NHS
Southend
Clinical Commissioning Group

NHS Southend Clinical Commissioning Group

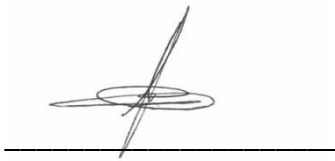
Operational Plan

2015-16

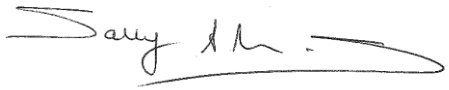
Giving the citizens of Southend the best possible opportunity to live long, fulfilling, healthy lives

Key Partner Signatures – NHS Southend CCG Operational Plan 2015/16

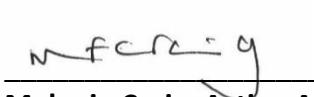
I hereby confirm the whole system sign off of the Southend CCG Operational Plan 2015/16 on 27th February 2015:



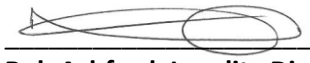
Dr José Garcia, Chair
NHS Southend CCG



Sally Morris, Chief Executive
South Essex Partnership NHS Foundation Trust



Melanie Craig, Acting Accountable Office
NHS Southend CCG



Rob Ashford, Locality Director (Essex)
East of England Ambulance Service NHS Trust

Rob Tinlin, Chief Executive
Southend-on-Sea Borough Council

Ian Stidston, Accountable Officer
NHS Castle Point & Rochford CCG

Sue Hardy, Deputy Chief Executive
Southend University Hospital NHS Foundation Trust

Foreword

This plan is the second year of our five year strategy to deliver improved health services to the citizens of Southend-on-Sea. Our programme for 2015/16 is both exciting and challenging and relies on a whole-system approach for its delivery.

Together with our partners we aim to deliver on four key areas of focus as well as a number of other initiatives to improve the lives of the citizens of the borough.

For 2015/16 we are specifically focusing on:

- Delivering six clinical transformation programmes in partnership with NHS Southend University Hospital Foundation Trust and NHS Castle Point and Rochford Clinical Commissioning Group (Stroke; Musculoskeletal; Ophthalmology; Diabetes; Ambulatory Care and Children's Services).
- Implementing Better Care Fund programme (and integrated Pioneer programme) in partnership with Southend-on-Sea Borough Council (SBC).
- Increasing our focus on Mental Health and Learning Disability Services (Dementia; IAPT; Winterbourne)
- Strengthening and building on our solid foundation to consistently deliver the core constitutional standards and our financial plan.

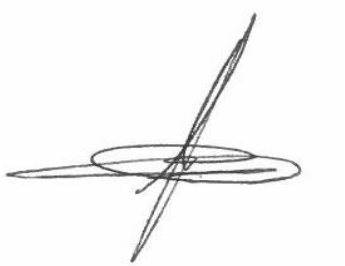
This plan has been developed by NHS Southend Clinical Commissioning Group (CCG) in conjunction with member practices and partner organisations (relative to specific sections).

We continue to improve and progress on the foundations put in place during 2014/15. Our Plan, the work streams within the plan and the ambitions have been discussed and agreed at our Governing Body, clinical executive and our GP member forums to ensure support from clinical commissioners. All our plans are based on needs assessment data as evidenced by the Director of Public Health's annual report for 2014/15 and the draft Joint Strategic Needs Assessment.

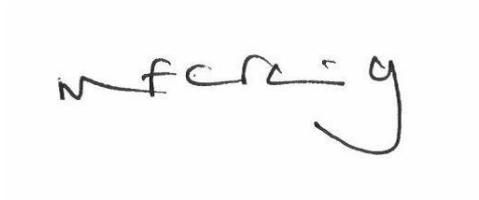
We are working with our partners as a health and social care economy to be clear about how the system will achieve sustainable service and financial performance whilst delivering quality and productivity improvements.

This has included individual discussions with our two key providers - Southend University Hospital NHS Foundation Trust (SUHFT) and South Essex Partnership NHS Foundation Trust (SEPT) - as well as with our main commissioning partners, Southend-on-Sea Borough Council and Castle Point and Rochford CCG.

We have separated this report into nine sections, each of which focusses on different areas of delivery and responsibility and where we set out our ambitions for the coming year. A one page summary can be found on the following page.



Dr. José Garcia-Lobera
GP, Governing Body Member and Chair of the CCG



Melanie Craig
Acting Accountable Officer

Dr Krishna Chaturvedi
GP, Governing Body Member and Chair of Clinical Executive Committee

Key areas of focus for the 2015/16 operational plan

1. **Deliver six priority transformation schemes in partnership with SUHFT and CP&R CCG (Stroke; Musculoskeletal; Ophthalmology; Diabetes; Ambulatory Care and Children's Services).**
2. **Implement Better Care Fund programme (and integrated Pioneer programme) in partnership with Southend-on-Sea Borough Council (SBC)**
3. **Increase our focus on Mental Health and Learning Disability Services (Dementia; IAPT; Winterbourne)**
4. **Strengthen and build on our solid foundation to consistently deliver the core constitutional standards and our financial plan**

Access

Meeting the NHS Constitution standards and mandate commitments.

A&E: System Resilience Group, working with partners in SE Essex, to consistently meet the national operating standard (95%) & clinical standards for 7 day services. Systems wide focus on respiratory admissions, improving quality of care to care homes & domiciliary care providers.
Winter resilience: Commission the most effective winter resilience schemes in 15/16. Early planning & testing for post black escalation & increasing uptake of flu and pneumonia vaccinations. Focus on care homes patients to reduce admissions.
RTT: Work with SUHFT on theatre utilisation & productivity, re-profiling outpatient clinics, continued outsourcing where appropriate. Continue to ensure rigour around PTL management.
Cancer: Strong focus on 62 day wait in line with Cancer Recovery Plan. Explore opportunities for collaborative arrangements starting with Urology pathway.
Diagnostics: Increase provision of community endoscopy & community ultrasound services through re- procurement led by CP&R.
IAPT: Deliver new max waiting times for IAPT through continued engagement with GP, SEPT and the voluntary sector. Jointly commission Community Recovery College with SBC.
Dementia: Jointly commission Dementia services with SBC for community support. Ensure continued increase in diagnosis rates
Early intervention: Strengthen local services to support EIP, work with partners on local action for Crisis Care concordat. Promote Personal Health Budgets
Primary Care: Support the development of a GP federation. Support practices to increase access and move towards 7 day services. Support practice led initiatives to reduce emergency admissions.

Outcomes

Delivery across the five domains and seven outcome measures

Improving health: Priority attention given to 6 major transformation programmes working with partners in CP&R, SUHFT and the community to improve clinical outcomes, quality of life and ensure delivery across the 5 domain and 7 outcome measures. The programmes are:
Stroke: Improving clinical outcomes by transformation across the entire stroke pathway, building on our existing excellence in stroke care.
Diabetes: Developing an integrated service to improve outcomes for people with diabetes.
Ambulatory Care: Redesigning care pathways to reduce time spent in hospital settings, improve patient experience and ensure greater continuity of care.
Ophthalmology: Redesign of pathways to increase community access and ensure greater productivity and efficiency.
Children's services: Transform pathways of care in children's services through child and carer centred services in community and primary care settings.
MSK: redesign MSK services to increase productivity and efficiency.
Reducing health inequalities: Through the "Success for All" National Lottery funded programme, support programmes to improve outcomes for the 0-3's across six deprived wards in Southend. Promote empowerment and engagement to communities in Southend through the c2c programme.
Parity of esteem: Increase investment in MH services and, following the successful pilot over the winter, permanently commission RAID (rapid assessment interface and discharge) service for people with MH extending the service to link with CAMHs and Drug and Alcohol services.

Quality

Patient safety: Continued zero tolerance of MRSA and infection control targets. Implement amended national early warning scoring tool (NEWS). Support provider to deliver CQUINS for GP advice, respiratory, cancer survivorship &clinical trials.
Patient experience: Implement a "tell us how it is" programme by meeting patients & public inviting comments on their experiences of healthcare.
Compassion in practice: Monitor the embedding of 6Cs in hearts, minds and practice of frontline staff through targeted visits and discussions.
Safeguarding: Implementation of MASH (safeguarding hub). Implement protocols for protection of people living in own homes or supported living, ensuring liberties are not deprived. Implement the updated accountability & assurance framework.
Children: support clinicians in identifying triggers to recognise potential victims of Child Sexual Exploitation (CSE). Increase vigilance for safety of children & adolescents requiring Mental Health services.
Staff satisfaction: Introduce programme to monitor staff satisfaction levels on a regular basis. Continue regular staff briefings. Build on and increase, communication with staff through different media and extend benefits i.e. NHS discount and lease car programme, new induction pack.
Seven day services: Following a system exercise in 14/15, implement 7 day services programme supporting the hospital as national early adopter site.
Response to Francis, Berwick and Winterbourne View
Reconfiguration: Work in partnership to accelerate the transformation of care for people with LD and the lessons learned from the Winterbourne report, overseen through the creation of a new system wide Transformation of Care Board.

Delivering value

Financial resilience; delivering VFM for taxpayers and patients and procurement

Surplus/Deficit: 2015/16 moves into in-year surplus achieving 1% surplus (£2.3m). Net QIPP delivery £7.2m.
Underlying cumulative deficit: Fully repaid by 2016/17
Investments: Identified for Primary Care and community services and system resilience, with investments to support QIPP in CHC and Medicines management.
0.5% contingency: Identified as well as QIPP contingency against stretch delivery target
Activity assumptions: Have been modelled by speciality, with generic growth at 0.68%, acute in line with national planning guidance. CHC non-demographic growth 10% and prescribing 4%.
BCF : Our assumptions in the plan link to BCF plans. We aim for a 3.5% reduction in emergency admissions.

Transformation programmes, reconfiguration plans and reprocurement

- Transformation in Stroke, MSK, Ophthalmology, Diabetes, Ambulatory Care and Children's Services
- Better Care Fund in partnership with SBC.
- Care Act – working with Health & Wellbeing Board
- SEND reforms
- Care Homes and domiciliary care providers – Vanguard bid led by SUHFT through the System Resilience Group
- Re-procurement – community diagnostics, Essex wide CAMHs (led by W.Essex CCG).
- Learning Disability – Essex wide procurement for additional capacity and community support

NHS
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Section 1: Southend

In this section:

- **The Southend Health System**
- **NHS Southend Clinical Commissioning Group (CCG)**
- **Our Partners**

1. Southend CCG and the wider health system

The Southend Health System

The Southend health system comprises a wide partnership of agencies and is committed to a shared ambition of improving the health and wellbeing of our communities. The vision of the Southend Health and Wellbeing Board is to ensure that everyone living in Southend-on-Sea has the best possible opportunity to live long, fulfilling and healthy lives.

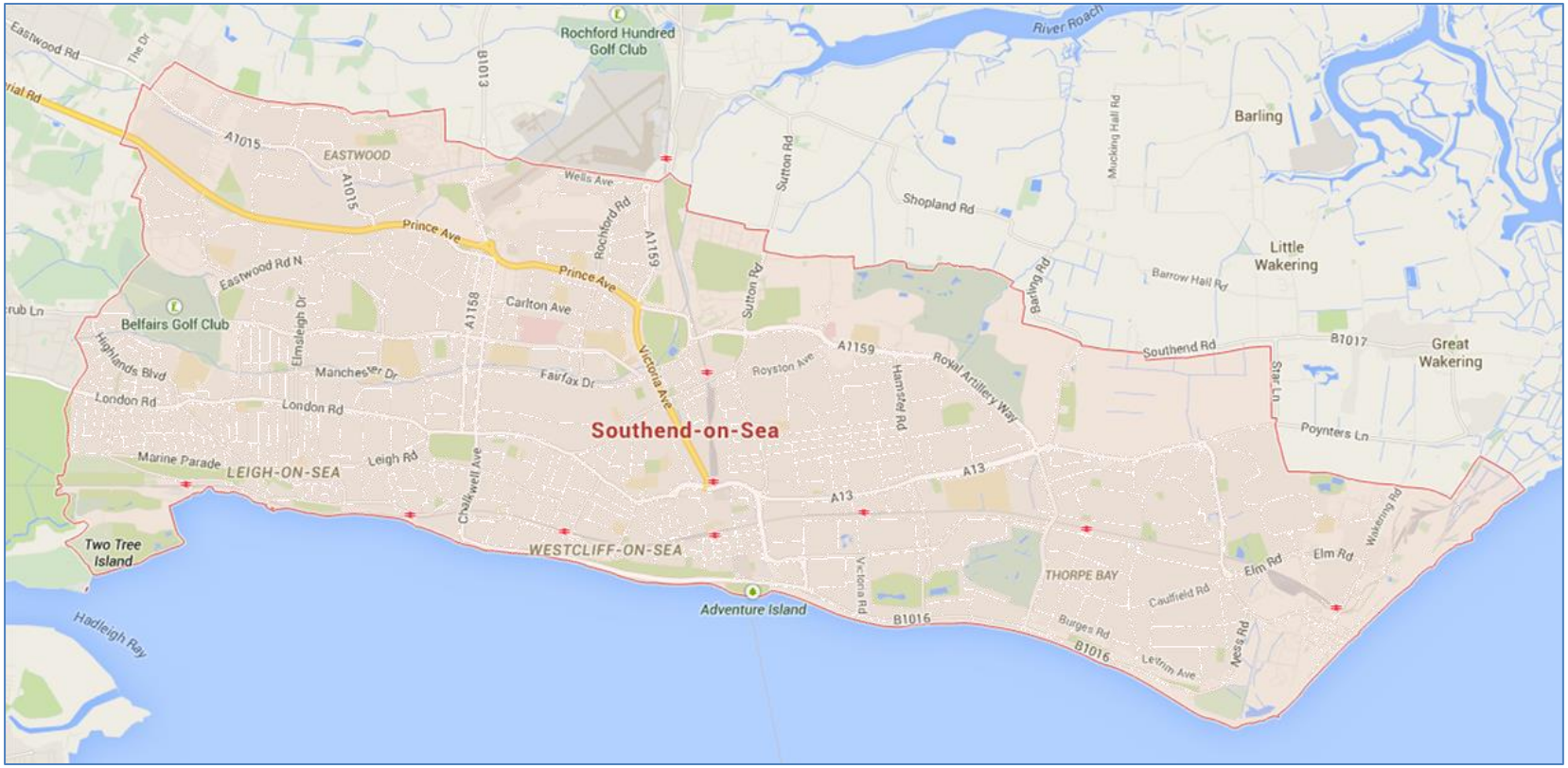
The Southend health system influences many factors that affect our communities' health and wellbeing from housing, education and social care to leisure opportunities and health care. We are committed to working closely with our partners and with our communities to ensure that we contribute effectively to the achievement of this vision and jointly make Southend an even better place to be.

Southend is one of the UK's more densely populated areas and the health system serves a resident population of more than 183,000 people; 29 per cent of the population is under 25 years old while 18.3 per cent is aged over 65. The proportion of the population aged 85 or older is 2.9 per cent [Census 2011].

The population of Southend is predicted to increase by 3.8 per cent (6,600) by 2018 and by 9.3 per cent (16,400) by 2025. The 65-and-over age group is predicted to increase by 9.1 per cent (2,980) by 2018 and by 24 per cent (7,884) by 2025 and this will drive a much greater increase in demand.

The health of people in Southend is varied compared with the England average. There are a number of areas where we have higher disease prevalence than the England average. These include cardiovascular disease, heart failure, hypothyroidism and mental health [CCG Outcomes Tool]. Southend is expected to face significant increases in the prevalence of several chronic diseases including COPD (projected 11 per cent increase by 2015), diabetes (projected 12.5 per cent increase in 2015), stroke (projected 9.5 per cent increase in 2015) and hypertension (projected 4.5 per cent increase in 2015).

Life expectancy for men is similar to the England average, whereas for women it is lower that the England average. However life expectancy varies across Southend as there are significant inequalities for the population: life expectancy is 9.1 years lower for men and 8.8 years lower for women in the most deprived areas than in the least deprived areas.



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.

NHS Southend Clinical Commissioning Group (CCG)

NHS Southend CCG is a clinically led organisation made up of a group of GPs and clinicians, led by Dr. José Garcia-Lobera, which commissions health services for our local communities. This places us in the best position possible to shape healthcare for the people we serve. The CCG is made up of 35 member GP practices and covers Southend, Leigh, Chalkwell, Westcliff, Thorpe Bay and Shoeburyness. We work with our practices to improve the quality of primary care, and we engage with individual member practices via our GP member's forum and linked GP arrangements. This enables our GPs to be more involved with our commissioning work. Our **values**, which have been shaped by our staff and stakeholders, fully align with the principles laid out in the NHS Constitution.

Clinically led
Clinicians play a central role in leading our organisation.
Centred on patients, families and carers
We place patients, families and carers at the centre of everything we do.
Equalities
We will be relentless in our efforts to reduce inequalities in our population and ensure that the services we commission are accessible to all who need them.
Safety
All providers we commission must demonstrate delivering a safe service is their top priority. Safeguarding training will be provided to all staff groups.

Quality
We will strive to maximise quality by promoting optimal use of evidence based guidelines.
Best use of public money
We will demonstrate strong population involvement, governance and accountability to assure we are achieving best value for money.
Excellence and professionalism
We will create a professional environment that motivates its people to perform and excel.
Working across organisation's in partnership
We will be proactive in seeking opportunities to advance our cause through joint collaboration with neighbouring commissioners, commissioning support unit, acute, community and mental health trusts, local council, and other key stakeholders.

NHS Southend Clinical Commissioning Group Governing Body

Dr José Garcia Lobera,
GP, Chair

Dr Krishna Chaturvedi
GP, Clinical Executive Committee Chair

Dr Bilquis Agha
GP

Dr Fahim Khan
GP

Dr Peter Long
GP

Dr Devesh Sharma
Secondary Care Consultant

Dr Kelvin Ng
GP

Dr Brian Houston
GP

Charles Cormack
Lay Member Governance & Deputy-Chair

Melanie Craig
Acting Accountable Officer

Jason Skinner
Chief Finance Officer

Linda Dowse
Chief Nurse

Janis Gibson
Lay Member Patient and Public Involvement

Simon Leftley
Director of People (SBC)

Dr Andrea Atherton
Director of Public Health (SBC)

Corporate Responsibilities

We continue to prioritise the management of risk to ensure there is no impact on the organisation's objectives. We do this by recognising risk in our day to day work. Our risk management strategy shows our commitment to managing clinical, corporate and financial risk and is regularly reviewed by the CCG's auditors. The Governing Body Assurance Framework and the Corporate Risk register are the reporting mechanisms where risks are reported and monitored through the CCG's internal governance committee structures.

- Robust approach to risk management
- Risk management strategy regularly reviewed by auditors
- Governing Body Assurance Framework (GBAF) and corporate risk register (CRR), regularly updated
- GBAF presented to Governing Body meetings in public to demonstrate openness and transparency in our approach to risk and also the audit and risk committee to provide assurance. The CRR is presented to each meeting of the QFP (monthly). These risk registers are also presented to the weekly operational executive group on a monthly basis, to ensure additional scrutiny.
- During 2013/14 the CCG adopted constructive feedback from its internal auditors in relation to how it manages risk and also from internal audit reports on governance and risk. The CCG's template for risk management has also been shared across other CCGs in South Essex as an example of good practice in this area.
- In addition, the Quality, Finance and Performance (QFP) committee has approved recommendations to include operational risk owners and also to identify all risks as belonging to financial, operational or compliance categories.
- A further development in this area is the creation of a dedicated monthly risk management meeting, attended by risk owners, where robust discussions take place in relation to all risks. This ensures that the risks are fully understood, that they are recorded on the appropriate register and are scored appropriately. This approach was recommended by the CCG's external auditors in November 2014 and adopted in December 2014.

Policy Governance

- Where policies relate to a specialist area, such as HR, Information Governance, IT or Procurement, the CCG's commissioning support unit lead on these.

- All policies are developed by the CCG and are then ratified through the CCG's internal governance processes.

- The staff involvement group will also receive internal policies for comment, enabling additional scrutiny and input to policies that have an impact on staff.

Freedom of Information (FOI) and Information Governance (IG)

- The CCG uses FOI requests to learn about the sort of information the public are interested in and endeavours to provide as much as possible on the website and take a proactive approach.

- All staff undertake their annual IG training and this contributes to the CCG's IG toolkit, last year achieving an 84% rate of compliance.

- All staff are made aware of their individual responsibilities in relation to data protection and confidentiality of patient and other sensitive information.

Progress in 2014/15

We are moving into our third year with a more solid foundation for our organisation. We have strengthened our clinical and managerial teams and reduced the use of interim managers, to build organisational memory and ensure we have the capacity and capabilities to ensure future sustainability.

We have new clinical leadership with a new Chair, Dr. José Garcia-Lobera, and for the clinical executive we have appointed Dr Krishna Chaturvedi as chair. They have brought with them extensive knowledge and experience of the health challenges facing Southend to help us shape and deliver our challenging commissioning agenda now and in the future.

This has been a defining year for Southend CCG:

- We have delivered the first year of our Financial Recovery Plan achieving our planned financial position for 2014/15 and forecasting to return a surplus in 2015/16.
- We have improved our delivery of our constitutional targets
- We have established a strong system resilience group which has overseen the delivery of an emergency care improvement plan which has:
    - strengthened our A&E performance
    - strengthened our Referral to Treatment Time (RTT) performance
- During our first full year of Pioneer status, we have accelerated our partnership work with Southend Borough Council and other partners to further integrate health and social care
- Our Better Care Fund application was approved, one of only two CCGs in the east to achieve this
- Our QIPP programme continues to support the delivery of organisational objectives.
- We were one of the partners in the Big Lottery Fund application and won £40m over the next 10 years for our 'Stronger Families, Future Communities' project which was a major achievement.
- Following various reviews of our sustainability as a commissioning organisation we have agreed our position with partners to form two separate strategic alliances, one with NHS Castle Point and Rochford CCG and the other with Southend Borough Council. These are outlined later in this document.
- We have made a significant decision with regards to our approach to referral management, which we have been reviewing for the past two years. This is an important issue as, historically, there has been inequalities for patients across the borough.

2015/16

As a result of an organisational review we carried out in the summer, we recruited to a number of key roles within the organisation to strengthen the managerial leadership and clinical leadership team. We have ensured that the financial position of the CCG - which underpins the services and developments we commission - is returned to a strong footing. We aim to build on the recovery we have already made and cement the progress on our constitutional standards.

As we enter our third year as an organisation we will continue to build on these foundations to help plan ahead and enhance the positive working relations we have with partners. We will work closely with our partners on our six main transformational areas of focus which we developed through a series of workshops and joint sessions, these being:

1. Stroke services
2. MSK services
3. Opthalmology
4. Diabetes
5. Ambulatory Care
6. Children's services

We are working collaboratively with the hospital to deliver emergency, elective and non-elective care improvements and have identified dedicated resources to work alongside SUHFT management to deliver on area such as Referral to Treatment Time (RTT) and ambulance waiting times.

Our work with South Essex University Partnership Trust (SEPT) has also progressed with collaborative clinical and managerial arrangements in place around *Improving Access to Psychological Therapies* (IAPT) and Dementia services. 2015/16 will bring additional challenges for both organisations around the new Mental Health waiting time targets, the continued progress on IAPT and Dementia and partnership working on the mental health crisis care concordat. Our response to the Winterbourne Report is in our Transformation of Care section.

We will continue to exploit the two key alliances we have, with NHS Castle Point and Rochford CCG and Southend Borough Council.

With CP&R CCG we are building a joint acute commissioning and contracting team with a joint director who will be a member of both CCGs' governing bodies.

This will ensure that we are making joint decisions around services that we share including ambulance, hospital and community services as well as our joint Quality, Innovation, Productivity and Prevention (QIPP) plans. This team will also lead the delivery of the six transformation programmes for both CCGs.

Our work to integrate health and social care in accelerating with Southend-on-Sea Borough Council. We have built an integrated commissioning team with a joint Associate Director of Integrated Care. This team leads on the commissioning of children's, older people's, learning disabilities and mental health services for both the council and the CCG.

Along with our partners, we have set ourselves a significant challenge to make Southend 'the healthiest town in England by 2020'. This is based on an agreed commitment to a transformational change programme which, at its heart, has a strong strategic alliance to deliver a *step change* in health and social care in Southend.

There are a number of large projects which also commit us to significant partner working with local government, other NHS organisations and the voluntary sector, including our Pioneer status and the Better Care Fund. Through the BCF, the CCG and the Council plan to invest more than £12m in a jointly managed fund to improve the lives of our population.

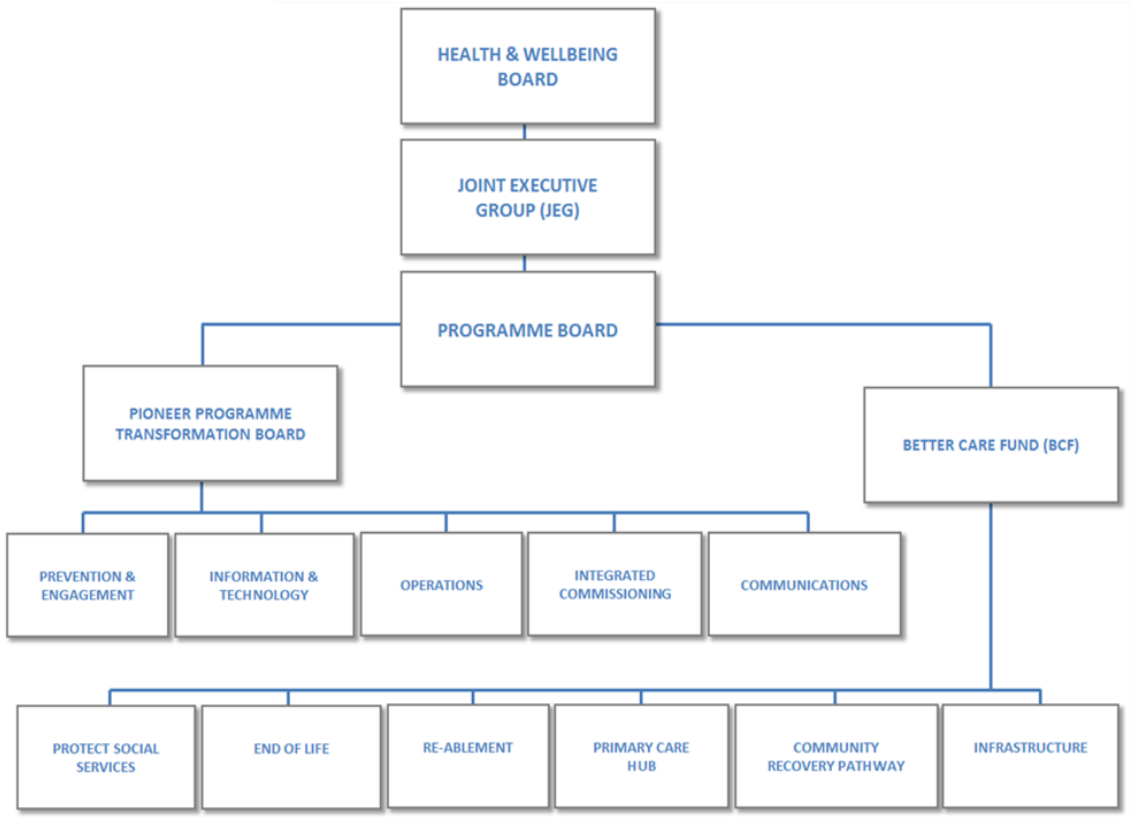
During a visit to Southend, the Government Minister for Care praised the innovative work of health and social care staff. Rt Hon Norman Lamb MP, Minister of State for Care and Support (*pictured*) visited the borough to see how the Pioneer project was progressing just over a year after the Government announced Southend as one of just 14 Pioneer areas in the country. Mr Lamb said: "I had an excellent visit to the Southend Pioneer service. It was great to see the energy and enthusiasm of health and care staff and hear about their how they are working together to make changes that have a real impact on improving services for local people."

"It was great to see the energy and enthusiasm of health and care staff"
Rt. Hon Norman Lamb MP, Minister of State for Care and Support

Rt Hon Norman Lamb MP, Minister of State for Care and Support meets Acting Accountable Office Melanie Craig and CCG Chair Dr. José Garcia Lobera GP during his visit to the Southend Pioneer project.

Data sharing sits at the heart of much of the partnership planning and integrated services we hope to undertake in the coming year. This is a complex issue but Southend CCG and the Council are leading the way to create a solution which will benefit all parts of the UK which are seeking to integrate the delivery of health and social care.

The Government has provisionally approved Southend's data sharing plan with conditions and the Pioneer team are now reviewing those conditions in order to take this project to the next stage. A successful outcome will enable doctors, nurses, social workers and volunteers to work together in a far more integrated fashion to deliver a more personal and joined-up service for patients, particularly those with multiple care needs. Providing a strategic overview of all partnership work, the borough's Health and Wellbeing Board ensures there is communication and coordination between all partners.



The HWB is made up of local statutory organisations and health related partners who are working together to improve health and wellbeing for Southend's citizens.

It is chaired by Cllr David Norman MBE and Dr. José Garcia-Lobera is deputy chair. Its ambition is that everyone living in Southend has the best possible opportunity to live long, fulfilling, healthy lives. Sitting beneath this is the Joint Executive Group which has a primary focus on Better Care Fund, Integrated Pioneer programme and Access to 7-day services.

Patient and Public Participation and Engagement

Patient Participation Groups (PPGs) are practice-based groups that create a partnership between patients and the GP practice so they can work together to improve services provided by the practice. NHS Southend CCG supports the chairs of each PPG through the Patient Participation Group Forum (PPGF). This gives the CCG first-hand knowledge of the experience and views of users of the service in all parts of Southend. It also gives the opportunity for good practice to be shared and disseminated by the members of the Forum.

The CCG also has a Patient & Public Engagement & Involvement Steering Group, made up of representatives from local groups and voluntary organisations. The steering group has a different role to the PPGF, as its purpose is to organise and oversee engagement and involvement activity for the CCG. The CCG hosts meetings for both groups as well as briefings and training events.

Our Partners

Partnership working has become increasingly vital in the planning and delivery of health and social care in Southend. As such, NHS Southend CCG is in a formal strategic partnership through the Southend Health and Wellbeing Board and its sub-groups. This section details our partners and the role each plays in assisting NHS Southend CCG in planning and delivering health and social care across the borough.

Southend GP practices

NHS Southend CCG is made up of 35 GP member practices of which 11 are operated by a single GP. We have a high percentage of smaller practices – 23 have a registered list of under 5000. One practice has closed in the past year and its patient list dispersed following the retirement of a GP running a single-handed practice. We work with our member practices to support improvements 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. We also have linked GPs for specific areas and through this programme they are able to engage more fully with CCG planning and commissioning.

Southend-on-Sea Borough Council

Southend 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 45 per cent of its revenue spending. The Council is a key partner for the development of integrated care. We have partnered with the Council to deliver our joint Better Care Fund (BCF) initiative allowing us to work together to create a health and social care economy in which the population can access optimal care and enable urgent care to be delivered with maximum efficiency and effectiveness. We will also continue our progress from 2014/15 on fully integrated joint commissioning led by our joint Associate Director of Integrated Care and her joint commissioning team for children's services, learning disability services, mental health and older people's services.

NHS Castle Point and Rochford Clinical Commissioning Group

NHS Castle Point and Rochford CCG is our neighbouring CCG. We share our acute provider (Southend University Hospital NHS Foundation Trust) and community and mental health provider (South Essex Partnership University NHS Foundation Trust). We have established a joint clinical executive with NHS Castle Point and Rochford CCG and we make joint decisions about shared services and providers. We are also working together with the CCG to deliver six transformation programmes through our joint acute commissioning and contracting team.

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. In 2015/16 the Trust will be a key player in the delivery of the joint schemes we have identified with Castle Point and Rochford CCG to deliver better care in Stroke, MSK, Opthalmology, Diabetes, Ambulatory Care and Children's services.

As part of the acute services pathway review we are exploring opportunities across the system to ensure our five Essex hospitals are resilient and maximise opportunities for collaboration to improve quality and clinical outcomes.

South Essex Partnership University NHS Foundation Trust (SEPT)

SEPT is a successful Foundation Trust 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 is the provider of most community and mental health services in Southend. In 2015/16 we will be working closely with the Trust and exploiting our already positive relationship to ensure that the agendas around parity, mental health and Winterbourne are all progressed substantially.

NHS England

NHS England oversees the budget, planning, delivery and day-to-day operation of the commissioning side of the NHS and so works closely with Southend CCG to assure the delivery of its plan and statutory obligations. Additionally we will continue to work closely with NHS England to be involved in decisions around the commissioning of primary care services through our level one status for co-commissioning, and to work closely with them on specialist commissioning to ensure that patient pathways are seamless.

Healthwatch Southend

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

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.

Integrated Care 24 (IC24)

IC24 is a major not-for-profit social enterprise company which provides a range of primary care services. In Southend, it is the provider of our NHS111 service as well as the out-of-hours service for GPs.

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 more than 900,000 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.

North East London Commissioning Support Unit (NELCSU)

NEL CSU provides expert support and advice to Southend CCG deliver improved health services to the local populations. For Southend CCG the CSU provides a range of services including technical finance, contracting, business intelligence, HR support and ICT.

We also work with a number of other partners in our delivery of health services across the locality including Arden CSU, Attain and other CCG partners across the whole of Essex. NHS Southend CCG also hosts a number of services and functions for other CCG partners, including medicines management, quality and safeguarding.

Section 2: Outcomes

In this section:

Outcomes

- Improving Health (Clinical Transformational Programmes)
- Better Care Fund
- Medicines Management
- Continuing Healthcare
- Reducing Health Inequalities

2.0 Outcomes

We 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. We will measure the impact and outcomes of our work using the NHS Outcomes Framework. We continue to progress our performance measure trajectories identified in 2014/15 over the next five years. We have ensured the main themes in the 5 Year Forward View are integrated into our plans.

These performance measures also align to our Better Care Fund (delivered in partnership with Southend Borough Council), quality premium, NHS Constitution Measures and additional local measures where relevant. The NHS Outcomes Framework sets out five domains for improvement. These are:

- Preventing people from dying prematurely
- Enhancing quality of life for people with long term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm

Each of these domains have aligned outcome measures which we can use to identify those areas where we are doing well and those where we need to improve. To develop our targets against each of the outcome measures we have examined our past and current performance and the performance of peer comparator CCGs (using Commissioning for Value comparator group). Where there is a national target, we will aim to reach that target, otherwise we have set ourselves targets on the basis of improving performance to achieve the next quartile across the target period.

5 Domains for Improvement

Preventing people from dying prematurely

Enhancing quality of life for people with long term conditions

Helping people to recover from episodes of ill health or following injury

Ensuring people have a positive experience of care

Treating and caring for people in a safe environment and protecting them from avoidable harm

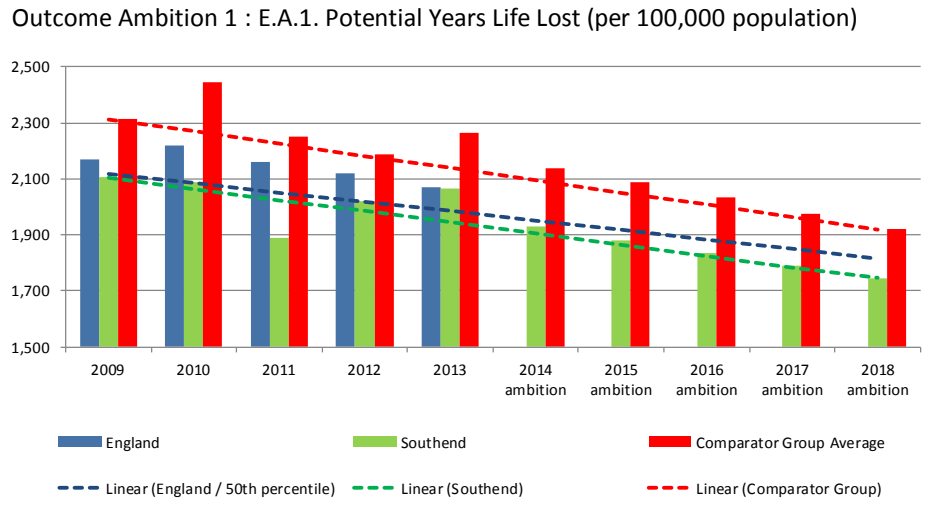
In addition to the national outcome ambitions we have also selected the following measure as a local ambition for our population; Improving and maintaining our Dementia ambitions. Further detail can be found in the Access section of this document, under '*Mental Health: Dementia'*.

