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SOUTHEND-ON-SEA CITY COUNCIL

Health & Wellbeing Board

Date: Monday, 6th March, 2023
Time: 5.00 pm
Place: Committee Room 1
Contact: Robert Harris - Principal Democratic Services Officer
Email: committeesection@southend.gov.uk

A G E N D A

1 **Apologies for Absence**

2 **Declarations of Interest**

3 **Minutes of the Meeting held on Thursday, 8 December 2022** (Pages 3 - 6)

FOR DECISION

NONE

******** **FOR DISCUSSION**

4 **Draft Integrated Care Strategy for Mid and South Essex** (Pages 7 - 54)
Report from Director of Strategic Partnerships attached

5 **Developing the SEE Alliance Plan Update** (Pages 55 - 88)
Presentation slides from SEE Alliance Director attached

6 **NetPark Wellbeing Project**
Report of Director of Culture and Tourism to follow

7 **A Better Start Southend Update** (Pages 89 - 104)
Joint report of the ABSS Director and Independent Chair

******** **FOR INFORMATION**

8 **Health Protection Updates** (Pages 105 - 106)
Report of Director of Public Health attached

9 **SEE Communications and Engagement Network** (Pages 107 - 108)
Presentation slides from SEE Alliance Director attached

10 **Able Like Mabel Falls Campaign** (Pages 109 - 116)
Presentation slides from SEE Alliance Director attached

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SOUTHEND-ON-SEA CITY COUNCIL

Meeting of Health & Wellbeing Board

Date: Thursday, 8th December, 2022
Place: Committee Room 1 - Civic Suite

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Present: Councillor K Mitchell (Chair)
Dr T Syed (Vice-Chair)
Councillors Davidson, Sadza, Mulroney and Terry.
R Hallett (SEE Alliance), R Polkinghorne (SCC), K Ramkhelawon (SCC), O Richards, L Gale, T Poore, A Khaldi,

In Attendance: Councillor L Salter (Observer – Chair of People Scrutiny Committee)
R Harris, B Leigh, P Hill, T Ruwona and A Taylor.

Start/End Time: 5.00 pm - 7.40 pm

544 Apologies for Absence

Apologies for absence were received from Councillor Moyies, J Gardner, M Marks, A Quinn, M Atkinson, S Dolling, G Halksworth and M Olsen.

545 Declarations of Interest

(a) Cllr Mitchell – Minute 551 (A Better Start Southend (ABSS)) - A Better Start Southend (ABSS) is in partnership with Hamlet Court Road in Harmony Community Group – the Councillor is the Chair of this group;

(b) Cllr Salter - Minute 318 (Mental Health Urgent Care Department), Minute 317 (Developing the SEE Alliance Plan) and Minute 319 (Winter Plan / Actions) – Husband is a consultant surgeon at Southend Hospital; Daughter is a consultant at Basildon Hospital; Son-in-law is a GP in Southend-on-Sea;

546 Appointment of Vice-Chair

The Chair welcomed Dr Taz Syed as the new Vice-Chair of the Board following Dr Jose Garcia Lobero's departure.

The Chair, on behalf of the Board, thanked Dr Jose Garcia for his significant contributions.

547 Minutes of the Meeting held on Wednesday, 7 September 2022

Resolved:

That the Minutes of the Meeting held on Wednesday, 7 September 2022, be confirmed as a correct record.

548 Southend, Essex and Thurrock (SET) Dementia Strategy 2022-2026

The Board considered a report of the Director of Commissioning presenting the final draft of the Southend, Essex, and Thurrock (SET) Dementia Strategy 2022-2026, following consultation. The Board also received a powerpoint presentation providing additional information.

The Board asked questions which were responded to by the Director of Commissioning.

Resolved:

That the SET Dementia Strategy 2022-2026, as set out in Appendix A to the submitted report, be endorsed and that it be noted that partner organisations may adopt the strategy via their own decision-making processes.

549 Better Care Fund - Discharge Fund

The Board considered a report of the Lead Commissioner, Older People and Southend City Council BCF Lead, presenting a general overview of the potential winter pressures and the current winter planning situation. The report also set out the proposed expenditure and suggested projects for the Social Care Discharge Fund 2022-23 that will be distributed through the Better Care Fund.

The Board noted the tight timescale for submission to the BCF for the Social Care Discharge Fund by 16th of December 2022.

The Board also asked questions which were responded to by officers and representatives from Mid and South Essex.

Resolved:

That the final Adult Social Care Discharge Fund be delegated to the Chair for approval and submission by 15th of December 2022. This is due to the submission date required by the Adult Social Care Discharge Fund, and the short time available to prepare a final plan.

550 Proposal for the development of a joint Southend, Essex and Thurrock Drugs & Alcohol Steering Board

The Board considered a report of the Director of Public Health presenting a proposal for the development of a joint Drugs & Alcohol Steering board across Southend, Essex and Thurrock (SET) together with the benefits, risks and key challenges establishing a joint Board.

The Board asked questions which were responded to by the Director of Public health.

Resolved:

That the proposal to establish a joint Southend, Essex and Thurrock (SET) Drugs and Alcohol Steering Board, to be adopted as we move forward with the strategy, be approved.

551 A Better Start Southend (ABSS) Update

The Board considered a joint report of the Director and Chair of ABSS presenting an update on the key developments since September 2022.
The Board asked questions which were responded to by the ABSS Director and Chair.

The Board congratulated the ABSS on their success winning two prestigious Children and Young People Now awards and commented on the excellent and invaluable work undertaken by ABSS.

Resolved:

1. That the content of the submitted report be noted.

2. That A Better Start Southend be congratulated and commended on their two prestigious Children and Young People Now awards, highlighting the power of partnership, community and a focus on system change early years work.

552 Developing the SEE Alliance Plan

The Board received and considered a joint powerpoint presentation from the Alliance Director presenting an overview of the Mid and South Essex Integrated Care Strategy concept paper and Alliance planning.

The Board asked questions which were responded to by the Alliance Director and Chief Officer, Healthwatch Southend.

Resolved:

That the Alliance Director and Chief Officer, Healthwatch Southend, be thanked for their informative and invaluable presentation and that further progress be presented to future meetings of the Board.

553 Mental Health Urgent Care Department - Basildon Hospital Site

The Board received and considered a powerpoint presentation presenting an overview of the development of the Mental Health Urgent Care Department at Basildon Hospital. The presentation slides would be added to the agenda following the meeting.

The Board asked questions which were responded to by representatives from Mid and South Essex.

Resolved:

That the representatives from Mid and South Essex be thanked for their informative and valuable presentation.

554 Winter Plan / Actions

The Board received and considered a powerpoint presentation from the Alliance Director setting out the work taking place to manage the potential winter pressures.

The Board noted the range of programmes being delivered in partnership with a range of organisations and within primary care. The Board also asked questions which were responded to by the Alliance Director.

Resolved:

That the Alliance Director be thanked for the informative and invaluable presentation.

555 Drug and Alcohol Progress Update

The Board considered a joint report of the Director of Commissioning and Director of Public Health presenting an update on progress in implementing the requirements of the National Drug Strategy, 'From Harm to Hope', with particular regard to:

- The development of Strategic Partnership arrangements and the introduction of a Southend Drug & Alcohol Executive Group
- The delivery of a local joint strategic needs assessment to inform our understanding of need and gaps in service provision
- Progress against the development of a local Drugs & Alcohol strategy
- Progress against the proposals for the use of the Year 1 (2022/23) round of the Supplemental Substance Misuse Treatment & Recovery Grant (SSMTRG)
- Progress against the proposals for the use of the latest round of funding for the Rough Sleeping Drug & Alcohol Treatment Grant (RSDATG)

The Board asked questions which were responded to by officers.

Resolved:

That the submitted report and the actions taken to date, be noted.

556 Health Protection Updates

The Board considered a report of the Director of Public Health presenting an update concerning the on-going management of the COVID-19 and wider Health Protection response.

The Board asked questions which were responded to by the Director of Public Health.

Resolved:

That the on-going operations and steer of the Health Protection Board and the Oversight and Engagement Board, be noted.

Chair: _____

Southend Health & Wellbeing Board

Agenda Item No.

4

Report of

To

Health & Wellbeing Board

On

6th March 2023

Report prepared by:
Jeff Banks, Director of Strategic Partnerships
Mid and South Essex Integrated Care System

For information only		For discussion	X	Approval required	

Draft Integrated Care Strategy for Mid and South Essex

Part 1 (Public Agenda Item)

1 Purpose of Report

1.1 The purpose of this report is to present the Draft Integrated Care Strategy produced by the Mid and South Essex (MSE) Integrated Care Partnership covering the wider Integrated Care System. The objective is:

- For the board to receive and endorse the completed MSE Integrated Care Strategy
- For partners to note the priorities and feedback to their respective organisations and networks
- To consider how best the ICS and Southend-on-Sea City Council and Southend Health & Wellbeing Board can come together to facilitate ongoing collaboration.

1.2 The Integrated Care Strategy is included as ***Appendix One***

2 Recommendations

2.1 The Southend Health & Wellbeing Board approves the Integrated Care Strategy presented by MSE Integrated Care Partnership and offers observations about how the work is taken forward as appropriate.

3 Background

3.1 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.

3.2 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.

3.3 There are three ICSs servicing the population of Essex;

- Mid and South Essex ICS
- Suffolk and North East Essex ICS
- Hertfordshire and West Essex ICS

3.4 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"*.

3.5 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"*.

3.6 MSE Integrated Care Partnership have complied with this requirement and produced an Integrated Care Strategy, following wide-ranging engagement with partners and residents. Details of the process for developing the strategies has been presented to the Southend Health & Wellbeing Board on 7th September 2022.

4 Health and wellbeing boards and subsidiarity

4.1 In preparing the Strategy, the ICP has fully considered the Joint Strategic Needs Assessment and the Local Health and Wellbeing Strategies of all upper tier local authorities, in this case, Southend-on-Sea City Council.

4.2 The Guidance states *"The health and wellbeing board remains responsible for producing both the joint strategic needs assessment and the joint local health and wellbeing strategy (they will be required to consider revising the joint local health and wellbeing strategy on receiving a new integrated care strategy). The integrated care strategy should complement the production of these local strategies. It should identify where needs could be better addressed at integrated care system level and bring learning from across places and the system to drive improvement and innovation, for example challenges that could be met by integrating the workforce or considering population health and care needs and services over this larger area. It should not replace or supersede the joint local health and wellbeing strategies, which will continue to have a vital role at place".*

4.3 As such, Members should *"consider revising the joint local health and wellbeing strategy on receiving a new integrated care strategy"* at the appropriate time.

4.4 In turn, the Guidance states *"Whenever the integrated care partnership receives a new joint strategic needs assessment from a health and wellbeing board, it must consider whether the integrated care strategy needs to be revised. Where possible, we suggest that integrated care partnerships work with health and wellbeing boards, local authorities, and integrated care board to align the timelines of their strategies"*.

5 Options

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

6 Financial implications

6.1 There are no financial implications arising from this item.

7 Legal implications

7.1 The Health and Wellbeing Board is only required to *"consider revising the joint local health and wellbeing strategy on receiving a new integrated care strategy"* at the appropriate time. The Board is however, asked to formally *approve*, which will send a strong signal for support for the health and care partners who form the ICP.

8 Equality and Diversity implications

8.1 The Public Sector Equality Duty applies to the Council when it makes decisions. The duty requires us to have regard to the need to:

(a) Eliminate unlawful discrimination, harassment and victimisation and other behaviour prohibited by the Act. In summary, the Act makes discrimination etc. on the grounds of a protected characteristic unlawful
(b) Advance equality of opportunity between people who share a protected characteristic and those who do not.
(c) Foster good relations between people who share a protected characteristic and those who do not including tackling prejudice and promoting understanding.

8.2 The protected characteristics are age, disability, gender reassignment, pregnancy and maternity, marriage and civil partnership, race, religion or belief, gender, and sexual orientation. The Act states that 'marriage and civil partnership' is not a relevant protected characteristic for (b) or (c) although it is relevant for (a).

8.3 An Equality Impact Assessment has not been undertaken by SCC for this work, as it falls within the responsibility of other statutory partners.

9 List of appendices

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

10 List of Background papers

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
link https://www.gov.uk/government/publications/guidance-on-the-preparation-of-integrated-care-strategies/guidance-on-the-preparation-of-integrated-care-strategies

Mid and South Essex Integrated Care System

NHS
Mid and South Essex

Mid and South Essex ICS

Integrated Care Strategy

2022-2033

December 2022

Table of Contents

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:

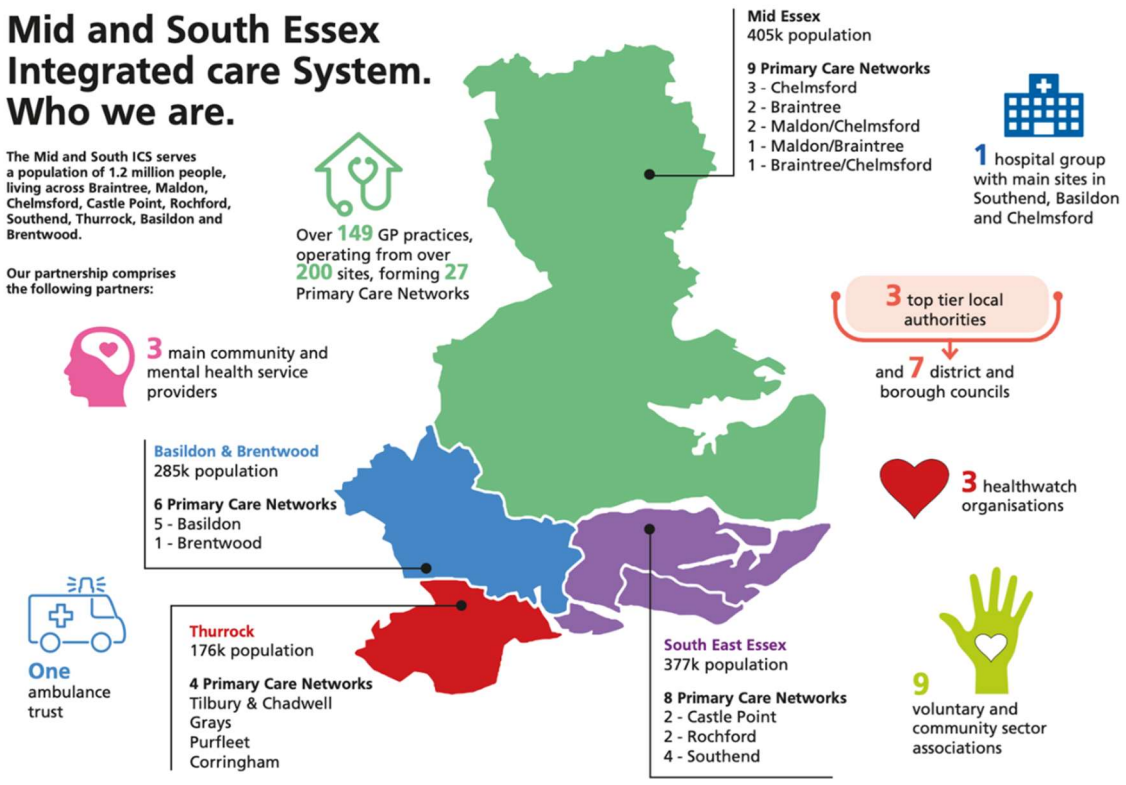
- ***Neighbourhoods:*** The areas covered by our 27 Primary Care Networks, and local neighbourhood teams, etc.
- ***Places:*** The areas covered by our four Alliances, covering Mid Essex, Basildon and Brentwood, Thurrock and South East Essex.
- ***System:*** The whole of Mid and South Essex.

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.

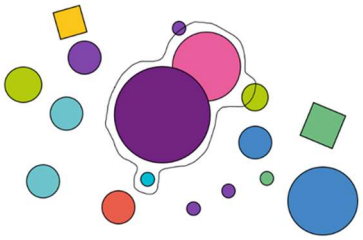
W1	***We*** *will work together with our communities to develop a simple and accessible campaign which unites residents and services around a Common Endeavour, which will be owned by residents and the widest possible range of partners and stakeholders. (W1 - 09/23)*
I1	***I*** *will understand what the 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

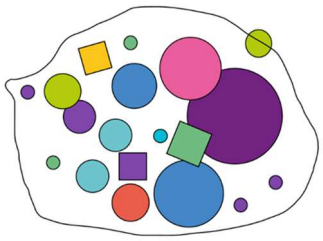
Working to this Common Endeavour will require a new model of partnership. Alongside continued influence from the statutory boards and forums which feed into the ICP, we will need to become much broader and more inclusive, ensuring engagement of a more diverse range of contributors, feeding into the formal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

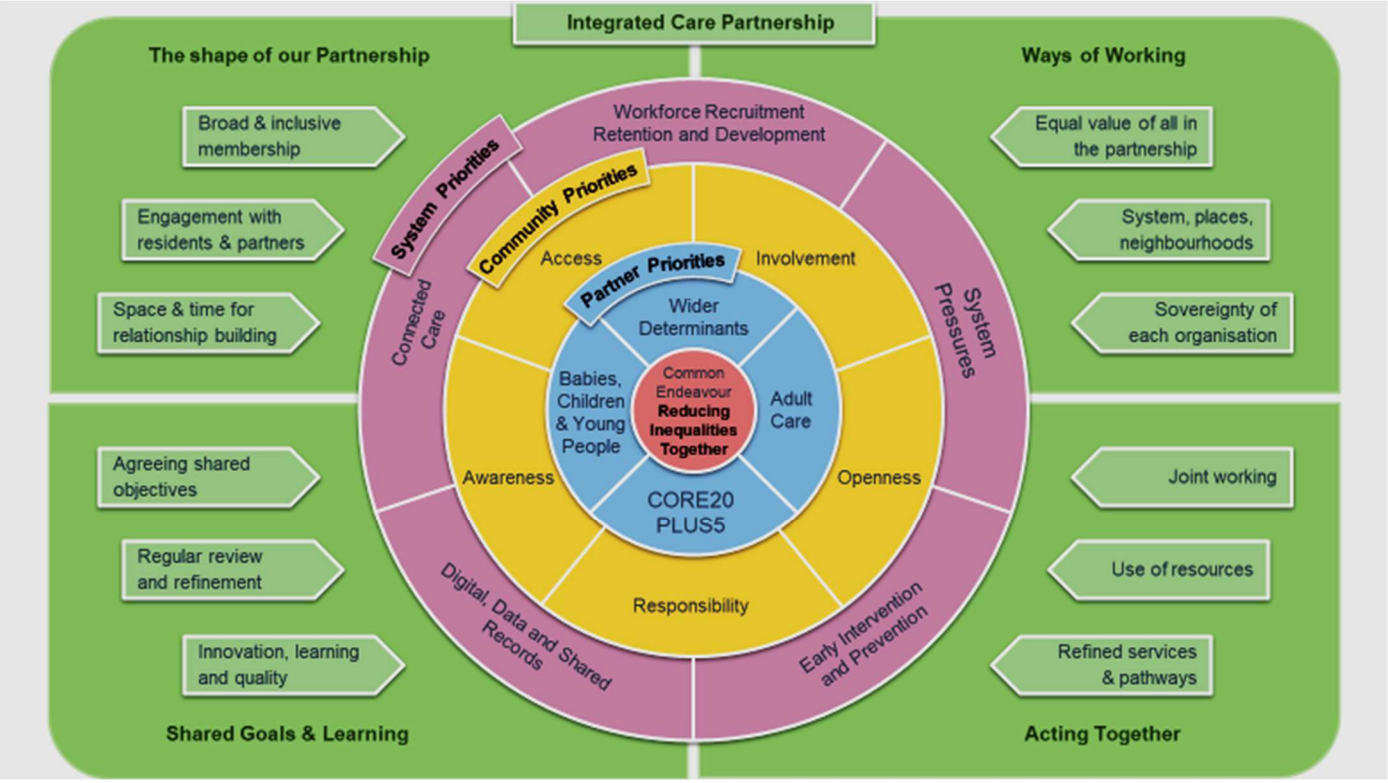
Our commitment to working together, locally, recognises that we can only achieve the change we wished to see, by harnessing all the talents, building personal and community resilience and mobilising communities effectively around our Common Endeavour.

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.

