Southend, Essex & Thurrock Suicide Prevention Plan an established bereavement working group is mapping the availability of national and local resources to establish a single point of local online presence, The group is also designing a pathway for responding to suspected and confirmed death by suicide including establishing the point of entry (ongoing discussions with Essex Police and the Essex Coroner).

15.7 Mental health data

Commissioners and providers ensure data quality is proactively reviewed, national guidance is adhered to and the breadth of data submitted to the MHSDS accurately reflects local activity. This is undertaken as part of contract monitoring and it means:

- // All providers being compliant with MHSDS v4 Information Standards Notice (ISN) from 1 April 2019; EPUT is compliant with MHSDS V4 and have been successfully submitting since May 2019.
- // All providers submitting interventions to the MHSDS using SNOMED CT codes. Action plan is currently being implemented in line with Trust CQUIN to ensure SNOMED codes are implemented within EPUT from Q3 2019/20

15.8 Digital Mental Health

- // EPUT has a robust, published IM&T Strategy through to 2022.
- // Digital maturity - the second digital maturity assessment placed EPUT between the second and third quartiles, plans in place to improve
- // EPUT already offers a range of self-management apps, digital consultations and digitally- enabled models of therapy
- // Digital clinical decision making tools
- // EPUT's IM&T Strategy includes full interoperability to national standards (FIHR and Snomed) supported by the Tiani Health Information Exchange (HIE).
- // EPUT's IM&T Strategy is fully funded for all planned projects and therefore additional financial resource is not required at this point.

IAPT providers

All IAPT providers (including EPUT) are compliant with the new data quality requirements and monitoring is via the Information Assurance Framework and contract arrangements.

15.9 Mental Health Investment

The system commits to the mental health investment standard. Further detail can be found in Appendix 5.

16. Children and Young People's Mental Health

To deliver the LTP requirements for Children and Young People (CYP), partners are working closely with West Essex CCG, the lead commissioners for CYP mental health services. The work being undertaken is summarised below:-

0-25 Pathway

- // Transforming our CYPMHS to move to a 0-25 years' service offer, this will be achieved by:
 - // Increasing access age range for 18-25yrs into our service
 - // Increasing wider CYPMHS delivering within the CCG's offer provision to 18-25yrs
 - // Delivering more lower level mental health intervention to CYP 0-25yrs
- // Working with Adult commissioners/providers and NHS England to count the 18-25yrs cohort towards the access target.

Eating Disorders

- // Utilise the CYP Eating Disorder (ED) funding investment to support ensuring full staffing to the specialist CYPED service
- // Work with the voluntary and community sector to deliver an early intervention service offer around CYPED to support; awareness, self-referral, professional awareness and sign-posting

Comprehensive 0-25 support offer

- // Transforming our CYPMHS to move to a 0-25 years' service offer, this will be achieved by:
 - // Increasing access age range for 18-25yrs into our CAMHS service
 - // Increasing wider CYPMH Service offer to deliver provision to 18-25yrs; achieved by service redesign and roll-out/ embedding of current pilots
- // Working collaboratively to ensure we offer an 'every age' service offer to 0-25years population in need of mental health support, this will be achieved by:
 - // Children's and Adults mental health commissioners aligning service offers and agreeing that the 18-25years cohort have choice of access based on need.
 - // Working with providers to ensure alignment and patient choice of access is available and delivered on clinical and patient suitability

Mental Health Support Teams (MHSTs)

We will train and roll out MHSTs in the current phases, and will apply for further funding as this comes available. We are working towards the national and regional targets to deliver MHSTs across the region by 2023/24.

- // Ensure MHSTs activity is submitted to MHSDS and counted towards the access target, this will be achieved by:
- // Ensuring the delivery providers have access and can submit data to MHSDS

24/7 Crisis Provision

We already have in place a 24/7 crisis provision for CYP for crisis assessment and brief response. The service is currently mobilising a wider service offer to include intensive support and home treatment functions. This will be fully mobilised by April 2020.

We plan to evaluate the new model in 2021 and ensure continuation of a 24/7 crisis provision for CYP which offers crisis assessment, brief response, intensive support, home treatment functions and better alignment with A&E, acute hospitals, Tier 4- admissions and admission prevention

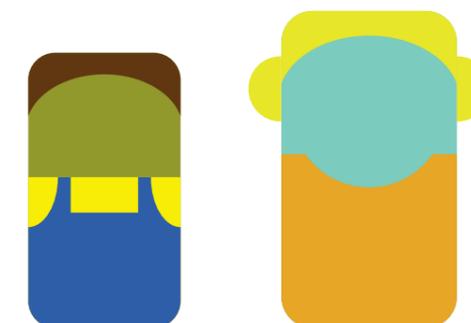
Local Transformation Plan

The Southend, Essex & Thurrock Local Transformation Plan is in year five (2019/20) was refreshed and published by 31st October 2019. The LTP will be refreshed for its final year in 2020/21 with sustainability aligned to the NHS LTP

CYP mental health plans align with those for children and young people with learning disability, autism, special educational needs and disability (SEND), children and young people's services and health and justice, from 2022/23

Southend, Essex & Thurrock will work towards aligning CYPMH plans by 2022/23 by joining CYP work stream plans and moving towards a CYP system wide strategy.

Children's mental health has been a key transformation plan for Thurrock's Health and Wellbeing Board. Following recommendations from the Children and Young People's Mental Health JSNA product developed by the Public Health Team in 2018 which focused on prevention by exploring risk and protective factors, Thurrock has just recently implemented a School Mental Wellbeing Service (SWS). This is a partnership approach between Thurrock Council, Thurrock CCG and local schools and academies with a main focus to strengthen and improve the emotional wellbeing and mental health of school aged children and young people, as well as supporting families and school staff. The programme represents a £1M investment in the mental health of our children and young people. The service is a universal offer with an ambition to provide a whole school approach to emotional and mental health needs of children and young people in school and enabling mentally healthy school environment.



17. New Models of Care in Mental Health – Provider Collaboratives

In line with the NHS Long Term Plan, mental health providers are collaborating to deliver new models of secondary care. The anticipated benefits for patients include:

- // Care closer to home
- // More consistent and high quality care through standardising our approaches
- // Greater influence from patients on the design of care at both service and individual level
- // More 'joined up' care with close working between NHS providers and private sector partners

The following trusts have formed an aspiring East of England Collaborative:

- // Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)
- // Central and North West London NHS Foundation Trust (CNWL)
- // East London NHS Foundation Trust (ELFT)
- // Essex Partnership University NHS Foundation Trust (EPUT)
- // Hertfordshire Partnership NHS University Foundation Trust (HPFT)
- // Norfolk and Suffolk NHS Foundation Trust (NSFT)

In early 2019, NHSE invited applications from trusts to form new care model collaboratives in respect of the following services:

- // Low and medium secure mental health services including those for patients with a learning disability
- // Specialised eating disorder services
- // Child and adolescent mental health services

The designated lead providers are EPUT for low and medium secure services, HPFT for CAMH and CPFT for Eating Disorders.

Community Forensic Services

The collaborative agreed that EPUT as lead provider of low and medium secure services would submit an Essex-focused bid to set up community forensic services on a pilot basis during 2019/20 and 2020/21. Negotiations continue between EPUT and NHSE in this respect.

18. Improving our planned care services

Clinical Lead: Pathway specific clinical leads in place

Senior Responsible Owners: **Jane Farrell**, Managing Director, Broomfield Hospital
Karen Wesson, Director of Commissioning, Mid & South Essex CCGs Acute Commissioning Team.

Current Provision & Future Plans

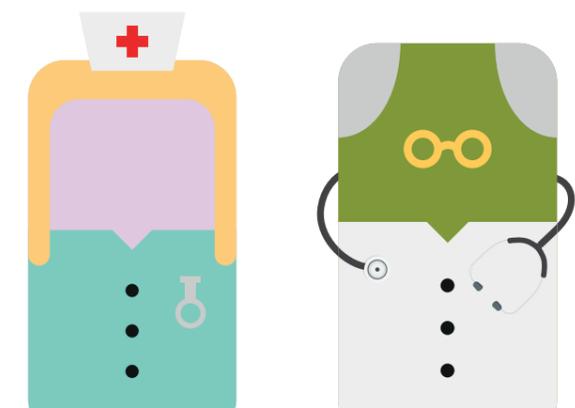
We are taking steps to address long waits for treatment, but have significant capacity constraints as a result of the demand for urgent care services. One of the key principles of our hospital reconfiguration programme was to separate, where safe and possible, the provision of planned care from emergency care so as to protect planned care capacity, particularly over times when the system experiences more pressure than usual on the emergency care pathway, eg winter, bank holidays, etc.

An Elective Care Programme Board has been established (July 2019) to oversee the redesign of system-wide pathways to support delivery of planned care standards (as identified through use of Right Care and Model Hospital data).

Our Commitments

- // We will reduce the number of 52 week waits to zero by focussing on the longest waiting patients waiting over 40 weeks.
- // We will implement the national tools and functions aimed at supporting planned care, including advice and guidance, apps for appointments, capacity alerts and triaging at point of referral to reduce demand for elective services.
- // We are considering the use of new models of care including first contact practitioners and non-acute models of care, self-management, etc.
- // We will redesign our outpatient services to ease pressure on planned care pathways and ensure we are using the most appropriate ways of managing elective care demand.
- // We are focussing on an initial set of pathways to conduct detailed, system-wide demand and capacity assessments; these are ophthalmology, dermatology, neurology, urology, orthopaedics and gastroenterology. Collectively, these pathways account for over half the waiting list across the three hospitals. We will have national assistance from the Intensive Support Team on this demand and capacity work.

The system recognises that this programme cannot solely be focussed on hospital provision and a whole pathway approach is required to ensure that models established are fully utilised across mid and south Essex by all sectors.



Backlog Clearance

Waiting lists have grown over recent years and we have a large number of patients waiting over 18 weeks for treatment. The trusts and CCGs are discussing how best to achieve the commitments in the LTP, within the context of the currently available capacity and the financial challenges faced by the system.

Long Waits

We are committed to reducing the number of patients waiting over 52 weeks for treatment to zero by April 2020. We have clear plans in place to ensure this.

Currently Mid Essex Hospital is not reporting on elective care data; the hospital expects to return to reporting in April 2020.

First Contact Practitioners

Nationally, over 30 million working days are lost due to musculoskeletal (MSK) conditions every year, and they account for 30% of GP consultations in England. NHSE have identified the First Contact Practitioner (FCP) service as a High Impact Intervention for elective care transformation. CCGs in south east Essex were identified as a pilot site and in September 2018 the CCGs commissioned a FCP pilot, which aimed to introduce physiotherapists into Primary Care to address the MSK workload in general practice. This was based on the learning from National best practice, and focussed on embedding clinicians from within the main local provider; in this case Southend Hospital.

Since January 2019 there have been 2.5WTE FCPs working within one of the PCNs. The scheme had been very successful, with 96% of appointments being filled; only 1% DNA rate; and nearly 80% of all appointments being discharged with no onward referral (to either GP or hospital). This success enabled the south east CCGs to commission a second test site in another PCN, which is due to mobilise in December 2019.

Thurrock is also piloting direct access to MSK FCPs. As of April 2020, Thurrock will have one FCP operating within each of its four PCNs. The model will see full MSK assessment, triage and physiotherapy services provided across 7 sites in Thurrock, offering extended access appointments 7 days per week, including evenings and weekends. The service will include direct access to diagnostics, including ultrasound and MRI as well as scan-guided procedures. Through this work, we expect to deliver faster access to MSK and physiotherapy services for patients and a reduction in the use of hospital services. This brings care closer to home for patients in Thurrock as part of its overall place-based strategy.

The impact and learning from all 3 of the pilot sites will be measured, analysed and shared across the Health and Care Partnership to inform future commissioning decisions.

Evidence Based Interventions

There is a single policy for most evidence based interventions which reflects national guidance and provides equity for our patient population. The policy also supports the management of demand through patients not being listed for those procedures with little clinical evidence for them to be undertaken. There is a consistent full individual funding request process in place.

This is overseen by the CCG Joint Committee.

How will planned care services be delivered in future?



You

Individuals will maintain healthy lifestyles, with support, where required, to reduce key risk factors that lead to ill health and the need for planned treatment.



Neighbourhood

By diversifying the workforce within PCNs, people will get swifter access to the right health or care professional to get help with a developing condition – this might be a physiotherapist, a pharmacist, and specialist nurse or a GP.

When thinking about treatment options, patients will receive personalised support to enable shared decision-making.

Close work with community and voluntary sector organisations will support patients and their families to access a wider range of services – for example, community groups, exercise classes, and support groups.

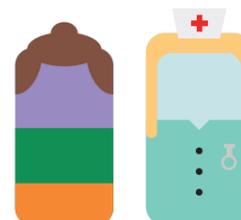


Place

Where safe and possible, a range of outpatient and diagnostic tests will be available closer to home to support patients to access care more locally.

Similarly, rehabilitation and reablement services will be available to support patients to return to full health after having had an operation or treatment.

Patients that require bed-based rehabilitation and support will usually be able to receive this at place-level, and support to get them home will be provided by discharge teams, social care and health care practitioners working together.



System

At system level, we will work together to:

- // Reduce unwarranted variation in access, quality and outcomes for our elective care services.
- // Identify appropriate digital solutions that will help patients manage their condition.
- // Make best use of our estates and infrastructure to deliver care closer to home.

19. Improving our cardiovascular services

Clinical Lead: **Dr Rebecca Morgan**, GP Lead
 Senior Responsible Owner: **Karen Wesson**, Director of Commissioning, Mid & South Essex CCGs, Acute Commissioning Team

Section 9 above on prevention highlights the work we are doing in partnership to prevent cardiovascular disease across our three local authority areas.

As a partnership we have agreed to take atrial fibrillation (AF) as a focus area to support the cardiovascular disease (CVD) programme of work, following successful work in Thurrock. In May 2019 the CCGs agreed a programme to:

- // Review patients currently on AF medication to ensure that they are medicated appropriately,
- // Review patients on the AF GP practice register that are not currently medicated, and
- // Case find new patients.

To progress this work, the system has secured support from our Academic Health Science Network partner, UCLPartners, to provide programme management support using the experience they have gained from similar projects across London. We have also appointed a GP lead for this work, funded through the GP Retention Intensive Support Site.

The UCLP programme manager and clinical lead are working closely with commissioning leads, primary care teams, medicines management, locality pharmacists, GPs and public health to improve the detection and protection of AF patients across mid and south Essex.

Locally, our places, working with local authorities will be implementing wider prevention programmes according to local need.

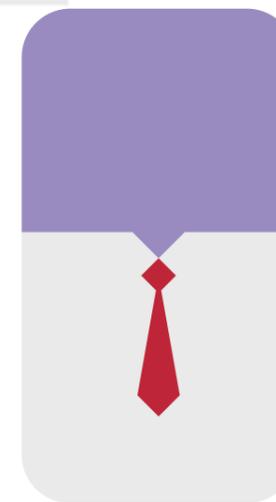
20. Improving our cardiac services

Clinical Lead: **Dr Stuart Harris**, Group Clinical Director, Cardiovascular, Mid & South Essex University Hospitals Group
 Senior Responsible Owners: **Tom Abell**, Deputy Chief Executive, Mid & South Essex University Hospitals Group
Karen Wesson, Director of Commissioning, Mid & South Essex CCGs Acute Commissioning Team.

Our STEMI and NSTEMI pathways operate within a networked model with the Essex Cardiothoracic Centre (CTC) in Basildon. Opportunities to improve these pathways have been identified and were subject to East of England Clinical Senate scrutiny, public consultation and Secretary of State approval.

Our revised pathways will accelerate access to the CTC for NSTEMI patients to increase the proportion of patients who undergo angiography within the 72 hour target and reduce duplication in diagnostics between receiving hospital and the CTC, thereby reducing length of stay by two to three days for these patients.

This new pathway is scheduled for implementation during 2020. In advance of this a pilot of the new pathway will be undertaken with a seven day cardiology service being implemented at Basildon Hospital and NSTEMI patients being accelerated to Basildon from Broomfield Hospital. An evaluation of this service will be undertaken during February and March 2020 to inform the implementation of the system wide model.



21. Improving our stroke services

Clinical Lead: **Dr Indi Gupta**, Group Clinical Director, Specialist Medicine, Mid & South Essex University Hospitals Group
 Senior Responsible Owners: **Tom Abell**, Deputy Chief Executive, Mid & South Essex University Hospitals Group
Karen Wesson, Director of Commissioning, Mid & South Essex CCGs Acute Commissioning Team.

We have a comprehensive stroke work programme that is developing a standardised stroke pathway - from prevention to rehabilitation care - for the population of mid and south Essex, informed by NHS Right Care and other nationally recognised models. The work covers the following key components:

21.1 Prevention

As above, AF is a particular focus for the system as are the activities described in the prevention section, above.

