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

Cabinet

The meeting will be held at **7.00 pm** on **15 June 2022**

Committee Room 2, Civic Offices, New Road, Grays, RM17 6SL

Membership:

Councillors Rob Gledhill (Leader), Mark Coxshall (Deputy Leader), Qaisar Abbas, Shane Hebb, Jack Duffin, Deborah Huelin, Andrew Jefferies, Barry Johnson, Ben Maney and Luke Spillman

Agenda

Open to Public and Press

1 Apologies for Absence

2 Minutes **5 - 24**

To approve as a correct record the minutes of Cabinet held on 9 March 2022 and 23 March 2022.

3 Items of Urgent Business

To receive additional items that the Chair is of the opinion should be considered as a matter of urgency, in accordance with Section 100B (4) (b) of the Local Government Act 1972.

4 Declaration of Interests

5 Statements by the Leader

6 Briefings on Policy, Budget and Other Issues

7 Petitions submitted by Members of the Public

8 Questions from Non-Executive Members

9 Matters Referred to the Cabinet for Consideration by an Overview and Scrutiny Committee

10	**Thurrock Health and Wellbeing Strategy Refresh 2022-2026 (Decision: 110610)**	**25 - 56**
11	**Integrated Care Partnership (ICP) (Decision: 110611)**	**57 - 146**
12	**Statement of Community Involvement (Decision: 110612)**	**147 - 198**
13	**Appointments to Outside Bodies, Statutory and Other Panels**	**199 - 206**

Queries regarding this Agenda or notification of apologies:

Please contact Lucy Tricker, Senior Democratic Services Officer by sending an email to Direct.Democracy@thurrock.gov.uk

Agenda published on: **7 June 2022**

Information for members of the public and councillors

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DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF

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

Helpful Reminders for Members

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

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

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

Does the business to be transacted at the meeting

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

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

Disclosable Pecuniary Interests shall include your interests or those of:

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

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

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

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

Pecuniary

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

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

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

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

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

Non- pecuniary

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

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

Our Vision and Priorities for Thurrock

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

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

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

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

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

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

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

Minutes of the Meeting of the Cabinet held on 9 March 2022 at 7.00 pm

The deadline for call-ins is Monday 21 March 2022 at 5.00pm

Present:	Councillors Robert Gledhill (Leader), Shane Hebb (Deputy Leader), Mark Coxshall, Jack Duffin, Deborah Huelin, Barry Johnson and Ben Maney
Apologies:	Councillors Andrew Jefferies, Allen Mayes and Luke Spillman
In attendance:	Lyn Carpenter, Chief Executive Matthew Boulter, Democratic Services and Governance Manager, and Interim Monitoring Officer Lucy Tricker, Senior Democratic Services Officer

Before the start of the Meeting, all present were advised that the meeting was being recorded, with the recording to be made available on the Council's website.

98. Minutes

The minutes of the Cabinet meeting held on 9 February 2022 were approved as a correct record.

99. Items of Urgent Business

There were no items of urgent business.

100. Declaration of Interests

The were no interests declared.

101. Statements by the Leader

The Leader began his statement by describing how Thurrock Council had joined other local authorities across the country in flying the Ukrainian flag as a show of solidarity as they fought to retain their freedoms. He commented that Councillors from across the Chamber had come together to show their unequivocal support for the brave Ukrainians, and to share their disgust at the brutal and unjustified attack from the Russian Federation. He commented that the Ukrainians had proven how hard they were willing to fight for their freedoms and democracy. He felt they were brave, determined and resolute in their opposition to the invasion from Russian aggressors. He commented that Thurrock had published information on its website to show residents the best way to support the Ukrainians, such as by donating to trusted charities who were working hard on the ground.

The Leader moved on and stated that COVID restrictions had now come to an end in England, and both Scotland and Wales were scheduled to end their COVID restrictions at the end of the month. He explained that the country was now moving to a position of being able to live with COVID, and thanked residents for the dedication and sacrifices over the past two years to allow the country to get to this position. The Leader explained that although the virus still existed, he hoped it would become endemic and urged residents to get vaccinated. He stated that officers and the NHS were continuing to champion the vaccine in local communities by providing information to allow residents to make informed decisions and creating community-based pop-up vaccine centres across the borough in coming weeks.

The Leader commented that the first tree for the Queen had been planted in South Ockendon a couple of weeks' ago, and the Mayor would be planting another tree this Friday. He explained that over the course of the coming weeks a new tree would be planted in every ward. He stated that Ward Members had selected both the type of tree and the location, and these were being planted to celebrate the Platinum Jubilee as part of the national Queen's Green Canopy scheme, with each one having a plaque to mark the occasion. He commented that the Council were committed to ensuring appropriate trees were planted in suitable areas throughout the borough to create natural sanctuaries for residents to enjoy. He mentioned that as well as the trees being planted for the Queen's Jubilee, the Council would also be planting more than 3,400 new whips and trees thanks to £285,000 funding from the Forestry Commission.

The Leader summarised and outlined the Clean It, Cut It and Fill It update. He stated that since April 2021: 3,175 potholes had been filled, more than 99% within agreed timeframes; 1,586 fly-tips had been cleared; 255 Fixed Penalty Notices had been issued and eight vehicles seized in relation to this crime; and 3,965 Fixed Penalty Notices issued for offences such as littering and spitting.

102. Briefings on Policy, Budget and Other Issues

Councillor Huelin explained that she had recently visited the new Cromwell Road care centre, which she felt provided an excellent service for users. She stated that the new centre had transformed old administration areas into areas for service users including: a designated high-tech games room; a craft room; hairdressers; pamper room; a virtual befriending service; and a wheelchair friendly kitchen that could be utilised by both professionals and residents. She explained that the centre also had landscaped gardens, an outdoor gym, and was open for longer hours in the evenings and weekends. Councillor Huelin added that the meals on wheels service was currently in place on site, and this was being delivered by a high-quality microenterprise.

103. Petitions submitted by Members of the Public

No petitions had been submitted by members of the public.

104. Questions from Non-Executive Members

The Leader stated that one question had been submitted by a Non-Executive Member, and this would be heard during the item to which it related.

105. Matters Referred to the Cabinet for Consideration by an Overview and Scrutiny Committee

Other than those items already contained within the agenda, no items had been referred to the Cabinet for their consideration by an overview and scrutiny committee. The Leader explained that as members of the public were in attendance, these items would be heard first.

106. Petition 557 - Renaming of B1335

Councillor Maney introduced the report and stated that Cabinet had adopted the Naming and Numbering of Streets and Highways Assets Policy in July 2021, which enabled the Council to receive requests for the naming of roads, including after living or deceased people, which Cabinet would then determine. He explained that at November's Full Council, Councillor Van Day had submitted a petition with over 230 signatures, calling for the B1335, Aveley Bypass, to be renamed in honour of the late Lance Corporal Nicky Mason. Councillor Maney stated that Lance Corporal Mason had been serving in Afghanistan with the 2nd battalion Parachute Regiment when he was killed by an explosion in September 2008 at the age of 26. He stated that as a lifelong Aveley resident he knew of Lance Corporal Mason, albeit not closely, and felt that his loss had greatly impacted the tightknit Aveley community, and impacted even more so his family including his father Dennis and brother Lee. He added that both Dennis and Lee had done so much to support ex-service members and to keep Lance Corporal Mason's memory alive, and both fully supported the call to rename the Aveley Bypass as proposed.

Councillor Maney felt that the public outpouring of support for Councillor Van Day's petition was evidence that time had not erased the sense of loss felt by the community, and the petition had continued to attract more submissions even after its presentation to Full Council last year. He explained that even though there had been overwhelming public support for the proposal, one objection had been received from one of the local community forums. He felt that the objection was not a view shared by the wider community and was not supported by any of the three Aveley Ward Councillors, who had been directly elected to represent their residents. He mentioned that the longer established Aveley forum, chaired by Rev. Alan Field, had previously approached the Council with a desire to rename a road or area after Lance Corporal Mason. Councillor Maney felt that the hundreds of names added to the petition outweighed the sole objection received. He asked Cabinet to evaluate the objection and urged Cabinet members to respectfully disagree.

Councillor Maney explained that the Aveley bypass was the main route through Aveley and would have been well known to Lance Corporal Mason, who would have had to cross the road many times enroute to his local

secondary school. He stated that Lance Corporal Mason had served directly in the fight against Islamic extremism and had made the ultimate sacrifice whilst doing so. He felt that those who fought terrorists overseas did so in order that people back at home, including Aveley residents, could live beyond the reach of extremists. Councillor Maney felt that it would be a fitting memorial to Lance Corporal Mason if the Aveley bypass were to be renamed and bear his name, and would also be a comfort to Lance Corporal Mason's family to see him commemorated in this way. He summarised and asked Cabinet Members to consider the proposal, and if minded to agree, decide upon a new name for the road.

Councillor Van Day asked his question as follows: *"will the Portfolio Holder agree to take into consideration Lance Corporal Nicky Mason's father's wish for how the old Aveley bypass be renamed?"* Councillor Maney replied that the wishes of Lance Corporal Mason's family would be at the heart of the decision taken by Cabinet, all of whom would work with the family.

Lance Corporal Mason's brother, Mr. Lee Mason, was invited to speak by the Leader and felt that the most fitting name for the road would be Lance Corporal Nicky Mason Way.

Councillor Huelin recognised that the forum who were objecting to the proposal formed only part of the Aveley community, and both forums from Aveley had been involved in discussions regarding the proposal. She welcomed the petition that had been submitted to Full Council by Councillor Van Day, which she felt included voices from across the community. Councillor Coxshall queried why there were two forums in Aveley. He also apologised to the Mason family for the delay in getting to this stage, and asked the Portfolio Holder as to why there had been a delay. Councillor Huelin explained that although there were currently two forums in Aveley, officers would restart their work with these forums after purdah to see if they could be united. Councillor Maney replied that there had been a delay as the Council's previous position did not support the naming of roads after people living or deceased. He confirmed that he had not personally agreed with this policy and therefore the new policy had been agreed by Cabinet last year. He felt that the new policy recognised deserving people, and thanked Councillor Van Day, the Mason family, and the Aveley community for their hard work on this proposal. The Leader agreed that the new policy recognised deserving people.

Cabinet agreed that the B1335, Aveley Bypass, should be renamed to 'Lance Corporal Nicky Mason Way'.

RESOLVED: That Cabinet:

1. Agreed to rename the Aveley Bypass as Lance Corporal Nicky Mason Way.

Councillor Van Day left the meeting at 7.27pm.

107. Lower Thames Crossing Task Force Update Report (Decision: 110606)

Councillor Massey introduced the report and stated that it provided an update on the work of the Task Force from November 2021 until January 2022. He stated that the November meeting had been postponed until December, and the Task Force had received a presentation from the Transport Action Network, which had detailed various legal challenges which could relate to the LTC, for example changes in the government's climate and environmental regulations. He explained that questions had been asked regarding the World Health Organisation (WHO) regulations on PM2.5, the Climate Change Act and low carbon budgets. He felt that electric vehicles would play an important part in the future of the UK travel network, and these were discussed by the Task Force in relation to the LTC, particularly possible future options relating to LGVs and HGVs becoming non-petrol/diesel.

Councillor Massey moved on and explained that the December agenda included an update on the Hatch Report, which had become a regular item for the Task Force. He stated that some of the Hatch measures were proving difficult to secure, and the Task Force had raised concern regarding smart speed limits, legacy worker accommodation, air quality and noise pollution along the route, and HGV routes during construction phase. He explained that work was ongoing between the Council and National Highways regarding these mitigation measures. Councillor Massey explained that carbon hubs were also discussed during the meeting, but more definition was required regarding how they would be incorporated into the LTC, as well as potential issues regarding the historic landfill along the coast.

Councillor Massey explained that at the January meeting of the Task Force they had discussed the impact of the Thames Freeport on the LTC, mainly around the local road connectivity to the LTC. He stated that the Council were working with Thames Gateway, Port of Tilbury, and DP World to discuss the implications of the LTC. He explained that, as suggested by Cabinet, the main areas of discussion had included the A13 Manorway and A13 Orsett Cock junctions, as the current plans were not seen as optimal by the Council, which could lead to an increase in traffic around the ports. He stated that one road that both the Council and the ports would be pushing for in Development Consent Order version 2 (DCOv2) would be the Tilbury Link Road, as this would provide some local connectivity to the LTC. He commented that the Task Force remained concerned regarding the lack of available baseline health impact and traffic data from National Highways, as much of this information may not be available until after DCOv2 submission. He stated that concern was also raised across the Task Force regarding the expected future consultation that could be held during purdah. He summarised and stated that the Task Force would be meeting on Monday 14 March, and would be discussing the Orsett Cock/A13 junction, as well as the latest proposed consultation.

The Leader confirmed that he had written to National Highways regarding their suggestion of holding a consultation during purdah. Councillor Coxshall agreed that there should be no consultation during the purdah period and

thanked Cabinet and the LTC Task Force for their sustained pressure on the matter. He highlighted that the new Freeport required sufficient connectivity for both residents and businesses, for example at the Asda roundabout. He felt that the LTC needed to include provision for local connectivity as this could benefit both residents and the port, for example additional connections and junctions between the local road network and the proposed LTC. The Leader thanked Councillor Massey for this consistent attendance at Cabinet to provide regular update on the work of the Task Force, and felt pleased to see the approach the Task Force were taking and the feedback they were receiving.

RESOLVED: That Cabinet:

1. Noted the work of the Task Force

Reason for decision: as outlined in the report
This decision is subject to call-in

Councillor Massey left the meeting at 7.36pm.

108. Financial Update - Quarter 3 2021/22 (Decision: 110607)

Councillor Hebb introduced the report and stated that it provided an update on the Council's finances for quarter 3 2021/22. He explained that this report was focussed on Children's Social Care as there remained a pressure of £0.385m on the service. He explained that there were positive controls surrounding this pressure and officers were following correct processes, but the pressure required further mitigation. He added that the Children's Social Care budget had been affected by two recent unregulated placements, but assured Cabinet that detailed work was ongoing by officers, which included innovative new ideas to reduce the pressure on the budget caused by unregulated placements. Councillor Hebb moved on and stated that the number of Looked After Children in Thurrock had reduced by nine over quarter 3, but this had not affected budgetary pressures as some individual cases cost more than others, due to the services required by some children. He added that there was also a service pressure of £0.6m due to the number of cases of children in remand. He thanked all council departments for their hard work on the budget, which could ensure that the most vulnerable in Thurrock received the correct care. He urged residents to apply for the Local Council Tax Scheme if they were struggling to pay their council tax, and to contact the council if they were unable to pay any fines.

Councillor Hebb moved on and outlined the capital programme. He stated that in 2021/22 the capital budget had been £32.4m, of which £27m had been spent and approximately £7m remained. He stated that the remaining £7m would be reprofiled for the next quarter. He highlighted point 7.9 of the report which outlined Thurrock's ambitious future plans for the high rises in Blackshots. He described how this could be a difficult process, but would remain a focus for the council moving forward. He stated that the breadth of services provided by local authorities around the country continued to

increase, but explained that this was an issue that was being explored by the Local Government Association and other organisations.

Councillor Johnson explained that although there remained pressures within the Children's Social Care budget officers worked hard to ensure that every child received a good level of care, and children remained at the forefront of the team. Councillor Huelin thanked the Adult Social Care and Transformation teams for their hard work mitigating pressures within the Adult Social Care budgets whilst still improving and transforming services. She explained that the Council had continued to deliver services to residents throughout the pandemic, and were seeing an increased rate of residents requiring longer-term care. She explained that officers were working closely with the NHS to ensure appropriate preventative care was provided when necessary.

RESOLVED: That Cabinet:

1. Commented on the forecast financial outturn position for 2021/22.

Reason for decision: as outlined in the report
This decision is subject to call-in

109. Report on Asset Related Savings (Decision: 110608)

Councillor Coxshall introduced the report and stated that it provided Cabinet with an update on the Thameside Complex, and a statement had been submitted to Cabinet and Corporate Overview and Scrutiny on behalf of Thurrock Lifestyle Solutions. He stated that lots of work had been undertaken on this proposal, which would hopefully be completed within the next few months. He felt that transferring the asset to the community would improve the arts and culture offer within Thurrock. He explained that the Council were working with the relevant community groups to ensure good governance and legal standing surrounding the transfer, which he felt would also help the community groups apply for funding in the future. Councillor Coxshall assured Cabinet that the Thameside continued to take bookings and would have opportunities to apply for external funding in future. Councillor Huelin added that the conversation between the Council, community groups and other partners continued to move forward, and thanked officers and community members for their hard work. Councillor Hebb agreed that transferring the Thameside Theatre to the community would improve arts in Thurrock, and felt pleased to see that the proposal would have good governance.

RESOLVED: That Cabinet:

1. Noted the main points from the discussions with the community and through the ongoing wider Roundtable meetings.

2. Supported the relevant Portfolio Holders and Officers to continue with further discussions with the community over the future of the Thameside building and related services, and that a recommendation is made to Cabinet for final decision no later than July 2022.

Reason for decision: as outlined in the report
This decision is subject to call-in

110. CO1 - Redevelopment Update (Decision: 110610)

Councillor Coxshall introduced the report and stated that the proposal consisted of approximately 56 one-bedroom flats and 26 two-bedroom flats on the current CO1 site. He explained that there had been numerous options available to deliver the site, but if the recommendations were agreed by Cabinet, then the site would be delivered, owned and managed solely through the Housing Revenue Account (HRA) and would be solely high-quality council housing. He stated that this scheme would increase the amount of council housing stock available, and would work towards the Council's objective of 'fewer buildings, better services'. Councillor Hebb added that the scheme would rationalise the Council's assets as it would reduce the amount of office space, improve energy efficiency, and improve services, whilst also reducing the Council's cost. He stated that the proposal would improve housing for local residents and would provide additional homes.

The Leader stated that housing officers, Members and the Portfolio Holder were currently working on delivering a number of schemes, including the redevelopment of Blackshots, by demolishing the existing high-rises in the area and building new houses and apartments. He stated that the detail surrounding this scheme would be presented to overview and scrutiny and Cabinet in the future, but would work to improve housing for residents in the Blackshots tower blocks. He explained that there were currently three high-rises comprising of 168 flats, 155 of which were council owned and 13 privately owned. He stated that the Council would work with the leaseholders of these flats as the project developed. The Leader commented that residents in the high-rises would be decanted into new housing in the area, which would be formed of both houses and flats, ensuring different provision was accessible to residents. He added that officers and Members were also re-opening proposals regarding the high-rises in Grays and Tilbury, as these high-rises could also suffer from problems with damp and mould. He summarised and stated that the housing team and Cabinet would be considering the whole of the HRA and council housing stock across the borough.

Councillor Maney thanked the Leader for those reassurances regarding the future of the Blackshots estate. He stated that as Ward Councillor for the area he regularly met with housing officers and was working hard to ensure the tower blocks were demolished and good housing built for those residents. He understood that this could be a long journey, as it could be difficult to demolish the tower blocks, but felt that the Council were moving in the right direction with the project. He added that some of the high-rises in the borough, including the tower blocks in Grays, suffered from problems with damp and mould, as the high-rises were at end of life and needed replacing. Councillor Coxshall added that any new high-rises that were considered in the future needed to be of good quality design and well-maintained. He

commented that some Thurrock residents enjoyed living in tower blocks due to the sense of community, and felt that there were opportunities for new high-density housing options in places such as town centres. The Leader commented that high-rises could have nice views, and modern high-rises may not suffer as much with damp and mould due to modern building standards. He summarised and stated that this could be a long project and work would be ongoing in the meantime to maintain the current high-rises.

RESOLVED: That Cabinet:

1. Approved the proposed redevelopment of CO1 be 100% funded through the HRA.

2. Approved that the scheme proposed is to be directly delivered by the Council and the properties be owned, managed and let by the Council through the HRA.

3. Noted that consultants are appointed to take the scheme through to planning submission subject to formal approvals and consultation.

Reason for decision: as outlined in the report
This decision is subject to call-in

111. Parking Policy and Strategy, Parking Design & Development Standards, and Parking Enforcement Strategy (Decision: 110611)

Councillor Maney introduced the report and stated that it sought endorsement for a suite of documents which, if approved, would shape the Council's policy and approach in respect of vehicle parking in the borough. He stated that it was important that the Council implemented an updated Parking Policy and Strategy document, along with a set of Parking Standards, in order to meet current national objectives and keep pace with changing transport trends and vehicle ownership. He stated that the two documents contained within the report would assist the Council in ensuring the right level of parking provision across the borough and make sure it was of appropriate design and standard. Councillor Maney explained that the documents would also guide the parking requirements for future developments, both residential and commercial, and would form part of the Local Plan. He stated that the third document presented in the report outlined the Parking Enforcement Strategy, which would allow the Council to be clear and responsive to parking issues across Thurrock.

Councillor Maney stated that all three documents had been subject to public consultation and had broadly attracted support. He stated that residents had voiced a greater desire to see verge and pavement parking enforced more widely, and mentioned that officers were currently in the process of designing a number of pilot schemes which would prohibit anti-social parking in selected areas. He summarised and stated that the report and accompanying documents had been considered by the Planning, Transport and Regeneration Overview and Scrutiny Committee twice, and a number of their

recommendations had been included in the report. He thanked the Committee and the Chair for their hard work scrutinising the report, which would ensure the strategies and principles it contained worked for residents and businesses.

The Leader thanked officers and the Portfolio Holder for their hard work on the report and felt it good to see that HGV no parking areas were being proposed. He felt that this issue could cause problems for residents as HGVs could park in residential areas for numerous days, and hoped the pilot scheme preventing this issue was successful. The Leader highlighted page 101 of the agenda, and felt that as the level of car ownership increased across the borough, the level of parking provision in new homes and flats should also increase. He commented that parking provision should be realistic and managed through the documents in the report. He also felt that the number of cars per household allowed to park in controlled parking zones should be increased from three to four or five, as the majority of households across the country often had more than three cars. He also wished to see passive provision for electric vehicle (EV) charging in new homes built across Thurrock. He felt that the wording for this proposal be changed from ‘could’ to ‘should’ as this would ensure that new homes would be future-proof and would help to increase the number of EV’s in Thurrock. He highlighted page 126 of the agenda and felt it was good to see the documents also increased the number of on-street EV charging stations in town centres and residential areas, and felt pleased to see the Council were partnering with Connect Kerb on this scheme.

RESOLVED: That Cabinet:

1. Approved the Parking Policy and Strategy document for adoption by Thurrock Council.

2. Approved the Parking Design & Development Standards document adoption by Thurrock Council.

3. Approved the Parking Enforcement Strategy document for adoption by Thurrock Council.

Reason for decision: as outlined in the report
This decision is subject to call-in

112. Integrated Transport Block Capital Programme 2022/23 & Highways Maintenance Allocation and Programme 2022/23 (Decision: 110612)

Councillor Maney introduced the report and stated that the Council had a duty to report on the 2021/22 grant funding that had been received from the Department for Transport, and to agree the programme allocations in line with transport priorities. He stated that the 2022/23 Integrated Transport Block allocation amounted to £978,000 which would be used to fund a range of transport projects such as road safety engineering and improved EV charging facilities. He highlighted the table at point 3.3 of the report outlined the coming

year's programme and the funding allocations. He mentioned that recommendation 3.3 of the report did allow for variations of these funding allocations where necessary in accordance with the delegated authority process.

Councillor Maney stated that the Council would also manage a proposed £1.383m grant settlement in the form of the Highways Maintenance Block allocation, and stated that this money was not ringfenced and allowed for some flexibility in terms of spend which was outlined in appendix 2 of the report. He stated that both programmes within the report required Cabinet approval and would be delivered in line with the Council's Transport Strategy and Assets Management Strategy. He added that although any aspect of the ITB could not formally be approved by Cabinet, the Safer Routes to School programme had been a central part of the ITB programme for many years, and had helped improve safety at schools across the borough. He stated that the Safer Routes to School programme would remain unchanged for the 2022/23 financial year and would receive a £250,000 allocation. Councillor Maney explained that he had asked officers to consider whether the scheme should be absorbed into a broader programme which he felt could better capture other council priorities, whilst ensuring school safety. He stated that work would be undertaken on this over the coming months to establish whether this should be reflected in next year's ITB report.

RESOLVED: That Cabinet:

1. Approved the ITB Capital Programme allocations, policy and prioritisation direction for the DfT ITB Block funding under the key policy areas of Road Safety Engineering, Safer Routes to School, Area Intervention Programme and EV charging programmes.

2. Approved the Highways Maintenance Block Allocation Programme (as detailed in Appendix 2) for 2022/23.

3. Approved the process which delegated authority to the Director of Public Realm, in consultation with the Cabinet Member for Highways and Transport, to review and make local changes to the ITB programme and the DfT Maintenance Block Allocation programme, as well as other funding allocations that may arise within year.

Reason for decision: as outlined in the report
This decision is subject to call-in

113. Commissioning Report - Advocacy (Decision: 110613)

Councillor Huelin introduced the report and stated that it provided a voice to vulnerable residents with learning difficulties and mental health issues across Thurrock, who struggled to express themselves and required an advocate. She explained that the Advocacy service provided people with specialised training to represent vulnerable adults and help them verbalise their needs and secure their rights. She explained that some of this service was statutory

and some discretionary, currently with some of the service supplied via the Council and some of the service supplied via government commissioning services. She described how this system had proven to be confusing for some service users and therefore the government had transferred responsibility to local authorities. She explained that the tender for this service would reduce the confusion for service users and would seek to find a provider whose experts could work across different areas of advocacy and disabilities to provide residents with a continuity of service and ease of contract renewal in future.

The Leader, Councillor Coxshall and the Chief Executive left at 8.29pm.

Councillor Huelin explained that there may be times in future where the Council would need to spot purchase advocacy services, for example for adults receiving specialised care outside of the borough and not within the working area covered by the contract. She stated that the report would improve the efficiency of the Council and would protect the rights of the most vulnerable residents. She stated that the Council would also be asking those that tender to allow for a 25-50% increase in demand due to the rise of people requiring care post-COVID. Councillor Huelin summarised and highlighted point 5.1 on page 209 of the agenda which stated that the results of the consultation with service users would be shared with Cabinet. She stated that the consultation was currently underway and would take time due to the sensitivities of those being consulted.

RESOLVED: That Cabinet:

1. Agreed that the new Advocacy contract is procured in line with the contents of this paper.

Reason for decision: as outlined in the report
This decision is subject to call-in

114. Quarter 3 (April to December 2021) Corporate Performance Report 2021/22

Councillor Duffin introduced the report and stated that the majority of Key Performance Indicators had met their target for quarter three despite ongoing challenges relating to the COVID-19 pandemic. He stated that the number of apprenticeships had decreased during quarter three, but had previously increased in quarter two. Councillor Duffin proposed a change to the table on page 224 of the agenda and asked if officers could include a new box which would outline the direction of travel for those KPIs that had missed target.

Councillor Hebb felt pleased to see that service delivery had continued during the pandemic, and felt pleased that the KPI regarding payment of business rates and council tax had met its target. He urged residents to contact the council and apply for the Local Council Tax Scheme if they struggled to pay their council tax bill.

RESOLVED: That Cabinet:

1. Noted and commented upon the performance of the key corporate performance indicators in particular those areas which are off target and the impact of COVID-19.

2. Identified any areas which require additional consideration.

Cabinet adjourned at 8.35pm

The Leader, Councillor Coxshall and the Chief Executive arrived at 8.45pm.

Cabinet reconvened at 8.45pm.

115. Thames Freeport: Business Rates Policy and Governance Structure (Decision: 110609)

Councillor Hebb introduced the report and stated that the Council currently retained approximately 38% of business rates collected due to central government's scheme of reallocation. He explained that the Council would be able to keep 100% of business rates collected from within the Freeport area which he felt would have a positive impact on the Council and local residents. He stated that the business rates policy was outlined at Appendix 1 of the report, and point 3.2 of the report highlighted that discretionary relief would be available to businesses for five years from the point at which each beneficiary first received relief. He stated that although the report was technical, he felt that the Freeport would provide new opportunities and connectivity for local residents and businesses.

Councillor Coxshall felt that the Freeport scheme was moving quickly, as it was hoped that Thames Freeport would the first of eight Freeports across the country up and running. He stated that the Freeport would bring approximately £400m of investment into the borough and officers and Members could soon begin conversations about how to spend this investment in the future. He added that the Freeport would also bring approximately 24,000 new jobs into the area, which could not be jobs that had been relocated from other areas. Councillor Coxshall stated that Thames Freeport would work in synergy with the other Freeports, such as Freeport East in Harwich. He stated that conversations needed to continue regarding the governance structure surrounding the Freeport to ensure that it worked effectively and efficiently.

The Leader thanked officers and Members for their hard work on the report, and to ensure that the Thames Freeport would be the first of its kind up and running. He stated that there needed to be good governance surrounding the Freeport, as well as detailed understanding of government targets and how these would meet strategic objectives. The Chief Executive added that the Full Business Case submitted to the government was being used by the Department for Levelling Up, Housing and Communities as a best practice example and was being shared with the governments of the devolved nations.

RESOLVED: That Cabinet:

1. Approved the Thames Freeport Business Rates Policy at Appendix 1.

2. Delegated authority to the Section 151 Officer to make necessary amendments to the policy as required, in consultation with the Cabinet Member for Finance and the Cabinet Member for Regeneration, Strategic Planning and External Relationships.

3. Approved the Chief Executive's appointment as the Council's representative on the Thames Freeport Governance Board, who will be responsible for briefing and updating the Leader of the Council, the Cabinet Member for Finance, and the Cabinet Member for Regeneration. Strategic Planning and External Relationships on key and significant activity.

Reason for decision: as outlined in the report
This decision is subject to call-in

Cabinet agreed that the following recommendations would be adjourned to a later Cabinet meeting:

4. Endorsed that relevant Officers participate in and represent the Council on the various Thames Freeport Sub-committees as necessary and delegated authority to the Chief Executive to appoint officers to appropriate sub-committees e.g. Skills, Levelling Up and Regeneration.

5. Delegated authority to the Chief Executive, in consultation with the Corporate Director of Resources and Place Delivery and the Monitoring Officer, to enter into any Memoranda of Understanding with government and Freeport bodies in order to deliver the activities of Thames Freeport, in consultation with the Leader of the Council, Cabinet Member for Finance and Cabinet Member for Regeneration, Strategic Planning and External Relationships.

The meeting finished at 9.04 pm

Approved as a true and correct record

CHAIR

DATE

Any queries regarding these Minutes, please contact
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Draft Minutes of the Reconvened 9 March 2022 Meeting of the Cabinet held on 23 March 2022 at 6.00pm

The deadline for call-ins is Friday 1 April 2022 at 5.00pm

Present:	Councillors Rob Gledhill (Leader), Shane Hebb (Deputy Leader) *(arrived 6.07pm)*, Mark Coxshall, Deborah Huelin, Andrew Jefferies, Barry Johnson, Allen Mayes, and Luke Spillman
Apologies:	Councillors Jack Duffin and Ben Maney
In attendance:	Lyn Carpenter, Chief Executive Matthew Boulter, Democratic Services and Governance Manager, and Interim Monitoring Officer Lucy Tricker, Senior Democratic Services Officer

Before the start of the Meeting, all present were advised that the meeting was being recorded and would be uploaded to the Council's website.

115. Thames Freeport: Business Rates Policy and Governance Structure (Decision: 110609)

The Leader welcomed Members to the reconvened Cabinet meeting, which had been adjourned on 9 March 2022, to discuss two recommendations relating to the Thames Freeport report. He stated that the Interim Monitoring Officer had been present at the 9 March meeting and had confirmed that Cabinet had followed the correct governance process regarding the adjournment and reconvening. He added that Members who had not been present at the adjourned Cabinet meeting could comment and vote on the recommendations being heard at this meeting. The Leader stated that events had moved on rapidly since the adjournment on 9 March and felt appalled by recent events regarding P&O Ferries. He explained that due to these events, he would be proposing alternative recommendations for 1.4 and 1.5.

Councillor Coxshall proposed that a new report regarding the Thames Freeport be brought to a future Cabinet meeting, which could outline all governance options for the Freeport and would provide the basis for a full discussion of these options. He felt that the Freeport would be a fantastic opportunity for the borough, as it could bring approximately £300m in business rate retention. He hoped that DP World would reoffer jobs to the 800 people who had been let go, and would be reoffered jobs at good rates rather

than £1.88 per hour. He felt disgusted that DP World and P&O Ferries thought this was an acceptable level of pay. He added that this pay rate could also give an unfair competitive advantage to P&O Ferries.

Councillor Hebb arrived at 6.07pm.

The Leader stated that although the Thames Freeport would provide £300mn in business rate retention and levelling up opportunities for residents, Cabinet wanted to have all options outlined, including confirmation of central government's plans. He stated that he would be proposing a pause to ensure Thurrock had all available information before moving forward. He thanked the Chief Executive and all officers for their hard work on this issue over the previous evening and weekend. He added that Thurrock wanted to buy-in to the Thames Freeport as it could be beneficial to the local area, but did not want to do so at the expense of others.

Councillor Huelin stated that she was the Ward Councillor for Corringham and Fobbing, and came from a family of seafarers. She felt disgusted by the behaviour of the senior leadership at DP World and P&O Ferries, as they seemed to be able to pay almost £150m promoting a golf tour, but did not have the money to pay for merchant navy pensions. She agreed with proposals to pause and wait for more information. Councillor Spillman thanked Councillor Coxshall and the Jackie Doyle-Price MP for their hard work on this issue. He felt that recent actions by DP World were a misjudgement, as DP World and the UK had previously had a mutually beneficial relationship, but recent actions had put future opportunities for DP World in the UK at risk. He stated that recent years had been difficult for industries such as bus companies, airlines, and ferry operators, but processes had to be followed correctly. He felt shocked by the actions of P&O Ferries, but felt proud of the position that Thurrock Council were taking on the issue. He felt that the behaviour of P&O Ferries was not acceptable in the twenty first century and agreed that the level of pay they were offering would put other ferry companies at a competitive disadvantage.

The Leader stated that workers in UK waters should be paid the national living wage as a minimum. Councillor Hebb added that the recent actions of DP World and P&O Ferries were not in the spirit of private enterprise. He stated that there were practices in place regarding consultation and collaboration with employees. He understood that 2022 had been a difficult year for ferry operators, but felt that 800 people had now lost their jobs in circumstances that did not align with modern labour relations. He stated that P&O Ferries were an established and long-running company, but their recent actions would cause challenges for employees and their families, as well as with other private and public sector organisations. The Leader summarised and

reiterated that DP World would remain a partner in Thames Freeport, unless otherwise directed by government. He stated that the Thames Freeport scheme had many moving parts, and was one of the largest schemes being undertaken in the area.

The Leader proposed an alternative recommendation 1.4 as follows: *"Agreed that a full report would be brought back to Cabinet to explore all options available in relation to the governance of the Thames Freeport, following conclusion of the UK government's review."* This was agreed by all Cabinet Members.

The Leader proposed an alternative recommendation 1.5 as follows: *"Cabinet condemns the actions of P&O Ferries and agrees that the Leader will write to the Thames Freeport asking that they pause their work in relation to governance arrangements, until the UK government's review is completed".* This was agreed by all Cabinet Members.

RESOLVED: That Cabinet:

4. Agreed that a full report would be brought back to Cabinet to explore all options available in relation to the governance of the Thames Freeport, following conclusion of the UK government's review.

5. Condemned the actions of P&O Ferries and agreed that the Leader will write to the Thames Freeport asking that they pause their work in relation to governance arrangements, until the UK government's review is completed.

Reason for decision: as outlined in the report
This decision is subject to call-in

The meeting finished at 6.23 pm

Approved as a true and correct record

CHAIR

DATE

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15 June 2022	ITEM: 10 Decision: 110610
Cabinet	
Thurrock Health and Wellbeing Strategy Refresh 2022-26	
Wards and communities affected: All	**Key Decision:** None
Report of: Councillor Deborah Huelin, Cabinet Member for Adults and Health	
Accountable Assistant Director: Dr Jo Broadbent, Director of Public Health	
Accountable Director: Ian Wake, Corporate Director for Adults, Housing & Health	

Executive Summary

This paper presents the final draft of the refreshed Thurrock Health & Wellbeing Strategy (HWBS) 2022-26 (attached at Appendix 1) and asks the Cabinet for feedback.

1. Recommendation(s):

1.1 Cabinet is asked to:

- **Review and comment on the final draft Strategy at Appendix 1, considering the proposed Domains and Goals**

2. Introduction and Background

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

2.2 Thurrock agreed its first HWBS in 2013. The second and current HWBS was launched in July 2016 and can be accessed here: https://www.thurrock.gov.uk/strategies/health-and-well-being-strategy

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

3. Overview of the Refreshed HWBS 2022-26

3.1 Preparatory work with system partners and HWBB Chair identified key influences on Health & Wellbeing and suggested that the HWBS needs to:

- Be high level and strategic
- Be highly ambitious and set out genuinely new plans rather than just describe what has already been done
- Provide a clear narrative that drives the work of all aspects of the local authority, NHS and third sector
- Address resident priorities and be co-designed with residents
- Be place and locality based and take a strengths and assets approach, not focused only on deficits or services

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

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

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

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

4 Consultation outcomes

4.1 A summary of the consultation exercise is provided below and a full Consultation Report has been produced. Proposals for the refreshed HWBS have been refined to reflect consultation outcomes, and the changes made in response to community feedback are detailed in the full Consultation Report.

4.2 Over 750 comments were received through a short 'user friendly' questionnaire developed in conjunction with the CVS and Healthwatch, which sought the public's views on the six Domains that have been proposed for the refreshed Strategy. In excess of 300 residents or professionals involved in the planning, commissioning or delivery or health and care services provided feedback on strategy consultation proposals through community and professional forums and meetings.

4.3 Officers attended Scrutiny Committees, Group meetings and a range of stakeholder meetings to seek feedback. Direct face to face engagement was impacted by

COVID-19 but Thurrock CVS and Healthwatch engaged directly with residents and also ran two workshops comprising representatives from several CVS organisations operating in Thurrock.

4.4 Key themes arising in feedback comprised:

Accessibility

IT, digital exclusion. Feedback provided by elected members was reinforced by respondents across responding to priorities across a number of domains. It was acknowledged that digital exclusion is increasingly a barrier for some people to access services. It was felt that alternatives routes to access were still required and that services could not be completely digitally accessed as this would exclude some individuals.