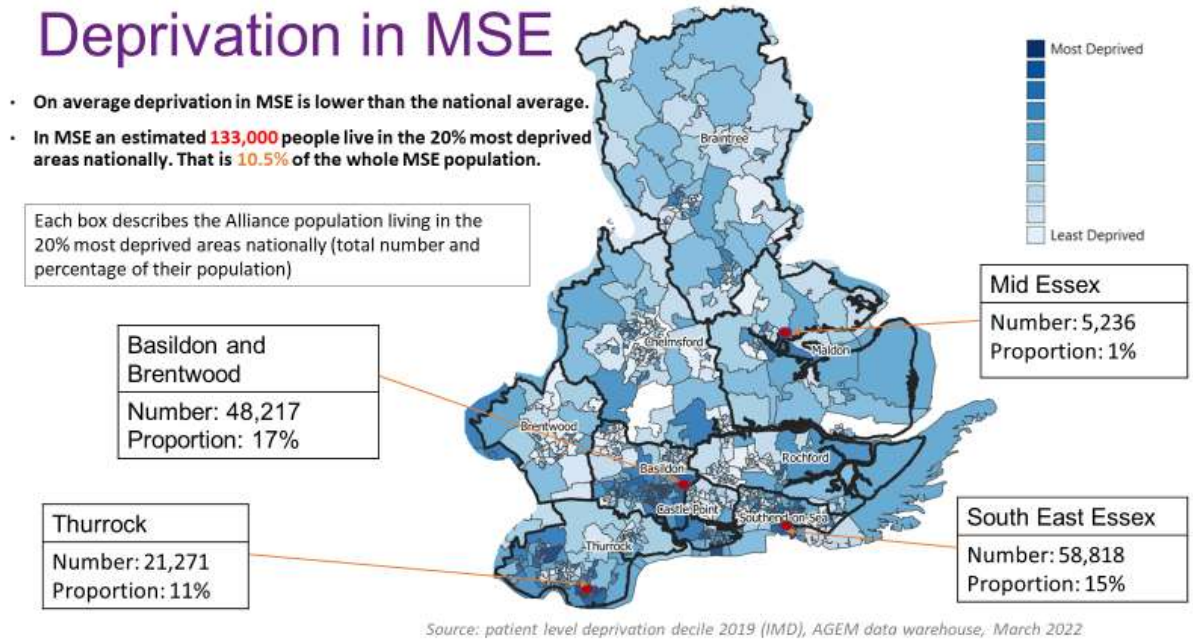
8.6. Resources

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.

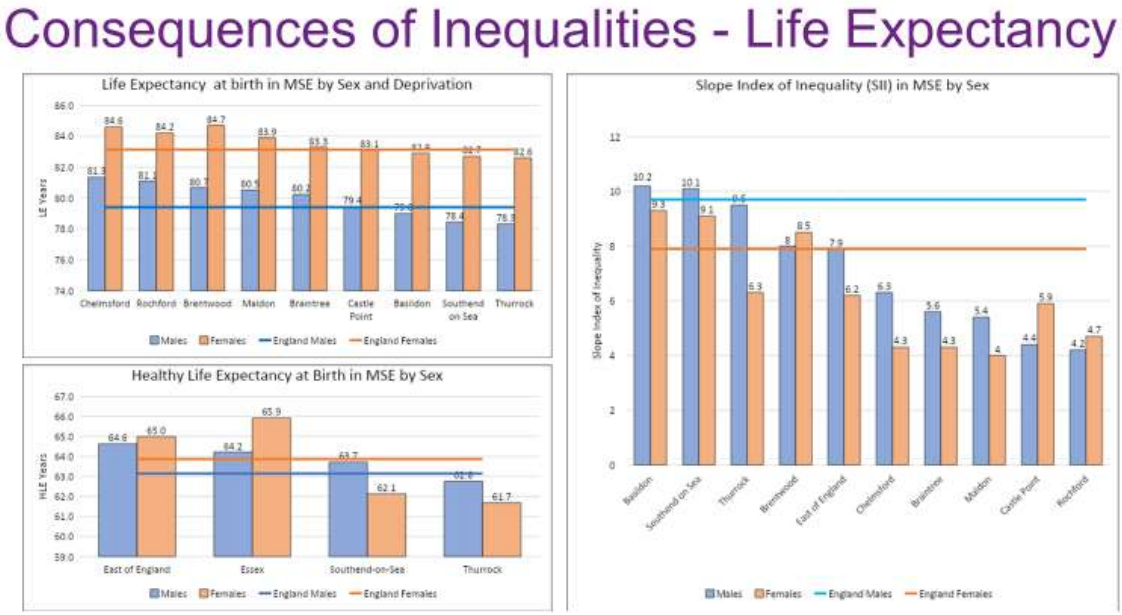
W26	***We*** *will identify and secure the resources needed to ensure the ICP can deliver against the priorities it has set. (W26 - 04/23 and ongoing)*
I17	***I*** *will feel able to engage and contribute to the ongoing work of the Partnership. (I17 - 03/24 and ongoing)*

Appendix One

Population health data - snapshot



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

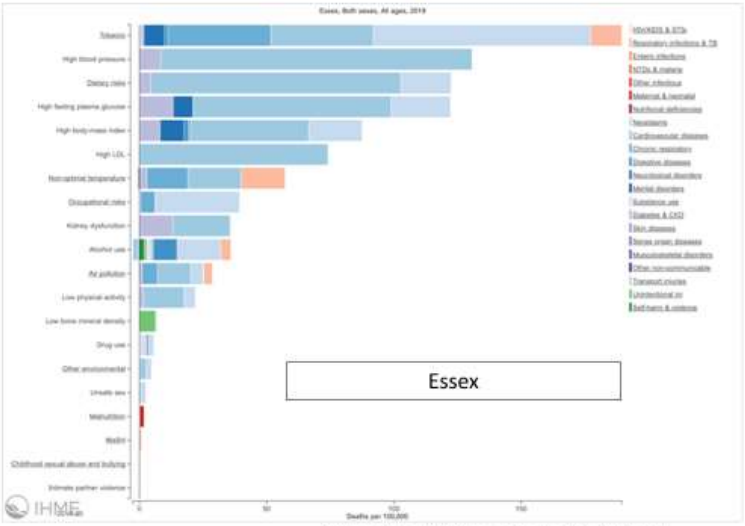


Risk Factors for Premature Mortality

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

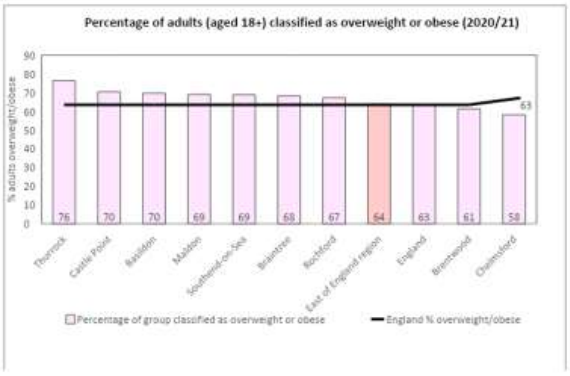


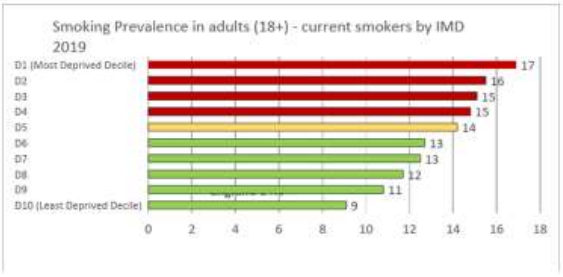
Source: Global Burden of Disease Study (2019)

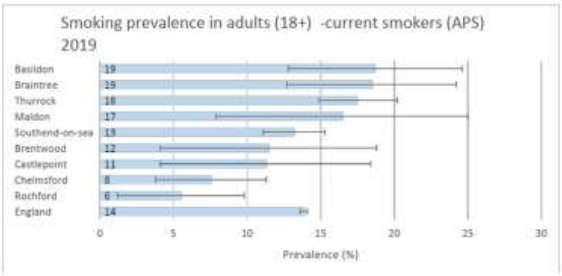
Inequality & Behavioural Risk Factors

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.

Mid and South Essex Integrated Care System

NHS
Mid and South Essex

SEE Alliance 5 Year Plan

DRAFT

What is the purpose of the Alliance?

Mid and South Essex Integrated Care System

To reduce health inequalities:

We believe by working together we will improve lives for the better.

We will provide opportunities for our residents to make informed choices and to have control over their health and wellbeing.

By becoming proactive, joined up influential voices focused on the experience of people.

A plan that we all own will be more meaningful, we will all feel responsible to deliver it, and talk confidently about it

Collective ambition for the plan, SEE Alliance development session, Sept 2022

1

Alliance Plan Development Team actions:

- concept paper
- working title – *What About Ethel?*
- reviewed JSNA data

Ethel represents our residents who are at the heart of the plan

Sept 2022

2

Concept for the plan tested with stakeholders

Castle Point & Rochford Health & Wellbeing Board

Southend City Council Health & Wellbeing Board Informal session

Interactive session with SEE Alliance Partnership

Agreed we need a neighbourhood focused plan about work we deliver together

Dec 2022

3

Developed neighbourhood profiles with actionable insight

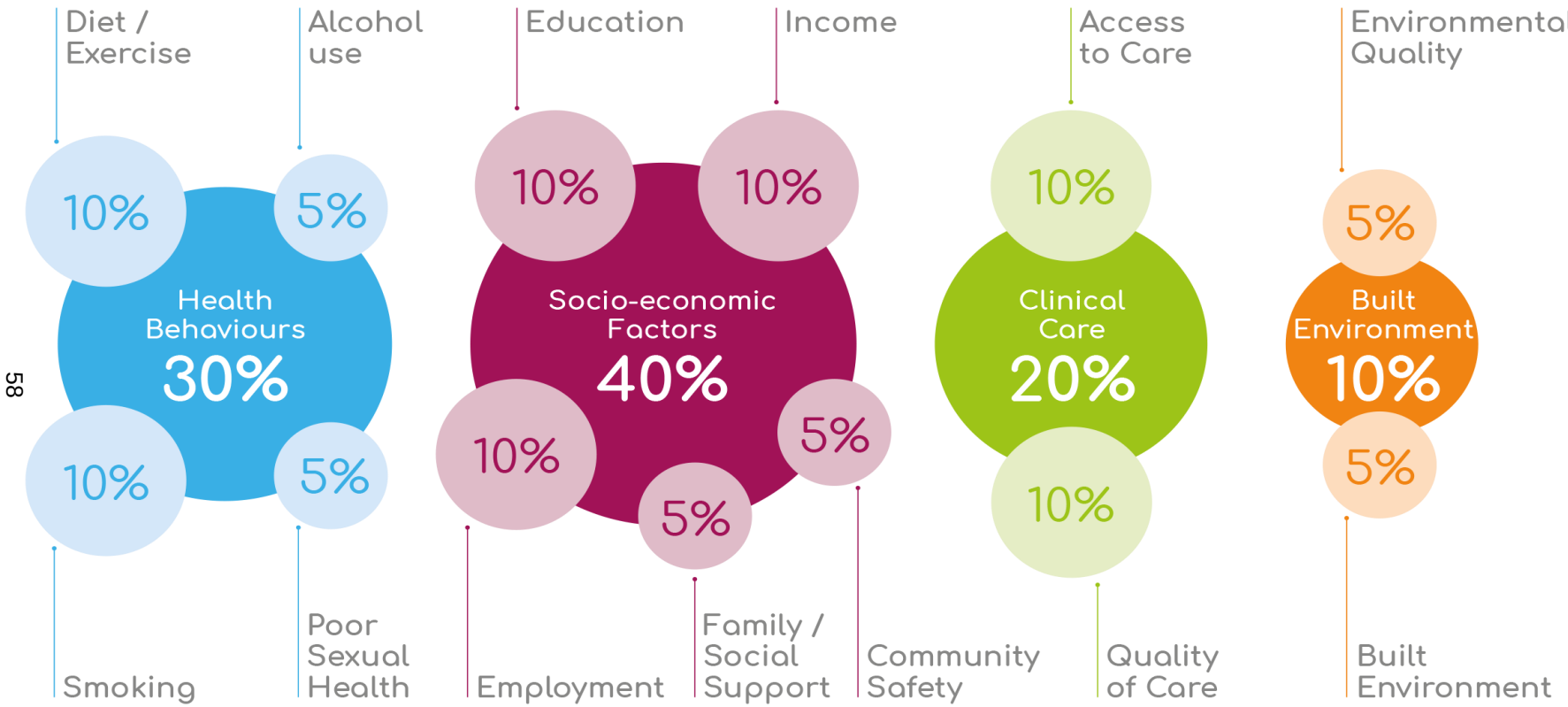
Newly formed SEE Comms and Engagement network lead an asset-based session with stakeholders on health and wellbeing

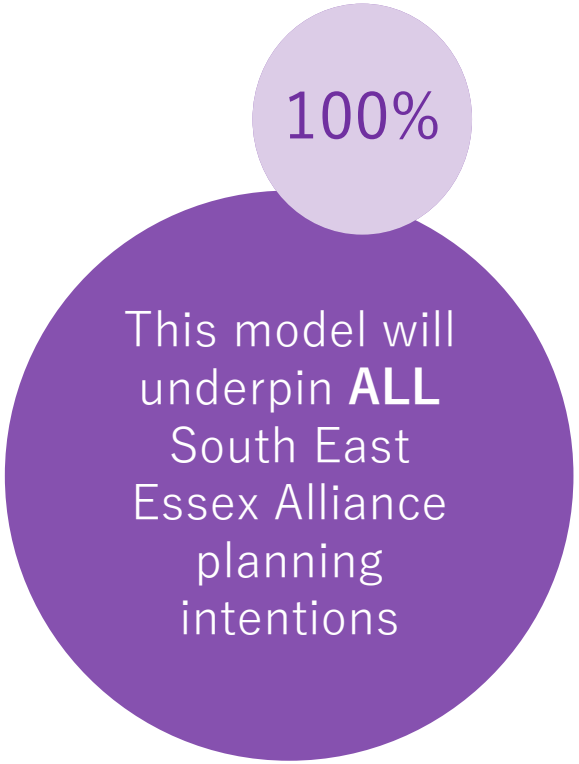
Southend City Council partner us to provide data analytic support

Feb 2023

Draft neighbourhood profiles are used to inform PCN strategy workshop

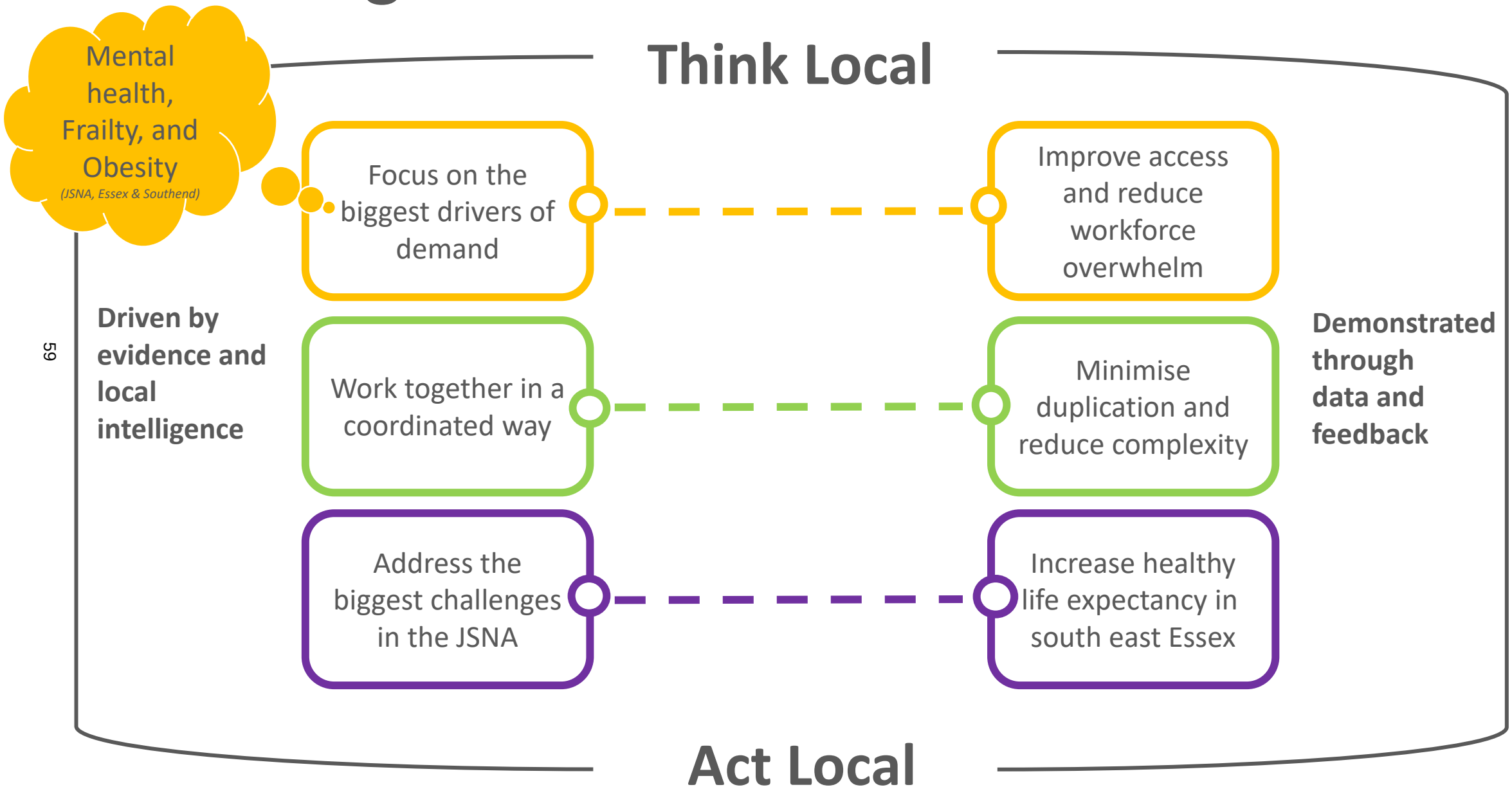
To address inequalities we must look at the wider determinants of health





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

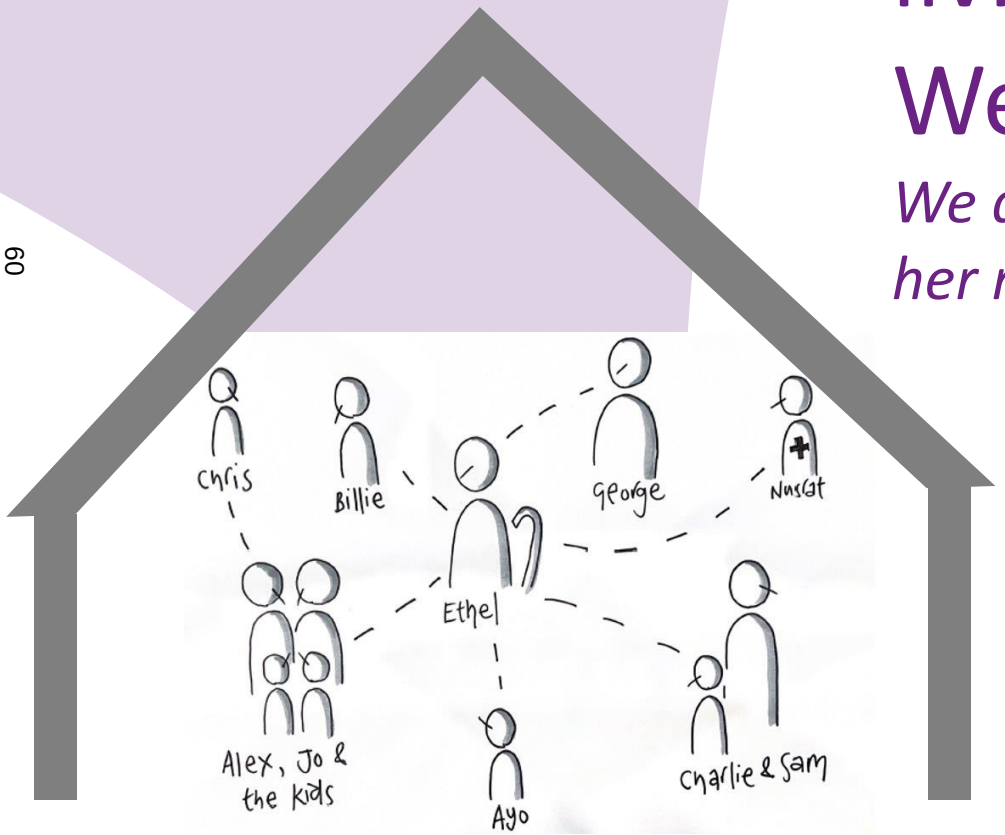
Connecting the dots...



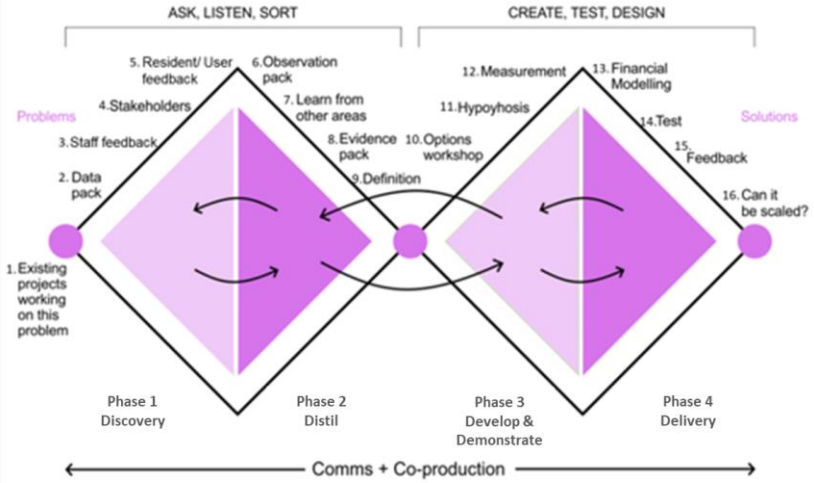
Meet Ethel.

Ethel is a 79 year old woman living in Milton Ward, part of the West Central neighbourhood.

