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SOUTHEND-ON-SEA CITY COUNCIL

Health & Wellbeing Board

Date: Wednesday, 6th September, 2023
Time: 5.00 pm
Place: Committee Room 1
Contact: Robert Harris

Email: committeesection@southend.gov.uk

A G E N D A

1 **Apologies for Absence**

2 **Declarations of Interest**

3 **Public Questions**

4 **Minutes of the Meeting held on Thursday, 15 June 2023** (Pages 3 - 6)

******** **ITEMS FOR DECISION**

5 **Southend, Essex and Thurrock (SET) Mental Health Strategy** (Pages 7 - 32)
Report from Head of Adult Strategy Commissioning

******** **ITEMS FOR DISCUSSION**

6 **COPD Community Connectors**
Joint update from Chief Officer (Healthwatch Southend) and Chief Executive Officer (SAVS) (no papers)

7 **Ageing, Living and Caring Well Strategy End of Year Report** (Pages 33 - 58)
Report of Head of Adult Strategic Commissioning

8 **Annual Public Health Report** (Pages 59 - 110)
Report of Director of Public Health

9 **Children and Young People - Core20Plus Update**
Presentation from Director, SEE Alliance and Director of Strategic Partnerships

10 **A Better Start Southend Update** (Pages 111 - 124)
Joint report of ABSS Director and Chair

******** **ITEMS FOR INFORMATION**

11 **LeDeR Annual/end of year Report** (Pages 125 - 188)
Report of Director of Public Health

12 **Better Care Fund Submission 2023/24** (Pages 189 - 268)
Report of Lead Commissioner (Older Adults)

13 **Area SEND Inspection and Area Strategic Plan**
Report of Director Education, Inclusion and Early Years (to follow)

SOUTHEND-ON-SEA CITY COUNCIL

Meeting of Health & Wellbeing Board

Date: Thursday, 15th June, 2023
Place: Council Chamber - Civic Suite

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Present: Councillor J Moyies (Chair)
Councillors H Boyd, M Davidson, M Sadza, A Jones
M Harvey, M Marks, R Polkinghorne, K Ramkhelawon, O Richards, C McCarron, L Gale, H Patel, A Khaldi and T Poore.

In Attendance: R Harris and J Budd.

Start/End Time: 5.00 pm - 6.25 pm

1 Apologies for Absence

Apologies for absence were received from Councillor Mulroney (no substitute), A Quinn, A Pike and J Banks.

2 Declarations of Interest

There were no declarations of interest at this meeting.

3 Minutes of the Meeting held on Monday, 6 March 2023

Resolved:

That the Minutes of the Meeting held on Monday, 6th March 2023, be confirmed as a correct record.

4 Public Questions

There were no questions from the public at this meeting.

5 Southend Drugs and Alcohol Strategy 2023 - 2025: Our collective priorities for delivering the Governments 10 year drugs strategy

The Board considered a joint report of the Director of Commissioning and Director of Public Health presenting an update on the development and implementation of the Southend Drugs and Alcohol Strategy, as well as the proposed governance and decision-making arrangements for 2023/24.

The Board asked questions which were responded to by officers.

Resolved:

1. That the Southend Drugs and Alcohol Strategy 2023-2025, be approved.

2. That the proposed governance arrangements, as put forward by the Southend, Essex and Thurrock Drugs and Alcohol Partnership, as set out in the submitted report, be approved.

3. That the local priorities as set out in the report, be noted.

6 A Better Start Southend Update

The Board considered a report of the Independent Chair, A Better Start Southend, presenting an update on key developments since the last meeting.

The Board asked questions which were responded to by the ABSS Chair and Director.

Resolved:

1. That the submitted report be noted.

2. That it be noted that A Better Start Southend has set its Core Strategy key priorities for the final phase of the programme.

7 Health Inequalities programme for 2022/23 and 2023/24

The Board received a presentation providing an update on the work of South East Essex Alliance to narrow the gap in health and care inequalities and covered a range of funded projects and the next steps.

The Board asked questions which were responded to by the Deputy Director, SEE Alliance.

Resolved:

That the presentation updating on the actions being taken by SEE Alliance to narrow the gap in health and care inequalities, be noted.

8 NHS Mid and South Essex Joint Forward Plan

The Board considered a report of the Director of Strategic Partnerships, Mid and South Essex, presenting the draft five-year Joint Forward Plan for Mid and South Essex.

The Board asked questions which were responded to by the Deputy Director, SEE Alliance. The Board commented on some of the system wide challenges that need to be addressed which included access to GPs and digital exclusion.

The Board also discussed the alignment of resources across the whole health and care system and the need to align and use common language across the partnership.

Resolved:

That the draft Joint Forward Plan (JFP) produced by Mid and South Essex ICB, be acknowledged and that the Chair, on behalf of the Board, formally writes to

SEE Alliance confirming that the JFP appropriately takes into account and aligns with the strategies and priorities of the Southend Health and Wellbeing Board.

9 Health Protection Updates

The Board received a verbal update from the Director of Public Health concerning the health protection response.

The Board noted that Covid was not a significant concern in Southend and that quarterly updates would be provided to the Board going forward.

Resolved:

That the verbal update on health protection, be noted.

Chair: _____

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Item No.

5

Southend Health & Wellbeing Board

Report of the Director of Commissioning

To

Health & Wellbeing Board

On

6th September 2023

Report prepared by:
Richard Watson, Deputy Chief Executive and Director of Strategy and Transformation (Essex County Council)
Alastair Mitchell-Baker, (Tricordant)

Presented by:
Tracey Schneider Head of Adult Strategic Commissioning

For information only		For discussion		Approval required	

Southend Essex and Thurrock Mental Health Strategy

Title
Southend Essex and Thurrock Mental Health Strategy
Lead Director
Richard Watson, Deputy Chief Executive and Director of Strategy and Transformation
Author(s)
Richard Watson, Deputy Chief Executive and Director of Strategy and Transformation Alastair Mitchell-Baker, Tricordant
Purpose
To provide an update on the development of Southend Essex and Thurrock Mental Health Strategy from 2023 to 2028 for SNEE ICB.
Recommendation:
To endorse the draft strategy which has been developed collaboratively with partners and is consistent with our Integrated Care Partnership Strategy and Joint Forward Plan, and to support the establishment of a Strategy Implementation Group to support and coordinate collaborative working across partners to implement the strategy.

1. Background

Over the past 9 months we have worked with partners across Southend, Essex, and Thurrock (SET), supported by an external consultancy, Tricordant, to

- Understand the population needs around mental health informed by the Essex JSNA, national and local data and extensive engagement with local professionals, partners and service users.
- Respond to the identified needs within the context of national policy and local ICP strategies through developing a revised 'all age' strategy building on the 2017 version.
- Explore options for working together to support implementation of the strategy.
- Develop supporting enabler and implementation plans.

The core partners have included:

- North East Essex (part of Suffolk and North East Essex ICS) (NEE)
- West Essex (part of Hertfordshire and West Essex ICS) (WE)
- Mid and South Essex ICS (MSE)
- Southend City Council (SCC)
- Essex County Council (ECC)
- Thurrock Council (TC)
- Essex Partnership University NHS Foundation Trust (EPUT) – provider of adult services
- North East London NHS Foundation Trust (NELFT) – provider of children and young people's services

In addition, Essex Police (EP) have been engaged and are keen to be part of the arrangements established. A range of Voluntary, Community, Faith, and Social Enterprise (VCFSE) sector organisations have also been engaged in developing the strategy and will continue to be key partners in the next phase of implementation.

2. Southend Essex and Thurrock All-Age Mental Health Strategy

The strategy has been developed based on the population health needs analysis and building on previous work. It aims to co-ordinate the approach across the Southend Essex and Thurrock aligned with the local strategies produced by the three Integrated Care Partnerships, covering Mid and South Essex, North East Essex (part of the Suffolk and NEE ICS) and West Essex (part of the Hertfordshire and West Essex ICS). The three ICB Joint Forward Plans provide more detail around local service development.

The strategy is deliberately brief and lays out the 'all age' vision and principles we will work to and the outcomes to be achieved over the next five years, guided by a set of I-Statements. It is shown in summary form below.

3. Implementation

A significant challenge of the previous 2017 Strategy was not its content, much is still relevant, but its implementation. The complexity of the local socio-political geography and changing NHS landscape made a joined-up approach challenging. The impact of this complexity is a likely consideration of the current Essex Mental Health Independent Inquiry. In recognition of the complexity the 3 local NHS systems have previously commissioned a Mental Health Taskforce Review. This review process has helped to develop a more joined up approach across the 3 ICBs, which provides a good platform for further collaborative working across partners.

System partners have therefore been determined to develop effective mechanisms for ensuring implementation of the strategy whilst recognising most of the delivery will continue to be at local Place level with ICBs, Local authorities, providers, VCFSE and other partners working together with people with lived experience, typically in local Alliances.

Partners have developed proposals for a '**Southend, Essex and Thurrock All-Age MH Strategy Implementation Group**' (SIG) focussed on overseeing a limited range of key strategic issues around overall strategy delivery and SET system development with partners sharing leadership of individual workstreams as appropriate. It will build on the existing informal working arrangements established for oversight of the strategy development itself.

The SIG is a collective 'decision recommending body' of SROs and equivalent from the core statutory partners, together with people with lived experience. Formal decision making will continue to be in line with individual organisation's internal governance approvals.

The main functions for the group are proposed to be.

a) **Oversight and monitoring of overall SET All Age Mental Health Strategy delivery**, recognising subsidiarity at place level. 'Place' in this context means at least local authority level [ECC, SCC, TC] and also the 6 Alliances across SET, where NHS, local authority and VCSE partners work together.

b) **Delivering SET level outcomes for specialist services** [Eating Disorders, Peri-natal, Personality Disorder, and Bedded care including Inpatient beds and supported accommodation.]

c) **Coordination and alignment across key pathways including Crisis**, including admission and discharge planning, and with EoE MH Provider Collaborative, and between adult and CYP.

d) **Information sharing and learning with a focus on equity** including reporting at Place and SET level on demand, service capacity and performance, locality service models and transformation programmes, outcomes and funding.

e) **Coordination and alignment across key enabler areas** such as quality and safety, workforce, digital, public mental health, population health mgt, contracting, outcomes and performance metrics.

f) **Advising on decisions, system linkages and issues** which may be the responsibility of individual Places or organisations, but which can impact across SET. e.g. Substance Misuse, Crisis Concordat, Suicide Prevention, Safeguarding and Police MH Risk Assessment Groups and with Regional groups such as EoE Specialist MH Provider Collaborative.

g) **Facilitating alignment and simplification of system governance**. It is recognised there are a plethora of ad hoc groups which have been established in lieu of a coordinated and joined up approach across the SET system.

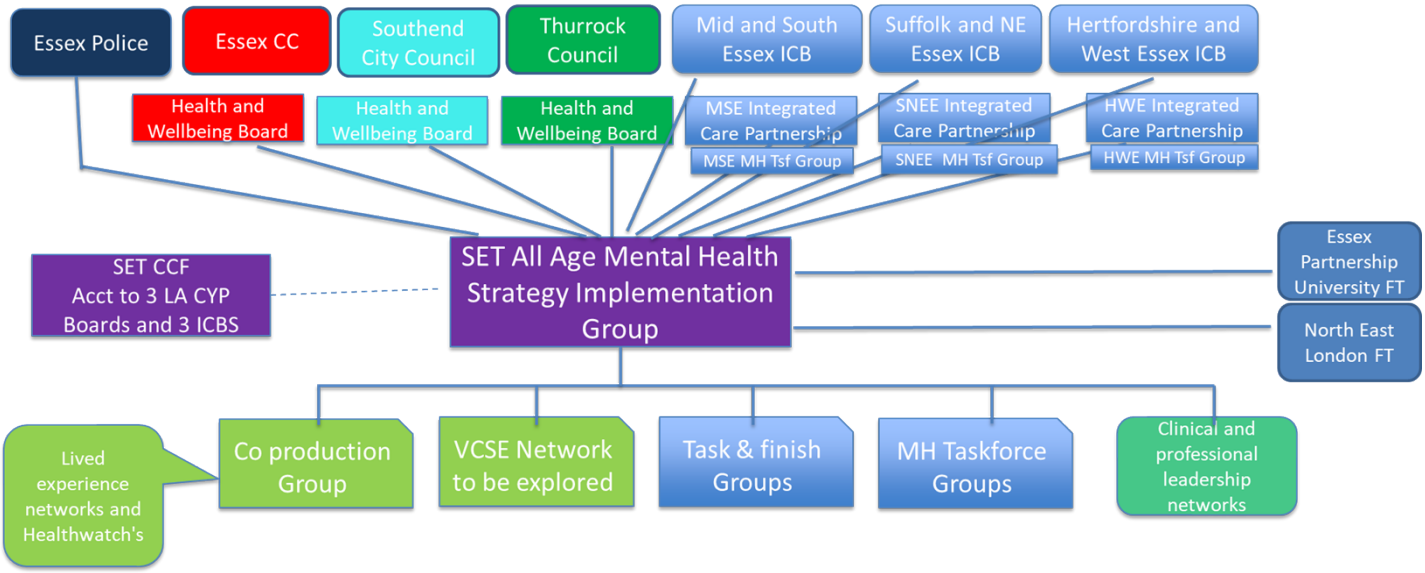
h) **Horizon scanning and sense making.** Identifying new and emerging issues and opportunities and facilitating agreement about how they are best addressed.

The SIG will work with a range of supporting groups, including many which exist already, including.

- The existing Collaborative Children's Forum which oversees a single contract for the commissioning of CYP mental health services
- Existing MH Taskforce groups adapted as required following a current external review process.
- New supporting groups, only where needed, which are likely to include:
    - Co-production – challenging and supporting the system to ensure co-production is embedded.

- Development of joined up approaches to key enablers such as finance, outcome and performance reporting, workforce and digital.
- Key areas where enhanced focus is needed such as embedding a holistic approach around transition.

The proposed governance of the SIG is shown below.



It has been agreed by partners that the SIG is hosted by Essex CC with support of a jointly funded 'Business Manager' who will coordinate agendas and officer co-working across partners. They will be supported by the growing number of jointly funded partnership roles working across ICBs, local authorities and providers. The initial chair is proposed to be the SNEE ICB Director of Strategy and Transformation, Richard Watson.

The working of the SIG will be formally reviewed after 6 to 9 months, and following publication of Essex Mental Health Independent Inquiry, to identify any changes required to its operation. This may include more formal development of its governance and working arrangements, including learning lessons from the development of local mental health system collaboratives in Suffolk and Hertfordshire.

4. Next steps

Once agreed by all partners,

a) The Southend, Essex and Thurrock All-Age MH Strategy will be published and shared with the public and partners.

b) The Southend, Essex and Thurrock All-Age MH Strategy Implementation Group' will be formally established and will develop a work programme and supporting working arrangements.

c) Regular (6 monthly?) reports on strategy Implementation progress will be produced by SIG for each partner.

5. Recommendation:

The Board are asked to endorse the Southend Essex and Thurrock All-Age Mental Health Strategy, recognising it has been the product of extensive engagement and input from across a diverse range of stakeholders and partners.

The Board are asked to agree and support the establishment of the Southend, Essex and Thurrock All-Age MH Strategy Implementation Group, recognising it has been the product of extensive engagement and discussion with partners.

The Board are asked to note it will receive regular updates on progress with implementation of the strategy and development of collaborative working arrangements.

Southend Essex and Thurrock

Mental Health Strategy

Suffolk and North East Essex
Integrated Care Partnership

Hertfordshire and
West Essex Integrated
Care System

Contents

Introduction

Health and care leaders across Southend, Essex, and Thurrock (SET) are working to further improve the lives of those who live with mental ill health. This brief and practical all-age strategy sets out the vision and principles we will work to and the outcomes to be achieved over the next five years.

Our vision is to promote good emotional and mental health for everyone, reduce health inequalities and to improve life outcomes for those with mental ill health, enabling them to recover and live well.

This strategy builds on previous work and aligns with the local strategies produced by the three Integrated Care Partnerships[1], covering:

- Mid and South Essex
- North East Essex (part of the Suffolk and NEE ICS[2])
- West Essex (part of the Hertfordshire and West Essex ICS).

[1] Integrated Care Partnerships (ICP) are a statutory committee jointly formed between the NHS Integrated Care Board (ICB) and all upper tier local authorities that fall within the Integrated Care Systems (ICS) area.
[2] Integrated Care Systems (ICS) are partnerships of organisations that come together to plan and deliver joined up health and care services to improve the lives of people who live and work in the area.

Southend, Essex, and Thurrock System Partners

Organisations from across a complex geography are working together in partnership and are committed to ongoing learning as part of the delivery of the strategy:

- North East Essex (NEE)
- West Essex (WE)
- Mid and South Essex ICS (MSE)
- Southend City Council (SCC)
- Essex County Council (ECC)
- Thurrock Council (TC)
- Essex Police (EP)
- Essex Partnership University NHS Foundation Trust (EPUT) – provider of adult services
- North East London NHS Foundation Trust (NELFT) – provider of children and young people's services

People who use mental health services, families, and carers with lived experience, and Voluntary, Community, and Social Enterprise (VCSE) sector organisations have also been engaged in developing the strategy and will continue to be key partners in delivering it.

Appendix 1 contains further detail of each of the individual geographies covering the Place based partnerships.

The vision and deliverables of this strategy

We have a clear vision for this strategy, and from working with groups of people with lived experience of mental ill health we have co-produced a list of ‘’What Matters to People’ which informs the outcomes to be delivered through the strategy.

Southend, Essex, and Thurrock Mental Health Strategy on a Page 2023-28

OUR VISION

To promote good emotional and mental health for everyone, reduce health inequalities and to improve life outcomes for those with mental ill health, enabling them to recover and live well.

KEY OUTCOMES

- Improved wellbeing levels across Southend, Essex and Thurrock population
- Reduced health inequalities
- Reduced premature mortality for people with serious mental illness

WHAT MATTERS TO PEOPLE

- I am treated with respect and dignity by services when I need support
- I have good emotional and mental health and am proactive in managing my physical and mental health
- I can easily access and identify the support I need to live well. I can do this in a timely way
- I have opportunities to engage in education, training, and/or meaningful employment
- I feel safe and supported
- I have somewhere suitable to live with access to community networks
- I am able to develop and maintain relationships that matter to me.

WHAT IS NEEDED

Adults, Children and Young People

- Have good mental health
- Are enabled to recover
- Are supported to maximise their potential in Education, Training and Employment,
- Can access social networks and feel a connection to their local community or the community they want to be part of
- Can live as independently as possible in accommodation that is suitable for their needs
- Are supported to determine and achieve their individual outcomes.

WHAT WE WILL ACTION

- Co-producing plans and services with people with lived experience
- Increasing joined up working
- Focus on the wider determinants of mental ill health – housing, education and employment not just clinical intervention
- Increasing all age holistic approaches including families
- Improving data and quality
- Reducing inequalities related to mental health
- Embedding trauma informed care
- Ensuring common standards across services
- Working more closely with voluntary, community, faith and social enterprise partners
- Supporting our staff and volunteers to work safely, effectively and sustainably
- Joined up and sustainable workforce planning
- Digital support to access services and for help with recovery

Prevention & Early Intervention

Acute & Crisis Services | Supporting Recovery

[Type text]

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PRIORITIES FOR THIS STRATEGY – Adults

Prevention & Early intervention

- Provide information and support on wellbeing and managing risks to mental health to help people to maintain good mental and physical health. This could be from non-clinical voluntary services as well as formal services.
- Ensure people have access to local community-based support for their mental health throughout their lives. This should include integrated therapies, especially for people who have complex needs and/ or are particularly vulnerable.
- Ensure people with severe mental illness receive a full annual health check and follow-up interventions
- Improve access to adult eating disorder services
- Increase access to specialist perinatal mental health care for all new and expectant mothers
- Review mental health support for older people recognising the need to support carers, and the impact of social isolation and loneliness
- Improve coordination of support for people through key life transitions especially for 18-25 year olds.
- Embed a 'think family' approach to consider and support the needs of a whole family around a person

Acute and Crisis Services

- Improve pathways and access to community-based support during a mental health crisis to avoid escalation and/ or inpatient admission.
- Ensure prompt access to good quality first response care in an emergency that includes mental health assessment and support
- Improve safety of mental health inpatient environments
- Reduce hospital admissions for mental health conditions, including emergency admissions for self-harm, through improved community support
- Reduce time spent in inappropriate out of area placements by adults needing non-specialist mental health inpatient care

Supporting recovery

- Improve access to effective Talking Therapies for everyone who needs support
- Improve access to integrated, holistic and recovery-focused mental health support for adults with severe mental illness
- Develop supported accommodation in the community to support timely discharge from hospital settings
- Improve and embed integrated pathways to access housing, education, employment, self directed support and skills, particularly for people severe mental illness
- Work with local employers and partners to develop suitable opportunities and roles for people with severe mental illness

Priorities for this Strategy – Children and Young People

Prevention & Early intervention

- Improve access to wellbeing advice and support in communities and schools
- Improve access to FREED (first episode rapid early intervention for eating disorders) and for ARFID (Avoidant restrictive food intake disorder)
- Improve access to trauma informed services through communities or schools
- Improve access to infant mental health services
- Increase access to CAMHS (Children and Adolescent Mental Health Services).
- Increase access to health and justice mental health provision
- Increase provision of mental health in schools teams across Essex
- Continue expansion of non-clinical services to support prevention and a wider determinant of health approach to children, young people, and their families/carers
- Embed a 'think family' approach to consider and support the needs of a whole family around a child
- Develop digital support for children and young people's mental health
- Develop mental health workers in primary care

Acute and Crisis Services

- Improve access to intensive support in the community
- Improve access to the crisis team from hospital or home
- Ensure 24/7 access to crisis care and support and continue to develop these services
- Reduce hospital admissions, especially for those with mental health and learning disabilities/autism
- Reduce length of stays (where appropriate) for inpatients
- Integrate mental health services for children and young people with acute trusts
- Reduce hospital admissions for self-harm by rolling out the self-harm tool kit to schools and other settings
- Expand of the community mental health and CYP learning disability and neurodevelopment team
- Mobilise at risk mental health state (ARMS) teams

Supporting recovery

- Increase access and choice of support and treatment options for young people
- Increase pathways to support the Young Adults 18-25 Transition
- Increase 'step down' services from more intensive to less intensive support
- Improve access to home feeding support teams for eating disorders
- Improve integrated pathways to access education, training, and employment
- Increase access to digital support
- Increase non-clinical support for recovery programmes
- Support children to stay with their families whilst receiving services so that less children with mental health needs entering the care system

How we have developed this strategy

To develop the strategy, we commissioned external consultants (Tricordant) who worked with a steering group of system leaders. Tricordant interviewed the leaders and held two system-wide workshops to obtain a clear sense of direction for the strategy.

Conversations were held with over 100 individuals, groups or organisations representing those with lived experience. This included Mind and Healthwatch, as well as smaller and more locally based organisations such as Trustlinks and Southend Association of Voluntary Services (SAVS) through to very specific groups such as those representing Bangladeshi women and African men.

The Tricordant team included experts by experience. A consultant psychiatrist and an executive mental health nurse carried out research into the specific population needs by working with public health colleagues and local clinicians and professionals and by using data from the local Mental Health Joint Strategic Needs Assessment (JSNA) and key national and local data sources.

Why do we need this strategy?

Societal and Economic cost of mental illness

Poor mental health has a huge impact on the overall health and wellbeing of people and is increasing. Suicide is the leading cause of death for men under 50 with 75% of all suicides being men[3]. Suicide in women aged 24 or under in 2021 saw the largest increase since ONS began recording them in 1981[4]. Depression is now the third most common cause of disability[5]. 1 in 4 people will have mental health challenges at some point in their lives[6].

Poor mental health can impact on schooling and educational attainment, ability to work and stay in work, quality of relationships and experiences of ageing. Half of mental ill health starts by age 15 and 75% develops by age 18[7].

The economic cost of mental ill health is estimated to be approximately £100 billion for the UK [8] which suggests it is around £3.2 billion for Southend, Essex, and Thurrock. 72% of the economic cost is considered to be from lost productivity due to absence from work. The 15-49 age group accounts for 56% of the economic cost and the 50-69 group at 27%. Within Southend, Essex, and Thurrock approximately £400

[3] NHSE Tackling the root cause of suicide https://www.england.nhs.uk/blog/tackling-the-root-causes-of-suicide/
[4] https://mentalhealthinnovations.org/news-and-information/latest-news/ons-report-shows-alarming-rise-in-suicide-rates-among-young-women.
[5] https://www.who.int/news-room/fact-sheets/detail/depression
[6] https://www.mind.org.uk/information-support/types-of-mental-health-problems/statistics-and-facts-about-mental-health/how-common-are-mental-health-problems/
[7] https://mhfaengland.org/mhfa-centre/research-and-evaluation/mental-health-statistics/
[8] https://www.lse.ac.uk/News/Latest-news-from-LSE/2022/c-Mar-22/

million is spent each year by the NHS, Local Authorities, and Police on emotional wellbeing and mental health.

Population needs

Our engagement and research has identified the following key challenges for Southend, Essex, and Thurrock.[9] ICP strategies include more detailed information for their local populations. Many of these facts are not unique to this area and impact much of the UK.

- **Large and growing demand**
  - The number of adults with common (mild and moderate) mental health problems in the population is approximately 1 in 6
  - 1 in 6 children and young people (CYP) also have mental health problems, an increase from 1 in 9 only 5 years ago[10]
  - There is a smaller, but growing, number of people with severe mental ill health causing significant ongoing impact on their daily lives
  - Current services, particularly for adults, do not appear to match population needs and current or predicted demand
  - There has been a significant deterioration in mental health and wellbeing through Covid 19 and the impact is anticipated to be ongoing
  - Mental health services are experiencing unprecedented demand with a 76% increase in new referrals in February 2022 compared to the same month in 2020, which led to approximately 5% more total mental health contacts in that same period. Children and young people contacts increased by 16% during the same period
  - Mental ill health has a strong correlation with deprivation and the cost-of-living pressure is expected to add to challenges for those living in deprivation and increase the number who will suffer anxiety and depression.
  - The older population in Southend, Essex and Thurrock is expected to increase by 32,000 people by 2027. National data indicates that 1 in 4 are likely to be affected by depression and only an estimated 15% will receive NHS help[11]
- **Demand presents across the whole system,** not just specialist mental health providers. It significantly impacts

[9] Unless stated data is drawn from the accompanying document 'Mental Health– Population Health Needs in Southend, Essex and Thurrock' or from https://mhfaengland.org/mhfa-centre/research-and-evaluation/mental-health-statistics/.

[10] https://www.youngminds.org.uk/about-us/media-centre/mental-health-statistics

[11] https://www.mentalhealth.org.uk/explore-mental-health/mental-health-statistics/older-people-statistics

Primary Care, A&E departments, and the Police amongst others

  - It is estimated nationally that 40% of GP appointments are for mental health related issues
  - 15-25% of all incidents Essex Police responds to involve mental health[12]

- **Physical and mental health challenges** are often linked with both experienced by many people
- **Complexity through multiple conditions is common** among individuals with mental illness including links with learning disabilities, substance misuse, offending and social exclusion
- **Certain groups are disproportionately affected** by mental health issues as these can be made more complex by the interaction of different categories of social identity. For example, people from different genders or ethnic groups, LGBTQ+ people, travellers, young adults, older people, and people living in poverty, may receive **inequitable service provision and care.** This can be perpetuated by the inaccessibility of services e.g., for people with low levels of literacy or where English is not the first language or for other cultural reasons
  - Many people find it difficult to access mental health services via their GP
- **Inequality and service variation**
  - The prevalence of common mental health problems varies across Southend, Essex, and Thurrock
  - There is also significant variation in premature mortality in people with severe mental illness
  - Provision varies across areas even when levels of deprivation and resources are accounted for
  - Many people with mental health needs from London Boroughs are placed in Southend, which increases demand.
- Between a quarter to a half of adult mental illness may be **preventable with appropriate interventions in childhood and adolescence**
- Only half of adults in contact with specialist mental health services are in stable and **appropriate accommodation**.
- People in contact with specialist mental health services have a 73% lower **employment** rate than the general population. T

Across Southend, Essex, and Thurrock there are significant local mental health challenges, for example[13]:

- Southend has high rates of common and severe mental health
- Tendring has challenges around mental and behavioural disorders, admissions for self-harm, and suicide

[12] Mental Ill Health Problem Profile 2022, Essex Police

[13] Based on various sources quoted in the Joint Strategic Needs Analysis

- Thurrock has increasing numbers of children with social, emotional, and mental health needs, and high premature mortality for people with severe mental illness

Taking these community needs into consideration is key. This strategy aims to ensure that need drives provision and provision meets need. We want to have the right provision in the right place for every citizen across Southend, Essex, and Thurrock who requires support and care for their mental health.

National Policy Drivers

In implementing this strategy, we will ensure we meet the specific requirements of relevant national strategies whilst delivering the needs of the local population.

The government Department of Health and Social Care are due to publish a Major Conditions Strategy during 2023. This strategy will tackle the conditions that contribute most to the burden of disease in England, including mental ill health, and the increasing number of people living with multiple conditions. This joined-up strategy will ensure that mental ill health is considered alongside physical health conditions. A separate national suicide prevention strategy will also be produced during 2023.

Several other national initiatives are under way such as:

- reform of the Mental Health Act
- reform of Care Programme Approach (CPA), a package of care for people with mental health problems
- Adult Social Care reform, including charging reform
- refresh of the Triangle of Care, a best practice guide that includes and recognises carers as partners in care
- Levelling Up, the government agenda to improve opportunities for everyone across the UK

All of these initiatives will help contribute to the success of this strategy.

Views from Lived Experience

To develop this strategy, we have listened to individuals and groups with lived experience. We have heard some consistent key themes about what people want:

Availability of services

- More clarity and consistency regarding referral pathways to avoid re-referrals or people falling through the gaps
- Shorter waiting lists, especially for children and young people
- Increased provision of personality disorder services
- More resources directed to early intervention and prevention services
- Improved access to primary care services, including in-person GP appointments

Person centred care

- Less need for people to repeat their stories
- More continuity of care and improved communication, especially for those on waiting lists
- Better care coordination and sharing of information, particularly across organisational boundaries and fragmented services
- More choice regarding therapy and treatments, for example where people would prefer to be referred to voluntary, community, and social enterprise providers (VCSE)
- Better listening to understand and tailor care to meet individual need
- Greater engagement with families and carers as partners in care.

Inequalities and inequities

- More accessible and inclusive services that can meet a range of needs
- Less stigma around mental illness across health, care, and public services
- A more consistent base level-standard to reduce disparities between services across Southend, Essex, and Thurrock.
- Greater engagement with people from ethnic and minority communities
- More meaningful involvement and co-production opportunities to strengthen the voice of lived experience
- Better support for transitions of care, particularly between young people and adult services, and inpatient and community services.

Stories of improvement

Whilst we heard many concerns from those with lived experience we did also hear about good experiences, services, and initiatives that we can continue to build on. A few examples of these are:

- Social prescribing link workers in Southend and the Friends for Lives suicide intervention and prevention service
- The children and young people mental health support team in schools in West Essex and the partnership with EPUT to provide seven mental health coaches integrated with Primary Care Networks (PCNs)
- Projects such as the Trust Links Growing Together project, the Colchester based Bangladeshi Women's Association and the Crisis Café in North East Essex, which all provide additional mental health support including out of hours
- Initiatives by Mind in Mid and South East Essex, such as 'Somewhere to Turn' and their supported housing solutions that give people greater independence

- Integrated PCN mental health teams in Thurrock that have multidisciplinary working and psychiatrists running clinics within surgeries. They are also changing their use of language, such as using the term ‘transfers’ instead of ‘discharge’ to reduce people’s fear of losing a service.

Moving forward from previous strategy

Many aspects of the previous 2017-21 SET mental health strategy are still relevant, and implementation continues. Despite some of the great work that has happened across the system during challenging times, many people's interactions with, or ability to access health and care services can still be difficult. Many people report that they are not seeing benefits from the changes and investment in services.

Whilst recognising the difficulties of the previous few years it is important to also acknowledge the areas of success. Examples include:

- An enhanced emotional wellbeing offer for children and young people
- New adult urgent care pathways including mental health facilities at emergency departments
- An improved community offer for adults, including support to primary care
- Enhanced community support for people with personality disorders
- Extended employment support to prevent people losing their jobs
- Integration of physical and mental health community services in West Essex to better meet the needs of older people, in particular those with multiple long-term conditions
- Improved culture of learning and improvement within mental health services

Specific focus on Children and Young People

This is an all-age strategy which also covers children and young people; however, it is important to stress our specific areas of focus for this important group. These are:

- Eating Disorder Services
- Crisis Services
- MH Services and Acute Trusts- improving integration
- Mental Health Support Teams working with Education
- Access and Outcomes
- Use of digital technology
- Young Adults 18-25 transition
- CYP specialist workforce

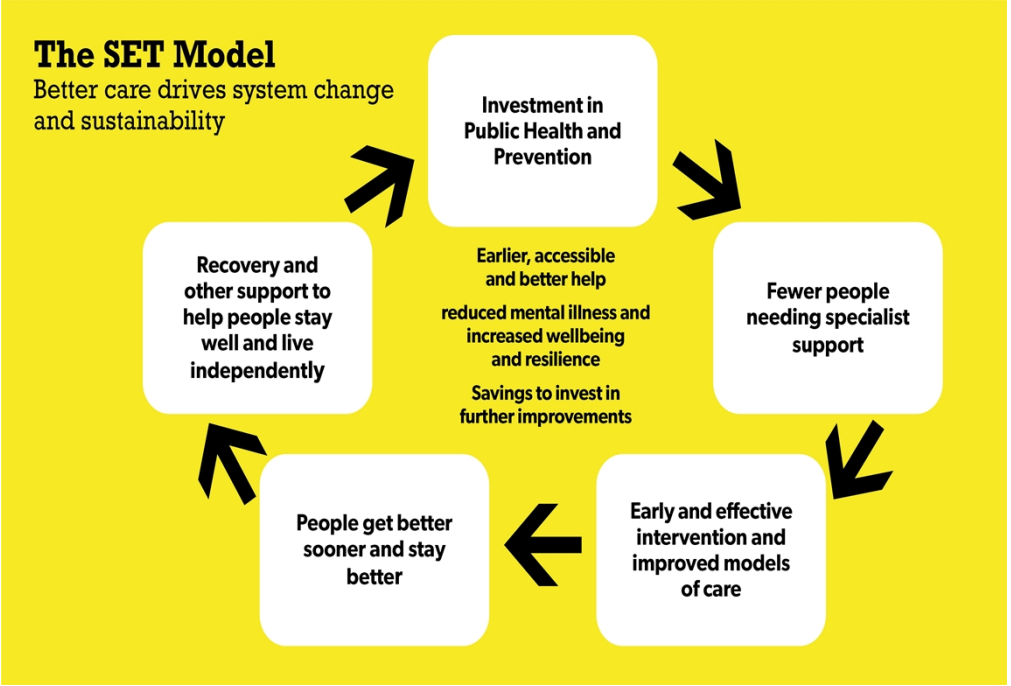
Across Southend, Essex, and Thurrock we will also be working together to support children and young people to manage risks such as the potential for online harm and use of harmful behaviours. This helps enable them to be supported

in the community by preventing need for admission into care or hospital.

There is an annually updated local transformation plan for Children and Young People in place which supports this strategy.

Developing our local model: better care drives system change and sustainability

The diagram below summarises the strategic approach for Southend, Essex, and Thurrock which seeks to further improve our approach to prevention, early intervention, and community support within the context of the wider determinants of mental health, to reduce the need for hospitalised care.



Focussing on the wider determinants of mental health

Wellbeing and mental health challenges affect all of us. Everyone seeks to maintain their own emotional and mental health and support those around us. This is not always easy or possible, especially if there is a background of trauma. When people experience deterioration in their emotional and mental health, this causes distress and can lead to crisis. In our services we want to work with people to understand and address the root of the 'triggers' for deterioration in their

emotional and mental health as well as helping them respond to the symptoms.

It is widely accepted that clinical care only contributes to 20% of the impact on people's general health outcomes. Social and economic factors have double that impact, and in mental health we know that disadvantage and discrimination have a disproportionate impact. We want to work together with communities to develop their capacity to be supportive, inclusive, resilient, and emotionally healthy places for children, young people, and adults.

Whilst the clinical services provided by the NHS have a vital part to play, the role of local authorities and local VCSE organisations and networks is also critical for influencing the factors which support people's mental health.

Local authorities have duties under the Care Act and Children's' Act to promote the wellbeing of individuals and to provide services which help to prevent, reduce, or delay peoples' needs developing, including the impacts on children of adverse childhood experiences. We plan to strengthen our work with families, carers, and schools to improve emotional wellbeing and prevent long term mental ill health in children and young people. Through this strategy we are also committed to further strengthening support for older people.

We are focused on ensuring equity of service provision across the Southend, Essex, and Thurrock geography to improve outcomes for people of all ages in all our communities. We are working together at both the larger geography and local levels to plan and further improve services at the right population level.

Each of the three ICPs have been developing their strategies, with a key leadership role for local authorities in leading, commissioning and coordinating wellbeing, prevention, and community mental health services. There is an active programme of public mental health across SET which aims to develop a prevention strategy to reduce the risk of mental ill health and the need for specialist support. This also links to local approaches to service transformation, Levelling Up and improving Population Health.

Early and effective help and support

Where people do become unwell and need support, this model and the priority areas we have outlined in the strategy will help ensure people can easily access the treatment they need when and where they need it.

Focusing on recovery

Local Authorities have a role in empowering people who have mental illness, as well as their unpaid carers, and wider communities. They enable people to lead fulfilling and independent lives by providing information, advice, advocacy and offering practical support with everyday activities including for example housing, employment, finance and debt advice, direct payments, and technology. We recognise that recovery is enabled as people grow their ability to access a

life with purpose, meaning and a voice. It is more than just the absence of symptoms.

We want to make sure people have the right place to live and can access meaningful activity such as education and employment whilst they are in recovery. A new supported accommodation model is working to help ensure more people live in stable and appropriate accommodation, and there is also work underway to improve support to enter and stay in employment.

Suicide Prevention

The Southend, Essex and Thurrock Suicide Prevention Board strategy and delivery plans will align to support the ambition of this Mental Health strategy and associated plans. The Board has an all-age approach to preventing suicide which is underpinned by the priorities agreed within the national suicide prevention strategy.

Workforce

The organisations working in the SET mental health system face significant workforce pressures. Recruitment and retention are difficult and there are high vacancy and turnover rates; this is a national situation and not just local to Southend, Essex, and Thurrock. The shortage of staff places pressure on our workforce and could limit achievement of our strategic objectives if not quickly addressed.
To overcome this, we are working to reimagine what the workforce could look like and implement new workforce models. Our desire to move care into the community where appropriate, rather than using inpatient facilities, will ease pressure on the inpatient workforce and create the opportunity for different job roles in the community.

We want to create exciting employment opportunities for the workforce to develop new or existing careers within the Southend, Essex, and Thurrock geography. This will include improving support for the wider social care and VCSE workforce within the mental health system and creating positive cultures and working experiences for all of our workforce.

Digital Technology

Digital technology is a key enabler to support people within a joined up mental health care system. During the life of this strategy, we will develop digital technology for staff to share information more easily and for people with mental health needs to access more services online.

We are aware that digital technology is not easy to use for everyone and will work to support digital inclusion and provide alternative options for people using services.

Implementation and monitoring achievement

A plan is being developed to implement the strategy, which will be overseen by a Strategy Implementation Group of senior leaders across the SET mental health and care system. Most of the implementation will be led by partners working in their local places.

There will be clear responsibility and accountability across the system for improving individual outcomes, creating the conditions for promoting good mental health, and delivering services where needed. We will publish information on how partners will work together across the system and the governance arrangements through which decisions will be made. This will include links to other key workstreams such as suicide prevention, and overarching governance boards at Alliances[14], Local Authorities, ICSs and Health and Wellbeing Boards.

An outcomes framework and key performance indicators (KPIs) will be made available with regular ongoing reporting to demonstrate the status of the work and progress achieved to implement the strategy. Measures will include the reported experiences and perceptions from those with lived experience and will be made publicly available.

To measure performance improvement, we will use the financial year 2020-2021 as our baseline, except for where a specific national or local target is already in place.

A key challenge is to ensure that the work to implement this strategy is coproduced with support and input from those with lived experience. This involvement should be genuine and give equal voice to people who traditionally may not have been involved, especially those from ethnic and minority communities. System leaders are working with local lived experience networks to agree the best ways to ensure their meaningful involvement to develop new collaborative decision-making arrangements.

This is an important strategy for the people of Southend, Essex, and Thurrock. The leaders of the local authorities and NHS are determined to make it work and deliver improved prevention and early intervention, as well as high quality care, support, and treatment for those living with mental ill health. Success will come from working together to address the wider determinants of emotional and mental health and reduce the impact of mental ill health.

[14] See appendix 9. There are 6 Alliances across SET, made up of NHS, Local Authority and VCFSE partners focussed on a place covered by a unitary authority and/or district council. These are Thurrock, South East Essex which includes Southend City, Basildon & Brentwood, Mid Essex, West Essex and North East Essex.

Appendix

Local Geographies

West Essex: Population 319,000
Hertfordshire and West Essex ICB works with Essex County Council (ECC) and the 3 District Councils of Epping Forrest, Harlow and Uttlesford, in the West Essex Health and Care Partnership. The partnership has focussed on joining up community mental health services with physical community health services, integrated around primary care.

North East Essex: Population 341,000
Suffolk and North East Essex ICB works with ECC and the 2 Borough/District Councils of Colchester and Tendring in the North East Essex Health and Wellbeing Alliance which is a collaboration of commissioners, providers and other system partners working together to transform the health and wellbeing of the population of North East Essex as an integrated system. Their approach is for everyone at all stages of their life to be able to Live Well, so they work towards outcomes using the 6 domains of the Live Well mode including 'Feel Well; Supporting mental wellbeing' and 'Be Well; Empowering adults to make healthy lifestyle choices.'

Mid Essex: Population 402,000
Mid and South Essex ICB also work with ECC and the 3 Borough/District Councils of Chelmsford, Braintree, and Maldon, in the local NHS Alliance which covers Mid Essex. Existing areas of focus for the Mid Essex Alliance includes suicide prevention.

Southend City Council: Population 183,000
Southend City Council, and Mid and South Essex ICB are the statutory commissioners of mental health services for Southend. The Council's social care vision is to work collaboratively with people to enable them to live safe, well and independently in the community, connected to the people and things they love. This is outlined in **3 key strategies around Living Well, Caring Well and Ageing Well**. Through a strengths-based focus, there is a drive to transform care and support to ensure that there are flexible options that enable independence. In particular, local partners are working together to address the disproportionate number of people in residential care, often placed by London Boroughs.

Thurrock: Population 178,000
Thurrock is a unitary authority area with borough status. It is part of the London commuter belt and an area of regeneration within the Thames Gateway redevelopment zone. The local authority, Thurrock Council, and Mid and South Essex ICB are the statutory commissioners of mental health services and are implementing an ambitious local strategy, Better Care Together Thurrock, developed by local partners through the Thurrock Integrated Care Alliance (TICA). The strategy sets out Thurrock's collective plans to transform, improve and integrate health, care and third sector services for adults and older people, to improve their wellbeing.

Key aspects relevant to this strategy include:

- Human learning Systems as the core guiding approach
- Strengths and assets-based approach to community engagement and development,
- Co-production with residents and communities to develop radically new models of care
- Integrating and transforming community mental health services with General Practice in the context of Primary Care Networks and a wider integrated housing, care and wellbeing workforce
- Transformation in local community mental health services has already begun to see significant reductions in access times and improved quality, and an enhanced focus on recovery
- Focusing on proactive and preventative care using Population Health Management.

Basildon & Brentwood: Population 264,000
Mid and South Essex ICB also work with ECC and the 2 District Councils of Basildon Point and Brentwood in the local NHS Alliance which covers Basildon & Brentwood. The Basildon and Brentwood Alliance is committed to:

- Understanding and working with communities
- Joining up and co-ordinating services around people's needs
- Addressing non-medical factors that affect the health and wellbeing of local people
- Supporting quality and sustainability of local services

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Adult Social Care Strategies Annual Report
April 2022 – March 2023

Caring Well / Living Well / Ageing Well

Author: Strategic Commissioning Team
Version: Version 3
Review / Revision Date: August 2023

CONTENTS

1. Background

Transforming Care and Support

The council's overall direction for adult social care is built on three core strategies named 'Ageing Well', 'Caring Well', and 'Living Well', setting out priorities over the next five years. The three strategies were co-designed with people who use services and their friends and families. They focus on how the council will support people across the city, whether they are older people, those with a care and support need with learning disabilities, mental health challenges, autism, living with additional physical or sensory difficulty, or the friends and family of people with additional needs.

We have annual action plans to move forward the delivery of each strategy and take us to where we want to be by 2027. Partnership groups have been formed to manage the development, delivery, and monitoring of the yearly action plans for each strategy. These will build on the work of the previous year and in reaction to emerging needs and trends.

All action plans contain a desire to further develop co-production and ensure links across services and other department plans and strategies to reduce duplication and make efficient use of available resources.

The first year of work has focused on understanding and aligning what is already in place across partners, providers and the city to ensure delivery of the strategies. Alongside this a focus on what needs to be developed has been crucial to ensure we are able to deliver on the second-year ambitions.

As a result of this approach the report will identify actions and developments undertaken but it may be to early to detail the outcomes achieved. This will be picked upon in subsequent year evaluations.

2. Common Priority Areas

2.1. Links to Other Priorities and Strategies

We aim to optimise resources and minimise duplication by collaborating with other health and local authority strategies and projects.

To achieve this, we have formed three partnership groups: Living Well, Caring Well, and Ageing Well. These groups consist of representatives from various sectors, including council, health, and service providers. The members of these partnership groups gather input and updates from different forums in Southend, Mid & South Essex, Greater Essex, and the wider region. This effective process ensures strong connections throughout the system.

2.2. Coproduction and Engagement Development

Across all Strategies and Partnership groups, there was a commitment to include local voices. To achieve this outcome, we aimed to produce:

- A test and learn coproduction framework.
- Your Say Southend pages for each strategy aiming to have residents involved and engaged, with feedback loops on progress made.

Residents have been attending engagement sessions across the three strategy themes, sharing their lived experience with our Coproduction Lead Officer.

Initially hesitant to be part of a more formal board structure, trust has been gradually building. Confidence in the process is developing with the desire that over time they will be happy to be part of more formal partnership groups.

Coproduction takes time and resources such as a dedicated Officer alongside a budget to hire facilities, provide refreshments and pay expenses. This includes recompense when residents spend large amounts of their time in workshops.

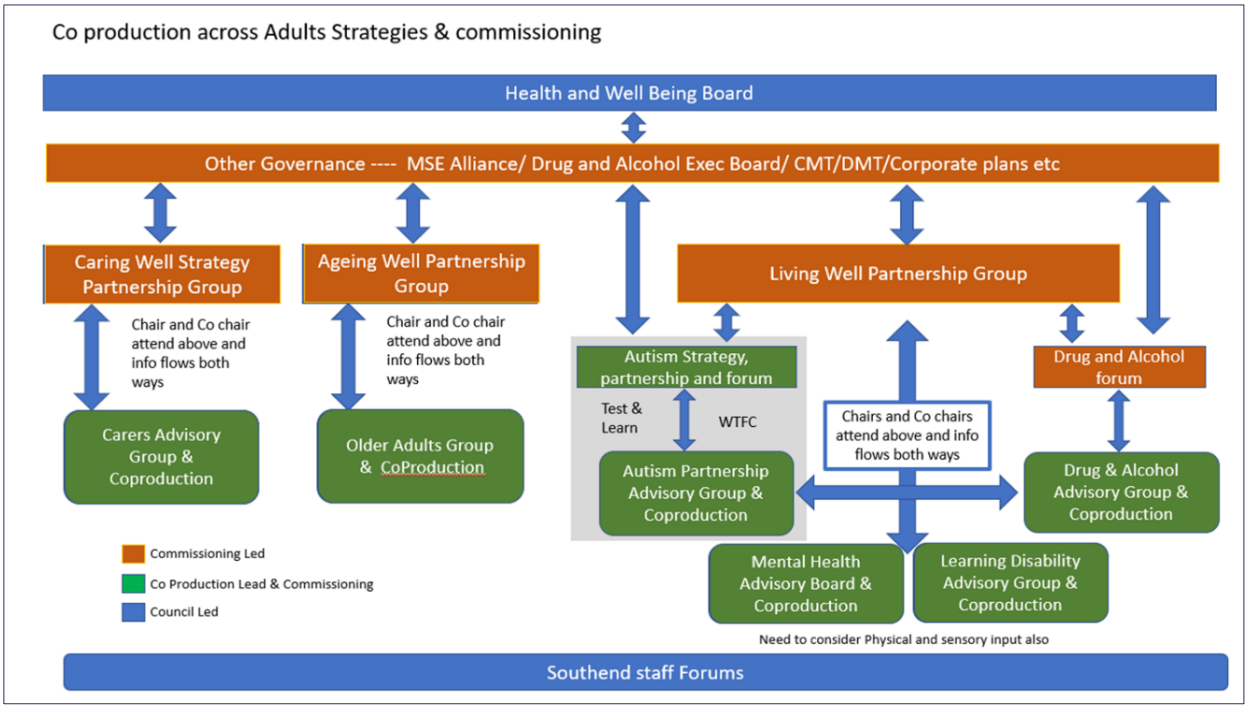
- A 12-month “test and learn” co-production framework is now in place.
- In 2022-2023 SCC appointed a Coproduction Lead (on an 18-month fixed term contract) to take forward this pathway work and embed this as business as usual going forward.
- Work has been undertaken to build trust and working relationships with various groups to gain interest for partnership group working and achieving the desire for resident led advisory boards feeding in and taking part in the strategy partnerships.
- The ‘Co-production Framework’ document was completed as a test and learn document. This will lead to the development of a full strategy, incorporating our learning, during the Summer of 2023.

The online engagement platform ‘Your Say Southend’ has launched which includes information of the strategy and plans in place for engagement tools such as Surveys to be used.

- The Ageing Well page is now live on the Your Say Southend, with the Ageing Well Survey open for consultation.

- The Living Well page is live on Your Say Southend, with the Living Well Survey open for consultation.
- The Caring Well Engagement Page is live on Your Say Southend providing information on the strategy.

These platforms will remain open as a means of online engagement for the duration of the strategies. Allowing a mixture of online engagement and consultation to go alongside the face-to-face sessions and coproduction to ensure we are inclusive and providing opportunities to all.



3. Caring Well

Our ‘Caring Well’ strategy is a joint strategy with health colleagues that focuses on the needs of unpaid carers, sometimes called ‘hidden carers’, which can be children or adults that find themselves in a position caring for a family member, partner or friend. These carers play a significant role in preventing the need for a more formal care provision, and the health and social care system relies on this unpaid support.

Priorities and action plans within this strategy focus on the priority areas of:

1. identifying, respecting and valuing carers
2. providing suitable information and support
3. developing carers voice, knowledge and understanding
4. assessing carers needs
5. maintaining carers balance by connecting with communities and being able to take a break
6. recognising health and wellbeing needs,
7. helping carers stay in, enter or return to work education or training (if appropriate)
8. being prepared for changes and encouraging integration and partnership working to meet people’s needs.

Priority Areas (Total 10)

3.1. Links to Other Priorities and Strategies, covered above as part of 2.1 (Page 3)

3.2. Coproduction and Engagement Development, covered above as part of 2.2 (Page 3)

3.3. Identifying, Respect and Valuing Carers

Identifying carers and encouraging them to come forward and to self-identify as a carer is an important step in preventing them from developing needs of their own and enabling them to remain safe and well.

A number of activities were undertaken and measured for effect, these focused on:

Increasing the number of registered carers:

- There has been an increase from 1,037 to 1,333 registered with Carers First.
- There has been an increase from 5,700 to over 7,000 registered with a GP.

Increase in Carers GP health check:

- There has been an increase from 15 in 2022 to 28 in 2023.
- Further work has been done on expanding health checks via other means, such as Carers Intensive Support and Everyone Health moving forward.

Increasing awareness of carers:

- The Southend Commissioned carers support contract under Carers First has improved awareness of carers support through hosting and attending events, eg presenting at Primary Care Networks across Southend, attending support groups monthly (Dementia group, SAVs), working with hospitals, linking in young people in their transition to adult team, whilst also maintaining regular attendance at weekly social care meetings.

Increased awareness of young carers:

- Carer awareness has been raised through the Young Carers Festival scheduled for June 2023 at YMCA Fairthorne Manor in Southampton. Funding has been secured for 13 young individuals to participate in the event. Additionally, other initiatives to enhance awareness include organising a 'Young Carers Action Day' and establishing a 'Young Carers Council'.

Carer feedback highlights the need for increased support in accessing health checks and mental health services. In the coming year (2023/2024), the focus will be on collaborating with GPs to create a 'Carers Welcome Pack' and ensuring widespread availability of communications to all agencies. This pack will cover support, awareness, registration with GPs, and referrals for health checks. Additionally, training will be provided for young carers.

To raise awareness about carers, health colleagues have been collaborating with Primary Care Network (PCN) coordinator roles to identify pilot programs.

Funding has been secured to expand the Carers Intensive Support (CIS) service, enabling the provision of health checks later this year. Priority for reviews will be given to carers aged 65 years and above.

3.4. Information and Support for Carers: Access to information

In the 2020 Southend-on-Sea Family Carers Survey, 44% of carers said they were not able to access the information, advice and guidance they needed to support them in their caring role.

To achieve this outcome, the actions set included:

Improving advice and guidance on discharge from hospital:

- Carers First working with Carers and health have developed a ‘Discharge Booklet’ for Southend Hospital. Between November 2022 to April 2023, Carers First had 109 Website views, and 73 pocket guide print requests and 9 people sign up to Carers First Newsletter and 112 Pocket guide downloads.

Young Carers access to information and advice:

- Carers First now has a whole family approach, supporting young carers to link in with the young carers service and supporting young carers with transition to Carers First offers at 17 years old.
- The council’s digital offer has been updated with mailboxes created for young carers to contact the council’s Young Carers Service (youngcarers@southend.gov.uk . The mailbox initially created as a contact us feature is now used for promotion and wide distribution. The mailbox acts as a central contact point for young carers and is also used by the friends and families of young carers to find out about services for young carers.

Live Well Platform review:

- The online offer for Live Well Southend was launched this summer. Carers services will form a part of this platform.

Updates to the council website and information for carers:

- A Review of adult social care website has led to identifying changes necessary to best inform carers. Plans are in place to update the website in summer 2023 working with the feedback from carers.

As the Discharge Booklet has been created with a view to be regularly updated, the action will now be closed and be replaced with a new action to raise awareness of the Discharge Booklet among professionals and carers.

All other actions under this outcome will remain as ongoing, with the focus on digital platforms and websites, to be ready for later this year.

3.5. Carers Voice Knowledge and Understanding

Many carers have told us they do not feel listened to and are often cut out of conversations between health and care professionals. We were also told that they needed help in navigating the systems and in developing their understanding and resilience.

To achieve this outcome, the actions set included*:*

Ensuring carers know what support they can access:

- All partners have been working with carers to increase registration. This has included helping carers access other support including advice on benefits (figures above 3.1).
- Carers have been actively participating in planning and reviewing their progress on their Star Assessments with Carers First.

Developing carers understanding and resilience:

- Increased and targeted peer support is being offered to carers through opportunities such as male carer peer support groups and drop-in sessions for carers to share their feedback and experiences.
- Dedicated young carers sessions have been organised to give young carers a voice and the opportunity to meet and speak with other peers.
- Essex Partnership University Trust health colleagues have also been organising Carers Health and Wellbeing drop-in sessions and young carers sessions.

Helping to measure carers progress:

- Carers First has assisted carers in completing Carers Star Assessments to gauge progress and identify areas where additional support is required. The overall feedback from carers has been positive, as they are able to track their advancements, improvements, and identify areas of increased pressure.

Ongoing partnership work will continue, to support and inform carers of opportunities in the community. Peer support and Star Assessments have been well received and this work will be continuing into the next year. These opportunities have allowed carers to receive targeted guidance on issues they have been facing – such as financial advice.

3.6. Assessing Carers Needs

The feedback from carers is that they do not understand what the carer's assessment is for, with many viewing it as an assessment of their finances or their ability to care for the person.

To achieve this outcome, the actions set included:

Providing carers information on carers assessments and the carers offer via the council website:

- Updated Southend Council webpage will be launching in 2023.
- Carers assessments can be shared across the LA and Carers First, reducing duplication and simplifying the information pathway to carers.

Assessing carers' needs through referrals, carers assessments and support mechanisms:

- Through a joint partnership with the Council, Carers First will be undertaking carer assessments from September 2023.
- Liaising with internal teams, care providers and stakeholders to understand carer's needs. Information sharing pathways have been developed through the Liquid Logic system.
- Young carer referral process has been improved, streamlined and actively operating in schools.

Ensuring carers are fully recognised and receive effective, appropriate support:

- Young carers are now supported in schools with training being offered to help identify issues they may be having.
- A Young Carer & Schools Award Programme has been introduced.
- A Young Carers Group new initiative has launched, with one school already up and running.

Future work will focus on the renewed website launch and the carers online offer. Plus increasing young carer awareness by sharing information on the referral pathway in the community and making training available to schools to identify young carers.

3.7. Maintaining Balance including connecting with communities, taking a break and Health and Wellbeing

From the 2011 census we know that carers have worse general health than those who do not provide care and that generally their health deteriorates the more hours of care they provide. Similarly, carers have told us that their role can often feel all-encompassing, meaning they lose their sense of self and are no longer able to do the things they used to do or continue with the relationships they once had.

To achieve this outcome, the actions set included:

Ensuring carers receive quality time to be themselves, able to consider their own health and wellbeing needs and increasing carers connection to the wider community:

- Promotion through Carers First of discounted days out for carers. This has included massage and wellbeing sessions, "Lighten the Load" (a campaign that supports carers financially) and a FREE SIM card campaign.
- Working with our SCC leisure teams 'Fusion Lifestyle' a reduced gym membership offer.
- Working with our culture teams a range of carer groups and activities now available – e.g., Theatre backstage tours and opportunities to attend sporting events (National Diving Competition).

Utilising Community Builders / Connectors to identify and support carers needs:

- Community Builders, working in specific Southend wards. Regular liaison with Southend Association of Voluntary Services (SAVS) and frequently meet local people with skills, interests, businesses.
- Promoting and signposting carers to the Your Say Southend Engagement page and relevant support / services.

Exploring digital and technological solutions to understand how this could help deliver care and provide support and reassurance to carers:

- Assistive Technology – new project underway investigating current care equipment and responder support.
- New digital technology research to identify potential equipment to aid in assuring carers.

Future work will focus on continuing the Community Builders relationships in the community to increase awareness and engagement with services. The Assistive Technology project recommendation paper is due for completion in Summer 2023 which we will work from with a carers focus.

3.8. Helping Carers

The carers we spoke to told us that whilst they recognised how important being active was for both their mental and physical health, it was just not a priority due the demands placed on them. Many carers also told us it was important to have something to keep them going and to help them maintain their personal identity. This could be work, volunteering, pursuing an interest, or anything that is not directly related to their caring role

To achieve this outcome, the actions set included:

Helping carers to stay in, enter or return to work:

- Building links with the employment sector though internal discussions with economic development and skill teams.
- Carers First – attending events to build recognition of carers and to help identify employment and training opportunities.

Reviewing existing services and identifying potential changes to provide carers with more time to access work, education and training:

- New Dementia Service offering a family carers education and support programme in Southend and Castle Point & Rochford (CPR) run by nurses.

Building links with employers and considering employment carer recognition:

- Carers First have attended Southend Business Partnership Breakfast event and also South Essex College Breakfast forum aimed at employers in the Care Sector.
- Carers First – Employer Friendly Booklet produced and shared with SCC. Also available to download by employers and carers.

Future work will focus on supporting carers to identify leisure and employment offers to improve their outcomes and assist with their care plans. Essex Partnership University Trust

(EPUT) colleagues will continue working on the Carers Education Programme and help employers better understand the responsibilities of carers.

3.9. Prepared for Changes

In the Southend-on-Sea Family Carers Survey 2020, 72% of carers said they did not feel prepared for changes in their caring role.

To achieve this outcome, the actions set included:

Contingency planning – raise awareness of how to plan for different stages in caring including a focus on young carers:

- 'End of Life' care knowledge – a session was hosted with the partnership group; attended by professionals across the council, voluntary sector, health and Providers in Southend to understand how 'End of Life' care can be provided.

Increase the number and quality of contingency and change plans:

- Carers First – over 200 carers have been supported to develop a contingency plan.

Ensure carers are better prepared for changes in the future, both for the carer and cared for:

- The Local Authority is working with Health colleagues to share contingency plans for carers across the system through shared data.
- 71 respite breaks, year to date for appointments provided through Carers First.

Future focus will be to increase the number of carers with contingency plans and create a standardised approach to completing a contingency plan. We will look to collaborate with GPs and Hospitals to share the plans with permission.

EPUT's Carers Intensive Support team (CIS) will continue to support carers with time limited interventions and to encourage more Health Checks.

3.10. Integration & Partnership

When we spoke to carers, they told us they found the health and social care system to be very complex and it was hard to understand the roles of the different councils and health systems.

To achieve this outcome, the actions set included:

Working to have better joined-up services with the Primary Care Network, GPs, and Community services:

- Increased collaborative working (SCC Youth Worker and Carers First), actively attending carer groups and presenting at local surgeries.
- Carers First in partnership working with social prescribers.

Have more aligned services and better co-working internally, with stakeholders and at the primary care network level:

- Communications taking place to set-up a Parent Carer Support Group which could be promoted to all registered families.

- Young carers actively advised about Southend Young Carers which will inform them of the additional services available to them - different activities available between different services.

Hold more conversations with carers and implement a more holistic approach to understand carer needs:

- Young carers team are working with Carers First to secure funding to set up a Parent Carer Support group and work together to refine signposting between organisations.
- Southend Targeted Youth Service – provide outreach and centre-based activities to support identified young carers aged between 5 to 25 including young adults with a disability.
- Carers First - carers directed to Legal & General Financial Services for a free 30-minute consultation to look at the financial and legal aspects of caring.

Identify and create “Champions” within departments across health and social care:

- Adult Social Care Social Work / Occupational Therapy Teams now have Champions in each team.
- Hospital teams also have champions identified and in place.

Future work will promote joint working between Health, Community groups, the council and Carers First to continue attendance at carers groups and surgeries. We will identify more Champions across organisations to support awareness. The Carers Assessment will continue to focus on supporting carers’ needs, to identify barriers and develop individual plans. The CIS team will continue to increase and record Health Checks on Health’s System1 database.

4. Living Well

The 'Living Well' strategy looks at the needs and wellbeing of adults of working age with additional needs such as physical, sensory, learning difficulties, mental health challenges and autism. Best practice has shown our residents living with these challenges would benefit from a person-centred approach to care, which supports them to live independently and be involved within their local community.

Priorities and action plans within this strategy focus on the priority areas of:

1. improving people's health and wellbeing promoting health lifestyles.
2. preventing the number of hospital and care home admissions.
3. developing suitable housing and principles of housing support.
4. delivering health, care, support, and housing in a more joined up way.
5. encouraging community inclusion and ensuring integrated person-centred services that enable people to take control of their care and focus on their strengths.

Priority Areas (Total 7)

4.1. Links to Other Priorities and Strategies, covered above as part of 2.1 (Page 3)
4.2. Coproduction and Engagement Development, covered above as part of 2.2 (Page 3)

4.3. Health & Wellbeing – Promoting healthy lifestyles for the adult population.

We need to recognise the importance of promoting healthy and actively lifestyles to Southend's adult population. Individuals with mental and physical health conditions have poorer health outcomes than the general population. They should be supported with services that promote good health and well-being.

To achieve this outcome, the actions set included:

We have already mentioned the carers Health Check work in section Caring Well Section 3.3. This section will focus on working age adults who are not carers.

Increase Health Checks for Learning Disabilities and Mental Health:

- Increase in uptakes of Health Checks for Learning Disabilities and Mental Health will now form part of the upcoming framework for community-based support services which will go live in 2023. This will ensure providers are supporting residents with their health checks and wider health appointments including sexual health, female health and dentistry.

Instigation of new drug & alcohol services contract and funding:

- Drug & Alcohol Treatment Service contract in place since 1st April 2022 following allocation of additional grants from the Office for Health Improvement & Disparities (OHID).
- Drug & Alcohol Needs Assessment delivered in November 2022. Key areas of emerging strategic priority: prevention and early intervention, reducing drug-related deaths, improving support for those in the criminal justice system, reducing drug and alcohol-related crime, improving outcomes for an ageing treatment population, place-based approach to building recovery in communities.

- Local Southend Drug & Alcohol Strategy development in progress. All feedback now held and final Strategy version was presented to the Health & Wellbeing Board in June 2023. People with lived experience of substance misuse have been included in sharing their experience at the Drug and Alcohol Strategic Executive Group.

Joint working with Department of Work and Pensions and economic development teams to consider opportunities:

- The economic development team has launched “Multiply” - a new project supporting adults to get qualifications. This will aim to help adults seek employment opportunities and build confidence.

Initiate local hubs at venues such as day opportunities, links to Everyone Health, Sexual heath, and NHS:

- Conversations and discussions held with Southend Care Ltd to start a learning disability ‘hub’ at their Viking and P49 day opportunities. This is alongside other work in redesigning the pathways through day opportunities and, where suitable, linking into an employability skills pathway.

