APPENDIX 1

NHS
Essex Partnership University
NHS Foundation Trust

STRATEGIC PLAN
WEST ESSEX COMMUNITY CARE UNIT

Introduction

Essex Partnership University NHS Foundation Trust (EPUT) has agreed a new vision, purpose, strategic objectives and values (below). This plan sets out how the West Essex Community care unit will deliver on the vision, purpose, strategic objectives, and values over the next five years.

This plan has been developed through discussion with EPUT staff, service users, carers, families, and partner organisations. Engagement was informed by a review of the policy and strategic context, and analysis of demand and capacity across EPUT's services. Along with the plans for EPUT's other care units, this plan forms the basis of the Trust Strategic Plan for 2023/24 to 2027/28.

ABOUT THE CARE UNIT

The The West Essex Community care unit provides adult primary and community mental health services alongside community physical health services across Epping, Harlow and Uttlesford. The West Essex care unit sits within the Hertfordshire and West Essex Integrated Care System (ICS). The Princess Alexandra Hospital is developing plans for a new hospital. Its 2030 strategy supports that development and envisages a significant shift of activity in the community and an increase in digital care.

Journey so far

The West Essex Community care unit is a successful early implementer site for the model described in the Community Mental Health Framework. The team has shared learning from the transformation journey with services across the country.

West Essex has a history of good partnerships working with both NHS and local authority partners. It is one of two areas in Essex where EPUT provides a full range of community physical and mental health services. The team has built on these strengths to drive the integration of community services and alignment to the West Essex Health Care Partnership Out of Hospital model by developing the Care Co-ordination Centre (CCC), which is central to the new model and new integrated services such as specialist dementia and frailty teams.

The West Essex Health Care Partnership (WEHCP) brings together EPUT community and mental health services, Essex County Council, Princess Alexandra Hospital NHS Trust and six Primary Care Networks (PCNs). The Partnership operates at the West Essex place and has developed a 10-year plan which aligns with the NHS Long-Term Plan published in January 2019. The plan identifies both the clinical and non-clinical strategic priorities which will enable the improvement of local services, better health and care outcomes for our local population and a framework that will support the delivery of financial system efficiencies for the health economy. The Princess Alexandra Hospital is developing plans for a new hospital. Its 2030 strategy supports that development and envisages a significant shift of activity in the community and an increase in digital care.

Both national policy and partner strategies reflect similar themes about how health and care services need to change to meet the current and future needs of the population.

Demand

The older adult population within Essex is set to increase in size significantly over the next 5 years **(8.3%, 32,000 extra older adults)**. West Essex will see a faster increase than the rest of Essex in this cohort size of 10%, an extra 6000 older adults. Uttlesford District Council will see a rise of **14%** in older adults, and although generally considered less deprived, the volume of increase and relative rurality of this area will exacerbate pressures here particularly.

In specialist community mental health, the data suggests that with continuing trends the three integrated community teams could anticipate a smaller but potentially more acute caseload over time. Currently, the data shows a downward trend in referrals. For **Q1 2022/23** the number of referrals was down **34%** on the previous year, and the services expressed in engagement that acuity feels to be increasing across the area though this is neither fully substantiated nor disproved by the data for the mental health teams.

Within urgent and scheduled care, there has been a drop off in referrals to the three Integrated community teams during 2021-2022 following a spike during the pandemic, however, the caseload steadily rose from January to August 2021. The data suggest that acuity is increasing can be substantiated as this caseload is rising, and when comparing **FY 2019/20** and **2021/22** patients are staying for longer (average days on caseload increased from **13.5** to **17.1** days), the average number of contacts attended across a referral increased from 4 to 5 and the total clinical care time per patient across their referral also increased. The demand is expected to further increase with the introduction of the Urgent Community Response Team (UCRT) in November 2021 and the realisation of the out-of-hospital model of care however this impact is yet to be quantified.

Service user, carer, and family engagement

The Trust Strategic Plan sets out our engagement with service users, carers and families.

People have told us that they want:

- Accessible and inclusive services
- Choice of services and treatments
- Services designed and developed through co-production
- Trust and confidence in services, and continuity of care
- Better supported transitions between services
- Tackling stigma
- Better support whilst waiting.

Challenges and opportunities

The population of West Essex is living longer, growing, and marked by significant differences in health experience and outcomes between its least and most deprived communities. Whilst there are no areas within West Essex that are in the most deprived decile according to the Index of Multiple Deprivation, there are wards in the second most deprived decile in England.

