Mid and South Essex Integrated Care System

NHS Mid and South Essex

MSE Integrated Care Partnership, 16 November 2022

Agenda Number: 12
Mid and South Essex Integrated Care Strategy: Concept Paper

Summary Report

1. Purpose of Report

This Concept Paper aims to:

- Frame the health and care challenges in Mid and South Essex (MSE)
- Explain the purpose of the Integrated Care Partnership (ICP) and how it fits within the wider health and care system
- Share the main messages emerging from our engagement work to date
- Share a draft outline of the ambitions for a new model of partnership and the potential Integrated Care Strategy

This paper is being shared with a range of partners to elicit feedback and gain consensus on the direction of travel prior to finalising by the end of December.

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4. Responsible Committees

Integrated Care Partnership & Integrated Care Strategy Working Group.

5. Financial Implications

Not applicable at this stage.

6. Details of patient or public engagement or consultation

Included in body of report.

7. Conflicts of Interest

None identified.

8. Recommendation/s

(i) To consider the Concept Paper and offer comments and observations
(ii) To agree this as the basis for the final drafting of the full Integrated Care Strategy

'Our Common Endeavour'

Mid and South Essex Integrated Care Strategy: Concept Paper

"There is a Greek word called 'Praxis' and that means the integration of your beliefs with your behaviour"

John Assaraf

1. Context

"The ICP will bring together a broad alliance of partners concerned with improving the care, health and wellbeing of the population, with membership determined locally. The ICP is responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the population in the ICS area."

NHS England, What are Integrated Care Systems?

Our health and care systems are stretched to capacity and in some cases beyond. What have been typically regarded as 'winter pressures' are now evident year-round. Demand for health and care services has increased exponentially, outpacing funding provided by central government to both the NHS and local authorities. The impact of the COVIDCovid-19 pandemic and workforce pressures have created unprecedented waiting lists for consultant-led referrals, cancer diagnosis, etc. causing significant backlog with treatment, and consequential impacts on quality of life for individuals and on primary care and adult social services. Pressure on urgent and emergency care for both NHS and Social Care services is extreme. There is a mismatch between:

Demand	Capacity
Where we are best supported	Where we seek support
Our desire to invest in early intervention and prevention	The requirement to prioritise urgent and emergency care and support
Our willingness as citizens to be involved	Opportunities to become involved
Our desire to trust systems and services	Our experiences and messages we receive

A great deal of our resources is invested in dealing with the consequences of long-term conditions such as obesity, diabetes and mental ill-health - but much

less on helping people to maintain or improve their own health and wellbeing and finding effective support within their communities.

Changing this dynamic is a major social challenge of our time. This will require a significant reset, with action required by all partners, including our community groups. It is not enough to do things differently; we need to be prepared to do different things.

This includes a mindset-shift about the future role of residents and community organisations as full and equal value partners in creating better health and care outcomes. It is not just about providers 'getting it right', for the public, it is about a new covenant with the public that asks them directly to partner with services to help themselves stay healthy and well.

To achieve this, our ICP strategy needs to include a shared public statement of ambition, bringing together citizens and services in a single 'Common Endeavour'. This will be informed by evidence and experience, accompanied by clarity about what must happen to deliver our objectives, what actions we will pursue to get there, along with the measures to know that we are successful.

Furthermore, our Strategy needs to establish a mechanism for receiving regular updates on system performance, and emerging challenges and opportunities, providing space for partners (statutory, private, voluntary and community sector and citizens) to give, and take weight, at times of serious system pressure.

2. Engagement

2.1 Engagement Approach

Our overall approach to developing the Integrated Care Strategy was agreed by the Chair and the three Vice Chairs of the ICP, with support from the three local Health Watch organisations, and confirmed in the Partnership's first meeting in September 2022.

It was essential that the building-blocks of the strategy were informed by a range of conversations with citizens, community organisations, clinicians, care professionals and leaders in the NHS and public services. Accordingly, we have undertaken:

1. ***Review of Partner Strategies and JSNAs:*** 27 publicly available strategies and plans from partner organisations within the MSE ICP as well as the relevant JSNAs. Each strategy covered a three-to-five-year period between 2018 and 2026.
2. ***Health inequality data analysis:*** we reviewed the evidence of need from the analyses of Population Health Management health inequality data packs and JSNAs.
3. ***Engagement:*** eight workshops based in community venues, collectively engaging over 170 people. We used the 'Essex is United – Your Questions Answered' Facebook group to ask a series of questions of the general public. Each was viewed on average 1,700 times, with an average

of 280 comments and votes on each question.

We did not start with a firm proposal and test this with partners and stakeholders, we have worked through an 'appreciative enquiry' approach (focussing on what is working well how we can do more of this) developing the proposals in this Concept Paper from these conversations. Feedback has been extremely positive and, in comparison to many ICS systems, we have undertaken significantly more engagement work in this process. However, there is more work to do, especially in gathering the views and experiences of local people, including those from marginalised groups who are seldom heard – often referred to as 'Inclusion Health Groups'. This will become an ongoing feature of the work of the Integrated Care Partnership.

All our conversations and analysis reinforce the message that things need to change. All understand that improving the health and care of people in MSE depends on every part of the ICP playing a part in a re-balancing of our ICS in MSE towards prevention, early intervention and anticipatory care.

2.2 Review of Partner Strategies

The review identified several overarching themes in existing strategies.

First, the need to address the **persistent inequalities** that residents face, which result in lower quality of life and shorter life expectancy for many, particularly in parts of Basildon, Thurrock and Southend. Partners agree that redeeming this starts by acknowledging and investing in the wider determinants of health and ensuring pathway design begins with prevention and early intervention, including with children and young people, where many future health problems are seeded.

Second, MSE has a **growing and ageing population**. With this come a wide array of conditions including dementia, cardiovascular disease, cancer, diabetes and chronic obstructive pulmonary disease, as well as the wider challenges of frailty and increased social isolation. It is vital that solutions better meet the increasing volume and complexity of need in a sustainable way, including the provision of care closer to home. This is a ticking time-bomb in terms of future pressure on ICS partners across health and care services if we do not act now.

Third, **mental health conditions** are increasing in both adults and children and in some areas suicide rates are increasing at a worrying pace. Supporting people to feel comfortable talking about mental health, reducing stigma and encouraging communities to work together are highlighted as key to improving mental health and wellbeing. Community partners have a particularly important role to play in the here and now, well before people present into mental health services for children and adults.

Full detail of the Review of Partner Strategies is included as an appendix to this paper.

2.3 Health Inequality Data

The health inequality data analysis indicated that:

- The significant majority of MSE's most economically deprived population live in Basildon (where 17% population are part of the 20% most deprived nationally), Southend (15% population) and Thurrock (11% population).
- Inequalities attributable to socio-economic factors that lead to premature mortality are driven by cardio-vascular disease, cancer and chronic obstructive pulmonary disease.
- These can be mitigated by addressing inequalities in the wider determinants of health such as smoking, obesity and high blood pressure (as per the Robert Wood Johnson Foundation model).
- Data suggest that (i) smoking prevalence amongst adults is particularly high in Basildon and Thurrock, and (ii) the proportion of adults identified as overweight or obese is particularly high in Thurrock.

However, it is recognised that, as the Office of National Statistics state in notes to their English Indices of Deprivation *"Not everyone living in a deprived neighbourhood is deprived, and many deprived people live in non-deprived areas".*

2.4 Findings

We have actively sought involvement of a wide range of statutory and non-statutory organisations and community groups who are involved in the provision of health and social care services.

Although some experiences varied, the engagement workshops confirmed that improved relationships between partner organisations and increased collaboration, particularly at Alliance level was evident, and that conversations are more evidence-based, with an increased focus on shared outcomes rather than inputs and activities.

However, they also identified several key challenges:

System	*Community*
• Lack of clarity about the respective roles of the Integrated Care Partnership, Integrated Care Board, Health & Wellbeing Boards and Alliances. • Financial restrictions and 'red tape' mean funding does not flow around the system between partners easily enough. Budgets are often not aligned, let alone pooled. • Difficult to prioritise and fund prevention	• We encourage people to go to services for issues that they could address themselves, or within their community. • Top-down approach does not reflect the priorities or needs of residents and local communities. Insufficient service user engagement. • Services are difficult to get hold of – there are not enough appointments and long delays.

and early intervention when there is not enough capacity to meet urgent demands (though this should not be a 'get out clause'). • Duplication and friction across patient pathways due to operational silos and lack of shared records. • Workforce recruitment, development and retention issues leading to staff shortages and risk of burnout.	• Individuals are sometimes concerned about asking for help, because they don't believe they will be seen or listened to or will be adding pressure on services. • Individuals were frustrated that some people used the wrong services, and this could place lives at risk as treatment for those who had a genuine need for that service could not access it (e.g., A&E services).
Communication and engagement • Communication with residents, patients and service users is too complex and one-directional, making it difficult for people to understand choices, leading to default use of A&E or GPs and feeling uninvolved and disenfranchised.	*Partnerships* • Concern amongst voluntary and community sector partners around equality of access to the most important conversations and decision making, with a desire to move to a more equal partnership.

Full details of the Findings of the Engagement Workshops are included as an appendix to this paper.

3. The Concept

3.1 The Common Endeavour

"Whether sitting as committee members or on advisory panels, we expect the people and communities of every system to be fully involved in all aspects of the development of the ICP integrated care strategy. We expect ICPs to set out how it has involved, engaged and listened to local people and explained how they have acted in response to these views. This is a minimum requirement. We expect ICPs to develop proposals for engagement with people in their areas which ensure that their plans and strategies deliver what people need and expect"

Integrated care partnership (ICP): engagement summary

Engagement in designing our Integrated Care Strategy is essential, but in Mid and South Essex we wish to go further. We wish to see citizens and services united around a single ***'Common Endeavour'*** that brings us all together in common cause. This will involve the development of a simple, accessible and inclusive campaign model, in which citizens and services agree a shared social mission of purpose, through which we will harness the potential of all of our wide assets and opportunities.

The Common Endeavour will express our desire to work together to eliminate avoidable health and care inequalities by creating a broad and equal partnership of individuals, organisations and agencies, focussing on prevention

and early intervention and providing high-quality, joined-up health and care services, when and where people need them.

This cannot be achieved by statutory partners alone. We must invite community organisations, citizens and others to join us in our Common Endeavour. Together we will significantly increase focus on individual and community engagement, wider determinants, early intervention and prevention, with a transformed role for communities in relation to health and care, and residents helping themselves and each other.

This means an alignment of our efforts with the ICP acting as the fulcrum for community mobilisation alongside statutory and voluntary services This will involve a ‘re-setting’ of our partnership with the public.

The ‘ask’ to citizens needs to be to do everything they can to maintain their own health and wellbeing and that of their families, neighbours, and communities, keeping the health and care services ‘in reserve’ for when we most need them. The corresponding ‘asks’ to the Integrated Care System should be to: first, support people to manage their own health by helping ‘upstream’ in a cost-effective manner before problems become expensive and irretrievable ‘downstream’; and second, to properly integrate services around the individual once they need formal services.

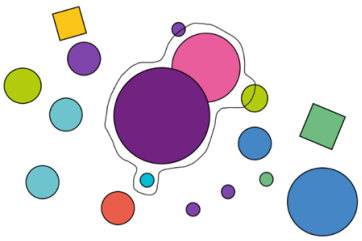
3.2 A New Model of Partnership

The message from our engagement activities is clear - the partnership must work differently if the population’s confidence in the system is to be maintained and long-term health and care challenges are to be met. The partnership needs to be agile and purposeful, bringing together the resources needed to do the job, with a clear focus on the ‘destination’ (i.e., what we want to achieve) but also on the ‘journey’ (i.e., how we will work together to achieve it).

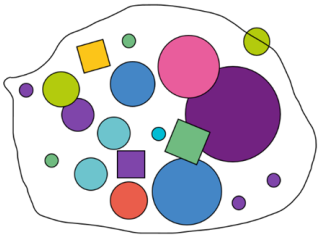
This requires a new model of partnership. Alongside continued influence from the statutory boards and forums which feed into the ICP, we will need to become much broader and more inclusive, ensuring engagement of a more diverse range of contributors, feeding into the formal ICP meetings themselves.

Non-statutory partners are keen to have a prominent voice in the ICP and to see their role reflected in its strategy. We believe an ‘equal value partnership’, where contributions of all partners, large and small, are equally valued, and fed through into the partnership, will enable us to achieve better outcomes for the residents of MSE.

A New Model of Engagement



Integrated Care System Today



Integrated Care System Tomorrow

Currently, a number of potentially powerful partners and allies (e.g., private adult social care providers, community pharmacy, schools, colleges and early years providers, patient representatives, etc.) feel peripheral in terms of voice and influence – and insufficiently co-opted into the system for supporting health and care outcomes.

As such, we propose to engage a more diverse set of organisations and individuals than have previously been able to contribute to the development of health and care strategy. In order to achieve this, the ICP will bring together the following standing groups to support and influence our Common Endeavour:

- A Community Assembly.
- Independent and private providers' network.
- A community voices network - feeding in the community engagement work undertaken at a system and Alliance level and by our Health Watch partners.

The Community Assembly provides an opportunity to connect around universal and societal challenges. Distinctive in its diversity of Voluntary and Community Sector actors, the co-production of an Assembly model will support the amplification of best practice approaches that embrace human learning systems, drive better community representation, increase creativity in problem solving and insight gathering with communities of place, purpose, and interest. If we are to truly act purposefully and learn together as a whole system, the Assembly model is critical in creating the foundations of resilient, citizen-led communities that can level up equitably.

The Independent and Private Providers network will meet the requirement to engage with adult social care providers and bring together the diverse experiences of partners operating commercially to provide health and care services.

Engagement of partners and stakeholders will not be an occasional duty but will be a permanent feature of the work of the ICP. There will be a range of debates, talks, and workshops throughout the year, feeding to and from an annual symposium or conference. These will be open to all contributors – not just those organisations and individuals who attend the statutory ICP.

There will be a clear agreement defining how partners give and receive support as part of the ICP, including the new forums proposed but also existing forums, and networks. This will assist the development of trust and respect for contributions from VCS organisations, social enterprises, education partners, and citizens.

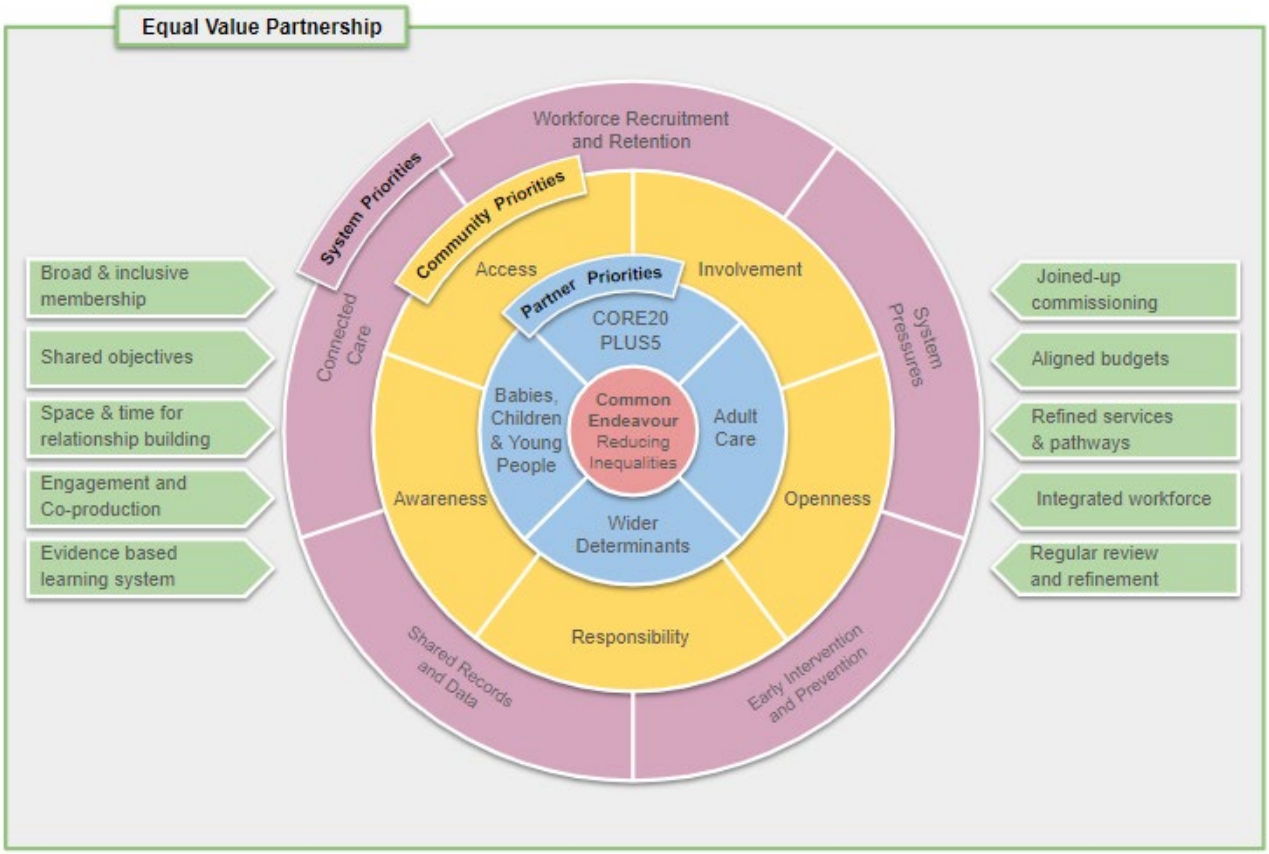
The Partnership will not just be a 'talking shop', it will set specific tasks and require tools and resources to complete these. Initially, a small, agile infrastructure will support the work of the Partnership, but this will grow over time as we demonstrate the impact of this way of working and as we identify additional opportunities. All partners will be expected to contribute time, skills and expertise as part of the ongoing work of the ICP.