Geographical locations and the importance of providing opportunities to access to residents across the borough through affordable and well connected public transport, active travel, provision of local based services and support

Capacity of services – access to primary care, mental health support and wider services and support was a key theme within feedback.

Informing residents

Effectively communicating with residents using a range of methods
Recognising that a range of approaches to community engagement and empowerment are needed - for example, online and social media approaches to engagement will not reach all community members, including many who are more vulnerable

Feedback recognised people wanting to improve their own health and wellbeing and the importance of providing information and guidance to facilitate that.

Communicating with residents and raise awareness of support and options that are available to them, single points of contact / lead support to help people navigate the system.

The Environment

Mitigating the impact of housing and commercial developments by ensuring that supporting infrastructure is in place and developments consider health and wellbeing.

Providing access to green and open spaces, public transport and active travel across the borough.

Opportunities for people to remain active and socialise in a safe environment. The importance of supporting improvements in Air Quality.

Mental Health

The impact of COVID on social isolation and loneliness and the adverse impact it has had on groups already marginalized

Respondents welcomed the refreshed Strategy providing specific focus on the provision of mental health support for residents, including access to mental health support, with appropriate capacity and timeliness of services.

The link between mental ill health and wider determinants of health such as long-term unemployment was acknowledged, a focus on employment and growth in relation to mental health was welcomed

5 Governance

5.1 The duty to produce the HWBS statutorily falls to the HWBB. Democratic Services have advised that this means that final sign-off must be by the partnership HWBB, and all other Council committees and partner agency governance structures are consultees to the Strategy. The proposed governance timetable for formal sign-off of the HWBS is therefore as below –

Action	Date
Council Directors Board	6-April 22
Health Overview and Scrutiny Committee	7-Jun 22
MSE ICS Board	9-Jun 22
Cabinet	15-Jun 22
Health & Wellbeing Board	24-Jun 22
Full Council	29-Jun 22

5.2 It is proposed that three versions of the Strategy will be produced to ensure broad accessibility to the report:

- The attached main Strategy document at Appendix 1
- An Accessible version to comply with website publication guidance
- An Easy Read version, being produced in conjunction with Inclusive Communication Essex Team, Hertfordshire Partnership University NHS Foundation Trust

5.3 A Communications Plan for the launch of the strategy is being prepared in conjunction with communications leads from HWBB member organisations. Subsequent to the Strategy being agreed, further work will be undertaken to establish appropriate ways of monitoring and reporting progress to the Board.

6 Reasons for Recommendation

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

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

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

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

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

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

9. Implications

9.1 **Financial**

Implications verified by: **Mike Jones**

Strategic Lead Finance*

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

*Implications remain as previously verified.

9.2 **Legal**

Implications verified by: **Lindsey Marks**

Deputy Head of Law*

The Health and Social Care Act 2012 established a responsibility for Councils and CCGs to jointly prepare Health and Wellbeing Strategies for the local area as defined by the Health and Wellbeing Board.

*Implications remain as previously verified.

9.3 **Diversity and Equality**

Implications verified by: **Rebecca Lee**

Community Development and Equalities Team Manager

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

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

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

8. Appendices to the report

Appendix 1 – Final Draft Health and Wellbeing Strategy 2022-26

Report Authors

Dr Jo Broadbent

Director for Public Health

Darren Kristiansen

Business Manager AHH, Secretary to HWB

THURROCK HEALTH AND WELLBEING STRATEGY 2022 TO 2026

Levelling the Playing Field in Thurrock

Created through the partnership of Thurrock Health and Wellbeing Board

1. Chair’s Foreword

Cllr Huelin,
Chair of Thurrock HWB
Portfolio Holder and Cabinet member for Health and Care

<<Additional text to be included by Cllr Huelin>>

2. Executive Summary

Thurrock's Vision for Health & Wellbeing – Levelling the Playing Field

The Health & Wellbeing Board has a statutory duty to publish a Health & Wellbeing Strategy for the local community, and this document presents the Board's Vision for health and wellbeing in Thurrock for 2022-26.

The Board's Vision of **Levelling the Playing Field** aims to tackle the many causes of poor health that are not level across Thurrock. These include individuals' health risk behaviours such as smoking and the quality of clinical care that people receive, but the greatest influences on overall community health are wider determinants of health. These include high-quality education, access to employment and other opportunities, warm and safe homes, access to green spaces and leisure, strong and resilient communities and effective public protection. Thurrock experiences an unlevel playing field in each of these areas and this Strategy aims to level up those inequities.

How will we Level the Playing Field?

To truly Level the Playing Field in Thurrock, the Health & Wellbeing Strategy needs to take a broad approach and focus on all these areas as part of Place-Shaping. The Strategy sets out goals and action across six broad domains that influence the determinants of health listed above:

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

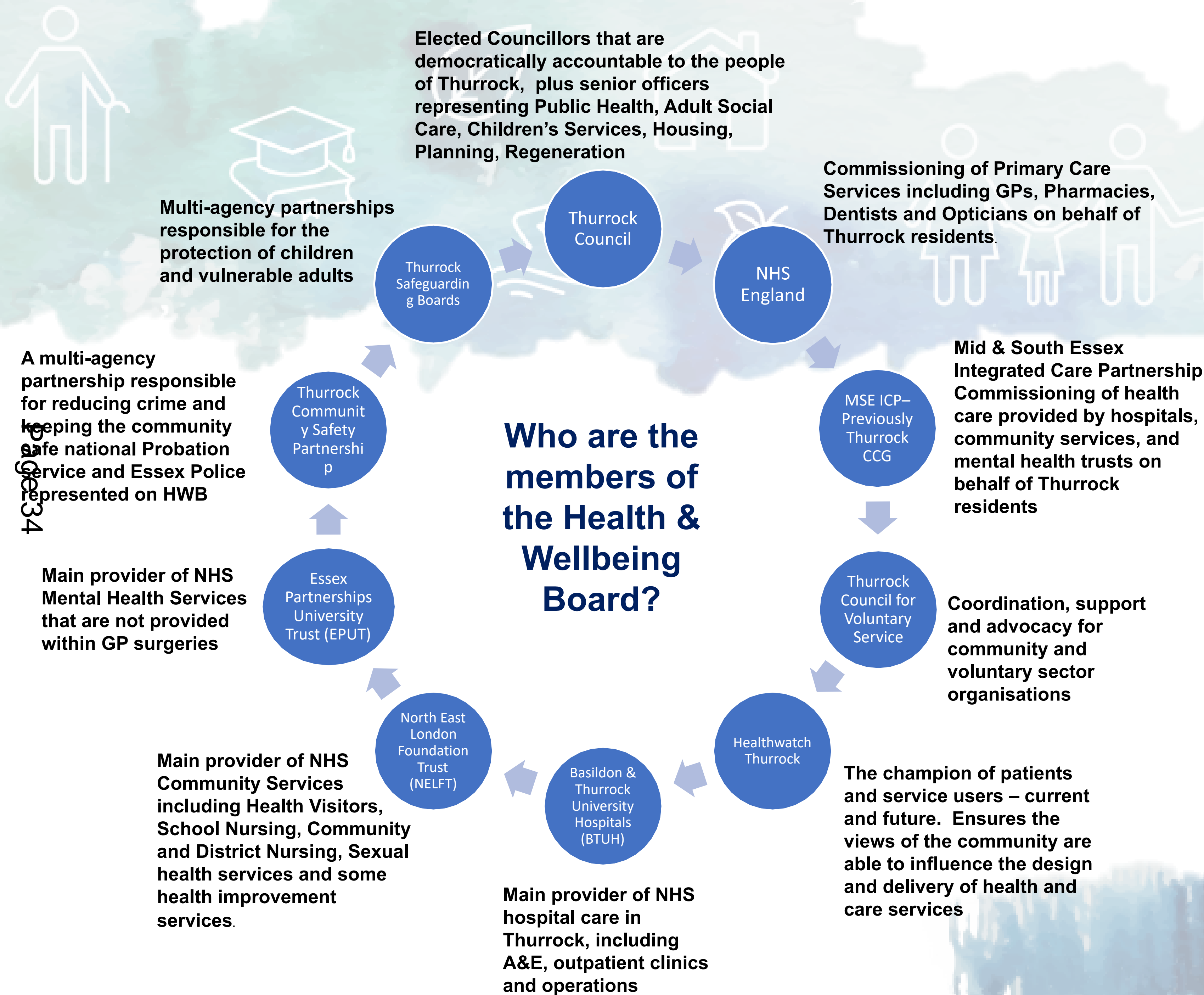
The Strategy will embed health and wellbeing actions in all these areas across key strategies in Thurrock, including NHS plans, the Local Plan and the Backing Thurrock Economic Growth Strategy, encompassing the Thames Freeport. It will drive ambitious collective action across every Council department, and through the NHS and other key system partners to address the unfairness that leads to multiple unlevel playing fields in Thurrock.

What will the Impact be?

The Health & Wellbeing Board has engaged with residents and stakeholders from across Thurrock to identify what matters most to residents and what their priorities for levelling the playing field are. The Health & Wellbeing Strategy will reduce variation in these drivers of poor health and reduce the inequalities in health outcomes we see across the Borough.

The actions set out in the Strategy will help achieve the Government's Levelling Up ambition of increasing Healthy Life Expectancy and reducing the gap between local areas where it is highest and lowest - currently the Healthy Life Expectancy gap is 8 years across Thurrock.

3. Thurrock's Health and Wellbeing Board



The Health & Wellbeing Strategy

- The Health & Wellbeing Board (HWBB) members have a collective statutory duty to produce a Health & Wellbeing Strategy (HWBS). Partners such as the NHS must have regard to the HWBS when planning their strategy.
- It is one of three highest level strategic documents driving Place Shaping for the local system partners (alongside the Local Plan and Backing Thurrock Economic Strategy)
- It is a whole system plan for community Health & Wellbeing, co-ordinating strategic thinking of all members to deliver quantifiable gains in health and well being of residents
- This strategy has been jointly developed by all members of the HWBB.

4. Thurrock the Place

Based at the heart of the Thames Gateway in close proximity to the east of London, Thurrock is a busy borough with picturesque towns, reams of beautiful countryside and 18 miles of river frontage. We are a borough of contrasts with urban areas of Grays, Tilbury and Purfleet to the south and rural villages and open countryside to the north.

The Thurrock Community

The population of Thurrock is just over 175,000. Population growth has been strong in recent years, with an 11.3% growth in population since the last census in 2011. This strong growth is projected to continue over the next decade with a further increase of 9.2% expected by 2030.

Thurrock is a relatively young place, with an average age of 36.9 years old compared to the England average of 40.2 years old. Just under 26% of the population are aged under 18 years. The recent trend for both England and Thurrock has been towards an increase in the average age, and we can expect to see this trend continue. Presently in Thurrock there are almost 6,000 individuals aged 80+, with close to 1,000 individuals aged 90+.

Within its geographic area of 165km², Thurrock hosts a diverse range of people and places. Over 130 different languages are spoken by children in Thurrock as their main language, and whilst most residents in Thurrock were born in the UK, over 10% were born overseas. White British is the most common ethnicity reported by Thurrock residents at 77% of the population. The second largest ethnic group is Black/African/Caribbean and Black British at 9% followed by all other White at 7%. It is estimated that 3,120 people have a learning difficulty, which accounts for just under 2% of the Thurrock population.

The most recent deprivation scores show that Thurrock has several areas that fall within the 10% most deprived locations in the country, but also some areas that fall within the most affluent in the country.

The more deprived areas are mainly located in and around Tilbury, with further areas in South Ockendon, Grays and areas of Corringham also suffering from higher levels of deprivation. Less deprived areas tend to be found in Thurrock's more rural locations, around South Chafford, and in some areas to the north of Grays.

Growth & Opportunities

Thurrock is home to some of the most exciting growth opportunities in the country. Our growth programme is highly ambitious and £6Bn has already been invested by the private sector in Thurrock up until 2017, with 7,000 new jobs created and 1,170 new businesses choosing Thurrock including leading ports and logistics centres, retail and creative industries. More broadly, over 1,000 acres of land are ready for commercial development with 30,000 new homes likely to be built. Thurrock is at the heart of global trade and logistics, with no fewer than three international ports and excellent road transport links.

Future growth and transformational ventures include the Thames Freeport, regeneration in urban areas such as Purfleet, and the Association of South Essex Local Authorities (ASELA) plans.

5. Health & Wellbeing in Thurrock

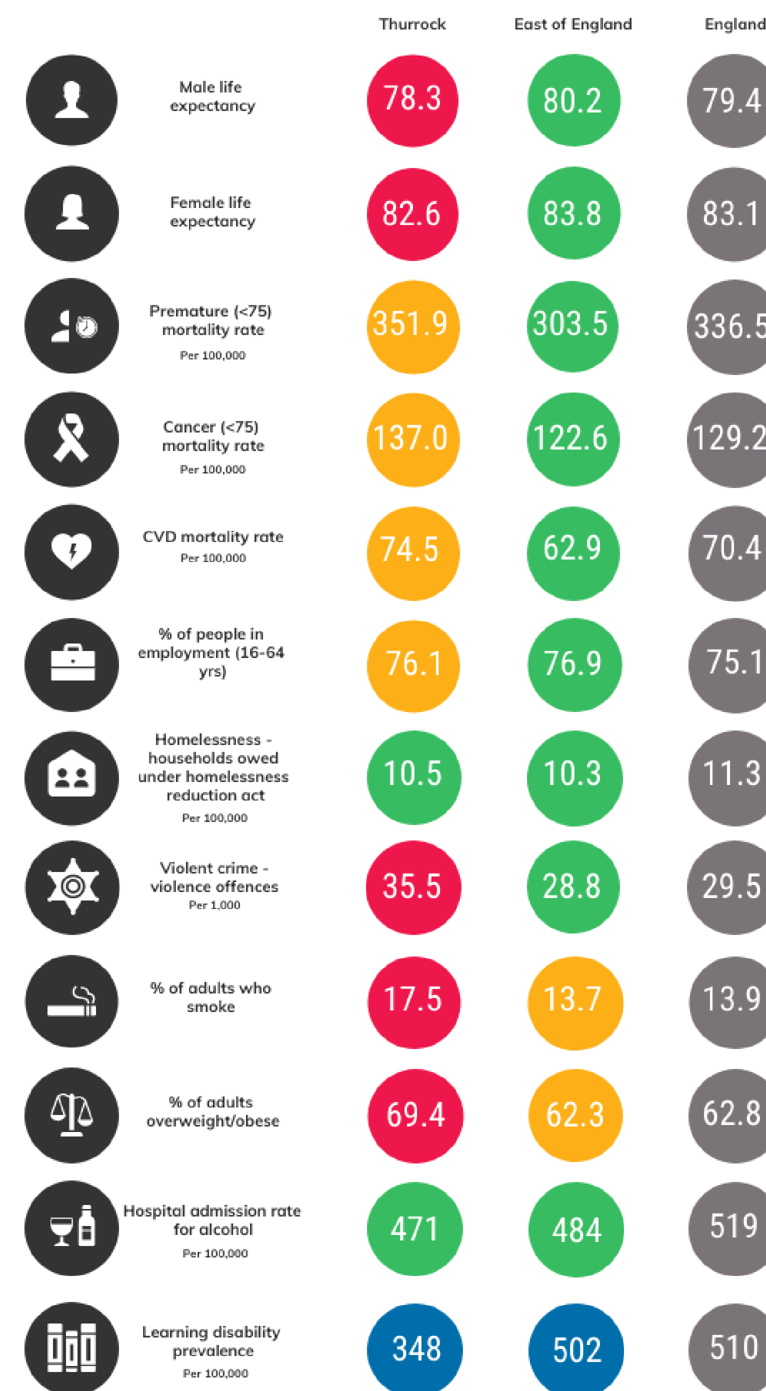
There is variation in health outcomes across Thurrock. Life Expectancy (LE) is the highest-level indicator of health inequality, and life expectancy for both men and women in Thurrock is significantly worse than the average for England. LE is significantly lower in Thurrock than average across England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

The greatest contributor to inequality in health outcomes in Thurrock is smoking. We know that smoking is the leading preventable cause of premature mortality in the country. Thurrock's overall smoking prevalence of 17.5% is significantly higher than in England and within some of the more deprived areas the prevalence is higher still. Data for pregnant women also shows high prevalence of smoking during pregnancy.

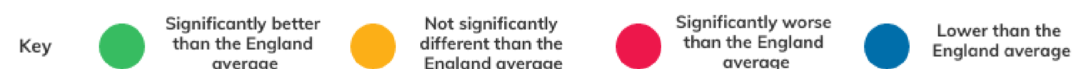
The proportion of adults classified as overweight or obese is also significantly higher in Thurrock, and higher still in the most deprived areas. 69.4% of adults are classified as overweight or obese, significantly higher than the England average at 62.8%. In 2019-20 the prevalence of overweight children at year 6 (age 10-11) in Thurrock was at 39.6% which is also significantly above the England average of 35.2%.

Cardiovascular diseases (CVD) are also an area of concern for the community. The most recent data for stroke, hypertension and coronary heart disease (CHD) prevalence at borough level are in line with national averages, however CVD related outcomes are known to be worse in the more deprived areas of Thurrock. Diabetes prevalence in Thurrock remains above the regional average.

Wider determinants of health are also important factors to also consider when looking at population data, and there is a mixed picture with regard to wider determinants in Thurrock. Thurrock's employment rate is 76.1% which is slightly above the England national average of 75.1% but not significantly so. Housing is a key factor underpinning health and wellbeing. For Thurrock, the number of households owed a duty under homelessness prevention is 10.5 per 100,000 which is lower than the England average of 11.3, and the quality of the housing stock in Thurrock is mixed. Crime has a considerable impact on the community, and the rate of violence offences in Thurrock (35.5 per 1,000) is significantly above the England rate of 29.5 per 1,000 population.



Indicator	Thurrock	East of England	England
Male life expectancy	78.3	80.2	79.4
Female life expectancy	82.6	83.8	83.1
Premature (<75) mortality rate Per 100,000	351.9	303.5	336.5
Cancer (<75) mortality rate Per 100,000	137.0	122.6	129.2
CVD mortality rate Per 100,000	74.5	62.9	70.4
% of people in employment (16-64 yrs)	76.1	76.9	75.1
Homelessness - households owed under homelessness reduction act Per 100,000	10.5	10.3	11.3
Violent crime - violence offences Per 1,000	35.5	28.8	29.5
% of adults who smoke	17.5	13.7	13.9
% of adults overweight/obese	69.4	62.3	62.8
Hospital admission rate for alcohol Per 100,000	471	484	519
Learning disability prevalence Per 100,000	348	502	510



6. Thurrock's Vision for Health and Wellbeing - Levelling the Playing Field

National Policy – Levelling Up

The Government's 'Levelling Up' White Paper sets out a number of Missions to address regional and local inequalities that unfairly hold back communities, ranging from employment and educational attainment to housing quality and crime.

Variation in Life Expectancy and Healthy Life Expectancy

Healthy Life Expectancy (HLE) is how long an individual can expect to live in good health. Variation in HLE is a measure of the health inequity that exists within and between populations. Mission 7 of the White Paper sets out an ambition that by 2030, the gap in HLE between local areas where it is highest and lowest will have narrowed, and by 2035 HLE will rise by five years.

HLE in Thurrock is 63 years for males and 61 years for females, but this hides considerable variation within the local community, as illustrated below. Individuals in the least deprived parts of Thurrock can expect to live between 6.4 to 8.7 years longer than those in the most deprived areas. In terms of HLE, people in the most affluent areas of Thurrock experience 8 years more healthy life than those in the most deprived, with women in the most deprived areas experiencing 22 years in poor health.

Thurrock's Vision for Health & Wellbeing – Levelling the Playing Field

Thurrock's Vision for Health & Wellbeing is to Level the Playing Field and reduce the variations in LE and HLE that we see within Thurrock. In order to meet the Government's ambitions for reducing the gap in HLE, concerted action is required to improve both length and quality of life across Thurrock and to reduce variations within the community.

In line with the White Paper ambitions, the Vision to Level the Playing Field identifies and sets out ambitious plans to tackle the many drivers of poor health that are not level across Thurrock, including the wider determinants of health.

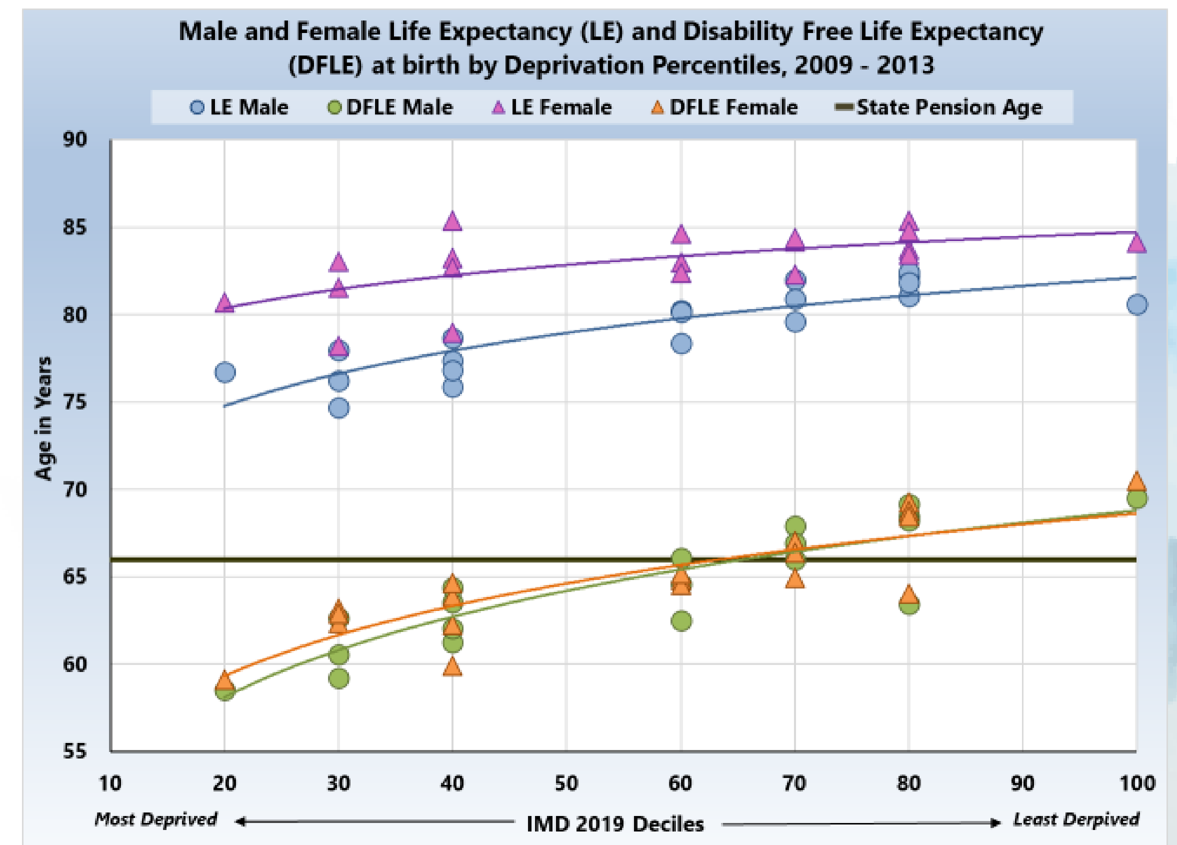
Addressing Unlevel Playing Fields in Thurrock

There is a clear unlevel playing field between areas of higher and lower levels of deprivation. Areas of higher deprivation tend to be home to a greater number of individuals working in routine and manual roles, with lower levels of income and poorer educational attainment. Within these areas we also see a higher prevalence of health risk behaviours such as smoking, poorer diet and low levels of physical activity. In turn these drive higher rates of long-term health conditions – which often co-exist alongside poorer mental health outcomes. In Thurrock, all age and premature death (<75 years) is significantly worse than England average overall, specifically for cancer and circulatory disease deaths, and is related to deprivation.

We will address inequalities in health status and LE across Thurrock not just between socioeconomic groups, but also between many different groups. For example, variation is seen between different ethnicities, between people living with physical or learning disabilities and people with long term serious mental illness, compared to the general population. People with a learning disability have a LE 14-17 years lower than the general population in England.

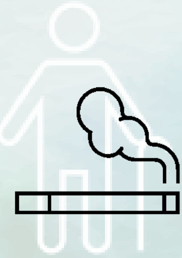
Intergenerational health inequalities still persist in Thurrock. Opportunities for every resident to reach their full potential are not shared equally, and levelling this playing field is a key focus of the HWBS.

Our Vision of Levelling the Playing Field will also address the unacceptable variation in access, service quality and outcome across health, care and wellbeing services with those with the greatest need often getting the poorest services and outcomes.



7. Where is the Playing Field not Level in Thurrock?

The playing field not level in many key areas that impact each one of the Council's priorities of **People**, **Place** and **Prosperity** -



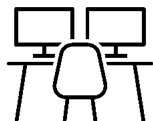
Smoking and obesity are key drivers of unequal health outcomes. Both smoking and obesity are significantly worse in Thurrock than across England and drive premature deaths from health conditions such as heart disease.

Around two thirds of people with **long term health conditions** such as high blood pressure and mental ill health are not diagnosed and not receiving support. We know that certain communities have higher rates of these conditions including people living in less affluent areas, men, people with learning disability, young people and older adults, unpaid carers, certain minority ethnic groups, LGBTQ+ people.

People who felt most lonely and disconnected from their local community prior to COVID-19 in the UK now have even higher levels of loneliness. This includes young people, people living alone, on low incomes, who are out of work, or living with a mental health condition and/or learning disability.

Residents are concerned about the **ease of seeing a GP**, and we know that access and capacity in primary care differs across the borough, and sometimes within the same Ward. **Quality of care** also varies for both physical and mental health conditions.

Educational attainment is generally good across Thurrock, but children who are NEET, have SEND, are Children Looked After or In Need, and from some minority ethnic groups do not achieve the same levels as their peers. While overall, 61% of GCSE pupils in Thurrock achieved 9-4 in 2019, only 10% of pupils with three disadvantages did.



The proportion of **adults in employment, the claimant count and the impact of economic growth** varies between communities in Thurrock. Groups that experience inequality in employment include 18-24 year olds, those living with a physical or learning disability and those with chronic diseases such as serious mental illness and musculoskeletal conditions.

Housing affordability is a major challenge in Thurrock, with over half of households not being able to purchase a home in the borough.

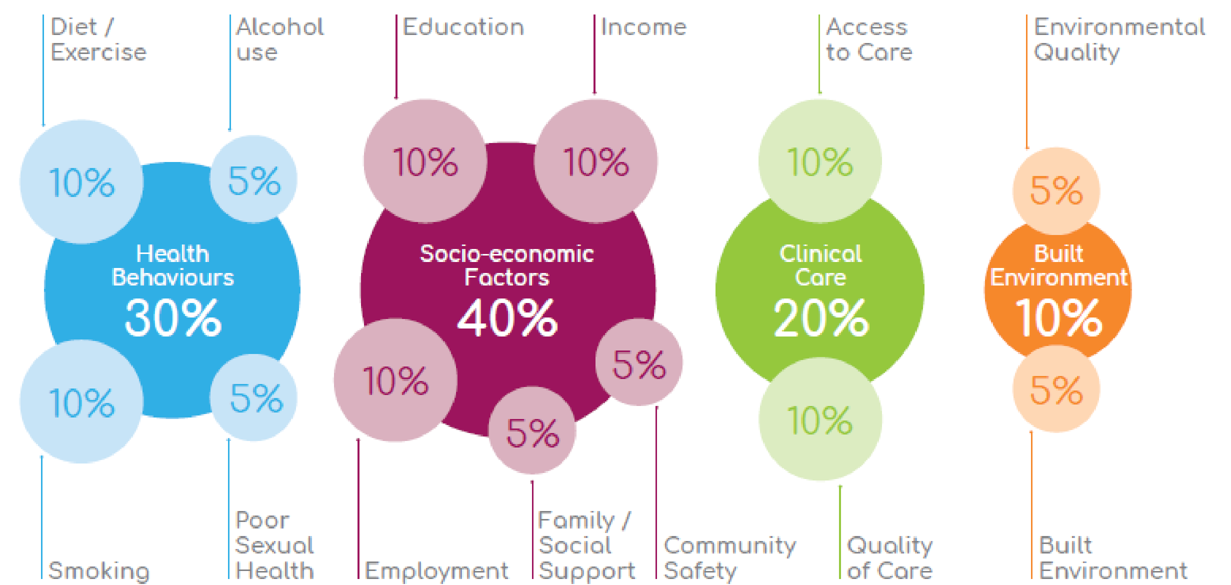
The **fear and risk of crime** continues to be a challenge for many community groups. The rates of recorded **violent crimes** are higher in Thurrock compared to England and have risen sharply since 2013. The Thurrock Youth Offending Service are seeing young people with a more entrenched pattern of offending and a greater degree of complexity and risk. National data indicates that 1 in 5 working-age women have experienced sexual violence.

8. How do we Level the Playing Field? - Wider Determinants of Health

The health & wellbeing status of individuals and communities is driven by broad and complex influences. Mid & South Essex Health & Care Partnership (MSE HCP) strategy identifies a range of impacts on health status, and that socio-economic factors have the greatest overall impact.

The King's Fund highlight the following wider health determinants as being crucial drivers of population health:

- Income
- Housing
- Education
- Best Start in Life
- Spatial planning
- Warmer & Safer Homes
- Strong & Resilient Communities
- Access to Green Spaces & Leisure
- Transport & Active Travel
- Jobs & Work
- Built & Green Environment
- Public Protection



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

To truly Level the Playing Field, Thurrock HWB Strategy needs to take a broad approach and focus on all these areas as part of Place-Shaping. It will drive collective action across every Council department, and through the NHS and other key system partners to address the unfairness that leads to multiple unlevel playing fields across all the determinants of health.

The large-scale growth and transformation opportunities that Thurrock has will be key to delivering this Vision, including -

National 'Levelling Up' agenda opportunities for Thurrock:

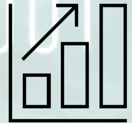
- Thames Freeport & Backing Thurrock agenda – secure inclusive and sustainable growth
- The Towns Fund – creating opportunity in more deprived areas; promoting arts, culture & physical activity
- Skills Fund & Apprenticeships – opportunities for local young people

ASELA Anchor Programme opportunities for Thurrock:

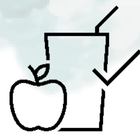
- Infrastructure & Housing – affordable housing, transport & infrastructure
- Technical University – skills development for adults & young people
- South Essex Estuary Park - green & blue spaces, improved air quality

9. Health & Wellbeing Board Principles for Action to Level the Playing Field

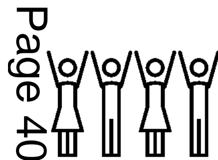
The members of the HWBB have agreed that the actions to Level the Playing Field will take account of the following principles:



Reducing inequality in health and wellbeing - We want things to get better for everyone, but we are also committed to ensuring that the most disadvantaged communities enjoy the same levels of opportunity, health and wellbeing as the most affluent.



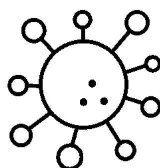
Prevention is better than cure - Rather than waiting for people to need help, we want Thurrock to be a place where people stay well for as long as possible. *Early intervention*



Empowering people and communities - We don't just want to do things for people but give people the opportunity to find their own solutions and make healthy choices, taking account of different abilities to act and ensuring multiple access points to services.

Person-led & strengths-based approach - Good health and care services should be organised around the needs of people, not around the needs of organisations. This includes using a Human Learning Systems approach to planning as well as the navigation and delivery of support and should build on community strengths and build social value.

Making good health and wellbeing everyone's responsibility – The organisations making up the HWBB have a shared priority to promote good health and reduce inequality, driving these principles through everything we do.



Retain the positives from COVID-19 and address the challenges – We will retain and build on positives from COVID-19 such as communities building on their strengths and partnerships working together on shared priorities, at the same time as seeking to mitigate the negative impacts of the COVID-19 pandemic.

10. Thurrock's Vision for Health and Wellbeing – Strategic Fit

Thurrock Council Strategic Approach

Thurrock Council has three established corporate priorities of **People**, **Place** and **Prosperity.** The Health & Wellbeing Strategy is aligned to these three priorities, and is the key strategic document outlining the Council's aspirations for its **People.**

With so many exciting and important initiatives, it is crucial that the work across all areas of the Council and with our partners is coordinated and complementary in order to deliver the corporate priorities for the benefit of Thurrock residents and businesses.

This strategy aims to ensure that Levelling the Playing Field is a key consideration across all of the Council's strategic agenda of **People**, **Place** and **Prosperity.**

NHS Mid & South Essex Health & Care Partnership Strategic Approach

Mid and South Essex Health and Care Partnership

Our Vision

A health and care partnership working for a better quality of life in a thriving mid and south Essex, with every resident making informed choices in a strengthened health and care system

Through working in partnership at every level, MSE HCP aims to **reduce inequalities** through the following actions, which also align to the Council's priorities:

- **Creating opportunities** – education, employment, housing, growth
- **Supporting health and wellbeing** – healthy lifestyles and behaviours, focus on prevention and self-care
- **Bringing care closer to home** – where safe and possible
- **Improving and transforming** our services – integrating care for and with our residents

This strategy will ensure that we work in tandem with the MSE HCP partnership on reducing inequalities in Thurrock.

11. Thurrock's Vision for Health and Wellbeing – People, Place & Prosperity

Thurrock Vision: An ambitious and collaborative community which is proud of its heritage and excited by its diverse opportunities and future		
Thurrock Council Corporate Priorities		
PEOPLE - A borough where people of all ages are proud to work and play, live and stay	**PLACE - A heritage-rich borough which is ambitious for its future**	**PROSPERITY - A borough which enables everyone to achieve their aspirations**
High quality, consistent and accessible public services which are right first time	Roads, houses and public spaces that connect people and places	Attractive opportunities for businesses and investors to enhance the local economy
Build on our partnerships with statutory, community, voluntary and faith groups to work together to improve health and wellbeing	Clean environments that everyone has reason to take pride in	Vocational and academic education, skills and job opportunities for all
Communities are empowered to make choices and be safer and stronger together	Fewer public buildings with better services	Commercial, entrepreneurial and connected public services
Thurrock Council Corporate Priority Projects 2021		
Transform the council and service delivery through new operating models and ways of working	Progress the **Local Plan** to support place-making and guide future sustainable development	Deliver **Backing Thurrock**, our Economic Growth Strategy, to strengthen and grow the economy for the benefit of residents and businesses
Refresh and deliver the **Health and Wellbeing Strategy** with health and other partners to tackle inequalities and the wider determinants of health	Deliver major regeneration and infrastructure projects contributing to growth including the government funded Towns Fund proposals	Work with private sector partners to deliver the Thames Freeport to unlock new jobs and skills opportunities through investment and enable levelling up
Embed the Collaborative Communities Framework – work with partners to redefine the council's role to achieve better outcomes for residents, especially the most vulnerable, through collaboration and co-design	Redefine to create a leaner asset base to reduce costs and support long term financial sustainability	Work collectively through ASELA to deliver strategic projects that secure greater prosperity and opportunities for residents and businesses

PLACE - How will Place-Shaping Level the Playing Field?
Improved accessibility and equity of access to education, employment, healthcare and green spaces through walking and cycling infrastructure, and improved public transport. This will be built into all new major developments including Thames Freeport and targeting use of retained business rates
The Local Plan and the design of new neighbourhoods will enhance community resilience and social capital, reduce antisocial behaviour, designing crime out and physical activity in. Improved physical and mental well-being will be a key consideration for new planning policies and in the determination of planning applications
Council procurements, capital schemes and new developments should be linked to a Social Value Framework and contain employment initiatives to provide opportunities for local people

PROSPERITY - How will Economic Growth Level the Playing Field?
Enhance access to vocational, academic and skills education for all, supporting adults experiencing barriers to learning and promoting progression into employment
Using the major economic growth interventions such as the Thames Freeport to create job opportunities for all, with more residents from vulnerable and deprived groups in sustained employment
Supporting local business aspirations to generate wealth and employment, promoting social enterprises and helping small business and micro-enterprises to grow

12. Thurrock's Vision for Health and Wellbeing - How Health & Wellbeing Strategies fit together

Thurrock Joint Health and Wellbeing Strategy 2022-2026

- High level
- All age
- Aspirational
- Engage all partners in wellbeing agenda
- Coherent vision for 'Thurrock the place'
- Threads everything together
- Focus on the 'what' and outcomes
- Statutory document that ICS must have regard to.

Brighter Futures Strategy

Focuses on children and young people's wellbeing and how services for children and young people will integrate and improve

Better Care Together Thurrock – The Case for Further Change

Focuses on adults' wellbeing and the transformation and integration of adult health, care and third sector services with the community

Other Health and Wellbeing Strategies

For example:
Collaborative Communities Framework
Violence and Vulnerability
Housing & Homelessness
Tobacco Control
Whole Systems Obesity
Community Safety Partnership Plan

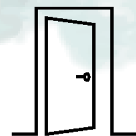
- More detailed
- More topic, age, setting focused
- Mechanics of the 'how'
- Explains impact at place and system level
- Outcomes at topic/locality/individual level
- Explains impact on overall place / system level
- Deals with the money

- For each Goal we have mapped the underpinning strategies and the strategic group that will lead on delivery.
- Progress measures have been identified to monitor impact on high level Outcomes over the lifetime of the strategy, plus Activity and Process milestones detailing key actions to deliver on the ambitions. These will be detailed in an appendix to the strategy.

13. Community Priorities for Health & Wellbeing

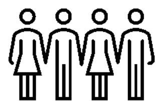
Stakeholder & Community Engagement took place between October & December 2021. Feedback was received from 1,300 individuals and from numerous stakeholder and community groups.

Key themes from the feedback covered each of the **People**, **Place** and **Prosperity** priorities:



Accessibility

- **Capacity and accessibility of services**, with availability of face to face support from the most appropriate professionals to support their health needs, including Primary Care access.
- **IT & digital exclusion.** It was acknowledged that digital exclusion is a barrier for some people to access services. It was felt that a variety of routes to access were required so as not to exclude some individuals.
- **Geographical locations** and the importance of providing access to services to residents across the borough through affordable and well-connected public transport, active travel, provision of local based services and support.

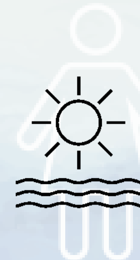


Supporting Residents and Wider Communities

- **Communicating support that is available to residents** to enable them to access the most appropriate support and supporting health and wellbeing by awareness raising and education, advice and guidance.
- **Support to develop communities** in terms of community cohesion and communities getting to know one another, building community resilience, and pride of place.

