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, 12 March at 1.45 pm – 3.30 pm

Function Room 1, Barleylands, Barleylands Road, Billericay, Essex, CM11 2UD

Agenda

No	Time	Title	Action	Papers	Lead / Presenter	Page No
		Opening Business				
1.	1.45 pm	Welcome & apologies	Note	-	Prof. Michael Thorne	-
2.	1.48 pm	Declarations of interest	Note	Verbal	Prof. Michael Thorne	-
3.	1.50 pm	Questions from the Public	Note	Verbal	Prof. Michael Thorne	-
4.	1.52 pm	Approval of minutes of the ICP meeting held on 11 December 2024 and matters arising	Approve	Attached	Prof. Michael Thorne	2 - 10
5.	1.53 pm	Review of Action Log *No outstanding actions*	Note	Verbal	Prof. Michael Thorne	-
		Partnership Working				
6.	1.55 pm	Healthy Work • Connect to Work Programme • Work Well Plans	Discuss	Attached	Sarah Muckle / Kellianne Clark / Kevin Garrod	11 – 35
7.	2.20 pm	Basildon and Brentwood Alliance *Partnership Case Study*	Discuss	Attached	Pam Green	36 – 117
8.	3.10 pm	MSE VCSE Engagement & Refresh	Discuss	Attached	Geoffrey Ocen / Claire Hankey	118 - 126
9.	3.30 pm	Closing Remarks	N/A	Verbal	Prof. Michael Thorne	-

DRAFT Minutes of Mid & South Essex Integrated Care Partnership (ICP) Meeting

Wednesday, 11 December at 1.30 pm – 3.45 pm

Council Chambers, Chelmsford Civic Centre, Civic Centre, Duke Street, Chelmsford, Essex, CM1 1JE

Attendees

Members

- Professor Mike Thorne (MT), Chair of Mid and South Essex Integrated Care Partnership
- Cllr John Spence (JS), Essex Health & Wellbeing Board Chair & ICP Vice-Chair, Essex County Council
- Cllr Maxine Sadza (MS), Essex Health & Wellbeing Board Chair & ICP Vice-Chair, Southend City Council
- Cllr Mark Hooper (MH), Thurrock Health & Wellbeing Board Chair & ICP Vice-Chair, Thurrock Council
- Tom Abell (TA), Chief Executive Officer, MSE ICB
- Nick Presmeg (NP), Director of Adult Social Care, Essex County Council
- Robert Persey (RP), Director of Adult Social Care, Thurrock Council
- Claire Hankey (CH), Director of Communications & Partnerships, MSE ICB
- Daniel Doherty (DD), Alliance Director, Mid Essex, MSE ICB
- Aleksandra Mecan (AM), Alliance Director, Thurrock, MSE ICB
- Kathy Bonney (KB), Chief People Officer, MSE ICB
- Sharon Stoltz (SS), Director of Public Health, Thurrock Council
- Dr Reg Rehal (RR), Thurrock Alliance Clinical Lead, MSE ICB
- Nigel Beverly (NB), Chair, MSEFT
- Eileen Taylor (ET), Chair, Northeast London NHS Foundation Trust (NELFT)
- Giles Thorpe (GT), Chief Nurse, MSE ICB
- Matthew Sweeting (MS), Chief Medical Officer, MSE ICB
- Lorraine Jarvis (LJ), Chief Officer, Chelmsford CVS
- Sheila Salmon (SSa), Chair, Essex Partnership University Trust (EPUT)
- Mark Bailham (MB), Non-Executive Member (NEM), MSE ICB
- Owen Richards (OR), Chief Executive Officer (CEO), Healthwatch Southend
- Krishna Ramkhelawon (KR), Director of Public Health, Southend City Council
- Steve Smith, Chief Executive Officer, Havens Hospice
- Professor Shahina Pardhan (SP), Associate NEM, MSE ICB
- Camille Cronin (CC), Director of Research and Professor of Nursing, University of Essex
- Paul Dodson (PD), Director of Strategy and Resources, Maldon District Council
- Cllr Jane Fleming (JF), Elected Member, Essex County Council

Page 1 of 9

- Ru Watkins (RW), Chief Executive, Hamlin Trust
- Cllr Lynsey McCarthy-Calvert (LM-C), Council Mayor, Castle Point Borough Council

Other attendees

- Clare Angell (CA), Deputy Director of BCYP, SEND and Specialised Commissioning, MSE ICB
- Marie McEntee (MM), Senior Manager BCYP and SEND, MSE ICB
- Emma Timpson (ET), Associate Director Prevention and Health Inequalities, MSE ICB
- Sophia Morris (SM), System Clinical Lead for Inequalities, MSE ICB
- Margaret Allen (MA), Deputy Alliance Director, Thurrock, MSE ICB
- Chris Wade (CW), Head of Housing Solutions, Thurrock Council
- Tonino Cook, Executive Business Manager (Minutes), MSE ICB
- Evie McMahon, Business Manager, MSE ICB
- Peter Blackman, Member of the Public

Apologies

- Robert Parkinson (RP), Chair, Provide CIC
- Mark Heasman (MH), Group Chief Executive Officer, Provide CIC
- Lucy Wightman (LW), Chief Executive Officer and Chief Nurse, Provide Health
- Rebecca Jarvis (RJ), Alliance Director, Southeast Essex, MSE ICB
- Pam Green (PG), Alliance Director Basildon and Brentwood, MSE ICB
- Mark Harvey (MH), Director of Adult Social Services, Southend City Council
- Barry Frostick (BF), Chief Digital and Information Officer, MSE ICB
- Grant Taylor (GT), Head of Culture and Health, Basildon Borough Council
- Professor Victoria Joffe (VJ), Dean, University of Essex
- Dr Brian Balmer (BB), Chief Executive Officer, Essex Local Medical Committee (LMC)
- Jennifer Kearton (JK), Chief Finance Officer, MSE ICB
- Cllr Julie Gooding, Lead Member, Rochford District Council
- Peter Fairley (PF), Director of Integration and Partnerships, Essex County Council
- Cllr Graham Butland, Leader of the Cabinet, Braintree District Council
- Sheila Murphy, Corporate Director for Children Services, Thurrock Council
- Cllr John Mason, Leader of the Council, Rochford District Council
- Jonathan Stephenson, CEO, Rochford District Council
- Cllr Richard Siddall, Leader of the Council, Maldon District Council
- Michael Marks, Director of Children Services, Southend City Council
- Emily Hough (EH), Executive Director of Strategy & Corporate Services, MSE ICB

1. Welcome and Apologies

MT welcomed members to the meeting and reminded members of the public that the ICP is a meeting held in public to enable transparent decision making, not a public meeting, and therefore members of the public would be unable to interact with the Partnership during discussions.

Apologies were noted as listed above.

2. Declarations of Interest

MT reminded members of their obligation to declare any interests in relation to the issues discussed at the beginning of the meeting, at the start of each relevant agenda item, or should a relevant interest become apparent during an item under discussion, in order that these interests could be managed. MT noted that each member will have a conflict for their sovereign organisation.

No additional conflicts of interests were raised.

3. Questions from the Public

MT advised that questions had been submitted by members of the public, as set out below.

Peter Blackman asked three questions to the Integrated Care Partnership:

1. What progress had been made since the last meeting on 11 September 2024 towards ensuring the VCFSE Community Assembly is re-engaged in discussing priorities and delivery plans for the health and wellbeing of the local communities throughout Mid & South Essex, including that of South Woodham Ferrers.

2. What has been done by the four Alliances since the last meeting to increase their engagement with local and common interest community organisations i.e. grassroots ones?

3. The NHS England report “Embedding VCSE in ICSs – Temperature Check” of the position from June 2024 Survey shows MSE ICP to be well behind with this. Is this a breach of regulatory mandatory work*? What has been done with MSE ICS’s share of the £4.8m invested in Embedding the VCSE sector in ICSs’ programmes between 2018 and 2023?

CH updated that since the last ICP meeting on 11 September 2024, progress has included an ongoing series of conversations with sector leaders and a joint working session with the Alliances and Essex County Council to look at how MSE can work more closely and avoid duplication in approach.

CH noted that Geoffrey Ocen, one of the ICB’s Associate Non-Executive Members has been asked by the ICP chair Mike Thorne, to support this work and to oversee how the system can develop and relaunch a strategic VCFSE Assembly for the system.

The four Alliances have continued to enhance their local engagement alongside several VCSFE organisations including community events to support vaccination uptake and health promotion opportunities, such as slipper swaps and blood pressure monitoring.

Page 3 of 9

Centrally, the ICB have also held our first Research Engagement Network celebration event, as well as digital and outreach engagement on key topics such as barriers to breast screening uptake, diabetes and hospital discharge. More information can be found on the ICS website.

The original funding provided by NHS England to support Embedding VCSE in ICSs, which was circa £10K for MSE, was allocated to support capacity-building for VCFSE organisations to establish early formal engagement structures.

The report referenced highlights several helpful areas for improvement in working across both sectors, albeit not specific to MSE ICP where several VCFSE leaders have membership.

CH recognised there is always more work to do to ensure the VCFSE sector is recognised and valued as a vital partner in shaping and delivering our local health and wellbeing priorities.

Resolved: The Partnership NOTED the questions from members of the public.

4. Minutes of Previous Meeting, 11 September 2024

MT referred to the draft minutes of the meeting held on 11 September 2024. No comments, questions, or amendments were raised.

Resolved: The Partnership APPROVED the minutes of the ICP meeting held on 11 September 2024, as an accurate record.

5. Review of Action log

MT noted there were no outstanding actions for review.

Resolved: The Partnership NOTED the update on the action log.

6. Healthy Starts – Programme Update

CA provided an overview of work underway within the Healthy Starts programme, which forms part of the broader Babies, Children, and Young People (BCYP) programme of work. CA noted a key focus has been ensuring strategic initiatives align at both system and place levels, ensuring consistency and impact across MSE.

MM noted that Healthy Starts fits into the five key healthy programmes agreed by the ICP (Healthy Start, Healthy Weight, Healthy Heart, Healthy Minds, and Healthy Housing).

Each of these areas operates under a dedicated governance structure. The system Growing Well Board provides oversight for the Healthy Starts programme, with membership drawn from both local authorities and NHS partners. The board is chaired by Dr Giles Thorpe, Chief Nurse, MSE ICB.

The Healthy Starts programme focuses on six priority areas:

- Special Educational Needs and Disabilities (SEND)
- Neurodiversity
- Long-Term Conditions

Page 4 of 9

- Oral Health
- Community Services
- Acute Services

It was noted that SEND and Oral Health have been identified as key priority areas for the Integrated Care Partnership (ICP), while all six areas remain a focus for the Integrated Care Board (ICB).

MM noted that CYP fit into each of the four other healthy programme areas, with interdependencies for each:

- Healthy Weight: A gap exists between current commissioning arrangements across Tier 2 services commissioned by local authorities, and health commissioned hub models. As a result, has resulted in a gap between services, especially for children who fall between the two services. Work is ongoing to bridge this service gap, ensuring children receive the support they need.
- Healthy Hearts: While primarily targeted at adults with cardiovascular disease, improved management of diabetes, epilepsy, and asthma in children is crucial for long-term health outcomes.
- Healthy Minds: Focus on re-procuring CYP counselling services and increasing mental health practitioner support within Primary Care Networks (PCNs), with fourteen out of twenty-seven PCNs currently serviced by a dedicated mental health practitioner.
- Healthy Housing: The primary focus is on asthma and its links to damp and mould in housing conditions, ensuring a coordinated approach across health and housing sectors.

MT queried the role of digital transformation within Children and Young People (CYP) services. CA responded that within the SEND agenda, access to high-quality digital advice and resources is a key priority. Research indicates that 60% of CYP prefer to seek support online, compared to 19% of parents and carers. Moving forward, digital-first access will be a focus for future transformation efforts.

SS referenced the HOSC task and finish group on childhood obesity, which highlighted integration challenges between local authority and health services.CA agreed that stronger partnerships and structured joint conversations are needed to align efforts at the system and place levels. Mapping work has begun in Southend, with plans to replicate this approach in Thurrock.

MS queried the involvement of lived experience champions.CA confirmed that the CYP group includes strong parent and carer representation, but further engagement with lived experience groups would be valuable.

ET raised concerns about eating disorder (ED) pathways for children, citing gaps in coverage across Essex. CA acknowledged the issue, noting that children are often seen too late, sometimes with stunted growth or acute needs. Transport challenges were also raised, with some ED services only accessible for families on benefits. Work is ongoing to improve efficiency and focus on early intervention.

Page 5 of 9

RW highlighted positive collaborative work with the voluntary and social enterprise (VSE) sector and queried how alliances could further support Healthy Starts. CA confirmed that the Growing Well Programme Board includes VSE representation, but further engagement will be explored.

LM highlighted challenges in accessing SEND and neurodiversity services, including long diagnosis waits and limited school support.CA acknowledged this as a “wicked problem” with previous investment not yet yielding expected impact. The priority remains on preventative support, ensuring early identification and consistent service quality. Work is underway with the University of Essex to conduct a needs analysis.

MT thanked colleagues for their contributions and the ongoing work to drive improvements within the Healthy Starts programme.

Resolved: The Partnership NOTED the Healthy Starts update.

7. Partnership Case Study – Thurrock Alliance

MT welcomed colleagues from Thurrock alliance, noting that this update is part of regular alliance-level reporting to each ICP meeting.

AM noted the focus of the update on housing and homelessness, cardiovascular disease (CVD), and early years oral health. AM updated that the Better Care Together Thurrock Strategy aims to ensure people are supported to start well, live well, and age well. AM outlined the five key areas of the strategy:

1. Prevention as a priority
2. Tackling health and wellbeing inequalities
3. The importance of place and local assets
4. An evidence-based and community insight-led approach
5. Co-production

RP noted the context that Thurrock’s population has grown to just under 180,000, a 11.6% increase in a decade, with continued growth expected. The age profile is lower than the East of England average, with high levels of deprivation. Life expectancy gaps remain significant (9.4 years for men, 6.5 years for women). However, healthy life expectancy is low (early 60s for both men and women), meaning most individuals enter retirement with some level of poor health.

Over the past 10 years, a strong focus has been placed on integrated working across public health, NHS, social care, and children’s services. Multi-Disciplinary Teams (MDTs) are now embedded to provide person-centred care.

CW provided an update on the work underway to tackle homelessness and housing across Thurrock. CW noted that 64% of homes in Thurrock are owner-occupied, 18% social rented (approximately 10,000 units), and 18% privately rented. Homelessness has seen significant increases, with a 100% rise in applications over the past 10 years. Primary causes of homelessness include family and friend evictions, historically manageable due to housing availability, but now a growing challenge.

Page 6 of 9

The Complex Housing Intervention Programme (CHIP) trial launched one year ago and has now been extended to three years due to its success. This programme supports individuals in housing crisis, providing access to Psychologists, Drug & Alcohol Workers, Mental Health Social Workers, and Senior Local Area Coordinators.

Housing First has successfully provided stable housing for vulnerable individuals, preventing crises. Five dedicated Housing First spaces are available, with additional funding secured for Enhanced Housing First.

CW highlighted a case study, in which a 24-hour care package costing approximately £122k per year was successfully transitioned to a self-contained flat under Enhanced Housing First, with intensive support. The result was a reduction in care package costs to just 6 hours per week. This included property and wellbeing check-ins which enable early interventions, tackling wider determinants of health, such as housing safety issues.

RR updated on the work to address card cardiovascular disease (CVD) across Thurrock. RR noted 71% of hypertension patients are now adequately treated, with a target of 80% by March 2025. Many other areas range from 59.5%-65.8% treatment rates. RR noted that data also shows:

- 69% of patients under 79 have blood pressure controlled to under 140/90 mmHg (above the system average).
- 81.5% of patients aged 80+ have blood pressure below 150/90 mmHg (again, above the system average).

A collaborative approach is being used, involving GP surgeries, Public Health teams, community pharmacies, and off-site NHS health checks in shopping centres and community hubs.

MA updated on Thurrock's Early Years Oral Health Programme. MA noted that Thurrock has a Large and diverse young population (27.1% 0-19 years old), with 1 in 5 under 16's (21.2%) in Thurrock growing up in poverty, higher than the national rate.

As a result, a Supervised Tooth Brushing (STB) programme is being implemented across ten schools and family hubs in high-deprivation areas. The programme has been in delivery for 11 months, and has already seen:

- 82 educational programme events delivered.
- 17 out of 20 Early Years settings onboarded for STB.
- 2,062 individuals engaged (parents, carers, children, and staff)
- 93 Early Years workforce members trained.
- 10,831 toothcare packages distributed.
- 421 children signposted to dental practices.
- The number of children registered with Thurrock dental practices increased by 378 over the past year.

Page 7 of 9

MS noted that wellbeing checks often identify wider issues beyond health and social care, such as financial hardship and housing concerns.

DD queried whether lipid management and CVD interventions have led to measurable reductions in strokes and heart attacks. RR responded that it is too early to assess impact, but an outcome review is scheduled for March.

MT concluded that the success of the Thurrock strategy relies heavily on strong system partnerships and relationships. MT thanked colleagues for their involvement and delivery of Thurrock's strategy.

Resolved: The Partnership NOTED the Thurrock Alliance Partnership update.

8. ICP Ambitions – Population Health Improvement Board (PHIB)

ET and KR provided an update on the work of the Population Health Improvement Board (PHIB). ET updated PHIB has been in place for two years to address health inequalities across the system. The PHIB has initially focused on five priority areas, designed as short-term goals, but these have evolved into multi-year programmes. The long-term ambitions, aiming to quantify progress over 5-10 years will help guide resource allocation and investment priorities, ensuring sustainable improvements in health outcomes.

As a result of the work done over the last two years, gaps were highlighted in existing programmes, including Healthy Living, which has now seen expansion of the Over-40s Health Check Programme, with further work to extend immunisation initiatives and Healthy Work, and the introduction of the Work Well Programme, which aims to align with the broader Healthy Living strategy while exploring further cross-system collaboration opportunities.

ET noted that efforts are underway to align outcome measures to ensure a cohesive approach to reducing health inequalities and improving patient outcomes. The need for ambitious long-term goals was emphasised, ensuring consistent system-wide focus on priority areas. This work has been developed in collaboration with Directors of Public Health (DPHs) across the system.

KR highlighted that some areas require stronger strategic focus. There is a continued aim to standardise language and priorities across councils, reduce duplication, and ensure collaborative working across the ICP.

SS raised concerns about workplace health, noting that over 30% of the working population are off sick on fit notes. Addressing this issue is essential for achieving the Council's health ambitions, and it remains a common challenge across the system.

Resolved: The Partnership NOTED the report and update on ICP Ambitions.

Resolved: The Partnership APPROVED option A of the revised ICP programme approach, incorporating Healthy Aging into the wider Healthies programme.

9. Core20PLUS5 Community Connectors

OR and SM provided an update on the Core20PLUS5 programme, highlighting its role in reducing health inequalities and improving community engagement. The programme is

Page 8 of 9

supported by NHS England and focuses on access, outcomes, and patient experience as part of the triple aim approach.

OR noted the Community Connectors target geographically disadvantaged areas and key priority areas under Core20PLUS5. The bidding process for additional funding was successful in Wave 2, with the system being one of the first to focus on respiratory conditions. The programme adopts a co-design approach, working closely with local residents and patient groups to shape services.

OR highlighted the Breathe Easy Group in Southend which has been instrumental in supporting individuals with chronic respiratory problems.

SM noted the value of lived experience is a core principle, with a group of approximately 10 individuals (patients and carers) acting as Community Connectors, fostering shared experiences and contributing to service design. Power-sharing with connectors has been a priority, ensuring they sit alongside decision-makers and influence the development of the programme.

OR noted the programme initially launched in six wards in Southend, identified as having the greatest health inequalities for COPD. Further funding of £20,000 has now been allocated by NHS England, with additional financial support from the Essex Better Care Fund, allowing for roll-out to Castle Point & Rochford.

Unlike other initiatives, this programme is not focused on numerical monitoring but rather on qualitative narrative and the impact of real-life changes.

OR noted engaging with multiple decision-makers across different sectors (clinical teams, estates staff, and local authorities) remains a challenge. With digital exclusion remaining a barrier—many Community Connectors did not use digital methods initially, but support is now in place to address this gap.

Resolved: The Partnership NOTED the update on the Core20PLUS5 Community Connectors programme.

10. Any other Business

No other business was raised.

11. Date of Next Meeting

Date: Wednesday, 12 March 2025
Time: 13:00 – 15:45
Venue: Barleylands, Basildon.

Page 9 of 9

Meeting of MSE Integrated Care Partnership on 12 March 2025

Agenda Number: 6

Healthy Work Programme Update (Connect to Work & Work Well)

Summary Report

1. Purpose of Report

To provide Mid and South Essex Integrated Care Partnership an overview of the Connect to Work (CtW) programme and ICS Work Well activity and outline how the planned programme links to and embraces devolution and integrates with partners to deliver social and economic well-being.

2. Executive Lead

- Sarah Muckle, SRO for Healthy Work, Director of Wellbeing, Public Health and Communities, ECC

3. Report Authors

- Kevin Garrod, Anchor Programme Manager - Local Value Lead, MSEFT
- Johnathon Cuthbertson, Head of Employability and Skills, Essex County Council
- Kellianne Clark, Work & Health lead Mid and South Essex ICB

4. Responsible Committees

N/A

5. Link to the ICP's Strategic Objectives

ICP Strategy Common Endeavour to Reduce Health Inequalities and its Objective 4 to support the development of social and economic wellbeing.

6. Impact Assessments

Essex County Council have completed an EQIA.

7. Financial Implications

N/A

8. Details of patient or public engagement or consultation

Connect to Work have engaged, and will continue to, with system partners the programme will be supported by a communications strategy and implementation plan.

