Mid and South Essex Integrated Care System

NHS Mid and South Essex Integrated Care Board

Meeting of Mid and South Essex Integrated Care Partnership

Wednesday, 6 December 2023 at 10.00 pm – 1.00 pm

Council Chamber, Chelmsford Civic Centre, Duke St, Chelmsford CM1 1JE

Agenda

No	Time	Title	Action	Papers	Lead / Presenter	Page No
		Opening Business				
1.	10.00 am	Coffee and networking	N/A	-	Prof. Michael Thorne	-
2.	10.15 am	Welcome & apologies	Note	-	Prof Michael Thorne	-
3.	10.16 am	Declarations of interest	Note	Attached	Prof. Michael Thorne	-
4.	10.17 am	Approval of minutes of the ICP meeting held on 28 June 2023 and matters arising (not on agenda)	Approve	Attached	Prof. Michael Thorne	2
5.	10.18 am	Review of Action Log	Note	Attached	Prof. Michael Thorne	10
6.	10.20 am	Questions from the Public	Note	Verbal	Prof. Michael Thorne	-
7.	10.30 am	Delivering the Integrated Care Partnership Strategy	Note	Attached	Emily Hough	21
8.	10.50 am	Update from Population Health Improvement Board (PHIB)	Note	Attached	Emma Timpson	31
	11.15am	**BREAK (15 minutes)**				
9.	11.30 pm	Community Assembly Update	Note	Verbal	Ru Watkins Steve Smith Rachel Brett	-
10.	12.05 pm	Smoking Control and Reducing Tobacco Dependency in MSE	Note	Attached	Emma Timpson, Dr Sophia Morris, Dr Pete Scolding & Kellianne Clark	47
11.	12.35 pm	System Pressures	Note	Attached	Pam Green	67
12.	12.50 pm	Any Other Business	Note	Verbal	Prof. Michael Thorne	-
13.	12.55 pm	Date and time of next Integrated Care Partnership Meeting: 13 March 2024, 10:00 am – 1.00 pm Committee Room 4a, Southend Civic Centre, Victoria Avenue, Southend-on-Sea, SS2 6ER	Note	Verbal	Prof. Michael Thorne	-
14.	1.00 pm	Closing Remarks & Networking Opportunity	N/A	Verbal	Prof. Michael Thorne	-

Mid and South Essex Integrated Care System

Mid & South Essex Integrated Care Partnership (ICP)

Minutes

28th June 2023, 10:00 – 13:00

Committee Room 4a, Civic Centre, Victoria Avenue, Southend-on-Sea, SS2 6ER

Membership Attendees:

- Professor Michael Thorne **(Chair)**, **MT**, Chair of Mid and South Essex Integrated Care Partnership - *MSE ICB*
- Cllr George Coxshall, **GC**, Vice Chair, Mid & South Essex Integrated Care Partnership - *Thurrock Council*
- Anthony McKeever, **AM**, Chief Executive Officer - *MSE ICB*
- Jeff Banks, **JB**, Director of Strategic Partnerships - *MSE ICB*
- Mark Harvey, **MH**, Executive Director, Adults & Communities - *Southend City Council*
- Cllr Lynsey McCarthy-Calvert, **LM**, Councillor - *Castle Point Borough Council*
- Paul Dodson, **PD**, Director of Strategy & Resources - *Maldon District Council*
- Nick Presmeg, **NP**, Director of Adult Social Care - *Essex County Council*
- Jo Cripps, **JC**, Executive Director Strategy & Partnerships - *MSE ICB*
- Lucy Wightman, **LW**, Director of Public Health - *Essex County Council*
- Owen Richards, **OR**, Chief Officer - *Healthwatch Southend*
- Brian Balmer, **BB**, Chief Executive Officer - *Essex LMC*
- Camille Cronin, **CC**, Professor of Nursing - *University of Essex*
- Robert Parkinson, **RP**, Chair - *PROVIDE*
- Mark Heasman, **MH**, Chief Executive Officer - *PROVIDE*
- Steve Smith, **SS**, Chief Executive Officer - *Haven Hospices*
- Leighton Hammett, **LH**, Chief Superintendent (Strategic Lead for Partnerships and Prevention) - *Essex Police*
- Kim James, **KJ**, Chief Officer - *Healthwatch Thurrock*
- Kirsty O'Callaghan, **KOC**, Director of Community Resilience, Mobilisation & Transformation - *MSE ICB*
- Grant Taylor, **GT**, Head of Culture and Health - *Basildon Borough Council*
- Nigel Beverley, **NB**, Chair - *MSE NHSFT*
- Cllr Jeff Henry, **JH**, District Councillor & Chair of HOSC - *Essex County Council*
- Jo Broadbent, **JB**, Interim Director of Public Health - *Thurrock Council*
- Sara Zaidi, **SZ**, Clinical Lead - *MSE ICB*
- Shahina Pardhan, **SP**, Non-Executive Member - *MSE ICB*
- Daniel Doherty, **DD**, Alliance Director Mid Essex - *MSE ICB*
- Nigel Harrison, **NH**, Pro Vice Chancellor & Dean - *Anglia Ruskin University*
- Tegan Gardiner **(Minutes), TG**, Business Manager Strategy & Partnerships - *MSE ICB*

Other Attendees:

- Ru Watkins, **RW**, Chief Executive Officer - *Hamelin Trust*
- Felicity Ayre, **FA**, Health & Justice Partnership Co-ordinator - *Probation Service*
- Shehryar Khan, **SK**, Senior Business Support Administrator Strategy & Partnerships - *MSE ICB*
- Cllr Jane Flemming, **JF**, Councillor - Essex County *Council (on behalf of Cllr John Spence)*
- Sian Brand, **SB,** *Writtle University (on behalf of Tim Middleton)*
- Dr James Hickling, **JH,** Deputy Medical Director - *MSE ICB (on behalf of Dr Ronan Fenton)*
- Cllr Holly Whitbread, **HW**, District Councillor & Deputy Cabinet Member for Health and Adult Social Care - *Essex County Council*
- Kevin Harviw, **KH,** *Member of West Road PPG (Member of the Public)*
- Ellie McGreggor, **EMG**, *SOS Rape Crisis (Member of the Public)*
- Chantelle Dzewo, **CD**, *(Member of the Public)*
- Thomas Vellender, **TV,** *HBSUK (Member of the Public)*
- Maggie Cleary, **MC,** *Send the Right Message (STRM) (Member of the Public)*
- May Hamilton, **MH,** *Breathe Easy CC Volunteer (Member of the Public)*
- Chris Gasper, **CG**, *PPG Chair (Member of the Public)*
- Sara Hadden, **SH,** *SAVS (Member of the Public)*
- Peter Blackman, **PB**, *South Woodham Ferrers Health & Social Care Group (Member of the Public)*
- Alison Thorpe, **AT**, (*Member of the Public)*

Apologies:

- Cllr John Spence, **JS**, Vice Chair, Mid & South Essex Integrated Care Partnership - *Essex County Council*
- Stephanie Dawe, **SD**, Chief Executive Officer - *PROVIDE*
- Simon Wood, **SW**, Regional Director of Strategy & Transformation EOE - *NHSE/I*
- Krishna Ramkhelawon, **KR**, Director of Public Health - *Southend Council*
- Stephen LieBrecht, **SL**, Director of Adult Social Care Operations - *Southend Council*
- Ian Wake, **IW**, Corporate Director for Adults, Housing and Health - *Thurrock Council*
- Chris Martin, **CM**, Director for Strategic Commissioning (Children and Families) - *Essex County Council*
- Michael Marks, **MM**, Executive Director for Children and Public Health - *Southend Council*
- Cllr Tony Ball, **TB**, Cabinet Member Education Excellence, Life Long Learning and Employability - *Essex County Council*
- Tim Middleton, **TM**, Vice Chancellor - *Writtle University*
- Samantha Glover, **SG**, Chief Executive Officer - *Healthwatch*
- Mandie Skeat, **MS**, Deputy Chief Executive Officer - *Basildon Borough Council*
- Cllr Julie Gooding, **JG**, Executive Lead Member for Leisure, Tourism & Wellbeing - *Rochford District Council*
- Cllr Lisa Newport, **LN**, Lead Member for Communities & Health - *Rochford District Council*
- Matt Sweeting, **MS**, Mid Essex Clinical Lead - *MSE ICB*
- Claire Hankey, **CH**, Director of Communications & Engagement - *MSE ICB*

- Ronan Fenton, **RF**, System Medical Director - *MSE ICB*
- Ruth Jackson, **RJ**, Chief People Officer - *MSE ICB*
- Pam Green, **PG**, Alliance Director Basildon & Brentwood - *MSE ICB*
- Frances Bolger, **FB**, Interim Chief Nurse - *MSE ICB*
- Barry Frostick, **BF**, Chief Digital & Information Officer - *MSE ICB*
- Mark Bailham, **MB**, Non-Executive Member - *MSE ICB*
- Geoffery Ocen, **GO**, Non-Executive Member - *MSE ICB*
- Peter Fairley, **PF**, Director of Strategy Policy & Integration (People) - *Essex County Council*

Meeting Opened 10:15

1. Welcome & Apologies

MT welcomed everyone to the meeting and explained that the focus today's meeting will be an interactive discussion following feedback on the previous meeting.

A round of introductions was completed for new members in attendance and apologies were noted as listed above.

2. Conflicts of Interest

MT requested members to submit any new declarations of interest relevant to the agenda, taking into consideration that all members have an interest in their own statutory organisation.

No declarations of interest were raised.

The Integrated Care Partnership (ICP) NOTED the addition of no new declarations of interest.

3. Approval of Minutes

The draft minutes of last the meeting, held on 20th March 2023, were approved as an accurate record with no comments or questions received.

The ICP AGREED the minutes of the last meeting, 20th March 2023, to be an accurate record.

4. Approved Committee Minutes

The minutes from the sub-committee meetings, Population Health Improvement Board (PHIB) and Community Assembly (Co-Production Group), were noted. No questions were raised regarding the work of the sub-committees.

MT advised the group two more networks will report into the ICP within the next 6 months, the Independent & Private Providers' Network, and the Community Voices Network.

The ICP NOTED the minutes of the sub-committees, Population Health Improvement Board (PHIB) and Community Assembly (Co-Production Group).

The ICP NOTED that two new networks, the Independent & Private Providers' Network and the Community Voices Network, will report into the ICP within the next six months

5. Questions From the Public

All questions raised by members of the public were submitted in writing prior to the meeting and responses to the questions were emailed to the relevant persons after the meeting.

Gina Denham asked a two-part question to the ICP. Jeff Banks provided responses to the questions raised. Gina was not in attendance at the meeting, responses to the questions were emailed to Gina.

Question 1:

> *"Based on your aspiration to be inclusive of residents, have you proactively reached out to Essex's local LGBTQIA+ community groups or organisations, such as Transpire and Southend Pride to hear their voices as residents?"*

Response provided by Jeff Banks:

> Partners across the Integrated Care System are committed to tackling inequalities in health and care access, experience, and outcomes and this includes residents from the LGBTQ+ community where we recognise there is inequality. There are a range of forums where our LGBTQ+ staff, who in many instances are also residents, can reflect their experiences and offer feedback on the services we provide. In 2022, our partner, Mid and South Essex Foundation Trust, received a national award for its commitment to supporting lesbian, gay, bi, trans and queer people in the workplace. Our commitment to the Pride in Practice scheme helps build Primary Care practitioners' confidence to support LGBTQ+ patients, and we have been working with the LGBT Foundation to offer training to a number of our GP surgeries around LGBTQ+ healthcare and the health inequalities faced by people who are LGBTQ+ including gay and lesbian people wanting to adopt children and support for the delivery of effective signposting and social prescribing for LGBTQ+ communities. We now have 25 GP surgeries who have been accredited through this scheme and we understand we are the first ICS in the East of England to adopt the programme and the first in the south of the UK outside of London. Ryan Smith, Pride in Practice Manager, South of England for the LGBT Foundation has said "Mid and South Essex being the first East of England ICS to get awarded are blazing a trail, and we hope to see this wonderful example picked up by more ICSs while we continue our work here".

Question 2:

> *"If you have not reached out, what are your plans concerning hearing their voices?"*

Response provided by Jeff Banks:

> Whilst we have links with some LGBTQ+ organisations and those who identify as part of this community are part of our engagement and consultation work, we recognise there is always more to do and we would welcome further opportunities to engage with representative groups to better understand the experiences of LGBTQ+ community. We have made contact with the representative organisations suggested (Transpire and Southend Pride) and will be pleased to receive further suggestions from partners in respect of other groups or forums we could engage with further.

Rodney Fraser raised a question for the ICP, Jeff Banks provided a response to the question raised. Rodney was not in attendance at the meeting, responses to the questions were emailed to Rodney.

Question 3:

> *"May a patient request a copy of a communication between MSE and a local surgery, when it relates to the patient concerned. If so, how extensive is the overview?"*

Response provided by Jeff Banks:

> Under the UK GDPR & Data Protection Act, individuals have a right of access to information held about them by an organisation. All residents have the right to ask an organisation whether they are using or storing your personal information. They may request copies of personal information, verbally or in writing, this is called the 'right of access' and is commonly known as making a Subject Access Request or SAR. The right to see information held about a patient is very broad and will usually include full details of all information retained by the organisation.
>
> If the communications in question are not about the individual as such, but about how the local surgery manages engagement with members of the public more broadly e.g., in relation to an online reviews, etc. but the communications do not name the individual concerned, this may not be considered personal information and would not therefore be covered by a SAR. The individual would need to ask for this information under a broader Freedom of Information enquiry, which is a slightly different way of obtaining information about the work of a public authority.
>
> Either way, we would be very keen to have a conversation about this and to help the resident obtain the information they are looking for. The residents may make contact with their surgery or PCN directly or make enquiries using the emails address MSEICB.SAR@nhs.net Further information on the right of access can be found on the Information Commissioner's Office's website, specifically here: https://ico.org.uk/for-the-public/your-right-to-get-copies-of-your-data/

Peter Blackman raised a question for the ICP. Anthony McKeever provided a response to the question. Peter was present at the meeting.

Question 4:

> *"What will be the impact on the development and delivery of the Integrated Care Strategy Joint Delivery Plan of the forthcoming severe cuts in the finances and resources of the MSE ICB? How will partnership working be affected? What will be the effect on the development of partnership working at Alliance, Neighbourhood and local/interest community levels? What can the people and communities of South Woodham Ferrers expect and do to help?"*

Response provided by Anthony McKeever:

The Mid and South Essex Integrated Care Strategy (2023-2033) was adopted by partners on the 20th March this year and sets out a bold and ambitious long term vision for the Integrated Care System in Mid and South Essex. This work was developed by our Integrated Care Partnership (ICP). The NHS Joint Forward Plan sets out how NHS partners will work together over the next 5 years to help achieve the NHS ambitions. This was developed by the NHS Integrated Care Board (ICB). Both documents will be reviewed and refreshed annually, and in the case of the Integrated Care Strategy, each time our upper tier local authorities refresh their own Local Health and Wellbeing Strategies or produce a new Joint Strategic Needs Assessments. Both pieces of work are designed to adapt and change over time, considering our performance and local challenges and opportunities, as and when they arise.

On 24th May this year, I wrote to all partners informing them that Mid and South Essex ICB, and its counterparts across the country, had been asked by NHS England to deliver a significant reduction in their running costs by 2025. This national mandate is to reduce running costs (known as the running cost allowance) by 30 per cent over the next two years. Running costs are costs that are not related to the delivery of front-line patient care. Locally and in line with feedback, the ICB has set about achieving the required reduction in the course of the current financial year of 2023/24. Accordingly, the ICB has now launched a formal consultation with our teams on a proposed structure for ICB, alongside extensive engagement with ICB partners.

The Integrated Care Strategy describes a partnership approach to achieving our ambitions, working together in what we call a 'Common Endeavour'. It describes a broad and equal partnership of individuals, organisations, and agencies, focusing on prevention, early intervention and providing high-quality, joined-up health and social care services, when and where people need them. From time to time, individual partners will of course face challenges, but the purpose of a partnership approach is to ensure that we can continue to work to achieve our ambitions, giving and taking weight at times of challenge. The ICB remains fully committed to playing a full and active part in our 'Common Endeavour' and working together to achieve the ambitions identified in the Integrated Care Strategy.

The ICB, and its local authority partners, have been at the forefront of advancing the 'subsidiarity' principle, which asserts that any central authority should have a subsidiary, or secondary role, performing only those tasks which cannot be performed

at a more local level. This will not change. Further, we will continue to provide resource, through our Alliances and at a system-level, to work with local communities, as we simply cannot do it without them. The 'Common Endeavour' involves us all, both in organisations and agencies and as residents. We welcome the opportunity of working with the community in South Woodham Ferrers, and I acknowledge the important work of the South Woodham Ferrers Health & Social Care Group, and the work taking place in communities and through groups like it, across mid and south Essex. We thank you for your support.

The ICP NOTED all questions raised from members of the public.

6. Workshop Session, Integrated Care Strategy Delivery (Jeff Banks)

The Integrated Care Strategy were approved in March 2023 and has been well received both locally and nationally. There has been positive feedback from workshops looking at the outcome's framework. There has been a desire expressed to move away from the traditional 'Theory of Change' approach as this can have predictable inputs and outputs and this needs to be adapted to account for changing circumstances.

The Population Health Improvement Board (PHIB) has created a dashboard and framework focusing on deliverables around health inequalities, prevention and intervention that can be used to support the Strategy and prevent duplication of work.

There have been several successful engagement activities run throughout the progress of the Strategy, including Spring Conversations, work with priority 'Inclusion Groups' and the Essex is United Facebook page and local groups. It is evident the conversations and feedback needs to continuous to allow the coproduction to become more fluid.

It was noted, wider meetings have been had with the education sector, both Primary and Secondary level recognise and support the work of the ICP.

The objectives of today's session are to seek the ICPs views on the developing delivery mechanism and approaches, to agree a series of annual deliverables which ICP members wish to focus upon, agree on are reporting model and process, to seek members views on contributions they may be able to make and to agree the next steps.

Each table was provided with a worksheet to complete with the following key themes *(responses to the worksheets can be found under **Workshop Session, Plenary** in these minutes)*:

- Developing Partnerships
- Reporting on Progress
- Communications & Engagement
- Resources & Operation Model

The attending members of the public were asked to participate in the workshop and joined the table discussions with partners.

7. Workshop Session, Plenary (Prof. Michael Thorne)

During the plenary of the workshop MT asked the attendees to feedback on their responses to the questions. Using the feedback from the group clear operating models and proposals will be developed and the models will make it clear what change is wanted.

Key themes highlighted from the workshop session were:

- To grow our own future workforce to meet the needs of services and our community by working with local universities, front line staff (in all sectors) to ensure they are supported and there are development opportunities.
- Using lived experience and case studies as well as numbers to amplify the work of providers and further develop provider collaboration and to use CQC ratings to support each other effectively where there are concerns.
- Using coproduction to understand the needs of the community to tailor services and support o place and people.
- To have continuous genuine engagement, feedback, and conversations to share progress and understand how the impact on the conversations as well as going to people and being prepared to have the difficult conversations.
- To share roles and understand shared ambitions. This is starting to happen now, but it needs to be amplified and happen more frequently. Including, being prepared for successful pilots and pull resources together for things that work well for the population.
- To harness the power of community organisations to build inclusive networks and engage meaningfully.
- To commit to reach out and understand assets to help deploy those assets as part of a common endeavour where available.

The ICP NOTED the responses from the workshop activity and AGREED to use the responses to develop delivery mechanisms and approaches, a series of annual deliverables and a reporting process for progress.

ACTION: Tegan Gardiner to collate responses from the workshops and include them within the minutes.

ACTION: Jeff Banks, Mike Thorne and Tegan Gardiner to review the responses and feedback the proposed delivery mechanisms and approaches, a series of annual deliverables and a reporting process for progress at the next meeting.

The collated responses to the workshop questions can be found below (pages 9 – 13)

Mid and South Essex Integrated Care System

Developing Our Partnership

Starters for ten…

- Ensuring ICP members remain active and involved and prioritise attendance.
- Develop the Community Assembly, Independent and Private Providers' Network and Community Voices Network, ensuring the ICP members are influenced directly by a broad range of contributions.
- Develop an effective approach for reporting to/from sub-committees and
- forums.
- Ensure the ICP remains broad, inclusive and representative of the communities we serve.
- Ensure we are reflecting the views of residents in the work of the ICP.

What does good look like?	How will we get involved & support?
• Real Co-production • Grow our own future workforce through our universities, etc. to meet the future workforce & service needs *(*also linked to Opportunities)* • Delivery • Meet people where they are • Using clear language • Location of meetings (diversity of location)	• Support networking & training for frontline staff across health, social care & others • Stewardship with Partners • Finance engagement Provider Collaboration

Opportunities	Practical Proposals

• *Influence university clinical curriculum to include things such as, prevention, public health, community development, ABCD, frailty, blended roles across sectors
• Create student placements across the system
• Empowering frontline staff e.g., social cares:
  ○ Development opportunities
  ○ Direct access to request support for clients
  ○ Networks for frontline staff including social care staff
• Cycle of Communication (You Said – We Did)
• Different Venues
	• Amplify strengths & build assets

Challenges
• Meaningful co-production • Sustainable VCS sector funding so sector can play full part in system & service delivery • Creating development opportunities when funding is limited • Professionalisation of care workforce in system delivered through commercial contracts • Reaching unstrung (faith/minority) • Integration with Alliances

Mid and South Essex Integrated Care System

Reporting On Progress

Starters for ten…

- Develop an annual work cycle and plan and ensure we are reflecting on our effectiveness as an ICP and agree upon the process for reporting progress.
- Ensure we have the right balance between attending to business, receiving reports and updates, and learning opportunities.
- Determine the best and most appropriate way to ensure alignment across partners to ensure we are capitalising on opportunities presented by the ICP and best able to address challenges when they arise.
- Ensure effective support for and connection with the work of other boards and forums, including the Health and Wellbeing Boards, children and adults' partnership boards, and other specialist boards, and where local authorities and agencies are working to address wider determinants of health.
- Develop our reporting processes, including the proposed annual report and annual conference or symposium.

What does good look like?	How will we get involved & support?
• Shift resources to prevention • Identify key interventions (evidence based) that deliver LTP outcomes e.g., regular eye tests • A well trained, empowered & informed local workforce • Clear dashboard • Narrative driving numbers • Simplicity • Understand future/current issues across the system • Lots on reassurance – more proactive shouldn't have been summarised by CQC	• Learn pathways • More open sessions for Partners to feedback

Opportunities	Practical Proposals
• Open the door (welcome other opinions) • Assembly • Intent of brining PROVIDE network • Devolved leadership • Decentralised Model • Stewardship • Reporting to people on things that are important to them	• Nigel Beverley to fulfil discussion with Provider Network Call & joint outcome • Fuller development of stewardship model • Evolve assembly with councillors of local Government • Working groups – leads to generation of action

Challenges
• Appetite for Risk • Bubble mentality • How brave do we all want to be? • Data sharing • Holding MSE/EPUT to account • Reassuring patients/residents • Pendulum swings between 'hard' and soft' • Organisations being pushed apart due to system pressures • Lots of small organisations, system has to get bigger

Communications & Engagement

Starters for ten…

- Draw together partners to undertake work on designing and developing the public-facing campaign model aligned with our shared Common Endeavour.
- Determine how partners wish to be informed of the work of the ICP, and how we effectively disseminate our learning.
- Ensure we engage fully with our expert colleagues, partners, and residents in developing this work.

What does good look like?	How will we get involved & support?
• Meaningful co-production as well as clear communication on services etc. and how to access • Create messages in a way that is understandable • Going to where the audience are • Learn from and utilise the community • Have the difficult conversations • Lived experience & co-production • Co-design • Genuine engagement • Accessible and personalised information • Trying different approaches (both digital and non-digital – not everyone has digital access) • Make it relevant • Degree of understanding about ICB/ICB – correct power imbalance	• Engage community voices in discussions about resourcing & priorities • Integrate our ways of comms & engagement support • Use of Community Assembly • Influences of change • Understand from publics P.O.V and their needs • Ensure to build inclusive networks to communicate, engage & deliver

Opportunities	Practical Proposals
• SAVS/CVS Community Connector roles • Integrated Neighbourhood Teams should enhance access to system resources for individuals • Learn from successes e.g., 'Team Around the Child' • Digital influence • Community assets • Local councillors • Create a different model • Enrol residents/community with us • Golden thread flows through the systems • Ambassador roles	• Use of digital • Simple list of who does what in the system • Integrate out comms & engagement • Targeting campaigns to be bespoke, using community reach trusted partners • Use common language • Use lived experience to develop our engagements

Challenges
• Clear & simple communication • Understanding the need for better data sharing • Impact on outcome, how do we understand and measure? • Harness the power of community organisations

Mid and South Essex Integrated Care System

Resources & Operational Model

Starters for ten…

- Identify what support Partners are able to commit to the work of the ICP.
- Develop an operational model which brings these resources together to support our Common Endeavour.

What does good look like?	How will we get involved & support?
• Shift resources to prevention & demonstrate additional activity/evidenced based practice upstream before people get unwell • Improved access & support for underserved communities, empower communities • Integrated posts • Pooled budgets around agreed spend/outcome • Devolved leading model • A system of staff who understand how to identify whole needs and can refer and support across the whole system • All partners understand their role and power to influence within the ICP • Collectively buy-in • Ensure knowledge of ICP is shared at all levels • Keeping sight of and engaging with service users • True integration – joint posts, pooled budgets etc, everyone's issue, better understanding of context, benefits for end user • Include patients & carers • Good communication/information • Equipment • Key worker housing • Future proof workforce	• A universal pledge to commit to get it done at the appropriate place or system • Review ICP membership – i.e., probation gap • Continue joint work as current e.g., PHIB • What's common?

Opportunities	Practical Proposals

• Fully understand the resource assets in systems & communities in order to maximise impact & narrow the gap between strategy & operations
• Identify & build team across the system *(including VCS)* by network marketing principal approach e.g "know a person who can…"
• Identify key influences in the system
• Stewardship
• Getting on with it
• Earlier prevention & intervention through tech (frontline)
	• Develop a plan for how to shift over time an additional 1% of system funding to prevention:
	  ○ Need & outcome lead investment (PHIB)
	  ○ Multi-year to shift resource
	  ○ Sustainable prevention role for VCS
	  ○ *?% previous shift in ICS strategy – at least 1% = £30M+*
	• Amplify stewardship
	• Insight work – Who? How? Analysis
	• Divert funding to VCSE longer term

Opportunities	Practical Proposals
• Data sharing • Using data well • Create clear messaging across all systems • Joined up working creating more efficient working • More conversations about joint posts/structures • Push on integrated records - ? easier at Alliance Level • Act where we collectively can • Sustainability	• Integrated workforce Health & Social Care • Early pathways and engagement with local education establishments to attract local talent and diversity withing the community – wider recruitment opportunities • Identifying ambassadors within partner organisations to feed into the ICP • Presumption of partnership • Apprenticeships • CEO level conversations • Patient department away days – joint focus • Decisive – what can't be changed to focus on what we can change • Engagement • Be prepared for successful pilots

Challenges
• Sustainable funding • Building in long-term sustainability & change not just short-term initiatives e.g., how can we shift additional 1% to prevention as per Hewitt Review? – Need a plan • Appetite for risk defect • Technology – frontline? • Funding – VCSE • Easy system to refer • Short term funding isn't good. • Communication - how does agency know about space • Who decides structure for joint posts? • Loss of organisation memory/relationship with restructures • Challenging acute spend to reinvest in new • Acknowledge sovereignty of NHS/LA

8. Partnership Responses to Complex Needs – Health, Social Care, Policing & Probation (Leighton Hammett & Felicity Ayre)

Leighton Hammett gave a presentation on Integrated Care Systems & Community Safety. The Community Safety Partnerships (CSPs) consist of representatives from responsible authorities including:

- Police
- Local Authorities
- Fire & Rescue Authorities
- Probation Service
- Health Service

Efforts are made by the responsible authorities to protect local communities from crime and to enhance peoples sense of security. To allow the CSP to develop intelligence and provide an evidence base which decisions can be made, effective information sharing between authorities is crucial. This decision making should then help direct appropriate responses to:

- Prevent and reduce crime, disorder, and anti-social behaviour
- Apprehend and prosecute offenders
- Reduce re-offending
- Address issues associated with the misuse of drugs and alcohol
- Enhance public reassurance and confidence in the services that are in place to improve community safety.