Future work will focus on arranging a Health and Wellbeing event in Autumn 2023 and finalising the Southeast Essex Alliance Plan and Health Hub Model. The Greater Essex Drug and Alcohol Partnership will increase engagement with Department for Work and Pensions colleagues who currently engage with the Essex Partnership. More check-ins on commissioned services will be organised and coproduction opportunities will increase.

4.4. Prevention – Preventing people from going into hospitals and care homes

We want to reduce the number of hospital and residential care admissions in Southend. We recognise that our current offer of support for people in their own homes needs modernisation.

Feedback from residents on preventing admission to care home and hospitals included positive experiences with Mental Health support whilst in hospital however once they returned home, there was a lack of support – and residents would like to see this improved. The focus on next year will look to support people in their discharge process, by increasing awareness of the support offered through the information and guidance service when they return are back home.

To achieve this outcome, the actions set included:

To prevent people from going into hospitals and care homes through a new Information, Advice and Guidance offer:

- New contracts in place include providing outreach hubs across the city, with both digital and telephone options. The commissioned Information, Advice and Guidance Service provides free support to the community to maximise independence. This task will be closed with a focus to increase awareness the information and guidance offer to residents.

Learning Disability transformation work, refining pathways:

- The Learning Disabilities pathway projects have been working in improving awareness of clients’ pathway and a refined service delivery, through ensuring

organisational policies and procedures reflect duties, laws and allow people to have choice and control.

Mental health transformation from EPUT:

- Lead commissioners have been working collectively with EPUT to increase awareness of clients' pathway and have refined service delivery to ensure all services work seamlessly together.

Disabled Facilities Grant and equipment and technology reviews:

- As previously outlined (on Page 8), the Assistive Technology review project and recommendation paper is currently being finalised. There is ongoing work to review what technology is available to allow people to remain at home safely with technological adaptations. The Disabled Facilities Grant forms part of this activity.

For next year, the focus on Learning Disability and mental health transformation will be continuing.

4.5. Housing – Deliver health, care and housing in a more joined up way

We need to ensure suitable accommodation and care support is available across the City to enable people with care and support needs to live as independently as possible. Other care models must be explored such as Extra Care, Supported Living or Shared Lives to reduce the overall amount of residential provision.

To achieve this outcome, the actions set included:

Review of individual accommodation without associated care:

- A Joint Strategic Need Assessment for Housing is being worked on and due to be published in Summer 2023.

Complete an audit on all accommodation with care:

- In June 2022 a number of sessions were held with people more likely to use supported living provision now or in the future. Through this process, a set of supported living and day opportunity ‘principles’ were agreed upon which are now feeding into upcoming contracts.
- An audit was completed on the Southend Supported Living and Residential properties at the start of 2022. This audit looked at the property itself and upkeep, as well as the staffing and the residents.
- The audit outcomes led to further discussions and investigations which have been expanded in upcoming contracts and are being further explored with the council’s housing teams, such as size of rooms and types of properties.

Refine and deliver commissioned Transitional Supported Housing and Housing First:

- The Transitional Supported Housing contract was reviewed and renewed following a procurement process going live in June 2022. Work is still ongoing by providers delivering the transitional supported housing project to assist young people, young parents, people with mental ill health and ex-offenders to become ready for independent living.

- A scoping exercise commenced in November 2022 to review the Severe and Multiple Disadvantage Services (complex needs hostel) and Intensive Housing Support Service (support contract from Housing First properties).

Investigate use of assistive technology:

- An initial paper investigating the use of technology was submitted to management which has led to a far wider piece of work taking place investigating technology as an individual aid as well as for monitoring and assessments.

Moving ahead, an Assistive Technology paper will be finalized by end of Summer 2023, outlining potential recommendations for follow-up by this partnership group.

The Southend Council commissioning team is currently collaborating with the housing team to assess upcoming properties that cater to individuals' needs and establish principles for properties and homes. In April 2023, the procurement of a Supported Living framework for individuals with Learning Disabilities, Mental Health conditions, Autism, and sensory or physical disabilities will commence, with implementation expected by the end of 2023.

4.6. Community – Involved and digitally included

Being digitally literate and connected allows people to be well-informed, access benefits and employment and connect with people. Currently, there is a lack of training and equipment available to support people, so they feel excluded. People need to be properly informed, matched to opportunities and assistance.

To achieve this outcome, the actions set included:

Develop local schemes such as the ‘Good Neighbours’ scheme:

- Internally the council has developed the ‘Good Neighbours’ scheme, which is now active in the city. Since the pandemic, the scheme has been used to encourage people to look after their neighbours. The scheme, led by the Communities Team at the Council, supports neighbours to help those who may be frail or shielding, as well as providing guidance to access help and support.

Promote Social Prescribers and Community Connectors based in Locality Integrated Networks:

- The process of providing a Livewell Southend Social Prescribing Digital Tool has been progressed.
- A Southend Social Prescribing system wide delivery update report has been completed.
- Social Prescribing has been aligned to the system wide Information, Advice and Guidance (IAG) workstream.
- Social Prescribing Link Workers have delivered social prescribing across all Primary Care Networks.
- The council has looked at ways of involving the community and recording the number of community conversations, to measure the promotion of Social Prescribers and Community Connectors.

Live Well digital platform review and refresh:

- The digital platform activity is ongoing. Feedback from residents and the public has been included in the design of this platform solution to make it easier for residents to navigate the website. A platform refresh went live in late June 2023 with additional improvements planned later in the year.

Review leisure activities and clubs available for adults of working age:

- The Wellbeing Referral Programme has started – initially a pilot physical activity programme aimed at adults with one or more long-term health conditions and/or high BMI. Likely to attract older adults. This will be delivered by Everyone Health and Fusion Lifestyle.
- The evaluation of leisure activities and clubs available for adults of working age has been reviewed by Public Health.
- Note that a bid to the Shared Prosperity Fund to support a volunteering hub in the city has been rejected.
- The review of leisure activities can be closed, as the review concluded with recommendations made for each sport.

Increase engagement of older adults in sports and physical activities:

- More adults are aware and engaging in activities for a healthier lifestyle.

The future focus of work will be developing the Live Well Southend Social Prescribing Action Plan, implementing the Social Prescribing Digital Tool and launching the new digital website. Ensuring the Wellbeing Referral scheme is a success and supporting residents to access leisure activities. Continued support of social prescribers and community connects in the council. Further work with local organisations to target specific groups such as over 50s. Reviewing digital accessibility, as feedback has shown people have expressed concerns about this.

4.7. Integrated Strengths-based Person-Centred Care – enable people to take control of their care and focus on their strengths

Use a strengths-based approach to support the persons individual resilience and focus on what they are able to achieve. It is important that people only have to tell their story once. We want to work with people in a holistic way to understand them as individuals and their carer(s) needs, to enable them to achieve the results that are most important to them.

To achieve this outcome, the actions set included:

Introduce three conversation methods of social care intervention roll out via innovation hubs:

- In 2023, we decided to move away from the structure and process of the three conversations, however the learning and practice development has had a positive impact on our approach.
- This learning solidified an already strong staff engagement culture, which supported the redesign of our assessment, care planning and safeguarding forms.

Activity centred around Learning Disabilities transformation, including refining pathways and projects that help people access opportunities and services.

- Refining the pathway through day opportunities to support people entering the workforce via Making It Work.

- Identifying people with an aspiration to work, working on a joint plan with the Social Work teams to increase skills through the day service.

Use of contracts and brokerage for a strength-based approach:

- New contracts for service provision have now been put in place such as the Supported Living contract which is currently out to tender (June 2023).

This action set will now be closed but there will still be a can-do approach to focus on what matters to people and think creatively for things to happen. The council is also moving forward in the development of a new social care model which should be live later this year (2023).

5. Ageing Well

This Ageing Well strategy considers the needs of people as they get older. Whilst similar strategies are typically aimed at people who are 65 and over, which has traditionally been when people have retired, many people may not regard themselves as 'old' at this age. It is for this reason that the Ageing Well Strategy does not limit its ambition to an arbitrary age but instead aims to create an environment and a community that embraces ageing and allows people of all ages to live well together in Southend.

The age range covered by the strategy includes a wide variety of needs from the active and well to those who will have significant care needs. The strategy builds on the priorities set out in the Adult Social Care Milestone Recovery Plans 2020-2022. Projects taken forward under these plans have already begun to address long-standing inequalities. It is important to recognise that this strategy was just the starting point in an ongoing conversation with people and we will continue to review this strategy based on those conversations. The Ageing Well Strategy includes a delivery plan which is updated annually and co-produced through engagement with support groups across Southend.

Priorities and action plans within this strategy focus on the priority areas of:

1. World Health Organisation (WHO) 'Age Friendly City'
2. Outdoor Spaces and Buildings
3. Transport – Transport that is age-friendly
4. Housing – Bring housing up to modern standards
5. Social Participation – connecting communities
6. Respect and social inclusion
7. Civic Participation and employment
8. Communication and information
9. Community Support and health and social care services focus on keeping older people physically active to maintain their strength and mobility and promote positive mental health

Priority Areas (Total 11)

5.1. Links to Other Priorities and Strategies, covered above as part of 2.1 (Page 3)

5.2. Coproduction and Engagement Development, covered above as part of 2.2 (Page 3)

5.3. World Health Organisation (WHO) 'Age Friendly City'

The WHO Age-friendly Cities network connects cities and organisations with the common vision of making their community a great place to grow old in. The focus is on local level action that fosters the full participation of older people in community life and promotes healthy and active ageing. It is the ambition that within the five-year Ageing Well strategy period, Southend will become a member of the Age Friendly Communities network.

To achieve this outcome, the actions set included:

Consult with residents against the WHO checklist, for feedback on the strengths and weaknesses of Southend:

- We have consulted with residents, first using the WHO checklist. Feedback on the original engagement had been that the checklist was not user-friendly. The co-

production lead adapted the checklist and carried out workshops and activities to gather more positive responses.
- A Survey has been designed, which has been staggered, to make it more accessible and topic specific. The Surveys are on the Your Say Southend website and the information has been distributed to all Ageing Well Steering Group Members.

The future focus of work will be to build on the work already completed to establish a firm baseline for where Southend is to date against the main priority areas.

5.4. Outdoor Spaces & Buildings

The outside environment and public buildings have a major impact on the mobility, independence and quality of life of older people. As part of the baseline assessment, we will carry out an audit of public buildings to recommend improvements to accessibility. We will also work to incorporate good design for older people into the Southend Local Plan.

To achieve this outcome, the actions set included:

Carry out an audit of resident's opinions, to be used as a baseline for the work needed in future years:
- A Survey was designed and added to the Your Say Southend website. Initial feedback was that the Survey was not user friendly and needed to be adapted. A smaller group was established to review the Survey and to design a more user-friendly version. This has now been completed, with the updated Survey added to the Your Say Southend website and distributed to all stakeholders.

This action set will be continuing into the next year, as there is still a need to establish the baseline for Southend in terms of how residents currently feel about the city.

5.5. Transport – Transport that is age-friendly.

The most frequent reasons for not using public transport among those 65 and over are that it's not convenient and doesn't go where they want. Driving rates also decrease with older age, therefore better transport in age-friendly communities is important. We will carry out a review of transport availability and options for older people and create community-focused solutions to promote local employment and economic opportunities.

To achieve this outcome, the actions set included:

Carry out an audit of resident's opinions, to be used as a baseline for the work needed in future years:
- Please refer to outcome set included in 5.4.

5.6. Housing – Bring housing up to modern standards.

We need to move away from an over-reliance on residential and nursing care homes for older people. This will significantly reduce council commissioned care home beds and decrease placements into these homes. The shift will be to Extra Care Housing and care at home (National Surveys show that >80% of homeowners aged 65+ want to remain at home). This will be realised by an increased investment in reablement and short-term care, a

significant increase in care at home and a programme of cultural and practice changes to be embedded into Adult Social Care operations.

To achieve this outcome, the actions set included:

Bringing housing up to modern standards

- An audit / residents' opinions are being gathered in the Your Say Southend Website and information is being shared with the partnership group.

Review of individual accommodation without associated care

- An Older Persons Housing Needs assessment has been carried out in 2022, with review of scheduled findings to be reviewed in a cross-departmental discussion. The baseline is being used for future planning.

Complete an Audit on all accommodation with care

- An accommodation with care audit has been undertaken. The information gathered is being used to develop new specification for council contracts. Ongoing stakeholder engagements have continued along with coproduction session with supported living residents.

Investigate use of assistive technology

- A report has been completed on technological, which has been shared with departmental leads in commissioning, with further exploration planned to complete a wider review of use of technology and equipment.

The future focus of work will be gaining an understanding of the wider population in Southend, in particular homeowners. Future work will also look at research to understand the wider population of Southend. We would like to hold sessions for people living longer at home. Also, completing the research into assistive technology and use this review to shape future actions.

5.7. Social Participation – Connecting communities.

People over 50 who volunteer or actively participate in their community tend to be happier as a result. Interacting with people is essential to help prevent loneliness. Circa 10,000 older people living alone at home in Southend will be supported to connect with well-established Southend social networks. This will be via referrals from their GP or other contacts to 'Community Connectors' – people living in the Borough who volunteer to help through their local knowledge and networking skills.

To achieve this outcome, the actions set included:

Carry out an audit of resident's opinions, to be used as a baseline for the work needed in future years:

- Please refer to outcome set included in 5.4.

Develop the creation of local schemes such as the Good Neighbour's scheme:

- Awarded the ‘Infrastructure’ bid to SAVS for the Volunteer Hub due to start 2023-2024.

Increase engagement of older adults in sports and physical activities:

- Some of the physical activity provision for older people was reviewed from service user feedback. Service providers Fusion Lifestyle and Everyone Health have worked to deliver the wellbeing referral programme and are using feedback from the service users to ensure future provision is of the best possible standard to give a people a positive experience with their physical activity and/or healthy lifestyle journey.

The future focus of work will be to establish the baseline for how residents currently feel about Southend. Link with existing groups to avoid duplication. Look into top-up funding to offer a ‘gold-standard’ volunteer hub model. Address current and future needs for physical activity.

5.8. Respect & Social Inclusion

60% of people over 50 don't think that older people have enough respect in society. A priority will be to promote intergenerational understanding and respect through positive messages about the value of older people in Southend and their community contribution. Also, by increasing the opportunity for older and younger people to work together in the City.

To achieve this outcome, the actions set included:

Review current contracts and subsequent activities, ensure all new contracts include respect and social inclusion as a priority area:

- There have now been clauses added in the specifications on new contracts to ensure strength based, socially inclusive services rather than silos. New contracts have a focus on community inclusion.

Understand activities and gaps in provision; increasing the opportunity for older and younger people to work together in Southend:

- A pledge from Commissioning that Social Value and Social Inclusion should be factored into newly issued contracts as they are developed specifically in the scope of healthy lifestyles services to inform when recommissioning of the service in 2024.

Pledge from commissioning that Social Value and Social Inclusion will be factored into all newly issued contracts as they are developed:

- Social Value and Social Inclusion were included in the review of the Healthy Lifestyles services.

Moving forward the 3-conversation model is no longer in use and this measure in 2023-24 will be aligned with a new social care delivery model.

5.9. Civic Participation & Employment

Good quality volunteering in later life has a measurable positive impact on mental health and paid work can have a positive impact on wellbeing, as well as finances. The opportunities for this diminish with age: 72.3% of people aged 50-64 are in work, compared to 85% of people aged 25-49. We will work with the existing VCSE sector, such as Southend Association of Voluntary Services (SAVS) and Volunteering Matters, to coordinate a volunteering bureau and expand the range of opportunities for older people to get involved in volunteering.

To achieve this outcome, the actions set included:

Expand the range of opportunities for older people to get involved in volunteering or paid work:

- The Volunteer Hub contract has been awarded to SAVS, who can take this work forward in 2023-2024. This work will be continuing.

The focus for next year will be to obtain a baseline for Southend, to help determine the need for volunteer opportunities; and the range of activities people can get involved in. Wider funding opportunities also need to be considered to expand the Volunteer Hub model.

5.10. Communication & Information

While most information is now shared online, 47% of people aged 75 and over have never used the internet. There is a diverse range of Information, Advice and Guidance (IAG) services targeting older people in Southend and evidence of duplication of effort. A streamlined service offer will target those most at need and a project to review all of the IAG provided and the current digital platform (Livewell Southend) has already commenced.

To achieve this outcome, the actions set included:

To understand what is available and increase digital awareness in the older generation:

- This work is now intended to be scheduled for later in the year due to staff leaving specific roles and lack of capacity to deliver this initiative. However following engagement with residents earlier in the year from the Communities Team, there was difficulties raised around digital access, skills and confidence.

To deliver an enhanced IAG holistic offer, to support and enable people to live independently:

- The improved IAG offer is now in place and the contract includes providing outreach hubs across the city to deliver a holistic offer to support people to live independently.

Live Well Digital Platform – review and refresh:

- The updated Live Well Digital Platform went live at the end of June 2023 with additional enhancements planned for later in the year.

The future focus of work will be to review the use of digital for the future action plan, as we are moving towards a more digital way of working. For example, the e-consult through GPs. We need to consider the issue around digital access skills and confidence. Continue to capture data to monitor the effectiveness and consider how this work links with surgeries.

5.11. Community Support & Health and Social Care Services

Increased investment in fall prevention will lead to longer–term savings and promote better outcomes for older people. Existing physical activity programmes should target more deprived areas in Southend and communities with poorer health outcomes and the existing frailty pathway should be further developed. A stronger assessment / early identification of people likely to fall is already being planned and a review of the current offer and outcomes achieved will place a stronger emphasis on preventing falls, rather than just the fall recovery.

To achieve this outcome, the actions set included:

Improve information and the promotion of: Falls Prevention, Physical Activity and MECC:

- Falls prevention strength and balance classes – 150 people completed the 36-week course in year 3 (June 2021 – May 2022), with 83% achieving an improved reading

on the TUG test; 77% on the Confbal test; 83% of 180 degree turn test and 85% had an improved reading on functional reach test.

Provision of services which focus on and promote independence and well-being:

- Contracts now established for expansion of physical activity wellbeing referral, targeting those at increased risk of long-term health conditions.

Re-imagining of the homecare style services into supporting independence services:

- Engagement has begun with homecare providers, through a soft market test, 121 sessions and workshops.

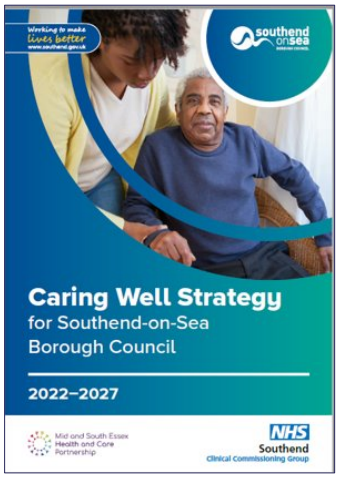
The focus for next year is to map and understand the broader offer across Southend to identify gaps and opportunities for improved access/signposting. The target to increase capacity is from 290 starters per year to 1,500 starters and to expand the range of activities on offer. The work on falls prevention / physical activity is continuing, to see how many more people can access this service moving forward and is a priority for the ICS. We will use feedback from engagement with homecare providers to help reshape the service to support independence.

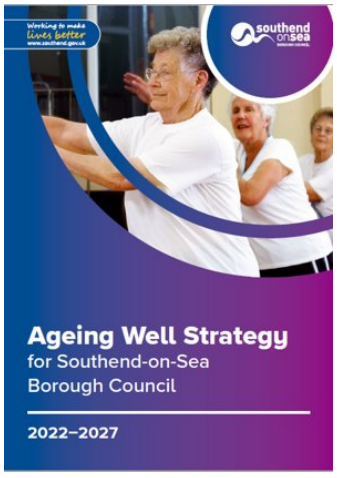
6. The Year Ahead

Action Plans are detailed work plans that shape and guide the most important part of the Strategic Commissioning process.

The overall focus for Year 2 will be to:

- Maintain Caring Well / Living Well / Aging Well partnership groups to further develop and manage each of the Action Plans, ensuring Health, Social Care, Providers and people with lived experience are accurately represented.
- Review the strategy documents based upon local changes and updated good practice.
- Work to regularly review where we are now against the established baseline, to allow us to monitor progress on where we want to get to by 2027.
- Use a standardised process for ongoing engagement and co-production and continue to build on these open discussions.
- Continue to provide Annual Reports demonstrating the progress of the Action Plans for Caring Well / Living Well / Ageing Well in Southend.
- Report on progress of the annual Action Plans for 2022 / 2023 for Caring Well, Living Well and Aging Well in Southend in December 2023.





Southend-on-Sea City Council

Agenda Item No.

8

Meeting:	Health and Wellbeing Board
Date:	6th September 2023
Classification:	Part 1
Key Decision:	No
Title of Report:	Director of Public Health Annual Report: 2022-23

Executive Director: Michael Marks, Executive Director, Children & Public Health
Report Author: Krishna Ramkhelawon, Director of Public Health

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1. Executive Summary

1.1. The Director of Public Health (DPH) is required to produce an annual report every year. Attached as appendix 1 is the DPH report for Southend for 2022-23., with a focus on Prevention. The Annual report was presented and approved at Cabinet on 18th July 2023

1.2. The DPH annual report reviews the work for the 2022 – 23 and identifies the DPH's priorities for 2023 – 24. This year's report will focus on data and intelligence led key areas and covers the following four themes:

1.2.1 Tackling health inequalities using the Core20PLUS5 frameworks – Adults and Children.

1.2.2 Promoting Healthier Lifestyles- Stop Smoking, Healthy weight

1.2.3 Early detection of long-term conditions, with a focus on Cardiovascular conditions and Diabetes.

1.2.4 Transforming Children, Young People and Families services, with a lens on Protecting and Safeguarding young people and the development of Family and Community hubs.

1.2.5 It is imperative that HWB Board members collaborate further on improving data and information sharing and set this as a collective priority for Southend.

1.3. An updated summary of actions on the progress made against each of the recommendations from last year's Annual Report is included.

2. Recommendations

The Board is asked to note the content of the 2022 – 2023 Annual Public Report.

3. Background

3.1. The Health and Social Care Act 2012 requires the Director of Public Health to prepare an annual report on the health of the local population. This is an independent report which the local authority is required to publish.

3.2. The Council has a statutory duty to protect the health of the local population. The 2022-23 Annual Public Health Report highlights the key issues and actions to address those issues for the people in Southend.

3.3. The report is an opportunity to identify issues that impact on the health and wellbeing of the local population, highlight any concerns and make recommendations for further action.

3.4. The reporting theme on Prevention including the use of ‘ infographics’ was agreed with cross-party Councillors.

3.5. This is building on previous years’ reporting format.

4. Reasons for Decisions

The Health and Social Care Act 2012 requires Directors of Public Health to prepare an annual report on the health of their local population and for it to be published.

5. Other Options

There are no other options presented as it is a statutory duty of the Director of Public Health to prepare an Annual Public Health Report.

6. Financial Implications

All Public Health Services are delivered within the budget of the Public Health Grant funding that the Council is allocated by the Government.

7. Legal Implications

There are no legal implications arising directly from this report**.**

8. Policy Context

Contribution to Council’s Southend 2050 Ambition and Priorities and the Mid and South Essex (MSE) Health and Care Partnership’s shared priorities.

9. Carbon Impact

9.1. N/A

10. Equalities

The Annual Public Health Report provides evidence that population health needs are assessed and considered and utilises all the information produced in our local Joint Strategic Needs Assessment.

11. Consultation

Not applicable

12. Appendices

Appendix 1: Director of Public Heath Annual Report :2022- 23.
Background documents are referenced throughout the Annual Public Health Report, with direct web-links.

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Southend-on-Sea City Council

Director of Public Health Annual Report 2022/23

Focus on Prevention

Contents

Introduction

This report reflects on some of the key achievements since last year's Director of Public Health's annual report, some challenges and highlights areas for further collaboration with partners to enable us continue to protect and improve the health and wellbeing of visitors, students and residents of Southend-on-Sea city.

The impact of living with COVID is still emerging. However, there has been a reduction in disability-free life expectancy. This is a stark reminder that we must endeavour to increase our collective effort in preventing ill-health and supporting people in making healthier lifestyle choices. In my role as the Director of Public Health and an independent advocate for the City's public health, the focus of this report will be on some key areas of prevention and responding to the cost-of-living crisis and its impact on wellbeing.

The Mid and South Essex Integrated Care Partnership has drawn on the City Council's ambition, the recently published health inequalities Core20PLUS5 frameworks, one each for adults and children services and a number of key national drivers, to publish their local strategy for reducing health inequalities and improving health and care services with a focus on tackling the wider determinants of health.

Plans have been drawn up and aligned to the Southend Health and Wellbeing Strategy by the South East Essex Alliance with a focus on neighbourhoods mirroring work also in progress across the localities in the City. We are building on good practice, engendered by a learning and development culture as well as more meaningful engagement with our communities, to become more efficient and empower residents to own the chosen approach through co-production. The adults Core20PLUS5 plan will also address challenges with maternal and infant health and wellbeing and wider inequalities.

We know that there is a growing mental health and wellbeing need across our communities, which has been further exacerbated by the cost-of-living crisis. It makes this timely for the Council and partners to develop a strategy to tackle poverty and reduce the challenge posed by food security and the impact of climate change on health and wellbeing.

Childhood should be the happiest time in a person's life, yet for thousands of children who make poor lifestyle choices and develop mental illness in childhood or adolescence, the reality can be very different. Therefore, it is incumbent on me to sharpen the focus on highlighting our local concerns with the health and wellbeing of children and young people. The South East Essex Alliance is developing a plan to focus on priority areas identified through the Core20PLUS5 and we are renewing a number of local initiatives aimed at supporting this population group to improve their lifestyles, based on more recent engagements.

From addressing our challenges with young children's oral health and childhood illnesses, to addressing the antecedents leading to childhood adverse experiences, further compounded by neglect and the need to provide more support on parenting. We have a duty to address these needs and also explore further how to improve the lives of children who are neurodivergent, after the recent review of the SEND services in Southend.

We are uniquely placed as a City to consider how best to utilise our assets, in partnership with our residents, building on a plethora of good practice locally and emerging evidence. Southend should lead on the development of a Family and Community Hub system approach to transform the services for children and families ensuring all parents/carers can access the support they need when they need it, to increase opportunities to give all children in Southend the best start in life, helping to protect them from factors that could impact their development and life chances.

It is imperative that we set data and information sharing as a strategic priority across agencies.

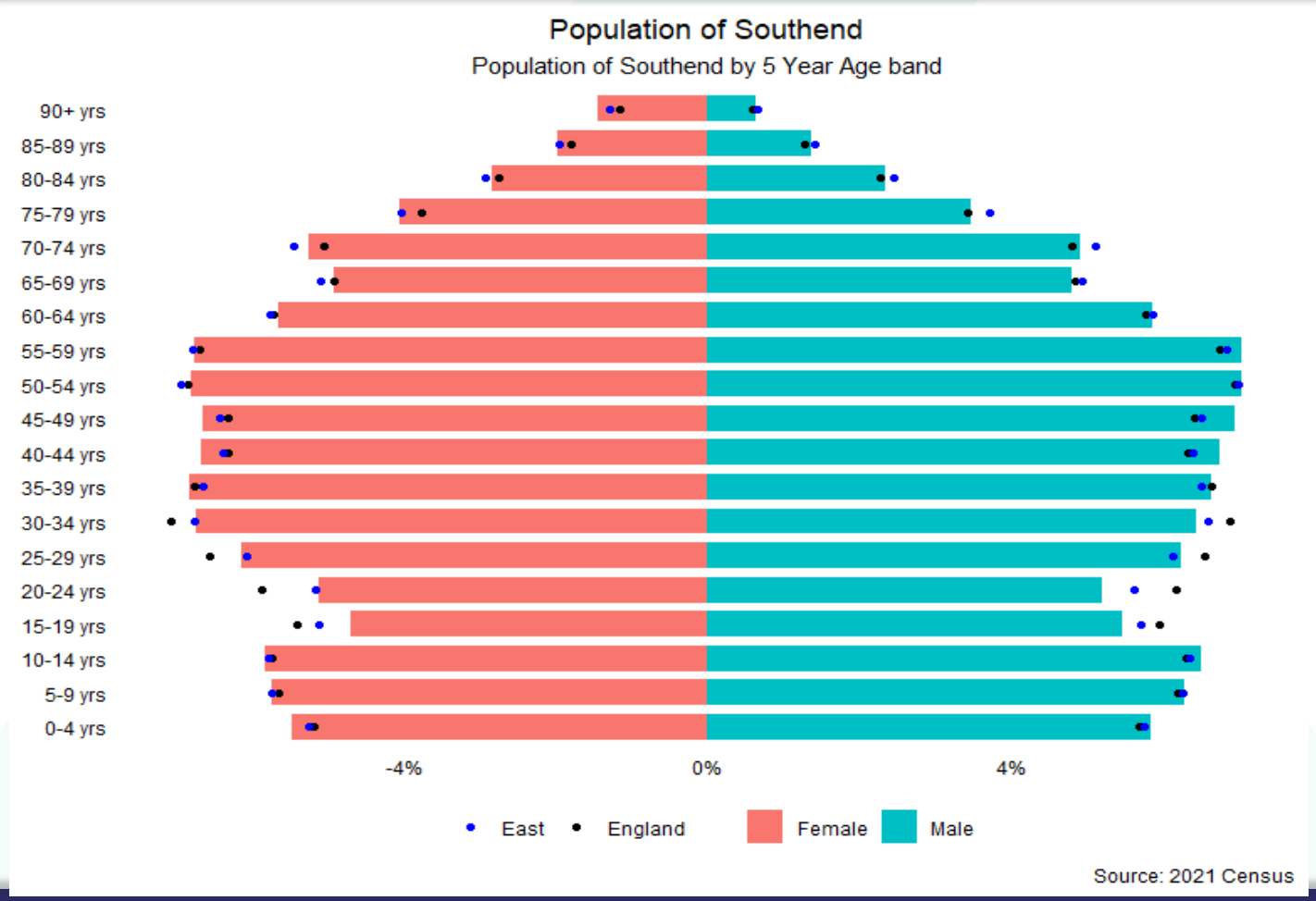
Population

The main difference between the population of Southend and the national average, is that Southend has a lower percentage of residents between the ages of 15 and 34 for both males and females.

For males, this difference extends to residents aged between 15 and 39 years.

Southend's female population over the age of 70 years is proportionately higher than the national average.

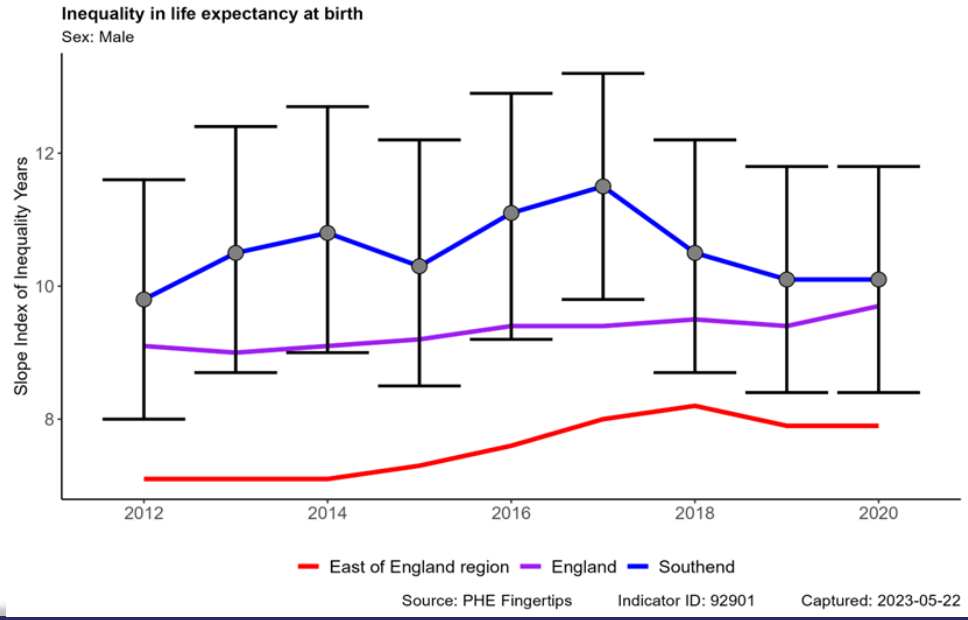
Southend also has large communities living in more disadvantaged areas, mainly across six wards on the east coast and more centrally around the City centre.

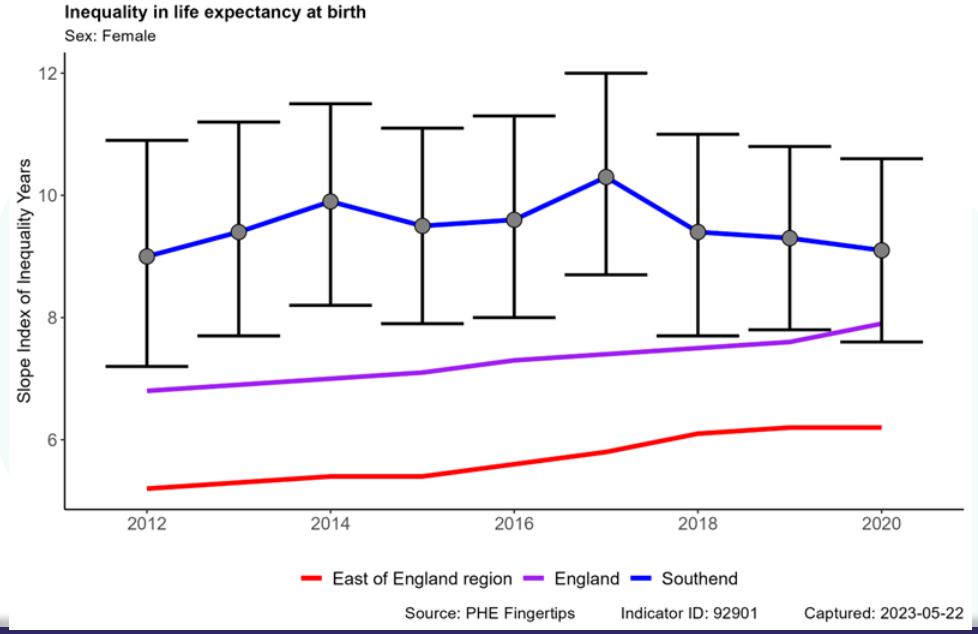


Inequality in Life Expectancy

The Slope index of inequality is the measure of the difference in life expectancy between those in the most deprived areas, and those in the least. Southend is statistically similar to England in the most recent data (2018-20), and is notably higher than the East of England Region, this is true for both males and females. There is no statistical trend in the data between 2015 and 2020, although this is yet to take into account the impact of Covid-19.

However, disability-free life expectancy (DFLE) in the UK decreased significantly for both males and females between 2015 to 2017 and 2018 to 2020; this change was driven by decreases in England and Scotland.





Health Inequalities - Core20 PLUS5 – Adults & Children

Southend-on-Sea City Council

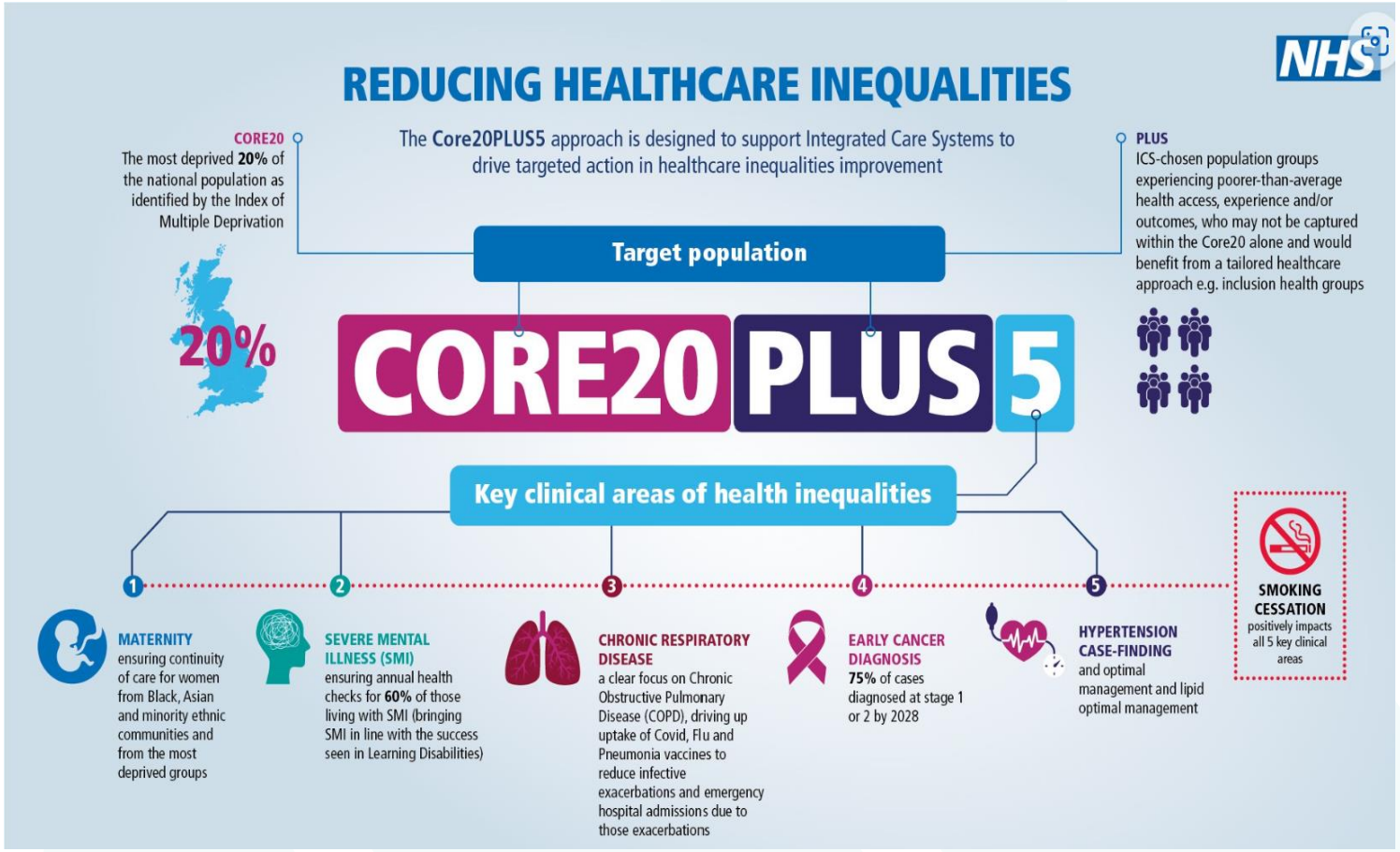
Core20 PLUS 5 - Adults

Core20PLUS5 is a national NHS approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a **target population** – the 'Core20PLUS5' – and identifies '5' focus **clinical areas** requiring accelerated improvement.

The Core20 is the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD).

The 'PLUS' is the chosen population groups who may not be captured within the Core20 alone. For Mid and South Essex, this is Deprivation, Ethnic Minority, LD, Gypsy, Roma & Travellers, Children and Young People, LBGTQ+, Homelessness.

The 5 clinical areas to focus are Maternity, severe mental illness, COPD, early cancer diagnosis and hypertension.



Smoking Cessation

Smoking cessation has the potential to have a real impact on all 5 clinical areas in Core20PLUS5 and we continue to be innovative in our approach. This has produced some remarkable outcomes in reducing tobacco smoking and supporting our drive to meet the Smoke Free target (<5% smokers) by 2030.

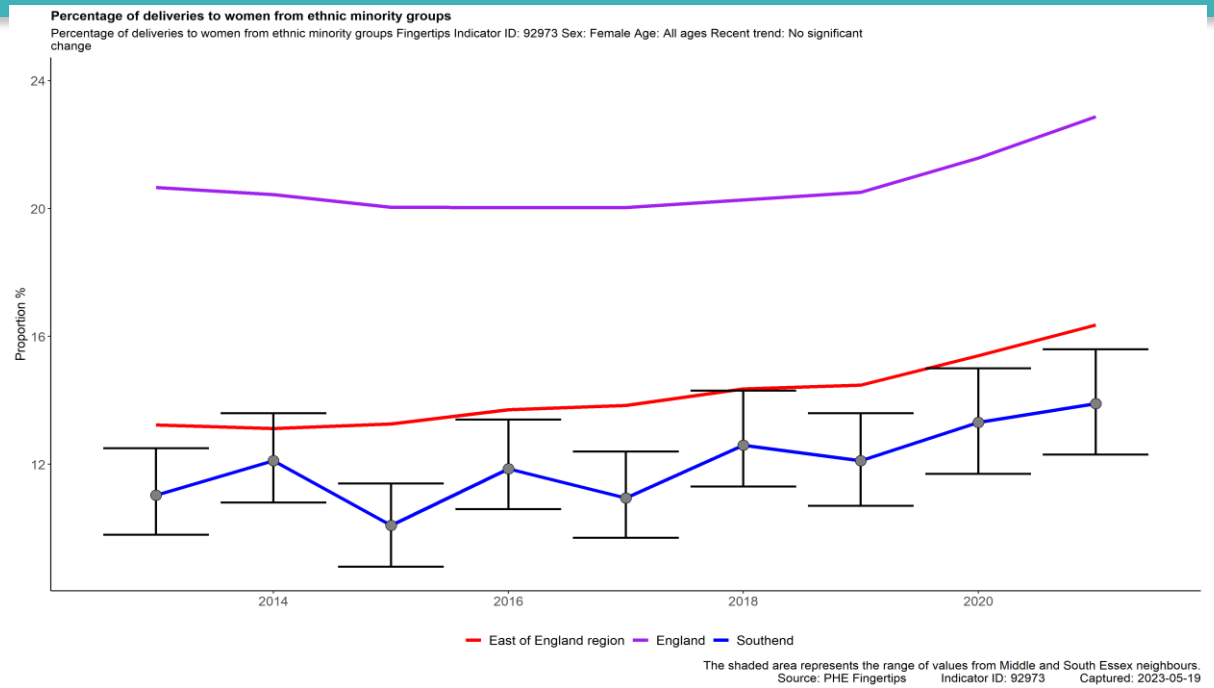
Southend on Sea Stop Smoking Service Providers

- GP setting: 29 GPs = 12 Week Support at a Surgery
- Pharmacy setting: 11 Community Pharmacists = 12 Week Support Participating Pharmacy Scheme 'Walk-in Service' (with a one-off prescription fee) + 2 x NRT product supplied FREE
- Alan Carr Easyway: Allen Carr Easyway Drug-free 5-6 hour Seminar. Phase 1 = 140 places + Phase 2 = 70 places
- Vape shops: 4 Vape Shops = Vape 'SWAP' Smoking Service 12 Week Self-referral Support Service + Client receives a FREE starter kit
- Acute trust: Opt-out referral pathway + Focus on all people admitted to acute and mental health hospitals and all pregnant smokers will be offered smoking cessation.

Date	Registered	Quit	Quit %
2018/19	1634	735	45%
2019/20	1499	613	40%
2020/21	743	337	45%
2021/22	1147	481	42%
2022/23	1369	572	41%

Southend-on-Sea City Council

Maternity



A pregnant woman's booking appointment allows scheduling of her ultrasound scan, identification of women who might need more than usual care, either because of medical history or social circumstances, for discussion of antenatal screening, taking blood pressure and measuring the woman's height and weight, identification of risk factors such as smoking and offering support, discussion of mood and mental health. Southend has a statistically worse proportion of women with early access to maternity care compared to the national and regional average and has established a dedicated joint Public Health Midwife, with Southend Hospital and A Better Start Southend, which is already improving access as well as key health outcomes, such as quitting smoking habits, improved infant feeding/breastfeeding and community-led parenting support. We now need to build on this.

Mental Health - Perinatal Mental Health

Perinatal mental health can affect up to one in five women during pregnancy and up to one year after birth. Common perinatal mental health illnesses include anxiety disorders, depression, post-traumatic stress disorder, eating disorders and stress-related conditions such as adjustment disorder.

Latest report shows that the number of maternal deaths caused by mental health problems is increasing. It also finds that many of the women (1 in 9) who died faced multiple disadvantages, including mental health problems, domestic abuse and addiction.

Significantly, mental ill-health and heart disease are now on an equal footing as the cause of maternal deaths in the UK.

The NHS Long Term Plan builds on the commitments outlined in the *Five Year Forward View for Mental Health* to transform specialist PMH services across England. The NHS aim to ensure that by 2023/24, at least 66,000 women with moderate/complex to severe PMH difficulties can access care and support in the community.

Key Maternal Mental Health Findings:

Suicide remains the leading cause of direct maternal death in the first postnatal year, few had a formal mental health diagnosis but had a history of trauma.

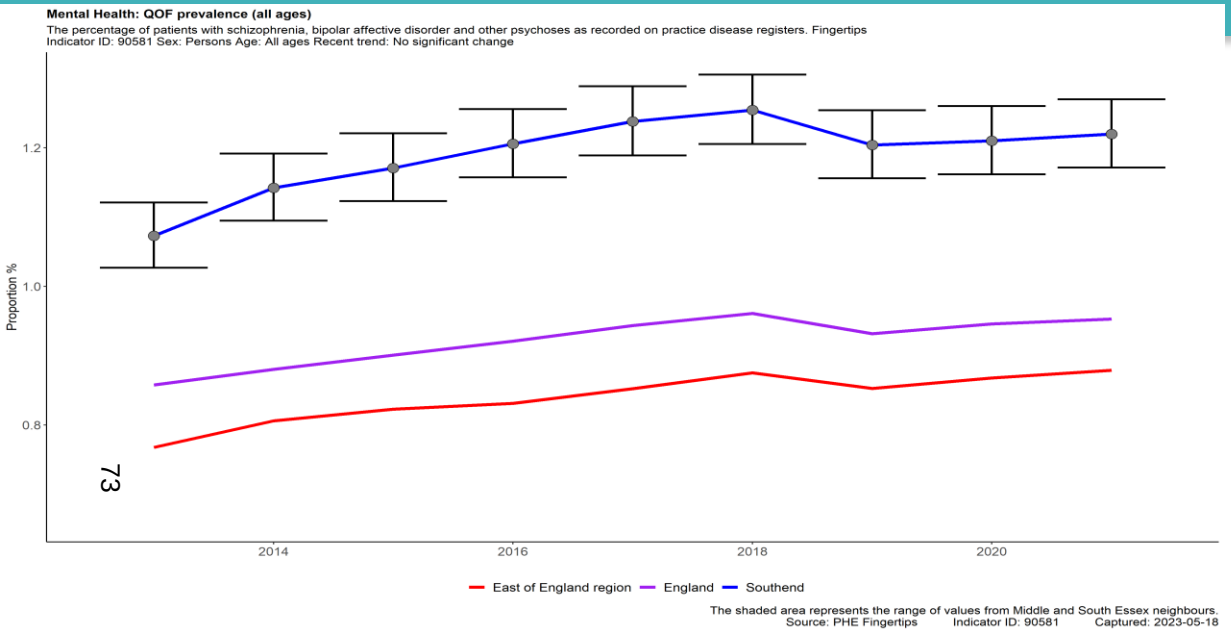
Mortality - 40% of deaths within the year after pregnancy were from mental health-related causes.

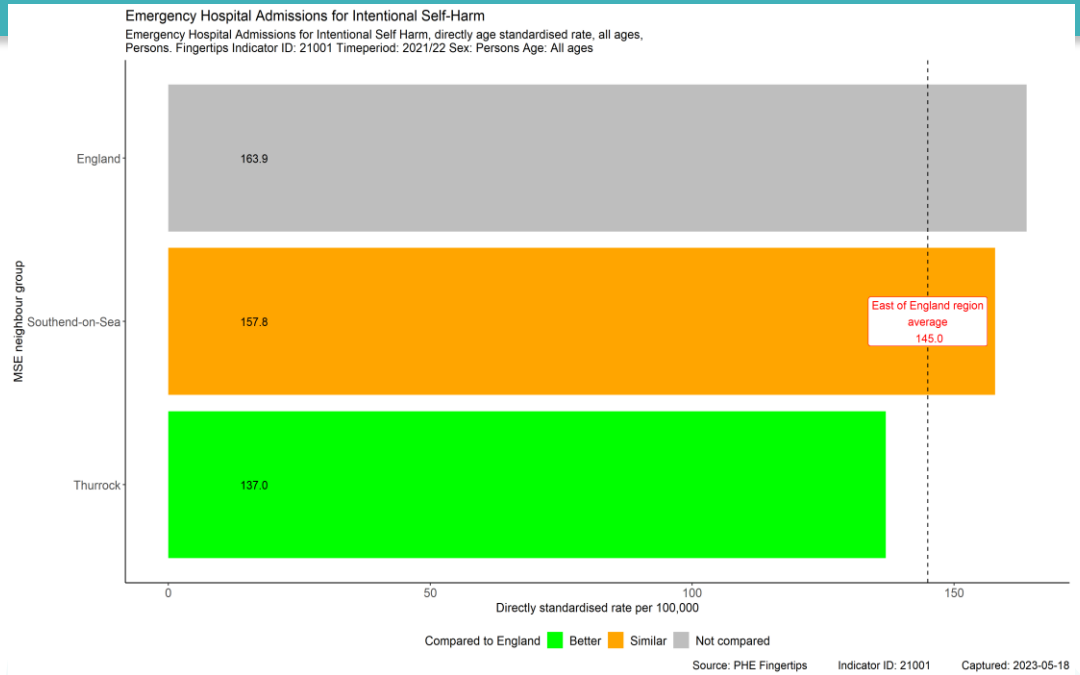
Ethnic disadvantage - there remains a more than three-fold difference in maternal mortality rates among women from Black ethnic origin, and an almost two-fold difference amongst women from Asian ethnic origin, compared to White women.

If left untreated, mental health issues can have significant and long-lasting effects on the woman, the child, and the wider family. Local specialist service is available to pregnant people in Southend, referrals can be made via Maternity, Health Visiting or through Primary Care.

We can achieve better success across the mental health and wellbeing agenda, through collaborative data sharing which has the potential to make a meaningful contribution to improving the quality of care and wellbeing.

Mental Health – Severe Illness & Self-Harm

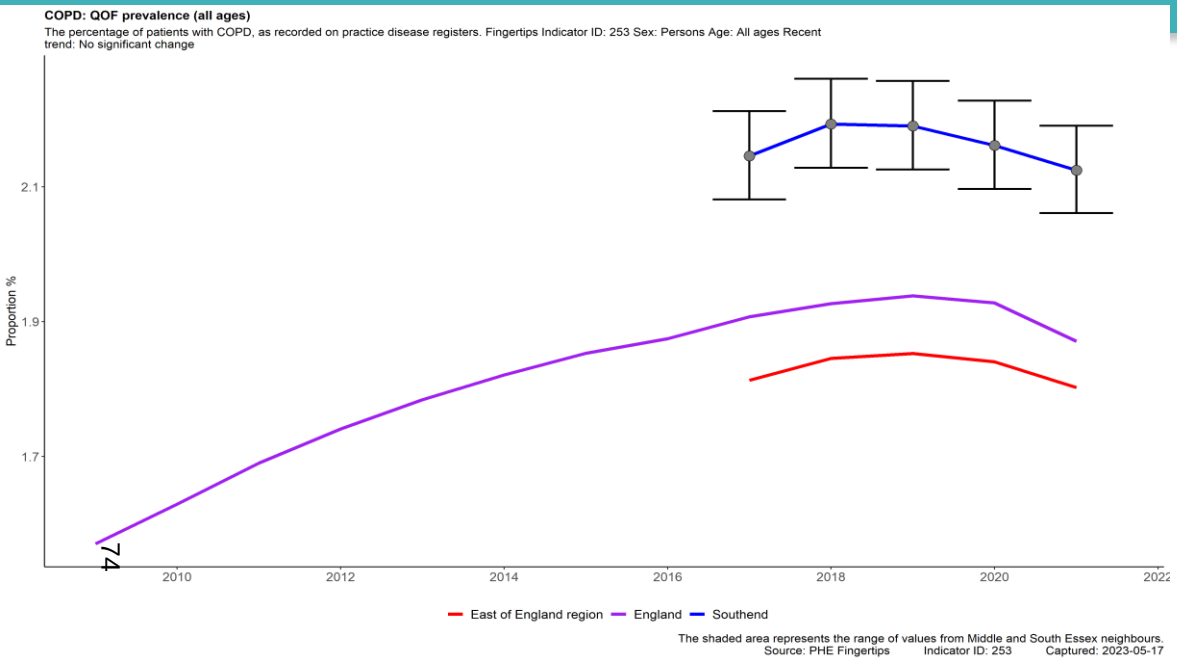


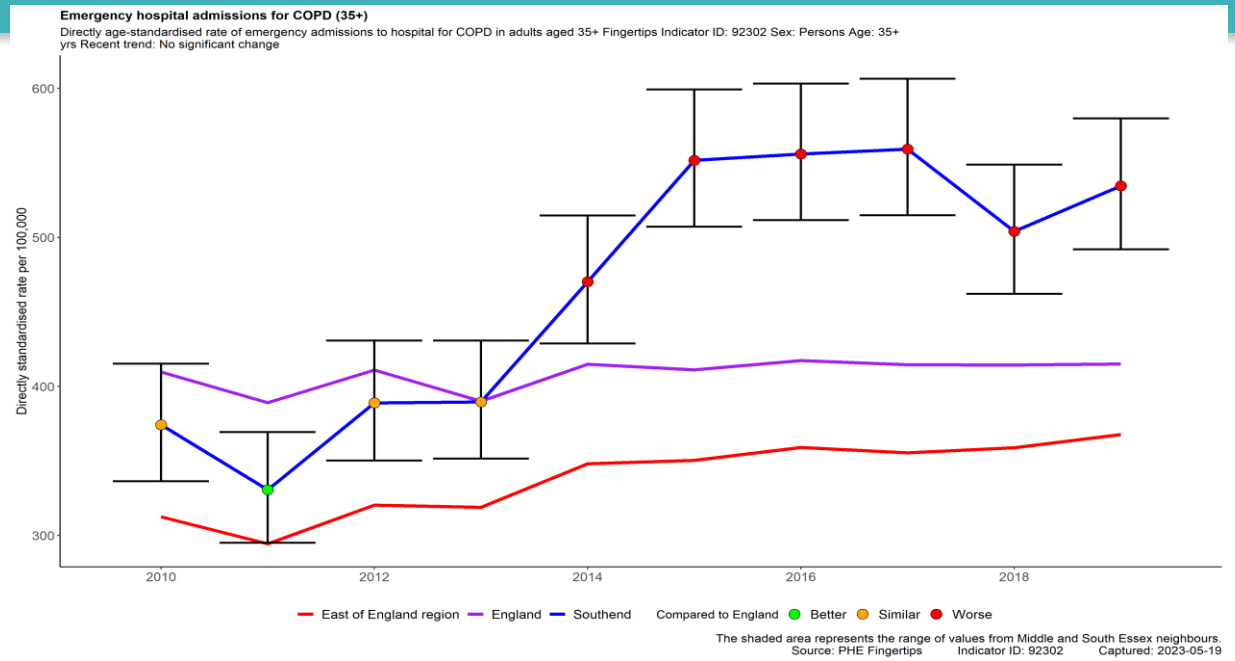


Southend's prevalence of more **severe mental illness** (includes diagnosis of schizophrenia, bipolar affective disorder and other psychoses) shows no significant trend in recent years and is higher than the national and regional average.

Self-Harm - This indicator is a measure of intentional self-harm which results in approximately 110,000 inpatient admissions to hospital each year in England; 99% are emergency admissions. There is a significant and persistent risk of future suicide following an episode of self-harm. Southend has a similar rate of emergency admission per 100,000 residents to the national and regional averages.

Respiratory Illness - COPD

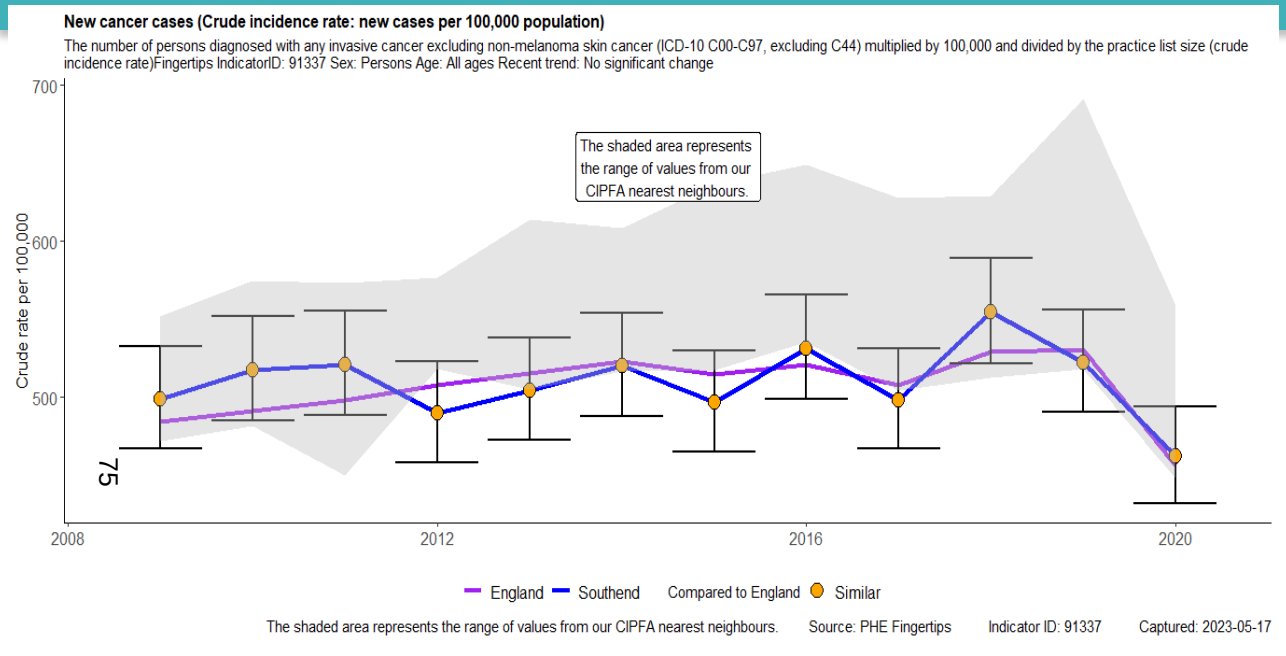


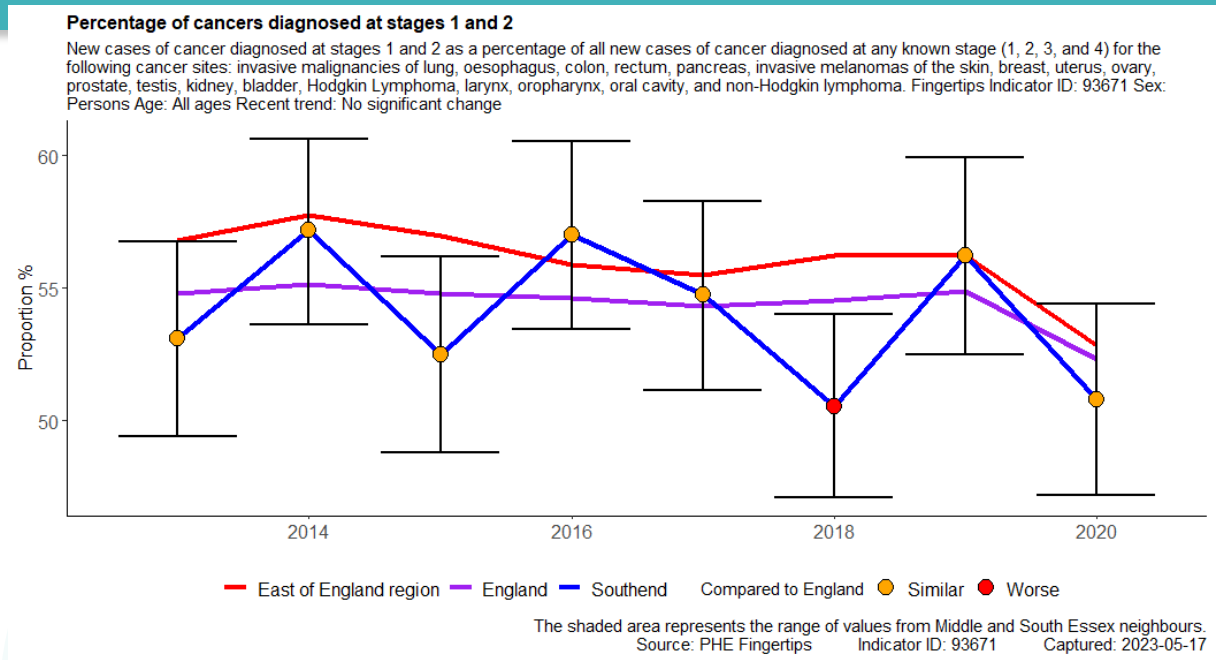


Chronic Obstructive Pulmonary Disease (COPD) is a common disabling condition with a high mortality. The most effective treatment is smoking cessation. Outside of pharmacotherapy, pulmonary rehabilitation has proven to produce an improvement in quality of life. Southend has a similar trend to the national and regional average although at a statistically significantly higher level.

In Southend, **emergency hospital admissions** for COPD has no overall trend, in recent years, and is statistically worse than the national and regional average.

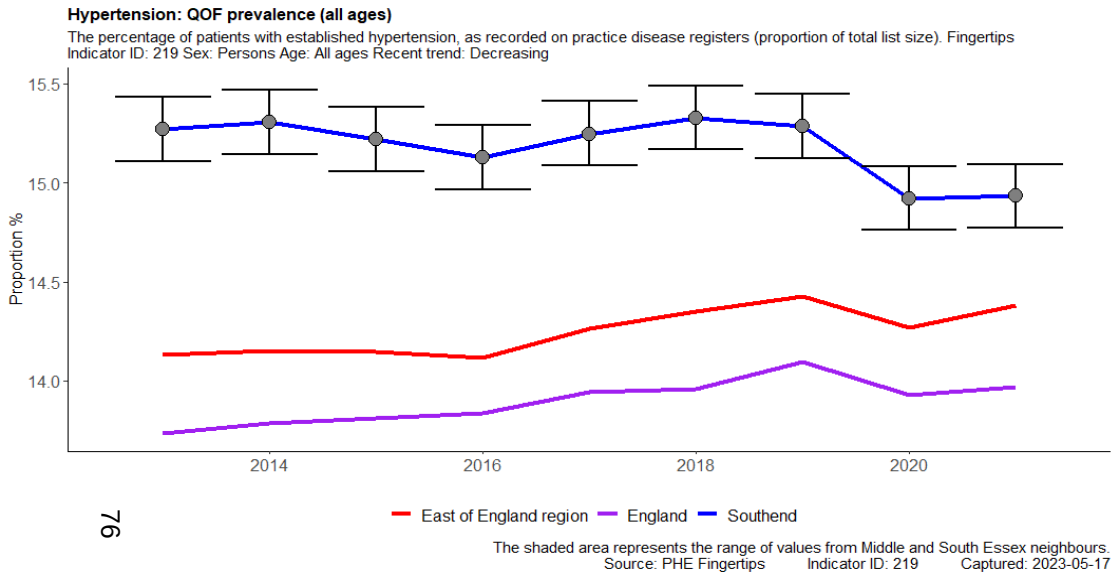
Cancer

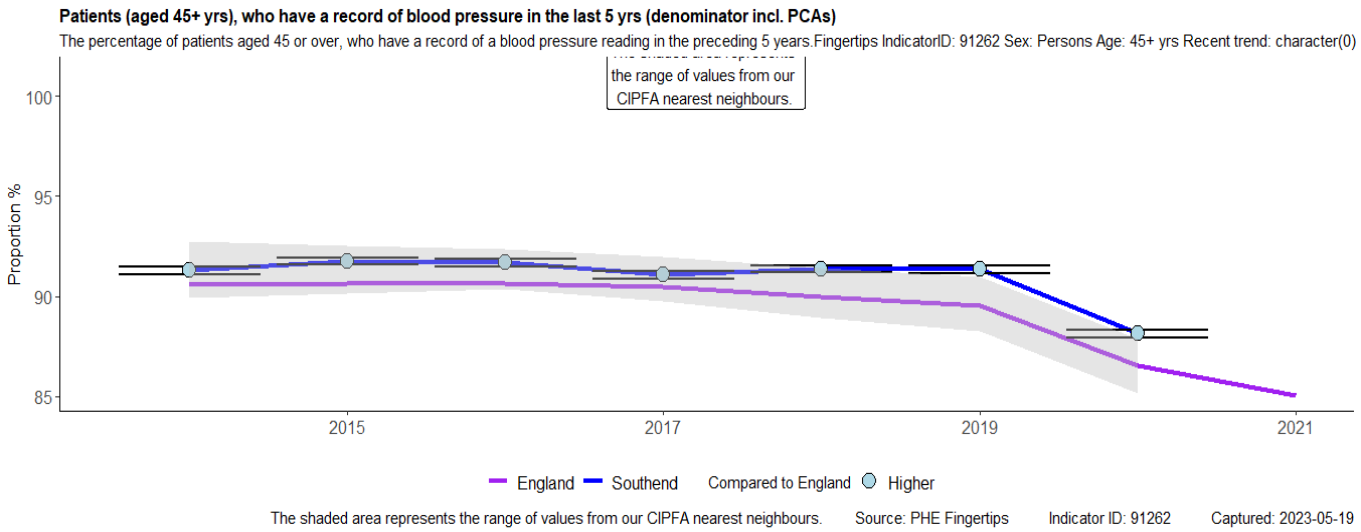




Stage at diagnosis is a measure of how much a cancer has grown and spread, with advanced stages meaning the cancer is bigger or has spread to other parts of the body (metastasis) and consequentially patient outcomes are worse for management and treatment. In **Southend**, the proportion of cancers diagnoses at early stages (1 and 2) has been similar to the national average and east of England average since 2016 apart from a dip in 2018. Overall, there is no significant trend. There has been no significant trend in new cancer cases with the incidence rate similar to the national average. Improving local data sharing protocols will be beneficial in better supporting local campaigns and raising awareness.