Data and information are fragmented within EPUT and with partner organisations presenting a barrier to integration. Clinical information is recorded in multiple patient record systems making it difficult to understand the whole picture for an individual service user or across a team's caseload, and there is a lack of access to partner organisations' information systems. This makes care coordination

between teams and services more complicated and creates duplication.

Recruitment and retention are a challenge nationally in the NHS and features of the West Essex geography can make attracting staff to the service more difficult. There is competition from providers in London, Cambridge, and Hertfordshire, and variable application of the High Cost of Living allowance across the three districts of West Essex adds to this challenge. There is a high turnover rate and, combined with recruitment and retention challenges, this has created a workforce skill gap. Some staff say they are exhausted from the pandemic and the staff survey reflects that redeployed staff had a poorer experience in areas such as learning and recognition.

Managers want to have better data and support to understand their workforce and to plan and develop service capacity.

A non-statutory Independent Inquiry is currently investigating the circumstances of mental health inpatient deaths across NHS Trusts in Essex between 2000 and 2020. The Inquiry is currently collecting evidence, hearing from a range of witnesses including families, patients, staff and relevant organisations. The next phases will involve analysing this evidence and preparing a report and recommendations. EPUT will respond to the recommendations made, ensuring all actions required are completed. All care units will be active participants in any actions required to ensure a full cascade across operational services.

Key risks for West Essex Community services include:

- Recruitment and retention
- Staff well-being and recovery
- Access to data and real-time clinical information
- Connection and alignment with local providers
- High caseloads with increasing complexity/acuity
- Rejecting and excluding referrals.

VISION, PURPOSE, AND STRATEGIC OBJECTIVES

Vision

"To be the leading health and wellbeing service in the provision of mental health and community care."

West Essex Community Services will contribute to the delivery of the vision by:

- Delivering a **healthier future** for the population of West Essex through our partnerships with our health and care organisations, staff, the voluntary sector, and our population
- Implementing the **Care Co-ordination Centre** with our partners to improve people's outcomes and experience by navigating people to services at the right time, in the right place
- Developing **Integrated neighbourhood teams** that wrap around the six West Essex PCN's to meet the health and care needs of the individual, carers and family
- Enable people to receive end-of-life support at home or in their preferred place of choice
- Develop new **Integrated Care Worker roles** to provide flexible support across pathways and help join-up care
- West Essex's strategy is to build on current resources to **further psychological therapies and interventions** within the Care Unit in line with the National Institute for Health and Care Excellence (NICE) guidance.

Purpose

"We care for people every day. What we do together, matters."

Our vision for West Essex Community care unit focuses on co-production, working together with service users, their families, and supporters, with our colleagues across EPUT and with our partners across health, care, education, emergency services and the voluntary and community sector including lived experience representatives.

Working together as one to provide the best possible care and support for people when they need it. Fostering and nurturing an environment where our people are engaged, listened to, supported, and helped to grow. We want to provide holistic care with increased self-management and prevention support to help the population remain healthier for longer and out of the hospital. Accessible services tailored to the needs of our population with easy access and a seamless patient experience. We want to ensure a good experience for people who use our local health and care services.

Strategic objectives

We have four strategic objectives to achieve our vision:

- We will deliver safe, high quality integrated care services
- We will enable each other to be the best we can be
- We will work with our partners to make our services better
- We will help our communities to thrive

We have set out our key priorities to achieve these objectives in the next section.

Values

Our values underpin all that we do:

