Essex Partnership University
NHS Foundation Trust

MID AND SOUTH ESSEX JOINT COMMITTEE - PART 1 - IN PUBLIC

MID AND SOUTH ESSEX JOINT COMMITTEE - PART 1 - IN PUBLIC

28 November 2024

11:00 GMT Europe/London

Brentwood Community Hospital - Crescent Drive, Brentwood, Essex CM14 8DR - conference room

AGENDA

AGENDA

Robert Parkinson

MID AND SOUTH ESSEX COMMUNITY COLLABORATIVE JOINT COMMITTEE - PART 1
Thursday 28th November 2024 ? 11.00am ? 12.30pm
Brentwood Community Hospital, Crescent Drive, Brentwood, Essex ? Conference Room

REFERENCES

Only PDFs are attached

Agenda (Part 1) 28.11.2024.pdf

Mid and South Essex Community Collaborative

AGENDA

MID AND SOUTH ESSEX COMMUNITY COLLABORATIVE

JOINT COMMITTEE

Thursday 28th November 2024 – 11am – 12:20pm

Brentwood Community Hospital, Crescent Drive, Brentwood, Essex – Conference Room

No.	ITEM	LEAD	REQUIREMENT	PAPERS	TIME
Formalities and Administration					
1.	**Welcome and Introductions:**	Robert Parkinson, Chair	Information	Verbal	11:00
2.	**Declarations of Interest**	Robert Parkinson	Information	Attached	11:01
3.	**Minutes of meeting 26th September 2024**	Robert Parkinson	Decision	Attached	11:02
4.	**Action log following 26th September 2024**	Robert Parkinson	Information	Attached	11:03
5.	**Matters arising from previous minutes**	Robert Parkinson	Information	Verbal	11:04
Collaborative Update					
6.	**MSE Community Collaborative Update Report**	James Wilson	Information	Attached	11.05
7.	**Service User Case Study – Virtual Wards**	Sarah Little	Information	Presentation	11:10
Strategy & Transformation					
8.	**Strategic Priority Update: Reducing Demand on Acute Service Provision**	James Wilson	Information	Attached	11:25
10.	**Service User Priorities**	Lee Chester / Stephanie McNichol	Information	Attached	11:35
Assurance					
11.	**Accountability Framework**	Alex Green	Assurance	Attached	11:45
12.	**Risk Management**	James Wilson	Discussion	Attached	11:50
13.	**Exception reporting**	James Wilson	Information	Verbal	12:00
Finance					
14.	**MSE Community Collaborative Finance and Efficiency Update**	Trevor Smith	Assurance	Verbal	12:05
Questions from the Public					
15.		Robert Parkinson	Verbal		12.10
Any Other Business					
16.			Verbal		12:15
Meeting End					12:20

Future agenda items:
January 2025
Electronic Patient Record
Review MSECC Joint Committee Membership

Date of next meeting:
Thursday 30th January 2025 – EPUT, The Lodge, Lodge Approach, Wickford, Essex SS11 7XX - Training Room 1

Membership	
Robert Parkinson – Meeting Chair	Group Chair - Provide CIC
Luis Canto E Castro	Patient Representative
Dr Anna Davey	Deputy Medical Director for Engagement - MSEICB
Dan Doherty	Mid Essex Alliance Director - MSE ICS
Caroline Dollery	Non-Executive Director - NELFT
Simon Evans-Evans	Governance Director - NELFT
Alex Green	Executive Chief Operating Director - EPUT
Mark Harvey	Director of Adult Social Services – Southend City Council
Brid Johnson	Chief Operating Officer - NELFT
Milind Karele	Executive Medical Director - EPUT
John Lutchmiah	Patient Representative
Wellington Makala	Executive Chief Nurse - NELFT
Siobhan Morrison	Group Chief People Officer – Provide CIC
Robert Persey	Interim Executive Director for Adults and Health – Thurrock Council Council
Nick Presmeg	Director of Adult Social Services – Essex County Council
Philip Richards	Chief Finance Officer - Provide
Sheila Salmon	Chair – EPUT
Tania Sitch	Non-Executive Director
Michelle Stapleton	System Integrated Care Pathway Director - MSEFT
Trevor Smith	Executive Chief Finance Officer, EPUT
Eileen Taylor	Chair - NELFT
Lucy Wightman	CEO, Provide Health
James Wilson	Transformation Director - MSECC

1. WELCOME AND INTRODUCTIONS

Standing item | Robert Parkinson | 11.00am

Introductions:
Dr Judith Friedman
Executive Director of Allied Health Professions, Psychological Professions and Social Work

Robert Persey
Interim Executive Director for Adults and Health - Thurrock County Council

Observing:
Caroline Finch
Head of Allied Health Professionals- Adult Acute and Urgent Care Division
Occupational Therapist and Sensory Integration Practitioner
Hertfordshire Partnership University NHS Foundation Trust

Apologies are noted from:
Anna Davey
Dan Doherty
Mark Harvey
Wellington Makala
Sheila Salmon - Susan Lees deputising
Tania Sitch - Sultan Taylor deputising
Eileen Taylor
Lucy Wightman

2. DECLARATION OF INTEREST

Standing item | Robert Parkinson | 11.01am

REFERENCES

Only PDFs are attached

Declaration of Interest register MSECC Joint Committee November 2024.pdf

REGISTER OF POTENTIAL CONFLICT OF INTERESTS FOR THE MID AND SOUTH ESSEX COMMUNITY COLLABORATIVE - 2024/2025							
NAME	**POSITION**	**ORGANISATION**	**FINANCIAL INTERESTS**	**NON-FINANCIAL PROFESSIONAL INTERESTS**	**NON-FINANCIAL PERSONAL INTERESTS**	**INDIRECT INTERESTS**	**DATE SIGNED**
Allum Caroline	Chief Medical Officer	North East London Foundation Trust (NELFT)	Employee of NELFT Consultant Radiologist - Royal Free London NHSFT				10.01.2024
Castro Luis Canto E	Lived Experience Leader	Essex Partnership University Trust (EPUT), North East London Foundation Trust (NELFT) and Provide Community Interest Company (CIC)	Mildon Ltd - Consultant As an EDI Consultancy, we have been doing work with NHSE, NELFT and there are possibilities of other Trusts acquiring our services should they so choose				06.06.2024
Davey Anna Dr	General Practitioner	Mid and South Essex Integrated Care Board (MSEICB)	GP Partner - The Coggeshall Surgery GP Partner - Colne Valley Primary Care Network	Primary Care Partner, Member on the MSEICB Member of the GP Provider Collaborative for MSE	None	None	25.07.2024
Doherty Dan	Alliance Director, Mid Essex	Mid and South Essex Integrated Care Board (MSEICB)	Employee of MSEICB	Non Executive Board Member - Active Essex		Spouse is a Community Physiotherapist at North East London Foundation Trust (NELFT)	04.07.2024
Dollery Caroline Dr.	Primary Care Non-Executive Director	North East London Foundation Trust (NELFT)	GP Partner - Beacon Health Group Clinical Director - Aegros PCN	Trustee - Open Road Charity - Chair their Clinical Governance Committee and sit on Board Trustee - Kids Inspire - Safeguarding lead and sit on Board Trustee - Rural Communities of Essex, on Board and sit on Finance Committee			08.04.2024
Green Alex	Executive Chief Operating Officer	Essex Partnership University Trust (EPUT)	Employee of EPUT	None	None	None	04.07.2024
Harvey Mark							
Johnson Brid	Chief Operating Officer	North East London Foundation Trust (NELFT)				Partner is a Non-Executive Director at Mid and South Essex Integrated Care Board (MSEICB)	03.06.2024
Karele Milind Dr	Executive Medical Director	Essex Partnership University Trust (EPUT)	Employee of EPUT	None	None	None	24.07.2024
Lutchmiah John	Lived Experience Leader	Essex Partnership University Trust (EPUT), North East London Foundation Trust (NELFT) and Provide Community Interest Company (CIC)	Patient Board member - NELFT	None	None	None	25.07.2024
Makala Wellington	Executive Chief Nursing Officer/Executive Director AHP & Psychological Professions	North East London Foundation Trust (NELFT)	Adhoc Consultant work				12.01.2024
Morrison Siobhan	Group Chief People Officer	Provide Community Interest Company (Provide CIC)	Employee of Provide CIC Director - React Homecare Limited Director - Provide Care Solutions Ltd				05.07.2024
Parkinson Robert	Group Chair	Provide Community Interest Company (Provide CIC)		Foundation Governor - St John's School, Horsham			04.07.2024
Persey Robert	Interim Executive Director for Adults and Health	Thurrock County Council					
Presmeg Nick							
Richards Philip	Chief Finance Officer	Provide Community Interest Company (Provide CIC)	Employee of Provide CIC Director - Albion Outlook Ltd Director - Provide Wellbeing Ltd Director - Brantree Healthcare Ltd Director - Provide Digital Ltd Director - Provide Group Ltd Director - Provide Care Solutions Ltd Director - Provide Property Ltd Director - React Homecare Ltd				25.06.2024
Salmon Sheila	Chair	Essex Partnership University Trust (EPUT)	Chair - Essex Partnership University Trust	Emeritus Professor of Health Development - Anglia Ruskin University		My son was appointed through open external competition to an 8d role in People and Culture Directorate.	06.11.2024
Sitch Tania	Non-Executive Director	Provide Community Interest Company (Provide CIC)	Employee of Provide CIC Director - React Director - Provide Care Solutions	Trustee - Thurrock Community and Voluntary Services (CVS)			30.05.2024
Stapleton Michelle	System Integrated Care Pathway Director	Mid and south essex Foundation Trust	NIL	NIL	NIL	NIL	20.11.2024
Taylor Eileen	Chair	North East London Foundation Trust (NELFT)	Chair - East London Foundation Trust (ELFT) Non-Executive Director & Senior Independent Director - MUFG Securities EMEA Plc Chair - North East London ICS Mental Health Learning Disability and Autism Committee				05.06.2024
Wightman Lucy	CEO Provide Health & Group Chief Nurse	Provide Community Interest Company (Provide CIC)	Employee of Provide CIC	Honarary Professorship - University of Essex Member - Health Council at Reform (Health Think Tank) Fellow - Faculty of Public Health Member - UK Public Health Register (UKPHR) Member - Nursing and Midwifery Council (NMC) Member - Royal College of Nursing (RCN)			03.09.2024
Wilson James	Director of Transformation	Hosted by Essex Partnership University Trust (EPUT) on behalf of our Mid and South Essex Community Collaborative	Employee of EPUT	Trustee - Hamelin Trust	Wife is a finance business partner at Essex County Council	Brother is a partner at PWC Consultancy	06.06.2024