We are creating a pen portrait of Ethel and developing her network of family, friends, and care givers



Phases of work



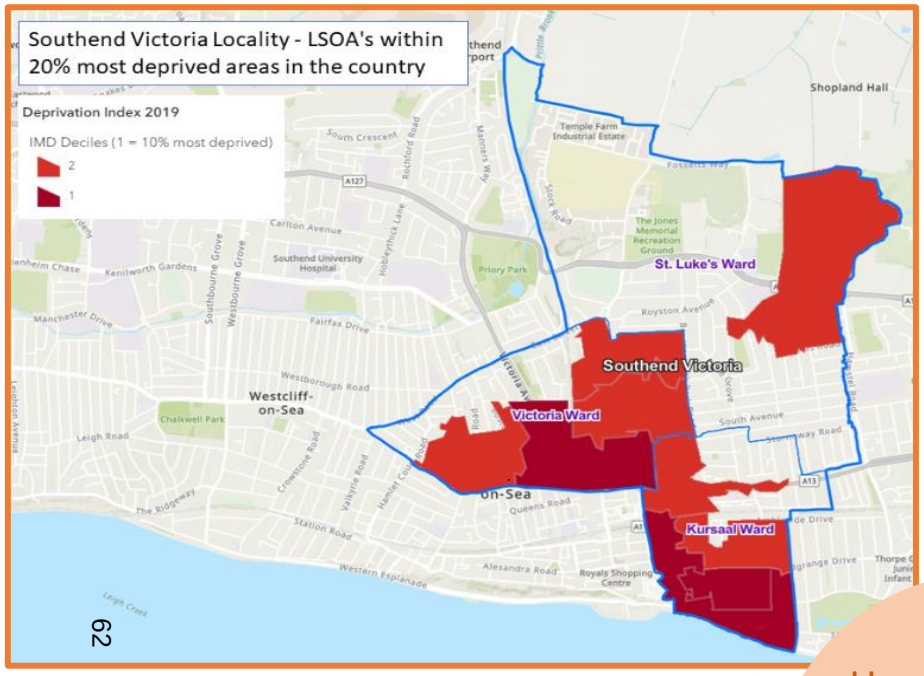
Discovery – Gather data and intelligence, understand the problem, and examine through different lenses

Distil – Channel the insight and intelligence to create a shared understanding so we can focus effort in the right ways and places

Develop and demonstrate – Build hypotheses and ideas and collaboratively test them, learn from them, and refine them to create the right solutions

Delivery – Work together to deliver the solutions that demonstrate impact. Evaluate and share the learning.

Southend Victoria

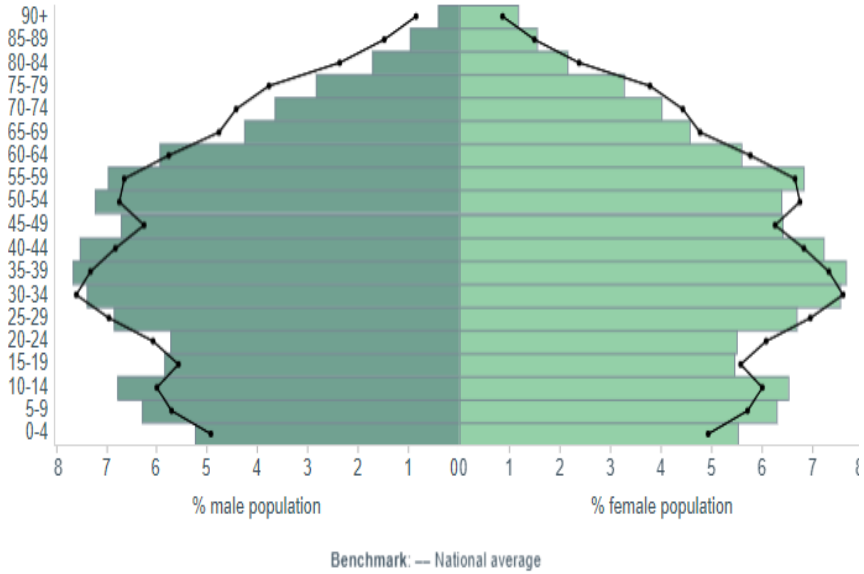


Demographics

36,300 people

16,200 households

3,035 (19%) households are in **fuel poverty**



Younger than average population

CORE20|PLUS|5

Southend Victoria PCN has **the most deprived practice population** across MSE

48% or 15,426 people in Southend Victoria *live in one of England's 20% most deprived areas*

PCN deprivation score ranked 210/1264 PCNs in England *(very high deprivation)*

Unemployment is high
St Lukes 6.2%
Victoria 8.9%
Kursaal 11.9%
England 5%

Black and minority ethnic (BAME) population is **18%**
England 19%

Limiting long term illness or disability
St Lukes 17.8%
Victoria 21.3%
Kursaal 18.9%
England 17.7%

In Victoria Ward **42% of people over 65 live alone**

The incidence of Emergency Hospital admissions for **Hip Fractures in people 65+ 2016/17 - 2020/21 was 122.3. Higher** than the England average of 100

Southend Victoria

CORE20|PLUS|5

Adults

Maternity

Higher birth rate than the England average – 68.8 live births per 1,000 population
(Victoria 75.4; Kursaal 68.8; St Luke's 62.1; England 59.2)

Serious mental illness

High emergency admission rates for intentional self-harm – 127.7 (SAR)
(Victoria 144.3; Kursaal 164.8; St Luke's 73.2; England 100.0)

Chronic respiratory disease

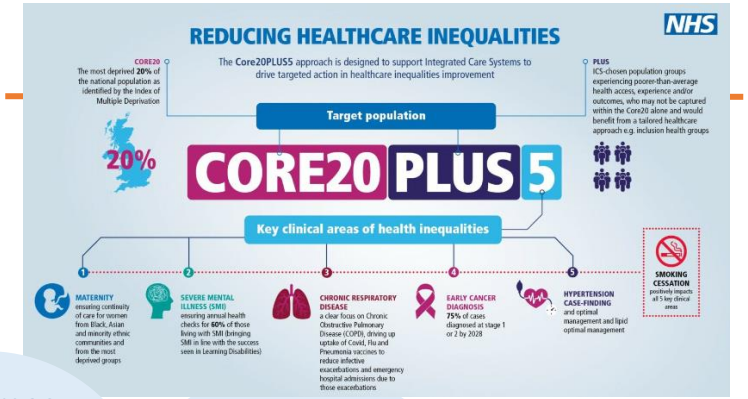
Very high emergency admission rates for COPD – 240.1 (SAR)
(Victoria 275.0; Kursaal 302.8; St Luke's 73.2; England 142.6)

Early cancer diagnosis

Across Southend 52.3% of cancers are diagnosed at stages 1 & 2
(England 53.4% - higher is better)

Hypertension case finding

QOF prevalence 14.10% - could be indicative of younger population or the need for greater case finding
(England 14%)



A third more likely to be admitted to hospital for intentional self harm

2.5% of the population live in poverty and have a CVD or respiratory condition

2.5 times more likely to be admitted to hospital with COPD

126.3 (SAR) **Hospital admissions for alcohol-attributable conditions**
(England ave. 100)

122.5 (SAR) **emergency admissions for Stroke**
(England ave. 100)

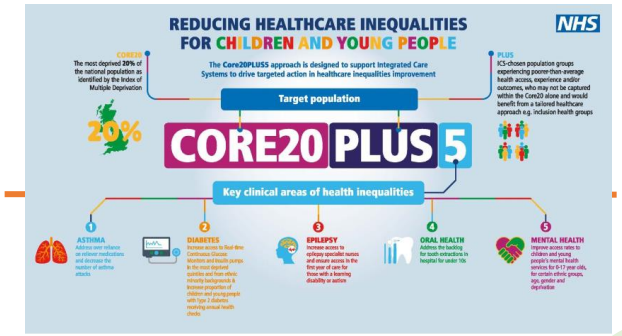
128.9 (SIR) **incidence of Lung Cancer**
(England ave. 100)

116.1 (SAR) **emergency admissions for Coronary Heart Disease**
(England ave. 100)

https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/

Southend Victoria

CORE20|PLUS|5



42.4% of year Six children are overweight or obese

East of England average 33.2%

4.4% of 15 year olds are regular smokers

England average 5.4%
National Target 3%

Children

Asthma

Lower hospital admission for under 19yr olds with asthma – 71.17 (per 100,000 pop)

(England 120.03)

Diabetes

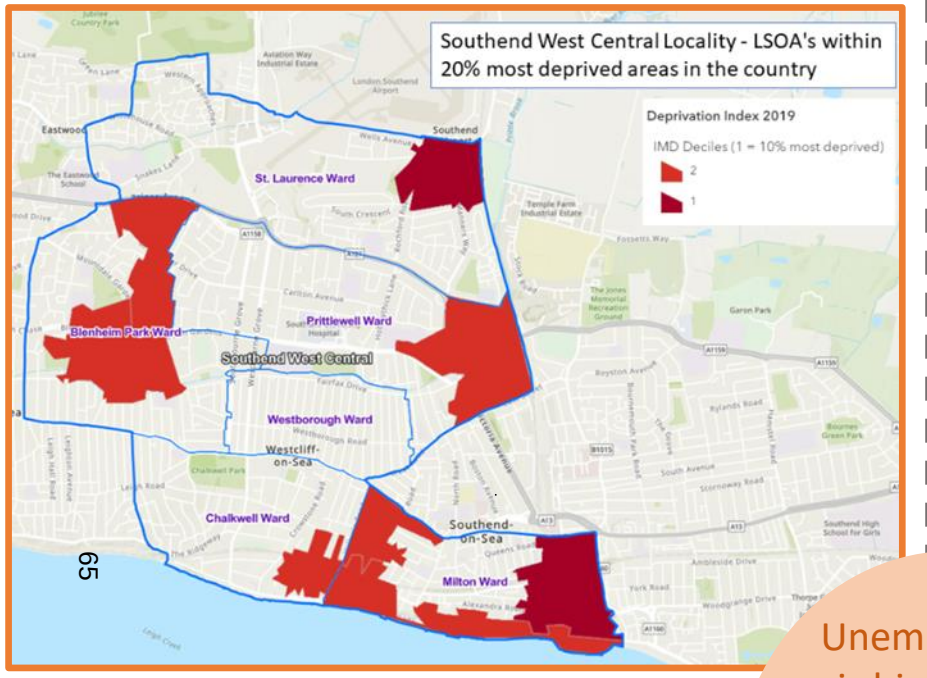
Epilepsy

Oral health

Mental health

Data coming soon

Southend West Central



Demographics

65,200 people

28,100 households

4,439 (15.7%) households are in **fuel poverty**

Younger than average population

CORE20|PLUS|5

*West Central PCN has **the widest variation of deprivation** across MSE*

*29% or 18,773 **people in West Central** live in one of England's 20% most deprived areas*

PCN deprivation score ranked 411/1264 PCNs in England *(high deprivation)*

Unemployment is higher than average **6.13% (9.90% in Milton ward)** *England 5%*

Black and minority ethnic (BAME) population is **18.3%** *England 19%*

Limiting long term illness or disability **18.7% of the population** *England 17.7%*

In West Central **33.5% of people over 65 live alone**

The incidence of Emergency Hospital admissions for **Hip Fractures in people 65+ 2016/17 - 2020/21 was 116.9. Higher** than the England average of 100

Southend West Central

CORE20|PLUS|5

Adults

Maternity

Higher birth rate than the England average – 65.2 live births per 1,000 population
(England 59.2)

Serious mental illness

Lower emergency admission rates for intentional self-harm – 75.2 (SAR)
(England 100.0)

Chronic respiratory disease

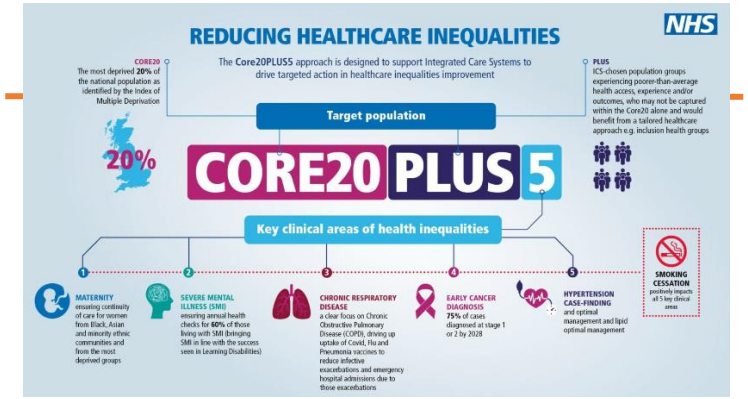
High emergency admission rates for COPD – 152.2 (SAR)
(England 142.6)

Early cancer diagnosis

Across Southend 52.3% of cancers are diagnosed at stages 1 & 2
(England 53.4% - higher is better)

Hypertension case finding

QOF prevalence 12.9% - could be indicative of younger population or the need for greater case finding
(England 14%)



2% of the population live in poverty and have a CVD or respiratory condition

1.5 times more likely to be admitted to hospital with COPD

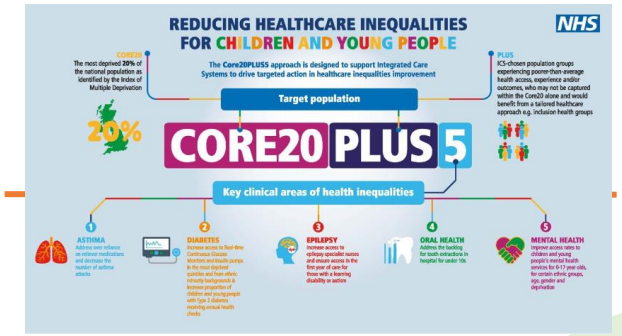
116.4 (SAR) **emergency admissions for Coronary Heart Disease**
(England ave. 100)

126.8 (SAR) **emergency admissions for Stroke**
(England ave. 100)

https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/

Southend West Central

CORE20|PLUS|5



34.5% of year Six children are overweight or obese

East of England average 33.2%

5.7% of 15 year olds are regular smokers

England average 5.4%
National Target 3%

Children

Asthma

Moderately high hospital admission for under 19yr olds with asthma – 111.94 (per 100,000 pop) *(England 120.03)*

Diabetes

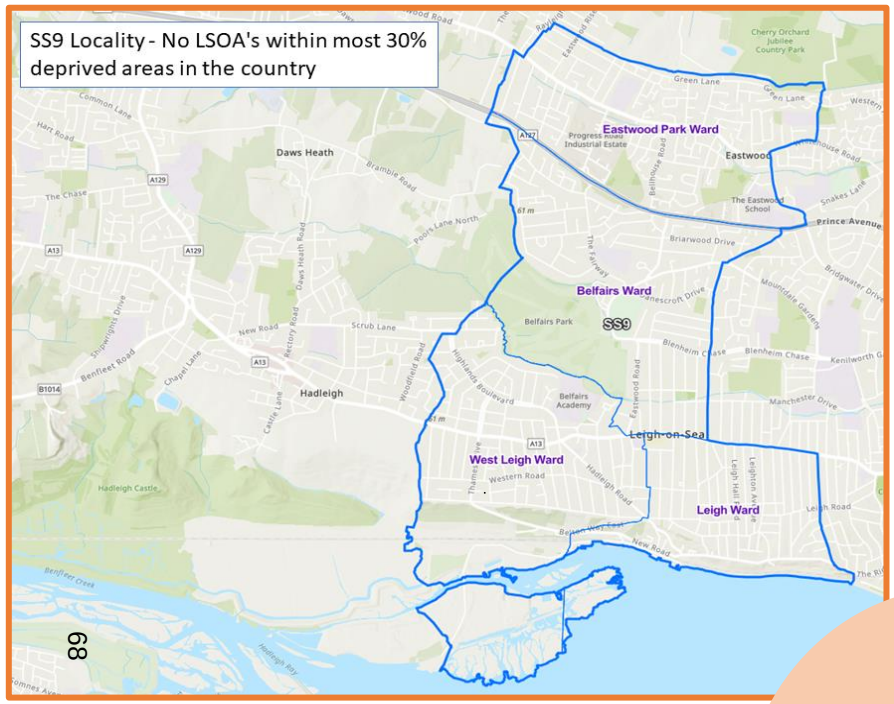
Epilepsy

Oral health

Mental health

Data coming soon

SS9

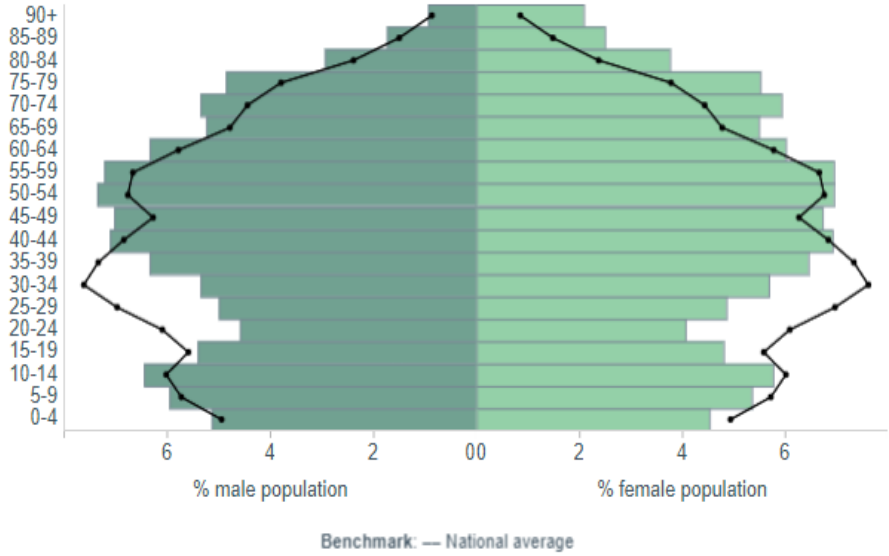


Demographics

38,200 people

16,800 households

1,971 (11.7%) households are in **fuel poverty**



Older than average population

CORE20|PLUS|5

SS9 PCN has one of the **least deprived practice population** across MSE

6% or 3,255 people in SS9 live in one of England's 20% most deprived areas

PCN deprivation score ranked 1006/1264 PCNs in England (low deprivation)

Unemployment is LOW **3.35%** *England 5%*

Black and minority ethnic (BAME) population is **6.2%** *England 19%*

Limiting long term illness or disability **16.7% of the population** *England 17.7%*

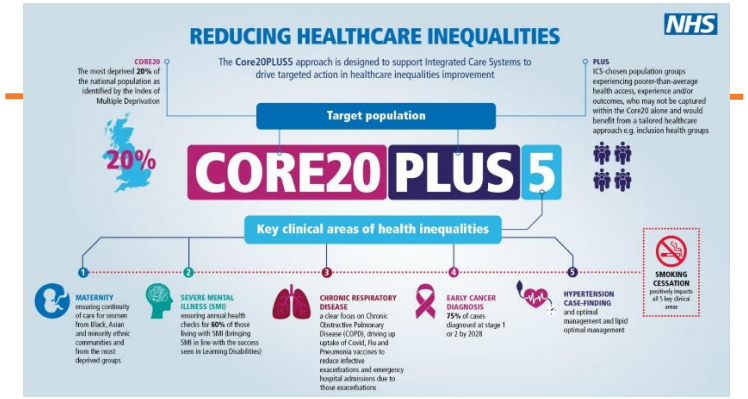
In SS9 **32.6% of people over 65 live alone**

The incidence of Emergency Hospital admissions for **Hip Fractures in people 65+ 2016/17 - 2020/21 was 93.5. Lower** than the England average of 100

SS9

CORE20|PLUS|5

Adults



Maternity

Birth rate similar to the England average – 60.0 live births per 1,000 population
(England 59.2)

Serious mental illness

Low emergency admission rates for intentional self-harm – 55.1 (SAR)
(England 100.0)

Chronic respiratory disease

Lower emergency admission rates for COPD – 78.9 (SAR)
(England 142.6)

Early cancer diagnosis

Across Southend 52.3% of cancers are diagnosed at stages 1 & 2
(England 53.4% - higher is better)

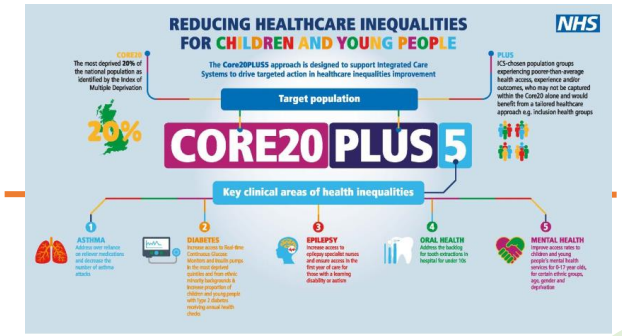
Hypertension case finding

QOF prevalence 16.6% - could be indicative of older population or evidence of proactive case finding
(England 14%)

1.8% of the population live in poverty and have a CVD or respiratory condition

108.7 (SIR per hundred) **incidence of breast cancer**
(England ave. 100)

https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/



25.9% of year Six children are overweight or obese

East of England average 33.2%

9.6% of 15 year olds are regular smokers

England average 5.4%
National Target 3%

Children

Asthma

Lower hospital admission for under 19yr olds with asthma – 70.29 (per 100,000 pop)
(England 120.03)

