Mid and South Essex
Health and Care
Partnership

Our 5 Year Plan for Improving Health and Care

Working together for better lives

Mid and South Essex
Health and Care
Partnership

Introduction

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 affect our health and 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 that 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.

So we are changing the way we work together and 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.

It also explains our how locally we will deliver the commitments set out in the national NHS Long Term plan (**www.longtermplan.nhs.uk**)

But our plan isn't just about the NHS because we need to think wider than that. We have linked up with our local councils and social care teams, look at housing, our environment and air quality as well as how we can prevent poor health in to first place.

Our Partnership

Our five year plan has been written by the Mid and South Essex Health and Care Partnership, which brings together all of the health and care organisations working to support healthier communities in our area.

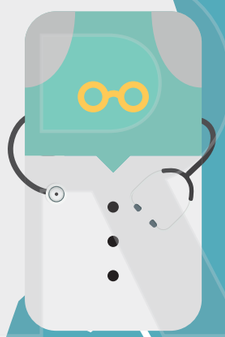
Our Partnership includes local GP practices, our hospitals, community care, social services and mental health teams.

Together we are committed to finding lasting solutions to the common challenges that can prevent us from delivering the best possible care and support services to the 1.2 million people who live in mid and south Essex.

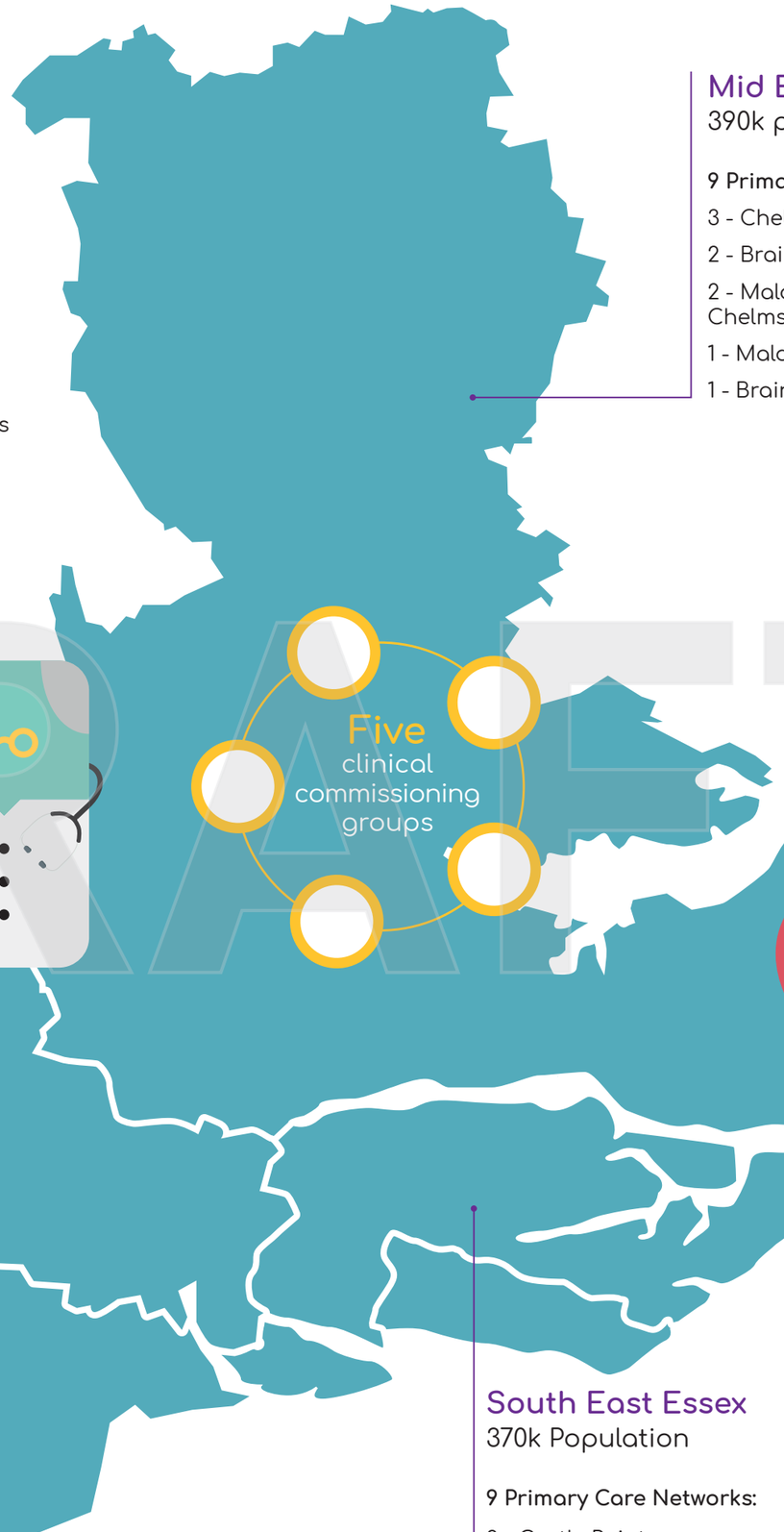
This document is a summary of our plans over the next five years and the full document is available to read on our Partnership website.

