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29 November 2019

HEALTH & WELLBEING BOARD - WEDNESDAY, 4TH DECEMBER, 2019

Please find enclosed, for consideration at the next meeting of the Health & Wellbeing Board taking place on Wednesday, 4th December, 2019, the following appendices that were unavailable when the agenda was printed.

These appendices are for background information and relate to Appendix 2 of the Better Care Fund report.

Agenda No	Item
9	**Better Care Fund (BCF) Plan (Pages 1 - 218)**

Background appendices A, B, C, D and E attached

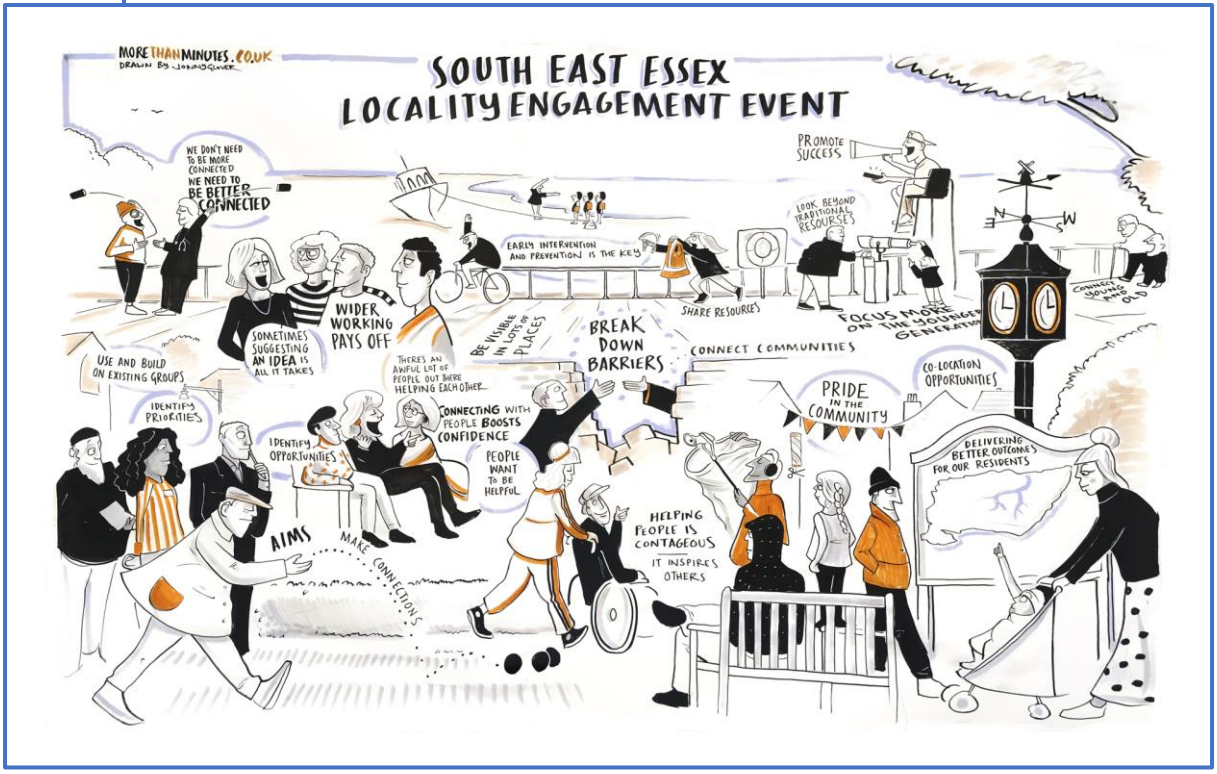
Robert Harris
Principal Democratic Services Officer

9

South East Essex Locality Partnership

Locality Strategy

Living Well in Thriving Communities



Contents

1. Introduction, Purpose and Audience

Why do we need this document and who it is aimed at?

Health and Social Care organisations in South East Essex (SEE) share an ambition to **improve the wellbeing and lives of the people they serve**. They will work with each other and with the local populations to **organise services and mobilise resources within the communities.** The approach will be based **around the needs and locations of people, rather than boundaries of organisations** and will focus on prevention and supporting the strengths of communities and individuals.

The purpose of this document is to;

- Provide a central point of reference that for all key stakeholders, binding them together through a joint ambition that demonstrates the strength of the SEE partnership that exists;
- Outline the approach that we will adopt across SEE to deliver new models of integrated care, with a focus on individuals, prevention, strength based approaches and community resilience;
- To provide a framework for the creation of a business plan for each of the SEE Localities that will support not only the operational development but the strategic development of Localities

Across SEE all statutory organisations have been working towards implementing new models of integrated care, bringing together traditional siloed services such as community physical and mental health services, adult social care and the third sector, to operate in a way that meets the needs of individuals and communities in a different, more holistic way.

Good progress has been made, however this approach has generally been driven by individual organisations, and their own priorities. It is considered that the greatest opportunity will be achieved by working strategically across a SEE footprint, but enabling local level design and implementation of changes to meet specific needs of the local population.

The decision to work across SEE's multiple health and care commissioning boundaries has resulted in a need to re-articulate the vision, core objectives and principles to ensure all partners are using the same language, with the same interpretation, and towards the same end point.

As such key system leaders have collectively defined the model of care that we aspire to and agreed an approach to implementation that focuses on bottom-up design principles and the empowerment of the public and frontline staff.

This document describes the principles that the system wishes to work under, defining how it will enable new ways of working to take hold, and how this aligns with complimentary strategies under development and already in existence, such as;

- Mid and South Essex Primary Care Strategy;
- Southend, Essex and Thurrock Mental Health and Wellbeing Strategy 2017-2021;
- Southend 2050;
- Southend Adult Social Care Transformation;
- Digital Essex 2020;
- The strategy for Acute Service reconfiguration;
- Essex County Council Organisation Strategy 2017-2021

This document is structured to enable the reader to understand the

- the problem we are trying to solve;
- the SEE vision for the future, and
- how we will implement this vision and the next steps that are required.

Once agreed this document will be used as the foundation to enable development of Locality diagnostics and implementation plans which will describe current population needs and solutions in place within each area, and a plan for moving towards the new model of care – this will include current utilisation of workforce and health and social care resources.

2. Context and Case for Change

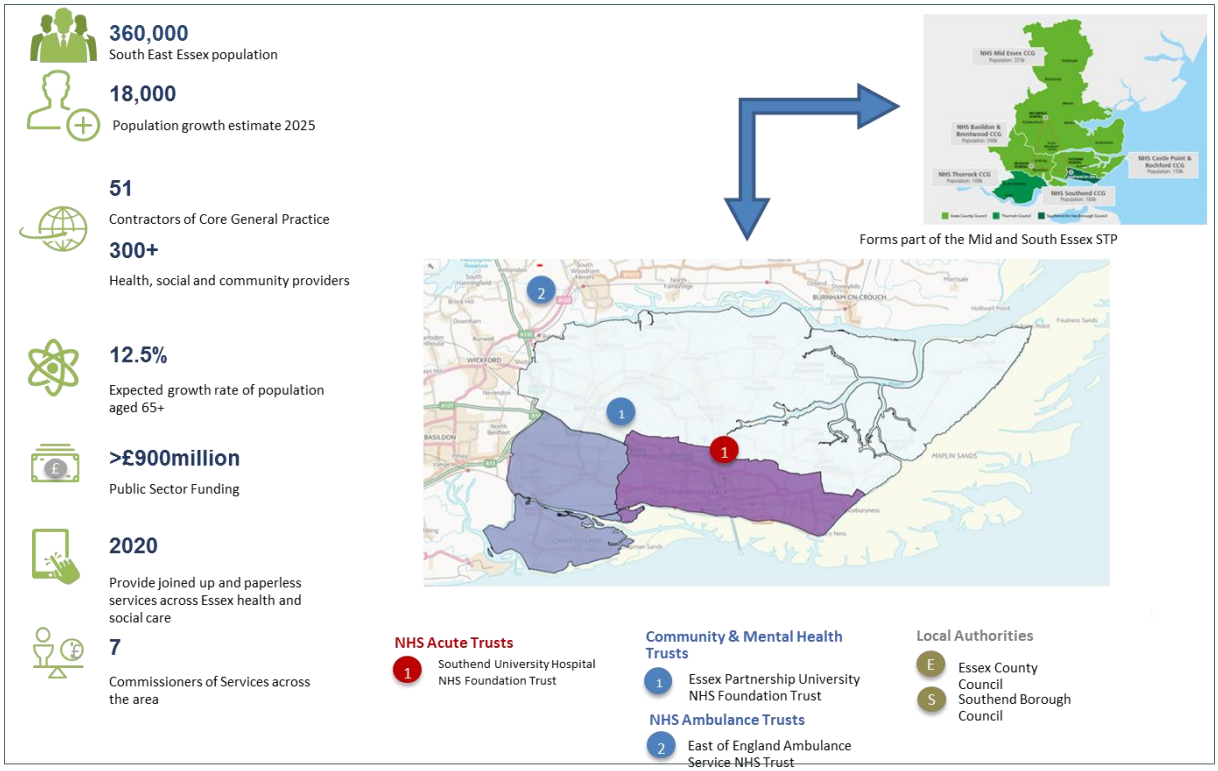
A quick portrait of the patch and the organisations within it

South East Essex, like many other areas, is a complex landscape of health and social care commissioners and providers and third sector organisations. SEE is rich in community assets which currently work, some through partnership, some through silo's, in support of communities and individuals. The area is diverse on many fronts; poverty, affluence, ethnicity and age. The SEE area also forms part of the Mid and South Essex Sustainability and Transformation Partnership (STP) planning footprint.

The complex nature of SEE aligned with increasing demand for services, unaligned workforce cultures, reducing community resilience and decreasing resource means that we have to find our way through and deliver support, preventative interventions and integrated services on a population needs basis.

To navigate our way through this complexity a strategic programme of transformation is required. It is intended that this transformation programme seeks input and oversight from all key organisations and sectors. Whilst this is summarised in the diagram below the discussions to date informing this vision have included

- Castle Point Association of Voluntary Services (CAVs)
- Essex County Council (ECC)
    - Commissioners
    - Social Care
    - Public Health
- Essex Partnership NHS Foundation Trust (EPUT)
- General Practice (GPs)
- NHS Castle Point and Rochford Clinical Commissioning Group (CPRCCG)
- NHS Southend Clinical Commissioning Group (Southend CCG)
- Southend Association of Voluntary Services SAVs)
- Southend Borough Council (SBC)
    - People Commissioners
    - Place
    - Social Care
    - Public Health
- Southend University NHS Foundation (SUHFT)



The individuals present have been representing the views of their individual organisations, the patients and public that they serve and represent, and the alignment with the ambitions of the wider system.

All partners want to move to a model of care that is no longer re-active, and places greater emphasis on keeping people well, and within their own community.

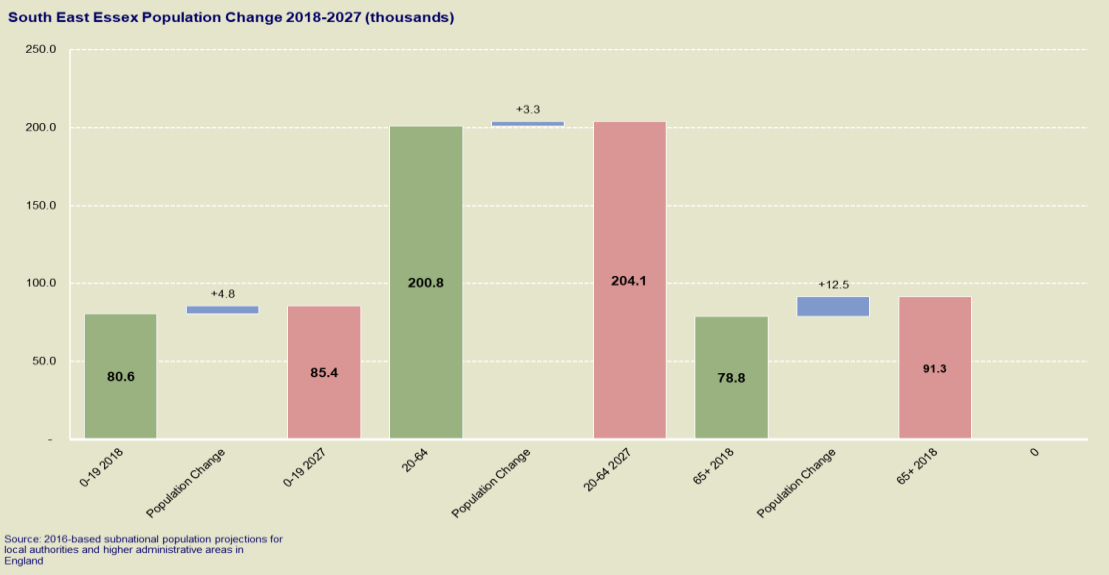
Case for Change

A short narrative on the challenges faced locally

The local system is under intense pressure as a result of a multitude of issues including but not limited to a growing population, reduced funding for adult social care and a plateauing of funding for the NHS, an increase in individuals experiencing problems with their mental health, multiple long-term conditions, social circumstances and an increase and variable ask of statutory services. These are challenges that are faced all across the country, and have been articulated many times.

In simple terms the system as it is currently operating is no longer fit for purpose. It does not work collaboratively across itself, or with the public it serves, to make best use of the assets that is has at its disposal. The way it currently operates is not operationally or financially sustainable now, and simple projections of population growth compared to statutory funding increases shows that this challenge is only going to grow.

Moving forward SEE will see a growth in population of 6%, or 20,000 people, over the next 10 years (2018-2027, ONS 2016-based subnational population projections) – this coupled with funding pressures, and lifestyle choices, will under the current model of care and support lead to an exponential, and unmanageable demand for public services.



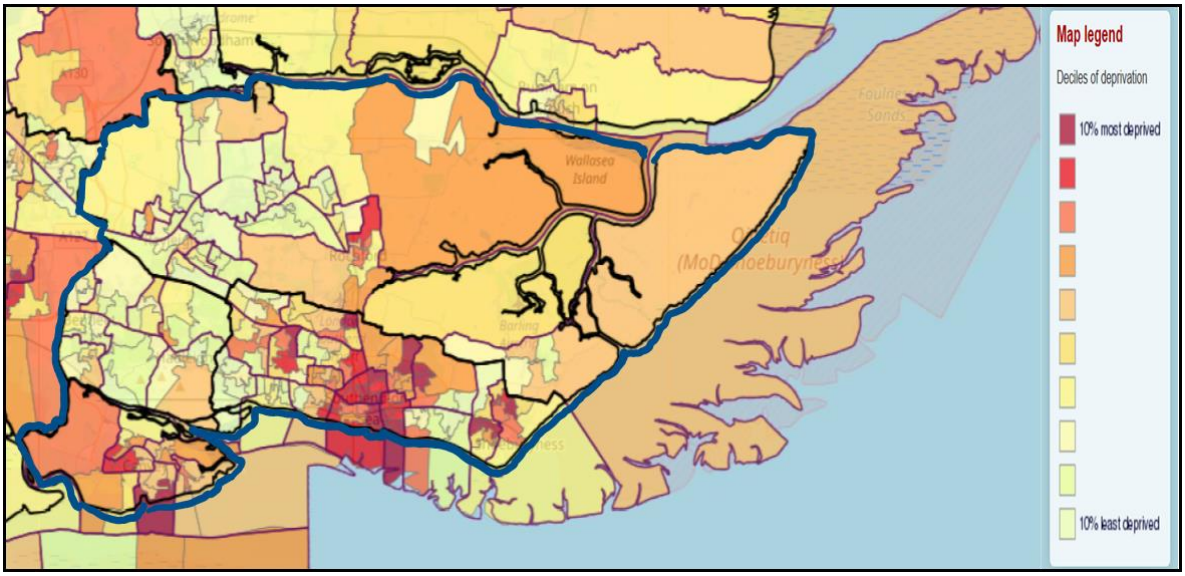
South East Essex as an area is one that contains within it a collection of smaller communities, each with their own specific care needs based upon the demographic of the population living there.

It also has a complex and varied health profile as summarised within Public Health Englands Local Authority Health Profiles 2018[1]

	Caste Point	Rochford	Southend-on-Sea
Health in summary	The health of people in Castle Point is varied with the England average. About 15% (2,100) of children live in low income families. Life expectancy for both men and women is similar than the England average	The health of people in Rochford is generally better than the England average. Rochford is one of the 20% least deprived district/unitary authorities in England, however about 10% (1,300) of children live in low income families. Life expectancy for both men and women is higher than the England average	The health of people in Southend-on-Sea is varied with the England average. About 19% (6,300) of children live in low income families. Life expectancy for men is lower than the England average
Health Inequalities	Life expectancy is 6.6 years lower for men and 3.6 years lower for women in the most deprived areas of Castle Point than in the least deprived areas	Life expectancy is 3.9 years lower for men and 5.4 years lower for women in the most deprived areas of Rochford than in the least deprived areas	Life expectancy is 11.1 years lower for men and 9.7 years lower for women in the most deprived areas of Southend-on-Sea than in the least deprived areas

As is illustrated below, the footprint has areas that sit across the national Index of Multiple Deprivation, meaning that what is suitable in terms of support, service offer, and system expectation in one area, is not necessarily suitable within another.

[1] https://fingertips.phe.org.uk/profile/health-profiles/area-search-results/E12000006?search_type=list-child-areas&place_name=East%20of%20England



Traditional approaches to commissioning and service provision have looked at the footprint as a whole – however with this change in demand and variability of need it is apparent that it is not appropriate to look at need at this macro level. It is also not appropriate to separately look at needs and symptoms, isolate the relationship between child health and future adult health, mental health and physical health, or an individuals health and care needs and the environment that they live and work in.

The system also lacks the resources – both people and financial - to continue to provide services in traditional ways, either for the current needs of the population, or projected needs based on demographic changes and population increases.

Top down direction and service development has resulted in fragmented and isolated services, with individuals and groups falling through gaps in services and interventions – designed to meet the needs of groups of individuals identified by high-level system analysis, resulting in duplication of effort and time, and suboptimal outcomes and experiences.

The Financial Case and Logic Model

Analysing the available Health and Social Care funding in south east Essex is as equally complex as the commissioning landscape. Whilst it is easily identifiable at organisational level it is not easily analysed at locality or function level.

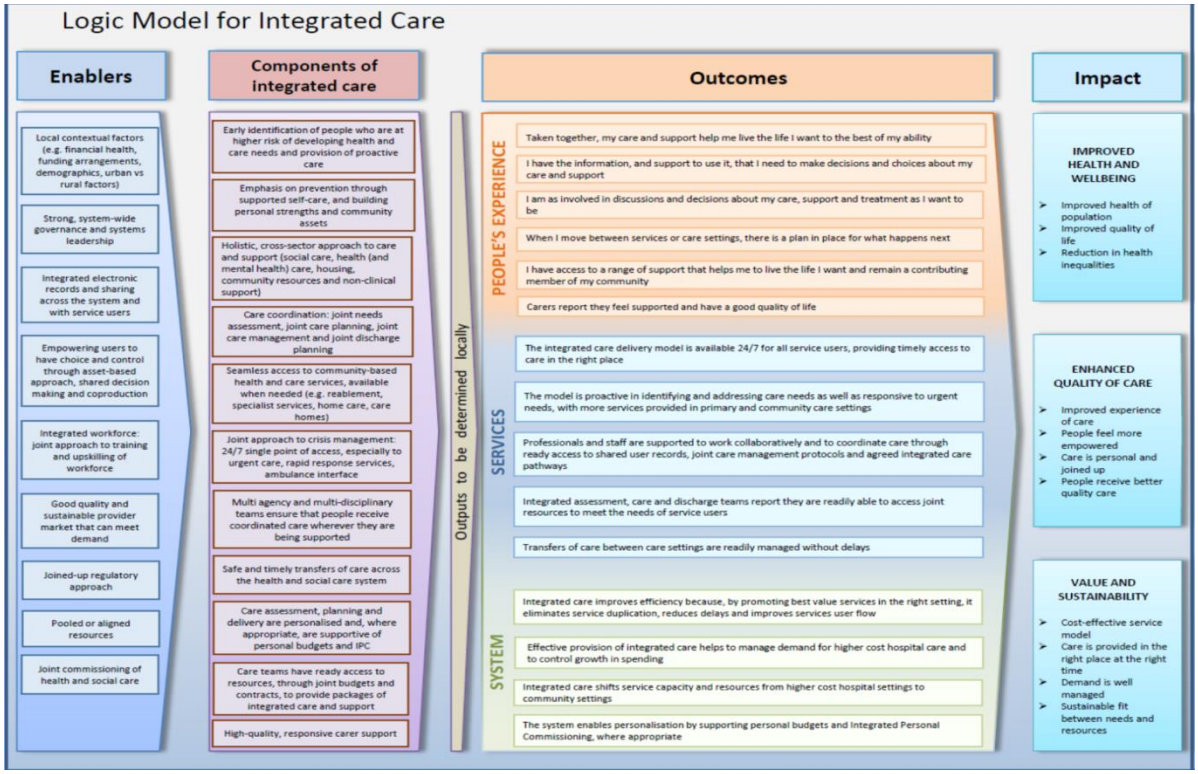
Further complexity exists with Local Authority arrangements such as the differences in scope between Essex County Council and Southend Borough Council and the role of District Councils within Essex County Council boundaries.

Most organisations also report spend against contracts or providers and not against patient cohorts, and performance is measured by outputs as opposed to outcomes.

The financial/economic case supporting the implementation of new models of care as described within this document is based on emerging evidence and a strong logic model as illustrated below. Whilst this is not ideal in terms of confidence of success, what is absolutely clear, and well-articulated in other system and organisations documents, is that the status quo – continuing to deliver services in a reactive, un-coordinated and personal deficit focused way – is unsustainable from a resource perspective, be that financial, workforce, time or any other that is able to be measured.

The Social Care Institute for Excellence have developed a Logic Model for Integrated Care which goes some way to supporting the thinking behind the financial and economic case – particularly when it comes to ensuring that

the system makes best use of its available resource, and the reasonable assumption that improved quality in itself reduces costs incurred.

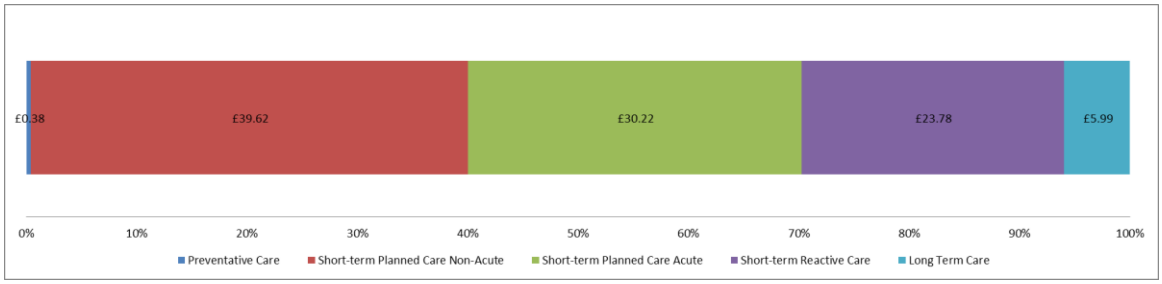


What is apparent through a simplistic analysis of CCG spend incurred within the system is that the majority of current health commissioner resource is utilised either on on-going care, or re-actively responding to rapid deterioration in need – as opposed to investing in preventative care. Whilst not easily analysed anecdote suggests that a similar review of Local Authority spends would see a similar focus on residents with current needs as opposed to investments on keeping people well.

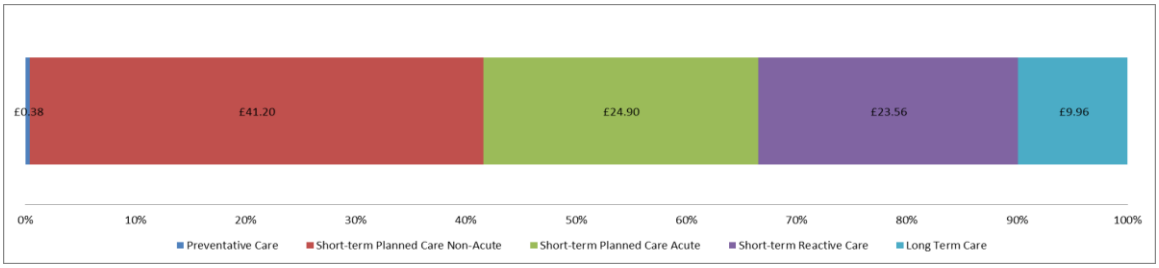
Both CCG's generally report spend against provider sectors, or commissioning programmes. The vast majority of the CCG spend will be on meeting the identified health needs of the population, with very little committed towards the fit and healthy population – this has been further influenced by the removal of Public Health funding from CCG budgets when they were formed, with this money being realigned to local authorities.

The graph below illustrates that for every £100 spent by the Castle Point and Rochford CCG

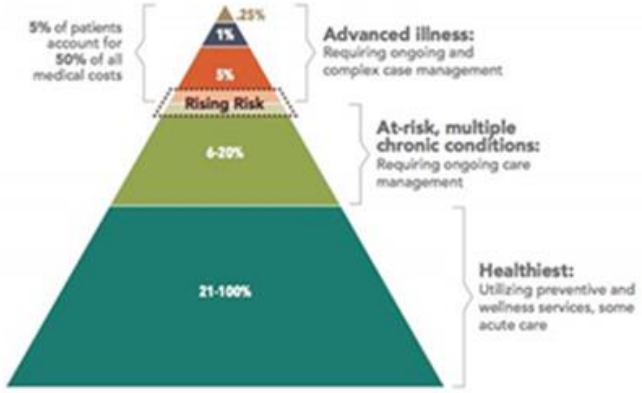
- £39.62 is committed to meeting short-term (non-permanent) health needs in a planned manner, assuming patients do not remain on caseloads in perpetuity. This covers nearly all spend areas of primary and community care
- £30.22 on planned acute services such as Out-patient appointments and Elective inpatient and daycases
- £23.78 is spent on reactive care covering Accident and Emergency and Non-Elective admissions
- £5.99 is spent on meeting the on-going needs of patients receiving Continuing Healthcare, and
- 38p is spent on services commissioned to proactively support individuals, the majority of whom have been identified as already having a health or care need



Whilst the numbers are slightly different for Southend the overall picture of how resource is utilised is not materially different.



What this shows is that the majority of CCG spend is utilised on the estimated 20% of patients that have a care need now, with very little committed towards maintaining the health of the population. This approach to funding care is unlikely to be sustainable in the future as the projected gap between available resources and population demand increases.



The Public Health Case

Disease and harm prevention at a population level

The rationale and benefits for individuals where disease prevention interventions are implemented are recognised and well known. The impact on individual diseases of immunisation programmes, screening programmes, and health promotion programmes, for instance, can be clear and has been analysed and demonstrated through clinical research and evaluation over the past century. However the benefits for health and social care systems from population level prevention programmes are only recently being quantified through an emerging research evidence base.

It is important to note that investing in population level disease prevention is primarily about improving lives rather than producing financial savings or reducing healthcare demand. Successful prevention at population level can increase life expectancy and consequently increase care needs in the future. However, ambitions for prevention interventions may include reduction in demand pressures for key services such as urgent and

emergency care and re-allocation of resource to facilitate improved efficacy, efficiency, and equity in health and social care services.

Health promotion and disease prevention must take account of a complex system of determinants. These familial, social, and economic determinants may require different specific interventions and these interventions may impact on multiple disease areas. With multiple interventions impacting on multiple conditions, it has traditionally proved difficult to definitively link specific population-level interventions with specific outcomes. We do know that the potential positive health impact accrued from successful population-level interventions is greater than that for interventions targeted at high-risk groups. However, these interventions require more resource, and buy-in from the wider population and policy makers where interventions impact upon individuals who are unlikely to benefit personally. This is known as the prevention paradox where large proportions of a population who are at low risk receive no immediately discernible individual health benefit from a population-level intervention.

Celebrated Public Health case studies such as the North Karelia Project in Finland showed that population level interventions with buy-in from healthcare services, social care services, industry, regional government and local communities could reduce levels of coronary heart disease from global high levels to rates comparable with European neighbours. This was through changing health-impacting behaviours across the whole population, not just those who were identified as being at high risk. The British Family Heart Study intervention and the German Cardiovascular Prevention Project are both examples of large-scale population-level prevention programmes that showed a significant decrease in the prevalence of cardiovascular disease risk factors for the population participating. The evidence base has led to NICE recommending cross-sector population-level programmes within its Cardiovascular Disease Prevention Guideline (PH25)[2].

Population Health Management

It is clear that there is a strong rationale for matching evidence-based intervention and resource to identified population health need. A robust, effective, and equitable healthcare system requires effective systems for identifying and quantifying need. The population health management (PHM) approach encompasses a range of models which attempt to quantify levels of need through aggregation and triangulation of patient and population health data and effectively managing that identified need. A successful PHM model starts from the perspective of understanding people's lives and the impact that disease has upon them and modelling pathways of care around this rather than treating isolated episodes of illness. This means that systems must take account of social factors in designing service access and demand parameters. Healthcare providers such as Kaiser Permanente in the United States have suggested from their activity data that around four fifths of patients identified as being at highest risk of being the highest users of their services have at least one unmet social need[3].

This approach seeks to group patients with similar health needs. The population segmentation that PHM brings aims to quantify the multi-factorial increase in cost to health and social care systems of multi-morbidity and the impact of deprivation on health outcomes in specific health systems. The evidence base for PHM is, however, slim as the approach has only recently been taken up.

Examples of the successful impact of PHM on health systems and health outcomes are emerging, with case studies in the London Borough of Camden showing initial reductions in emergency admissions, emergency bed days, and overall secondary care financial savings. For diabetes, identification of untreated diabetes patients and consequent reductions in amputations and unplanned admissions was seen, leading to the borough achieving nationally-rates outstanding outcomes[4]. Imperial College has also undertaken early evaluation of five

[2] Cardiovascular disease prevention: Public health guideline [PH25]. 2010. Available at: https://www.nice.org.uk/guidance/ph25/chapter/1-Recommendations

[3] Shah N et al. 2016. Health care that targets unmet social needs. New England Journal of Medicine Catalyst (Note: this is a journal article rather than a peer reviewed paper where data would be available for scrutiny.)

[4] Sayer C et al. 2017. Toward accountable care: achieving value and integration via population health management. New England Journal of Medicine Catalyst.
(Same note as above.)

vanguard sites for risk stratification in England and published their report in 2017. While there is minimal robust evidence at this early stage in the vanguard sites' operations, it found early anecdotal evidence of improvements to tailored care for patients by paramedics and reductions in lengths of stay and delayed transfers of care (which are potentially linked to the programme). However, more time is required before the evaluation would be able to fully determine whether there is stronger quantifiable and attributable evidence for the efficacy of the programmes.

It may be the case that population health management will produce most benefit from triangulating and cross-referencing health-impacting data to identify where individuals are not accessing evidence-based healthcare or social support where the need is identified. Linking data sets may enable us to better assess whether the systems we have in place are working and where improvements can be made.

3. Our vision for the future

'what' is it that we wish to achieve across south east Essex

There is a desire from all partners to invert our existing model of care, for future solutions to be driven by the lived experiences of the public and staff within an area – for they know and appreciate the challenges faced within communities. The desire includes the mobilisation of all the assets at our disposal (within Local Authorities, Health and 3rd Sector) which can be used to engage communities and empower a supportive functionality.

It is the ambition for the system to move from a reactive model of care and enable an improved focus on prevention, self-care, personal responsibility, empowerment and wider community resilience. The model will articulate how support individuals require can be delivered against this backdrop that is person centred, integrated and that provide the best possible outcomes for the individual.

Locality Working - A Place-Based Approach

Traditional models of commissioning and provision have failed to deliver sufficient benefit to local communities. In line with national direction there is local move to adopt a place based approach, focusing on the needs of local communities as opposed to the amalgamated needs within traditional organisational boundaries.

The national agenda of public service reform and the integration of health and social care emphasise the growing requirement for localised responses to the demands and challenges facing health and social care in particular, and the public sector more generally. However, the perceived failure of conventional approaches to reduce inequalities and prevent problems is still leading to poorer outcomes for people despite local services responding to the complex needs of individuals, families and communities.

In response, policy and legislative developments are increasingly placing priority on collaborative working between people who provide services and those who use them. This aims to enable people to exercise choice and exert greater control over the types of support needed for better personal health and wellbeing outcomes by engaging partners with the flexibility and scope for innovation.

Place-based approaches may be one way of encouraging this way of working and may help to generate innovative ways to tackle some of these issues. This is explored in the examples that follow.

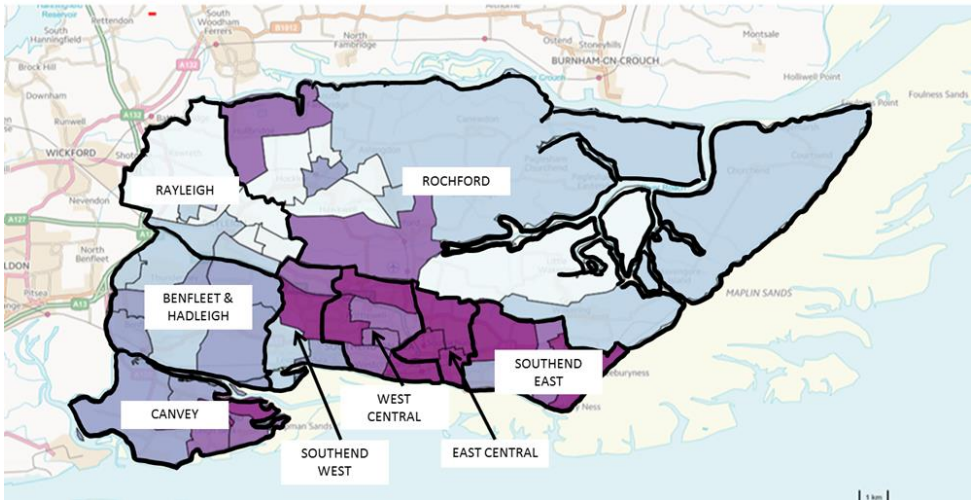
Traditional top-down approaches to change, or transformation, that rely on an overarching system (or national) view that is then broken down into sub-systems (local views) are not considered as the best option for maximising the collective power of individuals, communities and the third and statutory sectors. By focusing on the deficits, rather than the assets, top-down approaches can sometimes be criticised for undervaluing the importance of local knowledge and assets and, as a result, the differentiation between local and systemic/national issues becomes misunderstood. This can be problematic, particularly when thinking about

improving health and wellbeing, as it can cause us to think that the wider perspective is all that matters and prevent us from understanding local needs.

Place-based working is a grass roots, person-centred, approach used to meet the unique needs of people in one given location by working together to use the best available resources and collaborate to gain local knowledge and insight. By working collaboratively with the people who live and work locally, it aims to build a picture of the system from a local perspective, taking an asset-based approach that seeks to highlight the strengths, capacity and knowledge of all those involved.

There are a number of issues with the precursors to place-based approaches (e.g. active regional development, place-blind methods or community planning) such as a misdiagnosis of issues, lack of an asset-based approach, tokenistic community engagement and short-term horizons. Together, these have led to an increased demand for approaches that value the importance of place, while also understanding the need for embedded, person-centred ways of working. While these approaches sought to improve local resources, they didn't have any specific place-based considerations and therefore could be considered 'top-down' as opposed to community focused 'bottom-up' approaches. A place-based approach, on the other hand, acknowledges the complexity of people's lives by working in direct partnership with a range of people and provides one way of uncovering the needs and strengths of local communities.

Within SEE we have identified 8 Localities to work across in terms of a place-based approach, 4 in Southend and 4 across Castle Point and Rochford. These are as identified below, and illustrated on the map



System Ambitions

Improving Outcomes and a move to a sustainable, prevention and empowerment focused health and care system

It is collectively agreed that the current approach to commissioning, delivery and the subsequent monitoring of success is not conducive to supporting the development of a locality approach. Providers often have conflicting priorities as a result of different approaches to commissioning, and no ability to obtain a system view of current and future priorities.

It is considered that a move to measuring outcomes will address the first issue – and the system is in the process of identifying how an Outcomes Framework may be structured.

For this to be successful all parties need to agree the key outcomes the system wishes to achieve, and commission and provide services that ultimately contribute to the delivery of these

It has been agreed that outcomes should be relevant to an all age, all need population, and by definition is something that matters to

- The person
- The community
- The population as a whole

The outcomes need to reflect clinical quality, quality of service provision and ensure the right balance between this and personal experience/satisfaction and the need to assess outcomes for the whole population, as opposed to separating different population groups.

Current thoughts are built around the development of a three tiered approach to the framework

- Domains – what is important and SEE is intending to improve
  - Draft wording agreed and included in the slide deck for comment
- Outcome – outward facing narrative of what is to be achieved
  - Wording still requires agreement
- Indicators – how the outcomes are to be measured at a locality level
  - Agreed that whilst there is a likely to be a core set of indicators that are consistent across all localities, there is a desire to have locality specific indicators that reflect the needs of the specific population
  - As a principle utilise existing indicators if appropriate
  - Current localities not sufficiently mature to define their own indicators

Where appropriate these will need to be aligned with contracted KPI's

Commissioning partners across south east Essex came together and have agreed that the four domains that they wish to focus on are as follows

1. Health and Wellbeing: Indicators linked to population health outcomes, prevention, independence and lifestyle factors;
2. Care Quality and Experience: Indicators linked to positive personal experience, safe and effective care, and partnership development between people and community assets;
3. Sustainability: Indicators focusing on the impact of the integrated and collaborative working on financial and clinical sustainability of the community and the system; and
4. Transformation Drivers: This category includes measures that will help to drive improvements and change in the other outcome areas, in particular changing clinical and people culture.

Stating an ambition to work towards outcomes, instead of outputs, is not a new concept but one that has been voiced in a multitude of forums over recent years. It is also sometimes difficult to translate this ambition into reality. Whilst work is required to agree the set of indicators that will measure achievement of this it is not unreasonable to assume during the early stages of development the system will use existing measures to underpin and assess the approach.

As such the system should collectively work towards improve the following, existing, measures;

Health and Wellbeing		
Goal	Indicator	Source
Reducing inequality in life expectancy at birth	Slope index of inequality in life expectancy at birth within English local authorities	PHOF
Improving quality of life	Social care-related quality of life Health related quality of life for people with long-term conditions Quality of life for carers	ASCOF CCCG IAF ASCOF & CCG IAF
Improvements in the number of people physically active	Percentage of physically active and inactive adults	PHOF
Reducing childhood obesity	Child excess weight in 4-5 and 10-11 year olds	PHOF
Reducing Social Isolation	Proportion of people who use services, and their carers, who reported that they had as much social contact as they would like	ASCOF

Ensuring people have access to necessary information and advice	The proportion of people who use services and carers who find it easy to find information about services	ASCOF
Increase the number of people accessing therapies for common mental health conditions	Increase the proportion of people with a common mental health problem accessing Improving Access to Psychological Therapies (IAPT) treatment	IAPT data set
Care Quality and Experience		
Goal	Indicator	Source
Increase the number of people who are able to manage	People with a long-term condition feeling supported to manage their condition	CCG IAF
Reduce the number of premature deaths that should not occur in the presence of timely and effective healthcare	Potential years of life lost (PYLL) from causes considered amenable to healthcare	PHOF
Reducing the number of people attending A&E with mental health needs, who could have these met more effectively	Number/proportion of people attending A&E with mental health needs	To be identified
Improving staff health and wellbeing	Staff satisfaction, and reporting of 'I' statements	To be identified
Delaying and reducing the need for care	Proportion of people still at home 91 days after discharge	ASCOF
Overall satisfaction with services	Overall satisfaction of people who use services with their care and support Overall satisfaction of carers	ASCOF ASCOF
Increase the number of people who die in their preferred place/experience a good death	Percentage of deaths which take place in hospital	CCG IAF
Sustainability		
Goal	Indicator	Source
Measure the levels of co-ordination between hospitals, community and social care services	Delayed Transfers of Care attributable to the NHS and Social Care per 100,000 population	CCG IAF & ASCOF
Reducing the utilisation of hospital beds following emergency admission	Population use of hospital beds following emergency admission	CCG IAF
Reducing the utilisation of long-term residential/domiciliary care provision	Average age of patients starting long-term packages of care (residential or domiciliary)	To be identified

Development Process

Significant work has been undertaken during 2018 to develop and articulate the local model of care with key stakeholders.

It is anticipated that the interpretation of this model will be consistent across the eight locality areas that form the basis of the transformation programme, but with local variation for implementation where population needs, partnership offers and available 'assets' dictate.

At the heart of the Locality Model are the following principles

- Move from an acute-centric model of care to one that focuses on
  - Independence / self-responsibility adopting the principle of focusing on peoples strengths
  - Utilisation of community assets
  - Promotion of preventative activity and utilisation of the principle of making every contact count
  - Integrated working
  - Outcomes driven

- Move to a system of GP led care
- Enable locality models to develop utilising the collective opportunity of statutory, third sector, community and personal assets to meet the needs of the person and the population
- Enable cross organisational working to support the delivery of the collective outcomes
- This has resulted in the model as illustrated on the following page

The model is in full alignment with the STP Primary Care Strategy which has two key proposals at the heart of its model

- Moving away from a system in which services are principally GP delivered to one where services are GP led
- Encouraging and enabling practices to come together to form and lead localities serving populations of approximately 30 - 40,000 people

Principles behind the Model of Care

A strengths-based approach to care, support and inclusion says let's look first at what people can do with their skills and their resources and what can the people around them do in their relationships and their communities. People need to be seen as more than just their care needs – they need to be experts and in charge of their own lives.
Alex Fox, chief executive of the charity Shared Lives

The phrases 'strengths-based approach' and 'asset-based approach' are often used interchangeably. The term 'strength' refers to different elements that help or enable the individual to deal with challenges in life in general and in meeting their needs and achieving their desired outcomes in particular. These elements include:

- their personal resources, abilities, skills, knowledge, potential, etc.
- their social network and its resources, abilities, skills, etc.
- community resources, also known as 'social capital' and/or 'universal resources'.

Strengths-based practice is a collaborative process between the person and those supporting them, allowing them to work together to determine an outcome that draws on the person's strengths and assets. As such, it concerns itself principally with the quality of the relationship that develops between those providing and those being supported, as well as the elements that the person seeking support brings to the process.

The vision for south east Essex is the development of new models of care that align with the narrative above and are robust, resilient and sustainable while encompassing health, social care and third sector as well as the wider health and wellbeing of the individual. We want to work with the population as a whole on geographical footprints at sub CCG/LA level – these footprints are known as Localities – with populations between 30-50,000 people, enabling greater community design, and variability in approach and types/ways of service provision to meet the specific community needs.

It is essential that the Locality approach is built alongside resilient and sustainable General Practice and align with the movement to locality based primary care as described in the Mid and South Essex Primary Care Strategy. The success of the system is reliant on closer partnership working, and the collaboration of expertise and resources, by those working within localities.

The arrangement into Localities and the transition to a new model of care will also need to reflect the differing offers of partnership from the two Local Authorities within SEE.

The development of Localities is at the very core of and underpins the priorities for for Southend Borough Council (SBC). The Locality approach is pivotal to the Southend2050 visioning work and is supported by the closer matrix working across SBC.

During the course of 2018 SBC led the development of a resident and stakeholder ambition for the future of the Borough. The work has identified the sort of place residents and stakeholders want Southend to be. As a result

of this work 5 key themes / outcomes have been agreed which will be the drivers for how SBC engage with the development of Localities. The themes are;

- Pride and Joy;
- Safe and Well;
- Active and Involved;
- Opportunity and Prosperity; and
- Connected and Smart.

By 2050, Southenders are proud of what Southend has to offer, they feel safe in all aspects of their lives and are well enough to live fulfilling lives. By 2050 our communities are active and involved and feel invested, Southend is a successful place and our prosperity is shared amongst all people and the people can easily get in, out and around the borough, all supported by a world class digital infrastructure.

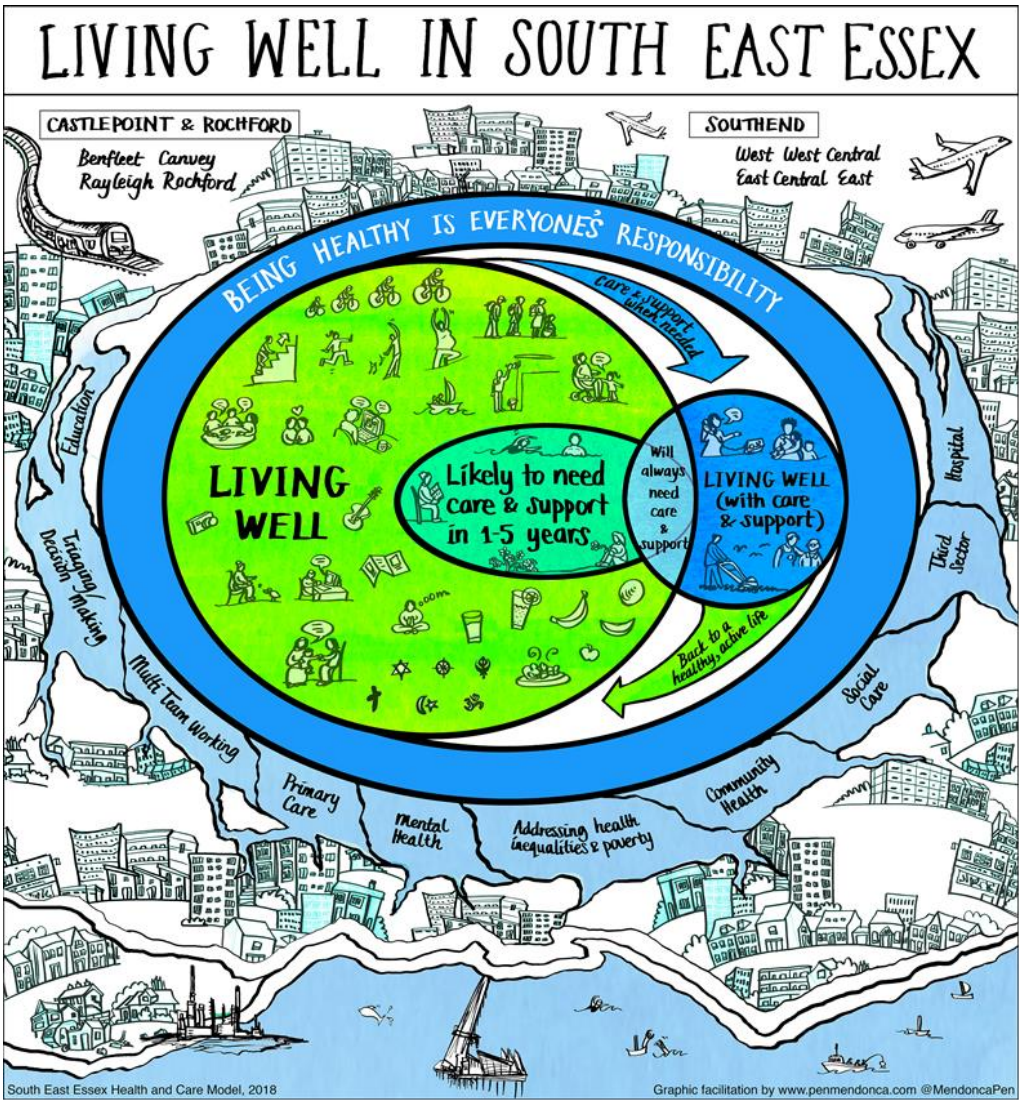
To deliver the themes and outcomes a roadmap has been developed which describes the journey from now to 2050. The roadmap focuses on the next 5 years and sets out clear actions that will be taken during this time.

The ambition for 2050 is at the very core of developing Localities in the Borough. Southend are committed to implementing this strategy and using all available resources innovatively to contribute to the delivery of the agreed outcomes.

The partnership working offer from Southend is mature enough to be able to mobilise resource and assets across the entire Local Authority spectrum.

The offer from Essex County Council (ECC) is as equally detailed as SBC but different. ECC want to see a transformational shift from a focus on long-term care and support to those in crisis to early intervention and enabling people to live independently for as long as possible, by making the best and most sustainable use of all available resources. ECC is committed to working with partners as part of multi-disciplinary teams and delivery of the locality model built on a foundation of integrated working.

The Model of Care



The model of care designed for south east Essex is one that focusses on enabling people to remain independent. It is a model that moves the focus to pre-emptive and pro-active care and ensuring communities and individuals have access to the necessary assets to enable this to happen.

In addition to this ambition for the whole population it fundamentally focuses on the community as consisting of four distinct cohorts

1. Those that do not require care or support at this point in time, nor are they expected to require care or support over the next five years
2. Those that, based on a variety of factors are likely to require care and support within the next five years, and the expectation that they are identified and provided able to access solutions that either defer or delay the requirement for care
3. Those that, despite of the best intentions of the individual, their community and support network do require the support of formal services – in this instance the system collectively works to ensure they continue to live well with care and/or support in place and return to living an unsupported healthy and active life in a safe and timely manner, and
4. Those that will always need care and support who will receive services that enable them to live well regardless of the complexity of need

The Role of the Hospital

In any health and care economy the physical status of the local acute trust gives the public the impression that this is the default place to get their needs met – be it through the clinical advice of a consultant for on-going management of a long-term condition, or through the 'easy' access to medical support through the front door of the Accident and Emergency department. South East Essex is no exception with the model of care that has evolved, certainly in terms of current spend, being particularly acute centric – this is despite the fact that 90% of health contacts are undertaken across both primary and community care providers and outside the walls and responsibilities of the local acute provider.

Whilst the 'Living Well in Thriving Communities' model has a focus on personal and community resilience and the strengthening of support available within the community (primary, community and through social care), there is no denying that people will continue to need a level of care and support that is either best provided, or overseen, by the clinical/medical expertise available through an acute provider. The model of care however places an emphasis on both timely – and where possible pre-emptive - intervention and the pro-active return of individuals to their normal place of residence with any required on-going care and support delivered outside of a hospital ward.

For this to be successful there would be an expectation that those responsible for delivering support within the locality setting link with acute colleagues to ensure the care provided is seamless, and the drive is to ensure the individual returns to their normal place of residence in a safe and timely manner.