WE CARE • WE LEARN • WE EMPOWER

New International Recruits at Induction

STRATEGIC OBJECTIVE 1:
WE WILL DELIVER SAFE, HIGH QUALITY INTEGRATED SERVICES

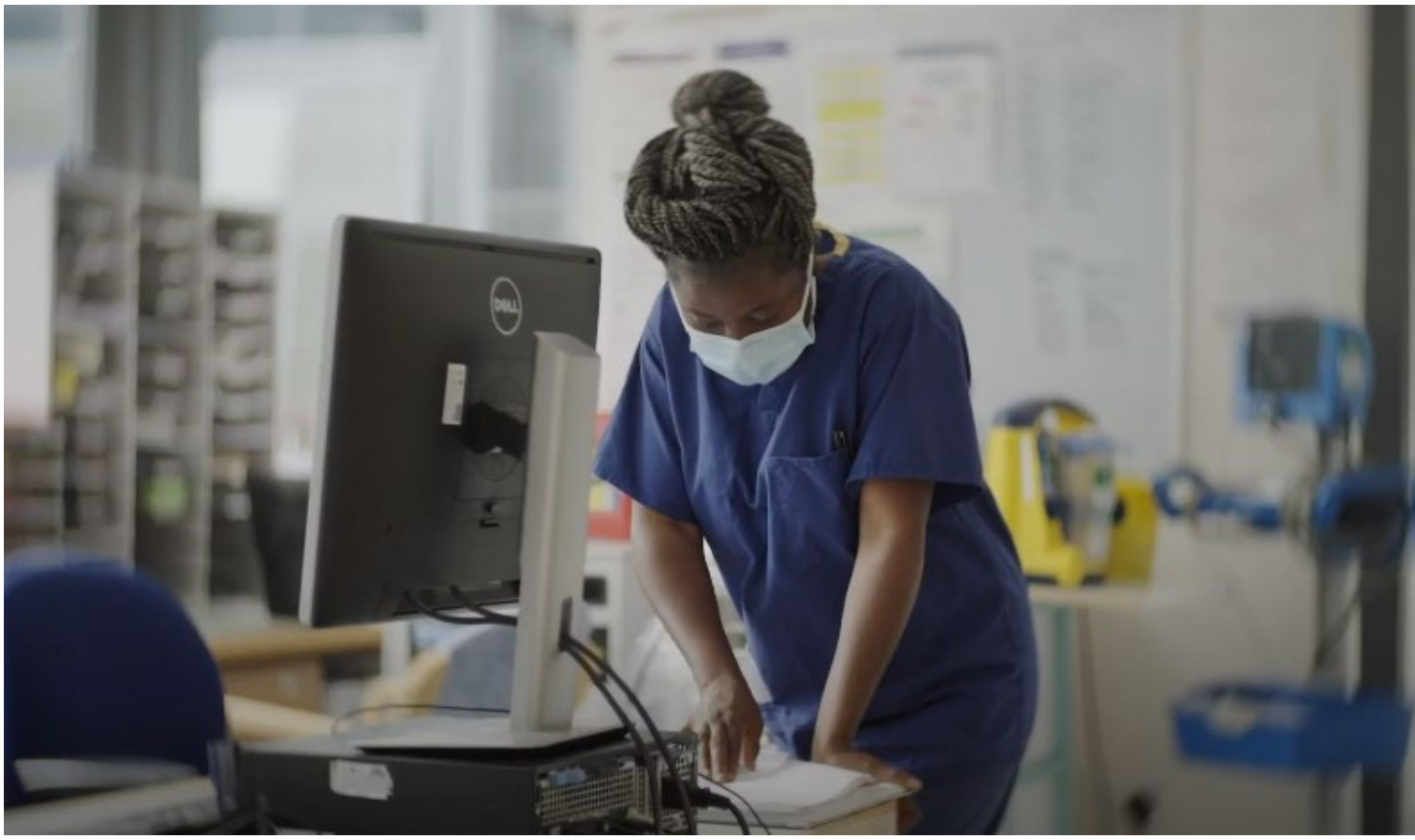
Introduction

We have seen great progress in joining up services in West Essex, the Care Co-ordination Centre (CCC) is at the centre of the West Essex Health and Care Partnership transformation programme to support the delivery of the Out of Hospital Strategy. The CCC is the engine room for services across West Essex across community health, community mental health, and acute and social care. The CCC will provide a "helicopter" view of demand and capacity. Nationally and Regionally the CCC is held up as the flagship illustrating the way forward for integrated working and joining up services.

The CCC ensures a single timely and coordinated response to everyone focusing on person-centred care. The CCC will create a single real-time view across the system that keeps all partners informed from referral to outcome allowing visibility. The CCC enables collaborative, flexible working with a simple referral process that prevents duplication and is a trusted service the CCC has an experienced workforce at the front door, harnessing technology and promoting multi-disciplinary problem-solving. This continues to be a programme in development.

Our key priorities

- Continue with the implementation of the CCC, including mapping and improvement of policies and processes.
- Create a local reducing restrictive practice group to feed into the Trust reducing restrictive group.
- Deliver more proactive care by working with system partners to connect data and develop population health management approaches.
- Improve community service productivity through the adoption of digital tools, such as auto-scheduler to maximise clinical time.
- Improve end-of-life pathways to provide seamless care transfer and support more people at home.
- Deliver system-wide awareness, identification, and treatment programme for depression in over 65s across West Essex.
- Successfully piloting management of part of the East of England Ambulance Service NHS Trust (EEAST) stack.
- Further development of the integrated neighbourhood teams and primary care relationships.