Hypertension





High blood pressure, or hypertension, rarely has noticeable symptoms. But if untreated, it increases the risk of serious problems such as heart attacks and strokes. Southend has a statistically higher prevalence of hypertension compared to both the national and regional averages. The trend is decreasing unlike the national and regional averages although Southend remains higher in comparison.

Locally, in patients aged over 45 who have hypertension, there is no trend in recent data, with a reduction in 2020. Southend remains statistically higher proportionally than the national average and at the upper range compared to our statistical neighbours.

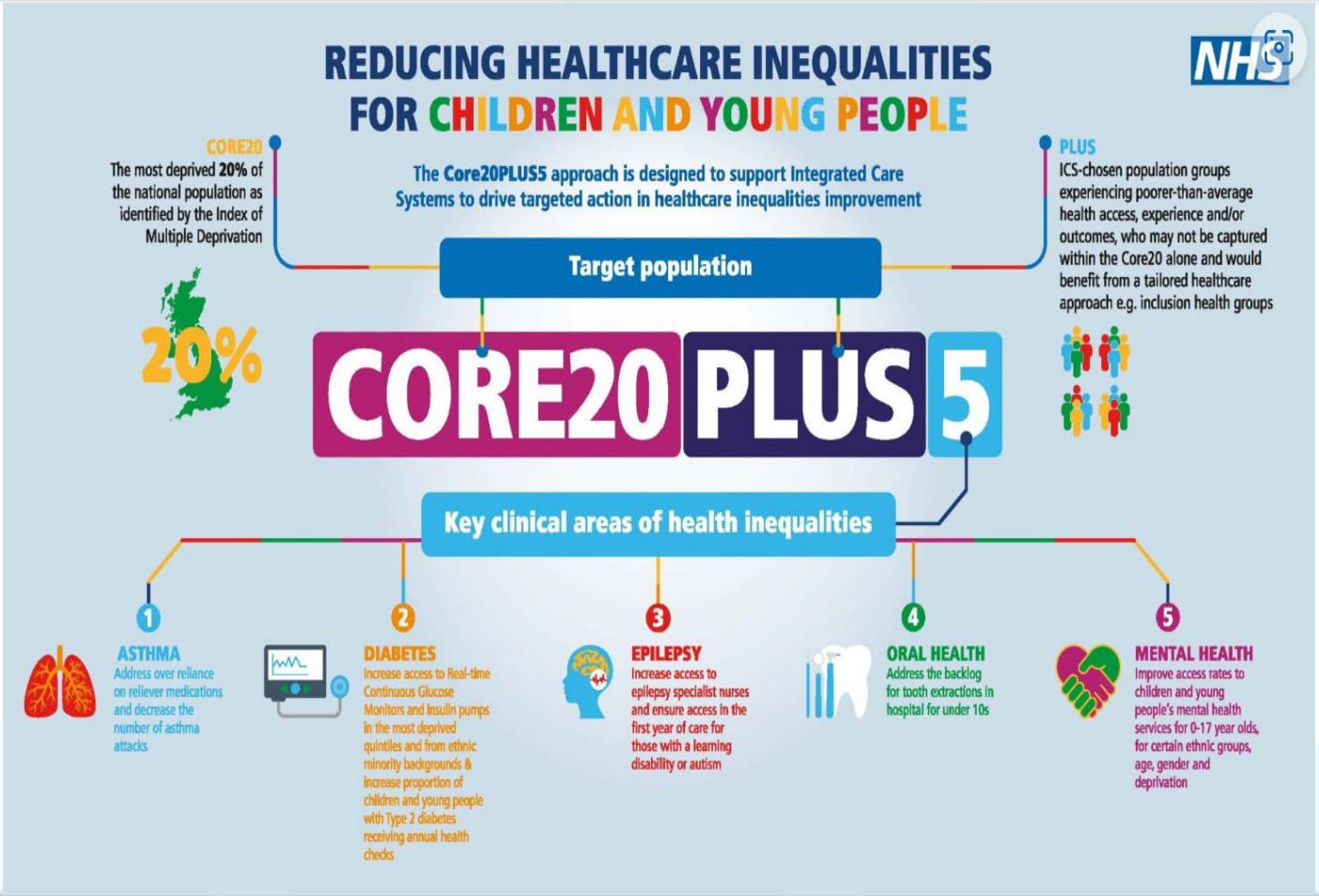
Core20 PLUS5 - Children

Core20 PLUS5 is an approach to reducing health inequalities for children and young people. The approach defines a target population cohort and identifies '5' focus clinical areas requiring accelerated improvement.

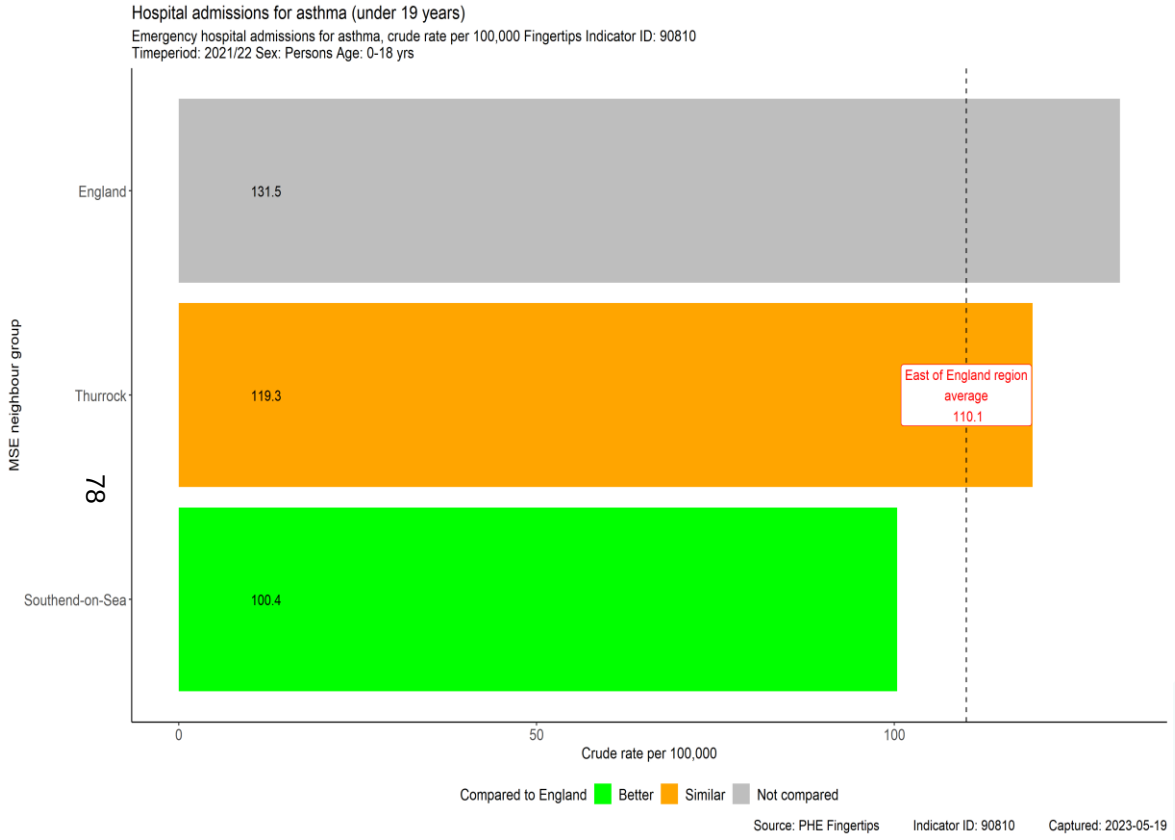
The Core20 refers to the most deprived 20% of the national population. The 'PLUS' refers to the local chosen population groups experiencing poorer-than-average health access, experiences and/or outcomes, who may not be captured within the Core20 and would benefit from a tailored healthcare approach and better support people who are socially excluded.

Asthma, diabetes, epilepsy, oral health, and mental health have been identified as the five key clinical areas of health inequality for children and young people.

Locally, the Children and Young People Growing Well Board is driving forward the identification of the PLUS population groups for targeted actions across Mid and South Essex and a detailed plan will be produced during 2023.



Childhood Asthma



Asthma is a chronic respiratory condition characterized by symptoms including cough, wheeze, chest tightness, and shortness of breath, and variable expiratory airflow limitation, that can vary over time and in intensity.

The disease has different underlying causes and variations in severity, clinical development, and response to treatment. **Symptoms** can be triggered by factors including exercise, allergen or irritant exposure, changes in weather, and viral respiratory infections.

Symptoms may resolve spontaneously or in response to medication and may sometimes be absent for weeks or months at a time.

Acute asthma exacerbation is a term used to describe the onset of severe asthma symptoms, which can be life-threatening.

Southend had statistically lower number of hospital admissions for residents under 19 for asthma than the national average. The national picture, reported by clinicians, is pointing to an increase in prevalence and will require more definitive local action.

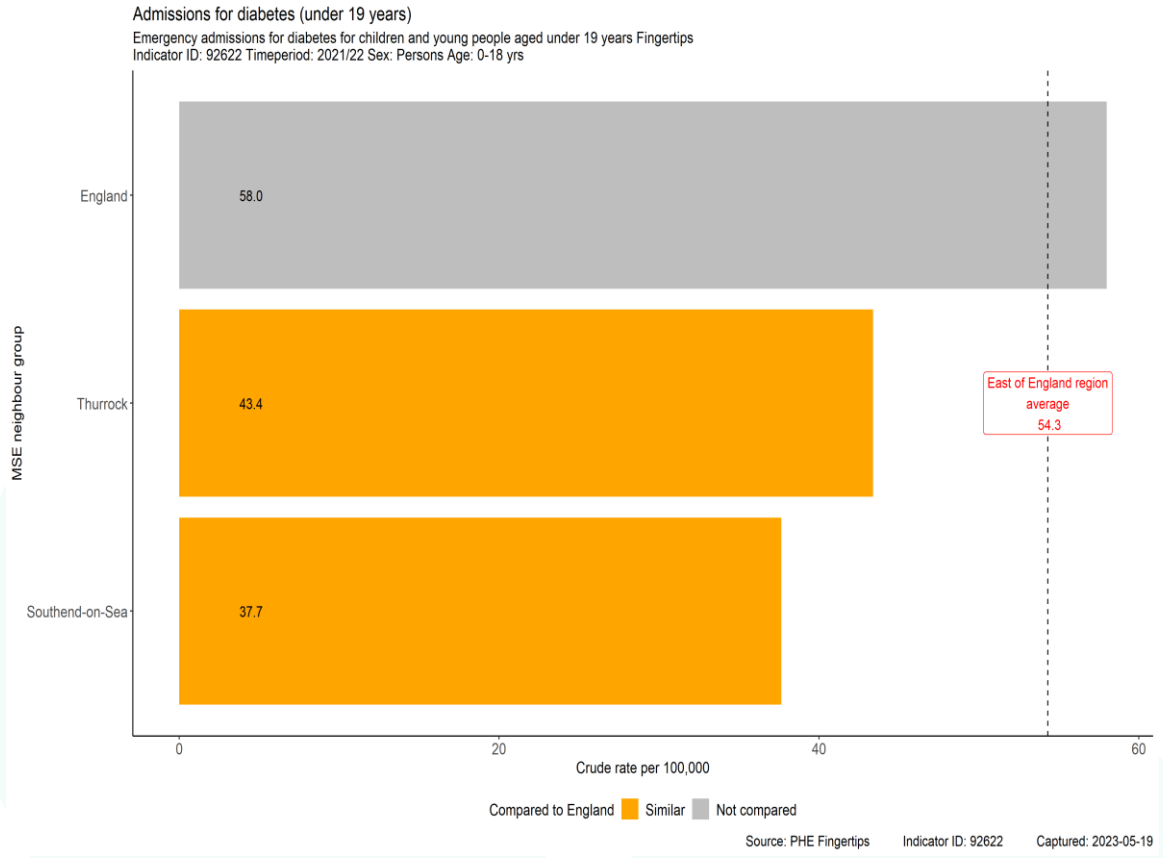
Childhood Diabetes

Diabetes is an increasingly common long-term condition in children and young people. In 2019, there were an estimated 36,000 children in the UK with diabetes under the age of 19 (31,500 in 2015). **Type 1 diabetes** constitutes the vast majority (90%) of diabetes in children and young people.

Type 2 diabetes is much less common in children and young people. It is more common in obese or overweight people, and in people of South Asian and Afro-Caribbean ethnicity. Unlike Type 1 diabetes, prevalence is strongly associated with deprivation.

Diabetes is associated with long term complications, such as eye and kidney disease, heart disease, especially if poorly controlled. Diabetic ketoacidosis (DKA – which is almost exclusively linked to Type 1 diabetes) is a potentially life-threatening condition requiring emergency admission to hospital and can be fatal if not promptly treated.

Southend had a statistically similar number of emergency admission for diabetes in residents under 19 years, to the national and regional averages.



Epilepsy in Children

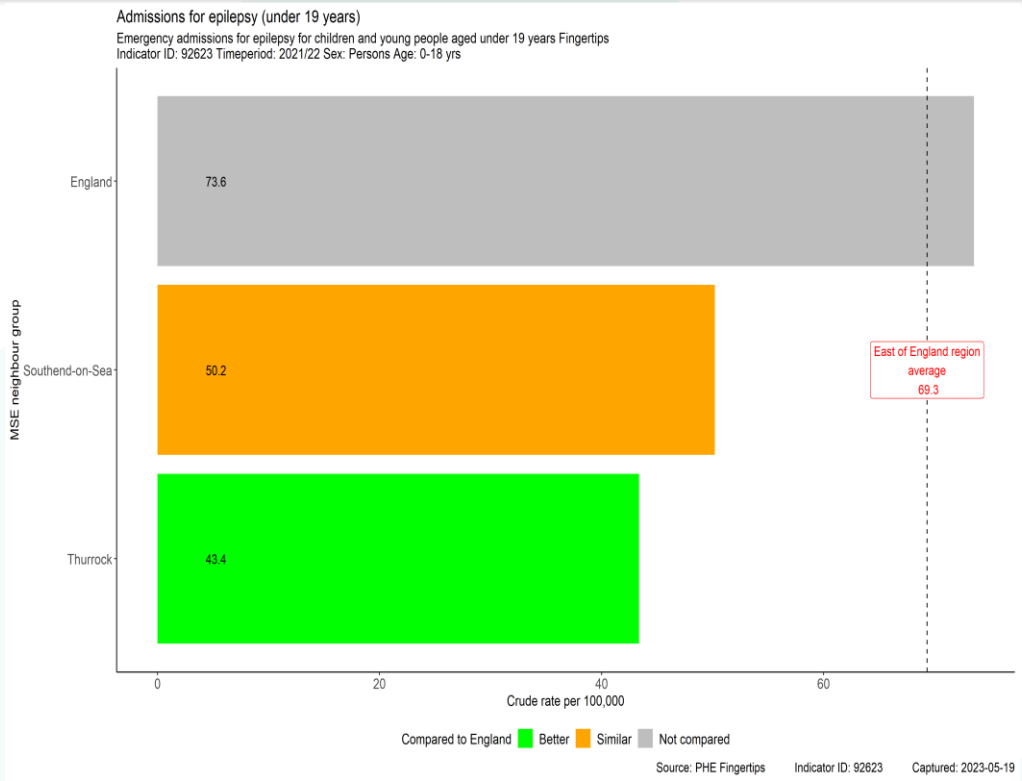
Epilepsy is the most common significant long-term neurological condition of childhood and affects an estimated 112,000 children and young people in the UK.

Definitive diagnosis is difficult due to lack of specific diagnostic test, and therefore both under and over diagnosis occurs. Recorded prevalence of epilepsy has reduced in recent years, which may partly reflect more specific diagnosis. However, even among those who have a diagnosis of epilepsy, up to a third continue to have seizures despite treatment.

Epilepsy is associated with a higher risk of **mental health problems**. 37% of children with epilepsy have a co-existing mental health disorder, a higher prevalence than found in other long term childhood conditions. National audit found that only 12.8% NHS Trusts provided mental health provision within epilepsy clinics.

Not all **emergency admissions** to hospital for epilepsy or seizures are avoidable. However, there is evidence that education, support with epilepsy medications and emergency seizure management plans can reduce emergency admissions.

Transition to adult epilepsy services is a time of increased risk, and well-coordinated specialist epilepsy services can reduce mortality among young people with epilepsy after transition to adult services. Nationally, in 2018, only 35.8% of NHS trusts had a dedicated outpatient clinic for young people with epilepsies.



Southend had a statistically similar number of emergency admission for epilepsy in residents under 19 to the national and regional average.

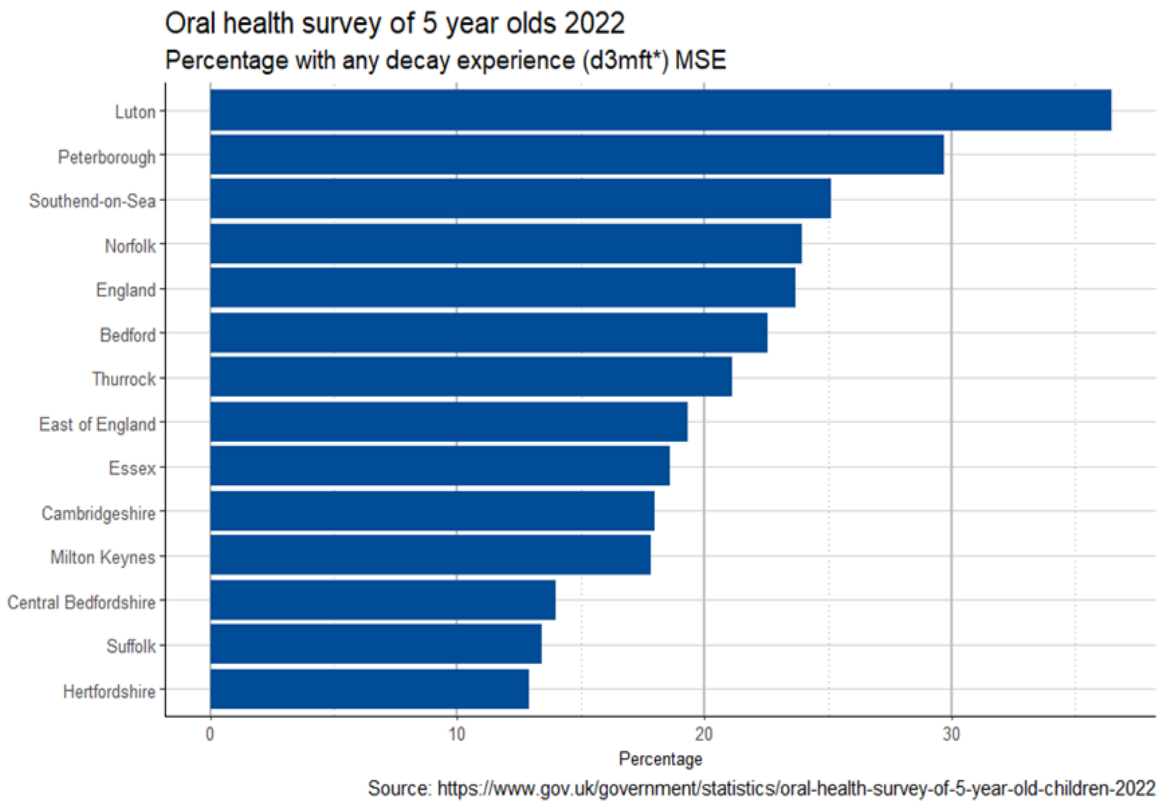
Children Oral Health

Dental extractions remain a primary reason for children to require a hospital admission. Tooth decay can be prevented with changes to diet and good oral habits, complimented by timely access to dental services. Although rates in England have been decreasing, it is a key area of improvement for children in Southend.

In 2021, there were 20 children in **Southend** admitted to hospital for dental caries. Tooth decay has been a common reason for hospital admission among children aged 5 to 9 for the past three years. In the oral health survey 2022 Southend had a high percentage of children with decay experience when compared to east of England neighbours.

Poor oral health can impact on many activities of daily living such as eating, sleep as well as wellbeing. It impacts on school attendance, delays in speech and language development and can cause more dental problems later in life. For young children, tooth extractions usually require a general anaesthetic and an admission to hospital.

Children from **lower socioeconomic groups** have a greater prevalence and severity. There was variation in prevalence of experience of dental decay by **ethnic group** and more significantly higher in the 'Other Ethnic Groups' and the Asian/Asian British' ethnic group.



Children & Young People - Mental Health & Wellbeing

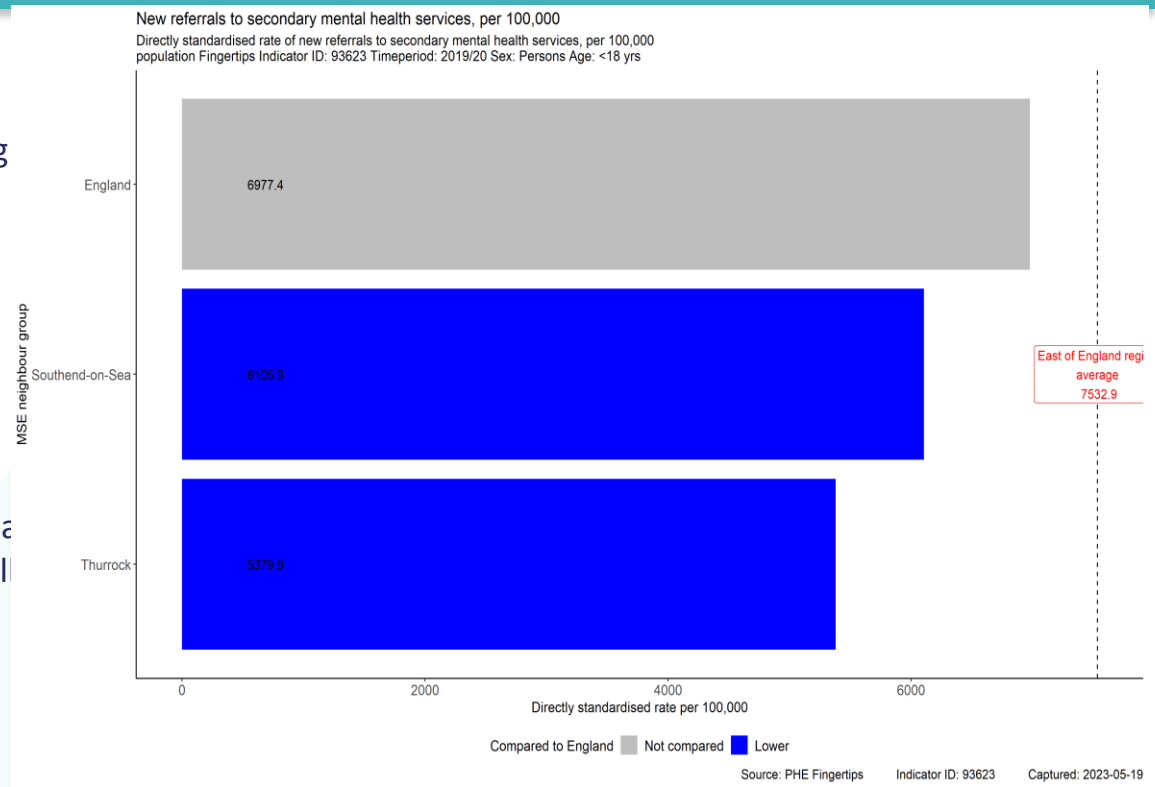
Today's children and young people are considered to have worse mental health outcomes compared to previous generations, exacerbated by the Covid-19 pandemic.

Mental health disorders are a leading cause of **health-related disabilities** in children and young people. These illnesses can have a devastating impact on their physical health, their relationships, and their future prospects, and they don't always receive timely support.

Children's **mental health services** locally continue to see rising demand, increased acuity and complexity of presentations, lengthier periods of intervention to mitigate risks, and growing caseloads. The long-term impact cannot be underestimated, and it is important that we put mental health on a level footing with physical health for them in Southend.

Conditions such as neurodiversity, autism, anxiety, low mood, depression, conduct disorders and eating disorders can stop some young people achieving what they want in life and making a full contribution to society. The challenge often extends into a person's adult life, with half of all mental health conditions beginning before the age of 14.

The traumatic impact of **abuse and neglect** increases the likelihood of children developing a range of mental health issues – both during childhood and in later life. Children in care are more likely than their peers to have a mental health difficulty.



Mental health and emotional wellbeing may be experienced differently by different groups of children and young people, and this can be influenced in particular by age, gender (including LGBTQ+), economic disadvantage, special educational needs and/or disability (SEND), and ethnicity (such experiences of discrimination).

Southend had a lower rate of new referrals to secondary mental health services per 100,000 residents under 18 than the national and regional averages.

Mental Wellbeing - What can make a difference?

Being mentally healthy should be about being supported with the right support at the right time to avoid a crisis in order to feel and function well in a way that is appropriate to the individual.

Improvements to adult mental health provision, including perinatally, are vital to prevent mental ill health developing in children. Nurturing family relationships and supportive home environment which promote positive attachments is an important factor for promoting good mental health in children and young people. Early support and intervention can help build resilient families and children. Providing effective mental health support for children who have experienced abuse and neglect can help them recover from its effects.

The **Southend, Essex and Thurrock plan** for the transformation of mental health services and support for children, young people and young adults is expanding mental health services by increasing access to broader mental health services to complement the existing core CAMHS provision and developing ways to further enhance and broaden the ways in which families and carers engage with services at a local level in schools, at home and in the community. Actions include:

- Improved mental health training for health professionals. Mental health should be a core part of the training curriculum for all health professionals who deal with children and young people.
- Advocate for the mental health of local children and young people. Working more collaboratively on improving meaningful data sharing on mental health prevalence and service capacity to articulate the needs of the local population.
- Encourage integrated working between organisations and agencies across the whole children's workforce. Integration of practice, education, pathways and commissioning will ensure that prevention, recognition, early intervention, support and onward referral is commonly addressed by professionals.

Support to Improve Lifestyles

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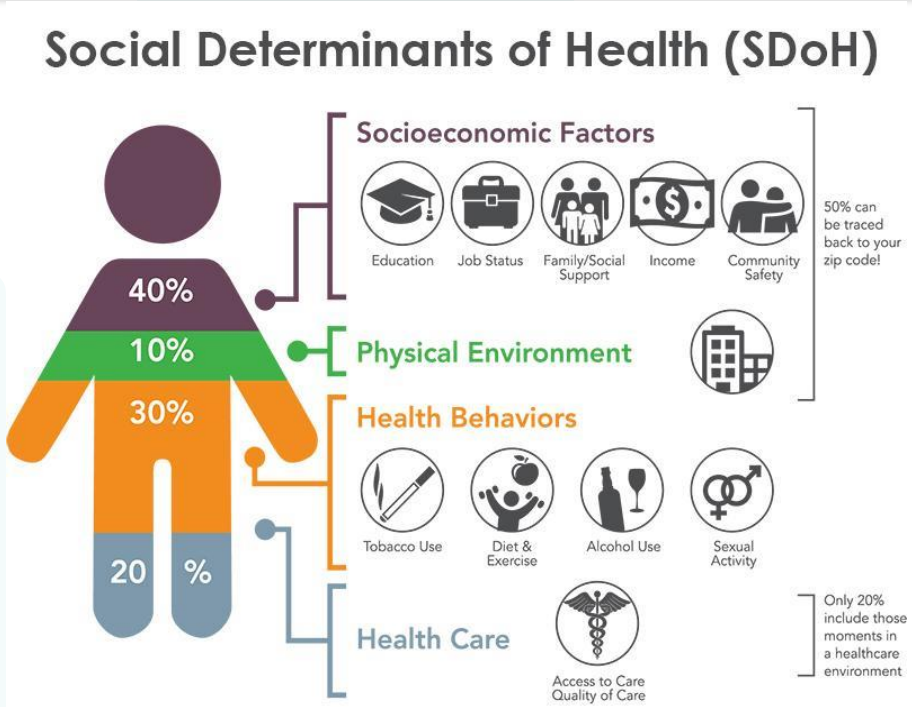
Prevention & Social Determinants of Health

People's **health-related behaviours** are influenced by a range of factors including social, economic and physical environment as well as mental wellbeing. By making it easier for people to adopt healthy behaviours and improve their physical environment, we can support to reduce the burden of disease and help **narrow the gap in health inequalities** arising from long term conditions such as obesity, cancers, heart conditions, stroke, respiratory disease and dementia as well as social inequalities.

Southend wants to have an environment and community in which healthier choices are the easy choices.

Primary prevention aims to prevent disease or injury before it ever occurs. We can make it easier for people to be able to make healthier choices and reduce the risk of developing ill health, disease and premature death.

Secondary prevention aims to reduce the impact of disease or ill health that has already occurred and includes treatment to support the changes in behaviours or lifestyle factors that are needed to improve a person's healthy life expectancy and increased years in good health. That means the provision of tailored help and support for tobacco addiction, drug and alcohol misuse and obesity.



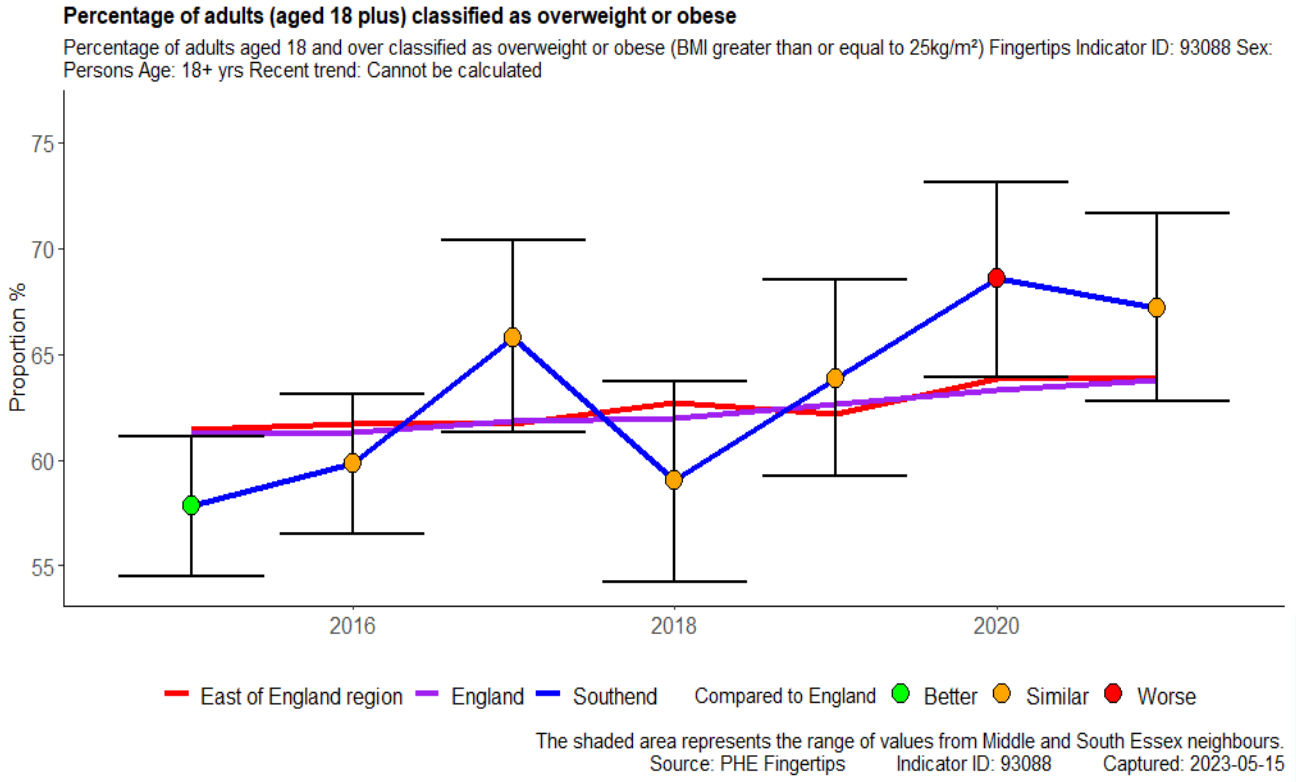
To embed prevention across the work that we do, public health will focus on opportunities to support healthier behaviours, which build on the strengths and protective factors that influence behaviours across the life course, whilst reducing the risk factors. This involves a holistic view which considers how we work to address the wider determinants of health, with targeted socioeconomic interventions in our more disadvantaged communities.

Healthy Weight - Adults

Being **overweight and obese** can lead to significant health issues for adults across the life course and into old age. Including on their physical and mental wellbeing.

There is no singular intervention that can tackle obesity on its own, at population or at an individual level. Causes of obesity are multi-factorial, including biological; physiological; psycho-social; behavioural; and environmental factors.

In **Southend**, the percentage of adults classified as overweight or obese is statistically similar to the national and regional averages; with more recent data showing an upward trend.



Childhood Obesity

Tackling childhood obesity is a long-term challenge and remains a top public health priority.

Obesity increases the risk of developing a range of health conditions in childhood and later life is associated with reduced life expectancy and a range of health conditions including Type 2 diabetes, cardiovascular disease, liver and respiratory disease and cancer. Obesity can also have an impact on mental health and wellbeing and eating disorders.

Children who are overweight are much more likely to become obese adults. There is a **marked inequality in obesity (obese only)** among children from either Black or Asian backgrounds; in the Asian group, the increase in prevalence is three-fold between Reception year and Year 6.

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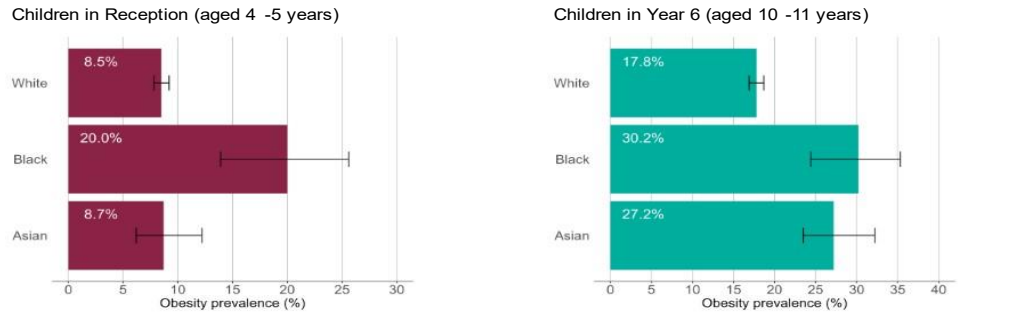
Obesity prevalence by ethnic group in Southend -on-Sea
National Child Measurement Programme



Data combined 5-years, (2016 to 2017, 2017 to 2018, 2018 to 2019, 2019 to 2020, and 2021 to 2022), see note on slide 16
95% confidence intervals are displayed on the chart

Office for Health Improvement and Disparities 13

Prevalence of overweight (including obesity) in Southend-on-Sea by age
National Child Measurement Programme 2021 to 2022

Around 1 in 5 children (21.5%) in Reception (aged 4 -5 years) were overweight or living with obesity

Around 2 in 5 children (37.8%) in Year 6 (aged 10 -11 years) were overweight or living with obesity

Office for Health Improvement and Disparities 4

The National Child Measurement Programme (NCMP) measures the height and weight of over one-million children in Reception (age 4-5 years) and Year 6 (age 10-11 years) each year in primary schools in England. The data shows that nearly 2 in 5 children leaving primary school are overweight or obese (37.8%), with 1 in 5 living with being obese (23%).

Childhood Obesity & Link to Deprivation/Ethnicity

Children residing in the most disadvantaged areas are more than twice as likely to be living with obesity than those in the least deprived areas.

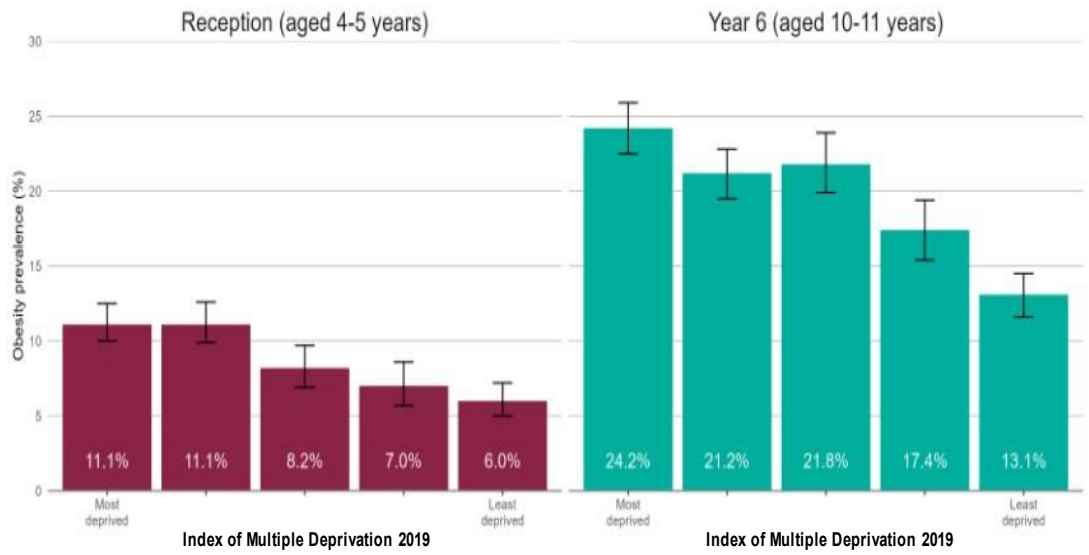
The sample of data collected across schools, for Reception Year and Year 6 pupils, provides a valuable insight into local obesity rates and has enabled more targeted interventions in supporting parents and young people to improve their weight management strategies.

Children from Black and minority ethnic families are also more likely than children from white families to be overweight or obese and this inequality gap is gradually increasing. These disparities are reflected in the childhood obesity profile for **Southend**.

Following the successful trial of the **Health4life** programme – 6 weeks of support for parents and young people on achieving and maintaining healthier lifestyles - we have teamed up with Southend United Community Education Trust to extend this programme for those aged 5-16 years. We continue to explore new avenues with local partners to improve access to more physical recreations through Active Southend.

Obesity prevalence by deprivation and age in Southend -on-Sea

National Child Measurement Programme



Data combined 5 years, (2016 to 2017, 2017 to 2018, 2018 to 2019, 2019 to 2020, and 2021 to 2022), see note on slide 16
95% confidence intervals are displayed on the chart

Office for Health Improvement and Disparities

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Smoking

Smoking is uniquely harmful, to both smokers and people around them. Smoking is one of the main causes of health inequalities in England, with the harm concentrated in disadvantaged communities and groups.

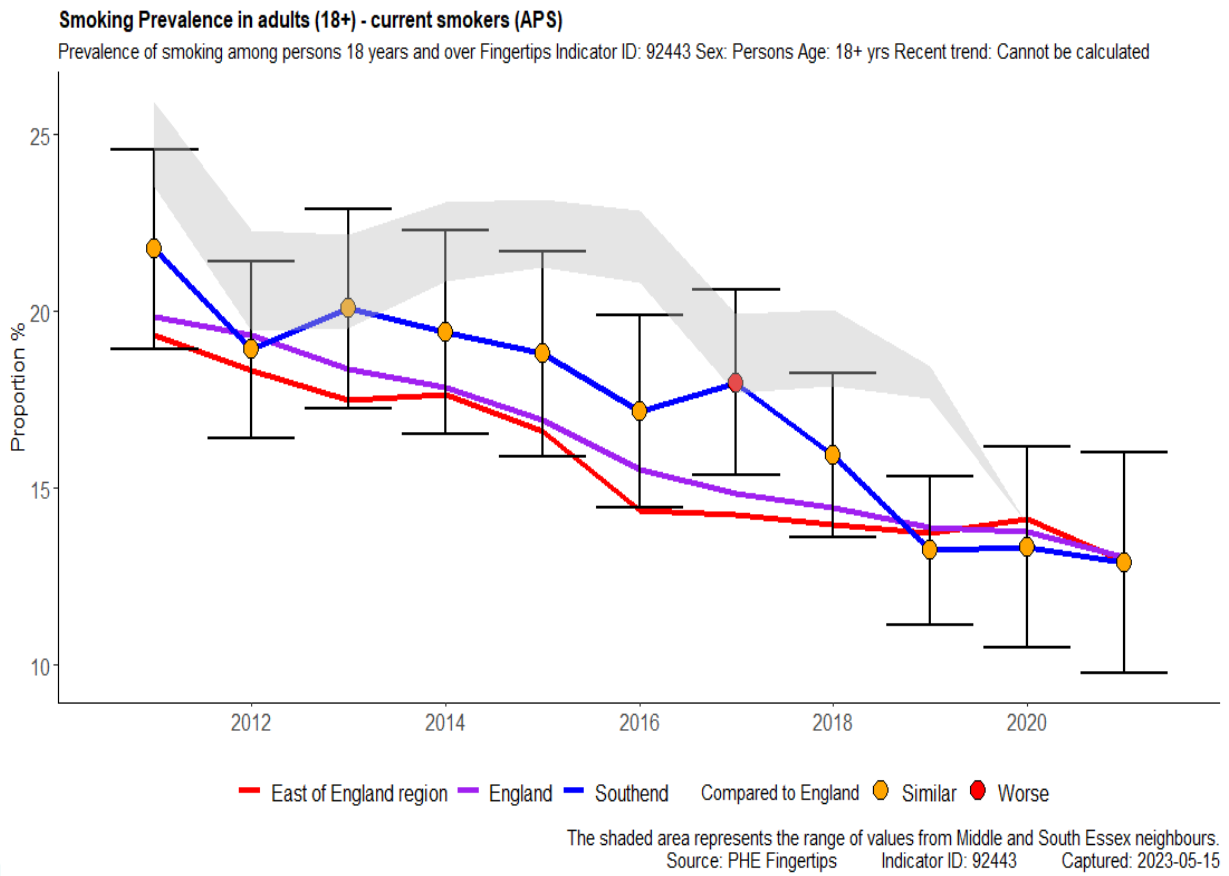
Although **smoking prevalence** has continued to decline year-on-year over the last 12 years, this stands at 13% of adults living in England who still smoke.

Smoking is a leading preventable cause of illness and premature death. In England, there were an estimated 506,100 smoking-related hospital admissions in 2019-20. One in 4 patients in a hospital bed is a smoker, with GPs seeing 35% more smokers than non-smokers.

The **health benefits** are considerable, including for people with a pre-existing smoking-related disease. Benefits include shortened hospital stay, fewer clinical complications and infections, increased survival rate from surgery, better wound healing and fewer re-admissions post-surgery.

Supporting smokers in contact with the healthcare system to quit is a prevention priority in the NHS Long Term Plan and in supporting to realise the national **smoke-free ambition by 2030** - defined as adult smoking prevalence of 5% or less.

Southend has a significantly similar prevalence of smoking to the national and regional averages with an overall downward trend.



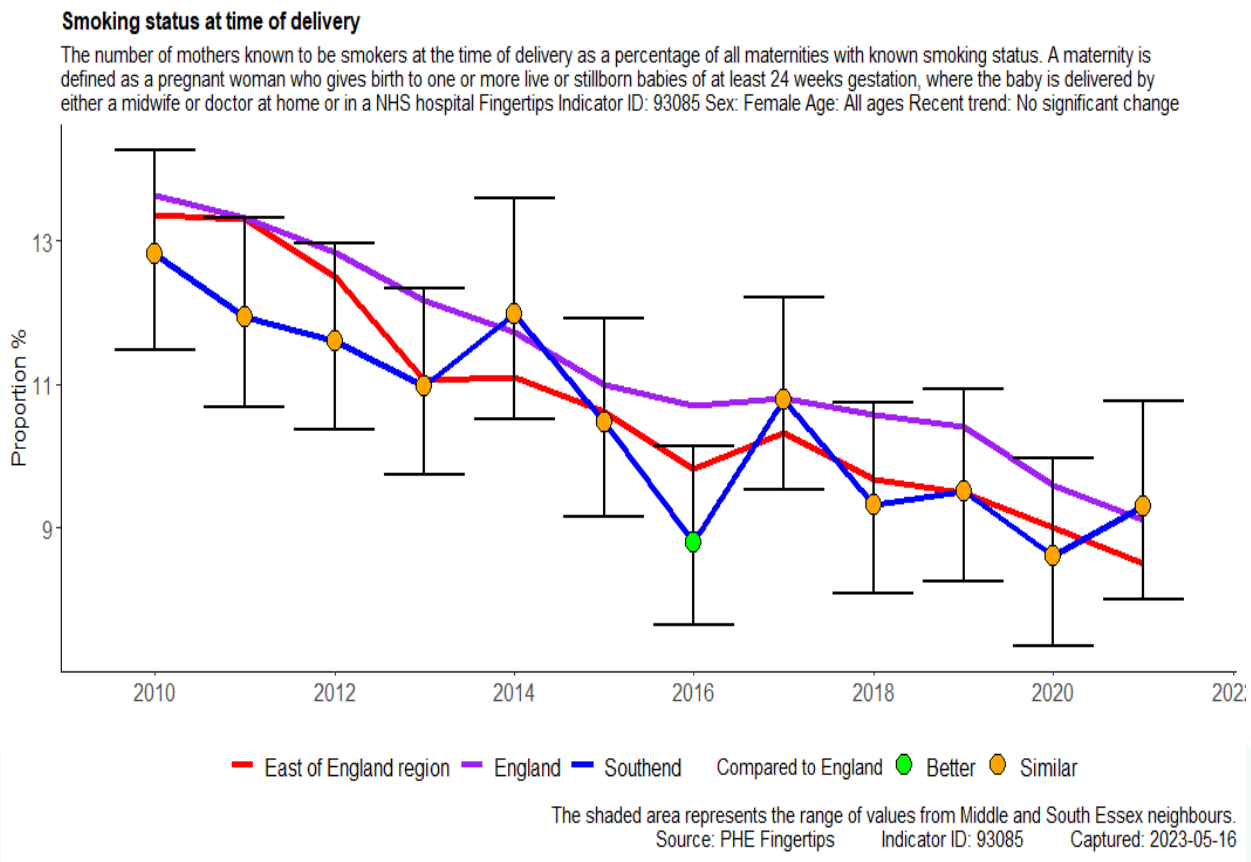
Smoking in Pregnancy

Smoking in pregnancy is the leading modifiable risk factor for poor birth outcomes, including stillbirth, miscarriage, and pre-term birth. Smoking during pregnancy also increases the risk of children developing several respiratory conditions, attention and hyperactivity difficulties, problems of the ear, nose and throat, obesity, and diabetes.

As at 2020/21, 9.6% of women were smoking at time of delivery (with 28% being under the age of 20), which equates to around 51,500 babies born to pregnant smokers in England each year. Rates of smoking in pregnancy have a strong social and age gradient with poorer and younger women much more like to smoke in pregnancy.

The smoking in pregnancy reduction target was set at 'less than 6%' by 2022, in the Tobacco Control Plan for England (2017); measured as smoking at time of delivery. This measure has been achieved in different regions across the country with smoking cessation services becoming part of the local maternity model.

Southend has a significantly similar prevalence of smoking at time of delivery to the national and regional averages with an overall downward trend.



Emotional Health and Wellbeing

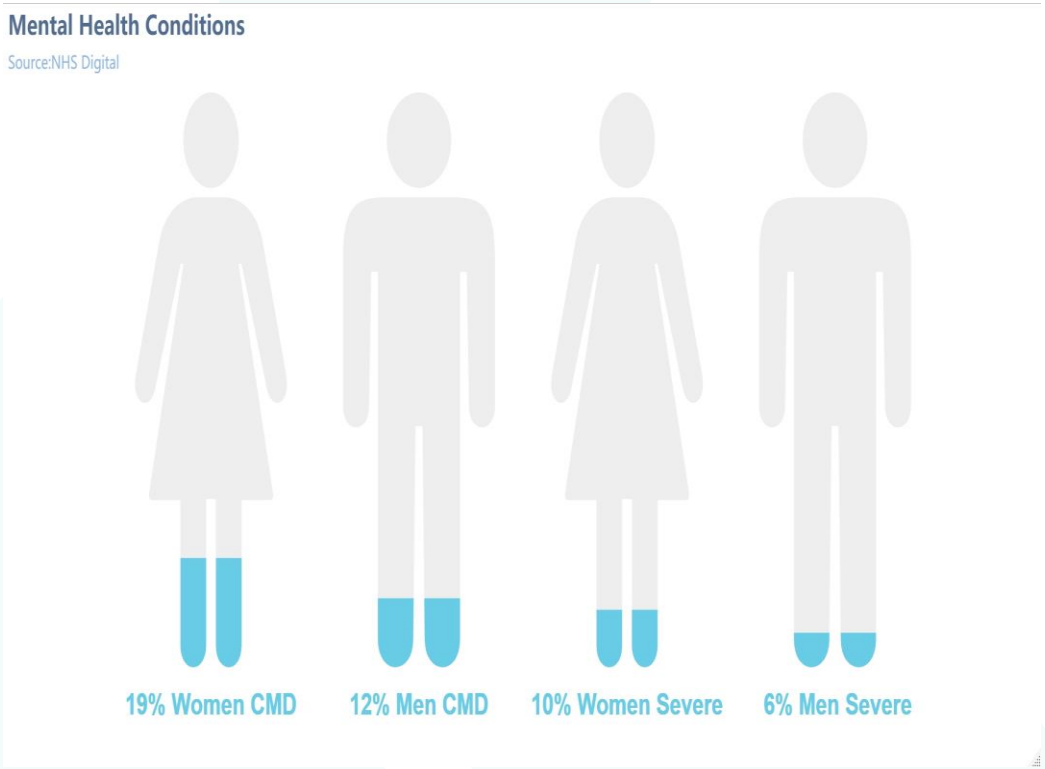
Mental health problems are common, with 1 in 6 adults reporting a common mental health disorder (CMD) such as anxiety, and there are close to 551,000 people in England with more **severe mental illness** (SMI) such as schizophrenia or bipolar disorder.

Problems are often hidden, stigma is still widespread, and many people are not receiving support to access services.

Together with substance misuse, mental illness accounts for 21.3% of the total burden of disease in England. Poor mental health is estimated to carry an **economic and social cost** of £105 billion a year in England.

Mental health problems and suicide can be preventable. Promoting good mental health and wellbeing will impact on physical health and many other aspects of people's lives such as healthy lifestyle and to manage and recover from physical health conditions.

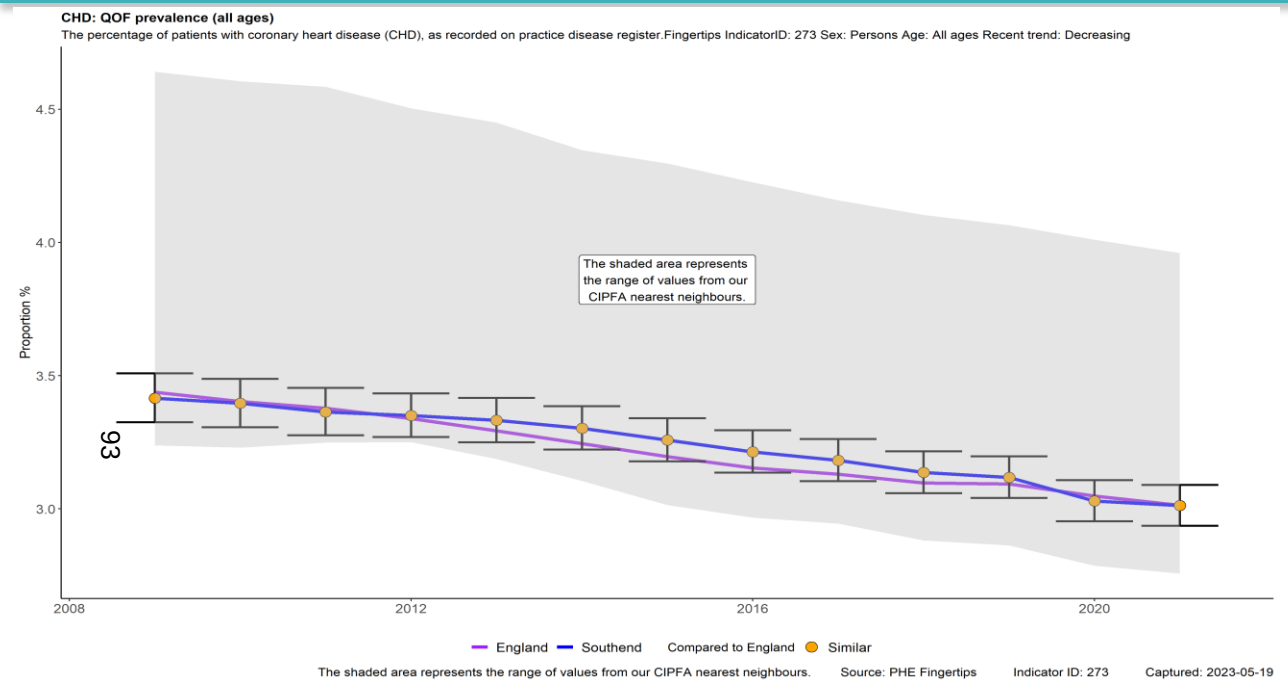
People with physical health problems, especially long-term conditions, are at increased risk of poor mental health - particularly depression and anxiety. Around 30% of people with any long-term physical health condition also have a mental health problem. Poor mental health, in turn, exacerbates some long-term conditions, such as chronic pain.

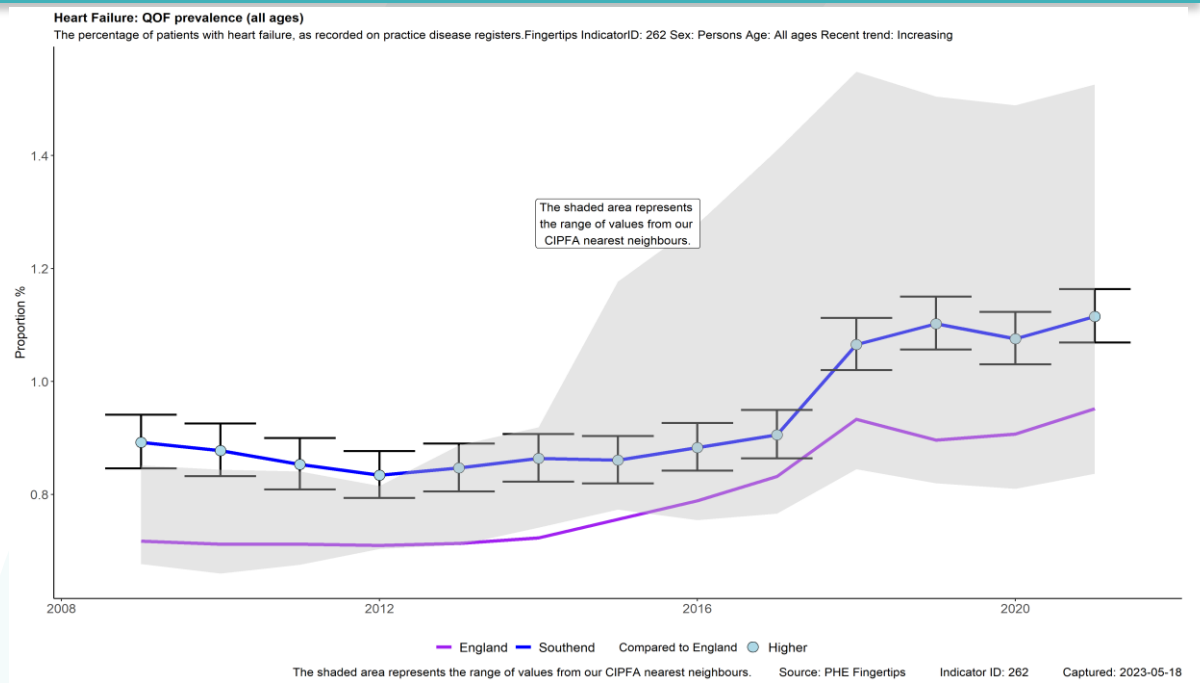


Long Term Conditions

Other key areas of focus for prevention

Cardiovascular Conditions





Coronary heart disease (CHD) is the single most common cause of premature death in the UK. Evidence relating to the management of CHD is well established and if implemented can reduce the risk of death from CHD and improve the quality of life for patients. **Southend** is statistically similar to the national average and has a downward trend.

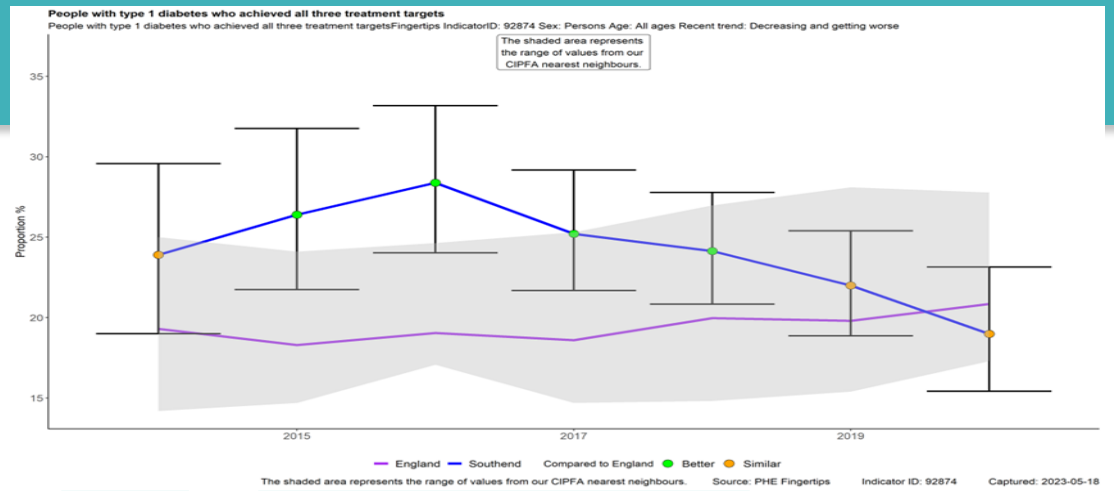
Heart Failure (HF) is responsible for a dramatic impairment of quality of life, carries a poor prognosis for patients, and is very costly for the NHS to treat (second only to stroke). In **Southend**, the prevalence of heart failure is increasing compared to our statistical neighbours and England.

Diabetes

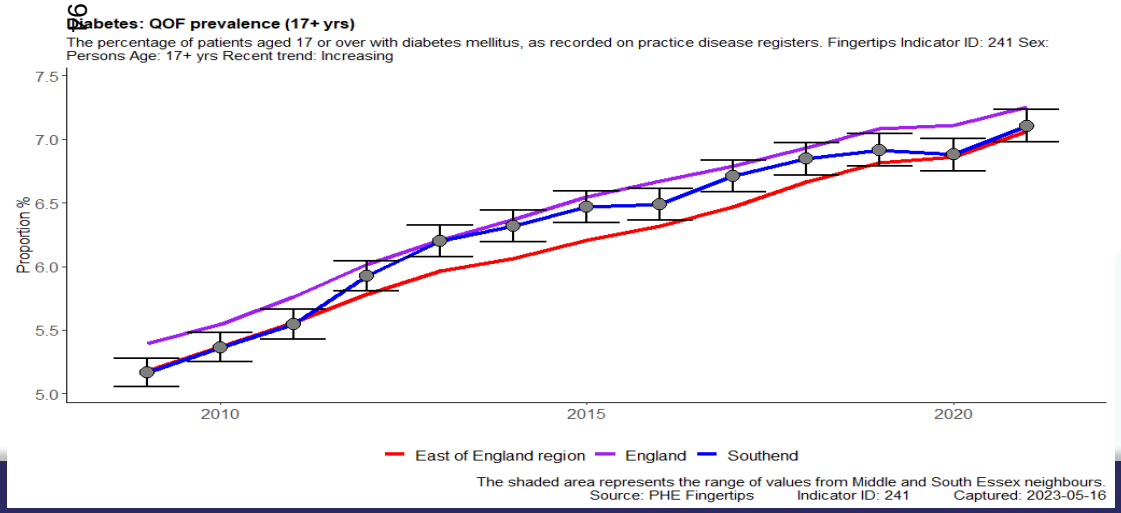
Diabetes mellitus is one of the most common diseases affecting all age groups with over three million people in the UK having the condition.

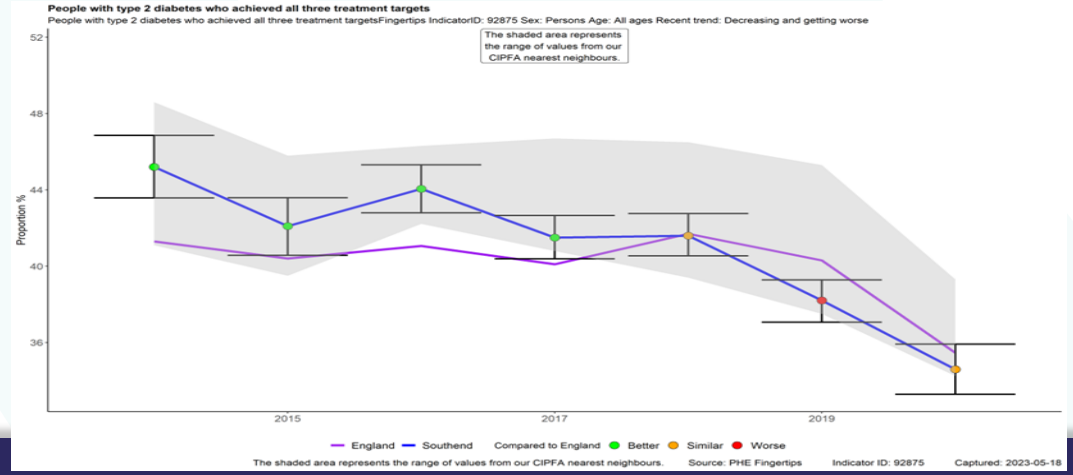
Effective control and monitoring can reduce mortality and morbidity. Much of the management and monitoring of diabetic patients, particularly patients with Type 2 diabetes is undertaken by the GP and members of the primary care team.

In **Southend**, the prevalence of diabetes has been increasing for the past 3 years; City is statistically similar to the regional average but lower than the national average.



In **Southend**, in both Type 1 and Type 2 diabetes patients there has been a downward trend in patients who meet all three treatment targets. For Type 1, whilst this is statistically similar to the national trend, Southend has seen a sustained drop in the management if diabetic patients.





Transforming Children & Young People and Families Services

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> Protecting & Safeguarding Young People
> Family and Community Hubs

Protecting & Safeguarding Young People

Southend has seen a widening in inequalities exacerbated by the Covid-19 pandemic and the current cost of living crisis. **Poverty and child neglect** are highly correlated as poverty leads to hardships for families which impact on parents' capacity to meet the needs of their children.

Effective Support Early – we want children, young people, and families to receive the right support and help at the right time, at the right place, as early as possible in the life of a problem.

Preventative and **early help** responses to neglect are critical to avoid issues from escalating and children experiencing further harm. Interventions need to be of a kind and duration that improve and sustain the safety of children and young people and help parents to develop supportive caring family relationships that strengthen resilience in their children.

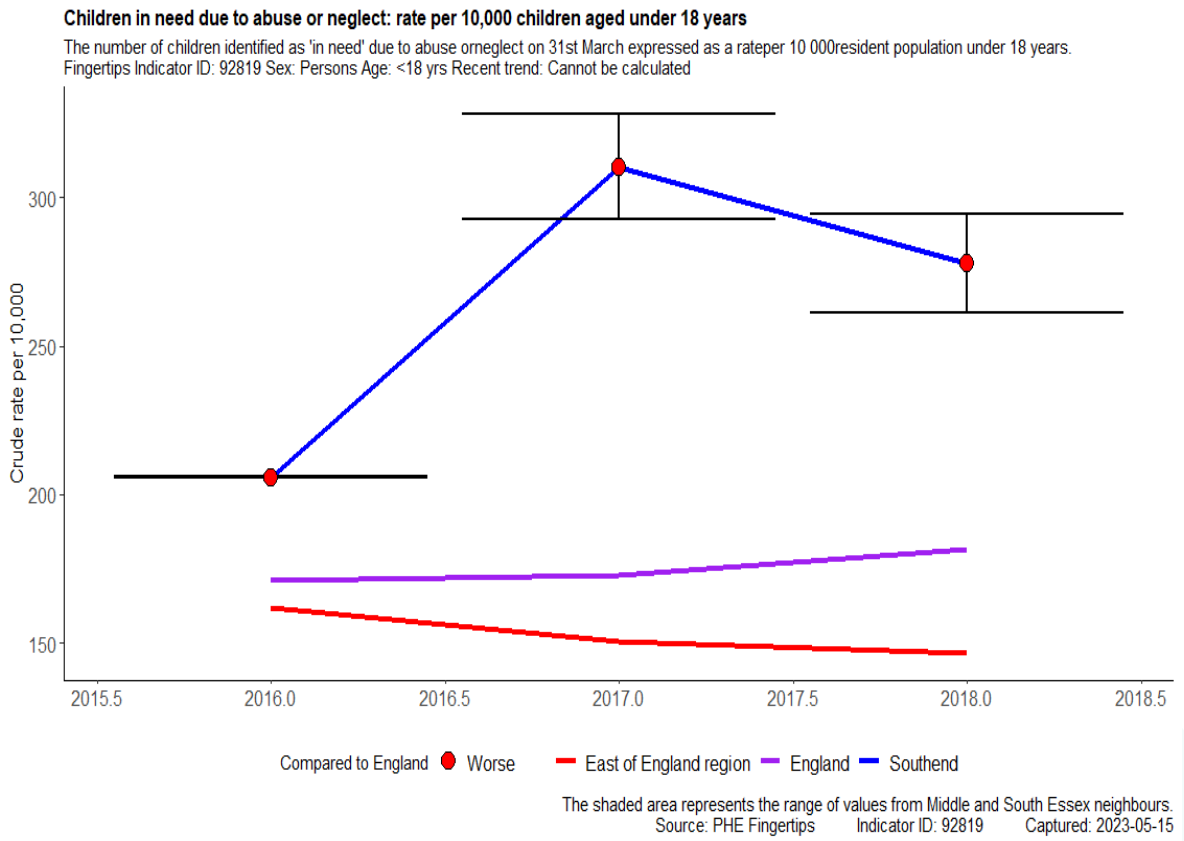
Protecting & Safeguarding Young People

Every child deserves the **best start to life** and most children in Southend experience a happy supportive childhood that prepares them for adulthood.

