Mid and South Essex Community Collaborative

NHS

Annual Report

2023/2024

The Mid and South Essex Community Collaborative (MSECC) is a partnership arrangement of three organisations who deliver community services in mid and south Essex; Essex Partnership University Trust (EPUT), North East London Foundation Trust (NELFT) and Provide Community Interest Company (Provide Community).

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Collaborative Director Statement

Welcome to the MSECC Annual Report for 2023/2024. I wish to thank our colleagues who make up our collaborative, as they have dedicated themselves to improving community services for the population of mid and south Essex. I am delighted to see this hard work coming to fruition.

This year there has been a noticeable acceleration in our progress, with our colleagues putting in dedicated efforts to ensure the timely execution of our ambitious plans. We are now witnessing the tangible outcomes of our staff's commitment, contributing to the success of our collaborative ambition. This translates to enhanced care and improved experiences for our communities which I am proud to share in this report.

As we continue to progress it is important to me that we continue to work together to address the priorities for health in mid and south Essex. I recognise the importance of engaging with our workforce, working together with our partners and stakeholders in health and social care, and ensuring our residents are empowered to help us design services fit for now and in the future.

In a world of advancing technology and innovation, I am committed to ensuring we make the best use of our resources and continue to identify ways we can improve and transform our services to better serve our population.

The pressures faced across health and care mean this is not easy. I thank our colleagues for thier commitment and dedication in helping the people we care for. We cannot do it without you.

James Wilson
Collaborative Director
MSECC

Chair's Statement

I was delighted to begin my term as Chair of the Mid and South Essex Community Collaborative in July 2023. I've been privileged to work with partners from across the mid and south Essex system in our shared endeavour to improve access, experience and outcomes, ensuring local residents of all ages receive high quality, technology-enabled, integrated care as close to home as possible.

It has been wonderful to see the collaborative continue to receive national accolades. This year we were shortlisted for the 2023 HSJ Award for "Provider Collaboration of the Year". We have also continued to reap the benefits of being selected last year to be part of the NHS England Provider Collaborative Innovator Scheme. However, it is the positive feedback that I've heard from our patients and our staff that has been the most rewarding part of my role as Chair. On all of my visits to our services I've been struck by the keenness and willingness of our staff to work collaboratively to provide care that truly puts patients at the centre of an integrated offer.

As a collaborative, we are committed to strengthening the voice of patients and carers in all we do and to coproduce; this will be a major focus in the year ahead. We also look forward to deepening our ties with local authority, voluntary, community and social enterprise (VCSE) and primary care partners and to continuing our fruitful working relationship with Mid and South Essex NHS Foundation Trust. Increasingly, our focus will also be on understanding and addressing the health inequalities that remain entrenched in some of the areas we serve, pursuing our ultimate goal of improving the health of the populations we serve.

The MSE Community Collaborative is at the start of a very exciting journey and I look forward to what we will achieve for our communities in the year ahead.

Eileen Taylor
Chair
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.

Our objectives

We have seven overarching strategic objectives to support our vision:

- Higher quality sustainable services
- Effective use of resources
- Better outcomes for people
- Unified provider voice
- Reduction in variation and duplication
- Improved staff experience and retention
- Health equality and equitable access

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 highlights this year

Improving experiences for service users

Referral to treatment (RTT) wait times (people waiting for treatment once referred): Reduced to **under 65+ weeks** for April and May 2024

7% reduction in wait times for Speech and Language Therapy in 2024 compared to 2023

720 **daily admissions avoided** through treatment of priority 1 patients by community nurses

5% reduction in Wheelchair services' total wait times from 2023 to 2024

Contacts with patients

Year on year increase in total number of contacts:

1.54m

Total number of community collaborative contacts, a **12% increase** from 22/23

770,000

Total number of community collaborative contacts by district nurses, a **13% increase** from 22/23

31,000

Total number of contacts by Urgent Community Response Team, **10% increase** from 22/23

Supporting the system

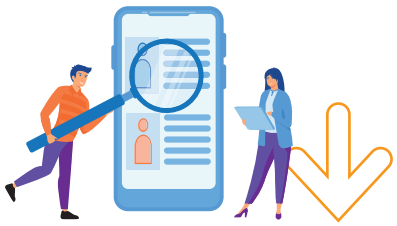
3,600

admissions to the MSE virtual wards in 23/24, a **20% increase** from 22/23

8,200

admissions avoided by our MSE Urgent Community Response Team (UCRT) in 23/24

Our workforce



Continuing decrease in clinical vacancy rates. In February 24 our vacancy rate was 10%, a **20% decrease** from February 23.

