Hertfordshire and
West Essex Integrated
Care Partnership

~~Appendix 1~~

Hertfordshire and West Essex
Integrated Care Strategy

Improving health and care through early help and prevention

2023 – 2033

Contents

Foreword from Councillor Richard Roberts, Rt.Hon. Paul Burstow, and Councillor John Spence

Caring for our residents' wellbeing and supporting those who face the biggest challenges to living healthy, independent lives, is at the heart of everything we do in Hertfordshire and west Essex.

This strategy sets out the ways in which we will work to ensure that we can all live, work and play in healthy and safe communities where everyone's contributions are valued, and we all have the opportunities and support we need to thrive.

We know that each person's health and wellbeing is shaped by their childhood experiences, the home and environment they grew up in, their finances, education, employment opportunities, and access to vital public services.

We have developed our 10-year strategy by listening to the views and experiences of residents and staff, looking at the information which shows where the needs are greatest, and focusing on those priority areas where we can make the biggest positive impact together.

Together, we will work to:

- Give every child the best start in life
- Support our communities and places to be healthy and sustainable
- Support our residents to maintain healthy lifestyles
- Enable our residents to age well and support people living with dementia
- Improve support to people living with life-long conditions, long term health conditions, physical disabilities, and their families
- Improve our residents' mental health and outcomes for those with learning disabilities and autism.

Our response to the COVID-19 pandemic showed what can be achieved when communities come together to support each other, and the NHS, councils, and the voluntary and community sector work together with a common aim.

With our combined commitment, expertise and resources, our partnership of 28 organisations, which have joined forces through the Integrated Care Partnership, will help to deliver these priorities together, building a brighter and healthier future for everyone who lives and works in our area, so that we can all enjoy the very best that Hertfordshire and west Essex have to offer.

Cllr Richard Roberts, Leader of Hertfordshire County Council, Chair of Hertfordshire and West Essex Integrated Care Partnership, and Chair of Hertfordshire Health and Wellbeing Board

Rt.Hon. Paul Burstow, Independent Chair of Integrated Care Board, and Vice Chair of Hertfordshire and West Essex Integrated Care Partnership

Councillor John Spence, Cabinet Member for Health and Adult Social Care, Essex County Council

About the strategy

The opportunity for change

Hertfordshire and West Essex are great places to live, work, learn and do business. Home to 1.6 million people and more than 60,000 businesses, we have many excellent schools and other local services. Many residents live in vibrant urban centres or in rural communities in stunning countryside.

In Hertfordshire and in West Essex there was already a strong tradition of partnership working prior to the pandemic. Mental health, learning disability and Child and Adolescent Mental Health Services (CAMHS) are jointly commissioned by Hertfordshire County Council and the NHS. There are established processes for joint commissioning in many other areas. The level of integrated commissioning and joined up service delivery accelerated significantly during the pandemic – particularly through the Discharge to Assess (DTA) model for co-ordination of health and care support which allows people to leave hospital as soon as they are fit to do so.

New integrated care systems build on that spirit of collective purpose, decisive action, and innovation that we saw during the pandemic. ICSs are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area.

The purpose of ICSs is to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience, and access
- enhance productivity and value for money
- help the NHS support broader social and economic development

In Hertfordshire and West Essex we are already on the journey to develop excellent integrated working. Partners within the ICS are eager to scale up their ambition and to demand of ourselves that we work differently together to achieve a step change in health and care outcomes for our residents.

Partners within the ICS have come together to form the Hertfordshire and West Essex Integrated Care Partnership (ICP). The ICP is a joint committee, established by the Hertfordshire and West Essex Integrated Care Board, Essex County Council and Hertfordshire County Council, to improve health and care in Hertfordshire and west Essex. It is a statutory committee, that brings together organisations involved with improving the heath, care, and wellbeing of the population in order to facilitate joint action to improve health and care services and to influence the wider determinants of health and broader social and economic development.

The ICP provides a forum for NHS leaders and local authorities to come together as equal partners, alongside a broad alliance of organisations and representatives concerned with improving the health and wellbeing of our population. It allows system partners to agree shared objectives, work on joint challenges, and support places and organisations that comprise the system in the interests of people and communities.

Scope of the strategy

Our integrated care strategy sets out our vision, scope, and approach. Drawing on the assessed needs from the Hertfordshire and Essex joint strategic needs assessments, it outlines how we will work together as a system to improve the health and wellbeing of people living and working in Hertfordshire and West Essex, including increasing the years that people live in good health and reducing the gap between the healthiest and the least healthy in our community.

Our approach recognises the importance of health and care services for health, and also that health is the result of a complex interplay of factors that include our friends and family, our neighbourhood and community, as well as wider influences from education, employment, housing and other areas, as outlined in Figures 1 and 2 below:

Figure 1: The factors that influence an individual's health and wellbeing (source: The Health Foundation)

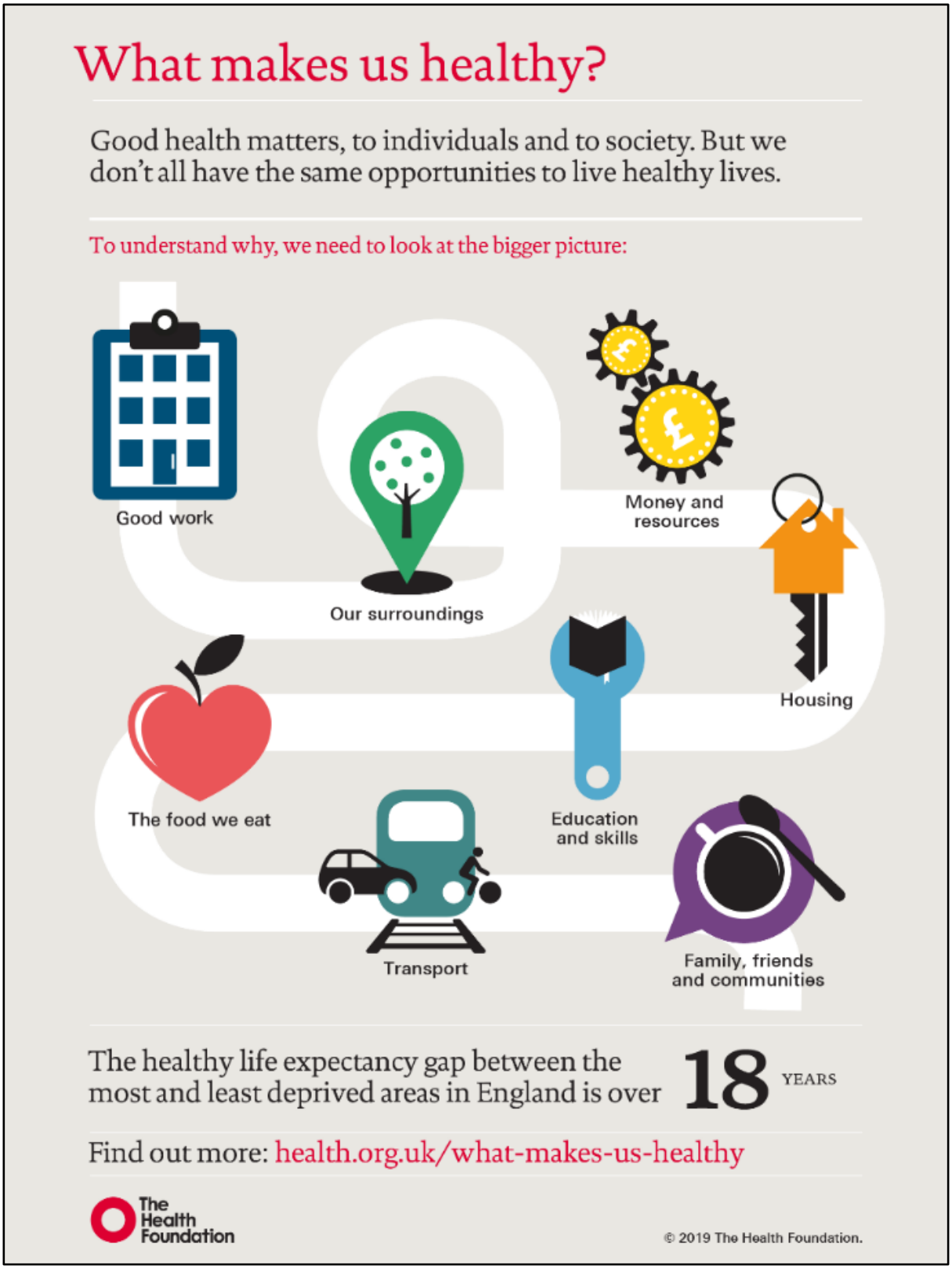


Figure 2 – What makes us healthy. Source: The Health Foundation (2019)

Our strategy outlines how we will do things differently, whether by accelerating the pace of integration already underway or by identifying new opportunities to join up health and care. It also sets out how we will reach beyond services to join up work with local authorities and the voluntary and community sector on other things that influence health, such as employment, housing, and education.