Taking on these issues of community safety requires collaboration between multiple agencies. For these problems to be understood, each of these agencies must share information related to certain community safety problems.

Mental health and policing go hand in hand:

- In the last 12 months Essex police has taken 17,909 incidents of mental health, with the peak of demand in December 2022 with 1,778 incidents.
- 45.27% of those who enter police custody, are identified as having some form of mental health risk assessment, equating to 10,121 custody records.
- The top 5 mental health callers in May 2023 called the Police a combined total of 420 times.

Housing is a big solution to support policing, community safety and the wider detriments of health. Those who are homeless are more likely to be unemployed, have poor mental health, have long-term physical health issues, or use drugs compared to the general population. The longer someone experiences rough sleeping, the more likely they are to develop complex needs and need more help to rebuild their lives. Together members of the ICP can work together more and understand what is driving complex needs to prevent people from getting into a position where there needs require complex interventions.

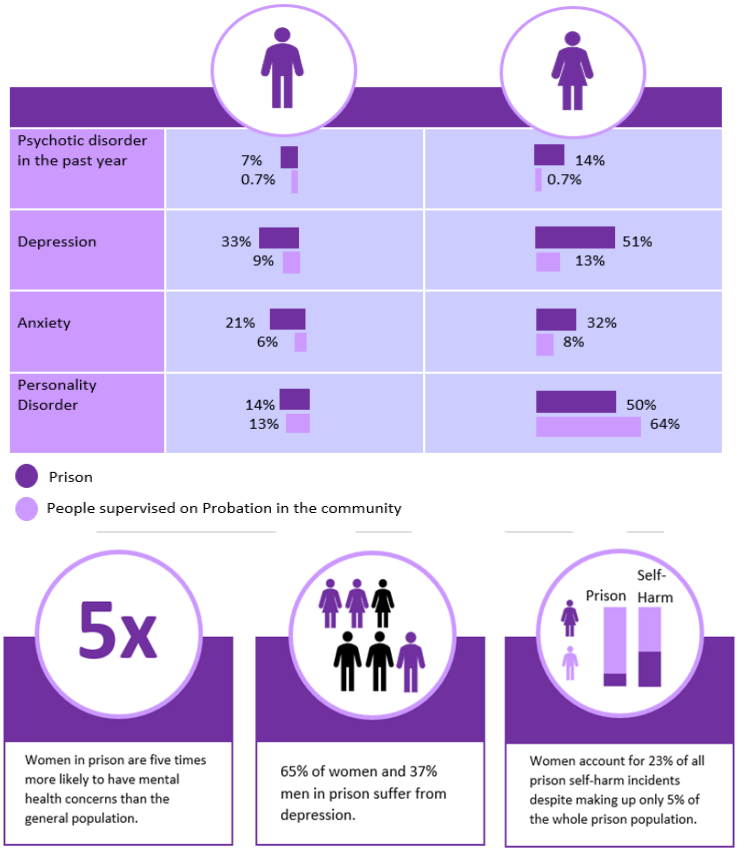
Those households that have become homeless due to domestic abuse reasons since April 2020 have remained consistently between 11% and 16.5% of the total of all households that have become

homeless. Since the start of 2021/22 this has been 15% or over, indicating an overall rise of those with a domestic abuse reason over the last 18 months.

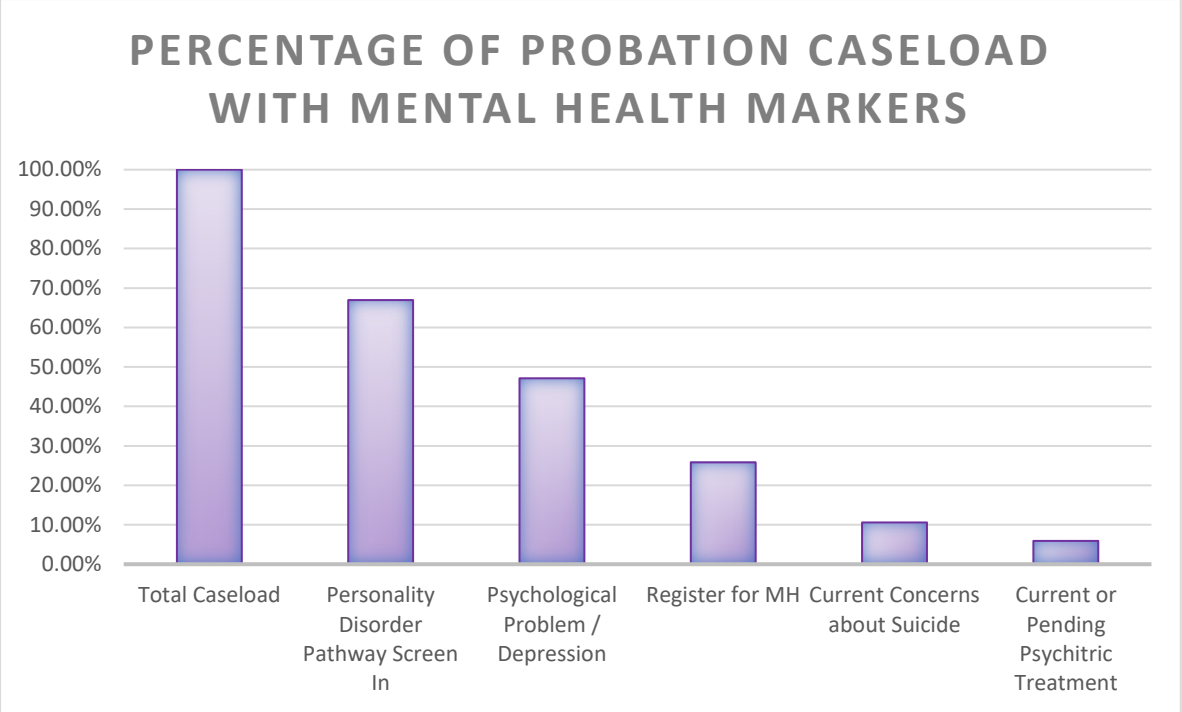
Felicity Ayre gave a presentation on the Probation Service. The Dame Carol Black Review has linked probation to the health agenda in the community to build relationships between organisations to ensure people in the probation service have access to services to meet their needs. The Probation Service attends local partnership groups to help drive innovation and cultural change and work collaboratively with others.

Health & Justice Partnership Coordinators have a pivotal role in the local leadership of the health and justice agenda in the community by acting as a link between national policy developments and local delivery.

National statistics were provided for people on probation:



Regional statistics were for people on probation:



Regionally, Essex is significantly higher than the rest of the region for those on probation who require drug rehabilitation requirements (DRR) and alcohol treatment requirements (ATR). With 119 people on probation requiring ATR and 116 requiring DRR compared to Suffolk having 67 people requiring ATR and 53 requiring DRR and Hertfordshire having 29 people requiring ATR and 37 requiring DRR.

Across Mid & South Essex, the probation service currently works with 4,439 individuals, of which 3,981 are male and 458 are female. These people on probation are some of the most vulnerable in our society and include those who are homeless, have substance misuse, ill mental health, domestic abuse, childhood trauma, neurodiversity and an aging population.

In Mid & South Essex:

- 1,117 people known to the Service have an active identification of ill mental health, this only accounts for those who have a diagnosis or have told the Service of their ill mental health. (*There are also people suffering who may not have made the service aware of their issues and therefore not part of this figure)*
- 1,084 people known to the Service have actively told the Service they are involved in domestic abuse, either as a perpetrator or a victim.
- 1,025 people known to the Service are sleeping rough or struggling with accommodation.

FA advised complex cases are difficult to manage and shared a case study about people who are released from custardy without medication and health support often have poor outcomes.

A Health & Justice Co-ordinator was contacted late on a Friday as a person on probation was very unwell following a release from prison with no medication for his epilepsy, homeless and with no financial funding. The Co-ordinator was able to source priority accommodation, emergency medication and referrals to the Reconnect Service and the Community Initiative to Reduce Violence

(CIRV). The person is now attending regular Probation appointments and has thanked staff for their support stating, *"If you hadn't helped me, I could have died".*

Working with as a Partnership is a key part of the risk assessment and on-going management of people on probation. The Partnership currently works with providers including with the Police, NHS, Substance Misuse Treatment providers and Housing.

The areas of challenge that have been identified with the partnership approach are:

- Dual diagnosis
- Secondary Mental Health Services
- Aging population and associated care issues
- Homelessness amongst our most complex individuals
- Friday/last minute releases

The ICP were asked to consider "*How can you help to improve and develop our partnership approach?"*

It was stated the ICP's pan for health and social inequalities can help support the areas of challenge identified. Long term sustainable support is required, the ICP can influence this support by sending strong signals to see action and progress. The ICP are keen to see better alignment of support around vulnerable individuals.

The Community Safety Hub in Chelmsford has allowed Mid Essex Alliance to co-locate with the Community Safety Partnership. The has supported a multiagency approach to address domestic violence and homelessness.

A need was identified to agree the Mental Health Collaborative Terms of Reference, which should be happening in due course.

The ICP should act as the catalyst for change and call to action partners around the table.

ACTION: Leighton Hammett & Anthony McKeever to work together to turn the statement *"How can you help to improve and develop our partnership approach?"* into 3 things that can be worked on to bring the Alliances together and merge with other partners and develop a working group.

9. Mid & South Essex Joint Forward Plan (Jeff Banks)

MT informed the ICP, that the Joint Forward Plan has completed the process for endorsement from all three Health & Wellbeing Boards. He explained the ICB has produced a 5 year Joint Forward Plan to articulate how NHS partnerships will work together to support both the visions of NHS England and the ICP.

The final document will be published in due course.

AK advised he will come to the ICP with an update on what has been done, by who and by when in December.

The ICP NOTED the attached draft Joint Forward Plan has received endorsement from all three Health & Wellbeing Boards and will be published in due course.

ACTION: Anthony McKeever took an action to update the ICP on the progress of the Joint Forward Plan and the work that has been completed at the December ICP meeting.

10. Closing Remarks & Networking Opportunity

MT thanked everyone for their attendance today and welcomed feedback on the structure of today's meeting.

Please direct feedback following the meeting to: mseics.partnership@nhs.net

Papers Attached for Information

The NHS ICS Annual Impact Report was shared with the ICP for information.

The ICP NOTED the attached NHS ICS Annual Impact Report for information only.

Meeting Closed 13:00

Date & Time of Next Meeting

The next meeting will take place on Tuesday 5th September 13:00 – 14:00 and will be held in Committee Room 1, Civic Offices, New Road, Grays, RM17 6SLER.

Agenda Item 5 - MSE ICP Meeting Action Log

Action No	Meeting Date	Agenda No	Agenda Item and Action Required	Lead	Deadline	Update/Outcome	Status
1	28/06/2023	7	**Workshop Session, Plenary** Tegan Gardiner to collate responses from the workshops and include them within the minutes.	Tegan Gardiner	05/09/2023	Collated workshop responses included within the distributed minutes (Appendix 1)	Complete
2	28/06/2023	7	**Workshop Session, Plenary** Jeff Banks, Mike Thorne and Tegan Gardiner to review the responses and feedback the proposed delivery mechanisms and approaches, a series of annual deliverables and a reporting process for progress at the next meeting.	Jeff Banks/Mike Thorne	05/09/2023	New delivery group proposed to take forward the implementation of the Strategy (see agenda item 7)	In Progress
3	28/06/2023	8	**Partnership Responses to Complex Needs – Health, Social Care, Policing & Probation** Leighton Hammett & Anthony McKeever to work together to turn the statement "How can you help to improve and develop our partnership approach?" into 3 things that can be worked on to bring the Alliances together and merge with other partners and develop a working group.	Leighton Hammet/Anthony McKeever	06/12/2023	Progress report will be brought to next ICP meeting	In Progress

MSE Integrated Care Partnership, 6 December 2023

Agenda Number: 7

Delivering the Integrated Care Partnership Strategy

Summary Report

1. Purpose of Report

To provide a suggested way forward to develop an implementation plan for the Integrated Care Partnership (ICP) Strategy

2. Executive Lead

Emily Hough, Executive Director, Strategy & Corporate Services, Mid and South Essex ICB

3. Report Author

Emily Hough, Executive Director, Strategy & Corporate Services, Mid and South Essex ICB

4. Responsible Committees

Integrated Care Partnership

5. Link to the ICP's Strategic Objectives

ICP Strategy Common Endeavour to Reduce Health Inequalities

6. Financial Implications

N/A

7. Details of patient or public engagement or consultation

The ICP strategy was developed with engagement from stakeholders across the ICP. Further engagement will be required in developing the delivery plan.

8. Conflicts of Interest

None identified.

9. Recommendations

The Integrated Care Partnership is asked to note progress in delivering improvements to the services for the population of Mid and South Essex and support proposals to establish a Delivery Group to develop a 2024/25 delivery plan to support implementation of the strategy.

Implementing the MSE Integrated Care Partnership Strategy

1. Executive Summary

Mid and South Essex (MSE) Integrated Care Partnership (ICP) published its Integrated Care Strategy for 2023-2033 in March 2023. Since then, members of the ICP have been working collectively to improve the health and wellbeing of the population of mid and south Essex. However, a delivery plan to support implementation of the commitments in the strategy has not yet been developed.

This report sets out a recommended way forward to develop a delivery plan for 2024/25 by establishing a small Delivery Group to agree priorities and develop delivery plans for the next financial year. The core membership of the group will be senior officers from local government and health partners across the system and its Alliances. The group will engage with the ICP's Community Assembly to ensure that the views of local voluntary, community, faith and social enterprise (VCFSE) sector are included in this work.

Recognising that the whole system is facing significant financial challenges, the Delivery Group will set out the resources required to deliver on the agreed 2024/25 priorities within the strategy, maximising opportunities to draw on community assets across MSE.

2. The ICP Strategy

The ICP Strategy includes insights from 27 publicly available strategies and plans from partner organisations within MSE ICP, as well as the relevant Joint Strategic Needs Assessments (JSNA) and additional analysis from MSE's Population Health Management Team. Over 170 people from across the system were engaged in eight workshops that sought views to help shape the strategy, with an additional 280 comments and votes gathered from online engagement.

Central to the strategy is the 'Common Endeavour' of reducing health inequalities together. This joint commitment recognises that all members of the partnership have a role to play in improving the overall population health of residents by addressing the barriers to good health that some communities experience more than others.

Four partner priorities were identified as critical to supporting the commitment to improve population health and reduce health inequalities:

1) **Working together to address the 'wider determinants of health' (WDOH)**. These are often described as the non-medical factors that influence health outcomes, such as the conditions in which people are born, grow, work, live and age and social and environmental situations they find themselves in. MSE is using the model based on the work of the Robert Wood Johnson Foundation to categorise WDOH (see figure 1 below).

2) **Addressing health inequalities for people of all ages.** Across MSE there are several groups that have poorer health outcomes and experience greater health inequalities than others. The ICP is committed to addressing any barriers to health and wellbeing experienced by these groups, and to working with them to improve their overall health outcomes. MSE is using the national 'Core20PLUS5' frameworks to inform this work. These frameworks encourage a focus on those living in the most deprived 20% nationally, as identified by the national Index of Multiple Deprivation (IMD); and on five clinical areas which require accelerated improvement – maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis, and hypertension case-finding and optimal management and

lipid optimal management. Additional local groups that are experiencing poorer health outcomes have also been identified by MSE (see section 3).

3) **Adult Care:** Several priority areas to improve health and care services for adults across MSE were identified in the strategy: supporting people to age well; mental health and suicide prevention; loneliness and isolation; learning disabilities and autism; high-intensity users of services including alcohol and substance misuse, and adult end of life and palliative care. Improving services for people in these areas will deliver improved outcomes.

4) **Babies, Children and Young People:** To support everyone born in MSE to have a good start in life, the ICP has identified the need to focus on improving services across maternity and early years health; children and adolescent mental health; special educational needs and disabilities; prevention of adult health conditions; maternal and children's health weight; education including the health schools programmes; health inequalities experienced by looked after children and care leavers and children's end of life and palliative care. Supporting children to be healthy is part of ensuring they can participate in education, which will contribute to their wellbeing as they age.

Work with the **community** has identified five priorities for how they would like to see services develop as the strategy is implemented:

1) **Access**: ensuring good access to health and care services that aligns with need, with more personalised care available closer to home.

2) **Openness**: with clear and honest conversations between residents and health and care services so that they understand what to expect from services and how to access them in the right way.

3) **Involvement**: maximising the resources across our communities by providing opportunities for them to engage in the development of services.

4) **Awareness**: helping residents and patients understand what services are available, when they are available and how they can appropriately access them.

5) **Responsibility**: with residents taking responsibility for their own health and wellbeing and participating in healthy behaviours and seeking help from the right part of the system when they need it.

System partners also identified five priorities for joint working across MSE:

1) **System pressures:** working together to plan and manage health and care capacity across MSE to ensure that care is available to those who need it, particularly at points when the system will face more pressure.

2) **Workforce recruitment, retention and development:** developing the skills across our workforce, building capacity and capability and aligning workforce strategies across the ICP to help make MSE a great place for people to work in, whatever part of the system they are employed, so that more people want to progress their careers within MSE.

3) **Early intervention and prevention:** focusing on ways that we can help improve the health of the whole population, as well as targeting prevention support for specific groups.

4) **Connecting care:** working to connect and personalise care for individuals, so that they experience a more seamless and integrated offer of support.

5) **Digital, data and shared records:** sharing data and digital solutions that will give us improved insights into our population needs and inform service development, including use of digital tools that can support both residents and care providers.

These partner, community and system priorities have been set out in a 'plan on a page' (see figure 2 below), which also describes some of the principles for how we work together to implement the strategy.

Figure 1: Social Determinants of Health – based on Robert Wood Johnson Foundation model

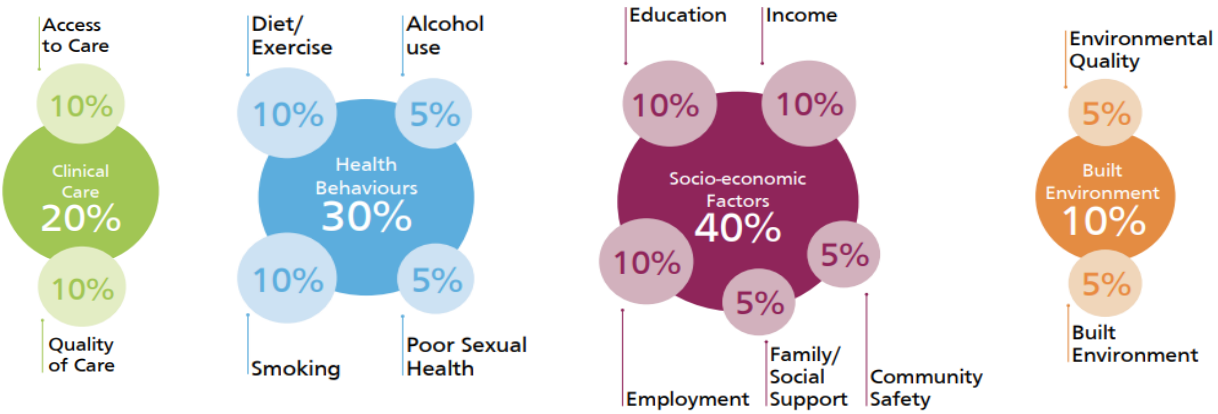
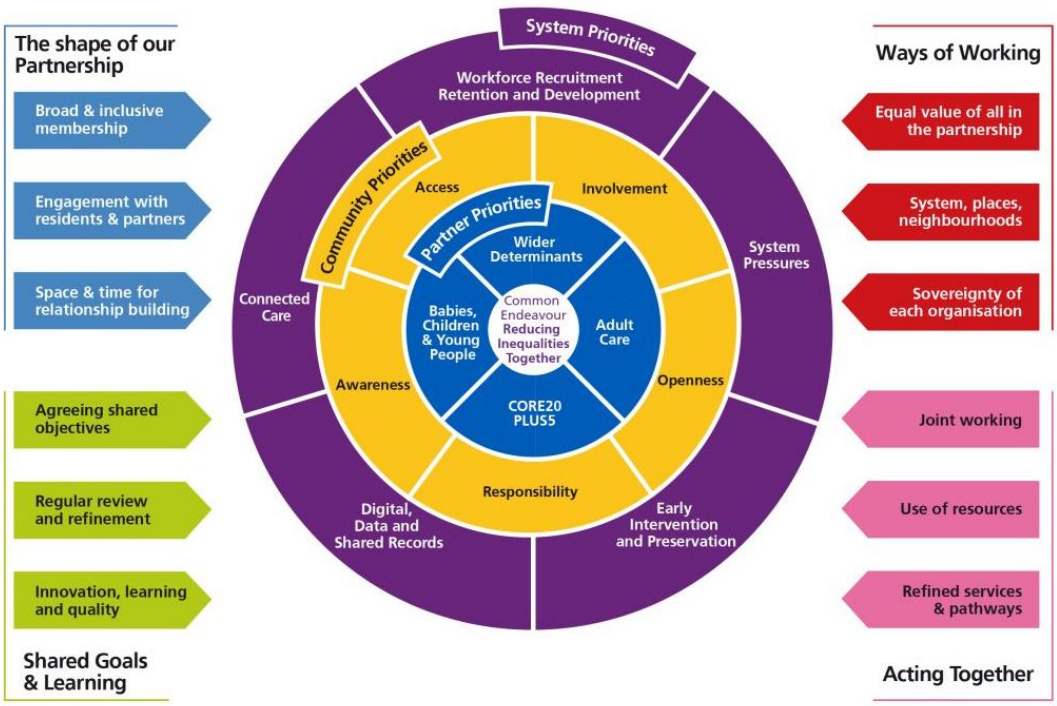


Figure 2: ICP 'Plan on a Page'



3. Progress in implementing the ICP Strategy

Whilst there is not yet a delivery plan to support the ICP Strategy, this has not stopped progress in delivering against the commitments and priorities set out above.

The table below highlights some of the progress that has been made against the partner and system priorities identified in the strategy.

Priority	Progress
Wider Determinants of Health	• Adopt a Health in All Policies approach to policy development and decision-making within the ICB to ensure WDH and inequalities are considered and addressed through all activity. • Work with local authority colleagues to deliver the Levelling Up strategy across the MSE footprint, with a focus on areas of greatest deprivation, to ensure access to opportunity and good outcomes, in all aspects of life, are equitable. • Commissioned activity via the Essex Wellbeing Service (in Essex County) to support healthier lives, smoking cessation, weight management courses and a range of early help and advice to support people's wellbeing. • The pioneering work of Active Essex with Sport England through the local delivery pilot (in Basildon, as well as Colchester and Tendring) to use asset-based community development approaches to tackle high levels of physical inactivity in areas of high deprivation. • Essex County Council (ECC) and MSEFT have played leading roles in the development of the Essex Anchors Network and the development of an Anchors Toolkit, showcasing how core organisations such as councils, the NHS and our universities can act as an 'anchor' to help promote social value and support employment opportunities for local people, including those from marginalised groups such as adults with learning disabilities. • The launch of a new ECC approach to social value through its procurement and commissioning; and • The work of ECC's climate action commission which set out recommendations for moving the county towards a more sustainable and net zero future, supported by a £250 million investment budget (ECC was awarded an A-rating for actions to tackle climate change in 2022). • Support local research to better understand the prevalence of, and impactful interventions to address, the wider determinants of health in MSE, specifically in relation to coastal deprivation, education and employment opportunities, housing availability and quality and wider infrastructure/access to services and opportunities

Priority	Progress

Addressing health inequalities for people of all ages	• Local groups experiencing health inequalities ('PLUS' groups) identified across MSE, including:
	  – those from an ethnic minority background.
	  – people at risk of homelessness.
	  – carers.
	  – those with a learning disability.
	  – Gypsy, Roma, Traveller and Showman groups and Veterans.
	  – children and young people with neurodiversity and
	  – children and young people with Special Educational Needs and Disabilities.
	
	• Collating more detailed information and analysis on these groups to inform targeted support.
	
	• Initiated a stocktake of current services for people experiencing homelessness to identify specific opportunities to improve services for this group

Adult Care	• Ageing Well Stewardship group supporting improvements of care for people living with or at risk of frailty or dementia – so far over 9,000 people have benefitted from preventative, personalised care. This work recently won a Health Service Journal award for 'Data-driven Transformation'. • An all-age end of life and palliative care strategic delivery plan is being developed. • The mental health urgent care department opened in March 2023 in Basildon and is the first of its kind in Essex, the unit was designed with support from people with lived experience to ensure it provides a safe, calm and therapeutic environment. The department is managed by EPUT and staffed by specialist doctors, nurses, and other healthcare professionals from EPUT, Mid and South Essex NHS Foundation Trust, and East of England Ambulance Service, the team also work with community services and charities. • The Essex Learning Disability Partnership programme developed enhanced physical health checks to maximise the opportunity of a health check with the most vulnerable in order to keep people physically healthy for longer.

Priority	Progress
Babies, Children and Young People	• A maternal mental health service has been developed to provide support to pregnant people across Southend Essex and Thurrock (SET). Smoking cessation midwives have now been appointed at all three sites to support a family approach to stopping smoking. • Children and Young People (CYP) Mental Health: Positive Pathways Youth (PPY) (Thurrock) service model is now fully operational following a pilot in 2019. PPY offers a community assets or social prescribing / link working approach, supported by a youth facilitator from Thurrock and Brentwood MIND, enabling young people to be matched with local provision where it exists and to access additional resources available locally. This service delivery also links to the MSE ICB personalisation agenda where this model has an option for a Personal Health Budget (PHB). • Special Education Needs and Disability (SEND): If a young person with a learning disability (LD) (with or without autism) has needs which can only be met by specialist LD services then Essex Learning Disability Partnership (ELDP) offers support at an early stage. • Transitional Care - where ongoing support is required on transition from children's to adult services, community children's practitioners support and input into the transition plans. Where young people are reaching the end of their treatment plan with children's service but may also be approaching adulthood, young people, parents and carers are provided with information on where to go if a new need arises or if there is a change in needs. • All Age end of life and palliative care strategic delivery plan will include support for Babies, Children and Young People.
System pressures	• System Coordination Centre meets 7 days a week and brings all system partners together on a tactical call so that there is a shared awareness of pressures across the system and actions that can be used to address them. • Unscheduled Care Coordination Hub launched in November 2023 to help direct people with an urgent care need to the right pathway, helping avoid unnecessary ambulance conveyance to hospital.