The Environment

- **Mitigate the impact of housing and commercial developments** by ensuring that supporting infrastructure is in place and developments consider health and wellbeing.
- **Access to green and open spaces, public transport and active travel** across the borough.
- **Opportunities for people to remain active and socialise** in a safe environment.
- The importance of supporting improvements in **Air Quality.**



Mental Health

- **The impact of COVID** on social isolation and loneliness and the adverse impact it has had on groups already marginalized
- **Respondents welcomed the refreshed Strategy providing specific focus on the provision of mental health support for residents**, including access to mental health support, with appropriate capacity and timeliness of services
- The link between mental ill health and wider determinants of health such as long-term unemployment was acknowledged, a **focus on employment and growth in relation to mental health** was welcomed

Most people agreed that the six proposed Domains affect areas of people's lives that most impact on health and wellbeing. There was also agreement with many of the proposed Goals for each the Domains, with refinements being made to specific Goals based on feedback.

Engagement included a variety of methods including:

- **Have your say online -** Comments were collected online through the Council's Consultation Portal.
- **Have your say face-to-face -** The consultation was supported by Healthwatch Thurrock and Thurrock CVS. People from these independent organisations attended events across the borough and ran community sessions to ask about the proposals.
- **Discuss at a stakeholder or community meeting -** Community forums and groups, and Council and NHS meetings were attended to discuss the proposals.

A full report on the engagement findings and how they have influenced the content of the HWBS is appended as an Annex.

14. Six Domains of Health & Wellbeing in Thurrock

The HWBS is structured around 6 Domains, which cover the key wider determinants of health and the Community's priorities for Levelling the Playing Field. Each Domain relates to one of the Council's key priorities of People, Place and Prosperity:

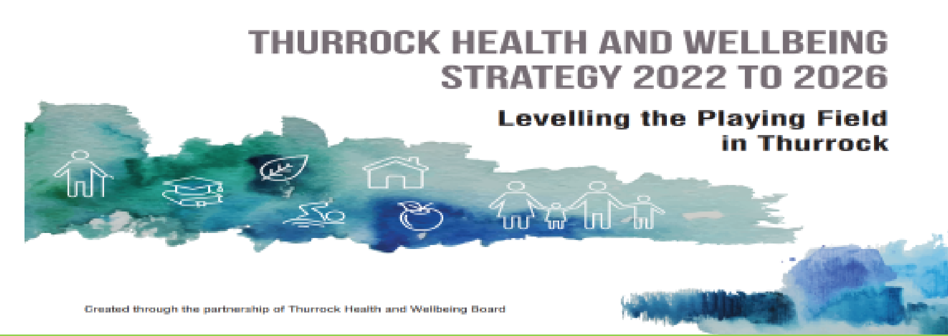
1. Staying Healthier for Longer
2. Building Strong & Cohesive Communities
3. Person-Led Health & Care
4. Opportunity for All
5. Housing & the Environment
6. Community Safety

Through engagement with residents and stakeholders, 3 or 4 priority Goals have been identified for each Domain. Delivery of the ambitions within these Goals is underpinned by a number of key topic-specific strategies, as illustrated.

Domain 1 - Staying Healthier for Longer	Domain 2 - Building Strong and Cohesive Communities	Domain 3 - Person-Led Health and Care	Domain 6 - Community Safety
Thurrock Further Case for Change Health & Care Strategy	Collaborative Communities Framework	Thurrock Further Case for Change Health & Care Strategy	Community Safety Partnership Plan
MSE HCP Long Term Plan	Thurrock Further Case for Change Health & Care Strategy	MSE HCP Long Term Plan	Violence Against Women & Girls Strategy
Brighter Futures Strategy	Stronger Together Thurrock		Youth Violence & Vulnerability Action Plan

Domain 5 - Housing and the Environment
Local Plan
Housing Strategy
Homelessness Strategy
Transport Strategy
Climate Change Strategy

Domain 4 - Opportunity for All
Backing Thurrock Economic Growth Strategy
Brighter Futures Strategy
Cultural Strategy

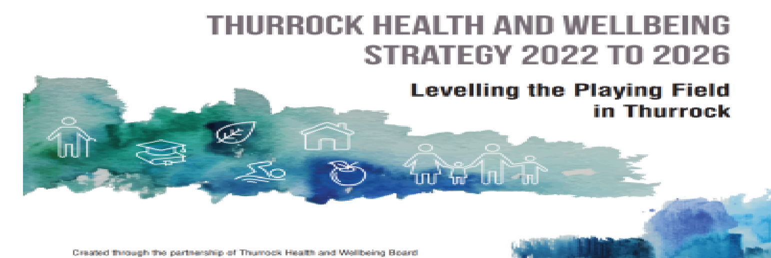


Domain 1 - Staying Healthier for Longer

Aligned with Thurrock Alliance Further Case for Change Health & Care Strategy & Brighter Futures Strategy

Ambition - Improve the prevention, identification and management of physical and mental health conditions, to ensure people live as long as possible in good health.

GOALS	Who doesn't experience a Level Playing Field?	How will we Level the Playing Field?	What Impact will it have?
1A. Work with communities to reduce smoking and obesity in Thurrock	• People living in the most deprived Wards • People living with serious mental illness • Pregnant women and families • Certain Minority Ethnic groups	• Developing and delivering a Whole System Tobacco Control Strategy – covering Prevention, Treatment & Enforcement, and focusing on the 8 most deprived Wards, people with mental health problems and pregnant women and their families • Refreshing & delivering the Whole System Obesity Strategy – covering Healthy Weight for Children, Community Influences, the Food Environment, Physical Activity & Weight Management	• Fewer people in Thurrock who smoke and reduced variation between community groups • Fewer Reception, Year 6 children and adults in Thurrock who are obese and reduced variation between community groups
1B. Work together to promote good mental health and reduce mental ill health and substance misuse in all communities in Thurrock	• Groups that are less likely to have their mental health needs met such as: Males, People with LTCs, People with Learning Disability, Younger and Older adults, unpaid Carers, certain Minority Ethnic groups, LGBTQ+ people • People living with serious mental illness • People transitioning from young people to adult to older adult mental health services • People living with substance misuse and their families	• Transforming mental healthcare through a new Integrated Primary and Community Mental Health model, and Emotional Wellbeing and Mental Health Service (EWMHS) for children and young people • Case finding for common mental illnesses in Primary Care - by screening via a tool in IT systems, as part of NHS Health Checks and using Population Health Management (PHM) • Co-producing with service users and families a new substance misuse model, integrated with wider services such as mental health and housing • Addressing unmet need in relation to drug & alcohol misuse, including inter-generational affects and the impact on wider determinants of health	• Improved quality of care for mental ill health • A greater proportion of people have their mental ill health diagnosed and treated • All young people transitioning to Adult Mental Health Services have a Joint Care Plan in place • All children are thriving and have access to the support they need through a strengthened whole school approach to mental wellbeing
1C. Continue to enhance identification and management of Long Term Conditions (LTCs) to improve physical and mental health	• People living in more deprived circumstances • The up to two thirds of people with common LTCs but who do not have a diagnosis • People with poorly managed LTCs • Communities at greater risk from LTCs, including Minority Ethnic groups, and people with Learning Disability or serious mental illness	• Establishing 4 new Integrated Medical Centres (IMCs) that will deliver a standardised LTC clinical model for all Thurrock residents, including those with multiple health needs, and address variation in capacity across IMCs so it is better matched to resident need • Funding LTC case finding in Primary and Community Care and using PHM to identify people with LTCs by improving data flows between hospital and primary care IT systems • Funding LTC treatment improvement in Primary Care to intervene earlier and prevent LTCs from worsening – for example by using PHM data to improve care for all	• Improved quality of care for LTCs e.g. a greater proportion of care for high blood pressure will meet national standards • A greater proportion of people will have their LTC diagnosed and treated • A greater percentage of individuals with Severe Mental Illness will receive a Physical Health Check

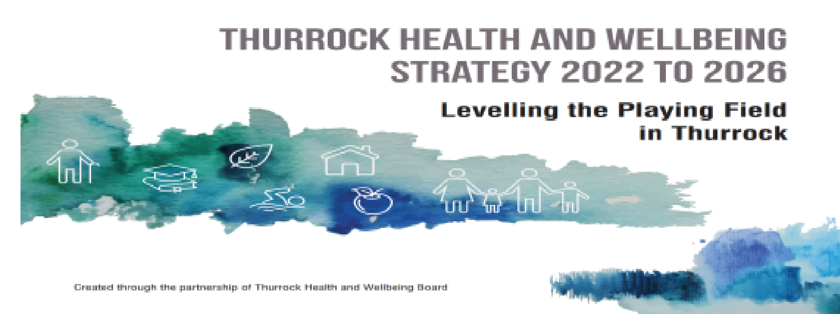


Domain 2 - Building Strong and Cohesive Communities

Aligned with Stronger Together Thurrock & the Collaborative Communities Framework (CCF)

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

GOALS	Who doesn't experience a Level Playing Field?	How will we Level the Playing Field?	What Impact will it have?
2A. Improve engagement with our residents to ensure everyone can have their voice heard	• Marginalised and Seldom Heard groups • People experiencing loneliness and social isolation, including those who were Shielding or who are at higher risk such as young people, people living alone, on low incomes, who are out of work, or living with a mental health condition and/or learning disability • The c. 20% of people who are digitally excluded	• Embedding the CCF Engagement ambition to enable residents to access information and be involved in decisions that affect their lives, using co-design and co-production to generate solutions, for example by - • Establishing service user-led Communities of Practice for each Primary Care Network (PCN) area to improve communication with local residents • Tackling digital exclusion - for example through ASELA and Public Health working together to install wifi in all Sheltered Housing sites, and addressing skills and confidence • Ensuring the Stronger Together directory is used widely across partners as the 'one-stop-shop' for residents to seek information about support	• Improved resident satisfaction with engaging with Thurrock Council • A greater percentage of Thurrock residents voting in local elections • Reduced Digital Exclusion • Residents will have improved access to information and support
2B. Ensure people have the skills, confidence and ability to contribute as active citizens and are empowered to co-design the decisions that affect their lives	• Marginalised and Seldom Heard groups • Disenfranchised or disempowered residents • Volunteers and unpaid Carers	• Embedding the CCF Empowerment ambition to empower and enable communities to champion change, for example by - • Using a participatory Human Learning Systems (HLS) approach to future health & care system transformation, delivering bespoke solutions co-designed with residents, ensuring that the system operates in the way people want it to and that communities are able to influence and direct decision making about health and care • Working with Community Builders, Community Reference Boards and PCN Communities of Practice to enable residents' views to influence local decision-making	• A greater proportion of residents feel that decisions taken that affect them are worthwhile • A greater percentage of volunteer placements filled within the Council
2C. Enhance equality and inclusiveness by promoting opportunities to bring different communities together to enhance shared experience and to embed a sense of belonging	• Diverse communities in Thurrock including minority ethnic groups, religious groups, LGBTQ+ people • Marginalised and Seldom Heard groups • Newcomers to the borough including Asylum Seekers • People experiencing loneliness and social isolation, including those at higher risk such as the Shielding cohort, young people, people living alone, on low incomes, who are out of work, or living with a mental health condition and/or learning disability	• Embedding the CCF Equality ambition for all to have equal opportunities to prosper in a connected community and contribute to a diverse and inclusive borough, for example - • Working with Community Builders, and Community Forums and Hubs in their provision of support to residents in their local areas, along with the ongoing maintenance of the Stronger Together directory • Preparing an annual calendar of events and activities in conjunction with partners - including community-led events such as Holocaust Memorial Day and Pride Month.	• Fewer adults aged 16+ report they felt lonely 'often or all of the time' • A greater number of events and activities in hubs/libraries that support well-being and strengthen community connections



Domain 3 - Person-Led Health and Care

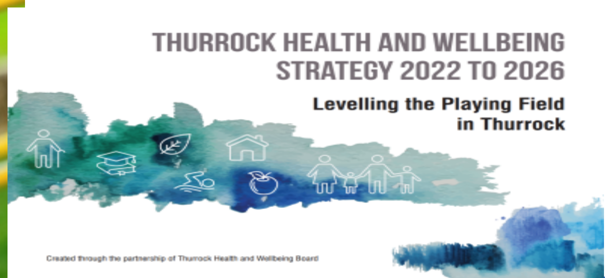
Aligned with Thurrock Alliance Further Case for Change Health & Care Strategy

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

GOALS	Who doesn't experience a Level Playing Field?	How will we Level the Playing Field?	What Impact will it have?
3A. Development of more integrated adult health and care services in Thurrock	• People living with multiple and complex health and care needs • People with unmet health and care needs • Unpaid Carers • People who need support to live independently • People living with dementia	• Improved, integrated and easy to access entry to care – the majority of care will be provided close to home by multi-disciplinary locality teams (Community Led Support) • Better management and coordination of multiple issues through a Human Learning System (HLS) approach to deliver bespoke solutions • Development of a Dementia Commissioning Strategy to support Dementia Friendly Communities	• More capacity across the system with a greater focus on prevention and early intervention • Bespoke solutions to complex care needs, with single care plans • Holistic support for people with dementia
3B. Improved Primary Care response that includes timely access, a reduced variation between practices and access to a range of professionals	• People living with multiple and complex health and care needs • People with unmet health and care needs • People with difficulty accessing health care	• All 4 IMCs operational by 2025, delivering a standardised clinical model that meet the specific requirements of the local community • Improving quality of care through single models of care, integrated data sets, and early identification, management and prevention of conditions • Collaboration and coordination with partners around PCN areas to enhance capacity and ensure people receive the right response first time • Levelling up funding to align with clinical need, supported by an appropriate mixed skill clinical workforce • Upgrading GP practices' telephony systems and ways of working online	• Equity of access to primary care reaching the level of the current best access for everyone • Better clinical outcomes overall and reduced variation in outcomes between GP practices • Patient satisfaction with practices levels up to the current best
3C. Delivery of a Single Workforce Locality Model – a health & care workforce that works across organisational boundaries to be able to provide a seamless and integrated response	• People living with multiple and complex health and care needs • Unpaid Carers • Frontline health and social care professionals • People who need support to live independently or have difficulty accessing care and support	• Development of professionals' integrated locality networks by PCN area • Reducing onwards rereferrals through integrated and coordinated access points across and within localities • Support solutions that incorporate the assets and strengths contained within communities and individuals • Integrated coordination of care for individuals receiving support from multiple organisations and blended staff roles that support more than one function	• Empowered staff focusing on what matters to residents • Access to a broader range of care and specialisms at locality level • Greater continuity of care for everyone
3D. Delivery of a new place-based model of Commissioning that makes the best use of available resources to focus on delivering outcomes that are unique to the individual	• People living with multiple and complex health and care needs • People with unmet health and care needs • People with difficulty accessing health care • People who need support to live independently	• Development of Communities of Interest that enable communities to direct, develop and influence health and care provision • Commissioning across functions through pooled and integrated budgets • Place-based commissioning – responding to local conditions and requirements through Community Reference Boards • A broadened and flexible marketplace that offers greater choice and increased opportunities for local providers - for example building on Micro-Enterprises	• Expanded support for community economic development, supporting a variety of health and care services for local people • Residents' voices will be at the heart of service redesign

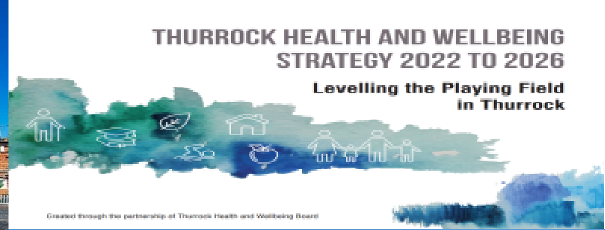
Domain 4 – Opportunity for All

Aligned with the Backing Thurrock Economic Strategy, major investments such as Thames Freeport and the Brighter Futures Strategy



Ambition - Thurrock will be a place of economic opportunity, with investment and wider regeneration programmes building a stronger and more vibrant economy, with local communities having the opportunity to contribute to and benefit from our economic successes. We want to support people in Thurrock to be aspirational, resilient and able to access high quality education and training; enabling them to develop skills to secure good quality employment and volunteering opportunities to live fulfilling lives and achieve their full potential.

GOALS	Who doesn't experience a Level Playing Field?	How will we Level the Playing Field?	What Impact will it have?
4A: Through raising aspirations and reducing the disadvantage gap, all children and young people are able to achieve their potential	• Children and young people, especially those who have Special Educational Needs (SEN), are Children Looked After (CLA), live in more deprived circumstances or are Not in Education, Employment of Training (NEET)	• Delivering the Brighter Futures aspirations to improve educational attainment • Thames Freeport Skills Plan will target dedicated interventions to improve skills, working directly with local schools to ensure local communities can take advantage of job opportunities from the Freeport	• All young people supported to gain qualifications, skills, and experience to progress into sustained employment • Improved educational attainment for all disadvantaged young people • All young people can access education and training, reducing NEET
4B: Raising aspirations and opportunities for adults to continue learning and developing skills, with a focus on groups that can benefit most	• Working-age people who are in low-skilled employment • People who are out of work, including with health-related barriers to work such as mental health, musculoskeletal problems, disabilities or caring responsibilities • Young adults entering the labour market	• A Freeport Skills Fund will be established to support skills programmes to ensure that local people are equipped to benefit from anticipated employment opportunities – focusing on young people and those with protected characteristics • ASELA Technical University to meet emerging and future employer needs through work-based learning, including degree apprenticeships, supporting young people entering work and reskilling those in employment • Thames Freeport Skills Accelerator programme will match workers to jobs, ensuring equality of access to skills development and job opportunities	• A greater number of adults in education in Thurrock Council • A greater proportion of young people achieve a L2 or L3 qualification by the age of 19
4C: Supporting the economically vulnerable through Delivering the Backing Thurrock Roadmap and Action Plan and the Thames Freeport	• Marginalised groups and those living in deprived circumstances • People who are out of work, including those with health-related barriers to working such as mental health, musculoskeletal problems, physical or learning disabilities, or who have caring responsibilities • Working-age people who are in low-skilled employment or who are economically vulnerable • Low-income households	• Tackling employment inequalities through - • Thames Freeport being underpinned by a Diversity Statement and EQIA , and actively monitoring equality, diversity and inclusion impacts • Delivering the Backing Thurrock Skills Action Plan to, enabling people to access the opportunities from a growing and successful Thurrock economy • Embedding recommendations of the Work and Health JSNA to improve access to work for people with mental health and MSK problems • Ensuring that contracts and capital schemes commissioned by the Council include action against at least one Social Value Framework priority outcome	• A greater proportion of working age adults in employment • Reduction in long term unemployment, with a focus on those with long term mental or physical health barriers to employment • The Thames Freeport economically benefits all in Thurrock • Increased Social Value contribution of the Council's commissioning
4D: Creating a vibrant place, that generates new businesses, increases prosperity and enables people across Thurrock to benefit from the transformational investment in major development schemes	• Marginalised groups and those living in more deprived circumstances • Working-age people who are out of work or economically vulnerable • Low-income households • Small businesses and Micro-enterprises	• Supporting local businesses to generate wealth and employment - for example though enabling residents to develop new businesses, social enterprises and micro enterprises; and developing a business workplace wellbeing programme • Working with the Business Board and Anchor Institutions to increase local recruitment, develop local supply chains, attract public and private investment, and making best use of assets to secure inclusive well-being • Supporting SME supply chain opportunities through Thames Freeport and other major investment programmes • Harnessing the power of culture and creativity to improve well-being and support economic growth through delivery of a Thurrock Cultural Strategy	• Reduced percentage of children living in absolute poverty • A greater number and range of businesses in Thurrock • Better understanding of the aspirations of the local business community • Residents have access to a range of cultural opportunities



Domain 5 - Housing and the Environment

Aligned with the Local Plan, Housing Strategy and Homelessness Strategy

Ambition - Fewer people will be at risk of homelessness and everyone will have access to high quality affordable homes that meet the needs of Thurrock residents. Homes and places in Thurrock will provide environments where everyone feels safe, healthy, connected and proud.

GOALS	Who doesn't experience a Level Playing Field?	How will we Level the Playing Field?	What Impact will it have?
5A. Reduce homelessness and increase the supply of affordable housing in Thurrock	• Homeless people and Rough Sleepers and those with No Recourse to Public Funds (NRPF) • People in insecure accommodation or at risk of eviction • Low-income households • First time buyers & Key Workers	• Delivering appropriate and timely support - for example by reducing out of area Temporary Accommodation (TA) placements and time in TA • Introducing a 'Thurrock Affordability Standard' for future housing delivery, alongside increasing Council-owned affordable rental properties • Using Development Management, the Housing Strategy and the Local Plan to deliver a min. provision of 35% of new residential developments to be affordable • The Local Plan will identify major development sites that can deliver 10 or more additional homes, and set targets for the mix of units in terms of type, size and tenure (including first, key worker and affordable homes)	• All households owed a duty of care under the homelessness reduction act receive support • Residents will have access to a range of affordable new build homes that prioritise providing housing for people with an established connection to the local area • Residents will have access to an appropriate mix of high-quality social housing
5B. Facilitate and encourage maintenance of good quality homes in Thurrock to support the health of residents, protecting them from hazards such as cold, damp and mould	• People in insecure housing • People in poor quality or over-crowded accommodation • Low-income households • Council, social & private tenants • People living in fuel poverty • People with health conditions that put them at greater risk from a poor standard of housing	• Improving the condition of housing in the public and private sector - for example by increasing use of renewable technologies in Council stock • Reducing fuel poverty - for example by investment in council housing, accessing Green Homes Grants for improvements in the private sector, and by improving Energy Performance Certificate (EPC) ratings across the borough	• Residents will have access to safe public and private rental sector homes • Residents will have access to programmes such as Well Homes to benefit priority groups such as people with LTCs, physical or learning disabilities and mental health needs • Fewer households in Fuel Poverty
5C. Provide safe, suitable and stable housing solutions for people who have or who are experiencing domestic abuse / violence and/or sexual abuse / violence	• Individuals and families experiencing domestic abuse / violence and / or sexual abuse / violence	• Implementing a joint protocol across all partners – to ensure access to a range of housing options and tailored initiatives to give people experiencing domestic and sexual abuse or violence an appropriate choice of accommodation.	• Everyone experiencing domestic and sexual abuse or violence will have access to a range of tailored housing options and initiatives
5D. Regeneration and future developments will seek to improve physical and mental health, reduce exposure to air pollution and to build community resilience and reduce antisocial behaviour	• People experiencing a poor quality of living environment and/or poor access to green space and/or air pollution • People experiencing anti-social behaviour • People with poor access to services and/or poor public transport access and/or who wish to walk and cycle more	• Local Plan policies, Health Impact Assessments (HIAs) for major new developments and the Transport Strategy will consider a full range of health and wellbeing issues including for example: Active Travel and Public Transport; access to green and open spaces; air quality; the food environment. • The Local Plan will put forward a range of planning policies that support the creation of healthier, safer and greener places which will be used by developers • Incorporating crime reduction e.g. 'Secure by Design' within the Council's Housing Strategy and the Local Plan Design Guide. • Implement the Council Climate Change Strategy and the borough high level Energy and Climate Strategy.	• All Council-led new build schemes will comply with Secured by Design standards • All regeneration and developments will promote physical & mental wellbeing, reduce exposure to air pollution, promote healthy food options, enhance community resilience, and reduce antisocial behaviour • New development will be supported by the right types of infrastructure and can be accessed by active/sustainable transport modes

Domain 6 - Community Safety

Aligned with Thurrock Community Safety Partnership Priorities and Brighter Futures Strategy

Ambition - Thurrock is a place where people feel and are safe to live, socialise, work and visit.
We will also ensure that victims/survivors of crime are able to access support to cope and recover from their experiences, should they need it.

GOALS	Who doesn't experience a Level Playing Field?	How will we Level the Playing Field?	What Impact will it have?
6A. Enable all children to live safely in their Communities	• Children and young people, especially those at increased risk from crime including those experiencing trauma, sexual exploitation, Adverse Childhood Experiences, and school exclusion	• Implement a Public Health approach to Youth Violence and Vulnerability – for example developing integrated data surveillance to identify the most at risk children and families and intervene early with tailored intervention packages • The Youth Offending Service (YOS) will support an ongoing reduction in reoffending • As part of the multi-agency approach to tackling Child Sexual Exploitation and to protect victims, implement a Contextual Safeguarding approach across the Thurrock Partnership • Act on insights from Youth Listening projects	• Decrease in episodes of children going missing • Reduce school exclusions as a result of knife crime • Decrease the percentage of YOS cohort of offenders who have reoffended • Reduce Child Sexual Exploitation • Build insights from Young People into the local response
6B. Work in partnership to reduce local levels of crime and opportunities for crime to take place, which will result in fewer victims of crime and make Thurrock a safer place to live	• All victims of crime, particularly the more vulnerable at greater risk of certain types of crime, including young people, older and vulnerable adults • People affected by the fear of crime and anti-social behaviour	• Implementing the Reducing Reoffending Plan for Thurrock and addressing the drivers of violence • Incorporating crime reduction approaches such as 'Designing Out Crime' and 'Secure by Design' within the Council's Housing Strategy and the Local Plan	• Reduce anti-social behaviour and the fear of crime it causes • Reduce community-based violence
6C. Improve the local response to supporting victims/survivors of abuse and exploitation to improve their health and wellbeing	• All victims of crime, particularly the more vulnerable at greater risk of exploitative crime, including older and vulnerable adults • Victims/survivors of abuse and exploitation, including those who are reluctant to seek support due to stigma, poor responses to disclosures or lack of awareness	• Implementing the Thurrock Violence Against Women and Girls Strategic Action Plan, including a survivor-led, strengths-based pathway of support, available to all genders • Designing strengths-based services based on the needs and experiences of victims/survivors	• Improve Domestic Abuse and Sexual Violence and Abuse services based on the findings from engagement with local victims/survivors
6D. Protect residents from being the victims of crime, with a focus on those with increased risk of experiencing exploitation and abuse	• All victims of crime, particularly the more vulnerable at greater risk of exploitative crime, including young people, older and vulnerable adults • Victims/survivors of abuse and exploitation, with a particular focus on women and girls who experience this type of crime disproportionately	• Implementing the Thurrock Violence Against Women and Girls Strategic Action Plan – for example the 'Transitions Process' supporting those transitioning from children's to adult social care support	• Reduce the number of vulnerable people aged 16-25 who enter the system at a point of crisis • Deliver a more individualised transition of vulnerable young people from children's to adult services

15. Impact of COVID-19 on Health & Wellbeing

Whilst evidence is still accumulating on the long-term impacts of COVID-19, the pandemic is likely to have significant and wide-ranging impacts across all of the Domains of the HWB Strategy. These include :

Direct impacts of COVID-19

- There was an increased burden of ill health and death due to COVID-19, with substantial inequalities across certain characteristics and socioeconomic groups in relation to risk of COVID-19 infection, complications and mortality, compounding existing health inequalities.

Indirect Impacts on Health & Care Services

- During the pandemic, there were significant reductions in the utilisation of health and care services, which is now manifesting as increased demand on the system, often with later stage presentation for care. Evidence showed a median reduction of 37% in service usage overall, highlighting non-emergency admissions, cancer treatment and mental health services as areas of particular concern. Around one quarter of excess deaths in the first year of the pandemic were not due to COVID-19 but due to other causes.

Wider societal and community impacts

- The pandemic has exposed and worsened existing inequalities and made some individuals and communities even more vulnerable than before. The pandemic has amplified existing structural inequalities in income and poverty, socioeconomic inequalities in education and skills, and intergenerational inequalities. There have been particular effects on children (including vulnerable children), families with children and young people, worsening effects related to lost education, social development and mental health, which are all variably affected and interlinked.

Impacts of COVID-19 that we intend to mitigate through the HWBS include:

- **Obesity** in Reception age children increased from 9.9% to 14.4% during the pandemic, and **early years child development** is likely to have been impacted. In June 2020, average occupancy rates in early years settings were 37%, just over half that in the same period in 2019 (77%)
- **Isolation and loneliness** have established impacts on health outcomes and increased dramatically during lockdown, with 40% reporting feeling lonely compared to 21% pre COVID-19. Those most at risk include the young, those living alone, on low incomes, out of work and/or with a mental health condition or learning disability
- During the early stages of the pandemic in particular, the **access to health services** reduced. Whilst overall primary care capacity had been restored to pre-pandemic levels, only 42% of Thurrock practices were providing same day appointments Face to Face against a target of 100% in Autumn 2021
- A large number of studies suggest that school closures have reduced **educational attainment,** with an expectation of a greater impact on already disadvantaged children, and that the attainment gap will widen as a result of the pandemic.
- There is evidence that a long-term economic downturn could impact businesses and **unemployment levels** and reduce household incomes, particularly for those on lower incomes, and to have affected younger workers (under 25) and older workers (over 65) the most
- Research conducted by the United Nations has described **violence against women and girls** during COVID-19 as the "shadow pandemic". In May 2020, the charity Refuge reported a ten-fold increase in the number of visits to its website. A survey conducted by Women's Aid showed that 67% of women who had been experiencing abuse prior to the pandemic said it had got worse during lockdown, with over three quarters saying that lockdown made it harder for them to escape abuse.

15. Impact of COVID-19 on Health & Wellbeing

Not all impacts of the pandemic have been negative, and there has been a mixed impact on communities in a number of ways:

- **Social connections** in neighbourhoods and communities were disrupted, exacerbating the increase in isolation and loneliness. However, there is evidence of positive impacts on community cohesion and empowerment that this Strategy aims to build on and maintain
- **Housing** has played an important role in the way COVID-19 has been experienced. Periods of lockdown made housing conditions matter more with evidence showing those living in secure, decent housing reported more positive experiences. National regulations increased the security of housing for some people during the pandemic, including previous **Rough Sleepers,** however overcrowded housing had a particularly strong correlation with high levels of COVID-19 deaths in England.

In terms of wider positive impacts, the pandemic has highlighted the following:

- The importance of good quality, **accessible outdoor space** for people. There is much evidence that suggests lockdown induced a shift in people's mobility and routine activities with the use of parks and green open spaces increasing dramatically, although the permanency of these changes is not yet known.
- **Smoking prevalence in** July 2020 was lower than the 2019 baseline. There has been an increase in the number of people attempting to quit smoking during the pandemic with two-fifths of smokers attempting to quit in the 3 months up to September 2020
- Other benefits were observed with improvements in **air quality,** likely linked to restrictions reducing mobility, and a reduction in almost all types of **crime** (with some exceptions as above)

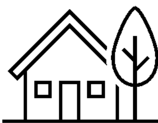
16. Achievements of the Health & Wellbeing Strategy 2016-21

Thurrock's previous five year Health and Wellbeing Strategy was launched in July 2016 and comprised five strategic goals, each underpinned by four objectives. What follows is a summary of selected key achievements over the lifetime of the Strategy:

1. Opportunity for All

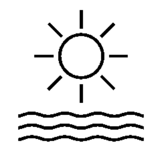
- Development of the Brighter Futures Children's Partnership including the full spectrum of partners responsible for planning and delivering health and care to the children, young people and families in Thurrock, including education and learning partners. The partnership published the Brighter Futures Strategy in 2021.
- In Thurrock, 97% of all Early Years providers have received ratings of 'good' or better by Ofsted, and a higher proportion of Thurrock children achieved a good level of development at the end of the Early Years Foundation Stage compared to England (73.7% vs 71.8%).
- The target to reduce teenage pregnancy was met, with 2019 data indicating a reduced conception rate of 19.5 conceptions per 1,000.
- In 2021, 2.1% of 16/17-yr-olds were not in employment, education or training (NEET). This rose during the pandemic, but is still below the national average of 7.4%.
- Children living in families in absolute poverty has reduced between 2015 and 2020 from 15.4% to 13.1%. During the same period, the national rate increased and is now 15.6%.

2. Healthier Environments



- Increased funding for physical activity and improvements to parks . This has led to improvements to parks and play sites across the borough, including Daisy Fields in Tilbury, Dilkes Park in South Ockendon and Grays Beach in Grays, and the launch of Cycle Hubs in Thurrock. At the same time, the percentage of physically active adults aged 19+ in Thurrock increased from 52% in 2017 to 58% in 2020.
- The Well Homes Service have helped improve quality of life for people living in privately rented housing through the removal of hazards, installation of insulation and heating measures, installation of safety features such as security lighting, and provision of cooking and storage facilities.
- Development of Supported Living services for individuals with learning disabilities, complex needs and/or Autism Spectrum Disorders in Aveley and Grays.
- Completion of 32 properties in a HAPPI scheme called Beaconsfield Place in Tilbury, with underground lifted car park and mobility scooter storage, an outdoor gym, an indoor communal area for tenants and a community space that will deliver different activities linking the local community with our sheltered tenants.
- A total of 233 Thurrock Council apprenticeships started between 2017 and 2021 across a range of business sectors including Social Work, Project Management, Business Admin and Town Planning. As of December 2021, 4.2% of residents aged 16-17 years old were undertaking an apprenticeship of some kind.
- Appointment of four Community Builders who are encouraging communities to have a voice in their local area, by helping to build relationships and connections between local people and organisations. They help groups to access healthy activities, training and local community funding.

3. Emotional Health & Wellbeing



- Investment and launch of a Perinatal Mental Health offer (*Together with Baby*) for new mothers. This is a service designed to help parents understand better their baby's emotional responses and communications as well as strengthen the relationship.
- The *Ask Teddi* app has been developed to enable families on a Thurrock-wide level to have access to a reliable source of personalised support 24/7. *Ask Teddi* offers personalised answers to frequently asked questions about giving 0-5 year olds the Best Start in Life, on a range of topics from breastfeeding to emotional wellbeing. Parents found the Ask Teddi app invaluable during lockdowns, helping them feel more knowledgeable and confident about caring for their child.
- Community leaders supported the development of Community Hubs and Forums across Thurrock, supporting the voluntary sector to access more sources of funding, and increasing Voluntary Sector grants for smaller organisations bringing communities together and reducing loneliness.
- The development of depression screening processes within a number of services and teams, better enabling them to identify people with unsupported depression and refer on for support. Alongside this we implemented a primary care programme to incentivise GP practices to complete reviews for newly-diagnosed patients.
- Investment in new mental health practitioners as part of the Primary Care Network teams and a new model of supporting those with mental health needs.

16. Achievements of the Health & Wellbeing Strategy 2016-21

4. Quality Care Centred Around the Person

- Significant steps have been taken against this objective, notably the implementation of a New Model of Care for health and care in Thurrock. This has resulted in the following progress being made:
- Local Area Coordination is Borough wide with 14 Local Area Coordinators in place – with significant numbers of examples where people have achieved the outcomes that matter to them, reduced reliance on services, and been reconnected with their communities, friends and families.
- The implementation of Community Led Support across Thurrock – locality-based social work teams who have focused on reducing the need for referrals and assessments and for providing people with solutions that reduce the need for formal care and support, using community assets as part of a care and support solutions.
- The implementation of Wellbeing Teams in Thurrock – introducing a strengths-based and innovative approach to providing support to people in their own home which moves away from the traditional 'time and task' model of domiciliary care.
- Health and care partners have continued to work on the development of the four Integrated Medical Centres (IMCs). The Centres will be located in Tilbury, Purfleet, Corringham and Grays – aligned with the four Primary Care Networks that operate in Thurrock. Progress has been made with one IMC due to open in Corringham in 2022. Centres in Tilbury and Purfleet are expected to open in 2024, with the remaining centre in Grays scheduled to open in 2025. Whilst there has been delay to the original anticipated opening dates, this has not prevented work from taking place to enhance existing capacity across health and social care, and to improve the quality of what is being provided.
- Introduction of successful Micro Enterprise services giving people greater choice when requiring support.

5. Healthier for Longer

- A multi-agency Whole System Obesity Strategy has been implemented across Thurrock, to enhance action across the borough to address child and adult obesity.
- The proportion adults who smoke in has fallen from 21.3% in 2015/16 to 17.5% in 2019/20. To inform further action, a Tobacco Control Joint Strategic Needs Assessment has been completed and will form the basis of the Whole System Tobacco Control Strategy for Thurrock
- The Active Thurrock Partnership linked with the County Sports Partnership to launch the county wide "Find your Active Programme." The partnership secured additional funding for Thurrock's sports clubs and organisations to respond to the challenges of engaging people who have become less physically active due to the pandemic and helping to improve mental health.
- Diagnoses of LTCs have increased - before the COVID-19 pandemic, the number of people on the hypertension register increased on average by 1700 each year.

Next Steps

- Following approval of proposed Domains and underpinning Goals, further work will be undertaken to on monitoring progress against the outcomes and progress measures. Delivery of the Strategy's ambitions will be through identified topic-specific strategies and delivery groups. Monitoring of progress will be undertaken annually.

- The public will be regularly engaged throughout the lifetime of the Strategy to ensure the priorities remain fit for purpose. Continued engagement on different programmes reflected within the Strategy e.g., Whole System Obesity will be undertaken to continue to ensure that achieving the ambitions in the Strategy is informed by co-design with residents.

Acknowledgements

- This Strategy has been jointly developed by representatives of all the member organisations of the HWB Board. Over 1,300 resident and stakeholder comments have contributed to refinement of this Strategy, for which we are very grateful.

- The HWB Board would like to thank all who contributed, with particular thanks due to Thurrock CVS, Healthwatch and Ngage who undertook face to face engagement with Thurrock residents on the contents of the Strategy, and to those residents who took the time to respond. Residents' comments have directly impacted the Goals and the actions contained in this Strategy; this is detailed in the accompanying Consultation Report.

<table>
<tr><td>15 June 2022</td><td>ITEM: 11
Decision: 110611</td></tr>
<tr><td colspan="2">Cabinet</td></tr>
<tr><td colspan="2">Integrated Care Partnership (ICP)</td></tr>
<tr><td>Wards and communities affected:
All</td><td>Key Decision:
Key Decision</td></tr>
<tr><td colspan="2">Report of: Councillor Deborah Huelin, Cabinet Member for Adults and Health</td></tr>
<tr><td colspan="2">Accountable Assistant Director: Not Applicable</td></tr>
<tr><td colspan="2">Accountable Director: Ian Wake, Corporate Director of Adults, Housing and Health</td></tr>
<tr><td colspan="2">This report is public</td></tr>
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Executive Summary

This report sets out the new legislative requirements within the Health and Care Act 2022 relating to Integrated Care Partnerships and for the Council to nominate and become a founding member of the Integrated Care Partnership (ICP).