Diabetes

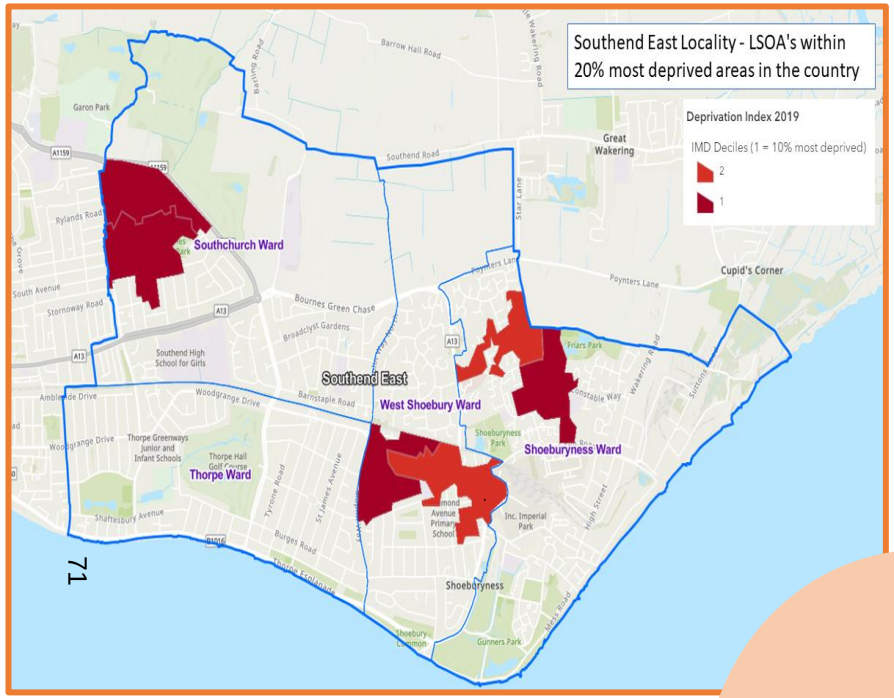
Epilepsy

Oral health

Mental health

Data coming soon

Southend East

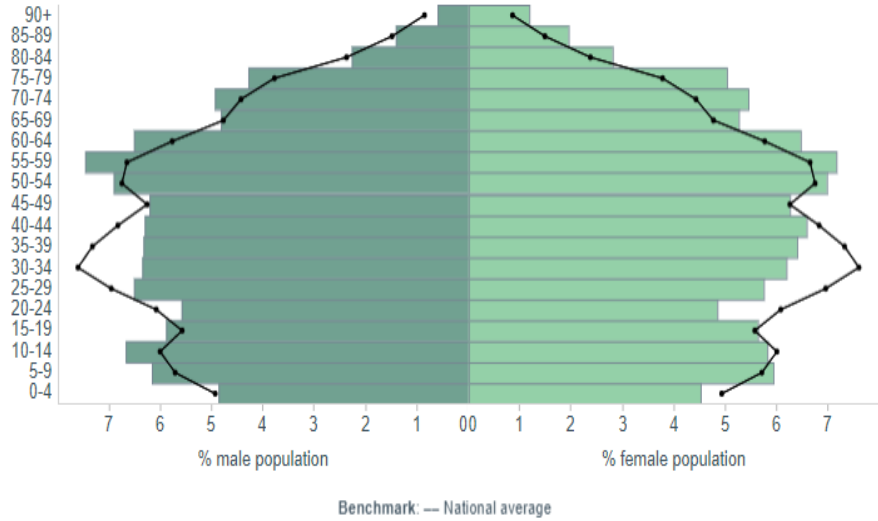


Demographics

41,100 people

17,200 households

2,288 (13.3%) households are in **fuel poverty**



Older than average population

CORE20|PLUS|5

Southend East PCN has one of the **more deprived practice populations** across MSE

25% or 9,419 people in Southend East live in one of England's 20% most deprived areas

PCN deprivation score ranked 490/1264 PCNs in England *(high deprivation)*

Unemployment is average **5.15%** *England 5%*

Black and minority ethnic (BAME) population is **9.7%** *England 19%*

Limiting long term illness or disability **19.1% of the population** *England 17.7%*

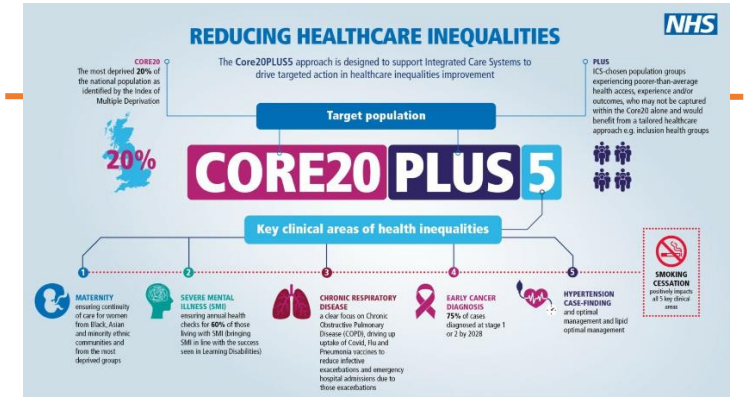
In Southend East **30% of people over 65 live alone**

The incidence of Emergency Hospital admissions for **Hip Fractures in people 65+ 2016/17 - 2020/21 was 90.5. Lower** than the England average of 100

Southend East

CORE20|PLUS|5

Adults



Maternity

Birth rate similar to the England average – 57.7 live births per 1,000 population
(England 59.2)

Serious mental illness

Below average emergency admission rates for intentional self-harm – 79.2 (SAR)
(England 100.0)

Chronic respiratory disease

Lower emergency admission rates for COPD – 99.2 (SAR)
(England 142.6)

Early cancer diagnosis

Across Southend 52.3% of cancers are diagnosed at stages 1 & 2
(England 53.4% - higher is better)

Hypertension case finding

QOF prevalence 15.4% - could be indicative of older population or evidence of proactive case finding
(England 14%)

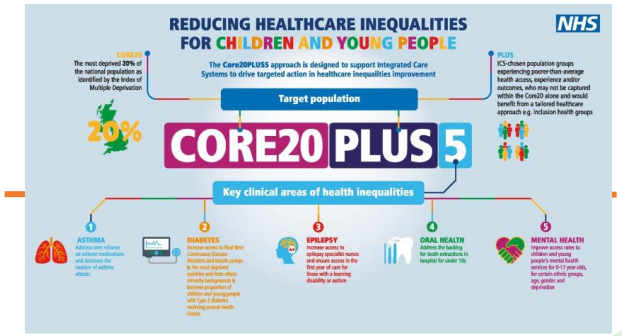
2% of the population live in poverty and have a CVD or respiratory condition

103.1 (SAR) **emergency admissions for Stroke**
(England ave. 100)

https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/

Southend East

CORE20|PLUS|5



34.7% of year Six children are overweight or obese

East of England average 33.2%

6.5% of 15 year olds are regular smokers

England average 5.4%
National Target 3%

Children

Asthma

Low hospital admission for under 19yr olds with asthma – 65.91 (per 100,000 pop)

(England 120.03)

Diabetes

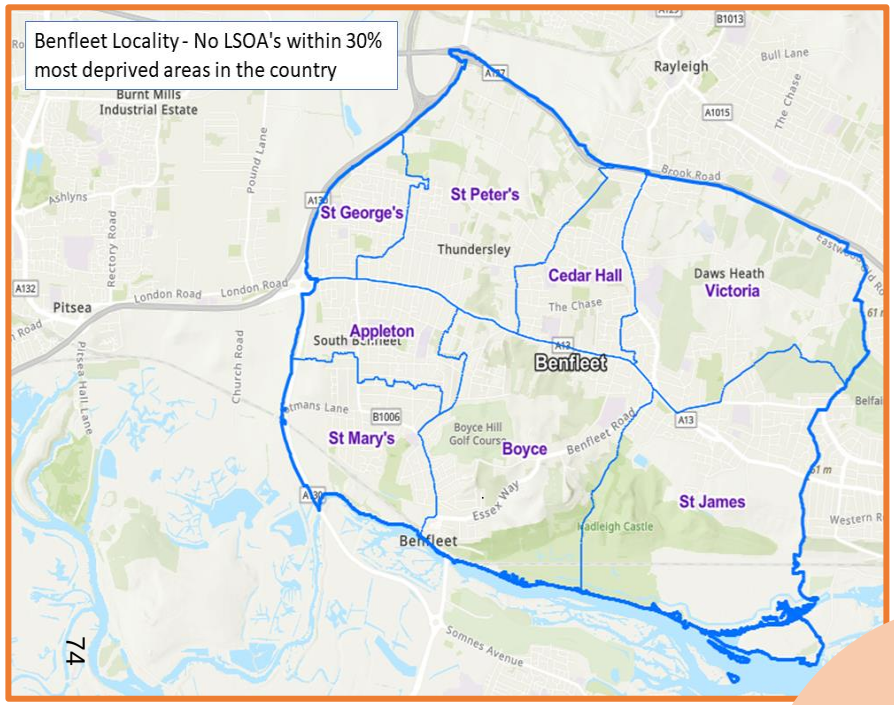
Epilepsy

Oral health

Mental health

Data coming soon

Benfleet

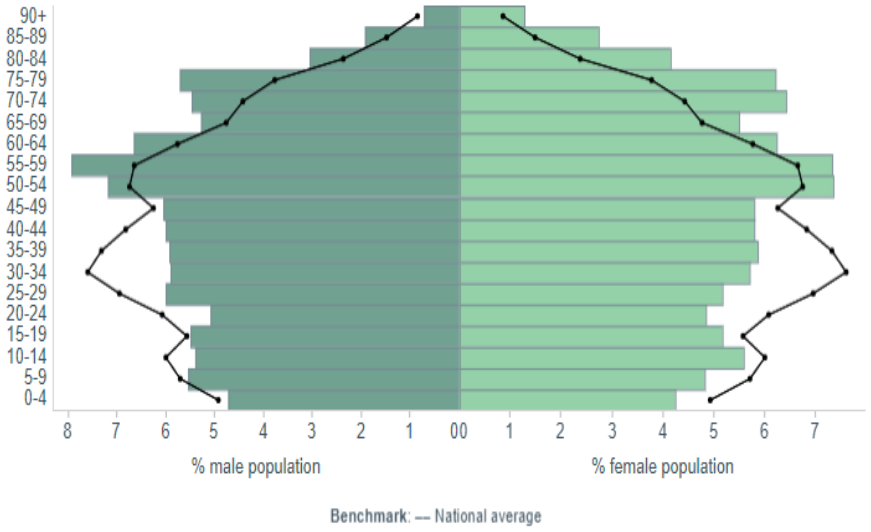


Demographics

51,600 people

21,300 households

2,130 (10%) households are in **fuel poverty**



Older than average population

CORE20|PLUS|5

Benfleet PCN has one of the **least deprived practice populations** across MSE

0% or 142 people in Benfleet live in one of England's 20% most deprived areas

Unemployment is low **2.9%** *England 5%*

PCN deprivation score ranked 1088/1264 PCNs in England *(low deprivation)*

Black and minority ethnic (BAME) population is **5.7%** *England 19%*

Limiting long term illness or disability **17.6% of the population** *England 17.7%*

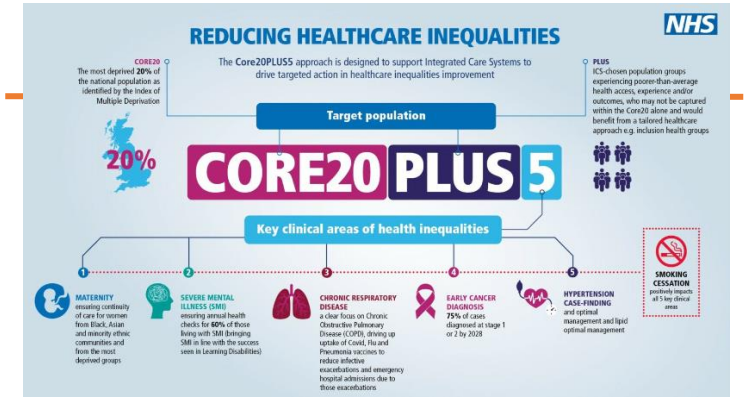
In Benfleet **26.5% of people over 65 live alone**

The incidence of Emergency Hospital admissions for **Hip Fractures in people 65+ 2016/17 - 2020/21 was 104.8. Higher** than the England average of 100

Benfleet

CORE20|PLUS|5

Adults



Maternity

Birth rate lower than the England average – 57.2 live births per 1,000 population
(England 59.2)

Serious mental illness

Low emergency admission rates for intentional self-harm – 53.6 (SAR)
(England 100.0)

Chronic respiratory disease

Low emergency admission rates for COPD – 77.9 (SAR)
(England 142.6)

Early cancer diagnosis

Across Castle Point & Rochford 51.1% of cancers are diagnosed at stages 1 & 2
(England 53.4% - higher is better)

Hypertension case finding

QOF prevalence 16.9% - could be indicative of older population or evidence of proactive case finding
(England 14%)

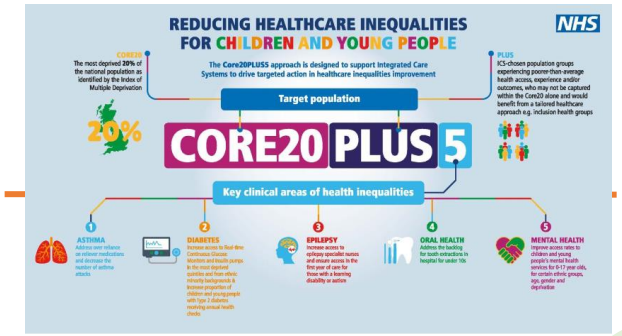
1.6% of the population live in poverty and have a CVD or respiratory condition

104.8 (SAR) **emergency admissions for hip fractures**
(England ave. 100)

https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/

Benfleet

CORE20|PLUS|5



Children

Asthma

Very low hospital admission for under 19yr olds with asthma – 35.7 (per 100,000 pop)
(England 120.03)

Diabetes

Epilepsy

Oral health

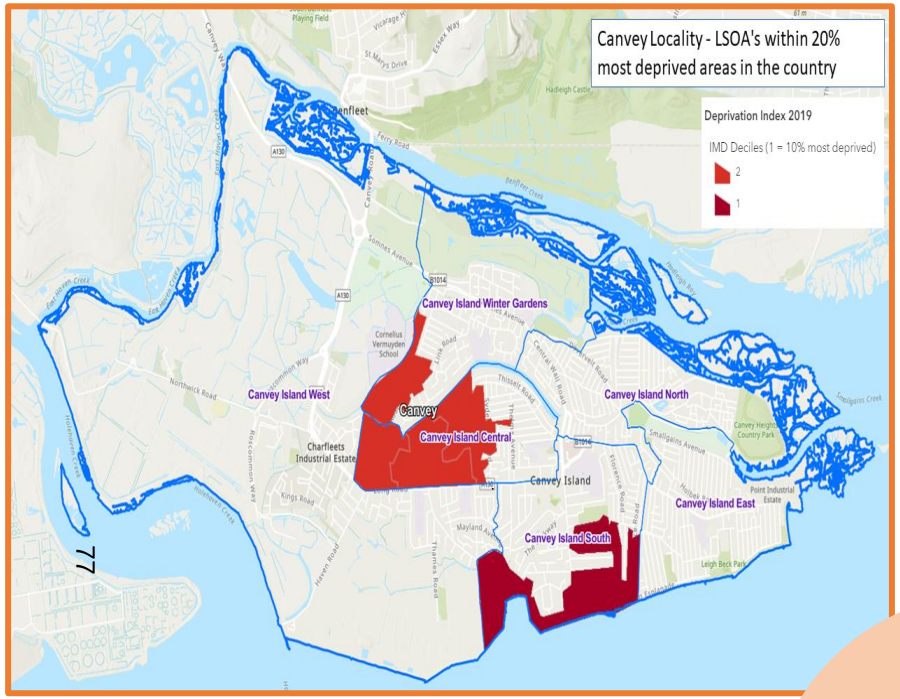
Mental health

Data coming soon

32.4% of year Six children are overweight or obese
East of England average 33.2%

7.3% of 15 year olds are regular smokers
England average 5.4%
National Target 3%

Canvey

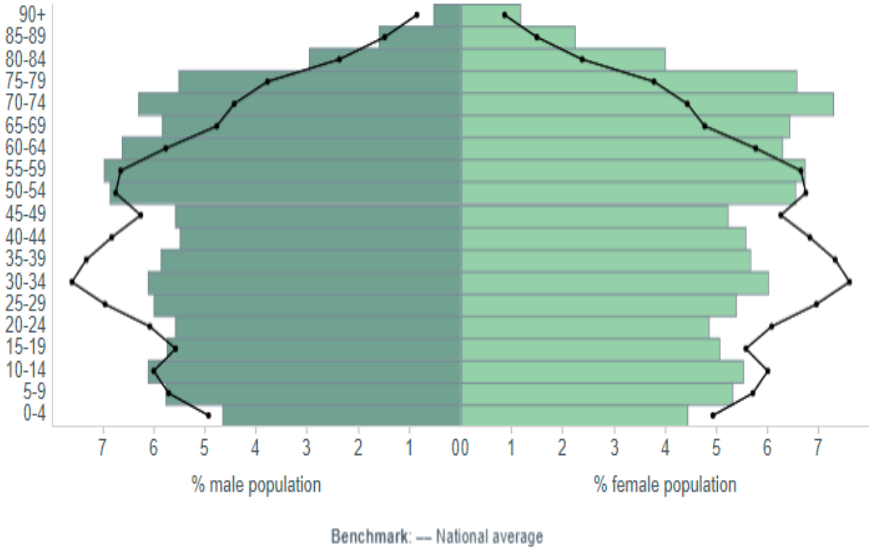


Demographics

38,300 people

16,200 households

2,106 (13%) households are in **fuel poverty**



Older than average population

CORE20|PLUS|5

Canvey PCN has one of the **more deprived practice populations** across MSE

21% or 8954 people on Canvey live in one of England's 20% most deprived areas

Unemployment is average **4.6%** *England 5%*

PCN deprivation score ranked 408/1264 PCNs in England *(high deprivation)*

Black and minority ethnic (BAME) population is **4.5%** *England 19%*

Limiting long term illness or disability **20.8% of the population** *England 17.7%*

In Canvey **29.9% of people over 65 live alone**

The incidence of Emergency Hospital admissions for **Hip Fractures in people 65+ 2016/17 - 2020/21 was 102.4. Higher** than the England average of 100

Canvey

CORE20|PLUS|5

Adults

Maternity

Birth rate the same as the England average – 59.2 live births per 1,000 population
(England 59.2)

Serious mental illness

Just below average emergency admission rates for intentional self-harm – 89.9 (SAR)
(England 100.0)

Chronic respiratory disease

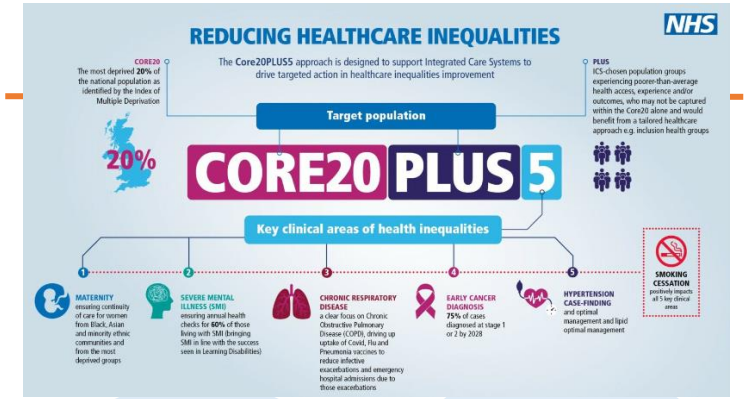
Above average emergency admission rates for COPD – 144.8 (SAR)
(England 142.6)

Early cancer diagnosis

Across Castle Point & Rochford 51.1% of cancers are diagnosed at stages 1 & 2
(England 53.4% - higher is better)

Hypertension case finding

QOF prevalence 20.5% - could be indicative of older population or evidence of proactive case finding
(England 14%)



1.6% of the population live in poverty and have a CVD or respiratory condition

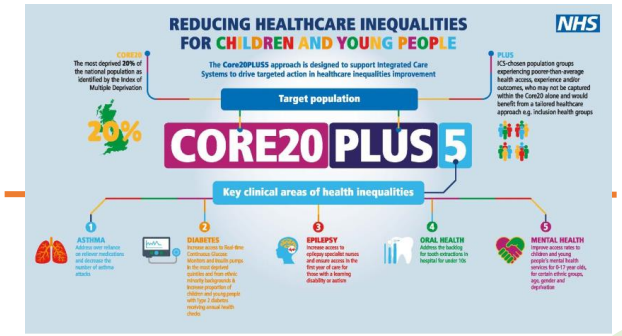
122.1 (SAR) **emergency admissions for Stroke**
(England ave. 100)

106.8 (SAR) **emergency admissions for Coronary Heart Disease**
(England ave. 100)

In Canvey Island South Ward emergency admission rates for intentional self harm are above average at 135.3 (SAR)
(England ave. 100.0)

