APPENDIX 3

STRATEGIC PLAN

NORTH EAST 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 North East 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 North East Essex Community care unit provides primary and community mental health services across Colchester and Tendring districts, as well as three trust-wide services: perinatal mental health; children's learning disability service (CLDS); and Allied Health Professional (AHP) services. The footprint of the community and primary care services is aligned to the North East Essex Alliance, one of three 'places' in the Suffolk and North East Essex Integrated Care System (ICS). Integrated primary care services are aligned to the six neighbourhoods within North East Essex.

Journey so far

Over the last two years, the care unit has transformed its community services from a cluster-based to a place-based approach, supporting alignment and integration with system partners. EPUT has led the development of neighbourhood teams within the place-based Alliance partnership and established six integrated neighbourhood teams aligned to Primary Care Networks (PCNs).

The place-based primary and community teams have developed positive relationships with a range of system partners, including voluntary sector partners with joint initiatives in place with The Haven, Community 360 and Tendring CVS. The trust-wide perinatal service is one of the highest performing perinatal teams in England, and had excellent peer review against CCQI Community Quality Standards in 2021. The Children's Learning Disability Service has continued to develop, and expanded provision of its specialist intervention for sensory impairment into South Essex.

Demand

The care unit has seen large increases in demand and activity. Perinatal services have seen a near three-fold increase in demand between 2019/20 and 2021/22, and referrals to the Single Point of Access in the first six months of 2022/23 increased by 20% on the same period in 2021. Overall demand resulting from population growth in North East Essex is forecast to grow relatively modestly, increasing by 4% between 2023 and 2028. Within this, we expect significant demand for services for people aged 18-25, particularly in Tendring. The older adult population will increase by 9%, or 7000 additional people. This population will be more elderly, with associated frailty and co-morbidities and an aging carer profile.

There are some other notable trends in our demand and capacity analysis:

- Demand for second Improving Access to Psychological Therapies (IAPT) treatments has increased, and with it the average wait between the first and second treatment has significantly increased
- Across the Trust, there has been a notable increase in the prevalence of eating disorders, and there is a lengthening waiting list for this service
- Average number of contacts and clinical time has increased for people using perinatal, community dementia and specialist mental health services, suggesting higher complexity
- There has been a decline in the numbers of people coming forward for dementia and memory services, suggesting that there may be unmet need
- The North East Essex Older Adults Home Treatment team (Urgent Care and Inpatient Care Unit) has seen a significant decrease in referrals received compared to pre-pandemic levels.

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 about their 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 while waiting.

Current challenges and opportunities

Community mental health services provided by EPUT are not currently integrated with physical health services. We have established a new collaborative arrangement with other community providers in North East Essex to support integration, but have not yet agreed the future model of community care with our collaborative partners. There is also more to do to develop positive relationships with primary care networks and strengthen our neighbourhood model.

There are significant health inequalities in North East Essex, reflected in large variation in life expectancy. Jaywick in Tendring is the most deprived area in the country, and there are other pockets of deprivation across the area. Both Colchester and Tendring districts have some of the highest rates of suicide in England, as well the highest rates in Essex of admissions to hospital for intentional self-harm, and detentions under the Mental Health Act. Tendring represents the highest Employment and Support Allowance claimants for mental and behavioural disorders per 1,000 working age population in Essex. The Suffolk and North East Essex Population Health Management programme identified progression of mental health need with age from anxiety and conduct disorders among teens to crisis, psychosis, self-harm and eating disorders.

There are high vacancy and staff turnover rates within North East Essex. Together with national workforce shortages, this has created staff shortages across professional groups and services, particularly for registered nurses and social workers. Recruitment and retention challenges are mirrored nationally in coastal areas with high levels of local deprivation. 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. The workforce is becoming relatively less experienced as staff leave.

Staff shortages mean that a proportion of the caseload is allocated to a named member of the management team. Through our significant work to monitor and support flow and capacity, we know that the gap in allocation is directly linked to the number of vacancies in the team. The impact on staff experience leaves staff feel fatigued or under pressure in their roles. Some lack time to reflect, and unable to undertake non-mandatory training and development, to engage in improvement and transformation initiatives or to build relationships across services and teams.