1. Recommendation(s)

1.1 To note the key elements of the Health and Care Act 2022 as set out in Section 2 of this report.

1.2 Agree to delegate authority to the Director of Public Health to act as the Council's founding representative to the Mid and South Essex ICP in order to establish the proposed governance arrangements with health and local authority partners.

1.3 Agree the draft Terms of Reference attached at Appendix 2 and delegate authority to the Monitoring Officer to make minor changes to these terms to ensure appropriate governance requirements are met.

1.4 To note that the Corporate Director of Adults, Housing and Health will sit on the shadow NHS Mid and South Essex Integrated Care Board (ICB) to represent the Council's views and interests and shall continue to sit on the Board as the Council's representative when the Board is formally established as statutory body.

2. Introduction and Background

2.1 On 6 July 2021, the Health and Care Bill was published, setting out key legislative proposals to reform the delivery and organisation of health services in England, to promote more joined-up services and to ensure more of a focus on improving health rather than simply providing health care services. The Bill has completed the final stages of its passage through parliament and received Royal Assent on 28 April 2022. The bill is now an Act of Parliament.

2.2 The purpose of the Act is to establish a legislative framework that supports collaboration rather than competition within health and care systems, and many of its proposals have been informed by NHS recommendations.

2.3 Integrated Care Systems (ICSs) are partnerships that bring providers and commissioners of NHS services across a geographical area together with local authorities and other local partners to plan health and care services collectively to meet the needs of their local population. Our local ICS covers the geographical area of Mid and South Essex.

2.4 The Health and Care Act introduces two part-statutory boards for each ICS: an Integrated Care Board (ICB), responsible for NHS strategic planning and allocation decisions; and an Integrated Care Partnership (ICP), responsible for bringing together a wider set of system partners to develop a plan to address the broader public health, health and social care needs of the local population.

2.5 The ICS will be strategically informed by the Mid and South Essex ICB. The eligibility criteria for nominees to the ICB, as outlined in Appendix C of the NHS issued Nominations and Selection Pack, restricts nominations to the Chief Executive or a relevant Executive level role in the participating local authorities. The Corporate Director of Adults, Housing and Health has the relevant seniority and expertise to fulfil the nomination criteria.

2.6 Our local ICP will link existing health partnerships and collaboration across the region, involving Thurrock, Southend and Essex County Councils. The ICP will be established with four founding members (one representative each from Thurrock, Southend and Essex County Council and the fourth member being a representative from the Integrated Care Board). These will be statutory members who will work together to expand the membership to relevant people and set the aims of the ICP, including developing the integrated care strategy.

2.7 The ICP is formed on the principle of equal partnership between the NHS and local government in delivering services. It is expected that each ICP will adopt a model of representation which reflects the diversity of the local provider sector and ensures meaningful engagement with providers of all shapes and sizes.

2.8 It is expected that ICPs will complement the activities of established Health and Well-being Boards (HWB) by providing knowledge at a local level. The Health and Care Act requires ICSs to give due regarding to Health and

Wellbeing Boards and Health and Wellbeing Strategies when making decisions about the planning of health, care and wellbeing services.

2.9 The founding members nominated to the ICP will meet from July 2022 to establish further membership and governance arrangements.

2.10 Appendix 1 contains the white paper relating to the Act and is included here so that Members have access to an overview of the proposals in context.

3. Issues, Options and Analysis of Options

3.1 The Council has a choice of whom it nominates as its founding member to the ICP. The recommendation of the Director of Public Health allows for a representative with extensive professional and Health knowledge to represent Thurrock at this specialist level and nominates the Chief Officer who has led on Thurrock's Health and Wellbeing Strategy refresh.

4. Reasons for Recommendation

4.1 The recommendations fulfil the legislative requirements of the Council to nominate to and engage with the formation of the ICP.

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

5.1 The Council, through its Monitoring Officer, has been consulted on the formation and terms of the ICP in collaboration with colleagues at Essex County and Southend councils. There has been consensus on how the nomination process will progress and each council will be pursuing a similar process to gain nominations.

5.2 The portfolio holders for Health & Air Quality and Adult Social Care & Communities have been consulted on the content of this report and the issue of the ICP.

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

6.1 Thurrock's Health & Wellbeing Board has a statutory duty to publish a Health & Wellbeing Strategy for the local community and has recently refreshed its Strategy for 2022-26. The Board's Vision of Levelling the Playing Field aims to tackle the many causes of poor health that are not level across Thurrock, and embed action across key strategies in Thurrock, including NHS plans, the Local Plan and the Backing Thurrock Economic Growth Strategy. It will drive ambitious collective action across every Council department and through the NHS and other key system partners to address the causes of unlevel playing fields in Thurrock. These include individual health risk behaviours such as smoking but also the quality of clinical care that people receive – making alignment with the ICP's priorities key in delivery of the Vision. The Director of

Public Health led on the HWB Strategy refresh and so is ideally placed to ensure this alignment.

7. Implications

7.1 Financial

Implications verified by: **Mike Jones**
Strategic Lead Finance

There are no direct financial implications from this nomination. Responsibility for ICS financial allocation and management rests with the ICB not the ICP.

7.2 Legal

Implications verified by: **Gina Clarke**
Corporate Governance Lawyer and Deputy Monitoring Officer

The Health and Care Act 2022 was enacted on 28 April 2022. The Act reforms how health and care services work together, putting integrated care systems on a statutory footing. The purpose of the legislation is to remove the barriers that prevent the NHS, Public Health, and Social Care services from being fully integrated. It creates the opportunity to plan and deliver services that are focused on the needs of local communities.

Following the enactment of the 2022 Act, statutory instruments will be made to formally establish each Integrated Care System for each area in England. However, the local NHS and responsible local authorities will need to prepare for the new arrangements, expected to commence in July.

Two of the new key arrangements that have been introduced by the Act is the establishment of:

(i) An Integrated Care Board (ICB) for areas in England
(ii) An Integrated Care Partnership (ICP) for areas in England

The ICB, an NHS body, will replace the Clinical Commissioning Group. The CCG's statutory duties and functions, and its staff will transfer to the ICB. The ICB will be responsible for implementing local NHS priorities and allocating resources and ensuring that the right activities are focused on securing the best outcomes for local communities.

The ICP will bring together the local NHS, the relevant local authorities, and other partners to develop a plan to address the broader health, public health and social care needs of the population. The Health and Care Act 2022 amends the Local Government and Public Involvement in Health Act 2007 so

that the ICB and all upper-tier local authorities that fall within the area of the ICB must establish an ICP. This will be a statutory joint committee of these bodies made under the new section 116ZA inserted in the 2007 Act. The ICP must include members appointed by the ICB and each responsible local authority and any members appointed by the ICP.

The ICP may determine its own procedures and arrangements including appointing the Chair and further members. The 2022 Act gives freedom and flexibility for local areas to make arrangements that are most appropriate for their circumstances and is conducive to collaborative working.

Membership of the ICP varies across areas, but commonly membership includes the ICB CEO, representatives from LAs, NHS healthcare providers, voluntary, community and social enterprise (VCSE) representatives, Healthwatch and public representatives. Many ICPs have also planned to have place representatives, and others are planning to draw representation from other partners including higher education and further education, social care providers, housing, police, justice, and Local Enterprise Partnerships.

The ICP when formally established will have a statutory duty to prepare an integrated care strategy on how to meet the needs of the population as identified in the joint strategic needs assessment from the health and wellbeing board/s that fall within the area of the ICB through the exercise of functions by either the ICB, NHS England and the upper tier local authorities.

The strategy must address whether the needs could be met more effectively using NHS/local authority section 75 agreements, using agreements to pool budgets or lead commissioning arrangements between local authorities and NHS bodies. It may also include a view on how health and social care could be more closely integrated with health-related services.

The ICP is required to have regard to the Secretary of State’s mandate to NHS England (national NHS priorities) and the statutory guidance on the ICS; and the ICP must involve Healthwatch and local people and communities in preparing the strategy.

The integrated care strategy must be published and shared with each responsible local authority, and the relevant integrated care board in that area.

Health and wellbeing boards in response to an integrated care strategy, must prepare a ‘joint local health and wellbeing strategy’ that sets out how the local authorities, integrated care board and NHS England will meet population needs in that area. An ICB, in the preparation of its joint-forward plan must also reference how the plan implements any relevant joint local health and wellbeing strategies to which the ICB is required to have regard.

Local authorities and integrated care boards have a statutory duty to have regard to the joint strategic needs assessment, the integrated care strategy, and the joint local health and wellbeing strategy when exercising their functions and NHS England must have also regard to them when exercising their functions related to the provision of health services in the area.

There may be further legal implications associated with the formal establishment of the ICB and ICP, which can be addressed in a future report.

7.3 **Diversity and Equality**

Implications verified by: **Roxanne Scanlon**

Community Engagement and Project Monitoring Officer

The establishment of the ICP will equally represent the interests of the three participating councils and NHS partners. The wider membership of the ICP will represent the wider relevant interests of health services in the region and will directly tackle health inequalities.

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

The ICP will directly link into the tackling of health inequalities as outlined in the report.

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

- Integrated care partnership (ICP) engagement document - GOV.UK (www.gov.uk)

9. Appendices to the report

- Appendix 1: Health and Social Care White Paper
- Appendix 2: The Draft Terms of Reference for the Mid and South Essex ICP.

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Department of Health & Social Care

Joining up care for people, places and populations

PUBLICATION: 09 FEBRUARY 2022

The government's proposals for health and care integration

CP 573

Joining up care for people, places and populations

Presented to Parliament
by the Minister of State for Health
by Command of Her Majesty

February 2022

CP 573

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Foreword: Rt Hon Sajid Javid, Health Secretary and Rt Hon Michael Gove, Secretary of State for Levelling Up, Housing and Communities

The storms we have weathered over the past two years have been a great test, but also a great teacher.

We have learned, most notably from our world-leading vaccination programme, that we are stronger when we work together and are united in our purpose and resolve.

We have also seen the moral outrage of persistent health disparities, mirroring other disparities in our society, illuminated as never before in our lifetimes. We have been reminded, once more, of the inextricable link between health services and social care.

So, as we recover and level up, it is right that we draw on our experience of the pandemic to bridge the gaps – between health and social care, between health outcomes in different places and within society – that are holding us back.

This is what our white paper aims to achieve by bringing together the NHS and local government to jointly deliver for local communities.

It sets out a new approach with citizens and outcomes at its heart instead of endless form-filling, unnavigable processes and a bureaucracy which sees too many people get lost in the system, not receiving the care they need. It is the start, not the end, of a new wave of reform which will both put power and opportunity in the hands of citizens and communities and build a state that is sustainable and just.

Through introducing a single person accountable for delivery of a shared plan at a local level, our proposals will ensure a more joined-up approach between health and social care. It will give health and social care professionals access to the right data and

technology to make more informed decisions, and it will also help to create a more agile workforce with care workers and nurses easily moving between roles in the NHS and the care sector.

Moreover, the white paper also delivers on our ambition to level up health outcomes over the long term.

It champions health and well-being as a real priority and places a much greater emphasis on prevention.

To that end, it promotes community-centred care to help people with disabilities, who are suffering from dementia and other mental health issues to live independent and healthy lives.

Crucially, we are proposing measures to help bridge the gap in Healthy Life Expectancy (HLE) between local areas by making sure there's universal access to high-quality treatments and support in all parts of the country.

At every step, this white paper has been shaped by the real-world experience of people as well as nurses, care workers and doctors on the front line, drawing on some of the great examples of collaborative working we have seen at a local level in recent years, not least over the pandemic.

It presents the next component of a bold vision for the future of health and social care in this country with people and patients at its very heart.

Executive Summary

The NHS and local government have delivered remarkable things for the public, in the most challenging circumstances, over the last 18 months. From the extraordinary success of the vaccine programme, to meeting the needs of people previously identified as Clinically Extremely Vulnerable and many other examples of reshaping services to continue to deliver care safely. There is a lot for local government and the NHS to be proud of and to learn from as we move into recovery from COVID-19. Through multi-agency community hubs, integrated neighbourhood teams, and other locally developed arrangements, local partners developed a shared understanding of local needs and made flexible use of resources across services to ensure that people got the support they needed. A vast range of other activity has been jointly delivered by various organisations thanks to a combined commitment to go beyond normal organisational boundaries and do whatever has been required to support their local residents. The resilience, commitment to finding a way through for citizens, and the willingness to innovate will all be just as important as we tackle the challenges ahead.

Among the lessons of the pandemic is the need to do more to bring the resources and skills of both the NHS and local government together to better serve the public. So, as well as record investment, NHS and local government reform will be needed to recover from the pandemic and deliver on the government's priorities, including on its central mission to level up every part of the UK. Our health and care system needs to take this agenda forward with real urgency if the challenges the sectors face - both in the short and long term - are to be met; and this will need to be done with the full involvement of local leaders and the public.

Successful integration is the planning, commissioning and delivery of co-ordinated, joined up and seamless services to support people to live healthy, independent and dignified lives and which improves outcomes for the population as a whole. Everyone should receive the right care, in the right place, at the right time.

We want to go further and faster in building integrated health and care services. People should experience joined up care which makes the best use of public resources and services. While a more integrated approach clearly will not address all of the challenges facing staff, joining up services around users can also improve job satisfaction for the staff delivering them - removing some of the barriers that stop staff delivering care as they would like. This requires change that builds on improvements made across the health and care sectors in recent years.

While progress has been made, our system remains fragmented and too often fails to deliver joined up services that meet people's needs. The goals of different parts of the system are not always sufficiently aligned to prioritise prevention, early intervention and

population health improvement to the extent that is required. That needs to be our focus if we are to continue building better health, tackling unjustifiable disparities in outcomes, and ensuring the sustainability of the NHS and other public services. People too often feel like they have to force services to work together, rather than experiencing joined-up health, public health, social care and other public services.

This paper is part of a wider set of mutually reinforcing reforms: our Adult Social Care Reform white paper, People at the Heart of Care; the Health and Care Bill and reforms to the public health system. It sets out our plans to make integrated health and social care a reality for everyone across England and to level up access, experience and outcomes across the country. Specifically, this paper:

- sets out our approach to designing shared outcomes which will place person-centred care, improving population health and reducing health disparities at the centre of our plans for reform, and ensuring that accompanying oversight arrangements and regulatory structures have a clear focus on the planning and delivery of these outcomes

- sets out proposals to strengthen the health and care services in places that feel familiar to the people living in them. While strategic, at-scale planning is carried out at the Integrated Care System[1] (ICS) level, places will be the engine for delivery and reform

- introduces an expectation for a single person, of accountable at place level, across health and social care, accountable for delivering shared outcomes and strong, effective leadership

- sets out how we will make progress on the key enablers of integration (workforce, digital and data and financial pooling and alignment) required to further join up services around people and populations

- reinforces the role of robust regulatory mechanisms to support the delivery of integrated care at place level

Joined up care: better for people and better for staff

As people who use health and care services require ever-more joined up care to meet their needs, achieving this will make all the difference both to the quality of care and to the sense of satisfaction for staff. Without a decisive shift to consistently joined up care, we will

[1]In this document we refer to 'Integrated Care Systems' or ICSs - an ICS is made up of both the Integrated Care Board (ICB) and the Integrated Care Partnership (ICP) that are set out in the Health and Care Bill. The term 'ICS' is also used to refer to the geographical area covered by the system.

continue to see fragmentation for people and frustration for staff. For example, closer working between primary and secondary care will improve access to specialist support and advice and enable care to be delivered closer to home, managing risk more effectively and keeping people healthy and independent. And closer working between mental health and social care services can reduce crisis admissions and improve the quality of life for those living with mental illness.

Unlocking the power of data across local authorities and the NHS will provide place-based leaders with the information to put in place new and innovative services to tackle the problems facing their communities. A more joined up approach will bring public health and NHS services much closer together to maximise the chances for health gain at every opportunity.

Shared outcomes which prioritise people and populations

Shared outcomes are a powerful means of bringing organisations together to deliver on a common purpose for the people they serve. We have set out the case for a new approach for designing and measuring progress against these. We will work with stakeholders to develop and introduce a framework with a focused set of national priorities, and an approach for prioritising shared outcomes at a local level, focused on individual and population health and wellbeing. We will set out a framework which makes space for local leaders to agree shared outcomes that meet the particular needs of their communities, whilst also supporting national priorities. Places will be able to choose health and care priorities that matter most to their citizens, alongside national commitments. Implementation of shared outcomes will begin from April 2023. There will be robust arrangements in place to assure both the planning and delivery of both national and local outcomes.

Ensuring strong leadership and accountability

Effective leadership, accountability and oversight are key to delivering integration. Local leaders - including in local government and the NHS, in partnership with their citizens - have a unique understanding of, and relationships with, their populations. We will make changes that bring together these leaders to deliver on shared outcomes in an accountable and transparent manner, through formal place-based arrangements which provide clarity over the responsibility for health and care services in each area. Several places such as Tameside have already successfully adopted arrangements of this kind.

We will set out criteria for place-level governance and accountability for the delivery of shared outcomes. We have suggested a model which meets those criteria and expect places to adopt either this specific governance model, or an equivalent, by Spring 2023.

The key characteristics needed in any model will be for it to develop a clear, shared plan and, crucially, to be able to demonstrate a track record of delivery against agreed shared outcomes over time, underpinned by pooled and aligned resources.

Local NHS and local authority leaders will be empowered to deliver against the agreed outcomes and will be accountable for delivery and performance against them. Any governance model should also provide clarity of decision-making, covering contentious issues, practical arrangements for managing risk and resolving disagreements between partners, and agreeing shared outcomes. There should be a single person, accountable for shared outcomes in each place or local area, working with local partners (e.g. an individual with a dual role across health and care or an individual who leads a place-based governance arrangement). This person will be agreed by the relevant local authority or authorities and Integrated Care Board (ICB). We would expect place-based arrangements to align with existing ICS boundaries as far as possible. We recognise that in some geographies this can be challenging, and we expect NHS and local authority partners to work together (drawing, where needed, on the flexibilities that the legislation will provide, subject to Parliament) to ensure that all citizens are able to benefit from effective arrangements wherever they live .These proposals will not change the current local democratic accountability or formal Accountable Officer duties within local authorities or those of the ICB and its Chief Executive.

Places will be supported by central government, NHS England, ICBs and others to develop arrangements which deliver the best outcomes for their populations.

Finance and integration

Financial frameworks and incentives can play a key role in enabling the integration of services and supporting service innovation.

Local leaders should have the flexibility to deploy resources to meet the health and care needs of their population, as necessary. NHS and local government organisations will be supported and encouraged to do more to align and pool budgets, both to ensure better use of resources to address immediate needs, but also to support long-term investment in population health and wellbeing.

Working within the principles set out in this paper, we will work with partners to develop guidance for local authorities and the NHS to support going further and faster on financial alignment and pooling. We will also review existing pooling arrangements (e.g. section 75, NHS Act 2006), with a view to simplifying the regulations for commissioners and providers across the NHS and local government to pool their budgets to achieve shared outcomes. This will continue to be subject to both NHS and local authority partners agreeing what constitutes a fair and appropriate contribution.

Digital and data: maximising transparency and personal choice

A core level of digital capability everywhere will be critical to delivering integrated health and care and enabling transformed models of care. When several organisations are involved in meeting the needs of one person, the data and information required to support them should be available in one place, enabling safe and proactive decision-making and a seamless experience for people.

Digital tools will empower people to look after their health and take greater control of their own care, offering flexibility and support - through the NHS App and NHS.uk, remote monitoring and digital health apps. We will aim to have shared care records for all citizens by 2024 that provide a single, functional health and care record which citizens, caregivers and care teams can all safely access.

We will support digital transformation by formally recognising the Digital Data and Technology profession within the NHS Agenda for Change and including basic digital, data and technology skills in the training of all health and care staff. We will support all health and care staff to be confident when recommending digital interventions to patients and individuals using services, based on what we know works and what people want to access.

To support place-based organisations, Integrated Care Systems (ICSs) will develop digital investment plans for bringing all organisations to the same level of digital maturity. These plans will outline how ICSs will ensure data flows seamlessly across all care settings and use tech to transform care so that it is person-centred and proactive at place level.

The digital and data transformations outlined in this document provide an opportunity for greater transparency. We will look to introduce mandatory reporting of outcomes for local places, putting citizens at the heart of what we do.

Delivering integration through our workforce and carers

The health and care workforce are our biggest asset, and they are at the heart of wrapping care and support around individuals. We want to ensure that staff feel confident, motivated and valued in their roles and that they can work together in a person's interests regardless of who they are employed by. Staff numbers and skills across teams should be planned to meet the needs of their local populations and places. They should also be able to progress their careers across the health and social care family, supporting the skills agenda in their local economy. Our proposals in this paper build on our proposals to support the social care workforce, as outlined in our Adult Social Care Reform white paper, People at the Heart of Care.

To achieve this, ICS will support joint health and care workforce planning at place level, working with both national and local organisations. We will improve initial training and ongoing learning and development opportunities for staff, create opportunities for joint continuous development and joint roles across health and social care and increase the number of clinical practice placements in adult social care for health undergraduates.

What this means for people and communities

Taken together, these reforms will support a better joined up health and care system, with people's wishes and wellbeing at its heart. Citizens with access to more information will be more empowered to make decisions about their care and have more choices about where and how they access care. Working with local places and ICSs, we will remove unnecessary barriers so places will be empowered to do what is best for their citizens. They will be supported to be transparent and accountable for the delivery on the outcomes which matter to communities, and variations in performance between areas will be addressed. The financial frameworks and incentives which support this will be reformed over time so that the way funding is allocated and accounted for does not prevent places and ICSs doing the right thing for the people they serve.

These reforms will help us develop a world-leading health and care system which works for every person, and where people work together to deliver continuous improvement in the delivery of health and care services. This is possible and necessary, and we will start making it a reality now.

1. Introduction: Delivering More Integrated Services for the 21st Century

The case for going further and faster on integration

1.1 When health and care organisations have a shared mission, work with their local citizens, and pool their ideas, energy and resources to serve the public, the result is often the delivery of outstanding quality and tailored, joined up care, which improves the experience and outcomes for individuals and populations. In recent years, and in particular during the pandemic, we have seen many examples of the power of collaborative working.

1.2 This is, however, far from the norm everywhere, and as the challenges of demography, the possibilities of technology and the expectations of citizens all grow, we will need to move beyond a health and care system where organisations and services operate in a compartmentalised way. People have a range of needs which cannot always be addressed neatly by one organisation or another. There is a greater need for holistic care that fits around these needs; our services, processes, institutions, and policies need to catch up. We know that, currently the public often experiences:

- a lack of coordination between the range of services looking after them. Information or actions can be lost between primary and secondary care; where primary care and hospital teams might have to form treatment plans without the crucial insights from a person's carer; or different specialists might focus only on one or two conditions, without considering the needs of a person holistically

- organisations that are forced or incentivised - by regulation or the financial framework - to focus on their narrow set of organisational outcomes, rather than a health and care service that considers the health needs of the whole community

- duplication in use of resources or patients' time. People being asked for the same information multiple times, by different organisations, which can lead to delays in diagnosis or treatment; or the use of NHS personal health budgets without considering whether an individual also has a personal budget for social care (and vice versa) and the impact on them of managing both budgets simultaneously

- delays in being discharged as a result of competing budgets and care processes

1.3 Ensuring there is holistic care that fits around people needs includes ensuring that people receive the right care and support, and can maintain healthy independent living, beginning with where they live, and the people they live with. Getting these housing arrangements right for individuals and communities is one example that requires the joining up of not just health and care partners, but a wider set of local government functions and housing providers. Today, too many people with care and support needs live in homes that do not provide a safe or stable environment. People's homes should allow effective care and support to be delivered regardless of their age, condition or health status. We want people to have choice over their housing arrangements, and we also want to ensure places 'think housing and community' when they develop local partnerships and plan and deliver health and care services.

1.4 Over the last few years, there has been a great deal of valuable work to bring about greater integration:

- GP practices are already working together with community health services, mental health, social care, pharmacy, hospital and voluntary services in their local areas in groups of practices known as Primary Care Networks (PCNs). Building on existing primary care services, they are enabling greater provision of proactive, personalised, coordinated and more integrated health and social care for people closer to home NHS Chief Executive, Amanda Pritchard, has asked Dr Claire Fuller (CEO Surrey Heartlands ICS) to lead a stocktake of how systems can enable more integrated primary care at neighbourhood and place, making an even more significant impact on improving the health of their local communities. This will report later in the spring

- the Better Care Fund was introduced to support places to integrate better by pooling budgets and ensuring there is joint planning between NHS commissioners and local authorities to deliver care. Better Care Fund plans have aided integrated work to support people to remain independent for longer, integration of reablement and improved performance on hospital discharge[2]

- new models of care and Sustainability and Transformation Partnerships (STPs) considered local health priorities, encouraged better joint planning of services and tested innovative models of integrated care. For example, provider collaboratives in mental health have been empowered to reconfigure

[2] The health and social care interface (nao.org.uk)

local services to reduce out of area placements and bring people closer to home to aid their recovery. STPs aimed to develop sustainable services to improve person-centred care in key areas and to improve hospital performance

- devolution, such as that seen in Greater Manchester, allows local places to have more flexibility to integrate care around the needs of their local populations

- local government and the NHS have jointly planned and commissioned some health services, to join up people's experience of care and address both prevention and treatment

1.5 We know there is more we can do to better integrate health and care services, joining up planning, commissioning and delivery. We must go further, faster. The experience of COVID-19 has shone a spotlight on the health disparities which persist across the country. We need to prioritise prevention decisively and collectively, so that we build health resilience and are well placed to meet the multiple health and care challenges of our changing demographic. Done right, integration will enable concerted, collaborative effort across the whole of the health and care system to reduce the disparity gap and improve population health. In February 2021 we set out our ambitions for the future of health and social care, and for legislative reform to support this, in Integration and innovation: working together to improve health and social care for all. These proposals, including (subject to Parliament) establishing statutory Integrated Care Boards (ICBs) and statutory Integrated Care Partnerships (ICPs), ensure the health and care system will be much better equipped to collaborate across boundaries, make joint decisions and form alliances to tackle shared problems[3].

1.6 These proposals were based on the learning from those at the forefront of delivering more integrated care and support locally; in particular how important their partnerships had been when responding to the COVID-19 pandemic. We remain committed to this direction of travel and just as proud of the achievements of our health and care services as they continue to rise to the ongoing operational challenges they face.

1.7 The creation of ICSs as a formal part of our health and care system is a critical opportunity to remove remaining barriers to integrated care and create the conditions for local partnerships to thrive. This paper builds on those ambitions

[3] In this document we refer to 'Integrated Care Systems' or ICSs - an ICS is made up of both the Integrated Care Board (ICB) and the Integrated Care Partnership (ICP) that are set out in the Health and Care Bill. The term 'ICS' is also used to refer to the geographical area covered by the system.

and provides further detail on our plans to empower leaders and strengthen collective working between the NHS and local government at place to work in partnership to achieve the best for those they serve.

Case study: Teesside

Sexual health services across Teesside's four local authorities, two CCGs and NHS England are collaboratively commissioned by one prime provider. With a strong focus on prevention, the new service has both improved access and achieved savings, and is highly rated by users, consistently getting a high score on the 'Friends and Family' test. It has enabled a greater focus on improving the sexual health of young people, including chlamydia screening, provision of young-people friendly services, access to contraception and outreach, and the prioritisation of HIV prevention. Using equity measures they monitor progress, not just at borough level but using universally shared outcomes.

Our vision for integrated health and care services

1.8 Integration is not an end in itself, but a way of improving health and care outcomes. Successful integration is the planning, commissioning and delivery of co-ordinated, joined up and seamless services to support people to live healthy, independent and dignified lives and which improves outcomes for the population as a whole. Everyone should receive the right care, in the right place, at the right time. Our vision is that integration makes a significant positive impact on population health through services that shift to prevention and address people's needs promptly and effectively; but it is also about the details and the experience of care - the things that often matter most to people, carers and families. This is captured in the 'Think Local Act Personal' statement below:

Everyone should be able to say: "I can plan my care with people who work together, to understand me and my carer(s), who allow me control, and bring together services to achieve the outcomes important to me." (National Voices, TLAP 2013)

1.9 This paper seeks to deliver this vision, through the introduction of shared outcomes, agreed by all local health and care organisations, and the delivery of which all local leaders will be held to account for. To facilitate this, we outline the place level accountability arrangements to underpin delivery and the arrangements for aligning and pooling of resources, digital transformation and changes to regulation that will enable change.

1.10 Integration needs to be delivered at every level:

- individuals: for people wanting to live lives which are as healthy and independent as possible, their communities, for carers and families
- neighbourhood and communities: areas covered by, for example, primary care and their community partners)
- place: a geographic area that is defined locally, but often covers around 250-500,000 people, for example at borough or county level
- system: usually larger geographies of about one million people which often (but not always) cover multiple places
- national: in this case, the whole of England

1.11 Our focus in this document is at place level. It is where local government and the NHS face a shared set of challenges at a scale that often works well for joint action. Strong places are also important for effective working at both system level (with many Integrated Care Systems investing a great deal of effort into developing places within their geography) and at neighbourhood and community level (where the support of places in making improvements happen is critical to success). Our responsibility in central government to facilitate and support improvements at place level, ensuring the right structures, accountability and leadership are in place to enable effective integration locally.

1.12 Whilst children's social care is not directly within scope of this paper, places are encouraged to consider the integration between and within children and adult health and care services wherever possible. The transition to ICSs represents a huge opportunity to improve the planning and provision of services to make sure they are more joined up and better meet the needs of babies, children, young people and families. The Independent Review of Children's Social Care is taking a fundamental look at the needs, experiences and outcomes of the children supported by children's social care. We will consider and respond to the recommendations and final report of the care review once it is published. Government is championing the continued join up of services, expanding family hubs to more areas across the country, and funding key programmes such as Supporting Families and supporting the implementation of the Early Years Healthy Development Review. At the recent Budget, we announced a £500m package for these services, to provide more support for families so that they can access the help and care that they need. Ensuring that every area has joined up, efficient local services, that are able to identify families in need and provide the right

support at the right time, will enable children and young people who rely on multiple public services to thrive.

1.13 This paper sets out our ambition for better integration across primary care, community health, adult social care, acute, mental health, public health and housing services which relate to health and social care.

1.14 Our plans will support the development of a health and care system which:

- is levelled-up in terms of outcomes and reduced disparities
- ensures people have access to health and care services which meet their needs, and experience outstanding quality care
- transforms where care is delivered, according to people's preferences (including at home and in the community). This includes ensuring that people are discharged in a timely, safe and efficient way from hospital
- enables people to access personalised information about their health and care - to give them more control over their own health and care journey - informed by excellent, timely data and integrated care records
- enables data and information sharing to support joined up and informed decisions around an individual's care, and better understanding of the needs and priorities of local populations
- is delivered by a capable, confident, multidisciplinary workforce which wraps services around individuals and their families and carers
- allows and encourages innovation and digitisation to ensure that we have the right tools which enable people to have their needs met in the right place
- has joined up, workforce planning at the system level to ensure the right people, with the right skills and training to deliver collaborative, person-centred care
- incentivises organisations to prioritise the same shared outcomes and goals, so rather than a narrow focus on their own organisational targets, they can think about health and care journeys and outcomes, to ensure people don't fall through gaps between services or settings, or bounce around the system
- incentivises organisations to collectively prioritise upstream interventions for individuals and communities, and increasingly allocate resource to improve population health and address disparities

- is driven forward by decisive leadership, who listen to and understand the needs of their local people and have clear accountability for delivering those outcomes

1.15 There is a widespread commitment to this agenda - we know health and care professionals and leaders want to do more to join up services. People want the services they use to be better joined up around their needs. Better integration can facilitate better care for people now, as well as in the long-term, as the importance of prevention grows.

1.16 Change is needed, and the potential reward - in better outcomes and value for citizens - is significant. Integration does not, of itself, guarantee improved outcomes - doing it well is what is required.

Our policies, interventions and the support we provide will therefore continue to promote the benefits of flexibility, local learning and the evolution of ways of working at place and system. The truly radical possibilities in this agenda are much more likely to be identified and realised by local organisations than through central prescription.

Case studies

Tom and Maureen:

Tom is 85 years old and has mild undiagnosed dementia, he is currently living at home with his wife of 60 years, Maureen, who has been his constant support. The couple have lived in their home for 55 years. Maureen, who is of similar age to her husband, suffers with pain in her heart from angina and has high blood pressure. It is of increasing concern to their children, Dan and Sarah - who do not live locally, that the couple do not receive support from local services. Tom and Maureen are unaware of where to seek help as both unfamiliar with and lack confidence when using digital technology and feel like they are able to support themselves. Tom suffered from a fall down the stairs and fractured his hip.

Bunmi

Bunmi is a woman with chronic obstructive pulmonary disease (COPD), osteoarthritis and early dementia. She lives in sheltered accommodation and is moving around less than she usually would. Bunmi still tries to attend church every Sunday, however over the past few weeks she has been struggling to get out because of her worsening health and it is affecting her mood

Kwame:

Kwame is from the North East of England and has just celebrated his 18th birthday. Kwame loves to be outdoors and is a big fan of Star Wars. He also has a learning disability, autism and when anxious, he can display behaviour that can be particularly challenging to services.

Kwame has spent several years in an out of area residential, educational placement arranged by the local authority. This caused considerable increase in his anxiety and behaviours, placing himself, staff and other children at risk. This led to him spending more time in self-imposed seclusion. He was admitted for treatment at a specialist children's hospital where he seriously assaulted a member of staff. To make the situation safer for people around him, Kwame's interaction with family and staff was done through a glass pane and intercom system.

Madeleine:

Madeleine is 65 years old and lives alone with her guide dog. She has been visually impaired since birth. She has two grown up children and one grandchild all of whom live abroad. Good technology means that she is in contact with them on a daily basis but gets practical support from being involved in her local community. In common with most visually impaired people, Madeleine does not have any statutory support but relies on the services provided by Guide Dogs for the Blind Association.

Mandeep

Mandeep is a 24-year-old who struggles to maintain a job due to issues with his mental health. He had learning difficulties which were undiagnosed, resulting in his inability to gain a formal qualification. This affected Mandeep's relationship with his family who did not understand why he was not achieving. Mandeep left home at 16 and stayed with friends or in supported accommodation when he could. He has type 2 diabetes and is often tired which has caused issues for him in the workplace. Mandeep is at risk of homelessness as he does not have a steady income and is unsure of where to go for help.

Richard

Richard has long term schizophrenia. He has spent many years constantly bouncing in and out of long stay psychiatric inpatient admissions, but he wanted to live at home independently. After a recent relapse and hospital admission, the ward team identified that part of the reason for his psychotic relapse was that he was falling behind rent payments and his house had damp/heating problems that he couldn't fix. While the clinical team on the ward worked to stabilise Richard, including taking his medication, they also sought

early input from local authority housing workers who work into the ward and could start on the paperwork to maintain Richard's tenancy and arrange work to get the damp sorted.

2. Shared outcomes

Summary

Collaboration is essential to delivering joined up care. Our frameworks should support organisations and systems to work together in pursuit of the same goals, which focus on individuals and population health and wellbeing.

It is right that the national government sets some delivery standards for organisations, to ensure that the public receive a consistent standard of care. But if we are to allow local leaders to work together to make the most of their shared resources on behalf of local people, we need to better support organisations to pull in the same direction.

Some outcomes and goals are appropriately set nationally, but we also need to make space for local leaders to agree shared outcomes that meet the particular needs of their communities. We need a new approach to setting shared priorities which is integrated and focuses on key outcomes which matter for people's health and wellbeing and improve population health. Some local organisations will be focused on the delivery of outcomes relatively independently of other organisations; but to respond to increasing complexity and multi-morbidity, services should be free to support partner organisations, even when they are not the main delivery agent. For example, hospitals should be incentivised to support public health outcomes, and primary care should be incentivised to support social care outcomes.

Following further work with stakeholders, we will set out a framework with a focused set of national priorities and an approach from which places can develop additional local priorities.

Implementation of shared outcomes will begin from April 2023. In parallel, we will ensure that accompanying oversight arrangements and regulatory structures have a clear focus on the planning and delivery of these outcomes.

As part of the shared outcome setting process, we will review alignment with other priority setting exercises and outcomes frameworks across the health and social care system and those related to local government delivery.

Why shared outcomes matter

2.1 Shared outcomes bring organisations and the people they serve together, and shared outcomes with clear plans for delivery make impactful change happen. We have seen this in both the Integrated Care Systems that have made the most progress in recent years and in the collaborative working during the pandemic. Priorities tend to be most effective when they are outcome-focused (rather than focusing on output or inputs), when they are specific, and when they reflect clearly the most important issues for local people. The right outcomes will encourage local innovation and positive change.

2.2 Currently, we have many and varied priorities and outcomes for the health and care system, used by different organisations for different purposes, albeit with some areas of overlap and alignment. There are Outcomes Frameworks for each of public health, the NHS and adult social care, as well as outcomes for local government more broadly. In parallel, priorities have been set in the NHS Long Term Plan and in the Government's Mandate to NHS England. Organisational priorities are also shaped by the broader regulatory framework and by statutory duties.

2.3 In recent years we have seen systems and local partnerships working together to deliver shared outcomes and we need our national frameworks to reflect the increasing importance of collaboration in pursuit of joined-up care for local people. Whilst acknowledging the varying roles the current outcomes do serve across the system, it is important that they do not pull local leaders away from collaboration, but rather enable partner organisations to work together to deliver against outcomes that truly matter to the people they serve.

2.4 As we increase our expectations of integrated working at system and place, it is right that we revisit how outcomes are articulated and prioritised- nationally and locally - to ensure that we are doing all we can to support the achievement of greater integration. This will be vital if we are to achieve a decisive shift to a model focused on population health and delivered through a shared understanding of population need and what can be done to improve services. Outcome frameworks, prioritisation exercises and associated processes designed for one or more organisation- or sector-specific purposes will need greater alignment if we want to go further and faster on integration.

2.5 What counts as a good outcome will, in many cases, require much closer working with people who use health and care services. This should result in people having more control in decision-making about what matters in their individual lives. This is perhaps more developed in social care than in health care, and it is becoming an increasingly important element of effective support for people with multiple

conditions. In defining shared outcomes, success will therefore be reflective of what individuals want for their own care and what will maximise their wellbeing, focused not only on an individual organisation's services but also the connections between organisations and services they provide.