The strategy sets out six strategic priorities for integrated work across the system. Each priority describes the outcomes we are seeking to achieve over the first five years of delivering this 10-year strategy. Delivery will be supported by the ICB 5-year Forward Plan and by system partners' plans.

We have taken the decision as a system to only focus on a few specific priorities, where there is the greatest need, and we can have the biggest impact by delivering collectively as a system. We recognise that system working is complex, and it is therefore better that we focus on a few areas that we do well together than trying to do a large number of things and risk failure. This does not mean the areas of needs not covered in this strategy will not be delivered. On the contrary, these will continue to be delivered through the organisations in our system as business as usual.

Our strategy also does not include the usual business that partners are required to carry out as part of statutory responsibilities. For example, it does not set out the NHS's responsibilities for meeting NHS England requirements, nor the County Councils' statutory responsibilities for social care. These 'must dos' will be covered by operational plans and business as usual governance. Instead this strategy focuses on the interface between the responsibilities of the NHS and local authorities for joined up planning, commissioning, and delivery of care for the local population.

Relationship to other plans and strategies

The Integrated Care Strategy is closely linked to a number of other strategies and plans, including the following:

Joint Strategic Needs Assessment (JSNA)

Our integrated care strategy is informed by the Essex JSNA and the Hertfordshire JSNA. The JSNA is an umbrella term to describe a series of topic-specific analyses of the health and care needs of the local population.

Hertfordshire Joint Strategic Needs Assessment

Essex's Joint Strategic Needs Assessment

Health and Wellbeing strategies

In Hertfordshire and Essex the JSNAs have informed the recent development of the Essex and Hertfordshire Health and Wellbeing strategies. These strategies were approved by the Health and Wellbeing Boards of Essex and Hertfordshire in May and June 2022, respectively. The two Health and Wellbeing strategies are similar in approach and content, each setting out a basket of priorities for local action and innovation, focused on improving health and wellbeing outcomes and reducing health inequalities.

Essex Joint Health and Wellbeing Strategy 2022 - 2026

Hertfordshire Health and Wellbeing Strategy 2022 – 2026

Hertfordshire Corporate Plan 2022 – 2025

The corporate plan sets out Hertfordshire County Council's vision for a cleaner, greener, and healthier Hertfordshire. The plan includes four priorities to deliver that vision: improving the health and wellbeing of our people, protecting, and improving our environment, supporting the sustainable and responsible growth of our county, and providing excellent services that are accessible for all.
Hertfordshire County Council - Corporate Plan 2022-25

Everyone's Essex 2021-2025

Everyone's Essex sets out Essex County Council's vision for renewing the economy, seeking equality, and being ambitious for the people of Essex as well as focusing on four key areas - the economy, the environment, children, and families, and promoting health, care, and wellbeing for all ages. Embedded in the plan is a renewed commitment to addressing inequalities and levelling up life chances for residents.
Everyone's Essex: our plan for levelling up the county 2021 to 2025

NHS Long Term Plan and other local NHS Strategies

The NHS Long Term Plan (LTP), published in January 2019, sets the direction for NHS organisations delivering care to patients across the country. The plan identifies five priorities and specifies in detail the action to be taken to meet these:

- Targeted care built around the patient
- Preventing illness and tackling health inequalities
- Boosting recruitment and retention of a highly skilled workforce
- Making better use of data and digital technology
- Maximising value for the taxpayer

Commissioners and providers of health services in HWE have plans in place to deliver the targets of the LTP. When the LTP is updated, this Integrated Care Strategy will be updated, as required, to ensure that it reflects any future requirements.

Hertfordshire and West Essex ICS Digital Strategy 2022-2032

This strategy covering health service provision focuses on enabling our professionals to transform services to meet the needs of our residents. It will do this by providing the right digital capabilities, including technology and infrastructure. It is these capabilities that will enable those that provide care to work together to create the best outcomes for people living in Hertfordshire and west Essex. It will enable improved access for residents, patients, and service users to information about themselves and allow them to interact digitally with their clinical and care professionals when it is appropriate and convenient to do so.

Hertfordshire and West Essex ICS People Strategy 2023-2025

This strategy supports integrated workforce planning, innovation and new ways of working, a sustainable workforce supply, improved staff wellbeing, experience, and education, talent, and leadership development.

Sustainability – the 2030 landmark

The effect of climate change is one of the biggest challenges of our time. The 2030 landmark is the target date that many organisations within the partnership have set themselves for becoming carbon neutral or for reaching milestones along this journey. Climate change has serious implications for our health and is already playing out in real time as witnessed through extreme weather events, such as heat waves, droughts, pollution and floods, which are caused by warming temperatures, which have become more severe in the past few years because of carbon emissions. Organisations within the ICP need to respond to these risks.

Adopting sustainable practices within our own organisations and across the ICS system, developing leadership and staff buy-in for efforts to improve environmental sustainability, influencing sustainable practices in the community including through helping shape community environments, behaviours and influencing local suppliers, will in turn influence and impact on our residents' health and wellbeing and contribute to a cleaner and healthier environment.

Hertfordshire County Council declared a Climate Emergency in Hertfordshire in 2019 and is committed to being a carbon neutral organisation by 2030 and has set out steps to embed sustainability in everything it does. Essex County Council is committed to becoming a net zero county by 2050 and has set itself a number of key targets to achieve this objective. The NHS launched the Greener NHS campaign in 2020 and a net zero commitment based on two major goals and a series of targets. The two main goals defined against the 1990 emissions baseline are:

- achieving net zero by 2040 for emissions that the NHS directly controls (the NHS Carbon Footprint), with an 80 per cent decrease by 2028 to 2032.
- Emissions that the NHS can influence (NHS Carbon Footprint plus) net zero by 2045, with an 80 per cent decrease by 2036 to 2039.

Acting sustainably will foster a green economy, energy independence, great places and a better quality of life. There is much to be done to meet the Climate Change Act target of net zero carbon emissions by 2050. To achieve this, environmental sustainability needs to be a golden thread that runs through every aspect of how organisations across our system operates, from how we deliver services, to the energy we consume, and the way organisations use their estates to how they embed, champion and influence businesses and local communities to support actions on environmental sustainability.

This will require leaders across the system to put sustainability firmly on the agenda, ensuring there are ambitious environmental targets in their organisations plans and in the ICB 5-year joint forward plan. When considering how we will deliver the strategy priorities we will ensure consideration is given to how our actions support our sustainability ambitions.

Our approach to developing the strategy

We established a multi-agency strategy development steering group with participation from the organisations and sectors represented on the Hertfordshire and West Essex ICP. Members of the group supported the development of the strategic priorities, including identifying need, gathering data to understand need, and providing challenge and sense-checking.

Engagement and involvement

A multi-agency communications and engagement group was established to develop and agree our approach to the public involvement and engagement which has informed this strategy.

We have gathered the views of residents, staff, communities and organisations in Hertfordshire and west Essex, and their insight has been invaluable. We have taken particular care to learn from those people that we typically hear from the least, and the people who advocate for them, as they often face the biggest challenges to leading healthy lives. This includes gathering views from people living with poverty, people living with addictions, people from minority ethnic groups and disadvantaged children and young people. The priorities in this strategy have been influenced and amended as a direct result of this work. The wealth of insight we have gained will be shared with everyone involved in delivery this strategy.

Guided by best practice and the requirements of the Health and Care Act 2022 we have:

- analysed some of the wealth of existing insight and recommendations gathered through qualitative and quantitative research by the public and voluntary sector, through a desk-based research exercise

- conducted four themed focus groups to understand the issues facing our people and communities, and to gather their recommendations for change

- surveyed the people who are employed by, or volunteer for those organisations which make up the Integrated Care Partnership, to understand their priorities and learn from their expertise as professionals and residents

- undertaken three strategy development workshops with representatives from ICP organisations