However, some children in Southend have a different childhood experience and are exposed to challenges, harmful experiences, and risks. These are known as adverse childhood experiences (ACEs) and can have a damaging effect on the health and emotional wellbeing of children and young people and can negatively impact their ability to thrive, be happy and achieve.

These experiences include witnessing or experiencing violence, abuse, and neglectful parenting, and living with parents who have poor mental health or misusing substances.

In Southend, **neglect** is the leading cause of children and families requiring additional support and children requiring child protection plans. Continued improvement in data sharing undertakings, would greatly improve health and care outcomes for our residents.

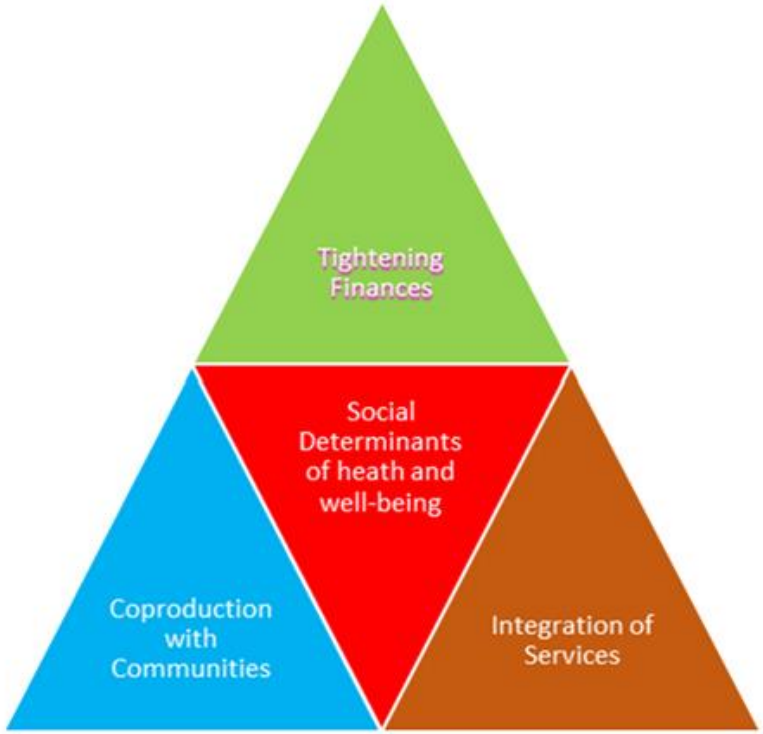


Family & Community Hubs - Context

Southend has seen a widening gap in inequalities exacerbated by the Covid-19 pandemic and the current cost of living crisis. The Council's wider ambition to accelerate change and ensure more cost-effective service provision and more efficient, co-ordinated service delivery, presents a real opportunity to transform the services for children and families across the City.

This is mirrored in the NHS's local strategy in tackling the wider determinants of health to improve health and wellbeing. Therefore, this transformational approach would be underpinned by:

1. the **social determinants of health**, highlighted by the Marmot report;
2. the **integration agenda**, at the heart of the vision for *The Best Start for Life;*
3. a greater focus on **co-production with communities**, as active partners;
4. addressing the growing **financial challenges**, by doing more with less.



Family & Community Hubs – Desired Outcomes

With the advent of the national launch of the Family Hub programme^, we are uniquely placed in the City to review our plethora of assets, good practice and the test-and-learn culture, to explore and co-design a more efficient and effective way of meeting the needs of our children, young people and families, enabling them to flourish.

This approach can bring together a number of resources including family centres, libraries, cultural sites and other community facilities to transform our service provision and:

- provide **support to parents and carers** so they are enabled to nurture their babies and children, improving health and education outcomes for all;
- contribute to a **reduction in inequalities in health and education outcomes** for babies, children and families across England by ensuring that support provided is communicated to all parents and carers, including those who are hardest to reach and/or most in need of it;
- **build the evidence base** for what works when it comes to improving health and education outcomes for babies, children and families in different delivery contexts.

One of the key enablers for success, is the need to improve communication between agencies by ensuring meaningful and necessary information sharing.

^ Family Hubs and Start for Life programme: local authority guide - GOV.UK (www.gov.uk)

Key Actions and Initiatives

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Key Actions & Initiatives

Initiative	23/24	Lead Partners
Core20PLUS5	The Mid and South Essex Integrated Care Partnership has developed a wider strategy and plan to target these areas, and are being delivered through the South East Essex Alliance.	MSE, SEE Alliance, SCC-Public Health and ASC
Smoking Cessation	Continue to promote stop smoking services and provide a range of support options to residents motivated to stop smoking Focus efforts on routine and manual occupations; residents during pregnancy and at time of delivery; those with a mental health condition; and the general population Deliver stop smoking services that align with NHS and evidence-based standards and guidelines Provide training and support to ensure accreditation standards of advisors are maintained and increase the number of advisors that can provide stop smoking support services Improve referral pathways for allied health and community services to support residents to access stop smoking services Reviewing the current stop smoking service offer and further scoping community pharmacy provision; Quit manager referrals through lifestyle and wellbeing services; Health behaviours Review; and education and training provision Exploring new ways of improving referrals onto the stop smoking service with the dedicated Public Health Midwife supporting engagement and training with clinicians. A new incentivisation scheme is being considered nationally to encourage pregnant smokers <20s to quit the habit.	MSE, SCC-Public Health
Maternal Mental Health	Local services are currently being reviewed with the possible introduction of the maternal mental health service. This service will include supporting families that have suffered early pregnancy loss and pregnant people who have had babies placed in foster care due to social circumstance. These families at present are not supported by the Perinatal Mental Health Teams.	MSE, EPUT, SUHFT, SCC -Public Health

Key Actions & Initiatives

Initiative	23/24	Lead Partners
Respiratory Illness	Southend was chosen and funded by OHID as a pilot location for COPD Connectors program from 2022-2024. This is to equip , empower and capture 'lived experience' of patients living with COPD in ABSS wards so to further inform resource allocation and improve access to care e.g Pulmonary Resus, Stretch and Breath classes etc thereby reduce A&E usage.	MSE, EPUT, SCC-ASC
Hypertension	We are focusing more interventions where the expected prevalence is likely to be higher, through targeted health checks and increasing other public health actions, such as improving physical wellbeing.	
Annual Health Checks	-Reviewing contract with Providers to support NHS delivery to eligible population groups -Working cross boundaries at SET level to create a joint template on recording to facilitate engagement and increase health check uptake	SCC -Public Health, SEE Alliance, PCNs
BP at home	-BP monitors distribution to residents in need to reverse inverse care laws -Improve recording through engaging with GP Practices - Supporting Primary Care Network (PCN) , Partners , Voluntary sector etc h to support and empower vulnerable residents with positive lifestyle choices	MSE, UCLP, PCN
COPD	-Continue to share knowledge, learning experiences and stories from the local area -To inform and influence service providers -Share information Build relationships with service providers	Southend Health watch and SAVS
Cancer	-Southend Lung Health Check commenced. -Pilot with Shoebury PCN for cervical screening and engaging neighbourhood community assets (hairdressers/nail bars etc) -Social marketing insights into barriers to breast screening, cervical screening & bowel screening for women 50+ population. -Review of the historical data and uptake at neighbourhood level of breast screening and cervical screening -Campaign at neighbourhood level for screening taking place in that neighbourhood (screening rounds) -Lung Health checks and early detection of lung cancer conditions, commenced in April 2023 -Work with GPs to improve ethnicity and postcode data recording with regards to Colon cancer -Continue to work with GPs with extending the pilot for Prostate cancer detection in the male population.	SCC -Public Health, PCNs, SEE Alliance

Key Actions & Initiatives

Initiative	23/24	Lead Partners
Diabetes in Children	-Explore improved diagnosis and ensuring that children are managed effectively in primary care, using the NICE guidance, is essential in preventing hospital admissions and poor wellbeing outcomes.	MSE, EPUT, SCC - Public Health
Epilepsy in Children	-Will look at improving diagnostics and management of people living with this conditions.	MSE, SCC -Public Health
Oral Health in Children	A system-wide approach to improve oral health and associated benefits for the most vulnerable children and young people. A new plan is in development to cover healthy eating and oral health campaigns, supervised teeth brushing in early years and school settings, provision of toothbrushes for high risk groups and improving access to dental services.	SCC -Public Health and Communities
Mental health- Severe Illness	Continue to improve access to Mental Health diagnostic, management and support and the agreed action with the Suicide Prevention plan Improve data sharing protocols	MSE, EPUT, ASC
Mental Wellbeing- Children	The **Southend, Essex and Thurrock plan** for the transformation of mental health services and support for children, young people and young adults is expanding mental health services by increasing access to broader mental health services to complement the existing core CAMHS provision and developing ways to further enhance and broaden the ways in which families and carers engage with services at a local level in schools, at home and in the community. Actions include: -Improved mental health training for health professionals. Mental health should be a core part of the training curriculum for all health professionals who deal with children and young people. -Advocate for the mental health of local children and young people. Use available data on mental health prevalence and service capacity to articulate the needs of the local population -Encourage integrated working and information sharing between organisations and agencies across the whole children's workforce. Integration of practice, education, pathways and commissioning will ensure that prevention, recognition, early intervention, support and onward referral is commonly addressed by professionals.	MSE, EPUT, SCC - Public Health and Education

Key Actions & Initiatives

Initiative	23/24	Lead Partners
Flu vaccines	Winter planning COVID Booster and Flu Campaigns Potential pop-up clinics to support increased uptake in low uptake areas. Collaborative working with Southend City Councils and PCNS	MSE, EPUT, Pharmacies, SCC - Public Health and ASC
Adult obesity	Continue to develop more varied opportunities to increase physical activity and promote healthy weight. We have started engagement to create a co-ordinated action across the whole system to support healthy food choices and promote a Healthy City policy-approach for Southend. -Extensive collaboration is afoot through the Population Health Improvement Board and the South East Essex Alliance, with a range of partners, to influence both primary and secondary prevention programmes.	MSE, SEE Alliance, SCC -Public Health , Planning and Environmental Health
Childhood obesity	Focus on healthy school settings and encouraging children and young people to adopt healthy behaviours and embed lifelong changes. Enhance school healthy eating programmes through supportive engagement and health education initiatives and offer a whole family Health4Life programme.	SCC -Public Health, Planning and Environmental Health, MSE , Schools
Protecting & Safeguarding Young People	Southend has an ambition to be a child friendly city and our approach to helping the most vulnerable children, young people, families, and communities needs to reflect these values. Development of a Southend Family and Community Hub system approach to transform the services for children and families will help provide opportunities to give all children in Southend the best start in life and improve meaningful information sharing between agencies.	SCC, MSE, Essex Police and partner agencies
Family & Community Hubs	The Council and partner agencies develop radical proposal to support the creation of a more energised approach to the provision of shared services for Children, Young People and Families, and a Family and Community hub model for the City.	SCC -Children & Public Health, Library services, Communities, ABSS, SEE Alliance, SAVS

Key Actions & Initiatives

Initiative	23/24	Lead Partners
Inequalities	Ethnic Minority Groups Supporting SEEA to start health focused neighbourhood conversation to share information on new PCN services, NHS Health checks etc in Southend. First conversation will be based at North Road Chapel ethnic minority ladies' group. Support COPD connectors to recruit someone with ethnic minority background. Carers and people with disability Continue to build relationship and share health related information/ services / campaigns with key community groups (SEND the Right Message, Little Heroes , Mencap, Carers First, Southend Carers etc.) People experiencing homelessness. Create health pop ups at food provision places such as SVP, One Love, Storehouse to carry out NHS health checks etc. (shall we discuss it with Everyone Heath or Sharna first)? Support COPD connectors to recruit a homeless person. Veterans Attend the Meet Your Army - The Army Engagement event to build on our network. Send out targeted information around specific health services/ provision and campaign through the stakeholders. Support COPD connectors to recruit a veteran. LGBTQ+ Working alongside GP practices to become LGBT Accredited, currently have x amount. Improving the birthing practices & experiences for transgender parents Working alongside Southend Health watch on a number of improvements to the LGBTQ+ experiences.	SCC, MSE, SEE Alliance, SAVS and HWB partners

APPENDICES

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Progress with 2021-22 Recommendations (1)

Recommendations		Update
Health Inequalities		
Life Expectancy, Key Health Risk Factors, Weight Management, Vaccinations		
1	Local partners are working strategically, to address factors that impact on peoples' weight, in more innovative and collaborative ways	Ongoing work on joint service specification and outcomes measure for tier 2 weight management services. Public Health have also secured support from the Town and Country Planning Association to support the development of a Healthy City framework for Southend and Food Policy
2	Following local community and partner engagement, the Health and Wellbeing Strategy for Southend was launched in late 2021. Weight management is a major priority within the action plan, that forms part of the strategy	The Southend Food Insights programme of work is complete to inform local programme to support food industry in healthy options and to lead into development of SCC Food Environment Policy. Achieved an increase in the number of people accessing a tier 2 weight management programme, from 476 in 2019-20, to 834 in 2021/22, with a forecast of over 900 for 2022/23. There has been a drop in people achieving 5-10% weight loss at 12-weeks across the programmes (20%), but an increase in people maintaining weight loss at 12 months (50%). A remedial action plan is in place to address.
3	Targeted interventions through the work of Everyone Health, with a particular focus on men's health and wellbeing.	Where male uptake has been low, in comparison to female attendance, Everyone Health (EH) have targeted men, to take part in their tier 2 adult weight management courses. Aimed at those with a BMI of 30 and above. EH are also working with football clubs, to encourage male adults onto their physical activity programme or their adult weight management courses.
4	As a system, we will need to explore all collaborative approaches to ensure we can optimise the use of hospital beds, increase our targeted preventative work and increase our efforts to mobilise our communities in self-care and adopting healthier lifestyles.	Marked improvements in targeted work with residents living in areas of highest deprivation – increase from 29% of those receiving support with healthy behaviours being from most deprived areas in 2021/22, to 36% in 2022/23. Better targeting of falls prevention services has been achieved, developing an offer which focusses on both primary and secondary prevention of falls. 30% of current cohort accessing a falls programme have been identified as at risk of a fall. Programme under review to minimise wait and optimise completion rate. Healthy Behaviours services review group has been established to facilitate a collaborative review of current healthy lifestyles offer and model, to inform the redesign and recommissioning of the contract post May 2024. Introduced active monitoring of social media engagements for the promotion of self-care and healthier lifestyles – 8,925 reached. Healthy behaviours service review is on track with predicted completion end of July 23. Good engagement from stakeholders and growing public engagement. Wellbeing referral scheme pilot has been launched with the aim of increasing targeted physical activity work with those at risk of long-term health conditions. Has led to increases in activity, however uptake significantly below anticipated targets.
5	In addition to the 'key actions' highlighted on slide 7 to address the challenge with weight management, we will explore further how we can help improve the food environment	Following the Insights work, Public Health will be exploring options to support food industry in a scheme to promote healthy options, working in partnership with Environmental Health. Helath4Life has restarted and updated for children overweight or obese from ages 5-16yrs. Mapping of health promotion material has been undertaken to 0-5 resources in order to ensure consistent messaging to parents. Insights work will influence the work happening for Healthy City framework moving forward.

Progress with 2021-22 Recommendations (2)

Recommendations		Update
6	Through the Health Protection Board, we will explore and deliver an improvement in the uptake of Flu (at risk groups), Covid and MMR vaccines during 2022-23	An MMR campaign ran in the community with a selection of mop up clinics offer MMR catch up. The health partners have written to children missing MMRs in order to invite them along to GP practices. Recent initiatives have been system wide collaborative working across the NHS Alliance/ Primary Care, Care Homes , NHSE screening and Immunisation Team, EPUT and local Maternity unit. Immunisations rates are still below expected levels across all areas.
Food Environment		
7	The Council is collaborating with local agencies to develop an Anti-Poverty Strategy, which will cover food poverty	The Tackling Poverty strategy was approved at Cabinet in January 23, we are now starting to implement the actions in the year one action plan. We have just been given the go ahead to employ a Tackling Poverty Project Lead to support this work – currently vacant.
8	Schools can adopt a number of policies to encourage pupils to purchase their lunch from the school canteen.	The school nursing service is being reviewed and redesigned post covid. A refresh of the Healthy Schools programme is underway and due to be completed by January 2024. A programme of work is underway to establish school profiles, including information on free school meals, free school meal offer and promotion of school based meals.
9	More is required locally to address food poverty and reduce food poverty. We are working with the local Food Alliance to optimise collaboration, explore social value contributions from local businesses, and ensure we can create a more sustainable approach to food clubs	Significant demand on the local food distribution points. The pilot with the FOOD Club across 3 areas of Southend has been extended for another 18 months (from Feb-23) to allow a more sustainable model to evolve with support from the Southend Food Alliance.
10	We will develop a Food Environment Policy across Southend where we will support citizens, young and old, to make healthier choices including in our educational settings, work with our business to support this approach, reduce wastage and reduce food poverty/insecurity. This may also include a local 'healthier options' award being explored with our Regulatory services team at the Council	The Town & Country Planning Association has been commissioned to support a series of workshops to help Southend develop a Healthy City framework and Food Policy. One workshop has been completed and a follow up is due in July 23. OHID have offered to underpin this work with training on Health Impact Assessment training, in order to ensure the organisation is recognising health impacts associated with planning decisions.
11	To promote and increase the uptake of the Healthy Start Scheme to support vulnerable children and families affected by food insecurity	Healthy Start and a universal pregnancy vitamin offer is underway. The scheme is being actively promoted by maternity, health visitors at the antenatal, new birth and 6 weeks visits, by ABSS, and by family centres. Health visiting are providing promotional flyers at visits, and there are promotional posters in the family centres, in Food Banks and at the Civic Centre. Teenage parents under little steps are signposted to Health Start. ABSS and CYPPH are collaborating on the development of a Healthy Start promotional video to further enhance the promotional message.
12	To enhance school healthy eating programmes and promote community growing initiatives	Work is ongoing and there are several primary schools that have growing initiatives- this area is being explored for an Enhanced Healthy Schools opportunity for the coming school year. The Health4Life programme is being delivered out of community venues and school settings in order to make access accessible across Southend School health profile development is underway and will include the school's approach to sourcing and growing local food. There are several Family Centres in partnership with ABSS, that have growing schemes and the Early Years Alliance Food Club.

Progress with 2021-22 Recommendations (3)

Recommendations		Update
Mental Health & Wellbeing		
Suicide Prevention		
13	Support the delivery of the Suicide Prevention Wave 3 Transformation Programme workstreams at a Southend resident and partner organisation level	The formal Mid and Southend Essex Integrated Care Service (MSE ICS) Suicide Prevention Wave 3 Transformation Programme concluded at the end of April 2023. Supporting delivery of the workstreams was actively undertaken by the PH lead with updates shared at the Southend Suicide Prevention Network and communications through the Councils internal and external digital platforms. Public Health is working with the MSE ICS and Southend, Essex and Thurrock LA colleagues on delivery of suicide prevention workstreams for 2023 to 2024 at the MSE ICS Suicide Prevention Oversight Group.
14	Restart the Southend Suicide Prevention Steering Group as a sub-group of the Southend, Essex, and Thurrock Suicide Prevention Steering Group	The Southend Suicide Prevention Network is operational and functioning. Public Health also has a key role on the Southend, Essex, and Thurrock Suicide Prevention Steering Group. The Southend Suicide Prevention Network has been operational since May 2022.
15	Increase the promotion of Let's Talk About Suicide Essex prevention training	Promotion of the Let's Talk About Suicide Essex prevention training continues through its dedicated website, with additional awareness raising on the Council internal and external media platforms.
16	Working in partnership, we will develop an action plan to address local opportunities and challenges in suicide prevention particularly focussed on men	The Southend Suicide Prevention Network has developed a proposed Ten Point Community Action Plan. The Plan is currently out for review by Network members. The Plan will also have input from the Southend Suicide Prevention Resident Engagement Forum that is currently operational and seeking insight from residents with targeted workshops (including men) during 2023.
17	Promoting national mental health and wellbeing campaigns through social media and working with partner organisations to raise awareness	In the final quarter of 2022-2023 Brew Monday; Time To Talk Day completed the promotional plans of the agreed mental health and wellbeing campaigns. Promotion includes awareness through the Southend Suicide Prevention Network; Children, Young People and Families Service; and the Councils internal and external media channels. Information will also be shared with the South East Essex Alliance and the Mid and South Essex Integrated Care Partnership.
18	With regards to Southend Veterans, we plan to do an investigative piece of work in the upcoming year, as it is known that they have huge health-social inequality needs and worse health and life outcomes compared to the general population	Working Party in place. Veterans Champion in place. Working closely with the NHS Alliance to identify Veterans in Southend. We have 9 veteran friendly accredited practices: Southend West Central PCN – 1, Southend Victoria PCN – 4,SS9 PCN – 2, Southend East PCN – 2 In addition, NHS is running a Veteran a training session for the wider GP surgeries. Currently we are looking at a BLESMA training; this is for both admin and clinicians as highlights issues impacting the 'whole patient journey' as opposed to just consulting styles and triggers. Working closely with Health Watch and Voluntary Sector as well so to further identify 'hidden' Veteran as Southend appears to have identified just 50% of the Veteran population across Southend. The Council now has a Veteran Champion
19	Further collaborative work between the Council, the NHS, other key partners and local families to ensure we improve the offer for young people with more complex needs	We are awaiting the final SEND Inspection report to review key recommendations.
Tackling Harmful Behaviour		
20	Further local data collation will be required to provide a better understanding of needs and impact	No Data collation took place due to other priorities. We would be looking for evidence of alcohol impact on individuals which can be tied to specific premises or if not, specific streets. Good examples include data collected in the Cardiff model and general hospital admissions where alcohol was a factor but not necessarily the cause.

Progress with 2021-22 Recommendations (4)

Recommendations		Update
21	The Licensing policy will be next reviewed in 2024, which will also incorporate new evidence of good practice	Will take effect 31 January 2025, please note health is not included as one of the government objectives.
22	Gambling policy will be next reviewed 2025, and will also incorporate new evidence of good practice	Where there is new evidence of good practice this will be considered and incorporated where relevant to Southend. This will take effect 3 January 2025.
23	For Illegal /Illicit tobacco, we are working closely with HMRC in this regard. We are currently in the planning stage for this year's programme and will likely need to source funding for it	We have planned to at least repeat the number of testing and seizure days this financial year. Intel from Southend has led to a national investigation of an enterprise containing around 40 retailers.
24	We will initiate a system approach in test purchasing for NIPs (Vaping), in protecting our citizens	We continue to undertaking test purchasing for NIPs. Test purchasing has resulted in good intelligence and subsequent seizures of illegal vapes in record numbers.
25	This summer, our test purchase operation will be targeting adult gaming centres (arcades) during the school holidays	Follow up test purchasing will be carried out on the premises that did not have the required controls in place. New control measures put in place on the premises which failed, and it has been brought into compliance.
Air Quality & Transport		
26	A Green Plan has been initiated to tackle some of the challenges in improving our Air Quality, as we will pledge to engage with school communities to promote Clear Air Day in June 2022 and annually thereafter	Council is recognised as Clean Air Day (CAD) official supporter. CAD Toolkit produced accessible to schools through School Learning network (SLN). 14 Schools actively engaged with activities and submitted artwork and displayed across Southend. Engagement with Youth Forum, community, Pledges made. Working on Clear Air Day 2023. Clean Air Hub page created on Your Say Southend to share information & updates and post pledges ongoing updates throughout the year https://yoursay.southend.gov.uk/clean-air-day-2022 . The Essex Air website has been redeveloped, which will provide a platform of Southend AQ updates and will link from the Council webpages. The Council awarded a grant to deliver a school's project over two years - aims to understand the air quality around 10 local schools, identify and implement appropriate measures and interventions that could be put in place. Southend selected for an automatic monitoring station to be installed to measure PM2.5 as part of the national network, for a more accurate picture of PM2.5 levels in Southend. For the domestic fuel burning: aim to raise awareness of the health impacts of domestic fuel burning.
27	The Southend Local Transport Plan 4 will be published in 2023 with a clear approach to support citizens to reduce their carbon footprint, encourage more young people to be consider alternative means of travel, including walking, cycling and e-scootering.	Deadline extended to 31 March 2024 – Team waiting for DfT LTP guidance which was due summer 2022, but still hasn't been issued.
28	Ensure we build resilience within Southend to continue the on-going management of the pandemic and reduce socio-economic consequences and well as health and wellbeing impact	Health Protection training package in place for annual refresh of the 'reserve' health protection response team from across the system. Recovery work progressing to minimise health and wellbeing risks and targeting more vulnerable groups, including for immunisations, health checks and wider lifestyle interventions. Additional work to tackle food poverty and cost of living crisis.

Agenda
Item No.
10

Southend Health and Wellbeing Board

Report by

Alex Khaldi, Independent Chair, A Better Start Southend

to

Health & Wellbeing Board on 6th September 2023

Report prepared by:

Tara Poore, Director, A Better Start Southend

	For discussion	X	For information only		Approval required

A Better Start Southend - update

Part 1 (Public Agenda Item)

1 Purpose of Report

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

2 Recommendations

HWB are asked to:

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

2. Note the progression of the ABSS Legacy and Sustainability Strategy.

3 Governance

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

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

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

- Partnership Board - Chair, Alex Khaldi, ABSS
- Executive Consultative Board - Chair, Alex Khaldi, ABSS
- Programme Group - Chair, Krishna Ramkhelawon, SCC

- Insight and Analysis Group - Chair, Michael Freeston, EYA
- Finance and Risk Group - Chair, Paul Grout, SCC
- Parents' Group - Rolling Parent Champion Chairs
- YourFamily Partnership Group - Chair, Emma Hawker, Parent Champion.

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

Engagement of Parent Champions within ABSS (Governance) Meetings and wider Co-Production

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

Southend Family Centres

Southend Family Centres and ABSS continue to work together to meet the needs of children and families in Southend. Exploration of opportunities to integrate further are currently taking place, with increased emphasis being placed on the pre-natal period, anti-poverty response and parenting support.

The National Lottery Community Fund (TNLCF)

ABSS continues to have a strong relationship with the TNLCF, the four other A Better Start (ABS) sites (Bradford, Blackpool, Lambeth and Nottingham) and evaluation partners. This sees a coming together to share learning and plan for the wind down of the national programme.

Recently, TNLCF, the five ABS sites, National Children's Bureau and renowned experts in childhood development came together to develop and deliver a virtual conference that showcased the most impactful elements of the programme and spoke to the challenges partnerships are facing due to the ongoing recovery from the Covid-19 pandemic, cost of living crisis on child development outcomes, families experiences and the need to be ever flexible in provision and the distribution of funding.

Over the next few months, ABSS will be developing a clear list of items to which intellectual property (IP) pertains. This will then form the beginning of a register of the IP items that will transfer to partners and delivery bodies.

4 ABSS Legacy and Sustainability

Commissioned Services

The ABSS Programme Team continue to work with commissioned delivery partners to determine their vision for services beyond 2025. All delivery partners are currently in the process of completing a Legacy and Sustainability plan which will set out their aspirations for the future, avenues of alternative funding sources, partnership working and interdependencies with other projects or services, impacts on staffing/team resource and beneficiaries, and the support needed to deliver these aspirations beyond 2025 as the ABSS Programme comes to an end.

Plans are underway to facilitate a commissioner's symposium, which will see bodies with commissioning responsibilities come together to explore the gaps in provision ABSS funding (ending) could leave in 2025. This is also an opportunity to ensure that priorities are not set in silo and is anticipated to bring the wider system together to align resources to ensure the most impact can continue to be made in Southend in years to come.

The Workforce Development Programme

The Workforce Development Programme consists of both an internal team focus and external early years and health professionals' focus. The internal programme is progressing at pace. The external programme is also developing, with planning taking place to deliver a schedule of learning events in 2024. Community development and resilience is also being considered in the external programme and events some events will be aimed at families and community members. The first of these events is expected to take place in early November 2023, and is likely to focus on Asset-Based Community Development (ABCD). Other events will look at sharing learning or evidence from the ABSS programme or on particular topics relating to child development. A working group has been established from the ABSS' Insights and Analysis Group (IAG) to oversee this work.

City Family Community Interest Company

In May 2022, approval was received to progress the ABSS Legacy and Sustainability Strategy (LSS) by the Partnership and The National Lottery Community Foundation (TNLCF). This was a pivotal moment in ABSS' journey and laid out the tangible plans required to ensure the legacy of ABSS and TNLCF investment can be felt in Southend for many years to come.

City Family CIC was established in September 2022, tasked initially, with driving forward key parts of the Legacy and Sustainability Strategy and set to become the nucleus of excellency in early years (EY) health, development and support provision in the area. City Family is now a formal strategic partner of the ABSS programme.

The ABSS Executive Consultative Board and The National Lottery Community Fund have undertaken a review of what is anticipated to deliver the final phase of the funding period to ensure the legacy and sustainability of ABSS can be driven forward most effectively, whilst the responsible and proper wind down of the programme is managed. This has culminated to a point where there is a requirement to split some of the programme functions to allow the right kind of focus on the main strands of activity.

ABSS will continue managing the core business functions of the programme – Commissioning, Research and Partnership, whilst City Family will become the delivery partner of Creche, Talking Transitions and YourFamily, aligned to the aims set out in the LSS.

Tara Poore has held the leadership roles across ABSS and City Family for the last year and it was previously agreed that this arrangement should be reviewed frequently to ensure capacity and potential conflicts of interest are considered and addressed. Furthermore, plans to outsource ABSS direct delivery services to City Family requires substantive, full time, leadership and administration in order to undertake business operations and provide stability and reassurance to transferring (and then transferred) staff. A solid infrastructure should also provide reassurance and commitment to EYA/ABSS, SCC, TNLCF and any potential new funders.

Tara Poore will be moving to the Chief Officer role (City Family), full-time, from October 2023, along with administrative support. Tara is the current MD and co-founder of City Family; and the City Family board unanimously agreed she should take on the Chief Officer role substantively and exclusively. The signatories to ABSS grant agreement (EYA, Southend City Council and TNLCF) also support this transfer as well as the ABSS Partnership Board.

Once the initial transfer (Infrastructure) has concluded, the process of transferring the Direct Delivery services will begin. It is anticipated this will happen in two stages. ABSS Creche and Family Hub coordination to be outsourced to City Family by November 2023. YourFamily and Talking Transitions outsourced to City Family by January 2024

An internal process will take place to appoint the ABSS Director, who we hope will be a candidate that has strong, strategic knowledge of the programme, and is well placed to steer the wind down. It

should be noted that Tara's substantive transfer to City Family is not being treated as a resignation, it is the natural progression point linked to the ABSS LSS and all efforts will be made to ensure there is stability across both ABSS and City Family.

5 Research and evidence

Programme Evaluation Partnership

The University of Essex Research team is conducting semi-structured qualitative interviews with beneficiaries and project delivery partners for the seventh round of reporting for the Formative Evaluation to be shared with ABSS in the first week of August 2023. The interviews allow the team to analyse beneficiaries' and staff narratives about the impact of the ABSS programme on families and how services are being delivered. More specifically, IDVA and Talking Transitions will receive their first round of reporting, which includes data from qualitative interviews with staff and professionals who participated in the Elklan Training. The new online survey instrument developed for Families Growing Together will be uploaded for online data collection.

The research team together with ABSS colleagues defined which projects to continue evaluating in the current form and which to move to a form of reporting that will summarise findings and recommendations from the wealth of evidence collected to date. This forms part of a wider conversation about how evidence from the formative evaluation can be used to support ABSS's legacy and sustainability strategy and programme of work. A summary report model, including snapshots of the projects' evaluation throughout their lifespan will be shared with ABSS by the end of September.

The second research paper arising from ABSS work: 'Making sense of organisational challenges and community resilience during Covid-19: A case-study of a multi-agency intervention tackling child poverty in England' is co-authored with ABSS colleagues and is in submission with 'Practice' journal.

Independent Programme-wide Summative Evaluation

Data collection for Phase 2 of the Summative Evaluation completed in June 2023. RSM interviewed a range of stakeholders, including strategic partners, delivery partners and members of the wider community. Surveys were used to explore the experiences of parents who have participated in ABSS activities, parents who have not participated in ABSS activities, and staff and volunteers working to deliver the ABSS programme and its projects. Participatory Action Research (PAR) has continued, with focus groups for each workstream meeting and using a range of activities to explore what has had impact in each area. The RSM team are now analysing the collected data and writing up their findings, with the Phase 2 report due to be published in late September 2023.

Data Analysis and Insights

The SCC OPI Data Team has been updating the ABSS Programme Outcomes dashboard with the latest annual data for 2022/23. This includes outcomes for maternity metrics, ASQ scores and educational attainment. An EYFS-specific analysis tool has been developed and will shortly be shared with the wider team. A significant piece of work was also conducted to provide 2 years' worth of outcome data to support the evaluation partner, RSM, together with estimates of the numbers of individuals participating in ABSS activities that potentially contributed to these outcomes.
Other work conducted by the OPI Data Team has included a number of ad-hoc requests for support with data enquiries, such as early years funding take up, ethnicity and language data, and breastfeeding rates. Support has also been provided to prepare for the migration of Family Centre support worker data to the Inform2 system. Regular work updating and maintaining the ABSS data dashboards also continues, and the team have provided sessions to colleagues in the programme office to demonstrate these tools and seek ideas for future developments.

6 Programme Activity and Reach

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

Between 1st April 2015 and 30th June 2023, a total of 6,636 unique primary beneficiaries engaged with the programme (from 5,541 by 30th June 2022). The programme is reach in the areas with highest deprivation continues to steadily grow month on month.

A further 1275 children accessed the Talking Transition Programme (aged 4-5) and are not captured in the above figures due to reporting differences and being out of the ABSS age range.

YourFamily

YourFamily's mission is 'to give children the best start in life, YourFamily builds trusting relationships with expectant parents and parents with young children to develop their strengths and resilience and connects them to community resources'. Alongside the mission, the emerging service principles are: YourFamily has trusting relationships at its heart, YourFamily works in partnership with parents, YourFamily builds on family's strengths, and YourFamily is part of an active community.

The activities delivered by YourFamily range from initial contact to group activities, such as workshops, play and learn and support groups, and one to one support. Underpinning the activities of the service are a number of outputs and outcomes that are centred on parent and family motivation, capability and opportunity. The service has recently developed measurement tools to capture outcomes and are working to generate a body of evidence to demonstrate impact across those areas through delivery of their activities. Currently, a data dashboard is being built and refined to provide easy access to impact data. Clearer oversight of the data will support the service to develop aspirations for the future.

The new Facebook group continues to grow with almost 150 parents now being part of the online YourFamily community. The new Toddler group at St Luke's Community Hub and the new Sunshine Stay & Play sessions at Labyrinth House have had an encouraging start as word of the new provisions begins to spread amongst parents and carers. The YourFamily team continue to support the monthly Family Centre Bibs & Bobs baby bank session, and due to the high demand seen at Bibs & Bobs, the team are developing a new weekly drop in baby bank facility in partnership with the One Love Project.

A new evidence-based Sleep Workshop with creche facilities was tested recently at Centre Place Family Centre. The high level of attendance and positive parent feedback confirmed the much-needed benefits of the session. The workshop is available to all families with children under 4 years and the aim is to provide information and advice relating to sleep to provide better outcomes for children and help reduce the need for specialist services at a later stage.

Community Ideas and Development Fund (CID Fund)

There has recently been a review on how this community fund is administered, this has seen an increase in applications being received, which has led to funding awards being made across Southend.

Three projects are now in mobilisation stage, with a further three going through the final contracting stage. Mobilising projects;

- Sunshine Baby Bank will be offering a 'bank' of equipment, a parent and toddler group based on early education supported by an educational psychologist and a music and movement session for families to attend.

- Trustlinks will be supporting families to get involved in improving the green areas around Centre Place Nursery and Family Centre, encouraging the community to come together and offering access to any support families require.
- Welcome to the UK will be able to meet the increased demand for support with form filing, understanding the health system and supporting the development of their children where English is an additional language.

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

7 Programme Management Office

Human Resources

A number of vacancies have recently been filled within the team and new team members joined in mid-July. The Communications and Marketing team welcomed Alicia Bannister as Communications and Marketing Officer, Joanne Armstrong as Communications and Marketing Assistant and the YourFamily team welcomed Rosslyn Allen as Volunteer Coordinator.

Recent interviews for the Business and Planning Lead and Research, Evaluation and Impact Officer roles were also successful with the Business and Planning Lead joining the team late August. Recruitment checks are still being completed for the Research, Evaluation and Impact Officer with the aim to start in September.

Recruitment for the Information Systems Project Manager has commenced with interviews taking place mid-August and the role of YourFamily Link Worker, to be based at Centre Place and dedicated to families attending the childcare setting there, will be advertised in the coming weeks.

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

Inform2 Customer Relationship Management System

Inform2 is the cloud-based customer relationship management (CRM) system which is initially being used by the YourFamily Team and Southend City Council's Family Centre's Family Support Team for case management and future reporting purposes, with a vision to roll-out wider in the coming year.

8 Reasons for Recommendations

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

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

2. Note the progression of the ABSS Legacy and Sustainability Strategy.

9 Financial / Resource Implications

There are no financial/resource implications for this report.

10 Legal Implications

There are no legal implications for this report.

11 Equality & Diversity

There are no equality and diversity implications for this report.

12 Appendices

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

Tara Poore, Director, ABSS

6th September 2023

Partnership Board Programme Activity Summary

Produced by the Operational Performance and Intelligence Team

21/08/2023

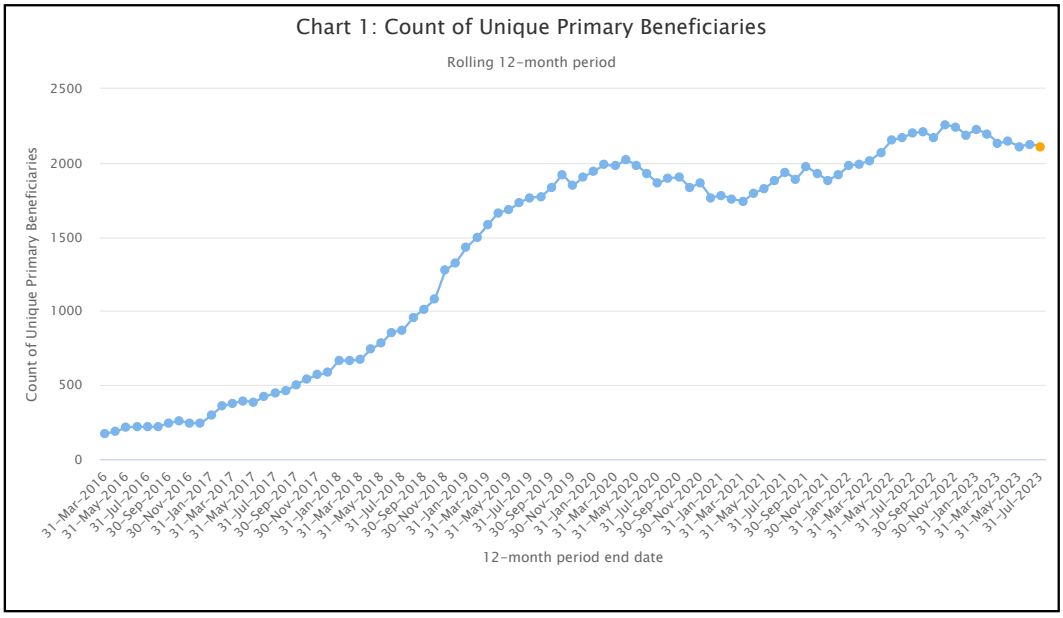
This short extract is based on the ABSS Programme Activity Dashboard for the period ending **31-Jul-2023**.

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

Section 1 - Programme Reach

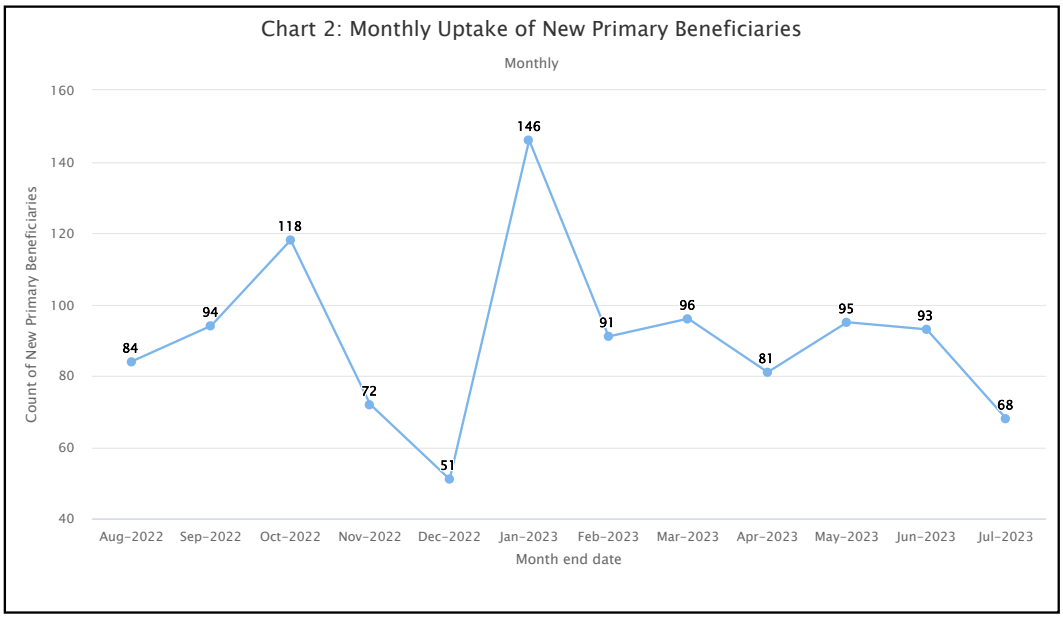
The total number of beneficiaries of the A Better Start Southend programme since April 2015 is now **6724**, which has risen from **6656** at the end of the previous month.

As chart 1 below shows, reach has continued to grow during the life of the programme and the total number of beneficiaries of A Better Start in the past 12 months was **2112**. This represents **47.9%** of all potential beneficiaries and is among the highest proportions achieved since the start of the programme. There has been an upwards trend in reach since March 2021 indicating a recovery from the effects of Covid, although there has been no short-term growth since October 2022.



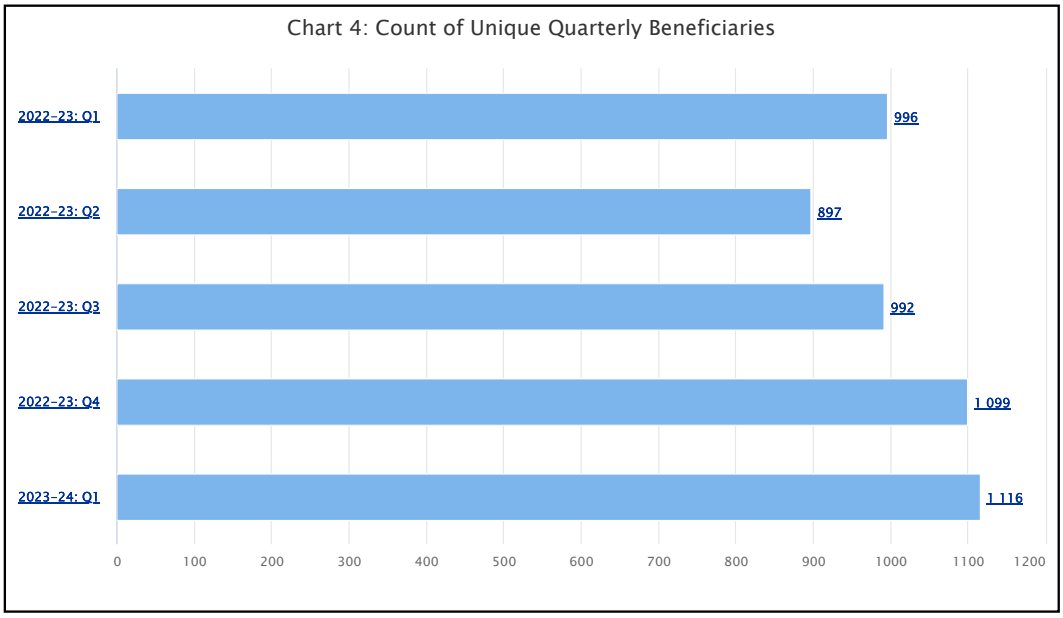
Section 2 - New Primary Beneficiaries

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

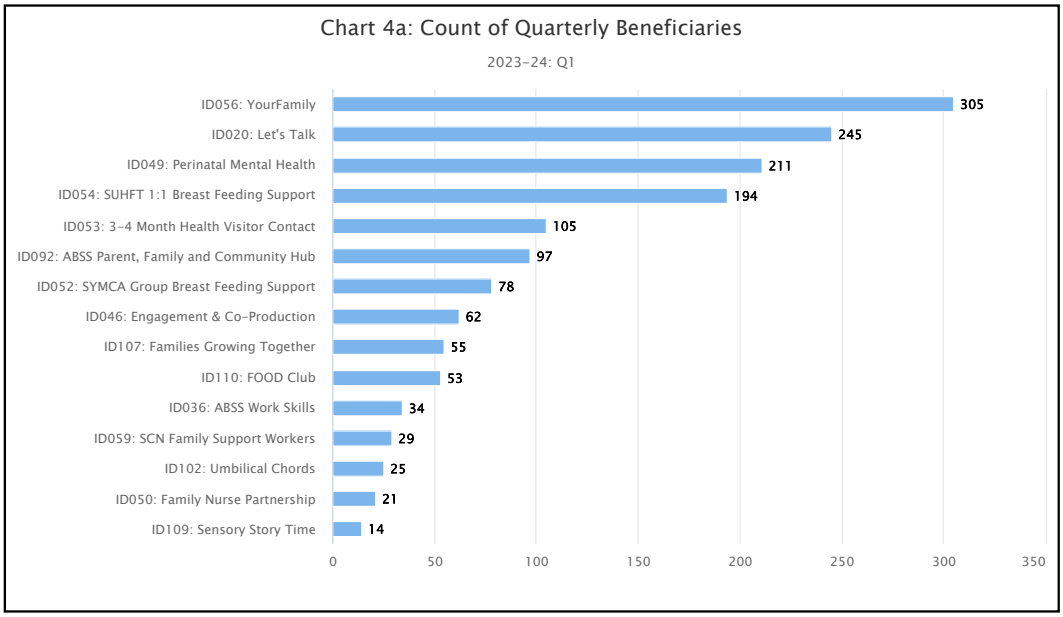


Section 3 - Project Delivery

As Chart 4 from the Programme Activity Dashboard shows below, activity was fairly consistent throughout the 2022-2023 financial year with quarter 1 (Apr - Jun) of 2023-2024 being busier in comparison to Q1 of last year.



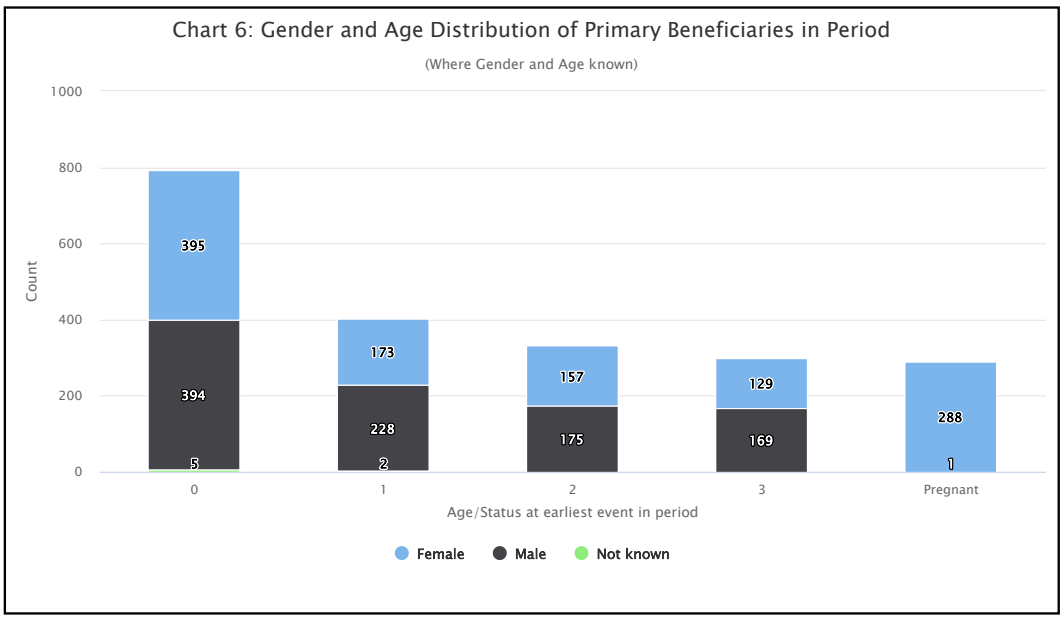
Quarter 1 of 2023-24 is displayed in Chart 4a at project level, showing the relative reach of each project in terms of numbers of primary beneficiaries. Note that the YourFamily project, which went live in April 2022, has shown significant growth and is now reporting the largest number of primary beneficiaries of all projects.



Section 4 - Age and Gender

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

The number of pregnant primary beneficiaries that participated in the past 12 months has decreased from **301** for the equivalent 12-month period ending one year ago.

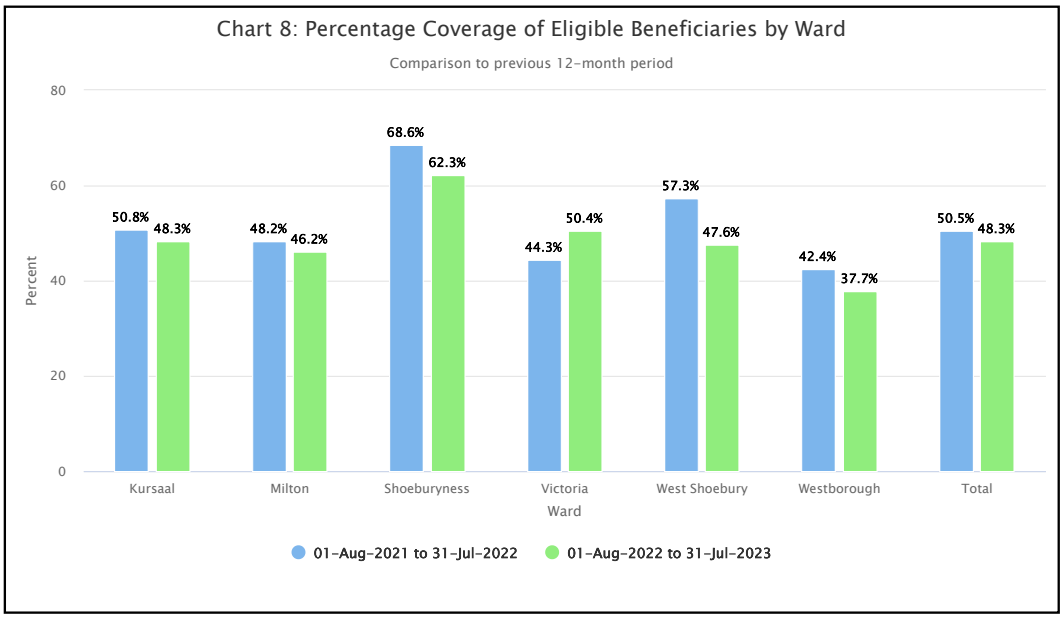


Section 5 - Delivery by Ward

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

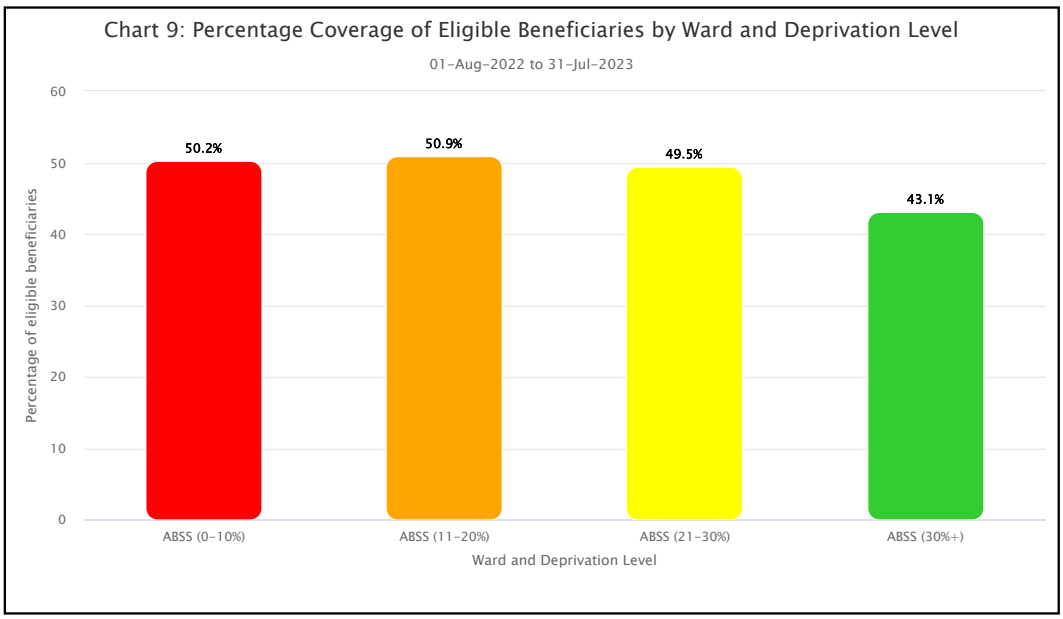
Reach within the Kursaal, Shoeburyness and Victoria wards all equal or exceed the average reach across the entire ABSS wards and reach in Milton, West Shoebury and Westborough is below the overall average.

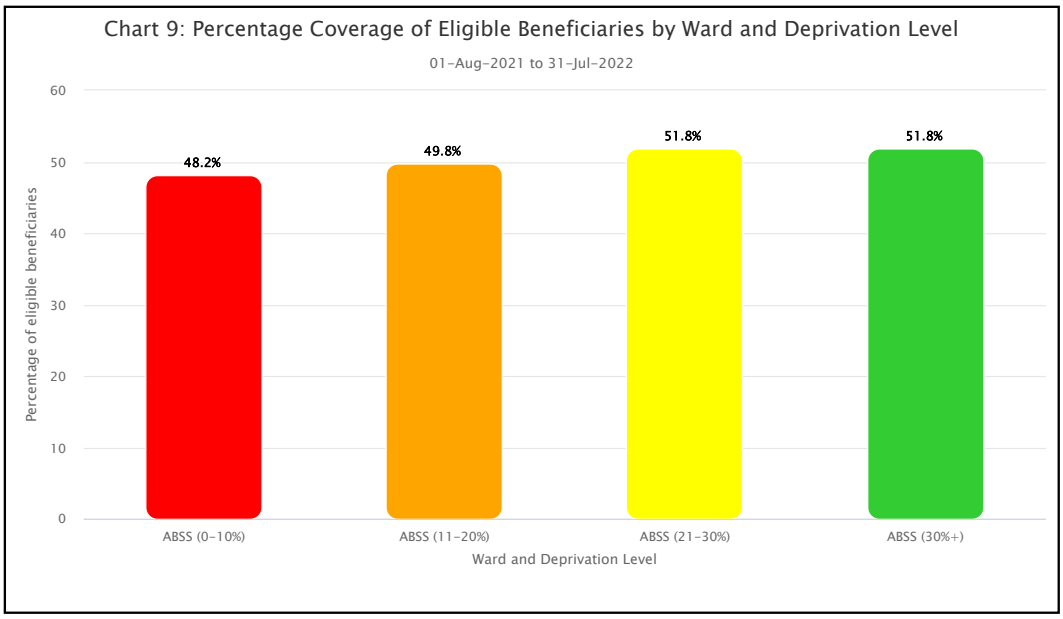
The difference in reach between the wards with the highest (Shoeburyness) and lowest (Westborough) reach is **24.6** percentage points.



Section 6 - Delivery by Deprivation Level

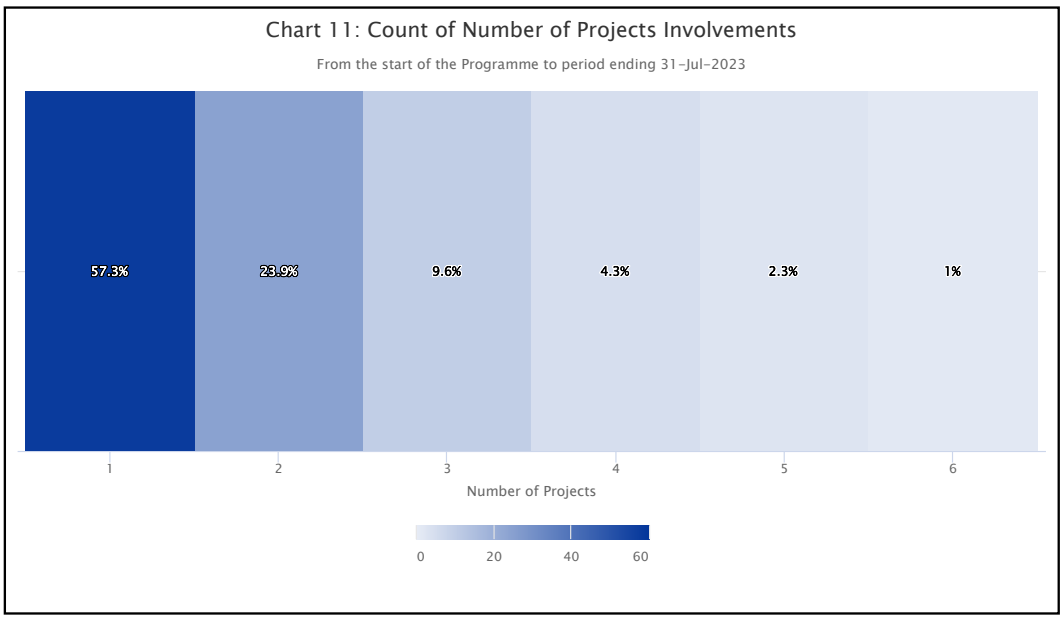
The two charts below are partial extracts from the Programme Activity Dashboard and show a comparison of percentage delivery to all eligible beneficiaries for the current and previous 12-month delivery periods, by deprivation deciles. The top chart shows the most recent 12-month period and displays a slightly higher level of reach in the 11-20% (the second decile, orange bar) most deprived areas. The percentages for the top two deciles have increased from the previous 12 month period, emphasizing the focus on delivery within the more deprived areas.





Section 7 - Participation in Multiple Projects

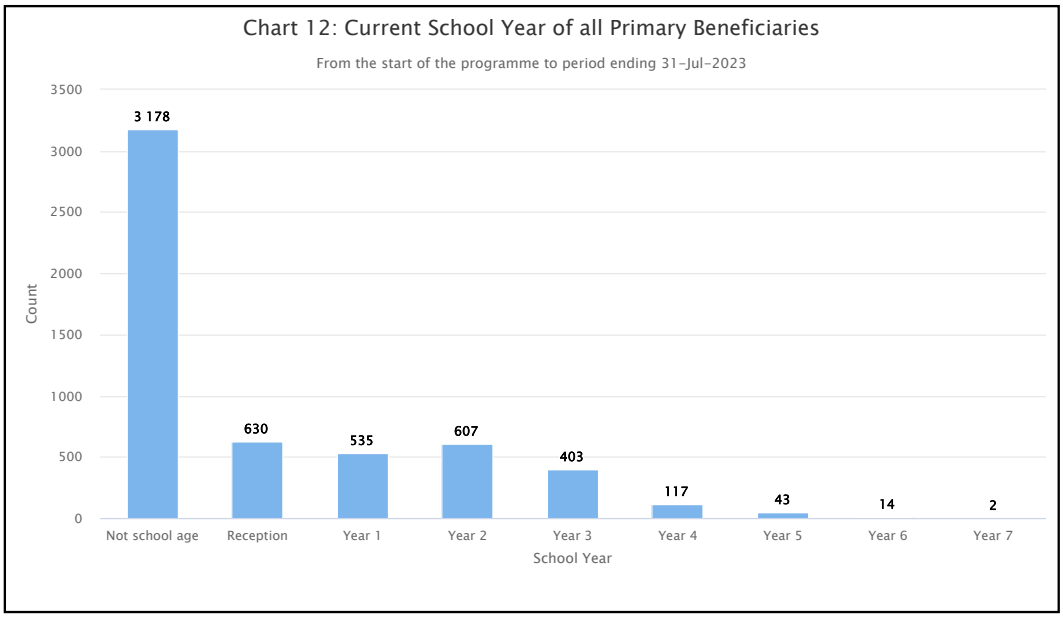
This chart shows the percentage of beneficiaries that have been involved in multiple projects over the course of the programme. For example, **42.7**% of all beneficiaries have been involved in more than one project, which demonstrates a good linkeage between projects and retention of beneficiaries.



Section 8 - Current School Year of Primary Beneficiaries

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

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



End of document.

Appendix Two- Project Names and Workstreams

Project ID	Project Title	Work Stream	Budget Work Stream	Delivery Status	Delivery Partner
ID054	**121 Breastfeeding**	D & N	D & N	In Delivery	MSE Hospital Trust
ID052	**Group Breastfeeding**	D & N	D & N	In Delivery	SYMCA
ID053	**3 - 4 Month Contact**	D & N	D & N	In Delivery	SCC
ID025	**HENRY Healthy Families**	D & N	D & N	Closed	HENRY
ID087	**Southend Supports Breastfeeding**	D & N	D & N	Mobilisation	SCC & ABSS
ID088	**Infant Feeding Supervisor Lead**	D & N	D & N	In Delivery	SCC
ID089	**Maternal Healthy Weight**	D & N	D & N	Paused	TBD
ID095	**UNICEF Accreditation**	D & N	D & N	Closed	
ID097	**Public Health Midwife**	D & N	D & N	In Delivery	SCC & MSE Hospital Trust
ID110	**FOOD Club**	D & N	D & N	In Delivery	Family Action
ID050	**Family Nurse Partnership**	S & E	S & E	In Delivery	EPUT
ID049	**Perinatal Mental Health**	S & E	S & E	In Delivery	EPUT
ID061	**Preparation for Parenthood**	S & E	S & E	Closed	HENRY
ID083	**Volunteer Home Visiting Service**	S & E	S & E	Closed	Home Start
ID107	**Families Growing Together**	S & E	S & E	In Delivery	Trustlinks
ID104	**IDVA**	S & E	S & E	In Delivery	Safe Steps
ID020	**Let's Talk**	C & L	C & L	In Delivery	EPUT
ID082	**WellComm Screening**	C & L	C & L	In Delivery	ABSS
ID091	**Talking Transitions**	C & L	C & L	In Delivery	ABSS
ID109	**Sensory Story Time**	C & L	C & L	In Delivery	Chaos and Calm
ID101	**Story Sacks**	C & L	CR	In Delivery	SAVS
ID102	**Umbilical Chords**	C & L	CR	In Delivery	SYMCA
ID046	**Engagement**	CR	CR	In Delivery	SAVS
ID064	**Engagement Fund**	CR	CR	In Delivery	SAVS
ID084	**CID Fund (Process and applications)**	CR	CR	In Delivery	ABSS
ID086	**Coproduction Champion**	CR	CR	Closed	SAVS, EYA, SCC
ID036	**Work Skills**	CR	CR	In Delivery	SCC
ID103	**Engagement Fund COVID-19**	CR	CR	Closed	SAVS

ID115	**Hamlet Court Road in Harmony**	CR	CR	In delivery	ABSS/Trustlinks
ID116	**Festival of Conversation / Events Assignment 2023/2024**	CR	SC	In Delivery	Bromfield Events & various partners
ID059	**Peer Support Workers for Social and Communication Needs**	SE	S & E	In Delivery	EYA
ID056	**YourFamily**	DD	S & E	In Delivery	ABSS
ID092	**ABSS Parent, Family and Community Hub**	DD	CR	In Delivery	ABSS
ID081	**Welcome to the UK**	SC	SC	In Delivery	Welcome to the UK
ID099	**Data Input - ESTART**	SC	SC	In Delivery	SCC
ID080	**First and Foremost**	SC	SC	Closed	EYA
ID079	**The Dartington Service Design (0-19 mapping)**	SC	SC	Closed	Dartington
ID078	**SCC Data Analysis**	SC	SC	In Delivery	SCC
ID048	**Joint Paediatric Clinic**	SC	SC	Closed	TBD
ID090	**Programme Evaluation Partnership**	SC	SC	In Delivery	UoE
ID106	**RSM Summative Evaluation**	SC	SC	In Delivery	RSM
ID098	**Information Governance Specialist Consultant**	SC	SC	In Delivery	Data Protection People
ID108	**Digital Strategy (Inform)**	SC	SC	In Delivery	SCC & ABSS
ID114	**Centre Place**	SC	D & N	Service Design	

Southend Health & Wellbeing Board

Agenda Item No.