St Margaret's Hospital, Epping

Care Coordination Centre

The CCC will identify the most appropriate pathway to meet the individual's needs reducing the impact on the patient, family, or carer in navigating the highly complex health and care landscape and reducing the frustration for people having to repeat their stories.

The CCC will include a multi-professional health and care team who will coordinate care and support for complex patients to prevent hospital admission and support safe discharge from the hospital back home.

The CCC connect teams, professionals, and information so people don't need to repeat their story. There will be a single referral/ access to community services and a clear referral process for professionals across the health and care system as well as access to multi-professional health and care advice and guidance.

How will we measure success?

- **Progression of the integrated CCC.**
- **Continued delivery of the West Essex HCP Out of Hospital Model.**
- **Appropriate/purposeful admission**
- **Dying at home.**
- **Measure depression in over 65s.**
- **EEAST Stack – completed.**
- **Complete integration of the neighbourhood teams and primary relationships.**
- **Supporting Healthcare Industry User Group (HIUG) initiative.**

What will be different?

People will receive the ***"right care in the right place at the right time."*** The CCC will ensure people receive a single timely and coordinated response from health, care, and community services. The CCC will connect teams, professionals, and information within the services, so people don't need to tell their stories repeatedly. There will be clear referral processes for professionals across the health and care system and access to multi-professional health and care advice and guidance. This is a target for year 1.

Services will have good quality real-time information with tools to support risk assessment and supporting predictive analysis of both caseloads and the local population, allowing the service to provide timely and proactive support to people. The community staff can update patient records wherever they're working including when visiting people in their homes via their laptops. Digital technology will improve to allow the EPR app to allow finer efficiency.

Across the six PCNs, integrated neighbourhood teams will support people to feel well by identifying more physical and mental health problems earlier and providing support that prevents those problems from becoming more serious. The integrated neighbourhood teams will provide specialist support to more people locally to help them manage their health and well-being at home or in a community setting.

Community, primary and urgent care services will work together to enable people to receive end end-of-life support at home or in their preferred place of choice, rather than in hospital. We will actively encourage the Essex County Council life stage model: start well, live well, die well.

STRATEGIC OBJECTIVE 2:
WE WILL ENABLE EACH OTHER TO BE THE BEST WE CAN BE

Introduction

We will build our team by supporting more local people to develop successful careers in health and care, continuing to introduce new roles and developing joint workforce models with our partners. We will create a caring and compassionate culture, where our staff can thrive and are supported to learn and grow. We will use a trauma-informed approach and restorative supervision, to support our staff to feel safe, supported and listened to. We will support our staff to develop their skills for integrated care delivery, with a focus on physical and mental healthcare.

We have created new roles in community mental health transformation, co-designed with the system. The new roles sit within the PCNs and provide mental health interventions for those who would not have been eligible for services in the past. The roles are fully integrated into the PCNs and straddle into the locality's complex terms enabling a continuity of care approach and supporting the adoption of a no wrong door and trusted assessor approach. EPUT has recruited four Sports Science graduates to support the delivery of Musculoskeletal Health (MSK) rehab programmes.

West Essex supported an initial cohort of 10 international nurses from India to the community hospital wards at Epping. The nurses were welcomed to the "family" and have been an invaluable asset to the wards and reducing the vacancy rate and use of bank and agency staff.

West Essex has been commissioned to provide a "bridging service" for Essex County Council. This service supports patients discharged from the hospital and or to prevent a hospital admission who require care support to recover. The staff providing this care will be trained as integrated care workers.

Through co-producing with the system partners, they recognised the wider determinants of mental health needs, the need for social connection and low-level skills support. The model included a new role of mental health coaches directly employed by MIND and working in partnership with the IMHPs. The feedback from our MIND partners has been very positive describing the relationship as ***"equal partners at the table"***. The integrated mental health service is outward-facing working with a variety of voluntary, community, social enterprise (VCSE) providers and embedded within several district council community hubs including Harlow and Waltham Abbey.

