APPENDIX 2

STRATEGIC PLAN

MID AND SOUTH ESSEX COMMUNITY CARE UNIT

Introduction

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

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

ABOUT THE CARE UNIT

The Mid and South Essex Community care unit provides adult primary and community mental health services in Mid and South Essex alongside community physical health services across South East Essex.

This care unit is part of The Mid and South Essex Community Collaborative which was formed in September 2020 to review how best community physical health services can best meet the needs of local communities.

We have recently implemented a new 'place' based leadership structure with partnership and community delivery directors for South East Essex, Basildon and Brentwood, Thurrock and Mid Essex.

Journey so far

We are part of the Mid and South Essex Community Collaborative, this means that community health services in South East Essex work closely with partner community provider organisations across the Mid and South Essex footprint sharing best practices and working to reduce inequalities across the patch.

There have been many innovations within community health services recently including the implementation of virtual wards and the introduction of the Urgent Community Response Team (UCRT), all supporting people to either stay out of hospital or be discharged from the hospital quicker than they otherwise would have been.

2022 saw the Lighthouse Children's Centre transfer from Mid and South Essex NHS Foundation Trust to EPUT provision providing an opportunity to embed this service in the local community.

Community Mental Health services in this care unit are well on the way in their transformation journey with each old 'CCG' area at a slightly different level of maturity but with all having a mental health specialist presence in primary care working across the system at the neighbourhood level. There is still work to do on this and the transformation of complex care mental health provision to a more strength-based, personalised care model.

Demand

The older adult population in Mid and South Essex is forecast to increase by 8% over the next five years or an extra 18,600 older adults. The increase is not even across all districts; it will be 5.8% in Basildon and Brentwood; 6.2% in Castle Point and Rochford; 8.8% in Mid Essex; 9.1% in Southend; and 8.4% in Thurrock. This population will be more elderly, with associated frailty and co-morbidities and an ageing carer profile.

There are some notable trends in our demand analysis:

- Demand for Dementia Intensive Support has increased strongly from the average monthly referrals for 2019/2020 was 588, for April 2021 onwards the figure was 1182.
- Acuity of cases seen in the First Response Teams appears to have increased between 2019/20 and 2022, with increases in the number of contacts per referral (2.1 to 3.2), in the average total clinical duration (106.9 to 150.9) and in average days on caseload have increased (36.1 to 109.8)
- Referrals and contacts within Integrated Adult Services have remained fairly consistent and slightly lower in Q1 of FY2022/23 than in 2019/20. Patients discharged in FY2021/22 were receiving 2.5 fewer care contacts on average than in FY2019/20 (from 12.5 to 10.0) and were on the caseload for approximately 20% fewer days.
- Acuity of cases seen in Community Podiatry also appears to have increased, as more patients are being seen in the community. There have been increases in contacts per referral (1.63 to 2.67), average total clinical duration per referral (17.28 to 53.65) and average days on caseload (22.52 to 91.32) when comparing 2020/2021 to 2021/2022.

Service user, carer, and family engagement

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

People have told us that they want:

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

Challenges and opportunities

EPUT operates in a complex system and has agreed on formal collaborative arrangements with partners across Mid and South Essex. There remain some barriers to joint working between partner organisations and a need to develop relationships and understanding across clinical teams. For example, staff say that lack of clarity on shared pathways or awareness of partner services can create delays in signposting or referring service users. We need to create new partnerships, such as with local employers, Jobcentre Plus, DWP and service users advocate groups to enhance our support and reflect people's whole needs.

Currently, mental health transformation is underway, with the establishment of integrated primary and community care teams, which may become the front door for mental health referrals in some localities. We need to develop the systems and ways of working to support this.

Mirroring national workforce shortages, there is a high vacancy rate across Mid and South Essex, which can create additional pressure on our teams to meet service demand. Local healthcare recruitment can be competitive, particularly with proximity to London and variable application of the High Cost of Living allowance across the area. Staff say that, at times, they are asked to complete tasks that they feel do not reflect their level of experience due to higher vacancies in some professional groups. Service pressures are having a knock-on impact on staff development, as there is a lack of cover to support training, and some staff say they feel fatigued. With increased demand for services, there is a risk that pressure on staff will increase and that this will affect health, wellbeing and morale.