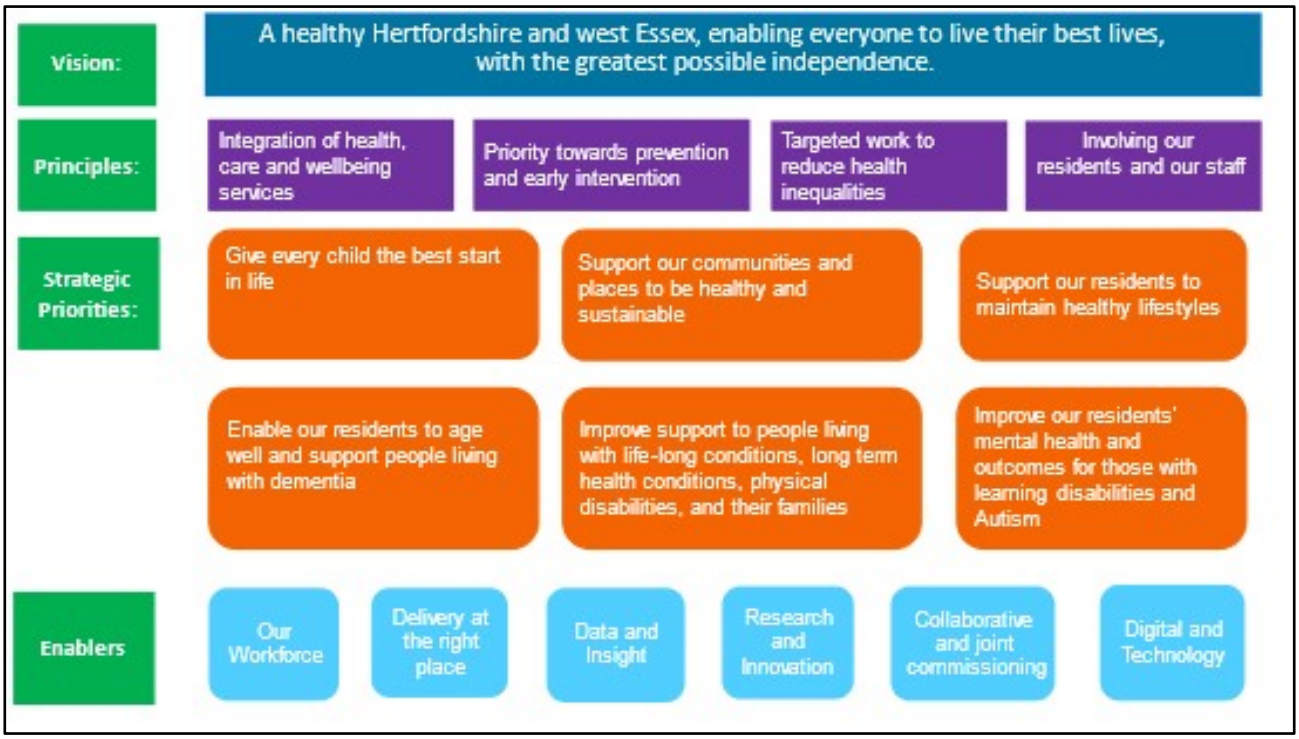
- attended a number of meetings and boards across the area to promote engagement and involvement with the developing strategy.

Engagement and involvement should be an active, ongoing process, which provides clear feedback about the way in which involvement has led to improvements. We are committed to fully involving people and communities across Hertfordshire and west Essex as the strategy is further developed and delivered.

Appendix 1 sets out a fuller description of our approach to involvement and engagement in the development of this strategy.

Our 10-year strategy

Our draft 10-year strategy on a page:



Our vision

A healthy Hertfordshire and West Essex, enabling everyone to live their best lives, with the greatest possible independence.

We are striving for a healthy Hertfordshire and west Essex where we can increase the years that our residents live in good health and lead their best possible lives with the greatest amount of independence

Four core principles underpin our vision and strategic priorities:

Principle 1

We will prioritise **opportunities for integrated planning, commissioning and delivery** of health, care, and wellbeing services so that people's experience of support and services is more joined up. We recognise that it is routine for health and care staff to work together across teams and between organisations. This strategy is about the big strategic swings where a more joined-up approach will bring local authority, NHS, and voluntary sector services much closer together to maximise the chances for health gain at every opportunity.

Principle 2

We will prioritise **prevention and early intervention**, reflecting the evidence that it is better to identify and deal with needs earlier rather than to respond when difficulties have become complex, which will then require intensive action by services. Preventative services are particularly effective in improving the longer-term life chances of children, young people, and their families. We will do more than just talk about prevention. We will act. We will look at how we can shift investment across our system so that we can support the priorities we have set ourselves for early intervention and prevention, at the same time still striving to improve services for those who need our help now.

Principle 3

We will prioritise targeted work to **reduce health inequalities** across our population and across all services and settings, reducing avoidable and unfair differences in health between different groups in society. We will utilise local intelligence including population health management systems to enable health and care staff to identify people most at risk of ill health and identify areas where health inequalities are greatest to ensure that resources can be targeted at people with the greatest need. We will also work in an integrated way to reduce the factors that contribute towards health inequalities.

Principle 4

We will **involve our residents** who use our services, their carers, and communities, along with our staff that deliver our services. We will engage with them at the earliest stages of service design, development, and evaluation. We recognise that those with 'lived experience' of a particular issue or condition, their families and carers, and the staff that support them are often best placed to advise on what support and services will make a positive difference to their lives. We are committed to working with our residents to improve our services and will listen to what our residents tell us and respond to their needs.

Our strategic priorities

Priority 1: give every child the best start in life
We will ensure that children in Hertfordshire and West Essex have the best opportunity to be safe and well and to reach their potential at school and beyond.

Priority 2: support our communities and places to be healthy and sustainable
We will work with our communities to improve our residents' health and wellbeing by reducing health inequalities and taking action on the wider determinants of health including housing, employment and the environment.

Priority 3: support our residents to maintain healthy lifestyles
We will support people to be physically active, eat healthily and maintain a healthy weight, and we will provide support and advice to prevent tobacco, alcohol and substance misuse.

Priority 4: enable our residents to age well and support people living with dementia
We will ensure our residents are supported to age healthily, with access to advice and services that enable them to live well and independently for as long as possible.

Priority 5: improve support to people living with life-long conditions, long term health conditions, physical disabilities, and their families
We will support people living with lifelong conditions, long term health conditions, physical disabilities and their families assisting them to take more control of their health and live a good quality of life.

Priority 6: improve our residents' mental health and outcomes for those with learning disabilities and autism
We will provide early help to our residents to prevent mental illness and support the health and wellbeing of those with a Severe Mental Illness (SMI), learning disabilities or autism.

Strategic priority 1: give every child the best start in life

We will ensure that children in Hertfordshire and west Essex have the best opportunity to be safe and well and to reach their potential at school and beyond.

Where we are now

The World Health Organisation's Global Strategy for Women's, Children's and Adolescent's Health, the NHS Long Term Plan, the Public Health Strategy: Giving every child the best start in life and the UNICEF Baby Friendly Initiative agree that the first 1001 days from conception to age 2 lay the foundations for a child's later cognitive, emotional, and physical development. We would extend that 'best start' through until a child is 5 years old.

In our area we see health concerns linked to social disadvantage, increasing social and emotional difficulties in young children, mapping through to school exclusions (including primary), youth justice entrants and increasing numbers of children with social and communication difficulties.

There is a gap in attainment and attendance for vulnerable children including Children Looked After (CLA) Special Educational Needs and Disability (SEND) and Youth Justice cohort.

There are increasing numbers of children needing crisis intervention, with numbers of CLA and those needing mental health specialist hospital provision increasing.

The national independent review of Children's Social Care (2022) shifts the lens towards locality based multi-agency family help and family safeguarding integrated service delivery. National Independent Review of Children's Social Care Report

The National Panel Review of Child Deaths (2022) emphasises the need to strengthen information sharing and decision-making across all agencies and to build on the skills of our workforce. National Panel Review of Child Deaths Report

Outcomes we want to achieve

As a parent:

- I can access appropriate services in my community and meet with other parents/carers and develop local support networks
- I know who I can contact for professional advice and support if I have a concern about the physical, cognitive, and emotional health needs of my child
- I know what I can do to help my child's development and I am helped to understand and respond to any additional needs my child has

As a child:

- I am safe, happy, and cared for in my home
- I enjoy learning and have friends and opportunities to play and socialise
- I am supported to be the best I can be

What will change

We will:

- Work together to coordinate support, make every contact count and reduce duplication between services
- Prioritise early help and early intervention so that families are supported early or as needs emerge, working together with early years providers, schools, youth services, and collaboratively with communities and families.
- Ensure children will achieve their best potential by the time they start school by working in partnership to remove barriers to early learning.
- Work with the Voluntary Community Faith and Social Enterprise Sector (VCFSE) sector and other partners to ensure a joined-up approach to supporting children and their families
- Ensure children's physical and mental health have parity of esteem
- Jointly plan and develop family centres into family hubs, with a focus on commissioning of community based and locality provision, embedding the continuum of support across universal, early family help and targeted help
- Jointly plan and commission family help and family safeguarding, with multi-disciplinary teams focused around community settings such as schools and family hubs, with services tailored to neighbourhood needs.
- Jointly plan and deliver early help across the SEND system, so that children with additional needs and their families have the right support at the right time and before statutory assessment; with continued planning of early help for children with emotional wellbeing concerns including school mental health support and parental advice and guidance.

Strategic priority 2: support our communities and places to be healthy and sustainable

We will work with our communities to improve our residents' health and wellbeing by reducing health inequalities and taking action on the wider determinants of health including housing, employment and the environment.

Where we are now

Housing costs and accessibility issues have significantly increased in England and with the current rising cost of living on top of this, the impact will be most felt by lower income households. Poor-quality housing, overcrowded housing, and unaffordable housing harm health. Evidence shows that exposure to poor housing conditions (including damp, cold, mould, noise) is strongly associated with poor health, both physical and mental[1]. Children living in cold homes are more than twice as likely to suffer from a variety of respiratory problems as children living in warm homes and mental health is negatively affected by fuel poverty and cold housing for all age groups[2].