2.6 A new approach to shared outcomes will ensure that organisations can work together, focusing on shared goals which improve outcomes for people and populations, and underpinned by measures which support this aim. Following publication, we will work with stakeholders to set out national priorities and a broader framework for local outcome prioritisation for implementation from April 2023.

Design Principles for a Shared Outcomes Framework

2.7 Generally, places are best placed to prioritise the outcomes for local people that matter the most.

2.8 Shared outcomes will need to be designed by partners across the system and with citizens, grounded in shared insight and understanding of the needs of the population.

2.9 Integration of services and ambition in improving outcomes go hand in hand. Where there is strong alignment, trust and common purpose between partner organisations, accompanied by a strong local role in identifying priorities, we expect to see high levels of ambition in the outcomes which places identify.

2.10 An approach for agreeing local outcomes will be an essential part of the shared outcomes framework. Some national priorities will, of course, always be needed to secure the improvements in care and outcomes that the public expect - such as those to support elective recovery and hospital discharge to ensure people receive the right care in the right place at the right time. To this end, the government will continue to set a Mandate for NHS England. We intend to set out a small and focused set of national priorities, which all places will be expected to deliver alongside their own local priorities. Local and national prioritisation and goal-setting processes should therefore be complementary and realistic. Central government will need to ensure that the priorities set at national level allow sufficient space for local prioritisation in pursuit of the needs of their local populations.

2.11 Outcomes will sit alongside - and complement - systems' and organisations' statutory responsibilities and wider regulatory frameworks, and our intention is to

address the problem of organisations being pulled in different directions by competing outcomes and targets.

2.12 There is also an important national role in ensuring that national and local outcomes work and sit together coherently such that there is clarity and consistency, and so that local organisations and partnerships are able to consider their own progress in comparison with others.

2.13 We do not intend that shared outcomes should add to the overall burden of national requirements. In defining national outcomes, we will consider what can be aligned or replaced from our current priority and outcome setting exercises and frameworks.

2.14 We want to focus on outcomes rather than outputs. Although outcomes are harder to measure and can take longer to deliver, they offer the best prospect of decisions and services which are both person-centred and improve population health over time. When outcomes are long term, we will need to identify interim or proxy metrics which demonstrate that organisations are collectively making progress towards them.

2.15 Our outcomes-centred approach must therefore be focused on the end goals of better person-centred health and care, improving population health and addressing disparities rather than on the process of integration per se. So, for example, outcomes should focus on areas such as people's experience of care, wellbeing, and independence, not on organisational processes or decision-making. Further illustrative examples of outcomes are provided below.

2.16 National bodies with a regulatory or oversight role will consider the setting and delivery of outcomes in discharging their regulatory duties.

Illustrative Examples of Shared Outcomes

Mental health

A shared outcome for mental health could mean people with mental illness living well in the community. A shared set of patient reported outcome measures (PROMs), could help align NHS clinical support with local authority support through social care, housing, and other services to improve recovery rates and quality of life for people living with mental illness.

Maternal smoking

Greater Manchester (GM) have taken a whole system approach to addressing smoking in pregnancy. Working collaboratively with Foundation Trusts, Clinical Commissioning Groups, maternity services and across 10 local authorities. GM have implemented a financial incentives scheme, which enables women to access shopping vouchers at certain timepoints during pregnancy and beyond, conditional on them remaining smoke free. Outcomes from this integrated approach include an increase in the number of women successfully stopping smoking, higher average birth weight of babies and reductions in the number of babies requiring neonatal care.

Enhanced Heath in Care Homes

Enhanced Health in Care Homes (EHCH) provides proactive care for care home residents and is delivered through a whole-system collaborative approach across health and care providers. Primary Care Networks must ensure that every care home has a named clinical lead, receives a weekly home round, and is supported by a multi-disciplinary team, and that every care home resident has a personalised care and support plan within 7 working days of admittance or readmittance. It involves a range of partners, including those from health (both primary and community care services), social care, voluntary, community, and social enterprise (VCSE) sector, as well as care homes, who are expected to work collaboratively with care homes to improve their local models over time.

As part of the care model, there are various shared outcomes which these providers are trying to achieve including:

a. high-quality personalised care within care homes

b. access to the right care and the right health services in the place of their choosing

c. reducing unnecessary conveyances to hospitals, hospital admissions, and bed days whilst ensuring the best care for people living in care home

Hospital discharge

Discharging people from hospital is an activity that needs acute, community, primary care and adult social care to work together. A shared outcome around discharge could bring together a group of outcomes in various existing frameworks to look beyond discharge to ‘right care, right place’.

What we will do

2.17 The government will undertake further engagement with partners and stakeholders and use these discussions to set a focused set of national outcomes alongside a

broader framework for local outcome priorities. Initially, outcomes will focus on health services, the public's health and adult social care. National and regional partners will play a key role in setting coordinated and consistent strategies to enable all organisations within the wider health and care landscape to align their activity to these national and local outcomes.

2.18 Places, working with local people and communities, will then identify and agree their local outcome priorities with reference to the broad framework. Places will agree action required to meet national and locally identified priorities.

2.19 Integrated Care Systems will provide support and challenge to each local area as to the assessment of need and local outcome selection and plans to meet both national and local outcomes. Plans should be in place for implementation from April 2023.

2.20 We expect local arrangements, and the ICSs they are within, to take the lead on identifying issues and barriers to delivery and bring about real change for citizens. The Care Quality Commission (CQC) will consider outcomes agreed at place level as part of its assessment of ICSs. The CQC will also continue to develop its assessment of individual providers, to ensure their contribution to plans that improve outcomes at place and ICS level are assessed as part of the overall oversight framework.

2.21 These will build on existing oversight arrangements, some of which we are aiming to strengthen through the Health and Care Bill. The CQC will play a critical role. In addition to its current role in regulating and inspecting health and care providers, the CQC will review integrated care systems including NHS care, public health, and adult social care and assess local authorities' delivery of their adult social care duties.

2.22 Working with partners, the CQC will consider both the starting position for each ICB and local authority, and the local and national priorities each area needs to manage, to help understand how all those responsible for health and care services are working together to deliver safe, high quality and integrated care for the public. Further work is underway to develop the detail and methodology of the CQC reviews, in line with existing oversight and support processes.

We will engage with partners and stakeholders to effectively design and implement shared outcomes. We will invite views on the following questions:

1. Are there examples where shared outcomes have successfully created or strengthened common purpose between partners within a place or system?

2. How can we get the balance right between local and national in setting outcomes and priorities?

3. How can we most effectively balance the need for information about progress (often addressed through process indicators) with a focus on achieving outcomes (which are usually measured and demonstrated over a longer timeframe)?

4. How should outcomes be best articulated to encourage closer working between the NHS and local government?

5. How can partners most effectively balance shared goals / outcomes with those that are specific to one or the other partner – are there examples, and how can those who are setting national and local goals be most helpful?

3. Leadership, accountability and finance

Summary

Leaders are essential for bringing partners together to deliver outcomes that really matter to people and populations.

We will empower effective leaders at place level to deliver the shared outcomes that matter for their populations by setting an expectation that by Spring 2023, all places within an Integrated Care System should adopt a model of accountability, with a clearly identified person responsible for delivering outcomes, working to ensure agreement between partners and providing clarity over decision making.

We will also work with the CQC and others to ensure there is effective regulation and oversight and that these new models achieve their purposes. CQC reviews will consider both how services deliver safe, high quality and integrated care to the public and the strength of integration within an ICS.

We will develop a national leadership programme, addressing the skills required to deliver effective system transformation and local partnerships, subject to the outcomes of the upcoming leadership review.

We want to build on progress in recent years to go further and faster in pooling and aligning funding to enable delivery at place level. Our expectation is that aligned financial arrangements and pooled budgets will become more widespread and grow to support more integrated models of service delivery, eventually covering much of funding for health and social care services at place level. These should be supported by robust frameworks to manage risk and deliver value for money.

To support this, we are reviewing section 75 of the NHS Act 2006 (which allows partners such as NHS bodies and councils to pool and align budgets) to simplify and update the underlying regulations.

Finally, we are reaffirming our commitment to personal health budgets, personal budgets, and integrated personal budgets as a means for supporting integration around individual patients and people who draw on care services.

3.1 Leaders are essential for bringing partners together to deliver outcomes that really matter to people and populations.

3.2 There are many great leaders in health and care across places in England who have made incredible progress to integrate health and care services and to join up care to improve outcomes for their populations.

3.3 At place level, this is especially important. Local leaders - including clinical and professional leaders - are well placed to understand the health and care needs of their local populations and to deliver the right change to level up health and care outcomes.

3.4 Effective local leaders are responsible - and seen to be responsible - for delivering the right outcomes and value for money, tackling health disparities, and for how well they have brought together the relevant partners to do so. We need to create the conditions to make this the norm in all places.

3.5 Many leaders, however, find that significant effort, persistence and resources are required to achieve the levels of collaboration and integration that match their ambitions and commitment. In particular:

- financial flows, priorities set nationally, and regulations can pull organisations away from shared goals
- managing complexity and a multitude of relevant actors can make partnership working difficult to do
- a reliance on relationships and 'soft' levers can work well in areas where there are strong relationships built over time, but lacks resilience as it is vulnerable to change in leadership, and is not universal
- support and incentives for leaders often focus on developing effective leaders for individual organisations within their siloes, rather than effective leadership of partnerships

Developing effective leadership for integration

3.6 The Health and Social Care Leadership Review will look to improve processes and strengthen the leadership of health and social care in England. It will consider how to foster and replicate the best examples of leadership and will aim to reduce regional disparities in efficiency and health outcomes. The review will report to the Secretary of State for Health and Social Care in early 2022 and will be followed by a delivery plan with clear timelines on implementing agreed recommendations.

3.7 Without pre-empting that review, we believe effective local leaders for health and care should:

- bring their partners together around a common agenda with decisive action in the interest of local people, even when it runs counter to organisational interests

- be able to judge when it is right to remove or challenge organisational boundaries and when it is better to make connections between distinct organisations

- be responsible for delivering outcomes, ensuring data is used and shared safely and effectively, to provide shared insight and a holistic understanding of the health and care needs of their local population

- focus decisions both on what happens at the point of care, and on what is of most benefit from a population perspective – taking a strong interest in what delivers value for money over time

- listen to the voices of people who draw - or may need to draw - on services when designing and improving those services and in defining which outcomes matter to individuals and populations

- support and enable clinical and adult social care leadership in the development and delivery of services

3.8 Again, subject to the recommendations of the leadership review, we will also look to develop a national leadership programme, addressing the skills required to deliver effective system transformation and local partnerships. This programme will also help to build locally the relationships and shared mission that we know is so important to successful integration.

Clear accountability

3.9 Effective integration and local prioritisation require both a strong, shared sense of purpose and clarity of accountability at place level, so everyone is clear who is responsible for delivering what, with which levers and what budgets. This has been demonstrated time and again in local places and wider health and care systems with a strong track record on integration.

3.10 All areas should ensure there is excellent value, good outcomes and improved experience for people. However, the specific areas for action will differ from place to place, as will the accountability arrangements that work best; as is already the case in the most successful places and systems. We therefore have not prescribed either. We do, however, want to ensure the benefits of integrated care are experienced in all places and as soon as possible, and to that end will set out

criteria for local governance and accountability for the delivery of shared outcomes. We have suggested a model which meets those criteria.

3.11 Success will depend on making rapid progress towards clarity of governance and clarity of scope in place-based arrangements. We are therefore setting the expectation that, by Spring 2023, all places within an ICS should adopt either a governance model as outlined below, or an equivalent model which achieves the same aims. The characteristics we would expect a governance model to have are:

- a clear, shared, resourced plan across the partner organisations for delivery of services within scope and for improving shared local outcomes
- over time, a track record of delivery against agreed / shared outcomes
- a significant and, in many cases, growing proportion of health and care activity and spend within that place, overseen by and funded through, resources held by the place-based arrangement

3.12 We would also expect a governance model to provide clarity of decision-making covering:

- contentious issues such as reshaping services within the place (and contributions to wider decisions such as reconfigurations across a wider geography)
- clear, practical arrangements for managing risk, resolving disagreements between local partners, and for agreeing the outcomes to be pursued locally in addition to any set nationally, with strong involvement for the health and care provider organisations for that place
- a single person, accountable for the delivery of the shared plan and outcomes for the place, working with local partners (e.g. an individual with a dual role across health and care or an individual lead for a ‘place board’ as outlined from paragraph 3.18). The single person will be agreed by the relevant local authority or authorities and ICB. This proposal will not change the current local democratic accountability or formal Accountable Officer duties within local authorities, those of the ICB Chief Executive or relevant national bodies, such as the ability of NHS England to exercise its functions and duties

3.13 These arrangements should, as a starting point, make use of existing structures and processes including Health and Wellbeing Boards and the Better Care Fund. They should also provide clarity about what is done at place and at system levels.

An accountability model and local innovation

3.14 We expect all local areas to put in place-based arrangements to bring together NHS and local authority leadership. This will include responsibility for effective commissioning and delivery of health and care services. Local health and care leaders set and agree the shared outcomes and will be held accountable for delivery of these outcomes.

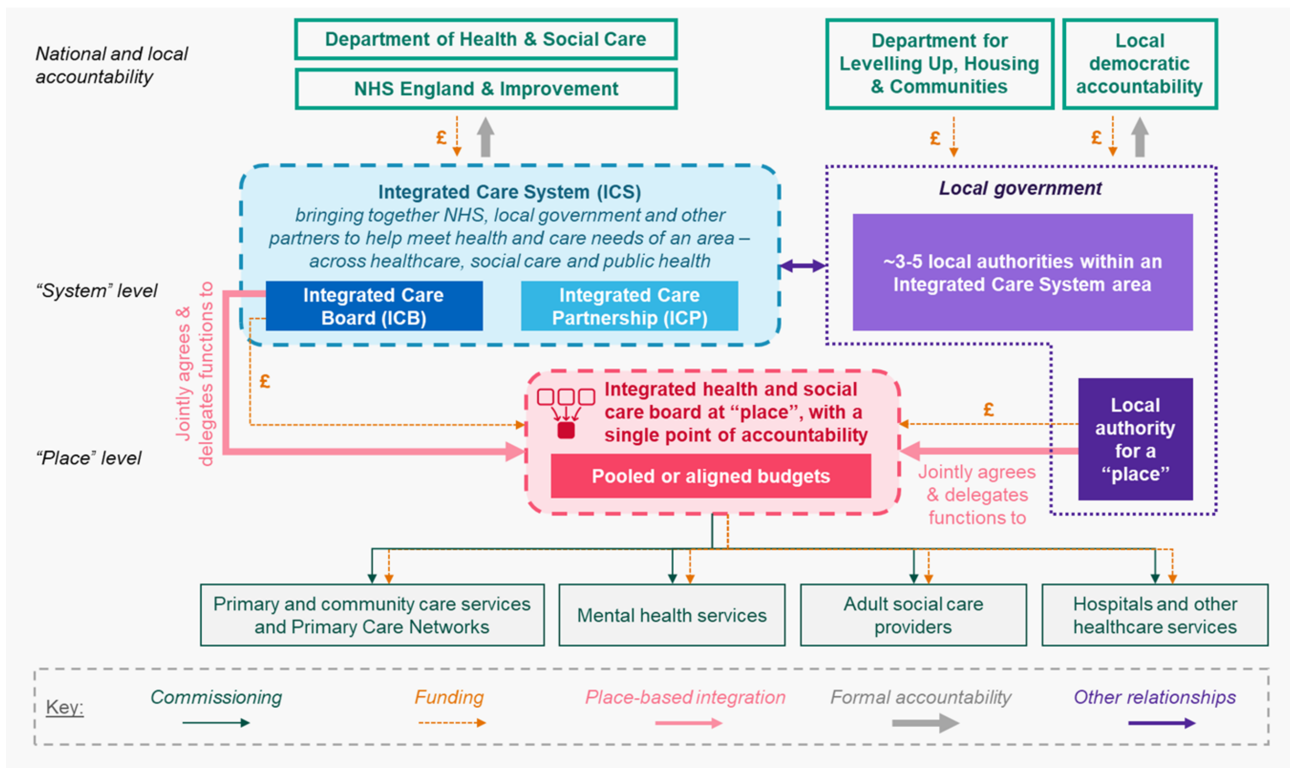
3.15 Places will be able to decide which model they adopt, and we have outlined one illustrative model (the place board model) that is a good basis for delivering the characteristics described above.

3.16 This will build on 'Thriving Places', the joint LGA – NHSE guidance published in September 2021.

3.17 Places will be supported in this work by their ICSs and by an NHS England/ local government support offer.

The place board model

3.18 In this arrangement, a 'place board' brings together partner organisations to pool resources, make decisions and plan jointly – with a single person accountable for the delivery of shared outcomes and plans, working with local partners. In this system the council and ICB would delegate their functions and budgets to the board. Integration of decision-making would be achieved through formal governance arrangements (likely to include definition of membership; responsibility for outcome-setting; responsibility for delivery of functions or programmes delegated; financial arrangements including pooling; and dispute resolution and decision-making). The place board lead would be agreed by the ICB and the local authority (or authorities) for the place.



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3.19 As the development of ICSs has shown, there is enormous potential within the health and care system to find innovative ways of managing and improving care, and we want to bring that same spirit to the development of places. We are likely to secure more value through setting challenges than through setting limits on that innovative potential. We would therefore stress that the model described here is simply a model, and not the only one. We believe it meets the criteria we have set out above, and so serves as a helpful illustration of what is needed; but the criteria are what really matter. Both places and ICSs vary in size, with some ICSs covering nearly three million people and others scaled to the same size as places within other systems. Strong systems and strong places complement and support each other; and this means that it will be important for all relevant partners to work together to agree suitable, proportionate, complementary governance arrangements at place and at system level. In the small number of cases where systems and places are effectively the same geography, we would not expect both place-based and ICS arrangements to be set up as that would be bureaucratic and unhelpful. There are no national plans for further changes to ICS boundaries.

[4] Note: This diagram this is a simplified example of potential governance arrangements and not a full representation of the richness, complexity and range of partnership working across the organisations within systems

3.20 In addition to clarity of governance, all places will need to develop ambitious plans for the scope of services and spend to be overseen by 'place-based' arrangements. From April 2023, arrangements for national and local shared outcomes will go live.

3.21 Those able to go further should do so by putting in place extensive inclusion of services and spend at a local level.

3.22 All local areas should work towards inclusion of services and spend by 2026. Of course, local partners would need to agree fairness in pooling arrangements set out at para 3.24 in working towards this goal.

Financial frameworks and incentives

3.23 Financial frameworks, like other critical enablers of integration such as leadership, workforce and digital are essential to realising our vision of integrated care. However, financial frameworks cannot and do not operate in isolation. They must align with and reinforce our wider strategic objectives and delivery approach, including regulatory, accountability, behavioural and organisational frameworks.

3.24 However, in practice, over the last decade, financial frameworks have often been cited as a barrier to the development and delivery of integrated approaches. There is no one-size-fits-all approach, given how different local systems are in terms of the populations they serve and the existing organisations they contain. However, this complexity is challenging to navigate, often requiring complex workarounds which make it hard to plan and share risk - this being critical to delivering integrated approaches. There are mechanisms that places can use to overcome this (e.g. pooled budgets underpinned by legislation through section 75 of NHS Act 2006), but there is scope to simplify and update these mechanisms. In this document, we refer to both 'pooling' and 'aligning' of resources. Pooling requires a more formal agreement while aligning resources - which can include significant resource and collaboration - is less formal. We want to ensure there is flexibility to enable as much collaboration and integration as possible. In some cases, particularly as arrangements at place mature, it may well make sense to put in place more formal pooling arrangements, and we would expect the overall level of pooling to increase in the years ahead. Pooling agreements will remain subject to both NHS and local authority leadership and NHS system and place leaders agreeing what constitutes a fair and appropriate contribution. A clear sense of fairness for all partners is an important basis for integration and, as we have seen in the most effective systems and partnerships in recent years, a strong culture of trust and mutual accountability allows partners to then focus on the pursuit of shared outcomes.

3.25 We have recognised these challenges. Within the NHS, through the Health and Care Bill (subject to bill passage) we are seeking to enable different parts of the health and care system to work together as part of a move towards a whole population-based approach. This will be underpinned by a collective approach to managing resources, with ICSs as the primary unit for NHS financial planning and accountability, operating with a single system funding envelope across acute, ambulance, community, mental health and primary care (starting with general practice).

3.26 Subject to bill passage, these changes will be complemented by other measures such as Joint Committees, as well as a holistic set of statutory duties and oversight. For example, there is the Triple Aim duty which covers the health and wellbeing of people in England, the quality of services provided or arranged by both themselves and other relevant bodies (NHS England, Trusts and Foundation Trusts, and ICBs), and the sustainable and efficient use of resources by both themselves and other relevant bodies. There are strengthened duties to cooperate, as well as clauses on system collaboration and financial management agreement in NHS standard contracts. We are also joining up services for individuals through expanding the use of personal health budgets (PHBs). The NHS Long Term Plan sets out the commitment to grant individuals more control over their own health, and more personalised care when they need it, through initiatives such as the national roll-out of the NHS's comprehensive model for personalised care across the country and accelerating the roll out of personal health budgets to give people greater choice and control over how care is planned and delivered (with up to 200,000 people benefiting from a PHB by 2023/24).

3.27 Pooling of funding to support joint delivery of services is not new and we have established mechanisms for doing this (such as the Better Care Fund (BCF) and section 75 of the 2006 Act). Many areas already use these mechanisms to ensure that the right funding is in the right place to support the delivery of shared objectives with pragmatic mechanisms to manage financial risk. There are examples of systems using these to enable ambitious models of integration which involve pooling a significant proportion of their funding. However, there are also examples of bureaucracy and conflict which prevent pragmatic attempts to improve services. This is not in the interests of those receiving or providing care – local organisations have a shared responsibility to maximise the outcomes of patients, service users and value for the taxpayer.

3.28 Our proposals in the Health and Social Care Bill seek to simplify the governance mechanisms around these arrangements, making it easier for local organisations to collaborate. However, as set out above, we want to go further to drive progress. Our vision for integration, centred around individuals and local populations requires shared objectives, dynamic and collaborative leadership; alongside

mechanisms to enable joint working (such as- pooled or aligned budgets). When set up effectively, framed around people and service delivery, these are an important way of putting the public pound towards a shared purpose.

3.29 The current system allows a lot of ambition using pooled budgets, but it largely relies on local leadership to drive this. Since 2015, through the Better Care Fund, local NHS commissioners (CCGs) have pooled a proportion of their allocations, alongside funding from local government to enable the delivery of joint plans to support person-centred integrated care. The 2019 review of the BCF concluded that it had been effective in incentivising areas to work more effectively, with over 90% of areas saying that the BCF had improved joint working in their locality consistently since 2017[5], and that any attempt to remove or dismantle a pooled budget scheme would be a clear backward step on integration. Moreover, places have voluntarily pooled increasing amounts of money into the BCF year-on-year. In 2020-21, voluntary contributions totalled £3bn above the nationally mandated minimum, double the figure in 2015-16. This represents significant progress and demonstrates what can be achieved through a framework with an element of national requirements and scope for local partners to go further. Later this year we will set out the policy framework for the BCF from 2023, including how the programme will support implementation of the new approach to integration at place level.

3.30 Despite this, we know that local systems say the arrangements to pool budgets can be complex and there are limitations which prevent the most ambitious models of integration. To address this, we will review the legislation covering pooled budgets (section 75a of the 2006 Act) and publish revised guidance. As indicated above, this will continue to be subject to both NHS and local authority partners agreeing locally what constitutes fair.

3.31 Local organisations must, of course, demonstrate careful consideration of value for money and use available funding in line with their respective accountabilities and delegations. Our vision is that this can, and should, also serve shared objectives and secure wider value. Wherever possible, pooled or aligned budgets should be routine and grow to support more integrated models of service delivery, eventually covering much of funding for health and social care services at place level.

3.32 Some systems are already doing this, and it needs to become the norm along with shared objectives and shared delivery plans to improve outcomes for patients and those who use care services. In line with our wider approach, we will not at this

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[5] Better Care Fund Policy Framework 20-21. [2021 to 2022 Better Care Fund policy framework - GOV.UK (www.gov.uk)]

point mandate how this is achieved, but our expectation is that funding should be pooled and aligned around pathways where the case for joined up care is most pressing. As progress accelerates, we will need to carefully consider the implications for existing mechanisms, including the BCF.

3.33 We will also build on the roll out of personal budgets and personal health budgets across health and social care. The overarching aim is an outcomes-based approach to provide patients and people who draw on social care and support with greater flexibility, choice and control over their care that enables services to be tailored to their particular health and care needs.

3.34 Integrated budgets support integration at an individual level by ensuring support is holistic and can improve a range of health, social care, work and education outcomes for people. Alongside reaffirming our commitment to personal health budgets and personal budgets we will continue to identify opportunities to promote the rollout by supporting places with guidance and sharing best practice.

Oversight and support

3.35 The Health and Care Bill, if passed into law, places a new duty on the CQC to review ICSs as a whole. This will help inform the public about the quality of health and care in their area and review progress against our aspirations for delivering better, more joined up care across ICSs. These reviews are required to look at how system partners are working together to deliver care. The use of resources will be a running theme in the different reviews and assessments, along with delivery against shared outcomes. The CQC will consider outcomes agreed at place level as part of its assessment of ICSs. CQC will also continue to develop its assessment of individual providers, to ensure their contribution to plans that improve outcomes at Place and ICS level are assessed as part of the overall oversight framework.

3.36 Working with partners, the CQC will consider both the starting position for each ICS and local authority, and the local and national priorities each area needs to manage to help understand how all those responsible for health and care services are working together to deliver safe, high quality and integrated care to the public. Further work is underway to develop the detail and methodology of the CQC reviews. This work will be complementary to existing oversight and support processes (including those used by NHS England to support integrated care systems, and sector led improvement in local government).

3.37 We will also work with others to ensure that local authorities also receive appropriate support to play their part in place-based arrangements.

To ensure these proposals on accountability, financial frameworks and oversight will be implemented effectively, we will engage with stakeholders and partners, inviting views on the following questions:

1. How can the approach to accountability set out in this paper be most effectively implemented? Are there current models in use that meet the criteria set out that could be helpfully shared?

2. What will be the key challenges in implementing the approach to accountability set out in the paper? How can they be most effectively met?

3. How can we improve sharing of best practice regarding pooled or aligned budgets?

4. What guidance would be helpful in enabling local partners to develop simplified and proportionate pooled or aligned budgets?

5. What examples are there of effective pooling or alignment of resources to integrate care / work to improve outcomes? What were the critical success factors?

6. What features of the current pooling regime (section 75) could be improved and how? Are there any barriers, regulatory or bureaucratic that would need to be addressed?

4. Digital and data

Summary

Joining up data and information is central to integrating services. All citizens should expect to have access to their own shared care record and for it to cover their health and care journey, with full access, where appropriate, for all the staff they come into contact with.

Health and adult social care providers within an Integrated Care System must reach a minimum level of digital maturity, and these providers should be connected to a shared care record. This will ensure each ICS has a functional and single health and adult social care record for each citizen by 2024, with work underway to enable full access for the person, their approved caregivers and care team to view and contribute to. A suite of standards for adult social care, co-designed with the sector, will enable providers across the NHS and adult social care sector to share information. This will begin with the consolidation of existing terminology standards by December 2022 Data to support an understanding of population health, including unmet need and disparities, should be fully shared across NHS and local authority organisations, to allow 'place boards' or equivalents, and ICSs to plan, commission and deliver shared outcomes, including public health and prevention services.

Each ICS will implement a population health platform with care coordination functionality that uses joined up data to support planning, proactive population health management and precision public health by 2025.

Digital integration will open up new ways for individuals to access health and adult social care services. There has been rapid expansion of digital channels in primary and secondary care services, but there is more we can do to ensure individuals can choose how they interact with services. By 2022, one million people will be supported by digitally enabled care pathways at home.

4.1 The effective use of data and technology to record and share information, is key to the integration of health and care. It will support citizens to take more control of their health and care. The joined up, real-time data that comes from an integrated health and care system will enable continuous improvement, as well as research into new treatments and support developers and innovators to build solutions that improve health and care.

4.2 Better integrated data and technology systems enable people to take greater control of their own health and care needs and preferences using digital tools to

manage their appointments, accessing additional support when they need it and contributing to their record at a time that is convenient to them.

4.3 People will move seamlessly between health and care settings because people and those supporting their health and care, including both professionals and unpaid carers, will be able to see and contribute to their care record and care plans.

4.4 They can be assured that they will not become lost in the gaps between services, either experiencing long delays or with risk factors that should be proactively managed, because data is joined up and everyone who needs it can access it.

4.5 Individuals will use technology to access information and services in more flexible ways, to keep themselves well, and support independence when living with a physical or learning disability, helping to reduce health disparities. They will be confident that health and care staff have their up-to-date information and preferences, regardless of the care setting and won't have to repeat details unnecessarily and understand, with increased transparency, how the health and care system protects and uses their data.,

Using Digital and Data to integrate care

Digitising: records of health and care delivery to be digital, not paper, everywhere

4.6 While more than 60% of NHS Trusts have made good progress into digitisation with 21% now digitally mature (as set out in the What Good Looks Like Framework), and only 10% continuing to rely heavily on paper, the picture is often much more challenging in social care. Only 40% of social care providers have electronic care records, with the rest largely paper based - and this is only improving slowly, at around 3% per year.

4.7 In our Adult Social Care Reform white paper, People at the Heart of Care, we committed to at least £150 million of new funding to deliver a programme of digital transformation over the next 3 years. Digitalisation will not only drive up the safety and quality of care, but also has the potential to increase productivity benefits for social care providers, with digital social care records expected to reduce the administrative burden placed on staff.

4.8 While we are making good progress, there is still work to be done to bring all organisations up to the minimum level of maturity as outlined in the What Good

Looks Like Framework. This framework will be extended to cover community health services and social care, and a tailored framework will be developed for nurses. We will provide support to enable every health and adult social care provider within Integrated Care Systems to reach a minimum level of digital maturity.

Connecting: different systems to exchange information

4.9 "Data Saves Lives", the draft data strategy for health and care, sets out a vision for data that moves seamlessly across health and care and has transparency at its core, giving people access to high quality, timely data to help them make choices about their care and improve outcomes. The data strategy sets out when and how information can be accessed and used by individuals, those caring for them and those planning services. A final version of the strategy will be published in early 2022.

4.10 Basic shared care records are now in place in all but one ICS. However, we must ensure that shared care records cover the entirety of a person's life and include both health and care, which they currently do not. For adult social care, we will ensure that within six months of providers having an operational digital social care record in place, they are able to connect to their local Shared Care Record, enabling staff to appropriately access and contribute to the record. We will also reinforce the use of the NHS number universally across social care to support this. Work is also underway to enable citizens to be able to access and contribute to their shared care records, building on successes to date.

4.11 Standards will be key to delivering integrated care. We will establish a suite of standards for adult social care, co-designed with the sector, to enable providers across the NHS and adult social care sector to share information. This will begin by developing a process to consolidate existing social care terminology standards by December 2022. We will develop a roadmap for standards development (April 2022), which will be underpinned by a new end to end process for development).

4.12 We will put in place systems to link and combine data to enable improved direct care and better analytics for population health management. This includes connecting data from every health and adult social care provider to provide a near real-time picture of NHS care, sharing consistent data at ICS, region and national levels to enable transformation of care pathways, and providing insight to all users through user led product design and supporting deployment functions.

4.13 The digital and data transformations outlined in this document provide an opportunity for greater transparency. We will look to introduce mandatory reporting of outcomes, for local places, for citizens at the heart of what we do.

Information governance

4.14 The Health and Social Care Information Governance (IG) Portal provides simplified advice and guidance on information sharing to health and social care providers. This includes an IG Framework for Shared Care Records to support the workforce to have the confidence to share information where appropriate and enable joined up care. This guidance recognises certain roles within the adult social care sector such as registered managers to be 'health and care professionals', which ensures that information can be more easily shared across health and social care settings.

4.15 Forthcoming proposals in the Health and Care Bill, if passed into law, will support integration introducing a power to mandate standards for how information is collected and stored, so that information flows through the system in a usable way. This will make sure that when it is accessed or provided (for whatever purpose), it is in a standard form, both readable by and consistently meaningful to the user or recipient). The Bill also proposes to create a statutory duty for organisations within the health and care system to share anonymous data.

Transforming: Digitally enabled transformation and the funding, skills and time needed to do it well

4.16 In social care we are driving rapid adoption of proven technologies, such as risk stratification tools, and will scale technology such as acoustic monitoring to prevent falls. By March 2024, over 20% of care homes will have acoustic monitoring solutions or equivalent care tech in place.

4.17 Tech has been demonstrated to have a positive impact on the quality and safety of care, including medications management and hydration monitoring to prevent urinary tract infections (UTIs) and benefits to people's wellbeing such as improved quality of sleep, through enabling more proactive and responsive models of care.

4.18 We continue to improve citizen access to information and services directly through NHS.uk and the NHS App. These products provide access to advice and guidance, individuals with access to their records, the ability to book appointments with their GP, order prescriptions, set preferences for data usage and organ donation, and access their COVID Pass.

Skills and workforce

4.19 NHSX has supported Health Education England to build the next cadre of digital leaders through the NHS Digital Academy. We are addressing the specialist tech skills gap through professionalising the digital profession, bringing in talented tech graduates, increasing the number of apprenticeships offered and harnessing talented entrepreneurial and analytical clinicians through the Clinical Entrepreneur scheme and new fellowships.

4.20 NHS England and NHSX, with partners, have created a 16,000 strong online community of practice (AnalystX) for data professionals and analysts to share knowledge, learning and development, supporting the development of analytical skills for transformation.

4.21 Ipsos MORI, the Institute of Public Care and Skills for Care have supported us with a review of the social care workforce's current digital skills and future skills needs, as well as the barriers and enablers to the use and effectiveness of digital technology in social care. We will use these insights to develop a comprehensive digital learning offer, as well as targeted leadership support, to build the capability and confidence of social care staff to drive change in their organisations. This offer will complement the wider workforce investment package outlined in our Adult Social Care Reform white paper, People at the Heart of Care.

4.22 Well-evidenced digital health technologies can empower patients to manage their own health and help frontline staff to provide high quality care and make best use of their time. The Digital Technology Assessment Criteria for health and social care (DTAC) gives staff, patients and citizens confidence that the digital health tools they use meet our clinical safety, data protection, technical security, interoperability and usability and accessibility standards.

Integrated Care Systems

4.23 An integrated health and care system requires data to flow seamlessly between staff, citizens and their carers. The insights generated will be used to make decisions more quickly, responsively and safely, proactively tailor services to the needs of populations, enable more personalised care and reduce unnecessary interventions. People will have the tools to stay healthy and independent and drive their own care when they need it and will be able to navigate the system and make the decisions that are best for them.

Population health management

4.24 ICBs are expected to agree a plan for embedding population health management capabilities and ensuring these are supported by the necessary data and digital infrastructure, such as linked data and digital interventions.

4.25 ICSs will use Population Health Management to help deliver personalised and predictive care based on an individual's risk. The inclusion of wider determinants of health, will be key to identifying and recognising the impact that factors outside of health and social care can have on the outcomes that people achieve. This must include information about people's living circumstances - for example homelessness or social isolation. The inclusion and transparency of workforce, operational capacity, and financial data across an ICS can also support better use of scarce resources, and improve productivity.

4.26 Real-time insights from joined-up, aggregated data can support multi-disciplinary working, clinical decision support, waiting list management and make the best use of new diagnostic centres in the community.

4.27 The digital transformation of screening will enable the identification of at-risk groups more accurately and target interventions towards them appropriately.

ICS first

4.28 We will take an 'ICS first' approach. This means encouraging organisations within an ICS to use the same digital systems, making it easier for them to interact and share information and providing care teams working across the same individual's pathway with accurate and timely data. Where necessary, we will intervene with ICSs and vendors - including by setting conditions of funding, producing guidance, providing support, encouraging disruption and leveraging other allies. This will allow ICSs to provide the best possible support to the places they contain, and the leaders of place-based arrangements.

4.29 Every ICS will need to ensure that all constituent organisations have a base level of digital capabilities and are connected to a shared care record by 2024 enabling individuals, their approved caregivers and their care team to view and contribute to the record.

4.30 ICSs have been asked to identify digital priorities to support the delivery of out-of-hospital models of care through the development of system digital investment plans, ensuring community health services providers are supported to develop robust digital strategies to support improvements in care delivery. Where appropriate, digital investment should be purchased and deployed at ICS level.

4.31 To achieve 80% adoption of digital social care records among CQC-registered social care providers by March 2024, ICSs must work with partners to drive adoption.

Rapid adoption

4.32 We will maintain the pace of adoption seen through the pandemic, when - at extraordinary speed - consultations moved online, clinicians and other staff worked from home, people were monitored remotely, including in care homes, and information flowed more effectively between care settings. This has changed the mindset of many staff and citizens about digitally enabled health and care - they do not want to go back to old ways of doing things.

4.33 We have a real opportunity to build on this progress and to truly integrate health and care services. To do this, we need to bring everyone on this journey, one which will ultimately transform how care is delivered, improving both safety and experience. We will do this by building transparency and trust through ongoing dialogue with citizens and developing our approach to Information Governance, giving confidence to the workforce and leveraging the maximum benefit from information. We will ensure we are inclusive, recognising that the use of digital services can create opportunities for people who struggle to access traditional services, as well as barriers for others, but should always be part of a multi-channel offering that reflect the preferences and needs of individuals. Digital investment plans should be finalised by June 2022 which include the steps being taken locally to support digital inclusion.

4.34 For adoption to be rapid, the frontline needs to be confident when recommending digital interventions, and people who use services need to be aware of and be able to access new products. There's a lot more we can do to increase confidence.

4.35 The NHS App will offer a personalised experience for users and encourage them to engage in tailored preventative activity (screening, immunisations and vaccinations, health checks etc). We will help people, their families, unpaid carers and care providers to understand what technologies are effective for helping

maintain independence and quality of life, such as smart home technologies that give medication reminders, or sensor-based tech that provides alerts if someone has had a fall.

