Mid and South Essex Community Collaborative

NHS

Annual Report

2024/2025

Mid and South Essex Community Collaborative is a partnership between Essex Partnership University Trust (EPUT), North East London Foundation Trust (NELFT) and Provide Community Interest Company (Provide CIC).

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Collaborative Lead Director Statement

I am proud of the progress the Mid and South Essex Community Collaborative (MSECC) has made in transforming how we deliver care to our communities. Now more than ever, has the importance of doing more in the community been essential to both patient outcomes and system sustainability.

Our efforts this year to enhance system capacity, improve productivity, and address health inequalities have shown the power of collaboration in achieving better outcomes for patients, staff, and partners.

This year we made significant steps forward in enhancing system capacity. We have optimised our intermediate care length of stay and are supporting both more complex and larger volumes of patients in the community through our virtual ward offer.

We have seen improved productivity through standardising our service offers and ensuring effective use of resources while reducing variation and duplication. It has been great to see vacancy rates across the collaborative having dropped significantly and we have invested in organisational development to support our cultural change.

Importantly, we have targeted more work on prevention this year, for example, with our pilot on early detection of cardiovascular disease, demonstrating the power of using our collective capacity to impact on longer term disease management.

At the heart of our delivery remains locality integration and the growth of our integrated neighbourhood teams. We have seen great progress in our transfer of care hubs, demonstrating how through partnership we can help people get the right support.

This progress is thanks to the dedication of our teams across the system. Thank you for your passion and hard work. Together, we're building a stronger, more connected healthcare system, delivering meaningful change for patients, communities, and colleagues.

James Wilson
Collaborative
Lead Director
MSECC

Chair's Statement

As Chair of the MSECC, I have had the privilege of seeing the progress we have made together over the past year. We have seen what is possible when we unite around a shared purpose; improving lives through compassionate, community-based care.

This has been a year of momentum. By thinking and working differently, we've built on our strong foundations for a more integrated, proactive healthcare system. Our focus on collaboration has enabled real change, from reducing hospital admissions to transforming how we support people in their homes. We are making bold choices and, importantly, delivering better outcomes for people.

We are entering a new chapter, one that demands even greater ambition and courage. Our health and care system continues to face complex challenges: rising demand, growing inequalities, and workforce pressures. These challenges are not insurmountable, but they do require us to remain open to change and committed to innovation.

Looking ahead, our focus must be on building a system that is not only fit for today but for the future. This means redesigning services around people, not organisations. It means embracing digital solutions, breaking down silos, and listening more closely to the voices of those we serve. Above all, it means recognising that each of us, whatever our role, has the power to shape a better, fairer system.

I know change can be difficult, especially in a time of pressure and uncertainty. But the past year has shown what's possible when we step forward together.

Thank you to colleagues for the energy, care, and commitment you bring.

Robert Parkinson
Group Chair of Provide Community Interest Company and Chair of MSECC

What is the MSECC?

The MSECC was formed in 2021 to explore how we can work together to deliver better care.

OUR VISION

To provide consistent and outstanding community health and care services.

OUR MISSION

To co-produce the MSE Community Collaborative which combines the strengths of EPUT, NELFT and Provide Community with the passion and commitment of staff to create healthier and happier communities in mid and south Essex.

MSECC GOVERNANCE

MSECC's strong identity and collaborative approach positions it as a trusted system partnership.

MSECC operates under a single contract, and a Joint Committee oversees decision making on behalf of all three community provider organisations. This committee includes wider partners and patient leaders to support effective decision making. A single Collaborative Executive functions below the Joint Committee with a joint accountability framework to provide assurance on delivery across operational, clinical, transformation and corporate functions.

This enables MSECC to have one strategic voice within the local Integrated Care System. Some of our key services have shared operational leadership, with aligned portfolios and standardised operating procedures and policies.

MSECC Strategic Priorities for 2024/25

- Building Resilient and Healthier Communities
- Creating an Integrated Delivery Environment and Culture
- Supporting More People in the Community
- Productivity and Cost Improvement

We focused on these areas to achieve our objectives:

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.

Some of our outcomes this year

Patients supported in community

We now deliver over

70,000

patient contacts every month in our community nursing teams. A **36% increase** in activity over the past 2 years.

Waiting times

Referral to treatment (RTT) waits. Adults seen **within 18 weeks maintained** over last 2 years.

Long waits over 52 weeks **eradicated.**

System flow and discharge

Frailty Virtual Wards: support over

2,400

people annually, saving over

25,000

hospital bed days.

