



Southend health system strategic plan 2014-19

THIS DOCUMENT IS DRAFT AND SUBJECT TO CHANGE AND APPROVAL

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How this plan has been developed

This plan has been developed by the Southend unit of planning through the Joint Executive Group (JEG) – a sub group of Southend Health and Wellbeing Board.

A series of strategic planning workshops with the Southend unit of planning were held between January and May 2014. Additionally, this plan is informed by patient and public engagement activities including a ‘Call to Action’ event held in January 2014.

This plan is being submitted by NHS Southend Clinical Commissioning Group on behalf of the Southend unit of planning.

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Document approval

Southend Health and Wellbeing Board	June 2014
Southend CCG Governing Body	June 2014

PENDING



Foreword

This strategic plan sets out our vision for the health system in Southend over the next five years.

Developing a five year plan has stimulated all the stakeholder organisations in Southend to work even better and more closely together to ensure that we are looking at the system as a whole, from the viewpoint of our citizens.

We have considered our areas of joint concern, been honest about our anxieties and hopes for the health and wellbeing of the people in Southend – and the capacity of our organisations to deal with the challenges we all face.

We have collaborated to define a vision and values that we really feel have the best interest of our citizens at its heart, and give an aspirational, yet realistic framework for us to work to, in order that we get the very best health outcomes for the people of Southend.

Bringing this plan to life will require the continued buy-in of the organisations who developed it.

We also need our citizens to understand their role in helping us make it happen – so that everyone living in Southend on Sea has the best possible opportunity to live long, fulfilling, healthy lives.

Southend health system strategic vision 2014-19 – plan on a page

We aim to ensure that everyone living in Southend on Sea has the best possible opportunity to live long, fulfilling, healthy lives.

System objective one:
our children to have the best start in life

System objective two:
to encourage and support local people to make healthier choices

System objective three:
to reduce the health gap between the most and least wealthy

System objective four:
people to have control over their lives and live as independently as possible

System objective five:
to enable our older population and those adults with social care needs to lead fulfilling lives as citizens

Intervention one:
Commissioning for prevention through:

- Integration pioneer programme/BCF schemes
- Roll out of the 'fulfilling lives' strategy for children (conception to three years 11 months)
- Closer working between NHS and local authority commissioners
- Implementing awareness schemes and education programmes
- Risk stratification and early intervention in primary care (primary care strategy)

Intervention two:
Building services around the needs of the citizen by:

- Developing wider primary care at scale through networks of GP practices (primary care strategy)
- Providing care closer to home
- Actively engaging with citizens and involving them in the development of our services

Governance arrangements

System wide governance arrangements including:

- Southend Health and Wellbeing Board
- Joint Executive Group (JEG)
- Success for all - Southend Children's partnership
- Urgent care working group

Measured using the following success criteria:

- Delivery of the system objectives
- Delivery of the outcome ambitions and constitution
- Financial recovery in line with financial recovery plan

System values and principles:

- Planning and operating as a single system; maximising our offer to the citizens of Southend by integrating services that are influential to health and wellbeing
- Understanding the needs of the people living in Southend-on-Sea and proactively addressing these to improve their health outcomes
- Providing access to the right care, at the right time, and in the right setting
- Creating an efficient and effective system that is focussed on quality of care and achieving the best outcomes for our citizens, delivered within our resources

Executive summary

This plan sets out the strategic vision for the Southend health system for the next five years to 2018/19, and how we intend to achieve this as a unit of planning.

This is the first time that all health and social care organisations in Southend have come together to develop an integrated, five-year system plan.

Our unit of planning has committed to continuing its strategic planning activities over the next twelve months, to strengthen our system by ensuring that there is full alignment between this five-year strategic plan, the hospital strategic plan and the Southend health and wellbeing strategy. We will continue to engage with our citizens as we plan and operate as a single system.

The interventions described in this plan are co-dependent; no single stream of work will achieve the whole-system change that is required to improve health outcomes for our citizens and ensure financial sustainability.

In Southend there are strong working relationships between NHS organisations and the local authority – Southend-on-Sea Borough Council. This has been strengthened over the last twelve months, since the establishment of Southend CCG means that the major commissioners of health and social care services in Southend are coterminous and commissioning services for the same population.

In November 2013, Southend was named as a national pioneer in health and social care integration, an accolade which recognises the great progress partners have made in joining up and improving health and social care services. In Southend, the Better Care Fund plan is fully aligned with the integration pioneer programme .

The integration pioneer programme is one of the tools that will support us to deliver seamless care for our citizens, through:

1. Commissioning: looking at opportunities for joint commissioning across health and social care.
2. Service delivery: taking forward service integration and building on the successes already achieved in Southend
3. Prevention and engagement: developing our prevention approach across health and social care and the voluntary and community sector

These work streams are driven and overseen through joint governance processes (see page 12).

Executive summary (cont.)

We are also taking a system-wide approach to our strategy for transforming services for children through the fulfilling lives strategy, which sets out plans for whole-system change to children's services, concentrating on prevention-led activities for families and children from conception through to pre-school age.

Getting primary care right is absolutely crucial to the future success of the health system in Southend, and our primary care strategy is another essential tool for ensuring our health system works for our citizens so they can access the right care, in the right place and at the right time.

We are currently developing the detail to support delivery of our primary care strategy alongside our expression of interest for co-commissioning defined elements of primary care. An overview of this can be found on page 34.

We are simultaneously looking at our system overall and a number of reviews have been commissioned to assess system sustainability and options for creating a more resilient system for the future. They are:

1. Acute services review – this pan-Essex review is looking at the configuration of hospital services across the county. It is being completed in two stages – the first stage, which is currently underway, is defining the scope of the review.
2. South East Essex services review – jointly commissioned with Castle Point and Rochford CCG, this review is looking at the organisational form of both South East Essex CCGs and will make recommendations on services that should be shared across the two organisations. It is also reviewing the organisations' QIPP schemes, ensuring that these can be delivered through a clear programme of work.
3. Southend system capacity review – this review was commissioned jointly by Southend CCG and Southend-on-Sea Borough Council. It identified the key drivers of demand for hospital services in Southend and areas of focus for freeing up system capacity to cope with future increases in demand.

Southend CCG started 2014-15 in financial deficit. Having entered financial recovery, the CCG has put in place a more rigorous approach to managing financial performance and is addressing the factors that caused the overspend in 2013/14. Our robust recovery plan will outline how the CCG will achieve financial balance over the next two years and ensure system sustainability in the years beyond – critical to the delivery of our system-wide strategy. See page 34.



THE SOUTHEND HEALTH SYSTEM

Introducing Southend

The Southend health system serves a resident population of over 180,000 people.

29 per cent of the population is under 25 years old, while 18.3 per cent are aged over 65. The proportion of the population aged 85 or older is 2.9 per cent [Census 2011].

Our population is ageing faster than populations in many other areas. By 2020, the total population is expected to grow by over 6000 – the population aged over 55 is expected to increase by over 12,000.

With the growth of an aging population and the drive to ensure earlier identification of some chronic conditions, we can expect to see a rise in disease prevalence and consequent demand for health and social care services.

