Public Document Pack

SOUTHEND-ON-SEA BOROUGH COUNCIL

Health & Wellbeing Board

Date: Wednesday, 20th June, 2018
Time: 5.00 pm
Place:
Contact:

Email: committeesection@southend.gov.uk

AGENDA

1 **Apologies for Absence**

2 **Declarations of Interest**

3 **Questions from Members of the Public**

4 **Minutes of the Meeting held on Wednesday 21st March 2018** (Pages 1 - 4)
Minutes attached.

******** **For Discussion**

5 **STP Update** (Pages 5 - 18)
Report attached

6 **Localities Update**
Report to follow

7 **Outcome from the JTAI Inspection** (Pages 19 - 38)
Report attached

8 **Partnership - Violence and Vulnerability: How Community Safety Partnership, Safeguarding and HWB all connect**
Power Point Presentation slides to be tabled

******** **For Noting**

9 **CCG Annual Report** (Pages 39 - 164)
Report attached

10 **A Better Start Southend Update** (Pages 165 - 174)
Report attached.

11 **Update from EPUT**
Verbal report (no papers)

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SOUTHEND-ON-SEA BOROUGH COUNCIL

Meeting of Health & Wellbeing Board
Date: Wednesday, 21st March, 2018
Place: Darwin Room - Tickfield

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Present: Councillor L Salter (Chair)
Dr J Garcia-Lobera (Vice-Chair)
Councillors Davidson, Moyies, Willis and Woodley
Mr S Leftley, Ms A Griffin, Mr S Dolling, Mr Freeston, Ms J Broadbent, Ms M Hathaway, Ms E Chidgey, Ms A Semmence, Mr N Rothnie

In Attendance: Mr I Ambrose, Mr R Harris, Mr I Diley and Mr L Watson

Start/End Time: 5.00 - 5.45 pm

844 Apologies for Absence

Apologies for absence were received from Councillor Lamb (no substitute), Yvonne Blucher (substitute: Neil Rothnie), Clare Panniker (no substitute) and Councillor Nevin (observer – Chair of People Scrutiny Committee).

845 Declarations of Interest

The following declarations of interest were made at the meeting:-

(a) Councillor Salter – Minute 849 (Sustainability and Transformation Partnership) – non-pecuniary interest – husband is consultant surgeon at Southend Hospital and holds senior posts at the hospital; son-in-law is a GP; daughter is a doctor at Broomfield Hospital;

(b) Dr J Garcia-Lobera – Minute 849 (Sustainability and Transformation Partnership) – non-pecuniary interest – GP in the Borough;

(c) Councillor Moyies – Minute 849 (Sustainability and Transformation Partnership) and Minute 853 (EPUT) – non-pecuniary interest – Council appointed Governor at EPUT.

846 Questions from Members of the Public

The Chair responded to a written question received from Mr Ali.

847 Minutes of the Meeting held on Wednesday 24th January 2018

Resolved:-

That the Minutes of the Meeting held on Wednesday 24th January 2018, be confirmed as a correct record and signed.

848 Better Care Fund Section 75

The Board considered a report of the Director of Finance and Resources setting out the operation of the Better Care Fund Pool during 2017/18 and 2018/19.

The Board sought clarification regarding the slippage to the Carer's Break scheme. Officers advised that work had been undertaken but no scheme expenditure was incurred and the scheme will begin operation in 2018/19.

Resolved:

1. That the variation to the 2017/18 Better Care Fund to allow the reallocation of the funds associated with the jointly commissioned Carer's Break scheme back to the respective parties for reinvestment back into their other Better Care Fund schemes, be approved.

2. That the financial flows of the 2018/19 Better Care Fund, be noted.

3. That the updated S75 Agreement between Southend-on-Sea Borough Council and NHS Southend Clinical Commissioning Group, be noted.

849 Response submitted to STP Public Consultation

The Board considered a report of the Integration Programme Manager providing an update on the draft proposed report to be presented to the Mid and South Essex Sustainability and Transformation Partnership (STP) regarding the formal public consultation on the STP proposals which ends on 23rd March 2018.

Resolved:

1. That the report be noted and the proposed points set out in Section 4, on which the report to be presented to the Mid and South Esex STP public consultation will be formed, be endorsed.

2. That the response be submitted by 23rd March 2018.

3. That delegated powers be granted to the Chair and Vice-Chair of Southend HWB to agree the report and, on behalf of the HWB, submit the response to the STP.

850 Physical Activity

The Board considered a report of the Deputy Chief Executive (People) which updated the Board on progress to date with the implementation of the Southend-on-Sea Physical Activity Strategy 2016-2021 and the refreshed action plan, including successes, challenges and future opportunities.

The Board was also informed that a survey was currently taking place to find out what people aged 16 and over think about physical activity in the Borough. The survey closes on 4th April 2018. More details on the survey can be accessed via the Council's website www.southend.gov.uk.

Resolved:

That the report, including successes, challenges and future opportunities and the infographics attached at Appendix 1, be noted.

851 A Better Start Southend Update

The Board considered a report of the acting Programme Director providing an update on the A Better Start Southend Programme.

The Board welcomed the layout, format and content of the report as it provided a much clearer focus then previous versions. The report also provided the correct level of detail and enables the Board to fulfil its role at the top of the ABSS governance structure.

Resolved:

That the report be noted.

852 Localities

The Board considered a report of the Integration Programme Manager providing a brief update regarding the formation of Localities for health and social care in the Borough.

A further report would be presented to the Board in June 2018.

Resolved:

That the progress towards developing Localities in Southend-on-Sea, be noted.

853 EPUT

The Chair agreed that EPUT be considered at this meeting as an urgent item.

In response to a question from a member of HWB regarding the BBC Radio 4 'File on Four' programme broadcast on the evening of 20th March 2018 the CCG Lead officer made a brief statement.

The programme featured a number of allegations about the care provided by EPUT mental health staff and the two former NHS Trusts. The CCG lead officer confirmed that EPUT were a key partner in Southend delivering a multitude of health services across the Borough. The CCG Lead Officer further confirmed that The Chief Executive of EPUT had made it very clear to the CCG that EPUT was working hard to fully address the allegations. They had implemented a number of measures for affected families and staff and were conducting an ongoing investigation.

The CCG Lead Officer highlighted that any further information made available by EPUT would be shared with HWB members and that an update would be provided in due course.

854 Vote of Thanks to the Chair

The Board took the opportunity to thank the Chair for the able way in which she had conducted the meetings over the last municipal year.

855 Provisional dates and times of Meetings 2018/19

Wednesday 20th June 2018 at 5pm;
Wednesday 19th September 2018 at 5pm;
Wednesday 5th December 2018 at 5pm;
Wednesday 23rd January 2019 at 5pm;
Wednesday 20th March 2019 at 5pm.

Chairman: _____

Mid & South Essex Sustainability and Transformation Partnership (STP)

Southend Health And Wellbeing Board

Update on consultation outcome and next steps

Jo Cripps – STP Programme Director
Tom Abell – Deputy Chief Executive (Basildon, Thurrock, Southend and Mid Essex Hospitals)
Dr Celia Skinner – Chief Medical Officer (Basildon, Thurrock, Southend and Mid Essex Hospitals)
Claire Hankey – STP Director of Communications and Engagement

20th June 2018

Developments since last meeting

- Public consultation completed; Joint HOSC response to consultation received
- Stage II Clinical Senate process completed
- Preparation for CCG Joint Committee decision-making underway
- Report of independent analysis of consultation feedback published
- STP Primary Care strategy completed; endorsed by CCG Joint Committee. CCG Boards to agree local implementation and investment plan during May/June.
- Newly formed STP Board, with direct representation of all local partners

A reminder of the overall STP plan

- Health and social care partners have **teamed up** to improve how people can get the right care they need, when they need it, and in the best place (home, community or in hospital)
- Plan aims to **meet the challenges** of today and demands of the future
- There are many examples of excellent care, but **we could do better**
- Our vision is to join up different health, care and voluntary services **around you and your needs** - physical, mental and social care
- Starts with help to **stay healthy** and avoid serious illness
- At home and in your community we are **building up GP and community services**, such as pharmacists, experienced nurses, physiotherapists and mental health therapists; and increasing our range of services available via GP practices

Your care in the best place – developments over next five yrs

Consultation on five principles for proposed future of hospital services

1. **The majority of hospital care will remain local** and each hospital will continue to have a 24hr A&E
2. **Certain more specialist services which need a hospital stay should be concentrated in one place**
3. **Access to specialist emergency services, such as stroke care, should be via your local (or nearest) A&E**, where you would be treated and, if needed, transferred to a specialist team
4. **Planned operations should, where possible, be separate** from patients who are coming into hospital in an emergency
5. **Some hospital services should be provided closer to you**, at home or in a local health centre

Overview of public consultation

- CCG Joint committee approved on 29th November 2017 (CCGs as commissioners must consult on service change)
- Consultation launched on 30th November 2017 closed on 23rd March 2018 – extended by two weeks from 9th March to allow further time for responses
- Activities included:
    - Publication of comprehensive consultation document and summary
    - Launch of website and online questionnaire
    - Large deliberative discussion events
    - Workshops and attendance at community meetings
    - Blogs, videos, animation (more than 49,000 views for animation alone)
    - Social media targeted advertising – e.g. placed on more than 200,000 newsfeeds on Facebook
    - Distribution of materials across the community networks of five CCGs and other STP partners including the hospitals
    - Telephone survey to a 750 representative sample of the pop0ulation across mid and south Essex
    - Extensive local press and media coverage

Consultation response

- More than 1300 responses to on-line survey plus a further 276 Thurrock specific
- Additional 750 telephone survey responses
- 124 paper responses
- 130 individual submissions in the form of letters and emails
- 37 submissions from organisations, community groups and elected representatives
- 16 large public events held (more than 700 attendees)
- 48 stakeholder meetings / workshops, including groups with protected characteristics under Equality law and those most likely to be impacted: e.g. stroke, renal and respiratory patients
- Significant social media activity

Estimated 4000 people took opportunity to participate

Consultation findings

- Report of independent analysis of consultation feedback published on 22nd May 2018.

Headlines:

- Broad agreement with overall principles as outlined in the consultation document
- Generally lower rate of support for principles in Southend
- Lower rate of support for principle 5 (Orsett Hospital changes) from Thurrock residents
- Consistent issues raised across all areas:
    - Need for strong transport infrastructure
    - Financial constraints
    - Workforce constraints

- In each of these areas, the STP already has work on-going

- Full report can be found at:

http://www.nhsmidandsouthessex.co.uk/have-your-say/outcome-of-consultation/

Preparing for decision-making

Preparation now underway for CCG Joint Committee decision-making in July. The decision-making business case will include:

- The independent outcome report – important to recognise consultation is not a "referendum" but to gain understanding of potential impact the proposed changes may have.

- Detailed plans on **Clinical Transport** service to move patients between sites where they would benefit from a period of specialist care. Protocols developed with experts in the East of England Ambulance Service and regional Trauma Networks. Work on detailed planning for workforce, fleet and financial requirements is underway.

- Plans for **Family/Carer Transport** are in development to support family and friends to visit hospital inpatients in a more distant hospital. These plans are being developed with expert support and with input from patients and carers.

- Outcome of the detailed, Stage II review of proposed service changes by the **East of England Clinical Senate**

- Completion of **equality and health inequality impact assessment work** – undertaken by individual CCGs as a result of joint work between STP team and Directors for Public Health from three local authorities.

Update on family and carer transport

External transport analysis and planning work has now been completed, alongside engagement events which were held during and after the formal consultation period to develop recommendations. Based on this work recommendations have been developed which fall under four themes:

- Improving accessibility to hospital for people living in **urban areas** through the creation of a shuttle service with three core routes.

- Improving accessibility to hospital for people who live in **smaller towns and villages** through a volunteer driver scheme and work with community transport providers.

- Improving use of **public transport and the shuttle service** through the provision of better information for patients, visitors and hospital staff alongside the implementation of incentives to move away from car use.

- Implementing a common approach to **staff transport** across the three hospitals, encouraging switches away from driving to work.

Update on clinical senate

Work with the clinical senate has now been completed with the trusts submitting detailed information about each of the proposals for service change, a site visit by the panel, alongside a panel day where around 30 members of trust staff attended.

- Overall, the **senate strongly supported** the proposals for service change, including for those service areas identified for consolidation.

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- We expect the senate to require some further detail to be produced for emergency general surgical services and in particular how cover arrangements would operate at Basildon Hospital as part of the proposals.

- Further encouragement (in line with previous senate reports) to seek further separation of elective and emergency care.

- To ensure that we develop ambitious, patient focused outcome measures to demonstrate improvement during implementation of any changes.

- To ensure that we have the necessary IT activities in place to ensure that clinical information can be accessed across the three hospitals.