UCRT: Almost

12,000

contacts with patients from January 2024 to January 2025, saving around

88,000

hospital bed days (Measured from 0-7 days after contact).

Intermediate Care (IMC) Beds: Length of Stay (LOS) reduction by an average of **30%** to

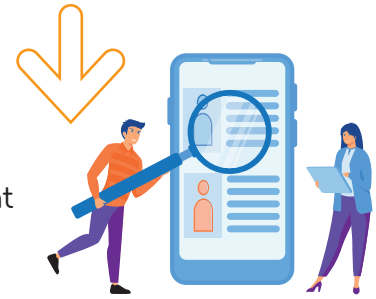
20 days.

Our Staff

We employ

1,750

Full-Time Equivalent (FTE) clinical members of staff.



FTE vacancy rate has dropped in 18 months from 11.34% to **5.82%**. Clinical vacancies down to **4.18%**, reduced from a peak of 13-15% in early 2023.

Improve

Improving the management of Cardiovascular Disease (CVD)

Building Resilient and Healthier Communities

Cardiovascular disease remains one of the leading causes of early death and health inequality across mid and south Essex.

We are working together across services to improve prevention, early detection, and long-term care. We are utilising the existing expertise, skills capacity and opportunity we have in community services.

Driving Impact in Cardiovascular Health

By analysing local health data and CVD programmes, we identified disparities in hypertension (high blood pressure) management and inequities in access to care. Stakeholder engagement with residents, community health teams, and local leaders provided critical insights into these challenges.

The programme has integrated with existing chronic disease management and health inequality initiatives, ensuring alignment rather than duplication. Our data revealed gaps in workforce confidence in managing hypertension.

Community respiratory services were identified as a strategic choice for piloting a new blood pressure management guidance, primarily because they already incorporate blood pressure monitoring into routine care. The guidance advises staff on what to do when blood pressure is abnormal, both too high or too low. This integration allows for the enhancement of existing practices without imposing additional procedures on patients or staff.

Two patient representatives joined the programme team to shape discussions and co-design the new guidance and University College London Partners (UCLP) provided training to our respiratory team on cardiovascular disease and blood pressure management, including implications for our frail population.

One of the patient representatives, Freddie McMahon said,

> "As a patient representative with high blood pressure, I've seen how this programme improves consistency in care. It shows how lived experience can help shape practical improvements that advance health equity and support both professionals and the communities they serve."

So far, the introduction of the guidance and training showed staff were more confident managing abnormal blood pressure. We are now ready to roll this out within other services with the introduction of a newly developed SystmOne (SystmOne is a digital platform used to manage patient records) protocol, supporting decision making when faced with abnormal blood pressures. The programme is in early stages, but indications show that this collaboration will drive meaningful change, fostering a shared purpose and cross-boundary working.

A collaborative approach in Community Beds

Supporting More People in the Community

Over the past year, we've seen the power of collaboration and operational alignment in enhancing staff and patient experiences, easing system pressures.

Strong leadership has unified the operational vision for community beds with a single pathway and point of contact. This clarity is reducing duplication and enabling clinical teams to focus on delivering high-quality patient care.

Multi-disciplinary huddles have been instrumental in fostering stronger relationships and a shared sense of priorities across teams. These meetings address challenges collectively and staff feel aligned and supported.

Rebecca Boyes leads on community beds for the MSECC and reflects on the progress:

> "The changes we've implemented have brought much-needed grip and control. Everyone knows what's happening and who is responsible, ensuring that our efforts are unified and focused."

This collaborative approach is further supported by active engagement with partners and stakeholders, reinforcing a systemwide commitment to improving patient flow and experience.

Through this work, and supported by system-wide initiatives, the Intermediate Care Beds Length of Stay (LOS) was reduced by an average of 30% to 20 days.

While challenges, such as data accessibility persist, the collective determination to address them underscores the progress made and the ongoing potential for improvement.

Celebrating the value of our Community Nurses

Building Resilient and Healthier Communities

Our community nursing teams are instrumental in looking after people in their own homes and keeping people out of hospital. Our community nursing teams saved almost 11,500 hospital occupied hospital bed days in the last 12 months.

Standardising care

By coming together, leaders have been prioritising the standardisation of care including an MSE-wide formulary for catheter care, which not only delivers value but ensures care is high quality and equitable. By engaging with partners within the hospital, intermediate care and social care partners, a new updated catheter pack for people leaving hospital is available across MSE.