We will be working with our partners from across the Southend health system to design the solutions that will enable us to deliver the ambitions we have set. At a glance our frameworks and measures are:

Below are the CCGs outcome ambitions with associated ambition targets upto 2018. These ambitions will be monitored via a performance system the CGG is developing to ensure sustained drive and focus towards the successful delivery of our ambition targets.

Each of our transformational programmes show which of the outcome ambitions the schemes relate to. These can be found at the bottom of each scheme.

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



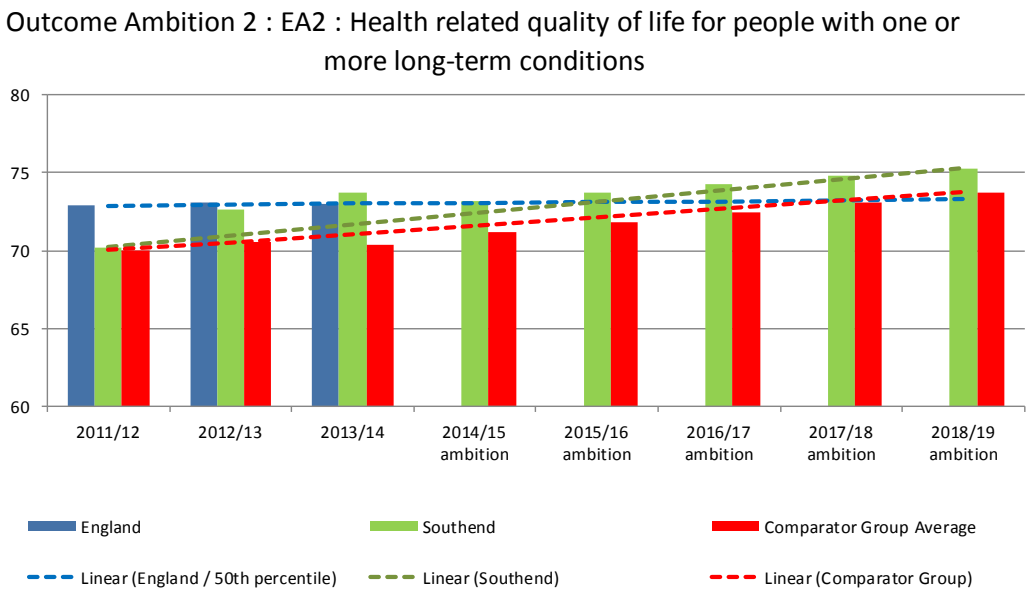
Date	Southend CCG Result / Target	% Change
2009	2,103.7	
2010	2,086.8	-0.8%
2011	1,886.7	-9.6%
2012	2,021.0	+7.1%
2013	2,067.3	+2.3%
2014 ambition	1,928.0	-6.7%
2015 ambition	1,881.6	-2.4%
2016 ambition	1,835.1	-2.5%
2017 ambition	1,790.6	-2.4%
2018 ambition	1,744.1	-2.6%

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). **Good performance is a low value.**

Frameworks: Outcome Ambition Measure and Quality Premium Measure (15% of Quality Premium). Please note: Quality Premium is based on the 2014/15 target.

Target: The national (Quality Premium) target was set at 3.2% for 2013 to 2014, and therefore a 16.0% drop by 2018.

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



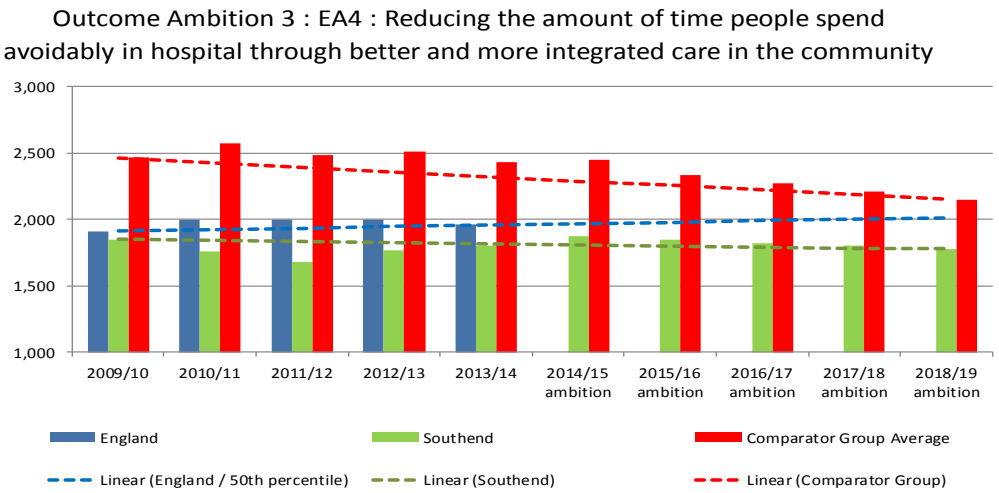
Date	Southend CCG Result / Target	% Change
2011/12	70.2	
2012/13	72.6	+3.4%
2013/14	73.7	+1.5%
2014/15 ambition	73.1	-0.8%
2015/16 ambition	73.7	+0.7%
2016/17 ambition	74.2	+0.7%
2017/18 ambition	74.8	+0.7%
2018/19 ambition	75.3	+0.7%

Definition: This indicator measures the average health status score of individuals who identify themselves as having a long-term condition (crude rate). **Good performance is a high value.**

Frameworks: Outcome Ambition measure.

Target: Given current performance, setting the 2018/19 target at 75.3 would bring the CCG into the existing best quartile (top 25%)

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



Date	Southend CCG Result / Target	% Change
2009/10	1,848.7	
2010/11	1,761.8	-4.7%
2011/12	1,679.9	-4.6%
2012/13	1,765.0	+5.1%
2013/14	1,801.8	+2.1%
2014/15 ambition	1,872.6	+3.9%
2015/16 ambition	1,848.3	-1.3%
2016/17 ambition	1,824.3	-1.3%
2017/18 ambition	1,800.5	-1.3%
2018/19 ambition	1,777.1	-1.3%

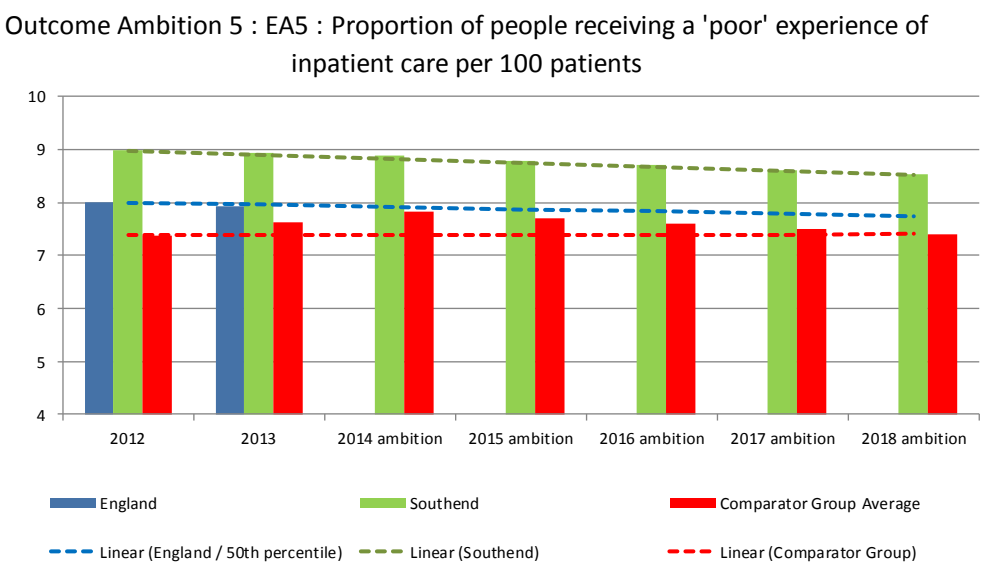
Definition: This is a composite measure of:

* 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.

Frameworks: Outcome Ambition Measure and Quality Premium Measure (accounts for 25% of Quality Premium) and Better Care Fund measure (although this works on a different geography).

Target: The target has been established as bringing the CCG to the next quartile (i.e. below 1,808) by 2018/19.

Outcome Ambition 5 : Increase the proportion of people having a positive experience of hospital care



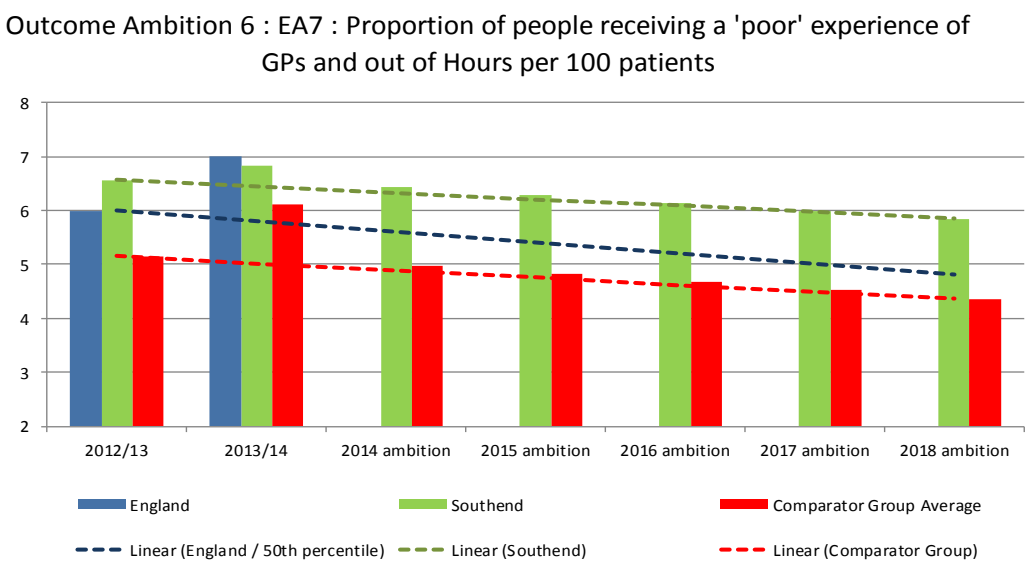
Date	Southend CCG Result / Target	% Change
2012	9.0	
2013	8.9	-0.5%
2014 ambition	8.9	-0.5%
2015 ambition	8.8	-1.0%
2016 ambition	8.7	-1.0%
2017 ambition	8.6	-1.0%
2018 ambition	8.5	-1.0%

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, adjusted for a score per patient). **Good performance is a low value.**

Frameworks: Outcome Ambition Measure

Target: The minimum CCG score from 2012 was 7.2 and maximum 13.9 per 100 patients. The target was established as a 5% reduction on the baseline.

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



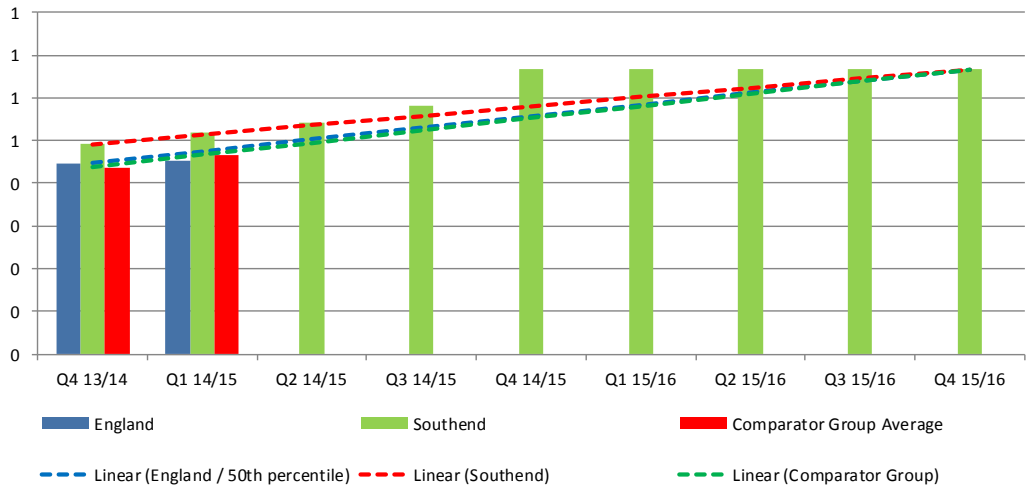
Date	Southend CCG Result / Target	% Change
2012/13	6.6	
2013/14	6.8	+4.1%
2014 ambition	6.4	-6.0%
2015 ambition	6.3	-2.3%
2016 ambition	6.1	-2.2%
2017 ambition	6.0	-2.4%
2018 ambition	5.9	-2.3%

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)

Frameworks: Outcome Ambition Measure

Target: The England average was 6.0 per 100 patients in 2012/13 and comparator group 5.2 per 100 patients. The stretch improvement is based on the CCG moving to the next quartile by 2018/19.

Local Ambition 1: Dementia Diagnosis Rates



Date	Southend CCG Result / Target	% Change
Q4 13/14	49.2%	
Q1 14/15	51.9%	+5.5%
Q2 14/15	54.2%	+4.4%
Q3 14/15	58.1%	+7.3%
Q4 14/15	66.7%	+14.8%
Q1 15/16	66.7%	+0.0%
Q2 15/16	66.7%	+0.0%
Q3 15/16	66.7%	+0.0%
Q4 15/16	66.7%	+0.0%

Definition: The proportion of the estimated number of people with dementia who will have a diagnosis and access to post diagnostic support.

Frameworks: Quality Outcomes Framework.

Target: The national target is 66.7% by the end of 2014/15 and we plan to achieve this target on an ongoing basis

2.1 Improving Health

We have designed a series of work streams to help us improve the health and wellbeing of people in Southend by the way that we commission services. Each of these work streams have been created in partnership and will help us achieve our ambitions as outlined in the 'Frameworks, measures and delivery' section of this plan.

All of these improvement work streams have been devised by taking a system-wide view of the health needs of the Southend population. Where possible and appropriate, we are commissioning services jointly with our partners. We have robust monitoring and governance processes in place to ensure the effective delivery of our improvement work streams. This section outlines our six key transformational programmes for 2015/16, which are:

1. Transformation Programme One: Stroke
2. Transformation Programme Two: MSK
3. Transformation Programme Three: Ophthalmology
4. Transformation Programme Four: Diabetes
5. Transformation Programme Five: Ambulatory Care
6. Transformation Programme Six: Children's Services

Our other priorities for improving health are:

- Better Care Fund
- Medicines Management
- Continuing Healthcare

There are also further transformational programmes around quality in other sections of this report, linked to mental health, learning disabilities and quality.

Clinical Transformational Programmes

Stroke

MSK

Ophthalmology

Diabetes

Ambulatory Care

Children's Services

Better Care Fund

Medicines Management

Continuing Healthcare

STROKE
CLINICAL TRANSFORMATION PROGRAMME ONE

Aim: Quality focused pathway redesign, leading to reduced mortality and disability, improved quality of life and patient experience.

Rationale for prioritisation: Stroke services in Southend are nationally recognised as achieving excellent standards of care and good outcomes. Continuing our close working partnership with both Southend Hospital and SEPT, we will commission enhanced and highly responsive services, beginning with patient presentation, progressing to the flow through the hospital service and finally delivering an evidence based model of specialist rehabilitation.

Local stroke experts believe modernising stroke services will optimise outcomes for patients, families and carers while also reducing the variation in stroke mortality. The requirement for local services to constantly develop and evolve is boosted by the continual advances in stroke care nationally.

Southend Hospital is a system leader in innovative stroke care, winning several awards for the development of the HOT TIA (transient ischaemic attack, or mini stroke) service and appointing a world class stroke specialist in surgical intervention.

Partners
SCCG, CP&R CCG, SUHFT

Leads
Dr Brian Houston, Dr Biju Kuriakose, Caroline McCarron

Outcomes for 2015/16
Reduced mortality
Increased independence
Lower cognitive and functional dependency
Improved access to intensive community rehabilitation

Resources
Dedicated clinical leads, project management support, finance and procurement support

Building on this success we plan to redesign the stroke rehabilitation pathway by enhancing early supported discharge services and providing wider access to community based stroke specialist rehabilitation.

Objectives	Activities	Governance	Measurement
Support the move towards centralised specialist stroke centres	Established local Stroke Network to continue.	Strong Clinical leadership through Planned Care Lead and Lead Stroke Consultant	Contractual KPIs relating to quality and outcomes i.e. % of time spent on the stroke unit, therapy provision
Achieve the level of success demonstrated by London hyper acute stroke units (HASUs)	*Collaborate with neighbouring CCGs, acute Trusts and Strategic Clinical Network to centralise specialist stroke services.*	Monthly monitoring of national stroke national audit program (SNAP) data via CCG performance meeting	Improved clinical outcomes on completion of rehabilitation.
Achieve further reduction in stroke mortality	Develop and implement primary and secondary prevention strategy	Bi-monthly monitoring of national SSNAP data via local Stroke Network	Reduced mortality rates
Support SUHFT to drive forward innovation in stroke care	Project group established to review the rehabilitation pathway and increase capacity of ESD services.	Bi-monthly monitoring by the Joint Clinical Executive Committee	
Support continued partnership working between acute and community stroke specialist services	Continue the extended pilot of psychological support for stroke patients, and analyse measurable benefits over 24 month period	Quality concerns monitored via SUHFT & SEPT clinical quality review group meetings	
Review the rehabilitation pathway from end to end		Escalation clauses written into contract in the event of poor performance or breach of contract	
Increase capacity of Stroke Early Supported Discharge Services (ESD)		Clinical Executive or Governing Body recommendation and/or decision in the event grave concerns about performance	
Support stroke specialist community services to deliver appropriate levels of therapy			
Improved clinical outcomes and reduced long term dependency			
Increased patient awareness of signs and symptoms i.e. FAST campaign			

Risk	Mitigation
Sustainability of HASU services in Southend University Hospital if catchment population not increased	Working with neighbouring CCGs and wider stakeholders to develop sustainable services
Insufficient resources available to make potential additional investment in additional services that would be required to support HASU status i.e. ambulance	Improved stroke services should generate efficiency savings, which would be reinvested in ambulance services as a priority
Recruitment, the limited number of stroke-specialist clinicians nationally may mean the Southend Hospital fails to fully recruit to deliver the service	SUHFT is developing a recruitment and retention plan to attract and keep appropriate specialist staff
Failure to adequately expand the early supported discharge initiative and review the rehabilitation pathway.	Pilot project has resulted in better patient outcomes and reduced long-term dependency on services

This work stream contributes to the achievement of the following targets, standards and ambitions:

- Outcome Ambition 1: E.A.1: Potential years of life lost from causes amenable to healthcare;
- Outcome Ambition 2: E.A.2: Health related quality of life for people with one or more long-term conditions;
- Outcome Ambition 3: E.A.4: Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community;
- Outcome Ambition 6: E.A.7: Increase the proportion of people having a positive experience of care outside of hospital, in general practice and in the community;

MUSCULOSKELETAL SERVICES (MSK)
CLINICAL TRANSFORMATION PROGRAMME TWO

Aim: Quality focused pathway redesign, combining a reduction in clinical variation and improved access to support services to optimise outcomes for patients and efficiencies for providers and commissioners.

Rationale for prioritisation: Population growth, especially within the elderly is putting MSK services under increasing pressure with local demand for MSK services increasing year-on-year. Outpatient appointments and elective admissions are all considerably higher than national averages, culminating in a higher than average cost for MSK services. Access to support services (i.e. diagnostics and physio) within primary care/community settings is limited. This combined with low referral thresholds leads to a heavy reliance on acute services. As a consequence, Southend Hospital is an outlier in terms of activity and cost; patient reported outcomes are poor in relation to the level of spend; and the national 18 week referral to treatment target is not met consistently.

In collaboration with local stakeholders we plan to develop an integrated MSK assessment and treatment model to span the pathway from first presentation in primary care through to potential surgery and focused rehabilitation with a strong emphasis on prevention, conservative management and enhanced community services. This new model will be designed to optimise outcomes at every stage of the pathway will provide operational and financial efficiencies whilst reducing the variation in care. This model is also intended to improve patient involvement in their own care options.

Partners
SCCG, CP&R CCG & SUHFT

Leads
Dr Brian Houston, Dr Biju Kuriakose, Caroline McCarron

Outcomes for 2015/16
Implementation of condition based pathways
Reduced variation in care
Improved clinical outcomes and patient experience
Intervention rates in line with national averages

Resources
Dedicated clinical leads and project manager appointment
Current spend circa £30m across Southend CCG and CP&R CCG.

Objectives	Activities	Governance	Measurement
Develop a fully integrated model for MSK services	Collaborative working with Castle Point & Rochford CCG and Southend University Hospital	Clinical leadership via Planned Care Lead	Reduction of activity and cost at specialty level to bring in line with national averages
Improved quality and consistency of referrals, standardising referral practices and reducing variation in Primary Care	Finalise development of an outcomes based MSK assessment and treatment model	Bi-monthly monitoring by the Joint Clinical Executive Committee	Increased levels of GP engagement measured through referral trends
High quality, seamless and responsive service	Focus on primary and secondary prevention in primary care	Monthly monitoring of key performance indicator (KPI) data via CCG Performance meeting	Improved patient experience.
Evidence based pathways and thresholds of care	Condition based pathways to be implemented	Escalation clauses written into contract in the event of poor performance or breach of contract	Contractual KPIs relating to quality and outcomes
Optimised outcomes at every stage of the pathway	Clinically led structured education in primary care	Clinical Executive or Governing Body recommendation and/or decision in the event grave concerns about performance	
Increased access to support services in primary care i.e. diagnostics, physio	Concentrated engagement with member practices		
Consistent achievement of 18 week referral to treatment times	Patient and wider stakeholder engagement		
Drive improvement where activity is inconsistent with national and local averages	Targeted practice visits, clinician to clinician		
Positive patient/family/carer experience Enhanced GP and allied health professional knowledge through structured education Reduce demand on secondary care services Effective use of resources, via a sustainable service providing good value for money	Monitor KPIs to ensure the service is meeting quality requirements		

Risk	Mitigation
Failure to achieve system wide consensus on the way forward	Partnership and collaborative working born out of a commitment to improve the quality and outcomes for MSK services
Failure to agree financial envelope for entire pathway provision	Detailed scoping and analysis
Provider non-compliance with protocols, thresholds, pathways etc. resulting in increased volumes	Strict monitoring through KPIs, escalation route to be agreed through contract
Disengagement of member practices resulting in minimal change to referral and treatment behaviours	Information pack to be developed explaining benefits of integration, pathways, positive changes etc.
Failure of member practices to participate in education	Structured sessions for both GPs and practice nurses, clear focus areas and continuing professional development points
Insufficient resources available to make potential additional investment in services i.e. increased physio provision	Improved access to support services should generate efficiency savings, which would be reinvested in the new model of care as a priority

This work stream contributes to the achievement of the following targets, standards and ambitions:

- Outcome Ambition 1: E.A.1: Potential years of life lost from causes amenable to healthcare;
- Outcome Ambition 2: E.A.2: Health related quality of life for people with one or more long-term conditions;
- Outcome Ambition 6: E.A.7: Increase the proportion of people having a positive experience of care outside of hospital, in general practice and in the community;

OPHTHALMOLOGY PROJECTS
CLINICAL TRANSFORMATION PROGRAMME THREE

Aim: Development of high quality alternative services in the community setting to address demand, standardise referral practice and ensure good eye health for our population

Rationale for prioritisation: Demand is growing for eye care services, our changing demographic and ageing population indicate that demand will continue to grow, directing the need for the development of sustainable services in an alternative setting.

The recently established South Essex Ophthalmology Network and illustrate the desire for partnership working across hospital, community and primary care services. Plans for local ophthalmology services are being delivered collaboratively through the Network to deliver a common vision to improve the eye health for the population of Southend and neighbouring areas.

Plans to develop alternative community services are a key focus for 2015/16 beginning with Shared Care Glaucoma. This will enable specialist acute and community based clinicians to share the responsibility for the long term follow up of stable glaucoma patients.

Further plans include the development of general community ophthalmology services, easy access to high quality services will improve the patient experience and reduce the pressure of demand on local hospital services.

Partners
SCCG, CP&R CCG, SUHFT, Community Opticians, Local Optical Committee

Leads
Dr Peter Long, Dr Biju Kuriakose, Emily Hughes

Outcomes for 2015/16
Increased community capacity
Reduced demand for hospital services
Follow up timescales achieved
Improved patient experience

Resources
Circa £10m across Southend CCG and CP&R CCG

Objectives	Activities	Governance	Measurement
Establish sustainable, quality ophthalmology services	South Essex Ophthalmology Network established, members from all 4 south Essex CCGs, SUHFT consultants and managers, Local Optical Committee representatives, local opticians and GPs plus a GP with a special interest	Clinical leadership via Planned Care Lead	Contractual KPIs relating to quality and outcomes
Develop high quality alternative service provision in the community	Shared vision for local eye care services agreed and priorities defined	Bi-monthly monitoring by South Essex Network	Reduction of GP referrals from baseline levels at CCG and practice levels
Develop and implement systems for shared care	Shared care glaucoma service specification developed and agreed system wide	Bi-monthly monitoring by the Joint Clinical Executive Committee	Reduction in cost of referrals from baseline levels
Ease demand and capacity pressures faced by SUHFT	Hospital based training in place for super optometrists	Monthly monitoring of key performance indicator (KPI) data via CCG Performance meeting	New to follow up ratio
Standardise referral practices and reduce variation in Primary Care	Public & patient engagement to develop future service models	Escalation clauses written into contract in the event of poor performance or breach of contract	% referrals directed to alternative specialties or services
Maximise patient choice from the most appropriate services available	Continued commissioning of Glaucoma triage service from local opticians	Clinical Executive or Governing Body recommendation and/or decision in the event grave concerns about performance	
Improved clinical outcomes and reduction in waiting times			
Excellent patient/family/carer experience			
Collate intelligent data to inform future commissioning decisions			

Risk	Mitigation
Failure to achieve system wide consensus on the way forward	Network role to facilitate discussion and recommend next steps
Failure to attract appropriate providers	Market research undertaken, wide scope of potential providers
Provider non-compliance with protocols, thresholds, pathways etc. resulting in increased volumes	Strict monitoring through KPIs, escalation route to be agreed through contract
Failure of SUHFT to identify gluacoma patients suitable for shared care	Patients already identified for transfer to shared care services.
Disengagement of member practices	Information pack to be developed explaining benefits of integration, pathways, positive changes etc.

This work stream contributes to the achievement of the following targets, standards and ambitions:

- Outcome Ambition 6: E.A.7: Increase the proportion of people having a positive experience of care outside of hospital, in general practice and in the community

DIABETES
CLINICAL TRANSFORMATION PROGRAMME FOUR

Aim: A seamless integrated care pathway providing high quality, responsive diabetes services spanning primary, community and acute care.

Rationale for prioritisation: Local diabetes services are currently operating in a fragmented way with inequitable levels of care and inconsistent outcomes. High levels of variation in primary care are evidenced by consistently poor QOF outcomes and poor recorded performance relating to the delivery of the NICE recommended care processes.

In addition, specialist acute and community diabetes services are unable to provide adequate levels of core diabetes care, gaps include specialist dietetic advice and insulin pump provision.

In collaboration with Castle Point & Rochford CCG we plan to implement a fully integrated acute and community service underpinned by primary care across south east Essex. This multi-disciplinary, consultant led service will provide high quality, seamless and responsive diabetes care through a tiered patient management approach, with clear treatment thresholds and management protocols.

Partners
SCCG, CP&R CCG, SUHFT & SEPT

Leads
Dr Peter Long, Dr Sunil Gupta, Emily Hughes

Outcomes for 2015/16
Reduction in emergency admissions
Reduction in 999 calls
Reduced variation in care
Improved QOF outcomes
Increased pump usage

Resources
Circa £1m across Southend CCG and CP&R CCG

A single seamless pathway will be in place to ensure consistent high level outcomes with additional patient and clinical education and expanded pump services. An integrated approach to provision of services is fundamental to the delivery of high-quality care to people with diabetes.

Objectives	Activities	Governance	Measurement
Fully integrated acute and community service underpinned by primary care across south east Essex	Agree Commission single contract with one chain of command and performance management route.	Clinical leadership via Planned Care Lead	Contractual KPIs relating to quality and outcomes i.e. patient participation in structured education
High quality, seamless and responsive diabetes service	Implement a defined integrated pathway with onward referral and management protocols embedded into the diabetes pathway.	Monthly monitoring of KPI data via CCG Performance meeting	Reduction of emergency admissions for diabetes
Tiered management approach – multi-disciplinary, consultant led	Clear referral/acceptance criteria for tiers 2, 3 & 4 and clear discharge protocols (with management plan)	Bi-monthly monitoring by the Joint Clinical Executive Committee	Reduction in cost of prescribing from baseline levels
Reduced variation of care delivered in primary care through clinical education	Provide structured education to primary care clinicians and AHPs	Monthly monitoring of prescribing activity via Drugs & Therapeutics Committee.	Improved QOF achievement at practice level
Individualised care planning agreed in partnership with patient, carers & health care professional	Additional structured education provision for patient/carers	Monthly reporting to Executive level via Quality, Finance & Performance meeting	
Improved self-management by patients and their family/carers through inclusion of goal setting	Utilise agreed prescribing formulary throughout primary, community and acute care	Escalation clauses written into contract in the event of poor performance or breach of contract	
Improved access to structured education delivered by accredited trainers	Patient and public engagement to shape services and collate feedback from changes	Clinical Executive or Governing Body recommendation and/or decision in the event grave concerns about performance	
Improved clinical outcomes and reduction in emergency admissions	Tiered patient management approach: GP led routine care and fulfilment of GP quality and outcomes framework (QOF) Diabetes Specialist Nurse led clinics for patients with poorly controlled diabetes referred via GP; MDT approach, consultant, district nursing service (DNS) & Dietician; Complex & challenging patients referred via GP or DNS Hospital led care i.e. advanced renal disease, acute foot, pregnancy, complex co-morbidities		
Reduced risk of complications due to diabetes Excellent patient/family/carer experience			

Risk	Mitigation
Failure to achieve true integration of acute and community services	Service specification details service requirements and expectations
Failure to agree financial envelope for entire pathway provision	Detailed scoping and analysis
Failure of member practices to participate in education	Structured sessions for both GPs and practice nurses, clear focus areas and continuing professional development points
Disengagement of member practices	Information pack to be developed explaining benefits of
Provider non-compliance with protocols, thresholds, pathways etc.	Strict monitoring through KPIs, escalation route to be agreed through resulting in increased volumes

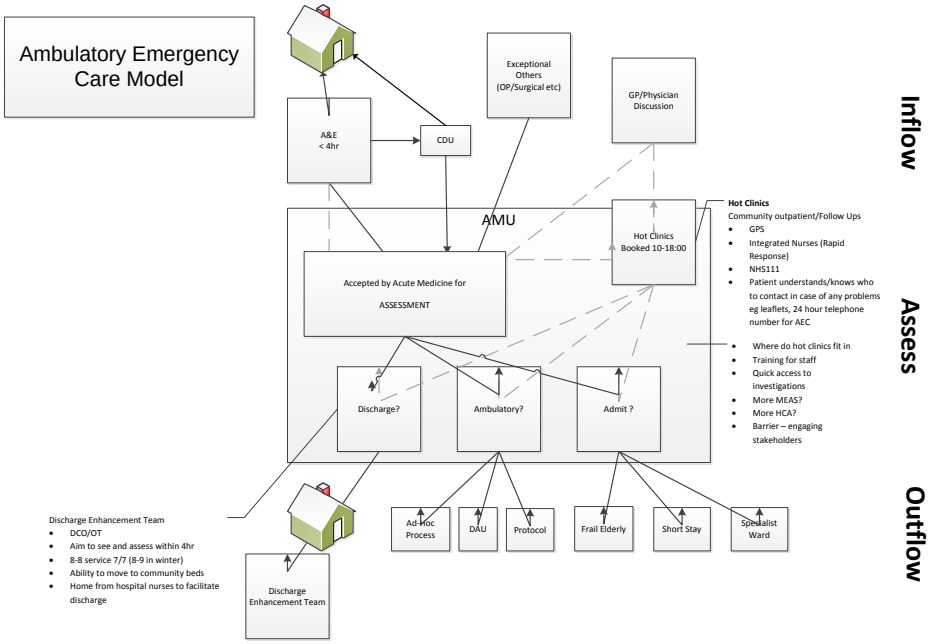
This work stream contributes to the achievement of the following targets, standards and ambitions:

- Outcome Ambition 1: E.A.1: Potential years of life lost from causes amenable to healthcare;
- Outcome Ambition 2: E.A.2: Health related quality of life for people with one or more long-term conditions;
- Outcome Ambition 3: E.A.4: Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community;
- Outcome Ambition 6: E.A.7: Increase the proportion of people having a positive experience of care outside of hospital, in general practice and in the community;

AMBULATORY CARE
CLINICAL TRANSFORMATION PROGRAMME FIVE

Aim: Implementing Ambulatory Care pathways to improve patient outcomes reduce admissions to wards and reduce costs.

Rationale for prioritisation: Non Elective length of stay has improved; however we have challenges around discharging of patients between 65 - 75 years of age. We need to focus on this cohort of patients to improve overall length of stay and support SUHFT in its Cost Improvement Programme of bed reductions.



Partners
SCCG, CP&R CCG, SUHFT, SEPT, EAST & SBC

Leads
Dr Adenike Popoola, Dr Roger Gardiner, Emily Hughes

Outcomes for 2015/16
Improved patient outcomes
Reduced admissions
Reduced costs

Objectives	Activities	Governance	Measurement
This is a whole system approach that includes both primary and secondary care to ensure patients who are assessed as appropriate for ACS are diagnosed and treated on the same day and then sent home with on-going clinical follow up as required.	Following support from Emergency Care Intensive Support Team, during 2014/15, SUHFT has been developing an Ambulatory Care Service (ACS) as part of its A&E recovery action plan.	This is a joint project with Castle Point & Rochford CCG who lead it on behalf of both CCGs.	Reduction in tariff price
SUHFT has developed a model, shown in the diagram on the previous page.	We have already made good progress, delivering new pathways within the acute setting for: • Deep Vein Thrombosis; • Cellulitis; • Syncope; • Pulmonary Embolism; and • Acute Headache.	General Practitioner clinical leads from both CCGs are part of the project group, which meets regularly with SUHFT.	Reduction in ward admissions
	In 2015/16, we want to include more pathways and broaden the scope of the pathways to include primary care. These include: • Chronic Heart Failure; • Chronic Obstructive Pulmonary Disease; • Jaundice; • Asthma; and • Urinary Tract Infection	The project reports on an exception basis to a Joint Clinical Executive Committee of both CCGs.	Improved patient flow in hospital

Risk	Mitigate
Availability of new workforce – medicine, nursing and support.	Look at options for recruitment and redeployment of existing staff. Staffing uplift agreed 2 x B7, 6 X B6 nurses - out to recruitment.
Lack of available and suitable new environment	Develop a business case for the resources required to deliver the service. Longer term plan to develop a purpose built ambulatory care unit.
Lack of time to safely develop new pathways	Consider how to support staff and release staff to work on the Frailty model
Difficulties in agreeing Ambulatory Emergency Care Model	Build Business case from evidence base. Return on investment model from Ambulatory care Network Group and careful commissioning of the service.
Contractual and Financial risks if the activity is not counted and recorded accurately.	Currently negotiated as part of contract for reduced rate within whole contract to allow cost saving to CCG and SUFHT to reduce their cost base across the contract.