The 2020, UK Climate Change Commission (UKCCC) Health Equity Report highlights how direct and indirect impacts of climate change will widen existing health inequalities in the UK. It warns that the most vulnerable will be hit hardest unless health equity is considered alongside future government greenhouse gas targets. Air pollution is the largest environmental risk to the public's health, contributing to cardiovascular disease, lung cancer and respiratory diseases. Poor air quality contributes to shortening life expectancy and disproportionately impacts the most vulnerable in society.

Access to good quality green space improves physical and mental health, improves community cohesion, and supports actions to mitigate the effects of climate change and protect biodiversity. Green spaces have been shown to improve cognitive and immune functions and to reduce mortality rates and health inequalities[3]. Access to and use of green spaces tends to reduce as the level of deprivation increases, which was highlighted during COVID-19 pandemic.

In Hertfordshire and west Essex health outcomes are mostly favourable when compared with the national picture however there are persistent health inequalities, especially in poorer areas and for specific groups such as people of all ages providing care. The COVID-19 pandemic exposed and widened these inequalities and led to many more people experiencing ill-health. For example:

- Unpaid carers provide critical support for people with health and social care needs. The support provided by carers is often physically and emotionally demanding, with consequences for carers' own health and wellbeing.
- Those in the most deprived areas in Hertfordshire and west Essex die 3-4 years earlier and spend up to 18 years longer in a state of poor health than those in the least deprived areas.
- On average, rough sleepers die 30 years earlier than the general population4.
- Health inequalities are most stark in Harlow, Stevenage, Watford, Welwyn Hatfield, and Broxbourne.

[1] Michael et al (2020) Health equity in England: The Marmot Review 10 years on. London: Institute of Health Equity

[2] Michael et al (2020) Health equity in England: The Marmot Review 10 years on. London: Institute of Health Equity

[3] Allen J, Balfour R (2014) Natural solutions for tackling health inequalities. Institute of Health Equity

4 Marmot et al (2020). Build Back Fairer: The Covid-19 Marmot Review

- Harlow at £545 and Stevenage at £476 are both significantly below the East of England average (£602) for median weekly pay for residents and workers (2021).
- In Hertfordshire and west Essex there are four districts that are below the East of England average (81%) percentage of people that are economically active. These are Stevenage, Welwyn Hatfield, Hertsmere and Harlow.

Outcomes we want to achieve

- I live in a safe, decent place that I can call home, which is accessible according to my needs, and designed so that I can be as independent as possible.
- I have access to benefits that I am entitled to, and I can afford access to paid activities.
- I have people in my life who care about me – family, friends, and people in my community.
- I know about and can access social groups, leisure, as well as health and care services.
- I feel welcome and safe in my local community, and I am satisfied with the local place where I live.
- I have opportunities to learn, volunteer and work, and I can do things that match my interests, skills, and abilities.
- I live in an environment which supports me to be healthy.

What will change

We will:

- Step-up our support to and engagement with communities and groups at risk of the worst health outcomes.
- Support people with disabilities or health conditions to get back to work or remain in work through inclusive employment practices.
- Increase recruitment from our most deprived communities and work with our supply chains to create local economic opportunities.
- Work in partnership to support the delivery of more homes, including key worker housing and implement the adoption of decent home standards in all social and private rented sector accommodation.
- Take shared action to increase the supply of good quality, decent and accessible supported accommodation for people with learning disabilities and autism, and physical disabilities.
- Increase community participation by embedding Asset Based Community Development (ABCD) principles (citizen-led, relationship-oriented, asset-based, placed-based, inclusion-focused) in our organisations, adopting a joined-up approach to social prescribing and securing social value.

- Work with partners to put health, equity, wellbeing, and sustainability at the heart of local planning and strategy and actively support health involvement in statutory local development plans.
- Ensure that consideration is given to reduce pollution and waste as well as to protect our natural areas.
- Work with partners to create healthy streets and places by promoting green spaces and working with partners to prioritise provision of new green spaces in areas of higher deprivation with better signage and signposting.
- Use the NHS England 'Core20PLUS5' framework to direct our approach with a focus on the five clinical areas prioritised in the NHS Long Term Plan i.e. continuity of maternity care for women in the most deprived areas and those from Black, Asian and minority ethnic groups; annual health checks for those with severe mental illness, chronic obstructive pulmonary disease management (with a focus on COVID-19, flu and pneumonia vaccination uptake), early cancer diagnosis and hypertension case-finding.
- Tackle unhealthy environments by delivering improved infrastructure for safe walking and cycling and by providing easy access to reliable public transport in local areas and promoting a more efficient transport network.

Strategic priority 3: support our residents to maintain healthy lifestyles

We will support people to be physically active, eat healthily, maintain a healthy weight and provide support and advice to prevent tobacco, alcohol and substance misuse.

Where we are now

Good nutrition, healthy weight and regular physical activity are essential for physical and emotional health. Poor diet and nutrition are key contributors to health problems, including tooth decay, excess weight, and frailty, as well as a number of diseases including type 2 diabetes, heart disease and stroke, and cancers.

Physical inactivity is a leading cause of premature mortality. People who have a physically active lifestyle have a 20-35% lower risk of cardiovascular disease, coronary heart disease and stroke compared to those who have a sedentary lifestyle. Regular physical activity is also associated with a reduced risk of diabetes, obesity, osteoporosis, and colon/breast cancer and with improved mental health. In older adults' physical activity is associated with increased cognitive and functional capacity.

Health behaviours including tobacco, alcohol and substance use account for 30% of the influence on health and wellbeing. Smoking and alcohol use are two of the six common risk factors for premature death, and the main causes of ill health such as cancer, heart disease and respiratory disease. Substance misuse is a significant factor in crime including homicide and domestic and intimate partner violence. Around 7% of the population of Great Britain (adults and children) were found to be negatively affected by someone else's gambling. Almost half (48%) of people who were affected by a spouse or partner's gambling reported a severe negative impact.

In Hertfordshire and west Essex:

- Areas with higher levels of deprivation (including Harlow, Broxbourne, Watford, and Stevenage) have the highest rates of childhood obesity. Rates of obesity at year 6 in Harlow are much higher than the national average.
- The number of adults who are overweight was similar to that of England in 2020/21, and still notably high at 62%, with wide variation between districts.
- Around 1 in 5 adults across our geography are physically inactive, which means around 20% of the adult population are at increased risk of a range of health conditions and diseases which are preventable through increased physical activity.
- Smoking prevalence in adults is similar or better than the England average for all districts in HWE; however, there is some variation between the areas with the lowest rates (St Albans at 5.4%) and the highest (Harlow at 18.9%).
- Whilst east and north Herts, south and west Herts and west Essex are all better than the national average for smoking rates in early pregnancy and at delivery, in west Herts 1 in 10 women and in Hertfordshire as a whole 1 in 15 women are smokers at this vital time.
- The relationship between drug use and mental health problems among young people is a particular concern. Research shows that mental health problems are experienced by the majority (70%) of drug users in community substance misuse treatment. Death by suicide is also common, with a history of drug misuse being recorded in 34% of all suicides in people experiencing mental health problems between 2008 and 2018-9.
- Whilst alcohol-related mortality is statistically similar to the national average across most districts, there is variation, with more deprived areas experiencing higher rates or alcohol-related mortality (Harlow highest at 38.8 per 100,000 compared to 27.1 in North Hertfordshire).
- The rates of admissions for alcohol specific conditions, by district, are all better than England average, yet vary across HWE from 291 per 100,000 in Broxbourne to 522 in Harlow.
- Poor mental health is a stronger predictor of at-risk gambling than both poor physical health and negative health behaviours, with the notable exception of alcohol.

Outcomes we want to achieve

- I can take care of my own health and wellbeing
- I know how to live a healthy life
- I feel supported by my community and local services to stay healthy
- I live in a smoke-free home, and I do not smoke during pregnancy
- I am physically active
- I am and my household is free of addiction

What will change

We will:

- Develop a new physical activity offer for our residents which:
    - Increases opportunities for physical activity for children, young people and adults in parks, schools, and community centres
    - Explores opportunities to give people on low incomes affordable access to exercise classes and leisure centres
    - Provides information to adults about how to integrate more physical activity into their daily lives and increases provision of support, advice, and services, including those who are housebound and frail, to help improve strength and mobility.
- Offer all people admitted to hospital who smoke access to NHS-funded tobacco treatment services and adapt the NHS-funded tobacco treatment service model for expectant mothers, and their partners, with a new smoke-free pregnancy pathway including focused sessions and treatments. A new universal smoking cessation offer will be made available as part of specialist mental health services for long-term users of specialist mental health, and in learning disability services.
- Improve pathways and outcomes for people who have a mental health issue and experience drug and alcohol problems and ensure an integrated new universal smoking cessation offer is also available as part of specialist mental health services for long-term users of specialist mental health, and services for people with learning disabilities and autism.
- Support hospitals with the highest rate of alcohol dependence-related admissions to establish hospital/community-based alcohol care teams to support people living with alcohol dependency and who have significant physical complications and or those with repeated hospital admissions.
- Support our residents in low-income households to have access to affordable healthy food and facilities to store and cook it.
- Support our residents most at risk of poor outcomes from being overweight including those with mental health conditions, physical disability or learning disability and autism.

