Mid and South Essex Integrated Care System

Meeting of Mid and South Essex Integrated Care Partnership (ICP)

Date: Monday 20 March 2023
Time: 13.00 - 16.00
Venue: Council Chamber, Civic Centre, Duke St, Chelmsford CM1 1JE

1. Coffee & Networking

Lead: Professor Michael Thorne CBE, ICB & ICP Chair
Time: 13.00

2. Welcome and Apologies

Lead: Professor Michael Thorne CBE, ICB & ICP Chair
Time: 13.15

3. Governance – Conflicts of Interest

Action: To Note
(i) For members to raise any declarations of interest relevant to the agenda & purpose of the ICP.
Papers: Verbal
Lead: Professor Michael Thorne CBE
Time: 13:18

4. Governance – Approval of Minutes

Action: To Approve
(i) Approve the minutes of the last Integrated Care Partnership
Papers: Attachment A *(page 7-21)*
Lead: Professor Michael Thorne CBE, ICB & ICP Chair
Time: 13:20

5. Governance – Approved Committee Minutes

Action: To Note
(i) To note the minutes of meetings for Population Health Improvement Board
(ii) To note the minutes of meetings for Community Assembly (Co-Production group)
Papers: Attachment B *(page 23-69)*
Lead: Professor Michael Thorne CBE, ICB & ICP Chair
Time: 13:23

6. Governance – Questions from the Public

Action: To Note
(i) To respond to any questions raised in advance of the Integrated Care Partnership.
Papers: Verbal
Lead: Professor Michael Thorne CBE, ICB & ICP Chair
Time: 13:25

7. Integrated Care Strategy

Action: To Approve
(i) To Note the development of the new Integrated Care Strategy
(ii) To Approve the Integrated Care Strategy, and ensure it sets out steps for delivery of the Theory of Change & Outcomes Framework.
Papers: Attachment C *(page 71-114)*
Lead: Jeff Banks, Director of Strategic Partnerships, NHS Mid and South Essex
Time: 13:30

8. Integrated Care Strategy – Theory of Change & Outcomes Framework

Action: To Note
(i) To Note and support the work undertaken to date on Theory of Change and Outcomes Framework and offer feedback.
(ii) To Note a completed Theory of Change & Outcomes Framework will come to the Partnership at it's next meeting.
Papers: Attachment D *(page 116-149)*
Lead: Jeff Banks, Director of Strategic Partnerships, NHS Mid and South Essex
Time: 13:40

9. MSE Anchor Programme

Action: To Note

(i) To request the ICP continues to support and invest in Mid and South Essex's Anchor programme

(ii) To request the ICP encourages Charter organisations and ICP members to evidence their contribution to its charter aspirations

(iii) To request the ICP encourages Health and Well Being Boards to understand the role that they can play in supporting Anchor work

(iv) For ICP members to consider and comment on the national development of metrics, frameworks and the programmes operating model or practice

Papers: Attachment E *(page 150-175)*

Lead: Charlotte Williams, Chief Improvement and Strategy Officer, Mid and South Essex NHS FT

Time: 13.50

10. Basildon & Brentwood Alliance – Community Development

Action: To Note

(i) To Note the update from Achieve Thrive Flourish, and the benefits of asset-based community development.

(ii) To Note the update from Sport for Confidence and consider the findings & recommendations of the PEM evaluation report.

Papers: Attachment F *(page 177-270)*

Lead: Pam Green, Alliance Director (Basildon & Brentwood), NHS Mid and South Essex | Rob Walters, Structure & Development Manager, Achieve Thrive Flourish (ATF) | Lyndsey Barrett, Lead Occupational Therapist, Sport for Confidence

Time: 14.15

11. Coproduction Community Assembly

Action: To Note

(i) To Note the views of communities and the VCSE as developed and progressed by the Co-production Community Assembly.

(ii) Support the formation of the Assembly connected to the ICS.

(iii) Support the development of the Assembly across the system with a suitably qualified chair and deputy chairs working in partnership with colleagues from Alliances, Local Authorities and VCSE.

(iv) Note that the assembly will provide support and constructive challenge within reasonable parameters of the ICS in surfacing the voice of communities and the voluntary sector. This feedback aims to serve as a heartbeat from within the ICS toward shaping decisions for the people we serve.

(v) Note that extensive co-production has been undertaken across communities and that further resourcing will be needed to develop sustainability of the VCSE and Assembly.

Papers: Attachment G *(page 272-276)*
Lead: Kirsty O'Callaghan, Director of Community Resilience, Mobilisation & Transformation, NHS Mid and South Essex
Time: 14.40

12. Thurrock Council – Local Area Coordination

Action: To Note

(i) To note the update from Thurrock Council on Local Area Coordination.

Papers: Attachment H *(page 278-290)*
Lead: Tania Sitch, Interim Joint Acting Assistant Director of Adult Social Care and Community Development | Karen Dodson, Senior Local Area Coordinator, Thurrock Council
Time: 14.55

13. Essex Disability Strategy

Action: To Note

(i) To Note the update on the Essex Disability Strategy.

(ii) To consider and discuss how roles of members and organisations represented on the partnership can support implementation of the strategy's aims.

Papers: Attachment I *(page 292-331)*
Lead: Ruth Harrington, Director of ASC for Adults with Disabilities, Essex County Council
Time: 15.20

14. Approach to Health Inequalities

Action: To Support
(i) To Support the approach outlined to reduce health inequalities in Mid and South Essex.
Papers: Attachment J *(page 333-352)*
Lead: Emma Timpson, Associate Director of Health Inequalities & Prevention, NHS Mid and South Essex | Sophia Morris, Health Inequalities Clinical Lead, NHS Mid and South Essex
Time: 15.40

15. Closing Remarks & Networking Opportunity

Lead: Professor Michael Thorne CBE, ICB & ICP Chair
Time: 16.00

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Minutes of Mid and South Essex Integrated Care Partnership (ICP)

Held on 16 November 2022, 13.00 – 16.00.

Council Chamber, Civic Centre, Duke St, Chelmsford, CM1 1JE

Members

- Professor Michael Thorne (MT), Chair of Mid and South Essex Integrated Care Partnership (MSE ICB).
- Cllr John Spence (JS), Vice Chair of Mid and South Essex Integrated Care Partnership (Essex County Council)
- Cllr Deborah Arnold (DA), Vice Chair of Mid and South Essex Integrated Care Partnership (Thurrock Council)
- Cllr Kay Mitchell (KM), Vice Chair of Mid and South Essex Integrated Care Partnership (Southend City Council)
- Owen Richards (OR), Chief Officer (Healthwatch Southend)
- Jeff Banks (JB), Director of Strategic Partnerships (MSE ICB)
- Brian Balmer (BB), Chief Executive Officer (Essex LMC)
- Claire Hankey (CH), Director of Communications and Engagement (MSE ICB)
- Nigel Beverley (NB), Chair (Mid and South Essex NHS FT)
- Krishna Ramkhelawon (KR), Director of Public Health (Southend City Council)
- Jo Cripps (JC), Executive Director of Strategy & Partnerships (MSE ICB)
- Tim Middleton (TM), Vice-Chancellor (Writtle University)
- Ruth Hallett (RH), Interim Alliance Director – South East Essex (MSE ICB)
- Stephen Porter (SP), Interim Alliance Director – Thurrock (MSE ICB)
- Daniel Doherty (DD), Alliance Director – Mid Essex (MSE ICB)
- Mandie Skeat (MS), Deputy Chief Executive Officer (Basildon Borough Council)
- Grant Taylor (GT), Head of Culture and Health (Basildon Borough Council)
- Steve Smith (StS), Chief Executive Officer (Haven Hospice)
- Kirsty O'Callaghan (KO'C), Director of Community Resilience, Mobilisation & Transformation (MSE ICB)
- Tiffany Hemming (TH), Interim Executive Director of Oversight & Assurance (MSE ICB)
- Sheila Salmon (SS), Chair (Essex Partnership University NHS FT)
- Camille Cronin (CC), Director of Research and Professor of Nursing (University of Essex)
- Stephanie Dawe (SD), Group Chief Nurse and Chief Operating Officer (Provide)
- Mark Heasman (MH), Chief Executive Officer (Provide)
- Sultan Taylor (ST), Interim Chair, (North East London NHS FT)
- Leighton Hammett (LH), Chief Superintendent (Essex Police)
- Anthony McKeever (AM), Chief Executive Officer (MSE ICB)
- Lorraine Jarvis (LJ), Chief Officer (Chelmsford CVS – representing MSE CVS Network)
- Stephen LieBrecht (SL), Director of Adult Social Care Operations (Southend City Council)
- Cllr Jeff Henry (JH), District Councillor & Chair of HOSC (Essex County Council)

- Cllr Lynsey McCarthy-Calbert (LC-C), District Councillor (Castle Point Borough Council)
- Dr Boye Tayo (BT), Clinical Lead - Basildon & Brentwood (MSE ICB)
- Paul Dodson (PD), Director of Strategy, Performance and Governance & Returning Officer (Maldon District Council)

Other attendees

- Emma Timpson (ET), Associate Director of Health Inequalities & Prevention (MSE ICB)
- Simon Williams (SW), Deputy Alliance Director – Basildon and Brentwood (MSE ICB - On behalf of Pam Green)
- Dr Pete Scolding (PS), Deputy Medical Director (MSE ICB)
- Dr Ed Cox (EC), Deputy Medical Director (MSE ICB - On behalf of Dr Ronan Fenton)
- Phill Read (PR), Associate Director of System Development (MSE ICB)
- Alison Stevens (AS), Chief Executive Officer (Farleigh Hospice)
- Eva Lew (EL), System Clinical Lead for End of Life (MSE ICS)
- Cllr Holly Whitbread (HW), District Councillor & Deputy Cabinet Member for Health and Adult Social Care (Essex Council)
- James Wilson (JW), Transformation Director (Mid and South Essex Community Collaborative)
- Lucy Crouch, NHS Graduate Management Trainee (MSE ICB)
- Katie Bartoletti, NHS Graduate Management Trainee (MSE ICB)
- Tonino Cook (TC), Business Manager – Strategy & Partnerships (MSE ICB - Minutes)

Apologies

- Pam Green (PG), Alliance Director – Basildon and Brentwood (MSE ICB)
- Derrick Louis (DL), Chair (Provide)
- Wendy Thomas (WT), Non-Executive Director (East of England Ambulance Service NHS FT)
- Simon Wood (SWo), Regional Director of Strategy & Transformation (NHS England)
- Jo Broadbent (JoB), Director of Public Health (Thurrock Council)
- Ian Wake (IW), Corporate Director for Adults, Housing & Health (Thurrock Council)
- Terry Dafter (TD), Director of Adult Social Care (Southend City Council)
- Helen Lincoln (HL), Executive Director for Children, Families and Education (Essex County Council)
- Michael Marks (MM), Executive Director for Children and Public Health (Southend City Council)
- Sheila Murphy (SM), Corporate Director of Children Services (Thurrock Council)
- Sam Glover (SG), Chief Executive Officer (Healthwatch Essex)
- Kim James (KJ), Chief Operating Officer & Strategic Lead (Healthwatch Thurrock)
- Cllr Simon Wootton (SWoo), Leader of the Council (Rochford District Council)
- Cllr Chris Hossack (CH), Leader of the Council (Brentwood Borough Council)
- Jonathan Stephenson (JSt), Chief Executive Officer (Rochford District Council & Brentwood Borough Council)
- Cllr Graham Butland (GB), Leader of the Council (Braintree District Council)

- Manjeet Sharma (MSh), Clinical Lead – Thurrock (MSE ICB)
- Sarah Zaidi (SZ), Clinical Lead – South East Essex (MSE ICB)
- Mike Thompson (MTh), Chief of Staff (MSE ICB)
- Ronan Fenton (RF), Chief Medical Director (MSE ICB)
- Ruth Jackson (RJ), Chief People Officer (MSE ICB)
- Frances Bolger (FB), Interim Chief Nurse (MSE ICB)
- Jen Kearton (JK), Director of Resources (MSE ICB)
- Lucy Wightman (LW), Director of Public Health (Essex County Council)
- Nick Presmeg (NP), Director of Adult Social Care (Essex County Council)
- Nigel Harrison (NH), Pro Vice-Chancellor & Dean (Anglia Ruskin University)
- Cllr Ann Davidson (AD), Councillor (Chelmsford City Council)
- Cllr Penny Channer (PC), Leader of the Council (Maldon District Council)
- Barry Frostick (BF), Chief Digital and Information Officer (MSE ICB)

1. Welcome and Apologies *(presented by Prof. Mike Thorne)*

MT welcomed everyone to the meeting, and thanked colleagues for their contributions to date to the new Integrated Care Strategy for mid and South Essex. MT advised the strategy has had important feedback from colleagues across the partnership, being recognised regionally due to the progress made compared to other systems.

Apologies were noted as listed above.

2. Conflicts of Interest *(presented by Prof. Mike Thorne)*

MT requested members to submit any new declarations of interest relevant to the agenda, taking into consideration that all members have an interest in their own statutory organisation. No declarations of interest were raised.

Resolved: The Integrated Care Partnership (ICP) NOTED the addition of no new declarations of interest.

3. Minutes of Previous Meeting *(presented by Prof. Mike Thorne)*

MT referred to the draft minutes of the Integrated Care Partnership (ICP) meeting held on 28 September 2022 and asked members if they had any comments or questions.

NB raised a comment on the discussion from the previous meeting, regarding clinical risk, and requested an update. AM confirmed since the last meeting a CEO forum had been organised for health partners to look at what needs to be completed to balance risk across the system. The group will specifically looking at Urgent and Emergency Care (UEC), with the development of a strategic centre which involves all partners, ahead of national directive, including 24/7 arrangements which could take actions in real time, as pressures arrive. The CEO forum had recently agreed a key measure to address first would be ambulance handover delays, specifically extreme delays (90th percentile).

AM confirmed Dr Ronan Fenton, System Medical Director, has convened a group of clinical & care professionals to meet and agree actions on risk across different clinical areas. AM stressed the need to work collaboratively, and collectively understand what each partner

can do to improve the system position. Actions would be coordinated through a control centre, overseen by CEOs of partner organisations.

JS raised a concern on mental health pressures, with people in places they shouldn't be, awaiting mental health assessments. JS commented on the importance of also talking about the positive work being done across the system, not just the negatives, highlighting the positive resident feedback from the recent Urgent Emergency Care Triage System within MSEFT.

NB agreed on the importance of highlighting positive work and thanked JS for the feedback on the service. NB requested clarification on the control centre, referenced by AM, and if it was clinically led. AM confirmed the control centre was a management centre, and clinical advice was built in, with mechanisms on how clinicians can feed into the centre to be agreed in the meeting Dr Ronan Fenton will be organising.

OR raised work being completed on UEC regionally, focusing on the front door, and not discharges. OR queried if there could be work done to look at the wider role of the system.

AM confirmed all parts of the system were being looked at, including discharges and pathways to virtual wards. Recent challenges were due to workforce issues, which partners are looking to address. AM confirmed the importance of not making rapid changes, working together to steadily change, working alongside local authority colleagues on discharge to assess arrangements. AM agreed on the need to ensure regional work is influenced by the system and will look further into what work is being completed.

Action: AM to explore the regional work being completed on Urgent and Emergency Care, and how the system can influence.

Resolved: The Partnership AGREED the minutes of the Integrated Care Partnership on 28 September 2022 to be an accurate record.

4. Questions from the Public *(presented by Jeff Banks)*

Trevor Fernandes, who was not present at the meeting, had submitted the following question in advance of the meeting:

"In reference to the draft People and Communities Strategy; How can we help you embed this approach in our communities?"

MT welcomed the question, and provided the following response to Mr Fernandes:

We welcome the commitment from key community champions, who will be crucial in supporting the development of the full People & Communities strategy.

Over the next two years we have committed to a programme of developing our approach which will be drawn from insights gained from a range of methods which includes outreach into communities. This is in line with our ambition to have residents at the heart of our partnership.

The integrated care partnership's engagement steering group is meeting for the first time this year. The forum gives all partners' the opportunity to share knowledge and pool

resources to ensure one another's channels are being effectively used to involve residents in plans for improving local health and wellbeing outcomes.

5. Community Collaborative *(presented by James Wilson & Sheila Salmon)*

SS provided an update on the Community Collaborative for mid and south Essex. SS noted the three organisations (Provide, NELFT & EPUT) have been collectively working as a collaborative for over two years, with a rotational chair across the organisations to be a truly collaborative function. The purpose of the collaborative is to deliver outstanding care, with additional strength in coming together to provide services across the system.

JW advised it took time to understand how the collaborative could effectively work together, initially starting in 2021 with a contractual joint venture agreement, which meant joint governance and a single board. A focus of the group was to set out a programme of change which would ensure services were built around communities, level up provision and remove historic health inequality issues across the patch. A single executive group was formed to drive this programme, with a group focused on transformation. The programme has resulted in operational teams coming together, and development of four operational directors which are place based across mid and south Essex geography.

JW commented on the scale of change, with a large organisational change required, including a change in culture from services historically commissioned by five Clinical Commissioning Groups (CCGs), to compete with each other, to now come together and deliver improved outcomes. JW noted on the priority to be integrated locally, encouraging staff to work across boundaries where they may have previously been limited.

Six priority outcomes were identified to be a focus for the collaborative:

1. **Higher quality sustainability services**

The introduction of virtual wards, currently with 120 beds, which has resulted in patients eight times less likely to decondition, and five times less likely to receive an infection. Plans to continue expansion, with MSE being a national forerunner.

2. **Reduction in variation and duplication**

The Introduction of pathways for respiratory, long covid & virtual wards, with new standardised care. Future work is to be done to ensure standardised care across all pathways, with diabetes recently now also having a common offer.

3. **Effective use of resources**

New ways of rostering for staff and the sharing innovation across the three organisations. Bidding together, as a collaborative, for money ranging from small to large, such as a few thousand for equipment needed by staff, up to multi-million submissions for pathways.

4. Unified provider voice

The importance of a unified voice, with single governance, engaged as one voice instead of three separate organisations and approaches.

5. Health equality and equitable access

The need to continue work across the system on equitable access, with outreach work recently completed with a vaccination van. Pilots are completed nationally, such as a recent stroke pilot, which will continue to improve health equality.

6. Improved staff experience and retention

Positive feedback to date with colleagues across the patch. Joint roles have been created which allow collaborative approach, and build further career paths to keep and retain staff, training together to work together.

A new publication from the Community Collaborative titled ‘Our Journey so Far’ would be published December 2022, acting as an annual report for the collaborative, highlighting its achievements to date.

JW thanked colleagues, and focused on the journey ahead, with a key focus to be on engagement with stakeholders across the partnership. JW opened the discussion with an ask for suggestions on how the collaborative could best be utilised across the system, and views on what should be their next priority.

SP queried how the collaborative is currently interfaced with family carers, highlighting the importance unpaid carers provide across health & social care to prevent admissions.

JW agreed on the important role unpaid carers play, and agreed the collaborative would address where it makes sense to do so. Four new integrated care partnership directors had been introduced which interface at alliance and local levels. JW noted the importance on not forcing a central position, instead utilising local alliances. Carers groups are already involved in areas of change which would impact them.

JS noted the use of language regarding alliances wrapped around Primary Care Networks (PCNs) inside the report provided, suggesting the avoidance of medicalised terms.

JW agreed, and apologised for the use of unclear language, clarifying the focus to ensure local teams are engaged, alongside local communities, to deliver integrated care in the area.

DA noted the use of the collaborative tackling system pressures, with a focus on effectively utilising communities, residents & the voluntary sector, recognising it is where the most cost-effective help can be made. DA highlighted the voice of community networks not represented as members of the ICP, not just going to workshops, but highlighting the importance of being in the room.

JB raised the concept paper for the Integrated Care Strategy, highlighting the importance of building engagement with communities, with their voice and hands central to the work of the partnership. JB noted a common theme from engagement during the strategy was

communities not feeling involved or engaged with. This continues to be a feature in the strategy.

KO'C raised the new Community Assembly, which builds and works with VCS groups ranging from digital community leaders, faith groups and businesses. KO'C highlighted the importance of engagement outside formal committees, reaching out in different forums to the community.

DA agreed on the work raised by JB & KO'C, noting the importance for communities to be not at arm's length, but at the table.

BT congratulated the collaborative on work done to date, and noted how far it has developed since establishment. BT commented on the importance of place based relationships, alongside formal relationships at Primary Care Network & GP level. BT queried how these relationships would be established with the Community Collaborative moving forward.

AM noted all partner's thanks on the work done to date to achieve consistency across the patch. AM noted two ambitions which he felt should be a priority for the collaborative. Firstly, addressing workforce challenges & bank/agency use, noting workforce continues to be a key constraint across all organisations. Furthermore, a single contracting mechanism across the collaborative.

DD noted his thanks to the work already being completed by the locality partnership directors, working closely with alliances, districts & neighbourhoods, engaging with local communities.

Resolved: The Integrated Care Partnership (ICP) NOTED the update from the Community Collaborative.

6. Children and Young People's Partnership *(presented by Jeff Banks)*

JB thanked colleagues for the opportunity to speak on the Children and Young People's Partnership, and the Children & Young People's Framework. JB noted the framework had been sent in advance, commenting it was not a static piece of work, detailing the focus is how the partnership will work together, rather than where it is currently. Contributors came across health, education, and social care within MSE, with 62 attendees across workshops. University of Essex had been commissioned for a research project on different models of partnership working, with the report now co-produced with a small group of 30 young people & their guardians. A video was shared detailing the responses from the Young People's Panel.

The framework has been tested and developed back with partners, with a refreshed version to showcase across different forums within the system. JB confirmed the Growing Well Programme Board will hold accountability for the work moving forward. JB noted his thanks to all the young people involved and asked the ICP to support the programme.

MT thanked colleagues for their work, and to the young people who took the opportunity to voice their views in the process. MT noted one of the most significant demands for young

people being mental health and queried what the views from young people were on how the system could best support.

JB noted the young people's involvement, with no topics being off limits for them, engaging positively and directly. JB shared information regarding a Southend Young People Council which did a campaign across schools for a mental health charter, in which all schools signed up to. JB noted the learning could be used for other areas in the system.

CS noted the Southend Young People Council is focused on those secondary school age, highlighting the importance for those in primary school age as well, as there is a rise in mental health issues at younger age groups as well. JB agreed on the need for all babies, young people & children to be engaged & treated equally.

HW queried the engagement with Essex County Council, and requested further engagement took place with colleagues. JB noted work to date with Chris Martin, and confirmed Helen Farmer would socialise further with colleagues if they felt not engaged.

SS congratulated colleagues on work done to date, noting how difficult it can be to reach children & young people, and amplify their voice. SS noted the impact young people have with mental health, with inpatient wards regularly visited by young people. SS requested if there was anything the Community Collaborative could do to support. JB thanked SS, and requested a meeting be arranged with Helen Farmer to discuss further.

LC-C noted the themes from teachers & pupils in schools, overwhelmed with mental health issues and not able to cope with the demand across primary & secondary schools. LC-C raised feedback received previously where mental health week, month & other exercises are seen as a tick box rather than actual support.

JB agreed on the impact mental health has in schools, and noted it was seen in the young people panel the group worked with. JB noted the young people were advocating for their own friends and families, with many who had their own experiences. JB highlighted the importance to ensure education partners are included in these discussions, including the 2,500 young people home educated across Essex. Building relationships with education colleagues was highlighted as key to the preventative agenda, and will be an example of how the system can work together.

DA thanked colleagues for the presentation and agreed with LC-C on the importance of working with schools. DA noted the high number of unpaid carers who were children, with some as young as age 7 who need their own support for mental health. DA noted young people are transitioning out of carers to young adults & adulthood, although their mental health problems do not go away. An importance was highlighted on the transition from young person to adult, ensuring they are supported throughout.

Resolved: The Integrated Care Partnership (ICP) NOTED the Children and Young People's Framework and AGREED to support.

7. NHS Alliance Director Update *(presented by Dan Doherty, Simon Williams, Ruth Hallett & Stephen Porter)*

SW confirmed he would be providing an update on behalf of all alliances within mid and south Essex.

The alliances are still adjusting to new structures with the establishment of the ICB, with change in leadership across many of the alliances. A focus on moving alliances away from being an NHS meeting, with wider membership, ensuring voices are around the table to make the right decisions for communities. SW noted the importance of wider organisations involved in alliances, including the voluntary sector who, at recent months, have had donations dramatically reduce due to the cost of living crisis. Other health providers including upper tier local authorities, district councils & borough councils play a key role in alliances for wider determinants of health.

SW noted a key focus for alliances will be to learn and share across each other, especially as all are at different stages of maturity.

RH noted health inequalities being a key focus for all alliances, especially due to recent health inequalities funding. RH updated that each alliance is at a different stage in the process for distribution of health inequalities funds:

Basildon and Brentwood Alliance have had all projects approved, with due diligence underway.

Mid Essex Alliance are rolling money over a 3-year period, with bid submissions currently being submitted.

South East Essex Alliance have had all bids submitted, and approved, with money to be distributed imminently.

Thurrock Alliance have had all bids submitted, with final checks currently underway.

RH noted the importance of balance across programmes, ensuring there is a mix of projects responding to the problems here and now, and those preparing for the future. Noting health inequalities cannot be fixed in five minutes, when they were not made in five minutes.

University of Essex have also been commissioned to support an evaluation and feedback process, building on learning for future work & programmes.

DD updated on Urgent and Emergency Care (EUC) trends across the system. DD noted three key analyses:

1. Biggest rises for attendance at Emergency Departments with children.

This increase is primarily with age group of under 5-10’s, with the largest increase within Thurrock at 19% increase. DD suggested this is likely due to a generation which were nurtured during lockdown and didn’t build resilience other children may have.

Alliances are taking steps to address, including workshops across primary care and GPs attending primary schools, speaking to staff & parents in understanding what is ‘too ill’ for school.

2. High intensity users

DD noted there were still a cohort of people who were identified as high intensity users, who attended A&E multiple times. Specifically, within Mid Essex, analysis showed those high intensity users generated 4 whole days of A&E attendances themselves, with one user attending A&E 89 times within a few months.

Different services were in place to support specific individuals, which may generate a need for other services such as drug & alcohol addiction, police, citizens advice or other agencies.

3. Vaccinations (COVID, Booster & Flu Vaccine)

DD updated that flu vaccinations are not as high as usual for the current time of year. A large piece of work is underway to understand specific populations, geographies & post codes to see low uptake areas and introduce targeted intervention.

DA noted Thurrock had the highest UEC admissions, and also the second lowest number of GPs in England, a key focus would need to be innovative ideas to attract GPs in the area.

DD agreed deprivation has a key role in UEC admissions, however, children are more sick across the country then previous years due to less resilience in their immune system. DD noted that there isn't a direct correlation between less GPs, with less patient satisfaction and increased UEC attendance.

OR noted the figures for high intensity users, with a focus on looking at individual cases as their reasons often times being multi-factorial. OR advised some schools were giving out slips to children who had hit their head requesting parents take them to get it checked out, linking in with wider determinants and how they refer to A&E may be a key role to figure out. OR raised social prescribing, with a lack of awareness in communities, and inside practices themselves, on what it can provide. A mindset you should go to your GP first, as opposed to pharmacies, social prescribers, or community assets.

KO'C noted the importance of social prescribing, although it is currently called many different things such as community ambassadors, community connectors and other names in different areas. KO'C confirmed a piece of work was underway to quantify the impact of social prescribing, agreeing it was a key asset to use, but it must be able to be quantified to be effective. KO'C noted the need to co-produce what a learning community would look like, and how different assets could be linked together.

SP agreed on the importance of quantifying social prescribing, suggesting a communications piece is required to fully showcase the different staff which were available, and that it was not a second-class service to receive.

Resolved: The Integrated Care Partnership (ICP) NOTED the updates from NHS Alliance Directors across mid and south Essex.

8. Integrated Weight Management Services Redesign *(presented by Dr Pete Scolding & Emma Timpson)*

PS advised he would be presenting on behalf of the wider system prevention team, and a full paper was sent in advance outlining the intention to partner with a commercial organisation in the area of healthy weight management for two years. PS noted this partnership would bring the benefit for a particular way of working in other clinical areas within prevention, to tackle obesity. PS commented on how wider partnerships with commercial organisations are already common place within Orthopaedics, Cardiology and other clinical settings. The principle on partnership with industry is to gain access to a service the system wouldn't usually have.

PS confirmed the partnership would be focused on enabling the health & care system to improve Weight Management Services (WMS), developing expertise in staff who work in the service, and the materials used. The partnership will also add further capacity to transform and improve services, including the recruitment to two specialise staff members, and access to a range of national experts including academic & professionals.

Resolved: The Integrated Care Partnership (ICP) AGREED to support the Integrated Weight Management Services Redesign programme, and partnership with industry.

9. Hospice Strategic Partnership & Recommendations for Palliative and End of Life Care Across MSE *(presented by Steve Smith & Alison Stevens)*

SS thanked the partnership for an opportunity to speak on an important topic, Palliative and End of Life Care across mid and south Essex.

SS opened with a background on the Hospice Strategic Partnership, noting the original creation in response to COVID. In line with changes to Clinical Commissioning Groups (CCGs), and the formation of Integrated Care Boards (ICBs), SS noted the need for the Hospice Strategic Partnership to also work in a collaborative way. SS noted the involvement of four hospices in the partnership, covering the whole of mid and south Essex.

The focus of the Hospice Strategic Partnership is Palliative and End of Live Care (PEoLC), which currently is facing many crisis across health and care. SS noted an additional key crisis upcoming, by 2040 the number of predicted deaths will surpass the number of births. SS noted MSE being an aging population, with a slightly higher then average age for England, with an ageing health and care workforce of 47% of NHS staff over 45, and the figure is expected to rise. Furthermore, Hospice UK reported 1 in 4 families do not get the support they need, with inequalities in access to end of life care. SS advised there were less resources, with greater complexity and a growing death population.

SS confirmed the Hospice Strategic Partnership were commissioned, by the CCGs, to commission a report on lived experience for PEoLC in mid and south Essex. The report covered all age population, with patient experience component, focusing on all wider system partners, not just hospices. SS confirmed over 200+ responses were received and resulted in around 50% not having a positive experience. SS noted the extreme emotional stories from residents, which included a very sensitive topic and in often cases resulted in

finger pointing to different agencies. Although the responses often ended in blame to a specific organisation by the respondent, it was noted this is not how the partnership wanted to work moving forward, with the ICS being a prime mechanism to address the issues raised.

The report raised three areas for solutions including; Sharing of knowledge and information, wellbeing for all (from diagnosis to death, and Communication & Access. Following the report, the Hospice Strategic Partnership developed five specific recommendations:

1. Presentation of report and findings to all stakeholders.
2. PEoLC PB led session that creates a task-based action plan prioritising 24/7 care, communication and information sharing, and bereavement services.
3. All alliances agree to have 'Living and Dying Well' as part of their strategy to show a consistent approach across MSE.
4. ICB request regular report on PEoLC PB action plan.
5. Lived Experience survey to be repeated in 12 months.

EL noted her thanks to the entire Hospice Partnership for their work, noting it's importance for end of life sector. EL stressed a huge opportunity to use PEoLC to be an exemplar for collaboration across health & social care, and beyond, requesting colleagues to engage with the PEoLC programme board if they would like to find out more.

MT thanked colleagues for the presentation, and queried involvement from Macmillan to date. EL confirmed Macmillan's involvement, noting the importance of building skills to engage with voluntary sector beyond health & social care, such as faith groups. EL confirmed the programme board's open mind to wider engagement with other groups.

CS, HW, EL, RH & LC-C opened a discussion on the importance of having open and frank conversations with friends, families & loved ones on end of life care, noting dying is a normal part of life which has now become medicalised, where a change in culture is needed in residents. The group noted on the need to support residents on managing these conversations, with the importance of choice.

Resolved: The Integrated Care Partnership (ICP) AGREED on the requirement for 'Living and Dying Well' to be featured in each ICS Alliance Strategy.

Resolved: The Integrated Care Partnership (ICP) AGREED for the Palliative and End of Life Care (PEoLC) Programme Board to action the PEoLC Survey Report

Resolved: The Integrated Care Partnership (ICP) AGREED for the ICB to have updates on the actions from the PEoLC report.

Action: TC to liaise with ICB Governance Team for PEoLC action reports to be on the forward planner for ICB meetings moving forward.

10. ICS Community Assembly *(presented by Kirsty O'Callaghan)*

KO'C updated the Partnership on work completed to date in the development of an ICS Community Assembly. KO'C confirmed a series of engagement sessions took place since the last meeting, which resulted in the system listening more, and talking less. A paper attached to the report provides a full overview of outputs for the session.

KO'C explained the formation of a new steering group which would support development of the assembly moving forward, with suggested membership included in the paper to co-produce what an effective assembly model looks like for mid and south Essex.

JS queried the proposed membership for the assembly, with the exclusion of local authority colleagues, requesting if they could be involved moving forward.

KO'C noted the importance of local authority colleagues, with the initial assembly focusing only on community organisations, with a separate group to follow with local authority colleagues and the community collaborative.

JS highlighted the importance of the local authority listening to people, to allow early engagement and support. A risk was raised that colleagues may not be able to support the assembly if they are not involved.

KO'C agreed on the option to co-opt people into the assembly, with a focus of the group to see what VCSE would like from the ICP, and the community themselves, instead of the other way round. KO'C noted it would be a risk to not have local authority colleagues involved in the Community Assembly but confirmed this would be a risk they would need to take on.

DA noted her thanked to KO'C, having recently attended one of the engagement workshops. DA noted however, that turnout from actual members of the community were not in the room and noted the importance they are heard from directly.

Resolved: The Integrated Care Partnership (ICP) NOTED the update on the ICS Community Assembly, and the proposed membership.

11. Integrated Care Strategy - Concept Paper *(presented by Jeff Banks)*

JB opened with a thanks to all colleagues around the ICP, noting all involvement to date has had an important role in the development of the draft concept paper for mid and south Essex's Integrated Care Strategy. JB noted the development of physical engagement and community workshops which took place, resulting in attendance of over 170+ residents, ranging from all sectors & communities. Furthermore, an online engagement process which engaged over 2,500 residents. JB confirmed further engagement was to take place, including with those in the ICP who may have not had a chance to engage to date.

JB explained the core focus of the concept paper, with a diagram detailing an Equal Value Partnership. At the centre of the partnership was a common endeavour, reducing health inequalities. This common endeavour would form the basis of all work from system level, down to communities, which sits at the heart of all work done in the area.

JB detailed the different layers creating an equal value partnership, with the common endeavour of health inequalities underpinning all. Firstly, Partnership Priorities:

- Core20PLUS5
- Babies Children & Young People (BCYP)
- Adult Care
- Wider Determinants.

Furthermore a set of Community Priorities:

- Access
- Involvement
- Openness
- Responsibility
- Awareness

Finally, a set of System Priorities:

- Connected Care
- Workforce Recruitment and Retention
- System Pressures
- Early Intervention and Prevention
- Shared Records and Data
- Connected Care

JB noted the importance each of these priorities play individually, and how they are all interlinked to ensure the health & care of residents within mid and south Essex would be positive, developing residents for the future.

Included in the diagram is an agenda for the ICP, which included:

- Broad & inclusive membership
- Shared objectives
- Joined-up commissioning
- Aligned Budgets
- Space & time for relationship building
- Refined services & pathways
- Engagement and Co-Production
- Integrated Workforce
- Evidence based learning system
- Regular review and refinement.

JB noted throughout the engagement process on the feedback from residents in how the system is engaging with residents prior to developing a strategy, rather then engaging after already creating a draft paper. JB noted commitment to continue to engage routinely, and regularly with those across the partnership & beyond. This includes further engagement with different boards and committees in the coming months.

JB finished his presentation with a request for an extraordinary meeting in December 2022 of the ICP to agree a draft strategy for submission nationally, in line with legislation.

Resolved: The Integrated Care Partnership (ICP) NOTED the draft concept paper for mid and south Essex's Integrated Care Strategy

Resolved: The Integrated Care Partnership (ICP) AGREED the draft concept paper should be used as a basis to develop the full Integrated Care Strategy.

Resolved: The Integrated Care Partnership (ICP) AGREED an extraordinary meeting in December 2022 with a focus to approve a draft Integrated Care Strategy for national submission.

12. Any Other Business

There was no other business discussed.

13. Date and Time of Next Board meeting

Monday, 20 March 2023 at 1.00 pm in The Council Chamber, Civic Centre, Duke St, Chelmsford, CM1 1JE

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MSE Integrated Care Partnership, 20 March 2023

Agenda Number: 05

Approved Committee Minutes

Summary Report

1. Purpose of Report

To reassure the Integrated Care Partnership (ICP) of the work ongoing for its subcommittees:

1. Population Health Improvement Board (PHIB)
2. Community Assembly Coproduction Group

2. Executive Lead

- **Name:** Jeff Banks
- **Job Title:** Director of Strategic Partnerships
- **Organisation:** NHS Mid and South Essex

3. Report Author

- **Name:** Tonino Cook
- **Job Title:** Business Manager
- **Organisation:** NHS Mid and South Essex

4. Responsible Committees

Minutes were approved at their relevant meetings.

5. Financial Implications

N/A

6. Details of patient or public engagement or consultation

N/A

7. Conflicts of Interest

None identified.

8. Recommendation/s

(i) To note the minutes of meetings for Population Health Improvement Board

(ii) To note the minutes of meetings for Community Assembly (Co-Production group)

DRAFT MINUTES

Meeting of the Population Health Improvement Board
Date: 10 November 2022
Time: 10:00 to 12:00
Venue: Microsoft Teams

Agenda

Lucy Wightman LW – Director, Wellbeing Public Health & Communities, Essex County Council.
Emma Timpson ET - Associate Director for Health Inequalities and Prevention, Mid & South Essex ICB.
Jo Cripps JC – Director, Strategy and Partnerships, Mid & South Essex ICB.
Jeff Banks JB – Director, Strategic Partnerships, Mid & South Essex ICB.
Jo Broadbent JoB – Director, Public Health Thurrock, and Lead for the ICS Population Health Management Program
Claire Hankey CH – Director, Communications and Engagement for the ICS.
Krishna Ramkhelawon KR – Dr, Public Health, Southend
Sophia Morris SM – System Clinical Lead, Health and Inequalities.
Anita Pereira AP - GP and System Clinical Lead, Health Inequalities and Personalised Care.
Pete Scolding PS - Assistant Medical Director, ICP and Senior Responsible Officer for Prevention.
Ronan Fenton RF - Medical Director, MSE ICS.
Dan Doherty DD - Alliance Director, MSE ICP
Stevie Attree SA – Personalised Care Program Lead, Mid & South Essex ICB.
Steve Gallagher SG – Director of Data and Business Intelligence, MSE ICB.
Preeti Sud (PrS) – Head of Strategy Unit, Mid & South Essex NHS Foundation Trust
Deborah Jeffery DJ – Executive Assistant to Chair & Non-Executive Members, MSE ICB.

1. Welcome and Apologies

Lead: Lucy Wightman
Time: 5 mins

LW welcomed all to the inaugural Population Health Improvement Board for Mid and South East Essex (PHIB NSE) and followed with introductions by all in attendance.

Apologies were noted as follows;

Dawn Scrafield – Chief Finance Officer, MSEFT
Barry Frostick – Chief Digital Information Officer, MSE ICB.
Peter Fairley - Director for Strategy and Integration, Adult Social Care, Essex County Council
Ruth Jackson – Executive Chief People Officer, MSE ICB

Owen Richards - Chief Officer, Healthwatch Southend

LW thanked all for coming together under the umbrella purpose of this new board and moved to item 2.

2. Terms of Reference

Action: To agree the Integrated Care Partnership have approved Terms of Reference for a Population Health Improvement Board and the proposed governance.
Papers: Attached
Lead: Lucy Wightman
Time: 5 mins

LW summarised the Terms of Reference (ToR) for the newly created Population Health Improvement Board (PHIB) and requested any feedback during today's meeting.
If all agree with any proposed changes, they can be signed-off virtually if necessary, but to also include review of the proposed governance.
LW advised that the PHIB will not have delegated powers but will coordinate advice and support to identify priorities for programs, supporting the delivery of the overarching Integrated Care Board (ICB) Strategies and the Integrated Care Partnership (ICP) Strategies.

To also include and bring together disparate programmes of work with focus on delivering the overarching ICB strategy as suggested, driving down inequalities with a focus on the Core20plus5 framework as defined by NHS England (NHSE) looking at how Population Health Management (PHM) activities, prevention activities, personalisation and anchor organisation activities help in the delivery of these.

LW advised the need to agree a Deputy Chair and would welcome volunteers or considerations.
LW asked the membership if there were any questions or concerns regards the ToR.

KR noted that public health is a core part of the membership and suggested that a clinical lead appointment would be important to the membership as well as providing advice to the ICB, it would be beneficial to understand the inter-relationship with the local Alliances and reporting from the Health and Wellbeing Boards.
LW agreed with the challenge regards Governance and accountability direct reporting lines and noted this can be added to the ToR for clarity.
LW also agreed with the point raised regards a Clinical Lead as Chair or Deputy Chair and asked again for any volunteers. None received.

JB commented on the reporting routes and updated that the Integrated Care Strategy (ICSt) will have and indicative organogram of the different boards including Health and Wellbeing Boards (HWB) and functions and how they report
LW noted the point made by KR of the need to ensure the whole agenda is adopted and embedded across clinical teams.

3. The Integrated Care Strategy

Action: To Note
(i) To note the approach to developing the Integrated care strategy around core ambition of improving health and care outcomes
Papers: To be attached
Lead: Jeff Banks
Time: 10 mins

LW introduced JBs work to develop the Integrated Care Strategy
JB expressed his appreciation for the contributions and input into the strategy and provided an update.
A series of workshops have taken place across a period of three weeks with over 170 attendees. A campaign has been held through the Essex Unite Facebook group and of the three questions asked there has been an average of 1700 engagements with those questions.

The strategy reflects the balance of both the system priorities and challenges of the community and partner priorities. Summarising the 27 input strategies revealed a common theme of reducing inequalities, as a common endeavour. Focus is on the outcomes to achieve in reducing health and care inequalities for our citizens and the journey of how we do it.
The concept paper summarising the broad approach, has been published today as part of the Integrated Care Partnership Board papers..

The draft strategy will be completed by 31st December following presentation at the Partnership Board.

JB expressed thanks to Claire Hankey and colleagues in Comms team in advance of the strategy going through a process of development for public facing in January 2023, with a presentation through our website. Case Studies will be included as well as good examples to highlight in the strategy.
The priorities have been refined down into four key components and the common endeavour, describes as North & South, East & West of our strategy.
North = Core20plus5, the NHS articulation of how and where we should be tackling health inequalities for our population.
South = wider determinants of health, particularly in our district and borough councils.
West = Adult Social Care, recognising the challenges of the ageing population, as well as Domiciliary Care, Frailty, etc.
East = Babies, Children and Young People, babies and children are human beings, in an earlier stage of development with the right to superb access to health and care services, but also a key driver for prevention and early intervention

JoB questioned where the focus should be on scarce resources to support the ICS's priorities, and if that will be in the ICS strategy or in the Population Health Improvement Strategy?
JB responded it will likely be a combination of both. The ICS is the high-level priorities that unite all of the partners and our wider communities that we serve. There will still be a need for Health and Wellbeing Boards or Governance Boards within our NHS

bodies to identify their key priorities and work out how they address them. The ICS will indicate what is considered to be the key system priorities and key work areas.

JB noted the concept of individualizing the targets is not yet developed in the ICS strategy and would welcome thoughts on the way we define targets and how we report to the Integrated Care Partnership Board.

LW commented it's about a program of work within a particular discipline and the strategy is going to be at a much higher level than that. JoB's concern of the risk, what does that mean and how do we translate that into a work program is key. Overtime we need to ensure we can demonstrate progress utilising a number of different enabling workstreams, to achieve a particular outcome. The overarching strategy will help define what the key outcomes would be to articulate as a set of priorities.
The January PHIB meeting, post-strategy sign-off is going to identify the outlined work program for this program of work and how do we want to articulate and demonstrate progress over time.
LW expressed her preference as an outcomes-based approach or priorities-based approach looking at individual organisations or workstreams and how they contribute to that, to get that matrix and collaborative working, with JoBs steer on ensuring that real translation into action.

JC expressed her understanding of the purpose of this board is to ensure that the scarce resources we have around PHM, Data and BI, prevention and self-care personalisation don't miss each other as this is a coordinating function.
It was noted that today's meeting is about current position and strategic intent for the work programmes.

4. Development of Population Health Improvement Strategy

Action: For discussion
(i) Development of Population Health Strategy that supports delivery of the ICS Strategy
Papers: Verbal discussion
Lead: Lucy Wightman & Emma Timpson
Time: 20 mins

LW commented the overarching question in the longer term of Population Health Improvement Strategy, is how all of these complementary, thematic or workstream areas contributes to delivering the areas identified of that overarching strategy and how the separate workstreams feel about a proposal that brings those together.

Question asked if there any workstream leads who feel that that would or wouldn't be a good idea?
PS agreed it would be a good idea and the right direction to move in. JoB also confirmed her support.

JB raised the importance of the PHIB identifying very clear targets and that the ICS has to create a framework where all of those input strategies are collected and shared, avoiding duplication and important it done at PHIB.

KR expressed he may have misunderstood the PHIB direction and was clarified by LW. There isn't an ICS strategy per se, but we have our joint Health and Wellbeing Strategies respecting those as we develop our Integrated Care Partnership Strategy. The Integrated Care Board Strategy is basically the NHS operational plan for the NHS organisations. Much like our 30 corporate plans, the Board Strategy is very much internal looking. The Partnership Strategy is the framework that says what we want to achieve for all of the residents in MSE. Part of which will identify areas requiring input and coordination of the strands that we want to bring together in this board. It would replace the need for a separate prevention strategy, a separate population health strategy, removing the need for individual work strands having strategies and will say based on these outcomes we want to achieve, how do we bring these things together to do that.
JC agreed with the explanation and simplified it as a delivery plan to enable the strategy but includes other things such as incentives that will need further thought and articulation regards how it fits together.
It was suggested that if strategies are a problematic term then perhaps refer to work plan.

KR expressed he would like to see a high-level disability plan with a number of programs and where they are delivering.

LW suggested a change in the reference from “strategies” to a “delivery plan”.
RF agreed with KR concerns and thanked him for raising the issue.

5. Programme Updates – Population Health Management (PHM)

Action: To Note
(i) To note the strategic intent of the Population Health Management programme across the ICS and progress to date
Papers: Attached/Presentation
Lead: Jo Broadbent
Time 10 mins

JoB gave an overview of PHM, how it has been approached to now, what is the work plan for the rest of the year and clarification of the approach longer term.
A proposal for Mid & South Essex to support the improvement of health and wellbeing of the population was also shared. The key facets are to use evidence-based interventions that have been targeted using integrated data.
PHM is about data, and it is based on data analysis, intervention, impact and outcomes.
Progress has been made on the infrastructure over the past year with the imminent arrival of the data platform and broadening access to the integrated data set built with Arden and GEM to capitalize on the infrastructure and build the insight and intelligence that drives PHM.

LW referred to the slides and suggested to include the word “positive” to be added before “impact”.

Work has been done to design interventions that will ultimately have an impact on population health and also health inequalities. Another element is incentives or investment, not just financial investment, but with resources combined will deliver that impact.
Health inequality packs were produced over the summer and will be updated as the census data comes out. Plan for next year to produce health inequality packs for Babies, Children and Young People.
Much of the data is health intelligence pulled together with some PHM insight to give more detailed information. There is a draft health and equalities assessment toolkit with a framework that multiple workstreams can use.

In view of this insight diabetes cards for Primary Care Networks (PCNs) have been produced to illustrate where they are across the pathway of primary/secondary prevention management and the diabetes targets.

A Joint Strategic Needs Assessment (JSNA) on self-care was produced last year for the whole of MSE area which the personalisation workstream might want to bring into its early consideration.

Regards the infrastructure and integrated data set and segmentation model, there are c.80% of the GP lists in the ICS and c.1.2m individual patient records with a gap of 20%. Linked data sets include secondary care data, community care data, mental health data, and adult social care records from Thurrock and Southend, with discussions regards obtaining Essex County Council Social care records also. Pilot work ongoing on the wider determinants of health data set and housing data in particular.

The multiple data items will be available more generally across the ICS once the data platform is in place in December with work going on in terms of information governance and training across the system.
The segmentation model slide consists of 10 segments. Every single one of the 1.2m individual records has been allocated to a segment related to each other in terms of clinical pathways and how individuals may move between the segments as their health status changes and they move between health and care services. A review in in c.6 months will identify how people may be moving between these segments giving an insight into people's actual experience and their journeys through health and social care, but also identifying opportunities for prevention that might have been missed, enabling targeting of specific prevention and health inequalities.

Work done on Thurrock Alliance level intervention looked at long term conditions and missed opportunities for prevention within the population.

At PCN level a project at Chelmsford saw a review undertaken to support the physical health of people with severe mental illness, a cohort of middle-aged people was looked at and what physical health issues they were struggling with. Working in reverse it identified physical health prevention opportunities that cohort may have missed and coproducing the intervention with that group of patients.

An example of the wider determinants of health data pilot project around fuel poverty in Thurrock was shared, based on insight from our housing teams and single view of debt data. Working through the information governance it is hoped to identify those households and link that to health data where there are individuals with health conditions particularly affected by fuel poverty which will assist in prioritising the intervention. There is a financial inclusion team giving advice on debt, housing and fuel poverty related issues to allow targeting that resource much more specifically and start to address wider determinants of health through PHM.
JoB shared the core PHM Team Workplan Q3 & 4 2022/23 which highlights the PHM teams work programme including work by Stephen Gallagher and the Business Intelligence (BI) Team, and opportunities coming up in the next 12 months.

LW thanked JoB and commented on the impact of the opportunities, financial sensitivity, different interventions and the potential return on investment and profiles.

SG provided an update on the PHM Data segment dataset going live at Christmas to include some of the dashboards.
The data is already there and growing weekly. Currently looking for good opportunities to start to evaluate and interrogate this data, but we need good use cases.
The data is created by a set of Power BI Dashboards which reflects that each individual resident has 154 attributes which can be viewed at individual level in its subdomains.

LW is keen to include deep dives into each of the enabling workstreams at future meetings.

ET questioned how we move to supporting team on interventions by applying quality improvement framework.
LW noted there is no quality representation at the meeting and suggested a key person or programme of work to link in more formally.

AP expressed her support with the data driven approach advising it resonates with clinicians and to get the true picture the data speaks volumes. The buy-in from clinician colleagues, Alliances and PCNs with this approach, will form those links with wider partners which is the direction needed.

Quality Improvement and Leadership skills was raised and how to upskill the Alliance colleagues. The QI Leadership programme funding will end so there is a requirement to maximise the small cohort of alumni to build the topology and maximise going forward.

It was questioned if the clinicians understood the opportunity AP raised earlier and although GP colleagues are aware of the practical benefit of population health, it may not be as well understood in more acute, mental health, community service and professional bodies.

RF suggested that further educational/ awareness was required with clinical colleagues.

It was noted to ensure these overlaps with JoB and the reference made to education as part of that PHM work plan.

Discussion followed regards weaving in the approach and capacity, building in the education around that and the more sustained workstreams. There needs to be tactical engagement once the delivery plan is developed, looking at Ageing, Adult Social Care, Babies Children and Young People, doing tactical pieces of work to demonstrate the impact.

DD questioned how do we ensure we devolve the actions to the most appropriate area and places to avoid repetitive conversations and oversight at other boards all of which often drive actions ? How do we ensure we have the ownership in the right places?

LW advised it refers back to strategy accountability and suggested a review of the logic model template which Identifies who are the doers versus who are the assurance organisations, bodies or boards, etc. The logic modelling helps identifies clear ownership around the actions that make the difference.

LW advised it is more complicated at ECC level because if its size.
It was noted the Consultation outcome was circulated around the purpose of the Health and Wellbeing Board now that the Integrated Care White paper has been published. There is a need to understand how those two strategic boards are going to work together and what does the Health and Wellbeing Board do now. We need to ensure to hold each other to account and that what we're talking about is delivery and what we're measuring is impact as well as political things to fulfil.

6. Programme Updates – Health Inequalities

Action: To Note
(i) To note the strategic intent of the Health Inequalities programme across the ICS and progress to date
Papers: Attached/Presentation
Lead: Dr Sophia Morris
Time 10 mins

SM shared slides providing an update on Health Inequality from where we have come from and where we are now.
Addressing health inequalities covers a number of areas where we are trying to create a difference and have a positive impact. Not just health but access to care, our quality and experience of care and some wider determinants. Work around prevention, the behavioural risks and health.
A programme plan was set out c.2.5 years ago prior to the ICS with four domains creating a culture of compassion, inclusivity, creating opportunities, workforce and people plan leaning on the evolving population health management approach.
That set a foundation of the work that's in place now and some of the approaches adopted around health inequalities.
Culture – there is good leadership around inequality as a system and committed to reducing health inequalities. An area of focus was equality impact assessments, which moving to a digital tool will allow working closely with PHM understanding our

data, where our inequality gaps are, particularly those population groups that we understood or experiencing more inequalities.

Creating opportunities was being done at place and the Anchor Institute was developing their programme plan. Overtime the workforce and people plan moved to the workforce and EDI groups.
It was agreed as an ICS we would commit to reducing inequalities as the core driver through the principles taking that proportionate universalism approach.

Considering how we use the Anchor Institution principles across our places and allowing place to have that ownership approach to reducing inequalities, there were a number of strategies needed to ensure they embedded inequalities.
A population health improvement framework was put forward to include four principles looking specifically at the integrated health and care system focusing on healthy behaviours and lifestyles and forming communities and places which are health, creating environments, focusing on wider determinants and enablers to steer and drive this approach.

Looking at leadership and organizational development, creating awareness, educating and- understanding about how and why we need to address health inequalities.
Looking at our asset-based community development approach, driven by our population health management work plan and resource allocation.

Ambitions are what we want in terms of population health, wider determinants, addressing increasing healthy life expectancy and community.
Short term impact is looking at primary care and elective recovery; addressing digital inclusion and looking at our dataset;
Mid-term impact is looking at preventative areas. Tobacco dependency, Weight Management, Alcohol and Children and Young People (CYP);
Long term impact looks at those wider determinants, education and physical environment.

The proposal as a system is about oversight and assurance taking some of those increasing our system capacity, looking at resource allocation and capacity for workforce and digital and where it is sensible to have system wide programs.
To summarise, it's about how to reduce inequalities from being a reactive health service to focusing more on prevention and Health Equity, particularly how we're going to be embedding proportionate universalism, strengthening our place-based approach to reducing inequalities, tackling variation in access and outcomes.

LW thanked SM for the presentation and noted the reinforced overlap between all of the different strands discussed today and the benefit of bringing them together into a single strategy.

JB questioned as a system, where do we define our plus groups and what are they ?
SM responded there are some plus groups identified but some may be missing which is where the Alliances have that insight to understand their communities and identify their plus groups working with PHM for data.

LW noted we need to be mindful and recognise there may be core plus groups, but also clinically specific plus groups such as sexual health services and/or domestic abuse services.

7. Programme Updates – Prevention

Action: To Note
(i) To note the strategic intent of the Prevention programme across the ICS and progress to date
Papers: Attached/Presentation
Lead: Dr Peter Scolding
Time 10 mins

PS shared slides and gave an overview of the areas of work that have been defined over the last year in terms of system level activity and a focussed updated on each area.

- Healthy Weight Management services has been developing a system level transformation, particularly tiers two to three and beyond services of tiers one to four. It has been agreed to go into partnership with industry to enable capacity and cross system working with health and local authority colleagues to drive that transformation work.
- Children and Young People services are a broader approach to healthy weight, what can the system add to that work outside of weight management services. A system level dashboard is focussed on activity of total eligible population, weight management service referrals, national diabetes prevention program referrals and now looking at place PCN practice level to understand what the activity levels are.
- Smoking - tobacco cessation focus has been primarily looking at the work associated with the NHS long term plan funding. Which, when up to full complement will bring in 10 new roles in patient settings, such as maternity, mental health and acute inpatient.
- Cardiovascular disease is primarily focused on the ABC, Atrial fibrillation, Blood pressure and Cholesterol. The Blood Pressure at Home program (BP@Home) has up to 54,000 people having had their reading checked at home. 1500 people have had their medication started or reviewed as well as general lifestyle and health behaviour advice given to every thousand people. Of that review of high blood pressure 900 people have been picked up as diabetic and 100 people have had high blood pressure and needed specialist care, but significant impact in terms of prevention.

The proactive care framework is in progress with Wave One and recruiting, with development of materials bringing a risk stratification approach into primary care settings. Searches via System One to identify and understand different cohorts of patients, matching with a workforce approach to ensure higher risk patients are seen by specialist nurses and GP's whilst lower risk patients can be seen by other clinicians within primary care settings.
Wave one will include practices from 9 different PCNs, with support from UCL partners; Wave Two will take a more targeted needs-based approach.

A review was undertaken of all the different prevention related activity across the system and those areas of work which we need to collaborate more and depend on each other to have that impact. The main area identified was “were making every contact count” approach, particularly in health services, recognising that there is a local authorities approach, but we could do better within health services.

The population health workstreams bring different areas together and focus on those workstreams is that universal offer on what's provided across the system and moving towards improving our targeted offer, working more closely with personalised care, inequalities and the PHM approach as discussed earlier.

8. Programme Updates – Personalised Care

Action: To Note
(i) To note the strategic intent of the Personalised Care programme across the ICS and progress to date
Papers: Attached/Presentation
Lead: Emma Timpson
Time 10 mins

ET introduced Stevie Attree to present the slides.

The personalised care model is the basis of interventions in terms of responding to population health need and to deliver on health inequalities.
Achievements from the last year include development and launch of our Coaching Skills Course, available to all health and care professionals. This will enhance our ability to make every contact count. These coaching skills are for all practitioners to deliver on those universal and personalised care and support plan issues.

Articles have been published in relevant health journals around embedding personalised care to address Mental Health needs and delivering on health inequalities.

Participation in the National Children's Bureau report evidenced the impact that personalised care has on reducing health inequalities through personalised care. Also working on our patient facing campaign.

Following co-production there is a campaign ready to launch called “Ask your questions”, which is about empowering people to participate in their care conversations. Working with the National Institute of Health Research (NIHR) around the prevalence of shared decision making and what recommendations our system needs to do that effectively to empower personalised care.
The report is due for Christmas publication with an article for the British Medical Journal (BMJ) with the NIHR.
More to come in the next few months with leadership and support from Anita Pereira around clinical leadership for proactive personalised care.

9. Programme Updates – Anchor programme

Action: To Note
(i) To note the strategic intent of the Anchor programme across the ICS and progress to date
Papers: Attached/Presentation
Lead: Preeti Sud
Time 10 mins

PrS provided an update on the context of the programme**.**

The Anchor Charter was signed in 2021 as a system commitment. With JB, as part of the Anchor program for the ICS that charter will be brought to life.
A review has taken place to identify how it can be done at local level, doing it once across Alliance's and once across system, and how that fits into the overall program. Within the hospital anchor programme there is a dashboard identifying deprivation ethnicity close to the frontline staff or staff delivering the services, providing awareness of the spread of their staff. There has been an improvement in the number of staff members willing to disclose their disability as well as within our staff workforce. There is a proposal that our analyst will sit with workforce analysts for all partner organisations as well as the system to support them.

With Essex County Council (ECC) support we have 1.5 people running the anchor program and that resource helped us bid for c.£0.5m of Community Renewal Fund (CRF), benefiting the Southend population. Therefore, through partnership in action we are connecting what we already have and delivering locally, but how do we bring those skills close to the ask of the recruiters?

An evaluation of the anchor program was presented to our Board and shared with system partners in May of this year and will follow up for the MSEFT anchor program. In terms of the Programme there is a whole program plan sitting behind it. A workshop is planned for 21st November, with the aim to make all those connections, what should we be doing locally and what we should do once for the system.
One to One meetings with the Alliances Directors are also taking place.

Horizon scanning or planning is taking place with innovations to fill the identified gaps for local anchors. Following that, conversations with local anchors will strengthen these partnerships.
The social value is about agreeing measurements and £0.5m worth of social value has been created through the UK CRF commitment.

The dashboard and the evaluation are planned to replicate some of the work done either through UK CRF or through the learning disability internships to ensure we make MSE the place where people want to come and work and live.

KR referenced the work around evolution in an earlier discussion and the need to collectively build on and not lose the momentum of the wider conversation happening around skills and learning.

Discussion followed regarding the need to highlight and share the impactful stories, the learning and the good news that demonstrates impact throughout MSE.

LW referred to the slide deck circulated and one which was specific to NHS anchors and questioned if it was a separate program of work where just NHS organizations are involved.
PrS responded the NHS is the last sector to get on board and an evidence review by the health Foundation of what is the evidence around hospitals as an anchor institution was published in August 2019. The local community identifies with the hospital as a building whereas universities and councils are anchors, as are hospitals. Thinking beyond what we do, secondary or primary care, it's about trying to bring NHS organisations on board.