Improve

Involving people to design our services is helping improve experience

- Higher quality sustainable services
- Health equality and equitable access
- Better outcomes for people
- Reduction in variation and duplication

Luis' story

The story of Luis serves as an inspiring testament to his pivotal role as a Lived-Experience Ambassador for the Mid and South Essex Community Collaborative (MSECC) Wheelchair Services.

Living with spinal muscular atrophy, Luis discovered that the initially provided wheelchair didn't meet his requirements. His proactive approach prompted a review of his needs, resulting in the provision of a new wheelchair that dramatically enhanced his independence.

Luis, who travels extensively for work, says his wheelchair is instrumental to his life. "It has enabled me to realise my full potential both professionally and personally, and for the first time I am proud to be the breadwinner for my family."

Matthew Goddard, Head of Community Occupational Therapy, Adult Speech and Language Therapy, Equipment & Southend Wheelchair Services, invited him to become a lived-experience ambassador. Matthew values the life experience that ambassadors like Luis bring to the collaborative effort, acknowledging the continual room for improvement in service delivery. He says, "Working within our system can often feel like a puzzle, having Luis on board with us supporting this work with his lived experience is like finding the missing piece."

A short video of Luis' story

Luis saw this as an opportunity to contribute to improving the wheelchair service experience for others. In his role, Luis actively participates in service meetings, offering solutions and perspectives to address challenges.

Luis brings a **patient's voice** and a fresh perspective to the service, contributing to a positive impact on the overall experience.

While acknowledging the robustness of the wheelchair services, Luis also recognises the importance of consistency in provision across all locations. He is committed to making a difference and contributing to the gold standard ambition for all three service providers.

Long COVID: Service users empowered to co-design services

- Better outcomes for people
- Reduction in variation and duplication
- Higher quality sustainable services

The service operates across mid and south Essex.

The aim was to address existing issues in the service delivery, such as poor feedback, disjointed pathways, a 9 month waiting list and lack of coproduction which was hindering patient engagement.

We initiated a thorough assessment by engaging with staff, exploring patient groups, and identifying problem areas, changes were implemented in the patient journey, waiting times were reduced, and group-based assessments were introduced for better peer support.

Long COVID Outcomes:

- Cut a 9-month waiting list to a couple of weeks, enhancing accessibility.
- Restructured service delivery, creating tailored interventions and group-based assessments, significantly improving patient engagement.
- Embraced coproduction as a core value, involving patients in decision-making, leading to impactful changes.
- Addressed a complaint about a leaflet through coproduction, resulting in an improved, informative version.
- Shifted to an online feedback form, dramatically increasing feedback volume and real-time response capabilities.
- Revised discharge processes to provide ongoing support and validate long COVID as a persistent condition.
- Ongoing initiatives include starting a carers group, working closely with employers, and addressing inequalities in access to services.

Future efforts will concentrate on addressing inequalities, increasing referral rates, and reaching out to those unaware of available help.

The leadership and innovative strategies in the Long COVID team have led to a significant transformation in the service in mid and south Essex. The case study showcases a journey from identified challenges to comprehensive solutions, highlighting the importance of patient involvement, coproduction, and continuous improvement in healthcare service delivery.

The team won an award at the Medipex Ltd NHS Innovation Awards for Improved Treatments, Therapies and Rehabilitation for this work.

Integrate

MSECC Workforce sharing: Change to Memorandum of Understanding (MOU) and Licence to Attend

- Effective use of resources
- Improved staff experience and retention
- Unified provider voice

Working collaboratively and having an MSE wide workforce strategy has allowed services to stay optimised and improve patient experience.