You can find out more about us and our plans at **www.msehealthandcarepartnership.co.uk**

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



Three main community and mental health service providers



Mid Essex
390k population

9 Primary Care Networks:

3 - Chelmsford

2 - Braintree

2 - Maldon/ Chelmsford

1 - Maldon/Braintree

1 - Braintree/Chelmsford

Five clinical commissioning groups

Basildon & Brentwood
276k Population

6 Primary Care Networks:

5 - Basildon

1 - Brentwood

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

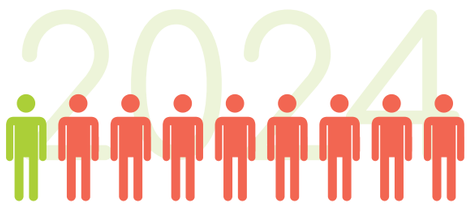
5 - Southend

Our Population

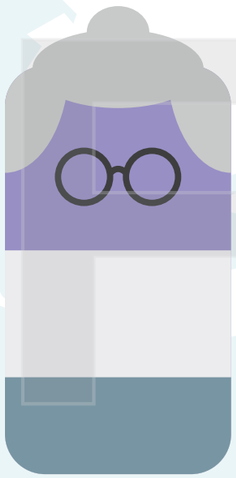
Our public health teams have created a Mid & South Essex Population Profile to describe our population in detail. The following headlines provide an overview for our area - but mask sometimes significant differences across the areas. The details contained within the profile pack, along with the Joint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

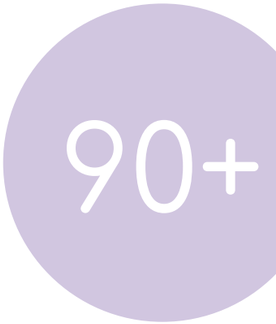
Demography

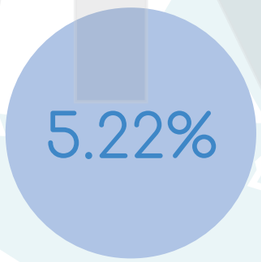
// In 2017 1 in 12 people were aged over 75; this is estimated to increase to 1 in 9 by 2024 and to 1 in 7 by 2039.



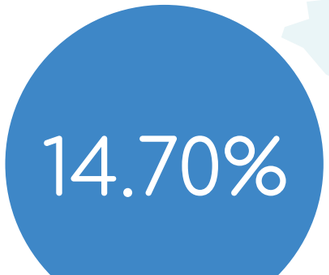
// Over the next 5 years the largest increase is forecast among 75 – 79 year olds. By 2034 the largest increases are forecast for the 90+ years population.







// 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.



// 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.

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

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.

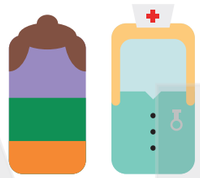
Our Ambitions

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 aim is to change this.

We have set four ambitions to help us reduce inequality, achieve our aims and deliver our vision:

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 can cause us to have poor health and mental illness. Up to 40 per cent of ill heath can be avoided so by getting a grip on issues sooner we can stop them become bigger problems in the future.