The health of people in Southend-on-Sea is varied compared with the England average and there are a number of areas where we have a higher disease prevalence than the England average. These include cardiovascular disease, heart failure, hypothyroidism and mental health problems [CCG Outcomes Tool]. Southend is expected to face significant increases in the prevalence of several chronic diseases including COPD, diabetes, stroke and hypertension over the next five years.

Southend has higher levels than the national average for smoking prevalence, percentage of inactive adults, hospital

stays for alcohol related harm, and injuries due to falls in women over 65. Southend also has lower levels of breast cancer screening coverage and breastfeeding.

There are significant inequalities for the population of Southend with regards to deprivation and life expectancy.

Deprivation levels (as measured by the Index of Multiple Deprivation or IMD) in Southend-on-Sea are higher than average and there are about 7,600 children that live in poverty. The average IMD score for Southend CCG is 23.6 (2012) compared to the England average of 21.5.

There is significant disparity between the life expectancy at birth for those living in the least deprived areas of Southend and those living in the most deprived areas. Based on death rates for 2006-2010, life expectancy for males living in the least deprived areas is 9.1 years longer than those living in the most deprived areas. For females, the range of difference is 8.8 years.

In addition to the resident population, the Southend health system – particularly the urgent care system – is subject to additional pressure from more than six million visitors who come to the town each year.

Southend health system – Southend CCG, its partners and providers

NHS Southend Clinical Commissioning Group (Southend CCG) operates as part of a wider health system, serving the borough's population of more than 180,000 residents.

We are in formal strategic partnership with our partners through the Southend Health and Wellbeing Board and its sub-groups.

The Health and Wellbeing Board is responsible for developing and implementing the Southend on Sea Health & Wellbeing Strategy, which outlines the key priorities for improving health and wellbeing for all of the borough's residents.

We also work closely with our partners on an operational level to ensure alignment of our activities.

Southend GP practices

NHS Southend CCG is made up of 36 GP member practices, of which 19 are operated by a single GP.

We work with our member practices to support improvement in the quality of primary care.

We engage with individual member practices via our GP Members Forum. The forum is used to consult with practices about commissioning plans and proposed service developments.

Southend-on-Sea Borough Council

Southend-on-Sea Borough Council is a unitary authority providing a wide range of services to local residents and businesses.

Adult and children's social care are an important part of its remit, and account for around 40% of its revenue spending. The Council is a key partner for the development of integrated care; particularly the integration of health and social care services for older people.

We have identified children's services, learning disability services and integrated care services as focus areas for developing joint commissioning.

NHS Castle Point and Rochford Clinical Commissioning Group

NHS Castle Point and Rochford Clinical Commissioning Group is our neighbouring CCG.

We share our acute provider – Southend University Hospital NHS Foundation Trust (SUHFT) – and community and mental health provider – South Essex Partnership University NHS Foundation Trust (SEPT). We have established a joint clinical executive with NHS Castle Point and Rochford Clinical Commissioning Group and we make joint decisions about shared services and providers.

Southend health system – Southend CCG, its partners and providers (cont.)

Healthwatch Southend

Healthwatch Southend exists to give a voice to the adults, children and young people of Southend-on-Sea and provides information about health and social care services in the area.

Each local authority is required by government to fund a local Healthwatch, to represent the views of patients, service users and the general public in the design and commissioning of health and social care services, and to offer an information and advice point to help local people navigate the ever more complicated health and social care system.

We have a strong collaborative working arrangement with Healthwatch Southend, which means that issues of concern can be addressed promptly. Healthwatch Southend acts as a critical friend for Southend CCG, while sharing its vision of service improvement for the population of Southend. It is well positioned to engage with and inform the public about important health and social care issues, and we attend their engagement events to provide expert health advice and information.

Healthwatch Southend sit on the Southend Health and Wellbeing Board and attend our meetings in public.

Southend Association of Voluntary Services (SAVS)

SAVS is a council for voluntary services, part of a national network of similar organisations. These support, promote and develop local community action. SAVS supports its members by providing them with a range of services and by acting as a voice for the local voluntary and community sector. Their job is to advise and support local, not-for-profit groups. These groups provide all manner of services to the local area and include social clubs, groups advising people who care for a relative at home, advice and activities for people with disabilities or health problems, tenants and residents' associations.

SAVS works as a conduit between us and the voluntary and community sector of Southend, and can help to explore how the voluntary and community sector can work together to improve healthcare for Southend.

NHS 111

Southend CCG supports the implementation of the non-emergency telephone service in our area. NHS 111 is a service which enables patients to access local NHS healthcare services in England. Patients are encouraged to use NHS 111 service if they require urgently medical help or advice but is not in a life threatening situation. It is intended that patients use this service before they attend the accident and emergency department.

Southend health system – Southend CCG, its partners and providers (cont.)

South Essex Partnership University NHS Foundation Trust (SEPT)

SEPT is one of the most successful Foundation Trusts in the country providing integrated care including mental health, learning disability, social care and community health services.

They work alongside partner organisations to deliver care and support to people in their own homes and from a number of hospital and community based premises.

SEPT are the provider of most community and mental health services in Southend.

Southend University Hospital NHS Foundation Trust (SUHFT)

SUHFT is the local hospital for residents of Southend and serves a catchment area with a population of 350,000.

The hospital provides a comprehensive range of acute services at its Prittlewell Chase site and outlying satellite clinics. These include acute medical and surgical specialties; general medicine; general surgery; orthopaedics; ear, nose and throat; ophthalmology; cancer treatments; renal dialysis; obstetrics and gynaecology, and children's services.

SUHFT is the South Essex surgical centre for uro-oncology and gynae-oncology surgery and is considered to be a centre of excellence for the care of stroke.

SUHFT has an accident and emergency department that deals with immediate and urgent threats to health.

East of England Ambulance Service NHS Trust (EEAST)

The East of England Ambulance service covers the six counties which make up the East of England – Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Norfolk and Suffolk.

The Trust provides a range of services, but is best known for 999 emergency services. It deals with 929,134 calls to 999 every year – responding to over 30,000 calls in Southend.

In addition the Trust handles more than one million non-emergency patient journeys to and from routine hospital appointments. EEAST have 11 emergency ambulances and three intermediate tier ambulances available at peaks of demand in Southend.

Southend unit of planning

Unit of planning

Our unit of planning is based around Southend-on-Sea Health and Wellbeing Board, which is made up of local statutory organisations and health related partners who are working in partnership to improve health and wellbeing for Southend's residents.

All stakeholders in the Southend health system have worked together to develop this strategic plan, co-creating through strategic planning workshops and via the Joint Executive Group (JEG).