Partnership Board

- Shadow STP Board meeting held in March (now inclusive of CCGs, acute trusts, community and mental health providers, three local authorities, three Healthwatch organisations and Service User Advisory Group).

- Supporting groups established:
  - STP Chairs Group (includes Health and Wellbeing Board Chairs) - first meeting held in April
  - Service User Advisory Group – newly constituted group met in May.
  - Local Clinical Cabinet in place – met in May
  - Executive Delivery Group – in development.

- STP development sessions in May and June to:
  - Establish the principles of partnership working for the STP
  - Agree a refreshed vision for the STP and the narrative to support this
  - Identify and agree pan-STP priorities; agree delivery plans and resourcing implications

- Broad agreement on cross-cutting work programmes:
  - Communications and Engagement
  - Workforce
  - Estates & IT
  - Digital
  - Finance

Thank you

Any questions?

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Agenda Item No. 7

Southend Health & Wellbeing Board

Report of
Margaret Hathaway, Interim Accountable Officer, Southend and Castle Point & Rochford CCGs

to
Health & Wellbeing Board
on
20th June 2018

Report prepared by:

Ruth Baker, Head of Children's Service Transformation

	For discussion	X	For information only		Approval required

Joint targeted area inspection (JTAI) of the multi-agency response to child sexual exploitation, children associated with gangs and at risk of exploitation and children missing from home, care or education in Southend-on-Sea

Part 1 (Public Agenda Item)

1 Purpose of Report

The purpose of this report is to;

1.1 To provide HWB with a background summary of the Joint Targeted Area Inspection findings and to advise of the action being taken in relation to the findings.

2 Recommendations

HWB are asked to;

2.1 Note the report

2.2 That progress against the action plan is reported to HWB for assurance in the Journey of the Child Annual report

3 Background

3.1 Between 19 and 23 March 2018, Ofsted, the Care Quality Commission (CQC), HMI Constabulary and Fire & Rescue services (HMICFRS) and HMI Probation (HMIP) undertook a joint inspection of the multi-agency response to child sexual exploitation, children at risk from gangs and exploitation and children missing from home, care and education. The JTAI was a joint inspection of children's services, Essex Police, the National Probation Service, the

Community Rehabilitation Company, Youth Offending Services and Health providers. 16 inspectors inspected services over the course of 3 full days spread over 4 days with formal feedback on the fifth day. The inspectors were from Ofsted, HMICFRS, HMIP and CQC. Ofsted were the lead inspection agency.

3.2 The inspection included a 'deep dive' focus on the response to children and young people experiencing these vulnerabilities.

3.3 The joint targeted area inspection (JTAI) included an evaluation MASH+. MASH+ is the multi-agency team which assesses the level of need and risk at the first point that a child is referred to the Council due to welfare concerns held by professionals or the public. In this JTAI, the evaluation of MASH+ focused on children presenting with the type of vulnerabilities which were the focus of the deep dive.

3.4 The inspection team also considered the effectiveness of the multi-agency leadership and management of this work, including the role played by the LSCB (LSCB).

3.5 The formal letter from the inspection was published on 9th May (see appendice 1)

3.6 The inspectors' feedback reflected the Council's view of the progress made against the Children's Services Improvement Plan and the areas of identified challenge and priority focus.

3.7 There were no areas for immediate action identified by the inspection team.

3.8 During the inspection the inspectors identified no children who were unsafe.

3.9 The letter identifies a number of areas of strong practice including the partnership response to children at risk of both criminal and sexual exploitation, the relationships between Council practitioners and young people, management oversight and decision making within the Council, the tenacity of practitioners, the Council's commitment to improving outcomes for children including the investment made in the services, the development of the adolescent intervention and prevention team, use of performance information and Council strategies relating to workforce development, recruitment and retention. In total the letter identifies 27 areas of strength across the partnership.

3.10 The letter identified 29 areas for improvement across the partnership. Of these 9 relate specifically to Council children's services. The areas for improvement identified were all, bar one very minor area, areas we had advised Ofsted were areas of focus for us prior to the inspection.

3.11 Action is being taken on the areas for development by all agencies inspected. It is of note that two of the areas for development are relatively easy to address as they relate to minutes of meetings being shared and the structure of a type of meeting.

3.12 The partnership is developing a joint action plan to address the identified areas for development so that we have a single plan across the children's system. The timescale for the completion of the plan is August however, as detailed above, improvement activity is already planned and being undertaken.

3.13 The Deputy Chief Executive, as DCS, will provide Ofsted with a written statement of proposed multi-agency response to the findings in the letter by 18th August 2018.

3.14 Progress against this plan will then be monitored by Childrens Services Improvement Board, by individual agencies, the LSCB and the Community Safety Partnership.

4 Reasons for Recommendations

4.1 The Council is required to submit to Ofsted, the statutory regulator, a written proposal of our multi-agency response to the findings of the inspection. We therefore have no other option than to comply with this requirement.

4.2 Safeguarding children is a statutory duty of relevant safeguarding agencies and therefore HWB members need to be assured that progress is being made against the action plan in order to discharge this duty. This is the reason for the recommendation for the progress against the action plan to be brought back to HWB during Q4 of 2018/19.

5 Financial / Resource Implications

5.1 None identified at this time however this may change once the multi-agency response to the findings is agreed.

6 Legal Implications

6.1 None

7 Equality & Diversity

7.1 One of the areas for improvement related to diversity and this will form part of our multi-agency response and action plan

8 Appendices

8.1 Southend on Sea Joint Targeted Area Inspection Report .

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9 May 2018

Simon Leftley, Deputy Chief Executive (People) & Statutory Director of Children's Services, Southend-on-Sea Borough Council
Margaret Hathaway, Interim Accountable Officer, NHS Southend CCG, NHS Castle Point & Rochford CCG
Tricia D'Orsi, Chief Nurse, NHS Southend CCG, NHS Castle Point & Rochford CCG
Roger Hirst, Police, Fire and Crime Commissioner
Stephen Kavanagh, Chief Constable of Essex Police
Carol Compton, Head of Youth Offending Service, Southend-on-Sea Borough Council
Alex Osler, CRC Director, Essex Community Rehabilitation Company
Steve Johnson Proctor, Divisional Director, National Probation Service
Liz Chidgey, Independent Chair of Southend-on-Sea LSCB

Dear local partnership,

Joint targeted area inspection of the multi-agency response to child sexual exploitation, children associated with gangs and at risk of exploitation and children missing from home, care or education in Southend-on-Sea

Between 19 and 23 March 2018, Ofsted, the Care Quality Commission (CQC), HMI Constabulary and Fire & Rescue services (HMICFRS) and HMI Probation (HMIP) undertook a joint inspection of the multi-agency response to these related areas of risk to children and young people in Southend-on-Sea.[1] This inspection included a 'deep dive' focus on the response to children and young people experiencing these vulnerabilities.

This letter to all the service leaders in the area outlines our findings about the effectiveness of partnership working and of the work of individual agencies in Southend-on-Sea.

The joint targeted area inspection (JTAI) included an evaluation of the multi-agency 'front door', which receives referrals when children may be in need or at risk of significant harm. In this JTAI, the evaluation of the multi-agency 'front door' focused on children at risk of sexual or criminal exploitation, those associated with gangs and those missing from home, care or education. Also included was a 'deep dive' focus on this vulnerable group of children and young people. Inspectors also considered the effectiveness of the multi-agency leadership and management of this work, including the role played by the local safeguarding children board (LSCB).

[1] This joint inspection was conducted under section 20 of the Children Act 2004.

Partner agencies in Southend-on-Sea have a shared commitment to tackling risk to children and young people from sexual and criminal exploitation, gangs and going missing from home, care or school. Inspectors met with staff across agencies, who are tenacious in their efforts to engage with, and make a positive difference for, vulnerable children and young people.

When agencies have worked collaboratively to tackle risks to specific groups of children, they have used the learning from these focused areas of work well to improve wider services. Strong working relationships between professionals have been a key element when interventions have been successful. However, the contribution that health agencies could make has not been fully realised. There is limited emphasis on their role within the child sexual exploitation action plan and they are not consistently involved in operational meetings to assess risk and to plan interventions for vulnerable children.

To date, the LSCB has not sufficiently fulfilled its role as a 'critical friend' to partner agencies in their work to safeguard children, nor has it exercised sufficient challenge and leadership in relation to how well they are protecting children from the risk of sexual exploitation. The independent chair is aware of these weaknesses and has put in place measures to address them, but these have not yet had a significant impact.

The co-location within the new multi-agency safeguarding hub (MASH+) of health, police and local authority professionals has helped to improve initial decision-making for children. The MASH+ has also been successfully integrated with an existing strong early help offer.

The partnership has a shared commitment to continuous improvement and inspectors found a number of examples of effective practice. Further work by the partnership will be required for this to be consistently achieved for all vulnerable children in Southend-on-Sea.

Key Strengths

- Work in Southend-on-Sea to tackle child sexual and criminal exploitation, gangs and the risks arising from going missing from home, care or school is underpinned by strong working relationships and a shared commitment and drive for continuous improvement. This is reflected in how agencies have used national best practice and local learning to enhance the quality and impact of services. When agencies, particularly the police and local authority, have worked together to tackle the risks for a specific group of children and young people, learning from this joint working has acted as a catalyst to enhance the quality and effectiveness of wider services, for example through building on the success of the adolescent intervention team. This team, originally created to work with a specific group of

young people, has been expanded with additional staffing and made available to all vulnerable young people for whom there are relevant concerns.

- Leaders and managers have created a culture across the partnership in which staff feel supported in working flexibly, collaboratively and 'going the extra mile' by continuing to work with young people even when they may not at first want to engage with the services they are offered. This tenacity is making a real difference for some highly vulnerable children.

- Collectively and individually, agencies have put in place a broad range of awareness raising, education and prevention work with children, families and professionals. This includes: work done by child exploitation and online protection 'ambassadors' with over 1600 teachers and schoolchildren; former gang members providing awareness-raising training with professionals about how to recognise early signs of gang affiliation; and work by a well-established network of 'champions' helping to tackle child sexual exploitation by ensuring that this work continues to have a high profile and by supporting and advising their colleagues to intervene successfully.

- The coordinator for children who go missing and child sexual exploitation practice leads enhance the effectiveness of both individual practitioners and key operational and strategic meetings through providing expert guidance and knowledge of best practice. They act as focal points for information and intelligence. The profile of and leadership provided by the named GP, both within and beyond health agencies, support greater awareness, confidence and the ability of staff to intervene effectively with vulnerable children.

- The partnership has put in place a framework of meetings and procedures that have the capacity to support effective sharing and analysis of data and intelligence. Within this framework, data and intelligence have been used well to support planning for individual, and some groups of, children as well as to target disruption activity. Pre-tasking and pre-multi-agency child sexual exploitation (MACE) meetings use a helpful breadth of information and intelligence to identify which children could most benefit from consideration at MACE. These meetings are generally well attended by a broad range of relevant professionals.

- The quality and timeliness of decision-making has been enhanced by the new MASH+, co-locating health, police and local authority professionals. Decisions are well matched to risk and need for almost all children. Staff working in the MASH+ value the benefits that co-location provides for swifter and more joined-up decision-making. In particular, strategy discussions are now almost always attended by a health representative alongside the police and local authority, and this is supporting better-informed decision-making. This was an area for development noted at the local authority's last inspection in 2016.

- An existing strong early help offer has also been further enhanced through co-location with MASH+. This supports swift and appropriate decisions for those children referred to MASH+ who may best benefit from an early help response and for those referred for early help whose level of need may warrant a statutory social work assessment. Young people's drug and alcohol services play a particularly effective role within the early help offer. This shared early help offer is further bolstered through the co-location of the 'volunteering matters' project.

- The commissioning and provider landscape is complex in Southend-on-Sea. The new Public Health and Integrated Commissioning Quality and Governance Group is aimed at strengthening quality and service delivery across universal, targeted and specialist health services. This partnership of local authority and CCG commissioners seeks to make best use of local resources, although it is at too early a stage to have had a significant impact to date.

- Well-focused work by the local authority has achieved improvements in key aspects of safeguarding services for children. These include the timeliness with which assessments are completed and the frequency with which children are seen. Strong system-leadership by the deputy chief executive has been a significant factor in engaging partner agencies in the creation of MASH+ and in the continuing development of a strong early help offer.

- A whole-council approach and the additional scrutiny and impetus provided by an improvement board has helped the local authority make progress and maintain its focus on areas of practice that are not consistently good, such as the quality of assessments and plans. Good corporate and political commitment to enhancing services to children is evident in the significant investment involved in putting in place a new electronic case recording system.