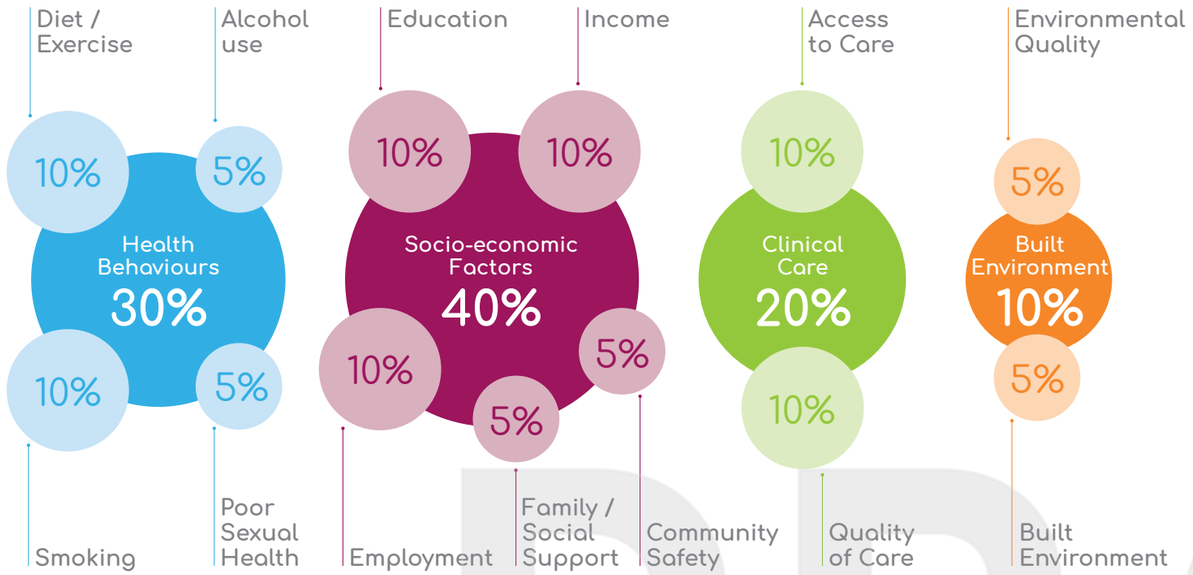
3. Bringing Care Closer to Home

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

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.

Why We Need To Change



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

We are helping more people than ever before

We need to change how local NHS and care organisations work together to care for people. The way we currently work together is too disjointed and this puts pressure on our staff and services. We need to be better at planning together so that we can make sure there aren't gaps in services, that there isn't any duplication or waste, and so that people who need care, can get it easily.

If we don't do anything, the pressure on our services will only increase, and we will not have enough money or staff to keep caring for people in the same way we do now.

Our population is growing

Our population is growing, people are generally living longer and the type of care that people need is changing. The number of people living in mid and south Essex will grow by over five per cent in the next five years and by more than 14 per cent in the next 20 years. Not all of these extra years are spent in good health either. As people get older, they are more likely to have several different health conditions at once. This has a real impact on day-to-day lives and can mean more support is needed to remain independent, as well as more care from a range of different professionals.

Supporting our staff

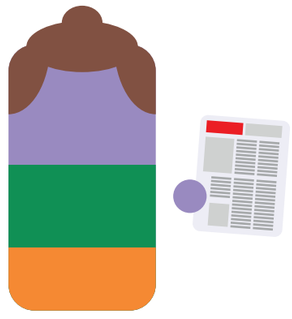
Across health and care recruiting people to work in a wide range of jobs is becoming more difficult and puts added pressure on our staff.

From nurses and social workers, to therapists and consultants across our area we have a large numbers of vacancies.

Its not just about how we attract new staff, we also want to make the working lives of our staff and for those in caring roles better for people. We want to develop more flexible careers and opportunities for training more fulfilling roles and a better work/life balance.

Technology is changing how we live and work

Too much of our technology is out of date and often our computer systems don't "talk" to each other and at the same time new technology is changing what we can do to look after ourselves, as well as how health and care services can treat and support people. We need to make the most of the opportunities that new technology offers so that we can provide the type of care that people now need, reduce the pressure on our services, make it easier for our staff to get the information they need to care for people, and so that people don't have to repeat their story as often.



What you have told us

We've heard from and spoken to lots of local people, organisations and health and care professionals to help develop our plan.

Here's a summary of what we have heard and how we are responding:

We should do more to keep people 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, 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 different professionals and services supporting individuals, working with them to shape their care, in locally based teams. We are also developing a shared care record which will enable all professionals to access to vital information when they need 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 it will help to reduce the pressure on our services and 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 are nothing without dedicated teams delivering high quality person-centred care. Ours plans sets out how we will recruit new people to work in the health and care sector, as well as do much more to retain our existing NHS and social care workforce.