Priority	Progress
	• Transfer of Care Hubs (TOCHs) bring local partners together to support effective discharges from hospital and avoid unnecessary admissions. • Winter comms campaign (#DoYourBit) in progress to support residents to know how they can look after their health and wellbeing during winter.
Workforce Recruitment, Retention and Development	• A newly formed People Board, with representation across the ICS, is working on a more joined-up approach to workforce, allowing: – Reduced duplication. – Benefits of scale. – A more consistent employee offer. • Priority workstreams in train are as follows: – Translation of the new long-term NHS National Workforce Strategy into a strategic workforce plan for the MSE workforce. – Roll-out of an Academy model for the recruitment and induction of support workers across health and social care. – Embedding the national EDI plan with its six 'high priority actions' as a common framework. – Joining up the leadership development offer across the system to give employees access to better development opportunities. – Increasing the take-up of roles that will transform capacity e.g. Allied Care Professionals (ACPs), Physician Associates & Additional Roles Reimbursement Schemes (ARRS) posts and promoting new apprenticeships. – Facilitating the movement of staff across the system through 'digital passports' and Memoranda of Understanding (MoUs).
Early intervention and prevention	• System-wide Population Health Improvement Board established to progress the population health, prevention and health inequalities agenda across MSE. • Work to progress smoking cessation and vaping policies to support a Smoke Free Essex by 2030 (See agenda item 10). • Focused work to target cardiovascular disease (CVD) prevention and increase the number of people with hypertension receiving treatment and the number of people at risk of CVD being on lipid lowering therapies, with additional funding to support the work secured from NHS England.

Priority	Progress
	• Population segmentation model development to identify groups of residents moving too quickly to sub-optimal health to develop earlier identification and treatment. • Approach to the 'First 5,000 households' project developed (see agenda item 8)
Connected Care	• Integrated Neighbourhood Teams are bringing together expertise across primary and community services to deliver comprehensive and coordinated care in the community. These multidisciplinary teams are working together to avoid duplication and offer patients the best possible experience.
Digital, data and shared records	• Trusts working to implement a single Electronic Patient Record which will help create a smoother care experience for patients and staff. • The system has started to implement a Digital Patient Interface, which will start to provide patient records into the hands of our residents across Mid and South Essex. • We have successfully procured a partner to support the implementation of a Shared Care Record solution for our professional staff to use - which will enhance our ability to share key information across our organisational boundaries. • Trusts working to implement a single Electronic Patient Record which will help create a smoother care experience for patients and staff. We are in mid procurement activity with our 200 clinical, operational and technical staff involved in evaluating a suitable solution. • We have launched Athena our Strategic Data Platform and have the ability to share information with all our partners across the system to support better decision making. With a roadmap of continuing developments provided through our business partner.

4. Developing the 2024/25 delivery plan

To develop a delivery plan for progressing implementation of the ICP Strategy in 2024/25, we are proposing to establish a small and focused Delivery Group that will meet three times between January and March 2024. This group will include a core group of senior officers from across the ICP partners. The group will focus on agreeing the strategic priorities for delivery in 2024/25, how those priorities will be

progressed within the system, including when the focus will be at a system or a more local level, and what resources will be required to progress delivery.

To ensure that the group engages with the broader membership of the ICP, members of the Delivery Group will seek views from colleagues across adult and children's social care, public health, clinical leadership, quality and safety, workforce, digital, finance and the Community Assembly.

The plan will also need to align with the delivery plans of the various ICP members, specifically the three Health and Wellbeing Board delivery plans and the Joint Forward Plan for the NHS Integrated Care Board.

As plans to deliver agreed priorities are progressed, they will need to focus on how all actions are working to improve population health and reduce health inequalities in how they:

1) **Partner:** Work in partnership to meet the health and care needs of the population of MSE, including where in the system programmes will be led from.

2) **Deliver:** Work together to delivery equitable access to high quality health and care services for all those who live in MSE.

3) **Enable:** Utilise our collective assets to deliver the best outcomes for the population of MSE.

Progress in this work will be brought back to the ICP Board in March.

5. Recommendations

The Integrated Care Partnership is asked to note progress in delivering improvements to the services for the population of Mid and South Essex and support proposals to establish a Delivery Group to develop a 2024/25 delivery plan to support implementation of the strategy.

MSE Integrated Care Partnership, 6 December 2023

Agenda Number: 8

Update from Population Health Improvement Board

Summary Report

1. Purpose of Report

To provide an update on the work of the Population Health Improvement Board to support reducing health inequalities for the population of mid and south Essex (MSE).

2. Executive Lead

Emily Hough, Executive Director of Strategy and Corporate Services.

3. Report Author

Emma Timpson, Associate Director Health Inequalities and Prevention.

4. Responsible Committees

This report reflects work overseen by the Population Health Improvement Board.

A report on the health inequalities funding went to the Integrated Care Board on 16 November 2023 and Finance and Investment Committee on 16 August 2023.

5. Link to the ICP's Strategic Objectives

Common endeavour: Reducing Inequalities Together.

6. Impact Assessments

No impact assessments have been undertaken on this project to date, but assessments are undertaken for individual projects.

7. Financial Implications

The MSE ICB has committed £3.4m recurrently to support the reduction of health inequalities. This is in addition to the work being undertaken across the NHS and other ICP members to ensure health inequalities are addressed in commissioning, contracting reviews and decision making regarding universal access to services.

8. Details of patient or public engagement or consultation

Patient and public engagement is embedded within the delivery of the Health Inequalities programme.

9. Conflicts of Interest

None Identified.

10. Recommendation/s

The Integrated Care Partnership is asked to note the work of the Population Health Improvement Board in supporting the common endeavour of reducing health inequalities together.

Reducing Health Inequalities

1. Introduction

Reducing health inequalities is at the heart of the mid and south Essex (MSE) Integrated Care System (ICS) strategy. The gap in life expectancy across MSE is as much as 12 years between some of the wealthiest and most deprived neighbourhoods. An estimated 133,000 people in MSE live in the 20% most deprived areas nationally, that equates to 10.5% of the total population of MSE.

Within MSE the top three contributors to premature mortality attributable to socioeconomic inequality are cancer, cardiovascular disease and respiratory disease (see **Appendix A** for further information). Alongside this, the greatest risk factors impacting on population health and health inequalities are tobacco, blood pressure and dietary risks. However, wider determinates of health, including lifestyle behaviours, socio-economic factors and environment account for up to 80% of variation in health outcomes.

The Population Health Improvement Board's (PHIB) work around health inequalities, prevention and personalisation have adopted the Core20PLUS5 frameworks for adults and children (see **Appendix B**).

In line with the framework the Population Health Improvement Board (PHIB) has identified a number of adult groups that are experiencing poorer than average health access, experience and/or outcomes across their communities. These 'PLUS' groups include:

- Those from an ethnic minority background.
- People at risk of homelessness.
- Carers.
- Those with a learning disability.
- Gypsy, Roma, Traveller and Showman groups.
- Veterans.

The Growing Well Board has also identified a number of specific children and young people groups, initially prioritising those with neurodiversity and Special Educational Needs and Disabilities (SEND).

Population Health Improvement Board

The Population Health Improvement Board (PHIB) was established in November 2022 with representation from partners across MSE ICP to drive an integrated approach to improving population health and reducing inequalities.

The PHIB has established nine principles for improving the health of the population (see Figure 1).

Figure 1: Nine principles for improving population health in MSE

The PHIB undertook its first annual effectiveness review in November 2023 and identified a number of achievements and areas for improvement:

Achievements	Areas for improvement
• Shared vision and direction • Partners commitment from across system to deliver the shared purpose • Alignment of strategic thinking • Oversight of health inequalities funding	• Set long term ambitions • Refresh priorities to include social determinants based on data on greatest gaps/opportunities • Develop a delivery plan to support implementation of priorities • Strengthen accountability between PHIB, HWBs and Alliances • Extend membership

The Terms of Reference for PHIB will be reviewed and updated to reflect the outcome of the effectiveness review and be brought back to the next meeting of the ICP. The Terms of Reference will reflect that PHIB will be the delivery group of the ICP on aspects relating to health inequalities, population health and prevention.

First 5,000 households

The ICP strategy set out an initial focus on the 'first 5,000 households', those who are experiencing the worst health outcomes and the greatest health inequalities. The work proposed to deliver on this commitment is being developed to identify the support needs of, not just the 'first 5,000' households in MSE, but all those who may be falling between the gaps of current services and suffering poorer health outcomes as a consequence. The approach proposed for this project will learn from how we support the 'first 5,000' to ensure that MSE is developing services to ensure equitable access and experience of care for all residents.

In line with this approach, the PHIB have supported the development of a system-wide framework for identifying and supporting households that will be implemented locally through the Alliances and their Integrated Neighbourhood Teams (INTs). This approach will set standards for identifying those with the poorest health outcomes and greatest barrier to accessing support, taking a localised and personalised approach to responding to their individual issues that can bring in partners from a wide range of sectors to help address the wider social determinants of health. A standardised approach to evaluation will be taken to enable a system-wide review of the issues and solutions facing this cohort, which can be used to ensure that we have appropriate solutions in place across the system to help others experiencing similar challenges.

The Population Health Management (PHM) team are supporting in the identification of households based on socioeconomic and health related drivers of poorer outcomes. The selection criteria are underpinned by the 'Core20PLUS5' frameworks which has been chosen as a system priority framework for addressing inequalities. Further engagement with the Alliances and an initial nine Integrated Neighbourhood teams will be undertaken during Q4 2023/24 and rolled out more widely to the other areas following a period of test and learn during 2024/25.

2. System Wide approach to improve population health and reducing health inequalities

The achievements of the MSE population health improvement and health inequalities programmes in 2023/24, along with next steps, are outlined in the tables below.

Overall Programme

Achievements	Next steps
A population health improvement framework has been developed based on the nine principles in figure 1 and the King's Fund model that emphasises a place based/Alliance integrated approach to delivery.	Sign off at PHIB in December and socialise across the system in Q4 2023/24.
Development of digital Health Inequalities Impact Assessment, 'ImpactEQ', which will be available to all health partners within the system to ensure high quality assessments are delivered consistently.	Completion of the test phase and roll out in Q4 2023/24.
Organisational and workforce development: • Published Core20PLUS5 articles and promoted across multiple forums/groups. • Active and well represented Health Inequalities Delivery Group that shares national, regional and local good practice.	Tackling Health Inequalities – Closing the gap in practice conference on 29 November 2023 in partnership with Royal College of General Practitioners. Programme plan for Year 2 of Community Connectors by January 2024.

Achievements	Next steps
• Health Inequality (HI) Clinical Leads supporting Alliances with HI governance and mapping of system and Alliance level interventions. • Finance leads' successful application for the Healthcare Financial Management Association (HFMA) Health Inequalities Finance Fellow Programme. • Core20 Community Connectors secured year two funding for community based Chronic Obstructive Pulmonary Disease (COPD) roles. • Allied Health Professionals (AHP) Inequalities webinar (system wide) hosted October 2023.	Implementation of Primary Care Network (PCN) HI Leads development programme supported by Health Creation - Q1 2024/25.
University of Essex undertaking evaluation of 2022/23 Health inequalities funded projects.	Draft evaluation report by February 2024 with final report by June 2024.

Population Health Management

Achievements	Next steps
• Progression of the Population Segmentation Dashboard to incorporate all revised segment definitions and criteria following clinical review. • Review of Disproportionate Care in MSE (to be published shortly) which will be used to demonstrate the need for re-allocation of resource across the system • Updated Adult Health Inequalities packs with new census data to support Alliances/PCNs to better understand populations • Approved CVD LES roll out across MSE aimed at improving early identification and management of CVD conditions	• Reformatting visuals of Dashboard for live roll out in the New Year • Review of PHM workplan to ensure alignment with ICB strategic priorities and reassess support for: • 5,000 Households • PCNS, and Stewardship Group support • Review and publish CYP Health Inequality Packs to support Alliances/PCNS to better understand their CYP populations and target areas within them • Identification of PLUS groups in MSE, broken down for each Alliance. • Delivery of CVD LES programme across identified PCNs in MSE

Core20PLUS5 Framework for Adults and Children

Achievements	Next steps
Core 20% most deprived • Cardiovascular Disease (CVD) Health inequalities funded schemes approved by Primary Care Commission Committee which targets funding towards most deprived areas to support Hypertension, BP@Home and Lipid management. • First 5,000 households outline drafted.	Implementation of CVD HI funded schemes with PCNs by March 2024. Approval of the first 5,000 households approach by December 2023 with implementation commencing via Integrated Neighbourhood Teams (INT) from Q4 2023/24.
PLUS groups • MSE PLUS groups identified. • Prioritisation for addressing adult PLUS group inequalities approved by PHIB.	Implementation of PLUS group priorities recommendations that include establishing a Homeless working group. PHM team to quantify health inequalities experienced by PLUS groups and make recommendations.
5 Clinical areas: • **Mental Health** – Serious Mental Health (SMI) Health check test and learn cycles commenced as part of Core20PLUS accelerator programme. • **Maternity** – Equity and Equality action plan in place and being implemented. • **Respiratory** – Pneumococcal vaccine communications plan in implementation that includes awareness and education campaign with a public survey to establish barriers underway. • **Cancer** – Lung cancer campaign launched and promotion of HI and cancer webinars and online learning. • **CVD** – Innovations in Health Inequalities Programme (InHIP) outreach into target communities commenced, CVD Local Enhanced Service (LES), BP@Home HI extension and Quality and Outcomes Framework (QOF) Lipids extension approved by Primary Care Commissioning Committee.	Develop scale up plan for SMI health checks based on learnings from test and learn – Q1 2024/25. Evaluate success of Pneumococcal campaign – Q3 2024/25. Recruit to communications/community engagement role (funded from 22/23 HI funding) to support outreach around cancer screening. Implementation of CVD LES, BP@Home and QOF Lipid extension by March 2024.
Children and Young People: • Growing Well Board adopted Core20PLUS5 Children and Young People (CYP) framework and 12 PLUS groups identified. • Childhood Asthma training for primary care undertaken with support comms toolkit.	Refinement of the CYP Core20PLUS5 framework and delivery plan – Q4 2023/24.

Reducing risks relating to lifestyle behaviours

Achievements	Next steps

• System wide workshop on future service mapping for an integrated weight management pathway. • Digital weight management service promoted via 'Time to Learn' sessions. • Tobacco cessation programme – successful recruitment to Maternity team. • Essex County Council released a policy statement on vaping. • Roll out of the Shared Decision Making four questions campaign with primary care.	Future state integrated Weight Management Service pathway Q4 204/25 Respond to national consultation on Tobacco and development of MSE system wide plan for Smokefree 2030

Personalised Care

Achievements	Next steps
• 'Adopting the coaching approach' training supports our vision of making Personalised Care the norm and is available to all health and care staff • Development of communication materials 'Ask 4 questions' campaign to support patients in shared decision making about their care and treatment • Collaboration with National Institute Health and Care Research regarding challenges of implementing Shared Decision Making.	Programme plan for 2024/25 to enable further spread across the system Roll out 'Ask 4 questions' communication materials across primary care and launch resident facing campaign

Anchor Programme

Achievements	Next steps
• Developing a programme to support the NHS to ensure it delivers social value in all it does • Reducing environmental impact – supporting net zero carbon emissions, reduced air pollution and increased staff active travel through the 'Essex Pedal Power' programme that has given away 150 biked to Basildon Hospital staff • Anchor Ambition that is increasing access to Employment Support Officers across all four MSE Alliances – since January 2023, 530 people have participated in the project with 113 successfully receiving job offers • Development of the Inclusive Employment workstream to promote placement opportunities for people with Learning Disabilities • Youth Work in Hospitals, with NHS England funding supporting an expansion of Essex County Council's Youth Service in Basildon Hospital. • Basildon Healthcare Innovation Incubator (Social Spark) that brings together local community organisations with health and social care to tackle health inequality.	• Essex Virtual Air Quality Summit – 1 December • Continued expansion of Employment support programmes, including work on pre-employment support • Work placements for those with learning disabilities to commence in Q4 2023/24 • Potential expansion of Youth Work in Hospitals to other sites

Ensuring equitable access through restoration of services

Achievements	Next steps
• Completeness of ethnicity recording continues to improve to 96% • Reporting of restoration of elective services by SEFT considers health inequalities alongside key actions. • Digital inclusion principles approved by PHIB.	Targeted support to practices that have lower data completeness.

Health inequalities funding

The ICB has committed £3.4 million recurrent funding to invest in programmes to reduce health inequalities. However, in August 2023, the Finance and Investment Committee supported a one-off non-recurrent contribution of £1.22 million from the 2022/23 and 2023/24 funding allocation to support the MSE system financial position. It also endorsed the multi-year approach advocated by PHIB and the award of Alliance 'Trusted Partner' contracts for a period of three years.

The HI funded 2022/23 projects continue to be implemented and the University of Essex will be producing an interim evaluation report in February 2024.

Projects funded by HI funding in 2022/23

Basildon & Brentwood Alliance	*Mid Essex Alliance*
• Child oral health • Transition from primary to secondary schools in deprived areas • Physical activity schemes supporting Core20 and specific plus groups • Social prescriber for children and families in areas of high deprivation • Young people employment opportunities from most deprived areas • Supporting those affected by dementia	• Young Carer support and their family members • Pilot COPD patient education • Outreach within traveller communities and SMI health checks • Extending transport services for those unable to attend clinic appointments • Men's Mental health • Outreach clinics in warm spaces • Sensory inequalities ambassador

South East Alliance	*Thurrock Alliance*
• Cardiovascular disease case finding and alleviating system flow pressures • Loneliness and improving access to service • Suicide prevention • Veterans mental health and access to services • Family and childhood mental health and resilience • Focus on mental health through the green agenda • Dental access for deprived and the young	• Obesity transformation • Lifestyle risk management through motivational interviewing • Workplace Health Champions to provide smoking cessation • Gypsy, Roma, Traveller and Showman communities improving access to health services • Thurrock's homeless communities improving access to health services • Health and digital literacy • Enhancing safeguarding, health and mental wellbeing for vulnerable young people and young parents

System wide • Population Health Management team support • Clinical leadership to support HI and Personalised care • Digital Health Inequalities Impact Assessment tool	• Extend outreach activities of the Respiratory van • Extend work of the Anchor Programme • Microgrants scheme for grants between £500 and £1500 • UoE evaluation of HI funded schemes

Of the 12 months recurrent funding of £3.4 million, £854,000 has been committed to the four Alliances via their trusted partners and £250,000 has been allocated to the Growing Well Board to prioritise work to reduce health inequalities for Children and Young People. A further £750,000 was allocated to fund the Public Health Management (PHM) team, anchor programme and other organisational development schemes across the system. The remaining £1.5 million is supporting system wide schemes working across MSE. An expression of interest process was implemented which has resulted in 9 projects totalling £1.3 million being prioritised. The remaining £200,000 will be prioritised by the PHIB based on incoming Expressions of Interest for projects.

3. Alliance Population Health and Inequalities Approaches

Reducing health inequalities is core to Alliance plans and delivery. A summary of the priorities and work being undertaken is detailed below.

Priorities and work being undertaken by each Alliance
Basildon and Brentwood Alliance A Health Inequalities Group is in place to oversee health inequalities interventions supported by the data provided in PCN health inequalities packs. The focus is on improving uptake of cancer screening, smoking cessation and weight management services. The Alliance is working with Sport for Confidence to support people with Learning Disabilities by undertaking co-productive workshops to design more accessible services and enable informed decisions about cancer screenings and vaccinations. Wellbeing cafes are being implemented across six PCNs in collaboration with motivated minds and Achieve Thrive Flourish. The public are being engaged in work to design interventions and support and working with voluntary and statutory services to offer specific support and educational talks.
Mid Essex Alliance Leadership and governance arrangements for health inequalities are being put in place. The Alliance is utilising the Thriving Places index to provide a framework to identify a clear plan and share interventions and allocation of resources.

Priorities and work being undertaken by each Alliance
There is a focus on population interventions, including health checks, Colne Valley Low Carb Programme, weight management services, sensory wellbeing specialist service and roll out of MSE wide initiatives. The Alliance is continuing to implement and evaluate HI funding initiatives for 2022/23 and work with C360 as trusted partner to support priorities for 2023/24 funding.
South East Essex (SEE) Alliance A formal subgroup of the SEE Alliance Committee, the SEE Health Inequalities and Population Health Management Group, was established in December 2021. It leads strategies for reducing health inequalities and population health management, identifies priorities including for HI funding, and responds and contributes to the plans developed by local Health and Wellbeing Boards and the MSE Integrated Care Partnership (ICP). PCN HI Leads Network is developing projects and interventions to target and deliver services to identified cohorts of residents which are both preventive/proactive and reactive. Current Priorities are: • Mental health & wellbeing, incorporating supporting long term independence; Aging Well; unpaid carers and autism. • Weight management, physical activity & obesity. • Alcohol & substance misuse. • Supporting long term independence incorporating social prescribing and loneliness and self-care community resilience. • Health inequity and wider determinants of health incorporating: the food environment and food poverty, homelessness and accommodation (decent, affordable, stable).
Thurrock Alliance The Thurrock Steering Group meets quarterly to review the population health and health inequalities action plan that takes recommendations from Health and Wellbeing Strategy, Joint Strategic Needs Assessments (JSNA) and public health reports. **The current focus is on:** • Obesity &Weight Management • NHS Health Checks • Hypertension • Substance misuse • Tobacco control • Case Finding/ detection • Long Term Condition Management • Cardiovascular disease • Primary Care Access and Quality • Access to health services – vulnerable groups • Mental Health

4. Governance

The PHIB meets monthly and receives programme updates regarding health inequalities, population health management, prevention, personalised care and

anchor programme. Its work plan also includes thematic discussions such as community development and engagement and strategic financial approach.

A health inequalities dashboard has been scoped, reflecting the work undertaken on the previous MSE Healthcare Partnership outcomes framework; proposed NHSE HI assurance metrics and the Core20PLUS5 frameworks. The dashboard is currently being reviewed by Arden GEM, the ICB's Business Intelligence provider to confirm a timetable for production.

The ICB Health Inequalities leads meet quarterly with the NHSE regional Health Inequalities Lead to discuss MSE's self-assessment maturity matrix. The quarter 2 assessment saw improvement in the areas of preventative programmes, leadership and hypertension case finding.

The PHIB programme updates have highlighted risks in relation to the ICB restructure which will impact on the organisation's capacity and focus to deliver in the short term, the fixed term nature of the prevention posts and the reduction in ICB capacity to lead and support personalised care programmes of work. As part of the ICB transition planning and the review of the PHIBs Terms of Reference the work programmes will be reviewed and opportunities taken to discuss with partners their respective leadership roles.

5. Recommendation(s)

The Integrated Care Partnership is asked to note the work across the ICP to reduce health inequalities for the population of mid and south Essex.

6. Appendices

Appendix A: Population Health Insights.

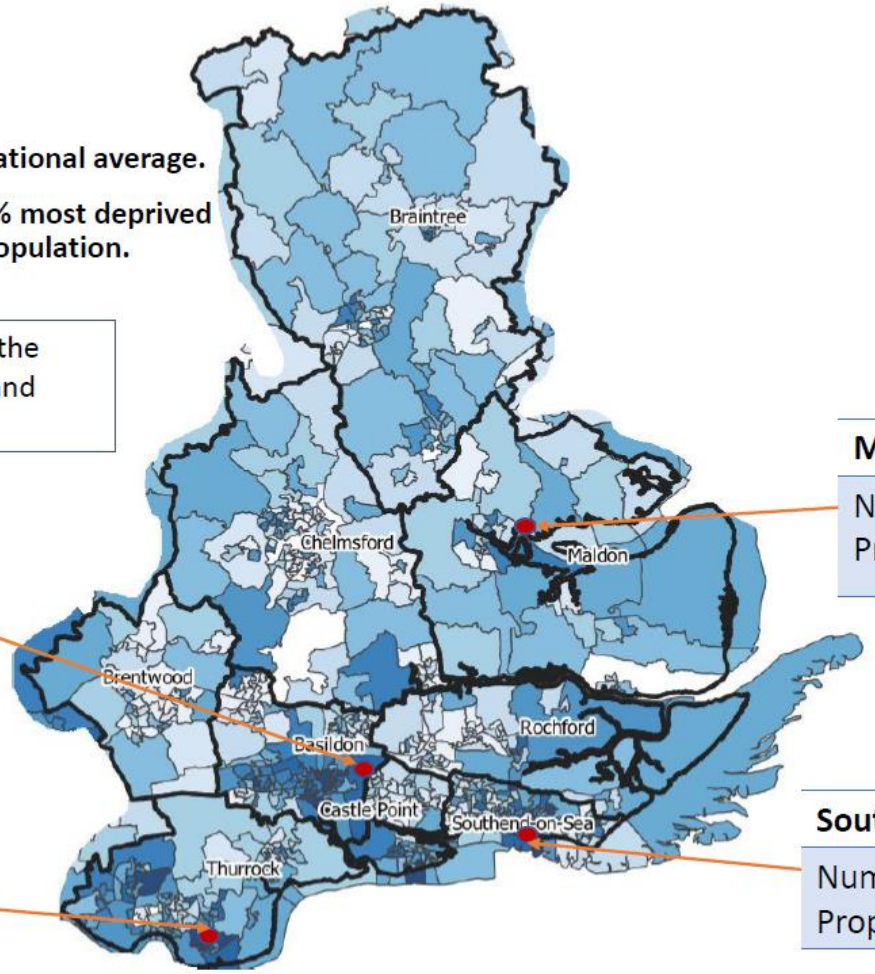
Appendix B: Core20PLUS5 frameworks (adults and children and young people).