This work stream contributes to the achievement of the following targets, standards and ambitions:

- Outcome Ambition 1: E.A.1: Potential years of life lost from causes amenable to healthcare;
- Outcome Ambition 2: E.A.2: Health related quality of life for people with one or more long-term conditions;
- Outcome Ambition 3: E.A.4: Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community;
- Outcome Ambition 6: E.A.7: Increase the proportion of people having a positive experience of care outside of hospital, in general practice and in the community;

CHILDREN'S SERVICES
CLINICAL TRANSFORMATION PROGRAMME SIX

Aim: Develop high quality community provision for paediatric care**.**

Rationale for prioritisation: Southend CCG is committed to providing children and young people with the best start in life. Local paediatric care relies heavily on hospital provided services, demand is increasing year on year, access to alternative or support services within primary care/community settings is limited and this is worsened by low referral thresholds and rising demand in new areas i.e. ASD and ADHD.

We will continue to foster a joint agency approach across local health, education and social care services to deliver the national vision of truly integrated care with the child and family at the heart of any decision. This approach will support the SEND agenda, the transition to education health and care plans (EHC) and personal health budgets (PHB).

Partners
SCCG, SBC, SUHFT, GPs, Schools

Leads
Dr. Kate Barusya, Dr. Sunil Gupta, James Peskett

Outcomes for 2015/16
Alternative community provision for Paediatrics

Resources
Dedicated clinical leads, project management support, finance and procurement support

Objectives	Activities	Governance	Measurement
Drive forward innovation in paediatric care and establish sustainable, quality services	Shared vision for local paediatric services agreed and priorities defined	Strong clinical leadership via Children & Young Persons Lead	Contractual KPIs relating to quality and outcomes
Develop high quality alternative service provision in the community	Map current local services across health, education and social care to identify gaps in service provision	Monthly monitoring of KPI data via CCG Performance meeting	Reduction of emergency admissions
Partnership working with local education and social care services to ensure whole system approach	Develop a fully integrated comprehensive community paediatric service including; Neuro Development i.e. Autistic Spectrum Disorder & ADHD, therapies i.e. dysphagia, allergies, constipation etc.	Bi-monthly monitoring by the Joint Clinical Executive Committee	Reduction of referrals to acute services
Child centred services with strong links to support services i.e. CAMHS	Focus on primary and secondary prevention	Escalation clauses written into contract in the event of poor performance or breach of contract	
Optimised outcomes at every stage of the pathway	Develop and implement evidence based pathways and thresholds of care	Clinical Executive or Governing Body recommendation and/or decision in the event grave concerns about performance	
Ease demand and capacity pressures faced by SUHFT	Concentrated engagement with member practices		
Standardise referral practices and reduce variation in Primary Care	Public & patient engagement to shape development of service models		
Develop joint commissioning arrangements in line with the SEND agenda	Implementation of new Child Death Rapid Response service from March 2015		
Implement robust EHC and PHB processes and panel arrangements			
Improved clinical outcomes and reduced long term dependency			
Excellent patient/family/carer experience			
Repatriation of tertiary activity to a local service			

BETTER CARE FUND

Southend Borough Council and the CCG have together developed an ambitious set of proposals to create a truly integrated health and social care system for Southend where professionals can share information and design an individual, all-encompassing care package for each patient or service user, reducing unnecessary hospital admissions and enabling people to remain independent in their own home for longer.

Building on our status as an integrated care Pioneer site, we will continue to develop innovative ways to achieve our vision:

- We want to create a health and social care economy in which the population can access optimal care and enable urgent care to be delivered with maximum efficiency and effectiveness. In achieving this vision we aim to adopt a system wide view and understand impacts across all key partners.
- We want to build on our current successes in integrated care delivery to ensure that our prevention offer and self-management options are fully developed and optimised and where longer-term care or support is needed it is provided around the service user or patient.
- We are using the BCF to protect social care services and work as strategic partners to re-model our urgent care and community provision with a focus on out of hospital care. In doing so, we will be will be focussing on how to deliver care and support through more integrated and coherent pathways to better serve the people of Southend.
- We will also aim to increase community resilience, helping people take more responsibility for their own health and wellbeing.
- We want to support Carers in their roll for caring for their friends, relatives and loved ones
- We want to offer health and social care services that offer choice and control for services users and patients over the services and support they need.

With our BCF plan approved, we will move forwards with the delivery on this vision set out in five schemes:

- 001 – Protect Social Services through Independent living (£4.781m)
- 002 – End of Life, Palliative Care & Community Services (£3m)
- 003 – Prevention including intermediate Care, Primary Care and transforming the Emergency Pathway (£3.051m); Reablement (£1.431m)
- 004 – Integrated Care through the GP Hub (£50k)
- 005 – Infrastructure to support integrated working (£0.459m)

Protect Social Services through Independent Living
BETTER CARE FUND: Scheme 001

Aim: To protect social care services through investment in services that support independent living and reduce reliance on all forms of institutional care

Rationale: Protecting social care services to ensure that people can still access the services they need is one of the six national conditions of the Better Care Fund. In Southend, we will ensure eligibility criteria and investment remains at required levels. To achieve this, our focus is on prevention and ensuring that health services are available earlier and in better co-ordinated ways to reduce demand on social care. This will help protect social care services which support the local health and social care economy.

Our investment in this scheme will fund a range of existing social care services to promote independence and Reablement, supporting carers and offering alternatives to longer-term reliance on residential care. This will reduce hospital admissions as well as reliance on long-term social care support and reduce admissions to residential care.

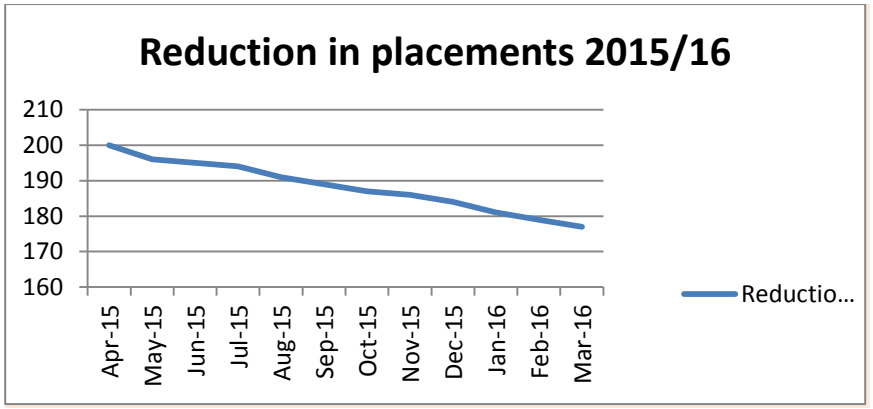
Partners
SCCG, SBC

Leads
Nadine Hassler, Martin Wintle

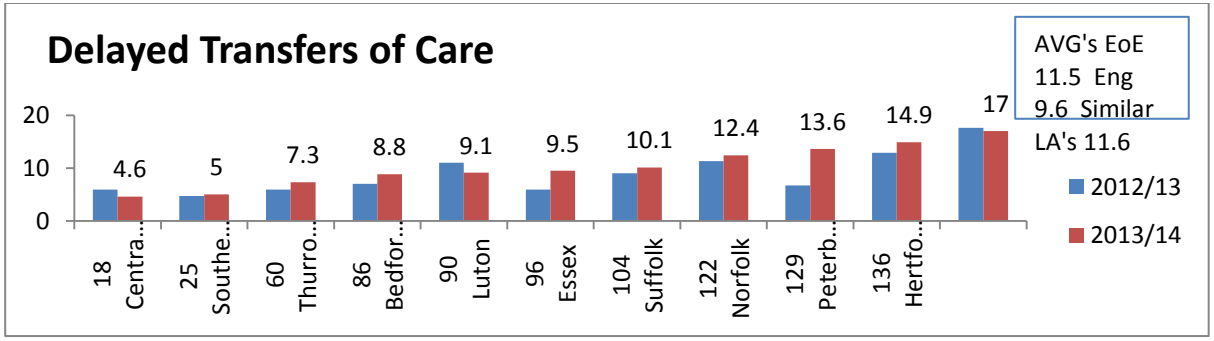
Outcomes for 2015/16
Reduction in permanent residential placements from 200 per year in April 2015 to 177 by March 2016
Reduction of 38 high care packages by March 2016
Review of current hospital and wider social work structure ensuring they support the modernisation agenda
Review the stroke rehabilitation and intermediate care pathway to reduce demand on institutional care
Review reablement capacity to ensure that it supports reduction in residential care use
Develop a case for extending 7 days working in social care

Resources
£4.781m investment

We are already seeing the impact of our investment in Reablement and offering people alternatives to residential care in a downward trend in existing care placements. Current performance puts us in a good position to meet our target of a further reduction in placements to 177 by March 2016.



Southend's performance on delayed transfers of care is good compared to the East of England and nationally. There were only 41 delayed discharges overall in 2013-14 which suggests that integrated working around hospital discharge arrangements is already working well. We want to build on this success and are therefore keen to maintain at least current levels of resource.



Objectives	Activities	Governance	Measurement
The scheme aims to reduce permanent admissions to residential care and reduce or delay reliance on longer term social care support in line with Southend Borough Council's corporate aims	Maintaining hospital social work services to support early assessment and discharge.	BCF governance	Increase in people with dementia supported at home Improvement of health related quality of life and wellbeing older people
Achievement of planned efficiency savings in social care for 2015/16 through improved Reablement performance amongst others	Maintain capacity within integrated teams and the Reablement service to minimise waiting times for assessment and support		Contributes to the achievement of 11.5% reduction in residential admissions Contributes to the achievement of reduction in the numbers of people requiring large care packages (longer term support) and number of high cost care packages
Ensure partners across the health and social care economy understand each other's service offerings and how they contribute to the overall system	Developing a discharge to assess model focusing on reducing admissions to residential care homes and hospital re-admission (link to scheme 3)		Reduction in emergency admissions due to falls, fractured neck of femur Reduction in unplanned hospital admissions and A&E attendances
Promotion of choice and control particularly for the frail, elderly who may be at increased risk of hospital admission.	Improve pathways for stroke rehab, dementia and intermediate care beds		Contributes to the reduction in the number of preventable re-admissions
Promotion of people's ability to stay safely in their own home or the community with an optimum level of independence	Market development, management and development of non-residential		Contributes to the reduction in the number delayed transfers of care
Promotion of timely and safe transfers of care from hospital to the community and continuing low levels of delayed transfers of care.	Extending the Single Point of Referral, (SPoR) to provide a seven day assessment and therapies service (link to scheme 3)		Contributes to the achievement of 3.5% total hospital admission reductions
Protect social care services through recognising that lack of resource for this scheme will put at risk the existing social care system which supports reductions in hospital admissions and timely discharge back into the community	Agreeing target population – risk stratification Maintaining performance whilst making disinvestments/reinvestments		Reduction in non-medical admissions to hospital for people with dementia Reducing the impact of carer stress and maintain levels of carer support

End of Life, Palliative Care & Community Services
BETTER CARE FUND: Scheme 002

Aim: To improve end of life care for people with a terminal illness to enable more people to remain in their own homes or other community settings during the final stages of their lives

Rationale: There are approximately 3,500 deaths in South East Essex each year, around 10% of which are sudden deaths. This leaves just over 3,100 potential cases for management within the community setting. Currently approximately 60% of those deaths occur in an acute hospital setting despite the fact that there is no clinical need for the person to be there.

We know that early identification of patients in the palliative stages of their illness is essential to ensuring appropriate wrap-around services that can best meet the needs of patients, their families and carers at this difficult time. Unfortunately, too many patients, including those with long-term conditions, are not recognised as moving into the palliative stages of their illness at the right time and therefore do not receive the quality and intensity of care they need at this stage in their lives.

At the same time, whilst the identification of patients with some illnesses such as cancer in the terminal stages of their lives is normally well documented, they do not always receive care in a coordinated way that supports them to achieve their preferred place of death.

Partners
SCCG, SBC

Leads
Robert Shaw, Carol Cranfield

Outcomes for 2015/16
Achieving earlier identification of patients in the palliative stage of their illness, especially those with non-cancer conditions
Reduction in inappropriate admissions during end-stage illness
Increase the proportion of patients dying in their preferred place of death

Resources
£3m investment

This scheme will ensure patients identified will be notified to all services through an end of life register. In addition, they will be supported to remain as well as they can, with effective symptom control through coordinated, proactive case management and additional support for family and carers to reduce the average number of inappropriate admissions within the last 12 months of life from 3 to 2.

Effective communication across all services and clearly documented care records will be key to the success of this scheme through ensuring that services are mobilised in a way that enable patients care needs to be met in the most appropriate setting. This will include clearly documented DNARs.

Objectives	Activities	Governance	Measurement
Redesign and remodel existing services to increase the number of people supported to people to "die happy" in their preferred place of death	Redesign and decommission where appropriate existing end of life pathways and jointly commission new pathways	BCF governance	Reduction in unnecessary hospital admissions for people requiring palliative care (£300k benefit)
Increased compliance with the end of life pathway	Develop better systems to identify people with long-term conditions who require palliative care, for example through risk stratification at MDT level	Clinical executive – monthly report	Increase in the number of people achieving their preferred place of care in the final stages of their lives
Early identification of patients in the palliative stages of their illness	Align end of life pathway with our new model of integrated community services, including the primary care hub		Increase in the number of people identified on the end of life register as being in the palliative stages of the illness and offered additional support
Better coordination of services across all sectors to support people to achieve their preferred	Shifting resources from acute to community health and social care		Reduction in non-elective admissions for patients on End of Life Pathway
Improved information, advice and signposting for patients, carers and families	Engagement, co-ordination and working with residential and nursing homes to identify people at end of life and help support them in the most appropriate way		Increase in the number of non-cancer patients on the end of life register
Protection of social services	Develop effective symptom control processes through coordinated proactive case management and additional support for families and carers		
	Effective information sharing through end of life register and integrated care records		

Prevention including intermediate Care, Primary Care and transforming the Emergency Pathway
BETTER CARE FUND: Scheme 003a

Aim: To reduce hospital admissions and protect social services by funding a change in approach to a system built around prevention, early intervention and actively promoting well-being in the community

Rationale: The number of older adults in Southend-on-Sea is forecast to rise dramatically. By 2025, it is estimated that the older adult population will increase by 22% to 40,700 people aged 65 and over, of which 12,800 will be aged 80 and over.

A significant proportion of our older population will experience a fall (approximately 27% of older people experienced a fall in the last 12 months) and an increasing number will be frail elderly.

At the same time, we are facing the risk of an increase in admissions to hospital as a result of projected increases in prevalence of chronic diseases including COPD, diabetes, stroke and hypertension.

We know that the development of effective and sustainable local preventative, intermediate care and self-management options can help alleviate these pressures on the system and they sit at the heart of our Better Care Fund plan. This view is evident in national policy; most recently the ambitions outlined in the Five Year Forward View and the universal duty to provide or arrange for services that prevent, delay or reduce people's needs for care and support under Care Act 2014.

Partners
SCCG, SBC

Leads
Martin Wintle, Nadine Hassler,

Outcomes for 2015/16
Detailed Business Case and target operating model
Deliver implementation plan including identification of quick wins
Establish Single Point of Access
Improved Care Pathways
Revised contract arrangements
Outcomes framework

Resources
£3.05m

Progress has been in made locally to provide high quality community services that keep people out of hospital wherever possible. This has been done through integration of health and social care services and collaborative working, such as our Single Point of Referral. However, we are continuing to experience a number of pressures on the system – particularly at weekends and during periods of unexpected surges in demand. As a result, some people have been admitted to hospital when they could have been better supported in a community setting.

Our work on the integrated Community Recovery and Independence model will address this capacity gap through strengthening and improving services aimed at preventing admissions into hospital, reducing length of stays; preventing and reducing the need for on-going packages of care and thereby reducing long-term dependencies on care and support.

As part of our Pioneer Programme we have held a series of multi-disciplinary workshops, which identified local areas of good practice as well as issues and key areas for improvement. This work has enabled us to shape the model in more details, leaving us in a good position to start implementation of this scheme in 2015-16.

Objectives	Activities	Governance	Measurement
This scheme sits at the heart of our vision to create a truly integrated, person-centred health and social care system built on the principle of enabling people to be as independent as possible on an ongoing basis	Deliver transformational change to community health and social care services to facilitate a true shift from services that react when someone reaches crisis point to a person-centred, integrated system that actively promotes well-being and supports people to remain independent and connected to their communities for as long as possible	BCF governance	Contributes to the reduction in total hospital admissions target of 3.5%
An efficient and sustainable system using resources as efficiently as possible			
Enabling the shift from reactive services to a system built around prevention, early intervention and actively promoting well-being	A review of existing services to understand capacity, pathways and how services are currently delivered was completed in 2014-15	Clinical executive – monthly report	Increase in overall satisfaction of people who use services
Empowering people to take more responsibility for their own health and wellbeing and be in control as much as they want to be	Evaluation of performance data and benchmarking to enable sound demand and financial modelling commences in 2014-15		Increase in effectiveness of integrated care
Establishing a single, integrated community recovery and independence pathway across health and social care to improve out of hospital care options including through the development of a discharge to assess scheme	Options appraisal of potential delivery mechanisms, i.e. aligning intermediate care to the hub or single service		Increase in the number of people who lead in their own care planning and goal setting
Preventing, reducing and delaying the needs for care and support as far as possible through supporting people to maintain or regain their independence and stay out of hospital wherever possible	Design of the target operating model built on the principles of seven day services, case coordination and person-centred care and support		Increase in the number of people who manage their own support as much as they wish, so that they are in control of what, how and when support is delivered to meet their needs
	Aligning fully integrated community health and social care services to the agreed primary care hub model		
Avoiding admissions and reducing delays of transfer through integrated rapid response, supported hospital discharge and observation	Development of systems, processes and protocols to underpin the delivery of the new model		Contributes to an increase in the number of people who are at home 91 says after Reablement

Recognising people are experts by experience and improving people's experience	Development of a communication and engagement strategy to ensure that the system is fully conversant with the revised pathways and referral routes		Contributes to an increase in the number of people who had reduced or no ongoing needs for care and support following Reablement
Establishing a system where people can the level and intensity of services they need and want at the right time tailored around the person including seven day services	Using the feedback from the series of workshops through 2014-15, which identified areas of good practice and current areas for improvement and enabled us to start shaping the model in more details, to develop a model for a fully integrated system ready to be implemented for 2016-17		Reduction in the number of emergency admissions for acute conditions that should not usually require hospital admission
	Identify the skills and resources required to deliver the new models of care including developing new roles, such as hybrid hospital discharge workers		Increase in the number of people who feel supported to manage their condition
	Building on the SPOR to move towards a single, integrated point of Access for health and social care from autumn 2015		Increase in the proportion of people who use services who say that those services have made them feel safe and secure

Reablement
BETTER CARE FUND: Scheme 003b

Aim: To protect social services and reduce hospital admissions through funding Reablement services with the aim of improving social care discharge management and admission avoidance

Rationale: Reablement complements the work of preventative and intermediate care services mentioned above and aims to provide a short term, time limited service to support people to retain or regain their skills, confidence and independence after a period of ill health or sudden change in need. At its core, Reablement aims to help people to do things for themselves, rather than doing things to or for them.

In 2013-14, 2.8% of older people in Southend received Reablement following hospital discharge (compared with 3.3% average in England). At the same time, the number of older people who are still at home 91 days following Reablement is below the national average.

This scheme intends to enhance local Reablement provision in order to ensure more people are able to access Reablement and ongoing recovery support and have the opportunity to stay in their own home for as long as possible.

Partners
SCCG, SBC

Leads
Sarah Baker, Linda Dowse

Outcomes for 2015/16
Full engagement with providers
Review of reablement specification and contract
Review of systems and processes
Identify SBC staffing requirements

Resources
£1.431 investment

This will enable us, in the future, to deliver a better service to more people with a similar level of resources as at present.

Objectives	Activities	Governance	Measurement
Facilitating seamless, timely care for patients on discharge from hospital, to promote ongoing recovery and independence and to prevent avoidable hospital admissions	Protecting existing Reablement funding to support decreases in the need for longer term support through utilisation of the Single Point of Referral, (SPOR) and continued access to safe and timely hospital discharge	BCF governance	Contributes to the reduction in total hospital admissions target of 3.5%
Ensuring people feel confident and safe at home following a period of Reablement with or without support in the community and is able to manage their health and wellbeing	Engage with Reablement providers in the Borough with to establish what is required to enable them to provide additional Reablement hours		Contributes to the reduction of re-admissions to hospital
Preventing, reducing and delaying the needs for care and support as far as possible through supporting people to maintain or regain their independence and stay out of hospital wherever possible	Identify the staffing required to broker additional Reablement packages		Contributes to an increase in the number of people who are at home 91 says after Reablement
Support carers through increasing their confidence in their own caring responsibilities	Meet with appropriate agencies to discuss logistics and implementation		Contributes to an increase in the number of people who had reduced or no ongoing needs for care and support following Reablement
Effective management of length of stay in intermediate care ward and hospital	Work with Reablement providers to deliver services that are flexible and responsive		Reduction in the number of emergency admissions for acute conditions that should not usually require hospital admission
Reablement providers work in partnership with people, families and carers in assessing problems and needs, goal setting, planning and implementing Reablement programmes	Work with Reablement providers to develop and skill their workforce to be able to effectively motivate and encourage people during their period of Reablement		Increase in the proportion of people who use services who say that those services have made them feel safe and secure
Promotion of good health, well-being, independence, dignity and social inclusion	Develop improved processes to minimise delayed discharge		Increase in the proportion of people experiencing continuity of care worker
Ensure compliance with the Care Act 2014			

Integrated Care through Primary Care Hubs
BETTER CARE FUND: Scheme 004

Aim: To ensure patients only go into hospital when they need specialist emergency care and there is no alternative in the community through the delivery of proactive, integrated health and social care and support around primary care hubs

Rationale: Primary care sits at the heart of the wider health and social care system and serves as the first point of contact for 80% of people. Primary care already includes a rich diversity of professionals ranging from GP's, nurse practitioners, nurses, opticians and pharmacists through to allied health professionals and social workers.

However, increasing demand on services and changing needs means that general practice needs to evolve and take a collaborative approach to meeting the holistic care needs of people in the future. Advances in technology and changing demographics means that more integrated care can be delivered in a primary care setting.

This scheme will deliver improved integration between health and care in the community and improve out of hospital care through the development of primary care hubs. This will involve organising networks of care including social care, voluntary and community organisations, community health services, mental health services and other partners across the system.

Partners
SCCG, SBC

Leads
Sadie Parker, Carol Cranfield

Outcomes for 2015/16
Development of the agreement model with task and finish groups
Identification of (financial) resources/ financial modelling
Workforce development of job descriptions for any new roles

Resources
£0.05m investment

The benefits of health and social care integration are well-documented. We know that properly coordinated care can achieve the best outcomes for people by giving them the best possible chance to receive appropriate care and support tailored to their individual needs in the community and enables them to stay in their own homes for longer. This is particularly true for people with long-term conditions (Southend has higher than average numbers of people with three or more long-term conditions) and the frail elderly.

Innovative health and social care integration is not new in Southend – we have made good progress through our Single Point of Referral and GP multi-disciplinary team meetings.

We have made good progress with evaluating the range of emerging models and identified a number of areas of good practice. At the same time, we recognise that not one size fits all and that we need to develop the right care model(s) for Southend.

Objectives	Activities	Governance	Measurement
Integrated and co-ordinated care – providing patient-centred co-ordinated health and social. Multi-disciplinary teams working together around the patient to deliver improved outcomes for them.	Options will be appraised and an appropriate model developed which will either involve the creation of one or more Primary Care Hub, depending on the agreed options – this will be followed by a pilot to test assumptions	BCF governance	Contributes to the reduction in total hospital admissions target of 3.5%
Accessible care – providing a responsive, timely and accessible service that responds to different patient preferences and needs. This will mean extending services to seven days.	Working with other CCG partners to resolve common issues, identify good practice and ensure the development of a sustainable model that meets local need	Clinical executive – monthly report	Increase in overall satisfaction of people who use services
Pro-active care – Moving away from traditional model of primary care will mean creating a more reactive system which treats people when they become ill, to one which co-ordinates care and support for people to stay well.	Enhancing primary care including improving access to primary care seven days a week		Increase in effectiveness of integrated care
			Increase in the number of people who lead in their own care planning and goal setting
Improved patient experience and outcomes – patients will experience a seamless service and improved health and wellbeing. They will have a named are co-ordinator supporting them to navigate through the range of services	Integrating district nurses, therapists, mental health nurses, health care assistants, palliative care nurses, social workers, and a diverse range of professionals around the hub		Increase in the number of people who manage their own support as much as they wish, so that they are in control of what, how and when support is delivered to meet their needs
Management of own health condition(s) – people will be able to manage their own short and long term health conditions; they will be supported and encouraged through education, information and advice.	Take a collaborative approach to meeting the holistic care needs of people - this will involve social care, voluntary and community organisations, community health services, mental health services and other partners working together to deliver co-ordinated and patient centred care		Contributes to an increase in the number of people who are at home 91 says after Reablement
Improved community pathways and alternatives to out of hospital care			Contributes to the reduction in unnecessary A&E attendances
Less fragmentation between services			Increase in people having positive experience of care

Infrastructure to support integrated working
BETTER CARE FUND: Scheme 005

Aim: To develop ICT to assist with new capital requirements under the Care Act and the further development of Telecare and Extra Care schemes which require capital investment.

Partners
SCCG, SBC

Leads
Jacqui Lansley, James Peskett

Outcomes for 2015/16
Assessment of need for extra care for people with dementia
Agreed design standards including site suitability assessment
Agreed financial model
Agreed service specification for dementia extra care
Agreed service model including staffing structure and agreement to affordability

Resources
£0.459m investment

Rationale:

Dementia extra care: Extra Care Housing is an innovative alternative to residential care for older people, which can enable people to live in the most appropriate accommodation via a range of housing options for differing levels of need and lifestyle. Research has identified the financial and economic benefits of extra care schemes for people with dementia.

The Extra care housing scheme will give people the opportunity to live independently in a home of their own, but with other services on hand if they need them. Enabling people to remain as in the community with as much independence as possible but with the 24 hour support they require will contribute towards the target of 3.5% reduction in hospital admissions.

Telecare: Telecare systems can include personal alarms, environmental sensors to detect smoke, water flooding, unlit gas and temperature, or movement sensors that detect if fridge doors are opened, a bed is occupied or if a person has fallen and cannot get up. Systems that are more sophisticated monitor many aspects of the home environment and communicate interactively with the person.

This scheme will make an additional investment in Telecare equipment and other assistive technology to help maintain health and well-being whilst supporting virtual communities in Southend and reduce isolation.

Investment in IT: Information and technology both have an important contribution to make in supporting the transformational change in the commissioning and delivery of care and support services that are required to implement the Care Act 2014.

This scheme will support Southend Borough Council's in ensuring it has the right IT systems in place to deliver the reforms. This will include improving interoperability between health and social care systems, patient participation and control and using the NHS number as common identifier.

Objectives	Activities	Governance	Measurement
Dementia Extra Care – Enabling people to live in the most appropriate accommodation via a range of housing options for differing levels of need and lifestyle; people with dementia will live independently and in a home-based environment, better outcomes for patients, prevents individuals feeling socially isolated, reduces admissions to hospital and residential care	Investment of capital monies to deliver extra care services for people with dementia through case review and assessment living to achieve an efficiency of £200k per annum from 15/16	BCF governance	Reduction in residential placements
			Reduction in avoidable hospital admissions
Telecare and Telehealth – Substantially reduce mortality, works in a preventative mode, reduce the need for admissions to hospital and residential care, allows people to retain independence in a home-based setting; maintains health & well-being and reduces isolation	Communication and engagement with providers		Reduction in individuals who are social isolated
	Development of the Section 75 agreement for integrated services		Better online information, advice and guidance for individuals and carers
Care Act Capital Monies – Improve IT systems to drive better care planning through shared data, provide performance information to monitor outcomes	Procure and implement IT solutions which meet local requirements and ensure staff are trained to use these systems		The required information of individuals and carers to meet the expectations of the care act is recorded electronically
			Increase in the level of data quality
			Technical changes are in place to support better data sharing
			Contributes to an increase in the number of people who manage their own support as much as they wish, so that they are in control of what, how and when support is delivered to meet their needs

Summary of Better Care Fund Schemes

				National Conditions					
Scheme	Investment	Return	Residential admission reduction	7 day Services	Protect Social Services	Data Sharing	Joint Assessment	Accountable Professional	Impact on Acute
001 Protect Social Services through Independent Living	£4.781M	£0.494M	£0.514M	Yes	Yes	Yes	Yes	Yes	Yes
002 End of Life	£3.000M	£0.300M		Yes	Yes			Yes	Yes
003a Prevention, int care, Primary Care, transforming Emergency Pathway	£3.051M	£0.360M		Yes	Yes	Yes	Yes		Yes
003b Prevention with reablement	£1.431M				Yes		Yes		Yes
004 Integrated Care through GP Hub	£0.050M	£0.350M		Yes	Yes	Yes	Yes	Yes	Yes
005 Infrastructure	£0.459M				Yes	Yes	Yes		Yes
Total	**£12.772M**	**£1.504M**	**£0.514M**						

MEDICINES MANAGEMENT

Aim: To ensure all prescribing is undertaken in a safe, evidence based and cost-effective manner and avoid further growth (normal expectation 4-8% growth per annum) on prescribing costs to achieve a QIPP saving of £1.6m.

Rationale: With an ageing population, over 100 care homes, increasing incidence of diabetes and COPD, it is vital that the CCG clearly understands how to influence the way medicines are being used across the health economy. The recently published Long term Conditions Health Needs Assessment indicates that Southend has a higher proportion of people with three or more long term conditions compared to the national average. This adds further pressure on a system that is already issuing over 2.5 million prescriptions per year at a cost of £26 million.

There remains significant variation in prescribing patterns amongst practices within the CCG (notably in relation to antibacterials) and it is vital in terms of best care and finances that this is addressed. There is good engagement with local practices as well as the hospital and this was enhanced during 2014 with specific support relating to dietetics resulting in improved knowledge and prescribing in both primary and secondary care. The CCG intends to further strengthen support to practices during 2015 by employing care home pharmacists and technicians to ensure patients are getting the full benefits of their medication (£125,000 investment required). Evidence suggests that for every £1 invested in such schemes, £2 can be saved.

Partners
SCCG, CP&R CCG, SUHFT, SEPT

Leads
Dr. José Garcia-Lobera
Dr Kelvin Ng
Simon Williams

Outcomes for 2015/16
Reduce variation in prescribing practice (particularly antibiotics)
Achieve QIPP target of £1.6 million
60% of practices live with Electronic Prescription Services

Resources
£0.2m additional investment to assist in managing the £26.7m

Medicines Management input is key to the CCG's clinical transformation projects and includes

- shared care agreements linked to MSK (250,000 prescriptions per annum at a cost of £2 million).
- formulary and guidelines for Diabetes (120,000 prescriptions at £2.3 million)
- formulary for Ophthalmology (60,000 prescriptions at £450,000).
- implementation of NICE Guidance relating to Stroke (40,000 prescriptions at £500,000).

Following on from the increased number of admissions due to respiratory disease the Medicines Management Team is also involved in rationalising the prescribing of inhalers (200,000 prescriptions at £3.4 million)and improving inhaler technique. This will be developed across a number of sectors including the hospital, community nurses, GPs, practice nurses and community pharmacists.

To underpin this work it is essential that available IT systems are used effectively and we will be working on a plan to create electronic discharge letters from the hospital to General Practice and to introduce Electronic Prescription Services across at least 60% of practices by the end of the year.

Medicines Management continues to progress the work outlined in the "Tackling inequalities in life expectancy in areas with worst health and deprivation". In relation to hypertensives, the CCG is prescribing 9% more than it was 3 years ago. In relation to cholesterol lowering, the CCG is prescribing 14% more than is was in 2011.

Objectives	Activities	Governance	Measurement
Reduce variation in prescribing practice	Support visits to outlier practices from Prescribing Leads and Medicines Management Team	Clinical leadership via Prescribing Leads	Monthly monitoring of prescribing spend
Ensure shared care guidelines for MSK medicines become embedded	Diabetes educational sessions delivered at members forum by Leads and Medicines Management Team	Monthly Drug and Therapeutics Committee	Year on year comparison of prescribed items and costs
Develop shared ophthalmology formulary	Inhaler technique cross organisation event to be arranged	Quarterly reporting to the Quality, Finance and Performance meeting	Benchmarking of prescribing with other CCGs
Improve cost-effectiveness of prescribing for respiratory disease	Monitor prescribing of MSK medicines in line with shared care	PMO/QIPP weekly meetings	Number of practice "Live" with EPS
Provide inhaler technique for all staff involved in respiratory care	Refreshed antibacterial strategy to be developed		QIPP milestones
Support the diabetes transformation project with agreed medication guidelines	Promote benefits of and provide appropriate support to practices regarding EPS		
Support practices in managing complex medication regimes for patients in care homes	Invite Consultants to attend Drug and Therapeutic meetings to gain agreement in key therapeutic areas (MSK, Diabetes, Respiratory)		
Reduce variance in prescribing of antibacterial medications			
Assist with implementation of Electronic Prescription Service (EPS) across all practices			

Risk	Mitigation
Lack of clinical engagement with changes to prescribing	Clinical champions Prescribing Incentive scheme Practice support and training Developing stronger relationships with senior clinicians in acute setting Use newsletters and clinical meetings to clarify and reinforce messages about prescribing protocols
Patients unhappy with change	Patient information sheets Practice support Fostering clear communication between clinicians and patients

This work stream contributes to the achievement of the following targets, standards and ambitions:

- QIPP and Outcome Ambitions 1&2 and Quality Premium AE9

CONTINUING HEALTHCARE (CHC)

Aim: Invest in CHC services to ensure safe delivery of community assessments, effective case management and appropriate pathways for CHC eligibility decision making.

Rationale: Southend CCG has increased its focus on CHC recognising that it is an outlier in relation to CHC activity. There is a significant financial challenge for Southend CCG and other CCGs as CHC activity and costs continue to increase.

From Midlands & East Funded Care Benchmarking Analysis for Quarter 1 in 2013/2014 - Southend CCG is ranked 3rd highest out of 61 for CHC total activity and ranked 16th highest out of 61 for CHC costs

The CCG commissioned a review in 2014 to understand the factors that contributed to the outlier position. It found that the majority of the Decision Support Tool (DSTs) decisions are being undertaken in acute settings, which directly impacts on recovery and eligibility. There are significant gaps in community services and service pathways that will require urgent action.

Partners
Southend Borough Council, SUHFT, SEPT Community Services, Care home providers, Domiciliary care providers

Leads
Dr Taz Syed, Linda Dowse

Outcomes for 2015/16
All CHC eligibility assessments and reviews undertaken within required timescales.
Case management of all complex cases

Resources
£0.2m additional investment to assist in managing the £21.3m budget for CHC

The CCG is taking forward the main recommendations of the review to;

- Reduce the number of assessments taking place in acute settings
- Review and evaluate Discharge to Assess arrangements
- Review of all high cost cases
- Review and monitor Care Home Specification to ensure includes specific training and staff competencies.
- Ensure processes in place to quickly review placements with short term 1 to 1 support or high intensive packages
- Develop pathways for end of life; dementia and stoke.
- Review opportunities for joint procurement and contracting with Southend Borough Council
- Review opportunity for integrated approach to quality monitoring with Southend Borough Council
- Review opportunity for joint market management with Southend Borough Council
- Request public health predictive analysis of CHC

Arden CSU has been contracted for CHC Core services, Retrospectives and PHB for CHC. Arden has proved to offer a level of expertise and experience to enable the CCG to take forward its priorities for the future and this will enable a more robust, clinical and cost effective, management and monitoring of identifying appropriate placements and packages of care for people eligible for Continuing Healthcare funding for identified care needs.

In 2015 the CCG is planning to invest in CHC services to ensure safe delivery of community assessments, effective case management and appropriate pathways for CHC eligibility decision making.

The CCG has successfully facilitated people receiving CHC funding to transfer to holding Personal Health Budgets. This allows individuals to take control of their health and lifestyle choices. The CCG is developing this service to manage the implementation of Personal Health Budgets for people with Long term Conditions from April 1st 2015.