- A well-thought-out approach to performance management supports frontline managers with accurate reports of performance in their teams, helps middle managers to understand and drive up performance and gives senior managers a clear line of sight to strengths and weaknesses in quality and performance. Investment in additional management capacity has strengthened decision-making. While not all oversight is of a consistently high standard, managers generally provide appropriate case direction and avoid delays in most children's cases.

- The local authority has a considered and well-targeted approach to workforce development. Training priorities such as assessment and decision-making, or, more recently, the work to support restorative approaches, are linked to identified organisational priorities and areas for development. Training is used well to enhance the quality of practice and improve outcomes for children.

- Successful recruitment in the last year has enabled the local authority to reduce its reliance on agency staff and reduce staff turnover. At the time of the inspection, there was only one social work vacancy. This has helped reduce social

workers' average caseloads and means that they are now able to visit children more frequently than a year ago. This in turn means that children are more likely to build relationships of trust with their workers that make a difference to their lives.

- The use of child sexual exploitation risk assessments is well embedded within social work teams. These assessments are completed for most children who could benefit from them. Most are updated when children's circumstances change, giving an up-to-date picture of risk to inform safety planning for the child.

- Children with complex needs and those at risk of child sexual exploitation, going missing and wider child exploitation benefit from intensive and targeted support from workers with specialist expertise. Work is reflected in children's records, and professionals generally know them and their families well.

- The local authority has a good understanding of patterns of attendance in schools within the borough. Data management and analysis relating to attendance and persistent absence is strong, informing actions undertaken each half term, and each week for children looked after. A dedicated working group focuses on direct work with specific children and settings. Exclusions, reduced timetables and persistent absentees are scrutinised closely and, when problems are identified, support and challenge to specific schools or settings are effective.

- The local authority maintains a record of children who are electively home educated (EHE). Any families known to local authority children's services who choose to home educate their children are visited swiftly to assess how well children are safeguarded. Staff use the fair access panel to ensure that places can be accessed in mainstream schools if this is appropriate. The authority has pro-actively provided training in the primary and secondary curriculum for parents of EHE children and has also liaised with both Ofsted and the Department for Education about possible unregistered schools in the borough.

- Essex Police's commitment to protecting children from harm is clear. Through well-focused intelligence work and strong leadership, the police have successfully engaged partner agencies and secured sufficient resources to identify and enhance the safety of some of the most vulnerable children in Southend-on-Sea. The force's 'plan on a page' sets out clear priorities and a drive to protect children from sexual and criminal exploitation, gangs and the risks arising from going missing. Training has a strong emphasis on the sexual and wider criminal exploitation of children. All frontline officers have been provided with a vulnerability guide to assist in the identification of children at risk.

- The force has an open approach to improving their responses to the sexual and criminal exploitation of children. A 'health check' conducted by the national working group has highlighted the Southend-on-Sea community policing team

hub approach to supporting vulnerable young people as a model of good practice. There is positive partnership outreach and disruption work between the team and the street engagement service. Rolling out an operation targeting people involved in drug-related crime (Operation Raptor) has strengthened the ability of agencies to combat the exploitation of vulnerable children, particularly through 'county-lines' drug running and by gangs. Inspectors saw examples of good practice by officers, including detailed and child-focused referrals through the national referral mechanism (NRM). Learning from national best practice, good use is being made of civil orders, such as community protection notices and child abduction warning notices (CAWNs), to safeguard vulnerable children.

- In the last 18 months, the police have been instrumental in raising awareness of modern slavery and human trafficking. Training a significant number of frontline professionals has led to the identification of more children who are criminally exploited and trafficked, with 20 referrals of children to the national referral mechanism in the past year. Relevant investigations reflect a shift from treating children as criminals to recognising their vulnerabilities and the wider context that may be leading to their offending behaviour, such as coercion or criminal exploitation by others. This shift in focus has also led to the force's missing person policy being amended, so that children who are regularly going missing are considered for referral to the NRM because of the potential for trafficking.

- The youth offending service (YOS), national probation service (NPS) and community rehabilitation company (CRC) staff have a good understanding of child sexual and criminal exploitation, gangs and the risks arising from going missing from home, care or school. This is supported by strong management oversight and supervision and is underpinned by the effective range of awareness raising and education across the partnership. Inspectors saw a significant amount of diversion work being successfully undertaken through the YOS triage programme and relatively low levels of young people subject to statutory supervision.

- Within NPS, case managers have a good understanding of escalation procedures, and inspectors saw examples of appropriate and informed professional challenge by probation officers when the MASH+ had not initially accepted referrals about children for whom there were safeguarding concerns. A good level of information-sharing in the early stages of the multi-agency public protection arrangements (MAPPA) process is helping to ensure robust risk management planning at the pre-release stage when there are child protection concerns.

- Health commissioners and providers take an active part, alongside other statutory agencies, in shaping local arrangements for protecting children and young people at risk of exploitation or abuse. A number of health partners are well engaged in work to implement the recently revised child sexual exploitation action plan, while others contribute to the various local child exploitation joint working forums.

- Effective information sharing and handover of care between different health practitioners, teams and services is crucial as children move through childhood and towards adulthood. This challenge is understood well by local leaders, who are making good progress in some key areas to ensure local health practitioners are alert to and better recognise risks to children and young people. The introduction of the Child Protection Information System in the emergency department at Southend University Hospital (SUH) and the 'flagging' of children at risk of sexual exploitation on information systems are important developments in raising the profile of children who are or may be vulnerable to harm or poor health outcomes. This means that relevant practitioners are aware of risks to young people's sexual health and can take prompt action to ensure that they are appropriately recognised, addressed and monitored.

- The emotional well-being and mental health service (EWMHS) has effective systems for referral to children's social care. The quality of referrals is steadily improving. EWMHS works well alongside the early help team, providing consultation advice, contributing to joint assessments and ensuring that children with increasing needs and behaviours of concern can promptly access services. The EWMHS adds value to the work of other teams such as the YOS and the young people's drug and alcohol team. This has led to improvements in the timeliness of access to specialist help for children with complex needs. EWMHS practitioners have been trained in evidence-based approaches to supporting children exposed to harm through sexual or criminal exploitation.

- The Safeguarding Children Forum and regular safeguarding newsletters produced by the clinical commissioning group (CCG) help reinforce expected standards of practice, and keep GPs informed about changes to local multi-agency arrangements and priorities. Learning events facilitated by the named GP, supported by safeguarding leads in other agencies, are highly rated. Inspectors observed one such event, which was effective in raising awareness about the experiences, care pathways and services available to children exposed to sexual abuse and exploitation. The development of health safeguarding champions in some services (including GPs and EWMHS) is having a positive impact on building the confidence and competence of the local workforce.

- Although areas for further improvement remain, local health agencies have taken action to address all recommendations for improvement identified in the CQC's previous inspection reports and have provided assurance to their trust boards and the LSCB that actions have been completed. For example, the co-location of health practitioners within the MASH+ provides prompt feedback and updates to case-holding health professionals about the outcomes of referrals. This has supported an improved standard of practice and levels of involvement in safeguarding children work since the last CQC inspection.

Case study: effective practice

Strong partnership working and a timely response tailored to the individual needs of a child have ensured that he is safer from harm. Risk, not only to him but also to the wider public, has been tackled effectively. He has built a relationship of trust with key professionals, providing a platform for further progress.

A 14-year-old has repeatedly gone missing. He has suffered from criminal exploitation and is at risk of sexual exploitation. A 'team around the teen', made up of four key professionals from his school, the police and the local authority, has created a tight network around him. This team of professionals has responded flexibly and creatively to reduce emerging risks before he suffers further harm. A recent example of this is when he was believed to be in possession of a knife. He had already been charged on a previous occasion with carrying a knife. When it was discovered that he was concealing a knife in his bedroom, it was recovered by the police officer known to the child during a well-co-ordinated joint visit with the adolescent intervention team worker.

Areas for improvement

- The current child sexual exploitation action plan, strategy and guidance documents are clear, up to date and contain specific actions, but are still very new and at too early a stage to have had a significant impact. It is not clear how local information, audit and scrutiny have underpinned the strategy, and some elements of the local approach are not as advanced as they could be. For example, work with local taxi drivers remains at an early stage of development. The focus on the contribution of health agencies is not strong enough. The strong working relationships that have underpinned much of the progress that has been made in developing and improving services for vulnerable children have not consistently been matched by an equally strong strategic drive and organisation. For example, Essex police produce an annual thematic assessment on a range of topics, with the current 2018/19 child sexual abuse and exploitation document providing not only national and county level information, but also the local Southend-on–Sea context. However, it was accepted by the partnership that the inclusion of broader partnership data would have benefited the report and assisted in the development, commissioning and targeting of services across the wider partnership.

- The implementation of MASH+ from December 2017. Not all partners are clear about the recent changes to systems and processes at the front door and not all partners have a sufficient understanding of the role of MASH+. Joint working between health practitioners and other agencies is not consistently strong,

particularly outside of the MASH+, where health engagement is continuing to improve. This has limited the speed and quality of information sharing for a few children. This lack of consistency and clarity about role and process and information sharing and engagement limits the collective ability of agencies to intervene as early and as effectively as they could with some children. Although the creation of MASH+ has led to an improvement in how well children's histories are recorded and taken into consideration in initial decision-making, inspectors saw some cases in which decision-making for individual children was too focused on the immediate presenting concern that led to the referral, and not enough weight was placed on longer-standing chronic concerns. Although inspectors saw no situations in which this has left children at immediate risk of significant harm, they did see examples of it leading to delay for some children in receiving the right level of services to match their needs.

- Decision-making in child protection strategy meetings is not consistently shared with the agencies in attendance. In a number of children's cases seen by inspectors, decisions about whether or not to commence a child protection investigation or to hold a child protection conference were taken by the local authority after meetings. Without a shared ownership of decisions, actions arising from these meetings are less well communicated and their completion is more difficult to monitor. Significant improvements achieved in the attendance of all relevant services, particularly health professionals, at strategy meetings convened by MASH+ are not as consistently achieved at strategy discussions held later in the process of intervention with children and their families. This has the potential to limit the range of information available and the quality of decision-making.

- When children missing from home and care are found, most are offered a return home interview. In some examples, well-focused and recorded return home interviews were used to help make sure that children and young people were receiving the services that best matched their individual needs. For example, learning from one interview led to a child's case being escalated from early help to a statutory social work service, while for another young person it identified peer groups, associates and patterns of behaviour that are helping professionals identify possible triggers for future episodes of going missing. However, while the majority of children and young people who have been missing from home or care are given the opportunity of a return home interview, the quality of information gathered and recorded is not consistently good. Further understanding and development of child-focused approaches are needed to ensure that individual children and young people's needs and voices are effectively sought and used to inform future planning to keep them safe.

- The diversity of children's identities and needs is not always understood and worked with to a consistently high standard. A lack of consistency in this area risks undermining the effectiveness of intervention. For example, some children with complex needs and educational histories who would benefit from having education, health and care plans (EHCP) do not currently have them.

- The conduct of MACE meetings lacks sufficient structure and rigour in considering the risks to individual children. This is also mirrored in the minutes of meetings, which are not consistently clear and sometimes lack relevant details, such as children's ages, while agreed actions often lack specificity and are not always well matched to presenting need. This does not support the tracking of action completion or monitoring of risk as effectively as it could. While a broad range of agencies generally attend, attendance is not always consistent for some key attendees, such as education and health professionals. Stronger connectivity is needed between the sexual health, maternity and EWMHS and the MACE processes to improve the depth of information available from these agencies to support best decision-making for vulnerable children and young people.

- Minutes and plans arising from multi-agency meetings, such as child protection strategy meetings and case conferences, child in need meetings and MACE meetings are not always sent to attendees in a timely manner and, in many cases, are not received at all. As a result, children, their families and the professionals who support them may not be clear about what is expected. This may limit the effectiveness of intervention.

- Although child sexual exploitation risk assessments are well embedded within the local authority, they are not always well used in other agencies. Inspectors found variable levels of confidence and competence in the use of the assessment tool to analyse risk, inform referrals or to escalate or reduce concerns for individual children or young people. Reporting on the use of CSE risk assessment tools within sexual health services is not yet in place to support the monitoring of trends.

- MAPPA meetings are generally only attended by police and NPS and therefore lack the benefit derived from a full multi-agency approach. Local authority staff only attend when there is a specific person already known to them being discussed, and other partners are often absent. This attendance gap has the potential to reduce the breadth of information and intelligence informing planning and decision-making.

- The LSCB has not sufficiently fulfilled its role as a 'critical friend' to partner agencies. Work by the board to assess how well agencies are tackling child sexual exploitation and associated vulnerabilities is under-developed. For example, the LSCB has not carried out any multi-agency audits to assess how well Southend-on-Sea children are being protected from sexual exploitation and it does not have a multi-agency dataset to measure performance in this area. This limits its ability to provide challenge and to drive improvement. The independent chair of the LSCB has recognised these shortcomings and, since taking up her role in early 2017, has worked to put in place structures to improve the functioning of the board. She meets regularly with senior leaders from the local authority and partner agencies and has instigated some positive challenge from the board.