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

VISION, PURPOSE, AND STRATEGIC OBJECTIVES

Vision

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

Mid and South Essex Community Services will contribute to the delivery of the vision by:

- Delivering high-quality personalised integrated models of care and support for service users, families, and communities to achieve better health and wellbeing outcomes
- Involving carers and families in our services, and ensuring our services are informed by the lived experience of our service users and those around them
- Progressing the work on the place-based clinical transformation that is redesigning the community mental health offer for people with complex care needs
- Supporting the local Alliance priorities
- Working collaboratively with our voluntary care sector (VCS) colleagues
- Supporting more local people to develop successful careers in health and care, and enabling our staff to thrive
- Champion co-production working with the patient experience team, EPUT and local Health Watch
- Supporting the development of new and more flexible roles, able to support people with a broader range of physical and mental health needs
- Continuing with community mental health transformation that creates teams that wrap around primary health networks with the ambition to further integrate these with physical health services.

Purpose

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

Our vision for Mid and South Essex Community Services focuses on bringing our services and partners together to improve services and outcomes for our population. What we do matters, and our plans will make every contact count for our service users, their carers, and their families.

We will strive to support a shift towards greater self-management of long-term conditions and engagement with local community assets recognising the wider determinants of health and wellbeing and how local communities have a role in this. Service users will be empowered to set their goals for recovery, and we will provide care, support, and treatment to help them achieve those goals.

Our plans will ensure we are delivering consistently high-quality care. By joining up services and being more person-centred, we want to improve support for people who experience health inequalities and those whose care may currently be fragmented.

We will learn from the experience of our service users and those around them, especially when things go wrong, and will use our understanding to improve our services. We will support our staff to learn new skills so they are confident in delivering our new model of care and will work with our partners to support learning across organisations.

Our development and well-being offer will enable our staff to thrive by giving them the support they need to achieve their career and health goals.

Strategic objectives

We have four strategic objectives to achieve our vision:

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

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

Values

Our values underpin all that we do:

WE CARE • WE LEARN • WE EMPOWER

New International Recruits at Induction

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

Introduction

We are working to rectify the high staff vacancies and ensure we provide safe, high-quality integrated care. We will work towards eradicating long waits for service users at the Lighthouse Children's Centre. Funding has been agreed upon to clear the backlog of waits alongside the model of care will be reviewed. There will be a focus on the integration of services across local neighbourhoods in the Mid and South Essex Community care unit. A clear mechanism for patients, service users, and carers to understand and receive support as they wait to hear about appointments.

There are well-utilised 'virtual wards' for respiratory and frailty, and we are considering the expansion of virtual wards and wider roll-out also include mental health. There will be a focus on joining-up support for people with several contacts with numerous health, care, and local authority services, including those with a dual mental health and addiction diagnosis and those with complex needs. Virtual wards for remote monitoring have implemented Wizan, the tool that takes all vital signs in patients' homes.

We have developed a Spirometry clinical cabin that focuses on clearing the backlog of patients through the pandemic. All areas in the care unit now have mental health workers in primary care.

As a care unit, we will work closely alongside our local alliances and Primary Care Network (PCNs) to support developing and delivering their strategies.

Our key priorities

- Bringing together strengths across the three providers and sharing learning to improve quality across the collaborative.
- Deliver the National Community Mental Health Framework Agreement with partners including Voluntary (Healthwatch and CVS) Housing Local Authority, Integrated Care Board, community and independent providers, Mind, Rethink and Trust links.
- Integrated neighbourhood teams will support in-reach of specialists and support early intervention and prevention with PCNs and primary care.
- Improve engagement with patients, carers, and families in discussions about the patient's care as standard practice through training, raising awareness and time allocation.
- Eradicating long waits for service users at the Lighthouse Children's Centre by focusing on ongoing recruitment using the recently received funding to support the clearing of the backlog.
- Create a mechanism to inform service users about waiting times before appointments and deliver early advice, information, and signposting to service users as they wait to hear about appointments and how they can best prepare for their eventual appointment.
- Expansion of virtual wards and consider wider roll-out also including mental health.

