Thurrock - An ambitious and collaborative community which is proud of its heritage and excited by its diverse opportunities and future

Health and Wellbeing Board

The meeting will be held at **10.30am** on **10 February 2023**

Council Chamber, Civic Offices CO3, New Road, Grays, Essex, RM17 6SL

Membership:

- Cllr D Arnold (Chair),
- Cllr B Johnson, Cllr S Ralph, Cllr S Liddiard, Cllr S Muldowney

Elected member substitutions as agreed at Full Council on 29 June 2022 comprise:
- Cllr Carter
- Cllr Halden

Wider membership
- Corporate Director of Adults, Housing and Health * (Ian Wake) – Interim Arrangements. Les Billingham Director ASC
- Corporate Director of Children's Services * (Sheila Murphy)
- Director of Public Health* (Jo Broadbent)
- Chief Executive of the Mid and South Essex Integrated Care Board (Anthony McKeever)*
- NHS Thurrock Alliance Director (Aleksandra Mecan)
- Chief Operating Officer HealthWatch Thurrock * (Kim James)
- Chair Thurrock Community Safety Partnership Board / Director Public Realm (Julie Rogers)
- Chair of the Adult Safeguarding Partnership or their senior representative (Jim Nicolson)
- Thurrock Local Safeguarding Children's Partnership or their senior representative (Sheila Murphy)
- Director level representation of Thurrock, North-East London Foundation Trust (NELFT) (Gill Burns)
- Partnership Director, Thurrock Council, NELFT and EPUT (Rita Thakaria)
- Executive member, (Mid and South Essex NHS Foundation Trust) Hannah Coffey / Michelle Stapleton)
- Executive Director of Community Services and Partnerships, Essex Partnership University Trust (EPUT) (Alex Green)
- Thurrock CVS (representative to be confirmed)
- Managing Director Fiona Ryan. Basildon & Thurrock University Hospital Trust
- Essex Police (Jenny Barnett CH/SUPT 42081127) / Chief Constable BJ Barrington.

Agenda

Open to Public and Press

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1	**Welcome & Introductions**	
2	**Minutes / action log**	**5 - 14**

To approve as a correct record the minutes of the Health and Wellbeing Board meeting held on 9 December 2022.

Minutes are provided within the meeting papers and the action log will be circulated electronically. If any members of the public wish to see the action log, please contact Claire Dixon (claire.dixon@thurrock.gov.uk)

3 Urgent items

4 Declaration of interests

5 Virtual items for consideration

Members approval will be sought at the meeting to consider the following Joint Needs Assessments virtually:

- Alcohol & Substance Misuse
- Self-Care for Long Term Conditions
- Active Travel

6 HWB Strategy Domains in focus - setting out plans for delivery. Domain 2: Building Strong and Cohesive Communities **15 - 40**

1. Members are asked to note that the covering report for this item is also provided for item 7.
2. This item provides a summary of Domains 2 and 4, priorities and setting out plans for delivery, year one.

7 HWB Strategy Domains in focus - setting out plans for delivery. Domain 4: Opportunity for All **41 - 54**

8 Verbal update on the current under doctoring position in Thurrock

9 Unpaid Carers - All Age Carers Strategy **55 - 66**

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Queries regarding this Agenda or notification of apologies:

Please contact Claire Dixon, Interim Business Manager by sending an email to claire.dixon@thurrock.gov.uk

Agenda published on: **2 February 2023**

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DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF

Breaching those parts identified as a pecuniary interest is potentially a criminal offence

Helpful Reminders for Members

- *Is your register of interests up to date?*
- *In particular have you declared to the Monitoring Officer all disclosable pecuniary interests?*
- *Have you checked the register to ensure that they have been recorded correctly?*

When should you declare an interest *at a meeting?*

- **What matters are being discussed at the meeting?** (including Council, Cabinet, Committees, Subs, Joint Committees and Joint Subs); or
- If you are a Cabinet Member making decisions other than in Cabinet **what matter is before you for single member decision?**

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Does the business to be transacted at the meeting

- **relate to; or**
- **likely to affect**

any of your registered interests and in particular any of your Disclosable Pecuniary Interests?

Disclosable Pecuniary Interests shall include your interests or those of:

- your spouse or civil partner's
- a person you are living with as husband/ wife
- a person you are living with as if you were civil partners

where you are aware that this other person has the interest.

A detailed description of a disclosable pecuniary interest is included in the Members Code of Conduct at Chapter 7 of the Constitution. **Please seek advice from the Monitoring Officer about disclosable pecuniary interests.**

What is a Non-Pecuniary interest? – this is an interest which is not pecuniary (as defined) but is nonetheless so significant that a member of the public with knowledge of the relevant facts, would reasonably regard to be so significant that it would materially impact upon your judgement of the public interest.

Pecuniary

If the interest is not already in the register you must (unless the interest has been agreed by the Monitoring Officer to be sensitive) disclose the existence and nature of the interest to the meeting

If the Interest is not entered in the register and is not the subject of a pending notification you must within 28 days notify the Monitoring Officer of the interest for inclusion in the register

Unless you have received dispensation upon previous application from the Monitoring Officer, you must:

- **Not participate or participate further in any discussion of the matter at a meeting;**
- **Not participate in any vote or further vote taken at the meeting; and**
- **leave the room while the item is being considered/voted upon**

If you are a Cabinet Member you may make arrangements for the matter to be dealt with by a third person but take no further steps

Non- pecuniary

Declare the nature and extent of your interest including enough detail to allow a member of the public to understand its nature

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You may participate and vote in the usual way but you should seek advice on Predetermination and Bias from the Monitoring Officer.

Our Vision and Priorities for Thurrock

An ambitious and collaborative community which is proud of its heritage and excited by its diverse opportunities and future.

1. **People** – a borough where people of all ages are proud to work and play, live and stay

    - High quality, consistent and accessible public services which are right first time
    - Build on our partnerships with statutory, community, voluntary and faith groups to work together to improve health and wellbeing
    - Communities are empowered to make choices and be safer and stronger together

2. **Place** – a heritage-rich borough which is ambitious for its future

    - Roads, houses and public spaces that connect people and places
    - Clean environments that everyone has reason to take pride in
    - Fewer public buildings with better services

3. **Prosperity** – a borough which enables everyone to achieve their aspirations

    - Attractive opportunities for businesses and investors to enhance the local economy
    - Vocational and academic education, skills and job opportunities for all
    - Commercial, entrepreneurial and connected public services

PUBLIC Minutes of the meeting of the Health and Wellbeing Board held on 9 December 2022 10.30am-12.30pm

Present:
Councillor Arnold (Chair)
Councillor Johnson
Councillor Liddiard
Councillor Ralph
Jo Broadbent, Director of Public Health
Sheila Murphy, Corporate Director for Children's Services
Stephen Porter, Interim Director, Thurrock Alliance
Aleksandra Mecan, Thurrock Alliance Director
Sharon Hall, North-East London Foundation Trust (NELFT)
Michelle Stapleton, Integrated Care Pathway Director, Mid and South Essex NHS Foundation Trust
Jim Nicolson, Adult Safeguarding Board
Terry Fisher, Thurrock Community Policing Team Inspector, Essex Police

Apologies:
Councillor Muldowney
Les Billingham, Interim Director for Adult Social Care
Julie Rogers, Chair Thurrock Community Safety Partnership Board / Director of Public Realm
Kim James, Chief Operating Officer, Healthwatch Thurrock
Gill Burns, Director of Children's Services, North East London Foundation Trust (NELFT)
Claire Panniker, Chief Executive, Mid and South Essex NHS Foundation Trust
Alex Green, Executive Director of Community Services and Partnerships, Essex Partnership University Trust (EPUT)
Andrew Pike, Executive Member, Mid and South Essex NHS Foundation Trust
Hannah Coffey, Executive Member, Mid and South Essex NHS Foundation Trust
Anthony McKeever, Chief Executive of the Mid and South Essex Integrated Care Board
Stephen Mayo, Director of Nursing – Patient Experience, Mid and South Essex Integrated Care System
Karen Grinney, HM Prison and Probation Service
BJ Harrington, Chief Constable, Essex Police
Jenny Barnett, Chief Superintendent, Essex Police

Guests:
Ewelina Sorbjan, Thurrock Council
Ceri Armstrong, Thurrock Council
Janet Simon, Thurrock Council
Helen Farmer, Mid and South Essex Integrated Care System
Alfred Bandakpara-Taylor, Mid and South Essex Integrated Care System
Milind Karale, Essex Partnership University Trust (EPUT)

1. Welcome, Introduction and Apologies

The meeting began at 10.35am.

Colleagues were welcomed and apologies were noted. Sharon Hall advised she was attending on behalf of Gill Burns.

The Chair encouraged Board members to attend future meetings in person and to prioritise attendance due to the importance of the issues and topics discussed.

Board members were reminded of the importance of submitting reports in a timely manner and on the correct committee report template. This template adheres to the Council's policies regarding easy read formatting and ensures consistency across all committees.

Members noted the Initial Health Assessments item would be considered after the Declarations of Interest (item 5).

2. Minutes / Action Log

The minutes of the Health and Wellbeing Board meeting held on 28 October 2022 were approved as a correct record.

Members reviewed the action and decision log, and this was updated accordingly.

3. Urgent Items – Adult Social Care Discharge Fund 2022-23

An urgent item was received for consideration, the Adult Social Care Discharge Fund 2022-23.

This item was presented by Ceri Armstrong, Thurrock Council. Key points included:

- On 18 November 2022, the Minister for Social Care announced the £500 million Adult Social Care Discharge Fund to support timely and safe discharge from hospital into the community by reducing the number of people delayed in hospital awaiting social care.
- The funding is to be distributed in two ways, with 40% of the money (£200 million) distributed as a section 31 grant to Local Authorities and the remainder (£300 million) to Integrated Commissioning Boards (ICBs). The Mid and South Essex ICB allocation is £3,215,380 and for Thurrock Council the allocation is £545,170.
- Funding will be allocated to ICBs and Local Authorities in two tranches. The first tranche (40% of the total allocation) will be in December and the second tranche (60% of the total allocation) in January 2023. The second tranche is contingent on receipt of an initial completed planning template (to be submitted four weeks after details of the fund are published) and meeting of the funding conditions. The funding allocation must be spent by the end of March 2023.
- The guidance published by the Department of Health and Social Care on the 18 November 2022 stipulates that 'the local authorities and ICB funding allocation should be pooled into local Better Care Fund section 75 agreements with plans for spend agreed by LA and ICB

chief executives and signed off by the Health and Wellbeing Board (HWB) under national condition 1 of the BCF.' Condition 1 is a jointly agreed plan between local health and social care commissioners and signed off by the HWB.

- The guidance further stipulates 'a completed spending template should be submitted four weeks after fund details are published (by 16 December 2022), confirming planned use of the additional funding and that the use of the funding has been agreed by the ICB and Local Authority.'
- The timescales for developing and agreeing spending plans are challenging for both the ICB and the Council.
- Thurrock Adult Social Care funding proposals include:
    - Provider incentives;
    - Funding to support complex discharge;
    - Over time funding for placement / Social Work staff to support seven-day discharge;
    - Increase in By Your Side funding (and potentially to other CVS initiatives to support discharge);
    - Payments for sessional Approved Mental Health Professional (AMHP) cover to support mental health discharge and support.
- This gives an estimated total spend of £510K leaving approximately £35k as a contingency for flexibility and other initiatives which result from performance monitoring, and lessons learned reviews.

During discussions, the following points were made:

- Members welcomed the additional funding for mental health and AMHPs as there is currently a shortfall in this area of health care.
- Members discussed the tight deadlines associated with the fund and the need for more proactive planning in relation to winter pressures. It was noted that the conditions of winter pressures funding change each year, with this year focusing on hospital beds and increasing capacity as a system. The monetary allocation also changes therefore providing challenges for future planning. Furthermore, it was recognised staffing and recruitment with the system remains a concern.

Decision: Members signed off the spending plan for the Adult Social Care Discharge Fund 2022-23.

4. Declaration of Interests

Councillor Ralph declared he is Thurrock Council's governor for the Essex Partnership University Trust (EPUT).

5. Initial Health Assessments

This item was introduced by Janet Simon, Thurrock Council and Helen Farmer, Mid and South Essex Integrated Care System. Key points included:

- When a child become looked after by Thurrock Council, it is a statutory requirement that they receive an assessment of their health within 20 working days; this is known as an Initial Health Assessment (IHA). The IHA must be completed by a medical practitioner and is coordinated jointly between Thurrock Council and the NHS.

- There are a range of factors that delay the IHA appointment, however a key
  challenge is the lack of capacity available to provide IHAs to all children placed in the local area. This is both a national and local issue.
- For example, 70% of IHA's completed by the current provider are for children outside of Thurrock. There has been a huge increase in foster care placements in Thurrock from other boroughs such as London and Kent therefore paediatric capacity has been a significant issue.
- Further issues driving current delay are:
  - Lack of available Paediatric Appointments in placement area;
  - Missed first appointments (via child declining or carer availability);
  - Lack of an available interpreter;
  - Changes of placement;
  - Lack of or late parental consent.
- It was highlighted that a IHA cannot be completed until the child comes into the care of the Local Authority therefore proactive planning is challenging.
- To improve the delivery of IHAs the following actions are being taken:
  - The ICB is commissioning additional capacity via an alternative provider;
  - The tracking system is being updated to an electronic and cross agency solution;
  - Weekly monitoring meetings will initially be chaired by the Assistant Director for Children's Social Care and Early Help with a clear and agreed escalation process.
- The arrangement with the Mid and South Essex alternative provider will begin in January 2023 once due diligence processes have been completed.

During discussions the following points were made:

- The updated report was welcomed by all, and the progress made is encouraging. It was noted the oversight and constructive challenge from the Board has helped the system to prioritise this statutory function therefore continued oversight is welcomed.

  Decision: The Board agreed to maintain oversight of IHA performance.

- Members were reassured that for all children requiring IHAs, 85% were completed within 56 days.
- The challenges associated with out of borough placements and the capacity constraints of Health colleagues were recognised. It was noted that on average there are 12 IHA referrals in one month, however recently there were 16 referrals within one week. This highlights the difficulty in system modelling as the number of referrals is not consistent. The additional capacity needed for these referrals meant that other clinics were cancelled.
- Colleagues agreed IHA referrals should not take preference over clinical need, however this was the necessary action needed to meet statutory requirements.

- Members noted the alternative provider has capacity within their paediatric service therefore commissioning can move away from a reactive to a proactive service.
- It was reiterated that the service providers have a responsibility to deliver IHAs locally, however the children already in the borough cannot be prioritised.
- Colleagues were advised that for those children who experienced a delay in their IHA being completed, a root cause analysis approach is being taken and a weekly meeting held to track each child. Members were reassured health interventions are not restricted if an IHA has not been completed therefore access to health care is not dependent on the IHA.
- Members discussed the recommendations from the 2019 Ofsted Inspection which included the improved of IHA performance. Improvements were made prior to the pandemic which included developments in systems and processes to streamline the assessments. However, during this time there were some delays within Children's Services, such as ensuring the correct paperwork and the attendance of translators.
  Since the pandemic, the capacity issue within the wider Health system has become more prominent therefore more has been invested into the IHA model.
- It was noted the performance data available is usually a month behind therefore members requested a further IHA update is provided to the Board in 2023 as part of monitoring the efficacy of the actions put in place to improve performance.

Action: A further update will be provided to the Board during the next municipal year (date to be confirmed) to ensure the changes and improvements to performance have been embedded and meet the legal IHA duty.

6. Health and Wellbeing (HWB) Strategy Domain in focus – Domain 3 Person-Led Health and Care. Summary of domain and priorities and setting out plans for delivery, year one.

This item was presented by Ceri Armstrong, Thurrock Council and Stephen Porter, Thurrock Alliance. Key points included:

- The aims and ambitions for Domain 3 include the delivery of better outcomes for individuals by using existing health and care resources, working at a place-based level, and ensuring resident's differences, and communities are reflected within this. The focus is to therefore deliver an approach around the person and system integration.
- Goal 3A relates to the development of more integrated adult health and care services in Thurrock. This will address the current fragmented services to achieve integrated locality networks that co-design single integrated bespoke solutions with residents.
- The key challenges associated with Goal 3A are changing organisational culture, resourcing constraints including investment and experimentation of new initiatives and navigation of the new health landscape to ensure a place-based focus.
- To mitigate these challenges, there is a need to empower staff to consider and trial different solutions as well as reducing the number of

'front doors' residents are often faced with when trying to access health and care services.

- Goal 3B focuses on improving the response from Primary Care, including timely access, a reduced variation between practices and access to a range of professionals.
- Thurrock is currently under doctored therefore a range of initiatives are being taken forward to encourage GPs to work within the borough, including: new telephony systems to improve access, an increase in the number of Additional Roles Reimbursement Scheme (ARRS) roles to 80, the recruitment of 12 additional GP fellows and the development of a clinical strategy for each of the four Primary Care Networks (PCNs).
- Goal 3C aims to deliver a Single Workforce Locality Model which is a health and care workforce that works across organisational boundaries to provide an integrated and seamless response. The launch of the Corringham Integrated Medical and Wellbeing Centre (IMWC) is an example of such collaborative and seamless working.
- Due to the complexity of change required, work will be undertaken over several phases, including the following activities: the development of blended roles, 'Trusted Assessors' and integrated locality networks, using Better Care Together 'Link Nurses' to understand how Community Health can work as part of a Single Workforce Locality Model and conducting several staff-led experiments to understand what needs to change and how.
- Goal 3D aims to deliver 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. The importance of commissioning is reiterated and the need to move away from 'time and task' type models of care as this reduces the opportunities to commission for learning and to improve the outcomes of individuals.

During discussions, the following points were made:

- Members welcomed the ongoing activities as the recruitment of GPs is a concern and anecdotal evidence was provided regarding the current waiting times for a child to receive a blood test in Thurrock. The waiting time is currently until the end of February 2023; however, a blood test can be undertaken within Southend the same day.
- Members were advised a meeting is due to be held before the Christmas period to discuss appointment waiting times as the phlebotomy services within South Ockendon have been paused. Colleagues are working to get these services reinstated and will be reviewing commissioning options.

  Action: Aleksandra Mecan to provide an update on the reinstatement of phlebotomy services within South Ockendon at the next Board meeting.

- It was recognised a considerable culture change is required to achieve these aims and ambitions; however, the transformation of services has been ongoing for over a decade. Furthermore, all changes have been developed alongside staff and various pilot test and learn experiments are underway as part of identifying if the changes are right and if they will work. This approach was used within the Community Led Support pilot whereby the experiment began with one

small team which was expanded as Social Workers were keen to take this positive approach forward with other teams. The test and learn experiments allow for learning and reflection.

- It has been reiterated to staff that specialisms are not being diluted by integrated working as it puts the person at the centre of their care.
- Colleagues noted the activities within this domain are regularly discussed at the Thurrock Integrated Care Alliance and Better Care Together Thurrock Executive meetings where positive feedback and support has been received for these practices.
- Members thanked all those involved with the development and launch of the Corringham IMWC as it is having a positive impact. The IMWC provides collaboration and support to residents on a variety of matters in one space.

Decision: Members considered and commented on the plans for delivering Domain 3 (Person-Led Health & Care) of the HWB Strategy.

7. HWB Strategy Domain in focus – Domain 5 Housing and the Environment. Summary of domain and priorities and setting out plans for delivery, year one.

This item was introduced by Jo Broadbent, Thurrock Council. Key points included:

- Domain 5 focuses on the wider determinants of health and has a broad remit, including housing affordability and the built and natural environment. The Council is working with key partners such as the Association of South Essex Local Authorities (ASELA) and the Police to take forward the agreed Domain goals.
- Domain 5 aims to ensure fewer people will be at risk of homelessness, and everyone will have access to high quality affordable homes that meet the needs of Thurrock residents. The aim is to make homes and places in Thurrock, environments where everyone feels safe, healthy, connected, and proud.
- The key underpinning strategies for this Domain include the Housing Strategy 22-27, the Homeless Prevention and Rough Sleeping Strategy, the Housing Domestic Abuse Policy, the Local Plan and the High-Level Energy and Climate Change Strategy.
- Goal 5A relates to preventing homelessness and the reduction of rough sleeping. The current cost of living crisis will have a big impact on this as well as the Thurrock affordability standard. Further information on this is contained within the Homeless Prevention and Rough Sleeping Strategy.
- Goal 5B aims to facilitate and encourage maintenance of good quality homes in Thurrock to promote the health of residents. This is a broad goal which includes both the standards of Council housing stock and that of the private sector. The Well Homes programme and the incentivising of energy efficiency are examples of activities to achieve this goal.
- Goal 5C aims to provide safe, suitable, and stable housing solutions for people who have or who are experiencing domestic abuse/violence and/or sexual abuse/violence therefore it is very specific in nature. This includes the streamlining of support to ensure access to a range of housing options for these vulnerable groups.

- Goal 5D focuses on the broader environment and seeks to improve physical and mental health via regeneration and future developments. This is a cross cutting and multifaceted area, for example the Local Plan and the Climate Change Strategy are fundamental to achieving the goal's aims and ambitions. The introduction of an Air Quality Monitoring Officer, health impact assessments and the design principles for future developments such as green space considerations are examples of activities to achieve this goal.

During discussions the following points were made:

- Members discussed the complexity of domestic abuse, particularly in relation to male victims and the differing standards of care for men. For example, there is not a male refuge centre available for or adequate support networks offered to male victims.
- Colleagues acknowledged the cultural and societal stigmas associated with disclosing incidents of male domestic violence, however, statistically there is more evidence that woman and girls are vulnerable to coercion and domestic abuse therefore the majority of service provision is for females.

  Action: Ewelina Sorbjan to raise the issues of service provision for male domestic violence and a dedicated refuge at the next Violence Against Women and Girls meeting.

- Members were advised the profile of male domestic violence is being raised and appropriate support and services promoted, however there is not a one size fits all approach to domestic violence due to the complexities involved. Furthermore, there is a difference between equity and equality of service.
- Colleagues welcomed the links between the Housing department and partners, particularly in relation to rough sleeping.
- Members welcomed the links to the various underpinning strategies as this enables colleagues to broaden their knowledge and understanding of the activities taking place to support the Strategy's goals and the work officers do on behalf of the borough's residents.

Decision: Members considered and commented on the plans for delivering Domain 5 (Housing & the Environment) of the HWB Strategy.

8. Business case for the Mental Health Urgent Care Department

This item was introduced by Alfred Bandakpara-Taylor, Mid and South Essex Integrated Care System and Milind Karale, Essex Partnership University Trust (EPUT). Key points included:

- The scope of the Mental Health Urgent Care Department (MHUCD) project is determined as a model for providing rapid intervention for patients with mental health needs without referrals, as an alternative to Accident and Emergency Departments. This will include construction of a new purpose-built facility, based in repurposed footprint of the current Mental Health Assessment Unit (MHAU) and development of a new operational service by end of March 2023 – this has been delayed from February as pathway policies and procedures are in development and recruitment has begun.

- The service aims to provide a 24/7 mental health urgent care service that enables a full and robust mental health assessment and onward care planning in a calm and therapeutic setting for patients in crisis, therefore providing a more positive patient experience.
- The service will be open to all patients from across Mid and South Essex, although it is expected that most patients will be drawn from Basildon, Thurrock and Southend.
- The service will provide rapid specialist assessment for all mental health patients over the age of 18, presenting to the unit in crisis including those with minor self-harm and intoxication. Furthermore, it will act as a hub to access and signpost to various resources in the community and voluntary sectors.