The Joint Executive Group comprises representatives from:

- Southend CCG
- Southend-on-Sea Borough Council
- Southend University Hospital NHS Foundation Trust
- South Essex Partnership NHS Foundation Trust
- Castle Point and Rochford CCG
- Southend Association of Voluntary Services

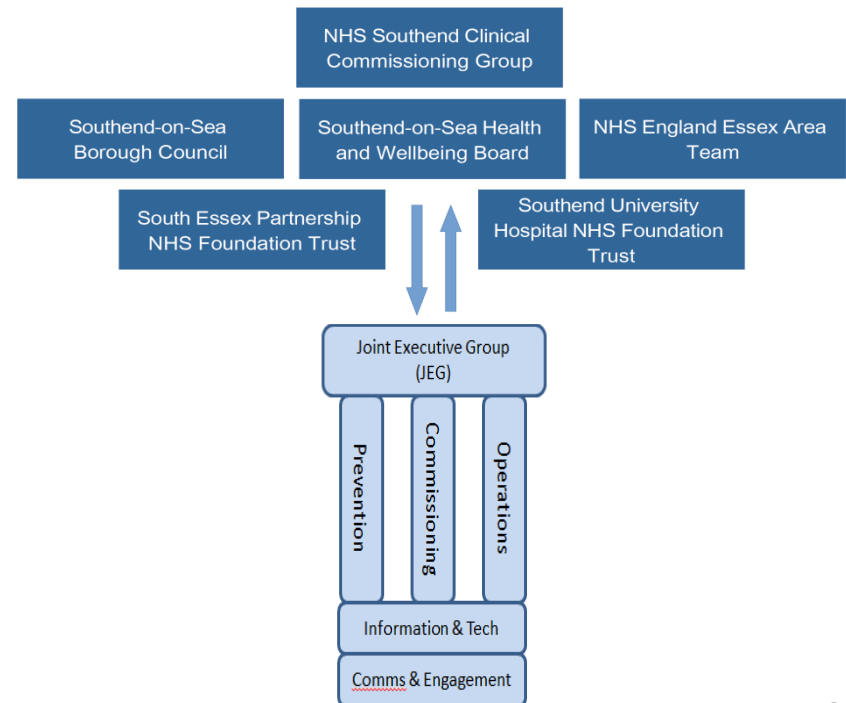
The JEG's primary areas of focus are:

- Better Care Fund
- Integrated Pioneer programme
- Access to 7-day services

It will also oversee a joint mental health and learning disability commissioning group (Southend CCG/Southend-on-Sea Borough Council) and children's and maternity services, plus ad-hoc requirements delegated from the Health and Wellbeing Board.

Our unit of planning has committed to continuing its strategic planning activities over the next twelve months, to ensure that there is full alignment between the five-year strategic plan, the hospital strategic plan and the Southend health and wellbeing strategy. This work will be led by the JEG, reporting to the Health and Wellbeing Board.

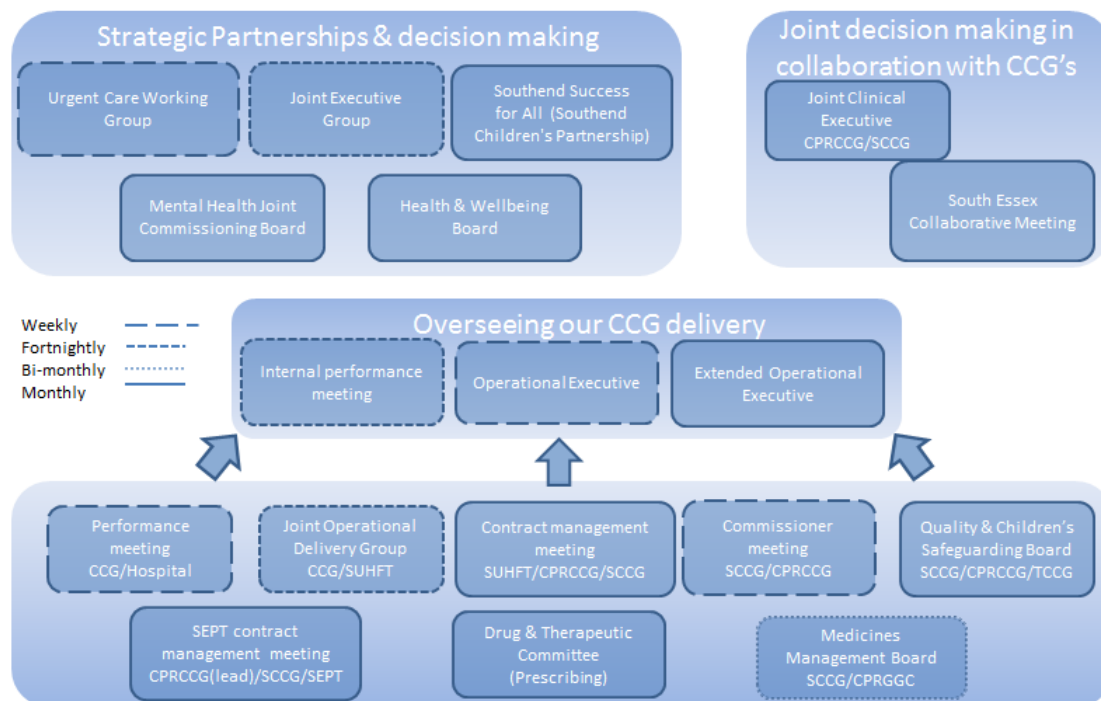
Southend unit of planning



Southend health system – delivery and governance

Our governance arrangements reflect the level of close partnership working within the Southend health system.

These robust structures and processes will ensure that our strategy is implemented with momentum and direction.



We are currently exploring further opportunities for joint commissioning between Southend CCG and Southend-on-Sea Borough Council, as recommended by the recent LGA peer review of Southend Health and Wellbeing Board. This work is being undertaken as part of the 'commissioning' work stream of the integration pioneer programme/Better Care Fund plan, reporting to the JEG.



OUR VISION

Southend health system strategic vision 2014-19

About our vision

Improving health outcomes and reducing inequality

The Southend health system, comprising a wide partnership of agencies, is committed to a shared ambition of improving the health and wellbeing of our communities.

There are significant inequalities for the population of Southend with regards to deprivation and life expectancy. The causes of poor health and wellbeing are multiple and are the result of a huge variety of factors that people experience over the course of their life. Generally, people who are poorer, less well educated and who live in more deprived areas tend to suffer more negative effects on their health and wellbeing.

The Southend health system influences many factors that affect our communities' health and wellbeing, from housing, to education, to social care, to leisure opportunities, to health care. Our strategic vision puts reducing the health gap between the most and least wealthy at the centre of our work.

Delivering a sustainable health system

The need to deliver sustainable services is recognised across the Southend health system, and this is acknowledged within our strategic vision. We are working together as a health and social care economy to be clear about how the system will achieve sustainable service and financial performance whilst delivering quality and productivity improvements.

Our two year recovery plan will focus on bringing our system into financial balance by the end of 2015/16 and ensuring sustainability in the years that follow.

Southend health system strategic vision 2014-19

Our vision is:

To ensure that everyone living in Southend on Sea has the best possible opportunity to live long, fulfilling, healthy lives.