Our key priorities

- Map staff skills and review skill requirements for future service delivery, identifying new staffing models and opportunities for new roles.
- Introduce new integrated care worker roles and competency framework for modular development of skills for integrated care to maximise capacity for delivery of health and care support.
- Provide structured training and opportunities to develop skills and experience across services, including rotational roles and rotational training, to create broader knowledge and skills required for person-centred care, and a method to support rotational arrangements between provider partners.
- Develop a programme of work experience and shadowing, enabling our local population to gain exposure and to learn about the potential roles and career opportunities within health and care.
- Identify career and development pathways via Pen Plan appraisals for all staff members regardless of ambition, and ensure protected time to undertake additional training or qualifications.
- Lead the way in the development of Band 4 associate practitioner roles, which supports the future pipeline for registered professional roles.
- Promote West Essex as an excellent place to work and become an employer of choice with exciting opportunities for the local population.
- Creation of joint/hybrid roles across providers.

End-of-life pathway

EPUT has implemented the Systm1 electronic end-of-life register (EPaCCs) to support patients to receive end end-of-life in their preferred place of death. The register includes information on the patient's preferred place of death, DNAR and status and is accessible to all GP practices on Systm1, St Clare Hospice, EEAST and Princess Alexandra Hospital palliative care team as a way of improving the experience for both patients, family, and carers for those at the end of their life. EPUT have employed a nurse to support practices to increase the uptake of the register.

Outstanding for End-of-Life Care, by the request of CQC West Essex has showcased the experience and written a case study to share with other trusts and has included a life-limiting nurse role within the integrated neighbourhood teams with the specific focus of supporting patients at the end of life, their family, and carers.

How will success be measured?

- **% of staff completing training and development.**
- **Increasing the number of students graduating with a permanent role staying at the end of a placement.**
- **% Staff completing Pen Plan appraisals.**
- **NHS Staff Survey – staff engagement theme.**
- **Reducing vacancy rate.**
- **Improved retention rate.**

What will be different?

We will promote West Essex community services as a great place to work and showcase our teams' diverse range of jobs and career development opportunities.

We will make a more precise development offer to current and prospective staff, including formal training and development support. We will ensure staff have the time to undertake training or qualification by protecting time in job plans.

New staff will have protected time to complete a structured induction programme and training before starting their clinical or operational duties and will have the support of a peer or buddy to settle into their new roles.

All staff will have high-quality 1:1 support, appraisals, and peer supervision and utilise the Pen Plan as outlined in the "Talent Framework". We will support current and aspiring managers to gain the management and leadership skills they need to support our staff well and cultivate happy and productive teams.

The development offer will enable staff to develop the skills necessary to deliver holistic person-centred care. We will develop a new role of Integrated Care Worker, who will be able to provide support across pathways and will support staff to develop competencies across disciplines. This will mean a more focused delivery for the service users, allowing the system partners to benefit from a more agile workforce supporting a range of specialists.

We will be developing non-registered roles with clear career pathways including the sports science graduates in MSK pathways and the use of clinical associate in psychology (CAP) roles for psychology initiatives such as the 18-25 pathway.

We will be collaborating with our IPS provider EmployAbility to look for employment opportunities within the organisation and ensure personal training programmes are in place whilst working with the Department of Work and Pensions (DWP).

We will continue to focus on the student experience and seek to retain an increasing number of students at the end of their placement with West Essex.

STRATEGIC OBJECTIVE 3:
WE WILL WORK WITH OUR PARTNERS TO MAKE OUR SERVICES BETTER

Introduction

EPUT is a significant partner in the WEHCP, the place-based health and care partnership within the Hertfordshire and West Essex ICS. EPUT and Essex County Council jointly developed the Out of Hospital strategy and model of care with commissioners in 2019. We are committed to strengthening and growing our partnerships - with service users, communities, health and care organisations, local authorities, education, community and voluntary organisations and other public services - to improve the health and well-being of the local population. We will introduce new lived experience roles and commit to designing and delivering our service in partnership with our people and communities.

We have established significant working relationships with the voluntary and community sector including MIND and WECAN Essex County Council Adult social care, local district councils and with our ICS provider partners. This includes Hertfordshire Partnership University NHS Foundation Trust, Hertfordshire Community NHS Trust, Princess Alexandra Hospital NHS Trust and EEAST.

At Place, EPUT is working with West Essex mental health commissioners who are undertaking a wide-ranging review and evaluation of the mental health transformation investment to assess the impact on current services including which a gap analysis of psychological interventions will form a part.