Principles of Collaboration

As individual organisations each partner has already stated their own vision and values. Whilst these are specific to each individual organisation, and would have been developed through wide organisational and stakeholder engagement, all organisations have common themes running through their values. Using these individual organisational values it is possible to extract a number of key principles that the system wishes to work to

- It is accepted that the combined strength of the system is greater than the individual strengths of the organisations that make it. As such a principle of **collaboration** shall be adhered to across south east Essex to address the challenges, and deliver the model as described in this document
- Previous attempts to redesign the system have failed in part as a result of what it sometimes referred to as the 'fortress mentality' – in order to overcome this the partners will be **open and honest** in the interactions with each other and the populations which they serve
- Underpinning both of these is need to be **compassionate and supportive** – not only towards the populations that they serve, but also to individual organisations positions. The system has a greater chance of overcoming challenges together, and accepting them as system challenges, as opposed to separate organisational ones

Ambition for the System

The local landscape

In this section we have set out our vision and described a number of the changes we want to make. These include:

- A focus on the importance of place/localities as a unit of planning
- A commitment to integrating services around the needs of individuals and communities
- Placing a strong emphasis on prevention
- Collectively defining and agreeing a single set of outcomes
- An expectation that collaboration will be the norm
- Enabling and encouraging local teams and professionals to have greater flexibility so that they can be driven by people's needs, not organisational or professional silos

We know that a key factor that will influence how rapidly we are able to make progress in delivering this plan is how effectively we, as a set of organisations, work together. If we work well, we will create an environment which supports and accelerates change; if we do not, there will be frequent obstacles and change will be slow.

We recognise that our local landscape is complex, with a large number of statutory and non-statutory bodies involved in the planning, funding and provision of services. In addition, not many of our organisations share a common geographic footprint, and most are simultaneously members of multiple 'systems' – sometimes very local, such as at neighbourhood or ward level, sometimes at all Southend or Castle Point or Rochford level; sometimes all of Essex or a sub-set of it; and sometimes at a regional or even national level.

There is no simple structural or organisational way of cutting through this complexity, and we are concerned that a focus on organisational form will be distracting. Therefore, our approach is to focus on two elements that we think will enable us to make the quickest progress in implementing our strategy: developing a Memorandum of Understanding; and taking a pragmatic approach to integration.

Memorandum of Understanding

While we have worked well as a set of organisations to develop this strategy, we know that delivering the changes we have set out will require us to go further and deepen our partnership.

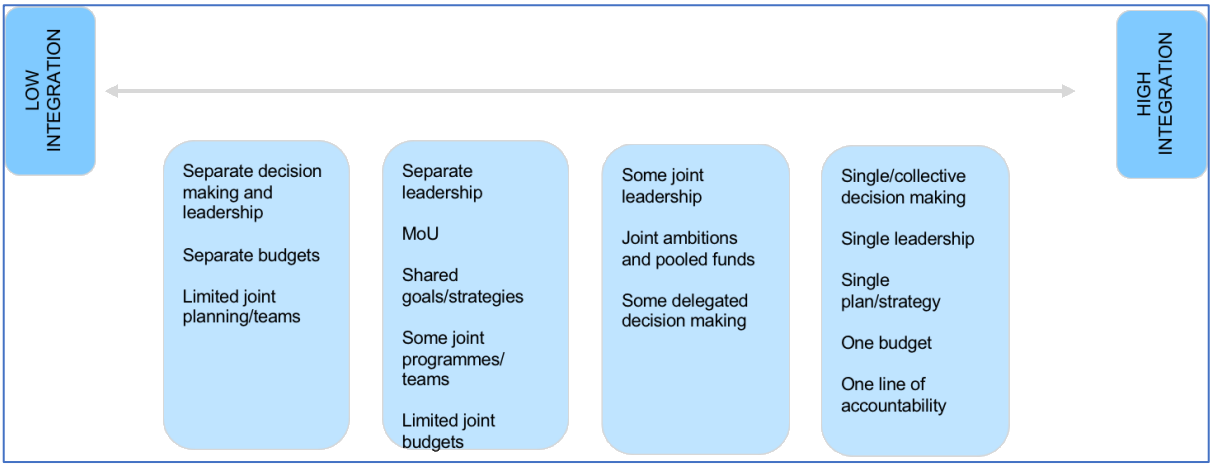
Therefore, we have committed to developing a Memorandum of Understanding (MoU) that will set out in clear language how we will work together, what principles we will follow and how we will behave. Whilst not legally binding, the MoU will clarify and codify the commitments we are making to one another and to local people.

We will develop this agreement over the coming months, and will ask all of our Boards and equivalent decision-making fora to formally sign up to this MoU. We aim to complete this work by the end of March 2019.

Features of integration

We know from other systems that there are a number of aspects or features that can help partnerships such as ours to successfully deliver ambitious plans like ours.

These span a spectrum from systems that have very limited integration to those that are highly integrated, with each displaying different features:



Our guiding principle in deciding where to place ourselves on this spectrum is to be pragmatic, and take decisions on an issue by issue basis. For example, if a particular aspect of our plan would best be delivered by a single organisation taking the lead on behalf of the wider system, then that is what we will do. Conversely, if we

consider that progress will be quicker by being much more integrated – for example by having delegated decision making, single teams and pooled budgets - then this is what we will do. Our over-riding principle is one of pragmatism – what matters is what works.

4. How we will implement our vision

How we plan to bring all of this together, including those things that are 'do once' either south east Essex wide or wider and the Development of the eight localities

Previous change programmes have generally operated in a way that separated commissioner and provider discussions. This has resulted in less than optimal implementation of solutions as there are often differences in interpretation of message when discussions are undertaken in separate rooms

Delivery of the ambitions stated in this document are reliant on system-wide transformation. It is reliant on clarity of message, consistent interpretation of asks and consistent understanding of answers. It will fail if organisational interests, or commissioner and provider separation, drives the discussions.

The success is reliant on strong partnerships across the system, between organisations, between staff and between the communities and individuals which they serve.

What are we going to do once?

We will ensure that where it makes sense to 'do things once' that the system will support this. This document clarifies the expectation that strategic direction will be defined once across the system, with this supported by a single approach to

- Defining the Model and ensuring consistency in model development where this makes sense. This includes
    - Where gaps in interventions or functions are identified within localities where this gap exists across multiple localities a single approach will be strived for – an example may include self-care and support resources for carers or those with on-going care and support needs
    - Standard operating procedures for functions such as MDT's or social prescribing
- Agreeing locality population health and wellbeing outcomes
- Developing and delivering an approach for the definition, extraction and analysis of information needed to support locality development
- Engagement and co-production with individuals, communities and organisations in south east Essex for development of localities and new operational service models

Current status of Localities

Discussions to date have identified a number of key elements that contribute to a strong locality model. A desk top assessment has been undertaken across these areas for the eight localities to develop a baseline of maturity as summarised below

	Benfleet & Hadleigh	Canvey	East	East Central	Rayleigh	Rochford	West	West Central
Primary Care Collaboration	◕	◑	◔	◑	◔	◑	◑	◔
Locality MDT's	◕	◕	◕	◕	◕	◕	◕	◕
Locality Design Teams	◑	◑	◑	◑	◑	◑	◑	◑
Social Prescribing	◔	◔	○	○	◔	◔	○	○
Locality Co-ordinators	◔	◔	○	○	◔	◔	○	○
Community Mental Health	○	○	○	○	○	○	○	○
Locality Health Needs Assessments	○	○	●	●	○	○	●	●
Suitable Estate Solution	◔	●	○	◑	◔	◔	◑	◑
Shared Data Solutions	◑	◑	◑	◑	◑	◑	◑	◑
Use of data to deliver Care	○	○	○	○	○	○	○	○

As part of the development of individual Locality Implementation Plans (see below) this desk top evaluation will be repeated with frontline staff and communities to get a consistent view of current provision and identify both locality and system areas of priority for development.

Locality Variation

It is acknowledged that whilst we can simplify need and challenges across the wider footprint each locality will have its own specific nuances based upon the key determinants of health

- Health behaviours such as tobacco use, Diet and Exercise and Alcohol and Drug use
- Access to and quality of clinical care
- Social and Economic factors such as Education standards, Employment levels and Income
- Physical Environment such as Air and Water quality and housing and transport

Collectively these contribute to the length and quality of life of an individual

Whilst further work is required in understanding the nuances between localities using the proxy measure of Life Expectancy and Health Life Expectancy it is undeniable that the variation across the footprint is unacceptable.

As of the 2011 census there is a 20 year gap between the areas with the highest and lowest expectancy levels across south east Essex

Life Expectancy

- Men born within the Kursaal Ward of Southend, and within Southend East Central Locality, has a Life Expectancy of 73.58 years compared to
- Women born in Hockley West, and within the Rochford Locality, has a Life Expectancy of 94.92 years

The variation in Health Life Expectancy is just as stark

- Men born within the Victoria Ward of Southend, and within Southend East Central Locality, has a Health Life Expectancy of 55.62 years compared to
- Women born in Hockley West, and within the Rochford Locality, has a Healthy Life Expectancy of 76.08 years

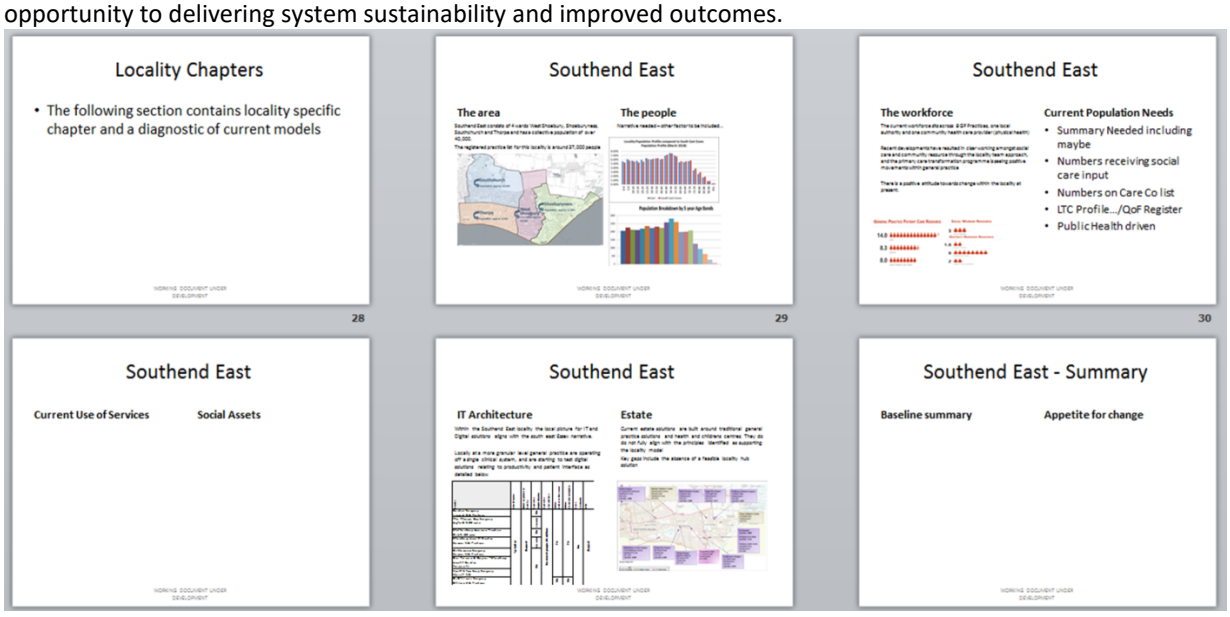
Detailed, and summary, locality needs assessments are being developed for each area, examples for the four Southend Localities can be seen in Appendix 1.

Locality Implementation Plans

In order to progress each locality will need to undertake a diagnostic that looks into the current situation in that area, assessing current and future needs of the population against the assets available to them. An example of what this may look like is included below. Following approval of 'Living Well in Thriving Communities' work will progress at pace to complete these, and develop locality level development plans that aim to address the gaps identified. These are likely to cover

- The need/service offer gap
- The numbers and skill mix required to close this gap, after any productivity opportunities
- Any estate implications
- An approach to innovation and digital

It is expected that the system look at innovative ways to address these gaps, including through alternative utilisation of available resource, and the refocusing of assets towards areas identified as providing the biggest opportunity to delivering system sustainability and improved outcomes.



Transformation Oversight

Programme oversight will operate through an approach of integration and collaboration – not one of separation. The arrangements that are evolving, and summarised below, are built on this principle and it is clear that it will require organisations, and interests, to be represented in multiple forums.

In regards to provide leadership and programme oversight the approach as described below shall be followed

1. The South East Essex Partnership will take on the role of Programme Board, providing system leadership and oversight to ensure delivery of the model, and any key challenges and risks to implementation are resolved

2. Operational design will be through both co-design and co-production at locality level, utilising where appropriate existing design teams that have been so effective to date in implementing practical on-the-ground changes to service provision
3. A forum will be developed that bridges the gap between these tiers to ensure operational challenges are addressed in a timely manner, there is a consistency of solution design where this is necessary, and there is strong cross learning arrangements in place between the eight localities to ensure best practice is implemented across the wider patch

The SEE Locality Partnership, launched in May 2018, will report into organisations governance channels where necessary, and into both Southend and Essex Health and Wellbeing Boards. Representation at this forum will be through senior executives of represented organisations to ensure the Partnership can effectively deliver against its objectives.

We will use this structure to programme manage the system transformation, including identifying available resource, system priorities and unblock issues that are impacting on delivery. We will ensure that there is cross fertilisation of all elements to ensure all stakeholders are involved in appropriate discussions, and that work is not undertaken in areas that do not align with the wider strategic vision.

The implementation will include the development of individual Locality Diagnostics and Implementation Plans, identifying the assets and deficits of the local areas, and developing plans to address these at a local level with the support of the wider system.

5. Enablers

Delivery of this model is reliant on many factors, a number of which cut across this ambition and others already in place.

It is not the desire to duplicate work, or further separate workstreams depending on strategic driver, but to bring together and align approaches to deliver the best possible outcomes.

As such a number of key enabler programmes of work will be needed to support the transformation to a new model, and where possible these will align with principles already agreed.

These principles are as outlined over the following sections

Engagement, Communications and Co-design

The development of Locality based models of care, which focus on prevention, personal empowerment and community resilience and the underlying principle of services and interventions being developed around the needs of the population, relies heavily on the assumption that local people will be involved in all levels of developing, implementing, reviewing and assessing the new models of care.

To support the development of localities the system needs appropriate resource from all organisations working to implement an engagement strategy built on

- the principles of involving, collaborating and devolving as described in the ladder of engagement – and evolution from current approaches to engagement, and
- an approach that enables system wide, and cross locality, communications and engagement where appropriate and specific locality focus to meet separate needs and requirements

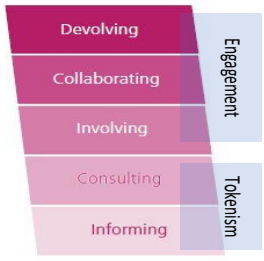
It is anticipated that shared resources are identified to address and manage these requirements and that a joint plan is developed and implemented to support the wider transformation of the system

This has been identified as a key risk to delivering any new model of care.

The 'Ladder of Engagement and Participation'

There are many different ways in which people might participate in health depending upon their personal circumstances and interest. The 'Ladder of Engagement and Participation' is a widely recognised model for understanding different forms and degrees of patient and public involvement, (based on the work of Sherry Arnstein[7]). Patient and public voice activity on every step of the ladder is valuable, although participation becomes more meaningful at the top of the ladder.

Devolving	Placing decision-making in the hands of the community and individuals. For example, Personal Health Budgets or a community development approach.
Collaborating	Working in partnership with communities and patients in each aspect of the decision, including the development of alternatives and the identification of the preferred solution.
Involving	Working directly with communities and patients to ensure that concerns and aspirations are consistently understood and considered. For example, partnership boards, reference groups and service users participating in policy groups.
Consulting	Obtaining community and individual feedback on analysis, alternatives and / or decisions. For example, surveys, door knocking, citizens' panels and focus groups.
Informing	Providing communities and individuals with balanced and objective information to assist them in understanding problems, alternatives, opportunities, solutions. For example, websites, newsletters and press releases.



Workforce

The Primary Care Strategy articulates the challenges faced within General Practice. It describes how a mix of rising demand, and an aging workforce, is leading to a situation where the capacity will not exist to meet the needs of the population under the current model of General Practice.

This is the same situation faced by social care and community health services. Continuing to operate within the boundaries of traditional roles and responsibilities will not enable the system to improve outcomes for patients

– and there is a real possibility that continuing in the same manner will not even enable the system to maintain the outcomes that it currently achieves.

Where care is needed it is important that the workforce is developed in a way where duplication is minimised – the anecdotal stories of multiple professionals visiting a patient in one day due to service 'specialisms' need to become a thing of the past.

In order to address this the system needs to move towards new roles, combining competencies so staff can address a more comprehensive range of needs, and enable best use of the resources available in the system.

This movement to new roles and ways of working will be driven from the ground up – as teams working in localities identify skills and knowledge gaps the system will work to address these rapidly through continuous training, shared across partners. Where the views from the public and frontline staff need to result in a strategic change across a wider system – for example educational bodies – this will be linked through workforce forums, such as the Local Workforce Action Board (LWAB) which has, according to Health Education England (HEE), two areas of responsibility; supporting STPs across a broad range of workforce and HR activity, and the local delivery of the HEE Mandate from the Department of Health and other key workforce priorities in line with national policies.
Its core functions form the pillars of the HEE offer to STPs and include:

- developing a clear understanding of the current and currently foreseeable future workforce – through robust workforce intelligence,
- a robust workforce strategy,
- a workforce transformation plan, and
- leadership and OD support to enable staff, patients and carers to confidently and competently lead change across pathways, organisations and systems.

The work of this strategic forum needs to be influenced by the on-the-ground learning that will come from local implementation.

Mirroring the approach of the Primary Care Strategy we have also identified a number of areas where, working as a system, we need to do more. We will need to agree how the work is co-ordinated but the local system needs to focus on

- Recruitment - we will develop system wide recruitment campaigns, including holding information evenings and running regular assessment centres for cohorts of staff. In this way, we think we will achieve a higher profile for the local system, our STP, encourage more applicants for local roles and be able to establish and 'at scale' approach to recruitment.
- Retention - we will explore the further steps we can take to encourage and enable existing staff to continue to work and contribute locally. This will include looking at incentives for key groups, better meeting development needs and identifying clearer opportunities for career progression.
- Workforce intelligence - we recognise that having clear, timely and accurate local workforce data is key if we are to plan effectively at CCG and higher at a STP level. We will work more closely with HEE, the Local Workforce Action Board and front-line staff to develop our workforce intelligence.
- New roles and job design - our new model of care relies on recruiting a wider range of staff, but also on developing new roles. In order to minimise duplication, we plan to work as a system to develop a common approach to these roles, such as standardised job descriptions, person specifications and competency frameworks.
- Role rotation - we are keen to explore how we can make all roles more attractive and rewarding. One aspect we will look at is designing roles that enable staff to move across localities and care settings. We think that such a development will lead to higher job satisfaction, improved professional development and better recruitment and retention.
- Training and development - our new model of care places considerable emphasis on all staff working to the top of their skill set. As a result, having comprehensive, ongoing training and development programmes for all staff groups will be vital.

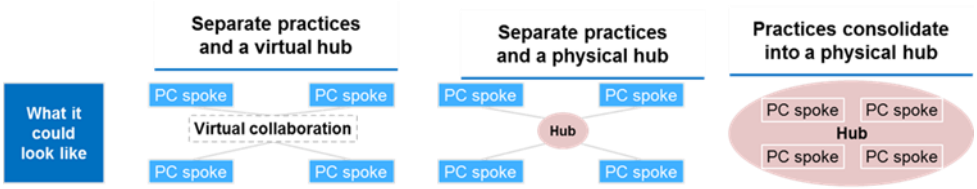
Estates

The principles of local health and care estates is consistent with the principles included in the STP Primary Care Strategy, and aligns with the recently drafted STP estates strategy.

Whilst it is anticipated that new ways of working will result in a likely change of setting for health and care interventions – ranging from self-care at home and community support, to provision of statutory services in fit for purpose estate – it is acknowledged that a significant amount of interventions will fall into the latter category.

As a starting point, all services should be provided in premises that are accessible, attractive and of high quality. But to fully deliver our new model of care we need to go further, by developing physical or virtual hubs that support locality working, provide accommodation for the staff we anticipate will deliver the model of care, enable services to be integrated and - where possible - co-located and be available for wider community level utilisation.

The Primary Care estates solution for service provision will be built around a hub and spoke model, with there being a number of possible interpretations, and it is expected that this aligns with the wider estates solutions for the local model of care.



There are a number of principles the system will work towards when developing future estates plans

- Each locality will have a Health & Social Community Care “Hub” providing integrated services including primary care, out of hospital, community, and third sector services;
- The Hub will provide services to at least 30,000 residents and must have the ability to operate 24 hours a day, seven days a week;
- The accommodation will be as flexible and generic as possible to allow an entire range of services to be delivered from it. There will be as little specialised clinical space as possible and dedicated space will be kept at a minimum;
- The precise services that are to be delivered from each Hub has yet to be defined and so, where a new facility may be required, the size of this cannot yet be determined. However, where a suitable Hub already exits, the service model may be influenced by the existing accommodation;
- If a suitable building already exists in a Locality that could be used as a Hub it must be identified as such providing it:
- Has the capacity to accommodate existing services plus a range of integrated care services;
- Is fit-for-purpose or could be made fit-for-purpose.
- Any LIFT building i.e. Canvey PCC that has a long-term lease commitment must be identified as the Locality Hub.
- Each Hub will have a number of spokes, dependant on the requirements of that locality;
- We will make best use of the available estate, such as Childrens Centres, in designing how the model will be implemented locally

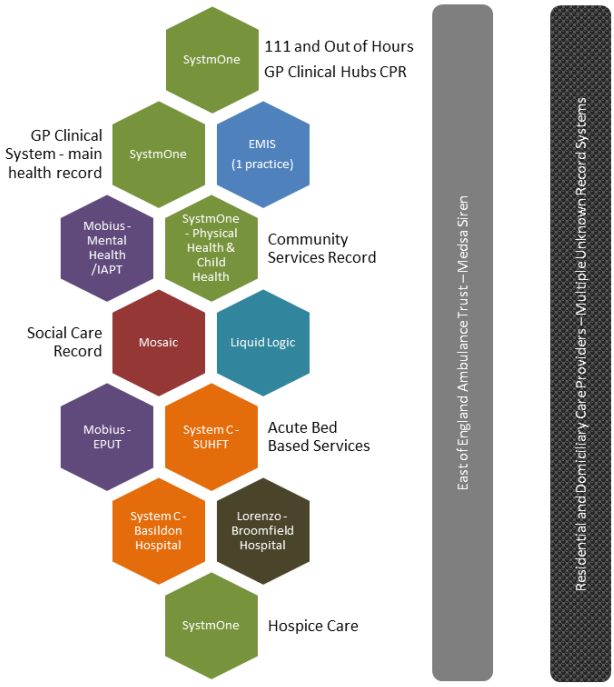
IT Systems

It is an undeniable fact that health and social care decision making is at its optimum when the professional has access to the most complete set of person specific information.

Unfortunately historic and current arrangements for commissioning and providing services have not encouraged collaboration across health and social care organisations when making decisions around IT architecture.

This has resulted in a fragmented arrangement of clinical and social care record systems, which in the main do not have the ability to interact with each other – the diagram and table below illustrates current arrangements

Area	Partner Organization	Clinical Information System
General Practice	51 practices	SystmOne (50) EMIS – 1 practice
Community Services	Essex Partnership University Trust (EPUT)	SystmOne
Secondary Care	Southend University Hospital Foundation Trust	System C *SystmOne for COPD Outpatients, Stroke and Palliative*
	Basildon and Thurrock University Hospital Foundation Trust	System C *SystmOne for Paediatrics, A&E and Pharmacy*
Mental Health	Essex Partnership University Trust (EPUT	Mobius
Ambulance Services	East of England Ambulance Trust	Medusa Siren
Hospice	Fairhaven's	SystmOne
	St Luke's	SystmOne
111	IC24	CLEO
Child Health	Essex Partnership University Trust (EPUT)	SystmOne
	Virgin	SystmOne
Out of Hours	IC24	SystmOne
Social Care	Essex County Council	Mosaic
	Southend Council	Liquid Logic (Adults and Children)
Residential and Domiciliary Care Provision	Multiple Providers	Multiple Unknown



It is essential that the system collectively identifies a way to overcome the challenges this creates. In order to do so the following principles are proposed in regards to IM&T infrastructure changes.

- IM&T changes will be driven by business or clinical need.
- New technologies may stimulate business or clinical change but will not drive it.
- Systems installed will be exploited to provide maximum benefits.
- Choice of systems will include requirements for interoperability.
- Choice of providers will include understanding their own development plans to ensure they are innovative, pro-active and in-keeping with the direction of the local system.

Digital Innovation

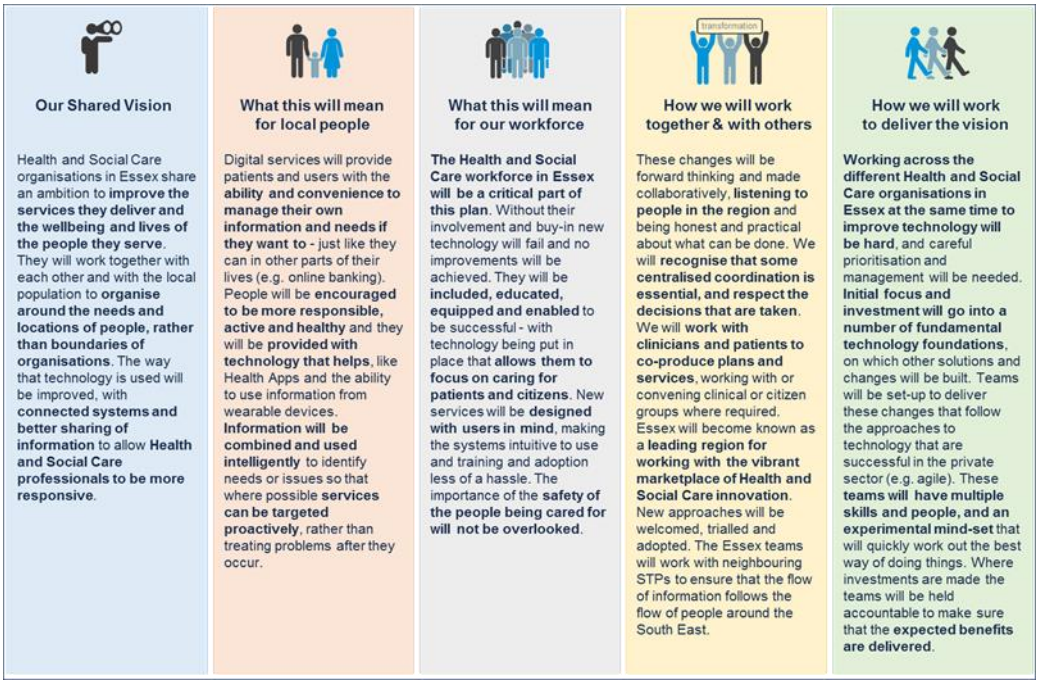
We know that the use of digital and other technologies across health and care settings as drivers for change is generally poor. In a world where people can bank, shop, arrange travel and 'socialise' through technology the offer locally to people for digital solutions to health and care needs is lacking.

There are many reasons why our uptake of digital solutions has been relatively slow. One key aspect is that there are now so many technologies and solutions available, and this makes it difficult to prioritise and sequence any roll out. A second factor is that in general decisions to purchase or roll out any particular solution rest with individual organisations, which inevitably results in a somewhat disjointed approach and makes 'at scale' decisions problematic. Thirdly, there is a recognised lack of skills and capacity in this area: we do not yet invest in roles whose prime purpose is to support practices and partners to implement digital solutions.

We know that the use of digital and other technologies will be a key enabler for our future model of care. Digital and other technologies have the potential to help with the better management of demand, create capacity

within services, reduce bureaucracy and support localities to operate at scale. We also know that to date we have made limited progress in this key area; work has been somewhat fragmented and we lack a unifying vision and architecture.

The Mid and South Essex STP Digital Strategy 2018 includes the following Digital Vision statement. This has been developed in collaboration across the whole of Mid and South Essex and all key stakeholders within south east Essex.



Our Shared Vision

Health and Social Care organisations in Essex share an ambition to **improve the services they deliver and the wellbeing and lives of the people they serve**. They will work together with each other and with the local population to **organise around the needs and locations of people, rather than boundaries of organisations**. The way that technology is used will be improved, with **connected systems and better sharing of information** to allow **Health and Social Care professionals to be more responsive**.

What this will mean for local people

Digital services will provide patients and users with the **ability and convenience to manage their own information and needs if they want to** - just like they can in other parts of their lives (e.g. online banking). People will be **encouraged to be more responsible, active and healthy** and they will be **provided with technology that helps**, like Health Apps and the ability to use information from wearable devices. **Information will be combined and used intelligently** to identify needs or issues so that where possible **services can be targeted proactively**, rather than treating problems after they occur.

What this will mean for our workforce

The Health and Social Care workforce in Essex will be a critical part of this plan. Without their involvement and buy-in new technology will fail and no improvements will be achieved. They will be **included, educated, equipped and enabled** to be successful - with technology being put in place that **allows them to focus on caring for patients and citizens**. New services will be **designed with users in mind**, making the systems intuitive to use and training and adoption less of a hassle. The importance of the **safety of the people being cared for will not be overlooked**.

How we will work together & with others

These changes will be forward thinking and made collaboratively, **listening to people in the region** and being honest and practical about what can be done. We will **recognise that some centralised coordination is essential, and respect the decisions that are taken**. We will **work with clinicians and patients to co-produce plans and services**, working with or convening clinical or citizen groups where required. Essex will become known as **a leading region for working with the vibrant marketplace of Health and Social Care innovation**. New approaches will be welcomed, trialled and adopted. The Essex teams will work with neighbouring STPs to ensure that the flow of information follows the flow of people around the South East.

How we will work to deliver the vision

Working across the different Health and Social Care organisations in Essex at the same time to improve technology will be hard, and careful prioritisation and management will be needed. **Initial focus and investment will go into a number of fundamental technology foundations**, on which other solutions and changes will be built. Teams will be set-up to deliver these changes that follow the approaches to technology that are successful in the private sector (e.g. agile). These **teams will have multiple skills and people, and an experimental mind-set** that will quickly work out the best way of doing things. Where investments are made the teams will be held accountable to make sure that the **expected benefits are delivered**.

The Primary Care Strategy also states that there are considerable opportunities to improve efficiency by taking a more systematic approach to the adoption and spread of digital technology. Without repeating the contents of this paper the following should be noted within this strategy

Digital as an enabler

It is anticipated that a number of potential solutions which, taken together, could help the system close the gap between demand and capacity. Several of these solutions are dependent upon, or would be significantly enhanced by, the systematic deployment of digital solutions. Examples include:

Managing demand

- *Self-care and community support*. These tools are well developed and have a range of applications, including apps and software that support behaviour change (for example people with diabetes) as well as providing online support for people with a wide range of conditions including anxiety and depression
- *Prediction and risk stratification*. There are a number of established tools that can support practices to risk stratify patients on their list and identify those patients that have 'rising risk'. This enables comprehensive care plans to be put in place for these individuals, enabling them to stay well for longer

Creating capacity

- *Patient pathways and treatment*. These tools can support patients and professionals to provide improved on-going care and reduce the need for regular consultations, for example through remote patient monitoring where the patient's readings are constantly logged and reported automatically, with anomalies or concerning patterns flagged to the patient and their GP

Operating at scale

- *Communication across settings*. Having access to patient level information across a range of care settings is vital, especially as patients are frequently in contact with multiple services. As well as

a core shared core record, further digital solutions now enable summary records to be held on smartphones, and for automatic communication with patients (such as appointment reminders, medication alerts etc.)

It is intended that local transformation aligns to the wider strategic intent included within the pan Essex document 'Digital Essex 2020' and the Primary Care Strategy, and that we utilise the collective voice of the South East Essex Partnership to influence these other programmes of work.

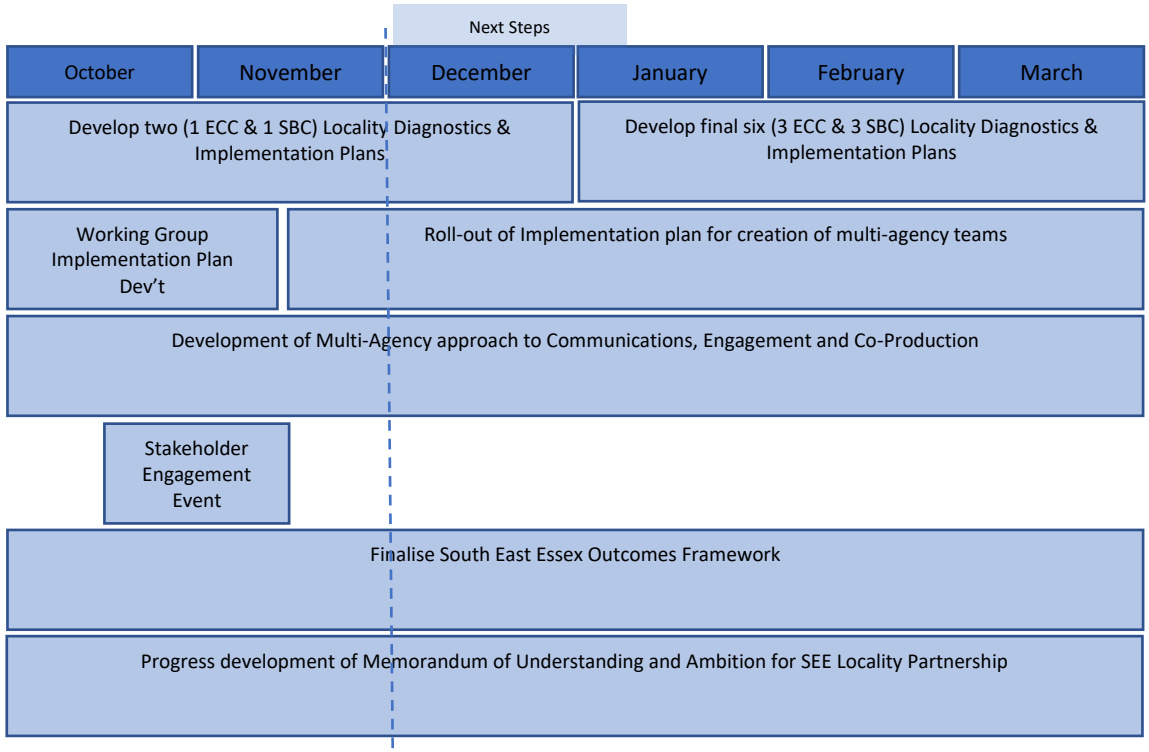
6. Next steps/timeline

As is the case with any proposed transformation stating the ambition and vision is only the first step. As has been articulated throughout this document work has been progressing locally in the absence of this single narrative.

Whole scale system change – and particularly the cultural change that is required to successfully deliver the ambition in this document – takes time, and needs to be supported by a methodical approach to delivery.

This approach will need to be organic in its nature to adapt to the changing requirements of the system, and the learning that will be developed through closer working with the populations served.

In order to ensure the programme receives the impetus required the following has been identified as key steps to be taken before the end of the current financial year, at the end of which more detailed locality specific plans are intended to be in place, and final arrangements for the necessary governance between the South East Essex Locality Partnership and front line staff are agreed



7. Appendices

Appendix 1 – Locality Needs Assessments

Better Care Fund 2019/20 Template

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a grey background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

For a more optimal view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance sheet for readability if required.

The details of each sheet within the template are outlined below.

Checklist (click to go to Checklist, included in the Cover sheet)

1. This section helps identify the data fields that have not been completed. All fields that appear as incomplete should be complete before sending to the Better Care Support Team.
2. It is sectioned out by sheet name and contains the description of the information required, cell reference for the question and the 'checker' column which updates automatically as questions within each sheet are completed.
3. The checker column will appear 'Red' and contain the word 'No' if the information has not been completed. Clicking on the corresponding 'Cell Reference' column will link to the incomplete cell for completion. Once completed the checker column will change to 'Green' and contain the word 'Yes'

4. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
5. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Complete Template'.
6. Please ensure that all boxes on the checklist are green before submission.

2. Cover (click to go to sheet)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.

2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to england.bettercaresupport@nhs.net
3. Please note that in line with fair processing of personal data we collect email addresses to communicate with key individuals from the local areas for various purposes relating to the delivery of the BCF plans including plan development, assurance, approval and provision of support.
We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.
Please let us know if any of the submitted contact information changes during the BCF planning cycle so we are able to communicate with the right people in a timely manner.

4. Strategic Narrative (click to go to sheet)

This section of the template should set out the agreed approach locally to integration of health & social care. The narratives should focus on updating existing plans, and changes since integration plans were set out until 2020 rather than reiterating them and can be short. Word limits have been applied to each section and these are indicated on the worksheet.

1. Approach to integrating care around the person. This should set out your approach to integrating health and social care around the people, particularly those with long term health and care needs. This should highlight developments since 2017 and cover areas such as prevention.
2 i. Approach to integrating services at HWB level (including any arrangements at neighbourhood level where relevant). This should set out the agreed approach and services that will be commissioned through the BCF. Where schemes are new or approaches locally have changed, you should set out a short rationale.
2 ii. DFG and wider services. This should describe your approach to integration and joint commissioning/delivery with wider services. In all cases this should include housing, and a short narrative on use of the DFG to support people with care needs to remain independent through adaptations or other capital expenditure on their homes. This should include any discretionary use of the DFG.
3. How your BCF plan and other local plans align with the wider system and support integrated approaches. Examples may include the read across to the STP (Sustainability Transformation Partnerships) or ICS (Integrated Care Systems) plan(s) for your area and any other relevant strategies.

You can attach (in the e-mail) visuals and illustrations to aid understanding if this will assist assurers in understanding your local approach.

5. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's Better Care Fund (BCF) plan and pooled budget for 2019/20. On selected the HWB from the Cover page, this sheet will be pre-populated with the minimum CCG contributions to the BCF, DFG (Disabled Facilities Grant), iBCF (improved Better Care Fund) and Winter Pressures allocations to be pooled within the BCF. These cannot be edited.
2. Please select whether any additional contributions to the BCF pool are being made from Local Authorities or the CCGs and as applicable enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources when planning expenditure. The fields for Additional contributions can be utilised to include any relevant carry-overs from the previous year.
3. Please use the comment boxes alongside to add any specific detail around this additional contribution including any relevant carry-overs assigned from previous years. All allocations are rounded to the nearest pound.
4. For any questions regarding the BCF funding allocations, please contact England.bettercaresupport@nhs.net

6. Expenditure (click to go to sheet)

This sheet should be used to set out the schemes that constitute the BCF plan for the HWB including the planned expenditure and the attributes to describe the scheme. This information is then aggregated and utilised to analyse the BCF plans nationally and sets the basis for future reporting and to particularly demonstrate that National Condition 2 and 3 are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and CCG minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.
On this sheet please enter the following information:
1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.
2. Scheme Name:
- This is a free field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.
3. Brief Description of Scheme
- This is free text field to include a brief headline description of the scheme being planned.
4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available at the end of the table (follow the link to the description section at the top of the main expenditure table).
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- While selecting schemes and sub-types, the sub-type field will be flagged in 'red' font if it is from a previously selected scheme type. In this case please clear the sub-type field and reselect from the dropdown if the subtype field is editable.
5. Planned Outputs
- The BCF Planning requirements document requires areas to set out planned outputs for certain scheme types (those which lend themselves to delivery of discrete units of delivery) to help to better understand and account for the activity funded through the BCF.
- The Planned Outputs fields will only be editable if one of the relevant scheme types is selected. Please select a relevant unit from the drop down and an estimate of the outputs expected over the year. This is a numerical field.

6. Metric Impact
- This field is collecting information on the metrics that a chem will impact on (rather than the actual planned impact on the metric)
- For the schemes being planned please select from the drop-down options of 'High-Medium-Low-n/a' to provide an indicative level of impact on the four BCF metrics. Where the scheme impacts multiple metrics, this can be expressed by selecting the appropriate level from the drop down for each of the metrics. For example, a discharge to assess scheme might have a medium impact on Delayed Transfers of Care and permanent admissions to residential care. Where the scheme is not expected to impact a metric, the 'n/a' option could be selected from the drop-down menu.
7. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "CCG minimum" then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.
8. Commissioner:
- Identify the commissioning entity for the scheme based on who commissions the scheme from the provider. If there is a single commissioner, please select the option from the drop-down list.
- Please note this field is utilised in the calculations for meeting National Condition 3.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and CCG/NHS and enter the respective percentages on the two columns alongside.
9. Provider:
- Please select the 'Provider' commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

10. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop-down list
- If the scheme is funding across multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.
11. Expenditure (£) 2019/20:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)
12. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2019/20 and will inform the understanding of planned spend for the iBCF and Winter Funding grants.

7. HICM (click to go to sheet)

National condition four of the BCF requires that areas continue to make progress in implementing the High Impact Change model for managing transfers of care and continue to work towards the centrally set expectations for reducing DToC. In the planning template, you should provide:
- An assessment of your current level of implementation against each of the 8 elements of the model – from a drop-down list
- Your planned level of implementation by the end March 2020 – again from a drop-down list

A narrative that sets out the approach to implementing the model further. The Narrative section in the HICM tab sets out further details.

8. Metrics (click to go to sheet)

This sheet should be used to set out the Health and Wellbeing Board's performance plans for each of the Better Care Fund metrics in 2019/20. The BCF requires plans to be agreed for the four metrics. This should build on planned and actual performance on these metrics in 2018/19.

1. Non-Elective Admissions (NEA) metric planning:
- BCF plans as in previous years mirror the latest CCG Operating Plans for the NEA metric. Therefore, this metric is not collected via this template.

2. Residential Admissions (RES) planning:
- This section requires inputting the information for the numerator of the measure.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care) for the Residential Admissions numerator measure.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from ONS subnational population projections.
- The annual rate is then calculated and populated based on the entered information.
- Please include a brief narrative associated with this metric plan

3. Reablement (REA) planning:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.
- Please include a brief narrative associated with this metric plan

4. Delayed Transfers of Care (DToC) planning:
- The expectations for this metric from 2018/19 are retained for 2019/20 and these are prepopulated.
- Please include a brief narrative associated with this metric plan.
- This narrative should include details of the plan, agreed between the local authority and the CCG for using the Winter Pressures grant to manage pressures on the system over Winter.

9. Planning Requirements (click to go to sheet)

This sheet requires the Health & Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2019/20 for further details.

The Key Lines of Enquiry (KLOE) underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

10. CCG-HWB Mapping (click to go to sheet)

The final sheet provides details of the CCG - HWB mapping used to calculate contributions to Health and Wellbeing Board level non-elective activity figures.

Better Care Fund 2019/20 Template

2. Cover

Version 0.1

Department of Health & Social Care

Ministry of Housing, Communities & Local Government

NHS

Please Note:
- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.
- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".
- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2019/20.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Southend-on-Sea
Completed by:	Nick Faint
E-mail:	nickfaint@gmail.com
Contact number:	01702 212 113
Who signed off the report on behalf of the Health and Wellbeing Board:	Cllr Trevor Harp
Will the HWB sign-off the plan after the submission date?	No
If yes, please indicate the date when the HWB meeting is scheduled:	

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Councillor	Trevor	Harp	cllrharp@southend.gov.uk
	Clinical Commissioning Group Accountable Officer (Lead)	n/a	Terry	Huff	t.huff@nhs.net
	Additional Clinical Commissioning Group(s) Accountable Officers	Dr	Jose	Garcia	jose.garcia@nhs.net
	Local Authority Chief Executive	n/a	Alison	Griffin	alisongriffin@southend.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)	n/a	Simon	Leftley	simonleftley@southend.gov.uk
	Better Care Fund Lead Official	n/a	Nick	Faint	nickfaint@southend.gov.uk
	LA Section 151 Officer	n/a	Joe	Chesterton	joechesterton@southend.gov.uk
Please add further area contacts that you would wish to be included in official correspondence -->					

**Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.*

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4. Strategic Narrative	Yes
5. Income	Yes
6. Expenditure	Yes
7. HICM	Yes
8. Metrics	Yes
9. Planning Requirements	Yes

<< Link to the Guidance sheet

Checklist

2. Cover

^^ Link back to top

	Cell Reference	Checker
Health & Wellbeing Board	D13	Yes
Completed by:	D15	Yes
E-mail:	D17	Yes
Contact number:	D19	Yes
Who signed off the report on behalf of the Health and Wellbeing Board:	D21	Yes
Will the HWB sign-off the plan after the submission date?	D23	Yes
If yes, please indicate the date when the HWB meeting is scheduled:	D24	Yes
Area Assurance Contact Details - Role:	C27 : C36	Yes
Area Assurance Contact Details - First name:	F27 : F36	Yes
Area Assurance Contact Details - Surname:	G27 : G36	Yes
Area Assurance Contact Details - E-mail:	H27 : H36	Yes

Sheet Complete	Yes

4. Strategic Narrative

^^ Link back to top

	Cell Reference	Checker
A) Person-centred outcomes:	B20	Yes
B) (i) Your approach to integrated services at HWB level (and neighbourhood where applicable):	B31	Yes
B) (ii) Your approach to integration with wider services (e.g. Housing):	B37	Yes
C) System level alignment:	B44	No

Sheet Complete	Yes

5. Income

^^ Link back to top

	Cell Reference	Checker
Are any additional LA Contributions being made in 2019/20?	C39	Yes
Additional Local Authority	B42 : B44	Yes
Additional LA Contribution	C42 : C44	Yes
Additional LA Contribution Narrative	D42 : D44	Yes
Are any additional CCG Contributions being made in 2019/20?	C59	Yes
Additional CCGs	B62 : B71	Yes
Additional CCG Contribution	C62 : C71	Yes
Additional CCG Contribution Narrative	D62 : D71	Yes

Sheet Complete	Yes

6. Expenditure

^^ Link back to top

	Cell Reference	Checker
Scheme ID:	B22 : B271	Yes
Scheme Name:	C22 : C271	Yes
Brief Description of Scheme:	D22 : D271	Yes
Scheme Type:	E22 : E271	Yes
Sub Types:	F22 : F271	Yes
Specify if scheme type is Other:	G22 : G271	Yes
Planned Output:	H22 : H271	Yes
Planned Output Unit Estimate:	I22 : I271	Yes
Impact: Non-Elective Admissions:	J22 : J271	Yes
Impact: Delayed Transfers of Care:	K22 : K271	Yes
Impact: Residential Admissions:	L22 : L271	Yes
Impact: Reablement:	M22 : M271	Yes
Area of Spend:	N22 : N271	Yes
Specify if area of spend is Other:	O22 : O271	Yes
Commissioner:	P22 : P271	Yes
Joint Commissioner %:	Q22 : Q271	Yes
Provider:	S22 : S271	Yes
Source of Funding:	T22 : T271	Yes
Expenditure:	U22 : U271	Yes
New/Existing Scheme:	V22 : V271	Yes

Sheet Complete	Yes

7. HICM

^^ Link back to top

	Cell Reference	Checker
Priorities for embedding elements of the HCIM for Managing Transfers of Care locally:	B11	Yes
Chg 1) Early discharge planning - Current Level:	D15	Yes
Chg 2) Systems to monitor patient flow - Current Level:	D16	Yes
Chg 3) Multi-disciplinary/Multi-agency discharge teams - Current Level:	D17	Yes
Chg 4) Home first / discharge to assess - Current Level:	D18	Yes
Chg 5) Seven-day service - Current Level:	D19	Yes
Chg 6) Trusted assessors - Current Level:	D20	Yes
Chg 7) Focus on choice - Current Level:	D21	Yes
Chg 8) Enhancing health in care homes - Current Level:	D22	Yes
Chg 1) Early discharge planning - Planned Level:	E15	Yes
Chg 2) Systems to monitor patient flow - Planned Level:	E16	Yes
Chg 3) Multi-disciplinary/Multi-agency discharge teams - Planned Level:	E17	Yes
Chg 4) Home first / discharge to assess - Planned Level:	E18	Yes
Chg 5) Seven-day service - Planned Level:	E19	Yes
Chg 6) Trusted assessors - Planned Level:	E20	Yes
Chg 7) Focus on choice - Planned Level:	E21	Yes
Chg 8) Enhancing health in care homes - Planned Level:	E22	Yes
Chg 1) Early discharge planning - Reasons:	F15	Yes
Chg 2) Systems to monitor patient flow - Reasons:	F16	Yes
Chg 3) Multi-disciplinary/Multi-agency discharge teams - Reasons:	F17	Yes
Chg 4) Home first / discharge to assess - Reasons:	F18	Yes
Chg 5) Seven-day service - Reasons:	F19	Yes
Chg 6) Trusted assessors - Reasons:	F20	Yes
Chg 7) Focus on choice - Reasons:	F21	Yes
Chg 8) Enhancing health in care homes - Reasons:	F22	Yes

Sheet Complete	Yes

8. Metrics ^^ Link back to top

	Cell Reference	Checker
Non-Elective Admissions: Overview Narrative:	E10	Yes
Delayed Transfers of Care: Overview Narrative:	E17	Yes
Residential Admissions Numerator:	F27	Yes
Residential Admissions: Overview Narrative:	G26	Yes
Reablement Numerator:	F39	Yes
Reablement Denominator:	F40	Yes
Reablement: Overview Narrative:	G38	Yes

Sheet Complete	Yes

9. Planning Requirements ^^ Link back to top

	Cell Reference	Checker
PR1: NC1: Jointly agreed plan - Plan to Meet	F8	Yes
PR2: NC1: Jointly agreed plan - Plan to Meet	F9	Yes
PR3: NC1: Jointly agreed plan - Plan to Meet	F10	Yes
PR4: NC2: Social Care Maintenance - Plan to Meet	F11	Yes
PR5: NC3: NHS commissioned Out of Hospital Services - Plan to Meet	F12	Yes
PR6: NC4: Implementation of the HICM for Managing Transfers of Care - Plan to Meet	F13	Yes
PR7: Agreed expenditure plan for all elements of the BCF - Plan to Meet	F14	Yes
PR8: Agreed expenditure plan for all elements of the BCF - Plan to Meet	F15	Yes
PR9: Metrics - Plan to Meet	F16	Yes
PR1: NC1: Jointly agreed plan - Actions in place if not	H8	Yes
PR2: NC1: Jointly agreed plan - Actions in place if not	H9	Yes
PR3: NC1: Jointly agreed plan - Actions in place if not	H10	Yes
PR4: NC2: Social Care Maintenance - Actions in place if not	H11	Yes
PR5: NC3: NHS commissioned Out of Hospital Services - Actions in place if not	H12	Yes
PR6: NC4: Implementation of the HICM for Managing Transfers of Care - Actions in place if not	H13	Yes
PR7: Agreed expenditure plan for all elements of the BCF - Actions in place if not	H14	Yes
PR8: Agreed expenditure plan for all elements of the BCF - Actions in place if not	H15	Yes
PR9: Metrics - Actions in place if not	H16	Yes
PR1: NC1: Jointly agreed plan - Timeframe if not met	I8	Yes
PR2: NC1: Jointly agreed plan - Timeframe if not met	I9	Yes
PR3: NC1: Jointly agreed plan - Timeframe if not met	I10	Yes
PR4: NC2: Social Care Maintenance - Timeframe if not met	I11	Yes
PR5: NC3: NHS commissioned Out of Hospital Services - Timeframe if not met	I12	Yes
PR6: NC4: Implementation of the HICM for Managing Transfers of Care - Timeframe if not met	I13	Yes
PR7: Agreed expenditure plan for all elements of the BCF - Timeframe if not met	I14	Yes
PR8: Agreed expenditure plan for all elements of the BCF - Timeframe if not met	I15	Yes
PR9: Metrics - Timeframe if not met	I16	Yes

Sheet Complete	Yes

^^ Link back to top

Better Care Fund 2019/20 Template

3. Summary

Selected Health and Wellbeing Board: Southend-on-Sea

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£1,516,820	£1,516,820	£0
Minimum CCG Contribution	£12,875,651	£12,875,651	£0
iBCF	£6,744,235	£6,744,235	£0
Winter Pressures Grant	£824,000	£824,000	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	£21,960,706	£21,960,706	£0

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£3,658,895
Planned spend	£6,811,808

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£6,092,959
Planned spend	£6,092,959

Scheme Types

Assistive Technologies and Equipment	£0
Care Act Implementation Related Duties	£0
Carers Services	£0
Community Based Schemes	£18,620,109
DFG Related Schemes	£1,516,820
Enablers for Integration	£0
HICM for Managing Transfer of Care	£1,488,630
Home Care or Domiciliary Care	£0
Housing Related Schemes	£0
Integrated Care Planning and Navigation	£260,987
Intermediate Care Services	£0
Personalised Budgeting and Commissioning	£0
Personalised Care at Home	£0
Prevention / Early Intervention	£74,160
Residential Placements	£0
Other	£0
Total	£21,960,706

HICM >>

		Planned level of maturity for 2019/2020
Chg 1	Early discharge planning	Exemplary
Chg 2	Systems to monitor patient flow	Exemplary
Chg 3	Multi-disciplinary/Multi-agency discharge teams	Exemplary
Chg 4	Home first / discharge to assess	Exemplary
Chg 5	Seven-day service	Mature
Chg 6	Trusted assessors	Mature
Chg 7	Focus on choice	Mature
Chg 8	Enhancing health in care homes	Mature

Metrics >>

Non-Elective Admissions
Delayed Transfer of Care

Go to Better Care Exchange >>

Residential Admissions		
		19/20 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	659.1844979

Reablement		
		19/20 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	0.8

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	PR1	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	PR4	Yes
NC3: NHS commissioned Out of Hospital Services	PR5	Yes
NC4: Implementation of the High Impact Change Model for Managing Transfers of Care	PR6	Yes
Agreed expenditure plan for all elements of the BCF	PR7	Yes
	PR8	Yes
Metrics	PR9	Yes

Better Care Fund 2019/20 Template

4. Strategic Narrative

Selected Health and Wellbeing Board: Southend-on-Sea

Please outline your approach towards integration of health & social care:

When providing your responses to the below sections, please highlight any learning from the previous planning round (2017-2019) and cover any priorities for reducing health inequalities under the Equality Act 2010.