3. MINUTES OF MEETING 26TH SEPTEMBER 2024

Standing item | Robert Parkinson | 11.02am

REFERENCES

Only PDFs are attached

MSECC Joint Committee 26.09.24 - Minutes v1 PART I appr TS RP JW.pdf

Mid and South Essex Community Collaborative

DRAFT MINUTES

MSE COMMUNITY COLLABORATIVE BOARD

PART I – IN PUBLIC

26th September 2024 – 11am-12.30pm

EPUT, The Lodge, Wickford SS11 7XX – Training Room 1

Members present:	
Luis Canto E Castro (LCEC)	Lived Experience Leader
Dr Anna Davey (AD)	Deputy Medical Director for Engagement - MSEICB
Dan Doherty (DD)	Mid Essex Alliance Director - MSE ICS
Caroline Dollery (CD)	Non-Executive Director - NELFT
Alex Green (AG)	Executive Chief Operating Director - EPUT
Brid Johnson (BJ)	Chief Operating Officer - NELFT
John Lutchmiah (JL)	Lived Experience Leader
Wellington Makala (WM)	Executive Chief Nursing Officer - NELFT
Siobhan Morrison (SM)	Group Chief People Officer – Provide CIC
Philip Richards (PR)	Chief Finance Officer – Provide CIC
Tania Sitch (TS) – Meeting Chair	Non-Executive Director – Provide CIC
Michelle Stapleton (MS)	System Integrated Care Pathway Director - MSEFT
Lucy Wightman (LW)	CEO, Provide Health
James Wilson (JW)	Transformation Director – MSECC
In Attendance:	
Clare Burns (CB)	Interim Executive Director of Partnerships - NELFT
Chris Jennings (CJ)	Assistant Trust Secretary - EPUT
Moira McGrath (MM)	Director Adult Social Care, Essex County Council
Invited Guests:	
Jody Hardy	Southend SEND Independent Forum
Philomena Johnson	Chair, Southend SEND Independent Forum
Kate Taft-Ringer	Quadrant lead South Essex, Essex Family Forum
Hannah van der Puije	Assistant Director of Children's Services, EPUT
Michael Smith	Head of Children's Services, NELFT
Ellie Williams	Project Manager, MSECC
Jo Debenham	Associate Director, Engagement & Workforce, MSECC
Apologies:	
Eileen Taylor (ET)	Chair - NELFT
Mark Harvey (MH)	Executive Director of Adult Social Services – Southend City Council
Milind Karele (MK)	Executive Medical Director - EPUT
Robert Parkinson (RP)	Group Chair - Provide CIC

Nick Presmeg (NP)	Executive Director of Adult Social Services – Essex County Council
Sheila Salmon (SS)	Chair – EPUT
Ian Wake (IW)	Director of Adult Social Services – Thurrock Council
Minutes:	
Claire McPherson (CM)	MSECC Joint Committee administration support

NO.	ITEM	ACTIONS
Formalities and Administration		
1.	**Welcome, Introduction and Apologies** In Robert Parkinson's absence, Tania Sitch (TS) chaired today's meeting. TS welcomed all and introductions were made. Moira McGrath was in attendance on behalf of Nick Presmeg. Alex Green joined the meeting remotely via Microsoft Teams. Anna Davey joined the meeting at 11:09.	
2.	**Declarations of Interest** No conflicts raised in relation to today's agenda.	
3.	**Minutes of meeting 25th July 2024** The minutes of the previous meeting, held on 25th July 2024 were accepted and agreed as an accurate recording of the meeting.	
4.	**Action Log following 25th July 2024** There was one open action on the action log updated as follows: Action 95 - Risk Review – SEE to work with CCLT to refresh this in the context of the new contract and bring back to board. Governance lead has now left NELFT. Chris Jennings has been helping to work through this to bring oversight of risk together across the 3 organisations. Chris updated that there are regular meetings in diaries to look at individual risk policies to find similarities. Work in progress. A joint risk register to be presented at November Meeting.	
5.	**Matters arising from previous minutes** None.	
Collaborative Update		
6.	**MSE Community Collaborative Update Report** JW highlighted the following from the update report within the agenda. The report was taken as read: • Work continues on optimising Length of Stay in our Stroke and Intermediate care beds. • The Collaborative team have been working with the ICB to review the outcomes from the Consultation on the Community and Stroke beds however there is a 6-month delay on the final decision. • Virtual Wards continue to be well occupied with ongoing work supported by Sue Graham. There has been a regional audit looking at outcomes delivered across our Virtual Wards - We benchmarked highest in region on level of acuity. We are shortly to have a Getting it Right First Time (GIRFT) review. • A single policy for RealWear headsets has been taken through our Joint Clinical Oversight Group (JCOG) for a consistent policy approach. RealWear is a piece of kit that will enable staff at base to connect with front line staff.	

	• With regards to workforce, the Organisational Development (OD) programme, for Partnership Directors and the next leadership level has been positively received, shortly to come to an end. Our Collaborative Executive Team (CCET) will receive a presentation from the collective group in due course. • We have recently welcomed Sharon Hall into our Collaborative as Interim Deputy Director of Children & Young People's Services and have said goodbye to Sarah Barnes, Director of Children & Young People. We thank Sarah for all her work. <u>Questions and comments :</u> • Lucy Wightman (LW) commented that we are not good at celebrating those things we do well and should work with our acute colleagues to see what other pathways may benefit from the Virtual Ward model. James Wilson (JW) responded that as funding is limited, our initial focus is around optimising the existing virtual wards. Unfortunately additional funding wasn't available for Cardiovascular Disease. There will be opportunities to cover more specialties from a wider virtual ward and given the wider context of acute pressures we know we need to support more at home. • After further conversation around communicating good news, case studies are published on LinkedIn, it was agreed that there is a continual challenge on the ground of awareness around community services in general, including Virtual Wards. This included gaining feedback from Primary Care and possibly getting a message out via clinical cabinet. JW agreed to take this forward as an action and consider what we can do further. **ACTION: JW to link with Anna Davey (AD) and Caroline Dollery (CD) to consider further/wider communication of good news stories. All colleagues to share ideas and opportunities to promote good news stories from the Collaborative.** • John Lutchmiah (JL) made the request for case studies/data/examples that can be shared to report on what our Collaborative is doing to patient groups, to show how he can best describe what we have improved. JW agreed to share case studies to assist. **ACTION: JW to share with JL examples of work the Collaborative are doing to improve services for service users.** • Clare Burns (CB) made the comment that in other collaboratives, the outcome of their board/joint committee meetings is a briefing that goes out to all stakeholders. This was agreed. **ACTION: JW to consider a briefing to ensure that the output of this meeting is circulated to all our stakeholders.** • Alex Green (AG) noted that it is community services week commencing 16th October 2024 and that region are calling for case studies to be published. Moira McGrath (MM) joined the meeting at 11:20.	**JW** **JW** **JW**
7.	**Service User Case Study – My Care Bridge** Presented by: Michael Smith, Head of Children's Services, NELFT Hannah van der Puije, Assistant Director of Children's Services, EPUT Kate Taft-Ringer, Quadrant Lead South Essex, Essex Family forum Philomena Johnson, Chair, Southend SEND Independent Forum Jody Hardy, Southend SEND Independent Forum	

	Michael Smith made introductions and gave background to My Care Bridge – that it is a product of collaboration across the 3 partner organisations and delivers on many elements: Reduces variation, improves families experience and offers the opportunity for further transformation and improvements going forwards. MS talked through the slide deck, describing that it is truly a collaborative piece of work and it brings clarity to parents as to where they are in the system. My Care Bridge launched at the end of August 2024 and as at last week, 226 referrals had been received. 250 schools are on board. Since its lunch we (project team) have had daily huddles with clinicians and administrators to identify any issues. The My Care Bridge presentation can be found at the end of the minutes. Colleagues with Michael fed back the positive difference the new process is making, in terms of reassurance, accessibility and an improved experience. Questions: • AD asked from a GP perspective – if a parent comes to GP advising that the teacher has concerns around ADHD, can the GP make the referral and with regards to Right to Choose, does that happen automatically via the Portal (My Care Bridge)? Michael responded that schools will now take the lead and make the referral, the GP would only make a referral if they were the first to notice any concerns. MS explained the service are wanting the school to take central role. With regards to Right to Choose MS advised that it doesn't happen automatically at the moment but are looking in the future for My Care Bridge to support Right to Choose. After further comments on this, Lucy Wightman (LW) agreed to pick this up with AD outside of the meeting. **ACTION: LW to follow up with Anna Davey on MyCareBridge and whether this could/should be used for Provide Wellbeing waiters as well.** Further conversation took place around the potential for extending this to adults and historical families already with a diagnosis in the system. All agreed that this was a fantastic solution and acknowledged the power of co-production, something that started as a thought and was now fully operational. Michael and colleagues attending for this item were thanked for their time today and left the meeting at 11:50am.	**LW**
Strategy & Transformation		
8.	**Productivity and Efficiency Deep Dive: Accelerating Delivery of the MSECC Target Operating Model** Presented by JW. The slides in the meeting pack were taken as read. There are 3 additional focus areas agreed in addition to the 24/25 Delivery Plan to deliver efficiency and productivity: • Implement consistent cost controls - Ensuring we have comparable cost control across the 3 providers; • Accelerate delivery of Target Operating Model (TOM) - How to accelerate delivery of what we are doing as a Community Collaborative, looking at how to prioritise where it makes sense to do things once.	