The MOU Licence to Attend was agreed by the Community Collaborative Leadership Team (CCLT) and offers a framework for services and teams to be able to work together in an integrated way and on occasion through a collaborative lead who manages staff across the three partner organisations.

The MOU:

We know we need to engage our workforce around the MOU and our aim is to continue to improve the MOU process to make it as easy as possible for colleagues to access this opportunity.

- Allow staff from partner clinical teams to work in an integrated way providing joint services across mid and south Essex but maintaining their sovereign employment.
- Allow teams from across the partners to work across their respective patches with other members of the collaborative.
- Allow staff sharing to support clinical pressures.
- Provide a workforce framework to support the Joint Contractual Venture Agreement (JCVA) (Agreement in which two or more parties come together and sign a contract outlining the terms under which they will work together).
- Give a solid workforce document to unblock other areas integral to collaborative working including access to data and systems.

Case Study

The Wheelchairs team in south east Essex recently had a job vacancy. Traditionally, it would take approximately up to a year for a new employee to integrate into a new team and be fully up to speed in the service. This could lead to longer wait times for patients and overworked staff. However, as part of the MSECC, positive working relationships have been formed and there is now access to a wider range of people and resources that can support each other. A member of staff working in the south west Essex Wheelchairs service hosted by NELFT was happy to work with the south east Essex team, hosted by EPUT. The process of this mutual aid has been seamless, with the member of staff being able to help the team straight away.

Integrated working has increased annual diabetes checks

Better outcomes for people

Health equality and equitable access

There are approximately 69,000 (5.7% population) people living with Diabetes across mid and south Essex (MSE) who could be at risk from diabetes complications, and additionally 28,705 people with Non-Diabetic Hyperglycaemia (NDH) at risk of developing Type 2 Diabetes within 3 years.

MSECC was successful in their bid for £199,000 from NHS England for the Diabetes Innovation Recovery Fund (DIRF). Despite the serious complications of diabetes, not all people with diabetes attend their critical diabetes annual health checks. The objective of this fund is to increase the amount of people with diabetes to get their annual diabetes checks, known as the 8 care processes.

By working as a system and by using data, it was identified that Southend Victoria Primary Care Network (PCN); a collaboration of nine GP practices, and Chadwell and Tilbury PCN; a collaboration of five GP practices, serving approximately 97,000 patients collectively, have the highest need in mid and south Essex, to increase the 8 care processes checks for people with diabetes.

Through a data-sharing agreement, MSECC has collaborated with the GP practices in the specified PCNs to establish direct contact with priority 1 patients, specifically those with diabetes most at risk who are currently not receiving their annual checks. The funding has provided an MSE Diabetes Lead and three Health Care Assistants, actively engaging with partners both within the community and across the system to enhance outreach efforts and build relationships. This has led to:

- Improved engagement with the local community is helping us understand the barriers behind the lack of participation in annual diabetes checks. This insight is integral to the ongoing process of adapting services to better align with the specific needs of the local population.
- Through outreach and engagement with stakeholders, a collaborative approach is being taken to co-design the service, aiming to address and reduce health inequalities by ensuring equitable access to health and care.

- Partnering with the engagement team at Southend Council enabled the healthcare team to connect with a local multicultural group, leading to the organisation of a health and wellbeing day at the local mosque. The team worked with Diabetes UK who provided booklets for people in the community offered in different languages, containing local information around mental health support, weight management and education.
- From September 2023 to February 2024, over 800 people had been seen to complete the 8-diabetes care processes, whom otherwise would not have attended. From the feedback from patients so far 100% of people said their care was Excellent and 100% felt that all aspects of their health and care was discussed.
- Other outreach efforts across the localities ensured a wide variety of people have been engaged with and checked with some people being diagnosed with diabetes for the first time.
- In addition to getting patients checked, the diabetes lead has also provided education to 60 health care professionals.
- In partnership with Impulse Leisure in Tilbury, a free 15 week diet and exercise course was offered to people with diabetes living in the area. Outcomes will be published later in 2024.
- The team secured £5,000 from The Queen's Nursing Institute to provide education to teenagers transitioning to adult diabetes services. Outcomes will be published later in 2024.
- Through speaking to patients and hearing their barriers in accessing their annual checks, we have learnt the process of booking checks needs to be easier. The learning will inform the development of a model for change for the way diabetes checks are conducted in GP surgeries and for the learning to be shared across all localities of MSE, so we can aim to reduce variation and ensure equity. The key aspects which will be implemented for the future is the relationship between the two PCNs and the specialist teams, creating a reduction in referrals to the specialist services.