Appendix A: Population Health insights

Deprivation in MSE

- **On average deprivation in MSE is lower than the national average.**
- **In MSE an estimated 133,000 people live in the 20% most deprived areas nationally. That is 10.5% of the whole MSE population.**

Each box describes the Alliance population living in the 20% most deprived areas nationally (total number and percentage of their population



Basildon and Brentwood

Number: 48,217
Proportion: 17%

Mid Essex

Number: 5,236
Proportion: 1%

Thurrock

Number: 21,271
Proportion: 11%

South East Essex

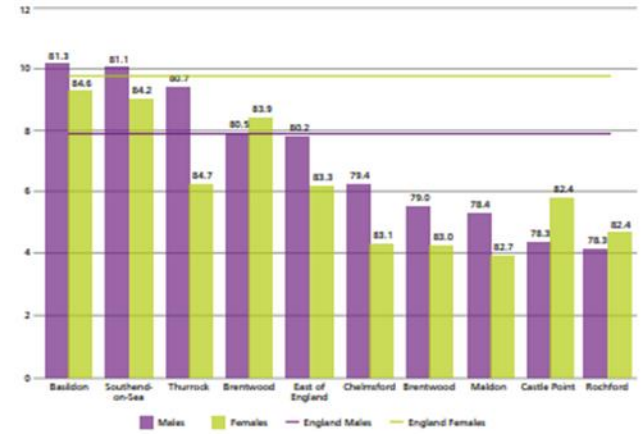
Number: 58,818
Proportion: 15%

Source: patient level deprivation decile 2019 (IMD), AGEM data warehouse, June 2023

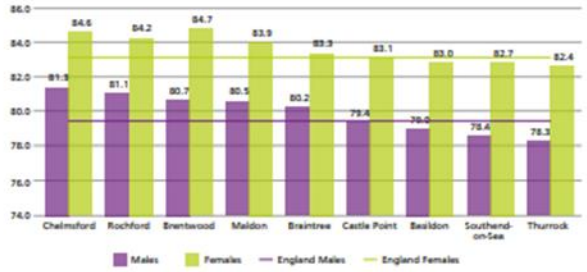
12

Consequences of Inequalities - Life Expectancy

Slope Index of Inequality (S11) in MSE by Sex



Life Expectancy at birth in MSE by Sex and Deprivation



Healthy Life Expectancy at Birth in MSE by Sex

Premature mortality attributable to socioeconomic inequality within MSE the three top contributors are:

- **Cancer**
- **Cardiovascular disease**
- **Respiratory disease (predominately COPD**

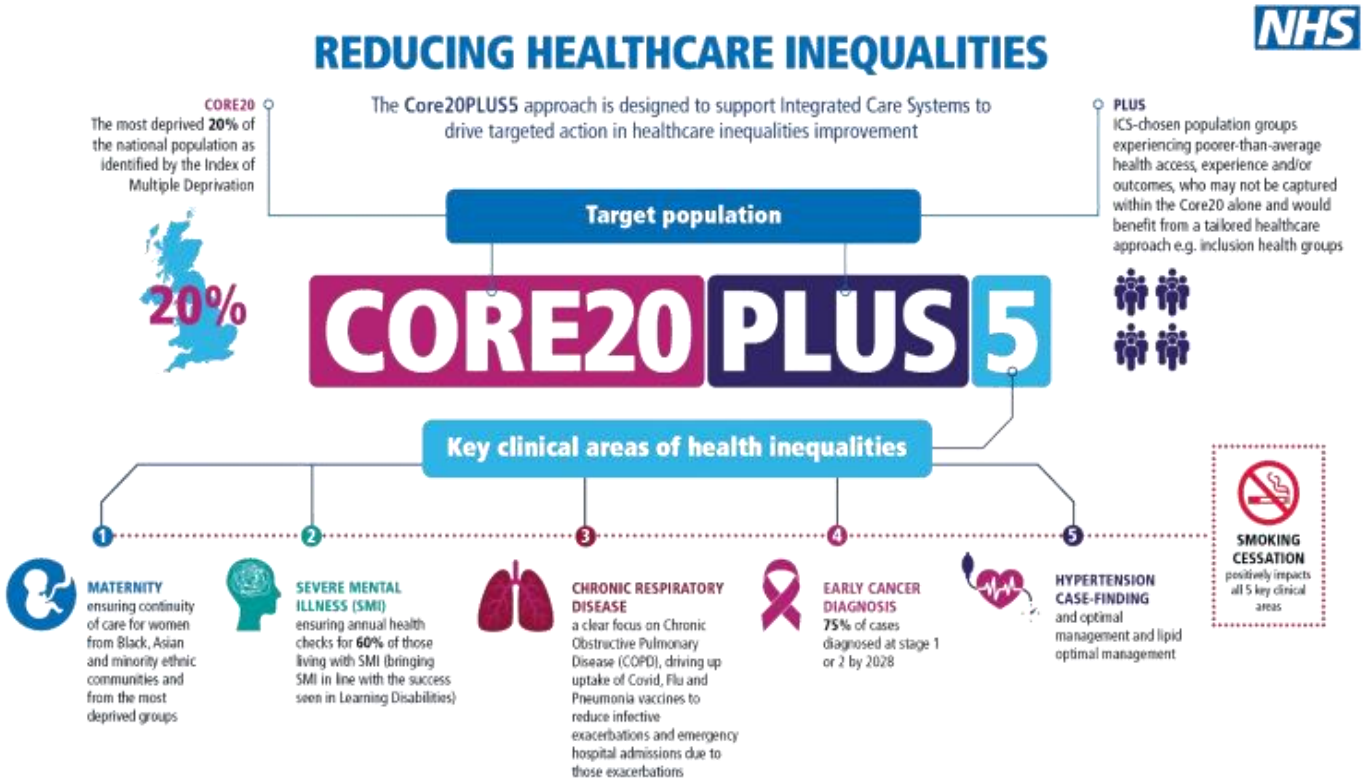
Global Burden of Disease Study identifies key cross-cutting risk factors. In MSE, the three with the greatest inpact are:

- Tobacco
- Blood Pressure
- Dietry Risks

These are the risk factors that will have the greatest impact on population health and health inequalities

Appendix B Core20PLUS5 frameworks

Adults



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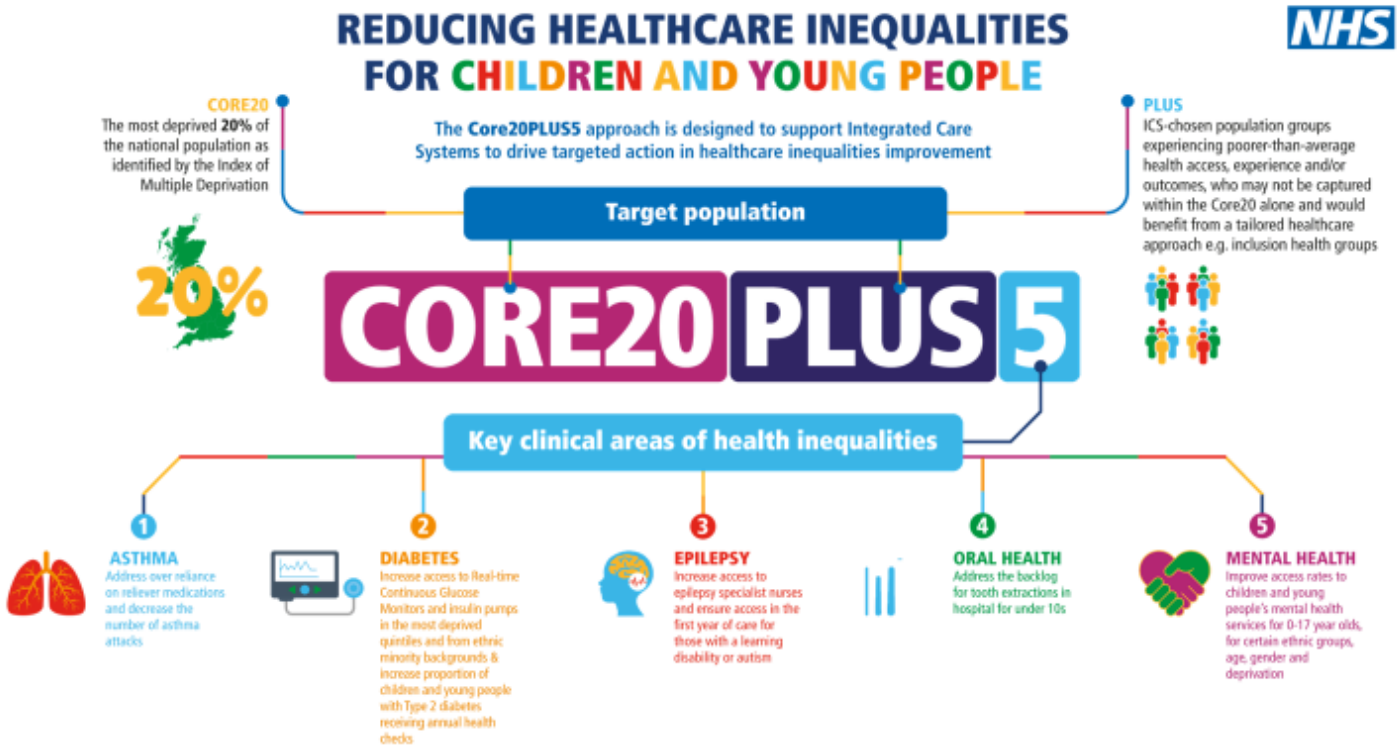


www.midandsouthessex.ics.nhs.uk

Mid and South Essex Integrated Care System

MSE Integrated Care Partnership, 6 December 2023

Agenda Number: 10

Tobacco Control and Smoking Cessation

Summary Report

1. Purpose of Report

To provide the Integrated Care Partnership (ICP) with an overview of the Tobacco Control and Smoking Cessation activity across the ICP.

2. Executive Lead

Dr Peter Scolding, Senior Responsible Officer, Mid and south Essex Integrated Care Board

3. Report Author

Kellianne Clark, Transformation Manager – Prevention, Mid and South Essex Integrated Care Board

The report was produced with input from Local Authority Public Health colleagues.

4. Responsible Committees

An update on tobacco control and smoking cessation was shared with the Population Health Improvement Board on 22 November 2023

5. Link to the ICP's Strategic Objectives

Common endeavour: Reducing Inequalities Together.

6. Financial Implications

Local Authority Public Health teams receive funding from the Government for local Stop Smoking Services in Essex, Southend, and Thurrock. They will also be receiving additional Section 31 grant funding following the Government announcement in October 2023.

The ICB receives Long Term Conditions funding for prevention, part of which is allocated to support delivery of inhouse maternity and inpatient acute and mental health smoking cessation services.

7. Details of patient or public engagement or consultation

The Local Authorities have undertaken public engagement with regard to youth vaping in Essex.

8. Conflicts of Interest

None identified.

9. Recommendation/s

The Integrated Care Partnership is asked to note the approach outlined to smoking cessation and tobacco control and:

- raise awareness of services provided locally and encourage professional and self-referrals to our services.
- endorse the recently proposed legislative change.
- share information from the paper that may be of interest to wider partners.

The consultation period for the proposed legislative changes concludes on 6 December 2023. However, partners are urged to continue lobbying and to support the legislation.

1. Impact of tobacco smoking in England and across Mid and South Essex

Tobacco is the single greatest entirely preventable cause of ill health, disability, and death in England, responsible for approximately 1,500 premature deaths a year across mid and south Essex ICB (MSE ICB). No other consumer product kills up to two-thirds of its users. Smoking increases the risk of stillbirth; can trigger asthma in children; is responsible for causing around 1 in 4 UK cancer deaths; is a major cause of premature heart disease, stroke and heart failure and increases the risk of dementia.

Smokers lose an average of ten years of life expectancy, or around one year for every four smoking years. It can also lead to people needing care and support a decade earlier than they would have otherwise, meaning many have a poorer quality of life. In addition, non-smokers can be exposed to second-hand smoke (passive smoking) which can lead to additional harm to them through no choice of their own - in particular children, pregnant women and their babies.

As a result, smoking puts significant pressure on health and care services. Almost every minute of every day someone is admitted to hospital because of smoking and up to 75,000 GP appointments could be attributed to smoking each month - equivalent to over 100 appointments every hour.

The most recent estimates suggest smoking has a societal cost of over £49 billion per year in England. This includes an annual £32 billion loss to productivity through smoking-related lost earnings, unemployment, and early death; as well as costs to the NHS and social care. Added costs involve how spending on tobacco reflects industry-level economic output, impacting on productivity. There are also extra expenses tied to informal care from friends and family plus unmet care needs, all contributing to social care costs.

Within MSE ICB, the total costs of smoking to society are £1.2 billion due to healthcare costs, lost productivity, social care costs and fires (**see Appendix 1**).

Those who are unemployed, on low incomes or living in areas of deprivation are far more likely to smoke than the general population. Smoking attributable mortality rates are 2.1 times higher in the most deprived local authorities than in the least deprived. In MSE there are many families pushed into poverty due to spending on tobacco, which totals around £2,500 a year for the average smoker (**see Appendix 2**).

Most smokers know about these risks and, because of them, want to quit - but the addictive nature of cigarettes means they cannot. Three-quarters of current smokers would never have started if they had the choice again and on average it takes around 30 quit attempts to succeed. The majority of smokers start in their youth and are then addicted for life. More than 4 in 5 smokers start before the age of 20. In short, it is much easier to prevent people from starting smoking in the first place. [1]

[1] Stopping the start: our new plan to create a smokefree generation - GOV.UK (www.gov.uk)

2. National commitments to a smoke free society

The UK Government is unwavering in its commitment to minimising tobacco-related harm. This dedication is evident in a series of recently introduced policies and initiatives, including:

- Increasing the legal age for tobacco purchases to 21.
- Enacting a smoking ban in public spaces.
- Initiating public awareness campaigns highlighting the health hazards of smoking.

To support this, the Government is consulting on proposals for new legislation which would raise the age of sale for tobacco, further regulate vaping to reduce its appeal to children, and would introduce new powers for local authorities to issue fixed penalty notices to enforce age of sale legislation for tobacco products and vapes.[2]

MSE is responding to the consultation in support of the Government action to reduce smoking (deadline for submissions is 6 December 2023). This aligns with public views within the East of England where 75% of adults in the East of England support the Government's ambition to reduce smoking prevalence by 2030 to 5% or less (fewer that 1 in 20 people) with just 7% opposed. 77% of adults support Government action to limit smoking or think government should do more.

The government has also committed to funding several initiatives to improve smoking cessation support, including an additional £70 million annually to support local authority led stop smoking services and £45 million over two years to roll out the national 'Swap to Stop' scheme, supporting people to stop smoking with the free provision of a vape kit and behavioural support.

NHS England's Long Term Plan also set out ambitions for a smokefree society by 2030. Key strategies to support this include:

- Expanding Stop Smoking Services (SSS) access, targeting vulnerable groups like pregnant women and those in deprived areas.
- Increasing availability of effective nicotine replacement therapy (NRT) products.
- Promoting e-cigarettes as a harm reduction tool for smokers unable or unwilling to quit completely.

Regionally the Associate Directors of Public Health (ADPH) across the East of England have set out a position statement on vaping (appendix 3) that reaffirms the government's commitment to protecting children and young people from the harms of vaping. The statement outlines a comprehensive plan to address youth vaping, including:

- Shifting social norms
- Reducing access to vape products
- Tightening e-cigarette regulations
- Supporting smokers to quit

[2] Creating a smokefree generation and tackling youth vaping - GOV.UK (www.gov.uk)

The Essex Youth Vaping report and the Southend Youth Vaping reports provide valuable insights into the prevalence and trends of youth vaping in these areas.[3,4]

3. Action to support a smoke free Mid & South Essex

In line with the national and regional efforts, Southend, Essex and Thurrock (SET) are implementing a comprehensive tobacco control strategy to achieve a smoke-free environment by 2030.

Work underway across MSE to support delivery of this ambitious work includes:

- **Tobacco control and vaping networks** to coordinate efforts in education, cessation support and the enforcement of underage sales restrictions including:
    - Office of Health and Disparities, East of England (EoE) Network.
    - Southend, Essex & Thurrock (SET) County Vaping Group.
    - Essex Wide Tobacco Network
    - Smokefree Generation Focus Group (EoE).
    - MSE Southend Midwife Network (now working with Everyone Health Midwife).
    - MSE Hospital Manager – Smoking Cessation Workers (Southend, Basildon & Broomfield hospital sites)
    - ICB Treating Tobacco Dependency Steering Group.

- A focus on **preventing youth uptake of smoking and vaping** across all three local authorities via active engagement through the Youth Vaping Survey. The results of the survey are informing work to reduce current usage and prevent uptake among Children and Young People in SET. This work will be supported by strategies relating to:
    - Youth Council concerns.
    - School workshops around smoking/vaping.
    - Youth Vaping toolkit.
    - Youth support to stop vaping..
    - Local authorities' (LA) Trading Standards test purchasing..
    - Youth Council involvement in test purchase operations (underage sales and illicit vapes).
    - Reporting of and seizure of illicit tobacco and vapes.

- Sharing **public health messages** that recognise that vapes continue to play an important part in smoking cessation for adult smokers building on the messaging from the Chief Medical Officer for England (2023): "If you smoke, vaping is much safer; If you don't smoke, don't vape; Marketing vapes to children is utterly unacceptable."

[3] Essex youth vaping survey: https://data.essex.gov.uk/dataset/24qw8/essex-youth-vaping
[4] Southend Youth Vaping Survey: SmartSouthend: https://youth-vaping-southend.hub.arcgis.com/

- Action to support smoking cessation in NHS patients, supported by targeted national investment from NHS England:

    - Development of a **smoke-free pregnancy pathway** has been developed for expectant mothers and their partners, offering focused behaviour change sessions and treatments.

    - Work to ensure all people who smoke and are admitted to an acute hospital bed receive NHS-funded tobacco treatment services including a Healthy Hospital Manager to lead the delivery of **smoking cessation services for acute inpatients**, staff training and improved data reporting on services.

    - Planning a universal smoking cessation program for **long-term users of specialist mental health inpatient services and learning disability services**, with the option to switch to e-cigarettes in inpatient settings. A shared approach is being considered across all three ICBs in Essex.

Additional work across local authorities include:

- **Essex County Council (ECC):**
    - Supporting Primary Care Networks with case finding to identify patients that smoke to increase smoking cessation uptake, create and tailor specific approaches of working with GP surgeries to increase smoking cessation uptake based on practice smoking population.
    - Essex Wellbeing Service (EWS) are continuing to provide new and updated Very Brief Advice (VBA) Training to staff in Primary Care so they know where patients can be referred to for support.
    - Offering targeted, evidence-based interventions for disadvantaged communities including rough sleepers across Essex day centres, with plans to extend to those living on the streets who are marginalised from other health services.
    - Essex County Fire and Rescue Service are working with EWS to ensure clients are offered smoking cessation support, including onward referral into EWS, as part of the safe and well home visits.
    - EWS are working with Estuary Social Housing provider to deliver a smoke free homes pilot project to be launched January/February 2024.
    - A new referral pathway has been developed to support the NHS Targeted Lung Health Check (TLHC) team in MSE so that they can refer patients to EWS after they have received their TLHC. This includes providing onsite smoking cessation assessment/clinic on the same day by a trained EWS smoking advisor.

- **Southend:**
    - Youth survey outcomes shared in the public domain.
    - Family Nurse Partnership 2022-2023 Maternity E-cig Financial Incentive Scheme (pilot for mothers & partners to receive financial incentive upon smoking quit) outcome to be shared 2024.

- We are looking to provide an online NRT and Vape offer but not via Swap to Stop.
- As part of the NHS Long Term Plan, we will continue to enhance our support towards smokers who are in the following cohorts:
  1. Routine & Manual Workers (1 in 4 smoke).
  2. Maternity (as part of mid and south Essex offer).
  3. Mental ill health.

- **Thurrock**
  - Increasing use of opt-out approach to stop smoking referrals so residents/patients are automatically referred to stop smoking services unless they opt out.
  - Support to Maternity smoking cessation pathway working with the new Basildon Maternity Team to shadow LA stop smoking service and build a stronger link with the maternity unit and enable partnership working on recruiting pregnant smokers who are not engaging.
  - Published a Tobacco Control Strategy, with a delivery plan for the strategy due for publication in the new year.
  - E-Cigarette offer available as part of the Thurrock Healthy Lifestyles stop smoking offer.
  - Stop Smoking presence within Family Hubs.
  - Thurrock now have a presence in the Basildon Mental Health unit within 'The Hub' which brings services and agencies together in a specific part of the hospital who can support patients and patient families. There is being supported by improved referral pathways.

4. Next steps

In addition to the programmes of work outlined above, we will continue to work collaboratively across the ICS on delivering the national aim of 'Smoke Free 2030'.

We will continue, through coordinated partnership-working, to develop a work plan regarding vaping control for children through the 'Essex Southend & Thurrock (EST) Youth Vaping Working Group.

We will work together to review the best use of discretionary NHS funding in 2024, such as the Government's Section 31 grant, to help deliver the smokefree ambition for England 2030. Areas of interest include:

- Staff stop smoking services.
- Embedding tobacco dependence services (TDT) in community mental health or talking therapies.
- Embedding TDT in emergency departments.
- Targeted Lung Health checks.
- Social Housing providers.
- Essex homelessness and rough sleepers.

We will review the outcomes of joint efforts to ensure access to nicotine replacement therapy for those on the Maternity pathway in Essex and Thurrock and will aim to develop consensus over a longer-term funding mechanism.

MSE ICB will support Mid and South Essex Hospitals NHS Foundation Trust, via investing NHS Long Term Plan funding in the QuitManager data collection tool, to record smoking cessation activity within the three hospital sites. This investment aims to improve data collection and ensure we are compliant with reporting requirements to NHS England. The software will also enable a more efficient referral system to our Local Authority Stop Smoking Services and help to capture data on population and system value.

Finally, we will continue the roll out of the smoking cessation programme for mental health inpatients.

5. Recommendation(s)

The Integrated Care Partnership is asked to note the approach outlined to smoking cessation and tobacco control and:

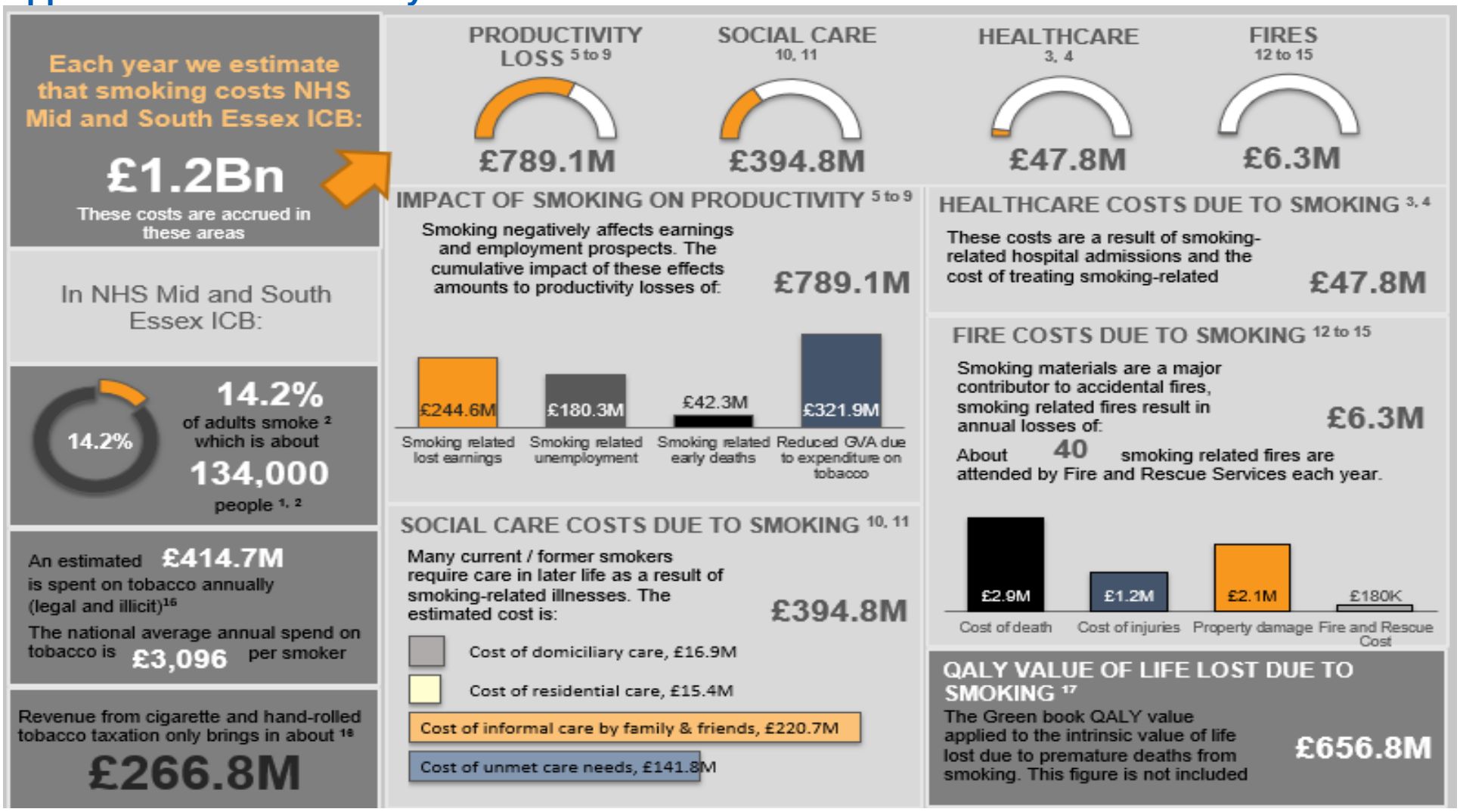
- Raise awareness of services provided locally and encourage professional and self-referrals to our services.
- Endorse the recently proposed legislative change.
- Share information from the paper that may be of interest to wider partners.

The consultation period for the proposed legislative changes concludes on 6 December 2023. However, partners are urged to continue lobbying and to support the legislation.

6. Appendices

1. ASH ICB Ready Reckoner 2023.
2. Core20PLUS5 data for MSE ICB.
3. East of England Position Statement on Vaping (separate document).
4. ECC Position Statement on Tobacco. .

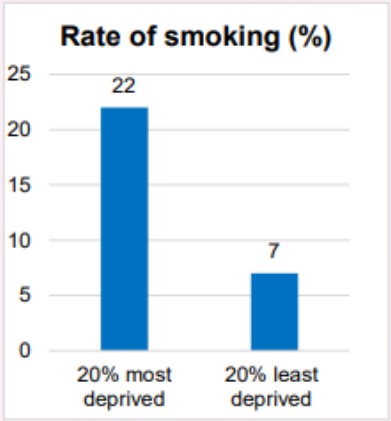
Appendix 1 ASH ICB Ready Reckoner



Infographic showing the impact of smoking across the ICP - Produced by Action on Smoking and Health (ASH) ASH ICB Ready Reckoner

Appendix 2 Core20PLUS5 data for MSE ICB

Core20: Above-average smoking rates among the most deprived reduces their healthy life expectancy and increases pressure on the NHS



In England a third of all smokers live in the most deprived two deciles.[1] In NHS Mid and South Essex ICB there are 109,000 smokers and 24% of people in routine and manual occupations smoke. Smoking costs your ICB £38.7m a year.[2]

Annually in your ICB smoking causes:

- 9,410 hospital admissions.[3]
- 1,469 premature deaths.[4]

Additional impact on communities in your ICB:

- 53,757 smoking households live in poverty.[5]
- 3,381 people out of work due to smoking.[6]
- 22,439 people receive informal care from friends and family because of smoking.[7]

PLUS: The most deprived groups have the highest smoking rates

National smoking rates among:

- People who are homeless (77%).[8]
- People entering prison (80%).[9]
- 11–16-year-olds with a mental disorder (22%).[10]
- People in social housing (26%).[11]

Smoking rates for those receiving addiction treatment in your ICB:

- Those receiving treatment for opioid addiction (69%).[12]
- Those receiving treatment for alcohol addiction (46%).[13]

5: Five clinical areas of focus are all impacted by smoking

1. Maternity	2. Severe Mental Illness	3. Chronic respiratory illness	4. Early cancer diagnosis	5. Hypertension
Smoking is the leading modifiable risk factor for poor birth outcomes. In your ICB 8%[14] of women smoke at time of delivery, 912 women annually.[15]	Smoking is the leading cause of the 10-20 year reduction in life expectancy for people with serious mental illness (SMI). In your ICB 42% of people with SMI smoke.[16]	Around 86% of all chronic obstructive pulmonary disease (COPD) deaths are caused by smoking. In your ICB 491 people a year die from COPD.[17]	Smoking is the leading preventable cause of cancer responsible for 27% of cancer deaths. In your ICB 653 people a year die from cancer caused by smoking.[18]	Smoking cessation is embedded in NICE guidelines on hypertension because smokers' CVD risk is double that of non-smokers. Nationally 9,300 people a year die from CVD caused by smoking.[19]

Infographic showing the Core20PLUS5 data for MSE ICB (Produced by ASH)

Appendix 4 Essex County Council Position Statement on Tobacco

Lucy Wightman, Director of Wellbeing, Public Health & Communities – October 2023

Background

Smoking is the UK's biggest preventable killer – causing around one in four cancer deaths and contributing to 64,000 wider smoking-related deaths per year in England. It puts huge pressure on the NHS (with almost one hospital admission every minute attributable to smoking and up to 75,000 GP appointments each month taken up by smoking-related illness) which in turn increases Adult Social Care and other Local Authority service demand. It is also one of the biggest drivers of health inequalities across the country – deaths from smoking are more than two times higher in the most deprived local authority areas, where more people smoke, compared to the most affluent.