Standardised prevention strategies across healthcare settings for wound care is being implemented. PURPOSE-T is a nationally recognised, clinically validated pressure ulcer risk assessment framework designed to improve patient outcomes.

By implementing PURPOSE-T and the updated Pressure Ulcer (PU) categorisation, we can ensure a unified approach across community, hospice, acute, and care home settings, leading to better patient care.

Head of Nursing and Clinical Quality at Farleigh Hospice, Alison Gray, said:

> "Farleigh Hospice has welcomed the opportunity to contribute to the rollout of PURPOSE-T and the new pressure ulcer categories. Working closely with our system partners has enabled us to share expertise and knowledge to promote high quality, evidence-based interventions for those within our care."

Integrate

Transfer of Care Hubs (TOCH)

- Creating an Integrated Delivery Environment and Culture
- Supporting More People in the Community

The Transfer of Care Hubs (TOCH) help coordinate care to ensure that individuals leaving hospital or receiving support at home, are placed on the correct pathway. This enables them to return home or move to an appropriate setting as quickly and safely as possible.

The four Transfer of Care Hubs across MSE have brought together key stakeholders to design individual models to reflect local needs, linking into Integrated Neighbourhood Teams. Serving as a system-wide coordination hub, TOCHs brings together relevant partners, and facilitates seamless collaboration, both physically and virtually. TOCHs are working to ensure that people receive the right care and support at the right time, to improve patient experience, decrease length of stays in hospital, avoid admissions and reduce readmissions to hospital.

Integration

The Basildon and Brentwood (BB) TOCH promotes integrated working, improving patient outcomes and ensuring smooth transitions from hospital to home. BB TOCH, with community services, social care and primary care working in partnership, provides vital support for vulnerable individuals in the area:

- Identifies hospital patients and assesses prior support.
- Collaborates with primary care teams to address ongoing health and social needs to prevent admissions and re-admissions to hospital.
- Ensures that safeguarding and social care support are in place.
- Person-centred approach.

Case study:

A service user was admitted for hip surgery and was found to have an unsafe home environment due to an inability to manage their belongings. Through the TOCH, the service user was discharged to rehabilitation services and alongside a family member and with consent, their home was assessed and modifications made. The service user returned home with a comprehensive care plan and social prescriber visits.

- The service user's quality of life was improved, demonstrating the value of effective teamwork.
- Proactive approach which removed risks at the service user's home, which could lead to readmission to hospital.

Improves communication

TOCH bridges communication gaps between acute and community, ensuring hospital staff have real-time access to vital patient information. It has also helped build relationships and awareness of community services with the hospital teams.

Hospital teams do not often have access to patient interactions with community or primary care services, which can result in missing key information such as recent GP visits or prescriptions. This may lead to delays and unnecessary repeat assessments.

To address this, a new TOCH Coordinator was placed at Broomfield Hospital to support staff. They trained teams to use SystmOne in read-only mode, enabling access to vital service user information and helping wards improve the quality of referrals by increasing understanding of available community services.

Key outcomes:

- Reduce duplicate assessments
- Minimise waiting times
- Enhance clinical decision-making
- Prevent unnecessary referrals
- Strengthen patient safety
- Streamline discharges

Tiptree Ward Patient Flow Coordinator, Portia Tofts said:

> "It has been very useful accessing patient information, especially when finding out more information where a person has had poor mental health. It has also helped understand more about what services are available in the community, and what support a patient already has in place."

Scan the QR code to watch our short video on the mid Essex TOCH.

Diabetes

Building Resilient and Healthier Communities

Supporting Adolescents with Diabetes

Managing diabetes as a young person presents unique challenges, particularly during the transition from paediatric to adult care. The diabetes teams have been working on a key initiative to improve support for adolescents with diabetes with engagement-focused community events.

One of the key challenges has been ensuring adolescents remain engaged in their diabetes management as they transition to adult services. To address this, the diabetes team, supported by The Queen's Nursing Institute, have hosted interactive events designed to provide education in a more relaxed and supportive environment. These events offer young people the chance to learn about their condition while feeling supported by peers and healthcare professionals. Feedback highlights the positive impact of these events, with many expressing increased confidence in managing their condition.

Advancing Diabetes Management with Hybrid Closed Loop Technology (HCL)

MSECC played a key role in shaping the business case for this initiative, ensuring it was embedded in local NHS strategy.

HCL technology is a system which automates insulin delivery based on continuous glucose monitoring, reducing the burden on service users and improving blood sugar control.