Spirometry Clinicabin, Rochford

Thurrock First is a vital first point of contact and single point of access for people requiring onward referrals, information, advice and support with their health, mental health, and adult social care needs.

Thurrock First Advisors also undertake assessments and reviews for adult social care (ASC) and ensure that people receive the appropriate support – and in doing so deliver ASC responsibilities contained within the Care Act 2014.

Thurrock First acts as a referral point for people requiring community health and mental health support – ensuring that referrals are sent to the correct teams and services so that the appropriate health support can be arranged and delivered.

Several of the referrals dealt with are time critical and require immediate action due to the level of risk or needs of the individual such as they are receiving end-of-life care. Without Thurrock First carrying out its role, there would be delayed discharges from hospitals, increased admissions, residents placed at risk of harm, and increased demand for other health, mental health, and adult social care services.

How will we measure success?

- **Recovery / Goal attainment score.**
- **Reduced crisis in community caseload.**
- **Reduced admissions/readmissions in community caseload.**
- **% Cases with high-quality care plans completed with user involvement.**
- **User, carer, and family experience.**
- **Users and families feel safe in EPUT's care.**
- **Reduction in serious incidents and self-harm.**
- **Staff survey – health and safety.**

What will be different?

Mid and South Essex Community care unit will move from the traditional way to a more individualised care approach and work with partners to join-up health, care, and community services.

We will be committing to clearing the backlog for the Children's Lighthouse Centre in Year 1.

People with mental health problems will have access to support, care, and treatment promptly, no matter where or how they seek that support.

Each time a person has contact with our mental health services, we will consider all their needs and develop a plan that helps them to achieve their own goals. Staff will work holistically reducing the burden on the individual to attend multiple appointments.

Teams will be connected across health, care, and community services to help people to access the necessary support, whether they need health, care, housing, or other support. Those teams will share information meaning people won't need to repeat their stories.

Within neighbourhoods, integrated primary care and community services will support feeling well, by identifying more mental health problems earlier and providing support that prevents those problems from becoming more serious. More people will be able to see specialist mental health professionals in primary care for both assessment and support.

Services will provide high-quality risk assessment, care planning, and ensure service users and those involved in their care are clear on the plan. Plans will support people to live well in their communities and enable service users and staff to take positive risks that support ongoing recovery.

There are options to create space in services keeping patients at home where appropriate the development of integrated workforce(s) with partners will help to reach patients and families.

Family and carers will be actively involved in caring for their loved ones. They will be able to share their concerns and other information with services and know whom to contact when their loved one is admitted to our services. Subject to the individual's agreement, they will be involved in conversations and decisions about their loved one's care allowing us to deliver safe, quality care.

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

Introduction

We know that staff recognise that different skills and roles are required in their teams to meet the population evolving needs to provide holistic person-centred care. We want to increase the range of skills in our multi-disciplinary teams (MDTs) and address current variations in access to some professionals, such as Allied Health Professionals and social workers, across teams. There is an opportunity to develop a more flexible, multi-skilled workforce to support a broader range of needs.

Staff will be encouraged and supported to thrive in their work roles and their roles as part of the communities. Staff will be supported to achieve and maintain good health and well-being, whatever that means for them. They will be able to access development programmes that help them achieve their goals. Strong teams will support each other, creating a sense of community at work. Teams, managers, and the wider organisation will celebrate their successes and recognise their effort.

Regarding recruitment challenges, we will be supporting the local workforce and apprenticeships. We will be actively supporting the corporate divisions at recruitment fairs and assisting where possible to encourage applications into our care unit. We plan to create a supportive culture in the care unit that will be an enjoyable and interesting place to work. We will encourage flexible working options for all staff allowing for work-life balance.

There needs to be consistent standards and policies across the organisation, as it will give staff greater clarity and support them to work more flexibly across teams and geographies. There will be transparent mechanisms for staff to provide feedback and contribute to improving policies and procedures.

The new partnership directors' roles have been a good start for integrated working. The Partnership Directors across the care unit bring together community mental health and physical health together in place, encouraging the building of strong relationships and collaboration across Mid and South Essex.