	• Accelerate single operating structure - Supporting a structure that enable us to deliver with opportunities to centre on outcomes of services working together. Question and comments: • Michelle Stapleton (MS) commented that when looking at integrated models you have a provider that can support – Acute. Digital and a single SystmOne unit; we are having joint Electronic Patient Record (EPR) in future and the opportunity around the Nova programme between EPUT and the acute. • JW said the opportunity to do pathways with the acute is strong and Virtual Ward work is already happening. There is an opportunity to do things differently to get consistency, such as admission avoidance and in the intermediate and stroke discharge space. With regards to the digital work, the opportunity for all 3 community providers to all use SystmOne consistently will make our workforce life easy, a common interface and the timelines for this are being worked through. A conversation took place around the amount of work required to bring alignment across the 3 community providers versus partnership working. MyCareTech, due to be recommissioned in 2027 was discussed and the need to identify areas where this may add value (test and learn opportunities). Additionally, putting in equipment post and initial assessment.	
Assurance		
9.	**Accountability Framework & Exception Reporting** Presented by JW. The paper in the meeting pack were taken as read and is to provide the Joint Committee with assurance. AG highlighted the following: • Our biggest risk is the slow progress made on the joint risk register. Have had resourcing issue. This has now been picked up and the Joint Committee will receive an aggregated risk register at November's meeting. • Struggled with Quality & Safety, there is a plan to take that this forwards and leads met on 20/09/24. • Risk around mandatory training with the ICB wanting a 95% target implemented, however we have expressed our concerns. • Community Paediatric waits remain long. • The Joint Committee are asked to note that the finance lead responsibility has shifted from Provide to EPUT. • The Mid and South Essex Community Collaborative (MSECC) Accountability Framework meeting going forwards from October will merge with the existing EPUT Accountability Framework in the interest of leadership productivity and reducing duplication. Questions and comments: In North East London Community Collaborative, Brid Johnson (BJ) commented that they have the same issue around Community Paediatric waits, and is there an opportunity to look at skill mixing collectively. BJ took action to make connections but to link in with LW first. **ACTION. BJ to look at broader connections around**	**BJ**

	Community Paediatric waits in North East London Community Collaborative and to link with LW. AG flagged we have been attending the regional CEO King's Network and there is likely to be more focus on community waits and that may give us a platform to look at alternatives.	
Finance		
10.	**MSECC Collaborative Finance Report** Presented by Philip Richards (PR). The paper in the meeting pack was taken as read. • The paper gives context to the sheer scale of the financial challenge we are facing. • PR reinforced e have dropped the extra funding for the Lighthouse Service, Paediatric waits and Podiatric surgery, however with no extra funding it will will impact with community waiting times. • PR noted that Provide has a different failure regime to NHS trusts and can't absorb the deficit. Questions and comments: A discussion took place that we are talking about things/services that we may stop and it would be useful to ask our service users. Public health, what are the things least impact and what are most effective. There needs to be joint prioritisation with our partners. Also discussed the importance of being clear that the voice of our service users must be heard and there needs to be transparency what we are doing and to remind ourselves of the impact on them. Clare Burns (CB) advised that NELFT Board have stated their position that they will not meet their control total and will not be putting financial delivery ahead of patients and quality. The focus is on delivering value and this may mean the finances are not achieved to maintain or improve the service offer. Phlip Richards noted that Provide are required to deliver a balanced financial position and this is potentially in conflict with the NELFT position. It was agreed to explore together how we best deliver value for our residents, whilst balancing the financial constraints we are operating in. BJ suggested we consider the Service User Priorities again to ensure any decisions around service changes are taking these into account. MS advised to look at the Unbundled tariff to review if any services were being provided that were not commissioned and this was discussed along with the ICB service restriction policy.	
Questions from the Public		
11.	No members of the public were present at today's meeting.	
12.	**Any other business** Agreed to bring back an item on Service User Priorities to next meeting, led by Jo Debenham. **ACTION: Service User Priorities to be added as an agenda item to November's meeting, led by Jo Debenham.** LW mentioned membership of this meeting and to invite Public Health to a future meeting to talk to us as they can help with prevention, public engagement and	**JW**

	funding. Agreed. **ACTION: LW to arrange for Public Health to be invited to a future meeting.** Jo Debenham, Associate Director Engagement & Workforce for the MSECC and Ellie Williams, Project Manager for the MSECC, who were observing today's meeting left at 12.25pm. **The meeting closed at 12.25pm and reconvened for Part II in private at 12.30pm.**	**LW**
Date of next meeting: Thursday 28th November 2024, 11am-1pm, Venue to be confirmed		

Signed ……. **Date……**
Tania Sitch, Chair

4. ACTION LOG FOLLOWING 26TH SEPTEMBER 2024

Standing item | Robert Parkinson | 11.03am

REFERENCES

Only PDFs are attached

Action Log - MSECC Joint Commiee Action Log updated AHEAD of mtg on 28.11.24.pdf

Mid and South Essex Community Collaborative Joint Committee
Open Actions

Action Number	Board Date	Agenda Item	Action	Owner	Due date for completion	Open/Closed	Comments
95	20.03.2024	Risk Review	SEE to work with CCLT to refresh this in the context of the new contract and bring back to board.	~~Simon Evans-Evans~~ Chris Jennings	~~04.06.2024~~ ~~25.07.2024~~ ~~26.09.2024~~ 28.11.2024	OPEN	To come to July Board. 25.07.2024 - SE-E updated that pulling together risks from the 3 partner organisations is taking loger than expected and gave assurance that this will be completed and presented to the next Joint Committee meeting in September 2024. 26.09.2024 - Governance lead has now left NELFT, update on the agenda regarding risk. Chris Jennings has been helping to work through this to bring oversight of risk together across the 3 organisations. Chris updated that there are regular meetings in diaries to look at individual risk policies to find similarities. Work in progress. A joint risk register to be presented at November Meeting.
105	26.09.2024	MSECC Update Report	Sharing of good news stories - JW to link with Anna Davey (AD) and Caroline Dollery (CD) to consider further/wider communication of good news stories. All colleagues to share ideas and opportunities to promote good news stories from the Collaborative.	James Wilson	28.11.24	CLOSED	UPDATE: Meeting held and CC comms plan shared.
106	26.09.2024	MSECC Update Report	JW to share with John Lutchmiah (JL) examples of work the Collaborative are doing to improve services for service users.	James Wilson	28.11.24	CLOSED	UPDATE: Complete. Close action.
107	26.09.2024	MSECC Update Report	JW to consider a briefing to ensure that the output of this meeting is circulated to all our stakeholders.	James Wilson	28.11.24	CLOSED	UPDATE: AAA summary report is shared to organisation governance leads for onwards distribution along with JC members and CCET members.
108	26.09.2024	Service User Case Study - MyCareBridge	LW to follow up with Anna Davey on MyCareBridge and whether this could/should be used for Provide Wellbeing waiters as well.	Lucy Wightman	28.11.24	CLOSED	Provide Wellbeing are planning to use the MyCareBridge portal and are in discussion. Anna also noted that she is hugely concerned around the ASD/ADHD pathway and noted that she is raising it with Tom Abell and has requested a summit to discuss.
109	26.09.2024	Accountability Framework & Exception Reporting	Brid Johnson (BJ) to look at broader connections around Community Paediatric waits in North East London Community Collaborative and to link with LW.	Brid Johnson	28.11.24	OPEN	Keep open. UPDATE: Brid has connected Sharon Hall with colleagues in North East London to arrange a discussion.
110	26.09.2024	Any Other Business	Service User Priorities to be added as an agenda item to November's meeting, led by Jo Debenham.	James Wilson	28.11.24	CLOSED	On agenda for 28.11.24. Close action.
111	26.09.2024	Any Other Business	LW to arrange for Public Health to be invited to a future meeting.	Lucy Wightman	28.11.24	OPEN	UPDATE: LW has reached out to the three DPH. Agreed to have 1 PH rep attend, with annual rotation between the 3 LA's. In progress with date to be agreed.
112	26.09.2024	Community Beds Consultation - DMBC	DD to feed back that the communication around the beds consultation to staff is not clear.	Dan Doherty	28.11.24	CLOSED	Feedback has been given to the project group.
113	26.09.2024	Community Beds Consultation - DMBC	DD to feed back about around risk to patient safety at St Peter's for Podiatry service.	Dan Doherty	28.11.24	CLOSED	Feedback has been given to the project group.
114	26.09.2024	Productivity and Efficiency	JW to update on Productivity and Efficiency at November's JC meeting.	James Wilson	28.11.24	CLOSED	On agenda for 28.11.24. Close action.

5. MATTERS ARISING FROM PREVIOUS MINUTES

Standing item | Robert Parkinson | 11.04am

6. MSE COMMUNITY COLLABORATIVE UPDATE REPORT

Standing item | James Wilson | 11.05am

REFERENCES

Only PDFs are attached

Collaborative Update Report 28.11.2024.pdf

Mid and South Essex Community Collaborative (MSECC)

Joint Committee

Meeting	Mid and South Essex Community Collaborative Joint Committee
Subject	Collaborative Update report
Date of Meeting	28th November 2024
Author	James Wilson, Lead Director, MSECC
Approved by Responsible Lead	James Wilson, Lead Director, MSECC

For Decision	For Assurance	For Information
☐	☐	☒

Purpose

To give an overview of progress, key strategic areas for the board to be aware of and key highlights to set the context for the proceeding board items.

The Joint Committee is asked to:

The Joint Committee is asked to note the contents of the report.

Forums where content has been previously discussed

MSE Community Collaborative Executive Team ☒
MSE Community Collaborative Strategy & Transformation ☒
MSE Community Collaborative Core Leadership Team ☒
MSE Community Collaborative Joint Clinical Oversight Group ☒
MSE Community Collaborative Finance Workstream ☒
Other ☐ Please specify:

Link to MSECC Strategic Priorities

Strategic Priority/ Contractual priority	**IMPROVE** *(Work together to optimise and drive consistent delivery of community services, reducing inequalities)*	**INTEGRATE** *(With wider partners, facilitate community physical and mental health services integration with developing neighbourhood models at place)*	**INNOVATE** *(Take a lead role within the system to develop and deliver innovative models of care and use of technology)*
Creating an integrated delivery environment and culture	☒	☒	☒
Building healthier and resilient communities	☒	☒	☒
Supporting more people at home (directly impacting on capacity required in acute sector)	☒	☒	☒
Productivity and cost improvement	☒	☒	☒

Are there any risks in the report that need to be noted, escalated on the risk register or added to the Board Assurance Framework?

None

Glossary for acronyms in report (if any)

MSE Joint Committee: Overview Nov 2024

The autumn period has seen a continued focus on how the Collaborative responds to the financial challenge of the new contracting envelope and the wider system pressure. Following the support at the last Joint Committee to progress the planned response of accelerating our Target Operating Model and structural response to meet the efficiency requirements, work has commenced. At its heart this work is about how we 'deliver value' by working better together and maximising our Target Operating Model. We have been working through the implications of this for each organisation to test understanding and alignment. This work is ongoing and this will be discussed further under the Finance and Efficiency item.