<u>Case Management for Other Individual Complex Packages of Care</u>
The CCG is developing robust case management in 2015/16 for individual packages of care for people with

complex needs that are not eligible for CHC funding. This will ensure that appropriate plans are in place to deliver safe and appropriate services in the right supportive environment.

In 2014/15, the CCG worked closely with Southend Borough Council in reviewing joint planning and funding arrangements and as part of the Pioneer Programme work and BCF. We have established joint meetings to explore opportunities for working more collaboratively ensuring care packages are truly focused on individuals needs.

The CCG is also working with the Council on reviewing the current care market in Southend - care homes and domiciliary care, by meeting with providers and discussing options for procurement, a clear specification on the expectations of commissioners for quality and safety of services and efficiently agreed pricings for packages of care.

Risk	Mitigation
Failure to undertake assessment and review of eligibility within required timescales for CHC patients could potentially leave patients receiving inappropriate care packages	Service Specification being agreed between provider and CCG with Key Performance indicators to ensure timescales met
Inability to recruit staff with required skill mix will impact on teams ability to provide effective assessment processes and case management	Provider has large workforce and capacity for ensuring cover, has successfully recruited and is in process of further recruiting to current vacancies
Lack of plan to implement Personal Health Budgets for patients with Long Term Condition post April 2015	Plan requested from provider for agreement by CCG by end February 2015 for
Failure to work collaboratively with Southend Borough Council in developing joint approach to providing individual focused care packages.	Joint working already underway and support of the Pioneer work and BCF.

This work stream contributes to the achievement of the following targets, standards and ambitions:

- Outcome Ambition 2: E.A.2: Health related quality of life for people with one or more long-term conditions;
- Outcome Ambition 6: E.A.7: Increase the proportion of people having a positive experience of care outside of hospital, in general practice and in the community;

2.2 Reducing health inequalities

Aim: To work in partnership with other agencies to deliver the priority outcomes set out in the Children and Young Peoples Plan and improve identified areas with the worse outcomes and experience of care.

Rationale for prioritisation: Equality, diversity and inclusion are key principles for how we operate as an NHS organisation. The NHS Constitution sets out that everyone counts and NHS resources will be used in the best way possible for the benefit of the whole community and that nobody is excluded, discriminated against or left behind.

Southend CCG is committed to providing children and young people with the best start in life. The Success for All Children Group continues to be the vehicle that facilitates agencies and organisations in Southend-on-Sea to work in partnership to improve outcomes for children, young people and their families living in Southend.

Partners
SCCG, SBC, SUHFT, GPs, Schools

Leads
Dr Kate Barusya, Dr Sunil Gupta, James Peskett

Outcomes for 2015/16

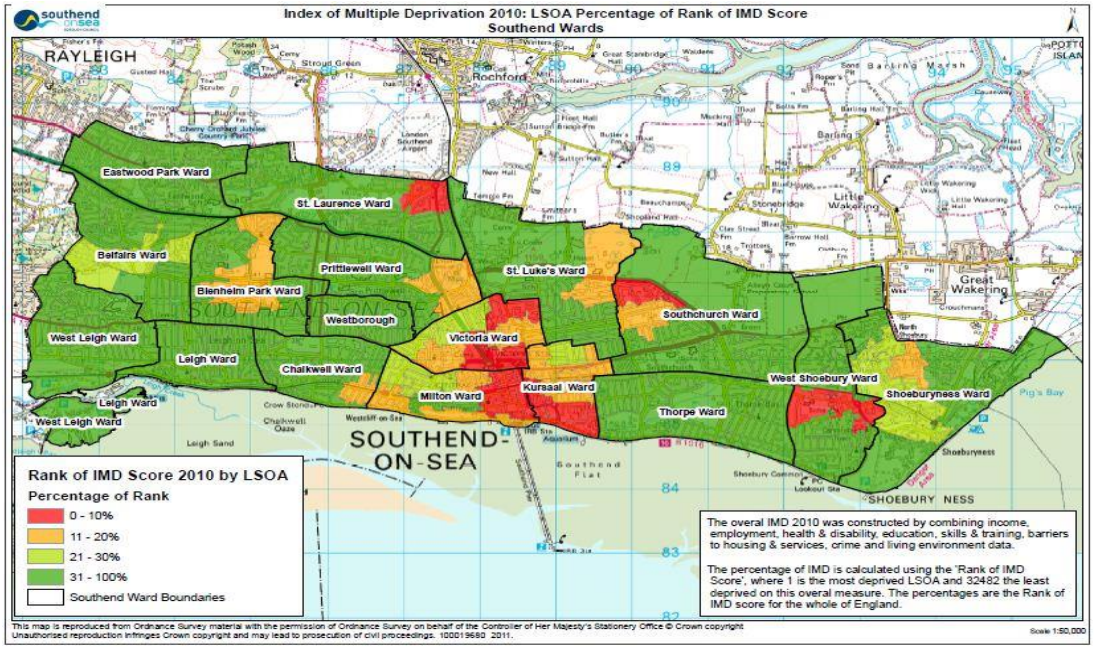
- Closing the divide between more advantaged and less advantaged children and families
- Supporting families at the earliest opportunity to prevent their needs escalating and to help them transition through our services
- Keeping young people safe
- Supporting young people & families to live healthier lifestyles
- Continuing to improve the life chances for looked after children and those on the edge of care
- Ensuring agencies proactively seek out and respond to the views of children and young people

There is now good evidence that deprivation and social exclusion can impact on a number of aspects of life including employment, crime, education and skills, health, housing and the environment.

From the Index of Multiple Deprivation (IMD), which is a measure of deprivation, nine communities in Southend-on-Sea fall within the 10% most deprived areas in England. These are situated within St. Laurence, West Shoebury, Kursaal, Milton, Southchurch, and Victoria wards. In comparison, Southend-on-Sea has eight communities ranked among the 10% least deprived in the whole of England. One community in Kursaal and one in Milton are in the 1% most deprived in the country.

At a Local Authority level Southend-on-Sea ranks as the 106th most deprived borough out of the 326 in the country.

The areas of deprivation within the Southend-on-Sea are shown in the map below taken from the draft local Joint Strategic Needs Assessment. The red areas denote the most deprived areas in the locality.



According to the 2011 Census Southend has 22,522 residents from all black and minority ethnic (BME) groups (including White Irish and White Other). People from ethnic groups other than white made up 8.4% of Southend residents. White minority groups represented 4.6% of the Southend population compared to 5.7% across England. The figure below shows a breakdown of estimated ethnic population in Southend.

Ethnic Group – Southend-on-Sea	Number	%
All usual residents	173,658	100.0
White	**159,023**	**91.6**
White: English/Welsh/Scottish/Northern Irish/British	151,136	87.0
White: Irish	1,496	0.9
White: Gypsy or Irish Traveller	162	0.1
White: Other White	6,229	3.6
Mixed/multiple ethnic groups	**3,651**	**2.1**
Mixed/multiple ethnic groups: White and Black Caribbean	1,039	0.6
Mixed/multiple ethnic groups: White and Black African	741	0.4
Mixed/multiple ethnic groups: White and Asian	977	0.6
Mixed/multiple ethnic groups: Other Mixed	894	0.5
Asian/Asian British	**6,440**	**3.7**
Asian/Asian British: Indian	1,810	1.0
Asian/Asian British: Pakistani	1,059	0.6
Asian/Asian British: Bangladeshi	933	0.5
Asian/Asian British: Chinese	1,084	0.6
Asian/Asian British: Other Asian	1,554	0.9
Black/African/Caribbean/Black British	**3,647**	**2.1**
Black/African/Caribbean/Black British: African	2,728	1.6
Black/African/Caribbean/Black British: Caribbean	524	0.3
Black/African/Caribbean/Black British: Other Black	395	0.2
Other ethnic group	**897**	**0.5**
Other ethnic group: Arab	297	0.2
Other ethnic group: Any other ethnic group	600	0.3

The legal duties around equality and health inequalities are fully incorporated into the CCG's work around equality and diversity. The CCG is currently refreshing its Equality and Diversity (E&D) Strategy, which was first approved by our Governing Body in 2012. The strategy, and all policy and procedural documents, relating to E&D are fully compliant with the new guidance. It sets out the CCGs commitment to meeting its statutory responsibilities for both patients and workforce.

In Southend, we work to ensure that physical and mental health services are available irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status. We take seriously our social duty to promote equality through the services we commission, paying particular attention to groups or sections of our communities where improvements in health and life expectancy are not on par with the rest of the population.

The CCG's Equality and Diversity working group now includes public health representation which enables robust discussion and decisions to address health inequalities. The JSNA is currently being refreshed by the public health team and the CCG will ensure that the key findings are considered when planning future activities.

Public health has confirmed that the Big Lottery Health Fund is being used to tackle the 5 main areas of deprivation within Southend. One of these is Bournes Green which is outlined in greater detail within section 3: Community Engagement and Empowerment.

Tackling the challenges we face around the deprivation within some of our localities and ensuring equal, fair and speedy access to all communities is a high priority. Southend CCG is an integral part of the multi-agency group tackling equality and diversity issues in the locality. The Success for All Children Group continues to be the vehicle that facilitates agencies and organisations in Southend-on-Sea to work in partnership to improve outcomes for children, young people and their families living in Southend.

We know that children with poor emotional wellbeing are more likely to develop mental health and drug and alcohol issues. We also know;

- There is additional support needed for young carers within the locality
- Paediatric care relies heavily of hospital provided services with alternatives needed within the community
- There are emerging issues and themes in relation children and young people as risk of sexual exploitation
- Delivering improved outcomes for looked after children

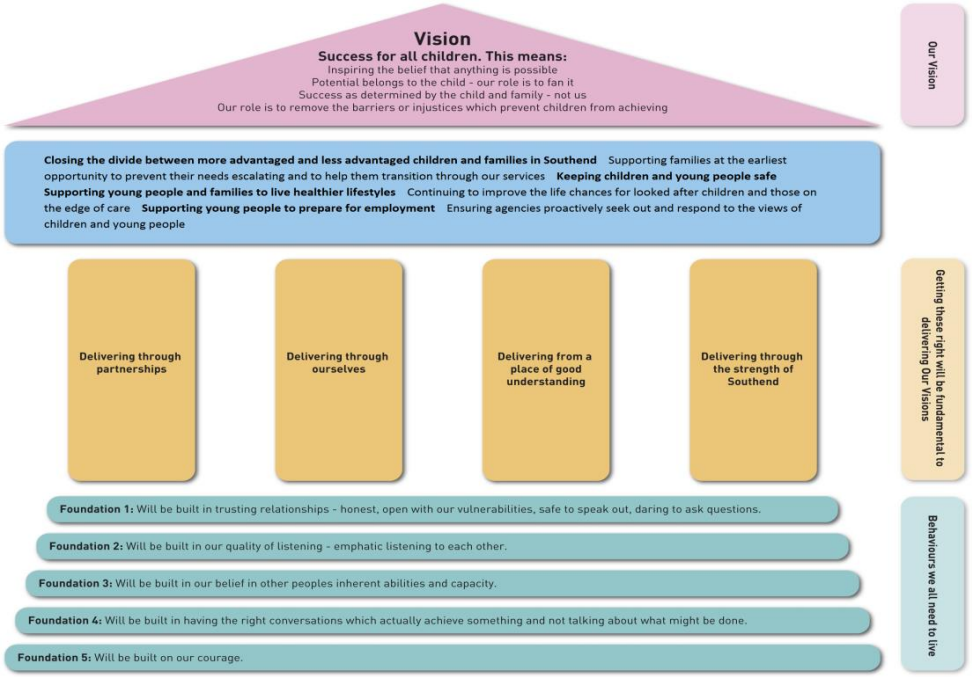
In 2015/16, a key priority will be supporting the delivery The Children and Young People's Plan. This Plan sets the key priorities and delivery plans we need to ensure progress and momentum.

The draft Joint Strategic Needs Analysis highlights six priority areas for focus in 2015-16 as follows;

- Closing the divide between more advantaged and less advantaged children and families in Southend
- Supporting families at the earliest opportunity to prevent their needs escalating and to help them transition through our services
- Keeping children and young people safe
- Supporting young people and families to live healthier lifestyles
- Continuing to improve the life chances for looked after children and those on the edge of care
- Ensuring agencies proactively seek out and respond to the views of children and young people

The Children and Young People's Plan sets the key priorities for improvement and the delivery plan sets out how, as partners, we will meet these identified needs and deliver the high quality services that our children, young people and families need.

All partners have agreed a shared vision.



Over the past year the Success for All Group has focused on delivering the priorities of the Children and Young People's Plan 2014 – 2015. Notable successes to highlight include;

- Successfully implementing the new Education, Health and Care Plans, including IT developments and training for staff and partners across Southend-on-Sea
- Across the partnership we have engaged service users in the design, delivery and commissioning of a number of key services including the new Emotional Health and Wellbeing Service, the provision of SEPT community services, and children's social work.

The priority areas for the partnership to focus on for 2015/16 are set out below in summary form. The priority areas have been drawn from the draft Joint Strategic Needs Analysis. These are;

1. Closing the divide between more advantaged and less advantaged children and families in Southend:
    - Education
    - Teenage Pregnancy
    - Young Carers
    - Young People Not in Education, Employment or Training (NEET)

2. Supporting families at the earliest opportunity to prevent their needs escalating and to help them transition through our services
    - Re-commissioning community based paediatric services and speech and language therapy and ASD service
    - Reviewing our Early Help Offer

3. Keeping children and young people safe
    - Addressing the emerging issues and themes on child sexual exploitation

4. Supporting young people and families to live healthier lifestyles
    - Children's emotional health and wellbeing services
    - Continuing to prevent and treat drug and alcohol misuse
    - Exercise

5. Continuing to improve the life chances for looked after children and those on the edge of care
    - Commissioning out of borough residential placements to improve education and health outcomes
    - Reviewing transition arrangements for leaving care

6. Ensuring agencies proactively seek out and respond to the views of children and young people

Implementing EDS2: The CCG has a robust Equality Delivery System (EDS2) action plan against which significant progress has been made. Whilst the QFP committee approved work against Goal 1 for 2014/15, progress has in fact been made against all four goals, demonstrating the CCG's positive approach to Equality and Diversity in general. The CCG's Equality and Diversity working group is dedicated to monitoring progress against the EDS action plan, which is reported to the Quality, Finance and Performance Committee on a quarterly basis. The EDS action plan is also published on our website.

Equality Impact Assessments: The CCG undertakes regular Equality Impact Assessments when considering new or revised services. The same process applies in situations where services are decommissioned. The CCG also undertakes Quality Impact Assessments for all commissioning activities and the QIA process is also a crucial feature of the QIPP process.

The NHS Workforce Race Equality Standard (WRES): This requires NHS providers to demonstrate progress against a number of indicators of workforce equality, including a specific indicator to address the low levels of Black and Minority Ethnic (BME) Board representation. The WRES will complement the EDS2 and we are currently waiting to find out how it will apply to us and what their specific responsibilities will be.

We expect to receive an annual report from all our main providers on progress against the WRES, which has now also been built into the 2015/16 contract from April 2015. Understanding and monitoring this information will enable us to set specific equality and diversity goals and objectives for the future.

In 2015-16 the CCG will collate workforce information where these are disclosed by staff members. The key performance indicators on gender, ethnicity and disability will be reported to the Governing Body on an annual basis to demonstrate how our workforce reflects the local population.

Southend CCG aims for 100% completion of mandatory training in relation to equality and diversity awareness. Our staff appraisal process includes a section on equality and diversity, against which staff are assessed in relation to their awareness and resulting behaviours in the workplace. This will help the CCG ensure there is no unintended bias towards or against particular protected groups.

NHS
Southend
Clinical Commissioning Group

Section 3: Access

In this section:

Convenient access for everyone

- Primary Care Engagement And Development
- Community Engagement And Empowerment
- Improvement Work Stream Cancer
- Mental Health (Parity Of Esteem)
- Mental Health – Dementia
- Mental Health - Improving Quality In Child And Adolescent Mental Health Services (CAMHS)
- Transforming Care - Improvement Work Stream: People With A Learning Disability
- Response To Francis, Berwick And Winterbourne View

Meeting the NHS Constitution standards

- NHS Constitutional Measures
- A&E Waiting times and Category A Ambulance Calls
- NHS Constitutional Measures – Cancer Waiting times

3.1 CONVENIENT ACCESS FOR EVERYONE

Southend CCG will ensure good access to the full range of services, including general practice and community services, especially mental health services in a way which is timely, convenient and specifically tailored to minority groups. Our plans include to improve early diagnosis for cancer and to track one-year cancer survival rates.

Primary Care Engagement And Development

Community Engagement And Empowerment

Connecting Communities

Cancer Services

Mental Health (Parity Of Esteem)
- Dementia
- Improving Quality In Child And Adolescent Mental Health Services (CAMHS)

Transforming Care - People With A Learning Disability

Response To Francis, Berwick And Winterbourne View

Primary Care Engagement And Development
Access Workstream 1

Aim: Support improvements in resilience, quality and access to primary care in Southend-on-Sea and reduce unnecessary clinical variation and avoidable admissions.

Rationale: Southend-on-Sea is unique in terms of its primary care provision. Many of our GP practices are single-handed or small practices and we have an ageing GP workforce with a significant proportion of salaried and sessional GPs.

We see significant variation between our practices for opening hours, referral rates, rates of emergency admissions and A&E attendances.

Southend-on-Sea has a high number of care home beds compared to the national average. This means we have a higher than average elderly population with increasing levels of frailty and complex needs. Providing proactive care to care home residents will enable us to improve the quality of care provided to reduce avoidable admissions.

NHS Southend CCG commissions services on behalf of 35 member GP practices, 11 of which are operated by a single GP. We recognise that GP practices are the cornerstone of the health system, and account for at least 80 per cent of all patient contact. Although we do not commission core GP services, it is a priority for us to work with our member practices to support improvement in the quality of primary care and share good practice to strengthen the ability of our members to respond well to demographic and contractual changes. This is particularly important in Southend as it may be more difficult for our smaller practices to respond to the recent changes to the national GP contract including the development of seven-day services.

Partners
NHS England direct commissioning team
Member GP practices
Patients and representative bodies

Leads
Dr Peter Long
Sadie Parker

Outcomes for 2015/16
3.5% reduction in emergency admissions
Majority of patients able to access GP services during core hours

Investment
£5 per head of population for clinical improvement collaborative
GP access programme
Aligning GP practices to care homes model

Transforming care to patients aged over 75 years

Using transformation funding (£5 per head) we will support practices to develop their services enabling them to care pro-actively for patients aged 75 years and over, living both at home and in residential care homes, and to improve access for both patients and health care professionals to GPs.

Developed by our clinical leads Dr. Peter Long and Dr. Kelvin Ng as well as Sadie Parker, our scheme enables our member practices to innovate and transform their service delivery for their own patient population. Practices have been invited to participate in the service which will provide freedom to practices to work individually or together. Data will be provided on a monthly basis to practices to enable them to monitor the impact of their transformed services on emergency admissions.

The scheme builds in the sharing of successes and good practice across our member practices through written case studies and through presentation at our regular member's forum meetings.

The scheme will be fully evaluated before a decision is recommended on future investment. It is expected the scheme will be cost neutral as a result of reducing the number of avoidable admissions through the provision of more responsive pro-active care. If all practices choose to participate, as many as 1,100 emergency admissions could be avoided by 31 March 2016.

Supporting improvements in the quality of primary care to reduce unwarranted clinical variation

We have identified that there is significant variation in clinical practice across our member practices including rates of referral, emergency admissions, access and prescribing. Our medicines management team will continue to support practices to prescribe in line with clinical guidelines and best practice and our clinical leads, supported by our primary care team, will work with our member practices to support our member practices in improving access and responsiveness.

The CCG inherited a number of referral management systems from its predecessor PCT. These were independently reviewed and as a result, our peer review educational evenings have been strengthened and the referral management system has been decommissioned.

Peer review evenings are held monthly and have been extended to all member practices. The sessions are led by our planned care clinical lead who works with a secondary care consultant, focusing on a particular specialty to provide an educational session peer reviewing anonymous referrals. The sessions are supplemented by a review of prescribing data and activity data for each of our member practices, led by the relevant clinical leads.

Our referral management clinical lead is developing a programme of support for practices to improve our rates of electronic referrals through the choose and book system. Currently approximately 50% of our referrals are electronic and the 2015/16 GMS contract includes a target of 80% by 31 March 2016. In order to support our member practices develop their systems for electronic referrals, we will do the following:

- Our clinical lead for referral management will be our choose and book champion
- We are currently auditing each practices' use of choose and book
- We have held a session with our practice managers forum
- We have arranged a session with our member practices at their April 2015 members forum to introduce our support programme
- Our clinical champion will begin visiting practices in May following the members forum to understand practices' use of choose and book along with any concerns, queries or technical issues
- We will work with our practice patient participation group forum so they can work within the practice to understand the benefits for patients and promote the choose and book system

We know we have variation between our practices in the levels of referrals made to secondary care services. The referral management system in place covered only a proportion of our practices and this has been decommissioned. Our referral management clinical lead will deliver a project during 2015/16 to address unwarranted clinical variation in our practices.

This project will initially focus on reviewing data on a GP practice level and on a speciality level against local averages and benchmarked against national averages. Outlying practices (both those with low levels and high levels of referrals) will be identified and visited by the clinical lead to discuss and understand their activity patterns and provide appropriate supportive interventions.
We will also review referrals at a specialty level in order to provide support and training through our peer

review educational meetings and through our members forums.
Planned outcomes are:

- Clinically appropriate levels of referrals across member practices
- A related reduction in spend on elective activity in secondary care
- An increase in electronic referral rates

A focus on improving access to our GP practices

Working in partnership with our colleagues at Southend Borough Council, we will develop a pilot project to deliver integrated working across health and social care based around registered GP practice populations. (This project forms part of our Better Care Fund plan and is consistent with the new models of care set out in the Five Year Forward View.) Our first hub will be designed and developed throughout 2015/16, evaluated and then rolled out to other areas in Southend-on-Sea.

A full options appraisal, learning from other successful models across the UK, will be considered and used by the project group to inform the development of a Southend model, which can be further refined to meet the individual needs of different practice (or groups of practices') populations.

We have been piloting seven day GP services in central Southend-on-Sea over the winter period. As part of a suite of services funded through resilience funding to support our urgent care system over the winter period, this pilot provides both GP and nurse urgent appointments on Saturdays and Sundays. The success of the pilot will be fully evaluated and in order to inform our future plans. This evaluation will also form part of the development of the primary care hub project.

Our clinical lead for GP engagement will deliver a project to support member practices in improving access to their services. We know there is significant variation in access across our member practices which impacts on other services, such as urgent care services and GP out of hours services.

We expect to commission independent support to work with practices identified as outliers from the GP Patient Survey results and locally collected information to individually identify areas for support and improvement. This will include a review of opening hours, appointment and clinician availability and will also pilot new ways of working, such as increasing online availability for patients, models such as telephone

triage and Doctor First.

We are developing a 'perfect practice' model with our clinical leads and our practice patient participation group forum and will use this as we develop our access support and development offer for member practices. The model will also support the commissioning of local services from our practices. We will continue to support member practices in their development of a GP federation in Southend, which will enable GP practices to work together to achieve better patient outcomes and to strengthen the resilience and sustainability of our member practices.

From April 2015, the GMS contract sets out that all practices are expected to have a patient participation group in place to support them in the provision of their services. We are supporting our practice patient participation group forum to develop a model of best practice for involving their patients which they will use to spread good practice and encourage more patient participation across Southend-on-Sea.

Co-commissioning primary care services

The CCG is involved with NHS England in the commissioning of primary care services, which is a position supported by the clinical leads and member practices. Officers from the CCG attend key NHS England decision-making meetings.

We will keep our position under review and building our capacity and capability in primary care commissioning so we can respond to any change in policy in the future. Our increased support for primary care development will enable us to support our member practices and increase pace in the delivery of our QIPP programmes to improve the sustainability of general practices in Southend-on-Sea.

We wish to continue to engage with both the sub-regional team of NHS England and our member practices to explore the potential benefits for 'place-based' commissioning that co-commissioning could bring. We will set up a co-commissioning steering group and we will develop a communications and engagement programme for our member practices before reviewing our position in October 2015.

The Essex area team has established an Essex transformation fund as a result of a programme to enable practices across Essex to transfer from PMS contracts to GMS contracts. In 2014/15, one joint bid from two

Southend CCG practices working with a private provider was successful. This bid focused on developing an app to support patients in managing minor ailments and in accessing care in alternative ways harnessing the latest developments in technology.

Southend CCG wishes to take the opportunity to manage the Essex transformation fund directly, liaising with the Local Medical Committee to ensure we invest appropriately to develop resilient and sustainable general practice in our area.

Education and training

Our CCG has a long history of providing education and training support to our member practices. In 2015/16, working with our partners in Castlepoint and Rochford CCG, we will continue to invest in the provision of emergency cover for protected time on a monthly basis.

Our clinical leads have considered how we can further strengthen how we deliver our members forums to ensure that we listen to our member practices and their feedback. We will provide at least six members forums each year which deliver consultant-led training to our member practices. The forums also enable clinical leads to engage member practices in commissioning and service transformation in line with our QIPP programmes.

We have developed an educational agreement which we will introduce to our practices for 2015/16 to ensure that we can be responsive to our member practices. Our clinical leads are currently reviewing how we can support existing smaller learning groups and will make a decision during March 2015.

We will continue to provide training and education through regular practice nurse forums, practice manager forums, and through our peer review sessions mentioned earlier.

Patient and public engagement

Our practice patient participation group forum is vital to supporting patient involvement in our GP practices. The new GMS contract requires all practices to have a patient participation group from April 2015; currently about half of our practices have functioning patient participation groups.

Our PPG forum is currently developing a model of best practice which they will use to develop their own practice groups as well as encouraging and supporting practices to implement their own PPGs.

The PPG forum will have a significant role to play in our improving access programme and also in supporting improvements in online access within their own GP practices.

The CCG has recently provided a joint training session to our PPG forum and patient and public engagement steering group.

The session also included CCG commissioners and was an opportunity to reinforce the CCG's commitment to patient and public engagement and for everyone to understand the benefits to improving commissioning.

Community Engagement and Empowerment
Access Workstream 2

Aim: To embed our patient and public engagement systems to ensure we add value to the commissioning of services, commissioning decisions and service redesign

Rationale: Our commissioning decisions should be informed by strong systems of patient and public engagement. In 2014/15 we have focused on establishing these systems, in 2015/16 we need to ensure they are embedded and add value to the commissioning of services.

We are a clinically led organisation, but it is vital our work is informed by a good understanding of patients' experience of services and their expectations and perceptions of the health services in the area. We must also use patient and public engagement and communication to support people to take good care of their own health and wellbeing and access services appropriately.

Partners
Healthwatch Southend
Southend Borough Council
Member GP practices
Southend Association of Voluntary Services (SAVS)

Leads
Janis Gibson, lay member
Sadie Parker

Outcomes for 2015/16
Double membership of the supporters scheme
3000 Twitter followers
Deliver one public event
Increase number of practice participation groups to 25
Publish communications and engagement strategy

Investment
£2000 for public event

Over the past year our activities have been focused on implementing our new approaches to patient and public engagement and further developing the tools and channels that we will use. We have designed our tools and channels in three strands:

Strand one: Supporters' scheme

Anyone in Southend can register with our supporters' scheme. By doing this, they will:

- receive news and information about health services in Southend
- be able to take part in consultation and engagement activities such as surveys and focus groups
- be more regularly involved in future projects if they wish.

We have publicised these opportunities online, at public events and with leaflets distributed via GP practices and other health care providers. People have the option to choose how involved they would like to be, and indicate particular subject matters that are of interest to them.

Strand two: Practice Patient Participation Group Forum

We have established a regular forum of representatives from each GP member practice where they can discuss issues and developments of joint concern, share best practice and report on patient experience. The focus of the forum for 2015/16 will be to encourage development of patient participation across Southend member practices and to support the development of our GP access work stream.

Strand three : Patient and Public Engagement and Involvement Steering Group

Our steering group is chaired by Matt King (Chief Executive Officer of Trust Links) and provides strategic-level advice and activity that will enable us to achieve our patient and public engagement objectives. The group is comprised of a cross-section of our Southend communities and also includes representatives from the Practice Patient Participation Group Forum which is chaired by former Southend mayor Sally Carr. It also includes representatives from Healthwatch Southend, voluntary and community sector groups and other individuals working with seldom-heard sections of society such as carers, homeless people and those with mental health problems.

The group has met several times in 2014/15 and will soon undertake some focused training on their roles to better understand how commissioning decisions benefit from their effective engagement. The focus of the group for 2015/16 will be to support the CCG in its development of a communications and engagement strategy, supporting the development of our transformation programmers and developing a strategy for closer working with the voluntary and community sector. The group will also begin to monitor the CCG's delivery plan for equality and diversity.

A&E diversion activity

In the winters of 2013/14 and 2014/15, we implemented a campaign to help people use health services appropriately and reduce inappropriate use of A&E. We worked with patient groups across Southend and with our partners in Castle Point and Rochford CCG to conduct an audit of people attending A&E with minor conditions. From this audit we identified some of the main types of inappropriate A&E attendance and designed a communications campaign to encourage people to use services such as NHS 111 rather than A&E.

We distributed information leaflets, used social media to publicise the campaign, placed adverts on buses and online and developed a children's book which has been distributed via schools and children's centres. We will evaluate the success of this campaign and build on this activity in future, particularly as part of our winter campaign.

Objectives	Activities	Governance	Measurement
To use stakeholder communications and engagement to improve the way that we commission health services for all people in Southend	Review and refresh stakeholder communications and engagement strategy (including internal communications)	Regular reporting to Quality, Finance and Performance	Increased levels of public and patient engagement (increased membership of supporters' scheme, increased social media activity).
To develop and build our web and social media presence to provide information and resources for patients and member practices	Develop and implement a planned programme of communications and engagement activities	Committee and Governing Body through our lay member for patient and public engagement	Clear patient and public input to commissioning
To improve working relationships with voluntary and community sector organisations	Develop and implement online tools to meet the different needs of a variety of stakeholders		
	Develop joint working with strategic partners' communications leads		
	Develop a strategy for closer working with the voluntary and community sector		
	Support clinical leads and CCG staff in embedding patient and public engagement in transformation programmes		

Risk	Mitigation
Lack of interest in CCG supporters scheme	A stakeholder communications and engagement strategy will be developed and underpinned by targeted marketing and communications activities to raise awareness of benefits

Community Engagement and Empowerment
Connecting Communities (C2) In Bournes Green Park Area
Access Work Stream 3

Aim: Supporting public health colleagues who are leading this project, the aim is to reduce health care costs (specifically childhood asthma, postnatal depression and teenage pregnancy) and to reduce the level of A&E attendances from the area.

Rationale: Bournes Green Park is located within the 10% most deprived areas in England. It has worse than average outcomes across a range of indicators including child development at aged 5, poor rates of general health, rates of emergency admissions and alcohol admissions.

The initiative will empower local residents and public service workers to improve health and wellbeing outcomes by addressing the some of the issues that have a direct impact on health, namely; unemployment, poor neighbour relations and other social and lifestyle factors. The scheme is being led by public health and delivered through a partnership of health, local authority and community partners, and aims to reduce health care costs (specifically childhood asthma, post natal depression and teenage pregnancy) and to reduce the use of A&E from the Bournes Green Park area.

Partners
Southend Borough Council (Public Health team)
Public sector partners
Local residents

Leads
Janis Gibson, Emma Tindell

Outcomes for 2015/16
Reduce healthcare costs
Reduce admissions to A&E

Resources
Continued time investment from engagement team

In 2014/15 we provided some grant funding to a public health improvement engagement initiative in the Bournes Green Park area of Southend. The CCG continues to form part of the steering group for this initiative which is being led by the public health team at Southend Borough Council.

The Bournes Green Park area of Southend includes approximately 1,100 households which can be described as being located within the 10 per cent most deprived areas in England. It is located within Southchurch ward, which has significantly worse than average outcomes across a range of health indicators including; child development at 5 years of age, rates of general health rated as bad or very bad, rates of limiting long term conditions or disability, rates of emergency hospital admissions for COPD and rates of hospital stays for alcohol related harm.

The initiative is being led by public health and delivered through a partnership of health, local authority and community partners, and aims to reduce health care costs (specifically childhood asthma, post natal depression and teenage pregnancy) and to reduce the use of A&E from the Bournes Green Park area.

It will achieve this by empowering local residents and public service workers to improve health and wellbeing outcomes by addressing the some of the issues that have a direct impact on health, namely; unemployment, poor neighbour relations and other social and lifestyle factors.

The initiative is utilising the innovative Connecting Communities (C2) seven-step model; a practical application of an assets-based approach to transforming challenging communities which has been developed over time using evidence from successful projects across the country. The C2 model adopts an invest-to-save approach with a clear focus on health promotion and community resilience. While this requires significant input from us and the other public sector partners in the early stages of implementation, it is the residents who will take the project forward in the mid to longer term, with reduced project input from the different agencies.

The programme has been running for approximately one year with all households in the target area contacted, either through face-to-face conversations or leaflet hand delivered to the household. Further

engagement events have taken place within the community and the group continues to seek to increase the number of residents taking part.

Objectives	Activities	Governance	Measurement
To reduce health care costs, specifically childhood asthma, post natal depression & teenage pregnancy from the Bournes Green Park area of Southend	Support election of long-term key roles, Chair & Vice Chair, Treasurer, Secretary and other roles identified by the interim group		Measurable outcomes from community action plan and evidence of visible transformational change, e.g. new play spaces
To reduce the use of A & E and hospital admissions from the Bournes Green Park area of Southend	Actively participate as part of the Bournes Green partnership		Reduced inappropriate use of health services (pending availability of data) Governance
To develop a more resilient and aspirational community in the Bournes Green Park area of Southend	Identify possibilities for measuring success of project with CSU information team		Regular updates to chief operating officer and lay member for patient and public engagement
Support the establishment of a community partnership with clear aims and ambitions for the future	Support the constitution of an official partnership - to operate out of a hub within the community		

Risk	Mitigation
Lack of engagement from residents and public sector partners	Strong steering group, regular meetings, proven programme for encouraging participation. Hold further listening event
Unavailability of data prevents ability to measure outcomes to measure success of project	Work with public health to identify postcode measures if data not accessible through CSU

Improvement Work Stream Cancer

Aim: To maintain our good performance across most of the cancer standards and to improve our performance in relation to the 62 day standard, as well as improve early diagnosis rates and one-year survival rates.

Rationale: Cancer services remain a national and local priority for the public, patients and the CCG. During 2014/15, a Cancer Recovery Plan was developed and implemented, which has already seen improvements in the 62 day standard. In addition, Southend is a specialist centre for urology and we wish to continue to support our commissioning and provider colleagues to support the urology pathway. There remains further work to be done to achieve the 62 day standard across all cancer sites; to increase rates of early diagnosis; and improve tracking of one-year survival rates.

Partners
Essex Local Cancer Forum, Castlepoint & Rochford CCG, East Of England Strategic Clinical Network (Cancer), Southend University Hospital NHS FT

Leads
Dr Peter Long, James Peskett

Outcomes for 2015/16
Maintain achievement against cancer standards and improve performance against 62 standard
Increase rates of early diagnosis through increased public awareness and greater access to diagnostics in primary care
Improved tracking of one-year survival rates through redesigned follow-up pathways

Objectives	Activities	Governance	Measurement
To work proactively with partners to maintain and improve health that will support a reduction in the future incidence of cancer	To engage in the East of England Strategic Clinical Network through representation and membership of the Essex Cancer Forum	'Cancer Plan' monitored through the South East Essex Cancer Network	Compliance against quality Standards for Cancer
To improve the detection of cancer at an early stage through increasing public	Working collaboratively with Castle Point and Rochford CCG to deliver a uniform approach to patient cancer care across Southend	Contractual compliance against Quality Standards and NICE guidance	Implementation of the South East Essex Cancer Plan
awareness and improved access to diagnostics in primary care.	Support the delivery of Improving Outcomes Guidance (IOG) compliance under the direction of the East of England Strategic Cancer Clinical Network		Increase in uptake of key screening programme against 2013/14 baseline
To improve the outcome indicators for cancer against 2013/14 baseline through a reduction in variation of treatment	In partnership with public health implement a communication campaign to raise awareness of cancer aligned to the 'Be Clear on Cancer Campaigns'		
	Deliver targeted primary prevention by building on the specialist smoking cessation services and the delivery of tier 2 weight management programmes.		
	Improve the appropriateness and quality of referrals and engage with members in relation to their responsibilities around early detection		
	Work with SUHFT to ensure appropriate capacity and resource to manage service demand for specialist urological cancer.		
	Improve patient pathways through the repatriation of targeted specialist services/diagnostics to the local health economy.		