11

Report of the Director of Public Health

To

Health & Wellbeing Board

on

6th September 2023

Report prepared by: Suzanna Edey, LeDeR's Senior Reviewer
Andrew Graham, LD Commissioner (Southend, Essex & Thurrock LeDeR Programme Local Area Contact)

For information only	X	For discussion		Approval required	

Learning Disability Mortality Review
Annual Report 2022-23

Part 1 (Public Agenda Item)

Purpose

This is to provide the Board with an update on the progress with the delivery of the action plan through the Southend, Essex and Thurrock's Learning Disability Mortality Review (LeDeR) Steering Group, during 2022-23.

Background

The Learning from Lives and Deaths (LeDeR) Programme started in 2017 with the aim to reduce the health inequalities faced by people who have a learning disability (LD). The LeDeR programme across Southend, Essex and Thurrock (SET) covers the footprints of 3 ICBs and 3 local authorities. The LD Health Equalities Team continues to deliver the LeDeR programme on behalf of the whole system, to commission specialist LD health services and to facilitate other national LD programmes (such as Stopping Over Medication of People with LD – STOMP and Transforming Care, which ensures people don't get stuck long term in LD Mental Health beds) across the same footprint.

Summary of the Report

The age at death of people with Learning Disability in Southend, Essex and Thurrock (SET) is gradually improving, but is still far from the rest of the population. 113 people (10 in Southend) with learning disability died across SET between April 2022 and March 2023. Since January 2022, the scope of LeDeR has been broadened to include reviews for people with Autism only (without a Learning Disability) and we are starting to see notifications for this group of people.

The SET LeDeR programme is fully compliant with the new national LeDeR policy and the recommendations from the Oliver McGowan review. The regional NHSE team have commended our performance, with us meeting the national standards. We continue to review our plans and ensure that areas of highest priority are being addressed as we continue to provide assurances via the Quality Panels. Since January 2023, we have shared a Senior Reviewer with Suffolk to achieve efficiencies and share learning. We are committed to maintaining good performance in respect of allocation and completion key metrics and the expected split between initial and focused reviews.

Across the SET footprint, there are many opportunities for people with Learning Disability and/or autism to be involved in the delivery of the programme. All Focused reviews are overseen by the Quality Panel which is supported by an expert by experience from Essex Carer's Network. There is also Family carer representation on the LeDeR Steering Group.

We are determined not to allow the impacts of Covid-19 have a long-term impact on people's health and social care, and we are paying particular attention to some key areas in 23/24 and beyond to hopefully ensure that this is not a downward trend. This includes:

- Monitoring uptake of Annual Health checks and completion of a Health Action Plan;
- Monitoring uptake of screening and vaccination to reduce un-necessary exclusions, including desensitisation work;
- Highlighting the importance of face-to-face appointments, especially where the patient is non-verbal or needs support with communication;
- Highlighting any variations from NICE guidelines, especially where this may result in late detection of cancer or late diagnoses;
- Working with Provider Quality Innovation to roll out training in key areas to care and support personnel in Essex.

Other key achievements include (please see the Highlights of Progress since Last Annual Report on page 33 of the main report):

- Following recommendations from the LeDeR Quality Panels, MSE Hospitals are working on a digital hospital passport which can be easily updated,
- ReSPECT is currently being rolled out. This is a process that supports meaningful conversations between one or more healthcare professionals and people, their carers/ family on how they want their future care to be given,
- Pneumonia and aspiration pneumonia remain the top causes of death and a number of interventions have been rolled out,
- Oliver McGowan Mandatory Training has commenced roll out across the three ICBs.

The focus on the recommendations (please see page 30 of the main report) in the report has proposed different ways of tackling known issues (rather than identifying fresh themes) to optimise the level of improvement.

We have a 3 year deliverable plan which identifies where we need to:

a) Prevent ill health
b) Improve management of health and
c) Remove inequalities

Recommendation

1. For the HWB Board to note the content of this report, attached as 3 documents:
    a. SET LeDeR Annual Report (main report)
    b. SET LeDeR Annual Report Summary slides
    c. LeDeR Annual Report Southend Trends slides
2. For the HWB Board to forward any suggestion that could enhance the delivery of the plan in 2022-23

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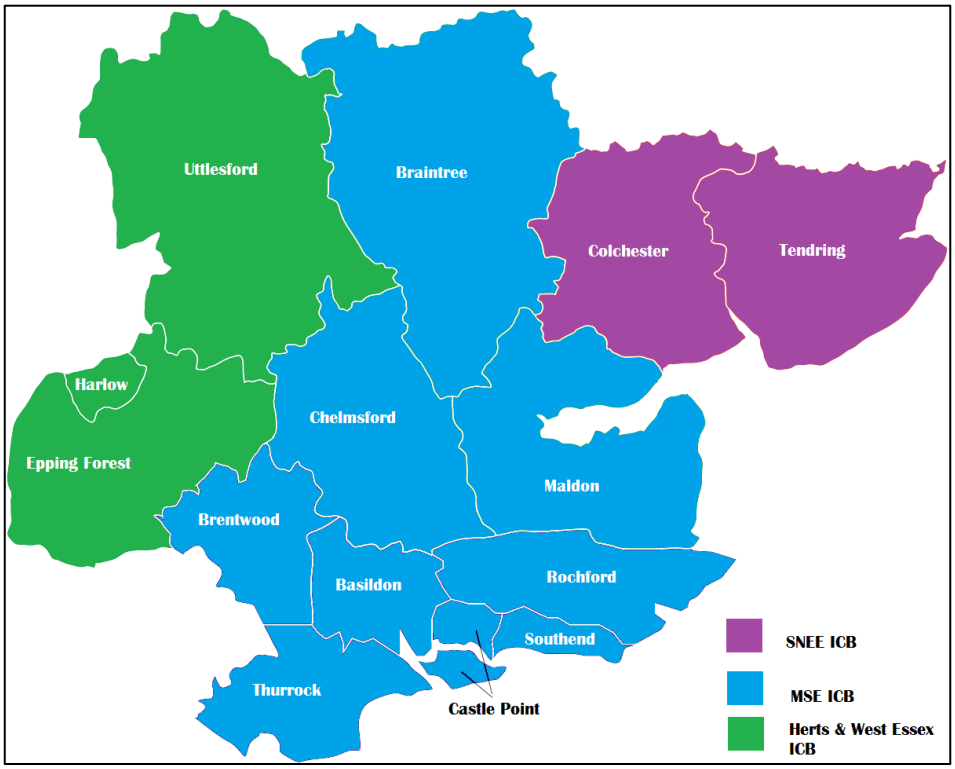
Southend, Essex and Thurrock (LeDeR) Annual Report 2022 - 2023

Learning from lives and deaths – People with a learning disability and autistic people



Version 2.3: August 2023

Contents

Foreword

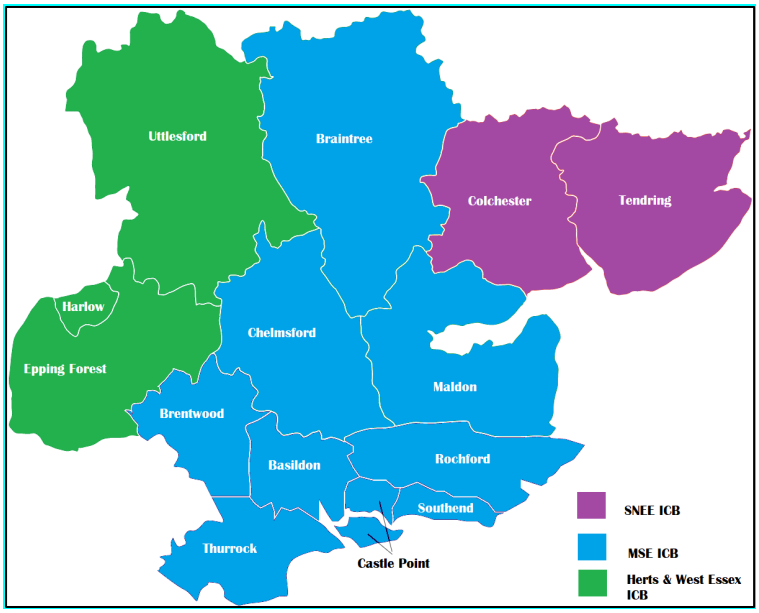
We welcome readers to the Southend, Essex and Thurrock (SET) LeDeR annual report for 2022-23. This report talks about the lives and deaths of people who lived in SET.

With the introduction of Integrated Care Boards (ICBs) from 1st July 2022, there are now three NHS boards working across SET;

Mid and South Essex (MSE)

Suffolk and North East Essex (SNEE)

Herts and West Essex (HWE)



Together as partners, we are committed to delivering the ambition set out in the Learning Disability and Autism NHS Long Term Plan to reduce health inequalities.

Throughout the report, we will sometimes split our information into three ICB areas to make it clear when we are talking about something which applies across all of SET, or whether there are differences across the County.

Since the last report, we have a shared Senior Reviewer working across SET and Suffolk, which has also helped us identify themes or concerns that are common across both counties

Throughout SET, we continue to work in partnership and remain committed to take the learning from LeDeR reviews, turning them into actions, and demonstrating change. This report will show the difference the programme has made to local people and their families and should give assurance of the ongoing commitment to service improvement.

The SET Transforming Care Partnership was set up do deliver the vision set out in Building the Right Support:

"Children, young people and adults with a learning disability and/or autism have the right to the same opportunities as anyone else to live satisfying and valued lives and to be treated with dignity and respect." (Department of Health and Social Care (2022) available at Building the Right Support Action Plan - GOV.UK (www.gov.uk)

The SET partnership Board continues to work across the three integrated care organisations and three Local Authorities which cover the County of Essex

Everyone's Essex sets out 5 commitments to Health for promoting health, care and wellbeing:

Healthy Lifestyles; promoting independence; place-based working (local partnerships); support for carers; levelling up health (Everyone's Essex: our plan for levelling up the county 2021-2025 available at Everyone's Essex: our plan for levelling up the county 2021 to 2025: Foreword from Kevin Bentley | Essex County Council)

Essex county Council published their 4 year strategy for disability in April 2023:

Essex_County_Council_Disability_Strategy_-_Meaningful_Lives_Matter.pdf

Essex County Council have an Ageing Well Programme

Ageing Well Programme

The 5 year all age autism strategy runs from 2020-2025:

All-age-autism-strategy-EasyRead-2020-2025.pdf (snapcharity.org)

The Relevant Strategies for Southend City Council are Ageing Well and Caring Well:

Ageing Well Strategy for Southend-on-Sea Borough Council 2022-2027
Caring Well Strategy for Southend-on-Sea Borough Council 2022-2027

Thurrock's Health and Wellbeing Strategy sets priorities for reducing inequalities in health and well-being, and for improving the health and well-being of the people of Thurrock:

Health and well-being strategy 2022-2026 | Health and well-being strategy | Thurrock Council

This Report will be made available in an Easy Read Format after having been approved by all relevant boards and adopted and published by MSE ICB

Acknowledgements

A special thanks to the LeDeR reviewers, health and social care providers, carers and families who have been central to supporting the LeDeR process and delivering the programme.

We acknowledge the ongoing support of Krishna Ramkhelawon Southend's Director of Public Health, who chairs the LeDeR steering group for SET.

We thank the dedicated members of the three LeDeR Quality Panels for their commitment, contribution and continued passion for improvement for people with a learning disability and autistic people.

We acknowledge our Health and Well Being Boards, the Learning Disability Health Equalities Board and the SET partnership for our ongoing governance and oversight arrangements, and a joint commitment for learning from the lives and deaths of people with a learning disability and autistic people.

We are grateful to the people from all agencies who make the notifications, our dedicated team of reviewers who work hard to make sure each review is carried out to the highest standard possible with the information available; we thank the family members and carers of people who have died for sharing the histories of their loved ones, and the Learning Disability Liaison Nurses for their dedicated input over the years.

We thank Rebekah Bailie at Essex County Council for laying the firm foundations of LeDeR in SET, and the wider Health Equalities Team at Essex County Council, the ongoing support from Essex Family Carers Network, our Suffolk and Hertfordshire colleagues, and LeDeR colleagues across the region for a commitment to collaborative working for better outcomes.

We remember Phil Brown, who transformed lives, and the people whose lives and deaths we have had the privilege to review and learn from, and in commitment to them we continue to strive for improvement across all aspects of health and care.

Executive Summary

The deaths of 113 people with learning disability and/or Autism were notified across SET between April 2022 and March 2023. This is a very similar number to the previous year when 116 deaths were notified. Since January 2022, the scope of LeDeR has been broadened to include reviews for people with Autism only (without a Learning Disability) and we are starting to see notifications for this group of people.

The average age of death has gone down somewhat this year, which we are monitoring. We believe that we are still seeing the impact of Covid-19 on our notifications and across health provision.

We remain compliant with the revised LeDeR policy in terms of team structure, and since January 2023 have shared a Senior Reviewer with Suffolk to achieve efficiencies and share learning.

We are committed to maintaining good performance in respect of allocation and completion KPIs and the expected split between initial and focused reviews. Although 2022-23 has been a challenging year in terms of staffing in the team, we have remained sighted on achieving the required number of completions in a timely manner whilst improving quality across reviews.

We have a 3-year deliverable plan which identifies where we need to a) prevent ill health b) improve management of health and c) remove inequalities and this reflects the commitment of all organisations, including public health. This is monitored by the LeDeR Steering group and is due to be reviewed this year.

Introduction

The aim of the Learning from Lives and Deaths (LeDeR) Programme is to reduce the health inequalities faced by people who have a learning disability.

The LeDeR programme to date has reported on deaths of people with learning disabilities aged 4 and above. The new LeDeR policy has brought the inclusion of those with a diagnosis of autism (aged 18 and over) into the programme from January 2022.

When somebody with a learning disability or autism dies, and their death is notified to LeDeR, we carry out a review of all aspects of the care and support they received – this might be Primary Care (from their GP Practice), care in Hospital, care and support from paid providers, or from family, or specialist services.

By reviewing all aspects of care and support, we are looking to improve quality by learning from what went well and making recommendations for change where things could have been better, to improve health outcomes for other people with learning disability and/or autism.

The LeDeR programme works alongside other quality improvement measures currently in place to reform services and improve health outcomes for people with a learning disability. If other reviews and enquiry processes need to take place, such as hospital structured judgement reviews (SJRs), serious incident reviews, safeguarding investigations, police investigations or a Coroner's report, the LeDeR review should be done after these are completed, so we can include the learning from their findings in our summaries.

The programme started in Essex in 2017. At that time, there were two things we wanted to see to show how LeDeR was making a difference:

1. We wanted the number of deaths notified to LeDeR to increase every year, as more people became aware of the programme, so that opportunities to learn were not missed
2. We wanted to see the average age of death of people with a learning disability increase, "to close the gap" as we knew that on average people with learning disability were dying up to 20+ years younger than the general population

We still want these things. However, the impact of Covid-19 throughout 2020 and 2021 had a significant impact on the numbers of deaths reported and the average age at death, and this is still seen across 2022 and 2023. Also, while we still have a steady increase in notifications for people with a learning disability, we have had very few for autistic people who didn't also have a learning disability.

It will take more time before we are confident that we are getting all the notifications we should, and we start to see an impact on the average age of death. However, in the meantime, this annual report provides an update on the achievements of the three Integrated Care Boards (ICBs) and Southend Essex and Thurrock (SET) Local Authorities and transforming care partnerships, and the changes already being seen.

The report will also report on the LeDeR learning from demographic data from notifications and reviews. It will provide an update on our progress since last year's report and then describe what we have learned from the reviews undertaken during this reporting year.

This report will also outline the governance arrangements for LeDeR across SET, and how partners are working together to promote improved outcomes and experiences for people with a learning disability and autistic people.

We will make the report available in 'easy read' format later in the year.

Involvement of people with a learning disability, experts by experience and families/carers

Across the SET footprint, there are many opportunities for people with Learning Disability and/or autism to be involved in the delivery of the programme. All Focussed reviews are overseen by a Quality Panel which is supported by an expert by experience from Essex Carer's Network. There is also Family carer representation on the LeDeR Steering Group, which monitors all recommendations and actions from reviews, and also the SET Partnership board.

The Learning Disability Health Equalities Board has maintained involvement from people with Learning Disability and Autism, but we recognise that there have been significant changes in ways of working, and this has potentially made it more difficult for people to be meaningfully engaged. This was due to changes in the ways we work which were the result of fewer face to face and more online meetings due to covid restrictions, plus the loss of some key personnel in Essex.

As a result, the Health Equalities team are recruiting associate commissioners with a Learning Disability plus dedicated support for them in the workplace, to ensure the voice of people with Learning disability does not become lost. We also have recruited a commissioner dedicated to Autism, as we are anticipating an increase in the number of "Autism only" reviews in 2023/24.

Delivery of the Programme

The LeDeR programme for SET is hosted by Essex County Council for the 7 Clinical Commissioning Groups (CCGs) in partnership with the three Local Authorities. This arrangement has continued under the newly formed ICBs in place of the old CCGs, and the SET reviewers are employed by Essex County Council. At the end of March 2023, the review team consisted of a Senior Reviewer covering both SET and Suffolk, one part time (0.6) permanent reviewer. This impacted on the capacity of the team to deliver the reviews in a timely way, although we were able to use the resource of some independent contracted reviewers. Since then, we have had a part time reviewer (0.6) return from a year's secondment, and we have recruited two additional part time reviewers (0.6 and 0.4), as well as a new commissioner who will be the SET LeDeR Local Area Contact (LAC) , freeing up additional time from the Senior Reviewer. We are also recruiting into a co-ordination and admin position to support all aspects of LeDeR.

We are monitoring the number of notifications being made to ensure that we now have sufficient capacity to deliver as many reviews as possible within the 6 months target.

Due to the historically lower numbers of notifications made in Suffolk County, the Senior Reviewer role is shared across SET and Suffolk, and two LD nurses are employed on a bank basis, with the Support of the Suffolk LAC and administrative support.

Governance arrangements

LeDeR is integral to the NHS 10 Year Plan, published in 2019, with the aim of improving the lives of people with learning disabilities nationally.

The Senior Responsible Officer Role is held by Nick Presmeg on behalf of Southend, Essex and Thurrock.

The Deputy Responsible Officer Role is held by Jeff Banks on behalf of Southend, Essex and Thurrock.

The ICB Chief Nurse is the Lead for the LeDeR programme in Mid and South Essex, and North East Essex and Herts. In West Essex, the ICB Lead is the Director of Strategy.

SET LeDeR Steering group – chaired by Southend's Director Of Public Health

This group has representation from senior leadership across Health and Social Care systems with the authority to affect change.

This group will review its original terms of reference in 2023 but will remain the key driver for change across all systems and be sighted on all reviews completed.

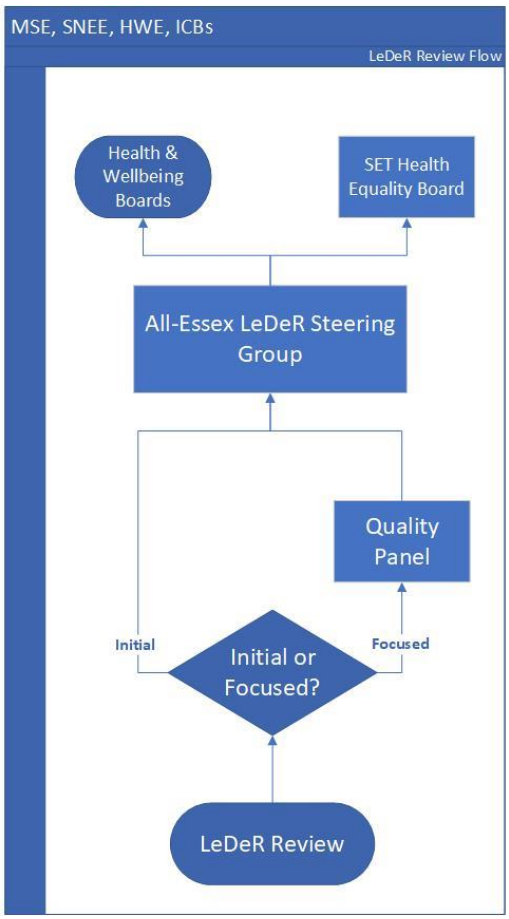
The Three Quality Panels

These groups convene separately for reviews from the MSE, NEE or WE areas. They are attended by an Expert by Experience from Essex Family Carers, with representation across the ICBs, Local Authorities, and the Learning Disability Specialist Health provider (ELDP – Essex Learning Disability Partnership). We are able to learn from practitioners who can help unpick anything tricky to understand or give a perspective on certain decisions.

In 2022/23 there were a number of changes to key personnel associated with the formation of the new ICBs, and so in 2023/24 we wish to identify a lead or leads across the three areas as a specialist to support reviews for people of any ethnic, racial or religious minority background.

We will also be investigating how we can involve colleagues from the Ambulance Trust to contribute to identified Quality Panels.

The image below represents how each group is involved in the Governance and oversight of LeDeR in SET.



Performance against national targets

The new LeDeR policy launched in March 2021 set out a plan for a 'lighter touch' initial review and it was expected that approximately 1/3 of reviews notified would move into the second focused review stage. Those focused reviews are guided by the reviewer and agreed by the Local Area Contact. The criteria for a focused review are:

- if it is believed there will be significant learning,
- when the family have requested a focused review,
- when the person has a diagnosis of Autism only,
- when the person is from a minority ethnic, racial, or religious background.

The key quality improvement measures which we continue to monitor across SET:

- 100% reviews to be completed within 6 months of notification (except where reviews are placed on hold for permitted reasons)
- At least 35% of reviews to be a focused review.
- Continued improvements to the quality of reviews to identify local learning.
- Progression of identified learning in a timely manner.

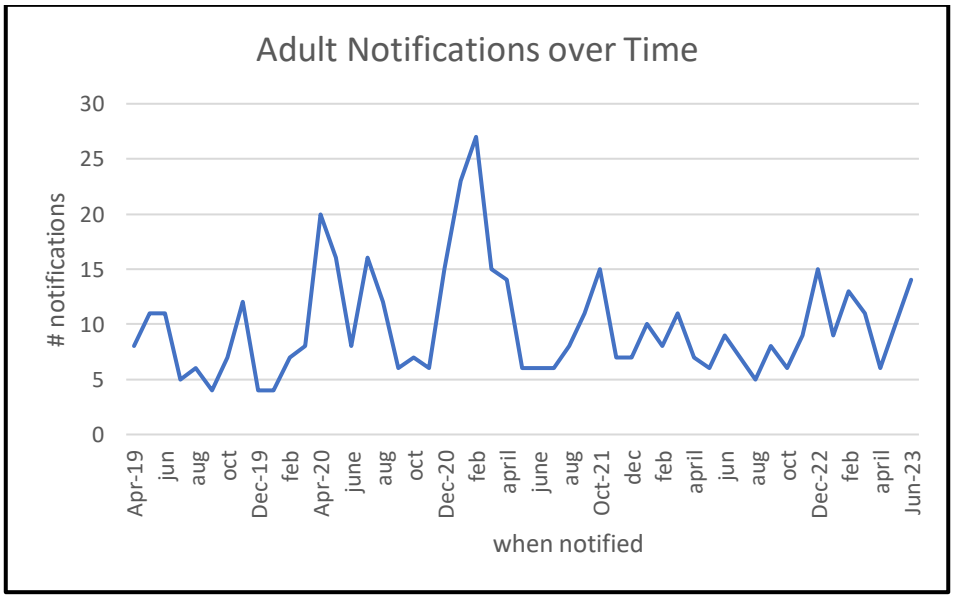
Our People, Performance, Themes and Trends

The data we are using

In this report, there are two sets of data we refer to.

The first is the set of **notifications.** This is the number of deaths notified to us at LeDeR in the year 22/23, meaning from 1st April 2022 to the 31st March 2023.

Since most notifications are made close to the day when the person died, this data is helpful for us to understand some of the trends around deaths as they occur. For example, this graphic:



is a clear indication of the impact on Covid-19, when notifications were at their highest, but also shows the impact of Winter on health.

Looking at notifications helps us to understand any changes on a year-by-year basis.

The second set of data we use is **completed reviews.** This would normally be for the same time period, from 1st April 2022 to 31st March 2023, but this year NHSE decided to extend the period by 10 weeks, as there was a problem in the online system which meant reviews could not be completed for a time, which meant there may not have been enough completed reviews to provide good data. We have decided for this report to mirror NHSE, so that our data will be in line with the National Annual report when it is published later this year. This does mean that our WE and NEE data covers a slightly different date range than the data being used in the HWE and SNEE reports, so there are slightly different numbers used in those areas. I will make it clear whether the data in the report relates to

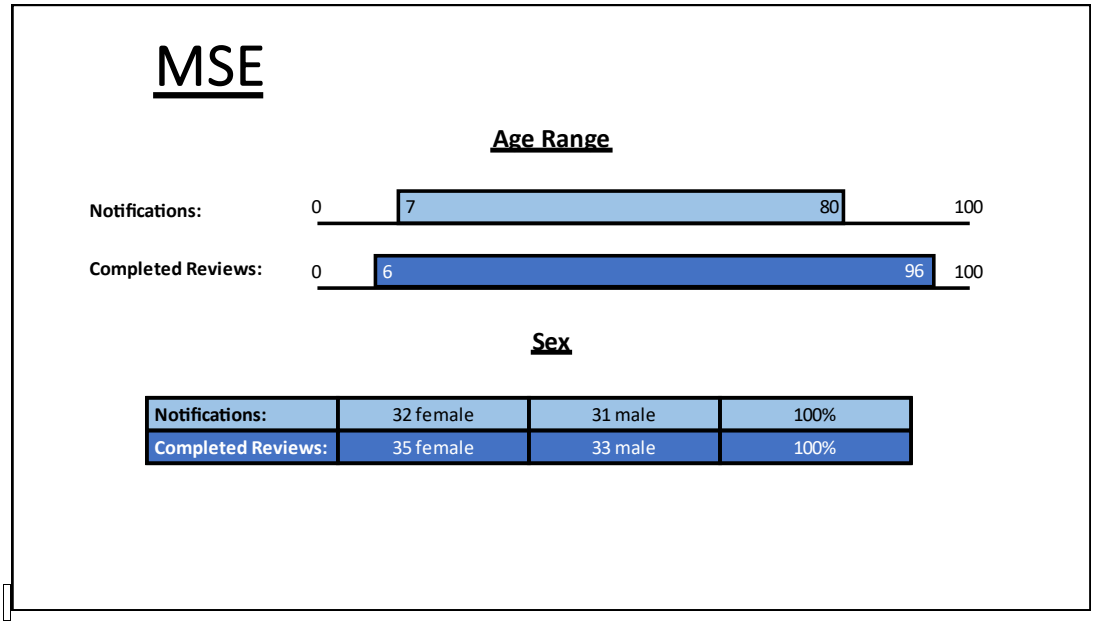
notifications in the year, which will nearly all be for people who died in that year, or completed reviews, some of which may be more than a year old.

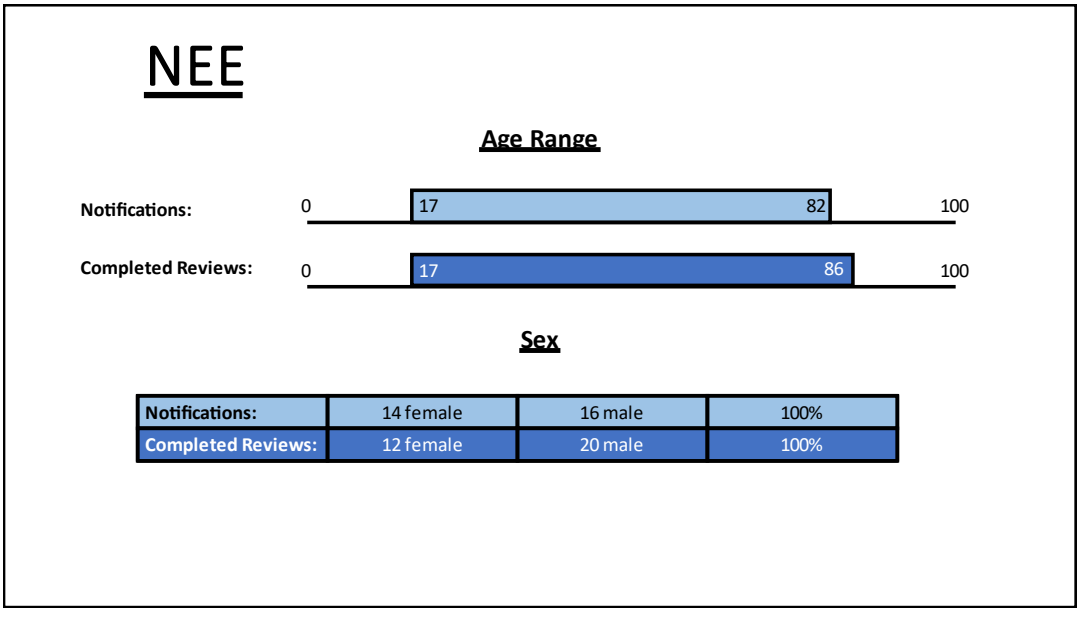
Notifications 2022-23

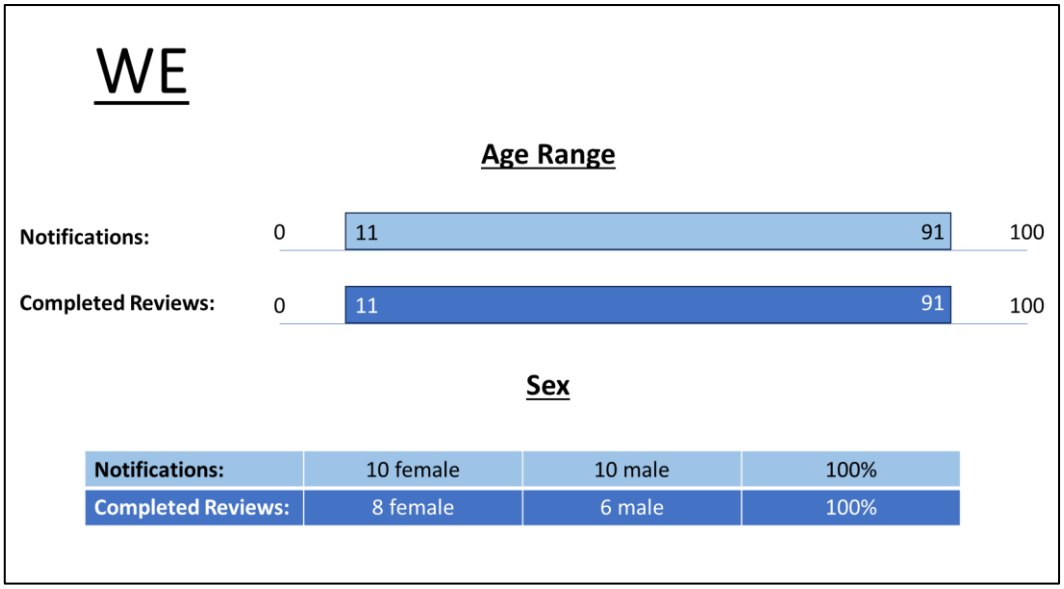
In 2022/23 we received a total of 113 notifications which included 7 child death notifications.

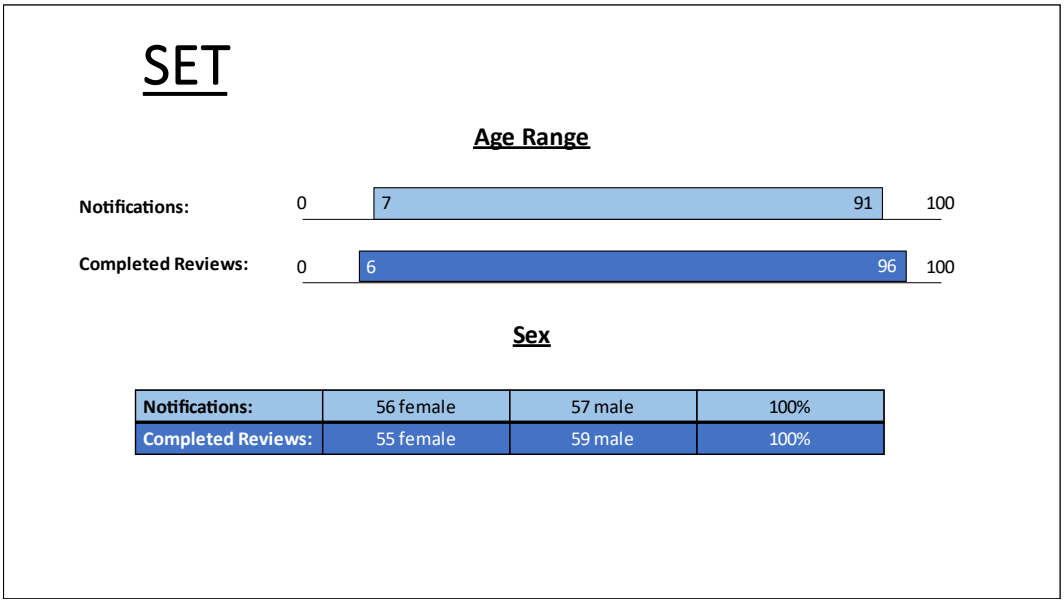
ICB	*April*	*May*	*June*	*July*	*August*	*Sept*	*Oct*	*Nov*	*Dec*	*January*	*February*	*March*	*Total*
MSE	4	4	7	5	3	3	3	3	9	5	6	11	63
WE	1	3	0	2	0	1	2	1	1	1	5	3	20
NEE	2	3	2	1	1	3	1	6	4	3	3	2	30
Essex total	7	10	9	8	4	7	6	10	14	8	14	16	113

Below is a comparison between notifications and completed reviews:









The number and nature of **completed reviews** in a year are broadly similar to the number of notifications, but they provide better data, as we know more about what happened once a review has been completed, and a number of reviews which were **notified** in 22/23 are not yet completed. The age range of completed reviews is broader than that of reviews notified in year by 6 years

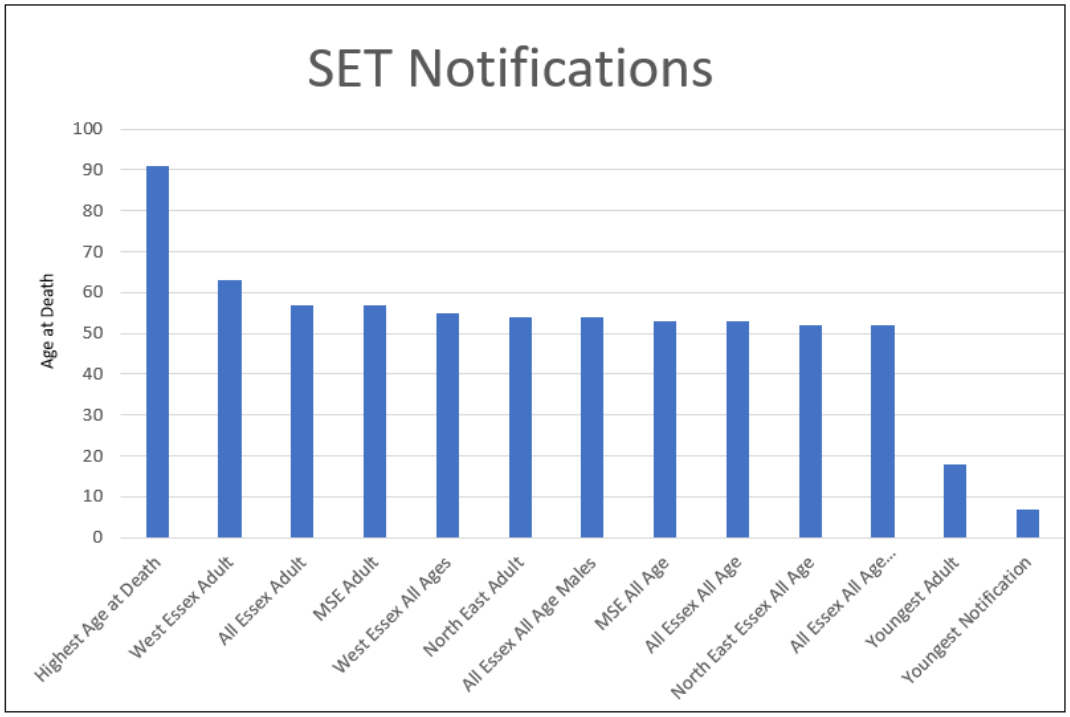
Age at death by notification

The King's College National LeDeR report 2021 leder-main-report-hyperlinked.pdf (kcl.ac.uk) highlighted that the median age at death was 61 for males and 60 for females based on notifications. Males with a Learning Disability died 22 years earlier than in the general population and females died 26 years younger than the general population.

Notifications in 22/23 for Essex show a drop in average age of death overall.

Last year the median average age of death was 65.5 years. This year we have broken down the average ages by sex and by ICB area.

Average Age at Death



The median average age at death for adults in Essex in 2022-23 was 57. In West Essex the average median age was a little higher at 63, but this is impacted by the small sample size and two 80+ notifications. In North East Essex the average age is lower at 54, but again this is influenced by the small sample size and two young adult deaths. The average age of death in MSE is 57, in line with the average age overall.

The reasons for this are not fully understood, and contrary to how it may first appear, not all negative. We have a few notifications for the deaths of very young adults who have outlived their initial prognoses, which is to say that they might have been expected to die in childhood, except for the very good care from family and professionals. This has the effect of decreasing our average age at death for adults, but not the average age at death overall.

Another reason we think the average age has gone down is because of the higher numbers of notifications we received during the peak of the covid-19 epidemic, when our average age at death actually increased. We think that some of the oldest adults died during covid, who might otherwise have died in 22/23, and therefore some of the oldest people are “missing” from this year’s numbers.

In the 2020/21 annual report there was 50 notifications for people between 60-69, 52 notifications for people between 70-79, 11 notifications for people above 80 years of age. In

the 2021/22 annual report there was 32 notifications for people between 60-69, 22 notifications for people between 70-79 and 15 notifications for people over 80 years of age.

As you can be seen from the evidence above, we lost a significant number of people above the age of 60 during covid. Especially when we consider that there are only 113 death notifications this year. Which is the same number as the number of adult's deaths that were over 60 when notified to LeDeR in 2020/21. Then in 2021/22 there were 69 people deaths notified of people over 60 which a significant number. It is important to note data shows the significant impact covid 19 had on our older adults with learning disabilities between 2020-2022 and therefore explains the lower average age of death in 2023.

We are determined not to allow the impacts of Covid-19 have a long-term impact on people's health and social care, and we are paying particular attention to some key areas in 23/24 and beyond to hopefully ensure that this is not a downward trend. This includes:

Monitoring uptake of Annual Health checks and completion of a Health Action Plan

Monitoring uptake of screening and vaccination working with Public Health colleagues to reduce un-necessary exclusions, including desensitisation work

Highlighting the importance of face-to-face appointments, especially where the patient is non-verbal or needs support with communication

Highlighting any variations from NICE guidelines, especially where this may result in late detection of cancer or late diagnoses

Working with Provider Quality Innovation to roll out training in key areas to care and support personnel in Essex.

For clarity the average age of death is calculated by omitting any notification under 18 years of age and then determining the average age of death amongst the adult notifications. This helps provide a realistic average age of death within the limitation of a small sample size.

Sex and Gender

During the LeDeR process, some aspects of healthcare we review is specific to the sex of the person who died, for example some of the screening offered.

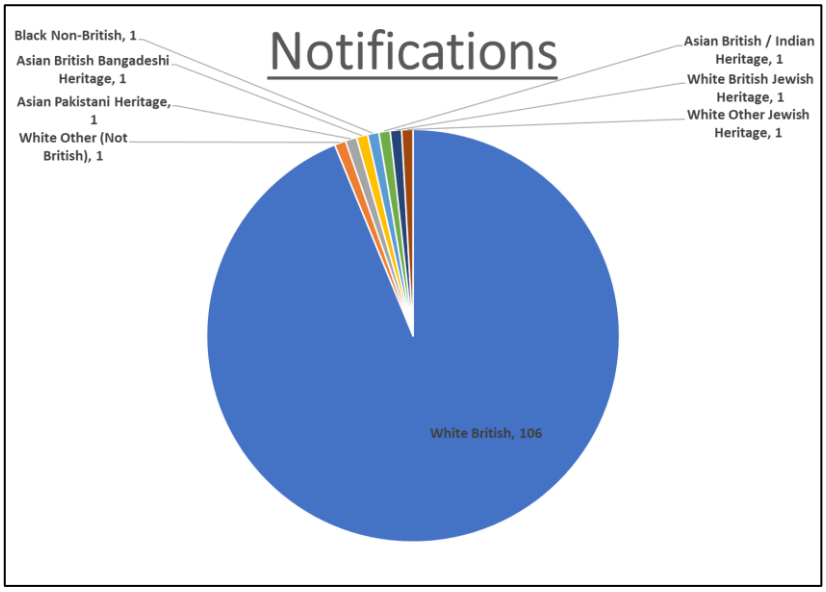
We received very similar number of notifications for women and men (56 female, 57 male), and also completed reviews for a similar number (55 female, 59 male).

We are able to record if a person who died identified as being a different gender to their biological sex, but so far we have not completed a review where that has been noted as the case. As conversations around sex and gender identity are becoming more normalised, we predict that this may change, and also if we start to be notified about more deaths of autistic people.

Ethnicity by completed reviews

The 2019 National LeDeR Report found that people from minority ethnic groups died at disproportionately younger ages than white British people. Nationally, of those who died in childhood (ages 4-17 years), 43% were from minority ethnic groups.

SET has a significantly lower number of deaths in people from minority ethnic backgrounds In 2022/23, only 7 LeDeR reviews were completed for people with a minority ethnic background and the rest were white British.



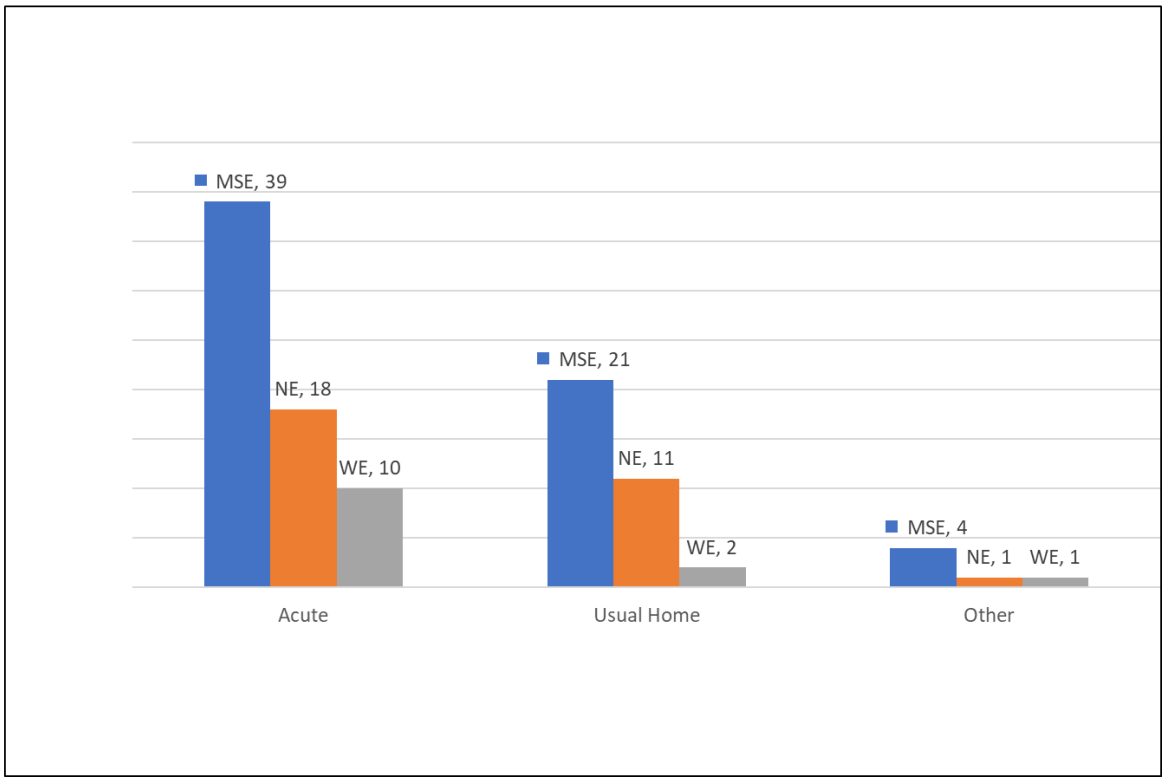
It seems likely that there is under-reporting of deaths across all minority groups. This is concerning, because it suggests that people from all minority ethnic backgrounds are less known to services for people with Learning Disability.

According to the latest 2021 census, the population in SET is predominantly white (90.4%), with non-white minorities representing the remaining 9.6% of the population. Asian people were the largest minority group in SET accounting for 3.7% of the population.

Place of death by notification

Nationally, the proportion of people with learning disabilities dying in hospital was 61% in 2021. We know that many people say that they would prefer to die at home. The NHS Long Term Plan identifies the ambition to avoid emergency admissions, and it is understood that dying at home in familiar surroundings is regarded as a preference by a majority in the general population

Place of Death



In 2022-23, 59% of people whose deaths were notified died in an Acute Hospital. That is the same percentage as last year.

The reviews have highlighted a number of reasons why people are not able to die at home, including:

When care providers do not feel able to take a person back home, as they do not offer the level of care and support the person needs at end of life.

When there is not a clear plan for a person to stay at home to die peacefully, and they are transported to hospital unnecessarily.

When a discharge from hospital is not well planned, and the person does not have the care, medication or equipment they need to remain at home.

We also know from reviews that where palliative care teams/hospice teams are involved at the end of someone's life, there is typically good planning, and care providers and families value this support.

One reason it might appear that more people die in their usual home than actually do, is that some people might classify a place as a "usual home" even if the person had lived there for a very short time, if being placed their effectively ended their previous living

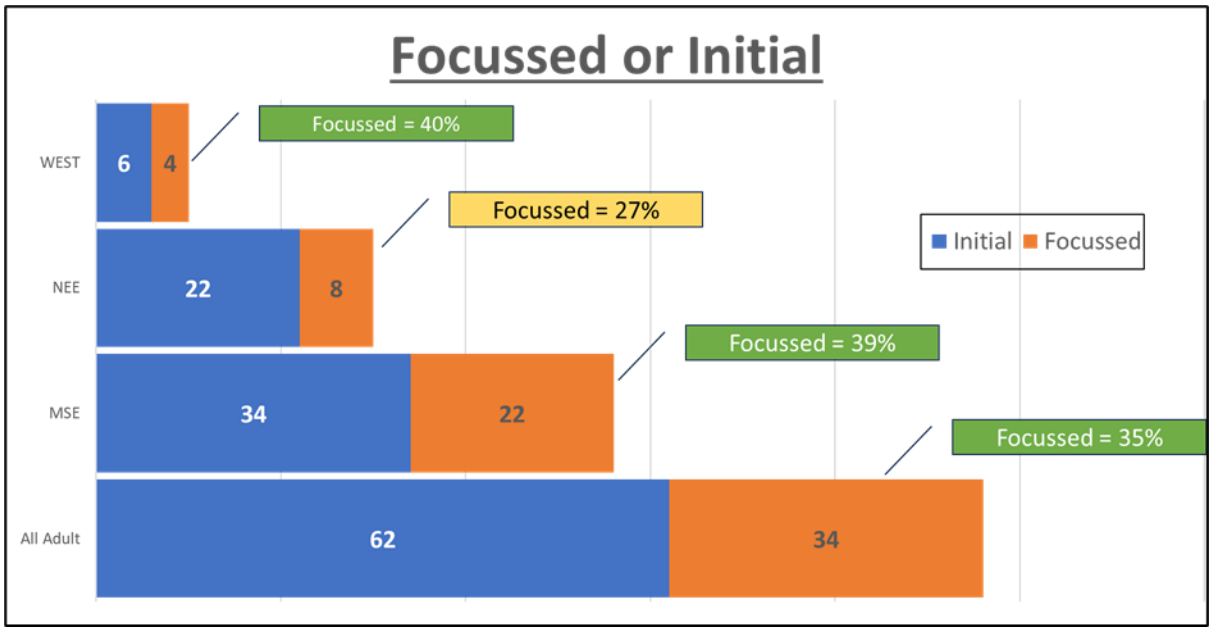
arrangement. The person with the Learning Disability may not have considered it their "usual home" and therefore it is likely that the number of people who died in the place they thought of as home is actually lower than 35.

Completed reviews

In 22/23 we completed:
10 Adult reviews for West Essex
30 Adult reviews for North East Essex
56 Adult reviews for Mid and South Essex

Adult reviews are either completed after the **Initial** review, or are selected for a more in-depth **Focussed** review

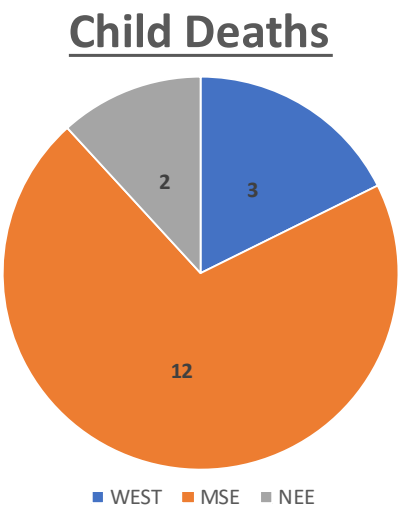
NHSE expects at least 35% of reviews to be focussed, which is in line with what we have done this year. Although the chart below shows that we are a little under 35% for NEE, that will balance out as we sign off the next Focussed reviews for completion in 23/24, which are mainly NEE reviews



The criteria for a focussed review are:

- if it is believed there will be significant or new learning,
- when the family have requested a focussed review,
- when the person has a diagnosis of Autism only,
  when the person is from a minority background.

We also completed 17 reviews of child deaths across the SET.



Total SET Deaths: 17

The child deaths are not reviewed by the LeDeR reviewers, as they are passed to the Child Death Overview Panels (CDOP), who will carry out a thorough inquiry. The Senior Reviewer will attend the CDOP if there is a LeDeR case being discussed and will receive copies of the completed review and will receive a copy of a Form C, which has details of the completed review by CDOP. Relevant learning from the Panel will be reported back to the LeDeR Steering Group.

From 1st July 2023, Child Deaths will no longer be considered under LeDeR, but the information and learning from the Child Death Reviews will be shared with the LeDeR Steering Group and analysed alongside LeDeR Data at a National Level.

Primary causes of death from completed reviews

The cause of death is described in 4 parts on death certificates:

1a disease or condition directly leading to death

1b other disease or condition (if any) leading to 1a

1c other disease or condition (if any) leading to 1b

Part 2 other significant conditions contributing to the death, but not related to the disease or condition causing it.

There are some marked differences in the leading causes of death for the general population and the individuals whose deaths were notified to LeDeR.

The most common causes of deaths in Essex recorded on people's death certificate at 1a as the primary cause of death are set out below in the table, which shows where there were three or more deaths of a single primary cause (listed at 1a on the death certificate) , or

where there were three or more deaths which are strongly related (for example Pneumonia, Community Acquired Pneumonia (CAP), and Hospital Acquired Pneumonia (HAP) are all shown, even though there was only one death recorded as HAP.

Primary Cause of Death	ICD codes		MSE	NEE	HWE	SET
Respiratory Conditions	J00-J99	Aspiration Pneumonia	14	4	1	19
		Bronchopneumonia	2	2		4
		Lower Respiratory Tract Infection/Chest Infection	3	1		4
		Respiratory Failure	2	2	1	5
		Pneumonia	12	4		16
		Hospital Acquired Pneumonia			1	1
		Community Acquired Pneumonia	1	2		3
		Covid-Pneumonia/ Pneumonitis/Covid-19	4		2	6
		Pulmonary Embolism/fibrosis	3			3
		Total Respiratory	**41**	**15**	**5**	**61**
Sepsis/ Septicaemia	A40-A41	Sepsis	2			2
		Urosepsis	1			1
		Septicaemia		1		1
		Septic Shock	1			1
		Total Sepsis	**4**	**1**		**5**
Cardiac/ circulatory system	I00-I99	Congestive heart Disease		1		1
		Congestive Cardiac Failure/ Cardiac Failure/Heart failure	4			4
		Intercerebral Haemorrhage	1			1
		Cardiac Arrest	2	3	1	6
		Obstructive Coronary Artery Disease/Atherosclerosis	1	1		2
		Dilated Cardiomyopathy	1			1
		Myocardial Infarction	1			1
		Myocarditis	1			1
		Other Cardiac	1		2	3
		Total Cardiac	**12**	**5**	**3**	**20**
Neoplasm/ Cancer	C00-D48	Metastatic Cancer	3		1	4
		Neoplasm		1		1
		Cancer of the Bowel	1			1
		Acute Myeloid Leukaemia		1		1
		Carcinomatosis		1		1
		Carcinoma	1		1	2
		Cancer of the Pancreas	1	1		2
		Total Neoplasm/Cancer	**6**	**4**	**2**	**11**
Dementia/ Alzheimer's	F01, F03, G30	Dementia	2	2		4
		Alzheimer's	1	2		3
		Total Dementia/Alzheimer's	**3**	**4**		**7**
Epilepsy	G40	Epilepsy	1			1
		Status Epilepticus	1			1
		Epilepsy Seizure			1	1
		Total Epilepsy			**1**	**3**

This shows that Respiratory conditions are by far the leading primary cause of death for people with a Learning Disability (61) , followed by Cardiac deaths (20), Cancers (11), Dementia (7) Sepsis (5) and Epilepsy (3)

For comparison, if we had reviewed a sample of deaths of people from the general population, we would expect to find the leading cause of death to be Dementia and Alzheimers (around 12 people) , followed by heart diseases (around 10 people) and chronic lower respiratory diseases (around 6 people).

Clearly there is a very great difference in the leading casues of death for people in the general population and people with a learning disability, and this continues to inform the work of the SET Health Equalities team and partners. In particular, there has been a focus on respiratory illness throughout 2022 and into 2023.

For more detail on the causes of death in the general population against the relevant ICD10 codes, the ONS website is helpful:

Deaths registered summary statistics, England and Wales - Office for National Statistics (ons.gov.uk) (accessed June 2023)

People with a learning disability often have poorer physical and mental health than other people and may face barriers to accessing health and care to keep them healthy. Too many people with a learning disability are dying earlier than they should, many from things which could have been treated or prevented.

Some deaths resulting from Sepsis, Cancers, Epilepsy and Diseases of the Circulatory or Respiratory system are classified as Avoidable Deaths in adults under 75, which make up the majority of deaths notified and reviews completed.

(for further detail, please see: Avoidable mortality in the UK QMI - Office for National Statistics (ons.gov.uk) accessed July 2023)

Genetic and Long-Term Conditions (LTCs)

The online LeDeR Platform did not collect data about people's genetic or long-term conditions in a uniform way across all reviews until January 2023. This means there is not a full year's data available, however by the time of the next annual report for 23/24, this data will be available.

For this year, we have done a manual count of all genetic and long term conditions mentioned in the reviews, which may not have captured every individual case, but nonetheless this has shown us some interesting trends which we can use to shape our reviews in 23/24, and will provide a useful comparison with the data available next year. We have identified 7 areas where we want to continue to work with agencies to make improvements; these are:

Down's Syndrome

Cerebral Palsy

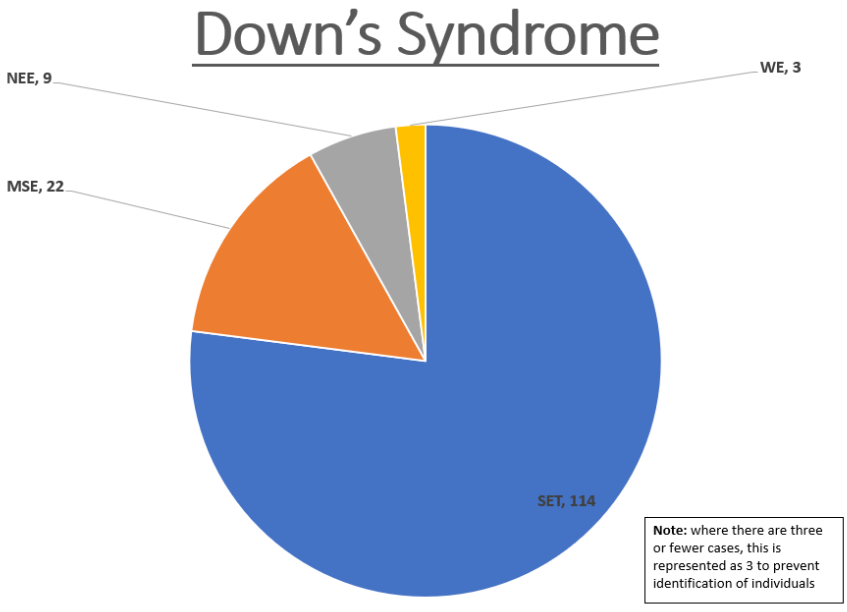
Epilepsy

Scoliosis

Dysphagia and PEG feeding

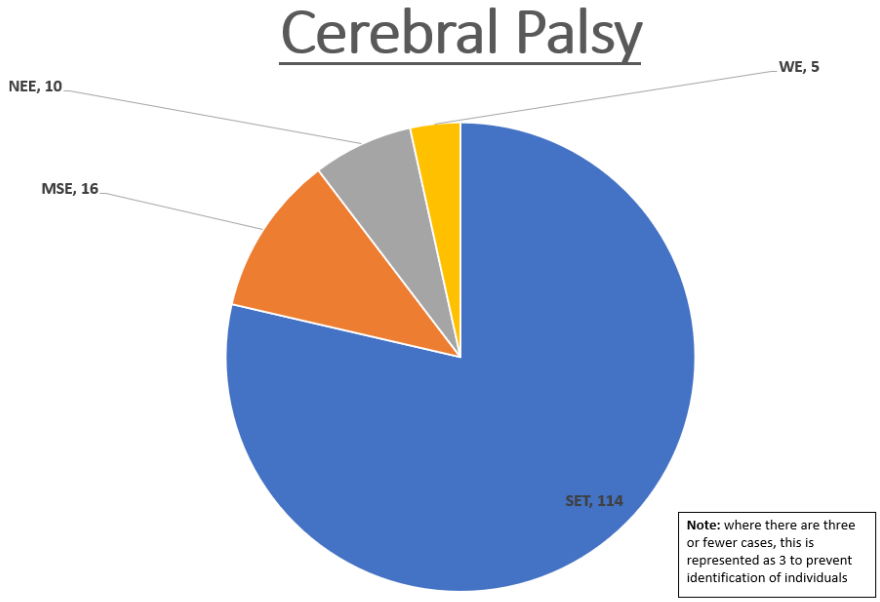
Constipation

Visual impairment

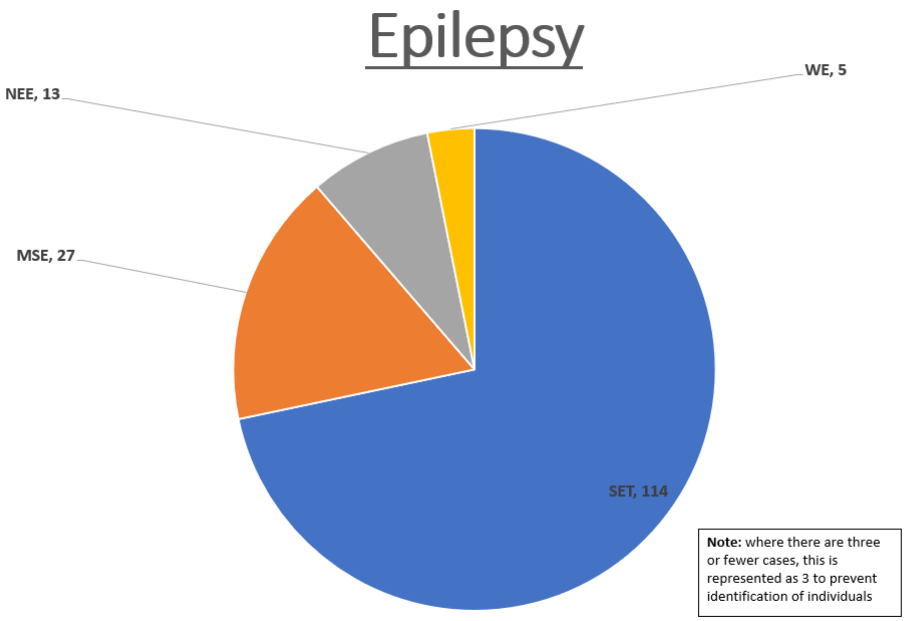


At least 34 (30%) of the completed reviews were for people with Down's syndrome. This genetic condition is associated with some other health conditions, and we should look at what reasonable adjustments we can make across health and social care to improve services for people with Down's syndrome.

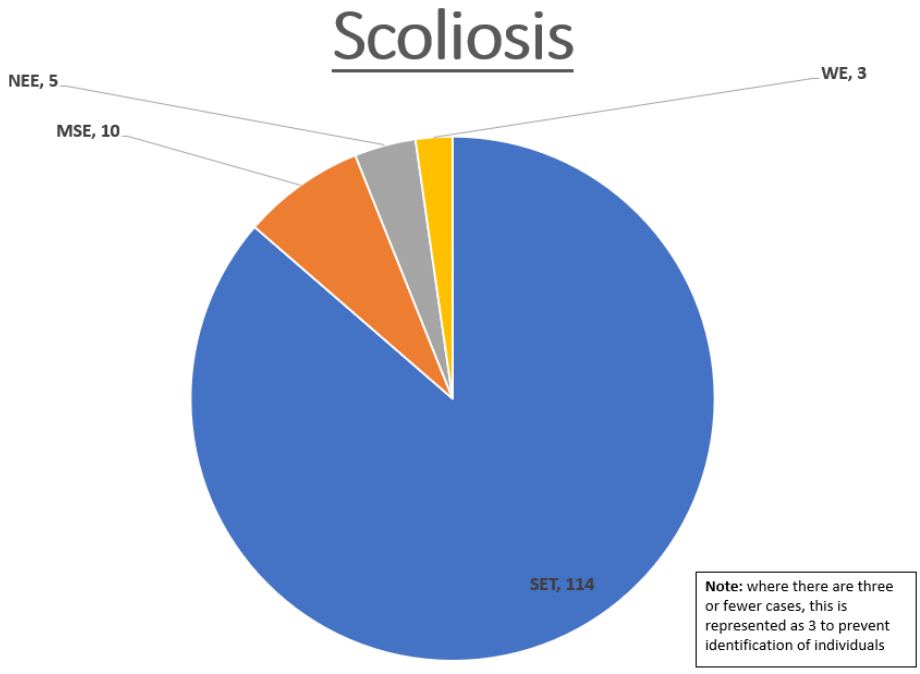
An example of this relates to dementia. Although everyone's health needs are unique, we do know that people with Down's syndrome typically experience symptoms of dementia at a younger age. We need to make sure that care providers are alert to the early symptoms, and that dementia assessment and support services do not exclude people with Down's Syndrome unnecessarily.



At least 31 (27%) of the completed reviews were for people living with Cerebral Palsy. We have noted in reviews that this group are most likely to have different perceptions of the level of their learning disability by professionals, and in particular where a person has communication needs which are not understood.



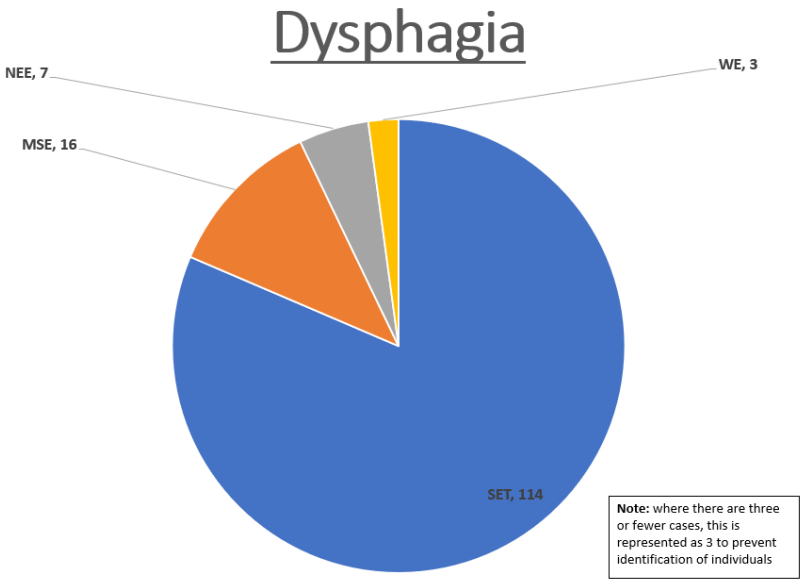
At least 45 (40%) of the completed reviews were for people with epilepsy. Many of those had well-managed epilepsy, managed through medication, with oversight from a Neurologist and or epilepsy nurse. In reviews, we are looking to ensure that care providers are appropriately trained, and that there are emergency plans and risk assessments in place. If someone has a seizure who doesn't have epilepsy, they should be referred to the First Fit clinics and fully assessed.