Please note that there are 4 responses required below, for questions: A), B(i), B(ii) and C)

Link to B) (i)
Link to B) (ii)
Link to C)

A) Person-centred outcomes Your approach to integrating care around the person, this may include (but is not limited to): - Prevention and self-care - Promoting choice and independence	
Remaining Word Limit:	206

Integrating Care around the person

It is collectively agreed across the South East Essex (SEE) (which includes Southend) system that the current approach to commissioning, delivery and the subsequent monitoring of success is not conducive to supporting the development of an agreed locality approach and providing integrated care around the person. Providers often have conflicting priorities as a result of different approaches to commissioning, and no ability to obtain a system view of current and future priorities.

It is considered that a move to measuring outcomes will address the first issue – and the system is in the process of identifying how an Outcomes Framework may be structured.

It has been agreed that outcomes should be relevant to an all age, all need population and that outcomes need to reflect clinical quality and quality of service provision. Further, outcomes need to ensure the right balance is struck so that personal experience/satisfaction is achieved.

The model of care 'Living Well in Thriving Communities' outlined in the SEE Locality Strategy (see Appendix A) and designed for SEE is one that focusses on enabling people to remain independent. It is a model that moves the focus to pre-emptive and pro-active care and ensuring communities and individuals have access to the necessary assets to enable this to happen.

In addition to this ambition for the whole population it fundamentally focuses on the community as consisting of four distinct cohorts

1. Those that do not require care or support at this point in time, nor are they expected to require care or support over the next five years
2. Those that, based on a variety of factors are likely to require care and support within the next five years, and the expectation that they are identified and provided able to access solutions that either defer or delay the requirement for care
3. Those that, despite of the best intentions of the individual, their community and support network do require the support of formal services – in this instance the system collectively works to ensure they continue to live well with care and/or support in place and return to living an unsupported healthy and active life in a safe and timely manner, and
4. Those that will always need care and support who will receive services that enable them to live well regardless of the complexity of need

The Role of the Hospital

In any health and care economy the physical status of the local acute trust gives the public the impression that this is the default place to get their needs met – be it through the clinical advice of a consultant for on-going management of a long-term condition, or through the 'easy' access to medical support through the front door of the Accident and Emergency department. SEE is no exception with the model of care that has evolved being particularly acute centric – this is despite the fact that 90% of health contacts are undertaken across both primary and community care providers and outside the walls and responsibilities of the local acute provider.

The agreed model of care 'Living Well in Thriving Communities' focuses on personal and community resilience and the strengthening of support available within the community (primary, community and through social care), there is no denying that people will continue to need a level of care and support that is either best provided, or overseen, by the clinical/medical expertise available through an acute provider. The model of care however places an emphasis on both timely – and where possible pre-emptive - intervention and the pro-active return of individuals to their normal place of residence with any required on-going care and support delivered outside of a hospital ward.

For this to be successful there would be an expectation that those responsible for delivering support within the locality setting link with acute colleagues to ensure the care provided is seamless, and the drive is to ensure the individual returns to their normal place of residence in a safe and timely manner.

Principles of Collaboration

As individual organisations each partner has already stated their own vision and values. Whilst these are specific to each individual organisation, and would have been developed through wide organisational and stakeholder engagement, all organisations have common themes running through their values. Using these individual organisational values it is possible to extract a number of key principles that the system wishes to work to;

• It is accepted that the combined strength of the system is greater than the individual strengths of the organisations that make it. As such a principle of collaboration shall be adhered to across SEE to address the challenges, and deliver the model as described in this document
• Previous attempts to redesign the system have failed in part as a result of what it sometimes referred to as the 'fortress mentality' – in order to overcome this the partners will be open and honest in the interactions with each other and the populations which they serve
• Underpinning both of these is the need to be compassionate and supportive – not only towards the populations that they serve, but also to individual organisations positions. The system has a greater chance of overcoming challenges together, and accepting them as system challenges, as opposed to separate

B) HWB level

(i) Your approach to integrated services at HWB level (and neighbourhood where applicable), this may include (but is not limited to):
- Joint commissioning arrangements - Alignment with primary care services (including PCNs (Primary Care Networks)) - Alignment of services and the approach to partnership with the VCS (Voluntary and Community Sector)

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Remaining Word Limit:	82

Joint Commissioning

The agreed priorities at a senior level are informed primarily by the Southend Joint Strategic Needs Assessment (Appendix B). To repsond to the agreed priorities our system leader have agreed a model of care, for the model of care to succeed providers and commissioners are required to work jointly together in partnership. To build the required partnership a set of principles and approaches (below) have been developed. Our system approach is unpinned by the agreed SEE Locality Strategy (Appendix A) and also by an agreed system Memorandum of Understanding (MoU) (Appendix C). The MoU clearly defines the ambition for SEE and also the way in which our system leaders plan to work together. The principles and approaches underpinning both our MoU and SEE Locality Strategy are that we will be;

• ambitious – both in what we are seeking to achieve and in embracing different ways of working – such as pooled budgets, single leadership or joint teams - where it makes sense to do so
• minded to integrate services – designing services around the needs and preferences of individuals and communities, not professional or organisational silos
• put the interests of local people first – even where this poses challenges for our individual organisations
• involve people – both in designing changes we want to make and in any decisions about their care
• recognise the importance of place – and the need to develop different models and services in each of our localities, driven by local needs and preferences
• focus on delivering better outcomes – measuring the things that matter to individuals, communities and the population as a whole
• prioritise prevention, wellbeing and building resilience – supporting people to live healthy lives and remain independent for as long as possible
• transparent – sharing information openly with one another and with the public
• generous – put resources (money and/or people) into shared projects and to support one another to deliver, and in recognising that leadership may come from any part of our system
• flexible and pragmatic – recognising that different problems will require different solutions and that a wide range of partners, including the third sector, have key roles developing solutions
• enabling – strive to create the conditions within which local leaders and staff can innovate, take responsibility and 'do the right thing', regardless of which organisation they work for

To ensure a system approach is taken to partnership working Southend's Health and Wellbeing Board have convened a SEE Locality Partnership Group with the responsibility for taking the lead on integration, Locality working and system ambition.

Engagement, Communications and Co-design

The development of Locality based models of care, which focus on prevention, personal empowerment and community resilience and the underlying principle of services and interventions being developed around the needs of the population, relies heavily on the assumption that local people will be involved in all levels of developing, implementing, reviewing and assessing the new models of care.

To support the development of Localities the system needs appropriate resource from all organisations working to implement an engagement strategy built on

• the principles of involving, collaborating and devolving as described in the ladder of engagement – and evolution from current approaches to engagement, and
• an approach that enables system wide, and cross locality, communications and engagement where appropriate and specific locality focus to meet separate needs and requirements

It is anticipated that shared resources are identified to address and manage these requirements and that a joint plan is developed and implemented to support the wider transformation of the system.

This has been identified as a key risk to delivering any new model of care.

Primary Care

Primary Care presents a significant challenge across the SEE system but are critical to the succesful delivery of integrated care. Variations in service quality, challenges in recruitment and retention, an ageing workforce and poor estate add up to variations in patient outcomes and increasing demand at an acute setting.

(ii) Your approach to integration with wider services (e.g. Housing), this should include:	
- Your approach to using the DFG to support the housing needs of people with disabilities or care needs. This should include any arrangements for strategic planning for the use of adaptations and technologies to support independent living in line with the	
Remaining Word Limit:	363

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Approach to integration with wider services
Promoting independent living and enabling people to exercise choice and control over their lives are consistent themes within our Locality planning, particularly for vulnerable people.
In Southend, the council have begun a journey to work with our residents to understand what their vision is for our Borough. During the course of 2018 an intense process of engagement was undertaken which delivered a jointly / collaboratively produced vision and set out outcomes known as Southend 2050 (see Appendix D). These outcomes remind us of our resonsibility to work across organisational boundaries and that all our actions have an impact on the health and wellbeing of our residents. Examples include the impact that housing, planning, infrastructure and the environment has on the health and wellbeing of our residents.
The strategic priorities and actions aligned to the Locality plan (Appendix A) also reflect the drive towards developing personalised services, which better reflect the requirements and choices of individual service users. People are assisted to achieve and/or maintain an independent living outcome through a range of housing services: such as housing options and advice, housing-related support, adaptations and assistive technology.
Prevention is a key component of the independent living theme, especially in relation to preventing accommodation loss that requires an individual or family to move to some form of institutional living such as hostel or residential care.
The promotion of independent living will set out how the system intend to tackle some of the most chronic manifestations of the housing challenge in Southend, such as reducing the number of homeless households in temporary accommodation and rough sleeping. The approach to housing has regard for the impact that living in temporary accommodation and rough sleeping has on family life, individual health and wellbeing, and the capacity of individulas to thrive and to realise their potential.
Our approach to housing also considers how housing options and housing-related support services will contribute to the safeguarding agenda for vulnerable individuals. Plans and actions relating to modernising housing provision for groups such as older people and people with learning disabilities also reflect the aim of promoting independent living. Our approach will also consider how this modernisation agenda can contribute to wider priorities such as reducing the need for vulnerable people to live in residential care settings.
As noted above there are a multitude of factors that affect an individuals health and wellbeing. The development of our Locality model attempts to take all these factors into account and we ensure that they are continually addressed through our governance approach to the delivery of the model.

C) System level alignment, for example this may include (but is not limited to):	
- How the BCF plan and other plans align to the wider integration landscape, such as STP/ICS plans - A brief description of joint governance arrangements for the BCF plan	
Remaining Word Limit:	715

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System level alignment is critical to the delivery of our plans for integration in Southend. The Southend BCF plan is completely aligned to the NHS Long Term plan and other national planning requirements. The BCF plan has been developed in parternship with the CCG Operational Plan (Appendix E) ensuring that the priorities and responses of each are aligned.

SEE (of which Southend is a part of) is an area within the Mid and South Essex STP. Resulting from the NHS Long Term plan is the requirement for STPs to produce a 5 year strategy to outline how areas will respond to the requirements to build Integrated Care Systems (ICS) by Apr 2021. Our BCF plan is aligned to the draft 5 year strategy through the fact that both have been clinically led, both are locally owned and both have realistic workforce plans.

The STP 5 year plan clearly articulates a journey to an ICS whereas the Locality and BCF plans make this journey a reality for the residents of Southend.

Firstly, we will work at a Locality level supporting the development of Locality teams. We will support the development of a culture built through partnerships and relationships. Integrated working will be actively encouraged, safe spaces will be created through which operational staff will be able to try different initiatives, learn and evolve. The community and community assets are at the centre of this plan as is a strength based approach. The initiatives developed will be in partnership with our communities, they will directly respond to a need and will place the person at the centre. Operational relationships across the entire system will be challenged, the wider determinants of health and wellbeing will be a major consideration. Most importantly, the learning from each initiative will be understood and used to evolve the next steps.

Examples within this first level that have already been delivered are: the development of a community group to address social isolation and loneliness (West Central Locality); regular Multi-Disciplinary Team working across (all Localities); the development of the 'hub' concept (East Central and East Localities); assistive technology and care homes (West Central Locality); dementia navigators (all Localities).

Future examples include the development of a community based asset around the new St Luke's Primary Care Centre (East Central Locality).

Secondly, our senior leaders will be challenged to work in partnership at both an individual and organisational level. This will be achieved through the development of outcomes, a plan to further pool budgets, work in true partnership with providers and strengthen relationships with the community and voluntary sector. Our leaders will listen to communities, residents, patients and operational staff. Outcomes will be 'made real' for our leaders so that they can understand the impact of their collective decision making.

Governance

The local health and care work is overseen by the South East Essex Partnership Group, chaired in rotation by a senior executive from either Southend on Sea Borough Council, Essex County Council or either of the two CCGs. The Partnership Group is a collaboration between organisations working to support the population in SEE and comprising the following partners:

- Southend CCG
- Castle Point & Rochford CCG
- Southend Borough Council
- Essex County Council
- Castle Point Borough Council
- Rochford District Council
- Essex Partnership University Hospitals NHS Foundation Trust (EPUT)
- Southend University Hospital NHS Foundation Trust (SUHFT)
- Southend Association of Voluntary Services (SAVS)
- Castle Point Association of Voluntary Services (CAVS)
- North East London NHS Foundation Trust (NELFT)

Better Care Fund 2019/20 Template

5. Income

Selected Health and Wellbeing Board: Southend-on-Sea

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Southend-on-Sea	£1,516,820
DFG breakerdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£1,516,820**

iBCF Contribution	Contribution
Southend-on-Sea	£6,744,235
Total iBCF Contribution	**£6,744,235**

Winter Pressures Grant	Contribution
Southend-on-Sea	£824,000
Total Winter Pressures Grant Contribution	**£824,000**

Are any additional LA Contributions being made in 2019/20? If yes, please detail below	No

Local Authority Additional Contribution	Contribution	Comments - please use this box clarify any specific uses or sources of funding
Total Additional Local Authority Contribution	**£0**	

CCG Minimum Contribution	Contribution
NHS Southend CCG	£12,875,651
Total Minimum CCG Contribution	**£12,875,651**

Are any additional CCG Contributions being made in 2019/20? If yes, please detail below	No

Additional CCG Contribution	Contribution	Comments - please use this box clarify any specific uses or sources of funding
Total Addition CCG Contribution	**£0**	
Total CCG Contribution	**£12,875,651**	

	2019/20
Total BCF Pooled Budget	**£21,960,706**

Funding Contributions Comments
Optional for any useful detail e.g. Carry over
n/a

Better Care Fund 2019/20 Template

6. Expenditure

Selected Health and Wellbeing Board: Southend-on-Sea

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£1,516,820	£1,516,820	£0
Minimum CCG Contribution	£12,875,651	£12,875,651	£0
iBCF	£6,744,235	£6,744,235	£0
Winter Pressures Grant	£824,000	£824,000	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	£21,960,706	£21,960,706	**£0**

Required Spend	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£3,658,895	£6,811,808	£0
Adult Social Care services spend from the minimum CCG allocations	£6,092,959	£6,092,959	£0

Link to Scheme Type description

						Planned Outputs		Metric Impact			
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Planned Output Unit	Planned Output Estimate	NEA	DTOC	RES	REA
1	DFG	Adaptions	DFG Related Schemes	Adaptations				Low	Medium	Medium	Medium
2	High Impact Model	High Impact Change Model for Managing Transfer of Care	HICM for Managing Transfer of Care	Other approaches				Medium	Medium	Medium	Medium
3	iBCF Social Care	Sustaining the social care market and supporting the system to cope with	Community Based Schemes					Medium	Medium	Medium	Medium
4	Reablement, including supporting the	Reablement including supporting the Care Act	Community Based Schemes					Medium	Medium	Medium	Medium
5	Protecting Social Care	Supporting the social care provision to help maintain independence	Community Based Schemes					Medium	Medium	Medium	Medium
6	CCG Schemes	The provision of community related health services	Community Based Schemes					Medium	Medium	Medium	Medium
7	Winter Pressures	Reablement or intermediate care at home	Community Based Schemes					Medium	Medium	Medium	Medium
8	Joint Carers	integrated carers services	Community Based Schemes					Medium	Medium	Medium	Medium
9	Community Health	Integrated community services	Community Based Schemes					Medium	Medium	Medium	Medium
10	Winter Pressures	Domiciliary Care packages (not reablement)	Community Based Schemes					Medium	Medium	Medium	Medium
11	Winter Pressures	Expansion of 7 day working	Prevention / Early Intervention	Other	Social Care Worker T&Cs			Medium	Medium	Medium	Medium
12	Winter Pressures	Hospital Social Worker	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Medium	Medium	Medium	Medium
13	Winter Pressures	Hospital Dementia Navigator	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Medium	Medium	Medium	Medium

14	Winter Pressures	Integrated Discharge Manager	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Medium	Medium	Medium	Medium
15	Winter Pressures	Community Dementia Support	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Medium	Medium	Medium	Medium

^^ Link back up

Scheme Type	Description	Sub Type
Assistive Technologies and Equipment	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Digital participation services).	Telecare Wellness Services Digital Participation Services Community Based Equipment Other
Care Act Implementation Related Duties	Funding planned towards the implementation of Care Act related duties.	Deprivation of Liberty Safeguards (DoLS) Other
Carers Services	Supporting people to sustain their role as carers and reduce the likelihood of crisis. Advice, advocacy, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence. This also includes the implementation of the Care Act as a sub-type.	Carer Advice and Support Respite Services Other
Community Based Schemes	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood level (eg: Integrated Neighbourhood Teams)	
DFG Related Schemes	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes.	Adaptations Other

Enablers for Integration	Schemes that build and develop the enabling foundations of health and social care integration encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.	
High Impact Change Model for Managing Transfer of Care	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM as such, is included in this section.	Chg 1. Early Discharge Planning Chg 2. Systems to Monitor Patient Flow Chg 3. Multi-Disciplinary/Multi-Agency Discharge Teams Chg 4. Home First / Discharge to Access Chg 5. Seven-Day Services Chg 6. Trusted Assessors Chg 7. Focus on Choice Chg 8. Enhancing Health in Care Homes Other - 'Red Bag' scheme Other approaches
Home Care or Domiciliary Care	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.	
Housing Related Schemes	This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.	

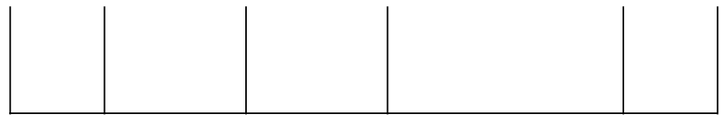
Integrated Care Planning and Navigation	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches like Single Point of Access (SPoA) and linking people to community assets. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams and the HICM for managing discharges, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.	Care Coordination Single Point of Access Care Planning, Assessment and Review Other
Intermediate Care Services	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.	Bed Based - Step Up/Down Rapid / Crisis Response Reablement/Rehabilitation Services Other

Personalised Budgeting and Commissioning	Various person centred approaches to commissioning and budgeting.	Personal Health Budgets Integrated Personalised Commissioning Direct Payments Other
Personalised Care at Home	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.	
Prevention / Early Intervention	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.	Social Prescribing Risk Stratification Choice Policy Other
Residential Placements	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.	Supported Living Learning Disability Extra Care Care Home Nursing Home Other
Other	Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.	

^^ Link back up

Expenditure								
Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
Social Care		LA			Local Authority	DFG	£1,516,820	Existing
Other	System investment	LA			Local Authority	iBCF	£1,488,630	Existing
Other	System investment	LA			Local Authority	iBCF	£5,255,605	Existing
Social Care		LA			Private Sector	Minimum CCG Contribution	£1,563,856	Existing
Social Care		LA			Local Authority	Minimum CCG Contribution	£4,470,872	Existing
Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£6,782,692	Existing
Social Care		LA			Private Sector	Winter Pressures Grant	£148,320	Existing
Social Care		Joint	50.0%	50.0%	Charity / Voluntary Sector	Minimum CCG Contribution	£58,231	Existing
Community Health		CCG			NHS Community Provider	Winter Pressures Grant	£142,773	Existing
Primary Care		LA			Private Sector	Winter Pressures Grant	£197,760	Existing
Social Care		LA			Local Authority	Winter Pressures Grant	£74,160	Existing
Social Care		LA			Local Authority	Winter Pressures Grant	£50,000	Existing
Social Care		LA			Local Authority	Winter Pressures Grant	£40,000	Existing

Social Care		LA			Local Authority	Winter Pressures Grant	£95,000	Existing
Social Care		LA			Local Authority	Winter Pressures Grant	£75,987	Existing



Better Care Fund 2019/20 Template

7. High Impact Change Model

Selected Health and Wellbeing Board: Southend-on-Sea

Explain your priorities for embedding elements of the High Impact Change Model for Managing Transfers of Care locally, including: - Current performance issues to be addressed - The changes that you are looking to embed further - including any changes in the context of commitments to reablement and Enhanced Health in Care Homes in the NHS Long-Term Plan - Anticipated improvements from this work
HICM We are delighted that our BCF plan for 2019/20 continues to support and drive our activities to integrate health with social care and support the implementation of the HICM. As we now deliver the plan for 2019 - 2020 our BCF activity will focus on further reductions in Non Elective admissions, maintaining the performance for residential care admissions achieved in the previous 2 years against a backdrop of transformational change and continuing to deliver strong

		Please enter current position of maturity	**Please enter the maturity level planned to be reached by March 2020**	**If the planned maturity level for 2019/20 is below established, please state reasons behind that?**
Chg 1	**Early discharge planning**	Mature	Exemplary	
Chg 2	**Systems to monitor patient flow**	Mature	Exemplary	
Chg 3	**Multi-disciplinary/Multi-agency discharge teams**	Mature	Exemplary	
Chg 4	**Home first / discharge to assess**	Mature	Exemplary	
Chg 5	**Seven-day service**	Established	Mature	
Chg 6	**Trusted assessors**	Established	Mature	
Chg 7	**Focus on choice**	Established	Mature	
Chg 8	**Enhancing health in care homes**	Established	Mature	

Better Care Fund 2019/20 Template

8. Metrics

Selected Health and Wellbeing Board: Southend-on-Sea

8.1 Non-Elective Admissions

	19/20 Plan	Overview Narrative
Total number of specific acute non-elective spells per 100,000 population	**Collection of the NEA metric plans via this template is not required** as the BCF NEA metric plans are based on the NEA CCG Operating plans submitted via SDCS.	The STP Strategic Urgent & Emergency Care Board oversees the delivery of improvements in urgent and emergency care provision, as well as transformation programmes to deliver alternatives to A&E, admissions avoidance, improved flow and effective discharge. To deliver the requirements of 2019/20 planning guidance, the focus of work is to: Continuing improvements in 111 provision – ensuring >50% of appropriate callers receive a clinical assessment and increasing the number of triaged patients who are

Plans are yet to be finalised and signed-off so are subject to change; **for the latest version of the NEA CCG operating plans at your HWB foot** in the first instance or write in to the support inbox:
ENGLAND.bettercaresupport@nhs.net

8.2 Delayed Transfers of Care

	19/20 Plan	Overview Narrative
Delayed Transfers of Care per day (daily delays) from hospital (aged 18+)	11.8	The detailed planning has been completed for 2019-20 prior to the submission of this plan and is aligned to the delivery of the HICM. The targets for 2019/19 have been provisionally set and aligned to the national DToC standards set via the BCF planning guidance. Southend has an extremely strong performance regarding DToC which is underpinned by strong partnership, integrated working and capacity / resource in the community. For example, during the course of 18/19 iBCF funded an investment for an Integrated Discharge Manager who was responsible for ensuring a co-ordinated discharge for complex cases as well as encouraging organisations involved in discharge to be part of a system change. Additionally iBCF has funded social work presence at the front door of

Please note that the plan figure for Greater Manchester has been combined, for HWBs in Greater Manchester please comment on individuals
Please note that due to the merger of Bournemouth, Christchurch and Poole to a new Local Authority will mean that planning information fro

8.3 Residential Admissions

		18/19 Plan	19/20 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	613	659	The Southend Outturn for 2018-19 was a rate 686 which was higher than our target. Reasons for this are currently being reviewed but the overlying demographics and increasing pressures in the acute environment are the underpinning reasons. Actions have been agreed resulting in a target for 2019-20 as outlined in the cell opposite.
	Numerator	215	238	
	Denominator	35,097	36,105	

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (
year using the 2016 based Sub-National Population Projections for Local Authorities in England;

Please note that due to the merger of the Bournemouth, Christchurch and Poole Local Authorities, this will mean that planning information fr

8.4 Reablement

		18/19 Plan	19/20 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	88.0%	80.0%	The Southend Outturn for 2018-19 was 61.1% which was significantly lower than our target. Reasons for this are currently being reviewed but also complex. Social Care have recently moved to a different case management system and also recommissioned reablement providers which has had a detrimental impact on reablement
	Numerator	88	80	
	Denominator	100	100	

Please note that due to the merger of the Bournemouth, Christchurch and Poole Local Authorities, this will mean that planning information fr

Please set out the overall plan in the HWB area for reducing Non-Elective Admissions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

:print please contact your local Better Care Manager (BCM)

Please set out the overall plan in the HWB area for reducing Delayed Transfers of Care to meet expectations set for your area. This should include any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric. Include in this, your agreed plan for using the Winter Pressures grant funding to support the local health and care system to manage demand pressures on the NHS, with particular reference to seasonal winter pressures.

HWBs rather than Greater Manchester as a whole.
m 2018/19 will not reflect the present geographies.

Please set out the overall plan in the HWB area for reducing rates of admission to residential and nursing homes for people over the age of 65, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

aged 65+) population projections are based on a calendar

om 2018/19 will not reflect the present geographies.

Please set out the overall plan in the HWB area for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

om 2018/19 will not reflect the present geographies.

Better Care Fund 2019/20 Template

9. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Southend-on-Sea

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)
NC1: Jointly agreed plan	PR1	**A jointly developed and agreed plan that all parties sign up to**	**Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted?** Has the HWB approved the plan/delegated approval pending its next meeting? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Do the governance arrangements described support collaboration and integrated care? Where the strategic narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure, metric and HICM sections of the plan been submitted for each HWB concerned?
	PR2	**A clear narrative for the integration of health and social care**	**Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that covers:** - Person centred care, including approaches to delivering joint assessments, promoting choice, independence and personalised care? - A clear approach at HWB level for integrating services that supports the overall approach to integrated care and confirmation that the approach supports delivery at the interface between health and social care? - A description of how the local BCF plan and other integration plans e.g. STP/ICSs align? - Is there a description of how the plan will contribute to reducing health inequalities (as per section 4 of the Health and Social Care Act) and to reduce inequalities for people with protected characteristics under the Equality Act 2010? This should include confirmation that equality impacts of the local BCF plan have been considered, a description of local priorities related to health inequality and equality that the BCF plan will contribute to addressing. Has the plan summarised any changes from the previous planning period? And noted (where appropriate) any lessons learnt?
	PR3	**A strategic, joined up plan for DFG spending**	**Is there confirmation that use of DFG has been agreed with housing authorities?** Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home. In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory Disabled Facilities Grants? or - The funding been passed in its entirety to district councils?
NC2: Social Care Maintenance	PR4	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the CCG minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?
NC3: NHS commissioned Out of Hospital Services	PR5	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	Does the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?
NC4: Implementation of the High Impact Change Model for Managing Transfers of Care	PR6	**Is there a plan for implementing the High Impact Change Model for managing transfers of care?**	**Does the BCF plan demonstrate a continued plan in place for implementing the High Impact Change Model for Managing Transfers of Care?** Has the area confirmed the current level of implementation and the planned level at March 2020 for all eight changes? Is there an accompanying overall narrative setting out the priorities and approach for ongoing implementation of the HICM? Does the level of ambition set out for implementing the HICM changes correspond to performance challenges in the system? If the current level of implementation is below established for any of the HICM changes, has the plan included a clear explanation and set of actions towards establishing the change as soon as possible in 2019-20?

Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	Have the planned schemes been assigned to the metrics they are aiming to make an impact on? Expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (tick-box) Is there an agreed plan for use of the Winter Pressures grant that sets out how the money will be used to address expected demand pressures on the Health system over Winter? **Has funding for the following from the CCG contribution been identified for the area?** - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?
	PR8	**Indication of outputs for specified scheme types**	Has the area set out the outputs corresponding to the planned scheme types (Note that this is only for where any of the specified set of scheme types requiring outputs are planned)? (auto-validated)
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric? Is there a proportionate range of scheme types and spend included in the expenditure section of the plan to support delivery of the metric ambitions for each of the metrics? Do the narrative plans for each metric set out clear and ambitious approaches to delivering improvements? **Have stretching metrics been agreed locally for:** - Metric 2: Long term admission to residential and nursing care homes - Metric 3: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement

Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
Yes	The Southend BCF plan is a mechanism through which our system can deliver integrated services and improve outcomes for the residents of Southend. The detail plan is contained		
Yes	The Southend BCF plan is a mechanism through which our system can deliver integrated services and improve outcomes for the residents of Southend. The detail plan is contained within both our Localities and Primary Care Networks and to suppor this plan; these are the JSNA, The SEE Locality		
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CCG to Health and Well-Being Board Mapping for 2019/20

HWB Code	LA Name	CCG Code	CCG Name	% CCG in HWB	% HWB in CCG
E09000002	Barking and Dagenham	07L	NHS Barking and Dagenham CCG	90.7%	87.4%
E09000002	Barking and Dagenham	08F	NHS Havering CCG	6.9%	8.3%
E09000002	Barking and Dagenham	08M	NHS Newham CCG	0.4%	0.6%
E09000002	Barking and Dagenham	08N	NHS Redbridge CCG	2.5%	3.5%
E09000002	Barking and Dagenham	08W	NHS Waltham Forest CCG	0.1%	0.1%
E09000003	Barnet	07M	NHS Barnet CCG	91.1%	92.1%
E09000003	Barnet	07P	NHS Brent CCG	2.0%	1.8%
E09000003	Barnet	07R	NHS Camden CCG	1.0%	0.7%
E09000003	Barnet	09A	NHS Central London (Westminster) CCG	0.2%	0.1%
E09000003	Barnet	07X	NHS Enfield CCG	3.0%	2.4%
E09000003	Barnet	08C	NHS Hammersmith and Fulham CCG	0.3%	0.2%
E09000003	Barnet	08D	NHS Haringey CCG	2.2%	1.6%
E09000003	Barnet	08E	NHS Harrow CCG	1.2%	0.8%
E09000003	Barnet	06N	NHS Herts Valleys CCG	0.0%	0.1%
E09000003	Barnet	08H	NHS Islington CCG	0.2%	0.1%
E09000003	Barnet	08Y	NHS West London (K&C & QPP) CCG	0.2%	0.1%
E08000016	Barnsley	02P	NHS Barnsley CCG	94.6%	98.1%
E08000016	Barnsley	02X	NHS Doncaster CCG	0.3%	0.4%
E08000016	Barnsley	03A	NHS Greater Huddersfield CCG	0.2%	0.2%
E08000016	Barnsley	03L	NHS Rotherham CCG	0.3%	0.3%
E08000016	Barnsley	03N	NHS Sheffield CCG	0.2%	0.4%
E08000016	Barnsley	03R	NHS Wakefield CCG	0.4%	0.6%
E06000022	Bath and North East Somerset	11E	NHS Bath and North East Somerset CCG	93.5%	98.3%
E06000022	Bath and North East Somerset	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	0.2%	0.9%
E06000022	Bath and North East Somerset	11X	NHS Somerset CCG	0.2%	0.5%
E06000022	Bath and North East Somerset	99N	NHS Wiltshire CCG	0.1%	0.3%
E06000055	Bedford	06F	NHS Bedfordshire CCG	37.7%	97.4%
E06000055	Bedford	06H	NHS Cambridgeshire and Peterborough CCG	0.4%	1.9%
E06000055	Bedford	04G	NHS Nene CCG	0.2%	0.6%
E09000004	Bexley	07N	NHS Bexley CCG	93.4%	89.8%
E09000004	Bexley	07Q	NHS Bromley CCG	0.1%	0.1%
E09000004	Bexley	09J	NHS Dartford, Gravesham and Swanley CCG	1.4%	1.5%
E09000004	Bexley	08A	NHS Greenwich CCG	7.2%	8.4%
E09000004	Bexley	08L	NHS Lewisham CCG	0.1%	0.1%
E08000025	Birmingham	15E	NHS Birmingham and Solihull CCG	78.4%	81.7%
E08000025	Birmingham	05C	NHS Dudley CCG	0.2%	0.0%
E08000025	Birmingham	05J	NHS Redditch and Bromsgrove CCG	3.1%	0.4%
E08000025	Birmingham	05L	NHS Sandwell and West Birmingham CCG	39.2%	17.8%
E08000025	Birmingham	05Y	NHS Walsall CCG	0.5%	0.1%
E06000008	Blackburn with Darwen	00Q	NHS Blackburn with Darwen CCG	88.9%	95.8%
E06000008	Blackburn with Darwen	00T	NHS Bolton CCG	1.2%	2.3%
E06000008	Blackburn with Darwen	00V	NHS Bury CCG	0.2%	0.2%
E06000008	Blackburn with Darwen	01A	NHS East Lancashire CCG	0.7%	1.7%
E06000009	Blackpool	00R	NHS Blackpool CCG	86.4%	97.6%
E06000009	Blackpool	02M	NHS Fylde & Wyre CCG	2.1%	2.4%
E08000001	Bolton	00T	NHS Bolton CCG	97.3%	97.5%
E08000001	Bolton	00V	NHS Bury CCG	1.5%	1.0%
E08000001	Bolton	00X	NHS Chorley and South Ribble CCG	0.2%	0.1%
E08000001	Bolton	01G	NHS Salford CCG	0.6%	0.5%
E08000001	Bolton	02H	NHS Wigan Borough CCG	0.8%	0.9%
E06000058	Bournemouth, Christchurch and Poole	11J	NHS Dorset CCG	52.4%	99.7%
E06000058	Bournemouth, Christchurch and Poole	11A	NHS West Hampshire CCG	0.2%	0.3%
E06000036	Bracknell Forest	15A	NHS Berkshire West CCG	0.5%	2.0%
E06000036	Bracknell Forest	15D	NHS East Berkshire CCG	26.1%	96.9%
E06000036	Bracknell Forest	99M	NHS North East Hampshire and Farnham CCG	0.6%	1.0%
E06000036	Bracknell Forest	10C	NHS Surrey Heath CCG	0.2%	0.1%
E08000032	Bradford	02N	NHS Airedale, Wharfdale and Craven CCG	67.2%	18.4%
E08000032	Bradford	02W	NHS Bradford City CCG	98.9%	23.9%
E08000032	Bradford	02R	NHS Bradford Districts CCG	98.0%	56.3%
E08000032	Bradford	02T	NHS Calderdale CCG	0.2%	0.0%
E08000032	Bradford	15F	NHS Leeds CCG	0.9%	1.4%
E08000032	Bradford	03J	NHS North Kirklees CCG	0.2%	0.0%

E09000005	Brent	07M	NHS Barnet CCG	2.3%	2.4%
E09000005	Brent	07P	NHS Brent CCG	89.7%	86.4%
E09000005	Brent	07R	NHS Camden CCG	3.9%	2.8%
E09000005	Brent	09A	NHS Central London (Westminster) CCG	1.3%	0.7%
E09000005	Brent	07W	NHS Ealing CCG	0.5%	0.6%
E09000005	Brent	08C	NHS Hammersmith and Fulham CCG	0.6%	0.4%
E09000005	Brent	08E	NHS Harrow CCG	5.9%	4.0%
E09000005	Brent	08Y	NHS West London (K&C & QPP) CCG	4.3%	2.7%
E06000043	Brighton and Hove	09D	NHS Brighton and Hove CCG	97.9%	99.7%
E06000043	Brighton and Hove	09G	NHS Coastal West Sussex CCG	0.1%	0.2%
E06000043	Brighton and Hove	99K	NHS High Weald Lewes Havens CCG	0.3%	0.1%
E06000023	Bristol, City of	11E	NHS Bath and North East Somerset CCG	0.1%	0.0%
E06000023	Bristol, City of	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	49.3%	100.0%
E09000006	Bromley	07N	NHS Bexley CCG	0.2%	0.1%
E09000006	Bromley	07Q	NHS Bromley CCG	94.6%	95.1%
E09000006	Bromley	07V	NHS Croydon CCG	1.2%	1.4%
E09000006	Bromley	08A	NHS Greenwich CCG	1.4%	1.2%
E09000006	Bromley	08C	NHS Hammersmith and Fulham CCG	0.1%	0.0%
E09000006	Bromley	08K	NHS Lambeth CCG	0.1%	0.2%
E09000006	Bromley	08L	NHS Lewisham CCG	1.9%	1.8%
E09000006	Bromley	99J	NHS West Kent CCG	0.1%	0.2%

E10000002	Buckinghamshire	06F	NHS Bedfordshire CCG	0.6%	0.5%
E10000002	Buckinghamshire	14Y	NHS Buckinghamshire CCG	94.4%	94.9%
E10000002	Buckinghamshire	15D	NHS East Berkshire CCG	1.4%	1.2%
E10000002	Buckinghamshire	06N	NHS Herts Valleys CCG	1.2%	1.4%
E10000002	Buckinghamshire	08G	NHS Hillingdon CCG	0.7%	0.4%
E10000002	Buckinghamshire	04F	NHS Milton Keynes CCG	1.3%	0.7%
E10000002	Buckinghamshire	04G	NHS Nene CCG	0.1%	0.2%
E10000002	Buckinghamshire	10Q	NHS Oxfordshire CCG	0.6%	0.7%
E08000002	Bury	00T	NHS Bolton CCG	0.8%	1.2%
E08000002	Bury	00V	NHS Bury CCG	94.0%	94.3%
E08000002	Bury	01A	NHS East Lancashire CCG	0.0%	0.2%
E08000002	Bury	01D	NHS Heywood, Middleton and Rochdale CCG	0.4%	0.5%
E08000002	Bury	14L	NHS Manchester CCG	0.6%	2.0%
E08000002	Bury	01G	NHS Salford CCG	1.4%	1.9%
E08000033	Calderdale	02R	NHS Bradford Districts CCG	0.4%	0.6%
E08000033	Calderdale	02T	NHS Calderdale CCG	98.4%	98.9%
E08000033	Calderdale	03A	NHS Greater Huddersfield CCG	0.3%	0.3%
E08000033	Calderdale	01D	NHS Heywood, Middleton and Rochdale CCG	0.1%	0.1%
E10000003	Cambridgeshire	06F	NHS Bedfordshire CCG	1.1%	0.7%
E10000003	Cambridgeshire	06H	NHS Cambridgeshire and Peterborough CCG	71.8%	96.7%
E10000003	Cambridgeshire	06K	NHS East and North Hertfordshire CCG	0.8%	0.7%
E10000003	Cambridgeshire	99D	NHS South Lincolnshire CCG	0.3%	0.0%
E10000003	Cambridgeshire	07H	NHS West Essex CCG	0.2%	0.1%
E10000003	Cambridgeshire	07J	NHS West Norfolk CCG	1.6%	0.4%
E10000003	Cambridgeshire	07K	NHS West Suffolk CCG	4.0%	1.4%
E09000007	Camden	07M	NHS Barnet CCG	0.2%	0.3%
E09000007	Camden	07P	NHS Brent CCG	1.3%	1.9%
E09000007	Camden	07R	NHS Camden CCG	83.9%	88.9%
E09000007	Camden	09A	NHS Central London (Westminster) CCG	5.6%	4.8%
E09000007	Camden	08C	NHS Hammersmith and Fulham CCG	0.4%	0.3%
E09000007	Camden	08D	NHS Haringey CCG	0.5%	0.6%
E09000007	Camden	08H	NHS Islington CCG	3.2%	3.0%
E09000007	Camden	08Y	NHS West London (K&C & QPP) CCG	0.3%	0.2%
E06000056	Central Bedfordshire	06F	NHS Bedfordshire CCG	56.6%	95.0%
E06000056	Central Bedfordshire	14Y	NHS Buckinghamshire CCG	0.8%	1.5%
E06000056	Central Bedfordshire	06K	NHS East and North Hertfordshire CCG	0.3%	0.6%
E06000056	Central Bedfordshire	06N	NHS Herts Valleys CCG	0.4%	0.9%
E06000056	Central Bedfordshire	06P	NHS Luton CCG	2.3%	1.9%
E06000056	Central Bedfordshire	04F	NHS Milton Keynes CCG	0.1%	0.1%
E06000049	Cheshire East	15M	NHS Derby and Derbyshire CCG	0.1%	0.3%
E06000049	Cheshire East	01C	NHS Eastern Cheshire CCG	96.4%	50.2%
E06000049	Cheshire East	05G	NHS North Staffordshire CCG	1.1%	0.6%
E06000049	Cheshire East	01R	NHS South Cheshire CCG	98.6%	45.8%
E06000049	Cheshire East	01W	NHS Stockport CCG	1.6%	1.2%
E06000049	Cheshire East	02A	NHS Trafford CCG	0.2%	0.1%
E06000049	Cheshire East	02D	NHS Vale Royal CCG	0.6%	0.2%
E06000049	Cheshire East	02E	NHS Warrington CCG	0.7%	0.4%
E06000049	Cheshire East	02F	NHS West Cheshire CCG	1.9%	1.2%
E06000050	Cheshire West and Chester	01C	NHS Eastern Cheshire CCG	1.2%	0.7%
E06000050	Cheshire West and Chester	01F	NHS Halton CCG	0.2%	0.0%
E06000050	Cheshire West and Chester	01R	NHS South Cheshire CCG	0.5%	0.2%
E06000050	Cheshire West and Chester	02D	NHS Vale Royal CCG	99.4%	29.5%
E06000050	Cheshire West and Chester	02E	NHS Warrington CCG	0.4%	0.3%
E06000050	Cheshire West and Chester	02F	NHS West Cheshire CCG	96.9%	69.1%
E06000050	Cheshire West and Chester	12F	NHS Wirral CCG	0.3%	0.3%
E09000001	City of London	07R	NHS Camden CCG	0.2%	7.0%
E09000001	City of London	09A	NHS Central London (Westminster) CCG	0.1%	2.5%
E09000001	City of London	07T	NHS City and Hackney CCG	1.8%	70.4%
E09000001	City of London	08C	NHS Hammersmith and Fulham CCG	0.0%	1.2%
E09000001	City of London	08H	NHS Islington CCG	0.1%	3.6%
E09000001	City of London	08V	NHS Tower Hamlets CCG	0.4%	15.0%
E09000001	City of London	08Y	NHS West London (K&C & QPP) CCG	0.0%	0.2%
E06000052	Cornwall & Scilly	15N	NHS Devon CCG	0.3%	0.6%
E06000052	Cornwall & Scilly	11N	NHS Kernow CCG	99.7%	99.4%
E06000047	County Durham	00D	NHS Durham Dales, Easington and Sedgefield CCG	97.0%	52.4%
E06000047	County Durham	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.1%	0.0%
E06000047	County Durham	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.1%	0.0%

E06000047	County Durham	13T	NHS Newcastle Gateshead CCG	0.7%	0.7%
E06000047	County Durham	00J	NHS North Durham CCG	96.7%	46.3%
E06000047	County Durham	00P	NHS Sunderland CCG	1.2%	0.6%
E08000026	Coventry	05A	NHS Coventry and Rugby CCG	74.5%	99.8%
E08000026	Coventry	05H	NHS Warwickshire North CCG	0.4%	0.2%
E09000008	Croydon	07Q	NHS Bromley CCG	1.6%	1.3%
E09000008	Croydon	07V	NHS Croydon CCG	95.3%	93.2%
E09000008	Croydon	09L	NHS East Surrey CCG	2.9%	1.3%
E09000008	Croydon	08C	NHS Hammersmith and Fulham CCG	0.2%	0.0%
E09000008	Croydon	08K	NHS Lambeth CCG	3.0%	3.0%
E09000008	Croydon	08R	NHS Merton CCG	0.8%	0.4%
E09000008	Croydon	08T	NHS Sutton CCG	0.8%	0.4%
E09000008	Croydon	08X	NHS Wandsworth CCG	0.5%	0.5%

E10000006	Cumbria	01K	NHS Morecambe Bay CCG	54.0%	36.6%
E10000006	Cumbria	01H	NHS North Cumbria CCG	99.9%	63.4%
E06000005	Darlington	00C	NHS Darlington CCG	98.2%	96.1%
E06000005	Darlington	00D	NHS Durham Dales, Easington and Sedgefield CCG	1.2%	3.2%
E06000005	Darlington	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.1%	0.2%
E06000005	Darlington	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.6%
E06000015	Derby	15M	NHS Derby and Derbyshire CCG	26.5%	100.0%
E10000007	Derbyshire	02Q	NHS Bassetlaw CCG	0.2%	0.0%
E10000007	Derbyshire	15M	NHS Derby and Derbyshire CCG	70.9%	92.6%
E10000007	Derbyshire	05D	NHS East Staffordshire CCG	7.9%	1.4%
E10000007	Derbyshire	01C	NHS Eastern Cheshire CCG	0.3%	0.0%
E10000007	Derbyshire	04E	NHS Mansfield and Ashfield CCG	2.1%	0.5%
E10000007	Derbyshire	04L	NHS Nottingham North and East CCG	0.3%	0.0%
E10000007	Derbyshire	04M	NHS Nottingham West CCG	5.1%	0.6%
E10000007	Derbyshire	03N	NHS Sheffield CCG	0.5%	0.4%
E10000007	Derbyshire	01W	NHS Stockport CCG	0.1%	0.0%
E10000007	Derbyshire	01Y	NHS Tameside and Glossop CCG	13.9%	4.3%
E10000007	Derbyshire	04V	NHS West Leicestershire CCG	0.5%	0.2%
E10000008	Devon	15N	NHS Devon CCG	65.7%	99.2%
E10000008	Devon	11J	NHS Dorset CCG	0.3%	0.3%
E10000008	Devon	11N	NHS Kernow CCG	0.3%	0.2%
E10000008	Devon	11X	NHS Somerset CCG	0.4%	0.3%
E08000017	Doncaster	02P	NHS Barnsley CCG	0.3%	0.3%
E08000017	Doncaster	02Q	NHS Bassetlaw CCG	1.5%	0.6%
E08000017	Doncaster	02X	NHS Doncaster CCG	96.8%	97.8%
E08000017	Doncaster	03L	NHS Rotherham CCG	1.5%	1.2%
E08000017	Doncaster	03R	NHS Wakefield CCG	0.1%	0.2%
E06000059	Dorset	11J	NHS Dorset CCG	46.0%	95.6%
E06000059	Dorset	11X	NHS Somerset CCG	0.6%	0.9%
E06000059	Dorset	11A	NHS West Hampshire CCG	1.7%	2.5%
E06000059	Dorset	99N	NHS Wiltshire CCG	0.7%	1.0%
E08000027	Dudley	15E	NHS Birmingham and Solihull CCG	0.1%	0.6%
E08000027	Dudley	05C	NHS Dudley CCG	93.3%	90.7%
E08000027	Dudley	05L	NHS Sandwell and West Birmingham CCG	3.9%	6.9%
E08000027	Dudley	06A	NHS Wolverhampton CCG	1.8%	1.5%
E08000027	Dudley	06D	NHS Wyre Forest CCG	0.8%	0.3%
E09000009	Ealing	07P	NHS Brent CCG	1.8%	1.6%
E09000009	Ealing	09A	NHS Central London (Westminster) CCG	0.2%	0.1%
E09000009	Ealing	07W	NHS Ealing CCG	86.9%	90.4%
E09000009	Ealing	08C	NHS Hammersmith and Fulham CCG	5.5%	3.1%
E09000009	Ealing	08E	NHS Harrow CCG	0.4%	0.3%
E09000009	Ealing	08G	NHS Hillingdon CCG	0.7%	0.5%
E09000009	Ealing	07Y	NHS Hounslow CCG	4.7%	3.5%
E09000009	Ealing	08Y	NHS West London (K&C & QPP) CCG	0.7%	0.4%
E06000011	East Riding of Yorkshire	02Y	NHS East Riding of Yorkshire CCG	97.3%	85.1%
E06000011	East Riding of Yorkshire	03F	NHS Hull CCG	9.2%	7.9%
E06000011	East Riding of Yorkshire	03M	NHS Scarborough and Ryedale CCG	0.7%	0.2%
E06000011	East Riding of Yorkshire	03Q	NHS Vale of York CCG	6.6%	6.8%
E10000011	East Sussex	09D	NHS Brighton and Hove CCG	1.0%	0.6%
E10000011	East Sussex	09F	NHS Eastbourne, Hailsham and Seaford CCG	100.0%	34.7%
E10000011	East Sussex	09P	NHS Hastings and Rother CCG	99.7%	33.3%
E10000011	East Sussex	99K	NHS High Weald Lewes Havens CCG	98.1%	29.6%
E10000011	East Sussex	09X	NHS Horsham and Mid Sussex CCG	2.8%	1.2%
E10000011	East Sussex	99J	NHS West Kent CCG	0.8%	0.7%
E09000010	Enfield	07M	NHS Barnet CCG	1.0%	1.2%
E09000010	Enfield	07T	NHS City and Hackney CCG	0.1%	0.1%
E09000010	Enfield	06K	NHS East and North Hertfordshire CCG	0.3%	0.6%
E09000010	Enfield	07X	NHS Enfield CCG	95.2%	90.9%
E09000010	Enfield	08C	NHS Hammersmith and Fulham CCG	0.1%	0.0%
E09000010	Enfield	08D	NHS Haringey CCG	7.7%	6.9%
E09000010	Enfield	06N	NHS Herts Valleys CCG	0.1%	0.2%
E09000010	Enfield	08H	NHS Islington CCG	0.2%	0.1%
E10000012	Essex	07L	NHS Barking and Dagenham CCG	0.1%	0.0%
E10000012	Essex	99E	NHS Basildon and Brentwood CCG	99.8%	18.2%
E10000012	Essex	06H	NHS Cambridgeshire and Peterborough CCG	0.1%	0.0%
E10000012	Essex	99F	NHS Castle Point and Rochford CCG	95.2%	11.5%
E10000012	Essex	06K	NHS East and North Hertfordshire CCG	1.6%	0.6%