21.2 The acute stroke pathway

The future acute stroke care pathway has been agreed through the 'Your Care in the Best Place' proposals which were subject to East of England Clinical Senate scrutiny, approved by the CCGs in July 2018, and by the Secretary of State in June 2019 following referral by Southend-on-Sea Council.

The future acute stroke pathway will see all three hospitals continuing to receive suspected strokes with optimised scanning and initial treatment (thrombolysis) with confirmed strokes then being transferred to a new acute stroke unit at Basildon Hospital for up to 72 hours for intensive care and support following which patients will be stepped down to either an Acute Stroke Unit at their local hospital, or home supported by early supported discharge services. The full model is planned to be in place by 2022. In line with the consultation the trusts have commissioned UCL to undertake an evaluation of the new model of care.

In advance of the full pathway changes the trusts are standardising initial assessment and diagnosis procedures with the three A&E departments, including the introduction of rapid access to MRI scanning for suspected strokes to improve treatment decisions and to support earlier referral for mechanical thrombectomy.

These service changes are being overseen by Stroke Project Board, led by Dr Indi Gupta, Group Clinical Director for Specialist Medicine, with clinical representatives from the three hospitals and community services. This board reports to the group wide Clinical Programme Board which in turn reports to the trust executive and Partnership Board.

The hospital group also currently provide a 'best endeavours' mechanical thrombectomy service at Southend Hospital. This service is currently under internal review to ensure it is safe and effective, alongside ongoing work with NHS England Specialised Commissioning on their proposed future network arrangements for thrombectomy services for the population of mid and south Essex.

The system is committed to working with NHSE on Integrated Stroke Delivery Networks, in line with national clinical guidance on stroke treatments.

21.3 Acute/community pathway

The five CCGs commission early supported discharge (ESD) via their local community providers and each provide services in a different way. At present, none of the services are commissioned to the National Clinical Guidelines for Stroke standards. The CCGs are currently undertaking a gap analysis to understand the future commissioning model for ESD with a view to offering a standardised service offer for the population. This has included criteria for bedded and non-bedded ESD services, multidisciplinary input, staffing, non-clinical and clinical follow-ups and six monthly reviews. A new pathway is currently being developed and will be reviewed by the Clinical Cabinet before a full business case is developed.

21.4 Rehabilitation

Across the seven CCGs in Essex, a neuro-rehab navigator role has been introduced. This has facilitated improved patient flow and reduced delays in acute inpatient beds. In addition, a procurement process has been undertaken for a provider of Level 2B inpatient and outreach neuro-rehabilitation. This will go through relevant governance processes in Q3 2019/20 with a view to commence mobilisation January 2020.



How will our stroke services be delivered in future?



You

Individuals will maintain healthy lifestyles, with support, where required, to reduce key risk factors that can lead to a stroke.



Neighbourhood

Our PCNs will be focussed on prevention, offering screening and health checks to those who may be at risk of developing conditions that may cause a stroke.

People will get swifter access to the right health or care professional to get help with a developing condition –this might be a pharmacist, and specialist nurse or a GP.

Close work with community and voluntary sector organisations will support patients and their families to access a wider range of services – for example, community groups, exercise classes, support groups,



Place

Early supported discharge and bed-based rehabilitation services following a stroke will, where possible, be provided at Place level. Services will be provided to a consistent set of standards, focussed on improving outcomes for patients and supporting their carers.

Support to get people home will be provided by integrated discharge teams - social care and health care practitioners working together.

Where safe and possible, a range of outpatient and diagnostic tests will be available closer to home to support patients to access care more locally. This may include 6-month and 12-month follow-ups post-stroke.



System

We will implement the new acute hospital stroke pathway to improve outcomes for patients who experience a stroke. The new pathway will reduce unwarranted variation in access, quality and outcomes for stroke services. Our neuro-navigation role will ensure patients get the right care for neuro-rehabilitation as close to home as possible

We will identify appropriate digital solutions that will help patients both reduce risks of having a stroke and support rehabilitation for stroke survivors.

Our estates strategy will support us delivering as much stroke care closer to home as is safe and possible.

22. Improving diabetes care

Clinical Lead: Dr Sammi Ozturk, GP lead

Senior Responsible Owner: Tricia D’Orsi, Chief Nurse, Castle Point & Rochford and Southend CCGs

We are committed to improving the quality and consistency of services to deliver best outcomes for people living with diabetes or at risk of developing the condition. Building upon existing best practice there is significant potential to improve services in both traditional and innovate ways and contribute to national targets in the following areas:

- // Prevention and Early Identification
- // Structured Education
- // 8 care processes and treatment targets
- // Diabetes foot pathway

Our Commitments

We are committed to achieving an improvement in outcomes for people at risk of developing, or living with diabetes. Our commitments include:

- // Prevention of the onset of type 2 diabetes
- // Promotion of awareness and earlier detection of type 1 and type 2
- // Reduction of the occurrence of diabetes related complications
- // Reduction of the impact of diabetes among hard to reach groups
- // Using evidence, research and data to strengthen our approach to prevention and care
- // Improvement of health care education

Current Provision & Future Plans

From 2017/18 data, the number of patients diagnosed with diabetes across the five CCGs is as follows:

2017/18 Data	Number of Registered Diabetes Patients		Population Prevalence % (17+)	
	Type 1	Type 2	CCG	England
Basildon & Brentwood	1,150	12,550	6.4	6.8
Castle Point & Rochford	850	9,845	7.2	
Mid-Essex	1,915	17,885	6.4	
Southend	770	8,565	6.7	
Thurrock	620	7,320	6.7	

22.1 Our ambitions:

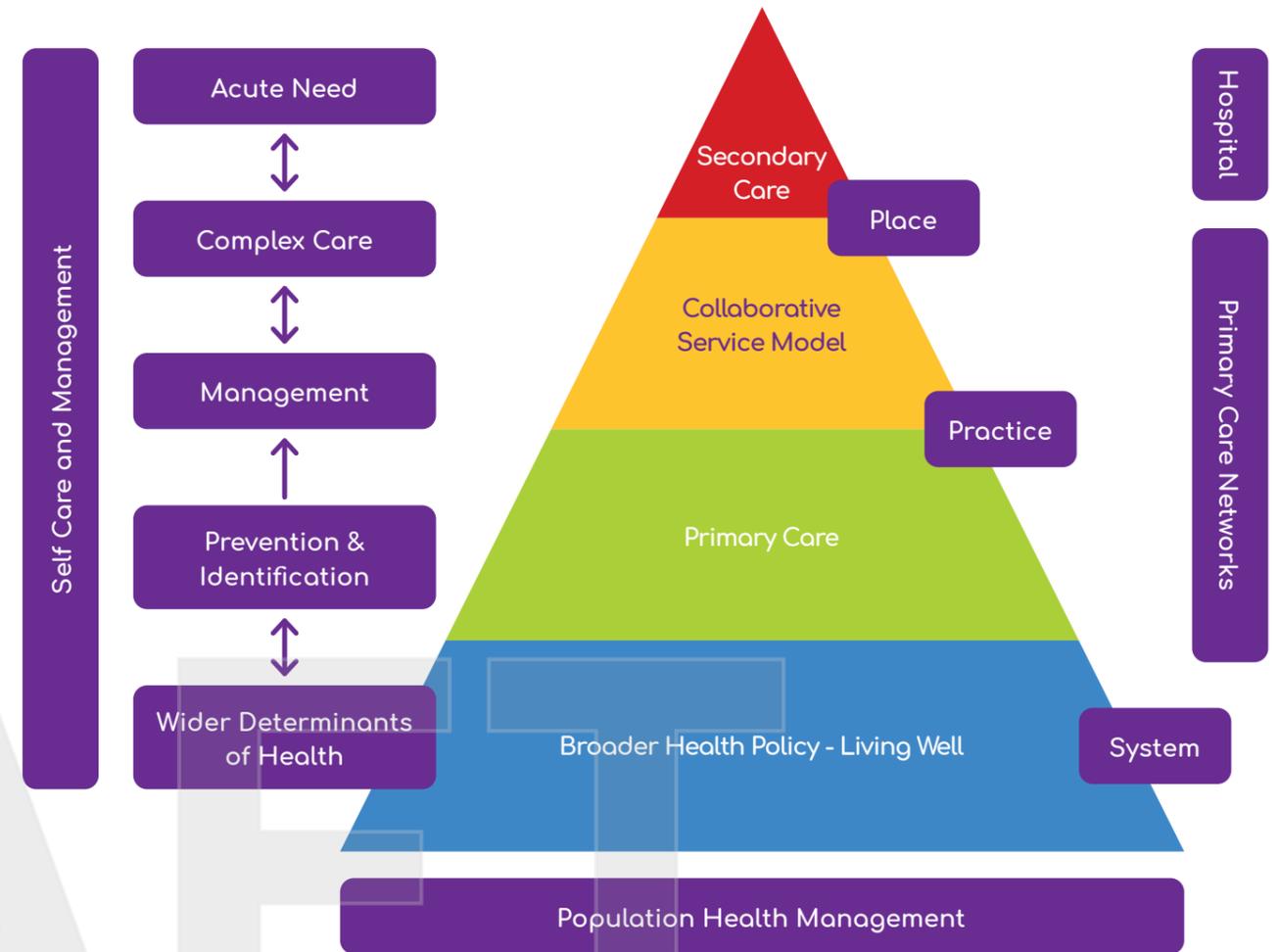
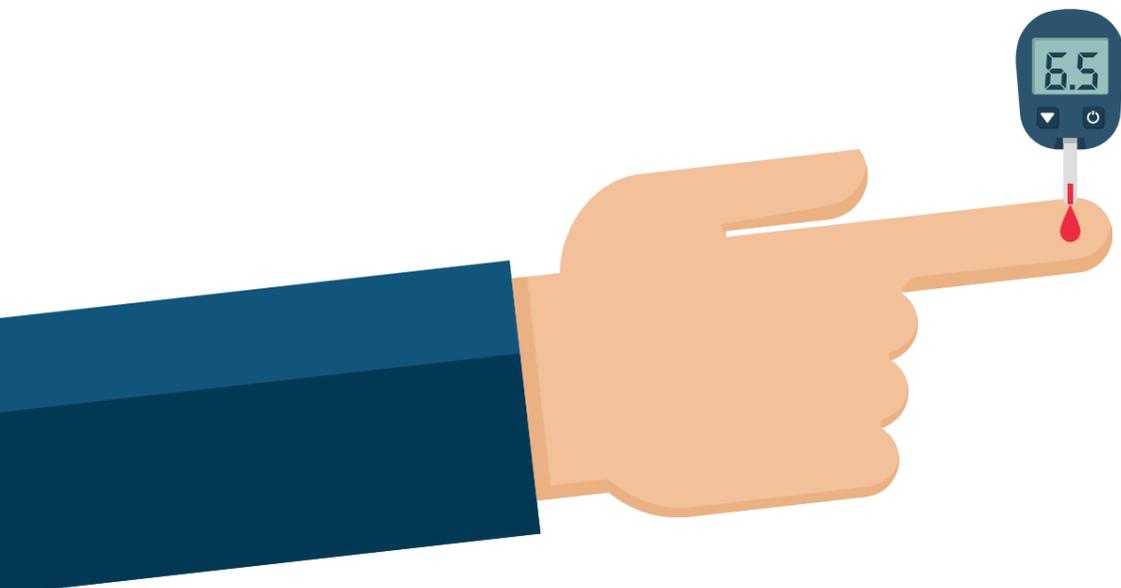
We are aiming for improvements in care processes for type 1 (from current 25% to 40% to bring us in line with national performance) and for type 2 (from current 35% to 60% to bring us in line with national performance).

We are also aiming for a 50-60% conversion rate (referral to intervention) for the National Diabetes Programme.

In order to achieve these ambitions, we have developed a diabetes framework which will be delivered within a model of care based on four tiers: broader determinants, including prevention; PCN (neighbourhood level); community care via a collaborative service (PCN/place-based) and hospital care. According to their individual needs, a person with diabetes may receive care in all of these settings. The majority of diabetes care is currently provided in primary care and community settings; and around 80% of care will be provided in these settings in future.

The collaborative service will be provided by a comprehensive diabetes skilled multidisciplinary team. Collaborative care by its definition requires all professionals involved in a person's care to work in partnership, including generalists, specialists, other health professionals and support staff, with the person living with diabetes and his/her family at the centre of their care. The workforce will be upskilled within the collaborative service to provide more specialist care in the community.

Where appropriate we will agree a mid and south Essex approach to elements of the model such as addressing the wider determinants of health. All tiers will be underpinned by a population health management approach with self-care and management being a fundamental component throughout.



As part of our improving diabetes care journey, we need to identify and support current workforce capacity and competency to deliver the future model of care. Implementing a new model of care to support diabetes management will include staff training and development needs.

The skills required to support effective diabetes care include many that are generic to all long term conditions, as well as others that are specific to diabetes.

This will involve:

- // acknowledging the philosophy and principles of support for self-management
- // identifying accountable leadership
- // identifying the population involved (risk stratification)
- // identifying the capacity of individuals to engage in the necessary processes and supporting them to do so
- // identifying the multidisciplinary teams involved and the roles and responsibilities of each team member in order to ensure that care is personalised and co-ordinated
- // using available evidence-based and quality-assured training
- // identifying robust metrics, data collection methods, analysis and feedback to drive improvement.

The diabetes framework will be implemented through the development of a competency framework which will identify the skills required to support individuals at differing stages of their diabetes experience. This will then inform necessary investment for continuing professional development across the primary, social and secondary care interface.

22.2 Digital Solutions

The MyDiabetes App has a number of embedded functions such as expert written information, structured education, blood glucose level (HbA1c) log and monitoring, programmes of simple activities and diet plans, and access to a pool of clinical specialists for advice and support in understanding Diabetes, the associated risks, and self-management of the condition.

MyDiabetes will be used by newly diagnosed Type 2 diabetes patients and provides a lifetime licence for the patient once registered; therefore the patient has access to the app, dipping in and out of the embedded functions as and when required

We will undertake a 6 to 12 month pilot (100 licences per CCG area) in addition to the face to face structured education courses currently provided.

22.3 Our Deliverables

Key Milestone Deliverables	Timeline
Health and Care Partnership five year Diabetes framework finalised and approved	Nov-19
Review and redesign Health and Care Partnership foot pathways community through to acute	Dec-19
Governance structure established (in line with existing forums)	Jan-20
Prevention/self care programmes identified across the wider health system	Feb-20
Benchmarking (gap analysis) against the framework completed	Feb-20
System-wide and CCG priority areas agreed and plans developed	May-20
Framework changes to service pathways implemented	Jun 20 - Mar 22
MyDiabetes app distributed to 100 Type 2 diabetes patients within each CCG (initial pilot) as part of the existing structured education pathway	May-20
NDPP referrals increased in line with yearly IP allocation	Aug 20 - Jul 24
Improvement in variances across practices in care processes and 3TTs	Mar-21
Diabetes workforce competencies developed based upon national guidelines	Sep-20
Workforce training needs identified	Mar-21
Collaborative working across PCN/Place - community and specialist	Apr 22 - Mar 23
Care model developed and procured (subject to PCN maturity)	Apr 23 - Sep 24
Care models implemented	Mar-25

23. Respiratory disease

Clinical Lead: Various

Senior Responsible Owner: Terry Huff, Accountable Officer, Castle Point & Rochford and Southend CCGs

Redesigning respiratory services is one of our transformation priorities.

Our vision is ultimately to improve the respiratory health and well-being of the population of mid and south Essex from the start to the end of their lives.

Our respiratory plans will initially focus on a defined scope of adult chronic respiratory disease before expanding to include acute and paediatric services

All CCG's have already implemented or planned initiatives to improve respiratory services and patient outcomes. Our programme will review and revise these initiatives to create a system-wide offer that meets national standards and LTP commitments, with a focus on ensuring prevention and self-care, ensuring as much care as possible is provided close to home.

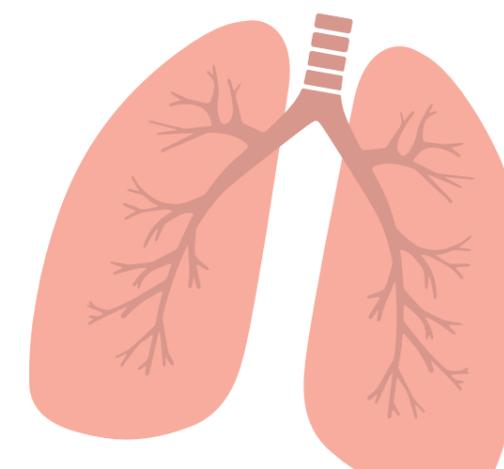
Programme objectives:

- // To create a consistent approach to respiratory care across mid & south Essex.
- // To increase early and accurate diagnosis of respiratory disease.
- // To promote better medicine management.
- // To improve education and support GPs to enable them to manage patients.
- // To comply with the requirements of the National Spirometry Register using targeted funding as it becomes available.
- // To promote self-management, including the MyCOPD app, to enable greater patient control of their own care.
- // To increase the uptake and completion of pulmonary rehabilitation programme, using targeted funding as it becomes available.
- // To reduce avoidable admissions for community acquired pneumonia.
- // To reduce hospital outpatient activity.
- // Deliver high quality integrated care in line with best practice guidelines

In order to achieve our vision, the respiratory Programme aims to support;

1. Prevention of respiratory ill health

We will increase awareness of how to maintain good respiratory health so that people are aware how to live healthy lifestyles and make informed healthy choices to minimise the risks of poor respiratory health. We will ensure that the activities of individual services and agencies support this aim.