WorkWell has engaged with local businesses and sought feedback from co-produced events with the DWP and Local Authority partners.

9. Conflicts of Interest

None

10. Recommendation/s

That ICP Board are asked to:

1. Support the Connect to Work Delivery plan.
2. Note the Greater Essex approach for Connect to Work and Get Britain Working Again Plan
3. Note the activity undertaken with WorkWell funding.

Healthy Work; Connect to Work & Work well Leadership Capacity Funding.

1. Introduction

The Government's "Get Britain Working Again" White Paper set out the Government's intention to devolve funding for supported employment, including £115m to local areas to deliver the 'Connect to Work Programme' a new DWP, voluntary Supported Employment programme for those considered economically inactive and /or unemployed and where their work is at risk The NHS Mandate for 2025-26 equally identifies that

> *Alongside our health mission, our ability to achieve the government's growth mission is dependent on a healthy, productive workforce. At the start of this year, 2.8 million people were economically inactive due to long-term illness.*
>
> *We know that 4.1 million people are in employment with a work-limiting health condition - an increase of 300,000 in the last year. The NHS plays a vital role in keeping people healthy and in work.*

The UK's economic inactivity rate has risen sharply since the pandemic, with over 900,000 additional people outside the labour market. In 2023-24 Mid and South Essex issued some 55,000 5–12week fit notes.

2. Purpose of the Report

To provide Mid and South Essex Integrated Care Partnership an overview of the Connect to Work (CtW) programme and ICB Work well activity and outline how the planned programme links to and embraces devolution and integrates with partners to deliver social and economic well-being.

3. Background and Overview of Connect to Work

The Connect to Work programme will support up to 2,600 economically inactive people at its peak capacity per year across Greater Essex of which 50% are expected to move into and sustain meaningful work. A limited number (15%) are expected to be supported to sustain their work.

Essex County Council (ECC) will act as the Lead Authority and Accountable Body, coproducing with partners the Connect to Work Programme across the Greater Essex. support will be delivered, explicitly, through two accredited supported employment models.

- Individual Placement and Support (IPS) – linking employment support with primary and secondary health services.
- Supported Employment Quality Framework (SEQF) more intensive employment support to overcome individual barriers to employment.

Target cohorts, defined by central Government, are those considered economically inactive, part of the 'hidden unemployed' (those not considered in current unemployment rates, who may be willing and able to work but not actively looking to do so). Participants may include those:

- Suffering from health conditions currently preventing them from working, individuals with a disability (as defined under section 6 of the Equality Act 2010)
- Disadvantaged groups including offenders/ex-offenders, carers, homeless people, veterans, individuals with a drug or alcohol dependency (history or current), refugees or victims of domestic abuse[1].

The programmes participants will need to be both eligible and suitable – many may be eligible but not suitable for the programme's mandated supported employment approach. Participants need to be ready for and want paid employment.

Sustained employment is Connect to Work's key outcome supporting primarily those out of work but also a small cohort of those in work. The programmes `place, train and maintain models, underpinned by IPS and SEQF standards, will support individuals through initial engagement, the identification of strengths and goals, matching to potential vacancies, engagement with their employer and ongoing support on and off the job.

Performance measures focus upon the number of participants starting the programme, achieving first earnings, 'out-of-work' participants achieving either a 'lower' or 'higher threshold job outcome'. The programmes performance will be assessed by DWP through analysis of monthly management information returns and compliance to IPS/SEQF quality assurance (Fidelity).

The support for skills and employment is a key component of devolution modelling, success with the Connect to Work programme will contribute to leveraging greater agency for Greater Essex.

4. WorkWell Leadership Capacity Funding

Separately, Mid and South Essex ICB received £89k of Work well leadership capacity funding in May 2024 and another £89k in January 2025 with the purpose to fund leadership roles to work across local partners to mobilise work and health integration.

This funding has been used to Fund a Band 8a (0.4WTE) & Band 7 (0.6 WTE, seconded from Mid & South Essex Foundation Trust) to provide resource to support this work. The initial purpose of this funding was to:

Strengthen Collective Leadership: Establish a system-wide *Healthy Work* group across Essex, Southend, and Thurrock, bringing together health, social care, and community organisations.

Map & Expand Best Practices: Identify existing initiatives, assess gaps, and create a framework to spread successful approaches into underserved areas.

Enhance Communication & Engagement: Develop a strategy with regular updates, newsletters, and stakeholder briefings. Explore ways to engage communities and gather local input.

1

Improve Data Utilisation: Work with the population health team to enhance data collection, analysis, and dashboards for informed decision-making. Conduct a review to identify areas for improvement.

Boost Local Engagement: Support events through Alliances, INTs, DWP and local authority to increase resident and partner involvement in *Healthy Work* initiatives.

As part of our mapping exercise, a newly developed tool has been created to enhance the identification of supported employment opportunities. The tool is being adopted by Essex Frontline, facilitating broader application and accessibility to both residents and clinicians. Essex Frontline is a large community project where organisations and services can sign up to improve people's knowledge and access to local services. Frontline workers, health and wellbeing service workers and the general public can use the platform to make referrals into health and wellbeing community services across Essex, Southend and Thurrock. Whilst Southend use Livewell and not Frontline, the Livewell app does 'talk' to and interact with Frontline and so users in Southend will also be able to access the information. A series of co-produced events have been organised in collaboration with the Department for Work and Pensions (DWP) and Local Authorities. These events have successfully connected health services, skills and training providers, and employers to foster a more integrated approach to supported employment.

A Monthly Work & Health Steering Group has been established to ensure sustained oversight and progress. Collaboration with Connect to Work is ongoing to ensure robust health care representation and interdisciplinary co-operation.

The ICB is currently developing its plans on how to further utilise the additional £89K received in January. We are currently exploring ways to facilitate in-hospital employment support for patients and family members who:

- Face work challenges due to illness or injury
- Have suddenly become carers.

5. Recommendation(s)

That ICP Board are asked to:

1. Support the Connect to Work Delivery plan.
2. Note the Greater Essex approach for Connect to Work and Get Britain Working Again Plan
3. Note the activity undertaken with Work well funding.

Essex County Council

Healthy Work : Connect to Work

Mid and South Essex Integrated Care Partnership Board

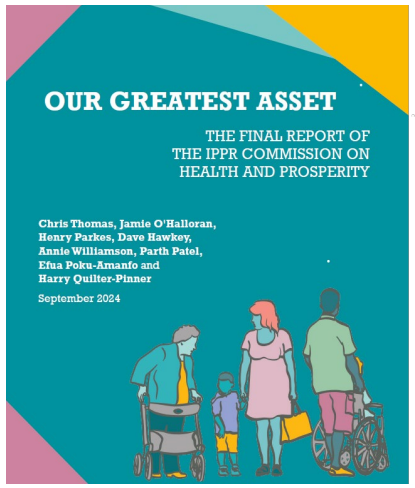
12th March 2025

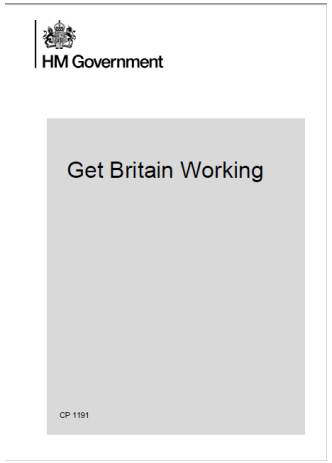
NHS Mandate 2025:

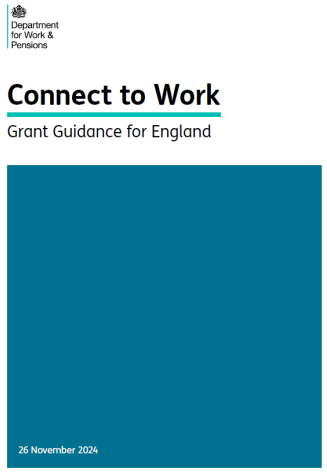
The Road to Recovery

Alongside our health mission, our ability to achieve the government's growth mission is dependent on a healthy, productive workforce. At the start of this year, 2.8 million people were economically inactive due to long-term illness.

We know that 4.1 million people are in employment with a work-limiting health condition - an increase of 300,000 in the last year. The NHS plays a vital role in keeping people healthy and in work.







Background & Context

The Connect to Work programme was launched in November 2024 and represents the first English commitment and investment to support the Get Britain Working Again white paper

1. Connect to Work will take a collaborative, locally led approach to tackling ‘Hidden Unemployment’. It will help connect local work, health and skills support using a place, train and maintain approach.

2. The funding provides a coherent, systematic and joined up approach to maximise the benefits available for individuals and local communities. Accountable Bodies (Essex County Council) will determine how the support is delivered locally, in line with local priorities.

3. The programme mandates the Individual Placement and Support (IPS) and Supported Employment Quality Framework (SEQF) models. These approaches focus on providing individualised personal support that is tailored to each individual’s specific needs and delivered end to end by Employment Specialist .

What is Connect to Work?

- A new DWP voluntary Supported Employment Programme (delivering through SEQF and IPS models) supporting those facing barriers to accessing employment with a small proportion also supporting those seeking to get into work.

- One of the ‘Stepping Stones to Devo’ – will form part of a devolved funding offer for a future Greater Essex MCA; recognised by the commissioning approach and geography from DWP.

- A significant step towards creating a more inclusive workforce by addressing the specific needs of individuals with barriers to employment fostering local collaboration and providing tailored support, to improve employment outcomes and contribute to the overall economic growth.

What is Connect to Work?

Supported Employment Programme will engage those in the specified cohorts to move into and sustain meaningful employment – right people at the right time.

The **supported employment models** have clear stages, principles, and compliance (Fidelity) to the models which is important, covering for example the principle IPS approach, provision for;

- Its integration into health structures (Multi-Disciplinary Teams)
- Leadership, workforce quality and caseload management
- Employer engagement and interagency working

Connect to Work outcomes, cohorts and fidelity

Focus on those who are economically inactive 'hidden unemployment' falling into the following categories:

- ✓ Health conditions.
- ✓ A person with a disability (as defined under section 6 of the Equality Act 2010).
- ✓ Disadvantaged groups including offenders/ex-offenders, carers/ex carers, homeless people, veterans, a person with drug or alcohol dependency (history or current), refugees, victims of domestic abuse.

Local Areas will not be able to extend or amend eligibility but will have flexibility to shape their offer around priority groups to reflect local need and provision of other employment support locally.

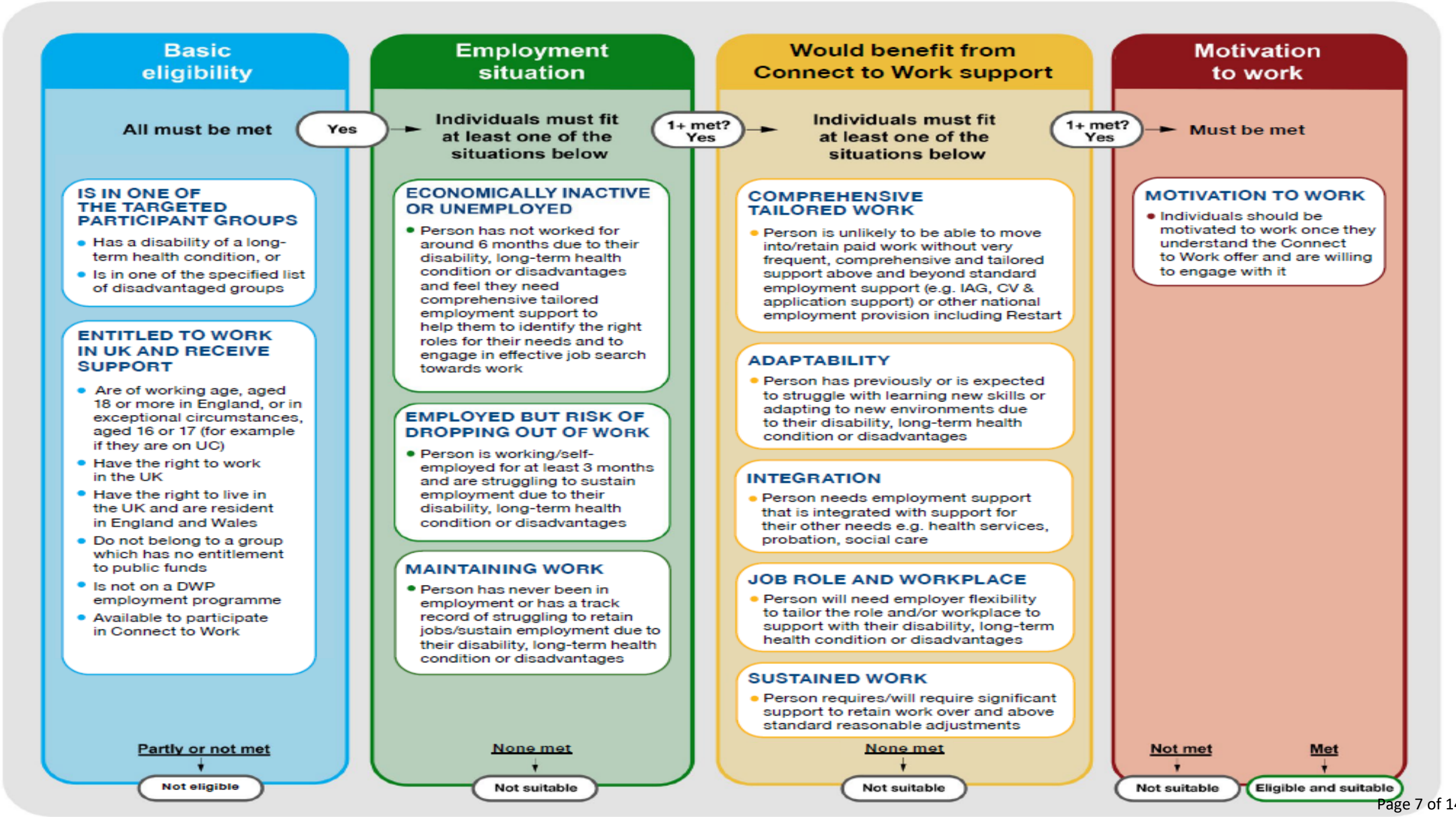
Full running 2,600 participants start – **1,300 Job Starts**

Ready and want to start work

Place, train and maintain

Performance Measures	
Job Starts	• At least 50% of total Programme Starts to achieve first earnings ('Out-of-Work' Participants). To be achieved up to 456 calendar days from the Participant's programme start date, or if extended up to 638 calendar days from the start date.
Outcomes (See Technical Note: Job Outcomes)	• At least 40% 'Out-of-Work' Participants of total Programme Starts to achieve a Lower Threshold Job Outcome. Earnings threshold calculation (9hrs x 13 weeks x NLW) and Self-employed equivalent measured over 13 cumulative weeks. To be achieved up to 456 calendar days from the Participant's start date, or if extended up to 638 calendar days from the start date.
	• At least 29% 'Out-of-Work' Participants of total Programme Starts to achieve a Higher Threshold Job Outcome. Earnings threshold calculation (18 hrs x 26 weeks x NLW) and Self-employed equivalent measured over 26 cumulative weeks. To be achieved up to 456 calendar days from the Participant's start date, or if extended up to 638 calendar days from the start date.
	• At least 80% of 'In-Work' Retention Support Participants to achieve a Higher Threshold Job Outcome (higher only – Employed and Self-employed Job Outcomes). Earnings threshold calculation (18 hrs x 26 weeks x NLW) and Self-employed equivalent measured over 26 cumulative weeks. To be achieved up to 365 calendar days from the Participant's start date.

Fidelity : Targeted, specialist employment support underpinned by IPS and SEQF standards designed to support recruitment and-long-term retention of individual employment.


Basic eligibility
All must be met
Yes
IS IN ONE OF THE TARGETED PARTICIPANT GROUPS
Has a disability of a long-term health condition, or
Is in one of the specified list of disadvantaged groups
ENTITLED TO WORK IN UK AND RECEIVE SUPPORT
Are of working age, aged 18 or more in England, or in exceptional circumstances, aged 16 or 17 (for example if they are on UC)
Have the right to work in the UK
Have the right to live in the UK and are resident in England and Wales
Do not belong to a group which has no entitlement to public funds
Is not on a DWP employment programme
Available to participate in Connect to Work
Partly or not met
Not eligible
Employment situation
Individuals must fit at least one of the situations below
1+ met? Yes
ECONOMICALLY INACTIVE OR UNEMPLOYED
Person has not worked for around 6 months due to their disability, long-term health condition or disadvantages and feel they need comprehensive tailored employment support to help them to identify the right roles for their needs and to engage in effective job search towards work
EMPLOYED BUT RISK OF DROPPING OUT OF WORK
Person is working/self-employed for at least 3 months and are struggling to sustain employment due to their disability, long-term health condition or disadvantages
MAINTAINING WORK
Person has never been in employment or has a track record of struggling to retain jobs/sustain employment due to their disability, long-term health condition or disadvantages
None met
Not suitable
Would benefit from Connect to Work support
Individuals must fit at least one of the situations below
1+ met? Yes
COMPREHENSIVE TAILORED WORK
Person is unlikely to be able to move into/retain paid work without very frequent, comprehensive and tailored support above and beyond standard employment support (e.g. IAG, CV & application support) or other national employment provision including Restart
ADAPTABILITY
Person has previously or is expected to struggle with learning new skills or adapting to new environments due to their disability, long-term health condition or disadvantages
INTEGRATION
Person needs employment support that is integrated with support for their other needs e.g. health services, probation, social care
JOB ROLE AND WORKPLACE
Person will need employer flexibility to tailor the role and/or workplace to support with their disability, long-term health condition or disadvantages
SUSTAINED WORK
Person requires/will require significant support to retain work over and above standard reasonable adjustments
None met
Not suitable
Motivation to work
Must be met
MOTIVATION TO WORK
Individuals should be motivated to work once they understand the Connect to Work offer and are willing to engage with it
Not met
Not suitable
Met
Eligible and suitable

Connect to Work in Greater Essex

- Essex County Council will be the Accountable Body for the programme leading the design and delivery for the Greater Essex (Essex, Thurrock and Southend.)
- Maximum grant £10.6m / year when fully mobilised outcome-based commissioning.
- Delivery commences June 2025* for a period of 2-5 years with a phased introduction of activity.
- Limited Job Retention capacity

Existing qualifying provision- extension /expansion

- Extend IPSPC for mild to moderate mental health (and other long term health conditions TBA e.g. musculoskeletal conditions) into Southend and Thurrock from April/May 2025 through grant funding to current provider Essex Partnership University NHS Trust (EPUT).
- Extend SEQF Inclusive Employment Programme for learning disabilities and autism into Southend and Thurrock from April/May 2025 and extend eligibility criteria to non-diagnosed and 16+ across Greater Essex. Grant funding to current provider Essex Cares Limited (ECL).

Additional capacity

Commission a new consortium of providers (Lead and Consortia model) for physical and sensory disabilities and long-term conditions, priority groups including Veterans ,Refugees, Offenders, Unpaid Carers, Care Leavers**.**

Zero Exclusion- all guidance cohorts including homeless people, a person with drug or alcohol dependency (history or current), victims of domestic abuse.

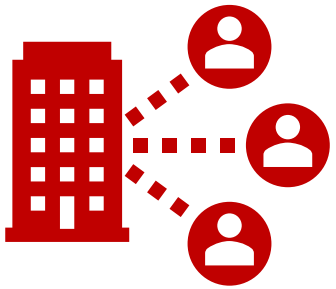
Priority geographical areas based on demand: Southend, Thurrock , Basildon, Colchester, Tendring, Chelmsford, Harlow/Loughton.

Consortium Delivery Model – One Team – integrated multi organisational service delivery

Greater Essex Programme elements (proposed)

Triage Service

- Recruitment suitability assessment and onboarding of residents.
- Multiple referral routes.
- Signposting to alternative provision for those not eligible.
- In-house (ECC) Delivery.



Employment Support Service

- IPS/SEQF employment support for eligible residents
- Help people to choose and find the right job, ongoing support for employer and employee to enable job retention.
- Employer Engagement
- Commissioned provider delivery (prime contractors with expertise in IPS/SEQF supported by specialist subcontractors working with target cohort groups.

Grants and Commissioned activity

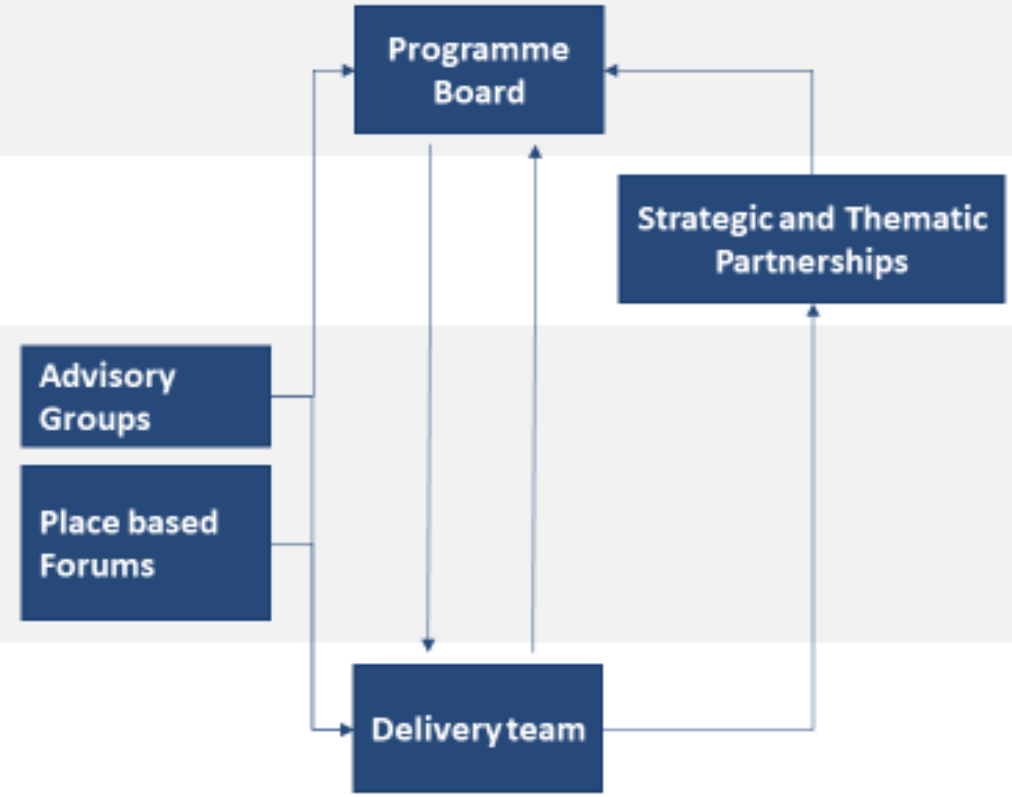
- Wrap-around to support individual engagement in the programme.
- Might include funding for training, equipment, travel etc. Can not include incentives for employers.
- Mix of ECC and commissioned service delivery.