Waiting lists have significantly improved in the care unit and this requires constant review to maintain flow and capacity. The care unit has been able to learn and improve from patient experience and learning from patient incidents and has had positive feedback from the ICS quality lead and the CQC around the grip and management of the waiting lists.

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

Key risks for the care unit include:

- Recruitment and retention; and recruitment at pace leading to inexperienced staff
- Management and mitigation of waiting lists, including high Children's Learning Disability Service demand and waiting list
- Allocation of community caseload
- Back to basics care processes and coordination
- Staff wellbeing and recovery
- Access to data and real-time clinical information, including lack of interoperable systems
- Relationship between EPUT and PCNs
- High access rates for specialist services, and interventions not keeping pace with demand
- High levels of safeguarding cases with complex needs
- Community capacity impacting ability to step back cases to community mental health teams.

VISION, PURPOSE, AND STRATEGIC OBJECTIVES

Vision

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

North East Essex Community care unit will contribute to delivery of the vision by:

- **Bringing more specialist mental health services into neighbourhoods:** We will align our specialist services to neighbourhood, in a way that reflects the needs of each locality and addresses health inequalities
- **Developing integrated person-centred community services with our partners:** We will work with our partners in the North East Essex Integrated Care Collaborative to bring together our services. We will develop a single care coordination centre, so that there is "no wrong door" and together we make every contact count for better health. We will develop our skills to deliver integrated care, with a focus on physical healthcare skills, trauma-informed care, digital skills and strength-based practice
- **Providing a leading perinatal mental health service:** We will continue to deliver a nationally high-performing perinatal mental health service and to inform further service development and quality initiatives at a national level
- **Reducing inequalities in access to healthcare and health outcomes:** We will reach into communities who experience health inequalities and develop initiatives to promote good health and improve access to healthcare.

Purpose

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

Our care unit vision for focuses on bringing together our services with our partners to improve access and health for our population. We will work together with lived experience to design and deliver our services. Every contact we have with people and communities matters. By working together, we will make every contact count for more and ensure our services wrap around the person and their needs.

We will take a trauma-informed approach to our care and with our staff. This means we will care compassionately, recognising the widespread impact of trauma and avoiding retraumatising people. We will support our colleagues across the system to understand and recognise trauma, and to learn from our trauma-informed approach.

We will support our staff to learn new skills and be confident in this trauma-informed approach and in delivering new integrated services. We will work with our partners to share our learning across organisations, and to build their skills and confidence in supporting people with serious mental illness, with trauma and those at risk of suicide.

We will support more local people into health and care roles. Together with our partners, we will support people to develop successful careers in the health and care sector including through training, qualification and the option to move more easily between health and care opportunities.

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 with our partners to join up our services for local people in North East Essex through the North East Essex Integrated Care Collaborative and North East Essex Alliance. Across Essex, we are working with partners to integrate services for expectant and new parents and for children with a learning disability. We will bring more of our specialist mental health services into local neighbourhoods, ensuring that those services reflect the needs of each locality. With our partners, we will bring together our information and our care coordination so that we wrap our services around the person. Learning from our staff and services users, we will continue to improve the quality of our care and will develop our high performing perinatal mental health service as a national leading service.