During discussions the following points were made:

- Members welcomed the report and agreed it is a positive and much needed project as it will reduce the wait for patients in A&E for a mental health assessment and it was recognised this model has already been developed in other areas such as Camden and Islington NHS Foundation Trust.
- The service will be able to support Street Triage as the emergency services will have a dedicated unit to take those in a mental health crisis to therefore the department offers a seamless pathway for support for those in need.
- Members raised concerns regarding funding for the MHUCD as there is there is no longer a Suicide Prevention Manager in post within the Integrated Care System, however colleagues were reassured there is separate funding for this service.
- Mid and South Essex colleagues confirmed they are committed to suicide prevention and that the programme will continue and will be funded after March 2023.
- The Board welcomed a progress update on the MHUCD – this will be scheduled for the next municipal year.

Action: An update on the Mental Health Urgent Care Department is to be provided to the Board in the next municipal year (date to be confirmed).

Decision: Members commented and noted the contents of the Business case for the Mental Health Urgent Care Department.

Due to the addition of the urgent item earlier in the meeting, the Violence and Vulnerability Board update was deferred. Board members were asked to provide Jo Broadbent with any questions on the supporting paper directly.

Members noted this was Stephen Porter's last Board meeting and that Aleksandra Mecan is now in post as the Thurrock Alliance Director. Colleagues thanked Stephen for his valuable contributions during his time in post.

The meeting finished at 12:33pm.

CHAIR……..

DATE……

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10 February 2023	**Items 6 & 7**
Health & Wellbeing Board	
Thurrock Health and Wellbeing Strategy 2022-26 Update	
Wards and communities affected: All	**Key Decision:** None
Report of: Jo Broadbent, Director of Public Health	
Accountable Director: Jo Broadbent, Director of Public Health	

Executive Summary

This paper presents an update on Domains 2 and 4 of the Thurrock Health & Wellbeing Strategy (HWBS) 2022-26 and asks the Board to consider and comment on the plans for delivering the Goals in these Domains.

1. Recommendation(s)

1.1 The Board is asked to:

- Consider and comment on the plans for delivering the Goals of the HWBS in Domain 2 – Building Strong and Cohesive Communities and Domain 4 – Opportunity for All

2. Introduction and Background

2.1 The Health & Wellbeing Board (HWBB) has a statutory duty to produce a HWBS. The HWBS is a whole system plan for health & wellbeing and a means to engage all partners in the wellbeing agenda, co-ordinating strategic thinking of all elements of the council and all system partners to deliver quantifiable gains in health and wellbeing of residents.

2.2 Thurrock agreed its first HWBS in 2013. The current HWBS was launched in July 2022 and can be accessed here: https://www.thurrock.gov.uk/health-and-well-being-strategy/health-and-well-being-strategy-2022-2026

2.3 Proposals for the HWBS were developed by multi-agency stakeholders including Thurrock Council ADs and Subject Matter Experts from across the system. The HWBB considered the proposals for the HWBS at its meeting in July 2021, including the Vision, the 6 Domain structure, and plans to engage with the wider public. A twelve week consultation exercise took place October-December 2021 and the attached Strategy document has been further developed to reflect engagement outcomes.

3. Overview of the Refreshed HWBS 2022-26

3.1. The Vision for the Strategy is *Levelling the Playing Field* and tackling inequalities is reflected throughout. Proposals to level the playing field have been developed based around six areas of people's lives, which we refer to as Domains, that cover the wider determinants of health and impact on people's health and wellbeing. These are:

1. Staying Healthier for Longer
2. Building Strong & Cohesive Communities
3. Person-Led Health & Care
4. Opportunity for All
5. Housing & the Environment
6. Community Safety

3.2. Through engagement with residents and stakeholders, 3-4 priority Goals have been identified for each Domain, with public feedback leading refinements of these Goals in the attached final draft. These set out specific actions to improve outcomes and specifically level the playing field and address inequalities.

3.3. Delivery of the ambitions within the Goals is underpinned by a number of key topic-specific strategies (such as the Housing Strategy, Better Care Together Thurrock Strategy etc), plus the Local Plan and the Backing Thurrock Economic Growth Strategy. Content proposals in the HWBS have been agreed with leads for these other strategic plans.

4. Consultation outcomes

4.1 A Consultation Report for the Strategy is provided on the website, which details how Goals were refined to reflect consultation outcomes. Over 750 comments were received through a short 'user friendly' questionnaire developed in conjunction with the CVS and Healthwatch, which sought the public's views on the six Domains that have been proposed for the refreshed Strategy. In excess of 300 residents or professionals involved in the planning, commissioning or delivery or health and care services provided feedback on strategy consultation proposals through community and professional forums and meetings. This resulted in over 1,300 individual comments on the proposals.

5. Governance

5.1. The HWBB agreed that in order to keep an oversight of delivery of the aims of the strategy, it would receive an update on each Domain annually. In the first year of delivery of the Strategy, the update will consist of an outline of the plans for each Domain and milestones for delivery. Strategies underpinning Domains 1, 3, 5 and 6 are attached at Appendix 1.

5.2. An overview of the plans for the following Domains were considered in October and December 2022:

- Domain 1 – Staying Healthier for Longer
- Domain 3 – Person-Led Health & Care (Appendix 2)
- Domain 5 – Housing & the Environment (Appendix 3)
- Domain 6 – Community Safety

5.3. An overview of the plans for the following Domains are appended to this report:
- Domain 2 – Building Strong and Cohesive Communities
- Domain 4 – Opportunity for All

6. Reasons for Recommendation

6.1. The HWBB has a collective statutory duty to produce a HWBS. It is one of two highest level statutory strategic documents for the Local Authority and system partners, the other being the Local Plan. The statutory status of the document means that the new Integrated Care Board (ICB) must have regard to it when planning their own strategy.

7. Consultation (including Overview and Scrutiny, if applicable)

7.1. The proposals in this paper reflect substantial consultation with professionals and the public as detailed above and in the full Consultation Report.

8. Impact on corporate policies, priorities, performance and community impact

8.1. The HWBS is one of three highest Place Shaping strategic documents for the Local Authority and system partners, the other being the Local Plan and Backing Thurrock Economic Development plan, with specific synergies between the three strategies being highlighted. It is a whole system plan for health & wellbeing and a means to engage all partners in the wellbeing agenda, co-ordinating strategic thinking of all elements of the council and all system partners to deliver quantifiable gains in health and wellbeing of residents.

8.2. In order to support delivery of the Council's Vision, the 6 Domains of the HWBS Strategy each relate to one of the Council's key priorities of People, Place and Prosperity, as outlined in the attached Strategy.

9. Implications (Replicated from the June 2022 paper on the HWBS)

9.1 Financial

Implications verified by: **Mike Jones**

Strategic Lead – Corporate Finance

The cost associated with the strategy refresh will be delivered within existing budgets or agreed through existing Council and partner agencies governance finance arrangements.

9.2 Legal

Implications verified by: **Daniel Longe, Principal Solicitor for Children and Adult Safeguarding and Education**

Section 196 of the Health and Social Care Act 2012 imposes an obligation on local authorities to establish a Health and Wellbeing Board to exercise the functions of the local authority and its partner integrated care boards (ICBs) to carry out the functions imposed upon it under sections 116 to 116B of the Local Government and Public Involvement in Health Act 2007.

In accordance with The Health and Wellbeing Boards Guidance 2022, HWBs are required to: “lead action at place level to improve people’s lives and remain responsible for promoting greater integration and partnership between the NHS, public health and local government”. These are achieved by HWBs carrying out: Joint Strategic Needs Assessments (JSNAs) and Joint Local Health and Wellbeing Strategies (JLHWSs). Accordingly, the proposed recommendations are within remit of the Health and Wellbeing Board.

9.3 **Diversity and Equality**

Implications verified by: **Roxanne Scanlon**

Community Development and Equalities Team

Implications have not changed since previous approval provided in July 2021.
The aim of the strategy is to improve the health and wellbeing of the population of Thurrock and reduce health and wellbeing inequalities. A community equality impact assessment (CEIA) will underpin the strategy and mitigate the risk of disproportionate negative impact for protected groups. This approach will ensure the strategy itself and implementation supports delivery of the council’s equality objectives while maintaining compliance with the Equality Act 2010 and Public Sector Equality Duty.

9.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder, or Impact on Looked After Children)

The refreshed Health and Wellbeing Strategy will facilitate crime and disorder priorities that relate specifically to health and wellbeing, further strengthening the relationship between the Health and Wellbeing Board and Community Safety Partnership. The focus of the strategy is to broadly focus on addressing inequalities in Thurrock.

10. Appendices to the report

Appendix 1 – Strategies underpinning Domains 1, 3, 5 and 6
Appendix 2 – Domain 2 – Building Strong and Cohesive Communities
Appendix 3 - Domain 4 – Opportunity for All

Report Authors: Dr Jo Broadbent, Director of Public Health
Darren Kristiansen, Business Manager AHH, Secretary to HWB
Dr Sara Godward, Assistant Director Public Health
Natalie Smith, Strategy Lead Community Development & Equalities

Appendix 1 – Strategies underpinning Domains 1, 3, 5 and 6

Links to Related Strategies

Domain 1

	Goal	Strategy	Link	Owner	Comments
A	**Work with communities to reduce smoking and obesity in Thurrock**	Better Care Together Thurrock Adult Health & Care Strategy	Thurrock Council - Better Care Together Thurrock: The Case for Further Change	TICA	Specifically chapter 6
		Tobacco Control Strategy	In development, based on the Tobacco Control JSNA Thurrock Council - Joint Strategic Needs Assessment: Whole systems tobacco control, 2021	Public Health	
		Brighter Futures Strategy 2021-26	Brighter Futures Strategy	Brighter Futures Board	
		Whole System Obesity Strategy	Thurrock Council - Whole systems obesity strategy, 2018-2021	Public Health	Being refreshed
		MSE ICS Strategy	https://www.midandsouthessex.ics.nhs.uk/publications/draft-mid-and-south-essex-integrated-care-strategy/	MSE ICS	Draft awaiting NHSE sign-off
		MSE Population Health / Health Inequalities / PHM / Prevention Strategies	In development	MSE ICS	Under review
B	**Work together to promote good mental health and reduce mental ill health and substance misuse in all**	Better Care Together Thurrock Adult Health & Care Strategy	Thurrock Council - Better Care Together Thurrock: The Case for Further Change	TICA	Specifically chapter 6
		MSE ICS Strategy	https://www.midandsouthessex.ics.nhs.uk/publications/draft-mid-and-south-essex-integrated-care-strategy/	MSE ICS	Draft awaiting NHSE sign-off
		Combatting Drugs Partnership Delivery Plan	In development, informed by the Substance Misuse Health needs Assessment Microsoft Word - Thurrock ASM HNA Draft Report vF	CDP	
		SET Mental Health Strategy	MH_Strategy_Lets_Talk.pdf (ctfassets.net) 2017-21 New strategy in development	SET MH Collaborative	The SET MH Collaborative is not

	communities in Thurrock				yet set up and the strategy will not be completed until Christmas
		Brighter Futures Strategy 2021-26	Brighter Futures Strategy	Brighter Futures Board	
C	**Continue to enhance identification and management of Long Term Conditions to improve physical and mental health outcomes for all**	Better Care Together Thurrock Adult Health & Care Strategy	Thurrock Council - Better Care Together Thurrock: The Case for Further Change	TICA	Specifically chapter 6
		MSE ICS Strategy	https://www.midandsouthessex.ics.nhs.uk/publications/draft-mid-and-south-essex-integrated-care-strategy/	MSE ICS	Draft awaiting NHSE sign-off
		MSE Population Health / Health Inequalities / PHM / Prevention Strategies	In development	MSE ICS	Under review
		Thurrock Alliance Case Finding Strategy	In scoping phase	TICA / HI and PHM workstream	Scope to be shared at first meeting

Domain 2

	Goal	Strategy	Link	Owner	Comments
A	**Improved engagement with our residents to ensure everyone can**	Better Care Together Thurrock Adult Health & Care Strategy	https://www.thurrock.gov.uk/health-and-well-being-strategy/case-for-further-change-2022-2026	TICA	Specifically, Chapter 4
		Collaborative Communities Framework	Thurrock Council - Collaborative Communities Framework	Thurrock Council	Delivery supported through the Stronger Together Partnership

	have their voice heard	Digital and Customer Experience Strategy 22-25	www.thurrock.gov.uk/digital-and-customer-experience-strategy	Thurrock Council	
		The Local Plan	Thurrock Borough Local Plan | Borough Local Plan | Thurrock Council	Thurrock Council	Currently under review
		MSE ICS Strategy	https://www.midandsouthessex.ics.nhs.uk/publications/draft-mid-and-south-essex-integrated-care-strategy/	MSE ICS	Draft awaiting NHSE sign-off
B	**Ensure people have the skills, confidence, and ability to contribute as active citizens and are empowered to co-design the decisions that affect their lives.**	Better Care Together Thurrock Adult Health & Care Strategy	https://www.thurrock.gov.uk/health-and-well-being-strategy/case-for-further-change-2022-2026	TICA	Specifically, Chapter 4
		MSE ICS Strategy	https://www.midandsouthessex.ics.nhs.uk/publications/draft-mid-and-south-essex-integrated-care-strategy/	MSE ICS	Draft awaiting NHSE sign-off
		Collaborative Communities Framework	Thurrock Council - Collaborative Communities Framework	Thurrock Council & CVS	Delivery supported through the Stronger Together Partnership
		Digital and Customer Experience Strategy 22-25	Thurrock Council	Thurrock Council	
		SET Mental Health Strategy	MH_Strategy_Lets_Talk.pdf (ctfassets.net) 2017-21 New strategy in development	SET MH System Collaborative	New strategy in final stages of development
C	**Enhance equality and inclusiveness by promoting**	Collaborative Communities Framework	Thurrock Council - Collaborative Communities Framework	Thurrock Council	Improving Equality Outcome Board established October 21

	opportunities to bring different communities together to enhance shared experience and to embed a sense of belonging.	Better Care Together Thurrock Adult Health & Care Strategy	democracy.thurrock.gov.uk/documents/s35004/Better Care Together Thurrock - The Case for Further Change Final.pdf	TICA	Specifically, Chapter 4
		MSE ICS Strategy	https://www.midandsouthessex.ics.nhs.uk/publications/draft-mid-and-south-essex-integrated-care-strategy/	MSE ICS	Draft awaiting NHSE sign-off
		Backing Thurrock	Backing Thurrock A Roadmap for Economic Recovery Resilience and a Return to Growth - Appendix 1.pdf	Thurrock Council	

Domain 3

	Goal	Strategy	Link	Owner	Comments
A	**Development of more integrated adult health and care services in Thurrock**	Better Care Together Thurrock Adult Health & Care Strategy	https://www.thurrock.gov.uk/health-and-well-being-strategy/case-for-further-change-2022-2026	Thurrock Integrated Care Alliance	Strategy for the development of a place-based and people-led health, care and wellbeing strategy.
		Mid and South Essex Integrated Care Strategy	https://www.midandsouthessex.ics.nhs.uk/publications/draft-mid-and-south-essex-integrated-care-strategy/	MSE ICS	Draft awaiting NHSE sign-off
B	**Improved Primary Care Response that includes**	Better Care Together Thurrock Adult Health & Care Strategy	https://www.thurrock.gov.uk/health-and-well-being-strategy/case-for-further-change-2022-2026	Thurrock Alliance	See above

	timely access, a reduced variation between practices and access to a range of professionals	Mid and South Essex Primary Care Strategy	https://www.midandsouthessex.ics.nhs.uk/publications/primary-care-strategy/	Mid and South Essex Integrated Care Board	
		Patient Aligned Care Teams (PACT)	Microsoft Word - FINAL 003 250522 - Fuller report[46].docx (england.nhs.uk)	Thurrock Integrated Care Board	Response to Fuller Report
		PCN Clinical Strategies	Being Developed in line with the Fuller Stocktake recommendations	Thurrock Alliance	In development
C	**Delivery of a Single Workforce Locality Model – a health and care workforce that works across organisational boundaries to be able to provide an integrated and seamless response**	Better Care Together Thurrock Adult Health & Care Strategy	https://www.thurrock.gov.uk/health-and-well-being-strategy/case-for-further-change-2022-2026	Thurrock Integrated Care Alliance	Specifically chapter 7
D	**Delivery of a new place-based model of commissioning that makes the best use of available resources to focus on delivering**	Better Care Together Thurrock Adult Health & Care Strategy	https://www.thurrock.gov.uk/health-and-well-being-strategy/case-for-further-change-2022-2026	See above	Specifically chapter 10
		Thurrock Care Market Development Strategy 2018-2023	Thurrock Council - Care market development strategy, 2018-2023	Thurrock Council	The Care Market Development Strategy is aimed at both existing and potential providers of Adult Social Care services in Thurrock to

	outcomes that are unique to the individual				ensure that we develop a diverse market that can meet the needs of local people.
		Better Care Fund Plan	Item 7i BCF. Thurrock HWB BCF Plan 2022-23 Narrative template Final 26092022.pdf		Thurrock's initial Better Care Fund Plan, and Better Care Fund Section 75 Agreement between the Council and NHS, was approved in 2015. The arrangement has allowed the creation of a pooled fund, to be operated in line with the terms of the Plan and the Agreement, to promote the integration of care and support services.

Domain 4

	Goal	Strategy	Link	Owner	Comments
A	**Through raising aspirations and reducing the disadvantage gap, all children and young people are able to achieve their potential**	Brighter Futures Strategy Support for children with SEND and LD	Brighter Futures Strategy Strategies and policies | Support for special educational needs and disability | Thurrock Council	Thurrock Council	Specifically strategic Priority 1 including the School Wellbeing Service Partnership Board, The SEND Board and Operational Group.
B	**Raising aspirations and opportunities for adults to continue learning and**	Adult learning skills strategy	TACC-Plan-on-a-Page-2021-24.pdf	Thurrock Council	

	developing skills, with a focus on groups that can benefit most				
C	**Supporting the economically vulnerable through Delivering the Backing Thurrock Roadmap and Action Plan and the Thames Freeport**	Work and Health JSNA	Thurrock Council - Joint Strategic Needs Assessment: Work and health, 2020	Thurrock Council	
		The Local Plan	Thurrock Borough Local Plan | Borough Local Plan | Thurrock Council	Thurrock Council	Currently being refreshed
		Backing Thurrock	People, place, prosperity | Investment and growth in Thurrock | Thurrock Council	Thurrock Council	Currently being refreshed
D	**Creating a vibrant place, that generates new businesses, increases prosperity and enables people across Thurrock to benefit from the transformational investment in major development schemes**	The Local Plan	Thurrock Borough Local Plan | Borough Local Plan | Thurrock Council	Thurrock Council	Currently being refreshed
		Backing Thurrock	People, place, prosperity | Investment and growth in Thurrock | Thurrock Council	Thurrock Council	Currently being refreshed
		Cultural strategy		Thurrock Council	In development

Domain 5

	Goal	Strategy	Link	Owner	Comments
A	**Reduce Homelessness and increase affordable housing supply**	Thurrock's Housing Strategy 22-27	Thurrock Council - Housing Strategy 2022-2027	Thurrock Council	
		The Local Plan	Thurrock Borough Local Plan | Borough Local Plan | Thurrock Council	Thurrock Council	Currently under review

		Homeless Prevention and Rough Sleeping Strategy	Thurrock Council - Homelessness prevention and rough sleeping strategy	Thurrock Council	
B	**Maintenance of good quality homes**	Thurrock's Housing Strategy 22-27	Thurrock Council - Housing Strategy 2022-2027	Thurrock Council	
		Housing Asset Management Strategy		Thurrock Council	
C	**Provision of safe, secure and stable housing for those who have or who are experiencing domestic abuse/violence and/or sexual abuse/violence**	Housing Domestic Abuse Policy		Thurrock Council	
D	**Regeneration and future development will seek to improve physical and mental health**	Thurrock Transport Strategy	Thurrock Council - Thurrock Transport Strategy, 2013-2026	Thurrock Council	
		The Local Plan	Thurrock Borough Local Plan | Borough Local Plan | Thurrock Council	Thurrock Council	Currently under review
		Thurrock Active Travel Needs Assessment	https://democracy.thurrock.gov.uk/documents/s36989/Appendix%201%20-%20Active%20Travel%20Needs%20Assessment.pdf	Thurrock Council	
		Thurrock Council Climate Change Strategy	In Development		
		Thurrock High Level Energy and Climate Strategy	In Development		

		Air Quality Strategy	Air Quality and Health Strategy	Thurrock Council	Currently being updated
		Whole Systems Obesity Strategy	https://www.thurrock.gov.uk/sites/default/files/assets/documents/jsna-obesity-201709-v01.pdf	Thurrock Council	Currently being updated

Domain 6

	Goal	Strategy	Link	Owner	Comments
A	**Enable all children to live safely in their Communities**	Essex Violence and Vulnerability Framework	Violence-and-Vulnerability-Framework-approved-June-2018.pdf (pfcc.police.uk)	Essex VVU	
		Serious Youth Violence Strategy	Yet to be developed	CSP	To be developed in line with the SV Duty - June 23 (first draft) to go to H&WBB, October 2023 – part of an Essex-wide Strategy
		Brighter Futures Strategy	Brighter Futures Strategy	Brighter Futures Board	
		Thurrock CSP annual delivery plan	Community Safety Partnership annual delivery plan, 2022/23	CSP	Priority 3. Violence and Vulnerability: Tackling gang related activity and offensive weapons to reduce drug driven violence
		Youth Justice Plan 21/24		YCGB	
		Thurrock LSCP Delivery Plan	Delivery Plan for 2020/22.	MACE	Priority 2 Violence and Vulnerabilities
		PFCC plan 22/24	www.essex.pfcc.police.uk	PFCC	Priority 2 reducing drug driven violence

		Crime Prevention Strategy for Essex 2021/25	Crime Prevention Strategy 2021-2025	Essex Police	Priority 1,4 and 8
		Thurrock's Annual Public Health Report on Youth Violence and Vulnerability 2019/20	Thurrock Council - Annual Public Health Report, 2019	LCSP and sub-committees	
B	**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**	Thurrock CSP annual delivery plan	Community Safety Partnership annual delivery plan, 2022/23	CSP	
		Modern Slavery and Human Trafficking Strategy		CSP / LSCP / ASgB	
		SET Reducing Reoffending Strategy 2020 – 2024		PFCC	
		Essex Hate Crime Prevention Strategy 2018/21		Safer Essex	Currently being refreshed
		Safeguarding Adults Guidelines	https://www.thurrock.gov.uk/keeping-safe-from-abuse/safeguarding-adults-agency-guidelines	Safeguarding Adults Board	
		Local Plan Design Guide	In development as part of the Local Plan	Place	
		PFCC plan 22/24	www.essex.pfcc.police.uk	PFCC	
		Crime Prevention Strategy for Essex 2021/25	Crime Prevention Strategy 2021-2025	Essex Police	
		Combatting Drugs Partnership Action Plan	In development	Combatting Drugs Partnership	
C	**Improve the local response to supporting victims/survivors of abuse and**	Thurrock CSP annual delivery plan	Community Safety Partnership annual delivery plan, 2022/23	CSP	Priority 1 and 2
		Violence Against Women and Girls Strategy 2020/23	Violence against women and girls	CSP	New Strategy from April 2023

	exploitation to improve their health and wellbeing	Thurrock's Housing Strategy 22-27	Housing Strategy	Thurrock Council	Including providing safe accommodation for those fleeing domestic and sexual abuse
		PFCC plan 22/24	www.essex.pfcc.police.uk	PFCC	Priority 3 and 4
		Crime Prevention Strategy for Essex 2021/25	Crime Prevention Strategy 2021-2025	Essex Police	Priority 5
		Harmful Sexual Behaviours Framework for Children & Young People in Thurrock	Yet to be developed	CSP	
D	**Protect residents from being the victims of crime, with a focus on those with increased risk of experiencing exploitation and abuse**	Thurrock CSP annual delivery plan	Community Safety Partnership annual delivery plan, 2022/23	CSP	Priority 1 and 2
		Violence Against Women and Girls Strategy 2020/23	Violence against women and girls	CSP	New Strategy from April 2023
		Crime Prevention Strategy for Essex 2021/25	Crime Prevention Strategy 2021-2025	Essex Police	Priority 11 Places
		Southend, Essex & Thurrock Domestic Abuse Board Strategy 2020-2025	Southend, Essex & Thurrock Domestic Abuse Board Strategy 2020-2025 - Southend and Thurrock Domestic Abuse Partnership (setdab.org)	SETDAB	

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Thurrock Health And Wellbeing Strategy 2022-2026

Levelling the Playing Field in Thurrock

Created through the partnership of Thurrock Health and Wellbeing Board

Introduction and overview report to Thurrock Health and Wellbeing Board

Domain 2 - Building Strong and Cohesive Communities

Domain 2 - Building Strong and Cohesive Communities

Domain Aims and Ambitions

We are committed to creating a fair, accessible and inclusive borough where everyone has a voice and an equal opportunity to succeed and thrive, and where community led ambitions are supported and actively encouraged.