LW offered her support of local authority, presentation or information noting all members are individually involved in the anchor work within in the local authorities and is keen that acute colleagues are on board.

10. Integration of work across the programmes

Action: For discussion
(i) To discuss how we harness the greatest impact for our local population across the programmes of work
Papers: Verbal discussion
Lead: Lucy Wightman
Time 20 mins

The integration of work across the programs was discussed earlier in conversations.

LW summarised her understanding that once the strategies are in draft form the group can start to extract what we understand our role is in helping to deliver the strategy with articulate priorities or outcomes.

A delivery plan will be developed to identify how different component parts are delivered to achieve that outcome, with clear ownership around each of those elements.
There will be a need to think about how we ensure that we recognise it as business as usual for each of the workstreams that contribute to that as well as the five areas of focus that we identify.

JoB raised the PHM has a lot to offer both upstream at the strategic planning and downstream at the intervention planning. As part of the discussion of integrating work across the programmes, how we can support that with PHM?

11. Any Other Business

Action: To Note/To Approve/For assurance
Papers: Verbal
Lead: Lucy Wightman
Time: 5 minutes

ET noted a number of items to discuss offline but will respond to individuals if there are any specific deep dives or items of discussion to bring to the next meeting.

LW thanked all for their attendance and input.
Meeting closed 12:06

12. Date of Next Meeting

22 December 2022, 10:00-12:00

DRAFT MINUTES

Meeting of the Population Health Improvement Board
Date: 22 December 2022
Time: 10:00 to 12:00
Venue: Microsoft Teams

Attendance

Lucy Wightman (LW) – Director, Wellbeing Public Health & Communities, Essex County Council (Chair)
Emma Timpson (ET) - Associate Director for Health Inequalities and Prevention, MSE ICB
Jo Cripps (JC) – Director, Strategy and Partnerships, Mid & South Essex ICB.
Jo Broadbent (JoB) – Director Public Health, Thurrock Council, and Lead for the ICS Population Health Management Program
Claire Hankey (CH) – Director Communications and Engagement, MSE ICB
Krishna Ramkhelawon (KR) – Dr, Public Health, Southend Council
Sophia Morris (SM) – System Clinical Lead for Health and Inequalities, MSE ICB
Pete Scolding (PS) - Assistant Medical Director and Senior Responsible Officer for Prevention, MSE ICB
Preeti Sud (PrS) – Head of Strategy Unit, Mid & South Essex NHS Foundation Trust
Owen Richards (OR) - Chief Officer, Healthwatch Southend
Helen Farmer (HF) - Interim Director for Children and Young people and LD, MSE ICB
Stephen Gallagher (SG) - ICS Director of Data, MSE ICB

Apologies

Jeff Banks (JB) – Director, Strategic Partnerships, MSE ICB
Anita Pereira (AP) - System Clinical Lead, Health Inequalities and Personalised Care, MSE ICB
Ronan Fenton (RF) - Medical Director, MSE ICB.
Dan Doherty (DD) - Alliance Director, MSE ICB
Stevie Attree (SA) – Personalised Care Program Lead, Mid & South Essex ICB.
Steve Gallagher (SG) – Director of Data and Business Intelligence, MSE ICB.
Jen Kearton (JK) – Chief Finance Officer, MSE ICB
Barry Frostick (BF) – Chief Digital Information Officer, MSE ICB.
Peter Fairley (PF) - Director for Strategy and Integration, Adult Social Care, Essex County Council
Ruth Jackson (RJ) – Executive Chief People Officer, MSE ICB
Chris Martin (CM) - Director for Strategic Commissioning (Children and Families, Essex County Council
Natarajan Sooraj (NS) - System Clinical Lead for Children and Young People, MSE ICB

1. Welcome and Apologies *(presented by Lucy Wightman)*

LW welcomed all members to the meeting, with apologies noted as above. All members agreed the minutes of the previous meeting.

RESOLVED – The Board APPROVED minutes of the last meeting as an accurate record.

2. Action Log *(presented by Lucy Wightman)*

LW provided thanks to colleagues for progress on the action log to date. Action 7 was raised as still in progress with ET, where an update will be provided later in the meeting. LW noted two actions still outstanding which will be started before the next meeting.

RESOLVED – The Board NOTED the action log, and progress to date.

3. Improving Health of Children and Young People *(presented by Helen Farmer & Dr Sophia Morris)*

SM provided an update to the board on the Core20PLUS5 Children and Young People Framework which was recently released and follows the principles applied for the adult framework. Core20 looks at the 20% most deprived population groups (nationally), and the PLUS5 groups (locally defined), which have been adjusted compared to the adults framework and will be looking beyond Gypsy, Roma and Traveller communities to areas with violence against children, such as SEND and LD groups. SM confirmed work locally to understand what areas these would be from data for Mid and South Essex. In addition there are five key clinical areas; Asthma, Diabetes, Epilepsy, Oral Health and Mental Health which will be a key focus in addressing health inequalities for Children and Young People. SM confirmed this new framework will support the system in developing an all age approach to health inequalities.

The new framework will be reviewed at three different levels including at a ICB, ICS and national level. Each of the five clinical areas will have a transformation board where their portfolio will sit, with ICBs having responsibilities for the deliverables which fall from the transformation boards. The wider ICS will also have specific priority areas in line with the framework which are: Obesity, Infant Mortality, Speech and Language, Immunisation and Vaccination, Learning Disability, Autism and SEND.

SM provided an overview of the data for Children and Young People in health inequalities, following the Child Morality and Social Deprivation National Child Report, which showcased Children and Young People affected by modifiable factors were more likely to have an increase in risk of death and social deprivation. The modifiable factors include social environment (such as financial difficulties, parental meatal health), physical environment (such as overcrowding in the home, unsuitable housing, cleanliness) and service provision (such as access to care, lack of communication, lack of coordination).

HF provided further in-depth review for each of the five key clinical areas in the Children and Young People Framework.

HF confirmed Asthma has had a lot of work nationally and regionally which means it is likely to be the more advanced of the three long term conditions in the clinical areas listed. The main outcome is to reduce the number of asthma attacks, and as a result, emergency attendances at hospital and preventable deaths. HF noted the Child Death Review Team and the Safeguarding Team have recommended a deep dive into the five deaths relating to Asthma within the Mid and South Essex footprint, which will support learning for the framework. One of the recommendations includes the establishment of Paediatric Network, which has already been well established for MSE and led by the clinical lead for Asthma, who is also the regional lead for East of England. In addition, MSE are also 1 of the 10 national sites developing an integrated care model for Asthma, which has resulted in additional investment over a three year period. Substantial work has already begun on the Asthma workstream, which includes specialist nurses which have been recruited in SEE, with the integrated model focusing on SEE, and funding to allow a further roll out across MSE. Further work is underway in how the workstream can have a system approach at Asthma including wider system determinants such as housing and air quality.

HF moved to Diabetes, which has a recommendation to improve glycaemic control, with data showcasing there is lower uptake in ethnic minority groups in Continuous Glucose Monitoring (CGM). This will be a focus nationally in understanding why this is, and how we can support locally with our lower uptake groups. Locally, this may have resulted in a large variation in process for the previous CCGs, as a result, the Medicines Management team recently submitting a business case to roll out CGM availability to all sites across Mid and South Essex, with an aim to be approved from early 2023. A new clinical lead has recently been recruited for diabetes, who will take the lead on developing a system-wide network for diabetes.

Oral Health has recently had a large deep dive on the work locally for Mid and South Essex, where too many Young People and Children required to have preventable extractions of teeth, with a large backlog which is causing further pain at school and disrupting their day to day life. SM confirmed analysis has recently been undertaken on the waiting list data which will be reviewed against deprivation and ethnicity by a Child Oral Health Improvement Steering Group who are looking to address the key outcomes for Oral Health and draft a strategy on how MSE will tackle Oral Health in Children and Young People.

HM addressed Mental Health, where a key focus in the past years has been access to mental health for Children and Young People. However, the new framework has a particular focus for access with at-risk groups within the population. HF confirmed this will be brought to the Commissioning Collaborative Forum for Essex, to understand how the data will be collected to support this work.

Epilepsy has recently also had a Clinical Lead recruited to lead the worksteam, with an audit underway to understand provision of specialist epilepsy nurses in Essex. Although all areas have an epilepsy nurse, the usage and roles vary different between each area in Mid and South Essex. HF confirmed there was a previous national audit for Epilepsy which resulted in 12 key findings and recommendations. However, the

previous CCGs never submitted data or completed the audit which is a key gap to address and understand where MSE may fall short in epilepsy for Children and Young People. Work is underway to address the audit and understand which key findings we will need to be actioned.

Furthermore, HF confirmed that ET and SM had recently attended the Growing Well Board and showcased the new Core20PLUS5, with a focus on understanding work already underway and to not duplicate asks across the system. HF confirmed the Growing Well Board were in agreement to having oversight and ownership of the children's agenda, and report to the Population Health Improvement Board on the work. HF requested the Board to support this recommendation.

KR thanked SM and HF for the presentation, and raised a concern on how best start in life is not currently addressed in the workplan presented on the original slide. However, the way priorities were aligned across the system at the end of the presentation showcased how prevention was included. KR suggested a change in the ordering of the presentation to best showcase the local priorities, and how these feed into the framework. KR supported the recommendation for the Growing Well Board to lead the work and suggested the workplan to also be presented at Health and Wellbeing Boards in the region.

JC queried the Growing Well Board attendance and if it is inclusive of all partners. HF confirmed the membership does include wider membership, but attendance has not recently been inclusive of the full range of partners. JC supported the approach, with a request for a mapping exercise to be undertaken to ensure the wider partnership is included on the Growing Well Board.

JoB suggested early intervention and prevention to be a cross cutting theme for all of the elements of the CORE20PLUS5 model. JoB raised a question on oral health and if Community Dental Services and OHID are involved in the Oral Health workstream. SM confirmed the regional OHID representative are involved, alongside three representatives from Community Dental Services. JoB raised an additional question on how the overall work links into the Children Data Equity workstream, where the PHM team are involved in creating a datapack for the work. HF confirmed the ICB had an opportunity to apply and work with the Health Equity Institute alongside Barnardo's, however, last week the ICB was told it was not successful in the bid. The group of stakeholders who were involvedagreed it was important to keep the work underway regardless, and there was agreement to continue. As a result, MSE will continue to be involved in the collaborative group for the programme, but not as a key ICB member.

OR queried the membership for the Growing Well Board and understanding if parent/carer involvement is a part of the membership for the board. OR also questioned on cross cutting areas which will span across both Children and Young People as well as Adults, such as Air Quality and Dentistry. HF confirmed cross cutting is a definite theme and a key risk where we may be duplicating work. The Growing Well Board will be key in addressing the cross cutting themes, and make sure we address a problem once and properly. HF confirmed that representation would be key for the Growing Well Board, but instead of having limited membership on the board itself, there will be a parallel Children's Panel which will feed into the work as a key input to drive & influence the work.

RESOLVED – The Board APPROVED the Growing Well Board leading the CORE20PLUS5 Children and Young People work, reporting into PHIB.

ACTION – LW / KR / JB to ensure CYP CORE20PLUS5 is presented at HWBs, reflecting local priorities and highlighting the need for obesity as a priority.

4. Population Health Improvement Outcomes *(presented by Emma Timpson)*

ET provided an update on Population Health Improvement Outcomes on behalf of Jeff Banks. With the development of the ICS Integrated Care Strategy, a key output was to work with University partners to develop an overarching theory of charge / logic model and detail a set of outcome measures. ET confirmed an existing Outcomes Framework was in place for MSE which covered areas for reducing health inequalities, creating opportunity, health and wellbeing, care closer to home and transforming services. A piece of work was required to understand what was happening at an ICS Integrated Care Strategy level, which will then be tied into the PHIB, and what further work needs to be undertaken to understand future workstreams which may be needed to deliver the relevant outcomes needed.

LW confirmed a further item will come in January to deep dive into this topic.

RESOLVED – The Board NOTED the update on Population Health Improvements Outcome, with a further item in January.

5. PHIB Forward Plan *(presented by Emma Timpson)*

ET shared the draft PHIB forward plan, starting with the published ICS Integrated Care Strategy in January 2023. Following the published strategy, there will be a set of strategic priorities for the ICS, which will define the PHIB's priorities to support the delivery of the strategy. ET suggested a February meeting will focus on a developmental session on the logic model for PHIB. March 2023 onwards will focus on a detailed workplan for delivery, with accountability and dashboards to receive assurance for the workplan, and performance. ET noted some may be long term outcomes. ET suggested a key focus on development time for PHIB, which would be every 4 months, and may include external speakers.

JoB raised a suggestion on explicating detailed workplans for sub-groups and enabling workstreams, and how they link together. JoB raised a concern on the deep dives suggested on the forward plan, and specifically the quantity of them, and if the suggestion is all areas will have their own deep dive. ET clarified that work needs to be undertaken to first define what is meant by a 'deep dive', the process surrounding them and how partners will be involved. ET confirmed some areas may be more of a programme update, compared to a formal data-driven deep dive. LW raised an action to work with ET on further refining the deep dive section of the forward plan, and specifically reviewing if certain programmes could be aligned together, and how existing capacity may be able to deliver the deep dives. KR identified that as system we need to agree future approach for JSNAs and deep dives.

PS suggested the inclusion of explicitly detailing Obesity and Smoking Cessation inside the forward plan. LW confirmed this addition, inside Lifestyle Prevention, keeping in consideration the wider determinants and cross cutting nature.

PrS suggested a need to understand how the enabler workstreams & sub groups feed into the reporting structure and timeframes to PHIB in line with their programme objectives. PrS suggested ET reaches out to other ICS' who are further ahead in the journey with PHM / a PHM Board, and understanding what their structure and governance looks like, and how it differs from MSE. PrS confirmed they could support in reaching out to other ICS teams.

RESOLVED - The Board AGREED the forward plan for the Population Health Improvement Board

ACTION – ET / LW to review the deep dive section of the forward plan, reviewing where different programmes could be linked together, existing capacity issues, and development of JSNAs in councils.

ACTION – ET to review other ICS PHM Boards and understand how their structure/governance may differ to PHIB.

6. Health Inequalities Funding Update *(presented by Emma Timpson)*

ET provided an update on the Health Inequalities Funding, which was shared previously. ET confirmed the primary allocation of funding was to the four alliances in MSE, with each alliance taking a different approach to how they allocate to their local population. There was some funding kept for system wide programmes, which includes PHM, Anchor, Microgrants and an overarching evaluation framework.

ET confirmed all alliance projects have been approved via a HI Funding Panel, and are currently underway with their local due-diligence and contracting process. SEE are slightly ahead the other alliances, where some projects have commenced.

The Microgrants scheme had £100k allocated to the different alliances, managed by MSE CVS Collaborative, led by Community360. The programme went live in November, with 32 applications to date.

A system wide evaluation process has been commissioned with the University of Essex, which would allow evaluation across all of the projects and provide a suite of tools to use and manage outcomes and lessons learnt.

PrS queried if any projects are focused on staff/workforce in relation to health and wellbeing, or is it solely resident focus, and if not, is it something that should be focused on. ET confirmed no applications were made on projects specifically supporting staff during the current cost of living crisis, only staffing projects related to training packages. An additional point of the funding was any projects had to be sustainable, without additional funding pots, which may have made projects for staff unviable. LW commented that she believes staff projects should not be eligible for funding from this specific pot, but absolutely agrees on the requirement, as employers, to support staff during the cost of living crisis.

LW raised a question on future funding and if there is an understanding for next year's allocation. JC confirmed there is no current confirmation on funding for next year, although there is an expectation on baseline funding for Health Inequalities, clarity is required on what form this takes. Planning guidance is expected to be released this month which should detail the funding and how it is meant to be used. The board agreed a future agenda item in January to understand what the planning guidance allows for, and depending on the guidance, to make a request to the ICB for a formal allocation of the baseline funding to be ringfenced for specific purposes. JC noted that the ICB was likely to go into financial recovery due to the forecast deficit position and therefore consideration should be given to the contributory resources of partner organisations could be collectively deployed to support the ambition of reducing health inequalities.

RESOLVED – The Board NOTED the update on Health Inequalities funding.

ACTION – ET to ensure Health Inequalities Funding is on the agenda for January 2023 meeting.

7. Programme Updates *(presented by Lucy Wightman)*

LW noted the programme updates which were shared with the meeting papers and confirmed ET will be working on a light touch template to support in the programme update reports to ensure consistency across the programmes. No specific programmes raised points by exception.

PrS raised that at an MSEFT Strategy Forum, which SM attended, a concern was raised on how PHIB is increasing visibility of PHM work at an ICS level. LW confirmed the programme update template could support this in an easily accessible way to easily share information across members inside, and outside the board. SM added a point on health inequalities being shown as a key, and visible, factor in any of our documents as an ICS. This includes our public facing board papers, policies etc. LW agreed and commented on how Governance is not shown as an enabler on the current PHIB forward plan, so should be considered as part of the review. JC confirmed that governance team are reviewing the governance process for ensuring the health inequalities are considered within strategy and service developments.

RESOLVED – The Board NOTED the Programme updates.

ACTION – JC to ensure that governance arrangements reflect embedding HI into Board papers and processes.

8. Any Other Business *(presented by Lucy Wightman)*

SM raised the Community Connectors Programme, which is based within Southend's six most deprived wards, where a second year of funding has been awarded. The award has been linked with the respiratory programme and will continue to work closely on addressing health inequalities.

LW provided thanks to all colleagues on the board, and ET for pulling together the board and pack.

9. Date of Next Meeting

19 January 2023, 10:00-12:00

DRAFT MINUTES

Meeting of the Population Health Improvement Board
Date: 19 January 2023
Time: 10:00 to 12:00
Venue: Microsoft Teams

Attendance

Lucy Wightman (LW) – Director, Wellbeing Public Health & Communities, Essex County Council (Chair)
Emma Timpson (ET) - Associate Director for Health Inequalities and Prevention, MSE ICB
Jo Cripps (JC) – Director, Strategy and Partnerships, Mid & South Essex ICB.
Jo Broadbent (JoB) – Director Public Health, Thurrock Council, and Lead for the ICS Population Health Management Program
Sophia Morris (SM) – System Clinical Lead for Health and Inequalities, MSE ICB
Ashley King (AK) - Director of Finance Primary Care & Strategic Programmes, MSE ICB
Jeff Banks (JB) – Director, Strategic Partnerships, MSE ICB
Anita Pereira (AP) - System Clinical Lead, Health Inequalities and Personalised Care, MSE ICB
Stephen Gallagher (SG) - ICS Director of Data, MSE ICB
Kevin Garrod (KG) - Anchor Programme Manager, MSEFT
Pete Scolding (PS) - Assistant Medical Director and Senior Responsible Officer for Prevention, MSE ICB
Krishna Ramkhelawon (KR) – Dr, Public Health, Southend Council

Apologies

Claire Hankey (CH) – Director Communications and Engagement, MSE ICB
Preeti Sud (PrS) – Head of Strategy Unit, Mid & South Essex NHS Foundation Trust
Owen Richards (OR) - Chief Officer, Healthwatch Southend
Ronan Fenton (RF) - Medical Director, MSE ICB.
Dan Doherty (DD) - Alliance Director, MSE ICB
Stevie Attree (SA) – Personalised Care Program Lead, Mid & South Essex ICB.
Jen Kearton (JK) – Chief Finance Officer, MSE ICB
Barry Frostick (BF) – Chief Digital Information Officer, MSE ICB.
Peter Fairley (PF) - Director for Strategy and Integration, Adult Social Care, Essex County Council
Ruth Jackson (RJ) – Executive Chief People Officer, MSE ICB
Chris Martin (CM) - Director for Strategic Commissioning (Children and Families, Essex County Council
Natarajan Sooraj (NS) - System Clinical Lead for Children and Young People, MSE ICB

1. Welcome and Apologies *(presented by Lucy Wightman)*

LW welcomed all members to the meeting, with apologies noted as above. All members agreed the minutes of the previous meeting.

RESOLVED – The Board NOTED apologies.

2. Minutes and Action Log *(presented by Lucy Wightman)*

LW updated on the position of outstanding actions:

- **A06 –** To progress during the meeting.
- **A07 –** Already under way and will progress in the meeting.
- **A08 –** Directors of Public Health to notify ET once dates are scheduled.
- **A09 –** Not started, to progress further following the meeting.
- **A10 –** ET confirmed, in discussion with regional colleagues, other ICS' are not in the same position as MSE with a single Population Health Board.
- **A11 –** Complete
- **A12 –** JC to link with JB on how best to move forward, considering when, and how, to share information with the ICB & ICP.

RESOLVED – The Board APPROVED minutes of the last meeting as an accurate record.

RESOLVED – The Board NOTED the action log, and progress to date.

3. Development of ICP Outcomes Framework & 4. Adoption of Theory of change and logic model approach *(presented by Lucy Wightman & Jeff Banks)*

JB thanked colleagues for involvement to date on the Integrated Care Strategy, highlighting the importance of linking with the Population Health Improvement Board due to the common endeavour of reducing health inequalities. JB confirmed the first tasks of the strategy to develop a Theory of Change, and an accompanying Logic Model with a set of outcomes and measures which will work in alignment with PHIB.

The Theory of Change will be a key tool used to describe and illustrate how and why we consider the actions taken, will achieve the expected outcomes set by the strategy. JB confirmed the core components of a Theory of Change being: A) The Definition of tasks/objectives, B) Analysis of Inputs, Processes, Outputs, Outcomes and Impact and C) Define a clear set of actions and anticipated outcomes.

The Outcomes Framework will be developed building on existing frameworks across those in the partnership, alongside the Theory of Change and Logic Model. It will refresh and review existing work, and synthesis in alignment with the Integrated Care Strategy, alongside wider system priorities.

JB confirmed the next steps to establish a small working group, with engagement of partners alongside external support from Higher Education Institutes. JB will develop an initial model for testing, with two workshops in the upcoming months to deep dive

on the models. JB advised the aim to have a draft to the Integrated Care Partnership in March, with adoption in April.

LW thanked JB for the work to date and the update to the Board, in addition LW noted the update previously on the first 5000 families for the Strategy and requested an update on the current thinking.

JB confirmed the 5000 families will still be a key component on the Theory of Change and Logic Model, with a specific cohort which will be prioritised to have the most impact, and quickly. JB advised there is still work underway on how best to identify what the first 5000 families looks like, working with Digital and Data colleagues, alongside PHM colleagues. JoB added work is underway already on fuel poverty in Thurrock, identifying key households which are impacted by fuel poverty, alongside health deprivation to be used as targeted health interventions. JoB suggested this may be used as a blueprint for the first 5000 families approach.

SM raised the need for a robust criteria on the first families approach, highlighting the possibility of moral and ethical concerns on how families are decided as being the most deprived, and what would define a family or household such as those in temporary accommodation. LW agreed, with the importance of evidencing the criteria, and why a decision has been made, as by nature a decision will exclude other households. KR agreed on the need for a targeted approach, with the 20% most deprived growing quickly, and likely to rise to 25% in the upcoming years. KR highlighted the importance on continuous review of wider determinants, such as food and fuel poverty alongside primary and secondary preventions, such as health checks.

JC highlighted the importance of viewing the targeted intervention in addition to all other work ongoing including CORE20+5 and place based work, ensuring resources are used effectively, as there is a concern resources could be used quickly on defining what the initial 5000 households look like. JC suggested a possible solution, aligning with some views raised in the initial strategy workshops, of randomly selecting households, which could be used as a key research piece across Mid and South Essex on how deprivation affects households, and the interventions which can support. LW agreed on the importance of viewing the work in the wider system intervention package, and welcomed the other approach to how to define the first households.

ACTION – ALL to contact Jeff Banks if they would like to join the initial reference group for the Integrated Care Strategy Theory of Change & Logic Model.

RESOLVED – The Board NOTED the progress to date on the Integrated Care Strategy Theory of Change & Logic Model.

4. Development of Population Health Improvement Dashboards *(presented by Emma Timpson & Stephen Gallagher)*

SG provided an update on the Strategic Data Platform, supporting Population Health Improvements. SG notified the board that MSE previously had an external consultancy to review how Business Intelligence would be used moving forward. The outcome of

the review set 29 recommendations on how Business Intelligence should be improved to be effectively utilised in the system. Of those 29 recommendations, 6 were aligned to Technology, which have all been introduced. This includes a new cloud platform, introduction of Microsoft technology, a cost effective consumption-based model, single data repository and pilot use cases built. SG confirmed the new cloud platform was finalised in December 2022, with one billion rows of data migrated, and steadily growing. The platform has built six dashboards in a span of 10 weeks, which has been built in support with Information Governance ensuring alignment with data protection legislation. SG confirmed the six new dashboards include PHM Segmentation, Health Inequalities, Diabetes, Stewardship (Aging Well & Cancer) and Urgent & Emergency Care.

SG advised 2023 delivery plan has already been developed with partners across the system, and the IT provider (NHS Arden & GEM Commissioning Support Unit). The plan will change over time, but provides an overarching plan for future dashboards and developments. SG notified the board there will is still additional resources being brought into the team to support the development of the programme, including a Data Quality Consultant, Data Architect and a Business Analyst.

ET thanked SG for the update, showcasing how digital is a key enabler to the programme of work for the board. ET continued to describe how the digital platform will support the board's portfolio, building on the existing MSE Outcomes Framework with three main themes for the remit of PHIB (Reducing Inequalities, Creating Opportunity and Health & Wellbeing). ET suggested the need for dashboards to track population outcomes at a high level, segmented by alliances, PCNs and practice level for granular level interventions and the prevention programme, looking at the lens of specific groups such as: 20% most deprived, Ethnicity, Age, Sex and the plus groups. ET confirmed the need for an agile approach, which the data platform supports, building on the specific groups over time rather than waiting for the full dataset before work begins.

Next steps include continuation of the existing working group which will oversee development, working with digital colleagues on how the MSE Outcomes Framework priorities can be reflected into a dashboard on the strategic platform. There will also be a reflection on outputs from the ICP outcomes development framework, with a review following on how best resources can be allocated to support further development of the framework.

RESOLVED – The Board NOTED the progress to date on the Strategic Data Platform and Development of Population Health Improvement Dashboards.

ACTION – SG to provide access to the new Strategic Data Platform to all members of PHIB

ACTION – ET to organise a future demo on the Strategic Data Platform for PHIB.

5. Programme Updates *(presented by Lucy Wightman)*

LW invited colleagues to present additional programme updates by exception.

ET provided an update on Personalised Care, with Terms of Reference (TOR) for a Personalised Care Steering group. ET requested approval to create the new Steering group.

RESOLVED – The Board NOTED the Programme Updates.

RESOLVED – The Board APPROVED the creation of a new Personalised Care Steering Group.

6. Financial strategy to support reduction in health inequalities *(presented by Ashley King)*

AK advised colleagues on the development of a financial strategy which will aim to support the reduction of health inequalities. AK confirmed the strategy will be iterative, in conjunction with PHIB, however will be an initial start to how the NHS can address local finances to support health inequalities.

AK confirmed the £3.4m received in 22/23 for Health Inequalities will also be included in baselines for 23/24 in a recurrent nature (£3.4mil plus growth). For 22/23, 75% of the funding was delegated to Alliances for prioritisation, which resulted in 65+ projects which are currently being mobilised, with an average value of circa £50k, and outcomes will unlikely to be known until December 2023. AK confirmed a Health Inequalities funding panel will consider learnings from 22/23, and how 23/24 is approached.

AK raised four questions for addressing health inequalities through financial strategy:

1. How do we target health inequalities funding to obtain best value (health need, determinant or geographical focus).
2. Do we use specific health inequalities funding to close the gap, improve the average or both within the agreed area.
3. Is this through an approach of marginal gain or ‘quick’ impact and sustain
4. Do we champion the concept of proportionate universalism to be included within existing and new investments from core, and other, allocations.

KR thanked AK for the presentation and a concern on the allocation for HI funds as different processes took place across alliances in 22/23 (some alliances being a 1-year investment, others over 3 years). Furthermore, a concern on investment on projects which are not sustainable, and how investments can be made to build community resilience with a targeted approach.

LW suggested that PHIB had a role in influencing the overall financial strategy and should challenge providers and local authority partners around activities to support prevention.

JC asked for assurance that the £3.4m health inequalities funding would not be absorbed into the baseline. AK confirmed that it has been identified separately in planning submissions.

AK confirmed his support for adopting Proportionate Universalism approach to the full health spending.

LW supported targeted tertiary prevention work around those highest users but an overall Proportionate Universalism approach should enable closing the gap in outcomes where inequalities exist then enabling the focus on improvements across the whole population.

JB agreed with the previous comments and suggest PHIB set out a strategic framework that adopts a principle of applying Proportionate Universalism in strategic planning, commissioning, pathways and contracts.

JB noted that Thurrock had been successful in incentivising primary care in a targeted way around cardiac care. This learning can be shared to inform planned primary care investment scheme.

SM noted workforce constraints and LW suggested the People Board could attend PHIB to present on their strategic approach.

LW cited another ICB that had committed health inequalities funding to invest into the infrastructure to support delivery.

JB commented around the complexity and that different approaches were required utilising different sets of resources including community assets.

AP supported adoption of Proportionate Universalism to recognise differential resource input required in primary into the most deprived areas.

AK thanked the group for their contributions and debate and commented that support for principle of proportional universalism should be incorporated into the Joint Forward Plan along with defining clear outcomes and assessment of return on investment.

LW thanked AK for his concise and clear presentation.

RESOLVED – The Board NOTED the update on Financial Strategy to support reduction in health inequalities.

RESOLVED – The Board NOTED the questions raised by AK on financial strategy.

ACTION – ET to ensure the questions raised by AK on financial strategy are brought back for further discussion.

7. Any Other Business *(presented by Lucy Wightman)*

No other business was raised.

8. Date of Next Meeting

22 February 2023, 10:00-12:00

Minutes of Community Assembly Co-Production Steering Group Committee Meeting

Held on 4.1.2023 / 10:30 am via MS Teams

Attendees

Members

- Kirsty O'Callaghan, Mid & South Essex ICS, Chair
- Simon Prestney, Mid & South Essex ICS
- Peter Blackman,
- Ru Watkins, Hamelin Trust
- Joanne Webb
- Peter Davey, Essex Association of local Councils
- Dick Madden
- Steve Smith, Havens Hospice
- Rachel Brett, ECVYS
- Simon Harris< Blaireau
- Sarah Troop, Maldon & District CVS

Other attendees

- Janet Smith, note taker

Apologies

- Simon Harniess, Essex Care Association
- Jeff Banks, Mid & South Essex ICS
- Carla Andrews, Motivated Minds
- James McDonnagh, lead for Traveller group
- Nic O'Brien, Home Start, Essex
- Sam Glover, Healthwatch

1. Welcome and Apologies

The Chair welcomed everyone to the first meeting of this group. The group has been pulled together to form a group based on the Community Assembly model and what this looks like for the community sector, to grow the model aid groups and interested citizens. Apologies were noted as listed above. Attendees were informed that the meeting would be recorded for the purpose of minute taking.

2. Declarations of Interest

The Chair asked members to note the Register of Interests and reminded everyone of their obligation to declare any interests in relation to the issues discussed at the beginning of the meeting, at the start of each relevant agenda item, or should a relevant interest become apparent during an item under discussion, in order that these interests could be managed.

The following declarations of interest were raised / There were no declarations raised.

3. Minutes

Not applicable

4. Action log

Not applicable

5. Community Assembly – ICP Paper

KoC shared her paper explaining the formation and set up of the co-production steering group.

Long discussions around the purpose of the group and who should be involved. We need to find ways to work with and for the community. We don't just want representatives, want to work together from an operation point of view, looking at resourcing together and where we make decisions around funding and how we engage together.

Discussed the diversity of the group, will have James McDonnagh, lead for the traveller community, Carla Andrews, from mental health, Ru Watkins, learning disabilities, older people represented by Simon Harniess. We also have to ensure they are the right people to represent the community and have the right skill set. We need to look at membership and have tried to include big and small organisations, Sam Glover from HealthWatch will be part of the group going forward.

6. Our Culture as a Group

SP ran through his experience of previous Community Assembly's and working for the NHS. To be a successful group we need: -

- A vocal advocate in system work, have great advocates with KO, JW and JB
- Pilot group needs to move forward
- Need to keep vested interest for communities, rather than individual organisations
- Need to get to know each other better
- Not a personal co-production, set up to move things forward for the ICS
- Turn up for meetings if you can, if you can't make a meeting and a decision is made, back the decision, have to trust the Consensus
- If a decision is on the fence, back the Chair to make the decision
- Don't worry if the first project is not in your skill set or too busy, say and let others take the lead, "there's a time to seed and a time to lead."
- Hold things together as a group, stay focused
- Moving from competition to co-production

RW ran through his previous experience working for ICS' and as a group we shouldn't be frightened of taking risks, we understand the risk and take it. We come to meetings without our `hats' on, we come for the community and people. If we don't move at pace and agility,

we won't achieve anything. There is no wrong, if we fail, we fail and learn. We will ultimately have a deep impact in the community in Essex. Lastly enjoy it, at times it will be incredibly hard, but it is unique.

Communication will be paramount in everything we do. We need to communicate with various organisations as we go through the phases, help them understand where we are and where we need to get to. We need to include organisations in Southend and Thurrock as well. Any communication needs to come out via the sector and ST will take that back, think we have it covered as much as we can on day 1. Discussed the length of communication and the need to be aware of language, not use acronyms and have easy-read versions.

7. How do we want to do this, what is the need?

What is the need, what is the evidence? KOC has all the population health data, aware of the differences in areas. ICP approach is if not about early intervention or prevention it doesn't work that well.

Seeing increased level of deprivation and mental health issues in the younger generation. Seen disjuncture between social and health care. Lack of economy of effort, lack of impact, feel that is where we are. Impact and effect are where hospices are, not just hospices, but they are incredibly powerful way to get a message out to the workforce. Why not integrate and develop processes and systems for communities to get them out of deprivation. This assembly will deal with very complex issues, we need to do it in bite sized chunks. Allan Kellehear wrote Building Compassionate Communities, we can take that model, it opens up everything, the role of everybody in building communities.

SS we are not clear at this stage what we need, what is the struggle. First, we need to align the vision from the ICS and alliances, we need to listen to the alliances within Mid and South Essex, that is our starting point. The other end of the scale, what we provide for communities and what they will provide for us. We need to start trying to align our strategies.

It is a good opportunity for understanding across the sectors and understand each other's strategies.

KOC showed a diagram she has put together around how this could work with suggested areas we need to work on. Will send out to all, please send comments to KOC between now and the next meeting.

Discussed face to face meetings may be better than virtual, Hamelin Trust are happy to host the first face to face meeting.

- Action: KOC will send out the data packs
- Action: RW will send out Building Compassionate Communities by Allan Kellehear
- Action: send KOC proposed current congress chart to all

8. Chair and Vice-Chair

We need an independent Chair as well as a Vice-Chair. Over the next week KOC will issue a role descriptor, the role of Chair will need to be a paid role. The appointment of Chair and Vice-Chair is mission critical to the success of the group so will push that through as quickly as possible. Feels wrong if ICB member of staff is Chair.

9. Any other Business

KOC will get hold of any strategy documents needed. The notes of the meeting will go out a week in advance of the next meeting. Meetings won't always be face-to-face, some will be teams and starting fortnightly, but would envisage will become monthly. Will come back with dates for face-to-face meetings.

Ask that everyone comes back with a roadmap of what you want to see happen in the short, medium and long term.

- Action – all to come back with a roadmap of what you want to see happen.

10. Date of Next Meeting

Wednesday 18th January 10:30 am

Minutes of Community Assembly Co-Production Steering Group Committee Meeting

Held on 18.1.2023 / 10:30 am via MS Teams

Attendees

Members

- Kirsty O'Callaghan, Mid & South Essex ICS, Chair
- Simon Prestney, Mid & South Essex ICS
- Joanne Webb
- Dick Madden
- Rachel Brett, ECVYS
- Simon Harris, Blaireau
- Sarah Troop, Maldon & District CVS
- Simon Harniess, Essex Care Association
- Jeff Banks, Mid & South Essex ICS
- James Quinn-McDonnagh, lead for Traveller group
- Nic O'Brien, Home Start, Essex
- Charlene Slade, Essex Association of Local Councils (on behalf of Peter Davey)

Other attendees

- Janet Smith, note taker

Apologies

- Ru Watkins, Hamelin Trust
- Peter Blackman
- Peter Davey, Essex Association of Local Councils
- Steve Smith, Havens Hospice
- Carla Andrews, Motivated Minds

1. Welcome and Apologies

The Chair welcomed everyone to the meeting. Apologies were noted as listed above. Attendees were informed that the meeting would be recorded for the purpose of minute taking.

2. Declarations of Interest

The Chair asked members to note the Register of Interests and reminded everyone of their obligation to declare any interests in relation to the issues discussed at the beginning of the meeting, at the start of each relevant agenda item, or should a relevant interest become apparent during an item under discussion, in order that these interests could be managed.

There were no declarations raised.

3. Minutes

The minutes of the last meeting on 4th January 2023 were received, no amendments.

Outcome: The minutes of the meeting held on 4th January 2023 were approved as an accurate record.

4. Action log

The action log was reviewed and the following updates noted:

5. Vision and Mission

SP - we need to look at why we are here, we need a vision and mission statement, we can look at it today and get the nuts and bolts on the face-to-face session next time. We need to think about:-

What does a thriving assembly look like for you in this setting?

Discussion responses: -

- Representation across the VCSE sector and a good understanding of the sector.
- Ensure representation within groups and across other groups to feed into the ICB.
- Opportunity to look at partnership board and work out what is achievable.
- Recognise the sovereignty of every voluntary sector, not here to take over, need your help.
- Need to trust each other and build relationships to affect change.
- All share the vision and hold dear the principals – committees can do great things when they come together.
- We will make mistakes, but we will learn from them, learn from each other.
- In a strong position to look at early prevention, but also to look at resilience in the community.
- Need to make it meaningful, what does it mean on the ground for communities?
- Need a shared ownership, `joint custody' type of vision.
- How are we aligning, hear from communities challenges and build trust in the communities.
- 21% of deaths in traveller community are due to suicide – how do we help the traveller community with mental health?
- We need to address inequalities and gaps in the community, we are here to challenge the system.
- Has to be action, not just discussion, otherwise trust won't be built.
- Sajid Javid called the health inequalities a `moral outrage', we need to ensure the services offered are the best they can be.
- Maldon CVS has some funding to work with farming communities around suicide – ST will speak to JQM to see if they can work together.

If we get to this time next year and felt we had achieved something amazing as a group, what does that look like for us?

- Having impacts and outcomes.
- Providing service provision to match the gaps and inequalities in care.

Where do you see us position in other sectors, where do we position ourselves?

- Success is people starting to use this assembly as a robust, effective sounding board and learning space.
- As a wider group, will have more impact collectively building relationships.
- We don't fall into the trap of just one voice, we will give them our hands and do something, voice and hands all the time.

We need to think about vision, aspiration to get to this time next year, what do we look like? Any thoughts or come with a phrase to next meeting, our vision for a thriving community assembly.

- All citizens are equal, none are more equal than others. Health inequalities is the theme that keeps coming out today.
- Move the needle on health inequalities by just 1% would be amazing – voice, hands, connection, resource and partnership.

Have thinking time, reflect on discussion today and see if can come up with suggestions for a vision and mission.

- Action: ST to work with JQM re suicide funding Maldon CVS has received.
- Action: all to reflect and have suggestions for vision/mission at next meeting.

6. Next meeting 1st February

The next meeting on 1st February will be a face-to-face meeting, can focus on health inequalities as a group and come up with three key objectives.

If anyone wants to facilitate running the session, please let SP know.

- Action: let SP know if you wish to facilitate the next session

7. Assembly Independent Chair Role Outline

The independent chair role outline was sent out prior to the meeting. It is a brief outline and will be going to the executive to sign off the funding if people are happy with it.

Had a pop-up group with RW and PB to get views, can look at it further in another session if people prefer to do that, need confirmation people are happy with the role descriptor.

Comments: –

- don't be afraid to be organic, go where needs are
- accessibility – be receptive to accessible ways of hosting the post
- vice-chairs for succession planning (assured part of the approach taken)

SP will add in changes, otherwise all happy with the job descriptor.

- Action: SP to add in the changes to the JD

8. Community Assembly Diagram

Discussed the community assembly diagram and SP ran through the different headings. Want to make it clear, this isn't just about voluntary sector organisations, this about citizens themselves. Large charities have very different objective to small charities, it is being respectful where people are, what they do, having different perspectives is important.

Some felt the chart needed to be simplified RB will work with SP on this.

- Action: RB and SP to simplify the assembly diagram

9. Any other Business

Summary of any other business or No other business was raised.

10. Date of Next Meeting

Wednesday 1st February 10:30 am at Hamelin Trust, 19 Radford Crescent, Billericay, CM12 0DU.

Minutes of Community Assembly Co-Production Steering Group Committee Meeting

Held on 1.2.23 / 10:30 am

Hamelin Trust, 19 Radford Crescent, Billericay, Essex, CM12 0DU and via MS Teams

Attendees

Members

- Kirsty O'Callaghan, Mid & South Essex ICS, Chair
- Simon Prestney, Mid & South Essex ICS
- Dick Madden
- Rachel Brett, ECVYS
- Simon Harris, Blaireau
- Simon Harniess, Essex Care Association
- Peter Blackman
- Charlene Slade, Essex Association of Local Councils
- Mike Eldred, Essex Association of Local Councils
- Steve Smith, Havens Hospice (Via Teams)
- Jeff Banks, Mid & South Essex ICS (via Teams)
- Sam Glover, Healthwatch (Via Teams)
- Simon Johnson, BBW CVS (via Teams)

Other attendees

- Janet Smith, note taker

Apologies

- Ru Watkins, Hamelin Trust
- Carla Andrews, Motivated Minds
- Joanne Webb
- Nic O'Brien, Home Start, Essex
- James Quinn-McDonnagh, lead for Traveller group
- Sarah Troop, Maldon & District CVS

1. Welcome and Apologies

The Chair welcomed everyone to the meeting. Apologies were noted as listed above. Attendees were informed that the meeting would be recorded for the purpose of minute taking.

2. Declarations of Interest

The Chair asked members to note the Register of Interests and reminded everyone of their obligation to declare any interests in relation to the issues discussed at the beginning of the meeting, at the start of each relevant agenda item, or should a relevant interest become apparent during an item under discussion, in order that these interests could be managed.

Declarations made by **I**CB Board and committee members are also listed in the Register of Interests available on the ICB website**.**

The following declarations of interest were raised / There were no declarations raised.

3. Minutes

The minutes of the last meeting on 18th January 2023 were received

Outcome: The minutes of the meeting held on 18th January 2023 were approved as an accurate record.

4. Action log

The action log was reviewed:

5. Why are we here

DM gave a brief overview of the ICS partnership and the subject of the meeting today to discuss vision and mission.

6. Vision

Attendees were split into groups to come up with a vision:-

Team A: `A two-way pathway of community voices speaking into and empowering positive change for local health and welfare.'

Team B: `To empower people and communities to connect around health, wellbeing and welfare, driving a common endeavour to improve equity and trust, whilst addressing societal issues that matter to them in the places they live.'

Team C (online) `parity and partnership, equity and equality being key to what we want to drive forward.'

7. Mission

In the same groups to come up with a mission:-

Team A `We will engage in, with and for communities to drive positive change to improve health, wellbeing and welfare for people in Mid and South Essex.

Strapline:- `today we engage for tomorrow's positive change.'

Team B `"Be Brave" – we will listen to evolving voices and needs of our communities, using accurate evidence to drive meaningful change to the lives of the people within the community.

Aims:-

- We will engage
- We will listen
- We will act
- We will trust each other
- We will work with inegrity and values

Team C (online) `to listen and act upon communities views'

A more detailed paper will follow

8. Any other Business

No other business was raised.

9. Date of Next Meeting

Wednesday 15th February 10:30 am via Teams.

Minutes of Community Assembly Co-Production Steering Group Committee Meeting

Held on 15.2.23 / 10:30 am

via MS Teams

Attendees

Members

- Kirsty O'Callaghan, Mid & South Essex ICS, Chair
- Dick Madden
- Ru Watkins, Hamelin Trust
- Rachel Brett, ECVYS
- Peter Blackman
- Charlene Slade, Essex Association of Local Councils
- Mike Eldred, Essex Association of Local Councils
- Steve Smith, Havens Hospice
- Jeff Banks, Mid & South Essex ICS
- Carla Andrews, Motivated Minds
- Joanne Webb
- Nic O'Brien, Home Start, Essex
- James Quinn-McDonnagh, lead for Traveller group

Other attendees

- Janet Smith, note taker

Apologies

- Sarah Troop, Maldon & District CVS
- Simon Prestney, Mid & South Essex ICS
- Simon Harris, Blaireau
- Simon Harniess, Essex Care Association
- Sam Glover, Healthwatch
- Simon Johnson, BBW CVS

1. Welcome

The Chair welcomed everyone to the meeting. Apologies were noted as listed above. Attendees were informed that the meeting would be recorded for the purpose of minute taking.

2. Declarations of Interest

The Chair asked members to note the Register of Interests and reminded everyone of their obligation to declare any interests in relation to the issues discussed at the beginning of the meeting, at the start of each relevant agenda item, or should a relevant interest become apparent during an item under discussion, in order that these interests could be managed.

Declarations made by **I**CB Board and committee members are also listed in the Register of Interests available on the ICB website**.**

The following declarations of interest were raised / There were no declarations raised.

3. Minutes

The minutes of the last meeting on 1st February 2023 were received

Outcome: The minutes of the meeting held on 1st February 2023 were approved as an accurate record.

4. Action log

The action log was reviewed:

5. Clarity on ICP ICB and ICS

All confirmed they had watched the video How does the NHS in England work and how is it changing? - YouTube PB gave an overview on ICP, ICB and ICS and explained bringing everyone together will be key for the assembly.

6. Vision, Mission and Values

RW Von Moltke said “no battle plan survives contact with the enemy.”

Vision and Mission
We have had discussions around vision and mission, the paper was sent out. We need to think if we want to simplify the language. Feel it is best to have a working group get together next Thursday 23rd February at 10 am at Hamelin Trust, Billericay, to work on revised wording, we will keep it as simple as possible. Anyone is welcome to join either in person or virtually.
Action: working group meeting Thursday 23rd February to work on vision and mission

Values
The document SP put together was sent out in advance of the meeting, a lot of the work has been done already around values. Values are important to the way we work, there is another piece of work to do to express the values. We will have another working group to establish the values we want and believe. Let us know if you would like to be part to the working group.
Action: JS to arrange a date and time for the values working group to meet

The aim of the working group will be to have the vision, mission and values completed for sign off at the next meeting.

7. Workstreams

The whole point of the assembly is about the individual, the person is centre of what we do.

RW ran through the workstream document circulated. Discussed the chart, all happy with the plan as it shows we are doing something, voice and hands – it is all about us doing.

We mustn't spend too long thinking, don't want to lose focus on what we are here to do, have to think about what we are trying to achieve, what right looks like.

Discussed RAVS, SAVS, CAVS etc. who would have more contacts with the individuals, have ST to represent those groups, but happy to ask Anthony Quinn (SAVs) to join the assembly.
Action: ask Anthony Quinn to join the assembly

We must all come with `hats off' to this meeting, have to come with that approach to achieve what we need to.

If anyone has any ideas on workstreams at a more strategic level, we have identified comms, please let RW know and he will pull all the ideas together. Please let RW have any thoughts/ideas by 23rd February.
Action: let RW have any ideas on workstreams by 23rd February

8. Any other Business

Draft integrated care strategy is out and to be agreed at a meeting on 20th March, please go through and pass on any comments to KoC, JB, DM and RW Draft Integrated Care Strategy - Mid and South Essex Integrated Care System (ics.nhs.uk)
Action: pass any comment on document to KoC, JB, DM and RW

9. Date of Next Meeting

Wednesday 1st March 10:30 am Hamelin Trust happy to host.

Minutes of Community Assembly Co-Production Steering Group Committee Meeting

Held on 1.3.23 / 10:30 am

via MS Teams

Attendees

Members

- Kirsty O'Callaghan, Mid & South Essex ICS
- Simon Prestney, Mid & South Essex ICS
- Dick Madden, Chair
- Peter Blackman, South Woodham Ferrers Health & Social Care group
- Charlene Slade, Essex Association of Local Councils
- Mike Eldred, Essex Association of Local Councils
- Simon Harris, Blaireau
- Simon Harniess, Essex Care Association
- Sam Glover, Healthwatch
- Simon Johnson, BBW CVS
- Steve Smith, Havens Hospice
- Jeff Banks, Mid & South Essex ICS
- Carla Andrews, Motivated Minds
- Joanne Webb, resident
- Nic O'Brien, Home Start, Essex

Other attendees (Guests)

- Alison Connolly, Mid Essex Alliance
- Neave Beard, Strenghtening Communities, ECC
- Lynn Gittins, Thurrock Council (on behalf of Natalie Smith)
- Sam Ball, South East Essex Alliance
- Romi Bose, NHS Mid & South Essex ICB & Thurrock Alliance
- Nicola Burston, Domesic abuse specialist
- Simon Williams, Basildon and Brentwood Alliance

- Janet Smith, note taker

Apologies

- Sarah Troop, Maldon & District CVS
- James Quinn-McDonnagh, lead for Traveller group
- Ru Watkins, Hamelin Trust
- Rachel Brett, ECVYS
- Les Billingham
- Tracey Harris

1. Welcome

The Chair welcomed everyone to the meeting. Apologies were noted as listed above. Attendees were informed that the meeting would be recorded for the purpose of minute taking. Existing members of the VCSE Coproduction Assembly introduced themselves and colleagues from each Alliance area and each Local Authority.

2. Declarations of Interest

The Chair asked members to note the Register of Interests and reminded everyone of their obligation to declare any interests in relation to the issues discussed at the beginning of the meeting, at the start of each relevant agenda item, or should a relevant interest become apparent during an item under discussion, in order that these interests could be managed.

Declarations made by ICB Board and committee members are also listed in the Register of Interests available on the ICB website**.**

The following declarations of interest were raised / There were no declarations raised.

3. Minutes

The minutes of the last meeting on 15th February 2023 were received.

Outcome: The minutes of the meeting held on 15th February 2023 were approved as an accurate record.

4. Agree vision, mission and values

Thank you to all members of the alliance for the active part they have played in getting the vision, mission and values together. Paper with suggested mission, vision and values was sent out. Looking for indorsement from the alliance so we can move forward. No amendments noted. Recommendation from alliance these are our vision, mission and values. KOC proposed, NOB seconded. All agreed these are the vision, mission and values.

5. Update from local authority partners

KOC just to be clear at this point, we haven't formed a formal community assembly, this is simply a co-production group. We have worked hard to think about what we want to achieve and agreed it is now important to invite our guests in to ensure we have the connectivity with place, how do we link, connect, amplify not duplicate what is already happening. There is always going to be a balance between system and place. We need to work together to ensure we have synergies around the priorities and workstreams. We won't have the same priorities as different populations in different parts of Essex. Have ICP meeting on 20th March to present our work to seek agreement to go on and build a future alliance.

How you would like this to work, how you see the future of the group.

Basildon & Brentwood alliance have examples of health trying to do everything, individuals struggling to navigate system, use as examples of what has worked well when joined

together in an integrated way and what could we have done differently. Could be two way process with nominated representatives working alongside.

Sam from South East Essex Alliance detailed that with Mental health it feels like we are chipping away at the edges. In mental health 99% of the funding is still locked for the NHS, as Alliances don't have much leverage for the flow of money. To be effective, need to get corporate strategic help to get the mental health money out to the community and voluntary sector.

Mid Essex Alliance have been doing some asset mapping with the CVS to understand where there are potential gaps and then do deep dive around live well areas to see if anything in place and if so what is the impact of that, so can link in with that. Also drafting an alliance plan around neighbourhood teams.

Thurrock are working on social enterprise, RB will find out the details so we don't duplicate. We will need clear communication, how we communicate with each other will be key.

ECC are currently doing a review on how they commission infrastructure support for VCS and see strong crossover with the work happening on assemblies for alignment.

Good discussions, to summarise, there is an appetite for representation at both a system and place based level. There could be the opportunity to share resources and moving forward there could be some key workstreams, it could be we want to work on social value together. We need to learn from best practice locally and nationally. Colleagues in Alliances and the Local Authorities were vocal about moving forwards together and how we integrate well between system, place and neighbourhoods with invitations to come to local meetings which are being followed up. It was agreed that we need strong representation from place in the formed group so there are strong connections and this had widespread support from attendees from all parts of the system.

6. Workstreams discussion

The previous discussion leads us onto the workstreams discussion, it won't get resolved today and we will draw on a smaller working group again as we did for the vision, mission and values. This is the start of the process and open for all to join in.

You will see on the agenda, some suggestions put forward, communication, data, mapping, workforce. We have already talked about the work the Mid Alliance are doing around mapping.

At this stage it is just about recording the proposals and taking it away to develop it further. Looked again at the workstream diagram RW explained at the last meeting. The lead into the discussion is what do we need to look at as a group so we achieve the vision and mission that we have now agreed.

Workstream suggestions:-

- Mental health – adult mental health, depression, anxiety etc. particularly around males in the 20-40 year age bracket.
- Communication – how do we communicate.
- Community resilience – upskilling communities to be more resilient. Connection and innovation, be honest and say what doesn't work – look at potential for alternatives.

See more engagement around mental health outside of the GPs, Happy Hub, mens sheds etc.

- Preventation – working on a preventative message – how can we support people early on? Can look at preventative support for a whole host of conditions, not just mental health.
- Trust framework – comes up time and again, accountability, risk, safeguarding, clinical supervision, etc. Organisations have trouble placing trust and faith, they say how can we trust you, don't know who does clinical supervision etc., so if we could have something to resolve it that says the group has gone through an induction or something similar around key topics. Need to build it from the communities up.
- Social value – need to identify what the voluntary sector actually provide, identify the benefits of what we bring as a sector.

7. Any other Business

Next steps – we will formally write up the mission, vision and values. Will pull together the workstreams and what they might look like.

There is a meeting on 20th March, some colleagues will attend to feedback the work done so far, along with some potential workstreams. Looking to get the sign off to become a `thing' and move forward accordingly. Early next week we will get a session in to plan the presentation, anyone wanting to join will be welcome. SP will be in touch with the date and time.

Action: SP to let everyone know when the session will be

8. Date of Next Meeting

Wednesday 15th March 10:30 am online.

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MSE Integrated Care Partnership, 20 March 2023

Agenda Number: 07

Mid and South Essex Integrated Care Strategy

Summary Report

1. Purpose of Report

The purpose of this report is to present the Draft Mid and South Essex Integrated Care Strategy, produced by the Integrated Care Partnership.

The Health and Care Act 2022 requires that:

"… integrated care boards must, in exercising any functions, have regard to the following so far as relevant -

[…]

(b)any integrated care strategy prepared under section 116ZB in relation to an area that coincides with or includes the whole or part of the responsible local authority's area"

2. Executive Lead

- **Name:** Jo Cripps
- **Job Title:** Executive Director of Strategy and Partnerships
- **Organisation:** NHS Mid and South Essex

3. Report Author

- **Name:** Jeff Banks
- **Job Title:** Director of Strategic Partnerships
- **Organisation:** NHS Mid and South Essex

4. Responsible Committees

Mid & South Essex Integrated Care Partnership.

The Strategy has also been presented & received support from the Health & Wellbeing Boards of the Upper Tier Local Authorities as follows:

Essex Health & Wellbeing Board (25.01.23)
Thurrock Health & Wellbeing Board (10.02.23)
Southend Health & Wellbeing Board (06.03.23)

5. Financial Implications

Section 8.6 identifies that partners will *"identify and secure the resources needed to ensure the ICP can deliver against the priorities it has set".* This will be addressed by partners in due course.

Section 7.4 identifies how the Integrated Care Partnership will seek to influence Partners' use of resources across the wider Integrated Care System.

6. Details of patient or public engagement or consultation

The following work was undertaken in the preparation of this Strategy:

1. ***Review of Partner Strategies and JSNAs:*** 27 publicly available strategies and plans from partner organisations within the MSE ICP as well as the relevant Joint Strategic Needs Assessments (JSNAs). Each strategy covered a three-to-five-year period between 2018 and 2026.
2. ***Health inequality data analysis:*** Partners reviewed the evidence of need from the analyses of Population Health Management health inequality data packs and JSNAs.
3. ***Engagement:*** eight workshops based in community venues, collectively engaging over 170 people. Partners 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. On publication of a Concept Paper, a further 20+ one-to-one and small group engagement sessions were held with Partners.

7. Conflicts of Interest

None identified.

8. Recommendation/s

The Integrated Care Partnership is asked to:

- Note the development and resident/community feedback to develop the strategy.
- Approve the Integrated Care Strategy.

Please note – *Any reports published to Mid and South Essex's Integrated Care Partnership will be published on a public website, and members of the public can attend any meeting of the Partnership.*

Please ensure all reports are suitable for public consumption & accessible to the public, avoiding jargon

Mid and South Essex Integrated Care System

Integrated Care Strategy

2023 - 2033

March 2023

Table of Contents

1 Context

1.1 The health and care system

Integrated Care Systems (ICSs) are partnerships of organisations coming together to plan and deliver joined up health and care services and 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 to meet 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 falling within the ICS's area (councils with responsibility for child 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).

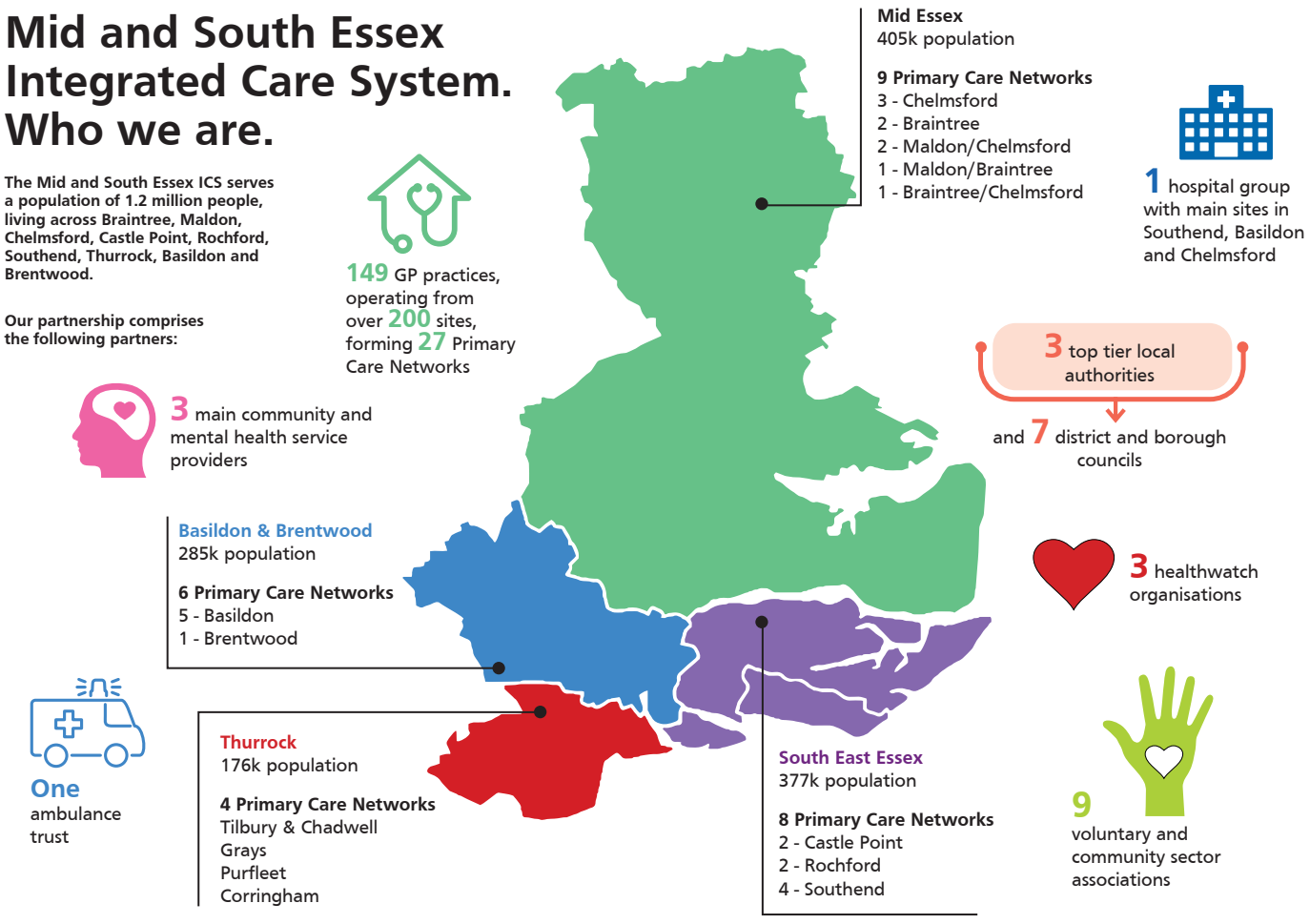
- **Primary care:**
  27 Primary Care Networks (PCN) covering 180 GP Practices. Page 2 of 35

- **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 details 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 prioritising 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, it 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, 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. It will require a significant reset, with action required by all partners, including those in the voluntary, community, faith and social enterprise sectors. The 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, asking 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'. Our 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 we are successful.