4.36 Led by clinicians, and in partnership with NHS England and Improvement, we will develop new pathways for musculoskeletal, dermatology, ophthalmology, perioperative and cardiovascular pathways used by approximately 20m people

4.37 Clinical decision support tools, within an electronic health record, will improve clinical outcomes and reduce unwarranted variation. Finally, approaches to regulation of health and care technologies must be proportionate and support the needs and priorities of the health and care system - such as virtual wards and reducing health disparities

5. The health and care workforce and carers

Summary

This chapter sets out proposals to ensure that staff working in health and care settings are supported to provide integrated services focused on the needs of people by:

- strengthening the role of workforce planning at ICS and local levels
- reviewing the regulatory and statutory requirements that prevent the flexible deployment of health and social care staff across sectors
- increasing the number of appropriate clinical interventions that social care workers can safely carry out by developing a national delegation framework of healthcare interventions
- exploring the introduction of an Integrated Skills Passport to enable health and care staff to transfer their skills and knowledge between the NHS, public health and social care
- increasing the number of learning experiences in social care, including health undergraduate degree programmes and for those undertaking apprenticeships
- exploring opportunities for cross-sector training and learning, joint roles for ASC and health staff in both regulated and unregulated roles
- promoting the importance of the roles of link workers, care navigators and care coordinators to ensure consistent access to these roles across the country

Our proposals will strengthen those laid out in the workforce chapter of our Adult Social Care Reform white paper, People at the Heart of Care, which are:

- a knowledge and skills framework, careers pathways and linked investment in learning and development to support progression for care workers and registered managers
- funding for Care Certificates, alongside significant work to create a delivery standard recognised across the sector. This will improve portability, so that care workers do not need to repeat the Care Certificate when moving roles
- continuous professional development budgets for registered nurses, nursing associates, occupational therapists and other allied health professionals

● investment in social worker training routes

● Initiatives to provide wellbeing and mental health support, and to improve access to occupational health

● a new digital hub for the workforce to access support, information and advice, and a portable record of learning and development

● new policies to identify and support best recruitment practices locally

● exploration of new national and local policies to ensure consistent implementation of the above, as well as higher standards of employment and care provided

The importance of workforce integration

5.1 It is through the staff delivering health and care that the ambitions of this paper will be delivered. People's interactions with health and social care services are through the workforce and, often, no single individual or team can provide all the care and support that a person needs. Joined-up services are delivered effectively when staff work together within and across organisations.

5.2 A workforce with a shared ambition for health, wellbeing and independence can improve the delivery of shared outcomes. Integrated services can only be delivered by a capable, confident, collaborative health and care workforce, which works together to wrap care and support around individuals, and which feels valued for the work they do.

An integrated workforce is where:

● staff work as part of a team to plan and deliver services based on the needs and wishes of the individual, and that takes into consideration the individual's wider family context

● staff numbers and skills across teams and organisations are planned to meet the needs of their local population

● staff feel confident in their roles and work together in the person's interests wherever they are employed

● staff understand what all organisations contribute, including the value of unpaid carers and wider community, and have clear processes, lines of communication and the technology and data needed for working with others

● if multiple staff are involved in delivery of services to support a person's care, they collectively have the skills and capacity to deliver the best person-centred care

● staff are empowered to use their skills to progress their careers across the health and care family

5.3 The response to the COVID-19 pandemic has shown what can be achieved when the workforce comes together to safeguard and promote health and wellbeing by breaking down boundaries in the system. We want to celebrate this approach by making it routine rather than something that only happens in a crisis, with barriers to collaboration removed and the workforce equipped to work across sectors.

5.4 Staff across health and social care already strive to provide person-centred care. Too often, however, structural and/or financial barriers get in the way of effective joint working. This is true within the health and social care sectors, as well as between them. The landscape is even more complex when we factor in public health, community health services, education, housing and homelessness provision, the voluntary, and community health services, and unpaid carers, all of which play a key role in providing joined-up care, support and treatment.

5.5 The new structures being put in place at a national and local level provide an opportunity to overcome these barriers. Through the Health and Care Bill, we are creating a legislative framework for partnership working which will bring the NHS, local government and social care closer together to help ensure everyone receives outstanding, person-centred, outcome-focused services they need. The workforce will be a key part of strategies and plans developed by ICBs and ICPs.

5.6 This government is committed to supporting the NHS, public health and social care workforces, with a focus on workforce capacity and capability. For example, we are delivering 50,000 more nurses in the NHS. Our Adult Social Care Reform white paper, People at the Heart of Care, sets out an ambitious vision to transform the workforce, with an unprecedented investment of at least £500 million. This will directly address some of the barriers to integration by improving learning and development and providing more opportunities for progression within adult social care.

Tackling the barriers to workforce integration

5.7 At a national level we can further facilitate workforce integration by removing barriers to collaborative planning and working. We will review regulatory and

statutory requirements that prevent the flexible deployment of health and social care staff across sectors. To make integration a reality, places must consider integration in a way that meets their local needs. The role of central government is to facilitate and support that, ensuring the right structures, accountability and leadership is in place to enable workforce integration locally.

Workforce planning

5.8 There are currently limited fora to develop shared approaches to workforce planning, and a lack of clarity about which national and local bodies are responsible for what. Planning is often carried out in isolation, meaning that social care providers and local authorities frequently compete with the NHS, or each other, to attract and retain staff. This siloed approach can also result in a lack of alignment with broader health services commissioned by local authorities, those delivering support to children and young people, unpaid carers, housing, and the voluntary sector.

5.9 To improve workforce planning, in July 2021, the Department commissioned Health Education England (HEE) to work with partners to review long-term strategic trends for the workforce. For the first time, regulated adult social care professions will be included in this framework, which will take a 15-year forward view to guide planning, education and training for the workforce. The framework will provide the information needed for ICBs to fulfil their role on shared workforce planning across health and social care services and will support localities to plan and improve services to meet the needs of people now and in the future.

5.10 Workforce planning is kept under close review by DHSC and other bodies. The Health and Care Bill will propose a that report that will set out the role and responsibility of each of the bodies (at national, regional and local level) in the system responsible for workforce planning in the NHS in England for the first time, to increase accountability and transparency and provide assurance that the system is making this issue a priority. This workforce accountability report will cover the whole of the NHS including primary, secondary, and community health services including where sections of the workforce are shared between health, public health and social care – for example, registered nurses.

5.11 Adult Social Care is a largely private sector market and core responsibilities of workforce planning and market shaping are devolved to local authorities who are accountable to their local populations for management and delivery under the Care Act. As set out in the Adult Social Care Reform white paper, People at the Heart of Care, we recognise the ongoing hard work by providers and local

authorities – working with system partners including the NHS – to address difficult workforce capacity issues. We will continue to work closely with local authorities and care providers to monitor workforce pressures, including identifying whether further action may be required.

5.12 We will further improve integrated workforce planning at place level by:

- working with local government and NHS England to strengthen guidance for systems and increase co-production with social care stakeholders, for example, by gathering intelligence about the experience and aspirations of people who use care and support services and have clear approaches to using these insights to inform decision-making and quality governance. Government will incorporate this into the development of guidance for ICPs, so that all components of an ICS are clear on the role they can play in integrated workforce planning across the whole health and care system

- encouraging the expansion of local feedback fora, building on good practice in a number of regions that have led to closer collaboration between NHS regional teams, local government, and other stakeholders such as Skills for Care representatives

- working closely with NHSE and system leaders across the comprehensive health and care system to support the development of ICSs' "people operating model" and to support places develop a 'one workforce' approach

- considering what further national action needs to be taken following the publication of the long-term strategic framework later this year, including what more is needed to support workforce planning for the unregulated adult social care workforce

Working within the devolved Greater Manchester Health and Social Care Partnership, Bury have created a strategic commissioning board which has equal representation from members of Bury Council and the borough's clinical commissioning group (CCG). The board brings together the governance of health and social care, allocation of shared resources including pooled budgets, and strategic commissioning across adult social care and health.

Crucially, the board brings together the whole of Bury's Cabinet with the CCG, including housing, public health, drug and alcohol services, and children's social care, allowing for joint workforce planning and commissioning of services to meet needs in a holistic way. This is reflected at a neighbourhood level, with integrated teams reporting to a single line manager, improving people's direct experience of health and social care.

Learning and development

5.13 Initial training and ongoing learning and development opportunities are an excellent opportunity to prepare people for partnership-working with other teams. Although some health and social care dual qualifications are available, there is disparity in access to, and quality of, learning and development opportunities for staff in adult social care compared to the NHS, which can act as a disincentive to enter or stay in the sector and can create barriers to partnership working.

5.14 Training and learning together can play a key role in enabling an integrated workforce, with staff from different sectors, and teams within a sector, learning together and gaining an understanding of the roles of others they work with. We will:

- work with national and local partners to identify ways to improve initial training and learning for staff in roles at the interface between health and social care, to ensure they have the skills and knowledge needed to work collaboratively across sectors

- identify opportunities for joint continuous professional development across sectors. This could involve joint training on topics such as mental capacity, frailty, and strengths-based and assets-based practice to help staff develop the understanding needed for team working

- move towards a more collective approach to promoting careers in health and social care: the view of health and social care as an integrated system with equal value should be reinforced as people make decisions around whether to pursue a career in health and social care, including career changers

North Tyneside Clinical Commissioning Group is working in partnership with four large care home providers to appoint seven Advanced Care Practitioners (ACP) nurse trainees as part of the Health Education England ACP apprentice scheme. This is introducing a new way of working with care home providers to enhance the health of residents. It is also supporting apprenticeships with a model that promotes career progression and staff development for care home staff.

Progression and movement within and between sectors

5.15 There are diverse, rewarding opportunities available in all parts of health and social care, but there are barriers to people moving across organisational boundaries. Even where roles have similar skills and responsibilities, there is often not a ‘healthy’ flow of workers between health and social care roles. This is, in

part, driven by a lack of cross-sector experience built into training; disparities in career progression, with adult social care in particular viewed as lacking opportunities compared to the NHS, and regulatory barriers.

5.16 We want to make it easier for the workforce to move between health and social care. Within primary care, roles are increasingly being recruited through rotational and joint employment models. We want to build on this approach, to encourage movement of staff within and between sectors, to help build knowledge, relationships, and experience of different settings.

5.17 The Adult Social Care Reform white paper, People at the Heart of Care, sets out how we will improve career pathways and progression within adult social care and support local areas to recruit people with the right skills and values to meet care needs now and in the future. We will provide funding to support local authorities to prepare their local markets for reform, including by moving towards paying providers a fair rate for care that reflects local costs, including workforce, where appropriate. In addition to this, we will:

- work with stakeholders to develop and test joint roles in health and social care, for example roles which support integrated care planning, which coordinate across sectors, or which allow people to work flexibly across settings

- consider the introduction of an Integrated Skills Passport to enable staff to transfer skills and knowledge between the NHS, public health and social care. NHSE/I and DHSC are developing skills passports to allow health and care workers to demonstrate their knowledge and skills so that employers can easily access this information when a worker moves between organisations

- increase the number of learning experiences in social care to understand perspectives across sectors, enhance future team working and create a sense of a joint health and social care career structure. This will include health undergraduate degree programmes and those undertaking apprenticeships. Our long-term ambition is for all health undergraduates to experience adult social care, to understand perspectives across sectors, enhance future team working, and create a sense of a joint health and social care career structure. To begin with, we will work with the Council of Deans to increase the number of trainee nurses who undertake a placement in adult social care

5.18 We will also remove barriers that prevent particular professions working across settings and make the best use of each person's skills. We will:

- promote the importance of the roles of link workers, named key worker and care navigator roles[6] as crucial enablers of integrated care provision. Current care navigator roles exist in multidisciplinary teams, or voluntary services, and are responsible for delivering assessments, advice, signposting, and coordination. Care managing in this way offers ways of sensibly sharing work and responsibility, helping to relieve front-line clinician pressures and improves overall quality of care for patients[7]. Building on good practice from across the UK and internationally[8], the roles support people at the interfaces between health and care and we will ensure that access to these types of roles are consistent across the country

- explore appropriate interventions that can be safely delegated or transferred between the sectors

- consider developing a national delegation framework of appropriate clinical interventions to increase the range of appropriate clinical interventions undertaken in care settings while ensuring safe, appropriate and confident practice and exploring what additional support care workers need. Our Adult Social Care Reform white paper, People at the Heart of Care, sets out plans for establishing a foundation for the future registration of social care staff in a way that benefits staff and care providers alike, which we intend to explore further. We want to build confidence in registered professionals delegating these interventions to social care workers

- commission research into how occupational therapists working in community health services and social care can work more effectively to complement one another

- create opportunities for social housing support and homelessness workers, often supporting people with care and support needs, to progress into adult social care, public health and health roles. This will include taking forward recommendations from HEE's scoping study with the Voluntary, Community and Social Enterprise Health and Wellbeing Alliance

- make the best use of the skills of pharmacy professionals by consulting on regulatory barriers, improving placement opportunities, and delivering the Pharmacy Integration Programme

[6] Care Navigation Competency Framework_Final.pdf (hee.nhs.uk)
[7] General Practice Forward View (england.nhs.uk)
[8] 1525785625_learning-from-japan-final.pdf (nuffieldtrust.org.uk)

Volunteering programmes significantly improve the experience of users of care and enable a greater level of support for staff. The pandemic saw excellent examples of the support they can offer, for example, the NHS Volunteer Responders Programme successfully supported thousands of people who were shielding in their communities. Building on the success of this programme, DHSC and NHSEI have been working together on how to build volunteering capacity for local health and social care systems. This type of joint action can strengthen community ties and improve life outcomes for health and social care users. The creation of 'blended' enhanced home care roles that take on elements of some interventions previously carried out by district nurses has been piloted in Tameside (Greater Manchester) with plans to scale up in other Greater Manchester localities.

Place-Based Workforce Integration

5.19 To deliver shared outcomes, local leaders will need to consider how the health and care workforce in the area can be deployed in the most effective way. This should prevent duplication across health and care, consider the impacts of one sector on the other, and ensure that citizens contact with members of both workforces is coherent and coordinated.

5.20 While national action can foster the conditions for workforce integration, to make this a reality, places must implement integration in a way that meets their needs. Changes in the Health and Care Bill will embed and speed up integration locally, with flexibility for areas to determine which models of integration will work best at place. For example, ICBs will have the flexibility to determine governance arrangements in their area – including the ability to create committees and delegate functions to them. This would allow systems to create local 'place'-based committees to plan care where appropriate. Every area should strive to achieve the greatest level of integration possible with appropriate governance arrangements for this at place level.

5.21 For the health, social care and public health workforce, ICSs will be a lynchpin between national organisations and places, providing a key forum for planning and direction setting. But it is at a more local level that the workforce makes integration a reality – and at an individual level where people experience the benefits of an integrated workforce. Local leaders will need to think about what workforce integration looks like in their area, the conditions that are needed, the practical steps required, and who needs to be involved in shaping this.

In The Principles of Workforce Integration, Skills for Care has identified six principles to aid areas in their development of workforce plans and workforce development in an integrated way:

● successful workforce integration focuses on better outcomes for people with care and support needs

● workforce integration involves the whole system

● to achieve genuine workforce integration, people need to acknowledge and overcome resistance to change and transition. There needs to be an acknowledgement of how integration will affect people's roles and professional identities

● a confident, engaged, motivated, knowledgeable and properly skilled workforce supporting active and engaged communities is at the heart of workforce integration

● process matters—it gives messages, creates opportunities, and demonstrates the way in which the workforce is valued

● successful workforce integration creates new relationships, networks and ways of working. Integrated workforce commissioning strategies give each of these attention, creating the circumstances in which all can thrive

5.22 Our proposals in the leadership, shared outcomes and accountability chapters will empower local leaders to embed these principles. Places must build a culture that supports integrated service delivery, sets a shared vision, develops a common language that truly covers the whole workforce, and engenders a culture of partnership. Involving and empowering the workforce directly will be crucial, for example through shared decision councils, as recommended in The Principles of Workforce Integration, adopting local "Integration Champions" or supporting local communities to build the partnerships and plans to embed housing as part of the local health and care system, as set out in our Adult Social Care Reform white paper, People at the Heart of Care.

5.23 There are a variety of models being implemented at place level. The NHS Long Term Plan, for example, includes a commitment to expand community multidisciplinary teams as a means to integrate primary and community health services, and many places have started to use multidisciplinary teams across other parts of the workforce. Other areas have found that physical co-location of staff has had an impact, or that a nominated key worker model is useful to provide a single point of contact for a person receiving care. The family hub model, which

emphasises building strong connections between services and families, and on building relationships, is an important way of bringing together[9].

Health and care leaders in Portsmouth – including Portsmouth City Council, NHS Portsmouth Clinical Commissioning Group, Solent NHS Trust, Portsmouth Hospitals NHS Trust, Portsmouth GP Alliance and local voluntary sector organisations – developed a blueprint setting out their ambition for integrated services. This Portsmouth Blueprint had at its heart the principle that first comes the person and family being cared for, then comes the team, and only after that comes the organisation. Partners have made extensive use of co-location to bring teams together, with the chief operating officer of Solent NHS Trust (which provides community and mental health services across Portsmouth, Southampton, Isle of Wight and Hampshire) being first to work from within the city council's headquarters. The civic offices now accommodate community nursing and social care, the learning disability service, health visiting, 0-19 young people's services, and school nursing for the centre and south of the city. As part of this, they will explore the role that family hubs can play in bringing together services in the community to support families.

Greater Manchester – Inclusive Workforce

Greater Manchester Combined Authority and Greater Manchester Health and Social Care Partnership co-invested in the Working Well Early Help programme, a health-led employment support programme for residents in all ten local authority areas in Greater Manchester. It supports individuals with a health condition or disability who have recently become unemployed or taken medical leave, to return to sustained employment. The programme is built upon early intervention through personalised and holistic support focused on addressing the barriers to employment and is integrated with local services, including health and skills services. The partnership and governance are set up through key partners including Local Leads from local authorities and GP Leads in each delivery area. Local Leads are designated members of staff from each of the local authorities who have a responsibility to oversee the performance of Working Well contracts at a borough level and are often from the Work and Skills team. Recent qualitative impact assessment indicates that the support has led to 53% positive health and wellbeing outcomes and 39% positive employment outcomes. Working Well Early Help is part of the wider family of Working Well programmes in Greater Manchester. Since its inception in 2014, Working Well has achieved employment outcomes for over 15,200 Greater Manchester residents.

[9] Family Hub model framework (publishing.service.gov.uk)

Due to its successes, Greater Manchester has also successfully negotiated for the opportunity to co-design, procure and deliver a localised version of the new Work and Health Programme which will support nearly 23,000 individuals across Greater Manchester until 2024.

Cornwall - Healthy Cornwall

Commercial fishing is known to be a physically and mentally straining occupation. The workforce is predominantly male and often less engaging with healthcare services for various reasons such as previous bad experience or working during normal assessment hours. Therefore, Healthy Cornwall (Cornwall Council), together with the GetSeaFit programme, co-ordinated and commissioned healthcare services and brought them to the quayside. The overall aim was to influence the NHS and local authority public health teams at a local level by highlighting the health needs of this vulnerable section of society, with traditionally a history of poor access to health and preventative services, whose work and lifestyle put them at risk of developing chronic and serious health issues later in life. Furthermore, it was envisaged that the wider long-term impact would be social change among fishing communities, with better physical and mental health which would lead to sustained hours at sea, less financial hardship, reduced deprivation and an improved home life through greater financial stability. Activities included conducting quayside health checks, holding health and wellbeing events and having regular informal conversations about health and wellbeing to raise awareness amongst this workforce. The GetSeaFit programme was a joint two-year initiative, with a time extension of seven months, run by the Fishermen's Mission and the Seafarers Hospital Society but also partners such as local GPs, opticians, dentists, health professionals and other charitable organisations. The programme has been successful and representatives from Healthy Cornwall are now trusted members of this community and fishermen and family members who received support are benefitting from better health and are encouraging their peers and fellow crew members to seek advice or treatment. Healthy Cornwall also modernised last September to an operating model that is much more focused on vulnerable groups with increased local initiatives.

Health and Social Care Volunteering

National and local volunteering programmes present great opportunities to build capacity in local systems, with volunteers providing support in a range of settings to assist staff and users of care. The pandemic saw excellent examples of the support they can offer, for

example, the NHS Volunteer Responders Programme successfully supported thousands of people who were shielding in their communities. Building on the success of this programme, DHSC and NHSEI have been working together on a scheme to build volunteering capacity for local health and social care systems. This type of joint action can strengthen community ties and improve life outcomes for health and social care users."

Workforce: Conclusion

5.24 Integration will be delivered by a workforce equipped with the skills and opportunities to move across the health, public health and social care family, supported by holistic workforce planning to ensure there are the right people to deliver the best outcomes for people and populations. Over the coming years we will work with national and local partners to achieve this vision. Alongside concerted action at a place level, this package of initiatives will improve integration between the health, public health and social care workforce, leading to improved outcomes, and better person-centred care and population health outcomes.

As we begin the implementation of these policies, we are seeking views from stakeholders and partners on the following questions:

1. What are the key opportunities and challenges for ensuring that we maximise the role of the health and care workforce in providing integrated care?

2. How can we ensure the health and social care workforces are able to work together in different settings and as effectively as possible?

3. Are there particular roles in the health or adult social care workforce that you feel would most benefit from increased knowledge of multi-agency working and the roles of other professionals?

4. What models of joint continuous professional development across health and social care have you seen work well? What are the barriers you have faced to increasing opportunities for joint training?

5. What types of role do you feel would most benefit from being more interchangeable across health/social care? What models do you feel already work well?

6. Conclusion: Impact on People and Next Steps

At the beginning of this document, you met Tom and Maureen, Bunmi, Kwame, Madeleine Mandeep and Richard. The policies proposed in this paper will have a material impact on their lives

Case studies

Tom and Maureen

Tom and Maureen have some digital skills as they use an iPad to keep in touch with their children, grandchildren and great grandchildren. With some support from their children they sign up to the NHS App where they can access their health and care records, book appointments and order repeat medication to be delivered to their door. Tom has given Dan and Sarah access so they can see test results, the outcome of conversations with his care team and can converse with the GP electronically.

To help Tom manage his diabetes more effectively alongside his dementia, he is given a glucose monitoring device so that his blood sugar levels are automatically recorded using a mobile app. This information can help Maureen see if they are high or low and where he might need adjustments to his insulin or diet. This automatically uploads data to his record so that Tom's clinical team can see how well he is managing his diabetes and offer the right kind of interventions.

These changes mean that Tom's diabetes is stable again and he and Maureen, as well as their children, have the information they need to empower them to manage his health at home and keep him independent at home for longer.

Tom was admitted to hospital where he received great care, however due to COVID-19 restrictions in the area, Dan and Sarah were not able to visit Tom. They supported their mother and discussed with medical professionals what would be best for their elderly parents going forward. Despite Maureen feeling extremely overwhelmed when a care assessment was carried out, there was much discussion of what could be done locally from their own home.

An assessment for dementia was completed in the hospital and his records were shared with his GP and local care services to ensure that they did not have to be repeated. Tom and his family were offered help with his diagnosis and his community mental health team were involved from the start.

After several weeks in hospital, Tom was discharged, and the detailed package of care was delivered. Dan and Sarah frequently visited and were kept informed by the local care team as to how their parents' conditions were and how they were being cared for personally.

Tom, Maureen and family are able to hold a meeting with his care worker to discuss the recent trips to A&E and the impact that is having on his dementia and wellbeing.

Care workers and nurses who care for Tom locally have recently taken part in shared learning days so that teams who support Tom at home have good working relationships and open communication. They were able to jointly work on a collaborative care plan with Tom and family to agree how his support needs have changed and develop and implement action plans.

The diabetes team encouraged Tom's care workers to build their competency in insulin management, and as a result they were able to delegate this intervention using the national framework so the care workers could provide insulin management for Tom. This helped reduce unnecessary interactions with multiple staff so Tom is not distressed due to his dementia.

These improvements in working across specialties mean that Tom is better able to manage his diabetes at home, and the family have a clearer picture of how his overall care is being managed.

Bunmi

A monitoring system is installed in Bunmi's home, which checks for changes in patterns of use of several connected home devices, including a kettle, a fridge, a bed mat and light switches in her bedroom and bathroom. Bunmi has allowed for this information to be recorded in her longitudinal health and care record.

As Bunmi's mobility deteriorates the system noticed that she was moving around her home a lot less than usual and sent an alert to the warden to check on Bunmi. On arrival to Bunmi's home, the warden used his smartphone to record some basic observations. These suggested a worsening of her conditions and were sent to Bunmi's multidisciplinary primary care team. The duty member of the multidisciplinary team reviewed Bunmi's longitudinal health and care record and care plan which is stored securely in the cloud. A clinician then visited Bunmi at home to prescribe medication which was delivered to her within 2 hours. The clinician also admitted Bunmi to the 'hospital at home' service, which monitors and supports her over the next few days without needing to admit her to hospital. To help Bunmi with her day-to-day life, the social care representative of the multidisciplinary team will use the system to book carer visits to help with shopping and laundry while Bunmi is unwell and recovering.

These changes mean that Bunmi has support for the management of her long-term conditions, allowing her to live well at home for longer. Bunmi and her multidisciplinary team have the means to identify when she needs additional support, and she is now feeling more confident to resume her day-to-day activities that make her happy.

Kwame

The lack of join up between the various services Kwame was using meant that there was no co-ordination from one provider to the other and Kwame was then caught up in a system where he could not receive the appropriate help he required.

A Multi-Disciplinary Team (MDT) identified a new placement for Kwame, with options including segregated living arrangements being replicated in the community. Meeting Kwame's requirements was challenging for several established providers but as Kwame was transitioning to adult services (16+), the option of adapting a property to become his long-term home was explored. Kwame was referred to a micro provider which runs small supports programmes using innovative individualised care. Placing Kwame at the centre of every decision they made, they invested time to get to know him, gaining his trust before he re-joined his local community.

After three months, many physical barriers preventing closer contact began to be removed. Kwame could now take excursions, started contacting his extended family, and his education was reinstated through digital platforms. Kwame applied for funds to buy and adapt a property and moved into his new home in the Summer of 2020.

Madeleine

For Madeleine the COVID-19 pandemic has highlighted how important good collaboration between the statutory sector and voluntary sector is as she was unable to get to any vaccination centre or carry out any tests. Once the situation had been explained to her GP surgery, they responded with at home visits. During one of the visits, the staff who had visited Madeleine picked up on how she has been affected by loneliness and how this had taken a toll on her wellbeing. She was recommended to the well-being team who signed her onto an ongoing well-being programme to tackle her loneliness. She was also put in touch with local volunteers who were able to help her with her shopping and other basic services in the community.

This local collaboration meant that Madeleine was able to access various basic services in her community that made her life more comfortable.

Mandeep

After contacting a charity that Mandeep had seen on the side of a bus, Mandeep went to see a GP who referred him to a crisis centre and provided him with self-care techniques to help manage his mental health problems. He was also referred to specialist help that would help Mandeep manage his diabetes.

At the crisis centre, Mandeep was able to work with social workers, care coordinators, community mental health and employment support. It was the first time he felt cared for and listened too. Through this engagement, Mandeep had continuity of support with people he trusted and this opportunity to gain his independence and gain practical life skills that will help Mandeep get and maintain a job. He secured a more suitable housing arrangement

Mandeep is more engaged than ever before in improving his health. He now has prescriptions to support his nutrition and his mental health has been far more stable. He is actively taking part in conversations about his future and has better understanding of his support needs. As a result, his personal care has improved greatly.

Richard

Richard was able to be discharged earlier than usual because he moved to a ‘step down’ bed where clinical teams and social workers helped him get back on his feet and get used to living life in the local community again. The community psychiatric nurse helped him manage his medicines, and social care and support workers helped him learn how to cook some recipes. The lead social worker supported Richard in applying for PIP payments and getting a new tenancy agreement sorted with the housing officers so he could move back home. While he was in the step down placement the team learned that Richard was a massive Tina Turner fan!

Richard was able to move home eventually, with home adaptations completed and a joint NHS and social care discharge package of support to keep helping him manage daily activities such as shopping and taking his medicines. The package also included a small ‘personalisation fund’ with which Richard chose to buy a few essential items for his kitchen, as well as a cheap last minute ticket deal to the Tina Turner musical, which was one of his long-standing personal life goals. Richard said that it was an experience he would never forget and going out to the theatre helped him feel valued as a person living in society again – it was something he had never imagined he would be able to do when he spent years living in psychiatric units. While his community health and social care package now costs slightly more than it did before, he has thrived and lived well at home and the costs are negligible compared to the NHS costs of repeat cycle of admissions.

Next Steps

6.1 To provide everyone with the person-centred care they need, we will:

- On shared outcomes, consult stakeholders and set out a framework with a concise number of national priorities and approach for developing additional local shared outcomes, by Spring 2023

- We will review alignment with other priority setting exercises and outcomes frameworks across health and social care system and those related to local government delivery

- Ensure implementation of shared outcomes will begin from April 2023

- On leadership, accountability and oversight, set an expectation that by Spring 2023, all places should adopt a model of accountability and provide clear responsibilities for decision making including over how services should be shaped to best meet the needs of people in their local area

- Review section 75 of the 2006 Act which underpins pooled budgets, to simplify and update the regulations

- We will work with partners to develop guidance for local authorities and the NHS to support going further and faster on financial alignment and pooling.

- Publish guidance on the scope of pooled budgets Spring 2023

- Work with the CQC and others to ensure the inspection and regulation regime supports and promotes the new shared outcomes and accountability arrangements at Place

- Develop a national leadership programme, addressing the skills required to deliver effective system transformation and place-based partnerships, subject to the outcomes of the upcoming leadership review

- Publish a final version of the Data Strategy for Health and Care will be published (Winter 2021/22)

- Ensure every health and adult social care provider within an ICS to reaches a minimum level of digital maturity

- Ensure all professionals have access to a functionally single health and adult social care record for each citizen (by 2024) with work underway to put these in the hands of citizens to view and contribute to

- Ensure each ICS will implement a population health platform with care coordination functionality, that uses joined up data to support planning, proactive population health management and precision public health (by 2025)

- Develop a standards roadmap (2022) and co-designed suite of standards for adult social care (Autumn 2023)

- Ensure 1 million people to be supported by digitally enabled care at home (by 2022)

- On workforce, strengthen the role of workforce planning at ICS and place levels

- Review barriers (including regulatory and statutory) to flexible movement and deployment of health and care staff at place level

- Develop a national delegation framework of appropriate clinical interventions to be used in care settings

- Increase the number of clinical practice placements in social care during training for other health professionals

- improve opportunities for cross-sector training and joint roles for ASC and NHS staff in both regulated and unregulated roles

- Appoint a set of front-runner areas in Spring 2023. These will trial the outcomes, accountability, regulatory and financial reforms discussed in this document

Questions for implementation

6.2 The policies outlined in this document build on the proposals in the Health and Care Bill and provides further indications of how we expect local organisations to make progress in integrating health and care, while also setting out some of the support we will provide. We are keen to learn and improve our understanding of what works as we begin the effective implementation of these proposals. To that end, we would like to invite views on a number of key issues to support progress towards implementation. As part of the engagement with stakeholders which we intend to start shortly (referred to above). We will therefore engage stakeholders across the sector with a view to answering the following questions:

Outcomes

(i) What role can outcomes play in forging common purpose between partners within a place or system – and can you point to examples of this?

(ii) How can we get the balance right between local and national in setting outcomes and priorities?

(iii) How can we most effectively balance the need for information about progress (often addressed through process indicators) with a resolute focus on achieving outcomes (where data can lag)?

(iv) How should outcomes be best articulated to encourage closer working between the NHS and local government?

(v) How can partners most effectively balance shared goals / outcomes with those that are specific to one or the other partner – are there examples, and how can those who are setting national and local goals be most helpful?

Financial

(vi) How can we improve sharing of best practice regarding pooled or aligned budgets?

(vii) What guidance would be helpful in enabling local partners to develop simplified and proportionate pooled or aligned budgets?

(viii) What examples are there of effective pooling or alignment of resources to integrate care / work to improve outcomes? What were the critical success factors?

(ix) What features of the current pooling regime (section 75) could be improved and how? Are there any barriers, regulatory or bureaucratic that would need to be addressed?

Accountability

(x) How can the approach to accountability set out in this paper be most effectively implemented? Are there current models in use that meet the criteria set out that could be helpfully shared?

(xi) What will be the key challenges in implementing the approach to accountability set out in the paper? How can they be most effectively met?

Workforce

(xii) What are the key opportunities and challenges for ensuring that we maximise the role of the health and care workforce in providing integrated care?

(xiii) How can we ensure the health and social care workforces are able to work together in different settings and as effectively as possible?

(xiv) Are there particular roles in the health or adult social care workforce that you feel would most benefit from increased knowledge of multi-agency working and the roles of other professionals?

(xv) What models of joint continuous professional development across health and social care have you seen work well? What are the barriers you have faced to increasing opportunities for joint training?

(xvi) What types of role do you feel would most benefit from being more interchangeable across health/social care? What models do you feel already work well?

Digital and data

(xvii) What are the key challenges and opportunities in taking forward the policies set out in this paper, and what examples of advanced / good practice are there that could help?

(xviii) How do we best ensure that all individuals and groups can take advantage of improvements in technology and how do we support this?

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Mid and South Essex
Health and Care
Partnership

Integrated Care Partnership
Terms of Reference Draft v1

Appendix 2

11 /5/22 Draft v1

Purpose

The Integrated Care Partnership (herein referred to as the ICP) is a partnership across Mid and South Essex, established by the Mid and South Essex Integrated Care Board and the three upper tier local authorities (Southend City Council, Essex County Council and Thurrock Council) as equal partners, with a focus on aligning purpose and ambitions to support the residents of Mid and South Essex. It is formed as a joint committee between the Mid and South Essex ICB and the upper tier local authorities.

The ICP will facilitate joint action to improve health and care outcomes, to influence the wider determinants of health and broader social and economic development.

Together, the Integrated Care Board (ICB) and the ICP forms the new statutory Integrated Care System (ICS).

The ICP has specific responsibility for developing the Mid and South Essex Integrated Care Strategy for the whole population. The strategy will take forward the health and wellbeing strategies of our upper tier health and wellbeing boards, use the best available evidence and data, covering health and social care (both children's and adult's social care), and seek to address the wider determinants of health and wellbeing. The strategy will be built bottom-up from local assessments of needs and assets identified through our four Alliances, district, borough, and city councils. The strategy will be focused on improving health and care outcomes, reducing inequalities, ensuring inclusion, and addressing the consequences of the pandemic for our communities.

While the ICP has no formal delegated powers from its constituent organisations, it will provide leadership, oversight, and support for system-wide activities, playing a key role in ensuring joint accountability to our population.

The ICP builds on the existing Health & Care Partnership and will therefore be underpinned by the existing Partnership Memorandum of Understanding (MoU), which will need to be

slightly amended in light of the agreed new membership of the ICP and these ToRs should be read in conjunction with that modified MoU.

The existing Health and Care Partnership 5-year Strategy (December 2019) describes the following high-level ambitions which will support the ICP in its definition of the integrated care strategy:

We will reduce health inequalities by:

- Creating opportunities for our residents, through education, employment, and socio-economic growth
- Support health and wellbeing, with a focus on prevention, self-care, and early identification
- Bring care closer to home, where safe and possible
- Transform and improve our services

This will be underpinned by:

- Strong clinical and multi-professional leadership
- Meaningful engagement with our communities to ensure true coproduction

Our Beliefs and Values as an Integrated Care Partnership

- **Subsidiarity -** devolving planning and delivery to the lowest possible level.
- **Respect for sovereignty** of statutory organisations
- **Collaboration** to bring about improved Standards, Outcomes and the application of Common Clinical Policies
- **A shared agenda** driven and owned by partners working together with a focus on **reducing health inequality**
- **Data Driven:** serving the individual needs of our population, not organisations
- **Delivery of integrated care,** with meaningful engagement with our communities
- **Asset and strengths-based approaches**, delivering care according to people's preferences
- **A focus on healthy lives –** prioritising prevention and self-care
- **Clinical and Care Professional engagement** at the earliest opportunity
- **Empowering front line staff to do the right thing** – through distributed leadership
- **Pragmatic pluralism** –differing needs across our populations require different approaches. Not a one size fits all approach

- **Innovative - trying** new and innovative approaches, test and learn

Our Responsibilities as an Integrated Care Partnership

As designated by the NHS, the ICPs responsibilities are to:

1. Develop the integrated care strategy for the population of Mid and South Essex.

2. Design and oversee a joint accountability framework to ensure delivery of the integrated care strategy.

3. Ensure the integrated care strategy:

   a. Is focused on reducing the inequalities that our population faces
   b. Uses the best available evidence and information, including the joint strategic needs assessments and health and wellbeing strategies of local authorities
   c. Is built 'from the bottom up' taking account of health inequalities, challenges, assets and resources locally at neighbourhood and Alliance level.
   d. Expands the range of organisations and partners involved in strategy development and delivery.
   e. Is underpinned by insights gained from our communities.
   f. Benefits from strong clinical and professional input and advice.

4. Agree and monitor delivery of Alliance plans (Basildon and Brentwood; Mid-Essex, South-East Essex and Thurrock), with a focus on shared learning and support.

5. Agree and have oversight of the statutory ICS health inequalities strategy.

6. Consider recommendations from partners and reach agreement on:

    - Priority work programmes and workstreams that would benefit from a cross-partnership approach
    - The apportionment of transformation monies from national bodies aligned to the ICP
    - The need to take joint action in relation to managing collective issues and challenges.

7. Commission specific advice from established groups – including but not limited to, the Clinical and Multi-professional Congress, our Population Health Management function, our Engagement Network, Healthwatch organisations, Stewardship groups, our Digital, Data and Technology Board, our People Board, our System Finance Leaders' Group, and our Estates function, in order to obtain subject matter expertise, leadership, advice and support in setting the strategic direction of the ICP.

8. Provide active support to the development of the four Alliances across Mid and South Essex, enabling local partnership arrangements, engagement and co-production, bringing together Local Authorities, voluntary and community groups, NHS partners and residents. Facilitate and support cross-Alliance working and sharing of best practice where this would benefit the population or provide efficiencies in our approach.

9. Ensure that the ICP has a greater focus on population health improvement, integration of health and care services around the needs of residents, and a focus on care provided in primary and community settings.

10. Provide a mechanism for joint action and joint decision-making for those issues which are best tackled on a wider scale.

For the avoidance of doubt, it is not a function of the ICP to duplicate the statutory functions of constituent organisations.