We want:

- our children to have the best start in life
- to encourage and support local people to make healthier choices
- to reduce the health gap between the most and least wealthy
- people to have control over their lives and live as independently as possible
- to enable our older population and those adults with social care needs to lead fulfilling lives as citizens

We will deliver this by:

- Planning and operating as a single system; maximising our offer to the citizens of Southend by integrating services that are influential to health and wellbeing
- Understanding the needs of the people living in Southend-on-Sea and proactively addressing these to improve their health outcomes
- Providing access to the right care, at the right time, and in the right setting
- Creating an efficient and effective system that is focussed on quality of care and achieving the best outcomes for our citizens, delivered within our resources

Our commitment

The Southend health system is committed to:

Ensuring that citizens will be fully included in all aspects of service design and change, and that patients will be fully empowered in their own care through continued dialogue and engagement with our citizens through the CCG's practice participation group forum, our involvement programme and by developing our engagement steering group. We will continue to invest in developing our relationship with Healthwatch Southend. Through the Southend Health and Wellbeing Board Communications and Engagement group we will deliver health and wellbeing education programmes that support the people of Southend to, take responsibility for and maintain their own health as far as possible; manage their own conditions through appropriate self-care; and choose health services that will provide the right care, at the right time and in the right setting. This strategic plan has been developed using feedback from our patient and public engagement activities including the call to action event held in January 2013.

Developing **wider primary care provided at scale** through the Primary Care Strategy.

Adopting a **modern model of integrated care** by planning and operating as a single system. The CCG will continue to work closely in partnership with Southend-on-Sea Borough Council and this relationship will be strengthened by establishing joint commissioning of health and social care services.

Providing **access to the highest quality urgent and emergency care** through the implementation of the South East Essex Urgent Care Strategy.

Ensuring a **step-change in the productivity of elective care** by implementing pathway improvements to deliver sustainability through our Joint Improvement Planning Framework (JIPF).

Supporting **specialised services concentrated in centres of excellence**, through the establishment of a Hyper Acute Stroke Unit in south Essex, and achieving the level of success demonstrated by London HASUs. (Further detail on p54&55 of operational plan)

System alignment

The Southend health system strategic vision has been developed through a series of planning workshops with the Southend unit of planning, which is centred around the Southend Health and Wellbeing Board.

Our strategic vision includes input from the voluntary and community sector and Healthwatch Southend and aligns completely with the Southend health and wellbeing strategy vision.

This plan is scheduled to be reviewed and approved by the Southend Health and Wellbeing Board at its meeting on 18 June 2014.

Our plan for the Better Care Fund in Southend was developed jointly by the CCG and Southend-on-Sea Borough Council. It aligns perfectly with our five-year strategic vision for the Southend health system as it aims to create a sustainable health and social care system which delivers high quality care in the most appropriate setting, improve the health and wellbeing of our population and achieve value for money.

The Southend Health and Wellbeing Strategy 2013-15 is available to download from www.southend.gov.uk/healthandwellbeing. The action plan that underpins the Southend health and wellbeing strategy is currently being updated, taking into account this five year strategic plan.



PLANNING FOR OUTCOMES

Alignment with the NHS Outcomes Framework

All partners within the Southend health system are committed to improving the health and wellbeing of our local communities and ensuring that the population of Southend has appropriate access to high-quality, safe care.

The NHS Outcomes Framework sets out 5 domains for improvement and seven aligned outcome ambitions as follows:

Domain 1: Preventing people from dying prematurely	1: Securing additional years of life for people with treatable mental and physical health conditions
Domain 2: Enhancing quality of life for people with long-term conditions	2: Improving the health related quality of life of people with one or more long-term conditions
Domain 3: Helping people to recover from episodes of ill health or following injury	3: Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital
	4: Increasing the proportion of older people living independently at home following discharge from hospital
Domain 4: Ensuring people have a positive experience of care	5: Increasing the number of people having a positive experience of hospital care
	6: Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm	7: Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care

We have worked closely with the NHS England Quality Strategy and Alignment team to ensure that the key outcomes of our strategic vision are aligned to the NHS Outcomes Framework (see appendix one). This will help us to drive improvement in health outcomes and measure our success through a range of indicators.

Our ambitions for improving outcomes

With our partners, we have developed a series of aspirational trajectories for our performance over the next five years using the NHS Outcomes Framework.

These measures in turn also align to the Better Care Fund (delivered in partnership with Southend-on-Sea Borough Council), quality premium, NHS Constitution Measures and additional local measures where relevant.

To develop our targets against each of the 7 outcome measures we examined our historical and current performance and the performance of comparator peer CCGs (using Commissioning for Value comparator group).

Information on the health profile (JSNA) of Southend has been provided by Public Health and this has been used to inform our plans for improving outcomes.

In many cases we set our target on the basis of improving performance to achieve the next CCG quartile across the target period. Where there is a national target, we aim to reach that target.

Our ambitions have been discussed and agreed at our clinical executive and our GP member forums to ensure support from clinical commissioners.

We held individual discussions with both Southend University Hospital NHS Foundation Trust (SUHFT) and South Essex Partnership NHS Foundation Trust (SEPT), our main providers, and commissioning partners Southend-on-Sea Borough Council and Castle Point and Rochford CCG, to ensure we are strategically aligned.

We have also met individually with our partners from across the Southend health system to discuss and align commissioning intentions.

Our operational plan 2014-16 sets out the activities we will be implementing over the next two years to support the achievement of these ambitions. On the following slides we highlight some strategic areas of focus against each ambition.

Outcome Ambition 1: Potential years of life lost from causes amenable to healthcare (per 100,000 population)

Our main areas of focus for achieving our ambition are reducing health inequality and improving outcomes for people with long term conditions.

We recognise that working collaboratively with system partners to address all factors influential to health and wellbeing will be the best approach to reducing inequality in life expectancy.

We are establishing joint commissioning arrangements between the CCG and Southend-on-Sea Borough Council for specific areas including:

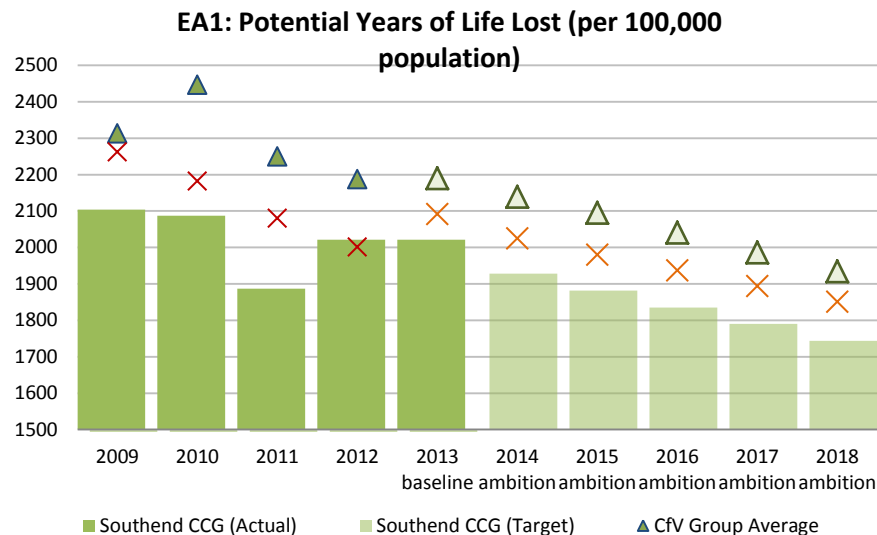
- Learning disability
- Mental health
- Children's services
- Maternity services
- Services for older people

By pooling our resources and taking a holistic approach to commission to meet the needs of the citizen, we will achieve better outcomes.