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

1.4 How we have developed this strategy

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 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 more than 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 it 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 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 and 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 expectancyfor many, particularly for residents in parts of Basildon, Thurrock and Southend. Partners agree 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 our solutions better meet the increasing volume and complexity of need in a sustainable way, including the provision of care closer to home. This pressure will only increase on Integrated Care System partners if we do not act now 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 supporting mental health and wellbeing ahead of escalation 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:

- A significant majority of Mid and South Essex's most economically deprived population live in Basildon (where 17% are part of the 20% most deprived nationally), Southend (15%) and Thurrock (11%).
- 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.

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 from a wide range of statutory and non-statutory organisations and community groups, involved in the provision of health and social care services.

Although some experiences varied, the engagement workshops confirmed improved relationships between partner organisations and increased collaboration, particularly at a local Alliance level, was evident and 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 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 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 onedirectional, 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

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 which all partners agreed. It was presented to the ICP in November 2022 and, following agreement, the initial Strategy was developed and agreed by Partners in December 2022.

In recognition of the scale of the task and the need to fundamentally change 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 taking into account progress made, as well as new challenges and opportunities arising. There will be a major review 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:
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:
www.thinklocalactpersonal.org.uk/Browse/Informationandadvice/CareandSupportJargonBuster

It is, however, important 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. They 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 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, police, fire and coastguard services, which all play a crucial role in keeping us safe and well. All are considered central to helping our Partnership achieve its objectives we hold 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 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 meet our statutory responsibilities and champion the highest standards in all 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, and 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 experiencing 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. It 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 the 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 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.

It 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 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: firstly, to support people to manage their own health by helping 'upstream' in a cost-effective manner before problems become serious, expensive, and irretrievable 'downstream'; secondly, to integrate provision around the individual once they need formal services.

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

What should partners and individuals expect?

WE STATEMENTS

- **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)

I STATEMENTS

- **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 engages positively with adult social care providers and brings 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 address 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 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. It will include the new proposed forums, as well as existing forums and networks. Assisting 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 them. 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 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 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.

What should partners and individuals expect?

WE STATEMENTS

- **We** will develop and maintain a map of the statutory boards and forums which feed into the work of the ICP and ensure there are clear mechanisms for communicating to and from these forums. (W2 - 10/23 and ongoing)
- **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)
- **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)
- **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)
- **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)
- **We** will always seek to work at the most appropriate local level, supporting our Alliances and local partnerships. (W7 - 09/23 and ongoing)

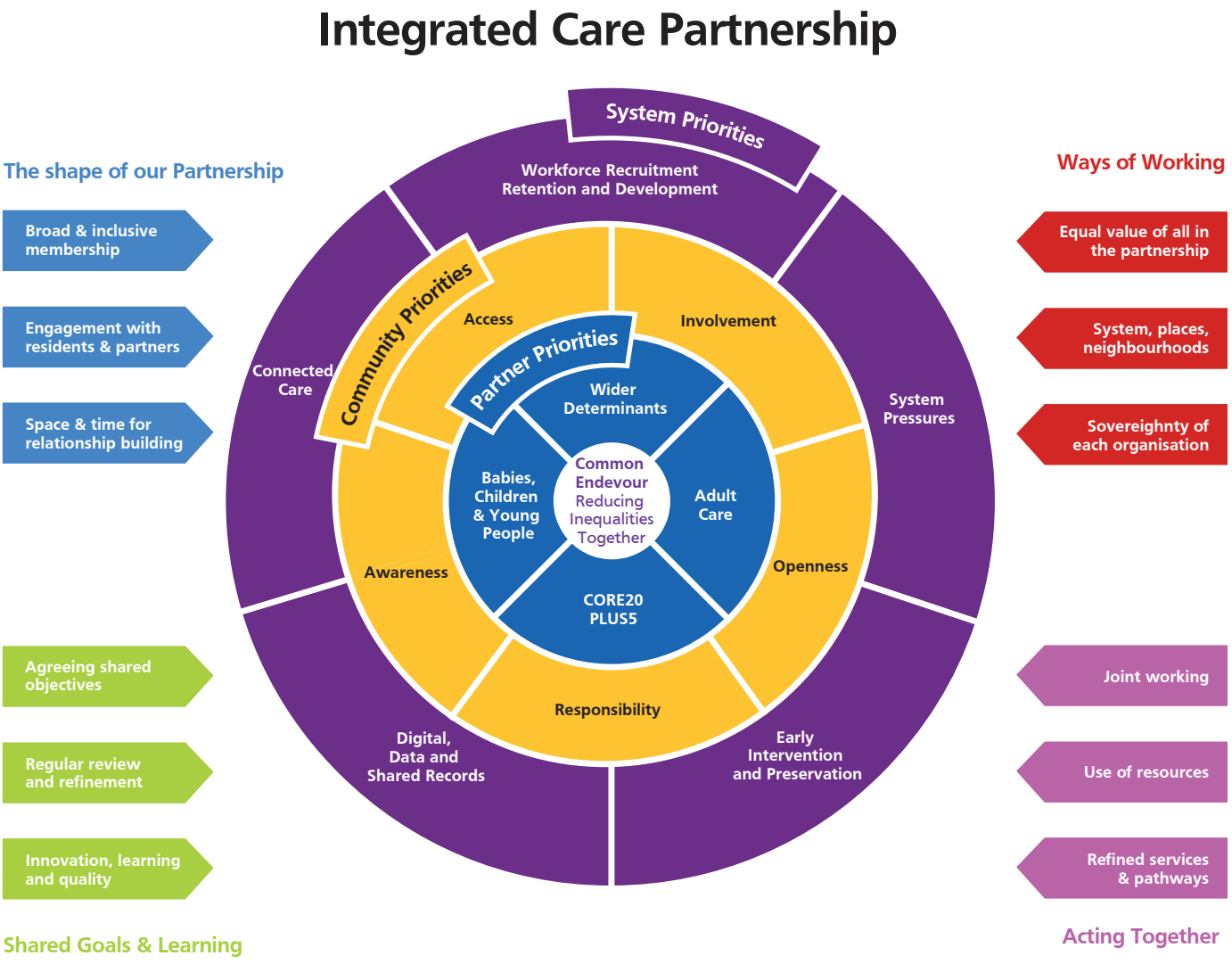
I STATEMENTS

- **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)
- **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 and 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 meet our objectives. It is, in effect, a 'plan on a page' which helps focus our thinking as a Partnership and as a System.



The Strategy indicates, in general terms, our shared priorities and the direction we wish to move in. 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 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 progress.

What should partners and individuals expect?

WE STATEMENTS

- **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)
- **We** will review our progress regularly and produce an annual report demonstrating the difference we are making. (W9 - 03/24 and ongoing)

I STATEMENTS

- **I** will be confident 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)

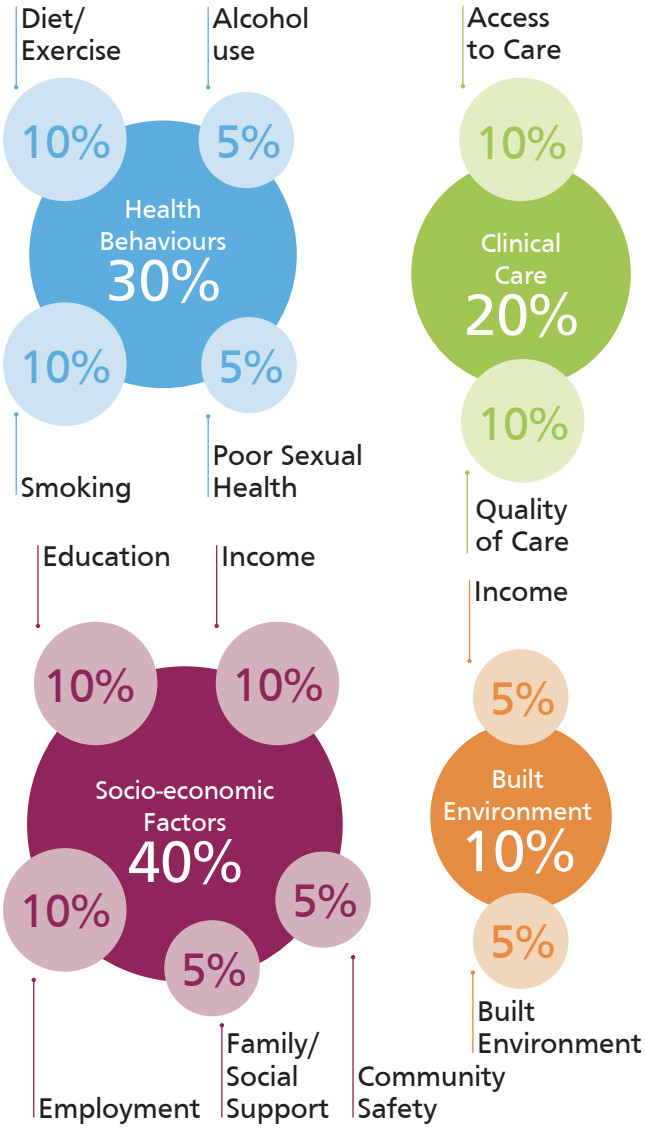
4 Partner Priorities

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 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 the tools available 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.

What should partners and individuals expect?

WE STATEMENTS

- **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)

I STATEMENTS

- **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 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.

    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: **www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalitiesimprovement-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 autism; 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: **www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalitiesimprovement-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.

What should partners and individuals expect?

WE STATEMENTS

- **We** will work together across our Partnership to address the priorities identified in the Core20PLUS5 frameworks. (W11 - 09/23 and ongoing)
- **We** will work together to define our local Core20PLUS5 targets and measures and review progress annually. (W12 - 09/23 and ongoing)
- **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)

I STATEMENTS

- **I** will see progress in tackling long standing health inequalities for all ages. (I6 -03/24 and ongoing)
- **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 it faces, 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 and treatment 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 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 a strong and vibrant voluntary sector, including user-led organisations, which 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.

What should partners and individuals expect?

WE STATEMENTS	I STATEMENTS
• **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)	• **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 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 on 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.

What should partners and individuals expect?

WE STATEMENTS

- **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)

I STATEMENTS

- **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 we will prioritise and work with. Our starting point will focus on a group of priority families and individuals experiencing the worst health and care outcomes.

A 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. It will include a major focus on prevention and early intervention across the wider determinants of health.

The '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 its 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.

What should partners and individuals expect?

WE STATEMENTS

- **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)

I STATEMENTS

- **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 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 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 with residents than is the case now. Historically, these residents have been marginal to the overall health and social care agenda 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 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 engagement and social media, but, recognising the impact of the 'digital divide', we will always offer different ways 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, it 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 taking 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 we do not put pressure on the same parts of the system when there are lots of other options.

The best 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 or 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.

What should partners and individuals expect?

WE STATEMENTS

- **We** will create 'one front door' for residents to access the vast majority of health and care services. (W17 - 04/24 and ongoing)
- **We** will work together to define our local targets for community resilience, mobilisation and transformation, and review progress annually. (W18 - 09/23 and ongoing)
- **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 - 04/24 and ongoing)

I STATEMENTS

- **I** will feel my care is closer to home and more personalised. (I11 - 03/24 and ongoing)
- **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 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 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 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 '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 was the disconnected nature of health and care services. We will work to ensure better connection between services, refinement of pathways and 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 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 and 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').

What should partners and individuals expect?

WE STATEMENTS

- **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)
- **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)
- **We** will increasingly invest in prevention and early intervention. (W22 - 03/24 and ongoing)
- **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)

I STATEMENTS

- 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)
- 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 which experience worse health outcomes. The idea of the ICP is to bring the voices and influence of the community into the conversation to help 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 seeking 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 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 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 at the most appropriate local level. This should mean we have as much decision-making as possible coming from the places and people affected by those decisions. So, the principle of subsidiarity, distributed leadership and working at place will be at the core of all 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 to be shared or innovation which can be jointly developed, 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 they are supported and have the opportunity to share their work through the ICP. In turn, we ask that they acknowledge, 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, from 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, 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 Partnership has considered the benefits of Section 75 agreements as part of preparing this Strategy. Whilst acknowledging 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 to 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.

What should partners and individuals expect?

WE STATEMENTS

- **We** will work together to define our working practices as a partnership, and review progress annually. (W24 - 09/23 and ongoing)
- **We** will ensure partner organisations are aligned on common goals and share plans and resources wherever effective. (W25 - 03/24 and ongoing)

I STATEMENTS

- 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, 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 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 Governance and operation

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.

What should partners and individuals expect?

WE STATEMENTS

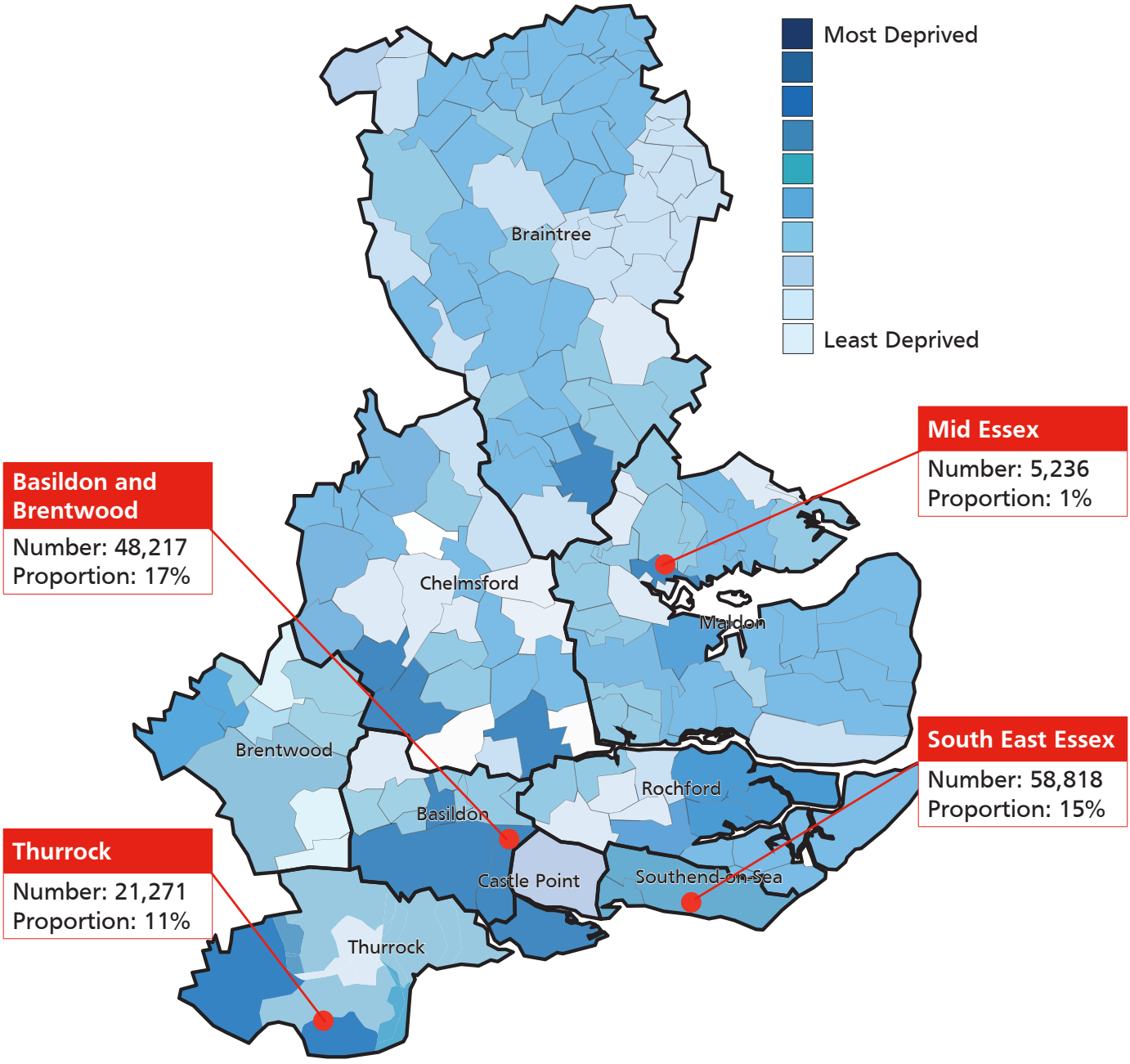
- **We** will identify and secure the resources needed to ensure the ICP can deliver against the priorities it has set. (W26 - 04/23 and ongoing)

I STATEMENTS

- **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



Deprivation in MSE

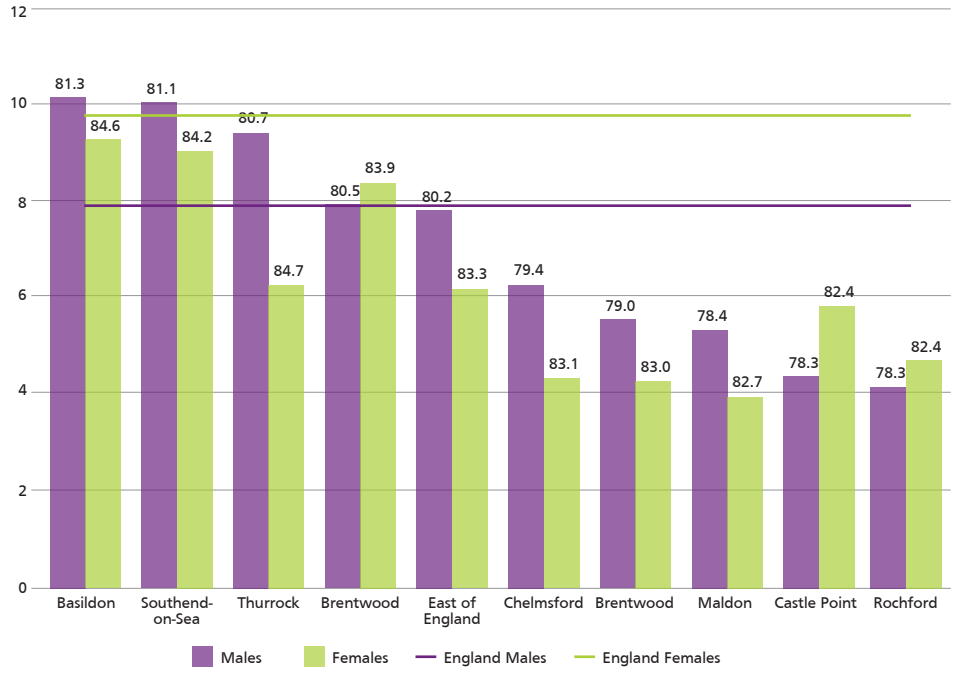
On average deprivation in MSE is lower than the national average.

In MSE an estimated **133,000** people live in the 20% most deprived areas nationally. That is **10.5**% of the whole MSE population.

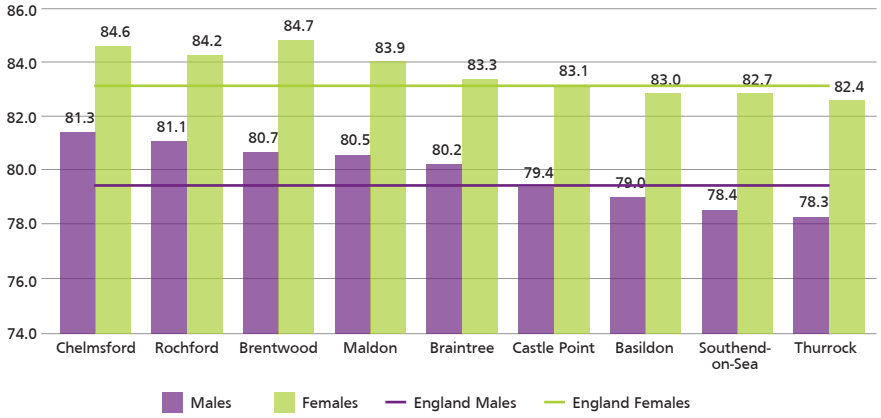
Each box describes the Alliance population living in the 20% most deprived areas nationally (total number and percentage of their population)

Consequences of Inequalities - Life Expectancy

Slope Index of Inequality (S11) in MSE by Sex



Life Expectancy at birth in MSE by Sex and Deprivation



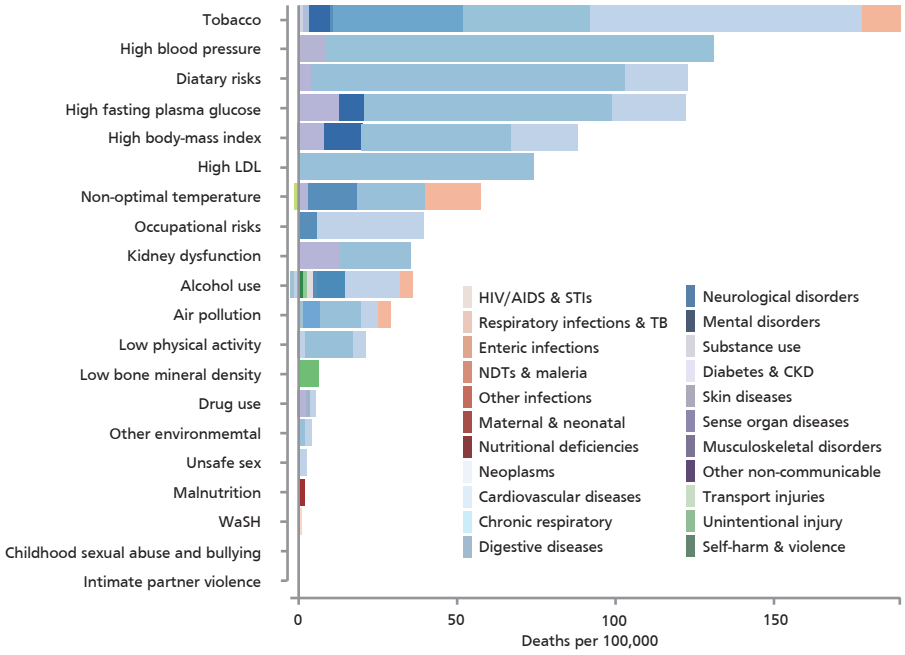
Healthy Life Expectancy at Birth in MSE by Sex

Risk Factors for Premature Mortality

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

- Tobacco
- Blood Pressure
- Dietry Risks

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

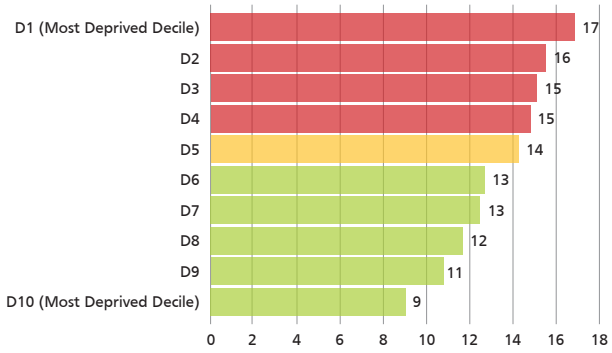


Inequality & Behavioural Risk Factors

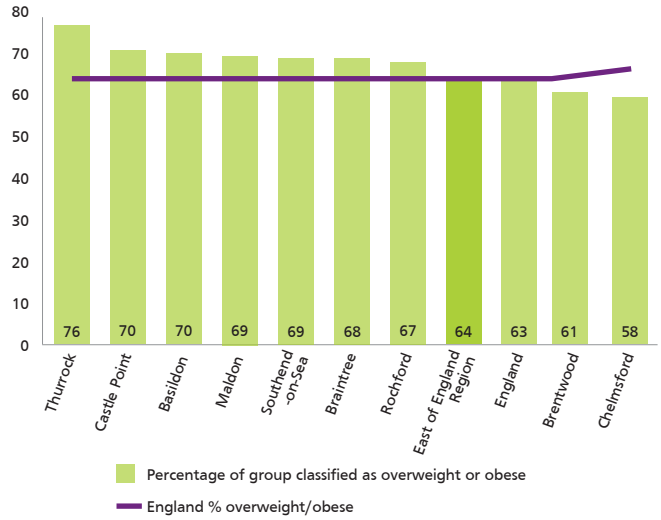
Global Burden of Disease Study - Cross-cutting risks

- Tobacco
- Blood Pressure
- Dietry Risks

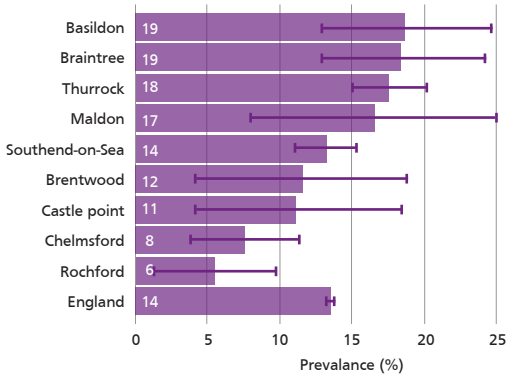
Smoking Prevalence in adults (18+) - current smokers by IMD 2019



Percentage of adults (aged 18+) classified as overweight or obese (2020/21)



Smoking Prevalence in adults (18+) - current smokers by APS 2019



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 regard for the guidance released 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

Statutory requirements	Further detail
In preparing the integrated care strategy, the integrated care partnership must, in particular, consider whether the needs could be more effectively met with an arrangement under section 75 of the NHS Act 2006.	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
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 those that react to health and care needs, to those 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, 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 it makes sense to do once at system level, whilst others that need to be handled 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 joint strategic needs assessment (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 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.

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Mid and South Essex Integrated Care System

MSE Integrated Care Partnership, 20 March 2023

Agenda Number: 08

Integrated Care Strategy – Theory of Change & Outcomes Framework

Summary Report

1. Purpose of Report

To provide the Integrated Care Partnership with an overview of the work undertaken to develop a Theory of Change and Outcomes Framework.

The Mid and South Essex Integrated Care Strategy identifies the following action for the Partnership:

"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".

And

"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."

This work is due to be completed by the end of April 2023 and this report describes progress and presents the initial model for the Outcomes Framework for comment.

2. Executive Lead

- **Name:** Jo Cripps
- **Job Title:** Executive Director of Strategy and Partnerships
- **Organisation:** NHS Mid and South Essex

3. Report Author

- **Name:** Jeff Banks
- **Job Title:** Director of Strategic Partnerships
- **Organisation:** NHS Mid and South Essex

4. Responsible Committees

MSE Integrated Care Partnership

5. Financial Implications

There are no financial implications relating to this paper at this stage.

6. Details of patient or public engagement or consultation

Extensive engagement was undertaken as part of the development of the MSE ICP Strategy.

7. Conflicts of Interest

None Identified

8. Recommendation/s

The Integrated Care Partnership is asked to note the work undertaken to date on Theory of Change and Outcomes Framework and offer feedback.

The Integrated Care Partnership will receive the completed Theory of Change and Outcomes Framework in April 2023 and will be asked to confirm agreement to ensure operational colleagues are appropriately directed in their work

Please note – *Any reports published to Mid and South Essex's Integrated Care Partnership will be published on a public website, and members of the public can attend any meeting of the Partnership.*

Please ensure all reports are suitable for public consumption & accessible to the public, avoiding jargon

Mid and South Essex Integrated Care System

NHS
Mid and South Essex

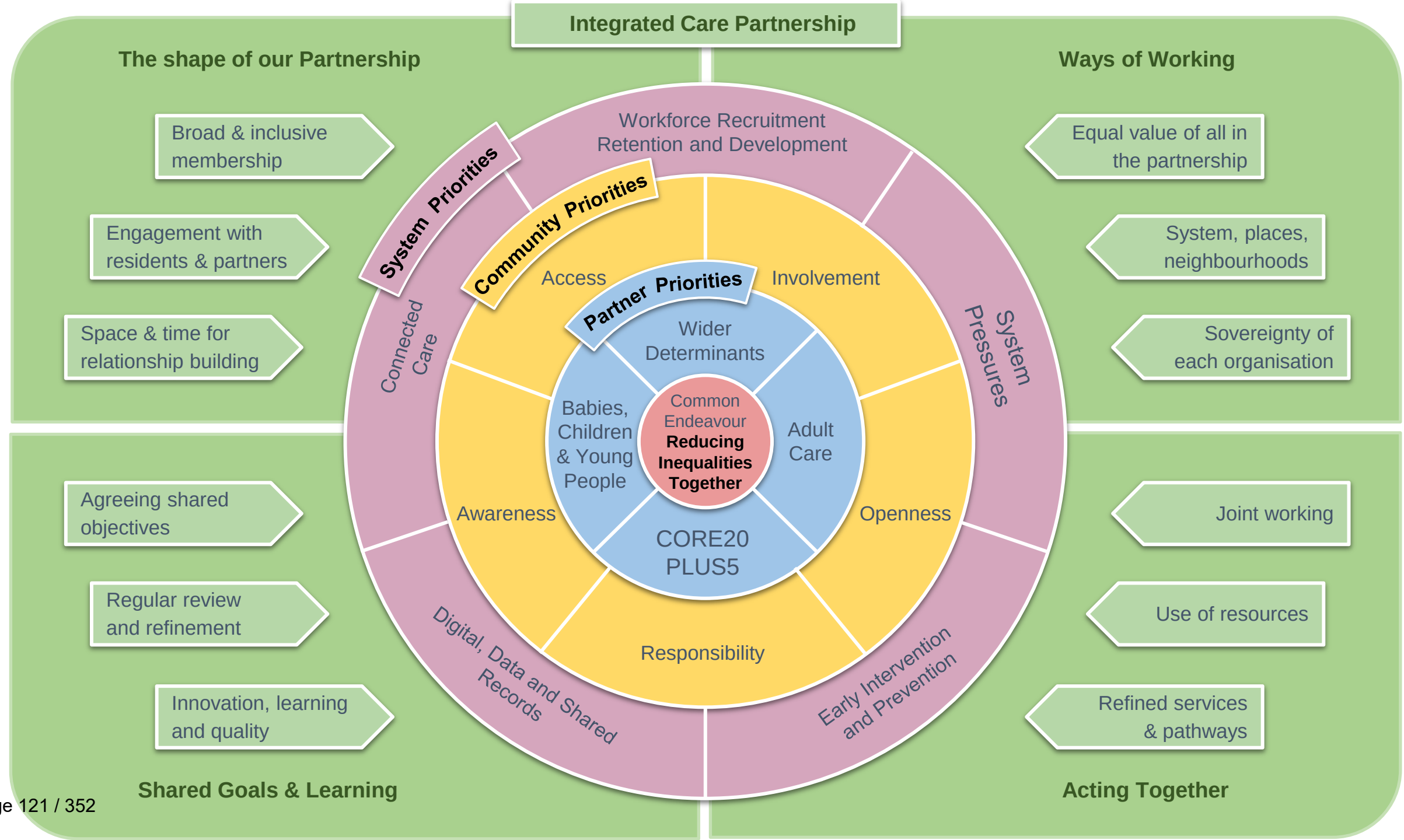
Mid & South Essex Integrated Care Strategy Theory of Change and Outcomes Framework

Jeff Banks, Director of Strategic Partnerships

March 2023

Our Strategy

Common Endeavour


Integrated Care Partnership
The shape of our Partnership
Ways of Working
Broad & inclusive membership
Engagement with residents & partners
Space & time for relationship building
Equal value of all in the partnership
System, places, neighbourhoods
Sovereignty of each organisation
Workforce Recruitment Retention and Development
System Priorities
Community Priorities
Partner Priorities
Access
Involvement
Wider Determinants
Babies, Children & Young People
Adult Care
Common Endeavour Reducing Inequalities Together
CORE20 PLUS5
Awareness
Openness
Responsibility
Connected Care
System Pressures
Digital, Data and Shared Records
Early Intervention and Prevention
Agreeing shared objectives
Regular review and refinement
Innovation, learning and quality
Joint working
Use of resources
Refined services & pathways
Shared Goals & Learning
Acting Together

*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.*

Mid and South Essex Integrated Care Strategy

*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*

Mid and South Essex Integrated Care Strategy

Agreed actions

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)*

Theory of Change

Theory of Change

[A] Theory of Change is essentially a comprehensive description and illustration of how and why a desired change is expected to happen in a particular context. It is focused in particular on mapping out […] what a programme or change initiative does (its activities or interventions) and how these lead to desired goals being achieved. It does this by first identifying the desired long-term goals and then works back from these to identify all the conditions (outcomes) that must be in place (and how these related to one another causally) for the goals to occur.

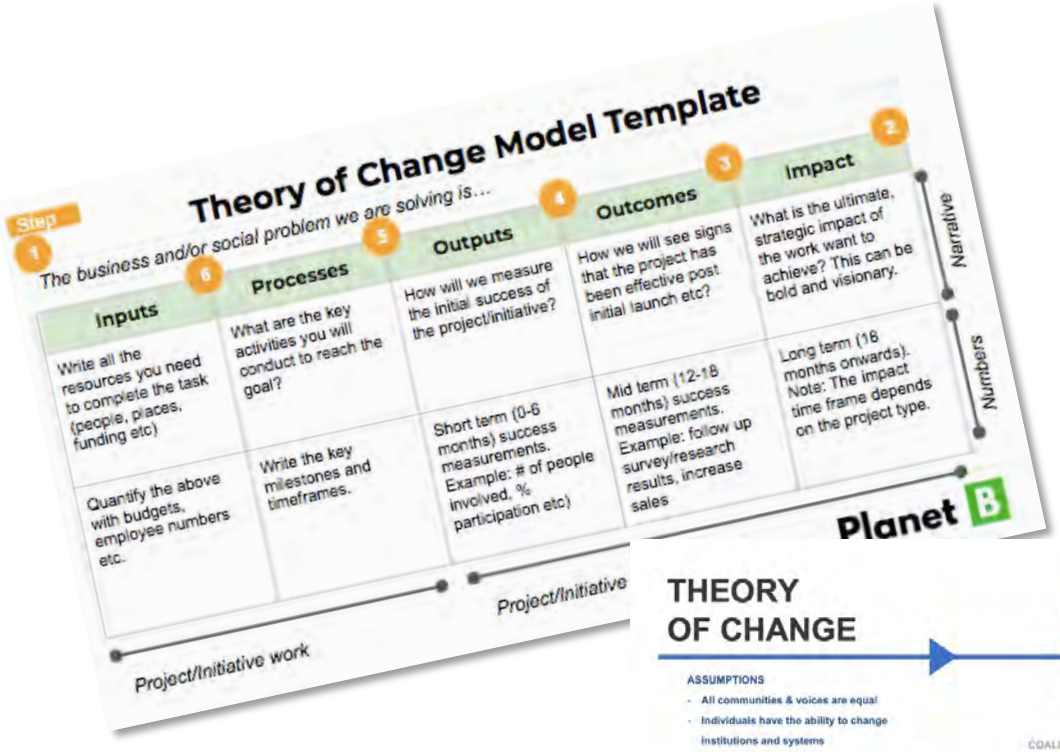
Center for Theory of Change

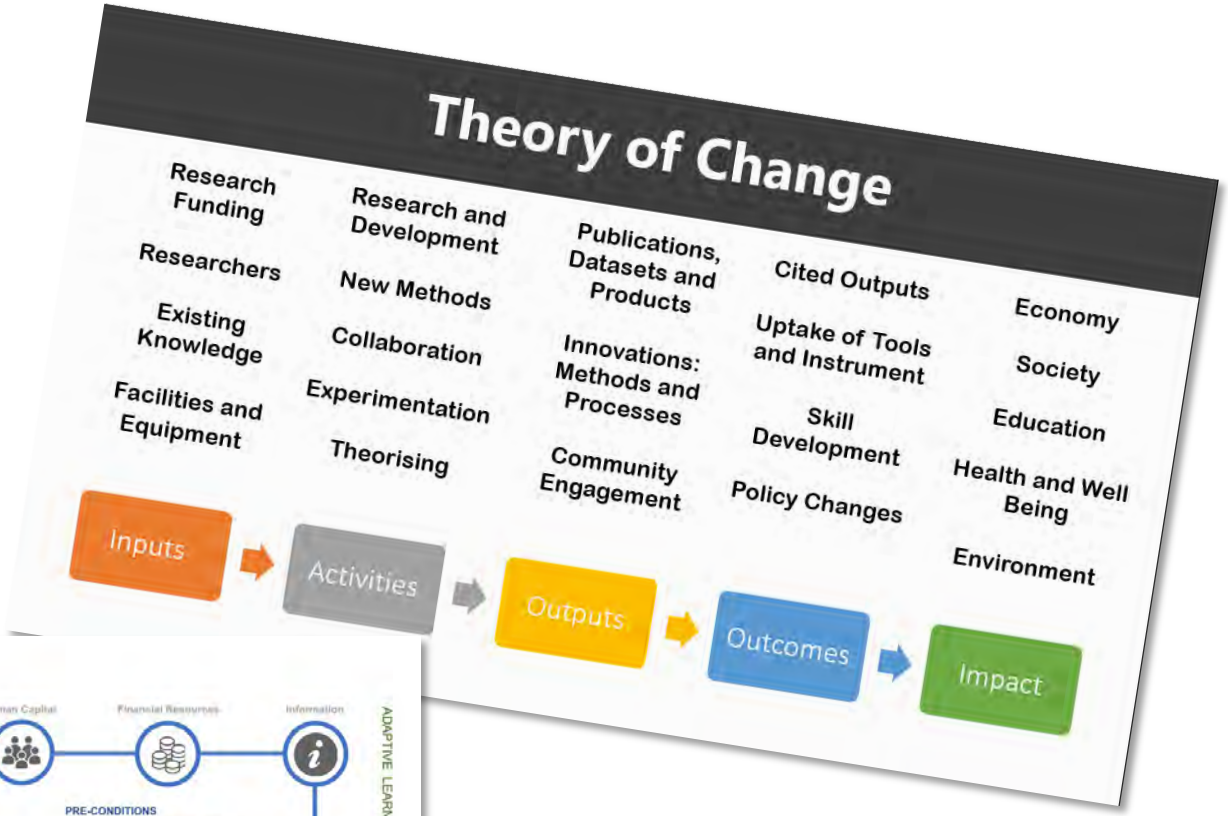
Theory of Change

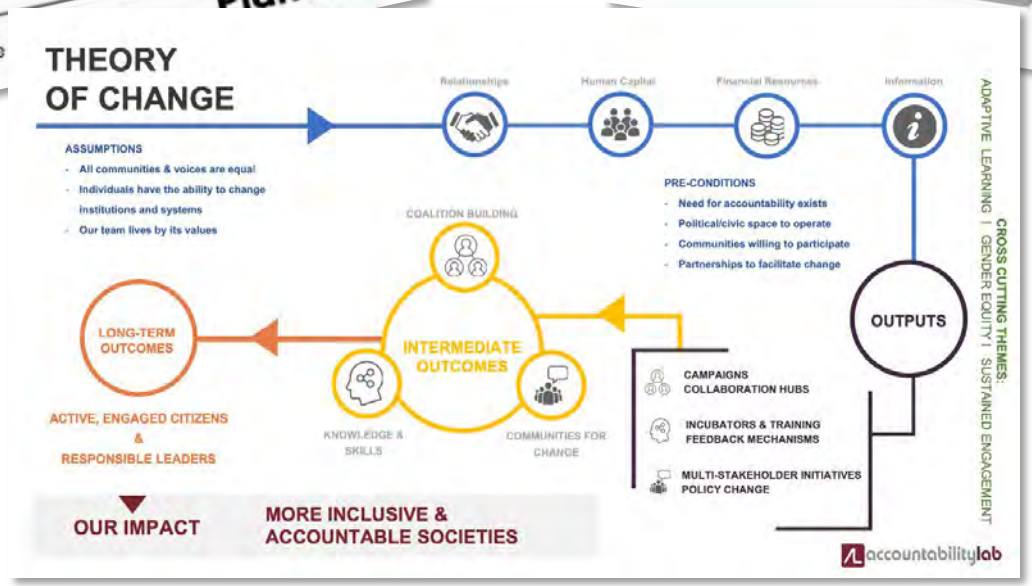
A Theory of Change is best described as a flow chart, diagram or description of why the activities you take part in will create the change you want to see in the world. It seeks to identify the resources that you will need, the main activities you will need to perform and, finally, the end products or services (outputs) which you will need to deliver. Crucially, it then identifies all of the step changes (outcomes) which will need to occur in order to deliver your long-term goal or mission.

www.analytics inaction.co

Examples


Theory of Change Model Template
The business and/or social problem we are solving is...
Step
Inputs
Processes
Outputs
Outcomes
Impact
Write all the resources you need to complete the task (people, places, funding etc)
What are the key activities you will conduct to reach the goal?
How will we measure the initial success of the project/initiative?
How we will see signs that the project has been effective post initial launch etc?
What is the ultimate, strategic impact of the work want to achieve? This can be bold and visionary.
Quantify the above with budgets, employee numbers etc.
Write the key milestones and timeframes.
Short term (0-6 months) success measurements. Example: # of people involved, % participation etc)
Mid term (12-18 months) success measurements. Example: follow up survey/research results, increase sales
Long term (18 months onwards). Note: The impact time frame depends on the project type.
Narrative
Numbers
Project/Initiative work
Project/Initiative
Planet B


Theory of Change
Research Funding
Researchers
Existing Knowledge
Facilities and Equipment
Research and Development
New Methods
Collaboration
Experimentation
Theorising
Publications, Datasets and Products
Innovations: Methods and Processes
Community Engagement
Cited Outputs
Uptake of Tools and Instrument
Skill Development
Policy Changes
Economy
Society
Education
Health and Well Being
Environment
Inputs
Activities
Outputs
Outcomes
Impact


THEORY OF CHANGE
ASSUMPTIONS
All communities & voices are equal
Individuals have the ability to change institutions and systems
Our team lives by its values
Relationships
Human Capital
Financial Resources
Information
PRE-CONDITIONS
Need for accountability exists
Political/civic space to operate
Communities willing to participate
Partnerships to facilitate change
COALITION BUILDING
LONG-TERM OUTCOMES
INTERMEDIATE OUTCOMES
OUTPUTS
ACTIVE, ENGAGED CITIZENS & RESPONSIBLE LEADERS
KNOWLEDGE & SKILLS
COMMUNITIES FOR CHANGE
CAMPAIGNS COLLABORATION HUBS
INCUBATORS & TRAINING FEEDBACK MECHANISMS
MULTI-STAKEHOLDER INITIATIVES POLICY CHANGE
CROSS CUTTING THEMES: ADAPTIVE LEARNING | GENDER EQUITY | SUSTAINED ENGAGEMENT
OUR IMPACT
MORE INCLUSIVE & ACCOUNTABLE SOCIETIES
accountabilitylab

Traditional ToC

- Definition of task/s and objectives
- Analysis of
    - *+ Inputs*
    - *+ Processes*
    - *+ Outputs*
    - *+ Outcomes*
    - *+ Impact*
- Clear set of actions and anticipated outcomes (measurable)

Progress

Work Undertaken

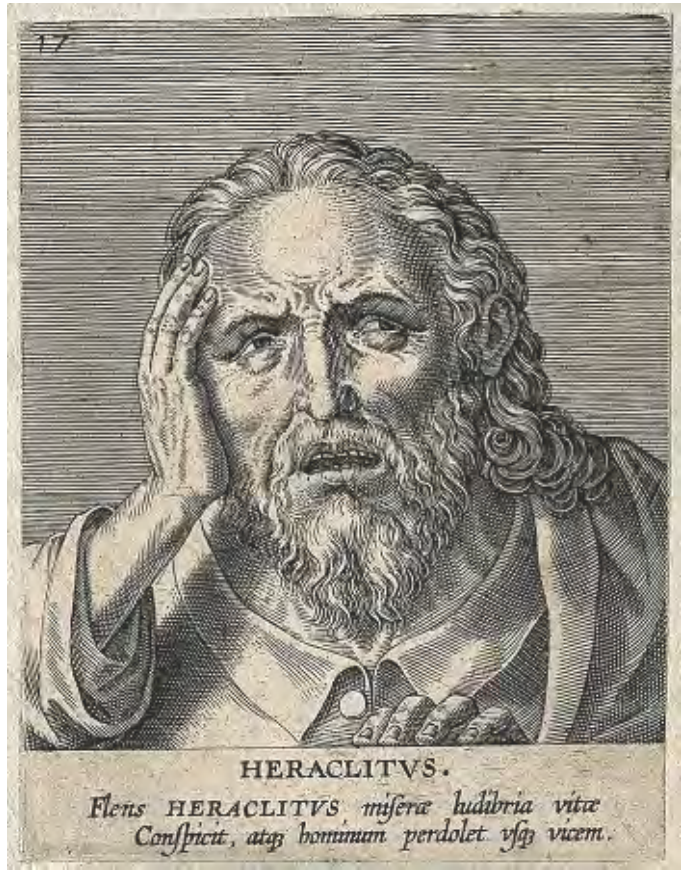
- Two workshops co-led by colleagues from the University of Essex, engaging 25+ partners including Executive and operational colleagues
- Exploration of ToC models
- Devlopment of an initial Outcomes Framework approach, appended to ICP report
- Analysis of combination of measures to be used including existing data/metrics and new work required

Feedback

“Everything changes and nothing remains still; and you cannot step twice into the same stream”.

The Only Constant in Life Is Change.”

Attributed to Greek Philosopher, Heraclitus



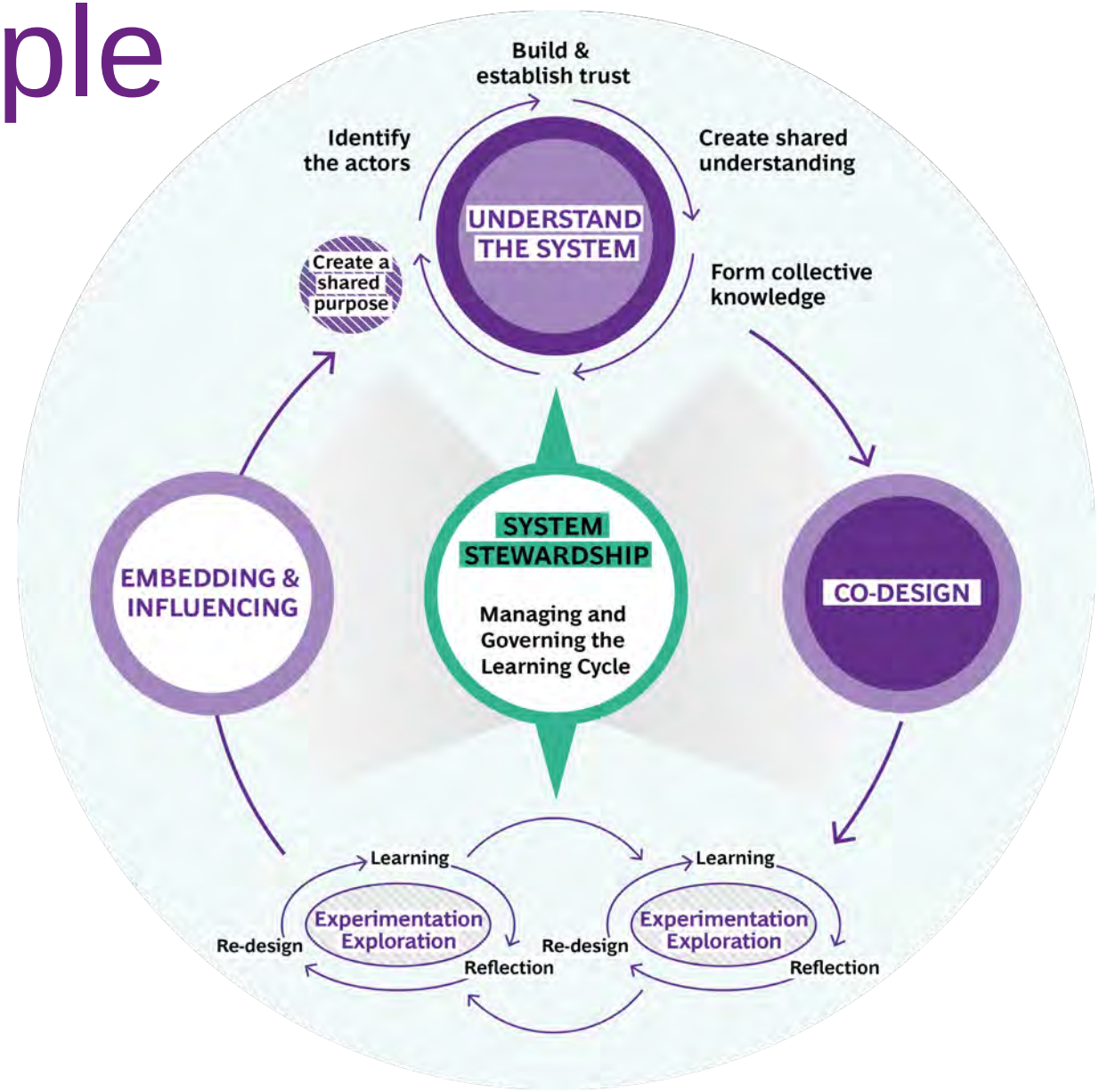
Feedback 1

- Partner feedback has clearly indicated that a traditional linear ToC approach, where inputs and deliverables are reasonably stable and outcomes predictable, may not suit a highly complex system with multiple variables and dependencies.
- The ICP is seeking a substantial *cultural change* in the way partners operate together with residents.
- An approach which embraces the complexity of our system, and the diversity of lived experience of residents, enabling us to work effectively in that complexity, is preferred

Feedback 2

- More aligned to the way the system operates in practice (e.g. Stewardship) and the cultural change we wish to see across health and care
- Additional time needed to engage residents and our more diverse partners in the process.
- Our Community Assembly provides the opportunity for this reflection
- The development of the ICP's operational plan and outcomes framework can develop concurrently
- The ToC approach will remain appropriate for many of the individual tasks the ICP will wish to progress

Example



In this model, 'system stewardship' may be provided by the ICP and its constituent committees.

Source: Centre for Public Impact.

Outcomes Framework

Background

- We have a body of work in place on this we are not starting from scratch!
- Developed alongside the ToC and Logic Model
- We will refresh and review existing work and synthesise
- Alignment with the ICP Strategy
- Alignment with wider system priorities

Outcomes Framework

- There is further work to be undertaken on capturing the outcomes of system partners as they develop e.g. Core20PLUS5, BCYP and adult health and care services, workforce, data and digital, etc.
- These components will be added to the framework over time
- Co-production work to develop ‘I’ statement outcome measures

Data and metrics

- Work is underway on developing a data dashboard for Health Inequalities
- The ICP will have to undertake a baseline and periodic survey of partner and resident experience of the health and care system, to determine impact
- Exploration of other available data, e.g. local authority residents surveys, Understanding Society (UK Household Longitudinal Study)
- Sits alongside ongoing engagement cycle generating real-time knowledge of partner and resident experiences

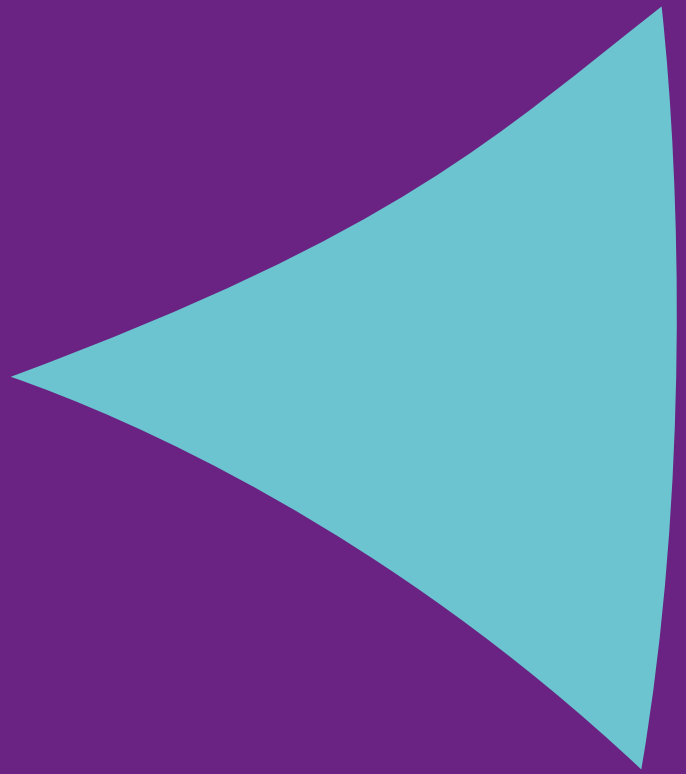
Next Steps

Next Steps

- Feedback from ICP
- Further workshop/s with Community Assembly
- Drafting an initial model for testing
- Further development of refreshed system Outcomes Framework
- Further co-production on ‘I’ statements
- Draft to ICP – April
- Adoption as the ICP delivery model moving forwards

Mid and South Essex Integrated Care System

NHS
Mid and South Essex



Jeff Banks, Director of Strategic Partnerships

jeff.banks2@nhs.net

www.midandsouthessex.ics.nhs.uk

ICP Core outcomes

	Planned Outcomes	***Planned Deliverables***	***SRO***	***SRO Title***	***Opps Lead***	***Planned Delivery Date***							***KPI / Outcome Monitoring***	***Board***
						23/24 Q1	***23/24 Q2***	***23/24 Q3***	***23/24 Q4***	***24/25***	***25/26***	***26/27***		
W1	Develop Common Endeavour campaign for reducing inequalities together	Work together with 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	Jeff Banks	Director of Strategic Partnerships	Jeff Banks Claire Hankey		09/23	→	→	→	→	→	+ ICP will have approved Common Endeavour Campaign model + Roll out of Common Endeavour Campaign + Review and amend campaign	ICP
W2	Map system-wide governance boards and committees and develop unified approach	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.	Jeff Banks	Director of Strategic Partnerships	Tonino Cooke			10/23	→	→	→	→	+ Governance processes mapped and agreed by ICS + Maintain governance map	ICP
W3	Increase partnership value of contribution of non-statutory partners	Ensure that our non-statutory partners are equally valued within our Partnership are demonstrably able to influence and contribute to achieving our shared objectives.	Jeff Banks	Director of Strategic Partnerships	Jeff Banks				03/24	→	→	→	+ A wider range of non-statutory partners express they are valued as part of the ICS, from starting baseline. + Partner value grows over time	ICP
W4	Broaden partner engagement in our Common Endeavour	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	Jeff Banks	Director of Strategic Partnerships	Jeff Banks			09/23	→	→	→	→	+ Develop a programme for engaging a wider range of partners in the work of the ICS. + A wider range of partners express they are contributing to the ICS, from stating baseline	ICP
W5	Establish new partnership fora	Establish the following forums: + Community Assembly + Independent and Private Providers Network + Community Voices Network to ensure a wider range of partners are able to influence and contribute to achieving our shared objectives.	Kirsty O'Callaghan	Director of Community Resilience, Mobilisation and Transformation	Kirsty O'Callaghan Jeff Banks			09/23	→	→	→	→	+ Three new fora will have been co-designed/developed and launched + Review and develop over time	ICP

W6	Diversify engagement with partners and communities	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	Jeff Banks	Director of Strategic Partnerships	Jeff Banks Kirsty O'Callaghan	04/23	→	→	→	→	→	→	+ Community conversations, workshops, seminars, and engagement activities co-produced + Review and develop over time	ICP
W7	Operate according to subsidiarity principle	Work at the most appropriate local level, supporting our Alliances and local partnerships	Jeff Banks	Director of Strategic Partnerships	Jeff Banks			09/23	→	→	→	→	+ Annual review of commitment to subsidiarity principle, demonstrates growing operation at appropriate local level	ICP
W8	ICP Theory of Change and Logic Model. Outcomes Framework refresh.	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)	Jeff Banks	Director of Strategic Partnerships	Jeff Banks	04/23	→	→	→	→	→	→	+ Theory of Change and Logic Model developed and approved by ICP + Outcomes Framework refreshed and agreed by ICP + Operational Plan developed and reviewed regularly	ICP
W9	Review progress regularly and report on outcomes and impact	Review ICP progress regularly and produce an annual report demonstrating the difference we are making.	Jeff Banks	Director of Strategic Partnerships	Jeff Banks				03/24	→	→	→	+ ICP reviews progress regularly + ICP annual report produced and disseminated	ICP
W10	Develop partnership working on wider determinants of health	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.	Jeff Banks	Director of Strategic Partnerships	Jeff Banks Emma Timpson				03/24	→	→	→	+ ICP Partners will work collectively on wider determinants, from starting baseline. + ICP Partners collective action on wider determinants grows over time	ICP
W11	Prioritise Core20PLUS5	Work together across our Partnership to address the priorities identified in the Core20PLUS5 frameworks	Jeff Banks	Director of Strategic Partnerships	Jeff Banks Emma Timpson		09/23	→	→	→	→	→	+ ICP Partners will work collectively on Core20PLUS5 frameworks, from starting baseline. + ICP Partners collective action on	ICP

													Core20PLUS5 grows over time	
W12	Defining Core20PLUS5 priorities	Work together to define our local Core20PLUS5 targets and measures and review progress annually. (W12 - 09/23 and ongoing)	Jeff Banks	Director of Strategic Partnerships	Jeff Banks Emma Timpson		09/23	→	→	→	→	→	+ ICP leads cross-sectoral work on defining Core20PLUS5 targets. + Review and develop over time	ICP
W13	Defining local PLUS groups	Work with our local Alliances to regularly review and update those local characteristics which form our priority PLUS groups	Jeff Banks	Director of Strategic Partnerships	Jeff Banks Emma Timpson		09/23	→	→	→	→	→	+ ICP leads cross-sectoral defining of local PLUS priority groups. + Review and develop over time	ICP
W14	Defining broader adult health and care priorities and outcome measures	Work together to define targets and measures for Adult Health and Social Care and review progress annually.	Jeff Banks	Director of Strategic Partnerships	Jeff Banks Emma Timpson		09/23	→	→	→	→	→	+ ICP leads cross-sectoral defining of adult integrated health and care priorities and outcome measures. + Review and develop over time	ICP
W15	Defining broader babies, children and young peoples' health and care priorities and outcome measures	Work together to define targets and measures for babies, children and young peoples' Health and Social Care and review progress annually.	Jeff Banks	Director of Strategic Partnerships	Jeff Banks Emma Timpson		09/23	→	→	→	→	→	+ ICP leads cross-sectoral defining of integrated targets and measures for babies, children and young peoples' health and social care. + Review and develop over time	ICP
W16	Define and prioritise work with first 5,000 priority households	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.	Jeff Banks	Director of Strategic Partnerships	Jeff Banks Emma Timpson		09/23	→	→	→	→	→	+ ICP leads cross-sectoral defining of specific cohort of c.5,000 households + Review and develop over time	ICP
W17	One front door	Create 'one front door' for residents to access the vast majority of health and care services. (W17 - 04/23 and ongoing)	Jeff Banks	Director of Strategic Partnerships	Jeff Banks Emma Timpson					04/24	→	→	+ ICP leads cross-sectoral developing 'one front door' approach + Review and develop over time	ICP
W18	Build community resilience and increase mobilisation	Work together to define our local targets for community resilience, mobilisation and transformation, and review progress annually. (W18 - 09/23 and ongoing)	Kirsty O'Callaghan	Director of Community Resilience, Mobilisation and Transformation	Kirsty O'Callaghan Simon Presney		09/23	→	→	→	→	→	+ ICP leads cross-sectoral defining of community resilience, mobilisation and transformation targets.	ICP

													+ Review and develop over time	
W19	Develop a culture of openness and transparency	Work to be develop a system that is more open and honest about what is and isn't going well, why, and what we can all do to make things better.	Jeff Banks	Director of Strategic Partnerships	Jeff Banks Kirsty O'Callaghan					04/24	→	→	+ ICP leads cross-sectoral work in creating a more open and honest ICS environment + Review and develop over time	ICP
W20	Defining broader system priorities, challenges	Work together to define our local targets for dealing with system priorities, challenges and opportunities and review progress annually.	Jeff Banks	Director of Strategic Partnerships	Jeff Banks Emma Timpson		09/23	→	→	→	→	→	+ ICP leads cross-sectoral defining of targets for dealing with system priorities, challenges and opportunities. + Review and develop over time	ICP
W21	ICP supports 'one workforce' approach improving workforce recruitment, retention and development.	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.	Jeff Banks	Director of Strategic Partnerships	Jeff Banks Emma Timpson				03/24	→	→	→	+ ICP Partners will work collectively to support 'one workforce' approach. + Review and develop over time	ICP
W21	Generate increased cross-sectoral investment in prevention and early intervention.	The ICS system increasingly invests in prevention and early intervention and approaches to tackling the wider determinants of health.	Jeff Banks	Director of Strategic Partnerships	Jeff Banks Emma Timpson				03/24	→	→	→	+ ICP Partners will work collectively to generate new and increased investment in early intervention and prevention. + Review and develop over time	ICP
W22	ICP supports development of shared data and digital systems	The ICP supports development of shared data and digital systems across the Partnership to provide greater insight and enable evidence-based decision making. (W23 - 03/24 and ongoing)	Stephen Gallagher	Director of Data and Business Intelligence	Stephen Gallagher				03/24	→	→	→	+ ICP Partners will work collectively to support shared data and digital systems + Review and develop over time	ICP
W24	ICP working practices	Work together to define our working practices as a partnership, and review progress annually.	Jeff Banks	Director of Strategic Partnerships	Jeff Banks		09/23	→	→	→	→	→	+ ICP defines working practices as a partnership. + Review and develop over time	ICP
W25	Partner alignment on Common Endeavour	Ensure partner organisations are aligned on common goals and share plans and resources wherever effective. (W25 - 03/24 and ongoing)	Jeff Banks	Director of Strategic Partnerships	Jeff Banks				03/24	→	→	→	+ ICP Partner organisations are aligned on common goals and share plans	ICP

													and resources wherever effective. + Review and develop over time	
W29	ICP Resourcing	ICP identifies and secures the resources needed to ensure the ICP can deliver against the priorities it has set. (W26 - 04/23 and ongoing)	Jeff Banks	Director of Strategic Partnerships	Jeff Banks	04/23	→	→	→	→	→	→	+ ICP identifies and secures resources required to meet objectives + Review and develop over time	ICP

Community Outcomes

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)
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)
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)
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)
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)
I8	I will see significant improvement in adult health and wellbeing outcomes (I8 - 03/24 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)
I10	I will see real progress in tackling the needs of the most vulnerable members of my community. (I10 - 03/24 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)
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)
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)
I17	I will feel able to engage and contribute to the ongoing work of the Partnership. (I17 - 03/24 and ongoing)

ICP Crosscutting principles, commitments, and responsibilities

C1	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.
C2	Relationship building	The ICP will always seek to develop and strengthen relationships with those parts of our system where there is little history of working together, or when previous efforts have not been successful.
C3	Equal value partnership	We will always value the role of our NHS Partners, local authorities, and wider contributors equally.
C4	Respecting sovereignty	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.
C5	Partner Boards and Forums	We have a number of proactive and powerful boards, partnerships and forums 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.