What we want to achieve

This domain focuses on reducing inequality for everyone, but we are also committed to ensuring that the most marginalised and seldom heard communities enjoy the same levels of opportunity, health and wellbeing as the most affluent.

We want to use a Human Learning Systems approach within services and activities building on community strengths and increasing social value. We will build on the positives from COVID-19 such as community led support whilst seeking to mitigate the negative impacts of the COVID-19 pandemic and increased cost of living. In doing so, we will give people the opportunity to find their own solutions, make healthy choices and access support when needed.

How this Domain levels the playing field

This will Level the Playing Field by:

- Improving resident satisfaction when engaging with Thurrock Council
- A greater proportion of residents feel that decisions taken that affect them are worthwhile.
- A greater percentage of Thurrock residents voting in local elections.
- Reduced digital exclusion.
- Residents will have improved access to information and support.
- A greater percentage of volunteer placements filled within the council.
- Fewer adults 16+ reporting they feel lonely ‘often or all of the time’.
- A greater number of events and activities in hubs/libraries that support well-being and strengthen community connections.

Domain Goals

- **2A. Improved engagement with our residents to ensure everyone can have their voice heard**
- **2B. Ensure people have the skills, confidence and ability to contribute as active citizens and are empowered to co-design the decisions that affect their lives.**
- **2C. Enhance equality and inclusiveness by promoting opportunities to bring different communities together to enhance shared experience and to embed a sense of belonging**

Goal 2A. Improved engagement with our residents to ensure everyone can have their voice heard.

What we want to achieve

Support the development of new approaches to engagement and co-design based on Primary Care Network areas. Supporting better use of resources to meet local priorities which are co-designed. Developing a single view on engagement outcomes, recognising a multitude of established and new engagement routes.

Some key challenges

- Traditional methods of engagement such as consultation and surveys are not always effective and communities often complain of consultation fatigue.
- Respondents to the consultation exercise on the strategy identified that that digital exclusion is increasingly a barrier for some people. It was felt that alternatives routes to access information were still required and that services could not be completely digitally accessed as this would exclude some individuals.
- Engagement often appeals more to settled communities and we need to ensure marginalised groups and those at risk of digital exclusion have opportunity to influence decisions that affect their lives.
- Low participation denies communities the opportunity to influence how plans are implemented meaning missed opportunities to meet local needs and to secure infrastructure funding.
- There is a correlation between someone feeling as if they cannot influence decisions, and how cohesive they feel their community is, a priority to improve in a growing borough.

Goal 2A. Improve engagement with our residents to ensure everyone can have their voice heard

How we will achieve this Goal

Implementing the Collaborative Communities Framework and Better Care Together Thurrock Strategy whilst exploring new opportunities to empower and involve all communities to participate as active citizens. Build on the community engagement already in place to help connect people around the issues they feel passionate about to make local improvements.

What will we do differently under this strategy?

Embed the Collaborative Communities Framework '**engagement**' ambition to enable residents to access information and be involved in decisions that affect their lives, using co-design and co-production to generate solutions by:

- Establishing service user-led Communities of Practice for each Primary Care Network (PCN) area to improve communication with local residents.
- Making best use of our community anchors i.e. community hubs and libraries to support place based engagement using a strengths-based approach to provide services and activities to reduce digital exclusion, increase access to information and put communities in touch with local people and groups for support or social interaction.
- Ensuring the Stronger Together directory is used widely across partners as the 'one-stop shop' for residents to seek information about support available to them.
- Tackle digital exclusion using the Customer Experience and Digital Strategy.
- Working with Community Builders, Community Forums, Hubs and the wider voluntary sector to connect residents in their local areas, and maintain the Stronger Together directory.

Goal 2B. Ensure people have the skills, confidence and ability to contribute as active citizens and are empowered to co-design the decisions that affect their lives

What we want to achieve

We want to ensure people feel able and confident to take part as active citizens and influence the decisions that affect their lives from life choices through to the decisions taken by services. This means helping people have access to the information to make choices and feel able to contribute their voice through face to face or digital means. It also means encouraging community led action to support local improvements.

Some key challenges

- The estimated prevalence of poor health literacy in working age adults (aged 16-64) in Thurrock is 44% (national average is 41%). This is worse than most of our region.
- Digital exclusion is increasingly a source of inequality. Digital inclusion is multi-faceted, and increasingly necessary for everyday living. In 2020, an estimated 4% of UK households did not have internet access and in 2021 an estimated 11.7 million people (~20% of the population) did not have the digital skills needed for extensive internet use.
- We need to improve how we communicate the evidence base that informs policy and the ability of residents to influence by sharing their concerns and experience in ways which are easy to access and facilitate.
- Supporting community led action requires a strong and thriving third sector at a time when funding opportunities are decreasing locally and nationally.

Goal 2B. Ensure people have the skills, confidence and ability to contribute as active citizens and are empowered to co-design the decisions that affect their lives

How we will achieve this Goal

Driving community resilience so that people feel secure and invested in their community provides the best foundation from which to encourage participation. We will encourage people to engage around the things that are important to them. We will support skills and opportunities for communities to find their own solutions to build stronger communities.

What will we do differently under this strategy?

Embedding the Collaborative Communities Framework (CCF) '**empowerment**' ambition to empower and enable communities to champion change, for example by:

- Implementing a health literacy project through our libraries in Chadwell and Tilbury to understand more about the health inequalities that impact residents in these areas and empower people to feel confident about accessing information and seeking support to address concerns.
- Tackling digital exclusion – for example through Association of South Essex Local Authorities (ASLEA) and Public Health working together to install Wi-Fi in all sheltered housing sites, and increasing skills and confidence.
- Working with Community Builders, Community Reference Boards and the Primary Care Networks (PCN) Communities of Practice to enable residents' views to influence local decision making.
- Supporting access to resources to invest in community led action such as Small Sparks.

Goal 2C. Enhance equality and inclusiveness by promoting opportunities to bring different communities together to enhance shared experience and to embed a sense of belonging

What we want to achieve

Ensure that services are accessible, free from prejudice and enable all to have equal opportunities to prosper and contribute to building a diverse and inclusive borough. Ensure that all citizens feel listened to and that they have a stake in their community where they can prosper. Ensure equalities are a 'real' consideration when forming policies. Support people to feel welcome and connected to where they live and to reduce loneliness.

Some key challenges

- The impact of COVID-19 on social isolation and loneliness, and the adverse impact it has had on groups already marginalised, was acknowledged by respondents to the consultation on the strategy.
- Diversity is increasing in Thurrock, with over one third of residents being from a non-White British ethnic background. The Census 2021 showed that 78 languages are spoken in Thurrock with English, Romanian, Polish, and Lithuanian being the most common, however 4,227 households have no one who spoke English as a main language.
- The fear and risk of crime continues to be a challenge for many community groups. The rates of recorded violent offences in Thurrock (35.5 per 1,000) is significantly above the England rate (29.5 per 1,000 population) - this has risen sharply since 2013.
- Around two thirds of people with long-term health conditions including blood pressure and mental ill health are undiagnosed and not receiving support. There are higher rates for these conditions for people living in less affluent areas, men, people with learning disability, young people and older adults, unpaid carers, certain minority ethnic groups and LGBTQ+ people.

Goal 2C Enhance equality and inclusiveness by promoting opportunities to bring different communities together to enhance shared experience and to embed a sense of belonging

How we will achieve this Goal

Establish an Improving Equality Outcomes Board to drive improvement across all policies, strategies and service transformation. Work with the Community Safety Partnership to tackle hate crime and prevent extremism. Embed a workforce development and learning programme to ensure staff have the skills and capacity to deliver on this agenda.

What will we do differently under this strategy?

We will embed the Collaborative Communities Framework (CCF) '**equality**' ambition for all to have equal opportunity to prosper in a connected community and contribute to a diverse and inclusive borough, for example by:

- Integrating health and equality impact assessment into a single Community Equality Impact Assessment model.
- Reviewing training and support for the preparation of Equality Impact Assessments.
- Strengthening community engagement opportunities for influencing Community Equality Impact Assessments.
- Improving the use of the data and intelligence we collect and hold concerning the diversity profile and experience of Thurrock residents using our services and use this to inform policy development to improve equality outcomes.
- Building on the legacy of TCCA and Our Road to encourage community led neighbourly help and support as seen during the lockdown, building connections across different communities
- Working with the Thurrock Community Safety Partnership to tackle hate crime and prevent extremism – we will work with communities to prevent hate incidents and crimes, encouraging reporting when incidents do happen.
- Preparing an annual calendar of events and activities to celebrate diversity with partners such as International Women's Day, Holocaust Memorial Day and Pride Month.

Domain 2 - Building Strong and Cohesive Communities
Key deliverables, commitments and milestones Year One (July 2022 - June 2023)

Goal 2A. Improved engagement with our residents to ensure everyone can have their voice heard

- A Community of Practice has been piloted helping to develop community links in Stanford le Hope and encouraging the hosting of Barclays Bank in Corringham Library when the bank decided to close its town branch.
- Focused mapping of assets by PCN area to include on the Stronger Together directory.
- 1,830 events in hubs and libraries between April - December '22 which bring people together and enable discussion to inform community led action.
- £100,000 investment into community grants to help recovery from Covid around agreed priorities.
- Community Builders have supported new connections, supporting local outcomes such as community pantries and warm spaces.

Goal 2B. Ensure people have the skills, confidence and ability to contribute as active citizens and are empowered to co-design the decisions that affect their lives.

- A Digital and Health Literacy pilot is being developed in Tilbury and Chadwell PCN to help residents to access information and raise awareness around health inequalities.
- Connecting all 29 sheltered housing sites to the Thurrock Council Network with Wi-Fi capability that will support public access, the Thurrock Corporate Network connecting staff and enabling Thurrock Council to have Gov Roam capability which could enable NHS staff to work remotely.
- We will pilot a new approach to developing capacity within a Community of Practice area in 2023.
- 95% of council volunteer placements were filled between April – December 2022. The number of placements increased from placement's available increased from 181 in April to 196 in December 2022.
- A learning programme to support the voluntary sector is being developed between CVS and TACC for delivery in 2023.

Goal 2C .Enhance equality and inclusiveness by promoting opportunities to bring different communities together to enhance shared experience and to embed a sense of belonging

- Establishing an Improving Equality Outcomes Board to support a pan Council approach to tackling inequality.
- Integration of Equality Impact Assessment and Health Impact Assessments.
- Welcome events for Ukrainian refugees and support for all refugees to embed a sense of belonging with practical support.
- Review of communications with Forums, regular engagement with Hubs and development support from Community Builders for example, supporting the development of Purfleet Community Hub.
- A calendar of events that promote cohesion with annual events (Remembering Srebrenica, Holocaust Memorial Day and Pride) as well as enabling community led activity e.g. Jubilee Street Parties and Christmas events with small sparks investment.
- A successful Interfaith Week to engage diverse faiths with services and over 50 meetings between community groups, the Communities Portfolio Holder and officers at the Town Hall to hear about their work, aspirations and to help resolve barriers to working in Thurrock.

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Thurrock Health And Wellbeing Strategy 2022-2026

Levelling the Playing Field in Thurrock

Created through the partnership of Thurrock Health and Wellbeing Board

Introduction and overview report to Thurrock Health and Wellbeing Board

Domain 4, Opportunity for All

Domain 4 Opportunity for all

Domain 4. Aims and ambitions

Thurrock will be a place of economic opportunity with inward investment to the borough and wider regeneration programmes creating new opportunities to the benefit of local communities.

We want to support people in Thurrock to be aspirational, resilient, and able to access high quality education and training; enabling them to develop skills to secure good quality employment and volunteering opportunities to live fulfilling lives and achieve their potential.

What we want to achieve

This domain focuses on the wider determinants of health and wellbeing including education, learning and skills, promoting collaboration across the whole system in raising aspirations and reducing disadvantage so that children and young people achieve their potential.

Delivering the Backing Thurrock Roadmap and Action Plan and supporting the economically vulnerable in developing resilience will result in more residents being able to benefit from local employment opportunities.

Creating a vibrant culture and local economy, encouraging investment in people and in places across Thurrock will allow people to benefit from the enormous opportunities generated through the Thames Freeport and other major developments.

There is a strong link with Domain 2 – Building Strong and Cohesive Communities

Domain 4 Opportunity for all

How this Domain levels the playing field

This will Level the Playing Field through:

- Reducing the gap in attainment in the most and least deprived groups of children and young people whilst ensuring educational progression for all will support a reduction in inequality through raising attainment, improving health outcomes and disrupting cycles of intergenerational disadvantage.
- Enabling opportunities for people to be able to improve their own social and economic situation and creating the environment for people to create their own opportunities.
- Working in partnership to support those in areas or circumstances that are resulting in inequality of outcomes and people living in disadvantaged circumstances, such as in low income households and in need of economic support.
- Increasing the proportion of people from vulnerable groups in employment.
- Increasing the earning potential of individuals through skills development and access to better jobs.
- Decreasing the proportion of children living in low income households.
- Working with communities to ensure that economic development and investment benefits the most deprived communities.

Domain 4 Opportunity for all

Four domain goals

4A Through raising aspirations and reducing the disadvantage gap, all children and young people are able to achieve their potential

4B Raising aspirations and opportunities for adults to continue learning and developing skills, with a focus on groups that can benefit most

4CSupporting the economically vulnerable through delivering the Backing Thurrock Roadmap and Action Plan and the Thames Freeport

4D Creating a vibrant place, that generates new businesses, increases prosperity and enables people across Thurrock to benefit from the transformational investment in major development schemes

Goal 4A. Through raising aspirations and reducing the disadvantage gap, all children and young people are able to achieve their potential

What we want to achieve

All Thurrock children and young people are making educational progress with aspirations for the future and the disadvantage gap reduced.

Some key challenges

Some children are at particular risk of lower educational attainment. These include children who are NEET, have SEND, are Children Looked After, and from some minority ethnic groups.

Being NEET occurs disproportionately among those already experiencing other sources of disadvantage; deprivation, socio-economic position, parental factors (such as employment, education, or attitudes), growing up in care, prior academic achievement, and school experiences are all risk factors.

The impact of missed schooling during the Covid-19 lockdown measures and restrictions is challenging in terms of recovering the lost learning; assessment was also disrupted during the pandemic with exam cancellations and teacher-assessed grades making measurement and benchmarking more difficult.

Goal 4A. Through raising aspirations and reducing the disadvantage gap, all children and young people are able to achieve their potential

How we will achieve this Goal

Through delivery of the Brighter Futures Strategy for children and young people in the context of Covid-19 recovery:
All children in Thurrock making good educational progress, with improved educational attainment for all disadvantaged children and young people
Support all young people to gain qualifications, skills and experience to progress into further and higher education, apprenticeships or sustained employment. Increased applications to higher education and apprenticeships from young people from disadvantaged backgrounds
Thames Freeport will work directly with local schools to ensure communities at the heart of the Freeport are able and equipped to take advantage of the higher paid jobs delivered through Thames Freeport's innovation.

What will we do differently under this strategy?

- Develop and implement a post-pandemic training and education plan.
- Provide additional support to children with SEND.
- Conduct a literature review to understand what works in reducing the educational gap in schools.
- Establish a plan of action with schools to eliminate the disadvantage gap experienced by young people at primary and secondary level.
- Equip educators with the tools and skills needed to eradicate cultural prejudice and bias.
- Establish mentoring services for young people prioritising those at risk for offending/offenders.
- Develop a model for an integrated Youth & Adults Education & Skills Offer.
- Promote the safeguarding and development of apprenticeships to support particularly young people and vulnerable people.
- Support the Mid & South Essex NHS Foundation Trust Anchor Youth Partnership scheme to enhance awareness of youth employment opportunities in the NHS.
- Facilitate careers advice, opportunities for contact with employers and experience of the workplace for young people to reduce chances of becoming NEET.

Goal 4B. Raising aspirations and opportunities for adults to continue learning and developing skills, with a focus on groups that can benefit most

What we want to achieve

An increase in the proportion of adults accessing learning and developing skills, with a focus on groups that can benefit most

Some key challenges

Increasing the proportions of adult learners who are from minority ethnic groups and from lower socioeconomic groups.

Increasing the proportion of adults engaged in improving essential skills and ultimately decreasing the proportion with no qualifications.

Equipping adults with the skills required to secure better paid jobs generated through inward investment. For example we are aware of existing shortages in welders, HGV drivers, people trained in coding.

Reducing social isolation and increasing community cohesion through learning and volunteering opportunities which provide skills including resilience and confidence building.

Improving and tailoring the support to adults with learning disability and other disadvantage.

Identifying the gaps in engagement and improving access across the age range, offering a variety of opportunities to appeal to the spectrum of learning and skills at all levels, creating a Skills Bridge.

Goal 4B. Raising aspirations and opportunities for adults to continue learning and developing skills, with a focus on groups that can benefit most

How we will achieve this Goal

The priority will be achieved through the Economic Development and Skills Partnership, 11-25 Strategy Group and Adult education providers as well as partnership working through supporting the delivery of the Backing Thurrock Strategy to increase adults learning and developing new skills.

What will we do differently under this strategy?

- Identify what the key skills needed are (e.g. literacy, numeracy, IT and resilience) and support adults and young people with developing these skills to allow an increased access to opportunities for further skills development and to fill employment gaps.
- Work collaboratively with the Essex Chamber of Commerce, the Local Enterprise Partnership and partners to expand available programme for people in Thurrock to benefit from skills development e.g. T-Levels.
- Support more adults that are disadvantaged e.g. due to learning disability to engage in learning and wellbeing activities.
- Support progression from engagement courses into employment, apprenticeships, volunteering, or further learning.
- Improve access to a good quality education and training to improve prospects of finding and remaining in good jobs.
- Help people understand and access careers advice and opportunities to retrain - building on the You Train You Gain initiative.
- Establish a Freeport Skills Fund to support skills programmes to ensure that local people are equipped to benefit from anticipated employment opportunities – focusing on young people and those with protected characteristics.
- Engage more people in Thurrock in enterprise including social enterprise, work experience and volunteering opportunities.

Goal 4C. Supporting the economically vulnerable through delivery of the Backing Thurrock Roadmap and Action Plan and the Thames Freeport

What we want to achieve

More residents in sustained employment with an increase from vulnerable and deprived groups. We want to see a reduction in residents needing to claim benefits through improved economic circumstances.

Some key challenges

Young workers (under 25) and older workers (over 65) are more likely to have left employment and remain economically inactive during the Covid-19 pandemic.

Areas with a higher degree of short term employment have been worse affected by the pandemic and the subsequent economic downturn.

Supporting people with long term conditions and learning disability to access and remain in employment is a challenge nationally and locally. There is a challenge of people in some of these groups being overlooked in relation to employment, for example, people with learning disability.

Maintaining Thurrock's excellent record of follow-up of younger people NEET (who are at risk of worsening financial and mental health) to support them to move into employment

While Thurrock is not an outlier nationally, there continues to be a gap in the employment rate between those with and without a long term condition.

Goal 4C. Supporting the economically vulnerable through delivery of the Backing Thurrock Roadmap and Action Plan and the Thames Freeport

How we will achieve this Goal

Through partnership working supporting the delivery of the Backing Thurrock Delivery Plan and delivery of the strategic recommendations highlighted in the Work and Health JSNA.

What will we do differently under this strategy?

- Implement the recommendations from the Work and Health JSNA to support long term unemployed Employment Support Allowance claimants back in to work.
- Improve support for those with existing mental health or musculo-skeletal (MSK) conditions to either find and/ or retain work
- Provide additional support for people with learning disability or another disadvantage
- Ensure residents are aware of the support available through consistent and clear communications.
- Consider how to support employers to support employee Health and Wellbeing
- Promote a range of different employment opportunities, which would support residents with different needs and commitments, including for example, carers.
- Establish an agreed definition and baseline measure for economically vulnerable residents
- Work in partnership to map the gaps that exist in industries / specific job roles and link people and employment opportunities.
- Maximise opportunities for residents to find and retain jobs during the construction and operation of the major regeneration projects.
- Work in partnership to ensure Council procurements for major capital schemes are linked into the Council Social Value Framework and contain local employment clauses to support an increase in the workforce from the local area and to provide opportunities for local people.

Goal 4D. Creating a vibrant place that generates new businesses, increases prosperity and enables people across Thurrock to benefit from the transformational investment in major development schemes

What we want to achieve

A place-based approach to create a vibrant economy and society. One where people want to live, work, play and learn. Where there is an entrepreneurial culture and increase in the number of businesses in Thurrock along with an increase in the proportion of people in employment in quality jobs developed through major developments and investment as well as individuals and communities having the opportunity to benefit from facilities, services and amenities that give people a better quality of life.

Some key challenges

Ensuring that economic development benefits the Thurrock residents including those from most deprived communities.

Supporting small businesses especially in their first year, especially since a high proportion of Thurrock employment is with small and medium size enterprises.

Creating connections and linkages to allow entrepreneurs and local business to identify and benefit from inward investment.

Encouraging technological advancement and development of online connectivity to support investment and growth.

Further developing the cultural offer through community engagement that reflects the needs and aspirations of the borough making Thurrock a place of cultural destination. Exploiting the opportunities that exist around Thurrock's unique placement in the region, the River Thames and associated use and history, the rich and mixed heritage of the Thurrock community, and developing SEE park.