Our key priorities

- With partners, develop our integrated neighbourhood teams, with in-reach and alignment of specialist mental health services to neighbourhood profiles, and support targeted inequalities projects, including drug and alcohol, health and housing, family outcomes primary care.
- Develop trauma-informed care for service users and staff and support the system in taking a kind and compassionate approach to trauma, working with HealthWatch to introduce Trauma Cards and a structured supervision approach to trauma and complex care.
- Deliver an integrated care co-ordination centre, supported by interoperable information systems, and explore new ways of integrated working as part of the North Essex Integrated Community Collaborative and a key stakeholder in the North East Essex Alliance.
- Continue to work collaboratively with Suffolk and North East Essex ICS, social care and Therapy for You to support and manage the waiting lists for intervention in North East Essex, and provide a single point of access.
- Introduce the Outcome Based Accountability Approach to review the quality of our services, and continue our focus on getting the basics right in our care planning and clinical processes, and on learning lessons across the Care Unit.
- Develop the systems and skills to use high-quality, real-time clinical information in management of caseloads, and introduce predictive analysis tools to identify people at risk of deterioration and crisis.
- Continue to provide a high-quality perinatal service nationally, working collaboratively with each ICS and aligned maternity services, and inform further service development and quality initiatives at a national level.
- Work collaboratively with each ICS, child and family services and local education authorities to provide high quality children's learning disability provision and maintain strong links with neighbouring commissioners to extend learning disability business opportunities.

Harwich Place Based Pilot

We are working with the local community and voluntary sector to support local service delivery according to need in EPUT base. This includes supporting food bank and Citizens Advice Bureau and having co-located clinics in local areas. We are taking a new approach to assigning and managing the Harwich case load across a small team, rather than on an individual basis.

Non-Complex Primary Care Service

We have successfully recruited workers based within primary care to support those with non-complex needs. This right place, right time local support is helping to prevent more serious mental illness, and has led to very low numbers stepped up to local treatment teams.

Perinatal Hubs

We have developed five perinatal hubs aligned to the five acute hospitals. Our peer support initiatives are supporting the whole family in the local area.

How will we measure success?

- **Positive user, carer and family experience and representation in transformation and service reviews.**
- **Staff feel safe at work.**
- **Attainment of user-defined goals and improved outcomes.**
- **Reduced crisis and admissions from community caseload.**
- **Care plans are high-quality and include user-defined goals.**
- **Reduction in serious incidents and self-harm.**
- **Reduction in staff burnout.**
- **Management of waiting lists.**

What will be different?

We will work with partners to join up health, care and community services and ensure there is “no wrong door” to care and support. An integrated care coordination centre will bring together our place-based services with our partners to ensure that people receive the right care at the right time from the right person or people. Joined up information systems will enable us to share information, coordinate care and communicate better with the people we serve.

We will continue to work collaboratively with our partners to develop our community specialist services. We will continue to increase access to and deliver a high-quality perinatal mental health service and outcomes.

We will identify more mental health problems earlier and more people will be able to access specialist assessment and support in primary care that prevents those problems becoming more serious. We will continue to improve access, and reduce waiting times, for specialist interventions.

Digital technology will support our clinical teams to identify people who have increased need or are at risk of deterioration and to offer earlier intervention to prevent poorer health.

We will take a trauma-informed approach across our care unit and support awareness and adoption of trauma-informed care across the wider system. Trauma Cards will identify individuals needs and stories, ensuring we provide compassionate care and do not retraumatise people.

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

Introduction

We will build our team by supporting more local people to develop successful careers in health and care, introducing new roles and developing joint workforce models with our partners. We will create a caring and compassionate culture, where our staff can thrive and are supported to learn and grow. We will use a trauma-informed approach and restorative supervision, to support our staff to feel safe, supported and listened to. We will support our staff to develop their skills for integrated care delivery, with a focus on physical healthcare, digital skills and strength-based practice in line with Asset-Based Community Development (ABCD).