However, these positive changes in the structure and functioning of the board are too recent for the board to add significant value to the work of partner agencies.

- The local authority has worked hard to improve the quality of assessments and plans, and while inspectors have seen the impact of this good work in a number of high-quality assessments and plans, this is not consistently the case. Some assessments lack a sufficiently sharp analysis of children's risks and needs and are not always updated when children's circumstances change over time, while many plans, whether they are for early help, child in need or child protection, lack clarity. Plans are often rather generic, lacking clear identification of risks and the actions needed to tackle them, and do not always sufficiently distinguish between the individual needs of brothers and sisters within larger families. This limits their effectiveness as a tool to monitor and drive progress for vulnerable children and young people.

- Although qualitative information from audits, peer reviews and other sources are used successfully by the local authority, such as in the development of the MASH+ and in monitoring the impact of improvement actions, there remains room for further improvement. Information from audits is not aligned closely enough with and included in performance documents. This would enhance the understanding of their quality and impact of practice, while the audits themselves lack a sufficiently sharp focus on identifying specific areas for individual or service improvement. In addition, the quality and impact of practice could be further enhanced through making better use of children's feedback.

- While the supervision received by social workers from their managers is regular, it is too often focused only on process and action completion. Supervision records lack sufficient focus on the lived experience of children and on giving workers the opportunity to reflect on the progress that children are making. This means that social workers do not always receive the clarity of guidance required to ensure that work with children is progressed as quickly and as well as it might be.

- The decision to use the HOLMES (Home Office large major enquiry system) to manage a recent operation to protect children from criminal and sexual exploitation and to disrupt the actions of perpetrators came as a result of difficulties in managing an operation with similar characteristics in the past. However, the information gathered was not routinely transferred to the main police computer systems and was therefore largely inaccessible to frontline officers who cannot access HOLMES. Although mitigated to some degree by the use of markers on the police national computer, which alert officers to a potential risk, this does not provide officers and staff with the detail needed to fully inform their decision-making.

- Greatest value is not currently being achieved from the community safety hub's very positive work in engaging children and young people and disrupting perpetrator activity. Officers do not receive training about statutory processes

before they attend partnership meetings such as child protection conferences. This limits their understanding of the procedures and processes involved and thus the potential effectiveness of their contributions. At present, the team does not have a broader investigative capability. This limits the benefit drawn from the team's particular role, for example the potential to map locations and numbers of young people and persons of interest to help target services.

- Current structures in Essex Police mean that it can be difficult to direct resources when intelligence received at a force level requires action at a local level. This may limit the timeliness of some interventions with vulnerable children. The force has recognised these limitations and has begun a review.

- Senior leaders in Essex Police have worked hard to improve responses to the sexual and criminal exploitation of children and young people, to gangs and to children who go missing. However, although current meeting structures provide a generally good level of strategic oversight, higher-level meetings could benefit from an overview and qualitative assessment of tactical delivery to provide reassurance that the strategic drive of the organisation to effectively safeguard vulnerable children is being translated into effective delivery at the frontline. A recent bid to introduce a dedicated audit team may provide a suitable framework for such a development.

- The force's approach to children detained in custody, who are often vulnerable and have complex needs, is not consistent. A recent review by a continuous improvement team found that requests recorded by custody staff to submit a notification to the local authority's children's services were not being actioned. This inspection found that this continues to be an area for development. Opportunities to provide intervention for children and young people are not consistently being taken at this early opportunity.

- The quality and timeliness of notifications that are submitted by frontline officers and staff to the local authority are inconsistent. The decision for these notifications to be submitted directly, without the need for supervisory oversight, was intended to ensure that they were submitted as quickly as possible. However, the current process has gaps in both compliance and quality. This means that some children may be left in need or at risk of harm without those agencies who could intervene having been informed. Although there are safety nets in place that significantly reduce the chances of vulnerable children being missed by agencies, such as the daily 'vulnerability meeting' in MASH+, it is clear that the notification system is not working as well or as consistently as is needed.

- Information from multi-agency meetings and panels is not always recorded on police systems in a timely and consistent fashion. This means that multi-agency decisions are not always visible to frontline officers and so their ability to respond effectively to safeguard children is limited.

- The lack of a current NPS office or formalised reporting facilities in Southend-on-Sea means that there are inconsistencies in the management of offenders and presents challenges to successful multi-agency working.

- While it is positive that a number of health organisations use a shared electronic recording system, with some health practitioners having read-only access to each other's records, key gaps remain in information governance and information-sharing protocols to enable MASH+ practitioners to have timely access to relevant information held by other health partners, including sexual health services, EWMHS and GPs.

- Joint protocols for information sharing and joint working between the EWMHS and school nursing service are not yet in place. This limits the ability to share information that could support better early identification of changes in young people's emotional health and well-being, including risks of going missing or vulnerability to exploitation or gang involvement.

- Case auditing and quality assurance of practice in health is not sufficiently strong to support ongoing learning and review and to help benchmark areas where targeted development work is still required. Although there are some good examples of learning and development activity, learning from national best practice has not been maximised.

- Supervision practice is inconsistent across health agencies. Inspectors also found that stronger management oversight is required in a number of areas to ensure that safeguarding referrals are of a consistently acceptable standard, for example with regard to referrals from the SUH emergency department and those completed by GPs. Coverage of level three training within the SUH emergency department and midwifery services continues to be an area for improvement to ensure that NHS trust targets are fully met.

- The knowledge of frontline health practitioners of criminal exploitation and gangs overall is relatively limited. Although SUH has recognised growing risk in this area, it still need to progress its intention to develop a joint pathway for the management and care of children involved with or harmed by gangs.

- Southend-on-Sea has a relatively high number of teenage parents and comparatively high use of emergency contraception and abortions. The child sexual exploitation action plan does not currently contain specific actions that are linked to supporting wider learning from information in this area.

- Children and young people accessing health services do not always benefit from a thorough assessment or analysis of their health needs. Records are often descriptive, lacking analysis of the impact of concerns and vulnerabilities on the child or young person. This limits the opportunity for children and young people

to have their needs fully understood or have the right services involved to appropriately meet their needs and to improve their outcomes.

- NPS court officers use a targeted approach to requesting child safeguarding information relevant to adults appearing before the courts. These are responded to swiftly by MASH+. This allows for appropriate information to inform pre-sentence reports and informs safe sentencing in these individual cases. However, not checking on safeguarding information in all cases means that safeguarding concerns about which court officers were unaware could be missed and so not inform recommendations and sentencing. This is a missed opportunity, particularly in the light of the creation of MASH+ as an enhanced multi-agency 'front door'.

Case study: areas for improvement

A previous lack of sufficiently joined-up working between agencies, weak planning and reactive practice has meant that a vulnerable teenager did not receive the right help and support when needed and agencies had not succeeded in ensuring that she is significantly safer.

The child was supported under a child-in-need plan following concerns about her poor mental health, risks of sexual exploitation and conflict between her parents. A recommendation to convene a child protection case conference was not acted on for several months. During this time, the child had stopped attending school, with little planning for an alternative education provision and no assessment of learning needs. Agencies' practice has been reactive rather than proactive. Not all key professionals have been included in the child's plan and not all of her needs have been addressed. It has taken several months for a multi-agency plan to be formulated, and parenting assessments have not been started. While one key professional has forged a good relationship with the child, much is still unknown about her life and new concerns around exploitation continue to emerge. Although more recent planning and interventions reflect a clearer focus and greater urgency, they have not yet significantly improved the child's safety.

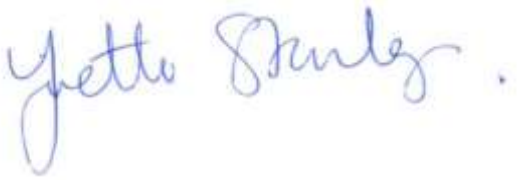
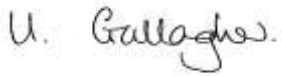
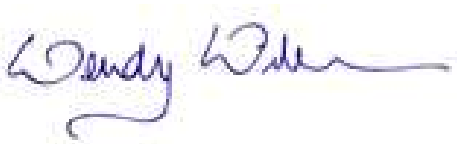
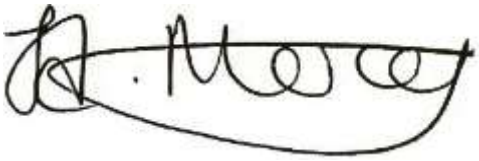
Next steps

The director of children's services should prepare a written statement of proposed action responding to the findings outlined in this letter. This should be a multi-agency response involving NPS, CRC, the clinical commissioning groups and health

providers in Southend-on-Sea and Essex police. The response should set out the actions for the partnership and, where appropriate, individual agencies[2].

The director of children's services should send the written statement of action to ProtectionOfChildren@ofsted.gov.uk by 18 August 2018. This statement will inform the lines of enquiry at any future joint or single agency activity by the inspectorates.

Yours sincerely

Ofsted	**Care Quality Commission**
 Yvette Stanley National Director, Social Care	 Ursula Gallagher Deputy Chief Inspector
HMI Constabulary	**HMI Probation**
 Wendy Williams Her Majesty's Inspector of Constabulary	 Helen Mercer Assistant Chief Inspector

2 The Children Act 2004 (Joint Area Reviews) Regulations 2015 www.legislation.gov.uk/uksi/2015/1792/contents/made enable Ofsted's chief inspector to determine which agency should make the written statement and which other agencies should cooperate in its writing.

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Agenda Item No. 9

Southend Health & Wellbeing Board

Report of
Margaret Hathaway, Interim Accountable Officer, Southend and Castle Point & Rochford CCGs

to
Health & Wellbeing Board
on
20 June 2018

Report prepared by:
Angela Wong Keet, Communications & Engagement Officer, Southend and Castle Point & Rochford CCGs

	For discussion	X	For information only		Approval required

Southend CCG's Annual Report and Accounts 2017/18

Part 1 (Public Agenda Item)

1 Purpose of Report

The purpose of this report is to;

1.1 Present Southend CCG's Annual Report and Accounts 2017/18 to the Health and Wellbeing Board

1.2 This year we have increased the level of reporting on the CCG's engagement activities/work. The Annual Report now includes personal contributions from our engagement steering group (Community Engagement and Advisory Group) members and from the Chair of our Patient Participation Focus Group.

2 Recommendations

HWB are asked to;

2.1 Note Southend CCG's Annual Report and Accounts 2017/18.

3 Background

3.1 Southend CCG is required to publish its Annual Report and Accounts as per national guidelines. Members of the Health and Wellbeing Board were given the opportunity to feedback on this report whilst it was in draft stage. The report is available on Southend CCG's website and will be presented at the CCG's Annual General Meeting in September (date to be confirmed).

4 Reasons for Recommendations

4.1 To share the CCG Annual Report and Accounts with local health and care partners and associates and to evidence the CCG has met its statutory obligations.

5 Financial / Resource Implications

5.1 Nil

6 Legal Implications

6.1 Nil

7 Equality & Diversity

7.1 Nil

8 Appendices

8.1 Southend CCG's Annual Report and Accounts 2017/18.

NHS
Southend
Clinical Commissioning Group

Annual Report and Accounts 2017/18

This document can be provided in alternative formats upon request such as, larger print, easy read, braille, audio format and different languages.

Version: 9 - 24 May 2018

Contents

Version control:

Version	Date	Details
V1	06/04/18	Circulated to Governing Body, Audit Committee, Clinical Executive, CMT and HWB.
V2	19/04/18	Working version
V3	20/04/18	Reviewed by SMN & LB
V4	20/04/18	Submitted to NHSE via Sharepoint & sent to external auditors
V5	17/05/18	Working version inc amends following feedback from auditors
V6	18/05/18	Financial statements added. Circulated to Audit Committee
V7	23/05/18	Final draft version to be approved by Audit Committee
V8	24/05/18	Final draft version taken to Audit Committee for final approval
V9	24/05/18	Final version incorporating audit committee feedback

WELCOME from our Chairman

Welcome to the Southend Clinical Commissioning Group Annual Report for 2017-18. This report highlights the things we have been doing over the past year, working with our partners across the borough and the wider region to ensure that people in Southend receive the high quality healthcare they deserve.

NHS Southend Clinical Commissioning Group consists of 35 GP practices - serving a population of 185,000. We are a clinically-led organisation responsible for commissioning healthcare services on your behalf. This means we plan, arrange and fund local health services.

This year we've had lots of conversations with our membership of GP practices, local residents, the providers of local health and care services, clinicians and other stakeholders in our community, to inform us in our decision making and to support people to live happier and healthier lives.