Risk	Mitigation
Disengagement of member practices	Clinical lead to work with disengaged practices. .
Provider non-compliance with protocols, thresholds, pathways	Strict monitoring through KPIs, escalation route to be agreed etc. resulting in increased volumes through contract
Local Providers unable to secure resources to repatriate specialist diagnostics.	

This work stream contributes to the achievement of the following targets, standards and ambitions:

- All constitutional measures on cancer waits;
- Outcome Ambition 1: E.A.1: Potential years of life lost from causes amenable to healthcare;
- Outcome Ambition 2: E.A.2: Health related quality of life for people with one or more long-term conditions;
- Outcome Ambition 3: E.A.4: Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community;
- Outcome Ambition 6: E.A.7: Increase the proportion of people having a positive experience of care outside of hospital, in general practice and in the community;

Mental Health including Parity of Esteem

Aim: To improve the quality and integration of mental health services by investing in services to deliver parity between physical and mental health and contribute to reducing the 20 year gap in life expectancy for people with a mental illness.

Rationale: Southend CCG's prevalence of mental health problems (QOF prevalence) is the highest in Essex (1.07% against an average of 0.75% across Essex as a whole) and we also have the highest proportion of people completing GP patient surveys who report they feel anxious or depressed (12.6% against an Essex average of 11.3%).

The CCG sees improving mental health, and access to local mental health services, as a key priority for 2015/16. We will be making additional investment in local services as part of our commitment to improving the mental health and wellbeing of our population.

Partners
SBC, CP&R CCG

Leads
Dr. José Garcia-Lobera, Hugh Johnston

Outcomes for 2015/16
Liaison psychiatry service
Improved crisis care, including for young people
IAPT targets achieved
Early intervention in psychosis

Resources
Circa £22m on mental health services in 2015/16

We have now established a dedicated mental health commissioner post. In 2015/16 we will build on the work we have already done with the Council to develop a fully integrated commissioning team for mental health and learning disability services. At the same time, we will continue to work closely with Castle Point and Rochford CCG that leads on commissioning secondary care and other mental health services across south Essex.

IAPT

We have made excellent progress in delivering the national priorities for people accessing local IAPT services. We have achieved our access target of 15% in the first three quarters of 2014/15 and are on track to achieve this target for the year. Our IAPT recovery rate has exceeded the 50% target throughout the year (acknowledging that there are differences between our provider's locally reported data and HSCIC). We have worked with our IAPT provider over the last year to re-design the service to maximise productivity. This has ensured that there will be sufficient capacity to achieve the new IAPT waiting time targets by April 2016.

Our objectives for 2015/16 are:

- To maintain uptake of Therapy For You (the south Essex IAPT service) by at least 15% of local population with common mental health problems.
- To develop plans with SEPT to build on the current 50% recovery rate within Therapy For You.
- To ensure with SEPT that service capacity and productivity is sufficient to meet the 18 week and 6 week waiting time targets for psychological therapies provided by IAPT services.

Crisis Care Concordat

The CCG will work in line with the guidance and frameworks provided by the Crisis Care Concordat, the national suicide prevention strategy and *Commissioning for Prevention* to improve support for people affected by a mental health crisis and to implement our Crisis Care Concordat Action Plan in 2015/16.

The South East Essex System Resilience Group has established a multi-agency mental health sub-group in 2014.

This group has brought together CCGs, SEPT, SUHFT, local authorities and the police and this has facilitated connections with a wider range of agencies and services relevant to people affected by mental health crises (e.g. housing services). This sub-group is responsible for the development and implementation of the south east Essex Crisis Care Concordat Action Plan. The group is identifying which resources are available within the crisis care pathway to ensure that we focus on patient safety, service user choice and to make sure individuals can be treated as close to home wherever possible. We have also identified a need to strengthen community services for children and young people with mental health conditions, particularly those such as self-harm, suicidality, disturbed behaviour, depression or acute psychoses which may present in crisis. The CCG has identified a potential additional investment of £1.09m to help meet these needs and develop mental health services.

The group has also focused on improving the experience of people with mental health problems who require emergency care. In 2014/15 we have piloted a liaison psychiatry service in Southend Hospital. This has addressed problems in delays in assessments for people presenting with mental health problems and has supported Southend Hospital's performance against the 4 hour A&E waiting time target. The sub-group has also contributed to the development of a county wide street triage service. This new joint service between Essex Police and local mental health Trusts has led to further diversions of people in crisis away from A&E and a substantial reduction in the number of people detained under Section 136 of the Mental Health Act. The group is now working on ensuring that there are effective care pathways from police custody suites and courts to make sure individuals with co-existing mental health and drug and alcohol issues can effectively access appropriate substance misuse services.

Our objectives for 2015/16 are:

- Continue to improve services for people in mental health crisis attending SUHFT emergency department through the work of the RAID liaison psychiatry service, including services for young people
- To implement the local Mental Health Crisis Concordat action plan.
- To support the HWB to develop a suicide prevention strategy which focuses on self-harm.
- To improve outcomes for patients and reduce the reliance on inpatient care models.
- To work with Castle Point & Rochford CCG to begin the implementation of PbR care packages to ensure a

systematic approach to delivering high quality treatment and support, and support the management of provider performance.

- To work with Southend Borough Council and Castle Point & Rochford CCG to strengthen local commissioning of mental health and learning disability services.
- To develop an integrated approach with Southend Borough Council to the development of local services that support early intervention, personalisation and self-management through projects such as a recovery college and personal health budgets
- To focus on improving service user experience
- To deliver care closer to home by improving our processes for individual placements
- To work with public health to develop a clearer understanding of suicidal behaviors in the local population.

Prevention, Recovery and Physical Health

Working with the Council and our local providers to strengthen specialist and primary care mental services will also be an important part of our work in 2015/16 to improve services for people in crisis. Implementing personal care packages should ensure effective service responses with a focus on recovery which is demonstrated by measuring outcomes and clearly shown in service specifications. We will be working with providers to collect, analyse and act on a range of agreed outcomes, including patient and carer experience and satisfaction feedback. We will be working to develop new services that address the need of people with mental health problems to give hope that they are able to lead as full a life as possible. This will include a specific focus on the Early Intervention in Psychosis (EIP) Service. The local EIP service is currently able to offer more than 50% of the people referred access to a NICE approved care package within less than two weeks of referral. We will be working with the local service provider to assess the potential for any developments that may assist in young people who are particularly vulnerable.

The CCG has worked with SEPT to develop additional support for people with severe mental illness to improve their physical health. The focus of this work in 2014/15 has been full implementation of appropriate processes for assessing, documenting and acting on cardio-metabolic risk factors in patients with schizophrenia. 90% of patients have now had an assessment of each of the six key cardio metabolic parameters - smoking status, lifestyle

(including exercise and diet), Body Mass Index, blood pressure, glucose regulation (HbA1c or fasting glucose or random glucose as appropriate), and blood lipids. This work will be continued and extended in 2015/16.

Our objectives for 2015/16 are:

- To invest additional resource in line with increases to the CCG's overall allocation to address local and national mental health priorities, particularly crisis care (including liaison psychiatry) and community services for children and young people with mental health problems.
- Reducing the 20 year gap in life expectancy for people with a mental illness compared to those in good health. To ensure that more than 50% people referred with a first episode of psychosis have access to a care package in line with NICE guidance within two weeks of referral.
- To continue to focus on improving the physical health of people with severe mental illness.
- To work with public health to begin planning to narrow the gap in life expectancy for people with mental health problems.
- JSNA is developed across health and social care to evidence more clearly the needs of Southend's' population.
- The Health and Wellbeing Board places an emphasis on mental wellbeing which includes promoting mental wellbeing in the workforce, reducing the stigma of mental illness and early intervention for those whose mental wellbeing is in jeopardy, for example experiencing debt problems.

<u>Dementia</u>

The CCG has also made significant progress towards the national target of ensuring that 66.7% of people with dementia have a diagnosis. We will maintain our focus on these areas in 2015/16, as well as ensuring that more than half of the people experiencing a first episode of psychosis have access to evidence based treatment within two weeks.

Our objective for 2015/16 is:

To work with Southend Borough Council to further develop services offering post-diagnostic support for people with dementia and to promote these services locally to increase uptake and early diagnosis

Objectives	Governance	Measurement
To continue the redesign of community mental health services to improve outcomes for patients and reduce the reliance on inpatient care models.	Following a review of local commissioning arrangements for mental health and learning disabilities services, the CCG has now established its own dedicated commissioner post and is working in partnership with Southend Borough Council and Castle Point and Rochford CCG (as the lead CCG for mental health commissioning). The CCG and Council are developing an integrated approach to commissioning and managing the local system of mental health and learning disability services. We are working together on the local implementation of the south Essex joint mental health strategy.	Measurement of referral numbers, numbers entering treatment, recovery rates and waiting times in Therapy For You (IAPT)
To work with Castle Point & Rochford CCG to begin the implementation of PbR care packages to ensure a systematic approach to delivering high quality treatment and support, and support the management of provider performance.		Measurement of milestones on QIPP projects
To work with Southend Borough Council and Castle Point & Rochford CCG to strengthen local commissioning of mental health and learning disability services.		Measurement of numbers of people diagnosed with dementia
Continue to improve services for people in mental health crisis attending SUHFT emergency department through the work of the RAID liaison psychiatry service and the multi-agency group that oversees this and other work relating to the crisis care concordat.		Measurement of numbers of people referred to secondary care mental health services by PbR cluster
To maintain uptake of Therapy For You (the south Essex IAPT service) by at least 15% of local population with common mental health problems.		Contractual KPIs with SEPT and other providers
To work with SEPT to develop plans to build on the current 50% recovery rate within Therapy For You.		Yearly national RAP (referral, assessment and packages of care) return from all Local Authorities on mental health social care data.
To work with SEPT to ensure that service capacity and productivity is sufficient to meet the 18 week and 6 week waiting time targets for psychological therapies provided		

by IAPT services.		
To pursue an integrated approach with Southend Borough Council to the development of local services that support early intervention, personalisation and self-management through projects such as a recovery college and personal health budgets		
To work with Southend Borough Council, Essex Police, service providers and other local partners, including people with lived experience, to implement the local Mental Health Crisis Concordat action plan.		
To work with Southend Borough Council to develop services to offer post-diagnostic support for people with dementia and to promote these services locally		
To ensure parity of esteem plan by working with public health to begin planning to narrow the gap in life expectancy for people with mental health problems.		
To focus on improving service user experience		
To deliver care closer to home by improving our processes for individual placements		
To work our partner CCG and Southend Borough Council to ensure that nobody with a learning disability becomes an inpatient inappropriately.		
To work with Southend Borough Council and our partner CCGs, service providers and other agencies across Essex to reduce reliance on inpatient care for people with a learning disabilities and to ensure that all inpatient placements are reviewed and that plans are in place to support people back into the community as appropriate.		
JSNA is developed across health and social care to evidence more clearly the needs of Southends' population.		

The Health and Wellbeing Board places an emphasis on mental wellbeing which includes promoting mental wellbeing in the workforce, reducing the stigma of mental illness and early intervention for those whose mental wellbeing is in jeopardy, for example experiencing debt problems.		
The HWB intends to develop a suicide prevention strategy which addresses self harm.		

This work stream contributes to the achievement of the following targets, standards and ambitions:

- Other Measure: E.A.S.2: IAPT Recovery Rate; Other Measure: E.A.S.1: Dementia Diagnosis Rate; Quality Premium: E.A.3: IAPT
- Rollout; Outcome Ambition 1: E.A.1: Potential years of life lost from causes amenable to healthcare (per 100,000 population);
- Outcome Ambition 2: E.A.2: Health related quality of life for people with one or more long-term conditions; Outcome Ambition 3:
- E.A.4: Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community;
- Outcome Ambition 6: E.A.7: Increase the proportion of people having a positive experience of care outside of hospital, in general practice and in the community

Mental Health – Dementia

Aim: To improve the quality of life for people with dementia

Rationale: By 2021 the number of people aged over 65 in Southend will increase by 45%, and the numbers over 85 by 85%. 5% of people over 65 will have dementia and 20% of those over 85. Consequently increased demand on services from people with dementia represents a significant challenge, and the CCG in working in partnership with Southend-on-Sea Borough Council (SBC) to ensure that local people have the services they need

We have developed an integrated approach to planning and commissioning for dementia with SBC, including an integrated team that will be further developed in 2015/16. From this approach we have developed joint commissioning intentions and in addition to a new range of community support services will also work with the Council to develop a new supported housing complex to offer a higher level of local service to support people in their own homes and avoid the need for residential care. In 2015/16 we will be working with SEPT and other south Essex CCGs to develop two 35 bed nursing homes for people with dementia and challenging behavior. This development will the south east Essex health economy manage the increasing demand for continuing health care from this client group.

Partners
SBC, SCCG, GPs, SEPT

Leads
Dr. José Garcia-Lobera, Hugh Johnston

Outcomes for 2015/16
To sustain independence and improve quality of life for people with dementia post diagnosis
To increase the proportion of people with dementia living independently at home following discharge
To increase the number of people with dementia and physical health conditions having a positive experience outside hospital in general practice and in the community

Resources
New dedicated commissioning post

We have demonstrated significant progress towards the national target for dementia diagnosis of 66.7% and towards our local aspirational higher goal of 77.2%. Our rate in December was 58.1%, a 3.4% increase over the previous month. The provision of post-diagnostic support is critical to building GPs confidence in the benefits of early diagnosis in primary care. The range of local post-diagnostic support services provided by the Alzheimer's society in Southend has been significantly strengthened in the last year, including a new dedicated service that will liaise directly with primary care services to raise GP's awareness of local provision and ensure that people are signposted to the support and services they need.

The CCG is committed to achieving and exceeding the 66.7% national target for dementia diagnoses. In 2015/16 we will continue to work with our local service provider to increase capacity in specialist memory assessment service clinics, and will continue to support individual GP practices where diagnosis rates fall below the target. During the last year we have:

- Developed an accredited training programme for dementia diagnosis by specialist nurses
- Developed pathways for diagnosis
- Piloted a hospital liaison psychiatry service that includes older adult psychiatry to provide support with diagnosis and clinical management of people with dementia in Southend Hospital
- Significantly increased community support commissioned from the Alzheimer's Society and other providers
- Dementia Intensive Support team is in place
- Supported the reduction of antipsychotics within care and residential homes
- The creation of the Southend Dementia Action Alliance and the roll out of the Dementia Friends programme across the Borough.

The aims of the Southend dementia work stream are set out within the South East Essex Dementia Strategy. The overarching principles are to provide services that are equitable and all people with dementia irrespective of their age have a fair access to services, by ensuring that:

- People affected by dementia will be supported in their own home or community for as long as possible
- People affected by dementia will have access to a pathway of care that delivers rapid and competent assessment of need

- People affected by dementia will have good physical health
- People affected by dementia will achieve the best possible quality outcomes of life
- People affected by dementia feel supported post diagnosis
- JSNA is developed across health and social care to evidence more clearly the needs of Southend's' population.
- 'Hard to reach' groups, such as people with learning disabilities and BME groups, are aware of dementia as an illness, ways to seek diagnosis and post diagnosis support.

As part of our strategy we will implement the priority areas identified in the report Closing the Gap; priorities for essential change in mental health services to achieve parity between mental and physical health services.

Objectives	Activities	Governance	Measurement
To sustain independence and improve quality of life for people with dementia post diagnosis	Implement training to: • Improve the quality of reviews for people with dementia in care and residential homes. • Increase awareness of dementia for wider community teams • Develop specialist resources within integrated teams • Develop diagnosis pathways for care and residential homes	The south east Essex Dementia Strategy and implementation plan is monitored by the Southend Dementia Steering Group. During 2015/16 the CCG and Southend Borough Council will move towards joint commissioning arrangements for people affected by dementia as part of our approach to closer working and integrated service planning and delivery under the Better Care Fund.	Reduced crisis admissions to hospital
To increase the proportion of people with dementia living independently at home following discharge	Increase capacity within memory clinics		Milestones on QIPP projects
To increase the number of people with dementia and physical health conditions having a positive experience outside hospital in general practice and in the community	Develop a shared care protocol to support clarity between partners within, health social care and the voluntary sector when diagnosing & caring for patients with dementia to ensure swift access to appropriate services.		Dementia diagnosis rates

	Build on the integration of the Dementia Intensive Support Team into community services to reduce admission to acute hospital		Reduced use of antipsychotics
	Build on existing reablement provision to better support patients with dementia		Contractual KPIs with SEPT and other providers
	To improve diagnostic rates in primary care		Quarterly targets that are outlined in the DSG (see caveat below)
	To improve outcomes by focusing on training and integration		
	To ensure parity of esteem plan by working closely with public health to begin planning to narrow the gap in life expectancy		
	To reduce inappropriate prescribing of antipsychotics		

Mental Health - Improving quality in child and adolescent mental health services (CAMHS)

Aim: The re-procurement of a Children and Young People's (CYP) Emotional Wellbeing and Mental Health service (EWMHS), traditionally referred to as Child and Adolescent Mental Health Services (CAMHS), across Southend, Essex and Thurrock.

Development of a stepped model of care - This approach is child and young person focussed and aims to deliver the most appropriate and least intensive level of care at the earliest stage that best meets need. This also enables movement up or down the steps as needs change.

Emotional Wellbeing & Mental Health service - To appoint a provider who will deliver improved outcomes for a greater number of children & young people who have emotional wellbeing and mental health needs.

Rationale: 58% of adults with severe mental illness first experienced mental health problems before the age of 14, having accessible and effective child and adolescent mental health services can have a major impact on adult mental health morbidity. CAMHS commissioners, providers and wider stakeholders, including users, have acknowledged that the current model of emotional wellbeing and mental health provision for children, young people, their families and carers provides insufficient integration between the traditional Tiers of CAMHS provision.

Partners
SBC, SCCG, CP&R, SEPT, SUHFT

Leads
Dr. José Garcia-Lobera, Hugh Johnston

Outcomes for 2015/16
Improved emotional wellbeing, resilience and esteem
Easier access &quicker response to services
Improved joint working with adult mental health
Reduced inappropriate use of A&E

Resources
New dedicated commissioner post

The independent Joint Strategic Needs Assessment of child and adolescent emotional wellbeing and mental health completed in summer 2013 concluded that there is no overall coherent integrated strategy within which services are commissioned and there is a complex, fragmented and poorly understood and accessed set of services in place.

The three Local Authorities (including Southend Borough Council), and seven Clinical Commissioning Groups (CCGs), are working in partnership across Southend, Essex and Thurrock to develop an improved response to children's emotional wellbeing and mental health needs. It is recognised that each partner brings a unique and important contribution to this process and all have agreed to work together to integrate commissioning, take an outcomes based and innovative approach and to develop more integrated pathways across health, social care and education.

A procurement process is currently underway and both Southend CCG and Southend Borough Council are fully involved. This new service will be in place from November 2015 with the clear aim to deliver improved outcomes for a greater number of children & young people who have emotional wellbeing and mental health needs. The approach will be child and young person focussed and will provide the most appropriate and least intensive level of care at the earliest stage that best meets need. The approach will give a graduated service with movement up or down the steps as needs change.

The key outcomes for the re-commissioned service are:

1. Improved emotional wellbeing/emotional intelligence, resilience and self-esteem for Children, young people, their families and carers
2. Children, young people, their families and carers receive easier access to services with a timely response to their needs
3. More children, young people, their families and carers are appropriately supported within other services (for their emotional wellbeing and mental health needs)
4. Practitioners have easier, increased and improved access to services for the children, young people and their families and carers they identify in need of support; and practitioners receive improved consultation, advice support, training and guidance from the service for themselves

5. Reduced inappropriate use of A&E to access EWMH Services
6. Vulnerable groups such as Looked After Children, Fostered/Adopted, leaving care, on the edge of care, with a severe learning disability and their families and carers receive priority assessments, combined with appropriate evidence-based interventions from the CYP EWMH service
7. More young people aged 14+ and their families and carers receive appropriate mental health support and experience a smooth transition to adult mental health services
8. More children, young people, their families and carers experience integrated service provision within EWMH provision, co-ordinated with other services without discriminatory, professional, organisational or locational barriers
9. Increased involvement of children, young people and their families and carers in contributing to, participating in and influencing service provision and development.
10. Parents and carers of children under 5 years old have increased access to EWMH services/interventions which enable and support positive attachment and the emotional wellbeing of their young children

Specifically improvements will be seen in the following areas:

Area	Improvement		Area	Improvement
Delivery Model	• Joint commissioning approach across all CCGs • Consistency through one provider commissioned to deliver a comprehensive service		Quality	• Wider range of effective evidence based interventions • Use of a pathway approach agreed and consistent across the whole area • Emphasis on joint working with other services
Age/ eligibility	• Improved joint working and planning between children's and adult mental health services • Admissions criteria consistent across		Referral/ approach	• Referrers informed within 2 days of referral • One "front door" into services for Essex with screening service located with Early Information and Advice Hub and Multi Agency

	Essex to meet the needs of each area • Improved joined up working to meet behavioral and emotional needs • Improved working between mental health and and other disabilities including learning disabilities • Improved working with local authorities through all stages of the placement journey			safeguarding Hub.
Delivery	• Strengthened outreach approach • Increased home based delivery • Increased delivery in local schools, health and community venues • Extension of opening hours • Focus on assertive crisis outreach • Follow up and outreach to engage those with needs who miss appointments		Vulnerable group and prioritisation	Prioritisation for: • Children looked after, fostered/ adopted, leaving care and on the edge of care • Children with severe learning disabilities and complex social, mental health and emotional health difficulties • Young offenders • Substance misuse
Crises Intervention	• Improved in and out of hours crisis delivery service • Clear and effective management of crises pathway • Work in partnership with A&E services on the delivery of mental health services • Support GPs to open outside of normal hours			

TRANSFORMING CARE

Improvement Work Stream: Services for People with A Learning Disability including Winterbourne

Aim: To improve the lives of adults with a Learning Disability and their carers

Rationale: Following the distressing and totally unacceptable circumstances uncovered at Winterbourne View Hospital, both in standards of care and in the length of time vulnerable people were left, unnecessarily, in assessment and treatment services, the CCG has been working with all partner agencies to implement the requirements of the Department of Health Review - 'Transforming Care: a national response to Winterbourne View Hospital'.

The CCG has worked to resettle people who were ready for discharge and is committed to closely monitoring those people who remain in assessment and treatment settings, ensuring that there is clear discharge planning in place to facilitate safe and effective discharge when the person is ready for discharge.

Partners
SBC, SUHFT, SEPT, NHSE, Primary care

Leads
Dr. José Garcia-Lobera, Hugh Johnston

Outcomes for 2015/16
No admission to assessment and treatment unless absolutely necessary
Clear discharge plans for people admitted for assessment and treatment
Effective monitoring of care delivery in assessment and treatment facilities
Improved access and acceptability of universal services for people with LD

Resources
Winterbourne – meeting the costs of moving service users into community care settings

However, the latest reports *Winterbourne View – Time for Change, 2014, Transforming care: 2 years on – January 2015, Transforming Care for People with Learning Disabilities – Next Steps* and the *National Audit Office report – Services for people with learning disabilities and challenging behaviour - February 2015* show that not as much progress has been made as was intended. The reports have confirmed that there was progress in discharging people, with 923 discharges by consultant psychiatrists between December 2013 and September 2014. However, 1,036 people have been admitted in the same period.

To achieve faster and more sustainable progress, it has been agreed that a better, nationally coordinated approach needs to be put in place that takes into consideration the recommendations of Winterbourne View – a time for change (2014) by Sir Stephen Bubb.

<u>Transforming Care Objectives 2015/2016</u>
The CCG has identified this as a key Improvement Work Stream, which will be monitored by the CCG Governing Body. Building on the work undertaken in 2014/2015, the workstream will –

- Ensure that people with a learning disability and/or autism in hospital who could be supported in the community are discharged in a safe, appropriately planned manner according to the individual's needs, and at the pace that will ensure success of the placement and better outcomes for the person.

- Ensure a challenge process is in place to check that there is no available alternative to admission for assessment and treatment – and where an individual does need to be admitted, they have an agreed discharge plan from the point of admission.

- Develop a clearer model for health and care services for people with a learning disability and/or autism who have a mental illness or behaviour that challenges, describing outcomes to be achieved, with associated performance indicators, what kind of services should be in place (covering inpatient capacity and community-based support), and standards that services should meet.

- Ensure care packages emphasise personalised care and support planning, personal budgets and personal health budgets.
- Work with partners and local providers to develop bespoke packages of care and accommodation for supported living
- Reflect quality standards and outcome metrics as above in specifications for services and
- Ensure all placements are closely monitored for discharge planning and quality of care.
- Implement the requirements of further work that is being undertaken under Transforming Care at National level on:

    - Empowering people and families
    - Getting the right care in the right place
    - Regulation and Inspection
    - Workforce Development
    - The proposed changes to the Mental Health Act 1983: Code of Practice

<u>Services for People with a Learning Disability</u>

Southend CCG is committed to ensuring all health and social care services are accessible and acceptable to people with a learning disability and their carers. Southend CCG works in partnership with the Local Authority, SUHFT and SEPT to ensure quality services are in place in Southend and CCG, the Local Authority and provider partners have worked in collaboration to develop the LD Self-Assessment framework. Progress will also continue during 2015/2016 to update the Autism Self-Assessment Framework in partnership with SBC. The purpose of the framework is to enable the local strategy groups to review their progress and support future planning with partners including people with autism and their families. Enabling increased access, understanding support and awareness of autism. This work will include reviewing diagnostic pathways and appropriate support services for people with Autism and Asperger's, in line with NICE guidelines.

Objectives	Governance	Measurement
Increase the take up of Annual Health Checks and Health Action Plans and improve their effectiveness.	Following a review of local commissioning arrangements for mental health and learning disabilities services, the CCG has now established its own dedicated commissioner post and is working in partnership with Southend Borough Council and Castle Point and Rochford CCG (as the lead CCG for commissioning specialist health learning disabilities services). The CCG and Council are developing an integrated approach to commissioning and managing the local system of mental health and learning disability services. We will work with and the local Learning Disabilities Partnership Board to develop a local learning disabilities strategy for 2015-18. The CCG will provide formal reports to the Governing Body on the progress against the Transforming Care workstream and also the objectives for improving provision of universal services for people with learning disabilities.	Contractual KPIs with SEPT and other providers
Increase the take up of health screening including cancers and make sure that take up reflects the general population.		Contractual KPIs with SEPT and other providers
Target people with Learning Disabilities in public health initiatives to improve health and well-being.		Monitoring against objectives of workstream
Ascertain across the local health system (Acute, community and primary) where reasonable adjustments can be made and make them, especially where there are quick wins and can be done without significant expenditure.		Case management of all people in assessment and treatment settings to ensure effective, timely discharge and quality of care provision
Maintain improvements in mental health services for people with Learning Disabilities by making reasonable adjustments in Memory Assessment Services.		
Use data across health and social care to develop joined up approaches for people with Learning Disabilities that lead to better outcomes.		
Make sure that people with Learning Disabilities benefit from the planned integration of services and that they are increasingly delivered in the most appropriate location to best meet their needs.		
Make our approach to behaviour that challenges align to whole systems approaches to health and social care integration within Southend-On-Sea to achieve sustainable and meaningful change.		

Risk	Mitigation
Failure to identify and to monitor discharge plans for people with LD in assessment and treatment settings.	Case management in place through Individual Placement Team and contract management of Byron Court, SEPT subject to weekly monitoring
Failure to monitor the quality of care for people with learning disabilities	Case management monitoring of placements of quality of care planning and provision of care. Contract monitoring of SEPT contract in liaison with CPR CCG.
Failure to work with people with learning disabilities, carers and other partners in developing services to ensure equal access and acceptability of services.	CCG is partner on LD Partnership Board with SBC and a member of the provider Learning Disability Committee. Both groups have representation of people with LD and carers.

Response to Francis and Berwick

Francis Report
Following the publication of the Francis Report the CCG identified the recommendations that were to be taken forward by both the CCG and its providers. This was shared with the providers and built into their own action plans – to gain a clear understanding of the whole system approach to ensuring that the lessons learnt from the enquiry into Mid Staffordshire Hospital were embraced and embedded into local delivery of care. The CCG has monitored the implementation of the recommendations through reports to the Quality, Finance and Performance Committee. The CCG has reviewed the action plans developed by providers and has regular feedback through the planned workplan of the CQRG to update on progress.

The CCG have developed joint action plans and have made good progress against the recommendations from the Francis report. The development of the Harm Free Care meeting offers an opportunity to share learning from incidents and best practice to enhance learning. SUHFT have undertaken CQC style quality inspections and these will be undertaken in the future and are supported by the CCG and Local Authority.

Berwick Report
The recommendations of this report highlight the focus on growing a culture which puts patients first, engages and empowers them and their carers, supports transparency and learning and takes responsibility for poor care. The CCG reported on the recommendation of this report through its governance Committee structure and has used the recommendations from the report to inform its agenda and work plan for the Clinical Quality review Group, specifically focusing on safety, culture and leadership.

One of the most significant recommendations from both reports is the Duty of Candour, which following the publication of the CQC report was a mandatory requirement from 27 November 2014. This requirement ensures that any patient who has suffered moderate harm has a verbal and written update on the progress of investigations.

3.2 MEETING THE NHS CONSTITUTION STANDARDS

The CCGs plans include commissioning sufficient services to deliver the NHS Constitution rights and pledges for patients on access to treatment including referral to treatment, A&E waiting times and cancer waiting times. Our plans also include how we will prepare and implement the new mental health access standards.

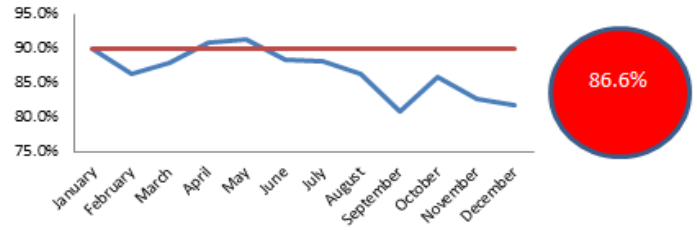
NHS Constitutional Measures: Referral to Treatment
We have made inroads into reducing the amount of time patients are waiting for their treatment (RTT). We have seen a reduction in both the list overall and those patients waiting more than eighteen weeks. These are measured by the incomplete pathway. For those patients need admission the amount of patients waiting over eighteen weeks has again reduced and we took advantage of the moratorium on performance in order to allow us to focus on reducing these waits.

Finally we have been making reductions in Out Patient lists, which has allowed greater control over patients requiring admission. In 2015/16 we are going to focus on reducing the back log further as we remain at risk of delivery of the standard through cancelled lists. We are developing a project with the Trust which will provide a much greater tolerance than the two days that we currently have.

From July–November, there was a moratorium on performance to allow Trusts to focus upon back log clearance therefore like many other Trusts we dropped our performance from July onwards as we tackled our back log issues.

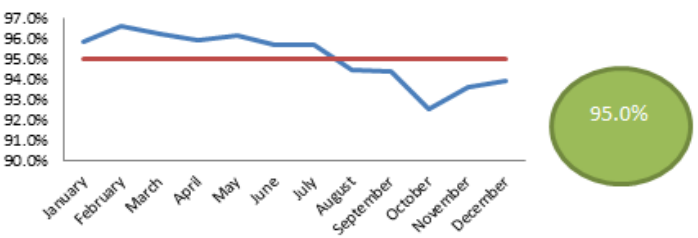
Our constitutional targets, and other statutory targets, can be found at Appendix 1.

Admitted Standard – 90% of patients to start treatment within a maximum of 18 weeks from referral. This is measured at Specialty level.



The Trust has been working on back log reduction with resulting agreed and planned drop in performance from July. Back log is now sitting at c230. During 2015-16 the focus is to create more tolerance in the delivery of the target so that it is not impacted by cancelled lists. This is to be delivered through revised theatre utilisation and productivity underpinned by revised Consultant PA sessions.

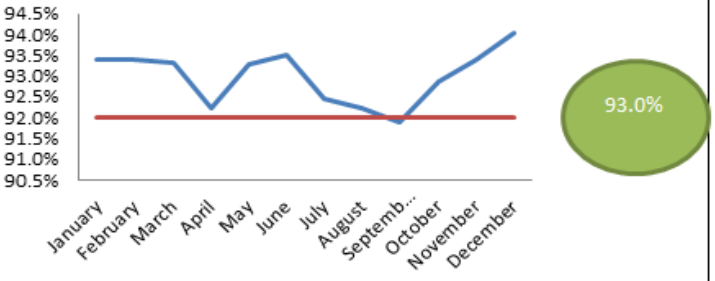
Non-Admitted – 95% of patients to start treatment within a maximum of 18 weeks from referral. This is measured at aggregate level.



The Trust has been working on both reducing back log and the overall size of its Out Patient waiting list. Back log has reduced down from c1,600 to c1,050.

During 2015-16 the focus is to further reduce the size of the list and create more control of the flow of patients moving into the admitted pathway. This is to be underpinned by a re-profiling of Out-patient clinics

Incompletes – 92% of patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral



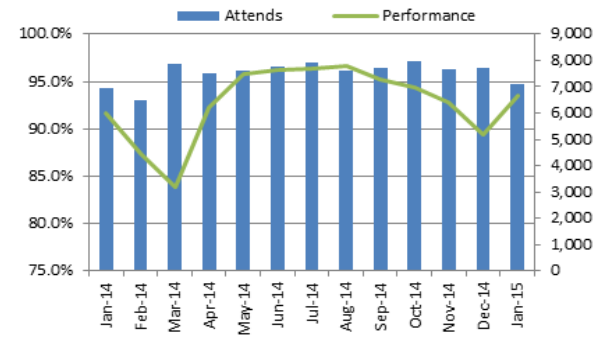
The Trust has been working on reducing the overall size of the Incompletes list and back log. Good progress has been made with over 2,000 reductions in patient pathways together with a significant reduction in long waiters where patients waiting over 25 weeks have halved.

During 2015-16 the focus will be to continue to reduce the overall size of the list again underpinned by work undertaken as part of the admitted and non-admitted pathways.

NHS Constitutional Measures

A&E Waiting times and Category A Ambulance Calls

Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E Department

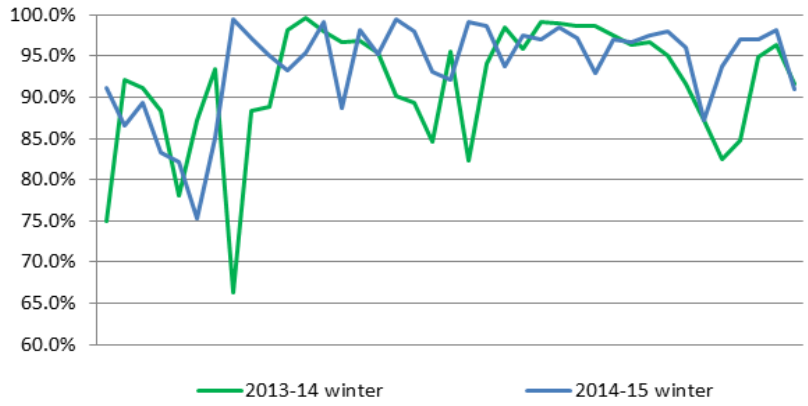


Looking forward to 2015_16 we are continuing the whole systems approach with a concerted focus upon reducing admissions. This is both a key element in our Better Care Fund and has been the main cause of our winter challenge this year.

The main area of focus will be around Care Home patients and the over 75s where we are developing Multi-Disciplinary Teas (MDTs) working to support patients to stay out of hospital. This will include End of Life care.