Here are a couple of short videos of people involved in the project:

Maria's story

Dr Olukanni

Graham's Story

Innovate

Supporting our ageing population

- Higher quality sustainable services
- Effective use of resources
- Better outcomes for people

The Ageing Well Stewards across mid and south Essex include health and care professionals from across our system, including colleagues from the MSECC. The stewards have been working on a series of initiatives to support our ageing population. The collaborative effort has led to the development of a Frailty Hotline Service (FHS), FrEDA (Frailty, End of Life and Dementia Assessment) tool and e-FraCCS (Electronic Frailty Care Co-ordination system).

Prior to these initiatives across the system, there was incorrect data and limited tools available for staff to ensure that patients were receiving best practice within Frailty services.

FrEDA is a common assessment tool which delivers and captures best practice within Frailty focusing on the use of seven high impact pro-active personalised actions. It launched across all teams and providers, such as PCNs, Community Teams, Hospices, Dementia Teams, Virtual Wards and more.

The results following the implementation of FrEDA across mid and south Essex have had a high impact, with some key highlights listed below:

- **12,000 New People with Frailty/Dementia/End of Life (EOL) needs identified in 1st year alone.**
- **50% Reduction in older people with >3 unplanned hospital admissions in their last 90 days of life.**
- **82% via the Frailty Hotline avoid emergency department (ED) attendance.**
- **5% reduction in 30-day hospital readmission rates (ICS wide since e-FraCCS and FrEDA go live), and 70% reduction in 30-day readmission rates in Integrated Neighbourhood Teams with highest FrEDA usage.**
- **Ability to collate and share care via an ICS wide electronic platform.**

The tool has united colleagues under a whole-person culture, using integrated tools so partners seamlessly collaborate for better patient outcomes, as opposed to siloed organisational practice. The team won a 'Data-Driven Transformation' Award in the 2023 HSJ Awards for this work.

Frailty Hotline Service (FHS) was set up to provide 24/7 advice and guidance to care home medical staff within mid and south Essex. The main aim was to keep people out of hospital and providing support to frailer older patients in their own places of residence.

A Frailty Virtual Ward (FVW) was established to complement FHS within mid and south Essex.

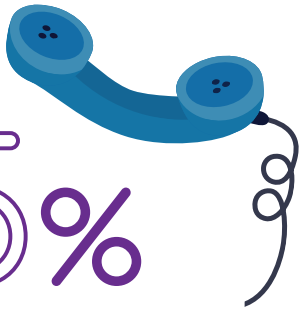
The FHS consists of:

- 5 secondary care consultant geriatricians
- Accessed by phone
- 7 days service
- 9am - 10pm weekdays and 9am - 10pm weekends
- 1:5 rota

Unified online portal 'Netcall' was used to directly call consultants. Documentation was completed on a dedicated Frailty Consultant Hotline tab on SystmOne, visible to all care providers. Data collection was automated via Netcall and SystmOne from March 2023 until January 2024.

Summary of outcomes

The total number of calls per month increased by ▲55%



Frailty Hotline has:

Saved 13,920 bed days

Helped admission avoidance by 80%

Saved nearly £500,000 per month

The innovative model of FHS with direct access to a Geriatrician showed a safe and efficient model to support frailer older patients in the community with appropriate signposting to Frailty Virtual Wards and other community services as an alternative to acute hospital emergency admission and treating the patient in the right place.