Our key priorities

- Recruit community apprentice roles within the care unit to "grow our own workforce" with a commitment recruitment from the local area, and build on the positive experience of Kick Start recruits moving into substantive clinical and admin roles.
- Develop a place-based approach to recruitment, linking in with local colleges, schools and employment fairs in North East Essex, and support development of a Suffolk and North East Essex employment passport, enabling people to remain and build their experience in local health and care roles.
- Embed implementation of a restorative supervision approach to staff wellbeing, which supports practitioners at all levels with the time to think and make decisions to support safe transition, care and support plans and safety planning. We will take a trauma-informed approach with staff.
- Take a learning approach to leadership, being honest and open when we don't get things right and try to make them right, and work with our leadership team to understand our impact on others and how we can strive to better support our communities and staff.
- Set out an attractive development offer for staff, which supports people to enhance their skill set in line with community transformation, including physical health care skills to support our "making every contact counts" approach.
- Develop enhanced multi-disciplinary team working across our services to ensure we have the right range of skills and experience to support individualised care.
- Explore development of new joint roles with the voluntary sector within our integrated neighbourhoods and develop peer support worker and care navigator roles, and provide joint approaches to supervision for our partners, such as social prescribers, to support their work with people with serious mental illness.
- Increase digital literacy and develop digital skills and leadership across the care unit, to support a digital-first approach to transformation, working with the corporate digital team.
- Review the effectiveness of AHP roles and services across the organisation and ensure they are fit for purpose.

Restorative Supervision

We invested in restorative supervision training and supervision within the care group to support residence within our teams. With the support of a leadership consultant, this helped us to learn and understand the impact on the leadership team looking at burn out and dehumanisation.

Perinatal flow

We went back to basic and used a flow and capacity lead to understand what we were doing well and what we needed to improve.

Joint Supervision

We have created a mutual agreement with Community 360 and Tendring CVS, EPUT provide clinical supervision for social prescribers in return for joint group facilitation.

How will we measure success?

- **Reduced vacancy rate and increased substantive staffing.**
- **Improved retention.**
- **Increased recruitment from local community.**
- **Increased uptake of, and satisfaction with, training and development.**
- **Staff and volunteer experience.**
- **Reduced staff sickness, and increased update of wellbeing support.**
- **Development of new AHP roles.**

What will be different?

We 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. There will be more opportunities for people to learn and to qualify while they are working, through an expanded range of traineeship and apprenticeship programmes.

Local employment passports, developed with our partners in Suffolk and North East Essex, will enable people to move more easily between health and care roles in different organisations. This will help people build a range of experience while retaining skills and knowledge in the health and care system. It can also support a more flexible approach to developing new services or when services are under pressure.

Staff will be supported to thrive within a caring culture, and with a clear offer to support their learning and wellbeing. Staff will be supported to build their skills, experience and their relationships, so that they are well-equipped to support integrated care and to use technology to enhance their practice.

Staff will feel well-supported and happy at work, and more staff will stay working in our services.

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

Introduction

We are committed to strengthening and growing our partnerships - with service users, communities, health and care organisations, local authorities, education, community and voluntary organisations and other public services - to improve health and healthcare. We will introduce new lived experience roles and commit to designing and delivering our service in partnership with our people and communities. As a key partner in the development of the North East Essex Integrated Care Collaborative, the North East Essex Alliance and local neighbourhood teams, we will seek opportunities to improve our services and capabilities together.

Our key priorities

- As a key partner in the North East Essex Integrated Care Collaborative, identify and pursue opportunities for formal and informal integration and develop a multi-agency integrated care coordination approach.
- Introduce lived experience roles within our local transformation and review projects, to ensure co-production in design and development of our services.
- Work with HealthWatch Essex to implement Trauma Cards across all care unit services, making every contact count and reducing the need for people with trauma to repeatedly tell their story.
- Be a key partner in development of integrated neighbourhoods and in the North East Essex Alliance, including leading on the Feel Well domain across our place.
- Provide learning and support to our system partners to help our colleagues feel more confident to work with people with serious mental illness.
- Train our team in the ABCD approach to strength-based practice and continue to work with community mental health transformation, recognising community assets, voluntary sector and the person as key stake holders.
- Working with local acute maternity hubs, develop our perinatal services and use digital technology and apps to support self-care and resilience.

Partnership with voluntary and community organisations

We are working with voluntary sector partners across North East Essex, to improve our care and support to local people.

Age UK has taken over the dementia support line from EPUT, and this is supporting transformation of other services.

Community 360 and Tendring CVS are providing safe warm spaces for people in our Assertive Outreach service.

The Haven is offering intensive discharge support for people North East Essex with complex trauma who are transitioning from inpatient services.