Its impact on quality of life is undeniable. Families have reported improved sleep, reduced anxiety, and greater independence for younger adults managing their diabetes.

Becky Tyler, a service user of the Hybrid Closed Loop said:

> "I can't thank the team enough for helping me switch to a hybrid closed loop pump. The system is user friendly and rather than controlling me, it allows me to make better informed choices. Just being able to see "insulin on board" as a feature is amazing. After a one week my time in range has increased from 41% to 73%. This is life changing. It is wonderful to wake up and not immediately think about injecting. I'm getting more restful nights and feel less anxious. It is comforting to catch a glance of my abdomen and legs without the small needle bruises. This is such a game changer, I feel more relaxed and confident. Most importantly I am more optimistic about my future. Thank you all for the fantastic care - I feel very fortunate and grateful."

Transforming Community Speech and Language Therapy (SALT)

Creating an Integrated Delivery Environment and Culture

Our speech and language teams have worked extensively on a bold and ambitious transformation of adult community speech and language therapy (SALT) services, driven by a shared goal: to improve access, equity, and quality of care for service users while supporting and retaining our workforce.

We have explored rotational posts across mid and south Essex to offer a vast range of experience to newly qualified speech and language therapists.

A new virtual triage and assessment model has shown that one senior clinician can significantly reduce referral-to-treatment times (RTT), freeing therapists to focus on intervention.

One clinical lead has provided essential guidance throughout this transformation. This encourages stability, professional leadership, and consistency in clinical practice and has led to the development of an MSE wide cross organisational team manager post.

We have unified clinical templates and documentation and we are now looking to create a single patient caseload to ensure equitable prioritisation based on clinical need.

Innovate

MyCareBridge

Transforming Children and Young People's Autism and ADHD Referrals

Creating an Integrated Delivery Environment and Culture

Children and young people's teams across MSE have been brought together to improve access to Autism and ADHD services.

The Autism and ADHD assessment pathway has historically been inconsistent across MSE. MyCareBridge serves as a single point of access, offering families and professionals live visibility of their referral status. The portal was developed in collaboration with clinicians, operational leads, system partners, and families, through the Family Forums.

It aims to make the referral process more transparent and accessible by:

- Providing families with real-time updates on referral progress
- Offering immediate access to a comprehensive library of local support resources
- Aligning with national best practices, as outlined by NHS England

Our administrative teams have been instrumental to the implementation of MyCareBridge and as we continue to refine and improve process, we remain focused on improving accessibility and ensuring that families receive the support they need at every step.

By harnessing digital innovation and fostering collaboration between health and education professionals, we are driving meaningful change in Autism and ADHD services.

Key outcomes:

- Over 3000 complete referrals received through MyCareBridge since launching.
- 50% of referrals were made directly from educational settings, which often leads to a more streamlined and coordinated referral between families and settings.
- Families are no longer having to book an appointment with the GP which streamlines the process of referrals, ensuring we are making it easier to support our most vulnerable children and young people.
- Initial feedback with families shows that most people find MyCareBridge easy to use and informative.

Transforming care with Frailty Virtual Wards

Supporting More People in the Community

The frailty virtual wards (FVW) provide proactive, personalised, and highly effective hospital-level care for approximately 2,400 frail people annually, significantly improving outcomes for one of the most vulnerable patient populations and keeping people out of hospital.

FVWs offer tailored care to meet complex, urgent and long-term health needs. Aligning with the "Home First" approach has improved discharge rates across all three Mid and South Essex NHS Foundation Trust sites.

One recent success story highlights a 90-year-old male patient with frailty and multiple health conditions. His proactive care plan included comprehensive assessments, frailty scoring, and personalised medication adjustments. He recovered within six days, avoided hospital admission, and maintained improved health and independence at home. His wife said, "The coordinated approach of the virtual ward gave us peace of mind and ensured my husband received care while staying at home."

Dr. Sarah Zaidi, Clinical Lead for Frailty & Urgent Care in Mid and South Essex, stated:

> "Frailty Virtual Wards are the future of healthcare, with proactive, personalised, and deeply attuned to the needs of our most vulnerable populations. By prioritising home-based care and reducing the revolving door of hospital admissions, we're transforming lives and delivering sustainable healthcare solutions."

Scan the QR code to watch our short videos for professionals referring to our VFW.

Strengthening our Workforce

Productivity and Cost Improvement

We continue to make significant strides in collectively strengthening and stabilising our workforce, ensuring that we have the right staff in place to deliver high-quality community healthcare. Over the past year, our collaborative efforts have led to a reduction in staff vacancies, improved workforce efficiencies, and a more robust approach to managing temporary staffing.