Essex has a robust approach to tobacco control to ensure that smoking prevalence continues to decline and we aim for our County to become smoke free by 2030. We have in place wider Essex networks for both tobacco control and vaping that help coordinate our actions for education, support people to quit and ensure enforcement of underage sales and seizures of illicit tobacco. In 2022 13.2% of the adult population in Essex were smokers and the districts with the highest prevalence were Basildon, Braintree and Harlow, all of which are above the national, regional and Essex levels. The estimated cost of smoking to the wider Essex system is £375m pa. (Ref: https://ash.org.uk/resources/view/ash-ready-reckoner)

As announced at the Conservative Party Conference 2023, the government is considering the introduction of a historic law to stop children who turn 14 this year or younger from ever legally being sold cigarettes in England, in a bid to create the first 'smokefree generation'. It is being billed as one of the most significant public health interventions in a generation, saving tens of thousands of lives and saving the health and social care system billions of pounds. Further investment will also be provided to systems, via the ring-fenced PH grant from 2024/25 onward, to double capacity in smoking cessation services, as well as dedicated funding to increase advertising for the services and for Trading Standards to undertake enforcement work.

New National Policy Position

Summary of the Governments proposal to address the harms caused by smoking and to curb the rise in youth vaping: Stopping the start: our new plan to create a smokefree generation - GOV.UK (www.gov.uk). Main proposals are:

1. ***We will create the first smoke-free generation*** *so children turning fourteen or younger this year will never be able to be legally sold cigarettes. This will mean effectively raising the age of sale by one year each year for this generation (born on or after 1 January 2009) to prevent them and future generations from ever taking up smoking in the first place, as there is no safe age to smoke*.

   This proposal would support ECC's current work in preventing young people taking up smoking and thus reducing smoking prevalence over time.

2. ***We will support people to quit smoking,*** *by more than doubling the funding available (to around £138 million) for local stop smoking services to support a total of around 360,000*

people a year to quit smoking. We will also be providing an additional £5 million this year and then £15 million a year thereafter to fund national tobacco marketing campaigns to explain the changes, the benefits of quitting and support available.

This proposal would in effect more than double the funding for stop smoking support services in Essex, with an additional annual investment of £1.95m. It could allow the trialling of new approaches in supporting residents to quit tobacco as well as enhanced projects within the NHS (e.g. acute, maternity and mental health services). We have concerns around smoking rates in our routine and manual workforce and, whilst we have had some recent notable success in reducing maternal smoking rates in Essex below the national ambition of 6%, it remains an area of important focus The magnitude of this additional funding would require additional insight to ensure optimum investment.

3. ***We will curb the rise in youth vaping*** *by consulting on measures to reduce the appeal and availability of vapes to children – striking a balance with ensuring vapes are available for adults to help them quit smoking.*

   This proposal will support our current work around youth vaping and appropriate adult vaping to quit tobacco.

4. ***We will strengthen enforcement activity,*** *through new funding (£30 million a year), new powers to fine rogue retailers on the spot who sell tobacco products or vapes to people underage, action to track down illicit tobacco and vaping products, and take further steps to enhance online age verification so that age of sale law is enforced across both online and face-to-face sales.*

   It is yet unclear on the amount of funding available to Essex County Council Trading Standards for enforcement activity and how the proposed £30m will be divided nationally amongst Border Force and HMRC, nor if the amount of funding will be sufficient to have an effect at retail level. The proposal of issuing on the spot fines is seen as a positive move that may help offset some of the additional activity.

Confirmation of PLT Position

In order for the proposed legislation and policy position to be progressed, the Chief Medical Officer is requesting local support. As the Director of Public Health for Essex I therefore need to establish how the political leadership of ECC wish to be associated with the proposals, specifically:

1. Are Cabinet happy to endorse the PMs position on increasing the purchase age of tobacco by one year every year to ensure we become a smoke-free nation?
2. If not, to note that I will provide an independent position statement into Government using a range of channels as a Public Health professional.
3. Are Cabinet happy for an approach to be made to key system partners seeking support of these proposals on behalf of ECC (e.g. provide briefing note and template letter/response for use in the national consultation and any other communications they wish to make)?
4. If not, to note that I will undertake this action independently as DPH, seeking endorsement from partners.

Additional Info

https://www.essexwellbeingservice.co.uk/services/stop-smoking

ADPH
East of England

NICOTINE VAPING POSITION STATEMENT

ADPH East of England

The Association of Directors of Public Health East of England (ADPH EoE) is the East of England regional arm of the representative body for Directors of Public Health in the UK.

This position statement on nicotine vaping should be read in conjunction with the ASH briefings and guidance for local authorities and schools and the ADPH position statement on tobacco. It has been developed following publication of Stopping the start; our new plan to create a smokefree generation, the Nicotine vaping in England 2022 evidence update, and the Chief Medical Officer for England's statement on vaping.

With thanks to the Association of Directors of Public Health North East for allowing us to adopt their position statement on nicotine vaping and to Essex County Council and the Office for Health Improvement and Disparities for their support in the development of this document.

"If you smoke, vaping is much safer; If you don't smoke, don't vape; Marketing vapes to children is utterly unacceptable." Chief Medical Officer (CMO) for England (2023)

Please note that for the purposes of this document, any references to vapes, vaping or e-cigarettes relate to nicotine-containing vapes, nicotine vaping and nicotine-containing e-cigarettes that comply with UK regulations.

OUR POSITION ON NICOTINE VAPING

- Tobacco remains the single biggest cause of preventable illness and death worldwide (WHO, 2023) with over 7,000 people in the East of England dying each year from smoking-related disease (OHID, 2023). Smoking tobacco is also a significant driver of health inequalities (ASH, 2019). Our priority for tobacco control is to reduce the number of people who smoke a known uniquely lethal product.

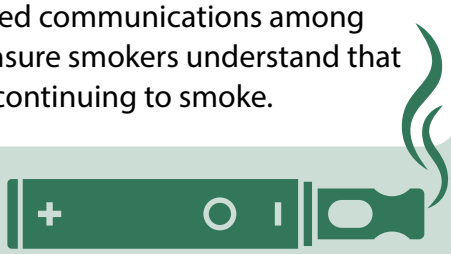
- The evidence is clear that, for smokers, vaping is a much less harmful option, and in the short and medium term, vaping poses a small fraction of the risks of smoking (GOV.UK, 2022). We must ensure that vaping is an affordable and accessible alternative for smokers who want to reduce their risk of dying from a smoking-related disease.

- We support the Government's plan to create a smokefree generation (GOV.UK, 2023). This plan critically identifies the important role vapes play in helping adult smokers to stop smoking.

- At the same time, we recognise that vaping is not risk-free (GOV.UK, 2022) and therefore vaping must be presented as an alternative to, or replacement for smoking, not a recreational activity which is appealing to the wider non-smoking population.

- Vaping is not for children and marketing vapes to children is utterly unacceptable (CMO, 2023). Whilst vaping can help people to quit smoking, those who don't smoke should not vape. We will shift the social norms for children and young people away from vaping, reduce the number of young people accessing vape products and the amount of non-compliant products available for sale. We will work closely with our Trading Standards colleagues to support compliance with regulations and to take enforcement action when necessary. We will also continue to advocate for tighter e-cigarette regulations where needed, ensuring the right balance is taken around protecting young people and supporting smokers to quit.

- The number of adults who now incorrectly believe e-cigarettes are as, or more harmful than cigarettes has increased (ASH, 2023). "Anxiety over youth vaping is obscuring the fact that switching from smoking will be much better for an individual's health. We must not be complacent about youth vaping and further regulation is needed, but so too is work to ensure more adults stop smoking and vaping is an effective means of doing that." (McNeill cited in ASH, 2023). We therefore support the delivery of evidence-based communications among stakeholders and the public to widen understanding and to ensure smokers understand that switching to vaping is a significantly less harmful option than continuing to smoke.



THE PROBLEM WITH SMOKING

Tobacco smoking is our biggest killer and a key contributor to avoidable health inequalities. Cigarettes are the only legal consumer product that, when used exactly as the manufacturer intends them to be used, will kill up to two thirds of long-term consumers (Khan, 2023).

Tobacco and vapes both contain nicotine, which is an addictive substance, but nicotine itself has been used safely for many years in medicines to help people stop smoking. However, tobacco and the smoke it produces, contains a toxic mix of over 6,000 chemicals, many of which are known to cause cancer as well as other fatal and life limiting conditions such as respiratory and cardiovascular disease, not just among smokers but also among those who are exposed to second-hand smoke.

Tobacco smoking is our biggest killer and a key contributor to avoidable health inequalities.

13.2% of adults in the East of England smoke (ONS, 2022). Whilst this is in line with the national average of 12.9% (ONS, 2022) an inequalities gap remains within the region. For example, the smoking rate among routine and manual workers is 23.9% (ONS, 2022). This results in a significantly negative impact on income as well as employment due to ill health and disability. The economic costs of smoking to the region due to lost earnings are £1.4bn per annum (ASH, 2023).

Amongst those with mental health conditions, the smoking rate is 23.7%, increasing to 39% (OHID, 2023) for those with serious mental illness. Those with serious mental illness are five times more likely to die before the age of 75 than the general population (GOV.UK, 2023) and smoking is the largest preventable cause of this inequality (Peckham et al, 2016). Smoking is also the leading cause of poor birth outcomes, yet 8.5% (OHID, 2023) of women in the East of England smoke at the time of delivery. Overall smoking costs the East of England approximately £1.8bn each year, with almost £205 million of this spent on health care and £128.4 million on social care (ASH, 2023).

Smoking damages and cuts short lives in extraordinary numbers. It causes disability and death throughout the life course (GOV.UK, 2023).

THE EVIDENCE BASE ON VAPING

The most robust evidence on nicotine vaping is contained within the Nicotine Vaping in England: 2022 evidence update (GOV.UK, 2022). The report is the most comprehensive to date, its focus being a systematic review of the evidence on the health risks of nicotine vaping. Based on the evidence within the review, a summary of conclusions is that:

- In the short and medium term, vaping poses a small fraction of the risks of smoking, but vaping is not risk-free, particularly for people who have never smoked.
- There is significantly lower exposure to harmful substances from vaping compared with smoking, as shown by biomarkers associated with the risk of cancer, respiratory and cardiovascular conditions. However, there is similar or higher exposure to harmful substances from vaping compared with not using any nicotine products.
- There is no significant increase of toxicant biomarkers after short-term second-hand exposure to vaping among people who do not smoke or vape.
- Exposure to second-hand tobacco smoke is dangerous. Compared with cigarettes, vaping products themselves produce little or no side-stream emissions and in households where tobacco smoking occurs, vapes offers a much safer alternative for non-smokers.

In the short and medium term, vaping poses a small fraction of the risks of smoking, but vaping is not risk-free particularly for people who have never smoked.

THE ROLE OF VAPING IN HELPING SMOKERS TO QUIT TOBACCO

Vapes are the most popular quitting aid in England and are up to twice as effective as available licensed nicotine replacement therapy. The Cochrane living systematic review on electronic cigarettes for smoking cessation (Hartmann-Boyce et al, 2022) shows that vaping is effective at stopping people smoking.

NICE recommends that smokers are encouraged to vape in their quit attempt (NICE, 2023). However, the majority who use them are doing so without behavioural support: quit rates will increase if behavioural support is provided alongside switching to vaping.

E-CIGARETTE REGULATION

E-cigarettes are regulated in the UK through legislation relating to quality, safety, age of sale and advertising.

Enforcement of laws on underage sales, sales of illegal products, and point of sale advertising is the responsibility of Trading Standards. Enforcement of other advertising and promotion of vaping to under-18s, for example on social media, is the responsibility of the Advertising Standards Authority.

However, there are concerns about the attractiveness of some vapes to children, that a proportion of retailers are selling to under 18s, and that products that don't comply with UK rules are easily accessed. In 'Stopping the Start: Our new plan to create a smokefree generation' the Government outlines proposals to tackle these issues. The plan commits to having the biggest impact possible on reducing youth vaping whilst ensuring that vapes continue to be available to adult smokers to help them stop smoking.

Vaping is not harm free.

We must not be complacent about youth vaping.

Marketing vapes to children is utterly unacceptable.

(CMO for England, 2023)

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Mid and South Essex Integrated Care System

NHS Mid and South Essex Integrated Care Board

MSE Integrated Care Partnership, 6 December 2023

Agenda Number: 11

Partnership Working Together to Better Manage System Pressures.

Summary Report

1. Purpose of Report

To provide the Mid and South Essex (MSE) Integrated Care Partnership (ICP) with an overview of system partnership working to mitigate system pressures.

2. Executive Lead

Pam Green**,** Alliance Director, Basildon and Brentwood, MSE ICB

3. Report Author

Various System Partners

4. Responsible Committees

Integrated Care Partnership

5. Link to the ICP's Strategic Objectives

Common Endeavour - Improving and Transforming our Services

6. Financial Implications

Any financial implications linked to the programmes of worked included within this report have been through the appropriate governance routes.

7. Details of patient or public engagement or consultation

Not applicable to this report.

8. Conflicts of Interest

None identified.

9. Recommendation/s

The Integrated Care Partnership is asked to note the report.

Partnerships Working Together to Better Manage System Pressures.

1. Introduction

The partners in MSE ICP recognise the role of equal partnership working as being the basis on which to build ongoing joint positive working relationships across NHS, local authorities and the voluntary community, faith and social enterprise (VCFSE) sector under the ICP leadership model.

We use a collective model of decision-making that seeks to find consensus between system partners, working through difficult issues where necessary.

We work together to ensure transparency and local accountability and champion co-production and inclusiveness in all of our joint workstreams aligned to the ICP Strategy and Joint Forward Plan (JFP).

Our work at ICP level, within the ICS, Alliances and workstreams, supports us to collectively understand our system and organisational pressures.

This report highlights how we have come together to support the system with a collective direction of travel to support our residents to have accessible, timely services and to plan for seasonal pressures.

It is also timely to celebrate successes together in the development of new services that support our aims and reduce service pressures, such as the Mental Health Emergency Department (ED), Unscheduled Care Coordination Hub, maturing virtual wards and the development of Transfer of Care Hubs (TOCH) and Integrated Neighbourhood Teams (INTs).

2. Main content of Report

The key to partnership working to reduce system pressures is supporting people in the community to keep them well, in both social care and health contexts, to avoid acute hospital admission, either for preventable physical health escalations or for urgent mental health needs and supporting timely step down to community care.

It is important to acknowledge that a significant number of residents will access community services from either a local authority, formal or informal support from the voluntary and faith sector or via primary care services, than will require an acute hospital stay in the same time period, yet we often focus on the pressures on acute services.

Working in partnership to focus on the community aspects of our work are equally as important for longer term resident wellbeing.

This overview highlights both community- and acute based partnership working but is not an exhaustive list of work within our system.

How we work together

We have several forums and partnership groups that support us to undertake the overview of system pressures and mitigate these, including:

- Our Alliances work across system partners to achieve collaborative local solutions, often with a community focus.
- The System Co-ordination Centre (SCC), an established partnership group within MSE, holds daily tactical calls to ensure that the System is aware of pressures and how partners can support flow across all services - this is informed by SHREWD, a cloud-based application that enables the whole health and social care system to access real-time data to identify areas of pressure quickly.
- The SCC works across the system with the Director who chairs the System Urgent Emergency Care Improvement & Transformation Board to review plans informed by the actual situation.
- MSE (Health) Chief Executive Officer Forum identified three key workstreams, Independence, Flow and Workforce. The flow workstream oversees programs instrumental to delivery of system working and shared delivery, including Intermediate Care, Virtual Ward & Discharge, Pathways and TOCH.
- System Oversight Assurance Committee (SOAC) is a main committee of the Integrated Care Board and maintains oversight of delivery versus commitment to ensure any risks can be mitigated and understood by the system.

Our communication Strategy

We have a clear and system supported Communication Strategy to support public and partners to stay ‘winter strong’, the aims of which are:

- To reach and involve key system audiences in the development of winter plans to ensure provision of safe and high-quality care.
- To equip people in MSE to take proactive measures to protect and improve their health and wellbeing this winter.
- Drive engagement towards resources available at Do Your Bit Essex, aiming to prevent minor health issues becoming severe problems and signpost people to community support.

The accompanying PowerPoint presentation provides information on several key work streams and initiatives undertaken in partnership to mitigate organisational and system pressure during the winter and longer-term. Some key headlines are:

Transfer of Care Hubs (TOCH)

The TOCHs form part of the MSE ICS system partnership response. This work fully involves Healthwatch, voluntary sector partners and stakeholders from all local authority providers. As part of winter 2023 planning all local authorities have been instrumental in supporting TOCHs “to support person effective centred discharges including complex care, housing cases and admission avoidance”.

The System Co-ordination Centre, via SHREWD reporting, receives operational performance by pathway that is utilised by TOCHs to determine their area of focus. Each TOCH will facilitate ‘pull’ from the acute hospital into community pathways, including the emerging INTs, as well as hospital admission avoidance, which will incorporate closer working with the Primary Care Networks (PCN).

Our community collaborative teams are taking a significant leadership role in the development of TOCHs, wrapping around the existing Integrated Discharge Teams at the acute Trust, alongside adult social care and partners.

Integrated Neighbourhood Teams (INTs)

INTs are multidisciplinary teams that collaborate with the TOCHs and utilise the expertise of community services to deliver comprehensive and coordinated care within the community. They play an integral role in admission avoidance pathways such as Urgent Community Response Team (UCRT) and virtual wards. By linking community services in resident support, they make the most of partnership working to avoid duplication. They also focus on understanding user experience outcomes linked to services and use this learning to improve services. Our INTs are maturing across the system.

Voluntary Sector Partnerships

Our voluntary sector partners working with the Voluntary Community Assembly have several support pathways in place to support residents across MSE.

These include as examples:

- Supported outreach clinics for vulnerable groups to access flu and COVID immunisations.
- Providing support to anyone at risk of the cold across localities. This could be via supply of food vouchers and parcels, fuel support (via linked Citizens' Advice services), purchase of white goods or cooking equipment, or help with warm clothing. Linking with the Essex County Council (ECC) housing support fund as needed.
- Teams will also be running a series of 'Welcome Hubs' across the district throughout winter for people to access support from the local community and voluntary sector (CVS) teams and from a range of community hubs. Attendees will also get warm refreshments.
- Support to the rough sleeping community and those with substance misuse support needs.
- Tenancy support (Peabody)
- Warm homes advice.

Community hub and VCSE support to the TOCH via CVS hubs and/or social prescribing offers linked to the locality TOCHs are an important part of the VCSFE offer to residents.

Local Authority Partnership Working

All three local authorities have led the way in best practice examples of partnership working and collaborative commissioning approaches, including but not limited to the 'Wellbeing Teams' model and 'Thurrock First' in Thurrock; Connected Southend and Southend Enhanced Discharge Service (SEDS) in Southend; and the Connect programme and future of integrated commissioning work in ECC as examples.

All three local authority teams have priorities linked to the development of the TOCHs, ensuring sufficient reablement capacity and supporting a robust domiciliary care market to maintain the system 'home first' approach.

Growth in 1:1 care home requests are being seen across the system. This is being explored across all three local authorities - it is possibly a small number of cases, but with high impact for the resident and system. We are working on a shared endeavour

to understand cases and best pathways (e.g. more intense short-term support for conditions such as delirium) with our Continuing Health Care Team.

We are currently seeing lower numbers of residents in the community awaiting sourcing in the domiciliary care market, a significantly improved position on the same time last year and during COVID.

ECL collaborations

In May 2023, a collaboration was formed between ECL (the trading name of Essex Cares Limited), MSE Community Collaborative and MSEFT to work together on the current and future model of Intermediate Care (IMC) services.

A series of workshops were held to review recently published IMC & Rehabilitation Services best practice guidance, against current local pathways and services.

Several service improvements were initiated based on this work including reducing handovers and improved team communications within the existing services.

The ECL team which delivers the Ward Led Enablement programme complement NHS staff on the ward and view the patients through a 'reablement lens'. It is a genuinely preventative service that eliminates the hospital acquired deconditioning many patients experience whilst in acute hospitals and supports residents to return home with reablement services in the community.

Two new substantive services commenced since 2023/24, which are beneficial to adults requiring mental health support:

- East of England Ambulance Service Trust (EEAST) Mental Health Joint Referral Car which is allocated to mental health calls by EEAST following them receiving a call via 999.

- Mental Health Emergency Department – Basildon hospital site, MSEFT. The service is for anyone age 18 years and above presenting with an urgent mental health problem, provided they don't have an urgent medical need. The service works in conjunction with existing Liaison services and is not a replacement for them.

Access to the service will be mostly via the 111 mental health option / professionals' line as well as the ability for 'walk in' self-presentations, if required.

A Partnership focus on reduction in length of stay within Adult Mental Health bedded units by undertaking:

- Weekly mini multi-agency discharge events (MADE) for both adults and older adult services.
- Long length of stay (LLOS) reviews led by senior clinicians.
- Joint learning with MSEFT on LLOS reduction.

The Unscheduled Care Coordination Hub:

The Unscheduled Care Co-ordination Hub went live from 13 November 2023 and is a clinical service to support the appropriate redirection of care away from ambulance conveyance and Emergency Departments and redirects into services such as the

Urgent community response teams, falls cars or other community support, enabling the care of our patients within the community with appropriate local support.

Out of hours Hospice support

IC24 are supporting the Hospice Collaborative during out of hours should the Hospice require clinical advice for their inpatients, predominantly around prescribing. The support will improve patient experience and promote admission avoidance into the acute setting.

Urgent Community Response Team (UCRT):

Full geographic substantive and embedded operational Urgent Community Response Team service provision from 0800-2200 seven days a week. The service covers all nine clinical conditions/needs, including level two falls, in line with the national 2-hour guidance.

Virtual Wards:

Through the System Discharge Executive Programme, a review of the current Virtual Ward (VW) model is in place to ensure it operates at higher capacity levels to support flow (recognising the national ask for 80% occupancy over winter). Current VWs include frailty and respiratory, with gaps identified in Heart Failure and Children's VW delivery. A prioritisation paper for allocation of system capacity monies will be reviewed at the System Discharge Executive in due course.

Community Bed flow

A Community Flow Improvement Programme commenced in October 2023 to reduce variation in length of stay and delayed discharges within IMC and Stroke beds, supported by the Integrated Discharge Team at MSEFT. The oversight and assurance on delivery is via the System Discharge Executive.

3. Findings/Conclusion

While our partnership working does not insulate the system from seasonal and year round pressures at both the front end of community and acute services and delivery of longer term work, such as assessments, reviews and the clearing of waiting lists, collaborations are providing innovative solutions and improved frontline networks of staff to the benefit of our population. A full system winter plan for submission to NHSE and to share with all partners is in development via the SCC to support operational pressures over the winter period.

4. Recommendation(s)

The Integrated Care Partnership is asked to note the report.

5. Appendices

Appendix 1 - Partnership working together to better manage System Pressures. Power point presentation.

Mid and South Essex Integrated Care System

NHS
Mid and South Essex

MSE System Partnerships: working together to better manage System Pressures

06th December 2023

www.midandsouthessex.ics.nhs.uk

Overview

The Partners in MSE ICP recognise the role of partnership working as being the basis on which to build ongoing joint positive working between all partners in Mid and South Essex ICS across NHS, local authorities and VCFSE sector with partners coming together under the ICP leadership model and committing to working together equally.

We seek to use a collective model of decision-making that seeks to find consensus between system partners and make decisions, including working though difficult issues where appropriate as partners.
We work together to ensure transparency and local accountability, to the residents we serve and to champion co-production and inclusiveness throughout the ICS in all of our joint workstreams aligned to the ICP Strategy and Joint forward plan.

Our work at ICP level, within the ICS and within Alliances support us to collectively understand our system and organisational pressures and to work together via our collective cross organisational workstreams and Alliances.

This overview seeks to show how we have come together to support the system and to have a collective direction of travel to support the residents of MSE to access accessible, timely services and to plan for seasonal pressures.
It is also timely to celebrate successes together in the development of new services that support our aims and reduce service pressures, such as the Mental Health ED, Unscheduled care Coordination hub, maturing virtual wards and the ongoing development of TOCH and Integrated Neighbourhood teams.

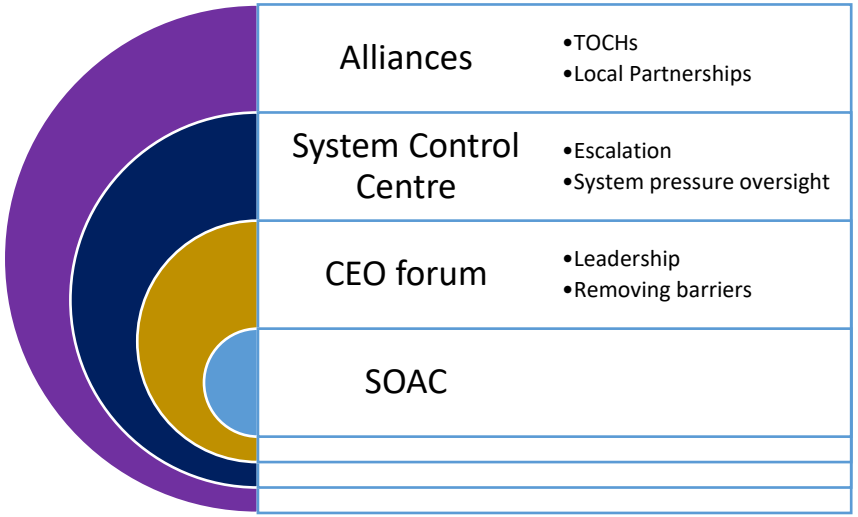
Mid and South Essex Integrated Care System

NHS
Mid and South Essex

Co-ordination & Strategy

Mid & South Essex working as a System

Key to the partnership ways of working to reduce system pressures is the focus on avoiding admission to acute hospitals either for preventable physical health escalations or for urgent mental health stay in health-based place of safety and supporting timely step down back to community care.



Alliances works across system partners to bring together local solutions and collaboration.

The System Co-ordination Centre (SCC) is well established partnership group within Mid and South Essex with a daily tactical call to the ensure that the System is aware of the system pressures and how we can work together as partners to support flow across all services - this is informed by Shrewd reporting.

The SCC works across the system with the Director being the Chair of the System Urgent Emergency Care Improvement & Transformation Board to enable review of plans to be prompted informed by the actual situation.

Mid-and South Essex (health) Chief Executive Officer Forum have identified three key workstreams, Independence, Flow and Workforce . The flow workstreams oversee programs of works that are instrumental to delivery of system working and shared delivery, including Intermediate Care, Virtual Ward & Discharge, Pathways and Transfer of Care Hubs.

System Oversight Assurance Committee is a subcommittee of the Integrated Care Board holds quarterly accountability Reviews of delivery versus commitment and plan is to ensure any risks can be mitigated and understood by the system.

Winter & Surge Communication Strategy

Why do we need everyone to do their bit this winter to reduce system pressures?