Our GP practices are now working increasingly closely with colleagues from across health and care services to deliver more joined care for patients. More services have been put in place within community settings and improvements made to access to a range of different professionals, so that patients are less likely to need to visit either their local hospital or GP. This includes mental health therapists, pharmacists and social workers, who are aligned to practices to help patients with more complex needs.

The hard work and dedication of our GP members and other clinicians never fails to impress, when it comes to commissioning the best possible care for local people. Over the coming year we will look to see how we can further strengthen our clinical leadership and restore robust governance arrangements and at the same time, make good progress in stabilising our finances.

We will continue to work closely with our local authorities to deliver joint commissioning plans for the Better Care Fund and we must continue working with local providers, to meet our NHS Constitution standards. It won't be an easy year but we believe by strengthening partnership working across the health and social care system, we can use our commissioning influence to start to live within our financial means, whilst still maintaining high quality and safe healthcare.

This year has also seen an important shift in our steps forward in transforming health and care services across south east Essex, with the five CCGs in mid and south Essex to act collectively in the planning, commissioning and monitoring of certain services, to meet the needs of the whole population of mid and south Essex. The ambition of this work is to reduce costly bureaucracy and ensure consistent planning for system-wide change. As part of this work, we saw the launch of a major public consultation across mid and south Essex called: 'Your Care, in the best place' http://www.nhsmidandsouthessex.co.uk/current-proposals/

Our aim, to ensure people receive the very best care, means we must focus on providing as many services locally as possible, so that people only have to travel when it is absolutely necessary. The principles of the proposals are to ensure access to the right hospital specialists 27/4, 7 days a week. The public consultation has now concluded and all information will now be gathered from a range of different stakeholders and the public at large in an independent outcome report which we will be considered along with other evidence, in a special meeting this summer for consideration and ultimately decision. I would like to thank everyone who has taken the time to feedback their views.

While there are still many things to be proud of, it is regrettable this year has been marked by a deteriorating financial position that has resulted in incurring a cumulative deficit of £10.8m, as at 31 March 2018. Consequently we had no choice other than to make incredibly tough decisions about the allocation of finances, including partial restriction of IVF treatments. This was a very difficult day

for the CCG, having to consider the complete picture for the local NHS – current demands for services are costing more than the money available. We have, however, made a commitment to review the situation and decision again next year.

There are number of factors which have driven us further into deficit, as set out in the financial performance review on page 19. This includes increased demand for healthcare at our local acute hospitals and delays in implementing planned service improvements.

In January 2018 the CCG was formally placed into 'special measures' due to concerns over the financial position. You can read more about this in the Accountable Officer's Foreword on page 6.

Over the past year we have become acutely aware that we need to work more with our local population. To get the very best out of the NHS we have to ensure we can help and support all to take better care of themselves, which includes stopping smoking, losing weight, exercising more and reducing consumption of alcohol.

My final words must be those of praise and thanks to all CCG staff and member practices for their tireless commitment and dedication throughout the year, to do the very best for our patients.

On behalf of the Governing Body I also wish to give thanks to our patients, local residents and patient, public and community groups, whose input continues to inform and influence our plans and work in providing accessible, high quality healthcare for the benefit of the whole community.

Dr Jose Garcia Lobera
Chair
Southend Clinical Commissioning Group

PERFORMANCE REPORT

Margaret Hathaway
Interim Accountable Officer
24 May 2018

Performance Overview

Accountable Officer's Foreword

2017/18 has been another very busy year which has brought with it a number of financial and operational challenges.

We all know that our NHS – both locally and nationally – is facing huge challenges. Health and care services are under pressure and need to change and adapt in response to the continuously increasing demand. Our populations continue to grow and people are living longer with more complex health conditions. Alongside all of this, the amount of money we have to spend on services is limited.

During the past year Southend CCG received an NHSE rating of 'Requires Improvement' as part of an annual review. As part of the action plan developed in response to this, the CCG set out to deliver improvements. However, due to the concerns over the CCG's financial position we were formally placed into 'Special Measures' in January 2018. This led to an Improvement Plan supported by a Financial Recovery Plan. Included within the plan were plans across five key 'Improvement Areas' identified by the CCG:

- Leadership, Structure and Organisational Development;
- Financial Management / Recovery;
- Governance and reporting arrangements;
- Commissioning and Contracting; and,
- Joint Committee / System Working;
- CCG Annual Assessment Areas for Improvement/Other External Recommendations.

We are grateful for the support we have received from NHS England in developing an improvement plan, the foundation to enable us to delivery our statutory duties. However we still recognise there is a great deal of work to be done. It's fair to say the next financial year will continue to be very challenging, but our aim and focus must be to deliver the required improvements and resolve our current financial deficit as quickly as possible.

While CCGs in special measures are performing at a level lower than required, it does not mean there have been failings in quality and safety. NHS England did in fact acknowledge many areas of strength and good practice, but our financial challenges are significant. To address our financial sustainability we have implemented an ambitious recovery plan to improve your care journey and deliver more cost efficient services. We continue to work proactively with our commissioning colleagues and our partners in the mid and south Essex Sustainability and Transformation Partnership (STP). Our aim is to have seamless health and social care which promotes positive health and wellbeing and supports people to manage their own care, wherever possible.

We were delegated to take on full responsibility for commissioning of primary care (GP) services from 1 April 2017. This gives us more opportunities to improve out-of-hospital services provision and deliver the new models of care set on in the NHS GP Forward View. See page 51 for more information on primary care commissioning.

A lot of our work in 2017/18 has focussed on strengthening the services we offer in the community. In partnership with Southend Borough Council and others, we have been focussing on how we will deliver better, joined-up preventative care and avoid unnecessary trips into hospital for those that can stay in the comfort of their homes. Our Integrated Neighbourhood Teams (in each of our localities) have developed over the past year we have seen good progress in achieving better,

integrated care with health and care professionals working together to anticipate patient needs before the point of crisis, see page 56 for more information.

Another example of delivering better, joined-up care includes the 'Falls Early Intervention Vehicle': an early intervention vehicle attends to most 999 calls in the area for falls. The vehicle carries trained Paramedics and an Occupational Therapist working together, lifting patients, carrying out treatment at home if this is possible, provides them with holistic assessments, equipment and refers them to appropriate services. This has led to a reduction in ambulance conveyances, A&E attendances and avoidable hospital admissions.

With rising demand for our health services as our older population increases and the number of residents with multiple and complex health and care needs grow, staff on the front line have been under significant pressures to deliver the level of care we all expect.

Over the last year we have invested in better access to GP and nurse appointment through two weekend hubs (one in central Southend and one in Shoeburyness) that provide GP / Nurse appointments on Saturday, Sunday and bank Holidays. We are already seeing positive feedback about this new service.

We have continued to make good progress in delivering more services closer to home. Examples of this include, over 2000 patients with diabetes who previously had to journey to hospital have seen their consultant in clinics in Southend, Benfleet, Westcliff and Rochford. We've also seen big improvements in the monitoring of irregular heartbeats in the community to reduce the chance of local residents having strokes. Advances in technology have meant simple devices that initially detect irregular heartbeats have been introduced in GP practices with 24-hour ECGs also now available in the community. The transformation of ophthalmology services is another great example of our progress in delivering more convenient healthcare services for our local community with many appointments that were previously carried out in hospital eye services now being done safely and conveniently at a high street Optician, for more information on this see page 47.

We have also invested in new ways to support local residents to keep healthy physically and mentally and to manage their own health, in their own home, where safe and appropriate. We have been leading the way in identifying and supporting residents with dementia in Southend. This provides a strong foundation for the work we will be undertaking going forward on integrating services for people with dementia into the four localities that will increasingly become the focus of how NHS and social care services will meet the needs of local people.

We are aware that we have had an increase in complaints during 2017/18 (detailed on page 24). We are committed to ensuring that we learn from all patient feedback. See page 26 for information about patient experience and engagement.

This year has seen us working more closely with our neighbouring CCGs across mid and south Essex, with the formation of the Joint Committee. This allows the five CCGs to collectively plan, commission and monitor services to meet the needs to the whole population of mid and south Essex. You can read more about the Joint Committee on page 12.

I would like to say a big thank you to all those working in the frontline of local health and care services, CCG staff and volunteers who have worked tirelessly over this past year. We are so fortunate to have so many hard working, passionate people who continue to act in a high professional way, ensuring that the need of the patient is at the centre of what they do. I would also like to thank all the local residents, patients and stakeholders who have shared their feedback on a number of aspects of CCG business. As detailed on page 26 we are keen to ensure that every part of our health and care system is shaped by those who use local services, ensuring patient representative is involved every step of the way.

2018/19 already promises to be another challenging year but it will also provide us with a chance to keep improving what we do for our residents while ensuring that local people have access to high quality services that meet their needs. It is vital that everything we do is focussed on getting the best possible outcomes for people, community-led and collaborative.

I hope you enjoy reading this Annual Report. We are keen to hear your thoughts on our work, and for you to become more involved in shaping the health and health services for local residents in Southend. For more information about how to get involved, please visit www.southendccg.nhs.uk

Margaret Hathaway
Interim Accountable Officer

About us

NHS Southend Clinical Commissioning Group (CCG) was formally established on 1 April 2013. We are a clinically led organisation that commission (buy) health services for our local population from an allocated budget. Southend CCG co-commission primary care services as of 2017.

Locality overview

Southend is one of the most densely populated areas in Essex and NHS Southend CCG covers a population of approximately 185,000 in Southend, Leigh, Westcliff and Thorpe Bay; with more than 18,000 patients over the age of 75.

Our Values

Clinically Led	**Quality**
Clinicians play a central role in leading our organisation	We will strive to maximise quality by promoting optimal use of evidence based guidelines
Centred on patients , families and carers	**Best use of public money**
We place patients, families and carers at the centre of everything we do.	We will demonstrate strong population involvement, governance and accountability to assure we are achieving best value for money
Equalities	**Excellence and professionalism**
We will be relentless in our efforts to reduce inequalities in our population and ensure that services we commission are accessible to all who need them.	We will create a professional environment that motivates its people to perform and excel

Safety	Working across organisations in partnership
All providers we commission must demonstrate delivering a safe service is their top priority. Safeguarding training will be provided to all staff groups.	We will be proactive in seeking opportunities to advance our cause through joint collaboration with neighbouring commissioners, commissioning support unit, acute, community and mental health trusts, local council and other key stakeholders.

Our Vision
Our vision is to ensure that everyone living in Southend–on-sea has the best possible opportunity to live long, fulfilling, healthy lives. We want:

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

Health and wellbeing strategy

The Accountable Officer and the Chair of the CCG are active participants in the Southend Health and Wellbeing Board (HWB), collaboratively working with partners to improve health and wellbeing for Southend's residents. The aspiration of the Southend HWB is that everyone living in Southend-on-Sea has the best possible opportunity to live long, fulfilling, healthy lives as expressed through three 'Broad Impact Goals', these are;

(1) Increased Physical Activity (prevention);
(2) Increased aspiration and opportunity (addressing inequality); and
(3) Increased personal responsibility.

During the course of this reporting year the Health and Wellbeing Board discussed a refresh to their strategy. This resulted in the approval of a strategy (2017 – 2021) which now focuses on increasing levels of physical activity whilst not losing site of the three Broad Impact Goals outlined above.

Throughout 2017/18 the Southend HWB has continued to drive discussion and progress on key issues aligned to the focus highlighted above within the local Health and Wellbeing Strategy. The HWB hosts regular, additional strategic discussions on relevant issues including Mental Health, development of Localities, Children & Young Peoples services and the mid and south Essex Sustainability & Transformation Plan (STP). This has enabled a system-wide approach to be agreed.

The CCG also ensured all members of the Health and Wellbeing Board had opportunity to provide feedback on the draft annual report before publication.

Key risks and challenges – the need for transformation
We already face an unprecedented demand upon our health and social care services at a time when funding levels are reducing. We know that these challenges will intensify over the coming years as our older population increases and the number of residents with multiple and complex health and care needs grow.

We have an ageing population with some significant health needs, and this is expected to grow over the next five years.

Due to these system pressures hospital and community services are under intense pressure, often relying upon agency staff to cover gaps in staffing. Services have evolved into complicated systems for patients, carers and even our own staff to navigate, which can result in inequitable provision and needless duplication.

In addition, we have a number of small GP practices and shortages in some staff groups, so effective workforce planning is essential to ensure that we are able to continue to meet the needs of our population.

Health inequalities are still increasing and demand for services is rising, so it is vital that we make the best use of our resources and ensure that services are sustainable for the years to come. The unprecedented financial and service pressures facing health and social care cannot be tackled by making incremental adjustments to existing services and ways of working.

As a result, our operational plan focuses on the need for transformation and change across acute, community, primary care services and workforce, with the aim of developing services that are needs, rather than system-led.