Chair and Vice Chair Arrangements

The Chair of Mid & South Essex ICB will act as Chair of the ICP. The chairs of the three upper tier local authorities Health and Wellbeing Boards (Southend City Council, Essex County Council and Thurrock Council) will act as vice chairs.

Voting

Membership of the ICP is given at Appendix 2.

The ICP will generally operate on the basis of forming a consensus on issues considered and will attempt to resolve in good faith any issues between partners, as per the principles of the Partnership MoU. It will seek to make any decisions on a "Best for Mid and South Essex" basis.

On the rare occasion that a vote is required to support a decision, for example, should that become necessary in respect of priorities for investment or apportionment of transformation funding, the ICP may make a decision provided that it is supported by a simple majority of ICP members present at the meeting. If notwithstanding a consensus decision cannot be achieved, the issue resolution process outlined in the MoU will be followed.

Accountability and Reporting

Minutes, and a summary of key messages arising from each meeting will be submitted to all members after each meeting and made available on the ICS website.

The ICP has no formal powers delegated by Partner organisations.

Conduct & Operation

The ICP will meet formally bi-monthly. Formal decision-making meetings will be held in public. A schedule of meetings will be published by the secretariat.

The agenda and supporting papers will be agreed by the Chair and Vice Chairs and be sent to members and attendees (and made available to the public for meetings held in public) no less than four working days before the meeting. A minimum of five working days' notice will be given when calling an extraordinary meeting.

Conflicts of Interest

Where any ICP member has an actual or potential personal conflict of interest (in other words, one which is not related to the role they undertake for the partner organisation) in relation to any matter under consideration at any meeting, the Chair shall decide, having regard to the nature of the potential or actual conflict of interest, whether or not that member may participate and/or vote in meetings (or parts of meetings) in which the relevant matter is discussed.

Where the Chair decides to exclude a member, the relevant organisation represented by that member may send a deputy to take the place of the conflicted member in relation to that matter.

Each member must abide by the policies of the organisation they represent in relation to conflicts of interest.

Secretariat

The secretariat function for the ICP will be provided by the Mid & South Essex ICB in partnership with upper tier local authorities. A member of the team will be responsible for

arranging meetings, recording notes and actions from each meeting and preparing agendas and ensuring these are agreed by the Chair and Vice Chairs.

Review

The terms of reference and the membership of the ICP will be reviewed at least annually.

Appendix 1

East of England Leadership Compact

In working together as a leadership community, we will adopt the following behaviours and hold each other to account for upholding these:

- We will put people first – our patients, staff, and citizens.
- We will support each other to deliver excellence in quality and performance.
- We will respect and trust each other and share important information, so there are no surprises
- We will have inclusive robust, honest, and realistic conversations where all voices are heard, views respected, and differences resolved for the greater good of our population.
- We will be compassionate and caring, supporting each other, especially in difficult times.
- We will value each other's contributions, celebrate successes collectively and learn from failure
- We will ensure our collective decisions are transparent and inclusive and we will abide by them.
- We will agree expectations and hold each other to account.
- We will be ambitious to improve health and wellbeing, sharing expertise, talent, knowledge, best practice, innovation and learning for the benefit of our patients, staff, and citizens
- We will work together to have a strong, united external voice for our region.

Appendix 2

Mid & South Essex ICP Membership

Membership
1. Chair, Mid & South Essex ICB (Chair)
2. Chair, Southend City Council Health & Wellbeing Board (Vice Chair)
3. Chair, Essex County Council Health & Wellbeing Board (Vice Chair)
4. Chair, Thurrock Council Health & Wellbeing Board (Vice Chair)
5. CEO, Mid & South Essex ICB
6. Chair of the Mid & South Essex Foundation Trust
7. Chair of the Essex Partnership NHS Foundation Trust
8. Chair of Provide CIC
9. Chair of the North East London NHS Foundation Trust
10. Lead Non-Executive Director of the East of England Ambulance Services Trust
11. Director of Public Health, Southend City Council
12. Director of Public Health, Essex County Council
13. Director of Public Health, Thurrock Council
14. Director of Adult Social Services, Southend City Council
15. Director of Adult Social Services, Essex County Council
16. Director of Adult Social Services, Thurrock Council
17. Director of Children's Services, Southend City Council
18. Director of Children's Services, Essex County Council
19. Director of Children's Services, Thurrock Council
20. Clinical Lead, Basildon & Brentwood Alliance
21. Alliance Director, Basildon & Brentwood Alliance
22. Clinical Lead, Mid-Essex Alliance
23. Alliance Director, Mid-Essex Alliance
24. Clinical Lead, South East Essex Alliance
25. Alliance Director, South East Essex Alliance
26. Clinical Lead, Thurrock Alliance
27. Alliance Director, Thurrock Alliance
28. Lead Officer, Basildon Council
29. Lead Officer, Braintree District Council
30. Lead Officer, Brentwood Council
31. Lead Officer, Castle Point Council

32. Lead Officer, Chelmsford City Council
33. Lead Officer, Maldon District Council
34. Lead Officer, Rochford Council
35. CEO, Essex Local Medical Committee
36. CEO, Healthwatch Southend
37. CEO, Healthwatch Essex
38. CEO, Healthwatch Thurrock
39. Representative of Mid & South Essex Community & Voluntary Sector Organisations
40. Representative of Hospice Sector
41. Representative of Anglia Ruskin University
42. Representative of University of Essex
43. Representative of Writtle University College
44. Locality Director, NHS England & Improvement
45. Executive Director of Strategy & Partnerships, Mid & South Essex ICB
46. Director of Communications & Engagement, Mid & South Essex ICB
47. Chief People Officer, Mid & South Essex ICB
48. Chief Finance Officer, Mid & South Essex ICB
49. Director of Strategic Partnerships, Mid & South Essex ICB
50. Medical Director, Mid & South Essex ICB

Deputies

If a member is unable to attend a meeting of the ICP, s/he will be responsible for identifying a suitable deputy to attend on their behalf. Such a deputy must have sufficient seniority and understanding of the issues to be considered to represent their organisation, Alliance, or group effectively. Deputies will be eligible to vote if required.

Additional Attendees

At the discretion of the Chair, additional representatives may be requested to attend meetings from time to time to participate in discussions or report on particular issues.

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15 June 2022	ITEM: 12 Decision: 110612
Cabinet	
Statement of Community Involvement	
Wards and communities affected: All	**Key Decision:** Key
Report of: Cllr Mark Coxshall, Deputy Leader and Cabinet Member for Regeneration and External Affairs	
Accountable Assistant Director: Leigh Nicholson, Assistant Director Planning, Transportation and Public Protection	
Accountable Director: Julie Rogers, Director of Public Realm	
This report is Public	

Executive Summary

The Council is required to prepare a Statement of Community Involvement which sets out how the Council will consult the local community and other stakeholders on planning matters.

A revised Statement of Community Involvement has been prepared to reflect current planning legislation, national policy and guidance and new methods of consultation and engagement. Best practice recommends that it should be subject to public consultation before it is adopted.

1. Recommendation(s)

1.1 To approve the draft Statement of Community Involvement (Appendix A) for public consultation and agree to delegate authority to the Director of Public Realm in consultation with the relevant Portfolio Holder to make any changes resulting from that consultation and to adopt the final version.

2. Introduction and Background

2.1 Planning is all about creating successful places that enable people to live healthier, more prosperous, and better-connected lives. It's also about supporting local businesses and making sure that the things that make our places special are protected. Planning decisions can be small in scale like an extension to your home or nationally significant like the expansion of a port and everything in-between. Planning genuinely affects everyone who lives,

works, and visits in a place. So, it is important that local communities and stakeholders are aware of and can participate in the planning process and be involved in planning decisions.

2.2 The Statement of Community Involvement (SCI) sets out how the Council will engage and consult with the local community and other stakeholders on planning matters. It explains the key stages and provides information on how and when the local community and other stakeholders can get involved in the preparation of planning documents and in planning application decisions.

2.3 The Council is required by national legislation to prepare a SCI which it should review and update every 5 years. The previous SCI for Thurrock was adopted in December 2015. Work on an update was started in 2019 with a consultation on a draft version undertaken during the end of 2019, however progress was halted in early 2020 due to the Council focusing its resources on responding to the COVID-19 pandemic.

2.4 As a consequence of the pandemic the Council, like its residents and businesses, has adapted to and established new ways of working and communicating effectively with others. These new methods are useful engagement tools which were not considered in 2019 draft. The pandemic also brought about temporary changes to how Councils could consult on planning matters which was in direct conflict with the approaches to consultation set out in SCIs published prior to 2020. Whilst restrictions and temporary changes to consultation have ceased it is important that any SCI update allows the Council to adapt its approach to consultation should the need ever arise.

2.5 The Council has therefore carried out a full review of the SCI, taking into account the changes proposed within the 2019 draft SCI and representations to the consultation, as well as subsequent legislative changes, revised national guidance and the Council's Collaborative Communities framework.

2.6 Main changes to the revised SCI (**Appendix A**) include:

- The introduction of the new Thurrock Collaborative Communities Framework.
- Updating consultation methods.
- Consolidating consultation information and engagement methods relevant to plan making into the relevant plan making chapter.
- Streamlining the preparation stages for Development Plan Documents, such as the Local Plan at the Regulation 18 stage.
- The council's approach to Planning Performance Agreements with those developing schemes both in plan-making and development management.
- Providing flexibility into how the Council will undertake planning consultations in exceptional circumstances.
- Integrating important information in the Appendices into the main body of the document.

3. Issues, Options and Analysis of Options

3.1 The Council has a responsibility and legal duty to produce an up-to-date SCI. The proposed revisions to the SCI are considered necessary to meet those requirements and to align with the Council's Collaborative Communities Framework. However, the Council is not required by legislation to consult when reviewing and updating its SCI prior to adoption and the current SCI does not stipulate this as a requirement.

3.2 The following two options have therefore been considered:

1. The Council could adopt the revised SCI without public consultation.
2. The Council could consult on the proposed changes to the SCI and adopt a final version that has taken into account any consultation comments received.

3.3 The preferred option is to consult on the proposed changes as this is recognised within national Planning Practice Guidance to be best practice.

4. Reasons for Recommendation

4.1 It is essential that the Council has an up-to-date SCI as set out in Section 18 of the Planning and Compulsory Purchase Act (2004) (as amended), and it is considered best practice to consult the public on the changes prior to adoption.

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

5.1 The revised SCI builds on the draft SCI which was approved and subject to consultation in 2019 by Cabinet. Following agreement by this committee public consultation will be carried out on the revised SCI prior to its adoption.

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

6.1 An up-to-date SCI is required to minimise the risk of legal challenge when preparing the Local Plan. The Local Plan has an impact on the delivery of all the Council's corporate objectives.

7. Implications

7.1 Financial

Implications verified by: **Laura Last**

Senior Management Accountant

There is a dedicated budget for plan making to cover the basic costs of preparing planning documents.

7.2 **Legal**

Implications verified by: **Mark Bowen**
Interim Head of Legal Services

The current system of plan making is contained in the Planning and Compulsory Purchase Act 2004 (as amended) and the Town & Country Planning (Local Planning) (England) Regulations 2012 (as amended) and supported by the National Planning Policy Framework and Planning Practice Guidance.

The Authority has a statutory duty pursuant to Section 18 of the PCPA 2004 to prepare a statement of community involvement which is a local development document that sets out the authority's policies on giving advice and guidance for neighbourhood planning and on how it will involve those persons with an interest in matters relating to development in their area on the preparation of specified planning documents.

7.3 **Diversity and Equality**

Implications verified by: **Rebecca Lee**
Community Development and Equalities Team Manager

The Council has a statutory duty under the Equality Act 2010 to promote equality of opportunity in the provision of services and employment opportunities between people who share a protected characteristic and people who do not share it. The Statement of Community Involvement will be subject to a Community Equality Impact Assessment to ensure that all sections of the community, including harder to reach groups, will have the opportunity to be involved in helping to shape the future planning and development of Thurrock both through plan-making and the consideration of development proposals.

The Statement of Community Involvement builds on the principles already set out in the Council's Collaborative Communities Framework and specifically "involving residents in the decisions that affect their lives using co-design and co-production methods in the issues facing Thurrock as well as the solutions".

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

None

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

- Statement of Community Involvement (November 2015) – https://www.thurrock.gov.uk/sites/default/files/assets/documents/statement_community_involvement_201511.pdf
- Draft Statement of Community Involvement (December 2019) - https://www.thurrock.gov.uk/sites/default/files/assets/documents/statement-community-involvement-201912-thurrock-draft.pdf

9. Appendices to the report

- Appendix A – Draft Statement of Community Involvement 2022

Report Author:

Laura Bage

Principal Planning Officer

Local Plans Team

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Thurrock Council

Appendix A

Statement of Community Involvement

DRAFT FOR CONSULTATION

June 2022

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1 INTRODUCTION

What is the Statement of Community Involvement?

1.1 Planning is all about creating successful places that enable people to live healthier, more prosperous, and better-connected lives. It's also about supporting local businesses and making sure that the things that make our places special are protected. Planning decisions can be small in scale like an extension to your home or nationally significant like the expansion of a port and everything in-between. Planning genuinely affects everyone who lives, works, and visits in a place. So, it is important that local communities and stakeholders are aware of and can participate in the planning process and be involved in planning decisions.

1.2 The Statement of Community Involvement (SCI) sets out how the Council will engage and consult with the local community and other stakeholders on planning matters by defining how and when they can get involved in the preparation of planning documents and in determining planning applications.

1.3 The Council, like all other local planning authorities is required by national legislation to prepare an SCI. This requirement is set out in Section 18 of the Planning and Compulsory Purchase Act 2004 (as amended).

Why is the Statement of Community Involvement being updated?

1.4 Local planning authorities are required to review and update their SCI every five years. The previous SCI for Thurrock was adopted in December 2015. Work on an update was started in 2019 with a consultation on a draft version undertaken during the end of 2019, however progress was halted in early 2020 due to the Council focusing its resources on responding to the COVID-19 pandemic.

1.5 As a consequence of the pandemic the Council, like Thurrock's residents and businesses, has adapted to and established new ways of working and communicating effectively with others. These new methods are useful engagement tools which weren't considered in 2019 draft. The pandemic also brought about temporary changes to how Councils could consult on planning matters which was in direct conflict with the approaches to consultation set out in SCIs published prior to 2020. Whilst restrictions and temporary changes to consultation have ceased it is important that any SCI update allows the Council to adapt its approach to consultation should the need ever arise.

1.6 The Council has therefore carried out a full review of the SCI, taking in to account the changes proposed within the 2019 draft SCI and representations to the consultation, as well as subsequent legislative changes, revised national guidance and the Council's Collaborative Communities framework.

How will the Statement of Community Involvement be monitored?

1.7 The Town and County Planning (Local Planning) (England) (Amendments) Regulations 2017 requires the Council to undertake a review of the SCI every five years, starting from the date of adoption, to see whether it is being effective. Changes in national legislation or guidance, and/or a review of the Borough's Development Plan may also trigger a review of the SCI.

2 THE COUNCIL'S APPROACH TO ENGAGEMENT

Thurrock Collaborative Communities Framework

2.1 The Council has published a new framework which sets out its commitment to giving local people and key stakeholders a greater role in shaping the borough by enabling them to co-design and influence decisions, address challenges and realise ambitions. The Council's vision for the framework is:

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

2.2 To help achieve the vision, the Council has identified several priorities which are centred around three themes and are as follows:

- **Engagement** - Involving residents in the decisions that affect their lives, using co-design and co-production methods in the issues facing Thurrock as well as the solutions.
- **Empowerment** - Supporting resilience within communities and voluntary sector networks through Asset-Based Community Development, supporting communities to champion change. We aim to enable communities to make a difference and to flourish, being clear about the role of public services.
- **Equality** - Ensuring services are free of prejudice and that our services enable all to have equal opportunities to prosper and contribute to building a diverse and inclusive borough, underpinned by 4 core equality outcomes:
    - access to services
    - supporting community integration and cohesion
    - improving resilience
    - workforce development

Engagement in Planning

2.3 The Council's approach to community engagement and involvement in the planning process, as set out within this SCI, is aligned with the priorities of the Collaborative Communities Framework. When undertaking planning consultations, the Council will:

- Place community engagement at the front of the process, ensuring that opportunities for involvement exist at the earliest opportunity.
- Keep the process simple by writing in plain English and explaining any planning terms that we use.
- Communicate clearly by explaining the reasons why we want to involve you and receive your comments.
- Use engagement methods that are relevant to the community being consulted and appropriate in scale.
- Make it easy for you to get involved by setting out when and where you can provide your comments.

- Be inclusive by providing information in an accessible format and encouraging involvement from groups that are not usually involved in the planning process.
- Be transparent and objective by presenting all relevant facts about development proposals and considering all reasonable policy options for the Local Plan.
- Share information using the Council's website, local libraries and at the Council Offices in Grays[1].
- Make sure your involvement is effective by ensuring all comments we receive are recorded, read and taken into consideration.

2.4 Opportunities for local communities and other stakeholders to engage in planning exist during the plan-making stage and during the development management stage which includes the consideration of planning applications and the enforcement of planning decisions. The scope for involvement for each planning process is set out below.

Plan Making See page 5	
What this means: The Council is responsible for preparing development plan documents and other planning documents such as supplementary planning documents which are used to guide development proposals and determine planning applications.	***Scope for community involvement:*** The Council needs to consult with stakeholders including local communities at key stages when preparing these documents and then uses the consultation responses to inform and shape the planning policies and guidance.

Development Management See page 21	
What this means: This is the process by which people have to apply to the Council for permission to carry out certain types of development. The Council monitors the implementation of planning permissions, investigates alleged cases of unauthorised development and takes action where it is appropriate to do so. Important to note that some types of development are permitted under national legislation and do not require planning permission and therefore won't include community involvement.	***Scope for community involvement:*** Most applications are subject to a period of public consultation to ensure the Council can take into account the views of local people and other stakeholders. Applications not subject to consultation include Lawful Development Certificates and non-material amendments. Significant applications are decided by elected Councillors (via committee). Developers are also encouraged to consult locally prior to submission of large-scale proposals. If it is believed that a possible breach of planning control has occurred anyone can report it and the enforcement team will

[1] In exceptional circumstances, such as health pandemics or the closure of public buildings, it may not be possible for documents to be viewed in person. The Council will always follow the most up to date government guidance and will promote effective community engagement using methods that are safe and practicable.

	investigate. Most breaches are reported by members of the public.

Neighbourhood Planning	See page 28
What this means:	***Scope for community involvement:***
Whilst part of plan making, neighbourhood planning is undertaken by the community. Through neighbourhood planning they can produce their own plans and proposals for their area. The Council has a duty to provide support and assistance to communities that undertake neighbourhood planning, and it is responsible for key stages in the process.	The Council needs to consult with stakeholders on applications for a neighbourhood area and neighbourhood forum. We will also publicise and consult on the pre-submission plan or development order. The neighbourhood forum will consult stakeholders when they prepare the draft plan or development order before it is submitted to the Council.

3 PLAN MAKING

3.1 Planning policies are used to make decisions on planning applications received by the Council. These policies are set out at a national level (in documents like the National Planning Policy Framework and Planning Practice Guidance) and at a local level through the Council's Development Plan which is made up of documents that are produced by the Council or jointly with other local planning authorities and any made neighbourhood plans produced by local groups designated as neighbourhood forums.

3.2 A Development Plan for an area contains the local planning policies which guide new development schemes on aspects relating to design, housing, employment, regeneration, protection and supply of green space, retail development and infrastructure. In Thurrock, the Council is also responsible for minerals and waste planning, so its Development Plan includes policies on minerals and waste.

3.3 The Development Plan may comprise of one Development Plan Document (DPD) also referred to as a Local Plan or several DPDs. The Development Plan sets out a vision for the future development of a place and includes a range of strategic, detailed and allocation policies to deliver that vision. Once adopted the policies within the Development Plan will form the main consideration in determining planning applications.

3.4 Supplementary Planning Documents (SPDs) are prepared to provide additional detail and guidance to support the policies and proposals in the Development Plan. They generally look at specific issues such as conservation and design and focus on a specific site or area. They do not form part of the Development Plan and as a result they do not have the same weight or status as policies in the Development Plan. SPDs and guidance notes are not examined by the Planning Inspectorate in the same way as the Local Plan, but they do go through public consultation and once adopted, they will be a 'material consideration' in determining planning applications.

3.5 Other planning documents that a Council is required to prepare includes an SCI, a Local Development Scheme which sets out the planning documents being prepared and the timetable for producing them, and an Authority Monitoring Report which provides information on the implementation of local planning policies. A Council may also decide to adopt a Community Infrastructure Levy which is a levy that a local planning authority can choose to charge on new developments to fund infrastructure.

3.6 Thurrock's current Development Plan is available to view via the Council's website (https://www.thurrock.gov.uk/current-development-plan). A new Local Plan is currently being prepared, the timetable for which is set out in the Local Development Scheme.

3.7 When preparing or updating planning documents, the Council must follow the preparation stages set out in national legislation. These state who the Council should consult and how they should undertake consultation. The stages and amount of engagement and consultation for each type of planning document are different.

3.8 This section of the SCI provides information on how the Council will prepare each of the documents that make up or support the Development Plan including what the stages for each are. First it will set out who the consultees are, how they can get involved and the ways in which the Council will seek their involvement.

Who can be involved?

3.9 Planning consultations are open to all, and the Council will ensure that everyone has the opportunity to have their say on proposed planning policies.

3.10 The Council is required through national legislation[2] to directly consult a number of 'specific consultation bodies', which are recognised as statutory organisations, when it is preparing planning policy documents. These include other public bodies such as neighbouring councils, Historic England, Natural England and the Environment Agency.

3.11 The Council will also consult 'general consultation bodies' which includes residents, landowners, interest groups and businesses that the Council considers is appropriate. If the consultation is on a specific topic or relates to a specific area within the borough, the Council may target the consultation towards those most likely to be affected, for example by setting up workshops on particular topics or hosting public exhibitions in certain settlements and areas. Where a consultation is on issues that affect the whole borough the Council will adopt consultation methods that seek to notify and engage as many individuals and stakeholders as possible.

3.12 A detailed list of both 'specific' and 'general' consultation bodies is provided within Appendix A.

3.13 In addition to the 'specific' and 'general' consultation bodies, the Council will seek to engage with those groups of the community who are generally under-represented in consultations and planning for a range of reasons. 'Hard to reach' groups include but are not limited to young people, the elderly, BAME, people with disabilities, Gypsy's and Traveller's and those with other protected characteristics.

3.14 Engaging with residents and other stakeholders is key to capturing local knowledge and to better understand the needs of all members of the community. To assist, the Council maintains a mailing list with the contact details of the various organisations, interest groups, residents, landowners, businesses and other stakeholders that it can notify of consultation and engagement events. This includes the statutory organisations but also anyone who has either commented upon previous consultation documents or expressed an interest in being notified of or involved in the preparation of planning documents. Those on the mailing list were contacted by the Council following the introduction of the General Data Protection Regulations (2018) (GDPR) and have confirmed they wish to remain on the list. All new subscribers to the mailing list are provided with the Council's privacy policy when signing up.

Consultation Database

Any organisation or individual can be added to the mailing list at any time by registering online at https://consult.thurrock.gov.uk/register or by contacting the Local Plans team either by email growth&strategy@thurrock.gov.uk or by calling 01375 652705 and providing their contact details.

[2] Town and Country Planning (Local Development) (England) Regulations 2012

The Duty to Cooperate

3.15 The Duty to Cooperate was introduced by the Localism Act (2011). It places a legal duty on local planning authorities and prescribed public bodies to engage constructively with each other, and on an ongoing basis, on strategic matters when preparing Local Plans and other planning policy documents. Strategic matters are those that have an impact on or relate to an area that crosses borough boundaries and includes housing, transport, education, waste management, marine, estuary and other environmental matters.

3.16 This duty is in addition to the existing requirements for consultation with these bodies as 'specific' consultation bodies in the preparation of planning documents. The list of prescribed bodies to be engaged under Duty to Co-operate is also set out in Appendix A.

Types of consultation and engagement methods

3.17 The Council will use a range of methods to inform and consult with the community and other stakeholders in preparing planning documents. The ways in which we engage with you and how you can have your say will vary depending on the issue. Different techniques may also be used at different stages in the preparation of a planning document.

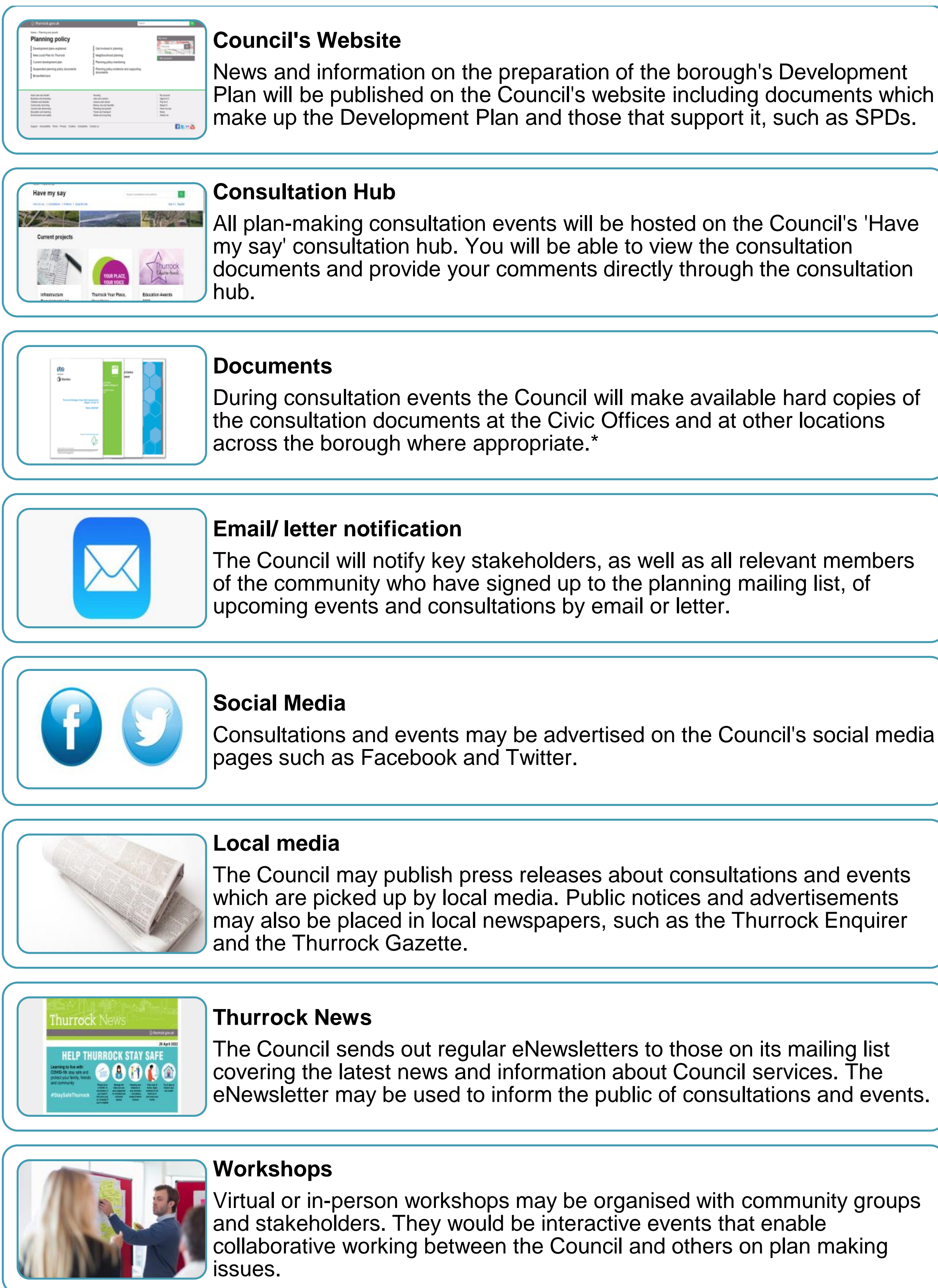
3.18 In response to the Covid-19 pandemic, the Council and its residents have had to adapt to new ways of working and communicating online. This has accelerated people's familiarity with online engagement tools and allowed a wider variety of people to easily access and participate in consultation events. We will continue to use a combination of online communication and engagement tools alongside traditional/face to face consultation methods to make sure that everyone who wants to, has the opportunity to engage with plan making in Thurrock.

3.19 The Council will always notify organisations and individuals where appropriate of any consultation events electronically using the Council's mailing list, or where a person does not have an email address, notifications by post will be sent to them to inform them of the consultation.

3.20 During consultation events and when publishing documents the Council will make all documents available to view on online, but it will also normally make them available for inspection at the Council's Civic offices in Grays and at local libraries in accordance with planning legislation. Prior to this SCI update, there was a temporary change to the rules for publicity and availability of documents in response to the Covid-19 pandemic where hard copies of documents were not available. This temporary change applied to planning consultations. Whilst these restrictions have been lifted, the Council is mindful that exceptional circumstances may arise in the future which could prevent the Council carrying out its consultations in the 'normal' way. In such circumstances the Council will follow the latest government guidance and will adapt and amend its methods of engagement to ensure that consultation during these times is undertaken in the safest and most practicable way possible.

3.21 Figure 1 identifies some of the consultation methods that we may use to engage with communities and stakeholders.

Figure 1: Plan-making consultation methods



Council's Website
News and information on the preparation of the borough's Development Plan will be published on the Council's website including documents which make up the Development Plan and those that support it, such as SPDs.

Consultation Hub
All plan-making consultation events will be hosted on the Council's 'Have my say' consultation hub. You will be able to view the consultation documents and provide your comments directly through the consultation hub.

Documents
During consultation events the Council will make available hard copies of the consultation documents at the Civic Offices and at other locations across the borough where appropriate.*

Email/ letter notification
The Council will notify key stakeholders, as well as all relevant members of the community who have signed up to the planning mailing list, of upcoming events and consultations by email or letter.

Social Media
Consultations and events may be advertised on the Council's social media pages such as Facebook and Twitter.

Local media
The Council may publish press releases about consultations and events which are picked up by local media. Public notices and advertisements may also be placed in local newspapers, such as the Thurrock Enquirer and the Thurrock Gazette.

Thurrock News
The Council sends out regular eNewsletters to those on its mailing list covering the latest news and information about Council services. The eNewsletter may be used to inform the public of consultations and events.

Workshops
Virtual or in-person workshops may be organised with community groups and stakeholders. They would be interactive events that enable collaborative working between the Council and others on plan making issues.

Exhibitions

Virtual or in-person exhibitions may be held providing specific information on consultations and events related to the preparation of planning documents.

Meetings and community forums

Council officers may attend/ host local meetings and forums to engage with communities and make them aware of consultations and events.

Your Place Your Voice Events

Different teams within the Council work together at these events to raise awareness and provide information on a range of matters or Council services. This may include hosting joint consultation and engagement events.

** Alternative arrangements will be made during exceptional circumstances if hard copies cannot be available to view within public buildings.*

3.22 The above list of engagement methods is not exhaustive. The Council will remain flexible in the methods that are used when engaging and will tailor the methods of engagement used to those most appropriate to the audience that it is seeking comments from. The Council will also consider new ways of engaging and communicating should they arise during the lifetime of this document.

Continuous engagement

3.23 In addition to the formal stages of consultation the Council will strive to maintain ongoing engagement with the relevant stakeholders throughout a plan's preparation.

Statements of Common Ground

3.24 To demonstrate effective and on-going joint working on strategic cross boundary matters with neighbouring authorities and other key bodies the Council will produce and maintain Statements of Common Ground in accordance with the National Planning Policy Framework. They will document how the Council has complied with the duty to cooperate and will set out the cross-boundary issues being addressed and the progress that has been made in cooperating to address them throughout the plan making process.

Planning Performance Agreements

3.25 The Council will also promote the use of voluntary Planning Performance Agreements with site promoters within plan making to encourage a more collaborative and proactive approach to evidence development, and the consideration and assessment of sites for future allocation. It is expected that such an approach will help deliver a faster and

more effective plan making process by enabling early consideration of all the fundamental issues relating to whether a particular site or strategic development may be acceptable in principle for allocation. It will also provide the opportunity for those involved to work together to secure the necessary funding and delivery of supporting infrastructure.

Responding to consultations

3.26 The easiest way to respond to a consultation on planning policy matters is to use the Council's online **'Have my say' Consultation Hub** (www.consult.thurrock.gov.uk). Key benefits of registering and making comments online include:

- Ability to view other consultees' comments - once they have been made
- Ability to update personal details instantly - in order to change your contact details
- Time saved - by viewing documents/comments as soon as they are available
- Environmental benefits - of using a paperless online system

3.27 Written responses can also be emailed to growth&strategy@thurrock.gov.uk or posted to Strategic Services, Thurrock Council, Civic Offices, New Road, Grays, Essex RM17 6SL.

3.28 All comments that the Council receives will be made available for the public to view. To comply with GDPR, personal details such as postal addresses, email addresses or telephone numbers will remain confidential.

3.29 Where comments are submitted to us using the Consultation Hub, an automatic email notification will be sent once the comment has been processed. Other comments will be acknowledged on request.

3.30 Once a consultation period has ended, we will seek to log all comments that we have received on the Consultation Hub and will summarise them, where appropriate. The Council acknowledges that an important part of community involvement is to feedback to those who have commented. When preparing the Local Plan, other DPDs, SPDs and other planning documents that are subject to consultation the Council will produce a Statement of Consultation which sets out the persons consulted, a summary of the main issues raised and how those issues have been addressed within the document.

What will you be expected to do?

3.31 To ensure that your involvement is effective when responding to consultations, you are expected to:

- Provide comments in a clear and concise way.
- Provide your comments within the published time period for that consultation activity or event.
- Be aware that all comments will be made publicly available.
- Be respectful of other people's views.
- If you are replying on behalf of a group or organisation, state how members of the group have been involved in formulating the response and how the full range of members' views have been represented.

Local Plans and other Development Plan Documents preparation stages

3.32 Table 1 sets outs the main stages in preparing the new Local Plan and any other DPD which the Council considers necessary to prepare, as well as the minimum level of consultation or notification that the Council will undertake when preparing these plans to comply with national legislation. The stages described are those specified in The Town and Country Planning (Local Planning) (England) Regulations 2012 (as amended) which includes at least two formal rounds of public consultation by the Council. The Council may choose to undertake additional rounds of consultation where it considers these are necessary and beneficial to the preparation of the plan.

3.33 The extent of any consultation undertaken for the Local Plan and other DPDs will be proportionate to the scale of issues involved in the plan and the stage at which the Council is consulting on it. Whilst Table 1 sets out the minimum consultation or notification that the Council will undertake, additional engagement methods may be adopted where relevant and practicable.

Table 1: Main stages and engagement during Local Plan preparation

Plan-making stage	Description of stage	What the Council will do
Stage 1: Evidence Gathering	• The Council will gather and analyse evidence to understand what the borough's current and future needs are. • This stage forms the basis of the evidence base that will support the preparation of the Local Plan. • This stage also informs the scoping stage of the Sustainability Appraisal (SA) which incorporates the requirements of the Strategic Environmental Assessment (SEA).	• This is not a formal consultation stage but the Council may request information from stakeholders and host workshops and meetings with key stakeholders.
Stage 2: Preparation (Regulation 18)	• The Council will undertake public consultation on what the Local Plan should contain and invite representations. • This could be undertaken in a single consultation on a 'Preferred Option' or draft Plan, or multiple consultations including an 'Issues and Options' style consultation and then consultation on a 'Preferred Option' or draft Plan.	• Notify specific and general consultees, as well as other relevant stakeholders that we are preparing a new Local Plan, provide information about the consultation, and invite comments for a minimum of 6 weeks. • Make the Local Plan available to view on our website and at the Civic Offices and various locations within the borough*.
Stage 3: Publication (Regulation 19 & 20)	• The Council will review comments received from the previous stages along with any additional evidence and prepare a draft version of the Local Plan that it intends to submit to the Secretary of State. This is called the Proposed Submission Plan or Pre-Submission Plan. • The Council is required to undertake a public consultation on the Proposed Submission Plan and invite representations which will be sent directly to the Secretary of State.	• Make a copy of the proposed submission documents and a statement of the representations procedure available to view on the Council's website and at the Civic Offices and various locations within the borough*. • Notify specific and general consultees that the statement of the representations procedure and a statement of the fact that the proposed submission documents are available for inspection and the places and times in which they can be inspected. • Invite comments for a minimum of 6 weeks.

Plan-making stage	Description of stage	What the Council will do

Stage 4: Submission & Examination (Regulation 22 & 24)	• The Proposed Submission Local Plan (along with its supporting evidence, Statement of Consultation and SA) are submitted to the Secretary of State to undergo an 'Independent Examination'.
	• The Local Plan is examined by a Planning Inspector and assessed on whether it has been prepared in accordance with the legal and procedural requirements, and whether it is sound.
	• This stage provides a further opportunity for anyone who has previously commented on the plan to present any concerns direct to the Planning Inspector.
		For Submission:
		• Submit the Local Plan and accompanying documents, including the Sustainability Appraisal Report and Statement of Consultation to the Secretary of State.
		• Make a copy of the Local Plan and all other accompanying documents, as well as a statement of the fact that the documents are available for inspection and of the places and times at which they can be inspected, available to view on the Council's website and at the Civic Offices and various locations within the borough*.
		• Notify specific and general consultees that the Local Plan and accompanying documents are available to view and the times and places where they can be viewed.
		• Notify those people who requested to be notified that the Local Plan has been submitted to the Secretary of State.
		For Examination:
		• At least 6 weeks before the examination hearings the Council will:
		    • Publish the arrangements (date, time, place) of the examination hearings and the name of the person appointed to carry out the examination on the Council's website and at the Civic Offices and various locations within the borough*.
		    • Notify any person who has made a representation during the Publication Stage, and has not withdrawn that representation, of the published information.

Stage 5:	• To conclude the Examination, the Planning Inspector will prepare and send the Council a report	• Publish on our website, at the Civic Offices and various locations within the borough*, a copy of the

Plan-making stage	Description of stage	What the Council will do
Inspector's Report	recommending any changes needed to make the plan 'sound' and confirm whether it can be 'adopted'. • These recommended changes may be subject to public consultation.	recommendations. • Notify those who requested to be notified that we have published the recommendations made by the Inspector. • If further consultation is required, the Council will undertake the consultation using the same approach and methods used during stages 2 and 3.