Socialisation and support

1. Alliances
2. Integrated Work and Health Leads
   Population Health Improvement Boards
3. Acutes and community providers
4. Unitary Authorities
5. VCSE /Providers
6. **DWP** /ICP's / **Full Council**

- **Employers, Greater Essex Business Board**
- **Health and Well Being Board's**
- **PCN's/INT**
- **Districts, Local Skills Improvement Plans**
- **North Essex Economic Board and South Essex Councils**

Connect to Work Governance



- Strategic leadership and oversight of the Programme
- Chaired by Exec Director (ICS or CA) with Econ Growth and /or Health responsibility
- Membership includes NHS, LAs, VCS, Employers and lay members

- Key stakeholder groups , including adjacent programmes and initiatives ICB Integrated Health and Work Strategy Groups

- Lived experience groupings , informal as well as formal e.g Inclusive Employment Alliance

- Place led coordination and integration – Alliances (INT's, PCN Economic Growth and employer input Small Business Forums s UKSPF

- Programme management
- Contracted provider leads
- Accountable Body functions
- Reporting into `Directors of Growth' and ICP's objective 4

Integrated Care Partnerships

Greater Essex CA

Integrated Health and Work Strategies

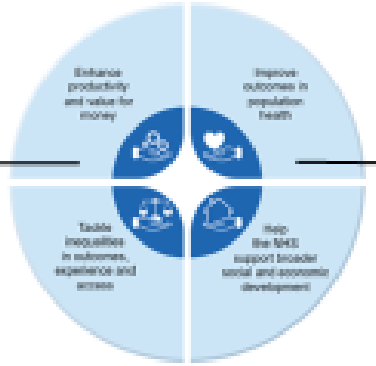
Unitary Authorities

Alliances and place-based partnerships

Public Health and Wellbeing

Economic Growth & DWP

Health and Wellbeing Board(s)



NHS Secondary Care

EPUT,MSEFT,PAH,ESNEFT

Adult Social care

DWP JCP

CtW Employer Engagement

DWP JCP Employer Engagement

Provider Collaboratives

Integrated Neighbourhood Teams

GP's surgeries /PCN's

Self Employed /SME's

Fed SM Business

Large / public Employers

Chambers of Commerce

Specialised work provision i.e. sight , hearing loss/ Burns

Neurodiverse and LD provision

IPS SMI

IAPT Talking Therapies

LSIP

VCSE organisations

CtW Providers

CtW Providers

CtW Providers

CtW Providers

Employers

Progress

- Socialisation developing - feedback focuses on service user voice, inclusion, performance
- Grant Costs Register – Finance , Existing provider costs, MIS @commissioning stage
- Feedback from DWP on draft informally, submitted Formal Plan – including GCR , **submitted to DWP late Feb**
- Cabinet papers initial submission for 15th April Full Council decision including equality assessment
- Initial Communications brief developed
- Fuller Extended detailed Project Plan developed

Next Steps

1. Specification for new consortia
2. Provider warm up /consultation
3. Triage detail
4. Central team recruitment
5. IPS CtW plan (was IPS PC)

..and importantly

- **Eligibility and Suitability – place, train and maintain**
- Mid and South Essex ICB's INT, GP's PCN
- Summary 2-3 slides
- **Work support activity that does not or will not meet the accredited standards or outcomes**
- Employer Engagement – activating larger employers and SME's
- **Skills,** participation support, Benefits Green paper
- Job Retention, in work support
- Competitive Jobs, **Inclusion** and Carving

Get Britian Working Again Greater Essex Strategy

Guidance shortly and MSE ICB H&W strategy

Mid and South Essex Integrated Care System

NHS
Mid and South Essex

Workwell Leadership Capacity Funding

March 2025 Update

Workwell Leadership Capacity Funding Update March 2025

Funding & Workforce

89K received (June 2024)

Funded: Band 8a (0.4wte) & Band 7 (0.6 WTE, seconded from the MSEFT)

Service Mapping

Reviewed existing supported employment services

Identified gaps and opportunities for improvement

Currently reviewing data further to produce a report

Created survey for employers to understand how long-term sickness affects local businesses and what support businesses need from system partners.

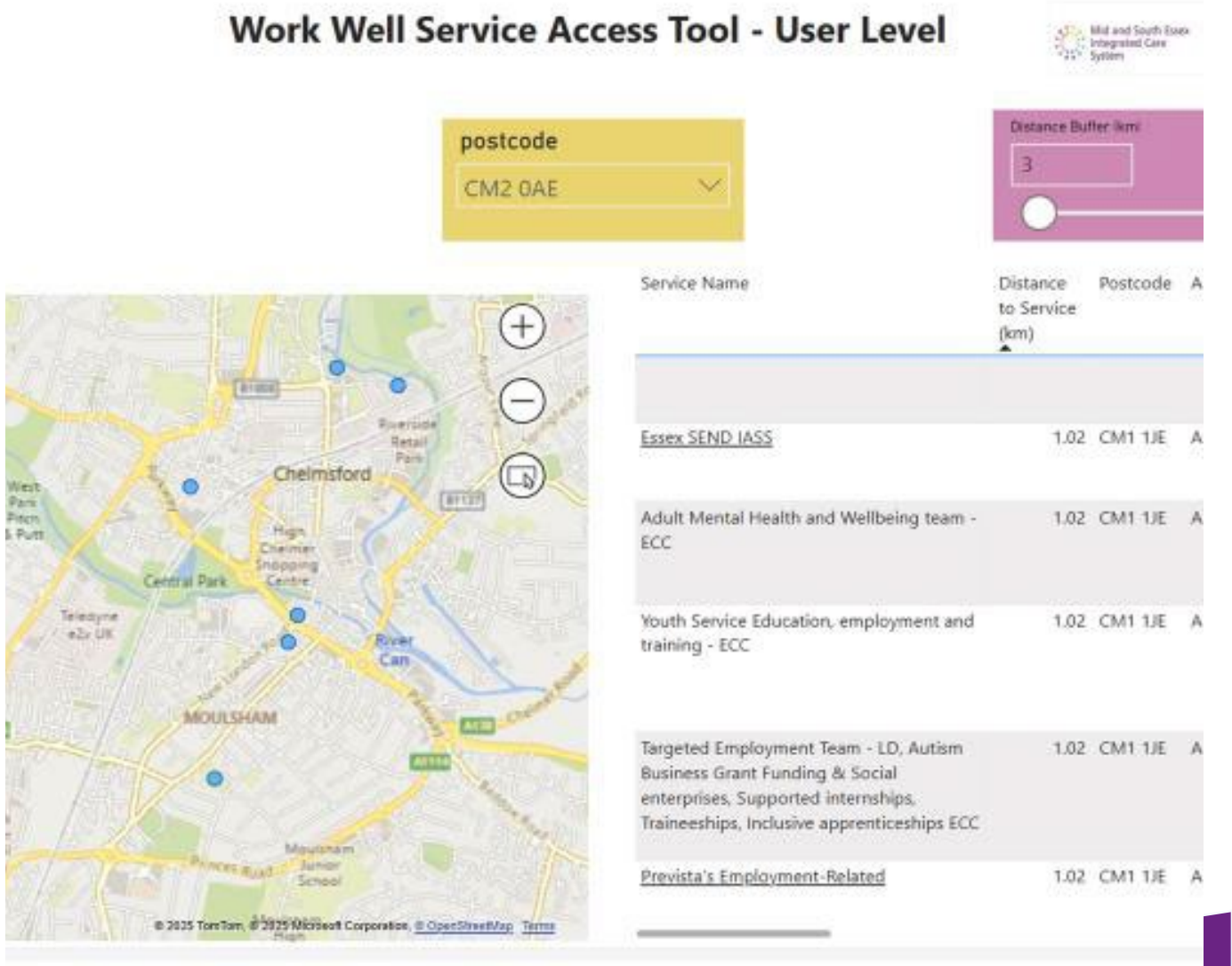
Governance & Collaboration

Monthly Work & Health steering Group established

Working with Connect to Work to ensure Health representation and collaboration

Innovative Tools & National Interest

- New tool created to support identification of supported employment, this will be added to Frontline, which is an online tool to help frontline workers and the public to quickly find details on local health and wellbeing services.
- Interest from regional and national stakeholders
- Neighboring ICBs keen to contribute to give full Greater Essex picture



Events & Impact

- We have co-produced events with DWP and Local Authorities which connected health services, skills/training providers and employers.
- The most recent event took place in Southend which had over 400 attendees, attendees were surveyed and the DWP are currently analysing the results.

Next Steps: Good Work = Good Health | Good Health = Good work

Developing an Integrated Approach

Strengthening the connection between health and employment in tandem with Connect to Work.

Embedding employment support within health and wellbeing events

The ICB has representation on the Greater Essex Connect to Work Governance Board, ensuring that our work complements rather than duplicates existing efforts. This partnership allows us to identify where we can best support residents in keeping their jobs or finding employment, recognising the clear link between employment and better health and wellbeing.

Exploring Employment Support in Hospital Settings

Looking at ways to provide employment support for patients and family members who:

- Face work challenges due to illness or injury
- Have suddenly become carers

Supported by additional £89K Work Well leadership funding

Next Steps: Good Work = Good Health | Good Health = Good work

Continuation of Co-Produced Events

A series of co-produced events have been organised in collaboration with the Department for Work and Pensions (DWP) and Local Authorities. These events have successfully connected health services, skills and training providers, and employers to foster a more integrated approach to supported employment.

Upcoming events planned in:

- Braintree
- Maldon
- Rochford/Rayleigh
- Canvey
- Chelmsford
- Thurrock

- Retrying Basildon **(**Previous pre-Christmas event had low engagement)

Ensuring access to holistic support addressing:

- Wider determinants of health
- Sustainable employment as part of recovery and wellbeing

Mid and South Essex Integrated Care System

NHS
Mid and South Essex

www.midandsouthessex.ics.nhs.uk

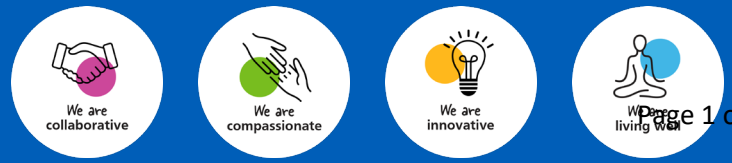
MSEICS MSEssex_ICS MSEssex_ICS Mid and South Essex Integrated Care System

NHS
Mid and South Essex

Integrated Neighbourhood Teams

The INT Model across Mid & South Essex
March 2025

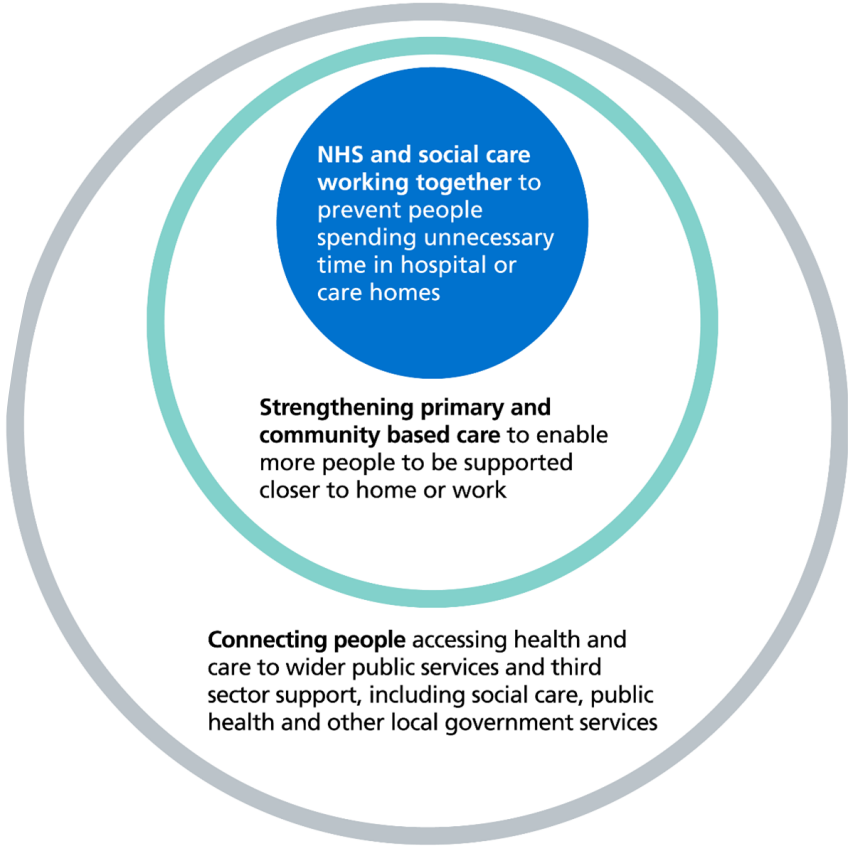
www.midandsouthessex.ics.nhs.uk



Scene Setting

2025/26 Neighbourhood Health Guidelines

- NHSE have recently published 2025/26 Neighbourhood Health Guidelines.
- Whilst more detail will be included within the 10-year plan (eta Spring), the expectation is that systems start to deliver on the 25/26 guidance imminently.
- **MSE ICB have reviewed these guidelines and generated an INT delivery model described within this slide pack.**



- NHS England » Neighbourhood health guidelines 2025/26

Must do within the 25/26 guidelines:

We must **standardise the 6 core components of existing practice** to achieve greater consistency of approach

1. **Population Health Management**
2. **Modern General Practice**
3. **Standardising Community Health Services**
4. **Neighbourhood MDTs**
5. **Integrated intermediate care with a 'Home First' approach**
6. **Urgent neighbourhood services**

6 core components of an effective neighbourhood service

Population health management

- A person-level, longitudinal, linked **dataset of all health and social care data**, underpinned by **appropriate data sharing** and processing agreements, expanding to wider public services over time
- A single system-wide PHM segmentation and risk stratification method, e.g. via Federated Data Platform

Modern general practice

- ICBs should continue to support general practice with the delivery of the **modern general practice model**
- This model should streamline care, improve access and continuity, and provision of more proactive care

Standardising community health services

- Utilisation of the **Standardising community health services publication** to maximise use of funding for local needs and priorities, including commissioning of community health services
- Connect mental and physical health services to ensure complete provision, and link with the VCFSE sector

Neighbourhood multidisciplinary teams (MDTs)

- **Multidisciplinary coordination of care** for population cohorts with complex health and care or social needs who require support from multiple services and organisations
- A **core team** assigned for **complex case management**, with links to an extended specialist team
- A **care coordinator** assigned to every person or their carer in the cohort as a clear point of contact

Integrated intermediate care

- Short-term rehab, reablement and recovery services delivered under a **therapy-led approach**
- **Home First approach** to delivery of assessment and interventions, underpinned by step-up referrals and step-down planning directly between community and acute services

Urgent neighbourhood services

- **Standardise and scale** services such as urgent community response and hospital at home, ensuring alignment with local demand, and with front-door acute services such as Urgent Treatment Centres
- Involve senior clinical decision makers as part of a **"call before convey"** approach in ambulance services, and enable healthcare staff and care home workers to access clinical advice without needing to call 999

Priority areas stated in the 25/26 guidelines

- The guidance clearly states focus for 25/26 should be "supporting adults and CYP with complex health and social care needs who require support from multiple services"

- This is because data indicates this is where care systems can make the most impact. The cohort equates to c.7% of the population and associated with 46% of hospital costs.

- Examples of population cohorts with complex needs include:

  - **adults with moderate or severe frailty (physical frailty or cognitive frailty, for example, dementia)**
  - **people of all ages with palliative care or end of life care needs**
  - adults with complex physical disabilities or multiple long-term health conditions
  - children and young people who need wider input, including specialist paediatric expertise into their physical and mental health and wellbeing
  - people of all ages with high intensity use of emergency departments

NHS
Mid and South Essex

A standardised approach to INT development across MSE

A model – for engagement

www.midandsouthessex.ics.nhs.uk

We are collaborative
We are compassionate
We are innovative
We are living well

Context

- Over the last 12-18 months of INT development, strong foundations have been laid and we are in a position to move from development to delivery.

- Some individual INTs have started exploring different topics/cohorts and/or undertaking different projects.

- Whilst this has been beneficial, it is important we now establish a delivery model that ensures consistency in the ‘INT offer’ for our residents to avoid inadvertently creating inequalities. This approach is in line with the 25/26 Neighbourhood Guidelines.

- The INT model explained over subsequent aims to move us towards this consistent approach, whilst still allowing for local nuance within our 24 individual INTs.

A model for INT delivery

1. The INT deliverables will be broken down into manageable pieces (‘focus areas’).

2. These focus areas will then be delivered at a consistent pace across our 24 INTs and in an order defined by population health data.

Frailty & End of Life (25/26 priority in guidelines)

Example: Babies, Children & Young People

Example: Mental Health

Example: Diabetes

Example: Other focus area

Example: Other focus area

How do we know when a focus area is ‘complete’?

- Each focus area will be accompanied by a ‘Playbook’ which will include a ‘checklist’ of key interventions for how to achieve the requirements for that focus area. For example, there will be a ‘Frailty & EoL Playbook’ as demonstrated on the next slide.

- Our ICS stewards (professionals from across different sectors) and other partners will need to determine the content for each Playbook based on the best available data and evidence.

Playbook Example: How to achieve the Frailty & EoL Focus Area

Key interventions / components

The key interventions will be determined by professionals in the field and included in the Playbook

Example

- ☑ Set up local MDTs to discuss patient care – to include readmissions and high frequency user data
- ☑ Ensure appropriate parts of FrEDA is completed at each contact (making every contact count)
- ❑ Ensure appropriate patients are added to MSE frailty register to allow clinical notes to be joined up for all services
- ❑ Adult Social Care (ASC) interventions (packages of care/placements/intermediate care), synchronised to MDTs
- ❑ Broad representation from Local Authority teams and services in MDTs (housing, public health, social work teams, brokerage etc)
- ❑ ASC direct access to primary care colleagues to reduce the number of 'hand offs' and inappropriate referrals, improving the resident's lived experience and outcomes.
- ❑ Community and voluntary sector working closely with ASC and health teams supporting help residents at home.

Playbook Example: How to achieve the Frailty & EoL Focus Area

The Playbook will also need to include summary outcome measures. For example:

Outcome One: Impact on system pressures / flow
- Increased primary care capacity to support access/extension of primary care appointment times
- 7-15% Reduction in avoidable acute admissions in the over 65yrs (inc. LTC, frailty & EoL)
- Up to 44% reduction in avoidable admissions by top 10% of service users
- Up to 36% reduction in ED attendances by top 10% of service users
- 40-70% reduction in acute length of stays of 2-6 days in over 65yrs+ with LTC/EoL
- Up to 18% reduction in acute excess bed days in over 65yrs
- 9% reduction in acute LoS in frequent attenders with complex needs
- 12% reduction in 30 day readmissions post MI

Example

Outcome Two: Cost
- To be confirmed/triangulated

Outcome Three: Lived experience
- Patient Survey – improve patient experience / outcomes / personalised care

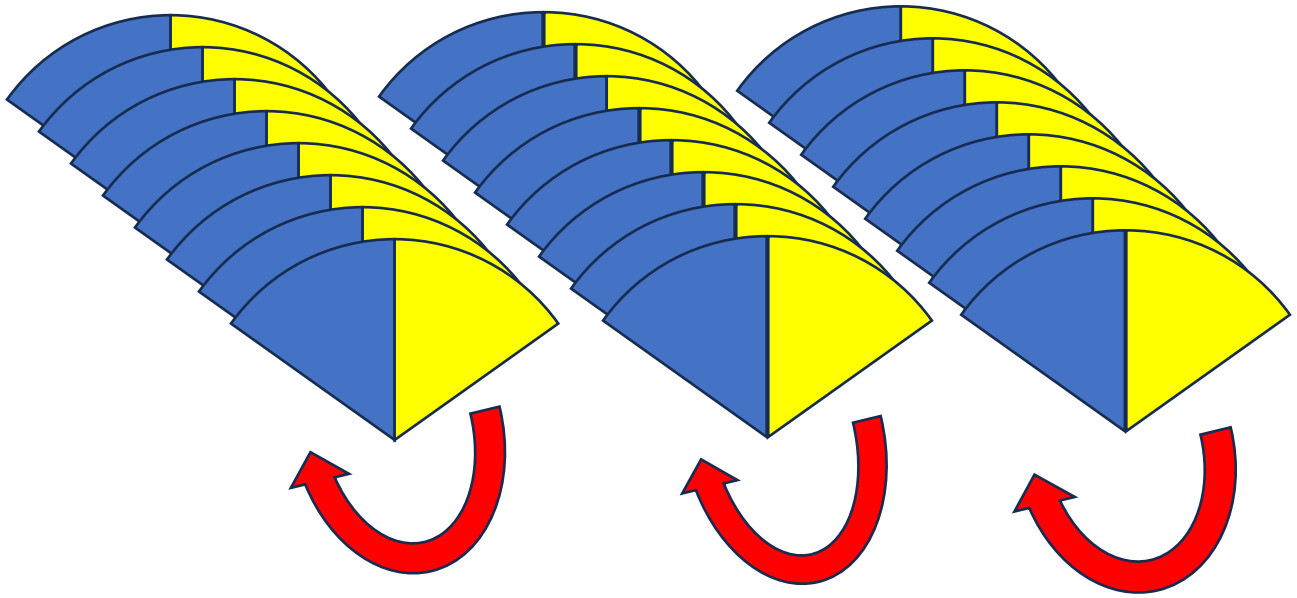
Outcome Four: Impact Workforce
- Staff survey – improving working arrangements and role satisfaction for staff
- % increase in recruitment and retention rates

Additional evaluation metrics
- % increase of patients on End of Life Register
- % increase dementia diagnosis rates

How does the model evolve?