Community 360 and EPUT are working together to provide a patient support group for people on our waiting list.

How will we measure success?

- **EPUT recognised as a key stakeholder in neighbourhood teams.**
- **Increased partner and community confidence in EPUT.**
- **Positive experience of lived experience roles.**
- **Number of users and staff with a Trauma Card.**
- **Implementation of the Community Framework.**
- **Shared performance and outcome targets are met.**
- **Staff being able to move around the ICS.**

What will be different?

Our services will be developed in partnership with people who have lived experience of our services and mental illness.

Through the North East Essex Integrated Care Collaborative, we will join up health, care and community services. We will develop an integrated care coordination model, which ensures there is “no wrong door” to care and support.

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

Working with our partners in primary care, local authorities, voluntary services and communities, we will develop vibrant neighbourhood services, which reflect the populations they serve.

We will recognise the voluntary, community and social enterprise sector as key partners in developing strength-based practice and connect our service users with community assets and services to support them.

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

STRATEGIC OBJECTIVE 4:
WE WILL HELP OUR COMMUNITIES TO THRIVE

Introduction

There are significant health inequalities in North East Essex and the people we see in both our perinatal mental health service and children's learning disabilities service are likely to have poorer health outcomes than the rest of the population. We want to level up opportunity and health outcomes in our population. We will build on our successful outreach and community support projects, and work with our partners to identify inequalities and develop initiatives to promote good health and improve access to healthcare.

Our key priorities

- Continue to work with our partners to identify inequalities across our neighbourhoods, perinatal services and children's learning disability services, and be key partners in the levelling up agenda within the North East Essex Alliance.
- With partners, continue our focus on suicide prevention, and support our colleagues outside of mental health services to develop their awareness and skills to identify and support people in distress and at risk of harm.
- Continue to highlight marginalised groups, including BAME, transient and travelling communities, and develop our outreach to difficult to engage groups including through the Shelter & Health EnListing Local Support (SHELLS) project, Harwich place-based pilot and ongoing projects in Jaywick Sands.
- As key partners in the neighbourhood teams, identify and develop prevention initiatives and offer advice, support and intervention for cases highlighted by our multi-agency partners.
- Work with our communities in areas of high violence and drug and alcohol use, to reduce risk of mental ill health and support good health and emotional safety, including through our support to the Nights of Safety, and working with the police and district and city councils.
- Offer good quality work and development opportunities for our local population through targeted local recruitment, and expanding apprenticeships.
- Recognise the voluntary sector as a key provider in the mental health framework and support the cultural shift in our communities, providers and staff that the voluntary sector are a trusted partner to support our communities and are indeed often best placed to do so.
- Support our teams to support and signpost to community assets and stop the practice of "not for us" and bouncing referrals, by developing our service directories and supporting staff to build relationships across community organisations.
- Use informal and formal data derived from multiple stakeholders to provide intelligence of community and place based need and use the trusted knowledge of local community connectors to support development of services.

SHELLS SOS Bus

The SHELLS (Shelter & Health EnListing Local Support) SOS bus is an award winning outreach service, designed

to support the homeless community in North East Essex. It operates with partner agencies to provide access to health, advocacy, mental health nursing, social prescribing, housing authority outreach teams, drug and alcohol support and signposting to all other local services. The SOS bus was piloted in Clacton at the end of 2020 and extended to Harwich, helping more than 650 people in its first year. The SHELLS SOS bus won the Health Equalities Award in the national finals of the NHS Parliamentary Awards 2022.

Community Support initiatives

The Tendring Team provided debriefing and support sessions to the local district council after a beach drowning, to the search and rescue team.

EPUT worked with Community 360, local police and trading standards officers on a night of safety in Colchester city centre.

Through neighbourhood data we identified a local car park as a suicide hotspot. We worked with local police and ICP car parks, Samaritans and Chelmsford City Council to problem solve and support development of security and support.

What will be different?

We will continue to work with local authority, NHS, voluntary and community services to reduce health inequalities across North East Essex.