Our key priorities

- Continue and consider expansion with rotational posts within Mid and South Essex and across care units to both attract staff and develop experience expanding across professions and bandings.
- Robust supervision and all staff to take part in the Pen Plan appraisals.
- Streamline policies and procedures; improve mechanisms for staff to feedback on them.
- Support the development of more flexible unregistered roles and competency framework for the modular development of skills for integrated care.
- Ensure an open supportive culture for staff, enabling a resilient and compassionate workforce through robust supervision by people in leadership positions, Mid and South Essex will support the Trust Strategy around cultural priorities.
- Making staff aware of the mechanisms of support available to them.
- Developing express working with the people and culture team and developing managers to support and lead happy and high-performing teams.
- Creating an inclusive culture of calling out poor behaviours, bullying, discrimination, and the freedom to speak up.
- Facilitation of joint working in collaboration (Human Learning System).

In South East Essex, we have developed a new Service Manager role to lead on older adult mental health, dementia, and frailty in the community. This bring together the Community Health Care Coordination and the Dementia & Older Adult Community Mental Health Services. which integrates both physical and mental health professionals into one service. This approach to MDT working supports early intervention and prevention as the staff have been upskilled to identify arising mental or physical health issues with their service users and manage or quickly share colleagues as appropriate. This supports the patient to be seen by fewer health care professionals, alleviates delays in care from referrals across teams, and causes less repetition of care; all of which improves the quality of service the person receives.

Across Mid and South Essex, FrEDA (Frailty, End of Life, Dementia Review and Assessment Template) is a new personalised care planning and support template within SystmOne that we have developed to support care coordination of our older adults. The template is adopted by all providers and localised to alliance need. It enables team members involved in an adults care within the FrEDA targeted cohort (Frail and/or End of Life) to easily review previous interactions and interventions to reduce duplication and open communication across physical and mental health professionals involved in their care. This improves MDT working and early intervention and is not only available to Mid and South Essex colleagues, but also to GPs. Staff can access training on FrEDA through the Mid and South Essex training platform.

How will we measure success?

- **Reduced vacancy rate.**
- **Improved retention.**
- **Increased recruitment from the local community.**
- **Increased uptake of, and satisfaction with, training and development.**
- **Staff experience.**
- **NHS Staff Survey – staff engagement theme.**

What will be different?

Mid and South Essex Community care unit will make a clear offer to current and prospective staff, which includes development and well-being support to allow each other to be the best we can be.

It will include a clear preceptorship offer for newly qualified staff, which develops their confidence and skills and offers opportunities for further learning and qualification. The staff will feel well-supported and happy at work, reducing the number of staff leaving the organisation, particularly in the first 1-2 years. There is also an opportunity to increase entry to the workforce through improved earn-and-learn opportunities, such as apprenticeships and sharing internally created videos such as “a nurse’s day” for potential recruits to grasp what the role looks like in reality. Provide has a trainee embarking on a traineeship in September 2022. It would be noteworthy to discuss their experience during the 12 weeks and if anything can be improved or adapted to encourage further traineeships.

The staff development offer will enable staff to develop the skills necessary to deliver holistic person-centred care. Offering support to staff to build experience and nurture relationships across a variety of settings will ensure they are well-equipped to support joined-up care. It will allow staff more time to care, reflect and complete training and development.

To allow clinical staff to make the best use of their time, they need improved processes and systems with more administrative and support roles positions.

Managers will look at balancing face-to-face and digital meetings to decrease digital fatigue among staff. EPUT is to implement an independent collaborative organisation panel allowing the line manager and the staff member to state their cases/reasons that would eradicate any bias around requesting flexible/condensed working hours with Mid and South Essex.

Mid and South Essex Community care unit will be well supported and encouraged to promote opportunities in their teams and to recruit for vacant positions with support from Corporate HR Teams. The recruitment campaigns will reach the community, and people who are interested in health and care careers will be able to learn more about roles and opportunities and how to apply.

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

Introduction

EPUT operates in a complex system. EPUT has agreed on formal collaborative arrangements with partners in Mid and South Essex. The Mid Essex Rough Sleeper Initiative Outreach Service, covering Epping and Braintree, was presented with the Working in Partnership award at the recent Essex Housing Awards.