2. Earlier detection of respiratory diseases

We will ensure people are aware of the signs and symptoms of respiratory diseases in order to encourage positive health-seeking behaviours and ensure robust services and pathways are in place to enable access to early investigation and treatment.

3. Primary Care and Community based support

We will provide a fully integrated approach to primary care and community based services, to ensure all community treatment and support services are aligned to best meet the needs of patients and carers, and facilitate seamless community services.

4. High Quality Hospital Services

We will ensure that pathways and services are in place so that people who need them receive prompt, effective treatment for their respiratory condition and have the best chance to optimise their quality of life and survival.

5. Promoting Self Care and Independence

We will make sure that people are placed at the centre of their own respiratory care, able to identify their individual needs and provided with appropriate, personalised information, support and interventions to help them.

6. Develop the workforce to support quality provision of respiratory care

We will implement an agreed competency framework for healthcare professionals involved in managing respiratory disease and support this with a flexible educational programme that is accessible to all healthcare professionals.

Our Expected Outcomes

Through working together on a system wide approach we expect to:

- // Reduce the prevalence of respiratory disease
- // Reduce the burden of respiratory disease
- // Reduce variation of care across the system for respiratory disease
- // Increase the number of patients accurately diagnosed with COPD and Asthma at an earlier stage of disease
- // Reduce reliance on secondary care services
- // Improve patient quality of life
- // Provide proactive care delivered by the right person at the right time

How will respiratory services be delivered in future?



You

Individuals will be supported to prevent the on-set of respiratory disease and self-manage their condition, including education programmes and support with healthier lifestyles. A range of digital tools (eg MyCOPD, asthma), will be available

Individuals with respiratory disease will have personalised care and management plans, and be at the heart of decision-making about their care.



Neighbourhood

Diversifying the workforce within PCNs will mean that patients get access to the right care professional for their needs to obtain education, advice and guidance – this could be from a pharmacist, a specialist nurse, therapist or GP.

PCNs will support practices to undertake proactive case finding and risk stratify patients to ensure that those at high risk receive the right care and support.

Structured medicine reviews and education will be undertaken.

PCNs will adopt consistent management approach for community acquired pneumonia – ensuring swift diagnosis and treatment.

Community teams will be aligned to PCNs, providing pulmonary rehabilitation, community clinics (including oxygen assessment clinics). Psychology services, nebuliser trials, home support and where required, palliative care support & end of life care co-ordination



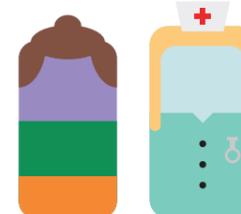
Place

At place level we will look to provide a respiratory diagnostic / assessment unit/HOT clinics and in-reach into acute services, along with supported early discharge from hospital.

We will offer flu immunisation at Place-level, with a focus on the most vulnerable.

We will bring as much care close to home as possible to prevent patients having to travel wherever we can.

We will offer effective smoking cessation services and ensure that all health and care professionals can offer brief advice on smoking cessation.



System

We will develop a single service specification for respiratory services and simplify points of access for patients.

The shared care record will assist health and care professionals to support people living with respiratory conditions.

We will develop and a workforce competency framework and deliver education programmes to our staff.

24. Redesigning Outpatient Care

Clinical Lead: Specialty-specific leads in place
 Senior Responsible Owner: Tom Abell, Deputy Chief Executive, Mid & South Essex University Hospitals Group

Outpatient redesign has been identified as one of our key transformation priorities.

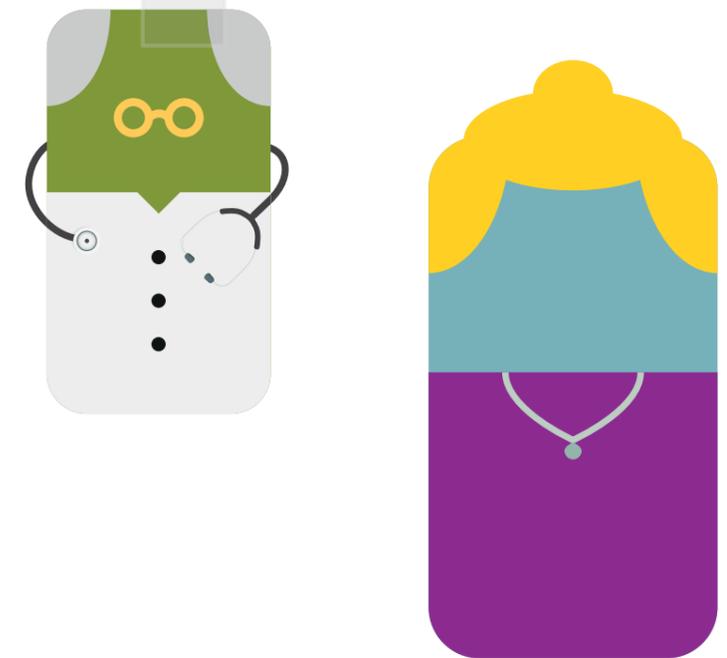
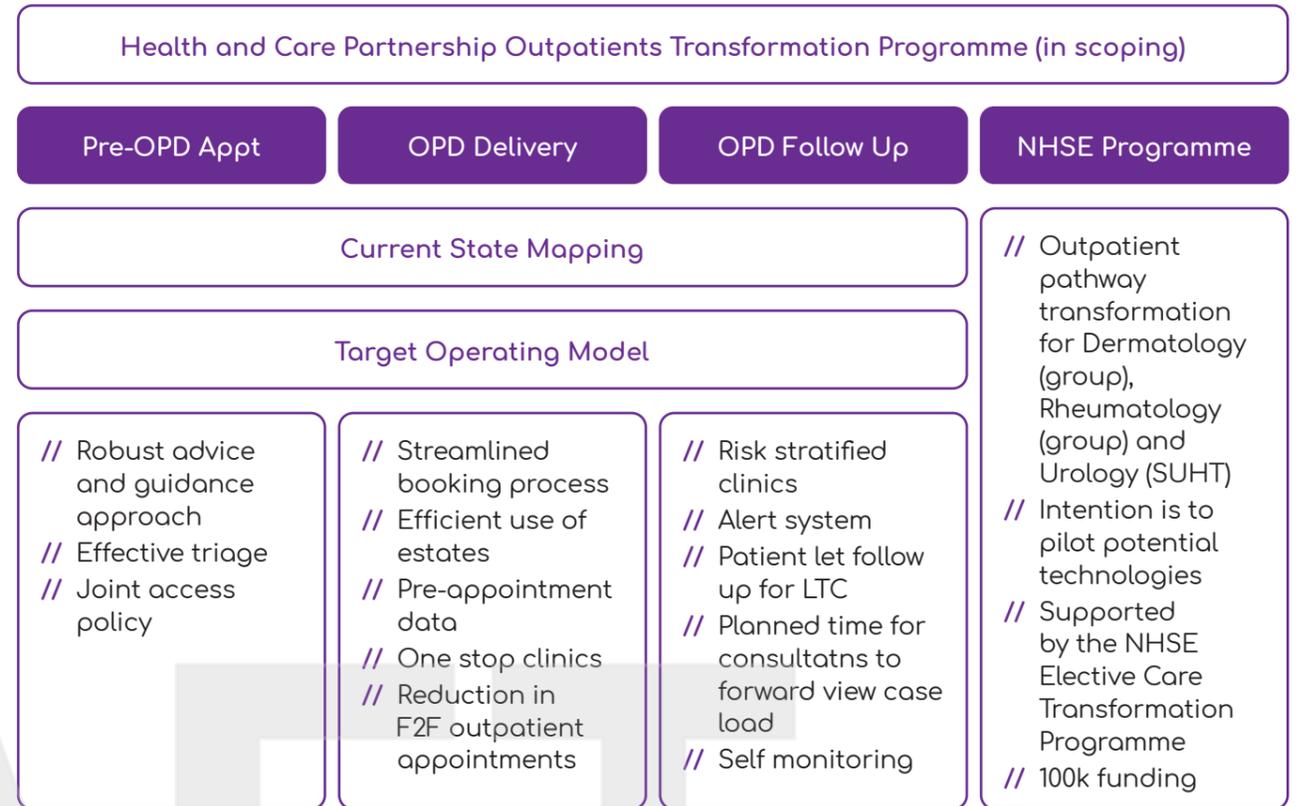
As part of the acute reconfiguration arrangements, we planned a significant reduction (274k fewer) outpatient appointments would need to be delivered in alternative ways to ensure sustainability of all services and while bringing as much care as possible closer to where people live. To deliver this reduction, we will need to work in different ways including taking a 'digital first' approach, reducing face-to-face appointments and bringing hospital clinicians into the community to support delivery of this service.

In planning our future estate requirement, we are mindful that we want to move as much care closer to where people live as possible to prevent people having to travel to hospital. Additionally, in planning the future estate as part of the capital business case for hospital reconfiguration and integration plans, we have a need to "right size" our outpatients departments. Our approach to this will use the latest technology and adoption of proven innovations to deliver new ways of working to support personalisation and choice for patients, while improving the capacity and utilisation of our services.

Our outpatient redesign programme has the following key objectives:

- // Reduce overall outpatient appointments
- // Reduce % of face to face outpatient appointments
- // Reduce variance across our three hospitals, optimising our administrative processes
- // Optimise Outpatient experience
- // Enhance Outpatient data analytics to enable continuous improvement
- // Adoption of a 'digital by default' approach

As well as taking a pathway approach to improvements (pre-OPD, OPD delivery, Follow-up), we are focussing on three key specialities as part of the NHS England Outpatient Transformation Programme (dermatology and rheumatology across the three hospitals, and urology at Southend Hospital). This work will involve commissioners, newly formed primary care networks and other community providers, also linking closely with our digital transformation and estates programmes.



25. Children & Young People

25.1 Maternity & Neonatal

Clinical Lead: **Teresa Kearney**, Chief Nurse, Basildon & Brentwood CCG
 Senior Responsible Owner: **Karen Berry**, Senior Maternity Commissioner, Basildon & Brentwood CCG

Positive, healthy pregnancies and births, and good early development have wider societal impacts for our population.

We aim to ensure that children and their families have the best quality of care throughout pregnancy and early life and that parents are given choice and control of their care and support.

The Maternity & Neonatal Long Term Plan commits to include the Better Births programme with Maternity and Neonatal ambitions. The mid and south Essex Local Maternity Service Transformation (LMS) programme has clear governance processes and a robust link is being developed across the system with interdependent programmes. We have established a Local Maternity System Transformation Board comprising representatives from commissioners, hospital providers, community services and patient representatives. A full report on our maternity and neonatal transformation programme can be found at Appendix 8.

Context

Across mid and south Essex, our maternity services deliver approximately 12,305 births/year. The acute hospital merger will provide the opportunity for our Maternity and Neonatal services to become standardised. There are two standalone midwifery units and three co-located midwife-led units.

Each acute hospital unit has a level 2 Neonatal unit. Our intensive care pathways operate as follows:

Southend Hospital / BTUH - The Royal London Hospital

Mid Essex - Cambridge University Trust and are part of the Cambridge Cluster hospitals

A capacity and demand analysis of mid and south Essex (2018) suggested birth rates in Essex were expected to remain steady over the next few years with a small expected increase in Basildon in 2020 and steady thereafter. Given the amount of cross border activity it is not immediately clear where this expected increased activity will have most impact. The information available suggests it is most likely to impact on BTUH and MEHT. Given the small increase in birth rate indicated, the requirement for additional staff does not appear to be significant at this time. However, we are aware there are significant housing developments within the area and the impact of these. Therefore, ongoing monitoring of the impact of this as well as increases in maternity bookings will be required by the Heads of Midwifery to ensure that any increase results in an by establishment uplift.

Saving babies lives care bundle version 2

Version two of the Saving Babies' Lives Care Bundle (SBLCBv2), has been produced to build on the achievements of version one and address the issues identified in the SPIRE evaluation. It aims to provide detailed information for providers and commissioners of maternity care on how to reduce perinatal mortality across England. The second version of the care bundle brings together five elements of care that are widely recognised as evidence-based and/or best practice:

1. Reducing smoking in pregnancy,
2. Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)
3. Raising awareness of reduced fetal movement (RFM)
4. Effective fetal monitoring during labour
5. Reducing preterm birth

Our current work and future plans

We are committed to delivering against the requirements of the Saving Babies' Lives Care Bundle. A deep dive performed in 2018 demonstrated the gaps in our compliance and we have clear plans in place to close these gaps (see Appendix 8) We are committed to making significant progress on the "halve it" ambition of halving rates of stillbirth and neonatal death, maternal death and brain injuries during birth by 50% by 2025:

Stillbirth rate

		Baseline 2016	2019/20	2020/21	2021/22	2022/23	2023/24
Numerator	The number of stillbirths during a calendar year	60	51	49	46	44	42
Denominator	The number of live births and stillbirths occurring during a calendar year.	13,987	13,987	13,987	13,987	13,987	13,987
Rate	Rate per 1,000 live births and still births	4.3	3.6	3.5	3.3	3.1	2.9

Neonatal Mortality rate

		Baseline 2016	2019/20	2020/21	2021/22	2022/23	2023/24
Numerator	The number of stillbirths during a calendar year	14	12	11	11	10	10
Denominator	The number of live births and stillbirths occurring during a calendar year.	13,927	13,927	13,927	13,927	13,927	13,927
Rate	Rate per 1,000 live births and still births	1.0	0.9	0.80	0.8	0.7	0.6

Improvement Programmes

All three maternity units in our LMS are fully engaged in the development and implementation of the NHS Improvement Maternity and Neonatal Quality Improvement programme.

Southend Hospital Maternity participated in Wave 2, specifically to improve the early recognition and management of deterioration during labour and early post-partum period. They completed a Quality Improvement piece of work on early identification and treatment of Sepsis.

Basildon Hospital Maternity are in Wave 3 and are undertaking a Quality Improvement initiative focussed on improving the proportion of smoke free pregnancies, this has included Carbon Dioxide monitoring at each point of contact. The LMS financial plan has supported the initiative for smoking cessation.

Mid Essex Hospital Maternity participated in Wave 3, the focus was on improving early the early recognition and management of deterioration during labour and early post-partum period. Their quality improvement project is in the management of post-partum haemorrhage.

The LMS are reporting the use of Magnesium sulphate for women in suspected labour under 27 weeks. They are exception reporting when this is not carried out, or when unable to transfer women to a tertiary unit prior to 27 weeks.

All three Maternity units are using the perinatal Mortality review tool to review all stillbirths and neonatal deaths. Learning from these is shared via a safety newsletter.

All three units take part in the National Neonatal Audit Programme (NNAP). The 2018 data results are available at Appendix 8.

Term babies admitted to the Neonatal unit are being reviewed locally to enhance learning and ascertain if the admissions could have been avoided, also consideration is given as to whether babies could have been cared for under a transitional care pathway which would reduce the likelihood of them being separated from their mothers. All three sites have an Avoiding Term Admissions to NICU (ATAIN) action plan, In addition to this there are action plans for each unit to introduce a transitional care service.

The LMS has considered the use of placental growth factor testing. This will be kept under review but not instituted at present.

Choice and Personalisation

Better Births state that all women should receive personalised care, centred on the woman, her baby and her family, based around their needs and decisions, where they have genuine choice, informed by unbiased information. The LMS is working to ensure that:

- // All women have a personalised care plan by 2021
- // All women can make choices about their maternity care, during pregnancy, birth and postnatally
- // More women can give birth in midwifery settings (at home and in midwifery units)

MSE Personalised Care and Support Plans are now completed; Maternity choices are available on each of the trust websites. The Maternity Direct App has gone live at BTUH, it will be developed to be available for all women to download and is a platform for health information for those who are able to download the app. The chat and appointment functionality will be available at BTUH, but not currently at Southend or MEHT, until IT integration has been achieved.

At present all Maternity units are using personalised care plans and these are given at booking ensuring the majority of women have a personalised care plan.

Continuity of carer.

At present, we are offering 12.9% of women the opportunity to have the same midwife throughout pregnancy, during birth and postnatally, against a requirement of 20%. We will continue to work with midwives, mothers and their families to implement continuity of carer so that, by March 2020 we progress towards 35% of women are being placed on a continuity of carer pathway and in March 2021, Most women will receive continuity of carer.