106.8 (SIR) **incidence of colorectal cancer**
(England ave. 100)

https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/



40.4% of year Six children are overweight or obese

East of England average 33.2%

4.3% of 15 year olds are regular smokers

England average 5.4%
National Target 3%

Children

Asthma

Low hospital admission for under 19yr olds with asthma – 63.1 (per 100,000 pop)
(England 120.03)

Diabetes

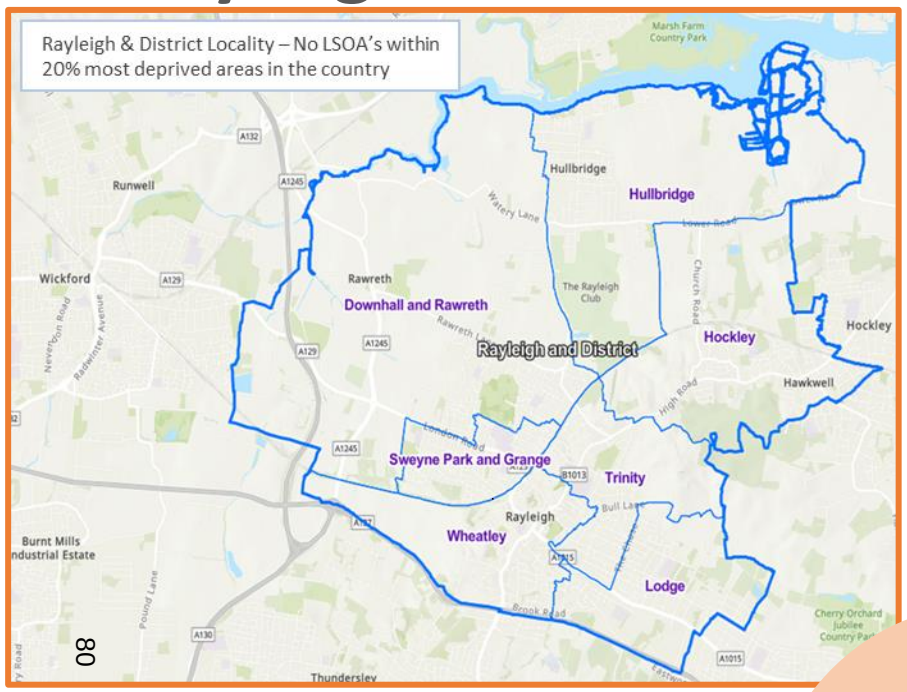
Epilepsy

Oral health

Mental health

Data coming soon

Rayleigh & District



Demographics

46,600 people

19,400 households

1,707 (8.8%) households are in **fuel poverty**

Older than average population

CORE20|PLUS|5

Rayleigh & District PCN is the **least deprived practice population** across MSE

0% or 128 people in Rayleigh & District live in one of England's 20% most deprived areas

Unemployment is low **2.8%** *England 5%*

PCN deprivation score ranked 1206/1264 PCNs in England *(very low deprivation)*

Black and minority ethnic (BAME) population is **4.2%** *England 19%*

Limiting long term illness or disability **20.8% of the population** *England 17.7%*

In Rayleigh & District **27.8% of people over 65 live alone**

The incidence of Emergency Hospital admissions for **Hip Fractures in people 65+ 2016/17 - 2020/21 was 99.3. Similar to** the England average of 100

Rayleigh & District

CORE20|PLUS|5

Adults

Maternity

Lower birth rate than the England average – 52.7 live births per 1,000 population
(England 59.2)

Serious mental illness

Very low emergency admission rates for intentional self-harm – 44.7 (SAR)
(England 100.0)

Chronic respiratory disease

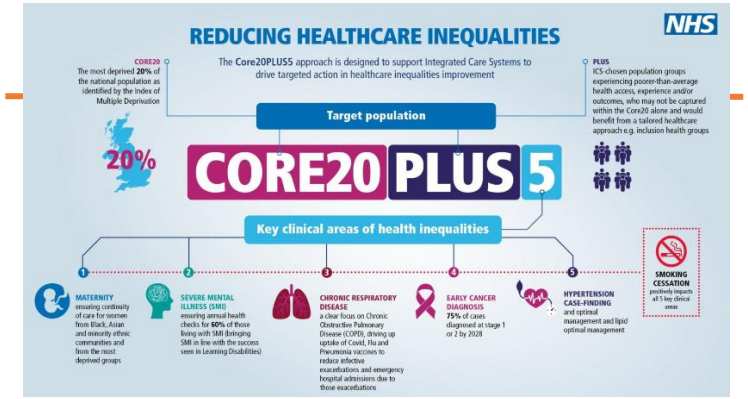
Below average emergency admission rates for COPD – 92.7 (SAR)
(England 142.6)

Early cancer diagnosis

Across Castle Point & Rochford 51.1% of cancers are diagnosed at stages 1 & 2
(England 53.4% - higher is better)

Hypertension case finding

QOF prevalence 16.8% - could be indicative of older population or evidence of proactive case finding
(England 14%)



1.6% of the population live in poverty and have a CVD or respiratory condition

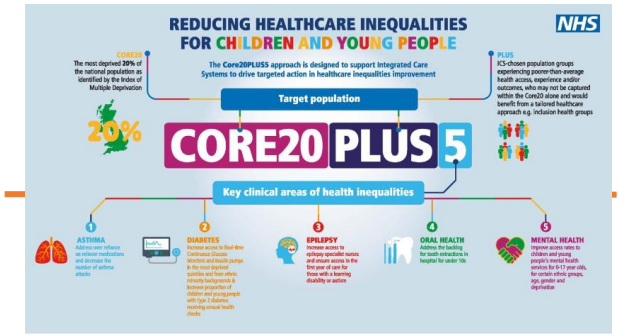
103.2 (SIR) **incidence of Prostate Cancer**
(England ave. 100)

108.3 (SIR) **incidence of Breast cancer**
(England ave. 100)

https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/

Rayleigh & District

CORE20|PLUS|5



29% of year Six children are overweight or obese

East of England average 33.2%

6.4% of 15 year olds are regular smokers

England average 5.4%
National Target 3%

Children

Asthma

Very low hospital admission for under 19yr olds with asthma – 30.94 (per 100,000 pop)
(England 120.03)

Diabetes

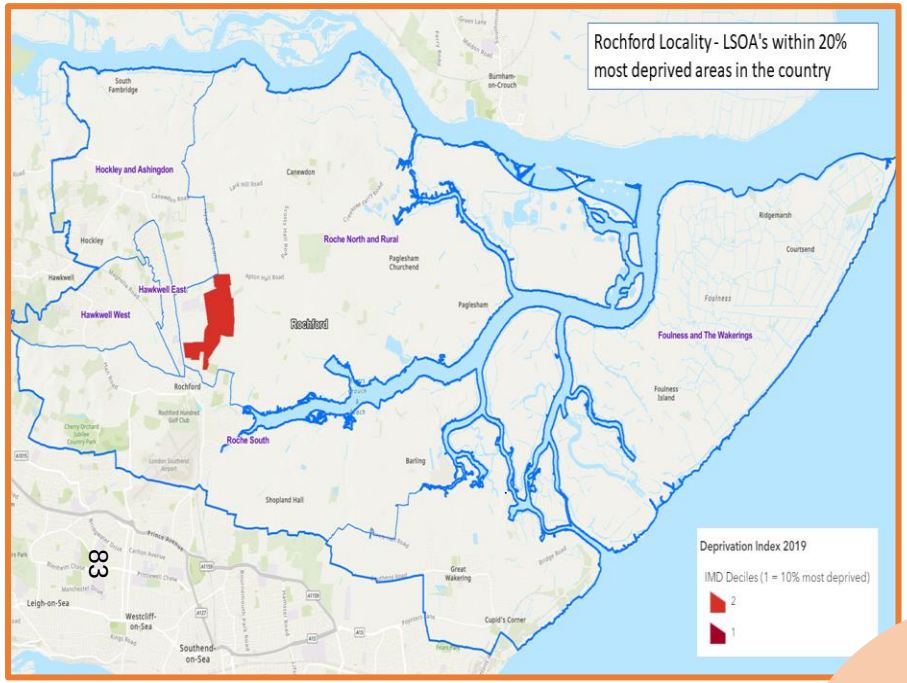
Epilepsy

Oral health

Mental health

Data coming soon

Rochford

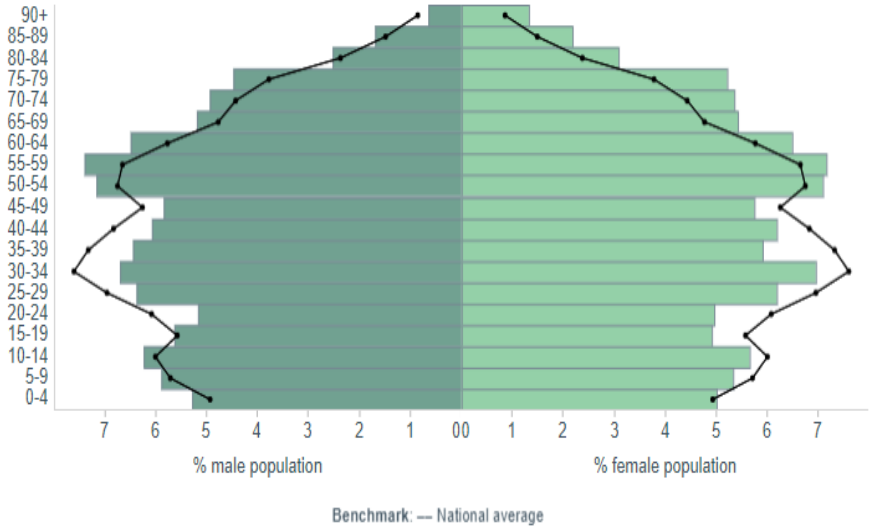


Demographics

40,900 people

17,100 households

1,864 (10.9%) households are in **fuel poverty**



Older than average population

CORE20|PLUS|5

Rochford PCN has a moderately deprived **practice population** across MSE

7% or 2,721 people in Rochford live in one of England's 20% most deprived areas

Unemployment is low **3.4%** *England 5%*

PCN deprivation score ranked 845/1264 PCNs in England *(average deprivation)*

Black and minority ethnic (BAME) population is **4.0%** *England 19%*

Limiting long term illness or disability **17.4% of the population** *England 17.7%*

In Rochford **28.1% of people over 65 live alone**

The incidence of Emergency Hospital admissions for **Hip Fractures in people 65+ 2016/17 - 2020/21 was 109.1. Higher than** the England average of 100

Rochford

CORE20|PLUS|5

Adults

Maternity

Lower birth rate than the England average – 57.5 live births per 1,000 population
(England 59.2)

Serious mental illness

Very low emergency admission rates for intentional self-harm – 56.8 (SAR)
(England 100.0)

Chronic respiratory disease

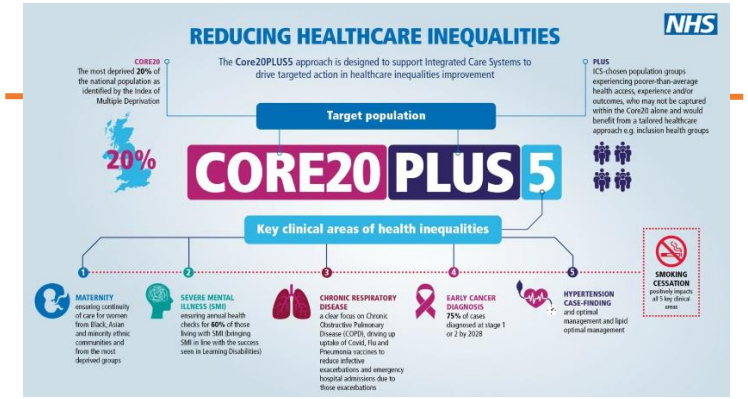
Below average emergency admission rates for COPD – 84.5 (SAR)
(England 142.6)

Early cancer diagnosis

Across Castle Point & Rochford 51.1% of cancers are diagnosed at stages 1 & 2
(England 53.4% - higher is better)

Hypertension case finding

QOF prevalence 16.1% - could be indicative of older population or evidence of proactive case finding
(England 14%)



1.8% of the population live in poverty and have a CVD or respiratory condition

117.7 (SIR) **incidence of Prostate Cancer**
(England ave. 100)

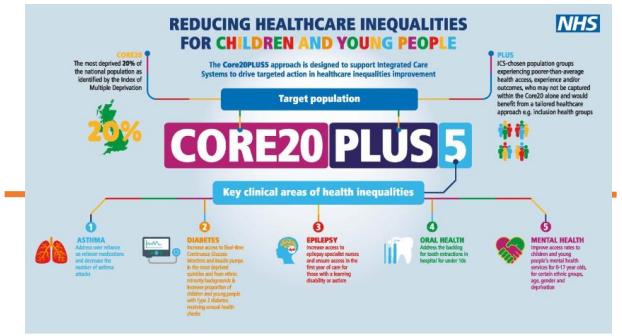
114.1(SAR) **emergency hospital admissions for Stroke**
(England ave. 100)

In Roche North & Rural Ward emergency admission rates for emergency hospital admissions for COPD are above average at 145.2 (SAR)
(England ave. 142.6)

https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/

Rochford

CORE20|PLUS|5



33% of year Six children are overweight or obese

East of England average 33.2%

5.7% of 15 year olds are regular smokers

England average 5.4%
National Target 3%

Children

Asthma

Very low hospital admission for under 19yr olds with asthma – 38.12 (per 100,000 pop)
(England 120.03)

Diabetes

Epilepsy

Oral health

Mental health

Data coming soon

One of the ways we will drive forward Alliance Plan delivery is through our Communication & Engagement Network. It will help ensure we are inclusive, co-productive, and informed in our work.

Mid and South Essex Integrated Care System

SOUTH EAST ESSEX ALLIANCE ENGAGEMENT

IN PARTNERSHIP WITH

Better Together Cavs · SAVS · RVRS

WHO IS THIS NETWORK FOR?

As part of this work, we have launched a new South East Essex Communications and Engagement network. This network is open to everybody and is a great space to get involved and grow your own work. By joining the membership, you will:

- Receive regular, relevant information about what is happening for and within South East Essex.
- Be invited to join workshops, meetings and networking events to connect with partners and build relationships.
- Get support from the network to help you build promotional materials and push your messaging out to more people.
- Find out about what communities already have in place and how you can build on & link with them.
- Be able to use the network to test an idea with a particular group of people and reach the right people for your work.

Want to get involved? Sign up here

WHAT WE WANT TO ACHIEVE

DISTRIBUTION & ANALYSIS

Analysing where assets have been distributed and evaluating their performance and impact

LOCALISED ASSETS

Working with partners & residents to produce & distribute relevant materials and communications for our local audiences

COMMUNITY LEADERS

Build relationships with community leaders so assets are coming from trusted, recognisable sources

SEE COMMUNICATIONS & ENGAGEMENT NETWORK

Development of a network that spans Rochford, Castlepoint & Southend. Mapping assets, skills gaps, partners and resources

CO-PRODUCTION & USER RESEARCH

Support with the co-production of assets and use user research techniques to inform the work

WORKING WITH THE WIDER SYSTEM

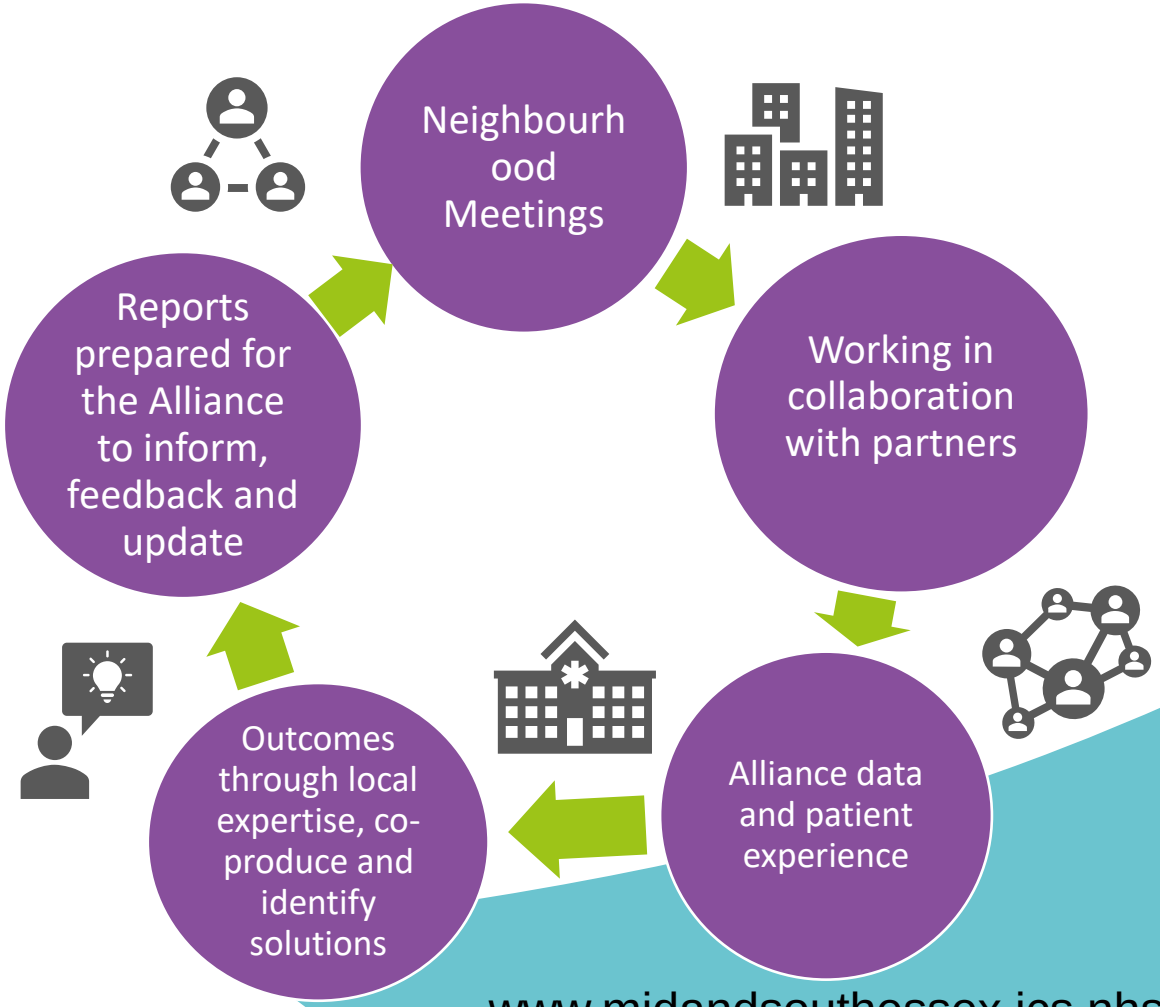
Attending Alliance meetings to share learnings and collaborate with ICS & system teams

www.midandsouthessex.ics.nhs.uk

Next Steps - Resident Feedback

We will ensure the voice of residents is heard by spending time with local people to listen to their valued experiences. Creating a feedback loop that is neighbourhood based.

- A regular **meeting** held in each neighbourhood which will create a space to listen and work in collaboration.
- Community conversations **"experts by experience voice".**
- Co-produced **solutions**, **story-telling** and inviting **feedback and opportunities** to **collaborate**
- Utilising **data** and **insights** to strengthen the story
- Ensuring work is **fed back** through the neighbourhood meetings and the Alliance.



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Agenda
Item No.
7

Southend Health and Wellbeing Board

Report by

Alex Khaldi, Independent Chair, A Better Start Southend

to

Health & Wellbeing Board on 3rd March 2023

Report prepared by:

Tara Poore, Director, A Better Start Southend

	For discussion	X	For information only		Approval required

A Better Start Southend - update

Part 1 (Public Agenda Item)

1 Purpose of Report

The purpose of this report is to provide an update from the Chair of A Better Start Southend (ABSS) on key developments since the last meeting.

2 Recommendations

HWB are asked to:

1. Note the content of the report and raise questions or comments with Alex Khaldi, Independent Chair of A Better Start Southend (ABSS).

2. Note that ABSS are focussing on a Partnership Workforce Development Programme that seeks to retain skills and experience in Southend and/or the early years space whilst addressing attrition issues that are expected to start arising as the programme nears the end of the Funding period.

3 Governance

The ABSS Programme continues to benefit from strong Partnership engagement, with positive participation at a range of levels for all core Partners, including:

- Early Years Alliance
- Southend City Council
- Essex Police
- Mid and South Essex Hospital Trust
- Essex Partnership University NHS Foundation Trust (EPUT)
- Mid and South Essex Integrated Care Board
- University of Essex
- Family Action
- SAVS

As a reminder, the ABSS Programme Governance structure comprises the following Groups:

- Partnership Board - Chair, Alex Khaldi, ABSS
- Executive Consultative Board - Chair, Alex Khaldi, ABSS
- Programme Group - Chair, Krishna Ramkhelawon, SCC
- Insight and Analysis Group - Chair, Michael Freeston, EYA
- Finance and Risk Group - Chair, Paul Grout, SCC
- Parents' Group - Rolling Parent Champion Chairs
- YourFamily Partnership Group - Chair, Emma Hawker, Parent Champion.

All ABSS governance meetings continue to take place regularly and are aligned to the governance schedule, to aid with oversight and scrutiny of ABSS Programme activity.