Goal 4D. Creating a vibrant place that generates new businesses, increases prosperity and enables people across Thurrock to benefit from the transformational investment in major development schemes

How we will achieve this goal

By taking a place-based approach, we will create the right conditions and environment for good growth and cultural opportunities for people to engage with and benefit from.

What will we do differently under this strategy?

- Work with local business leaders and anchor institutions to establish new ways of working to increase local recruitment, develop local supply chains, attract public and private inward investment and make best use of assets.
- Take an approach of community wealth building to support the creation of wealth in Thurrock and retaining that within the borough.
- Engage with Anchor Institutions to attract inward private and public investment
- Work with developers to secure benefits for local businesses and jobs for local residents.
- Support employers with upskilling employees to increase productivity and retention.
- Support small employers to use Apprenticeships funding to upskill and recruit staff.
- Support local businesses to generate wealth and employment in Thurrock
- Enable residents to start and develop new businesses, including social enterprises and micro enterprises, and help them to grow.
- Conduct a business survey to understand the aspirations and needs of the local business community

Domain 4, Opportunity for all.
Key deliverables, commitments and milestones in year one (July 2022 – June 23)

4A Through raising aspirations and reducing the disadvantage gap, all children and young people are able to achieve their potential

New SEND apprenticeships, supported Internships and traineeships
Implementation of Kickstart scheme (6 month placements for young people)
Greater Essex Careers Hub (Careers and Enterprise Company) linking of education to world of work
Next Top Boss competition (raising students' aspirations and enhancing skills for work)
Inspire programme delivering careers interviews in secondary school

4B Raising aspirations and opportunities for adults to continue learning and developing skills, with a focus on groups that can benefit most

Skills implementation plan agreed and scorecard developed to monitor progress
Start of Multiply numeracy programme (aged 19+) and extension of offer on digital skills

4CSupporting the economically vulnerable through delivering the Backing Thurrock Roadmap and Action Plan and the Thames Freeport

Backing Thurrock implementation group – whole system approach across council services, further education institutions, voluntary and business sectors
Successful bid to the UK Shared Prosperity Fund.
Targeted work to tackle those who are economically vulnerable, in poorer health, and at risk of fuel poverty
Tilbury Community Led Community Development project awarded 62 grants. Under evaluation
Developing workplace health offer to businesses including signposting to training and local services
Refreshed Thurrock Opportunities website, connecting residents to learning and work
Introduction of Thurrock Enterprise week and monthly newsletter for businesses
Freeport Skills plan pathfinder begun – support those most in need to benefit from work

4D Creating a vibrant place, that generates new businesses, increases prosperity and enables people across Thurrock to benefit from the transformational investment in major development schemes

Business survey undertaken and report complete. This will inform 23/24 programme of enhanced support
Multiple initiatives to improve townscapes in development, funded by the UKPSHF
Financial support to businesses affected by the pandemic. COVID-19 Additional Relief Fund
Established working group to develop an anchor institutions framework, include social value commitments

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10 February 2023	**Item 9**
Health & Wellbeing Board	
Unpaid Carers – All Age Carers Strategy	
Wards and communities affected: All	**Key Decision:** Key
Report of: Catherine Wilson – Strategic Lead Commissioning and Procurement	
Accountable Assistant Director: Ceri Armstrong – Acting Assistant Director of Adult Social Care and Community Development	
Accountable Director: Les Billingham – Acting Director of Adult Social Care	
This report is public	

Executive Summary

In 2015 it was estimated that Unpaid Carers provide £132 billion of support to vulnerable people in the UK. The numbers of people caring and the amount care being provided has increased significantly during the pandemic. It is accepted that Adult Social Care and Health could not meet the needs of service users (physically or financially) in our community if Carers did not continue within their roles.

The pandemic reinforced the importance of Unpaid Carers but also highlighted areas where improvement is needed. As such, we know we need to change our offer.

This report details the outcome of an extensive period of engagement with young and adult carers and mainly focusses on one area of improvement – the development of an all-age Carers Strategy/action plan. However, the report also details in appendix 1 the main activities we are currently undertaking operationally and in commissioning to transform our internal offer to carers.

1. Recommendation(s)

1.1 The Board notes the findings of the unpaid carers consultation and agrees the proposed approach to strategy/action plan development.

2. Introduction and Background

2.1 A Carer is a child, young person or adult who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without their support. The care they give is unpaid.

2.2 Unpaid Carers provide £132 billion of support (that would potentially have to be met for formal services) to vulnerable people in the UK, an average of £19,336 per carer. The numbers of people caring, and the amount of care being provided has increased significantly during the pandemic.

2.3 **Nationally 1 in 8 adults** (6 million people) are Carers and of these 1.2 million Carers provide more than 50 hours of care per week. However, this is based on pre-pandemic research – a vast amount of people took on caring responsibilities during this period. Carers UK estimate that overnight, an additional 4.5 million people became unpaid carers in March 2020, meaning 1 in 4 (26%) UK adults were providing unpaid care to an older, disabled or ill relative or friend at the height of the pandemic

2.4 Although we expect the numbers above to decrease slightly, the amount of unpaid carers have been rising significantly as the population ages and healthcare continues to improve. This assumption has been supported by the number of adult carers seeking support from our Carers Information, Advice and Support service – we have seen an increase of 100% compared with pre-pandemic levels.

2.5 **1 in 5 schoolchildren are estimated to be carers**. The impact of being a young carer are;

- More likely to have lower educational attainment than their peers and trying to balance the responsibilities of caring with school can impact on their mental health.

- One quarter of young carers aged 11 – 15 regularly miss school and this can have a lasting impact on the life chances.

- 1 in 3 young carers state that their caring role makes them feel stressed and research shows that 23% of young carers in the UK say their caring role has stopped them being able to make friends.

The demand for support mirrors adult carer services - we have seen a significant increase in the number of young carers seeking support from our Young Carers Support Service post pandemic.

We have recently been successful in securing Health Inequalities funding for additional resources to meet the mental health needs of young carers. This funding is for counselling support and art workshops which are to be held in the February half term.

2.6 In Thurrock it is estimated that more than 20,000 people are Carers. The 2011 census showed that 26% of those identifying as caring in Thurrock provide more than 50 hours per week. This is higher than region and national averages. Those carers providing the highest amount of care are twice as likely to be permanently sick or disabled as the general population.

2.7 Caring can be a rewarding experience but many face isolation, poverty, discrimination, ill health, frustration and resentment as a result of their caring role.

2.8 These caring responsibilities can have an adverse impact on carer's employment and education opportunities. Carers are also likely to have much poorer physical and mental health outcomes compared to the general population. This increased health risk is attributed by Carers to a lack of support.

2.9 Apart from the need to support Carers so that their role doesn't have such an adverse impact on their own wellbeing, without such support Carers are often unable to continue in the role. This impacts on the wellbeing of the cared for, often resulting in costly residential care and hospital admissions. There would be a significant financial impact on the health and social care system if carers did not continue to provide the level of care to family members and friends.

2.10 We also have a statutory responsibility to support carers. In 2014, The Care Act replaced most previous law regarding adult Carers. The Act strengthens recognition of the role of Carers, including for the first time, giving Carers parity of esteem to those they care for and a clear right to services.

2.11 The Children and Family Act 2014 gives young carers and young adult carers in England the right to a carers assessment and to have their needs met. The purpose of the legislation is to ensure that inappropriate or excessive caring by children is prevented or reduced.

2.12 As part of our Covid recovery we want to galvanise our offer to Carers including building on those areas that are proving to be successful. The pandemic highlighted what we do well but what also needs improving. It is also apparent that we needed to have greater alignment of adult and young people carer support. For example, a young carer is often supporting an adult social care or health service user and young carers do not remain young forever and transition themselves at the age of 18 to adult social care. Equally, we have the responsibility to support adult parent carers of disabled children and young people.

2.13 As such, post pandemic we are at the start of a larger transformation to support carers. We are aware that there are multiple priorities for Carers and several improvements that need to take place. We have attached the main initiatives currently in progress in the form of an action plan at appendix 1.

Further priorities and actions have and will come out of the engagement with carers; however, it was evident that some areas required attention before a full engagement exercise could report.

2.14 For the purpose of this report to the board we have focussed on one priority. The **Development of a Carers strategy/action plan**. We do not have an up-to-date adult carers strategy (it expired during the pandemic and it was agreed that it was not the appropriate time to refresh our approach), in addition the young carers strategy will soon be coming to an end. As such, in reference to 2.12 it was agreed that it would be positive to develop an all-age approach for the first time.

2.15 So much has changed as the result of the pandemic. We also know that the majority of carers are not known to social care and that some carers will not be open with the local authority about the difficulties they encounter in their caring role for fear they will be judged as not coping. As such, in preparation of commencing our all-age approach we felt it was prudent to seek someone outside of the Council to carry out the engagement.

2.16 Although our young carer and adult carers support services are best placed to represent carers, we felt we needed an organisation who would be independent of all existing carer support services (including internally provided social work support and carers short break service) so that we can capture the true voice of unpaid carers in Thurrock. As such we engaged Healthwatch Thurrock to carry out the engagement on our behalf. They were also tasked with collecting information to inform future commissioning activity around 'taking a break'.

2.17 The engagement exercise was comprehensive and collected information using a variety of mechanisms. At the time of planning the engagement we were still unsure whether further lockdowns would be likely, as such the engagement was over an extended period to take in the warmer weather in case some of the face-to-face engagement needed to be outdoors.

2.18 The findings of the engagement are embedded in section 8 of this document as the "Unpaid Carers Report" and should be read in conjunction with this document. The outcome from this engagement and proposed next steps are detailed in section 3.

3. Issues, Options and Analysis of Options

3.1 The Unpaid Carers Report shows that in the main most carers are only seeking small improvements to existing services to make their caring role easier.

Some of the issues identified have already been addressed since the engagement was undertaken e.g. waiting times/allocated hours for the 'sit in service'. As such carers should see an improvement in accessing this service over the coming weeks.

3.2 The Unpaid Carers Report is balanced and highlights the support/services that are working well (including our commissioned Carers Information, Advice and Support Services). It also evidences that many carers who chose to utilise a direct payment felt it has given them additional flexibility.

3.3 However, as there are many positives, there are many areas identified as requiring improvement across health and social care that all partners and the strategy need to address. These include but are not limited too;

Adult Carers Recommendations;

- Improve communication between different support services so as to avoid carers having to repeat themselves.
- Ensure timely follow up following referral into services.
- Better explanation of Carers Assessment process.
- Improve availability of information regarding support for carers. Having a central point of access, taking into consideration different digital abilities.
- Increase staff availability [largely in the 'sit in' service] so that allowances agreed in assessments can be met.
- Work with employers to see how carers can be supported in the workplace and ensure flexible working that can meet the needs of carers that wish to work.
- Provide training workshops to carers to support an improved understanding of the health condition of their loved one.
- Working with healthcare settings to ensure that patient notes reflect carer status/ability to speak on loved one's behalf.
- Making sessions on LPA/Guardianship available to carers.
- Working with carers to ensure they have plans in place for when/if something were to happen to them.

Young Carer Recommendations;

- To work with schools to ensure that Young Carers can be identified by members of staff so they can get the proper support.
- Timely referrals into the Young Carers Service.
- Expand the referral pathway into the Young Carers Service i.e., self-referral or referral by other services other than children's social care.
- Clearer signposting to pastoral care in schools and colleges.
- Reasonable adjustments made for young carers that take into account challenges at home e.g. adjusted detention times, warning systems for phone removal, quiet space in school.
- Carers support groups either teacher or peer led in all schools in Thurrock.

- Raising awareness of carers amongst student population to help young carer identification and reduce bullying.
- Raising awareness of different health conditions amongst student population to reduce bullying.
- More days out and activity opportunities for young carers, giving them time and space to embrace their hobbies

3.4 As the Unpaid Cares report document captures the voices of carers so well and articulates what needs to improve, a more targeted action plan rather than duplicating activity on a large strategy document feels more appropriate. An action plan that sits as an appendix to the engagement plan rather than the other way around is suggested as the way forward. We feel this will ensure that the document reflects the reality of carers in Thurrock and what they see as a priority rather than the views of professionals and clearly demonstrates our commitment to co-production.

3.5 Our suggested next steps are as follows;

- Hold an event in February inviting all partners to discuss the findings of the report and to start action planning – this will include professionals and unpaid carers. This event will also share the young carers 'pants' and 'tops' (the things that worked well and the things that don't', written by young carers) on a washing line as well as the videos of adult carer experience recorded as part of the engagement process.
- We will then hold subsequent meeting/s (where necessary – this may be targeted to those who cannot engage virtually) to agree final action plan.
- We will then pursue formal/wider consultation (as is our legal requirement) and seek formal sign off through the agreed accountability route.
- Post consultation, Healthwatch Thurrock have agreed to host a carers reference group (name to be decided) that will be independent of the council. In Thurrock, we may also have the option of the group being hosted by the User Led Organisation (ULO) depending on capacity long-term. However, Healthwatch have identified a number of carers who would like to be part of this during the engagement process. This independent group will review progress against the agreed action plan and also propose changes as the agenda progressed.

3.6 It is our intention that this document will be agreed by both health and social care partners. This is being explored during the planning stages.

4. Reasons for Recommendation

4.1 To develop an all age carers strategy/action plan based on what is important to carers in Thurrock.

4.2 To ensure that future actions and improvements to carers support are based on carer experience.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 Please see the attached the full unpaid carers engagement plan undertaken by Healthwatch Thurrock on behalf on Thurrock Council.

Unpaid Carers Engagement Plan FIN.

6. Impact on corporate policies, priorities, performance and community impact

6.1 Although a sustainable market for adult social care can be seen as positively impacting on all corporate policies, it is the 'People' priority and the desire to provide high quality public services that Is the most pertinent.

7. Implications

7.1 Financial

Implications verified by: **Mike Jones**

Strategic Lead – Corporate Finance

There are no financial implications in the development of the strategy. Financial implications may occur at a later stage when improvements/actions are agreed.

7.2 Legal

Implications verified by: **Daniel Longe**

Principal Solicitor, Children and Adult Safeguarding and Education

Section 10, 13 and 20 of the Care Act 2004 imposes a statutory duty on local authorities to carry out needs assessments of adults who provide care for others in its area and provided that they meet the statutory eligibility criteria under section 13, that local authority is required to meet the needs of that carer pursuant to section 20.

Section 96 of the Children and Families Act 2014, also imposes a duty on local authorities in relation to children who may be caring for others and for appropriate support to be made available for such children.

Therefore, the proposals in this report and appendices are in line with the local authority's statutory duties.

7.3 **Diversity and Equality**

Implications verified by: **Roxanne Scanlon**

Community Engagement and Project Monitoring Officer

The development of an all age carers strategy/action plan seeks to identify improvements to the information, advice and support of young and adult carers in Thurrock. As such, the development of the carers strategy should have a positive impact on carers in that it should secure improvement and inform the development of more flexible replacement care/respite services in the future. A full Community Equalities Impact Assessment will be completed as the strategy is developed.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder, or Impact on Looked After Children)

None

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

- Unpaid Carers Report

Unpaid Carers Report Healthwatch 2022.pdf

9. Appendices to the report

- Appendix 1 – Activities currently being undertaken in Adult Social Care (ASC) to support improvements to carer experience

10. Key points of interest within appendix 1

The main improvements currently underway operationally and in commissioning are;

- **Increased identification, support and assessment of carers –** moving to a place based working approach to aid increased identification**.**
- **Co-creation of new approach to Carers assessments** - we have developed a more meaningful assessment in partnership with carers
- **Support to stay in employment** – we have improved our in-house support to become a carer friendly workplace with the introduction of carers passports. We will know focus externally.

- **Implementation of a portal** – this IT solution is near completion and will allow the carers service (adult) to undertake assessments on our behalf (this is in response to feedback from carers). It will mean more carers will be able to access support in their role. It will also allow for carers to self-assess and we are currently exploring the carer service using the portal to support carers with a new approach to contingency planning.
- **Transition of Young Carers to Adult Services** – A new pathway has been agreed between Children and Adult Social Care to ensure a smooth transition for young carers becoming the responsibility of adult services. A peer support group has been jointly developed by our young carer and adult carer services to ensure young carers continue to access support post 18.

Report Author:

Sarah Turner

Commissioning Manager

Adult Social Care

Appendix 1

Increased identification, support and assessment of carers.
This is our main focus and one of the most difficult issue to overcome (it takes on average 5 years for someone to self-identify as a carer – often only accessing support at a time of crisis). Without improved identification of carers we are unable to provide/understand the support needed.

We are moving the adult carers support service to placed based to reflect how we deliver adult social care support. This will enable carers to draw upon the assets and circles of support in the local community to improve early identification and Carers outcomes. Some of this work has already been undertaken in the Grays and has resulted in 50% of all newly identified Carers now coming from this area.

Co-creation of new approach to Carers assessments.
We want to move the carers assessment to a strengths based approach (to mirror the cared for). This has just been finalised and has been shaped by carers.

Improved 'taking a break' (respite) and replacement care options.
–We need to ensure that we enable Carers to take a break from their caring role. Carer feedback suggests that our current services are not meeting this need. The information about what is working well, what isn't and what is missing has been collected as part of the engagement undertaken by Healthwatch Thurrock.

Support to stay in employment / help with financial difficulties.
The financial impact of caring is significant with many carers living in poverty. We need to support carers to remain in employment if they wish to (this is also a requirement of the Care Act) and increase the uptake of Carers allowance and other entitlements. We have internally improved our offer to carers (see below). We now need to promote carer friendly workplaces and good practice with other local employers.

Work with HR and OD has finalised to become a carer friendly workplace by supporting the implementation of a Carers Passport internally.

Implementation of a portal - to allow the Carers service to undertake assessments and reviews of carers needs on behalf of the council (to increase uptake of assessments but also because local research has shown that Carers in Thurrock are frustrated by having to repeat their 'story' and a lack of a consistent allocated worker). Long term this will also allow carers to self-assess. Developing the portal should have a significant impact on the support available to Carers not known to ASC, which in turn should improve the wellbeing of both the Carer and cared for long

term and stop the need for more costly interventions/crisis response. This is very near completion.

We are also exploring improved contingency planning arrangements for carers and hope to utilise both the carers support service (adults) and the portal to ensure carers have considered emergency arrangements. Long term the portal should also allow carers to self-assess should they wish too.

Health Inequalities Funding for Young Carers - We have recently been successful in securing Health Inequality funding for additional resources to meet the mental health needs of young carers. This funding is for counselling support and art workshops which are to be held in the February half term.

Transitions and Young Carers – Children and Adult Social Care services have recently put a new pathway in place for Young Carers transitioning to Adult Carer services.

In addition, both Adult and Children's Carer Support services have worked together to develop a peer support group for young carers who will move to adult services to ensure a smooth transition of support.

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10 February 2023	**Item 10**
Health & Wellbeing Board	
Mid and South Essex Integrated Care Strategy	
Wards and communities affected: All Essex	**Key Decision:** Key Decision
Report of: Jeff Banks - Director of Strategic Partnerships, Mid and South Essex Integrated Care System	
Accountable Assistant Director: N/A	
Accountable Director: Jeff Banks - Director of Strategic Partnerships, Mid and South Essex Integrated Care System	
This report is Public	

Executive Summary

The purpose of this report is to present the Integrated Care Strategy produced by the Integrated Care Partnership for Mid and South Essex and:

- For the board to receive and endorse the completed ICS strategy
- For partners to note the priorities and feedback to their respective organisations and networks
- To discuss and consider how to take forward any mutual working, and agree where a whole Essex footprint is required for delivery.
- To identify any areas of significant inconsistency or incompatibility with the JHWS or other key strategies and plans
- To consider how best the ICS and Council can come together to facilitate ongoing collaboration.

1. Recommendation(s)

1.1 The Board approves the Integrated Care Strategy and offers observations about how the work is taken forward as appropriate.

1.2 The Board endorses initial areas for additional joint working with the Integrated Care Partnership.

2. Introduction and Background

2.1 The Health and Care Act 2022 ("The Act") established 42 Integrated Care Systems (ICSs), which are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area.

2.2 Each ICS is made up of two main committees:

- **Integrated Care Board (ICB):** A statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget, and arranging for the provision of health services in the Integrated Care System area. The establishment of ICBs resulted in Clinical Commissioning Groups being closed.

- **Integrated Care Partnership (ICP):** A statutory committee jointly formed between the NHS ICB and all upper-tier local authorities that fall within the ICSs area (councils with responsibility for children's and adult social care and public health). 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 Integrated Care System area.

1.2 The Act and the associated 'Guidance on the Preparation of Integrated Care Strategies', published 29 July 2022 ("Guidance"), requires each Integrated Care Partnership to develop an Integrated Care Strategy which *"should set the direction of the system across the area of the integrated care board and integrated care partnership, setting out how commissioners in the NHS and local authorities, working with providers and other partners, can deliver more joined-up, preventative, and person-centred care for their whole population, across the course of their life".*

1.3 The Act states that ICPs must *"prepare"* and *"publish"* a strategy and *"give a copy of each integrated care strategy to […] the responsible local authorities whose areas coincide with or fall wholly or partly within its area"* and to the *"the integrated care board for its area".* The Guidance states that, "*the integrated care partnership would have to publish an initial strategy by December 2022".*

3. Issues, Options and Analysis of Options

3.1 Members are asked to approve the Integrated Care Strategy and proposals for joint working offering comments and observations to help improve the Strategy. This will enable the ICP to move forward with their work, with clear support from the Thurrock Health and Wellbeing Board and the comments and observations which they are asked to take into consideration.

4. Implications

4.1 Financial

Implications verified by: **Jeff Banks – Director of Strategic Partnerships, MSE ICS**

No Financial Impact

4.2 Legal

Implications verified by: **Jeff Banks – Director of Strategic Partnerships, MSE ICS**

No legal Impact

4.3 Diversity and Equality

Implications verified by: **Jeff Banks – Director of Strategic Partnerships, MSE ICS**

No Diversity and Equality impacts

4.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder, or Impact on Looked After Children)

No other implications

5. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

Members may wish to consider the Department of Health & Social Care Statutory guidance on the preparation of integrated care strategies, published 29th July 2022, which is available at this link https://www.gov.uk/government/publications/guidance-on-the-preparationof-integrated-care-strategies/guidance-on-the-preparation-of-integrated-carestrategies

6. Appendices to the report

- **Appendix One:** Mid and South Essex Integrated Care Strategy

Report Author:
Jeff Banks – Director of Strategic Partnerships, MSE ICS

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Mid and South Essex Integrated Care Strategy 2023-2033

December 2022

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Priorities for the Mid and South Essex Health and Care Partnership

1. Context

1.1. The health and care system

Integrated Care Systems (ICSs) are partnerships of organisations that come together to plan and deliver joined up health and care services and to improve the lives of people who live and work in their area.

Following several years of locally led development, recommendations from NHS England and the passage of the Health and Care Act (2022), forty-two ICSs were established across England on a statutory basis on 1st July 2022. The ICS is made up of two main committees:

- ***Integrated Care Board (ICB):*** A statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget, and arranging for the provision of health services in the Integrated Care System area. The establishment of ICBs resulted in Clinical Commissioning Groups being closed.
- ***Integrated Care Partnership (ICP):*** A statutory committee jointly formed between the NHS ICB and all upper-tier local authorities that fall within the ICSs area (councils with responsibility for children's and adult social care and public health). 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 Integrated Care System area.