We have welcomed the recent Darzi report with clear recommendations for the much needed shift of focus and resources towards community and primary care. This has been further reinforced by the ICB's 2025/26 Commissioning Intentions announcing a clear commitment to progress this locally. We discuss our response to this further on the agenda.

Leadership and Delivery

We continue to support the system financial recovery. Progress is being made in our delivery against the trajectories for improved length of stay in our Stroke and Intermediate care beds. Our virtual wards have now completed their national GIRFT (Getting it Right First Time) review which has highlighted some areas to improve to ensure we are meeting the national definitions for virtual wards.

Since its launch in August our teams have been focusing on making continuous improvements to the MyCareBridge portal and communicating and engaging with users to increase uptake and promote the benefits of using this new system. Specifically we have been attending GP, clinical and PCN practice manager meetings across mid and south Essex and have set up webinars and a user guide for educational settings as part of the ongoing engagement.

We continue to be challenged however on long waits for our Paediatric provision. As of 13th November, Mid and South Essex Community Collaborative (MSECC) is reporting 41 people are waiting 65 weeks or more for community services. These are all in SWE Community Paediatric services. An improvement plan and recovery trajectory is being developed supported by the ICB in relation to this and a joint summit is being planned between the primary care collaborative and MSECC to work on joint solutions across primary and community care.

During this period we have seen a renewed focus on the Integrated Neighbourhood model development and the MSECC is taking stock of how we collectively can support the overarching priority areas set by the ICB, including supporting Frailty. As a result we have invested in project management support to improve the uptake and use of the FrEDA (Frailty, End of Life and Dementia Assessment tool) and Frailty training across our community services.

It has been great to see how our UCRT Quality Improvement Staff and Service Improvement Programme has been developing over the last few months. This is using a QI approach to collectively identify areas of improvement for staff experience. Three geographically focussed away days will culminate in a joint collaborative away day early next year. We would like to

thank the NELFT Quality Improvement Team and in particular Kelly Anderson – Advanced Quality Improvement Practitioner, for leading this work.

I am pleased to note that with a presentation at the NHS Providers national conference, MSECC concluded their participation in the national 'Provider collaboratives: Improving equitably' programme, delivered in partnership by NHS Providers and the Q community, with support from the Health Foundation and NHS England. This work explored how community services can contribute to improving outcomes for CVD and will continue over the next 3 years. This provided extra focus for our CVD programme. The programme continues to progress and has completed the development of our MSECC Community Blood Pressure guidance and hypertension training. This includes attention to the risk of falls in people with Frailty as a result of hypotension. We have now also successfully recruited two lived experience ambassadors, who will support our CVD programme development and implementation.

People, Engagement and Communications

Our Organisational Development Programme continues for our Partnership Director and Assistant Director levels and will close with a combined event on Tuesday 3rd December. This event will bring together the learning from each OD programme and feed into plans for our next phase of cultural development and leadership programmes and spaces for 25/26.

We had a very well attended and energised Leadership Forum in September with a focus on our accelerated Target Operating Model. This focus will continued at our November meeting alongside presentations on the MSE Stewardship Programme interface with the collaborative and an update on our Cardiovascular Disease Programme.

Our Chief People Officers continue to collaborate and there is support from the group to develop a workforce model that will enable the acceleration of integration and will accompany our well-established Memorandum of Understanding (MOU) and License to Attend. We will update the joint committee as this develops.

It has been great to hear reported in our People workstream how our shared Collaborative Bank is progressing. This has now been live for over 6 months. This work contributes to an overall system commitment to reduce reliance on agency staff. Bank staff using this agreement and working cross-organisationally are reporting good experiences.

Patient Leadership

Our Patient Leadership work has continued with some positive engagement opportunities being explored out in our communities, bringing our collaborative along to existing community spaces and engagement groups. A report giving more detail on this area is included in the agenda. Our patient participation lead presented her work on the NELFT All Staff Briefing and is set to mirror that across the other two partners and we represented the collaborative at EPUT's Coproduction Conference at Saxon Hall on Thursday 10th October.

Health Inequalities

We are pleased to congratulate Jo Debenham on achieving Core20PLUS Ambassador Status with a graduation in September based on commitment to tackling health inequalities and

advancing the national Core20PLUS Agenda. We note other collaborative leaders are enrolled onto cohort 3 to continue this work.

As reported last month we are nearing a system wide stakeholder event for the Equality Delivery System Domain 1 Patient Access element. On Wednesday 4th December 2024 at Barleylands, system wide stakeholders, service leads and service users will rate accessibility of our Diabetes and Heart Failure Services leading to some areas of improvement in accessibility for equality groups in 2025.

And finally it was great to share events across our collaborative for Black History Month in October/November and see staff from across the partners in attendance.

7. SERVICE USER CASE STUDY - VIRTUAL WARDS

Information Item | Sarah Little | 11.10am

REFERENCES

Only PDFs are attached

Service user Case Study - Virtual Wards.pdf

Mid and South Essex Community Collaborative

Mid and South Essex Community Collaborative Joint Committee

Frailty Virtual Wards 28.11.24

1. Introduction

1.4 Virtual Wards

Effective governance and leadership:
Clear lines of clinical responsibility, consultant physician/ consultant practitioner/GP oversight for all patients.

Operating hours:
VWs should be staffed for **8am-8pm, 7 days a week,** with locally arranged provision for out of hours and access to speciality advice.

Admission criteria:
A **senior clinical decision-maker** should assess patients for admission. This may include **CGA, NEWS2, CFS, 4AT** and **holistic needs**.

Personalised care:
Patients and carers are given the information they need **for informed consent. Personalised interventions** and **advance care planning** should take place.

Daily board rounds:
Daily board rounds must be overseen by a **senior clinical decision-maker**, include medical input, and be supported by a **dedicated MDT.**

Diagnostics:
Patients should have access to the **same tests and urgent diagnostics as they would in hospital** (e.g. blood tests, CT scans, X-ray, MRI).

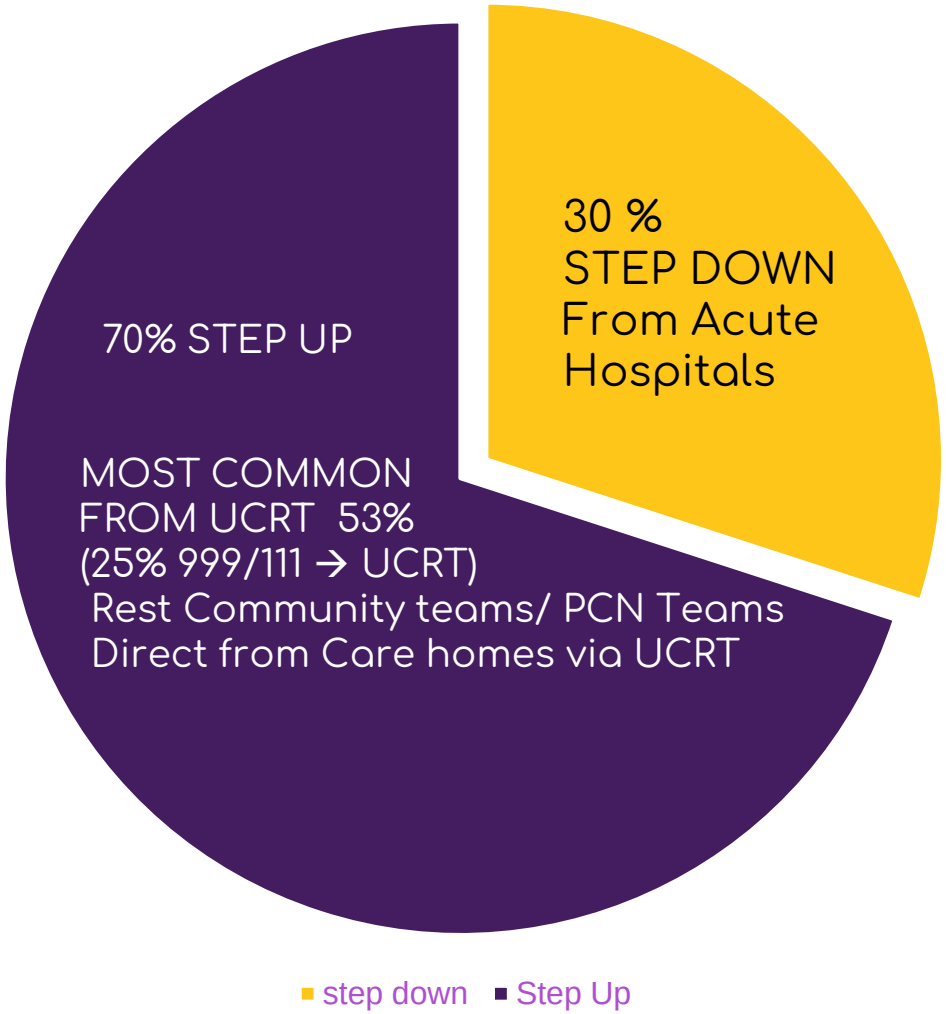
Interventions:
VWs should **offer in-person visits** in conjunction with care management/ monitoring. **Hospital-level interventions are provided.**

Technology-enabled care:
VWs should use **technology-enabling monitoring,** where appropriate. **EPR configuration** should be in place.

Pharmacy and optimisation:
VWs should have **equitable access to pharmacy**, and there should be **dedicated pharmacy professionals involved in daily board rounds** and MDT meetings when required.

Discharge:
VWs should deliver **time-limited interventions**. Estimated **discharge dates should be agreed on admission** and patients **discussed daily**.