Digital projects

We have focused on projects which bring long-term benefits to our Community Services through digitalisation of processes and enhancing how we use and interact with our Electronic Patient Record systems.

New technology will both make our community services roles more attractive and support existing staff whilst positions are filled, ultimately with the aim of making things easy for our clinicians and giving them more time to care for our service users.

These projects are in early stages of implementation and evaluation of these projects will be published later in the year of 2024.

Services have been piloting and trialling a number of innovative solutions and learning has been shared with colleagues working across the MSECC, including:

Autoplanner

Our Integrated Care Team in mid Essex have bases local to the populations they serve but their clinical staff are mobile, spending much of their time making home visits. The need to be mobile and agile was a key factor in assessing the solutions chosen.

Objectives included:

- Automate the scheduling of visits – saving time and mileage.
- Enable remote access to records – increasing number of records updated at the point of care.

The clearest evidence of improvement is the enormous change in the time taken to schedule visits, with a total of 532.5 hours of nursing time each week reduced to only 40 hours total across teams. All saved time is being diverted back into patient facing time.

Dragon One dictation

This is allowing our nurses to dictate directly into SystmOne records but also to control the Electronic Patient Record (EPR) with their voice, such as opening and navigating templates. Some nurses are already saving lots of time with a total of 159 hours typing time saved with a small number of staff fully onboarded. Work to deploy to all staff is ongoing.

One of the aims was to improve staff wellbeing, getting home on-time and reducing "unclaimed hours" that staff do record keeping. Feedback from staff is positive, and although it is too early to say if this has affected staff retention, this is a measure that will be monitored.

Testimonial from Kay Imburski
(District Nurse Team Leader, mid Essex):

"I have found the Dragon One software extremely helpful, I find my notes are much more detailed and I write so much more, it is saving me time every day and I am now reducing the amount of time I spend in my own time catching up on my documentation, a few teething problems with words that were not recognised and pronunciations etc. but using the "add that to the vocabulary" is really helpful and works well, best thing that has been introduced and I love it."

Virtual Wards

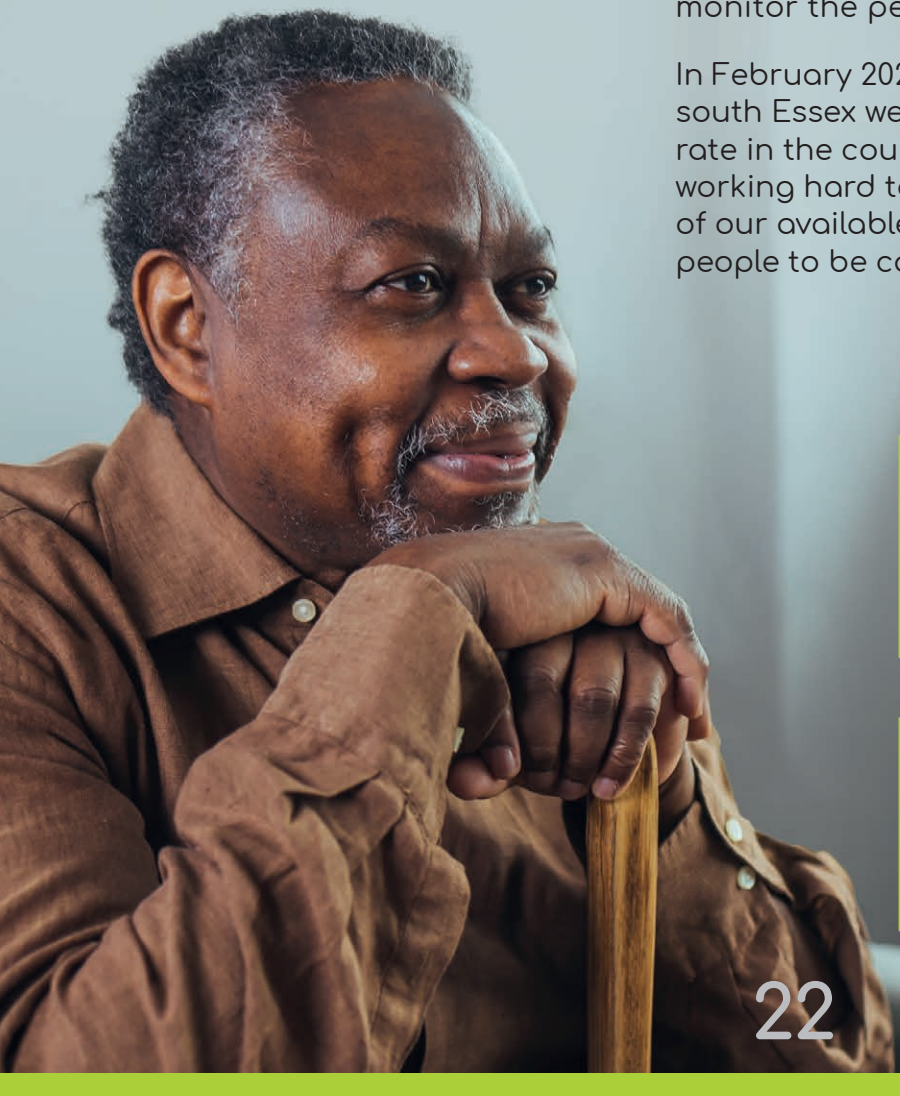
Virtual wards (also known as hospital at home) allow patients to get the care they need at home safely and conveniently, rather than being in hospital. The NHS is increasingly introducing virtual wards to support people at the place they call home, including care homes.