Historically, performance against cancer RTT targets has not always been strong in all areas. Specifically, there is room for improvement in two week waits for breast cancer and the urology pathway. As a CCG we are working closely with all our acute providers to modernise the way that all cancer pathways are applied, by effectively mapping patient flows to capacity and demand data.

Acute stroke services in Southend are amongst the best in the UK. We are confident that people treated for stroke in Southend have very good outcomes in comparison with people treated elsewhere in the country. However, the establishment of a hyper acute stroke unit in south Essex will further improve outcomes for people treated for stroke.

In addition, to improve stroke outcomes over the next five years we intend to put more of a focus on commissioning for prevention – and aligning CCG activities to the work of our local public health teams to address the causes of stroke, such as diet, physical activity and smoking.



Frameworks	Outcome Ambition Quality Premium (14/15)
Degree of Funding Attached	£132,270 (15% Quality Premium)
Good Performance is	A low value
CCG Lead is	
Current Performance is	At the baseline

Definition: This indicator measures the number of premature deaths occurring. Premature deaths are based on identified categories where it is believed that death could be avoided due to high quality healthcare being delivered. This is greatly impacted by health behaviours throughout life (e.g. smoking).

Outcome Ambition 2: Health related quality of life for people with one or more long-term conditions

We will achieve our ambition by enabling and supporting our citizens to manage their own health better.

Our operational plan sets out how we are introducing personal health budgets for people in receipt of continuing healthcare. From 2015 personal health budgets will also be available to people with other specified long term conditions.

Having a personal health budget gives citizens more control over the way they manage their own health.

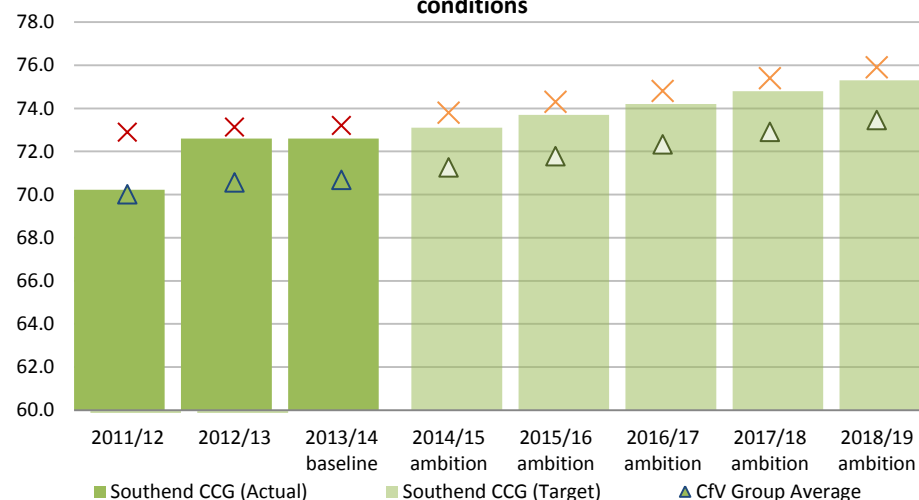
Fundamental to improving the quality of life for people with long term conditions is ensuring that they are able to access appropriate health services. We intend to build a health system in Southend that provides access to the right care, at the right time and in the right setting. This includes improving access to better primary care through our primary care strategy and building a system that encourages and enables citizens to access care closer to home.

Through the integration pioneer programme, the Southend health system is developing ways of working with the voluntary and community sector to build community resilience by addressing some of the factors that contribute to poor health and wellbeing, such as social isolation. As well as preventing citizens' need to access health and social care services, this work will improve the quality of life of people with one or more long term conditions.

We are committed as a health system to address the needs of the whole person – including mental health and wellbeing, and ensuring people with long term physical conditions also have access to appropriate psychological support.

Our work to achieve parity of esteem – as set out in our operational plan – is key to improving quality of life for people with a long term mental health condition.

EA2: Health related quality of life for people with long-term conditions



Frameworks	Outcome Ambition Better Care Fund
Degree of Funding Attached	Not applicable
Good Performance is	A high value
CCG Lead is	
Current Performance is	At the baseline

Definition: This indicator measures the average health status score of individuals who identify themselves as having a long-term condition (crude rate). This is captured via the GP Patient Survey. Units: total EQ-5D per 100 people with LTCs. Numerator is the sum of the weighted EQ-5D values for all responses from people identified as having a long term condition. The denominator is the weighted count of all responses from people identified as having a long term condition.

Outcome Ambition 3: Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community

Southend has a growing and ageing population, which means that developing good integrated care is crucially important to better manage the resulting increased demand for services.

In particular, a high number of our residents live in care homes, so the need to provide excellent primary and community care is paramount.

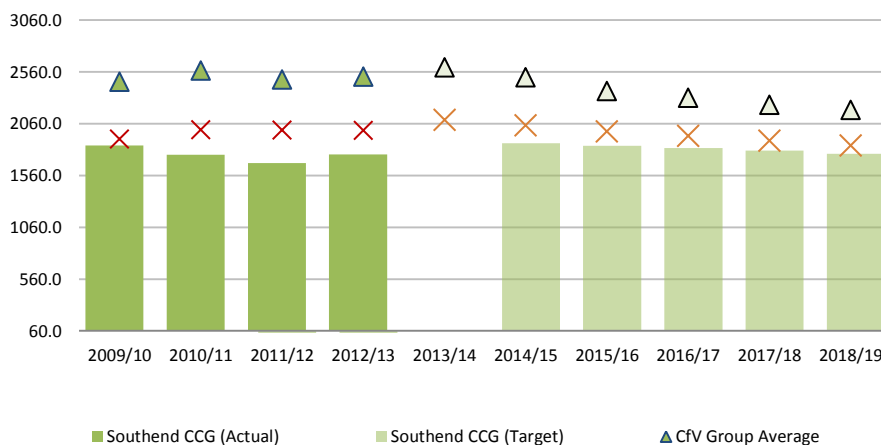
We are working to achieve this through the development of our primary care strategy (see page 34), and our integration pioneer programme/Better Care Fund plan (see pages 12, 13 & 25).

The integration pioneer programme and Better Care Fund plan build on the strong integration work already in place in Southend, as the development of integrated care is already well underway. A single point of referral (SPOR) has been established with partners. This is helping professionals work better together to prevent avoidable admissions to acute care of older people who require health and social care interventions. Plans are in place to extend the role of the SPOR in supporting integrated care in Southend.

In addition, multidisciplinary team meetings have been established. These are weekly forums of professionals where care plans for patients at high risk of an urgent acute admission are discussed and developed.

Our primary care strategy sets out how we will build on the multidisciplinary team approach.