Our work will be targeted towards women from BAME groups and those living in deprived areas, for whom midwifery-led continuity of carer is linked to significant improvements in clinical outcomes. By 2024 75% from Black/Black British and Asian/Asian British communities and women from the most deprived areas will receive continuity of carer.

Perinatal mental health.

Mental health and maternity executive leads have identified dedicated resources to lead the further development and expansion of the Specialist Community Specialist Perinatal Mental Health Service in line with increased investment to deliver the ambitions of the LTP. As an aligned resource with the LMS; the scope of work includes the requirements of Better Births implementation in regards to supporting emotional wellbeing and identifying mental health concerns at an early stage. Ensuring that wellbeing and mental health is a golden thread running through all services involved in providing care for women and their partners through preconception, antenatal and post-natal care. See section 15 and Appendix 8.

Maternal Smoking.

We are committed to reducing maternal smoking and aim to unify smoking cessation services available to women and their partners across the footprint. Smoking at time of delivery for 18/19.

Workforce

Workforce profiling has included Birth rate + reports from all three sites. This has demonstrated a midwifery workforce deficit of 30 WTE and a deficit of maternity support workers (MSW) of 14.5 WTE. All three Trusts provide maternity workforce statistics and use this information to support future planning of workforce numbers and skill mix. Reporting of workforce information will be aligned across the three Trusts.

Postnatal Care

All three sites are providing personalised care planning which includes postnatal planning in the antenatal period. Two sites have clear pathways for timely referral for women who experience issues with their pelvic health. We recognise that there needs to be greater emphasis on access to emotional and mental health support, and this is included in the perinatal mental review.

Infant feeding

Currently, only Mid-Essex have a tailored feeding strategy and so we will develop a tailored feeding strategy ideally across the system. Breast feeding support has diminished across the LMS and the Maternity Voices Partnership are looking at ideas to improve our service to women.

BTUH and SUHFT have infant feeding midwives with baby friendly accreditation initiative (BFI) whilst MEHT currently have a vacancy for this position and need to re apply for BFI.

DRAFT



How will maternity services be delivered in future?



You

Pregnant women will be supported to maintain healthy lifestyles, with support where required to reduce key risk factors. Eg smoking in pregnancy

Women will be able to access support and advice through the Maternity Direct App.



Neighbourhood

Swifter access to the right health and care professional through primary care networks.

Women will receive personalised support to develop care plans.

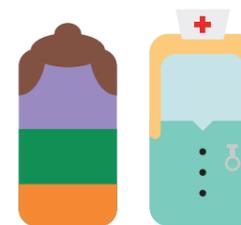
Close work with community and voluntary sector organisations will aide women and families in accessing a range of support services pre- and post-natally eg new mum groups, breastfeeding support.



Place

Where safe and possible, a range of outpatient appointments and diagnostic tests will be available closer to home.

Immunisations offered through place-based arrangements.



System

At a system level organisations will work together to further develop digital channels for accessing information, advice and support/

We will continue to develop and improve our maternity services, ensuring full adoption of the Better Births principled across our three maternity units and ensuring continuity of carer in line with LTP commitments.

25.2 Children and young people’s mental and physical health services

Clinical Lead: Dr Sooraj Natarajan

Mid and south Essex has a child population of circa 270k and although there are similarities in the health needs, there are also significant variations linked to demographics and wider health determinants. The joint strategic needs assessments undertaken across the footprint have informed commissioning priorities and will continue to support collaborative working across health and care partners.

Children and Young People Partnerships

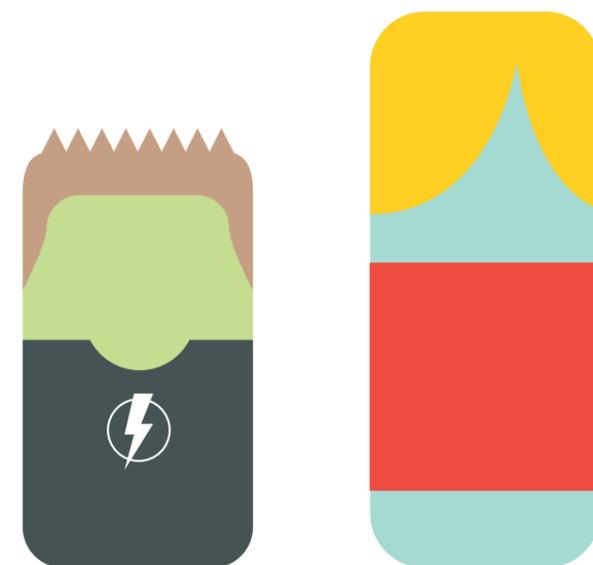
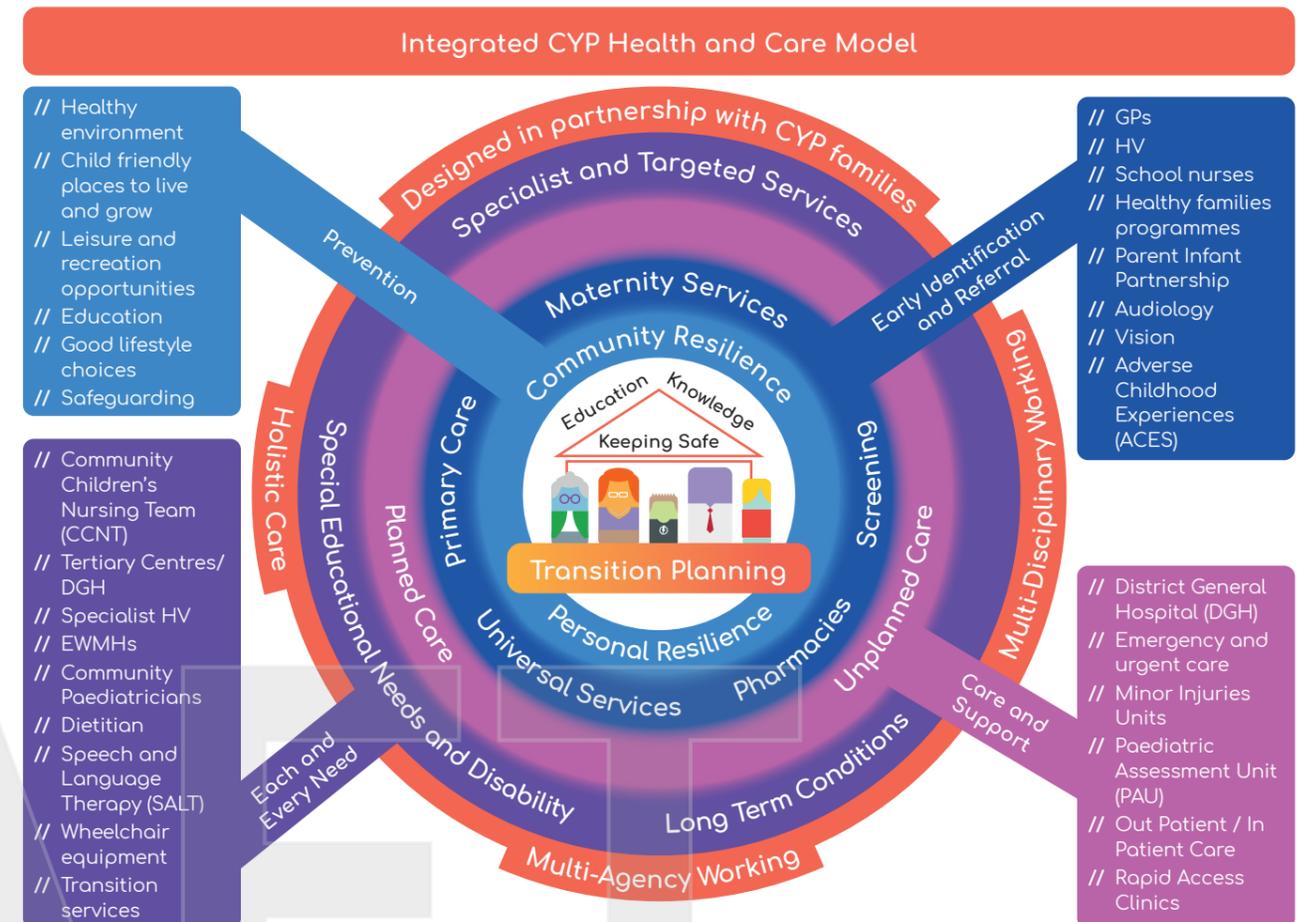
Children and Young People (CYP) Partnerships are currently aligned with the individual council and unitary footprints. This includes Essex Children’s Partnership Board, Thurrock Brighter Futures Board and Southend Success for All. These three partnerships will have oversight of presenting health inequalities and local needs; each reports to the relevant Health and Wellbeing Board. The delivery of the Families and Children Act in relation to Special Educational Needs and Disabilities (SEND) remains accountable on the local authority footprints supported by the SEND Partnership Boards. Safeguarding for CYP also has locality accountability; however Southend, Essex and Thurrock work in collaboration to have a consistent approach underpinned by the single Safeguarding and Child Protection Procedure.

Clinical leadership

To support the work across mid and south Essex there is a well-established Paediatric Clinical Engagement Group (PCEG) which brings together universal health and prevention services, children’s acute and community services. The PCEG has strong clinical leadership and is chaired by the CYP GP Lead.

PCEG and the primary care networks will work closely together to support integration across the health and care system for CYP with long term conditions including asthma, epilepsy and diabetes. This will include the ongoing and transfer of care to adult services and integration with education and wider settings who provide care for this group of children.

The PCEG has developed an overarching model to illustrate the integrated approach for children and young people (see below). The model illustrates the importance of taking a whole family holistic approach to prevention and early intervention and the potential benefits to be realised by maximising integration.



26. Learning Disability and Autism

Clinical Lead: Tricia D'Orsi, Chief Nurse, Castle Point and Rochford and Southend CCGs

Senior Responsible Owner: **Simon Leftley**, Deputy Chief Executive, Southend Borough Council, Chair of Transforming Care Partnership

We will deliver the Long Term Plan commitments to improve services and outcomes for people with learning disabilities, autism or both, through working across the existing Essex Transforming Care Partnership (TCP) that was set up in 2016.

The Essex Transforming Care Partnership consists of Southend CCG, Castle Point & Rochford CCG, Basildon & Brentwood CCG, Thurrock CCG, West Essex CCG, Mid Essex CCG, North-East Essex CCG, Essex County Council, Southend-on-Sea Borough Council and Thurrock Council. The Partnership covers all of the mid and south Essex footprint, but also sits across Hertfordshire and West Essex and Suffolk and North Essex.

Since its conception the Essex TCP has successfully delivered against the national Transforming Care agenda. Key achievements include:

- // Reducing admissions to adult learning disability in-patient facilities by over 50%;
- // Reducing overall learning disability adult in-patient numbers by 34% and exceeding the targets within the national Transforming Care programme;
- // Delivering a transformed local service model in line with "Building the Right Support" - the national service model for learning disability - through a new 7 year contract with Hertfordshire Partnership University NHS Foundation Trust (HPFT)
- // The establishment of a Pooled Budget underpinned by a Section 75 agreement across the partners;
- // The establishment of an integrated learning disability commissioning function funded by all partners and hosted by Essex County Council.

Since the publication of Valuing People in 2001 it has been clear that the wider determinants of health for people with learning disabilities – housing, employment, and healthy living are influenced best by Local Authorities. Those areas that achieved the greatest successes in reducing health inequalities have had strong partnerships between CCGs and Local Authorities. The Essex TCP has a senior responsible officer in place (Simon Leftley, Deputy Chief Executive, Southend Council) and the commissioning infrastructure to deliver the commitments within the Long Term Plan.

The Essex TCP also sees opportunities of working across all three Health and Care Partnership footprints. The areas that offer the greatest benefit for operating at this larger scale are low volume and high cost niche services where it makes sense to commission collaboratively. For example:

- // We are already working with the Suffolk TCP to explore opportunities around co-commissioning assessment and treatment services. Both Essex and Suffolk are looking to remodel their assessment and treatment units and doing this together would deliver improved economies of scale;

- // We are working with Hertfordshire, Suffolk and Norfolk to explore how we can commission low volume high cost in-patient beds to achieve the best value and ensure consistent quality standards.

The Essex Transforming Care Partnership has recently extended its terms of reference to address the wider health inequalities that people with learning disabilities and autism experience. In 2019/20 we will publish the first Health Equalities strategy bringing together the learning from Transforming Care, LeDeR, STOMP / STAMP and annual health checks into a coherent programme of work across the partnership.

The partnership has invested in a commissioning structure to deliver Learning Disabilities Mortality Reviews (LeDeR). Through the appointment of two permanent LeDeR reviewers, a LeDeR co-ordinator, a number of interim workers to address the backlog, and our existing reviewers within the local health and social care system, we will ensure reviews are undertaken within six months of the notification of death. The Essex TCP was one of the first areas to produce an annual LeDeR report and has an active steering group to address the identified themes from the reviews.

The Partnership also has steering groups for the Stopping Over Medication of People with a learning disability or autism and Supporting Treatment and Appropriate Medication in Paediatrics (STOMP-STAMP) programmes to ensure a consistency and efficiency across all seven CCGs.

Co-production has always been central to the work of the Essex TCP and experts by experience have been involved in shaping all aspects of the programme from co-producing the service model and specification to being full members of the board. Within the new commissioning structure two posts have been created for a person with a learning disability and a family carer and they will have responsibilities for developing systems to monitor the quality of care, support and treatment, and that local services are making reasonable adjustments.

The Partnership has already had considerable success in reducing adult inpatient usage and has plans to exceed its targets for both 19/20 and 20/21. The Partnership has also reduced the length of stay in adult in-patient services and actively uses the 12 point discharge plan to ensure people do not have to stay in hospital any longer than they need to. We will continue to actively monitor the use of seclusion, long term segregation, and restraint through our quality monitoring on in-patient services and through the Care and Treatment Review process to ensure these interventions are minimised and only used where absolutely necessary. We will also ensure that the providers we commission services from (both NHS and Independent Sector) meet the Learning Disability Improvement Standards.

The achievements in reducing adult in-patient services have been delivered through our new service model that went live in November 2018 that includes an enhanced community support service available seven days a week and a community forensic service. The Partnership has utilised capital to deliver housing solutions to discharge some of our long-term inpatients and we have a housing strategy in place to further reduce inpatient numbers.

The new seven year contract which covers the Partnership as a whole consists of the core services described in Building the Right Support, and a Local offer in which CCGs can tailor local services through their place plans to meet the needs of their populations. A key component within the place plans is improving the uptake of physical health checks to meet the target of 75%.

Our Priorities

A real focus of the Partnership over the next eighteen months will be children and young people with learning disabilities and autism. The Accelerator Pilot that was implemented in 2018/19 has illustrated how multi-disciplinary working and a person-centred offer can reduce crisis for children and young people with learning disabilities and their families. The current children's LD service that operates in north, mid and west Essex is being extended in 2019/20 to cover the Partnership as a whole to embed the learning from Accelerator Pilot. The Partnership will also be extending the model to include children and young people with autism and trial the use of keyworkers with access to flexible support including Personal Health Budgets in preparation for a roll out of the keyworker model in 2020/21. The Partnership with its local authority footprints also provides the best framework for testing the model for taking eye, hearing and dental services to children and young people in residential schools from 2021/22. The Health and Care Partnership is also reviewing its neurodevelopment pathways to ensure that C&YP with autism receive the support they need pre and post diagnosis; so that a diagnostic assessment is not just a Gateway to services but forms part of the overall support offer for this cohort.

The model for Children and Young People will align with the SEND plans for each of the three local authorities. The Partnership is also in the process of retendering for its CAMHS services (also on a TCP footprint) which provides an opportunity to ensure that the social care, education, and mental health offer for children and young people with autism are fully aligned to meet local need and reduce the need for in-patient admissions.

26.1 Special Educational Needs and Disability

The Children and Families Act 2014 requires Local Authorities and CCGs to work together to support the health element of services for children and young people with Special Educational Needs and Disability (SEND), enabling children and young people to have more say over what support and services are offered in the local area and the help they need to prepare for adulthood. Local Authorities publish information about the range of support available in their area for children and young people aged 0 to 25 years with SEND. This information is known as the 'Local Offer' and covers education, health and social care support and services.

Children and young people's needs are met from a range of NHS services, some are universal, such as GPs and health visitors and some are more specialised and may need an assessment or referral from a health or social care professional – these include, but are not limited to, speech and language therapy, community

paediatrics, physiotherapy, specialist children's nursing, continence services, emotional health and wellbeing services, continuing health care assessments and packages of care.

Ofsted and the Care Quality Commission are tasked with inspecting local areas on their effectiveness in fulfilling their duties under the Children and Families Act.