- Support children and young people to have access to information, advice, and support to maintain a healthy weight and access to leisure activities in their communities. Including access to effective local weight management services, specialist treatment and surgery for those that need it.
- Ensure people have access to education, information and advice on how to reduce harm from tobacco, gambling, alcohol and other substances and promote awareness of the risks and harm from tobacco, alcohol, gambling and other substances. Those most at risk will have access to targeted support, advice and treatment.

Strategic priority 4: enable our residents to age well and support people living with dementia

We will ensure our residents are supported to age healthily, with access to advice and services that enable them to live well and independently for as long as possible.

Where we are now:

- The population and proportion of those aged 65 and over is growing in both Herts, from 17.2% in 2020 to an expected 23.2% in 2043) and Essex (number of over 65-year-olds expected to grow by 28% in the next decade, and number of over 85s by 55%).
- Other data demonstrate social isolation, hospital admissions due to falls and fractures, reablement following hospital discharge as areas for improvement. Whilst there is a range of initiatives to improve clinical outcomes, ageing well is broader than this. Prevention is going to be key to ensure that the population keeps well for as long as possible, as the ageing population will inevitably result in a greater demand for our services.
- Pre-COVID-19 carers were approximately 10% of the population, this is expected to have grown since the pandemic.
- Those living with dementia face great personal uncertainty both during its early s tages and as their condition progresses. Dementia poses serious challenges for health and care services and has a higher health cost than cancer and heart disease. The condition is sometimes difficult to identify early, and once a diagnosis is given, it can be difficult to find the right support.
- People with dementia face an increased risk of health or care crisis, sometimes resulting in unplanned admission to hospital, often not the best place for them.
- Approximately 43% of NHS budget is spent on those aged 65+ years, who account for approximately 12% of the population.
- It is estimated that between 20% and 30% of hospital admissions in over 85s could be prevented by proactive case finding, frailty assessment, care planning and use of services outside of hospital

Outcomes we want to achieve:

- I know how to plan for older years to I can reach them in the best health
- I can live independently and take care of my own health and wellbeing, and manage the challenges life may throw at me for as long as I want
- I have choice, control and independence over my health and care support needs
- I feel socially connected and a valued and respected member of my community
- I know what support is available and how to access it
- I am treated with dignity and respect
- I will be asked for my end of life wishes and will be able to die, where practically possible, in my preferred place of care.

What will change:

We will:

- Work in an integrated way to support people to live well for longer, maintain independence and improve early diagnosis and support for those at risk of becoming frail, living with dementia and their families.
- Support people to increase physical activity and reduce loneliness and cognitive decline through connecting with their local communities by working collaboratively to provide information, advice, and support.
- Ensure local services, communities and the environment, including outdoor space, transport and buildings, are integrated and are age and dementia friendly.
- Improve support for people who look after family members, partners or friends because of their illness, frailty, or disability.
- Develop and support capacity of care homes and discharge arrangements, align specialist services with primary/ community and social care and resolve pathway issues around health and social care to improve flow of patients out of acute settings.
- Promote and encourage take up of the NHS Heath Check for people aged between 40 and 74 to help prevent the onset of disease (diabetes, heart disease, kidney disease, cancer, stroke and dementia).
- Improve provision of extra care housing for older people with health and care services embedded so our older residents can maintain their health, wellbeing, and independence into old age.
- Strengthen multi-disciplinary team approaches where professionals and the voluntary sector work together in an integrated way to provide tailored support that helps people live independently at home for longer.
- Ensure our information and advice offer is accessible to people affected by dementia throughout the course of their condition, including social and wellbeing opportunities in their local community.

- Review and strengthen our support offer to those diagnosed with Mild Cognitive Impairment (MCI) to reduce the likelihood of, or extend the period between, the development of dementia.
- Work to review and rollout dementia training for our workforce across health and care services.

Strategic priority 5: improve support to those living with life-long conditions, long term health conditions, physical disabilities, and their families

We will support people living with lifelong conditions, long term health conditions, physical disabilities and their families assisting them to take more control of their health and live a good quality of live.

Where we are now

- People with long-term conditions are 2-3 times more likely to experience mental health problems.
- 27.5% of the HWE population are estimated to be living with a long-term health condition.
- £7 out of every £10 spent in the NHS is spent caring for people with a long-term condition.
- Physical disability is defined as a “limitation on a person's physical functioning, mobility, dexterity or stamina” that has a “'substantial' and 'long-term'” negative effect on an individual’s ability to do normal daily activities. (Equality Act,2010). Approximately 6% of the HWE population consists of adults with a serious physical disability. With 14.3% of people having their day-to-day activities limited by their health (based upon Hertfordshire data).
- There is potential underdiagnosis for a range of long-term conditions, particularly hypertension and chronic kidney disease.
- Rates of emergency admissions are high for COPD (East & North Herts & South & West Herts), CHD (South & West Herts and West Essex) and heart failure (South & West Herts).
- Outcomes are worse, relative to the ICS average, in areas with higher levels of deprivation (Broxbourne, Harlow, Stevenage, Watford and Welwyn Hatfield).
- Services are not always person-centred in a way that allows individuals to become involved in decisions about their care. The model of care needs to move away from a disease-specific model to a more integrated approach, considering all existing conditions, ‘risk of’ conditions and the wider determinants of health that can impact on an individual.

Outcomes we want to achieve

- I feel supported to manage my long-term health condition or disability and the care I receive is co-ordinated.
- I understand my condition, feel in control of my care, and know where to go for help and can access support when I need it.
- I can care for my own health as well as the person that I care for.
- I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes that are important to me.
- I can access services and support.

What will change:

We will:

- Work more effectively as a system to develop and provide joined up integrated health and care services and facilities to support those living with long-term or life-long conditions or physical disability.
- Ensure robust and seamless transition pathways into adulthood that promote choice and independence.
- Support and empower people with long-term health conditions, physical disabilities, and their carers, to live healthily and independently, with better control over the care they receive.
- Support engagement in person-centred care through a range of activities including identifying and supporting champions to be local change agents.
- Work with our population, particularly those who are not currently accessing services, to lower risk factors and improve detection, diagnosis, and early-intervention for those developing long-term conditions. This includes delivering annual health checks for people with severe mental illness, learning disabilities and autism.
- Support our residents with physical disabilities, including neurological conditions, to improve their physical health and access preventative health services.
- Ensure women are supported through the menopause and encouraged to take up activities and use medication (where appropriate for their needs) to counteract the impact of hormone deficiency thereby reducing risks of cardiovascular disease, dementia and hip fractures in later years (Women's Health Strategy for England).
- Increase the number of residents who receive NHS health checks, including annual health and physical checks for those with a severe mental illness (SMI) or learning disability (LD) and annual reviews for residents that are frail or at risk of frailty.

Strategic priority 6: improve our residents' mental health and outcomes for those with learning disabilities and autism

We will provide early help to our residents to prevent mental illness and support the health and wellbeing of those with a severe mental illness (SMI), learning disabilities or autism.

Where we are now

- Mental disorders represent the second largest single cause of disability in the UK across all ages, with 1 in 4 adults experiencing at least one diagnosable mental health problem each year.
- The cost of mental-ill health to the UK economy is estimated at £105 billion a year, almost the cost of the entire NHS
- Mental health is known to be mutually and intrinsically linked with physical health and has been implicated as a risk factor for the development and progression of diseases, such as cardiovascular disease and diabetes
- Mental health problems are associated with higher rates of smoking and alcohol and drug abuse, lower educational outcomes, poorer employment prospects, social disadvantage, that in turn increase the risk for physical health problems. Poor physical health is common in people with an SMI. It is estimated that for people with SMI, 2 in 3 deaths are from physical illnesses that can be prevented
- In England and Wales, suicide was the leading cause of death in people aged 5-34 years in 2018. In males aged 20-34 years, almost 26% of deaths were by suicide. Research indicates that the impact of someone dying by suicide can impact 135 people with an estimated fiscal impact to the economy and those impacted of £1.7m (Knapp et al 2011) HWE has a similar suicide rate when compared to the national average. The suicide rate in Harlow is statistically higher than the national average.
- Social disadvantage and poverty are well documented as both consequences and causes of common and severe mental illness. The prevalence of severe mental illness is higher in more deprived areas. Housing issues and food insecurity have frequently been cited as having a negative impact on mental health.
- People with LD experience increased exposure to social determinants of poor health such as inadequate housing, unemployment, living in areas of deprivation, financial hardship, violence, discrimination, and social isolation. Rates of paid employment are substantially lower than the general population for those with LD known to local authorities. Exposure to these factors leads to adverse impacts on health and wellbeing, whereas paid employment is associated with better physical and mental health in people with LD. Employed adults are around half as likely to have a common mental disorder than those who were economically inactive or unemployed.