3.3 Ongoing Engagement Principles

In developing this new model of partnership, we believe that all MSE ICP partners will need to commit to a way of working on our Common Endeavour, including commitments to:

1. Work together as equal value partners united by a shared Common Endeavour.
2. Establish a small number of shared objectives and hold each other mutually accountable for delivering them, continually reviewing and refining objectives as new challenges and opportunities arise.
3. Ensure broad and inclusive engagement, with voice and influence throughout the work of the Partnership.
4. Create space and time for relationship building and trust. Ensure openness, transparency and local accountability, acknowledging when things have gone wrong.
5. Respect our differences and work through difficult issues together.
6. Champion creativity and co-productive activity, ensuring residents' voices are central to the decisions made about the way health and care is planned and delivered.
7. Ensure place-based partnership arrangements are respected and supported and have appropriate resource and autonomy to address community priorities, in line with the principle of subsidiarity.
8. Create a learning system, sharing evidence and insight across and beyond the ICS, crossing organisational and professional boundaries, with opportunities for reflection.

4. Our shared objectives and priorities



4.1 Partner Priorities

A focus on four key areas where our partners share common objectives.

Core20PLUS5

- Residents within the most deprived 10% of MSE, as identified by the index of multiple deprivation.
- Defined groups experiencing poorer than average health and care access, experience, and/or outcomes who may not be captured within the most deprived 10% - currently Gypsy, Roma and Traveller communities, Black, Asian and Minoritised Ethnic communities, Carers, Children and Adults with Learning Disabilities and Autism, Homeless People and Veterans, Care leavers, and Victims of Domestic Abuse and Domestic Violence.
- Maternity, Mental Illness, Chronic Respiratory Disease, Early Cancer Diagnosis, Hypertension, Smoking Cessation

The Wider Determinants of Health

- Recognising health and care is only part of the answer
- Healthy behaviours – 30%
  - Diet and exercise
  - Alcohol use
  - Smoking
  - Poor sexual health
- Socio-economic factors – 40%
  - Education
  - Income
  - Employment
  - Family/social support
- Clinical care – 20%
  - Access to care
  - Quality of care
- Environmental factors -10%
  - Environmental quality
  - Built environment

SOURCE: Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute in US to rank countries by health status

Adult Care

- The ageing population including dementia and frailty
- Adults with learning disabilities and autism
- Mental health including suicide prevention
- High intensity users including problem drug and alcohol users
- Adult end of life and palliative care

Babies, Children and Young People

- Maternity and early years health and care
- Children and adolescent mental health
- Special educational needs and disabilities
- Prevention of adult health conditions
- Maternal and children's healthy weight
- Healthy schools' programmes
- Health inequalities experienced by looked after children and care leavers
- Children's end of life and palliative care

Our starting point will be a focus on a group of priority families and individuals experiencing the worst health and care outcomes. These First '5,000 Families' will be the focus of our Common Endeavour. We will work together as a partnership to define the 'First 5,000' families and target our actions as a partnership on meeting their needs.

4.2 Community Priorities

A focus on five key areas expressed to us by communities.

Access

- Primary Care – supporting access to primary care and ensuring use of the full range of primary care services including community pharmacy, social prescribing, etc.
- Pressures on urgent and emergency care (NHS and Social Care)
- Ambulances
- Bringing care closer to home and promoting personalised care options

Involvement

- Asset Based Community Development
- Stronger partnership with Voluntary and Community Sector
- Building community cohesion, resilience, and mutual support
- Creating a culture of 'volunteerism'
- Encouraging citizens to see services as being 'in reserve'
- Addressing the 'digital divide'

Awareness

- Building understanding about how the system works
- Knowing what services are available and where
- Having access to the very best online and digital options

Openness

- Managing expectations of citizens
- Building trust – both in and from services
- Accepting when things have gone wrong and learning fast

Responsibility

- Supporting citizens to ask for help early
- Using the right services at the right time
- Self-care

4.3 System Priorities

A focus on five key system challenges and opportunities.

System pressures

- Working together to tackle acute system pressure and bottlenecks
- Sharing of resources and utilising support from a wider range of partners and communities

Workforce recruitment and retention

- Recruitment and retention of a skilled workforce
- Workforce development initiatives including through the Anchor Programme
- Ensuring health and care is an attractive career for our diverse communities

Early intervention and prevention

- Prioritise prevention, early intervention and anticipatory care
- Space for innovation (clinical and public health, voluntary and community sector)
- Using all the tools and talents
- Develop new models and approaches to 'upstream' investment

Connected care

- Ensuring better connection between services
- Refinement of pathways
- Effective joint commissioning

Shared records and data

- Development of population health management assets
- Digital synchronisation
- Data and Business Intelligence

- Data Democratisation

4.4 The equal value partnership

A focus on ten building blocks for our ICP.

- Broad and inclusive engagement feeding to the statutory board
- Agreeing shared objectives
- Space and time for relationship building
- Engagement and co-production
- Evidence-based learning systems
- Joined up commissioning
- Alignment of budgets
- Supporting the refinement of services and pathways
- Supporting the integration of the workforce, culturally and in practice
- Regular review and refinement of the Integrated Care Strategy as and when partners' priorities change and evolve

We will capitalise on opportunities, including supporting existing local forums, boards and partnerships, and the Anchor Network, in support of these objectives.

Subsidiarity, distributive leadership and working at 'place' will be a cross cutting theme in all that we do. The Integrated Care Partnership will never seek to diminish or weaken the sovereignty of our partner organisations and agencies or our powerful local Alliances, nor will the Integrated Care Strategy replace or replicate their strategies and operational plans. It will simply identify those shared priorities on which we will work together and describe how we will do so.

5. Conclusion

We have a major opportunity - as well as a moral obligation - in MSE to move the dial in relation to health and care outcomes, particularly for our most deprived groups. We have a solid base of partnership on which to build, with a diverse mix of organisations motivated to be actively involved in the development and delivery of the ICP strategy.

Our engagement activities to date have been thorough and a consensus has been emerging both about the scale of the challenge and the necessity of substantial change. There is a clear mission here for the system as a whole - a clear shared agenda.

As we continue development of the strategy, we welcome your views on the key themes raised in this paper. What resonates with you, what is unclear and what do you believe is missing?

6. Next Steps

In order to build from this Concept paper, to develop the full; draft strategy and plan, we will:

1. Reach **agreement on the broad concepts, approach, and priorities.**
2. Work with **partners and our communities** to agree how we communicate and mobilise our Common Endeavour.
3. Engage on a 1:1 and small group interview basis to test and refine the concepts to ensure **alignment** across the partners. Ensuring a clear focus, objective and set of priorities that align with health and care needs and system-level challenges.
4. Conduct **analysis** to more clearly evidence and define those groups experiencing poorer than average health and care access, experience, and/or outcomes who may not be captured within the Indices of Multiple Deprivation.
5. We will work with partners to agree **measures of success**, including a set of target outcomes against which progress can be assessed.
6. We will work with stakeholders from the NHS, local government and the VCSE sector to **establish a plan** for how the strategy should be implemented. Together we will identify practical actions that partners might take. This will draw on evidence from within and beyond the region about what is most effective.
7. We will assess the **infrastructure** requirements to support the work of the partnership including the need for effective system-wide communications.

Appendix 1 – Summary of Feedback from Engagement Workshops

Summary of Feedback from Engagement Workshops

Approach

A range of workshops took place in community venues across the region and one online. Jointly hosted with partners, these engaged over 170 people including professionals, voluntary and community sector organisations and patient and community representatives.

This has been supplemented with an online engagement using the 'Essex is United – Your Questions Answered' Facebook group to ask a series of questions of the general public over several days. Each was viewed on average 1,700 times, with an average of 280 comments and votes on each question.

Summary of Feedback

What is working well?

- **Good strategic relationships** between organisations have increased collaboration, particularly at Alliance level. Many more organisations are involved in the conversations.
- More **evidence-based** conversations with greater use of data.
- Shift to a focus on **shared outcomes.**
- More **person-centred** and personalised approach to delivery of care, and greater service user engagement.
- Taking a more **holistic approach** to people's health and wellbeing. Increased use of social prescribers, connecting people to community groups and statutory services.
- A **caring and committed workforce** willing to go extra for those that they care for
- The **vaccine programme** was well planned and executed. Covid gave shared purpose and helped build relationships, trust and shared solutions to a common problem.
- There are '**pockets of success**' for certain communities and services, e.g. individual GP surgeries, Southend discharge team, etc.
- NHS staff are perceived as dedicated and caring and doing their very best to support people.

What are the main challenges?

- **Clarity of governance** - Role of Care Boards, Partnership Boards, Health & Wellbeing Boards, and Alliances in the system need much more clarity to ensure effective accountability, governance and implementation.
- **Financial restrictions and red tape** - money is limited and what we have does not flow around the system between partners easily enough. Budgets are often not aligned, let alone pooled. There is a low appetite for risk within the NHS.
- **Hard to prioritise and fund prevention and early intervention** when there is not enough capacity to meet the urgent demands. Social care resources are being crowded out by health treatment needs. We still haven't got the balance right.
- **Top down approach** often does not reflect the local priorities or needs of residents and communities
- **Communication** with residents, patients and service users is too complex, so difficult for people to understand and they default to A&E or GPs. We need to help people understand.
- **Duplication and friction across patient pathways** due to operational silos and lack of shared records (e.g multiple blood tests are often required). Some organisations are doing things that others are better placed to do. Need to break down barriers between services and providers. Information and data sharing can be difficult. Care should be seamless.

- **Workforce recruitment, development and retention.** Many staff are at risk of burnout, and not recruiting people into different/new roles.
- **Culture of dependency** - we encourage people to go to services for issues that they could and should address themselves, or within their community.
- **Service user engagement** - we don't properly engage and involve residents in general - and those who have lived experience in particular - enough.
- **Increasing demand** - Winter pressures and the increasing cost of living put additional strain on a system that is already at capacity, especially noticeable at GPs, the hospital bottleneck of ambulances and discharge and long waiting lists.
- Not **commissioning enough in the community**, which could ease burden on key services.
- There is **insufficient representation** of interest groups influencing the ICP, e.g. General Practice, Patients/community voices, Adult Social Care Providers, Community Pharmacy, Optometrists, Dentistry, Safeguarding Chairs, Fire Service, Schools and Colleges, etc. Patient representation was seen to have lost focus/direction.
- **Services are difficult to get hold of** –' there are not enough appointments and long delays'.
- **People don't ask for help** because they think they won't get seen or will be add to the pressure on services.

What should we do differently together to improve effectiveness?

- Establish a **shared vision and priorities** that is coherent and relevant at 'place' and 'system' levels.
- **Ensure clarity and honesty** on what will and will not be prioritised.
- **Support and educate residents to take more responsibility to manage their health within the community**. Equip people have the confidence to help themselves - through health promotion, community engagement, community grants, signposting, validation etc.
- **Tear down boundaries**. Leave lanyards behind. Focus on shared outcomes. Rethink how the money flows. Increase placement and job shares. Join up patient records. Streamline referral pathways e.g.**,** from VCSEs to statutory. A better Better Care Fund with clearer governance around decision making.
- Treat **VCSEs as equal partners** and ensure longer term funding.
- **Define how subsidiarity works** so decisions are made at the right level with the right people in the room. Focus on local leadership and delivery not a centralised, top down approach. Engage at PCN and Alliance level as these are perceived to be generally working well.
- **Properly integrate Childrens, Young People & Family services** with a focus on prevention and early intervention. Children are our future – need to focus on developing support for children so we frontload better things for the future.
- Much more focus to project the **long term prevention and early intervention agenda** and not be crowded out by treatment / firefighting focus.
- Much more weight in discussions and decision making on the **wider determinants of health**, (i.e., transport, education, housing rather than just health & care).
- Ensure. **much more flexible access** to GP and Dentist appointments, not just 9-6pm Mon-Fri;
- **Commitment to co-production**. Create online and physical spaces for collaborative conversations.
- **Identify and share best practice** from the 'pockets of success' for sharing across the system; become a learning system; harness the passion of people who have achieved good outcomes from local services to promote them to others.
- **Better communication and engagement with residents**, community groups and service users - listen, trust, train and involve. Share positive stories. Avoid duplication (e.g., HealthWatch and ICP). Tailor communications and outreach for communities' needs and demographics, rather than relying on national campaigns and messaging.

- **Prioritise system-wide workforce** recruitment, development and retention. Identify hidden skills.
- Ensure there is opportunity for **more diverse partners to engage and contribute**
- It would help to **share information about what services are available**, and how to get better health outcomes.
- People value the support of friends, family members and neighbours when they need it, and would be happy to offer support back in return
- Services should be **more willing to admit when things have gone wrong** and not repeat mistakes.

What would people be most disappointed about if not included in the new strategy?

- A coherent **common purpose that is relevant to all. '**Equip us for the journey instead of focussing on how to get to a specific destination'.
- A focus on **prevention, early intervention and anticipatory care.**
- A focus on taking **personal and community responsibility**, volunteerism and active citizenship.
- **Simple, concrete and transparent plans with clear accountability**
- **Focus on Children and Young People, '**as **t**hey are the future'.
- **Start where the pressures are greatest** - older people. hospital discharge and ambulances. e.g., create a dedicated falls and frailty service. Recognition that winter pressures (acute care and discharge to social care) is a real risk to life and will be a defining problem not only for the next three months but the foreseeable future
- **Embed the principles of subsidiarity** – making sure local voices and place needs are heard and the varying needs of different MSE communities are not all addressed with a single blanket solution. A commitment to understanding communities' needs and decisions about them made at the most appropriate level in the ICS, building services and consensus from the bottom up wherever possible. Build on the success of the Alliances.
- **Tear down organisational boundaries** - need governance and decision making mechanisms for agreeing distribution of resources and budgets, avoiding duplication. A commitment to data sharing system wide. Social Care companies should be able to add to this digital health record as per Government targets for 2025.
- **Ensure VCSEs are at the decision making table** rather than engaged downstream.
- **Ensure residents voice is at the heart** - tell stories, make it real, examples, meaningful and ongoing representation of those with lived experience, Develop community assemblies and broaden existing community forums and parish panels to help identify opportunities for service collaboration and improvement
- **Commit to the development of the system wide workforce.** Attract staff to come into the professions. A clear plan to broaden and upskill the local health and care workforce.
- **Commit to significantly improving communication** between partners and communities through shared language and multi-disciplinary working.

How would people like to see the strategy communicated?

- **Different formats for different audiences** while ensuring **consistent messages** (e.g., quick start guide and then the full manual, a DIY manual).
- **Entertaining and motivating** – make people smile and feel good.
- **Focus on the person**, families at the centre and communities of organisational boundaries and politics; People-centred - particularly patients/service users but also between staff in different orgs. e.g. keep it simple (hide the complexity) in our communication so people can understand.
- **Emphasis on why does this matter**, why is it important and relevant to individual people, families and communities.
- **The respective needs of the system and place are recognised.**

Feedback notes from individual workshops

Online workshop, 28th September

What is working well?

- Sharing and collaboration - problem solving - different ways of working
- We are more inclusive
- Willingness to listen to each other and residents
- Communication with residents (SAVS)
- Have widened the coalition of who is involved in the conversation
- Social prescribers - going well - need to grow this
- Alliance conversations are constructive and not top down
- Difficult conversations across system partners (e.g. on winter pressures) are being held in a very grown up spirit (appropriate challenge but in supportive manner, focus on what's best for residents cf partners, reaching conclusions). Not always the case with other ICSs
- Shift from emotional to evidence based conversations e.g., use of data for health inequalities
- The three Health & Wellbeing Boards have aligned their strategies well
- Vaccine programme been well planned and executed
- Shift to focus on outcomes & the wider population instead of activities and individual organisation perspective
- Huge amount of comms, trying to explain with partners and public why CCGs have gone, changes, hopes and expectations of new system
- Doctors and dentists - get a lot of bad press but actually some things working really well and some great best practice e.g., digital
- Positive relationships across system partners. Covid gave us shared purpose and helped build relationships, trust and shared solutions to a common problem
- Board is progressing very quickly compared to elsewhere. Senior appointments have been made, which is really good to see.
- Meeting of partnership board, ToR etc has all been put together swiftly. Meeting today- projects from health and care being supported and really good discussion. Already starting to address challenges.
- Great, hard working people with enthusiasm. People love the challenge and want to do a great job and make a difference
- Work very well across partners and work closely together, across health and care. Much more of a joined up approach, Unpick issues together. Health and care records sharing- digital
- Transparency in finance to tackle challenges. Really good engagement. Mike Thorne is great at making sure we focus on all parts of system and don't focus on one area or another
- Technology is a positive and working well – vital to enable us to connect really well – previously a challenge
- BI is much better data analysis is better and the inclusion of working with key partners and data sharing
- Lot going on – but what's going well vaccination programme – jab process has been well organised booked and publicised – time taken to update patient records etc
- Dual diagnosis and mental health positivity – positive conversations collective responsibility
- Value in social prescribing – cultural shift – collective responsibility – whole person – doesn't need to be about diagnosis
- Using tech and teams to engage with partners patients and family members
- The pandemic partnerships and inclusivity – no barriers
- Getting people around the table vcs other voices ouder
- Working with evidence v emotions – better than before re health inequalities agenda

- Way in which we develop alliances – place focused strengths based – less commissioning behaviour more 3 sector vcs – place v system

What are the main challenges?