Frailty Virtual Ward- circa 5000 patients



MOST COMMON PRESENTATIONS

- Falls (including post "long lie"),
- Delirium
- Acute infections (Chest, Skin, Urine, GI)

- Medication induced/polypharmacy causing acute illness presentations/frailty syndromes (delirium/falls, U+E abnormalities hyponatraemia.. etc)

- LTC exacerbations/progression- e.g. heart failure, COPD, AKI

- Many (> 60%) with more severe frailty/ other severe multimorbidity who also have earlier or later stage previous unmet palliative/EOLC needs at risk of crisis

What has the acuity been?
CLCH Acuity tool snapshot analysis of MSE FVW patients:

Mid and South Essex Community Collaborative

CLCH Frailty Virtual Ward/Hospital at Home Acuity, dependency and service capacity tool

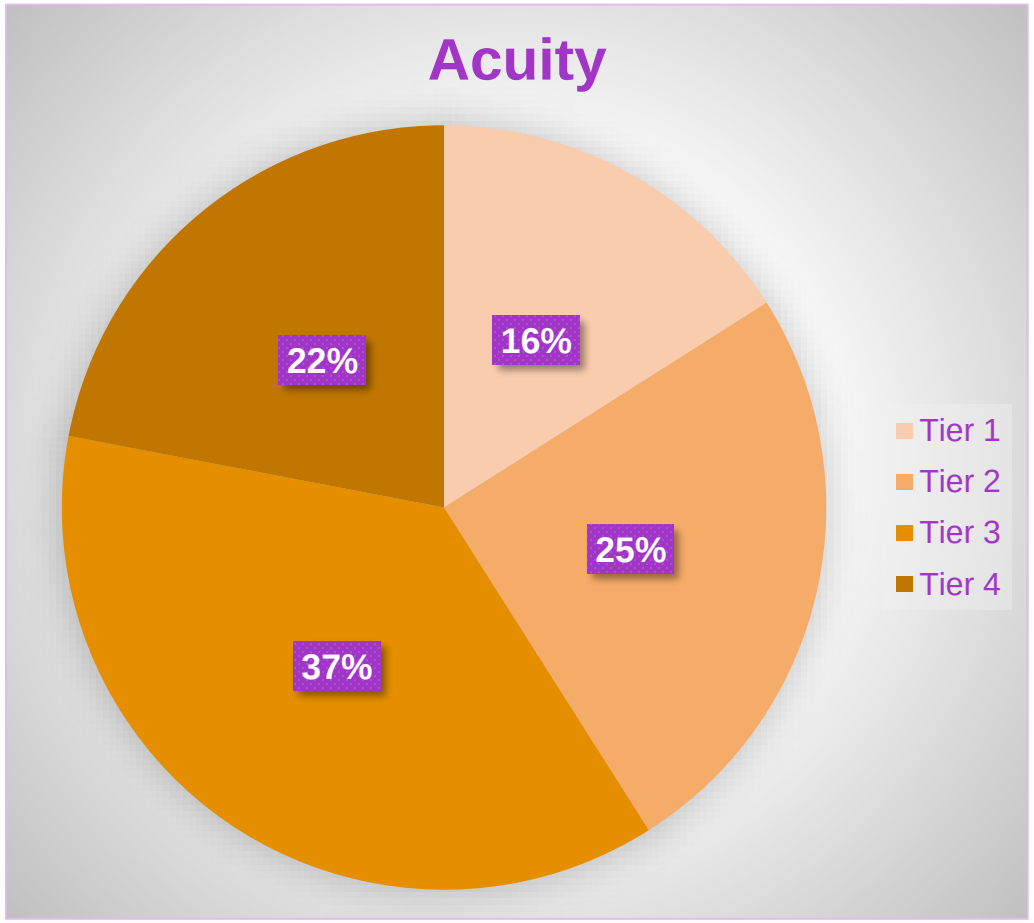
NHS Central London Community Healthcare NHS Trust

Purpose: The purpose of this tool is to demonstrate the clinical staffing skillset and capacity required to safely manage patients entering or open to Frailty Virtual Wards/ Hospital at Home pathways.
This tool will give an overview of the level of a patients needs that day by consideration across 5 domains;
1. Clinical complexity
2. Clinical Acuity NEWS2 score and clinical trajectory
3. Social complexity Clinical Frailty Score (shift from pre illness to current) and level of unmet social support
4 Intervention intensity frequency and duration of in person visits and care planning (i.e. liaison with other professionals and family, completing onward referrals. prescriptions)
5 Workforce requirement Skill level required to support needs and frequency of MDM/ward round
This tool links builds upon the Guys and St Thomas's Acuity and Dependency Tool (2021) Baker, E., Loreto Facultad, J., Slade, H., & Lee, G. (2021). A new tool to measure acuity in the community: a case study. *British Journal of Community Nursing*, 26(10), 482-492. https://doi.org/10.12968/bjcn.2021.26.10.482

Scoring: Patients are allocated of a caseload tier from 1 – 4 each day, determined by an MDT discussion.
Tier 1 is low acuity and complexity and would meet the minimum criteria to enter or remain on a VW caseload, Tier 4 reflects the highest level of acuity that can be safely managed on a VW. The tier is determined across each of the domains, the overall tier is set as the highest tier, for example if a patient need is a mixture of tier 2 and tier 3 across the domains – their overall Tier is 3

Outcome: The proportion of tiers across the caseload will allow services to provide context to the level of support needed by patients are currently on the caseload and determine available service capacity and capability for patients being referred into the service.

Clinical Complexity	Clinical Acuity	Social Complexity	Intervention Intensity	Workforce Requirement	Tier
One area for clinical focus (e.g. UTI, resolving HF exacerbation, resolving delirium)	Stable, improving trajectory Low acuity, NEWS2 0-2	CFS ≤7 and **current CFS level is unchanged** from that 2 weeks prior to acute illness Home environment and social needs met and not impacting on clinical delivery	Once a day routine in person visit (e.g Respiratory Physio), in person diagnostics (e.g bloods, ECG) **or** a virtual review **or** up to 1 hour of care planning required that day	Uni professional in person or virtual reviews SCDM reviews once a day via ward round or MDM discussion	Tier 1
Two areas for clinical focus (e.g, Unmanaged HF & COPD) **or** one area of clinical focus with a high risk comorbidity (e.g. LRTI and Immunocompromise) **or** acute deterioration with established cause and treatment commenced	Unstable, at risk of deterioration Low-Medium acuity, NEWS2 is 3-4, or 2 in one parameter	CFS ≤7 and **current CFS level would reflect a 1 level increase** from that 2 weeks prior to acute illness **or** Unmet needs in home environment or social support that require enhanced clinical care to address (e.g. extended visits, multi agency liaison)	Once a day time intensive visit (e.g new catheterisation) **or** twice daily routine visits (e.g nebuliser administration) **or** one routine visit and/or virtual review or > 1 hour of care planning in the same day	MDT in person reviews SCDM reviews once a day via ward round or MDM discussion	Tier 2
Acute deterioration with unknown cause and potential requirement for SDEC visit (e.g. Acute fluctuating delirium, not responding to first line treatment) **or** End of life care without Advanced Care Plan (ACP)	Unstable, deteriorating trajectory Medium acuity NEWS2 is 3-5, or 3 in one parameter	CFS ≤7 and **current CFS level would reflect a 2 level increase** from that 2 weeks prior to acute illness **or** New or significant unmet needs in home environment or social support that require additional clinical care to address (e.g. visiting in pairs)	Twice daily time intensive visits **or** MDT joint visit **or** one visit and > 1.5 hours of care planning in same day (e.g. Senior practitioner input for high risk interventions; first dose IV Ab, urgent end of life care planning)	Senior MDT in person reviews SCDM reviews twice daily via ward round or MDM discussion	Tier 3
Acutely unwell, rapidly deteriorating with likely requirement for conveyance to hospital (e.g. Risk of sepsis or patient refusing admission)	Unstable, rapidly deteriorating trajectory High acuity, NEWS2 is 5≥7	CFS 8 or 9, **or** CFS ≤7 and **current CFS level would reflect a 3 level increase** from that 2 weeks prior to acute illness **or** Safeguarding concerns that mean patient not safe in current place of residence	Urgent review and high level of in person monitoring (e.g New O_2 requirement) **or** ≥2 in person visits to monitor suitability to remain at home **or** one visit and > 3 hours of care planning in same day	SCDM or Consultant practitioner in person reviews **or** ongoing SCDM or Consultant practitioner care delivery throughout hours of operation	Tier 4



MSE FVW Acuity highest in EOE:
59 % tier 3 & 4
84% tier 2, 3 & 4

Mid and South Essex Community Collaborative

What else ? Outcomes so far

Key enabler Fr E D A

~ 3% reduction
30-day hospital readmission rates
ICS wide
For older people since FVW, Frailty Hotline e-Fra CCS & Fr E D A go live

- 5,000 patients
Supported in Frailty Virtual Wards
- 8 x less functional decline
- 2.5 X lower 30-day readmission %
- 5 X lower acquired infections
- Improved "95 % home first" discharge rates from acute trust across all 3 MSEFT sites

>50% Reduction in % of older people with > 3 unplanned hospital admissions in their last 90 days of life

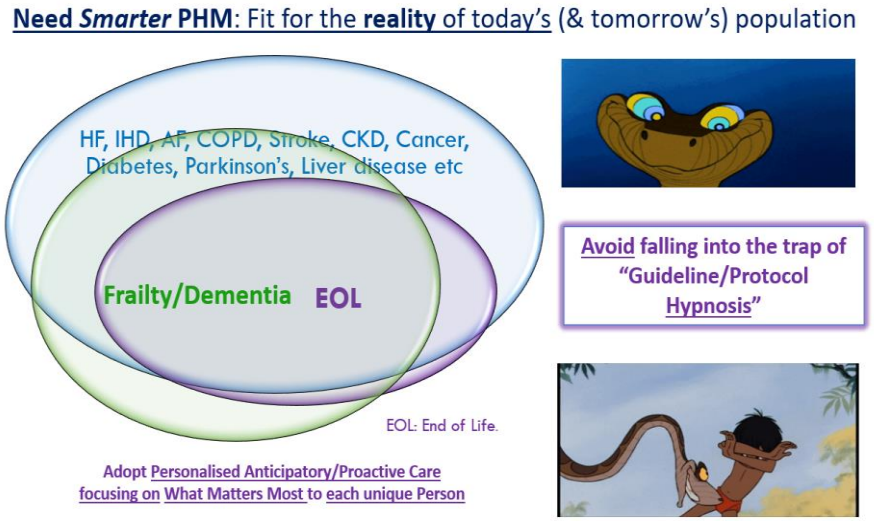
>82% avoid hospital from Frailty Medic Hotline over next 7 days
74% still avoided hospital 30 days later,
64% still had not touched a hospital even 3 months later

FRAIL+
Excellence in personalised care
Find Refer Assess Intervene Listen to Everybody's Business !