C6	Anchor movement	Our Partnership will work with our Anchor Network of larger institutions, to grow and develop the range of cross-cutting initiatives which are developed through that movement.
C7	Safeguarding	Our Partnership recognises we all have responsibility to safeguard children and vulnerable adults. 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 always engage with and involve specialist bodies, including local safeguarding partnerships, to ensure we are working with the best available advice and support.
C8	Equality, inclusion, and diversity	Our Partnership recognises we all have responsibility 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 proactively seek the involvement of minoritised communities, many of whom experience worse health outcomes
C9	Quality and risk management/mitigation	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 we will work to ensuring our collective services and supports are of the highest quality and well connected, we will reduce risk.
C10	Sustainability and the environment	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.
C5	Regulatory environment	Our partnership will continually monitor how we are meeting statutory and regulatory requirements as they exist now and in the future.
C6	Updates to the Strategy	Each time the Integrated Care Strategy is revised, this will be formally shared with 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. + The upper tier local authorities are required to consider the Integrated Care Strategy as they develop their own local plans. + 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.

MSE Integrated Care Partnership, 20 March 2023

Agenda Number: 09

Anchor Programme

Summary Report

1. Purpose of Report

To provide the partnership with an update on the Anchor Programme across Mid and South Essex and next steps Oct 1st – March 31st 2022/23

2. Executive Lead

- **Name:** Charlotte Williams
- **Job Title:** Chief Improvement and Strategy Officer
- **Organisation:** Mid and South Essex Foundation Trust

3. Report Author

- **Name:** Kevin Garrod
- **Job Title:** Anchor Programme Manager – Local Value Lead
- **Organisation:** Mid and South Essex Foundation Trust

4. Responsible Committees

N/A

5. Financial Implications

Ongoing investment and support for Anchor

6. Details of patient or public engagement or consultation

The imminent Impact Report and emergent Anchor plan will be shared and socialised across stakeholders including with the ICP, voluntary sector, further and higher education and key / relevant public and private sector organisations i.e Essex Chamber of Commerce (Essex Skills Improvement Plan) and Job Centre Plus.

7. Conflicts of Interest

None identified

8. Recommendation/s

- To request the ICP continues to support and invest in Mid and South Essex's Anchor programme
- To request the ICP encourages Charter organisations and ICP members to evidence their contribution to its charter aspirations
- To request the ICP encourages Health and Well Being Boards to understand the role that they can play in supporting Anchor work
- For ICP members to consider and comment on the national development of metrics, frameworks and the programmes operating model or practice

Please note – *Any reports published to Mid and South Essex's Integrated Care Partnership will be published on a public website, and members of the public can attend any meeting of the Partnership.*

Please ensure all reports are suitable for public consumption & accessible to the public, avoiding jargon.

MSE Anchor Programme

1. Introduction

The update will support ICP members understanding of Anchors, their purpose, how they support the ICS Strategy. It will profile existing MSEFT Anchor practice and preview the ICS Anchor Impact report and support partners to guide, develop and prioritise Anchors in Mid and South Essex

2. Main content of Report

The item will cover developing anchor thinking, and theory, exploring how Anchors delivery can support the development of social and economic wellbeing (NHS Objective 4 for ICS') and how together Anchor, MSE ICP and its members can help to reduce Inequalities.

The item will then explore MSEFT Anchor in practice, its focus on acting intentionally, with partners and at a proportionate scale. This will include specific examples and its emergent model or theory of change before previewing the forthcoming ICS Anchor Impact Report.

3. Conclusion

- Much progress has been, but the need to embed and deliver on the MSE Anchor Charter's ambitions has increased
- Mid and South Essex Foundation Trust led Anchor Programme continues to lead, and act in support of, the systems Anchor ambitions
- Partnership and collaboration across and with ICP partners and beyond have been a defining feature of progress to date

4. Recommendation(s)

- That the ICP continues to support and invest in Mid and South Essex Foundation Trust's Anchor programme
- That the ICP encourages Charter organisations and ICP members to evidence their contribution to its charter aspirations
- That the ICP encourages Health and Well Being Boards to understand the role that they can play in supporting Anchor work
- That ICP members consider and comment the national development of metrics, frameworks and the programmes operating model or practice

5. Appendices

Mid and South Essex Anchor Institutions Charter

Integrated Care Partnership and Anchors

Charlotte Williams
Chief Strategy & Improvement Officer

Preeti Sud
Head of Strategy Unit

Mid and South Essex Foundation Trust

Aims for the next 25 minutes

- To support ICP members understanding of Anchors, their purpose, how they support the ICS Strategy
- To profile existing MSEFT Anchor practice and preview the ICS Anchor Impact report
- To help partners to guide, develop and prioritise Anchors in Mid and South Essex

*"An anchor institution is one that, **alongside its main function**, plays a significant and recognised role in a locality by making a strategic contribution to the local economy."*

NHS
Mid and South Essex
NHS Foundation Trust

- Developing thinking
- NHS Objective 4
- MSE ICS, its partners and its Anchor Charter

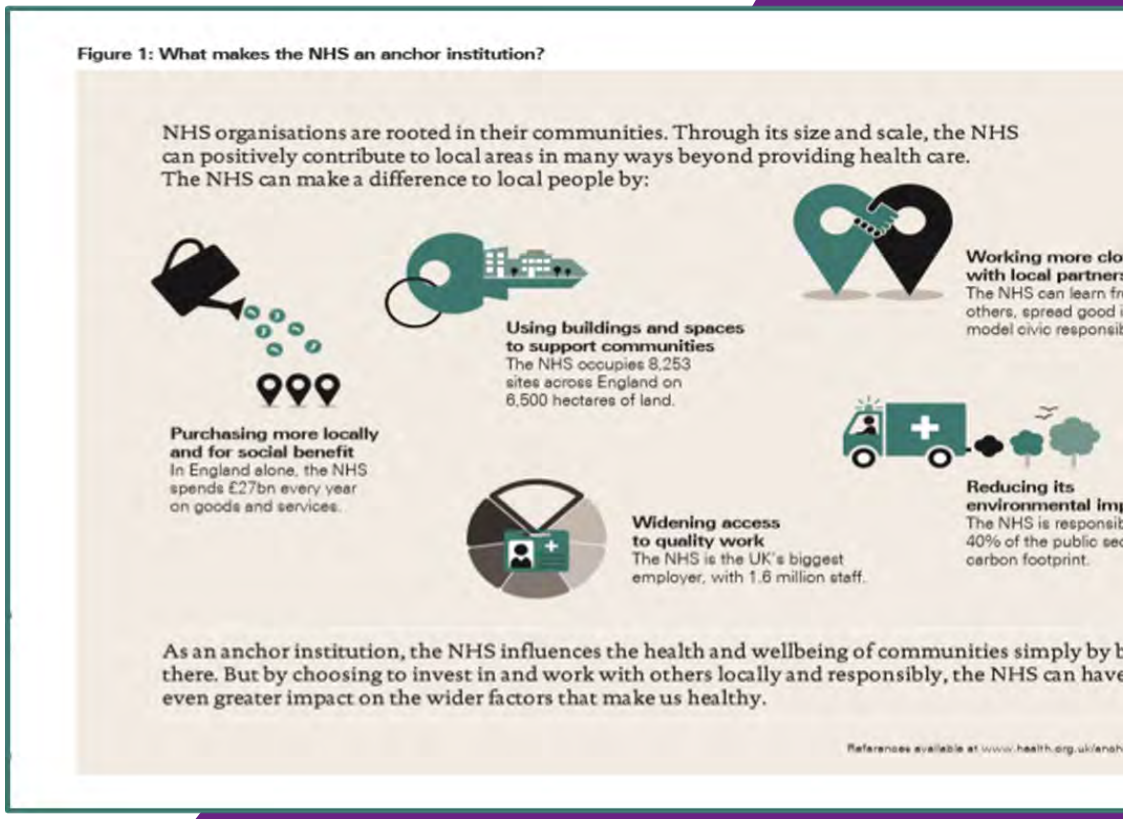


Figure 1: What makes the NHS an anchor institution?

NHS organisations are rooted in their communities. Through its size and scale, the NHS can positively contribute to local areas in many ways beyond providing health care. The NHS can make a difference to local people by:

Purchasing more locally and for social benefit
In England alone, the NHS spends £27bn every year on goods and services.

Using buildings and spaces to support communities
The NHS occupies 8,253 sites across England on 6,500 hectares of land.

Working more clo with local partner
The NHS can learn fr others, spread good model civic responsib

Widening access to quality work
The NHS is the UK's biggest employer, with 1.6 million staff.

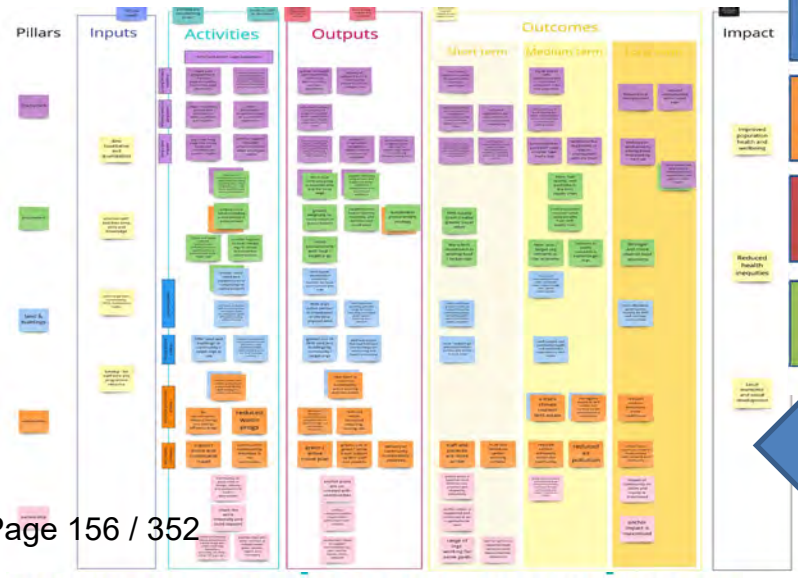
Reducing its environmental imp
The NHS is responsib 40% of the public sec carbon footprint.

As an anchor institution, the NHS influences the health and wellbeing of communities simply by b there. But by choosing to invest in and work with others locally and responsibly, the NHS can have even greater impact on the wider factors that make us healthy.

References available at www.health.org.uk/anch

The role of Anchors and Health Anchors

Essex Anchors Network 2021



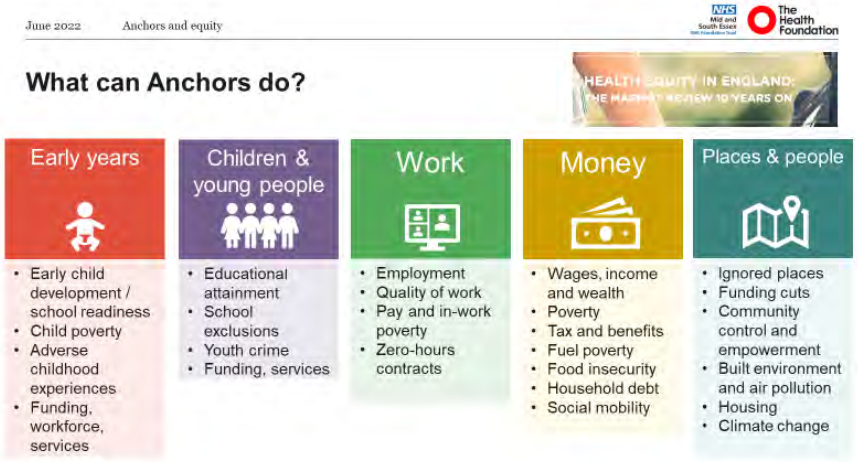
NHS England /UCLP
logic model for Anchors due April 23

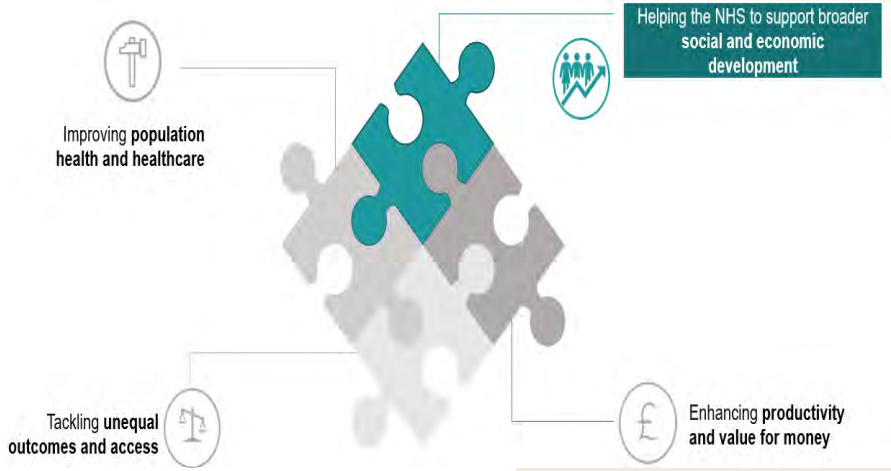
Health Anchors Learning Network

Key elements of successful anchor programmes, include

- Long-term commitment of funding and resources to drive anchor work forward acknowledging and supporting existing initiatives within the organisation which can contribute to an anchor mission initiatives.
- The active support and sponsorship of senior leaders
- A clear set of objectives for the anchor work, and real intentionality with how different parts of the organisation are working to achieve these objectives.
- Carefully managed risk to support a 'get up and go attitude' to anchor work throughout the organisation.

Health Foundation 2019-22





NHS Confederation

Unlocking the NHS's social and economic potential: creating a productive system

NHS Mid and South Essex NHS Foundation Trust

Research and Development

- How can we help attract inward investment?
- How can we increase the percentage of health R&D funding the system/region receives?
- What new industries are we seeking to develop?

Net Zero

- Are we addressing air quality in those areas most densely populated?
- What are the challenges in moving to a net zero local economy?
- Can we create or support local energy markets?

Employment and Skills

- How can we make our place more productive?
- Can we increase labour market participation in certain age groups?
- Can we retain graduates?

Civic Leadership

- How might we jointly invest our limited resources?
- What is our role in developing a stronger cultural offer for our area?
- How do we help improve pride in our place?

Population Health

- How do we ensure school readiness?
- What do our local small and medium-sized enterprises need to improve their productivity?
- In what NHS services would investment most address local productivity or unlock long-term savings elsewhere, for example in the criminal justice system?

Estates

- How can integrated public services support the diversity and sustainability of the high street?
- How experimental are we prepared to be in providing services?
- What are the housing needs of the local keyworker population?

Procurement

- How do we support diverse suppliers?
- Do our policies enable local procurement spend to reach those furthers from our supply chain?
- What do we want to change through procurement?

Anchor and its Charter,
Embedding and evolving principles and practice

As part of the development of Mid and South Essex Anchors, MSEICS has asked MSEFT to develop a programme of support that helps partners to identify and develop Anchor activity.

The work includes;

1. Gathering information through key partners /stakeholders to support planning and an ICS Anchor Impact Report

2. Progressing specific Do Once Projects system wide

3. Generating and nurturing `Anchor People' who can advocate, influence and support its principles adoption, adaption and implementation

Bringing 'our' Anchor charter to life
- Charter signatories workshop 21 Nov
- Bring together Anchors
- Do-once, collaboration and joint opportunities

Working more closely with local partners
- Alliances, VCSE sector and partners
- Horizon scanning for innovations and best practice on identified gaps for local anchors
- Strengthening partnerships with other programmes

Supporting Local and Social Value
- MSE wide social value measurements
- Net Zero programme
- Supporting local enterprise

Creating Insights and reporting Impact
- Workforce dashboard – Do-once
- Evaluation of Anchor activities across system
- Impact report

Identifying opportunities for Quality 'local' Work
- LD internships - Do-once
- Ambition 2025 – Do-once
- Close working with People Board

**A detailed programme plan supports this work*

Mid and South Essex Health and Care Partnership

Charter for the Mid and South Essex Partnership of Anchor Institutions

Mid and South Essex Health and Care Partnership has huge potential to add social value to the 1.2m people who live in our area, through:

- targeting inequalities
- creating the conditions to attract local investment and economic growth
- increasing educational aspiration and attainment among children and adults
- offering local employment opportunities
- addressing discrimination in all its forms
- creating a culture of diversity and inclusion – ensuring equality of opportunity for all
- leading the way in supporting the health and wellbeing of our workforce and our residents
- addressing concerning trends such as lowering aspirations of young people, and health disparities exacerbated by COVID-19.

An Anchor Institution commits itself to this cause, acting with intent and drive towards this goal.

As partners in our Health and Care Partnership we recognize the key role that we have to influence these areas, and the impact this will have on the health and wellbeing of our local communities. Evidence[1] has shown in the public sector we can make gains in considering our role in employment, education and life chances, procurement and estate, now and in the future through thinking about long-term impacts of our actions and sustainability.

We therefore sign below to recognize our commitment to consider, within our legal and regulatory limits, every opportunity to add social value through our decisions and actions as an organisation and as a Partnership. We will do this deliberately, and agree through this Charter to collaborate with partners to support our Anchor Institutions in this endeavour.

Our Anchor Partnership Principles

To work, an anchor needs a chain, and the Mid and South Essex Anchor Partnership will only succeed by having strong links and pulling together. We aim to build on existing relationships, engagement, intelligence and investment to deliver greater value and expand opportunity, leading to higher impact.

No single organisation can achieve as much on its own as an Anchor Institution as we can by drawing on, complementing and amplifying the strengths of each other. The Anchor Partnership will measure its success through the achievements of the partners below collectively against our shared goals.

Anchor

Supporting partners and the ICS Strategy

Reducing Inequalities Together

Tackling unfair and avoidable differences in health and care outcomes across the population, and between different groups within society

- Leading, owning and facilitating
- At all levels
- Place and partnership
- Aggregation and reach
- A collective common endeavour

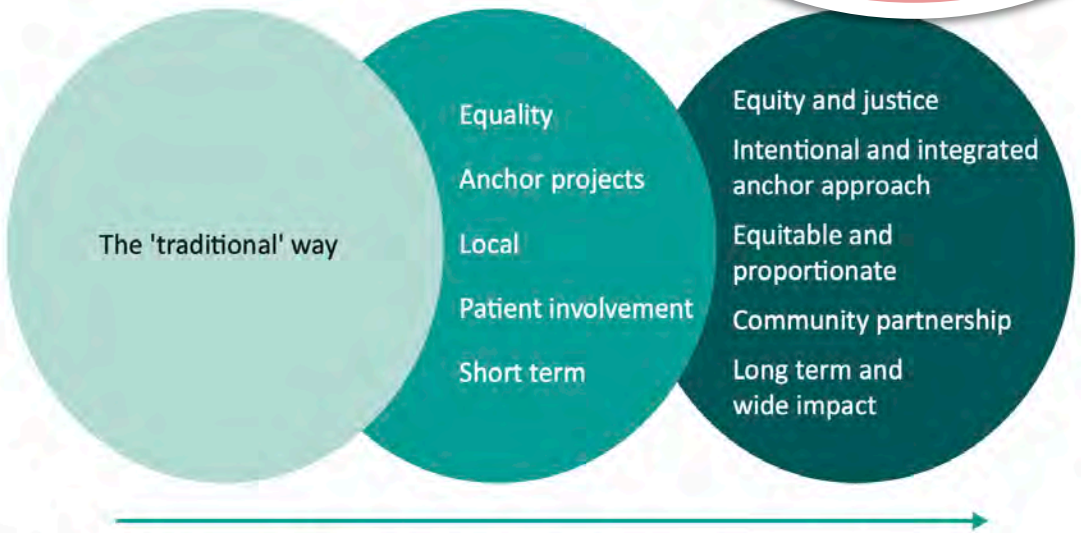
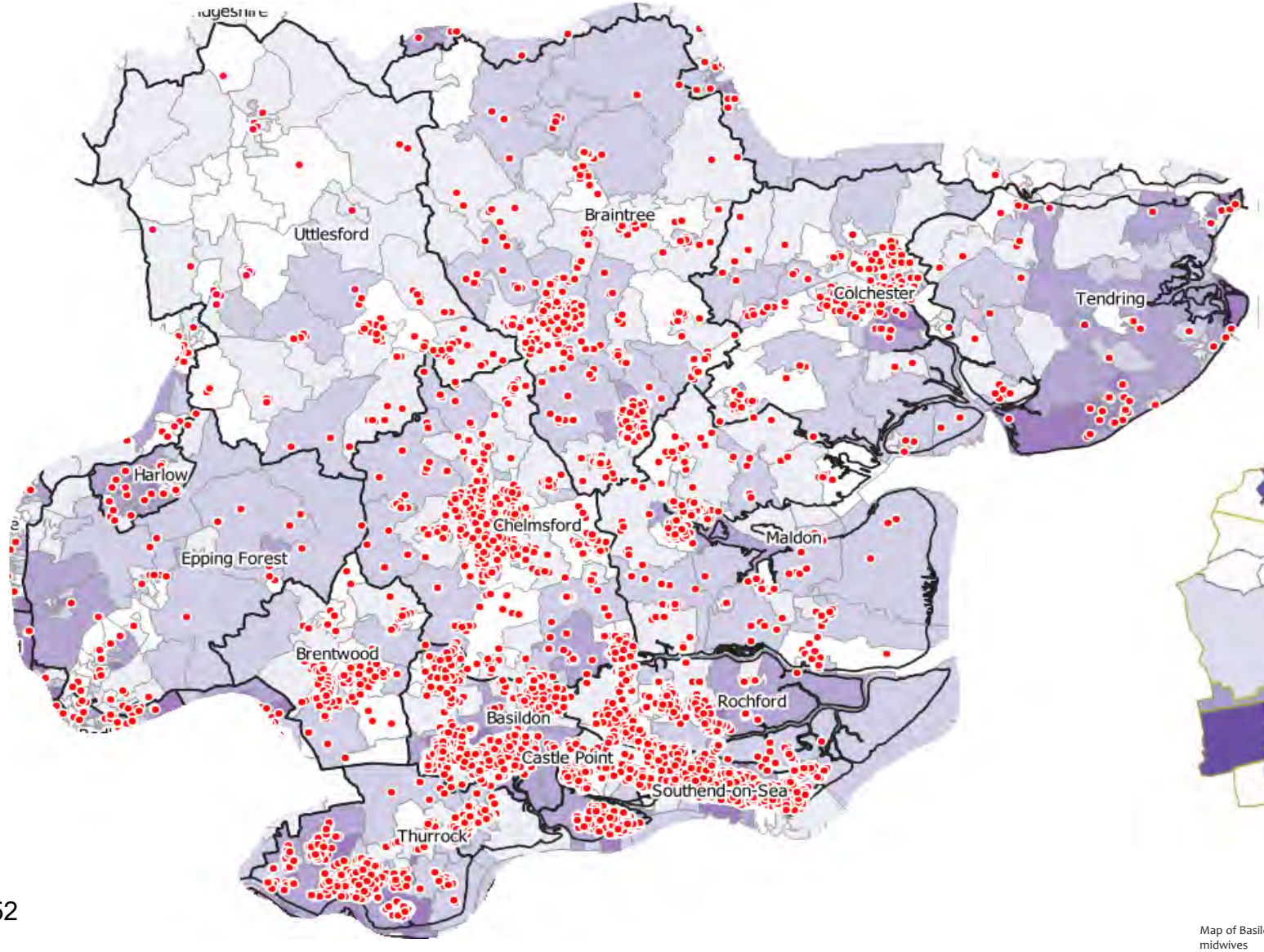


Fig 3. Five principles for moving anchor institution work towards equity.

Our People

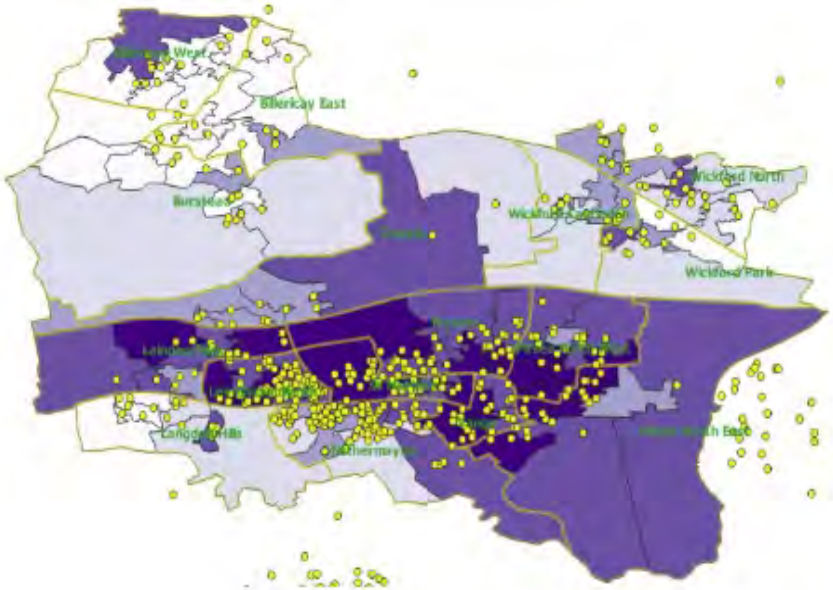
Their lived experience and their communities

Mid and South Essex NHS Foundation Trust



IMD Deprivation Quintile

- 1 - Most Deprived Quintile
- 2
- 3
- 4
- 5 - Least Deprived Quintile



Map of Basildon and Surrounding areas showing correlation between deprivation and homes of Basildon Hospital nurses & midwives

Strategic and collaborative partners

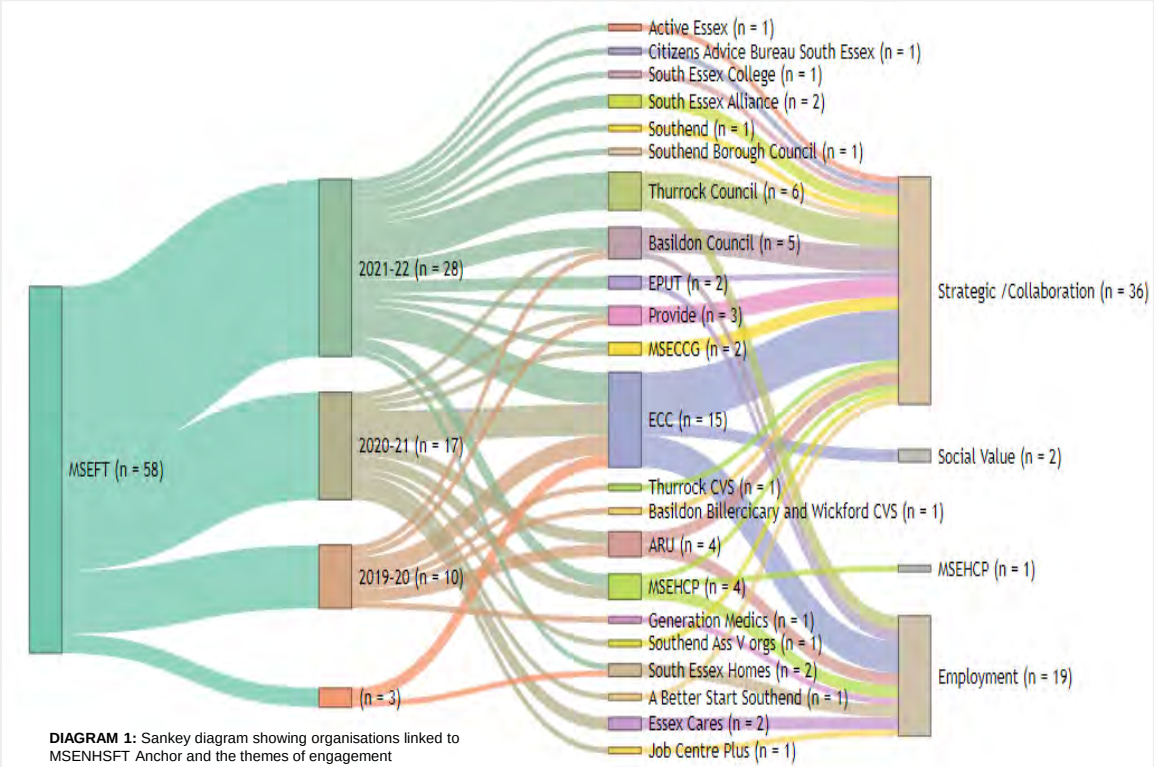


DIAGRAM 1: Sankey diagram showing organisations linked to MSENHSFT Anchor and the themes of engagement

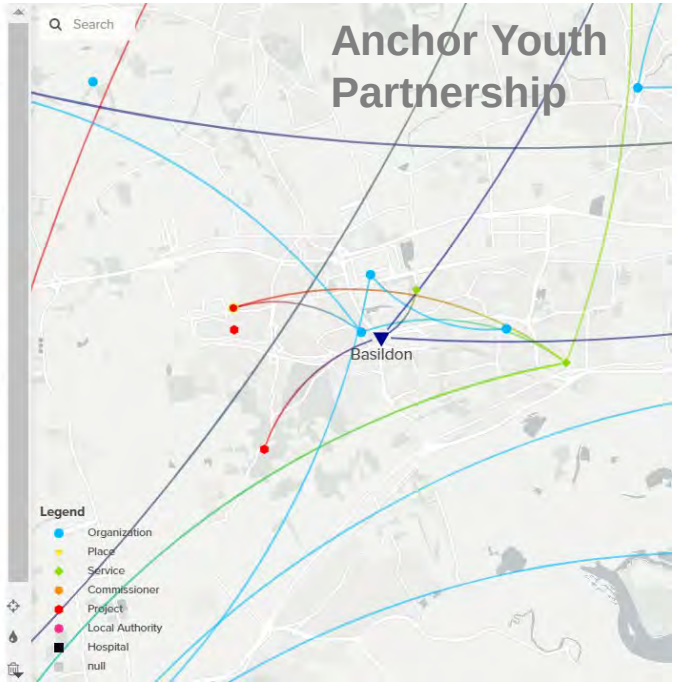
Basildon Advice Store

PROJECT

Basildon Council has partnered with local providers of skills, training and career advice to support local people in a welcoming and accessible space. The Advice Store is for anyone who is looking for help finding work or wants to gain new skills or retrain to enter more fulfilling, secure and better paid employment. Whether you are looking to change your career and need to update your skills, are currently unemployed and looking for work or leaving full time education and need advice on career options - the team at The Advice Store in Basildon Town Centre are here to help.
https://www.basildon.gov.uk/theadvicestore

Knowledge of Jobs and Careers Appropriate Support

ALLIANCE	South West Essex Alliance
AREA	Basildon
PILLAR TYPE	Employment Opportunities
POSTCODE	ADD POSTCODE



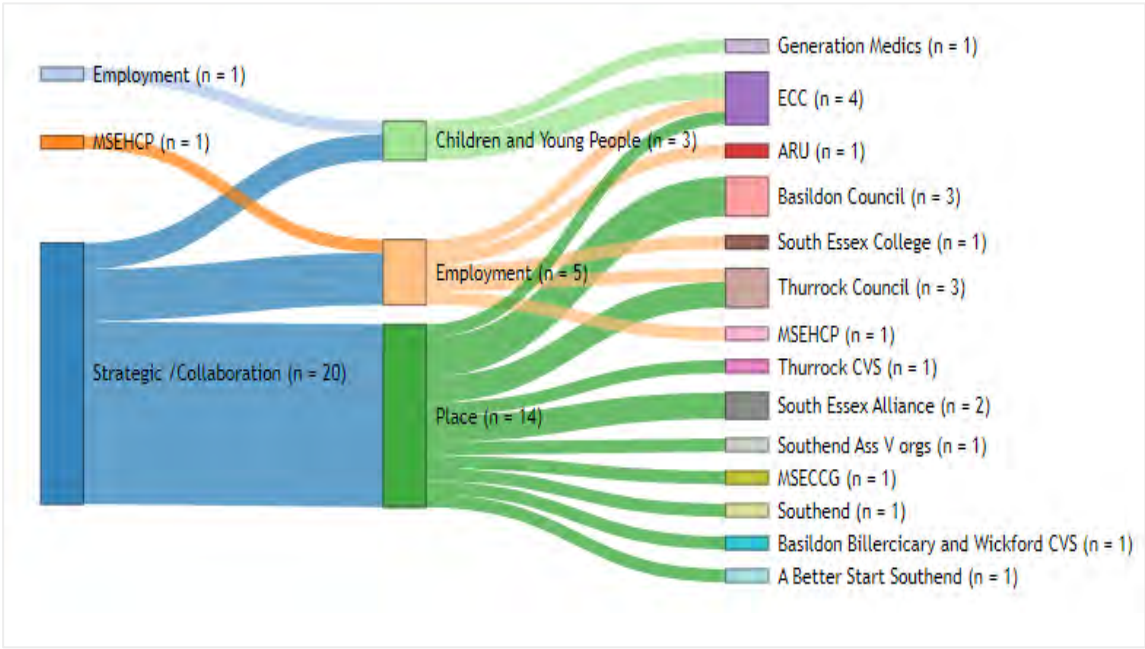


DIAGRAM 2: Sankey diagram showing further detail regarding nature of partner organisation relationships

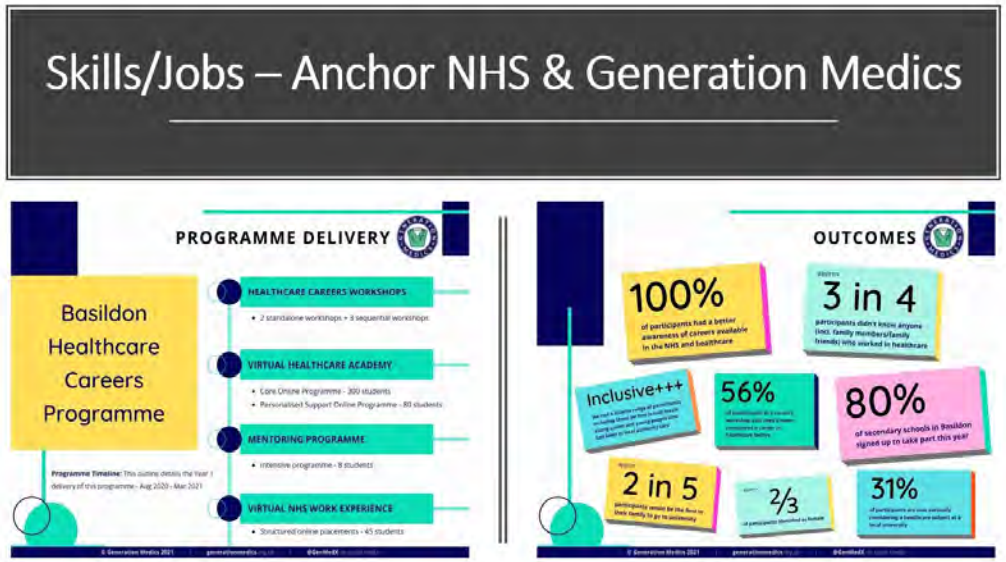
Operationalising Anchors

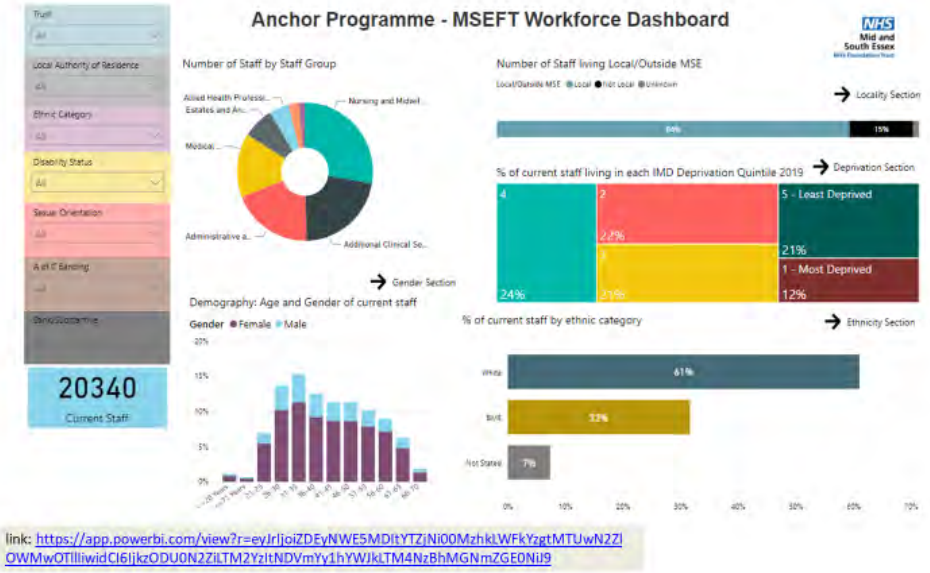
- Acting intentionally – thinking system wide
- The value of collaboration to reduce inequalities
- Operating concept

Collaboration that reduces inequality

- Across the hospitals and critically with partners
- With VCSE's
- Informed by data

https://www.england.nhs.uk/blog/unemployment-and-health-inequalities-innovative-approaches-in-mid-and-south-essex/



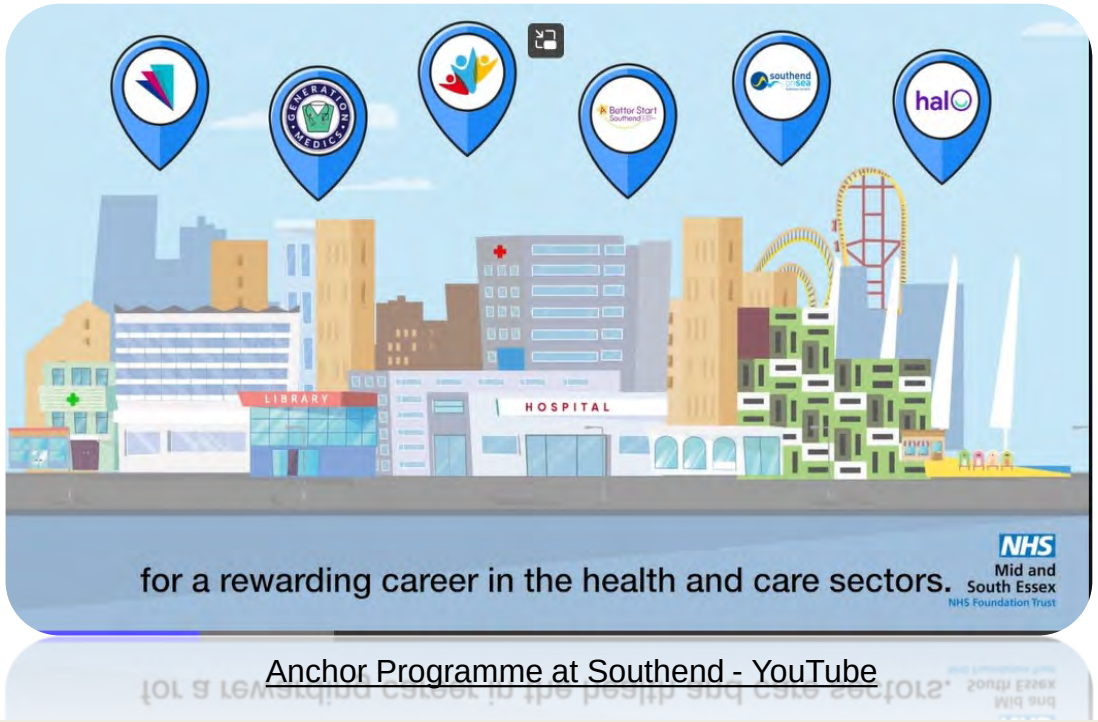


link: https://app.powerbi.com/view?r=eyJrIjoiZDEyNWE5MDItYTZjNi00MzhkLWFkYzgtMTUwN2ZlOWMwOTIlliwidCI6IjkzODU0N2ZiLTM2YzItNDVmYy1hYWJkLTM4NzBhMGNmZGE0NiJ9

Southend Ambition 2050

Moving people living in Southend who are unemployed or economically inactive, towards work at either Southend Hospital or the local health and care sector.

- ✓ Helps develop the local NHS and care workforce needed for the future.
- ✓ Tests if the strengthening of local routes, into the NHS and beyond, can improve recruitment and retention and an individual's well-being.



Anchor Programme at Southend - YouTube

What Next

- **Expanding the core service to a consistent Hospital and Alliance led footprint incorporating Basildon and Chelmsford**
- Helping this model become business as usual for Mid and South Essex NHS Foundation Trust and the local health sector
- Extend our support to Band 2 and 3 employees to support them to stay to progress, innovate and thrive
- To continue to work collaboratively with partners and seek solutions to the challenges that disadvantaged communities face

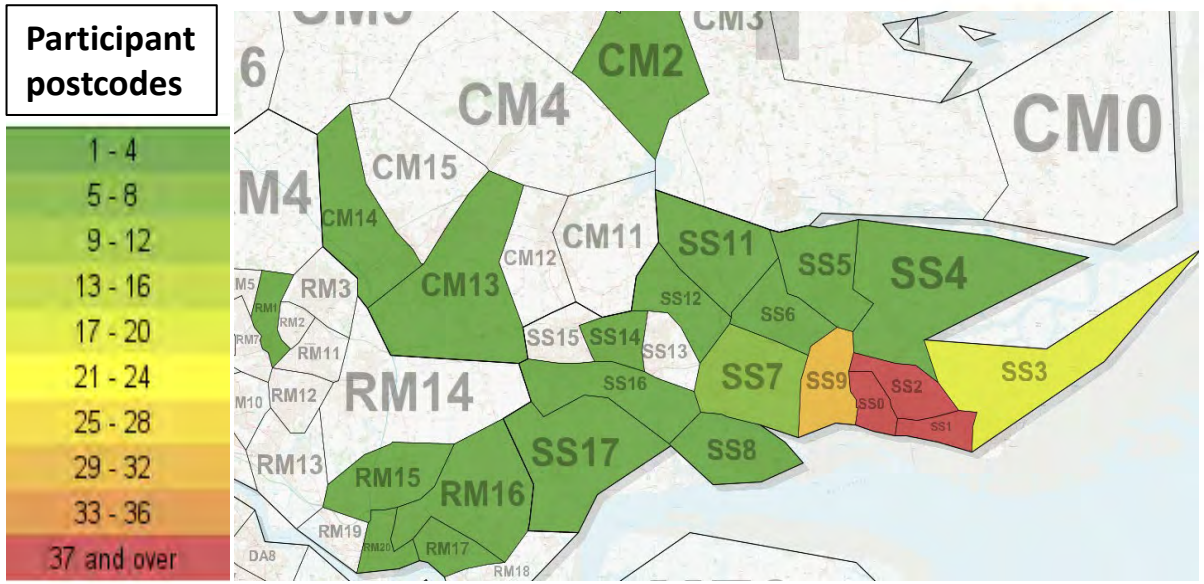
- changing thinking, expectations, and the everyday impact of economic hardship for residents;
- improving self-esteem and wellbeing for individuals and families;
- raising aspirations for children in families in the city's most deprived wards
- reducing poverty and inequality, and improving life chances.

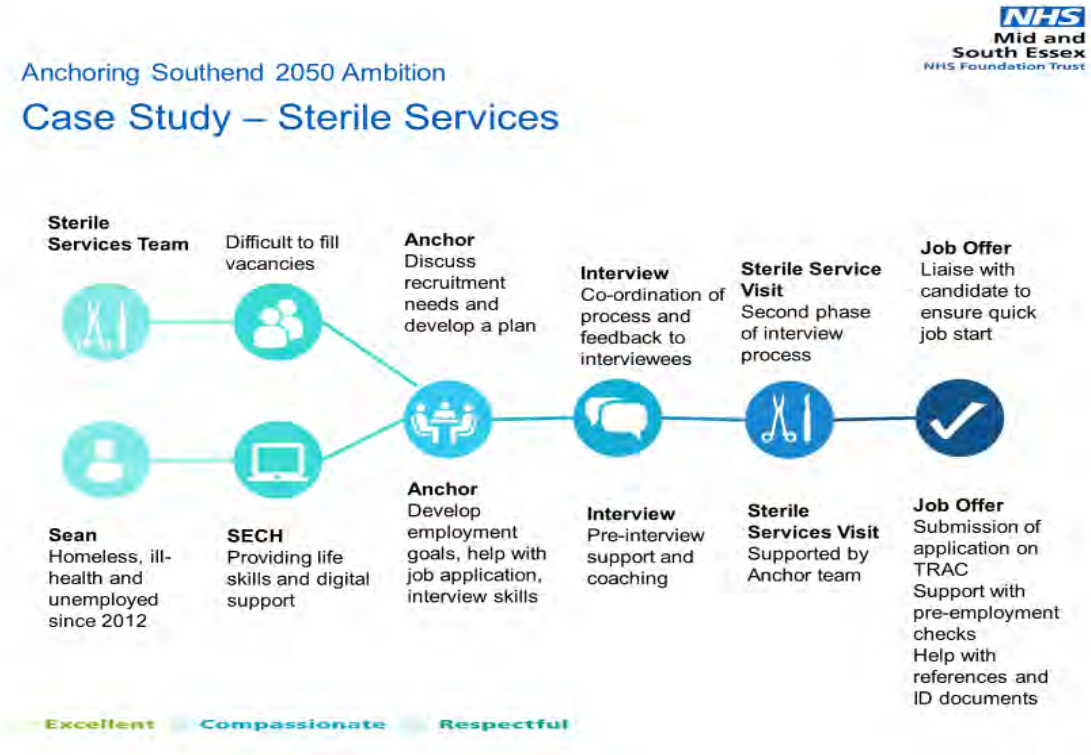
Targets, change and place

Southend Ambition 2050

[Anchor Programme - Participant reported change - Equality and Health Inequalities Network - FutureNHS Collaboration Platform]

	Targets to 31 Dec 2022	Actuals to 31 Dec 2022
Total Participants	625	623
Learners	200	201
Jobseekers	350	365
Accessing benefits support and/or require life skills	50	93
NHS Job Offers	0	106
Job Offers in other sectors	0	52
Organisations being supported to develop associated support	10	10





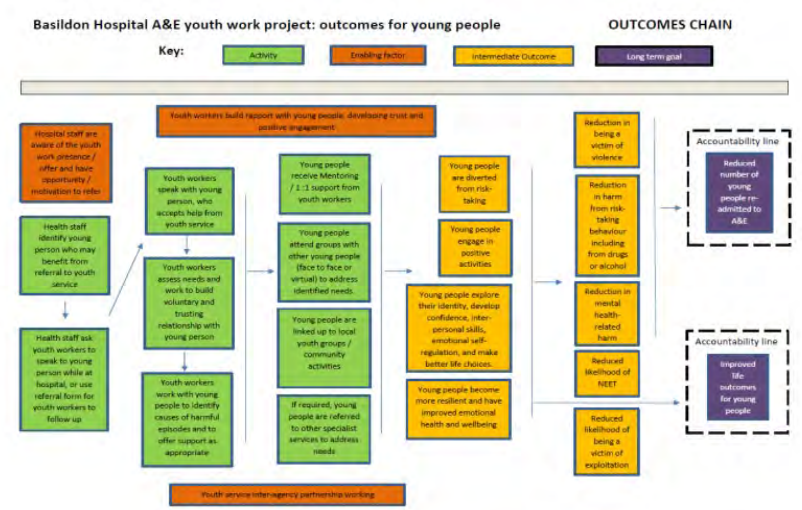
Excellent Compassionate Respectful

Reducing Inequality, Anchor and collaboration
Basildon

For the long term, the journey started in 2019

- ✓ Pedal Power
  Net Zero, Cost of Living ,Health and Well being
  With Basildon Council, Sport England and the Alliance

- ✓ Youth Work in Basildon A&E
  Mental Health and Violence
  With Essex Youth Service and Police and Crime Commissioner



- ✓ Basildon Social Innovation Incubator Feasibility study
  Developing of Social and Economic wellbeing
  With Essex County Council
  (Adult Social Care and Sector Development), Mid and South ICS and Basildon Council

Operating Practice –
A developing theory of change

Complex Issues

- Net Zero
- Employment and Cost of Living
- Childcare ,Young People and Employment
- Social Value
- Care closer to home

Place - Some people and /or places

- Ambition 25 with ACL/ JCP+, Reed and community anchors
- Social Value MSE offer
- Specific Job Cohorts – 0ver 50's, Mental Health vulnerable young people

Local - Partners, stakeholder's and people extending work

- Basildon Youth Work in A&E with ECC and Police and Crime Commissioner and potentially in Southend
- Ambition 2050 with JCP+/Reed and community anchors
- LD and Autism Work Placements

Outcomes

Improved population health hand well being

Reduced health Inequalities

Local economic and social development

System - most people, most places

- Workforce Dashboards
- Anchor Institutions, Essex and national Anchor Networks and Anchor Youth Partnership
- Care Group's and clinical leaders

Pilots, testing and learning

- Multiply –Numeracy for Pre-Employment and Diabetes Type 1
- Dr Me , *Big Five* (Health literacy and aspiration for schools)
- Hundo , NHS Careers and ECC – making applying for work easier

Socialising, tracking and testing appetites

- Essex Employer Friendly Charter and working family's support
- Basildon Social Innovation Incubator
- Alliances mapping and matching

Hype local - partners, stakeholder's and people

- Ambition 2050 with South Essex Community Hubs and A Better Start Southend and SUHT
- ARU Lived experience research, community safety and BTUH
- Basildon Pedal Power / LDP (Basildon Council, Alliance and Sport England)

Next Steps

- Plan for Mid and South Essex Anchors approach 23-25
- ICS Impact Report and Evaluation – June 1st 2023

  Features ICS partners and stakeholders

  Key Themes –

  Bringing people together

  Social Value, local value and local benefit

  Widening access to employment

  Healthy places

✓ Do Once projects progression

Conclusions

- Much progress has been, but the need to embed and deliver on the MSE Anchor Charter's ambitions has increased
- Mid and South Essex Foundation Trust led Anchor Programme continues to lead, and act in support of, the systems Anchor ambitions
- Partnership and collaboration across and with ICP partners and beyond have been a defining feature of progress to date

Excellent Compassionate Respectful

Recommendations

- That the ICP continues to support and invest in Mid and South Essex Foundation Trust's Anchor programme

- That the ICP encourages Charter organisations and ICP members to evidence their contribution to its charter aspirations

- That the ICP encourages Health and Well Being Boards to understand the role that they can play in supporting Anchor work

- That ICP members consider and comment the national development of metrics, frameworks and the programmes operating model or practice


Thank you

Mid and South Essex Health and Care Partnership

Charter for the Mid and South Essex Partnership of Anchor Institutions

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[1] Building healthier communities: the role of the NHS as an anchor institution, Health Foundation, August 2019

As employers

Creating More Opportunity for Good Work

Between us we employ over 40,000 people, many of whom live in the Mid and South Essex area. This fact gives added emphasis when carrying out our statutory duties and responsibilities. As our legal and professional frameworks allow, we will review our approaches and policies to create more opportunity for meaningful, good work locally; ensuring employment practices are as inclusive and accessible as possible, focusing on the opportunity to add social value and reduce inequality.

We will build an ambition to add social value within Mid and South Essex into our education and training portfolio, including through targeted engagement with young people, apprenticeships and career programmes linking to the wider public sector and local business, through widening participation.

We will increase opportunities for local people to volunteer and gather work experience in our organizations where this has been shown to lead to improvements in rates of employment, and aim to make these opportunities as inclusive as possible of those with particular needs or protected characteristics or from under-represented groups. We will also encourage staff to volunteer within their communities, to improve their health and wellbeing and to increase their community assets.

Health and Wellbeing at Work

We will ensure inclusive, healthy workplace wellbeing schemes, aiming to build active workplaces and supporting those with highest needs. We will encourage staff to help us with this agenda and where appropriate will build health and wellbeing messages into our work with communities e.g. schools.

We also commit to supporting lower paid staff reaching their potential via inclusive personal and professional development, and supporting them more broadly in their health, wellbeing and financial security where possible.

We will disclose how we are doing this and contribute relevant data to the Mid and South Essex Anchor Programme as available.

As purchasers

Supporting local enterprise
Insofar as is consistent with our statutory obligations or requirements from our regulators, we will procure locally and in line with good practice principles on procurement to maximize social value. This will include looking to develop routes for locally based micro, small and medium-sized enterprises to take on contracts from our organizations. This will also contribute to reducing our carbon footprint.

Social and environmental value from procuring goods and services
As regulatory processes allow, we will build social value into our supply chain contracts, expecting providers to quantify the social value returned to Mid and South Essex as part of the contracting process.

We will disclose how we are doing this and contribute relevant data to the Mid and South Essex Anchor Programme as available.

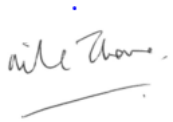
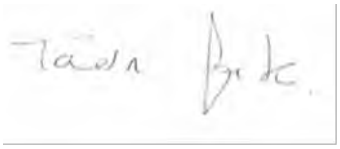
Leading by example for our environment

We will incorporate sustainability criteria into our contracts to reduce our environmental impact.

We will utilize our estate and facilities in support of staff and local communities e.g. through concepts such as green spaces, encouraging community groups and businesses to use our sites, and promoting active and green travel through and to our sites and processes.

We will work across sectors and industries to innovate and address inequality through access to resources such as energy, transport, housing, health and care and leisure for local communities including our own staff and their families.

We will disclose how we are doing this and contribute relevant data to the Mid and South Essex Anchor Programme as available.

 Professor Michael Thorne CBE Independent Chair Mid & South Essex Health & Care Partnership	 Anthony McKeever Executive Lead, Mid & South Essex Health & Care Partnership Joint Accountable Officer for the 5 CCGs
 Clare Panniker Chief Executive Mid & South Essex NHS Foundation Trust	 Paul Scott Chief Executive Essex Partnership University NHS Foundation Trust
 Oliver Shanley Chief Executive North East London NHS Foundation Trust	 Mark Heasman Chief Executive Provide CIC
 Ian Wake Corporate Director of Adults, Housing & Health Thurrock Council	 Tandra Forster Executive Director (Adults & Communities) Southend-on-Sea Borough Council
 Nick Presmeg Director of Adult Social Care Essex County Council	 Juliet Beal Director of Nursing & Quality East of England Ambulance Service Trust
 Owen Richards Strategic Manager Healthwatch Southend	 Sam Glover Chief Executive Healthwatch Essex
 Kim James Chief Operating Officer Healthwatch Thurrock	 Kristina Jackson Thurrock CVS on behalf of CVS organisations in Mid & South Essex

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Mid and South Essex Integrated Care System

MSE Integrated Care Partnership, 20 March 2023

Agenda Number: 10

Basildon & Brentwood Alliance – Community Development

Summary Report

1. Purpose of Report

To provide the Integrated Care Partnership with an overview of programmes underway within Basildon & Brentwood Alliance, including:

- An overview of how Achieve Thrive Flourish (ATF) is working with communities and stakeholders across South Essex to increase opportunities, connection, and wellbeing.
- An overview of Sport for Confidence and the Prevention and Enablement Model (PEM)

2. Executive Lead

- **Name:** Pam Green
- **Job Title:** Alliance Director (Basildon & Brentwood)
- **Organisation:** NHS Mid and South Essex

3. Report Author

- **Name:** Rob Walters / Lyndsey Berrett
- **Job Title:** Structure and Development Manager / Lead Occupational Therapist
- **Organisation:** Achieve Thrive Flourish (ATF) / Sport for Confidence

4. Responsible Committees

N/A

5. Financial Implications

Consideration around the conditions required to upscale ATF's work with identified communities e.g. Formalising a Health Centre Community Hub Pilot

6. Details of patient or public engagement or consultation

PEM has been independently evaluated by the University of Essex. The evaluation has consulted and been contributed too by participants, their families and carers and health and social care professionals across the system.

ATF works hand in hand with residents and stakeholders through our diverse daily community programme, activities and events across Basildon and South Essex, as well as focussed engagement work such as with the "Community Discovery Days"".

7. Conflicts of Interest

None identified.

8. Recommendation/s

(i) To Note the update from Achieve Thrive Flourish, and the benefits of asset-based community development.

(ii) To Note the update from Sport for Confidence and consider the findings & recommendations of the PEM evaluation report.

Please note – *Any reports published to Mid and South Essex's Integrated Care Partnership will be published on a public website, and members of the public can attend any meeting of the Partnership.*

Please ensure all reports are suitable for public consumption & accessible to the public, avoiding jargon.

ATF

Achieve Thrive Flourish

ENABLING CAPABLE COMMUNITIES TO INCREASE WELLBEING

March 2023

The story of ATF

EST. 2012:
"Achievement Through Football"

-Provided free, positive, diversionary football activities for at risk young people in Southend-on-Sea

NOW:
"Achieve Thrive Flourish"

-An asset-based charity offering a broad range of free, life-enhancing opportunities for at-risk children, young people and families across South Essex

ENGAGEMENT 'VEHICLES' INCLUDE:

- Group sports, games & fun physical activity
- Life coaching & intensive 1:1 support
  e.g. with youth in Criminal Justice System
- Volunteering and work readiness
- Community events, projects & celebrations
- Creativity, culture & heritage projects

ATF Achieve Thrive Flourish

www.atfcommunity.com

ATF'S PRACTICE OF CHANGE

ATF Achieve Thrive Flourish

'DISCOVERY DAYS'

1. Tap into ready-made communities e.g. schools/GP surgeries etc

2. Get to know local people -identify, involve & invest in local assets

RISK POSITIVE / 'POSITIVE DEVIANCE'

3. Have regular fun, free, meaningful activities, build connections & aspiration - Being part of something

4. Help with wider needs - e.g. counselling, food, advice etc - Addressing personal barriers

5. People want to give back: Community Connectors, volunteering & participation. ⇨Skills/experience

6. Vocational opportunities lead to more fulfilled lives...

Holistic wellbeing: Physical, emotional, relational, vocational

www.atfcommunity.com

Community Discovery Days

-Fun, interactive, asset-based, sessions with local residents and stakeholders

-Uncovering local strengths, pride, opportunities and ambitions in 90 mins

-Identifying, inspiring and nurturing local 'community connectors'

A. What's working well in this community?
B. What do we value in this community?
C. What are we proud here?
D. What do local people need?
E. How can local services help to improve the health, physical activity and wellbeing of people in this community?
F. Is anything getting in the way?
G. What do we want to do more of?
H. What are the possibilities?