EA4: Emergency Admissions Composite Measure



Frameworks	Outcome Ambition Quality Premium (for 14/15) Better Care Fund (different geography)
Degree of Funding Attached	£220,450 (25%) for Quality Premium in 2014/15
Good Performance is	A low value
CCG Lead is	
Current Performance is	At the baseline

Definition: This is a composite measure of: Unplanned hospitalisation for chronic ambulatory sensitive care conditions; Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s; Emergency admissions for acute conditions that should not usually require hospital admission; Emergency admissions for children with lower respiratory tract infections;

Please note: Target for 2014/15 is split into Q1: 477.4; Q2: 449.7; Q3: 464.2; Q4: 481.3

Outcome Ambition 4: Increasing the proportion of older people living independently at home following discharge from hospital

Our strategic vision sets out our desire for people to have control over their lives and live as independently as possible and to enable our older population and those adults with social care needs to lead fulfilling lives as citizens. Increasing the proportion of older people living independently at home following discharge from hospital is an important indicator of how well we are achieving these elements of our vision.

Our Better Care Fund plans will support the achievement of this vision and of this outcome.

Our Better Care Fund plans include the following focus areas:

- Improvement of the single point of referral (SPOR)
- Pilot seven day access to services
- Reducing admissions to acute care
- Integrated care records
- Hospital sector challenges
- Prevention/recovery in mental health

Integration of health and social care will be achieved through six Better Care Fund schemes:

- Independent living including reducing the reliance on residential care
- End of life, palliative care and community services
- Prevention including intermediate care and reablement services
- Primary and community care
- Infrastructure to support integrated working
- Transforming the emergency care pathway

Outcome Ambition 5: Increase the amount of people who have a positive experience of hospital care

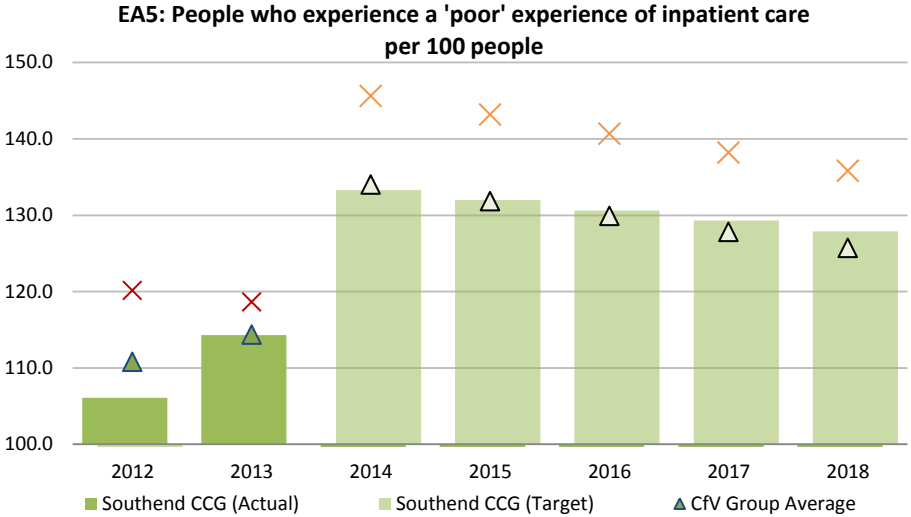
Several measures are used to monitor the experience that patients have in hospital.

The national friends and family test asks whether patients 'would recommend' the hospital to their friends and family.

The scores are then calculated to give the net promoter. The CCG will review the area by area data that supports the net promoter and seek to improve the outcomes of both the response rates and the net promoter score.

The net promoter score does not sit in isolation from other data related to patient experience within the hospitals and the CCG has a system of early warning indicators which it will use to triangulate all patient experience data, including patient satisfaction surveys, complaints, compliments and the CCG quality team will monitor the quality and safety of care and the experience of patients through the formal contract Clinical Quality Review Group and through the regular visits made to the hospital.

In addition, the CCG gathers first hand information from patients through its patient and public involvement activities.



Frameworks	Outcome Ambition
Degree of Funding Attached	Not applicable to Outcome Ambition
Good Performance is	A low value
CCG Lead is	
Current Performance is	At the baseline

Definition: This indicator measures the rate of responses of a 'poor' experience of inpatient care ('all care') per 100 patients. It is based on 15 questions relating to care. The target should therefore be to reduce the level of 'poor' responses (crude rate: applied to the CCG population). Source is the National Inpatient Survey.

Please note: the methodology for this metric has been revised following the submission of the ambition targets – these targets now require recalculation

Outcome Ambition 6: Increase the proportion of people having a positive experience of care outside of hospital, in general practice and in the community

Satisfaction with primary care is measured through primary care surveys. We are aiming for excellence in primary care through our primary care strategy, by supporting the provision of appropriate and acceptable front line primary care services at scale.

The CCG will be exploring opportunities for co-commissioning of primary care over the coming months.

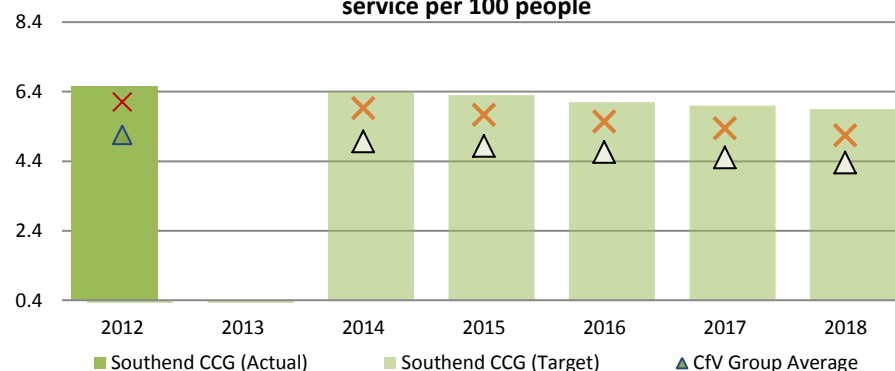
We also have a programme of work in place to address unwarranted clinical variation in primary care, details of which can be found in the Operational Plan 2014-16. er to define.

Satisfaction surveys are also undertaken for community services.

In community services the CCG will work closely with the lead commissioners for those services to gain assurances that patients are satisfied. This this will be through the mechanism of correlation of intelligence and ensuring that the patient experience in community settings is not lost.

It is not always clear where to complain in a community setting and the CCG will ensure that there is clear advice and help to support people in feeding back on their experience.

EA5: People who experience a 'poor' experience of GP and OOH service per 100 people



Frameworks	Outcome Ambition
Degree of Funding Attached	Not applicable to Outcome Ambition
Good Performance is	A low value
CCG Lead is	
Current Performance is	At the baseline

Definition: This composite indicator measures the number of people saying that they receive a fairly poor or very poor experience across 2 questions: GP surgery and Out of Hours service per 100 patients (crude rate: applied to the population)

Outcome Ambition 7: Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care

Safety of our patients is our first key priority and we closely monitor the standards of healthcare associated infections (HCAI) such as Meticillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile (C.Diff), ensuring that the infection prevention and control element of patient safety quality and experience is embedded within the commissioning process.

In the past year our providers have reported no cases of MRSA bacteraemia. It is recognised that we are now at an irreducible minimum level at which C.Diff infections will occur, even where the best quality care is provided. We will continue to review any cases in order to identify whether there have been any lapses in the quality of care provided to patients, and if so actions will be taken to address this with our providers.