>2-day shorter LOS compared to inpatient ward

Step Up in own home/UPR direct from community has shortest LOS usually <5- 7 days

Why is acknowledging who the population is with the highest/most frequent UEC needs so important ?



Avoid falling into the trap of "Guideline/Protocol Hypnosis"

Design SPOA + Virtual Hospital capacity, capability & skillsets to match the REALITY of our population demographic needs [*NOT the other way around by retrofitting our population to whatever VWS we may choose to have]*
Our BIGGEST Virtual ward needs to be FRAILTY

Focus on where the biggest impact benefits to Person, Population & System impact *really* lie-→

Prioritise PROACTIVE PERSONALISED care delivery along-side Reactive care delivery (via Fr EDA)

Only this can maximise improving population outcomes, experience of care, reduce avoidable "revolving door" risks and reduce premature mortality risks the most

Plus, help to prevent VWS becoming...
"Just another lane in the motorway"

Virtual WARD – REAL STORIES

90-year-old male , CFS 6 Moderate frailty ,

Recent falls-- low BP 110/60 on CVD meds

Presenting condition: Chest infection “very Poorly” NEWS2 score 6, CRP 196

<u>He really wanted to stay at home</u> (now + for future)

- UCRT pick up via 999 stack→ admitted to FVW treatment for infection, bloods & clinical monitoring
- Proactive care via Fr E D A → Delivered CGA, CFS Frailty scoring, 4AT, Falls Risk Assessment, reduced polypharmacy risks (stopped BP meds) , Personalised Advance Care planning ACP/PEACE etc
- Recovered quickly → Discharge from FVW after 6 days -bloods improved, CRP 19
- Better functioning & future falls risks/functional decline risks reduced.
- Remained at home, ongoing care well-coordinated, needs stable. NO hospital admissions since

A Carers Story

8. STRATEGIC PRIORITY UPDATE: REDUCING DEMAND ON ACUTE SERVICE PROVISION

Information Item | James Wilson | 11:25am

REFERENCES

Only PDFs are attached

Strategic Report 28.11.2024.pdf

Mid and South Essex Community Collaborative (MSECC)

Joint Committee

Meeting	Mid and South Essex Community Collaborative Joint Committee
Subject	Strategic Priority Update: Reducing demand on acute service provision
Date of Meeting	28th November 2024
Author	James Wilson, Lead Director, MSECC
Approved by Responsible Lead	James Wilson, Lead Director, MSECC

For Decision	For Assurance	For Information
☐	☒	☐

Purpose

The single contract for the collaborative has four strategic priorities. This update provides assurance to the Joint Committee on progress against one of these areas: How we are Impacting on capacity required in the acute sector.

The Joint Committee is asked to:

The Joint Committee is asked to note the assurance provided from this report on the progress made.

Forums where content has been previously discussed

MSE Community Collaborative Executive Team ☒
MSE Community Collaborative Strategy & Transformation ☒
MSE Community Collaborative Core Leadership Team ☒
MSE Community Collaborative Joint Clinical Oversight Group ☐
MSE Community Collaborative Finance Workstream ☐
Other ☐ Please specify:

Link to MSECC Strategic Priorities

Strategic Priority/ Contractual priority	**IMPROVE** *(Work together to optimise and drive consistent delivery of community services, reducing inequalities)*	**INTEGRATE** *(With wider partners, facilitate community physical and mental health services integration with developing neighbourhood models at place)*	**INNOVATE** *(Take a lead role within the system to develop and deliver innovative models of care and use of technology)*
Creating an integrated delivery environment and culture	☐	☐	☐
Building healthier and resilient communities	☐	☐	☐
Supporting more people at home (directly impacting on capacity required in acute sector)	☒	☒	☒
Productivity and cost improvement	☐	☐	☐

Are there any risks in the report that need to be noted, escalated on the risk register or added to the Board Assurance Framework?

None

Glossary for acronyms in report (if any)

Introduction

The single contract for the collaborative has four strategic priorities:

1. Creating an integrated delivery environment and culture
2. Building resilient and healthier communities
3. Impacting on capacity required in the acute sector
4. Productivity/Cost improvement

This update focuses on the progress against our third priority and how we are looking to achieve more people receiving treatment and support in their own home and optimising the recovery after periods of ill health.

Progress Update

Value and Impact reporting

To support with the quantification of our impact we have developed the Value and Impact report. This report translates our activity into a single common currency of acute occupied bed days. An early draft of this work has been previously shared with the Joint Committee. Work continues on the validation and development of the tool with our clinical teams and we have been testing the methodology both regionally and nationally. We are intending to use this as a basis of supporting local discussions to support further 'left shift' into the community.

Our current modelling assumptions include the following headlines:

- MSECC's Frailty Virtual Ward alone save approximately 1000 acute occupied bed days (OBDs) per month. The modelling we use for this uses the Acuity Tool data (only those with high acuity are included in the modelling) and deducts patients admitted to hospital within 7 days
- MSECC's UCRT (Urgent Community Response Team) saved 96,674 OBDs in the 12 months between Aug 2023 and July 2024. This modelling deducts any patient admitted within 30 days.

System flow and winter response

The work we are doing in relation to our third strategic priority sits in the context of system flow and winter response. This is something we are actively engaged in.

The new national OPEL framework has been shared in draft which includes additional focus on the community. We are working with system leads to ensure we meet the daily reporting requirements included within the OPEL framework.

Within the MSE system our new daily operational rhythm includes both our community beds and virtual wards coming together for tactical updates. These are feeding into the system infrastructure. We have been involved in supporting the development of the new system discharge cell that coordinates daily flow across the system.

We have submitted a winter plan to outline the actions we will be taking over winter. It should be noted our plans focus predominately on existing projects and actions underway due to the lack of further winter funding. This is a picture mirrored across all

partner organisations' winter plans. There is a collective system risk that without further funding, meeting winter demand without compromising on quality of care is at risk. Lack of timely transport capacity has also been highlighted as a risk across partners.

Virtual Ward Optimisation

Our Virtual Ward Optimisation is a key enabler to ongoing reduction in acute demand. We have a number of interrelated strands of work underway. These are looking to build on the success achieved and also to learn and evolve our model. We have a number of positives that provide a platform from which we are looking to build from.

- We now have supported over 6000 patients through our virtual wards
- We benchmark as one of the highest for level of acuity for our frailty virtual wards (FVW) in the region (> 83% of patients in FVW are in the highest category using the regional tool)
- We have embedded the new frailty assessment tool (FrEDA) into our virtual ward models. We identify all new patients with frailty and upload them to our ICS wide population electronic Frailty Care coordination register platform (e-FraCCS). This is facilitating better onward journey of the patient post discharge from the virtual ward to improve their care coordination, reduce revolving door avoidable readmission risks to acute trust
- We report on frailty scoring (we are now 100% compliant with frailty scoring all our patients) and delivery of Advanced Care planning to patients meeting last year of life prognostic indicators (currently meeting this being offered to > 80% of all appropriate patients).

We are progressing with four strands of work to further optimise:

1) The consultant hotline and oversight model: Looking to develop a sustainable model that integrates with the Mid and South Essex System Urgent Care Coordination Hub (UCCH)
2) Supporting technology: Reviewing and re procuring technology to support our teams to deliver an optimised virtual ward offer
3) Optimising our flow: Looking at how we maximise current capacity and occupancy, sharing learning and expertise across our virtual wards (e.g. IV administration)
4) Developing a longer term integrated model: This is looking at a virtual ward offer that moves away from speciality specific virtual wards, maximising our capacity, resources and skills across all our current virtual wards.

Work on all these interrelated strands is complex due to the cross system nature of the work programme. Progress is behind our current planned timescales due to change capacity constraints. We recently had a Getting it Right First Time (GIRFT) review undertaken across our virtual wards and this has provided helpful feedback and learning from which we are reprioritising our work plan.

Community beds and Stroke beds

A specific focus has been given to look at how we maximise the benefit of working as one to optimise our community and stroke bed length of stay. We have permissioned

Rebecca Boyes, Partnership Director to lead on the strategic development and operational oversight of this portfolio on behalf of all three organisations. A range of tactical and more strategic actions have been undertaken to support improvement. These include how the teams work as one, how we improve our understanding of the data, how we use this to drive actions and how we meet the system expectations around more timely responsive delivery.

Key areas of development and impact

- Team development: Revised leadership and time dedicated for team development
- Daily Oversight and Rhythm: 3x daily flow huddles focused on supporting, unblocking and providing escalation routes for flow challenges and issues
- Data: Focus on a common data set, improved granularity of information and improved sharing of information into the wider system
- Pathway improvements: Using long length of stay routine reviews to drive pathway improvements and learning
- Escalation: Utilising new discharge cell escalation routes to gain wider system support.

We have seen a significant impact in our length of stay as a result of this focused work. We are now just above the expected position of 22.1 average length of stay for intermediate care beds and we are slightly lower than our expected 42 days for stroke rehabilitation beds. Our occupancy is above our planned 91% which overall means we are on track for our agreed acute bed model impact. There is further work to do to ensure this is sustained.

9. SERVICE USER PRIORITIES

Information Item | Lee Chester/Stephanie McNichol | 11:35am

REFERENCES

Only PDFs are attached

Service User Priorities - Joint Committee November 2024.pdf

Mid and South Essex Community Collaborative (MSECC)

Joint Committee

Meeting	Mid and South Essex Community Collaborative Joint Committee
Subject	**Service User Priorities**
Date of Meeting	28 November 2024
Author	Lee Chester Associate Director of Nursing/Patient Experience
Approved by Responsible Lead	James Wilson – Collaborative Lead Director

For Decision	For Assurance	For Information
☐	☒	☐

Purpose

It was agreed that a paper would be presented at this meeting in order to give an update on the model of ensuring lived experience is at the heart of our decisions and priorities.

The Joint Committee is asked to:

The Joint committee are asked to note and make comments on progress in the area of patient voice highlighting any gaps in assurance. Outcome of discussion will be reflected in upcoming proposals.