Key facts and figures

Headquarters (as at 31 March 2018)	*Harcourt House, 5-15 Harcourt Avenue Southend-on-Sea, Essex SS2 6HT
Communities covered	Southend is covered by the unitary authority - Southend-on-Sea Borough Council
Population (registered GP)	Approx. 185,000 (registered)
Revenue Resource Limit (for 2017/18)	£267.4 million
Number of GP practices	30
Average Number of employees	62.13

***As of 25 May 2018 the official NHS Southend Clinical Commissioning Group address will have changed to**
NHS Southend CCG, Floor 6, Southend on Sea Borough Council, Civic Centre, Victoria Avenue, Southend on Sea, Essex, SS2 6ER

Where we buy your healthcare
NB: This is not an exhaustive list of all our providers. The following table gives a summary of our main health care providers in 2017/18

Type of Healthcare	Where we buy it from on your behalf
Community Services: This includes, district nursing, speech and language therapy, podiatry, paediatric community nursing.	• Essex Partnership University NHS Foundation Trust (EPUT) • ASD Assessment – from a range of specialist centres including Lorna Wing and Portland
NHS hospital services: This includes outpatient clinics, operations and emergency care	• Southend University Hospital NHS Foundation Trust (SUHFT) • Spire Wellesley • BMI Healthcare
Mental Health Services: This includes	• Essex Partnership University NHS

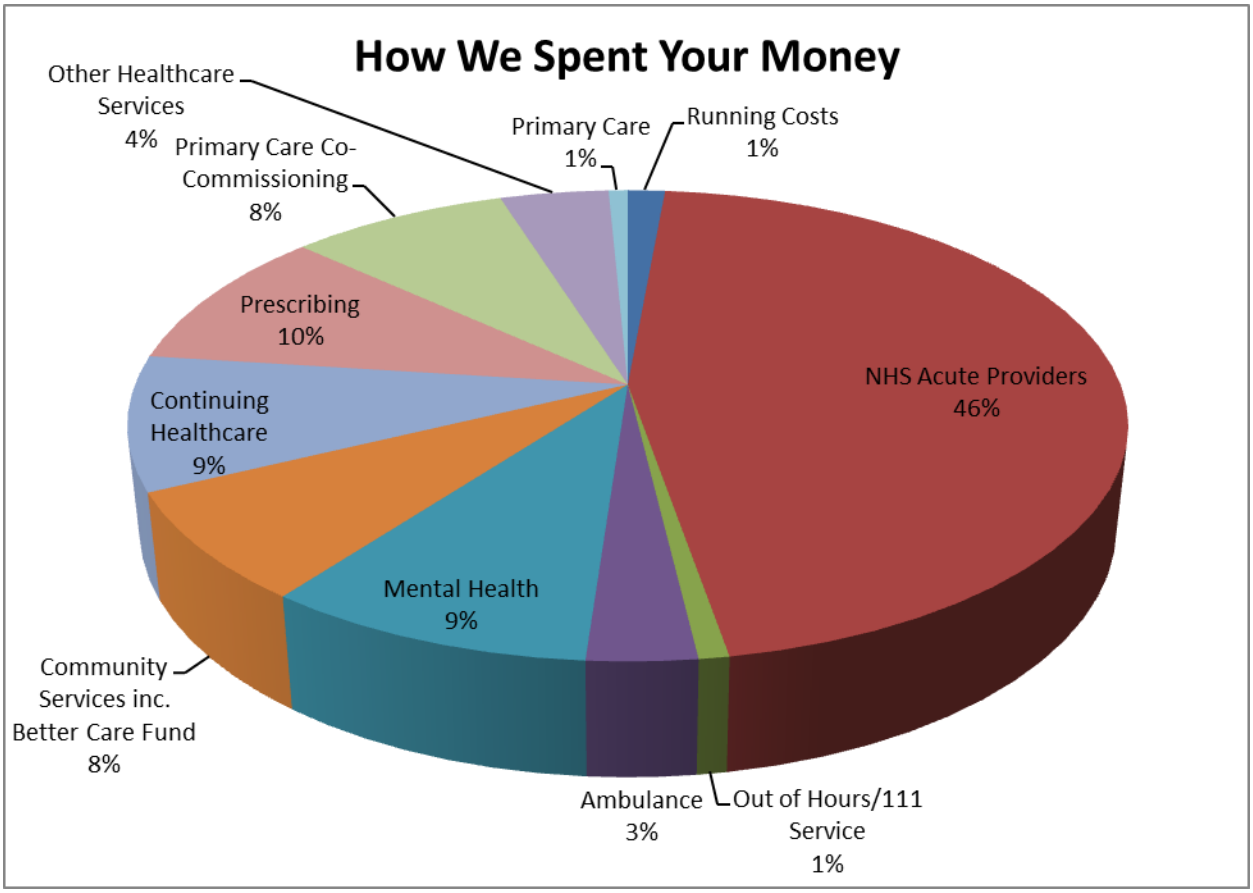
psychological therapies, community mental health teams emotional health and wellbeing service and learning disability services	Foundation Trust (EPUT) • Partnership arrangements with voluntary organisations • North East London Foundation NHS Trust (Emotional Health and Wellbeing Service – Formerly called Children and Adolescent Mental Health Services)
Palliative Care and End of Life Services	• Fair Havens Hospice • Little Havens Children's Hospice • EPIC (Essex Palliative Integrated Care Respite Service) • J's Hospice
Specialist health services: This includes treatment for specialist cardiac, renal, children's, neurosciences, cancer, genetics and many more.	NHS England Specialised Commissioning commissions these services on our behalf from specialist centres such as: • Basildon and Thurrock University Hospital NHS Foundation Trust • Great Ormond Street Hospital NHS Foundation Trust • The Royal Marsden NHS Foundation Trust •
Emergency health services and transport	East of England Ambulance Service NHS Trust
GP out of hours and urgent care services including NHS 111	IC24
Weekend Primary Care GP services	GP Healthcare Alliance

We also commission primary care services for our local population. See Co-commissioning of Primary Care section on page 51 for more details.

Financial performance

The 2017/18 financial year was a challenging one financially and the CCG reported an in-year deficit of £6.8m against our Revenue Resource Limit of £267.4m, and thus the CCG did not achieve its statutory requirement to break even. Also, the CCG did not meet the nationally set NHSE financial control total but it did, however, meet the revised plan total agreed after discussion with NHS England.

This chart shows the CCG's spend profile for the year, by expenditure category:



Achievement of Constitutional Targets

In addition to meeting our financial obligations we have a statutory obligation to meet a range of constitutional targets including: A&E transit times, Referral to Treatment Times, Cancer waiting times, mental health access targets and others. Our system continues to be under pressure with a range of targets such as access to psychological therapies, dementia diagnosis rates, Cancer 62 day targets, A&E four hour waiting times and the ambulance response rates. Whilst we are making some progress in addressing these pressures and have action plans in place, we need to ensure that sustainable systems and processes are in place to address shortfalls.

Five Year Forward View

The Five Year Forward View (2014) sets out a clear direction for the NHS and how future services could be configured, including outcomes based commissioning. There is an expectation that when people do need health services, patients will gain far greater control of their own care. In addition, the Care Act (2014) has a clear focus on wellbeing, preventing, reducing and delaying people's needs from developing. The Care Act sets out the integration agenda between local authorities and the NHS by making it a default position for the design and delivery of services.

Commissioning in mid and south Essex

During 2017, the five CCGs in mid and south Essex formed a Joint Committee with the purpose of enabling commissioners to act collectively in the planning, commissioning and monitoring of services, to meet the needs of the whole population of mid and south Essex.

To enable the Joint Committee to discharge its functions, and following a staff consultation process, relevant staff across the five CCGs have now formed a Joint Commissioning Team.

The Joint Committee comprises the Chairs and Accountable Officers of the five CCGs, as well as the Chief Nurse, Chief Finance Officer and Director of Commissioning for the Joint Commissioning Team. The Committee has a lead Accountable Officer, Caroline Rassell, and an independent chair, Professor Mike Bewick.

The functions of the Joint Committee include:

- Decisions on STP-wide service configurations
- Leadership of public consultation activities on significant service change
- Agreement of STP-wide service restriction policies
- Agreement of STP-wide outcomes, frameworks and pathways
- Agreement of the STP local health and care strategy

The Joint Committee has delegated responsibility for a range of functions including patient safety and quality, commissioning and contracting and performance management for the following services:

- All acute hospitals (NHS and independent sector)
- Integrated Urgent Care services, including NHS111
- Ambulance services
- Patient transport services
- Learning disability decision-making (with the existing pan-Essex arrangements)
- Acute mental health services

Importantly, the formation of the Joint Committee and Joint Commissioning Team will enable individual CCGs to focus on developing and enhancing primary, community and local mental health services, and to work closely with member practices and local authority colleagues to build strong localities to deliver a broader range of services outside hospital. Work is underway to develop an STP-wide primary care strategy which will be implemented by individual CCGs.

The Mid and South Essex Sustainability and Transformation Partnership (STP)
The mid and south Essex STP is one of 44 such partnerships covering all of England. The STP brings together local NHS organisations and councils to work together to improve health and care in the areas they serve.

This year, the mid and south Essex STP has launched a public consultation on proposals to improve hospital services for our 1.2m population. The proposals outline that the vast majority of care would remain within each of the three hospitals – including A&E and urgent care services, outpatient appointments, tests, scans and day case surgery. The proposed service changes are based around five key principles:

1. Improvements in A&E in all three hospitals – through the further development of assessment units for older people, children, and those with urgent medical, and urgent surgical conditions.

2. Some specialist inpatient services to be brought together in one place, where this would improve patient care and outcomes.

3. Access to specialist emergency services, such as stroke care, should be via the nearest A&E. There are specific proposals about the model of care for stroke patients.

4. Planned operations should, where possible, be separate from patients who are coming into hospital in an emergency.

5. Some hospital services should be provided closer to the community – either at home or in a local health centre (with specific proposals about Orsett Hospital).

The public consultation ran from 30 November 2017 – 23 March 2018. All feedback received during the wide-ranging consultation will be independently analysed and provided as part of the evidence to be considered by the CCG Joint Committee

The Joint Committee will consider the proposed service changes, alongside evidence including the consultation feedback, further assurance on clinical pathways, equality impact assessments, and travel and transport plans. The current plan is for the CCG Joint Committee to take decisions on service change in summer 2018, with implementation of these changes taking place over a number of years.

Highlights of our year 2017/18

We led a communications campaign with partners across mid and south Essex to encouraging people to cancel unwanted appointments & promote Patient Online as an easy way to do this has shown positive results. Of the data that we were sent, GP practices in Southend saw a 19% reduction in DNAs in April 2017. The campaign saw a mixture of newspaper coverage, bus advertising and social media. Special thanks to Southend United who let us use their pitch to illustrate the fact that an average of 12,000 appointments are missed every month across mid and south Essex – the same number of seats in the entire stadium. This partnership helped us to engage with a predominantly male audience that can be hard to reach. Thanks also to the local clinicians who were part of the photoshoot.

Working with our colleagues across the Mid and South Essex STP, we led a local communications campaign – in support of Asthma UK's #scarfie. The aim is to reduce the severity of asthma attacks by encouraging people with asthma to wear a scarf loosely around their mouth and nose – this warms up the air making it easier to breathe. The #scarfie asks people to upload photos of themselves wearing their scarf and post on social media. We localised the campaign to include scarfies on local landmarks, and got the whole community involved from schools to Southend United.

Last year also saw the creation of a new and regular editorial column in our local newspaper, fronted by our Chief Nurse, Tricia D'Orsi. The column shares public messages around keeping well, self-care advice and the appropriate use of NHS services. The column has also focused on flu and the importance of good hand hygiene in line with the national PHE campaign. Each column is shared via social media pages and to date has received positive feedback from members of the local community.

We held our first Quality Awards, jointly with Castle Point and Rochford CCG recognising the good work of the GPs and staff across south east Essex. Dr Terry Kemple, President of the Royal College of GPs hosted this special event.

There were five awards nominated by staff from CCG member practices and one nominated by the public, in partnership with our local newspaper, Echo, - the People's Choice award.

The categories were: Innovation, Leadership, Public engagement, Unsung hero and Using technology to improve quality

A review panel, including external stakeholders, evaluated all the nominations and agreed the winners for each category.

The winners for Southend CCG were:

Quality Awards 2017	Southend CCG Winners
Innovation award	Highlands Surgery
Leadership award	Dr Alex Shaw Highlands Surgery
Public engagement award	Karen Shea & Charlie Wood Pall Mall Surgery
Unsung hero award	Dr H Siddique Southend Medical Centre
Using technology to improve quality award	North Shoebury Surgery
People's choice award	Dr Jack & Learning Disabilities Health Check Team, Queensway Surgery

Well done to all those nominated to all staff for their hard work and commitment

We continued our tour of schools – with local GPs giving careers talks to students to encourage them to consider careers in medicine.