E10000012	Essex	08F	NHS Havering CCG	0.3%	0.0%
E10000012	Essex	06L	NHS Ipswich and East Suffolk CCG	0.2%	0.0%
E10000012	Essex	06Q	NHS Mid Essex CCG	100.0%	25.5%
E10000012	Essex	06T	NHS North East Essex CCG	98.6%	22.7%
E10000012	Essex	08N	NHS Redbridge CCG	2.9%	0.6%
E10000012	Essex	99G	NHS Southend CCG	3.3%	0.4%
E10000012	Essex	07G	NHS Thurrock CCG	1.4%	0.2%
E10000012	Essex	08W	NHS Waltham Forest CCG	0.5%	0.1%
E10000012	Essex	07H	NHS West Essex CCG	97.1%	19.8%
E10000012	Essex	07K	NHS West Suffolk CCG	2.3%	0.4%

E08000037	Gateshead	13T	NHS Newcastle Gateshead CCG	38.5%	97.7%
E08000037	Gateshead	00J	NHS North Durham CCG	0.9%	1.2%
E08000037	Gateshead	00L	NHS Northumberland CCG	0.5%	0.8%
E08000037	Gateshead	00N	NHS South Tyneside CCG	0.3%	0.2%
E08000037	Gateshead	00P	NHS Sunderland CCG	0.0%	0.1%
E10000013	Gloucestershire	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	0.1%	0.1%
E10000013	Gloucestershire	11M	NHS Gloucestershire CCG	97.6%	98.6%
E10000013	Gloucestershire	05F	NHS Herefordshire CCG	0.5%	0.1%
E10000013	Gloucestershire	10Q	NHS Oxfordshire CCG	0.2%	0.2%
E10000013	Gloucestershire	05R	NHS South Warwickshire CCG	0.6%	0.2%
E10000013	Gloucestershire	05T	NHS South Worcestershire CCG	1.1%	0.5%
E10000013	Gloucestershire	99N	NHS Wiltshire CCG	0.2%	0.2%
E09000011	Greenwich	07N	NHS Bexley CCG	5.1%	4.2%
E09000011	Greenwich	07Q	NHS Bromley CCG	1.1%	1.3%
E09000011	Greenwich	08A	NHS Greenwich CCG	89.2%	89.3%
E09000011	Greenwich	08C	NHS Hammersmith and Fulham CCG	0.2%	0.2%
E09000011	Greenwich	08L	NHS Lewisham CCG	4.4%	4.9%
E09000011	Greenwich	08Q	NHS Southwark CCG	0.1%	0.1%
E09000012	Hackney	07R	NHS Camden CCG	0.7%	0.7%
E09000012	Hackney	09A	NHS Central London (Westminster) CCG	0.2%	0.2%
E09000012	Hackney	07T	NHS City and Hackney CCG	90.2%	93.8%
E09000012	Hackney	08C	NHS Hammersmith and Fulham CCG	0.5%	0.4%
E09000012	Hackney	08D	NHS Haringey CCG	0.6%	0.7%
E09000012	Hackney	08H	NHS Islington CCG	4.6%	3.7%
E09000012	Hackney	08V	NHS Tower Hamlets CCG	0.5%	0.6%
E06000006	Halton	01F	NHS Halton CCG	98.2%	96.5%
E06000006	Halton	01J	NHS Knowsley CCG	0.2%	0.3%
E06000006	Halton	99A	NHS Liverpool CCG	0.3%	1.1%
E06000006	Halton	02E	NHS Warrington CCG	0.7%	1.1%
E06000006	Halton	02F	NHS West Cheshire CCG	0.6%	1.1%
E09000013	Hammersmith and Fulham	07P	NHS Brent CCG	0.3%	0.5%
E09000013	Hammersmith and Fulham	07R	NHS Camden CCG	0.1%	0.1%
E09000013	Hammersmith and Fulham	09A	NHS Central London (Westminster) CCG	2.5%	2.5%
E09000013	Hammersmith and Fulham	07W	NHS Ealing CCG	0.6%	1.1%
E09000013	Hammersmith and Fulham	08C	NHS Hammersmith and Fulham CCG	82.8%	87.6%
E09000013	Hammersmith and Fulham	07Y	NHS Hounslow CCG	0.5%	0.7%
E09000013	Hammersmith and Fulham	08X	NHS Wandsworth CCG	0.2%	0.3%
E09000013	Hammersmith and Fulham	08Y	NHS West London (K&C & QPP) CCG	6.5%	7.2%
E10000014	Hampshire	15A	NHS Berkshire West CCG	1.7%	0.6%
E10000014	Hampshire	09G	NHS Coastal West Sussex CCG	0.2%	0.1%
E10000014	Hampshire	11J	NHS Dorset CCG	0.5%	0.3%
E10000014	Hampshire	15D	NHS East Berkshire CCG	0.2%	0.0%
E10000014	Hampshire	10K	NHS Fareham and Gosport CCG	98.5%	14.3%
E10000014	Hampshire	09N	NHS Guildford and Waverley CCG	2.9%	0.5%
E10000014	Hampshire	99M	NHS North East Hampshire and Farnham CCG	76.5%	12.4%
E10000014	Hampshire	10J	NHS North Hampshire CCG	99.2%	15.9%
E10000014	Hampshire	10R	NHS Portsmouth CCG	4.4%	0.7%
E10000014	Hampshire	10V	NHS South Eastern Hampshire CCG	95.6%	14.6%
E10000014	Hampshire	10X	NHS Southampton CCG	5.1%	1.0%
E10000014	Hampshire	10C	NHS Surrey Heath CCG	0.8%	0.0%
E10000014	Hampshire	11A	NHS West Hampshire CCG	97.7%	39.1%
E10000014	Hampshire	99N	NHS Wiltshire CCG	1.3%	0.4%
E09000014	Haringey	07M	NHS Barnet CCG	1.0%	1.4%
E09000014	Haringey	07R	NHS Camden CCG	0.6%	0.6%
E09000014	Haringey	09A	NHS Central London (Westminster) CCG	0.1%	0.1%
E09000014	Haringey	07T	NHS City and Hackney CCG	3.1%	3.2%
E09000014	Haringey	07X	NHS Enfield CCG	1.3%	1.4%
E09000014	Haringey	08C	NHS Hammersmith and Fulham CCG	0.4%	0.3%
E09000014	Haringey	08D	NHS Haringey CCG	87.7%	91.0%
E09000014	Haringey	08H	NHS Islington CCG	2.5%	2.1%
E09000015	Harrow	07M	NHS Barnet CCG	4.3%	6.4%
E09000015	Harrow	07P	NHS Brent CCG	3.6%	4.8%
E09000015	Harrow	07W	NHS Ealing CCG	1.3%	2.1%
E09000015	Harrow	08C	NHS Hammersmith and Fulham CCG	0.1%	0.0%
E09000015	Harrow	08E	NHS Harrow CCG	89.7%	84.1%
E09000015	Harrow	06N	NHS Herts Valleys CCG	0.2%	0.5%
E09000015	Harrow	08G	NHS Hillingdon CCG	1.8%	2.0%

E09000015	Harrow	08Y	NHS West London (K&C & QPP) CCG	0.1%	0.1%

E06000001	Hartlepool	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.2%	0.6%
E06000001	Hartlepool	00K	NHS Hartlepool and Stockton-On-Tees CCG	32.4%	99.4%
E09000016	Havering	07L	NHS Barking and Dagenham CCG	3.5%	2.9%
E09000016	Havering	08F	NHS Havering CCG	91.7%	96.2%
E09000016	Havering	08M	NHS Newham CCG	0.1%	0.2%
E09000016	Havering	08N	NHS Redbridge CCG	0.6%	0.7%
E09000016	Havering	07G	NHS Thurrock CCG	0.1%	0.0%
E06000019	Herefordshire, County of	11M	NHS Gloucestershire CCG	0.3%	0.9%
E06000019	Herefordshire, County of	05F	NHS Herefordshire CCG	98.2%	97.3%
E06000019	Herefordshire, County of	05N	NHS Shropshire CCG	0.3%	0.5%
E06000019	Herefordshire, County of	05T	NHS South Worcestershire CCG	0.8%	1.3%
E10000015	Hertfordshire	07M	NHS Barnet CCG	0.2%	0.0%
E10000015	Hertfordshire	06F	NHS Bedfordshire CCG	0.1%	0.0%
E10000015	Hertfordshire	14Y	NHS Buckinghamshire CCG	0.2%	0.1%
E10000015	Hertfordshire	06H	NHS Cambridgeshire and Peterborough CCG	2.1%	1.6%
E10000015	Hertfordshire	06K	NHS East and North Hertfordshire CCG	97.0%	46.5%
E10000015	Hertfordshire	07X	NHS Enfield CCG	0.5%	0.1%
E10000015	Hertfordshire	08E	NHS Harrow CCG	0.6%	0.1%
E10000015	Hertfordshire	06N	NHS Herts Valleys CCG	98.0%	50.7%
E10000015	Hertfordshire	08G	NHS Hillingdon CCG	2.2%	0.6%
E10000015	Hertfordshire	06P	NHS Luton CCG	0.4%	0.0%
E10000015	Hertfordshire	07H	NHS West Essex CCG	0.8%	0.2%
E09000017	Hillingdon	14Y	NHS Buckinghamshire CCG	0.0%	0.1%
E09000017	Hillingdon	07W	NHS Ealing CCG	5.2%	6.9%
E09000017	Hillingdon	08C	NHS Hammersmith and Fulham CCG	0.5%	0.3%
E09000017	Hillingdon	08E	NHS Harrow CCG	2.2%	1.8%
E09000017	Hillingdon	08G	NHS Hillingdon CCG	94.3%	89.8%
E09000017	Hillingdon	07Y	NHS Hounslow CCG	1.1%	1.0%
E09000018	Hounslow	07W	NHS Ealing CCG	5.4%	7.4%
E09000018	Hounslow	08C	NHS Hammersmith and Fulham CCG	1.2%	0.9%
E09000018	Hounslow	08G	NHS Hillingdon CCG	0.2%	0.2%
E09000018	Hounslow	07Y	NHS Hounslow CCG	88.2%	87.1%
E09000018	Hounslow	09Y	NHS North West Surrey CCG	0.3%	0.4%
E09000018	Hounslow	08P	NHS Richmond CCG	5.7%	3.8%
E09000018	Hounslow	08Y	NHS West London (K&C & QPP) CCG	0.2%	0.1%
E06000046	Isle of Wight	10L	NHS Isle of Wight CCG	100.0%	100.0%
E09000019	Islington	07R	NHS Camden CCG	4.9%	5.4%
E09000019	Islington	09A	NHS Central London (Westminster) CCG	0.5%	0.5%
E09000019	Islington	07T	NHS City and Hackney CCG	3.4%	4.2%
E09000019	Islington	08C	NHS Hammersmith and Fulham CCG	0.5%	0.5%
E09000019	Islington	08D	NHS Haringey CCG	1.2%	1.5%
E09000019	Islington	08H	NHS Islington CCG	89.1%	87.9%
E09000020	Kensington and Chelsea	07P	NHS Brent CCG	0.0%	0.1%
E09000020	Kensington and Chelsea	07R	NHS Camden CCG	0.2%	0.3%
E09000020	Kensington and Chelsea	09A	NHS Central London (Westminster) CCG	4.0%	5.4%
E09000020	Kensington and Chelsea	08C	NHS Hammersmith and Fulham CCG	1.2%	1.7%
E09000020	Kensington and Chelsea	08Y	NHS West London (K&C & QPP) CCG	63.9%	92.5%
E10000016	Kent	09C	NHS Ashford CCG	100.0%	8.3%
E10000016	Kent	07N	NHS Bexley CCG	1.3%	0.2%
E10000016	Kent	07Q	NHS Bromley CCG	0.9%	0.2%
E10000016	Kent	09E	NHS Canterbury and Coastal CCG	100.0%	14.1%
E10000016	Kent	09J	NHS Dartford, Gravesham and Swanley CCG	98.3%	16.5%
E10000016	Kent	09L	NHS East Surrey CCG	0.1%	0.0%
E10000016	Kent	08A	NHS Greenwich CCG	0.2%	0.0%
E10000016	Kent	09P	NHS Hastings and Rother CCG	0.3%	0.0%
E10000016	Kent	99K	NHS High Weald Lewes Havens CCG	0.6%	0.0%
E10000016	Kent	09W	NHS Medway CCG	6.1%	1.1%
E10000016	Kent	10A	NHS South Kent Coast CCG	100.0%	12.9%
E10000016	Kent	10D	NHS Swale CCG	99.8%	7.1%
E10000016	Kent	10E	NHS Thanet CCG	100.0%	9.1%
E10000016	Kent	99J	NHS West Kent CCG	98.7%	30.4%
E06000010	Kingston upon Hull, City of	02Y	NHS East Riding of Yorkshire CCG	1.3%	1.4%
E06000010	Kingston upon Hull, City of	03F	NHS Hull CCG	90.8%	98.6%
E09000021	Kingston upon Thames	08J	NHS Kingston CCG	86.9%	95.9%
E09000021	Kingston upon Thames	08R	NHS Merton CCG	1.1%	1.3%
E09000021	Kingston upon Thames	08P	NHS Richmond CCG	0.7%	0.8%
E09000021	Kingston upon Thames	99H	NHS Surrey Downs CCG	0.7%	1.2%

E09000021	Kingston upon Thames	08T	NHS Sutton CCG	0.1%	0.1%
E09000021	Kingston upon Thames	08X	NHS Wandsworth CCG	0.3%	0.7%
E08000034	Kirklees	02P	NHS Barnsley CCG	0.1%	0.0%
E08000034	Kirklees	02R	NHS Bradford Districts CCG	1.0%	0.7%
E08000034	Kirklees	02T	NHS Calderdale CCG	1.4%	0.7%
E08000034	Kirklees	03A	NHS Greater Huddersfield CCG	99.6%	54.7%
E08000034	Kirklees	15F	NHS Leeds CCG	0.1%	0.3%
E08000034	Kirklees	03J	NHS North Kirklees CCG	98.9%	42.4%
E08000034	Kirklees	03R	NHS Wakefield CCG	1.5%	1.3%

E08000011	Knowsley	01F	NHS Halton CCG	1.0%	0.8%
E08000011	Knowsley	01J	NHS Knowsley CCG	86.8%	88.2%
E08000011	Knowsley	99A	NHS Liverpool CCG	2.4%	8.0%
E08000011	Knowsley	01T	NHS South Sefton CCG	0.1%	0.1%
E08000011	Knowsley	01X	NHS St Helens CCG	2.3%	2.8%
E09000022	Lambeth	07R	NHS Camden CCG	0.2%	0.1%
E09000022	Lambeth	09A	NHS Central London (Westminster) CCG	0.9%	0.6%
E09000022	Lambeth	07V	NHS Croydon CCG	0.7%	0.8%
E09000022	Lambeth	08C	NHS Hammersmith and Fulham CCG	0.6%	0.4%
E09000022	Lambeth	08K	NHS Lambeth CCG	85.5%	92.2%
E09000022	Lambeth	08R	NHS Merton CCG	1.0%	0.6%
E09000022	Lambeth	08Q	NHS Southwark CCG	1.9%	1.6%
E09000022	Lambeth	08X	NHS Wandsworth CCG	3.5%	3.7%
E09000022	Lambeth	08Y	NHS West London (K&C & QPP) CCG	0.1%	0.0%
E10000017	Lancashire	02N	NHS Airedale, Wharfdale and Craven CCG	0.2%	0.0%
E10000017	Lancashire	00Q	NHS Blackburn with Darwen CCG	11.1%	1.5%
E10000017	Lancashire	00R	NHS Blackpool CCG	13.6%	1.9%
E10000017	Lancashire	00T	NHS Bolton CCG	0.3%	0.0%
E10000017	Lancashire	00V	NHS Bury CCG	1.4%	0.2%
E10000017	Lancashire	00X	NHS Chorley and South Ribble CCG	99.8%	14.5%
E10000017	Lancashire	01A	NHS East Lancashire CCG	99.0%	30.0%
E10000017	Lancashire	02M	NHS Fylde & Wyre CCG	97.9%	13.8%
E10000017	Lancashire	01E	NHS Greater Preston CCG	100.0%	16.6%
E10000017	Lancashire	01D	NHS Heywood, Middleton and Rochdale CCG	0.9%	0.2%
E10000017	Lancashire	01J	NHS Knowsley CCG	0.1%	0.0%
E10000017	Lancashire	01K	NHS Morecambe Bay CCG	44.1%	12.1%
E10000017	Lancashire	01T	NHS South Sefton CCG	0.5%	0.0%
E10000017	Lancashire	01V	NHS Southport and Formby CCG	3.2%	0.3%
E10000017	Lancashire	01X	NHS St Helens CCG	0.5%	0.0%
E10000017	Lancashire	02G	NHS West Lancashire CCG	96.9%	8.7%
E10000017	Lancashire	02H	NHS Wigan Borough CCG	0.7%	0.2%
E08000035	Leeds	02N	NHS Airedale, Wharfdale and Craven CCG	0.1%	0.0%
E08000035	Leeds	02W	NHS Bradford City CCG	1.1%	0.2%
E08000035	Leeds	02R	NHS Bradford Districts CCG	0.5%	0.2%
E08000035	Leeds	15F	NHS Leeds CCG	97.7%	98.8%
E08000035	Leeds	03J	NHS North Kirklees CCG	0.3%	0.0%
E08000035	Leeds	03Q	NHS Vale of York CCG	0.6%	0.2%
E08000035	Leeds	03R	NHS Wakefield CCG	1.4%	0.6%
E06000016	Leicester	03W	NHS East Leicestershire and Rutland CCG	2.1%	1.8%
E06000016	Leicester	04C	NHS Leicester City CCG	92.8%	95.5%
E06000016	Leicester	04V	NHS West Leicestershire CCG	2.8%	2.7%
E10000018	Leicestershire	03V	NHS Corby CCG	0.5%	0.0%
E10000018	Leicestershire	15M	NHS Derby and Derbyshire CCG	0.4%	0.6%
E10000018	Leicestershire	03W	NHS East Leicestershire and Rutland CCG	85.5%	39.8%
E10000018	Leicestershire	04C	NHS Leicester City CCG	7.2%	4.1%
E10000018	Leicestershire	04N	NHS Rushcliffe CCG	5.4%	1.0%
E10000018	Leicestershire	04Q	NHS South West Lincolnshire CCG	5.6%	1.1%
E10000018	Leicestershire	05H	NHS Warwickshire North CCG	1.6%	0.4%
E10000018	Leicestershire	04V	NHS West Leicestershire CCG	96.2%	53.1%
E09000023	Lewisham	07Q	NHS Bromley CCG	1.4%	1.5%
E09000023	Lewisham	09A	NHS Central London (Westminster) CCG	0.2%	0.2%
E09000023	Lewisham	08A	NHS Greenwich CCG	2.1%	1.9%
E09000023	Lewisham	08C	NHS Hammersmith and Fulham CCG	0.3%	0.2%
E09000023	Lewisham	08K	NHS Lambeth CCG	0.3%	0.4%
E09000023	Lewisham	08L	NHS Lewisham CCG	91.5%	92.0%
E09000023	Lewisham	08Q	NHS Southwark CCG	3.9%	3.9%
E10000019	Lincolnshire	06H	NHS Cambridgeshire and Peterborough CCG	0.2%	0.3%
E10000019	Lincolnshire	03W	NHS East Leicestershire and Rutland CCG	0.2%	0.1%
E10000019	Lincolnshire	03T	NHS Lincolnshire East CCG	99.2%	32.0%
E10000019	Lincolnshire	04D	NHS Lincolnshire West CCG	98.6%	29.9%
E10000019	Lincolnshire	04H	NHS Newark & Sherwood CCG	2.4%	0.4%
E10000019	Lincolnshire	03H	NHS North East Lincolnshire CCG	2.7%	0.6%
E10000019	Lincolnshire	03K	NHS North Lincolnshire CCG	4.9%	1.1%
E10000019	Lincolnshire	99D	NHS South Lincolnshire CCG	90.8%	19.6%
E10000019	Lincolnshire	04Q	NHS South West Lincolnshire CCG	93.3%	16.1%
E08000012	Liverpool	01J	NHS Knowsley CCG	8.5%	2.7%
E08000012	Liverpool	99A	NHS Liverpool CCG	94.4%	96.3%

E08000012	Liverpool	01T	NHS South Sefton CCG	3.3%	1.0%
E06000032	Luton	06F	NHS Bedfordshire CCG	2.3%	4.5%
E06000032	Luton	06P	NHS Luton CCG	97.3%	95.5%
E08000003	Manchester	00V	NHS Bury CCG	0.4%	0.1%
E08000003	Manchester	01D	NHS Heywood, Middleton and Rochdale CCG	0.5%	0.2%
E08000003	Manchester	14L	NHS Manchester CCG	90.9%	95.6%
E08000003	Manchester	00Y	NHS Oldham CCG	0.9%	0.4%
E08000003	Manchester	01G	NHS Salford CCG	2.5%	1.1%
E08000003	Manchester	01W	NHS Stockport CCG	1.7%	0.8%
E08000003	Manchester	01Y	NHS Tameside and Glossop CCG	0.4%	0.2%
E08000003	Manchester	02A	NHS Trafford CCG	4.0%	1.6%

E06000035	Medway	09J	NHS Dartford, Gravesham and Swanley CCG	0.2%	0.2%
E06000035	Medway	09W	NHS Medway CCG	93.9%	99.5%
E06000035	Medway	10D	NHS Swale CCG	0.2%	0.0%
E06000035	Medway	99J	NHS West Kent CCG	0.2%	0.3%
E09000024	Merton	07V	NHS Croydon CCG	0.5%	0.9%
E09000024	Merton	08C	NHS Hammersmith and Fulham CCG	0.2%	0.2%
E09000024	Merton	08J	NHS Kingston CCG	3.4%	2.9%
E09000024	Merton	08K	NHS Lambeth CCG	1.0%	1.7%
E09000024	Merton	08R	NHS Merton CCG	87.7%	80.9%
E09000024	Merton	08T	NHS Sutton CCG	3.3%	2.6%
E09000024	Merton	08X	NHS Wandsworth CCG	6.6%	10.8%
E06000002	Middlesbrough	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.2%	0.2%
E06000002	Middlesbrough	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.3%
E06000002	Middlesbrough	00M	NHS South Tees CCG	52.3%	99.5%
E06000042	Milton Keynes	06F	NHS Bedfordshire CCG	1.5%	2.5%
E06000042	Milton Keynes	04F	NHS Milton Keynes CCG	95.5%	96.2%
E06000042	Milton Keynes	04G	NHS Nene CCG	0.6%	1.3%
E08000021	Newcastle upon Tyne	13T	NHS Newcastle Gateshead CCG	58.9%	95.2%
E08000021	Newcastle upon Tyne	99C	NHS North Tyneside CCG	5.9%	4.0%
E08000021	Newcastle upon Tyne	00L	NHS Northumberland CCG	0.8%	0.8%
E09000025	Newham	07L	NHS Barking and Dagenham CCG	0.5%	0.3%
E09000025	Newham	09A	NHS Central London (Westminster) CCG	0.7%	0.4%
E09000025	Newham	07T	NHS City and Hackney CCG	0.1%	0.0%
E09000025	Newham	08C	NHS Hammersmith and Fulham CCG	0.5%	0.3%
E09000025	Newham	08M	NHS Newham CCG	96.6%	97.3%
E09000025	Newham	08N	NHS Redbridge CCG	0.3%	0.2%
E09000025	Newham	08V	NHS Tower Hamlets CCG	0.2%	0.2%
E09000025	Newham	08W	NHS Waltham Forest CCG	1.7%	1.4%
E10000020	Norfolk	06H	NHS Cambridgeshire and Peterborough CCG	0.7%	0.7%
E10000020	Norfolk	06M	NHS Great Yarmouth and Waveney CCG	47.7%	12.2%
E10000020	Norfolk	06L	NHS Ipswich and East Suffolk CCG	0.2%	0.0%
E10000020	Norfolk	06V	NHS North Norfolk CCG	100.0%	18.6%
E10000020	Norfolk	06W	NHS Norwich CCG	100.0%	25.2%
E10000020	Norfolk	99D	NHS South Lincolnshire CCG	0.2%	0.0%
E10000020	Norfolk	06Y	NHS South Norfolk CCG	98.9%	24.1%
E10000020	Norfolk	07J	NHS West Norfolk CCG	98.4%	18.5%
E10000020	Norfolk	07K	NHS West Suffolk CCG	2.6%	0.7%
E06000012	North East Lincolnshire	03T	NHS Lincolnshire East CCG	0.8%	1.2%
E06000012	North East Lincolnshire	03H	NHS North East Lincolnshire CCG	95.9%	98.6%
E06000012	North East Lincolnshire	03K	NHS North Lincolnshire CCG	0.2%	0.2%
E06000013	North Lincolnshire	02Q	NHS Bassetlaw CCG	0.2%	0.2%
E06000013	North Lincolnshire	02X	NHS Doncaster CCG	0.0%	0.1%
E06000013	North Lincolnshire	02Y	NHS East Riding of Yorkshire CCG	0.0%	0.1%
E06000013	North Lincolnshire	04D	NHS Lincolnshire West CCG	1.0%	1.3%
E06000013	North Lincolnshire	03H	NHS North East Lincolnshire CCG	1.4%	1.4%
E06000013	North Lincolnshire	03K	NHS North Lincolnshire CCG	94.9%	96.9%
E06000024	North Somerset	11E	NHS Bath and North East Somerset CCG	1.6%	1.5%
E06000024	North Somerset	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	21.8%	98.3%
E06000024	North Somerset	11X	NHS Somerset CCG	0.0%	0.2%
E08000022	North Tyneside	13T	NHS Newcastle Gateshead CCG	1.0%	2.6%
E08000022	North Tyneside	99C	NHS North Tyneside CCG	93.2%	96.3%
E08000022	North Tyneside	00L	NHS Northumberland CCG	0.7%	1.1%
E10000023	North Yorkshire	02N	NHS Airedale, Wharfdale and Craven CCG	32.5%	8.3%
E10000023	North Yorkshire	00C	NHS Darlington CCG	1.3%	0.2%
E10000023	North Yorkshire	02X	NHS Doncaster CCG	0.2%	0.1%
E10000023	North Yorkshire	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.2%	0.1%
E10000023	North Yorkshire	01A	NHS East Lancashire CCG	0.1%	0.0%
E10000023	North Yorkshire	02Y	NHS East Riding of Yorkshire CCG	1.4%	0.7%
E10000023	North Yorkshire	03D	NHS Hambleton, Richmondshire and Whitby CCG	98.3%	22.8%
E10000023	North Yorkshire	03E	NHS Harrogate and Rural District CCG	99.8%	26.2%
E10000023	North Yorkshire	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.1%
E10000023	North Yorkshire	15F	NHS Leeds CCG	0.9%	1.3%
E10000023	North Yorkshire	01K	NHS Morecambe Bay CCG	1.9%	1.0%
E10000023	North Yorkshire	03M	NHS Scarborough and Ryedale CCG	99.3%	19.2%
E10000023	North Yorkshire	03Q	NHS Vale of York CCG	32.6%	18.8%
E10000023	North Yorkshire	03R	NHS Wakefield CCG	2.0%	1.2%
E10000021	Northamptonshire	06F	NHS Bedfordshire CCG	0.1%	0.0%

E10000021	Northamptonshire	06H	NHS Cambridgeshire and Peterborough CCG	1.6%	1.9%
E10000021	Northamptonshire	03V	NHS Corby CCG	99.2%	9.8%
E10000021	Northamptonshire	05A	NHS Coventry and Rugby CCG	0.3%	0.2%
E10000021	Northamptonshire	03W	NHS East Leicestershire and Rutland CCG	2.0%	0.8%
E10000021	Northamptonshire	04F	NHS Milton Keynes CCG	3.1%	1.2%
E10000021	Northamptonshire	04G	NHS Nene CCG	98.8%	84.9%
E10000021	Northamptonshire	10Q	NHS Oxfordshire CCG	1.1%	1.0%
E10000021	Northamptonshire	99D	NHS South Lincolnshire CCG	0.9%	0.2%
E06000057	Northumberland	13T	NHS Newcastle Gateshead CCG	0.3%	0.5%
E06000057	Northumberland	01H	NHS North Cumbria CCG	0.1%	0.1%
E06000057	Northumberland	00J	NHS North Durham CCG	0.2%	0.2%
E06000057	Northumberland	99C	NHS North Tyneside CCG	0.9%	0.6%
E06000057	Northumberland	00L	NHS Northumberland CCG	97.9%	98.7%

E06000018	Nottingham	04K	NHS Nottingham City CCG	89.9%	95.4%
E06000018	Nottingham	04L	NHS Nottingham North and East CCG	4.6%	2.0%
E06000018	Nottingham	04M	NHS Nottingham West CCG	4.1%	1.1%
E06000018	Nottingham	04N	NHS Rushcliffe CCG	4.3%	1.5%
E10000024	Nottinghamshire	02Q	NHS Bassetlaw CCG	97.1%	13.5%
E10000024	Nottinghamshire	15M	NHS Derby and Derbyshire CCG	1.5%	1.8%
E10000024	Nottinghamshire	02X	NHS Doncaster CCG	1.6%	0.6%
E10000024	Nottinghamshire	03W	NHS East Leicestershire and Rutland CCG	0.3%	0.1%
E10000024	Nottinghamshire	04D	NHS Lincolnshire West CCG	0.4%	0.1%
E10000024	Nottinghamshire	04E	NHS Mansfield and Ashfield CCG	97.9%	22.5%
E10000024	Nottinghamshire	04H	NHS Newark & Sherwood CCG	97.6%	15.6%
E10000024	Nottinghamshire	04K	NHS Nottingham City CCG	10.1%	4.6%
E10000024	Nottinghamshire	04L	NHS Nottingham North and East CCG	95.1%	17.2%
E10000024	Nottinghamshire	04M	NHS Nottingham West CCG	90.8%	10.2%
E10000024	Nottinghamshire	04N	NHS Rushcliffe CCG	90.3%	13.6%
E10000024	Nottinghamshire	04Q	NHS South West Lincolnshire CCG	0.7%	0.1%
E10000024	Nottinghamshire	04V	NHS West Leicestershire CCG	0.1%	0.0%
E08000004	Oldham	01D	NHS Heywood, Middleton and Rochdale CCG	1.5%	1.4%
E08000004	Oldham	14L	NHS Manchester CCG	0.8%	2.1%
E08000004	Oldham	00Y	NHS Oldham CCG	94.5%	96.3%
E08000004	Oldham	01Y	NHS Tameside and Glossop CCG	0.2%	0.2%
E10000025	Oxfordshire	15A	NHS Berkshire West CCG	0.5%	0.3%
E10000025	Oxfordshire	14Y	NHS Buckinghamshire CCG	2.4%	1.8%
E10000025	Oxfordshire	11M	NHS Gloucestershire CCG	0.2%	0.2%
E10000025	Oxfordshire	04G	NHS Nene CCG	0.1%	0.1%
E10000025	Oxfordshire	10Q	NHS Oxfordshire CCG	97.4%	96.5%
E10000025	Oxfordshire	05R	NHS South Warwickshire CCG	0.6%	0.2%
E10000025	Oxfordshire	12D	NHS Swindon CCG	2.7%	0.9%
E06000031	Peterborough	06H	NHS Cambridgeshire and Peterborough CCG	23.0%	96.3%
E06000031	Peterborough	99D	NHS South Lincolnshire CCG	5.1%	3.7%
E06000026	Plymouth	15N	NHS Devon CCG	22.1%	100.0%
E06000044	Portsmouth	10K	NHS Fareham and Gosport CCG	1.5%	1.4%
E06000044	Portsmouth	10R	NHS Portsmouth CCG	95.6%	98.4%
E06000044	Portsmouth	10V	NHS South Eastern Hampshire CCG	0.2%	0.2%
E06000038	Reading	15A	NHS Berkshire West CCG	35.3%	99.4%
E06000038	Reading	10Q	NHS Oxfordshire CCG	0.2%	0.6%
E09000026	Redbridge	07L	NHS Barking and Dagenham CCG	4.9%	3.3%
E09000026	Redbridge	08C	NHS Hammersmith and Fulham CCG	0.1%	0.1%
E09000026	Redbridge	08F	NHS Havering CCG	0.8%	0.7%
E09000026	Redbridge	08M	NHS Newham CCG	1.4%	1.7%
E09000026	Redbridge	08N	NHS Redbridge CCG	92.3%	89.4%
E09000026	Redbridge	08W	NHS Waltham Forest CCG	3.3%	3.1%
E09000026	Redbridge	07H	NHS West Essex CCG	1.8%	1.7%
E06000003	Redcar and Cleveland	03D	NHS Hambleton, Richmondshire and Whitby CCG	1.1%	1.1%
E06000003	Redcar and Cleveland	00M	NHS South Tees CCG	47.3%	98.9%
E09000027	Richmond upon Thames	08C	NHS Hammersmith and Fulham CCG	0.5%	0.5%
E09000027	Richmond upon Thames	07Y	NHS Hounslow CCG	4.9%	7.0%
E09000027	Richmond upon Thames	08J	NHS Kingston CCG	1.6%	1.5%
E09000027	Richmond upon Thames	08P	NHS Richmond CCG	91.7%	90.3%
E09000027	Richmond upon Thames	99H	NHS Surrey Downs CCG	0.0%	0.1%
E09000027	Richmond upon Thames	08X	NHS Wandsworth CCG	0.4%	0.7%
E08000005	Rochdale	00V	NHS Bury CCG	0.7%	0.6%
E08000005	Rochdale	01A	NHS East Lancashire CCG	0.2%	0.3%
E08000005	Rochdale	01D	NHS Heywood, Middleton and Rochdale CCG	96.5%	96.6%
E08000005	Rochdale	14L	NHS Manchester CCG	0.6%	1.6%
E08000005	Rochdale	00Y	NHS Oldham CCG	0.9%	1.0%
E08000018	Rotherham	02P	NHS Barnsley CCG	3.3%	3.1%
E08000018	Rotherham	02Q	NHS Bassetlaw CCG	1.0%	0.4%
E08000018	Rotherham	02X	NHS Doncaster CCG	1.1%	1.2%
E08000018	Rotherham	03L	NHS Rotherham CCG	97.9%	93.5%
E08000018	Rotherham	03N	NHS Sheffield CCG	0.8%	1.7%
E06000017	Rutland	06H	NHS Cambridgeshire and Peterborough CCG	0.0%	0.3%
E06000017	Rutland	03V	NHS Corby CCG	0.2%	0.5%
E06000017	Rutland	03W	NHS East Leicestershire and Rutland CCG	9.9%	86.3%
E06000017	Rutland	99D	NHS South Lincolnshire CCG	2.6%	11.5%
E06000017	Rutland	04Q	NHS South West Lincolnshire CCG	0.4%	1.4%
E08000006	Salford	00T	NHS Bolton CCG	0.2%	0.3%

E08000006	Salford	00V	NHS Bury CCG	1.8%	1.4%
E08000006	Salford	14L	NHS Manchester CCG	1.1%	2.5%
E08000006	Salford	01G	NHS Salford CCG	94.1%	94.6%
E08000006	Salford	02A	NHS Trafford CCG	0.2%	0.2%
E08000006	Salford	02H	NHS Wigan Borough CCG	0.9%	1.1%
E08000028	Sandwell	15E	NHS Birmingham and Solihull CCG	1.9%	7.0%
E08000028	Sandwell	05C	NHS Dudley CCG	3.0%	2.7%
E08000028	Sandwell	05L	NHS Sandwell and West Birmingham CCG	55.1%	88.6%
E08000028	Sandwell	05Y	NHS Walsall CCG	1.7%	1.3%
E08000028	Sandwell	06A	NHS Wolverhampton CCG	0.3%	0.3%
E08000014	Sefton	01J	NHS Knowsley CCG	1.8%	1.0%
E08000014	Sefton	99A	NHS Liverpool CCG	2.9%	5.3%
E08000014	Sefton	01T	NHS South Sefton CCG	96.0%	51.6%
E08000014	Sefton	01V	NHS Southport and Formby CCG	96.8%	41.9%
E08000014	Sefton	02G	NHS West Lancashire CCG	0.3%	0.1%

E08000019	Sheffield	02P	NHS Barnsley CCG	0.8%	0.4%
E08000019	Sheffield	15M	NHS Derby and Derbyshire CCG	0.2%	0.4%
E08000019	Sheffield	03L	NHS Rotherham CCG	0.4%	0.2%
E08000019	Sheffield	03N	NHS Sheffield CCG	98.5%	99.1%
E06000051	Shropshire	05F	NHS Herefordshire CCG	0.4%	0.3%
E06000051	Shropshire	05G	NHS North Staffordshire CCG	0.5%	0.3%
E06000051	Shropshire	05N	NHS Shropshire CCG	96.7%	95.4%
E06000051	Shropshire	01R	NHS South Cheshire CCG	0.4%	0.3%
E06000051	Shropshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	1.2%	0.9%
E06000051	Shropshire	05T	NHS South Worcestershire CCG	1.0%	1.0%
E06000051	Shropshire	05X	NHS Telford and Wrekin CCG	2.3%	1.4%
E06000051	Shropshire	02F	NHS West Cheshire CCG	0.1%	0.1%
E06000051	Shropshire	06D	NHS Wyre Forest CCG	0.8%	0.3%
E06000039	Slough	14Y	NHS Buckinghamshire CCG	1.8%	6.2%
E06000039	Slough	07W	NHS Ealing CCG	0.0%	0.1%
E06000039	Slough	15D	NHS East Berkshire CCG	33.8%	93.4%
E06000039	Slough	08G	NHS Hillingdon CCG	0.0%	0.1%
E06000039	Slough	07Y	NHS Hounslow CCG	0.0%	0.1%
E06000039	Slough	09Y	NHS North West Surrey CCG	0.0%	0.1%
E08000029	Solihull	15E	NHS Birmingham and Solihull CCG	17.0%	98.9%
E08000029	Solihull	05A	NHS Coventry and Rugby CCG	0.0%	0.1%
E08000029	Solihull	05J	NHS Redditch and Bromsgrove CCG	0.4%	0.3%
E08000029	Solihull	05L	NHS Sandwell and West Birmingham CCG	0.0%	0.1%
E08000029	Solihull	05R	NHS South Warwickshire CCG	0.4%	0.4%
E08000029	Solihull	05H	NHS Warwickshire North CCG	0.2%	0.2%
E10000027	Somerset	11E	NHS Bath and North East Somerset CCG	3.1%	1.1%
E10000027	Somerset	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	0.2%	0.3%
E10000027	Somerset	15N	NHS Devon CCG	0.2%	0.5%
E10000027	Somerset	11J	NHS Dorset CCG	0.5%	0.7%
E10000027	Somerset	11X	NHS Somerset CCG	98.5%	97.3%
E10000027	Somerset	99N	NHS Wiltshire CCG	0.1%	0.1%
E06000025	South Gloucestershire	11E	NHS Bath and North East Somerset CCG	0.8%	0.6%
E06000025	South Gloucestershire	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	28.2%	97.5%
E06000025	South Gloucestershire	11M	NHS Gloucestershire CCG	0.8%	1.8%
E06000025	South Gloucestershire	99N	NHS Wiltshire CCG	0.0%	0.1%
E08000023	South Tyneside	13T	NHS Newcastle Gateshead CCG	0.0%	0.2%
E08000023	South Tyneside	00N	NHS South Tyneside CCG	99.2%	99.2%
E08000023	South Tyneside	00P	NHS Sunderland CCG	0.3%	0.6%
E06000045	Southampton	10X	NHS Southampton CCG	94.9%	99.5%
E06000045	Southampton	11A	NHS West Hampshire CCG	0.2%	0.5%
E06000033	Southend-on-Sea	99F	NHS Castle Point and Rochford CCG	4.8%	4.7%
E06000033	Southend-on-Sea	99G	NHS Southend CCG	96.7%	95.3%
E09000028	Southwark	07R	NHS Camden CCG	0.3%	0.3%
E09000028	Southwark	09A	NHS Central London (Westminster) CCG	2.5%	1.6%
E09000028	Southwark	08C	NHS Hammersmith and Fulham CCG	0.7%	0.5%
E09000028	Southwark	08K	NHS Lambeth CCG	6.6%	7.7%
E09000028	Southwark	08L	NHS Lewisham CCG	2.1%	2.0%
E09000028	Southwark	08Q	NHS Southwark CCG	94.1%	87.9%
E09000028	Southwark	08X	NHS Wandsworth CCG	0.1%	0.1%
E08000013	St. Helens	01F	NHS Halton CCG	0.2%	0.1%
E08000013	St. Helens	01J	NHS Knowsley CCG	2.6%	2.3%
E08000013	St. Helens	01X	NHS St Helens CCG	91.2%	96.3%
E08000013	St. Helens	02E	NHS Warrington CCG	0.1%	0.1%
E08000013	St. Helens	02H	NHS Wigan Borough CCG	0.7%	1.2%
E10000028	Staffordshire	15E	NHS Birmingham and Solihull CCG	0.3%	0.4%
E10000028	Staffordshire	04Y	NHS Cannock Chase CCG	99.3%	14.9%
E10000028	Staffordshire	15M	NHS Derby and Derbyshire CCG	0.5%	0.5%
E10000028	Staffordshire	05C	NHS Dudley CCG	1.4%	0.5%
E10000028	Staffordshire	05D	NHS East Staffordshire CCG	92.1%	14.7%
E10000028	Staffordshire	01C	NHS Eastern Cheshire CCG	0.6%	0.1%
E10000028	Staffordshire	05G	NHS North Staffordshire CCG	95.1%	23.4%
E10000028	Staffordshire	05N	NHS Shropshire CCG	1.0%	0.3%
E10000028	Staffordshire	01R	NHS South Cheshire CCG	0.5%	0.1%
E10000028	Staffordshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	96.2%	23.6%
E10000028	Staffordshire	05V	NHS Stafford and Surrounds CCG	99.5%	16.7%
E10000028	Staffordshire	05W	NHS Stoke on Trent CCG	8.8%	2.9%
E10000028	Staffordshire	05X	NHS Telford and Wrekin CCG	1.0%	0.2%

E10000028	Staffordshire	05Y	NHS Walsall CCG	1.6%	0.5%
E10000028	Staffordshire	05H	NHS Warwickshire North CCG	1.1%	0.2%
E10000028	Staffordshire	06A	NHS Wolverhampton CCG	2.6%	0.8%
E10000028	Staffordshire	06D	NHS Wyre Forest CCG	0.2%	0.0%
E08000007	Stockport	01C	NHS Eastern Cheshire CCG	1.6%	1.1%
E08000007	Stockport	14L	NHS Manchester CCG	1.1%	2.2%
E08000007	Stockport	01W	NHS Stockport CCG	94.9%	96.5%
E08000007	Stockport	01Y	NHS Tameside and Glossop CCG	0.2%	0.2%
E06000004	Stockton-on-Tees	00C	NHS Darlington CCG	0.4%	0.2%
E06000004	Stockton-on-Tees	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.4%	0.6%
E06000004	Stockton-on-Tees	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.1%	0.1%
E06000004	Stockton-on-Tees	00K	NHS Hartlepool and Stockton-On-Tees CCG	66.9%	98.4%
E06000004	Stockton-on-Tees	00M	NHS South Tees CCG	0.4%	0.7%

E06000021	Stoke-on-Trent	05G	NHS North Staffordshire CCG	3.3%	2.7%
E06000021	Stoke-on-Trent	05V	NHS Stafford and Surrounds CCG	0.5%	0.3%
E06000021	Stoke-on-Trent	05W	NHS Stoke on Trent CCG	91.2%	97.1%
E10000029	Suffolk	06H	NHS Cambridgeshire and Peterborough CCG	0.2%	0.2%
E10000029	Suffolk	06M	NHS Great Yarmouth and Waveney CCG	52.3%	16.3%
E10000029	Suffolk	06L	NHS Ipswich and East Suffolk CCG	99.6%	52.9%
E10000029	Suffolk	06T	NHS North East Essex CCG	1.4%	0.6%
E10000029	Suffolk	06Y	NHS South Norfolk CCG	1.1%	0.3%
E10000029	Suffolk	07H	NHS West Essex CCG	0.1%	0.0%
E10000029	Suffolk	07K	NHS West Suffolk CCG	91.1%	29.7%
E08000024	Sunderland	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.9%	0.9%
E08000024	Sunderland	13T	NHS Newcastle Gateshead CCG	0.5%	0.9%
E08000024	Sunderland	00J	NHS North Durham CCG	2.2%	1.9%
E08000024	Sunderland	00N	NHS South Tyneside CCG	0.5%	0.3%
E08000024	Sunderland	00P	NHS Sunderland CCG	98.5%	96.0%
E10000030	Surrey	07Q	NHS Bromley CCG	0.4%	0.1%
E10000030	Surrey	09G	NHS Coastal West Sussex CCG	0.2%	0.0%
E10000030	Surrey	09H	NHS Crawley CCG	6.6%	0.7%
E10000030	Surrey	07V	NHS Croydon CCG	1.3%	0.4%
E10000030	Surrey	15D	NHS East Berkshire CCG	3.4%	1.2%
E10000030	Surrey	09L	NHS East Surrey CCG	96.6%	14.1%
E10000030	Surrey	09N	NHS Guildford and Waverley CCG	94.0%	16.9%
E10000030	Surrey	09X	NHS Horsham and Mid Sussex CCG	1.5%	0.3%
E10000030	Surrey	07Y	NHS Hounslow CCG	0.7%	0.2%
E10000030	Surrey	08J	NHS Kingston CCG	4.5%	0.7%
E10000030	Surrey	08R	NHS Merton CCG	0.3%	0.0%
E10000030	Surrey	99M	NHS North East Hampshire and Farnham CCG	23.0%	4.2%
E10000030	Surrey	10J	NHS North Hampshire CCG	0.1%	0.0%
E10000030	Surrey	09Y	NHS North West Surrey CCG	99.4%	29.5%
E10000030	Surrey	08P	NHS Richmond CCG	0.7%	0.1%
E10000030	Surrey	10V	NHS South Eastern Hampshire CCG	0.1%	0.0%
E10000030	Surrey	99H	NHS Surrey Downs CCG	97.4%	23.8%
E10000030	Surrey	10C	NHS Surrey Heath CCG	98.9%	7.6%
E10000030	Surrey	08T	NHS Sutton CCG	1.2%	0.2%
E10000030	Surrey	99J	NHS West Kent CCG	0.2%	0.0%
E09000029	Sutton	07V	NHS Croydon CCG	1.0%	1.9%
E09000029	Sutton	08J	NHS Kingston CCG	3.5%	3.4%
E09000029	Sutton	08K	NHS Lambeth CCG	0.1%	0.2%
E09000029	Sutton	08R	NHS Merton CCG	6.3%	6.7%
E09000029	Sutton	99H	NHS Surrey Downs CCG	1.3%	1.9%
E09000029	Sutton	08T	NHS Sutton CCG	94.7%	85.6%
E09000029	Sutton	08X	NHS Wandsworth CCG	0.2%	0.3%
E06000030	Swindon	11M	NHS Gloucestershire CCG	0.0%	0.2%
E06000030	Swindon	12D	NHS Swindon CCG	96.0%	98.2%
E06000030	Swindon	99N	NHS Wiltshire CCG	0.7%	1.5%
E08000008	Tameside	14L	NHS Manchester CCG	2.2%	5.8%
E08000008	Tameside	00Y	NHS Oldham CCG	3.6%	3.9%
E08000008	Tameside	01W	NHS Stockport CCG	1.8%	2.3%
E08000008	Tameside	01Y	NHS Tameside and Glossop CCG	85.2%	88.0%
E06000020	Telford and Wrekin	05N	NHS Shropshire CCG	1.8%	2.9%
E06000020	Telford and Wrekin	05X	NHS Telford and Wrekin CCG	96.7%	97.1%
E06000034	Thurrock	07L	NHS Barking and Dagenham CCG	0.3%	0.3%
E06000034	Thurrock	99E	NHS Basildon and Brentwood CCG	0.2%	0.3%
E06000034	Thurrock	08F	NHS Havering CCG	0.2%	0.4%
E06000034	Thurrock	07G	NHS Thurrock CCG	98.5%	99.0%
E06000027	Torbay	15N	NHS Devon CCG	11.7%	100.0%
E09000030	Tower Hamlets	07R	NHS Camden CCG	1.1%	0.9%
E09000030	Tower Hamlets	09A	NHS Central London (Westminster) CCG	0.5%	0.3%
E09000030	Tower Hamlets	07T	NHS City and Hackney CCG	0.9%	0.9%
E09000030	Tower Hamlets	08C	NHS Hammersmith and Fulham CCG	0.8%	0.5%
E09000030	Tower Hamlets	08H	NHS Islington CCG	0.2%	0.1%
E09000030	Tower Hamlets	08M	NHS Newham CCG	0.2%	0.2%
E09000030	Tower Hamlets	08V	NHS Tower Hamlets CCG	98.9%	96.9%
E08000009	Trafford	14L	NHS Manchester CCG	2.7%	7.0%
E08000009	Trafford	01G	NHS Salford CCG	0.1%	0.1%
E08000009	Trafford	02A	NHS Trafford CCG	95.7%	92.7%
E08000009	Trafford	02E	NHS Warrington CCG	0.1%	0.1%