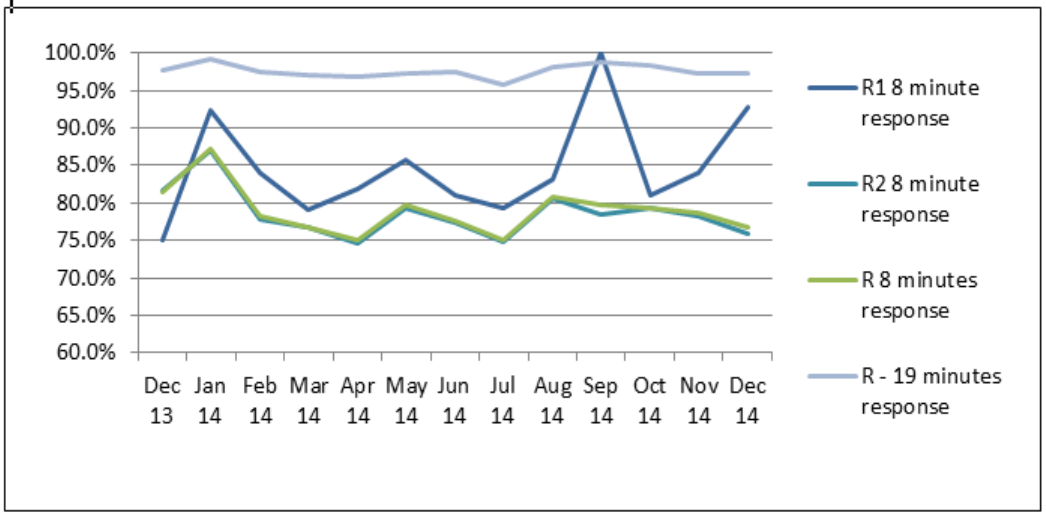
We had significant challenges during the last winter which didn't recover until the end of April. This culminated in a risk review summit around A&E and a resulting recovery action plan. This plan has been successfully implemented during the year resulting in achievement of the standard from May through to mid October. Most of the work was to make significant changes within A&E itself.

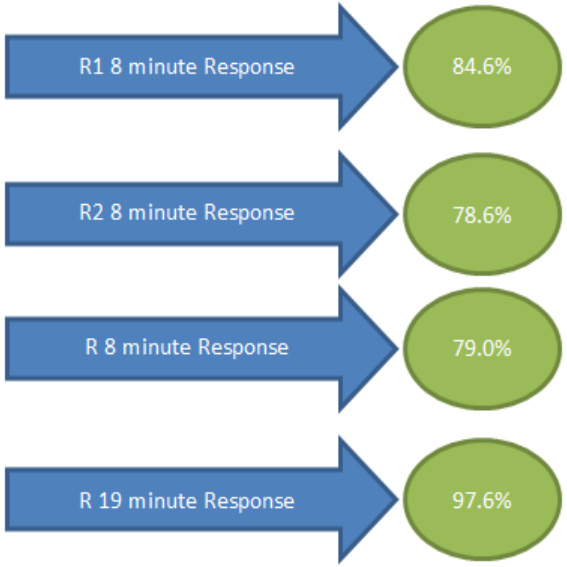
As we entered this current years winter pressure we saw performance drop, however due to the successful implementation of the RAP and much closer system wide working through the Systems Resilience Group we have been able to both mitigate the drop in performance and recover much quicker compared to last year as can be seen below.



2014_15 year to date performance remains strong at 94.3% compared to other Trusts in Essex.

Category A calls resulting in an emergency response arriving within 8 minutes and Category A calls resulting in an ambulance arriving at the scene **within 19 minutes.**





Again East of England Ambulance Service have delivered on core standards for response times throughout the year as indicated above. We continue to be challenged by EEAS over activity levels increasing across Essex and in particular for Southend those from Care Homes.

As noted above the key focus for Urgent care in 2015-16 is the reduction in admissions in the over 75s and those from Care Homes. These will support a planned reduction in ambulance conveyances to hospital and so reduce pressure on the service through activity levels.

NHS Constitutional Measures – Cancer Waiting times

Two Week waits

- Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP
- Maximum 2 week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected).

	Apr-14	May-14	Jun-14	Q1 Total	Jul-14	Aug-14	Sep-14	Q2 Total	Oct-14	Nov-14	YTD Total
14 day 2ww First Seen	606	514	590	**1710**	676	538	575	**1789**	732	642	***4873***
Breaches	39	26	42	**107**	40	32	17	**89**	29	26	***251***
Compliance	93.6%	94.9%	92.9%	**93.7%**	94.1%	94.1%	97.0%	**95.0%**	96.0%	96.0%	***94.8%***
14 day 2ww Symptomatic Breast First Seen	194	191	148	**533**	176	116	169	**461**	143	137	***1274***
Breaches	26	15	3	**44**	10	6	2	**18**	3	4	***69***
Compliance	86.6%	92.1%	98.0%	**91.7%**	94.3%	94.8%	98.8%	**96.1%**	97.9%	97.1%	***94.6%***

We have continued to achieve both two week standards throughout 14/15 with the exception of April and May. During the spring media story lines on Breast Cancer created an increase in referrals for suspect cancer. The Trust struggled to flex the capacity in the short time scale, however did subsequently adjust the capacity and returned and maintained the standard for the rest of the year and is compliant year to date as shown. As noted in the RTT section we are re-profiling the out-patient clinics to provide greater control and flexibility within clinics to react to demands and consistent year on year increases in urgent and suspected cancer referrals.

31 Day waits

	Apr-14	May-14	Jun-14	Q1 Total	Jul-14	Aug-14	Sep-14	Q2 Total	Oct-14	Nov-14	YTD Total
31 day First Treatment	166	165	166	**497**	185	167	171	**523**	173	143	***1336***
Breaches	3	6	2	**11**	2	6	3	**11**	2	9	***33***
Compliance	98.2%	96.4%	98.8%	**97.8%**	98.9%	96.4%	98.2%	**97.9%**	98.8%	93.7%	***97.5%***
31 day Subsequent Drug Treatment	113	116	132	**361**	162	102	131	**395**	110	104	***970***
Breaches	1	0	1	**2**	0	0	1	**1**	1	2	***6***
Compliance	99.1%	100%	99.2%	**99.4%**	100%	100%	99.2%	**99.7%**	99.1%	98.1%	***99.4%***
31 day Subsequent Surgery Treatment	17	26	24	**67**	18	14	24	**56**	25	11	***159***
Breaches	1	1	0	**2**	0	2	1	**3**	2	0	***7***
Compliance	94.1%	96.2%	100%	**97.0%**	100%	85.7%	95.8%	**94.6%**	92.0%	100%	***95.6%***
31 day Subsequent Radiotherapy Treatment	91	95	105	**291**	118	104	86	**308**	81	95	***775***
Breaches	0	0	1	**1**	0	1	1	**2**	1	1	***5***
Compliance	100%	100%	99.0%	**99.7%**	100%	99.0%	98.8%	**99.4%**	98.8%	98.9%	***99.4%***

Again we remain compliant year to date across all three standards, there were some challenges in the 31 day surgical standard, these are due to the low numbers of treatments therefore more than one breach in a month can result in the not achieving the standard. During November there was a challenge with capacity for Urology patients

on the Prostate pathway.

62 Day waits

	Apr-14	May-14	Jun-14	Q1 Total	Jul-14	Aug-14	Sep-14	Q2 Total	Oct-14	Nov-14	YTD Total
62 day 2ww First Treatment (Accountable)	75.5	58.5	71	**205**	87.5	71.5	70	**229**	79.5	51.5	***565***
Breaches	12.5	12	13	**37.5**	17.5	19	12	**48.5**	18	10	***114***
Compliance	83.4%	79.5%	81.7%	**81.7%**	80.0%	73.4%	82.9%	**78.8%**	77.4%	80.6%	***79.8%***
Adjusted 62 day 2ww First Treatment (Accountable) - pathways starting and ending at Southend only	64	47	58	**169**	75	56	59	**190**	69	45	***473***
Breaches	8	8	6	**22**	12	8	6	**26**	11	6	***65***
Compliance	87.5%	83.0%	89.7%	**87.0%**	84.0%	85.7%	89.8%	**86.3%**	84.1%	86.7%	***86.3%***
62 day Screening First Treatment (Accountable)	17.5	13	12	**42.5**	21	9	17	**47**	15	5.5	***110***
Breaches	0	0	1.5	**1.5**	0	0	1	**1**	0.5	1.5	***4.5***
Compliance	100%	100%	87.5%	**96.5%**	100%	100%	94.1%	**97.9%**	96.7%	72.7%	***95.9%***

We achieved the 62 day screen standard throughout the year with the exception of June and November. June was a challenge with capacity and November was purely done to very low numbers of patients attending treatment (5.5) which means that anything more than a shared breach will result in failing the standard. We do however remain compliant year to date.

For first treatment again we remain challenged in this pathway, predominantly driven by the patients on the prostate pathway. We have not achieved the standard all year and therefore remain un compliant year to date.

Progress on improvements in the cancer pathways have been on going in line with our recovery action plan approved by the Essex Area Team. This has been primarily focused upon the 62 day pathway, with changes to out-patients to create “one stop clinics” and recruitment of more oncologists. Progress throughout December and January has seen an improvement in performance for those patients waiting over 62 days down to eleven at the end of January 2015. We will continue with developments in the 62 day pathway with;

- The introduction of timed pathways,
- Enhanced monitoring within the Trust
- Closer working with other Trusts to prevent breaches
- Any patient waiting more than 62 days has a full RCA

NHS
Southend
Clinical Commissioning Group

Section 4: Quality

In this section:

- Patient Safety
- Patient Experience
- Compassion in practice
- Seven Day Services
- Safeguarding
- Staff Satisfaction and Organisational Development

Quality

The quality of patient care is a central concern and priority for Southend CCG, especially in this era of unprecedented financial challenge and rising demand. The CCG support the delivery of high quality, safe care through our programme of quality initiatives to ensure that patients and service users receive the best care possible in the least restrictive setting.

Southend CCG has a statutory responsibility under the Health and Social Care Act 2012 to formally monitor the quality of the services it commissions and to work collaboratively with other partners to ensure safe care and positive experience.

The CCG has established good working relationships within the local health and social care services to ensure that the complexity of health and social care appears seamless to the patient and also to ensure that the delivery of care is maintained to high standards. Through robust quality monitoring, joint initiatives and openness and transparency when things go wrong – the CCG is confident that the local health and social care system is committed to a person centred approach to planning and delivery of services.

The focus on quality and safety in the NHS has been the subject of several high profile reports on the quality and safety of patient care and the Care Act 2014 and the National Audit Office report on '*Care services for people with learning disabilities and challenging behaviour'* are the most recent impacting reports that the CCG will be looking to influence decisions and processes in 2015/2016.

4.1 Patient Safety

The CCG works closely with all providers to ensure that patient safety is the key priority within their organisation. The current systems and processes in place provide an effective reporting mechanism for incidents and serious incidents – and the process of investigation, improving and learning continues as part of the CCG and provider relationship.

In 2015/2016 the CCG and providers will continue the zero tolerance to MRSA and ensure effective infection control processes in place to stay within the agreed ceiling for Clostridium *difficile* infections (CDI) t is recognised that we are now at an irreducible minimum level at which CDI 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 that could have contributed to the development of CDI, and if so actions will be taken to address this with our providers.

CDI objectives for acute organisations (and CCGs) in 2015/16 have been calculated using the same methodology as for 2014/15 and delivers realistic improvement objectives for organisations with high CDI rates. This methodology requires acute organisations and CCGs to improve from where they are now, rather than from their previous CDI objective. The CDI objective for 2015/2016 is 36 for the CCG, the same as last year and the SUHFT objective is 29, which is an increase of 3 from last year.

SUHFT have been reviewing their documentation to alert to the deteriorating patient condition using an amended National Early Warning Scoring (NEWS) tool. This is in the process of being rolled out across the Trust and will be in place in all wards by the end of Q1 2015-16. In addition the Spire Wellesley has implemented this tool in response to actions from serious incident investigations. The use of these tools is aimed to reduce harm by the early detection of patient deterioration and to seek prompt clinical interventions.

The CCG and hospital have agreed quality improvements for 2015/2016 through the CQUIN process for a GP clinical advice line, effective respiratory care support, cancer survivorship and the undertaking of clinical trials.

Serious Incident reporting is positively encouraged across all provider organizations with a fair blame culture. The opportunities for learning are identified and with the use of the actions identified, change can be embedded into practice. SUHFT have introduced a 'Friday Newsletter' for staff to share new developments and learning.

The CCG receives monthly KPI and quality reports and quarterly integrated complaint, incidents and claims reports and review the outcomes and learning from patients experiences. This information is triangulated with external data in order to analyse the safety of service provision. This information is utilised to format the plan and agenda for quality visits.

Southend University Hospital has introduced 'CQC style' inspections which includes teams of staff including hospital staff, CCG staff, local authority staff and external experts, to review the quality and safety of services. These inspections will continue in 2015/2016 and the CCG will play an active role in involving GP clinical leads and the wider CCG clinical community in supporting this proactive approach.

The CCG and local providers recognise that a safety conscious culture within an organisation, understanding human factors and the on-going promotion of safety together with compassion and caring will create a safer environment for patients and a greater satisfaction for staff and we work together to enable this to happen.

The CCG has implemented a 3 monthly harm free event where all providers across South Essex come together to understand the current safety issues and share experience and learning. In 2015/16 the CCG intends to invite 'experts by experience 'to these events to discuss impact on patients, family and carers.

The Spire Hospital is seeking to introduce the SBAR communication tool as part of their 2015-16 CQUIN programme to enhance their culture and communication skills.

The CCG's GP forum has provided an opportunity for discussion on quality and safety of primary care services. The GP registration with the CQC has been discussed in detail with the CCG sharing knowledge and experience of understanding the CQC standards and the expectations of inspectors on CQC visits. In 2015/16 the CCG quality team

will be working more closely with individual practices to provide support and advice to enable services to consider national information on primary care quality and safety.

We have continued to monitor compliance in provider organisations to ensure that they have reached the 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 is in post to ensure we continue to achieve these standards, which dipped in December 2013 and January 2014. In addition the Patient Safety Thermometer data showed a corresponding fall in performance, further evidence of this was identified during a quality visit. NHS Southend University Hospital Foundation Trust (SUHFT) undertook a series of monthly audits throughout Q1 2014-15 and there has since been a consistent improvement in this standard, with achievement of the 95% standard since June 2014. This will continue to be closely monitored in 2015/2016 to maintain this improvement.

Spire Wellesley Hospital achieved 100 per cent harm free care in 2014/15. All patients were risk assessed for VTE and received appropriate prophylaxis. A CQRG Meeting has now been established to be held on a quarterly basis and any concerns relating to the outcomes from Patient Safety Thermometer will be included in discussions.

The CCG will continue to work closely with other commissioners and regulators to monitor care delivery in all providers. We have formal and informal links with the CQC and share intelligence through the Essex wide Quality Surveillance Group and the Essex Information Sharing Forum for care home and domiciliary care monitoring.

The CCG has forged strong relationships with the CQC Inspector for Southend area and meets with the Inspector on a regular basis to ensure a coordinated informed approach is taken to local providers.

The CCG uses the CQC Reports and Intelligent Monitoring information to inform the monitoring of provider services. This is triangulated with the information from other sources such as NHS Choices, Deanery Inspections and GMC/NMC Inspections – to enable a fuller view of provider quality, safety and patient experience.

The outcomes and recommendations of all inspections and reviews are discussed at the Clinical Quality Review Groups, held with provider services, and actions resulting are closely monitored through this group and reported back to the CCG Quality, Finance and performance Committee.

The Activities outlined in our 2014/2016 Operational Plan will continue to be progressed in 2015/2016

Activities

- Monitor hospital performance against the standard hospital mortality indicator (SHMI)
- Monitor information from Patient Safety Thermometer to ascertain themes and trends
- Attendance at Adult and Children Safeguarding Boards
- Attendance at relevant infection prevention and control
- meetings
- Undertake announced and unannounced visits to assess
- patient quality and safety at provider sites
- Quality Team undertake quality impact assessments for all QIPP Plans
- Continued monitoring of providers through quality visits
- Use of contractual levers to encourage engagement with
- learning
- Patients cared for in clean environment that meets the NHS
- National Specification for Cleanliness 2007
- To implement the requirements of the Care Act 2014
- To be compliant with Health and Social Care Act - Code of Practice for the Prevention of HCAI (20

The Management of Sepsis

The CCG is working with the acute and community providers across the Southend economy to reduce the incidence of sepsis through the implementation of the 'sepsis six'. The Sepsis Six are:

1. Administer high flow oxygen.
2. Take blood cultures
3. Give broad spectrum antibiotics

4. Give intravenous fluid challenges
5. Measure serum lactate and haemoglobin
6. Measure accurate hourly urine output

It is evidenced that by doing these six simple things in the first hour, can double a patient's chance of survival. The CCG will work with the hospital in reviewing current data to determine how improvements can be measured and the CCG is awaiting the national CQUIN for Sepsis for discussion with the hospital and progress will be monitored through the CQRG.

Acute Kidney Injury (AKI)
In line with the NICE pathway (Dec 2014), which applies to adults and children, the early recognition of the deteriorating condition due to AKI can improve outcomes. The CCG is working with the hospital and the ambulance service to consider the use of medication or contrast agents which could cause kidney impairment in vulnerable groups. This will be expected to be embedded within staff training to heighten knowledge and awareness.

Antibiotic prescribing in primary and secondary care
In 2015/2016 antimicrobial stewardship will continue to be included as a regular agenda item in provider organisation quality and HCAI meetings and is monitored by the CCG Medicines Management Team. Antimicrobial review forms part of all HCAI root cause analyses and post infection reviews and learning is shared and monitored through the South Essex HCAI Network Meeting as well as individual internal processes for provider services.

4.2 Patient Experience
We know that there is significant variation across Southend GP practices in patients reported satisfaction with access. We will undertake a programme of support to improve access in our member practices during 2015/16, as detailed in Access Workstream 1. We will share learning and best practice from pilot practices with our membership.

The Friends and Family Test was introduced for GP practices in December 2014. We have provided sessions to support our member practices in their new responsibilities as well as distributing FFT materials. We will support NHS England in working with member practices to report results from the FFT and to build this into our access programme work.

In 2015/2016 the CCG is introducing a 'Tell us how it is' programme with members of the CCG quality team going out to the local population including local shopping centres, schools, recreation areas and specifically targeted groups – to ask people to informally share their experience of local health services. The CCG Chief Nurse and Quality team will work closely with the CCG Head of Primary Care and Engagement to discuss with the CCG Engagement and Involvement Steering Group how the CCG can best work with their members to gain information the local populations understanding and experience of local health service provision.

<u>Current Activities</u>

- Work with providers to embed Compassion in Practice – '6 C's'
- Work with stakeholders to deliver customer care training
- Support launch of patient leader programme and other patient engagement programmes
- Promote awareness of FFT and response to data
- Roll out FFT pilot for learning disabilities and end of life care
- Make quality visits to engage with patients contemporaneously for feedback
- Develop new approaches with partners initially focusing on urgent and emergency services
- Hospital national pilot site for seven-day services
- rapid response for admission avoidance
- Seven-day A&E based social worker from to enhance prevention offer through advice and guidance to appropriate care pathways, for example falls reablement, prevent carer breakdown through early identification
- GP practice pilot – bid with CCG support
- Adopt skill mix models of delivery to address recognised staff shortages
- Workforce modelling to future proof services

Maternity Services

There are a variety of choices available to women in Southend.

- Women can discuss the option of a home birth service, which is also available for women having their first baby.
- Where appropriate women are seen within Hospital Led Consultant Care services.
- For women who may require a caesarean section, or who request a caesarean section, they meet initially with a midwife in a decision making clinic.
- The specialist fetal medicine unit that was completed in 2014 has enabled women in Southend to have the choice of care and close monitoring, throughout their pregnancy, at the local unit, who otherwise would have had to travel to London.
- Refurbishment of the Midwife Led service is currently underway and will in the future provide women with the choice of having their baby in a home from home environment. This unit will be called New Beginnings and will provide 4 birthing rooms that enable women to plan for an early discharge.
- Facilities to deliver in a midwife Led unit are currently in place, improvement's will be seen, when refurbishments are complete.
- Choice has been extended to the partners of women in delivery. They are now offered the opportunity to stay overnight in the post natal ward.
- For women who have experienced a traumatic delivery SUHFT provides a birth afterthought service, which helps women to discuss the birth and enable's safe planning and discussion of choices and for future pregnancies.

The Chief Nurse and quality team attend the Maternity Alliance meeting attended by SUHFT and women who use services. This enables the CCG to monitor services. Following a review by Birmingham Womens Hospital , instigated by the Trust - a series of recommendations were made and the CCG will be undertaking a full review of the actions taken in response to these recommendations in 2015/2016

Digital health records
Our practices are working with our CSU and NHS England to develop online capacity and so far 34 of our 35 practised have successfully uploaded summary care records for their patients. A number of practices have also gone live with electronic prescribing systems (with more planned in this coming year, supported through educational sessions for our GP practices) and we continuing to offer support and training to our member practices in the use of 'choose and book'. Southend Hospital provides all discharge summaries and pathology results through the ICE system electronically which are integrated automatically with SystmOne and Emis.

The Caldicott Review and the patient experience
The Government response to the Caldicott review in 2013 stated principles related to the right to access information and the impact on the patients experience. These principles are listed below and the CCG will address how these will be addressed through the CQRGs held with providers to form part of the regular monitoring of information governance systems.

- People's right to access information about themselves: In order to be open with patients' information should be easily available to enable patients to understand how they can access records.
- Direct care of individuals: There should be open working relationships between frontline professionals, to co-operate with each other and share information in the interests of patients and others. This information should only be shared with those undertaking direct care.
- Personal data breaches: Breaches in personal identifiable data should be reported as serious incidents in line with policy and the ICO guidance, we will continue to monitor these incidents and ensure that actions and learning are embedded to reduce further incidents.
- Information Governance and the law and Education and training: Information Governance training is mandatory for all staff, the CCG monitor compliance with mandatory training; these measures raise the profile and improve information security.
- Research: Robust ethics assurances and patient consent processes are essential when patient information is being used for research to maintain patient confidentiality. The CCG links with SUHFT research department to seek assurances.

- Children and families: Information sharing between health and social care needs to be robustly managed and take in consideration other organisations including schools. There should be good links between the CCG, social care and regulators, the CQC and Ofsted, to improve the safe sharing of information.
- New and emerging technologies: With ever increasing improvements in technology the use of virtual clinics have improved 'accessibility' to clinical reviews.

4.3 Compassion in practice

The CCG support the 6 C's by ensuring issues in patient safety, clinical standards and outcomes are high priority in their role of investigations of quality, incidents and HCAI's. With their expert support and input they can influence change in complex organisations helping staff to sustain high standards of care enabling them to provide excellent care and that no patient is harmed.

The CCG has worked closely with the SUHFT to develop a systematic approach to the embedding of the 6C's. It is proposed in 2015/2016 that the CQRG agenda will be adapted to reflect the 6C's to maintain focus on the importance of each area of discussion.

The Hospitals Nursing and Midwifery strategy has been developed to the vision for excellent care by excellent people, which has been developed through consultation with nurses, midwives and AHP leads. The vision is underpinned by the Trust quality strategy and has 6 key areas, which include: the 6C's; improving clinical outcomes & avoiding harm; improving patient experience; leadership for quality; partnership working and valuing staff.

The Trust is currently working on several different initiatives to maximise the 6C's, the well-being of patients and to improve health outcomes. For example: smoking cessation; heart failure and management of long term conditions.

The Trust has developed a strategy to support patient with learning disabilities (LD), developing a passport that the person with LD can carry when accessing hospital services. The Trust has worked in conjunction with service users with LD to develop 2 videos to help provide additional information regarding hospital services. It is planned for more videos to be developed.

The Early Rehab and Nursing (ERAN) service has been established which supports the early discharge of patients following hip and knee surgery. A comprehensive rehab plan supports the discharge by having regular visits.

A post for Dementia training has been created to help improve outcomes for patients with dementia.
The Trust monitors the friends and family test scores which are discussed each month at the Heads of Nursing meeting and BU meetings and reported to the Trust Board.

In addition there is a quarterly patient and carer service improvement focus group and Business Unit patient engagement groups. Patient experience data such as friends & family test; mystery shopper, complaints and compliments is incorporated in a report, which presented at the Quality Assurance Committee.

The Trusts diversity committee includes representation form the executive team, human resources service staff and service users and monitors feedback relating to inclusion and diversity issues and agrees actions for improvement as required

The Trust monitors quality against identified criteria which is discussed at Professional Nursing and Midwifery Forum and business unit meetings. Reports are received by the Trust board. Friends and Family results and complaints are also discussed. The Trust also monitors the staffing levels in the clinical areas on a daily basis reporting and has introduced an escalation process for managing and responding to patient safety concerns.

Following a project to enhance leadership for quality a proposal to fund increased supervisory time for ward managers has been agreed by the Trust Board, with professional development days at least three times a year for Matrons and Ward Managers. The programme includes leadership development and practice / service development. AHP and HCS leads have also participated in some of the development days to help enhance multi-professional and collaborative learning and leadership development.

The Trust has developed 3 leadership programmes for the development of different staff groups across the Trust. The Trust has also supported individuals from different areas with the National leadership Academy programmes.

The Trust undertakes a six-monthly workforce review utilising the Safer Nursing Care Tool. Recommendations for staff levels take into consideration these results and the Chief Nurse professional judgement. Following this review areas were identified as requiring uplift, which was then agreed by the board. There has been recruitment to these new establishments in a staged process and 2015/2016 will continue to work toward these uplifted establishments Staffing levels are monitored daily with a monthly report collated demonstrating fill rates for RN & HCA's.

The Trust will continue with values-based recruitment utilising the 6C's. Resources have been developed to support the probationary review process, which are underpinned by the 6C's.
The Trust is looking at the recruitment of staff to specialist roles that demonstrate commitment to the right staff, with the right skills.

Specific new roles have been created to address needs of services including Advanced Nurse Practitioner roles to deliver the Ambulatory care service.

Each Business unit is required to generate an action plan in response to the staff survey results. Results and progress against action plans are monitored at BU level.

The Trust has a "have your say" mailbox which allows staff to provide comments & suggestions. The board to ward programme enables executive and non-executive directors to visit the clinical areas on a regular basis and receive feedback from staff and patients.

In September the Trust conducted a 'perfect week' activity, which allowed non- clinical staff to visit clinical areas in coordinated approach to look at services and how patient flow could be improved. This is to be repeated in Theatres in 2015/2016

From 01/12/14 we implemented the first phase of a duty matron role. This will provide extended senior professional support for staff & safe care between 07:00 and 20:00 Monday to Friday.

4.4 Seven Day Services

Southend CCG is actively working with providers and is committed to offering more patient-focused services. Part of this commitment will be fulfilled by moving towards NHS services being made available seven days a week in acute and community services. Southend CCG, Southend Borough Council, Southend University Hospital Foundation Trust (SUHFT), South Essex Partnership NHS Foundation Trust (SEPT) and Castle Point & Rochford CCG are working together to enhance existing care pathways and developing new approaches across seven days.

Southend University Hospital Foundation Trust (SUHFT) is a national pilot site for seven day services and has programme of work in place in order to deliver seven days services in an acute setting:

- Improve continuity of care by having the same level of nursing and medical cover over the weekends
- Earlier treatment for patients will result in enhanced recovery for patients
- Review of shift handover
- Review of diagnostics
- Transfer to community and primary care

Delivering seven-day services is one of the underlying priorities of the Better Care Fund (BCF). We have therefore made seven day services a core design principle for the development of our fully integrated health and social care system in the community through our Community Recovery and Independence model and Primary Care Hub projects to be taken forward in 2015/2016.

In August 2014, the Joint Executive Group confirmed that a gap analysis of seven day services in and out of hospital should be completed in order to determine. This work was undertaken using the national assessment tool and concentrated on the following improvement priorities:

- Access to health and social care outside of the hospital
- 7 day services in the hospital
- Leaving the hospital after treatment to next place of care e.g. home, residential, palliative care

Priorities for 2015-16 include;

Extending the Single Point of Referral (SPOR)

- Extending the SPoR to provide a seven day assessment and therapies service
- Designing a fully integrated seven day point of access and referral for health and social care

Improvement target: From Level 1 to Level 3 - seven days a week with departments working together

Ensuring access to Primary care seven days a week

- Explore the development of seven-day working in primary care that can pprovide a responsive, timely and accessible service that responds to different patient preferences and needs
- Evaluating pilot weekend services to establish the demand and resource requirements to extend services to seven days
- Designing the target operating model for primary care hub built on the principles of seven day services, case coordination and person-centred care and support

Improvement target: From Level 1 to Level 2 - seven days a week but limited on a Saturday and Sunday

Mental health

- Some local services (IAPT already provide evening and weekend appointments. It would be desirable to extend this to other appointment based mental health services (e.g. psychiatric outpatients) to offer more flexibility
- The 24 / 7 availability of support for people in crisis will be the priority. This will feature in the local Crisis Care Concordat action plan.
- There can be a pattern of increased psychiatric admissions at weekends. We will work with CP&R CCG as lead commissioner to assess the impact of improved consultant medical cover at weekends to improve outcomes for patients and manage demand on mental health beds.

Improvement target: From Level 0 (Monday – Friday 9-5) to Level 2 - seven days a week but limited on a Saturday and Sunday

4.5 Safeguarding

The CCG is committed to protecting adults and children's right to live in safety, free from abuse and neglect. Organisations will work together to prevent and stop both the risks and experience of abuse or neglect, whilst at the same time making sure that the adult's wellbeing is promoted including having regard to their wishes, feelings and abuse.

Safeguarding Adults

The Care Act 2014 introduces new definitions of abuse including domestic abuse, modern slavery and self-neglect. In 2015/2016 the requirements of the revised NHS England Accountability and Assurance framework will be implemented within the CCG in liaison with stakeholders to ensure that the CCG continues to deliver its statutory duties and systems for protecting adults and children are embedded enhanced.

The CCG has noted the changes required as a result of the Supreme Court Ruling 2014 that has re emphasised the original intention of the Deprivation of Liberty Safeguards to protect people living in supported living settings. The CCG Adult Safeguarding lead has led a workstream across Essex to develop an action plan, a screening tool and a process for CCGs to follow Work is being undertaken to address the requirements for the CCG. The process and screening tool will be implemented in 2015/2016 with training and support from the regional team

The CCG is in the process of implementing the new NHS England Training and Competency Framework with regard to the Prevent agenda and monitors the main providers that it commissions with regard to their provision of training to their staff. In 2015/2016 the CCG will ensure that all providers actively report on their process for identifying and supporting any patients who are at risk from radicalisation.

The Care Act 2014 has required local systems to introduce a formal Adult Safeguarding Board to be on the same formal footing as the Local Safeguarding Children's Board. In Southend this Board is already in place and the Board are holding a development day to give all members the opportunity to develop the Board to meet the requirements of the Act.

Safeguarding Children

The Children Act (2004) makes the safeguarding of children a statutory responsibility for all NHS organisations. We have a duty to ensure that we make arrangements to safeguard and promote the welfare of children and young people that reflect the needs of the children in Southend.

To comply with national safeguarding requirements, we ensure that safeguarding is reflected within all partnership agreements. NHS Standard Contracts require providers to comply with the local Commissioner's Safeguarding Policies.

Our priorities for 2015/2016 include:

- Ensuring that young people requiring support for mental health issues are well supported by the current and future Child and Adolescent Mental Health Service
- Ensure that systems are in place to identify at an early stage any child or young person who presents in health settings and may be a victim of child sexual exploitation.

The following measures remain in place to ensure that safeguarding and promoting the welfare of children and adults is given priority and is discharged effectively across the whole local health community:

- Our Accountable Officer and Chief Nurse hold the Governing Body responsibility for ensuring that the we have safe systems in place for discharging its safeguarding responsibilities
- Our Governing Body receives a quarterly report on quality and performance which will include safeguarding issues for children and adults and any exceptional issues are also mentioned in the monthly report to Quality, Finance and Performance Committee
- Executive level CCG membership of Local Safeguarding Children's and Adults' Boards ensures that safeguarding is at the forefront of service planning
- Our Accountable Officer is a member of the Health and Wellbeing Board
- We work in close collaboration with Southend-on-Sea Borough Council to assess and ensure the provision of coordinated integrated services to meet the needs of the local population, including specialist services for vulnerable groups and looked after children
- We ensure that providers' safeguarding children and adult strategies and associated policies are in place

- We ensure that providers of services are held to account through regular review of safeguarding arrangements through quality scrutiny processes
- Designated nurses and doctors and the Lead for Adult Safeguarding offer professional expertise and advice regarding safeguarding matters
- The Chief Nurse provides advice and guidance to Southend-on-Sea Borough Council regarding the model of care for school nurses and looked after children

As part of our primary care development offer, we commission safeguarding training for our GP member practices.

Domestic abuse

Health professionals have a key role in identifying individuals subject to domestic abuse and assisting them to access specialist services. We are committed to working in partnership to address domestic violence in Southend and the CCG Designated Nurse for Safeguarding Children is the lead Essex designate for Domestic Abuse to coordinate approaches across greater Essex.

The CCG is a member of the Southend Domestic Abuse Strategy Group, which is a multi-disciplinary group comprising partners from NHS organisations, Southend-On-Sea Borough Council, Essex Police, Essex Probation Service and voluntary and community sector organisations.
The group exists to improve awareness of domestic abuse as a key issue in Southend and coordinate domestic abuse services across Southend to improve earlier intervention and response times.

In addition, voluntary and public sector partners across greater Essex have come together as part of the national community budgets pilot to develop coordinated plans to tackle domestic abuse.
The CCG has made a £30,000 contribution to support an expanded Independent Domestic Violence Advisor (IDVA) service across the county in. The ambition is that there should be 20 IDVAs across Essex; the number recommended by Coordinated Action Against Domestic Abuse (CAADA) based on the current volume of high risk domestic abuse incidents in the county.
A pan-Essex Joint Commissioning Group has been formed to produce a specification for a jointly-

commissioned, county-wide IDVA service for 2015/16 and beyond.

Female genital mutilation (FGM)
From April 2014, all NHS hospital Trusts are required to record information about the incidence of FGM and risk of FGM. They will be required to report on this information from 1 September 2014.
Tackling FGM in the UK – a joint report produced by the Royal Colleges of Midwives, Nursing and Obstetricians and Gynaecologists, says health professionals should identify girls at risk of FGM as early as possible. The report advises that "Girls born to mothers who have had FGM should be considered at risk of significant harm. They require monitoring through the children's safeguarding systems."

Child Sexual Exploitation
Southend local safeguarding children board (LSCB) has introduced a particular focus on safeguarding children at risk of sexual exploitation and has an overview of high-risk cases Information regarding local known and potential child sexual exploitation cases is shared with representatives from statutory agencies. The CCG Safeguarding Designate nurse is working closely with the hospital to ensure systems are in place to identify children who may be at risk from child sexual exploitation.

Forced Marriage
Forced Marriage is any marriage where one or both people do not consent to the marriage and pressure coercion or abuse is used to put pressure on the people to marry against their will. The CCG is committed to raising awareness of the issues so that people in this situation are identified before the marriage takes place and that staff are aware of the actions available to them should someone identify themselves as being under pressure to marry against their will.

4.6 Staff Satisfaction and Organisational Development

Staff Satisfaction
The CCG undertook a staff satisfaction survey in 2013 and implemented a series of team development sessions based on the feedback received. These were facilitated by an external coach, provided by the Leadership Academy

to all CCGs. All teams took away ideas from these sessions and worked in groups to come up with development ideas that could be put into practice.

The CCG is planning a further staff survey as part of a broad programme of organisational development.

Organisational Development (OD)
A new programme of OD is being planned, building on feedback from the staff survey and staff involvement group. This will also contain development for our Governing Body including a focus on clinical leadership.

The programme will be presented to the Governing Body in March 2015 for final approval. We have a programme planned with our external OD specialist for Governing Body and clinical lead development, and also for staff development. We also have joint OD programmes with the system leaders across Southend as part of the Pioneer programme.