This innovative approach is delivering high quality care for people at home – where they would rather be – either by preventing admissions or allowing them to leave hospital sooner to continue their treatment at home.

Just as in hospital, people on a virtual ward are cared for by a multidisciplinary team who can provide a range of tests and treatments.

Patients are reviewed daily by the clinical team and the 'ward round' may involve a home visit or take place through video technology. Many of the virtual wards use technology like, wearable headsets and other medical devices enabling clinical staff to easily check in and monitor the person's recovery.

In February 2024 the virtual wards in mid and south Essex were among the top for occupancy rate in the country. This means that we are working hard to ensure we are making best use of our available resources and allowing more people to be cared for at home.



How we have involved our stakeholders

We have continued to build upon the relationships we have with stakeholders to ensure we understand the needs of our partners, colleagues and the people we care for. We are proud to be engaging with our stakeholders as one unified, strategic voice.

By facilitating co-production, we are empowering our workforce and enabling them to deliver better health and care outcomes.

- Through our governance structure building trust and mutual respect
- Encouraging a culture of collaboration and organisational development work
- MSE update using existing communication channels
- MSE Collaborative stories and case studies shared via regular communication channels and the new MSECC LinkedIn Page
- Engagement opportunities (community nursing, leadership forum, engagement drop-in)
- Being selected to take part in the NHS Provider Collaborative Innovator Scheme
- The MSE Tissue Viability Teams taking part in the National Wound Care Strategy

What our colleagues say

Matthew Goddard
Head of Community Occupational Therapy, Adult SLT, Equipment & Southend Wheelchair Service, EPUT

"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 can 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."

Stephanie Dawe
CEO, Provide Health and Quality Lead, MSECC (23/24)

"Fostering a spirit of collaboration within our teams is crucial for conquering change and achieving shared goals. I have found that our collaboration has come from trusting each other, believing in common objectives and shared learning. I am very proud of the work our colleagues and partners have achieved in such a short space of time. I particularly want to mention our colleagues working within our IT, Governance and People services who are enabling our teams to work as one."

Sophia Flint
Divisional Operational Lead - Integrated Care Teams & Out of Hours Service, Provide Community

"Collaborating with other teams isn't just about sharing responsibilities; it's about enhancing patient care through collective expertise. By working together, we create a support network around our workforce and our patients, ensuring their needs are met and their outcomes optimised."

Kay Rumsey
Nurse Consultant, Community Nursing, NELFT

"Taking a collaborative approach can enhance communication, streamline processes, strengthen professional relationships, and ultimately enhance the care of individuals accessing health services. The collaborative work we undertook within catheter care showed great promise and bridged the gap between community and hospital services. I would welcome further commitment to working collaboratively in this area as I do see the potential in this work, to ensure we have the necessary capacity and capabilities across the system wide workforce."