Following recent inspections, our three local authorities have each been given a Written Statement of Action, detailing where improvements must be made to SEND services and the local offer. The CCGs and local authorities are keen to commit to being joint and active members of an improvement board and have further committed to reducing inequalities within joint commissioning arrangements, recognising the need to work to agreed outcomes. Work has already commenced to this effect with commissioners working with officers from the local authorities. The work includes:

- // The development of a joint outcomes framework
- // Undertaking a gap analysis against best practice for a universal 0-25 service to support early intervention. This is likely to lead to a jointly commissioned service for higher level needs for the specialist service.
- // Education Health and Care Plans and inclusion of health and social care - a working group has been established to oversee this

The Improvement Board will feed into the SEND strategic governance group.



27. System financial plans

Clinical Lead: Various (depending on efficiency plan)

Senior Responsible Owner: Chief Finance Officers

27.1 Five-year System Control Totals

Mid and south Essex has traditionally been a financially challenged system and this has impacted on our ability to provide investments into delivering high quality healthcare for our population.

Our five year financial planning is predicated on two initial high level aims:

- // To achieve the control total set for the system as a whole by the end of the planning period
- // To ensure that our financial planning is both credible and an enabler for the delivery of the commitments set out in the NHS Long Term Plan

Further to these initial challenges, we continue to explore further opportunities that will also allow us to:

- // Achieve the control totals for each year across the planning period; and
- // To achieve the control totals set for each individual NHS organisation

The starting point for planning is the published CCG allocations for the next five years that set out the funding available to deliver the ambitions of the Long Term Plan and ensure quality healthcare is delivered for our population. This funding amounts to £1.64bn in 2019/20, rising to £1.91bn in 2023/24 which equates to annual increases in funding of between 3.5% and 4.2% p.a.. Together with social care resources (circa £0.6bn) across our system our population will benefit from £2.5bn spent on care.



Our financial plans show the following position:

Summary by Organisation (£m)		2019/20	2020/21	2021/22	2022/23	2023/24
Net system position by organisation						
Mid-Essex	£000s	4.0	0.0	0.0	0.0	0.0
CPR	£000s	0.6	0.0	0.0	0.0	0.0
Southend	£000s	0.6	(0.0)	0.0	0.0	0.0
B&B	£000s	3.8	0.0	0.0	0.0	0.0
Thurrock	£000s	0.5	-	-	-	-
Total CCGs	£000s	9.5	0.0	0.0	0.0	0.0
Total MSE Group	£000s	(109.3)	(87.6)	(79.9)	(76.0)	(73.0)
EPUT	£000s	(0.4)	(0.0)	0.6	1.3	1.9
Underlying system position	£000s	(0.4)	(0.0)	0.6	1.3	1.9
National support (MRET/PSF/FRF)		34.5	-	-	-	-
Net reported system position		(65.7)	(87.6)	(79.3)	(74.7)	(71.1)
System issued control total		(39.6)	(81.9)	(78.2)	(74.7)	(71.1)
Surplus / (Deficit) to control total		(26.1)	(5.7)	(1.1)	0.0	0.0

This plan is not without its challenges however, particularly around the level of financial efficiencies required (totalling over £300m between the CCGs and provider trust programmes alone by 2023/24 on an anticipated annual allocation of £1.9bn). The key components of this include:

- // Demand management of £157m across the health economy delivered by commissioners in partnership with providers through a range of efficiency programmes previously known as QIPP.
- // Financial benefits of £19.4m across corporate and clinical areas as a result of the clinical reconfiguration work that can be enabled by the capital programme. In the event the capital programme is not approved these efficiencies would be at risk.
- // Cost efficiency programmes or CIP within the acute providers of £124m, which is equivalent to 4% of the cost base in each of the three providers in 2019-20. For 2020/21 we have planned on 3.0% efficiencies, reducing to 2.2% across the group by 2023/24.
- // financing of deficits. In the event the merger does not proceed these efficiencies would be at risk.
- // Due to the risks associated with delivering significant and concurrent cost reduction programmes as well as the dependency of certain benefits on the merger and estates programmes that have not yet received final approval, the baseline position includes a reserve of approximately 2% of the annual allocation by 2023-24.
- // There are also efficiencies being delivered in the other members for the purposes of developing SDP reporting including £21m by EPUT.

Our submission is compliant against the control total trajectory set by NHSE and NHSI in the years up to 2023/24 as a system. See Appendix 5 for further detail.

27.2 Efficiency plans

In order to deliver the required efficiencies, the system needs to deliver some £300m savings over five years. This level of efficiency cannot be delivered through usual transactional savings programmes - it requires the whole system transformation described in this strategy and delivery plan. We know that we are likely to have significant investment requirements to enable this level of saving including, but not limited to:

- // Further investment to improve mental health services
- // Further investment in primary and community care over and above the funding made available through the LTP.
- // One-off funding to deliver elective care standards (subject to available capacity)
- // Investment in prevention activities
- // IT investment -funding to bring the basic infrastructure up to standard to support digital transformation plans
- // Double-running/additional support for workforce costs
- // Investment in community schemes

Partners are working together to address the significant efficiency challenge. The NHS Efficiency Map provides helpful guidance for systems, under three key areas of focus:

Enablers for Efficiency – ensuring	Service Efficiency – focussing on	System Efficiency – working together to focus on
System leadership	Workforce optimisation	Urgent and emergency care
Board capability & governance	Clinical support services	Long-term conditions and frailty
Management capability & capacity	Clinical quality and efficiency	Integration of services
Use of evidence and best practice	Procurement	Integration with social care
Controls and reporting	Estates	Right Care opportunities
Digital maturity	Corporate Services	Focus on prevention and self-care
	Focus on productivity	
	Model Hospital	
	Patient Flow	

Partners will work together, through the System Finance Leaders Group, to develop options for transformation including investment requirement.

28. Supporting our staff

Clinical Lead: Various

Senior Responsible Owner: Sally Morris, Chief Executive, Essex Partnership University Foundation Trust & Chair of Local Workforce Action Board

Our staff is our most important asset; the lack of available personnel to fill vacant posts is also our biggest risk. All of the transformation programmes we are undertaking are aimed at making the best use of the available workforce, and supporting them to achieve fulfilling careers in our system.

We are supporting a range of innovative programmes to attract new staff and retain the existing and by Q4 2019/20 we will have developed our first joint health and care workforce strategy, with key ambitions for the future. All NHS and local authorities within the mid and south Essex footprint are collaborating on this and we see the development of the strategy as an important milestone in our work together.

In line with the themes of the Interim People Plan the Local Workforce Action Board (LWAB) will support the system to ensure we focus on:

- // **Making our system the best place to work** - offering greater opportunities for flexible working and ensuring that we take positive action to have greater representation of BAME staff on our senior leadership teams.
- // **Improving leadership culture** – executives and chairs in mid and south Essex have been supported by a bespoke development programme enabling those senior leaders to support the cultural values of our Partnership, demonstrating compassionate and inclusive leadership at all levels in our workforce.
- // **Delivering a holistic approach to workforce transformation and workforce growth** – we are developing a greater variety of new hybrid roles (especially on integrated services with local authority and NHS organisations), working closer with social care to develop joint approaches to role development. We are up-skilling staff and developing new roles such as trainee nurse associates and physician associates to resource the establishment of primary care networks.
- // **Change the workforce operating model** – the LWAB has commissioned a bespoke system that will provide quarterly system workforce reports. This will enable us to have far greater access to data to monitor workforce themes such reasons for leaving, attrition rates, and the level of vacancies by staff group.

As part of our responsibility of being a good employer and understanding how we can improve access to opportunity and embrace the opportunities that come from a diverse workforce, partners at the MSE Group of trusts have begun some work to gain insight into the workforce and the needs of key populations within. MSE has developed methodologies for organising workforce information by key characteristics and social factors that have potential to contribute to hindrances for some groups in accessing opportunities for development, new experiences or more varied roles. We can use this information to pick up patterns or trends which might need addressing. This is already helping us to identify where data capture can be improved, identify areas for targeted staff engagement and build upon important factors such as action in response to the NHS annual staff survey. We hope to build on this through co-development of plans with staff directly, and for specific work streams such as the NHS Hospital as an Anchor programme.

For our workforce, the Partnership Board as approved the following key priorities for 2019/20:

Retention & Recruitment

- // A systematic review of the current retention plans to develop a consistent system approach to retention initiatives. This includes identifying reasons for leaving, reviewing attrition rates and reasons, identifying the main areas of concerns in the nursing workforce initially (other staff groups to follow) and reviewing the use of resources such as application of the NHSI retention tools
- // Development of a rotational roles scheme across the system; this will be led by the Directors of Nursing network to develop a system approach to offer greater flexible career opportunities and reduce contractual/employment issues for rotational roles.
- // Development of a system approach to return to practice, which we will implement and monitor over a 12-month period.
- // Review and streamlining of current recruitment practices, building on the national NHS Employer streamlining hub approach.
- // Introduction of alternative workforce roles including physician associates, AHP associates and Advanced Clinical Practitioners. Partners will collaborate on workforce planning for these new roles.
- // Further development of the Nurse Association partnership, supported by £240K investment (19/20) from HEE to manage the pipeline and enable 130 additional trainees.
- // Explore ways to develop technology enhanced education and training.

Mid & south Essex Career Framework

We will develop a virtual "School" that will include the following:

- // A system career framework to support development through level one - level five apprenticeships with a whole career pathway. This will better clarify the career pathways and options for nursing staff in order to deliver on the ambition that all staff have the opportunity of embarking on a 'career and not just a job' recognising the investment in time and training that this will require.
- // Mid and south Essex cadet scheme via engagement with schools through to work-based placements – promotion of careers through 'chat' sessions, podcasts of 'A day in the life of', intensive simulation training for schools and colleges.
- // Develop the mid and south Essex passport – offering greater flexibility and career development opportunities across the system.
- // Working with Essex Skills Board, Essex Primary Care Careers, Skills for Care to promote health and care careers enabling more joint role development.
- // Roll out of the mid and south Essex newly qualified nursing preceptorship programme and dedicated web site.
- // Leadership development programmes - targeted on broadening diversity and inclusion in senior roles; link to the new leadership compact agreement to develop and embed cultures of compassion, inclusion and collaboration in the system.
- // Link with the Training Hubs for Primary & Community staff – refine and identify savings as a system on continued professional development courses.
- // Create leadership alumni networks (join up existing organisations/local authority).
- // Develop the Partnership talent academy to support the High Potential Pilot programme and system talent management approach

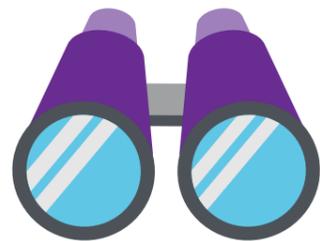


29. Digitally enabled care

Clinical Lead: Various depending on project
 Senior Responsible Owner: John Niland, Chief Executive, Provide CIC & Chair of the Partnership Digital Board

29.1 Our Digital Vision

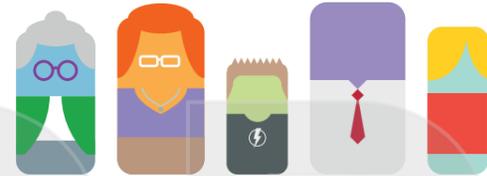
Taking a "digital first" approach is a fundamental part of the design principles we have adopted for our system. Our vision is as follows:



Our Shared Vision

Health and Social Care organisations in Essex share an ambition to **improve the services they deliver and the wellbeing and lives of the people they serve.**

They will work together with each other and with the local population to **organise around the needs and locations of people, rather than boundaries of organisations.** They way that technology is used will be improved, with **connected systems and better sharing of information** to allow **Health and Social Care professionals to be more responsive.**



What this will mean for local people

Digital services will provide patients and users with the **ability and convenience to manage their own information and needs if they want to** - just like they can in other parts of their lives (e.g. online banking).

People will be **encouraged to be more responsible, active and healthy** and they will be **provided with technology that helps**, like Health Apps and the ability to use information from wearable devices.

Information will be combined and used intelligently to identify needs or issues so that where possible **services can be targeted proactively** rather than treating problems after they occur.



What this will mean for our workforce

The Health and Social Care workforce in Essex will be a critical part of this plan. Without their involvement and buy-in new technology will fail and no improvements will be achieved. They will be **included, educated, equipped and enabled** to be successful - with technology being put in place that **allows them to focus on caring for patients and citizens.**

New services will be **designed with users in mind**, making the systems intuitive to use and training and adoption less of a hassle. The importance of the **safety of the people being cared for will not be overlooked.**



How will we work together & with others

These changes will be forward thinking and made collaboratively, **listening to people in the region** and being honest and practical about what can be done.

We will recognise that **some centralised coordination is essential, and respect the decisions that are taken.**

We will work with **clinicians and patients to co-produce plans and services**, working with or convening clinical or citizen groups where required.

Essex will become known as a **leading region for working with the vibrant marketplace of Health and Social Care innovation.**

New approaches will be welcomed, trialled and adopted. The Essex teams will work with neighbouring systems to ensure that the flow of information follows the flow of people.



How we will work to deliver the vision

Working across the different Health and Social Care organisations in Essex at the same time to improve technology will be hard, and careful prioritisation and management will be needed.

Initial focus and investment will go into a number of fundamental technology foundations, on which other solutions and changes will be built. Teams will be set-up to deliver these changes that follow the approaches to technology that are successful in the private sector (e.g. agile).

These **teams will have multiple skills and people, and an experimental mind-set** that will quickly work out the best way of doing things. Where investments are made the teams will be held accountable to make sure that the **expected benefits are delivered.**

29.2 Our Current Position

As a result of the financial and operational challenges faced across the footprint, the development of technology and digital maturity has been variable and limited to single organisations. We have been without a wider strategic framework for digital for some time.

The system has recently completed a maturity matrix which identified a very low level of digital maturity across the system – including our approach to investment in digital infrastructure. The results of this assessment will help us to set our two and five year strategy for digital transformation which will establish our overarching strategy, resource requirements and our project pipeline. We expect to have the strategy finalised by Q1 2020 following a further evaluation of the technical landscape to be completed as part of Shared Care Record programme.

29.3 Digital Roadmap

The development of the revised digital roadmap in 2018 created a sense of direction and identified nine areas for digital developments

1. Shared Care record
2. Right information right time
3. Joined up hospitals and wider Health and Care Partnership
4. Data quality and standards
5. Staff digital collaboration
6. Patients and citizen collaboration
7. Mobile IT and identity that 'just works'
8. Operational intelligence
9. Patient and citizen population intelligence

These were later distilled to three priorities for immediate attention:

- // Integrated Shared Care Record
- // Provider digitisation
- // Population health data

29.4 Integrated Shared care record

We have received national funding through the Health Sector Led Investment (HSLI) programme. All system partners agreed that this funding should be used to develop and implement an integrated shared care record, which would provide a central, consolidated digital view of service user/patient information, and make this accessible to health and social professionals across the Partnership to better support the delivery of safe, high quality care and support.

The shared record agreement is the first Partnership-wide digital project to be initiated and has been the catalyst for more collaborative digital governance and planning at a system-wide level.

A detailed implementation plan is under development, with the expected implementation dates for the Shared Care Record as follows:

Stage	Dates
Programme governance and plan	September 2019
Integration technical review and planning	January 2020
Health Info Exchange (HIE) connectors developed	February 2020
Data sharing agreements in place	February 2020
Local APIs developed	February 2020
Local Portal enhanced	March 2020
HIE links live	March 2020

It should be noted that this will be the very early stages of the programme to establish initial data sharing using technology already available; further developments and expansion will be required to realise the full vision of the Partnership. It is intended that the development of the Digital Delivery Strategy will further develop and inform these plans.

29.5 Provider digitalisation

The three acute trusts have a detailed digitalisation plan initially focused on technology linking across the three sites and wider partners.

The public consultation conducted in 2018 on acute service improvements, and the acute merger business case, all highlighted the need for technology to support the following ambition:

- // Build stronger neighbourhoods to deliver a broader range of primary and community services
- // Reduce the number of non-elective admissions into acute hospitals
- // Reconfigure acute services
- // Redesign clinical pathways to deliver improved outcomes
- // Support corporate services transformation
- // Support digital transformation in the wider health economy

To support these themes, the acute hospitals have adopted the following guiding principles as part of their "digital vision":

- // Rationalise, centralise, consolidate and standardise digital processes
- // Remove physical boundaries
- // Use of mobile, Wi-Fi, shared infrastructure
- // Data capture and (cyber) security

- // Information recorded digitally and captured once but used multiple times
- // Safe and secure but shared patient information
- // Patient pathway information capture, single version of the truth
- // Single consistent view of patient information within a patient-centric context
- // Supporting innovation and new ways of working
- // Speed of change, flexible approach
- // Reducing the burden on clinical staff, releasing time to care
- // Where appropriate tasks that can be performed by more untrained staff
- // Tasks should be automated
- // Seamless communication
- // Patients are able to do and take more responsibility for their own health needs

In delivering the digital vision, the digital experience for both staff and patients should be much improved, this work will also underpin the Integrated Shared Care Record as information must be available electronically as a pre-requisite. Further information on mental health provider digital plans can be found in section 15.