✓ **Achieve all the components of the Playbook and the INT is then considered to be delivering the 'core' INT offer for that focus area**

Within this INT model, we would see the INT's completing focus areas over an agreed period of time, such that all our 24 INTs are delivering at a consistent pace.



Over time, we would see INTs 'adding' to their collection of focus areas at the same pace, such that in the future (depending on how many focus areas there are), the INT is considered to be 'fully delivering'.

Discussion

This approach is currently being shared with INT stakeholders across our system.

Questions to support discussion….

- Does the concept make sense to you/your organisation?
- What other engagement needs to take place?
- What local initiatives should be linked in?

Mid and South Essex

Appendix Slides- Additional Information on 25/26 Neighbourhood Guidance

The 4 asks of the 25/26 guidance:

- **standardising 6 core components of existing practice** to achieve greater consistency of approach
- **bringing together the different components into an integrated service offer** to improve coordination and quality of care, with a focus on people with the most complex needs
- **scaling up** to enable more widespread adoption
- **rigorously evaluating** the impact of these actions, ways of working and enablers both in terms of outcomes for local people and effective use of public money

Impacts within the guidance that MUST be demonstrated (as a minimum)

1. Improving timely access to GP and U&EC
2. Preventing long and costly admissions
3. Preventing avoidable long-term admissions to residential or nursing care homes

"NHS England regional teams, working with local government partners and informed by the evidence generated from existing work in systems, should work with systems to agree locally what specific impacts they will seek to achieve during 2025/26. We expect these to include, as a minimum, **improving timely access** to general practice and urgent and emergency care, **preventing long and costly admissions** to hospital and **preventing avoidable long-term admissions** to residential or nursing care homes."

PCN

Integrated Neighbourhood Team

Central Basildon PCN

CENTRAL BASILDON

PRIMARY CARE NETWORK

"Improving lives together"

CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

Population Management MSE

Registered Population

1,337,108

Registered patients are assigned to segments according to levels of health need and complexity.

Total acute health cost

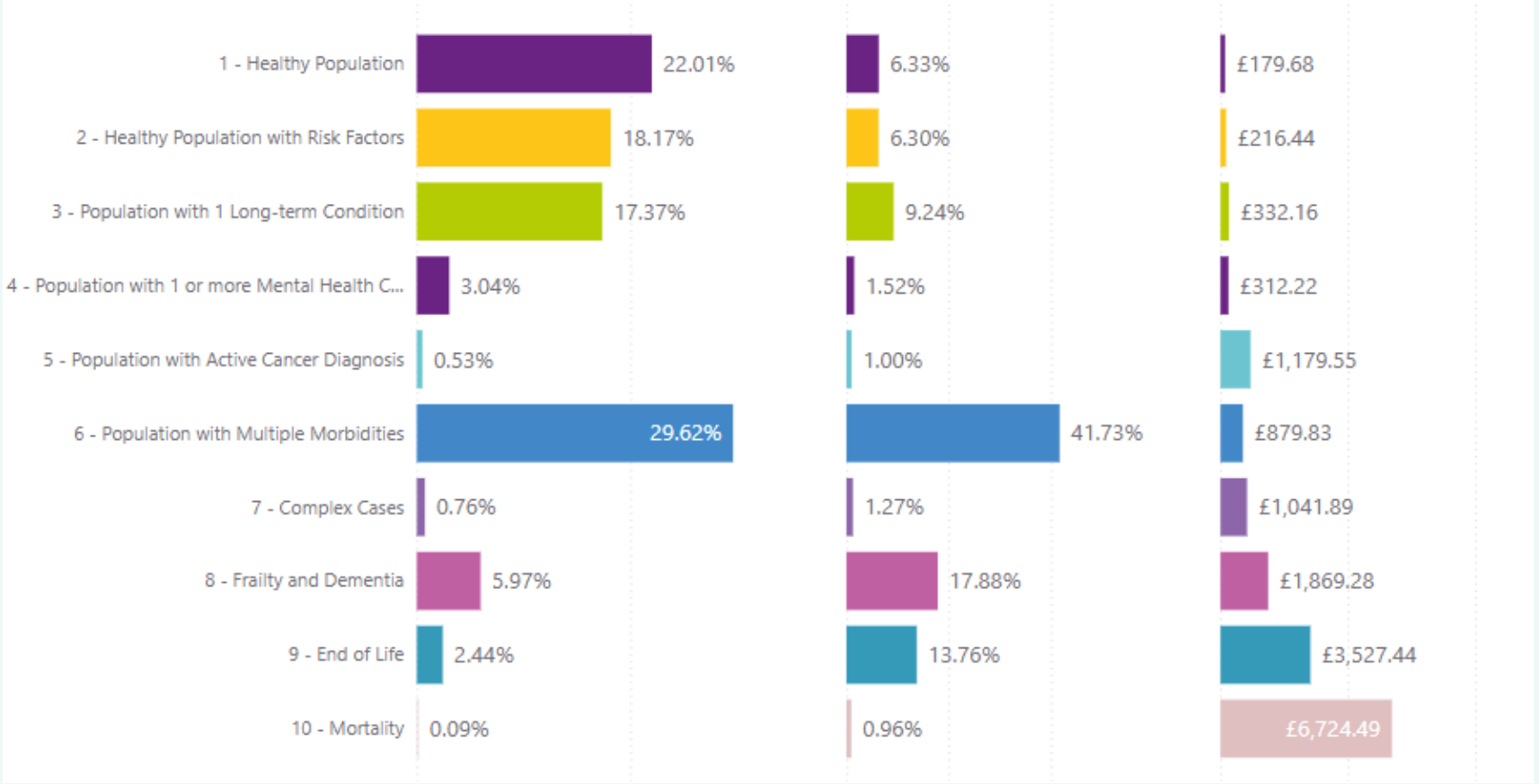
£834.90M

There is a larger proportion on total healthcare spend in segments with higher need and complexity

Per capita total acute health cost

£624.41

The total healthcare cost per capita can be used to compare segments within and between populations



CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

Population management
Basildon Brentwood & Thurrock

Registered Population

512,568

Registered patients are assigned to segments according to levels of health need and complexity.

Total acute health cost

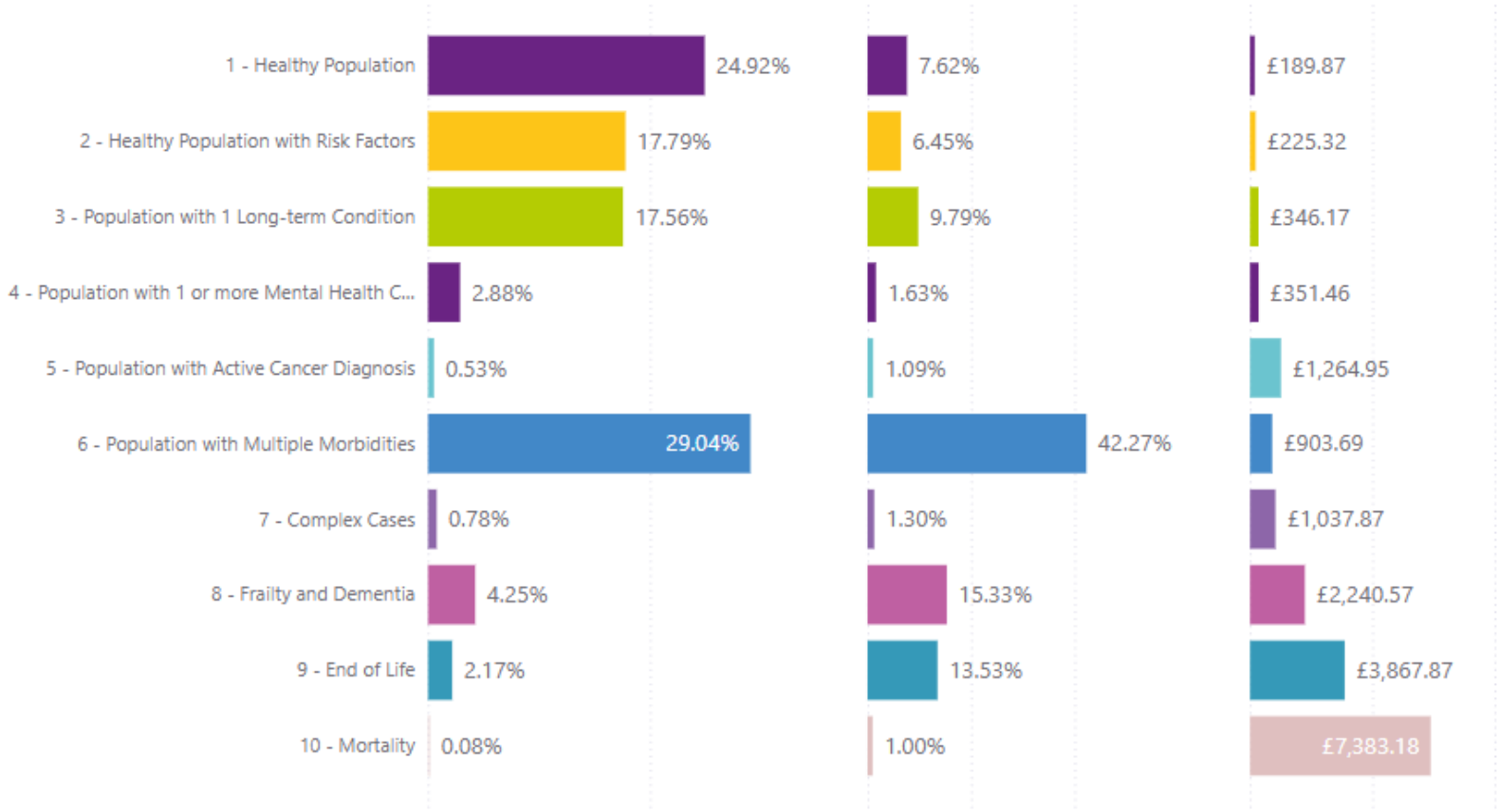
£318.24M

There is a larger proportion on total healthcare spend in segments with higher need and complexity

Per capita total acute health cost

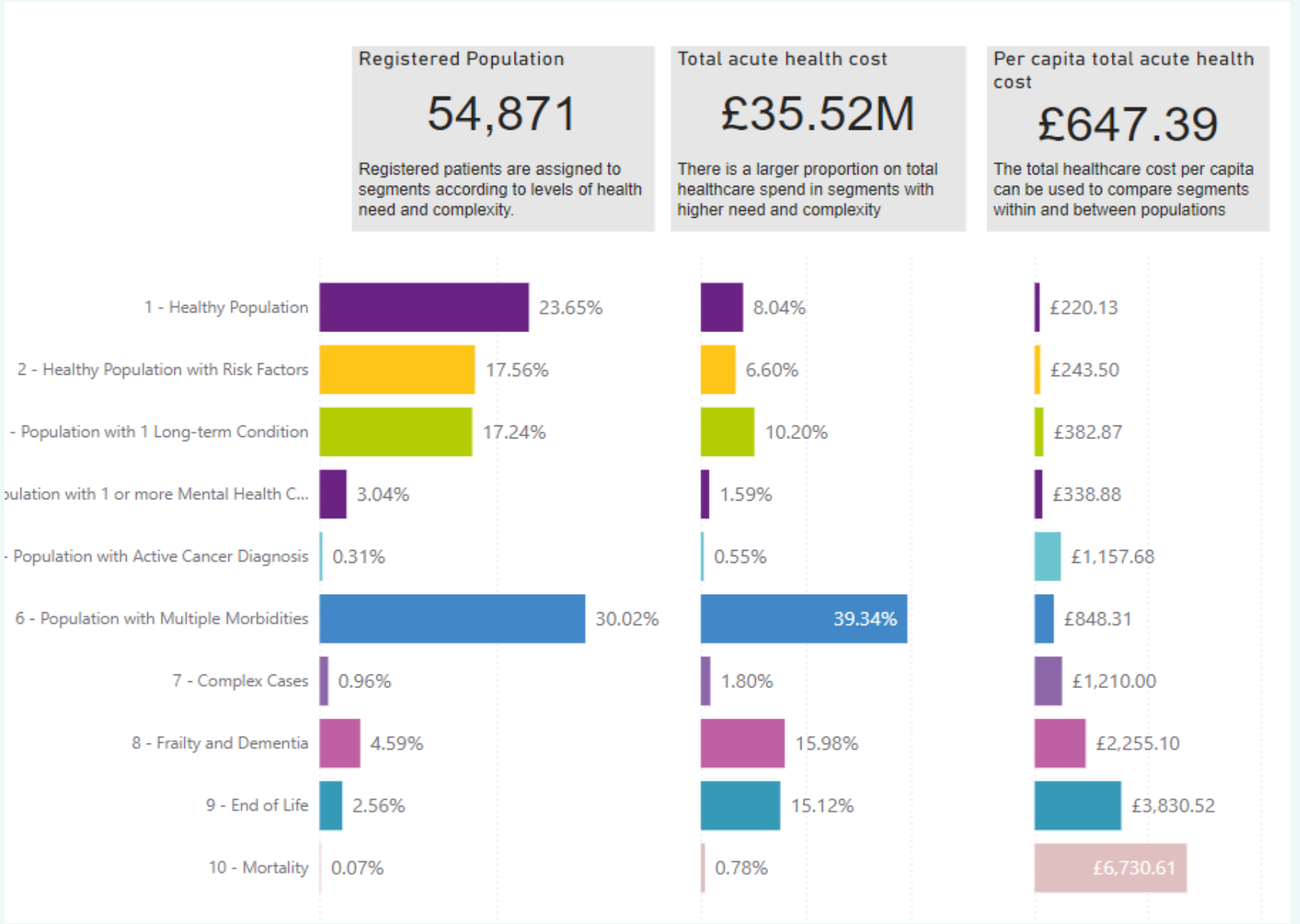
£620.88

The total healthcare cost per capita can be used to compare segments within and between populations



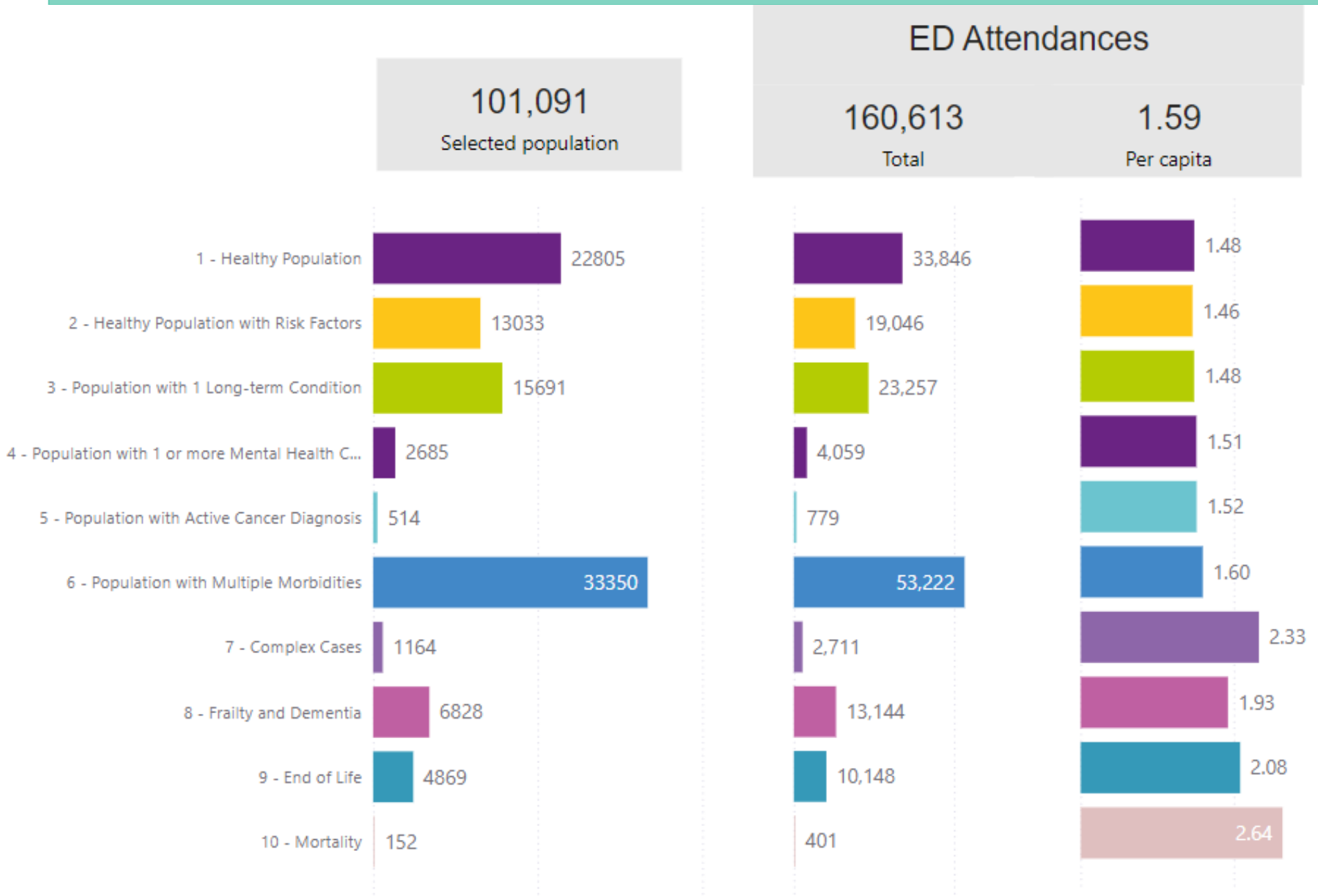
CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

Population management – CBPCN



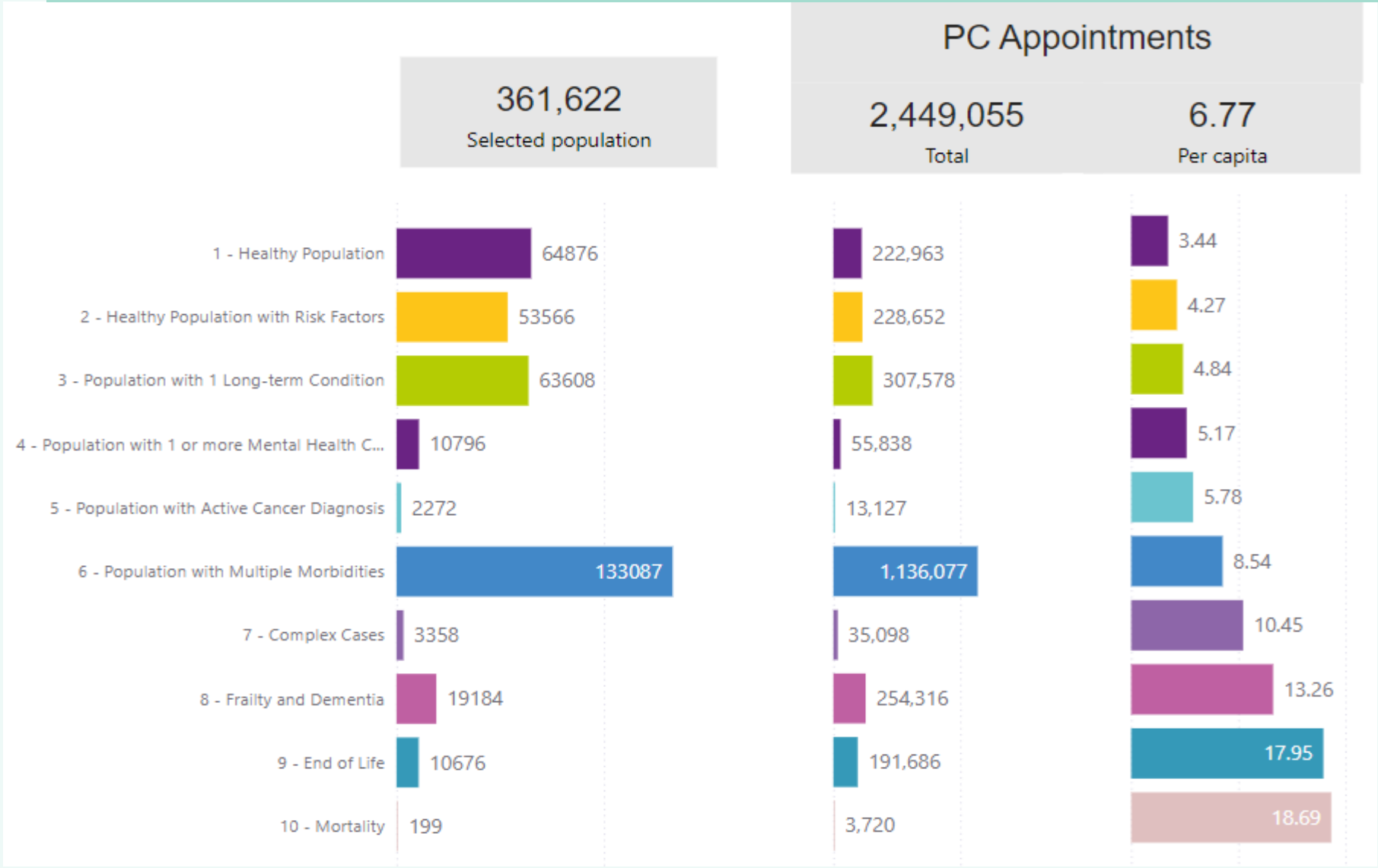
CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