There is a need to remove the current barriers that exist between partner organisations; some exist due to the lack of communication as to whom they're partnered with. The is an overlap with some services, and staff are keen to remove this barrier and exist side by side, empowering each other and recognising that they are all one organisation moving in the right direction with community collaboration.

Currently, Improving Access to Psychological Therapy (IAPT) services are provided by EPUT in the South East only, we are trying to improve relations by involving IAPT and exploring different mechanisms to build a strong integration across IAPT and secondary mental health.

We are joint working with acute hospitals supporting discharge and hospital admission prevention. We also have posted in our urgent community response team supporting the East of England Ambulance Service by having patients sent to them than having an ambulance sent out to the patient.

Our key priorities

- Work with our place to develop effective transfer of care hubs - (TOCH) will be in each locality, a national requirement which will assess patients for discharge and refer them to the best out-of-hospital setting and support package.
- Agree on a common endeavour with local providers and partners to build collaborative structures at place.
- Working with our internal partners across EPUT.
- Endeavour to create a culture of open communication with colleagues across the health and care system.
- Explore the application of Time to Care across community services to reduce the bureaucratic burden to release time for staff to care for their patients.
- Support a diverse approach to partnership working with local authority/Integrated Care System/social care and voluntary organisations.
- Working closely with our Alliance colleagues and supporting the development of the PCN strategies – Mid has appointed 3 neighbourhood programme managers via Essex County Council/Provide/Alliance to deliver the neighbourhood integration. Mental health will be included in this.
- Exploring joint posts with the voluntary sector e.g. Trust Links in South East.
- Continue the community collaborative work around levelling up across Mid and South Essex in community adult and children's services.
- Support the roll-out of open dialogue training as funded by the Health Inequalities Fund, which aligns with the already agreed principles of Human Learning Systems.

In the Thurrock locality, EPUT has fully established a Primary Care Mental Health service that are integrated within the PCN's working closely with GP's and partner organisations. The service offered an assessment and treatment opportunities for service users who been referred. This service has enabled prompt assessment between one to three days which has meant that service users been getting a rapid consultation and follow-up where needed.

The Primary Care Mental Health service is closely aligned with various services across Health, Social and voluntary, community, social enterprise (VCSE) organisations to ensure smooth pathways are in place that enable transfer of care or additional support required to meet service user's needs. The service also focuses in ensuring those with mental health needs have a holistic review which include physical well. The team operation will continue to develop in line with the Integrated Primary and Community Care (IPCC) transformation programme.

The success of the Primary Care Mental Health service is already being recognised in the locality with GP's and Service Users expressing satisfaction with the prompt and high standard of interventions that the residents are receiving.

How will we measure success?

- **Creation of care hubs.**
- **Agree common endeavours with partners.**
- **Develop further partnerships within the system.**
- **Supporting PCN strategies.**
- **Creation of joint posts with the voluntary sector.**
- **Deliver on the levelling up plan.**

What will be different?

We will enhance the current partnerships and build new relationships with other services that enable us to support people to recover and live fuller and more rewarding life.

Staff will be encouraged to build on all relationships allowing us to provide joined-up care.

We will continue to work with their existing partners and build on new fluid relationships within the system. We will partner with social care, housing, and voluntary organisations, realising the deeply rooted relationships will allow the collaborative to do away with the power imbalance and recognise that all providers add value.

We will continue to drive the development of integrated neighbourhoods, by working with our partners in primary care, local authorities, and voluntary and community services. We will focus on developing our partnerships with voluntary, community and social enterprise partners to help us increase our holistic services offer and our connection to our communities.

We will be affirming and creating new partnerships, such as with local employers, Jobcentre Plus, the Department of Working and Pensions (DWP) and service users advocate groups to support patients, service users and carers. This will enhance support delivery moving forward with the added element of focusing on existing relationships with partners.

Our partnerships will support colleagues in developing their skills, relationships, and confidence to "make every contact count". Mid and South Essex will explore opportunities for shared workforce approaches, joint learning programmes, and the colocation of our teams like the Thurrock model.

STRATEGIC OBJECTIVE 4:
WE WILL HELP OUR COMMUNITIES TO THRIVE

Introduction

Mid and South Essex Community care unit strategy is committed to addressing the wider determinants of health, such as housing, education, and income through our Partnership, recognising it takes everyone to join forces and tackle inequalities if it's to make a real difference. This includes addressing increased mental health prevalence, suicide, deprivation, educational attainment, and obesity within our population.