Sustainability and good corporate citizenship
The CCG has made significant progress in relation to sustainability and being a good corporate citizen. The CCG has made use of the national online tools available and has assessed itself as performing well in the relevant areas.

Our new office accommodation includes spyderphones in all meeting rooms, to facilitate dialling in for meeting attendees who would otherwise have to travel some distances.
The CCG has undertaken an exercise to reduce the amount of paper used, by a minimum of 10 per cent. This includes setting our printers to default double-sided and black and white and the introduction of printer codes is imminent which will reduce the amount of unclaimed printing. The CCG also orders recycled paper for printing purposes wherever possible. To date, the saving has been over £1,500.

The CCG supports flexible working and home working for staff who would otherwise have to travel significant distances. The CCG also has a robust hot-desking process to enable staff from our CSU to work alongside us. The CCG is also introducing staff benefit schemes that encourage travel by public transport and cycling to work.

The CCG is putting in place a full system of waste recycling, including food waste bins by March 2015.

Papers for many meetings are now only distributed electronically; attendees bring their laptops wherever possible and view papers this way. The use of overhead projectors at meetings is also becoming more widespread, to reduce the amount of paper that is used.

Staff health and wellbeing

The Staff Involvement Group was established in April 2014 and meet regularly. The overall purpose of the group is to provide a mechanism for staff involvement and effective two way communication across NHS Southend CCG and its hosted teams. To ensure CCG staff are motivated and involved in the CCG's activities and to promote health and wellbeing in the workplace.

Health and safety at work is a key consideration in all activities and the CCG commissions expert advice from a neighbouring CCG to ensure it meets all its statutory responsibilities. Following a recent office move, full H&S and fire risk assessments have been undertaken and all recommendations followed up as priority.

In terms of support for staff, all line managers are expected to conduct regular one to one meetings with their direct reports as well as holding regular team meetings, to ensure staff are up to date with the organisation's progress and understand how their individual roles contribute to this. Attendees of the weekly operational executive group are tasked with feeding back from this group, to their teams.

The office move has also led to a change in car parking arrangements, which for some staff involves a longer walk to a local car park. Advice was taken from our local security management specialists in relation to the personal health and safety of staff and was shared with all staff.

The CCG is also committed to regular appraisals, which contribute to staff feeling valued and recognised for their work. Our CSU will also be undertaking a full training needs analysis to ensure the CCG workforce is equipped with the necessary skills to succeed. Personal development is key and a number of staff have undertaken vocational and

other formal training relevant to their job roles. All staff, including governing body members, are expected to undertake a full suite of mandatory training programmes in order to ensure they are safe in their working practices.

Social events are organised wherever possible to ensure staff have a social side to their working life. A number of events have also been arranged during working hours to support local charities, including dress down days, cake bakes and Christmas jumpers.

Staff benefits – the CCG has recently approved a number of staff benefits, including home electronics and lease cars. For further consideration during 2014/15 are season ticket loans and a cycle to work scheme.

Staff receive a weekly newsletter keeping them up to date with all developments and are invited to contribute their own good news and success stories to share with colleagues.

The CCG holds monthly staff briefings, with presentations from its own teams or external sessions (for example Fraud Awareness).

A new induction pack has been prepared and updated to fit with the new headquarters. Induction is key to ensuring staff are familiar with their working environment and understand who to contact and what processes should be followed, in relation to their health and safety and general working environment.

Staff are encouraged to take their breaks and one of the new quiet rooms is block-booked out between 12 and 2pm every working day to allow people to eat their lunch away from their desk.

NHS
Southend
Clinical Commissioning Group

Section 5: Research and Innovation

In this section:

- Overview
- Section 251
- Year of Care
- FYFV Vanguard Project application to support care homes
- HOT TIA Referral
- Amber Alert/GP Practice Advice CQUIN
- Health And Wealth Information
- GP Advice CQUINS

5.0 RESEARCH AND INNOVATION

A collaborative of two of our member practices were successful in bidding for funding from the Essex area team transformation fund. The governance around prescribing is currently being investigated by our medicines management lead, and if appropriate will be developed going forward.

One of our clinical leads has developed an innovative scheme to support our member practices in being able to provide proactive care to our over 75 population with the aim of reducing avoidable admissions. Funded through the resulting reductions in admissions, the scheme does not prescribe what practices must do, enabling them to innovate and work individually or in groups to improve the quality of care they provide. Practices are encouraged to share best practice with each other through case studies and our GP members forum educational sessions.

Our clinical executive committee is the engine room of the CCG and ensures that our work is clinically led. The clinical executive consists of our Governing Body GPs and 4 further local GPs who are supported by CCG executive leads. All transformation is developed through our clinical executive committee to harness innovation and to ensure clinical leadership and engagement with member practices.

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The CCG in partnership with Southend Borough Council has been given provisional approval from the Confidentiality Advisory Group (CAG), subject to conditions, for a temporary exemption under s251 for a period of 12 months to share data across health and social care. The exemption will allow Southend to legally share data for the purposes of;

1. risk stratification;
2. case finding on an individual basis to enable preventative solutions for people with LTCs; and
3. identifying cohorts of people with similar conditions to enable preventative measures.

Full approval will also enable a comprehensive Better Care Fund performance management dashboard and predictive modeling to assist commissioning decisions. We are on course to resolve the conditions placed on Southend, by the CAG, by end of March 2015.

Year of Care

Southend CCG successfully secured one of 7 national pilots in 2011 to test 'A year of Care' funding Model for people with long term conditions. The Purpose of the pilot is to support health and social care teams in integrating care in a more successful and sustainable way by better aligning the funding flows and incentives with peoples' needs. The aim of this funding model is to improve outcomes and deliver a more effective use of resources by shifting the focus away from episodic, activity driven funding flows towards person centred care irrespective of organisational boundaries.

The key strengths of the Southend bid included a long history of successful partnership working with the local authority, the use of an integrated information system that supported both health and social care data (Caretrak) and support for the pilot across all our stakeholders.

Vanguard Project application to support care homes

We have recently submitted an application for New Model of Care. This will involve rethinking and redesigning the way care is delivered to residential and nursing homes within Southend CCG and in partnership with Castle Point and Rochford CCG areas which includes Essex County Council and Southend Borough Council.

There are national minimum quality standards covering both residential and nursing homes which are set and monitored by the Care Quality Commissioning. Councils and CCGs also have a role in their monitoring as part of the contractual arrangements with these homes. Contracts tend to be on an individual basis to reflect the fact that services are usually contracted on an individual basis unless there are block contract arrangements in place. The Care Act clearly sets out the responsibility of the Local Authority along with its partners to ensure the delivery of good quality provision at a local level.

Care homes are registered on an individual basis and consequently the provision of care for residents can be

variable. Residents of care homes are vulnerable to being admitted to hospital for conditions that could have been managed proactively within their normal place of residence and we are trying to address this unmet need. To do this we plan to address the following:

- Identify the variation of health care available for residents within care homes, and/or
- Identify a model that will provide additional health, social, allied health professionals' support and training to reduce inappropriate admission to hospital and enable homes to manage clients/patients where they reside.
- This model would be a revised business and clinical model that will support patients to remain within their Care and residential Homes.
- Create this model that can then be deployed across Southend and wider in to Essex

It is our aim to help show what the future NHS could look like, what integration can really mean in practice for different communities, patient groups and staff and across home and community based services, urgent and emergency care, and elective care and specialised services.

We will be looking to exemplify how much new care models can contribute to bridging the efficiency gap identified in the *Forward View and Quest for Quality (2011 British Geriatric Society).*

The care model will also exhibit different specific characteristics. These distinguish one care model from another. Our aim in discussing these specific characteristics here is to provide shape and definition, in a way that helps rather than restrict

Residents of care homes can have complex healthcare needs, reflecting multiple long-term conditions, disability and frailty. Our ambition is to integrate health and social care support models to ensure that care home residents have consistent access to health care that is appropriate to their needs. Thereby ensuring that care home residents have equal access and opportunity to healthcare. This will enable care homes to manage crises more proactively and reduce the need for hospital admission.

As part of our proposal we intend to engage with the residential and nursing home sector to encourage them to include care home staff within our existing health care assistant training programme which will:

- improve patient outcomes by up skilling staff,
- benefit the local economy by providing a better skilled workforce, hence increasing employment opportunities
- Improve standards within care homes through increasing skills
- Improve retention rates within care home staff by providing employment that is supported by training and development

We have experience of providing enhanced models of care into homes with our "Priory House" scheme where the CCG has block purchased beds with Care Home and provides joint support with Reablement from Council and the Acute Trust providing physio and nursing support to allow patients to step down into these Care Home beds.

Undoubtedly this has support the delivery of the 95% standard by enabling more controlled flow out of the hospital. As a result we are one of the only Trusts in Essex to regularly achieve the standard during this challenged winter period.

Our vision is to expand this and create a clinical / business model that will allow patients to then remain in these homes with support and therefore prevent admissions.

<u>HOT TIA Referral</u>
Southend CCG has successfully collaborated with Southend University Hospital's highly-regarded stroke team to develop a high-quality TIA (transient ischaemic attack, or mini stroke) service. A critical success factor is the online HOT referral, this is a multi-award winning, easy online form which automatically calculates ABCD risk and submits the referral to a dedicated hospital inbox with a receipt to the referring practices email. This system also provides guidance on what the next steps are for the patient (information sheet) dependent upon the risk calculation score.

This successful collaboration supported by pioneering IT design and development, demonstrates the CCGs drive to ensure quality services and sustainable outcomes are provided by secondary care. Approximately 40 strokes are expected to be prevented annually due to the innovative redesign of the TIA service. The TIA HOT referral services is multi award winning, the most recent achievement is the award of an NHS Innovation Challenge Prize for 2014-15.

Amber Alert/GP Practice Advice CQUIN

Southend CCG is working in partnership with Southend Hospital to develop an advice and guidance CQUIN (Commissioning for Quality and Innovation) for implementation in 2015/16. The CQUIN will take the form of a simple web based tool to enable GPs and GP practices to communicate with the Trust on non-urgent, clinical and operational issues. A clear focus on implementation, response times and recording of key themes will be the key to success.

Southend Hospital will take the lead through consultation and engagement with GP member practices to inform the remit and design of the service in order to ensure it meets the needs of general practice. Southend CCG will support the dialogue between clinicians to quickly and effectively resolve any queries arising from correspondence.

Health And Wealth Information

The NHS Constitution makes research one of the main aims of the NHS. The CCG supports local research by health service providers by linking to the local Research and Development team which is managed through SUHFT. The team oversees and supports all local research including primary, community, mental health and acute care research and is sending updates to the CCG to inform on current research activity. The local primary care services are active in many studies and this is now reported to the CCG Quality Finance and Performance Committee.

The hospital activity in research is reported through the CQRG and the CCG is supporting a local CQUIN for 2015/2016 to develop a focus in the hospital for commercially funded clinical research and increase the number of patients participating in clinical trials by the setting up of a Clinical Research Facility.
The development of a Clinical Research Facility (CRF) would integrate research as part of the hospital's core business. Commercially funded research would give patients a wider access to clinical trials of new drugs

whilst at the same time reducing drug costs. The CRF would be primarily involved in Phase II and Phase III clinical trials with a view, in the future, to undertake Phase I studies in collaboration with a NHS or commercial partner.

The Department of Health's report on Innovation, Health and Wealth, Accelerating adoption and Diffusion in the NHS which was published in December 2011 identifies actions for NHS organisations to take forward to ensure that research, innovation and best practice is embedded into the commissioning and delivery of care to improve patient outcomes and productivity. The CCG reported on the plans to take this work forward as part of its authorization process and progress against the requirements of the report.

Progress against these requirements is monitored through the CQRG in 2015/2016 the CCG will work closely with the Trust to develop systems further. Progress so far is shown below:-

<u>Digital First: To rapidly accelerate the use of assistive technologies in the NHS, aiming to improve at least 3 million lives over the next five years</u>
SUHFT's IM&T Strategy section 5.4 Enabling Integrated Care states that: Point of care testing, remote monitoring and telehealth will enable the Trust to care for patients outside the hospital setting and supported by providing patients with online access to their clinical information i.e. long term conditions management.

In 2015/2016 the Trust is planning to develop its own Clinical Electronic Document (CED) management solution to provide a Clinical and Patient Portal and remove paper-based clinical administration processes which take our doctors and nurses away from direct patient care. This in turn will enhance the care our patients receive and their experience of the patient journey. Electronic patient record management processes will also be supported by CED, enabling the sharing of patient information across both primary and secondary care in a controlled format, improving patient safety and quality of care.

The Trust previously adopted a phased approach to the implementation of CED, the first stage of which created electronic letters for clinical approval, together with a CED portal for uploading local and centrally scanned

documents, as well as the automatic uploading of digitally dictated letters. To date, this approach has supported Orthopaedics, Ophthalmology, Cardiology, Breast, Haematology, ENT and Vascular to run paperless clinics.

The aim of the project is to develop the following enhancements within the existing CED platform:

- patient access to their clinical records,
- sending discharge letters from additional clinical systems i.e. Maternity to GPs electronically,
- automatic patient context integration with other key clinical systems:
    - PACS
    - Radiology/Pathology reports and requests
    - Summary Care Record
    - Pre-operative assessment
    - E-Prescribing

Patients will be able to 'opt in' to a web-based Patient Portal, which will initially contain discharge and appointment letters. Patients will be able to subscribe to this service and access a secure site, which will inform then when new correspondence has been added to their file. Following approval by our internal Clinical Records Action Group, patients will also be able to view all documents within CED. Additionally, an online pre-operative assessment tool has recently been procured, which will allow patients to complete this stage of their journey, rather than having to attend a hospital appointment.

Clinical areas are also keen to upload measurements such as blood pressure and blood sugar levels, with the potential for patients to upload their own monitoring results for long term condition management, such as diabetes.

<u>The launch of a national drive to get full implementation of Oesophageal Doppler Monitoring (ODM) or similar fluid management monitoring technology, into practice across the NHS</u>
The Trust use the ODM IOFM for patients undergoing procedures stated in the appendix 3 of the National Technical Assistance Centre (NTAC) and we also use different technologies such as LiDCO for IOFM, and are in the process of modifying the theatre electronic system to allow them to record numbers accurately and in real time.
The renal unit has been issuing Blood Pressure (BP) monitors to Pre dialysis patients to better understand the home blood pressures. The readings can be emailed in to the unit or downloaded when the patient visits. Control of hypertension is an important part of protecting renal function and thus delaying or stopping the need for dialysis.

There is data to suggest these patients do as well as or better than patients seen regularly in clinic.

Commissioning services in line with NICE-SCIE guidance on supporting people with dementia

The CCG had a CQUIN in place for 2014/2015 to ensure that carers of people with dementia are given advice, information and support, all patients, over the age of 75, are visited within 72 hours of admission and assessed as part of the National Dementia CQUIN. Where there is an existing diagnosis of dementia, carers are handed booklets and leaflets of support available.

The family and/or carers, who received this information, are contacted by a telephone call to ensure they have all the information they need and if they need anything else.

Section 6: Delivering Value

In this section:

- Financial resilience; delivering value for money for taxpayers and patients and procurement
- Financial Summary and business rules
- Activity plan assumptions
- Financial Governance
- Quality, Innovation, Prevention and Productivity (QIPP)

6.0 Financial resilience; delivering value for money for taxpayers and patients and procurement

- Meeting the business rules on financial plans including surplus, contingency and non-recurrent expenditure
- Clear and credible plans that meet the efficiency challenge and are evidence based, including reference to benchmarks
- The clear link between service plans, financial and activity plans

NHS Southend CCG has faced a significant financial challenge during our first two years of operation. In 2013/14, we delivered a deficit position of £3.1m. This deficit position was driven by two key areas, being over activity within the hospital sector and increases in the number of patients receiving continuing healthcare.

The latter increase was offset in part through a collaboration agreement with our neighbouring CCG for 2013/14 but this collaboration agreement has been ceased, with a transition arrangement in place for 2014/15. For 2014/15 the organisation planned to deliver a deficit, albeit an improvement over 2013/14 at £2.1m, a position agreed with NHS England and reflecting our funding allocation and healthcare needs of the local population.

In order to achieve this position, we have needed to make efficiency savings of around £6m, against a total potential QIPP programme of £9.5m focusing on reducing acute activity for both planned and unplanned care, as well as extracting efficiencies in other areas such as medicines management and continuing healthcare. Despite significant pressures in three key areas of activity – acute activity, GP prescribing and continuing healthcare – we expect to achieve the planning target of £2.1m deficit in 2014/15.

In addition to the challenges faced during the past 2 years, the financial allocations published by NHS England during December 2013 identified us as being funded at a level below our target share of national CCG allocation. Originally we were more than 6 per cent below our fair share allocation, equating to a distance from target of over £12m.

The revised allocations announced in December 2014 have focused additional NHS funding to those CCGs who were furthest from target and this has resulted in an increased allocation for 2015/16 for Southend CCG. We do remain however more than 4 per cent below target, equating to a shortfall of £9m.

The cumulative effect of the current financial position, the underlying spend patterns, and the current distance from target continues to place us in a challenging position for 2015/16 onwards, until such time that the we begin to commission a sustainable level of services for the population we serve.

Financial summary and business rules

The table below shows the summary position for our Financial Plan for the period 2014/15 to 2018/19. The Operational Plan is built upon the organisation's underlying financial liabilities, agreed national planning assumptions and locally determined changes. It reflects expected movement in population demand, technological improvements and enhancements in medications available. The plan currently includes an efficiency programme which anticipates delivery of around £7m for 2015/16, along with a number of projects which focus on improving the quality of healthcare services delivered to our population. The QIPP programme equates to 3.1 per cent of the organisation's underlying spend. The efficiency programme comprises technical contract adjustments and efficiencies as well as transformational changes.

The transformational changes have been identified using available benchmarking data and local intelligence, and where appropriate these have been developed in partnership with Southend University Hospital NHS Foundation Trust and other partners. We have created a non-recurrent contingency in line with national planning requirements, affording the CCG flexibility during the year to deal with emerging cost pressures. There are a number of commitments that are planned to be met from these funds already identified for 2015/16.

We have identified key areas of investment for 2015/16. Some of these are national requirements, such as Mental Health Parity of Esteem and funding for winter pressures. We are also investing in community and primary care services locally as well as providing funding to manage key areas of activity supporting our QIPP programme, including medicines management and continuing healthcare. Additionally we have assumed a further £2.5m of risks materialising during 2015/16, in particular through areas such as unplanned activity growth or non-QIPP delivery.

There is also a specific risk relating to the Pay for Performance element of the BCF. If the CCG only achieves 50% of the target reduction in non-elective admissions then it only receives 50% of the funding. This would mean the CCG would bear the cost of both these non- elective admissions and the cost of investment in the BCF schemes.

For 2015/16 we are planning a surplus position of £2.3m, achieving the in-year requirement for a 1 per cent surplus. This will be used towards repaying the deficit brought forward from 2013/14 and 2014/15. The underlying financial position continues to improve from 2016/17 onwards as the organisation starts to achieve financial stability, fully repays the cumulative deficit from previous years and commissions a sustainable portfolio of services. The table on the following slide summarises the outcomes of the current financial plan.

Revenue Resource Limit

£ 000	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Recurrent	209,563	216,262	232,277	239,463	244,562	249,773
Non-Recurrent	1,664	(3,143)	(5,278)	(2,956)	2,037	5,570
Total	211,227	213,119	226,999	236,507	246,599	255,343

Income and Expenditure

Acute	126,298	120,870	123,316	125,871	126,777	129,002
Mental Health	22,319	22,314	22,393	22,751	23,161	23,602
Community	12,291	11,955	12,683	12,886	13,118	13,368
Continuing Care	15,822	19,804	23,958	25,737	27,208	28,720
Primary Care	28,771	28,354	30,790	31,947	33,136	34,361
Other Programme	4,565	7,126	11,752	9,001	11,301	12,301
Total Programme Costs	**210,066**	**210,423**	**224,892**	**228,193**	**234,701**	**241,354**
Running Costs	4,301	4,367	3,922	3,922	3,922	3,922
Contingency	-	3,607	1,142	2,355	2,406	2,459
Total Costs	**214,367**	**218,397**	**229,955**	**234,470**	**241,029**	**247,734**

£ 000	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Surplus/(Deficit) In-Year Movement	(3,140)	(2,138)	2,322	4,993	3,533	2,039
Surplus/(Deficit) Cumulative	(3,140)	(5,278)	(2,956)	2,037	5,570	7,609
Surplus/(Deficit) %	-1.49%	-2.48%	-1.30%	0.86%	2.26%	2.98%
Surplus (RAG)	RED	RED	RED	AMBER	GREEN	GREEN
Net Risk/Headroom		1,319	1,661	5,084	5,096	5,047
Risk Adjusted Surplus/(Deficit) Cumulative		(3,958)	(1,295)	7,121	10,666	12,655
Risk Adjusted Surplus/(Deficit) %		-1.86%	-0.57%	3.01%	4.33%	4.96%
Risk Adjusted Surplus/(Deficit) (RAG)		RED	RED	GREEN	GREEN	GREEN

Activity plan assumptions

The CCG has built its 2015/16 – 2018/19 financial model using the planning assumptions shown in the tables below. These have been informed by both national guidance and local knowledge.

Planning Assumptions

		2014/15	2015/16	2016/17	2017/18	2018/19
Allocation Growth (+%)	Programme	3.31%	5.99%	3.20%	2.20%	2.20%
	Running Costs	-1.87%	-10.19%	0.00%	0.00%	0.00%
	Weighted Average	3.20%	5.66%	3.14%	2.16%	2.16%
Gross Provider Efficiency (-%)	Acute	-4.00%	-3.80%	-3.80%	-3.80%	-3.80%
	Non Acute	-4.00%	-3.80%	-3.80%	-3.80%	-3.80%
Provider Inflation (+%)	Acute	2.50%	2.93%	3.00%	3.40%	3.40%
	Non Acute	2.20%	1.93%	2.80%	3.00%	3.00%
Demographic Growth (+/- %)		1.00%	0.68%	1.60%	1.60%	1.60%
Non-Demographic Growth (+/- %)	Acute	0.00%	1.32%	1.00%	1.00%	1.10%
	CHC	12.00%	10.32%	10.00%	8.00%	8.00%
	Prescribing	4.00%	4.32%	4.00%	4.00%	4.00%
	Other Non Acute	0.00%	0.32%	1.00%	1.00%	1.10%
Contingency (%)		1.69%	0.50%	1.00%	0.98%	0.96%
Non-Recurrent Headroom (%)		2.50%	1.02%	1.02%	1.02%	1.02%
Running Cost (spend per head (£)		23.48	20.97	20.86	20.75	20.64

Financial Governance
Robust Financial Procedures and Systems: We have prime financial policies and detailed financial policies in place. We also have an effective internal audit function reporting through the Audit Committee which reviewed financial controls during 2014/15 and will continue to do so in the future.

Effective Financial Reporting: We present financial reports to the Quality, Finance & Performance Committee and the Governing Body on a monthly basis. In addition we provide expert financial advice to other committees, clinicians and senior management within the CCG on all aspects of healthcare management.

The financial reporting is informed by subject matter experts, employed directly within the CCG, or through the support functions provided by NEL CSU.

These reports are discussed in detail on a monthly basis, with specialist reports on key areas also being presented at the Quality Finance & Performance Committee.

6.1 Quality, Innovation, Prevention and Productivity (QIPP)

There is strong evidence that high quality care delivered at the right time, in the right place is more cost effective, so this plan focusses on all four elements of QIPP; quality, innovation, prevention and productivity. In 2015/16 there will be continued focus on the final "P" for productivity to get the CCG back into financial balance. Clear accountability is vital, and a partnership blending clinical and managerial experience will give the best chance of success.

Programme	Clinical Leads	Executive Sponsor	Senior Manager	Total 2015/16 £000
Planned care (inc. LTC and cancer)	Dr Brian Houston Dr Peter Long Dr Fahin Khan	Joint Director of Acute Commissioning	Joint Head of Transformation	1,617
Unplanned care (inc. integrated care)	Dr Adenike Popoola Dr Sharon Hadley	Associate Director of Integrated Care	Head of Integrated Care	875
Medicines management	Dr Kelvin Ng Dr José Garcia	Chief Nurse	Head of Medicines Management	1,675
Mental health and LD	Dr José Garcia	Associate Director of Integrated Care	Head of Integrated Care	301
Continuing healthcare	Dr Taz Syed	Chief Nurse	CSU	1,080
Other		Chief Finance Officer	Head of Finance	1,750
Total				**7,298**

Planned Care

Scheme	Risk	Clinical Lead	Exec Lead	Rationale	Detail	Savings £000
SUHFT productivity	L	Dr Brian Houston Dr Peter Long	Joint Director of Acute Commissioning	Embedding and obtaining a full year effect of developments implemented in 2014/15.	Deliver a full year effect of Service Restriction Policy, New to follow up ratios and Consultant to consultant referrals..	1,209
MSK	M	Dr Brian Houston Dr Peter Long	Joint Director of Acute Commissioning	Elderly population growth is putting MSK services under increasing pressure, a strong emphasis on prevention, conservative management and enhanced physiotherapy services will ease pressure on acute services.	Development of a new model of care to support balanced decision making as well as improved patient involvement in their own care options.	150
GP Clinical Variation	H	Dr Peter Long Dr Fahin Khan	Joint Director of Acute Commissioning	GP generated outpatient first referrals are on an upward trajectory and the quality of referrals is variable.	Working at an individual practice level to improve the Quality of referrals into secondary care by triage, review and feedback.	150
Ophthalmology	M	Dr Brian Houston Dr Peter Long	Joint Director of Acute Commissioning (CP&R Lead Partner)	Local Acute service has significant capacity and demand pressures, and there is a lack of Community provision.	Commissioning of community glaucoma services in 2 phases. Phase 1 - review and expansion of Glaucoma Referral Refinement (GRR) community provision. Phase 2 – shared care	100

Planned Care

Scheme	Risk	Clinical Lead	Exec Lead	Rationale	Detail	Savings £000
Diabetes	M	Dr Brian Houston Dr Peter Long	Joint Director of Acute Commissioning (CP&R Lead Partner)	Inconsistent levels of care and outcomes across local services. High variation of treatment in primary care, insufficient capacity for patient education.	New contract basis to facilitate a fully integrated acute and community service. Single lead provider, tiered model (including dietetics, pumps and education) with detailed specification, clear single seamless referral pathway & thresholds.	8
Stroke	M	Dr Brian Houston Dr Peter Long	Joint Director of Acute Commissioning	SUHFT currently provide a good stroke service. However, they are not consistently meeting all the national quality markers, and the out of hospital rehabilitation service is fragmented.	Improvement of the flow through the acute services and development of an evidence based model of specialist rehabilitation.	0
TOTAL						**1,617**

Unplanned Care

Scheme	Risk	Clinical Lead	Exec Lead	Rationale	Detail	Savings £000
Reduction in non-elective admissions	H	Dr Adenike Popoola Dr Sharon Hadley	Joint Director of Acute Commissioning	Local plan agreed to reduce non-elective admissions by 3.5%.	A number of schemes including Respiratory, end of life care	550
Ambulatory Care	M	Dr Adenike Popoola Dr Sharon Hadley	Joint Director of Acute Commissioning (CP&R Lead Partner)	Rising elderly population with increasing co-morbidities. SUHFT AMU Audit suggested 77% of patients could have been treated as ambulatory.	Two pathways exist within Ambulatory Care Network, DVT & Cellulitis, three more proposed, PE , Atrial Fibrillation and Acute Headache Increase capacity and use of day assessment unit, and move towards upper quartile performance	200
Urgent Care Review	M	Dr Adenike Popoola Dr Sharon Hadley	Joint Director of Acute Commissioning	Significant growth	St Luke walk-in-centre re-procurement in 2015/16.	75
Reduction in Ambulance	H	Dr Adenike Popoola	Joint Director of Acute Commissioning	Significant growth	• Further development of see and treat schemes.	50

Medicines Management

Scheme	Risk	Clinical Lead	Exec Lead	Rationale	Detail	Savings £000
Central Nervous System	M	Dr Kelvin Ng Dr José Garcia	Chief Nurse	Important to provide prescribers with clear guidelines, in a rapidly changing area, to ensure patients receive cost- effective treatment. Currently an area of significant growth and opportunities to manage this without impacting on quality.	Pregabalin – clear guidelines/formulary developed, agreement with SUHFT and focus on incentive scheme and practice visits. Temazepam – switch to Zopiclone or reduce doses and stop. Quetiapine – change from slow release to immediate release. Melatonin – reduce unlicensed prescribing.	700
Endocrine	M	Dr Kelvin Ng Dr José Garcia	Chief Nurse	Recognised that diabetes prevalence is increasing and important to ensure patients are identified and treated early.	Focus on practice nurses as well as GPs. Audit of newer medicines against local guidance. Incentive scheme and practice visits. Training and education.	250
Respiratory	L	Dr Kelvin Ng Dr José	Chief Nurse	Need to ensure that patients are being regularly reviewed and trained to use inhalers effectively.	Focus on practice nurses Emphasis on reviews and stepping down treatment. Updated formulary.	150

Medicines Management

Scheme	Risk	Clinical Lead	Exec Lead	Rationale	Detail	Savings £000
Cardiovascular	L	Dr Kelvin Ng Dr José Garcia	Chief Nurse	Area of high cost and growth. Need to ensure guidelines are being followed to ensure patients receiving evidence based, cost-effective treatment.	Outliers identified. Incentive scheme and practice visits.	120
Generic	L	Dr Kelvin Ng Dr José Garcia	Chief Nurse	No clinical difference between branded and generic medicines but generics generally more cost-effective.	Outliers identified. Monthly reports generated and sent to practices.	115
Care home review	M	Dr Kelvin Ng Dr José Garcia	Chief Nurse	Increasing numbers of patients with complicated medication regimes, within our care homes.	Dedicated additional staff working as part of MDTs Improving medicine optimisation.	100
Traffic light	L	Dr Kelvin Ng Dr José Garcia	Chief Nurse	Some medicines that should only be prescribed in secondary care are being issued by GPs.	Practices identified and contacted, and prescriptions passed back to the hospital each month.	60
Appliances	L	Dr Kelvin Ng Dr José Garcia	Chief Nurse	Complicated area and currently little expertise in primary care that needs to be addressed.	Implement fair share policy. Outliers identified. Incentive scheme.	50

Mental Health and LD

Scheme	Risk	Clinical Lead	Exec Lead	Rationale	Detail	Savings £000
Dementia long stay wards	M	Dr José Garcia	Joint Director of Integrated Care	Remodeling of long stay wards.	Change admission and discharge criteria for all dementia patients in line with best practice guidance. Investment in dementia support team.	216
Learning Disability inpatient beds	L	Dr José Garcia	Joint Director of Integrated Care	Strategically move away from bed based to community services.	Currently being re-scoped through the reduction of assessment and treatment beds and an investment in community teams.	85
TOTAL						**301**

Continuing Healthcare

Scheme	Risk	Clinical Lead	Exec Lead	Rationale	Detail	Savings £000
Existing patient review; LD placements; ABI; Market Management	M	Dr Taz Syed	Chief Nurse	Legacy direct payment patients have not been reviewed to confirm the appropriate social care/healthcare percentages Learning disability patients to be reviewed for confirmation of nursing needs. Ongoing review of ABI patients presently residing in high cost rehabilitation facilities. A review of the local market for CHC providers has not been carried out for a number of years.	Carry out a joint review with SBC of existing packages and potentially move to a block bed purchase, rather than spot. Generally split 50/50 between the Council and SCCG and historical placement of patients into direct payments via the Local Authority have not been reviewed. Patients could potentially move to a lower cost facility after completing rehabilitation. Carry out a joint review with SBC of existing packages, potentially moving to block bed rather than a spot purchase.	1,080
TOTAL						**1,080**

Other

Scheme	Risk	Clinical Lead	Exec Lead	Rationale	Detail	Savings £000
SUHFT CQUIN	L	Dr Brian Houston Dr Peter Long	Joint Director of Acute Commissioning	Local health community is under significant financial stress.	Agreement reached with SUHFT for a non-recurrent reduction in the National CQUIN from 2.5% to 1%.	1,300
Referral Management System	M		Chief Finance Officer	Current service only covers part of the CCG.	Decommission existing provider, and work directly with individual GPs practices building on their existing systems.	360
Corporate and HQ savings	M	Dr José Garcia	Chief Finance Officer	Back office and support function need to ensure they are efficient and effective.	Rationalisation of HQ accommodation and a review of support costs.	90
TOTAL						**1,750**

Section 7: Urgent Care

In this section:

We have structured this section according to the five key elements of change in the Urgent and Emergency Care Review.

- Proving better support for people to self-care
- Helping people with urgent care needs to get the right advice in the right place, first time
- Providing highly responsive urgent care services outside of hospital (so people no longer choose to queue in A&E)
- Ensuring those people with more serious or life threatening emergency needs receive treatment in centres with the right facilities and expertise in order to maximise chances or survival and good recovery
- Connecting urgent and emergency services , so the overall system becomes more than the sum of its part

7.1 Proving better support for people to self-care

Providing better support for people to self-care is central to our vision for a fully integrated health and social care system in Southend. This is one of the underlying principles for the future.

Through our Community Recovery Pathway and Primary Care Hub projects, we will build an integrated care system that empowers people to take more responsibility for their own health and wellbeing and be as independent as possible. We will promote and enable people to self-care through:

- Ensuring people have access to the right information, advice and guidance about their health, conditions and individual care and support needs
- Introducing care coordination approaches and ensuring people have access to a named care coordinator throughout their customer journey
- Effective systems for care navigation are in place making best possible use of voluntary sector to help support people to stay independent

This will also include ensuring people access to professional help seven days a week when they're experiencing a crisis or simply need some advice to continue managing independently

We will be working with our colleagues at Southend Borough Council to jointly deliver person-centred, coordinated services that put people in control of their own lives and conditions and ensure people have access to a range of tools to help them self-care. Together, our initiatives to provide better access to services; ensure people with the most complex needs have a named care coordinator; and improve our available information and advice will contribute to a reduction in A&E attendances and unplanned admissions.

Working with our partners in social care public health to implement innovative self- management programmes, such as patient activation measures (PAM), with the aim of reducing unplanned hospital admissions for people with some long-term conditions

7.2 Helping people with urgent care needs to get the right advice in the right place, first time

The role of Primary Care Hubs in urgent care

Southend CCG recognises that change is needed in order to meet current and future challenges faced by the healthcare system, including increased demand, changing population needs and a changing workforce. We have taken the bold step to try and shift resources from the acute sector into primary care in order to better manage the increased demand and changing population needs.

General practice already provides a 'medical home' for patients underpinned by their life-long medical records. It is the first point of contact for people, where a high proportion of care is delivered close to home with the potential for a continuous relationship with the same clinical team from birth through to end of life. However, the traditional model of how primary care is delivered is not sustainable. A 'Call to Action' recognised this and highlighted world-class examples of general practice but stated that urgent action is needed to tackle significant variations in quality.

Southend CCG and Southend Borough Council are currently working together with other partners to develop a sustainable model that will better meet citizen's future health and social care needs. The 'Primary Care Hub' project aims to deliver integrated health and social care services from Primary Care settings possibly through GP hubs. All options are currently being appraised but whatever the model for delivery the following will be achieved:

1. *Integrated and coordinated care* – providing patient-centred coordinated health and social. Multi-disciplinary teams working together around the patient to deliver improved outcomes for them.

2. *Accessible care* – providing a responsive, timely and accessible service that responds to different patient preferences and needs. This will mean extending services to seven days.

3. *Pro-active care* – Moving away from traditional model of primary care will mean creating a more reactive system which treats people when they become ill, to one which co-ordinates care and support for people to stay well.

4. *Improved patient experience and outcomes* – patients will experience a seamless service and improved health and wellbeing. They will have a named are co-ordinator supporting them to navigate through the range of services

5. *Management of own health condition(s)* – people will be able to manage their own short and long term health conditions; they will be supported and encouraged through education, information and advice.

The provision of seamless and holistic health and social care services in the community will ensure services are delivered outside of hospital, and will reduce pressures on the hospital. The long-term plan is that more care will be provided in the community.