Stage 6: Adoption	• Where necessary the Council will amend the Local Plan to reflect the Planning Inspectors findings.
	• The Local Plan is then adopted by the Council and will be published on the website along with an Adoption Statement and the SA.
		• As soon as reasonably practicable after adoption the Council will:
		  • Send adoption statement to those who asked to be notified.
		  • Send adoption statement to Secretary of State
		  • Publish adopted plan, accompanying documents and adoption statement on website.
		  • Provide inspection copies of adopted plan, accompanying documents and adoption statement at the Civic Offices and various locations within the borough*.

** Alternative arrangements will be made during exceptional circumstances if hard copies cannot be available to view within public buildings.*

Supplementary Planning Documents and Interim Planning Guidance Notes preparation stages

3.34 When preparing an SPD, the Council must ensure that it has met all the statutory consultation requirements set out in The Town and Country Planning (Local Planning) (England) Regulations 2012 (as amended). The main stages in preparing these documents are set out in Table 2 along with the minimum level of engagement that the Council will undertake. The Council may also undertake engagement on other documents such as conservation area appraisals, masterplans, design codes and development briefs and will follow a similar process to preparing these as they would with an SPD or Interim Planning Guidance Note.

Table 2: Main stages and engagement during SPD preparation

Plan-making stage	Description of stage	What the Council will do
Stage 1: Evidence Gathering	• The Council will first establish where additional guidance is needed. This may include collecting and analysing additional evidence and seeking views from relevant stakeholders. • It is at this stage that the Council will identify whether a Strategic Environmental Assessment (SEA) is required.	• This is not a formal consultation stage but the Council may request information from stakeholders and host workshops and meetings with key stakeholders.
Stage 2: Consultation Draft (Regulation 12/13)	• The Council will first establish where additional guidance is needed. This may include collecting and analysing additional evidence and seeking views from relevant stakeholders. • It is at this stage that the Council will identify whether a Strategic Environmental Assessment (SEA) is required.	• Notify specific and general consultees, as well as other relevant stakeholders of the consultation and invite comments for a minimum of 4 weeks. • Make the SPD available to view on our website and at the Civic Offices and various locations within the borough*.

Stage 3: Adoption (Regulation 14)	• The Council will first establish where additional guidance is needed. This may include collecting and analysing additional evidence and seeking views from relevant stakeholders.
	• It is at this stage that the Council will identify whether a Strategic Environmental Assessment (SEA) is required.
		• Submit the SPD and the Statement of Consultation to the relevant committee for consideration and adoption (SPDs are not subject to independent examination).
		• Once adopted, the Council will:
		    • Publish the SPD, accompanying documents and adoption statement on the website.
		    • Provide inspection copies of the SPD, accompanying documents and adoption statement at the Civic Offices and various locations within the borough*.
		    • Send a copy of the adoption statement to anyone who requests to be notified of the SPD's adoption

** Alternative arrangements will be made during exceptional circumstances if hard copies cannot be available to view within public*

buildings.

Sustainability Appraisal and Strategic Environmental Assessment

3.35 Local Plans and other DPDs must be accompanied by a Sustainability Appraisal (SA) which incorporates the requirements of the Strategic Environmental Assessment (SEA) as set out in the Environmental Assessment of Plans and Programmes Regulations (2004) (as amended). The purpose of the SA is to promote sustainable development by assessing the extent to which the draft plan will achieve the social, economic and environmental objectives identified for the area. The SEA focuses only on the likely environmental effects of a plan and is often incorporated into a SA so that the potential environmental effects are given full consideration alongside social and economic issues. Other types of planning documents such as Supplementary Planning Documents and Neighbourhood Plans do not require a SA but a SEA may be required.

3.36 The Council is preparing an Integrated Impact Assessment (IIA) for the Local Plan which comprises the SA incorporating SEA, as well as a Health Impact Assessment and Equalities Impact Assessment. It will follow the same preparation process as a SA or standalone SEA in order to comply with the relevant legislation.

3.37 The first stage in undertaking a SA or a standalone SEA is to consider the scope of the appraisal process. It includes a review of other relevant plans, policies and programmes that relate to the local area; information on the present state of the local environment (the baseline); a discussion of the local sustainability issues and a series of sustainability objectives that must be considered when preparing the Local Plan.

3.38 National legislation requires the Council to consult the three statutory consultees, namely the Environment Agency, Natural England and Historic England, on the scope of the assessment which will be set out in a draft Scoping Report before it is approved by Council.

3.39 The SA or standalone SEA will then be undertaken throughout the preparation of the plan and a report will be produced at each of the main stages. When the Council consults on the Local Plan or other planning document it will also consult on the accompanying SA or SEA report.

Community Infrastructure Levy preparation stages

3.40 A Community Infrastructure Levy (CIL) is a tariff-based charging schedule that applies to specific types of development, such as housing. When planning permission is secured, developers will be required to pay a financial contribution, which is used to part-fund the provision and maintenance of necessary strategic and local infrastructure projects, such as transport, schools, health centres, flood defences, play areas and open spaces.

3.41 Local planning authorities are not required to produce a CIL but if they do it must be prepared in accordance with The Community Infrastructure Levy Regulations 2010 (as amended) which requires one formal round of public consultation. The stages involved in preparing a CIL and the minimum level of engagement that will be undertaken by the Council is set out in Table 3.

Table 3: Main stages and engagement during CIL preparation

Plan-making stage	Description of stage	What the Council will do
Stage 1: Evidence Gathering	• The Council will gather information to identify local infrastructure needs and funding gaps and assess the viability of developments.	• This is not a formal consultation stage but the Council may request information from stakeholders and host workshops and meetings with key stakeholders.
Stage 2: Draft Charging Schedule (Regulation 16 & 17)	• The Council will prepare a Draft Charging Schedule using the information it gathered during stage 1. • The Draft Charging Schedule with then be published for public consultation and the Council will invite representations.	• Make a copy of the draft charging schedule, supporting evidence and statement of the representations procedure, as well as a statement of the fact that the documents are available for inspection and of the places and times at which they can be inspected, available to view on the Council's website and at the Civic Offices and various locations within the borough*. • Publish in local newspapers a notice setting out the statement of the representations procedure and the statement of the fact that the documents are available for inspection and of the places and times at which they can be inspected. • Invite comments for a minimum of 4 weeks. • Send a copy of the draft charging schedule and the statement of representation procedure to the consultation bodies.
Stage 3: Submission & Examination (Regulation 19 & 20)	• The Charging Schedule along with the Statement of Consultation and any supporting documents are submitted to the Secretary of State for examination. • The Charging Schedule will then be examined by an independent examiner who will consider any representations received during consultation.	*For Submission:* • Submit the Draft Charging Schedule and accompanying documents, including the Statement of Consultation to the examiner. • Make a copy of the Draft Charging Schedule and all other accompanying documents available to view on the Council's website and at the Civic Offices and various locations within the borough*. • Notify those people who requested to be notified that the

Plan-making stage	Description of stage	What the Council will do
		draft charging schedule has been submitted to the examiner. *For Examination:* • Publish on our website and in the local newspaper, the time and place that the examination is to be held and the name of the examiner. • Inform anyone who made a representation on the Draft Charging Schedule and anyone who requested to be heard, the time and place that the examination is to be held and the name of the examiner.
Stage 4: Examiner's Report	• The examiner will prepare and send the Council a report setting out their recommendations and the reasons for those recommendation.	• Publish on our website, at the Civic Offices and various locations within the borough* a copy of the recommendations and reasons made by the examiner. • Notify those who requested to be notified that we have published the recommendations and reasons.
Stage 5: Approval and Publication (Regulation 25)	• The examiner will publish a report setting out recommendations and the reasons for those recommendations. • If approved, the Council with then publish (adopt) the CIL Charging Schedule.	• Publish the Charging Schedule and make available for inspection at the Civic Offices, other various locations within the borough* and on the website. • Publish in the local newspaper a notice that the Charging Schedule has been approved and where it can be viewed. • Notify those who requested to be notified that the Charging Schedule has been approved. • Send a copy of the Charging Schedule to each relevant consenting authority.

** Alternative arrangements will be made during exceptional circumstances if hard copies cannot be available to view within public buildings*

4 DEVELOPMENT MANAGEMENT

4.1 The Development Management process principally involves the consideration and determination of planning applications that are submitted to the Council. There are certain types of work that do not require planning permission. This is called '**permitted development'**. Full details of this can be found on the Planning Portal website https://www.planningportal.co.uk/.

4.2 Local planning authorities are required by law to consult individuals and public bodies on various planning applications, ranging from large-scale 'major' development to minerals or waste proposals to listed building consent to smaller household applications and changes of use. The Council takes into account all views expressed and all comments made before reaching a decision.

4.3 This section of the SCI sets out how the Council will involve the community and stakeholders at various stages of the planning application process. The three main stages in process are:

- Pre-application
- Planning Application
- Planning Appeals

4.4 This section also provides information on planning enforcement and the important role the community has in identifying potential breaches.

Pre-application stage

4.5 The Council encourages pre-application discussions for certain types of development before making a formal application. The objective of these discussions is to establish whether the principle of the development is acceptable and to enable early consideration of fundamental issues, such as design, infrastructure and affordable housing. The Council will provide comments on the proposal and help overcome any potential difficulties that may arise. The more issues that can be resolved at the pre-application stage, the more likely it is to result in a good quality and acceptable development. For more information on how to request pre-application advice or information on the fees charged, please visit: www.thurrock.gov.uk/pre-application-advice/pre-application-advice-service.

4.6 The National Planning Policy Framework (NPPF) recognises the potential of early engagement to improve the efficiency and effectiveness of the planning application system for everyone. While pre-application discussions are normally confidential between the applicant and the Council, however public engagement with the local community at this stage is strongly encouraged. The level of engagement should be proportionate to the nature and scale of the proposed development. The more controversial the proposal, the broader the range of consultation methods should be, to allow as many people as possible to have their say.

4.7 Engagement with statutory and non-statutory consultees, particularly infrastructure providers, is also likely to be beneficial prior to submitting a planning application.

Planning Performance Agreements

The Council is committed to dealing with major planning applications in a timely and effective way. The Council promotes the use of pre-application discussions for all proposals. However, for some proposals a Planning Performance Agreement (PPA) is encouraged as they can provide bespoke ongoing advice. In order for all parties to gain maximum benefit from a PPA, it is essential that there is engagement between developers, the Council, the local community and relevant stakeholders. The level of community engagement will be dependent upon the type of development proposal and will be identified in the PPA.

For more information on PPAs within development management, including fees please visit: www.thurrock.gov.uk/support-for-investors-developers-and-agents/planning-performance-agreements.

Local communities

4.8 The Council strongly encourages applicants of large-scale development proposals to involve local communities before the formal application stage begins. This enables local communities to put forward initial constructive comments and suggestions and may lead to fewer objections being made further down the line, which are then material to the determination of the application. However, this is dependent on the applicant and the Council cannot require applicants to involve the local community. The Localism Act (2011) introduced a requirement for developers to consult local communities before submitting planning applications for certain types of development, but this is limited to those specified in a development order.

4.9 It is recommended that pre-application consultation carried out by applicants with local communities should be in the form of meetings, presentations and/or exhibitions[3]. Applicants are encouraged to speak with the Council before arranging these events, so that they can be undertaken in a manner that is sensitive to the local community's concerns. However, any pre-application engagement undertaken with the community is done so by the applicant, independently of the Council. Therefore, it is important that any comments being made are directed to the applicant and not to the Council at this stage.

Design Review

4.10 All significant development proposals must also be assessed by our Design Review panel before a planning application is submitted. The Design Review panel operates under 10 nationally accepted design review principles and all reviews are focused on outcomes for people.

[3] During exceptional circumstances the Council will expect alternative engagement methods to be used by applicants to consult with the local community if face to face meetings, presentations and exhibitions cannot take place.

The planning application stage

4.11 Once the Council receives a planning application, it will be checked for validation purposes. To make a valid application, there are statutory and local information requirements which apply to each application type.

4.12 Once validated, the Council is obliged to undertake public consultation (it should be noted that not all application types are subject to notification or consultations procedures).

How and who the Council consult on planning applications

4.13 The Town and Country Planning (Development Management Procedure) Order 2015, including the amendments set out in Part 2 of the Town and Country Planning (Local Authority Consultations etc) (England) Order 2018, sets out the publicity and notification requirements for planning applications and is supplemented by other legislation in some cases. Such requirements involve placing a notice in the local press and/or displaying a site notice and/or serving notice on adjoining owners and occupiers of the site.

4.14 Statutory requirements for notifications and consultation vary for different types of application, and the type of notification will be dependent on the nature of the application. Table 4 sets out the minimum level of consultation that the Council will undertake for the different types of planning applications[4].

Table 4: Notification and consultation methods for different types of planning applications

<table>
<tr><th>Application Type</th><th>Method used</th></tr>
<tr><td>Application accompanied by an EIA (Environmental Impact Assessment</td><td rowspan="3">• Site Notice
• Newspaper Advert
• Website</td></tr>
<tr><td>Applications which do not accord with the development plan</td></tr>
<tr><td>Proposal affecting a public right of way</td></tr>
<tr><td>Major development</td><td>• Site Notice
• Letter to adjoining property
• Newspaper Advert
• Website</td></tr>
<tr><td>Minor development:</td><td>• Site Notice OR Letter to adjoining property</td></tr>
</table>

[4] During exceptional circumstances it may not be possible to comply with all the requirements to notify and consult on planning applications as set out in Table 4. The Council will always follow the most up to date government guidance and will use methods that are safe and practicable.

• ***Change of Use*** • ***Variation or removal of condition(s) attached to a previous approval*** • ***Householder development***	• Newspaper Advert ONLY where affecting the character or appearance of a Conservation Area or Listed Building • Website
Listed Building Consent	• Site Notice • Newspaper Advert • Website
Advertisement Consent	• Website
Approval of Details	
Non-material amendments	
Certificate of Lawful Use or Development (existing and proposed)	
Householder Prior Approval applications	• Letter to adjoining property • Website
Other Prior Approval Applications	• Site Notice OR Letter to adjoining property depending on legislative requirements • Website
Works to Protected Trees	• Site Notice • Website

4.15 There are a range of statutory consultees that must be consulted, depending on the type and nature of the planning application, as set out above. Letters to adjoining property means that owners and occupiers of any land which adjoins that to which a planning application relates are informed by letter and consulted on the application.

4.16 The Council informs the general public on planning applications in a more generalised way. All planning applications that we receive are published on the Council's website. In the case of major or controversial applications, where the Council considers there to be a wider impact resulting from a development proposal or where the Council is required, it will also display public site notices in proximity to the application site. Adverts are placed in the local newspaper(s) where required and provide another method of informing the general public on planning applications.

Viewing planning applications

4.17 Details of planning applications and appeals are available to view on the Council's

website using the planning application search facility at: https://regs.thurrock.gov.uk/online-applications/. This includes application forms, drawings and other supporting documentation, planning decisions and important dates. Some older applications are only available in paper form on public files at our Civic Offices, Grays. The Council's website also contains weekly and monthly lists of all planning applications and decisions made.

Having your say on planning applications

4.18 There are three ways you can comment on a planning application:

- Online: https://regs.thurrock.gov.uk/online-applications/
- Email: development.management@thurrock.gov.uk
- Post: Planning Services, Thurrock Council, Civic Offices, New Road, Grays, Essex RM17 6SL

4.19 Once comments are received, they are uploaded on to the Council's website. The Council will take account of all responses received as a result of its consultations on planning applications where the issues raised are material planning considerations.

4.20 You can make comments on planning applications up to the expiry date. The Council will use its discretion and take into account any comments received up until the case officer prepares their recommendation report.

4.21 Any comments you make will be a matter of public record and they will be visible on the Council's website and for public inspection at the Council Offices. We reserve the right to obscure any comments that we consider to be inflammatory before they are displayed on the website.

Making decisions on planning applications

4.22 The majority of applications are dealt within eight weeks (or 13 weeks for major applications). The results of any consultation will be reported and taken into account in decisions made by the Council.

4.23 Most planning applications are determined by officers under delegated powers. Major or contentious applications, or those that have been 'called in' by Councillors are taken to the Council's Planning Committee for determination.

4.24 If the decision is delegated, the case officer will prepare an Officer's report that will set out the officer's recommendation for approval or refusal. If the decision is to be made by Committee, a report will be prepared containing the officer's recommendations and presented to the Planning Committee. Meetings of the Council's Planning Committee are usually held every 4 weeks and members of the public are allowed to speak at the meeting.

4.25 Once a decision on an application has been reached, the Council will send out a decision notice to the applicant or their agent, where applicable and inform anyone who has submitted written to comments to us of the outcome of the decision.

Material Considerations

When a decision is made on a planning application, only certain issues are taken into account. These are often referred to as 'material planning considerations'. Weight attached to material considerations is a matter of judgement for the decision-taker; however, they must demonstrate that in reaching their decision they have considered all relevant matters. Further detail on this can be found in Appendix B.

Planning appeals

4.26 Where a planning application is refused, the applicant may appeal against the decision. There is also a right of appeal if the application has not been determined within the relevant time limit. Where an application goes to appeal, the Council will notify interested parties, such as neighbours, and will give them the right to submit their views in writing or in person, depending on the method of appeal.

4.27 For appeals decided by informal hearing or public inquiry, interested parties are also given the opportunity to appear before the Inspector at the hearing or inquiry. The Inspector will consider the evidence and decide whether to 'allow' or 'dismiss' the appeal.

4.28 The Planning Inspectorate will inform the Council and interested parties of the outcome. The Inspector's decision is binding on the Council, although it can be challenged on a point of law in the High Court. Third parties do not have the right to appeal decisions.

Nationally Significant Infrastructure Projects

4.29 Nationally Significant Infrastructure Projects (NSIPs) are usually large-scale developments, such as new ports, power generating stations (including wind farms) and electricity transmission lines, which require a type of consent known as 'development consent'. The Planning Inspectorate is responsible for the planning process for NSIPs, not the Council.

4.30 Any developer wishing to construct an NSIP must first apply to the Planning Inspectorate for consent to do so. The Planning Inspectorate examines the application and makes a recommendation to the relevant Secretary of State, who then decides whether to grant or refuse development consent.

Enforcement

4.1 The Council also has Planning Enforcement powers to resolve breaches of planning control but to do so it must firstly know about these instances, and secondly understand the level of harm caused. As such, local people play an essential role in this aspect of the planning system.

4.2 If you think that development may have been undertaken without planning consent it can be reported to the Council's Planning Enforcement Team for investigation. Further information about planning enforcement, enforcement procedure and how to report a

potential planning breach can be found online (https://www.thurrock.gov.uk/planning-enforcement/planning-breaches).

5 NEIGHBOURHOOD PLANNING

What is Neighbourhood Planning?

5.1 Neighbourhood planning was introduced by the 2011 Localism Act to give local communities the opportunity to draw up their own plans and proposals for shaping the future of their areas, as long as they comply with national and local strategic policies.

5.2 There are three types of neighbourhood planning available to communities:

- **Neighbourhood Plan** – enables a community to establish a vision and provide planning policies for the future use and development of land in the local community area. Once adopted, a neighbourhood plan will form part of the Council's development plan, against which all planning applications and proposals will be decided.
- **Neighbourhood Development Order** – allows communities to grant planning permission for certain types of development that they would like to see happen in their area.
- **Community Right to Build Order** – allows communities to grant planning permission for local small-scale developments that they would like to see, such as, housing, community facilities or shops.

5.3 Neighbourhood planning cannot be used to block the building of the homes and businesses considered to be necessary to meet the Borough's current and future needs. However, it can be used to influence the location, type, and design of new development.

What is the process for preparing a Neighbourhood Plan or Neighbourhood Development Order?

5.4 There are five main stages in preparing a neighbourhood plan or Order are set out in Table 5.

Table 5: Stages in preparing a neighbourhood plan or Order

Stages	What happens
Stage 1: Set up a Neighbourhood Forum and agree its planning area	• The community decides on the 'neighbourhood area' that they wish to prepare a neighbourhood plan or Order for. The only bodies that can produce a neighbourhood plan or Order in Thurrock are designated neighbourhood forums. • A neighbourhood forum must be a group of at least 21 people who either live in the neighbourhood area, work there or are elected members for all or part of the neighbourhood area. • Both the neighbourhood area and the

	neighbourhood forum will need to be formally designated by the Council to ensure that they make sense for planning purposes and do not overlap with any other neighbourhood planning area. Prior to this decision the Council must first publicise and consult on the area and forum applications for a minimum 6 weeks.

Stage 2: Preparing and consulting on a Neighbourhood Plan or Neighbourhood Development Order	• The preparation of the neighbourhood plan or Order is the most significant stage in the neighbourhood planning process. The neighbourhood forum must gather ideas for the area and develop proposals for the neighbourhood plan or Order.
	• Everyone who lives or works in or around the local community must be appropriately consulted on the proposals. This includes residents, local businesses and landowners, as well as relevant local, regional and national organisations and agencies. The Neighbourhood Planning (General) Regulations 2012 (as amended) sets out the requirements for consultation and publicity at key stages with those living or working in the neighbourhood area, and those who may have an interest in or are likely to be affected by the proposals (e.g. business). These are the minimum requirements, but engagement with all members of the local community should be an ongoing process from the beginning, to ensure the plan or Order is prepared with high levels of involvement and has local support at the referendum stage.
	• In preparing the draft plan or Order, proposals and policies must meet basic conditions which include being in accordance with:
	  ◦ International, European and national designations (e.g. heritage and natural environment), and European environmental and human rights laws;
	  ◦ National planning policies, advice and laws, including the National Planning Policy Framework;
	  ◦ Strategic policies and designations of the Council’s adopted development plan – plans and orders can propose more, but not less, development than is required for the area by the adopted development plan.

Stage 3: Submission and Independent Examination	• Once the forum has finalised the draft neighbourhood plan or Order it will submit it to the Council. The Council will then carry out its own formal consultation on the plan or Order for a

	minimum 6 weeks and then send the plan or Order to an independent examiner. The independent examiner will consider whether it meets the right basic standards and they will consider any representations or objections to the proposals. • The independent examination may be carried out in writing, with the examiner considering written representations, or, it may be held as a public meeting. • If the examiner considers that the plan or Order does not meet the right standards, they will suggest changes and recommend whether it should proceed to a referendum. The Council will then consider the examiner's views and decide whether to make those changes. If significant changes are recommended, then the neighbourhood forum may wish to re-consult with the local community before proceeding.
Stage 4: Community Referendum	• If the plan or Order is recommended for approval by the examiner, the plan or Order will then need to be put to a community referendum. This ensures that the local community has the final say on whether the plan or Order should come into effect. • Anyone who lives in the area that the plan or Order covers, and who are registered to vote in local elections, are entitled to vote in the referendum. In the case of a neighbourhood plan for a 'business area' a separate referendum will also be held for businesses (non-domestic rate payers). Each business will have one vote.
Stage 5: Legal adoption of your Neighbourhood Plan or Neighbourhood Development Order	• More than 50% of people voting in the referendum need to vote in favour of support, for the plan or Order to come into legal force. If there is conflict between the results of the resident and business referendums, then the decision on adoption of the neighbourhood plan will rest with the Council. • A neighbourhood plan comes into force as part of the statutory development plan once it has been approved at referendum. An Order must be made by the local authority before it has effect. • Once the plan or Order has been formally adopted by the Council and brought into legal effect, the Council is legally obliged to take it into consideration when assessing planning applications and other proposals for development in the area.

What is the process for preparing a Community Right to Build Order?

5.5 The process for preparing a Community Right to Build Order is similar to the process of preparing a Neighbourhood Development Order. The main difference is that these Orders are prepared by a local community organisation, not a designated neighbourhood forum.

5.6 To be eligible to develop a Community Right to Build Order in a particular neighbourhood area, the community organisation or group must consist of at least 10 members, all of whom must live in that neighbourhood area, in separate homes to each other. When an order is proposed, at least half of the organisation's members must live in the area. The organisation must also exist to further the economic, environmental and social well-being of the area, and any profits made as a result of Community Right to Build Orders must be used for the good of that community, not for private gain.

5.7 Both the neighbourhood area and the local community organisation need to be approved by the Council, to ensure they make sense for planning purposes and do not overlap with any other neighbourhood planning area.

5.8 The process for preparing, consulting and submitting a Community Right to Build Order so that it can be independently examined and then subject to a referendum is the same as a Neighbourhood Development Order. The Council will bring it into force if there is a majority vote in favour of the Order.

What role does the Council play in Neighbourhood Planning?

5.9 The Council has a statutory duty under the Town and Country Planning Act 1990 (as amended), to assist communities in the preparation of neighbourhood plans and Orders, and to take plans through a process of examination and referendum. It does not prepare neighbourhood plans or Orders.

5.10 The Council has six principal roles in the process of neighbourhood planning:

- To formally designate a neighbourhood area and neighbourhood forum for the purposes of neighbourhood planning.
- To provide technical advice and support for the preparation of the plan or Order.
- To validate and check a plan or Order prior to its submission for independent examination.
- To cover the costs of an independent examination of the plan or Order.
- To organise and cover the costs of a referendum, to ensure there is public support for the plan or Order.
- To 'make' the plan or Order if it has been prepared correctly and is supported by the local community.

5.11 In addition, subject to the availability of resources, the Council will endeavour to support communities undertaking neighbourhood planning by:

- Providing general guidance and advice.
- Attending meetings at key stages.

- Making available on the Council's website relevant studies and other background information.
- Providing information on the Council's website about planning policy and planning designations.
- Advising on any national or local funding opportunities.
- Providing details of relevant contacts, e.g. the Environment Agency, Historic England and National Highways.

5.12 The Council must be realistic as to what it can do to support neighbourhood planning in a cost-effective and time-efficient way. Support and assistance the Council provides will be proportionate to the nature of the plan or Order being prepared, the stage reached in plan making and the impact on the wider community.

6 APPENDICES

Appendix A - Plan-making consultees

Specific Consultation Bodies

- The Coal Authority
- Environment Agency
- Historic England
- Natural England
- The Marine Management Organisation
- Network Rail
- National Highways
- Homes England
- Neighbouring authorities
- Mayor of London
- NHS/Integrated Care Boards
- Police, Fire and Crime Commissioner
- Utility providers

General Consultation Bodies

Voluntary groups and those who represent the interests of different racial, ethnic and national groups; disabled persons; different religious groups; and persons carrying on businesses in Thurrock

Duty to Cooperate Bodies

- Neighbouring authorities
- Environment Agency
- Historic England
- Natural England
- Homes England
- The Civil Aviation Authority
- Marine Management Organisation.
- Mayor of London
- NHS/Integrated Care Boards
- Office of Rail Regulation
- Transport for London
- Network Rail
- Local Enterprise Partnership
- Local Nature Partnership

Appendix B – Material considerations

Material considerations can include, but are not limited to:

- the local plan
- development plan documents
- supplementary planning documents
- the statement of community involvement
- the authority monitoring report
- government planning policy and guidance
- the council's corporate policies
- highway safety and traffic levels
- noise, disturbance and smells resulting from the proposed development
- design, appearance and layout
- conservation of buildings, trees and open land
- flood risk
- the impact on the appearance of the area
- the effect on the level of daylight and privacy of existing property
- the need to safeguard the countryside or protected species of plant or animal
- planning case law and previous decisions
- the need for the development
- the planning history of the site

Issues that are not considered relevant to planning decisions include:

- private property rights, such as covenants
- the developer's identity, morals or motives
- the effect on the value of your property
- loss of a private view
- private neighbour disputes

Appendix C – Further information and advice on planning

National Planning Policy Framework

The National Planning Policy Framework sets out government's planning policies for England and how these are expected to be applied.

Website: https://www.gov.uk/government/publications/national-planning-policy-framework--2

Planning Practice Guidance

The Planning Practice Guidance (PPG) is a web based resource which contains planning guidance on various topics.

Website: https://www.gov.uk/government/collections/planning-practice-guidance

The Planning Portal

The Planning Portal is the Government's online tool for planning and building services. It provides information about the planning system, allows you to submit planning applications and find out about development in your area.

Website: https://www.planningportal.co.uk

Thurrock Council: Planning and Growth

The Council's website provides guidance on Planning Applications, the Borough's Development Plan, and Planning Enforcement process

Website: https://www.thurrock.gov.uk/planning-and-growth

Locality

Locality is the national membership network for community organisations. The website contains specialist advice, support and resources.

Website: www.locality.org.uk

Planning Aid England

Planning Aid England, which is provided by the Royal Town Planning Institute, offers free, independent and professional planning advice to individuals and communities who cannot afford to pay professional fees.

Website: www.rtpi.org.uk/planning-aid

The Planning Inspectorate

The Planning Inspectorate deals with planning appeals, national infrastructure planning applications, examinations of local plans and other planning-related and specialist casework in England and Wales.

Website: www.gov.uk/government/organisations/planning-inspectorate

7 GLOSSARY

Authority Monitoring Report (AMR)

This report looks at the implementation of the Local Development Scheme and how well the policies in the Local Development Documents are being achieved.

Community Infrastructure Levy

A levy which allows local authorities to raise funds from new development which can be used to pay for a wide range of infrastructure, including roads, schools, community facilities and open spaces.

Community Right to Build Order

A special type of Neighbourhood Development Order prepared by a community organisation and made by the local planning authority. It grants planning permission for a particular type of development in a particular area.

Core Strategy

A type of development plan document which sets out the long-term vision, spatial strategy and policies for future development of the Borough. The current adopted Core Strategy for Thurrock will be replaced by a new Local Plan once it is adopted.

Development Plan

Document(s) that set out the spatial vision, strategic objectives and policies for development in an area.

Development Plan Documents

All local planning authorities must produce Development Plan Documents, such as the Local Plan. These are spatial documents and are subject to independent examination.

Duty to Cooperate

This was created by the Localism Act 2011. It places a legal duty on the Council to engage on an ongoing basis with neighbouring local planning authorities and other bodies on issues that go beyond Thurrock’s boundary.

Equality Impact Assessment (EqIA)

An assessment of the plan is undertaken to ensure that it does not discriminate against disadvantaged or vulnerable people. In Thurrock, this is usually incorporated into the Sustainability Appraisal.

General Consultation Bodies

A list of organisations, groups and individuals as set out in The Town and Country Planning (Local Planning) (England) Regulations 2012 (as amended) who the Council deems appropriate to consult on the preparation of the Local Plan and other planning documents.

Habitat Regulation Assessment (HRA)

An assessment is required if a Plan or the policies it contains is likely to have a significant adverse effect on Special Areas of Conservation or Special Protection Areas. In Thurrock a HRA is usually incorporated into the Sustainability Appraisal.

Local Development Document

The collective term for documents that form part of the wider Local Plan and set out the spatial planning strategy for the area. These include Development Plan Documents and Supplementary Planning Documents.

Local Development Scheme (LDS)

This document sets out the timetable for the preparation of the Local Development Documents. It identifies which Development Plan Documents and Supplementary Planning Documents are to be produced and when.

Local Plan

A plan which sets out a vision and objectives for the development of an area. It identifies future needs and opportunities for housing, economic development, community facilities and infrastructure, whilst also protecting the built and natural environment, adapting to climate change and securing good design.

Major Planning Applications

Housing development of 10 or more dwellings, or a site area of 0.5 hectares or more. Other development where the floor space to be built is 1,000 sq m or more, or where the site area is 1 hectare or more.

Material Consideration

The issues that are taken into account when a decision is made on a planning application.

Minor Planning Applications

Housing development of less than 10 dwellings. Other development where the floorspace to be built is less than 1,000 sq m or where the site area is less than 1 hectare.

National Planning Policy Framework (NPPF)

The National Planning Policy Framework sets out government's planning policies for England and how these are expected to be applied.

Neighbourhood Development Plan

A neighbourhood plan is prepared by a designated neighbourhood forum for their neighbourhood area. It sets out the policies for development and use of land for all or part of the neighbourhood area.

Neighbourhood Planning

This was introduced by the Localism Act (2011) and allows local communities to shape new development in their area, through the building of homes, jobs and community facilities.

Planning Policy Guidance (PPG)

The Planning Practice Guidance (PPG) is a web based resource which contains planning guidance on various topics to support the effective implementation of the National Planning Policy Framework.

Permitted Development Rights

Certain minor changes that can be made to a house or building without the need for planning permission.

Specific Consultation Bodies

A list of bodies identified in The Town and Country Planning (Local Planning) (England) Regulations 2012 (as amended) which the Council must consult during preparation of its Local Plan.

Stakeholders

Stakeholders include any person or organisation, local or national, who has a legitimate interest in what happens in our area.

Statement of Community Involvement

A document that sets out the standards for involving the local community in the preparation of Local Plans and decisions on planning applications.

Statement of Consultation

A report or statement issued by the Council explaining how they have complied with the statement of community involvement during consultation on planning documents.

Strategic Environmental Assessment (SEA)

Assesses the environmental effects of a plan. In Thurrock SEAs are usually incorporated into the Sustainability Appraisal.

Supplementary Planning Document

A document that provides additional guidance to support the implementation of policies in the Development Plan.

Sustainability Appraisal (SA)

An appraisal undertaken during the preparation of a plan to assess its possible social, environmental and economic effects and to ensure that the plan contributes to the achievement of sustainable development.

15 June 2022	ITEM: 13
Cabinet	
Appointments to Outside Bodies, Statutory and other Panels	
Wards and communities affected: None	**Key Decision:** Non-key
Report of: Councillor Robert Gledhill, Leader of the Council & Portfolio Holder for Public Protection and Anti-Social Behaviour	
Accountable Assistant Director: Matthew Boulter, Democratic Services and Governance Manager, and Interim Monitoring Officer	
Accountable Director: Lyn Carpenter, Chief Executive	
This report is Public	

Executive Summary

This report requests the Cabinet to consider the nominations made by Group Leaders to Outside Bodies, Statutory and Other Panels for those appointments that are to be made by the Cabinet.

1. Recommendation(s)

1.1 That the nominations to Outside Bodies, Statutory and Other Panels be approved, as set out in Appendix 1 to this report (to be tabled when nominations are received).

2. Introduction and Background

2.1 Both the Full Council and the Cabinet have powers to appoint Members, officers and others to serve on Outside Bodies in a variety of capacities. Chapter 12, Part 2, of the Council's Constitution provides details of those Outside Bodies, Statutory and Other Panels where appointments are to be made by either Full Council or by the Cabinet.

3. Issues, Options and Analysis of Options

3.1 Nominations have been sought from Group Leaders for the appointments to Outside Bodies, Statutory and Other Panels that are required to be made by the Cabinet. Those nominations are set out in **Appendix 1** to this report, which will be tabled when nominations have been received.

3.2 Any changes to the appointments made will require the approval of the appointing body, be this Full Council or Cabinet.

3.3 There is an expectation that Members appointed to represent the Council on Outside Bodies will report back to the Council at least annually.

4. Reasons for Recommendation

4.1 The Cabinet should ensure that it continues to nominate representatives to sit on Outside Bodies, Statutory and other Panels so that its interests can be properly represented, together with those of the wider community.

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

5.1 In the course of seeking nominations, consultation has been undertaken with the Leaders of each of the political groups represented on the Council.

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

6.1 It is important for the Council to nominate to such bodies in order to ensure that it continues to represent the interests of both the Authority and the wider community.

7. Implications

7.1 **Financial**

Implications verified by: **Dammy Adewole**

Senior Management Accountant

There are no financial implications arising from this report.

7.2 **Legal**

Implications verified by: **Mark Bowen**

Interim Head of Legal

It is important that Members are correctly appointed, through the relevant Council meeting, to ensure they are indemnified in certain circumstances.

7.3 **Diversity and Equality**

Implications verified by: **Roxanne Scanlon**

Community Engagement and Project Monitoring Officer

The Council is under a statutory duty to ensure that equality and diversity is a key part of our decision making process. Therefore attention is drawn to the importance of ensuring that appointments to Outside Bodies, Statutory and Other Panels are underpinned by appropriate training on the statutory equality framework.

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

- None.

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

- None.

9. Appendices to the report

- Appendix 1 - Nominations of political groups to Outside Bodies, Statutory and Other Panels

Report Author:

Lucy Tricker & Kenna-Victoria Healey

Senior Democratic Services Officers

Resources and Place Delivery

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Cabinet Appointments to Outside Bodies, Statutory and Other Panels 2022/2023

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Organisation	No. to be appointed by Cabinet	Appointees
Anglian (Eastern) Regional Flood & Coastal Committee (1 seat held jointly, bi-annually, with Southend)	**1**	**1. Councillor** *(2021* – Councillor Collins*)*
Association for Public Services Excellence	**1**	**1. Councillor** *(2021* – Councillor Gledhill*)*
Mid and South Essex NHS Foundation Trust Council of Governors	**1**	**1. Councillor** *(2021* – Councillor Van Day)
Essex Partnership for Flood Management	**1**	**1. Councillor** *(2021*– Councillor Collins*)*
Essex County Traveller Unit	**1**	**1. Councillor** *(2021* – Councillor Gledhill*)*
Impulse Leisure (One appointment to be made by the Cabinet. A further appointment is required to be made by the Council.)	**1**	**1. Councillor**
Local Government Association	**2**	**1. Councillor** *(2021* – Councillor Johnson*)* **2. Councillor** *(2021* – Councillor Abbas*)*
Opportunity South Essex	**1**	**1. Councillor Coxshall** *(Appointed for a 5-year term in 2021)*
South East Local Enterprise Partnership – Strategic Board	**1**	**1. Councillor** *(2021* – Councillor Coxshall*)*
South East Local Enterprise Partnership – Accountability Board	**1**	**1. Councillor** *(2021* – Councillor Coxshall)
Thurrock Arts Council	**1**	**1. Councillor** *(2021*– Councillor Watson*)*
Thurrock Sports Council	**1**	**1. Councillor**

Organisation	No. to be appointed by Cabinet	Appointees
		(2021 – Councillor Jefferies)
Thames Estuary 2100 Strategic Programme Board	**1**	**1. Councillor** *(2021* – Councillor Coxshall*)*

STATUTORY AND OTHER PANELS TO BE APPOINTED

Organisation	No. to be appointed by Cabinet	Appointees
Thurrock Community Safety Partnership	1	**1. Councillor** *(2021* –Councillor Gledhill*)*
ASELA	1	**1. Councillor** *(2021* –Councillor Coxshall*)* (Appointee to be a Cabinet Member)
High House Production Park	1	**1. Councillor Coxshall** (Appointed for a 4-year term)