Basildon has led the way in employment and recruitment by working with Essex County Council to support people with learning difficulties to enter the workplace. Thurrock Council has worked with North East London NHS Foundation Trust to develop a new shared vision of an integrated front-line health and care worker, with a defined career pathway. These posts are being recruited to and have proved very popular in offering a new career choice where carer jobs were seen as unpopular. Essex County Council is starting work on how to explicitly recruit from more deprived areas, recognising that there are barriers to accessing work that will need to be addressed.

With the significant workforce challenges, partners are recognising the importance of working with our schools to address aspiration and employment issues, particularly in more deprived areas. The Essex Children's Partnership Board, including head teachers, has endorsed this approach. Basildon Hospital has embarked on an outreach programme to local schools to help improve interest and recruitment to NHS roles.

Our key priorities

- 'Grow our own workforce' initiatives including school/college engagement, work experience and apprenticeship offers.
- Continued focus on levelling up and reducing health inequalities across Mid and South Essex, we will engage a variety of initiatives and support identified by place.
- Support staff to thrive through a staff well-being offer, that includes practical and emotional support and financial well-being.
- With partners, focus on suicide prevention, including developing awareness and skills outside of mental health services.
- Actively involving carers and families in conversations about services and hearing their voices.
- Making Mental Health services more accessible by offering them from an increased number of locations so people don't have to travel to a particular place.

Rough sleepers service

The Southend Rough Sleepers Mental Health Team (RSMHT) provides specialist multi-disciplinary assessment and interventions for rough sleepers within Southend. The team works with people rough sleeping on the streets, people residing in supported accommodation provided by the local rough sleepers' network, and with people living in temporary accommodation as part of a housing rough sleeper initiative. Individuals who access the service typically have complex needs, often with concurrent drug and alcohol use. One service user who was recently suicidal and was supported in collaboration with colleagues within the rough sleepers' network stated that *'if I was still on the streets I'm not sure whether I would still be alive, … I now see a glimmer of hope!'*

How will we measure success?

- **% Staff recruited from local communities.**
- **Apprenticeships offered, utilisation of apprenticeship levy.**
- **Improved staff survey result – health and safety domain.**
- **Staff satisfaction with development and health and wellbeing offers – duplicated above.**
- **Improved suicide awareness.**

What will be different?

Mid and South Essex Community care unit will attract more local people into good quality work in health and care roles and support people to develop their skills for a successful career in this sector. Local people, particularly young people, will be able to learn more about roles and opportunities in health and care through engagement with schools, colleges and local communities supported by EPUT. People considering health and care roles can try out positions through work experience and volunteering opportunities. There will be more opportunities for people to learn and qualify whilst working through an expanded range of traineeship and apprenticeship programmes.

Services will use family-led decision-making approaches, such as Family Group Conferencing, that give families and their wider support networks the opportunity to find solutions. Specialist Services will encourage and enable families and carers to actively support their loved ones when they return home, including providing education about relevant health issues.

APPENDIX 1: POLICY CONTEXT

To ensure EPUT's strategy supports its partners' aims and ambitions, we have reviewed the strategies of EPUT's partners across Essex, Southend and Thurrock, as well as national policy for mental health and community services. Both national policy and partner strategies reflect similar themes about how health and care services need to change to meet the current and future needs of the population.

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

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

Category	Deliverable
Adult Common Mental Illnesses (IAPT)	IAPT-LTC service in place (maintaining current commitment) year-on-year (routine outcome monitoring)
Adult Severe Mental Illnesses (SMI) Community Care	Delivery of the Early Intervention in Psychosis standard
Adult Severe Mental Illnesses (SMI) Community Care	390,000 people* with SMI receiving physical health checks by 2023/24
Suicide Reduction	Deliver against multi-agency suicide prevention plans, working towards a national 10% reduction in suicides by 2020/21
Suicide Reduction	Localised suicide reduction programme rolled-out across all STPs/ICSs providing timely and appropriate support
Suicide Reduction	Suicide bereavement support services across all STPs/ICSs by 2023/24

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