- In Hertfordshire, the excess mortality rate for adults with a SMI is above the regional average and in Essex, the rate of premature mortality for those with a SMI is similar for cancer, cardiovascular disease, and respiratory illnesses. (HWE ICS Health Needs Analysis Overview, 2022).
- Mental health is a contributor to the gap in life expectancy between the most and least deprived areas in Hertfordshire and West Essex, 6.9% for males in Hertfordshire and 2.9% in West Essex and 10.3% for females 7.6% in West Essex, (Hertfordshire Public Health Evidence and Intelligence, 2022 and Essex Joint Strategic Needs Assessment 2021-22).
- In HWE there has been an increase each year over the last 3 years in percentage of adults reporting a long-term mental health condition.
- People with a learning disability on average die 23 years younger for men and 27 years younger for women than the wider population.

Outcomes we want to achieve:

- I am supported to have good mental health and I know how to access activities that promote my wellbeing
- My care and support are driven by my needs and what is important to me, rather than the needs of systems and processes
- I do not see multiple professionals to manage my health and I can access support through digital and online options should I want them
- I am supported to think about what will happen in the short, medium, and long-term. There will not be any surprises about the support and care I receive
- I have access to employment and volunteering opportunities
- My school/education setting, or workplace understands my neurodiversity and makes reasonable adjustments to ensure my participation
- My family and I are supported to get a diagnosis of my condition and support is provided whilst I await diagnosis.

What will change

We will:

- Reduce the gap in life expectancy between people with a learning disability and SMI compared to the general population.
- Ensure there are clear pathways and timely access to psychological therapies for children, young people and adults who require this support
- Develop and implement an integrated whole life approach for children, young people and adults with autism that includes a focus on home and school life, diagnosis and transition into adulthood, housing support, adult learning, and work opportunities.

- Improve integrated pathways to access housing, education, employment, and skills, particularly for people with learning disabilities and autism, physical disabilities and severe mental illness, embedding support within models of care.
- Work more effectively as a system to improve outcomes for our population with a mental health diagnosis or learning disabilities or autism by ensuring that reasonable adjustments are integrated in all pathways through implementing the NHS Accessible Standards.
- Develop and deliver an integrated neurodiversity service for children and young people
- Improve the physical, mental, emotional health and social wellbeing of people with learning disabilities and autistic people of all ages and their carers.
- Reduce suicide through a focus on system support of suicide prevention and having addressed the seven national priorities as set out Suicide Prevention: policy and practice
- Work with local employers and partners to ensure they develop suitable opportunities and roles for people with LD and SMI to access and maintain employment and to develop new skills and help employers feel able and confident to be making the reasonable adjustment required to help them to prosper in work.

Key enablers

The following will support the delivery of our strategic priorities:

Workforce

Our workforce, including the voluntary sector and volunteers (including carers), are crucial to the delivery of our ambitions. By supporting and utilising our existing and future workforce effectively through strengthening integrated working across our system, we will be able to avoid unhelpful competition between partners that could make workforce challenges worse. We must recognise the critical role of the care workforce in the private market and the key role the voluntary sector and carers plays in supporting better outcomes and supporting system resilience. We must also continue to give a strong voice to our staff – giving them time and resource to tell us where there needs to be improvement and innovation. It is important that we develop our workforce and address our workforce challenges and that all partners are engaged in the delivery of the ICS People Strategy.

Delivery at the right place

The Integration White Paper set out an expectation that partners work together at place level and that "places need to think *Housing & Communities* when developing a local partnership to plan and deliver health and care." We commit to building strong and inclusive local partnerships, joining up care and support with local partners, including with district councils, schools and communities, NHS, and the local voluntary and community sector.

Given the complex geography of our ICS, we will make sure we always identify the right place for commissioning, service delivery and programme implementation. The role of both County Councils, the 13 district and borough councils and the four health and care partnerships will be considered within this context.

Collaborative and joint commissioning

To support delivery of our integrated plans, we will identify further opportunities for collaborative and joint commissioning, learning from the strengths and challenges of arrangements currently in place between the NHS and the County Councils. We will particularly seek out further progress in continuing health care (CHC), integrated accommodation, children's and young people's health, and public health. In 2022/23 we will draw up plans for increased use of joint appointments, section 75 agreements, joint contracts, and a broader use of the Better Care Fund.

Data and insight

These are fundamental enablers for the strategy. The strategy has regard to the joint strategic needs assessments of both counties. The strategy should include details on how data and insight and will continue to inform and shape the work of the ICP, making sure that decision-making will be deeply rooted in the evidence and insights we collect.

Population health management approaches will not be possible without access to the widest set of data and analytical capability in our systems; they cannot just be NHS approaches. Strategies should promote more joint work and data-sharing, so it becomes the norm rather than the exception.

Research and innovation

To support the delivery of our strategic priorities, we need to utilise evidence from data, research, and practice to build our understanding of our population's health and care needs. We will also identify gaps and opportunities for research and utilise this information to inform the delivery of the strategy through continuous learning and improvement. we will adopt, test, and utilise proven innovation to address our population needs.

Digital and technology

Alongside the Hertfordshire and West Essex ICS Digital Strategy 2022-32 and other digital strategies, we need to drive plans to increase the use of digital and technology to promote flexible and efficient working practices; to enable quicker and better data sharing between organisations; to enable communities to self-help and self-serve; and to support digital inclusion and the digital maturation of organisations in the health and care sector.

How we will deliver the strategy

ICB 5-year Joint Forward Plan

The integrated care strategy will provide strategic direction for the ICB 5-year forward plan and other partners' forward plans. Discussions are already taking place within our system to ensure the best possible alignment between these strategies and plans. The initial plan is due for completion by 31st March 2023 and will be refreshed annually.

Governance and accountability

The strategy will be submitted for approval at the December 2022 meeting of the Hertfordshire and West Essex Integrated Care Partnership Board.

The ICP is the owner of the strategy. It will:

- direct organisations/partnerships within the system to work together on local services and initiatives that support the priority
- task a single organisation/partnership to lead on coordination of activity to deliver each priority
- ask for oversight and assurance of delivery of the strategy. It will do this by receiving regular reports on delivery against each priority and holding partners to account if delivery is ineffective.

The ICP will support delivery of the strategy by agreeing two or three areas of work for its annual work programme, providing direction, focus and support for these areas.

Dashboard for key metrics

Progress and delivery of each of the six priorities will be monitored by information dashboards which will collect data on key metrics. These will be co-produced with key stakeholders and developed in line with the ICB 5 year forward plan.

Annual monitoring and review

We will produce an annual report which provides a narrative account of our progress and challenges, and measures progress. We will look to incorporate residents' insights into this review.

Continuing to improve our strategy

As 2022/23 is a transition year, we will review our strategy in one year time to look for opportunities to improve its ambitions and content. We will also consider revising our strategy when a new JSNA is produced in line with Government expectations.

Appendices

Appendix 1: our approach to engagement in the development of the strategy – 'Start with people'

Effective engagement empowers people to shape, understand and access the services and support that are available to help them to lead healthier, happier lives. The Health and Care Act 2022 mobilises partners within Integrated Care Systems to work together to improve physical and mental health outcomes, and places legal duties on organisations to ensure that their actions are informed by the needs, experiences and aspirations of the people and communities they serve.

In drawing up this strategy, we have used a variety of methods to learn from the people and communities in Hertfordshire and west Essex, observing the Health and Care Act's requirement to use existing insight about the needs and experiences of those living and working in our area, and to work with the partner organisations that have close links to them.

Guidance on developing ICP strategies cites the following groups as those who face the biggest health inequalities, and who therefore should be engaged when drawing up the priorities of our strategy:

- black and minority ethnic voices
- children and young people
- children and young people with SEND
- disabled people
- inclusion health groups
- LGBTQ+ people
- Maternity Voices partnerships
- members of the Armed forces and their families
- older people
- parent and carer panels
- parents, carers and families (including new and expectant parents, and foster parents)
- peer supporters and informal advocates
- people in contact with the Criminal Justice System including offenders, and prisoners
- people living in deprived areas
- people who draw on care and support
- people who draw on mental health services, (including children and young people)

- people with a learning disability, autism and other neurodevelopmental disorders
- people with lived experience of suicide and self-harm
- religious and faith groups
- transient populations
- unpaid carers including people providing care at a distance, and young carers
- women's and men's health and care groups.

Our approach has sought to make the most of the information available to our system through the wealth of engagement work which has taken place in recent years, seeking out the views and experiences of people of those (such as the groups listed above) who face the biggest challenges to living healthy lives. Our learning from this work has been strengthened through additional engagement activities commissioned in order to shape the priorities of this 10-year strategy.

In summary, we have:

- analysed existing insight through a literature review of surveys and studies
- conducted targeted focus groups
- surveyed the ICP workforce and voluntary sector
- held system wide meetings to involve partner organisations and gather their input.