We will continue to ensure that we reach expected standards of venous thromboembolism (VTE) performance to improve the management of the VTE risk. There is a comprehensive training programme in place at SUHFT and a specialist VTE nurse in post to ensure we continue to achieve these standards.

We will continue to monitor and review the quality of healthcare provision using a number of different methods including clinical audits, performance indicators, serious incidents, patient experience feedback and mortality and morbidity data.

The CCG has worked with the hospital to introduce systems for early recognition of the deteriorating patient. This is vital in managing patient care and having a shared, multidisciplinary approach to monitoring acutely ill patients.

The hospital reports serious incidents and Never Events to the CCG and following a thorough investigation it is imperative that lessons are learnt both within the hospital and shared across other services to prevent reoccurrence. The CCG will undertake analysis of these incidents and again will triangulate with other data to ensure all is being done to prevent avoidable harm.



INVOLVING OUR CITIZENS

Patient and public engagement

Southend CCG held 'Help us design your NHS' - a Call to Action patient and public engagement event on 28 January 2014 to capture local priorities for the future of the health service in the area. The event included in depth discussions about a wide range of health care issues including:

- Hospital services
- Emergency services
- Mental health and wellbeing
- Services in the community
- Long-term conditions
- GP practices
- Self care

Further discussion has also been held through our monthly practice participation group forum meetings.

Key themes

Five key patient and public priority areas have emerged from our engagement activities:

1. Patient/carer information and education, responsibility for and involvement in own care
2. High-quality, appropriate and responsive urgent care
3. Better access to broader primary care
4. Seamless care across the health system
5. Personalised and holistic care for the individual patient - prevention, early intervention, mental health and individual needs

Our strategic vision for the Southend health system has been developed in view of the findings of our patient and public engagement activities and responds to the key themes.

We will continue to engage with our citizens as we work up our plans for developing wider primary care at scale, to ensure that our vision of excellent primary care aligns with their expectations and experience.



OPPORTUNITIES & INTERVENTIONS

Our strategy and transformational interventions

We have developed a strategy to move the health system in Southend from its current state to the health system described by our strategic vision by the implementation of a series of transformational interventions.

We are taking a whole-system view and understand the impacts of our interventions across the system - this is essential in order to ensure that we do not simply shift demand back and forth between separate social care and health services.

A key focus is on building community and system capacity and resilience, which will help us to be able to better manage future demand.

Our transformational interventions fall under two co-dependent areas of opportunity:

One: commissioning for prevention through:

- Integration pioneer programme/BCF schemes
- Roll out of the 'fulfilling lives' strategy for children (conception to three years 11 months)
- Closer working between NHS and local authority commissioners
- Implementing awareness schemes and education programmes
- Risk stratification and early intervention in primary care (primary care strategy)

Two: building services around the needs of the citizen by:

- Developing wider primary care at scale through networks of GP practices (primary care strategy)
- Providing care closer to home
- Actively engaging with citizens and involving them in the development of our services

These interventions are underpinned by key programmes of work including:

- Primary care strategy/co-commissioning
- Health and social care integration pioneer programme/BCF
- Fulfilling lives children's strategy
- Urgent care strategy

Note: published strategies are available to view via www.southendccq.nhs.uk

Our strategy in its entirety is dependent on in-system cultural and behavioural change, which will be stimulated enabled by the use of information technology and effective communications by commissioners, providers and citizens.

Primary care strategy

We are developing our primary care strategy to deliver the expectations of primary care as set out in *Everyone counts: planning for patients*, to support excellence in primary care and ensure tailored, integrated care for vulnerable and older people. This fits with the strategic intentions of the integration pioneer programme/Better Care Fund plan.

Our strategic intention is to have responsive, proactive primary care – with hospital care as the last resort, only for those who need specialist or emergency services.

We are exploring how we will support wider primary care at scale, so that patients can access the right care, at the right time and in the right place.

Our current thinking is that this will be delivered through networks of GP practices working together virtually or through primary care ‘hubs’, working closely with pharmacists and optometrists and taking a multi-disciplinary approach to ensure access to urgent primary care and community services for our citizens, seven days a week.

We are currently exploring opportunities for co-commissioning specific areas of primary care for our expression of interest, which will be submitted on 20 June.

We are considering expressing an interest in a phased approach to co-commissioning, beginning in shadow form with immediate effect, and starting formally in October 2014 with the following areas:

- working with patients and the public and the health and wellbeing board to assess needs and decide strategic priorities
- designing and negotiating local contracts e.g. PMS, APMS any enhanced services commissioned by NHS England
- deciding in what circumstances to bring in new providers and managing associated procurements and making decisions on practice mergers

Financial recovery

Southend CCG ended 2013/14 with a deficit of £3.1m, linked to over spend on acute hospital services and continuing healthcare.

This £3.1m deficit must be repaid, and the underlying £3m position recovered. We expect to achieve this over the next two years, reaching financial balance in 2016/17.

A two-stage approach, to stabilise and then sustain, has been agreed with NHS England.

The CCG's track record on QIPP management has been poor. To address this, our recovery plan includes more robust QIPP management, through a dedicated performance management office, monitored weekly by the recovery director.

Revenue Resource Limit						
£ 000	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Recurrent	209,563	216,262	225,962	232,941	237,886	242,957
Non-Recurrent	152	(1,533)	(3,667)	(1,661)	982	3,892
Total	209,715	214,729	222,295	231,280	238,868	246,849
Income and Expenditure						
Acute	124,973	121,249	120,821	122,543	123,967	125,880
Mental Health	22,852	22,339	22,080	22,389	22,747	23,133
Community	12,128	11,954	11,857	13,141	13,333	13,039
Continuing Care	15,264	19,804	24,360	26,186	27,700	29,259
Primary Care	27,714	28,811	29,109	30,171	31,261	32,381
Other Programme	3,871	6,266	7,366	7,366	7,366	8,366
Total Programme Costs	206,802	210,423	215,593	221,796	226,374	232,058
Running Costs	4,442	4,367	3,922	3,922	3,922	3,922
Contingency	-	3,607	4,441	4,580	4,679	4,781
Total Costs	211,244	218,396	223,956	230,298	234,975	240,761
£ 000	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Surplus/(Deficit) In-Year Movement	(1,529)	(2,139)	2,006	2,643	2,911	2,196
Surplus/(Deficit) Cumulative	(1,529)	(3,667)	(1,661)	982	3,892	6,089
Surplus/(Deficit) %	-0.73%	-1.71%	-0.75%	0.42%	1.63%	2.47%
Surplus (RAG)	RED	RED	RED	AMBER	GREEN	GREEN
Net Risk/Headroom		(181)	2,479	2,401	2,461	2,461
Risk Adjusted Surplus/(Deficit) Cumulative		(3,848)	818	3,383	6,354	8,549
Risk Adjusted Surplus/(Deficit) %		-1.79%	0.37%	1.46%	2.66%	3.46%
Risk Adjusted Surplus/(Deficit) (RAG)		RED	AMBER	GREEN	GREEN	GREEN

Any revised financial submissions will be reflected in the 20 June submission



APPENDIX ONE

Alignment with the NHS Outcomes Framework (cont.)