We will develop new service models that reach into communities, and ensure that services are accessible and sensitive to the needs of communities. This will include further drop-in or pop-up services, such as the SHELLS SOS bus, a partnership providing support to some of the most vulnerable people in Tendring.

Perinatal services will continue to monitor demand across the ICS and identify localities with high demand and identify early intervention to reduce health inequalities in mothers from marginalised communities.

We will attract more local people into good quality work in health and care roles, particularly people in our more deprived communities, and support people to develop their skills for a successful career in this sector.

Communities and the services supporting them will be more aware of the signs of distress and suicidal behaviour, and be better equipped to support people when they are in distress and at risk of harm.

How will we measure success?

- **Reduced disparity in access, experience and outcomes by demographic group.**
- **Improved suicide awareness in partner service and communities.**
- **Shared objectives for suicide reduction achieved.**
- **Positive user and staff experience of working with commissioned voluntary sector in mental health pathway.**
- **Increase in access to voluntary sector referrals.**
- **Increased joint employment initiatives.**

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**.

For community mental health services, the **Community Mental Health Framework** (CMHF) introduced a place-based community mental health model from 2021/22 and will replace the Care Programme Approach. The framework was tested in pilot areas, including West Essex, during 2020/21.

The CMHF describes services being provided at two levels:

- **Core service at neighbourhood level** bringing together mental health support in primary care, secondary care community mental health teams and residential settings. It includes consultation and care delivery as well as advocacy, education, employment, financial advice, housing, support groups.
- **More complex care at place level** including crisis, inpatient and specialist residential care, as well as intensive and assertive care for people at risk of exclusion from their community, including rough sleepers, people leaving the criminal justice system and complex needs.

A NHS England position statement on the **Care Programme Approach (CPA)** in 2021 stated the intention is to "shift away from an inequitable, rigid and arbitrary CPA classification and bring up the standard of care towards a minimum universal standard of high-quality care for everyone in need of community mental healthcare."

It emphasises five principles:

- Meaningful intervention-based care
- A named key worker for all service users with a clearer MDT approach
- High-quality co-produced and holistic personalised care and support planning for people with severe mental health problems living in the community
- Better support for and involvement of carers
- A much more accessible, responsive and flexible system.

The **NHS Long Term Plan** makes the following commitments relevant to North East Essex Community care unit:

Category	Deliverable
Adult Common Mental Illnesses (IAPT)	IAPT-LTC service in place (maintaining current commitment) year-on-year (routine outcome monitoring)
Adult Severe Mental Illnesses (SMI) Community Care	370,000 people* receiving care in new models of integrated primary and community care for people with SMI, including dedicated provision for groups with specific needs (including care for people with eating disorders, mental health rehabilitation needs and a 'personality disorder' diagnosis)
Adult Severe Mental Illnesses (SMI) Community Care	Delivery of the Early Intervention in Psychosis standard
Adult Severe Mental Illnesses (SMI) Community Care	390,000 people* with SMI receiving physical health checks by 2023/24
Adult Severe Mental Illnesses (SMI) Community Care	55,000 people* with SMI accessing Individual Placement and Support services by 2023/24
Suicide Reduction	Deliver against multi-agency suicide prevention plans, working towards a national 10% reduction in suicides by 2020/21
Suicide Reduction	Localised suicide reduction programme rolled-out across all STPs/ICSs providing timely and appropriate support
Suicide Reduction	Suicide bereavement support services across all STPs/ICSs by 2023/24
Specialist Community Perinatal Mental Health	Maternity Outreach Clinics in all STPs/ICSs by 2023/24
Specialist Community Perinatal Mental Health	Extended period of care from 12-24 months in community settings and increased availability of evidence-based psychological therapies by 2023/24
Specialist Community Perinatal Mental Health	At least 66,000 women* in total accessing specialist perinatal mental health services by 2023/24
Specialist Community Perinatal Mental Health	Evidence-based assessments for partners offered and signposting where required by 2023/24

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