E08000036	Wakefield	02P	NHS Barnsley CCG	0.9%	0.6%
E08000036	Wakefield	15F	NHS Leeds CCG	0.4%	1.0%
E08000036	Wakefield	03J	NHS North Kirklees CCG	0.6%	0.3%
E08000036	Wakefield	03R	NHS Wakefield CCG	94.5%	98.0%
E08000030	Walsall	15E	NHS Birmingham and Solihull CCG	1.1%	4.8%
E08000030	Walsall	04Y	NHS Cannock Chase CCG	0.7%	0.3%
E08000030	Walsall	05L	NHS Sandwell and West Birmingham CCG	1.6%	3.1%
E08000030	Walsall	05Y	NHS Walsall CCG	92.8%	90.4%
E08000030	Walsall	06A	NHS Wolverhampton CCG	1.4%	1.4%
E09000031	Waltham Forest	07T	NHS City and Hackney CCG	0.4%	0.4%
E09000031	Waltham Forest	08C	NHS Hammersmith and Fulham CCG	0.3%	0.2%
E09000031	Waltham Forest	08D	NHS Haringey CCG	0.1%	0.1%
E09000031	Waltham Forest	08M	NHS Newham CCG	1.3%	1.7%
E09000031	Waltham Forest	08N	NHS Redbridge CCG	1.4%	1.4%
E09000031	Waltham Forest	08W	NHS Waltham Forest CCG	94.3%	96.1%

E09000032	Wandsworth	09A	NHS Central London (Westminster) CCG	0.9%	0.6%
E09000032	Wandsworth	08C	NHS Hammersmith and Fulham CCG	1.0%	0.6%
E09000032	Wandsworth	08J	NHS Kingston CCG	0.1%	0.0%
E09000032	Wandsworth	08K	NHS Lambeth CCG	3.2%	3.5%
E09000032	Wandsworth	08R	NHS Merton CCG	2.8%	1.6%
E09000032	Wandsworth	08P	NHS Richmond CCG	1.3%	0.7%
E09000032	Wandsworth	08X	NHS Wandsworth CCG	88.3%	92.6%
E09000032	Wandsworth	08Y	NHS West London (K&C & QPP) CCG	0.7%	0.4%
E06000007	Warrington	01F	NHS Halton CCG	0.3%	0.2%
E06000007	Warrington	01G	NHS Salford CCG	0.5%	0.6%
E06000007	Warrington	01X	NHS St Helens CCG	2.2%	2.0%
E06000007	Warrington	02E	NHS Warrington CCG	97.6%	97.0%
E06000007	Warrington	02H	NHS Wigan Borough CCG	0.2%	0.2%
E10000031	Warwickshire	15E	NHS Birmingham and Solihull CCG	0.2%	0.5%
E10000031	Warwickshire	05A	NHS Coventry and Rugby CCG	25.2%	21.5%
E10000031	Warwickshire	11M	NHS Gloucestershire CCG	0.2%	0.2%
E10000031	Warwickshire	04G	NHS Nene CCG	0.2%	0.2%
E10000031	Warwickshire	10Q	NHS Oxfordshire CCG	0.3%	0.3%
E10000031	Warwickshire	05J	NHS Redditch and Bromsgrove CCG	0.7%	0.2%
E10000031	Warwickshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	0.8%	0.3%
E10000031	Warwickshire	05R	NHS South Warwickshire CCG	96.1%	45.8%
E10000031	Warwickshire	05H	NHS Warwickshire North CCG	96.7%	30.7%
E10000031	Warwickshire	04V	NHS West Leicestershire CCG	0.5%	0.3%
E06000037	West Berkshire	15A	NHS Berkshire West CCG	30.0%	97.6%
E06000037	West Berkshire	10J	NHS North Hampshire CCG	0.7%	0.9%
E06000037	West Berkshire	10Q	NHS Oxfordshire CCG	0.2%	1.1%
E06000037	West Berkshire	99N	NHS Wiltshire CCG	0.1%	0.4%
E10000032	West Sussex	09D	NHS Brighton and Hove CCG	1.1%	0.4%
E10000032	West Sussex	09G	NHS Coastal West Sussex CCG	99.5%	57.5%
E10000032	West Sussex	09H	NHS Crawley CCG	93.4%	14.0%
E10000032	West Sussex	09L	NHS East Surrey CCG	0.3%	0.0%
E10000032	West Sussex	09N	NHS Guildford and Waverley CCG	3.1%	0.8%
E10000032	West Sussex	99K	NHS High Weald Lewes Havens CCG	1.1%	0.2%
E10000032	West Sussex	09X	NHS Horsham and Mid Sussex CCG	95.7%	25.9%
E10000032	West Sussex	10V	NHS South Eastern Hampshire CCG	4.1%	1.0%
E10000032	West Sussex	99H	NHS Surrey Downs CCG	0.6%	0.2%
E09000033	Westminster	07P	NHS Brent CCG	1.3%	2.0%
E09000033	Westminster	07R	NHS Camden CCG	3.0%	3.4%
E09000033	Westminster	09A	NHS Central London (Westminster) CCG	79.3%	71.3%
E09000033	Westminster	08C	NHS Hammersmith and Fulham CCG	0.6%	0.6%
E09000033	Westminster	08K	NHS Lambeth CCG	0.1%	0.2%
E09000033	Westminster	08Y	NHS West London (K&C & QPP) CCG	23.1%	22.6%
E08000010	Wigan	00T	NHS Bolton CCG	0.2%	0.1%
E08000010	Wigan	01G	NHS Salford CCG	0.8%	0.6%
E08000010	Wigan	01X	NHS St Helens CCG	3.8%	2.2%
E08000010	Wigan	02E	NHS Warrington CCG	0.4%	0.2%
E08000010	Wigan	02G	NHS West Lancashire CCG	2.8%	1.0%
E08000010	Wigan	02H	NHS Wigan Borough CCG	96.7%	95.7%
E06000054	Wiltshire	11E	NHS Bath and North East Somerset CCG	0.9%	0.4%
E06000054	Wiltshire	15A	NHS Berkshire West CCG	0.2%	0.2%
E06000054	Wiltshire	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	0.2%	0.5%
E06000054	Wiltshire	11J	NHS Dorset CCG	0.3%	0.4%
E06000054	Wiltshire	11M	NHS Gloucestershire CCG	0.4%	0.5%
E06000054	Wiltshire	11X	NHS Somerset CCG	0.3%	0.4%
E06000054	Wiltshire	12D	NHS Swindon CCG	1.3%	0.6%
E06000054	Wiltshire	11A	NHS West Hampshire CCG	0.1%	0.2%
E06000054	Wiltshire	99N	NHS Wiltshire CCG	96.7%	96.8%
E06000040	Windsor and Maidenhead	15A	NHS Berkshire West CCG	0.4%	1.3%
E06000040	Windsor and Maidenhead	14Y	NHS Buckinghamshire CCG	0.3%	1.1%
E06000040	Windsor and Maidenhead	15D	NHS East Berkshire CCG	34.1%	96.9%
E06000040	Windsor and Maidenhead	09Y	NHS North West Surrey CCG	0.2%	0.5%
E06000040	Windsor and Maidenhead	10Q	NHS Oxfordshire CCG	0.0%	0.2%
E06000040	Windsor and Maidenhead	10C	NHS Surrey Heath CCG	0.1%	0.0%
E08000015	Wirral	02F	NHS West Cheshire CCG	0.4%	0.3%
E08000015	Wirral	12F	NHS Wirral CCG	99.7%	99.7%
E06000041	Wokingham	15A	NHS Berkshire West CCG	31.5%	97.0%
E06000041	Wokingham	15D	NHS East Berkshire CCG	1.0%	2.6%

E06000041	Wokingham	10Q	NHS Oxfordshire CCG	0.1%	0.4%
E08000031	Wolverhampton	05C	NHS Dudley CCG	1.3%	1.5%
E08000031	Wolverhampton	05L	NHS Sandwell and West Birmingham CCG	0.1%	0.3%
E08000031	Wolverhampton	05Q	NHS South East Staffs and Seisdon Peninsular CCG	1.8%	1.4%
E08000031	Wolverhampton	05Y	NHS Walsall CCG	3.4%	3.5%
E08000031	Wolverhampton	06A	NHS Wolverhampton CCG	93.8%	93.4%
E10000034	Worcestershire	15E	NHS Birmingham and Solihull CCG	0.9%	2.0%
E10000034	Worcestershire	05C	NHS Dudley CCG	0.7%	0.4%
E10000034	Worcestershire	11M	NHS Gloucestershire CCG	0.5%	0.6%
E10000034	Worcestershire	05F	NHS Herefordshire CCG	0.9%	0.3%
E10000034	Worcestershire	05J	NHS Redditch and Bromsgrove CCG	95.8%	27.7%
E10000034	Worcestershire	05N	NHS Shropshire CCG	0.3%	0.1%
E10000034	Worcestershire	05R	NHS South Warwickshire CCG	2.3%	1.1%
E10000034	Worcestershire	05T	NHS South Worcestershire CCG	97.2%	49.3%
E10000034	Worcestershire	06D	NHS Wyre Forest CCG	98.3%	18.6%
E06000014	York	03E	NHS Harrogate and Rural District CCG	0.2%	0.1%
E06000014	York	03Q	NHS Vale of York CCG	60.2%	99.9%

Produced by NHS England using data from National Health Applications and Infrastructure Services (NHAIS) as supplied by NHS Digital.

South East Essex Locality Partnership
Memorandum of Understanding
FINAL

Introduction

Over the last eighteen months, partners across South East Essex have been working closely together to rethink the way in which we organise and provide services with and for local people.

The increasing level of collaboration between us has been driven by a collective recognition that achieving the best outcomes for local people cannot be delivered by a single organisation acting alone. Rather, it requires an integrated, flexible model in which the focus is on enabling communities to build capacity and improving the lives and wellbeing of individuals and communities, not organisational boundaries or silos.

As a partnership, we have recently developed and published our Locality Strategy – *Living Well in Thriving Communities*. The purpose of our strategy is threefold: to provide a clear 'point of reference' by articulating our shared system ambition and intended way of working; to outline the approach we will take to developing new models of integrated care based on the establishment of localities; and to put in place a framework that supports the development of more detailed business plans for each of the emerging localities within SE Essex.

In our strategy, we committed to developing and formally agreeing this Memorandum of Understanding (MoU). We feel that it is important to publicly commit to working together, and to articulate the principles we will follow and how we will behave.

Purpose of this Memorandum of Understanding

The purpose of this MoU is to codify, in clear language, how the partners across South East Essex will work together. This includes setting out who the partners are, what we are seeking to achieve, the principles that will guide us, how we will behave and the expectations we are placing on one another.

While this MoU is not legally binding and does not give rise to any new rights or liabilities for any of the parties, it is an important document that binds us together. We envisage that the MoU will help us to hold one another to account as we implement our strategy, and will also provide the foundations for further integration at a future stage.

Parties to the Memorandum of Understanding

The following organisations are parties to the MoU:

- Castle Point Association of Voluntary Services (CAVs)
- Essex County Council (ECC)
- Essex Partnership NHS Foundation Trust (EPUT)
- NHS Castle Point and Rochford Clinical Commissioning Group (CPRCCG)
- NHS Southend Clinical Commissioning Group (Southend CCG)
- Southend Association of Voluntary Services SAVs)
- Southend Borough Council (SBC)
- Southend University NHS Foundation (SUHFT)

Primary Care (general practice) are also key members of our partnership. However, at this point, individual practices as service providers do not have an agreed mechanism for representing one another, although we anticipate this will change as localities develop and leaders emerge. In the interim, our intention is for primary care (as providers) to be represented by the two Clinical Commissioning Groups, which are membership organisations led by GPs.

As our model evolves and the Partnership develops, we are keen to involve a wider range of organisations as parties to this MoU. In particular, at the appropriate point we would welcome the participation of Castle Point and Rochford District Councils.

Our objectives

In our strategy, we set out our overall system ambition, which is to:

- improve the wellbeing and lives of the people we serve
- work with each other and the local population to organise services and mobilise resources within communities

- prioritise the needs and locations of people, rather than the boundaries of organisations
- focus on prevention and supporting the strengths of communities and individuals.

At the core of our strategy is the locality model. We view this model as central to designing and integrating services at a very local level, as well as being the principal way in which we will help to create social capital and build resilience within individuals and communities. Ensuring that there are effective, thriving localities is, as a consequence, a priority for the Partnership.

We are developing more detailed measures of how we will quantify and track progress in delivering against our collective ambition. We have split these into three levels or tiers: overall domains, which set out the broad areas we want to improve; outcomes, which describe in more detail what we are trying to achieve; and indicators, which set out how an outcome is measured at a locality level and quantify the targets we are setting.

The four domains that we have agreed, and that we are developing outcomes and indicators for, are:

- health and wellbeing – measuring population health, prevention, independence and lifestyle factors
- care quality and experience – looking at personal experience, quality and partnership development
- sustainability – focusing on the financial and clinical sustainability of the system
- transformation – such as changing culture amongst our workforce

Key principles

We have developed the following principles which will act as a guide in our system. We will:

- *Be ambitious* – both in what we are seeking to achieve and in embracing different ways of working – such as pooled budgets, single leadership or joint teams - where it makes sense to do so
- *Integrate services* – designing services around the needs and preferences of individuals and communities, not professional or organisational silos
- *Put the interests of local people first* – even where this poses challenges for our individual organisations
- *Involve people* – both in designing changes we want to make and in any decisions about their care
- *Recognise the importance of* place – and the need to develop different models and services in each of our localities, driven by local needs and preferences
- *Focus on delivering better outcomes* – measuring the things that matter to individuals, communities and the population as a whole

- *Prioritise prevention, wellbeing and building resilience* – supporting people to live healthy lives and remain independent for as long as possible
- *Be transparent* – sharing information openly with one another and with the public
- *Be generous* – put resources (money and/or people) into shared projects and to support one another to deliver, and in recognising that leadership may come from any part of our system
- *Be flexible and pragmatic* – recognising that different problems will require different solutions and that a wide range of partners, including the third sector, have key roles developing solutions
- *Be enabling* – strive to create the conditions within which local leaders and staff can innovate, take responsibility and 'do the right thing', regardless of which organisation they work for

Governance

Each organisation named above has formally signed off this MoU.

The key forum through which we work together is the South East Essex Partnership, which has senior representation from each of the partners. The Partnership is responsible for overseeing the implementation of our strategy and, by extension, the operation of this MoU.

The Partnership reports to both Southend and Essex Health and Wellbeing Boards.

Reviewing this agreement

We anticipate that our partnership will deepen and change over time as we implement our strategy and localities develop new ways of working.

As a result, we intend to review and update this MoU annually, with the first review in April 2020. This review will be conducted by the South East Essex Locality Partnership.

Signatures

Janis Gibson
Castle Point Association of Voluntary Services (CAVs)

Peter Fairley
Director for Integration and Partnerships
Essex County Council (ECC)

Malcolm McCann
Executive Director of Community Services & Partnerships
Essex Partnership NHS Foundation Trust (EPUT)

Kashif Siddiqui
Chair
NHS Castle Point and Rochford Clinical Commissioning Group (CPRCCG)

Jose Garcia
Chair
NHS Southend Clinical Commissioning Group (Southend CCG)

Kristina Jackson
Chief Executive
Southend Association of Voluntary Services (SAVs)

Simon Leftley
Deputy Chief Executive (people)
Southend Borough Council (SBC)

Yvonne Blucher
Managing Director
Southend University NHS Foundation (SUHFT)

March 2019

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OUR **AMBITION**

SOUTHEND 2050

be part of the conversation

FIVE YEAR ROAD MAP TO **2023**

OUR **AMBITION**

The year is 2050.

How does our borough, Southend-on-Sea, look and feel?

Inevitably the place has changed a lot since the early years of the century, but we've always kept sight of what makes Southend-on-Sea special. Prosperous and connected, but with a quality of life to match, Southend-on-Sea has led the way in how to grow a sustainable, inclusive city that has made the most of the life enhancing benefits of new technologies.

It all starts here – where we are known for our creativity, our cheek, our just-get-on-with-it independence and our welcoming sense of community. And so, whilst the growth of London and its transport network has made the capital feel closer than ever, we cherish our estuary identity – a seafront that still entertains and a coastline, from Shoebury garrison to the fishing village of Old Leigh, which always inspires. We believe it's our contrasts that give us our strength and ensures that Southend has a vibrant character of its own.

- **Pride and Joy:** People are proud of where they live – the historic buildings and well-designed new developments, the seafront and the open spaces. The city centre has generated jobs, homes and leisure opportunities, whilst the borough's focal centres all offer something different and distinctive. With its reputation for creativity and culture, as well as the draw of the seaside, Southend-on-Sea is a place that residents and visitors can enjoy in all seasons. Above all we continue to cherish our coastline as a place to come together, be well and enjoy life.

- **Safe and Well:** Public services, voluntary groups, strong community networks and smart technology combine to help people live long and healthy lives. Carefully planned homes and new developments have been designed to support mixed communities and personal independence, whilst access to the great outdoors keeps Southenders physically and mentally well. Effective, joined up enforcement ensures that people feel safe when they're out and high quality care is there for people when they need it.

- **Active and Involved:** Southend-on-Sea has grown, but our sense of togetherness has grown with it. That means there's a culture of serving the community, getting involved and making a difference, whether you're a native or a newcomer, young or old. This is a place where people know and support their neighbours, and where we all share responsibility for where we live. Southend in 2050 is a place that we're all building together – and that's what makes it work for everyone.

- **Opportunity and Prosperity:** Southend-on-Sea and its residents benefit from being close to London, but with so many options to build a career or grow a business locally, we're much more than a commuting town. Affordability and accessibility have made Southend-on-Sea popular with start-ups, giving us the edge in developing our tech and creative sectors, whilst helping to keep large, established employers investing in the borough. People here feel valued, nurtured and invested in. This means that they have a love of learning, a sense of curiosity and are ready for school, employment and the bright and varied life opportunities ahead of them.

- **Connected and Smart:** Southend is a leading digital city and an accessible place. It is easy to get to and easy to get around and easy for residents, visitors and businesses to park. Everyone can get out to enjoy the borough's thriving city centre, its neighbourhoods and its open spaces. Older people can be independent for longer. Local people also find it easy to get further afield with quick journey times into the capital and elsewhere, and an airport that has continued to open up business and leisure travel overseas – but in balance with the local environment.

SOUTHEND **ON-SEA**

it all starts here

OUR **AMBITION**

This ambition was developed following extensive conversations with those that live, work, visit, do business and study in Southend-on-Sea. These conversations asked people what they thought Southend-on-Sea should be like in 2050 and what steps are needed now, and in the coming years, to help achieve this. As a result, thousands of responses were provided through a range of methods including surveys, community events, partnership meetings, focus groups and social media. The feedback provides a rich source of information from which the ambition has been developed along with associated themes.

The ambition is grounded in the values of Southenders. It is bold, challenging, but achievable. It will, however, need all elements of our community to work together to make it a reality. We will also need our neighbouring boroughs, and central Government to play their part.

The ambition complements the Essex 2050 vision, The Future of Essex developed by Essex wide stakeholders and the emerging South Essex 'proposition', titled 'What sort of place are we making?' This is being developed by South Essex local authorities who are collectively looking to the future. Taking a longer view gives us the context to put the right building blocks in place to make our ambition a reality.

CHALLENGES AND **OPPORTUNITIES**

There is so much that we love about Southend-on-Sea. The sea, the beach, being close to our family and friends, our parks and open spaces, and having easy access to public transport, London, and the airport are some of the things that many people value.

We also heard about the things people don't like and which need more focus in the here and now. These include the quality of roads and pavements, crime and anti-social behaviour, parking and traffic congestion, the condition and future of the high street and the increase in homelessness, particularly in central Southend.

The borough faces major challenges. As our population increases, gets older, and birth rates rise, there will be greater demand for school places, homes, health and other public services. Our changing climate provides challenges to our valued coast. Our economy is also changing and we need a better skilled workforce to meet the needs of the future. This includes developments in robotics, artificial intelligence and technology. These have huge potential to enhance our lives by enabling independent living, ending the drudgery of many jobs and providing more leisure time. We also have significant and unacceptable inequalities across the borough, particularly relating to residents' health.

South Essex needs major investment in transport and infrastructure. The opening of Crossrail, as well as a new Thames crossing (from the end of the 2020s) will help connectivity to Southend-on-Sea. Further into the future, a relief road to the north and east of the borough could ease congestion and provide economic opportunities.

The loss of Government grant funding for the Council will continue to put pressure on budgets and by 2020 the Council will receive no grant at all. However, with a spend of around £228m, and more financial independence, the ability to shape our future and meet local needs is in our hands. This will mean, increasingly, the Council will move towards enabling others to do more for themselves, rather than being a universal and direct provider of services for all.

We all want Southend-on-Sea to be a place that people love to live in, love to visit, love to work, do business and study. People told us they want to be part of the solution and to continue the conversations on how to achieve the ambition. We are on a journey, and this road map is just the beginning.

SOUTHEND **2050**
and the five year road map

The Southend 2050 programme is not about one single publication or statement. It is a mind-set – one that looks to translate the desires of local people and stakeholders into action, something that looks to the long term, but also at the action that is needed now and in the medium-term.

Southend 2050 is made up of our ambition, associated themes and the outcomes we want to achieve. This Road Map, and all future delivery plans, strategies and policies will reflect this.

The Road Map outlines the Council's role in achieving the ambition and provides a high level guide for Councillors, staff, partners and others in aligning their capacity and resources to priorities. It will help in ensuring we are all working to achieve the same outcomes.

The Road Map also builds on our existing achievements and outlines what the Council wants to achieve in the coming five years. Our delivery plans will focus on achieving desired outcomes that reflect our ambition and focus on the next 12-18 months.

Transforming Together

Political, economic and other uncertainties remain and we heard a lot about how quickly things change and how different the world will be by 2050. The Council will also need to change fundamentally to be able to take advantage of the opportunities and challenges ahead. This will mean a Council that is more agile, more efficient, more entrepreneurial and more engaged with residents and customers.

Work is underway to put in place the conditions staff have identified as being necessary to make us 'match fit' for the future. These conditions will form an overarching transformation programme for the organisation and includes the need for:

- A clear vision & delivery strategy
- Digital enablement to support the vision
- A trusted, empowered and engaged workforce
- An appetite to invest in people and outcomes and to accept risk
- Closer collaboration with staff, members, residents and partners
- Simple and effective governance
- An open mind-set that will drive forward transformation and change

Complementing this work, the Council will shift to longer-term outcome based budgeting to support the delivery of the 2050 Ambition and associated Themes.

Transforming Together

WHAT PEOPLE TOLD US THEY WANT FOR **SOUTHEND-ON-SEA'S FUTURE**

PRIDE & JOY

The seafront continues to be our pride and joy

I'm proud to call Southend my home – It has a distinct and vibrant identity

Everyone looks after the place

We have the opportunities of a city but retain our local feel

Our town centres and public spaces are clean, attractive, thriving, and reflect our success

We visibly celebrate our heritage and culture

We are a 'destination' – People want to visit, live and study here all year round and from far and wide

Our parks and open spaces are well used, cherished and protected

I feel inspired by the arts, culture and attractions that are available year round in Southend

SAFE & WELL

Quality health care is there when I need it

Everyone feels safe at all times of the day

There is a reassuring police presence and innovative methods of enforcement right across Southend

Our older people are respected, valued, involved and well cared for

Anti social behaviour is not tolerated by Southenders

No rough sleeping/ begging in public spaces

We have creatively met housing need while enhancing the character of the area

My home suits my needs and is in harmony with the area

ACTIVE & INVOLVED

Young people feel invested in the future

When I talk, I feel that I am heard – I am taken seriously

We are developing Southend together – Everyone who wants to can be involved to make this happen

Southenders get together regularly – there are plenty of good places to do so

Southend is known for its warm welcome

Everyone takes responsibility for protecting our environment

There is no divide between young and old

A sense of family, and community, enjoying and supporting each other – a strong sense of settled communities

OPPORTUNITY & PROSPERITY

My educational opportunities have given me the best start in life

There are so many options for a rewarding career locally

Innovative and easily accessible start-up opportunities are helping new businesses to thrive and develop

We are well known as a hub for innovative and creative industries and ventures

There is a good balance of quality retail, residential and social space in our town centres

It's easy to do business here – bureaucracy is minimal and overheads are affordable

Large businesses support residents aspirations

CONNECTED & SMART

Easy connectivity with minimal barriers, however I choose to travel

Parking is cheap and easy for residents and visitors

We are leading the way on green and innovative travel

Technology / Digital connectivity and inclusion

Lots of opportunities to be in open spaces

It's easy for me to get around when I want – this helps my independence

Quick and easy links to London and beyond

The airport is thriving but operates in harmony with the area

PRIDE & JOY

Our focus for the next five years – themes and outcomes:

THEME 1:

PRIDE AND JOY

We already have much to be proud about, but there is so much more we can do together to make us even prouder.

With the ambition to become England's leading coastal tourist destination, we will work with local businesses and potential investors to develop and grow our tourism, cultural, creative and leisure offer. We will help to develop our visitor economy for the benefit of the whole borough. With our seven miles of coastline and the huge variety it offers visitors, Southend-on-Sea is becoming more than just a day-trip location. We must also continue to take advantage of our growing popularity as a 'staycation' destination.

People have repeatedly told us how much they value our **seafront** – the beaches, the water and the open spaces – both as a place for peace and for fun. This won't be taken for granted and so we will continue to invest and focus on this area to avoid erosion and further 'cliff slips', tackle growing flood risk and also encourage inward investment and seek external funding to ensure the seafront maintains its popularity and appeal with residents and visitors alike. Just as important to residents is the everyday street scene around them and we know that the cleanliness and state of repair of our streets and neighbourhoods serves as a highly visible indicator of our borough's overall state of health.

Over the next five years, our iconic, and ever popular **pier** will benefit from huge investment to sustain it for now and the future. This will include a redesigned pier entrance and new pavilion, housing a relocated pier museum. This development will provide a quality all-weather eating, drinking and cultural visitor experience, encouraging people to stay longer in our area.

Securing and enhancing our coastline is essential to ensure the safety and prosperity of the borough. Our investment programme will see improvements over the next five years to Shoebury and Leigh-on-Sea flood defences, complementing improvements at Two-Tree Island and followed by further enhancements over the long term through our Shoreline Strategy.

Other improvements at Shoebury Common North and new sun shelters at City Beach are just two developments that highlight our commitment to the entire seafront. Further work to help the port at Leigh-on-Sea remain accessible by all maritime users, including the fishing and cockling industries will also be considered.

We will continue to build on our reputation as a welcoming, vibrant and increasingly culturally diverse place. Our theatres, Metal Culture, The Forum and Focal Point gallery, along with our range of festivals across the year provide a rich foundation. Options for a new museum, to house, among other things, the Saxon burial and 'The London' shipwreck finds will be developed. Investment in the former Beecroft Gallery to transform it into artists' studios will also be an important step in developing new exciting spaces to allow artists to flourish as part of our burgeoning cultural scene.

By 2050 Southenders are fiercely proud of, and go out of their way, to champion what our city has to offer.

OUTCOMES
In five years' time:

- There is a tangible sense of pride in the place and local people are actively, and knowledgeably, talking up Southend-on-Sea.
- The variety and quality of our outstanding cultural and leisure offer has increased and we have become the first choice English coastal destination for visitors.
- We have invested in protecting and nurturing our coastline, which continues to be our much loved and best used asset.
- Our streets and public spaces are clean and inviting.

THEME 2:
SAFE AND WELL

Southend-on-Sea should feel safe for all who live, work and visit here – across our streets, town centres and open spaces. The Council's decision to increase resources for community safety will help. However, the focus on tackling gangs, 'county line' drug networks, safeguarding of the vulnerable, child sexual exploitation, domestic abuse, and modern slavery will require us to work with our agency partners even more effectively.

A key area of our focus will be our town centres. The Council will build on its excellent record of keeping young people at risk, out of the criminal justice system. Technology will increasingly play its part in making people safer.

For people to **live well** the conditions they live in have to be right –their diet, home, air they breathe, mental well-being and level of activity. Our focus will be on the prevention of illness, through increased physical activity; reducing inequalities, through raising people's aspirations and opportunities and making long term change through increased personal responsibility and participation. The need for a revised approach to the provision of **mental health** services has also been highlighted in response to concerns that some residents may not be receiving the level of access to services they need. Promoting the Youth Council's Mental Health Charter for schools will help in this regard. We also believe that new, modern and fit for purpose health facilities, which provide acute services for the area and meet the changing and developing needs of our residents, are required

Overall demand for **housing and levels of homelessness** is increasing. Our new housing vision will address these issues by: prioritising the supply of a range of safe, locally affordable, housing

options for sale and rent; creating inclusive healthy places to live and thrive; supporting people to live independently; encouraging good quality housing design management and maintenance and making homelessness brief and non-recurrent. Our approach will link closely to our aspirations as an emerging city, our ambitions for economic development, the creation of jobs, and workforce skills. We will continue to secure further funding to tackle rough sleeping specifically and our new housing company will look to increase the supply of housing for local people to buy and rent and new ways of improving conditions in the private rented sector.

We will ensure that **vulnerable children and adults** are safe and well looked after. This means working with families in a way that is responsive and gives them more power. We will roll out our programme to improve outcomes, promote resilience, reduce service duplication and enable staff. This will feature further developing our new approaches to work alongside clients, rather than making decisions about them (restorative practice), and working alongside communities to use and develop local assets to address local challenges (asset based community development).

In a world with ever increasing complex behaviour and health issues, the Council's own company, **Southend Care**, will continue to develop services, supporting people in our care homes, those with dementia, learning disabilities, autism and mental health issues, and look for opportunities to innovate and transform services. The new Priory, Delaware, Viking building and facilities will be a magnificent resource for those with care needs. Increased provision of accommodation for looked after children will be delivered locally to ensure they get the care and support they require to remain in their community.

The Better Start programme is investing £40m over ten years to improve the lives of Southend's very youngest residents. This means working with local people every step of the way to find out how to give every child who lives here the best possible start in life.

Southend-on-Sea is already one of the UK's 'Greenest' Cities (on the UK's Vitality Index). However, we want Southend-on-Sea to be a **Low Carbon City by 2020**, one that focuses on delivering low carbon growth, improving energy efficiency, providing a more sustainable future for our residents and businesses and one that protects and enhances our natural spaces, bio-diversity and habitats. This approach will help safeguard against rising energy costs and improve fuel security and air quality.

By 2050 people in Southend-on-Sea feel safe in all aspects of their lives and are well enough to live fulfilling lives

OUTCOMES
In five years' time:

- People in all parts of the borough feel safe and secure at all times.
- Southenders are remaining well enough to enjoy fulfilling lives, throughout their lives.
- We are well on our way to ensuring that everyone has a home that meets their needs.
- We are all effective at protecting and improving the quality of life for the most vulnerable in our community.
- We act as a green city with outstanding examples of energy efficient and carbon neutral buildings, green open spaces, streets, transport and recycling.

THEME 3:
ACTIVE AND INVOLVED

Everything we want to achieve depends on the collective effort of local people and partners. The conversations started by the 2050 programme will continue, looking at what works best and adapting as circumstances change and new challenges and opportunities arise. We will harness the energy of those who care about wanting to make a positive difference and create the right conditions for that approach to flourish. We will involve the local community in designing and delivering services, and making decisions.

Volunteers already add much needed and vital capacity to many existing public services, such as libraries, museums, youth clubs, schools and support groups. We value the skills and experiences of our residents, working alongside those with the time and energy to make a real difference in their communities. Over the next five years we will help communities develop their asset and skills bases so that they become increasingly effective at finding new and creative ways of tackling local issues at grass roots. We will work in partnership, creating and strengthening long term, sustainable relationships so that communities feel equipped and empowered to do more for themselves.

Our well-established voluntary sector will be key in this relationship - harnessing their expertise and knowledge to support those who want to use their local insights and vitality to make a positive contribution. Through **hands-on activity** local initiatives will continue to support

groups who want to enhance their local area and environment. This will grow and help create a greater sense of local pride and a cleaner, greener, more attractive place.

We will work hard to ensure that local people can live well in thriving communities with increasing integration of care services developed through a **locality approach** across south east Essex. Each **locality** will utilise local assets to support residents and patients whilst integrated primary, community and social care services work in multi-disciplinary teams. This approach will complement the intended reconfiguration of acute services across mid and south Essex.

The Council will promote more physical activity to improve people's health and happiness, with a particular focus on the large proportion of our population who undertake no physical activity at all. This will include looking to attract national sporting events, making walking and cycling easier and building physical activity into all areas of public life as much as possible.

We will use our commissioning and procurement power to ensure we secure the best possible outcomes whilst delivering wider social, economic and environmental benefits to the community and ensuring value for money.

By 2050 we have a thriving, active and involved community that feel invested in our city.

OUTCOMES
In five years' time:

- Even more Southenders agree that people from different backgrounds are valued and get on well together.
- The benefits of community connection are evident as more people come together to help, support and spend time with each other.
- Public services are routinely designed – and sometimes delivered – with their users to best meet their needs.
- A range of initiatives help communities come together to enhance their neighbourhood and environment.
- More people have active lifestyles and there are significantly fewer people who do not engage in any physical activity.

THEME 4:
OPPORTUNITY AND PROSPERITY

We aim that by 2023, the Southend economy will have addressed areas of economic underperformance to emerge as the leading economy in south Essex, with businesses and residents thriving. This will mean strengthening our identified Growth and Strategic sectors to increase average income and productivity, improve educational outcomes, improve business start-up and survival rates, and develop a more resilient, balanced and diverse economy that promotes growth.

The borough benefits from g**reat schools, colleges and a thriving university**. With nearly 9 out of 10 children currently in good or outstanding schools, we will prioritise our support on less successful schools and getting more local children into grammar schools.

However, those working in Southend-on-Sea currently have amongst the lowest average wages of urban areas in the country, while average house prices are amongst the highest in terms of affordability (with prices rising faster than elsewhere). The borough also has pockets of significant deprivation, with, for example, life expectancy varying by up to 10 years between the most and least affluent areas, resulting from a range of poorer social, economic and environmental conditions.

Our five year plans to help equip our people with skills for the future, including an improved education offer for adults will be an important part of breaking this cycle and producing an inclusive, efficient, and effective labour market, with clear and accessible career pathways. This will mean working with business and other partners to improve career advice and support and enhance more flexible skills provision, facilitate more

workplace experience and link to the borough's major regeneration projects – all of which will help to reduce social isolation.

Over the next five years it is predicted there will be a significant increase in housing in the borough (with around 5,000 additional homes). To meet the projected increase in school places the Council will explore all alternative methods, including further expansion and an additional secondary school, as necessary, to meet our statutory requirements to provide a school place for every child.

Re-imagining **our High Street** will be a critical piece of work. This will need to address retail in a changing world, housing provision, community safety and securing town centre property. A second phase of development at the Forum will be progressed, creating a vibrant, lively environment, enhancing the town's educational and cultural quarter and providing a significant boost to enhancing the economic vibrancy of the town.

A new Southend **Local Plan** will provide a clear and long-term planning framework to manage future development in a way that is sustainable and seeks to meet local housing needs, improve job opportunities, improve health and well-being, improve transport provision and infrastructure, and protect and enhance the natural and built environment.

Ambitious plans to transform the **Queensway** area will make significant progress. A new community of over 1,400 new homes will be created, providing better and new housing, improved connections to the high street and improved transport connectivity around the town.

The rejuvenation of **Victoria Avenue** as a key and vibrant gateway into our town centre will continue with derelict office blocks being turned into homes, cafes and shops.

Airport Business Park Southend will provide the nucleus for business growth, supporting key sectors such as aviation, medical technology and professional services, bringing up to 6,000 quality jobs to the area.

Plans to develop a year-round, all-weather leisure scheme including a cinema, restaurants, and a hotel at Seaway car park will be determined and appropriate planning consideration will be given to Southend United Football Club's plans to develop a new stadium, along with shops and homes at Fossetts Farm.

Work will also be undertaken to deliver the infrastructure led growth needed to deliver the south Essex Joint Strategic Plan, including business growth, additional housing and improved transport and green spaces.

By 2050 Southend on Sea is a successful city and we share our prosperity amongst all of our people.

OUTCOMES
In five years' time:

- The Local Plan is setting an exciting planning framework for the borough.
- We have a fast-evolving, re-imagined and thriving town centre, with an inviting mix of shops, homes, culture and leisure opportunities.
- Our children are school and life ready and our workforce is skilled and job ready.
- Key regeneration schemes, such as Queensway, seafront developments and the Airport Business Park are underway and bringing prosperity and job opportunities to the borough.
- Southend is a place that is renowned for its creative industries, where new businesses thrive and where established employers and others invest for the long term.

CONNECTED & SMART

THEME 5:
CONNECTED AND SMART

We know that moving around Southend is not always easy. Popularity and growth means that our roads can become congested at peak times and our public transport is not as accessible and connected as it could be.

We will continue to make the case for external funding to make improvements to our existing roads. We will also work collectively to promote and encourage the use of sustainable transport, support the introduction and use of **smart technology** and prepare for the inevitable wider use of electric and ultra-low emission vehicles. Promoting an integrated transport system, with, for example, a single use travel card for trains and buses, a more holistic bus service, improved cycle facilities on and near other means of travel and better communication of travel options will be pursued.

Long term strategy and planning will be essential, and so we will look seriously at the potential for a relief road to the north and east of the borough to ease congestion. This will be done in conjunction with south Essex wide plans for new infrastructure across the region, including new homes, schools, businesses and health services.

More immediate priorities are being addressed through our 10-year programme of **highways improvements**, which include recent and ongoing improvements to the A127 which have increased capacity and traffic flow and have helped to enable developments like Airport Business Park Southend.

Our approach to parking and access to the town will support tourism, retail and leisure as well as business and residents. It aims to meet needs through a modern parking management system that harnesses smart technology, uses competitive pricing, reduces 'traffic cruising' and improves air quality.

We will continue to support the success of London Southend Airport, whilst being sensitive to the impact it has on local residents. Its success is a key component of welcoming people from around Europe and a key driver of our plans to develop a high quality business park, including an Innovation Centre.

There is compelling evidence that air pollution is a significant contributor to preventable ill health and early death. Our three year action plan, which has a focus on transport to improve traffic flow, walking, cycling, electric vehicles, trains and improved passenger transport will be crucial to **improving health** locally.

We will become a leading digital city, with private sector investment providing full fibre enablement, superfast broadband and free public Wi-Fi, benefiting business and residents. An enhanced and integrated operations centre will enable us and others to better engage with our community, providing smarter ways of meeting needs, for all, in relation to safety, traffic flow, parking, waste/recycling, air quality, retail offers and leisure opportunities. As well as access, we will support our people in having the right skills, confidence and motivation to use digital technology, while meeting the needs of those who are unable to do so.

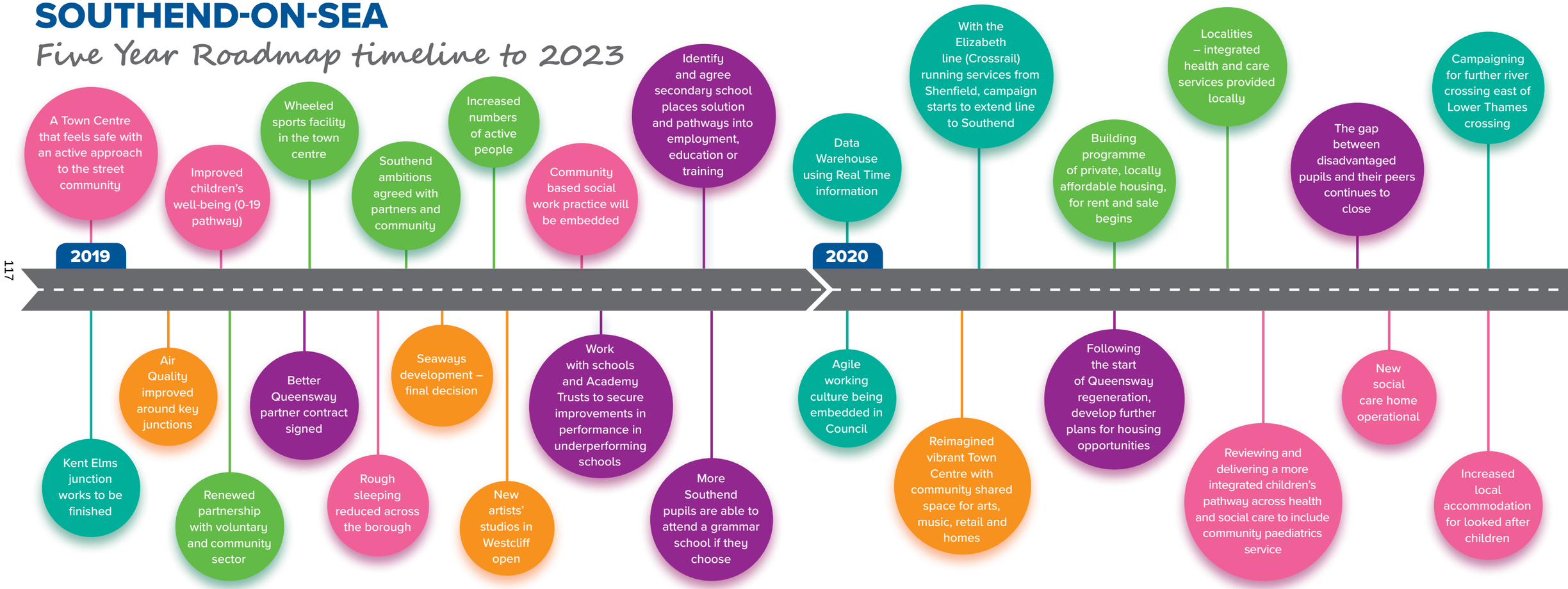
By 2050 people can easily get in, out and around our borough and we have a world class digital infrastructure.

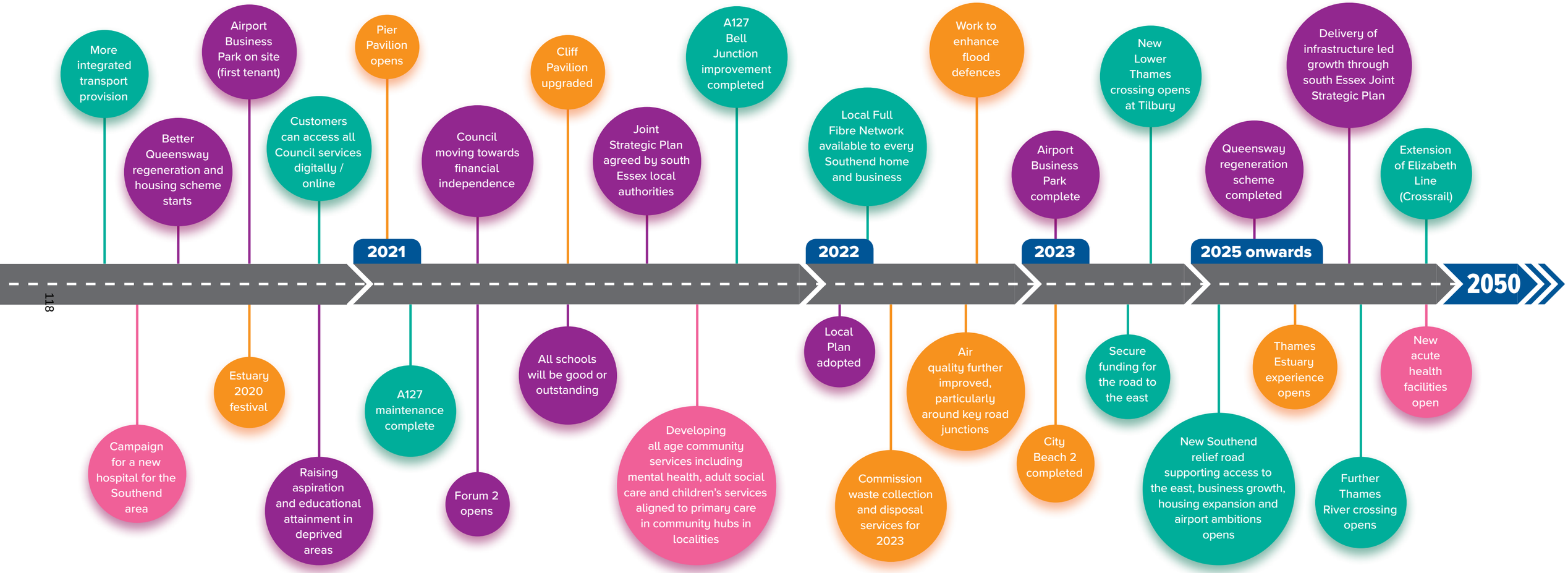
OUTCOMES
In five years' time:

- It is easier for residents, visitors and people who work here to get in and around the borough.
- People have a wide choice of transport options.
- We are leading the way in making public and private travel smart, clean and green.
- Southend is a leading digital city with world class infrastructure, that enables the whole population.

SOUTHEND-ON-SEA

Five Year Roadmap timeline to 2023




More integrated transport provision
Better Queensway regeneration and housing scheme starts
Airport Business Park on site (first tenant)
Customers can access all Council services digitally / online
Pier Pavilion opens
Council moving towards financial independence
Cliff Pavilion upgraded
Joint Strategic Plan agreed by south Essex local authorities
A127 Bell Junction improvement completed
Local Full Fibre Network available to every Southend home and business
Work to enhance flood defences
Airport Business Park complete
New Lower Thames crossing opens at Tilbury
Queensway regeneration scheme completed
Delivery of infrastructure led growth through south Essex Joint Strategic Plan
Extension of Elizabeth Line (Crossrail)
2021
2022
2023
2025 onwards
2050
Campaign for a new hospital for the Southend area
Estuary 2020 festival
Raising aspiration and educational attainment in deprived areas
A127 maintenance complete
Forum 2 opens
All schools will be good or outstanding
Developing all age community services including mental health, adult social care and children's services aligned to primary care in community hubs in localities
Local Plan adopted
Commission waste collection and disposal services for 2023
Air quality further improved, particularly around key road junctions
City Beach 2 completed
Secure funding for the road to the east
New Southend relief road supporting access to the east, business growth, housing expansion and airport ambitions opens
Thames Estuary experience opens
Further Thames River crossing opens
New acute health facilities open

Published December 2018

This document is published by Southend-on-Sea Borough Council. A summary can be provided in alternative formats such as Braille, audio-tape or in large print.

Translations of this document in alternative languages are also available upon request.

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www.southend.gov.uk

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Version: 7

Commissioning Operational Plan 2019-2020

NHS Castle Point and Rochford Clinical Commissioning Group
NHS Southend Clinical Commissioning Group

Contents

This plan has been completed by the Executive and Governing Body of Castle Point and Rochford and Southend CCGs in conjunction with member practices a number of partner organisations (relative to specific sections). It sets out how we will work together and deliver specific commitments to improve performance in key priorities like cancer, maternity and mental health during 2019/20. It forms the first stage in our response to the NHS Long Term Plan. Notably this includes joint working with Essex County Council and Southend Borough Councils in respect of proposals for implementation of the Better Care Fund and joint commissioning of services. The CCG also liaises closely with key provider organisations, e.g. Southend University Hospital NHS Foundation Trust (SUHFT) and Essex Partnership University Trust (EPUT) in respect of the system unplanned care programme, new pathways of care, etc.

Any enquiries about the plan should in the first instance be addressed to:

NHS Castle Point and Rochford Clinical Commissioning Group & NHS Southend Clinical Commissioning Group

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6th Floor|Civic Centre|Victoria Avenue|Southend on Sea | Essex |SS2 6ER

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Document control	Reviewed by:/when	Comments:
Draft v1	• NHS Southend CCG & NHS Castle Point and Rochford CCG Governing Bodies: March 2019	Priorities proposed
Draft v2	• CMT	Priorities reviewed
Draft v4	• Joint Clinical Executive Committee	

Foreword

By Terry Huff, Accountable Officer

This document sets out our priorities and ambitions for the transitional year of 2019/20. It forms part of the mid and south Essex Sustainability and Transformation Plan and reflects our local aspiration to meet the national priorities identified in the Long Term Plan, published this January.

The Plan outlines progress made in relation to integrated care both locally and on a broader mid and south Essex footprint, and details the specific commitments that we are making as a partnership towards delivery and performance during 2019/20.

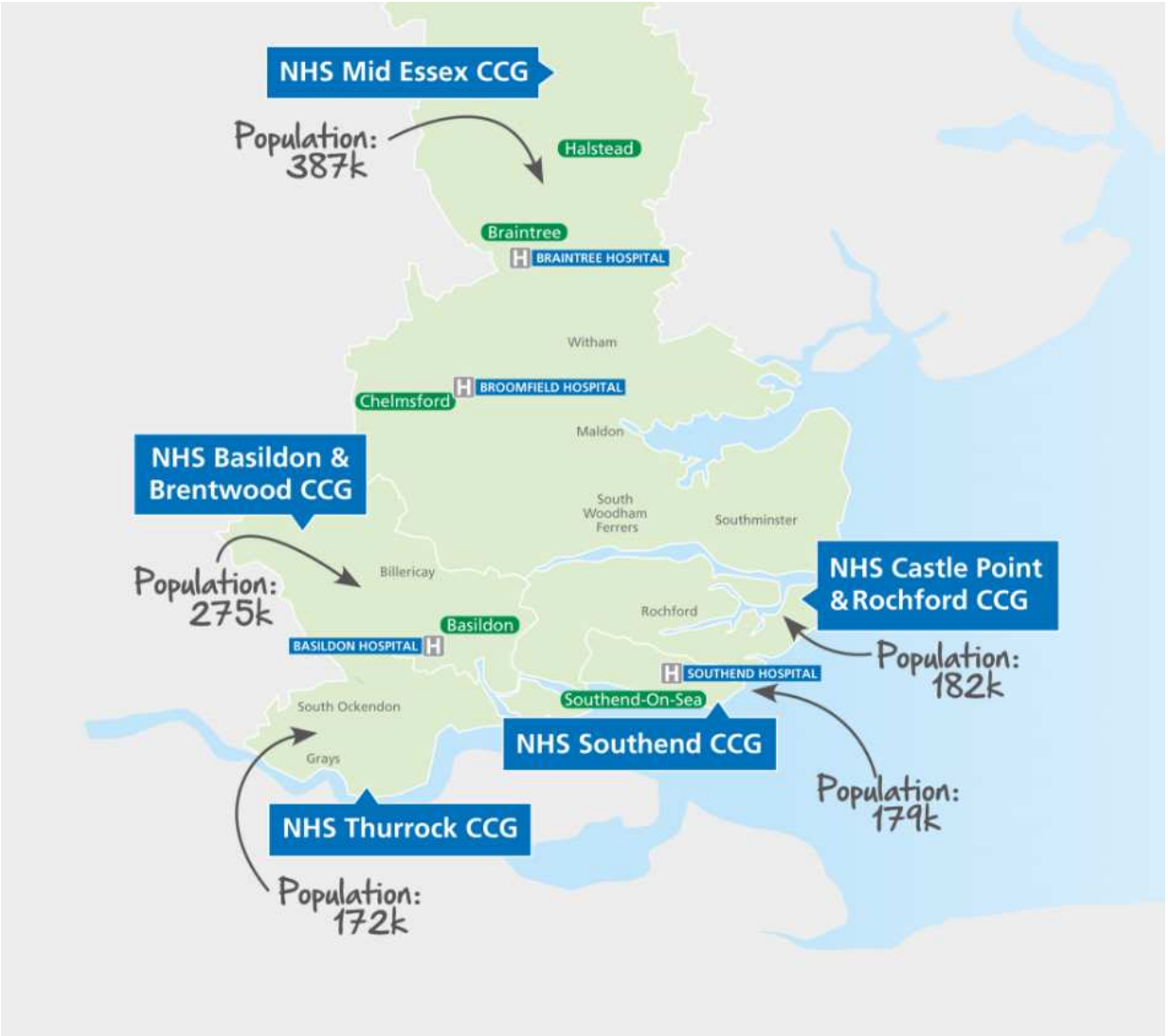
Over the next few months we will be continually engaging with our local population and our stakeholders to refresh our Plans in order that we can submit our response to the Long Term Plan in the autumn.