In Mid and South Essex, our ICS is made up of a wide range of partners, supporting our population of 1.2m people. We operate at several levels, ensuring we always organise our work and deliver services at the most local appropriate level and closest to the residents we serve:

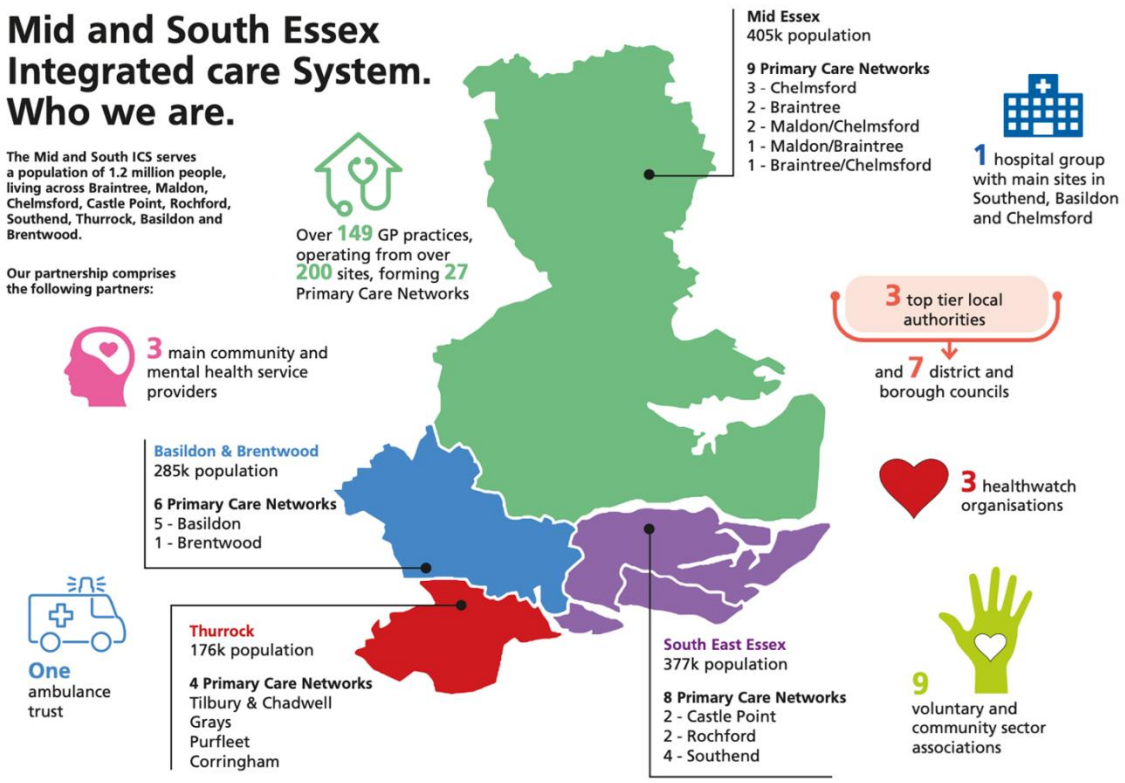
- ***Neighbourhoods:*** The areas covered by our 27 Primary Care Networks, and local neighbourhood teams, etc.
- ***Places:*** The areas covered by our four Alliances, covering Mid Essex, Basildon and Brentwood, Thurrock and South East Essex.
- ***System:*** The whole of Mid and South Essex.

Our Partnership includes;

- ***Three upper tier local authorities:*** Essex County Council, Southend-on-Sea City Council (unitary), and 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) and Provide CIC.
- ***One ambulance service provider:*** East of England Ambulance Service NHS Foundation Trust (EEAST).
- ***Primary care:*** 27 Primary Care Networks (PCN) covering 180 GP Practices.

- ***Three local independent watchdog bodies:*** Healthwatch Essex, Healthwatch Southend and Healthwatch Thurrock.
- ***Nine community and voluntary sector associations:*** 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 (RRAVS), Southend Association of Voluntary Services (SAVS) and Thurrock CVS.
- ***Other partners:*** Essex Police, Essex County Fire and Rescue Service, parish and town councils, the Local Medical Committee, local universities and colleges, and community and faith organisations.

The diagram below shows the shape of our Partnership:



1.2. Our successes

In Mid and South Essex we are building on firm foundations. The organisations and agencies working to improve health and social care outcomes for our residents have been working together positively for several years, starting with the formation of a Sustainability and Transformation Partnership in 2017, leading to the establishment of the Mid and South Essex Health and Care Partnership. In 2020 we agreed a Memorandum of Understanding, committing us to work together on a set of nine priorities:

1. Prevention.
2. Partnership.
3. Whole Systems Thinking.
4. Strengths and Asset Based Approach.
5. Subsidiarity.
6. Empowering Front-Line Staff to do the Right Thing.
7. Pragmatic Pluralism.
8. Health Intelligence and the Evidence Base.
9. Innovation.

Appendix Three describes how the Mid and South Essex Health and Care Partnership described these priorities/principles.

A draft strategy was produced, which, along with our practical experience of working together, has substantially informed our thinking. Although our previous strategy could not be formalised due to us having to prioritise our response to the COVID-19 pandemic, now our Integrated Care System has been given legal standing under the Health and Care Act (2022), we will build on our excellent track record of partnership working to take this work forward over the next decade through this Integrated Care Strategy.

1.3. Our challenges

Our health and care systems are stretched beyond capacity. What have been typically regarded as 'winter pressures' are now evident year-round. Demand for health and social care services has increased exponentially, outpacing funding provided from central government to both the NHS and local authorities.

The impact of the COVID-19 pandemic and workforce pressures have created unprecedented waiting lists. In many areas, such as consultant-led referrals and cancer diagnosis and treatment, this has caused significant backlogs and consequential impacts on quality of life for individuals. Pressure on primary care, children's and adult social care, and urgent and emergency services is extreme.

At a system and community level, we recognise 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
Our desire to give equal value to all system players	The dominance of key system players such as the NHS or adult social care

Most of our resources are invested in dealing with the consequences of long-term conditions, such as obesity, diabetes and mental ill-health and leaving much less available for 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 those in the voluntary, community, faith, and social enterprise sectors. This change will necessitate a mindset-shift about the future role of residents and community organisations, moving them to a position where both are seen and treated as full and equal value partners in creating better health and care outcomes. Our future health and social care system cannot simply be about providers or services 'getting it right' for the public; it must involve a new covenant with residents and community organisations, that asks them directly to partner with services to help our residents stay healthy and well.

"It is not enough to do things differently; we need to be prepared to do different things."

To achieve this shift, our Strategy includes a shared public statement of ambition, bringing together residents and services in a single *'Common Endeavour'.* This ambition is informed by evidence and experience, supported by clarity about what must happen to deliver our objectives, what actions we will pursue to get there and underpinned by the measures to know that we are successful.

To support our Strategy, we are also establishing clear mechanism for our Partnership to receiving and consider regular updates on system performance, alongside providing space to explore emerging challenges and opportunities.

1.4. How we have developed this strategy

"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 Integrated Care Partnership's Integrated Care Strategy. We expect Integrated Care Partnerships 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 Integrated Care Partnerships 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: engagement summary

Our overall approach to developing this Strategy was agreed by the Chair and the three Vice Chairs of the ICP, with support from the three local Healthwatch organisations and confirmed in the Partnership's first meeting in September 2022. We knew it was essential that the building-blocks of our strategy were informed by a range of conversations with residents, community organisations, clinicians, care professionals and leaders in the NHS, plus our local authorities. Accordingly, we have undertaken:

- ***A Review of Partner Strategies and Joint Strategic Needs Assessments:*** We reviewed 27 publicly available strategies and plans from partner organisations within the Mid and South Essex ICP as well as the relevant Joint Strategic Needs Assessments. Each strategy covered a three-to-five-year period between 2018 and 2026.
- ***A Health inequality data analysis:*** We reviewed the evidence of need as identified in the Joint Strategic Needs Assessments published by our three upper tier local authorities (Southend, Essex and Thurrock) and from our own Population Health Management team's health inequality data packs.
- ***Engagement:*** We held eight workshops based in community venues, collectively engaging over 170 people from all parts of our system, including elected councillors, system leaders, staff and, most importantly, members of our community. We also 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.

In terms of our approach, we did not start with a firm proposal and test this with partners and stakeholders, rather, we adopted an *'appreciative enquiry'* approach (focusing on what is working well and how we can do more of this), developing the proposals into an initial 'Concept Paper' which we then presented back to the colleagues, partners and community members who had contributed. We then held a further 25+ one-to-one and small group meetings with partner organisations and agencies.

Feedback has been extremely positive, and we are proud of the engagement work we have undertaken as part of this process. However, we know there is more work to do, especially in gathering the views and experiences of residents and a broader section of staff who work in our health and care system. We also want to undertake more work with residents who come

from more marginalised groups who are less often heard, often referred to as *'Inclusion Health Groups'.* This will become an ongoing feature of the work of the ICP as it moves forward. Engagement will not be a one-off event, it will be an ongoing, permanent feature of how we will work together as a Partnership.

All our conversations and analysis have reinforced the message that things need to change. There is a common understanding that improving the health and care of residents in Mid and South Essex depends on every part of the ICP playing a part in a rebalancing of our health and social care system towards prevention, early intervention, and anticipatory care, learning from partners who do this well and promoting and sharing best practice.

1.5. Review of partner strategies

Our review of 27 partner strategies identified many overarching themes, including:

- ***Persistent inequalities*:** These lead to lower quality of life and shorter life expectancy for many, particularly for residents in parts of Basildon, Thurrock and Southend. Partners agree that eradicating these differences starts by acknowledging and investing in the wider determinants of health and ensuring pathway design begins with prevention and early intervention. This must also involve a real focus on babies, children, and young people, where many future health problems are seeded.
- ***Growing and ageing population***: With this comes 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 Integrated Care System partners across health and care services if we do not act now.
- ***Mental health conditions:*** These 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 to mental health services for children and adults.

1.6. Our communities - evidence of need

We have undertaken an in-depth review of health inequality data, gathered from the Joint Strategic Needs Assessment published by our three upper tier local authorities (Southend, Essex, and Thurrock) and the ICP's Population Health Management team. This has generated a strong foundation for our work together as partners. **Appendix One** provides a snapshot of the challenges we face together.

In particular, there is evidence that:

- The significant majority of Mid and South Essex'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).
- Premature mortality caused by cardio-vascular disease, cancer, and chronic obstructive pulmonary disease is particularly high amongst disadvantaged groups, driven by inequalities attributable to a range of socio-economic factors.
- Smoking prevalence amongst adults is particularly high in Basildon and Thurrock.
- 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 states in the notes to the English Indices of Deprivation, *"Not everyone living in a deprived neighbourhood is deprived, and many deprived people live in non-deprived areas".*

In Mid and South Essex, we have invested as individual partners, and as a system, in developing our data and business intelligence capability and capacity. We have an established Population Health Management team, reporting to a Population Health Improvement Board.

"Stories are data with soul"

Brené Brown

We will continue to develop this capability to support our Partnership's work, using the very best available evidence, both in terms of quantitative and qualitative data. Quantitative data tells us about need and outcomes in terms of numbers or metrics - qualitative data tells us about needs and outcomes from the stories of those we are, and wish to be, supporting. We acknowledge there is more work to do on this.

1.7. Engagement 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 a local 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 ● Lack of clarity about the respective roles of the ICP, ICB, Health & Wellbeing Boards and Alliances. ● Financial restrictions and 'red tape' mean funding does not flow around the system easily enough. Budgets are often not aligned, let alone pooled. ● Difficult to prioritise and fund prevention and early intervention and meet urgent demands (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 lead to staff shortages and risk of burnout.	***Community*** ● 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. There is also insufficient service user engagement. ● Services are difficult to access. There are not enough appointments and long delays. ● 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, which could block access for those with genuine need.
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.

1.8. This strategy

"The integrated care strategy should set the direction of the system […] setting out how commissioners in the NHS and local authorities, working with providers and other partners, can deliver more joined-up, preventative, and person-centred care [it is] an opportunity to do things differently to before […] reaching beyond 'traditional' health and social care services to consider the wider determinants of health or joining-up health, social care and wider services."

Guidance on the preparation of integrated care strategies - July 2022

Following the engagement work undertaken, a 'Concept Paper' was produced, proposing how the ICP could articulate a single Integrated Care Strategy and outlining the priorities on which partners all agreed. This was presented to the ICP in November 2022 and, following agreement on this, this initial Strategy was developed and agreed by Partners in December 2022.

In recognition of the scale of the task and the need to change fundamentally the relationship between systems, services and our relationship with residents, the Strategy is presented as a ten-year plan, with reviews to take place annually to take into account progress made as well as new challenges and opportunities that arise. There will be a major review at the midway point in five years' time, commencing in the 2026/7 financial year.

There is a requirement that, on completion, we present our Strategy to the NHS ICB and the Health and Wellbeing Boards of our upper tier local authorities. The Strategy must be refreshed every time the upper tier local authorities publish a revised Joint Strategic Needs Assessment and/or a revised local Health and Wellbeing Strategy. In turn, the upper tier local authorities are required to consider the Integrated Care Strategy as they develop their own local plans. In addition, the ICB must have regard to the Integrated Care Strategy in how it exercises its statutory functions as the unitary authority for the NHS in Mid and South Essex.

It should be noted that the ICP will never seek to diminish or weaken the sovereignty of our partner organisations and agencies or our powerful local Alliances, nor will our Strategy replace or replicate their strategies and operational plans. It is simply intended to identify those shared priorities on which we will all work together and describe how we will do so.

In preparing this Strategy, we have had regard for the regulatory and statutory requirements, particularly the four key aims established for ICS:

- Improving outcomes in population health and health care.
- Tackling inequalities in outcomes, experience, and access.
- Enhancing productivity and value for money.
- Supporting broader social and economic development.

We have also had regard for the 'Triple Aim' established for NHS bodies that plan and commission services, which requires them to consider the effects of decisions on:

- The health and wellbeing of the people of England (including inequalities in that health and wellbeing).
- The quality of services provided or arranged by both themselves and other relevant bodies (including inequalities in benefits from those services).
- The sustainable and efficient use of resources by themselves and other relevant bodies.

For each of the key priorities outlined in this Strategy, there are ***'I statements'*** describing the change that residents should expect to see as a result of partners implementing this Strategy.

There are also ***'We statements'*** confirming in broad terms the commitments the Partnership makes and how these will be measured. We number these (e.g., *I7*, *W3*) and include a date by which we will expect to have made progress (in the format, month/year). The detailed measures and milestones we will use to identify how we are performing will be developed further in the early stages of implementing our Strategy.

The Strategy will be published on the Mid and South Essex Integrated Care System website, in an accessible and engaging format, and will be regularly updated as work progresses, and changes are agreed by the Partnership as a result of new challenges and opportunities. The website will include examples of good practice, and the experiences of our staff, partners, and residents, all regularly updated. We have and will always ensure material related to this strategy is accessible to those with limited access to the internet.

1.9. The language we use

We recognise that it is natural that any group of people working together in a specific field or sector will create short-hand language and use acronyms and abbreviations to help them manage their work more efficiently. However, we will always seek to use accessible language and plain English, particularly when we are communicating with those new to our system or members of the public.

The Kings Fund provides a helpful glossary of commonly used health terms which can be found at this link: https://www.kingsfund.org.uk/health-care-explained/jargon-buster.

The 'Think Local Act Personal' glossary also includes terms related to social care and can be viewed at this link: https://www.thinklocalactpersonal.org.uk/Browse/Informationandadvice/CareandSupportJargonBuster/.

It is, however, important that we have agreement on what we mean when using terms and phrases in this Strategy. When we use the word **'Residents'** we refer to all members of the community living and working in Mid and South Essex, including those who receive services from our partners. These might elsewhere be referred to as 'members of the public', 'citizens', 'service users', 'patients', 'clients' or 'beneficiaries'.

When we refer to **'services'** we mean the support provided now or in the future by our partners, including by local health and social care agencies in the statutory sector (the NHS and local authorities) and those working as part of the voluntary, community, faith, or social enterprise sectors.

We use the word **'health'** to refer to the mental or physical health of residents, and **'health services'** when describing the services provided by our partners to support mental or physical health conditions as and when they arise.

We use the phrase **'social care'** when referring to the non-health-related needs of residents, such as personal or home care, residential or day care, and the wider assistance residents may need to live their lives as comfortably and independently as possible. Care needs may arise as a result of age, illness, disability, or concerns regarding the safety of children or vulnerable adults. When we say **'social care services'** we refer to the services provided by our partners which support social care outcomes. Very often, residents will need support from both health and social care services.

When we refer collectively to **'health and social care services'** we include the broad range of health and wellbeing offers. For pregnant women and children, we include health visiting services, school nurses and a range of children and young people's health and wellbeing services. We also acknowledge the valuable services our partners provide in formal and informal education, leisure, managing and caring for outdoor spaces and the environment,

travel, highways, housing, planning and the work of our local schools, colleges, and universities, plus police, fire, and coastguard services, which all play a crucial role in keeping us safe and well. All of these are considered central to helping our Partnership achieve its objectives and we hold these with equal value.

We use the phrase **'primary care'** to describe the services residents often use as the first point of contact with services for their health needs, usually provided by professionals such as GPs, pharmacists, dentists, and optometrists. We also include **'social prescribing'** in this definition, which is where professionals refer residents to support in the community to improve their health and wellbeing, and the services which make this happen.

The phrase **'urgent and emergency care'** is often used to refer to emergency health services, provided by accident and emergency departments at our three hospitals. However, in this Strategy, we are equally concerned about urgent social care services, such as those which respond when a child or vulnerable adult is in danger or requires immediate support to ensure their wellbeing is protected or when residents experience acute mental health crises.

When we say '**public health'** we refer to the statutory services which work to reduce the causes of ill-health and improve residents' health and wellbeing through, for example, health protection - action for clean air, water and food, infectious disease control, protection against environmental health hazards, chemical incidents, and other emergency responses.

Overall, it is our intention to use inclusive language. As such, when we present this Strategy to different audiences, we will ensure that the language we use and the way we present the Strategy is accessible to the people we are addressing.

1.10. Risk, safeguarding and equality

Our Partnership recognises we all have responsibility to safeguard children and vulnerable adults and to promote equality and inclusion for all our residents. We will ensure that we meet our statutory responsibilities and champion the highest standards in all that we do, ensuring joint accountability when they fall short of our expectations. We will meet the Public Sector Equality Duty, but seek to go further, with our health and care system being an exemplar; setting a high standard for our Partners, our system, and our communities.

We will support the development of shared approaches and tools, including health equality impact assessment approaches.

We acknowledge that risk thrives in gaps - the space between services and at transition points. It also occurs when our work goes unchecked and poor practice goes unchallenged. By working better together as Partners and with our residents and by having the space and opportunity to deal swiftly with challenges and to build on opportunities, plus by ensuring our collective services and supports are of the highest quality and well connected, we will reduce risk.

1.11. Sustainability and the environment

Similarly, our Partnership recognises we all have a part to play in meeting sustainability goals and tackling the climate crisis. We recognise that the impact of not doing so will have significant detrimental impact on our residents and in particular those experience greater disadvantage. To support health and wellbeing of our residents, we must play our part in protecting our local and global environment and ecosystems, conserving natural resources, and supporting sustainable, thriving communities. This will remain a key cross-cutting theme in the work of our individual Partners, and for our ICP more broadly, particularly through our support of partnership initiatives through the Anchor Network.

2. Our Common Endeavour

2.1. Reducing inequalities together

Central to our vision is our desire to see residents united with health and social care services around the single ***'Common Endeavour'*** of reducing inequalities together.

The Common Endeavour will express our desire to work to eliminate avoidable health and care inequalities by creating a broad and equal partnership of individuals, organisations, and agencies, focusing on prevention, early intervention and providing high-quality, joined-up health and social care services, when and where people need them.

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

To achieve this will necessitate an alignment of our efforts, with the ICP acting as the fulcrum for engagement and community mobilisation, working alongside statutory and voluntary services and involving a 're-setting' of our partnership with residents.

We will develop a simple, accessible, and inclusive campaign model, in which residents and services agree on a 'shared social mission of purpose', through which we will harness the full potential of all contributors.

The 'ask' of us as residents is that we do everything we can to maintain our own health and wellbeing and that of our families, neighbours, and communities, keeping health and care services 'in reserve' for when we need them most.

The corresponding 'ask' of the ICS will be: first, to support people to manage their own health by helping 'upstream' in a cost-effective manner before problems become serious, expensive, and irretrievable 'downstream'; and second, to integrate services around the individual once they need formal services.

We recognise this working together on this Common Endeavour will require, **commitment**, **courage**, and most importantly, **trust**. Working together positively to build these will be central theme for our Partnership.

W1	***We*** *will work together with our communities to develop a simple and accessible campaign which unites residents and services around a Common Endeavour, which will be owned by residents and the widest possible range of partners and stakeholders. (W1 - 09/23)*
I1	***I*** *will understand what the ICS is and how I can contribute to improving health and social care outcomes for myself, my family, and my neighbourhood. (I1 - 03/24 and ongoing)*

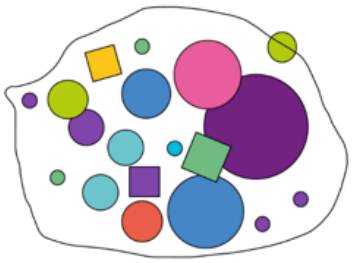
2.2. A new model partnership

Working to this Common Endeavour will require 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 our Partnership and to see their role reflected in its strategy. We believe an 'equal value partnership', where the 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 Mid and South Essex.

A New Model of Participation

Integrated Care System Conceptual Model - Present State



Integrated Care System Conceptual Model - Future State

(Lines delineates elements we consider to be inside 'the system'.)

Currently, several potentially powerful partners and allies (e.g., private adult social care providers, community pharmacy, schools, colleges and early years providers and users of services) 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 strategies. To achieve this, our Partnership will bring together the following initial standing groups to support and influence the work of our Partnership:

- A Community Assembly.
- An Independent and Private Providers' Network.
- A Community Voices Network.

The Community Assembly will provide an opportunity for us to connect around universal and societal challenges. Distinctive in its diversity of voluntary, community, faith and social enterprise 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 act purposefully and learn together as a whole system, the Assembly model is critical in creating the foundations of resilient, resident-led communities that can level up equitably.

The Independent and Private Providers network will meet the guidance that the ICP engage positively with adult social care providers and bring together the diverse experiences of partners operating commercially to provide health and care services including for adults and children. The Partnership is keen to ensure there is positive engagement, so we hear and are able to addressing the challenges and opportunities with our independent and private providers, to support market maturity, market development and build capacity.

The Community Voices Network will focus and share the community engagement work being undertaken across our system and at a local Alliance level, and by our Healthwatch partners.

Engagement of partners and stakeholders will not be an occasional duty but will be a permanent feature of the work of our Partnership. There will be a range of debates, talks, and workshops throughout the year, feeding into and from an annual symposium or conference.

These will be open to all contributors, not just those organisations and individuals who attend the statutory Partnership meetings.

There will be a clear agreement defining how partners give and receive support to each other as part of our Partnership. This will include the new proposed forums, as well as existing forums and networks. This will assist the development of trust and respect for contributions from voluntary, community, faith and social enterprise sector partners, independent and private providers, education partners and residents.

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.