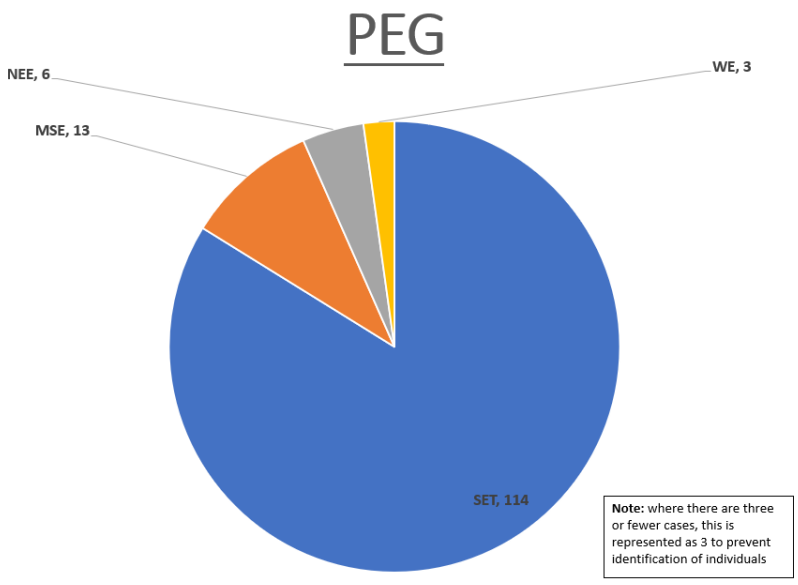


At least 18 (16%) of people had scoliosis, and we think the number could be much higher, as some reviews use different language such as "postural difficulties". Posture is extremely

important to consider when people are eating and drinking, because good posturing can reduce the risk of a person aspirating, and also important to understand how to support people with postural difference to mobilise/keep mobile, as this can also have an impact on their overall health.

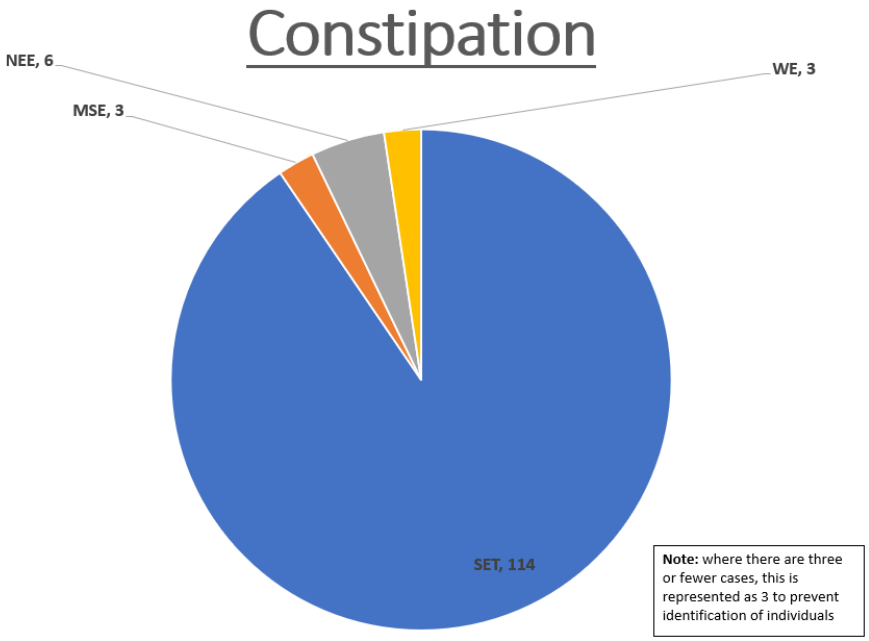
Reviews have shown us the positive influence of Speech and Language Teams (SALT) in training and supporting care providers to encourage good posture for eating and drinking, and there is evidence of good working between SALT, Occupational therapy teams, and equipment services. However, a number of reviews highlight delays in people being able to access equipment which will meet their needs, which creates a risk of health deterioration.





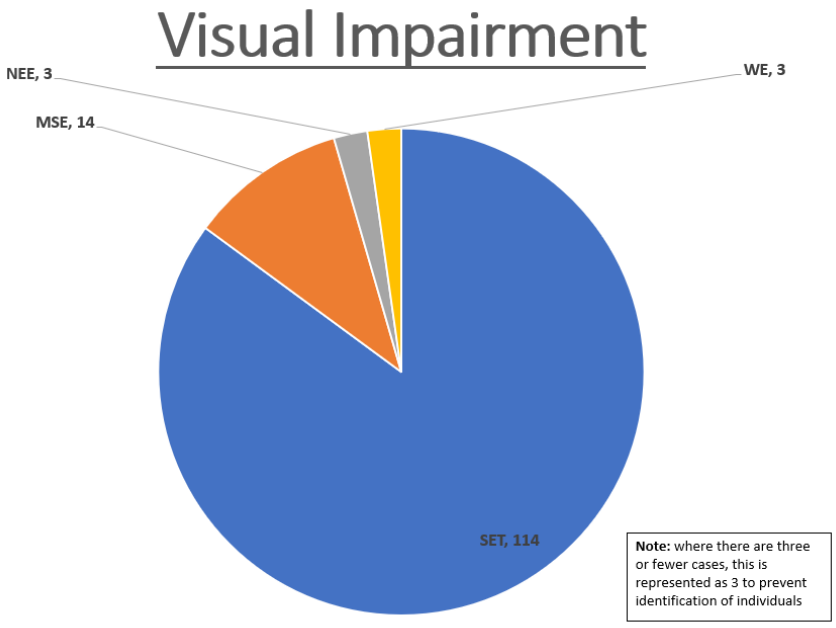
At least 26 (23%) of reviews directly talk about dysphagia, and we think the number of people affected is higher, as some reviews use terms such as swallowing difficulties. 22

reviews were for people who were PEG fed. Dysphagia is a very significant condition given the high numbers of people who die from Aspiration Pneumonia. Again, where SALT teams are involved in a person's care, they are able to support care providers to manage the condition.



12 (10%) of the reviews directly talk about the effects of constipation, and we understand how dangerous this condition can be if unresolved, and how painful. We will ensure all learning from the case of Richard Handley is carried forward into reviews where constipation is a feature.

Richard Handley: 'Gross failures' in constipation death - BBC News (accessed Jun 2023)



20 (17%) of reviews were for people with significant visual impairment. To date, we have not

made many recommendations around improving services for this group of people, and so for 23/24 we will make it a priority to consider how services made reasonable adjustments to accommodate their needs.

DNACPR numbers

Before January 2023, the LeDeR online platform did not routinely capture whether a person had a DNACPR (Do Not Attempt Cardiopulmonary Resuscitation – sometimes called a DNR or DNAR). Again, we have manually counted and captured those reviews where reviewers explicitly state they have seen confirmation that a DNACPR is in place.

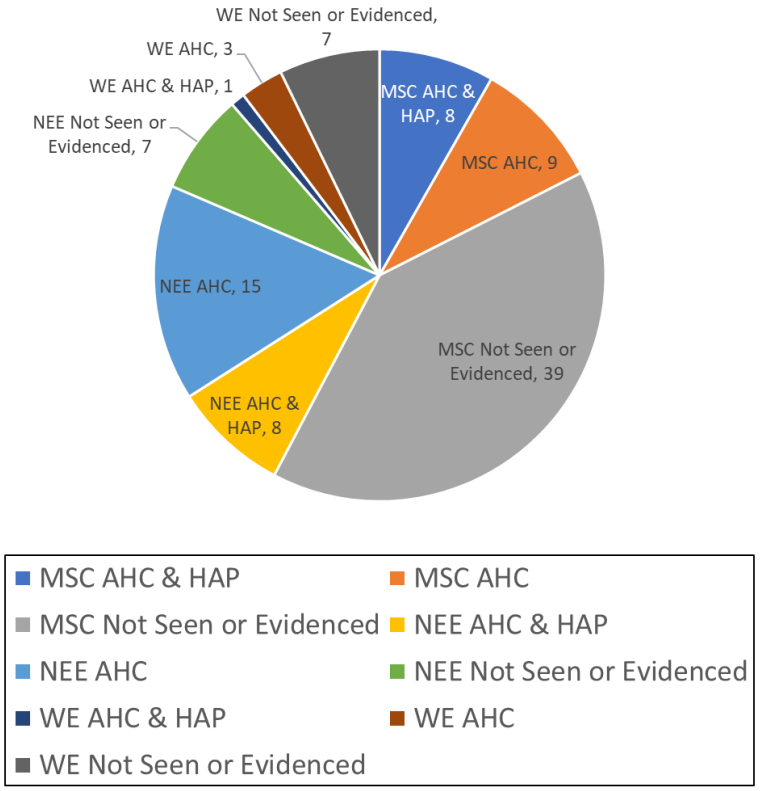
	DNACPR confirmed
MSE	55%
NEE	70%
WE	76%

The majority of reviews did have DNACPRs in place, and as part of the review process we are asked to consider whether they were correctly completed and followed. One area where we have seen improvement is that DNACPR documents sometimes used to cite Learning Disability as a clinical reason not to resuscitate. However, our Learning Disability Liaison Nurses and have been proactive at challenging this, and this is now an infrequent occurrence. We do wish to continue to see improvements in respect of consultation with the person concerned, family, carers, and the involvement of advocates. We want to see better evidence that Capacity Assessments are carried out and clear best interests decisions with rationale where appropriate, and also the involvement of an IMCA (independent Mental Capacity Advocate) especially in hospitals.

Annual Health Checks

For most of 2022/23, the LeDeR system didn't specifically ask for annual health check information to be recorded in initial reviews, although in older reviews, it is often included in the narrative. The Pie-chart below shows only the reviews where the Annual Health Check and/or Health Action Plan has been confirmed by the reviewer – we are confident that in reality a much higher proportion of Annual Health Checks are carried out, and there is targeted work ongoing to improve uptake and quality in this area.

Annual Health Checks & Health Action Plans

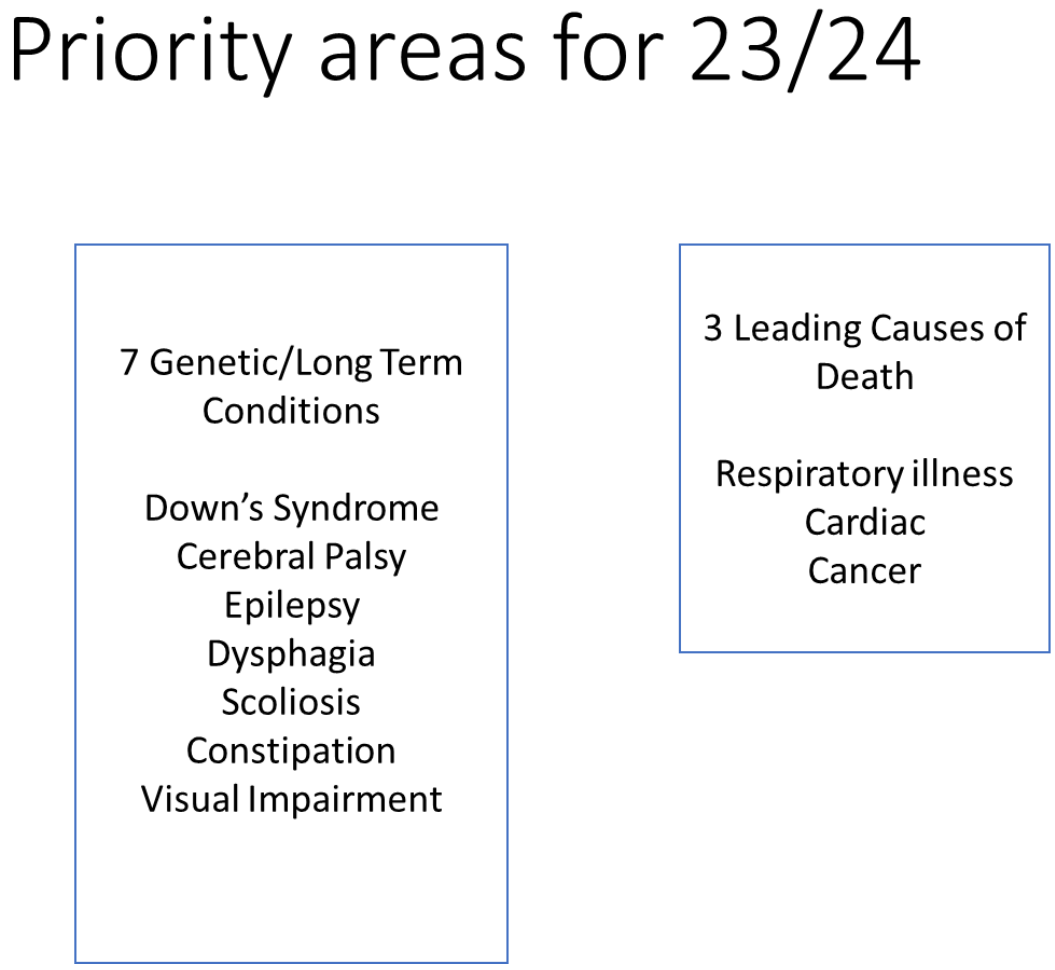


(Note – only those 14+ are eligible to receive an annual health check)

Whilst there is evidence that annual health checks and Health Action Plans are being carried out, there are also concerns raised about the quality of some annual health checks and health action plans, and improving quality is the focus of the Annual Health Check working group. We also secured additional funding from NHSE to support people who had previously missed out on a health check to attend.

Themes and learning from 22-23

Analysis of the leading causes of death and prevalent genetic and long term conditions identifies a “Top Ten” for 2023/34, to better understand the landscape and to identify areas for improvement and reduce the impact of living with these conditions.



There are also a number of consistent themes, and some new emerging themes from 22-23, including the following:

Emerging Themes from 22-23 reviews

- Systemwide need for increased focus on preventative health care
  - Weight management
  - Public health screening uptake
- Lack of advocacy
- Need for transparency around Best Interest Decisions, especially decisions not to treat
- Improved quality of Annual Health Checks, and a clear Health Action Plan
- Missed or late diagnoses
- Oral Health, access to dentistry
- Mental health, access to appropriate services
- Timely and appropriate referrals
- Planning for ageing (people with LD and their carers)
- Lack of clear pathways
- People's histories becoming "lost", family history not considered
- MCAs being carried out appropriately and correctly recorded

Autism Reviews

Although we have been able to carry out a LeDeR Review following the notification of a death of a person with Autism only (no Learning Disability), there have been very few notifications, nationally and locally in SET.

To date we have had three or fewer notifications for an individual with Autism Only. However, we have had a small additional number of notifications where Autism was the primary need, but the person had also been given a diagnosis of a mild Learning Disability. We have also been made aware of an out-of-scope death of an autistic person who did not have a formal diagnosis, which is one of the criteria of eligibility for a LeDeR Review.

In 23/24, we will make sure that every reviewer has access to Autism Training, and work with NHSE to promote LeDeR to Mental health and other professionals and supporters of people with Autism, to encourage in-scope notifications.

Summary Of Recommendations

Our key recommendations based on the themes identified within this report are:

1. **Continue to increase the number of Annual Health Checks that people over 14 with Learning Disabilities receive** to proactively identify any additional support needs they may have.
2. **A Health Action Plan should be created when an Annual Health Check is completed** to improve the health of the individual and prevent / reduce / delay the need for crisis care.
3. **Promote overall awareness of LeDeR** to increase notifications for those who have died who had a Learning Disabilities and / or Autism.
4. **Target awareness of LeDeR to those that work with individuals / communities that are Non-White British** as there is a lack of representation in notifications. Investigate if there is a connection with notifications to access to health care for these groups.
5. **Utilise reasonable adjustments to allow for face to face appointments** for those with a Learning Disability and / or Autism to enable early diagnosis of health issues and cancers.
6. **Continue to support targeted work to address respiratory conditions** that are by far the leading primary cause of death in LeDeR.
7. **Encourage use of Healthcare Passports** to make accessing services as positive as possible and to avoid histories being lost.
8. **There should be increased access to dental services both mainstream and specialist.** To achieve this, we will promote existing oral health training available for provides and unpaid carers. Alongside working with the Meaning Lives Matters Programme and other aligned projects to promote access to dental health across SET.
9. **Plans for ageing should be discussed with individuals and their carers.** To ensure there is a clear plan for a person's future and enhance the opportunity for individuals to die peacefully in their place of choosing. This will be achieved by linking with the Essex County Council Ageing Well Programme and the Southend Ageing Well Strategy. Along with other aligned work across SET.
10. **Support the training of the workforce across SET on Mental Capacity Assessments and promote the use of Mental Capacity Assessments (where appropriate)** along with best practice of how to record them.
11. **Analyse pathways of support for those with Cerebral palsy and /or Down's Syndrome** as a priority these conditions are experienced by a significant number of people whose deaths were notified to us.
12. **Raise awareness of the other most common genetic and long term conditions** that are experienced by those whose deaths were notified to LeDeR as well as how to access appropriate support. This includes Epilepsy, Dysphasia, Scoliosis, Constipation and Visual Impairment.
13. **Promote the importance of advocacy to people with Learning Disabilities and / or Autism across the health and social care system.** Work with commissioners across SET to understand the existing as well as future offer, the eligibility and promote the

use of advocacy. Use of a formal or informal advocate to be flagged in future reviews.

NHS England LeDeR Annual Report

The themes identified in this report mirror a number of the recommendations made in last year's National Report (2021 LeDeR report into the avoidable deaths of people with learning disabilities - King's College London (kcl.ac.uk)). However, this Southend, Essex and Thurrock LeDeR Annual report 22/23 was written and published in advance of the 2022 NHS England LeDeR Annual Report which is due in the Autumn of 2023. Once the national report is published the local themes, trends and findings will be compared against the national context. Any similarities or differences between the national and local report will be reported via governance.

It is also important to note that the period the national report analyses is different to the local report as the national report analyses notifications between 1st January 2022 – 31st December 2022. Whereas the SET LeDeR Annual Report along with the majority other reports within the East of England colleagues has analysed the notifications from April 2022 to March 2023.

Highlights of Progress since Last Annual Report

Aspiration pneumonia conference – having highlighted the prevalence of Aspiration Pneumonia in the Learning Disability Cohort, as a direct result of recommendations from the LeDeR Quality panels, Provider Quality Innovation in partnership with the HE team are presenting an Aspiration Pneumonia conference for learning and sharing good practice – Autumn 2023

Ageing Well Program – is now in its second year which has been driven forward by the Provider Quality Innovation Team in partnership with Essex County Council colleagues.

End Of Life Programme – this is being led by the Provider Quality Innovation and delivered in partnership with Essex Hospices.

Health Equalities team representation on working groups for : Aspiration Pneumonia, Pneumonia, Dementia, Frailty, STOMP oversight group, AHCs

AHCs – having secured funding for additional support for people who had "missed" an annual health check, this project has delivered additional health-checks, and in particular this is shown in the AHC data collected for NEE

Digital Hospital Passports – following recommendations from the LeDeR Quality Panels, MSE Hospitals are working on a digital hospital passport which can be easily updated

Gold Standard review for Autism /Suicide – The Health Equalities team supported the development of a "Gold Standard" approach to this specialist area of reviews, and this has already been shared with SNEE ICB and is available to all reviewers

Care co-ordination and Dynamic Support register and shaping of new ELDP contract – as a result of LeDeR Recommendations, the Essex Learning Disability Partnership (Specialist health) has adapted the provision to include a care-co-ordination role, and in addition the dynamic support register is in place, and key personnel actively involved in LeDeR will be involved in shaping the next contract

ReSPECT is currently being rolled out**.** ReSPECT is a process that supports meaningful conversations between one or more healthcare professionals and people, their carers/family on how they want their future care to be given. The ReSPECT form is a summary of personalised choices for a person's clinical care in the event of an emergency when that person may not have the capacity to express those choices themselves.

The process reflects both patient preferences and clinical judgement, including a recommendation on whether CPR should be attempted if a person's heart and breathing stops. This Supports the DNACPR process and is an excellent opportunity to ensure the wishes and feelings of people with a learning disability and autistic people are captured.

Oliver McGowan Mandatory Training has commenced roll out across the three ICBs. All the LeDeR Team will eventually have received all tiers of the training

Access to sytsm1 – Laptops have been procured to allow the review team access to released flagged GP records, which should assist in the quality and timeliness of reviews being completed.

Report Origin & Endorsements

This Southend, Essex and Thurrock LeDeR Annual report 22/23 was written in accordance with the requirement from the NHS. The report is commissioned by the Learning Disability Health Equality Board and formally signed off by the SET LeDeR Steering Group.

This report is endorsed by the Learning Disability / Autism Health Equality Board which is led by:

Nick Presmeg	(LD HE Board SRO)
Jeff Banks	(LD HE Board Vice SRO)

The report is formally signed off by SET LeDeR Steering Group which is led by:

Krishna Ramkhelawon	(SET LeDeR Steering Group Chair)

This year's report was produced by the SET LeDeR Team, the lead author was:

Suzanna Edey	(SET Senior Reviewer)

Local LeDeR contacts

If you would like any further information on the work that is happening in SET please contact:

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Appendix 1 case study – Adam

Adam's health started to deteriorate in September 2021 when his mum took him to hospital with pain in his back. She explained to the hospital staff that Adam had a very high pain threshold and that he was in a lot of pain.

They were kept waiting from 10.00pm in the evening, they were told he needed a scan as there was inflammation in his body; they were moved to another area at 4.00 and at 4.45am were told that "they didn't do scans at night" and to go home and see their GP.

Whilst in hospital Adam had been given two doses of Morphine for the pain, but was discharged with no pain relief. Adam's mum felt he had been discriminated against she said that they saw a person with a learning disability, who was overweight and who was difficult to deal with.

No information about Adam's visit to the hospital was received by his GP. Adam's mum said that Adam was angry, that they didn't help him.

Adam would find hospital's stressful due to his autism, he found being kept waiting caused him frustration and anger and this could lead to behaviours which could be seen as challenging.

Mum wrote a letter of complaint as she felt Adam had been discriminated against. She received a reply that said the doctor didn't feel he had discriminated against Adam, but he agreed a letter was not sent to inform doctor of hospital admission to A&E.

Mum took Adam to GP as she felt there was something seriously wrong. At that time, she was supporting her husband who had terminal bowel cancer. The Doctor listened to her and Adam's concerns and arranged an ultrasound. The GP referred him to liver specialist after the ultrasound for a colonoscopy

Staff at (different) hospital were brilliant, they talked to Adam and made him comfortable. They made reasonable adjustments and allowed Adam to have his Phone so he could talk to his mum through-out the procedure. After the procedure the Consultant spoke to Adam's mum and told her that it was likely that Adam had bowel cancer.

Adam was referred for a PET scan, mum spoke about how they really helped Adam through the procedure that she was allowed to be present though from a distance due to Adam being radioactive. Adam was diagnosed with terminal cancer, ring tumours, disease in nodes and liver.

She said that the learning disability liaison nurse was with them at as many hospital appointments as possible. However, the staff all took on board that Adam could exhibit behaviours that could be challenging.

Adam's oncologist was very good. She explained that though Adam's cancer was not curable it was treatable, and that immunotherapy would help. Adam also received good support from his Mental health team.

The hospice become involved in Adam's care and support.

Appointments were usually well managed, as Adam needed that the appointments happened on time. Adam would become angry if he was kept waiting.
Whilst undergoing treatment Adam was supported 24-hour care in his own home. He had a good team of support staff who mum said were more like family.

During this time the care provider business was sold, but Adam was able to keep the staff who had good knowledge of his needs.

Adam's health continued to deteriorate and becoming less aware of the people around him, and there were plans to start him on chemotherapy.

Adam and his mum wanted to arrange for Adam to come home to live. It was important that this happened whilst maintaining the same staff team. There were meetings arranged but no one from social services came and the meetings were cancelled.

All staff around Adam worked to secure a meeting with social services and his support package was changed to ensure he was able to move home to mum's house with support in place. His support staff had been helping mum while the transition was being arranged, they would bring Adam home to visit and would be on call if needed.

By the end of August 2022 Adam moves home with support in place. Mum had arranged GP transfer, hospice support transfer.

When Adam is admitted to hospital Mum stayed with him 24 hours a day. His support staff are with him in the hospital. At first, he is placed on a ward but is moved to a side ward. Adam's mum said the staff were wonderful; she was very clear that this was all staff, inclusive of Porters, catering staff, nurses, and doctors. Adam's mum remembered that Adam didn't like the noise that the drinks trolley made. The woman who pushed it would always apologise to Adam and ask if it was ok to give mum a cup of tea.

Adam's medication was explained to him and even at end of life he was given options about when to take certain medication. When Adam died the nursing staff and Adam's mum prepared his body together.

Adam's mum said that at Adam's funeral there were lots of people from the hospital who had cared for Adam and that it was very special to her that they came.

This review was taken to a focussed review, and subsequently Adam's mum has agreed to be videoed to share her experience and Adam's story, and this will be used as training within the ICB

Appendix 2 – EOY performance Data

ICS	all notifications from sep 2017 to (31/3/23)	% ics split	no (from total notifications) who are CYP	% of child deaths of ICS total deaths	No. awaiting allocation	in progress	% in progress	No. Complete	% complete	percentage of reviews completed as initial	percentage of reviews completed as focussed target >35%	
North East	209	30%	11	5%	2	27	13%	180	86%	75	25	
West	78	11%	10	13%	2	11	14%	65	83%	64	36	
MSE	403	58%	36	9%	10	45	11%	348	86%	67	33	
Total	690		57		14	83		593	86%			

KPI completion within 6 months	Number of adult deaths notifed this year from April 22	Complete within 6 months	complete outside 6 months	in progress and under 6 months old	in progress and over 6 months old	still to allocate	reviews from before April 22 (on hold or DSCRO)	No of child deaths notified this year from April	complete within 6 months	in progress over 6 months old	still to allocate	child reviews on hold from 21-22
NEE	28	3	4	13	6	2	4	2	0	1	0	0
WEST	15	4	1	7	1	2	1	3	0	1	0	0
MSE	60	14	4	26	6	10	5	7	0	3	0	0
Total	103	21	9	46	13	14	10	12	0	5	0	0

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Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Essex County Council

Suffolk & North East Essex Integrated Care System

Southend-on-Sea City Council

Mid and South Essex Integrated Care System

thurrock.gov.uk

LeDeR Annual Report 2022/23 Summary Slides

Introduction

The Learning from Lives and Deaths (LeDeR) Programme started in 2017 with the aim to reduce the health inequalities faced by people who have a learning disability (LD).

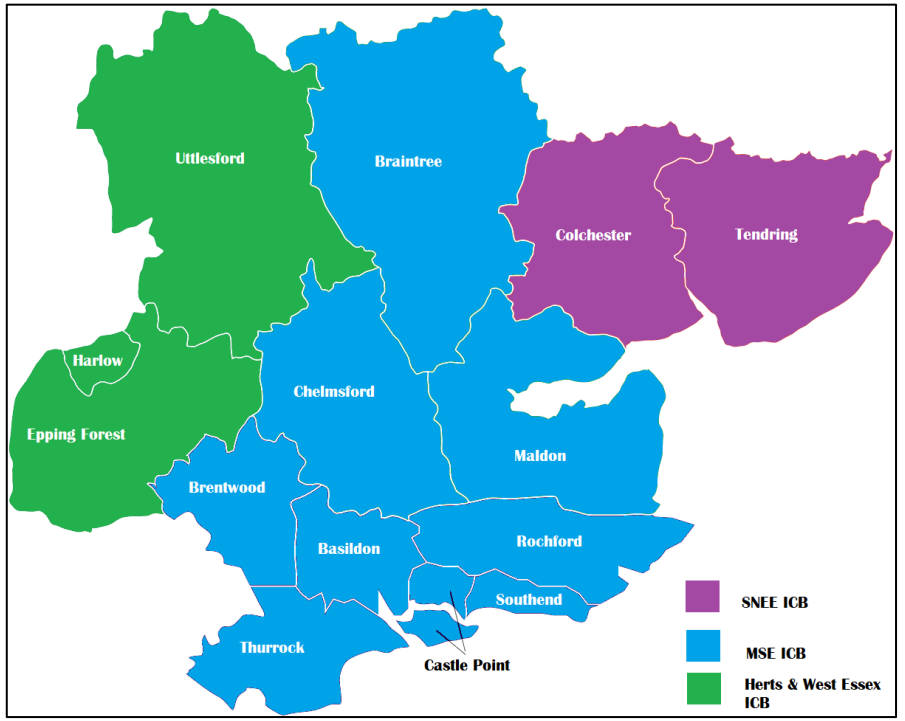
As of July 2023 LeDeR reports on deaths of people with LD and or Autism aged 18 and above. However, before July 2023 LeDeR reported on deaths of children aged 4 and over with LD and or Autism. When somebody with a learning disability or autism dies, their death should be notified to LeDeR.

LeDeR is a review of all aspects of the care and support a person received in their life and death. This is done to improve quality of care and support by learning from what went well, and making recommendations for changes.

The LeDeR programme works alongside other quality improvement measures currently in place to reform services and improve health outcomes. If other reviews and enquiry processes need to take place then the LeDeR review will be put on hold until after these are completed, to ensure we capture the learning from the findings in our reviews.

When the LeDeR programme started there were two things we wanted to achieve across SET:

1. We wanted the number of deaths notified to LeDeR to increase every year.
2. We wanted to see the average age of death of people with a learning disability increase, “to close the gap” as on average people with LD were dying up to 20+ years younger than the general population.



LeDeR Annual Report At A Glance

- Respiratory conditions remain the leading primary cause of death across all ages and all areas.
- Face to face contact matters, especially in respect of early identification of symptoms.
- Cerebral palsy and /or Down's Syndrome are experienced by a significant number of people whose deaths were notified to us, and we would do well to ensure all aspects of provision, specialist and mainstream, consider how their services can be adapted and adjusted to anticipate the needs of people with one or both of these diagnoses.
- Planning and professional curiosity is evidenced by multi-disciplinary working. Especially Quality Panels and also in the care of a person where there is some level of complexity.
- We continue to see a lack of representation of non-white British residents within our notifications, we believe this may be due to under reporting of deaths to LeDeR of our non-white British residents. This must be improved and we need to be open to the possibility there might be a link between notifications and access to services for these groups.

LeDeR Programme

We remain compliant with the revised LeDeR policy in terms of team structure, and since January 2023 have shared a Senior Reviewer with Suffolk to achieve efficiencies and share learning.

We are committed to maintaining good performance in respect of allocation and completion KPIs and the expected split between initial and focused reviews.

Although 2022-23 has been a challenging year in terms of staffing in the team, we have remained sighted on achieving the required number of completions in a timely manner whilst improving quality across reviews.

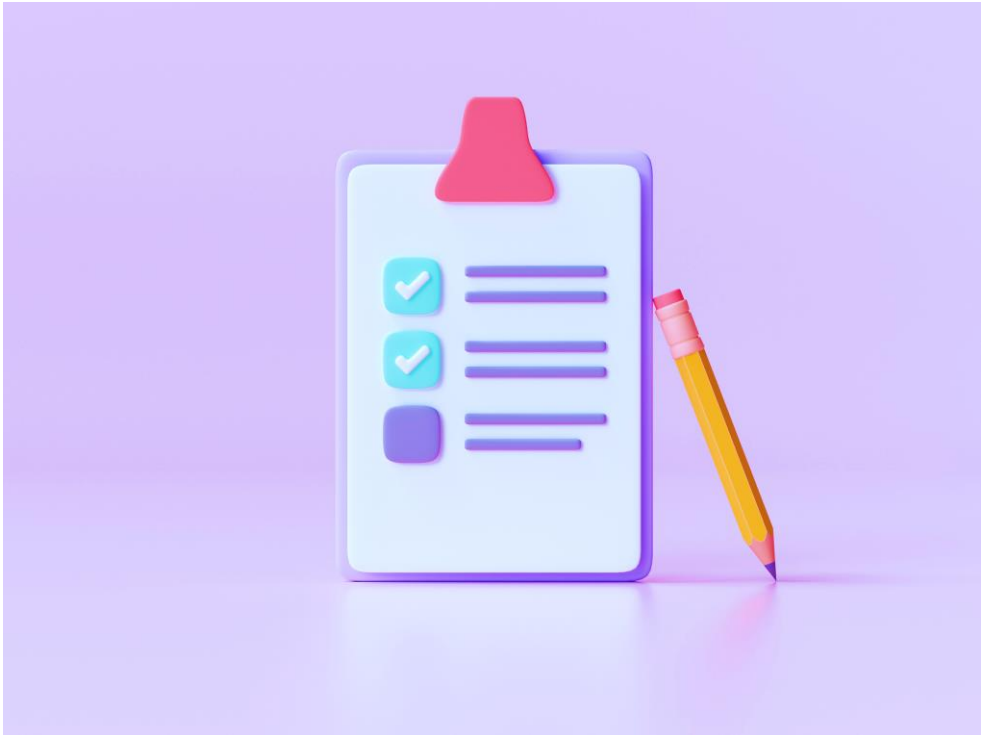
We have a 3 year deliverable plan which identifies where we need to:

a) prevent ill health

b) improve management of health and

c) remove inequalities

This plan reflects the commitment of all organisations, including public health. This is monitored by the LeDeR Steering Group and is due to be reviewed this year.



Trends: Notifications

Notifications

The deaths of 113 people with learning disability and/or Autism were notified across SET between April 2022 and March 2023.

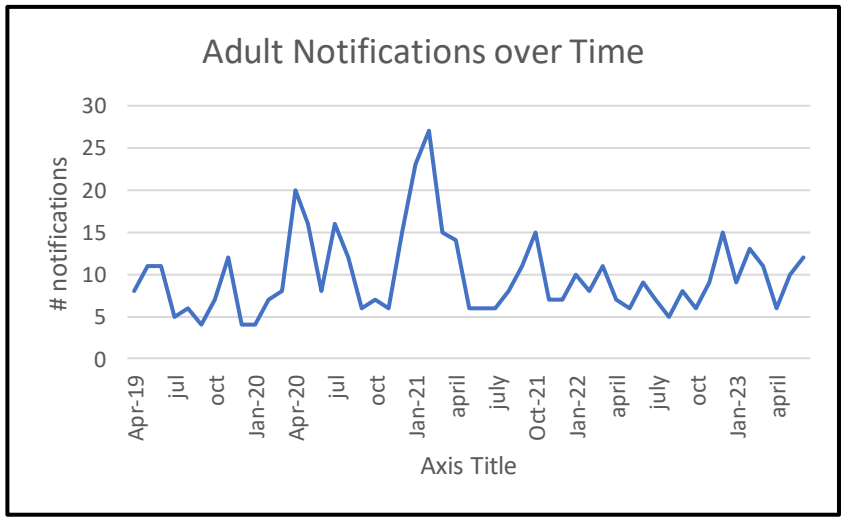
ICB	April	May	June	July	August	September	October	November	December	January	February	March	Total
MSE	4	4	7	5	3	3	3	3	9	5	6	11	63
WE	1	3	0	2	0	1	2	1	1	1	5	3	20
NEE	2	3	2	1	1	3	1	6	4	3	3	2	30
SET Total	7	10	9	8	4	7	6	10	14	8	14	16	113

This is a very similar number to the previous year when 116 deaths were notified. Since January 2022, the scope of LeDeR has been broadened to include reviews for people with Autism only (without a Learning Disability) and we are starting to see notifications for this group of people.

Notifications Since April 2019

Since most notifications are made close to the day when the person died, this data is helpful for us to understand some of the trends around deaths as they occur.

When analysing the data there is a clear indication of the impact of Covid-19, when notifications were at their highest, but also shows the impact of Winter on health.

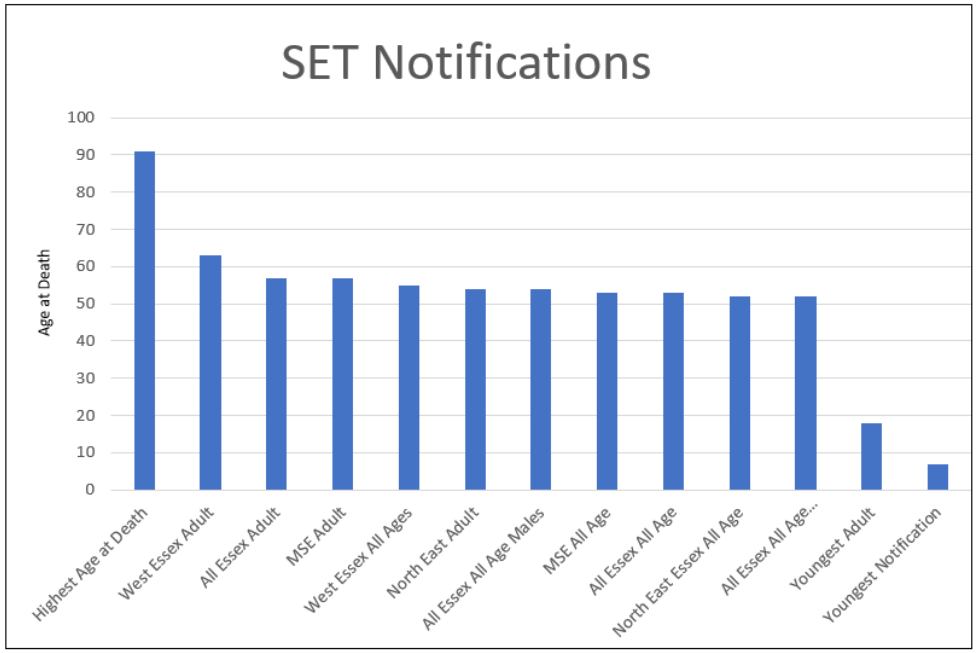


Trends: Age Of Death Of Those Reviewed

Deaths Of Those Reviewed

This has resulted in the average age of death going down slightly this year, which we are monitoring. We believe that we are still seeing the impact of Covid-19 on our notifications and across health provision.

The impact of Covid-19 throughout 2020 and 2021 had a significant impact on the numbers of deaths reported and the average age at death. This impact continues to be seen across 2022 and 2023.



Average Age Of Death

The median average age at death for adults across SET in 2022/23 was 57. This down from last years median average age of death across SET for 2021/22 which was 65.5 years.

- **In West Essex the average median age was a little higher at 63**, but this is impacted by the small sample size and two 80+ notifications.
- **In North East Essex the average age is lower at 54**, but again this is influenced by the small sample size and two young adult deaths.
- **The average age of death in MSE is 57**, in line with the average age overall.

The average age of death is calculated by omitting any notification under 18 years of age and then determining the average age of death amongst the adult notifications. This helps provide a realistic average age of death within the limitation of a small sample size.

Trends: Primary Cause Of Death

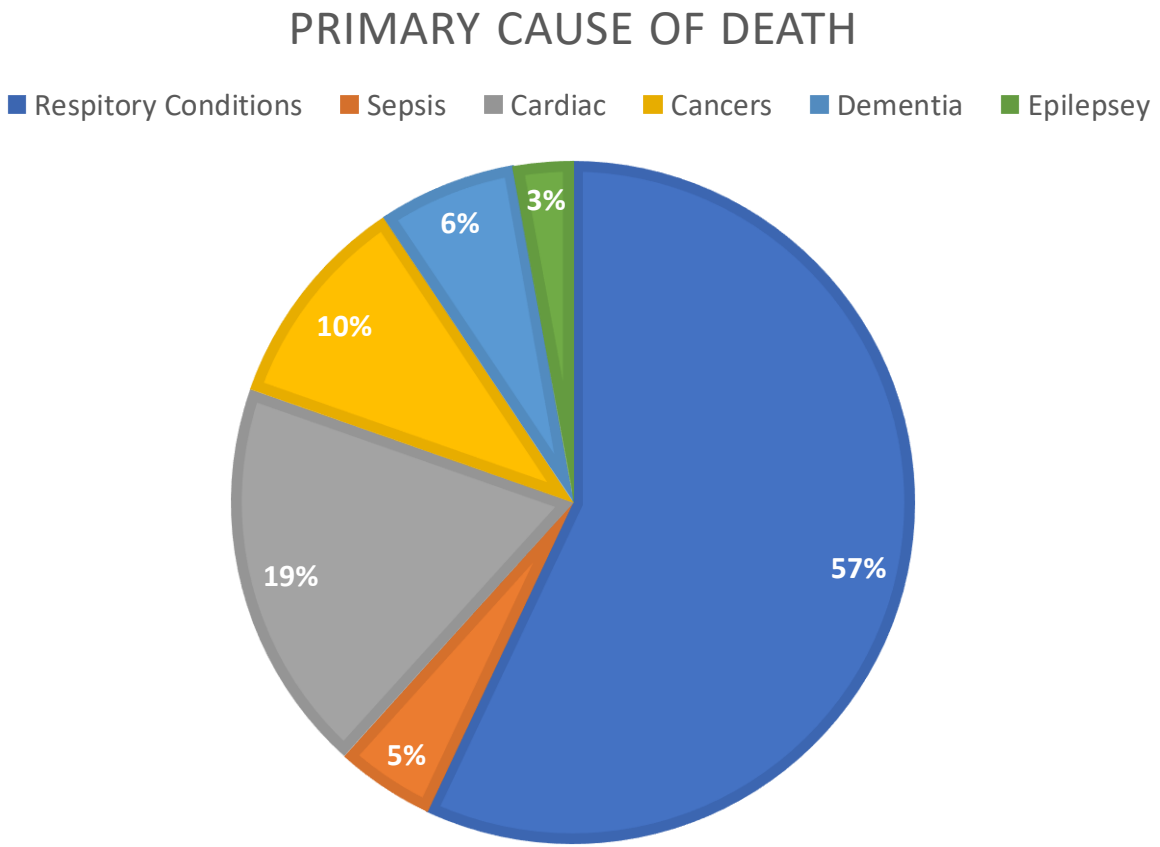
From those reviewed respiratory conditions are by far the leading primary cause of death for people with a Learning Disability totalling (61), followed by Cardiac deaths (20) and Cancers (11).

The pie chart on the right shows the split between the six primary causes of death which impact 107 out of the 113 notified deaths we received.

For comparison, if we had reviewed a sample of deaths of people from the general population, we would expect to find the leading cause of death to be Dementia and Alzheimer's (around 12 people) , followed by heart diseases (around 10 people) and chronic lower respiratory diseases (around 6 people).

Clearly there is a very great difference in the leading causes of death for people in the general population and people with a learning disability.

This continues to inform the work of the SET Health Equalities Team and Partners. In particular, there has been a focus on respiratory illness throughout 2022 and into 2023.



Trends: Annual Health Checks & Health Action Plans

NHSE data for March 2023 shows Annual Health Checks have risen in comparison to March 2022. We know there has been significant work across SET to ensure that more people over 14 years of age are receiving their checks. Unfortunately from the NHSE data we can see that not every annual health check results in an accompanying action plan being drafted.

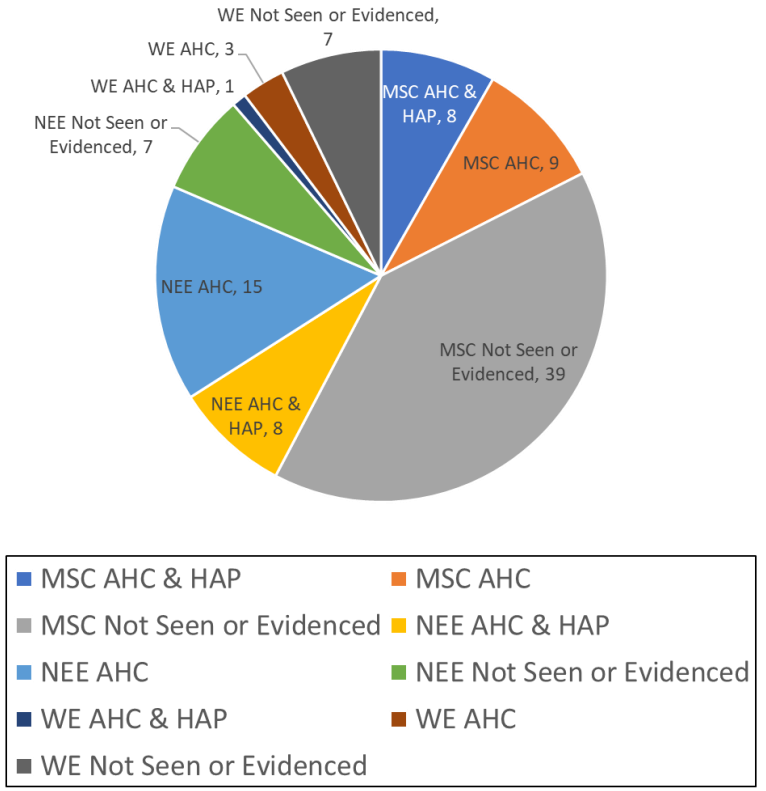
There were 97 reviews that we were able to analyse to determine if an Annual Health Check had been carried out for 22/23.

In 54.6% of the reviews Annual Health Checks had not been seen or evidenced. This shows there is more work to be done in improving access to health checks and action plans for those who could benefit from them most.

Whilst there is evidence that Annual Health Checks and Health Action Plans are being carried out there are also concerns raised about the quality of some of the checks and action plans.

Over the next 12 months we would want to see the number of Annual Health Checks and Health Action Plans continue to rise and the quality of these also improve.

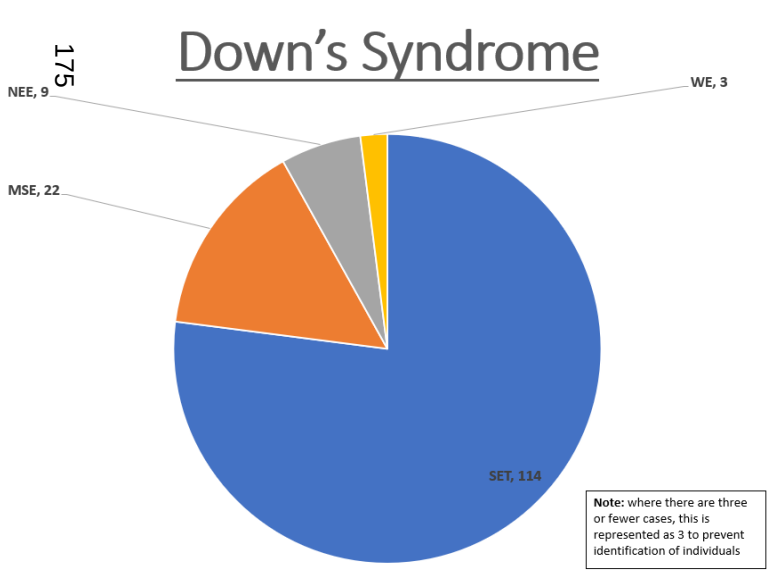
Annual Health Checks & Health Action Plans

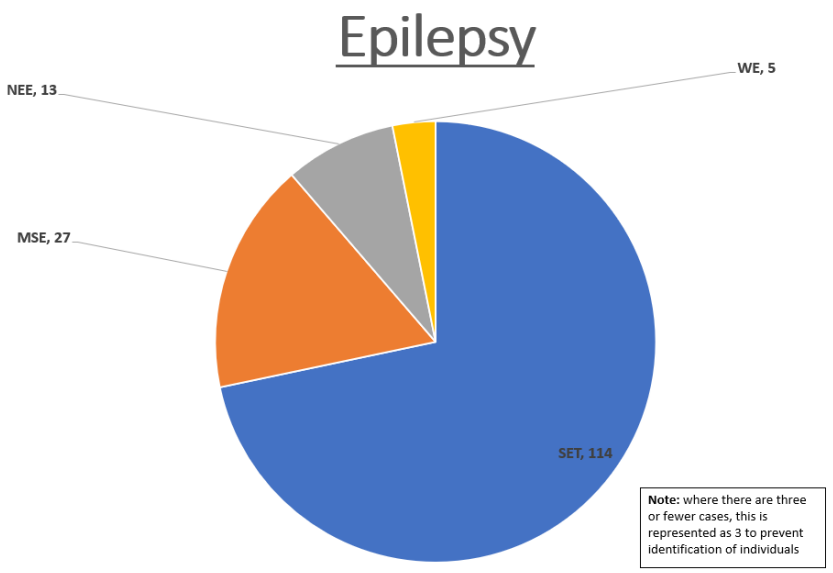


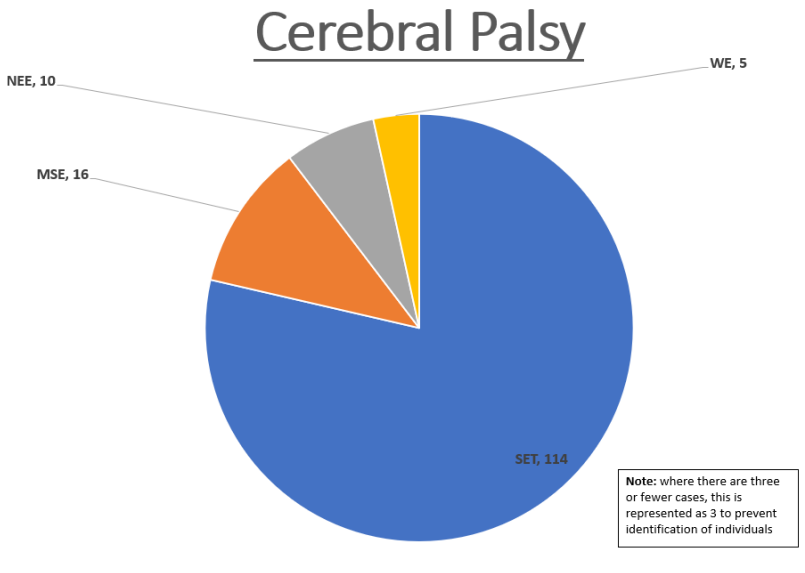
Trends: Genetic & Long Term Conditions

People with a Learning Disability often have poorer physical and mental health than other people and may face barriers to accessing health and care to keep them healthy. Too many people with a learning disability are dying earlier than they should, many from things which could have been treated or prevented. Therefore, we must consider the genetic and long term conditions that people with a Learning Disability and or Autism have and how it is manged.

The three most common genetic & long term conditions that people had in the reviews were:







Trends: Genetic & Long Term Conditions

The seven genetic / long term conditions that should be considered a priority based on this years reviews are:

- Down's Syndrome.
- Cerebral Palsy.
- Epilepsy.
- Dysphasia.
- Scoliosis.
- Constipation.
- Visual Impairment.

Themes Identified From The Reviews

- Systemwide Need For Increased Focus On Preventive Health.
- Improved Quality Of Annual Health Checks With A Clear Action Plan.
- Mental Health, Access To Appropriate Services.
- Lack Of Advocacy.
- Missed Or Late Diagnosis.
- Timely and Appropriate Referrals.
- Need For Transparency Around Best Interest Decisions, Especially Decisions Not To Treat.
- Oral Health, Access To Dentistry.
- Planning For Ageing
- Lack Of Clear Pathways.
- People's Histories Becoming "Lost".
- MCA's Being Carried Out Appropriately And Correctly Recorded.

Recommendations

1. **Continue to increase the number of Annual Health Checks that people over 14 with Learning Disabilities receive** to proactively identify any additional support needs they may have.
2. **A Health Action Plan should be created when an Annual Health Check is completed** to improve the health of the individual and prevent / reduce / delay the need for crisis care.
3. **Promote overall awareness of LeDeR** to increase notifications for those who have died who had a Learning Disabilities and / or Autism.
4. **Target awareness of LeDeR to those that work with individuals / communities that are Non-White British** as there is a lack of representation in notifications. Investigate if there is a connection with notifications to access to health care for these groups.
5. **Utilise reasonable adjustments to allow for face to face appointments** for those with a Learning Disability and / or Autism to enable early diagnosis of health issues and cancers.
6. **Continue to support targeted work to address respiratory conditions** that are by far the leading primary cause of death in LeDeR.
7. **Encourage use of Healthcare Passp**orts to make accessing services as positive as possible and to avoid histories being lost.

Recommendations Continued

8. **There should be increased access to dental services both mainstream and specialist.** To achieve this, we will promote existing oral health training available for provides and unpaid carers. Alongside working with the Meaning Lives Matters Programme and other aligned projects to promote access to dental health across SET.

9. **Plans for ageing should be discussed with individuals and their carers.** To ensure there is a clear plan for a person's future and enhance the opportunity for individuals to die peacefully in their place of choosing. This will be achieved by linking with the Essex County Council Ageing Well Programme and the Southend Ageing Well Strategy. Along with other aligned work across SET.

10. **Support the training of the workforce across SET on Mental Capacity Assessments and promote the use of Mental Capacity Assessments (where appropriate)** along with best practice of how to record them.

11. **Analyse pathways of support for those with Cerebral palsy and /or Down's Syndrome** as a priority these conditions are experienced by a significant number of people whose deaths were notified to us.

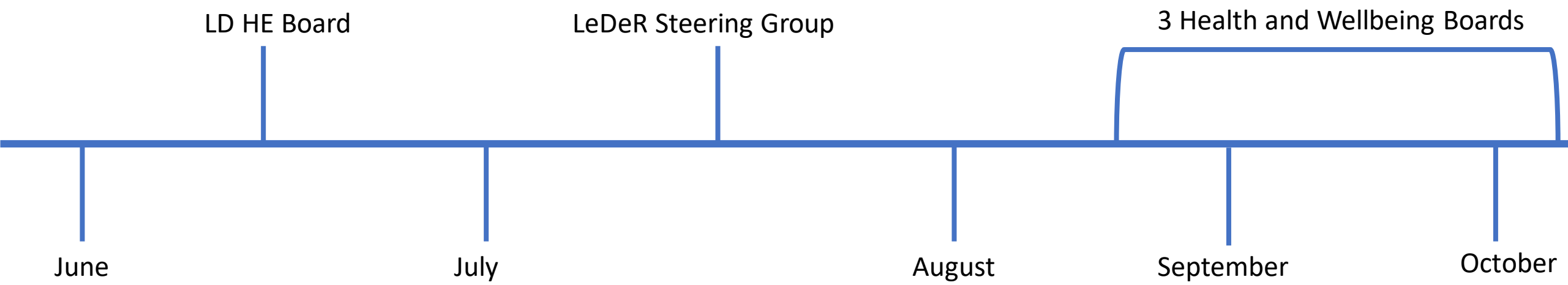
12. **Raise awareness of the other most common genetic and long term conditions** that are experienced by those whose deaths were notified to LeDeR as well as how to access appropriate support. This includes Epilepsy, Dysphasia, Scoliosis, Constipation and Visual Impairment.

13. **Promote the importance of advocacy to people with Learning Disabilities and / or Autism across the health and social care system.** Work with commissioners across SET to understand the existing as well as future offer, the eligibility and promote the use of advocacy. Use of a formal or informal advocate to be flagged in future reviews.

Governance Process

- The LeDeR report will be taken to the LeDeR Steering Group for formal sign off.
- Then it will progress to the three Health and Wellbeing Boards across the SET footprint by the end of October and published in September in compliance with NHSE timelines.
- After it has completed this governance journey the report will be published and be available for wider sharing.

Timeline



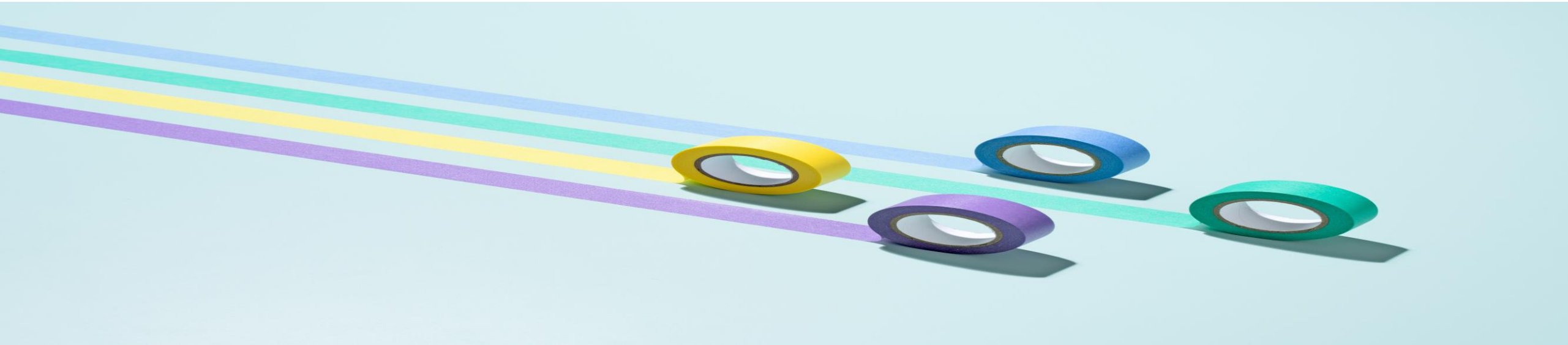
Next Steps

1. Take the LeDeR Annual Report through the governance process.

2. Promote the learning and recommendations from the LeDeR Annual Report to ensure the insight is embedded across SET.

3. Once the report has completed the governance process an ‘easy read’ version of the report will be created and made available later in the year.

4. The SET LeDeR Annual report 22/23 was written before the 2022 NHS England LeDeR Annual Report was published. The national report is due in the Autumn of 2023. Once the national report is published the local themes, trends and findings will be compared against the national context. Any similarities or differences between the national and local report will be reported via governance.



Thank you

If you would like any further information on LeDeR in SET please contact:

Andrew Graham

LeDeR Programme Local Area Contact (LAC)

Email: Andrew.Graham@essex.gov.uk

Mid and South Essex Integrated Care System

Southend-on-Sea City Council

LeDeR Annual Report 2022/23 Southend Trends

Introduction

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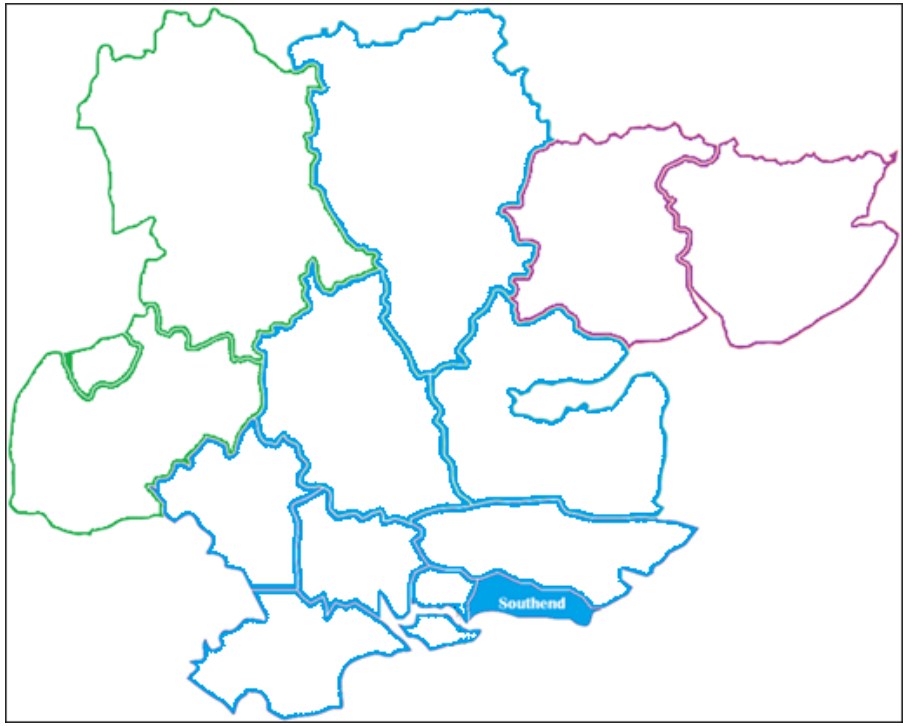

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When the LeDeR programme started there were two things we wanted to achieve across Southend, Essex and Thurrock:

1. We wanted the number of deaths notified to LeDeR to increase every year.
2. We wanted to see the average age of death of people with a learning disability increase, “to close the gap” as on average people with LD were dying up to 20+ years younger than the general population.

This set of slides identifies some trends from a Southend perspective.

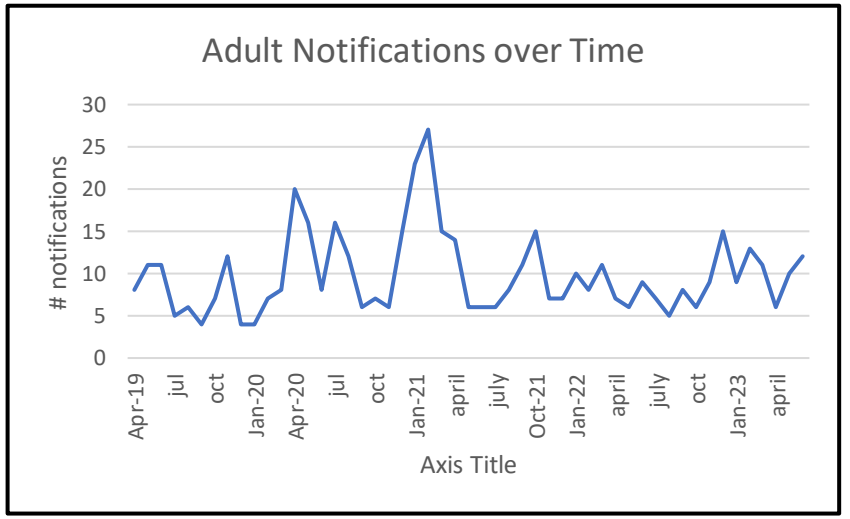
Trends: Notifications

Notifications

In 2022/23 out of 113 notifications across Southend, Essex and Thurrock (SET). Of those 113 notification we had 10 notifications to LeDeR from Southend across the year. Of those 9 were for deaths that occurred within the period April 2022 and March 2023. The other remaining notification occurred before this time period.

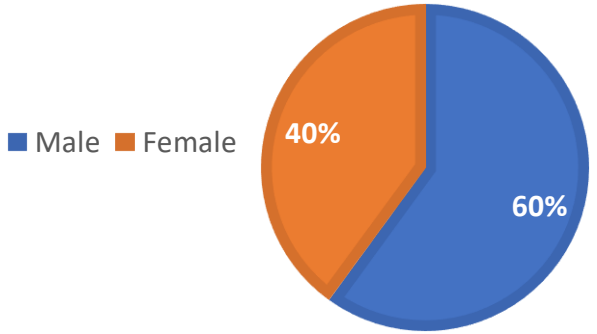
Most notifications are made close to the day when the person died, this data is helpful for us to understand some of the trends around deaths as they occur.

The notifications of deaths in Southend were spread out throughout the year. This is in contrast to the SET footprint as a whole where we typically we see an increase in notifications each winter (see right SET 'Adult Notifications Over Time' graph).



Gender of Notifications Received

In 2022/23 out of 10 notifications received from Southend 6 were male and 4 were female. This is similar to the gender split in notifications across SET.

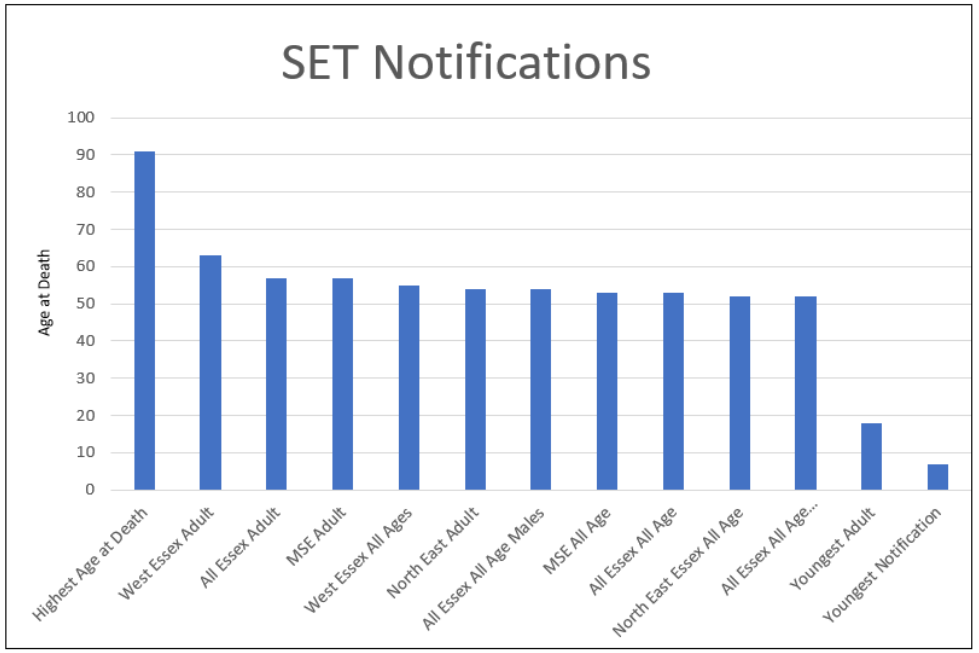


Trends: Average Age Of Death Of Notifications

Deaths Of Those Reviewed

Overall the average age of death has gone down slightly this year across SET, which we are monitoring. We believe that we are still seeing the impact of Covid-19 on our notifications and across health provision.

The impact of Covid-19 throughout 2020 and 2021 had a significant impact on the numbers of deaths reported and the average age at death. This impact continues to be seen across 2022 and 2023.



Average Age Of Death

The median average age of death in Southend was 53.8. This is younger than the average age across MSE and the SET Footprint which was 57.3. Although it is important to note that 10 deaths is a very small sample size and this could be why it is below the average age of death across SET as a whole**.**

Within the notifications for Southend for this year the age range was 19-79.

However, it is important to note more people are dying in their 40s than you would typically expect – 4 out of 10 notification. Across SET the largest decade of death is typically people in their 60s. Out of the SET LeDeR Annual report we had 7 deaths of people in their 40s notified. 4 out of the 7 deaths which were notified came from Southend. This is a Southend specific trend.