- Digital footprint and inclusion
- Access to GPs and dentists
- Lack of continuity of information and guidance to the public - residents have to tell their stories many times
- Too many meetings, not enough action, we meet a lot we don't collaborate
- Service integration (particularly
- Recruitment of GPs, nurses, dentists
- Role of Care Boards, Partnership Boards, Alliances in the system need much more clarity to ensure effective accountability and governance
- Lack of a consistent, shared evaluation framework
- Political - confusion around new ABCD priorities
- Pound: really large system wide deficit, how to collectively manage across system
- People:recruitment across board very challenging and to a lesser extent retention
- Hold our nerve and not regress to old ways of working as we face tough challenges e.g., shared sovereignty, community based urgent care, focus on prevention as much as treatment
- 'Urgent is enemy of the important '
- Digital- LAs are well ahead of the NHS
- Communication - with residents and clinicians/professionals about ICP
- Treat the whole person not just presenting symptoms
- Social care resources are being crowded out by health treatment needs
- Not enough focus on wider determinants of health (especially housing, transport, education) - need to ensure right people in the room, link up data records
- Duplication/friction across patient pathways due to lack of shared records (e.g. Multiple blood tests by different partners)
- Communication is a problem. Difficult to get a response from people. Hopeless at promoting ourselves and telling the public about all the good things we do
- Understanding resources, and how behaviours of population mean we continue to react and create treatment services rather than prevention services
- Connectivity of professionals (particularly clinical colleagues)- willingness to connect and talk to each other. Care should be seamless. Need to break down barriers between services and providers
- Digital- Amazon- don't think twice about accessing what you need from there, but in healthcare this doesn't happen. Not clear how to access info and care at different times. What does this look like in digital era to support prevention agenda
- Prevention is going to be key but is one of the biggest challenges. Challenge because so heavily oriented into treatment. Not looking at bigger picture of focus on prevention
- Hold our nerve, don't let short term firefighting take our eye of longer term agenda of prevention and early intervention, wider determinants of health
- Engagement with the public and citizens. Work and projects need to start with them. Need to get them to tell us issues and what matters to them and help us develop solutions, rather than engaging on a solution we've already developed based on what we 'think' we know
- Culture and mindset change. Need to give ourselves time to do this properly
- Need for a joined up approach and knowing who is talking to who. Consistency of care across all areas
- How do the public and citizens see things and do they understand everything? We need to help people understand. Navigating care is often very difficult.
- Still haven't got the balance right of focusing on prevention.
- Voluntary sector, issues with not having long term funding

- Community, family, service user voice- have made some headway but more to do
- Retention of staff and recruitment. Not recruiting people into different/new roles- tend to stick to what we know, doctors, nurses etc
- Cross boundary working and joint appointments
- Costs all go into treatment. Need to break the cycle. Need to get the population to help us to start to turn the curve. Need to help people to behave differently and understand the importance of prevention. We encourage people to focus on treatment when in crisis in the way we have set services up
- Understanding the whole system. Who does what and where? (E.g good practice around Asthma?)
- Pathways are unclear
- Share successes
- Appointment for primary care dentistry
- Understanding whole systems who is who and what are they for so we can be more efficient
- Difficulty off loading ambulances very frightening capacity is challenging
- Care sector market a real challenge
- Loneliness x2 people
- Gp access
- Transitions from children to adults – whole family approach
- Recruitment and retention of staff and volunteers
- Complex integrated care systems 3 in essex
- Using data in the right ways – paracetamol and anxiety piece need better data – so more real stories etc
- Who does what – difficult – who is responsible – website confusing
- Lack of communication and patient engagement
- We need to shout about success and don't
- Community groups assets – powerful assets – are we working with them to full potential
- Urgent is the enemy of thinking space – will take our energy from investment in important things to do EIP Preventions anticipatory care – need to create bandwidth to do both
- Loneliness and isolation – if we can achieve something tangible quickly – who is in which posts
- Connecting what we have don't let people bed in – expectations and honesty with the public
- Real conversations on what we can't do anymore with the public – not all things to all people

<u>What should we do differently together to be significantly more effective?</u>

- Easier referral pathways from VCS to statutory
- Communication and engagement with residents, community groups and service users - listen to us, trust us, train us and involve us
- Push back responsibility on the country. Empower, support and educate residents to manage health within the community (especially within Mental Health - children and families) - not everything needs to go through GPs
- Working across boundaries - understand each others' worlds - move towards a common language - increase placement and job shares - need to rethink how the money flows
- Share experiences more between services - how to find out what is happening where - where is the good practice?
- Use technology better - share data to avoid people having to tell their stories many times
- Increase flexibility to retain staff
- Work more with schools to feed health messages - e.g. a health worker on staff
- Truly integrate Childrens. Young People & Family services with focus on prevention and early intervention

- Common narrative and terminology (eg resident, citizen, patient etc) - common endeavour , strategy on a page
- More baseline measurement in evaluations to know the starting points
- Much more focus to project the long term prevention agenda and not be crowded out by treatment / firefighting focus
- Much more weight in discussions on the wider determinants of health, transport, education, housing etc rather than just health & care
- Joined up patient records within and across health, care etc
- Recognise life has changed and we need to change with it e.g. much more flexible access to GP and Dentist appointments, not just 9-6pm Mon-Fri
- Communicating together shouting about positives
- Amplifying achievements publicly – need an event each month
- Need to not forget those that cannot access the system electronically etc – we are in danger of losing people – many people mis-directed via 111 – don't know who to go to –
- Clarity of pathways and need for local and hyper local information – news – could be better together
- Care compare medi shout – to bring elective lists down etc
- Transparency about why the capacity challenges would encourage more compassion and a collective will to tackle societal issues built on collective understanding
- Children are our future – need to focus on developing support for children so we frontload better things for the future – stop thinking about the sickest and children and families
- Sharing information not holding at certain levels – but doing it positively
- Need to be united behind a common purpose and communicate in a relevant way
- Treating people like a whole person etc
- Staff at coal face involved and valued – we could do that better together voices heard
- Making every contact count and empowering patients etc – equip people increase personal resilience – health literacy – shifting dependence on services etc.

Whitham Community Hub: Saturday October 1st

Reaction to dead cat exercise:

Kids chasing the ball (£)
Grappling with jelly
Taking the competition out of the system
Hard to navigate the system – levels of connectedness. Sure Starts used to help as a ;point of focus, integration and information sharing
Every Child Matters model for ICS (same perm sec)
So much time pulling people out of the river. Why fall in the river? Access, access, access seems to be the priority
You can never have enough focus on prevention and early intervention
Too much work/need and not enough people and time so have to get patients through
Many more section 37 patients via prison
People want reassurance they're doing OK (e.g. GP visit for a child with sniffle)
Here to help people have the confidence to help themselves

What's working well

- Community hubs (e.g., this venue)
- Much more listening to people's experience as patients e.g., Changing dementia patients' pathways to include early diagnosis e.g., immediate intro to dementia support worker
- Bring difficult conversations closer to community / home – local model for people

- Systems coming together, coalesce around the person
- Often this was driven by a particular GP, with focus on buy-in – plus there was enough capacity at the clinic to get them through, incentives more to collaborate rather than compete
- Not much!
- Orgs are talking to each other much more than in the past, things are starting to emerge, relationships being built, but it is so slow
- Witham GP practises working well together and have good availability/ accessibility
- Neighbourhood forums and community work
- Getting better at celebrating success

Main challenges

- Protection of self and organisation (self-interest) cf working together
- People willing to work together at partnership meetings, but NHS managers so snowed under that when they go back to the day job and snowed under so revert to type cf collaboration
- Pharmacists, 111, hospital walk-ins, A&E not working together; NHS good on front line but upper echelons are there to protect themselves rather than promote local health & wellbeing
- Getting someone a social worker, a carers assessment, delays
- Quality and accessibility of social care can be poor, not very human which can lead to people into carte homes and/or A&E, whereas better care packages at home could have kept them there for longer
- PCNs are so snowed under how they will have capacity to get out and talk to community groups
- Ambulance waiting times
- Lack of joined up data, shared records, too much red tape
- Poor communication
- Absence of honesty e.g., NHS reorg is not working, open conversation about what's broken how can you improve it, single health and social care records, telling your story once)
- Just getting things done!
- More equal value partnerships (i.e. VCSEs)
- More positive stories and community spirit (as per COVID)

What could we do differently together to be more effective

- Be prepared to talk to VCSEs much more not just an intra-NHS conversation
- Big concern that Witham residents ignored for 20 years despite relatively poor outcomes
- Need many more GPs
- Cross-party long-term plan for NHS and social care
- Long term focus
- Stop the game of musical chairs CCGs, ICBs etc
- More listening, remember people come into a good job but are human
- Improve funding per capita
- Might be involved in conversation but may not be right org to deliver the service
- Take greater responsibility for own health e.g., 20% kids at reception obese – public health messages (how to sell), community hubs
- Cross party view on importance of prevention (obesity 20% stat)
- Many more SureStart centres?
- 2-3 hours of PE per week in school …encourage lifelong skills and anti-obesity
- Focus on actions rather than blame

Three things that should be in the IC strategy

- Focus on prevention
- A commitment to data sharing from NHS hospitals/GPs/Pharmacists to Social Care companies. This will include access to SystmOne as well as other health records. In addition, Social Care companies should be able to add to this digital health record as per Government targets for 2025. An early commitment to this would be a huge benefit to patient outcomes.
- Focus on taking personal responsibility
- Look at demographics of the area and make sure local needs issues are addressed Increased health care facilities in Witham
- Simple, concrete and transparent
- No brick walls
- Accountability – deliverables process for communicating progress / learnings
- Info sharing, iterative
- Valuing contribution from small orgs
- Building and flying the helicopter at same time
- Comms plan: How does the system work, is it working, what are we doing to revise things that are not
- Equip us for the journey cf how to get to a specific destination (iterative)

The Strategy - I'd like it to be …..

- Different formats for different audiences, consistent messages (quick start guide and then the manual, DIY manual)
- Different for different audiences (clinicians, general public)
- Entertaining – make me smile and feel good
- Focus on the person, families at the centre and communities cf organisational boundaries and politics
- Why does this matter, why important to individual people and families
- Not interested in what's under the bonnet
- System and place differences recognised

St Edmunds Hall, Southend: Tues 4th October

What is working well

- Introduction of social prescribers
- Southend enhanced discharge - collaboration between health and social care to re-able people and prevent admission into hospital
- Some great projects, services and activities in the voluntary sector (e.g. Trust Links)
- We are starting great conversations about Young Onset Diagnosis and Pathway
- Dedicated workforce
- More collaboration and greater desire to work together and find solutions together
- More respect for health workers since covid
- Greater emphasis on wider determinants of health and reducing health inequalities
- More focus on localities
- There is so much goodwill and enthusiasm, it just needs to be utilised
- Opportunity to really work together around prevention
- Livewell Southend
- Lots of grassroots organisations

What are the challenges?

- Communication with the public. Lack of information for how to access provision. Accessing information and sign-posting. You don't know what you don't know

- Not enough communication. Too many acronyms.
- Community is not driving the direction. Still top down.
- GPs are too isolated. Do their own things.
- Community services that haven't opened post lockdown - leaving gaps in information communication and physical assets
- Not enough collaboration - need to improve communication between services and with the 3rd sector. Too siloed. Duplication of services since no overall knowledge of all organisations.
- GP and A&E overload - only obvious doors and very narrow - lots of pressure on them
- Don't have time to do prevention or early intervention. Not a priority. Not funded enough. Prevention is lost in translation.
- Not enough NHS investment into Children
- There is so much reactive response to demand that there is no time to act strategically
- Social isolation increased
- Reducing systemic turnover of personnel
- Need for greater autonomy
- Trying to centralise everything. Need place based services.
- Governance and pace of decision making
- Huge demand, mental health social care, poverty, inequality, safeguarding
- Insufficient resources, not enough money, especially in the voluntary sector
- Getting new volunteers
- Digital dependency

<u>What should we do differently together to be significantly more effective?</u>

- Shared vision within the health community and single voice to the public
- Better communication where services can be obtained and "you said we did" or "we all said, we all did"
- Increase in networks, steering groups sharing information and referrals
- Focus on shared outcomes - put aside perceived boundaries
- Focus on people rather than organisations (warm handovers, team around the family, unmeasurable need)
- Early access - before the threshold, before crisis
- Prevention - little and often to pick up the little things
- People with lived experience leading
- Users to deliverers
- Focus on reducing inequalities for children and young people in Southend

<u>Things we would be disappointed if they didn't appear in the strategy:</u>

Group 1:

1. Communication and collaboration
2. Access / prevention - really understand community needs
3. Volunteerism and active citizenship
4. Children and Young People

Group 2:

1. **People-centred** - particularly patients/service users but also between staff in different orgs. e.g. keep it simple (hide the complexity) in our communication so people can understand
2. **Community responsibility** - Invest in creating the environment for a wild flower meadow to bloom. Means more freedom, less control, greater risk!
3. **Support for community services** to enable better prevention and early access/intervention

Group 3:

1. **Lived experience** - tell stories, make it real, examples,

2. **Communication strategy** - social media, need to speak where people are listening, and get people to listen.
3. **Community responsibility**, not done to - social isolation, street, neighbourhood, will be individual to each community.
4. Need a clear **common purpose**

Witham, Wednesday 5th October

Things that work well

- Social prescribing (with the recognition that growing mental health needs are putting pressure on both the prescribers and services referred into)
- Growing willingness to discuss mental health issues openly, supported by the health and care system
- SMS text message reminders for appointments and routine screenings
- Shared working/office space by some organisations has increased referrals and collaboration between them
- Close working between second-tier wellbeing officers and their communities
- Cross promotion by partners of wellbeing activities like CVS walking groups in some areas

Things that could be improved

- Too much duplication rather than “doing things once”
- Statutory services are not recognising the value of the third sector enough – “equity of esteem”
- Inter-partner communications, especially with regard to longer-term goals and anticipated risks
- More trust needs to be built between partners, and between statutory services and communities
- Too much reliance on services rather than oneself and common sense

Areas where we could make improvements

- Better communication of strategies between partners to avoid duplication and facilitate sharing of resources
- Activate citizens to enable more self-care and intra-community support
- Harness the passion of people who have achieved good outcomes from local services to promote them to others – adopt the Alcoholics Anonymous “fellowship model” more consistently

Omissions from any strategy draft that would be disappointing

- Budgets should be aligned with block contracts and grant models
- Develop community assemblies and broaden existing community forums and parish panels to help identify opportunities for service collaboration and improvement

Happy Hub, Basildon, Thursday 6th October

Dead Cat

- The system is slow, but extraordinary people can make things happen. Need to fix the system

What is working well

- Supporting colleagues with their workload to achieve success
- Giving customers hope
- Different organisations being together at multidisciplinary meetings
- Individual quality of care
- Compassionate staff who want to do a good job
- Focus on person centred care delivery
- I have excellent access to primary care, because I know how the system works

What are the challenges

- Accountability is burdensome and not clear
- Low appetite for risk
- Culture does not fuel effective collaboration
- The money is not always in the right place
- Workforce - not enough or wrong skills
- Competing priorities for your time
- Collective working is hard when put in competition for funding
- Staffing is hard when funding is not secure
- Commissioning
- Lack of first hand experience from decision makers. Too distant from the action
- Systems aren't flexible enough to accommodate individuals' needs
- Access to services
- Recruitment
- Lack of coordination of collaboration

What should we do differently together to be significantly more effective?

- Create space for conversations
- Invest in capacity
- Have a trust/framework
- Coproduce
- Listen more than you speak
- Beg forgiveness, not seek permission
- Collaborate / talk
- Share ideas and information
- Intervene
- Share knowledge and resources
- Communicate but not have meetings for sake of meetings
- Make it personal - Give a shit.
- Empower staff to make decisions
- Share data together securely
- Clearly identify boundaries
- Integrate tech
- Share information
- Double-run (pilot programme) - rather than quick hand-over
- Listen to people

Aveley, Monday 10th October

What is working well

- Existing good networks, strategic relationships, rapport across organisations
- Most are willing to work towards the same goals e.g. we're all working to improve health
- Already taking a preventative approach
- Things are starting to change! Ball has just started rolling
- All talking together
- Alliances working well with partners
- Commitment to people's wellbeing – everyone in the Thurrock alliance seems to want to do the best for their population ("Their hearts are in the right place")
- Strength of the voluntary sector, community groups and cooperation through each respective CVS and equivalent network (accepting that 20% of the population are activated and delivering for the remaining passive 80% of the population)
- Technology has in some cases improved choice and offered more options for people to receive the right service
- There are 'pockets of success' for certain communities and services

What are the challenges

- Silos, systems, redtape, referrals, communication,
- Lack of trust
- Different focus
- Reactive / proactive balance is not right and hard to get right
- Decisions come top-down instead of grassroots up
- Lack of relationships - people don't know each other, just refer into the dark
- Fitting everything together and keeping everyone happy
- Sharing resources - not enough of it, very protectionist - duplication - orgs doing things that others are better placed to do
- Information and data sharing can be difficult
- Different understanding and expectation of roles. Does everyone understand each others' roles and contribution?
- Budgets - are we always sharing these? Organisations may be cautious about this
- Not enough involvement from statutory services in local messaging – cascaded communications tend to be very general and anodyne rather than reflecting the needs and concerns of local people, e.g. over the cost of living crisis
- One delegate said: "Nothing's working that well, is it? Everything is stretched, understaffed or underperforming."
- Too much communication is centralised, putting out messages that the system things people should be hearing rather than what people actually need or want to hear
- Questionable balance between reducing inequalities and addressing the needs of the heaviest service users, who are generally
- Too much focus on NHS
- How to integrate ICP with HWBs
- Recruitment, development and retention of system wide workforce, underpinned by clear action plan with specific accountabilities
- Pace of change too fast - too much going on to get anything done
- Nailing shared vision and budget alignment across the whole system
- Governance disparity of power (e.g. Essex CC so much bigger than Thurrock)
- Lack of investment in Health Watch
- Are we all using the RWJ framework?
- Personnel change too frequently (officers, councillors)- have to start from scratch each time (esp VCSEs)
- Social ROI seen as voodoo economics and preventative business cases not valued
- Escalation cycle is punitive and negative
- Lack of clear comms

- Lack of shared objectives
- Complacency
- Silo working = should work as one big team
- Financial, governance structures puts orgs first and system/residents second - need to break org boundaries
- Winter pressures
- Cost of living
- Local partners and groups not seen as equal partners
- Capacity to build the relationships to make partnership working effective whilst doing the day job
- Lack of understanding of what is good and effective
- Workforce burnout, staff vacancies, focus on clinical outcomes rather than wellbeing
- How do local plans, alliances etc link up with OCP and avoid duplication?
- How does strategy bring meaning and common purpose to all the disparate partner strategies?