Basildon community programme

February 2023 - Basildon engagement snapshot
811 individuals / 3806 total engagements

- **Weekly Community Hubs** in Felmores, Lee Chapel North and Laindon (wk1 at Laindon Health Centre hub session saw 38 patients engage)
- **Wellbeing activities & opportunities** across Basildon throughout the week include:
  - Sports and physical activity sessions, youth clubs, cooking classes, parenting courses, free counselling support, coffee mornings, tea time clubs, holiday clubs, community events and celebrations, 1:1 youth support, ParkPlay, "Discovery Days"

ATF - BASILDON

WEEKLY SCHEDULE

MONDAY

Community Hub, Briscoes Primary School
All welcome
Free support, advice & games
16:30 - 17:30

Timberlog Youth Centre,
Teens,
Food, games, socialise
15:30 - 17:00

TUESDAY

Community Drop in with Kelly
Briscoes Primary School
Free support & advice
08:30 - 15:00

WEDNESDAY

Briscoes Primary, Community Session, all welcome
17:00 - 18:00

Vange Community Centre, community session, all welcome
17:00 - 19:00

FRIDAY

Briscoes Primary Youth Club Primary Age welcome
18:30 - 20:00

King Edward Community Centre,
Fun games, 11 - 16 yrs
17:00 - 19:00

SATURDAY

Vange ParkPlay
9:30 - 11:30
Northlands ParkPlay
9:30 - 11:30
Eversley ParkPlay
9:30 - 11:30
Gloucester ParkPlay
10:00 - 12:00
Mopsies ParkPlay
10:30 - 12:30

KEY INFO

All of these sessions are free and open to the whole community - we can't wait to see you there!
If you have any questions please email:
rlong@atfcommunity.com

ATF - LAINDON

WEEKLY SCHEDULE

THURSDAY

Janet Duke Community Hub
All welcome, support & advice
9:00 - 13:00

Somercotes Cage Community Centre
All welcome
15:30 - 17:00

FRIDAY

Drop In Support Hub, Laindon Health Centre
13:30 - 16:00

Markhams Chase Multisport community session
All welcome 15:30-17:00

King Edward Community Centre
17:00 - 19:00

SATURDAY

Markhams Chase ParkPlay
9:30 - 11:30

Markhams Chase Community Session
Football
13:00 - 15:00

KEY INFO

All of these sessions are free and open to the whole community - we can't wait to see you there!

If you have any questions please email:
rlong@atfcommunity.com


ATF
"ATF came along when I was in a bad place and they never gave up on me no matter how much of a pain I was.
Thank you will never be enough to repay the gratitude and appreciation I have for ATF"
- Jan, 21 years old

WHAT CHALLENGES ARE OUR COMMUNITIES FACING?

Food & nutrition

Mental and emotional wellness

Isolation

Cost of sports/activities

Obscured pathways into meaningful employment

The lure into county lines/ criminal behaviour

Perceived lack of opportunity

Low self worth/ self belief

Generational poverty/ hindered aspiration

Lack of positive role models/parental capacity

Lack of self care

Attraction of unhealthy behaviours

Impact/legacy of Covid

Difficult experiences with education

Lack of positive attention/ investment of time

Stability/ consistency at home

THROUGH OUR ACTIVITIES WE ARE SEEING. . . .

Increased belonging, self worth & confidence

Improved self care

Increased physical activity and finding that enjoyable

Sense of wellbeing / Reduction in anxiety and depression

Willingness to get involved and help others

Strong sense of belonging, connection and meaning

Community "reclaiming" public spaces

Increased capacity for community members to take care of each other – Less need for services/support

People volunteering / paid work and eventually getting jobs

Improved school attendance

HELPING YOUNG PEOPLE DEVELOP POSITIVE FUTURES

FUN, FREE, REGULAR COMMUNITY ACTIVITIES

- A wide range of free, fun and meaningful activities multiple days per week for all levels and interests

Develops wellbeing + acts as gateway to other beneficial opportunities...

POSITIVE FUTURES 8-WK COURSE

- Inspiring 8-week course for young people at risk, uncovering the realities and lived experience of destructive choices and exploring alternative pathways for success

1:1 COUNSELLING & PSYCHOTHERAPY

- Personal therapy with qualified community practitioners, freely & quickly accessible for participants

1:1 COACHING

- Intensive 1:1 coaching for young people at risk, with built in SMART goals and inspiring opportunities to support positive choices

"FUTURE MAKERS" VOCATIONAL PATHWAYS

- Programme for young people at risk of diminished outcomes, to broaden opportunities, skills and aspirations, in partnership with key local employers

Images from www.freepik.com


“I got into trouble when I was younger and ended up in prison. ATF has literally saved my life and I’m so proud to now be working as a coach, helping young people develop their confidence and avoid the mistakes I made”
-Ash, ATF coach
A.J

Opportunities & Added value

- ATF's priorities 2023-25:
  - Helping our communities connect and be well
  - Helping our communities grow and develop
  - Developing Positive Futures for young people

- Intentional resourcing can unlock the potential of a Health Centre Community Wellbeing Hub pilot incl. Essex Pedal Power/Share Shack models

- Added value: ATF leverages significant additional funding/resources, which directly benefit Basildon residents

We value your partnership!

Together, we can provide life changing projects, activities and opportunities for communities across South Essex

ATF

STUART LONG | CHIEF EXECUTIVE
ROB WALTERS | DEVELOPMENT

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Hardwiring Physical Activity into Health & Social Care

PREVENTION & ENABLEMENT MODEL

INDEPENDENT EVALUATION REPORT

SPORT FOR CONFIDENCE

Active Essex Local Delivery Pilot

Essex County Council

University of Essex

Setting the Scene

WHAT IS 'PEM'?

The Prevention and Enablement Model (PEM) is a test and learn initiative in Essex that launched in August 2020 with Adult Social Care at Essex County Council, Active Essex, and Sport for Confidence CIC as key strategic and delivery partners. PEM adopts a whole systems change approach in Health and Adult Social Care to improve the lives of people living with disabilities and/or long-term health conditions. Its overarching theme is to encourage and support people to be more active and is delivered via a system of unique partnerships across the county's Adult Social Care sector, with four interrelated workstreams.

Objectives

- **System**
  Develop system-led opportunities to be active
- **Embed**
  Embed physical activity in the system
- **Workforce**
  Create practice-based learning and transform ways of working
- **Impact**
  Test and learn from the impact of this transformation

Workstreams

- Care Homes
- Community Partnerships (Reconnect)
- Physical Activity in Occupational Therapy
- Strength and Balance

Key Findings

1. SYSTEM-LED OPPORTUNITIES

Successes

- **Developing an integrated falls prevention programme**
- **Delivering inclusive activity sessions in leisure centres with Occupational Therapists**
- **Enabling and supporting Health and Social Care professionals to embed physical activity into their everyday practice**

The reach of these opportunities continues to grow and in the last two years:

- **Over 900 unique users** attended the integrated falls prevention programme and community-based sessions
- We had **average attendances of over 1000 per month** within community-based sessions *(includes individuals attending multiple times per week)*

Physical activity has been used as a tool to enable independence and achieve wider outcomes. **PEM has provided choice and empowered individuals and groups.** This was underpinned by the initial work to understand existing provision and uses evidence-based and place-based solutions.

Key Findings

2. EMBEDDING PHYSICAL ACTIVITY

Successes

PEM has made excellent progress in embedding physical activity with a preventative focus across the Essex system.

Creating an exciting and ongoing shift in culture and practice in Health and Social Care, particularly in Care Homes and Occupational Therapy. A ripple effect has also been seen across other Healthcare Professionals who have interacted with PEM.

A great example of this is the ongoing work of Care Homes, upskilling staff in physical activity and being recognised for taking part in the NHS East of England Winter Deconditioning Games. Embedding physical activity across the system has been underpinned by:

- **Understanding the system and its leverage points**
- **Facilitative leadership**
- **Alignment with national policies**
- **Individuals and organisations across the system developing a shared vision and working collaboratively**

Key Findings

3. WORKFORCE DEVELOPMENT & PRACTICE-BASED LEARNING

Successes

A key focus and success of PEM was to develop knowledge, skills, and capacity in the Health and Social Care workforce, through training and education. The importance of this was highlighted by baseline data showing:

- Care Home staff and Occupational Therapists had previously received limited or no training in physical activity promotion
- Physical activity was discussed with less than half of their service users
- Conversations typically focused on general physical activity rather than muscle strengthening activity and breaking up sedentary behaviour
- Barriers to promoting physical activity were: time, knowledge, skills, resources and support

Recipients highly valued the training, not just for the knowledge and skills that it developed, but also the opportunity it provided to build networks to share best practice. Alongside workshops, a key driver of success was the provision of ongoing mentorship. Through this work, **PEM has enabled, developed, and supported many of the workforce to embed physical activity into their daily practice and has enhanced job satisfaction.**

Key Findings

4.
THE IMPACT OF PEM

Successes

Qualitative insights revealed that people who accessed PEM services perceived themselves to have experienced several benefits including enhanced:

- **Health**
- **Wellbeing**
- **Confidence**
- **Skills**
- **Routine & Structure**
- **Independence**

Similarly, quantitative analysis suggest that PEM has a demonstrable and significant impact on physical activity and wellbeing. Individuals who had participated in PEM for longer, had higher physical activity levels and more favourable attitudes to physical activity, wellbeing, subjective health and self-efficacy.

The Value of PEM:

- Using the WELLBY to compare those involved in PEM for 1-month, compared to those just starting out, demonstrated **a difference in life satisfaction estimated to equate to £22,230 per person, per year**
- When considered against direct running costs, **PEM could deliver an estimated £58.71 of social value per each £1 invested**
- **A slight decrease was also seen in self-reported service use** (i.e., day care, formal/ informal support, GP visits, ambulance calls & hospital visits). A tentative estimate equates this to a cost saving of £365.23 per PEM participant, per year, split across Adult Social Care (£163.34) and the wider system (£201.90)

Summary

SO WHAT?

The innovative and integrated approach taken by PEM has provided key learnings towards achieving transformational change, embedding physical activity into the system and improving the the lives of people living with disabilities and/or long-term health conditions.

These learnings could be used in the development and iteration of PEM itself or to apply learning to other similar programmes.

KEY LEARNINGS

Scaling the value of reduced service use and higher life satisfaction to the typical number of unique users in Community Partnerships/Reconnect (where most data were collected) suggests that the total annual social value could exceed £20 million.

There is a clear desire to scale up and replicate the model from its leaders, the workforce, and its participants. The need is evident and the PEM pilot has demonstrated how the infrastructure and learning can be used to help reach new participants, locations and professionals within the wider eco-system.

PEM could deliver £58.71 of social value per each £1 invested

Summary

RECOMMENDATIONS

The whole systems and preventative approach of PEM has made exciting progress and had demonstrable impact.
A number of key ingredients have been identified in its success. The recommendations highlighted moving forward are:

System

It is important to develop further understanding of the needs and resources within systems. Opportunities that adopt a whole systems, place-based and preventative approaches should then be co-produced and co-funded (e.g, Health and Social Care). Opportunities and programmes should be evidence-based; integrating community insight, scientific evidence, and the tacit knowledge of Health and Social Care Professionals.

Workforce

Education should be extended to reach more Care Home staff, Occupational Therapists, and other Healthcare Professionals. Workshops should be co-designed with some Care Home staff, Occupational Therapists, and other professionals to ensure that the content is tailored to different contexts and perspectives. Further ongoing support including mentoring and infrastructure would help to ensure the workforce is able to continue to deliver physical activity in many contexts. Longer-term changes to working practices should be monitored and evaluated.

Impact

PEM or similar preventative programmes should be developed to apply the learning from the current Test and Learn programme, but maintaining a focus on people living with disabilities and/or long-term health conditions. Monitoring and evaluation should track individuals over time and integrate additional objective measures of service use to understand the longer-term impact and benefits across the system.

Embed

It is important to more strongly embed physical activity into Adult Social Care, Health and wider systems, and ensure targeted pathways are sustainable. Additional political supporters and organisations within the system should be identified, and partnerships developed around a shared vision and common language.

"There is an understanding there now because the conversations are happening. We are now not inaccurately signposting people with referral forms, we are engaged in a dialogue with other parts of the system about how we can support people, and that is a big change."

PEM Delivery Team Member

"They treat everyone equal, and that has never been in our world... It is like somewhere you can fit in, be a human being and have a life here you can't outside. It is like so powerful what they give and what they have opened the doors to do, it just makes me emotional."

Carer

Further Information

We are committed to playing our part in reducing inequalities that exist within society.

Get in touch to learn more.

SPORT FOR CONFIDENCE

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sportforconf

sport-for-confidence-cic

@sportforconf

#playyourpart

Prevention and Enablement Model Evaluation Report




November 2022

University of Essex | STATE OF LIFE | University of Suffolk

Contents

Evaluation Consortium

This report was **written for the Essex County Council, Active Essex and partners by an Evaluation Consortium** led by the University of Essex. The current consortium comprises academics at the **University of Essex** and the **University of Suffolk**, and Commercial Partners at **State of Life**. This report summarises the evaluation findings in relation to the **Prevention and Enablement Model (PEM)** from **August 2020 to August 2022.** Some data in the report were collected within the **Essex Local Delivery Pilot (LDP)** evaluation contract, which ran between August 2019 and December 2021. In addition to members of the PEM evaluation consortium, the LDP evaluation team included other academics at the University of Essex, Brunel University and Sheffield Hallam University, and commercial partners. LDP evaluation reports and associated outputs from 2019-2021 are available to offer broader context to the current PEM report.

Academics in the PEM Evaluation Consortium

- Dr Paul Freeman[1] (Lead)
- Professor Valerie Gladwell[1, 2]
- Akua Accra[1]

Commercial Partner in the PEM Evaluation Consortium

- State of Life

Members of LDP Evaluation Consortium

- Professor Valerie Gladwell[1, 2]
- Dr Paul Freeman[1]
- Dr Anna Pettican[1]
- Professor Gina Yannitell Reinhardt[1]
- Professor Louise Mansfield[3]
- Professor Rob Copeland[4]
- Professor Gavin Sandercock[1]
- Dr Tarek Al-Baghal[1]
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For any questions regarding this report please contact Dr Paul Freeman
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Executive Summary

What is the Prevention and Enablement Model?

The Prevention and Enablement Model (PEM) is a test and learn initiative in Essex that launched in August 2020 with Adult Social Care at Essex County Council, Active Essex, and Sport for Confidence CIC as key strategic and delivery partners. PEM also brings together a diverse range of wider partners across Adult Social Care, the NHS, and the third sector (e.g., local councils, Essex County Council teams, Provider Quality Innovation Team, and care homes) in a whole system approach to improve the lives of people living with disabilities and/or long-term health conditions. Its overarching theme is to encourage and support people to be more active and is delivered via a system of unique partnerships across the county's Adult Social Care sector, with four interrelated workstreams: Care Homes, Community Partnerships (Reconnect), Physical Activity in Occupational Therapy, and Strength and Balance.

Objectives of PEM

1. **SYSTEM** - To develop system-led opportunities for disabled people and those with long-term health conditions and to encourage them to be active in their local community, reconnecting them to their local area.
2. **EMBED** - To embed physical activity in the system, and to redesign a targeted pathway to achieve this.
3. **WORKFORCE** - To create practice-based learning opportunities that transform ways of working by increasing the confidence and capability across the integrated workforce in using physical activity as a tool for health.
4. **IMPACT** - To test and learn the impact of this transformation and build a case to scale up across Essex.

Context: Why is PEM needed now?

Addressing physical inactivity is a global public health priority. Similar to other developed nations (Guthold et al., 2018), only 61.4% of adults in England and 59.3% of adults in Essex do 150 minutes or more of moderate intensity physical activity per week (Active Lives data, 2020/21). Further, certain groups have a higher prevalence of physical inactivity, including individuals with disabilities and/or long-term health conditions. This mirrors evidence beyond physical activity, with deteriorations in health and widening health inequalities across England (Marmot et al., 2020). Heron et al (2019) estimated the cost to the NHS of sedentary behaviour was £0.8 billion in 2016/17.

There have been numerous calls in Health and Adult Social Care to have a greater focus on prevention and integrated approaches rather than conventional intervention-focused practice (e.g., Anderson et al., 2021; Care Act 2014; NHS Long-Term Plan). Masters et al (2017) conducted a review of international studies and found that the median Return on Investment of public health interventions was £14 for every £1 spent. By tackling physical inactivity in a progressive, preventative and integrated manner across Adult Social Care, Health and the

third sector, PEM could be a pioneering programme that enhances activity, wellbeing, and independence.

Evaluation Approach

The evaluation used a mixed methods approach to collect data from across the system to understand the design, implementation, and impact of PEM. Methods included questionnaires, interviews, focus groups, and reflective logs, along with looking at objective service use data and documentary analysis.

Key Findings

System-led opportunities

PEM has successfully developed a range of system-led, co-designed and context-specific opportunities to promote active lifestyles and connections within communities. These include:

- An integrated falls prevention programme
- Inclusive activity sessions in leisure centres
- Enabling and supporting Health and Social Care professionals to embed physical activity into their practice and everyday work

The reach of these opportunities continues to grow. In the last two years:

- The Community Partnerships sessions have had over 900 unique users in total, and an average of over 800 attendances per month.
- The follow-on sessions within the integrated falls prevention programme have had an average of 150 attendances per month.
- The majority of people who accessed these services had a disability or long-term health condition.

Although physical activity is central to many opportunities, it is often a tool to enable independence and wider outcomes. The success of developing and implementing system-led opportunities was underpinned by initial work to understand existing provision and identify evidence-based and place-based solutions that met the needs of individuals, groups, and communities. PEM has provided choice and empowered individuals and groups.

The evolving restrictions of the COVID-19 pandemic was a key challenge that impacted the design, implementation, and reach of PEM, and necessitated a flexible and agile approach. Further, a number of individuals who attended PEM sessions have become long-term attendees. Although these sessions provide opportunities for the individuals, it is important to consider the intended function of PEM or similar programmes, specifically whether they should be a perpetual service that people become regular and long-term users of and/or an opportunity to develop skills, confidence and the ability to access a wider range of services in the community.

Embedding physical activity

Beyond the provision of opportunities, PEM has made excellent progress to embed physical activity and a preventative focus across the Essex system. There is an exciting and ongoing shift in culture and practice in Health and Social Care, particularly in Care Homes and Occupational Therapy. However, there has also been a ripple effect to other Healthcare Professionals who have interacted with PEM. The work of a number of Care Homes was recognised in the NHS East of England Winter Deconditioning Games.

The successful embedding of physical activity across the system has been underpinned by a number of factors including:

- Understanding the system and leverage points
- Facilitative leadership
- Alignment with national policies
- Individuals and organisations across the system developing a shared vision and working in a collaborative and integrated manner

Despite the success, interviewees recognised that work is still needed to further improve how different services and Healthcare Professionals can work more effectively together. Further, it is important for all individuals and organisations who interact with people who access PEM services to receive education and support to understand the varied needs of individuals with disabilities and long-term health conditions and to help facilitate a holistic and positive experience for them.

Workforce development and practice-based learning

A key focus and success of PEM was to develop knowledge, skills, and capacity in the Health and Social Care workforce through training and education. Baseline data highlighted that:

- Care Home staff and Occupational Therapists had received limited or no training in physical activity promotion
- They typically discussed physical activity with fewer than half of their service users
- Conversations typically focused on general physical activity rather than muscle strengthening activity and breaking up sedentary behaviour
- Barriers included such as time, knowledge, skills, resources, and support

Recipients highly valued the training, not just for the knowledge and skills that it developed, but also the opportunity to build networks to share best practice. Alongside workshops, a key driver of success was the provision of ongoing mentorship. Through this work, PEM has enabled, developed, and supported many of the workforce to embed physical activity into their daily practice and has enhanced their job satisfaction. A number of Occupational Therapists also reported that PEM has taken them back to their professional roots and stimulated conversations across the sector.

Some interviewees, however, suggested that co-design could be strengthened in the development of future education to ensure that contextual factors are fully recognised. Further, even after training, some members of the workforce appeared to see physical activity as something that *could* be discussed with *some* individuals rather than a topic that *should* be discussed with *most*.

The impact and cost effectiveness of PEM

Beyond the points above regarding the provision of opportunities, embedding physical activity and workforce development, qualitative insights revealed that people who accessed PEM services perceived themselves to have experienced a number of benefits including enhanced:

- Health
- Wellbeing
- Confidence
- Skills
- Routine and structure
- Independence

Similarly, self-report quantitative data suggested that PEM has a demonstrable and significant impact on physical activity and wellbeing. Individuals who had participated in PEM for longer, had higher physical activity levels, and more favourable attitudes to physical activity, wellbeing, subjective health, and self-efficacy.

Data were compared to the Active Lives Survey, a nationally representative survey. This comparison suggested that PEM may have the effect of lifting a person living with a disability or long-term health condition to similar physical activity levels and wellbeing as typically reported by non-disabled people. These effects were mostly still apparent even after controlling for demographic variables. This suggests that PEM could play a crucial role in reducing health inequalities between individuals with and without long-term health conditions. However, the limitations of the PEM research design means causal relationships cannot be inferred.

Self-reported service use (i.e., day care, formal/informal support, GP visits, ambulance calls, and hospital visits) also showed a slight decrease in people who accessed PEM services.

- A *tentative* estimate is that this reduction in service use equates to a cost saving of £365.23 per PEM participant per year split across Adult Social Care (£163.34) and the wider system (£201.90).

Further, a novel aspect of the evaluation was the work of State of Life to follow the 2021 Wellbeing Supplementary Guidance in the Treasury's Green Book and apply the treasury recommended WELLBY to monetise the wellbeing value of PEM. Taking the difference reported by individuals about to start PEM to those with over one month of involvement in PEM, this difference in life satisfaction is estimated to equate to a monetary value of £22,230 per person per year.

Scaling the value of reduced service use and higher life satisfaction to the typical number of unique users in Community Partnerships/Reconnect (where most data were collected) suggests that the total annual social value could exceed £20 million. When this benefit is considered against *direct* running costs, PEM could deliver up to an estimated £58.71 of social value per each £1 invested. This is mainly due to the extremely high association between participation in the programme and improved personal wellbeing. That is, within

the £58.71, the value of reduced service use equated to 95p compared to the value of increased wellbeing of £57.76.

Higher levels of wellbeing may deliver social value through potentially enabling individuals to engage in employment, volunteering, and other activities, and thus potentially bringing direct and indirect benefits to Adult Social Care, Health and wider society. Although some of these benefits may be directly quantifiable savings to specific parts of a system, other benefits may be more qualitative, and harder to quantify and attribute to system settings. To provide more robust and certain estimates of both the social value and specific savings within the system, future evaluation should seek to include estimates of indirect costs, increase the sample sizes across all PEM workstreams, track individuals over time, and use additional objective data on service use and cost benefits.

Key Recommendations

System-led opportunities

It is important to develop further understanding of the needs and resources within systems. Opportunities that adopt a whole systems, place-based and preventative approaches should then be co-produced and co-funded (e.g., Health and Social Care). Opportunities and programmes should be evidence-based, integrating community insight, scientific evidence, and the tacit knowledge of Health and Social Care Professionals.

Embed physical activity

It is important to more strongly embed physical activity into Adult Social Care, Health and wider systems, and ensure targeted pathways are sustainable. Additional political supporters and organisations within the system should be identified, and partnerships developed around a shared vision and common language.

Workforce

Education should be extended to reach more Care Home staff, Occupational Therapists, and other Healthcare Professionals. Workshops should be co-designed with some Care Home staff, Occupational Therapists, and other professionals to ensure that the content is tailored to different contexts and perspectives. Further ongoing support including mentoring and infrastructure would help to ensure the workforce is able to continue to deliver physical activity in many contexts. Longer-term changes to working practices should be monitored and evaluated.

Impact

PEM or similar preventative programmes should be developed to apply the learning from the current Test and Learn programme, but maintaining a focus on people living with disabilities and/or long-term health conditions. Monitoring and evaluation should track individuals over time and integrate additional objective measures of service use to understand the longer-term impact and benefits across the system.

Introduction

What is PEM?

The Prevention and Enablement Model (PEM) is a test and learn initiative in Essex that launched in August 2020, with Adult Social Care at Essex County Council, Active Essex, and Sport for Confidence CIC as key strategic and delivery partners. PEM adopts a whole systems change approach in Adult Social Care to improve the lives of people living with disabilities and/or long-term health conditions, and encourage and support people to be more active, happier, and live more independently. To achieve this, an innovative and progressive programme was developed and implemented that drew together a system of unique partnerships across the county spanning the Adult Social Care, the NHS, and the third sector (e.g., local councils, Essex County Council teams, Provider Quality and Innovation Teams, and care homes) with physical activity at the core of day to day interventions.

PEM focuses on four key objectives across four workstreams covering Tendring, Colchester and Basildon – the three Essex Local Delivery Pilot (LDP) localities. The Essex LDP is one of 12 sites funded by Sport England to test innovative whole systems approaches to tackle physical inactivity and improve wider social and economic outcomes. Since its inception in 2017, the Essex LDP has developed and implemented a broad range of innovative programs, structures and actions, and provided initial funding and support for PEM.

PEM vision

The PEM vision is to ensure that all Essex citizens can be active, be a member of their community, be happy, and live independently.

Objectives of PEM

1. **SYSTEM** - To develop system-led opportunities for disabled people and those with long-term health conditions and to encourage them to be active in their local community, reconnecting them to their local area.
2. **EMBED** - To embed physical activity in the system, and to redesign a targeted pathway to achieve this.
3. **WORKFORCE** - To create practice-based learning opportunities that transform ways of working by increasing the confidence and capability across the integrated workforce in using physical activity as a tool for health.
4. **IMPACT** - To test and learn the impact of this transformation.

PEM workstreams

1. **Care Homes -** An education programme and monthly mentoring from an Occupational Therapist and Provider Quality Innovation Team for Care Home staff to enable and support the integration of physical activity into practice.
2. **Community Partnerships (Reconnect) -** A programme of community-based inclusive sport sessions delivered by Sport for Confidence in local leisure centres.
3. **Physical Activity in Occupational Therapy -** A practice development programme for Occupational Therapists to enable and support the integration of physical activity into practice.

4. **Strength and Balance -** An integrated community-based strength and balance pathway that followed existing Otago sessions to provide 'step-on' provision to sessions delivered by Sport for Confidence in local leisure centres.

Note, only the Community Partnerships and Strength and Balance workstreams were still delivering at the time of this report.

Context: Why is PEM needed now?

Addressing physical inactivity is a global public health priority. Inactivity is associated with a range of health problems such as increased risk of heart disease, obesity, Type 1 diabetes and some cancers, and Heron et al (2019) estimated the cost to the NHS of sedentary behaviour was £0.8 billion in 2016/17. The UK Chief Medical Officers' Physical Activity Guidelines recommend that adults should aim to be physically active every day, do muscle strengthening activities on at least two days a week, accumulate at least 150 minutes of moderate intensity activity (or 75 minutes of vigorous activity, or shorter bouts of very vigorous activity or a combination of these), and to minimise sedentary time. However, similar to other developed nations (Guthold et al., 2018), only 61.4% of adults in England do 150 minutes or more moderate intensity physical activity per week and only 42.8% do two or more sessions of muscle strengthening activity per week (Active Lives data, 2020/21). Figures in Essex are 59.3% (see Table 1) and 43.3% respectively.

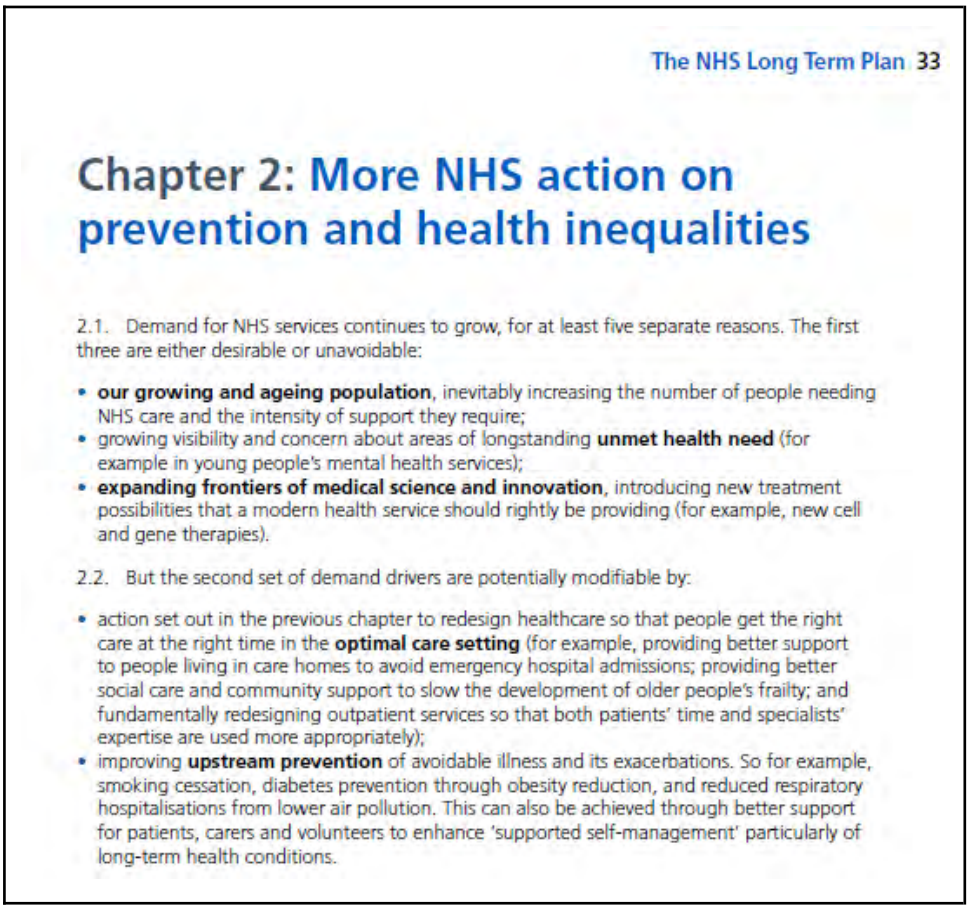
Table 1. *Estimated percentages of individuals across England, Essex and Local Authorities in Essex who exceeded 150 minutes of physical activity a week (data from: https://activelives.sportengland.org/Home/AdultData)*

Location	Nov 15-16	May 16-17	Nov 16-17	May 17-18	Nov 17-18	May 18-19	Nov 18-19	May 19-20	Nov 19-20	May 20-21	Nov 20/21
England	62.1	62.0	61.8	62.3	62.6	63.2	63.3	62.8	61.4	60.9	61.4
Essex	61.0	61.5	61.1	61.6	63.0	62.7	61.6	61.6	61.7	59.8	59.3
Basildon	61.7	60.1	57.1	57.6	57.2	60.3	60.3	56.4	54.1	55.1	57.4
Braintree	50.1	58.1	63.1	66.2	62.4	61.0	62.0	58.0	58.2	58.0	56.9
Brentwood	65.2	68.8	67.6	62.3	63.6	68.6	70.7	68.6	66.7	66.4	64.7
Castle Point	64.3	56.2	54.2	58.0	64.7	64.4	58.9	57.7	61.1	58.9	57.6
Chelmsford	61.5	63.0	64.6	59.0	58.1	66.6	65.6	63.8	66.2	65.5	62.8
Colchester	68.4	64.6	62.2	64.0	63.9	63.9	66.7	71.7	70.0	59.5	57.6
Epping Forest	66.0	64.1	63.5	64.6	64.1%	64.1	62.3	61.8	61.7	61.2	62.8
Harlow	57.4	61.6	59.7	55.7	58.2	59.1	57.8	57.6	56.8	54.8	54.5
Maldon	60.3	61.3	62.5	65.3	64.4	67.1	63.6	66.7	67.8	62.6	61.2
Rochford	59.7	63.2	65.8	65.3	66.2	65.5	62.8	58.4	58.0	60.8	60.6
Southend-on-Sea	63.4	58.6	59.3	64.5	58.3	56.1	59.8	60.9	59.4	57.6	57.5
Tendring	54.1	54.8	52.1	55.8	56.8	53.9	54.4	55.9	57.8	53.7	53.8
Thurrock	51.7	52.9	54.9	57.9	57.0	56.3	54.0	51.1	51.5	52.7	50.2
Uttlesford	63.5	65.5	65.4	66.7	67.2	68.8	69.5	62.7	63.0	66.0	67.2

Beyond those overall statistics, certain groups have a higher prevalence of physical inactivity and sedentary behaviour, including individuals with disabilities and/or long-term health conditions. For example, in Essex, only 44.7% of individuals with a disability or long-term health conditions do 150 minutes or more of moderate intensity physical activity per week (Active Lives data, 2020/21). Further, COVID-19 has compounded and perpetuated these inequalities in participation levels. This mirrors evidence beyond physical activity, with deteriorations in health and widening health inequalities across England (Marmot et al., 2020). Now, more than ever, there is a need to innovate to support disabled people and people with long-term health conditions to move more and to tackle health inequalities.

Preventative approaches

There have been numerous calls in Health and Adult Social Care to have a greater focus on prevention and integrated approaches rather than conventional intervention-focused practice. For example, the NHS Long-Term Plan emphasises the importance of reducing growth in demand for care via improved integration and prevention. A recent LSE-Lancet Commission on the future of the NHS made a number of recommendations including to strengthen the prevention of disease and disability and preparedness to protect against threats to health, to develop a sustainable, skilled and inclusive health and care workforce, and to improve integration between health, social care, and public health across different providers (Anderson et al., 2021).



The NHS Long Term Plan 33

Chapter 2: More NHS action on prevention and health inequalities

2.1. Demand for NHS services continues to grow, for at least five separate reasons. The first three are either desirable or unavoidable:

- **our growing and ageing population**, inevitably increasing the number of people needing NHS care and the intensity of support they require;
- growing visibility and concern about areas of longstanding **unmet health need** (for example in young people's mental health services);
- **expanding frontiers of medical science and innovation**, introducing new treatment possibilities that a modern health service should rightly be providing (for example, new cell and gene therapies).

2.2. But the second set of demand drivers are potentially modifiable by:

- action set out in the previous chapter to redesign healthcare so that people get the right care at the right time in the **optimal care setting** (for example, providing better support to people living in care homes to avoid emergency hospital admissions; providing better social care and community support to slow the development of older people's frailty; and fundamentally redesigning outpatient services so that both patients' time and specialists' expertise are used more appropriately);
- improving **upstream prevention** of avoidable illness and its exacerbations. So for example, smoking cessation, diabetes prevention through obesity reduction, and reduced respiratory hospitalisations from lower air pollution. This can also be achieved through better support for patients, carers and volunteers to enhance 'supported self-management' particularly of long-term health conditions.

Figure 1. *Excerpt from the NHS Long-Term Plan (NHS, 2019).*

> "Renew the focus on and provide funding for prevention and health promotion within the NHS and relevant sectors and evaluate the return on these investments. As part of this renewed focus, each constituent country should develop and implement a strategy across government departments to promote health, wellbeing, and equity in all public policies." (Anderson et al., 2021).

Further, the Care Act 2014 requires local authorities to ensure that they integrate wellbeing into Health and Social Care provision with an aim to prevent or delay health related issues and hospitalisation. The concept of wellbeing is broad in its definition and encompasses all things that may assist an individual with an illness or impairment to live balanced lives, both safely and independently (SCIE, 2020).

> "Prevention is about helping people stay healthy, happy and independent for as long as possible. This means reducing the chances of problems from arising in the first place and, when they do, supporting people to manage them as effectively as possible. Prevention is as important at seventy years old as it is at age seven." (Department of Health & Social Care, 2018, p. 4).

As noted in a report by the Department of Health & Social Care, the economic value of preventative health is significant. Masters et al (2017) conducted a review of international studies and found that the median Return on Investment of public health interventions was £14 for every £1 spent. More recent work by State of Life, using the new, treasury recommended WELLBY measure, found that 'parkrun' could be up to 25 times more cost effective than the NHS at producing health benefits. The new treasury Green Book emphasises the importance of welfare economics, wellbeing and a WELLBY measure that is benchmarked to the NHS measure of economic cost and value the QALY has enabled an startling analysis to show how valuable prevention is compared to cure. This could help herald the long sought after revolution in healthcare that shifts more investment to preventative healthcare than a costly and overburdened treatment model.

By tackling physical inactivity, PEM is therefore a pioneering programme that seeks to address the wellbeing of this population using physical activity as a tool within a whole systems and preventative approach - it is timely, cost efficient, relevant, and essential. And now, for the first time, we can estimate how this compares to the NHS cost of healthcare.

> *"There is a massive focus within Health and Social Care on how we shift from long-term care and support prevention and early intervention and obviously social care has a legal responsibility to promote wellbeing, as part of the Care Act."* PEM Strategic team member

Whole systems approaches

There is increasing interest in the role of whole system approaches to tackle public health issues, including increasing physical activity levels and reducing health inequalities. For

example, the World Health Organisation European Region's Physical Activity Strategy emphasised the importance of integrated, multi-sectorial and partnership based approaches, alongside other guiding principles such as empowering people and communities, adaptability of physical activity programmes and the use of evidence-based strategies. Similarly, the World Federation of Occupational Therapists endorsed the WHO strategy and highlighted the role and commitment of Occupational Therapists in working with governments at all levels, non-governmental organisations and service users to address and implement the strategy.

Despite the above, evidence of how to operationalise and implement whole system approaches in Health and Social Care issues is limited. Therefore, it can be difficult to decide how to direct, plan and evaluate such efforts (Bagnall et al., 2019). The LDP and PEM have exciting potential to generate insight and learning that can contribute to the emerging evidence-base to tackle physical inactivity, health inequalities, and wider health issues. The LDP evaluation team drew on existing literature (e.g., Bagnall et al., 2019; World Health Organisation, 2018; NICE, 2010) to develop the ten features of successful whole systems approaches to tackling physical inactivity. These are shown in Figure 2 and they informed the evaluation of PEM through providing a frame of reference to understand the progress of PEM and key factors that have contributed to its successes and challenges.

A whole system approach is a method by which whole system change can be achieved. It is defined as: *"…an ongoing, dynamic and flexible way of working. It enables local stakeholders, including communities, to come together, share an understanding of the reality of the challenge, consider how the local system is operating and where there are the greatest opportunities for change. Stakeholders agree actions and decide as a network how to work together in an integrated way to bring about sustainable, long-term systems change"* (Public Health England, 2019, p. 17).

Figure 2. *Ten features of a successful whole systems approach to tackling physical inactivity* (Essex LDP Evaluation Report, 2022; Bagnall et al., 2019; NICE, 2010; World Health Organisation, 2018). See Appendix for definitions.

PEM logic models

At the start of the PEM programme, the PEM leadership team for each workstream started to develop logic models. These highlighted the intended activities, participation, and outcomes. These were refined through the programme and shaped the implementation and evaluation of PEM. The appendix provides an example of the logic model from the Strength and Balance workstream and the key outcomes in the logic model of each workstream.

> *"When the project plans were designed, every work stream then had a working group attached to it, which then met regularly and developed a logic model and reviewed it with regular meetings with an allocated lead. Those meetings have meant that you're constantly having to come back and report on what you're doing and why you're doing."*
> PEM Strategic team member

Aim of this report

The aim of this report is to summarise evaluation findings in relation to PEM from August 2020 to August 2022. The report is structured around the four key objectives of PEM. It highlights key findings relating to both successes and challenges within the four objectives, and then provides evidence-based recommendations that have been formulated from the evaluation findings. This report is not a detailed examination of each PEM workstream in isolation, but rather considers PEM as one overarching programme. However, activities, examples, and learning from unique workstreams are provided where they help to understand the design, implementation, and impact of PEM.

Evaluation approach

The evaluation used a mixed methods approach to collect data from across the system and to examine the design, implementation, and impact of PEM. We drew on the Medical Research Council's guidance on the process evaluation of complex interventions (Moore et al., 2015). In doing so, we were not only interested in the outcomes of PEM, but also learning relating to the design, implementation, reach, and the influence of context (Moore et al., 2015). The data collection was informed by the logic models developed by the PEM team and methods used in the wider evaluation of the Essex LDP. The methods are described below and Table 2 summarises the methods, purpose, participants, and the workstream and objective they addressed.

For all aspects of the evaluation, we obtained the relevant research governance permissions and approvals. For example, ethical approval for the evaluation was granted by an Ethics Review committee at the University of Essex, and the Strength and Balance evaluation was registered with North East London NHS Foundation Trust and East Suffolk and North Essex NHS Foundation Trust as this workstream had referrals via NHS pathways.

Interviews

We conducted 29 semi-structured interviews (Mean duration = 34.8 minutes) with key stakeholders including people who accessed PEM services and their carers, Essex County Council and Active Essex staff, commissioners, and leaders and deliverers of PEM workstreams to explore the design, implementation, and impact of PEM and to understand the successes and challenges. Interviews focused primarily on PEM, but some explored wider aspects of the LDP. Interviews were conducted online or in person and were recorded and transcribed for subsequent analysis. Due to interviewee circumstances, one interview was not audio-recorded but the interviewer took comprehensive notes, which were included in the analysis alongside the transcripts.

Focus groups

We conducted 11 focus groups (Mean duration = 43.5 minutes) with a range of individuals including leaders and key staff within PEM workstreams, carers, and people who accessed PEM services. Focus groups were useful for bringing together groups of people to discuss a shared experience or issue. Focus groups typically involved 3-6 participants. The facilitator had a list of questions and prompts to facilitate discussion between participants, and to gain a sense of where experiences or views were similar or differed. Focus groups were conducted online or in person and were recorded and transcribed for analysis.

Reflective logs

Reflection is a way that individuals and systems learn from an experience to enhance understanding and development (Andrews, 2000). Drawing on work undertaken in the Essex LDP, we adopted the Driscoll model of reflection (Driscoll, 2006) as a framework to elicit reflections and learning within PEM. The model is orientated around three questions: What? So What? Now What? A total of 24 reflective logs were completed by leaders and

workforce in PEM based on those three questions to capture learning after a significant event or issue.

Questionnaires

We designed and used questionnaires within the PEM to collect information from a) the workforce who participated in training workshops/events and b) people who accessed PEM services. Questions were primarily a closed response format (i.e., a list of options on a scale), but the workforce questionnaire included some open response format (e.g., to provide brief reflections on the training and impact). Many of the questions had been used in Essex LDP and were taken from established and validated questionnaires to allow comparisons to national-level datasets. Participants typically completed the questionnaires online, although paper copies were available.

Workforce questionnaires

A total of 78 baseline workforce questionnaires were completed (27 in the Care Home workstream, 44 in Physical Activity in Occupational Therapy, and 7 the workstream was not reported) from the workforce training events. Participants were predominantly female (83.1%) and white (80.5%), with a range of ages (e.g., 25-34: 22.6%; 35-44: 22.6%; 45-54: 26.2%). The workforce were asked questions around their role, perceptions of advising service users on physical activity, previous training around physical activity, and perceptions of PEM. All participants from the baseline sample were invited to complete a follow-up survey 6 months later, but only 6 responses were received. As such, no quantitative analysis was viable on the follow-up data, but qualitative reflections were analysed.

Questionnaires from people who accessed PEM services

A total of 190 service user questionnaires were completed (82 by service users and 96 from carers by proxy, the remainder being partially or fully blank). Questions focused on their health, wellbeing and length of participation in the PEM programmes. These surveys, designed in collaboration with the PEM workstreams, had at the core the key questions and approach recommended in the HM Treasury 2021 Supplementary guidance on measurement and evaluation of wellbeing. As such, we were able to analyse and apply the new, innovative and progressive measures of economic value for wellbeing that serve also as an important tool to understand the economic value of preventative health measures like physical activity, mental health, and community interventions.

Alongside wellbeing questions there were also a new set of questions designed to track self-reported changes in use of NHS services like GP visits and ambulance call outs. This was, and is very experimental, and the methodology was developed to deal with any absence of objective data on actual service use. The findings should be treated as indicative given the novel approach used.

Objective service use

Within the Care Home workstream, we were provided data from the East of England Ambulance Service on the frequency, nature, and cost of 999 and 111 calls made from each

care home involved in PEM along with ambulance visits. Data spanned 2019 (i.e., pre-PEM) to July 2022, which allowed examination of potential changes in the number of and reasons for 999 and 111 calls and ambulance visits before and during PEM.

Documentary analysis

Documentary analysis involved reviewing documents in relation to PEM to understand the need for PEM, and how it aligned with, and informed, local and national policy and practice in Adult Social Care and Health.

Table 2. *Data collections methods, purpose, participants, and the workstream and objective they addressed.*

Data Source	Purpose	Participants	Workstream				Objectives			
			CH	PAOT	CP	S&B	System	Embed	Workforce	Impact
Interviews	To explore the design, implementation, and impact of PEM	Leaders, deliverers and key stakeholders	✔	✔	✔	✔	✔	✔	✔	✔
Interviews	To explore experiences within and impact of PEM	Service users and carers			✔	✔	✔	✔		✔
Reflective logs	To capture key learning from PEM	Leaders and workforce	✔	✔	✔	✔	✔	✔	✔	✔
Focus groups	To explore the design, implementation, and impact of PEM	Leaders and key stakeholders				✔	✔	✔	✔	✔
Focus groups	To explore the implementation and impact of PEM	Workforce	✔				✔	✔	✔	✔
Focus groups	To explore experiences within and impact of PEM	Service users and carers			✔	✔	✔	✔		✔
Questionnaires	To explore the need for and impact of training in PEM	Workforce	✔	✔					✔	✔
Questionnaires	To explore the impact of PEM on individual outcomes and perceived service use	Service users			✔	✔				✔
Objective service use data	To explore the impact of PEM	Service users	✔							✔

Notes - CH: Care Homes; PAOT: Physical activity in Occupational Therapy; CP: Community Partnerships/Reconnect; S&B: Strength and Balance

System-led opportunities to promote active lifestyles and connection with communities

Key Findings

- PEM developed a range of **system-led**, **co-designed**, and **context-specific opportunities** to promote active lifestyles and connections within communities.
  - e.g., **integrated falls prevention programme**, **inclusive activity sessions** in leisure centres, and supporting Health and Social Care professionals to embed **physical activity into practice**.
- **Over 900 unique users** have attended the integrated falls prevention programme and community-based sessions, with an average of **over 1000 attendances per month**.
- Success was underpinned by understanding existing provision, **building on strengths and assets**, developing **evidence-based and place-based solutions**, and ensuring opportunities were **inclusive, flexible** and **supportive**.

Understanding existing provision and opportunities for PEM

The first objective of PEM was to develop system-led opportunities for people living with disabilities and long-term health conditions. Initial work included workshops and mapping current provision within the LDP areas and more widely across Essex to build on strengths and address gaps. Stakeholders were engaged early in the process and have evolved and grown in numbers over time. These contributed a myriad of knowledge, resources, and expertise of working within Health and Social Care and with different groups contributing to the co-design of place-based, context-specific solutions. A number of opportunities and projects were subsequently identified within the four workstreams.

"We had quite a lot of engagement first of all. And it was very much based on, with varying partners across the system to try to understand and kind of start to gauge how people kind of associated physical activity and how it was being used… We did a series of workshops, and I think that some of the outputs of that is really important in us developing PEM as a model." PEM Strategic team member

Evidence-based practice

Alongside the insight obtained by stakeholders across the system including service users, the PEM Design and Delivery team emphasised the importance of basing decisions on contemporary scientific evidence. For example, the whole systems approach aligns with the call for systems-thinking and integrated approaches to promote physical activity and tackle health inequalities (e.g., World Health Organisation, 2018). The Strength and Balance workstream offers a transition pathway from an existing commissioned Otago Exercise Programme (delivered by NELFT and ESNEFT). Falls prevention programmes and strength and balance training have been shown to reduce fall and reduce hospital admissions in a cost-effective manner (Public Health England, 2018).

"When you first start out with an idea, you have to base it on evidence and you have to base it on the need." PEM Delivery team member

In the Strength and Balance pathway, following a 12-week Otago programme that was separately commissioned by the NHS via iBCF funding, individuals could progress on to Stronger My Way sessions. In these integrated services, attention was paid to the importance of step-on provision and support to facilitate successful transitions. For example, Healthcare Professionals from the step-on provision attended some of the Otago sessions to build relationships with, and provide support to, individuals. The duration, design and content of specific sessions also reflect current evidence and guidelines.

"*So with the Strength and Balance pathway that we have created, with that is that they do their 12 weeks with [NAME], the physio assistant. They do a PSI pathway so they do they exercises for 12 weeks and we then do a six week transition period where they come to us and we do six weeks of activities that they can do in the leisure centre so that it gives them a taste of what they can do…and then after the six weeks transition sessions we then support them to come to our sessions so there is that longevity and pathway. So they don't just go to a physio and do 12 weeks and that is it. We want them to continue so that the work that the physios have done is* sustained *and maintained in the community."* PEM Delivery team member

Current scale and reach of PEM

Following initial work to understand the existing system and opportunities, a multi-faceted programme was developed within PEM and the specific workstreams. This included the provision of sessions for members of local communities (e.g., see example Community Partnerships/Reconnect sessions in Figure 3), integrated services (e.g., in Strength and Balance workstream), and workforce development (e.g., training sessions in Care Homes and Physical Activity in Occupational Therapy workstreams).

Figure 3. *Examples of some of the activities offered within the Community Partnerships/Reconnect and Strength and Balance workstreams. (Note, some sessions shown are also wider services offered by Sport for Confidence and funded outside of PEM).*

The engagement statistics by service users and the workforce (education and training) with the different workstreams was provided by the PEM team and is summarised in Table 3. Elements were impacted by COVID-19 restrictions and in places limited by capacity, but the current engagement and scale is promising.

Meeting the needs of individuals, groups and communities

Central to the successful provision and uptake of opportunities was meeting the needs of individuals and tailoring opportunities accordingly. Communicating and listening with a range of stakeholders, including service users was central to this endeavour, and provided vital insight to understand barriers to participation and identify solutions. For example, consulting with people over what sessions to run, accessible advertising materials, and issues such as lighting and noise within the building. The understanding and knowledge shown by the PEM team of different health conditions was widely recognised by interview participants, along with how this influenced the choice, design and implementation of group sessions.

"It takes communication, it takes dedication, and working together...They [PEM staff] listen and then implement that...it doesn't always work...but together we seem to be able to establish how to do it right." Carer
"They [PEM] have enabled us [partner organisation] to take that next step we have been looking for because before them there was nothing out there for people with [chronic health condition] and unfortunately there is not a lot of understanding." Healthcare Professional

Table 3. *The current number of sessions and engagement with these across the PEM workstreams (data correct as of 18th August 2022).*

Workstream	No. of Sessions & Per Session Average (users)	Per Month Average (users)	Total Unique Attendance to date (users)
Care Homes (Basildon)	8 Workshops delivered with a minimum of 2 PEM Ambassadors per care home. Regular visits from Sport for Confidence OTs and Provider Quality Innovation Team to offer ongoing support and mentorship to PEM care homes.		
Care Homes (Colchester)			
Care Homes (Tendring)			
Community Partnerships/ Reconnect (Colchester)	8 sessions per week 11 users on average	297	332
Community Partnerships/ Reconnect (Tendring / Clacton)	7 sessions per week 6 users on average	160	163
Community Partnerships/ Reconnect (Basildon)	7 sessions per week 13 users on average	356	407
Basildon Inclusive Cycling (part of South Community Partnerships/ Reconnect)	1 session per week. 36 users per month. 9 users unique attendance		
North Inclusive Cycling (part of North Community Partnerships/ Reconnect)	1 session per week. 28 users per month. 7 users unique attendance		
Strength and Balance	2 sessions across Colchester, Clacton and Tendring per week. Average 12 users per session. Average 144 attendances per month. 3 talks per month to Strength and Balance users provided by SFC Occupational Therapist. 1 session in Basildon each week. South: 1 session a week for 23 weeks. Total attendances 126, unique users 30, average attendance per session 5. With 8 talks to NELFT users (2 per cohort)		
Physical Activity In Occupational Therapy	The programme ended in July 2021, but Sport for Confidence have continued to see a significant increase in the number of Occupational Therapists liaising with their team and accessing sessions with their service users. Sport for Confidence are regularly working with OT students and see an average of 12 students per month.		

The delivery of Community Partnerships/Reconnect sessions by a Sports Coach and Occupational Therapist also provides capacity and scope for people who access PEM services to receive individual, bespoke support within and beyond the main session (see example case study below). This includes helping individuals, such as those recovering from a stroke or experiencing health issues, to implement the advice received from their GP

and other Healthcare Professionals. This is consistent with intended outcomes of PEM such as providing tailored interventions in group settings.

Case study: One-to-one support

The PEM team works with a male asylum seeker in his twenties. He has some physical deformities including a limb, and some sensory difficulties.

Occupational deprivation is a term used by Occupational Therapists to describe when people are unable to do the things that they want and need to do due to external restrictions in their lives. Asylum seekers can experience occupational deprivation, along with the loss of valued activities, cultural norms, religious customs and social support systems. They often have to live in environments that are not conducive for a meaningful daily life, all of which can have a negative impact on health and wellbeing (Morville & Erlandsson, 2013). Further, although they are able to register with a local GP, they often face difficulties accessing services (BMA, 2019).

The individual was referred to PEM by Care 4 Calais as part of his rehab programme. The PEM team gathered information by talking to the individual, Care 4 Calais, and others involved in his care (e.g., social worker). An informal initial assessment was conducted when he first visited PEM, and together with him and others involved in his care the PEM team identified his needs, set goals, and created a plan of action,

The individual has several Healthcare Professionals involved in his care, but he can sometimes struggle to keep up with the different professionals involved and his appointment times, partly due to the language barrier, which can impact his ability to access healthcare services.

The action phase of the Occupational Therapy process is ongoing and he is attending weekly exercise sessions. Occupational Therapists within the PEM team are looking at this individual holistically, they are focused on both his mental and physical health, how they are related, and his ability to engage in his community, activities and services. In addition to the physical benefits of the exercise sessions (e.g., increased physical activity, building strength), there are a range of other benefits from the sessions. He is away from his friends and family and spends much of his time at home, so the sessions provide an opportunity for him to leave his flat and be involved in a community activity, and socialise with staff and other participants. He is still adjusting to a new country, so the sessions provide an opportunity for him to get used to using public transport, accessing the leisure centre, paying for his session, and navigating the facilities. The benefits extend beyond the one-hour session and impacted his activities and skills in all other areas of his life.

Beyond the exercise sessions, the PEM team have organised meetings with the other professionals involved in his care and are creating a communication card for him. This will include details of everyone involved in his care, what their duties are, their contact details, his upcoming appointments, and updates on his care. This will make it easier for him to understand his care, and it can also be shown to other professionals, which will be

particularly useful as he sometimes finds the language barrier challenging. Although there are many people involved in his care, no one has yet collated the information to help him.

Moving forward, the PEM team will continue to monitor and reassess his plan where required. The main goals for him are to support communication services, improve his access to healthcare, and improve his skills and knowledge outside of the exercise sessions.

In education sessions with Care Home staff and Occupational Therapists, the PEM team collaborated with them to understand how physical activity could be effectively integrated into their context and practice; this often was about adding small movement into daily routines (e.g., while brushing teeth, breaking up sedentary time) rather than bespoke physical activity sessions. This was in recognition that carers have limited time and capacity, and has helped engagement by both the workforce and people who access their services.

"Trying to give people ideas about how physical activity can be implemented in everyday life in a way that is not too disturbing to their routines but can also be added in as part of routine. So adding in movement rather than physical activity as such… It is pitching it in a way that is manageable for the staff to be able to implement." PEM Delivery team member

Physical activity as a means to enhance independence

Although physical activity is central to PEM, the opportunities created and services offered extend beyond traditional sport and exercise. The emphasis is on 'meaningful activity' and how it enables individuals to live happier, more autonomous lifestyles and make real choices around how they want to spend their time. This includes the development of a range of transferable skills that might be needed to reduce the need for support services or to secure voluntary or paid employment. For example, it may encompass developing the standing endurance necessary to cook meals independently or crucial social or leadership skills.

"It is about breaking down the barriers, helping people engage with physical activity to help them in life… So if for example someone needs to learn how to time food in an oven, we can make them a referee and they can time on a stopwatch and build up their skills that way… The idea is by working on these skills we can reduce the impact on social services and NHS care, so hopefully they will need less care when they go home because they will be a little more independent." PEM Delivery team member

The holistic focus reflects the practice of Occupational Therapists who aim to work in a person-centred manner to identify an individual's barriers to participation, identifying what skills are needed, and grading activities appropriately to the client's level. They then specifically craft environments to enable that individual to participate in the activity of their choosing, therefore achieving more balance in their lives through participating in meaningful

activity and developing productive roles and routines. This is an inherent part of how PEM works and its success.

> *"As an OT we have that extra layer of expertise to say well actually the relevance here for that individual with cycling is now independence following a brain injury and that they are no longer able to drive. So cycling is no longer an activity but an occupation as it is now going to hold significant importance for that individual and impact on other areas of their life."* PEM Delivery team member

Inclusivity

Community Partnerships/Reconnect and other aspects of PEM are inclusive in nature with a 'no labels' approach. This encourages a sense of belonging and inclusion for participants, and challenges assumptions and social transformation. However, adjustments are made to optimise sensory stimuli, equipment and the degree of challenge for individuals or groups. Participants noted that many other services have exclusion criteria which can limit opportunities, often for those with most need, and PEM was deliberately set up to do things differently.

> *"I've tried running an able-bodied come disability life. It didn't work, because people looked at the disability, but didn't understand that I was a person as well as the disability. Didn't ask me how I wanted to deal with certain situations. Didn't ask me what equipment I wanted to use… [At PEM] I've never heard anybody say no to anyone or turned people away. Whereas, when I've volunteered in the able-bodied world, it's been, "Oh, but," "Oh, but," "Yes, but," "No, but," "You have a disability. So why do you want to try that?"* PEM Service user

> *"They treat everyone equal, and that has never been in our world… It is like somewhere you can fit in, be a human being and have a life here you can't outside. It is like so powerful what they give and what they have opened the doors to do, it just makes me emotional."* Carer

Choice and support

PEM has empowered and supported individuals to identify their own, preferred solutions for being active. This has often involved raising awareness of opportunities for being active within and beyond sessions, and to work with individuals to remove barriers to participation. The empowerment of individuals is not restricted to facilitating the choice of sessions, but also how some sessions are typically delivered. For example, programmes have been designed to encourage individuals to explore different movements and develop a sense of ownership, and feelings of competence in their physical abilities. Consistent with motivational theories (e.g., Self-Determination Theory; Deci & Ryan, 1985), this has provided an autonomy supportive environment that has given individuals a sense of choice and

empowerment, thereby enhancing motivation towards physical activity. Indeed, the support that PEM staff offer to both individuals and carers was widely recognised.

> *I had in my mind that the [staff] would be there to guide people in a step-by-step session. But what I saw was free flowing and empowering to the participants. Participants feeling empowered to explore."* Healthcare Professional

> *"It is their [staff] attitude, the way they are with people, the way they see people. They think outside the box. They genuinely care. Nothing is too much for them… They are unique."* PEM Service user

Flexibility and adaptability

PEM has a central ethos around inclusivity, physical activity, and enabling independence and happiness, but the specific sessions were adjusted due to COVID-19, local context, resources, and ongoing dialogue and feedback with stakeholders. The PEM team, workstreams and activities have been agile and flexible to meet the evolving constraints during periods of lockdown and associated regulations, such as shifting delivery online where necessary. Similarly, sessions are adjusted based on the facilities and resources in leisure centres, so what is possible in one location might not be feasible elsewhere. Feedback from participants and other stakeholders has also been pro-actively solicited and acted upon where possible. These factors have meant the original plans and logic models have needed to be reviewed and updated, and the PEM has evolved slightly differently to how some individuals had originally envisaged.

> *"It is really measuring the value of that session and if it needs to change or not, and being responsive to the feedback you get about that session. It might be that the session is really good and valuable to people, but it is not at the right time so then we have to change the time of it… so it is being really adaptive and responsive to what the participants are saying."* PEM Delivery team member

> *"It has evolved and grown and it has actually grown perhaps differently to how I thought it would originally grow. So we've got great community partners existing already, but I think some of our community partners had quite set ideas about how they wanted to work in sport and leisure, what it would look like and obviously with lockdown and covid, certain groups and how they came about were directed by that opportunity, like the track session for example, which was a crisis group that came about through stay connected."* PEM Strategic team member

Challenges and developments

Leaders emphasised the scale and ambition of PEM was at times daunting, but also immensely exciting and rewarding. Delivery staff also noted that some of the sessions had reached capacity. This may, in part, be due to the inclusive nature of PEM that welcomes a

diverse range of individuals. It is important to explore mechanisms to prevent a waiting-list system developing that might prevent those most in need of support accessing PEM sessions in a timely manner.

> *"Having four workstreams and being involved in every single one, which was essential that we were, but just that sheer volume of work and the job at hand. I've kind of over the years seen two-year project groups tackle one of these workstreams. And in the 12-month test and learn, we've had four. So just being very honest, I feel like it was a mountain to climb, which is why I really wanna reflect on what's been achieved because I think it is quite phenomenal."* PEM Strategic team member

Following the above, a number of individuals who attended PEM sessions had become long-term attendees. Although these sessions typically provide opportunities for the individuals, it is important to consider the purpose of PEM sessions or similar programmes, specifically whether they should be a perpetual service that people become regular and long-term users of and/or an opportunity to develop skills, confidence and the ability to access a wider range of services in the community. This could facilitate further progress towards outcomes such as increasing independence, reconnecting people with their local area, and facilitating access/use of other wellbeing services.