- 33% of people attend the Emergency Department that have no intervention or diagnostic undertaken and are discharged after consultation.
- On average last winter across the three hospital sites there were 32 patients in beds as a result of flu and 94 due to covid. Please help by encouraging the people and staff of MSE to have their vaccinations ahead of Christmas.
- Last winter bed occupancy operated at 98%, this year the national aim is 92% occupancy support ambulance offload, Emergency Department management and patient flow.
- This year we have the new Mental Health Urgent Care Department located in Basildon which has 5 spaces to be able to see and treat people. The service is open for people to walk into and for EEAST to transfer into.
- The Unscheduled Care C-ordination Hub went live on 13 November 2023 to support patients accessing the right urgent care the first time.

Aims of our communication Strategy

To reach and involve key system audiences in the development of winter plans that will ensure the provision of safe and high-quality care. To equip people in mid and south Essex to take proactive measures in protecting and improving their health and wellbeing this winter. Drive engagement towards resources available at Do Your Bit Essex, aiming to prevent minor health issues from escalating into severe problems and signpost to community support.

Creative

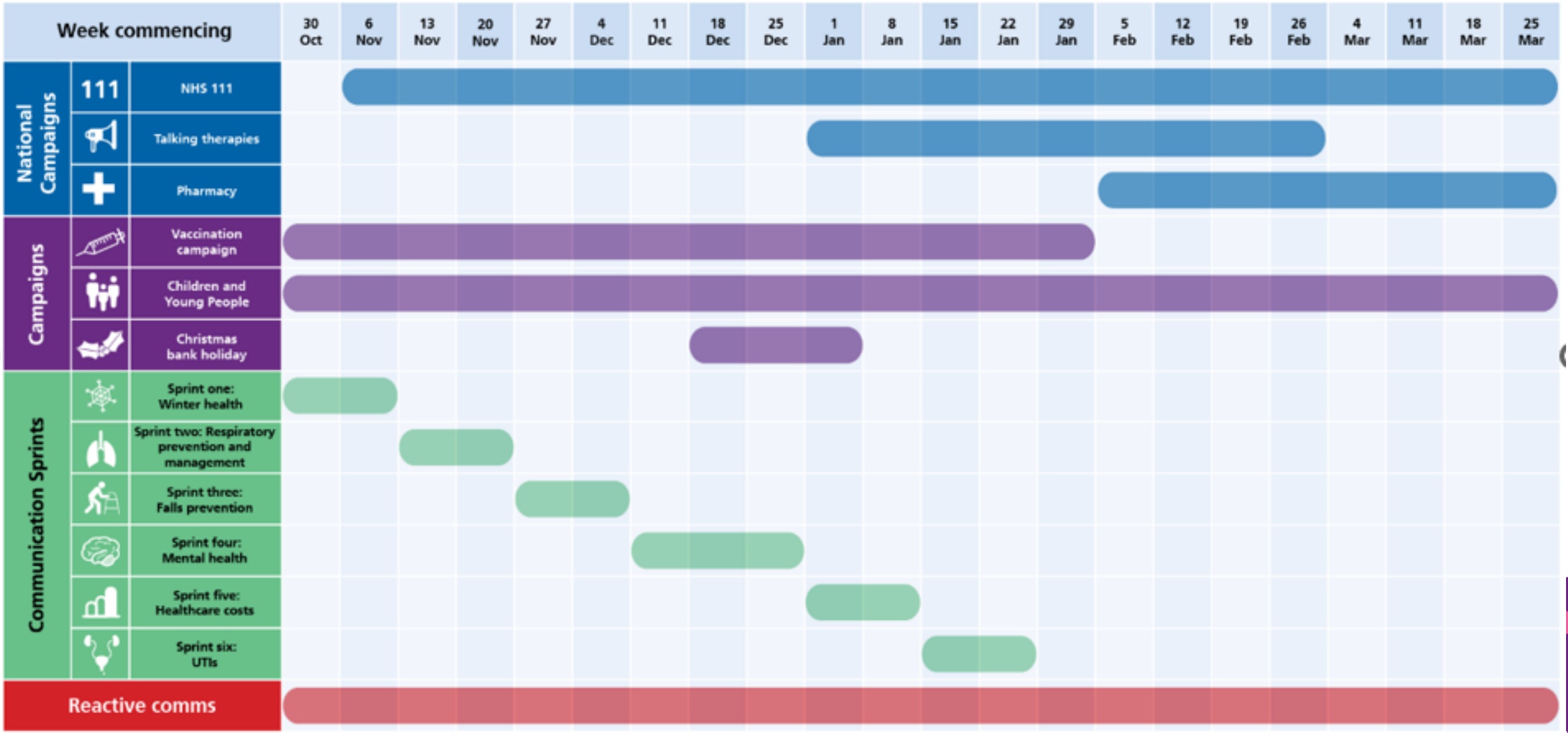
Blend of national and local to allow for localisation.

Implementation

Themed phases and will use the following channels:

- **NHS Channels:** Winter hub www.doyourbitessex.nhs.uk
- **Partnerships:** campaign toolkits, working with partner to leverage internal and external channels and networks. Bus wrap/school competition. System digital marketing comms group. Work with alliances to amplify in their communities
- **E-marketing**: Winter email alerts
- **PR:** Press releases plus regular GP column with local
- '**Paid for' channels:** Integrated advertising campaign, exploring Meta/Google Pmax/podcasts, buses, booklets, outdoor advertising.
- **Issues management / reactive comms handling**

Winter Communications Activity



Mid and South Essex Integrated Care System

NHS
Mid and South Essex

Community Support & Discharge

www.midandsouthessex.ics.nhs.uk

Transfer of Care Hubs

The Transfer of Care Hubs (TOCH) form part of the MSE ICS system partnership response. This work involves Healthwatch and Voluntary sector partners, and stakeholders from all local authority providers. As part of winter 2023 planning all Local Authorities have supported the importance of TOCHs “to support person effective centred discharges including complex care, housing cases and admission avoidance”.

The System Co-ordination Centre via SHREWD has daily operational performance by pathway that will be utilised by TOCHs to determine the area of focus for each of the TOCHs. Each TOCH will facilitate pull from the acute hospital into the community pathways including the emerging Integrated Neighbourhood Teams as well as admission avoidance to reduce the need for hospitalisation, which will incorporate close working with Primary Care Networks, acute, community, primary, social care, housing, and voluntary sectors.

TOCH Approach for Delivery:

- Building on the existing integrated discharge teams Each of the four Alliances to have TOCHs in place by 30 November 2023. Model operates seven days per week from 8:00am to 6:00pm with the IDT as core.
- Supporting a model that knows their population whose core principle is home first.
- TOCHs are a virtual hub that act as local health and social care system-level coordinating centre linking all relevant services across sectors to aid discharge and recovery and admission avoidance. They are the lead for progressing discharge planning and coordination of the pathway reducing the need for duplication with acute teams during their operational working hours.
- Step down - Coordinating discharge, flow and reducing re-admission through proactive interventions e.g., Voluntary Community or Social Enterprise pathways.

Primary Care – Winter Resilience Planning

- Primary Medical Services
  - The ICB has commissioned a Winter Access Scheme utilising £700k of non recurrent funding.
    - The scheme focusses on respiratory conditions, a proactive element providing longer appointments, a reactive element providing additional capacity during peak respiratory season.
    - This scheme is expected to deliver circa 22k additional appointments.
  - Through our Integrated Neighbourhood Scheme, PCNs have been implementing a number of complex care schemes and urgent & episodic care schemes that will improve our resilience this winter and beyond
    - For example, “on the day hubs” will increase the availability of clinicians (in particular ARRS staff) to support the peak of winter pressures,
    - MDTs focussing on mental health will support the health and wellbeing of patients with poor mental health
    - Our workforce hub is supporting recruitment and retention initiatives across the whole primary care workforce
  - Through the Access Recovery Programme
    - Promote pathways that are alternative pathways to primary medical services
    - A number of practices have transitioned across to Cloud Based Telephony,
    - PCNs have made progress on their Capacity and Access initiatives
    - Following Support Level Framework meetings, a number of practices have demonstrated how they have moved to the “Modern General Practice” model.
- Community Pharmacy
  - As part of our overarching winter communications campaign, the ICB is promoting community pharmacy as a first option care provider for many winter ailments.
  - In addition, we have established a working group who will rapidly roll out “Pharmacy First” at the earliest opportunity.
- Dental Services
  - The ICB has commissioned an Urgent Access Dental Pilot which has enabled access to 30k additional 30 min dental appointments in the evening, weekends and bank holidays.
  - By early December, we expect to have fully integrated this pilot to enable 111 to directly book into the additional capacity minimising patients presenting to ED or primary medical care.

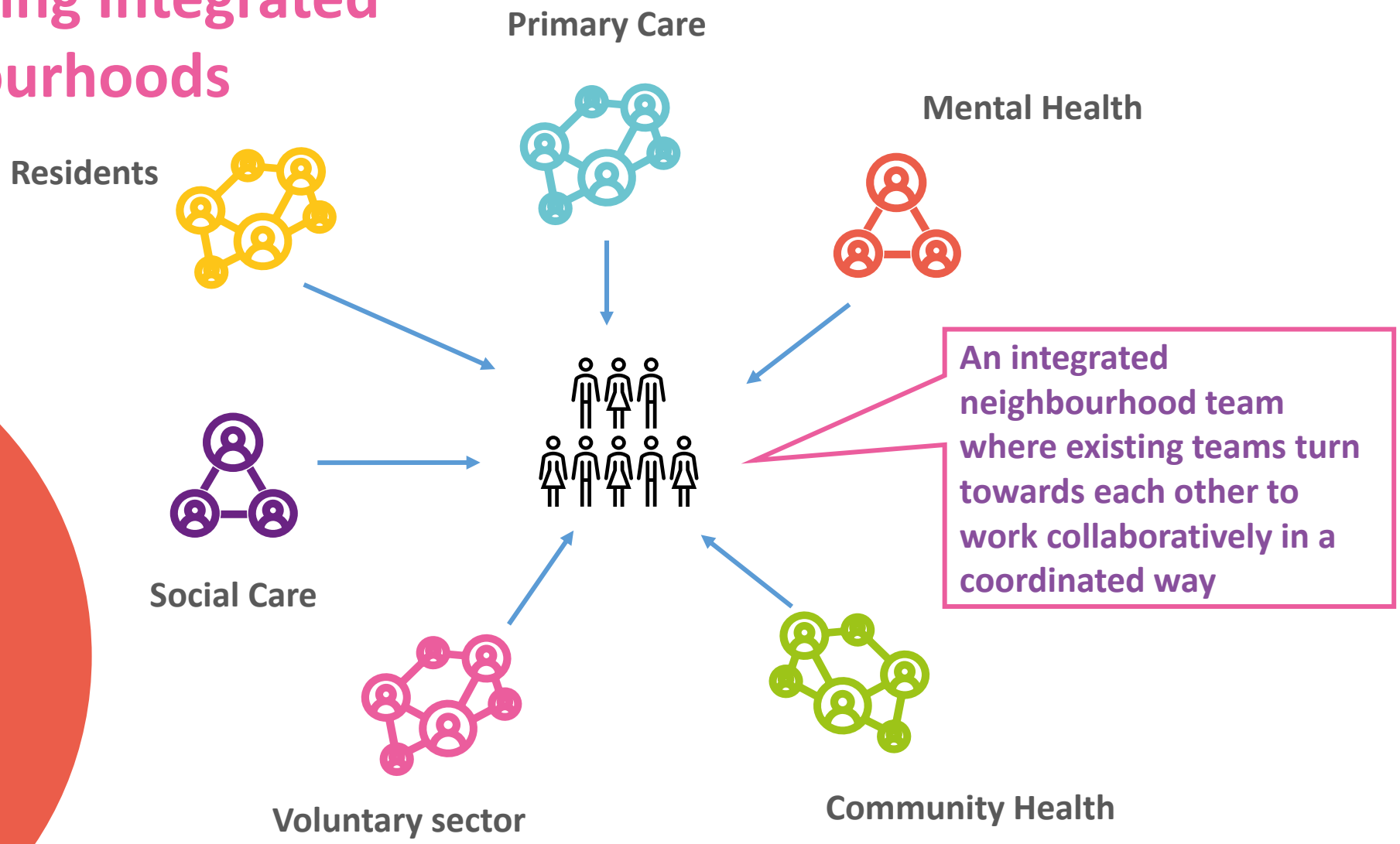
Consultations in Primary Care (MSE)

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Total Consultations	**449,285**	**518,743**	**489,805**	**487,270**	**496,472**	**535,737**	**595,996**	**577,412**	**491,490**	**543,250**	**498,148**	**587,830**

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Total Consultations	**455,709**	**530,814**	**567,921**	**530,970**	**541,657**	**607,795**	**647,702**
Net change	1.43%	2.33%	15.95%	8.97%	9.10%	13.45%	8.68%

Developing Integrated Neighbourhoods

The heart of the INT vision is to bring together previously siloed teams and professionals to do things differently and create <u>united</u> shared capacity



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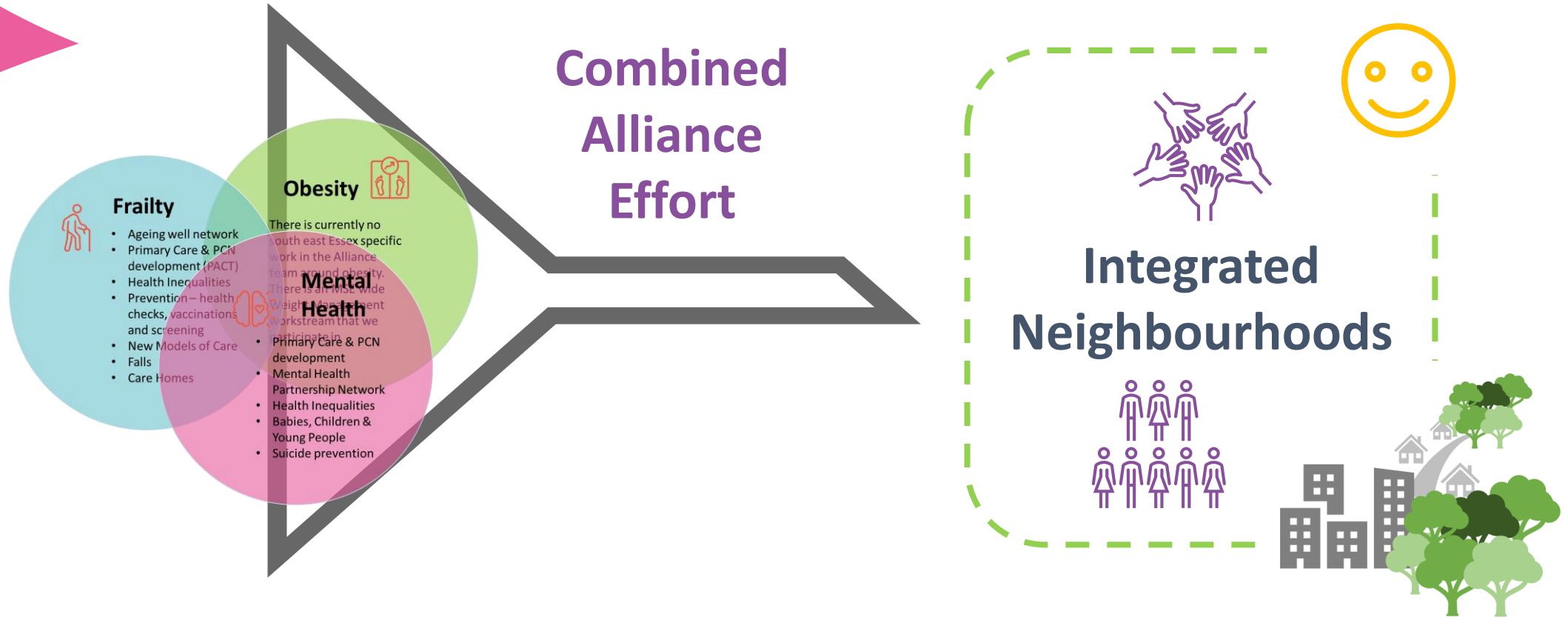
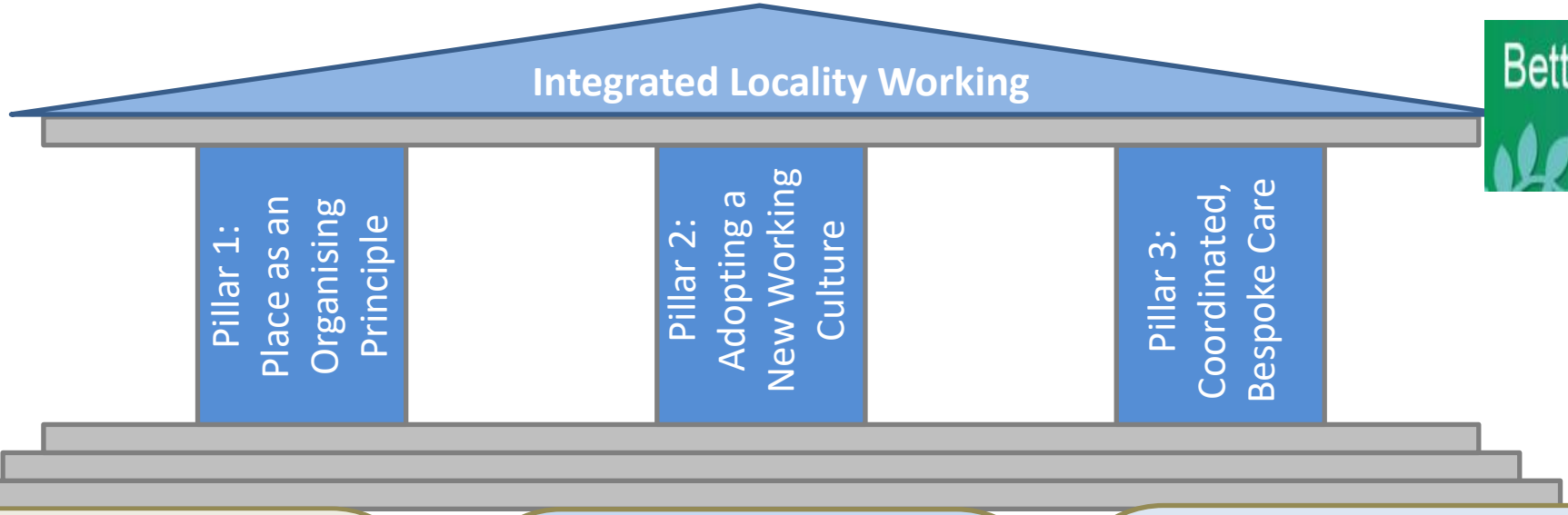
How can we all work together to deliver?



The Mid and South East Essex Alliances are already committed to delivering through Integrated Neighbourhoods this SEE diagram shows how collective effort is funnelled via INTs.

Integrated Locality Working



Better Care Together Thurrock

Place as an Organising Principle

PCN Locality as the Planning Footprint.

The Integrated Medical Centre acts as the locality 'hub'

A Single Integrated Locality Network.

- Relationships not referrals
- Alignment of named professionals within larger teams
- Support from small specialist teams brokered in + upskilling.

A New Working Culture

Empowered Staff

- Free to use judgement within broad framework of principles

Solutions not services.

A Learning Culture

Focus on what matters to residents.

- Build relationship and goal setting with residents

Coordinated, Bespoke Care

Bespoke Solutions to Complex Problems

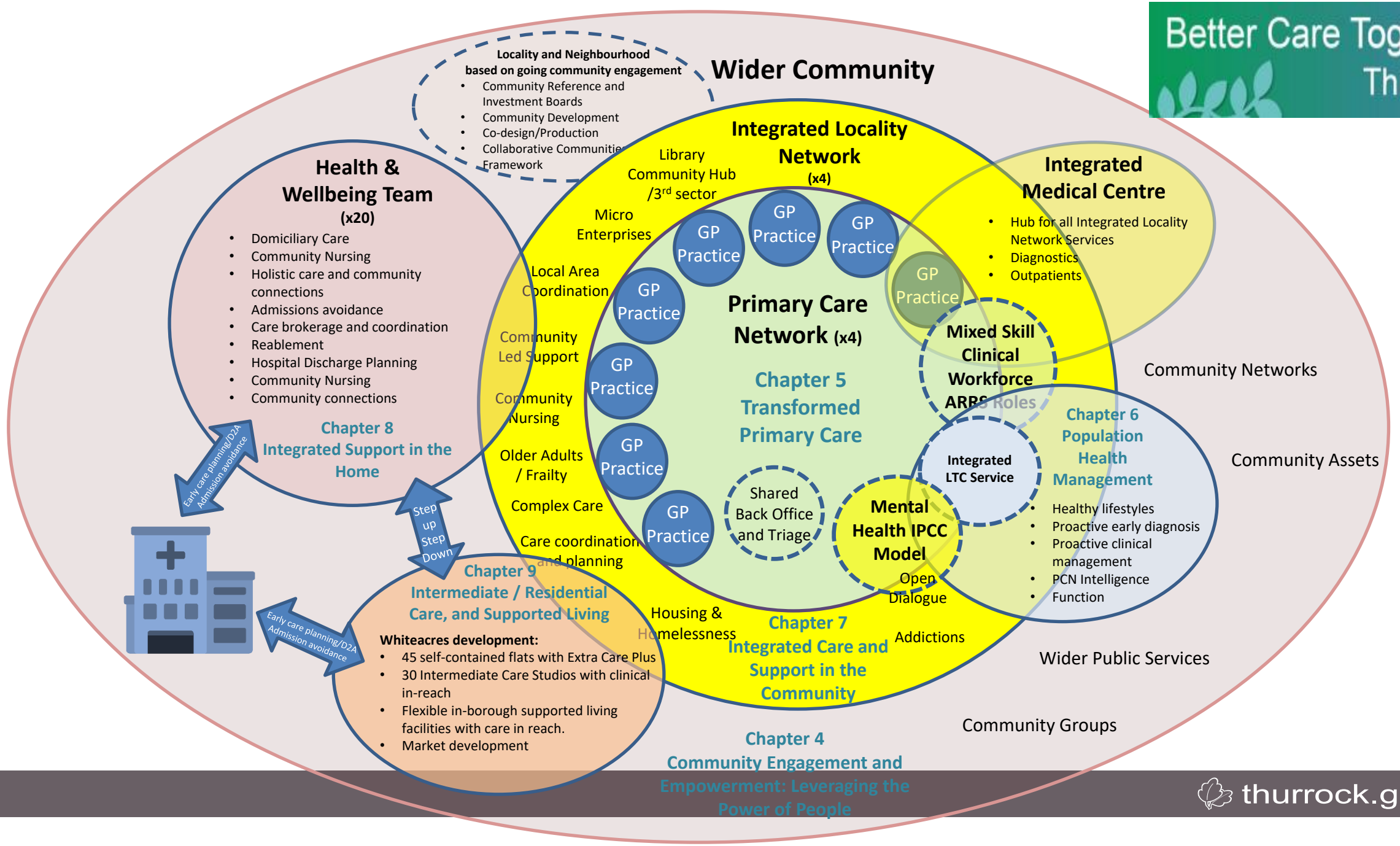
Care Coordination.

- A single named person brokers all care required as part of the solution.

Single Integrated Care Plans

- For the most complex individuals l
- Linked to the goals that the resident has set for themselves.
- Across NHS, 3rd sector and LA.

Better Care Together
Thurrock



VCSE Partnership Pathways

Our VCSE partners working with the voluntary community assembly have a number of support pathways in place to support residents across MSE.

These include as examples (not an exhaustive list)

- Supported outreach clinics for vulnerable groups to access flu and covid immunisations
- Providing support to anyone at risk of the cold across localities. This could be via supply of food vouchers and parcels, fuel support (via linked Citizens Advice services), purchase of white good or cooking equipment or help with warm clothing. Linking with the ECC housing support fund as needed.
- Teams will also be running a series of Welcome hubs across the district throughout Winter for people to access support from the local CVS teams and from a range of community hub, attendees will also get warm refreshments.
- Support to the rough sleeping community and those with substance misuse support needs
- Tenancy support (Peabody)
- Warm homes advice

Community hub and VCSE support to the TOCH via CVS hubs and or social prescribing offers linked to the locality TOCHs are also key maturing areas of worl.

Urgent Community response Teams

The Mid and South Essex Community Collaborative has brought together the three community providers to support the system and provide a key integrator function for community services. Areas of impact include:

Urgent Community Response Team (UCRT):

Full geographic substantive and embedded operational Urgent Community Response Team service provision from 0800-2200 seven days a week. The service covers all nine clinical conditions/needs, including level two falls, in line with the national 2-hour guidance.

- All clinicians can undertake wound closure using skin adhesive to support with management of minor injuries sustained during a fall.
- Expanding beyond the nine clinical conditions has commenced.
- Intravenous Therapy (IV) is live through collaborative working with the frailty virtual ward and Hospital at Home teams.
- Point of Care Testing offer is live.
- UCRT and Virtual Wards continue to explore opportunities to strengthen the virtual hospital model and increase step up referrals from the community and care homes reducing the need for acute admission.
- UCRT continue to work closely with EEAST to increase referrals into the service. Urgent Community Response Team pull suitable category three to category five calls from the ambulance 999 stack using the EEAST Clerical portal.

Our UCRT teams working in partnership with EEAST have taken over 2500 patients off the 999 call stack, who would have otherwise been seen by an ambulance crew.

Community Nursing Teams

Community Nursing:

- For many people with long term illness the community nursing services are key to support their ongoing health conditions and keeping people safe at home
- Our community nursing teams play an important role in supporting self management and sign posting people where necessary to the support network around them
- Our community teams play a large role in supporting avoidable admissions.

Virtual Wards

Through the System Discharge Executive Programme a review of the current Virtual Ward model is in place to ensure it operates at higher capacity levels to support flow (recognising the national ask for 80% occupancy over winter). Current Virtual Wards include frailty and respiratory, with gaps identified in Heart Failure and Children's VW delivery.

Flow optimisation through the virtual wards.

- To optimise Virtual Ward flow regular MDTs are held throughout the week to facilitate discharge planning, team includes consultant, pharmacist, therapists and social care.
- To further optimise Virtual Ward there are touchpoints throughout the day between UCRT and Virtual Ward teams to maximise referrals, as well as liaison with frailty teams in the hospital to identify suitable patients for admission to frailty virtual wards.
- Regular Pharmacist led medication reviews take place across the virtual wards.
- Formation of a work stream looking at how social care and the community teams work together to raise awareness of Frailty Virtual Ward and how to refer and develop referral pathways and clarify routes to access social care.
- Recruitment and training is ongoing to increase staffing capacity and skill mix.

6500 plus patients referred into Virtual Wards since the programme commenced – all of these would have received treatment in an acute hospital bed – saving over 30,000 acute bed days hospital.

Mid and South Essex Integrated Care System

NHS
Mid and South Essex

Attendance & Admission Avoidance

www.midandsouthessex.ics.nhs.uk

Primary Care

- The Integrated Care Board is putting in place a winter access scheme focussed on respiratory conditions:
  - Proactive scheme that seeks to reduce the risk of complex patients suffering exacerbations
  - Reactive scheme that increases primary care capacity during peak respiratory season

- Primary Care Networks are collaborating on several schemes to try and improve the management of both complex care and episodic care. Across Mid & South Essex, there are nine Integrated Neighbourhood Teams in place.