By working together, we are identifying opportunities to optimise our workforce and ensure our services are resourced to meet patient needs, such as utilising the 'Licence to Attend'. This creates more ways for our workforce to collaborate across MSE, improving access to care for our residents and supporting staff development.

The positive progress made this year is a testament to the dedication and collaboration of our workforce teams. By working together, we are creating a stronger, more sustainable workforce that will continue to provide high-quality care for our communities.

How we have involved people

We believe that patient participation is at the heart of delivering high-quality, inclusive, and effective community health services. By actively involving patients and service users in decision-making, service development, and engagement activities, we ensure that our services reflect the real needs of the communities we serve.

This is more than just listening; it's about empowering individuals to shape the care they receive. Through meaningful engagement, we can co-design services that improve accessibility, effectiveness, and patient satisfaction. By integrating lived experiences into service development, we address inequalities and enhance health outcomes across mid and south Essex.

Engaging

MSECC has taken a proactive approach to patient engagement through various initiatives:

- Lakeside Engagement Event: This event provided opportunities for direct patient interaction, including blood pressure checks, and recruitment of patient involvement representatives.
- Braintree Village Engagement Event: A series of community hub days brought together services such as MSE Recovery College, Carers First, and Autism Central.
- Support Groups and Health Networks: Ongoing engagement includes Diabetes Support Groups, COPD patient meetings, the Stroke Joint Patient Voice Group, and community bus outreach targeting seldom-heard communities.

What our patient representatives say

One of our patient participation representatives on the MSECC Committee, Luis Canto E Castro said:

> "Being part of the Committee has given me a real appreciation for how much work happens behind the scenes in the NHS. It's vital that patient voices are included in decision-making to ensure services truly meet the needs of the communities they serve. As a patient representative, I bring lived experience to the table, helping to shape services that are accessible, inclusive, and effective. Having different perspectives ensures decisions aren't made in isolation, and that everyone, regardless of their background or abilities is considered. The only thing I'd change is that we allow more time at these meetings to ensure we get to input into some of the detail, as I still think there is a way to go to make sure all demographic groups are not left out of receiving important services."

Luis Canto E Castro

Looking ahead

Looking to next year we are well positioned to work in partnership with the wider system to support more people in the community, standardise our offer for the population and drive further innovation in our care models.

We know the financial backdrop is challenging and this will drive the necessity to work as one, deliver value and new collaborative models of care. Working with our ICB and partners we will set out an ambitious but prioritised programme of change that enables us to best meet the needs of our population and support a sustainable health and care system for mid and south Essex.

What our colleagues say

Chris Wright
Director of Programmes and Digital Development, Provide Community

"I am a big believer in collaboration and fully support the direction of travel of the MSE strategic plan. I look forward to our MSE-wide meetings. Personally, I am grateful to learn from the people I work with and to tap into the knowledge available to me now. Collaborative working in my experience means putting dents in waiting lists, reducing complaints and better care for patients."

Samuel Owiredu
Interim Deputy Director, Basildon and Brentwood

"Working as part of a collaborative has given colleagues the opportunities to see the bigger picture when it comes to our healthcare system, rather than work in our own areas. It has allowed me to engage with colleagues across all of mid and south Essex, which has helped us develop and innovate together. We've been able to share ideas, tackle common challenges, and learn from each other in ways that simply wouldn't be possible working in isolation. One great example is the Transfer of Care Hub, where colleagues from acute, community, mental health, and social care services are working side by side to improve the patient journey and ensure people get the right care, in the right place, at the right time. It's not always easy, but the benefits for our teams and, most importantly, for patients are clear."

Hannah Bannister
Service lead, COPD, Oxygen, Mid Essex Pulmonary Rehab, Virtual Respiratory Ward and Ambulatory Spirometry Service

"I've developed strong relationships with my counterparts across our partner organisations. We regularly meet to share insights, tackle common challenges, and explore opportunities, which helps us stay aligned with our shared mission of reducing health inequalities across MSE. Our team was also proud to be part of the cardiovascular pilot, a valuable opportunity that has enabled us to grow, learn, and stay connected to local priorities through the Collaborative."

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epunft.communications@nhs.net

Equality and Diversity:
We are committed to meet and provide equitable and accessible care and support for all our patients by working in partnership with you and communicating these needs at the earliest, so that appropriate arrangements could be made.

Mid and South Essex Community Collaborative

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