Rita Thakaria
Partnership Director, Thurrock

"I am excited by the work we have achieved but also what the future looks like for integrated care across mid and south Essex. Our colleagues and partners have embraced collaborative working and have been enthused by the opportunities. As the Partnership Director for Thurrock and the Lead Director for Urgent Community Response Team and Speech and Language Therapy I am particularly proud of how teams have come together to achieve a more integrated service across mid and south Essex.

It is not always easy and we are continuing to learn and reflect but from what I can see our workforce, partners and our wider communities are on board as the value and benefits are starting to be realised. We are all trying to achieve the same goal: better outcomes for our communities. So, the more we do together the more benefit we see for our population."

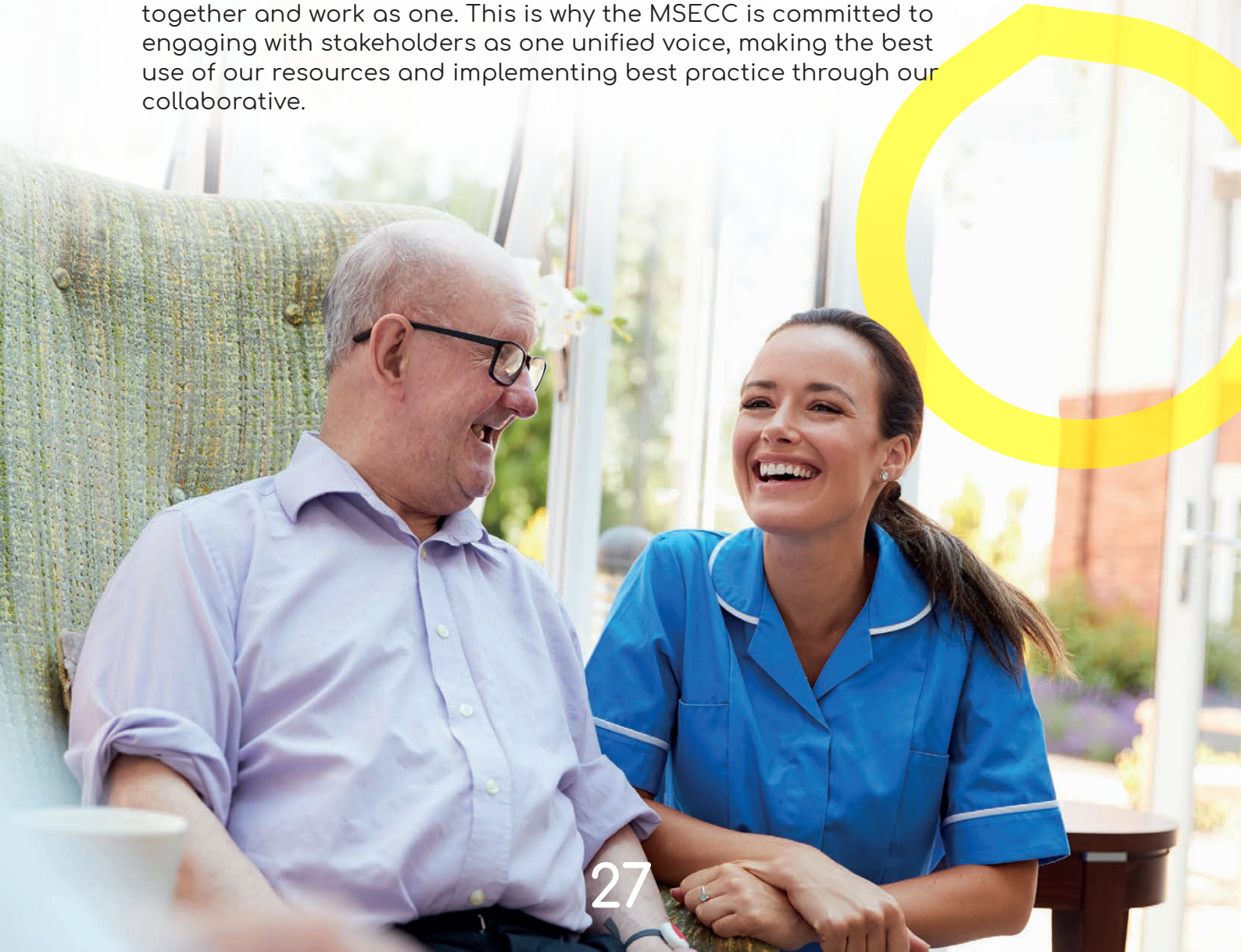
What next?