Our role in wider system working

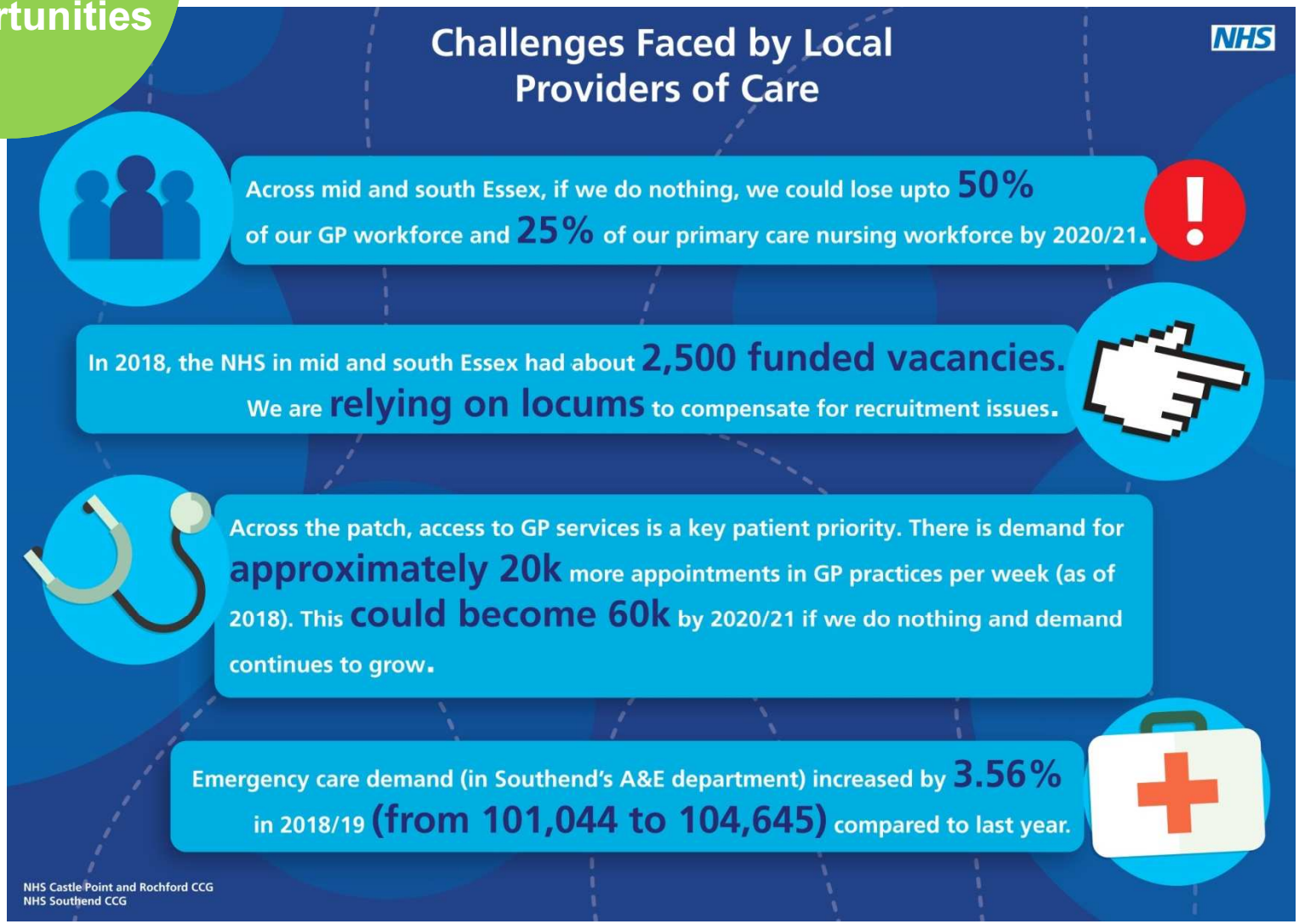
We are part of the mid and south Essex Sustainability and Transformation Partnership (STP) that includes:

5 Clinical Commissioning Groups (CCGs)
Over 180 GP practices
3 x Councils:
6 x NHS Trusts (3 x hospital, 2 x community/mental health & 1 x ambulance trust)

Together with a wide range of independent service providers and voluntary organisations.



1 Our Challenges & Opportunities



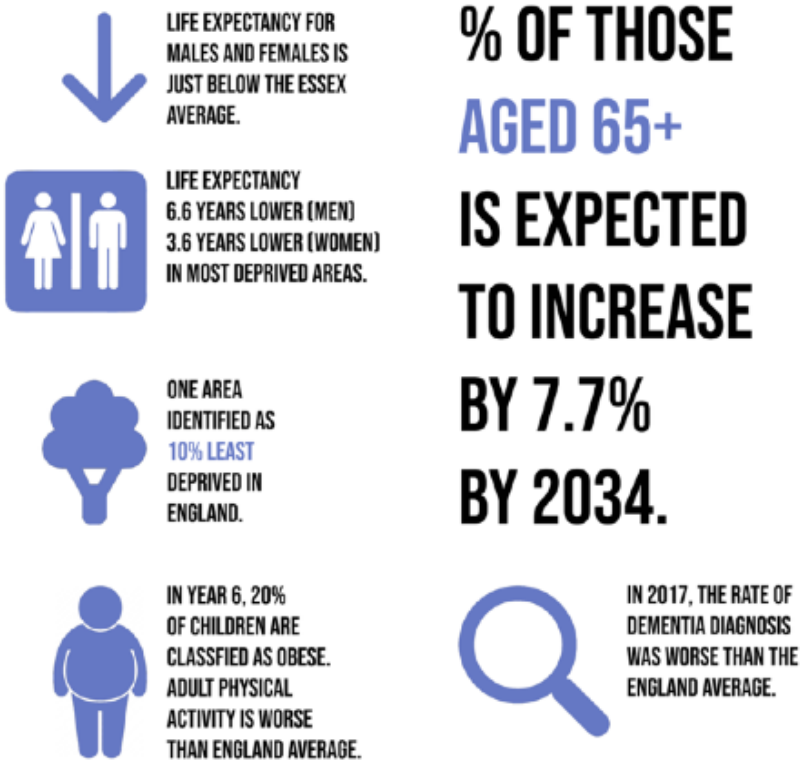
1 Our Challenges & Opportunities

Public health issues in Southend

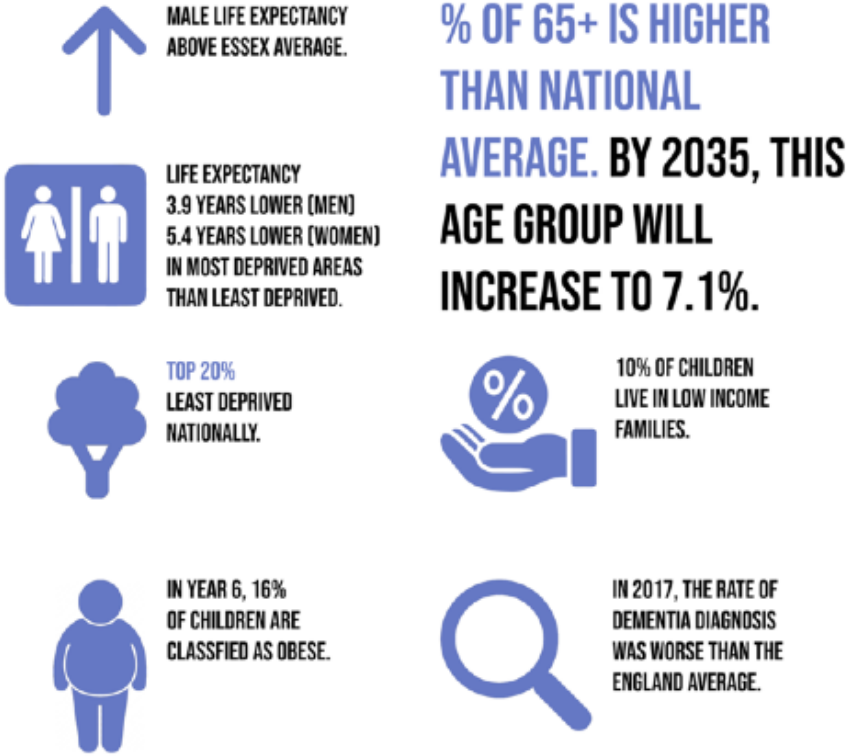
Southend

1 Our Challenges & Opportunities

Public health issues in Castle Point and Rochford



Castle Point



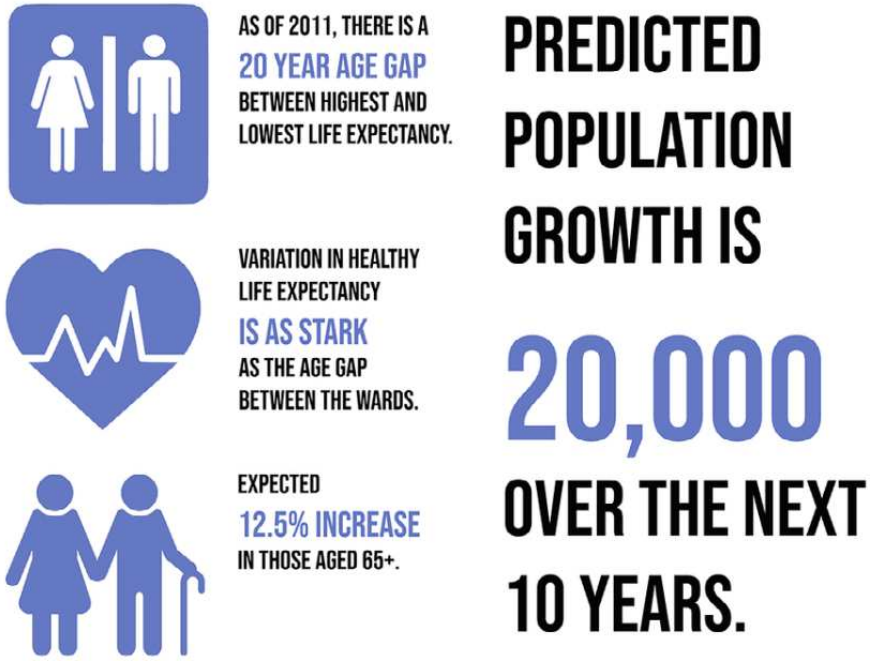
Rochford

1 Our Challenges & Opportunities

Demographics in south east Essex

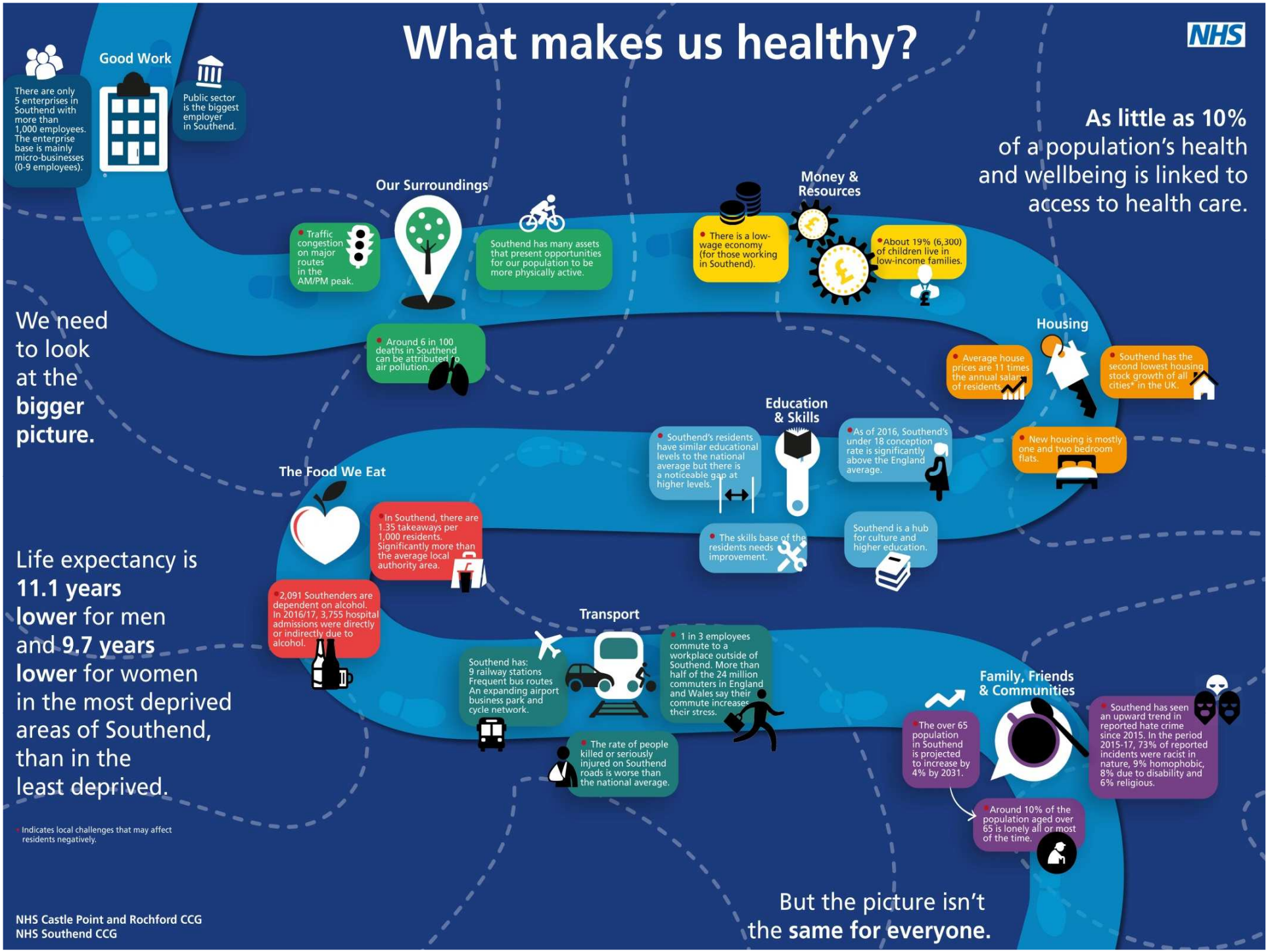
- Significant health inequalities with higher rates of obesity, cancer, mental health, dementia compared to the wider population

- A changing population with increasing diversity, people living longer with one or more health issues & therefore a high reliance on health and care services



- Service quality issues including a high reliance on emergency services, late diagnoses and treatment and access to services

- Areas of high deprivation with high proportions relying on benefits, experiencing fuel poverty, unemployment, poor housing, environment


What makes us healthy?
NHS
As little as 10% of a population's health and wellbeing is linked to access to health care.
We need to look at the bigger picture.
Life expectancy is 11.1 years lower for men and 9.7 years lower for women in the most deprived areas of Southend, than in the least deprived.
Indicates local challenges that may affect residents negatively.
Good Work
There are only 5 enterprises in Southend with more than 1,000 employees. The enterprise base is mainly micro-businesses (0-9 employees).
Public sector is the biggest employer in Southend.
Our Surroundings
Traffic congestion on major routes in the AM/PM peak.
Southend has many assets that present opportunities for our population to be more physically active.
Around 6 in 100 deaths in Southend can be attributed to air pollution.
Money & Resources
There is a low-wage economy (for those working in Southend).
About 19% (6,300) of children live in low-income families.
Housing
Average house prices are 11 times the annual salary of residents.
Southend has the second lowest housing stock growth of all cities* in the UK.
New housing is mostly one and two bedroom flats.
Education & Skills
Southend's residents have similar educational levels to the national average but there is a noticeable gap at higher levels.
As of 2016, Southend's under 18 conception rate is significantly above the England average.
The skills base of the residents needs improvement.
Southend is a hub for culture and higher education.
The Food We Eat
In Southend, there are 1.35 takeaways per 1,000 residents. Significantly more than the average local authority area.
2,091 Southenders are dependent on alcohol. In 2016/17, 3,755 hospital admissions were directly or indirectly due to alcohol.
Transport
Southend has: 9 railway stations Frequent bus routes An expanding airport business park and cycle network.
1 in 3 employees commute to a workplace outside of Southend. More than half of the 24 million commuters in England and Wales say their commute increases their stress.
The rate of people killed or seriously injured on Southend roads is worse than the national average.
Family, Friends & Communities
The over 65 population in Southend is projected to increase by 4% by 2031.
Around 10% of the population aged over 65 is lonely all or most of the time.
Southend has seen an upward trend in reported hate crime since 2015. In the period 2015-17, 73% of reported incidents were racist in nature, 9% homophobic, 8% due to disability and 6% religious.
But the picture isn't the same for everyone.
NHS Castle Point and Rochford CCG
NHS Southend CCG


What makes us healthy?
NHS
Good Work
There are only 5 enterprises employing more than 250 emplo-yees in Castle Point and Rochford.
Micro-business (0-9 employees) account for just over 90% of enterprises.
Our Surroundings
Around 6 in 100 deaths in Castle Point and Rochford can be attributed to air pollution.
Castle Point and Rochford has many assets that present opportunities for our population to be more physically active.
Money & Resources
Generally, wages are higher in Castle Point and Rochford than England as a whole, except for part-time female workers in Castle Point.
About 10% of children in Rochford and 14% in Castle Point live in low-income families.
As little as 10% of a population's health and wellbeing is linked to access to healthcare.
We need to look at the bigger picture.
Housing
Only 8% of new houses in Essex County were built in Castle Point and Rochford in 2017/18.
The average house prices in Castle Point and Rochford are 9-10 times the average annual earnings.
Education & Skills
Adults with low educational attainment account for 48% of adults in Castle Point and 41% in Rochford.
As of 2017, the under 18 conception rate in Castle Point and Rochford was below the England average.
The Food We Eat
In Castle Point and Rochford there are 0.7 takeaways per 1,000 residents which is less than the average for a local authority area.
Hospital admissions due to alchohol related harm were significantly lower in Castle Point and Rochford than the national average.
Life expectancy is 6 years lower in Castle Point for men (3.2 years in Rochford) and 4.3 years lower for women (4.4 years in Rochford) in the most deprived areas, than in the least deprived.
Transport
South east Essex has: 9 railway stations Frequent bus routes An expanding airport business park and cycle network.
Over 50,000 people use motorised transport to commute to work in Castle Point and Rochford.
The rate of people killed or seriously injured on roads in Castle Point and Rochford is similar to the national average.
Family, Friends & Communities
Violent crime in Castle Point and Rochford is significantly below the national average.
The over 65 population in Castle Point and Rochford is projected to increase by 19% by 2030.
Of those aged 65 and over, 28% live alone in Castle Point and Rochford.
Indicates local challenges that may affect residents negatively.
But the picture isn't the same for everyone.
NHS Castle Point and Rochford CCG
NHS Southend CCG

2 Our Strategic response

Strategic response

- A **changing population** with **increasing diversity**, people **living longer** with **one or more health issues** & therefore a **high reliance on health and care services**
- Significant **health inequalities** with higher rates of **obesity, cancer, mental health, dementia** compared to the wider population
- Service **quality issues** including a **high reliance on emergency services**, late diagnoses & treatment & access to services
- **Areas of high deprivation** with high proportions relying on benefits, experiencing fuel poverty, unemployment, poor housing, environment

→ **Seamless, joined-up services for people**

→ **A focus on prevention rather than treatment**

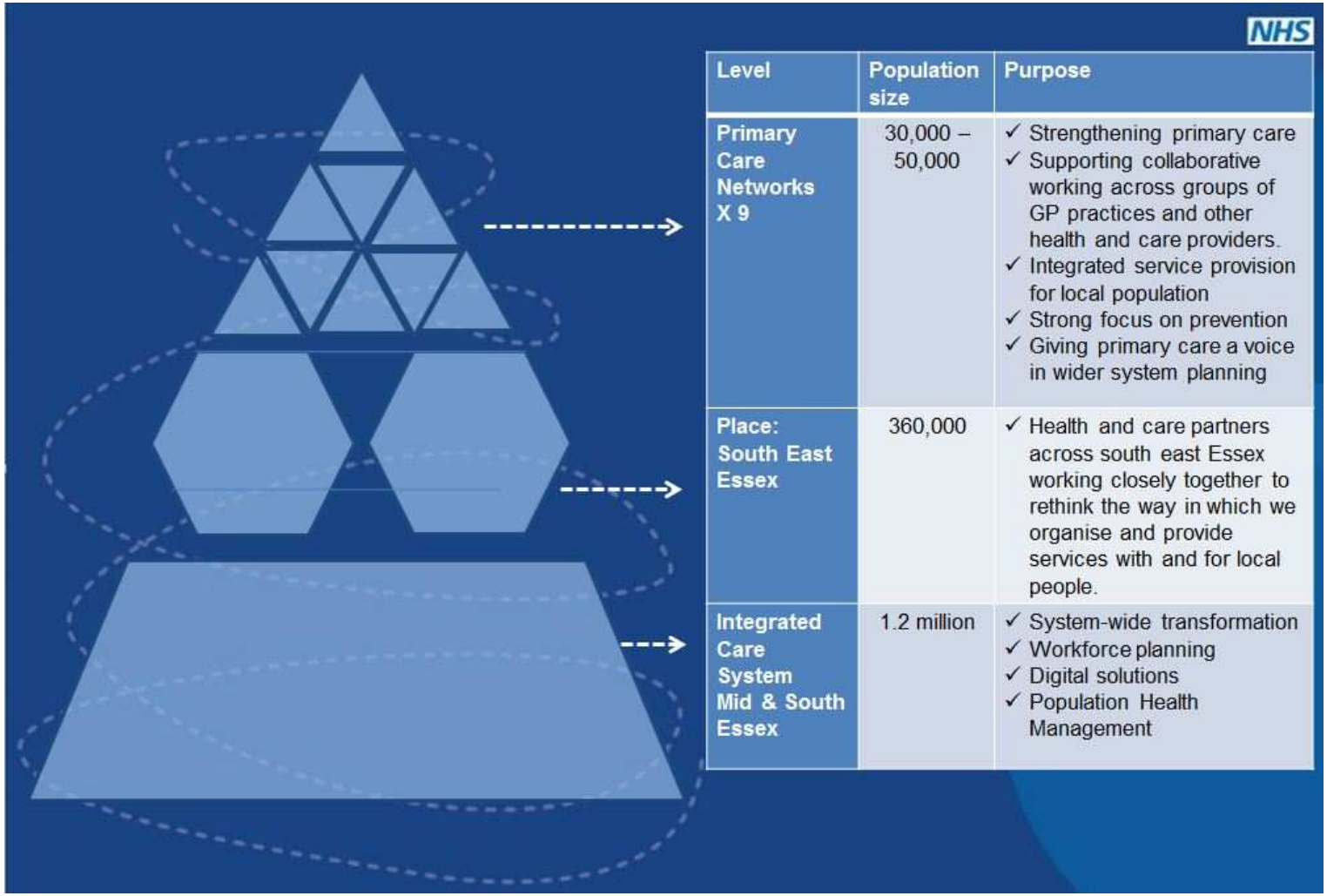
→ **Delivering national & local priorities**

Enablers

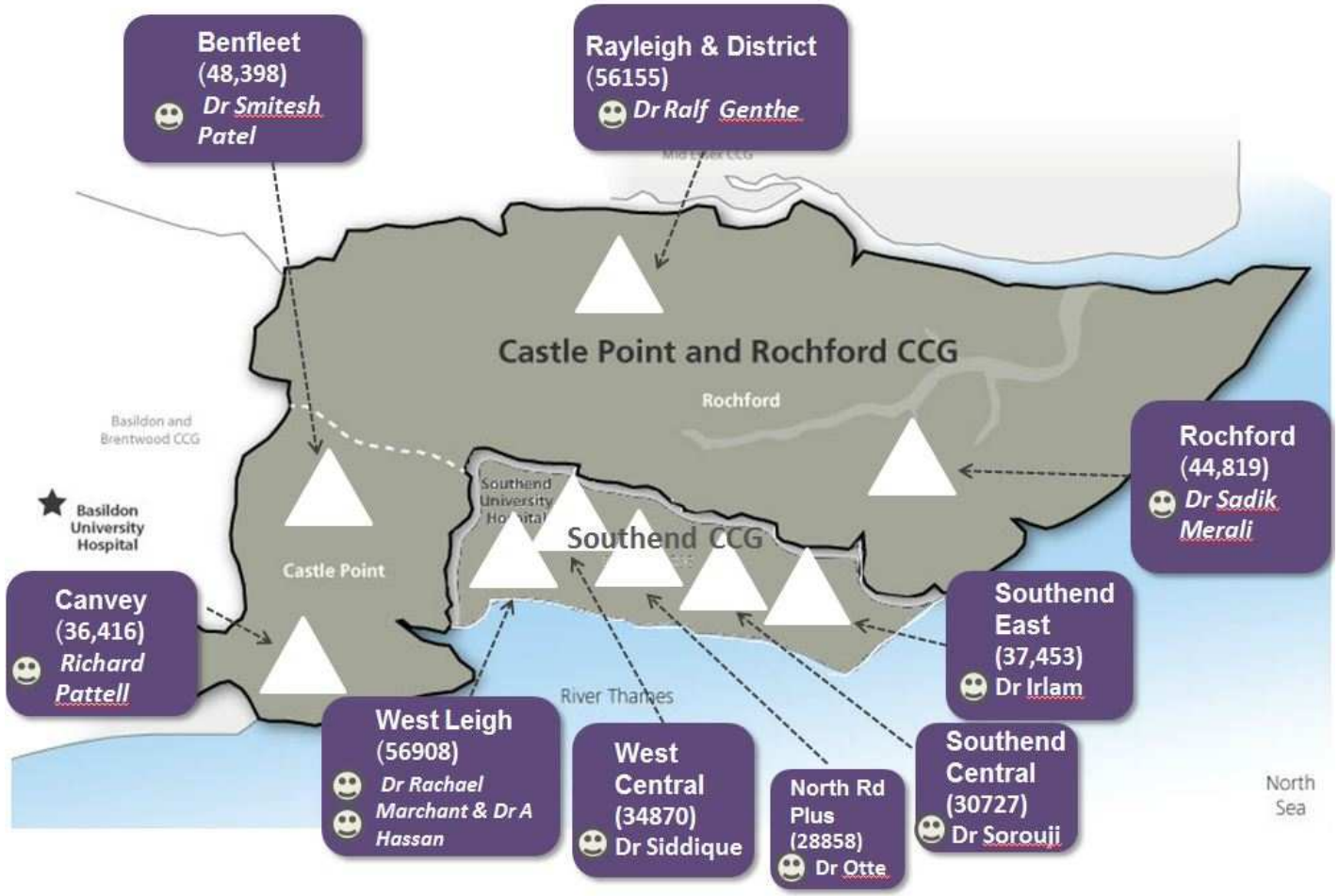
- Finance
- Technology
- Workforce
- Communications & Engagement
- Estate & Infrastructure
- Quality
- Governance
- Data & Information

Partnerships in south east Essex

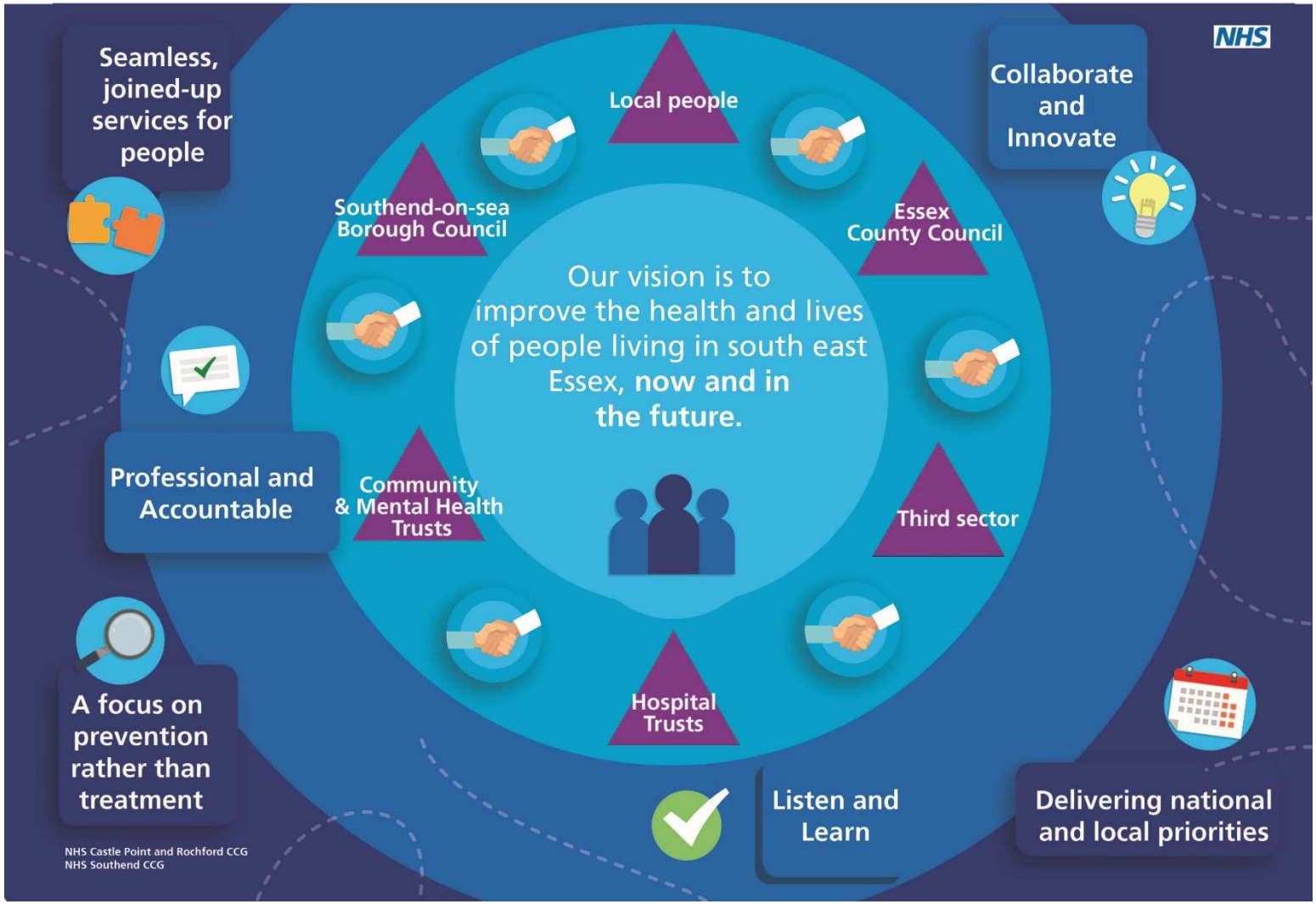
Across **south east Essex** partners come together across **three different tiers** of **integration**.



Partnerships in south east Essex
Primary Care Networks



Partnerships in south east Essex
South East Essex Partnership Group



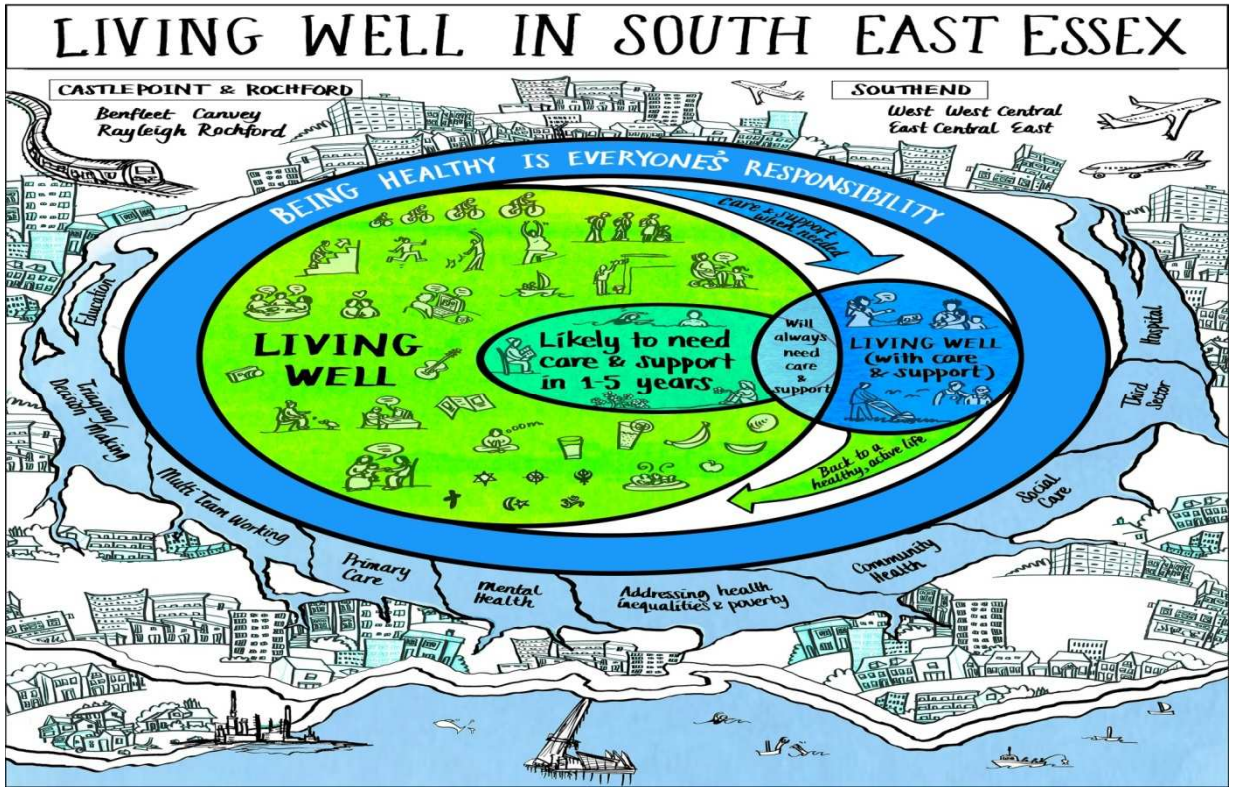
South East Essex – proposed model for health and care

We have already come together with local councils & local health services in partnerships around commissioning & through place-based collaborative partnerships.

We are working together to improve the health and wellbeing of the people living in south east Essex, focussing on ensuring:

People get the information, support & access to whatever they need to live healthy lives for as long as possible.

As we refresh our work programmes there is an opportunity to work with partners across the STP to assess what should be done at a place-based level



Current plans have been reviewed in the light of the NHS Long Term Plan - we are identifying any gaps in what we currently do & what the Plan asks us to do in the future.

South East Essex – aspirations of local people and partners

Our role in wider system working

Many of the challenges we face in south east Essex are shared across a wider geography with many organisations working across lots of different areas.

We are therefore part of a wider system, working together with partners across **mid and south Essex** to tackle problems together where it makes sense i.e.:

We are working together to develop a health and care workforce of the right size and capabilities, that meets the needs of our residents

We are developing digital solutions to help support people and deliver care in a safe and efficient way.

We are committed to system-level transformation to ensure we can deliver care of the highest standards

2, Our Strategic response

Seamless, joined-up services for people

A focus on prevention rather than treatment

Delivering national & local priorities

Key Priority Areas

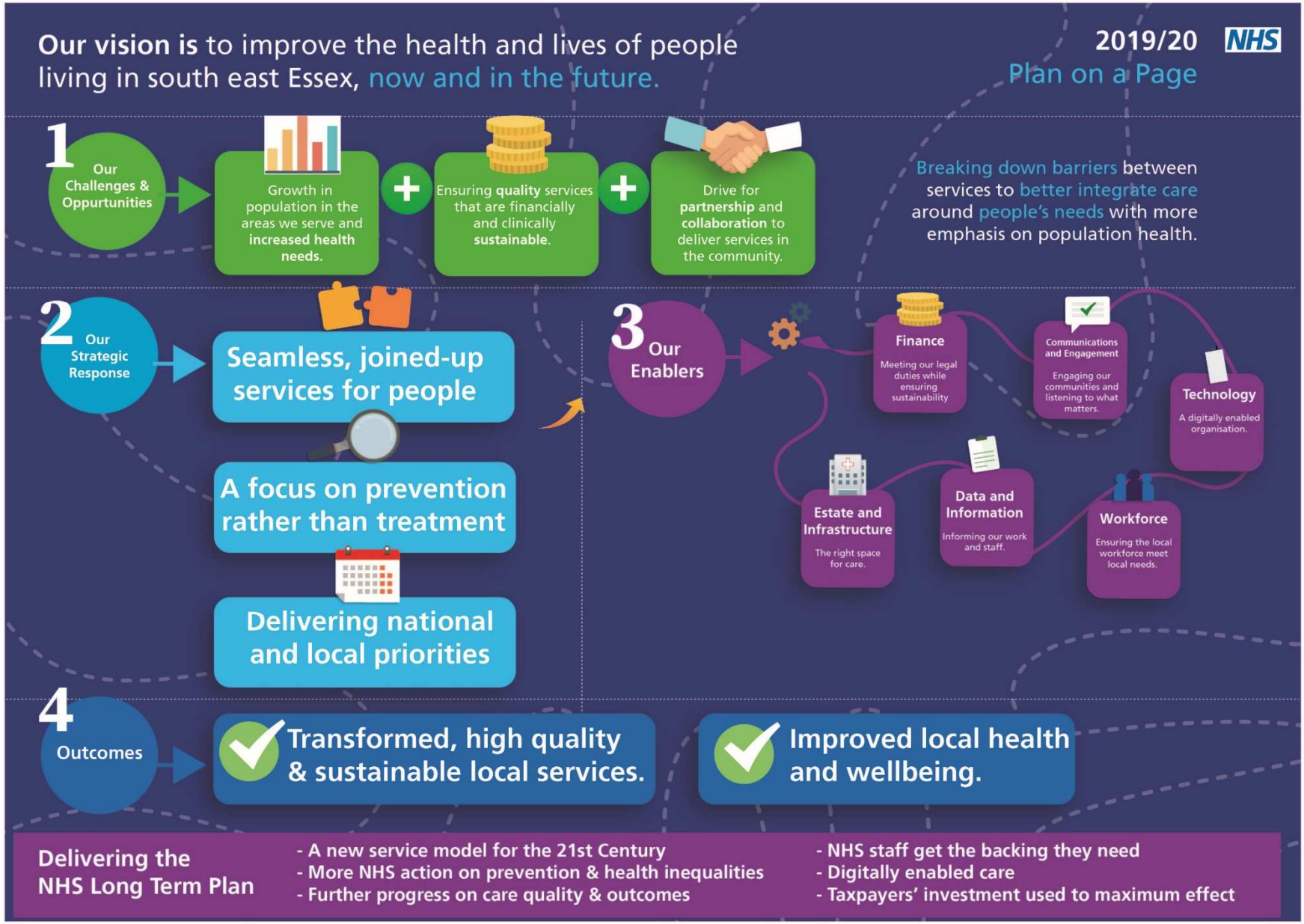
- Improved care in the community
- Strengthened GP services
- Children & families incl. SEND
- Maternity services

- Cancer
- Supporting self care and prevention
  - Respiratory
  - Diabetes (STP)
  - Frailty
  - Cardiology

Constitutional standards

- Mental Health – adults & children
- Urgent & emergency care (STP)
- Elective Care
- Learning Disabilities
- Creating efficiencies
- Workforce, OD, Leadership
- Quality & Safeguarding

Plan on a page: south east Essex



Our Plans for 2019/20

Key Priority Areas – the detail:

Seamless, joined-up services for people

Strengthened GP Services

Improved care in the community

Children & families incl. SEND

Maternity services

STRENGTHENED GP SERVICES

STP-wide programme: Primary Care Strategy

Programme Objective: To implement the Primary Care Strategy

Programme Description

The STP has an agreed primary care strategy – CCGs are responsible for implementation taking account of local priorities and existing services in place , overseen by a STP Primary Care Transformation Board, and supported by work streams on workforce, digital, leadership and estates.

The system will focus on further embedding the requirements of the primary care strategy (incorporating the GPFV) and the helpful new requirements of the recently published GP contract including implementation of Primary Care Networks. Current progress:

- 26 geographically aligned 'Primary Care Networks' in place by 15th May with all the population covered by a network
- Clinical Directors identified for PCNs and personal development plans identified – by July 2019
- Some PCNs already operating at level 2 on the maturity matrix
- All practices wi-fi enabled.
- Comprehensive primary care estates strategy in development with focus on optimisation of buildings

Staff development

- Strong workforce development plan implementation through the training hub.
- C.100 additional staff working in General Practice, many through 'Network' type arrangements across multiple practices and workforce being increasingly diverse
- 350 practice staff have undertaken care navigation training improving the interface with patients

The focus for 2019/20 will be supporting the development of place-based arrangements across the STP. The stakeholder event *Who* Cares? Held at the end of January, will support the system to develop a STP-wide locality strategy, outlining ambitions for local health and care and, importantly, an evaluation framework to enable the system to track progress.

STRENGTHENED GP SERVICES

STP-wide programme: Primary Care Strategy

2019/20 Deliverables – Network DES/PCN Development	
Q1	Finalise and approve Network DES requirements Develop support 'offer/framework' for Clinical Directors and PCNs
Q2	Issue support offer in partnership with LMC through Clinical Directors
Q3	Facilitate discussions between Clinical Directors and other PCN partners to achieve operational collaboration between Primary, Community and Social Care for 2020/21
Q4	Agree arrangements for 2020/21 Network DES

2019/20 Deliverables – Practice Resilience	
Q1	Agree STP wide offer through Primary Care Programme Board
Q2	Issue offer to practices through PCNs
Q3	Award funding for implementation
Q4	Review requirements for 2020/21 programme of support

2019/20 Deliverables – PCN Data Requirements/Risk Stratification	
Q1	Finalise IG arrangements for sharing of data
Q2	Engage with Clinical Directors to understand data requirements for PCNs
Q3	Implement outcomes of discussions
Q4	

STRENGTHENED GP SERVICES

CCG Programme: Local Implementation of Primary Care Strategy

Programme Objective: To implement the Primary Care Strategy

Programme Description

The strategy was agreed in June 2018 focuses on meeting the demand and capacity gap by:-

1. Increasing capacity (81% of solutions)
2. Collaboration, and
3. Managing demand and reduce workload
   - I. Improved Triage (12%)
   - II. Pro-active and Risk Stratified Care (3%)
   - III. Reduced GP Admin Burden (3%)

https://www.england.nhs.uk/blog/your-doctor-can-see-you-now-but-do-you-actually-need-to-see-a-doctor/

Outcomes and benefits

Key Risks

Improvement capacity and pace of change
Time to embed changes and influence patient behaviour
Workforce availability
Access to data and analytics to plan, target and evaluate interventions
Funding streams (and timing) make financial planning challenging
Maturity of digital offers and pace of development of existing systems

Key Projects and Timescales

Date	Initiatives
1st Apr 2019	• Locality Enhanced Access Services becomes operational in all eight Localities
Q1	• Agree Provider/Locality led initiatives for 2019/20 • Launch Membership Development Programme • QI Collaboratives Commence • Preparation for Primary Care Networks DES and wider Contract Reforms • Agree Digital Roadmap • Review and Update Implementation and Investment Plan
Q2 – Q4	• Launch of Primary Care Networks • Implementation of schemes agreed in Q1

Costs and Financial benefits

Summary Investment Plan 2018/19-20 20/21 shown below – *to be revised May 2019*

Primary care financial bridge: Castle Point & Rochford CCG	2017/18	2018/19	2019/20	2020/21
Income	22.9	23.6	24.4	25.4
Expenditure	21.8	23.6	24.5	25.7
In-year Position	1.1	0.0	-0.2	-0.3
Workforce		-0.8	-2.0	-2.8
Estates		-0.1	-0.1	-0.1
Other Enablers		-0.5	-0.5	-0.5
Future model		-1.4	-2.6	-3.4
CCG baseline funding		2.0	2.1	2.3
STF allocation (GPFV)		0.0	0.0	2.5
End-state 20/21		0.6	-0.6	1.1

Primary care financial bridge: Southend CCG	2017/18	2018/19	2019/20	2020/21
Income	24.2	24.8	25.6	26.8
Expenditure	22.9	24.8	25.7	27.0
In-year Position	1.3	0.0	-0.1	-0.2
Workforce		-0.4	-2.3	-3.0
Estates		-0.1	-0.1	-0.1
Other Enablers		-0.9	-0.5	-0.4
Future model		-1.4	-2.9	-3.5
CCG baseline funding		1.8	2.5	2.7
STF allocation (GPFV)		0.0	0.0	2.6
End-state 20/21		0.5	-0.5	1.6

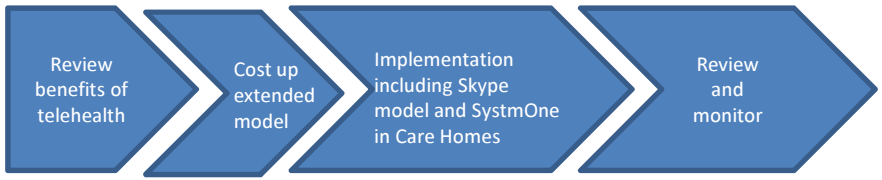
IMPROVED CARE IN THE COMMUNITY

CCG Programme: Deteriorating Patient

Programme Objective: To enhance focus on early detection and management of UTIs and Sepsis by bolstering the existing district nursing team and enabling it with Telehealth technology (operating in care homes and expanding to include elderly care homes and patients within the community outside of the current caseload, through additional resource).

Programme Description

The project is to review and build upon the opportunity that the one year pilot has provided.



Outcomes and benefits

- Reduction in A&E attendance & NELs
- Improved public awareness, patient empowerment
- Enhanced relationships between primary care, secondary care and CCGs
- Reduction in lives lost / impacted relating to sepsis
- Improved care within care homes
- Quality of life improved relating to catheter care

Key Risks

- Buy in from care homes to utilise telehealth appropriately.
- Buy in from practices to utilise surgery pods.
- Access to notes for Sepsis 0-4 audit.

Key Projects and Timescales

Project	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20	2020 onwards
Sepsis					
Extend care home pilot					
Extend surgery pods					
Circulate books to schools					
Review 0-4 audit results					
Introduce SystmOne in care homes					
Catheter Care					
Review audit results					
Flip flow catheters					
Hydration					
Consider benefits realised by other CCGs through use of technology					
Skype – 14 day rule					
Agree model with EPUT (May 2019)					
Purchase licences and roll out.					

Costs and Financial benefits

Investments Required: Currently being scoped

Savings: TBC

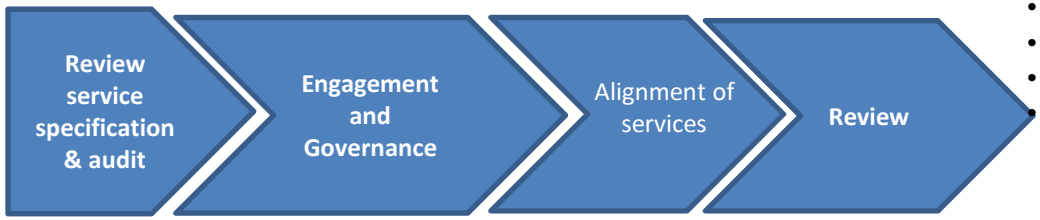
IMPROVED CARE IN THE COMMUNITY

CCG Programme: Care Co-ordination

Programme Objective: Care Co-Ordination service is a population health management service through the use of risk stratification identifying and accepting frail and vulnerable patients before they reach crisis point requiring urgent interaction.

Programme Description

The project is to align the two services across Southend and CPR which took place during 2018/19 but there is still some variation in delivery.



Key Projects and Timescales

- December 2018 – LCG engagement with GPs, EPUT
- December 2018-March 2019 – GP engagement in CP&R
- December 2018 – Audit undertaken
- January 2019 – Governance routes established
- March 2019 – CEC approval (planned for mid-March 2019)
- April 2019 – Review Care Co-ordination through SDOG (Service Development Oversight Group) and contractualise (pending CEC/CCG approval)

Outcomes and benefits

- The alignment project which required nil investment has identified a variation on the hours / days both teams work. CP&R Care Co was set up to work 7 days per week 9-5pm and their caseload increased as more patients were identified by each GP Practice. Southend Complex Care was set up to work 5 days per week 8-6pm
- Care Co-Ordination will continue to develop to support locality development focusing on the population needs.

Costs and Financial benefits

Investments Required: Nil **Savings:** Business as usual

Key Risks

- Care Co-Ordination does not deliver prevention and key service objectives.

Carer Executive Lead: Jacqui Lansley Operational Lead: Tracy Harris Clinical Lead: TBC

CCG Programme: Carers

Programme Objective: to jointly invest with Southend Borough Council in a comprehensive range of services to support unpaid Carers.