This year both Southend and CP&R CCGs became involved in the sepsis campaign, which saw us engaging with local care agencies and the GP practices. We provided posters on catheter care in the community and signs in the elderly as well as posters and leaflets on what to look out for in children to be displayed at all of our practices. There was an evening presentation that the GPs were invited to, held at Southend Hospital linked in with the Sepsis campaign.

Pall Mall surgery in Southend became the first practice in the area to be officially accredited as 'dementia friendly' by Academic Health Science Network (ASHN). This is after the implementation of the iSPACE project which is designed to improve the patient experience by implementing the following 6 steps.

1. **Identify** one or two Dementia Champions in the practice
2. **Staff** who are skilled and have time to care
3. **Partnership** working with carers, family and friends
4. **Assessment** and early identification of dementia
5. **Care plans** which are person centred
6. **Environments** that are dementia friendly

The weekend GP service was started in Southend. Patients registered with a Southend GP practice are now able to access weekend and bank holiday appointments from Southend Medical Centre and North Shoebury Surgery. A GP is available between 10am-3pm and a nurse between 10am and 2pm every Saturday, Sunday and bank holiday for pre-booked appointments.

Christmas Advent Calendar - Another year, another calendar. This year, health professionals across mid and south Essex launched a video advent calendar aimed at raising awareness of key winter health risks and offers advice on local health services available over the Christmas period – as well as general self-care advice.

Performance analysis

From 1 April 2017 to 31 March 2018 NHS Southend CCG has successfully delivered the following key objectives:

- Exceeded dementia diagnosis rate standard by 7.8% (74.8%)
- Reduction in the percentage of woman that are smoking at the time of delivery
- Establishment of an Integrated Diabetes Service.

Key challenges continue to be:

- Addressing poor performance against constitutional standards (Including Cancer, 18 week pathways and Ambulance response)
- Working with all partners to ensure safe provision of care
- Cancer 62 day wait standard
- Ensure clear understanding and interpretation of data, to ensure the correct decisions are made
- Maintaining current momentum in Improving Access to Psychological Therapies (IAPT) services to meet performance targets in 2017/18
- Managing other organisations expectations
- Driving forward whole economy programmes to reduce Health Care Acquired Infections (HCAI)
- Maintain delivery of the Quality, Improvement, Productivity and Prevention (QIPP) plan and associated work
- Achieving financial statutory duties in a sustainable way.

Performance data

We constantly strive to improve our performance and commission high quality services for the population of Southend, within our available budget.

Our performance is measured by a number of different indicators covering many aspects of our performance. Health and care data on NHS performance – compiled by various sources including NHS England and the Department of Health – is available on 'My NHS' (www.nhs.uk/mynhs). This

includes data on our performance in different aspects of health and care. Examples of performance data available on ‘My NHS’ include:

- Dementia
- Year end assurance for 2016/17 - Southend CCG assessed as ‘requires improvement’
- Urgent and emergency care
- Mental health – including IAPT
- Sustainability

Performance summary:
The table which follows shows the CCGs key targets that it has monitored during 2017/18. We have achieved a number of these targets. However, as can be seen, over the past 12 months the CCG is most challenged in its Accident and Emergency, Cancer and Referral to Treatment targets which have delivered below the required standard.

We have reviewed our performance and in the process of agreeing constitutional standard recovery trajectories for improved delivery with NHS England and NHS Improvement. Our aim is to ensure long term sustainability and provide our regulators with assurance and confidence of our performance.

SUHFT closely monitors patients on the cancer 62 day pathway in relation to breaches which enables them to identify, via root cause analysis investigation, and address issues that impact on the pathway timescales. Whilst systems have been designed to take in to account the practicalities of managing very complex diagnostic pathways it should be recognised that some breaches may be directly related to what is in the best interest of the patient , for example patients may not be clinically fit for cancer treatment or choose to defer diagnosis or treatment.

Our Performance

2017/2018 Constitutional Standard Performance

Please note that this data is for the year 2017/18 (unless otherwise stated).

CATEGORY	SUB-CATEGORY	TARGET	PERFORMANCE
Accident and Emergency	Seen within 4 hours	95%	86.84%
Referral to Treatment	Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral	93%	86.66%
Cancer	Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%	92.97%
	Maximum two-week wait for people referred for investigation of breast symptoms even if cancer is not initially suspected.	93%	93.78%
	Maximum one month (31-day) wait from diagnosis to first treatment	96%	94.64%
	Maximum 31-day wait for subsequent treatment (drugs)	98%	99.10%
	Maximum 31-day wait for subsequent treatment (surgery)	94%	85.47%
	Maximum 31-day wait for subsequent treatment (palliative)	96%	100%
	Maximum 31-day wait for subsequent treatment (radiotherapy)	94%	98.3%
	Maximum two-month (62-day) wait from urgent GP referral to first definitive treatment	85%	76.37%
	Maximum two-month (62-day) wait from urgent GP referral to first definitive treatment for NHS screening	90%	90.3%
Improving Access to Psychological Therapies (IAPT)	Access	15.85%	17.34%
	Recovery Rate - 50% of the people who are treated in IAPT services recover	50%	47.10%
Dementia	Diagnosis Rate - 66.7% of the estimated prevalence of people with dementia should have a diagnosis	66.7%	74.79%
Learning Disability Health Checks	Annual Health Checks - increase the take up of Annual Health Checks and Health Action Plans for people with a learning disability	63%	55.67%
Clostridium difficile	C.Diff – number of reported cases	36 cases	58 cases

Methicillin resistant Staphylococcus aureus (MRSA) Bacteraemia	MRSA	0	6

Financial Performance

Revenue Expenditure
NHS Southend CCG recorded an in-year deficit of £6.8m at the end of the financial year for 2017/18. The deficit met the revised control total set by NHS England for the CCG, however the CCG has not met its statutory duty to breakeven. The CCG had a brought-forward deficit of £4m and thus closed the year with a cumulative deficit of £10.8m.

Revenue Resource Limit (RRL)	£267.4m
Performance	£274.2m

Capital Expenditure
The CCG did not receive a 2017/18 Capital Resources Limit.

Value for Money
Ensuring value for public money is an important principle of the CCG. To ensure value for money is achieved, appropriate procurement procedures are in place, including the tendering of goods and services where necessary.

A key priority for the CCG looking forward is to ensure that maximum value for money is being achieved through effective commissioning arrangements, given that the majority of the CCGs expenditure is spent on commissioning healthcare services. Whilst all healthcare providers are required to deliver a continuous programme of QIPP, the CCG must also demonstrate that it is properly considering the health needs of the local population and commissioning those services that address those needs.

During 2017/18, the CCG has been working with our NHS and social care colleagues across South Essex in developing system-wide Quality, Improvement, Productivity and Prevention plans setting out how we will respond to the challenging financial climate in which the NHS and the wider public sector will operate over the coming years.

The CCG has a number of plans for service redesign, service transformation and procurement for the forthcoming financial year, all with the aim of improving service quality and ensuring the commissioning of value for money services for the CCG's resident population.

2018/19 Financial Plans
The Governing Body approved the 2018/19 budget at its March 2018 meeting in public. The plan delivers a deficit of £3.5m which is the agreed target control total set by NHS England. Nationally, CCGs who are in a deficit position, but who achieve their control totals (£3.5m for Southend) will have access to the centrally created Commissioner Sustainability Fund (CSF). The CSF will be released to CCGs achieving their control total, and will be equal and opposite to the target value. The working assumption, therefore, is that the CCG will deliver an in-year breakeven position.
It is worthy to note that within this budget is an inherent requirement to deliver significant efficiency savings of £14.5m, through our Quality, Innovation, Productivity and Prevention Programme.

Our challenge remains to maintain and improve the quality of services we commission on behalf of the local population, whilst delivering significant productivity savings.

Please see Annual Accounts for the full set of financial statements for the year ended 31 March 2018.

Sustainable Development

Sustainability has been recognised at a national level as an integral part of delivering high quality healthcare, efficiently. We are required to produce a Sustainability Report covering our performance on greenhouse gas emissions, waste management, and use of finite resources, in line with HM Treasury guidance: Public Sector Annual Reports – Sustainable Development Reporting Guidance December 2014. The CCG recognises that sustainability is not about, nor should it be restricted to initiatives that directly reduce carbon emissions.

Sustainability is about reflecting upon how the NHS operates, asking why we operate as we do and seeking better, less resource dependent methods and behaviours for improving outcomes.

Improving quality

Each CCG must exercise its functions with a view to securing continuous improvement in the quality of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness.

In accordance with the section 14R NHS Act 2006 a CCG must act to secure continuous improvement in the outcomes that are achieved to ensure services are safe, effective and deliver a positive patient experience.

The CCG's current rating of 'Requires Improvement' reflects the challenges in the local health economy in particular reflecting the financial and workforce issues impacting on service delivery.

Quality Assurance Framework

The CCG recognises that quality governance relies on a combination of structures and processes at and below Governing Body level to assure organisation wide quality performance.

The CCG framework for commissioning high quality services outlines how the organisation meets the recommendations within the National Quality Board reports and subsequent legislative requirements for CCGs to ensure the quality of care commissioned. It includes the governance architecture in terms of a communication and reporting structures, roles and responsibilities and relevant supporting guidelines and procedures. The CCG Commissioning for Quality Framework:

- Sets out the arrangements for informing priorities, providing early warning for action and delivering assurance on quality to the CCG Governing Body
- Supports the interface with all commissioned services including NHS Foundation Trusts, independent contractors, voluntary and private sector providers as well as the Local Authority
- Recognises the requirement of the CCG to work effectively and openly with other commissioning organisations and regulators to identify and address the risk of potential failure in care
- Recognises the importance of patient and service user participation

Definition of Quality

The CCG basis our understanding of quality on Lord Darzi defined quality in terms of safety, effectiveness and patient experience.

- Patient safety. This means ensuring the environment is safe and clean and reducing avoidable harm

- Patient experience. Quality of care includes quality of caring. This means how personal care is, the compassion, dignity and respect with which patients are treated. It can only be improved by analysing and understanding patient satisfaction with their own experiences.
- Effectiveness of care. This means understanding success rates from different treatments for different conditions. Assessing this will include clinical measures such as mortality or survival rates, complication rates and measures of clinical improvement.

Quality Assurance Framework
Four key principles have informed the development of our quality assurance framework:

- Quality is everyone's business
- Patients first
- Our population must be involved and their voices heard
- We will be open and honest, share information and intelligence and work collaboratively

Our approach is underpinned by our values and behaviours, the roles and responsibilities of all individuals and organisations that form the health care system, the organisational structures that have been put in place and the processes we utilise.

The CCG workforce will:

- Respect and display the values and behaviours that put patients at the heart of everything we do
- Value every person as an individual ensuring dignity and respect for all
- Show a commitment to quality of care and show integrity and accountability in our interactions
- Show compassion when making decisions
- Strive to improve health and well-being and people's experiences of the NHS
- Recognise that everyone counts and use our resources for the benefit of the whole community

The roles and responsibilities for individuals and organisations for quality are established by statute by the National Quality Board.

The CCG is responsible for commissioning services that meet the needs of our local population and provides:

- assurance of the quality of the care that is commissioned
- proactive and coordinated action to address potential or actual quality failures and inform the Care Quality Commission (CQC)
- contracts with our providers to secure continuously improving quality care

The services commissioned by the CCG must meet, as a minimum requirement, the CQC's essential standards of quality and safety and the CCG must be aware of the information contained within the CQC's Quality and Risk Profiles.

The NHS Commissioning Board has established a national set of Quality Surveillance Groups (QSG) at local and regional levels. The role of these groups is to bring together local intelligence relating to particular service providers. The Accountable Officer and Chief Nurse of the CCG attends the local QSG as part of the system wide quality assurance system.

Internal governance
An integral component to the infrastructure for quality governance in the CCG is the establishment of the Quality, Finance and Performance Committee, a formal committee of the CCG. This Committee has the role of assuring the Governing Body of the quality and safety of all health interventions commissioned by the CCG. The Committee is the formal mechanism by which the

CCG discharges its responsibilities for clinical quality and sets the strategic direction for clinical governance.

The remit of the committee is to:

- Provide oversight and give assurance to the Governing Body that the patient and patient feedback is kept at the centre of all decision making.
- Assure the quality of the service commissioned.
- To promote continuous improvement, learning and innovation with respect to, clinical effectiveness, safety of services and patient experience.