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 is as a real opportunity to make sure our residents get the right care they need by the most appropriate professional, at the time they need it.

Improving mental health care needs to be a priority area.

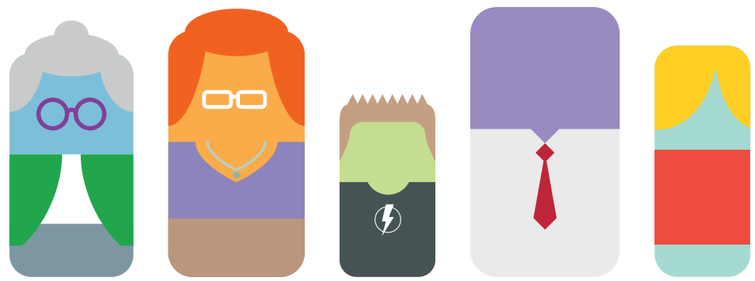
We want people of all ages to be able to get the help and support they need quickly and easily, so that their mental health needs are treated early. We are increasing our focus on prevention and wellbeing, as well as providing appropriate support for people in crisis and effective inpatient care.

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

Our plan is centred around linking up everybody in our communities to help keep people healthy, well and active, to support people when they're 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 getting to services and the care they may need. Our plan aims to ensure our services join-up in the very heart of our communities to make 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.



Our five year plan

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 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.

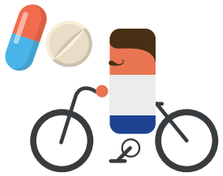
Supporting Primary Care Networks will be four "Place", partnerships covering the areas South East Essex, Thurrock, Basildon and Brentwood and Mid Essex.

These will bring together groups of Primary Care Networks, with local council teams, community service and mental health providers, the hospital teams serving that location and voluntary sector partners to ensure the health and care needs of their local population are met.

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.

As well as explaining how we will work together we also set out in our plan how we will deliver over the next five years the commitments set out in the national NHS Long Term Plan 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 their life.
These include:



Prevention

// Providing information and support for people to look after themselves including on-line and digital options.

// 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

// 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 C entre 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

// 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

// 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

// 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

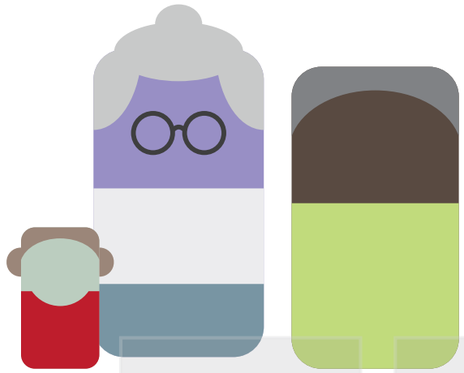
// piloting the MyDiabetes app with 500 newly diagnosed Type 2 diabetics to support them to understand and better manage their condition and reduce the risk of more serious complications developing

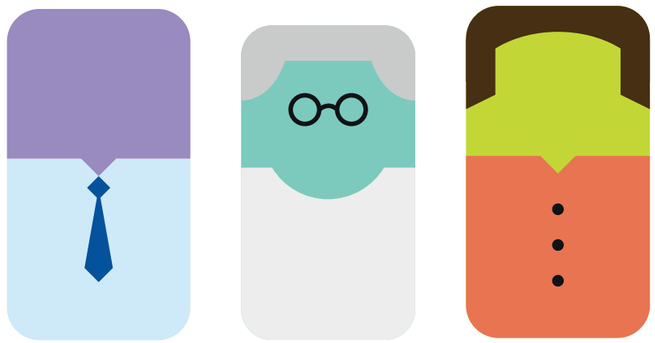
Maternity

// 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

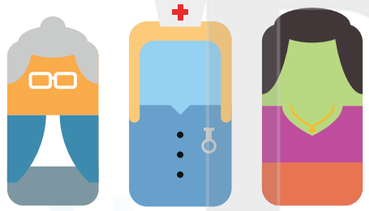
// reviewing our current mental health services to support women both before and after birth to make it easier for those in need to access support.





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.