> *"It is having that wider vision about ensuring all residents have the ability to be active, live independently and be a part of the community… So the community partnerships objectives, it's really about delivering interventions which are based in a community group setting but I guess, aims to reconnect participants to the community by rebuilding occupational balance, structure and independence etc"* PEM Strategic team member

Nationally, the COVID-19 pandemic led to a drop in physical activity levels and poorer mental wellbeing, and amplified some inequalities, but this reinforced the importance of PEM. The pandemic, however, significantly altered the planning, implementation, and delivery of PEM. As noted above, adjustments were successfully made, but potentially impacted the scale and impact of PEM. Similarly, the shift to online delivery provided a vital service to individuals experiencing social isolation, but did present a challenge around access to equipment and digital literacy.

> *"It was difficult for them [staff members] to get time during the day to incorporate that. There is so much to do in a care home… During their supervision they were coming back to us and saying 'when can we do this?'"* PEM Workforce training recipient

Despite the great progress in developing system-led opportunities, individual barriers to participation could still be problematic. For example, care home staff noted issues around competing demands on their time. Further, some care home residents could not attend external sessions (e.g., there was a desire to attend Strong My Way and/or Community Partnerships/Reconnect sessions) due to transport and cost of travel. Similarly, some

people who accessed Strength and Balance services struggled with transitioning to a larger and louder group. However, there was also evidence that working across the system could help resolve some of these issues, such as securing transport from voluntary services or health professionals working together to facilitate a smooth transition between groups and services (e.g., deliverer of a follow-on service attending some initial sessions in the initial programme). Despite the above challenges, there was a desire to take lessons from PEM and apply to similar initiatives in future.

Embedding physical activity in the system

Key Findings

- PEM has made excellent progress to **embedding physical activity and a preventative focus** across the Essex system. There is an exciting and ongoing **shift in culture and practice** in Health and Social Care, particularly in Care Homes and Occupational Therapy.
    - The work of a number of Care Homes was recognised in the NHS East of England Winter Deconditioning Games.
- Key factors that have contributed to embedding physical activity and a preventative focus include **understanding the system** and leverage points, **facilitative leadership**, alignment with national policies, and organisations having a **shared vision** and working in a **collaborative and integrated** manner.
- Despite the success, interviewees recognised integration across system settings and the flow of services for individuals could still be improved.

Understanding the system

The second objective was to embed physical activity in this system, and to redesign a targeted pathway to achieve this. Consistent with successful features of whole systems approaches, work was undertaken to understand the Adult Social Care system and how it might interact with other systems to influence individuals' physical activity, and enabled them to lead independent and happy lives. In doing so, it was important to detect system components and connections between them, understand the behaviour of the system, and identify leverage points in order to drive transformation (Tsasis et al., 2012).

"It's complex. So just at a really high level, we have Adult Social Care Essex County Council, but equally we have 12 district and borough councils that are all interconnected…it's not just Social Care, it's the wider corporate agendas from communities to public health, to housing, all interrelated. Then you have a health system…We have three integrated care systems in Essex, and then we have a multitude of different providers across the care market, the voluntary community sector, education. All of those players are interrelated to the overarching view of what we want to do in PEM."
PEM Strategic team member

Facilitative leadership

A consistent thread in most interviews was the crucial role played by strong and supportive leadership within PEM and across the County and Borough/District Councils. Leaders provided political support and advocacy to underpin the efforts and direction of PEM. A number of leaders were clearly invested in the vision of PEM from the outset, giving support and time. In doing so, they facilitated connections across the system and some served as critical friends to shape the direction of PEM.

"I think key has been incredibly strong leadership and advocacy from [person's name], and also I think, incredible energy and enthusiasm from [person's name]. I think, I really think those two carry the whole thing, which I think is hugely important… But obviously for system change, we need to turn that into bringing everybody else along as well." PEM Strategic team member

"I currently have monthly meetings with [Key council worker] to give him an update on what we are doing here and then he helps us out if there is anything going on in the local community, he'll point me to it and then we can integrate with them… So he is good at identifying what is going on in the community and then community assets and we can tap into those and he is a good link for that." PEM Delivery team member

Alignment with national policies and guidelines

Participants highlighted that PEM is a timely and innovative model that aligns with current directions in national policies in the health, care and physical activity sectors, and those recommended by the Government, NHS, and World Health Organisation. For example, PEM aligns well with campaigns such as We Are Undefeatable and the move towards Integrated Care Systems that meet health and care needs through partnership working. The focus on a preventative approach that promotes wellbeing through participation in physical and recreational activity aligns with the Care Act (2014), which also provides a legislative context. Through robust evaluation and evidence gathering, there is a real opportunity for PEM to lead the way and make a significant contribution to the evidence-base that could inform policy and practice at local, national and international level. However, PEM was recognised as having a distinct philosophy and set of values that reflected local needs and the current strengths within the Essex system.

"It starts to get us to look, open up the conversations with our adults, rather than purely just meet the immediate need that they've identified as having difficulty with. It really connects us back to the Care Act. The wellbeing agenda, prevention, preventing people from disabilities to… well, not preventing them from disabilities, but preventing them from deteriorating. Starting to look at increasing their abilities, delaying the onset of probably a downward spiral and being able to try and enable them in areas that they're able to probably improve and increase in." PEM Strategic team member

Shared understanding and vision

Interviewees highlighted that tackling physical inactivity within the context of a whole system approach involved bringing multiple system stakeholders who share a vision. This was evident in each stage of PEM, including planning, implementation and ongoing developments. Regular meetings and the development of logic models facilitated mutual understanding within and across the workstreams. This approach of bringing individuals

together to agree a vision and action plan was also evident within specific programmes and activities across PEM

> *"Each workstream did the like logic model and took it through a very logical process as to why are we doing this? What is this actually going to look like? And I think that helped people see, you know, feel like they were part of it, and just be really clear on what the roles and responsibilities were."* PEM Strategic team member

Collaboration and integration

The development and evolution of PEM has been founded on each workstream working together and with wider stakeholders to ensure an integrated and progressive approach. Key organisations have included local authorities such as Essex County Council and Borough/District Councils, teams within the Councils (e.g., Provider Quality Innovation Team), Sport for Confidence, Active Essex, NHS Trusts, leisure centres, and care homes. They have adopted a collaborative approach to explore and capitalise on the needs, resources, and opportunities within the system. This ensured that PEM complemented existing and emerging initiatives in Essex, such as Find your Active, the Essex LDP, and bite-size sessions for care providers. These bite-size sessions were developed by Provider Quality Innovation Team Occupational Therapists to address a need for more training opportunities. Indeed, the Quality and Innovation Team brought care home staff together early on in the programme to explore what support was needed within PEM, which informed the support provided to care homes. Organisations with different knowledge, skills and resources can offer a more holistic and effective approach when working collaboratively than working in silos. Stronger integration has also allowed organisations to understand other places to which they can signpost individuals.

> *"I think what's been key really is collaboration. It's having those regular meetings, the open forums to talk through ideas with other professionals. I think it has really been key to being successful."* PEM Strategic team member

> *"There is an understanding there now because the conversations are happening. We are now not inaccurately signposting people with referral forms, we are engaged in a dialogue with other parts of the system about how we can support people, and that is a big change."* PEM Delivery team member

Key ingredients that have facilitated effective partnership working include time to build relationships, clear roles, similar values, trust, and a shared vision. Partnerships have continued to evolve throughout and beyond PEM. For example, PEM delivery staff have also gone on to facilitate a Community Network Group that brings together a diverse range of stakeholders to collaborate on wider societal issues. In this sense, PEM has provided a structure and an example of what can be achieved through a systems thinking approach and stimulated an interest in adopting it more widely.

Collaboration and integration beyond PEM

Below are example Members of a Community Network Group in Colchester that was developed alongside PEM and facilitated by PEM staff.

Social workers from Adult Social Care, Fire safety officers, Local link support team/OTs, Community 360, EPUT Mental health team/OT's, Mind, Beacon House OTs, Dedham Community Farm OTs, Age Concern, One Colchester, Employability team, IAPT – Therapy for You, Colchester Borough Council, Open door Colchester, Futures in Mind, CVS Tendring, Essex Cares, Carers First, Phoenix Futures, Healthwatch Essex, Enable East, Colchester Borough Homes.

"Really helpful to hear all the work everyone is doing. Thanks for hosting [NAME - PEM Delivery team member]. This group is invaluable to keep connected to services locally and assist our work with clients." Feedback from Community Network Group member

Changing culture and practice

PEM has contributed to a change in culture and a re-orientation of practice within the system. Participants reported that there has been a greater focus and commitment to preventative approaches and embedding physical activity into practice. Workshops and training sessions have been an indication of what might be achieved through physical activity across both Occupational Therapists and Care Home staff. Following workshops, Adult Social Care Occupational Therapists have developed their own sessions to talk about how physical activity could be utilised within their work. In this sense, PEM sessions stimulated conversations and actions, rather than being the start and end point. Such findings offer evidence of progress towards intended outcomes such as changing culture and practice and embedding physical activity in interactions,

"Yeh, so I don't think there has been that real commitment before, to looking at prevention in a practical approach really. I've heard of lots of similar, potentially, activities which have gone on in care homes where they have supplied hoola-hoops and boccia kits maybe but actually what we're doing now is actually trying to change culture, which I think is the huge different piece that PEM is on in terms of this journey." PEM Strategic team member.

Many interviewees noted that PEM had gone beyond previous approaches to increase physical activity through focusing on education and support. This was perceived to contribute to a shift in culture rather than just provision of just equipment or ad hoc exercise classes. Indeed, many participants felt the follow-up support provided had been crucial to success, as it has provided opportunities to discuss issues and novel solutions.

External recognition and ongoing developments

A number of Care Home staff highlighted the importance of learning more about physical activity, and had embraced the opportunity to integrate it into practice. The work of the care homes in this regard was recognised at the NHS East of England Winter Deconditioning Games, with three care homes from PEM receiving gold medals. The chance to link PEM and wider work of the Find your Active to these games was perceived to have energised the care homes. To build on these successes, the Provider Quality Innovation team then launched the Gemstone Challenge, which is an 8 month challenge designed to encourage care homes to further embed the learning from PEM and Find your Active workshops. Over 50 care homes signed up to take part in the first two months.

"The key learning from linking the Deconditioning Games to the PEM programme and also the Find Your Active workshops was that it energised the homes to continue implementing what they had learnt and to embed it into their daily working practices. Being awarded medals, by NHS England, gave the homes a sense of accomplishment and something they could promote in their organisations and externally." Essex County Council employee

Challenges and developments

Despite the success of embedding physical activity into the system and informing policy and practice, there was recognition that there are areas that can be further developed and strengthened, including continuing efforts to offer more integrated services, holistic focus, communication, and continued education. There were reservations about the flow of services still experienced by some individuals and that there needs to still be more integration between different services that they encounter. However, PEM offers rich insight and examples of how this can be improved. For example, Occupational Therapists were engaging with fellow health professionals (e.g., GPs, physiotherapists) and provided support for individuals needing to follow rehabilitation programmes. In places this was facilitated by the location of various services (e.g., in the same building or in close proximity), but communication between different Healthcare Professionals was vital.

"We just need more integrated teams, and then I think we would have a better ability to sort of get more coherence around how we see activity and recovery and things like that." PEM Strategic team member

The move towards preventative approaches at local and national levels and a focus on active lifestyles for disabled individuals and those living with long-term conditions was welcomed, but it was perceived that further work is needed. It was emphasised that as well as supporting these individuals, campaigns and educational approaches need to include all areas of the system that might interact with them. For example, interviewees felt that education could be extended beyond Healthcare Professionals to care providers, such as families and carers.

"I feel that the potential education need of care providers is more obvious as well. You know, it's one thing having therapists or thinking this way, but the people are in the houses actually working and supporting people, our family, carers and paid carers and I don't think there's enough investment in their training." PEM Strategic team member

Great progress has been made working with leisure centre staff to ensure they feel comfortable and confident in interacting with individuals with different communicative needs. However, there was a perception that some groups and individuals are still experiencing a sense of exclusion from some services across the system. Similarly, there was some concern that programmes might be relying too heavily on medical models of disability and that social models should be more strongly considered to inform the design of programmes.

"I kind of see at the minute this massive drive with sport and physical activity to link up with health and social care, and social prescribing and GP referral schemes… That is wonderful… There is the potential to head off down the wrong route and go down a medical model… We are almost going to just have a medical system that uses sport and physical activity rather than a fully integrated system which celebrates people and says how can you use physical activity in your life as a norm." PEM Strategic team member

There was a desire to see the lessons from PEM applied to help inform current and future programmes as appropriate, but recognition that other programmes, organisations and parts of the system might be impacted by contextual factors. Allowing sufficient time and planning similar initiatives would be essential to success. For example, it will be important to identify key leaders who can provide support and then allow time to build relationships with them and other stakeholders. Indeed, in the current iterations of PEM some areas of the programme advanced more quickly in locations where there was already a strong network of partners. Further, engaging with communication and evaluation teams earlier in the planning process was also highlighted as a key issue in future developments to ensure the right messaging and evaluation tools can be in place from the outset.

"We are quite casual with our language sometimes through PEM and with physical activity and I think that has become a barrier... We need to think a lot more carefully about how we use our language in relation to PEM and to move away from activity levels, and I think that is something that is so ingrained in the system that it is going to be quite hard to do, but I think if that message comes from the top around meaningful and relevant." PEM Strategic member

"We are a lot more established in the South...so I think that has affected the way that Reconnect has run.... Our partnership with [Key council worker] is incredibly strong and he believes in what we do because he has had a long time to see what we do and is invested in what we do whereas in the North, I think those system partners may not be as strong because those relationships haven't been built yet." PEM Delivery team member

Workforce: Practice-based learning opportunities to enable use of physical activity as a tool for health

Key Findings

- Baseline data highlighted a **need for training and education**, with Care Home staff and Occupational Therapists reporting that they had received limited or no training in physical activity promotion, and they typically discussed physical activity with fewer than half of their service users.
    - Barriers were time, knowledge, skills, resources, and support.
- Training was highly valued and developed **knowledge and skills**, **stimulated conversations**, and provided an opportunity to **build networks** to share best practice.
    - Alongside training sessions, a key driver of success was the provision of **ongoing mentorship**.
- PEM has enabled and supported many of the workforce to **embed physical activity into practice** and enhanced their **job satisfaction**.
    - A number of Occupational Therapists reported PEM had taken them back to their professional roots.
- Some interviewees suggested that co-design could be strengthened in the development of future education to ensure that contextual factors are fully recognised.

Training and education

Consistent with one of the key success factors in whole systems approaches to tackle public health issues, the third objective for PEM focused on capacity building. The PEM team identified the need to create education and practice-based learning opportunities to increase the confidence and capability of the workforce to physical activity as a tool for health, particularly in Care Home staff and Occupational Therapists. Similarly, qualitative interviews and the baseline survey of participants in PEM training programmes supported the need for training, with the majority of respondents indicating that they had received no previous training/education on physical activity promotion/prescription (CH = 71.4%; PA in OT = 53.5% - see Figure 4).

"There seems to be an issue about people's confidence to address physical activity to promote exercise. You know, the typical response of an OT is do I need some training to prescribe exercise?" PEM Strategic team member

"It's about upskilling the care staff rather than relying on the OT. It's about trying to get the change in mindset for the care staff [...] that there are things that they can do." PEM Delivery team member

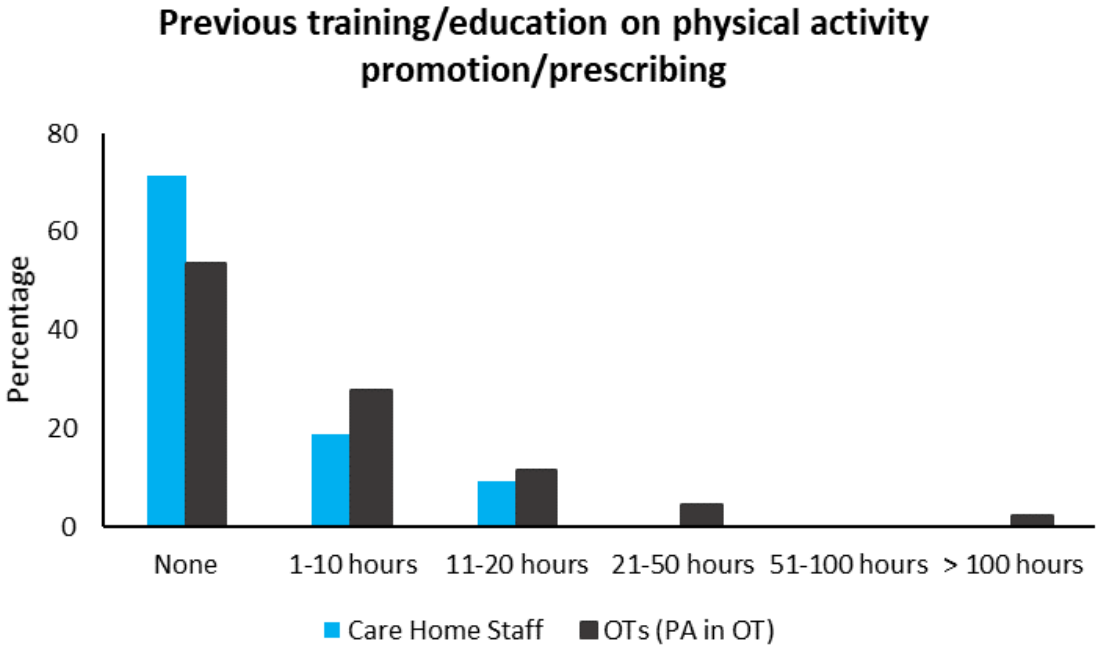


Figure 4. *The amount of previous training/education on physical activity promotion/prescribing by workshop participants at PEM baseline.*

Existing practice and the role of physical activity

The survey found that, prior to involvement with PEM, participants typically discussed physical activity with less than half of their service users (CH = 41.5%; PA in OT = 40.9%). Discussions are typically focused on general physical activity (CH = 54.2%; PA in OT = 84.1%), and not as often on muscle strengthening activity (CH = 29.2%; PA in OT = 36.4%) or breaking up sedentary behaviour (CH = 37.5%; PA in OT = 59.1%). However, the importance of muscle strengthening activity and breaking up sedentary behaviour are emphasised in the UK Chief Medical Officers' guidelines on physical activity.

The survey also found that participants were typically *motivated* to provide physical activity advice to their service users, but many lack the knowledge, skills, resources, time and support (see Figure 5). Time pressures, resources and support are consistent with barriers in the wider literature. For example, Clark et al. (2017) found that key barriers to physical activity guideline implementation in Canadian doctors and nurses not only include knowledge, but other factors such as competing priorities, lack of incentives, and limited access to pragmatic programmes and resources.

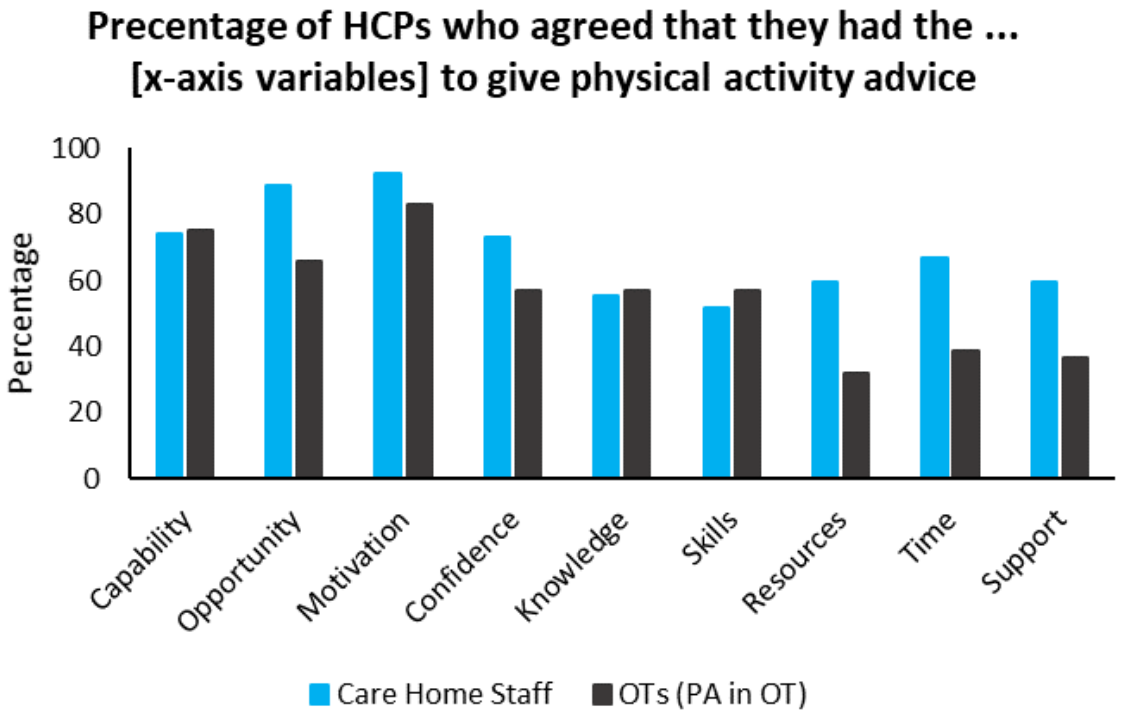


Figure 5. *The perceptions of Care Home staff and Occupational Therapists at PEM baseline in relation to providing physical activity advice.*

Example training workshop for Care Home workstream

Workshop aims

- Increase understanding of how physical activity can be used holistically
- Improve confidence with using physical interventions
- Support staff to increase resident's engagement in meaningful activity
- Reduce the risk of falls
- Increased independence in activities of daily living for residents'

Workshop content

- An overview of Sport for Confidence CIC
- An overview of why the carers role in supporting people to be active is so important
- The benefits of physical activity in the care home
- Occupational Therapy and Meaningful Activities
- How to use physical activity as an assessment tool – Practical session
- How to integrate into daily practice
- How to assess and monitor functioning level – Outcome measures
- Opportunities and ongoing support

Example aims of training workshop for Occupational Therapy and Physical Activity workstream

Workshop aims

- To explore the use of physical activity in Occupational Therapy practice
- To celebrate the unique contribution of Occupational Therapists using physical activity as both a therapeutic means and ends
- To empowering OT's to confidently embrace physical activity and physical interventions, to achieve the Care Act strategic aims

Workshop feedback

- *"This was an inspiring session that has encouraged me to re-evaluate my own delivery of practice"*
- *"This training reminded me how physical activity can be used as a therapeutic intervention. In ASC we tend to focus on equipment and care but this training encourages me to think of ways to connect people to their community and engage in sports to better their health, well-being and therapeutic outcomes."*

The value of training and education

On completion of the training programmes, participants perceived a range of benefits of the education and wanted further training. They were motivated to apply the lessons learnt from the training into their own work. Occupational Therapists in particular perceived that PEM enabled them to return to 'their roots', a way of working that is more aligned with their professional philosophy and skills, which should support the sustainability of PEM. The value of Occupational Therapy was recognised by many interviewees, and highlighted a central to the success of PEM. However, it was not only the development of knowledge around physical activity that participants valued, but also the opportunity to build relationships. Further details on the impact of training are presented under the next objective (see Impact).

"By connecting with local initiatives such as Sport for Confidence it enables me to access specialist services (exercise, strength based work, community connections) that I may not always have the time to advise on in my work load." PEM Workforce training recipient

Mentoring and support

Although the workshops and training sessions were highly valued, follow-on conversations and support has been vital to the success of PEM. In the Physical Activity in Occupational Therapy workstream, the training generated an interest in different ways of work and provided a stimulus for Occupational Therapists to meet and share ideas outside of the PEM sessions. In the Care Homes workstream, staff valued the opportunity to meet with PEM staff on a regular basis and receive ongoing mentorship and support to implement ideas into practice.

"We support the care home ambassadors, so we have created some care home ambassadors for each care home, someone who is responsible for activities and engaging their residents with physical activity and we support them long-arm. Every two weeks we check in with them, give them ideas that they can do in the care home to keep it all fresh. They keep their residents active." PEM Delivery team member

Challenges and developments

Despite the success of the training and education programmes with PEM, some of the leaders and workforce provided reflections on how these could have been improved. Some people spoke of the need to more strongly involve a wider range of individuals in co-producing the content of workshops to ensure it best reflects the context in which different individuals operate (e.g., different members of the Occupational Therapy and Care Home workforce, other Health and Social Care Professionals and end-users). For example, the elements of the approach adopted in leisure centres might not translate to Occupational Therapists who work in other community settings. Alongside developing training, it might be that follow-on support includes mentorship to help individuals adapt, embed and share learning across their places of work.

"During the training there was some enthusiastic responses, but also some fairly muted responses, and I think what was going on was the OT were trying to process. OK. I could see myself doing that if I was doing what you were doing where you were doing it. But how can I relate that to what I'm doing in my practice and what my job and my role is here?" PEM Strategic team member

"You know, originally I thought we would … get some training … but what's been complex is thinking about the role that they [OTs] are in, the context they work in, which adults they're dealing with, and what the scope is to do." PEM Workforce training recipient

Participants also reflected on the need for more time to build relationships further strengthening relationships and to ensure actions could be properly resourced and implemented. Further, even after training, some participants appeared to see physical activity as something that *could* be discussed with *some* individuals rather than a topic that *should* be discussed with *most*. As such, additional time, training, support, and resources may be needed to realise the full potential of the workforce workstream and to enable individuals to fully integrate physical activity into their practice.

The impact of PEM

Key Findings

- Qualitative insights revealed that PEM service users perceived themselves to have experienced numerous benefits including **enhanced health, wellbeing**, confidence, **skills**, routine and structure, and **independence**.
- Survey data found that individuals who had participated in PEM for longer had higher **physical activity** levels, and more favourable attitudes to physical activity, wellbeing, subjective health, and self-efficacy.
- Comparison to data from the Active Lives Survey, suggests that PEM may have the effect of lifting a person living with a disability or long-term health condition to similar physical activity levels and wellbeing as typically reported by non-disabled people.
    - This suggests that PEM could play a crucial role in **reducing health inequalities** between individuals with and without long-term health conditions, although limitations of the research design means causal relationships cannot be inferred.
- Self-reported service use showed a slight decrease in PEM participants.
    - A tentative estimate is that this reduction in service use equates to **a cost saving of £365.23 per PEM participant per year** split across Adult Social Care (£163.34) and the wider system (£201.90).
- Taking the difference reported by individuals about to start PEM to those with over one month of involvement in PEM, **the difference in life satisfaction is estimated to equate to a monetary value of £22,230 per person per year**.
    - When this benefit is considered against direct running costs, PEM (specifically Community Partnerships/Reconnect) could deliver **an estimated £58.71 of social value per each £1 invested**. This is mainly due to increased wellbeing (£57.76) rather than direct cost reductions in service use (95p).
- **To provide more robust and certain estimates**, future evaluation should seek to increase the **sample sizes** across all PEM workstreams, **track individuals** over time, and use **additional objective data** on service use and cost benefits.

Impact on the workforce - Qualitative insights

Developing knowledge, skills and partnerships

Participants in interviews and focus groups valued the workshops and training provided in PEM, particularly the opportunity to learn more about physical activity and to build relationships. They reported that PEM had strengthened their knowledge, skills and confidence to embed physical activity in their practice and daily work. It was not just the content of the workshops that contributed to this, but the opportunity to develop networks to share ideas and best practice. The training and education was also perceived to have been a stimulus to change the nature of conversations across the system.

"It makes you look at things outside the norm. It can just be little snippets as well, like if you are brushing your teeth, you can be moving while brushing your teeth. It is not just about setting up big activities which is what tends to happen in care homes. It is about doing little one to one things with people." PEM Workforce training recipient

"It's changed some of the conversations that Social Care OTs are having with people and partnership organisations." PEM Strategic team member

Enabling and inspiring how physical activity is used

Training and education has directly helped the workforce to embed physical activity into their practice. They highlighted various ways in which they now use physical activity as a tool for health, including directing individuals to external activities, introducing group activities in care homes, and more informal activities with individuals to embed activity into everyday life. This was perceived to have had demonstrable impact on their residents, such as improved sleep, social connections, and wellbeing. Participants also highlighted how there has been a ripple effect in which their own changes to practice had inspired colleagues and other professionals to take action through. For example, in Community Partnerships/Reconnect, staff from a partner organisation who brought individuals to the sessions noted that they had been inspired to adopt the principles and activities they had observed into their own contexts.

"We [staff at partner organisation] are now trying to find what is it they [service users] can do at home that they are doing here at the sports centre, at [organisation] to help try and maintain it." Healthcare Professional

"It was so exciting to have another person who was on our wavelength, bringing different ideas. That was amazing!" PEM Workforce training recipient

Example Care Home activities

Below are examples of the range of approaches and activities implemented across care homes following PEM workshops.

- Formal and informal physical activity sessions
  - e.g., chair yoga, dance classes, mini Olympics, walking clubs
- Incorporating movement into everyday activity
  - e.g., when passing objects to a resident, instead of placing them directly onto the lap, stand further away to encourage them to reach forward
- Encouraging meaningful activity to maintain functional ability
  - e.g., supporting a resident to manage the care home garden
- Care planning
  - Personalised exercises included in care plan for all staff

Job satisfaction

A number of individuals in interviews, focus groups, and surveys discussed how their involvement in PEM had positively impacted on their job. The underlying ethos and principles of PEM around physical activity and facilitating happy and independent lifestyles was highly valued. Some participants felt that it had returned them to their roots, while others perceived it had added a new dimension to their roles. Collectively this contributed to higher levels of job satisfaction.

"This initiative has brought a great dimension to my role and personally I have found this has recharged my passion for sports and integrating meaningfully in my role." PEM Workforce training recipient

Impact on service users - Qualitative insights

Building social connections and relationships with others

Community Partnerships/Reconnect and Strength and Balance both targeted improvements in social outcomes, such as reductions in isolation and loneliness, and increased participation and connection with communities and a sense of belonging. The majority of interviewed service users reported that participation in PEM had reduced their social isolation and enabled social connections to be built. PEM successfully facilitated the process of connecting vulnerable, socially isolated individuals with each other to experience friendship, togetherness and fun times, and thereby reduced loneliness and helped to integrate them with local services and others in their community.

"It just feels like little this little group that look out for each other, and I think, I think it gives us all a sense of purpose and belonging, because essentially when you get a disability, you can feel very, very isolated and that's one part of the problem with it being disabled in this country. This doesn't make you feel that way and it makes you feel all as one. So it's like a family. So that's one of the biggest things with it." PEM Service user

Interviewees also perceived that PEM sessions felt like a 'safe space', and were an extremely valuable part of their week. They enabled participants to feel equal to others and the only opportunity that they had to build relationships without feeling judged or categorised, or to have fun and have their thoughts taken away from their disability related issues.

"I've found a safe environment to socialise and make friends… Once I left school, I never thought I would have those opportunities again and I say it saved my life because I can just reach out the hand and know that I can possibly get a professional or friend to talk things through with." PEM Service user

Development of life-roles through the acquiring of new skills and the new opportunities available

Short- and medium-term outcomes in Community Partnerships/Reconnect included developing vocational/employment skills and rebuilding occupational balance. Interviewees commonly reported that PEM had facilitated the acquiring of new skills and presented them with new opportunities. Many participants had developed new life roles, such as progressing onto volunteering from being a participant or taking on part-time employment. Academic literature highlights that life-roles are necessary for a fulfilling life, as they encourage goal-directed behaviours that promote routines, purposefulness, self-esteem, responsibility, and resilience (Zafran, 2020, Sansonetti et al., 2018). PEM, in facilitating this process, enabled previously vulnerable and isolated individuals an opportunity to develop several life-roles from being passive observers to active members of a public gym, members of a social group, volunteers, and autonomous and independent individuals. Central to this outcome was the ability of Occupational Therapists to use their professional skill-set to implement graded approaches and activity analysis to help participants develop more basic life skills.

"Sport was always something I've really enjoyed, and as I got older, I wanted to start making a difference to other people. I think for me, joining as a coach, it has been an absolute Godsend for me in terms of my own mental health and overall well being. Because I mean back then I did join at a very low point in my life, and since then moments of it has dramatically improved in that regard." PEM Delivery team member (previously a service user)

Improved confidence

Community Partnerships/Reconnect targeted improvements in confidence. Many people who accessed PEM services reported an increase in self-confidence and whilst the mechanisms of change were not well defined by participants, the learning of new skills, the new opportunities available, supportive environment, and the increased endurance and strength from physical activity itself seemed to be the most prevalent causes. The participants' descriptions of pre- post functioning made it clear that they felt more confident in their intrinsic abilities and were prepared to push themselves further after participating in PEM sessions. The variety of classes on offer played a part in the building of their confidence too, as it enabled choice and autonomy over what activities were participated in, which then enabled them to participate in activities that they felt more capable and confident in.

"And I think, the thing I thought about the world of sport, things were closed off to me. So, the one to one support as well, that's been really helpful and given me the confidence." PEM Service user

"Doing something that I used to do a long time ago but haven't done since being disabled it's really kind of made me realise that there's this whole world of sport and things I can do that. I just thought it would be beyond my reach. And that my life was kind of much smaller and much more limited to kind of safe activities." PEM Service user

Structure and routine

The fixed timetable of sessions were effective at helping the participants develop a structure and routine in their lives. Many of the participants interviewed reported that PEM classes were the only groups that they attended and that they were attending them regularly. As reported by Clark (2000), routines can help to either compromise or optimise the life opportunities of disabled people. In PEM, the development of routines centred on participation in sessions, optimised opportunities around life satisfaction, physical activity, social connection, productivity, reducing self-limiting beliefs and practices (such as sedentary activity or mistrust in people and society), and instilling a sense of purpose.

"From there they referred me to a social worker and then the social worker got me here… It's just kind of just grown for me from that one session a week, to four days a week and having that opportunity to kind of explore beyond just what I'm doing here. And those different goals that you can achieve. This has been really, really, really positive for me." PEM Service user

"Coming here gave me a reason to wake up in the morning, every reason to go to bed early because my sleep pattern was, I would find myself being asleep all day and awake for half the night, which is not the way to go." PEM Service user

Positive emotions

All people who accessed PEM services used significant amounts of positive language to describe their experiences and how PEM contributes to positive emotions, feelings of joy, good times, empowerment, and satisfaction. There is a substantial literature base on how positive emotions can influence health, such as increased optimism and coping skills, and reduced depression, complaints and boredom (e.g., Tugade et al., 2005).

> *"It has made a huge difference to my life, a huge difference. I am happy. I did not know I could feel this happiness. I always thought I was going to feel sad."* PEM Service user

Given their positive experiences in PEM, one individual and their carer had been inspired to write poems, which they asked if they could share during their interview. They kindly granted permission for them to be included in this report (see one example below and the other in the Appendix).

Sports for Confidence is an awesome place to be..

The motion is active as well as attractive
The participants are like stars as well as all the staff
They make you smile and keep you going
To make you fit in, no matter what venue you go in
S – Special, F – Friendly, C – Challenge
They look at sport with lots of support
They keep looking at your future
It's like having your own personal tutor
You gotcha love the boccia, throw or roll your ball
There is a clue, just be you
To get in gear and have no fear
You'll be wanting to come back and back and back
SFC always have your back

Health and wellbeing

PEM workstreams target improvement in individuals' health and wellbeing. Physical activity is well known to strengthen muscle groups and improve mental wellbeing. It has also been evidenced to reduce the risk of cardiovascular disease, hypertension, diabetes, cancer and many more ailments (e.g., Warburton & Bredin, 2019). All people who accessed PEM services and many care homes staff spoke of improvement to mental and/or physical health and wellbeing. Benefits included increased functioning (e.g., greater standing endurance), life satisfaction, taking greater pleasure in hobbies, and better coping mechanisms when dealing with a fall, along with reduced stress, anxiety and depression and fewer issues with pressure sores in care home residents.

"They [care home residents] are all getting the confidence and you know to mobilise independently or even their eating and drinking improved. You know sometimes people can hold their cutlery or something now because of their hands and you know the muscle movements, they, they improved. I'm not saying there are miracles, but you know still there are improvements in their physical strength." Care Home staff

"I've been able to use my arms and things a lot better and if I fell I could never pick myself up, but because I've strengthened my legs here, I've learnt how to go on my hands and knees and stretch myself up. I had a fall about a month ago, and I was so pleased that I managed to get myself up, because I wouldn't have done, if I hadn't been coming to the classes." PEM Service user

"I can stand for a lot longer in the kitchen than what I did before, and I can do gardening. It's made gardening a lot more pleasurable" PEM Service user

"The resident wanted to sit in her room all day with the pressure sore, and with this project and the walking club and everything we encourage, this person is now walking confidently and the pressure sore healed." Care Home staff

Case study: Reflections from a Community Partnerships/Reconnect servicer user

Since joining Sensory Swim, Mondays are my new favourite day of the week. To be able to get out of the wheelchair and into the pool is such a feeling of freedom and physical ease and support, and the session is really great fun. There is such a wonderful vibrant energy with all the participants having an enjoyable time. The OT, OTA and coaches are really supportive and helpful. Full of encouragement. Working with you to find the best flotation devices to support what you are looking to achieve. Taking time to go over all information about equipment so you are safe.

I have noticed various improvements in my body since I began these sessions. I have recently moved into a new property with a steep-ish ramp. I had been suffering pain and discomfort in my spine from pulling the wheelchair up the ramp with my arms and bars. The swimming using a noodle and a hand held float allows me to stretch my spine and build up strength in the spinal muscles at a better angle and my back is no longer hurting. I also usually pull my wheelchair around the house with one good leg but since swimming has allowed my body to use different muscles in two legs whilst being supported I noticed that my body is returning to often using two legs to move the wheelchair around the house. I've also been able to practise walking in the water and doing various leg exercises as I'm fully supported by floats and water.

I have recently joined in with the Stronger My Way session. This is so much fun. The games really make me laugh, which is very beneficial. There are some games that are

not quite as easy for me due to the wheelchair and I can feel a bit sad, however, the team always find a way for me to be included, so, if they can find a way to say 'yes' to me being included, I find a way to raise my spirits and find my 'yes' to joining in. It's always worth finding a way to make it work. I've noticed that this session acts as a warm up for the swimming after it. I have managed to complete much more improvement in swimming since beginning this class.

Wider beneficiaries

The qualitative data provided strong evidence of the benefits to people who access PEM services. Importantly, however, benefits extended beyond the individual to parents, carers, and other health professionals. Parents and carers valued the opportunity that PEM provided to make connections with other individuals with caring responsibilities to share stories and build connections. Similarly, healthcare professionals who have observed and engaged with PEM sessions have been inspired to integrate some of the principles and activities they observed within their own practice. The findings provide evidence that PEM has made good progress towards intended outcomes such as increased support network for carers and developing partnerships and networks.

"I learnt that the session was not just beneficial to the service user but also to their carers... it is important to understand all outcomes to truly understand a legacy." Reflective log from PEM stakeholder

"We are shifting the culture in the care homes we are working with but also, like a stone thrown into water, this is making ripples out to the other care providers as well through some peer learning and other opportunities that PEM has shone the light onto". PEM Delivery team

Impact on service users - Insight from wellbeing and activity survey

To estimate the impact of the PEM programme on participants' wellbeing and physical activity levels, the Evaluation Consortium including State of Life and Impact Reporting deployed a quantitative survey on a Progressive Web Application (PWA), which means that the respondents were able to self-complete the questionnaire online by accessing a specific URL.

A total of 190 responses to the survey (178 excluding largely blank responses) were received; slightly more than half of these throughout the entire year 2021, and the remainder - in July and August 2022.

The sample was about 70% Male, 92% White, 94% not working (either unemployed or not in the labour force due to age or disability), and 81% reported having a disability or long-term health condition. For 65% of the total sample, their condition limits daily activities.

Although we did not have an explicit control group that matches the demographic composition of PEM participants (it is indeed unclear where or how people for this population outside of PEM could be recruited), we received varied responses to the question regarding the duration of involvement with PEM:

- 21 were about to start the programme
- 32 had been involved for less than a month
- 57 had been involved between one month and one year
- 68 had been involved for more than a year.

Exploiting this variation can help us estimate and infer the impact of PEM on key outcomes of interest, including wellbeing, physical activity, and Health and Social Care services use. Below we report on the key outcome levels across these duration of involvement categories and also compare them to statistics from the very large and nationally representative Active Lives Survey, which samples up to 200,000 people in England every year.

Health and wellbeing

Looking at the statistics, there was a strong positive trend. The longer that individuals had participated in PEM, the better they scored on measures of personal wellbeing, subjective general health, and self-efficacy (see Table 4). Trust was the only outcome not to display this pattern.

Comparing the results to Active Lives Survey data, a large nationally representative survey, shows that people who were about to start PEM reported poorer outcomes than the average respondent with a limiting disability in the English population. However, for individuals who had participated in PEM for more than a year, all personal wellbeing outcomes except anxiety were above (better than) the average in the Active Lives Survey for those who do not have any disability. Therefore PEM may have the effect of lifting wellbeing for disabled people to levels typically reported by non-disabled people.

Table 4. *Health and wellbeing outcomes in PEM service users as a function of length of involvement and comparisons to Active Lives (AL) data.*

Outcome	About to start	Less than a month	Up to a year	More than a year	AL data: no disability	AL: limiting disability
Sample size	21	32	57	68	107621	22091
Life satisfaction	4.84	6.7	7.24	7.93	7.48	5.86
Happiness	5.05	6.88	6.96	7.52	7.5	6.02
Anxiety	6.47	4.67	4.93	4.48	2.95	4.28
Worthwhile	5.16	6.86	7.63	7.73	7.67	6.39
General health	2.6	2.68	3.12	3.01	4.19*	2.93*
Self-efficacy	3.1	3.26	3.73	3.92	3.91	3.32
Trust locals	3.4	3.7	3.53	3.25	3.43	3.2
Loneliness	1.84	1.9	1.71	1.7	1.48	1.82

Notes: AL - Active Lives Survey (2015-2019)
* Different answer options are used in this survey for this question: Active Lives has 5 - Very Good; 4 - Good; 3 - Fair; 2 - Bad; 1 - Very Bad; The PEM survey follows the Understanding Society scale: 5 - Excellent; 4 - Very Good; 3 - Good; 2 - Fair; 1 - Poor. Higher numeric scores are expected on the Active Lives scale as a consequence; someone with good health would yield a value of 4 in Active Lives and 3 in the PEM survey.

Physical activity

Individuals who were about to start PEM reported lower levels of physical activity than the subgroup with a limiting disability in the Active Lives Survey. They engaged in over two times fewer minutes of moderate equivalent activity per week on average, had a lower proportion of active respondents (≥ 150 minutes/week), and a higher proportion of inactive respondents (<30 minutes a week). Individuals who had participated in PEM for more than a year, however, had physical activity levels come closer to the Active Lives subgroup without a disability.

It is worth noting that the way minutes of total physical activity are derived for respondents in the Active Lives Survey may lead to an overstatement. This is because it is derived as the sum of the minutes of physical activity contributed by every sport that the respondent mentioned in an introductory question on sports participation. However, there is potential double counting, as some respondents may think of an activity they engaged in and tick the box for several different activities that they think it counts under.

Individuals who were about to start PEM participants had relatively low perceptions of capability, opportunity, and motivation to be physically active, only slightly higher than the sub-group with a limiting disability in the Active Lives Survey. Individuals who had participated in PEM for more than one year had more positive perceptions towards physical

activity than the Active Lives sub-group without a disability. This suggests that PEM may be particularly effective at fostering positive attitudes towards physical activity.

The main conclusion for physical activity levels and attitudes is the same as for wellbeing - PEM may increase physical activity levels and perceptions towards activity of a disabled person to similar mean scores typically reported by non-disabled people.

Table 5. *Physical activity behaviour and cognitions in PEM service users as a function of length of involvement and comparisons to Active Lives data.*

Outcome	About to start	Less than a month	Up to a year	More than a year	AL data - no disability	AL - limiting disability
Sample size	21	32	57	68	463656	127823
Minutes of mod+ activity / week*	163	453	294	565	707*	419*
% Active	28.6	46.4	48.1	57.1	68.3	43.3
% Inactive	50	25	22.2	27	19.4	43.3
Capability	3.4	3.84	4.13	4.35	4.33	3.06
Opportunity	3.7	3.84	4.39	4.44	4.14	3.37
Motivation	3.75	3.87	4.19	4.37	4.02	3.39

Notes: AL - Active Lives Survey (2015-2019)
* We believe totals for all physical activity may be exaggerated (see above)

Regression analysis insights

Given the unusually large differences in wellbeing and other outcomes above, one must ask the question whether these differences might be due to something else than PEM participation. Especially since our survey is not longitudinal, the respondents in the different duration of involvement subgroups are different people. We use multivariate regression analysis to control for any differences in observable demographic characteristics.

Table 6 shows the relationship between duration of involvement in PEM and life satisfaction, for the full sample and other key subgroups in the sample. The numbers in the table indicate the estimated difference in life satisfaction between being ‘about to start’ and other durations (column headings), while controlling for age, gender, employment status, ethnicity, disability and general health.

This relationship remained very strong and statistically significant even after controlling for other factors. This was also true for the Community Partnerships/Reconnect subsample, and other PEM workstreams. It is true for both self-completed responses and responses completed by a carer, even though statistical significance is diminished due to lower sample sizes.

Table 6. *Results of regression analyses of length of involvement in PEM predicting life satisfaction.*

Subsample	Less than a month	Up to a year	More than a year
Life sat. - full sample	1.333**	1.714***	2.191***
Community Partnerships/Reconnect only	0.937	1.916***	2.358***
Other PEM workstreams	-0.723	-1.357	-0.996
Proxy/carer responses	1.652*	1.306	2.001***
Self-completed responses	0.169	1.522	1.470

OLS regressions with heteroskedasticity-robust standard error. *p<0.1, **p<0.05, ***p<0.01.

Table 7 displays the associations between longer involvement in PEM and other outcomes (for the full sample only). There was also a strong and statistically significant relationship between PEM involvement (at least long-term involvement) and the other wellbeing measures, as well as self-efficacy. The relationship between PEM participation and physical activity, trust and loneliness was less clear after controlling for observable demographics.

Table 7. *Results of regression analyses of length of involvement in PEM predicting measures of wellbeing, health, and physical activity*

Model	Less than a month	Up to a year	More than a year
Happiness (0-10)	1.011	1.003	1.273**
Anxiety (0-10)†	-1.830**	-1.347*	-1.788**
Worthwhile (0-10)	0.828	1.659***	1.846***
Self-efficacy (1-5)	0.102	0.424	0.730**
Trust (1-5)	0.330	0.064	-0.194
Loneliness (1-3)†	0.313	0.094	0.062
Minutes of moderate+ phys. act. per week	90.568	-295.598	46.007
Active (>150 mins)	-0.026	0.073	0.190
Inactive (<30 mins)†	0.044	-0.028	-0.081

OLS regressions with heteroskedasticity-robust standard error. *p<0.1, **p<0.05, ***p<0.01.
†Negative measures - a lower score represents a better outcome.

Interpretation and causality

A goal of PEM is to improve the wellbeing, self-reliance, and health of people with disabilities through engaging them in physical activity.

At a first glance, a majority of people who access PEM services are indeed physically active, and display very positive attitudes towards physical activity. Both the levels of and attitudes towards physical activity improve considerably with duration of involvement in PEM.

Specifically, individuals about to start PEM had relatively low activity levels and attitudes, lower than respondents in the Active Lives survey with a limiting disability. Individuals who had participated in PEM for more than a year were closer in physical activity levels to the Active Lives sub-group without a disability, and attitudes were even more positive. This suggests that the aim of PEM to increase physical activity is being realised successfully.

Life satisfaction among people who accessed PEM services for more than a year was higher than even for non-disabled respondents in the Active Lives survey; the same for happiness and feeling that life is worthwhile. General health was lower than national survey sample averages but still higher than the averages for disabled people subgroups (taking into account that the Active Lives answer scale for the health question is skewed towards higher scores than the one we used in the PEM survey). Self-efficacy was also comparable to the mean score of non-disabled people in Active Lives.

There was significant variation in the length of time respondents had been engaged with PEM. Over 30% had participated for more than a year and thus had sufficient time to be exposed to PEM and experience its effects. On the other hand, around 30% had participated for less than a month or had not even started, which provides a reasonably-sized comparison group so that the results had some statistical significance.

The findings provide some evidence that many positive outcomes of PEM are being achieved, albeit some participants do continue to engage with PEM for long periods, which was not necessarily the intention and may need consideration in future (see earlier points on page 27-28). Despite this, there is evidence that PEM can help mitigate inequalities in physical activity, wellbeing, health, and self-efficacy, and bring people with disabilities/long-term health conditions closer to the outcome levels typically reported by people without disabilities/long-term health conditions. However, this is not the case for trust, and to some extent anxiety and loneliness, which improve but not enough to reach Active Lives averages for individuals without a disability/long-term health condition. Note that anxiety levels among PEM service users were particularly high.

Caveat: The current research design and available data do not allow us to establish causality or provide any robust evidence to say that it is participation in PEM that was definitely responsible for individuals' higher wellbeing or higher proportion of active people as opposed to their counterparts with disabilities in national surveys. We also cannot be certain that the respondents in our survey were representative of the entire pool of PEM participants.

Self-reported use of Health and Social Care services

Another important benefit of PEM postulated in the logic models was a reduction in Health and Social Care services use. The idea was that PEM should enable participants to live a more independent life and therefore be less reliant on day care or a carer visiting them. Furthermore, improving their general health and physical activity should lead to fewer GP visits and hospital admissions, thus reducing costs to the NHS.

The most accurate way to track service use and reduced use would be to link patient numbers of individuals to service use over time. This is possible but comes with significant

investment in time and data protocols to ensure GDPR compliance. Essex County Council are working on this but in the interim we took a subjective, survey based approach that was and is very experimental.

To try to assess the impact of PEM on service use, we included several questions on Health and Social Care services use in the PWA survey. They refer to six kinds of social care and medical services (column 1 of Table 8). The first set of questions asked about the current average level of service use (column 2). The second set asked the respondents to estimate how much they were using the service now in relative terms, compared to six months ago.

Based on this and the Unit Cost of Health and Social Care data, as well as a series of assumptions, we were able to provide a crude estimate of the average savings per person resulting from the reduction in service use associated with PEM participation. This was equal to approximately £365 per person per year (we transformed all measures in column 1 into yearly equivalent values). Out of that total, £163.34 is more attributable to cost savings for adult social care (Day care, formal support), with £201.90 more attributable to wider parts of the system (£128.99 in informal support; £72.91 across medical/health savings).

Table 8. *Self-reported changes in service use by PEM participants and associated cost savings.*

Service	Average level now	% using a lot less – (minus) % a lot more	% using a bit less – (minus) % a bit more	Reduction per person*	Unit cost**	Savings per person
Day care (sessions/month)	9.97	-3%	-3.00%	-0.105	£74.05	**-£93.02**
Formal support (hours/week)	61.86	0.00%	4.50%	0.278	£17.71	**£256.36**
Informal support (hours/week)	41.81	-6.50%	19.60%	0.140	£17.71	**£128.99**
Hospital admission (instances/6 mo.)	2.62	0.00%	6.80%	0.018	£1,854	**£66.06**
GP visit (instances/month)	2.35	0.00%	4.10%	0.010	£39	**£4.51**
Ambulance call-out (instances/month)	1.56	2.20%	-4.50%	0.002	£125	**£2.34**
Total						**£365.23**

*Based on the (arbitrary) assumption that ‘a bit less’ is a 10% reduction in service use and ‘a lot less’ is a 25% reduction in service use

**Sources: Information from the finance department of the Essex County Council on the average cost of a day care session and an hour of domiciliary care; PSSRU Unit Costs of Health and Social Care for hospital admissions, GP visits and ambulance call-outs.

Reduced service use is small, but this may still be a positive and significant finding

There may be several possible and plausible explanations for why there was only a small reduction in service use by the PEM participants despite such a profoundly positive improvement in health and wellbeing. However, even a small reduction or a lack of any increase in healthcare service use is important. Below are a few reflections on why, based on the qualitative interviews with the workforce and the team's collective understanding of PEM participants, their level of need and use of healthcare services.

1. A vast majority of PEM participants have long-term disabilities and chronic health conditions which may be untreatable or even deteriorating in nature, and therefore it is unrealistic to expect a disappearance of the need to regularly use Health and Social care services.
2. Related to the long-term health conditions of the PEM participants could be the case that without PEM there could be a progressive increase in service use (that is, the counterfactual, in the absence of PEM) and that participation in PEM mitigates against an increase in service use.
3. Those participating in PEM and with long-term disability and / or deteriorating health conditions are likely to have a care package ascribed to them that is relatively fixed - i.e., the patient has a limited ability to reduce their level of care in the period measured by this study.
4. According to the workforce consulted throughout the process - some individuals in PEM will "never" ask for reduced care as they will likely always have a need and a way that they can use the extra help to improve their lives.
5. An increase or lack of decrease in service use may not indicate a worsening of the respondents' health condition, but rather greater willingness to use Health and Social Care services to address existing health conditions. Indeed, the PEM workforce's consistent (often weekly) contact with clients would often mean responding to participants' medical issues and identifying new needs that previously haven't been addressed. This could often result in recommending a visit to the GP.
6. The change in service use may be affected by the overall trend as the UK society slowly returns to normal following the COVID-19 pandemic. The overall trend is of an increasing Health and Social Care service use, as these services (e.g., in-person GP consultations) were often severely restricted during the peak phases of pandemic and the associated lockdowns.
7. It may be that a reduction of service use by the patient takes a little more time to take effect and may materialise after the time that we have been able to observe.

"If we can sort of like be there at the very start rather than maybe third stage or maybe fourth stage we could make a difference where these people are concerned. Money-wise, it would cost a lot less money." Healthcare professional

"We have also noticed that they maintain it, so the [chronic health condition] hasn't worsened. [It] has not gone away, but it has not got no worse. And we can say that with all our members." Healthcare professional

All things considered, the positive wellbeing impacts and indication of reduced service, albeit marginal, suggest that PEM is having a positive effect but perhaps through a different mechanism than originally forecast. That is, as noted previously, a number of individuals engage with PEM over a longer time-period instead (and/or alongside) of other services in the community.

The mitigating points 1 to 7 above are informed by the qualitative interviews with PEM participants and workforce. There is certainly scope for further study of objective data linked to patient numbers to extend the analysis of the current quantitative data and the qualitative feedback from patients and workforce. Such a study would be pioneering in healthcare.

Economic valuation

Based on the current (imperfect) data, we can estimate the economic impact to UK society from the reduced use of Health and Social Care services associated with PEM participation (for at least 7 months) of **£365 per person per year** (Adult social care: £163.34; Wider system: £201.90).

We do not know how long these effects last, the only way to estimate this duration is to track and observe PEM participants for long periods of time, which is a difficult and costly undertaking. Therefore, to be on the conservative side, we have assumed that the effects are concurrent (only happening as long as a person is still participating in PEM).

Furthermore, the improvement in life satisfaction associated with PEM participation can be monetised using wellbeing valuation techniques. We use the unit value of £13,000 / WELLBY, recommended by the recently released Wellbeing Supplementary Guidance to HMT Green Book. We applied this to the estimated life satisfaction increase associated with PEM participation for at least a month in our regression analysis, which is 1.71. The monetary value of this increase would be **£22,230 per person per year**.

We scaled up the values per person to the typical number of unique regular participants in the Community Partnerships/Reconnect workstream and Inclusive Cycling. These numbers were provided by the PEM. See this online appendix for more detailed information and calculations.

There are several reasons why we do not consider the other workstreams for cost-benefit analysis:

- The PA-OT and Care Homes interventions are not delivered to the residents/patients directly, but rather to staff members who then work with the residents/patients. As a consequence, there were no records of final beneficiaries.
- As in the regression results table above, the association between PEM participation and wellbeing was driven by the Community Partnerships/Reconnect subgroup.
- Survey sampling was mostly done through the Community Partnerships/Reconnect sessions, and therefore even respondents who indicated other workstreams will also have participated in Community Partnerships/Reconnect.
- To produce a more conservative estimate.

Table 9. *Potential benefits and cost savings from reduced service use and enhanced wellbeing of Community Partnerships/Reconnect.*

PEM workstream	Unique participants	Value of reduced service use	Value of increased wellbeing	Total benefits
Community Partnerships/ Reconnect (Colchester)	332	£121,257	£7,380,360	£7,501,617
Community Partnerships/ Reconnect (Tendring / Clacton)	163	£59,533	£3,623,490	£3,683,023
Community Partnerships/ Reconnect (Basildon)	407	£148,649	£9,047,610	£9,196,259
Basildon Inclusive Cycling	16	£5,844	£355,680	£361,524
Total				**£20,742,423**

Costs and net benefit

The final step was to add together the yearly costs and benefits of the PEM programme to calculate its bottom line metrics for policy evaluation - the net benefit and Benefit-cost ratio. Total costs of current PEM projects were obtained from the Operations Director at Sport for Confidence.

Table 10. *Total direct costs of PEM for 2020-2022.*

	Cost
Costs - 2020-21	£197,520
Costs - 2021-22	£155,770
Costs - total	£353,290
Total benefits	£20,742,423
Net benefit	**£20,389,133**
Benefit-cost ratio	**58.71**

Note: PEM has been running for 2 years at the time of writing this report. However, the unique number of participants in the previous table counts people who joined at different points in time, therefore we assumed the average exposure to the wellbeing benefits from PEM to be 1 year and only count 1 year's worth of benefits. We also considered the full expenditure associated with PEM rather than the share allocated to Community Partnerships/Reconnect only, to be on the conservative side, as some participants moved across workstreams.

Social Value
"The appraisal of social value, also known as public value, is based on the principles and ideas of welfare economics and concerns overall social welfare efficiency, not simply economic market efficiency. Social or public value therefore includes all significant costs and benefits that affect the welfare and wellbeing of the population, not just market effects. For example, environmental, cultural, health, social care, justice and security effects are included." HM Treasury Green Book (2022), Section 2.1

PEM is a highly socially desirable investment, delivering over £58 of social value per each £1 invested. This is mainly because of the extremely high association between participation in the programme and improved personal wellbeing. That is, the value of reduced service use equated to 95p compared to the value of increased wellbeing being £57.76. This could be because PEM participants start with low levels of wellbeing to begin with, and lifting their wellbeing is easier than for the average person. If it is the main reason, then interventions such as PEM (i.e. targeting people with disabilities/long-term health conditions or who otherwise have problems with self-care and doing usual activities) are indeed one of the most effective ways to create more welfare in society. For comparison, Sport England's social return on investment study suggested sport has a return of £4 for every £1 spent.

Higher levels of wellbeing may deliver social value through potentially enabling individuals to engage in employment, volunteering, and other activities, and thus potentially bringing direct and indirect benefits to Adult Social Care, Health and wider society. While some of these benefits may be directly quantifiable savings to specific parts of a system, such as reduced use of GPs, hospital or social care, other benefits may be more qualitative, and harder to quantify and attribute to system settings. Further research and evaluation are needed to track service users over time to explore specific impacts (including cost savings) on service use, employment, and engagement with wider community services. However, wellbeing itself is valuable, not just as a means of performing other activities or bringing actual monetary savings to public institutions.

The idea of wellbeing as the ultimate objective of public policy has been advanced in, for example, Frijters and Krekel's A Handbook of Wellbeing for Policy-Making and the HM Treasury Green Book. Within this line of thinking, £20 million may not translate to an actual monetary saving in specific parts of the system. Rather, the £20 million is a monetary equivalent estimate of the amount of wellbeing generated by a programme, using a common yardstick that everyone is used to - money. It (roughly) represents the equivalent amount of money that the group of affected people (in total) would be willing to pay or give up to experience the wellbeing increase that the programme has generated for them, although the effects might be spread unevenly across participants.

Estimates could be influenced by limitations in the research design (e.g., selection bias). All previously identified caveats apply regarding the validity of these economic findings. In truth, the actual a) number of PEM participants and b) average wellbeing impacts of PEM, c) average level of service use reduction as a consequence of PEM may be different. In this situation, the social value, net benefit and social return on investment ratio would also be different. We hope that more robust data may become available in the future that will help to

refine these estimates and increase their accuracy and validity. Further, it should be noted that estimates do not account for aligned work that was funded outside of PEM that may have also contributed to benefits.