Literature review

Rich feedback on public and voluntary sector services in Hertfordshire and west Essex, capturing people's lived experiences, and their views and suggestions, is available through reports, surveys and feedback documents. These source studies vary widely in scale, methodology and scope – from qualitative studies of 12 young people living in a secure mental health unit, to quantitative, demographically representative studies of 1,000 Hertfordshire residents and 15,500 NHS employees from across our ICB area. We developed a template to enable us to summarise each report/survey/feedback document considered, pulling out key findings, recommendations and where possible, direct quotes from participants.

This work was then fed into and cross-referenced with our developing ICP strategy. As well as insight into specific areas, such as caring, addiction, or dementia, for example, some themes emerged, including loneliness and mental health concerns. The importance of, and access to timely, culturally sensitive and appropriate information and sources of support was revealed as a priority for many people.

Some of the studies reviewed include:

- Addressing obesity in Stevenage, Hertfordshire: a consultation with young people, 2019
- CDA (Community Development Action) COVID recovery survey, August 2021
- Healthwatch Essex 2017 – Dementia Voices
- Essex Health and Wellbeing Survey Report, 2022-2026
- Sweet!3 - Healthwatch Essex into experiences of young people in secure MH unit 2018/19
- HCC's Children and Young People's Health and Wellbeing Survey 2021
- Hertfordshire Health and Wellbeing Survey Report, Jan-Feb 2022
- Healthwatch Hertfordshire: Making local healthcare equal: Healthcare concerns in Black and Asian communities. September 2022
- NHS staff survey, Autumn 2021
- Addiction: gambling, drugs and alcohol - Healthwatch Essex - April 2022
- Mental health self-care in Essex, 2016-2017
- Young mental health ambassador discussions on body image - Healthwatch Essex August 2022
- Consultation on health and wellbeing services in Hertfordshire

A directory of the source studies drawn from (where these have been made publicly available) will be created on the ICS website, in the ICP section, where they will form an 'insight bank' resource for service providers and commissioners from both the public and voluntary sector. They will be shared with the strategy development team in order to inform the ongoing development and delivery of the strategy.

Focus Groups

In order to ensure that the priorities of people who can struggle to make their voices heard through traditional engagement activities have been taken into account in developing this strategy, a specialist research organisation was commissioned to hold targeted focus groups.

Four separate groups were held, attended by public and voluntary sector representatives who work with and advocate for:

1. people living with poverty
2. inclusion health groups
3. people from Black and Minority Ethnic backgrounds
4. parents, children and young people.

Each group was asked:

- What are the main issues and challenges that impact on the health and quality of life of the people you work with?

- What are the measures that could be taken that would help?
- How can organisations be more joined up to deliver the change being suggested?
- What can your organisation do to support?
- Are the developing priorities in our strategy the right priorities?
- Is there anything else we should include?

The summary findings from each group follow below:

Focus group one – recommendations from participants working with people living with poverty

- Need to be flexible and tailor actions and measures to neighbourhoods; 'centralisation' can be a problem.
- People need to better understand the long-term impact of a poor diet and obesity; there is still lack of understanding.
- Access to services can be difficult – need to make this simple and sometimes 'human' rather than always online.
- Replicate the good things that happened during covid pandemic: consistent messaging; outreach activity; covid marshals
- Better to use trusted community members, not the council
- Need all partners to know what everyone else is doing – still fragmented. There are some examples of where this works.
- Make more use of social prescribers – and not just responsive, but could be more proactive
- Value in people taking more control themselves, rather than expecting or waiting for something
- There is lots happening, but funding is a problem (including public health funding)
- Businesses who want to help (as they did in covid) and to give something to communities should be supported and matched to community.

Views on the draft strategy priorities from participants working with people living with poverty

- The environment was seen as a key concern which has an impact on all our priorities – however there was some doubt as to whether environmental improvements could be delivered.
- Prioritising children is important as there are long term benefits from this. There should be much more engagement with schools – make use of them as the centre of their communities,
- Scepticism about delivery of strategy – requires so many partners and if it is just NHS delivering then won't work as so much else that is important.
- How are we going to measure the effectiveness of the strategy and whether its priorities are delivered?

Focus group two – recommendations from participants working with 'inclusion' health groups

- Problem that health professionals don't live in same communities/understand the people they support -they can't see that someone might need to choose between paying a bus fare to the foodbank or to the GP.
- Relationship between GP practices and local people can become confrontational, and opportunities are missed to identify other issues where help could be provided.
- Services need to signpost well – not rebuff. There is always a group who can help – even if just advice or a cup of tea.
- People get used to certain services – GPs and hospitals – and the shift to others can be difficult.
- Services work in an isolated way and have their own priorities, rather than everyone looking at the community or situation as a whole. They don't see how what they do (e.g. planning dept) has impact on health, for example.
- More joined-up working has started but needs much more co-ordination; sharing workspace could help.
- Make better use of social prescribers.
- Resources in voluntary sector a problem as number of volunteers has dropped since height of covid pandemic. Fewer volunteers to support.

Views on the draft strategy priorities from participants working with 'inclusion' health groups:

- Priorities need to be more precisely and simply worded so people can understand.
- Targeting to help reduce inequalities is good and it happens; need to be careful doesn't come at the expense of wider improvements in healthcare.
- Priorities feel just like normal business – what we should be doing anyway.
- Carers should feature more prominently in the strategy – family carers.
- Women should feature more prominently in the strategy.

Focus group three - recommendations from participants working with people from Black, Asian and Minority Ethnic Groups

- The impact of the cost of living is huge – 70% of calls to Herts Help advice line concerning cost of living.
- The accessibility of services to South Asian communities is important - language barriers and the cultural sensitivity and understanding of staff on the front lines of the services.
- Lack of trust in authorities and health and wellbeing services because of overt racism. Several examples were given.

- Lack of trust in police amongst these communities – trust damage by 'stop and search' policies.
- Lack of continuity of care (mental health services).
- Cultural insensitivity – e.g., mental health counsellors who do not understand or try to challenge people's religious beliefs.
- Challenges VCFSE face because of the increase in pressure on their services. One of the participants runs a charity but also is also runs a shop and works full time. Their business gets busy towards Christmas – just as there is increased demand and pressure on the VCFSE sector.
- Funding goes to established VCFSE organisations for outreach into communities that these organisations have limited experience with – this comes at the expense of smaller organisations that have better links but are less well known.
- Participants wanted to see a greater emphasis on supporting grassroots organisations to support people from South Asian communities.
- Having places of worship was seen as an important way in which issues of mental health could be addressed. Places of worship could also be places where authorities reach out to these communities. Difficulties with securing planning permission to build a temple in Watford.
- Participants discussed the need for people within these communities to have decision making power, rather than to simply be consulted.

Views on the draft strategy priorities from participants working with people from Black, Asian and Minority Ethnic Groups:

- Participants were generally supportive of the priorities and their comments were related to checking that specific groups were included in these priorities – for instance carers. There was a particular concern for young carers from South Asian communities who are often involved in care and support for adult relatives because they are often more fluent in English and better placed to navigate systems in the UK.

Focus group four - recommendations from participants working with children and young people

- Mental health problems and lack of access to services was mentioned by most in the group as being the biggest issue affecting the wellbeing of young people.
- Teachers are struggling to cope with issues their students present with due to lack of time, training or awareness of what support is most appropriate.
- An increasing issue at present is young people who are struggling with their gender identity, particularly common among those with autism.
- Social prescribing is an important way of supporting young people.
- A Scottish initiative which is training all teachers in nurture-based practice which is seen to be working very well and reducing exclusions from school.

- Having spaces where young people can speak to adults who are separate from family and friends is beneficial.
- We need to link up our community organisations and their activities.
- Tackling cross border issues and infrastructure barriers is important.
- We need to have agreed targets and outcomes and long-term funding in place.
- Support for teachers, parents and others in contact with vulnerable young people is key.

Views on the draft priorities from participants working with children and young people

- A number of the issues linked to the priorities could be closely related to adverse childhood experiences. Preventative measures could mitigate against these.
- The workforce priority is critical across the NHS and other partners.
- Funding that is on short-term cycles is deemed a problem that could mitigate the ability to deliver some long-term priorities
- Some felt there were too many priorities, how will they all be delivered?
- How would priorities be monitored?
- Reducing health inequalities was seen as underlying all the other nine and the group was not sure whether this needs to be a priority, or a general principle

Responding to the focus group findings

The insights obtained as a direct result of these focus groups have helped shape our strategy. For example, although there was generally positive feedback about the 10 priorities that participants reviewed, there was concern there could be too many, and that they would not therefore be achievable. The number of priorities has since been reduced.

It was also noted that the priorities need to be expressed in clear language that can be understood by everyone. This has been taken on board by the strategy development team. Some themes, such as the importance of early help, the need for services to be 'joined up', the need for effective signposting of services and better awareness of services will need to run throughout the delivery of every priority.