7.3 Providing highly responsive urgent care services outside of hospital (so people no longer choose to queue in A&E)

Summary of the use of 111

We have developed the protocols within NHS 111 to facilitate greater clinical decision making on Green pathways and where appropriate prevent 111 dispatch for ambulance conveyance to hospital. During the last three weeks that this has been in operation we have seen a significant decrease in the number of ambulance dispatches.

Frail Elderly Model

We are working with colleagues at Castlepoint and Rochford CCG in their development of a frail elderly model, which focuses on effective risk stratification, increased use of MDT and the principle of case coordination. One of the key areas for development is an improved rapid response service, which we aim to commission jointly for Southend and Castlepoint and Rochford, through:

- Better access to shared clinical systems between health and social care
- Establishing joint posts and management arrangements
- Availability of rapid equipment services
- Ensuring rapid response is always available within 2 hours
- A night time sitting service to 'hold' patients until the morning when all services are available
- Better use of the voluntary sector

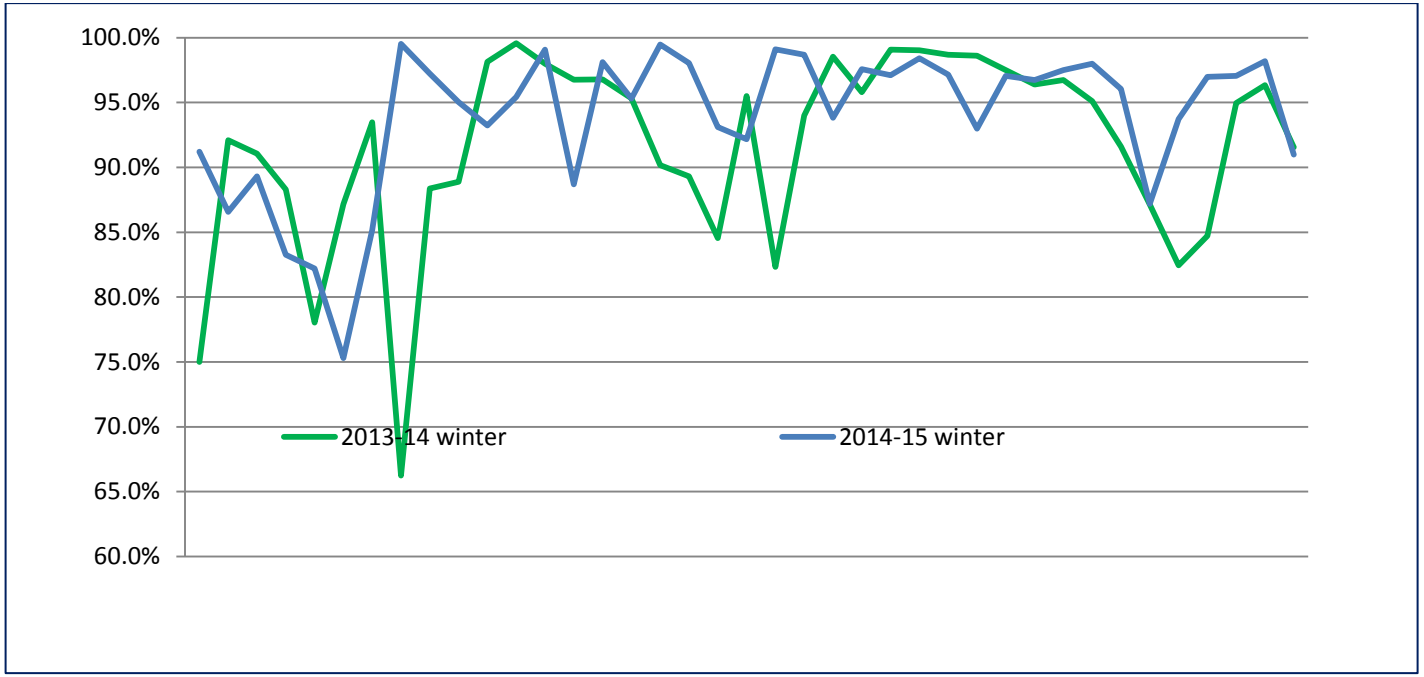
Urgent Care Review

The planned move of the St Luke's GP practice and associated Minor Injuries Unit, allows the CCG to rethink the urgent care pathway across South East Essex. Southend and Castlepoint & Rochford CCGs are currently considering options for replacing the current Minor Injuries Unit at St Luke's. Options could include: the relocation of the current Unit; or creating an Urgent Care Centre on the front-end of A&E. Whichever option is selected, the CCGs and local providers are keen to explore the new flexibilities outlined in the *Five Year Forward View.* The CCGs are planning to decide on a preferred option in May, with implementation from Q3 2015/16.

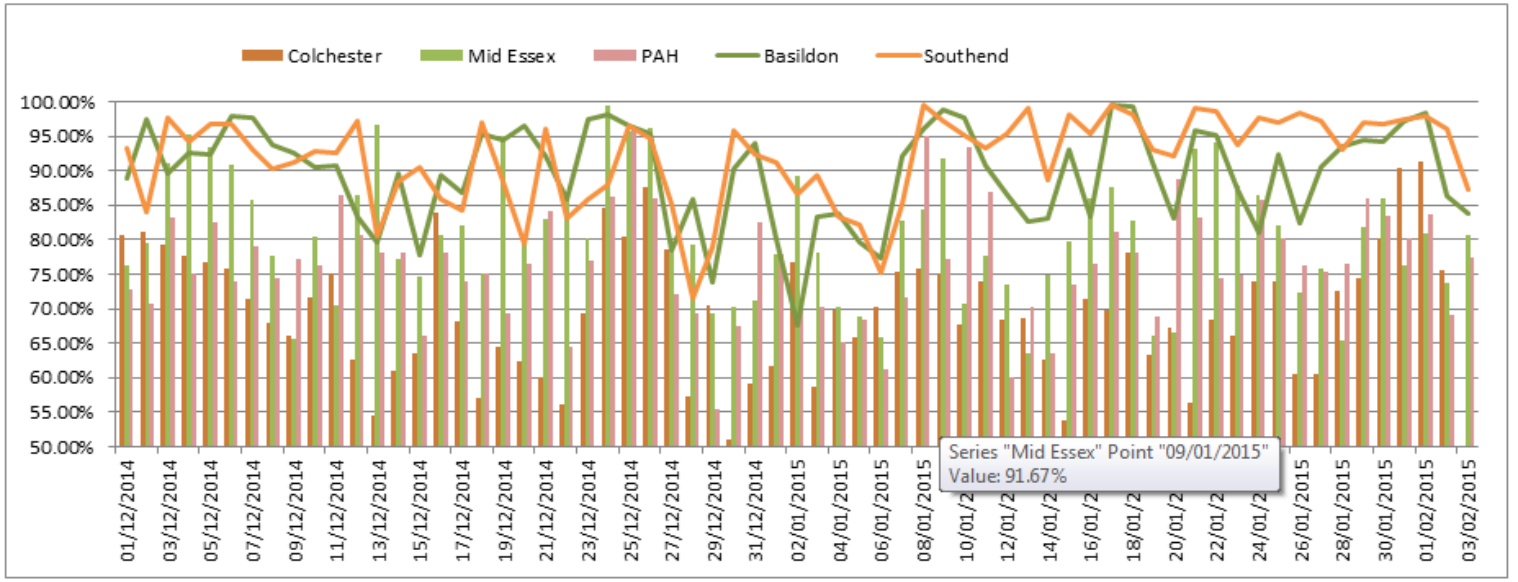
7.4 Ensuring those people with more serious or life threatening emergency needs receive treatment in centres with the right facilities and expertise in order to maximise chances or survival and good recovery

Achieving the Standards

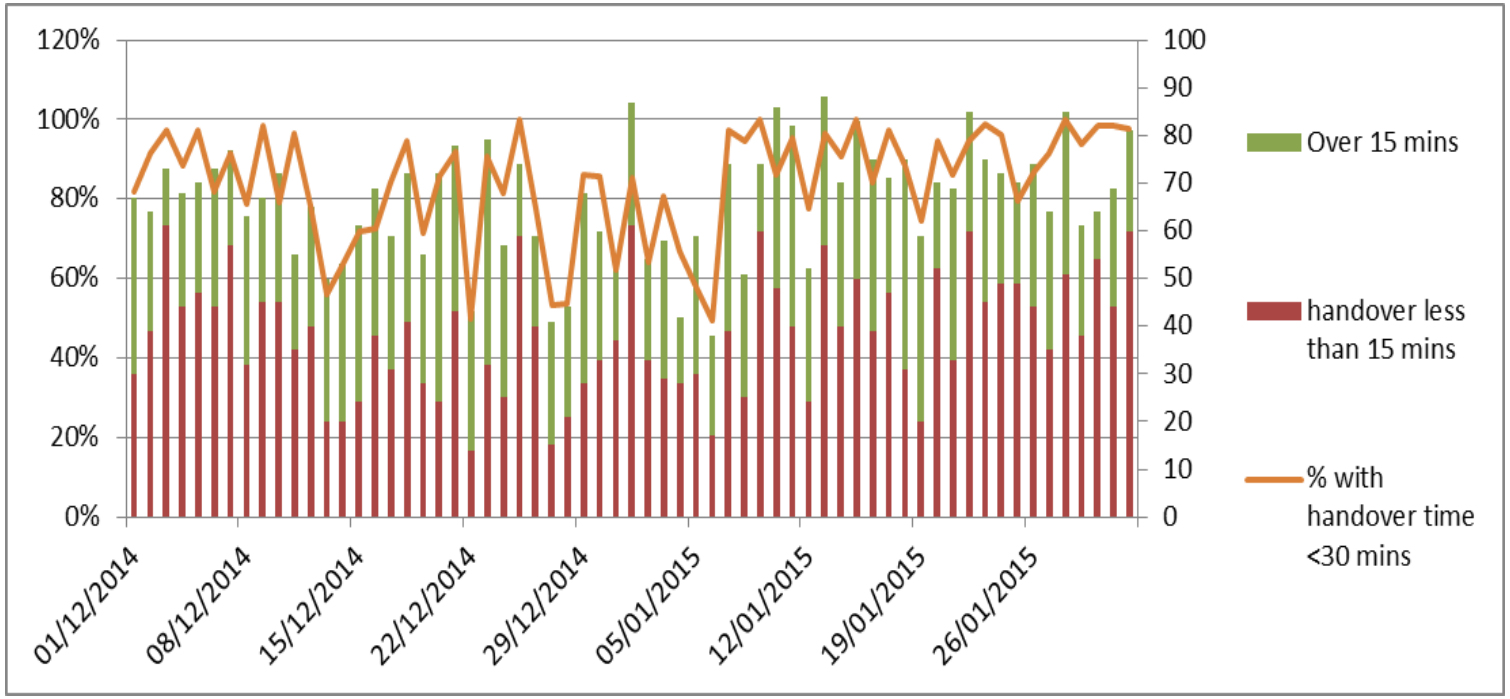
The chart below shows performance against the A&E standard, comparing 2013/14 to 2014/15. Performance this year has showed a lesser drop during the holiday period and a quicker and more sustained recovery.


100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
70.0%
65.0%
60.0%
2013-14 winter
2014-15 winter

- The chart below shows SUHFT performance against the A&E standard compared to other Essex trusts for the period December 2014 to February 2015. Southend has shown greater resilience during the winter period.

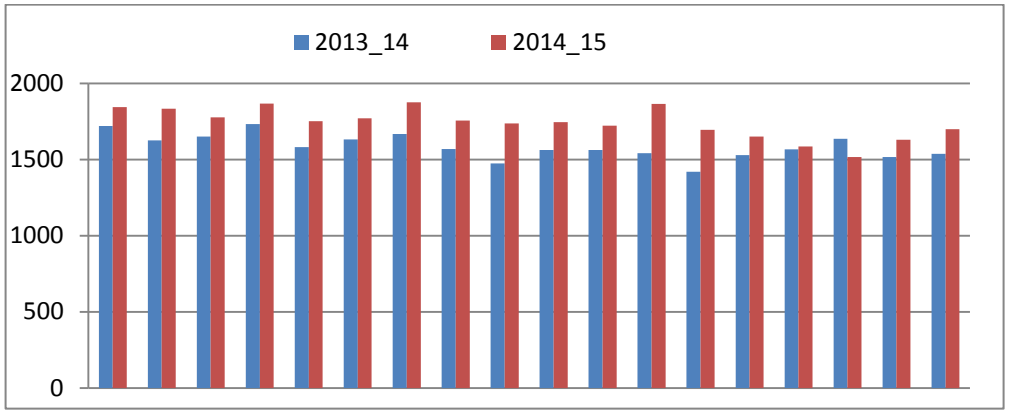


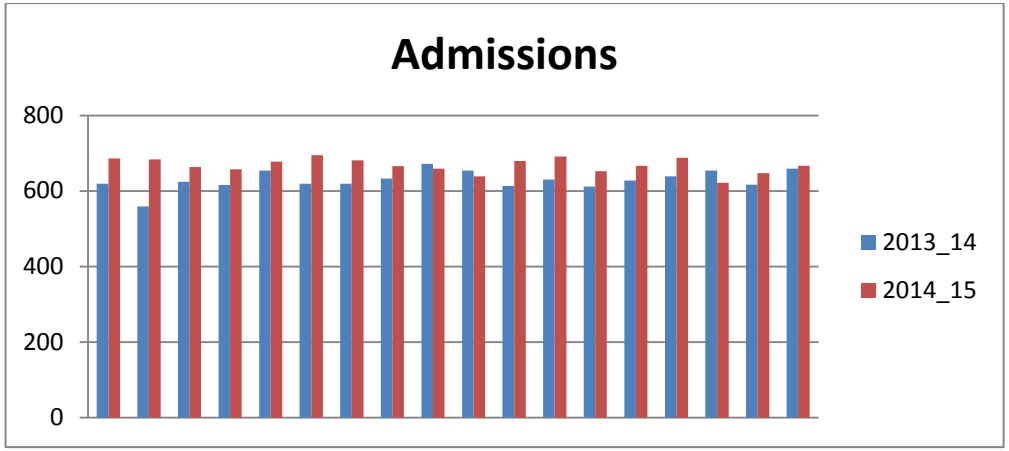
The chart below shows ambulance handover performance for the period December 2014 to February 2015. Overall ambulance handover performance remained within target during the winter period. There were several days where we had cohorting of patients by the ambulance service rather than Trust. In particular for one day we used the day surgery unit after 5pm for cohorting.



Flow into the Hospital

The following two charts show A&E attendances and non-elective admissionns, comparing 2013/14 with 2014/15. Compared to last year, attendances were slightly down but admission were up for the winter period, suggesting resilience projects in the community have had some effect on demand, but that the acuity of patients attending has proportionally increased. This is confirmed by an observed increase in the average length-of-stay over the same period. A significant proportion of the extra admissions are for patients with respiratory conditions. In addition, we continue to experience periodic surges in ambulance arrivals, which placess pressure on A&E and critical care.

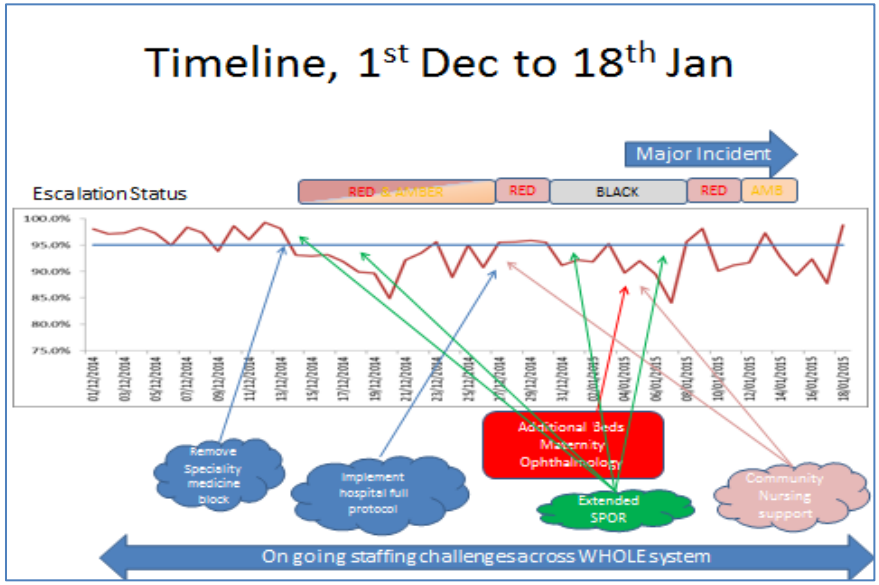



Admissions
800
600
400
200
0
2013_14
2014_15

Winter Period Look Back

As in previous years, we experienced severe pressures during the Christmas and New Year period. However, unlike previous years and other health economies in Essex, this year we recovered more quickly and sustainably.
This is certainly, in part, down to the way we have responded by coming together as a system, through the work of the System Resilience Group (SRG) and System Resilience Operational Group (SROG).

From December 27th through to January 8th the system was under significant pressure. With SUHFT escalating to Black and Significant Internal Incident on one occassion. (See table below) At the peak of the Significant Incident there was over 90 medical outliers and borders. Staffing levels were stretched and in some cases down to one qualified nurse on a ward. Staff from SEPT worked in SUFHT to support the increased medical levels.



We continue to have challenging days, but these are effectively managed and allow us to achieve the standard most days.

In 2015/16, the resilience funding will be included in CCG base line positions. We are looking to address some of our more medium term issues so that we can continue to improve and be better prepared as a system moving into Easter and the next winter period. These include:

- Provision of a more structured intermediate care process, rather than purchasing individual care home beds.
- Review and scope for potential new location for CICC and wider rehabilitation.
- Improved clinical model for supporting the over 75s and care homes to enable people to stay at home rather than being admitted.
- Increased levels and types of packages of care and wider reablement.
- Alternative models for minor injuries and walk-ins'

7.5 Connecting urgent and emergency services , so the overall system becomes more than the sum of its part

The South East Essex System Resilience Group (SRG) and System Resilience Operational Group (SROG), both chaired by Southend CCG, have developed effective partnership working between all the agencies involved in urgent and emergency care.

When performance began to deteriorate, during the winter period, SRG proactively took the step to begin meeting weekly; and also put in place extra measures to manage on-call rotas. SRG is now looking forward to developing a more strategic view; with SROG being responsible for the day-to-day management of the urgent and emergency care system. This process has already begun with SRG establishing Task and Finish Groups for

- Respiratory project – actions in the community, care homes and hospital to tackle the spike in respiratory admissions we have seen this winter;
- Urgent Care Review – to support an options appraisal for a replacement service to the Walk in Centre, currently collocated with the St Luke's practice;

- Support for Care Homes – linking to our Better Care Fund (BCF) plans and our *Five Year Forward View* Vanguard project bid, inadequate support for patients in care homes has been a consistent theme during 2014/15; and
- Mainstreaming Winter Resilience – SRG will shortly receive an evaluation of the 2014/15 Winter Resilience Schemes, after which some services will need to be commissioned on a permanent basis.

The next step is for SROG to prepare an evaluation of the Winter Resilience Projects, during March 2015, with a view to seeing which services should be mainstreamed. For example, the RAID service, which has been funded as a pilot, will now be embedded into contracts and the service model extended.

Looking forward, SRG will work closely with the Better Care Fund Programme Board to coordinate projects that will improve urgent and emergency care. The SRG partners are keen to explore together the new flexibilities outlined in the *Five Year Forward View* to help do this.

<u>Resilience Projects</u>
To deliver the most effective schemes possible, a robust bidding process was established that provides a framework where providers can focus on proposals for meeting our priorities to prevent A&E attendences and reduce non-elective admissions. The providers who bid included: SUHFT, SEPT, SBC, ESSEX CC, GP Practices, CP&R CG Federation, voluntary sector and independent sector providers.

The System Resilience Plan 2014/15 stated our approach to ensuring operational resilience is maintained throughout the winter period, with particular focus on Urgent Care and Planned Care. The core aim of the plan is to sustain this position throughout the winter period through the provision of enhanced community services and capacity to prevent attendances and admissions to SUHFT and to support it to improve its bed flow position.

During February 2014, we held a "look back" event with all stakeholders to identify the challenges during the winter period: what worked well and the areas that didn't. This event, together with the following reviews, shaped the resilience plan;

- Intermediate Care and Community Review
- RTT review, Intensive Support team review and Recovery Action Plan
- Emergency Care Summit and Review leading to a Recovery Action Plan
- The "Perfect Week" pilot and ECIST reviews

We also used the National Minimum standards for Urgent Care checklist to bench our plans and to assist in the identification of gaps and resolving these within the plan. The overall focus for the plan is to provide more community facing services and reablement capacity around SUHFT, rather than just focusing on acute beds to manage the Urgent Care agenda. We identified a number of themes that were included in the plan to be delivered through resilience funding and RTT funding.

The following table details all the resilience schemes in place, providing additional support around attendance and admissions avoidance, support flow through the hospital and support discharges and helping people stay at home.

Ref	Org	Service proposal	Surge support
021	SUHFT	Ambulatory Care MDT	Discharge and flow
060	Family Mosaic	Primary Care Health Link Workers to deliver short period of intensive support to vulnerable people who have additional needs that result in greater demands on GP's and other health and social care professionals.	Attendance avoidance
028	CAREWATCH	Enhanced Domiciliary Care and 'toileting Turning Service'.	Attendance and admission avoidance
027	Southend Medical Centre	7-day GP services	Attendance avoidance
051	SUHFT	Pharmacy Level 4 clinical service and TTA Transcribing to Medicine.	Discharge and flow
055	SUHFT	Increased senior medical cover in DAU which will enable reach in service to A & E and AMU and increase capacity to take same day GP referrals.	Discharge and flow

001	Canvey Island Youth Project	Counselling for young people	Attendance and admission avoidance
032	Southend Vineyard	Community Care Stream Project Support to vulnerable people by providing food, and health advice at their Café and helping them to manage / improve their health in the community.	Attendance and admission avoidance
065	CPR CCG on behalf of South East Essex System.	Increasing capacity of Intermediate Care Services	Admission avoidance and helping people remain at home / intermediate care.

016	SEPT	Mental Health Liaison Service in Southend hospital	Discharge and flow
022	Southend YMCA	SOS Bus offering triage service, first aid, brief advice and guidance and harm minimisation to vulnerable persons.	Attendance and admission avoidance
O33	SAVS	Warm and Well service providing home visits to 140 elderly and frail residents to reduce winter pressures.	Attendance and admission avoidance
034	SAVS	Talking Health Patient Engagement project - promote health initiatives and advice through door-to-door engagement.	Attendance and admission avoidance
046	SUHFT	Weekend Home from hospital Service	Discharge, flow and supporting people to stay at home.
064	CPR & SCCG	Communications	Attendance avoidance

066	East of England Ambulance Service	Addition of two stretcher resources and qualified Ambulance Care Assistants to support short notice discharges	Discharge and flow

In addition to these schemes, further investment through Monitor was provided for additional support to SUHFT to deliver increased patient flow.

Appendix 01: NHS Constitution Standards

NHS Constitution standards	Collection Period	2013/14 Actual	2014/15 Actual	2015/16 National Standard	2015/16 Target	
A&E Waits						
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department	Quarterly	92.46%	94.15% YTD	95%	95%	
Cat A Ambulance calls						
Category A calls resulting in an emergency response arriving within 8 minutes – Red 1	Monthly		84.60%	75%	75%	
Category A calls resulting in an emergency response arriving within 8 minutes – Red 2	Monthly		78.60%	75%	75%	
Category A calls resulting in an ambulance arriving at the scene within 19 minutes	Monthly		97.60%	95%	95%	
Referral To Treatment waiting times for non-urgent consultant-led treatment						
Admitted patients to start treatment within a maximum of 18 weeks from referral	Monthly	90%	84%	90%	92%	
Non-admitted patients to start treatment within a maximum of 18 weeks from referral	Monthly	95%	93%	95%	95%	
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral	Monthly	93%	94%	92%	93%	

NHS Constitution standards	Collection Period	2013/14 Actual	2014/15 Actual	2015/16 National Standard	2015/16 Target	
Diagnostic test waiting times						
Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral	Monthly	99%	99%	99%	99%	
Cancer waits – two-week wait						
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	Quarterly	> 93%	94.8% (M8 YTD)	93%	93%	
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	Quarterly	93%	94.6% (M8 YTD)	93%	93%	
Cancer waits – 31 days						
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers	Quarterly	> 96%	97.5% (M8 YTD)	96%	98%	
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	Quarterly	> 98%	99.4% (M8 YTD)	98%	100%	
Maximum 31-day wait for subsequent treatment where that treatment is surgery	Quarterly	> 94%	95.6% (M8 YTD)	94%	97%	
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	Quarterly	> 94%	99.4% (M8 YTD)	94%	99%	

NHS Constitution standards	Collection Period	2013/14 Actual	2014/15 Actual	2015/16 National Standard	2015/16 Target	
Cancer waits – 62 days						
Maximum two-month (62-day) wait from urgent GP referral to first definitive treatment for cancer	Quarterly	81.30%	79.8% (M8 YTD)	85%	94%	
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	Quarterly	> 90%	95.9% (M8 YTD)	90%	93%	
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set	Quarterly		78.4% (M8 YTD)	Not set	100%	
NHS Constitution supporting measures	**Collection Period**	**2013/14 Actual**	**2014/15 Actual**	**2015/16 National Standard**	**2015/16 Target**	
Mental health						
Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period	Quarterly	96%	98% (Q1-Q3)	95%	95%	
Referral To Treatment waiting times for non-urgent consultant-led treatment						
Zero tolerance 52 week waits	Monthly		2 (YTD)	0	0	
Mixed Sex Accommodation Breaches						
Minimise breaches	Monthly	0	0		Nil	

NHS Constitution standards	Collection Period	2013/14 Actual	2014/15 Actual	2015/16 National Standard	2015/16 Target	
Cancelled Operations						
All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice.	Quarterly	0	0 to December 2014		Nil	
A&E waits						
No waits from decision to admit to admission over 12 hours	Quarterly		1 (YTD)		Nil	
Cancelled Operations						
No urgent operation to be cancelled for a second time	Monthly	0	0		Nil	
Ambulance Handovers						
All handovers between ambulance and A&E must take place within 15 minutes and crews should be ready to accept new calls within a further 15 minutes. Financial penalties, in both cases, for delays over 30 minutes and over an hour.	Only collected in winter	88%	91% (YTD)		91%	

NHS Constitution standards	Collection Period	2013/14 Actual	2014/15 Actual	2015/16 National Standard	2015/16 Target	
Infection	**Collection Period**	**2013/14 Actual**	**2014/15 Actual**	**2015/16 National Standard**	**2015/16 Target**	
Number of C. difficile infections	Monthly	31	31 (Q3 YTD) Annual Ceiling 36	locally set	33	
MRSA zero tolerance	Monthly		3 (Q3 YTD)	0	0	
Mental Health	**Collection Period**	**2013/14 Actual**	**2014/15 Actual**	**2015/16 National Standard**	**2015/16 Target**	
Dementia						
% diagnosis rate	Monthly		58.1% (M9)	66.70%	66.70%	
IAPT						
IAPT access proportion	Quarterly	12.8%	7.8% (Q2 YTD)	15% annually	15%	
IAPT recovery rate	Quarterly	52.8%	51.4% (Q1-Q3)	50%	50%	

NHS Constitution standards	Collection Period	2013/14 Actual	2014/15 Actual	2015/16 National Standard	2015/16 Target	
***New* Mental health access waits**						
IAPT						
The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period	Quarterly			95% by April 2016	95% by April 2016	
The proportion of people that wait 18 weeks or less from referral to their first IAPT treatment appointment against the number of people who enter treatment in the reporting period	Quarterly				95% by April 2016	
The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period	Quarterly			75% by April 2016	75% by April 2016	
The proportion of people that wait 6 weeks or less from referral to their first IAPT treatment appointment against the number of people who enter treatment in the reporting period	Quarterly				75% by April 2016	
Operational recovery indicator, to capture:						
Number of ended referrals in the reporting period that received a course of treatment against the number of ended referrals in the reporting period that received a single treatment appointment				TBC	TBC	

NHS Constitution standards	Collection Period	2013/14 Actual	2014/15 Actual	2015/16 National Standard	2015/16 Target	
Average number of treatment sessions				TBC	TBC	
Re-focusing service provision on less severe cases (in development)				TBC	TBC	
Early Intervention in Psychosis						
More than 50% of people experiencing a first episode of psychosis will be treated with a NICE approved care package within two weeks of referral (in development)				>50% by April 2016	>50% by April 2016	
Liaison Psychiatry						
% of acute trusts with an effective model of liaison psychiatry (all ages, appropriate to the size, acuity and specialty of the hospital) (in development)			100%	100% by 2020	100%	
***New* Transforming Care**	**Collection Period**	**2013/14 Actual**	**2014/15 Actual**	**2015/16 National Standard**	**2015/16 Target**	
Total number of patients in in-patient beds for mental and/or behavioural healthcare who have either learning disabilities and/or autistic spectrum disorder (including Asperger's syndrome)	Quarterly		4		3	
Numbers of admissions to in-patient beds for mental and/or behavioural healthcare who have either learning disabilities and/or autistic spectrum disorder (including Asperger's syndrome).	Quarterly		0		0	

NHS Constitution standards	Collection Period	2013/14 Actual	2014/15 Actual	2015/16 National Standard	2015/16 Target	
Numbers of patients discharged to community settings	Quarterly		1		1	
Patients without a care coordinator	Quarterly		0		0	
Patients not on the register	Quarterly		TBC		TBC	
Patients without a review in the last 26 weeks	Quarterly		0		0	
Better Care Fund	**Collection Period**	**2013/14 Actual**	**2014/15 Actual**	**2015/16 National Standard**	**2015/16 Target**	
Transfers						
Delayed transfers of care	Monthly	2.8% (Avg for year)	2.5% (Avg YTD)		2.4% average	
Admissions						
Emergency admissions [non-electives] collected via BCF template in 14/15	Monthly		18,691		656 spells	
Admissions to residential and nursing care	Annual	206	119			
Reablement						
Effectiveness of reablement	Annual	80	84.4			
Patient experience						
Patient and service-user experience	Annual	78	79			
New Bed Days					TBC	

NHS Constitution standards	Collection Period	2013/14 Actual	2014/15 Actual	2015/16 National Standard	2015/16 Target	
***new* Quality Premium 2015/16**	**Collection Period**	**2013/14 Actual**	**2014/15 Actual**	**2015/16 National Standard**	**2015/16 Target**	
Measures to be confirmed by NHSE						
Outcome Measure	**Collection Period**	**2013/14 Actual**	**2014/15 Actual**	**2015/16 National Standard**	**2015/16 Target**	
Composite indicator comprised of (i) GP services, (ii) GP Out of Hours	Annual		80.3% (to Jan 2014)			
Patient experience of inpatient care	Annual	91.1	91.1		91.2	
Hospital deaths attributable to problems in care *This indicator is still in development*						
Health related quality of life for people with long-term conditions	Annual	73.7	73.1		73.7	
NB: In 2016/17 a new measure will be introduced regarding one year cancer survival rates						

NHS Constitution standards	Collection Period	2013/14 Actual	2014/15 Actual	2015/16 National Standard	2015/16 Target	
Primary Care	**Collection Period**	**2013/14 Actual**	**2014/15 Actual**	**2015/16 National Standard**	**2015/16 Target**	
Patient satisfaction						
Satisfaction with the quality of consultation at the GP practice	Bi-annual release, annual data		80.0% (to Jan 2014)		TBC	
Satisfaction with the overall care received at the surgery	Bi-annual release, annual data		83.7% (to Jan 2014)		TBC	
Satisfaction with accessing primary care	Bi-annual release, annual data		80.1% (to Jan 2014)		TBC	

Appendix 02: Glossary

A&E	Accident and emergency	CQRG	Clinical Quality Review Groups
ABI	Acquired brain injury	CQUIN	Commissioning for quality and innovation
ACS	Ambulatory Care Services	CRF	Clinical Research Facility
ADHD	Attention Deficit Hyperactivity Disorder	CRR	Corporate Risk Register
AHP	Allied Health Professional	CSE	Child Sexual Exploitation
AKI	Acute Kidney Injury	CSU	Commissioning Support Unit
AMU	Acute medical unit	CYP	Children's and Young People
ASD	Autistic spectrum disorder	DIST	Dementia Intensive Support Team
BCF	Better Care Fund	DNAR	Do Not Attempt Resuscitation
BME	Black Minority Ethnic	DNS	District Nursing Service
BP	Blood Pressure	DVT	Deep vein thrombosis
C2C	Consultant to consultant	EDS	Equality Delivery System
CAADA	Coordinated Action Against Domestic Abuse	EDS	Equality Delivery System
CAG	Confidentiality Advisory Group	EEAST	East of England Ambulance Service
CAMHS	Child and adolescent mental health services	EHC	Education Health and Care
CCG	Clinical Commissioning Group	EIP	Early Intervention in Psychosis
CCO	Chief Clinical Officer	EPS	Electronic Prescription Service
CDI	National Early Warning Scoring	ERAN	Early Rehab and Nursing
CED	Clinical Electronic Document	ESD	Early Supported Discharge
CHC	Continuing healthcare	EWMHS	Emotional Wellbeing and Mental Health Service
CHUFT	Colchester Hospital University NHS Foundation Trust	FFT	Friends and Family Test
CICC	Cumberlege Intermediate Care Centre	FGM	Female Genital Mutilation
CNS	Central nervous system	FOI	Freedom of Information
COO	Chief Operating Officer	FYFV	Five Year Forward View

COPD	Chronic obstructive pulmonary disease	GBAF	Governing Body Assurance Framework
CP&R	Castle Point and Rochford CCG	GMC	General Medical Council
CQC	Care Quality Commission	GMS	General Medical Services
HASU	Hyper acute stroke unit	NICE	National Institute for Clinical Excellence
HASU	Hyper acute stroke unit	NMC	Nursing and Midwifery Council
HCAI	Health Care Acquired Infection	NTAC	National Technical Assistance Centre
HR	Human Resources	OD	Organisational Development
HSCIC	Health and Social Care Information Centre	PACS	Primary and Acute Care System
IAPT	Improving access to psychological therapies	PBR	Payment by results
IC	Integrated Care	PCT	Primary Care Trust
ICO	Integrated Care Organisation	PE	Pulmonary embolism
IDVA	Independent Domestic Violence Advisor	PHB	Personal Health Budget
IG	Information Governance	PICU	Psychiatric Intensive Care Unit
IMD	Index of Multiple Deprivation	PMO	Project Management Office
JIP	Joint improvement plan	PMS	Personal Medical Services
JSNA	Joint Service Needs Assessment	PPG	Patient and Participation Group
KPI	Key Performance Indicator	PPGF	Patient Participation Group Forum
LA	Local authority	PTL	Patient Tracking List
LAT	Local Area Team	QFP	Quality, Finance and Performance
LD	Learning disability	QIA	Quality Impact Assessments
LSCB	Local Safeguarding Children Board	QIPP	Quality, Innovation, Prevention and Productivity
LTC	Long-term conditions	QOF	Quality Outcomes Framework
MASH	Multi Agency Safeguarding Hubs	RAID	Rapid Assessment, Interface and Discharge
MDT	Multi-disciplinary team	RAP	Referral, Assessment and Packages of Care
MEHT	Mid Essex Hospital Services NHS Trust	RTT	Referral to Treatment
MH	Mental Health	SAVS	Southend Association of Voluntary Services
MRSA	Meticillin-resistant Staphylococcus aureus	SBAR	system Background Assessment Recommendation

MSK	Musculoskeletal
NEET	Not in Education, Employment or Training
NELCSU	North & East London CSU
SEND	Special Educational Needs and Disabilities
SEPT	South Essex Partnership NHS Foundation Trust
SHMI	Standard Hospital Mortality Indicator
SPOR	Single point of referral
SRG	System Resilience Group
SRP	Service Restriction Policy
SUHFT	Southend University Hospital NHS Foundation Trust
T&O	Trauma and orthopedics
TIA	Transient Ischemic Attack
TOR	Terms of Reference
VSO	Voluntary Service Organisation
VTE	Venous Thromboembolism
SBC	Southend-On-Sea Borough Council
SE	South Essex
SEN	Special educational needs