Programme Description

The programme has and will involve consultation with Carers on the support they need, some pilots services have been commissioned in response and require review . There is an opportunity to build on the outcomes achieved in the one year pilot funding for Carers and act on lessons learned

Key Projects and Timescales

1. Carers Summit allows professional discussion and review of current services. **10 June 2019**
2. Paper written to CCG and SBC governance with recommendations going forward. **Mid June**
3. If approved notify currently funded services that are going to cease **September 2019**.
4. Redesign services for gaps identified. **June 2019**
5. Invite applications for newly designed services **July 2019**

Outcomes and benefits

1. To reduce unnecessary hospital admissions/A&E attendances/111 calls
2. Access to dedicated information, advice and guidance
3. Access to dedicated EOL respite/care out of hours
4. To improve carers independence, physical health and emotional wellbeing
5. To empower and support Carers to manage their caring roles and have a life outside of caring
6. To ensure Carers receive the right support, at the right time, in the right place

Costs and Financial benefits

Investments Required:

£100,000

Savings:

Qualitative benefits for Carers. For the respite service we anticipate 100 admissions will be saved at avg. cost of £1,800 per admission. Gross saving £180,000, net saving £153,000 (investment cost is split equally between SCCG and SBC)

Key Risks

1. Low take up of service due to lack of support from other professionals and failure to promote services.
2. Services fail to deliver outcomes.

Single Point of Referral Executive Lead: Jacqui Lansley Operational Lead: Caroline McCarron Clinical Lead: TBC

CCG Programme: [Single Point of Referral - SPOR]

Programme Objective: To fully integrate the Health & Care functions of SPOR, ensuring a partnership approach and optimal outcomes

Programme Description:

SPOR is a key support function for GPs and professionals across health and care, providing access to community services, assisting hospital discharge and avoid unnecessary admissions to hospital. Collaborative working between health and social care teams is key to achieve the desired outcomes.

Outcomes and benefits: Synchronisation of 'front door' services with locality development

Reduced inequalities in health and social care in S.E.E.
Improved delivery of out-of-hospital triage, assessment and care planning
Improved co-ordination of care pathways
SMART objectives to improve outcomes for people
Decision-making at the centre of combined services

Key Risks: Acute hospital pressures reducing service's ability to respond appropriately to community referrals

Key Projects and Timescales:

September to December 2018: On site meetings with Staff
December 2018: Discussions with EPUT Data Team
December 2018: Discussions with SBC Data Team
December 2018: Review report completed
January 2019: Recommendations raised
February 2019: CMT sign off report and recommendations
March 2019: Council EDMT sign off
April to July 2019: Mobilisation of new model

Costs and Financial benefits

Investments Required: None **Savings: Business as usual**

End of Life Executive Lead: Jacqui Lansley Operational Lead: Caroline McCarron Clinical Lead: Mark Metcalfe

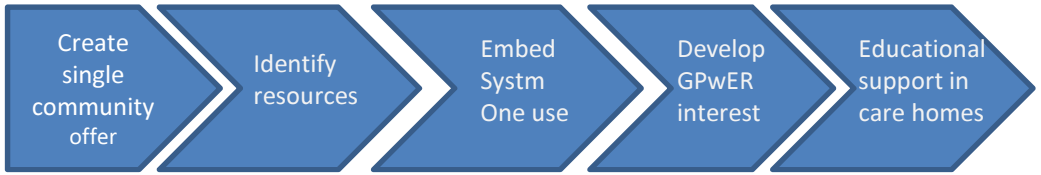
CCG Programme: SystmOne – Palliative Care

Programme Objective: To embed a ***dedicated single comprehensive team approach*** at EPUT in line with CQC findings.

Programme Description

Aims/Objectives

1. 2. To establish a dedicated single point of contact (SPC) to support professionals/ patients/carers 24/7
3. To enhance the existing support to patients and carers out of hours, pockets of respite are available but not consistently with no access to dedicated palliative care.
4. To embed the use of System one across all providers, specific focus on SUHFT GSF wards/ED and EEAST.
5. Additional educational support for Care Homes.
6. Supporting GP practices to deliver quality EOL care in line with new contract
7. Enhanced Medical Model in community (GPwER accountable to
8.Access to community Palliative Care Beds…..Step up Step down



Key Projects and Timescales

1. **Single community offer** under one specification / KPI's by June 2019.
2. **SPC** – Resource/provider/investment defined in business case end February 19, phase one mobilisation end April 19, recruitment additional resource end August 19, 24/7 service mobilised October 2019.
3. **OOHs respite/care** – Resource/Investment defined in business case end February 19, provider workshop for existing providers to ensure shared approach and objectives March 19, additional resource mobilised October 2019 (allowing for potential procurement).
4. **System One -** embedded in GSF wards at SUHFT
5. **Care Homes –** Continue to provide dedicated EOL training to all Care Homes.

Outcomes and benefits

1. To reduce unnecessary hospital admissions/A&E attendances/111 calls
2. Access to dedicated 24/7 information, advice and guidance
3. Access to dedicated EOL respite/care out of hours
4. To improve patient and carer experience

Costs and Financial benefits

Investments Required: TBC **Savings: TBC**

Key Risks

- Coding/recording does not include EOL flags, limiting ability to identify baseline data to understand palliative/ EOL activity/trends
- Financial assumptions not met through implementation of initiatives
- No or limited impact on demand for hospital services and NEL admissions
- Failure to publicise the SPC widely/ providers not willing to engage so the resource is not effectively utilised

Benfleet Executive Lead: Simon Williams /Jacqui Lansley Operational / Clinical Lead: Dependant on locality

CCG Programme: Localities - Implementation

Programme Objective: Traditional models of commissioning and provision have failed to deliver sufficient benefit to local communities. In line with national direction there is local move to adopt a place based approach, focusing on the needs of local communities as opposed to the amalgamated needs within traditional organisational boundaries.

Programme Description

Traditional models of commissioning and provision have failed to deliver sufficient benefit to local communities. In line with national direction there is local move to adopt a place based approach, focusing on the needs of local communities as opposed to the amalgamated needs within traditional organisational boundaries. CCG spend incurred within the system is largely utilised either on on-going care, or re-actively responding to rapid deterioration in need – as opposed to investing in preventative care..

Outcomes and benefits

- Reduction in secondary care use through an enhanced primary care and community care offer in each locality;
- Integrated care pathways reducing inefficiencies, hand-offs between agencies and better quality and value for money
- Overall improved well-being for residents living in each of the 8 localities, feeling more connected and empowered.
- Reduction in health inequalities across the South East Essex area.

Key Risks

- Poor engagement across the SEE stakeholders, residents and key partners
- Continued inappropriate tilisation of A&E, hospital Trust and institutional services away from resident's own homes and communities.
- Two different Local Authorities creates the potential for two tiered systems of community offer from each authority.

Key Projects and Timescales

- Autumn 2018 – SEE sign-off Locality Strategy
- Nov-Jan – 2018/19 – Locality dashboard development (Southend); design groups across 8 localities;
- Feb 2019 – Locality Development Manager roles created and recruited to (Southend)
- March 2019 – Locality Development Manager roles created and out to advert
- April/May 2019 – Workplan development for localities implementation (12-24 month plan)
- Governance (SEE Partnership) June/July 2019 (estimated)

Costs and Financial benefits

Investments Required: Not identified **Savings: Not identifed**

CHILDREN'S SERVICES

CCG Programme: [Children's Transformation Programme]

Programme Objective: Programme Objective: To transform the delivery of CYP services ensuring high quality care in the most appropriate place at the right time, ensuring improved outcomes and experiences for CYP and their families.

Programme Description

Outcomes and benefits

- Reduction in paediatric outpatient, A&E attendance & NELs
- CYP will receive care closer to home
- Parents and families become more resilient and self-empowered
- Improved relationships between primary and secondary care
- Primary and community care staff will feel more confident dealing with paediatric issues
- Addressing gaps in our services such as dysphagia, epilepsy
- Reduce health inequalities for children and young people

Key Risks

- Current financial envelope does not meet the required investment
- Engagement from primary care, acute sector and others is insufficient to deliver the identified projects
- New models of care do not achieve the anticipated reduction in activity
- Lack of progress against the Written Statement of Action and SEND Code of Practice

Key Projects and Timescales

- Joint Paediatric Clinic – phased approach – operational n 6 localities by end of 19/20 and fully operational in 8 localities by Q1 2020/21
  Paediatric Feeding and Swallowing service – designed, commissioned and mobilised by Q3 19/20
- Paediatric Community Nursing – further design and recruitment in Q1 & Q2 19/20, with mobilisation beginning in Q3 19/20
- Rapid access improvements including a paediatric hotline – April 2019 onwards (test and learn for 3-6 months)
- Critical pathway review – mapping process began in March 2019, and to continue throughout 2019
- Development Delay and Behaviour Pathway – co-design the pathway in Q1 & Q2, with phase implementation from Q3 onwards

Costs and Financial benefits

Investments Required: £2,121,916

Savings: reductions across several areas

Area	%age reduction
A&E	13%
NEL	10%
Paed Outpatients	28%
VB09Z & VB11Z	17%
Lighthouse Centre	10%

Total potential reductions are £1,997,878 as well as potential £255,000+ reduction in prescription costs for cows milk allergy, ADHD and enteral feeding

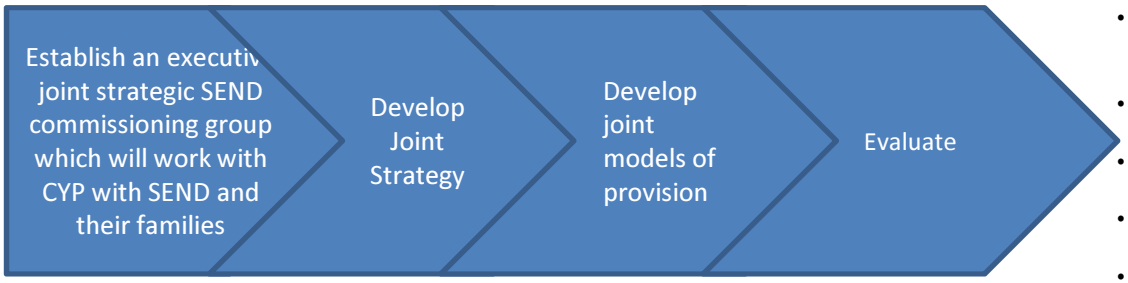
CHILDREN'S SERVICES: SEND

Children and Young People SEND Provision : Jacqui Lansley Operational Lead: Caroline McCarron Clinical Lead: Dr Kate Barusya

CCG Programme: [Enhance SEND provision]

Programme Objective: To ensure precisely co-ordinated joint priorities are developed for children and young people with SEND

Programme Description



Outcomes and benefits

- The SEND reforms are embedded at leadership level with good knowledge of individual and collective responsibilities under the SEN Code of Practice.
- Leaders continually challenge collective accountability and performance to ensure that required improvements are delivered
- Commissioning of services for children and young people with SEND is undertaken jointly by leaders and in collaboration with Children and young people with SEND and their families.
- The Local Offer is co-produced, is well promoted, is fit for purpose and meets the needs of children and families.
- The voice of children and young people with SEND and their parents will be embedded In the work of the local area and inform Service design.
- The area delivers its statutory duties to children and young people with SEND in a timely, transparent and person centred way.

Key Risks

- **Southend** – Ensuring actions are undertaken to meet the requirements of the Written Statement of Action – Re-inspection in 2020
- **CPR** – Ensuring delivery meets the requirements of the SEND Joint Local Area Inspection Framework for forthcoming inspection of the Essex County area

Key Projects and Timescales

- Establish an executive joint strategic SEND commissioning group which will work with children and young people with SEND and their families – Q2
- Commission and deliver SEND training and development sessions with leaders – Q2
- Designated Medical/Clinical Officer – agreement on way forward in Q2 followed by the necessary recruitment
- Development Delay and Behaviour Pathway – co-design the pathway in Q1 & Q2, with phase implementation from Q3 onwards
- Develop a clear strategy to promote and support the process of personalisation
- Establish a Local Offer of Provision Review Group Q2/3
- Review and improve all systems and processes relating to EHCP assessment and planning Q2-4
- Review and improve systems, and access to systems, for recording and storing information across the area for EHCPs – Q2
- Improve recording, tracking and knowledge of the outcomes sought by children and young people with SEND, their aspirations, welfare and lived experience – Q4
- Review data collection, sharing protocols, and joint area working – Q2
- Review and relaunch key services and documents for supporting children and young people with SEND in mainstream schools – Q2
- Remodel provision to ensure consistent delivery of delivery across specialist and mainstream schools, including enhancing joint commissioning opportunities- Q2-4
- Transforming Care – Pilot Intensive Positive Behaviour Support initiatives for children at risk of hospitalisation or behaviour that challenges

Costs and Financial benefits

Investments Required: **Savings:**N/A

MATERNITY SERVICES

STP- wide programme

Programme Objective: Oversee delivery of *Better Births* maternity transformation programmes.

Programme Description

The STP LMS transformation plan has been approved by regulators. The plan sets out ambitious but realistic plans for delivering improvements to maternity services. In line with *Better Births* the LMS has described its work programme for the coming year. The focus of work will be on:

- Workforce planning – focussing on personalisation and safety, ensuring staff are trained and supported in their role.
- Implementing standardised pathways to increase choice for women (so that more women can have choice of midwife units for birth by 2021)
- Increase the number of women offered continuity of care and ensuring high quality pathways for high risk/vulnerable women.
- Ensuring all women have a personalised care plan by 2021.
- Improving the safety of maternity services, with a focus on system-wide implementation of the *Saving Babies Lives Care Bundle* v2 by March 2020.
- Taking action on neonatal mortality in accordance with NICE guidelines and guidelines.
- Reducing rates of still-birth, maternal and neonatal death and brain injury
- Ensuring good practice in reporting of incidents and external reviews where appropriate
- The LMS has a credible plan for how its financial allocation will be spent, and is it on track to spend it in the year.

Board Sponsor: Lisa Allen, AO, Basildon & Brentwood CCG

Local Maternity Services Board

Delivery Lead: Teresa Kearney, Chief Nurse, BBCCG

MATERNITY SERVICES - LMS Plan 2019/20

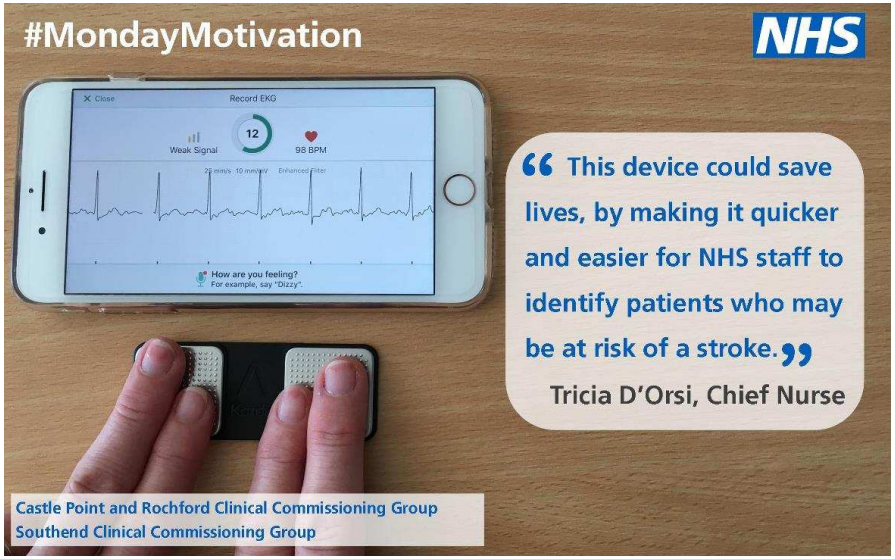
Deliverable	When	Trajectory
Workforce– focussing on personalisation and safety, ensuring staff are trained and supported in their role.	Q1	3 MSB maternity units have delivered HEE funded CofC training to staff
Implementing standardised pathways to increase choice for women (so that more women can have choice of midwife units for birth by 2021)	Q1 Q2 Q3 Q4	70% Target: 72% 2018/19: 70% 75% 2019/20: 80% 80% 2020/21: 90%
Increase the number of women offered continuity of care and ensuring high quality pathways for high risk/vulnerable women.	Q1 Q2 Q3 Q4	20% 25% 30% 35% (end of Q4 35%)
Ensuring all women have a personalised care plan by 2021	Q1 Q2 Q3 Q4	20% 50% 75% 95% (end of Q4 95%)
All providers to undertake a Gap analysis for postnatal care.	Q1	All providers and commissioners have agreed a postnatal improvement plan by September 2019
Taking action on neonatal mortality in accordance with NICE guidelines and deliver ATAIN (Avoiding Term Admissions Into Neonatal units) programme.	Q1 to Q4	Continue to participate in Mat Neo (NHSI and NQI programmes) through AHSNs
Deliver improvements in safety towards the 2020 ambition to reduce stillbirths, neonatal deaths, maternal death and brain injuries by 20% and by 50% in 2025, including full implementation of the Saving Babies Lives Care Bundle by March 2019 and Saving Babies lives Care Bundle v2 by 2020.	Q1 to Q4 Q1	4.98 Based on 2015 MBBRACE data combined neonatal and still birth rate Fully implemented in 3 MSB maternity units from Q4
Ensuring good practice in reporting of incidents and external reviews where appropriate	Q1	Establish Maternity safety sub-group of the LMS Board to oversee sharing of incidents, implementing Saving Babies Lives, Maternity and Neonatal Health Safety Collaborative.

A focus on prevention rather that treatment

Cancer

Supporting self care and prevention

- Respiratory
- Diabetes (STP)
- Frailty
- Cardiology



CANCER SERVICES

STP-wide Programme:

Programme Objective: Oversee cancer transformation programmes & cancer performance.

To support delivery of the cancer requirements of the 2019/20 planning guidance and the long-term plan, the STP has established a local governance across all providers and commissioners, as well as patient representatives and charities through the Cancer Alliance.

The focus of work is to:

Performance:

- Consistently deliver 2 week-wait cancer standards
- Recover 62 day cancer standard performance
- Implement timed pathway for oesopho-gastric cancers, LGI, Lung & Prostate.

Prevention & Screening:

- Improve uptake in screening for breast, cervical and bowel cancers
- National programme of lung checks (Thurrock)
- FIT in Primary care for symptomatic patients – implementation14/02/19 with estimated 2,680 negative results

New models of care

- Increase early detection - 62% of cancers are diagnosed at stages 1 and 2 by end of 2020/21
- Reduce number of cancers diagnosed as an emergency presentation
- Collect mandatory data to support implementation of 28day diagnosis
- Roll out rapid diagnostic centres
- Implement risk stratified follow-up two thirds of breast cancer patients by end 2019/20
- Deliver on phase I cancer workforce plans

Key Projects and Timescales

2019/20 Deliverables	
Q1	• FIT fully embedded in Primary Care • LES in place for Cancer Care Reviews • Vague Symptom MDC in place across the MSB • Risk Stratified Breast • 2 week standard
Q2	• Risk Stratified Pathway Colorectal
Q3	• Thurrock Lung Health Check • 62 day cancer standard
Q4	• Risk Stratified Pathway Prostate • Timed pathways implemented

Board Sponsor: Donald McGeachy, Medical Director, Joint Commissioning Team

Cancer Alliance & Cancer Board

Delivery Lead: Karen Wesson, Joint Commissioning Team

Key Risks

Respiratory Executive Lead: Simon Williams Operational Lead: Paul Taylor Clinical Lead: Sharon Hadley

CCG Programme: Respiratory

Programme Objective: To develop fully integrated respiratory services that will support and up-skill primary care, support the development of locality based services, move care closer to home and reduce the burden on hospital services, resulting in coordinated care, reduced hospital visits, and short and coordinated diagnostic pathways with the consequences; being improved patient outcomes, patient experience

Programme Description:-

The respiratory work stream brings together a number of QIPP schemes, initiatives and projects across the patient pathway

Aims/Objectives;

1. Develop Integrated Locality provision to provide support to a wider cohort of COPD patients with a focus on proactive care and prevention.
2. Slow deterioration and improve awareness and compliance.
3. Embed joint working practices and clinical leadership across acute & community teams
4. Improved support to Primary Care to identify and manage patients.
5. Improved access to psychology.
6. Improve access and uptake of Pulmonary Rehabilitation

Outcomes and benefits

- Deliver care in line with guidance and best practice
- Reducing high cost care as a result of early intervention
- Reduce morbidity and mortality
- Reduced emergency admissions
- Reduced readmissions due to acute exacerbations
- Care closer to home
- Efficiency saving using a lower cost provider
- Management of lower complexity patients outside of acute
- Optimising treatment & Improve medication compliance
- Up skill and support local primary care
- Releasing capacity in hospital to treat complex patients more quickly

Key Risks

Failure of primary care community to engage with developments and projects
GPwER fails to have impact as desired

Key Projects and Timescales

Project	Timescales
Case finding and patient review in Primary Care	June 2019
Primary Care support Programme – Education and management support	May – Dec 2019
myCOPD roll out to primary and Community care	June 2019
IAPT Pilot	July 2019
Locality Based respiratory services	July 2019
GPwER deployment	June 2019
New models of Pulmonary Rehab	April 2019

Costs and Financial benefits

Investments Required:

GPwER Costs - £96,000

Total investment = 96,000

Savings:

COPD/Asthma NELs= £131,100
All Respiratory ED attendances: = £5,83.00
OPA - £149,962
GPwER – 179,872

Total Net Cost Benefit = £370,017

SUPPORTING SELF CARE & PREVENTION

CCG Programme: Frailty

Programme Objective: Frailty is a long term condition in its own right which requires moving away from assessing and treating individual conditions and diseases as separate entities and moving towards assessment and treatment of the whole person.

Programme Description

The project is using the 10 national principles to transform current pathways to provide a consistent, responsive approach to the management of frail and vulnerable people across health and social care focusing on delivery of frailty services to the developing localities. This scope of this programme includes the falls project.

Outcomes and benefits

- Measurable improvement in the quality of life of frail and vulnerable people
- Reduction in excess bed days and ultimately admission avoidance
- Reduced pressure on primary care
- Raise awareness and improved understanding of the management of frailty for both staff, carers and the people themselves

Key Risks

- System partners engagement and commitment not sufficient to transform service delivery to meet the locality needs of the frail and vulnerable people
- The success of the programme is dependent on the implementation of an agreed STP shared care record

Key Projects and Timescales

- February 2019 – Frailty Key Stakeholder workshop
- March 2019 – Frailty Steering Group
- April 2019 – Identified Workstreams initiated
- April – June 2019 – Workstreams scoping & pathway development
- July 2019 – Report back to SEE Partnership Board for approval
- July 2019 – CEC approval
- August 2019 – Further governance to be determined by programme requirements, financial or otherwise

Costs and Financial benefits

Investments Required: TBC **Savings:** TBC

Executive Lead: Simon Williams Operational: Lynne Smith Clinical Lead: Biju Kariakose

CCG Programme: Cardiology

Programme Objective: Enhancement of the Community Heart Failure Service (CHFS) to support, treat and care for all Heart Failure patients whose condition meets the service access criteria

Programme Description

The cardiology focused transformation programme consists of two interrelated initiatives to support patients diagnosed with Heart Failure through increasing the access to the CHFS for medicines management, education and support and to be able to provide IV diuretics in the patient home.

Outcomes and benefits

- Reduce non elective emergency and short stay admissions
- Reduce excess bed days
- Improve health outcomes and quality of life for HF patients
- Support self-management of HF patients preventing exacerbation of conditions

Key Risks

- Recruitment of suitably qualified staff to support the CHFS to deliver the enhanced service requirements
- SUHFT and Primary care referring patients suitable HF patients to the CHFS to achieve the desired outcomes

Key Projects and Timescales

- August 2017 – Cardiology Heart Failure scoping exercise
- October 2017 – Frailty Stakeholder Steering Group
- November 2017 – Joint Demand Management Group
- December onwards 2017 – Staff Recruitment
- July 2018 – Community IV Diuretic service to commence
- October 2018 – Enhanced CHFS commenced
- October 2018 – Refinement of activity and admission avoidance reporting
- October 2018 onwards – Staff recruitment to fill vacancies
- November 2019 – Project end – BAU to be confirmed

Costs and Financial benefits

Investments Required: £269,642

Net Savings: £219,517

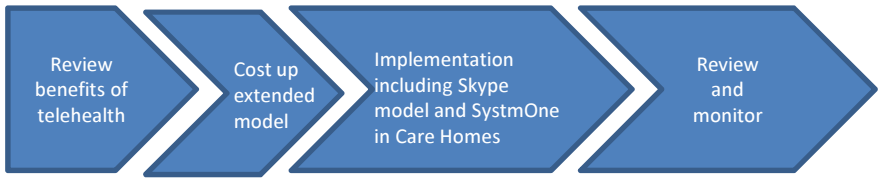
Deteriorating Patient Executive Lead: Tricia D'Orsi Operational Lead: Michelle Angell Clinical Lead: Sunil Gupta

CCG Programme: Deteriorating Patient

Programme Objective: To enhance focus on early detection and management of UTIs and Sepsis by bolstering the existing district nursing team and enabling it with Telehealth technology (operating in care homes and expanding to include elderly care homes and patients within the community outside of the current caseload, through additional resource).

Programme Description

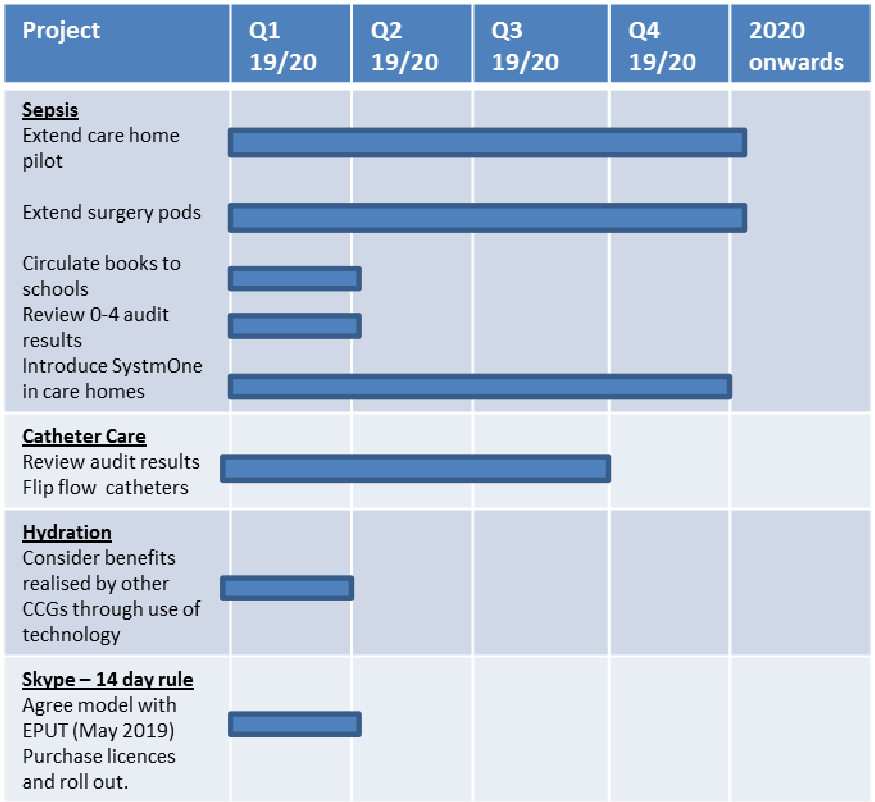
The project is to review and build upon the opportunity that the one year pilot has provided.



Outcomes and benefits

- Reduction in A&E attendance & NELs
- Improved public awareness, patient empowerment
- Enhanced relationships between primary care, secondary care and CCGs
- Reduction in lives lost / impacted relating to sepsis
- Improved care within care homes
- Quality of life improved relating to catheter care

Key Projects and Timescales



Key Risks

- Buy in from care homes to utilise telehealth appropriately.
- Buy in from practices to utilise surgery pods.
- Access to notes for Sepsis 0-4 audit.

Costs and Financial benefits

Investments Required: Currently being scoped

Savings: TBC

Delivering national & local priorities

Constitutional standards

Mental Health – adults & children

Urgent & emergency care (STP)

Elective Care

Learning Disabilities

Creating efficiencies

Workforce, OD, Leadership

Quality & Safeguarding

Quality and Constitutional Standards

Quality

- **NHS Castlepoint and Rochford CCG and NHS Southend CCG**

- **Objective:**

The CCG utilises the Joint Quality Strategy 2018, which sets out the quality agenda for the two South East Essex CCGs; NHS Castle Point & Rochford CCG and NHS Southend CCG to underpin its work to minimise the risk of harm to patients and improve patient experience. Quality looks at three core principles:

- Patient safety
- Clinical effectiveness
- Patient experience

The priorities below are set out using these three headings :

The focus of work is to:

Patient Safety

- Monitor and manage the process of concerns and complaints management.
- Monitor and quality assure serious incident investigations/ escalation of concerns and supporting action plans.
- Review quality matrix in all CCG contracts that relates to risk and safety
- Support the implementation of primary care networks ensuring patient safety is maintained through to transformation.
- Enhance Care Homes model is implemented and supported within both CCGs
- Collaborate with CQC, Health watch and Local Authority to ensure that the quality safety /safeguarding agenda is embedded
- Clinical audit: Catheterised patient, 0-4 yrs Sepsis.

Patient Experience

- Work in partnership with communications regarding quality focussed initiatives
- Further audits relating to friends and family, how is it for you audit (CHC)

Clinical Effectiveness

- Implementation, monitoring of the CQUINs Programme 2019/2020.
- Programme of Quality assurance visit for GP/Primary Care , EPUT Community Services, Southend University Hospital Foundation Trust (in collaboration with JCT)
- Specialist School Nursing Audit
- Oversight of the training program for fundamental of care for care homes.
- Glenwood School audit
- Developing a quality improvement programme for Primary Care.

Key Risks

- Failure to implement above may result in potential harm to the patient due to poor monitoring/oversight resulting in a potential reputational risk to the CCG.

- **Key Projects and Timescales**

2019/20 Deliverables	
Q1	• Cquin submission • Quality Schedule for contracts proposed submission • Quality assurance visits SUHFT • Ongoing Community contract monitoring and review • Catheter Audit, 0-4yrs Sepsis.
Q2	• CHC Patient Quality Audit • PHB NHSE reporting and Frequent attender PHB consideration • Ongoing Community contract monitoring and review
Q3	• Review and implementation of Quality Strategy. • Glenwood School audit and findings to be presented August 2019. • Develop a primary care quality assurance programme with Primary Care Commissioning. • Ongoing Community contract monitoring and review
Q4	• CHC Quality Audit • Year end schemes review for next financial year planning • Ongoing Community contract monitoring and review

Executive Lead
Tricia D,Orsi Chief Nurse

Implementation Lead
Lorraine Coyle
Deputy Chief Nurse

Emergency Care

- Consultation period started on 22nd May 2019 to look at alternative access standards to the current Hospital 4 hour standard.
- In Midlands and East Region the following sites are testing new measures:
  - Addenbrookes
  - West Suffolk (Bury St Edmunds)
  - Luton and Dunstable
- Southend Hospital currently monitoring new measures in the background

- Recent letter from Dr Ann Radmore (NHSE/I Regional Director for East of England) requesting that all Trusts achieve 90% performance against 4 hour standard for June 2019 onwards. Currently working across local A&E Delivery Board to collate a return to support this position.

- NHS Long Term Plan requires each site to open Urgent Treatment Centre over the next 18 months. NHSE/I currently meeting to advise how this would interact with sites that already operate GP Streaming (such as Southend Hospital).

Referral To Treatment Times

- RTT performance monitored by the Joint Commissioning Team as part of the acute block contract.
- Performance currently challenged and requires significant improvement
- RTT Access standards also being reviewed as part of proposed changes to national access standards.

Cancer Treatment

- Cancer performance monitored by the Joint Commissioning Team as part of the acute block contract.
- Performance currently challenged and requires significant improvement
- Cancer standards also being reviewed as part of proposed changes to national access standards.
- Recommendations have been made to JCT to look at other sites regionally and nationally that are performing well to understand how best practice can be applied locally.
- Significant local shortfall in Consultant Clinical Oncologist roles means that whilst specific tumour pathway improvements have been identified, full turnaround is impacted by specialist staffing shortages.
- Focus happening on the rapid diagnostic vague symptom pathway (RD VSP) to alleviate some of the unnecessary demand on 2 week wait referral pathway

Personal Health Budgets

Personal health budgets are a way of personalising care, based around what matters to people and their individual strengths and needs. They are one component of the NHS's comprehensive model of personalised care which will, as part of the NHS Long Term Plan, transform 2.5 million lives by 2023/24.

A personal health budget is an amount of money to support the identified healthcare and wellbeing needs of an individual, which is planned and agreed between the individual, or their representative, and the local clinical commissioning group (CCG). It isn't new money, but a different way of spending health funding to meet the needs of an individual.

Locally:

- Since 1st April 2019, all CHC funded domiciliary care packages are required to be delivered via PHB; this is now in place for both Southend CCG and Castle Point & Rochford CCG
- Personal Health Wheelchair Budgets (PHWB) are now available as an all-age offer since the beginning of this year.
- Some provisional scoping is being undertaken in collaboration with the acute trust with regard to frequent attender cohort and the possibility to impact on wellbeing outcomes with identified and targeted PHB's.
- Currently exploring opportunity to consider PHB for continence products

SAFEGUARDING

CCG PROGRAMME: Safeguarding Child/Adult Statutory Responsibilities

Programme Objective: Protect and promote the welfare of children and adults at risk of abuse and neglect

Programme Description

Working with Local Authorities, Essex Police, Health providers and relevant agencies to ensure the CCGs' statutory responsibilities to safeguard children and adults at risk are met.

For 2019/20 this will include:

Development of the new multi-agency Safeguarding Partnership arrangements in line with the Children & Social Care Act 2017 and *Working Together to Safeguard Children* 2018.
Undertaking a review of the Health Executive Forum and Safeguarding Clinical Network (SCN) so that there is the right level of influence on safeguarding arrangements in line with NHS England *Safeguarding Accountability and Assurance Framework.*
Working with Partners through Safeguarding Adults Boards to support the implementation of the strategic plans. Developing a safeguarding culture that focuses on the personalised outcomes desired by people with care and support needs who may have been abused (Making Safeguarding Personal).
Work with Partners through the Domestic Abuse Board and improve the recognition and response to domestic abuse through all commissioned health services and Primary Care.
Ensuring that safeguarding principles are a continual and fundamental part of the CCGs' commissioning strategy and processes, and are prioritised as a key thread in the development of Primary Care Networks and Integrated Care systems.
Work with Health providers and Local Authorities to meet statutory requirements for Initial and Review Health Assessments

SAFEGUARDING

Implement the SCN Looked After Children Health Strategy reflecting current local and national priorities.

Ensure all commissioned services implement the Mental Capacity (Amendment) Act 2019 with particular reference to Liberty Protection Safeguards.

Work with Local Authorities to ensure that vulnerable people, particularly those with learning disabilities and autism, receive safe, appropriate, high quality care.

Promote the Prevent duty (Counter Terrorism and Security Act 2015) in Primary Care and commissioned services so that all staff working in health care settings can identify children and vulnerable adults at risk of radicalisation or extremism and respond accordingly.

Ensure that robust arrangements are in place in the developing Integrated Health and Social Care system; this will include assurance from partners of effective safeguarding systems in Integrated Care Communities.

Continue to strengthen safeguarding practice and arrangements in Primary Care through learning & development and the implementation of recommendations from case reviews.

Work with statutory partners to further develop the multi-agency response to Contextual Safeguarding to improve identification, the management of risk and protective response to children at risk of sexual and criminal exploitation. Further develop health practitioners recognition and response to vulnerable adults at risk of sexual and criminal exploitation

Utilise the integrated governance systems and processes to provide assurance that all commissioned provider services have robust systems in place, are meeting safeguarding standards and acting on safeguarding concerns.

MENTAL HEALTH

STP-wide Programme

Programme Objective: to oversee both transformation and performance activities & to support delivery of the Mental Health Forward View.

Programme Description

The STP Board has agreed to provide support funding to source external expertise and capacity to review the pan-Essex Mental health Strategy and to help the system to define a costed model for delivering this. The focus of work in 2019/20 will be to:

- Ensure MHIS is delivered and prioritised to deliver best value for the system.
- Continued development of the mental health workforce, working through the LWAB with HEE, health and social care providers and wider groups
- Continued transformation of children and young people's mental health services through the LTP including crisis care
- Improvements in per-natal mental health services
- Increase access to IAPT and development of plans for access to IAPT services for patients with severe mental illness
- Improvements to community mental health services and working with emerging primary care networks.
- Implementation of crisis and home treatment service in Q4
- On-going developments to move MEHT towards core24 provision for mental health liaison
- Standardisation of practice for EIP across the STP to share learning
- Use of transformation funding for IPS - @ CCG level
- Continued improvements in dementia diagnosis at CCG level
- Continued work on the suicide prevention plan with public health partners
- Ensuring providers submit high quality data to the MHMDS and IAPT data set
- Continued implementation of Liaison and Diversion services

Key Projects and Timescales

2019/20 Deliverables	
Q1	• Complete phase 1 of costed delivery plan • Sign off suicide prevention plan at MH Partnership board • Perinatal delivery plan • EIP delivery plan
Q2	• Complete phase 2 and 3 of costed delivery plan including workforce, estates and digital plans
Q3	• Recruitment/Mobilisation of 24/7 community crisis service (subject to governance approval
Q4	• Delivery of 22% IAPT access target • 24/7 community crisis service live

Board Sponsor: Sally Morris, CEO, EPUT

Mental Health Partnership Board

Delivery Lead: Mark Tebbs

MENTAL HEALTH

CCG Programme: Parity Esteem/Physical Health of People with SMI

Programme Objective: That by 2020/21, at least 60% of people with Serious mental Illness (SMI) in South East Essex have their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention.

Programme Description

To develop an inclusive, locality approach to improving the physical health outcomes of people experiencing SMI. This will be done by improving access to, and quality of, physical health checks AND follow up interventions for people with SMI

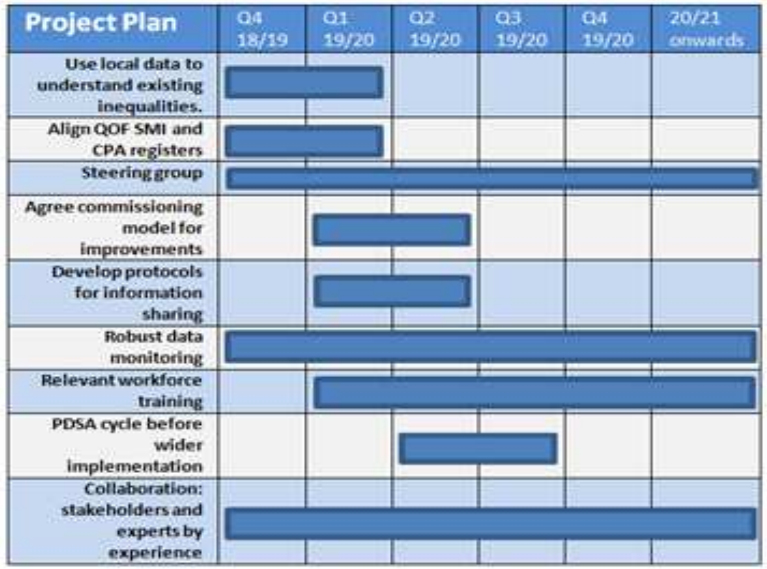
Outcomes and benefits

- Facilitate meaningful co-production of locality approaches and models for commissioning.
- To link /interface with parallel programmes such as NHS health check and LD health checks.
- To continue to monitor, improve, and sustain improvements in the physical health care of people with SMI.
- Improved confidence and competency within primary care for managing the health needs of people with SMI.
- Expected Outcome: an increase in the percentage of people on the GP SMI register who receive a full annual physical health assessment and appropriate follow up care. Southend and CP&R (to achieve *at least* national target of 60%).

Key Risks

- Information sharing between primary and secondary care.
- Staff capacity.
- Staff competencies.

Key Projects and Timescales



Costs and Financial benefits

Investments Required:

Investment required: £250k in 19/20

CCG Programme: Psychological interventions for people with long term conditions

Programme Objective: To ensure appropriate psychological support is available for people with long term conditions

Programme Description

To integrate psychological therapy interventions into care pathways for people with long term conditions. The aim will be to build on the successful work already being undertaken in SUHFT with respect to COPD and stroke; improving access to support for people with COPD into the respiratory medicine pathways in the community and primary care, and using learning from this to broaden the range of conditions where this support is available. It is likely that diabetes will be an important area for expanding this work. In addition to being an NHSE requirement to achieve NHS Constitution standards relating to access to psychological interventions, this has proven beneficial impact on the wellbeing of people with long term conditions and reduces levels of service utilisation in both primary and secondary care.

Outcomes and benefits

Offering psychological interventions to people with long term physical health conditions has proven impact in terms of both improving the wellbeing of individual patients and also reducing overall levels of service utilisation by people with long term conditions in both primary and secondary care.

Key Risks

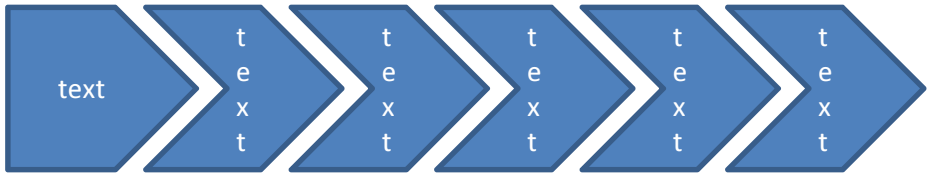
Introducing psychological interventions into pathways for people with long term conditions requires planning, commissioning and managing services across the traditional boundaries between physical and mental health services, hospital and community services, and primary and secondary care

CCG Programme: Dementia Pathway

Programme Objective: That through 2020/21, both CCGs continue to meet the constitutional target that of 66.7% of all diagnosed with dementia have a dementia diagnosis and access to good post diagnostic support. That both CCGs are in the upper quartile for dementia care plan reviews by Q4 19/20.

Programme Description

To develop an inclusive, locality approach to reducing the length of and streamlining the dementia diagnostic pathway. To also improve the post diagnostic support offer by offering improved access to and a consistent quality experience of dementia care plan reviews. Ensure dementia is included in EOL.



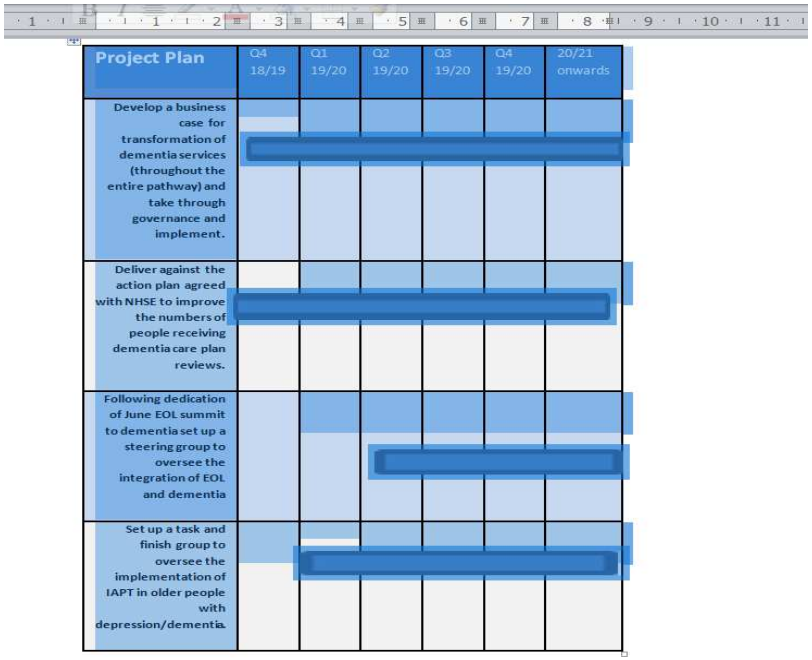
Outcomes and benefits

- A prevention focus to support early risk awareness and identification
- Access to support at the right time including bespoke treatment; minimum time in secondary care and greater understanding of need.
- Appropriate support mechanisms in place; trusted system and happier and healthier experience for both people with dementia and their carers.
- CCGs' continue to achieve and exceed the national ambition of 66.7% for dementia diagnosis rates and are in the upper quartile nationally for dementia care plan reviews.

Key Risks

- IG
- Staff capacity and investment.
- Engagement with primary care.

Key Projects and Timescales



Costs and Financial benefits

Investments Required:

Savings:

Investment required: Not known at this stage

CCG Programme: Care pathway for people with personality disorders and high intensity service users

Programme Objective: Effective local planning and implementation of the new care pathway for people with personality disorders and piloting a new dedicated service for people who use local services most intensely

Programme Description

Implementation of a new care pathway for people with a personality disorder is an important part of the STP mental health transformation programme. People with personality disorders, including significant numbers who also have comorbid mental health problems, form a significant proportion of the EPUT secondary care mental health service caseload. The introduction of new evidence based approaches to provide higher levels of support for people with a personality disorder and, critically, staff in primary care and specialist mental health services who work with them has the potential to significantly improve outcomes for these patients. It has now been agreed that the implementation of the new care pathway will start from April 2020, but this will require detailed planning and will build on programmes of work that are already underway for people who are intensive users of local services. On of these projects will commence in August and will focus on providing a new approach to care planning and working with six people who are the most intensive users of local services (including A&E, police and specialist mental health).

Outcomes and benefits

Admission to local inpatient mental health services frequently represents the only viable option currently available when people with a personality disorder present with significant levels of distress. Improving the support available for people in the community is expected to lead to reduced lengths of stay and a reduction in admissions to acute mental health wards.

URGENT & EMERGENCY CARE

STP-wide programme

Programme Objective: **Oversee urgent and emergency care transformation programmes & overview of urgent care performance.**

Programme Description

The STP Strategic Urgent & Emergency Care Board oversees the delivery of improvements in urgent and emergency care provision, as well as transformation programmes to deliver alternatives to A&E, admissions avoidance, improved flow and effective discharge. To deliver the requirements of 2019/20 planning guidance, the focus of work is to:

- Continuing improvements in 111 provision – ensuring >50% of appropriate callers receive a clinical assessment and increasing the number of triaged patients who are booked a face-to-face appointment where appropriate.
- Review and further develop the Directory of Services to ensure <1% of 111 dispositions are "A&E by default"
- Work with providers to reduce unnecessary ambulance conveyance
- Work with the lead commissioner for ambulance services to ensure ambulance response times met and that ambulance service meets baseline digital maternity
- Link with acute hospitals to reduce ambulance handover delays
- Enhancing the capacity of same day emergency care (SDEC) ensuring 30% of current non-elective admissions are treated via SDEC by end of March 2020.
- Continued implementation of Teletracking across three hospital sites to improve patient flow and supporting the reduction in long-stay patients by 40% by the end of March 2020, based on 2017/18 baseline
- Continue progress with reducing delayed transfers of care
- Continued cross-system working at times of pressure (eg. STP "winter room")
- Await outcome of clinical standards review work on A&E waiting time standards

2019/20 Deliverables	
Q1	Delivery of 111 performance (calls answered within 60 secs) Delivery of > 50% callers receiving clinical assessment Clinical review of A&E dispositions from 111 Explore SW Essex roll-out of High intensity user scheme.
Q2	Extended hours for ambulatory – 70 hrs/week each site.
Q3	Extended hours for frailty - 70 hours/week each site.
Q4	Mental health crisis service in place and integrated with 111 Implementation of ESDAR pilot across STP

Note: other transformation schemes also link to the urgent care work stream:

- Development of Community Crisis Treatment Teams
- Working with Newton Europe to define and refine the pathways out of hospital with aim of streaming and ensure capacity = demand
- Implementing the 24/7 Crisis mental health business case to ensure that patients access the right care at the right time.

Board Sponsor: Clare Panniker, CEO, Acute Hospitals

Strategic A&E Board

Delivery Lead: Andrew Pike

ELECTIVE CARE

STP-wide programme

Programme Objective: **Various programmes ensuring delivery of elective care transformation programmes.**

Programme Description

The system has implemented relevant recommendations from the elective care handbooks, including ophthalmology, MSK, and advice and guidance. For 2019/20, the system will continue to embed best practice in these areas and also focus on:

- Continuing to offer patients a choice of provider
- Ensuring that Patients waiting more than 6 months have the option of being seen by an alternative provider (the mechanism for this is being discussed at present)
- Ensuring that waiting lists are maintained at March 2018 levels
- Zero 52 week waits
- Delivery of the system transformation plan to redesign outpatient services
- Ensuring that patients with musculoskeletal issues have access to a physiotherapist as a first point of contact.
- The system awaits the outcome of the clinical standards review work
- Continued work on ophthalmology.

To note: Mid-Essex Hospital has not yet returned to reporting on RTT. The above commitments will need to be carefully reviewed as the Trust returns to reporting.

At the time of drafting RTT recovery trajectories have yet to be agreed between commissioners and providers so deliverables remain to be confirmed.

2019/20 Deliverables	
Q1	Agreement of RTT backlog reduction trajectories and zero 52 week plan for BTUH and SUFT. Outpatient transformation scoping with MSB and CCG Joint Committee
Q2	MEHT community ophthalmology service fully mobilised Review of SE pilot for first contact practitioner. Increase specialities available to provide capacity alerts at point of referral
Q3	Preparatory work for MEHT return to reporting. Improved utilisation of advice and guidance MEHT return to RTT reporting
Q4	Delivery of zero 52 week waits (excluding MEHT)

Board Sponsor: Various

Various (ophthalmology, MSK. Advice and guidance)

Delivery Lead: Karen Wesson

LEARNING DISABILITIES

STP-wide programme: Transforming Care

Programme Objective: [text]

Programme Description

Working with key partners through the LD Health Equalities Partnership Board, the STP is committed to addressing the health inequalities that people with LD and / or Autism continue to experience. The work will focus on ensuring:

- 75% of people with learning disabilities receiving an Annual Health Check by March 2019.
- Improved experience of health services for people with learning disabilities.
- Accessible mainstream health services (Primary, Acute, MH etc.)
- Reduced differences in healthy life expectancy between communities
- Improved health outcomes for people with LD & Autism
- Enhanced quality of life and care for people in inpatient and community settings
- Reduced inappropriate admissions and improved timely, safe discharge
- Personal Health Budgets are offered to people with learning disabilities

The STP has recently re-commissioned the Specialist LD Adult Healthcare service in line with service model described in Building the Right Support and will extend this service, during 19/20, to an "All Age" model. The new service will also work alongside primary, acute and mental health services to support them in making reasonable adjustments to ensure people with LD and Autism have access to the same quality of services as the general population.

The STP will work with Primary Care, the new Specialist LD Health service, and the three Local Authorities to improve the uptake of Annual Health Checks to 75%, and to ensure that people with LD are not being prescribed psychotropic medication inappropriately (STOMP).

The STP is also part of the Essex wide LeDeR programme and will ensure the learning from mortality reviews is used to drive improvements in local health and care services.

As part of the pan-Essex Transforming Care programme, the STP has already reduced the number of in-patients and the number of hospital beds across the partnership. CCGs will continue this programme to ensure that no more than 30 adults per million and 12 to 15 children per million with LD and / or Autism will be cared for in an inpatient facility.