- Several actions are being taken forward as part of our Primary Care Access Recovery Plan:
  - Development of alternative dispositions to general practice,
  - Roll out of Cloud Based Telephony
  - Use of digital tools
  - Development of total triage and care navigation

- Urgent access pathway for dental services which increases access to dental services at weekends and bank holidays.
- Direct access pathways for people with urgent Mental Health problems

Adult Mental Health

Two new substantive services have commenced since 2023/24, which are beneficial to adults requiring mental health support:

- EEAST Ambulance Mental Health Joint Referral Car
- Mental Health Emergency Department – Basildon site MSEFT

EEAST Ambulance Mental Health Joint Referral Car

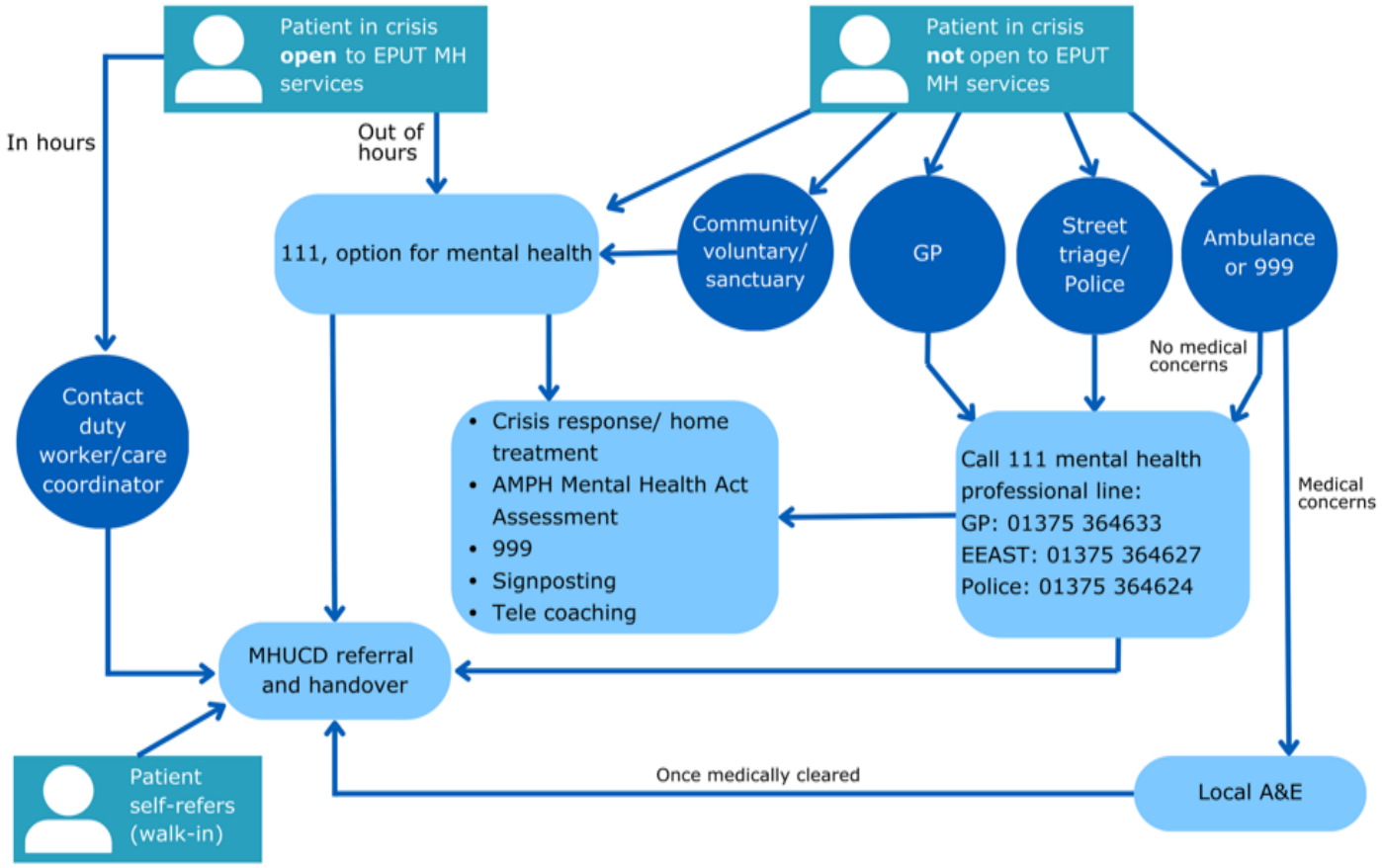
- Current provision 1300 -0100 hours – current service provision until 31 March 2024
- The Mental Health Joint Referral Car is allocated to mental health calls by EEAST following them receiving a call via 999
- The team review live ambulance demand screens and respond to calls and offer advice to Emergency Operations Centre or crews on scene to present and attendance avoidance to an acute Emergency Department and support to ensure the patient is put onto the correct pathway.
- Due to the multi-agency staffing of the car the aim is to offer the right care, in the right place, at the right time and ensure that every contact counts.

- During the first six months the outputs from the Mental Health Joint Referral Car are:
  - 514 patients seen face to face.
  - Have given advice by telephone to 445 crews/patients
  - Of the 514 patients seen face to face 90 were conveyed to ED
  - Non conveyance rate of 82%

Adult Mental Health - ED

EPUT Mental Health Emergency Department – Basildon site MSEFT

- The service is for anyone of the age 18 years and above presenting with an urgent mental health problem in Mid and South Essex, provided they don't have an urgent medical need
- The service will provide a service for people living in the area serviced by Mid and South Essex Integrated Care System. In terms of general hospitals this will include Basildon, Broomfield and Southend hospitals.
- The service works in conjunction with existing Liaison services and is not a replacement for them.
- Access to the service will be mostly via the 111 mental health option / professionals' line as well as the ability for "walk in" self-presentations if required



Adult Mental Health Bed flow

Partnership focus on Reduction in length of stay :

- Weekly mini MADE events for both adults and older adult services
- Scheduling of SUPER made events through winter
- Long length of stay reviews led by senior clinicians
- Implementation of the ‘time to care’ operating model
- Focus on the gaps identified in the National MH discharge challenge:
- EDD and CFFD reporting and proactive management of capacity
- Continued roll out of Red2Green principles supported by the learning from the acute trust in sharing learning from existing work on this in the acute
- Reduction in variation across ward and locality MDT working and effectiveness
- Review of the discharge co-ordination function, further strengthening the team, aligning roles and responsibilities with the flow improvement agenda

Purposeful admission/Admission control:

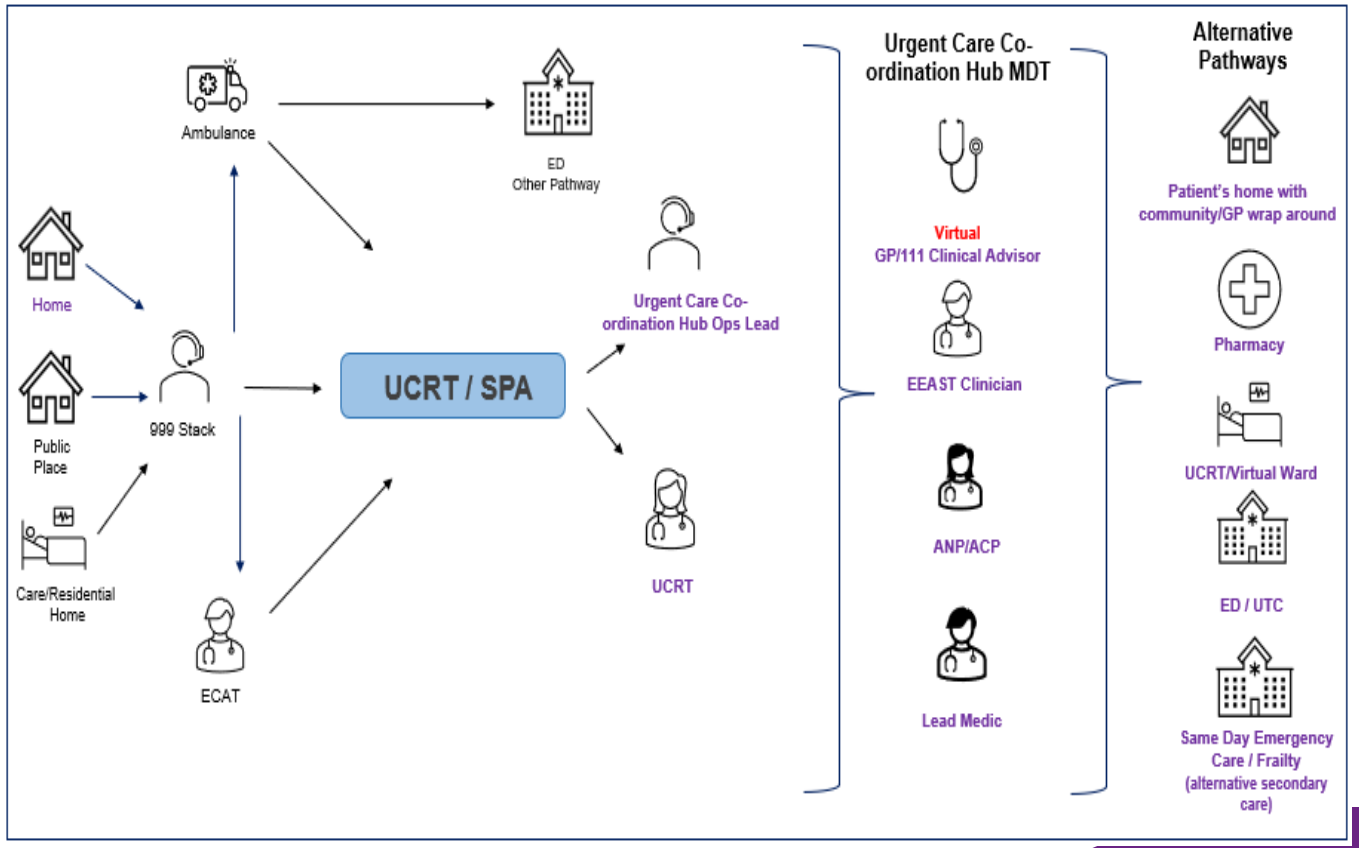
- Senior clinical and nursing review of all patients awaiting informal admission, with re-routing to alternative pathways as appropriate, on an ongoing basis daily
- Increase VCSE support to Southeast Adult Mental Health Community Teams
- 111, select MH communication campaigns and awareness of MH service provision outside of ED

Maintaining Senior Clinical engagement in the Flow improvement programme:

- Bi – weekly Clinical Flow Meetings attended by all senior clinicians across home treatment and inpatient services

Unscheduled Care Co-ordination Hub

Following a one-week soft launch in September 2023 test and learn the concept of a call before you convey model prior to a hard launch. The Unscheduled Care Co-ordination Hub went live from 13 November 2023, which is a clinical service provision to move away from ambulance conveyance to Emergency Departments and shifts to an integrated multidisciplinary approach to urgent care at a system level and enabling the care of our patients within the community with appropriate local support.



The Unscheduled Care Co-ordination Hub consists of a multi-disciplinary team of clinicians and admin staff, working from a blend of providers across the MSE Integrated Care System located at Rochford Hospital. The team will have direct links to ambulance control and live visibility of 999 demand, as well as Shrewd with an overarching aim of optimising alternative pathways and avoiding inappropriate ambulance conveyance to Emergency Departments.

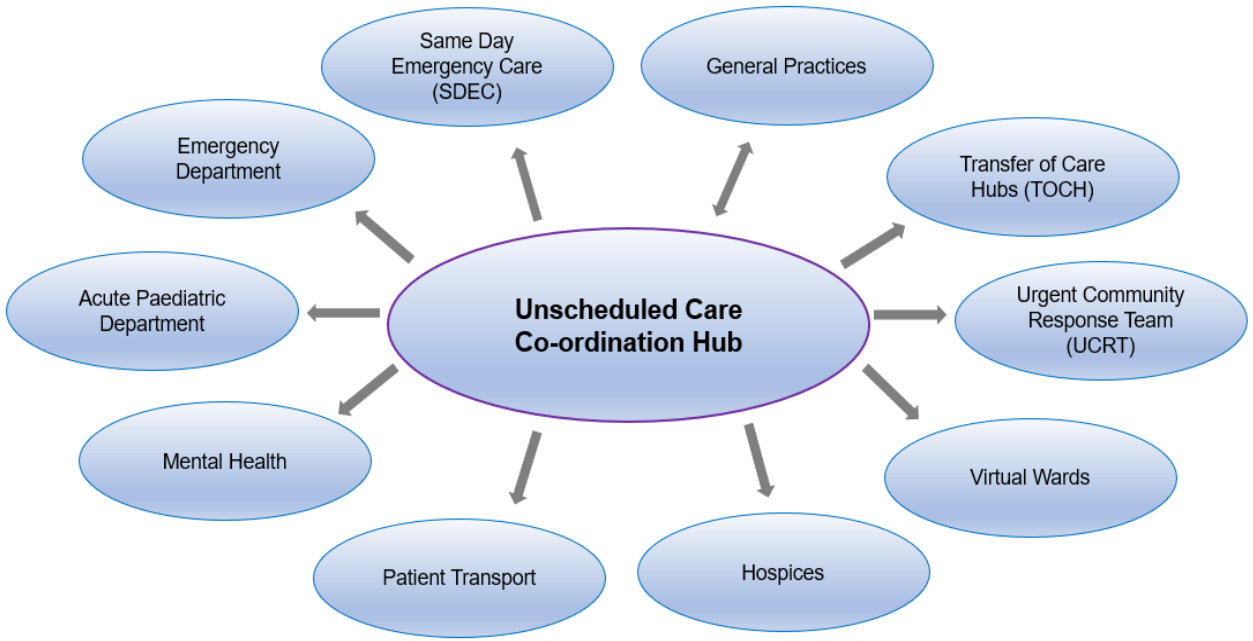
Unscheduled Care Co-ordination Hub Overview

All Ambulance crews to have access to call the Single Point of Access number for the clinical team if they were considering conveyancing of a patient to the Emergency Department, which is not deemed an emergency conveyance.

The operational hours for the Unscheduled Care Co-ordination Hub are operational 7 days a week: **Monday to Friday - 0800-1900 and weekend and Bank Holiday: 0800-1700**

The anticipated outcomes from the introduction of the Unscheduled Care Co-ordination Hub implementation across Mid & South Essex:

- Reduction in ambulance conveyances to Mid & South Essex Foundation Trust hospitals
- Improvement in category 2 handover times
- Increase in the use of UCRT and Virtual ward capacity for cases that can be treated at home
- Reduction in referrals rejections from EEAST to UCRT
- Increase attendances to Same Day Emergency Care
- Improved system partner working relationships
- Supporting EEAST crews with urgent care pathway and access knowledge



NHS111 Partnerships

Single Virtual Contact Centre
Single Virtual Contact Centre pilot testing progressing across the East of England to demonstrate the efficiencies of sharing calls across 111 providers to improve patient experience and wait times

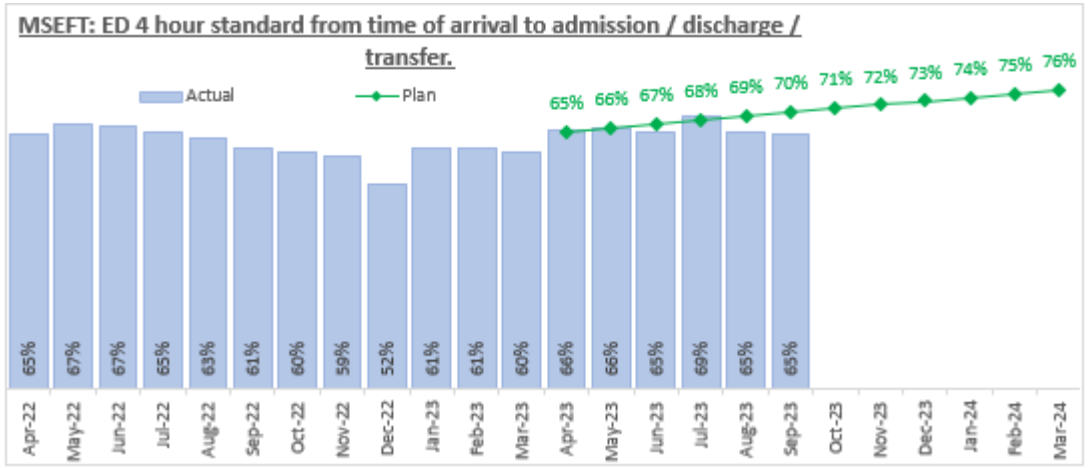
Unscheduled Care Co-ordination Hub
IC24 are supporting in providing virtual support to the Hub and offering out of hours GP bookable slots.

Out of hours Hospice support
IC24 are supporting the Hospice Collaborative during out of hours should the Hospice require clinical advice for their inpatients and predominantly around prescribing. The support will improve patient experience and promote admission avoidance into the acute setting.

Work in progress, IC24 are involved with end-of-life workstreams within to support the development of an end-of-life ACP module, led by Huddersfield University and in co-operation with University of Essex, further increasing the quality of end-of-life services.

Ambulance Handover

Our Hospital teams continue to focus on reducing the length of time an ambulance has to wait at hospital to handover their patient to the emergency department team.
The following graph shows current reported position against trajectory.



Mid and South Essex Foundation Trust intend to deliver 76% of patients seen, admitted and discharged within four hours by March 2024.

Hospital Ambulance Liaison Officer (Halo) at each MSEFT site. Their role is to support flow from point of ambulance arrival to handover and release crews to return to the community to attend to other people who are waiting for an ambulance.

Specific deliverables to support ambulance handovers:

- Ambulance cohorting capacity is available at each hospital site, use of these is dependent upon staffing to safely manage patient load. This is coordinated between EEAST Halo and the Emergency Department and relevant hospital Site Director or Operations or delegated deputy.
- MSEFT implement across their organisation mutual aid between sites to support with ambulance handover delays during period of surge. In hours this will be approved between the Hospital site Director of Operation, and outside of core hours the Hospital Oncall Teams. The System Control Centre will have oversight and support divert management where necessary.

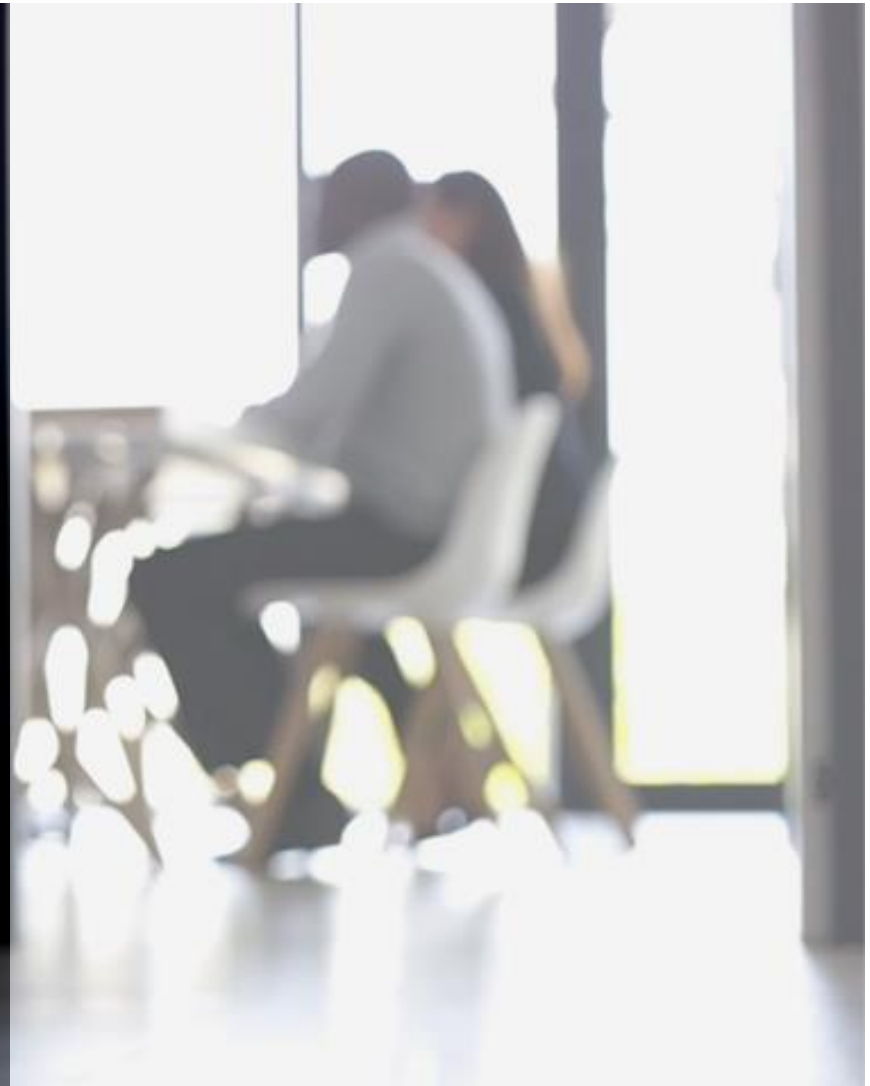
MSE IPAC

Our Plans for 2024/25

In May 2023, a collaboration was formed between ECL, MSECC and MSEFT to work together on the current and future model of Intermediate Care services.

A series of workshops were held to review recently published IMC & Rehabilitation Services best practice guidance, against current local pathways and services.

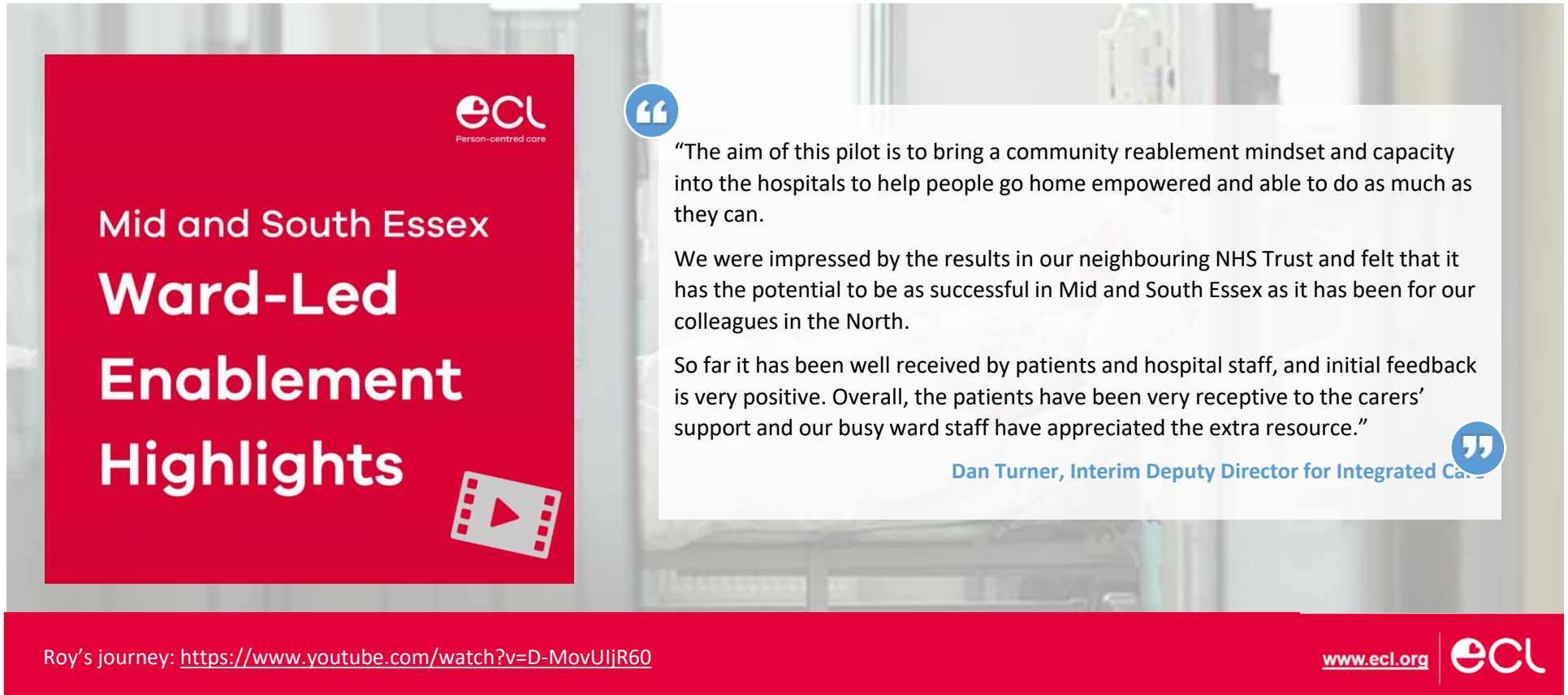
Opportunities were identified and a proposed integrated IMC model was co-designed, commencing with integrating our collective services for pathway 1, including a link to supporting community rehabilitation services.



Ward Led Enablement in MSE

DHSC studies have shown that a 10-day hospital stay can cause 10 years' worth of muscle aging, with older patients spending up to 83% of their time in bed and a further 12% in a chair.

The ECL team delivering the WLE programme complement NHS staff on the ward and view the patients through a 'Reablement lens'. It is a genuinely preventative service that eliminates the hospital acquired deconditioning many patients experience whilst in acute hospitals.



Local Authorities: Essex County Council

Our preparatory work has identified principles of approach based on the learning from winter 2022-23 and other previous years as well as our ongoing partnership transformation work linked to Connect and the future of Intermediate care. The intention for these was to act as a point of reference to assess proposals as they came forward. The principles agreed were:

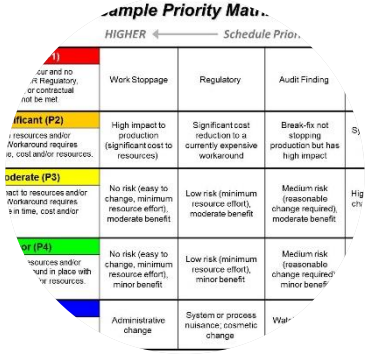
Principles of approach – Winter 2023-24

- To comply with the guidance around funding sources
- Do not further complicate systems – build on what's already there with a focus on 'home first'
- Bring providers into the planning conversations where possible
- Work collaboratively across Health and Social Care to support design, implementations and visibility of our initiatives
- To explore admission avoidance solutions where funding source guidance allows
- Focus on fewer but larger interventions, which will support clearer evaluation of impact
- Where possible, build in the ability for provision to flex for demand
- Ensure good data collection and systemic sharing of insight

Current ECC data headlines – entering winter

Spot reablement growth

Growth in the use of spot reablement in all areas. 13% growth projected for 2023-24 (P5)

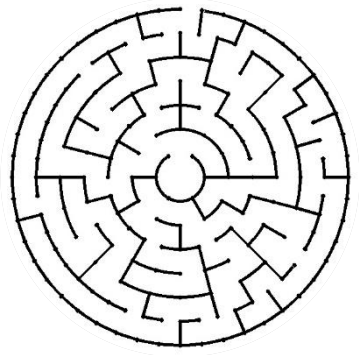


People not always going to right place at the right time

Our analysis suggests that over 50% of spot placements do not have reablement potential. Priority matrix approach will support right place, right time.

Little ‘unsourced’ care

Our latest sitrep indicates there are zero cases currently awaiting sourcing in the domiciliary care market, a significantly improved position.



Growth in 1:1 care home requests

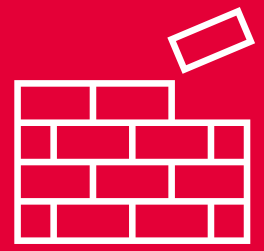
Being explored. Possibly small number, high impact. Need shared endeavour to understand cases and best pathways (e.g. EPUT OPMH, CHC, possible more intense short-term support for conditions such as delirium)

Countywide initiatives

A number of schemes and initiatives cover a countywide footprint. In establishing these, or continuing to fund them from the previous year, we are informed on where pressures have been, or are likely to occur, over winter and into the next year for future planning.