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

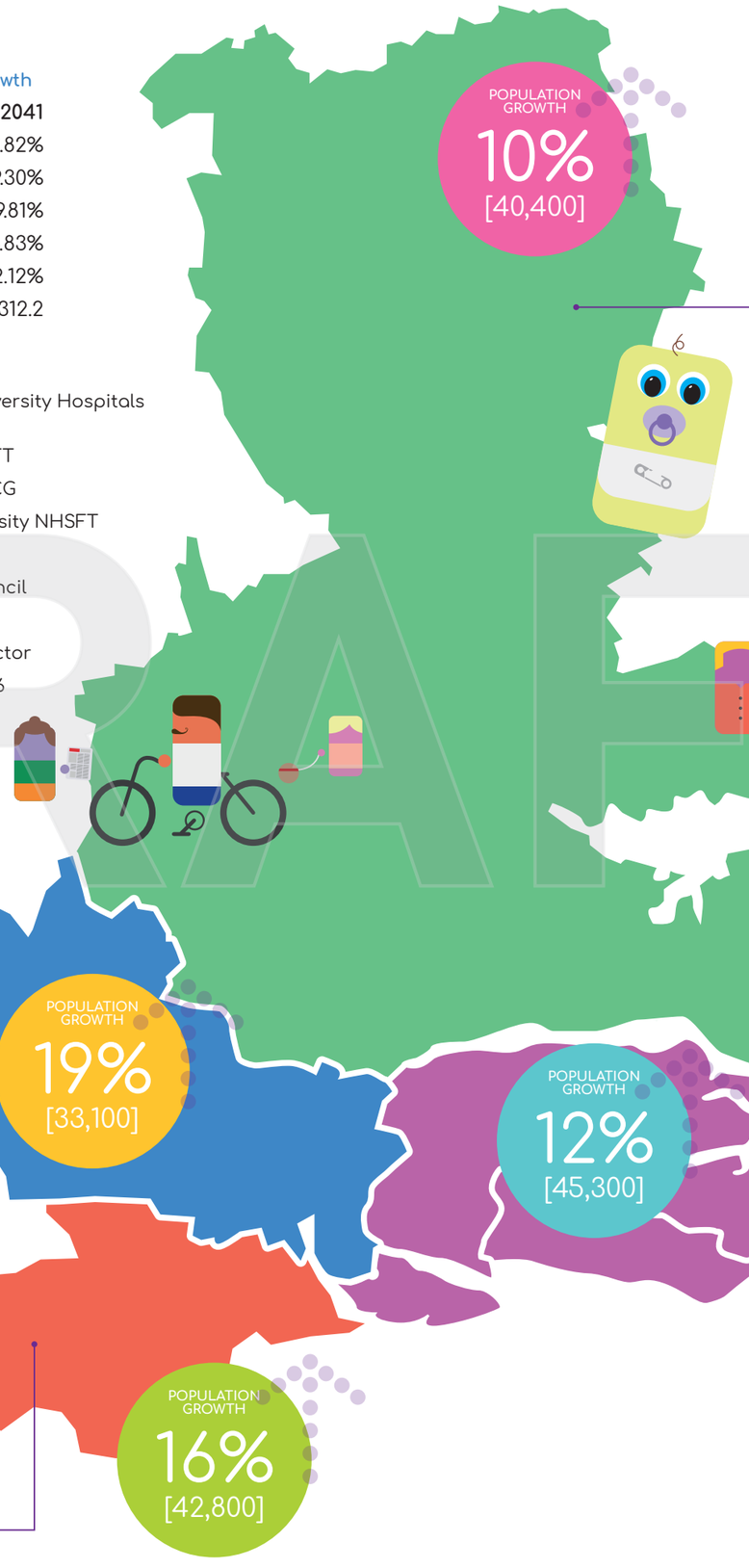
Basildon Council

Community Voluntary Sector

Primary Care Networks – 6

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



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

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

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

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

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

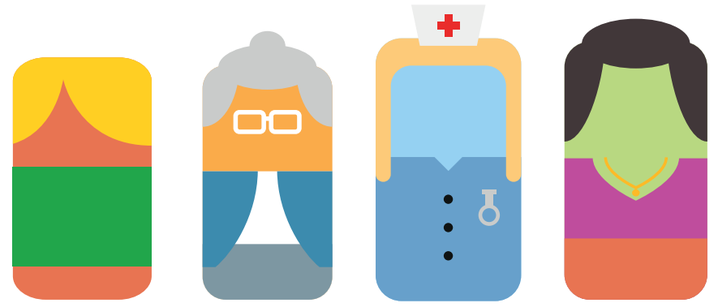
Community Voluntary Sector

North East London NHSFT

Primary Care Networks - 9

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

Linked to our ambitions we have developed a set of outcomes we can measure to keep us on track in the key areas we believe, by working differently we can make a difference.