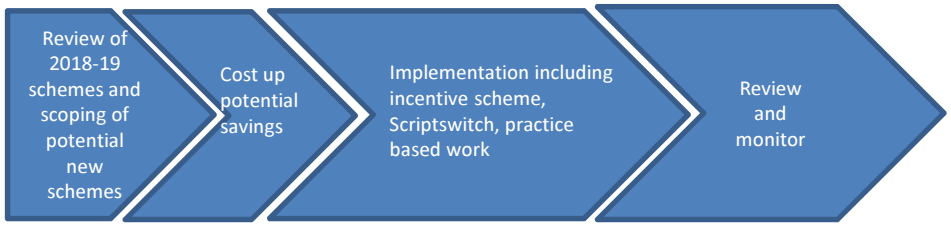
CREATING EFFICIENCIES

CCG Programme: Medicines Management

Programme Objective: To ensure all prescribing is carried out in a safe, evidence based, cost-effective manner using agreed formularies, strategies and engagement.

Programme Description

The project is to build upon and enhance previous successful schemes.



Outcomes and benefits

- Maximise Scriptswitch savings
- Support more cost-effective prescribing
- Increase public awareness of self care
- Improved care within care homes

Key Risks

- Buy in from GP practices
- Staffing – a number of pharmacists recently left t0 work in GP practices
- Fluctuating medicine costs

Key Projects and Timescales

Scriptswitch
Contract in place for 1st April
Monthly monitoring to ensure delivery
Prescribing Incentive Scheme
Targets agreed by April 2019
Practice visits to be completed for outlier practices by June 2019
Monthly monitoring and sharing with practices

Care Homes
Link with Essex pilot
Recruitment of staff (March-April 2019)

Over the Counter Medicines
Continue to support practices with public communications (ongoing)
Monthly monitoring

Limited Value Medicines
Review new proposed list
Maximise new agreement with BUHT (1ST QTR 2019)

Costs and Financial benefits

Investments Required: tbc **Savings:** £1.7m CPR, £1.6m Southend

RightCare Executive Lead: Mark BarkerOperational Lead: Jenni Speller Clinical Lead:

CCG Programme: [RightCare]

Programme Objective: To further develop, refine and embed our use of the RightCare Delivery methodology.

Programme Description

The NHS RightCare programme aims to improve care and reduce unwarranted variation. Its delivery methodology is based around three simple principles ;

- **Diagnose** the issues and identify the opportunities with data, evidence and intelligence
- **Develop** solutions, guidance and innovation
- **Deliver** improvements for patients, populations and systems

https://www.england.nhs.uk/rightcare/what-is-nhs-rightcare/

Outcomes and benefits

The CCGs must maintain a continuous list of improvement opportunities to ensure that QIPP requirements can be met each year. An effective RightCare Programme will support us to do this.

Key Risks

Tbd

Key Projects and Timescales

Detailed Programme plan and governance arrangements being developed with NHS England RightCare Delivery Lead. Key 19/20 objectives are :-

- **Implement national priority initiatives** for **cardiovascular** and **respiratory** conditions
- **Address variation and improve care** in at least one additional pathway
- **Implement a High Intensity User support offer** for demand management in urgent and emergency care
- **Work with GPs using NHS RightCare data** to identify opportunities and outliers and increase the focus on the development of primary care service to further reduce referrals and follow-ups

Costs and Financial benefits

Tbd

Continuing Health Care Executive Lead: Tricia D'Orsi Operational Lead: Matt Gillam Clinical Lead: Mark Metcalfe

CCG Programme: Continuing Health Care

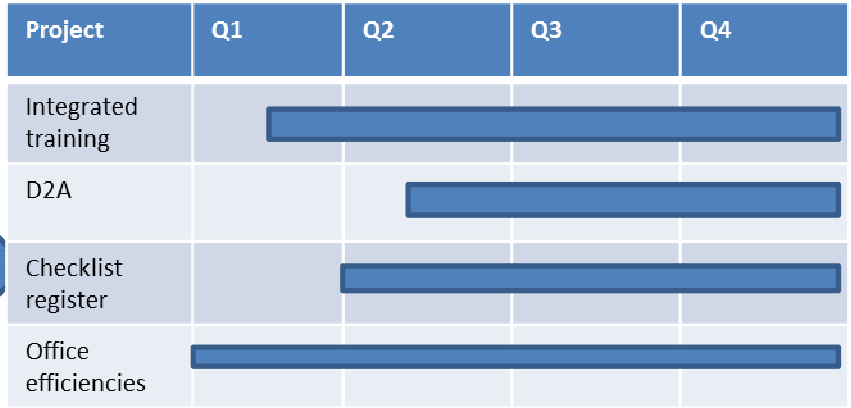
Programme Objective: To establish mechanisms to ensure people are only assessed against the eligibility criteria for NHS funded Continuing Healthcare when they are at their optimum. To establish greater whole system understanding of CHC and to ensure robust and timely review and monitoring for NHS funded cases, to ensure an equitable approach to delivery of care which is free at the point of delivery.

To explore commissioning opportunities in the community, which will support the deteriorating patient and thus reduce the incidences of hospital attendances and the general reliance of NHS funded CHC.

Programme Description

Integrated Training and Education programme
Discharge to Assess
Checklist Practitioner register
Office Efficiencies

Key Projects and Timescales



Outcomes and benefits

Greater awareness of CHC eligibility criteria
Reduced undertaking of CHC assessments in inappropriate environment
Greater opportunity to support patient recovery pathway, prior to assessment
Greater accountability of CHC assessment processes
Improved timeliness of CHC assessments and outcome notification

Costs and Financial benefits

Investments Required: Currently being scoped.

Savings: Some savings will be wider system savings, rather than direct CHC spend.

Key Risks

Relationship with Local Authorities and Acute trust
Current workload/staffing levels reduces opportunities to undertake training programme

Workforce Executive Lead: Charlotte Dillaway Operational Lead: Michelle Angell Clinical Lead: Kate Barusya

CCG Programme: 20% Reduction on Running Costs

Programme Objective: [Reduce running costs by 20% by 2021]

Programme Description

Undertake a review of all running costs and identify savings linked to running costs.

Outcomes and benefits

- Meet national reduction in running costs standard.
- Ensure all contracts meet value for money requirements.

Key Risks

- Insufficient capacity to deliver key objectives.

Key Projects and Timescales

Project	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20	2020 onwards
Utilities Review all utilities and look for savings					
Estates Savings Review estates utilisation and identify potential savings					
Procurement Contract Undertake options appraisal of procurement provision – contract up for renewal Sept '19					
Structure Review existing vacancies/ways of working					

Costs and Financial benefits

Investments Required: None

Savings: 20% against running costs by 2021 (£750k per CCG)

3, Our Enablers

Enabling programmes

Finance

Communications & Engagement

Technology

Estate & Infrastructure

Data & Information

Workforce

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Achieving Financial Sustainability

Finance – Castle Point & Rochford CCG

- We have produced a base budget/financial plan for 2019/20, supporting the delivery of the key financial metrics under which we are measured by NHS England and enabling the delivery of the strategic direction agreed by the Governing Body. These financial plans include a detailed annual plan by service type, coupled with details of annual QIPP schemes and investments. The Plan is consistent with the strategic direction of the Sustainability and Transformation Plan.

- The plans enable us to deliver on all of our targets and the underpinning activity and assumptions are being triangulated with Southend CCG for our main acute contract, along with the SUHFT, with whom we remain in a block contract arrangement for 2019/20.

- Our financial plan meets the requirements of the recently published planning guidance and complies with NHS England's "business rules", under which the CCG is obliged to operate.

- The plan now exceeds the requirements of the Midlands and East published control totals, by generating a surplus of £579k, in line with regionally agreed contributions to help support the financial pressures faced within the Cambridge & Peterborough for 2019/20.

- **Current Position and Key Issues**
- *Resource Allocation* - Movements in our recurrent allocation from 2018/19 to 2019/20 are included within the table below:

Allocation Type	18/19	19/20
Total Programme Allocation	233,332	247,026
Total Running Costs Allocation	3,882	3,883
Total Primary Care Co-Commissioning Allocation	23,587	24,311
GRAND TOTAL ALLOCATION	**260,801**	**275,220**

Our overall movements in relation to our 2019/20 allocation as follows;

- Programme growth of 5.9%
- Primary Care Co-Commissioning growth of .1%
- Running costs, no material change.
- Overall allocation growth of 5.5%

Finance – Castle Point & Rochford CCG

2019/20 Expenditure - The following table details, by service type, our financial plans for 2019/20. (Fuller detail is available on request)

TOTAL ALLOCATION	**275,220**
Expenditure	**19/20 Plan £k**
Acute Services	141,916
EEAST Services	7,923
Mental Health Services	19,175
Community Services	10,087
Continuing Care Services	14,518
Prescribing	29,373
Other Primary Care Services	3,024
Primary Care Co-Commissioning	24,311
BCF	11,718
Other Programme Services	8,139
Running Costs	3,486
Contingency Reserve	1,376
Unidentified QIPP	(406)
TOTAL EXPENDITURE	**274,641**
Surplus/(Deficit)	**579**

Reserves Utilisation - We have established a 0.5% contingency reserve, in line with national guidance, along with a cost pressure reserve, both of which give mitigation against any financial pressures encountered in-year.

Expenditure can only be authorised from reserves with express agreement of the Chief Finance Officer and must demonstrate value for money.

QIPP Challenge – Castle Point & Rochford CCG

- The CCG has an £8.3 million gross QIPP target for 2019/20, equating to 3% of allocation.
- The table below details the QIPP schemes for 2019/20. We are confident of meeting our 2019/20 QIPP challenge and we have identified the work streams and service line savings which we will be aggressively pursue to ensure we deliver our statutory financial obligations. The summary table below sets out the current level of identified QIPP by contract/service area.
- Our overarching aim is to focus on closing the current planning gap, whilst working to identify a QIPP programme of at least 20% higher than the QIPP target, thus ensuring that there is mitigation against any slippage or under delivery.
- The Rightcare programme in 2019/20 will be a key component of QIPP and Transformation Plans.

Summary of QIPP Schemes

Expenditure Category	QIPP Value (£k)
Acute Services	4,681
Continuing Care Services	1,000
Prescribing	1,712
Other Programme Services	65
Running Costs	400
Planning Gap	406
GRAND TOTAL	**8,264**
Aspirational Headroom Target (20%)	**1,653**

2019/20 QIPP Projects - Castle Point & Rochford CCG

Project	Net QIPP Saving £000	Status
FYE of 18/19 schemes	1,045	Delivered
Evidence Based Interventions – MSB	811	Delivered
High Cost Drugs – SUHFT/EPUT/MEHT	726	Delivered
Avastin	84	Delivered
Garfield House	65	Delivered
Prescribing	1,712	In progress
Decommission / recommission acute to community	1,000	In progress
CHC Assessments Review	450	In progress
Running Cost Efficiencies	400	In progress
Evidence Based Interventions – Non MSB	302	In progress
Follow Up – Outpatients	300	In progress
Use of Hilton Nursing Services (Pilot)	250	In progress
Development of hospice partnerships	150	In progress

Project	Net QIPP Saving £000	Status
Extend PHB Focus	150	In progress
Working Age Adults	100	In progress
LPTP Acute Review	100	In progress
Outpatient – Primary Care	58	In progress
0-4 Paediatric Clinics	55	In progress
Minor Ops Review	50	In progress
Wound Care	50	In progress
CHC Office efficiencies	-	Scoping
Standardising Primary Care	-	Scoping
Review of payments	-	Scoping
MSK	-	Scoping
MSK – Rheumatology	-	Scoping
Rawreth and Clifton	-	Scoping

Finance – Southend CCG

- We have produced a base budget/financial plan for 2019/20, supporting the delivery of the key financial metrics under which we are measured by NHS England and enabling the delivery of the strategic direction agreed by the Governing Body. These financial plans include a detailed annual plan by service type, coupled with details of annual QIPP schemes and investments. The Plan is consistent with the strategic direction of the Sustainability and Transformation Plan.

- The plans enable us to deliver on all of our targets and the underpinning activity and assumptions are being triangulated with Southend CCG for our main acute contract, along with the SUHFT, with whom we remain in a block contract arrangement for 2019/20.

- Our financial plan meets the requirements of the recently published planning guidance and complies with NHS England's "business rules", under which the CCG is obliged to operate.

- The plan now exceeds the requirements of the Midlands and East published control totals, by generating a surplus of £610k, in line with regionally agreed contributions to help support the financial pressures faced within the Cambridge & Peterborough for 2019/20.

- **Current Position and Key Issues**
- *Resource Allocation* - Movements in our recurrent allocation from 2018/19 to 2019/20 are included within the table below:

Allocation Type	18/19	19/20
Total Programme Allocation	245,794	260,733
Total Running Costs Allocation	3,919	3,933
Total Primary Care Co-Commissioning Allocation	24,764	25,575
GRAND TOTAL ALLOCATION	**274,477**	**290,241**

Our overall movements in relation to our 2019/20 allocation as follows;

- Programme growth of 6.1%
- Primary Care Co-Commissioning growth of 3.3%
- Running costs, no material change.
- Overall allocation growth of 5.7%

Finance – Southend CCG

2019/20 Expenditure - The following table details, by service type, our financial plans for 2019/20. (Fuller detail is available on request)

TOTAL ALLOCATION	**290,241**
Expenditure	**19/20 Plan £k**
Acute Services	137,323
EEAST Services	9,497
Mental Health Services	29,350
Community Services	10,802
Continuing Care Services	23,166
Prescribing	28,282
Other Primary Care Services	3,117
Primary Care Co-Commissioning	25,575
BCF	12,604
Other Programme Services	5,180
Running Costs	3,519
Contingency Reserve	1,451
Unidentified QIPP	(235)
TOTAL EXPENDITURE	**289,631**
Surplus/(Deficit)	**610**

Reserves Utilisation - We have established a 0.5% contingency reserve, in line with national guidance, giving mitigation against any financial pressures encountered in-year.

Expenditure can only be authorised from reserves with express agreement of the Chief Finance Officer and must demonstrate value for money.

Communications & Engagement

- *NEW* CCG Communications and Engagement Strategy for 2019-21.

- The strategy builds on the development and successes of previous communications & engagement strategies, as well as learning from feedback from independent reports such as the 360 stakeholder survey, internal effectiveness surveys, staff surveys and the Impact Assessment Framework Patient and Community Indicator.

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- It also considers how we can benchmark our achievements and our work, providing a framework to enable people to check how successful we have been in our aims.

- Strengthened internal processes to embed public involvement in the CCGs work to ensure the patient voice is integral to the commissioning cycle.

TECHNOLOGY

STP programme

Programme Objective : Digital Transformation

Programme Description

System partners have agreed a specification and business case to access NHSE funding on provider-led digitalisation. The system has prioritised the development of an integrated shared care record. A preferred provider has been identified and a memorandum of understanding will be in place across key partners. During 2019/20 detailed implementation will take place, involving service users and professionals from across health and social care.

This work links closely with the ambition to develop our approach to population health management and prevention as the (anonymised) data from the shared care record will provide opportunities to segment and target interventions in a more structured and evidence-based manner.

The STP is partnering with neighbouring STPs on the LHRCE programme (led by Suffolk and North East Essex ICS).

Through the STP Digital 2020 Board, a refresh of the digital strategy will be undertaken, to ensure the system is prioritising relevant digital transformation priorities and meeting new requirements outlined in the GP contract reform relating to digital capability and competence of practices, and digital access for patients.

2019/20 Deliverables	
Q1	Local implementation of NHS App (connection date 27/5/19) Review membership and ToR of STP Digital Board. Define programme plan for Shared Care Record Implementation. Discussion on LHRCE programme with neighbouring STPs
Q2	Contractual requirement for all practices to make at least 25% of appointments available for on-line booking Commence implementation of Shared Care Record.
Q3	Local preparation for GP IT Futures implementation from 1 January 2020 Local preparation for Primary Care Enabling Services implementation from 1st October 2019
Q4	On-line consultation software to be made available to every practice

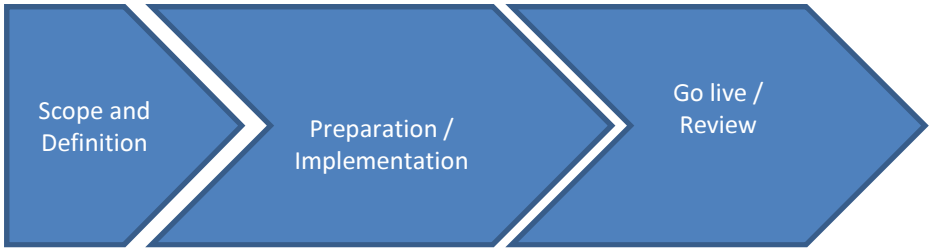
TECHNOLOGY

CCG Programme: IT: Preparing for the future

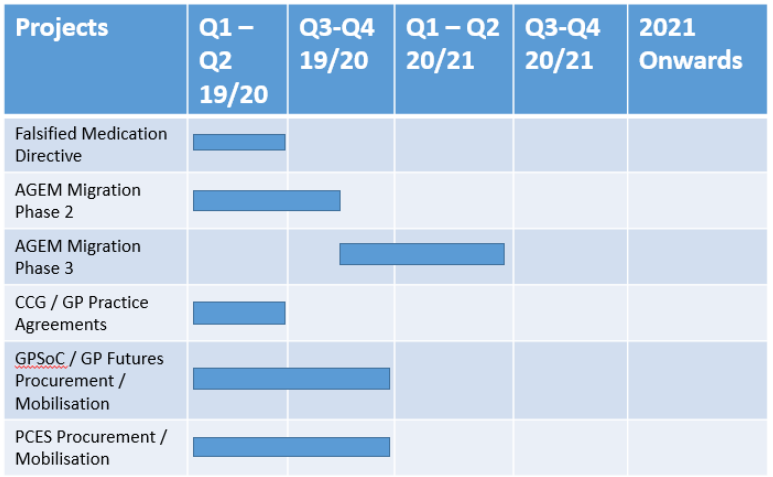
Programme Objective: [To build on CCG corporate IT infrastructure and plan for the future in procuring fit for purpose services]

Programme Description

To ensure IT platform is expanded and that contracts are in place as required for all services



Key Projects and Timescales



Outcomes and benefits

- GP practices compliance with Falsified Medication Directive.
- CCG Corporate estate upgraded to Windows 10 before support for Windows 7 ends in January 2020 and start utilising Office 365
- Agreements in place with every GP practice in line with the GPIT Operating Model
- Contracts in place for GP Clinical Systems beyond GPSoC
- PCES procured for Primary Care Contractors beyond regional contract expiry.

Costs and Financial benefits

Investments Required: None **Savings:** None

Key Risks

- Insufficient capacity to deliver key objectives.

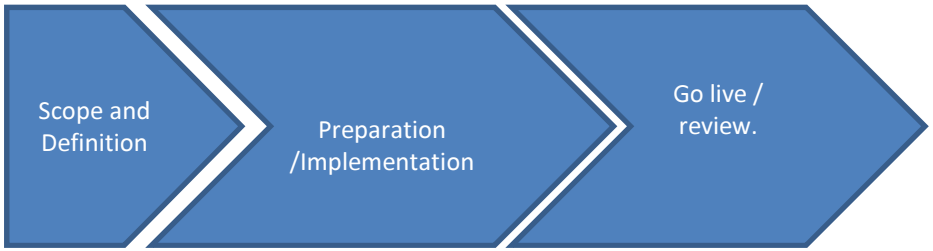
IT: Improve Primary Care IT Provision Executive Lead: Charlotte Dillaway Operational Lead: Peter King Clinical Lead: Taz Syed

CCG Programme: IT: Improve Primary Care IT Provision

Programme Objective: [To improve core IT provision within GP practices]

Programme Description

To ensure compliance with the GPIT Operating Model and improve core IT provision within GP Practices



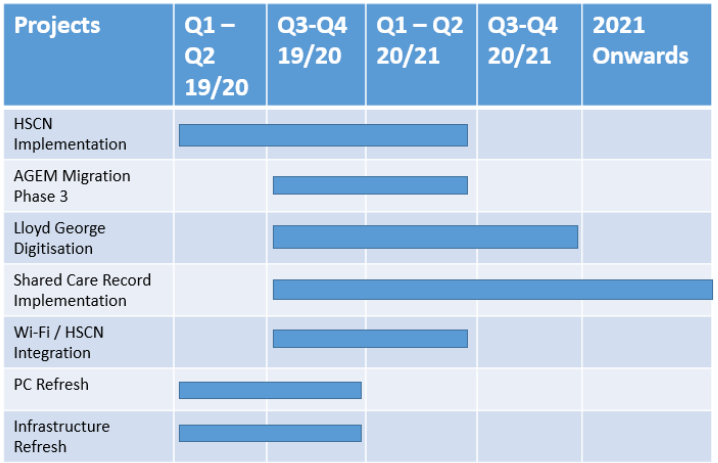
Outcomes and benefits

- N3 replaced with HSCN giving better connectivity and reducing cost
- PCs compliant with GPIT Operating Model and upgraded to Windows 10 prior to support ceasing for Windows 7 in January 2020
- Notes digitised to maximise estates utilisation

Key Risks

- Insufficient capacity to deliver key objectives.

Key Projects and Timescales



Costs and Financial benefits

Investments Required:
STP Capital plan of £1m

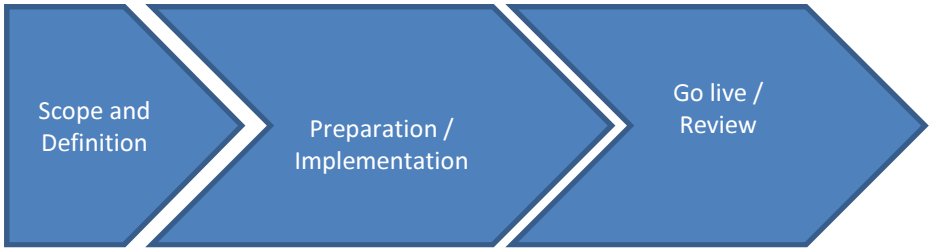
Savings:
HSCN completion will reduce running costs

CCG Programme: IT: Local Projects

Programme Objective: [To deliver IT enablers within local projects]

Programme Description

To ensure IT change / transformation occurs as an enabler of other workstreams



Outcomes and benefits

- Local projects completed
- Working lives improved
- Better access to Primary Care
- Cost savings from changing from ISDN to SIP
- Greater efficiency with electronic letters and system wide cost saving in postage

Key Risks

- Insufficient capacity to deliver key objectives.

Key Projects and Timescales

Projects	Q1 – Q2 19/20	Q3-Q4 19/20	Q1 – Q2 20/21	Q3-Q4 20/21	2021 Onwards
Krishnan / Sathanandan Merger					
Valkyrie Surgery Expansion					
Clevertouch / Skype					
CHC Surface Pro Deployments					
Dr Zaidi Refurbishment					
Corporate Hardware Refresh					
GP Mobile Working					
St Lukes Refurbishment					
Castle Road SIP Lines					
Highlands SystmOne migration					
A&E Electronic Discharge Letters					

Costs and Financial benefits

Investments Required: **Savings:**

Estates & Infrastructure

WORKFORCE

STP Programme: Workforce

Programme Objective: [text]

Programme Description

Working through the Local Workforce Action Board, and with funding provided by HEE, the system is taking steps, through innovative programmes, to attract new staff and retain existing. This includes:

Development of an innovative newly qualified nursing preceptorship programme
An innovative GP workforce programme including supporting practice resilience, working with newly qualified GPs and practice nurses, EU recruitment and working with those at the end of career to support on-going, flexible working.
Development of baseline system workforce data, enabling a pilot for system workforce planning.
Participation as a national pilot site for the NHS Leadership Academy High Potential scheme recognising the need to develop leaders who are able to collaborate across traditional organisational boundaries and lead effectively to address complex challenges. This scheme will also look to increase the diversity in the cadre of our future leaders.
A wide-ranging OD and leadership offer for the system to attract talent, develop staff and support system-working.

The **focus for 2019/20** will be to use HEE/national funding to focus on a small number of high impact programmes. This will include:

Undertake market research on recruitment – how to attract staff to work/return to work in mid and south Essex, enabling targeted campaigns with proven impact
Development of a joint health and care workforce strategy (awaiting the national workforce strategy)
Develop a STP Leadership hub to manage and coordinate the various OD and personal development opportunities available to the system to support the STPs ambitions.
Focussed development of hybrid roles to support health and care provision.
Develop a detailed mental health workforce strategy to deliver requirements of the MHFV and Long-term Plan commitments.
Continue the work of the GP training hub to support the primary care strategy and delivery of the GPFV

WORKFORCE

STP Programme: Workforce

Key Risks

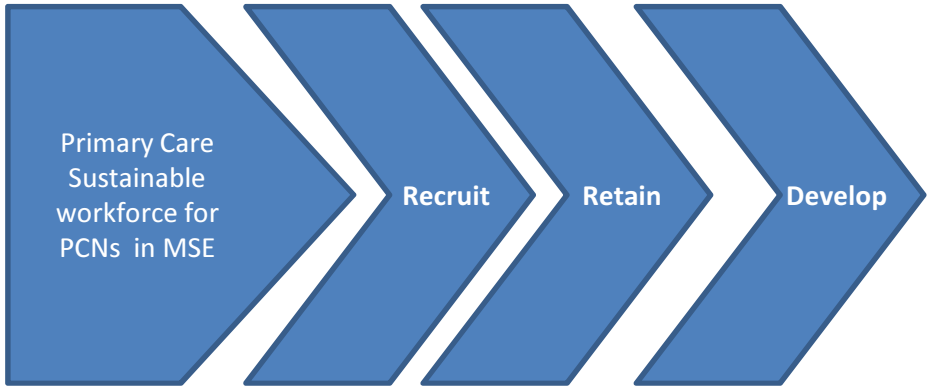
- Securing a sufficient workforce is a challenge for all aspects of the system.
- Key Risks:
  - High vacancy rates and long-term vacancies across all sectors.
  - High agency use resulting in potential quality risks and cost pressures
  - Impact of high agency use on continuity of care, discharge planning, etc.
  - Impact of removal of the nursing bursary
  - Ageing workforce profile (particularly in primary care and mental health)
  - Leaving the EU – across all sectors, but particularly in domiciliary care market and care homes
- Individual providers, and the GP workforce hub, have detailed workforce plans, aimed at addressing gaps; there is also coordinated work through the STPs LWAB (see over).
- The national workforce strategy is awaited.

WORKFORCE

CCG Programme: Workforce

Programme Objective: [text]

Programme Description



Outcomes and benefits

- Sustainable workforce with correct skill mix
- Increase number of appointments for patients
- Decrease in burnout
- 15 min - Patients see right person at the right time –less visits

Key Risks

- We fail to recruit or retain
- Staff do not find development opportunities attractive
- Workforce does not meet the need of the population

Key Projects and Timescales

GP Retention -2019/20
GP Recruitment -2019/20
GPN Retention & Recruitment -2019/20 (GPN 10 PP)
Apprenticeships for Primary Care -2019/20
Tier 2 Visa Support – establish support by May 2019
International Recruitment – 2019/20
CPD/ACP Development Programme 2019/20
Recruit AHPs – 2019/20
Recruit Social Prescribers – 2019/20
Recruit/retain and develop admin roles
15 min Pilot – Pilot to report - June 2019
Maternity Keeping in Touch Days Pilot -2019/20
First5 Champions launch – July 2019
Adapt website for Single Point of Access – September 2019
Develop Portfolio & Fellowships Programme - start Aug 2019

Costs and Financial benefits

Investments Required:

- GP Retention fund from NHSE 2019/20
£ 132,975
- GPRISS B/F approx. £300k

Savings:

Nil

DATA & INFORMATION

Population Health- Executive Lead: Director of Partnerships and Integration – CPR Operational Lead: Jenni Speller Clinical Lead:

CCG Programme: [Population Health]

Programme Objective: To implement a Population Health approach .

Programme Description

The CCGs are working to establish a programme of Population Health Management (PHM) along with colleagues in the South East Essex Partnership and across Mid and South Essex.

Delivery of these new service models will be strongly linked to the development of PCNs, and integrated health and care locality models.

Outcomes and benefits

Tbd – at system, population and individual level

Key Risks

Tbd

Key Projects and Timescales

Detailed programme plan to be developed. Three stands of work are underway:-

1.Developing a whole system PHM Programme across Mid & South Essex – Led by Peter Fairley , Director, Strategy, Policy & Integration (People) , ECC

2. Developing our PHM Intelligence Approach in South East Essex – Led by Alison Foster, Joint Transformation Analyst, PMO

3. Implementing the AGEM Risk Stratification Tool – Led by Jennifer Speller, AD Primary Care /AGEM

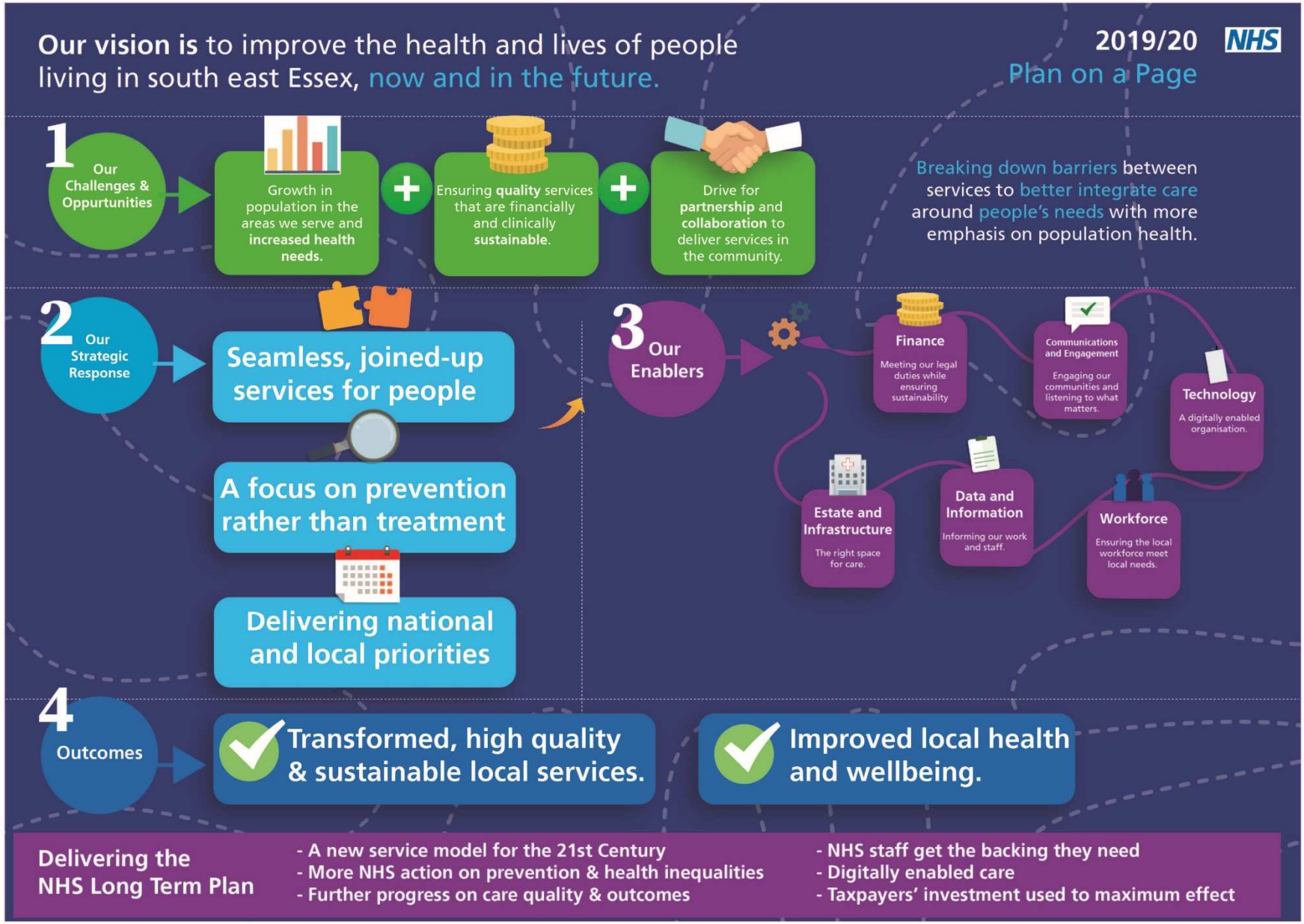
Costs and Financial benefits

Tbd

4,
Outcomes

Outcomes

Plan on a page: south east Essex



STP-wide Enabling Programmes

Workforce

Support the development of a health and care workforce fit for the needs of our population.

Lead OD initiatives across the STP.

Board Sponsor: Sally Morris, CEO, EPUT

Local Workforce Action Board + Sub-groups

Delivery Lead: Phil Carver, HEE

Estates

Deliver on the STP Estates Strategy, making best use of estate and supporting planning and delivery of new facilities.

Board Sponsor: Caroline Rassell , AO Mid-Essex CCG, SRO Local Health & Care

STP Estates Forum

Delivery Lead: Kerry Harding

Digital

Oversee delivery of the agreed STP digital strategy.

Oversee implementation of the shared care record.

Board Sponsor: John Niland, CEO, Provide

Digital 2020 Board

Delivery Lead: Martin Callingham

STP-wide Activity Assumptions

- The commissioners and MSB group have submitted activity plans for 2019/20. The activity growth uplifts are shown in the table below and reflect national planning guidance regarding growth:

Point of Delivery	SUFT Growth %	BTUH Growth %	MEHT Growth %
A&E	3.40	4.50	4.70
First OP	2.70	1.00	3.10
Follow-up OP	2.80	1.00	4.10
Elective Totals	-	3.80	-
Daycase Totals	2.00	2.60	4.60
Emergency Excluding Zero LOS Totals	2.00	4.50	1.80
Emergency Zero LOS Totals	5.50	0.30	1.80

- These growth numbers have been provisionally agreed for the current plan, at the time of writing MSB Group has a view that the BTUH activity will be higher growth. The MEHT and SUFT agree on the growth assumptions.

- It is important to emphasise that RTT recovery trajectories have not yet been agreed between commissioners and providers and so these figures are subject to change; the CCG position included level of activity for RTT backlog clearance, and impact of Evidence Based Interventions, however the MSB Group position did not include this. Activity changes as a result of IR allocation movements were not reflected by CCG or MSB Group in this submission. These discussions are ongoing and will continue beyond the submission of the draft operational plans.

STP-wide Activity Assumptions

- Activity assumptions must also be set against the STP financial objectives of
    - Living within the Annual Plan budgets for 2019/20;
    - Supporting the delivery of STP Control Total ;
    - All contracts signed-off by 21st March 2019;
    - Supporting the system wide savings programme
    - Enabling cultural change to facilitate more collaborative working across the system
- Activity shifts associated with clinical reconfiguration changes have not been included until the terms of reference and the timeline of the referrals to the Secretary of State by Southend on Sea Borough Council and Thurrock Council have been confirmed. For the draft plan submission Activity shifts associated with the clinical reconfiguration set out in the acute reconfiguration plan in respect of Urology, Interventional radiology, vascular phase 1, Trauma and Orthopaedics phase 1 have not been modelled

STP-wide Capacity Planning

Urgent Care, Winter Planning:

- The STP adopted a model of closer working through winter to ensure shared understanding and mutual aid where possible. This process was managed through the establishment of winter resilience rooms at both STP and local hospital/system, jointly staffed by health and social care partners to pick up issues, maintain up to date information and ensure system grip. Lessons from this approach will be considered to support the development of the 2019/20 winter plan.
- All three Trusts implemented Teletracking in 2018/19 and will continue to embed the system to continue to drive improvements in flow by maximising the use of Teletracking as the key enabling tool.

Elective Care:

- **Basildon**
- RTT recovery activity is planned to return to and improve on the Trust waiting list size as at March 2018 position (subject to agreement with commissioners regarding backlog clearance). There will be more focus on the use of virtual clinics by increasing the utilisation of the Advice & Guidance service and telephone results clinics to manage demand on Outpatient clinics. 52 week breach risks are monitored weekly and the Trust does not expect to report 52 week breaches in 2019/20.
- **Southend**
- RTT recovery activity is planned to return to and improve on the Trust waiting list size as at March 2018 (subject to agreement with Commissioners re backlog clearance). There will be more focus on the use of virtual clinics by increasing the utilisation of the Advice & Guidance service and telephone results clinics to manage demand on Outpatient clinics. The introduction of ophthalmology community pathways will provide additional capacity to continue to improve the ophthalmology position. Pathways are currently being developed for gastroenterology and neurology. Urology remains a pressure point.
- The Trust will implement the recommendations from the NHSI review of RTT. It has identified two key issues to address to ensure there are no 52 week waits from March 2019 which are to improve validation and clinical decision making. Delivery of these will be monitored through the weekly Planned Care Board.

STP-wide Capacity Planning

- **Mid Essex**
- The Trust is not currently reporting RTT data. A provisional return to reporting date of September 2019 (August 2019 data) has been set. The Trust has developed a return to reporting action plan and has committed to reduce the number of 52 week waits to zero in line with national guidance apart from a few challenged specialties. Ongoing workforce issues at MEHT create an on-going challenge to ensure he provision of elective case operations are completed as planned

High Level STP System Transformation Schemes

Scheme	Ambition/Potential Opportunity	Identified Lead
Outpatient transformation	Reduce 240k face to face OP appointments over three years in line with PCBC/DMBC; joint work across all msb and CCGs reviewing use of Advice & Guidance, N:FU ratios, C2C referrals across msb sites and specialties; use of email and phone alternatives to face to face appointments; reviewing need for some OP at all.	Clare Panniker, CEO Acute Hospitals
System corporate redesign	Currently assessing scope of programme aiming to create a single PMO to manage system wide efficiencies; this will develop into wider corporate services that could potentially be shared at a cheaper cost to the STP overall. Would welcome support from NHSE with knowledge of other STPs who have adopted this approach.	Andy Ray. Chief Finance Officer, CCG Joint Team
Prescribing/high cost drugs	Opportunity is estimated to be c£2 million reduction, largely due to national changes to biosimilar opportunity.	Sanjeev Sharma & Simon Worrall, Chief Pharmacists msb group and CCG Joint Committee
Cardiovascular disease Diabetes	Right Care Opportunity. Right Care STP data pack of Dec 16 gives overall CVD opportunity of c£5m. Scoping underway to assess feasibility.	Tricia D'Orsi, Chief Nurse, CPRCCG
Cardiovascular disease – Stroke/AF	Right Care Opportunity. Stroke opportunities exist despite referral to SoS for main service reconfiguration. Right Care STP data pack of Dec 16 gives overall CVD opportunity of c£5m. Scoping underway to assess feasibility. Clinical Cabinet is prioritising AF as a programme for 19/20. Support from UCLP under discussion.	Karen Wesson, Director of Commissioning, CCG Joint Team
Respiratory disease	Right Care Opportunity. Implemented myCOPD in 18/19 with limited success. Right Care STP data pack of Dec 16 (most up to date) gives overall opportunity of c£4million. Scoping underway to assess feasibility.	Stephanie Dawe, Chief Nurse, NELFT & Provide
Cancer	Quality and performance initiative primarily including using additional funding available to TCCG for Lung Health Checks. Right Care STP data pack of Dec 16 (most up to date) gives opportunity of c£5.4 million. Scoping underway to assess feasibility.	Karen Wesson, Director of Commissioning, CCG Joint Team

High Level STP System Transformation Schemes cont/

Scheme	Ambition/Potential Opportunity	Identified Lead
Admission avoidance	Developing a common community offering across the STP; initial service specification drafted and will progress in line with common commissioning of community services across CCGs. Will include High Intensity Users – Rightcare estimate opportunity at c£900k across STP if Top 50 A&E users managed in this way. Liaising with Delivery Partner to assess feasibility.	Stephanie Dawe, Chief Nurse, NELFT & Provide
Mental Health crisis care/RAID	Implementing RAID fully across msb sites and introduction of 24/7 crisis service. Business case shared with EPUT for agreement £3 million investment to generate savings in NEL activity.	Mark Tebbs, Director of Mental Health Commissioning
System discharge pathways	Work being developed by ECC; ECC leading procurement of external support for diagnostic work and action planning.	Currently scoping work with local authorities
Avastin prescribing	An ambition of 500k has been identified relating to use of avastin for Wet AMD.	Sanjeev Sharma & Simon Worrall, Chief Pharmacists msb group and CCG Joint Committee
Evidence Based Interventions	Reduction of c. 3,700 procedures with an overall financial value of c£3.2 million according to NHSE EBI data (n.b. NHSE data excludes OP activity which for some procedures is significant e.g. removal of benign skin lesions additional c1,500 procedures at c£200k). Some challenges with quantification of opportunity as NHSE data will not be able to identify patients with prior approval so expectation is for lower figure overall and replicating NSHE methodology gives different numbers.	Donald McGeachy, Medical Director, CCG Joint Team

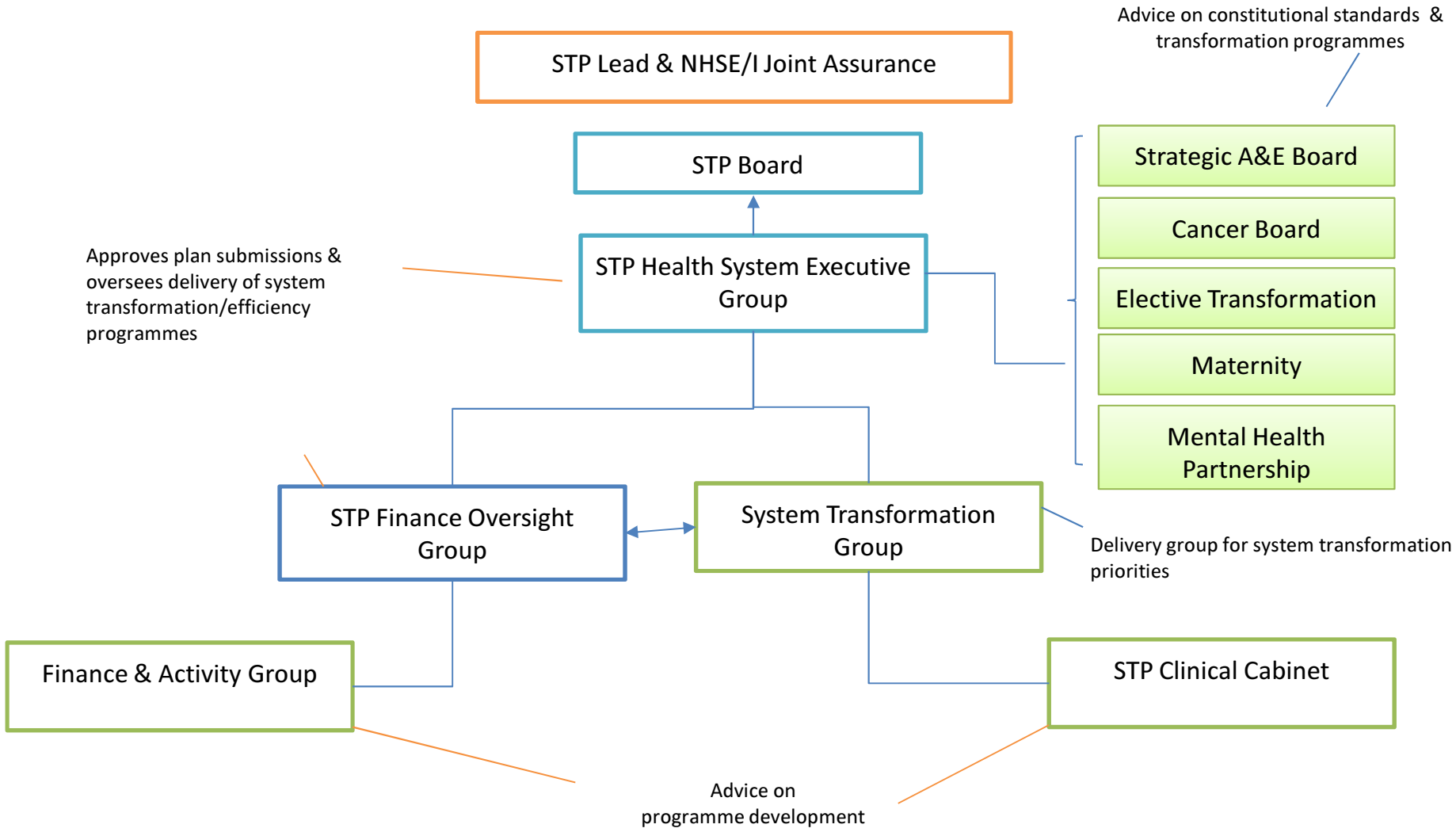
Mid & South Essex STP Governance

The Mid and South Essex STP Board is independently chaired by Dr Anita Donley OBE, and comprises executive representatives from all partner organisations within the STP footprint:

- Acute Hospital Group (Basildon Hospital, Southend Hospital and Broomfield Hospital)
- Local Authorities (Essex County Council, Southend-on-Sea Borough Council, Thurrock Council)
- Clinical Commissioning Groups (Basildon & Brentwood, Castle Point & Rochford, Mid-Essex, Southend and Thurrock)
- Community and mental health providers (Provide, NELFT, EPUT)
- Healthwatch organisations (Essex, Thurrock, Southend)
- Chairs of STP Advisory Groups (see below)

- The Board is supported by the following advisory groups:
  - Clinical Cabinet – a group of senior multi-professional clinicians who provide advice and support to the STP on clinical matters
  - Chairs' Group – comprising the chairs of all partner organisations in the STP including chairs of Health and Wellbeing Boards and Healthwatch
  - Service User Advisory Group – comprising chairs of patient reference groups from CCGs, as well as Trust governors who provide advice and challenge to STP plans
  - Finance Oversight Group – comprising Trust CEOs and the lead AO for the CCG Joint Committee, as well as Finance Directors and the STP Programme Director – the group oversees financial planning for the STP.
- For NHS planning purposes the organisations within the STP footprint are the three acute Trusts, five CCGs and EPUT (71.4%).

Governance for NHS Planning



STP next steps: 2019/20

- The immediate priorities for the STP as a whole are to:

  - Develop a 5 year strategic plan involving all partners:
    - Deloitte is providing support to the STP Board and STP Chairs' Group
    - Discussions with local authorities are under way

  - Resolve STP leadership – this will include:
    - Recruitment of an independent chair (scheduled September 2019)
    - Recruitment of an Executive Lead for the STP (November 2019)

  - Define clear plans for moving to an Integrated Care System and continue to evolve governance arrangements on our journey towards ICS status.

  - Build a single team (comprising eg PMO, change management, finance, BI functions) to support system-wide programmes

  - Investigate further opportunities to share corporate resource across the system in pursuit of best value for money for our residents.

STP: Strategic Programmes

Acute Reconfiguration

Delivery of agreed changes to acute hospital services *

Board Sponsor: Clare Panniker, CEO Acute Hospitals

Acute Portfolio Group

Delivery Lead: Tom Abell

Primary Care & Localities

Oversee delivery of STP Primary Care strategy

Oversee development and function of localities/primary care networks

Board Sponsor: Caroline Rassell , AO Mid-Essex CCG, SRO Local Health & Care

Primary Care Transformation Board

Delivery Lead: Ashley King

Population Health Management & Prevention

Maximise the wealth of data and advanced analytical techniques to improve insights to predict and target interventions to improve health outcomes.

Board Sponsor: Peter Fairley, Director of Integration, Essex County Council

Population Health Management & Prevention Working Group

Delivery lead: TBC

*subject to outcome of Secretary of State referrals

Risks to Delivery

Michelle to add

213

National Planning Guidance

The planning guidance is aligned to the primary areas within the Mid and South Essex (MSE) commissioning work plan:

- Specialised Services will work with local systems to align spend at a system level. The defined priority work areas for Specialised Services are; cancer treatment, mental health, learning disability and autism, cardiovascular, reducing mortality for critically ill babies, children and young people, long term conditions e.g. hepatitis C, gender dysphoria, genomics and personalised care
- Procedures of Lower Clinical Priority – implementation of national guidance on the "17 interventions" and 18 items which should not be routinely prescribed that have been identified through the national review – see slide 33
- Develop the Clinical Assessment Service and Directory of Services through NHS 111 to reduce directions to A&E – see slide 17
- Delivery of the ambulance standards including handover at A&E – see slide 17

National Planning Guidance

- Urgent and Emergency Care – see slide 17 :

–Type 1 A&E will move to consistent "same day emergency care" (SDEC model to increase the proportion of admissions discharged the same day from 1/5 to 1/3 (without increasing proportion of non SDEC 0 day admissions)

–Improved clinical pathways for most serious illness/injury

–STP/ICS develop robust assumptions and "demand management"

–Reduction in long stay patients (>21 days) and Delayed Transfers of Care

–Continue the redesign of urgent care services including Urgent Treatment Centres

- Referral to Treatment:

–Patients right to choose is protected and providers, or CCGs, must contact patients waiting more than 6 months to offer an alternative provider

- No patient should wait more than 52 weeks and penalties to both providers and commissioners will apply

–Total waiting lists must reduce below the March 2018 starting baseline

–A marked reduction in waiting lists through streamlined care, use of technology and alternative outpatient models

- Productivity and Efficiency

–Reducing variation e.g. Right Care (cardiovascular, respiratory and one area of priority for local determination)

–Developing of robust and affordable estates strategies

–Use of Innovation e.g. flash glucose monitoring will receive a national budget

National Planning Guidance

- Cancer – see slide 40:

–The respective Cancer Alliances (Cheshire and Merseyside and Greater Manchester) will work on behalf of STP/ICPs to oversee and transform services with a continued focus on:

1. The eight cancer waiting time standards
2. Preparing for the 28 day Faster Diagnostic Standard to be introduced in 2020

Learning Disability and Autism

- Continue to reduce reliance on inpatient care
- Annual health check s (75% of people on register)
- Learning from Deaths reviews

Workforce

- Providers workforce plans need to be updated to reflect the latest context and challenges
- Maximise recruitment opportunities and use of bank rather than agency capacity
- Focus on a range of opportunities to improve retention

1.7 National Planning Guidance

- Mental Health ?:

–CCGs must increase investment by the rate of growth in their funding (which must be specifically delivered by the same percentage increase in children and young peoples services)

- Primary Care and Community Services – see slide 14-16 :

–Continued investment including £1.50 for developing primary care networks (PCNs). Networks must be established by June.
–Investment should be greater than CCG overall uplift
–A primary care strategy must be included in the system strategy due by the Autumn
–CCGs will need to undertake internal audits to assure of their discharging of delegated commissioning functions
–STP/ICS must ensure PCNs receive analytics (population segmentation and risk stratification) in order to aid symptomatic and preventative programmes

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