EPUT provides both physical and mental community health services in West Essex and is uniquely placed to integrate services and increase parity

The integrated primary care mental health services are embedded within several local hubs in Epping Forest and Harlow. In Epping Forest, the integrated practitioners have co-delivered physical and mental health well-being groups working alongside district council colleagues. They have also been involved in initiatives with the fire brigade to access hard-to-reach residents. Working collaboratively with these community partners enables access to a very wide range of community and voluntary sector resources. This access is two-way and provides opportunities for voluntary sector organisations to support people who have not accessed services that are appropriate to meet their individual needs.

Our key priorities

- Continued development of partnership working with both statutory and non-statutory health and care partners.
- Create and recruit the leadership roles for each of the integrated neighbourhood teams and develop new ways of working across primary and community care.
- Strengthen links with care agencies providing domiciliary care and carers to improve carer involvement.
- Develop an approach to co-production working with members of our community with lived experience of our services and work with partners to develop system-wide approaches to involvement and co-production.
- Continue to develop and support active use of the system-wide directory of services (DOS).
- Continue to participate and contribute to the West Essex Health Care Partnership governance and development of integrated pathways of care.
- Continue to contribute to and influence collaboration initiatives with voluntary, community and social enterprise sector such as the Suicide Prevention initiatives led by MIND.
- Committing further to WEHCP by contributing and delivering the Out of Hospital Model of Care.
- Continue to work with EEAST to support low category 999 calls as a safe alternative to hospital attendance.
- Continue to deliver the key functions of the Integrated Neighbourhood Teams working together to proactively support our complex patients.

What will be different?

Our services will be developed in partnership with people who have lived experience of our services and mental illness. We are working towards the WEHCP vision of ***"Working together as one to provide the best possible care and support for people when they need it."***

We will work with our partners to ensure our information systems are connected and support us to develop our services.

The CCC and integrated neighbourhood teams will bring partners together to support the needs of the individual, family, and carers. Teams will increasingly work across organisations and multi-agency and multi-disciplinary teams will plan and deliver care together, removing the need for many referrals and handoffs.

One of the key functions of the integrated neighbourhood teams is to work together to proactively support patients with complex health and care needs, to support this approach, we have worked with leads from across the partner organisations to develop the Integrated Neighbourhood Team Approach to Anticipatory Care. We will endeavour to make good progress on the six Integrated Neighbourhood Teams.

The aim is to support our complex patients, through an anticipatory care planning approach, enabling earlier intervention and prevention and reduction in an escalation of need.

We will continue to develop initiatives working across our service boundaries, to improve joint working and reduce unwarranted variation. For example, our mental health teams are working with Hertfordshire Partnership NHS Foundation Trust to develop cross-border working protocols.

We will build on current resources to further psychological therapies and interventions within the care unit in line with the NICE guidance. The care unit specialist mental health teams have with additional investment established an 18-25 pathway that provides people with psychologically informed interventions. The community specialist mental health teams and integrated primary care teams also include a range of psychological interventions.

We will further work closely with the consortium of voluntary organisations in West Essex (WECAN) and have established innovative ways of supporting people to remain out of the hospital or to be discharged earlier by providing a wide range of practical and immediate help. We continue to work in partnership with EEAST to 'pull' urgent calls, which can be treated by responsive community teams preventing unnecessary journeys and admission to the hospital.

Our partnerships will support colleagues to develop their skills, relationships, and confidence to "make every contact count". We will explore opportunities for shared workforce approaches and joint learning programmes. We will support our partners to increase their confidence in working with people with serious mental illness, and their awareness of trauma and suicide. We will seek opportunities to learn from the strengths of our partners.

Integrated Neighbourhood Teams

The aim is to work as an Integrated Neighbourhood Team to support our complex patients, through an anticipatory care planning approach, enabling earlier intervention and prevention and reduction in an escalation of need.

Dengie Neighbourhood Team

To test a model of true integration with community nursing, adult social care and domiciliary care with a network of other professionals wrapped around the team. The desire is to enable the team to work together without the barriers that come with working for individual organisations, to deliver holistic and personalised care and support to adults.

Outcomes

- Significant reduction in levels of unsourced care
- Reduction in average waiting time for care packages
- Increase in workforce satisfaction

How will we measure success?

- **Capture staff, user, and carer experience.**
- **EPUT being recognised as a key stakeholder in the neighbourhood teams.**
- **Staff being able to move around the ICS.**
- **Reduction in urgent patient contacts where the service user is high-frequency user e.g. GP practice, social care, community care.**

STRATEGIC OBJECTIVE 4:
WE WILL HELP OUR COMMUNITIES TO THRIVE

Introduction

There are significant health inequalities in West Essex. We want to increase life expectancy, increase the average age at death in adults and increase disease-free life expectancy. We want to focus on reducing the gap in age at death between the most and least deprived deciles, reduce the rates of suicide, and reduce the proportion of the population who are digitally excluded either by lack of equipment, connectivity, skills, cost, or confidence to be able to access clinical services.