The importance of identifying ways and means of evidencing actions that lead to the delivery of the strategy's priorities was highlighted. This is an area where ongoing public and staff engagement and involvement will be vital in order to maintain confidence in the strategy and the organisations which have developed and own it.

The detailed insight gathered will contribute to the development of the Joint Forward Plan, which will be our system's delivery plan for the integrated care strategy.

Surveying the ICP workforce and voluntary sector

An anonymous survey seeking the views of staff and volunteers working for Integrated Care Partnership organisations was distributed across our system, with the support of system partners. More than 750 responses were received over a two week period.

Respondents were largely drawn from the NHS and local government (both district and county councils), with the voluntary, community, faith and social enterprise sector and other public services, including the police service, also represented. 66% of respondents reported having some contact with, or offering support to, service users, patients, or members of the public.

The survey offered respondents the opportunity to give their views on some or all of the 10 draft priorities they were presented with, both in terms of the personal potential impact of those priorities on themselves and their families, and the wider potential impact on their communities and the people they serve through their work.

The majority of respondents (59%) chose to comment on workforce as a priority, selecting 'Recruit, develop and retain the people we need to provide health and care services for our population, ensuring that we have enough people with the right skills to deliver the best possible services'. This suggests that as the survey was taken primarily by people living and working in Hertfordshire and West Essex, respondents were interested in the priority most relevant to their career and progression.

Just under half of respondents chose to comment on a priority relating to mental and emotional health (48%) and a priority which focused on measures to ensure people maintain a healthy weight (47%). A priority which focused on addiction and its impact on health and wellbeing, had the fewest responses (24%), although of those 24%, more than half said that this priority would have an impact on them as individuals, and two thirds said this would impact their family or friends.

When asked in an open question whether they wanted to comment on the strategy priorities overall, 180 respondents raised the following issues:

- Generally positive sentiments (41%)
- Needs adequate staff/skills processes to be delivered (14%)
- Needs detail on delivery, monitoring and evaluation (12%)
- Needs adequate funding to be delivered (11%)
- Improved partnership working needed for this to work (9%)
- Co-production needed/would be useful (7%)
- People need to be enabled to take ownership of their own health/have access to right information and services (6%)
- Focus on those most in need/do a small set of things well rather than too many not very well (2%)

When completed, the detailed survey report will be made available to the strategy team and the public, via the ICP web pages on the Hertfordshire and West Essex Integrated Care System website.

System Wide Meetings

As part of our engagement plan in developing this strategy we have attended over 30 meetings with senior leaders to present the draft strategy and obtain feedback. This engagement has been crucial in ensuring that our strategy meets the needs of all our partners.

HWE Integrated Care Partnership	Hertfordshire Mental Health, Learning Disabilities and Autism (MHLDA) Collaborative Board	Children's Services Core Board - HCC
Healthwatch Community Assembly (Hertfordshire)	Healthwatch Community Assembly (Essex)	District & Borough CEO Group (HCC)
HWE ICS Health Inequalities Strategic Board	Hertfordshire Health & Wellbeing Board	Health & Wellbeing Board (ECC)
ICB Primary Care Senior Management Team Meeting	Public Health Management Board - HCC	HCC Cabinet Members Panel - webinar
Scrutiny Committee (HCC)	Health Overview & Scrutiny Committee (Essex CC)	Adult Care Services Senior Management Board (ACSMB) HCC
Essex Children's Board	HWE Integrated Care Partnership Committee	Essex Partners Board (ECC)
ICB Board Meeting	HWE ICB Design & Delivery Board	ICS PMO Team Meeting
East & North Hertfordshire Health Care Partnership Board	South and West Herts Health Care Partnership Board	West Essex Health & Care Partnership Board

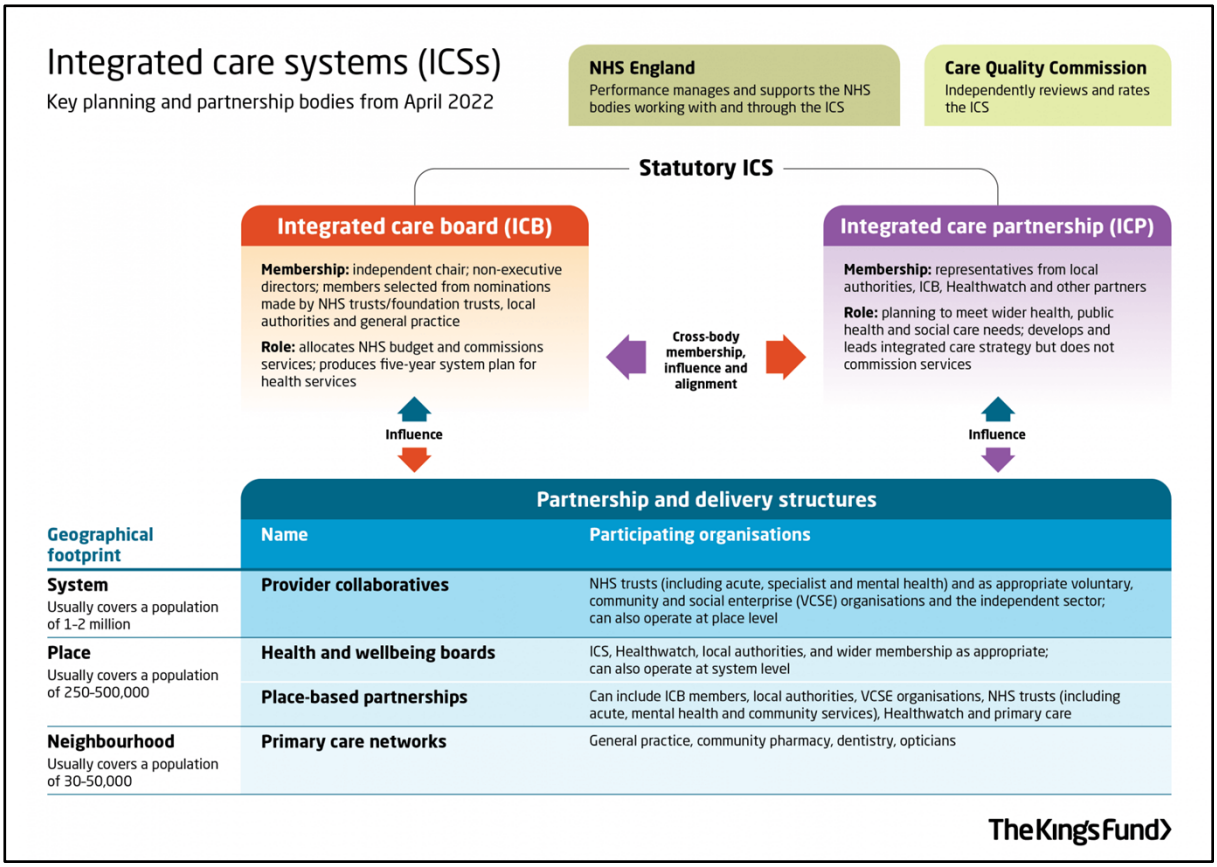
Conclusion

Engagement and involvement should be an active, ongoing process, which provides clear feedback about the way in which involvement has led to improvements. We are committed to fully involving people and communities across Hertfordshire and west Essex as the strategy is further developed and delivered. Updates will be posted to the ICP pages of the Hertfordshire and West Essex Integrated Care System website and through a wide range of communications channels. Those directly involved will be kept informed so that they can see the impact that their views have made.

Appendix 2: glossary of acronyms

ABCD	Asset Based Community Development (ABCD) principles *(citizen-led, relationship oriented, asset-based, placed-based, inclusion focused)*
ADHD	Attention Deficit Hyperactivity Disorder
BCF	Better Care Fund *[government fund to support the integration of health and care]*
CAMHS	Child and Adolescent Mental Health Services
CLA	Children Looked After
COPD	Chronic Obstructive Pulmonary Disease
CVD	Cardiovascular Disease
DTA	Discharge to Assess
EOE	East of England
HCP	Health Care Partnership *[an alliance of health and care organisations organised on a geographical footprint or within a sector (e.g. mental health)]*
HWE	Hertfordshire and West Essex
ICB	Integrated Care Board *[NHS organisation responsible for NHS services]*
ICP	Integrated Care Partnership *[statutory committee for improving health and wellbeing outcomes]*
ICS	Integrated Care System *[made up of the ICB and ICP and other elements]*
JSNA	Joint Strategic Needs *Assessment [a responsibility of Health and Wellbeing Boards]*
LD	Learning Disability
LeDeR	Learning Disabilities Mortality Review *[a requirement to review the deaths of people with learning disabilities for learning]*
LMNS	Local Maternity and Neonatal System
LTP	NHS Long Term Plan
MCI	Mild Cognitive Impairment
SEND	Special Educational Needs and Disability
SMI	Severe Mental Illness
VCFSE	Voluntary Community Faith and Social Enterprise Sector

Appendix 3: integrated Care Systems Explained



Source: Integrated care systems: how will they work under the Health and Care Act? The King's Fund (www.kingsfund.org.uk)