The Partnership must work differently if the population's confidence in the system is to be regained and maintained and our long-term health and care challenges met. The Partnership needs to be agile and purposeful, bring together the resources needed to do the job and have a clear focus on the 'destination' (i.e., what we want to achieve) and the 'journey' (i.e., how we will work together to achieve it).

2.3. Working together locally

As a Partnership, we firmly believe that we act best, when we act locally. This is often described as the 'subsidiarity' principle, which asserts that any central authority should have a subsidiary, or secondary role performing only those tasks which cannot be performed at a more local level. As such, we will always do work where work is best done. This will include the following:

- ***Neighbourhoods:*** The areas covered by our 27 Primary Care Networks (PCNs) and local neighbourhood teams, etc.
- ***Places:*** The areas covered by our four Alliances, covering Mid Essex, Basildon and Brentwood, Thurrock and South East Essex.
- ***System:*** The whole of Mid and South Essex.

We have set up the Integrated Care System to work at a system, place, and neighbourhood level, because needs, challenges and opportunities differ at each level of our operation. What might be good for Tilbury, for example, may not be right for the Dengie; what works for Braintree, may not be right for Basildon.

The strength of work at a local level is demonstrated by the partnerships formed by our powerful local Alliances, Councils and Health and Wellbeing Boards, alongside Primary Care Networks and Healthwatch organisations, and our community and voluntary sector associations. Examples of this work include integrated neighbourhood teams, including Local Area Coordinator services, PCN Aligned Community Teams (PACT), and our developing Social Prescribing offers.

"Co-production is when you as an individual influence the support and services you receive, or when groups of people get together to influence the way that services are designed, commissioned and delivered".

The Care Act 2014 - Care and Support Statutory Guidance

We will also work together, championing co-production as the foundation of successful action across our system.

We are also committed to supporting personalised care, so residents have choice and control over the way their care is planned and delivered. Based on 'what matters' to us as residents, and our individual strengths and needs, we will support the six principles of personalised care:

1. Shared decision making.
2. Personalised care and support planning.
3. Enabling choice, including legal rights to choice.
4. Social prescribing and community-based support.
5. Supported self-management.
6. Personal health budgets and integrated personal budgets.

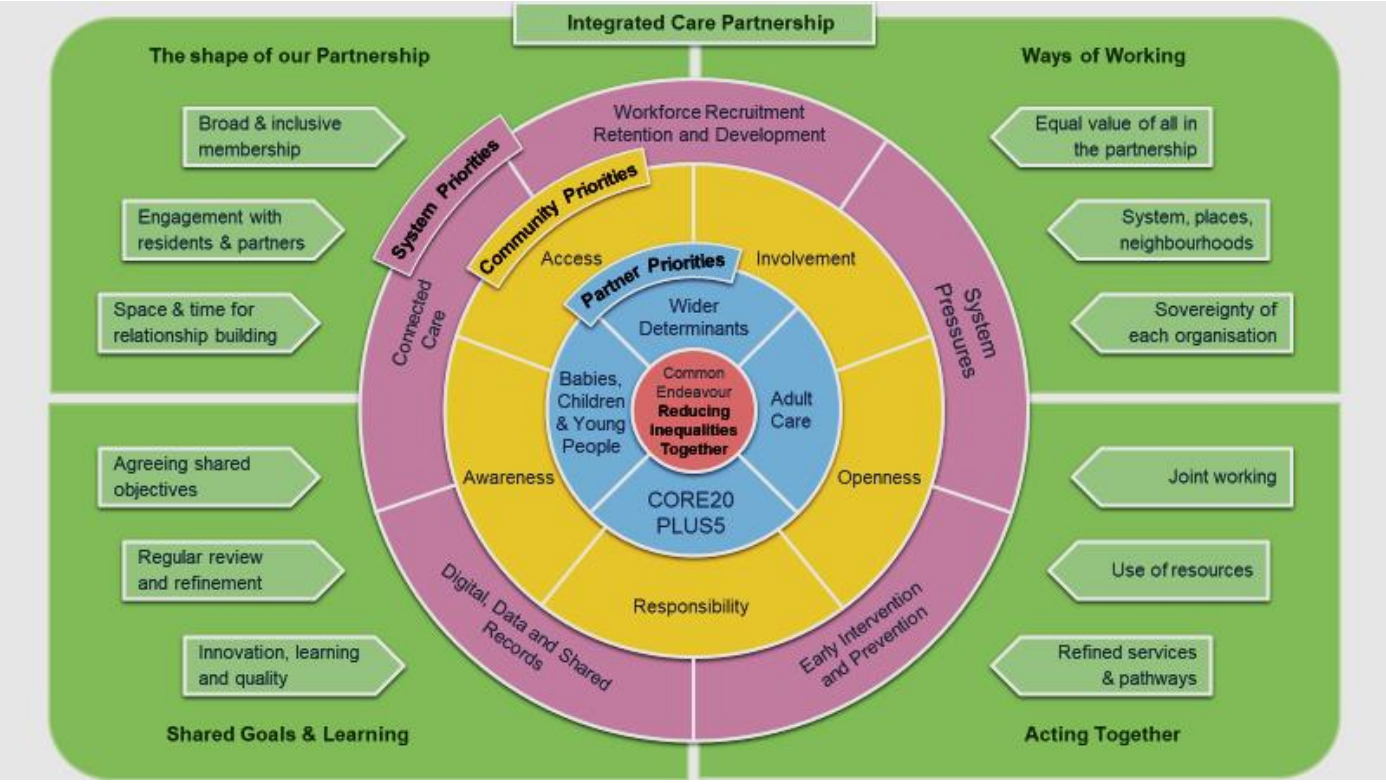
Our commitment to working together, locally, recognises that we can only achieve the change we wished to see, by harnessing all the talents, building personal and community resilience and mobilising communities effectively around our Common Endeavour.

W2	***We** will develop and maintain a map of the statutory boards and forums which feed into the work of the ICP and ensure that there are clear mechanisms for communicating to and from these forums. (W2 - 10/23 and ongoing)*
W3	***We** will ensure that our non-statutory partners are equally valued within our Partnership are demonstrably able to influence and contribute to achieving our shared objectives. (W3 - 03/24 and ongoing)*
W4	***We** will engage with partners who do not currently attend our ICP and ensure that they are able to influence and contribute to achieving our shared objectives. (W4 - 09/23)*
W5	***We** will establish a Community Assembly, an Independent and Private Providers Network, and a Community Voices Network to ensure a wider range of partners are able to influence and contribute to achieving our shared objectives. (W5 - 09/23)*
W6	***We** will develop an ongoing series of community conversations, workshops, seminars, and engagement activities, which draw together a much wider set of contributors into the work of our ICP. (W6 - 04/23 and ongoing)*
W7	***We** will always seek to work at the most appropriate local level, supporting our Alliances and local partnerships. (W7 - 09/23 and ongoing)*
I2	***I** will recognise the ICS and the ICP as a force for change, and value and respect the contributions being made to improve health and care outcomes at a local level and together. (I2 - 03/24 and ongoing)*
I3	***I** will experience health and care services as being both locally and individually responsive to my needs and those of my neighbourhood. (I3 - 09/23 and ongoing)*

3.Our shared objectives and priorities

3.1. Defining our reviewing our shared priorities

The first task for us has been to develop a clear model which articulates our Common Endeavour, alongside our Partner Priorities, Community Priorities, and key System Priorities, on which we will work together to help us meet our objectives. This is, in effect, a 'plan on a page' which helps focus our thinking as a Partnership and as a System.



This Strategy indicates in general terms our shared priorities and the direction that we wish to move in together. However, one of our first tasks will be to develop and agree a *'Theory of Change'* followed by an accompanying *'Logic Model'*, a detailed description and illustration of how and why we feel our desired changes will happen at a system and community level, along with a graphical depiction of the chain of causes and effects and contributing factors which we anticipate will contribute to us achieving our desired outcomes.

With this, we will develop a set of outcomes and measures, building on those we have already established as a Partnership and as individual Partners, which we will use to review our progress. We will undertake this work with independent support and challenge from our university partners, ensuring we are developing our approach based on the latest research evidence of what has been shown to work in health, social care, and community development.

The ICP will review progress on our agreed outcomes and measures, publishing an annual report on our progress.

W8	***We*** *will work together with the support of our university partners to develop an overarching Theory of Change/Logic Model, and a detailed set of outcome measures. (W8 - 04/23 and ongoing)*
W9	***We*** *will review our progress regularly and produce an annual report demonstrating the difference we are making. (W9 - 03/24 and ongoing)*
I4	***I*** *will be confident that the health and care system in Mid and South Essex is working purposefully and with clear aims and objectives, reporting regularly on progress and holding the wider system to account. (I4 - 03/24 and ongoing)*

4. Partner Priorities

The ICP agrees there are four key areas where our Partner's priorities align, referred to as the north, south, east, and west of our Integrated Care Strategy.

4.1. Determinants of health

At the ***'north'*** of our Strategy is our recognition that having access to high quality health and social care services only plays a part in ensuring we have good health and wellbeing. Much more important are a range of other factors which have nothing to do with hospitals, doctors, nurses, or social workers. Some of these we cannot control that much, but others we can - and should - try to influence. Moving forward, the role of our Partnership will be increasingly about working together to tackle the wider determinants of health (sometimes referred to as 'social determinants of health').

The model below, based upon the work of the Robert Wood Johnson Foundation, demonstrates the areas where we can have an impact on health and care outcomes for our communities.

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

With its broad and inclusive membership, the ICP is uniquely placed to lead work to address the wider determinants of health working closely with our local Alliances and health and Wellbeing Boards and other partnerships. The coming together of our NHS services, children's and adult social care and public health, with our partners in district, borough, and city councils, the voluntary, community, faith, and social enterprise sector, plus our experience as leading 'anchor institutions', gives us the opportunity to ensure we are using all of the tools available to us to create circumstances in which our communities can have good health and wellbeing. Moreover, as we develop our partnership with communities themselves, we can ensure they are able to mobilise, at an individual, family and community level, to be part of the change they wish to see.

We will promote key cross-sectoral developments, such as 'Health in All Policies' and 'Health Inequality Impact Assessments' which seek to reinforce our commitment to tackling the wider determinants of health together.

W10	***We*** *will work together across our Partnership to address the wider determinants of health which impact on health and care outcomes for our communities and promote cross-sectoral developments which reinforce this approach. (W10 - 03/24 and ongoing)*
I5	***I*** *will see progress in tackling wider determinants of health, including socio-economic factors, healthy behaviours, and the built environment. (I5 - 03/24 and ongoing)*

4.2. Core20PLUS5 - health priorities for all ages

To the ***'south'*** of our Strategy, is the Core20PLUS5 framework developed by Government with engagement from a wide range of partners and stakeholders. This recognises the groups, across all ages, who experience the greatest health inequalities and the specific conditions where outcomes are poorest. The framework provides a powerful starting point for our actions to address inequalities. The frameworks include the following:

For adults

- ***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:*** Population groups identified at a local level. Populations we would expect to see identified are ethnic minority communities; people with a learning disability and autistic people; people with multiple long-term health conditions; other groups that share protected characteristics as defined by the Equality Act 2010; groups experiencing social exclusion, known as inclusion health groups, coastal communities (where there may be small areas of high deprivation hidden amongst relative affluence). Inclusion health groups include people experiencing homelessness, drug and alcohol dependence, vulnerable migrants including refugees and asylum seekers, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups.

  In Mid and South Essex, we have identified Gypsy, Roma and Traveller communities, Black, Asian, and Minoritised Ethnic communities, Carers, Adults with Learning Disabilities and Autism, Homeless People, Veterans, Armed Forces Communities and their families, Care Leavers, and Victims of Domestic Abuse and Domestic Violence.

  As a Partnership, we will work to better understand the needs of these groups and engage proactively with communities to do so. We will encourage our Partners to work closely with these communities in the planning and delivery of services.

- ***Five:*** There are five clinical areas of focus which require accelerated improvement. Governance for these five focus areas sits with national programmes; national and regional teams coordinate activity across local systems to achieve national aims.

  1. ***Maternity:*** Ensuring continuity of care for women from Black, Asian and minoritised 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 at least 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 the uptake of COVID-19, 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:*** Interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.

   In addition, we recognise smoking cessation is a cross cutting priority because smoking tobacco has an impact on all of these five health conditions. Locally, we would add to this list tackling rates of obesity.

The NHS Core20PLUS5 model for adults can be viewed at the following link: https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/

For babies, children, and young people

- ***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. For children and young people wider sources of data may also be helpful including the national child mortality database and data available on the Fingertips platform.

- ***PLUS:*** Population groups including 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. There should be specific inclusion of young carers, looked after children/care leavers and those in contact with the justice system. Inclusion health groups focus on children and young people where their families 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.

- ***Five:*** The final part sets out five clinical areas of focus. The five areas of focus are part of wider actions for ICB and ICPs to achieve system change and improve care for children and young people. Governance for these five focus areas sits with national programmes, whilst national and regional teams coordinate local systems to achieve these aims.

  1. ***Asthma:*** Address over reliance on reliever medications and decrease the number of asthma attacks.

  2. ***Diabetes:*** Increase access to real-time continuous glucose monitors and insulin pumps across the most deprived quintiles and from ethnic minority backgrounds and increase proportion of those with Type 2 diabetes receiving recommended NICE care processes.

  3. ***Epilepsy:*** Increase access to epilepsy specialist nurses and ensure access in the first year of care for those with a learning disability or autism.

  4. ***Oral health:*** Tooth extractions due to decay for children admitted as inpatients in hospital, aged 10 years and under.

5. ***Mental health:*** Improve access rates to children and young people's mental health services for 0-17 year olds, for certain ethnic groups, age, gender, and deprivation.

The NHS Core20PLUS5 model for babies, children and young people can be viewed at the following link:
https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/core20plus5-cyp/

As a Partnership, we also recognise the impact of 'co-morbidity' (where a resident has two or more diseases or medical conditions). Residents frequently have several conditions and if we can connect services provided by different partners across health and social care and wider community support, we will more effectively address the underlying lifestyle and behaviour issues which may be causing ill health.

We also recognise that 'intersectionality' (the interconnected nature of social categorisations such as race, class, and gender disability) can apply to a given individual or group, regarded as creating overlapping and interdependent systems of discrimination or disadvantage.

"Intersectionality is a metaphor for understanding the ways that multiple forms of inequality or disadvantage sometimes compound themselves and create obstacles that often are not understood among conventional ways of thinking"

Professor Kimberlé Crenshaw

For both children and adults, this framework establishes very specific national targets for improving health outcomes, but through the 'Plus' groups, we are encouraged to respond to local needs and the unique characteristics of our population in Mid and South Essex. The ICP will regularly review local data and evidence identifying the local characteristics which identify priority groups in our area.

W11	***We*** *will work together across our Partnership to address the priorities identified in the Core20PLUS5 frameworks. (W11 - 09/23 and ongoing)*
W12	***We*** *will work together to define our local Core20PLUS5 targets and measures and review progress annually. (W12 - 09/23 and ongoing)*
W13	***We*** *will work with our local Alliances to regularly review and update those local characteristics which form our priority PLUS groups. (W13 - 09/23 and annually)*
I6	***I*** *will see progress in tackling long standing health inequalities for all ages. (I6 - 03/24 and ongoing)*
I7	***I*** *will see improvement in outcomes in the specific clinical areas. (I7 - 03/24 and ongoing)*

4.3. Adult Care

To the ***'east'*** of our Strategy, is our recognition that our Partnership must act together on the challenges which our partners and communities face, in offering and receiving support for broader adult health and social care needs. We will work to support Partners meeting the needs of adults in health and social care and support the development and delivery of their own strategic priorities and operational plans. In particular, we will focus on the following areas:

The ageing population

We have an ageing population with increasing demands for support from those living with dementia, increased frailty, and the range of health conditions which are related to old age and their carers. The demands for domiciliary or home care and residential care for those unable to live independently, is and will continue to cause significant pressure on our systems and services. Enabling older people to remain at home, for as long as possible, is both a practical and moral imperative. We recognise a number of health conditions impact on quality of life, including those related to mobility, chronic pain, cataracts and glaucoma, etc.

Mental health and suicide prevention

Providing support for those experiencing mental ill health, including treatment for serious mental illness and suicide prevention is a key challenge. Services are stretched to their limits and in some cases are failing residents. Partners are committed to working upstream, harnessing the reach of our wider Partnership to prevent mild to moderate mental health problems leading to serious mental illness and to deal with mental health needs effectively as a Partnership. We will work to ensure we have high quality, safe inpatient care, including psychiatric intensive care, where required, and that inpatient stays are as short and as close to home as possible.

Learning disabilities and autism

Partners agree that adults with learning disabilities and autism should be a particular focus of attention, recognising outcomes are significantly worse across a range of measures for this group. Partners are committed to improving access to and take-up of preventative services, including regular health checks and screening, developing sustainable personal assistant support, mentoring and outreach services. We wish to see a reduction in the need for inpatient accommodation and prompt discharge to community care. In Mid and South Essex, we have strong and vibrant voluntary sector organisations, including user-led organisations, who we will work with to build the effectiveness of our support for adults with learning disabilities and autism and to engage residents with lived experiences in the design and delivery of services.

High-intensity users of services including alcohol and substance misuse

In Mid and South Essex, we have undertaken successful pilot projects tackling high intensity users of multiple services, including alcohol and substance misuse. We recognise that these users, often with multiple health and social care needs, place extreme demands on our primary and urgent and emergency care, our adult social care services, and for our partners working in housing, policing and community safety. They challenge the communities in which they live. In many cases, these residents have extremely poor quality of life and health outcomes. We will build on our experiences to develop and refine multi-agency interventions, alongside our communities, to prevent residents from becoming high-intensity users, and to manage support better in the community.

Adult end of life and palliative care

We have some outstanding services in adult end of life and palliative care, particularly through our local hospice services. As a partnership, we are well placed to meet and exceed the guidance for services, including addressing inequity of access to services, strengthening, and aligning commissioning, and building community capabilities.

Loneliness and isolation

For adults of all ages, loneliness and isolation are known to worsen health outcomes, reduce healthy life expectancy, and quality of life, adding pressure on services. We have heard a clear message from residents that they want to address loneliness and isolation, in both our rural and urban communities, and our partnerships with primary care networks, social prescribing and the voluntary, community, faith and social enterprise sector, will support this work.

W14	***We*** *will work together to define our local targets and measures for Adult Health and Social Care and review progress annually. (W14 - 09/23 and ongoing)*
I8	***I*** *will see significant improvement in adult health and wellbeing outcomes (I8 - 03/24 and ongoing)*

4.4. Babies, children and young people

To the ***'west'*** of our Strategy is our recognition that we must get things right for babies, children, and young people because they deserve the very best start in life, but also because this can lead to long-term improvement in outcomes of adults. We have excellent examples of partnership working in this area and strong service offers. We will continue to focus our efforts on:

Maternity and early years health and care

Maternity and early years health and care is an area served by a wide variety of service providers in a wide range of locations across Mid and South Essex. We will support our Partners by sharing learning and offering support with connecting services and offers, to ensure consistency of approach and improvement in outcomes. In particular, we will support the work undertaken by our health visiting and school nursing services and wider children and family wellbeing services, including in our excellent family hubs and children's centres, recognising the unique role these services can offer to ensuring families are strong and resilient and able to gain access to support when and where they need it. We recognise that there is inequality in outcome within maternity services, and system performance challenges. We will work together to tackle these and to ensure all maternity and early years health and care services are connected and aligned.

Children and adolescent mental health

We recognise that there is a growing problem with children and adolescent mental health, and, in many cases, demand is outpacing capacity. As with adults, our Partnership is uniquely placed to work upstream, tackling the causes of mental health issues for children and young people, including adverse childhood experiences, supporting families, and building children

and young people's resilience and access to support for mild or moderate mental health issues. We will work to ensure we have high quality, safe child and adolescent mental health services, and high-quality local inpatient care where needed, and that any interventions or treatments are as effective as possible and connected to long-term support within the community and in our schools and colleges.

Special educational needs and disabilities

Providing effective support for children and young people with special educational needs and disabilities is an area where most of our Partners, including those in health, education, and social care, have a statutory duty, and where close partnership working is essential to ensure needs are met. This is an area where our partners have experienced challenge, and are working proactively with parents and carers to build more effective local offers. In Mid and South Essex, we have strong and effective Parent Carer Forums, keen to support the evolution of services for children with special educational needs and disabilities, and we will work with them closely to ensure early identification of needs, prompt and effective referral to specialist support, and in the design and delivery of service offers.

Prevention of adult health conditions

We recognise that many long-term adult health conditions are seeded in childhood, including conditions related to healthy weight, poor diet and nutrition, limited access to healthy lifestyles and exercise, mental health, and speech and language development. Early action by Partners, to tackle early concerns about the health and wellbeing of children, ensuring families are supported to make healthy lifestyle choices and children are forming good habits, will stave off many long-term issues.

Maternal and children's healthy weight

Our partnership is particularly concerned to see joined-up action on childhood obesity and maternal and children's healthy weight, which we recognise as one of the key factors contributing to longer-term health conditions.

Education including the healthy schools' programmes

We recognise that our colleagues in education play an important role in supporting the health and wellbeing of children and young people, often without due recognition of support. Developing our support for early years settings and schools will have a significant impact in improving population health outcomes. Education is also recognised as one of the wider determinants of health. Children and young people, who do well at school and move into secure employment and housing, have better outcomes across a range of measures.

We also recognise the unique challenges and opportunities that arise within our special education and alternative provision settings, and where children are home-schooled (elective home educated children). Our Partnership will strengthen relationships with our education colleagues, ensuring they are supported and can effectively offer support with improving health and social care outcomes for children and young people.

Health inequalities experienced by looked after children and care leavers

Our partnership recognises that looked after children experience significant health inequality, and we will work closely with our children's social care partners to ensure they receive access to excellent healthcare services, which are co-designed to address the unique barriers they experience.

Children's end of life and palliative care

As with adults, our ambition is to meet and exceed the guidance for children's end of life and palliative care, including addressing inequity of access to services, strengthening, and aligning commissioning and building community capabilities.

W15	***We*** *will work together to define our local targets and measures for Children's Health and Social Care and review progress annually. (W15 - 09/23 and ongoing)*
I9	***I*** *will see significant improvement in health, care and wellbeing outcomes for babies, children, and young people (I9 - 03/24 and ongoing)*

4.5. The first 5,000 households

Partners agree that, in addition to identifying specific thematic priorities, we will also work together to identify a specific cohort of residents that we will prioritise and work and alongside as part of our work. Our starting point will be a focus on a group of priority families and individuals experiencing the worst health and care outcomes.

This targeted, practical approach will allow us to innovate and learn about how the partnership can work in a highly collaborative way across organisational boundaries to better understand and support the needs of these households. This will include a major focus on prevention and early intervention across the wider determinants of health.

These 'First 5,000' households will be the initial focus of our Common Endeavour. We will work together as a partnership to define who is in this group, understand their needs, and develop and deliver a plan of collective action. We will agree on clear workstreams (e.g., data sharing and common referral mechanisms), timings, measures of success and accountabilities to track progress. The work of our Population Health Management team will be central in developing this work.