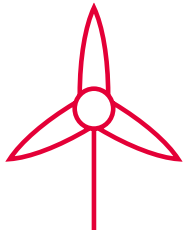
Key schemes and initiatives are:

- Recovery to Home beds (care home premium and void cover)
- Dementia Discharge Support
- Mental Health capacity (AMHPs)
- Funding allocated for incentive payments or other pressures (for example ‘Spot’ reablement – any slippage is likely to be directed here)
- Roll out of prioritisation matrix
- Note: additional support for market resilience via MSIF and social care grant funding rate increases and training claims fund



60% ECC Discharge Fund allocation dedicated to centrally managed initiatives.
A number of these build on existing work and schemes.

How are we focusing our work?



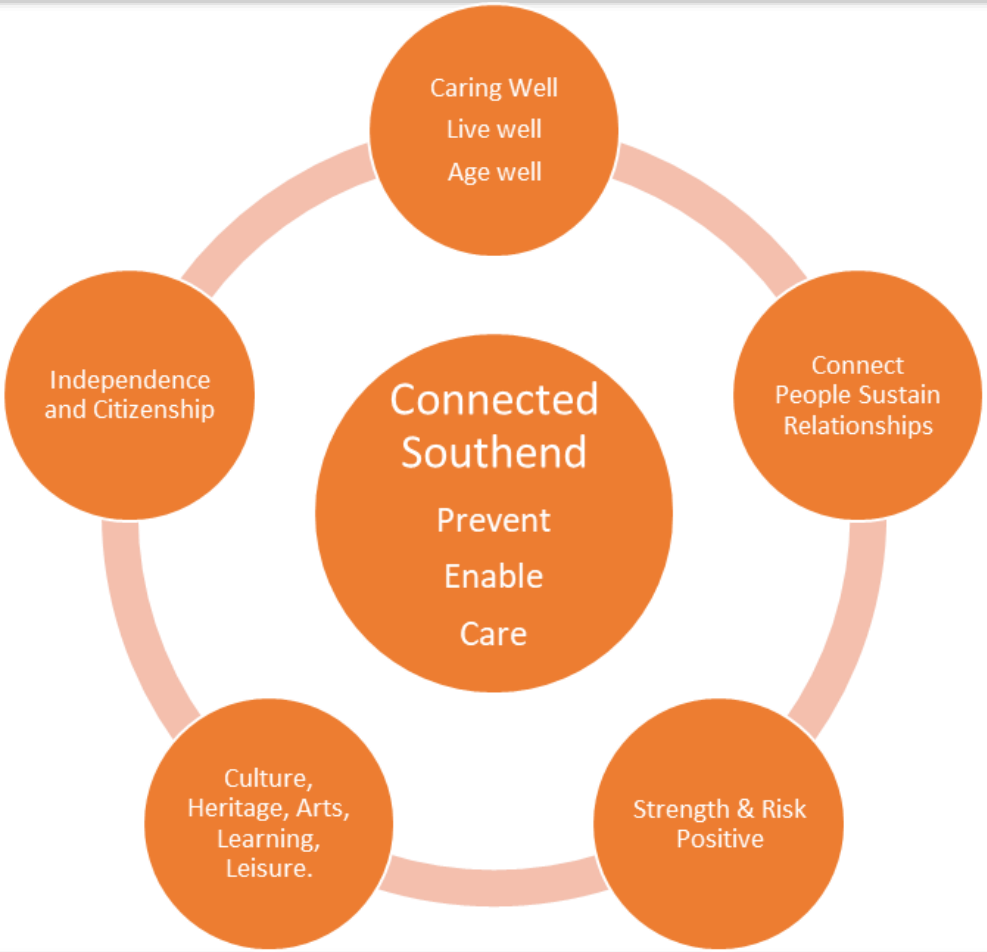
Our plans reflect the changed dynamics in social care markets. Domiciliary care workforce position is improved. Our current pressure is on ensuring adults are offered and the availability of the right service on discharge.

The approach goes beyond funding 'schemes'; it includes process improvement. An example of this is the continued roll out of the Connect Prioritisation Matrix which supports better use of capacity we have in place.

From our experience, System planning is about more than the mobilisation of front-line schemes. It also needs to consider regular touchpoints, updates, information flows and evaluation. This has been a part of our planning dialogue. Each scheme has been formed with KPIs in mind and overall key metrics will continue to be monitored in order to assess the health of each system. These include:

- Volume of people waiting assessment from ECC
- Volume of people waiting sourcing of care (by care type and district)
- Intermediate Care capacity and utilisation

Priorities for Winter - Connected Southend



Connected Southend is Southend's whole service approach to community practice, personalised enablement, new models of commissioning and social care support across the city. In essence it is our new approach to providing the very best information, advice, prevention, support and social care.

Alongside this the Connected Southend has the heart of the city embedded within though our use and support of voluntary and community groups, our arts, culture leisure and heritage.

During winter 2023/24 there will be a focus on moving the service towards this operating model.

Southend-on-Sea City Council

Priorities for Winter 2023/24

Connected Southend	A proportionate, outcome focussed approach that ensures everyone, regardless of eligibility and care and support needs can benefit from having a strengths-based conversion based on professional analysis and skilled advice.
	Everything we do will enable citizenship and the rights and responsibilities that go with this.
Discharge Community Hub	Delivered by the local voluntary service to supporteople who are dsicharged from hospital (Pathway 0 and Pathway 1).
Southend Enhanced Discharge Service Review – Next Steps	Evaluation of the SCIE Review for the SEDS Service.
SRS Reablement Capacity and Brook Meadows Capacity	Sustain capacity at 1200hrs and strengthen delivery quality and outcomes for people.
	Agile use of the Brook Meadows Beds
	To support better outcomes and enhance ability to support more complex cases.
Targeted financial and support incentive schemes for care providers	Focussed at rewarding safe hospital discharges
	Ensuring the right people have access to the most appropriate pathways to meet need.
Winter planning: additional winter capacity	Enhance the capacity in Southend during peak periods of activity to ensure demand is met.
Winter planning; reporting and flow management	SHREWD
	LAPEL
Workforce Development	Initiatives to support the trasnforamtion and improvementof Adults SocialCare
	launch of the Social Care Provider Hub to support Social Care Providers to have access to information, advice, tranning and events.
	Developmental workshops and acceddited training for all providers to strengthen the market.
	Early alignment with Clinical Team Managers to enhance clinical training for providers.
SEE TOCH	Mobilisation of the SEE TOCH
	Exploring digital innovation to support a TOCH
Reablement Early Intervention	ECL supporting ward staff with reablement activities in the acute settings to aid faster dsicharge.
Quality Assurance and improvement plan	Focused work on internal and external quality delivery over winter periods

Southend·on·Sea City Council

Local Authorities: Southend City Council

The Winter Discharge Funding plans have been developed with internal Adult Social Care colleagues and our Integrated Care Partnership Leads to ensure the schemes which are being delivered in 2023-24 support the local care system during the winter.

Scheme	Description / rationale
Able 2 Recover	With health care moving into the community and a focus on individuals remaining at home, there is a need to adopt a range of projects which incorporates and supports the transformation and improvement of Adult Social Care.
Reablement Early Intervention	This provision to provide reablement early intervention / outreach for hospital patients identified as Adult Social Care clients awaiting discharge potentially requiring reablement. This is a ward led reablement scheme which will work in the hospital. The service will exclude patients referred to SEDs or those identified with no reablement potential.
Provider Incentive Scheme	A range of provider initiatives will be available to deliver beds or packages during high winter pressures.
Southend Enhanced Discharge Service (SEDs)	This therapy led service provides extra personal care / rehabilitation to people discharged on Pathway 1, for up to 14 days post hospital discharge during the winter.
Southend Care Ltd Enhanced Reablement Capacity	A provision of reablement through therapy led goal setting and is step up hours.
Discharge Community Hub	This scheme is in partnership with MSE Alliance and is delivered by the local voluntary service n Southend to support people who are discharged from hospital (Pathway 0 and Pathway 1).
Workforce Development	A range of projects and initiatives to support the transformation and improvement of Adult Social Care.

Thurrock Council Winter Plans 2023-24 As part of broader local transformation delivery Better Care Together Thurrock Strategy Delivery 2022-2026

https://democracy.thurrock.gov.uk/documents/s34501/Appendix%20B%20-%20Better%20Care%20Together%20Thurrock%20-%20Further%20Case%20for%20Change%20-%20Full%20Version.pdf

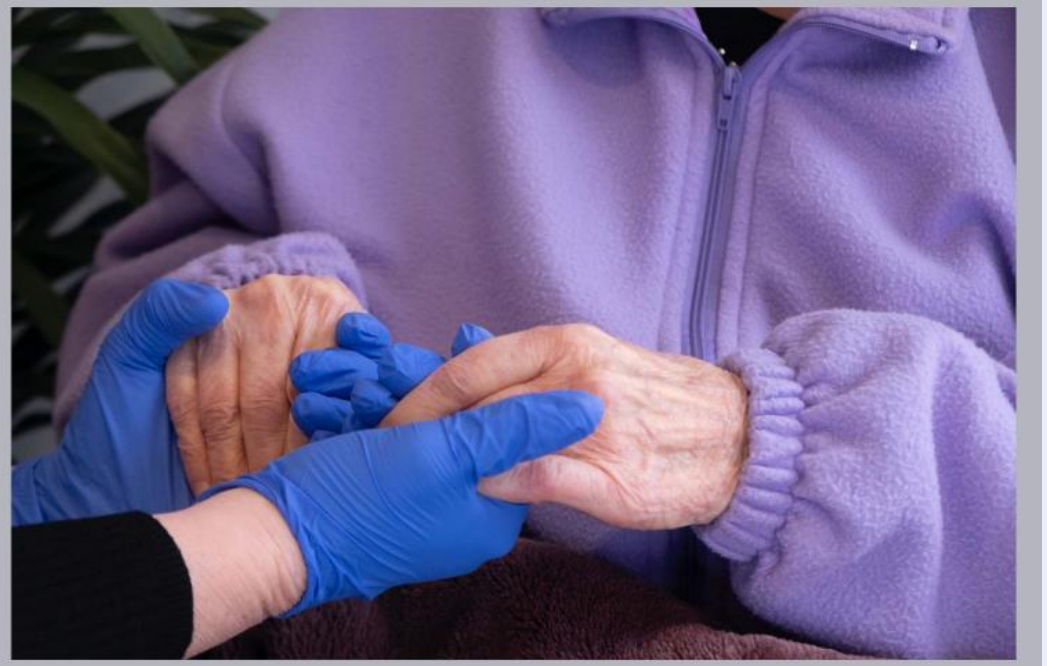
https://www.england.nhs.uk/publication/next-steps-for-integrating-primary-care-fuller-stocktake-report/

https://www.thurrock.gov.uk/sites/default/files/assets/documents/brighter-futures-strategy-2021-2026-v01.pdf

Many strategies – one aim

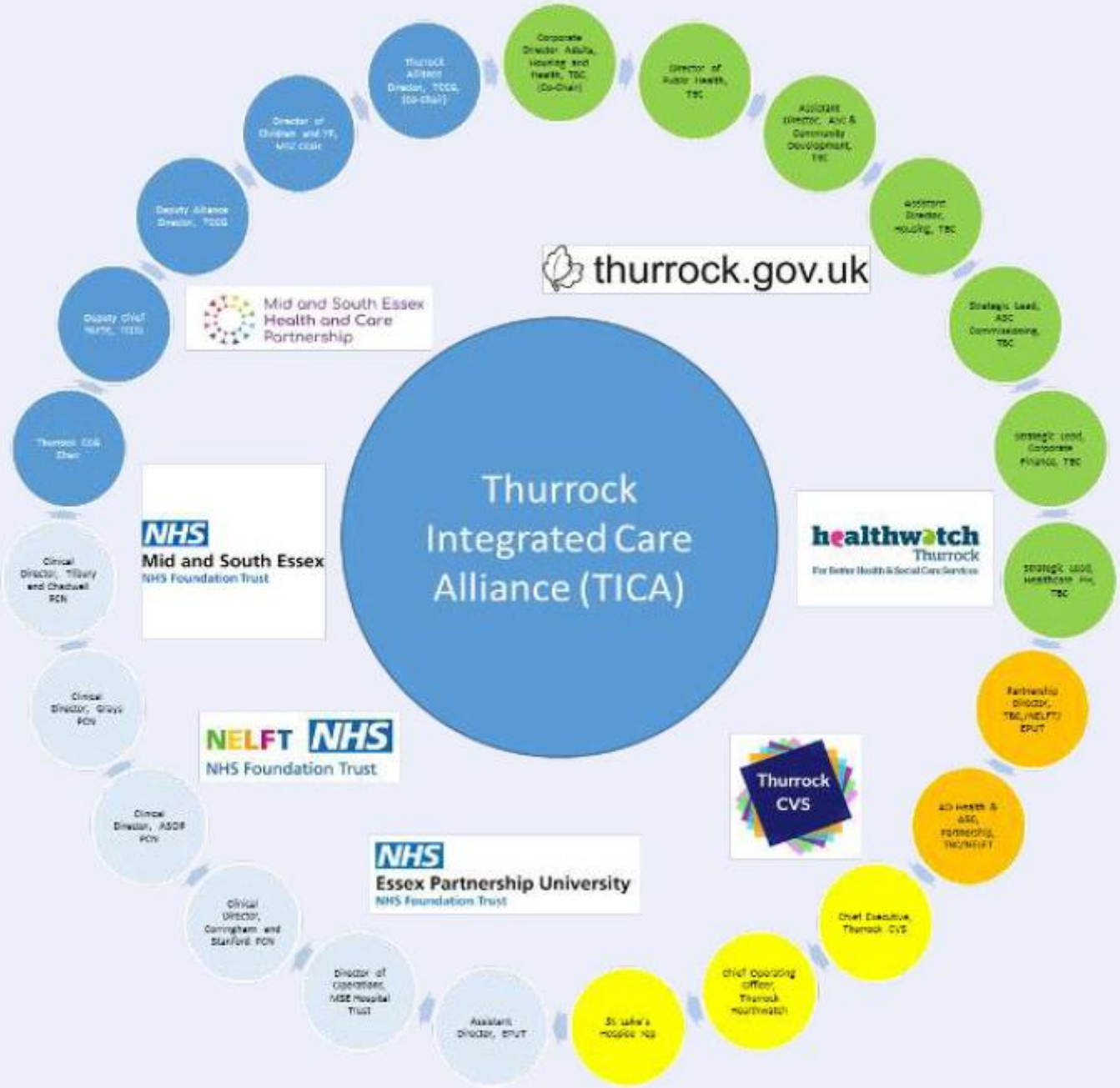
Collaboration to improve outcomes

Better Care Together Thurrock



Better Care Together Thurrock

The Case for Further Change
2022-2026



Local Authorities: Accessing Care and Support in Thurrock

The council has very clear pathways to access care and support when needed, this includes the provision of the following services:

- Thurrock First
- UCRT
- Out of Hours Domiciliary Care provision
- Emergency Telecare provision
- 7 day a week hospital discharge provision
- Emergency Duty

Thurrock Jointly commissioned teams

Since the inception of the Better Care Fund (BCF), the Authority has taken the opportunity to jointly commission a number of specialist services, these include

- Thurrock Care at Home
- Urgent Care and Response Team (UCRT)
- Thurrock First (our joint first point of contact service)
- Intermediate Care beds based at our in-house care home (Collins House)
- Equipment Contract
- Dementia Connect provision

Our work includes partnership work in the following areas:

Transfer of Care Hub – enhance current model and approach

Use of HEE funding to implement blended roles to support joint working for discharge

Continue progression of Human learning system test and learns re mental health and housing , high intensity users across health and care

Further development of INTs –'press the button' and shared space usage

Winter workforce plans developed in conjunction with health colleagues

'press the button' MDTs vs planned MDTs and a weekly SPUR (Thurrock partners huddle) capacity /pressures meeting

Winter Specific -Workforce mitigation

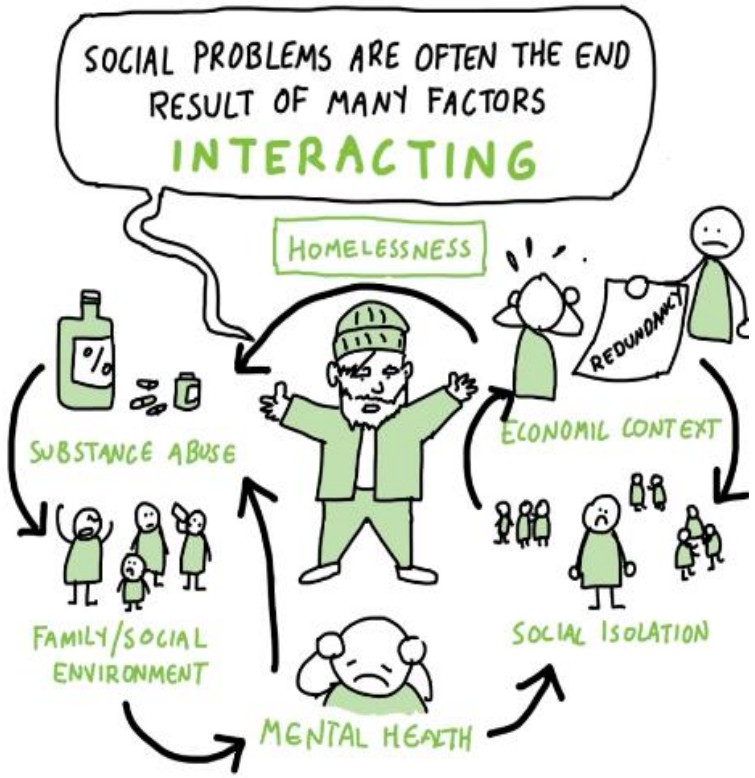
Grant monies will be used to support providers with recruitment and retention to support with timely hospital discharge
Grant monies will also be used to pay staff incentives to ensure consistency over the Christmas period
The placements and brokerage teams will be available to support hospital with arranging discharge on pathway 1 – 3, additional resource in place for the winter period

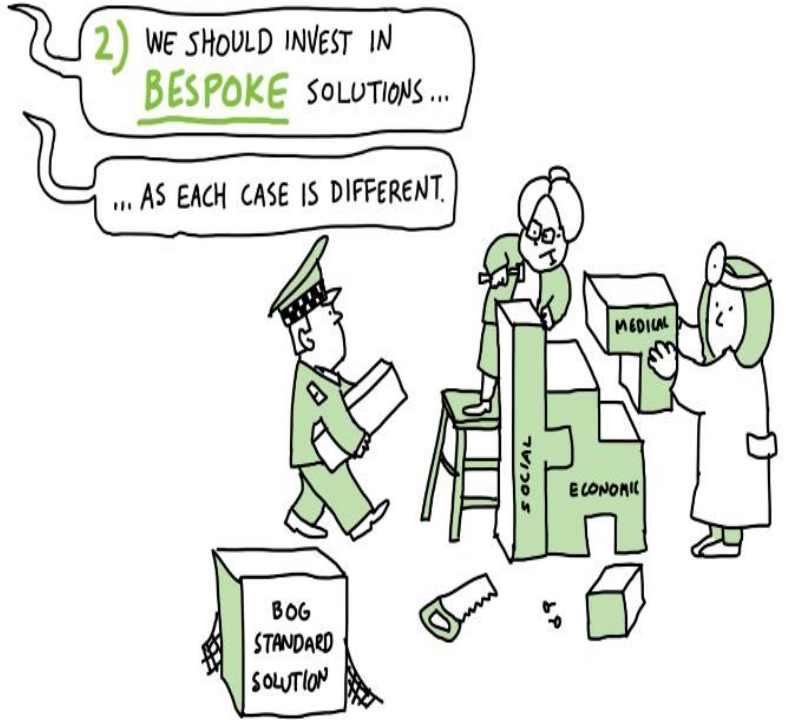
Winter Specific - Market incentives

Market incentives and initiatives	• Incentives in place to encourage providers to take on work at times when discharge may have been problematic historically i.e. Christmas and new year • Interim beds in Collins House to support discharge or prevent admission • Use of MSIF monies to continue to continue to fund home care for 7 days following hospital admission, hours not being utilised to be used to support others in the community to avoid hospital admissions
Market sustainability and pricing	• Use of MSIF monies to ensure market sustainability within Thurrock. • New tender process commenced with longer contract period to ensure market stability . • Support for providers to implement international recruitment to support timely discharge
Contingency planning	• POLR (Provider of Last Resort) arrangement in place to ensure capacity is available to step in at short notice in the event an existing provider cannot deliver safe levels of care. • To ensure all providers have their RAG rating in place and updated so that it can be implemented in times of crisis or to support with discharges

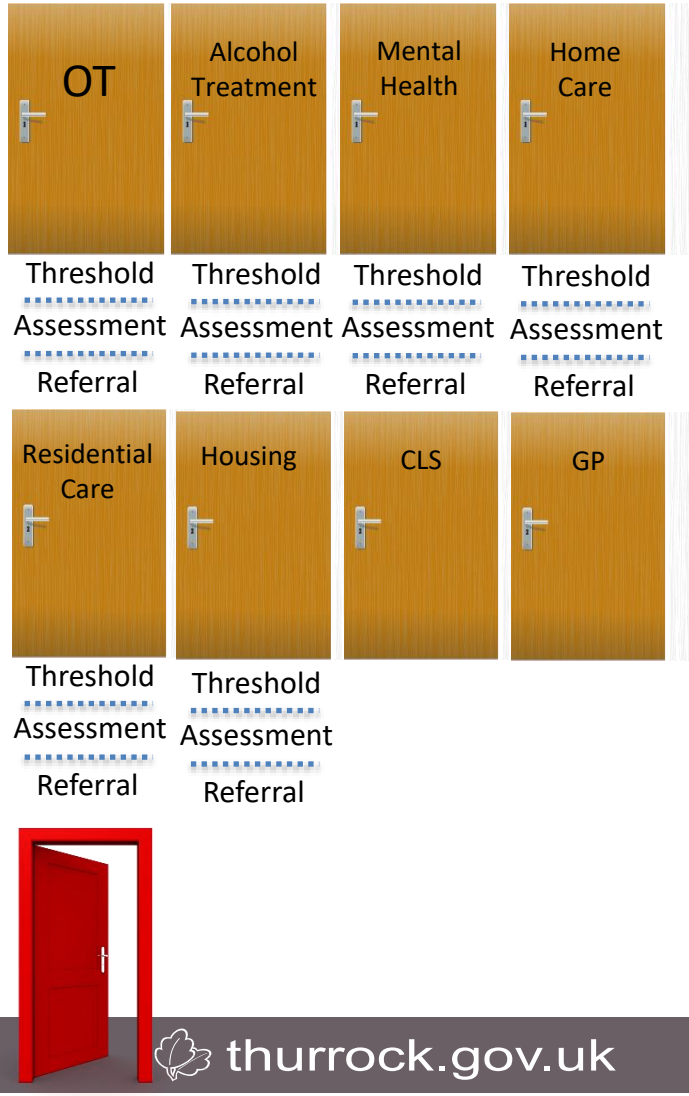
Better Care Together
Thurrock

Preventing Failure Demand Through Integration and 'Human' Public Service

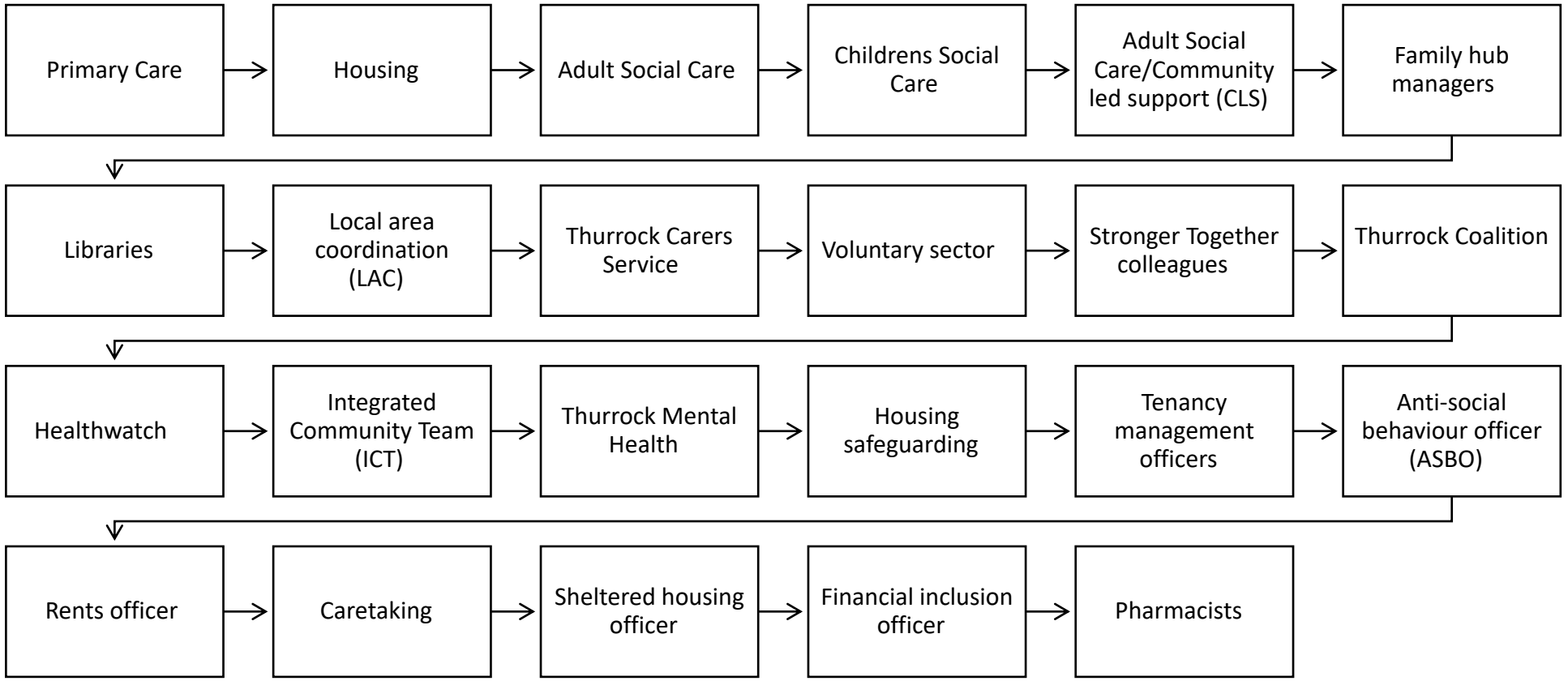




The 'Need Paradox'



Example _Members of SLH (INT4) – so far!



Chapter 8:
Integrated Support in the Home

Holistic care from fewer people

Wellbeing Teams Model

Blended roles – Wellbeing teams will soon be able to deliver delegated nursing duties

We now have an approved governance arrangement and via HEE funding are recruiting a clinical trainer /advisor

Areas for ongoing work

We recognise the work so far is a step The following are areas of focus for partnership teams over the next 6 – 12 months

Ongoing developments of Integrated Neighbourhood teams across all 4 Alliances

Future development of multiparter transfer of care hubs to further solidify seamless working

Ongoing cross partner learning and sharing good practice in breaking down barriers and supporting front line teams to network across boundaries

Encouraging codesign and cross partner working to support finding solutions and improving services for residents