<u>What should we do differently together to be more effective?</u>

- Talk and communicate more - build relationships
- Plan things together
- Identify areas where resources can have the biggest impact e.g. working upstream, population health management.
- Engage at PCN and alliance level as these are generally working well
- More integration of resources and shared budgets in developing shared solutions
- Recognising that we sometimes need to take a step back from delivery to enable and facilitate self-care and personal responsibility for wellbeing
- Tailoring communications and outreach for communities' needs and demographics, rather than relying on national campaigns and messaging
- Develop community-based digital literacy solutions and recognise that using multiple 'front ends' (whether app or website) for different services will overwhelm some residents, disengaging them from the service and possibly worsening their outcomes
- Encourage and support closer CVS collaboration at alliance level
- Ensure that solutions aimed to support one sector of the community do not inadvertently disadvantage another
- Identify best practice from the 'pockets of success' for sharing across the system, with the acknowledgement it might not work across all services or alliances
- Promote social prescribers rather than GPs as the centre of and first point of contact for care and wellbeing delivery – with an acknowledgement this is a major shift in culture that could take years to achieve and the proviso that upskilling be enabled where needed
- Adopt human learning systems approach
- Give budgets to local systems / place based agenda - local leadership and delivery not top down
- Encourage and explain the benefits of partnership - overcome the fear of losing out
- ICS should facilitate and empower not instruct
- Shared language
- Principle of subsidiarity
- How do we mobilise the public ?
- 'Book of everything ' what we're doing, where we are, where we are going
- Pool budget resources
- Much more focus on prevention
- Clarity and honesty on what we will and will not prioritise (leadership, tough decisions)
- Reduce number of meetings
- Not being afraid to change

- Asset based community development
- Collaborative working spaces across orgs
- Defining how subsidiarity works so decisions made at right level
- Clear and shared vision, objectives and goals with a strong link to how individuals contribute in their roles

What 3 things, would you be disappointed if they weren't in the Strategy?

Group 1:

1. **Prioritise prevention and early intervention** approach.
2. **Share resources** - need a mechanism for sharing and agreeing distribution of resources and budgets. Governance. Improve the flow of money, and commissioning, pooled budgets, working across organisational boundaries, avoiding duplication.
3. **Use what we've got** - the strengths of the community. Using the wider workforce (e.g. ARRS roles), strengths-based, create a more person centred approach

- All working towards a **common purpose of reducing inequalities**.
  Start where the pressures are greatest. Eg. Older People. hospital discharge and ambulances. So create a dedicated falls and frailty service, to release pressure on ambulances when people fall and do preventative work to prevent falls

Group 2:

- A commitment to understanding communities' needs and decisions about them made at the most appropriate level in the ICS, building services and consensus from the bottom up wherever possible
- A clear plan to broaden and upskill the local health and care workforce
- Acknowledgement that one-size-fits-all is not the best approach for all types of service development, and that the needs of MSE communities can vary widely
- Effective two-way communications and engagement with communities and the voluntary groups who know them best
- Insufficient trust in the knowledge and experience of people working on the ground with communities
- A commitment to improving communication between partners through common language and multi-disciplinary working
- Recognition that winter pressures (acute care and discharge to social care) is a real risk to life and will be a defining problem not only for the next three months but the foreseeable future
- **Overarching theme: Subsidiarity** – making sure local voices are heard and the varying needs of different MSE communities are not all addressed with a single blanket solution

Group 3:

- Continuous co-production (done with not to)
- Tear down organisational boundaries
- VCSEs are highly valued and are at the decision making table rather than engaged downstream
- The strategy needs to be our system 'firewall'

Happy Hub, Basildon, Tuesday 11th October

What is going well

- Prioritise the sickest
- Increased communication channels
- Mid Alliance infrastructure (roles, meetings, relationships, resource, funding, desire)
- PCN community engagement

- Desire and commitment to addressing health inequalities
- Moving away from tick-box. Moving towards personalisation
- Innovative ideas and creative thoughts are welcomed
- Maturing relationships
- My GP surgery
- GP access is great if you know the system
- Social prescribing
- Values and commitment of most staff
- Exploring digital solutions and looking for other creative solutions
- Passion and goodwill for things to be better and recognition that we must
- Appreciation of VCSE (especially in Thurrock)
- LDP work
- Alliances as a middle ground to take info to and from (esp SE)
- Hospices
- Openness of partners to new ways of working and relationship building
- Cancer care
- Emergency care
- Air ambulances
- Cancer research
- Volunteering
- Covid vaccine devt and delivery
- NHS and LA partnership
- Talking and writing about co-production
- Creative wellbeing services for those with mental health
- Some high level shared goals e.g., prevention
- Shared outcome framework
- Personalised care implementation in mental health services
- Building new relationships between partners

<u>What are the challenges</u>

- Mental health and ADHD prevention, access and waiting lists
- Commissioning priorities
- Not commissioning enough in the community
- Faith in service as a whole from service users
- Avoiding duplications of resource
- Having time to build trust relationships and taking time to really listen to experience of users
- Currently too reactive, need to be preventative
- Increasing demand on a system at capacity
- Top down management, both middle managers and national political pressure)
- Time to learn, to engage, to build
- Overworked and exhausted staff. If staff have a lack of faith in services and the system, how can we promote it to the community?
- Staff undervalued by managers. Staff retention
- Conflicting, not aligned: governance, priorities, budgets, IT
- Waiting times
- Hospital discharge
- Behaviour change
- Professional silos, working across boundaries
- Lack of comms for local communities
- Investment in prevention
- Shared outcomes and targets
- Stop looking at need and look at the whole person

- Too top down and centralised
- Too much one size fits all

What should we do differently together to be more effective?

- Release structures so relationships can build and strengthen
- Offer and receive open and honest feedback from colleagues in different organisations
- Maturity in data collection and analysis
- Hospital recognises A&E queues are from lack of community response and funding of social services
- Clarity on governance structures
- As part of prevention, looking at food, nutrition and diet, not just physical activity
- Early intervention, rapid diagnosis of treatable illness (mental and physical)
- Have more faith in less 'mature' projects i.e. early intervention
- Enable more self-help (may involve health promotion, community engagement, community grants, signposting, validation)
- Work with communities to co-design solutions
- Clear mechanisms for people to share their lived experience
- Genuine cf tokenistic partnership working
- Become a learning system
- Value qualitative evidence
- Long term VCSE funding
- Pool/ align budgets for shared problems
- Visit and replicate services that work well
- Staff recruitment and retention- cross system development, identify hidden skills
- Reinvest % treatment savings tinto prevention
- A better better care fund with clearer governance /TOR around decision making
- Reduce duplication in citizen engagement (HW, ICP, etc)
- Leave lanyards behind -invest in bringing people together building trust around shared challenges and opportunities

What three things would you be disappointed in if they weren't in the strategy?

1. **Community resources to avoid hospital admissions and improve discharge** - focus on prevention (exercise and diet, etc)
2. **Managing workforce crisis in health and social care.** Promote staff to come into the professions
3. **Voice of the residents** - meaningful and ongoing representation of those with lived experience
4. Focus on Place (people don't feel they live in MSE)
5. A commitment to a culture that values co-production - with residents and a wide range of partners such as VCSEs
6. Really clear approach to prevention and how it will be resourced

Appendix 2 – Summary Review of Input Strategies

MSE ICP Strategy

Summary Review of Input Strategies

Contents:

1. Introduction

As a result of the Health and Care Act 2022 - which formally established the Integrated Care System (ICS) with Integrated Care Boards (ICBs) and Integrated Care Partnership (ICPs) from 1st July 2022 - each ICP must produce an Integrated Care Strategy by December 2022.

This document provides a summary of the strategies of partners within the Mid and South Essex (MSE) ICP, ahead of an exercise to set the MSE Integrated Care Strategy. We have termed these partner strategies 'input strategies' as it is important that the new Integrated Care Strategy is driven by, and aligns with, the priorities of its partner organisations.

A Strategy and Plan for 2019-24 for the MSE Health and Care Partnership (a precursor to the ICP) was published in draft form (although never formally ratified) in December 2019. Whilst the remit of the ICP is different, there is certainly considerable overlap and we anticipate that much of that Strategy will still be valid for the ICP going forward.

Since then however, much has happened, not least the Covid pandemic, the Health and Care Act 2022 and effectively a new government. Whilst few of the health, social and system issues we were facing then, will have gone away, the events of the past three years have brought new issues into focus - accelerated integration of the health and social care system, sharper focus on inequalities and a greater need for innovative ways of working.

2. Approach

A review was undertaken of publicly available strategies and plans from partner organisations within the MSE ICP. The organisations that make up the partnership deliver a range of health and care services across mid and south Essex, including hospital, mental health, social care, community and voluntary services.

When reviewing the strategies, priorities were identified across four broad areas:

1. Health
2. Social Care
3. Wider Determinants of Health
4. System Priorities

Each strategy covered a three to five year period between 2018 and 2026.

Strategies were reviewed from the following partner organisations (see Appendices A & B for details):

- MSE Health and Care Partnership
- Three upper tier local authorities
- Seven district, borough and city councils
- One acute hospital trust
- Three NHS community providers, collectively the MSE Community Collaborative
- One ambulance service provider
- Three local independent Healthwatch bodies

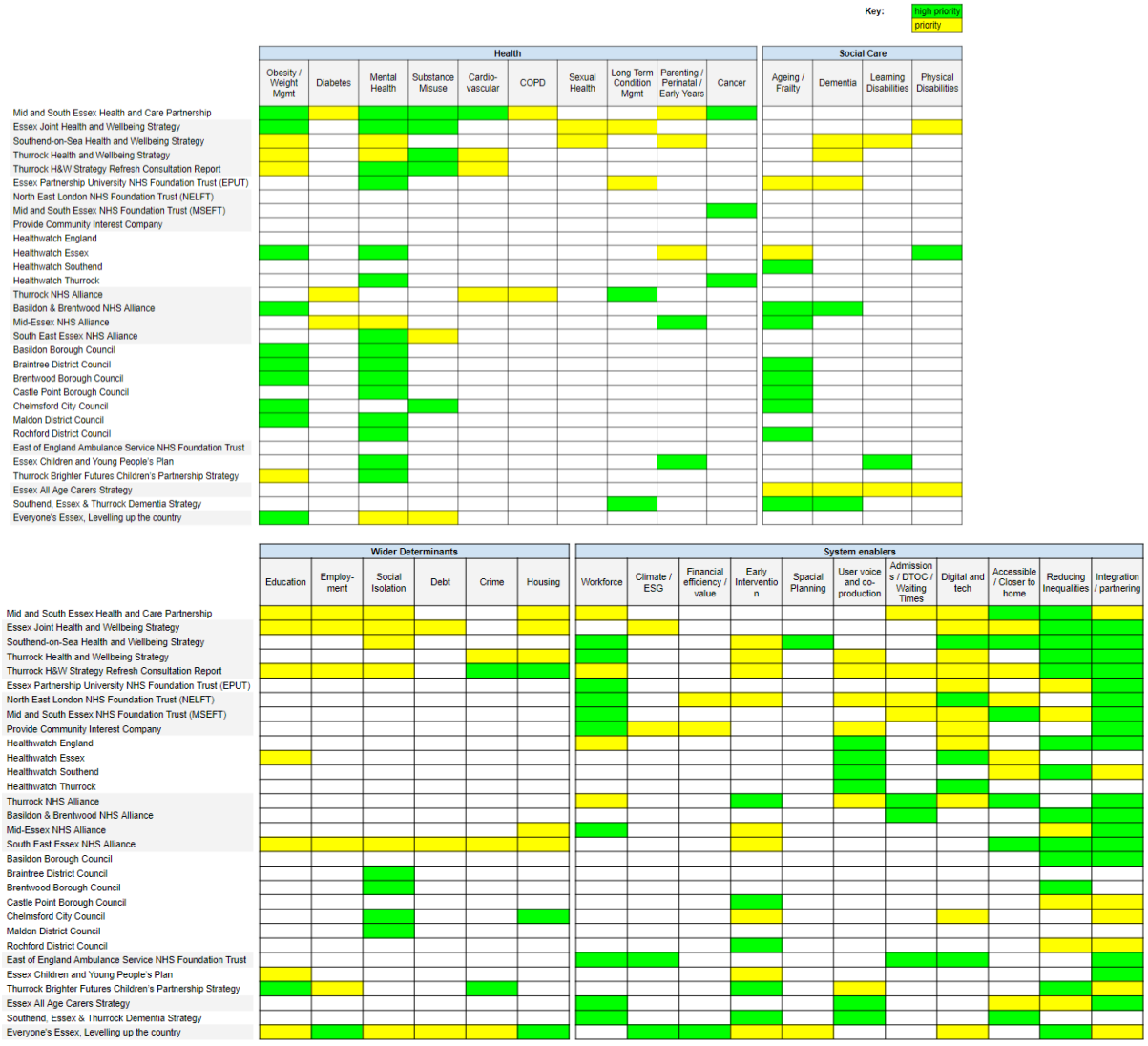
Publicly available strategies were not available for all partner organisations within the MSE ICP. For these organisations, relevant documents and materials were reviewed where possible. These include:

- 27 Primary Care Networks (PCN) covering 180 GP Practices
- Nine councils for voluntary services (CVSs)
- Essex Police
- Essex County Fire and Rescue Service
- Parish and town councils
- Local medical committee
- Local university and colleges
- Community and faith organisations

Alongside the strategies, the review also considered the Joint Strategic Needs Assessments (JSNAs) of the three upper tier local authorities.

3. Summary Table

The tables below provide a graphical comparison of the relative stated priorities of partner organisations.



4. Key Findings

4.1 Context

The Mid and South Essex Integrated Care System serves a population of 1.2 million people, living across Braintree, Maldon, Chelmsford, Castle Point, Rochford, Southend, Thurrock, Basildon and Brentwood.

The total population size of Mid and South Essex is projected to increase and get older. Over the next 5 years the largest increase is forecast among 75 – 79 year olds. By 2034 the largest increases are forecast for the 90+ years population.

Deprivation has increased across the 1.2m population. Overall Essex is performing worse than national comparisons for reading and maths scores creating a disadvantage for future schooling and ultimately skills for work. The productivity gap is increasing between mid and south Essex and national comparators.

There are high and increasing proportions of overweight or obese adults. There are increasing numbers of overweight or obese children in early years schooling. Some areas have high and increasing rates of Coronary Heart Disease, Hypertension, Stroke, Diabetes and Chronic Obstructive Pulmonary Disease. More people in this area die from cancer, heart disease and liver disease than expected. More people are being diagnosed with dementia. Mental health conditions are increasing in adults and children and in some areas suicide rates are increasing.

4.2 Headline themes

There is a considerable degree of consistency between the strategic priorities of the MSE ICP organisations. This is perhaps unsurprising given the shared population, health and social needs (as articulated in the JSNAs of the three upper tier local authorities) as well as the high levels of existing collaboration between partners.

There are three overarching themes.

First, the need to address the persistent ***inequalities*** that residents face, which result in lower quality of life and shorter life expectancy for many, particularly in parts of Basildon, Thurrock and Southend. Partners agree that redeeming this starts by acknowledging and investing in the wider determinants of health and ensuring pathway design begins with prevention and early intervention, including with children and young people, where many future health problems are seeded.

Second, MSE has a ***growing and ageing population***. With this come a wide array of conditions including dementia, cardiovascular disease, diabetes and chronic obstructive pulmonary disease, as well as the wider challenges of frailty and increased social isolation. It is vital that solutions better meet the increasing volume and complexity of need in a sustainable way, including the provision of care closer to home.

Third, ***mental health conditions*** are increasing in both adults and children and in some areas suicide rates are increasing at a worrying pace. Supporting people to feel comfortable talking about mental health, reducing stigma and encouraging communities to work together are highlighted as key to improving mental health and wellbeing. Community partners have a particularly important role to play in the here and now, well before people present into CAMHS or other formal mental health services.

For the purpose of this review, the strategic priorities have been categorised into four major areas: Health; Social Care; the wider determinants of health; and system priorities.

4.3 Health priorities

The priority health conditions that partners across the MSE Integrated Care System have most frequently chosen to prioritise are:

Obesity and weight management: addressing obesity, improving diet and increasing physical activity

Mental health: improving mental health and wellbeing by reducing the stigma and increasing the support available

Cancer: investing in early detection, regular reviews and personalised care plans to improve survival rates

Other common priorities included: **drug and alcohol misuse, cardiovascular disease, sexual health, COPD, long term condition management**, and **perinatal services**.

For each of these, partners all expressed the need for greater focus on **prevention, early intervention** and **anticipatory care.**

4.4 Social Care priorities

Within Social Care the **ageing** population is undoubtedly the most pressing and urgent challenge shared by partner organisations. Several identified the need to be working together to focus on ensuring appropriate services for **dementia**, **frailty** and **long-term condition** management.

Partners are prioritising services to enable **children and young people to achieve their potential, be healthy, and safe.**

In addition, partners recognised the need for support for **those in care** and for people with **disabilities** to properly access services.

4.5 Wider Determinants of Health

As key employers and commissioners of services, partnership organisations are well placed to impact on local economic opportunities and to focus on addressing inequalities.

For many partners, especially those working with older people, **social isolation** and loneliness is a huge challenge and exacerbates underlying health and wellbeing issues. It is therefore one of the most frequently addressed determinants.

Other major areas of identified opportunity include **employment** and recruitment practice, local **procurement** targeted at small and medium sized business, and work with schools and other **education** providers to encourage educational attainment and aspiration.

4.6 System enabler priorities

There is wide recognition across all partners of the need to **reduce inequalities** across the system. This requires investment in prevention and in addressing the wider determinants of health.

Deeper **partnership and integration** was cited as a core priority in nearly every partner strategy, which demonstrates a widespread recognition of, and commitment to, the work of the evolving Integrated Care System.

Many partners are embracing the need to adopt new models of care. In particular those that increase the **accessibility** of services, and bring care **closer to home**. Joining up the different health, care and voluntary sector services, whether that is through support online, or by bringing health and care services into the community.

The opportunities for **digital technology** go well beyond online support, and partners cited it as an important enabler. Enhanced data insights, connected interoperable systems and better sharing of information to allow Health and Social Care professionals to be more responsive to patients' needs and ensure that decision-making is deeply rooted in evidence and insights. Technology, medical advances and new ways of working to enable us to treat people at an earlier stage and avoid more serious illness.

Finally, partners demonstrated a high commitment to the **workforce**, ensuring effective recruitment and retention across all health and care services, including the development of new roles, and opportunities for staff development across the wider system rather than just within individual organisations.

4.6 Measuring success

The clear majority of strategies have an action plan that has been developed to broadly cover all the priority areas, detailing shared goals, tasks, outputs, outcomes and success measures, task leads and delivery teams.

Performance monitoring frameworks have been developed, which will be monitored and reported on to respective Health and Wellbeing Boards. Impact will be evaluated using both quantitative and

qualitative methods, including feedback from local people, performance indicators and health and wellbeing outcome measures.