Trends: Completed Reviews Primary Cause Of Death

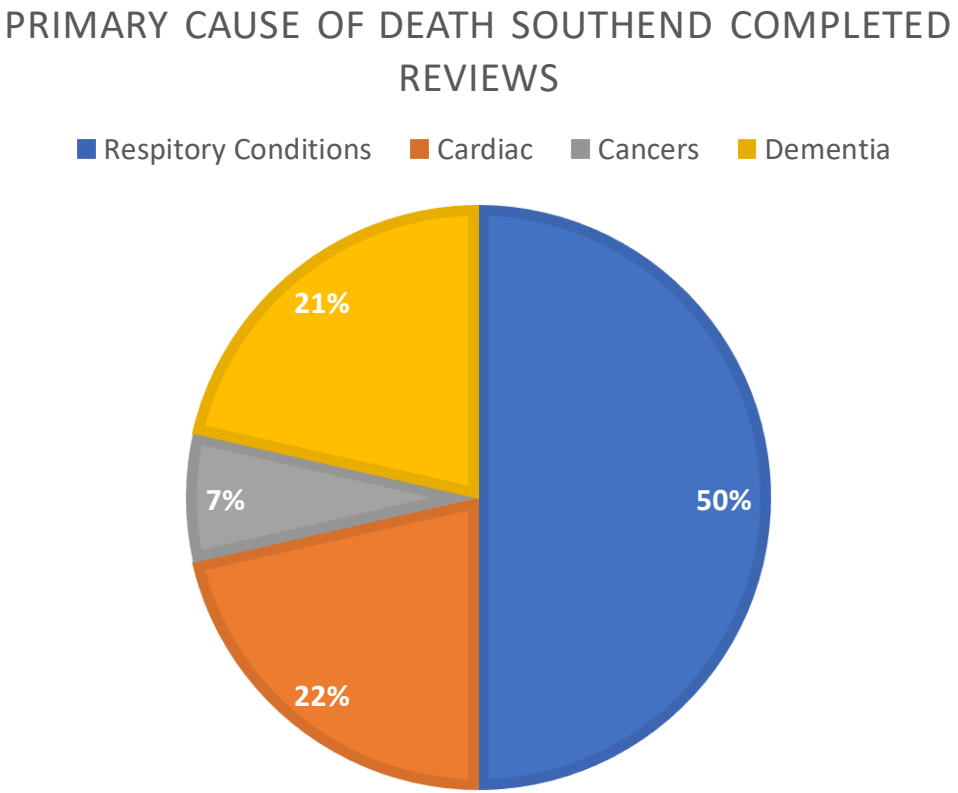
Out of the 14 completed reviews this year the leading cause of death was respiratory conditions which mirrors the trend across SET .

The respiratory conditions within primary cause of death are broken down as 1 recorded as bronchopneumonia, 1 recorded as community acquired pneumonia and 5 recorded as aspiration pneumonia. Covid 19 is also referred to within cause 1.b on one patients death certificate.

The other primary causes of death in Southend completed reviews were 3 recorded as dementia/Alzheimer's, 1 recorded as cancer and 3 recorded as cardiac/circulatory. The pie chart on the right shows the split between the four primary causes of death.

For comparison, if we had reviewed a sample of deaths of people from the general population, we would expect to find the leading cause of death to be Dementia and Alzheimer's, followed by heart diseases and chronic lower respiratory diseases.

Clearly there is a difference in the leading causes of death for people in the general population and people with a learning disability. This continues to inform the work of the SET Health Equalities Team and Partners. In particular, there has been a focus on respiratory illness throughout 2022 and into 2023.



Trends: Completed Reviews Other Key Takeaways

- Out of the 14 completed reviews were 13 White British and 1 was Asian British.

- 50% of the reviews we completed were of people who died in hospital. The remainder died at home, in hospice or a nursing home.

- For most of 2022/23, the LeDeR system did not specifically collect Annual Health Check information to be recorded in initial reviews. However, in the majority of reviews it is captured in the narrative along with information on any accompanying Health Action Plan. Therefore, we can conclude that out of the completed reviews the majority had received annual health check within the year (10 confirmed, 2 don't know, 2 not up to date). However, only 3 Health Action Plans were seen by reviewers.

- There were six people with downs syndrome and 6 with epilepsy which matches the trend across SET that a high number of people who were reviewed were managing a genetic and / or long term health condition.

- There were no cross cutting themes across the Southend completed reviews that were different to the SET footprint as a whole. So the themes and recommendations from the SET LeDeR Annual Report 2022/23 will fully apply to Southend.

Southend Health & Wellbeing Board

Agenda Item No.

12

Report of the Director of Commissioning

To

Health & Wellbeing Board

On

6th September 2023

Report prepared by: Jeremy Budd, Director of Commissioning

For information only	x	For discussion		Approval required	

Better Care Fund

(Southend on Sea Borough Council/ Integrated Care System)

Better Care Fund 2022-23 update for sign off, Better Care Fund Joint Narrative Plan 2023-25 and Section 75 agreement 2023-25

Part 1 (Public Agenda Item)

Purpose

The purpose of this report:

1. To provide members of the Health and Wellbeing Board (HWB) the 2022-23 end of year BCF submission, following sign off from the Chair of HWB to the NHSE BCF National Team on 23rd May 2023

2. To provide members of the Health and Wellbeing Board (HWB), the BCF joint narrative plan 2023 - 2025 submission, made to NHS England on 30th June 2023 following sign off from the Chair of HWB, in conjunction with the Executive Director Adults and Communities, Southend-on-Sea City Council (SCC) and NHS Alliance Director, Mid and South Essex Integrated Care System (ICB).

3. To seek approval of the draft Section 75 Partnership Agreement between Southend on Sea City Council and Mid and South Essex Integrated Care System for the management of the Better Care Fund (BCF) for the period 2023-2025. The document is with the Legal Team to seek approval on the Terms and Conditions of the document. The proposed framework agreement is included in the Appendix to this report.

Recommendation

1. The Board to note and approve the proposed Southend BCF 2022/23 end of year submission.
2. The Board to note and approve the proposed Southend 2023-25 Better Care Fund Joint Narrative Plan.
3. The Board approves the proposed draft Section 75 Partnership Agreement proposal for the management of the Better Care Fund and notes that the schedules to the agreement relating to the Better Care Fund plan for 2023-25. Noting that this document is currently waiting approval on the Terms and Conditions from the Legal Team.

Background

The Better Care Fund (BCF) has been providing a mechanism for joint health, housing, and social care planning, commissioning, and funding for nearly 10 years. It focuses on personalised, integrated approaches to health and care which support people to remain independent at home or to return to independence after an episode in the hospital. It brings together ring-fenced budgets from NHS Integrated Care Board (ICB) allocations and funding paid directly to Local Government, including Disabled Facilities Grant (DFG), Additional Discharge Funding, and the improved Better Care Fund (iBCF).

1. End of Year BCF 2022-23 Submission

The end of year submission focuses on key successes and challenges this year, including a narrative on meeting all BCF metrics.

- All four BCF metrics were on track for meeting targets.

Two key successes and two challenges of this year:

Outline two key successes observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2022-23		
Success 1	Joint Commissioning of health and social care	In Supporting People to Live Healthier Lives, Southend-on-Sea City Council (SCC) and partners have taken a collaborative approach to the development of an integrated discharge model, the Southend Enhanced Discharge Service (SEDS). The Southend Enhanced Discharge Service (SEDs) model was developed in partnership with the Mid and South Essex NHS Foundation Trust (MSEFT) and Essex Partnership University NHS Foundation Trust (EPUT) and is jointly funded by SCC and the Mid & South Essex ICB (MSEICB). SEDs is designed to support prompt discharge from hospital, providing appropriate assessment, care and support in the home environment. The service brings together an integrated team of hospital staff, occupational therapists,

		physiotherapists, social workers, and community workers to collectively support people to recover at home and maintain their independence. Partners retain oversight of the activity and performance of SEDs through a dedicated strategic forum.
Success 2	**Strong, system-wide governance and systems leadership**	Governance for the BCF Plan sits within the Better Care Fund Management Group, who perform this function on behalf of the Health and Wellbeing Board, and with the authority of the two key partners: Southend City Council and the Mid and South Essex Integrated Care Board. The role of the Southend Better Care Fund Management Group meets informally every month and then formally on a quarterly basis since July 2021. Their main purpose of the group is to oversee the BCF plan and provide; **1. Direction** • Make recommendations to support delivery of the programme (e.g.: changes to the plans, schemes, or budget) • Provide a solution planning forum for barriers to delivery • Approval of project and work-stream proposals and initiatives • Oversee and direct the work of the programme on behalf of SCC and MSEICB. **2. Assurance** • Report on programme activity, including a quarterly report • Manage risks, issues and dependencies • Evaluation of outcomes and associated decisions **3. Communication** Stakeholder engagement and management including assisting the programme to achieve a high profile within the local area and wider community. **4. Sustainability** Ensure that there is a sustainable approach beyond the life of the programme, including decommissioning of projects and/or transitioning activity to “business as usual” when funding decreases. The Southend Better Care Fund Management Group meets quarterly, with decisions being made by majority vote. The BCF Group reports to the Southend Health and Wellbeing Board on a regular basis, with the voting members

		of the BCF Group also being on the Health and Wellbeing Board.
Outline two key challenges observed toward driving the enablers for integration (expressed in SCIE's logical model) in 2022-23		
Challenge 1	**Local contextual factors (e.g. financial health, funding arrangements, demographics, urban vs rural factors)**	There are marked socio-economic and health inequalities between different wards in the borough, which were exacerbated by coronavirus pandemic. As well as the increase in the borough's population, the age profile of Southend is changing, with a growing number of older people, and a significant proportion of population presenting with more complex needs for longer. The impact of austerity on services provided in the community has had a long and lasting impact. SCC has seen unprecedented workforce and retention issues in the care market, as well as in the community and acute sector. Improving health outcomes by addressing and reducing variation within the wider determinants of health (education, housing, employment and income) is a vital and integral part of our system response plans, to meet the needs of the community. The Winter Discharge Fund has provided a welcome opportunity to bolster service provision and enhance the lived experience of residents in Southend. However, the timing and notification of available funding presented a number of challenges which limited the mobilisation of impactful programmes. The provision of additional capacity within the local market and local providers is often predicated on additional workforce and the timeline did not allow sufficiently for this to take place through existing recruitment processes.
Challenge 2	**Good quality and sustainable provider market that can meet demand**	Throughout 2022-23, SCC have been working closely with care sector partners to support the development and maturity of the local care market. Huge strides have been made in this area which have positively impacted on capacity and demand issues over the winter period. Despite these positive steps, challenges do remain, particularly in terms of residential care. A number of initiatives and incentives have been deployed including investment in provider rates. Our focus is to collectively build stronger relationships with the Care Home market and alternative contracting models i.e., potential for long term block contracts rather than spot purchasing agreements.

2. Better Care Fund National Policy Framework 2023-25

The Better Care Funds are managed locally, and in each Local Authority the Council is legally obliged to submit and agreed BCF plan jointly with their local Integrated Care Board (ICB) which adheres to the national guidance.

There is an annually agreed health minimum contribution to each local authority area. For the current 2023-24 financial year, the contribution for Southend-on-Sea ICS is £15.977m. Southend-on-Sea City Council's contribution for 2023-24 financial year is £10.980m which includes all funding sources shown below.

Better Care Fund Finance and Plans 2023-25

A completed planning template confirms the expenditure plan, Capacity, and Demand modelling.

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2
DFG	£1,721,065	£1,721,065	£1,721,065	£1,721,065
Minimum NHS Contribution	£15,977,498	£16,881,824	£15,977,498	£16,881,824
iBCF	£7,797,498	£7,797,498	£7,797,498	£7,797,498
Additional LA Contribution	£368,848	£0	£368,848	£0
Additional ICB Contribution	£0	£0	£0	£0
Local Authority Discharge Funding	£1,093,197	£1,821,922	£1,093,197	£1,821,922
ICB Discharge Funding	£1,198,780	£1,666,320	£1,198,780	£1,666,320
Total	**£28,156,886**	**£29,888,629**	**£28,156,886**	**£29,888,629**

The above chart is taken from the BCF 2023-25 Planning Template.

The expenditure for the funding sources meets the conditions which are outlined in the Better Care Fund conditions and includes:

Scheme Type	Source of Funding	Expenditure 23/24 (£)	Expenditure 24/25 (£)
High Impact Change Model for Managing Transfer of Care	LA BCF	£1,064,740	£1,075,387
Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery)	LA BCF	£2,009,461	£2,029,556
Home Care Additional Packages	LA BCF	£2,551,111	£2,940,455
Home-based intermediate care services	LA BCF	£785,489	£793,344
Southend Enhanced Discharge Service (SEDs) High Impact Change Model for Managing Transfer of Care	LA BCF	£500,000	£500,000
Active Recovery (Reablement) - High Impact Change Model for Managing Transfer of Care	LA BCF	£250,000	£250,000
Carers Services	LA BCF	£150,000	£150,000
Community Based Schemes	iBCF	£150,000	£150,000
Residential Placements	iBCF	£2,087,000	£2,087,000
Additional Home Care Packages	iBCF	£2,087,000	£2,087,000
Southend Reablement Service	iBCF	£770,012	£770,012
Learning Disability Services	iBCF	£1,750,000	£1,750,000
Range of projects which support the transformation and improvement of adult social care.	iBCF	£853,486	£853,486
Disabled Facilities Grant Assistive Technologies and Equipment	DFG	£1,721,065	£1,721,065
Transformation Projects	Additional LA Contribution	£368,848	£0
Able to Recover Monitoring and responding to system demand and capacity	LA Discharge Funding	£200,000	£200,000

Reablement Early Intervention	LA Discharge Funding	£12,500	£12,500
Provider Incentive Scheme	LA Discharge Funding	£50,000	£50,000
Seasonal Intelligence Provide tools and training to ensure the data monitoring highlights winter pressures	LA Discharge Funding	£2,075	£2,075
Southend Enhanced Discharge Service (SEDs) To support Winter Pressures	LA Discharge Funding	£300,000	£300,000
Southend Care Ltd Enhanced Reablement Capacity	LA Discharge Funding	£100,000	£100,000
Discharge Community Hub	LA Discharge Funding	£40,000	£40,000
Workforce Development	LA Discharge Funding	£366,490	£366,490
Resource to be allocated dependent on requirements in winter e.g., designated setting	LA Discharge Funding	£22,132	£750,857
MSE ICB - Community Services - Other Community provision, to assist flow and prompt discharge	ICB BCF	£2,966,993	£3,134,925
MSE ICB - Community Services - Bed based intermediate Care Services	ICB BCF	£1,502,737	£1,587,792
MSE ICB - Community Services - Urgent Community Response Service	ICB BCF	£821,318	£867,805
MSE ICB - Community Services - Virtual Wards	ICB BCF	£769,186	£812,722
MSE ICB - Southend Community Services - Dementia Support Service	ICB BCF	£1,024,018	£1,081,978
MSE ICB - Southend Community Services - Equipment Service Provision - EPUT	ICB BCF	£568,411	£600,583
MSE ICB - Southend Havens Hospice	ICB BCF	£605,260	£639,517
MSE ICB - Southend Carers - Carers Breaks	ICB BCF	£158,774	£167,760
MSE ICB Discharge spend - Ward based enablement	ICB Discharge Funding	£99,118	£137,776
MSE ICB Discharge spend - Acute Discharge Schemes	ICB Discharge Funding	£1,061,271	£1,475,062
MSE ICB Discharge spend - Transport	ICB Discharge Funding	£12,728	£17,692
MSE ICB Discharge spend - Welfare Support Discharge to Assess pathway 0	ICB Discharge Funding	£25,232	£35,073

A narrative plan has been completed, which outlines how the Better Care Fund is used in Southend-on-Sea to support local priorities. The narrative also defines lessons learned from 2022/23 and how these have influenced the BCF Plans for 2023-25. A majority of the plan reflects the 2022-23 submission with little change to content.

- The vision for the BCF over 2023-25 is to support people to live healthy, independent, and dignified lives, through joining up health, social care, and housing services seamlessly around the person. This vision is underpinned by the two core BCF objectives:
  - Enable people to stay well, safe, and independent at home for longer.
  - Provide the right care in the right place at the right time.

- As with previous years, the Southend-on-Sea Better Care Fund plan is developed and delivered within the context set by the:
  - The Joint Southend Health and Wellbeing Board Strategy 2021-24.
  - The Adult Social Care Strategies – Ageing Well, Caring Well and Living Well 2022-2027 alongside the SCC Market Position Statement.
  - The Mid and South Essex Integrated Care Partnership (ICP) Strategy 2023-2033.

- The South East Essex (SEE) Alliance Framework Plan.

The Better Care Fund schemes have been reviewed to ensure they are aligned with the plans for Southend-on-Sea and local priorities along with the BCF National conditions and central to the delivery of the BCF priorities. Some of the fully fund-specific needs include:

- Early Discharge Planning to improve patient flow.
- Systems to monitor patient flow which identify barriers to system flow and to investigate causation and mitigate.
- Multi-disciplinary, multi-agency discharge teams (including voluntary and community sector) support the Southend Enhanced Discharge Service and Reablement Therapy Led Service along with the Hospital Discharge Team.
- Home First Discharge to Assess enables people to go home as soon as possible after acute treatment.
- Trusted Assessors to be implemented with Home Care agencies to work with Occupational Therapists to order equipment for reablement led support at home.
- Improved Discharge to Care Homes which include the Urgent Response Care Team and the reduction in readmission from Care Homes.
- Home aid and adaptation service to support independence at home.
- Extra care available to ensure people are able to live independently as long as possible.

Appendix a

The 2023-25 Joint Narrative Plan.

<u>BCF National Conditions</u>

The national conditions for the BCF for 2023 to 2025 are broadly like 2022-23 and continue to require a minimum spending level on social care and community health services.

- Plans to be jointly agreed.
- Enabling people to stay well, safe, and independent at home for longer.
- Provide the right care in the right place at the right time.
- Maintaining NHS contribution to adult social care and investment in NHS-commissioned out-of-hospital services.

<u>Southend BCF and IBCF governance</u>

The Southend-on-Sea programme sits under the Southend BCF Management group, which is a joint Council and NHS group which has NHS acute trust and community provider representation. The BCF Management group has financial authority for decision-making, however, reports to the Health and Wellbeing Board.

3. Better Care Fund Section 75 Agreement

A draft Section 75 framework agreement setting out how the Better Care Funds will be managed by Southend-on-Sea City Council and Mid and South Essex Integrated Care System (ICB) included as Appendix 2 to this report.

The proposed agreement is to cover the period 1st April 2023 to 31st March 2025. The previous agreement commenced on 1st April 2020 to 31st March 2023 and has now lapsed.

The BCF arrangements allow for the operation of pooled budgets where funds are jointly managed and controlled by both parties.

Provisional financial allocation of the BCF funds for both the Council and the ICB in 2023/2024 and 2024/25 is as set out in the table below:

Detail BCF	**2023/24**	**2024/25**
	£000s	**£000s**
ICB Minimal Contribution	**15,977**	**16,882**
SCC Directly Commissioned Schemes		
Protecting Social Services	6,025	6,445
Reablement, including support for the Care Act 2014	1,535	1,543
Sub Total	**7,561**	**7,989**
Counter invoice from ICB to fund Directly Commissioned Schemes	**8,417**	**8,893**
ICB Directly Commissioned schemes		
Community services	7,653	8,086
Havens hospice grant	605	640
Carers	159	168
Sub-total	**8,417**	**8,893**

The Section 75 framework agreement will be shared and approved at the next Southend Better Care Fund Management Group. This group is part of the formal governance of the Better Care Fund in Southend as set out in Schedule 2 to the framework agreement.

Appendix b

Draft Section 75 Framework Partnership Agreement proposal relating to the Commissioning of Health and Social Care Services using the Better Care Fund 1st April 2023- 31st March 2025.

HM Government

NHS England

BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans. Although the template is optional, we ask that BCF planning leads ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 25 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Cover

Health and Wellbeing Board(s).

Southend-on- Sea Health and Wellbeing Board

Bodies involved strategically and operationally in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils).

The Southend-on-Sea Plan for 2023/25 is part of a wider programme of work to integrate health and care across the City of Southend-on-Sea for the benefit of local residents and the community. The following bodies are those who are involved both strategically and operationally in preparing the plan:

Southend on Sea City Council;

Mid and South Essex Integrated Care Board;

South East Essex Alliance.

How have you gone about involving these stakeholders?

The current aims and objectives for Southend-on-Sea City Council's (SCC) Adult Social Care (ASC) are set out in its three core strategies; "Ageing Well", "Caring Well" and "Living Well". In addition to the three core strategies a number of supporting strategies and policies have been established with others scheduled for development.

Southend-on-Sea City Council and Adult Social Care have an established model for the co-production of its vision, strategies, policies, and services. This can be evidenced in the development of the new Supporting Living contracts, multiple engagement sessions were held with service users and providers. Adult Social Care acknowledges that further work is required to embed co-production at a strategic, planning, and operational level.

The Mid & South Essex Integrated Care Partnership (ICP) Strategy 2023-2033, has been developed in collaboration with key strategic partners, supported by the Chair of the ICP Board and the three Vice Chairs (respective Health & Wellbeing Board Chairs) and the three local Healthwatch organisations. The essential building blocks of the strategy were informed by a range of conversations with residents, community organisations, clinicians, care professionals and leaders in health and care.

At a local place-based level the South East Essex (SEE) Alliance has, through sustained and active engagement, developed a robust Alliance Framework Plan. This partnership plan focuses on the development of neighbourhoods, tackling the wider determinants of health and reducing health inequalities. The Alliance plan has established a strong foundation for working together as partners in Southend.

In Southend, opportunities for collaborative commissioning are explored at regular meetings with all organisations mentioned above, wherever appropriate. There are strong joint working arrangements across system partners which are well embedded to deliver an integrated approach to health and care in Southend-on-Sea. These are underpinned by regular meetings which focus on areas for development and transformation.

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

Governance for the BCF Plan sits with the Better Care Fund Management Group.

This group performs the governance function on behalf of the Health and Wellbeing Board, with the authority of the two key partners: Southend City Council and the Mid and South Essex Integrated Care Board (MSE ICB).

The role of the Southend Better Care Fund Management Group is to oversee the BCF plan and provide:

Direction

- Make recommendations to support the delivery of the programme (e.g: changes to the plans, schemes, or budget)
- Provide a solution planning forum for barriers to delivery
- Approval of project and work-stream proposals and initiatives
- Oversee and direct the work of the programme on behalf of SCC and MSEICB.

Assurance:

- Report on programme activity, including a quarterly report
- Manage risks, issues, and dependencies
- Evaluation of outcomes and associated decisions

Communication:

- Stakeholder engagement and management including assisting the programme to achieve a high profile within the local area and wider community.

Sustainability:

- Ensure that there is a sustainable approach beyond the life of the programme, including decommissioning of projects and/or transitioning activity to “business as usual” when funding decreases.

The BCF Management Group meets quarterly, with decisions being made by majority vote.

The BCF Group reports to the Southend Health and Wellbeing Board on a regular basis, with the voting members of the BCF Group also being on the Health and Wellbeing Board.

Executive summary

This should include:

- Priorities for 2023-25
- Key changes since previous BCF plan.

The City of Southend sits within the complex health and care system that makes up the Mid & South Essex Integrated Care Partnership (ICS). The ICS spans 3 local authorities, 5 district councils and multiple NHS providers of acute and community-based care.

In 2020, Southend-on-Sea was the second most densely populated area in the East of England region.

The population in the last decade has increased and the number of people of state pension age is estimated to be around 300 per 1,000 working-age population. There is an ageing population in Southend. In 2021, the proportion of the population aged 65+ (19.1%) is significantly greater than that for the population aged under 15 (17.8%).

Seven out of Southend-on-Sea's 17 wards are in the 10% most deprived neighbourhoods nationally (decile 1).

Southend City Council (SCC) and Mid & South Essex Integrated Care Board (ICB) are committed to working to build and empower strong and inclusive place-partnerships at the Alliance level, joining up care and support with local partners, including NHS, local authorities, district councils, schools, communities, and the local voluntary and community sector.

Our Joint Southend Health and Wellbeing Strategy 2021/24, considers how we can influence the wider determinants of health and wellbeing, which includes the social, economic and environmental conditions that influence the health of individuals and populations.

Within the Southend Health & Wellbeing Strategy, we describe the challenges we face but also describe some of the opportunities too. We know that, within Southend, despite the challenges, our strong partnerships and commitment to working together in the health and social care system, means we are well-placed to deliver sustainable, long-term improvements. Together, we will protect people and help them to live longer in good health.

We must change the culture, mobilise our collective leadership and work more effectively hand-in-hand with local communities, so better health outcomes can be achieved for the people of Southend. We have already made great strides in our collaboration and whilst partnering is crucial in delivering our vision, we have a responsibility to collaborate in delivering the NHS long-term strategy and the Southend 2050 outcomes, all informed by the Joint Strategic Needs Assessment (JSNA) and the Annual Public Health Report.

The alignment of organisational priorities and actions will serve to advance local service development and shared outcomes.

Southend-on-Sea's BCF plan has an initial focus on hospital discharge but will also incorporate admission avoidance during 2023-25.

Our priorities will focus on the key areas as noted below:

Health inequalities – Improving health outcomes by addressing and reducing variation within the wider determinants of health (education, housing, employment and income).

Effective Partnering – Partnership work in a coordinated way to ensure system alignment, shared resources and focus on co-production, to make Southend a healthier place.

Accessible Services – Ensure health services are designed to be as accessible as possible for users, identifying, reducing, and removing barriers to access.

Workforce Development – Skilled workforce to support the borough's health and well-being needs.

Spatial Planning – Use active environment design and spatial planning, so that the places and spaces in Southend-on-Sea encourage and facilitate activity in everyday life, making a healthy lifestyle as easy as possible.

Information and Digital Resources – Ensure all residents can access clear and consistent information and services.

Unpaid Carers – Looking after our unpaid carers and ensuring we provide the relevant support which they require. Ensuring we continue to work with the Caring Well Partnership Group to assure the right initiatives are in place.

Coordinated Communications – Work with partners to develop our communications and health campaign strategies, to increase awareness of health risks, raise awareness of local services and support and encourage people to take action to improve their health and wellbeing.

Over the next 2 years, Southend-on-Sea's plan will support the aims of the BCF by linking programmes of work such as urgent and emergency care, long-term conditions, prevention and early intervention. We will continue to deliver a range of projects in 2023-25 which were implemented in the previous BCF plan and will continue to develop existing services. As well as introducing new opportunities, avoiding duplication and inefficiencies within the system to ensure that delivery is meeting the right needs of targeted populations. We anticipate that our priorities will reduce gaps and support local people to live independently, meeting and receiving the care which they need.

The initiatives which have been demonstrated in our 2023-25 BCF plans for reablement and rehabilitation will continue to step up and step down where necessary. This will continue to fluctuate because we have capacity when required.

In Southend-on-Sea, we will continue to support and work with providers in health and care across our local system in finding solutions to the key challenges which include winter pressures.

National Condition 1: Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person centred health, social care and housing services including:

- Joint priorities for 2023-25
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to continued integration of health and social care. Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.

Our Better Care Fund Plan builds upon the work undertaken in Southend through the last year of BCF funding. This saw the ongoing development and growth of the South East Essex (SEE) Alliance partnership and enhanced the ethos of the SEE Locality Strategy, bringing together local partners and stakeholders, including Providers, VCS, and Housing who share an ambition to improve the well-being and lives of the people they serve. South East Essex, covering Southend, Castle Point, and Rochford, is the local “place” that forms part of the Mid and South Essex Integrated Care Partnership.

In 2023-25 the BCF will ensure collaborative and joint partnerships working to streamline access to care and provide more proactive, personalised care with support from multidisciplinary teams of professionals ensuring healthy communities are created and meeting people’s needs for integration of health and social care.

Opportunities for collaborative commissioning are explored wherever appropriate. Our BCF plan incorporates the ambitions of all the strategic partners in SEE, all of which have been subject to a significant level of consultation and engagement with stakeholders and partners, drawing out a coherent strategic direction for the health and social care system across Southend. Central to our collective vision is our desire to see residents united with health and social care services around the single ‘Common Endeavour’ of reducing inequalities together. The BCF plan is grounded within our joint Health and Wellbeing Strategy, Mid & South Essex Integrated Care Strategy, joint strategic needs assessment (JSNA), Locality Strategy, and the plans of our Alliance partner organisations.

Southend City Council has developed three core strategies; ‘Ageing Well’, ‘Caring Well’, and ‘Living Well’, setting out priorities over the next five years. The three strategies were co-designed with people who use services and their friends and families, partners, and stakeholders.

Our BCF plan for 2023-25 recognises both national and local challenges, including affordability challenges for social care and the NHS. It includes consideration of both iBCF and Winter Discharge Fund with associated conditions to be met. The stabilisation of the home care and residential care markets, improving discharge arrangements and supporting the structural deficit in social care funding which would otherwise make such steps unsustainable are also included.

The programme across 2023-25 will deliver a range of initiatives within new models too including Trusted Assessor along with the development of a skilled workforce, to support the improvement and transformation of adult social care. The priorities together will ensure people get out of the hospital as soon as they are medically ready and will, wherever possible, return home. Anybody requiring ongoing care will be able to access the right care, in the right place at the right time.

Our BCF plan also acknowledges the growing pressures on community health services as a consequence of increasing demands in local acute hospitals and primary care services. Levels of demand across primary care, acute hospitals, community health, mental health, social care and VCS sectors are at unprecedented levels due to a number of factors. Through our BCF and other local collaborative planning processes, Southend City Council, MSE ICB, and other local partners will be working together through 2023/25 to balance these unprecedented demands on existing services and consequent system pressures.

The winter discharge fund in 2022/23 supported the delivery of a number of test and learn initiatives including:

Ward enablement – Pilot to bring a Reablement mindset and capacity into a frailty/DME ward at Southend Hospital, supporting a reduction in unintended Hospital Acquired Functional Decline. 3 staff, 7 days per week including a dedicated Trusted Assessor and two Care Assistants 6 hours per day. Outcomes show a reduction a ward-base falls and readmissions and measurable improvement in mobility at the point of discharge in comparison with similar wards.

Dedicated patient Transport Customer Relationships Manager – Based in Southend Hospital to optimise and prioritise complex discharges. This role assists in maintaining patient flow during periods of severe pressure and acts as a conduit between HTG-UK Control (PTS provider) and hospital colleagues. Outcomes show a significant reduction in re-bedded patients and reduced waiting times for patient readiness.

Mental Health Discharge to Assess Nurses – Based in the Emergency Department at Southend Hospital, providing an immediate/rapid triage to determine the safety and appropriateness of conveying the person home and carrying out a full assessment at home.

The market provider incentives were used to support timely and safe discharge from the hospital to where ongoing care and support are needed. One of the key challenges we wanted to address through this initiative was to support our homecare providers to best handle the local workforce capacity pressures and thereby improve timely and safe discharge from the hospital where ongoing care and support is needed at home.

Southend Enhanced Discharge Service (SEDS) - Developed jointly with key strategic partners this service brings together hospital staff, occupational therapists, physiotherapists, social workers, and community workers to collectively support people to recover at home and maintain their independence following a hospital stay. At the moment we are committed to a one full year review. At this stage, we are looking at undertaking evaluations following the first year of running the service.

Community Hubs – Established to reduce both length of stay and readmissions to hospital, through a risk-assessed onward support package. Key to the success of this project is the confidence of the hospital teams to discharge in the knowledge that welfare is being picked up on discharge and support provided in the community via the voluntary sector (VCSE). Working in partnership with the VCSE sector will enable social support, for people through “Hospital to Home” to ensure their

Carers Intensive Support Services – This pilot service has provided practical and emotional support to carers approaching a crisis with time-limited intensive interventions adopting a person-centred bio psycho social approach. The service will be further enhanced in 2023/24 to focus on Carers Health Checks (Physical, Mental, Social and Emotional Health incl housing).

Each of the above services will continue and be further developed and enhanced through the BCF plan going forward.

An established Southend BCF Management Group with key partners which include senior management from Southend-on-Sea City Council, ICB/Alliance and colleagues from local voluntary organisations have been established. This group is part of our governance arrangements whilst planning priorities and reviewing key themes and activities across Southend. They also have financial oversight of BCF governed through Section 75 Agreement agreed through the Health Wellbeing Board.

National Condition 2

Use this section to describe how your area will meet BCF objective 1: **Enabling people to stay well, safe and independent at home for longer.**

Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home. This could include:

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and proactive care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake
- how work to support unpaid carers and deliver housing adaptations will support this objective.

The relationship and partnership between Southend City Council and the Integrated Care System is very strong. Together we all continue to expand our collaborative approach with key strategic partners, aligning strategic commissioning with integrated neighbourhood/locality approaches.

Embedding a strength and asset-based approach is a key priority, utilising a different lens to view individuals, families, and communities. A strength and asset-based approach seeks to view individuals holistically and explore their abilities and circumstances, rather than focusing on their weaknesses and deficits. The most critical variable in this approach is where individuals are encouraged to identify the goals that they want to achieve and work towards attaining these goals that empower the individual. Reablement, active recovery and tools for independent living are central to this approach and are adopted across services.

We have been working towards Integrated Neighbourhood Teams in Southend and have made considerable inroads, all of which align with the recommendations arising from the Fuller Stocktake. PACT (PCN Aligned Community Teams) integrates the delivery of health and care to people with complex needs, so services and support are coordinated and aligned in ways which make sense to the local population. PACT is not a service, but an operational model which unites workflow at the neighbourhood level to deliver real-time multi-agency working between primary care, community nursing, mental health dementia teams, palliative care, adult social care, care providers and voluntary sector assets to provide efficient proactive care. Digital and IT solutions are enabling this live, day-to-day, working across multiple professionals who are creating a ‘one team’ identity. In turn, this is reducing repeated, reactive, urgent demand on teams and services as capacity becomes united and efficiently coordinated ensuring local residents get the right support, by the right team, at the right place and time for them. In the two most advanced PACT’s, both frailty focussed, readmissions have been reduced by approximately 10%, this is a significant gain for both resident and family experience and also system demands. Resident and family feedback is overwhelmingly positive.

In SS9 PCN a dedicated Mental Health PACT is emerging, building on the success of the frailty model outlined above, the mental health PACT will include Primary Care Mental Health practitioners, other community mental health teams, community physical health, ASC and voluntary sector partners. Early indications are positive and we fully expect the model to change the outlook and approach to mental health in Primary Care.

The overall direction for adult social care is built on three core strategies named ‘Ageing Well’, ‘Caring Well’, and ‘Living Well’, setting out priorities over the next five years. The three strategies were co-designed with people who use services and their friends and families, partners, and stakeholders.

The strategies are only one part of a process, and to move forward delivery of each strategy, there are associated annual action plans of activities to enable movement from the starting point of where we are to where we want to be by 2027. Partnership groups including all strategic partners have been formed to manage the development, delivery, and monitoring of the yearly action plans for each strategy which will build on the work of the previous year and in reaction to emerging needs and trends.

Alongside the ambitions of these strategies, SCC has developed a Market Position Statement, which summarises supply and demand in the local area along with highlighting business opportunities. The Market Position Statement starts the process of explaining what care services and support are needed in the area and why. Based on a review of supply, demand quality, diversity, cost challenges and workforce pressures the sustainability in Southend-on-Sea is challenged, though it has seen small improvements since severe challenges in 2021. In addition, SEE Alliance and Southend City Council, regularly review supply, demand, and market sustainability in addition to local data available through the Social Care JSNA.

The collaborative development of the Southend Enhance Discharge Service (SEDS) model will continue to be enhanced through working with acute, community and VCSE partners. SEDs provide a full and complete therapy-led hospital discharge assessment at home, helping to determine future needs and critically support recovery in the home environment fully utilising the home-first ethos.

Carers of all ages, play a significant role in preventing the need for more formal care and support for the people they look after. The health and social care system continues to rely heavily on unpaid care, it has a central role in our health economy and there would be a huge cost involved should we need to replace this care. In Southend, we recognise that supporting carers is the responsibility of everyone. This includes organisations working directly with carers and the cared for, across the statutory and voluntary sector, and with the community, and families. We have shared responsibility to provide an effective, efficient and coordinated service to support carers’ health and wellbeing.

Through the BCF a pilot Carers Intensive Support service has been mobilised, the service will be further enhanced in 2023/24 with the dedicated capacity to support the proactive identification and support offered to carers of older adults, or to support carers over the age of 65 who are carers of any age 'cared for', as well as an annual carer 'health check' that will link back to health to ensure we are mitigating against carer breakdown.

Virtual wards are developing and evolving at pace in Southend and across MSE, they are delivering improved outcomes compared to traditional pathways, by reducing functional decline and risk of infections. Virtual Wards are one of the biggest opportunities we have to reduce system pressures and improve flow. MSE is being recognised nationally for the progress we have made so far in rapidly mobilising Virtual Wards, and the clarity of understanding that we have developed around the next steps However, we recognise that there are challenges and opportunities to improve as we go through 2023/24/25.

National Condition 2 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?

  how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

We recognise the challenges in the local system particularly market capacity and sustainability. We have winter planning short-term mitigations in place locally and are enacting long-term workforce plans and price reviews to increase the hourly rate for the care sector. Albeit the care market capacity issue will remain a significant risk to the system of any further unexpected upsurge. The implementation of a care settings meeting in order that the Local Authority has the management of market pressures escalation level.

There has been a substantial focus on hospital readmission rates at both South East Essex place and wider Mid and South Essex system levels. The MSE Clinical Care and Outcomes Review Group has oversight and leads on readmissions for the ICP. At a local level, this system-level work and plans link with the South East Essex Urgent and Emergency Care Delivery Group. Detailed analysis to identify root causes and contributory factors to readmissions will be undertaken in 2023. This will inform future work that will be coordinated and reported to the BCF management group.

Improving flow to support the discharge of people home, alongside the demands of flu, COVID, industrial disputes and capacity has exerted pressures impacting the whole health and care system, and this is likely to continue in the short to medium term.

A Seasonal Intelligence team has recently been established to analyse and produce regular reporting for adult social care, this information is used to plan and adapt services to best meet local needs. Unfortunately, there have been no previous data in place to enable the plotting of trends for this current year and therefore we cannot understand the full gap reduction for 2023-24. However, reporting needs are developing and evolving as intelligence improves and trends emerge so we will have better knowledge in future years. Joint working with strategic partners will support an evolving picture of access and

delivery of key services, identifying any potential gaps and challenges/barriers in system flow. This will enable us to ensure our priorities are in the right area, at the right time for the right people.

SHREWD has been in place since 2022/23 and is used in all partner daily situational seasonal intelligence awareness meetings to monitor and review system flow, pressure and risk. Monitoring of data and close collaboration with partner colleagues in MSEFT and ASC Operations, to identify challenges/barriers in system flow, investigate causation and mitigate. Development work is ongoing to support a cycle of continuous improvement.

The winter discharge fund also supported a Patient Transport Customer Relations Manager to optimise discharges. Dedicated senior capacity in the acute setting focussed on building ward-level relationships, identifying and mitigating any issues and prioritising journeys for those with care packages ready to start, end-of-life patients etc. Positive feedback evidence increased communication and better relationships, improved patient experience and a significant reduction in both delays and the number of patients re-bedded overnight due to insufficient capacity/delays. This initiative will be extended into 2023/24 for continued benefit.

Development work is ongoing to support a cycle of continuous improvement.

The Hospital Discharge activity has been provided from the draft activity submission of the NHS Operational Planning 2023/24 and is based on actual trend data across the three MSEFT sites and then on a % across Essex 69%, Southend 17% and Thurrock 14%.

We are expanding and considering our Mental Health pathway and also the connection with the Voluntary Sector. Progress in this area continues and is required in this area.

National Condition 2 (cont)

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25, and how these services will impact on the following metrics:

- unplanned admissions to hospital for chronic ambulatory care sensitive conditions
- emergency hospital admissions following a fall for people over the age of 65
- the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.

The Southend Enhanced Discharge Service (SEDs) model was collaboratively developed with strategic health and care partners and is jointly funded through the BCF. SEDs are a discharge service which provides a full and complete therapy-led hospital discharge assessment at home for Southend residents rather than an assessment being provided by the hospital before discharge. It enables patients to leave the hospital sooner with appropriate provision of care at home, where they then tend to recover more quickly.

Physiotherapists and Occupational Therapists are involved in assessing patients in the context of their own homes rather than in the hospital ward. It has also led to significantly more efficient triage to appropriate community-based services (such as reablement services, long-term home care support, voluntary sector support, occupational therapy and physiotherapy) than previous systems. This creative model of discharge has resulted in considerable efficiencies and improvements to patient care.

2023/24 will see the development of a Trusted Assessor Pilot, which will be working alongside the SEDs service and supporting residents who have accessed reablement post-SEDs and are identified as needing long-term care provision. It is anticipated the pilot will ensure packages of support are adjusted appropriately will improve flow. We recognise that implementing this model as soon as possible will be crucial to enable early engagement with patients, families and carers.

SHREWD is a Resilience Application led by MSEFT Resilience and Operations, partner organisations across South East Essex have implemented the SHREWD system. Supporting holistic, integrated oversight. It is a system resilience dashboard which visually identifies areas of pressure. The system shows current and inbound demand, bottlenecks, flow and the capacity in use and available.

We have continued to strengthen the discharge process according to “home first” principles. We have introduced reablement capacity (1200 hours per week) with the Southend Reablement Service which will support this home-first model. This was

increased from a starting point of around 500 hours delivered per week in February 2022 which then increased to 900 hours.

Winter funding supported the development of a pilot ‘ward enablement’ service at Southend Hospital, this therapy lead initiative focused on supporting and encouraging patients to be physically active. Simple things like getting dressed every morning and increasing physical activity levels have successfully reduced length of stay, readmissions and the number of ward-based falls, all of which contribute to reduced demand for complex care packages. This initiative will be extended into 2023/24 and further enhanced for maximum benefit.

Most of our BCF initiatives, seek to enable more people to live longer, independent lives within their communities and ensure more high-cost, high-dependency care in residential and nursing homes is only used when absolutely needed.

In Southend-on-Sea, the priority for local people is to ensure it is “Home First” wherever possible. We continue to aim to minimise permanent admissions into residential and nursing care homes for people aged 65+. Our outturn for 2022-23 was 429.79 and the number of permanent admissions to residential care is in line with the target figure. It is anticipated that the data for Quarter 2 will be more meaningful for reporting.

National Condition 3

Use this section to describe how your area will meet BCF objective 2: **Provide the right care in the right place at the right time.**

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support safe and timely discharge, including:

- ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support, in line with the Government's hospital discharge and community support guidance.

- How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.

- Implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.

The Southend Enhanced Discharge Service (SEDs) is a discharge service which provides a full and complete therapy-led hospital discharge assessment at home for Southend residents rather than an assessment being provided by the hospital before discharge. It enables patients to leave the hospital sooner with appropriate provision of care at home, where they then tend to recover more quickly. Physiotherapists and Occupational Therapists are involved in assessing patients in the context of their own home rather than in the hospital ward. It has also led to significantly more efficient triage to appropriate community-based services (such as reablement services, long-term home care support, voluntary sector support, occupational therapy and physiotherapy) than previous systems. This creative model of discharge has resulted in considerable efficiencies and improvements to patient care. To support flow Southend-on-Sea City Council are active partners at the SEDS strategic forum where improvements and performance are mediated. This will ensure that care and support interventions are provided at the right time, by the person with the most appropriate skills, in order to get the right care, first time, every time.

Winter funding supported the development of "Community Hubs", based on support services established during the Covid pandemic, the Community Hubs provided essential voluntary sector support at the point of discharge. The main focus of Community Hubs is to reduce both length of stay and readmissions to hospital, through a risk-assessed onward support package. Key to the success of this project is the confidence of the hospital teams to discharge in the knowledge that welfare is being picked up on discharge and support provided in the community. This is the driving force behind safely improving discharge speed to reduce the length of stay. A critical element is being able to ensure there is support in the community, hence the engagement and involvement of voluntary sector-delivered

community hubs to support with a wide range of services that prevent readmissions and a positive onward path for individuals who have been discharged.

Integrated Neighbourhood Teams/PACT (PCN aligned community teams) in Southend is developing at pace, building on existing partnership working and taking a broader and more holistic approach to the delivery of integrated health and care to people with complex needs, so services and support are coordinated and aligned in ways which make sense to the local population. PACT is not a service, but an operational model which unites workflow at the neighbourhood level to deliver real-time multi-agency working between primary care, community nursing, mental health dementia teams, palliative care, adult social care, care providers and voluntary sector assets to provide efficient proactive care. Digital and IT solutions are enabling this live day-to-day working across multiple professionals who are creating a 'one team' identity supporting discharges and ensuring local residents get the right support, by the right team, at the right place and time for them.

The priorities for the 2023-25 Better Care Fund plans continue to maintain Home First to keep local people out of residentidential care homes unless really necessary. The priorities listed in our Capacity and Demand will ensure this is delivered. Our Community Hubs support our Home First approach by continuing to deliver transfer to care to maximise local people to having independence and using their offers to ensure this.

The ongoing development of a transfer of care hub (TOCH) is a key focus for the coming year, building on the existing infrastructure and resources to deliver responsive and coordinated care in the right place at the right time. Proactive and coordinated care, supported by community physical and mental health providers and voluntary and third-sector partners will support system flow both for admission avoidance and discharge.

The Dementia Community Support Team (DCST) are a dementia community team offering bespoke support from pre-diagnosis through to the end of life for people living with dementia and their carers. Forming part of an integrated service that wraps around people living with dementia with a focus on supporting the carers throughout the period of engagement, empowering and enabling both carer and cared for, to live the life they would like with their diagnosis. The service provides easy access, no wrong door approach for residents and our partners in health, social care and the community. This provides seamless care with no visible handoffs to the people supported. The team's ethos is that dementia is everybody's business and work with partners to develop bespoke training packages which are used to enhance knowledge, skills and understanding of how to support a person with dementia across the systems.

A number of transformation programmes and initiatives are already underway in Southend-on-Sea which can be built upon, and having the opportunity to avoid duplication and inefficiencies in the system and utilising the Better Care Fund as an enabler where appropriate to enable the right care, in the right place at the right time.

National Condition 3 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. improved provision of support in a person's own home, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
- planned changes to your BCF plan as a result of this work.
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?
    - how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

The Southend Enhanced Discharge Service (SEDs) model was developed in partnership with the Mid and South Essex NHS Foundation Trust (MSEFT) and Essex Partnership University NHS Foundation Trust (EPUT) and is jointly funded by SCC and the Mid & South Essex ICB (MSEICB). SEDs are designed to support prompt discharge from the hospital, providing appropriate assessment, care and support in the home environment. The service brings together an integrated team of hospital staff, occupational therapists, physiotherapists, social workers, and community workers to collectively support people to

recover at home and maintain their independence. Partners retain oversight of the activity and performance of SEDs through a dedicated strategic forum.

We are working positively to monitor patient experiences and outcomes in order to get a true sense of patient purpose. We anticipate that evaluation will be taking place in 2023-24 and with the implementation of a SHREWD

Not monitoring outcomes in the way we intended and we will be changing this process. Working on a positive move to monitor patient experience and outcomes to get a true sense of patient purpose.

Community Hubs – Established to reduce both length of stay and readmissions to hospital, through a risk-assessed onward support package. Key to the success of this project is the confidence of the hospital teams to discharge in the knowledge that welfare is being picked up on discharge and support provided in the community via the voluntary sector. These hubs were set up to support our community and based on feedback from those who use them, it has been recognised that they could have a meaningful impact for pathways 1 and 2.

The estimated net need for residential care to 2040 is c.-430 bed spaces. Whilst there is the sufficiency of supply for standard residential care there is a shortage of nursing care. There is an estimated net need for nursing care to 2033 c.370 bed spaces. This reflects the growth in the 75+ household population to 2040 (47%) and the projected increase in complex care needs amongst this population, including a projected increase in the number of older people living with dementia-related needs.

A move to a care home is not seen as “aspirational”, the evidence from local research is that older people are generally not interested in a move to a care home.

A majority of older people in Southend-on-Sea who have care needs or may develop care needs are seeking to receive care in their home, whether they “stay put” or move to specialised housing for older people.

Southend-on-Sea older people residents who want to “stay put” are seeking better support to remain living in their existing homes for longer, such as access to aids, adaptations and technology to support independence.

The outturn for permanent admissions into residential and nursing care for people 65+ is 429.79 in 2022/23. At present, we cannot draw significant conclusions as we require further quarter figures in this financial year. The number of council-supported older adults (aged 65+) whose long-term support needs were met by a change of setting to residential and nursing care during the year is currently 43 (rate: 124.03) with a target of 170 Sequels. This is based on the recording of outcomes for older adults where the intention is for a permanent placement.

However, the avoidance of residential care remains a focus to ensure people remain at home for as long as possible.

National Condition 3 (cont)

Set out how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metrics:

- Discharge to usual place of residence

The Southend Enhanced Discharge Service (SEDS) was implemented in 22 working days from the initial concept in the summer of 2022.

The SEDS is intended to help people leave the hospital sooner and be better supported at home. It is an innovative service which brings together a number of teams within the hospital, MSE Integrated Systems, and Southend City Council to collectively support people to return and remain at home after a hospital stay.

Its primary aim is the provision of a therapy-led assessment service. It also picks up people who have been discharged without support but where support is necessary. The service is delivering effective strengths-based person-centred interventions to help people to meet their personal goals.

After the service, people who need additional or ongoing support will move into either reablement or ongoing homecare.

A SEDS multidisciplinary team is in place, meeting regularly to review people's progress and make decisions regarding referrals, the best onward pathway and providing seamless links to other services.

This service has provided a significant amount of learning which will shape the future of this successful service.

SEDs are not the only answer to Hospital Discharge in Southend. We do offer contractual stability from care providers who deliver a service to the person returning home.

Ward Enablement – Pilot to bringing a Reablement mindset and capacity into a Frailty/DME ward at Southend Hospital, supporting a reduction in unintended Hospital Acquired Functional Decline. 3 staff, 7 days per week including a dedicated Trusted Assessor and two Care Assistants 6 hours per day. Outcomes show a reduction in ward-based falls and readmissions and measurable improvement in mobility at the point of discharge in comparison with similar wards. There are plans in place to further enhance this offer and further evaluate in 2023-24.

Mental Health Discharge to Assess Nurses – Based in the Emergency Department at Southend Hospital, providing an immediate/rapid triage to determine the safety and appropriateness of conveying the person home and carrying out a full assessment at home.

There are a number of supportive teams in Southend Hospital to support hospital discharge. These teams include Carers First and Dementia Support which aid carers.

National Condition 3 (cont)

Set out progress in implementing the High Impact Change Model for managing transfers of care, any areas for improvement identified and planned work to address these.

High Impact Change Model plans

Self-assessment against high-impact change model:

Impact change	Where are you now?	What do you need to do?	When will it be done by?	How will you know it has been successful?
Early discharge planning	Plans are developing Plans are in place	Set expectations on admission Southend enhanced Discharge Service	ongoing-2023/24	Improved patient flow Patients informed regarding plans/options
Systems to monitor patient flow	Plans are developing Plans are developing	Consistent systems within Trust which includes a live tracker which is staffed between 7am and 10pm, 7 days a week. This is updated with patient details, demographics and is accessible to SEDs therapists in order to add assessment data. SHREWD is a Resilience Application	Ongoing Ongoing	Identification of barriers to system flow. The SEDs data is reported into the IDT figures, which are shared across the trust and with external partners along with provided in system escalation calls. SEDS MDT meet 3 times weekly to discuss the flow through the system and escalation emails on top to support with system pressures. SHREWD is used in all partner daily situational seasonal

		Led by MSEFT Resilience and Operations, partner organisations across South East Essex have implemented the SHREWD system. Supporting holistic, integrated oversight. It is a system resilience dashboard which visually identifies areas of pressure. The system shows current and inbound demand, flow and bottlenecks and the capacity in use and available.		intelligence awareness meetings to monitor and review system flow, pressure and risk. Monitoring of data and close collaboration with partner colleagues in MSEFT and ASC Operations, to identify challenges/barriers in system flow, investigate causation and mitigate. Development work is ongoing to support a cycle of continuous improvement.
Multi-disciplinary, multi-agency discharge teams (including voluntary and community sector)	Established Established	Hospital discharge team. Southend enhanced Discharge Service pilot	On-going	Improved flow and patient experience
Home First Discharge to Assess	Established Established Established	Hospital discharge team. Southend Enhanced Discharge Service Reablement therapy-led service	Ongoing	People are able to go home as soon as possible after acute treatment.
Flexible working patterns	Established	The whole system to operate at this level Clinical cover/decision-making over weekends for discharge	Ongoing	Consistent discharge picture through the week
Trusted assessors	To be implemented	Home care agencies trusted assessors trained with OTs to order equipment for	Ongoing	Minimise duplication

		reablement led support at home		
Engagement and choice	Established	Protocols and processes in place to be understood and followed	Ongoing	Choice issued at the correct time Patients aware of discharge expectations on admission
Improved discharge to care homes	Plans are developing	111 support to care homes and GP support Urgent Response Care Team Medication management pharmacy support	Ongoing	Reduction in readmission from care homes
Housing and related services	Established Plans are developing	Home aid and adaptation service Extra care	Ongoing	Independence at home

National Condition 3 (cont)

Please describe how you have used BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered?

When considering how we will be using the BCF funding, iBCF and ASC Discharge Fund we have ensured that they are delivered under the duties of the Health and Care Act 2022.

In February 2021, the Government published the White Paper 'Integration and Innovation: working together to improve health and social care for all' and announced it would be followed by a Health and Care Bill. The White Paper had the following key themes: working together to integrate care; reducing bureaucracy; and improving accountability and public confidence.

The Health and Care Bill was published in July 2021 and provided a new legislative framework to facilitate greater collaboration within the NHS and between the NHS, local government and other partners, and to support the recovery from the pandemic. The Health and Care Act 2022 received Royal Assent on 28th April 2022.

The Act is a wide-ranging and complex piece of legislation with many measures that concern internal NHS operations. Provisions in the Act come into force at different times and has been supported by secondary legislation, statutory guidance, and good practice guidance.

Other key publications and policy reforms aimed at transforming health, care and wellbeing, in particular improving health and care services through better health and care integration and tackling growing health inequalities are:

- The health and care integration White Paper 'Joining up care for people, places and populations'
- The adult social care reform white paper 'People at the heart of care'
- The White Paper 'Levelling up the United Kingdom'
- The Government's report 'Build Back Better: Our Plan for Health and Social Care'.
- The Equality Act 2010: Equality Act 2010: guidance - GOV.UK (www.gov.uk)
- Core20PLUS5 – An approach to reducing health inequalities: Core20PLUS5

Taking these legislations and policy reforms into consideration, and system challenges described above, our plan sets out our aims to deliver the best outcomes for local people.

Supporting unpaid carers

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

In Southend we recognise that supporting carers is the responsibility of everyone. This includes organisations working directly with carers and the cared for, across the statutory and voluntary sector, and with the community, and families. We have shared responsibility to provide an effective, efficient, and co-ordinated service to support carers health and wellbeing.

Southend-on-Sea City Council's 'Caring Well' strategy is a joint strategy with health colleagues. It focuses on the needs of unpaid carers, sometimes called 'hidden carers', which can be anyone who finds themselves in a position of caring for another adult.

Carers play a significant role in preventing the need for a more formal care provision, and the health and social care system relies on this unpaid support. Priorities and action plans within this strategy focus on the following specific areas:

- identifying, respecting, and valuing carers.
- providing suitable information and support.
- developing carers, knowledge, and understanding.
- assessing carers' needs.
- maintaining carers' balance by connecting with communities and being able to take a break.
- recognising health and well-being needs.
- helping carers stay in, enter or return to work education or training (if appropriate).
- being prepared for changes and,
- encouraging integration and partnership working to meet people's needs.

Positive collaboration within Southend City Council Adult Social Care teams have produced a better service and approach for carers locally. There is now a new referral pathway, a dynamic new offer to support people in caring for their loved ones, along with more detailed information on Southend-on-Sea City Council's website. Further work will be undertaken from 2023, in fielding and carrying out non-complex carers assessments directly by the Carers First Service (Southend-on-Sea City Council's commissioned provider) to improve and deliver more targeted support. Southend-on-Sea City Council review people's experiences and views through the Carers' Survey along with service user feedback through Carers' First and finally on a monthly basis with the Caring Well Strategy meetings.

In collaboration with Carers' First, Southend City Council are working with people at a much earlier stage to prevent escalation through effective outreach. The aim is to prevent carer breakdown and support carers resilience thereby adding to the longevity of the caring role.

A Carers Partnership Group has been set up, which has representation from Health, Southend City Council, Carers Groups, Public Health and other interested parties. Using information gathered from Carers First and Southend Carers, many issues and actions have

been progressed this last year which have included Hospital Discharge, End of Life, Contingency Planning, Health Checks, GP Registration, Finance and Carers Assessment.

In the first year of the Caring Well action plan where these elements were addressed and local actions taken, we have seen an increase from 1,037 to 1,333 carers registered with Carers First and an increase from 5,700 to over 7,000 of carers registered with a GP. Their Positive collaboration within Southend City Council Adult Social Care teams has produced a better service and approach for carers locally. There is now a new referral pathway, a dynamic new offer to support people in caring for their loved ones, along with more detailed information on Southend-on-Sea City Council's website. Further work will be undertaken from 2023, in carrying out non-complex carers assessments directly by the Carers First Service (Southend-on-Sea City Council's commissioned provider) to improve and deliver more targeted support. Southend-on-Sea City Council review people's experiences and views through the Carers' Survey along with service user feedback through Carers' First and finally on a monthly basis with the Caring Well Strategy meetings.

MSE ICB are committed to improving outcomes for carers and are active participants in the Commitment to Carers Programme and utilises an ICS/PLACE/Neighbourhood/PCN Maturity Matrix. Southend based initiatives include a pilot with our Primary Care Networks (PCNs) improving carer identification and access to annual health checks for Carers as well as improving the communication between carers support agencies, local authorities and health to provide a more consistent offer to carers and reducing the burden of care.

Through the BCF a pilot Carers Intensive Support and Carer Health Check service has been mobilised, providing additional and dedicated capacity to support the proactive identification and support offered to carers of older adults, or to support carers over the age of 65 who are carers of any age 'cared for', as well as an annual carer 'healthcheck' that will link back to health to ensure we are mitigating against carer breakdown.

The Dementia Community Support Team provides enhanced support to people living with dementia and their carers in Southend. This community-focused service offers accessible and flexible support tailored to reflect the needs of those they are supporting. The Locality Dementia Navigator supports people and their families throughout the dementia experience, offering support and guidance to give an understanding of dementia and the day-to-day challenges it may bring. The Dementia Navigators will also provide Information on preparing for the future and accessing other services within the city.

Disabled Facilities Grant (DFG) and wider services

What is your strategic approach to using housing support, including DFG funding, that supports independence at home?

Statutory Disabled Facility Grants (DFG) will continue to be delivered via the Better Care Fund which significantly contributes towards helping older and vulnerable homeowners remain in their properties; this meets one of the key aims of the BCF to prevent people from being admitted into hospital or residential care.

The Adaptations Team is still working with the effects of both COVID and Brexit with the impact on the supply chain of materials being available. They continued to work with contractors to support the service and have received firm commitments from 2 contractors for the next few months to support the service. However, the nationwide shortage of materials and labour will continue to impact Social Housing Adaptations creating some delays.

The Council has a significant population of 182,463 (Feb 2020) and as such has seen a steady increase in the demand for disabled facility grants. Traditionally disabled facility grants pay for a range of adaptations to people's homes, including Level Access Showers, Ramps, Stairlifts, and extensions to provide ground-floor bedrooms and bathrooms. However, the incorporation of the DFG within the Better Care Fund has encouraged the Council and ICB to think strategically about the use of home aids/adaptations and the use of technologies to support people in their own homes and there are plans to use DFG capital for Extra Care housing provision.

Since Cabinet approval of the "new" DFG Policy in June 2021 we have been able to utilise discretionary funds to support larger adaptations. We have enabled larger works to be approved by offering a deferred loan which will be repaid to Southend City Council when the property is sold. Many residents who may have been assessed as having a large contribution towards the work, are happy to consider this option as they desperately require major adaptations to enable them to remain living in their own home by supporting their health and wellbeing.

Our dedicated DFG lead is the Adaptations Team Manager within the Adults & Communities Department who reports both finance and activity to the BCF Management Board (terms of reference embedded on Page 2 above) which holds oversight and governance responsibility of DFG spend.

In the health and social care side of the Disabled Facilities Grant (DFG), the demand for Occupational Therapy is increasing as their assessment and intervention skills are recognised as a critical element of ensuring people receive appropriate and effective care and support. At any one time, many assessment requests received by Adult Social Care are for individuals who are seeking non-complex adaptations through the DFG.

In complex cases, Occupational Therapists may require the support of a Technical Officer to identify what adaptations are reasonable and practicable to install given the structural limitations of the property.

Designated collaboration with Social Workers is often required to assist residents through the process of having the adaptations completed, especially if they require LD or MH support.

Housing plays a large part in the adaptation service as we work with the Housing Team to enable adaptations to Social Housing tenants who may be under-occupying the property but due to ill health or age are unable to move out, so adaptations support them to remain independent.

We also work with Housing Solutions to enable older tenants to look at moving to sheltered or residential complexes so that the property can be freed up for families who are on the housing waiting list.

An opportunity has also arisen for us to share our inclusive design skills with our Strategic Housing colleagues. With our own SCC developments and those of private developers, we can ensure, where possible, that the accessible standards required by the current building regulations are applied.

Also, the Adaptations Team have developed an inclusive specification for Southend-on-Sea City Council built homes, this is updated as new ideas or products are developed. With planning applications from private developers, we ensure, not only those properties are built to current inclusive Building Standards but where possible the scheme is a mixed tenure and `not creating a “them and us” situation.

Affordable, buy or rent are developed together across the site.

Additional information (not assured)

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? (Y/N)

Y

If so, what is the amount that is allocated for these discretionary uses and how many districts use this funding?

£29,824.04

There is only one unitary authority with no districts.

Equality and health inequalities

How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include

- Changes from previous BCF plan
- How equality impacts of the local BCF plan have been considered
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Changes to local priorities related to health inequality and equality and how activities in the document will address these
- Any actions moving forward that can contribute to reducing these differences in outcomes
- How priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.

Equality and Health Inequalities

Our BCF draws together a range of strategies and policies which have, in their development been subject to an assessment of their impact upon key groups within our population. In addition, BCF is driven by national policy and legislative duties, designed to positively impact upon both the health and social care system and importantly, upon individuals' improved health, self-care, and well-being, seeking to address inequalities and improve outcomes informed by our Joint Strategic Needs Assessments.

Reduce health inequalities

We will take a place-based approach for reducing health inequalities, including mental and physical health inequalities, and life expectancy inequality across Southend-on-Sea.

The needs of Southend's residents vary significantly from area to area. The ICS 5-year strategy outlines the reduction of health inequalities as a key ambition. Building on the Southend Localities Strategy comprehensive locality profiles are emerging to help build an in-depth understanding of local needs.

Adults Social Care JSNA Summary | Adults Social Care (arcgis.com)

About Southend General | About Southend (arcgis.com)

Our independent public health report for 2021/22 reflects on our some of our local health inequalities along with the focusing on work to tackle the wider determinants of health and the growing obesity epidemic, the approach with collective endeavours is shaping the local food environment. A number of areas have been highly impacted by COVID and we must refocus as we learn to learn to live with COVID. Some of the key areas in tackling health inequalities will be led jointly by the NHS and the City Council with a determined resolve of improving healthy life expectancy whilst accelerating recovery in health and care services.

COVID-19 has impacted significantly on mental wellbeing, from people dealing with illness and bereavement, the consequences of living with restrictions, the closure of schools, workplaces and businesses.

There are a number of other areas where we need to refocus our collective approach and refresh our thinking including: obesity and the food environment, drug and alcohol misuse, loneliness and self-care, the wellbeing of some our more vulnerable groups, such as ‘inclusion health groups’ (Core20Plus5 priority groups) people who are classed as unpaid carers, people living with autism and those who are affected by homelessness.

The report provides a brief outline of the challenges that these groups face in our communities and how we are addressing some of these concerns whilst highlighting what more we can drive forward to improve their health outcomes. It is also an opportunity to consider how to deploy our efforts to review our investment approach in related services, optimise our collaboration with the community sector and continue to enable our communities to play a more active role in both designing services and empowering their self-determination.

As a collection of initiatives, there will also be a review to ensure that the cumulative effect of changes has not or does not unduly affect any one cohort of people.

ICB-funded health and inequality programmes are focused on core20plus5 and are closely aligned with the priorities as defined in the Executive Summary.

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1st April 2023 to 31st March 2025

SOUTHEND ON SEA CITY COUNCIL

and

MID and SOUTH ESSEX INTEGRATED CARE SYSTEM

FRAMEWORK PARTNERSHIP AGREEMENT RELATING TO THE COMMISSIONING OF HEALTH AND SOCIAL CARE SERVICES USING THE BETTER CARE FUND 1 APRIL 2023 - 31 MARCH 2025

Fleet Place House | 2 Fleet Place | Holborn Viaduct | London EC4M 7RF
T 0870 194 1000 F 0870 194 7800

Contents

THIS AGREEMENT is made on day of 2023

PARTIES

(1) **SOUTHEND-ON-SEA CITY COUNCIL of Civic Centre, Victoria Avenue, Southend on Sea, Essex, SS2 6ER (the "Council")**

(2) **MID AND SOUTH ESSEX INTEGRATED CARE SYSTEM of Civic Centre, Victoria Avenue, Southend on Sea, Essex, SS2 6ER (the "ICS")**

BACKGROUND

(A) The Council has responsibility for commissioning and/or providing social care services on behalf of the population of the borough of Southend on Sea.

(B) The ICS has the responsibility for commissioning health services pursuant to the 2006 Act in the borough of Southend on Sea.