The Mid and South Essex Community Collaborative has the commitment from the system to continue working together to improve outcomes for people. We are delighted to have been awarded a three year contract by the Mid and South Essex Integrated Care Board to deliver community services across MSE.

The NHS is under huge pressure, and we understand the importance of getting this right, for our patients, service users, residents and staff.

Our collaboration is built on trust, and we are proud to be improving workforce experience and retention, creating services fit for the future, reducing duplication and benefiting the wider system.

But we know we need to do more to make this a reality for all of our colleagues and our population. Working together is no longer a strategy; it is a need. To ensure the best outcomes for our population, services within social and health care need to come together and work as one. This is why the MSECC is committed to engaging with stakeholders as one unified voice, making the best use of our resources and implementing best practice through our collaborative.



2024/2025 – our focus

Over the past year, we have seen growing evidence of the value that community services bring to our service users and the wider system. The aim in the MSECC is to improve effectiveness, cost-efficiency, and patient outcomes by shifting the focus away from hospital-based care and emphasising prevention and community-based services and treating people in their homes.

We will continue to work with our colleagues in transforming our focus community services and will also explore further:

Ensuring the best use of our resources

To enable improved collaborative working through increased alignment of financial management processes, and to identify opportunities for financial efficiencies within the collaborative.

Cardiovascular Disease (CVD)

To develop and implement and test a community health intervention that supports improved outcomes for people at risk of or living with CVD.

Place-based Integration

To integrate local community physical and mental health services with developing neighbourhood models within all four Mid and South Essex Alliances.

Children & Young People (CYP) and Complex Families

To address variation and improve CYP and family experience of service provision by delivering optimised and aligned MSE models of care, particularly for neurodiversity pathways.

Virtual Hospital

To release acute sector capacity by optimising and increasing our virtual bed capacity and our urgent community response (UCRT) offer.

Estates

To rationalise MSE community estates and deliver cost improvements related to estate utilisation.

Community Beds Consultation - Outcome Implementation

To implement a new model of community bed delivery, and relocate any in-scope community collaborative outpatient services as required, in line with the outcome of the public community beds consultation.

Diabetes

To support people with diabetes to live well, and to address inequities in diabetes care across MSE by delivering an optimised, consistent and locally integrated model of diabetes care for MSE.

Governance

To optimise MSECC governance to enable the effective delivery of MSECC's strategic programme.

> Thank you to each and every one of our colleagues who have worked within the Mid and South Essex Community Collaborative and our partners for their unwavering commitment and dedication to our collaboration.

Our Governance structure

MSECC implemented its own governance structure with delegated decision-making and oversight of community services from the sovereign organisations (EPUT, NELFT and Provide Community) to the MSECC Joint Committee, Community Collaborative Leadership Team, and Joint Clinical Oversight Group. Legal considerations led to the adoption of a joint venture model, allowing streamlined conversations while accommodating the community interest business model within Provide Community.

A plan for 24/25 is in place to evolve our current governance to match the maturity of our delivery in reducing duplication.

The new governance arrangements comprise of the following key elements:

- Refreshed Collaboration Agreement.
- Transition to the MSECC Joint Committee, including full delegated authority.
- Introduction of an Accountability Framework.
- The development of a suite of Quality Memoranda.

Mid and South Essex Community Collaborative

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 audio  another language

Please contact us:

askus@communitycollaborative.co.uk

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

The 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 Community).

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