W16	***We*** *will identify a specific cohort of c.5,000 households experiencing poor health and care outcomes and develop and deliver a plan to better understand and support their needs. (W16 - 09/23 and ongoing)*
I10	***I*** *will see real progress in tackling the needs of the most vulnerable members of my community. (I10 - 03/24 and ongoing)*

5. Community Priorities

5.1. Access

Our communities are particularly concerned about having good access to primary care and ensuring residents use the full range of primary care services available, including community pharmacy, social prescribing, etc. They are also concerned about pressures on urgent and emergency care (NHS and Social Care) and ambulances. They want to see care brought closer to home and a greater emphasis on personalised care solutions and choices.

5.2. Openness

For many of our residents, the health and social care system looks like a closed book, something that keeps its conversations to itself. This leads to both a lack of trust and a feeling of disengagement. At its most extreme, the system is seen to close ranks when things go wrong, rather than being open and honest.

For our health and care system to flourish in Mid and South Essex, we need to embrace an openness that has not yet been achieved in many places in the UK. For our Partnership with residents to mean anything at all, we must be honest about what is and is not going well and what we can all do to make things better, together. This kind of dialogue already happens in small pockets - including our three Healthwatch organisations - but these are quite small conversations. We need much bigger conversations that take place from a starting point of openness and trust in our residents. We need to talk with residents about what they can expect from services, including primary care, urgent and emergency care, and children's and adult social care.

5.3. Involvement

It is important that we work together to build trust – both in and from services and accept when things have gone wrong and learn fast from feedback and criticism. To do so, we must create more, and more varied, opportunities for residents to become involved in the work of our Partnership.

We are keen to define our communities as much by their capabilities, talents, and strengths, as by their perceived deficits - illness, deprivation, needs, etc. If our vision of a Common Endeavour is to flourish, we need to be able to build on these strengths as well as what might be missing in communities. It's a shift of mindset, certainly on the part of statutory bodies and even some voluntary and community sector organisations: a shift from doing 'to' towards doing 'with'.

All of this points to our Partnership having much stronger, active engagement of residents than is the case now. Historically, these residents have been marginal to the overall health and social care agenda including in terms of resources. Funding for voluntary and community sector and community development and mobilisation has been fixed-term and finite - the first to be cut back when system pressures arise. This will need to change if we are to build the community cohesion, resilience, and mutual support necessary to shift the dial in terms of helping residents to do more to maintain their own health and that of their families and communities.

Our Partnership is committed to developing co-productive practice, expanding engagement and mobilising communities, voluntary, community, faith, and social enterprise sectors and

local businesses and employees, so they can become part of the change they wish to see. Our local Alliances will be front and centre in this work, feeding through to the ICP directly and via the Community Assembly and Community Voices Network. We will use all the tools available to us, including digital enragement and social media, but, recognising the impact of the 'digital divide', we will always offer different way for people to become involved.

5.4. Awareness

Some of our residents describe the heath and care system as a 'mystery' and, potentially, a 'minefield'. For our future health and social care system to work, the system must be better at explaining how it works, what services are available and where, and what can and cannot be done. A big part of this is about creating one 'front door' for support. Where this has been tried, it has been successful. This involves abolishing many of the distinctions in the health and social care services that mean everything to professionals, but next to nothing to residents. One front door, both digitally and in real world services. We will work across our Partnership, particularly with our Healthwatch partners who have been promoting this agenda for some time.

5.5. Responsibility

The best way we can improve our health and wellbeing is by seeing ourselves as part of a team. Even a tiny decision we, as residents, make about the health and wellbeing of ourselves, a family member, or someone in our community might help cut waiting times, ease pressure at A&E, or even save a life by helping an ambulance be ready to respond to an emergency. We should think of health and social care like a 'chain' of events. Every time we do something - however big or small - we change something further along the 'chain'.

For example, by getting daily exercise (even a walk in the park) we improve our health, and we may only see our GP four times in a year, not nine. By sharing our experience of parenthood with a new mum and directing her to trusted sources of information and advice, we might eliminate an unnecessary visit to an overcrowded A&E.

If we need help, the health and social care system is always there, but we should think about using it like climbing up a ladder: always start on the lowest step - like asking friends or family for advice. If that will not do, we can visit our local pharmacy, before going to our GP. What's important is that we do not put pressure on the same bits of the system when there are lots of other options.

The biggest thing we can do to help is to look after ourselves. Every GP appointment or hospital visit that does not happen releases pressure on the system. Stopping smoking, being more active, and looking after our mental health will make a massive difference up the 'chain' if enough of us do it. Everyone in our community is part of making things better. However, we must not be discouraged from seeking early help when needed and in accessing urgent and emergency care at times of crisis.

Our aim is to build strong and resilient communities, where people are able to support themselves, their families, neighbourhoods, and the wider communities. We will grow a spirit of purposeful 'volunteerism' at the heart of our system.

W17	*We will create 'one front door' for residents to access the vast majority of health and care services. (W17 - 04/23 and ongoing)*
W18	*We will work together to define our local targets for community resilience, mobilisation and transformation, and review progress annually. (W18 - 09/23 and ongoing)*
W19	*We will be open and honest about what is and isn't going well, why, and what we can all do to make things better. (W19 - 04/23 and ongoing)*
I11	*I will feel my care is closer to home and more personalised. (I11 - 03/24 and ongoing)*
I12	*I will feel that everyone in our community is part of making health and care better and understand my part in that team effort. (I12 - 03/24 and ongoing)*

6. System Priorities

6.1. System pressures

We are all aware of the pressure on our systems at both primary care, urgent and emergency care, ambulances, waiting lists for treatment including elective surgery, challenges with safe discharge from hospital and pressure on children and adult social care.

Our Partnership will work together to tackle acute system pressure and bottlenecks, managing resources effectively and engaging a wider range of partners and communities in supporting the improvements we wish to see.

We will plan ahead, developing protocols for mobilising wider support for the times when we know the system will be under pressure and to support us with unexpected challenges.

6.2. Workforce recruitment, retention, and development

We are facing unprecedented challenges in recruitment and retention across the health, social care, and community sectors. Some of this is beyond the control of our ICP and will take time to put right.

We will develop a ‘one workforce’ approach, that aligns people strategies across our system, and will seek to make Mid and South Essex a place that values and develops the talents of our people. We will recognise the importance of ‘skills’ as opposed to focusing on traditional ‘roles’ when determining who we need to undertake specific pieces of work. We will also utilise the talents of a wider range of people including, for example, practice nurses, community pharmacists, social prescribers, and voluntary sector staff. We will recognise and support initiatives which develop our allied health professionals, who deliver high-quality care to patients and clients across a wide range of care pathways and in a variety of different settings. We will have equal interest in those providing services in our large institutions, and those working in the community and in residents’ homes (including the public, private and voluntary sector).

Our employed staff will be supported by a growing body of well-trained volunteers, working to ensure the precious time of our clinical and social work professionals are put to best use.

Whilst we recognise the work is often challenging, we will prioritise safe working and a good work life balance, and ensure that we do not place our clinical, ancillary and support staff, social work professionals and voluntary sector workforce under undue pressure. We will work to ensure staff are supported and protected from harm, and can work flexibly, where they have caring responsibilities themselves, or to maintain their own health and wellbeing. We will work closely with our employed and voluntary colleagues, to ensure they are supported and supportive of our Common Endeavour.

We will work with our Anchor Network of larger institutions, to grow and develop workforce development initiatives and engage closely with our partners in secondary, further, and higher education, to develop the pipeline for our future workforce in both health and care settings, in the public, private and voluntary sector.

6.3. Early intervention and prevention

The evidence on the effectiveness of early intervention and prevention is overwhelming. It saves not only millions of pounds but also untold levels of human illness and suffering.

This starts with our ‘First 5,000 households’, working with those people who, without early support, will experience poor outcomes and become a much bigger weight on the health and care system. We will support them now so that they need fewer health and care services down the line. We will use all the tools and talents available to us, including those in all our communities, and will invest in new models of care and support that we know will save us money ‘downstream’ – and make for happier healthier lives for our residents.

We will develop a unified population health improvement approach, building on the best available population health management evidence, and create space for innovation, in health and social care and public health, and within our voluntary, community, faith, and social enterprise sector and local businesses. We recognise that ‘non-medicalised’ community-based support is often best placed to achieve the change we wish to see, and will explore new models of investment, seeking to resolve the challenge of unlocking resources for preventative work now, when the benefits will not be experienced, in some cases, for many years to come.

6.4. Connecting care

In the engagement work for this Strategy, one of the biggest concerns of residents concerned the disconnected nature of health and care services. We will work to ensure better connection between services, refinement of pathways and ensure effective joint commissioning and accountability. From a resident’s perspective, we want people to experience health and care as one seamless, integrated offer of support.

6.5. Digital, data and shared records

We will develop strong shared data and digital systems to provide insight and enable evidence-based decision making with the aim of improving the health and wellbeing of the local population, reducing inequalities, and addressing current and future needs.

At the same time any newly developed digital solutions will be more resident-centric in their approach and design, empowering residents to take greater control of their digital presence within our system. We will also use digital tools to communicate and engage with our residents and help them join us in our Common Endeavour, whilst remaining aware of the need to address the ‘digital divide’ supporting those who do not have access to digital technologies.

This will drive economies of scale, standardisation of technologies as well as supporting the delivery of more coordinated care and enabling our health and care professionals to do their jobs more efficiently.

We will support our Population Health Management team, in developing consistent, reliable evidence about the needs of our residents and the approaches evidence demonstrates will have best impact (i.e., ‘actionable insights’).

W20	***We*** *will work together to define our local targets for dealing with system priorities, challenges and opportunities and review progress annually. (W20 - 09/23 and ongoing)*
W21	***We*** *will significantly improve the recruitment and retention of staff across the health and care system by adopting a 'one workforce' approach, making people feel more valued, empowered, developed, and respected. (W21 - 03/24 and ongoing)*
W22	***We*** *will increasingly invest in prevention and early. (W22 - 03/24 and ongoing)*
W23	***We*** *will develop shared data and digital systems across the Partnership to provide greater insight and enable evidence-based decision making. (W23 - 03/24 and ongoing)*
I13	***I*** *will feel that health and care services are much more 'joined up' and I only need to tell my story once. (I13 - 03/24 and ongoing)*
I14	***I*** *will feel that my health and care needs were identified and supported early enough to reduce the need for higher-level services and increase my chances of living independently. (I14 - 03/24 and ongoing)*

7. How we will work together

7.1. Shape of the partnership

Broad and Inclusive membership

To work as it should, the ICP will draw upon the skills and experience of partners beyond the NHS and Councils and will reach deep into our community and voluntary organisations.

Through the actions identified previously, we will ensure all potential contributors are able to engage in our work, and join us in our Common Endeavour, and will regularly review and develop our approach to engaging with wider partners, including local business, leisure, schools, colleges, environmental protection, etc.

We will proactively seek the involvement of minoritised communities, many of whom experience worse health outcomes. The idea of the ICP is to bring the voices and influence of the community into the conversation so that this helps shape the way resources are allocated.

We will always engage with and involve specialist bodies, including local safeguarding partnerships, to ensure we are working with the best available advice and support.

Engagement with residents and partners

Engagement is not a one-off event; it will be a continuing conversation. The ICP will become the focus for engagement work, as a collecting point for a range of views and perspectives from Partners and the many forums that seek insight from residents. The Community Assembly, Independent and Private Providers' Network and Community Voices Network, will be central to this objective and the ICP will conduct continuing outreach as part of its work so that residents and diverse partners, have clear routes for influencing and contributing to the work of the ICP. We will champion the benefits of co-production, support Partners by sharing experiences, promote training and continuing professional development, and explore the creation of co-production toolkits.

Space and time for relationship building

The ICP is not just a collection of voices, it is also a place to curate relationships between different parts of our health and care system. This takes time and effort, particularly with those parts of the system where there is little history of working together, or when previous efforts have not been successful. Experience tells us that 'change happens at the speed of trust' and stronger relationships are key to making health and social care work better. We see the ICP as a focus for making these relationships as productive as possible.

7.2. Ways of working

Equal value partnership

The principle that all the participants in the ICP are of equal value is one that is central to its success. We will always value the role of our NHS Partners, local authorities, and wider contributors equally.

For a long time, many of the organisations involved in health and care, particularly at community level, have felt like second-class players in the conversation about the kind of health and care services we need. This has meant that many have slowly become disengaged or frustrated. The ICP is about resetting this and underlining the fundamental role of the wider community in the way health and care is planned and delivered.

System, place, neighbourhoods

We are organising much of our efforts in the ICP the most appropriate local level. This should mean that we have as much decision-making as possible coming from the places and people affected by these decisions. So, the principle of subsidiarity, distributed leadership and working at place will be at the core of all that we do.

We are also building good relationships with our neighbouring systems:

- *Hertfordshire and West Essex Integrated Care System.*
- *Suffolk and North East Essex Integrated Care System.*
- *North East London Integrated Care System.*

Where it is appropriate and adds value, we will work with our neighbours, particularly across the whole Essex footprint, where there is learning that can be shared or innovation which can be jointly developed, but also to ensure consistency of experience and outcomes for our residents.

We will tell the story of our progress and our successes nationally and internationally, particularly through our work with university partners, recognising that building our reputation will lead to greater opportunity for investment in our local work.

Sovereignty of member organisations

Our Integrated Care System is an attempt to bring together many independent organisations and agencies, rather than create a single organisational entity. The Partnership is designed to be the glue holding this together and maximising cooperation and collaboration between its constituent parts.

While we will want to ensure that residents benefit, where needed, from ‘one front door’ when dealing with the health and care system, this support will, in reality, come from a wide range of different ‘sovereign’ organisations.

We have a number of proactive and powerful boards, partnerships and forums and a well-established Anchor Network, and will ensure that they are supported and have the opportunity to share their work through the ICP. In turn, we ask that they knowledge, support and contribute towards the shared objectives articulated in this Strategy.

7.3. Shared goals and learning

Agreeing shared objectives

A key task of the ICP is to achieve an alignment between all the organisations involved in health and care in Mid and South Essex, our acute hospitals through to neighbourhood level voluntary groups supporting people to stay healthy and well.

Part of our work in developing this Strategy was to review the strategic and operational plans of our members and pull together shared objectives. When we did this, we found a very high

level of congruity around priorities: prevention and early intervention, reducing inequalities in health outcomes and delivering more health and care closer to communities. There is remarkable alignment here and this is a solid basis for the ICP's work in the 2020s and beyond. We will, however, continually review strategies and operational plans of our partners as they develop and change over time, taking these into consideration in the evolution of our shared Integrated Care Strategy.

Regular review and refinement

The ICP is new and will develop over time. Our shared objectives will evolve, and corresponding outcome measures, which will be established during the early part of 2023, will continue to develop as our partnership matures. We will regularly review performance, publishing an annual report on our progress.

Innovation, learning and quality improvement

The work of the Partnership will be based upon the best available evidence and research. We will commit to rapid test and learn, and longer-term pilot projects, which explore new, innovative approaches, backed up by solid research and evaluation. Working with our university partners, we will share the findings openly, at a local, regional, and national level, building our reputation as a centre of learning and development in the health and care sector.

We will regularly consider and review how we can best meet assessed needs and work to secure a continuous and sustainable improvement in care quality and outcomes, including with reference to the National Quality Board guidance and other frameworks which support quality improvement.

7.4. Acting together

Joint working

In line with our commitment to develop effective partnership working to better meet the needs of residents, we will regularly review opportunities for joint commissioning and closer partnership working. We will consider when and how our residents' needs could be better met through an arrangement, such as the pooling of budgets, under Section 75 of the NHS Act (2006). Section 75 can be a key tool to enable integration and our Partnerships has considered the benefits of Section 75 agreements as part of preparing this Strategy. Whilst acknowledging that the Partnership is not a commissioner of services - that remains the responsibility of our partner organisations and agencies - we will always promote and encourage and expect joint commissioning to take place, where it better meets the needs of our residents.

Use of resources

Our Partnership sees the use of our system's physical, financial, and human resources, and the deployment of our data digital and intellectual property assets, as being key to the success of our work together as a system.

Together, we will set targets and expectations around the effective use of financial resources, particularly in relation to our objective of seeing increasing investment in early intervention and prevention. It follows that we will aim to flex resources between different care and service areas over time. We will have the courage to do things differently and do different things, but will also expect our partners to stop or change things which are not working.

As partnership working develops and it becomes easier to provide more care in or closer to people's homes, we will expect to see the proportion of spend in acute and crisis interventions in health and care reduce significantly, as investment in primary care and early intervention and prevention goes up.

Partners are already working collaboratively (e.g., through our multi-agency 'Stewardship' groups, refining and developing our approach to key care areas) to establish how resources can be best used, to best meet the needs of our residents and to ensure maximum efficiency and benefit. Where joint opportunities arise, for example, the Better Care Fund, or the Adult Social Care Discharge Fund, we will expect partners to work together in a spirit of cooperation and mutual agreement to determine how and where these funds are re-allocated.

Refinement of services and pathways

Our Partnership will play a key role, through our engagement work and commitment innovation and learning and quality improvement, and in our assessment of risk, in ensuring that pathways are refined and improved to better meet the needs of residents. In particular, we will ensure that pathways actively include more diverse contributors, including those services and supports provided by our voluntary, community, faith and social enterprise sector and local businesses.

W24	***We*** *will work together to define our working practices as a partnership, and review progress annually. (W24 - 09/23 and ongoing)*
W25	***We*** *will ensure partner organisations are aligned on common goals and share plans and resources wherever effective. (W25 - 03/24 and ongoing)*
I16	***I*** *will see the ICP as a powerful advocate for health and care, working positively to effect change at a neighbourhood, place, and system level. (I16 - 03/24 and ongoing)*

8. Governance and operation

8.1. Our board

Our ICP is chaired by an Independent Chair, with three Vice Chairs - being the Chairs of the Health and Wellbeing Boards of our upper tier local authorities.

Our formal Partnership meetings will always be held in public, and there will be ample opportunity for engagement with a wider range of partners and stakeholders through an ongoing series of debates, talks and workshops throughout the year, feeding to and from an annual symposium or conference.

The business of the meetings will be conducted professionally, with decisions clearly recorded and communicated. A standard meeting Agenda and Annual Business Cycle will be developed, giving clarity about expectations, to ensuring no statutory or regulatory requirements fall off the agenda. However, in addition to attending to business, every meeting will provide opportunities for networking and relationship building, with a focus on discussion, debate, and shared learning. We will explore opportunities for teambuilding and improving our working relationships.

8.2. Inputs and outputs

Our Partnership will work together with our three local authority Health and Wellbeing Boards and our local Alliance Boards/Committees. A representative from the Partnership will attend these boards, ensuring there is a consistent exchange of ideas and influence.

In addition to establishing a new Community Assembly, Independent and Private Providers Network, and Community Voices Network which will feed directly into the work of the Partnership, we will map all boards, groups and forums convened by our partners responding to their own local, sectoral, or thematic areas of work. We will ensure that there are clear routes for receiving and sharing information from these boards and forums, and in turn sharing the work of the Partnership.

8.3. Membership

The membership of our ICP is well established but will be kept under regular review. Residents, partners, and stakeholders not currently attending the formal Partnership meetings should feel able to influence and inform the work of the Partnership. As our engagement work matures, we will consider whether an alternative, representative membership model may be appropriate, to formalise arrangements allowing established forums and committees to nominate representatives who may attend the formal Partnership meetings.

8.4. Terms of reference and values

The Terms of Reference, format and structure of our meetings will be regularly reviewed, in line with good governance standards. Partners have an agreed set of values, developed as part of the formation of our predecessor body, the Mid and South Essex Health and Care Partnership. This will be reviewed and updated as and when required.

8.5. Regulatory and statutory requirements

As a statutory committee, we will continually monitor how we are meeting statutory and regulatory requirements as they exist now and in the future. **Appendix Two** addresses the requirements for the formation of the ICP and the development of this Integrated Care Strategy.

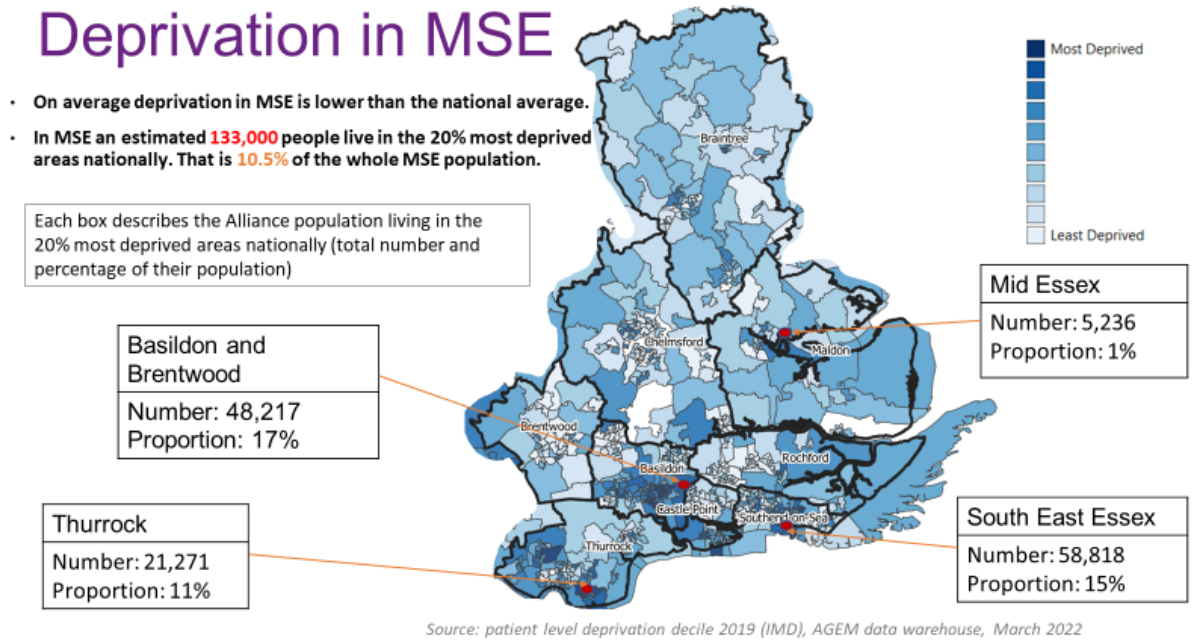
8.6. Resources

We will identify the resources needed to ensure our Partnership is able to manage its work effectively. 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 our Partnership.