Population Health

Further detail on our work on population health management can be found in section 35.

29.8 Region-wide Work – East Accord & the Local Health and Care Record (LHCR) Board

The East Accord, which is a collaboration of digital leaders from across the East of England region are working together to develop an information sharing environment that improves the lives of people in the East of England with the following agreed principles:

- // Adopting standards that move towards intuitive and flexible technology that joins up effectively
- // Designing safe, secure and useful ways of sharing information to build trust among our partners and people
- // Demonstrating digital leadership, creating the conditions for genuine transformation
- // Collaborating by default
- // Acting as ambassadors and advocates of best practice

The Accord links closely with the Local Health & Care Record Board (LHCR). Both have focused on core activities that can be developed once and used across the region – this includes development of core data standards and a common approach to information governance and information sharing. The work will

mature in during 2019/20 to support the formal development of a wave three LHCR application for transformation funding. This will be a multi-year, multi-million-pound accelerant to our local health and care record programmes,

Fundamentally the LHCR approach in the East is about progressing collectively so that:

1. Our residents and staff have easy access to relevant information
2. Our residents and staff are provided useful information
3. Information provides value to our residents, our staff and the wider public sector

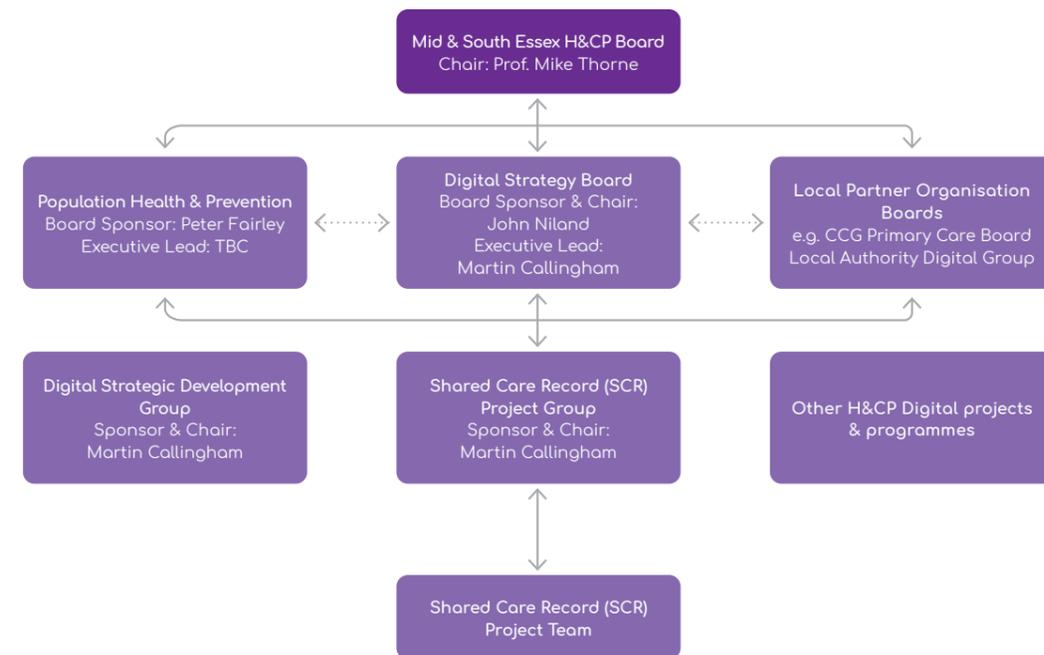
We commit to the requirements identified in the LTP for Local Health and Care Records, with the following specific commitments identified:

- // Protecting patient’s privacy and give them control over their record
- // Ensuring that Patients’ Personal Health Records hold a care plan that incorporates information added by the patient themselves or their authorised carer
- // Ensuring LHCR platforms provide open and free APIs for developers to create new solutions
- // Moving care plans and Summary Care Record (SCR) to the individual’s local health and care record over the next 5 years
- // Ensuring that, by 2024 LHCRs will cover the whole country

29.9 Digital Governance

We have established a Digital Board to oversee digital programmes in the broadest sense (health and care).

Through increasing collaborative working, based on shared objectives, our digital board is progressing and, through alignment with the LTP, our digital priorities are being developed. The governance for the Digital Board is given below:



29.10 Digital Deliverables

Below are the deliverables defined so far as part of the Partnership digital programme, these will be further developed and enhanced as the Digital Board develops and identifies its delivery strategy.

Activity	2019/20	2020/21	2021/22	2022/23
Digital strategy completed		Q1		
Shared Care record - Stage 1 complete	Q4			
Shared Care record - Stage 2 complete		Q3		
Digital Maturity Assessment - Ongoing	Q3	Q1 & Q4	Q2 & Q3	Q1 & Q2
Review of Digital Landscape	Q1			
LHCR Governance & Engagement established	Q3			
Provider Digitisation to support the acute hospital merger	Q4			

See also the Primary Care Digital Transformation in section 11.3



30. Estates

Clinical Lead: Various, depending on specific programme.

Senior Responsible Owner: Kerry Harding, Director of Estates, Mid & South Essex CCGs

Our first system-wide estates checkpoint with NHS England/Improvement was completed with full input from local authorities, providers, and commissioners. We will now produce a full system-wide estates strategy, incorporating individual estates strategies from across partners, ensuring we are able to see clear linkages between them and identify how, as a combined ambition, our estate will facilitate new models of care, best value for money and improved patient outcomes.

We are using our clinical strategy to drive forward estates provision. We have developed a clear governance structure for estates, which has the mid and south Essex Estates Forum at its heart. This forum is attended by representatives across the system including public health and One Public Estate (OPE), as well as digital and workforce leads. The forum is the vehicle for sharing information about proposed and live projects, providing a clear understanding of the work that is being developed across the system and giving the opportunity for projects to evolve to include wider system input. The objective to working in this way is to reduce duplication, promote shared use of buildings and joint projects, and ensure that we look to use current public assets before building new, maximising value for money and sustainability.

The pipeline of estates projects has been developed from the forum and is updated as a live document by all participants. This provides an overview of estates projects either current or identified within individual strategies as requirement for the next 15 years. This transparency has supported the development of joint projects to reduce the overall capital and revenue implications, whilst at the same time supporting new models of care. The information within the pipeline also forms the basis of individual Infrastructure Delivery Plans to support local authority Local Development Plans.

We have developed a robust prioritisation process to enable us, as partners, to consider estates developments in the round and ensure that priority is given to projects that will support the overall aims and priorities of the Partnership.

We are taking an innovative approach to utilise funding streams to address some of our fundamental challenges – such as negotiating S106/CIL funding to support digital/IT initiatives and to cover one-off recruitment costs. We are also currently exploring the possibility of securing funds to pay off university fees for newly qualified clinical staff to support recruitment and retention across the system, so that we can encourage clinical staff to stay in mid and south Essex and develop their careers. We are also utilising traditional S106 capital contributions to new builds to offset future revenue implications.

Our estates plan supports our operating model as follows:

- // Increase the availability of services outside of the acute hospital setting
- // Develop sustainable and resilient primary care based around 28 PCNs and extend primary care access by:
 - // increased operating hours and seven day working to improve access and maximise estate utilisation
 - // expanded the range of providers (additional professional groups) working in general practice
 - // offer improved access to 'alternative' community-based provider services – e.g. MSK, pharmacy, third sector, dental services.
- // Integrate primary, community, out of hospital and social care services within neighbourhoods to provide more care closer to where people live
- // Place a greater emphasis on prevention and encouraging people to take more responsibility for their own health and wellbeing to include increase in social prescribing
- // Support the reconfiguration of mental health inpatient estate to remove dormitories
- // Support the digital strategy including developing systems to provide the option for every patient to access digital GP consultations by 2024
- // Continued liaison with public health colleagues to deliver and implement objectives to ensure that preventative care is available to the population and that planning policy reflects our agenda to encourage our communities to live well and take greater responsibility for their own health and wellbeing
- // Ensure every Place has adequate and appropriate provision, based on its demographic and need, of the following services:
 - // Screening and diagnostics
 - // Diabetes prevention, treatment and management
 - // Treatment and management of respiratory conditions
 - // Children's health services
 - // Learning disability and autism services
 - // Mental health services for children and adults
 - // Healthy ageing services
 - // Maternity services



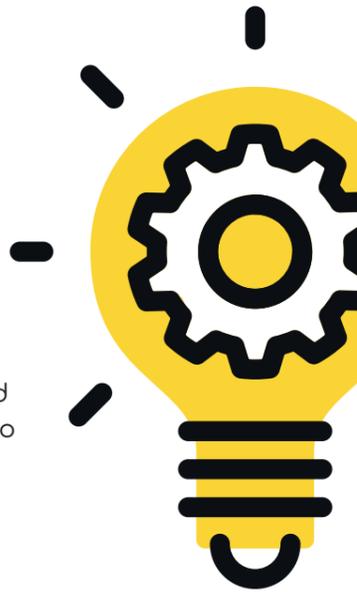
31. Innovation

We have an extensive programme of innovation activity, supporting local innovators and entrepreneurs, helping adopt approved innovations developed externally, and matching local transformation and improvement needs to new models of care.

Our Partnership-wide Innovation Advisory Group is chaired by Professor Tony Young, a consultant urological surgeon from Southend Hospital, and Chair and Director of Medical Innovation at Anglia Ruskin University. Professor Young also leads the NHS Clinical Entrepreneurs Programme and is the National Clinical Lead for innovation at NHS England.

Our innovation programme includes:

- // The MSE Innovation Fellowship for local staff members and NHS Clinical Entrepreneurs to receive mentorship, training and support to take forward ideas under the themes of workforce improvement or enhancing patient safety. The scheme will have its second intake in October 2019, and includes mentors from across primary, community and acute sectors.
- // Developing local products which meet local needs, such as SMART mortality reporting and quality improvement tool, and the development of the Maternity Direct secure chat service.
- // A range of innovation challenges for local staff, as well as support for budding ideas through Health Enterprise East and Invest Essex, with the clinical check and challenge via the Clinical Cabinet.
- // Providing direct advice to members of staff with innovative ideas, their development and adoption, with the first dedicated Innovation Programme Manager appointed in November 2018, further expansion of the support team planned in late 2019.
- // Promoting and signposting staff to innovation opportunities including new proven products, processes and care pathways, working with Academic Health Science Networks and connecting staff to successful innovators in other provider organisations and signposting staff to regional and national innovation competitions eg. Health Enterprise East's MedTech Accelerator, national Life Sciences Innovation Fund and recent bids from radiology and stroke services.
- // We continue to act as a partner in the NHS England Clinical Entrepreneur programme, now entering a fourth year. This programme has provided selected clinical entrepreneurs with honorary contracts with partnership organisations, to provide them with a real world test-bed site to help develop their innovations.
- // We have developed a Ways of Working agreement with the wider health care industry, agreed in March 2019, to help support innovation and bring in additional resources for transformational improvement locally. This has been recognised as national good practice by the AHSN Network and ABPI.



The hospitals have recently launched Maternity Direct+ – a secure telemedicine chat app which connects an NHS midwife with a pregnant woman for non-urgent queries and stores their text chat in the patient record. The aim of the app is to support pregnant women, enable midwives to answer straightforward queries, thus reducing unnecessary visits to the unit and to A&E, and to differentiate routine queries and those which require further attention.

32. Research

Partner organisations are active members of the NIHR Clinical Research Network for North Thames, one of the best recruiting networks in the country.

The merger of our acute providers in April 2020 will improve set up and facilitate recruitment to research studies across a combined patient population of 1.2m. This will attract commercial research activity and associated financial benefits. Research active clinical staff will be able to recruit patients to research studies from whichever site they are working and patients will have an equal opportunity to participate. This increases the research opportunity for patients, increases income to the trusts and encourages recruitment and retention of high calibre research staff.

As founding partners in the UCLPartners Applied Research Collaborative (ARC) we have helped to inform the areas of focus within the ARC. Through the hospitals' Strategy Unit and the Clinical Cabinet, we will ensure relevant findings are tested and disseminated, as well as having the opportunity to influence the portfolio to support population health.



33. Clinical Leadership

Ensuring the safety and quality of our services is core to our work. It is important that our clinicians and professionals working across the system drive our transformation plans and have confidence in them.

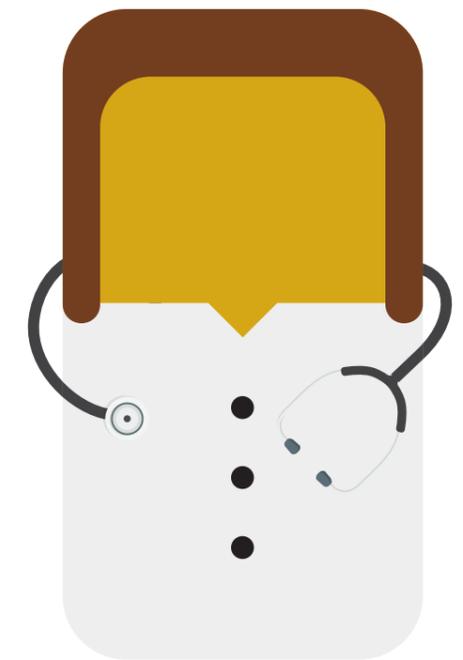
The Clinical Cabinet is a forum of senior clinical representatives from across the system. The Clinical Cabinet oversees and reviews clinical pathway changes that are being considered across the system, ensuring that changes have clinical and professional buy-in and maintain the golden thread of delivering the highest standards of quality and safety.

The Cabinet is multi-disciplinary in nature and comprises senior nurses, GPs, consultants, allied health professionals (including therapists, pharmacists, and paramedics), from across the system who are involved in delivering health and care services to the population. In recognising the critical role that allied health professionals play in delivering health and care services, we will be establishing a Partnership AHP Council in the coming months. The Council will provide an important focal point for developing new models of integrated care.

The cabinet played a critical role in developing options for acute hospital service change, and crucially offered local "check and challenge" to the proposed changes that were later supported by the East of England Clinical Senate and the CCG Joint Committee. It continues to play a role in supporting the implementation of acute hospital service improvements.

Each of our clinical programmes (diabetes, stroke, mental health, maternity, cardiovascular etc) has a designated clinical lead, and each programme feeds in to the Clinical Cabinet to provide the clinical "check and challenge" of plans as they develop.

As we move to the next phase of our development - Integrated Care System designation - the cabinet will be considering its future composition in order to ensure broad clinical and non-clinical, professional representation, including Clinical Directors of our Primary Care Networks.



34. Approach to Quality & Safety

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

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 in defining, measuring and evaluating the quality of services
- // A better understanding of quality variation across integrated pathways, rather than looking at quality in silos
- // The structure, process and guidance needed by teams working on new models of care to ensure regulatory compliance
- // Better use of data, including the effective triangulation of multiple sources of data and quality surveillance that focuses on early warning and prevention rather than multiple investigations after the event
- // Agreement on the approach to defining, measuring and monitoring quality which will be required under new contractual arrangements.

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



35. Population Health Management & Prevention

Our approach to population health management and prevention is to make better use of the wealth of data that partners in the system collect and to use this intelligently to understand our population and plan/target interventions appropriately. Collecting, collating and analysing data can be achieved at system level, enabling the targeting of interventions locally where these have most impact.

Population health management will:

- // Support front line teams to design and deliver care and support to meet individual needs.
- // Enable our PCNs to work with local partners to deliver personalised care
- // Support NHS and local authority commissioners to better predict need and design services to meet needs more appropriately.

Capabilities for Population Health Management

There are three core capabilities required for an impactful population health management programme:

- // **Infrastructure** – the basic building blocks including a defined population, digitalised providers and linked records, digital infrastructure and information governance processes
- // **Intelligence** – building the capacity and capability within the system to support analytical requirements and provide system-wide insight. Using this intelligence to make best impact and report on progress for the system.
- // **Interventions** – using proactive clinical and non-clinical interventions to prevent ill-health, reduce risk and address inequalities. This will support us to realign our workforce, target assistive technologies and digital tools to support patients and being able to use information to build aligned incentives.

We are developing our system-wide Population Health Management & Prevention Strategy and this will be approved by the Partnership Board in December 2019.

Our strategy uses the framework of the 3 core competencies, with key priorities within each. We will use specific areas/conditions to test and learn our approach.