Cost-effectiveness analysis and comparison to the NHS

The WELLBY can be linked to the NHS measure for health improvements - the QALY (Quality Adjusted Life Year), enabling a broad comparison between the value and cost effectiveness of physical activity-based preventative health and wellbeing programmes such as PEM and the NHS costs for similar outcomes. Namely, research has been conducted which shows that the average cost spent by the NHS per QALY generated is around £15,000. Given that a QALY can be considered equivalent to 6 WELLBY, this means that the cost-effectiveness of the NHS in generating wellbeing is £2,500 / WELLBY (for details, see Frijters & Krekel, 2021).

PEM generates 1595 WELLBYs with a total programme cost of just over £350,000. Therefore, the expenditure per each WELLBY generated is £221. This estimate suggests that PEM may be 12 times more cost-effective at generating wellbeing than the average NHS intervention. This finding for PEM is similar to a 2021 study conducted by State of Life that found parkrun was 25 times more cost effective than the NHS at generating health and wellbeing. This is a helpful comparison given that parkrun does not have the infrastructure and overhead costs of PEM.

One reason why PEM could be more cost-effective than the NHS in terms of its ability to generate social welfare in the population is because PEM is a preventative health measure. It focuses on managing and preventing health problems and mitigating health inequalities in a non-medical environment rather than clinicians treating and curing these problems in hospitals, which involves significant expenses. This is not to suggest PEM and other physical activity programmes and preventative measures are a substitute for the NHS, but that their value as a cost reducing complement to the NHS seems positive and relevant. This focus on preventative health is outlined in the 2019 Green Paper on the future of health prevention. Further, and as noted previously, it is important to consider the purpose and role of PEM or similar programmes in terms of whether they should provide a long-term service for some/all individuals versus providing an opportunity to develop skills, knowledge and confidence before transitioning to wider services.

There is enormous potential in social cost-benefit analysis and wellbeing cost-effectiveness analysis using the WELLBY to determine which projects and programmes are most cost effective at improving the health of the nation. We hope this pioneering study stimulates more interest in the physical activity, health, and social care sectors.

Emergency response data

Within the Care Home workstream, we analysed data from the East of England Ambulance Service on the frequency, reason for, and cost of 999 and 111 calls made from each care home involved in PEM along with ambulance visits. Data spanned 2019 (i.e., pre-PEM) to July 2022, which allowed examination of potential changes in the number of and reason for 999 and 111 calls and ambulance visits before and during PEM. Nine care homes engaged

with PEM during the evaluation period, with five starting in May 2021, three starting in October 2021, and one starting in January 2022 (see Table 11). In recognition of the COVID-19 pandemic and any potential impact this may have had across the Care Home sector and use of emergency services, data from two separate control periods are included (0A – available data from pre-COVID lockdowns; 0B – data after the first COVID lockdown, but pre-PEM).

Table 11. *Number of care homes included in the analysis across time.*

Cluster	Period				
	0A Apr 19-Feb 20	0B Mar 20-Apr 21	1 May 21-Sep 21	2 Oct 21-Dec 21	3 Jan 22-Jul 22
1	5 homes	5 homes	5 homes	5 homes	4/5 homes*
2	3 homes	3 homes	3 homes	3 homes	3 homes
3	1 home	1 home	1 home	1 home	1 home

Before the introduction of PEM; Care homes engaged with PEM

* One care home closed down during this period and was excluded from the analysis thereafter.

In the subsequent analysis, all data were adjusted for care home size (number of residents) and the different number of months of each time period, along with removing duplicate calls. Further, although there were nine care homes within PEM across the evaluation period, it should be noted that the PEM team reported that the homes had engaged to different extents. All five care homes in Cluster 1 and 3 were reported to have been engaged or very engaged. This included attending training delivered by Sport for Confidence, the Provider Quality Innovation Team and Active Essex, engagement with follow-up mentoring/support by an Occupational Therapist and other Adult Social Care staff, clear evidence of how learning had been implemented, and in most cases engagement with wider projects such as Prosper and Find Your Active workshops. In contrast, some of the care homes in Cluster 2 were perceived to have been less engaged. Although staff had attended training by Sport for Confidence, there was less engagement in follow-up support and less clear evidence of how learning had been embedded in practice.

There was significant variation within and across care homes in terms of the total number of 999 and 111 calls. However, there was no obvious trend for fewer total calls after engagement in PEM, and in the case of Cluster 2 care homes an overall increase (see Table 12). Similarly, there was no clear reduction in the cost of total calls and ambulance visits before and during PEM. However, the sample size is small, and the differing levels of engagement with PEM and various changes in COVID-related restrictions may have influenced the findings.

Table 12. *Average number of 999 and 111 calls per 10 residents per month across time.*

Cluster	Period				
	0A Apr 19-Feb 20	0B Mar 20-Apr 21	1 May 21-Sep 21	2 Oct 21-Dec 21	3 Jan 22-Jul 22
1	1.39	1.15	1.17	1.51	1.46
2	1.76	1.83	2.64	3.13	2.66
3	1.74	1.49	1.21	1.25	1.39

Beyond the overall number of calls, we examined the number of calls that were related to falls as opposed to other reasons. This reflected that two outcomes of the Care Home workstream were to reduce the number of falls and hospital admissions from falls. Similar to above, there was a notable degree of variation in the data, but a small trend in Cluster 1 for fewer calls relating to falls after engagement with PEM (see Table 13). That is, the average number of falls across homes in Cluster 1 fell from 0.33 falls per 10 residents per month before PEM to 0.28 falls per 10 residents per month during/after PEM. To provide more robust estimates, it would be important to track the falls across all care homes over a longer period, examine subsequent action (e.g., was ambulance visit necessary, was the individual transferred to hospital?) and explore the use of control clusters more fully. Alongside this small trend in the absolute number of falls leading to a 999/111 call, there was a reduction in the percentage of 999/111 calls relating to falls across all care homes. For example, in Cluster 1, falls accounted for 19.7% of all 999/111 calls before PEM, but this reduced to 14.0% of 999/111 calls during/after PEM.

Table 13. *Average number of 999 and 111 calls for falls per 10 residents per month across time.*

Cluster	Period				
	0A Apr 19-Feb 20	0B Mar 20-Apr 21	1 May 21-Sep 21	2 Oct 21-Dec 21	3 Jan 22-Jul 22
1	0.39	0.28	0.24	0.33	0.28
2	0.49	0.44	0.85	0.70	0.58
3	0.40	0.33	0.28	0.27	0.27

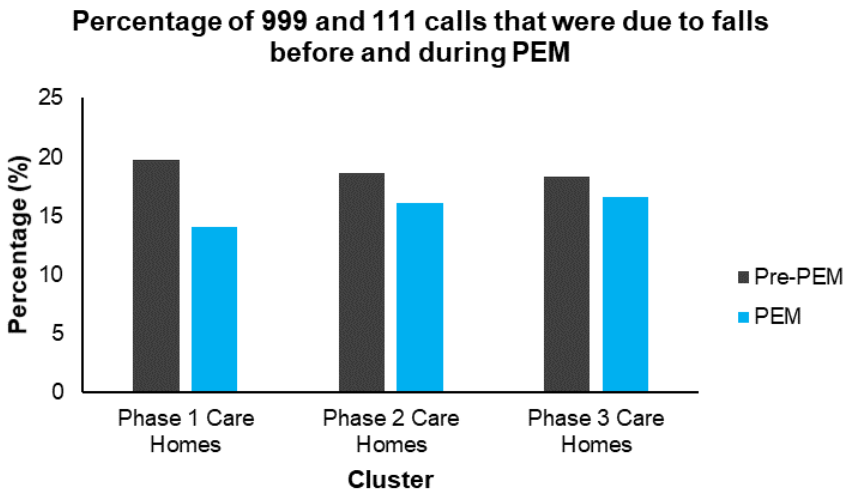


Figure 6. *Percentage of 999 and 111 calls that were due to falls before and during PEM.*

Challenges and developments

Despite the positive impact of PEM on improving (or maintaining) health and wellbeing, reducing service use and potentially saving costs, the evidence would be strengthened by further data within each workstream. This could include increasing the sample size, tracking individuals over time, and using additional objective data on service use and associated cost benefits. Although the economic analysis focused primarily on the Community Partnerships/Reconnect pathway, qualitative data demonstrated that stakeholders recognised the potential economic impact of all PEM workstreams and its value as an overarching programme. Further, given the benefits of PEM (or similar programmes in future) may be seen across Adult Social Care, Health and wider system settings, it is important to consider equitable approaches to the funding and resourcing of preventative programmes for which direct and indirect savings span beyond a sole commissioning organisation.

> *"If someone in this home falls and they are on a blood thinner, we call an ambulance. You know, so if you are stopping that [falls] you are saving on ambulances… Invest in this, less falls, less phone calls, less hospitals, less [need for] physios and OTs because staff are more confident with movement, handling and you know how to maintain people's mobility and what they can do… It all has a knock on effect, GPs, the amount of behaviours and medicines that might have been prescribed."* PEM Care Home staff

Recommendations

The whole systems and preventative approach of PEM has made exciting progress and had demonstrable impact over since August 2020. Although further development, testing and evaluation should be undertaken, the innovative and integrated approach in Adult Social Care and Health could offer transformational change, embed physical activity into the system, improve the lives of people living with disabilities and/or long-term health conditions, mitigate health inequalities and support individuals to be more active, happier, and live more independently. This could be a development and iteration of PEM itself or through applying the learning form PEM to other similar programmes. Below are a number of recommendations to support future work.

System-led opportunities

PEM has successfully identified and developed a range of opportunities across the system to facilitate active and independent lifestyles. It is important to develop further understanding of the needs, opportunities, and resources within systems and to use this insight to design whole systems, evidence-based and placed-based approaches that tackle physical inactivity in marginalised populations. In doing so, the following specific recommendations should be considered.

1. Opportunities and programmes should be developed in partnership across the system, with the potential to more fully engage organisations across the Health system who could contribute knowledge, expertise and resources, and who could potentially experience direct and indirect benefits from whole-systems and preventative programmes.
2. It is important to integrate community insight, scientific evidence, and the tacit knowledge of Health and Social Care professionals to identify and implement opportunities that fit local context.
3. Opportunities should be co-produced with people who access PEM (or similar) services to ensure that they are placed-based, inclusive and accessible.
4. Interventions should create an autonomy supportive environment to empower people who access PEM (or similar) services, promote independence, and provide them choice and flexibility.

Embed physical activity

PEM has made important progress in embedding physical activity across the system, and for organisations to collaborate with a preventative focus. This has been supported by alignment with national policies, facilitative leadership, and cultivating a shared vision purpose. However, further work is needed to more strongly embed physical activity in the system and ensure targeted pathways are sustainable. In doing so, the following specific recommendations should be considered.

1. It is important to periodically review and map the system within and across Adult Social Care, Health and related sectors to identify and capitalise on potential links between organisations.
2. If PEM is developed and/or lessons applied to other programmes, key political supporters and leaders should be identified to provide advocacy and direction.

3. Continue to work collaboratively using common language and a vision to facilitate a culture change across the Health and Social Care system, and to further explore mechanisms to develop engagement and input within and across the system.

Workforce

The current findings highlight that there is a need for physical training in Care Home staff and Occupational Therapists, it is valued by recipients, and it can inform working practices. It is therefore recommended that teams across Adult Social Care and Health continue to work with their staff to understand education and training needs and how to embed the principles into their work. In doing so, the following specific recommendations should be considered.

1. Workshops and training should be co-designed with some Care Home staff, Occupational Therapists, other Health and Social Care Professionals, and end-users to ensure that the content is tailored to different contexts and perspectives.
2. Facilitators and barriers to implementing physical activity advice should be identified and tackled, and Health and Social Care Professionals equipped with the tools and confidence to help challenge and improve systems and approaches in their respective contexts.
3. It is important to monitor the longer-term changes to working practices after the training.
4. Opportunities to embed physical activity content in formal education programmes should be explored.
5. Ongoing support including mentoring and infrastructure would help to ensure the workforce was able to continue to deliver physical activity in many contexts.

Impact

Involvement in PEM was associated with higher levels of physical activity and wellbeing, and individuals leading more independent lifestyles, and with small reductions in the use of some healthcare services. As such, it is recommended that the lessons from PEM be applied to informed current and future programmes. In doing so, the following specific recommendations should be considered.

1. PEM and similar programmes should maintain a focus on people living with disabilities and/or long-term health conditions and to support individuals to be active in their local community, live more independently, and feel connected with their local area.
2. Monitoring and evaluation should seek to increase sample size, track individuals over time, and integrate objective measures of service use to understand the longer-term impact and key drivers of change upon individual and system outcomes and to disseminate this learning local, nationally and internationally.
3. Alongside measuring impact in direct service users of PEM (e.g., Community Partnerships/Reconnect or Strength and Balance), efforts should be made to examine the subsequent impact on services users who engage with recipients of training programmes who have changed their working practices (e.g., indirect beneficiaries of Care Home and Physical Activity in Occupational Therapy.

Appendix

Table 14. *Ten features of a successful whole systems approach to tackling physical inactivity developed by Essex LDP evaluation team.*
(adapted from Bagnall et al., 2019; Global Advocacy for Physical Activity (GAPA) the Advocacy Council of the International Society for Physical Activity and Health (ISPAH)., 2010; World Health Organisation, 2018). Also Collaborate nine building blocks of system infrastructure.

Feature	Definition
Identifying a system	Explicit recognition of the system with the interacting, self-regulating and evolving elements of a complex adaptive system. Recognition given that a wide range of bodies with no overt interest in or objectives referring to physical (in)activity may have a role in the system and therefore that the boundaries of the system may be broad. The identification and progress of the system might also extend to/align with the development and dissemination of a national action plan for physical activity.
Capacity building	An explicit goal to support communities and organisations within the system. Actions could include capacity building through multi-sectoral partnerships, the development of workforce capabilities, and enabling financing mechanisms across all relevant sectors.
Creativity and innovation	Mechanisms to support and encourage local creativity and/or innovation, to reorient services and funding to prioritise physical (in)activity. Consequently, activities and benefits might be broad and further reaching (such as cleaner air, reduced traffic congestion, greater social connections etc).
Relationships	Methods of working and specific activities to develop and maintain effective relationships within and between organisations. Specifically, actions aimed at increasing population levels of physical activity and planned and performed through partnerships and collaborations, which take different forms and involve different sectors at multiple levels.
Engagement	Clear methods to enhance the ability of people, organisations and sectors to engage community members in programme development and delivery. Such community-level/place-based engagement should have the goal of creating and promoting access to opportunities and programmes, across multiple settings, to help people of all ages and abilities to engage in regular physical activity as individuals, families, and communities.
Communication	Mechanisms to support communication between the various stakeholders and organisations within the system, which strives for an increase in programmes and opportunities that help people of all ages and abilities to engage in regular physical activity as individuals, families, and communities.
Embedded action and policies	Practices and policy frameworks explicitly set out for tackling physical inactivity within organisations within the system, through creating and maintaining environments that promote and safeguard the rights of all people, of all ages, to have equitable access to safe places and spaces, in their cities and communities, in which to engage in regular physical activity according to ability.
Robust and sustainable	Clear strategies to resource existing and new projects and staff, in order to increase knowledge of, and appreciation for, the multiple benefits of regular physical activity according to ability and at all ages. A tangible and supportive policy framework and related regulatory actions are required to achieve sustainable change.
Facilitative leadership	Strong strategic support and appropriate resourcing developed at all levels, which enables community-level/place-based approaches, appropriate governance, leadership, advocacy, and information systems to address physical (in)activity.
Monitoring and evaluation	Well-articulated methods to provide ongoing feedback into the system, to drive change to enhance effectiveness and acceptability.

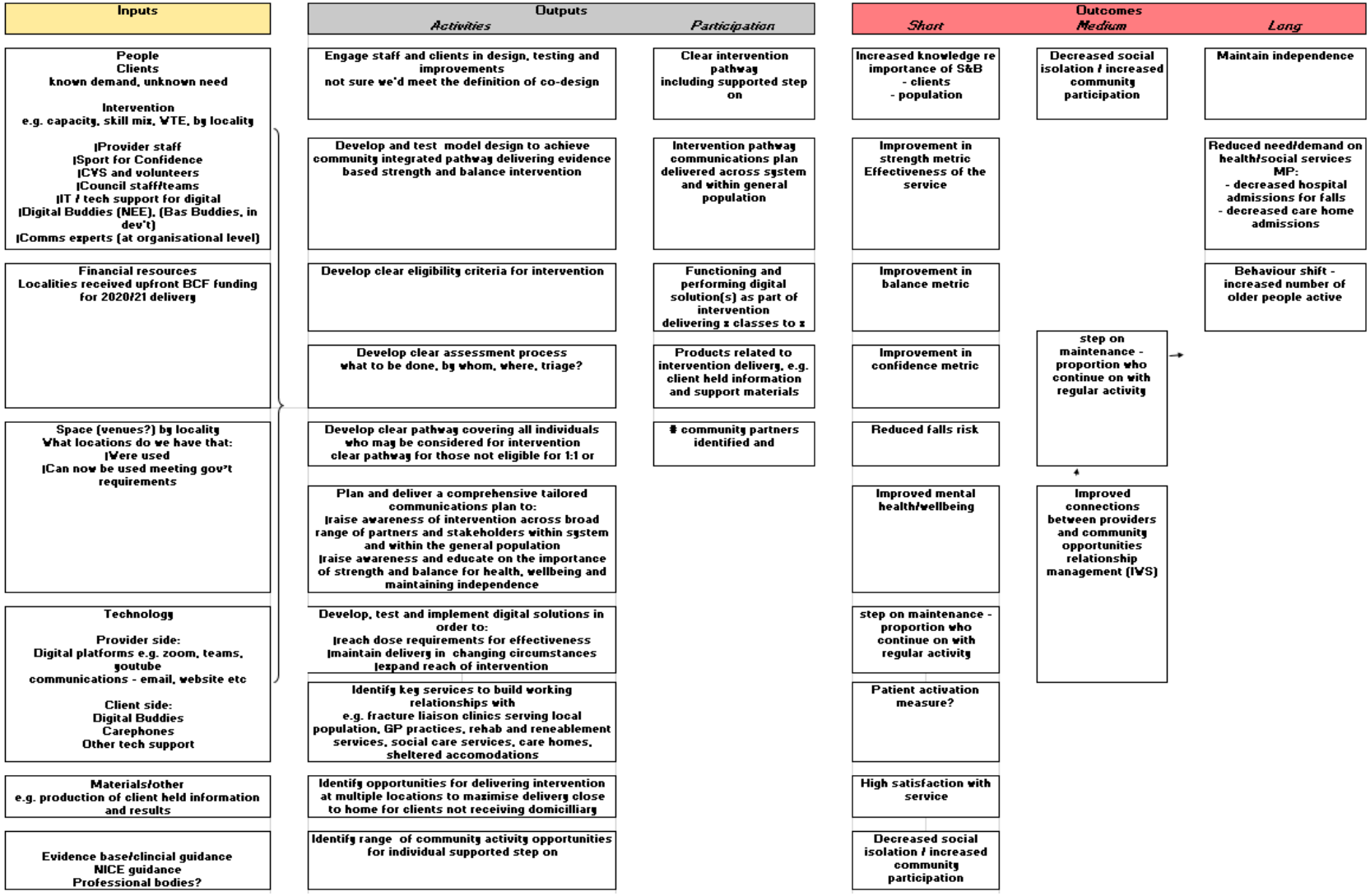


Figure 7. *Logic model developed by the PEM team for the Strength and Balance workstream.*

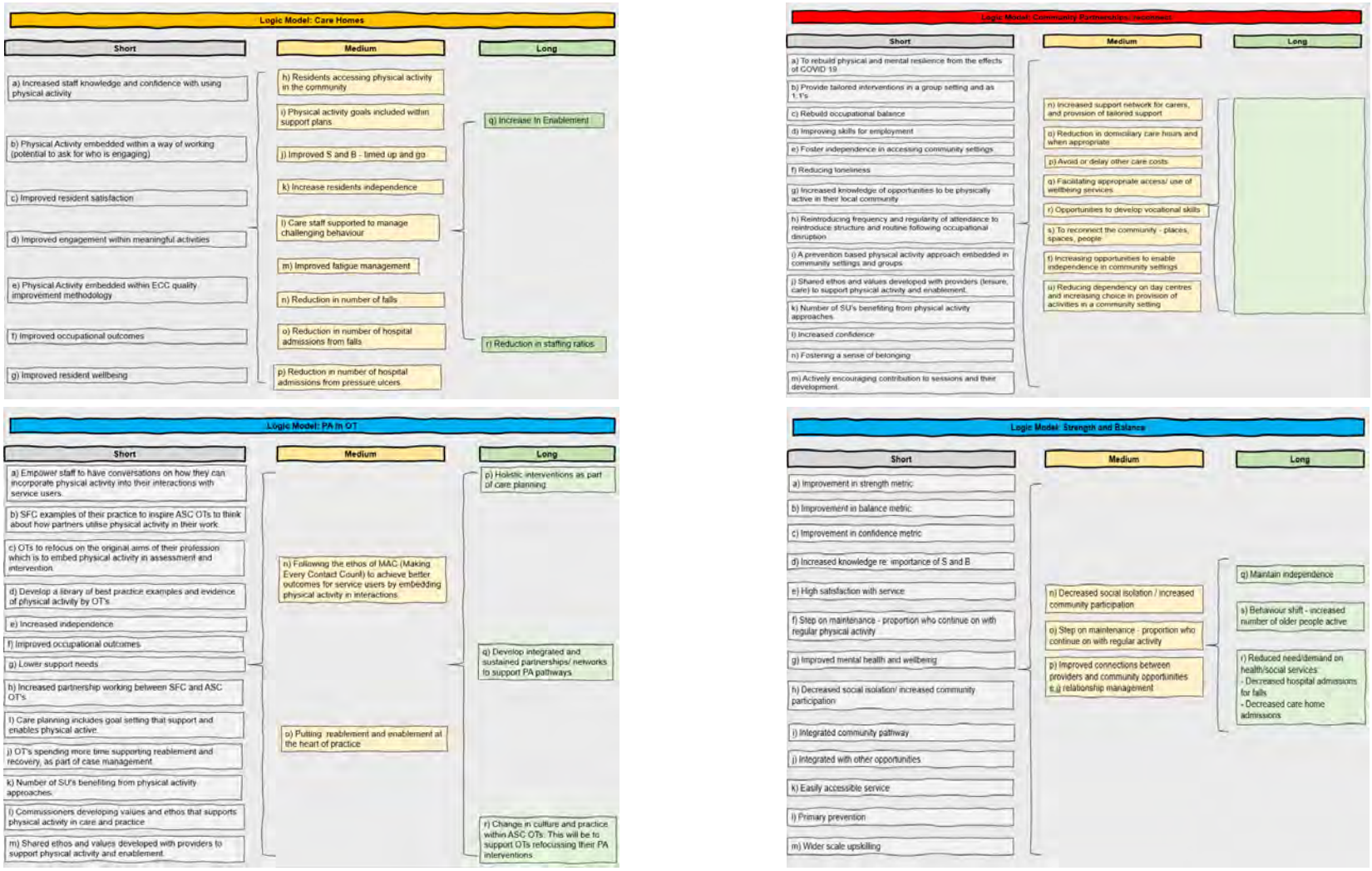


Figure 8. *Outcomes for each workstream listed by the PEM team in the refined logic models.*

A poem written by a carer who attended PEM sessions

I'm writing this poem straight from the heart because Sports for Confidence you really do play a very big part
Do you even realise how much you have done
You deserve a medal each & everyone

Your staff put their heart & soul into their jobs
It shows so much so please don't ever stop
Your needed so much in so many ways
You make people have a happier day

You give purpose & meaning a reason for life
When people are suffering & in so much pain
Sports for Confidence your keeping them sane

You have something that's special I've not seen before
You make people wanted & give them much more
The time that you give the effort you use & the staff that you choose

Your perfect to help people you work from your hearts
& encourage every single person to want to take part
The energy you share to show that you care
Your doing so much by being just there

Your genuinely kind in all that you do
Your respectful & thoughtful it's clearly in you all
Your remarkable staff you deserve so much praise
Your amazing type of people who can take sadness away

I hope that you realise how important you are
The difference that you make to everyone near & from a far
What you all give you make people want to live

No matter what health problems people do have
You treat them with dignity & stop them feeling bad

You give people freedom & give them some life
You find out their strengths & help people build
But at the same time you keep them feeling chilled

When life's full of darkness you show people the light
You give people a future & give them all hope
So day by day you help people to cope

Sports for Confidence be proud of what you do
As people have life & it's all because of you
So when you all read this it's meant from my heart
because Sports for Confidence you play the biggest part

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MSE Integrated Care Partnership, 20 March 2023

Agenda Number: 11

Coproduction Community Assembly

Summary Report

1. Purpose of Report

To provide the Integrated Care Partnership (ICP) the vision, mission, and values of the Coproduction Community Assembly to progress into a formal Community Assembly connected to the ICS and the development of the chair position.

2. Executive Lead

- **Name:** Kirsty O'Callaghan
- **Job Title:** Director of Community Mobilisation, Transformation & Resilience
- **Organisation:** NHS Mid and South Essex ICB

3. Report Author

- **Name:** Simon Prestney
- **Job Title:** Head of Community Mobilisation, Transformation & Resilience
- **Organisation:** NHS Mid and South Essex ICB

4. Responsible Committees

Coproduction Community Assembly

5. Financial Implications

Not identified at this stage.

6. Details of patient or public engagement or consultation

The Coproduction Community Assembly has been created after consultation meetings with over 270 members of the public across 10 meetings before formation. Digital engagement included over 3000 members of the public using Essex is United Platform

7. Conflicts of Interest

There are no conflicts of interest for the coproduction group. Conflicts of interests for the assembly will be conducted prior to formal setup.

8. Recommendation/s

The Integrated Care Partnership is asked to:

1. Note the views of communities and the VCSE through this presentation to the ICP as developed and progressed by the Co-production Community Assembly.
2. Support the formation of the Assembly connected to the ICS.
3. Support the development of the Assembly across the system with a suitably qualified chair and deputy chairs working in partnership with colleagues from Alliances, Local Authorities and VCSE.
4. Note that the assembly will provide support and constructive challenge within reasonable parameters of the ICS in surfacing the voice of communities and the voluntary sector. This feedback aims to serve as a heartbeat from within the ICS toward shaping decisions for the people we serve.
5. Note that extensive co-production has been undertaken across communities and that further resourcing will be needed to develop sustainability of the VCSE and Assembly.

Coproduction Community Assembly

1. Introduction

The Coproduction Community Assembly has been agreed in previous ICP meetings (see appendix a) and is fundamental to delivery of our Integrated Care Strategy. Once developed the Assembly will embed Communities and the VCSE (Voluntary, Community and Social Enterprise) to become the heartbeat through the Integrated Care System to support its work and decision-making, shaped on the needs of the resident. The approach advocated by NHSE in advisory papers has been adopted (see appendix b).

Our Integrated Care Strategy states that:

"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 seeking insight from residents. The Community Assembly […] will be central to this objective and the ICP will conduct continuing outreach as part of its work so 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." **(Integrated Care Strategy P31)**

"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." **(Integrated Care Strategy P14).**

2. Main content of Report

The Coproduction approach used in developing the integrated care strategy has involved face-to-face engagement in 10 sessions of 270 citizens and community leaders (including infrastructure and VCSE organisation leaders) and over 3000 digital engagements prior to formation.

This coproduction approach continues through the Coproduction Community Assembly work that has gathered 16 community ambassadors / leaders, VCSE leaders and infrastructure leaders to form a Vision, Mission, and Values paper (see appendix c) and emerging workstreams.

Colleagues from Alliances and Local Authorities joined the last coproduction session. There was excellent engagement around the developments and on how the work will develop, complement, and build on existing activity at Place.

3. Findings/Conclusion

The findings are that there has been excellent engagement with communities, the VCSE, colleagues from local authorities and Alliances toward the advocated approach. Mission, Vision, Values, and some early stage Workstreams are forming. There is encouragement widely from the engagement undertaken that the work is hitting the mark in the approach advocated by NHSE and that the Coproduction Assembly should move toward formation to develop the next phase of work in relation to workstreams and alignment with place-based activities.

4. Recommendation(s)

The Integrated Care Partnership is asked to:

1. Note the views of communities and the VCSE through this presentation to the ICP as developed and progressed by the Co-production Community Assembly.
2. Support the formation of the Assembly connected to the ICS.
3. Support the development of the Assembly across the system with a suitably qualified chair and deputy chairs working in partnership with colleagues from Alliances, Local Authorities and VCSE.
4. Note that the assembly will provide support and constructive challenge within reasonable parameters of the ICS in surfacing the voice of communities and the voluntary sector. This feedback aims to serve as a heartbeat from within the ICS toward shaping decisions for the people we serve.
5. Note that extensive co-production has been undertaken across communities and that further resourcing will be needed to develop sustainability of the VCSE and Assembly.

Appendices

Appendix B – Advisory NHSE papers on working with the VCSE and working with communities

NHS E Guidance – Working with People & Communities

NHSE Guidance – Partnerships with VCSE

Appendix C – Vision, Mission, and Values.

Suggested mission statement: To engage with communities, understand their needs and, together with partners, act to improve the health and wellbeing of people in Mid and South Essex.

Suggested vision statement: To empower people and communities to drive positive change that improves health and wellbeing for all.

Suggested **Values**

Focused:

Ambitious in our approach to goals, flexible and pragmatic on how we achieve them

We know when to be rigorous and when to get out of our own way

We are honest, clear and kind, putting purpose above ego.

Innovate:

We think all ideas are valuable and no idea is boring

We are reflective, inviting challenge, whilst being kind in our critique

We are curious, listen actively and have a thirst to learn, stretch ourselves and others.

Brave:

We like to make abstract ideas as solid as possible

We use our intuition, and we are not afraid to be imperfect or vulnerable in order to ensure we build connection.

We know when things need to be good enough or perfect

Fair:

We tell the truth and shape ideas with people who are impacted by our work

We make our work and opportunities accessible to all

We convene and collaborate, actively participating in debate and disagreement, but we collectively own our decisions

Communicate:

We listen carefully and engage constructively to understand requirements and build trust.

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MSE Integrated Care Partnership, 20 March 2023

Agenda Number: 12

Thurrock Council – Local Area Coordination

Summary Report

1. Purpose of Report

To provide the Integrated Care Partnership with an overview of Local Area Coordination and the benefits Thurrock Council has seen since implementation.

2. Executive Lead

- **Name:** Les Billingham
- **Job Title:** Acting Director of Adult Social Care and Community Development
- **Organisation:** Thurrock Council

3. Report Author

- **Name:** Karen Dobson
- **Job Title:** Senior Coach Local Area Coordination
- **Organisation:** Thurrock Council

4. Responsible Committees

Not applicable.

5. Financial Implications

None for the partnership specific to this presentation

6. Details of patient or public engagement or consultation

None specific to this presentation

7. Conflicts of Interest

None identified.

8. Recommendation/s

The Integrated Care Partnership is asked to note the contents of the presentation

Our Experience Of Leading And Implementing Local Area Coordination Over 10 years In Thurrock

Tania Sitch & Karen Dobson

History Of Local Area Coordination (LAC)

LAC program in Thurrock was implemented in 2014 with 3 LAC's and today has 16 LAC's across the whole of the borough 1 LAC per 10,000 of the population approx

Set up by Steering Group of partners including all now in the Alliance. Funded by Public Health, Fire, Adult Social Care and Health

Over 30 years of LAC evidence – 1988 in Western Australia to 2009 in England and Wales

There have been more than 16 academic evaluations across the LAC programs –
Thurrock Kingfisher SROI report in 2017 evidence £4 saving for every £1 invested

Outcomes include

Reductions in demand for Health/Social Care and Housing

and improved outcomes for people and communities

References include "Power and Connection" a widely available book published in 2021 with insights and evidence from Thurrock and 2022 LAC highlighted in the House of Lords enquiry report.

What Is Local Area Coordination

The Role of Local Area Coordination

- It is an innovative approach that integrates a range of existing/previous roles and delivers them locally in partnership with local people and communities
- 80% of Coordinators time spent working in the community with individuals and families of all ages and backgrounds
- The approach helps people identify their own “vision of a good life” and work towards this through building personal networks and local connection
- LAC’s provide practical assistance as well as information, advice and support
- LAC’s are graded the same as a social worker or nurse – for good reason

Supporting communities to build local capacity

- The other 20% of time is spent supporting local community activity particularly where there are gaps and opportunities. This is where the LAC can add value to the local Asset Based Community Development (ABCD) and community connector.

Supporting transformation and system change

- LAC works best when it is connected into an integrated support system and equally it can help areas seeking to enhance integrated system too – by offering insights into the value of investing in places and learning coming back from people and communities. It is no means a quick fix but areas do see immediate positive outcomes in the short term and more transformative one in the longer term.

10 Distinguishing Features Of LAC

LAC's are rooted in **communities**, not office based. They are **accessible, approachable and flexible.**

Introductions come from anyone or anywhere – **no referral, no eligibility criteria, just a conversation.**

LACs **take time to get to know people**, investing in **trusting relationships,** and stay in touch .

LACs see **people as experts in their own life**. They won't try and prescribe solutions or "fix" people.

LACs look to **support people through natural community connections not services. LAC's build communities**

The **relationship with the LAC lasts for as long as necessary** and starts earlier in people's journey .

There is **limited or no paperwork.** Bureaucracy is greatly reduced.

LACs work by having **one foot in communities and one in the service system**.

LAC's walk alongside some of the most **vulnerable and with the most challenging lives**

LACs **help people avoid getting lost in the gaps between different services** and **help services work together better.**

What Do Evaluations Consistently Tell Us ?

People And Community Outcomes

- Improved access to **information, community solutions and benefits entitlement.**
- Increase capacity of families to continue in a caring community.
- Increased connections to supportive relationships – **reduced isolation.**
- Better resourced communities – **filling the gaps**
- Support into volunteering, training and employment
- Preventing crisis through **early intervention** and supporting people who don't meet eligibility criteria
- Preventing **repeated crisis** by staying in touch and supporting **sustainable** outcomes
- Improved access to specialist services

In Thurrock an SROI independent evaluation in 2017 showed for every £1 invested £4 was saved

What Do Evaluations Consistently Tell Us ?

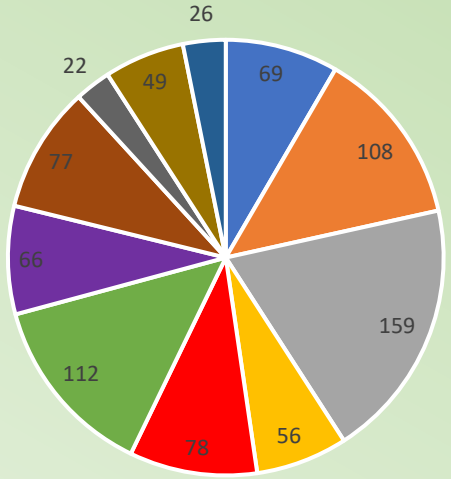
System Outcomes

Reduced dependence/costs on health, housing and social services including:

- Reductions in evictions and costs to housing.
- Visits to GP and A and E
- Dependence on formal health and social services
- Referrals to Mental Health and Adult Social Care
- Safeguarding concerns, people leaving safeguarding sooner
- Smoking and Alcohol Consumption
- Dependence on day services
- Out of area placements

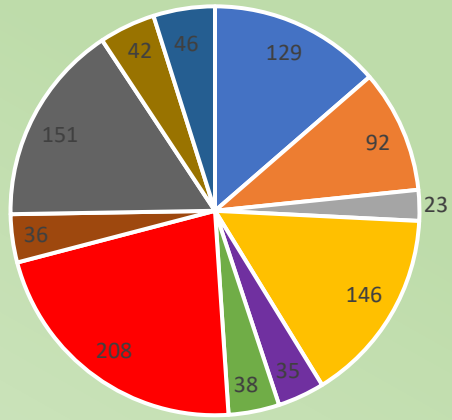
An independent evaluation for Leicestershire County Council showed over 12 months of LAC they supported 53 critical incidents and created an avoidance cost of £4.7 million. In Derby City Council over 10-12 months 50 people were supported and saved estimated £800k to health and care services

Support Outcome



- Financially more independent
- Improved health and well being
- Improved knowledge – widen my choices and options to make my own decisions
- Improved living conditions
- Less reliant on services
- Making new connections improved supportive network (promoting feeling strong resilient less isolated)
- Prevented Self-neglect and promoted self-value
- Reduce cost to the system with a community solution prevented lengthy assessments
- Supported to access formal services - when required care package or support through specialised teams
- Supported to develop a new support/community group (promoting active citizenship)
- Supported to employment, volunteering or education (promoting active citizenship)

Main Support



- Access to benefit entitlement - independence widening of options and choices
- Access to health services incl hospital GP's comm based health support
- Connected to commissioned services in the community to help with recovery: Inclusions Recovery College, Drug and Alcohol Services, weight Management
- Connected to Well-being support in the comm nurturing non-formal Relationships
- Prevented enforcement action, debt/eviction
- Prevented homelessness - feeling safe
- Provided advocacy and navigation to access accurate information promoting independence and well-being
- Reduction in care assessments with the use of micro enterprises - self funded
- Supported to connect with their neighbourhood and/or community assets
- Supported to gain funding or donations from the community
- Supported to secure suitable accommodation - reduction of care and crisis prevention

Best way to impact is stories

What was different ?

- Walking alongside and promoting people taking a lead in their vision of a good life
- LAC went along with Lauren until ready to go alone
- Long term relationship
- No assessment
- Supporting and promoting local and natural connections to build on resilience and independence

The Best Way to evidence impact is stories

What was different ?

- Introductions not referrals (coming from a broad range of places)
- Having conversations with people to understand what is important to them person-centered support – giving them time
- Knowing and helping to build inclusive and welcoming communities
- Looking for other natural resources alongside formal services –
- Helped to navigate services
- Supporting people new to their communities

Best way to evidence impact is stories

What is different?

- Time to find out people's strengths and stay with them
- Connections – LAC's know the assets, people and communities
- Supporting community assets to co-produce support alongside services at a local level
- Supporting gaps in services with community solutions using places and people

The best way to evidence impact is stories

What is different?

- Having conversations rather than assessments
- LAC is not time bound – keep trying to connect with people
- The importance of building a trusting relationship
- Having a voice
- Building resilience to nurture people become active citizens in the communities where they live

A few last comments

- Evaluation/evidence – what does it say about what we are doing now !!!!!!!!!!!!!!!
- Reduce, Prevent and Delay is a requirement of the Care Act
- LAC cannot be diluted – stick to the 10 Principles for the right outcomes
- Community solutions not services
- It will lead to transformation – recruitment, strengths based, community , self-management

Thank you for listening

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Mid and South Essex Integrated Care System

MSE Integrated Care Partnership, 20 March 2023

Agenda Number: 13

Essex Disability Strategy

Summary Report

1. Purpose of Report

This report presents the disability strategy document, titled “Meaningful Lives Matter - Our plan for people of all abilities in Essex,” which is pending formal endorsement by Cabinet at ECC.

The report invites partnership members to discuss how their role or organisation can support implementation of the strategy following its launch in April 2023.

2. Executive Lead

- **Name:** Peter Fairley
- **Job Title:** Director of Strategy and Health Integration
- **Organisation:** Essex County Council

3. Report Author

- **Name:** Ruth Harrington
- **Job Title:** Director of ASC for Adults with Disabilities
- **Organisation:** Essex County Council

4. Responsible Committees

Essex Health and Wellbeing Board – 25th January 2023: Action to engage with ICPs to ensure alignment with ICS strategies.

5. Financial Implications

There are no direct additional financial implications associated with the endorsement of the strategy. The Meaningful Lives Matter (MLM) programme is already delivering on making life better for people with Learning Disabilities and/or Autism in Essex and therefore, any costs associated with this delivery of the Disability Strategy are part of the MLM Programme budget.

6. Details of patient or public engagement or consultation

Over the last few years, engagement with people with disabilities and the carers, providers and partners who have a role in providing support to them has indicated what people want in their lives and what their main strengths and challenges are. Over the past year we have undertaken more focused engagement such as surveys, 1:1 interviews and group discussion sessions. Our learning from these has uncovered four

key aspirations that people with disabilities have told us are most important to them in their lives and that have formed the core of the strategy document.

ECC consulted with the public over a twelve-week period between 1st December and 23rd February. We invited feedback on the content of the strategy from all residents of Essex, particularly people with disabilities, their carers and families and people who support people with disabilities as part of their work. The consultation has been made as accessible to a wide range of needs as possible and has included in-person and online focus groups and drop-in sessions with people with disabilities. In total 208 people were engaged in the consultation.

7. Conflicts of Interest

None identified.

8. Recommendation/s

To consider and discuss how roles of members and organisations represented on the partnership can support implementation of the strategy's aims.

Please note – *Any reports published to Mid and South Essex's Integrated Care Partnership will be published on a public website, and members of the public can attend any meeting of the Partnership.*

Please ensure all reports are suitable for public consumption & accessible to the public, avoiding jargon.

Essex Disability Strategy

1. Introduction

This report presents the disability strategy document, titled “Meaningful Lives Matter - Our plan for people of all abilities in Essex,” which is pending formal endorsement by Cabinet at ECC.

The strategy document sets a clear ambition and commitment to help improve the lives of people with disabilities. It is for the next 4 years and covers adults in Essex who have a learning disability, a physical disability or a sensory impairment.

2. Main content of Report

The document presents 4 key aspirations that people with disabilities have told us are most important to them in their lives. These are:

- Meaningful relationships within a community, including with families, partners, friends, groups of people with similar interests and paid or unpaid carers
- A suitable place to live and call home, whether that is a person’s own home or another accommodation that best allows their needs to be met
- Ability to maintain as good health and wellbeing as possible, including financial wellbeing, and personal safety.
- Access to meaningful activity during the day, such as education, employment and volunteering, or other fulfilling day activities, which may include opportunities to contribute to society and the economy.

The strategy aligns closely with ECC’s Everyone’s Essex 4-year plan for levelling up, the Adult Social Care (ASC) strategic framework, and related strategies such as the Carers Strategy. The strategy is in accordance with the Care Act and its principles around community-based support and prevention, and the Health and Care Act and integration.

ECC consulted with the public over a twelve-week period between 1st December and 23rd February. We invited feedback on the content of the strategy from all residents of Essex, particularly people with disabilities, their carers and families and people who support people with disabilities as part of their work. The consultation has been made as accessible to a wide range of needs as possible and has included in-person and online focus groups and drop-in sessions with people with disabilities. In total 208 people were engaged in the consultation.

Feedback received in the consultation showed us that most people agreed with the priorities and areas of focus of strategy document and with the scope of the strategy. However, it highlighted that a few aspects were missing, in particular financial support. We have amended the document to include these aspects, incorporating financial support within the theme of staying safe and well to recognise financial wellbeing as an important component of overall wellbeing.

A significant number of people felt strongly that autism on its own should be included within the strategy. To recognise this, we have extended the strategy’s scope to include people with autism where they experience it to be disabling, regardless of whether they have another disability.

3. Findings/Conclusion

The strategy document sets out where we need to address barriers that are getting in the way of what people want from their lives and will guide our future work with adults with disabilities to help do this. The Meaningful Lives Matter programme is already delivering and will develop its future work to deliver against the 4 key aspirations.

Yet to fully address barriers and maximise outcomes for people with disabilities, more work is needed across the whole system to improve accessibility and enable the change that needs to happen.

4. Recommendation(s)

To consider and discuss how roles of members and organisations represented on the partnership can support implementation of the strategy's aims.

5. Appendices

Meaningful Lives Matter - Our plan for people of all abilities in Essex

Engagement and Consultation Pack

Title: ‘Meaningful Lives Matter – Our plan for a more inclusive Essex

Foreword by Councillor John Spence

As someone who has been blind for over 30 years, I know at first hand how others can – quite understandably – focus on what disabled people cannot do rather than what we can. From their earliest days, disabled children may experience protective parents concerned for their welfare. They may experience challenges in understanding how best their challenges can be met, whether in school or in their voluntary activities. Moving onto higher education and the workplace can be quite a challenge.

Yet my overall experience, when thinking of all those whom I have met, and with whom I have worked and played, is that those who are disabled want to live exactly the same as all those around them. They want to enjoy quality of life and, where possible, live independently of others; to progress in their chosen workplace and leisure activities; to have people offer respect because of what they do, rather than sympathy or sadness.

At the heart of the County’s disability strategy is this ambition. Our vision is for people with disabilities to live the best lives they can. In this strategy document, Essex County Council sets out how we will work with individuals to achieve a series of goals. We understand that this strategy needs to be the platform on which world-class plans are achieved and delivered. We need to work constantly to ensure full integration both with other County Council pieces of work, such as the carers strategy; and with all the plans being delivered through other strategic and voluntary organisations at national, county and district levels.

<u>Section 1:</u>

Introduction

People with disabilities have the right to the best life they can have. But right now they often get left out of things. The things that are important to us, and make all our lives meaningful, don’t always happen for people with disabilities.

We believe that people are disabled by barriers - things in the world around them that stop them from living a normal life - instead of by their health problem or how they are different from other people. We want to remove barriers so that people can live better lives.

We are already helping lots of people in Essex to live the best life they can. We need to make sure this is the case for every person. We want to help people get what they want and expect from their lives. To do this we will support people by understanding who they are as a person and what they might need across the whole of their life.

The number of people who have a disability and who might need help from social care is going up. We need to use our money carefully to make sure we have enough to help people in the future.

This plan will set out the change we want to bring about. It will make a commitment to people in Essex who have a disability. It will show where we can work better together with others.

The Meaningful Lives Matter work is already helping to make life better for people with learning disabilities and autism in Essex. Now we want it to help make life better for people with sight and hearing loss and physical disabilities too.

What is this strategy about?

This strategy will help us plan what needs to change. It will include:

- how things are being done now
- how people feel about things now
- what we need to do in the future to make things better

This strategy is for people in Essex who have:

- a learning disability
- a physical disability including people with brain injury
- a sensory impairment – part or full loss of eyesight and/ or hearing.

This includes 'invisible' disabilities that are not easy for others to see.

The strategy covers people who have more than one disability. It covers people who have autism as well as one of these disabilities or who consider their autism itself to be a disability. The strategy doesn't cover everyone who has autism or neurodivergence as these don't always mean a person has a disability. People with autism might also be interested in our All-age autism strategy, which was developed through the Essex All Age Autism Partnership. People with mental ill health might be interested in the Mental Health Strategy, which will be published later this year.

We recognise that language is important when talking about disability and autism. Different people prefer different terms. For example, some people use the terms 'autistic people' and 'disabled people', 'neurodiverse, autistic or disabled community', 'people with autism' and 'people with disabilities', or others. In this document, we will be using the terms 'people with autism' and 'people with disabilities'.

Some people have support from social care. Other people are not in contact with social care.

We are looking at the things that help people in life. This will include:

- where people live
- who they spend time with
- what they do for work or in their free time
- health services
- social care services

To write this strategy we have spoken with lots of people with disabilities and listened to their experiences and ideas. We have spoken with families and carers. We have spoken with other organisations. We learnt that for a good strategy:

- we need to keep talking and working with people
- we need to be creative and bold
- we need to measure whether we are making things better and how much.

The strategy is for the next 4 years. We can't do everything in 4 years, but we can make a good start.

How does this strategy link to other strategies?

The Disability Strategy will work towards the Everyone's Essex plan: our plan for levelling up the county. The plan has four areas of focus: the economy, the environment, children and families and promoting health, care and wellbeing for everyone who needs support – this last one is a very important part of the strategy.

Our plan for levelling up has a focus on children and adults with learning disabilities. We know that these groups, along with some others, need extra help to access opportunities.

This strategy will work together with other things we have to do and choose to do:

- Equality Act 2010
- Accessible Information Standard 2016
- The Care Act 2014
- Levelling Up Essex 2022
- Essex Mental Health Strategy
- Essex SEND Strategy 2022-2027
- Essex All-age autism strategy 2020-2025
- Essex Carers Strategy 2022
- Essex Ageing Well approach
- Essex Joint Health and Wellbeing Strategy 2022-2026
- Essex County Council Housing Strategy 2021-2025

Why is this strategy important?

There are more people with disabilities living in Essex every year. About 1 in every 6 people in Essex has a long-term health problem or disability.

There are also more people with disabilities who need help every year. This is partly because some people didn't get the help they needed during the pandemic. Other people feel more alone and are less independent since the pandemic.

The number of people with sensory impairment is set to grow from 240,000 (in 2020) to 310,000 (in 2030).

The number of people with learning disabilities who need help from social care will likely go up by 8% by 2030.

Some people get help from social care. Some people get help from other places. We want to make sure everyone gets the help they need. Where we can, we also want to stop people's needs getting worse.

Lots of people with a learning disability tell us that they have enough social contact. Many also say that they can spend time on things they enjoy. But this is not true for everyone. Over 30% of people with physical or sensory needs tell us they don't have enough social contact. Over 40% of people with physical or sensory needs say they cannot do the things they want to do.

It is getting harder to pay for all the things we would like to. It is not clear how much money we will have in the future or what it will need to cover. Because of this we need to spend money carefully.

Adult Social Care in Essex

In Adult Social Care we want to help people and communities to live the best lives they can.

This strategy will help us work towards the things we want to make happen for people. We want people to:

- have friends and have people around them that they love
- be independent and feel good about themselves
- have choice and control over their lives
- be able to work if they choose to
- access meaningful activity
- get the same good health and care service as everyone else
- have a comfortable home
- be involved in their local community
- be safe.

This strategy will also be guided by how we work in Adult Social Care:

- We work together with many different organisations
- We make sure our care and support is right for each individual person
- We do everything we can to support people as close to where they live as we can.
- We are always trying to improve what we do
- We work with you to decide what is needed and what works best.
- We always try to deal with problems as soon as we can before things get worse.

There are some extra things that are important for people with disabilities:

- Individuals should feel their disability is fully understood by the people around them,
- Support should change when needs change.

Section 2

We have talked with lots of people with disabilities. We have learned that:

- people want to have good relationships.
- people want to live somewhere that feels like home.
- people want to stay healthy, well and safe.
- people want to do things that are important to them and their community and that help them to feel part of something. This might include working in a job or learning new things.

We will look at each of these things in more detail. There are links that go between each of them and some ideas that keep coming up in all of them. For example, people want to:

- make choices
- get the care and support they need when they need it
- be seen as they are and for what they can do as well as what they can't
- be treated with respect

Good relationships

What you told us

You told us that you want to grow and keep good relationships in your life. Many people said they like to spend time with people that they get on well with. People want to love and be loved and have people around them who understand them and their disability too.

Sometimes you also need help from other people. You might get help from your family or friends, or from a person whose job it is to help you.

Some people feel left out from the normal things that others do together. You might find it hard to access local places or not know about groups you could join. Some of you do not feel safe going out alone or lack confidence. Because of this you might feel lonely or have difficulties with your health and wellbeing. The COVID-19 pandemic has made this worse for lots of you.

> *"It's really hard to meet up with other people like you. So that makes you feel very isolated and alone. I don't know if there is any groups for disabled people in my local area. And I wouldn't have a clue where to find that information either…"*

> *"I tend to find myself either decline invitations or [say] yeah, yeah, I'd really love to come and then cancel at the last minute, because it's just too much hassle and overwhelming."*

Some people only have a small group of people who are there for them. This means that the carers they need help from have to work very hard.

Carers and support workers don't always understand disabilities. This might mean people don't get support the way they need it. Other people you meet often do not understand disabilities, especially disabilities that are harder to see. Some of you feel judged by others because of this.

> *"People see me in that snapshot in a shop… they think 'what's wrong with her'?...but they don't know I've had to go and lie down for like the rest of the day."*

<u>What else do we know?</u>
People with disabilities are more likely to feel lonely than other people. Over 30% of people with physical or sensory needs told us they do not have enough social contact. Lots of people in society don't understand how certain health problems or disabilities affect people. Some people don't have the right help to be able to communicate with others or to go out to places to meet people.

Lots of people who have help from social care have good conversations with their social worker. They are seen for who they are. But there aren't enough social workers and people sometimes wait a long time to see one. Social workers are busy and can be

rushed. They spend less time face-to-face with people than they used to. This sometimes means they don't have time to help people plan for the future.

We found out lots about what carers need when we spoke with them. This can be seen in the Carers Strategy.

Where do we need to focus?
We will make sure that in the future:

- more people have the chance to love others and be loved
- people feel more a part of their local community
- people feel closer to other people who like the same things they do
- people feel better understood by those around them.

Some people need help to go out, make connections and to see friends. We want to make it easy for people to find and get the help they need to keep up or make new relationships.

We are making changes to how people who work in social care help people. They will:

- understand that everyone deserves to have loving relationships
- help people to stay close to their friends and family
- help people make new friends if they want to
- understand every single person is different. This includes understanding different disabilities and understanding trauma.
- help people with their communication

To do this we will look at how we find the right staff within our services and the services we pay for. We will support staff to have the right skills and to have the time to meet with people face-to-face. We will support all staff to think about the good relationships we need and how we help people find and keep these relationships at different times in our lives. This includes for young people as they come into adulthood.

We will also work with communities. Communities are found in local places like the village or town where you live or where people who enjoy the same things come together. They might include groups of people who meet up to talk about a shared interest or do activities they enjoy together. We will help communities to learn more about disabilities. We will ask them to welcome and include people with disabilities. We want community spaces to be easy to access and feel safe.

We need to listen to and work with people with disabilities more. This will help make sure change makes things better.

A place to feel at home
What you told us

You told us that where you live is important. You want to live in a safe place that feels like home. You need your home to work for you. This means you can move around and do things within your home. It may also mean it is close to transport that you can access and places that you can go out to.

You want to have a choice in where you live. Some people want to live on their own. Most people want to live close to family and friends and feel part of their local area.

The right care and support is important to making your home work for you. Some people have to go a long way from their local area to find the right place to live with the right support. It can also take a long time to find the right place.

> *"We've basically been in that position for the last four years, we've had about four different assessments done. And we're kind of still just stuck in a position where the living conditions aren't brilliant."*

What else do we know?

20% of people with physical or sensory needs tell us that their home does not meet all their needs. There aren't enough of the right places to live for some people with complex needs. There are not enough care workers with the right skills in some areas.

In October 2022, 215 people with learning disabilities were living in out-of-county supported living or residential care. This is too many.

Some people could live more independently than they do now. People don't always have information on what is available.

Services are not always set up to help people to progress.

Where do we need to focus?

We will make sure that in the future:

- more people have their own home if they want this. This might be a private home or in Supported Living. This will help them to be more independent.
- more people have short term help to learn independent living skills. This could be through living with a Shared Lives host. Or it could be another option such as a short term residential services.
- there will be suitable housing options for adults with very complex needs.

To do this we are making changes to how social workers and care staff help people. They will:

- work to help people to be more independent
- focus on what a person can do instead of what they can't
- help people to make choices and plans.

We will also work with the care market to increase the choice of places to live within Essex. We want as many people as possible to have their own front door. We will help to make sure people have the information they need to find the right home for them.

The right technology and equipment can help people to live in their own home or access the community independently. It can also help to keep people safe and reassure families without being too intrusive. We will help to make sure there is enough of this and that it is easy to find.

Staying healthy, safe and well

What you told us

You told us that looking after your health is important. You would like to stay well and be able to get help quickly if you are unwell. You also want to feel safe.

You do not always have the right information to know about what could help you, especially early on in adult life. This makes it hard for you to keep yourself well. Sometimes there is a long wait for services. When you do use services you may have to repeat the same information about yourself lots of times. You may find your preferred methods of communication are not recorded.

You would like to feel more in control of your health and care. Getting an illness or disability can change your life and be difficult to deal with. If you need help with your mental health you need this to be from someone who understands your disability.

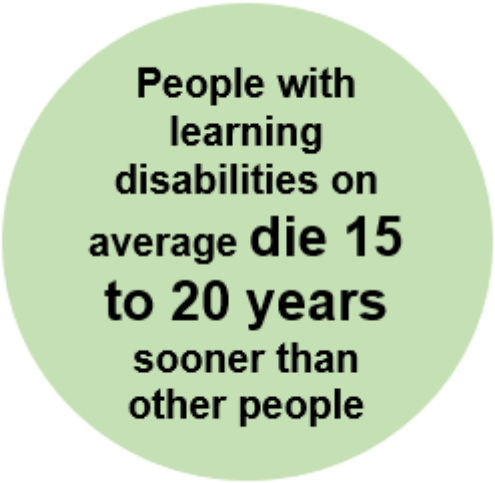
Some people find it hard to plan for the future. Many don't think about how their health might change over time or as they get older. Lots of people are worried about money. Having a disability can come with lots of extra costs. The benefits system can be complicated and stressful to use. Lots of people need extra help with this.

What else do we know?

Over 30% of people with disabilities say they don't feel as safe as they would like.

Disability can be a result of illness. Disability also makes poor health and mental illness more likely.

The number of health checks for people with learning disabilities has been increasing year on year and continues to do so. More people also have a Health Action Plan.



Yet many people with learning disabilities die earlier in life than other people. They are more likely to be unwell with physical or mental illness and not get the right treatment quickly enough.

Poor health and disability increase the need for social care. People often do not plan ahead for changes in their health.

More people feel alone or have had mental illness since the pandemic. The things that help them may have stopped or had delays. Lots of people are finding things hard because of the cost of living.

We know that services like health and social care are not always joined up. Services can be hard to access.

Where do we need to focus?

We will make sure that in the future:

- more people feel that their physical and mental health is good
- more people know how to feel even better
- people have the technology and equipment that helps them to live their lives.
- people can get information and support to help them with their finances

To do this we will work with partners like the NHS to:

- grow skills and awareness around disabilities
- help stop people getting unwell where we can
- diagnose people quickly and make sure their needs are known about
- help people recover their health or increase what they can do after an illness or injury.
- make sure services help people with disabilities to be active and healthy
- give people control over their own health and care records
- help people to plan ahead for changes in health and finances

This will include sharing information, costs and staff to make sure services join up.

To do this, we will take action on things that make it more likely for people to get unwell. For example, where people don't have a job or enough money, or live in poor housing.

We will help people get the information and treatment they need to get well and stay well. This includes young people who are leaving school or college. All services should meet the Accessible Information Standard.

Being active

What you told us

You told us that you like to do things that are important to you and your community. You want to feel part of something. Some of you would like to have a job or keep and develop the jobs you have. Some of you want to learn new things or help other people. You want to play a role in the world around you, spend time with other people and have fun.

However, it can be difficult to find a job or information about what it is like to have a job, the support available and how having a job will impact benefits. There are also barriers in both applying for jobs and getting to work. You might feel limited in the types of jobs you can apply for.

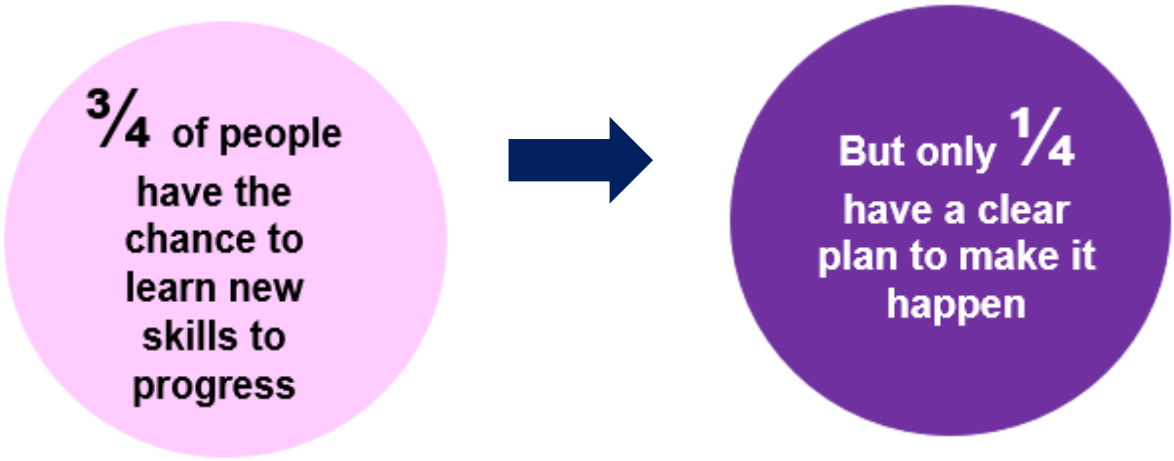
> *"But I'm at the point now where I would like to do something, but trying to get a job, with the conditions I've got and the fact that I'm probably not that reliable…its quite hard to get a job."*

Some people have low confidence in their skills and abilities. Lots of people feel that those around them have low expectations of them.

What else do we know?

People with disabilities are less likely to have a job than other people. If they have a job, they are less likely to be paid for the work that they do.

Lots of people don't understand how certain health problems or disabilities affect people. This can make it harder to work with a disability.



Where do we need to focus?

We will make sure that in the future:

- more people who want to work will be able to work
- people who already work feel supported in their job and able to progress
- people have choice and control over what they do every day

To help more people with disabilities start and stay in a job we will:

- make sure this is part of conversations with social workers and support workers
- include a person's family in conversations about getting and keeping a job
- focus on what people can do instead of what they cannot do.
- talk to businesses about why they should give more paid jobs to people with disabilities, and help them to do this.
- help people to access transport to get to work.