System objective one: our children to have the best start in life

1

1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare

i Adults ii Children and young people

Reducing deaths in babies and young children

1.6 i Infant mortality (PHOF 4.1*)

ii Neonatal mortality and stillbirths

iii Five year survival from all cancers in children

2

ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s

3

Preventing lower respiratory tract infections (LRTI) in children from becoming serious

3.2 Emergency admissions for children with LRTI

4

Improving children and young people's experience of healthcare

4.8 *Children and young people's experience of outpatient services*

5

Improving the safety of maternity services

5.5 Admission of full-term babies to neonatal care

Delivering safe care to children in acute settings

5.6 Incidence of harm to children due to 'failure to monitor'

System objective two: to encourage and support local people to make healthier choices

1

1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare

i Adults ii Children and young people

1b Life expectancy at 75

i Males ii Females

Reducing premature mortality from the major causes of death

1.1 Under 75 mortality rate from cardiovascular disease (PHOF 4.4*)

1.2 Under 75 mortality rate from respiratory disease (PHOF 4.7*)

1.3 Under 75 mortality rate from liver disease (PHOF 4.6*)

1.4 Under 75 mortality rate from cancer (PHOF 4.5*)

i One- and ii Five-year survival from all cancers

iii One- and iv Five-year survival from breast, lung and colorectal cancer

Reducing deaths in babies and young children

1.6 i Infant mortality (PHOF 4.1*)

ii Neonatal mortality and stillbirths

iii Five year survival from all cancers in children

2

2 Health-related quality of life for people with long-term conditions (ASCOF 1A**)

Reducing time spent in hospital by people with long-term conditions

2.3 i Unplanned hospitalisation for chronic ambulatory care sensitive conditions

ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s

Enhancing quality of life for carers

2.4 Health-related quality of life for carers (ASCOF 1D**)

Alignment with the NHS Outcomes Framework (cont.)

System objective three: to reduce the health gap between the most and least wealthy

1

1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare

i Adults ii Children and young people

1b Life expectancy at 75

i Males ii Females

Reducing premature mortality from the major causes of death

1.1 Under 75 mortality rate from cardiovascular disease (PHOF 4.4*)

1.2 Under 75 mortality rate from respiratory disease (PHOF 4.7*)

1.3 Under 75 mortality rate from liver disease (PHOF 4.6*)

1.4 Under 75 mortality rate from cancer (PHOF 4.5*)

i One- and ii Five-year survival from all cancers

iii One- and iv Five-year survival from breast, lung and colorectal cancer

Reducing premature death in people with serious mental illness

1.5 Excess under 75 mortality rate in adults with serious mental illness (PHOF 4.9*)

Reducing deaths in babies and young children

1.6 i Infant mortality (PHOF 4.1*)

ii Neonatal mortality and stillbirths

iii Five year survival from all cancers in children

2

2 Health-related quality of life for people with long-term conditions (ASCOF 1A**)

Improving functional ability in people with long-term conditions

2.2 Employment of people with long-term conditions (ASCOF 1E**, PHOF 1.8*)

Reducing time spent in hospital by people with long-term conditions

2.3 i Unplanned hospitalisation for chronic ambulatory care sensitive conditions

ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s

Enhancing quality of life for people with mental illness

2.5 Employment of people with mental illness (ASCOF 1F** & PHOF 1.8**)

Alignment with the NHS Outcomes Framework (cont.)

System objective four: people to have control over their lives and live as independently as possible

2

2 Health-related quality of life for people with long-term conditions (ASCOF 1A**)

Ensuring people feel supported to manage their condition

2.1 Proportion of people feeling supported to manage their condition

Improving functional ability in people with long-term conditions

2.2 Employment of people with long-term conditions (ASCOF 1E**, PHOF 1.8*)

Reducing time spent in hospital by people with long-term conditions

2.3 i Unplanned hospitalisation for chronic ambulatory care sensitive conditions
ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s

Enhancing quality of life for carers

2.4 Health-related quality of life for carers (ASCOF 1D**)

Enhancing quality of life for people with mental illness

2.5 Employment of people with mental illness (ASCOF 1F** & PHOF 1.8**)

4

4a Patient experience of primary care

i GP services
ii GP Out-of-hours services
iii NHS dental services

4b Patient experience of hospital care

Improving hospitals' responsiveness to personal needs

4.2 Responsiveness to in-patients' personal needs

Improving the experience of care for people at the end of their lives

4.6 Bereaved carers' views on the quality of care in the last 3 months of life

Improving experience of healthcare for people with mental illness

4.7 Patient experience of community mental health services

3

3a Emergency admissions for acute conditions that should not usually require hospital admission
3b Emergency readmissions within 30 days of discharge from hospital (PHOF 4.11*)

Improving outcomes from planned treatments

3.1 Total health gain as assessed by patients for elective procedures
i Hip replacement ii Knee replacement iii Groin hernia iv Varicose veins
v Psychological therapies

Preventing lower respiratory tract infections (LRTI) in children from becoming serious

3.2 Emergency admissions for children with LRTI

Improving recovery from injuries and trauma

3.3 Survival from major trauma

Improving recovery from stroke

3.4 Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months

Improving recovery from fragility fractures

3.5 Proportion of patients recovering to their previous levels of mobility/walking ability at i 30 and ii 120 days

Helping older people to recover their independence after illness or injury

3.6 i Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation service (ASCOF 2B[1]*)
ii Proportion offered rehabilitation following discharge from acute or community hospital (ASCOF 2B[2]*)

Alignment with the NHS Outcomes Framework (cont.)

System objective five: to enable our older population and those adults with social care needs to lead fulfilling lives as citizens

1

1b Life expectancy at 75
i Males ii Females

Reducing premature death in people with a learning disability

1.7 Excess under 60 mortality rate in adults with a learning disability

2

2 Health-related quality of life for people with long-term conditions (ASCOF 1A^{**})

Enhancing quality of life for people with mental illness

2.5 Employment of people with mental illness (ASCOF 1F^{**} & PHOF 1.8^{**})

Enhancing quality of life for people with dementia

2.6 i Estimated diagnosis rate for people with dementia (PHOF 4.16^{*})
ii A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life (ASCOF 2F^{**})

3

Improving recovery from stroke

3.4 Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months

Improving recovery from fragility fractures

3.5 Proportion of patients recovering to their previous levels of mobility/walking ability at i 30 and ii 120 days

Helping older people to recover their independence after illness or injury

3.6 i Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation service (ASCOF 2B[1]^{*})
ii Proportion offered rehabilitation following discharge from acute or community hospital (ASCOF 2B[2]^{*})

4

4a Patient experience of primary care

i GP services

ii GP Out-of-hours services

iii NHS dental services

4b Patient experience of hospital care

4c Friends and family test

Improving people's experience of integrated care

4.9 People's experience of integrated care (ASCOF 3E^{**})

Improving experience of healthcare for people with mental illness

4.7 Patient experience of community mental health services



Strategic Plan 2014-19

Published June 2014