ABSS Legacy and Sustainability Strategy

As the Programme enters into the final two years of operation, the legacy and sustainability strategy moves from being a distinct workstream to becoming the lens that all ABSS work mmust be viewed through, therefore, legacy and sustainability will become an integral business as usual element of the Programme going forward.

There are a number of pieces of work that are progressing with a legacy and sustainability thread running through them:

- Workforce Development Programme, which will consider both internal and external staff skills for delivering current services across the partnership.

- Conducting assessments of the future viability of individual projects and programmes of work alongside discussions with delivery partners about their long-term aspirations and setting out a structure of the role ABSS can play, e.g., facilitating skills-building for grant sourcing and bid writing, supporting discussions between partners to determine common agendas (e.g. breastfeeding), establishing connections between organisation where funding might be available for the continuation of integrated service delivery, supporting where organisations decide not to continue or merge with other organisations.

- Developing proposals for commissioned services to terminate, change or continue based on their achievement of outcomes and the priorities of other commissioners and public bodies.

- Development of a plan for the continuation of a partnership working approach across Southend, working closely with Southend City Council's early years team.

- Continue building the evidence for the feasibility of the development of a Centre of Excellence and determine next steps.

- Determining the legal status of intellectual property (such as branding, web addresses and service models), and information (such as that held about beneficiaries and newsletter sign-ups)

City Family Community Interest Company (CIC) was incorporated as a legal entity in September 2022, this milestone demonstrates key commitment from the ABSS Partnership to drive forward the

Legacy and Sustainability Strategy. City Family CIC has recently undertaken the recruitment of the non-founding Board members and will soon announce who is taking on these roles. A business development lead has also been recently recruitment and will work to support ABSS and City Family CIC in horizon scanning for succession funding and wider income opportunities.

Engagement of Parent Champions within ABSS (Governance) Meetings

All committees and groups include the active participation of engaged parents, with Terms of Reference stating that no meeting is quorate unless there is parent and Partner presence at each forum.

Southend Family Centres

Southend Family Centres and ABSS continue to work together to meet the needs of children and families in Southend. Exploration of opportunities to integrate further are currently taking place. As it currently stands, I chair this meeting, working alongside SCC colleagues and the Southend family network

The National Lottery Community Fund (TNLCF)

TNLCF continue to work with all five ABS sites across England and the National Children's Bureau to share best practice in workforce development, communication, research, and sustainability planning. An annual event is being organised on 16th March 2023, hosted jointly by the NCB and the five ABS sites as a virtual event, focusing on the challenge of delivering early years support in the context of the current cost of living crisis. The event is open to an external audience across public, academic, voluntary and community sectors and professional bodies.

4 Evidence Project

Programme Evaluation Partnership

The University of Essex Research team held semi-structured qualitative interviews with 55 beneficiaries for the sixth round of reporting for the Formative Evaluation, which was shared with ABSS at the end of January 2023. The interviews allowed the team to analyse beneficiaries' narratives about the impact of the ABSS programme on families and how services are being delivered. Three new projects were brought into the Formative Evaluation – Families Growing Together, Early Years Independent Domestic Violence Advocate project, and YourFamily.

In an effort to build an accessible evidence base to inform their work, the team are compiling a series of 'evidence maps' which link the existing evidence to logics underpinning specific ABSS programmes or thematic areas. This is a 'light touch' piece of work, with each visual map no longer than a single page, backed up and linked to detailed evidence and literature. The intention is to provide a primer for stakeholders wanting to understand more about the evidence base for a programme or initiative. The first of these explored what the available evidence reveals about the relationship between breastfeeding and long-term outcomes beyond early childhood. The team is now beginning the second 'evidence' map', this one relating to the relationship between early communication stiumli and long-term outcomes for children's overall development.

The second research paper arising from ABSS work: 'Making sense of organisational challenges and community resilience during Covid-19: A case-study of a multi-agency intervention tackling child poverty in England' is co-authored with ABSS colleagues and is now in the final stages of review prior to submission for publication to the British Journal of Social Work.

Independent Programme-wide Summative Evaluation

Actions from the report on Phase 1 of the Summative Evaluation prepared by independent evaluators RSM in August 2022 have been included in work planning. These actions are being monitored to ensure that the recommendations are carried through.

Phase 2 of the evaluation continues to be developed by RSM. A series of meetings with the Co-Design Group including ABSS parents, other local community members, and ABSS partners from statutory and voluntary organisations has taken place with RSM to develop the design. This included discussion about how RSM can best engage with staff, families and wider members of the community to encourage larger numbers to respond to surveys and other evaluation activities.

Outcomes Reporting

The SCC OPI Data Team continues with regular work refreshing the data dashboards and completing the Q3 Lottery return for the 2022-2023 year.

A new online dashboard has now been fully developed and deployed to assist with monitoring of consent uptake which will enable data matching for evaluation purposes by NatCen for the national evaluation of the ABS programme. The dashboard is refreshed weekly and may be accessed by SCC, ABSS and NatCen to identify the level of uptake of consent across each of the wards.

Workforce Development Programme

As the ABSS programme moves into its final stages, with core Lottery funding ending on 31st March 2025, planning for the longer-term legacy of ABSS is underway. At the same time, new challenges around maintaining the delivery of effective services towards the end of contracted periods, and ensuring that the people involved in providing those services have successful transitions into whatever comes next, have come to the fore. While some services and job roles will continue in a similar form to currently, others will change significantly or come to an end. Such periods of change present opportunities, but also include significant levels of uncertainty.

This Workforce Development Programme recognises these opportunities and challenges. It outlines areas where the ABSS partnership can support individuals and the services they work within to identify and address challenges, to make the most of opportunities, and to ensure that the learning and insights from the ABSS programme have a positive influence in Southend beyond 2025.

The nature of this work has moved from being a Workforce Development Strategy to a Workforce Development Programme, to reflect that it sits within other wider strategic work and is focused on actions to take progress in this area forward. A draft version of the Programme is being developed by a small group within the team and will be shared more widely in coming weeks. This includes consideration of the results of a survey about immediate training needs and longer-term training aspirations for ABSS core staff, to identify areas where ABSS can offer opportunities to staff. It also considers the needs of wider workforce groups, including staff employed by Delivery Partners, volunteers, and the wider Early Years workforce in Southend.

Festival of Conversations

The evaluation of the ABSS Festival of Conversations has been completed.

In total, 40 events were held during the two weeks of the Festival. The evaluation identified that the Festival was successful at attracting its intended audience and delivered a series of varied and enjoyable events in venues across Southend. 512 adults and 413 children registered at events (397 being unique individuals). Many of these had not previously engaged with ABSS, including families

living outside ABSS wards. Many parents reported that events had a positive impact on their children, in particular allowing them to interact with other children, build their confidence and try out new activities or new experiences. Parents also reported that events increased their knowledge of specific topics, gave them ideas of activities to try and new ways to interact with their children, and allowed them to spend time together as a family or meeting other parents.

Recommendations arising from the evaluation focused on planning processes and timing, roles and responsibilities, and ensuring sufficient resources were in place to allow all activities to be carried out and timetables to be adhered to. Consideration was also given to the timing of any future Festival.

An extract of the ABSS Data Dashboard titled '**Partnership Board Programme Activity Summary'** is shown in **Appendix One**

5 Programme Activity and Reach

The number of beneficiaries engaging with the ABSS programme continues to increase.

- Between 1st April 2015 and 31st December 2022, a total of 5,980 unique primary beneficiaries engaged with the programme.

- In the 12-month period to 31st December 2022, there were 2,114 primary unique beneficiaries, representing 46.2% of those eligible.

- This was a rise from 1,922 unique beneficiaries (42% of eligible) in the 12 months to 31st December 2021.

- Of the 2,114 unique beneficiaries in the 12 months to 31st December 2022, 1,050 were new beneficiaries engaging with ABSS for the first time. This was a small rise from 1,028 in the same period the previous year.

- The highest level of reach was seen in Shoeburyness ward, with 57.2% of those eligible participating in the year to 31st December 2022.

- The lowest was in Westborough ward (39.2%), however Westborough also saw the largest change in its reach during that period, rising from 32.5% in the 12 months to 31st December 2021.

Looking at reach by target areas for deprivation (deciles on the Index of Multiple Deprivation) in the 12 months to 31st December 2022:

- 51.3% of those eligible living in areas of the highest deprivation (0-10% IMD), up from 45.7% in the previous 12-month period.

- Engagement also rose with those living in the second-highest target areas (11-20%, rising from 39.1% to 44.6%) and third-highest target areas (21-30%, rising from 43% to 47.4%) during the same period.

Commissioned Services

Examples of some key Programme highlights are included below: Listed detail – Appendix Two

Perinatal Mental health

Data from Q2 and Q3 (July to December 2022) indicates that there were 233 (54 new) beneficiaries accessing the Perinatal Mental Health Visitor Service, a slight increase in the number of beneficiaries compared with the previous reporting period (Q4 and Q1, 2022) where there were 222. The reach of the service into areas of significant deprivation – according to SCC – at present is reported to be 82.8%. The representation of non-white beneficiaries engaging with the service is currently reported as 26% and a slight increase in the reach of the service into areas of high deprivation (from 80.6% to 82.8%). Data on adults attending the service by relationship to child shows the participation of 36 fathers, which represents fathers' participation at 15.5%, a slight increase of 1.6% from the previous reporting period.

In a recent survey of those beneficiaries who received specialised health professional visits (one to one) 75% 'strongly agreed' that support from a specialist mental health visitor had led to '*feel(ing) better equipped to cope with my thoughts and feelings'*. A majority of respondents (84.24%) agreed that they had developed 'strategies, tips or other types of support' through their involvement with the service.

All respondents (100%) reported that it was easy to take part in the Perinatal Mental Health visiting service.

PIP'S Treasure Hunt

PIP's Treasure Hunt is an activity-based event that is co-produced by the Treasure Hunt Team made up of ABSS Parent Champions, ABSS Engagement Team, ABSS Marcomms, Your Family Connectors, SAVS Community Builders and ABSS Project Management Team. It is supported by local organisations and businesses including Southend Family Centres, SAVS, Trust Links, Southend City Libraries, Little Heroes, Little Libraries, Southend Museums, METAL, The Ironworks and The Haven Community Hub.

The aims of the PIP's Treasure Hunt are to:

- Create activities families can enjoy together.
- Support families during costly school holidays by providing free activities.
- Encourage families to visit local outdoor or community spaces.
- Ensure all families living in ABSS wards can participate regardless of family size, income, or transport available to them.
- Build awareness of PIP and the ABSS Programme.

PIPS's Treasure hunt is taking place in the school Easter school holidays from 1st – 16th April 2023. During the event images of PIP, tasks and information regarding ABSS will be "hidden" at participating venues across Southend City.

There are two types of locations, the first being places images and text can be safely displayed without the worry of being taken down/lost e.g., inside a window. The second are places where no safe display area is available, like parks, where GPS will automatically award points and bonus tasks will be presented within the app.

Families can play the treasure hunt by downloading a free app that lists the locations players can find PIP and/or collect points, there is a fair representation of locations within each ABSS ward allowing families to walk to several locations near their home to collect points. The top 10 teams will be listed on a scoreboard within the app.

Points will be awarded for:

- Getting to an identified location (the players phone does this automatically using GPS).
- Finding PIP and scanning a QR code.
- Answering PIP's questions (these can be time limited).

The app allows users to download tasks before leaving the house/wi-fi location then complete tasks without needing to use mobile data.

A marketing strategy combining online, and printed advertisements will be co-produced by the ABSS Marketing Team and Parent Champions. Your Family Connectors, the Engagement Team, and Parent Champions will oversee distribution of marketing flyers along with willing partners such as Trust Links, the Parent & Community Hub, Welcome2theUK etc.

The app will not collect players contact details so where possible feedback will be encouraged via a QR code displayed on the app and within game print outs.

Family Support Workers for Social Communication Needs

During quarter three the project supported 21 families, 11 families were supported face to face and 10 chose a combination of face to face and virtual contact. 19 families were supported longer than 6 weeks and this has been the case all year to date and is responding to the increasing level of need families are presenting with.

This project signposts families to a range of additional services with the majority, 111, going to ABSS projects, 68 to health services followed by approximately 25 to charities, organisations to support equipment needs and organisations that offer grants and financial support.

Details of all ABSS programmes in delivery are attached for reference - see Appendix Two

6 Programme Management Office

The Programme Management Office (PMO) recently reviewed and realigned areas of responsibility within the team. Within the Project Team, Julie Lannon will now lead on the Communication and Language and Community Resilience workstreams and Nicky Ficken will lead on Diet and Nutrition and Social and Emotional. Nia Thomas will be providing leadership of the YourFamily team aligning this with the Legacy and Sustainability work.

Human Resources

Vacancies have recently been filled for the Communications and Marketing and Research, Evaluation and Impact Lead roles. Melanie Larke will be commencing as Communications and Marketing Lead from mid-February and final onboarding checks are being completed for the candidate for Research, Evaluation and Impact Lead with the hope that they will be starting at the end of February. Job advertisements for fixed-term Officer and Administration positions within these areas will soon be completed to bring the teams up to full capacity.

All future vacancies within ABSS will be reviewed by the Senior Programme Team as they arise to ensure they are aligned with the Legacy and Sustainability plans and the end of the funding period in 2025.

Inform2 Customer Relationship Management System

Inform2 is the cloud-based customer relationship management (CRM) system which is initially being used by the (ABSS) YourFamily Team and Southend City Council's Family Centre's Family Support

Team for case management and future reporting purposes, with a vision to roll-out wider in the coming year.

Since the implementation of the new project management structure project plans and a series of standardised documentation has been put together, designed to guide the control and execution of the project through its lifecycle.

It is expected that development work for final front-end team and parent use will commence in mid-February with an expected go live date of end of March.

7 Communications and Marketing

The Start for Life Guidance in relation to the Start for Life Offer will be reviewed and good practice will be drawn on to ensure that the information provided to Southend families is accessible, clear, accurate and updated.

Work has been underway to build the new Communication & Language webpage which is currently under review and is nearing completion.

Social media output continues to promote ABSS and YourFamily updates, relevant national campaigns and news from our Delivery Partners. However, a review of the ABSS social media strategy is required to encompass the necessary messaging of Legacy and Sustainability while keeping the community aware of current news and support.

On the lead up to Christmas ABSS ran a Cost-of-Living social media advent calendar campaign with the purpose to signpost the community to local support that's available.

Short term plans include:

- working with Safe Steps to create videos aimed at professionals to support families with young children where domestic abuse is being experienced,
- providing marketing support for the promotion of Pip's Treasure Hunt during the Easter holidays using an Actionbound app,
- promotion of Herd In The City for which ABSS have sponsored and will have of an elephant sculpture in the trail, and
- further developing Southend Supports Breastfeeding which will grow in visibility over the coming months with the main focus being World Breastfeeding Week in August.

8 Reasons for Recommendations

ABSS Governance have reviewed and approved activities at the appropriate level. The Health and Wellbeing Board are asked to:

1. Note the contents of the report and raise opportunities with Tara Poore, ABSS Director or Alex Khaldi, Independent Chair of A Better Start Southend (ABSS).

2. Note that ABSS are focussing on a Partnership Workforce Development Programme that seeks to retain skills and experience in Southend and/or the early years space whilst addressing attrition issues that are expected to start arising as the programme nears the end of the Funding period.

9 Financial / Resource Implications

There are no financial/resource implications for this report.

10 Legal Implications

. There are no legal implications for this report.

11 Equality & Diversity

There are no equality and diversity implications for this report.

12 Appendices

Appendix One – ABSS Partnership Board Programme Activity Summary
Appendix Two - ABSS Project Names and Workstreams

Tara Poore, Director, ABSS

3rd March 2023

Partnership Board Programme Activity Summary

Produced by the Operational Performance and Intelligence Team

22/02/2023

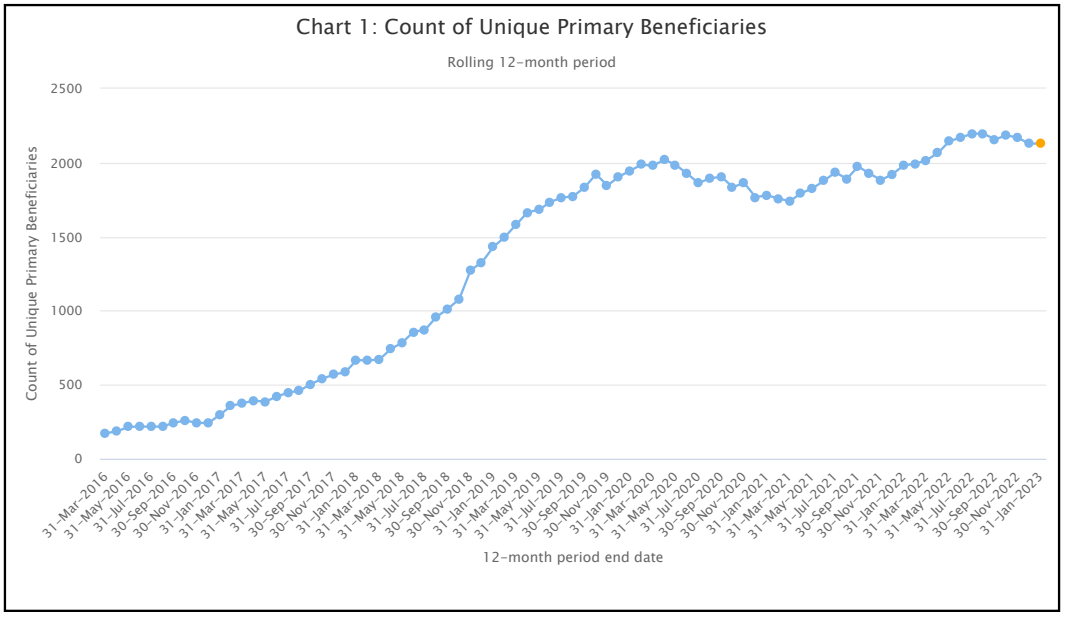
This short extract is based on the ABSS Programme Activity Dashboard for the period ending **31-Jan-2023**.

For further details please click the following link to view the full dashboard:
https://sbcdata.shinyapps.io/ABSS_Programme_Activity/
(https://sbcdata.shinyapps.io/ABSS_Programme_Activity/).

Section 1 - Programme Reach

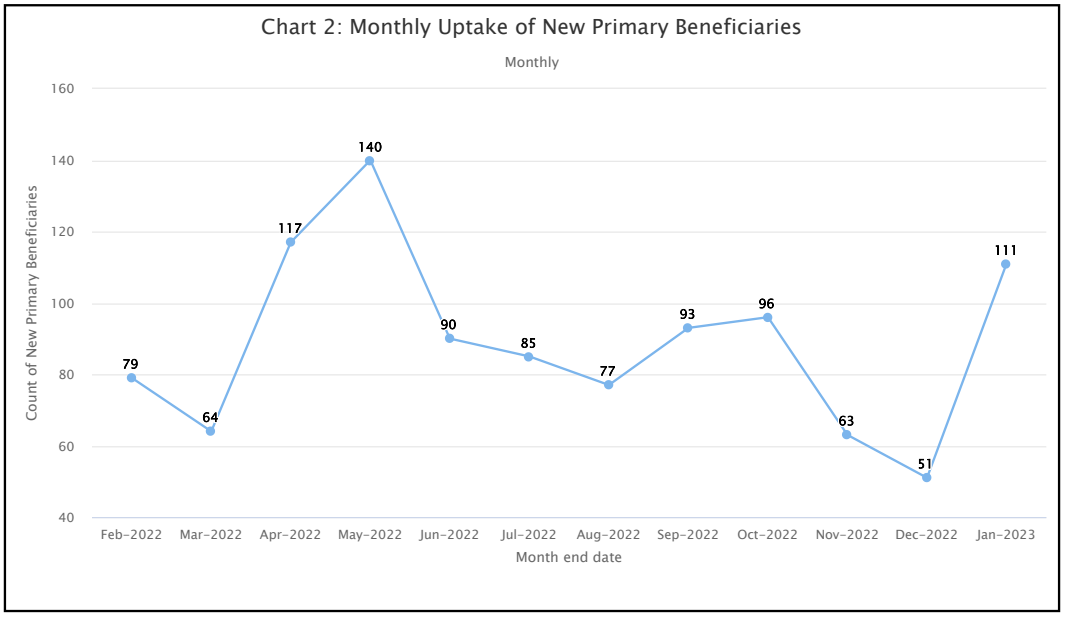
The total number of beneficiaries of the A Better Start Southend programme since April 2015 is now **6104**, which has risen from **5993** at the end of the previous month.

As chart 1 below shows, reach has continued to grow during the life of the programme and the total number of beneficiaries of A Better Start in the past 12 months was **2130**. This represents **46.6%** of all potential beneficiaries and is amongst the highest proportions achieved since the start of the programme. Growth in reach had been consistent since November 2021 indicating a recovery from the effects of Covid, although there has been no further since July 2022.