We will work with and through our communities to improve health access and outcomes for those experiencing health inequalities. We need to understand the experiences of our communities better and how we can develop services that are accessible and effective. Building on learning from other systems, we will engage with faith and cultural communities and work with our community partners to engage with other 'hidden' communities. We envisage that our approach will include "pop-up" or "drop-in" services located within communities.

There will be no wrong front doors to accessing care. The model will enable service users with a full range of mental and physical health needs to access care and ensures the availability of appropriate services for those (and their carers) with severe mental health needs. EPUT as the provider of both community physical and mental health services will enable a more integrated approach to meeting the physical health needs of those with Severe Mental Illness (SMI). There is a need to actively seek out underserved and invisible communities and ensure services can support diverse populations.

Harlow has been identified by Essex County Council as an area of focus for levelling-up. EPUT will work alongside our Essex County Council partners and other system partners to support the delivery of the 20 commitments which are divided into four key areas: economy, environment, health, and family. The plan whilst ambitious is certainly attainable.

Our key priorities

- Support the creation of, or access to, community 'hubs' focusing on mental and physical health care enabling more local delivery, as well as collaborative working spaces.
- Take appropriate services into the community, as well as deliver 'pop-up' activities to create service awareness and promote well-being initiatives.
- Work with community agents and social prescribers to increase awareness of and access to EPUT services via the CCC and develop alternative pathways for support.
- Use West Essex's profile and skills to support other community organisations (e.g. coaching, mentoring, consulting).
- Continue with the levelling-up plans for Harlow especially focusing on the Essex Green Infrastructure Strategy which will help to bring many social, economic, and environmental benefits.
- Support the delivery of Core20Plus5 to reduce healthcare inequalities across the West Essex system.
- Improve engagement with "invisible communities" by working with local trusted community organisations and agents to build relationships to support the health and well-being of those invisible individuals.
- With partners, continue our focus on suicide prevention, and support our colleagues outside of mental health services to develop their awareness and skills to identify and support people in distress and at risk of harm.
- As key partners in the integrated neighbourhood teams, identify and develop prevention initiatives and offer advice, support and intervention for cases highlighted by our multi-agency partners.

Independent Living Centre, Bishop's Stortford

Harlow "Levelling-Up" Programme

EPUT is supporting the multi-agency approach to addressing health inequality in Harlow. Essex County Council has identified Harlow as a priority area. EPUT community mental health practitioners are supporting community hubs weekly in Waltham Abbey and Harlow with advice and guidance alongside partners from the Citizens Advice Bureau, district/town council representatives and other voluntary organisations to provide proactive advice and guidance.

The CCC has had access to the EEAST online CAD since 25 October 2022 which enables the clinicians in the CCC to see patients on the EEAST stack who have been triaged as category 3, 4 and 5 calls - on the first day four out of six calls saw these patients safely cared for in the community.

The West Essex pulmonary rehabilitation programme has embarked on a pilot in Q3 2022-23 to increase access for people with the use of digital technology to provide a home-based virtual reality rehab programme.

How will we measure success?

- **Positive person and staff experience of working with commissioned voluntary sector as part of mental health pathway.**
- **Increase in access to voluntary sector referrals.**
- **Joint employment initiatives.**
- **Improved suicide awareness in partner services and communities.**
- **Reduction in suicides.**
- **Increase in the number of "pop ups".**

What will be different?

West Essex is committed to delivering a healthier future for its population through partnerships with health and care organisations, staff, the voluntary sector, and the population.

West Essex will make this approach to partnership across their communities and population "business as usual" and will offer unique skills and knowledge to help partners deliver better services. West Essex will engage with partnership approaches to ensure they are effective in improving the health and well-being of the local population.

West Essex will work with and through the communities to improve health access and outcomes for those experiencing health inequalities. The need to understand the experiences of the communities better and how they can develop services that are accessible and effective.

Building on learning from other systems, West Essex will engage with faith and cultural communities and work with community partners to engage with other 'hidden' communities. They envisage that their approach will include "pop-up" or "drop-in" services positioned within communities.