We help young people to get ready for their adult lives. An important part of this for lots of young people is getting ready to get a job and go to work.

For people who can't work right now, we will help them to do other things that are important to them. They might like to go out in their community or visit new places, volunteer or learn a new skill or hobby.

Section 3:

How we will make it happen

We recognise that everyone with a disability has different lives, strengths and ambitions. We will need to do different things for different people to meet our ambitions. The Meaningful Lives Matter project is working towards the four goals in this strategy in the following ways:

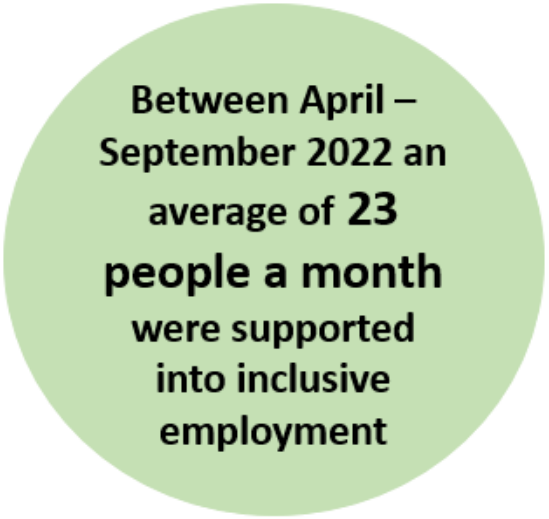
For *good relationships:* Local Linked Support teams are helping people with learning disabilities and/ or autism to build relationships with others. We would like to expand

this kind of support to people with a physical or sensory need. Our “Bfriends” peer support and mentoring service is being piloted. If that goes well we could expand this across Essex.

For *a place to feel home:* We have “Move On Workers” to help adults move to the most suitable home for them. We are looking at developing purpose- built accommodation for people with brain injuries.

For staying healthy, safe and well: We are working with health services to make it easier for people to use services. We want to make sure staff understand, and are well trained to look after people as they get older. We are making changes to the Essex Sensory Service. This is so it will have better advice and guidance and shorter waiting times.

For *being active:* We are working hard to help people get and stay in paid work. We work with local businesses to get them to give paid jobs to people with a learning disability and/or autism. We have one of the biggest inclusive employment services in the country. We are looking at how this service can grow even more. We want to work with care providers to make sure activities help people to learn new skills. We also want activities to connect people to their communities.



We will continue to make these planned changes but also:

- think about the order in which things need to happen and what is most important
- continue to empower people with disabilities and their carers and families to work with us as partners in making sure people get the care and support they need
- keep people up to date on what is happening, using the Meaningful Lives Matter programme
- test new ideas before rolling them out
- spend money carefully and on the right things
- consider how our work can help protect and reduce harm to the environment

We will make sure that other work going on supports this strategy. This includes work around:

- social care practice and workforce

- the different services that are on offer. For example, helping to make more places suitable for people with disabilities to live.
- joining up health and care services. For example, asking health partners to look at how their plans can keep people healthy.
- technology
- data and information

We will think about other ways we can make changes. This could include:

- teaching people to be more aware of disabilities and how to make sure services are easy to access
- working with a range of organisations like the police, job centres, leisure centres and teams that plan new places.
- sharing information with people and communities

The Adult Leadership Team at ECC will oversee what needs to happen in Adult Social Care. This group has directors for different parts of Essex. It also has other senior people from ECC.

How we'll know if it's worked

We will look to talk with people with disabilities about how things are going in their lives. We will also look at data. We want to understand how things are changing. We want to make sure things get better over time.

We will aim to measure things like:

- the number of adults we have helped to move from a residential home to community care. We want this to go up.
- the number of adults who have received a learning disability health check and health action plan from their GP practice. We want this to go up.
- the % of adults who had all their needs met by Local Linked Support. We want this to go up.
- the % change in adults' 'happiness index' after using Local Linked Support. We want this to go up.
- the number of new Shared Lives placements. We want this to go up.
- the number of people living in residential care or supported living outside Essex. We want this to go down.
- the number of people with disabilities who have a paid job. We want this to go up.
- the % of people with disabilities who live in a care home. We want this to go down.
- the % of people who have help from social care who are moving towards their personal goals. We want this to go up.
- the % of people who have help from social care who have three or more 'good' relationships in their life. We want this to go up.

Where we can, we will look at how things are changing in different parts of Essex. We will also look at how things are changing for people of different race, gender, and sexual orientation. This is because we want things to get better for everyone. We want the change to be fair.

The budget

Essex has £835m in the budget to spend over the next 3 years on services that support adults with a physical, sensory or learning disability and/ or autism. There is also £45m to support young adults aged 18-25 within the Transitions service, and £15m for in-house services such as Shared Lives, Short Breaks respite care and Short-Term Enablement.

Within the context of financial constraints, increasing demand, pandemic recovery and closer working with health partners, adults with disabilities are a priority for Essex County Council.

A key part of this strategy will be delivering good outcomes efficiently within the financial resource available against rising demand.

Any investments needed to support the action plan to deliver the strategy will be subject to a separate decision.

Disability Strategy Engagement and Consultation findings

March 2023

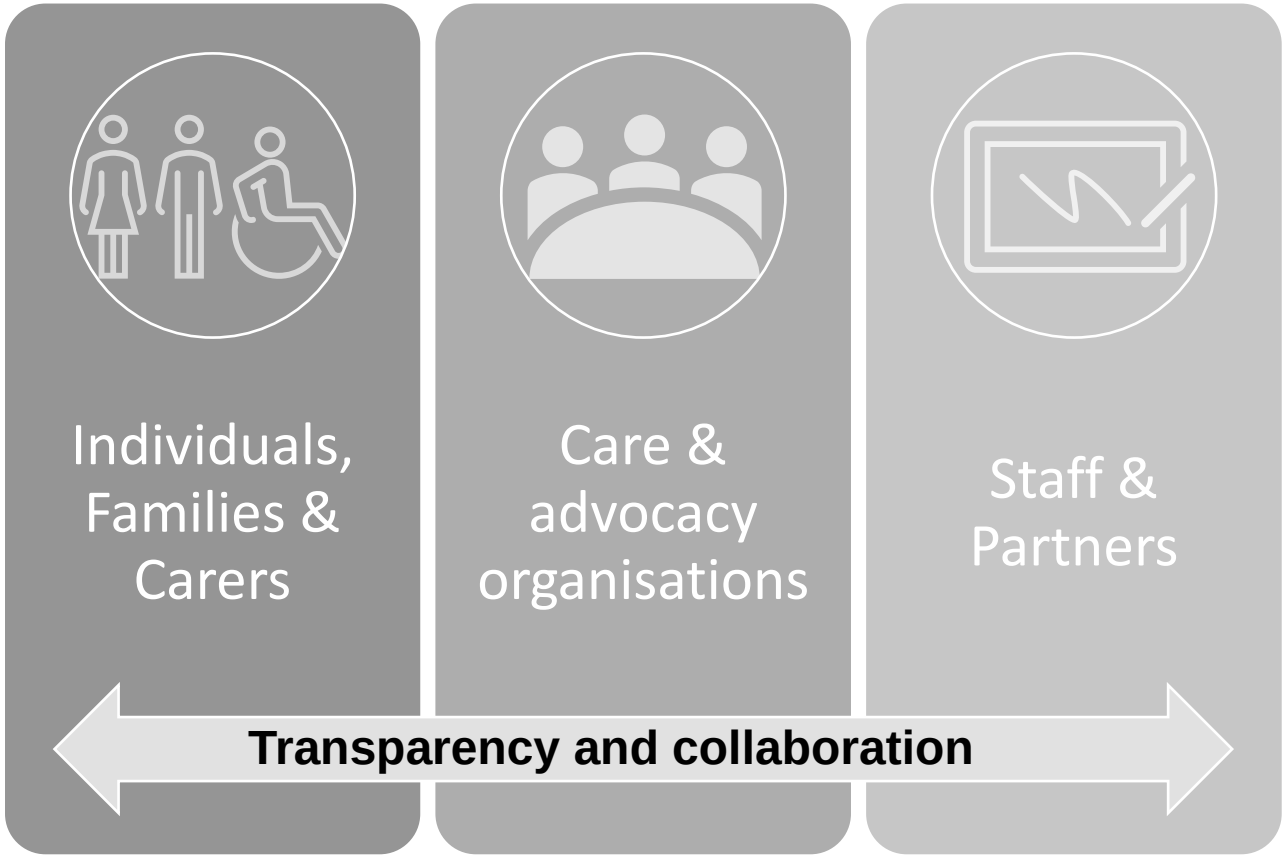
Essex County Council

What is this engagement report?

During the process of creating Essex County Council's new Disability Strategy, we have conducted various forms of engagement and consultation with adults, partners, staff, and providers. This has included one-to-one interviews conducted by QA Research, an independent research organisation, as well as forums, formal & informal meetings, and various surveys.

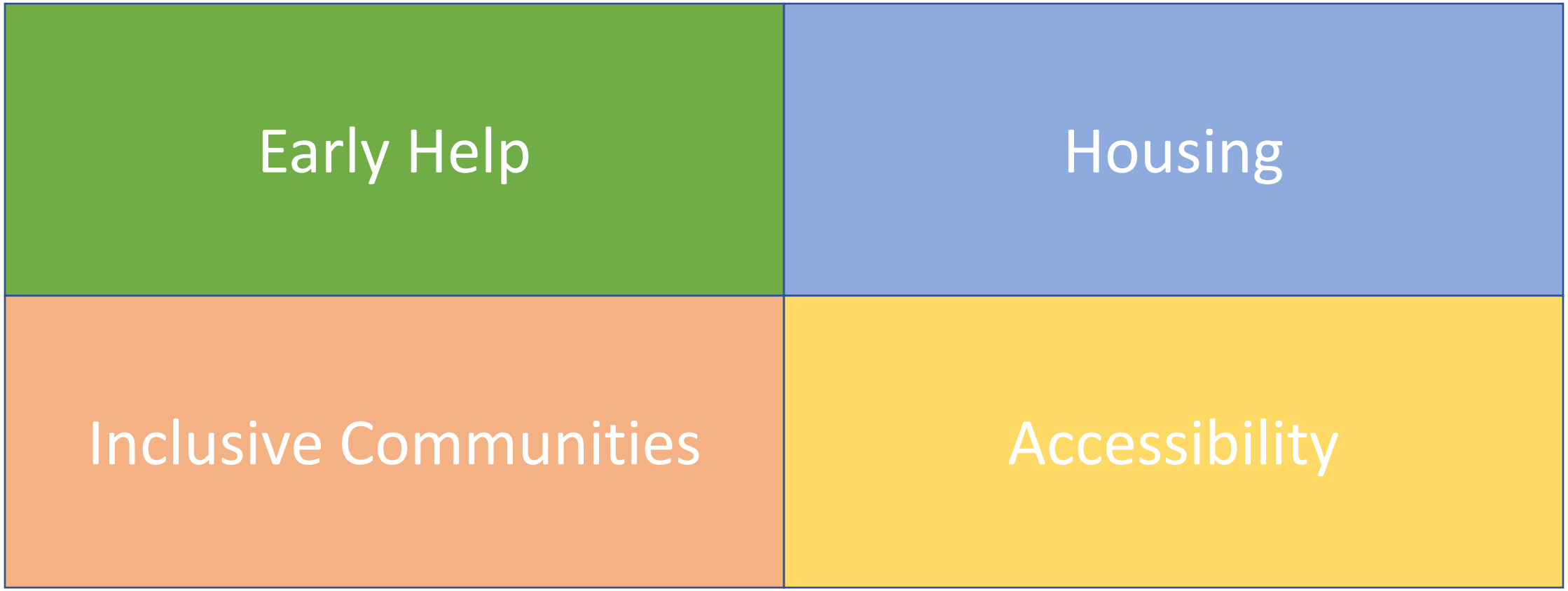
This was with the aim of capturing key themes regarding what is important to include within the strategy and the workings behind it. An important part of the creation of a strategy to ensure it meets the requirements and needs of those who it will impact the most.

This pack documents the findings and also helps to show how the key themes of our engagement have gone on to help shape the strategy.



Engagement Feedback

Engagement Priorities



Engagement Feedback

Early Help

I am not getting help early enough – Work for Change

Adults with lived experience were sent a questionnaire and took part in a two-day workshop to establish what needed prioritising to shape the future of our sensory service..

One key theme that came out was that adults felt they were not receiving support early enough. Also, that they were in need of extra and on-going support.

Housing

People want to feel safe in their home – Collaborate Essex

Our work with Collaborate Essex helped to show the importance of housing for residents and how it ties in to other key topics such as choice & control, being a part of a community, and accessibility.

Similarly, the QA research revealed that respondents were concerned that housing was a real concern for people and made them anxious about the future.

Engagement Feedback

Inclusive Communities

[Adults] want inclusion within communities and social networks – Provider Survey

Being a part of a community helps adults to feel accepted and allows them to more easily find meaningful activity.

A well developed community can also offer additional support to adults. The QA research showed that some adults were already providing informal support to other people with disabilities in their community.

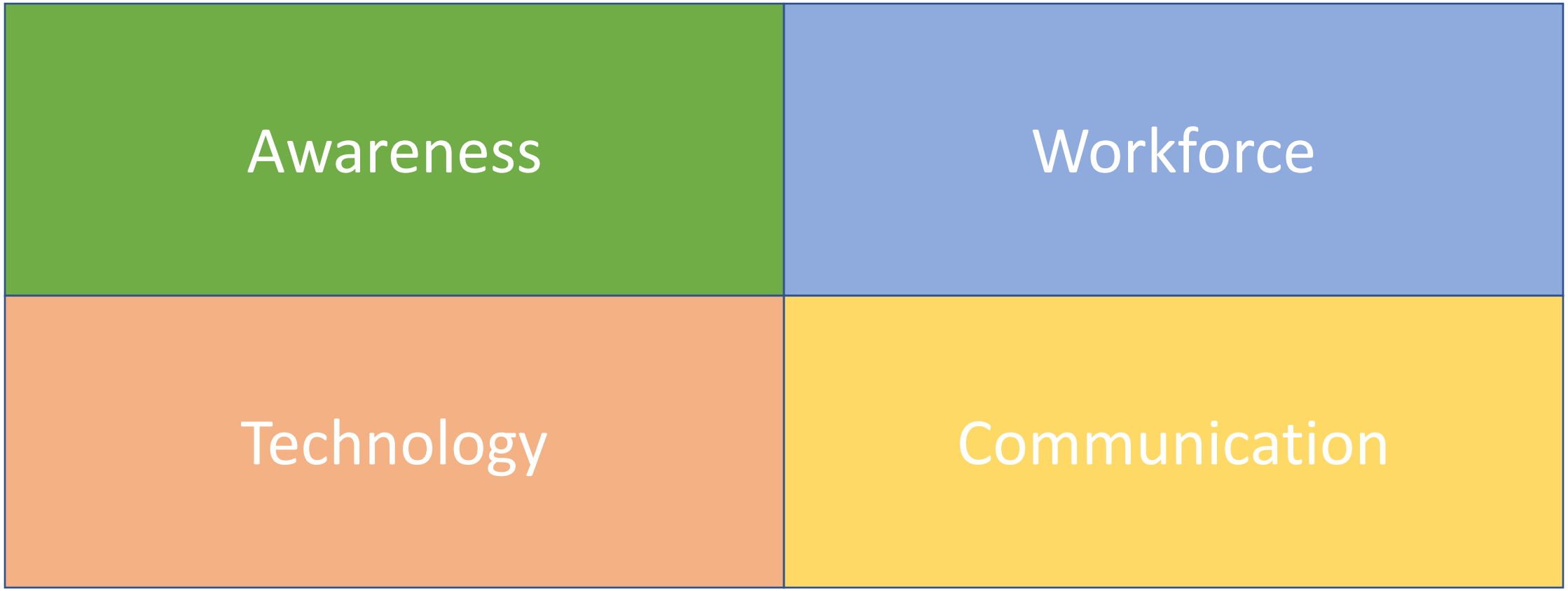
Accessibility

A significant challenge to people living with disabilities are inaccessible services – Provider Survey

Within the provider survey multiple respondents flagged the challenges faced by people living with disabilities due to issues around the accessibility of services.

There was also a desire to maintain a balance across services. Whilst some new innovations, such as online services, may be a positive for others they are not appropriate.

Engagement Priorities pt.2



Engagement Feedback

Awareness

There is a gap in knowledge of bus drivers around disabilities and reasonable adjustments – ECC Staff 121

Whilst bus drivers were provided as a specific example within the feedback from staff, the idea that the awareness of symptoms and how to make reasonable adjustments are key factors that could be more widely applied. For example, from the QA research:

""I will walk in places, and sometimes people don't know what to do with me, They either go over the top or just don't just don't want to come talk to me."

It was also brought up in the provider survey that the lack of awareness can be a challenge to people living with disabilities.

Workforce

How would this affect specialist social worker roles which have declined over the years? - ECC Staff

Those who engaged in our processes have been keen to understand how the changes will impact staff roles.

There was also a desire to "focus on joint working". Providers in particular saw collaborative working as a way of achieving better outcomes.

Engagement Feedback

Technology

What is the role of technology in supporting the strategy?

Some of the participants in our engagement have been digitally confident, others less so.

Whilst we need to ensure we have a good digital offer, there needs to be multiple routes of communication that people can use to contact us.

Participants of the QA research spoke about how difficult they found it to fill in complicated forms in general, and sometimes this was more difficult if the form was online.

Communication

Inaccessible communications delay or prevent people getting support – Provider Survey

The importance of communication was repeatedly highlighted throughout engagement. It not only helps with awareness and helping adults feel accepted, but it makes it more likely that they have good outcomes and their support isn't delayed.

Good communication early on can also help to alleviate concerns the adult may have about the future.

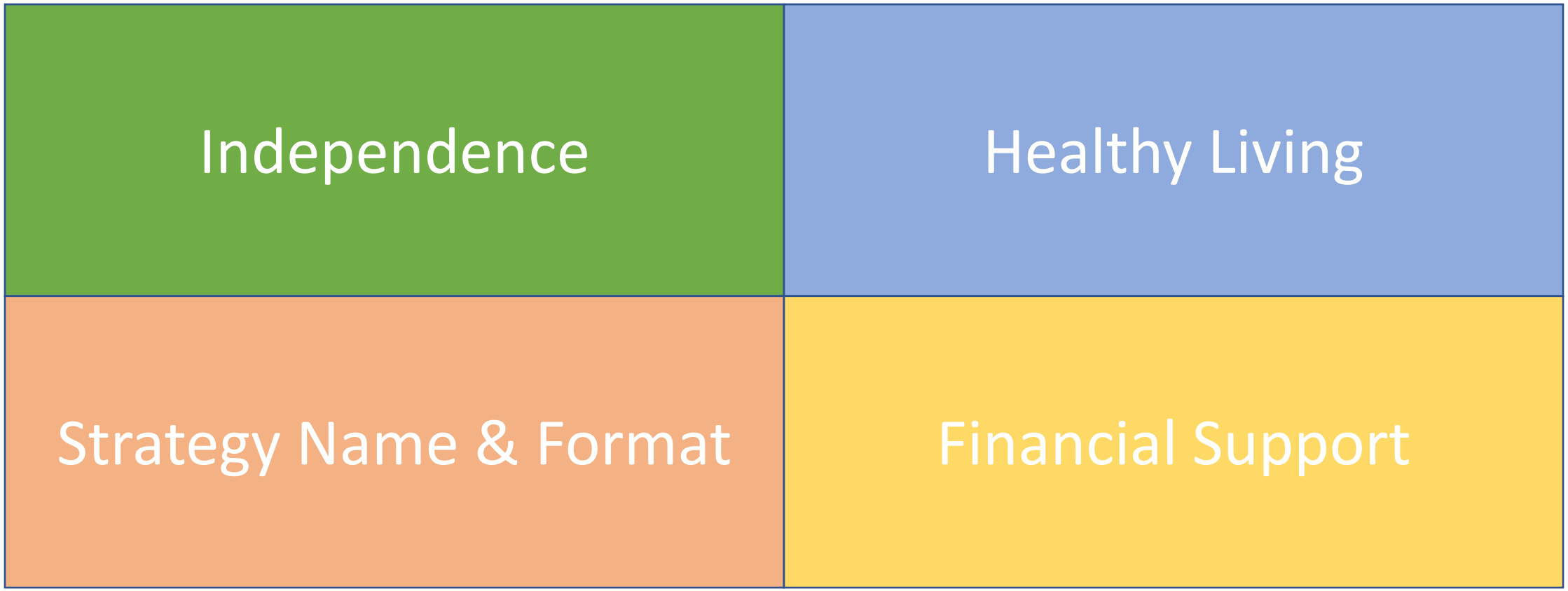
Initial Feedback

Below are just some of the ways that our initial engagement has helped to form the first draft of the Disability Strategy:

We have included people with autism in the strategy	During initial engagement it has become clear that adults with autism feel they should be included in the strategy in some way, complimenting the already existing Autism Strategy. As such people who have autism as well as another disability are included in this work.
We are focusing on the housing market	You told us that where you live is important. You want to live in a safe place that feels like home. You need your home to work for you. Therefore, we have committed to make improvements to the housing market for adults with disabilities to help people have their own home if they want it.
We want people to find the help they need to keep or make new relationships	You told us that you want to grow and keep good relationships in your life. We will support all staff to think about the good relationships we need and how we help other people connect. We will also work with communities to welcome and include people with disabilities.

Further Engagement

QA Research: Priorities



QA Research: Feedback

Independence

The need for independence was paramount for participants – QA Research

A key response across various engagement routes was the need for independence.

This branches across many topics as areas such as good housing, inclusive communities, communication, and meaningful activity can all help to provide a person with independence.

Healthy Living

Participants noted that they are not able to access as many health services as they used to- QA Research

Respondents of the QA research highlighted that due to financial cutbacks they have been unable to access certain health services, such as podiatry services and hydrotherapy.

For adults to lead healthy lives they require accessible services that are able to match the needs of the adult.

QA Research: Feedback

Strategy Name & Format

Maybe more on the positive side of what can we do for you rather than disability strategy? – QA Research

Whilst some respondents to the QA research were fine with the use of "Disability Strategy" there were others who flagged concerns.

One adult stated that "strategy" makes it sound like a "game" and felt that "plan" might be simpler.

Some participants did not necessarily identify with the term 'disabled' and thought others might have similar views, or felt that hidden disabilities might not be covered by this term.

Financial Support

It feels like begging… absolute hell, I feel like Oliver with his begging bowl… It's a really awful service – QA Research

The topic of income and financial support caused respondents to the research the most stress.

Participants found the benefits system very stressful. Processes are complicated and people do not feel they are treated as an individual or with much dignity. Assessment processes were perceived as being designed to see people at a snapshot in time, without a holistic picture of their needs.

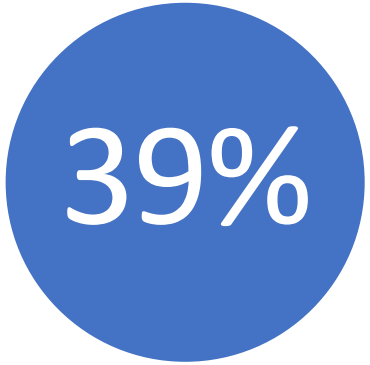
This will be exacerbated by the cost-of-living crisis.

Consultation

We have sought to make our consultation as accessible as possible with various alternative formats and ways to participate. These include easy-read, large print, and audio versions of strategy, as well as options to participate by telephone or face-to-face at a drop-in. The main topic that has been fed back to us that is missing is **financial support**.

We held **8** events at 4 different locations in Essex, including Colchester, Basildon and Harlow, and online.

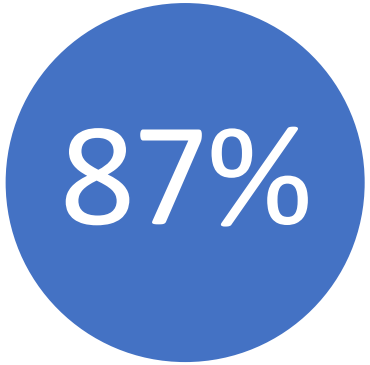
95% of respondents either “strongly agree” or “mostly agree” that our areas of focus in the strategy are correct.



Roughly **39%** of respondents to the consultation either have, or support someone with, a learning disability and autism.

80% of respondents strongly agreed that to have good relationships social care staff need to understand that every single person is different

We have received **169** online responses to the consultation & **44** people have joined focus group meetings



Roughly **87%** of respondents were white-British and roughly **75%** were female.

Consultation Feedback

Below are just some of the ways that our engagement throughout the consultation period has helped to form the newest draft of the Disability Strategy:

We have included young people & transitions	During our engagement with focus groups you told us that work on transition planning should be an area of focus. This is something we have taken on board and have included in within the Strategy.
We have included financial support and financial wellbeing	It has become clear that one of the key requests for support has been on the matter of financial support and financial wellbeing. We are including financial support and financial wellbeing within the “Keeping Well” section of the strategy

Autism

Involving Autism

It was clear from our engagement with autistic adults and other stakeholders that there was a desire for adults with autism to be included in the strategy in some way.

Have autistic people steering the strategy. – PACT & Adult support groups

One individual at an autism networking event felt "incredibly strongly" that autism should be included – Autistic adult employed by a local charity

Autism should be included in the strategy – Sister of a service user with autism

"I don't [recognise myself as having a disability], but I do recognise that I have struggles that other people don't. So although I initially don't, maybe I do". – Quote from an autistic female

The world makes it a disability. – PACT & Adult support groups

The reality for many autistic people is that some aspects can be incredibly disabling. – Connecting Without Limits

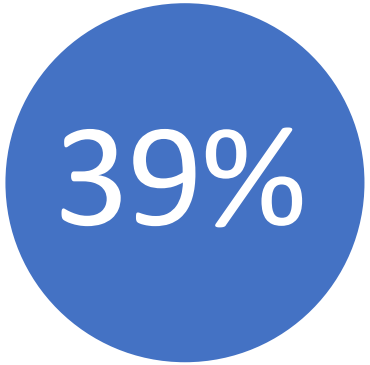
Communicating Autism

When it comes to communication, there are two main areas of work that are highlighted, lack of communication and wrong communication or narrow communication.

There is a lack of communication	*"Feels that autism is a disability and that if there was more awareness and knowledge he may have received better support at a younger age …'*	A lack of communication and availability of information in early years can lead to people at a later age habituating themselves to behaviours that exasperates struggles incrementally. Lack of communication is not just centred around the unavailability of information, it is centred around inability to communicate the information that is available at the right time and in the right way.
We provide the wrong communication	'… *whilst some people may wish to focus on the gifts of Autism, the reality for many autistic people is that some aspects can be incredibly disabling, such as sensory issues, social anxiety, relationships, mental health etc*	Within wrong communication, the main theme that has come about is the overemphasis on the positive aspects of Autism, or as one adult quoted it the 'gifts of autism'. Another danger of wrong communication of the positive aspects is not considering high functioning autistic individuals as having disability. The communication needs to be inclusive of all aspects.

Consultation & Autism

72% of online respondents agreed that our initial approach to including autism in the strategy was the correct thing to do. However, **27%** disagreed with this, meaning it is not a unanimous decision.



Of the online respondents who identify as having a disability, **39%** of them stated to have a learning disability & autism.

We initially included autism on the basis that if an individual has autism and another disability, then they would be included within the strategy.

In our engagement throughout the process we have heard conflicting views on the inclusion of autism within the strategy. We have since taken onboard the feedback and, whilst recognising that not everybody feels that autism is a disability, there are those who do feel disabled by their autism. As such, we recognise the need to define it on an individual basis. For some people autism will be disabling and they are included within our strategy.

Annex

Provider Engagement

- Essex care market provider forums
- Survey of Essex care providers
- PI Partnership Group
- Sensory Community Partners
- Autism Wider Network
- Autism networking event
- A family perspective

Residents Engagement

- Working Together For Change – Survey of adults with lived experience
- Family and carers engagement survey
- Healthwatch/Collaborate Essex
- Sensory Strategic Partnership Group
- Physical Impairment Steering Group
- Support4Sight focus groups
- Sport for Confidence focus groups
- Local Linked Support drop-ins
- Essex Carers Network focus group

Staff & Partner Engagement

- Essex County Council staff one-to-ones
- Essex County Council staff forums
- LD&A Ops Meeting
- Countywide Practice Forum
- PSI managers meeting
- Strategic Partnership Group
- Disabilities commissioning meeting
- PSI South – Pre forum
- LD/PSI Forum
- Health Inequalities meeting
- South East alliance meeting
- Southend Council meeting
- Thurrock Council meeting
- B&B alliance meeting
- Adults Leadership Team
- Meetings with quadrants

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MSE Integrated Care Partnership, 20 March 2023

Agenda Number: 14

Approach to Health Inequalities

Summary Report

1. Purpose of Report

To provide the Integrated Care Partnership with an overview of the approach to Health Inequalities in Mid and South Essex

2. Executive Lead

- **Name:** Jeff Banks
- **Job Title:** Director of Strategic Partnerships
- **Organisation:** NHS Mid and South Essex

3. Report Author

- **Name:** Emma Timpson / Sophia Morris
- **Job Title:** Associate Director Health Inequalities & Prevention / Clinical Lead Health Inequalities
- **Organisation:** NHS Mid and South Essex

4. Responsible Committees

Population Health Improvement Board (PHIB) oversees the Health Inequalities programme.

5. Financial Implications

Health inequalities funding of £3.4m in 2022/23 has been allocated to support innovative partnership solutions to address health inequalities across the four Alliances within Mid and South Essex. Discussions are underway with regards to the allocation of an ICB budget for 2023/24 (TBC) including leverage targets for securing additional resources.

6. Details of patient or public engagement or consultation

Extensive engagement was undertaken as part of the development of the MSE ICP Strategy that identifies the common endeavour to ‘Reduce Inequalities Together’.

7. Conflicts of Interest

None identified

8. Recommendation/s

The Integrated Care Partnership is asked to support the approach outlined to reduce health inequalities.

Mid and South Essex Integrated Care System

NHS
Mid and South Essex

Approach to Health Inequalities – Presentation from Population Health Improvement Board (PHIB)

Mid and South Essex Integrated Care Partnership Board
20 March 2023


Integrated Care Partnership
The shape of our Partnership
Ways of Working
Broad & inclusive membership
Engagement with residents & partners
Space & time for relationship building
Equal value of all in the partnership
System, places, neighbourhoods
Sovereignty of each organisation
Workforce Recruitment Retention and Development
System Priorities
Community Priorities
Partner Priorities
Access
Involvement
Wider Determinants
Babies, Children & Young People
Adult Care
Common Endeavour Reducing Inequalities Together
CORE20 PLUS5
Awareness
Openness
Responsibility
Connected Care
System Pressures
Digital, Data and Shared Records
Early Intervention and Prevention
Agreeing shared objectives
Regular review and refinement
Innovation, learning and quality
Joint working
Use of resources
Refined services & pathways
Shared Goals & Learning
Acting Together

MSE ICS commits to reducing health inequalities guided by the following principles

Reducing inequalities is everyone's business, it is the core driver for all that we do. To reduce inequalities, we will ensure that achieving health equity is the "golden thread" through all transformation programs. All transformation plans will need to demonstrate mitigation to creating or exacerbating inequalities.

Proportionate universalism approaches to how we invest in our services and design interventions. In our focus on health equity the ICS will distribute resources proportionately to the needs of those experiencing inequalities. Addressing inequalities within MSE will be driven by a financial strategy to invest resources which deliver long term impact. This will include investing in those areas under-served and most affected by the inverse care law, prioritising different levels of investment and service to adequately take account of differences in need between different populations.

Tackling the wider determinants of health will be a key focus in reducing inequalities. We will focus particularly on our 20% most deprived areas and those population groups which have are at highest risk of experiencing poor access to care, experience of health services and have worst health outcomes

Take a life course approach will be taken to put into place sustainable interventions across the life course to reduce the effect of social inequality.

Place the voices of our communities and residents particularly those at risk of experiencing inequalities at the centre of how we design and implement services. We will devolve resources to place and locality level to invest in community infrastructure to have a continuous conversation with residents. Assets based approach to co-designing and co-productions of solutions tailored to communities' identified needs .

Preventative interventions to improve health outcomes will have a targeted approach driven by an understanding of the needs of those mostly likely to experience inequalities

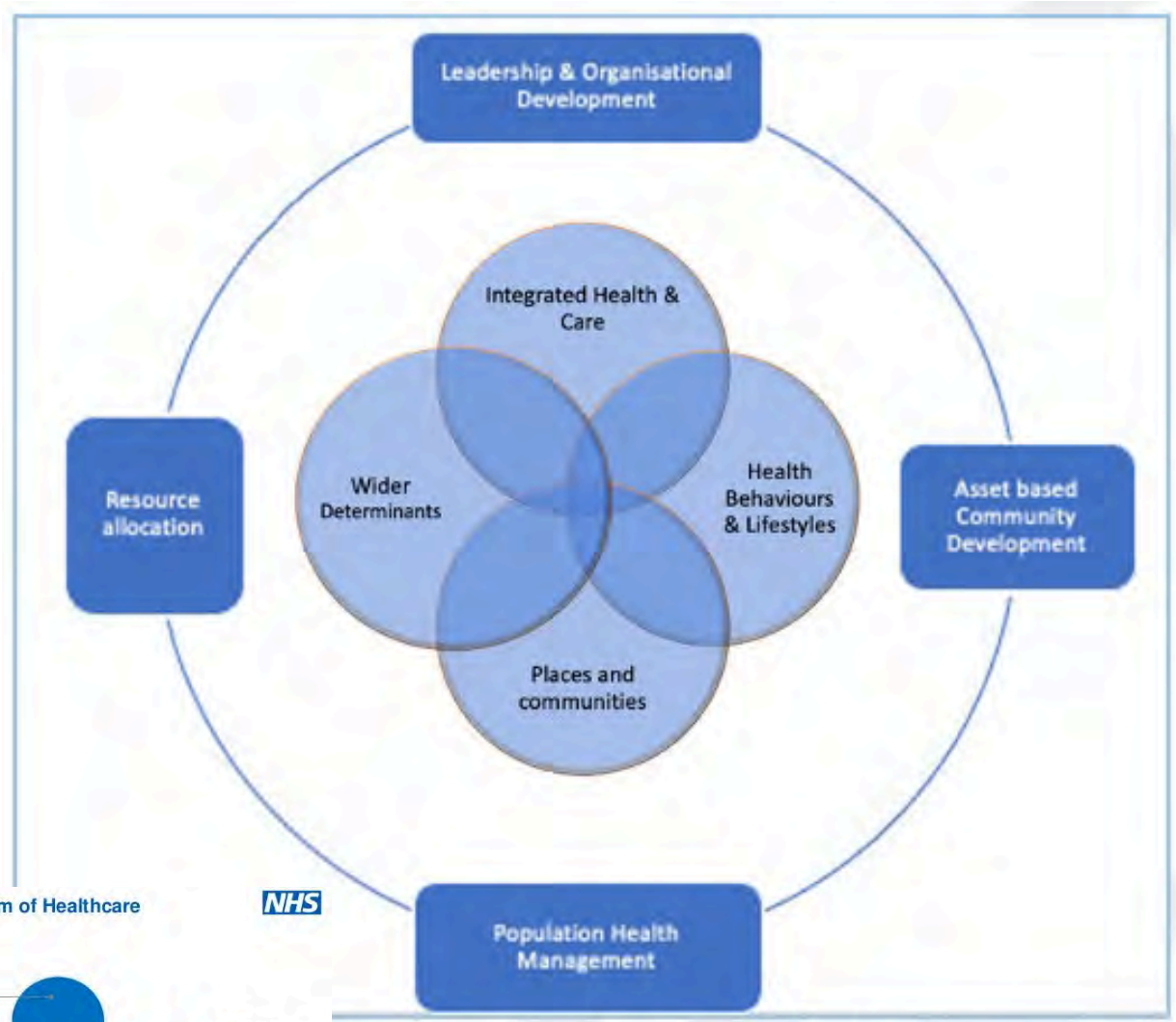
Use a Population Health Approach to plan and deliver health & care services which focuses on proactive care and considers wider determinants of health. Where appropriate population health management approaches informed by local intelligence will be adopted as a tool to enhance improvements.

Act as anchor institutions We will use our position as anchor institutes to invest back into our communities. By teaming up with health and care partners, local councils and the voluntary and education sector, we can reduce our environmental impact and create exciting and innovative employment opportunities for those we serve.

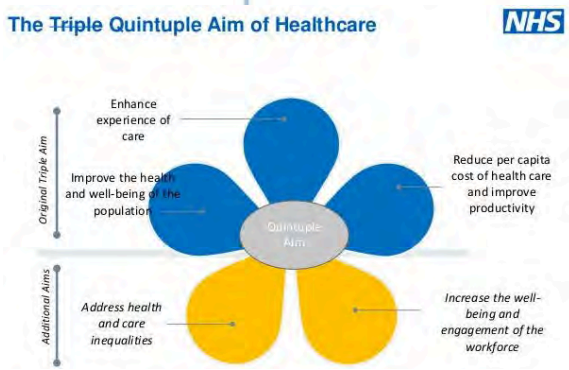
Place based action to reducing inequalities will see that the most transformational action to reduce inequalities will be delivered at a place and neighbourhood level. *S*ubsidiarity - devolving planning and delivery to the lowest possible level.

POPULATION HEALTH IMPROVEMENT FRAMEWORK

- Our actions to addressing inequalities will be guided by our ambition to improve population health outcomes by addressing the drivers of health inequalities.
- Using a population health framework, we will focus on delivering integrated care which goes further than treating ill health, moving towards a proactive preventative model of care which addresses the causes of poor health outcomes and the wider socioeconomic determinants of health.
- The expected outcome will be that we will reduce the impact of inequalities for our residents leading to a reduction in the life expectancy gap and our residents will enjoy longer, healthier lives in thriving connected communities.



Population Health Improvement Framework (outer circle illustrates enablers)



MSE Population Health Improvement Framework Objectives

INTERGRATED HEALTH & CARE SERVICES

Ensuring equitable access, excellent experience and optimal outcomes for all by addressing unwarranted variations in our services and moving towards a joined-up health & care system

- Embedding comprehensive use of equality impact assessments (EQIA)
- Focus on co-designing of services with residents with an effort to engage those from vulnerable groups.
- Restore services inclusively to ensure at risks groups are not further disadvantaged.
- Proactive health management for groups at greatest risk of poor health outcomes prioritising a focus on identifying those at risk or in earlier stages of illness.
- Maturing the adoption of the model of personalised care
- Reducing inequalities in outcomes of Core 20 five clinical areas

HEALTH BEHAVIOURS & LIFESTYLES

Delivering evidence-based prevention programs with a focus on those experiencing inequalities and supporting residents to make informed choice to adopt healthier lifestyles

- Supporting residents to make informed choices by providing the knowledge, skills and confidence to lead healthy lifestyles and self-care.
- Services and interventions will consider the impact of wider determinants of health on an individual's ability and capacity to adopt health behaviours which minimise risk factors, their vulnerability to worsening health and adopting self-care strategies.
- Embedding a Make Every Contact Count approach across all clinical pathways and settings.
- Patient activation identified to be developed as an effective tool to support individual's knowledge, skill, and confidence to adopt positive health behaviours and self care.

PLACES & COMMUNITIES

Working closely with our partners to create healthier places, build community resilience and promote community connectedness

- Using local data (JSNAs, PHM) and community insight to understand the social and health needs of local communities
- Identify where improvements within the built, natural and social environments will realise meaningful health and wellbeing gains.
- Consider how interventions at place will add value by simultaneously improving population health and strengthen community bonds.
- Proactively work with partners to identify opportunities such as redevelopments to place integrated health services closer to communities.

WIDER DETERMINANTS

Our collaborative action will focus on improving social, economic and environmental drivers of inequalities

- Upstream action to foster strategies which promotes a "Health In all Our Policies" approach which aims to prevent socioeconomic inequalities thus improving health and wellbeing.
- Using our position as Anchor Institutes to support socioeconomic development
- Further social value creation to through a considered approach in how the procurement of services has wider benefits on the social determinants of health.

System Delivery of Inequalities Improvement

Neighbourhood

Proactive integrated person centred care to support residents to improve their health & wellbeing

Multidisciplinary workforce - joint working across all sectors

Innovative approaches to support improved health & well-being outcomes - MECC

Workforce skills development (e.g. social prescribing, shared decision making, self care)

Subsidiarity

Place/Alliance

Place plans defining measurable action plans to address inequalities

Integrated care approach - working across Primary, secondary and community care

Collaborative place plan informed by an understanding of local population needs with transparent accountability arrangement

Strengthened community engagement and co-production with a focus on those groups most at risk of experiencing inequalities

Subsidiarity

System

Oversight & Assurance – including monitoring and evaluation

Support cross organisational development towards an equitable health and care partnership

Define a financial strategic plan which outlines investment to addressing inequalities

Co-ordination of system wide health improvement programmes

Increase system capacity to address inequalities (1) Resource allocation (2) Workforce capacity (3) Digital

Healthcare inequalities - an NHS England priority

Published on 23rd December 2022, includes three key priorities for ICBs:

1: Recover our core services and productivity

2: Make progress against LTP ambitions

3: Continue transforming the NHS for the future

Five strategic priorities:

1: Restore NHS services inclusively

2: Mitigate against digital exclusion

3: Ensure datasets are complete and timely

4: Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes

5: Strengthen leadership and accountability

Section 2c: Embedding measures to improve health and reduce inequalities

*excerpt only for illustrative purposes

Key actions

- Continue to d**eliver against the five strategic priorities** for tackling health inequalities and:
  - take a **quality improvement approach t**o addressing health inequalities and reflect the **Core20PLUS5 approach** in plans
  - consider the specific needs of **children and young people and reflect the Core20PLUS5** – an approach to reducing health inequalities for children and young people in plans
  - establish **High Intensity Use (HIU) services** to support demand management in UEC.
- Funding is provided through core ICB allocations to support the delivery of system plans developed with public health, local authority, VCSE and other partners. The formula includes an **adjustment to weight resources to areas with higher avoidable mortality and the £200m of additional funding allocated for health inequalities** in 2022/23 is also **being made recurrent in 2023/24.**

Reducing Inequalities

Our Vision

"Everyone living in Mid and South Essex has the same opportunity to lead a healthy life, no matter where they live or who they are. We want to increase healthy life expectancy, allowing people to live longer, happier and healthier lives, promoting prevention of ill health, independence and personalised care"

Enablers

- System Oversight
- Financial Capacity
- Population Intelligence & Insight
- Engagement & Co-production
- Organisational development

Priority Areas - Core20PLUS5 Framework for Delivery

Clinical Priorities (CYP)

Asthma,
Oral health,
Epilepsy,
Mental health,
Diabetes

Clinical Priorities (Adult)

Respiratory,
Maternity,
Cancer,
Mental Health,
CVD

System Priorities (CYP)

Obesity,
Infant mortality,
Speech and language,
Immunisation & vaccination,
Learning Disability,
SEND
Autism

System Priorities (Adults)

Core20 (Deprivation),
PLUS Groups*,
Obesity,
Tobacco dependency

REDUCING HEALTHCARE INEQUALITIES

The **Core20PLUS5** approach is designed to support Integrated Care Systems to drive targeted action in healthcare inequalities improvement

CORE20
The most deprived **20%** of the national population as identified by the Index of Multiple Deprivation

Target population

CORE20 PLUS 5

PLUS
ICS-chosen population groups experiencing poorer-than-average health access, experience and/or outcomes, who may not be captured within the Core20 alone and would benefit from a tailored healthcare approach e.g. inclusion health groups

Key clinical areas of health inequalities

1. **MATERNITY**
ensuring continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups

2. **SEVERE MENTAL ILLNESS (SMI)**
ensuring annual health checks for **60%** of those living with SMI (bringing SMI in line with the success seen in Learning Disabilities)

3. **CHRONIC RESPIRATORY DISEASE**
a clear focus on Chronic Obstructive Pulmonary Disease (COPD), driving up uptake of Covid, Flu and Pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations

4. **EARLY CANCER DIAGNOSIS**
75% of cases diagnosed at stage 1 or 2 by 2028

5. **HYPERTENSION CASE-FINDING**
and optimal management and lipid optimal management

SMOKING CESSATION
positively impacts all 5 key clinical areas

REDUCING HEALTHCARE INEQUALITIES FOR CHILDREN AND YOUNG PEOPLE

NHS

CORE20
The most deprived **20%** of the national population as identified by the Index of Multiple Deprivation

The **Core20PLUS5** approach is designed to support Integrated Care Systems to drive targeted action in healthcare inequalities improvement

Target population

CORE20 PLUS 5

PLUS
ICS-chosen population groups experiencing poorer-than-average health access, experience and/or outcomes, who may not be captured within the Core20 alone and would benefit from a tailored healthcare approach e.g. inclusion health groups

Key clinical areas of health inequalities

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 in the most deprived quintiles and from ethnic minority backgrounds & increase proportion of children and young people with Type 2 diabetes receiving annual health checks

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**
Address the backlog for tooth extractions in hospital for under 10s

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

Examples of work happening across Mid and South Essex

Core20% Most deprived communities

Examples

- MSE Anchor programme has brought together MSEFT with South Essex Community Hub (SECH) and other partners to support people living in some of the most deprived areas of Southend to secure quality work at Southend Hospital or in another local health or care organisation.
- Core20plus Connectors programme' focusing on COPD and working within the six most deprived wards in Southend. The project involves collecting local knowledge, offering patients support, engaging with decision-makers and co-designing services.
- Utilising the 'Outreach bus' 'to visit the deprived areas within Canvey to increase hypertension case finding, cancer screening and vaccination uptake, health and wellbeing advice and onward referral thus increasing contact with appropriate services and alleviating loneliness and increasing wellbeing

PLUS groups

Examples

- 'Southend Integrated care for Homeless' brings together the NHS, Southend-on-Sea Borough Council, food banks, soup kitchens, hostels, outreach teams, hospital, mental health and substance misuse providers to deliver an integrated health service to those experiencing homelessness.
- 'Improving access to health services for Thurrock's Gypsy, Roma, Traveller and Showman communities' by establishing a monthly programme of visits to each of the key sites in order to a) introduce key services to the community, b) deliver some preventative health interventions, and c) facilitate subsequent registration with a GP practice.
- MSE ICS working with National Institute for Health and Care Research, lead by Uni of Essex establishing Community of Practice for improvements with Gypsy, Roma and Traveller population groups.
- Support When it Matters (SWIM) commissioned to undertake deep dive with BAME communities in SE Essex on their mental health needs.

Progress against 5 strategic priorities

Waiting list analysis completed by ethnicity, sex and deprivation

- Action plans developed to reduce barriers to equitable access
- An Equality Health Impact Assessment for elective recovery will be finalised by the end of 2022/23 that reviews data and evidence and sets out the mitigating actions required to reduce disparities in access and outcomes

Mitigate against digital exclusion

- Digital inclusion framework developed
- Maintaining access to face to face consultations
- Examples being undertaken across Partnership; Superfast Essex, digital buddies, digital champions and spreading across NHS settings such as care homes, utilising Cardmedic to support access of health literature and translation where English is not first language

Ensure datasets are complete and timely

- Promote recording of ethnicity and protected characteristics through “My Health Matters” with residents of the need to maintain updated patient records
- Ethnicity recording is now in excess of 80% across primary care, community services and acute hospitals.
- In 2022/23 we saw a 10% improvement in the data completeness of recording of ethnicity in primary care following some targeted work to improve data collection.

Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes

- ***Maternity***. Recruitment continues to support the continuity of carer programme with 47 WTE midwives appointed in Q3 2022/23 and 10 of 12 funded internationally recruited midwives will be in post by end of March 2023.
- ***SMI Health checks.*** There has been improvement from 54% to 60% of people with Severe Mental Illness within MSE having their annual health check. However, we want to improve the uptake of the health check and subsequent interventions further so during 2023/24 we will be working with the Institute of Healthcare Improvement as one of 7 ICS Core20Plus accelerator sites.
- ***Chronic Respiratory Disease***. We continue to utilise the roving van and bus to reach out into communities where uptake is lower to promote the uptake of Flu and Covid vaccinations along with other health promotion and prevention initiatives such as the integrated breathlessness pathway.
- ***Early Cancer Diagnosis***. PCNs receive data by deprivation and includes protected groups including patients with LD, BAME patients, patients with SMI. Opportunities for improvement in uptake are identified, support provided and information on best practice shared including tailored communication packages. Thurrock Lung Health Checks pilot was completed in 2022/23 for all GP practices. This resulted in the detection of 22 Lung cancers of which 12 were stage one or two and nine other cancers were found.
- ***Hypertension***. MSE ICS was a national trailblazer pilot to BP@Home supporting residents improve their health outcomes through self-monitoring their blood pressure at home. Currently over 62,000 residents are participating in the program. The Integrated Breathlessness and Diagnostic service utilises the outreach van to undertake BP and ECG observations, referring to the relevant services and providing lifestyle advice and guidance / signposting.

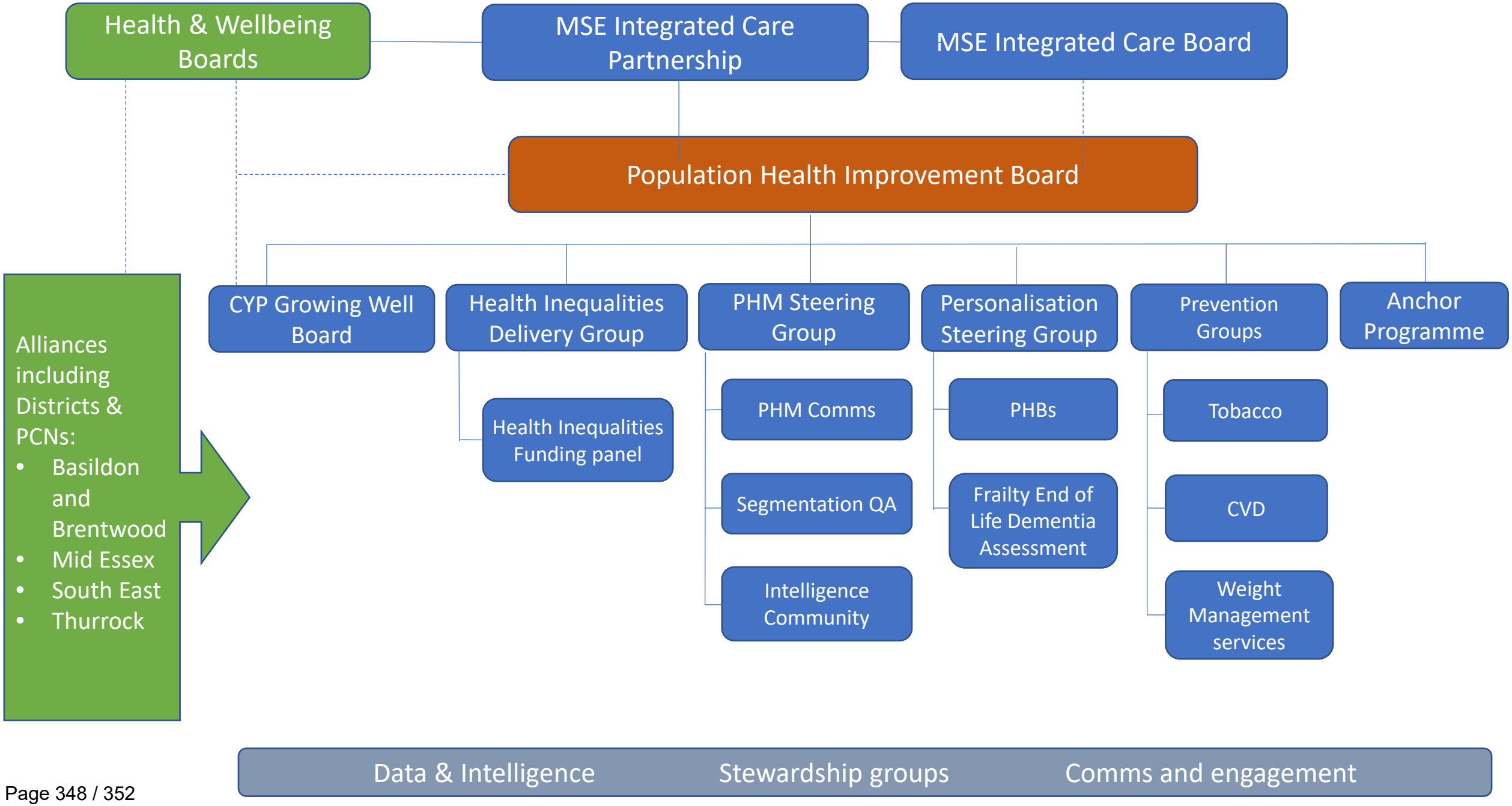
Population Health Improvement Board (PHIB)

The ICS 5-year Strategy and the strategies of our three upper tier local authority Health and Wellbeing Boards all have the reduction of health inequalities as a key ambition. The PHIB will enable prioritisation, coordination and oversight of ICS-wide activities to generate best impact for the population whilst taking into account the interplay with partner organisations related priorities and workplans. This includes:

- The overarching integrated care strategy for Mid & South Essex
- The ICS health inequalities strategy and core20+5 framework
- Population health management activities
- Prevention activities related to the wider determinants of health
- Personalised care arrangements
- Anchor charter activities

The PHIB is chaired by the Director of Public Health, ECC and has representation from:

- Directors of Public Health for Southend and Thurrock
- Clinical Senior Responsibilities Officers for Population Health Management, Health Inequalities and Prevention
- ICB Executive Directors
- Local Authority lead(s) for Adult and Children services
- NHS Provider Health Inequalities Lead
- Healthwatch


Health & Wellbeing Boards
MSE Integrated Care Partnership
MSE Integrated Care Board
Population Health Improvement Board
Alliances including Districts & PCNs:
• Basildon and Brentwood
• Mid Essex
• South East
• Thurrock
CYP Growing Well Board
Health Inequalities Delivery Group
PHM Steering Group
Personalisation Steering Group
Prevention Groups
Anchor Programme
Health Inequalities Funding panel
PHM Comms
Segmentation QA
Intelligence Community
PHBs
Frailty End of Life Dementia Assessment
Tobacco
CVD
Weight Management services
Data & Intelligence
Stewardship groups
Comms and engagement

CORE20PLUS5

NHS England architecture to support delivery of **Core20PLUS5**; NHS England's approach to reducing healthcare inequalities

CORE20PLUS CONNECTORS

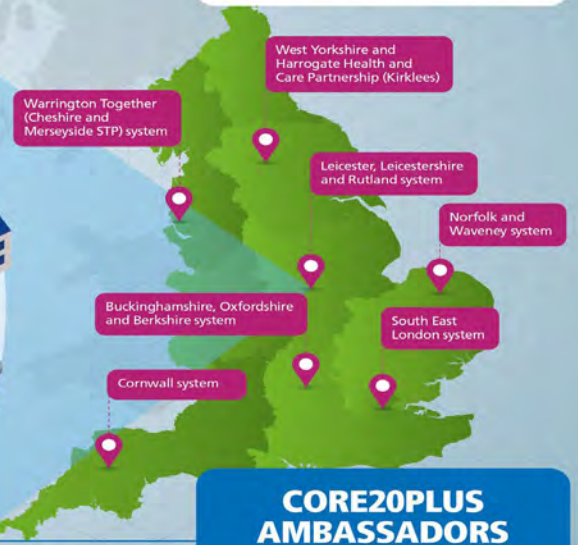
Connectors are people who are part of those communities who are often not well supported by existing services, experience health inequalities, and who can help change these services to support their community better. This will include taking practical steps locally for health improvement in excluded communities.

CORE20PLUS COLLABORATIVE

The collaborative brings together strategic partners and experts working to reduce and prevent healthcare inequalities. Members are drawn from NHS England's key stakeholders, the wider NHS and strategic system partners including arms length bodies, think tanks, charities and academic partners.

CORE20PLUS ACCELERATORS

Accelerator sites are integrated care systems (ICSs) supported to accelerate progress on Core20PLUS5 priorities using a quality improvement approach. Learning and development on best practice in healthcare inequalities improvement will be shared nationally across ICSs.



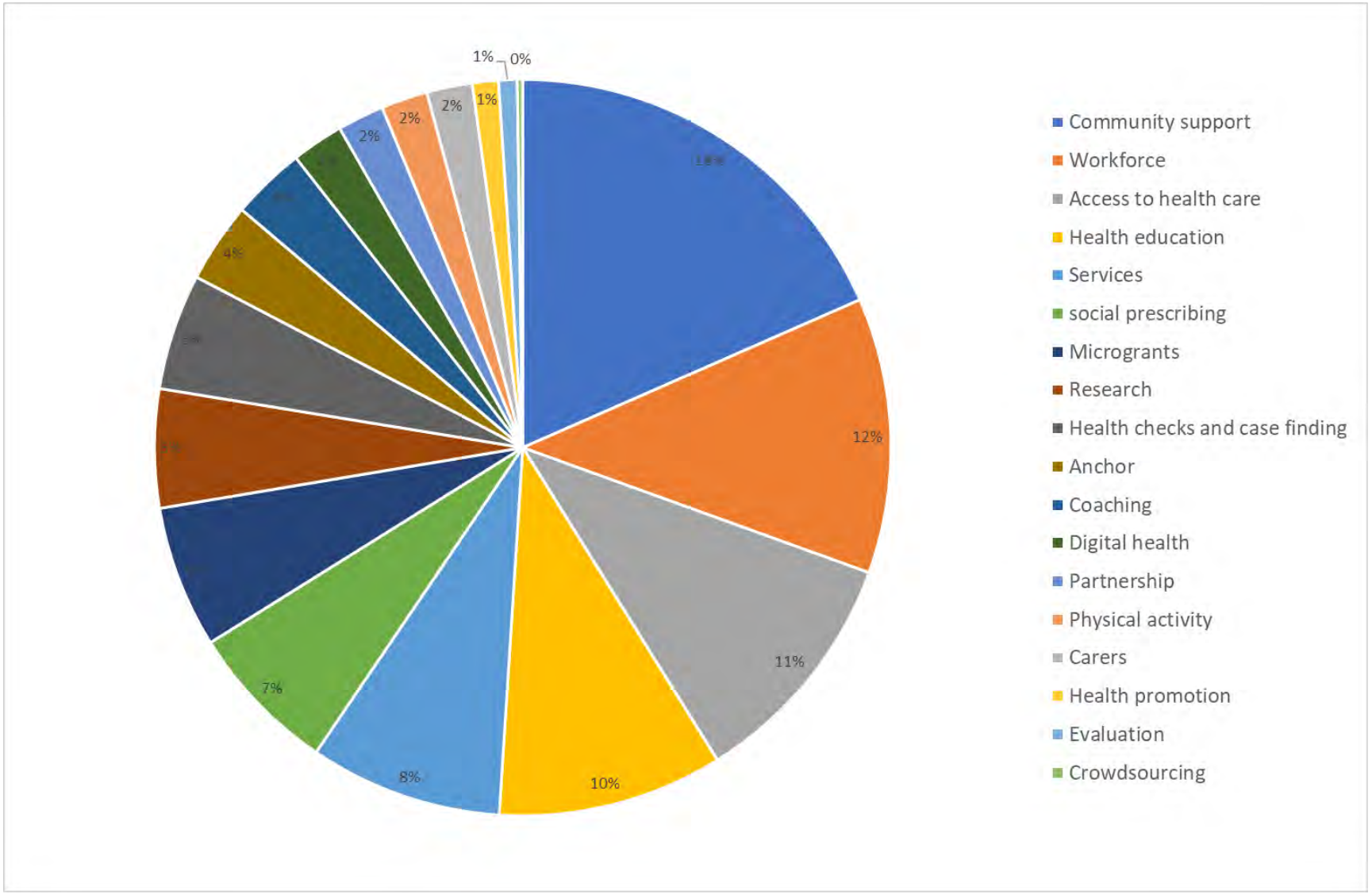
CORE20PLUS AMBASSADORS

Ambassadors are people working within or across integrated care systems (ICSs) who are committed to narrowing healthcare inequalities and will use their role and influence to progress Core20PLUS5 at a local level.

Health Inequalities Funding

- NHSE have allocated **£3.399m** to Mid & South Essex to support the reduction of Health Inequalities for 2022/23
- MSE Partnership Board apportioned funding to the Alliances:
    - Basildon & Brentwood £604k
    - Mid Essex £753k
    - South East Essex £840k
    - Thurrock £443k
- System wide programmes £760k:
    - Establishment of a population health improvement board & oversee delivery across ICS, extension of anchor work and small contingency
    - Micro-grants centrally administered but with decisions about awards made by Alliances
    - Evaluation framework supported by University of Essex

Health Inequalities Funding distribution



Mid and South Essex Integrated Care System

NHS
Mid and South Essex

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