Summary of Key Points/implications:

The paper gives an overview of our approach to ensuring lived experience is at the heart of transformation

Forums where content has been previously discussed

MSE Community Collaborative Executive Team ☐
MSE Community Collaborative Strategy & Transformation ☐
MSE Community Collaborative Core Leadership Team ☐
MSE Community Collaborative Joint Clinical Oversight Group ☐
MSE Community Collaborative Finance Workstream ☐
Other ☐ Please specify:

Link to MSECC Strategic Priorities

Strategic Priority/ Contractual priority	**IMPROVE** *(Work together to optimise and drive consistent delivery of community services, reducing inequalities)*	**INTEGRATE** *(With wider partners, facilitate community physical and mental health services integration with developing neighbourhood models at place)*	**INNOVATE** *(Take a lead role within the system to develop and deliver innovative models of care and use of technology)*
Creating an integrated delivery environment and culture	☒	☒	☐
Building healthier and resilient communities	☐	☐	☐
Supporting more people at home (directly impacting on capacity required in acute sector)	☐	☐	☐
Productivity and cost improvement	☒	☐	☐

Are there any risks in the report that need to be noted, escalated on the risk register or added to the Board Assurance Framework?
None
Glossary for acronyms in report (if any)
SRO - Senior Responsible Officer
Supporting documents/ appendices that can be provided on request
MSECC Strategic Plan MSECC Delivery Plan & Milestones

1. Background

As a result of a discussion at Joint Committee in September 2024, it was agreed that a paper would be presented at this meeting in order to give an update on the model of ensuring lived experience is at the heart of our decisions and priorities.

The current model of delivery & oversight of Patient leadership is as follows:-

- Senior Responsible Officer:
  Debbie Smith (role)
- Delivery/milestone leads
  Lee Chester
  Stephanie McNichol
- Programme Team oversight
  Jo Debenham – Associate Director for Workforce and Engagement
- Monthly Patient Engagement Milestone Delivery Group
  EPUT, NELFT and PROVIDE Patient Participation Leads
- 6 weekly meetings with Health watch and ICB Patient Participation Leads

2. Patient voice in the MSECC Strategic Plan

Stakeholder engagement formed a key part of setting our strategic priorities in 2022.

Working in conjunction with Health watch who designed our original patient engagement strategy, we joined up with the MSE ICB who were consulting publicly on their 10-year strategic plan of which the community collaborative formed part. In addition, we asked 3 key questions to communities and stakeholders:

- What is important to you in the delivery of community health services?
- Does the MSECC strategic plan reflect what is important to you?
- Any other feedback

This was summarised in a full report to this board – 'Engagement on the strategic plan – May 2023' but included the following key areas:-

- Delivered engagement sessions across a wide range of internal and external stakeholder groups using the above 3 questions

- Comprehensive literature reviews from relevant system wide community engagement including consultation on the ICB 10 year plan & community beds engagement exercise.

3. Progress on our delivery priorities and Milestones 2024 - 2025

Our existing patient engagement strategy (co-produced with Health watch) sets out the following 5 commitments:

- Ensure that lived experience is at the heart of decision making
- Make certain co-production is fundamental when designing, redeveloping or delivering services
- Understand and meet the communication needs of our service users
- Adhere to the accessible information standards
- Work in collaboration to deliver the key principles

As a result, 3 key milestones were agreed for this year as follows:-

Improve	19. Communications & Engagement (1/2) SRO: Carrie-Ann Wade (Communications) and Debbie Smith (Engagement)		
Milestones	**Completion date**	**Delivery Lead**	**SRO**
Patient Leadership representation on Boards Membership of collaborative board reflects patient voice and systems and processes implemented to support.	Q2 2024/25	Lee Chester Steph McNichol	Debbie Smith
Patient Related Experience Measures Appropriate PREM metrics are collected & reported across MSECC to enable us to monitor, compare and respond to unwarranted variation in patient experience aligned to those services set out in 24/25 delivery plan	Q1 2024/25	Lee Chester Steph McNichol	Debbie Smith
Healthwatch Engagement Strategy Review and update existing strategy as part of wider engagement framework	Q1 2024/25 Quarterly review	Lee Chester Steph McNichol	Debbie Smith

Milestone 1 – Patient Leadership Representation on Boards (COMPLETE)

We are pleased to have welcomed our two Lived Experience Leaders to this Public facing board as fully voting members to ensure lived experience and patient voice is at the heart of strategic decision-making. The support from John Lutchmiah and Luis Canto E Castro in and around this committee has been of great value and we thank them both.

In addition, there is a standing agenda item at each Joint Committee bringing lived experience case studies bringing valuable insights and examples of co-design. These have included our work on tackling health inequalities in Diabetes, the coproduction of the Mycarebridge portal for ASD and our Wheelchair service lived experience.

We also made it a mandatory requirement that our successful Patient Participation Lead role could evidence Lived Experience as an essential criteria of the role.

Milestone 2 – Patient Related Experience Measures (DEVELOPPING)

Significant work has taken place to align Friends and Family Test and I Want Great Care survey results for the collaborative in scope services. This has been an area of challenge but we are now able to report a baseline as part of our accountability framework reporting. It has however highlighted some challenges in terms of reporting by service line & equality information, response rates locally and the ability to understand feedback from an equality perspective.

Milestone 3 – Health Watch Engagement Strategy (ON TRACK)

Building on the excellent relationship we hold with health watch who designed our original strategy we have agreed that the refresh will take place in-house delivered by our own patient leadership team. This will consist of an internal alignment of priorities and models by our leaders – and a separate set of engagement workshops and discussions with our patients and service users to seek refreshed views on the 3 key questions set out in section 2 of this report relating to community health service priorities and our strategic plan.

Key will be clear agreement by all partners on our standards & levels of patient participation

In addition to the above, there has been a wide range of progress – enabled by the resourcing of a short-term Patient Participation Lead role, which is being discussed and reported shortly within the executive decision making group as part of a review of the existing resource and model to support going forward. Please see Appendix 1 – overview of progress against Patient Leadership Milestones, which brings to life some of the work underway to bring patients into the redesign space.

General examples of patient voice impacting service design

Alongside our agreed milestones we have been pleased to see some clear service design and impact from patient participation including:-

Diabetes health inequalities project – as presented to this committee we worked closely with people from seldom heard groups to understand how best to give them access to annual health checks. As a result we visited mosques and community groups and reported a clear increase in the numbers of people accessing their annual diabetes health checks and associated care.

CYP ASD – as presented to this committee the full design and implementation of the ASD portal was in coproduction with families and carers who continue to work alongside us in the next steps

Heart Failure - in order to understand how our heart failure patients accessed our services we carried out Patient engagement sessions held at ‘Hearts and Minds’ support groups and have uncovered a clear disparity in access to services dependent on where you live. This is now a work stream for 2025 to review the Service Specification and access thresholds with our ICB.

Transfer of Care Hubs – our attendance at community engagement events resulted in lived experience examples being brought back into the TOCH delivery group and a potential lived experience ambassador willing to share their experience of discharge after a stroke. We also worked closely with Thurrock Healthwatch on their experience survey which was also reported back to the delivery group.

Mobile Delivery Outreach Van (Mid) – using a mobile van – we have taken our services out into the community including underserved communities. This has proved invaluable in improving access to community health services such as respiratory & long covid and sexual health services Currently being used by our Mid and South East partner with a 'shared wheels' piece about to commence in order to widen access to all 3 collaborative partners. Supporting an approach where we reach out to our communities for engagement and do not expect them to serve us. We are planning to present this work at a future Joint Committee.

Wheelchair Services- our very own Joint Committee member Luis joined us initially due to his work as a lived experience ambassador and service user of our wheelchair services. He has been a valued member of the wheelchair transformation team and recently his work was shared at this committee via a case study illustrating how the MSECC wheelchair service has improved his experience.

Wound Care – the collaborative wound care service used volunteers to reach out to service users to discuss their experiences which were fed into a specific patient engagement workplan.

5. Next steps

There has been good progress in this area and next steps include-

- Establish feedback mechanism for the patient voice to be embedded into the MSE Collaborative
- Continued illustrative examples and case studies of patient participation at Joint Committee
- Future Patient Leadership Model & Resource paper to Collaborative Executive Team
- Agreement on aligned remuneration packages and bandings for lived experience recognition and reward
- Further work via the Accountability Framework meetings to progress quality of Patient related Experience measures by service line and equality information
- Co-designing a refreshed patient leadership strategy
- A revised version of this report with proposed actions will be discussed at the MSECC Quality Triangulation Group and nursing and quality board
- Investigation of the use of volunteers to support the lived experience agenda

Oversight for this work will be delivered by our Monthly Patient Engagement and Coproduction Delivery Group chaired by the Senior Responsible Officer – Debbie Smith Director of Nursing / Patient Experience and attended by all three partners who are key to the success of geographical lived experience.

6. Action required

Joint committee members are asked to note and discuss the contents of this report.

Lee Chester
Associate Director of Nursing/Patient Experience

18 November 2024

10. ACCOUNTABILITY FRAMEWORK

Standing item | Alex Green | 11:45pm

REFERENCES

Only PDFs are attached

Accountability Framework Report 26.11.2024.pdf

Assurance Report
To
Mid & South Essex Joint Committee

Subject	**Mid & South Essex Community Collaborative Assurance Framework**
Date of meeting	28 November 2024
Author	Graeme Jones, Director, Vaughan Jones Ltd
Approved by lead	James Wilson, Transformation Director, MSECC

For Decision Members are being asked to make a decision	For assurance Members are being provided with assurance	For Discussion Members are being asked to consider or discuss an item, or guidance/support is being sought	For Information Members are being asked to note for information only, with no discussion required
☐	☒	☐	☐

1. BACKGROUND / GOVERNANCE

The aim of the report is to provide the MSECC Joint Committee with assurance on the work of the collaborative and a summary of key discussions from the MSECC Assurance Framework meeting in November.

2. RISKS

There has been further progress in developing a single aggregated risk register for the Community Collaborative, which is now being led by the Director of Governance at EPUT. A draft risk register will be presented to the Collaborative Leadership meeting for comment on 27 November. The Accountability Framework meetings and a Leadership Team workshop have been used to inform the draft risk register. The risk process will include clarification of the role and link to the professional forums.

3. AREAS FOR ESCALATIONS TO THE MID AND SOUTH ESSEX JOINT COMMITTEE

The Accountability Framework meeting in November agreed to escalate the following issues to the Joint Committee:

1. Community Paediatric waits remain high across the Collaborative. Short term additional capacity actions are in place and a longer term recovery trajectory will be presented to the December Accountability Framework meeting.
2. The Collaborative has received a GIRFT report reviewing the Virtual Wards. The Collaborative Leadership Team are drafting a response to provide assurance on clinical safety, informed by a risk assessment, and developing a response plan to the report. The Accountability Framework meeting discussed taking patients beyond the core scope of the commissioned service. The key actions in response to the GIRFT report will be presented to the Accountability Framework in December and delivery of the plan will be part of future reporting.
3. There are a range of financial challenges for the Collaborative in developing processes There is a focus in the Chief Finance Officer group on the work to aggregate financial reporting, to reach a position in which service line metrics can be reported and to manage a number of cost

pressures including The Lighthouse service, District Nursing, Wheelchairs and the Drugs budgets.