Having a set of shared outcomes for the ICP will be critical in ensuring all partners have a shared purpose. Several outcomes frameworks could form the basis of a future shared framework, including one developed around the ambitions in the MSE Heath and Care Partnership Strategy and a framework from Essex County Council that combines the Live Well stages of life with the wider determinants of health.

Appendix A: List of input strategies

The review included strategies from the following partner organisations within the MSE ICP:

Three upper tier local authorities:

- Essex County Council
- Southend-on-Sea City Council (unitary)
- Thurrock Council (unitary)

Seven district councils:

- Basildon Borough Council
- Braintree District Council
- Brentwood Borough Council
- Castle Point Borough Council
- Chelmsford City Council
- Maldon District Council
- Rochford District Council

One acute hospital provider:

- Mid and South Essex NHS Foundation Trust (MSEFT)

Mid and South Essex Community Collaborative, bringing together NHS community services in mid and south Essex:

- Essex Partnership University NHS Foundation Trust (EPUT)
- North East London NHS Foundation Trust (NELFT)
- Provide

One ambulance service provider:

- East of England Ambulance Service NHS Foundation Trust (EEAST)

Three local independent watchdog bodies:

- Healthwatch Essex
- Healthwatch Southend
- Healthwatch Thurrock

Publicly available strategies were not available for all partner organisations within the MSE ICP. For these organisations, relevant documents and materials were reviewed where possible. These include:

Primary care:

- 27 Primary Care Networks (PCN) covering 180 GP Practices

Nine community voluntary services

- Basildon, Billericay and Wickford CVS
- Brentwood CVS

- Castle Point Association of Voluntary Services (CAVS)
- Chelmsford CVS
- Community 360 (covering the Braintree District)
- Maldon and District CVS
- Rayleigh, Rochford and District Association for Voluntary Service (RRAVS)
- Southend Association of Voluntary Services (SAVS)
- Thurrock CVS

Other partners include:

- Essex Police
- Essex County Fire and Rescue Service
- parish and town councils
- local medical committee
- local university and colleges
- community and faith organisations

Appendix B: Summary of Input Strategies

The following summaries are short condensed versions of the strategies of the partner organisations. The research team have endeavoured to capture the essence of the individual strategies, using verbatim extracts as much as possible.

B1. Mid and South Essex Health and Care Partnership, 2019-24

Context

There are high and increasing proportions of overweight or obese adults. There are increasing numbers of overweight or obese children in early years schooling. Some areas have high and increasing rates of Coronary Heart Disease, Hypertension, Stroke, Diabetes and Chronic Obstructive Pulmonary Disease. More people in this area die from cancer, heart disease and liver disease than expected. More people are being diagnosed with dementia. Mental health conditions are increasing in adults and children and in some areas suicide rates are increasing.

Strategic Priorities

1) Ensuring Equality: Addressing Inequality & Reducing Unwarranted Variation

2) Creating Opportunities: Education, Employment, Housing & Growth

Tackling wider determinants ~ a system of anchors

As key employers and commissioners of services, partnership organisations are well placed to impact on local economic opportunities and to focus on addressing inequalities. Major areas of opportunity include employment and recruitment practice, local procurement targeted at small and medium sized business, and work with schools and other education providers to encourage educational attainment and aspiration.

Employment and Recruitment

Basildon Hospital is leading work in this area and is seen as a national lead with a focus on understanding the local job market. The hospital is also working with Essex County Council to support people with learning difficulties to enter the workplace.

Thurrock Council have worked with NELFT 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.

Working with Schools

As large employing organisations with 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. With support from a public health grant, Basildon Hospital is embarking on an outreach programme to local schools to help improve interest and recruitment to NHS roles.

Procurement

Partners are committed to supporting the local economy and commissioning services locally where possible. Essex County Council performs well compared to other counties with over two thirds of commissioned spend

occurring within Essex, and one third with small and medium sized enterprises. As a system we will consider how best we can work within existing procurement regulations to support the local economy and will also consider how to ensure local social value is in contracts, including, for example, the number care leavers or people with physical and learning difficulties employed.

3) Health & Wellbeing:

- Providing information and support for people to self-care including through on-line and digital options.
- Providing good housing through the Local Plan of each local authority, with a particular focus on the quality of housing
- Improving diet and increasing physical activity by building on the "Livewell" and "Active Essex" initiatives, and targeted investment from Sport England.
- Weight management services supported by a range of community-led delivery partnership
- Ensuring good air quality
- Offering smoking cessation services and smoke free environment
- Working to improve alcohol treatment services across our three hospitals, ensuring links to wider mental health and community drug and alcohol support services.
- Identifying and supporting individuals at risk of developing ill health, for example through the National Diabetes Prevention Programme.
  Providing people with long-term conditions access to talking therapies to prevent the onset of anxiety and depression as a result of their condition,
- Using social prescribing to provide help to people who have "social" needs, for example, through provision of information and guidance on housing or welfare issues.
- Signposting people to local support mechanisms in their communities that help to address issues of social isolation and loneliness.

4) Moving more care closer to home

- We are committed to bringing as many services as possible closer to people's homes – whether that is through digital channels, where residents can access support on-line or through designated apps, or by bringing a range of physical, mental health and social care services into the community.
- It is our intention that the vast majority of services will be delivered locally – including lifestyle support services, outpatient appointments, some diagnostic tests and long-term condition support. We will also ensure swift and safe return to home for our residents after a period of hospitalisation.

Measures of Success

This table below shows the system-wide outcomes framework that has been developed by Public Health colleagues across the three Local Authorities and suggests some indicative metrics that could be used to measure the impact of our progress in working together over time.

TABLE 1	Reducing Inequalities	Creating Opportunity	Health & Wellbeing	Moving care closer to home	Transforming our services
How will we know we've made a difference?	Inequality will reduce and our residents will enjoy longer, healthier lives.	Our children achieve good development and educational attainment. Employment will rise. Homelessness will reduce and we will have good housing stock.	Our residents live long, healthy lives, and are supported to make good decisions on their own health and wellbeing.	Our residents report good access to and experience of primary and community services.	Our residents have consistent, timely access to safe, high quality health and care services. The outcomes from our services are improved,
What metrics will we use to track progress?	• Slope Index of Inequality • Healthy Life Expectancy measures	• School Readiness • Percentage of people in employment • Educational attainment • Statutory homelessness • Number of non-decent dwellings • Air quality	• % of adults classified as overweight or obese. • Reception and year 6 prevalence of overweight children • % of adults physically active • Smoking prevalence • Admissions for alcohol related conditions • QOF prevalence for diabetes, AF, CHD, hypertension, cholesterol. • % of people self-caring after reablement • Patient Activation Measures	• Patients reporting good overall experience with practice appointment times and good experience of making an appointment. • Patients reporting a positive experience of their GP practice. • Delayed transfer of care • A&E attendances conveyed by ambulance	• Breast and bowel screening uptake • Cancer waiting times • Elective waiting times • % of residents with high self-reported happiness • Reduction in depression cases • Reduction in self-harm • Reduction in suicide • Treatment and recovery rates for IAPT services • Physical health checks for patients with serious mental illness • Mental health admissions to hospital

B2. Essex Joint Health and Wellbeing Strategy, 2022-26

Context

- Almost two thirds of adults remaining overweight and obese, with this number increasing.
- Physical activity is low, with almost a third of adults being inactive. Similarly, most recent data suggests less than half of Essex young people do enough physical activity to benefit their health, and this has worsened since the covid pandemic.
- Essex, like most areas, has an ageing population with the number of over 65-year-olds set to grow by 28% in the next decade whilst the number of over 85s is set to grow even further by 55%.
- Loneliness remains an increasing challenge, based on the Essex Resident survey around a third of the population feel they lack companionship (34%) and feel isolated from others (33%) some of the time or often. 36% feel left out some of the time or often. Additionally, many areas in Essex have very high suicide rates predating the pandemic with 4 areas in Essex being within the top twenty areas in England with the highest rates.
- Essex have some of the greatest levels of deprivation nationally. Increasing life expectancy has stalled and even reversed in some areas.. The pandemic has further highlighted the differences we see between health and wellbeing outcomes of specific populations and communities.
- Covid has impacted on health care services with long waits for hospital treatment.

Strategic Priorities

Vision: To improve the health and wellbeing of all people in Essex by creating a culture and environment that reduces inequalities and enables residents of all ages to live healthier lives.

To really support the NHS, the HWB will focus on supporting poor health prevention and improving health; as examples, reductions in heart disease will require economic growth and better jobs and better lifestyle choices around exercise, diet and smoking as well as clinical risk identification and action and diabetes management will require good lifestyle choices and access to weight management support for all who are overweight as well as more intensive clinical interventions targeted at those at most risk.

Essex is a large, geographically variable place so our approach to delivery of this strategy will be through a place-based approach working with our partners at the appropriate level of place in order to achieve our ambitions.

1) Improving Mental Health and Wellbeing

- Mental health and emotional wellbeing remain high on the agenda of all partners in Essex, perhaps more-so now due to the COVID-19 pandemic. Health inequalities related to mental health and emotional wellbeing will be drawn out in the delivery action plan. Essex must give focus to the mental health and wellbeing of children and young people. Suicide is of specific concern within this broader issue, with four Essex districts amongst the top twenty in the country for high suicide rates - Tendring, Colchester, Harlow and Brentwood.
- Support the mental health and emotional wellbeing of children and families with a focus on vulnerable groups who have been hit the hardest by the pandemic as evidence on this emerges.

- Improve outcomes across multiple dimensions of life for adults with long term mental health conditions.
- Reduce loneliness and social isolation.
- Reduce suicide through a focus on system support of suicide prevention and having addressed the 7 national priorities.
- Develop collective actions to tackle health inequalities arising from the wider determinants of health that adversely interact with poor mental health including employment, loneliness, social isolation, debt and housing.

2) Physical Activity and Healthy Weight

- Preventing excess weight, maintaining a healthy weight and ensuring people can get enough physical activity requires a whole system place-based approach that addresses environments that support or promote obesity or do not support being physically active and ensuring that these encourage and support positive behaviour change.
- Enable children, young people and their families to be more physically active and that they understand the importance of an active lifestyle, healthier diets and healthy weight.
- Improve levels of physical activity amongst adults by helping them find ways to integrate physical activity into their daily lives.
- Improve nutritional awareness, healthy eating, and help low-income households to access affordable healthy food options.
- Support weight loss in communities through the development of healthier designed places by addressing environments that support or promote obesity
- Help residents with long term conditions and disabilities get the same access to physical activity as other residents.

3) Supporting long-term independence

- Residents of all ages experience a variety of different long-term conditions that without timely and appropriate support can have a detrimental impact on their quality of life and lead to the development of additional health and care needs in the longer term and the needs of residents and their carers is considered through this priority.
- Improve access to advice and guidance including financial support advice across the system so that residents with long-term conditions and their carers can better manage their conditions.
- Reduce digital exclusion to improve access to advice and support online, and connect with their friends, family, and communities in the digital space.
- Help all residents to have better access to opportunities in education, work, skills, housing, and their social lives. Ensure that advice and guidance we provide to residents is up-to-date, is accessible and provided in a uniform way across our partners so that people can more easily navigate the information, advice, and guidance we provide.

4) Alcohol and Substance Misuse

- Alcohol misuse is prevalent across society, but it is often the most vulnerable individuals and groups who are impacted most severely with the estimated impacts of alcohol related harm costing the health service alone over £3.5 billion annually.
- Improve access to advice, support and treatment for residents experiencing alcohol or substance use issues and co- existing conditions within the community.
- Work across the system to help address the challenges of county lines and drugs related criminality and exploitation of vulnerable people.
- Educate children, young people, adults, and families on the risks associated with alcohol and substance misuse.

5. Health Inequalities & The Wider Determinants of Health

- Ensure that all children have access to quality parenting, early years provision and education that provide the foundations for later in life.
- Address food poverty and ensure that all children can access healthy food.
- Improve access to employment, education and training for adults and young people in our most deprived and disadvantaged communities.
- Embed the use of health impact assessments in planning practice to ensure new planning proposals do not negatively impact on health, health services or widen health inequalities.
- Support residents who are digitally excluded, either by lack of equipment, connectivity, skills, cost, or confidence to be able to access services and information to benefit their education, career development, access to clinical services and personal wellbeing.
- Reduce barriers to accessing health and care services for families with low-incomes, children and young people who are in or who have been in care, people with learning disabilities, and other cohorts at greatest risk of poor health outcomes.

Foundational Principles

To support the development of this JHWS in Autumn 2021 we brought together partners for a series of workshops to explore what their individual local priorities are, what challenges are being experienced across the system and explore how we need to work collectively to deliver on the ambitions of our new strategy.

From these activities we identified number of principles for how we can work together better which we are calling our “Foundations for Collective Success”:

- Focus on prevention and early intervention as a cornerstone to long- term sustainability.
- Work collectively to address the wider determinants of health that drive poorer outcomes and long-term health inequalities.
- Make use of good data and analytics but also understanding and valuing the lived experience of our residents and service users.
- Understand residents’ journeys through the system to improve access to advice and support.
- Work with local communities using an Asset Based Community Development (ABCD) approach to support ground up community action on local issues wherever possible – not just “doing to” our communities from the top down.
- Adopt the principle of “universal proportionalism” in how we plan and allocate resources. We will be clear on what is our universal offer to all residents and which specific groups, cohorts, communities, or places might need extra support.as we develop action plans with partners.
- Set clear expectations for residents on health and care support from the system – what we can do and what we can’t.
- Recognise the impact of multiple conditions, behaviours and inequalities on the health and wellbeing of our residents.

- Think about how we use our collective assets more effectively and efficiently to deliver our shared ambitions and improve outcomes for our residents.
- Adopt policies and behaviours that are aligned to our wider commitments around climate change.
- Strengthen the local health and care system by encouraging more people to work in the sector and developing the role of the voluntary and community sector and communities in health and care.
- Build on best practice and evidence- based solutions and to innovate, test, and learn from new initiatives that help address emerging issues and trends and increase efficiency.
- Work together to make the best use of the opportunities new technology and emerging practice presents us.

Measures of Success

The Robert Wood Johnson model provides a framework that recognises the wide range of impacts on health and demonstrates the need for us to tackle all these elements with a focus on those that both have the biggest impact on health and are amenable to system action.

ECC has also commenced work on an outcomes framework, that could be adapted for MSE ICP, that combines:

- The Live Well stages of life from cradle to the grave
- The wider determinants of health that influence the conditions of life at each life stage
- Articulating these into a set of 'I' statements so we can capture lived experience

B3. Southend-on-Sea Health and Wellbeing Strategy, 2021-24

Context

There are marked social and inequalities between different wards in the borough, which will be exacerbated by the unexpected coronavirus pandemic. Life expectancy is 10.5 years lower for men and 9.4 years lower for women in the most disadvantaged areas of Southend-on-Sea than in the least disadvantaged areas. This is significantly worse than the England average.

As well as the increase in the borough's population (c+10% by 2031), the age profile of Southend is changing, with a growing number of older people, and a significant proportion of population aged 0 -19 years. The proportion of the population who are of working age is projected to decrease by 3% by 2031 while the over 65 population is projected to increase by 4%.

Dementia is a long term, progressive condition associated with complex needs and, especially in the later stages, high levels of dependency and morbidity. The recorded dementia prevalence amongst people aged 65+ registered with a Southend GP was 5.08% in 20206. This is higher than England (3.97%) and the East of England (3.95%).

Strategic Priorities

1) Health inequalities

- Improving health outcomes by addressing and reducing variation within the wider determinants of health (education, housing, employment and income).
- Work with partners in the Mid and South Essex Anchor Programme to develop the Council and NHS organisations as 'anchor institutions'.
- Targeting key population groups (older people,carers, residents with disability,learning disability and mental health needs; minority ethnic communities who may have socio-economic disadvantage and / or social isolation).

2) Effective Partnering

- Partnerships work in a coordinated way to ensure system alignment, shared resources and focus on co-production, to make Southend a healthier place.
- Continue to work closely with Essex County Council, Thurrock Council and the 12 local district councils as part of the greater Essex system.
- Continue to be an active partner in the Mid and South Essex Integrated Care System, working with the NHS and its partners ensure a strategic whole system approach to meeting the health and care needs across mid and south Essex.
- Co-ordinate use of community champions, volunteers and ambassadors to improve understanding of the needs of local groups and communities, engage with marginalised or vulnerable groups, and promote health and wellbeing information and services.

3) Accessible Services

- Ensure health services are designed to be as accessible as possible for users, identifying, reducing and removing barriers to access.
- Embed a culture of co-design and co-production across Southend's agencies and organisations, to help promote services and make them more accessible.
- Prioritise prevention and early intervention work to prevent disease or injury. Individual staff to 'make every contact count' (MECC) and to signpost to services and sources of support.
- Improving access to sexual health services and providing opportunities to reduce teenage pregnancies
- Include social prescribing in the health and wellbeing offer (moving to include self-referral), so that residents are supported to access community organisations.
- Ensure people with dementia are supported and receive the appropriate services in an appropriate and easily accessible manner.
- Work strategically with partners to ensure that targeted work is carried out around suicide and harm prevention, particularly with groups that are a higher risk.
- Ensure people with learning disabilities, autism and all neuro-divergent challenges, are supported and receive the appropriate services, improving the uptake of learning disability health checks, implementing the recommendations of the new autism strategy and delivery of the learning disabilities mortality review programme (LeDeR) recommendations.
- Provide easily accessible and appropriate weight management pathways and programmes for adults and children to meet the needs of different population groups. These should include advice on diet, nutrition, lifestyle and behaviour change and a more accessible universal offer to promote healthy weight.
- Provide and signpost parents to useful resources and support, to help with the challenges of parenting and enable better family outcomes.
- Identify, reach and give appropriate support to people experiencing social isolation and loneliness. Support may include help to build and improve social connection and / or improve independence, signposting to services and activities e.g., befriending or buddying schemes, educational, cultural and social activities, or community engagement activities like volunteering.