ED Attendance Basildon Brentwood Thurrock



CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

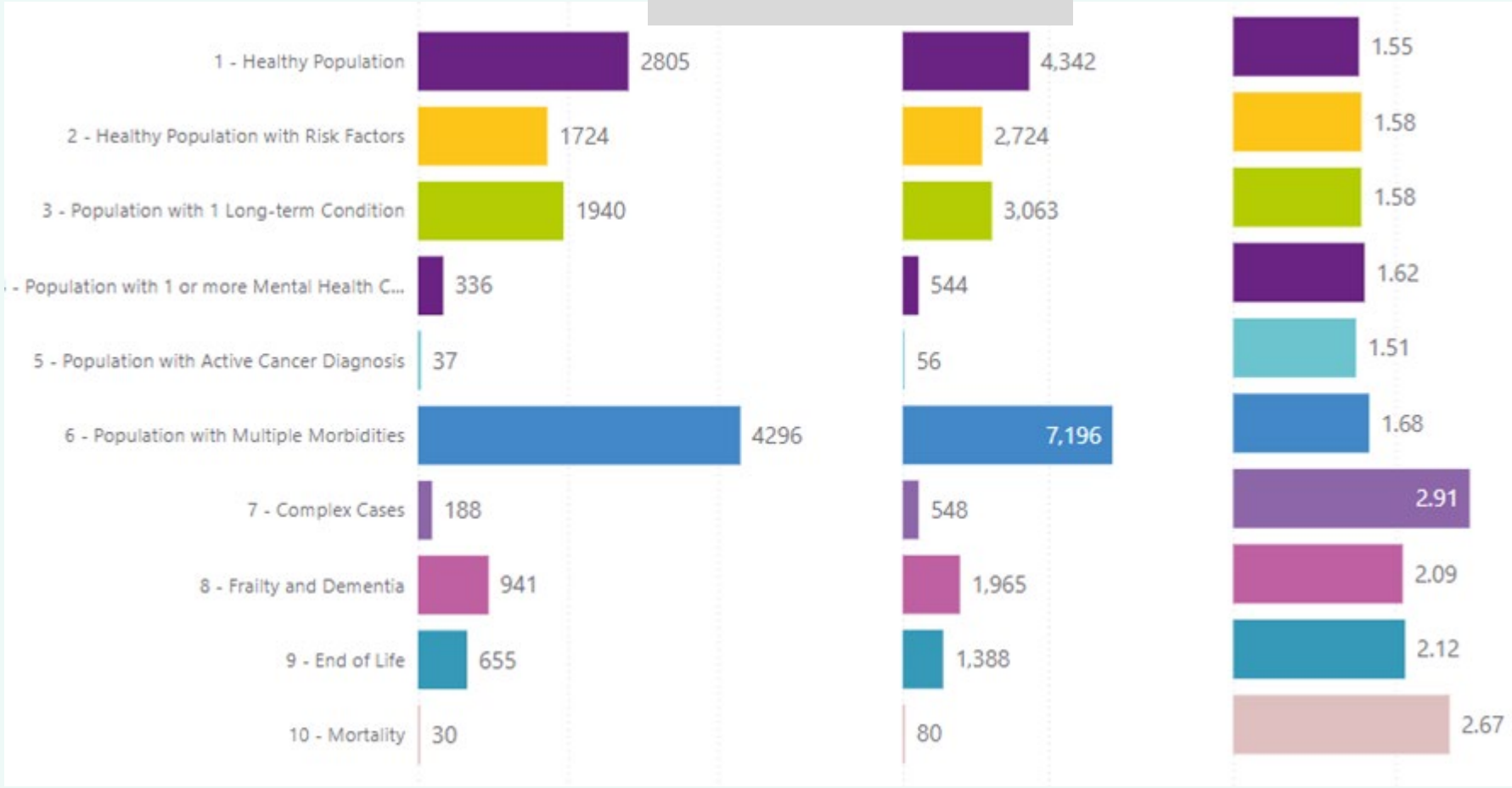
Primary Care Appointments last 12 months Basildon, Brentwood and Thurrock



CENTRAL BASILDO
PRIMARY CARE NETW
"Improving lives together"

ED attendances last 12 months-CBPCN

12,952 Selected Population	21,906 Total	1.69 Per Capita



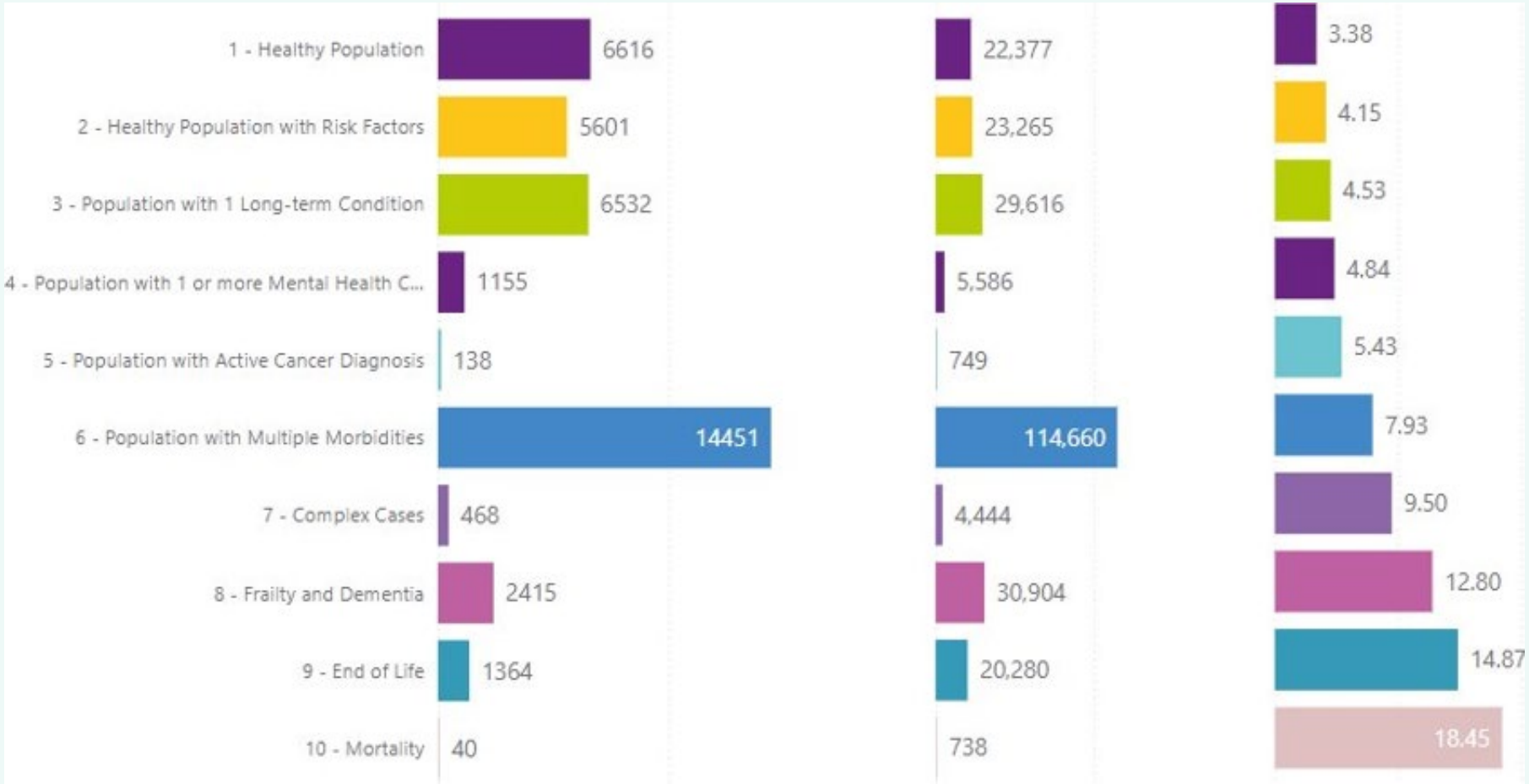
CENTRAL BASILDO
PRIMARY CARE NETW
"Improving lives together"

Primary Care Appointments last 12 months-CBPCN

38780
Selected Population

252,619
Appointments

6.51
Per Capita



CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

- Increasing Demand
- Dwindling GP numbers

- ICB
- PCN and ARRS scheme

CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

Primary care network (PCN)

- Central Basildon PCN
- 9 practices
- 50,000 patients

CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

Additional Roles Reimbursement Scheme

Clinical Pharmacist	Mental Health Practitioner
Health and Wellbeing Coach	CYP Mental Health Practitioners
Social Prescriber Link worker	Pharmacy Technicians
Digital and Transformation Lead	GP Assistants
Physician Associate	Care - Coordinator
Physiotherapist	Occupational Therapist
Podiatrist	Dietitian

CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

Summer of 2022

Pam and Simon

Came for a meeting

Next steps for integrating primary care: Fuller Stocktake report

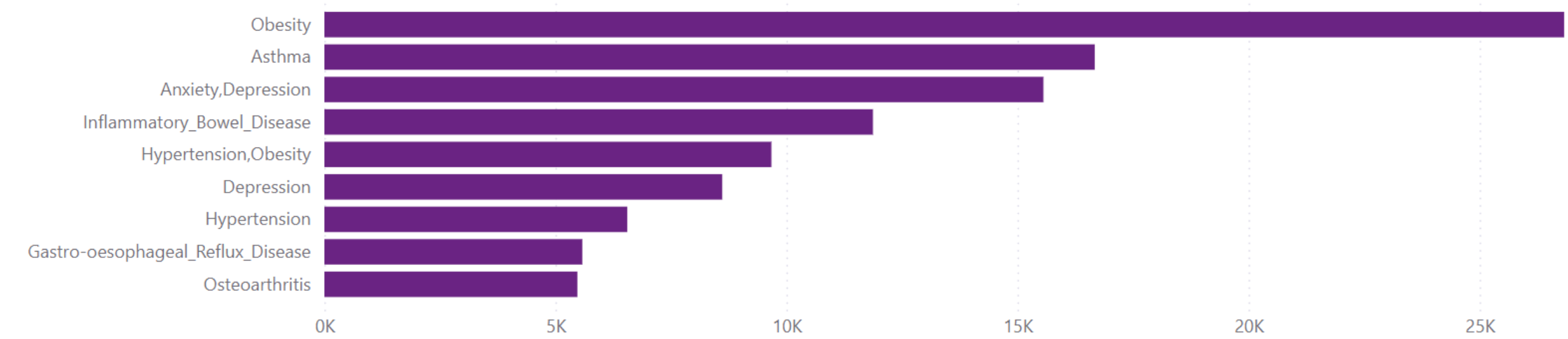
Commissioned by NHS England and NHS Improvement from Dr Claire Fuller, CEO (designate) Surrey Heartlands ICS

MAY 2022

Integrating Primary Care with other services

CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

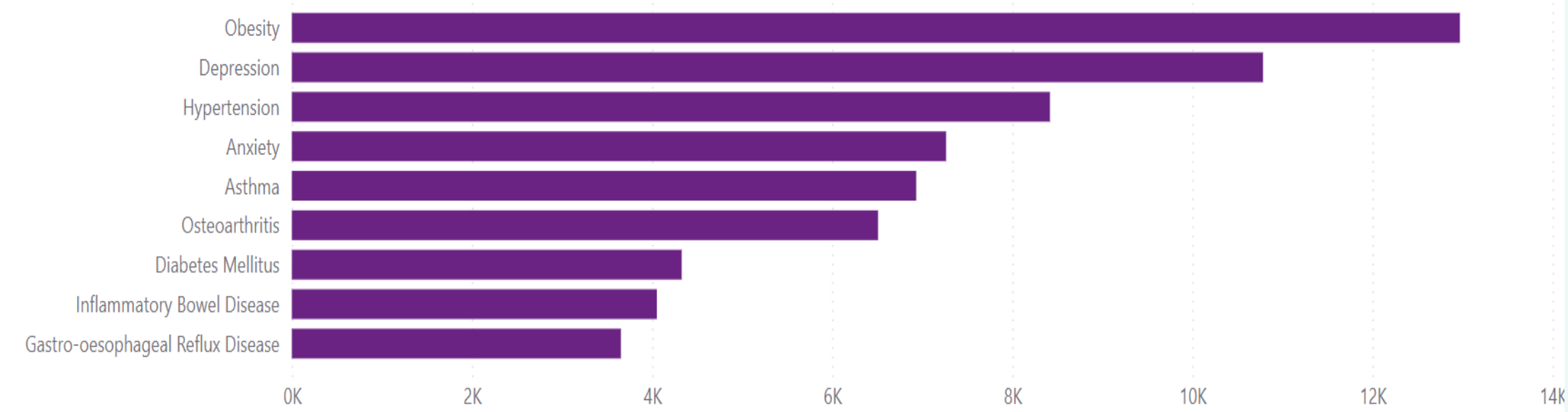
Basildon Brentwood and Thurrock Population Long Term Conditions



LTC Mix	Population	% of Population
Obesity	26828	8.50%
Asthma	16670	5.28%
Anxiety,Depression	15560	2.47%
Inflammatory_Bowel_Disease	11871	3.76%
Hypertension,Obesity	9674	1.53%
Depression	8610	2.73%
Hypertension	6555	2.08%
Gastro-oesophageal_Reflux_Disease	5582	1.77%
Osteoarthritis	5475	1.73%

CENTRAL BASILDON
PRIMARY CARE NETWOR
"Improving lives together"

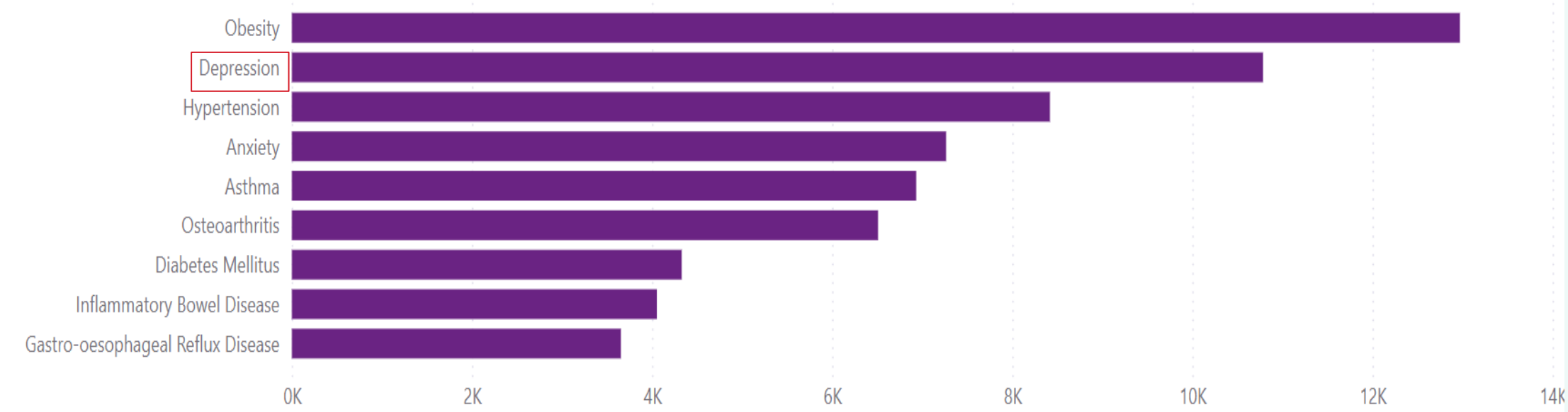
CBPCN Population by Long Term Conditions



LTC	Population	% of Population
Obesity	12970	23.64%
Depression	10784	19.65%
Hypertension	8418	15.34%
Anxiety	7265	13.24%
Asthma	6933	12.64%
Osteoarthritis	6509	11.86%
Diabetes Mellitus	4329	7.89%
Inflammatory Bowel Disease	4053	7.39%
Gastro-oesophageal Reflux Disease	3654	6.66%
Chronic Kidney Disease	2552	4.65%

CENTRAL BASILDON
PRIMARY CARE NETWOR
"Improving lives together"

CBPCN Population by Long Term Conditions



LTC	Population	% of Population
Obesity	12970	23.64%
Depression	10784	19.65%
Hypertension	8418	15.34%
Anxiety	7265	13.24%
Asthma	6933	12.64%
Osteoarthritis	6509	11.86%
Diabetes Mellitus	4329	7.89%
Inflammatory Bowel Disease	4053	7.39%
Gastro-oesophageal Reflux Disease	3654	6.66%
Chronic Kidney Disease	2552	4.65%

CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

Deep Dive 3 SURGERIES

Population of 10,000

1/5 Of our PCN

September of 2022
Sample Week

CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

READ Code	Count
(XaF8d) Medication review done	689
(XE0Xs) Chest infection NOS	124
(Xa7I0) Tonsillitis	71
(XE0e0) Infection of urinary tract	59
(XaJCO) Medication review with patient	49
(XaK6f) Depression interim review	49
(Xa2o8) Infection of the upper respiratory tract	49
(Xa1sb) Viral upper respiratory tract infection	46
(Y281b) Cancer safety netting	43
(XaFqt) Suspected UTI	43
(X00Sb) Mixed anxiety and depressive disorder	37
(XM1QW) Respiratory tract infection	35
(X75Xk) Temperature	33
(XE0Ub) Hypertension	31
(XaF6J) Minor surgery done	27
(XM1QE) Ear infection	26
(Xaleq) Asthma annual review	25
(XM1QH) Sinusitis	22
(X00mG) Pharyngitis	21
(X00SO) Depressive disorder	21
(XE0re) Depressed mood	20
(E2002) Generalised anxiety disorder	19
(XE0rD) Constipation	17

GP Appointment
September week

1556

CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

READ Code	Count
(XaF8d) Medication review done	689
(XE0Xs) Chest infection NOS	124
(Xa7I0) Tonsillitis	71
(XE0e0) Infection of urinary tract	59
(XaJCO) Medication review with patient	49
(XaK6f) Depression interim review	49
(Xa2o8) Infection of the upper respiratory tract	49
(Xa1sb) Viral upper respiratory tract infection	46
(Y281b) Cancer safety netting	43
(XaFqt) Suspected UTI	43
(X00Sb) Mixed anxiety and depressive disorder	37
(XM1QW) Respiratory tract infection	35
(X75Xk) Temperature	33
(XE0Ub) Hypertension	31
(XaF6J) Minor surgery done	27
(XM1QE) Ear infection	26
(XaIeq) Asthma annual review	25
(XM1QH) Sinusitis	22
(X00mG) Pharyngitis	21
(X00SO) Depressive disorder	21
(XE0re) Depressed mood	20
(E2002) Generalised anxiety disorder	19
(XE0rD) Constipation	17

GP Appointment
September week

1556

CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

READ Code	Count
(XaF8d) Medication review done	689
(XE0Xs) Chest infection NOS	124
(Xa7I0) Tonsillitis	71
(XE0e0) Infection of urinary tract	59
(XaJCO) Medication review with patient	49
(XaK6f) Depression interim review	49
(Xa2o8) Infection of the upper respiratory tract	49
(Xa1sb) Viral upper respiratory tract infection	46
(Y281b) Cancer safety netting	43
(XaFqt) Suspected UTI	43
(X00Sb) Mixed anxiety and depressive disorder	37
(XM1QW) Respiratory tract infection	35
(X75Xk) Temperature	33
(XE0Ub) Hypertension	31
(XaF6J) Minor surgery done	27
(XM1QE) Ear infection	26
(XaIeq) Asthma annual review	25
(XM1QH) Sinusitis	22
(X00mG) Pharyngitis	21
(X00SO) Depressive disorder	21
(XE0re) Depressed mood	20
(E2002) Generalised anxiety disorder	19
(XE0rD) Constipation	17

GP Appointment
September week

1556

146

CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

Frequent Attenders

Adults	Central Basildon PCN
Top Diagnoses	A&E Atts
No abnormality detected (finding)	54
Patient walked out (finding)	36
Depressive disorder (disorder)	26
Chronic obstructive lung disease (disorder)	22
Referral to service (procedure)	20
Lower respiratory tract infection (disorder)	16
Not Recorded	13
Alcohol intoxication (disorder)	12
Lower urinary tract infectious disease (disorder)	12
Atrial fibrillation (disorder)	8
Gastritis (disorder)	8
Blood in urine (finding)	7
Upper gastrointestinal hemorrhage (disorder)	7
Acute exacerbation of chronic obstructive airways dis	7
Anxiety disorder (disorder)	6
Urinary tract infectious disease (disorder)	6
Hypercapnic respiratory failure (disorder)	6
Acute coronary syndrome (disorder)	5
Uncomplicated alcohol withdrawal (disorder)	5
Overdose of antidepressant drug (disorder)	5
Chronic liver disease (disorder)	5
Vasovagal syncope (disorder)	5
Chronic renal failure syndrome (disorder)	5