This plan for is for the next five years but we know that some of our ambitions and goals will take longer, particularly how we tackle some of the wider causes of poor health and wellbeing such as education, employment and income opportunities.

We all have a role to play in how we work together to do that – as public services, as individuals, families and communities - all taking responsibility to think differently about our health and wellbeing.

We believe that together we really can make a difference.

	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.	// Slope Index of Inequality // Healthy Life Expectancy measures

Creating Opportunity	Our children achieve good development and educational attainment.
	
	Employment will rise.
	
	Homelessness will reduce and we will have good housing stock.
		// School Readiness
		// Percentage of people in employment
		// Educational attainment
		// Statutory homelessness
		// Number of non-decent dwellings
		// Air quality

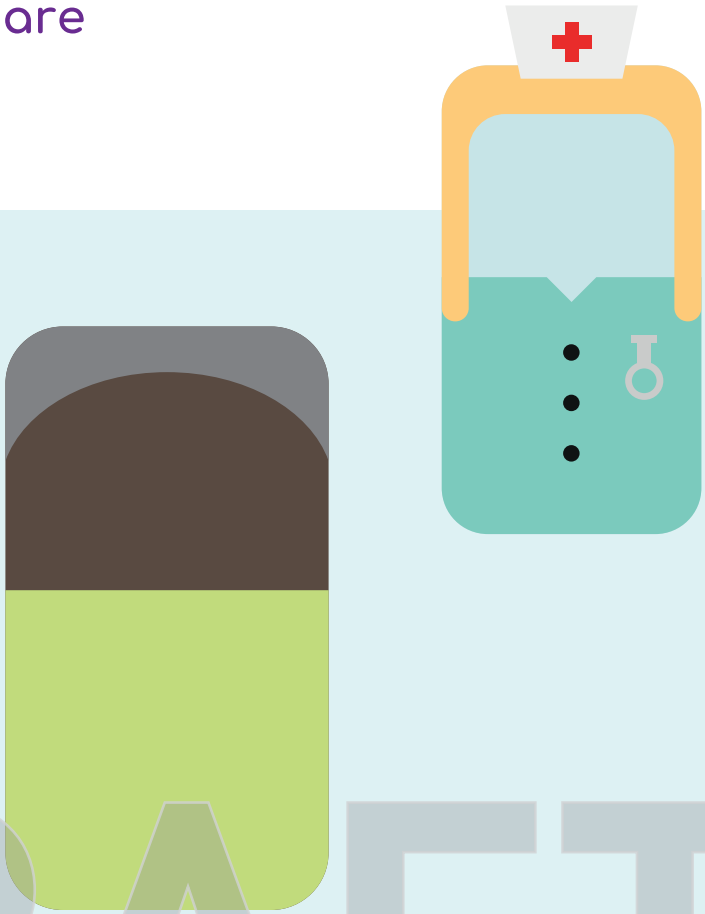
Health & Wellbeing	Our residents live long, healthy lives, and are supported to make good decisions on their own health and wellbeing.	// % of adults classified as overweight or obese.
		// Reception and year 6 prevalence of overweight children
		// % of adults physically active
		// Smoking prevalence
		// Admissions for alcohol related conditions
		// QOF prevalence for diabetes, AF, CHD, hypertension, cholesterol.
		// % of people self-caring after reablement
		// Patient Activation Measures

	How will we know we've made a difference?	What metrics will we use to track progress?

Moving care closer to home	Our residents report good access to and experience of primary and community services.	// 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

Transforming our services	Our residents have consistent, timely access to safe, high quality health and care services.
	
	The outcomes from our services are improved.
		// 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

Mid and South Essex
Health and Care
Partnership



Call 01268 594534

or email btu-tr.midsouthessexstp@nhs.net

Mid and South Essex
Health and Care Partnership
c/o Basildon Brentwood CCG,
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