4) Workforce Development

- Skilled workforce to support the borough's health and wellbeing needs.
- Provide MECC and mental health first aid training for the health and social care and wider public sector, business and third sector workforce, to empower them to use day to day interactions to support people make positive changes for their health and wellbeing.
- Continue to engage with volunteers, to aid with the health and wellbeing needs

- Support health and care providers to train their staff to deliver personalised care and brief interventions (making every contact count) to improve client outcomes and experience. This includes supporting the Personalised Care Institute (PSI), to help staff develop and support the NHS Long Term Plan

5) Spatial Planning

- Use active environment design and spatial planning, so that the places and spaces in Southend encourage and facilitate activity in everyday life, making a healthy lifestyle as easy as possible. Such as, development control around fast food and alcohol, designing out crime, use of open space, and so on
- Maintain and develop safe spaces for play, sport and social interaction, accessible for all. Develop integrated active travel networks, which are safe and connected for walking, cycling and for public transport. Make better use of our existing natural and built environments to encourage healthy lifestyles for all.

6) Information and Digital Resources

- Ensure all residents can access clear and consistent information and services.
- Help people improve residents' digital skills and stay safe when using online services; support the delivery of the Southend Digital Inclusion Workstreams, including targeted work to address digital inequality – people who have limited or no digital access and skills.
- Continue the development of inclusive digital information and resources to help make health and care delivery more personal, convenient and secure.
- Maximise IT optimisation between partner agencies, which can deliver more effective digital solutions, increase the availability of digital devices and improve the connectivity between systems.

7) Coordinated Communications

- Work with partners to develop our communications and health campaigns strategies, to increase awareness of health risks, raise awareness of local services and support and encourage people to take action to improve their health and wellbeing.

Measures of Success

An action plan has been developed to broadly cover all the priority areas, detailing the shared goals, tasks, outputs, outcomes and success measures, task leads and delivery teams.

There will be a performance monitoring framework, which Leads will monitor and report on the implementation of the plans and their impact. This will be done via the Public Health Senior Management Team on a monthly basis and twice a year to the Southend Health and Wellbeing Board. We will be linked into various partnership boards as well to report on progress. Impact will be evaluated using both quantitative and qualitative methods, including feedback from local people, performance indicators and health and wellbeing outcome measures.

B4. Thurrock Health and Wellbeing Strategy, 2022-26

Context

- Life Expectancy (LE) is the highest-level indicator of health inequality, and life expectancy for both men and women in Thurrock is significantly worse than the average for England.
- LE is significantly lower in Thurrock than average across England for both men (78.3 years versus 79.4 years) and women (82.6 years versus 83.1 years).
- The greatest contributor to inequality in health outcomes in Thurrock is smoking.

- We know that smoking is the leading preventable cause of premature mortality in the country. Thurrock's overall smoking prevalence of 17.5% is significantly higher than in England and within some of the more deprived areas the prevalence is higher still. Data for pregnant women also shows high prevalence of smoking during pregnancy.
- Cardiovascular diseases (CVD) are also an area of concern for the community. The most recent data for stroke, hypertension and coronary heart disease (CHD) prevalence at borough level are in line with national averages, however CVD related outcomes are known to be worse in the more deprived areas of Thurrock. Diabetes prevalence in Thurrock remains above the regional average
- The proportion of adults classified as overweight or obese is also significantly higher in Thurrock, and higher still in the most deprived areas. 69.4% of adults are classified as overweight or obese, significantly higher than the England average at 62.8%. In 2019-20 the prevalence of overweight children at year 6 (age 10-11) in Thurrock was at 39.6% which is also significantly above the England average of 35.2%.
- Wider determinants of health are also important factors to also consider when looking at population data, and there is a mixed picture with regard to wider determinants in Thurrock. Thurrock's employment rate is 76.1% which is slightly above the England national average of 75.1% but not significantly so.
- The proportion of people living with a learning disability in Thurrock is lower than the average for England.
- Housing is a key factor underpinning health and wellbeing. For Thurrock, the number of households owed a duty under homelessness prevention is 10.5 per 100,000 which is lower than the England average of 11.3, and the quality of the housing stock in Thurrock is mixed.
- Crime has a considerable impact on the community, and the rate of violence offences in Thurrock (35.5 per 1,000) is significantly above the England rate of 29.5 per 1,000 population.

Strategic Principles

- ***Reducing inequality in health and wellbeing*** – We want things to get better for everyone, but we are also committed to ensuring that the most disadvantaged communities enjoy the same levels of opportunity, health and wellbeing as the most affluent.
- ***Prevention is better than cure*** – Rather than waiting for people to need help, we want Thurrock to be a place where people stay well for as long as possible. *Early intervention*
- ***Empowering people and communities*** – We don't just want to do things for people but give people the opportunity to find their own solutions and make healthy choices, taking account of different abilities to act and ensuring multiple access points to services.
- ***Person-led and strengths-based approach*** – Good health and care services should be organised around the needs of people, not around the needs of organisations. This includes using a Human Learning Systems approach to planning as well as the navigation and delivery of support and should build on community strengths and build social value
- ***Making good health and wellbeing everyone's responsibility*** – The organisations making up the HWBB have a shared priority to promote good health and reduce inequality, driving these principles through everything we do.
- ***Retain the positives from COVID-19 and address the challenges*** – We will retain and build on positives from COVID-19 such as communities building on their strengths and partnerships working together on shared priorities, at the same time as seeking to mitigate the negative impacts of the COVID-19 pandemic.

Strategic Priorities

- **Ambition:** Better outcomes for individuals that take place close to home and make the best use of health and care resources.

1) Development of more integrated adult health and care services in Thurrock

- Improved, integrated and easy to access entry to care – the majority of care will be provided close to home by multi-disciplinary locality teams (Community Led Support)
- Better management and coordination of multiple issues through a Human Learning System (HLS) approach to deliver bespoke solutions
- Development of a Dementia Commissioning Strategy to support Dementia Friendly Communities

2) Improved Primary Care response that includes timely access, a reduced variation between practices and access to a range of professionals

- All four Integrated Medical Centres (IMCs) operational by 2025, delivering a standardised clinical model that meet the specific requirements of the local community
- Improving quality of care through single models of care, integrated data sets, and early identification, management and prevention of conditions
- Collaboration and coordination with partners around Primary Care Network (PCN) areas to enhance capacity and ensure people receive the right response first time
- Upgrading GP practices' telephony systems and ways of working online

3) Delivery of a Single Workforce Locality Model – a health and care workforce that works across organisational boundaries to be able to provide a seamless and integrated response

- Development of professionals' integrated locality networks by Primary Care Network area
- Reducing onwards rereferrals through integrated and coordinated access points across and within localities
- Support solutions that incorporate the assets and strengths contained within communities and individuals
- Integrated coordination of care for individuals receiving support from multiple organisations and blended staff roles that support more than one function

4) Delivery of a new place-based model of commissioning that makes the best use of available resources to focus on delivering outcomes that are unique to the individual

- Development of Communities of Interest that enable communities to direct, develop and influence health and care provision
- Commissioning across functions through pooled and integrated budgets
- Place-based commissioning – responding to local conditions and requirements through Community Reference Boards
- A broadened and flexible marketplace that offers greater choice and increased opportunities for local providers – for example, building on Micro-Enterprises

Measures of Success

- More capacity across the system with a greater focus on prevention and early intervention
- Bespoke solutions to complex care needs, with single care plans
- Equity of access to primary care reaching the level of the current best access for everyone
- Better clinical outcomes overall and reduced variation in outcomes between GP practices
- Patient satisfaction with practices levels up to the current best
- Empowered staff focusing on what matters to residents

- Access to a broader range of care and specialisms at locality level
- Greater continuity of care for everyone
- Expanded support for community economic development, supporting a variety of health and care services for local people
- Residents' voices will be at the heart of service redesign

B5. Essex Partnership University NHS Foundation Trust (EPUT), 2019-24

Context

- Providing many community health, mental health and learning disability services to support more than 3.2 million people living across Luton and Bedfordshire, Essex and Suffolk.
- We are a large employer in the East of England with more than 5,400 staff working across more than 200 sites. We also provide services in people's home and community settings.
- The NHS Long Term Plan outlines the following as key to the NHS' success, new service model for the 21st century, action on prevention and reducing health inequalities, progress on care quality and outcomes, NHS staff getting the backing they need, digitally-enabled care to be mainstream across the NHS and taxpayers' investment used to maximum effect.

Strategic Priorities

1) To continuously improve service user experience and outcomes through the delivery of high quality, safe, and innovative services, specifically:

- The creation of specialist teams and advice and support for people with a personality disorder
- Build upon our service for older people with dementia that provides greater care and support in the community
- Focusing on physical healthcare for people with mental health conditions
- Integrating teams by leveraging opportunities arising from the provision of community and mental health services
- Integrated community wound care
- Frailty care coordination
- Developing IT to support clinicians and to enhance independence for patients and service users

2) To be a high performing health and care organisation and in the top 25% of community and mental health Foundation Trusts, specifically:

- Work closely with GPs and the voluntary sector in developing a wider range of services to support people with mental health conditions in primary care
- Multi agency working to avoid hospital admission and facilitate discharge
- Develop our organisation development agenda to support culture change
- Developing IT to support clinicians
- We are learning from incidents and achieving our safety ambitions
- We are maximising research and innovations in care to increase patient experience
- Improved and maintained learning, leadership and development leading to enhanced opportunities for staff to progress their careers and further develop their skills to develop capabilities and build capacity for the organisation
- Maintained a high level of staff satisfaction through trained, supported, healthy, resilient and diverse workforce

3) To be a valued system leader focused on integrated solutions that are shaped by the communities we serve, specifically:

- Providing services as close to primary care as possible
- Develop and embed a new 24/7 urgent and emergency crisis care service.
- Work closely with GPs and the voluntary sector in developing a wider range of services to support people with mental health conditions in primary care
- To develop in collaboration with other NHS partners new care models for specialist services.
- Develop our out of hospital initiatives including iMSK and other long term conditions.

Measures of Success

- Strong partnership working across our three STPs, including work with the third sector.
- Our services have a leadership role in the health systems which enable partners to identify and proactively address challenges and meet the needs of the population.
- Digital maturity across our systems.
- Working collaboratively as a partner to a financially sustainable and thriving STP.
- Reduced health inequalities across our STPs operated collaboratively and transparently to deliver high value pathways of care across organisational barriers
- Enabled easier access to psychological therapies for people who need it.
- Supported people living with mental health problems to find work.
- Provided easy access to 24/7 crisis care
- Supported carers.
- Through integration improved the physical health of those with mental illness.
- Improved the physical and mental health of those suffering with long term medical conditions.
- Continued working with our universities to take forward research activities.
- Improved access to physical and mental services for children and young people.

B6. North East London NHS Foundation Trust (NELFT), 2018-23

Strategic Priorities

- **1) Best Care: we will provide the best care for our patients, families and communities who use our services.**
  - Our best care means improving the health of our population by providing high quality, effective, patient led and safe care.
  - We will develop quality management systems to identify clinical variation and areas for improvement.
  - We will use our Quality Improvement approach to improve health of the population whilst improving patients' experience of care (Triple Aim).
  - You can view a summary of our Best Care strategy here.
- **2) Best People: we will retain, develop, empower and engage with our people, so they effectively deliver Best Care through existing and new care models, making NELFT the NHS employer of choice.**
  - We will ensure our people have the best quality experience of working with NELFT so they can deliver the Best Care to our communities.
  - We will continuously improve the experience of our staff through the appointment, retention and development of best people.
  - You can view our Best People strategy here.

- **3) Best Partner: we will effectively engage in our local health and care systems to develop collaborative partnership models which improve patient care.**
  - We will ensure we listen and hear from our patients, carers and communities to shape the services we provide.
  - We will strengthen our community engagement to support and address equality of access and respond to our patients and communities feedback.
- **4) Best Value: we will ensure services are delivered at the best value and highest quality by reducing variation whilst maintaining financial stability.**
  - We will make use of Digital and technology to improve our services and offers to our patients and our people.
  - We will use our Quality Improvement approach to improve service productivity and efficiency (Triple Aim).

Measures of Success

- Achieving a GOOD or OUTSTANDING CQC inspection rating
- Benchmarking in the top 20% of FFTs within 2 years
- Move to top 20% of best employers within 2 years

- **B7. Mid and South Essex NHS Foundation Trust (MSEFT)**

Context

3 large acute hospitals (Basildon, Chelmsford and Southend), and 3 other hospitals (Braintree, Maldon and Orsett).

- **Three-year goals**
  1. **High quality local services -** Build local services that are high quality and integrated.
  2. **Equitable access -** Driving equity as our priority, including in specialist services, taking advantage of digital.
  3. **Opportunities for our staff -** Invest in becoming an employer where everyone has an opportunity to grow, innovate and improve.
-
- **Strategic objectives**
  1. Keep our patients **safe** every day by minimising avoidable harm and maintaining appropriate numbers of skilled and capable staff in all the places we provide care.
  2. Improve **access** to cancer care and reduce **waiting times** for planned care for our patients.
  3. Enhance the skills and confidence of our people to realise the benefits of **innovation and technology** for them and our patients.
  4. Value our people through structured and supportive conversations about health, wellbeing and **individual development** between them and their manager.
  5. **Embed the Trust's values** of excellent, compassionate and respectful behaviour, leading to improved engagement and retention.
  6. Work as an effective partner in our financially sustainable Health and Care Partnership to improve **population health** outcomes.

- **B8. Provide CIC, 2021-24**

Mission

An ambitious, employee-owned social enterprise, growing in size and influence. We transform lives by treating, caring and educating people.

Strategic Priorities

Out mission of transforming lives will be delivered by our strategies to:

- Maintain Current Contracts and expand our reach
- Win new contracts and acquire new business
- Innovate for the future of health and social care

With responsibility as an organisation for:

1) Our People: Attracting, retaining and developing colleagues with the best talent. Driving high levels of motivation and engagement

- A motivated workforce which has a high level of engaged colleagues. Through targeted action plans increase levels of colleague engagement.
- As a member-owned organisation, members play an active role providing social value in our local economy

2) Our Customers: Delivering exceptional levels of care to our communities. Measuring and improving health outcomes

- Deliver high quality care throughout the Group. Deliver a minimum rating of GOOD or equivalent for all parts of the group. Through the Member Engagement Strategy increase member voting participation across the Group
- Deliver a first class Customer and Patient Experience. Establish joint working across NHS Community Providers as part of the Joint Venture or ICS configuration.

3) Our Finances: Increasing the size and financial health of the group supported by an ambitious growth strategy

- Grow our Business to continue to secure our future. Achieve a minimum annualised Turnover of £120m by March 2024.
- Use our resources wisely to allow for continued investment in our services and communities. Achieve an EBITDA of 7% by 2024.

4) Our Community: Creating real social value by maximising the investment in long-term positive impact on our communities

- Maximise the contribution we make in our communities. Achieve an investment of £800k by 2024.
- Encourage colleagues to be creative and to generate business solutions to problems and showcase new ideas. To achieve a positive Return on Investment by 2024.

We will achieve this:

- Through actively looking for opportunities to **partner with others, or acquire businesses** or act as a lead provider with suitable organisations. We are excited at the prospect of becoming a lead provider for aspects of the community network in Mid & South Essex.
- By playing a significant part in **the new ICS**, acting as a real “System Team Player”, fostering excellent stakeholder relationships.
- By putting the “Customer First” in all decisions and looking to constantly drive up our quality through **engagement and co-production**.
- By enhancing our **business intelligence** through the development of balanced scorecards, providing our organisational dashboard at group, directorate and divisional levels and enhancing our approach to horizon scanning and business strategy

- By having a highly **engaged and motivated workforce** who truly value being a member owned organisation.
- By taking significant steps to develop our **digital presence** in all our markets, supporting our customers and our workforce to experience high quality, innovative service models.

Measures of Success

We will measure progress:

- by the Engagement Index in the colleague engagement survey and monitored through team action plans.
- Through an increase in the number of members voting at the Annual Members Meeting and the Award of Charitable Donations
- through internal annual review. External validation will occur sometime before 2024.
- through % positive customer feedback on 3 service pathways measured per year reflecting an increase in co-production.
- through monthly income run rate in final month of each year.
- through our annual accounts.
- through our social value action plan & community grants.
- through ROI (finance, quality or patient satisfaction) on each project that is supported.

B9. Healthwatch England, 2021-26

Strategic Priorities

1) To build a sustainable and high-performing network of local Healthwatch services.

- Invest in engagement: Our staff and volunteers are our ears on the ground at the heart of communities, listening carefully to arising issues. However, with the pandemic restricting traditional face-to-face events and necessitating a rapid switch to digital engagement, we will ensure our staff have the skills, technology and funding to reach people.
- Build community links: We are proud to be part of the communities we serve. We want to understand the extent of our community links and identify gaps to ensure we are reaching and prioritising people who are not always listened to.
- Timely high-quality information: We want our network to be informed on the latest health, public health and social care matters, so that they can be a local point of knowledge for communities. put the experiences of people needing or using health, public health and social care services.

2) Find out the experiences of people needing or using health, public health and social care services

- Support regions: Until now, our communications and influence have been targeted at a local or national level. However, in line with the development of Integrated Care Systems and NHS regions, we will provide more insight at a regional and sub-regional level and work closely with Integrated Care Systems and regional structures to support their work.
- Build relationships with stakeholders: We want to be better known and understood by a range of people who work in health, public health and social care, so that they feel confident referring people to us and using our insight to improve services. To aid this, we will regularly brief stakeholders on important issues, public and patient concerns, and the impact we make.

3) To seek the views of those who are seldom heard and reduce the barriers they face.

- Hear from Black and Asian people: COVID-19 has had a disproportionate impact on Black and Asian people. We will prioritise gaining insights from these groups to identify gaps in data and knowledge and understand the barriers that prevent people from being heard.
- Use equality and diversity to frame our work: We are proud of the work we do hearing the views of people that many other organisations find difficult to engage with. Significant work has already been done to listen to specific communities and understand their experiences, but we want to take this further.
- Work in partnership: We will develop specific partnerships with organisations that have close links with communities creating mutually beneficial opportunities.

4) To act on what we hear to improve health and care policy and practice.