APPENDIX 1: POLICY CONTEXT

To ensure EPUT's strategy supports its partners' aims and ambitions, we have reviewed national policy for mental health and community services and the strategies of EPUT's partners across Essex, Southend and Thurrock, including the One Health and Care Partnership and Princess Alexandra Hospital's 2030 Strategy. Both national policy and partner strategies reflect similar themes about how health and care services need to change to meet the current and future needs of the population.

- Services will become **increasingly joined up** across health and care; primary and secondary healthcare; and mental and physical health.
- NHS services will **collaborate w**ith health, care and other services to support integration; this includes 'place' level alliances; neighbourhood partnerships; and provider collaboratives.
- **'Places'** will be the engine for delivery and reform of health and care services, bringing together health and care partners to deliver on a shared plan and outcomes.
- Better use and integration of **data** will support joined-up care and risk-based approaches to **population health management**.
- Providers will involve service users, communities and staff in **co-production** of services and development.
- Care will be **person-centred**, and take account of an individual's context, goals and respond to all of their needs.
- Joined up services will ensure that there is '**no wrong door**' to access care and support.
- A more **flexible workforce** will operate across service and organisational boundaries to provide joined up and person-centred care.
- Services will increasingly focus on **prevention and earlier intervention**, providing pre-emptive and proactive care that helps people be and stay well.
- People will be supported to **live well in their communities**: improved community support will reduce admissions and support people to when they are discharged from inpatient and long-term care.
- **Peer support workers** will provide informal support and care navigation for service users, and will support clinical services to understand and learn from user experience.
- Health services will work with partners to reduce **health inequalities** in the population.
- More services will be available online and using **digital applications.**

The **NHS Long Term Plan** makes the following commitments relevant to **Community Mental Health services**:

Category	Deliverable
Adult Common Mental Illnesses (IAPT)	IAPT-LTC service in place (maintaining current commitment) year-on-year (routine outcome monitoring)
Adult Severe Mental Illnesses (SMI) Community Care	370,000 people* receiving care in new models of integrated primary and community care for people with SMI, including dedicated provision for groups with specific needs (including care for people with eating disorders, mental health rehabilitation needs and a 'personality disorder' diagnosis)
Adult Severe Mental Illnesses (SMI) Community Care	Delivery of the Early Intervention in Psychosis standard
Adult Severe Mental Illnesses (SMI) Community Care	390,000 people* with SMI receiving physical health checks by 2023/24
Adult Severe Mental Illnesses (SMI) Community Care	55,000 people* with SMI accessing Individual Placement and Support services by 2023/24
Suicide Reduction	Deliver against multi-agency suicide prevention plans, working towards a national 10% reduction in suicides by 2020/21
Suicide Reduction	Localised suicide reduction programme rolled-out across all STPs/ICSs providing timely and appropriate support
Suicide Reduction	Suicide bereavement support services across all STPs/ICSs by 2023/24

**These are national targets, EPUT will be contributing towards the national targets*

The **NHS Long Term Plan** makes the following commitments relevant to **Community Health Services**:

- **A new NHS offer of urgent community response and recovery support**: People will receive services within two hours in a crisis and a two-day referral for reablement care. Access will be improved through a single point of access for people requiring urgent care in the community.
- **Guaranteed NHS support for people living in care homes**: Care homes will have timely access to out of hours support and end of life care, and support to have easier and secure access to patient information.
- **Supporting people to age well**: Primary care networks will bring together primary care, community teams, social care and the voluntary sector to help their local population to stay well, manage their health and live independently at home for longer. This includes better identification of older people with moderate frailty at particular risk of deterioration, and a proactive personalised care and support offer.

The West Essex **One Health and Care Partnership (OHCP)** vision is:

"To help everyone in our area live long and healthy lives by supporting independence and providing seamless care."

The OHCP goals are:

1. Help people live independent, healthy and longer lives
2. Tackle health inequalities
3. Improve mental health and life chances of people with mental health issues
4. Improve services and outcomes for health and care
5. Transform our resources together to achieve more for the community

OHCP has agreed an out-of-hospital model based five core elements as below:

The Princess Alexandra Hospital NHS Trust 2030 vision is to be **modern, integrated** and **outstanding**.

The vision is based on five priorities - transforming our care, our culture, digital

health, corporate transformation and our new hospital – and five core objectives: patients, people, performance, places and pounds. It is underpinned by PAHT's values: patient at heart, everyday excellence and creative collaboration.

The PAHT 2030 vision describes a significant shift of hospital care into the community, working in collaboration with primary and community providers, and providing more remote and digitally-enabled care.