Our Vision:

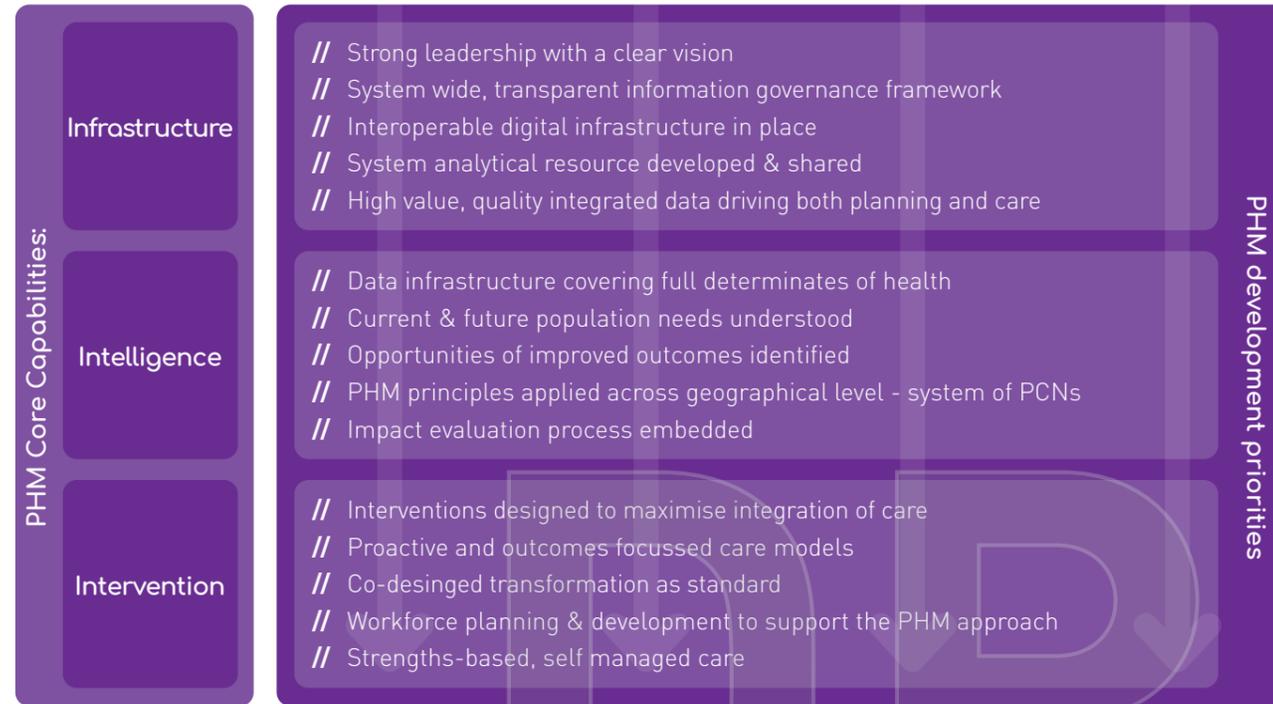
We want to support the population to manage their own health, to prevent avoidable illness and improve their health and wellbeing. We will do this through intelligent use of data analytics to understand how timely access to health & care services along with the wider social & environmental context can have an impact. We will target evidence-based clinical and non-clinical interventions to address inequality & inequity, leading to better lives for all.

M&SE Health and Care Partnership

Pilot areas

PHM

Strategy



We are working with colleagues across the region to develop our approach and ensure we make best use of resources.

Population Health Approach in Action

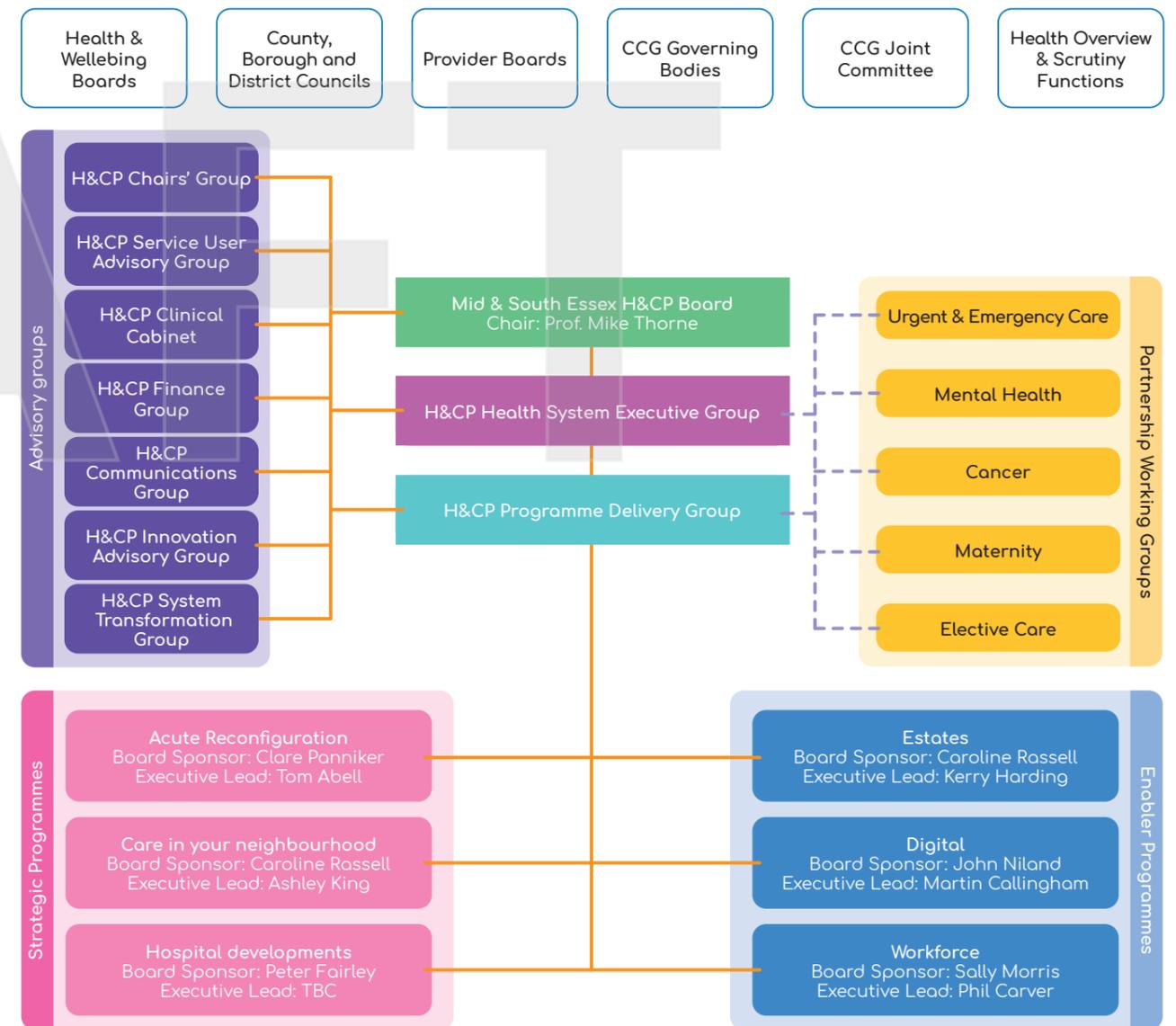
The strategy unit of MSE University Hospitals Group is working with partners in south east Essex to combine CCG and hospital data to understand more about the south east population by looking from both perspectives at demand. We are focusing on respiratory (specifically COPD) as a proof of concept to build up an understanding of the pathway of patients with COPD prior to an admission to hospital, and identify the significant factors that drive admission. In doing this we hope to understand more about the needs of the population and how to respond more preventatively to these to avoid escalation of COPD in the future where possible. All data will be presented at a locality level.

By combining data from multiple sources we can begin to develop predictive models, allowing us to predict hospital admission beforehand and understand when and how to intervene. There are limitations to these models, largely based on data availability, rules regarding sharing, and also some topics do not lend themselves as easily to prediction, so this is part of our exploration. By doing this we can start to use data more intelligently as a predictive tool that allows us to focus on prevention rather than reacting to growing demand. The technique may also help us to support patients effectively to reduce escalation of conditions by focusing on preventative action in a more targeted way.

36. Building our Integrated Care System

36.1 Existing system governance arrangements

At present, the Mid and South Essex Health and Care Partnership Board comprises chief executives of provider organisations, accountable officers from the CCGs, lead officers from the three local authorities and a number of representatives from advisory groups and partner organisations. The Board has no decision-making authority as this resides within individual organisations. An overview of current governance and key programmes is given below:



It is an immediate priority of the newly appointed independent chair to review the governance and delivery structure for the Board to enable development to an Integrated Care System.

36.2 ICS development plan

In line with LTP requirements, partners are committed to the Mid and South Essex Health & Care Partnership achieving Integrated Care System designation by April 2021. We will draw upon learning and published research to ensure that we use experiences from other systems who are further along this journey.

36.3 Benefits of ICS Designation

We believe that achieving ICS designation will provide the following benefits:

- // Put our residents first, delivering person-centred care, close to home, and give them confidence that the changes we are making work well for them.
- // Support system partners to collaborate and to take decisions together.
- // Create a willingness for partners to invest outside of existing organisational boundaries to support transformation and develop essential social infrastructure;
- // Support communities to thrive, through improved education, employment and economic growth, attracting investment to our area.
- // Enable a collaborative approach to improving our performance and outcomes against national standards, demonstrating real impact for our population,
- // Commission against consistent standards and outcome measures, rather than traditional methods of commissioning and contracting.
- // Enable us to use our collective workforce resources more wisely, and support our staff to work in different ways with a “system” ethos.
- // Safely and securely share information and records across the NHS and local authority partners – and use the vast quantity of data we have to effectively target resources and interventions.
- // Reduce waste, duplication of effort and resource to unlock efficiencies.
- // Streamline decision-making and governance processes.
- // Support financial stability and joint decision-making on investments, while holding the system to account for effective delivery.
- // Take a proactive stance on self-assurance, earning autonomy from our regulators to self-regulate on most issues.

36.4 Our plan to achieve ICS designation

In July 2018, we undertook a self-assessment against a number of criteria set out by NHSE/I. Through this self-assessment, we identified that our key areas for development were;

- // Our relationships with and between wider system partners, particularly our Health and Wellbeing Boards and Integrated Care Partnerships at Place level as these develop.
- // Our leadership – to ensure streamlined decision-making and closer collaboration of partners.
- // Our commissioning approach – with the streamlining of NHS commissioning functions under the direction of a single accountable officer and executive team for the five CCGs in mid and south Essex.
- // Our governance – to ensure that decisions are taken at the right level, by the right partners, to support good governance and stewardship of public money, while also supporting the integration and collaboration of services in an “organisationally agnostic” manner.
- // Our methods of ensuring a strong user “voice” in local plans, and ensuring that insight gained from local co-production and engagement work is used at system level.
- // The need to progress to a population health based system that encourages partnership working for a defined population, has access to, and uses population-level data to understand needs, focusing on prevention and the wider determinants of health.
- // Developing an outcomes focussed approach in everything we do.
- // Our ability to self-regulate – particularly on matters of operational performance and sustainability – ensuring we can hold ourselves to account for the performance of our system and that we take the appropriate steps to ensure sustainability of our services.
- // Our financial strength – both to ensure our plans support bringing the system into financial balance, and also to ensure we have robust and aligned mechanisms to take decisions about public money at a system level, where appropriate.
- // The efficiency of our work – reducing duplication and consolidating “back office” functions to support the system.
- // Defining the transformation resource requirements, ensuring we have the right resources in place to deliver on our transformation plans.

36.5 System architecture & leadership

At present, partners operate in a complex system and this creates challenges for effective and streamlined decision-making. There will be, however, significant change to our current system architecture that will help to simplify the system:

- // In April 2020, our three hospitals will merge, creating a single organisation with a consolidated clinical strategy. This will streamline functions and decision-making across the hospital group and release significant efficiencies which will be reinvested in our new operational model.
- // Early in 2020, our five CCGs will appoint a single accountable officer to operate across the five organisations.
- // It is our intention for this joint accountable officer to also be the lead executive for the Health & Care Partnership.
- // All five CCG Governing Bodies have agreed to commence work on a merger application to be made in September 2020. This will be subject to wide stakeholder engagement in the coming months, particularly with member practices.

36.6 Developing our approach to strategic commissioning

Effective commissioning at the right level across the ICS will be vital to create an environment in which our system is focussed on outcomes, our places and neighbourhoods are able to flourish and the benefits of integrated care can be realised.

This will require significant changes to the way in which we commission services, involving co-design with our communities and a much greater focus on prevention and population health. Statutory commissioning organisations will need to work differently with providers in order to have maximum influence on the health and wellbeing of our population. We must better involve community and voluntary sector organisations and develop asset-based and outcomes-focussed commissioning frameworks. We also need to ensure that we commission at the most appropriate level across the system.

As described above, our CCGs will have a single accountable officer and executive team – and will be required to deliver 20% savings on running costs. The single AO will also be the executive lead for the ICS and will play a significant role in supporting the Independent Chair to deliver the agreed ICS objectives and build relationships with internal and external stakeholders. The AO will also play a key role in the development of our four Integrated Care Partnerships, supporting them to ensure effective local delivery.

Early in 2020 we will appoint the Joint Accountable Officer and Health and Care Partnership/ICS Executive Lead. During 2020/21 they will:

- // Consider the resource required to support ICS development. Their priority will be to ensure capacity to support system moving forward by refocussing resource currently within five CCGs to a system-wide purpose
- // Appoint to the joint executive team for the CCGs.
- // Prepare an application for CCG merger in September 2020, which will be subject to agreement by CCG Governing Bodies and approval by NHS England. If approved, CCGs will merge in April 2021.
- // Continue to operate with 5 CCGs, but as an interim measure towards greater collaborative working, consider whether the current CCG Joint Committee arrangements can be expanded to enable more decisions to be made once across the system.
- // Develop a plan for the movement of delegated commissioning so that by April 2021, the five CCGs have taken on this function. While there are no current plans to take on commissioning of pharmacy, optometry and dentistry services, we will continue to work in close partnership with NHSE/I to ensure we are obtaining maximum impact from these services for our populations at neighbourhood and place level.
- // In line with strategic commissioning plans, continue to work in partnership with NHS Specialised Commissioning with the longer-term aim to be more involved in the commissioning of specialised services provided across mid and south Essex. Some work has already started, for example, in relation to mental health provider collaboration.
- // Continue to work with Specialised Commissioning on health and justice commissioning, particularly on pathways into and out of detention and links with children and young people's mental health.

36.7 System performance oversight and intervention

As we become an Integrated Care System, we will need to develop our approach to self-assurance and regulation against national standards. Our Health and Wellbeing Boards will play a role in holding the ICS and our Places to account for delivery of our plans and our ability to positively impact outcomes for our population.

Health Overview and Scrutiny Committee (HOSC) functions continue to play an important role their statutory role in scrutinising major service change. Where changes span the three local authorities, a Joint HOSC will be formed.

36.10 ICS Development timeline:

Activity	2019/20		2020/21				2021/22	
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
LEADERSHIP								
Appointment of Independent Chair	✓							
Central resource infrastructure agreed			■	■				
Review of clinical and professional leadership		■						
Implement new model for clinical and professional leadership			■	■				
RELATIONSHIPS & GOVERNANCE								
Secure resources to support for system governance review	✓							
Review of governance arrangements at system level to include decision-making, accountability, self-regulation.		■	■					
Agree relationships between “place” and “system” to enable places to deliver		■						
Test governance arrangements with stakeholders				■				
Agree framework for service user input		■						
Implement Citizen’s Panel			■					

Activity	2019/20		2020/21				2021/22	
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
FINANCIAL MATURITY								
Agreement of 5 year control totals	✓							
Review of finance oversight arrangements (NHS)		■	■					
Test and agree finance oversight arrangements with regulators				■				
Delivery of agreed financial recovery plans		■	■	■	■	■	■	■
SELF-REGULATION – QUALITY, SAFETY & OPERATIONAL PERFORMANCE								
Agree system-wide objectives with regulators (care quality and health outcomes, reductions in inequalities, implementation of integrated care models and improvements in financial and operational performance)		■	■					
Run assurance processes in shadow form (with regulators)				■	■	■		
Evaluate self-regulation approach and agree future arrangements with regulators							■	■
PROVIDER DEVELOPMENTS								
Acute trust merger		■						
Mental health provider collaborative (new care models)		■						
GPs/PCNs deliver new service specifications			■	■	■	■	■	■

Activity	2019/20		2020/21				2021/22	
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
STRATEGIC COMMISSIONING								
CCGs agree to progress single AO & Executive Team	✓							
Appointment of Single AO for CCGs & Executive Lead for ICS		■						
Appointment of CCG Executive Team			■					
Engagement on future commissioning landscape			■	■				
CCGs to submit merger application					■			
CCG merger (subject to approval from NHSE/I)							■	
POPULATION HEALTH								
Population health strategy approved by Health and Care Partnership Board required to deliver including resources		■						
Agree and adopt Health and Care Partnership-wide outcomes framework		■						
PCNs supported to develop population health approach			■	■	■	■	■	■
WORKFORCE DEVELOPMENT								
Joint Health & Care Workforce Strategy agreed, organisational development needs		■						
Agree retention & recruitment strategy								
Implement Partnership "School"								
DIGITAL								
System Digital Strategy agreed		■						
Early implementation of Shared Care Record			■					
Digital maturity assessment		■		■		■		■

37. Arrangements for Ensuring Delivery

This section sets out the practical steps needed to deliver our five Year Strategy and LTP commitments. It includes programme resources, governance, risk management.