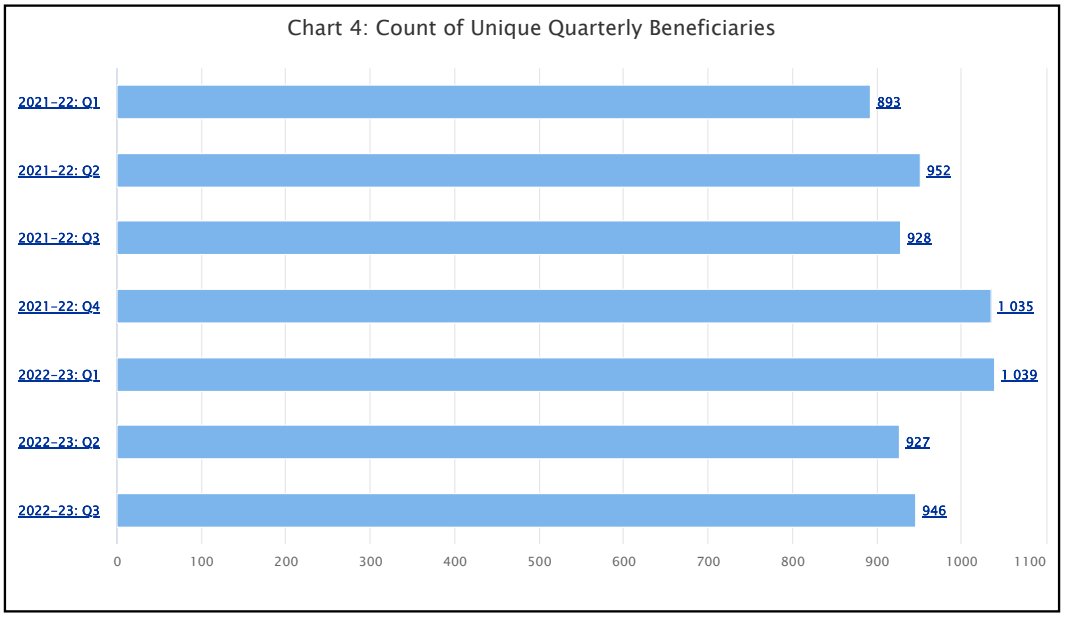
Section 2 - New Primary Beneficiaries

Chart 2 shows that new families continue to be introduced to the programme each month and the number of new beneficiaries shows a peak at the start of the new calendar year.

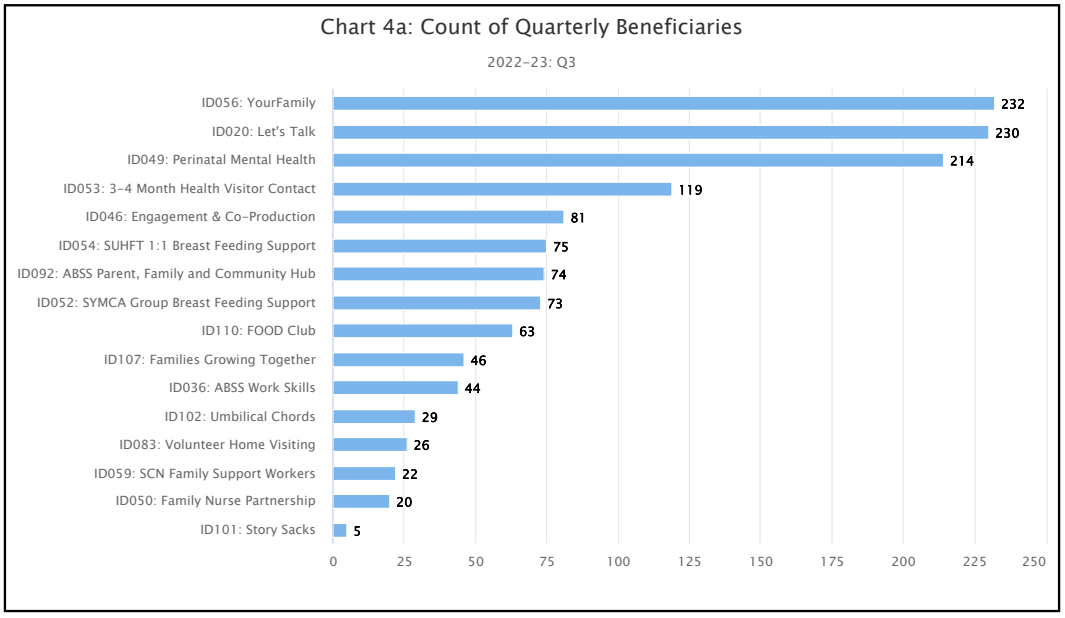


Section 3 - Project Delivery

As Chart 4 from the Programme Activity Dashboard shows below, quarter 1 (Apr - Jun) of the current financial year was the busiest quarter and activity has reduced to some extent since that period.



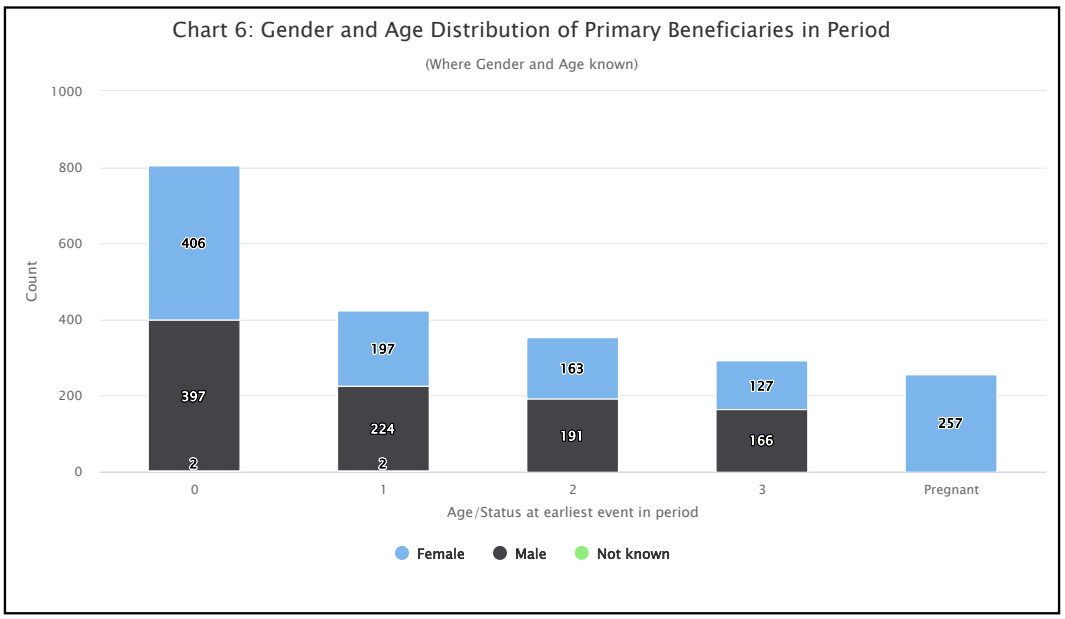
Quarter 3 of 2022-23 is displayed in Chart 4a at project level, showing the relative reach of each project in terms of numbers of primary beneficiaries. Note that the YourFamily project which was live from April 2022 is now included in project data and is now reporting the largest number of primary beneficiaries of all projects.



Section 4 - Age and Gender

Chart 6 extracted from the Programme Activity Dashboard below shows that there is a fairly even distribution of male and female beneficiaries and that there is an emphasis on engaging children from the earliest stage in their lives (i.e. age 0).

The number of pregnant primary beneficiaries that participated in the past 12 months has decreased from **323** for the equivalent 12-month period ending one year ago.

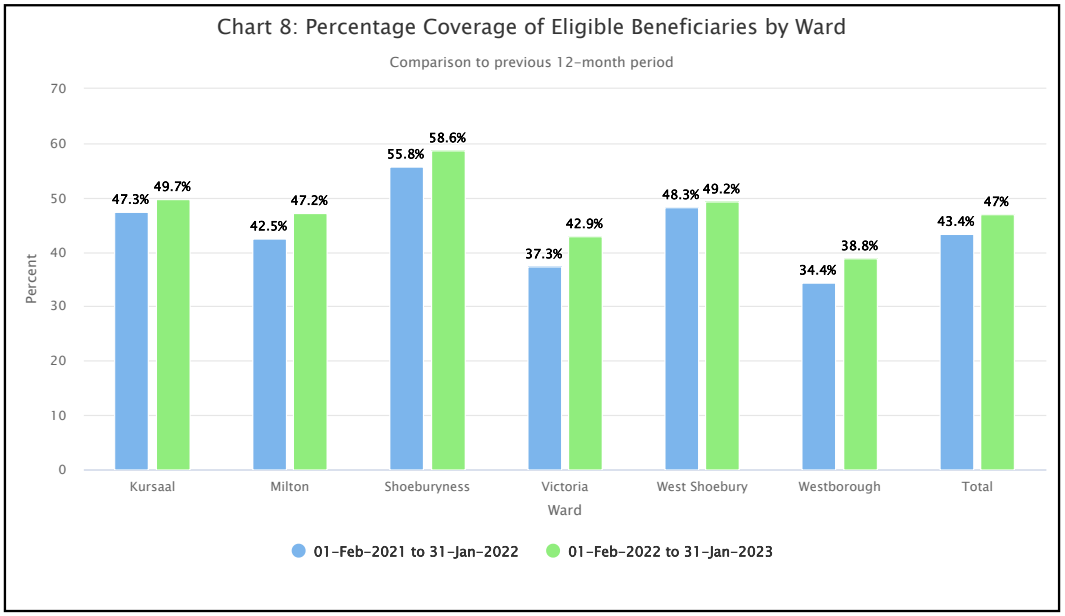


Section 5 - Delivery by Ward

Chart 8 extracted from the Programme Activity Dashboard shows a comparison of the percentage of eligible primary beneficiaries that have participated in an ABSS project during the past 12 months compared to the previous 12-month period. Over the combined ABSS wards (see the far right-hand bars) this percentage has increased and this is also the case for each of the individual wards.

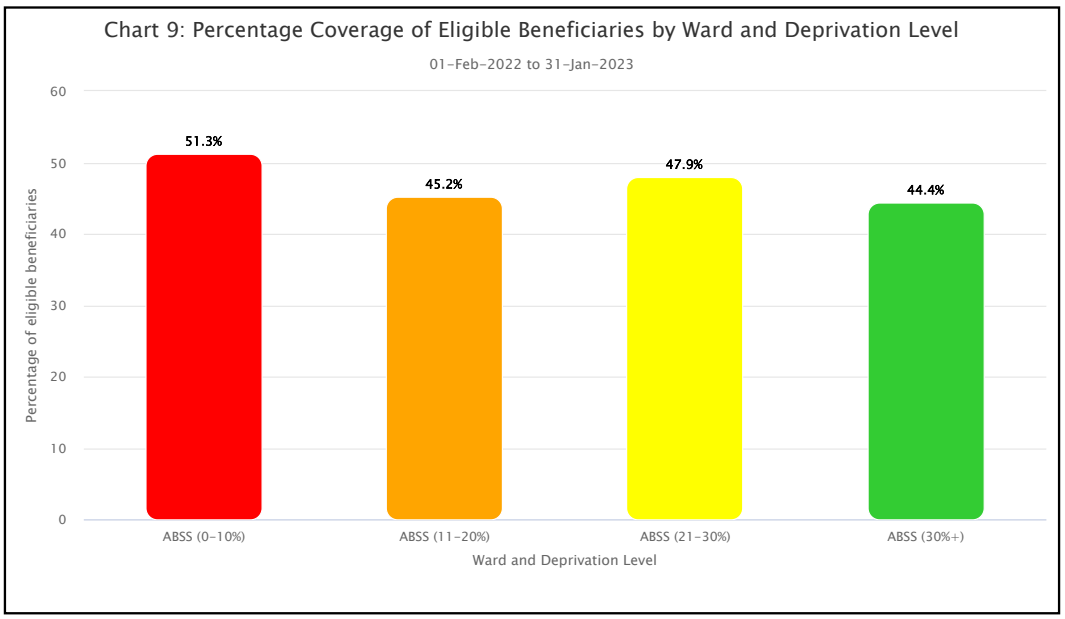
Reach within the Kursaal, Milton, Shoeburyness and West Shoebury all equal or exceed the average reach across the entire ABSS wards and reach in Victoria and Westborough is below the overall average.

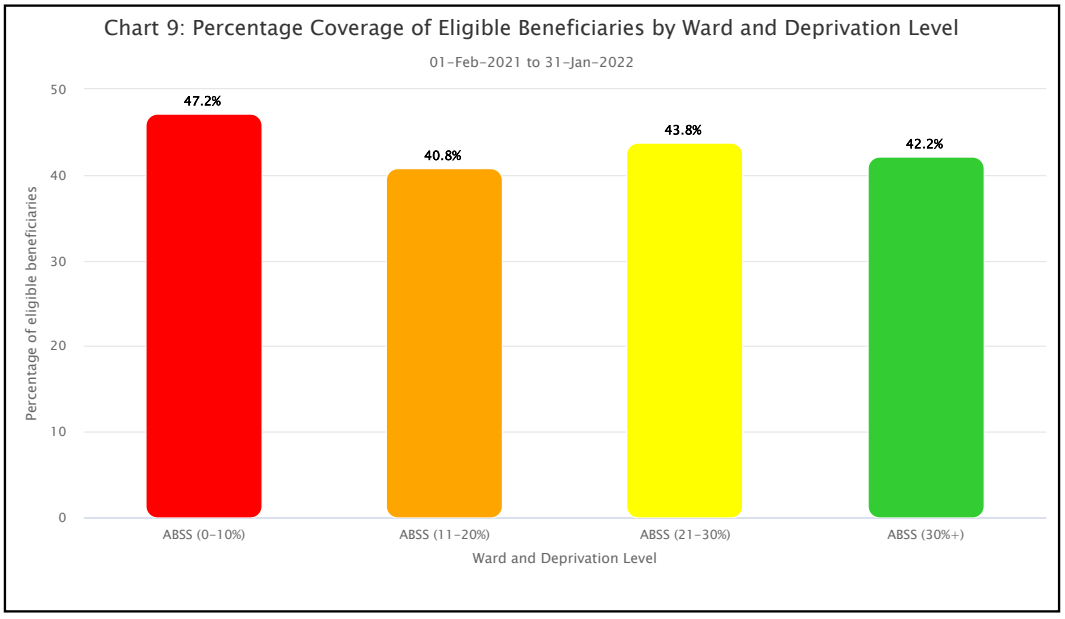
The difference in reach between the wards with the highest and lowest reach is **19.8** percentage points.



Section 6 - Delivery by Deprivation Level

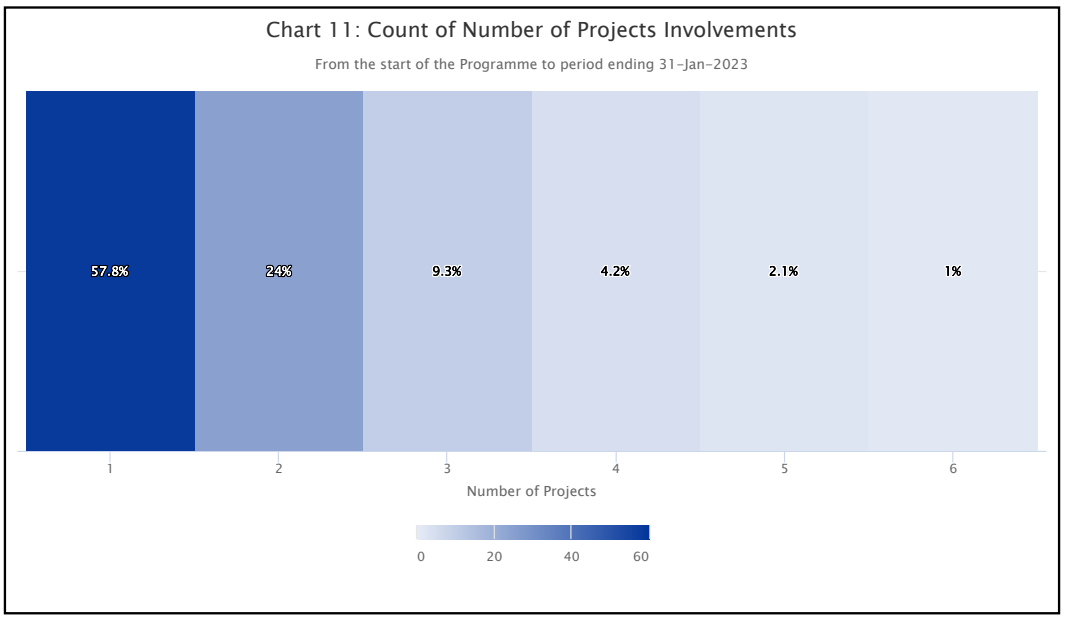
The two charts below are partial extracts from the Programme Activity Dashboard and show a comparison of percentage delivery to all eligible beneficiaries for the current and previous 12-month delivery periods, by deprivation deciles. The top chart shows the most recent 12-month period and displays a higher level of reach in the most deprived areas (red bars). The percentages for all deprivation areas have increased from the previous 12 month period.





Section 7 - Participation in Multiple Projects

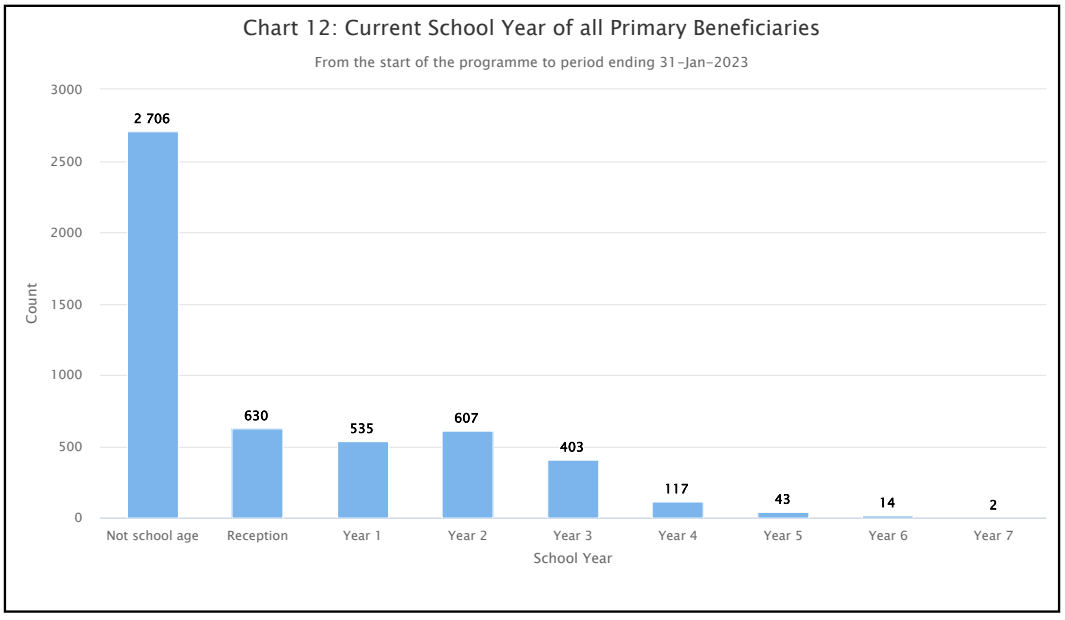
This chart shows the percentage of beneficiaries that have been involved in multiple projects over the course of the programme. For example, **42.2**% of all beneficiaries have been involved in more than one project, which demonstrates a good linkeage between projects and retention of beneficiaries.



Section 8 - Current School Year of Primary Beneficiaries

This final chart shows the current school year of all current and past primary beneficiaries. This is helpful when considering that a number of outcome measures reported to the National Lottery Community Fund are age-related. For example, the Early Years Foundation Stage Profile (EYFSP) and one of the National School Measurement Programme (NCMP) measures are taken during the reception year. The ability of A Better Start to improve these population-level outcomes is dependent on a significant proportion of those children being reached by the ABSS Programme.

For further details of outcome measures please click the following link to view the full dashboard: https://sbcdata.shinyapps.io/ABSS_COF_Tool/ (https://sbcdata.shinyapps.io/ABSS_COF_Tool/).



End of document.