(C) The Better Care Fund has been established by the Government to provide funds to local areas to support the integration of health and social care and to seek to achieve the National Conditions and Local Objectives. It is a requirement of the Better Care Fund that the ICS and the Council establish a pooled fund for this purpose.

(D) Section 75 of the 2006 Act gives powers to local authorities and clinical commissioning groups to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions.

(E) The purpose of this Agreement is to set out the terms on which the Partners have agreed to collaborate and to establish a framework through which the Partners can secure the future position of health and social care services through lead or joint commissioning arrangements. It is also means through which the Partners will pool funds and align budgets as agreed between the Partners.

(F) The aims and benefits of the Partners in entering into this Agreement are to:

a) improve the quality and efficiency of the Services,

b) meet the National Conditions and Local Objectives,

c) make more effective use of resources through the establishment and maintenance of a pooled fund for revenue expenditure on the Services,

for the benefit of the population of Southend on Sea.

(G) The Partners are entering into this Agreement in exercise of the powers referred to in Section 75 of the 2006 Act and/or Section 13Z(2) and 14Z(3) of the 2006 Act as applicable, to the extent that exercise of these powers is required for this Agreement.

1 DEFINED TERMS AND INTERPRETATION[1]

1.1 In this Agreement, save where the context requires otherwise, the following words, terms and expressions shall have the following meanings:

1998 Act means the Data Protection Act 1998.

2000 Act means the Freedom of Information Act 2000.

2004 Regulations means the Environmental Information Regulations 2004.

2006 Act means the National Health Service Act 2006.

Affected Partner means, in the context of Clause 23, the Partner whose obligations under the Agreement have been affected by the occurrence of a Force Majeure Event

Agreement means this agreement including its Schedules and Appendices.

Annual Report means the annual report produced by the Partners in accordance with Clause 20 (Review)

Approved Expenditure means any expenditure approved by the Partners in writing or as set out in the Scheme Specification in relation to an Individual Service above any Contract Price, Permitted Expenditure or agreed Third Party Costs.

Authorised Officers means an officer of each Partner appointed to be that Partner's representative for the purpose of this Agreement.

BCF Quarterly Report means the quarterly report produced by the Partners and provided to the Health and Wellbeing Board

BCF 2023 Agreement means the agreement between the Parties in respect of the Better Care Fund for the period commencing 1 April 2023

Better Care Fund means the Better Care Fund as described in NHS England Publications Gateway Ref. No.00314 and NHS England Publications Gateway Ref. No.00535 as relevant to the Partners.

Better Care Fund Plan means the plan agreed by the Partners for the relevant Financial Year setting out the Partners plan for the use of the Better Care Fund [as attached as Schedule 6].

Better Care Fund Requirements means any and all requirements on the ICS and Council in relation to the Better Care Fund set out in Law and guidance published by the Department of Health.

ICS Statutory Duties means the Duties of the ICS pursuant to Sections 14P to 14Z2 of the 2006 Act

Change in Law means the coming into effect or repeal (without re-enactment or consolidation) in England of any Law, or any amendment or variation to any Law, or any judgment of a relevant court of law which changes binding precedent in England after the Commencement Date

Commencement Date means 00:01 hrs on 1 April 2023.

Confidential Information means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement and the Services and:

(a) which comprises Personal Data or Sensitive Personal Data or which relates to any patient or his treatment or medical history;

[1] Definitions should be finalised once main body of Agreement is finalised.

(b) the release of which is likely to prejudice the commercial interests of a Partner or the interests of a Service User respectively; or

(c) which is a trade secret.

Contract Price means any sum payable under a Services Contract as consideration for the provision of goods, equipment, or services as required as part of the Services and which, for the avoidance of doubt, does not include any Default Liability.

Default Liability means any sum which is agreed or determined by Law or in accordance with the terms of a Services Contract to be payable by any Partner(s) as a consequence of (i) breach by any or all of the Partners of an obligation(s) in whole or in part) under a Services Contract or (ii) any act or omission of a third party for which any or all of the Partners are, under the terms of the relevant Services Contract.[2]

Financial Contributions means the financial contributions made by each Partner to a Pooled Fund in any Financial Year.

Financial Year means each financial year running from 1 April in any year to 31 March in the following calendar year.

Force Majeure Event means one or more of the following:

(a) war, civil war (whether declared or undeclared), riot or armed conflict;

(b) acts of terrorism;

(c) acts of God;

(d) fire or flood;

(e) industrial action;

(f) prevention from or hindrance in obtaining raw materials, energy or other supplies;

(g) any form of contamination or virus outbreak; and

(h) any other event,

in each case where such event is beyond the reasonable control of the Partner claiming relief

Functions means the NHS Functions and the Health-Related Functions

Health Related Functions means those of the health-related functions of the Council, specified in Regulation 6 of the Regulations as relevant to the commissioning of the Services and which may be further described in the relevant Scheme Specification.[3]

Host Partner means for each Pooled Fund the Partner that will host the Pooled Fund and for any Non-Pooled Fund the Partner that will host the Non-Pooled Fund

Health and Wellbeing Board means the Health and Wellbeing Board established by the Council pursuant to Section 194 of the Health and Social Care Act 2012.

Indirect Losses means loss of profits, loss of use, loss of production, increased operating costs, loss of business, loss of business opportunity, loss of reputation or goodwill or any other consequential or indirect loss of any nature, whether arising in tort or on any other basis.

Individual Scheme means one of the schemes which has been agreed by the Partners to be included within this Agreement using the powers under Section 75 as documented in a Scheme Specification.

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2 Default Liability are costs incurred by a lead partner as a result of that Partner breaching a contract. Will the Lead Partner be able to use Pooled Fund monies to cover these costs? Should this be expanded to cover other liabilities such as Judicial Review liabilities of either Partner? Further consideration will always be needed on this.

3 Here and in the definition of NHS functions the widest definition is used. This should be cut down in the relevant specification to identify the function being undertaken in the commissioning of the service.

Integrated Commissioning means arrangements by which both Partners commission Services in relation to an individual Scheme on behalf of each other in exercise of both the NHS Functions and Council Functions through integrated structures.

Joint (Aligned) Commissioning means a mechanism by which the Partners jointly commission a Service. For the avoidance of doubt, a joint (aligned) commissioning arrangement does not involve the delegation of any functions pursuant to Section 75.

Law means:

(a) any statute or proclamation or any delegated or subordinate legislation;

(b) any enforceable community right within the meaning of Section 2(1) European Communities Act 1972;

(c) any guidance, direction, or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and

(d) any judgment of a relevant court of law which is a binding precedent in England.

Lead Commissioning Arrangements means the arrangements by which one Partner commissions Services in relation to an Individual Scheme on behalf of the other Partner in exercise of both the NHS Functions and the Health-Related Functions.

Lead Partner means the Partner responsible for commissioning an Individual Service under a Scheme Specification.

Losses means all damage, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services), proceedings, demands and charges whether arising under statute, contract or at common law but excluding Indirect Losses and "Loss" shall be interpreted accordingly.

Month means a calendar month.

National Conditions mean the national conditions as set out in the National Guidance as are amended or replaced from time to time.

National Guidance means any and all guidance in relation to the Better Care Fund as issued from to time to time by NHS England, the Department of Communities and Local Government, the Department of Health, the Local Government Association either collectively or separately.

NHS Functions means those of the NHS functions listed in Regulation 5 of the Regulations as are exercisable by the ICS as are relevant to the commissioning of the Services and which may be further described in each Service Schedule.

Non-Pooled Fund means the budget detailing the financial contributions of the Partners which are not included in a Pooled Fund in respect of a particular Service as set out in the relevant Scheme Specification.

Non-Recurrent Payments means funding provided by a Partner to a Pooled Fund in addition to the Financial Contributions pursuant to arrangements agreed in accordance with Clause [8.4].

Overspend means any expenditure from a Pooled Fund in a Financial Year which exceeds the Financial Contributions for that Financial Year.

Partner means each of the ICS and the Council, and references to "**Partners**" shall be construed accordingly.

Partnership Board[4] means the partnership board responsible for review of performance and oversight of this Agreement as set out in Clause 19.2 and Schedule 2 or such other arrangements for governance as the Partners agree.

Partnership Board Quarterly Reports means the reports that the Pooled Fund Manager shall produce and provide to the Partnership Board on a Quarterly basis

Permitted Budget means in relation to a Service where the Council is the Provider, the budget that the Partners have set in relation to the Service.

Permitted Expenditure has the meaning given in Clause [7.3].

Personal Data means Personal Data as defined by the 1998 Act.

Pooled Fund means any pooled fund established and maintained by the Partners as a pooled fund in accordance with the Regulations.

Pooled Fund Manager means such officer of the Host Partner which includes a Section 113 Officer for the relevant Pooled Fund established under an Individual Scheme as is nominated by the Host Partner from time to time to manage the Pooled Fund in accordance with Clause [10].

Provider means a provider of any Services commissioned under the arrangements set out in this Agreement [including the Council where the Council is a provider of any Services].

Public Health England means the SOSH trading as Public Health England.

Quarter means each of the following periods in a Financial Year:

1 April to 30 June

1 July to 30 September

1 October to 31 December

1 January to 31 March

and "**Quarterly**" shall be interpreted accordingly.

Regulations means the means the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 No 617 (as amended).

Scheme Specification means a specification setting out the arrangements for an Individual Scheme agreed by the Partners to be commissioned under this Agreement.

Sensitive Personal Data means Sensitive Personal Data as defined in the 1998 Act.

Services means such health and social care services as agreed from time to time by the Partners as commissioned under the arrangements set out in this Agreement and more specifically defined in each Scheme Specification.

Services Contract means an agreement entered into by one or more of the Partners in exercise of its obligations under this Agreement to secure the provision of the Services in accordance with the relevant Individual Scheme.

Service Users means those individuals for whom the Partners have a responsibility to commission the Services.

SOSH means the Secretary of State for Health.

[5]

Third Party Costs means all such third-party costs (including legal and other professional fees) in respect of each Individual Scheme as a Partner reasonably and properly incurs in the proper performance of its obligations under this Agreement and as agreed by the Partnership Board.][5]

Underspend means any expenditure from the Pooled Fund in a Financial Year which is less than the aggregate value of the Financial Contributions for that Financial Year.

Working Day means 8.00am to 6.00pm on any day except Saturday, Sunday, Christmas Day, Good Friday or a day which is a bank holiday (in England) under the Banking & Financial Dealings Act 1971.

1.2 In this Agreement, all references to any statute or statutory provision shall be deemed to include references to any statute or statutory provision which amends, extends, consolidates or replaces the same and shall include any orders, regulations, codes of practice, instruments or other subordinate legislation made thereunder and any conditions attaching thereto. Where relevant, references to English statutes and statutory provisions shall be construed as references also to equivalent statutes, statutory provisions and rules of law in other jurisdictions.

1.3 Any headings to Clauses, together with the front cover and the index are for convenience only and shall not affect the meaning of this Agreement. Unless the contrary is stated, references to Clauses and Schedules shall mean the clauses and schedules of this Agreement.

1.4 Any reference to the Partners shall include their respective statutory successors, employees and agents.

1.5 In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

1.6 Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

1.7 In this Agreement, words importing any particular gender include all other genders, and the term "person" includes any individual, partnership, firm, trust, body corporate, government, governmental body, trust, agency, unincorporated body of persons or association and a reference to a person includes a reference to that person's successors and permitted assigns.

1.8 In this Agreement, words importing the singular only shall include the plural and vice versa.

1.9 In this Agreement, "staff" and "employees" shall have the same meaning and shall include reference to any full or part time employee or officer, director, manager, and agent.

1.10 Subject to the contrary being stated expressly or implied from the context in these terms and conditions, all communication between the Partners shall be in writing.

1.11 Unless expressly stated otherwise, all monetary amounts are expressed in pounds sterling but in the event that pound's sterling is replaced as legal tender in the United Kingdom by a different currency then all monetary amounts shall be converted into such other currency at the rate prevailing on the date such other currency first became legal tender in the United Kingdom.

1.12 All references to the Agreement include (subject to all relevant approvals) a reference to the Agreement as amended, supplemented, substituted, novated or assigned from time to time.

2 TERM

2.1 This Agreement shall come into force on the Commencement Date

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5 For discussion between the Parties. These are costs incurred by a Lead Partner such as legal fees and any other professional fees that have to be paid to a third party. The Parties should consider whether any third party costs can be paid for using Pooled Funds. For discussion between the Parties. The current drafting provides that these can be charged where it is agreed specifically in a Service Specification or with prior agreement of both parties.

2.2 This Agreement shall continue until it is terminated in accordance with Clause [21]

2.3 The duration of the arrangements for each Individual Scheme shall be as set out in the relevant Scheme Specification or if not set out, for the duration of this Agreement unless terminated earlier by the Partners.

2.4 This Agreement supersedes the BCF 2015 Agreement without prejudice to the rights and liabilities of the Partners under the BCF 2015 Agreement.

3 GENERAL PRINCIPLES[6]

3.1 Nothing in this Agreement shall affect:

3.1.1 the liabilities of the Partners to each other or to any third parties for the exercise of their respective functions and obligations (including the Functions); or

3.1.2 any power or duty to recover charges for the provision of any services (including the Services) in the exercise of any local authority function.

3.2 The Partners agree to:

3.2.1 treat each other with respect and an equality of esteem;

3.2.2 be open with information about the performance and financial status of each; and

3.2.3 provide early information and notice about relevant problems.

3.3 For the avoidance of doubt, the aims and outcomes relating to an Individual Scheme may be set out in the relevant Scheme specification.

4 PARTNERSHIP FLEXIBILITIES

4.1 This Agreement sets out the mechanism through which the Partners will work together to commission services. This may include one or more of the following commissioning mechanisms:

4.1.1 Lead Commissioning Arrangements;

4.1.2 Integrated Commissioning;

4.1.3 Joint (Aligned) Commissioning

4.1.4 the establishment of one or more Pooled Funds

in relation to Individual Schemes (the "Flexibilities")

4.2 Where there is Lead Commissioning Arrangements and the ICS is Lead Partner the Council delegates to the ICS and the ICS agrees to exercise, on the Council's behalf, the Health-Related Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the NHS Functions.

4.3 Where there is Lead Commissioning Arrangements and the Council is Lead Partner, the ICS delegates to the Council and the Council agrees to exercise on the ICS's behalf the NHS Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the Health-Related Functions.

4.4 Where the powers of a Partner to delegate any of its statutory powers or functions are restricted, such limitations will automatically be deemed to apply to the relevant Scheme Specification and the Partners

[7]

shall agree arrangements designed to achieve the greatest degree of delegation to the other Partner necessary for the purposes of this Agreement which is consistent with the statutory constraints.[7]

4.5 [At the Commencement Date the Partners agree that the following shall be in place:

4.5.1 The following Individual Schemes with Lead Commissioning with Council as Lead Partner:

(a) Intermediate Care Beds (Brook Meadows)

(b) Carers Contract

(c) Dementia Support

(d) Single Point of Access

(e) Hospital Team

(f) Active Recovery

(g) Home Care

(h) Reablement

(i) Residential Care

4.5.2 The following Individual Schemes with Lead Commissioning with ICB as Lead Partner:

Community Service Lines

a) Integrated Community Teams
b) Southend Enhanced Discharge Service (SEDs)
c) Collaborative Care Team
d) SPOR (Health Element)
e) Stroke (Community Service)
f) Pressure Relieving Equipment
g) Continence
h) Rosedale Therapy Input
i) Occupational Therapy
j) SWIFT/UCRT Original
k) Older People Community Mental Health Teams (inc. Assessment Service)
l) Dementia Intensive Support Team
m) Older People Day Care (Mental Health)
n) Reablement Beds
o) Havens Hospice Grant
p) Carers

FUNCTIONS

[8]

4.6 The purpose of this Agreement is to establish a framework through which the Partners can secure the provision of health and social care services in accordance with the terms of this Agreement.

4.7 This Agreement shall include such Functions as shall be agreed from time to time by the Partners as are necessary to commission the Services in accordance with their obligations under this Agreement.

4.8 The Scheme Specifications for the Individual Schemes included as part of this Agreement at the Commencement Date are set out in Schedule 1 Part 2.

4.9 Where the Partners add a new Individual Scheme to this Agreement a Scheme Specification for each Individual Scheme shall be completed and approved by each Partner [in accordance with the variation procedure set out in Clause 30 (Variations)]. Each new Scheme Specification shall be substantially in the form set out in Schedule 1 Part 1.

4.10 The Partners shall not enter into a Scheme Specification in respect of an Individual Scheme unless they are satisfied that the Individual Scheme in question will improve health and well-being in accordance with this Agreement.

4.11 The introduction of any Individual Scheme will be subject to business case approval by the [Partnership Board][8] [in accordance with the variation procedure set out in Clause 29 (Variations)].

5 COMMISSIONING ARRANGEMENTS

General

5.1 The Partners shall comply with the commissioning arrangements as set out in the relevant Scheme Specification

5.2 The Partnership Board will report back to the Health and Wellbeing Board as required by its Terms of Reference.

5.3 The Partners shall comply with all relevant legal duties and guidance of both Partners in relation to the Services being commissioned.

5.4 Each Partner shall keep the other Partner and the Partnership Board regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in a Pooled Fund or Non-Pooled Fund.

5.5 Where there are Integrated Commissioning or Lead Commissioning Arrangements in respect of an Individual Scheme then prior to any new Services Contract being entered into the Partners shall agree in writing:

5.5.1 how the liability under each Services Contract shall be apportioned in the event of termination of the relevant Individual Scheme; and

5.5.2 whether the Services Contract should give rights to third parties (and in particular if a Partner is not a party to the Services Contract to that Partner, the Partners shall consider whether or not the Partner that is not to be a party to the Services Contract should be afforded any rights to enforce any terms of the Services Contract under the Contracts (Rights of Third Parties) Act 1999 and if it is agreed that such rights should be afforded the Partner entering the Services Contract shall ensure as far as is reasonably possible that such rights that have been agreed are included in the Services Contract and shall establish how liability under the Services Contract shall be apportioned in the event of termination of the relevant Individual Scheme.

5.6 The Partners shall comply with the arrangements in respect of Joint (Aligned) Commissioning as set out in the relevant Scheme Specification, which shall include where applicable arrangements in respect of the Services Contracts.

Integrated Commissioning

5.7 Where there are Integrated Commissioning arrangements in respect of an Individual Scheme:

5.7.1 the Partners shall work in cooperation and shall endeavour to ensure that Services in fulfilment of the NHS Functions and Health Related Functions are commissioned with all due skill, care and attention.

5.7.2 Both Partners shall work in cooperation and endeavour to ensure that the relevant Services as set out in each Scheme Specification are commissioned within each Partners Financial Contribution in respect of that particular Service in each Financial Year.

Appointment of a Lead Partner

5.8 Where there are Lead Commissioning Arrangements in respect of an Individual Scheme the Lead Partner shall:

5.8.1 exercise the NHS Functions in conjunction with the Health-Related Functions as identified in the relevant Scheme Specification;

5.8.2 endeavour to ensure that the NHS Functions and the Health-Related Functions are funded within the parameters of the Financial Contributions of each Partner in relation to each particular Service in each Financial Year.

5.8.3 commission Services for individuals who meet the eligibility criteria set out in the relevant Scheme Specification;

5.8.4 contract with Provider(s) for the provision of the Services on terms agreed with the other Partner;

5.8.5 comply with all relevant legal duties and guidance of both Partners in relation to the Services being commissioned;

5.8.6 where Services are commissioned using the NHS Standard Form Contract, perform the obligations of the "Commissioner" and "Co-ordinating Commissioner" with all due skill, care and attention and where Services are commissioned using any other form of contract to perform its obligations with all due skill and attention;

[9]undertake performance management and contract monitoring of all Service Contracts including (without limitation) the use of contract notices where Services fail to deliver contracted requirements;[10]

5.8.7 make payment of all sums due to a Provider pursuant to the terms of any Services Contract; and

5.8.8 keep the other Partner and Partnership Board regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in a Pooled Fund or Non-Pooled Fund.

6 ESTABLISHMENT OF A POOLED FUND

6.1 In exercise of their respective powers under Section 75 of the 2006 Act, the Partners have agreed to establish and maintain such pooled funds for revenue expenditure as agreed by the Partners as set out in the Service Specifications. At the Commencement Date there shall be a single Pooled Fund in respect of this Agreement

6.2 Each Pooled Fund shall be managed and maintained in accordance with the terms of this Agreement.

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[10]

6.3 Subject to Clause 6.4, it is agreed that the monies held in a Pooled Fund may only be expended on the following:

6.3.1 the Contract Price;

6.3.2 where the Council is to be the Provider, the Permitted Budget;

6.3.3 Third Party Costs where these are set out in the relevant Scheme Specification or as otherwise agreed in advance in writing by the Partnership Board

6.3.4 Approved Expenditure as set out in the relevant Scheme Specification or as otherwise agreed in advance in writing by the Partnership Board

("Permitted Expenditure")

6.4 The Partners may only depart from the definition of Permitted Expenditure to include or exclude other revenue expenditure with the express written agreement of each Partner.

6.5 For the avoidance of doubt, monies held in the Pooled Fund may not be expended on Default Liabilities unless this is agreed by all Partners in accordance with Clause 6.4.

6.6 Pursuant to this Agreement, the Partners agree to appoint a Host Partner for each of the Pooled Funds set out in the Scheme Specifications. The Host Partner shall be the Partner responsible for:

6.6.1 holding all monies contributed to the Pooled Fund on behalf of itself and the other Partners;

6.6.2 providing the financial administrative systems for the Pooled Fund; and

6.6.3 appointing the Pooled Fund Manager;

6.6.4 ensuring that the Pooled Fund Manager complies with its obligations under this Agreement.

7 POOLED FUND MANAGEMENT – NB NOT CURRENTLY IN USE

7.1 When introducing a Pooled Fund, the Partners shall agree:

7.1.1 which of the Partners shall act as Host Partner for the purposes of Regulations 7(4) and 7(5) and shall provide the financial administrative systems for the Pooled Fund;

7.1.2 which officer of the Host Partner shall act as the Pooled Fund Manager for the purposes of Regulation 7(4) of the Regulations.

7.2 The Pooled Fund Manager for each Pooled Fund shall have the following duties and responsibilities:

7.2.1 the day-to-day operation and management of the Pooled Fund;

7.2.2 ensuring that all expenditure from the Pooled Fund is in accordance with the provisions of this Agreement and the relevant Scheme Specification;

7.2.3 maintaining an overview of all joint financial issues affecting the Partners in relation to the Services and the Pooled Fund;

7.2.4 ensuring that full and proper records for accounting purposes are kept in respect of the Pooled Fund;

7.2.5 reporting to the Partnership Board as required by this Agreement and by the Partnership Board;

7.2.6 ensuring action is taken to manage any projected under or overspends relating to the Pooled Fund in accordance with this Agreement;

7.2.7 preparing and submitting to the Partnership Board Quarterly Reports (or more frequent reports if required by the Partnership Board) and an annual return about the income and expenditure from the Pooled Fund together with such other information as may be required by the Partners and the Partnership Board to monitor the effectiveness of the Pooled Fund and to enable the Partners to complete their own financial accounts and returns. The Partners agree to provide all necessary information to the Pooled Fund Manager in time for the reporting requirements to be met including (without limitation) comply with any reporting requirements as may be required by relevant National Guidance;

7.2.8 preparing and submitting reports to the Health and Wellbeing Board as may be required by it and any relevant National Guidance including (without limitation) supplying Quarterly Reports referred to in Clause 8.2.7 above to the Health and Wellbeing Board.

7.3 In carrying out their responsibilities as provided under Clause 8.2, the Pooled Fund Manager shall:

7.3.1 have regard to National Guidance and the recommendations of the Partnership Board; and

7.3.2 be accountable to the Partners for delivery of those responsibilities.

7.4 The Partnership Board may agree to the viring of funds between Pooled Funds or amending the allocation of the Pooled Fund between Individual Schemes.

8 NON-POOLED FUNDS

8.1 Any Financial Contributions agreed to be held within a Non-Pooled Fund will be notionally held in a fund established solely for the purposes agreed by the Partners. For the avoidance of doubt, a Non-Pooled Fund does not constitute a pooled fund for the purposes of Regulation 7 of the Partnership Regulations.

8.2 When introducing a Non-Pooled Fund in respect of an Individual Scheme, the Partners shall agree:

8.2.1 which Partner if any[11] shall host the Non-Pooled Fund

8.2.2 how and when Financial Contributions shall be made to the Non-Pooled Fund.

8.3 The Host Partner will be responsible for establishing the financial and administrative support necessary to enable the effective and efficient management of the Non-Pooled Fund, meeting all required accounting and auditing obligations.

8.4 [Both Partners shall ensure that any Services commissioned using a Non-Pooled Fund are commissioned solely in accordance with the relevant Scheme Specification]

8.5 Where there are Joint (Aligned) Commissioning arrangements, both Partners shall work in cooperation and shall endeavour to ensure that:

8.5.1 the NHS Functions funded from a Non-Pooled Fund are carried out within the ICS Financial Contribution to the Non- Pooled Fund for the relevant Service in each Financial Year; and

8.5.2 the Health-Related Functions funded from a Non-Pooled Fund are carried out within the Council's Financial Contribution to the Non-Pooled Fund for the relevant Service in each Financial Year.

9 FINANCIAL CONTRIBUTIONS

9.1 The Financial Contribution of the ICS and the Council to any Pooled Fund or Non-Pooled Fund for the first Financial Year of operation shall be as set out in Schedule 3.

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[12]

9.2 The Financial Contribution of the ICS and the Council to any Pooled Fund or Non-Pooled Fund for each subsequent Financial Year of operation shall be subject to review by the Partners and in line with national guidance.

9.3 Financial contributions in each financial year shall be paid to the fund in twelve [insert alternative proposal based on previous arrangements] equal instalments receivable on the 5th working day of the month commencing April 2023.

9.4 With the exception of Clause [13], no provision of this Agreement shall preclude the Partners from making additional contributions of Non-Recurrent Payments to a Pooled Fund from time to time by mutual agreement. Any such additional contributions of Non-Recurrent Payments shall be explicitly recorded in Partnership Board minutes and recorded in the budget statement as a separate item.

10 NON-FINANCIAL CONTRIBUTIONS

10.1 Unless set out in a Scheme Specification or otherwise agreed by the Partners, each Partner shall provide the non-financial contributions for any Service that they are Lead Partner or as required in order to comply with its obligations under this Agreement in respect of the commissioning of a particular Service. These contributions shall be provided at no charge to the other Partners or to the Pooled Fund.

10.2 Each Scheme Specification shall set out non-financial contributions of each Partner including staff (including the Pooled Fund Manager), premises, IT support and other non-financial resources necessary to perform its obligations pursuant to this Agreement (including, but not limited to, management of Services Contracts and the Pooled Fund).

11 RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPENDS

Risk share arrangements

11.1 The Partners have agreed risk share arrangements as set out in Schedule 3, which provide for risk share arrangements arising within the commissioning of services from the Pooled Funds as set out in National Guidance.

Overspends in Pooled Fund

11.2 Subject to Clause 12.1, the Host Partner for the relevant Pooled Fund shall manage expenditure from a Pooled Fund within the Financial Contributions and shall use reasonable endeavours to ensure that the expenditure is limited to Permitted Expenditure.

11.3 The Host Partner shall not be in breach of its obligations under this Agreement if an Overspend occurs PROVIDED THAT it has used reasonable endeavours to ensure that the only expenditure from a Pooled Fund has been in accordance with Permitted Expenditure and it has informed the Partnership Board in accordance with Clause 12.4.

11.4 In the event that the Pooled Fund Manager identifies an actual or projected Overspend the Pooled Fund Manager must ensure that the Partnership Board is informed as soon as reasonably possible and the provisions of the relevant Scheme Specification and Schedule [3] shall apply.

Overspends in Non-Pooled Funds

11.5 Where in Joint (Aligned) Commissioning Arrangements either Partner forecasts an Overspend in relation to a Partners Financial Contribution to a Non-Pooled Fund that Partner shall as soon as reasonably practicable inform the other Partner and the Partnership Board.

11.6 Where there is a Lead Commissioning Arrangement the Lead Partner is responsible for the management of the Non-Pooled Fund. The Lead Partner shall as soon as reasonably practicable inform the other Partner [and the Partnership Board].

Underspend

11.7 In the event that expenditure from any Pooled Fund or Non Pooled Fund in any Financial Year is less than the aggregate value of the Financial Contributions made for that Financial Year or where the expenditure in relation to an Individual Scheme is less than the agreed allocation to that particular Individual Scheme the Partners shall agree how the monies shall be spent, carried forward and/or returned to the Partners and the provisions of Schedule 3 shall apply. Such arrangements shall be subject to the Law and the Standing Orders and Standing Financial Instructions (or equivalent) of the Partners.

12 CAPITAL EXPENDITURE

12.1 Except as provided in Clause 12.2, neither Pooled Funds nor Non-Pooled Funds shall normally be applied towards any one-off expenditure on goods and/or services, which will provide continuing benefit and would historically have been funded from the capital budgets of one of the Partners. If a need for capital expenditure is identified this must be agreed by the Partners.

12.2 The Partners agree that capital expenditure may be made from Pooled Funds where this is in accordance with National Guidance.

13 VAT

The Partners shall agree the treatment of each Pooled Fund for VAT purposes in accordance with any relevant guidance from HM Customs and Excise.

14 AUDIT AND RIGHT OF ACCESS

14.1 All Partners shall promote a culture of probity and sound financial discipline and control. The Host Partner shall arrange for the audit of the accounts of the relevant Pooled Fund and shall require the appropriate person or body appointed to exercise the functions of the Audit Commission under section 28(1)(d) of the Audit Commission Act 1998, by virtue of an order made under section 49(5) of the Local Audit and Accountability Act 2014 to make arrangements to certify an annual return of those accounts under Section 28(1) of the Audit Commission Act 1998.

14.2 All internal and external auditors and all other persons authorised by the Partners will be given the right of access by them to any document, information or explanation they require from any employee, member of the relevant Partner in order to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

14.3 The Partners shall comply with relevant NHS finance and accounting obligations as required by relevant Law and/or National Guidance.

15 LIABILITIES AND INSURANCE AND INDEMNITY

15.1 [Subject to Clause 16.2, and 16.3, if a Partner (“First Partner”) incurs a Loss arising out of or in connection with this Agreement (including a Loos arising under an Individual Scheme) as a consequence of any act or omission of another Partner (“Other Partner”) which constitutes negligence, fraud or a breach of contract in relation to this Agreement or any Services Contract then the Other Partner shall be liable to the First Partner for that Loss and shall indemnify the First Partner accordingly.

15.2 Clause 16.1 shall only apply to the extent that the acts or omissions of the Other Partner contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Partner acting in accordance with the instructions or requests of the First Partner or the Partnership Board.

15.3 If any third party makes a claim or intimates an intention to make a claim against either Partner, which may reasonably be considered as likely to give rise to liability under this Clause 16. the Partner that may claim against the other indemnifying Partner will:

15.3.1 as soon as reasonably practicable give written notice of that matter to the Other Partner specifying in reasonable detail the nature of the relevant claim;

15.3.2 not make any admission of liability, agreement or compromise in relation to the relevant claim without the prior written consent of the Other Partner (such consent not to be unreasonably conditioned, withheld or delayed);

15.3.3 give the Other Partner and its professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts, documents and records within its power or control so as to enable the Indemnifying Partner and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant claim.

15.4 Each Partner shall ensure that they maintain policies of insurance (or equivalent arrangements through schemes operated by the National Health Service Litigation Authority) in respect of all potential liabilities arising from this Agreement and in the event of Losses shall seek to recover such Loss through the relevant policy of insurance (or equivalent arrangement).

15.5 Each Partner shall at all times take all reasonable steps to minimise and mitigate any loss for which one party is entitled to bring a claim against the other pursuant to this Agreement.

Conduct of Claims

15.6 In respect of the indemnities given in this Clause 15:

15.6.1 the indemnified Partner shall give written notice to the indemnifying Partner as soon as is practicable of the details of any claim or proceedings brought or threatened against it in respect of which a claim will or may be made under the relevant indemnity;

15.6.2 the indemnifying Partner shall at its own expense have the exclusive right to defend conduct and/or settle all claims and proceedings to the extent that such claims or proceedings may be covered by the relevant indemnity provided that where there is an impact upon the indemnified Partner, the indemnifying Partner shall consult with the indemnified Partner about the conduct and/or settlement of such claims and proceedings and shall at all times keep the indemnified Partner informed of all material matters.

15.6.3 the indemnifying and indemnified Partners shall each give to the other all such cooperation as may reasonably be required in connection with any threatened or actual claim or proceedings which are or may be covered by a relevant indemnity.

16 STANDARDS OF CONDUCT AND SERVICE

16.1 The Partners will at all times comply with Law and ensure good corporate governance in respect of each Partner (including the Partners respective Standing Orders and Standing Financial Instructions).

16.2 The Council is subject to the duty of Best Value under the Local Government Act 1999. This Agreement and the operation of the Pooled Fund is therefore subject to the Council's obligations for Best Value and the other Partners will co-operate with all reasonable requests from the Council which the Council considers necessary in order to fulfil its Best Value obligations.

16.3 The ICS is subject to the ICS Statutory Duties and these incorporate a duty of clinical governance, which is a framework through which they are accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This Agreement and the operation of the Pooled Funds are therefore subject to ensuring compliance with the ICS Statutory Duties and clinical governance obligations.

16.4 The Partners are committed to an approach to equality and equal opportunities as represented in their respective policies. The Partners will maintain and develop these policies as applied to service provision, with the aim of developing a joint strategy for all elements of the service.

17 CONFLICTS OF INTEREST

17.1 The Partners shall comply with the policy for identifying and managing conflicts of interest as agreed by the Partners from time to time.

18 GOVERNANCE

18.1 Overall strategic oversight of partnership working between the Partners is vested in the Health and Well Being Board, which for these purposes shall make recommendations to the Partners as to any action it considers necessary.

18.2 The Partners have established a Partnership Board- to be known as the “Southend Better Care Fund Management Group” to

19.2.1 Approve commencement of new activity

19.2.2 Approve roles and responsibilities

19.2.3 Delegate assurance roles

19.2.4 Review definition documents

19.2.5 Agree scope extensions to existing activities

19.2.6 Agree addition of projects

19.2.7 Act as an escalation point for any issues that cannot be resolved at the project or work stream level

19.2.8 Monitoring and programme finances

19.2.9 Ensuring progress against significant milestones and strategic objectives

19.2.10 Approving any required changes

19.2.11 Monitoring any significant risks and issues

19.2.12 Agree communications

19.2.13 Agree project closures and benefit reports

The Partnership Board is based on a joint working group structure. Each member of the Partnership Board shall be an officer of one of the Partners and will have individual delegated responsibility from the Partner employing them to make decisions which enable the Partnership Board to carry out its objects, roles, duties and functions as set out in this Clause 19 and Schedule 2.

18.3 The terms of reference of the Partnership Board shall be as set out in Schedule [2] as may be amended or varied by written agreed from time to time.

18.4 Each Partner shall nominate an overall BCF Lead. For Southend on Sea Borough Council this is Taslima Qureshi, Head of Strategic Commissioning and for Southend ICS this is Hugh Johnston, Interim Head of Transformation.

18.5 Each Partner has secured internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

18.6 The Partnership Board shall be responsible for the overall approval of the Individual Schemes and the financial management set out in Clause 12 and Schedule 3.

18.7 The Health and Wellbeing Board shall be responsible for ensuring compliance with the Better Care Fund Plan and the strategic direction of the Better Care Fund.

18.8 Each Scheme Specification shall confirm the governance arrangements in respect of the Individual Scheme and how that Individual Scheme is reported to the Partnership Board and Health and Wellbeing Board.

19 REVIEW

19.1 The Partners shall produce a BCF Quarterly Report which shall be provided to the Health and Wellbeing Board in such form and setting out such information as required by National Guidance and any additional information required by the Health and Wellbeing Board or National Commissioning Board

19.2 Save where the Partnership Board agree alternative arrangements (including alternative frequencies) the Partners shall undertake an annual review ("**Annual Review**") of the operation of this Agreement, any [Pooled Fund and Non-Pooled Fund] and the provision of the Services within 3 Months of the end of each Financial Year.

19.3 Subject to any variations to this process required by the Partnership Board, Annual Reviews shall be conducted in good faith.

19.4 The Partners shall within 20 Working Days of the annual review prepare an Annual Report including the information as required by National Guidance and any other information required by the Health and Wellbeing Board. A copy of this report shall be provided to the Health and Wellbeing Board and Partnership Board.

19.5 In the event that the Partners fail to meet the requirements of the Better Care Fund Plan and NHS England the Partners shall provide full co-operation with NHS England to agree a recovery plan.

20 COMPLAINTS

The Partners' own complaints procedures shall apply to this Agreement. The Partners agree to assist one another in the management of complaints arising from this Agreement or the provision of the Services.

21 TERMINATION & DEFAULT

21.1 Unless otherwise agreed in the relevant Scheme Specification, each Individual Scheme may be terminated by either Partner giving not less than 12-Months' notice in writing or such shorter notice period agreed between the Partners provided that:

21.1.1 such termination is possible in accordance with the National Guidance and Law; and

21.1.2 that the Partners ensure that the statutory Better Care Fund Requirements continue to be met, and

for the avoidance of doubt the operation of the Agreement shall continue in respect of the remaining Individual Services.

21.2 If any Partner ("Relevant Partner") fails to meet any of its obligations under this Agreement, the other Partners (acting jointly) may by notice require the Relevant Partner to take such reasonable action within a reasonable timescale as the other Partners may specify to rectify such failure. Should the Relevant Partner fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 23.

21.3 Termination of this Agreement (whether by effluxion of time or otherwise) shall be without prejudice to the Partners' rights in respect of any antecedent breach and the provisions of Clauses 12,15,16,21,22,25,26,27,28,32,33,37 and 39[12]

21.4 In the event of termination of this Agreement, the Partners agree to cooperate to ensure an orderly wind down of their joint activities and to use their best endeavours to minimise disruption to the health and social care which is provided to the Service Users.

21.5 Upon termination of this Agreement for any reason whatsoever the following shall apply:

21.5.1 the Partners agree that they will work together and co-operate to ensure that the winding down and disaggregation of the integrated and joint activities to the separate responsibilities of the Partners is carried out smoothly and with as little disruption as possible to service users, employees, the Partners and third parties, so as to minimise costs and liabilities of each Partner in doing so;

21.5.2 where either Partner has entered into a Service Contract which continues after the termination of this Agreement, both Partners shall continue to contribute to the Contract Price in accordance with the agreed contribution for that Service prior to termination and will enter into all appropriate legal documentation required in respect of this;

21.5.3 the Lead Partner shall make reasonable endeavours to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place the Lead Partner in breach of the Service Contract) where the other Partner requests the same in writing Provided that the Lead Partner shall not be required to make any payments to the Provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment.

21.5.4 where a Service Contract held by a Lead Partner relates all or partially to services which relate to the other Partner's Functions then provided that the Service Contract allows the other Partner may request that the Lead Partner assigns the Service Contract in whole or part upon the same terms mutatis mutandis as the original contract.

21.5.5 the Partnership Board shall continue to operate for the purposes of functions associated with this Agreement for the remainder of any contracts and commitments relating to this Agreement; and

21.5.6 Termination of this Agreement shall have no effect on the liability of any rights or remedies of either Partner already accrued, prior to the date upon which such termination takes effect.

21.6 In the event of termination in relation to an Individual Scheme the provisions of Clause 22.6 shall apply mutatis mutandis in relation to the Individual Scheme (as though references as to this Agreement were to that Individual Scheme).

22 DISPUTE RESOLUTION

22.1 In the event of a dispute between the Partners arising out of this Agreement, either Partner may serve written notice of the dispute on the other Partner, setting out full details of the dispute.

22.2 The Authorised Officer shall meet in good faith as soon as possible and in any event within seven (7) days of notice of the dispute being served pursuant to Clause 22.1, at a meeting convened for the purpose of resolving the dispute.

22.3 If the dispute remains after the meeting detailed in Clause 22.2 has taken place, the Partners' respective Chief Executive and the ICS Chair or nominees shall meet in good faith as soon as possible after the relevant meeting and in any event with fourteen (14) days of the date of the meeting, for the purpose of resolving the dispute.

22.4 If the dispute remains after the meeting detailed in Clause 22.3 has taken place, then the Partners will attempt to settle such dispute by mediation in accordance with the CEDR Model Mediation Procedure or any other model mediation procedure as agreed by the Partners. To initiate a mediation, either Partner may give notice in writing (a **"Mediation Notice"**) to the other requesting mediation of the dispute and shall send a copy thereof to CEDR or an equivalent mediation organisation as agreed by the Partners asking them to nominate a mediator. The mediation shall commence within twenty (20) Working Days of the Mediation Notice being served. Neither Partner will terminate such mediation until each of them has made its opening presentation and the mediator has met each of them separately for at least one (1) hour. Thereafter, paragraph 14 of the Model Mediation Procedure will apply (or the equivalent paragraph of any other model mediation procedure agreed by the Partners). The Partners will co-operate with any person appointed as mediator, providing him with such information and other assistance as he shall require and will pay his costs as he shall determine or in the absence of such determination such costs will be shared equally.

22.5 Nothing in the procedure set out in this Clause 23 shall in any way affect either Partner's right to terminate this Agreement in accordance with any of its terms or take immediate legal action.

23 FORCE MAJEURE

23.1 Neither Partner shall be entitled to bring a claim for a breach of obligations under this Agreement by the other Partner or incur any liability to the other Partner for any losses or damages incurred by that Partner to the extent that a Force Majeure Event occurs and it is prevented from carrying out its obligations by that Force Majeure Event.

23.2 On the occurrence of a Force Majeure Event, the Affected Partner shall notify the other Partner as soon as practicable. Such notification shall include details of the Force Majeure Event, including evidence of its effect on the obligations of the Affected Partner and any action proposed to mitigate its effect.

23.3 As soon as practicable, following notification as detailed in Clause 24.2, the Partners shall consult with each other in good faith and use all best endeavours to agree appropriate terms to mitigate the effects of the Force Majeure Event and, subject to Clause 24.4, facilitate the continued performance of the Agreement.

23.4 If the Force Majeure Event continues for a period of more than [sixty (60) days], either Partner shall have the right to terminate the Agreement by giving [fourteen (14) days] written notice of termination to the other Partner. For the avoidance of doubt, no compensation shall be payable by either Partner as a direct consequence of this Agreement being terminated in accordance with this Clause.

24 CONFIDENTIALITY

24.1 In respect of any Confidential Information a Partner receives from another Partner (the "**Discloser**") and subject always to the remainder of this Clause 25, each Partner (the "**Recipient**") undertakes to keep secret and strictly confidential and shall not disclose any such Confidential Information to any third party, without the Discloser's prior written consent provided that:

24.1.1 the Recipient shall not be prevented from using any general knowledge, experience or skills which were in its possession prior to the Commencement Date; and

24.1.2 the provisions of this Clause 25 shall not apply to any Confidential Information which:

(a) is in or enters the public domain other than by breach of the Agreement or other act or omission of the Recipient; or

(b) is obtained by a third party who is lawfully authorised to disclose such information.

24.2 Nothing in this Clause 25 shall prevent the Recipient from disclosing Confidential Information where it is required to do so in fulfilment of statutory obligations or by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable Law.

24.3 Each Partner:

24.3.1 may only disclose Confidential Information to its employees and professional advisors to the extent strictly necessary for such employees to carry out their duties under the Agreement; and

24.3.2 will ensure that, where Confidential Information is disclosed in accordance with Clause 25.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 25;

24.3.3 shall not use Confidential Information other than strictly for the performance of its obligations under this Agreement.

25 FREEDOM OF INFORMATION AND ENVIRONMENTAL INFORMATION REGULATIONS

25.1 The Partners agree that they will each cooperate with each other to enable any Partner receiving a request for information under the 2000 Act or the 2004 Regulations to respond to a request promptly and within the statutory timescales. This cooperation shall include but not be limited to finding, retrieving and supplying information held, directing requests to other Partners as appropriate and responding to any requests by the Partner receiving a request for comments or other assistance.

25.2 Any and all agreements between the Partners as to confidentiality shall be subject to their duties under the 2000 Act and 2004 Regulations. No Partner shall be in breach of Clause 26 if it makes disclosures of information in accordance with the 2000 Act and/or 2004 Regulations.

26 OMBUDSMEN

The Partners will co-operate with any investigation undertaken by the Health Service Commissioner for England or the Local Government Commissioner for England (or both of them) in connection with this Agreement.

27 INFORMATION SHARING

The Partners will comply with the information governance protocol as agreed between the Partners from time to time.

28 NOTICES

28.1 Any notice to be given under this Agreement shall either be delivered personally or sent by facsimile or sent by first class post or electronic mail. The address for service of each Partner shall be as set out in Clause 29.3 or such other address as each Partner may previously have notified to the other Partner in writing. A notice shall be deemed to have been served if:

28.1.1 personally delivered, at the time of delivery;

28.1.2 sent by facsimile, at the time of transmission;

28.1.3 posted, at the expiration of forty-eight (48) hours after the envelope containing the same was delivered into the custody of the postal authorities; and

28.1.4 if sent by electronic mail, at the time of transmission and a telephone call must be made to the recipient warning the recipient that an electronic mail message has been sent to him (as evidenced by a contemporaneous note of the Partner sending the notice) and a hard

copy of such notice is also sent by first class recorded delivery post (airmail if overseas) on the same day as that on which the electronic mail is sent.

28.2 In proving such service, it shall be sufficient to prove that personal delivery was made, or that the envelope containing such notice was properly addressed and delivered into the custody of the postal authority as prepaid first class or airmail letter (as appropriate), or that the facsimile was transmitted on a tested line or that the correct transmission report was received from the facsimile machine sending the notice, or that the electronic mail was properly addressed and no message was received informing the sender that it had not been received by the recipient (as the case may be).

28.3 The address for service of notices as referred to in Clause 29.1 shall be as follows unless otherwise notified to the other Partner in writing:

28.3.1 if to the Council, addressed to the Executive Director Adults and Communities:

Tel:
Email:

and

28.3.2 if to the ICS, addressed to the ICS Director, South East Essex:

Tel:
Email:

29 VARIATION

29.1 No variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each of the Partners subject to approval by the Partnership Board as set out in this Clause.

29.2 Where the Partners agree that there will be:

29.2.1 a new Pooled Fund;

29.2.2 a new Individual Scheme; or

29.2.3 an amendment to a current Individual Scheme,

the Partnership Board shall agree the new or amended Individual Scheme and this must be signed by the Partners. A request to vary an Individual Scheme, which may include (without limitation) a change in the level of Financial Contributions or other matters set out in the relevant Scheme Specification may be made by any Partner but will require agreement from all of the Partners in accordance with the process set out in Clause 30.3. The notice period for any variation unless otherwise agreed by the Partners shall be 3 Months or in line with the notice period for variations within the associated Service Contract(s), whichever is the shortest.

29.3 The following approach shall, unless otherwise agreed, be followed by the Partnership Board:

29.3.1 on receipt of a request from one Partners to vary the Agreement including (without limitation) the introduction of a new Individual Scheme or amendments to an existing Individual Scheme, the Partnership Board will first undertake an impact assessment and identify those Service Contracts likely to be affected;

29.3.2 the Partnership Board will agree whether those Service Contracts affected by the proposed variation should continue, be varied or terminated, taking note of the Service Contract terms and conditions and ensuring that the Partners holding the Service Contract/s is not put in breach of contract; its statutory obligations or financially disadvantaged;

29.3.3 wherever possible agreement will be reached to reduce the level of funding in the Service Contract(s) in line with any reduction in budget; and

29.3.4 should this not be possible and one Partner is left financially disadvantaged as a result of holding a Service Contract for which the budget has been reduced, then the financial risk will, unless otherwise agreed, be shared equally between the Partners[13].

30 CHANGE IN LAW

30.1 The Partners shall ascertain, observe, perform and comply with all relevant Laws, and shall do and execute or cause to be done and executed all acts required to be done under or by virtue of any Laws.

30.2 On the occurrence of any Change in Law, the Partners shall agree in good faith any amendment required to this Agreement as a result of the Change in Law subject to the Partners using all reasonable endeavours to mitigate the adverse effects of such Change in Law and taking all reasonable steps to minimise any increase in costs arising from such Change in Law.

30.3 In the event of failure by the Partners to agree the relevant amendments to the Agreement (as appropriate), the Clause 22 (Dispute Resolution) shall apply.

31 WAIVER

No failure or delay by any Partner to exercise any right, power or remedy will operate as a waiver of it nor will any partial exercise preclude any further exercise of the same or of some other right to remedy.

32 SEVERANCE

If any provision of this Agreement, not being of a fundamental nature, shall be held to be illegal or unenforceable, the enforceability of the remainder of this Agreement shall not thereby be affected.

33 ASSIGNMENT AND SUB CONTRACTING

The Partners shall not subcontract, assign or transfer the whole or any part of this Agreement, without the prior written consent of the other Partners, which shall not be unreasonably withheld or delayed. This shall not apply to any assignment to a statutory successor of all or part of a Partner's statutory functions.

34 EXCLUSION OF PARTNERSHIP AND AGENCY

34.1 Nothing in this Agreement shall create or be deemed to create a partnership under the Partnership Act 1890 or the Limited Partnership Act 1907, a joint venture or the relationship of employer and employee between the Partners or render either Partner directly liable to any third party for the debts, liabilities or obligations of the other.

34.2 Except as expressly provided otherwise in this Agreement or where the context or any statutory provision otherwise necessarily requires, neither Partner will have authority to, or hold itself out as having authority to:

34.2.1 act as an agent of the other;

34.2.2 make any representations or give any warranties to third parties on behalf of or in respect of the other; or

34.2.3 bind the other in any way.

35 THIRD PARTY RIGHTS

Unless the right of enforcement is expressly provided, no third party shall have the right to pursue any right under this Contract pursuant to the Contracts (Rights of Third Parties) Act 1999 or otherwise.

36 ENTIRE AGREEMENT

36.1 The terms herein contained together with the contents of the Schedules constitute the complete agreement between the Partners with respect to the subject matter hereof and supersede all previous communications representations understandings and agreement and any representation promise or condition not incorporated herein shall not be binding on any Partner.

36.2 No agreement or understanding varying or extending or pursuant to any of the terms or provisions hereof shall be binding upon any Partner unless in writing and signed by a duly authorised officer or representative of the parties.

37 COUNTERPARTS

This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

38 GOVERNING LAW AND JURISDICTION

38.1 This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the laws of England and Wales.

38.2 Subject to Clause 23 (Dispute Resolution), the Partners irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may arises out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

IN WITNESS WHEREOF this Agreement has been executed by the Partners on the date of this Agreement

Signed for and on behalf of
SOUTHEND ON SEA CITY COUNCIL

Mark Harvey, Executive Director,
Adults & Communities

Signed for on behalf of **MID AND SOUTH ESSEX INTEGRATED CARE SYSTEM**

_____
, ICS Director
Authorised Signatory

SCHEDULE 1 – SCHEME SPECIFICATIONS

For Southend on Sea City Council, the following schemes have been approved for the period 2023-24:

Scheme Name	Description
Intermediate Care Beds (Brook Meadows)	30 short term intermediate care beds, therapy/ recovery led model of support
SED (Southend enhanced discharge) service	therapy led personal care/rehabilitation to people discharged from hospital on Pathway 1, for up to 14 days post hospital discharge
Carers contract	Unpaid carers support service providing practical and emotional support
Dementia Support	A community-based dementia support offer to support those living with dementia and their carers to live well and as independently as possible in the community.
Single Point of Access	Provision of a Single Point of Access to adult social care teams.
Hospital Team	Provision of a dedicated team to support the Discharge to Assess Policy and guidance
Active Recovery	Aligned operational teams across adult social care and health co-located in Localities of Southend and geographically aligned with the Primary Care Networks (PCNs) in Southend.
Home Care	Personal care at home to maximise independence at home
Reablement	Reablement complements the work of intermediate care services and aims to provide a short term, time limited service to support people to retain or regain their independence at times of change and transition.
Residential Care	Provision of residential care for those 65 and over

For Southend ICS, the following schemes have been agreed for 2023-24:

Scheme Name	Description
Integrated Community Teams	The provision of community-based health services
Collaborative Care Team	The provision of community-based health services
SPOR (Health Element)	The provision of community-based health services
Tissue Viability	The provision of community-based health services
Leg Ulcer	The provision of community-based health services
Stroke (Community Service)	The provision of community-based health services
Pressure Relieving Equipment	The provision of community-based health services
Continence	The provision of community-based health services
Wheelchair Services	The provision of community-based health services
Rosedale Therapy Input	The provision of community-based health services
Occupational Therapy	The provision of community-based health services
SWIFT/UCRT Original	The provision of community-based health services
Enhanced Heart Failure	The provision of community-based health services
Older People Community Mental Health Teams (inc. Assessment Service)	The provision of community-based health services
Dementia Intensive Support Team	The provision of community-based health services
Older People Day Care (Mental Health)	The provision of community-based health services
Reablement Beds	The provision of community-based health services
Havens Hospice Grant	End of Life Services
Carers	Carers services

SCHEDULE 2 – GOVERNANCE

1 Partnership Board [TO BE KNOWN AS THE SOUTHEND BCF MANAGEMENT GROUP]

1.1 The membership of the Partnership Board will be as follows:

1.1.1 ICS: Tricia D'Orsi, NHS Alliance Director, Ashley King NHS Alliance Finance Director, Caroline McCarron, Deputy NHS Alliance Director

or a deputy to be notified to the other members in advance of any meeting;

1.1.2 the Council: Mark Harvey (Executive Director, Adults and Communities), Jeremy Budd (Director Commissioning), Joe Chesterton (Executive Director Finance and Resources)

or a deputy to be notified in writing to Chair in advance of any meeting;

1.1.3 other organisations by invitation.

2 Role of Partnership Board

3 The Partnership Board shall provide:

3.1.1 Direction:

- Make recommendations to support delivery of the programme (eg: changes to the plans, schemes or budget)
- Provide a solution planning forum for barriers to delivery
- Approval of project and work-stream proposals and initiatives
- Oversee and direct the work of the programme on behalf of SBC and SICS.

3.1.2 Assurance:

- Report on programme activity, including a quarterly report including direct reporting to the Health and Wellbeing Board
- Manage risks, issues and dependencies
- Evaluation of outcomes and associated decisions.

3.1.3 Communication:

- Stakeholder engagement and management including assisting the programme to achieve a high profile within the local area and wider community.

3.1.4 Sustainability:

- Ensure that there is a sustainable approach beyond the life of the programme, including decommissioning of projects and/or transitioning activity to "business as usual" when funding decreases.

4 Partnership Board Support

The Partnership Board will be supported by officers from the Partners from time to time.

5 Meetings

5.1 The Partnership Board will meet monthly at a time to be agreed.

5.1.1 The meeting will be quorate when there are:

5.1.2 Two (2) voting members from the ICS: or a deputy of either to be notified to the Council in advance of any meeting; and

5.1.3 Two (2) voting members from the Council or a deputy of either to be notified in writing to the ICS in advance of any meeting.

5.1.4 Each party to the BCF section 75 (SICS and SBC) shall have 3 voting members. Deputies for voting members may be notified in advance of the meeting. The appointed BCF officer for each party shall not be a voting member.

5.2 Decisions of the Partnership Board shall be made unanimously. Where unanimity is not reached then the item in question will in the first instance be referred to the next meeting of the Partnership Board. If no unanimity is reached on the second occasion it is discussed then the matter shall be dealt with in accordance with the dispute resolution procedure set out in the Agreement.

5.3 Where a Partner is not present and has not given prior written notification of its intended position on a matter to be discussed, then those present may not make or record commitments on behalf of that Partner in any way.

5.4 Minutes of all decisions shall be kept and copied to the Authorised Officers within [seven (7)] days of every meeting. Minutes of the BCF Management Group will be a matter of public record and will be shared with the Southend Health and Wellbeing Board.

6 Delegated Authority

6.1 The BCF Management Group is authorised within the limit of delegated Authority for its members (which is received through their respective organisation's own standing orders and financial scheme of delegation).

7 Information and Reports

Each Pooled Fund Manager shall supply to the Partnership Board on a Quarterly basis the financial and activity information as required under the Agreement.

8 Post-termination

The Partnership Board shall continue to operate in accordance with this Schedule following any termination of this Agreement but shall endeavour to ensure that the benefits of any contracts are received by the Partners in the same proportions as their respective contributions at that time.

SCHEDULE 3 – FINANCIAL ARRANGEMENTS, RISK SHARE AND OVERSPENDS

1 Unless the context otherwise requires, the defined terms used in this Schedule shall have the same meanings as set out in Clause 1 of the main body of Agreement.

2 Subject to any contrary provision in the relevant Scheme Specification, the Parties agree that Overspends or Underspends shall be managed in accordance with this Schedule 3.

Financial Contributions

3 Financial contributions in each financial year shall be paid to the fund in twelve equal instalments receivable on the 5th working day of the month commencing April 2023.

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2
DFG	£1,721,065	£1,721,065	£1,721,065	£1,721,065
Minimum NHS Contribution	£15,977,498	£16,881,824	£15,977,498	£16,881,824
iBCF	£7,797,498	£7,797,498	£7,797,498	£7,797,498
Additional LA Contribution	£368,848	£0	£368,848	£0
Additional ICB Contribution	£0	£0	£0	£0
Local Authority Discharge Funding	£1,093,197	£1,821,922	£1,093,197	£1,821,922
ICB Discharge Funding	£1,198,780	£1,666,320	£1,198,780	£1,666,320
Total	**£28,156,886**	**£29,888,629**	**£28,156,886**	**£29,888,629**

Risk Share

Partners contributions will be limited to the value as identified within the included plans. There will be no risk share arrangements in place.,

Overspend

4 The Partnership Board shall consider what action to take in respect of any actual or potential Overspends

5 The Partnership Board shall act reasonably having taken into consideration all relevant factors including, where appropriate the Better Care Fund Plan and any agreed outcomes and any other budgetary constraints agree appropriate action in relation to Overspends which may include the following:

5.1 whether there is any action that can be taken in order to contain expenditure;

SCHEDULE 4– JOINT WORKING OBLIGATIONS

Part 1 – LEAD PARTNER OBLIGATIONS

Terminology used in this Schedule shall have the meaning attributed to it in the NHS Standard Form Contract save where this Agreement or the context requires otherwise.

1 The Lead Partner shall notify the other Partners if it receives or serves:

1.1 a Change in Control Notice;

1.2 a Notice of an Event of Force Majeure;

1.3 a Contract Query;

1.4 Exception Reports

and provide copies of the same.

2 The Lead Partner shall provide the other Partners with copies of any and all:

2.1 CQUIN Performance Reports;

2.2 Monthly Activity Reports;

2.3 Review Records; and

2.4 Remedial Action Plans;

2.5 JI Reports;

2.6 Service Quality Performance Report;

3 The Lead Partner shall consult with the other Partners before attending:

3.1 an Activity Management Meeting;

3.2 Contract Management Meeting;

3.3 Review Meeting;

and, to the extent the Service Contract permits, raise issues reasonably requested by a Partner at those meetings.

4 The Lead Partner shall not:

4.1 permanently or temporarily withhold or retain monies pursuant to the Withholding and Retaining of Payment Provisions;

4.2 vary any Provider Plans (excluding Remedial Action Plans);

4.3 agree (or vary) the terms of a Joint Investigation or a Joint Action Plan;

4.4 give any approvals under the Service Contract;

4.5 agree to or propose any variation to the Service Contract (including any Schedule or Appendices);

4.6 suspend all or part of the Services;

4.7 serve any notice to terminate the Service Contract (in whole or in part);

4.8 serve any notice;

4.9 agree (or vary) the terms of a Succession Plan;

without the prior approval of the other Partners (acting through the [JCB]) such approval not to be unreasonably withheld or delayed.

5 The Lead Partner shall advise the other Partners of any matter which has been referred for dispute and agree what (if any) matters will require the prior approval of one or more of the other Partners as part of that process.

6 The Lead Partner shall notify the other Partners of the outcome of any Dispute that is agreed or determined by Dispute Resolution

7 The Lead Partner shall share copies of any reports submitted by the Service Provider to the Lead Partner pursuant to the Service Contract (including audit reports)

Part 2 – OBLIGATIONS OF THE OTHER PARTNER

Terminology used in this Schedule shall have the meaning attributed to it in the NHS Standard Form Contract save where this Agreement or the context requires otherwise.

1 Each Partner shall (at its own cost) provide such cooperation, assistance and support to the Lead Partner (including the provision of data and other information) as is reasonably necessary to enable the Lead Partner to:

1.1 resolve disputes pursuant to a Service Contract;

1.2 comply with its obligations pursuant to a Service Contract and this Agreement;

1.3 ensure continuity and a smooth transfer of any Services that have been suspended, expired or terminated pursuant to the terms of the relevant Service Contract;

2 No Partner shall unreasonably withhold or delay consent requested by the Lead Partner.

3 Each Partner (other than the Lead Partner) shall:

3.1 comply with the requirements imposed on the Lead Partner pursuant to the relevant Service Contract in relation to any information disclosed to the other Partners;

3.2 notify the Lead Partner of any matters that might prevent the Lead Partner from giving any of the warranties set out in a Services Contract or which might cause the Lead Partner to be in breach of warranty.

SCHEDULE 5 – PERFORMANCE ARRANGEMENTS

NOT USED

SCHEDULE 6 – BETTER CARE FUND PLAN

The schedules below detail the planned use of the overall BCF funds for both 2023/24 and 2024/25.

NHS Commissioned Out of Hospital spend from the minimum ICB allocation	2023-24	2024-25
Minimum required spend	£15,977,498	£
Discharge Fund	£1,198,780	£1,166,320

Adult Social Care services spend from the minimum ICB allocations	2023-24	2024-25
Disabled Facilities Grant (DFG)	£1,721, 065	£1,721, 065
Local Authority Discharge Fund	£1,093,197	£1,821,922
iBCF	£7,797,498	£7,797,498
Local Authority Contribution	£368,848	£0

Scheme Type	Source of Funding	Expenditure 23/24 (£)	Expenditure 24/25 (£)
High Impact Change Model for Managing Transfer of Care	LA BCF	£1,064,740	£1,075,387
Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery)	LA BCF	£2,009,461	£2,029,556
Home Care Additional Packages	LA BCF	£2,551,111	£2,940,455
Home-based intermediate care services	LA BCF	£785,489	£793,344
Southend Enhanced Discharge Service (SEDs) High Impact Change Model for Managing Transfer of Care	LA BCF	£500,000	£500,000
Active Recovery (Reablement) - High Impact Change Model for Managing Transfer of Care	LA BCF	£250,000	£250,000
Carers Services	LA BCF	£150,000	£150,000
Community Based Schemes	iBCF	£150,000	£150,000
Residential Placements	iBCF	£2,087,000	£2,087,000
Additional Home Care Packages	iBCF	£2,087,000	£2,087,000
Southend Reablement Service	iBCF	£770,012	£770,012
Learning Disability Services	iBCF	£1,750,000	£1,750,000

Range of projects which support the transformation and improvement of adult social care.	iBCF	£853,486	£853,486
Disabled Facilities Grant Assistive Technologies and Equipment	DFG	£1,721,065	£1,721,065
Transformation Projects	Additional LA Contribution	£368,848	£0
Able to Recover Monitoring and responding to system demand and capacity	LA Discharge Funding	£200,000	£200,000
Reablement Early Intervention	LA Discharge Funding	£12,500	£12,500
Provider Incentive Scheme	LA Discharge Funding	£50,000	£50,000
Seasonal Intelligence Provide tools and training to ensure the data monitoring highlights winter pressures	LA Discharge Funding	£2,075	£2,075
Southend Enhanced Discharge Service (SEDs) To support Winter Pressures	LA Discharge Funding	£300,000	£300,000
Southend Care Ltd Enhanced Reablement Capacity	LA Discharge Funding	£100,000	£100,000
Discharge Community Hub	LA Discharge Funding	£40,000	£40,000
Workforce Development	LA Discharge Funding	£366,490	£366,490
Resource to be allocated dependent on requirements in winter e.g., designated setting	LA Discharge Funding	£22,132	£750,857
MSE ICB - Community Services - Other Community provision, to assist flow and prompt discharge	ICB BCF	£2,966,993	£3,134,925
MSE ICB - Community Services - Bed based intermediate Care Services	ICB BCF	£1,502,737	£1,587,792
MSE ICB - Community Services - Urgent Community Response Service	ICB BCF	£821,318	£867,805
MSE ICB - Community Services - Virtual Wards	ICB BCF	£769,186	£812,722
MSE ICB - Southend Community Services - Dementia Support Service	ICB BCF	£1,024,018	£1,081,978
MSE ICB - Southend Community Services - Equipment Service Provision - EPUT	ICB BCF	£568,411	£600,583
MSE ICB - Southend Havens Hospice	ICB BCF	£605,260	£639,517
MSE ICB - Southend Carers - Carers Breaks	ICB BCF	£158,774	£167,760
MSE ICB Discharge spend - Ward based enablement	ICB Discharge Funding	£99,118	£137,776
MSE ICB Discharge spend - Acute Discharge Schemes	ICB Discharge Funding	£1,061,271	£1,475,062
MSE ICB Discharge spend - Transport	ICB Discharge Funding	£12,728	£17,692
MSE ICB Discharge spend - Welfare Support Discharge to Assess pathway 0	ICB Discharge Funding	£25,232	£35,073

NB: An agreed BCF plan for 2023-25 will be inserted here once the NHS England BCF templates are approved.

SCHEDULE 7 – POLICY FOR THE MANAGEMENT OF CONFLICTS OF INTEREST

NOT USED

SCHEDULE 8 – INFORMATION GOVERNANCE PROTOCOL

NOT USED

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