Patient Attending
A&E
> 10 times

CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

Frequent Attenders

Adults	Central Basildon PCN
Top Diagnoses	A&E Atts
No abnormality detected (finding)	54
Patient walked out (finding)	36
Depressive disorder (disorder)	26
Chronic obstructive lung disease (disorder)	22
Referral to service (procedure)	20
Lower respiratory tract infection (disorder)	16
Not Recorded	13
Alcohol intoxication (disorder)	12
Lower urinary tract infectious disease (disorder)	12
Atrial fibrillation (disorder)	8
Gastritis (disorder)	8
Blood in urine (finding)	7
Upper gastrointestinal hemorrhage (disorder)	7
Acute exacerbation of chronic obstructive airways dis	7
Anxiety disorder (disorder)	6
Urinary tract infectious disease (disorder)	6
Hypercapnic respiratory failure (disorder)	6
Acute coronary syndrome (disorder)	5
Uncomplicated alcohol withdrawal (disorder)	5
Overdose of antidepressant drug (disorder)	5
Chronic liver disease (disorder)	5
Vasovagal syncope (disorder)	5
Chronic renal failure syndrome (disorder)	5

Patient Attending
A&E
> 10 times

CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

Frequent Attenders

Adults	Central Basildon PCN
Top Diagnoses	A&E Atts
No abnormality detected (finding)	54
Patient walked out (finding)	36
Depressive disorder (disorder)	26
Chronic obstructive lung disease (disorder)	22
Referral to service (procedure)	20
Lower respiratory tract infection (disorder)	16
Not Recorded	13
Alcohol intoxication (disorder)	12
Lower urinary tract infectious disease (disorder)	12
Atrial fibrillation (disorder)	8
Gastritis (disorder)	8
Blood in urine (finding)	7
Upper gastrointestinal hemorrhage (disorder)	7
Acute exacerbation of chronic obstructive airways dis	7
Anxiety disorder (disorder)	6
Urinary tract infectious disease (disorder)	6
Hypercapnic respiratory failure (disorder)	6
Acute coronary syndrome (disorder)	5
Uncomplicated alcohol withdrawal (disorder)	5
Overdose of antidepressant drug (disorder)	5
Chronic liver disease (disorder)	5
Vasovagal syncope (disorder)	5
Chronic renal failure syndrome (disorder)	5

Patient Attending
A&E
> 10 times

37

CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

READ Code	Count
(XaF8d) Medication review done	689
(XE0Xs) Chest infection NOS	124
(Xa7I0) Tonsillitis	71
(XE0e0) Infection of urinary tract	59
(XaJCO) Medication review with patient	49
(XaK6f) Depression interim review	49
(Xa2o8) Infection of the upper respiratory tract	49
(Xa1sb) Viral upper respiratory tract infection	46
(Y281b) Cancer safety netting	43
(XaFqt) Suspected UTI	43
(X00Sb) Mixed anxiety and depressive disorder	37
(XM1QW) Respiratory tract infection	35
(X75Xk) Temperature	33
(XE0Ub) Hypertension	31
(XaF6J) Minor surgery done	27
(XM1QE) Ear infection	26
(XaIeq) Asthma annual review	25
(XM1QH) Sinusitis	22
(X00mG) Pharyngitis	21
(X00SO) Depressive disorder	21
(XE0re) Depressed mood	20
(E2002) Generalised anxiety disorder	19
(XE0rD) Constipation	17

GP Appointment
September week

1556

146

CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

Central Basildon PCN

- Patient attending > 10 times

2080

CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

Deep Dive of 3 surgeries

- Patients attending > 10 times

2080

- Age - 15 years – 45 years

- 52% - mental health issues

CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

WHY ?

- A study was done on primary care GP appointment and A&E attendance
- Result revealed that **Young Adults** had a high rate of attendance.
- That over 80% of these patients were on medications for Anxiety, Depression or Mental health.
- Majority of the patients with the highest rate of attendance to the GP and A&E are the same patient.

- **Triggering factors (Social, financial, economic or physical health)**

CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

Young Adults

Mental Health issues

Non-Medical reasons

CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

INTEGRATED NEIGHBOURHOOD TEAMS

Clinical Director	Subrata Basu
PCN manager	Carol Teatino
INT Care Co-ordinator	Nnamdi Ndukwe
Digital and Transformation Lead	Thanuya Mampilly
ARRS	8 different ARRS
GP Surgery	9 PCN Surgeries

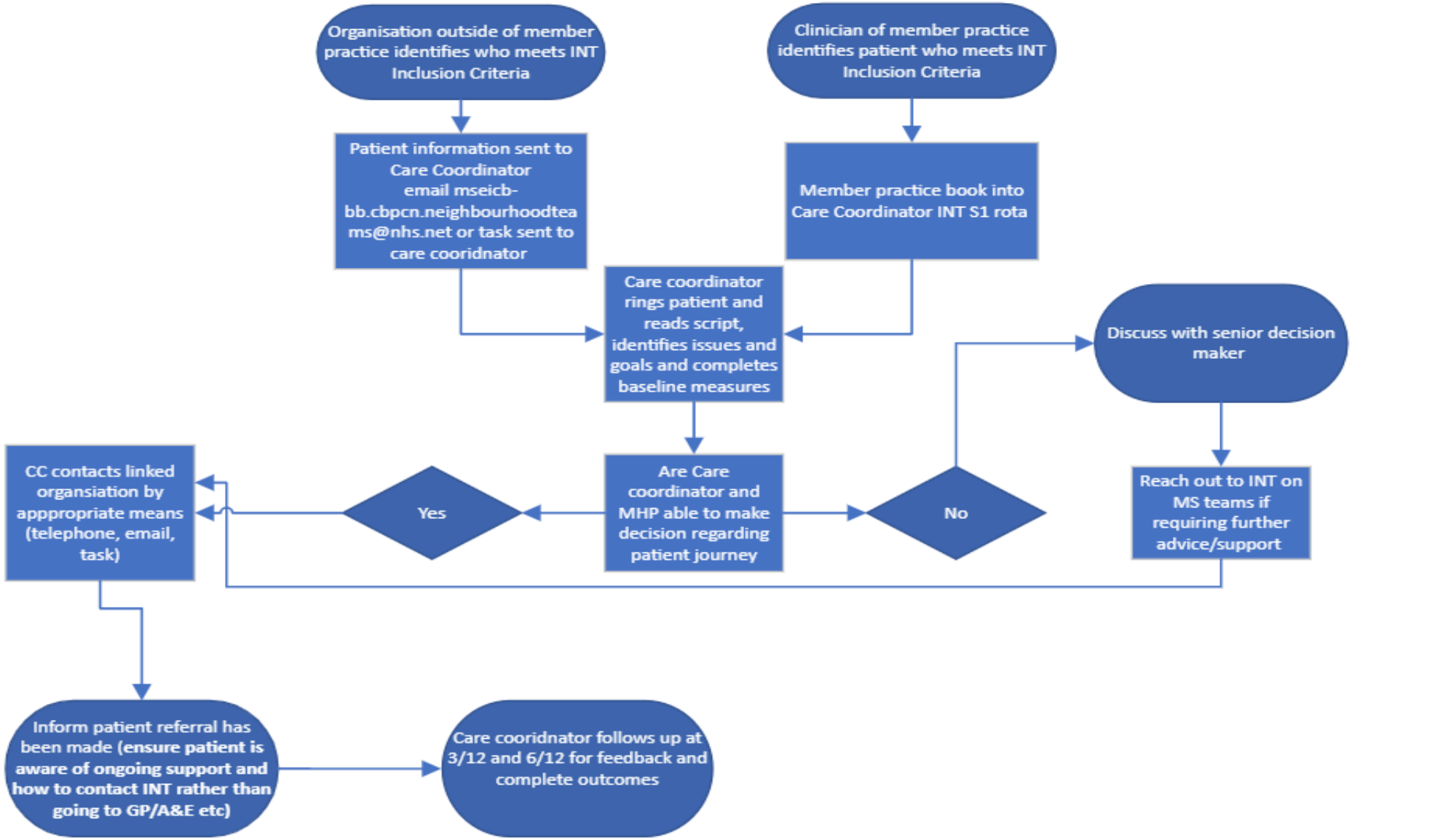
CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

INTEGRATED NEIGHBOURHOOD TEAMS

INT Definition: The Integrated Neighbourhood Team envisions the seamless integration of care systems across diverse organizations, both within and outside the health sector. Our goal is to provide health and care services that are not only meaningful but tailored to the unique needs of the local population. This necessitates the breaking down of organizational boundaries, the cultivation of collaboration, and the establishment of mutually beneficial relationships to support individuals within the community.

Integrated neighbourhood teams

Expands on the PCN model and creates true neighbourhood integration, a way of harnessing all local community assets and existing teams to work together in a coordinated and purposeful way.


Organisation outside of member practice identifies who meets INT Inclusion Criteria
Clinician of member practice identifies patient who meets INT Inclusion Criteria
Patient information sent to Care Coordinator email mseicb-bb.cbpcn.neighbourhoodteams@nhs.net or task sent to care cooridnator
Member practice book into Care Coordinator INT S1 rota
Care coordinator rings patient and reads script, identifies issues and goals and completes baseline measures
Discuss with senior decision maker
CC contacts linked organsiation by apppropriate means (telephone, email, task)
Yes
Are Care coordinator and MHP able to make decision regarding patient journey
No
Reach out to INT on MS teams if requiring further advice/support
Inform patient referral has been made (ensure patient is aware of ongoing support and how to contact INT rather than going to GP/A&E etc)
Care cooridnator follows up at 3/12 and 6/12 for feedback and complete outcomes

The **February 2023** resolution continue.....

To facilitate a seamless take off, the Lead Care Coordinator was commissioned to **shadow** the identified services and organizations, with the goal of commencing support for the chosen cohort by **mid-April**

This strategic approach was to ensures a purposeful insight on these services operate, the unique referral protocol, their triaging systems and coordinated relationship for the purpose of supporting our patients and impacting our community.

CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

Services

EPUT	Vital Health Group
Basildon Council	NEFT
Essex Police	Essex Fire service
Basildon Minds	Motivated Minds
Positive pathways	Sports for confidence
Basildon Frontline	First Response Team
Essex well-being service	Sanctuary
Citizens Advise	Peabody
Yoga4Health	Andys men's club
Motivated Minds	Trust links
Everyone Active	Craig Tyler trust
Active Essex	Basildon Community Transport
Positive Pathway	Pain Management Clinic
Health & Wellbeing coaches	Essex Wellbeing
Social Prescriber	

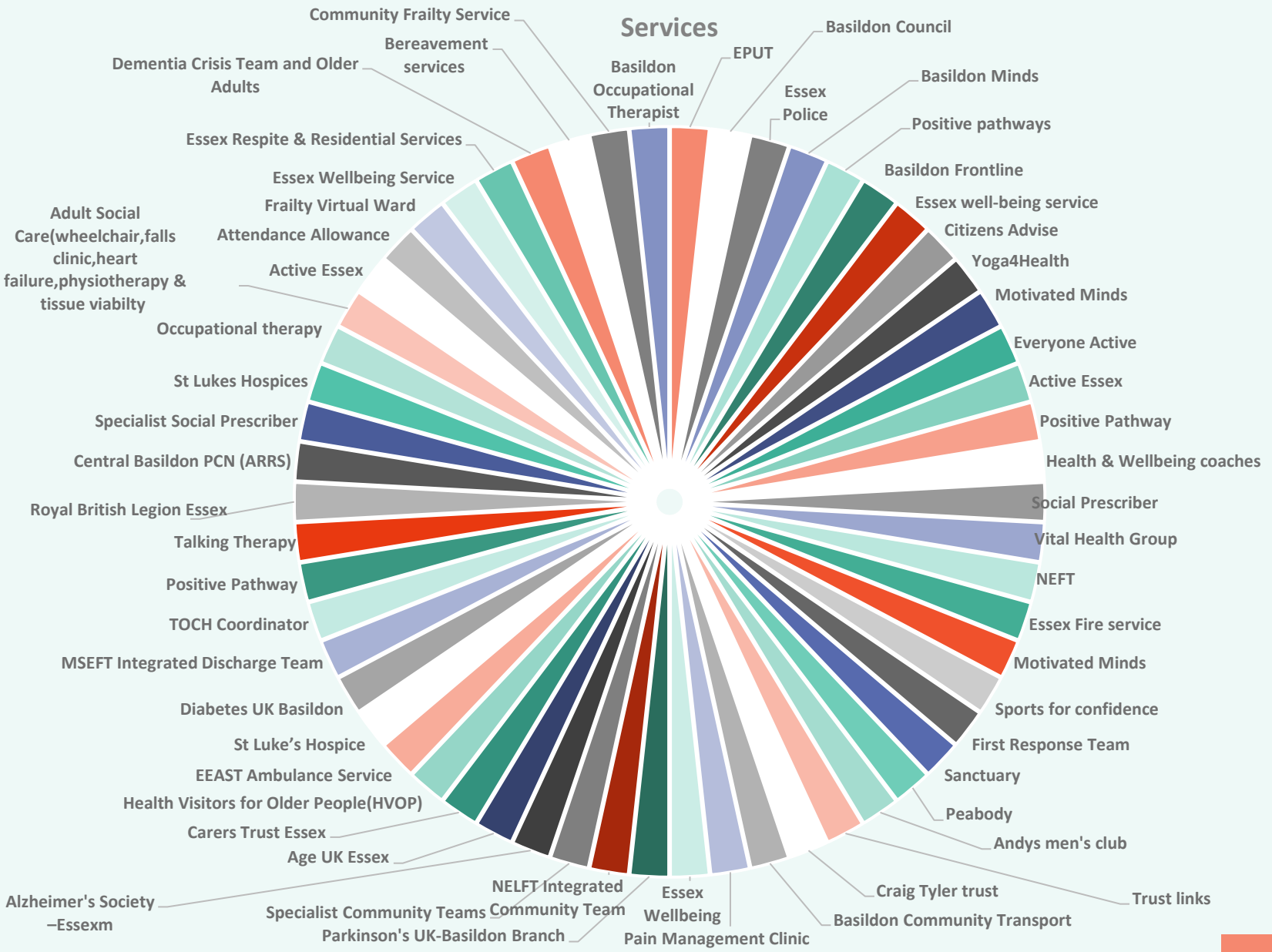
CENTRAL BASILDON PRIMARY CARE NETWORK
"Improving lives together"

Services

Parkinson's UK-Basildon Branch	Central Basildon PCN (ARRS)
NELFT Integrated Community Team	Specialist Social Prescriber
Specialist Community Teams	St Lukes Hospices
Alzheimer's Society –Essexm	Occupational therapy
Age UK Essex	Adult Social Care(wheelchair,falls clinic,heart failure,physiotherapy & tissue viabilty
Carers Trust Essex	Active Essex
Health Visitors for Older People(HVOP)	Attendance Allowance
EEAST Ambulance Service	Frailty Virtual Ward
St Luke's Hospice	Essex Wellbeing Service
Diabetes UK Basildon	Essex Respite & Residential Services
MSEFT Integrated Discharge Team	
TOCH Coordinator	Dementia Crisis Team and Older Adults
Positive Pathway	Bereavement services
Talking Therapy	Community Frailty Service
Royal British Legion Essex	Basildon Occupational Therapist

CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

Services

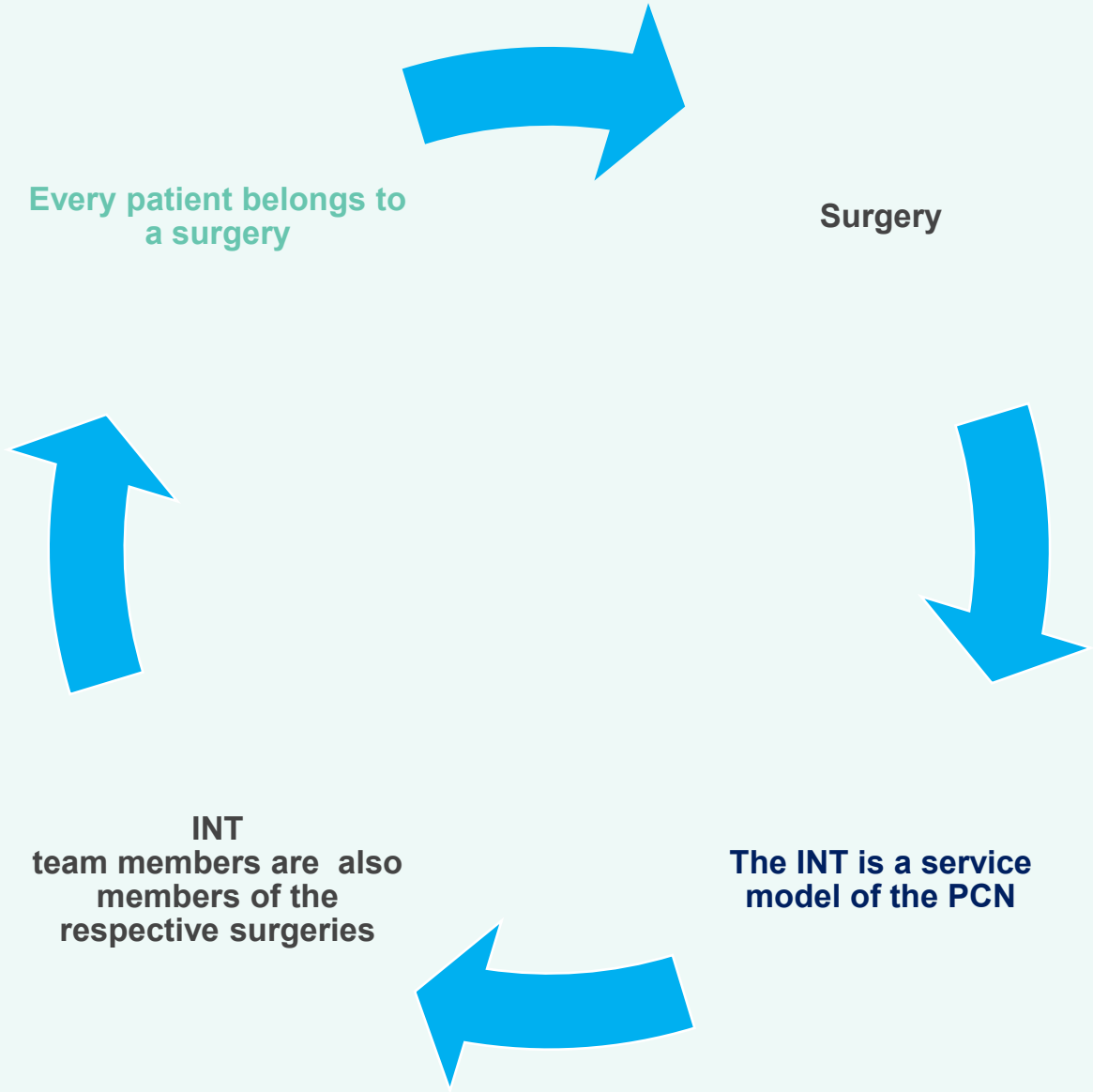


CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

Care Navigator Training

CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

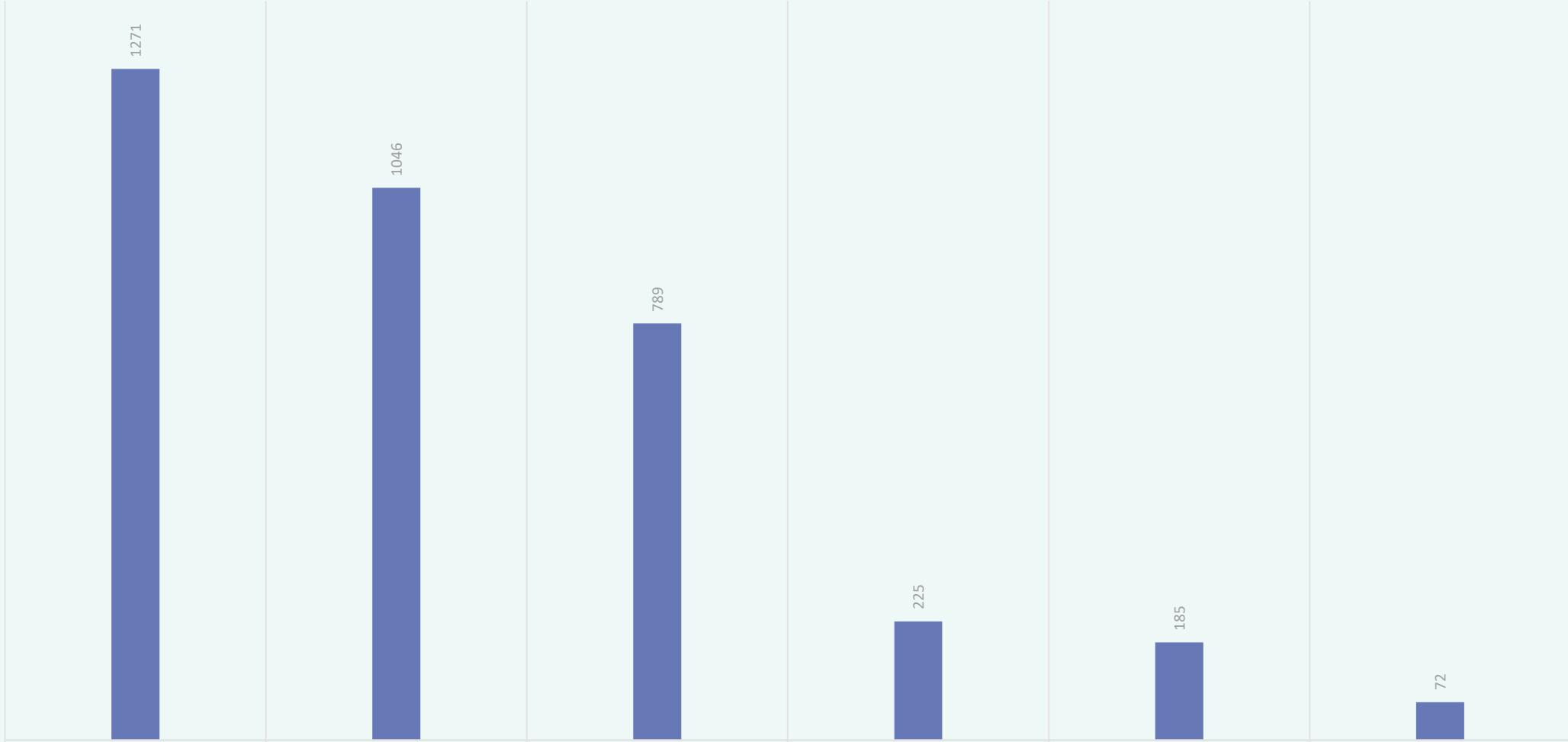
Referral Protocol




Sample Referral Detail
This patient is struggling, rising anxiety, overwhelmed with a lot of things, kindly help

CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

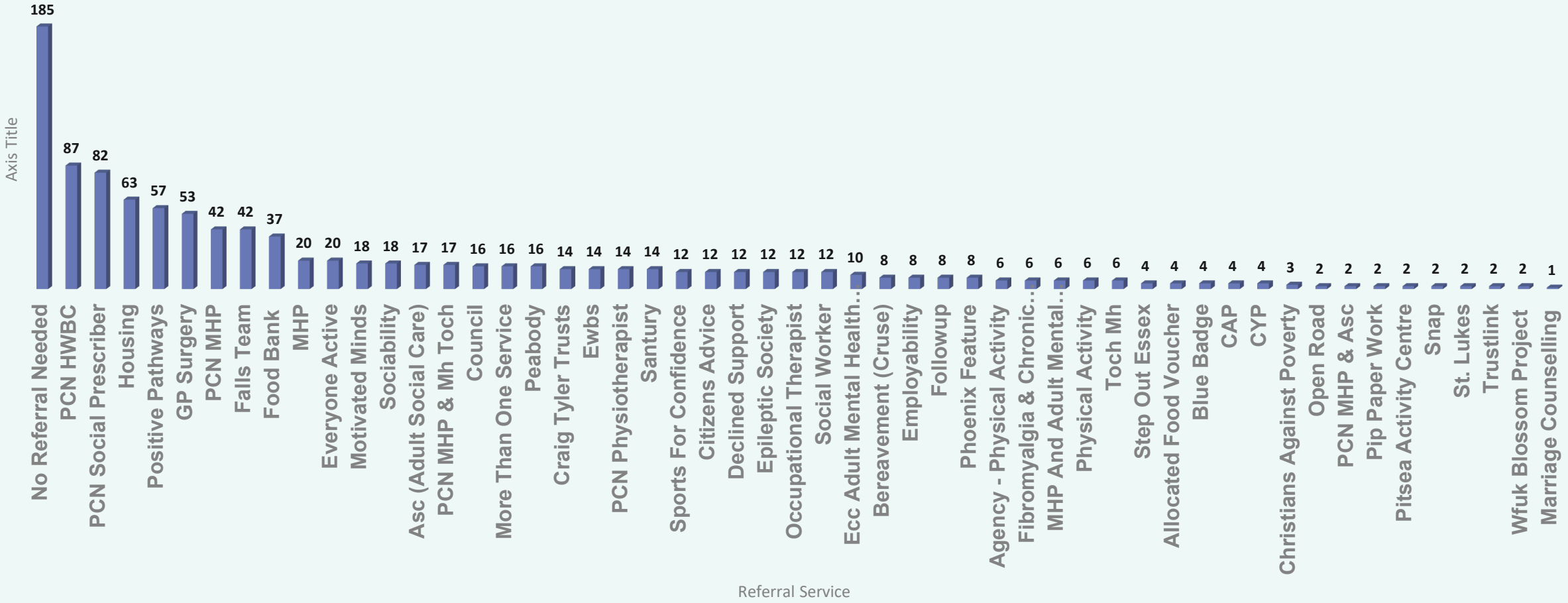
Booked into Care Co-Ordinator Rota



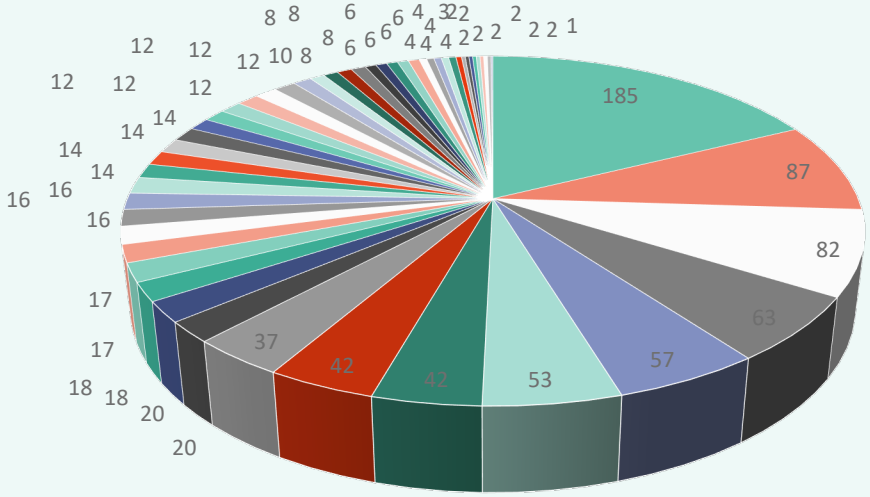
	Attempted contact	Initial Assessment	Sent to other services and resolved	Unreachable	Resolved by Care Co-ordinator without any intervention	Care Ongoing
Count	1271	1046	789	225	185	72

CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

MH INT Care Co-Ordinator Referral Pattern



CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"



52 Services

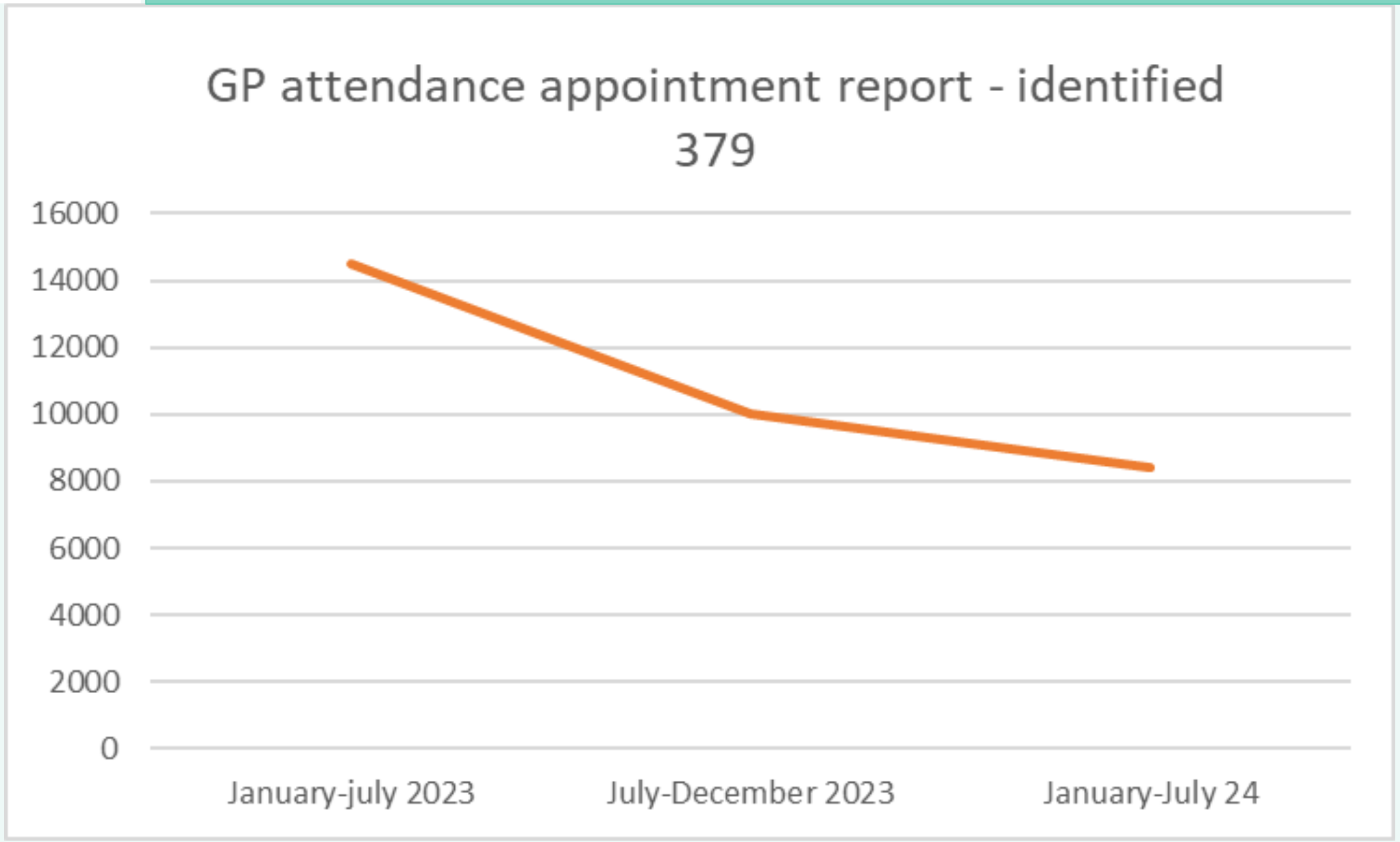
- No Referral Needed
- Housing
- PCN MHP
- MHP
- Sociability
- Council
- Craig Tyler Trusts
- Santury
- Declined Support
- Social Worker
- Employability
- Agency - Physical Activity
- Physical Activity
- Allocated Food Voucher
- CYP
- PCN MHP & Asc
- Snap
- Wfuk Blossom Project
- PCN HWBC
- Positive Pathways
- Falls Team
- Everyone Active
- Asc (Adult Social Care)
- More Than One Service
- Ewbs
- Sports For Confidence
- Epileptic Society
- Ecc Adult Mental Health Team
- Followup
- Fibromyalgia & Chronic Fatigue Syndrome Support Group
- Toch Mh
- Blue Badge
- Christians Against Poverty
- Pip Paper Work
- St. Lukes
- Marriage Counselling
- PCN Social Prescriber
- GP Surgery
- Food Bank
- Motivated Minds
- PCN MHP & Mh Toch
- Peabody
- PCN Physiotherapist
- Citizens Advice
- Occupational Therapist
- Bereavement (Cruse)
- Phoenix Feature
- MHP And Adult Mental Health Services Ecc
- Step Out Essex
- CAP
- Open Road
- Pitsea Activity Centre
- Trustlink

CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

Outcome

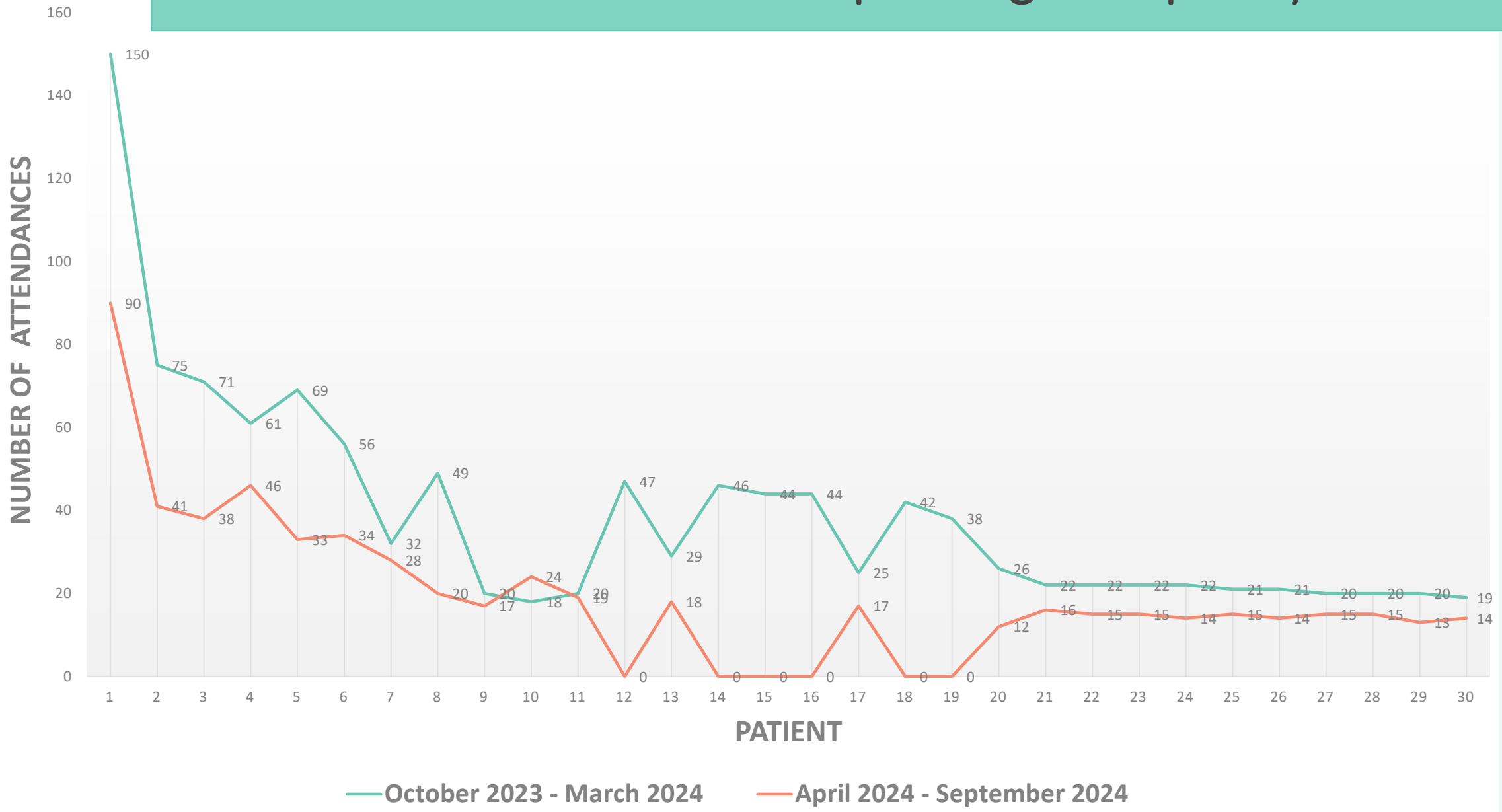
CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

Patients GP Attendance >25 times / year



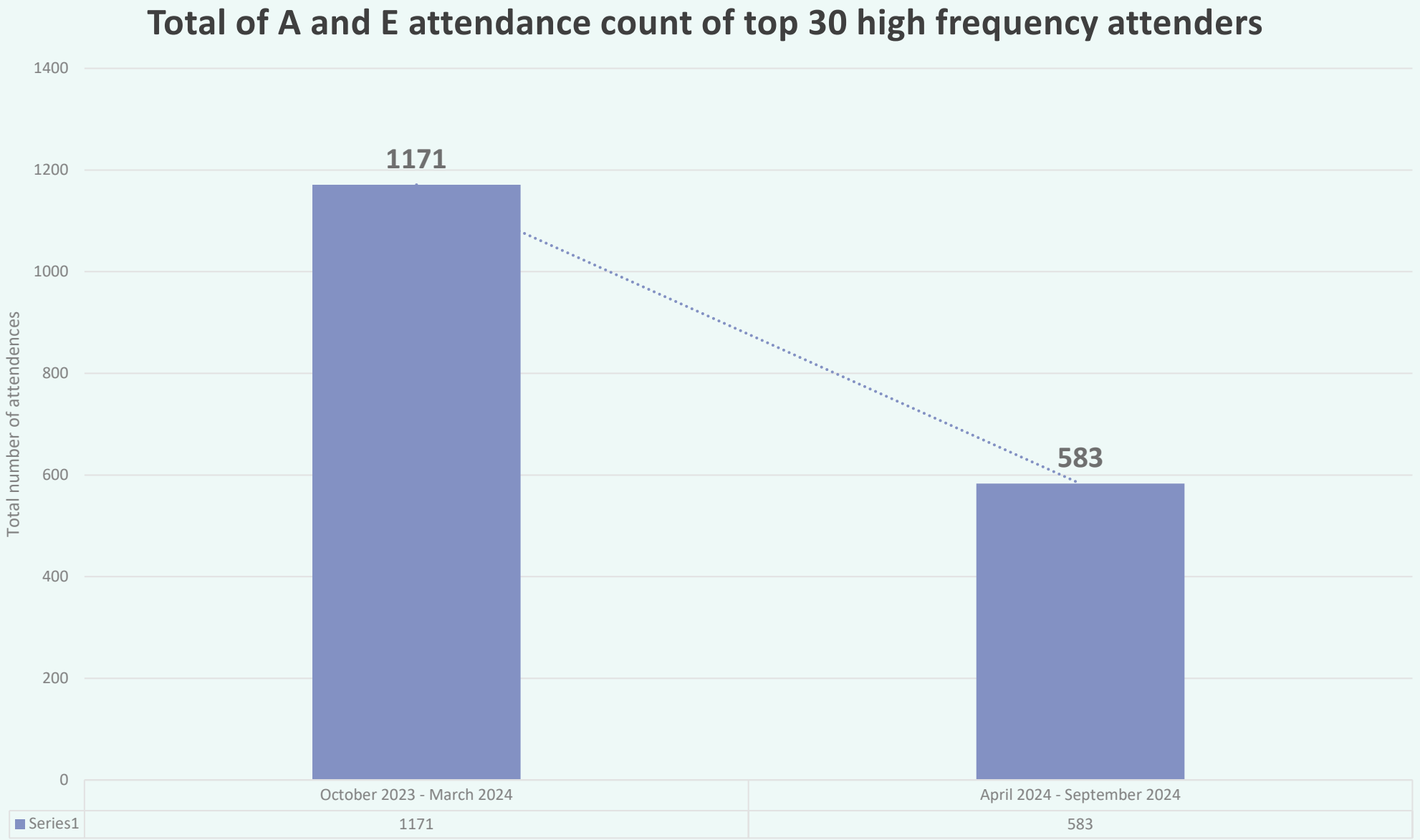
CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

A and E attendance count of top 30 High Frequency Attenders



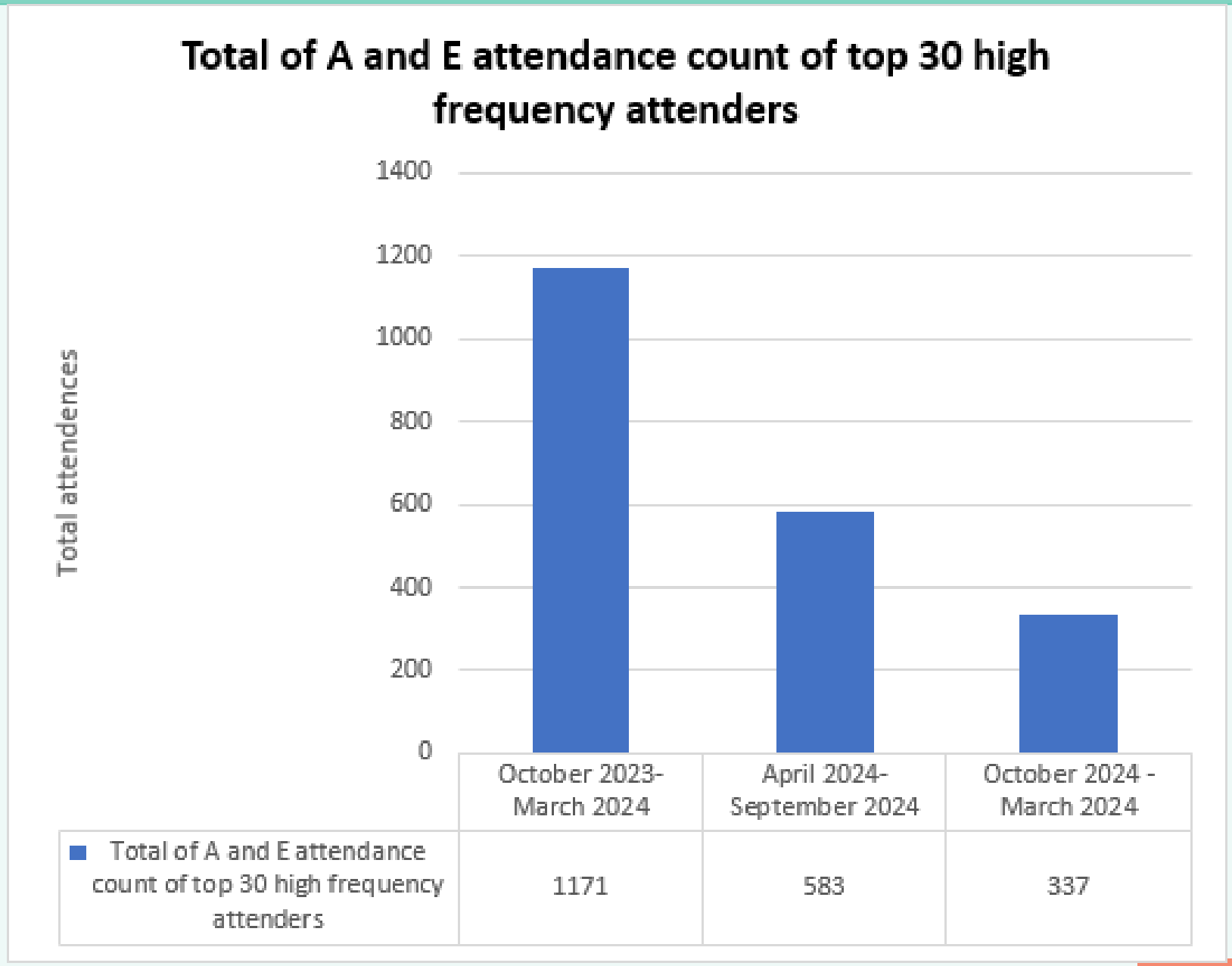
CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