- Build strong and mutually beneficial partnerships and relationships with a range of organisations: We will continue to respond to Government, NHSE and other key stakeholders using our evidence base to improve policy, legislation and guidance. We will ensure that our evidence is used at an early stage to help inform the development of strategic positions. We will bring important issues to the attention of policy makers and push for them to be addressed. We will also build mutually beneficial partnerships with academic institutions.
- Act as a critical friend and contribute to policy development: Our independence from Government is central to our way of working. We will act as a critical friend to use our evidence to raise concerns and, when necessary, use our statutory powers.
- Ensure our network is kept abreast of policy developments: The pace of policy development is fast. We will keep the Healthwatch network up to date on complex policy issues so that they are equipped to make a difference in their local area.

5) To build on and share our expertise in engagement.

- Build partnerships with organisations to strengthen our engagement approaches: Since Healthwatch launched, we have developed a rich tapestry of localised approaches to listen to the views of the diverse communities we serve. Our first step in making this knowledge more widely available will be defining our approach to public engagement and then identifying the engagement techniques that deliver the greatest return for specific communities and the services they use. We will then develop our long-term plan to share and build expertise in public engagement over the year ahead.

6) To be a strong, well-governed organisation and use our resources for the greatest impact.

- Use our limited resources for the greatest impact: Our National Committee will continue to hold Healthwatch England to account.
- To ensure we use our resources appropriately, we will carry out a value for money review of our contracts and reduce our management costs by at least 10%.
- Transition to new offices: In 2021, we will oversee a smooth transition to new offices and ensure that staff continue to benefit from the flexibility we provided during the pandemic.
- Listen to and value our staff: We will continue to provide staff with opportunities to help improve the organisation and support their own development. We will invest in staff training and development, introduce new ways of working and provide opportunities for individuals to lead pieces of work. The Staff Engagement Group will play a key role in looking after the welfare of our team. We will also develop the relationship between our National Committee and staff.
- Accountability: Our Committee will maintain the highest levels of governance. In line with good practice, we will carry out a governance review and ensure that National Committee members get the support and training they need to carry out their functions.
- Our commitment to equality, diversity and inclusion: We will review our National Committee and staff team to ensure our people are diverse and reflect the population we serve

B10. Healthwatch Essex, 2020-23

Mission

Collecting lived experience, challenging the health and social care system and effecting positive change for the people of Essex.

Strategic Priorities

Year One | 2020-21

- This year we will continue to deliver high quality research, including a project focused on **obesity** and an impact evaluation of our own portfolio of work.
- Through our engagement team we will work with partners to deliver a model for **collaboration with adults with an experience of disability** – a project known as 'Collaborate Essex'.
- It will remain a priority to develop our Patient Partner programmes which are currently focusing on **young adults' mental health** and **maternity pathways**.
- Our focused engagement work will concentrate on the **personalised agenda for care**, including **Personal Health Budgets** and we will deliver our third **primary school-focused engagement** project, Lively Lives 3.
- Through our information team, we will develop and diversify our approach through new **technology** and bespoke **outreach models of engagement**.
- We will establish a marketing programme for HWE Insights to continue to build a robust commercial arm of Healthwatch Essex.

Year Two | 2021 - 2022

- This year we will deliver research projects based around the topics of **suicide** and **social prescribing**.
- We will also have developed joint research projects with our partners including The University of Essex, Anglia Ruskin University and NHS research partners, such as the National Institute for Health Research.
- Our engagement team will be focused on working with the Integrated Care Systems and the NHS Alliances to continue to place **lived experience** at the heart of their conversations and designs.
- Focus will be placed on expanding and embedding the work of the Essex **Neurology** Network.
- We will build on the work already completed - delivering an e-learning course and developing the county-wide rehabilitation agenda - by launching an exciting new project with the network.
- As part of their futures planning, the information team will establish a new review service.
- The service will offer, to stakeholders across the region, the ability to independently review incidents, funding, services and contracts on behalf of others.

Year Three | 2022- 2023

- In this year we will be working with our partners to review their strategies and plans.
- This will include looking back at the progress of the NHS long term plan, the ICS (Integrated Care System) five-year plans and the **mental health & social care** green papers.
- We will also support our partners, Active Essex, in reviewing the Essex Local Delivery Pilot – a project funded by Sport England to tackle **inactivity in deprived areas** across the county.
- This work will focus specifically on **families, older people** and people with **mental health** conditions in Basildon, Colchester and Tendring - demonstrating a grass roots approach to whole system change.

- By year three of our strategy will have established a role and position within all three Integrated care systems in our footprint, ensuring people using the services are actively **involved in their design**.

B11. Healthwatch Southend, 2021-22

Vision
Health and care that works for you. People want health and social care support that works – helps them to stay well, get the best out of services and manage any conditions they face.

Priorities
The top issues that people told us they wanted services to focus on are:

- Easier access to GPs
- Improved communications with Hospital
- Transport links to improve access
- Support for Vulnerable children

CCGs identified separate priorities that created difficulties in commissioning services covering a wider area than that covered by an individual CCG. Hospitals, ambulance services and mental health services are some of these.

Some inconsistencies were also identified in the current health and social services systems for example:

- A significant difference in life expectation for people living in adjacent areas.
- People presenting to the NHS with serious conditions that would have been less serious had they been identified earlier, especially those who are frail and elderly.

These are particular examples that have been selected as a priority to seek to improve.

B12. Healthwatch Thurrock, 2021-22

Strategic Priorities

1) Cancer Conversations: Better awareness of Access to services

2) Mental Health: Sharing of knowledge with partner organisations highlighting gaps in services.

3) Coronavirus: Pop up Vaccination Centre for hard to reach communities

4) Internet Usage with Older People: Introduction of free Wifi in communal areas of Care Homes

B.13 Basildon Council Health and Wellbeing Strategy, 2020-25

Strategic Priorities:
Basildon Council is committed to improving the health and wellbeing of borough residents and communities by working towards three key priorities:

1) reducing the prevalence of adult and child obesity

- Provision of play areas and maintenance of the public realm and green spaces. Play Strategy revenue being carried out to ascertain how we best deliver good quality play provision.
- Provision of health facilities. Contract management and excellent working relationships with providers of facilities and users of our parks.
- Ensure the Council is an active partner in Essex-wide initiatives such as 'Tuck IN' healthy choices campaign, which works in partnership with small independent caterers offering takeaways to make small changes to promote healthier ingredients
- Ensure a variety of opportunities for physical health support is provided throughout the workplace.

2) improving mental health and wellbeing

- Ensuring a key staff wellbeing focus on mental health with opportunities to highlight available support, raise awareness and consultation.
- For residents experiencing loneliness in sheltered housing there is an opportunity to utilise the communal halls to help tackle the issue of loneliness in the community.
- Working with mental health groups and charities to promote parks and open spaces which are proven to increase mental wellbeing.
- Providing business rates reductions for voluntary sector providers working to this agenda.
- Community rate reductions for hall hirers working to this agenda

3) reducing health inequalities by tackling the wider determinants of health

- Provision of a Winter night shelter to alleviate rough sleeping
- The Advice store – enabling access to skills and employment
- Employment and Skills plan by the Council's Economic Development team exploring ways of improving skills and employment prospects in the borough
- Developing an Early Years Policy.
- The development of our Air Pollution Plan which will enhance provision through ever greater walking and cycling,

By adopting a holistic approach that considers the impact our services have on the **wider determinants of health**, we believe we can have a greater impact on reducing **health inequalities** and thereby improve the health experienced by residents of the borough. Crucial to the success of this way of working is the involvement and contribution of our **communities and partners who will shape and drive new approaches**.

Enabler 1: Working as a partnership with key stakeholders
Enabler 2: Basildon Council adopting a whole systems approach to health and wellbeing
Enabler 3: The Community at the heart of what we do

Measures of success

Progress of the strategy will be measured at both local and county-wide levels against the Essex Joint Health and Wellbeing Strategy and Public Health Outcomes Framework. We aim to ensure that all health and wellbeing outcomes will be effectively evaluated and provide an evidence base.

B14. Braintree Health & Wellbeing Strategy, 2019-23

Context

- An ageing population

- Increasing obesity rates.
- A number of high risk groups with preventable health conditions
- Increasing in number of adults in substance misuse treatment.
- Increasing rate of diabetes.
- Third worst rate of hospital admissions due to hip fractures in the county.
- Increasing number of people with dementia.
- Average levels of child poverty, but some pockets of high deprivation.
- Low percentage of school children achieving a good level of development at age 5, including those eligible for free school meals.
- Second highest proportion of persistent secondary absenteeism in the County.
- Slightly higher levels of employment in the county.
- An average percentage of adults who are inactive.

Key outcomes

1. More young families having the **best start** in life
2. More people undertaking regular **physical activity**, which will in turn produce longer term health benefits.
3. Residents in the District will have **access to the best clinical services** when they fall ill.
4. Residents have access to the best information to allow them to consume the right type and quantity of **food** to benefit their health.
5. The district will have good quality, enhanced services for the early intervention, prevention, treatment and recovery of **mental health** problems across all ages.
6. Our **ageing population** has more opportunities to improve their health and wellbeing enabling a better quality of life in the future.
7. Reduce the number of elderly population who feel **socially isolated** and alone.

Measures of Success

The Public Health Outcomes Framework is a comprehensive list of desired outcomes and indicators that help measure how well public health and wellbeing is being improved and protected in an area. The Health and Wellbeing Panel will focus on a selection of these indicators that: (a) require the most improvement and (b) will best indicate progress towards the outcomes in this strategy

B15. Basildon Health & Wellbeing Strategy, 2020-25

Strategic Priorities

We believe that everyone has the right to enjoy good health and wellbeing. This is why Basildon Council is committed to improving the health and wellbeing of borough residents and communities by working towards three key priorities:

1) reducing the prevalence of adult and child obesity

2) improving mental health and wellbeing

3) reducing health inequalities by tackling the wider determinants of health

- By adopting a holistic approach that considers the impact our services have on the **wider determinants of health**, we believe we can have a greater impact on reducing **health inequalities** and thereby improve the health experienced by residents of the borough.
- Crucial to the success of this way of working is the **involvement and contribution of our communities and partners** who will shape and drive new approaches.
- Through community engagement and the use of external existing data, we have gathered and developed a rich understanding of the ambitions from our residents and our local businesses, and identified actions we can collectively take as an organisation, ensuring that we work effectively with partners to achieve these.
- We will build on existing relationships and develop new ones with stakeholders where needed, strengthening existing partnerships across the Borough to ensure we work effectively together. We know that much great work already happens within communities, often informally, and by harnessing the strengths of the Borough we can create a place where people are healthier, happier, independent and active.

B16. Brentwood Health & Wellbeing Strategy, 2020-23

Strategic Priorities

The vision is to ensure that residents of the borough live long healthy, independent active lives. Brentwood Health and Wellbeing Board is committed to improving the health and wellbeing of borough residents and communities and reducing health inequalities by working towards three key priorities:

1) Supporting everyone to Start Well

2) Helping people Live Well:

- Reducing the prevalence of adult and child obesity
- Reduce social isolation across the generations

3) Improving our ability to Age Well

In addition to the key priorities it is deemed there are concurrent themes across all our actions and focus, these form the backbone of everything we aim to achieve through the strategy. These are:

- Mental Wellness
- Resilient Communities
- Connecting people
- Encouraging physical activity

Live well Campaign

The Livewell campaign is designed to engage communities, families, and individuals with the aim of providing information about all that is on offer in Brentwood and Essex to improve health and wellbeing. Health and wellbeing for Brentwood works within the framework of the Essex wide Livewell initiative.

1. Start well – Support to help you and your family live happy and healthier lives
2. Be well – How to get you more active and stay active at any age
3. Feel well – To help you achieve a state of mental wellbeing in which you can realise your potential and cope with the stresses of life
4. Stay well - Self-care tips and techniques and general lifestyle changes to help you live a long and healthy life

5. Eat well - Information and advice about weight loss and healthy weight management and how good nutrition can help.
6. Age well - To help you enjoy a better later life by protecting yourself from illness, dealing with long term conditions, keeping active, coping with loneliness and staying independent.

B17. Castle Point & Rochford Health & Wellbeing Strategy, 2022-25

Vision

Castle Point and Rochford will be inclusive places where everyone is empowered, informed, and supported to live healthy lives.

Strategic Priorities

Our strategy is centred around **early intervention and prevention**. It focuses on what can be done at a local, grass roots level to make sure everyone has equal opportunities to:

- lead healthy lives and **stay in good health** for as long as possible
- **prevent health issues** from occurring that can cause people to become unwell
- **address problems at an earlier** stage to stop them getting worse
- **receive the right help** and support when they need it.

We are focusing on an all-age approach across our four priorities:

1. mental health and wellbeing,
2. physical health and wellbeing,
3. ageing well, and
4. community resilience.

These outline the areas we plan to tackle to help improve the health and wellbeing of our residents and reduce health inequalities.

We have solid foundations to build upon. The strength in our collaborative working and the many assets in our communities. We need to preserve, maintain, and capitalise on these to ensure that what our residents value is sustained. Our strategy highlights the importance of maximising our assets, helping people to help themselves, and working together with our communities to design services tailored to individual needs.

- **Our Strategy Key Pillars**

We have centred our strategy around three pillars:

1) People – to improve the health and wellbeing of our residents across all ages and target resource proportionately based on need

2) Purpose – for residents to feel empowered to improve their health and wellbeing, and to build resilience, to enable them to live well

3) Place – working at a local level to build healthy, active, and thriving communities that people feel connected to.

- **Our Strategy Principles**

We have also based our strategy on 10 key principles that underpin its delivery:

1. **Early intervention and prevention**. This means stopping problems from happening, where possible, and dealing with them at an earlier stage when they do so that they don't get worse

2. Helping people to be **resilient**. This means having the knowledge, skills, and confidence to manage their health and be able to bounce back from tough times
3. Supporting people in a wholesome way, taking account of their individual needs and circumstances. We call this a **person-centred approach.**
4. **Working together** to build, strengthen, and maintain relationships and trust, and join up better with services
5. **Reducing health inequalities** by tackling the social factors that affect health
6. Being able to **adapt and respond** to ever-changing needs, mobilise resources quickly, and scale up when needed
7. **Sharing information** to make it easier to know who does what and where so that we all know what is available near where we live
8. **Clear communication**. Spreading messages in different ways. This means we can reach more people and makes it easier for them to find, access and connect into the help they need
9. Making best use of our **assets**. These can be things like our buildings, but also knowledge and resources
10. **A place-based approach**. Creating opportunities, as well as the right environment for people to live well

B18. Chelmsford Health & Wellbeing Strategy

Vision

Our vision is to work with communities and residents to reduce health inequalities and improve the opportunities for adults and children so that they can enjoy a healthy, safe, and fulfilling life

We want the district covered by Chelmsford City Council to be a place where:

- the physical environment in which our residents live will improve their health and wellbeing
- children grow up to reach their full potential and are happy
- older people feel valued and supported in their local communities
- people have access to good employment and work opportunities
- people stay healthy and enjoy life and have the resilience to cope with life's changes
- people can expect to enjoy good health, whatever their social or economic circumstances
- people are connected to their communities and to each other

Strategic Principles

A set of principles have been identified to enable and set the foundation for decision making and evaluating actions against our identified health and wellbeing priorities. It is important to ensure we work towards contributing to and facilitating a sustainable health system through shifting focus from health-related work and care to prevention, early intervention, and resilience.

1. **Partnership working** A commitment to a holistic and partnership approach to improving health and wellbeing in the district, enabling statutory and voluntary sector organisations to work collaboratively with communities and build on existing assets (ABCD approach).
2. **A focus on prevention of ill health and early intervention** Prevent and tackle the wider causes of illhealth, poor life choices, and health conditions.
3. **Increase communication and making use of technology** On-going and effective communication, co-production, and engagement with residents and partners about health issues. We will raise awareness of local activities and events by using the "livewell" platform for information and guidance to help communicate health and wellbeing messages.

4. **Improve mental health and wellbeing** To improve mental health and wellbeing, ensuring mental health is regarded across all streams of work. Ensure that the promotion of health and wellbeing features in all strategies and plan where possible.
5. **Effective health service and self-care** Contribute to achieving effective health services and promoting self-care by utilising and promoting the Connect Well self-care, self-refer platform.

Strategic Priorities

1) Reduce excess weight and obesity and increase physical activity in adults and children

2) Alleviate loneliness and social isolation

3) Improve poor housing including fuel poverty and thermal comfort

4) Enable people to age well

5) Reduce alcohol, substance misuse and behavioural addictions (including supply of illegal substances)

Chelmsford City Council's contribution to Public Health:

1. A safer and greener place
2. Fairer and inclusive growth
3. Healthy, active and enjoyable lives
4. Connected Chelmsford

B19. Maldon Health & Wellbeing Strategy, 2021-23

The District has three main health priorities:
1) Obesity
2) Mental Health
3) Social Isolation

Included within the Maldon Corporate Plan:

Community Outcomes
Through our projects, actions, communication, partnerships and policies we will work to support our communities, the health and well-being of our residents, and to provide safe and clean places to live in and enjoy.