37.1 Programme management and resources

The Partnership will implement a robust programme management and governance structure which ensures accountability through clear allocation of roles and responsibilities, and provides assurance through regular reporting, enabling quick identification and addressing any issues as they arise.

37.2 Governance Structure

In order to deliver the requirements of the LTP and achieve ICS designation, detailed work will be undertaken on our governance structure at system level, and our governance arrangements between system and "place". This will include a review of the current Partnership Board, work programmes and advisory mechanisms.

37.3 Programme roles and responsibilities

An executive delivery group has been established, chaired by the Programme Director. Its membership includes the executive lead for each current work stream to ensure that colleagues are aware of developments. The programme meetings occur bi-monthly and the outcome, in the form of programme overview plans are submitted to the Partnership Board for information.

Once governance arrangements are agreed, we will review existing Executive Delivery Group arrangements to ensure that agreed priority programme achieve their objectives in full and on time.

37.4 Approach to risk management

The Partnership approach to risk management is designed to ensure that the risks and issues are identified, assessed, and mitigation plans developed in a risk management plan. All risks will have a responsible owner identified.

Each specific programme has its own risk log and items elevated to Partnership level are those significant risks that require partners to address together.

The overarching risk management policy is based on an iterative process of:

- // Identifying and prioritising the risks to the achievement of the programme aims and objectives;
- // Evaluating the likelihood of those risks being realised and the impact should they be realised;
- // Managing the risks efficiently, effectively and economically.

The key risks for the Partnership are as follows:

Risks	Mitigations
Partners do not agree the core vision for the Partnership	Partnership Board clarifies and agrees the core vision for the Partnership.
The system does not manage demand for services effectively	Focus on prevention and wider determinants of health – work to agreed outcomes framework to monitor progress, Aligned plans across partners to reduce avoidable admissions, improve performances and reduce length of stay. Teams aligned to PCNs to ensure community capacity to meet demand.
Failure to attract and retain an appropriately skilled health and care workforce.	Address workforce needs by developing new roles, and career opportunities for current staff. Work with partners to address eg housing and education needs. Exploit partner organisations as Anchors programme – seek to raise educational attainment and aspiration and attract staff to public sector roles.
Financial risks are not managed appropriately	System finance leaders developing ICS financial framework which will describe how control totals and risk will be managed collectively. Partners support resolving system challenges together.
System governance does not provide for effective transparency and accountability to the public	Develop system governance framework with openness and transparency at the center. Publish information about allocation of resources and expected outcomes.
Access to treatment (including cancer, elective care and emergency care) is below standard and does not provide good care for our residents	Integrated programme agreed to tackle prevention, early intervention and diagnosis, waiting times for treatment and support post-treatment. All partners in the system are involved and engaged.

The Programme Office maintains the Risk Register for the Programme. Project risk registers are maintained by the project manager/work stream leads and risks escalated where necessary via reporting.



Appendices

1. Mid & South Essex Health & Care Partnership Profile
2. NHS Long Term Plan Engagement; report of Thurrock Healthwatch
3. Mid & South Essex Outcomes Framework (draft)
4. Mid & South Essex Workforce Plans
5. Mid & South Essex NHS Finance Plans
6. Mid & South Essex Cancer Transformation Plan
7. Mid & South Essex Mental Health Plans
8. Mid & South Essex Local Maternity Services
9. Mid & South Essex NHS Estates Strategy

Glossary of Terms

#

111 The NHS 111 service is a free-to-call, non-emergency medical helpline, available 24 hours a day, to be used for health information, advice and access to urgent care.

A

A&E Accident and emergency

Academic Health Science Network (AHSN) Created by NHS England to work with local health and care systems to select, encourage, develop and deliver innovative solutions that improve patient care and aid economic growth across our region

Acute care health care where a patient receives active but short-term treatment for a severe injury or episode of illness, an urgent medical condition, or recovery from surgery

Acute medical unit The first point of entry into hospital for patients who have been referred as emergencies by their GP or who require admission from the A&E department.

Advanced Nurse Practitioner (ANP) The role includes assessing the patient, making differential diagnosis and ordering relevant investigations, providing treatment (including prescribing) and admitting/discharging patients.

Agenda for Change The main pay system for staff in the NHS, except doctors, dentists and senior managers. Abbreviated to AfC and also known as NHS Terms and Conditions of Service

Allied Health Professionals (AHPs) AHPs is an umbrella term for therapists, chiropodists, dietitians, occupational therapists, orthoptists, paramedics, physiotherapists, prosthetists, psychologists, psychotherapists, radiographers, and speech and language therapists among others.

B

BAME Black and minority ethnic

Better Births policy to improve maternity provision and services

Better Care Fund (BCF) A local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their wellbeing as the focus of health and care services, and shifting resources into social care and community services for the benefit of the people, communities and health and care systems.

C

CAMHS Child and Adolescent Mental Health Services

Care Quality Commission the body which regulates health and care services in England to ensure they are safe, effective, compassionate and well led.

CIC community interest company with the objective of benefiting society rather than financial gain

Clinical Commissioning Group (CCG) Clinically-led statutory NHS body responsible for the planning and commissioning of health care services for their local area.

D R A F T

Commissioning The process of planning, agreeing and monitoring services. Commissioning of health services can take place at the local level by CCGs, or at a nation-wide level by NHS England. Local authorities also commission social care.

Co-morbidity Co-morbidity is the simultaneous presence of two or more health conditions or diseases in the same patient.

Continuing Healthcare NHS continuing healthcare is health and social care outside of hospital that is arranged and funded by the NHS. It is available for people who need ongoing healthcare and is sometimes called fully funded NHS care.

Consultation Public bodies have a duty to consult people when changing commissioned services. The decision to consult is usually triggered when there is a legal requirement to do so and this depends upon the level of service change.

COPD chronic obstructive pulmonary disease

Co-production Co-production is when an individual influences the support and services received, or when groups of people get together to influence the way that services are designed, commissioned and delivered. Fundamentally, co-production recognises that people who use services (and their families) have knowledge and experience that can be used to improve services. The Social Care Institute for Excellence describes co-production as “people who use services and carers working in equal partnerships with professionals toward shared goals.”

D

DASS Director of Adult Social Services

Deprivation lack of the basic resources considered necessary for well being

DHSC the government's Department of Health and Social Care

Discharge to Assess Short term funded support to enable discharge from hospital, whilst still requiring some level of care

DPH Director of Public Health

Domiciliary Care Worker A domiciliary care worker is someone who visits a person's home to help them with general household tasks, personal care or any other activity that allows them to maintain their independence and quality of life at home.

E

Elective care Treatment that is scheduled in advance as it does not involve a medical emergency.

Enabler A person or system that makes something possible. In the NHS enablers are the systems and processes that help achieve change and improvement.

End of Life Care care provided in the last months or weeks of life to provide relief and support prior to death

Engagement a term commonly associated with many forms of patient, service user or public involvement. It describes processes, both formal and informal, through which commissioners may invite local communities to become involved in discussion about the shape of their local services.

Equality Impact Assessment (EIA) A process designed to ensure that a policy, project or scheme does not discriminate against any disadvantaged or vulnerable people.

Estates Strategy Supports the delivery of the system's overall strategy and vision for estates.

F

FIT Bowel Cancer screening The faecal immunochemical test (FIT) is an improved screening test that detects hidden traces of blood that could indicate bowel cancer or pre-cancerous growths known as polyps.

Frailty a collection of symptoms including weakness as a result of being older

G

Global Digital Exemplar An internationally recognised NHS provider delivering improvements in care quality through world-class digital technologies and information.

General Medical Council (GMC) The GMC works to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.

General Medical Services Contract (GMS) The GMS contract is the contract between general practices and the NHS for delivering primary care services to local communities. It is a nationally negotiated contract that sets out the core range of services provided by family doctors (GPs), their staff and a national tariff.

Governance The way that organisations ensure they run themselves efficiently and effectively, and the way organisations are open and accountable to the people they serve for the work they do.

GP general practitioner

H

Health and Wellbeing Board a statutory formal committee of the local authority that promotes greater integration and partnership between bodies from the NHS, public health and local government. It produces a joint strategic needs assessment and a joint health and wellbeing strategy for their local population.

Health Education England Health Education England is an executive non-departmental public body which provides national leadership and coordinates education and training within the health and public health workforce within England.

Health inequalities Differences in health status between different population groups, or in the personal, social, economic, and environmental factors that influence health status.

Health Overview and Scrutiny Committee (HOSC) Reviews and scrutinises matters relating to the planning, provision and operation of local health services. A Joint Health Scrutiny Committee oversees matters that span the Mid & South Essex Health and Care Partnership.

Healthwatch Local organisations which listen to the needs, experiences and concerns of people who use health and social care services to make sure that service commissioners and providers put people at the heart of care. Healthwatch Thurrock, Healthwatch Southend and Healthwatch Essex work across mid and south Essex.

I

IAPT Improving Access to Psychological Therapies A service providing evidence-based treatments for people with anxiety and depression.

Inpatient resident attending hospital who is required to stay in overnight or more to receive treatment or care

Integrated Care System (ICS) A partnership of NHS organisations, local councils, the voluntary sector and others in a geographical area, who take collective responsibility for managing resources, standards, and improving the health of the population they serve.

J

Joint Strategic Needs Assessment (JSNA) This looks at the current and future health and care needs of local populations to inform and guide the planning and social care services within a local authority area.

K

L

Learning from Deaths Review (LeDeR) National programme to support local areas to review the deaths of people with learning disabilities, identify learning from those deaths, and take forward the learning into service improvement initiatives.

LOS: Length of stay – The time a patient will spend in hospital

Local Medical Committee (LMC) represent the interests of NHS general practitioners in a defined location

Local Pharmaceutical Committee (LPC) represent the interests of NHS pharmacists in a defined location

Local Workforce Action Board (LWAB) Support Health and Care Partnerships across a broad range workforce and HR activity, and the local delivery of the Health Education England Mandate and other key workforce priorities in line with national policies.

Long Term Condition a condition that cannot be cured; but can be controlled by medication and other therapies such as diabetes

M

Magnetic resonance imaging (MRI) An imaging technique that uses powerful magnetic fields and radio waves to provide detailed cross-sectional or three-dimensional images of the body.

Model of Care A model of care is the overarching design for the provision of a particular type of health care service that is shaped by a theoretical basis, evidence-based practice and defined standards which broadly define the way health services are delivered.

Mortality Rate Mortality rate, or death rate, is the rate of actual deaths to expected deaths.

Multi-disciplinary team A team of professionals from one or more disciplines, which can include social care as well as health, who together make decisions regarding recommended treatment of individual patients. Such teams may be organised for a specific condition, e.g. cancer, or in a specific setting, e.g. a hospital.

MyCOPD An app helps people with COPD (chronic obstructive pulmonary disease) to better manage their condition.

MyDiabetes An app that helps people with diabetes to better manage their condition.

N

National Institute for Health and Care Excellence (NICE) Evidence-based guidance for clinicians, commissioners and providers of health and care.

Neighbourhood integrated care across a range of services around populations of between 30,000 and 50,000. These services typically include general practices, community teams, some mental health services and adult social care.

NHS England/Improvement (NHSE/I) Sets the priorities and direction of the NHS in England, and encourages and informs the national debate to improve health and care. It commissions some NHS services directly, and delegates authority to CCGs to commission other services.

NHS Long Term Plan The plan for the transformation of NHS services in England over the next 10 years, to improve quality of care and the health outcomes of the population.

NMC The Nursing and Midwifery Council. A regulatory body that maintains a register of nurses, midwives and health visitors

O

Outcome the result of treatment, surgery or support from health and care services

Out of hospital care A form of care that is available outside of major hospitals, often referred to as primary and community care. 'Primary care' is the advice and treatment you receive from your local GP.

Outpatient resident attending a planned hospital appointment for treatment or care but not staying overnight

P

Pathways A patient pathway is the route that a patient will take from their first contact with an NHS member of staff (usually their GP), through referral, to the completion of their treatment. It also covers the period from entry into a hospital or a treatment centre until the patient leaves.

Personal Health Budget (PHB) An amount of money to support the identified healthcare and wellbeing needs of an individual, which is planned and agreed between the individual, or their representative, and the local clinical commissioner. It is a different way of spending health funding to meet the needs of an individual, and gives the individual greater choice and control over their care.

Personalisation Shifting the culture and practice of care so that services are better coordinated and centred around the individual.

Perinatal status immediately following the birth of a child

PHE Public Health England.

Population health management Collection and analysis of data on patients and the public, to help improve planning and management of health and care services in the local system.

Prenatal stage of pregnancy before giving birth of a child

Primary care Primarily GP practices, but also includes community pharmacists, dentists and opticians.

Primary Care Networks (PCN) Groups of GP practices working together and with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas.

Providers Acute, ambulance, community and mental health services that treat patients and service users in the NHS; social care providers including local authorities, care homes and home care organisations; and community and voluntary organisations.

Public Health Public health is concerned with improving the health of the population rather than treating the diseases of individual patients.

Q

Quality, Innovation, Productivity and Prevention (QIPP) transformation programme for the NHS, involving all NHS staff, clinicians, and the voluntary sector aimed at improving the quality of care the

Quality and Outcomes Framework (QOF) Indicators of the overall achievement of a GP practice through a points system. Practices aim to deliver high quality care across a range of areas for which they score points.

R

Re-ablement Services to maximise people's long-term independence, choice and quality of life, while at the same time attempting to minimise the need for ongoing support.

Reconfiguration Changing the arrangement, structure or model of organisations or services.

Referral to Treatment (RTT) The framework for referral to treatment consultant-led waiting times to ensure that each patient's waiting time clock starts and stops fairly and consistently.

Residential Care Residential care refers to long-term care provided to adults or children in a residential setting rather than their own homes. Some residential settings are designed to meet a specific care need e.g. those living with dementia or a terminal illness.

Rightcare NHS programme to improve spend and outcomes in care, by diagnosing the issues and using evidence to identify opportunities for improvement, developing solutions and delivering improvements for patients, populations and systems.

Risk stratification Identifying patients who are at high risk of an adverse event so that they can be offered preventive care and support to avoid health problems.

S

Secondary care Either planned (elective) care such as surgery or an operation, or urgent and emergency care provided by a hospital.

Self care or self management All the actions taken by people to recognise, treat and manage their own health, either independently or in partnership with the healthcare system.

Skills for Health Skills for Health provide workforce solutions designed to improve healthcare, raise quality and improve productivity and financial performance. Skills for Health is a not-for-profit organisation for the whole UK health sector.

Slope Index of Inequality (SII) A measure of the difference in life expectancy between the most and least deprived sections of the local population.

Social Care Social care is the provision of social work, personal care, protection or social support services to children or adults in need or at risk, or adults with needs arising from illness, disability, old age or poverty.

Social Prescribing Social prescribing is a means of referring patients to a range of local, non-clinical services which are typically planned and delivered by voluntary and community sector organisations.

Sustainability and Transformation Partnership (Health and Care Partnership)

Created in 2016, to bring local health and care leaders together to plan around the long-term needs of local communities. England is divided into 44 Health and Care Partnerships, including our area, mid & south Essex.

System unified health and care commissioners and providers operating to deliver what cannot be achieved in neighbourhoods and places, to improve and transform care, to provide oversight and accountability at ICS level.

T

T&O Trauma and orthopaedic. Covers injuries and conditions relating to bones, joints, ligaments, tendons, muscles and nerves

Tertiary care Treatment given in a regional hospital that provides highly specialised care, for example in cardiac surgery or cancer care

Third sector The third sector encompasses the full range of non-public, not-for-profit organisations that are non-governmental and 'value driven'; that is, motivated by the desire to further social, environmental or cultural objectives rather than to make a profit.

U

Urgent and emergency care (UEC) Services the NHS provides if you need urgent or emergency medical help

V

VCS Voluntary and Community Sector

W

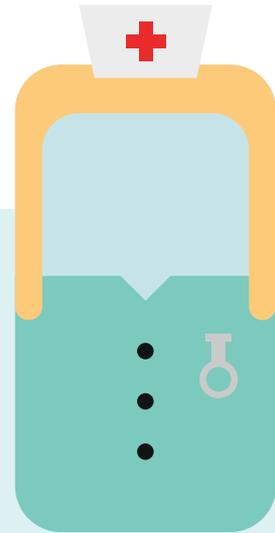
WTE: Whole time equivalent: A way to measure an employees' hours of work for example 1WTE equals a person working full time hours

Y

Z



Mid and South Essex
Health and Care
Partnership



DRAFT

Call [01268 594534](tel:01268594534)

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Working together for better lives