4. Domain leads – There has been inconsistent attendance at the Accountability Framework meetings from the lead Directors for the different domains most notably Quality and Safety. We need senior leadership attendance if this is to be the forum for Collaborative partner organisations to gain their assurance.

Agenda item	Decision made	Comments Including reasons for approval or rejection, expected impact/consequence, next steps, and timeline

4. ASSURANCE

The Accountability Framework meeting in November agreed to highlight the following actions and assurance to the Joint Committee:

1. There is positive delivery against most of the agreed Transformation, Operational Performance, Quality and Safety and Workforce and Culture indicators.
2. There has been good progress in reducing the vacancy rate across the Collaborative. It is at an 18 month low at 7.6% in aggregate.
3. The Quality and Safety leads group are developing guidance on the consistent reporting, sharing, ownership and management of incidents.
4. There has been further progress towards the agreed targets for length of stay in the community beds.
5. The Chief People Officer and Chief Finance Officer groups have a focus on temporary staffing. The data pack to the Accountability Framework meetings includes much more detail on temporary staffing.
6. There has been further work to enable the sharing of clinical staff and the licence to attend model. This was an area of focus at the November Accountability Framework meeting.
7. The Chief People Officer group and Chief Finance Officer group will meet together to share and plan their work on service line reporting.
8. The sign off of the overall community service contract is very close.

5. RECOMMENDATIONS / NEXT STEPS

The Joint Committee is asked to note the areas of escalation and assurance. The Joint Committee is asked to receive an aggregated risk register for the collaborative following review at the Accountability Framework meeting in November.

11. RISK MANAGEMENT

Discussion Item | James Wilson | 11:50am

REFERENCES

Only PDFs are attached

Risk Report 28.11.2024.pdf

Mid and South Essex Community Collaborative (MSECC)

Joint Committee

Meeting	Mid and South Essex Community Collaborative Joint Committee
Subject	**Risk Report**
Date of Meeting	28 November 2024
Author	Denver Greenhalgh, Senior Director of Governance EPUT
Approved by Responsible Lead	James Wilson, Transformation Director

For Decision	For Assurance	For Information
☐	☐	☒

Purpose

This report provides an update on the work undertaken to develop a risk log for the Mid & South Community Collaborative.

The Joint Committee is asked to:

The Committee is asked to receive the report and confirm programme of work.

Summary of Key Points/implications:

The Joint Committee had previously requested a risk log / register be established for the collaborative to allow a joined up approach for the identification and mitigation of risks. Since the request, work has been taken forward to establish a programme of work to achieve this action.

This paper outlines the work to date and the proposed process for the development of a Collaborative risk register, including:

- A shared approach for risk management
- A stated risk appetite
- An agreed risk tolerance
- An agreed reporting structure

Forums where content has been previously discussed

MSE Community Collaborative Executive Team ☒
MSE Community Collaborative Strategy & Transformation ☐
MSE Community Collaborative Core Leadership Team ☐
MSE Community Collaborative Joint Clinical Oversight Group ☐
MSE Community Collaborative Finance Work stream ☐
Other ☒ Please specify: Accountability Framework Meeting

Link to MSECC Strategic Priorities

Strategic Priority/ Contractual priority	IMPROVE *(Work together to optimise and drive consistent delivery of community services, reducing inequalities)*	INTEGRATE *(With wider partners, facilitate community physical and mental health services integration with developing neighbourhood models at place)*	INNOVATE *(Take a lead role within the system to develop and deliver innovative models of care and use of technology)*
Creating an integrated delivery environment and culture	☐	☐	☐
Building healthier and resilient communities	☐	☐	☐
Supporting more people at home (directly impacting on capacity required in acute sector)	☐	☐	☐
Productivity and cost improvement	☐	☐	☐

Are there any risks in the report that need to be noted, escalated on the risk register or added to the Board Assurance Framework?

None

Glossary for acronyms in report (if any)

Supporting documents/ appendices that can be provided on request

Risk Management Approach for MSECC

1. Introduction

As we mature the formal arrangements for shared accountability for the transformation and delivery of community services, having an agreed approach to risk management will be a key building block for decision making and allocation of resources across the portfolio of services.

Our collective role is to have an informed consideration of risk and risk tolerance to underpin our strategy, decision-making and the allocation of resources (Risk Appetite). And, we take responsibility for ensuring that the Collaborative has appropriate risk identification and risk management process in place. This will include an agreed approach to systematically assessing and managing our risks; and will cover clinical, financial and corporate risks. Through this approach we will have due regard to compliance with the terms of all partner organisational licenses (e.g. FT Provider License, CQC registration requirements).

This paper outlines the work to date and the proposed process for the development of a Collaborative risk register, including:

- A shared approach for risk management
- A stated risk appetite
- An agreed risk tolerance
- An agreed reporting structure

2. A Shared Approach

Risk management is underpinned by our ability to identify potential risks (not confusing these with issues). A mapping exercise of each partner organisation risk management policies is underway, with indication of significant commonality. Each utilising the 5x5 risk matrix approach (diagram below for illustrative purposes) and the use of electronic risk register.

		CONSEQUENCE				
		1 Insignificant	2 Minor	3 Moderate	4 Major	5 Extreme
LIKELIHOOD	**1 – Rare** - Not expected to occur	1 LOW	2 LOW	3 LOW	4 MODERATE	5 MODERATE
	2 – Unlikely – Occurs infrequently	2 LOW	4 MODERATE	6 MODERATE	8 HIGH	10 HIGH
	3 – Possible – Once or twice a year	3 LOW	6 MODERATE	9 HIGH	12 HIGH	15 EXTREME
	4 – Likely – Hazard will occur but is not persistent. There are no issues of custom and practice	4 MODERATE	8 HIGH	12 HIGH	16 EXTREME	20 EXTREME
	5 – Certain – Constant threat is custom and practice	5 MODERATE	10 HIGH	15 EXTREME	20 EXTREME	25 EXTREME

There is also a consistent definition of risk management, in that it is 'assessment and management of risks, through recognising which events (hazards) may lead to harm in the future and minimising their likelihood (how often) and consequence (how bad).

Therefore achieving a consistent approach (framework) for the Collaborative is highly feasible, with agreement of risk ownership, monitoring and review of progress with any actions taken to deal with them.

Further to this, members will need to agree a reporting structure and what level of risks reporting to where within the Collaborative Governance structure. For example only do we want one or the other (or both):

- Strategic Risk Register (akin to a Board Assurance Framework) reporting through the Joint Committee.

- Collaborative Risk Register (escalation threshold all risks) reporting through the accountability framework meetings.

As part of this programme of work (once risk assessments have been completed) options will be offered for consideration.

3. Risk Appetite

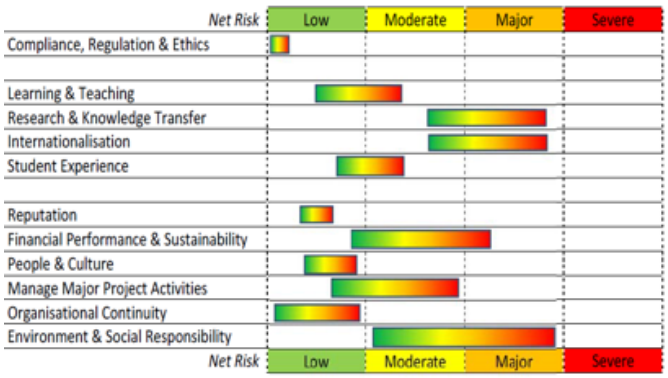
In having a Collaborative risk appetite statement, we will create a collective understanding of the amount and type of risks that we are prepared to accept, tolerate or be exposed to at any point in time. Members will be able to:

- explain the view on risk to all working within the remit of the Collaborative Agreement

- an informed approach to decision making as to whether treat, tolerate, transfer or eliminate a risk

- guide for the prioritisation and focus when there are competing risks

It is proposed to hold a seminar with the joint committee to discuss and set risk appetite utilising the Good Governance Institute model and aligning with our risk management scoring frame to enable ease of use.



(Picture for illustration only)

4. Risk Tolerance

Risk tolerance is subtly different to risk appetite in that it reflects the boundaries within which the Collaborative leadership are willing to allow the true day-to-day risk profile of the portfolio to fluctuate. It is therefore the level of risk we expect management to manage.

By setting a tolerance the members will communicate the threshold whereby escalation to the Joint Committee for consideration is required. The Committee will then give consideration to the impact on other objectives, competing resources, and timescales.

The seminar will discuss the different approaches to 'tolerance' and agree a preferred option for inclusion with the risk management frame.

5. Initial Identification of Risks

A risk and issues workshop was held with partnership directors with the output identifying risk within the themes below (noting ongoing risk profiling):

- Governance and Structure
- Commissioning and System
- Quality and Safety
- Operational Performance
- Workforce and Culture
- Finance and Resources
- Strategy, transformation and external relations

The next steps are to fully analyse these headlines to create risk entries, risk controls and risk mitigations with the relevant leads within the Collaborative.

6. Next Steps

To run a short programme to deliver a fully functional risk register framework for the Community Collaborative.

	Dec'24	Jan '25	Feb '25	Mar '25	April '25
Risk Appetite and Risk Tolerance Seminar					
Draft Risk Management Frame					
Draft Reporting Templates					
Risk Assessments fully worked up					
Risk Register Reporting					

In the interim period, the Joint Committee is asked to consider whether an aggregate of entries from respective operational risk registers would be beneficial to report.

12. EXCEPTION REPORTING

Discussion Item | James Wilson | 12.00pm

13. MSE COMMUNITY COLLABORATIVE FINANCE AND EFFICIENCY UPDATE

Standing item | Trevor Smith | 12:05pm

Verbal

14. QUESTIONS FROM THE PUBLIC

Standing item | Robert Parkinson | 12.10pm

15. ANY OTHER BUSINESS

Standing item | Robert Parkinson | 12.10pm