50% reduction in top 30 Frequent A&E Attenders



CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

Continued reduction in Frequent A&E Attenders



CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

- Tapped into 60 other services
- Improved patient lives
- Reduced A&E attendance
- Reduced GP surgery attendance

- ? More

CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

Future Planning

CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

Future Planning

Summary Data

In the previous 12 months

3,589 high attender visits to A&E

2.8% of all visits

£629,909 in expenditure

399 patients

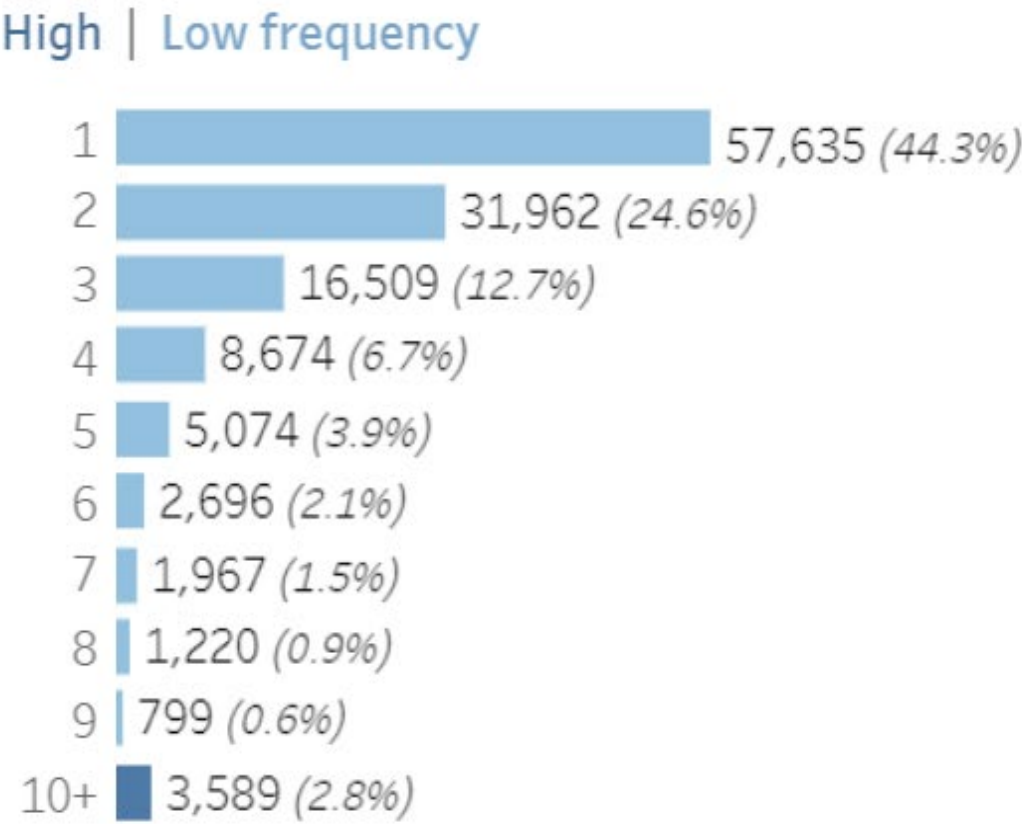
5,863 hours*

*(arrival to conclusion)

Date range from Sep 23 to Aug 24

Distribution of Attends *previous 12 months*

By selected unit: Attendances



CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

Future Planning

- Replicate our model
- 399 patients
- A&E attendance by 50%
- Appointment - 3589 - 1795
- ~ £300,000

CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

Future Planning

- Simple Project
- No extra funding
- ARRS Funding
- Patient benefit through existing but **UNKNOWN** services

CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

Central Basildon PCN

CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

Learning Difficulty - Health check

86.15%

Target – 60 – 80 %

CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

High Risk CVD patients

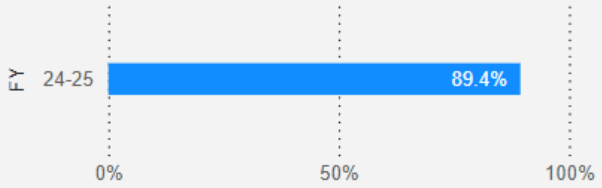
Health and Well-Being Indicators

NHS
Mid and South Essex

Alliance: All | PCN: Central Basildon PCN | Practice: All

Weight Management

Percentage of attended with a BMI > 25



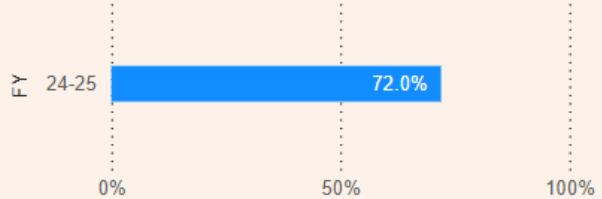
% attended signposted to weight management

Smoking

Attended cohort who are smokers, and are receiving specialist treatment support

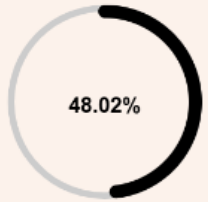
Flu Vaccinations

Percentage of attended with a age > 65 yrs



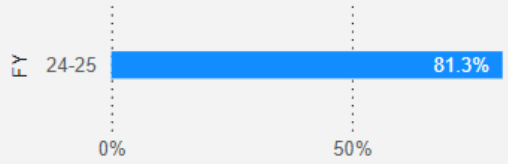
% Percentage of >=65 y/o attended who have had a flu vaccination

Percentage of <65 y/o attended who are in a risk group and have had a flu vaccination



Mental Health

Percentage of those who have attended a clinic and now have a depression or anxiety score recorded.



Mental health referrals to those who have attended and are deemed eligible for a referral

CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

Young Diabetes Patients

Review and advice - Family

130 patients

ANP led – service – 50% success

CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

Spirometry (Lung Function Test)

- NELFT
- **65** patients waiting for 9 -12 month
  - Not proper treatment
- Our own spirometry
- December – March – **257**

CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

Summer Patient Event

CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

Summer Patient Event

CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

Additional Roles Reimbursement Scheme

Clinical Pharmacist	Mental Health Practitioner
Health and Wellbeing Coach	CYP Mental Health Practitioners
Social Prescriber Link worker	Pharmacy Technicians
Digital and Transformation Lead	GP Assistants
Physician Associate	Care - Coordinator
Physiotherapist	

Total of 34 staff

CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

ARRS Appointments

Role	Count
Admin Team	32034
ANP T2D Nurse	299
Care Co-ordinators	16555
GP	924
GP Trainee	119
Health and Wellbeing Coaches	4350
INT Care Co-ordinators	2483
Mental Health Practitioner Children	289
Nurse Trainee	729
Pharmacy Team	24857
Physiotherapist	7173
Research Nurse	2124
Social Prescriber	6596
Spirometry	256
Grand Total	**98788**

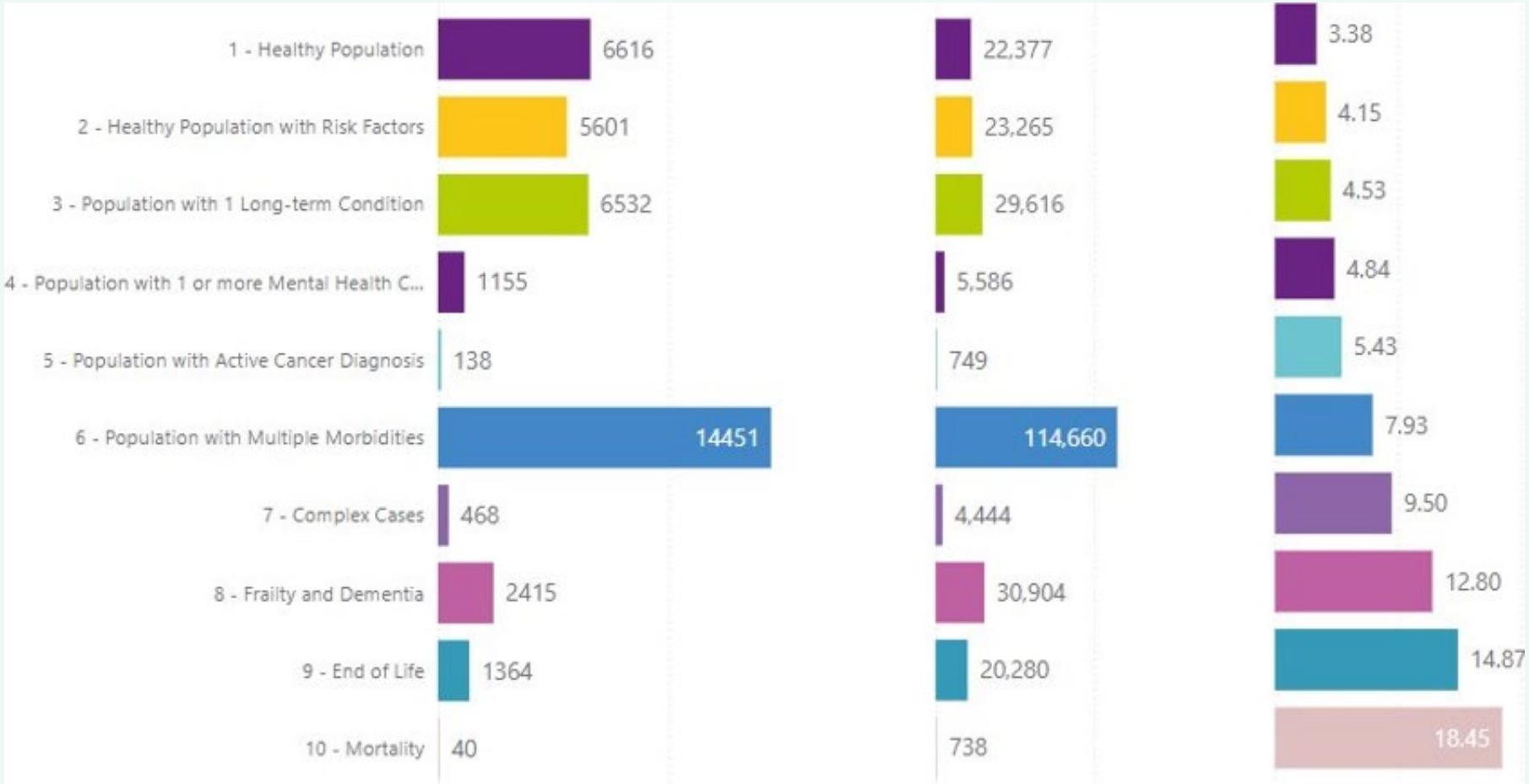
CENTRAL BASILDO
PRIMARY CARE NETW
"Improving lives together"

Primary Care Appointments last 12 months-CBPCN

38780
Selected Population

252,619
Appointments

6.51
Per Capita



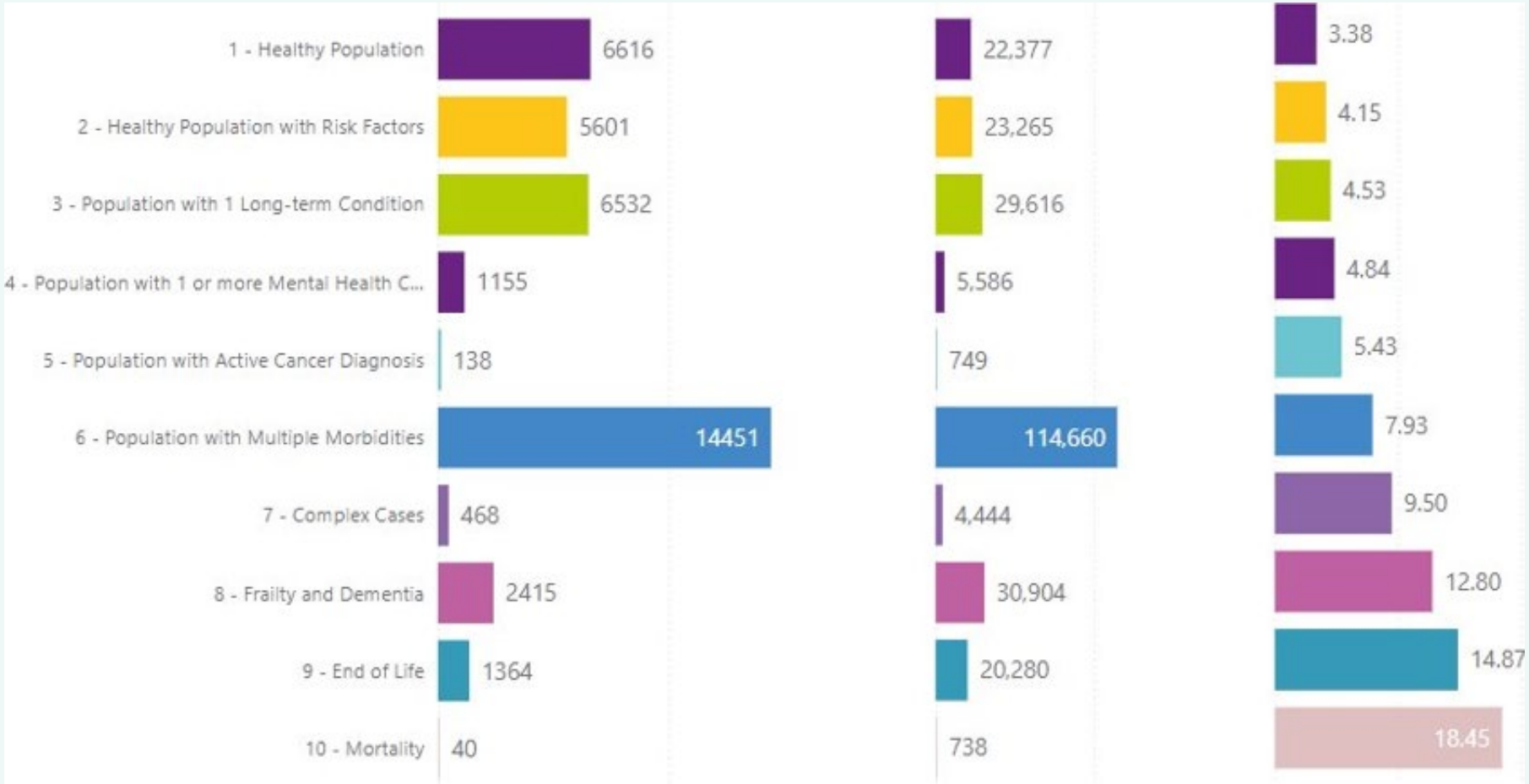
CENTRAL BASILDO
PRIMARY CARE NETW
"Improving lives together"

Primary Care Appointments last 12 months-CBPCN

54,871
Total Population

351,407
Appointments

6.40
Per Capita



CENTRAL BASILDON
PRIMARY CARE NETWORK
"Improving lives together"

PCN INT

- VISION
- Support – Alliance
- PCN / INT – Success Story


Integrated
Neighbourhood
Team

NHS
Mid and South Essex

Strengthening VCFSE Engagement: A Strategic Approach

March 2025

www.midandsouthessex.ics.nhs.uk

We are collaborative
We are compassionate
We are innovative
We are living well

Introduction and Context

- The Voluntary, Community, Faith, and Social Enterprise (VCFSE) sector is a key component of the Mid and South Essex Integrated Care Partnership (ICP) and Integrated Care Board (ICB), playing a vital role in improving population health and reducing inequalities.

- The Working with People and Communities guidance from NHS England sets the expectation that health and care systems actively engage with the VCFSE sector to enhance service co-design and delivery. This guidance underscores the need for a structured, strategic approach to embedding VCFSE voices in decision-making, ensuring their contributions shape health and care outcomes effectively.

- Recognising this, the ICP/ICB Chair has appointed Dr Geoffrey Ocen, a Non-Executive Member (NEM) to provide leadership in VCFSE engagement. Geoffrey, along with Claire Hankey Director of Communications and Partnerships, conducted structured interviews with key leaders across the VCFSE sector during November and December 2024 to gather insights on challenges, opportunities, and existing engagement structures. This process has informed the development of a new proposed model to complement, rather than duplicate, existing initiatives.

Insights from VCSFE discussions

1. Existing VCFSE Engagement

Through mapping current VCFSE involvement, several key touchpoints have been identified across governance, service delivery, and community engagement. These include:

- **Strategic Input**
  - Representation in the ICS Partnership Board, shaping system-wide decision-making.
  - VCFSE leads are instrumental in place-based leadership across our four alliances.
  - Delivery and engagement in Place-Based Partnerships aligned to local priorities.
  - Contributions to ICS strategies and population health management to address inequalities.
  - Thematic Working Group participation including Health Inequalities, Prevention, Cancer and Mental Health.

- **Service Delivery**
  - VCFSE-led social prescribing services, integrated with primary care networks (PCNs) and integrated neighbourhood teams (INTs).
  - Peer support for mental health, long-term conditions, and disability groups.
  - Crisis response services, including hospital discharge support and homelessness interventions.

- **Engagement with Communities**
  - Patient and public involvement through community listening events and co-design initiatives.
  - Inclusion programs to enhance health literacy, accessibility and technology-enabled care.
  - Securing sustainable funding through joint commissioning models and advocacy for fair processes.

2. Making the Case for a VCFSE Assembly

While significant VCFSE engagement already exists, structured interviews highlighted the need for a dedicated strategic forum that aligns system-wide efforts. The proposed VCFSE Assembly will complement existing workstreams by:

- **Providing system-wide insight:** Offering a coordinated perspective that strengthens connections between local, place-based efforts and ICP/ICB strategy.
- **Avoiding duplication:** Ensuring discussions at our place-based partnerships and other working groups inform, rather than replicate priorities.
- **Enhancing policy influence:** Enabling the VCFSE sector to contribute proactively to strategic planning at the highest decision-making levels.
- **Strengthening VCFSE resilience:** Promoting a strategic approach to commissioning that enables long-term collaboration, enhances capacity, and integrates system-wide planning and delivery.

3. Structure and Implementation

To operationalise the Assembly, the following framework is recommended:

Governance and Leadership

- The Assembly will be chaired in the interim by the appointed NEM, ensuring integration with ICP/ICB governance structures alongside a VCSFE vice chair.
- A Community Assembly Leadership Group will act as intermediary between wider VCFSE organisations and statutory bodies. The Group to be constituted following further engagement with the Sector.
- Reporting mechanisms will be formalised, with biannual updates to the ICP Board.

Communication and Collaboration

- A central engagement strategy will align all VCFSE efforts under a unified vision.
- Digital platforms and newsletters will facilitate transparent information-sharing.
- Wider bi-annual open Assembly meetings will ensure inclusive feedback and strategic input.

Measuring Progress and Impact

- Key Performance Indicators (KPIs) will be co-produced to track engagement effectiveness.
- Annual reviews will assess the impact of VCFSE contributions on system-wide health outcomes and factors promoting effective collaboration.
- A peer-learning network with other ICSs and local authorities will encourage knowledge sharing and innovation.

4. Risks and Mitigation

Lack of Funding and Resources

- Advocate for a collective funding stream through partners to support VCFSE engagement.
- Leverage external grants and partnerships to support financial sustainability.
- Maximise existing funded roles for administrative and strategic support.

Lack of Engagement from the Sector

- Establish clear incentives for participation, such as capacity-building opportunities.
- Strengthen communication channels to maintain sector-wide visibility and involvement.
- Implement targeted outreach and engagement campaigns to encourage broad participation.

Duplication of Efforts

- Ensure alignment with existing Place-Based Partnerships and working groups
- Use the Assembly to provide strategic oversight, rather than duplicating operational activities.

Sustainability and Long-Term Impact

- Develop a long-term strategic roadmap with clearly defined milestones.
- Introduce ongoing evaluation mechanisms to refine engagement approaches over time.
- Foster a culture of collaboration, ensuring the VCFSE sector remains a core partner

Conclusion

- The Mid and South Essex ICS has a strong foundation of VCFSE engagement across governance, service delivery, and community initiatives. However, structured interviews with sector leaders and system partners have highlighted the need for a strategic, system-wide Assembly that can provide overarching insight, prevent duplication, and enhance policy influence.
- By implementing this model, the ICP and ICB can:
  - Foster a cohesive and structured engagement framework.
  - Improve collaborative decision-making and financial sustainability.
  - Strengthen VCFSE representation in strategic planning.
  - Align community-driven efforts with ICS health priorities.

Next Steps

- **Re-engage the local VCFSE**: Arrange an in-person meeting with key VCFSE leaders to discuss the report, agree the way forward and establish the leadership group
- **Establish Governance Structures:** Defining the roles and responsibilities of the Community Assembly, developing terms of reference and engagement protocols in partnership with VCFSE and establishing membership recruitment mechanism
- **Monitor and evaluate:** establishing metrics and processes to monitor the effectiveness of the engagement model in partnership with VCFSE
- **Provide an update to the ICP:** initially on the agreed way forward but also with regular updates to feedback on activity and outcomes.