W26	***We*** *will identify and secure the resources needed to ensure the ICP can deliver against the priorities it has set. (W26 - 04/23 and ongoing)*
I17	***I*** *will feel able to engage and contribute to the ongoing work of the Partnership. (I17 - 03/24 and ongoing)*

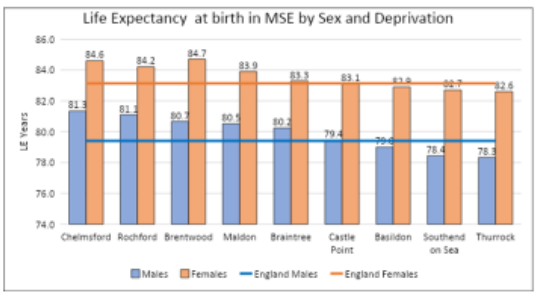
Appendix One

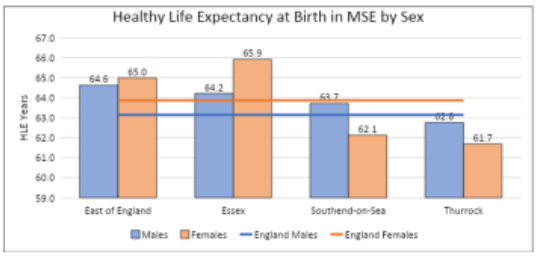
Population health data - snapshot

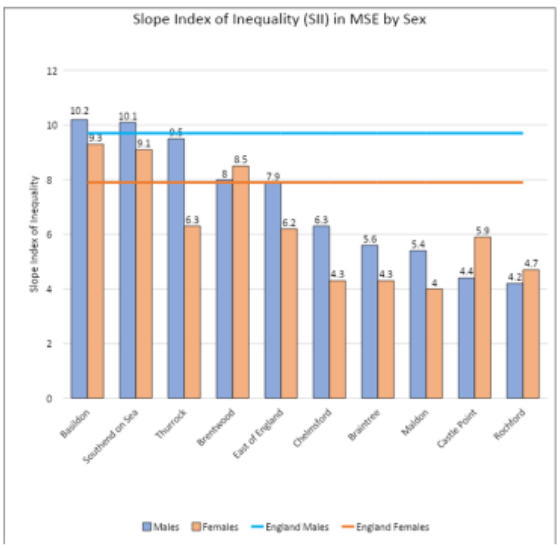


Source: patient level deprivation decile 2019 (IMD), AGEM data warehouse, March 2022

Consequences of Inequalities - Life Expectancy





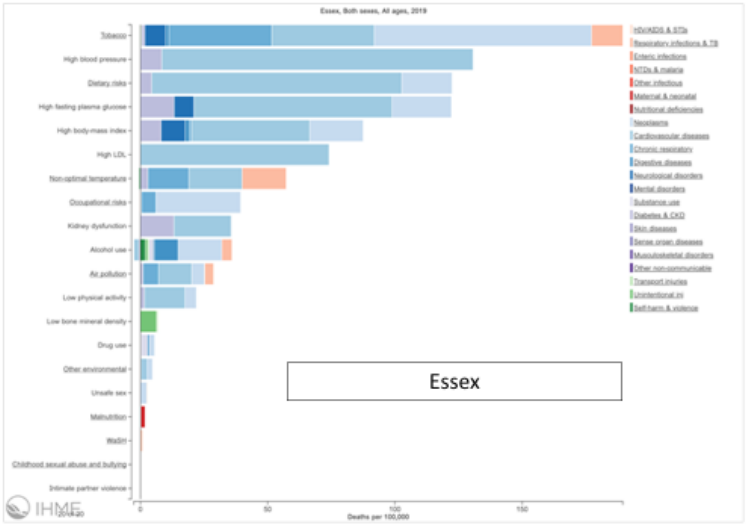


Risk Factors for Premature Mortality

Global Burden of Disease Study identifies key cross-cutting risk factors. In MSE, the 3 with the greatest impact are:

- Tobacco
- Blood Pressure
- Dietary Risks

These are the risk factors that will have the greatest impact on population health and health inequalities

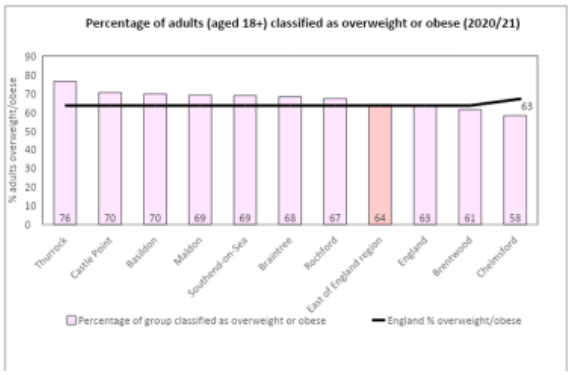


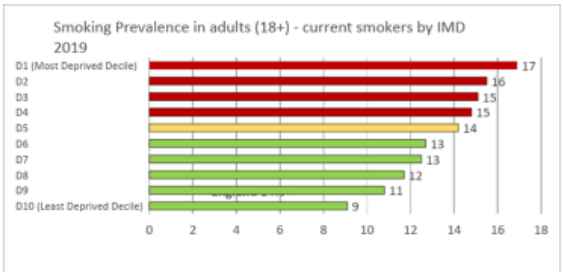
Source: Global Burden of Disease Study (2019)

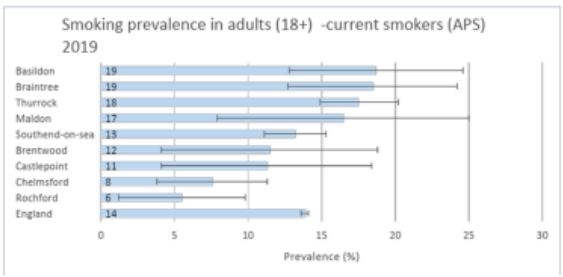
Inequality & Behavioural Risk Factors

Global Burden of Disease Study - Cross-cutting risks

- Tobacco
- Blood Pressure
- Dietary Risks







Appendix Two

Regulatory and statutory requirements

In forming our ICP and developing this Strategy, we have met the regulatory requirements set out by the Department for Health and Social Care, which can be summarised as follows:

> *"Integrated care partnerships (ICPs) will operate as a statutory committee, bringing together the NHS and local authorities as equal partners to focus more widely on health, public health and social care. ICPs will include representatives from the ICB, the local authorities within their area and other partners such as NHS providers, public health, social care, housing services, and voluntary, community and social enterprise (VCSE) organisations. They will be responsible for developing an integrated care strategy, which sets out how the wider health needs of the local population will be met. This should be informed by any relevant joint strategic needs assessments. In developing its integrated care strategy, the ICP must involve the local Healthwatch, the VCSE sector, and people and communities living in the area. ICPs will not directly commission services"*
>
> *The Kings Fund*

We have had regard for the guidance released including guidance on:

- The preparation of integrated care strategies by integrated care partnerships
- Health and wellbeing boards and how they will work with and within integrated care systems
- Principles for integrated care partnership engagement with adult social care providers
- Principles for integrated care partnership engagement with health overview and scrutiny committees.

We have met the requirements identified including:

Statutory requirements	Further detail
The integrated care strategy must set out how the 'assessed needs' from the joint strategic needs assessments in relation to its area are to be met by the functions of integrated care boards for its area, NHSE, or partner local authorities.	We have reviewed the needs including the Joint Strategic Needs Assessments and our Population health Management data. We have identified how we will continue to review and refresh our shared objectives as needs change and new opportunities arise. We have identified shared outcomes; considered quality improvement, joint working and section 75 of the NHS Act 2006; personalised care; disparities in health and social care; population health and prevention; health protection; babies, children, young people, and their families, and health ageing; workforce; research and innovation; 'health-related services'; data and information sharing. See Section 1.5 through to 1.7
In preparing the integrated care strategy, the integrated care partnership must, in particular, consider whether the needs could be more effectively met with an	We have considered joint working and identified when and how we will expect Partners to enter into joint commissioning arrangements under Section 75 of the NHS Act 2006' in this document for further detail on this requirement. See Section 7.4

arrangement under section 75 of the NHS Act 2006.	
The integrated care partnership may include a statement on better integration of health or social care services with 'health-related' services in the integrated care strategy.	We have included a statement to this effect. See Section 7
The integrated care partnership must have regard to the NHS mandate in preparing the integrated care strategy.	We have had regard for the NHS Mandate See Section 1.8
The integrated care partnership must involve in the preparation of the integrated care strategy: local Healthwatch organisations whose areas coincide with, or fall wholly or partly within the integrated care partnership's area; and people who live and work in the area.	We have engaged widely and indicated how/when we will undertake further ongoing engagement with people who live and work in the area. See Section 1.4
The integrated care partnership must publish the integrated care strategy and give a copy to each partner local authority and each integrated care board that is a partner to one of those local authorities.	The Integrated care Strategy has been published and copies given to each partner local authority and each integrated care board. The Partnership has identified how it will disseminate the Strategy with the wider community and engage them in our work moving forwards.
Integrated care partnerships must consider revising the integrated care strategy whenever they receive a joint strategic needs assessment.	The Partnership has identified how/when it will review its objectives on receipt of updated joint strategic needs assessments. See Section 1.8

The Integrated Care Partnership will regularly review new guidance and changes in requirements, including, but not limited to, setting, and reviewing common objectives, inspection, audit, financial regulations, safeguarding and equal opportunities.

Appendix Three

Priorities for the Mid and South Essex Health and Care Partnership

1. **Prevention.** We will transform services from ones that react to health and care needs, to ones that play a proactive part in keeping our residents as healthy and independent for as long as possible. We will intervene earlier to help people remain well. We recognise that this approach is both good for our population's health and wellbeing, and saves money in the longer term.

2. **Partnership.** *Progress occurs at the speed of trust.* We will ensure that future transformation and integration builds upon the strong relationships and partnerships at System, Place and Locality/PCN level and seek to protect and nurture these relationships. We will ensure that future partnership arrangements include the widest possible range of stakeholders. As partners, at every level we will act for the benefit of the population we serve, and not for organisational self-interest. We will ensure that our residents are engaged as equal partners in decision making on future transformation activity at the most appropriate level.

3. **Whole Systems Thinking.** We recognise the value of coordinated action across all providers at each level of the system, as the best way to address the health and wellbeing challenges that our residents face. We have developed a single outcomes framework that operates across System, Place and Locality footprints. We seek to define population outcomes based contracts that coordinate action across multiple providers to ensure our system becomes sustainable over the long term.

4. **Strengths and Asset Based Approach.** We believe in a 'strengths and solutions' based approach. We see the individual as a whole person with differing needs and wants, not a passive recipient of "top down" services. We will harness and empower individuals to solve their own problems, with service providers support to 'fill the gaps'. We will leverage existing community and third sector assets in care delivery, connecting individuals with support outside of traditional NHS or Social Care interventions. This strengths based approach to delivering care will generate positive and varied solutions tailored to the wider wellbeing needs of each resident, not a 'one size fits all' option.

5. **Subsidiarity.** We believe in 'building from the bottom up'. We want to plan and deliver care in the heart of our communities. We recognise that PCNs and localities are the building blocks around which integration best occurs. We will devolve planning and delivery down to the lowest possible level where it makes sense to do so. Our starting point for service delivery, transformation and integration will be locality/sub locality level and we will only plan, commission and deliver services over wider geographical footprints where a clear case can be made that this is necessary.

6. **Empowering front line staff to do the right thing.** We believe in 'distributed leadership'; harnessing the creativity and energy of staff. We will move from a transactional model of commissioning to an approach that focuses on outcomes.

7. **Pragmatic Pluralism**. We recognise that across the system and our places there is a considerable heterogeneity of need between populations. We recognise that there are some actions that it makes sense to do once at system level, whilst others that need to be done

differently in different places and localities. We will respect this diversity and develop pragmatic solutions that respond to it.

8. **Health Intelligence and the evidence base.** We recognise the importance of health intelligence and published evidence to fully understand and then best respond to ensure a high quality of care. We will use our JSNA programmes to understand the needs of our residents and improve their outcomes. We will look for opportunities for joint working between the three Public Health teams on shared health intelligence products. We know that different population groups have different care needs and we will use Population Health Management techniques like risk stratification and predictive modelling developed from our integrated health and care record system to identify and segment ‘at risk’ cohorts in our population and design targeted, tailored and proactive evidence based interventions to keep people well.

9. **Innovation.** Transforming the way we work means trying new and innovative approaches. To make progress we will try and test new approaches, evaluating as we go, keeping the best and not admonishing ourselves where we fail and not being afraid to stop things that have not worked.

10 February 2023	**Item 11**
Health & Wellbeing Board	
Suicide Prevention across Thurrock and the wider Southend, Essex & Thurrock (SET) geography	
Wards and communities affected: All	**Key Decision:** Not applicable
Report of: Jane Gardner, Deputy Police, Fire and Crime Commissioner and Maria Payne, Strategic Lead – Public Health	
Accountable Assistant Director: N/A – partner report	
Accountable Director: N/A – partner report	
This report is Public	

Executive Summary

This report aims to both provide Board Members with oversight of existing activity regarding suicide prevention within Thurrock, including how it aligns with other priority areas and the greater Essex footprint, and start a broader discussion about sustainability of this work programme.

1. Recommendation(s)

1.1 Note the contents of this report, including the observations around sustainability of the programme.

1.2 Lend leadership support to this continued agenda.

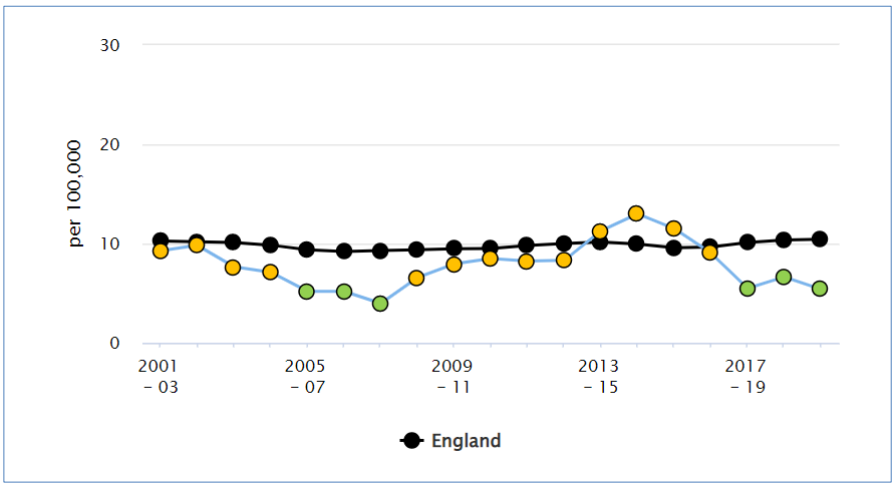
2. Introduction and Background

2.1 The devastating impact of suicide on family, friends, work colleagues and the wider community is well documented. In 2012 the Government pledged its commitment to reducing the number of suicides in England as set out in the National Suicide Prevention Strategy, Preventing Suicide in England, and has subsequently re-confirmed this commitment via publication of a number of cross-government progress reports against the pledges made within.

2.2 The complexity around suicide prevention is compounded by the fact that no single organisation can tackle this alone. What is required is a whole system, cohesive, multi-agency approach, which brings together local government, primary and acute healthcare settings, including Mental Health, the criminal justice system, emergency services, workplaces, communities and the voluntary sector.

2.3 The most recent published data on deaths by suicide shows that Thurrock has a significantly lower rate than the national average (see figure below – green dots indicate the years where the Thurrock rate fell significantly below the national rate, and the yellow dots indicated a similar rate).

Figure 1: Suicide rate per 100,000 in Thurrock and England



2.4 This equates to 26 deaths in Thurrock registered as suicides between 2019-21. However, these statistics have limitations in what they can tell us:

- they would only be deaths formally ruled as suicides by the coroner, so excludes any with open verdicts where similar preventative opportunities might have existed
- there are substantial delays in the publication of these statistics from when the deaths occurred – the median length of time between death occurring and the inquest conclusion (determining suicide as cause of death) was 120 days for Thurrock in 2021.
- we do not have wider information on the demographics or circumstances behind these deaths to direct preventative activity.

2.5 Since April 2021, Thurrock Council Public Health colleagues have had access via a signed data sharing agreement to monthly information from the SET-wide Real Time Suicide Surveillance (RTSS) System which is run by Essex Police and contains details captured by the Police on all deaths they attend which could be categorised as suicides according to the Ovenstone Criteria. Within this system the Police are able to record demographics, method, location, information that the next of kin / person who found the deceased was able to tell them, and whether the deceased was known to the Police previously.

2.6 This insight has been used to maintain a more current oversight of likely need, as well as potential contributing factors and therefore direct opportunities for preventative work or key partner organisations to work with.

2.7 In 2021/22 there were 129 suspected suicides recorded across SET. At least 52 of them had been in contact with either the Police or Mental Health services within the last six months, and other common factors identified within these individuals included the presence of previous suicidal or self-harm behaviour or ideation, domestic abuse, relationship or economic issues, and substance misuse.

3. Ongoing work

3.1 Mid and South Essex ICB have been in receipt of wave 3 suicide prevention transformation funding from NHS England for the period covering April 2020-March 2023. The programmes of work it has funded have covered Thurrock and have included:

- recruitment of a programme manager to coordinate and drive the work
- investment into the development of a website to host the Lets Talk About Suicide Essex training offer, which neighbouring ICS colleagues also now invest into
- funding of dedicated communications resource to raise the profile of suicide prevention across MSE. An example of a campaign they led on was the *Light Up Essex* campaign which resulted in a number of buildings including the Thameside Theatre who had agreed to turn their lights green to show their support for suicide prevention
- development of a self-harm prevention and management toolkit for adults
- rollout of a suicide prevention training programme which included training of primary care clinicians and numerous other frontline professionals (e.g. Probation, Council staff, voluntary sector staff etc)
- rollout of a Community Fund to increase voluntary sector capacity to projects that were focussed on suicide prevention work.
- rollout of a new pathway of Wellbeing Calls for those newly diagnosed with depression who might be potentially vulnerable to suicidal thoughts. In Thurrock this has been provided by Thurrock and Brentwood MIND.

3.2 The above work has been funded by ringfenced monies, and future investment into them is currently being discussed within ICB forums. The success of these projects has been seen regionally and nationally, and is due to the effective partnership working in place between ICB, public health, police, voluntary sector, communications and wider colleagues passionate about this agenda.

3.3 We recognise that there is additional work happening in other forums or funded via other mechanisms that will be contributing to the prevention of suicides. In Thurrock the Public Health lead is linking in with other colleagues via forums such as the Thurrock Safeguarding Adult Board, the Thurrock Mental Health Transformation Board and the Thurrock Integrated Emotional Wellbeing Partnership to gain a broader view of local work.

3.4 Thurrock Public Health are also active members of the Southend Essex and Thurrock Suicide Prevention Partnership Board, which is chaired by the Deputy Police, Fire and Crime Commissioner for Essex. This Board is made of senior stakeholders from a range of organisations, including Police, Local Authority (Social Care / Public Health), NHS (ICBs / various Foundation Trusts), voluntary sector, university colleagues, DWP, substance misuse providers and many others who work in roles with individuals who may be at higher risk of suicide.

3.5 The SET Suicide Prevention Partnership Board meets quarterly and has recently agreed some terms of reference. It will be responsible for overseeing the local response to the nationally directed priority areas as well as reacting to local trends in response to the RTSS findings.

3.6 There will be a new national Suicide Prevention Strategy due out in 2023, which we expect to have some slightly revised priority areas. Insight from national colleagues indicates that we will be asked to prioritise preventative activity around:

- Impact of COVID
- Gambling
- Domestic Violence
- Ethnicity
- Online Harms
- Economic stresses
- Children and Young People
- Data
- LGBTQ+ individuals

3.7 Once this strategic direction is confirmed, we will ensure our local partnership response is directed accordingly, though we have already begun with progress in a number of these areas in response to local observations within our RTSS intelligence.

3.8 A separate stream of monies has been awarded to Mid and South Essex ICB for the provision of postvention support for those bereaved by suicide from April 2022-March 2024. Up to now these individuals have generally been supported within the voluntary sector, but without specific resource or training to do this. Thurrock Public Health have been working with colleagues such as Essex Police, Southend and Essex County Council Public Health colleagues, existing voluntary organisations, Essex Wellbeing Service and the Coroner to plan out a support pathway – this would also include Thurrock First as a navigation point for our residents and those discussions are underway.

3.9 The funding above has been used to pay for some specialist suicide bereavement training (a number of Thurrock colleagues have attended this), and to commission a specialist provider to deliver the postvention support for those bereaved individuals. It is hoped this will launch across MSE in the near future.

4. Next steps and asks from partners

4.1 We are presenting this paper today both to give an overview on current work, but also to ask for broader support and endorsement with this agenda – whether that is nominations for representations at the SET Board, leadership of specific work areas or support with the conversations on sustaining existing work.

4.2 We are also exploring possibilities for expanding the current data that informs our RTSS system, in particular how we can ensure we capture the data listed in point 3.6 which might be required nationally, but also how to unite information from social care, health and other partners. Ideally, we would also like to be able to profile suicide attempts, though we accept this would be more complex.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 The discussion points in this report have been raised at the Southend Essex and Thurrock Suicide Prevention Partnership Board which has multi-agency attendance, and some also at Essex County Council's Health and Wellbeing Board meeting on 23rd November.

6. Impact on corporate policies, priorities, performance and community impact

6.1 The contents of this report most closely align with the *People* priority for Thurrock Council, in that we are "*build[ing] on our partnerships with statutory, community, voluntary and faith groups to work together to improve health and wellbeing".*

6.2 The approach also aligns with some key commitments in the new Mid and South Essex ICS strategy 2023-2033 of which Thurrock is a signatory:

"Together, we will set targets and expectations around the effective use of financial resources, particularly in relation to our objective of seeing increasing investment in early intervention and prevention." (section 7.4)

"Our Partnership will play a key role, through our engagement work and commitment innovation and learning and quality improvement, and in our assessment of risk, in ensuring that pathways are refined and improved to better meet the needs of residents. In particular, we will ensure that pathways actively include more diverse contributors, including those services and supports provided by our voluntary, community, faith and social enterprise sector and local businesses." (section 7.4)

7. Implications

7.1 Financial

Implications verified by: **Bradley Herbert**

Senior Management Accountant

There are no specific financial implications arising from this report for the council. The report details a number of Mid and South Essex-wide programmes which may be coming to an end in March 2023. However, it is not the ask on the Thurrock Health and Wellbeing Board to cover these costs. Every death by suicide has a large economic impact, with around most of the cost of that attributed to the impact on the quality of life of those bereaved by suicide. There is an economic case to favour work that aims to reduce these impacts with preventative collaboration with partners.

7.2 Legal

Implications verified by: **Daniel Longe**

Principal Solicitor for Children and Adult Safeguarding and Education, LBBD on behalf of Thurrock Legal.

Following the publication of the 2012 strategy, councils were given the responsibility of developing local suicide prevention action plans. In Thurrock this approach has largely been taken in partnership with Essex and Southend colleagues. There are no specific legal obligations around aspects of the suicide prevention / postvention work programme as outlined above.

However, this remains in line with the local authority's general powers under sections 1 to 6 of the Localism Act 2011, which provides this local authority with a wide range of powers to embark on projects for the benefit of the authority, its area or persons resident or present in its area. Prevention of suicide would assist in benefiting the authority and its residents.

7.3 Diversity and Equality

Implications verified by: **Roxanne Scanlon**

Community Engagement and Project Monitoring Officer

This report sets out a local approach to suicide prevention which highlights the collective responsibility of partners. The insight from the Real Time Suicide Surveillance System and the likely themes identified in the upcoming national strategy indicate there are groups of residents at higher risk of suicide who would benefit from greater focus.

A Community Equality Impact Assessment should be undertaken to direct this approach for our Thurrock communities.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder, or Impact on Looked After Children)

This work outlines an approach which looks to focus on the identified preventative opportunities for suicide, but which will also ultimately contribute to broader improvements on population mental health and wellbeing.

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

- National Suicide Prevention Strategy 2012, *Preventing Suicide in England*
- Real Time Suicide Surveillance insight report 2021-22

9. Appendices to the report

- None

10. Key points of interest within appendices

- N/A

Report Author:

Maria Payne

Strategic Lead – Public Health

Adult, Housing & Health Directorate

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