- Working with our communities and partners to improve the **physical health** and well-being of our residents
- Working with our communities and partners to improve the **mental health** and well-being of our residents
- Working with our communities, schools and partners, to improve our children and young peoples ' health and well-being, giving them the **best start in life**
- Ensuring the **safety** and wellbeing of our vulnerable children, adults and families

- Building on the strengths of our communities and what they can do to support themselves and **help each other** to thrive

B20. East of England Ambulance Service NHS Foundation Trust (EEAST), 2020-25

Vision
Outstanding care, exceptional people, every hour of every day

Strategic Priorities

1) Be an exceptional place to work, volunteer and learn
- Workforce strategy, including volunteers: develop, engage and empower our staff, keeping patients are at the heart of everything we do
- Organisational development (OD) strategy: develop the right culture that supports the wellbeing of our workforce and the delivery of high quality patient care
- Education and learning strategy: improve the quality of education and training provision within EEAST
- Communications and engagement strategy: successful communication enabling us to engage more effectively with the communities we serve

2) Provide outstanding quality of care and performance
- Clinical strategy: provide individualised safe and effective patient care to improve outcomes; deliver innovative, evidence-based practice using quality improvement methodology; and support and develop our staff and volunteers
- Research and innovation strategy: as a partner of the National Institute for Health Research's Eastern Clinical Research Network, we are committed to contributing to world-class research that transforms people's lives, promotes economic growth and advances science
- Quality improvement strategy: establish a sustainable process which embeds quality improvement in all aspects of Trust business – an essential part of our staff engagement approach; reduce clinical variation; and establish a quality improvement faculty

3) Be excellent collaborators and innovators as system partners
- Digital strategy: a robust digital environment which aims for 99.999% availability of our core digital services, which include telephony, data/information, network and critical control room applications.
- Urgent and emergency care strategy: place ambulance services at the heart of urgent and emergency care while maximising our ability to coordinate services on behalf of our partners

4) Be an environmentally and financially sustainable organisation
- Commercial strategy: attract investment into EEAST to support the delivery of patient services and create greater financial sustainability
- Sustainability strategy: clear and unambiguous targets which complement our commitment to being a good corporate citizen and shows how we will govern, manage and implement our sustainable healthcare plans.
- Procurement strategy: we will increase efficiency and effectiveness in purchasing and logistics so that we can provide the best possible value for money and maximise the amount spent on direct patient care
- Make ready, feet and estates strategies: delivering a modern and pleasant environment for our staff to work in, as well as the operational and financial efficiencies which are required to help us provide high quality, sustainable services

B21. Essex Children and Young People's Plan, 2020-

Context

We work within a complex children and young people's landscape that incorporates upwards of 550 schools and academies, three Sustainability and Transformation Partnerships, of which the 5 Essex Clinical Commissioning Groups are part, three police divisions, twelve district, borough and city councils and the two bordering unitary authorities of Thurrock and Southend. There is also a thriving voluntary and community sector providing support to children, young people and adults, which is critical to the delivery of our Plan.

Strategic Priorities

The Partnership has a wide scope of activity and to deliver the identified outcomes we will work from now until the next plan review by organising ourselves around three key priorities:

1) improving emotional wellbeing for children, young people and families

- We will continue to work through our existing forums, led by the EWMH sub group of the Children and Young People's Strategic Partnership, to ensure we collaborate across the system to provide good quality, accessible support for children and young people experiencing emotional wellbeing and mental health difficulties. We will embed national and local programmes of support

2) improving outcomes for those with special educational needs and/or disabilities – including continue to improve services and experience for SEND and reduce postcode lotteries, continuing to address areas for improvement identified in recent inspections from Ofsted and CQC

- We will work together within existing forums, led by the SEND Improvement Board, to ensure that collectively we each play our part in delivering the actions identified in the 2019 Essex Local Area SEND Inspection.

3) supporting parenting

- We will embed this priority within existing parent forums led by the Southend, Essex and Thurrock Parenting Reference Group, with the aim of strengthening our collective efforts to continue to share and develop good quality information, advice and guidance, and where appropriate, support to ensure parents' personal needs and those of their children are met.

Measures of Success

A lead for each of these outcomes will sit on the Children and Young People's Strategic Partnership Board. This lead will report progress with the existing action plans for each outcome to the Board. The Board will provide support and challenge and identify where added value could come from further collaborative activity.

B22. Essex All Age Carers Strategy, 2022-26

Context

- The UK Census data for 2011 identified the number of adults providing unpaid care in Essex was 146,211. However, in 2015 Carers UK said in its 'Valuing Carers' report that it estimates there are now probably 153,926 of you in Essex.
- Nationally the estimate of young carers in the UK is 1 in 12; that equates to an average of 2 children or young people in every classroom across the country. It is estimated there are more than 10,000 of you in Essex who are under 18 and providing care to a family member.

Strategic Priorities

This All-Age Carers Strategy sets out six commitments, informed by you, that outline how we aim to give you the support you need when you need it; promote the inspirational care you give; and promote your rights as an unpaid carer.

1) Carers can easily access the information, advice, guidance and support when they need it and early into their caring role

2) Develop professional practice and processes to improve identification and support to carers.

3) Improve transitions for carers as they move through specific phases or life events in their caring role

4) Carers will have increased opportunity to access good quality support,

5) Carers' needs and rights will be understood and recognised across Essex communities.

6) Carers will be the experts that influence, shape and be involved in the decisions that are intended to improve their support and wellbeing.

Through this, we will enable the following outcomes:

- Resilient children and young people
- Stable and thriving families
- Inclusive and supportive schools and communities
- Safe and accessible neighbourhoods

Measures of Success

We will be using a range of methods and tools to collect important data and information that helps us evidence our progress in delivering the 6 commitments that will produce the desired outcomes. This includes for example; national and local surveys, adult social care and health data, feedback and case studies.

B23. Southend, Essex and Thurrock Dementia Strategy, 2022-26

As published in the Stage two consultation

Context

- In Southend, Essex and Thurrock there are 15,280 people who have been diagnosed with dementia.
- We think there may be another 9,000 people with dementia but who have not been diagnosed.
- We think the number of people with dementia will increase by 33% by 2030.

Strategic Priorities

Our main aims are to make sure that:

- people feel that we understand them. They can get the right support when they need it.
- everyone is aware of the impact of dementia
- everyone involved in the lives of people with dementia have the right skills and training.
- we do everything we can to help reduce the number of people who get dementia.

Based on what you have told us we think that our 9 priorities are still the right things to do. These are:

1) Prevention To help people live healthy lives, with little support for as long as possible.
2) Supporting unpaid carers To make sure that people who care for those with dementia have all the support they need.
3) Reducing the risk of crisis To make sure we are quick to help people if things become difficult.
4) A knowledgeable and skilled workforce To make sure that those who work with people with dementia have the right skills and training.
5) Finding information and advice To make sure that people know where to find the information they need
6) Diagnosis and support To make sure people find out what is wrong with them as soon as possible, and they get support when they do.
7) Living well with dementia in the community To help people to stay living in their home community for as long as possible.
8) Living well in long term care To make sure that Care Homes are part of the community and that people who live in care homes can still do the things that interest them.
9) End of life To help people with dementia to plan what happens at the end of their life. This might be things like who is with them, or where they die

B24: Everyone's Essex: our plan for levelling up the county, 2021-2025

Strategic Priorities

1) Economy

We have 5 commitments for the economy.

- **Good jobs -** We will work hard to address the impacts of the Covid pandemic on unemployment by supporting business recovery and building a stronger economy for the future, enabling people to build the skills they need to be part of it, and working alongside Essex businesses to help reduce barriers to employment for disadvantaged groups.
- **Infrastructure -** We will deliver and maintain high quality infrastructure to improve opportunities for people living in Essex as well as supporting a growing economy and the delivery of new homes and communities by investing in the region of £1 billion by the end of this council.
- **Future growth and investment -** We will help grow existing businesses and the economic sectors of the future in Essex, including the arts, and secure high levels of new investment by working with partners to promote the county, by creating the conditions for growth and by maximising the impact of public sector spend within the county.
- **Green growth -** We will develop Essex as a centre for innovation, supporting new technologies and business models to enable our economy to transition to net zero and secure green jobs for the future by ensuring we have the right local skills and drawing in investment opportunities.

- **Levelling up the economy -** We will work to level up the economy by addressing the drivers of socioeconomic inequality (including income, education, employment, health and housing), based on the foundation of good jobs and a higher skilled and healthier workforce.

2) Environment

We have 5 commitments for the environment.

- **Net zero -** We will work across the council and the county to hit our net zero targets, by ensuring that the council significantly reduces its carbon footprint, whilst also supporting an acceleration in the progress towards sustainable housing and energy, and active and alternative forms of travel across the county.
- **Transport and built environment -** We will deliver a step change in sustainable travel across the county, by growing passenger transport and active travel, and will ensure we support the move towards net zero, climate resilient developments, including our new garden communities, by delivering sustainable, healthy neighbourhoods for the future.
- **Minimise waste -** We will minimise the impact on the environment by supporting residents and businesses to reduce waste and increase the amounts recycled, and by working with others to deliver a more circular economy whereby we better protect our natural resources through the efficient and ongoing reuse of materials.
- **Green communities -** We will work with communities and businesses, providing advice and support to enable and empower local action to reduce greenhouse gas emissions and build climate resilience.
- **Levelling up the environment -** We will help all our communities to enjoy a high-quality environment, by making them more resilient against flooding, heat stress and water shortages, by enhancing our county's green infrastructure and by reducing air pollution.

3) Health

We have 5 commitments for promoting health, care and wellbeing for all the parts of our population who need our support.

- **Health lifestyles -** We will aim to increase the proportion of people able to live healthy lifestyles by embedding a community-first approach, by helping people to overcome social isolation, mental ill health and substance misuse, and by helping people to live fit and active lifestyles.
- **Promoting independence -** We will work with key partners and the adult safeguarding board to help individuals to live free from abuse and neglect and will enable residents to live independently by assisting them to access suitable accommodation, supporting access to employment and meaningful activities, and enabling independence at home through reablement, care technology, and market shaping to ensure strong domiciliary support, and investment in housing.
- **Place-based working** - We will deliver better care that meets the needs of residents by joining up care and support with local partners in a place, including with district councils, health partners and the local voluntary and community sector.
- **Carers -** We will help those carers of all ages whose caring duties are impacting most on their wellbeing by achieving a step change in the advice, guidance and support we provide to support wellbeing and independence, and by targeting it at those who need it most.
- **Levelling up health -** We will seek to reduce health inequalities by bringing together partners and communities to address the socio-economic drivers that underpin poor health outcomes, such as poor housing, poverty, economic insecurity and low skills.

4) Family

We have 5 commitments for children and families.

- **Education outcomes -** We will achieve educational excellence and high standards for all children and young people as we recover from the pandemic, by working in partnership with early years

providers, schools, colleges and universities, by building greater coherence across the system and by engaging businesses, communities and the arts sector in supporting education outcomes.

- **Family resilience and stability -** We will work to strengthen family resilience and stability, as part of thriving communities, by embedding an approach that tackles the drivers of family instability and provide support to low income, vulnerable and working families.
- **Safety -** We will continue to improve the safety of Essex residents, including children and young people, by sustaining our nationally recognised approach to early intervention, safeguarding and neglect, addressing domestic abuse, child criminal and sexual exploitation, and peer on peer violence and abuse. We will continue close working with our partners to help make our communities safer and address key issues such as violence and vulnerability, and safety for women and girls.
- **Outcomes for vulnerable children -** We will work to improve outcomes for the most vulnerable and disadvantaged groups including Children in Care, Care Leavers, Children with SEND and children from BAME communities, by working with children, young people and partners across the system.
- **Levelling up outcomes for families -** We will work to address inequalities affecting children and families by focusing on recovery from the pandemic, tackling family poverty, mental health support, emotional wellbeing and healthy, active and productive lifestyles, and making sure that we engage hard to reach groups.

B25: Thurrock Brighter Futures Children's Partnership Strategy

Context

There have been a number of challenges over the last three years, including local area budgets and increased service demand. However, the most prolific challenge of recent times has been the COVID- 19 Pandemic. Most of the challenges that have arisen for children have been related to the wider response to the pandemic; these include social, educational, and health impacts due to the closure of schools and the refocussing of health services during the pandemic and national lockdowns resulting in missed or delayed health appointments.

Many children are likely to have been impacted by the economic changes resulting from the pandemic response, such as loss or change in parental income, increased negative health behaviours such as more sedentary time, and increased stress of those around them impacting on the child's emotional wellbeing. Children may have suffered from isolation and boredom, with the vast majority of children having missed around 6 months of formal education; this is particularly true of children who face disadvantage. It is likely that there has been an increase in vulnerability, adverse childhood experiences, abuse, and family relationship issues.

Underlying Principles

Prioritisation: Due to the potential volume of priorities, we have sought to prioritise our efforts based on the following: issues where Thurrock is an outlier from comparators; issues where we are outliers and the trend is worsening; a JSNA product has highlighted a need and made recommendations for action that has not yet been taken; an inspection has been undertaken which requires changes in a particular area; there is a desire locally to shape a particular area for the purposes of achieving transformational change

Outcomes focused: The impact of our strategy will be measured by success criteria derived from national and local performance measures. We will take a layered approach to understanding success including case studies, service reviews and young people's voice.

Reducing inequality: If inequalities are not tackled at an early age, it is unlikely that this gap will be narrowed as children get older. Investing in the early years can help to address health inequalities that disadvantage some from the very beginning of their lives. There is also a strong incentive to invest in the early years from an economic perspective, as the long-term savings that can be generated are considerable.

Value driven: In delivering our strategy there are seven wellbeing aspirations we want for all our children and young people. We want them to: Have the best start in life; Be safe from harm and have the help they need; Have healthy and active lives; Be prepared for adult life; Feel they can have their say and be listened to; Have a good education that enables them to achieve their full potential; Be happy and thriving.

Co- Production: In developing this strategy partners have sought to co-produce with service users. Co-production can help make the best use of resources, deliver better outcomes for people who use services, and build stronger communities. In the writing of this strategy we have put the following critical values in place in order to meaningfully coproduce: equality, diversity, accessibility, and reciprocity.

Asset focused: We have sought to focus on identifying our strengths and assets, as well as our needs and difficulties.

Strategic Priorities

1) All children are enabled to achieve their potential

- Support young people to gain qualifications, skills, and experience to progress into sustained employment
- Improve educational attainment for all disadvantaged children and young people
- All children are able to access education

2) Children are able to access the services they need and be healthy, focussing on prevention and early intervention

- All children start school ready to learn
- All children achieve a healthy weight. All children are protected from illness and disease
- All children receive the care they need in the right place.

3) All children live safely in their communities – with a focus on Youth Justice

- Further develop surveillance to identify the most at risk children and families and intervene early with tailored intervention packages
- Deliver targeted and tailored primary prevention for populations with greater need
- Intervene early with tailored secondary prevention to reduce the harms of exposure to violence and violence risk behaviours
- Provide tertiary prevention for perpetrators and victims of violence to reduce further harm

4) Children and their families experience good emotional health and wellbeing

- Strengthen our whole school approach, with a view to ensuring all children are thriving and have access to the support they need
- Identify and implement solutions which recognise needs early and improve access to targeted and specialist interventions
- Tackle the social inequalities that put young people at a disadvantage to achieving good mental health

B26: Thurrock Health and Wellbeing Strategy Refresh Consultation Report 2022

Context

Evidence shows us that Thurrock experiences inequalities both as a whole when compared to England and also within the borough. Life Expectancy for Thurrock has 5 fallen below the England average in the past 10 years. Inequalities and an uneven playing field are experienced by many different community groups within Thurrock in different ways. This includes people of different genders, ages, ethnicities, socio-economic status and LGBTQ+ people. Across Thurrock there is a 9 year life expectancy gap between men and a 6 year gap for women between those living in the most and least affluent communities.

Strategic Priorities

1) Staying Healthier for Longer (with a particular focus on mental health and substance misuse)

- Work with communities to reduce smoking and obesity in Thurrock
- Work together to improve prevention of ill health and promotion of good health in all communities to reduce Health Inequalities in Thurrock
- Continue to enhance identification and management of Long Term Conditions to improve physical and mental health outcomes for all
- Prioritise Post-COVID-19 Service Recovery and Reset to meet New and Worsening Health Needs

2) Building Strong and Cohesive Communities

- Improve the way we engage with our residents to ensure everyone can have their voice heard.
- Ensure people have the skills, confidence and ability to contribute as active citizens and are empowered to influence the decisions that affect their lives
- Promote opportunities to bring different communities together to enhance shared experience and to embed a sense of belonging

3) Person Led Health and Care

- Development of more integrated adult health and care services in Thurrock
- Improved Primary Care response that includes timely access, a reduced variation between practices and access to a range of professionals
- Delivery of a Single Workforce Locality Model – a health and care workforce that works across organisational boundaries to be able to provide a seamless and integrated response.
- Delivery of a new place-based model of Commissioning that makes the best use of available resources to focus on delivering outcomes that are unique to the individual.

4) Opportunity for All

- Through raising aspirations and reducing the disadvantage gap, all Thurrock children and young people are able to achieve their potential.
- Raising aspirations and opportunities for adults to continue learning and developing skills, with a focus on groups that can benefit most
- Delivering the Backing Thurrock Plan in a way that supports the economically vulnerable in developing resilience and resulting in more residents being able to benefit from employment opportunities
- Working in partnership to level up opportunity and reduce the inequality that 38 exists physically and socially for people living in disadvantaged circumstances.
- Creating a vibrant cultural offer and local economy, encouraging investment in people and in places across Thurrock to benefit from the enormous opportunities generated through the Thames Freeport and other major developments such as SEE Park.

5) Housing and the Environment

- Reduce homelessness in Thurrock
- Facilitate and encourage maintenance of good quality homes in Thurrock to support the health of residents, protecting them from hazards such as cold, damp and mould
- Provide safe, suitable and stable housing solutions for people who have or who are experiencing domestic abuse / violence and / or sexual abuse / violence.

- Regeneration and future developments will improve health through opportunities to increase physical activity, promote mental wellbeing and reduce exposure to air pollution
- Regeneration and future developments will seek to build community resilience and social capital, and reduce antisocial behaviour, to improve the quality of environment experienced by all people in Thurrock.

6) Community Safety

- We want all children to live safely in their communities
- Work in partnership to reduce local levels of crime and opportunities for crime to take place, which will result in fewer victims of crime and make Thurrock a safer place to live
- Improve the local response to supporting victims/survivors of crimes to improve their health and wellbeing
- Work in partnership to prevent and deter crime, with a focus on those with increased risk of experiencing crime

B27: CORE20PLUS5

Core20PLUS5 is a national NHS England and NHS Improvement approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.

- **Core20**

The most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). The IMD has seven domains with indicators accounting for a wide range of social determinants of health.

- **PLUS**

PLUS population groups we would expect to see identified are ethnic minority communities; inclusion health groups; people with a learning disability and autistic people; coastal communities with pockets of deprivation hidden amongst relative affluence; people with multi-morbidities; and protected characteristic groups; amongst others. Inclusion health groups include: people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups.

- **5**

The final part sets out five clinical areas of focus. Governance for these five focus areas sits with national programmes; national and regional teams coordinate local systems to achieve national aims.

1. Maternity: ensuring continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups. This model of care requires appropriate staffing levels to be implemented safely.
2. Severe mental illness (SMI): ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in learning disabilities).
3. Chronic respiratory disease: a clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.
4. Early cancer diagnosis: 75% of cases diagnosed at stage 1 or 2 by 2028.

5. Hypertension case-finding and optimal management and lipid optimal management: to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.