Appendix Two- Project Names and Workstreams

Project ID	Project Title	Work Stream	Budget Work Stream	Delivery Status	Delivery Partner
ID054	**121 Breastfeeding**	D & N	D & N	In Delivery	MSE Hospital Trust
ID052	**Group Breastfeeding**	D & N	D & N	In Delivery	YMCA
ID053	**3 - 4 Month Contact**	D & N	D & N	In Delivery	SCC
ID025	**HENRY Healthy Families**	D & N	D & N	Closed	HENRY
ID087	**Southend Supports Breastfeeding**	D & N	D & N	Mobilisation	SCC & EYA
ID088	**Infant Feeding Supervisor Lead**	D & N	D & N	In Delivery	SCC
ID089	**Maternal Healthy Weight**	D & N	D & N	Paused	TBD
ID095	**UNICEF Accreditation**	D & N	D & N	Paused	TBD
ID097	**Public Health Midwife**	D & N	D & N	In Delivery	SCC & EPUT
ID110	**FOOD Club**	D & N	D & N	In Delivery	Family Action
ID050	**Family Nurse Partnership**	S & E	S & E	In Delivery	EPUT
ID049	**Perinatal Mental Health**	S & E	S & E	In Delivery	EPUT
ID061	**Preparation for Parenthood**	S & E	S & E	Closed	HENRY
ID083	**Volunteer Home Visiting Service**	S & E	S & E	(ending 31/03/23)	Home Start
ID107	**Families Growing Together**	S & E	S & E	In Delivery	Trustlinks
ID104	**IDVA**	S & E	S & E	In Delivery	Safe Steps
ID020	**Let's Talk**	C & L	C & L	In Delivery	EPUT
ID082	**WellComm Screening**	C & L	C & L	In Delivery	EYA
ID091	**Talking Transitions**	C & L	C & L	In Delivery	EYA
ID109	**Sensory Story Time**	C & L	C & L	Paused	Chaos and Calm
ID101	**Story Sacks**	C & L	CR	In Delivery	SAVS
ID102	**Umbilical Chords**	C & L	CR	In Delivery	YMCA
ID046	**Engagement**	CR	CR	In Delivery	SAVS
ID064	**Engagement Fund**	CR	CR	In Delivery	SAVS
ID084	**CID Fund (Process and applications)**	CR	CR	In Delivery	N/A

ID086	**Coproduction Champion**	CR	CR	Now part of Engagement	SAVS, EYA, SCC
ID036	**Work Skills**	CR	CR	In Delivery	SCC
ID103	**Engagement Fund COVID-19**	CR	CR	Closed	SAVS
ID115	**Hamlet Court Road in Harmony**	CR	CR	Paused	
ID116	**Festival of Conversation**	CR	SC	Paused	Bromfield Events & various partners
ID059	**FSW SCN**	SE	S & E	In Delivery	East Anglia Hub
ID056	**Your Family**	DD	S & E	In Delivery	EYA/ABSS
ID092	**ABSS Parent, Family and Community Hub**	DD	CR	In Delivery	ABSS
ID081	**Welcome to the UK**	SC	SC	In Delivery	Welcome to the UK
ID099	**Data Input - ESTART**	SC	SC	In Delivery	SCC
ID080	**First and Foremost**	SC	SC	Closed	EYA
ID079	**The Dartington Service Design (0-19 mapping)**	SC	SC	Closed	Dartington
ID078	**SCC Data Analysis**	SC	SC	In Delivery	SCC
ID048	**Joint Paediatric Clinic**	SC	SC	Paused	TBD
ID090	**Programme Evaluation Partnership**	SC	SC	In Delivery	UoE
ID106	**RSM Summative Evaluation**	SC	SC	In Delivery	RSM
ID098	**Information Governance Specialist Consultant**	SC	SC	In Delivery	Data Protection People
ID108	**Digital Strategy (Inform)**	SC	SC	In Delivery	SCC & ABSS
ID114	**Centre Place**	SC	D & N	Service Design	

Southend Health & Wellbeing Board

Agenda Item No.

8

Report of the Director of Public Health

To

Health & Wellbeing Board

on

6th March 2023

Report prepared by: Krishna Ramkhelawon,
Director of Public Health

For information only	X	For discussion		Approval required	

Health Protection Update
Updates from the Health Protection Board and the Oversight and Engagement Board

Part 1 (Public Agenda Item)

Purpose

This is to provide an update on-going management of the COVID-19 and wider Health Protection response.

Background

We are now learning to live with Covid whilst continuously reviewing the evolution this virus and its impact on our communities. Collectively, we continue to play an important role in the ongoing management of local outbreaks.

Other areas of concern for health protection are now our renewed focus, including any emerging new challenge posed across the country. We have also being working to drive up the uptake of MMR, DTP (diphtheria, tetanus and pertussis) Flu and Covid booster vaccines.

Local Boards Activities

The Health Protection Board (HPB) meets monthly and continues to receive the local Health Protection Surveillance Report and necessary actions – last meeting 30th January 2023.

As of the 23rd February, the Covid-19 rates is 46.5 per 100,000, which is slightly below the East of England rate of 49.6. This is slight upward trend since the start of February 2023.

The Council and UKHSA continue to work closely with care homes which are the higher risk settings for transmissions and consequential impact on health and wellbeing. As at the 24th February, we had only one care home with a Covid outbreak but none with flu outbreak.

We are completing a few more community vaccination clinics till the end of March, when the Flu immunisation season will be over.

There has been a marginal increase in Covid admissions to hospital, in the week commencing 20th February, but this is still within expected range for this time of the year.

In early January, the smallpox vaccination service has been transferred from the current sexual health service provider (Brook Southend) to a local pharmacy, to allow Brook Southend to recover any backlog in our sexual health services, which resulted in this emergency response. There is good report on access to this service.

Other health protection risks, including infection from Strep A/iGas are minimal and being managed effectively by UKHSA currently.

The Health Protection Oversight and Engagement Board provides leadership on our communication and engagement activities, including refreshing our messaging to the public and local businesses. The Board's remit has moved to cover the wider remit of health protection matters – last meeting was held on the 11th January 2023.

No key action was necessary from the Board.

For Noting

1. For the HWB Board to note on the on-going operations and steer of these two sub-committees.

Mid and South Essex Integrated Care System

SOUTH EAST ESSEX ALLIANCE ENGAGEMENT

IN PARTNERSHIP WITH

Better Together Cavs · SAVS Southend Association of Voluntary Services · RAVS

WHO IS THIS NETWORK FOR?

As part of this work, we have launched a new South East Essex Communications and Engagement network. This network is open to everybody and is a great space to get involved and grow your own work. By joining the membership, you will:

- Receive regular, relevant information about what is happening for and within South East Essex.
- Be invited to join workshops, meetings and networking events to connect with partners and build relationships.
- Get support from the network to help you build promotional materials and push your messaging out to more people.
- Find out about what communities already have in place and how you can build on & link with them.
- Be able to use the network to test an idea with a particular group of people and reach the right people for your work.

Want to get involved? Sign up here

WHAT WE WANT TO ACHIEVE

DISTRIBUTION & ANALYSIS

The network can support you with identifying the best places for you to distribute to ensure maximum impact. Through peer support, you can also get help to shape your assets

COMMUNITY LEADERS

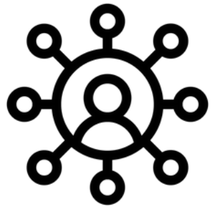
Working with community leaders like you to deliver regular, relevant information and equipping you to share with your audience and users

CO-PRODUCTION

Supporting you with any testing or resident engagement work to make sure the right people are engaging.

ASSETS FOR OUR COMMUNITIES

Using the voice of our residents and partners to shape local assets that are relevant to your community/communities



COMMUNICATIONS & ENGAGEMENT NETWORK

Connecting Rochford, Castle Point & Southend to spread your message further and reach new people

LINKING UP OUR WORK WITH THE SYSTEM

Sharing everything we do locally up the chain to drive change at a local and a wider system level

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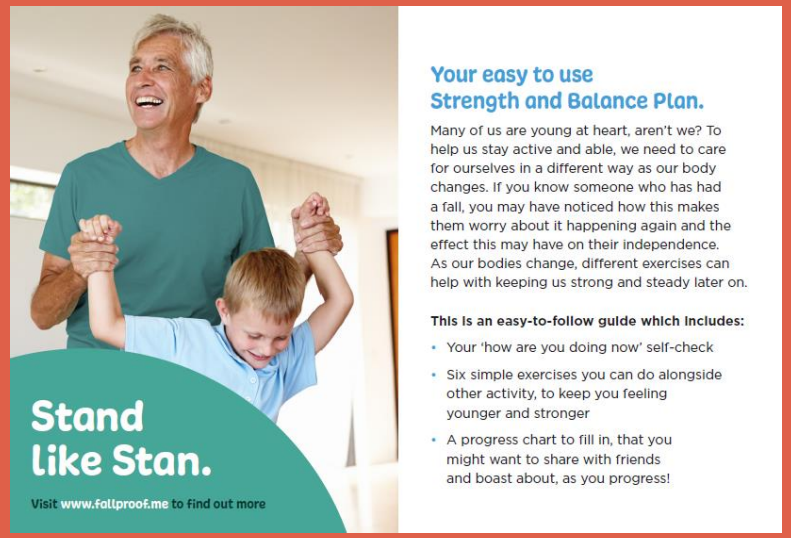
we can move

Fall-proof

Strength and balance plan

Campaign materials



Your easy to use Strength and Balance Plan.

Many of us are young at heart, aren't we? To help us stay active and able, we need to care for ourselves in a different way as our body changes. If you know someone who has had a fall, you may have noticed how this makes them worry about it happening again and the effect this may have on their independence. As our bodies change, different exercises can help with keeping us strong and steady later on.

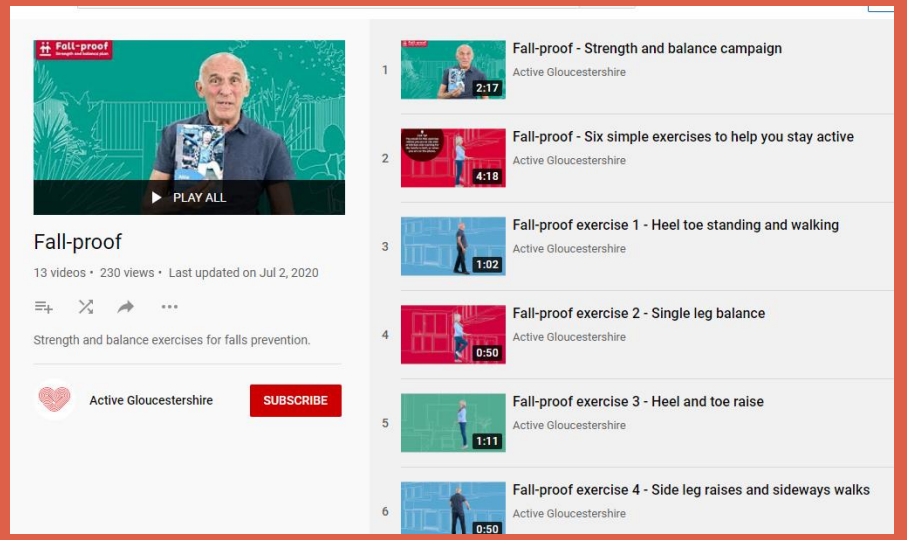
This is an easy-to-follow guide which includes:

- Your 'how are you doing now' self-check
- Six simple exercises you can do alongside other activity, to keep you feeling younger and stronger
- A progress chart to fill in, that you might want to share with friends and boast about, as you progress!

RESOURCE

Fall-proof champions

Are you an inspirational individual who want to support older adults?



Your progress chart.

Remember to repeat this seven day progress chart every week to monitor your progression over time.

Name:

Date:

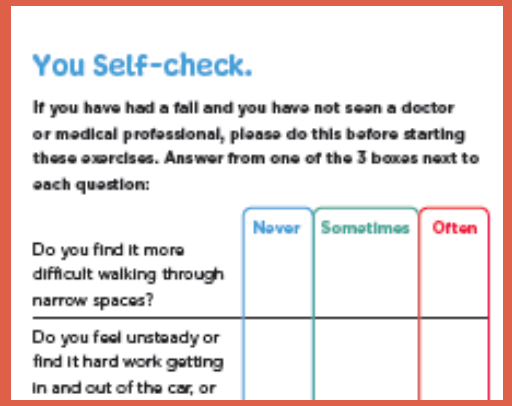
	Day one	Day two	Day three
Heel to toe standing and walking			
Single leg balance			
Heel to toe raise			
Side leg raises and walks			
Sit to stand			
Stepping up a step			

Sit to stand score after one month: ☐ **Sit to stand score after two months:** ☐

Collateral designed applying COM-B intervention functions

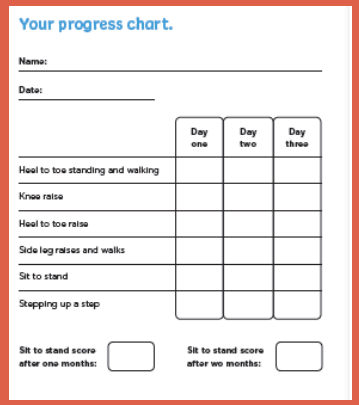
111

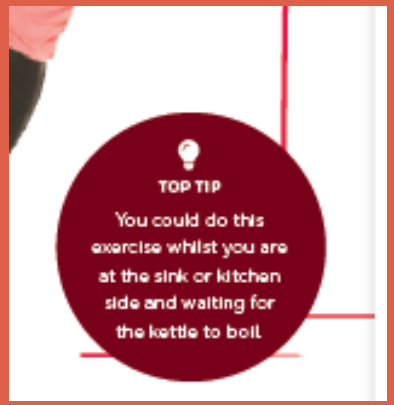
Modelling and persuasion - Catchy strapline related to benefits of behaviour and relevant imagery



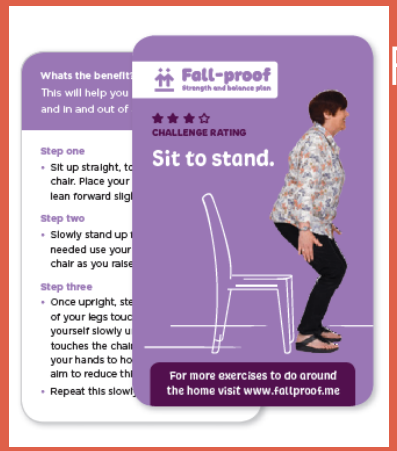
Education - Self check on daily activities

Enablement and training – self regulation





Tips on how to embed the behaviours – habit stacking



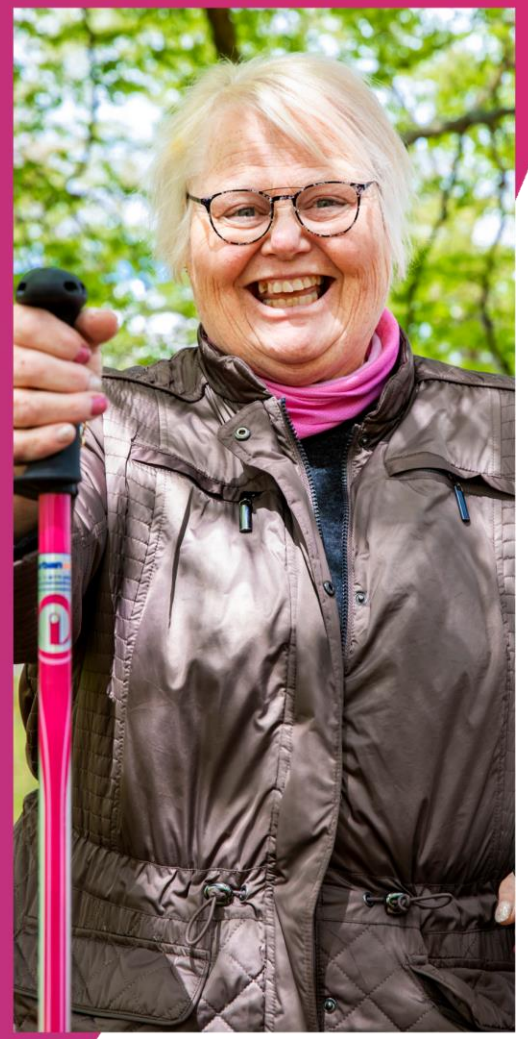
Prompts to remind you to do the behaviour – Environmental restructure in the home

Underpinning Fit for the Future, is the Find Your Active campaign, which will amplify the messaging and agenda of this new 10-year strategy.

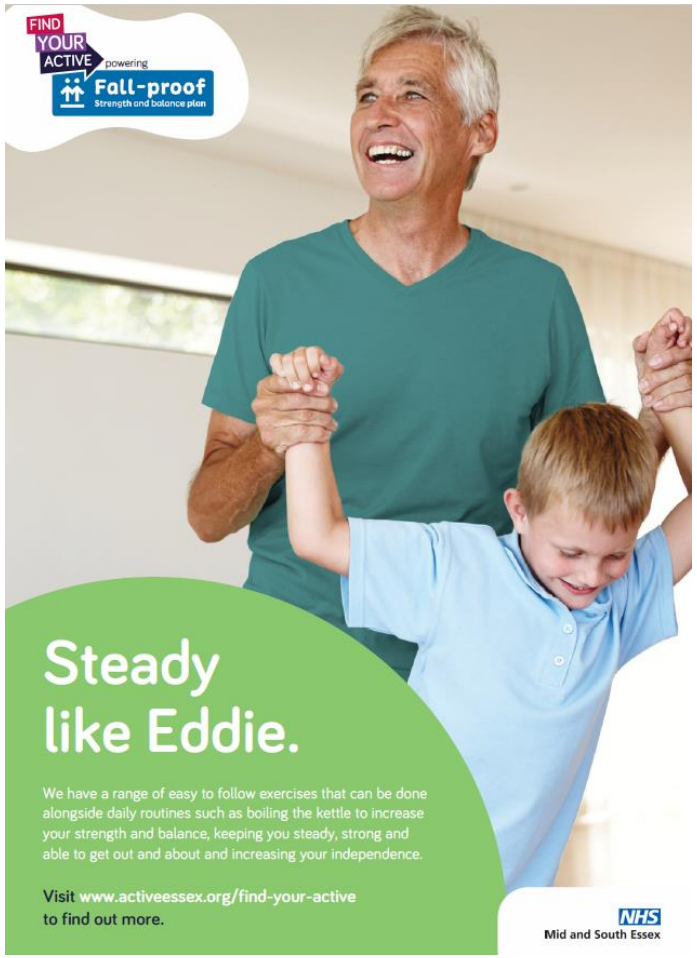
The Find Your Active campaign celebrates the fact that everyone can enjoy the huge benefits of being active - it's just about finding what is right for you. Find your Active shines a light on all of the different ways and opportunities to get active around Essex.

Find Your Active aims to bring together all of the providers of physical activity and sport in Essex to promote their offer using the same brand with a clear message that being active is fun, good for you, and for everyone. Many people need support and encouragement to be active, which is why Find Your Active encourages every community to have an ambassador to champion movement.

There are lots of ways to get involved in the Find Your Active campaign, just head to: www.activeessex.org/find-your-active/




FIND YOUR ACTIVE powering Fall-proof Strength and balance plan
Strong like Ron.
We have a range of easy to follow exercises that can be done alongside daily routines such as boiling the kettle to increase your strength and balance, keeping you steady, strong and able to get out and about and increasing your independence.
Pick up a movement guide or visit www.activeessex.org/find-your-active to find out more.
NHS Mid and South Essex


FIND YOUR ACTIVE powering Fall-proof Strength and balance plan
Steady like Eddie.
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FIND YOUR ACTIVE powering Fall-proof Strength and balance plan
Able like Mabel.
Your easy to use guide for exercises at home.


FIND YOUR ACTIVE powering Fall-proof Strength and balance plan
Tell us your story!
Show us your progress and become an inspiration to others.
administration@activeessex.org
@ActiveEssex
www.activeessex.org
Going past the stairs?
Now's the time for... stepping up a step.
★★☆☆
CHALLENGE RATING
Stand like Stan.
NHS Mid and South Essex


FIND YOUR ACTIVE powering Fall-proof Strength and balance plan
Tell us your story!
Show us your progress and become an inspiration to others.
administration@activeessex.org
@ActiveEssex
www.activeessex.org
Making a bite to eat?
Now's the time for... heel and toe raises.
★☆☆☆
CHALLENGE RATING
Steady like Eddie.
NHS Mid and South Essex

Key Next Steps – Website

Able Like Mabel page on the Active Essex Page is here: https://www.activeessex.org/able-like-mabel/

On here, we will host:

- Expression of interest form for partner organisations wishing to receive Able Like Mabel resources to distribute to residents, patients and clients
- Downloadable booklet and activity cards for anyone to be able to download and access in digital / print yourself format
- YouTube video links that complement the booklet
- *Find Your Active near you* button – linking to the Find Your Active Activity finder which is open data compliant and free for organisations to add sessions to
- Link to advice on how to *Find Your Active* for the first time
- Link to contact information for your local *Find Your Active Community Connector* who can call residents to share information of local community groups and classes and attend a session with them if they feel nervous or would like support

Key Next Steps – Printing and Distribution

Physical resources

- Orders made through Active Essex website
- Active Essex will order packs for print and collate at county hall
- Packs will be distributed either via from county hall direct to organisations or sent to local pick up points for collection
- Initial print run of 10k will include CPR&S logos specific, website downloadable resources and future resources will be MSE
- Partner form to include request for AE to allow for progress updates

Key Next Steps – Marketing and Comms

- For SEE, an initial list of organisations and contacts has been collected by Jo Tyler, these will be directly emailed requesting them to officially request packs via the Able Like Mabel webpage.
- A FYA communication and marketing toolkit will be sent to SEE Alliance for wider distribution, this will include newsletter, website and social media copy and assets
- Three phase comms plan, Active Essex will send partners:

Friday 17th February:
Full update, website made live, partner organisations information to express interest in receiving packs live.
Monday 20th February:
Marketing and communication pack sent to partners, which will include comms, press release, social media posts, assets and graphics for future posts
Thursday 23rd February 10am: Press release and first comms will be scheduled for release
Mid March: First printed resources distributed
Ongoing: Regular sharing of good news stories and updated comms toolkit

We're committed to ensure resident stay active and independent for longer! The #FindYourActive #AbleLikeMabel resources are a great way to engage with residents to encourage them to introduce small movements to the daily routine, whilst feeling supported to do so. Explore more here: www.activeessex.org/able-like-mabel