Quality governance roles and responsibilities
Below are the key roles and responsibilities for quality governance within the CCG:

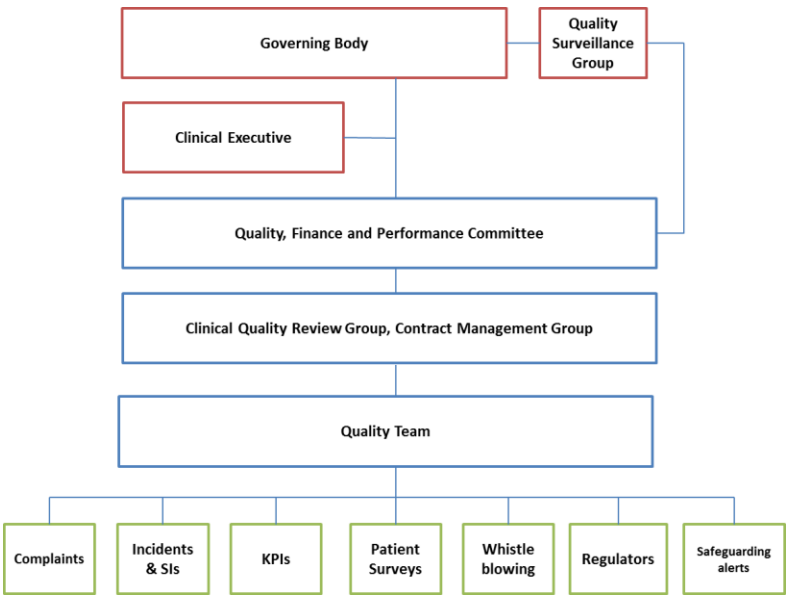
Governing Body responsibilities
The Governing Body has the responsibility to assure itself that there are the systems and processes in place in the CCG to monitor quality in commissioned services.

Accountable Officer
The Accountable Officer holds ultimate responsibility for ensuring that the CCG is meeting its statutory requirements for quality and patient safety and that there are mechanisms in place for the CCG to recognise where there are concerns or failures in commissioned services or in the CCGs ability to monitor the quality and safety of services.

Executive Nurse
The Executive Nurse (Chief Nurse) holds the Board responsibility for giving assurance to the CCG in relation to the quality and safety of services being delivered to the local population. The Executive Nurse oversees the processes and systems to ensure all national and local requirements to maintain and improve quality, safety and patient experience and will be expected to report to the Governing Body any concerns.

All staff
All staff in the CCG regardless of their function will have a role to play in supporting the CCG to commission high quality services.

Below is the CCG structure for ensuring information flows and concerns are raised and actioned.



Processes for provider assurance (Acute)
Provider assurance for Southend University Hospital Trust is through a provider specific Clinical Quality Review Groups (CQRG). These meetings are arranged by the CCG Quality Team and constitute a face to face, commissioner to provider quality review meeting. The CCG leads this meeting on behalf of the other CCGs in Essex as lead commissioner.

The CCG is alerted to potential or actual quality failures by exception reporting to the CQRG. Key performance indicators set nationally and locally are scrutinised and triangulated with internal and external sources of intelligence to monitor performance and hold the provider to account. In addition the CCG visits the provider to assess the environment and to speak to patients and staff about their experiences. Information from the CQRG is escalated to the CCG Quality, Finance and Performance Committee and when necessary escalated to the Clinical Executive Committee and local Quality Surveillance Group (QSG) where required.

Provider Assurance Community Services
Quality standards for the community services provided by Essex University Partnership NHS Foundation Trust (EPUT) are monitored at the CQRG led by Castle Point and Rochford CCG. The process for scrutinising quality indicators and reporting by exception through the CCG and to the QSG are the same as above.

Provider Assurance Mental Health Services
The quality of services provided by SEPT are monitored at a CQRG led by Castle Point and Rochford CCG attended by Southend CCG. The process for scrutinising quality indicators and reporting by exception through the CCG and to the QSG are the same as above.

Provider Assurance Independent Providers
Provider assurance for independent providers is through the CQRG mechanism. These meetings are arranged by Southend CCG Quality Team as lead commissioner on behalf of the other CCGs in Essex.

Other statutory functions

Safeguarding
The CCG acknowledges its statutory responsibility and has a clear governance process in place for safeguarding children and vulnerable adults. The CCG works in partnership with the local Authority and the Executive Nurse is a member of the Southend Children and Adult Safeguarding Boards. The designate professionals for safeguarding children and adults are within the hosted arrangements for the South Essex CCGs and the Quality team work closely with the safeguarding teams in the Local Authority.

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

Our priorities for 2017/2018 included:

- Support the Prevent Agenda through raising awareness through training and participating in the channel Panel.
- Working with adult and children's services to promote a 'Think Family' approach
- Ensure that systems are in place to identify at an early stage any child or young person who presents in health care settings and may be a victim of child sexual abuse and/or exploitation.
- Increase clinician awareness in the recognition of and safeguarding response to children/adults at risk of or exposed to Domestic Abuse, Honour Based Abuse and Female Genital Mutilation.

- Support the implementation of the Safeguarding Children and Adult Board Business Plans.

Infection control
The CCG hosts the infection control team on behalf of the 4 South Essex CCGs. Work takes place to investigate cases of MRSA bacteraemia and Clostridium difficile to understand if clinical practice was adequate and if any lessons can be learnt. The team supports visits to providers to assess the quality of the environment.

Clostridium difficile infection (CDI)
During 2017/18, SUHFT had 33 cases exceeding the objective ceiling of 30. Patient safety themes from RCA review meetings include delay in isolation, documentation (stool charts not commenced or not completed) and incorrectly labelled specimen pots. However there were no direct lapses in care associated with CDI. Ribotype strains identified are diverse which is felt to reflect the distribution and carriage in the community.

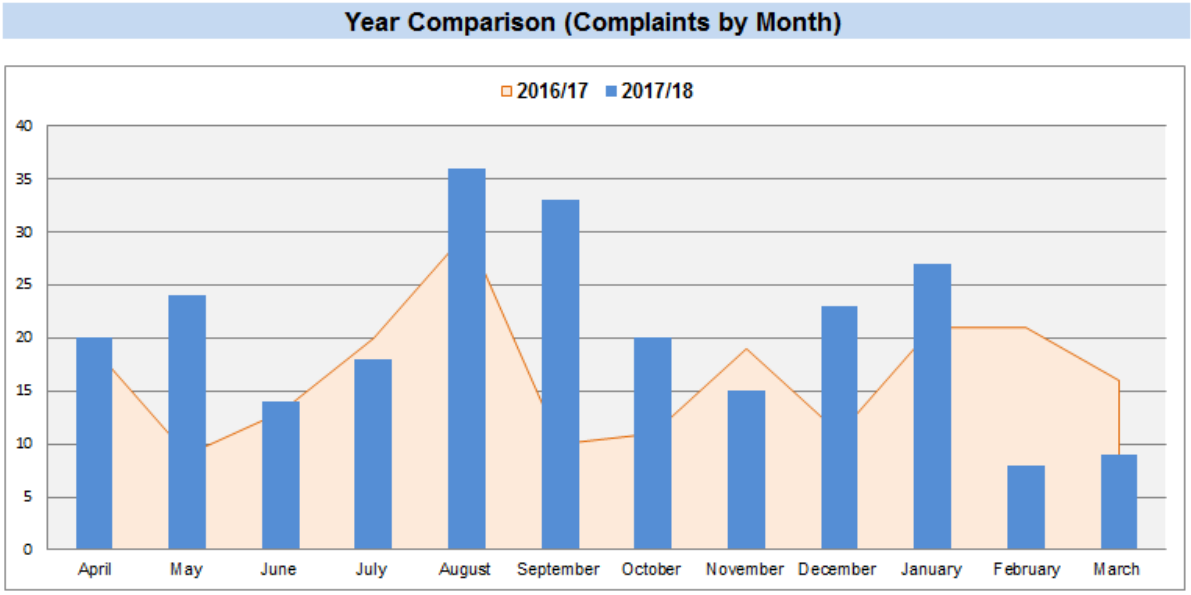
Complaints
During 2017/18 247 complaints were received at the CCG an increase of 21% on the 200 received during 2016/17.

- 132 of these complaints were formally investigated and the cases have been closed.
- 76 remain open due to the CCGs on-going investigations. Some of these complaints are running in conjunction with other local or national processes such as the appeals process for Continuing Healthcare and Individual Funding Requests for those patients requesting treatment which is not usually commissioned by the NHS.
- The remaining 39 were transferred to the responsible organisation for investigation and completion.

The following table shows a breakdown of the number of complaints received by responsible organisation or department and the number of complaints

Department	No received
SCCG Medicines Management	48
Southend University Hospital NHS Foundation Trust	32
NHS England	26
CCG CHC / Arden & Greater East Midlands Commissioning Support Unit	26
SCCG Integrated Commissioning	21
SCCG General concerns/queries	16
Southend Individual General Practice	11
Castle Point and Rochford CCG	11
SCCG Primary Care	10
Southend Borough Council	9
SCCG Acute Commissioning	9
Multiple Organisations	8
Essex Partnership University NHS Foundation Trust	7
SCCG Individual Funding Requests	5
SCCG Communications and Engagement	4
East of England Ambulance Service NHS Trust	1
Basildon and Thurrock Hospitals NHS Foundation Trust	1
Spire Wellesley Hospital	1
Sustainability and Transformation Partnership	1

The table below shows the year on year comparison on the number of complaints received per month at the CCG.



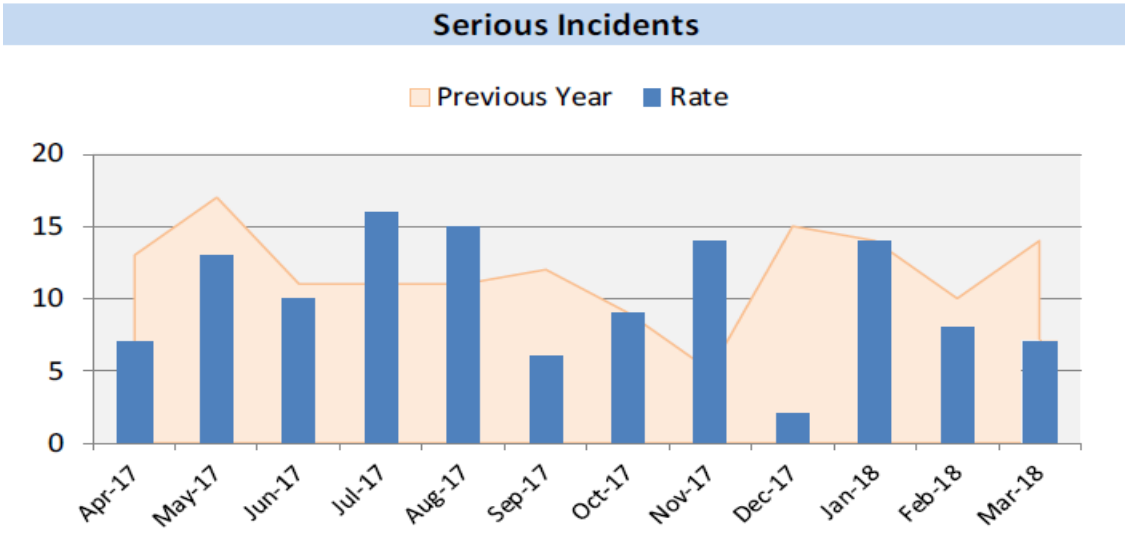
The number of complaints received through 2017/18 has steadily increased on last year's figures however the numbers received within February and March 2018 dropped considerably. Between March 2017 and February 2018 the CCG implemented a large scale change within medicines management around the prescribing of over the counter medications and ran a consultation on whether or not the NHS should continue to fund specialist fertility services (IVF). These two workstreams contributed to the high number of complaints and concerns received by the CCG. It is now believed the numbers of contacts being made by complainants has reduced due to the time which has now elapsed since these two pieces of work were implemented.

In addition to this the number of complaints received regarding the provision of Autistic Spectrum Disorder (ASD) assessments has also reduced; pilots with providers are underway and the children on the waiting lists are now receiving appointments; some have already been assessed by a service. The CCG continues to work on securing longer term providers to continue the service going forward.

As reported throughout the year the main themes were discontinuing prescriptions for medications which can be purchased over the counter, delays with Continuing Healthcare retrospective reviews and access to primary care services.

Serious Incidents

The CCG met regularly with SUHFT to review progress with serious incident (SI) investigations and action planning. The Chief Nurse and relevant Nursing staff within the quality team reviewed route cause analysis reports and action plans relating to SIs and made the decision to close or request further assurance where necessary.



Patient experience
Patient experience in providers is monitored throughout the year through the CQRG process. Specifically Friends and Family is monitored alongside patient and staff surveys. Complaints also form part of the triangulation of information of the user's experience of NHS services. The CCG also directly assesses patient experience when undertaking provider site visits. Most patients continue to report satisfaction with NHS services in Southend.

NHS Continuing Healthcare
Southend CCG has responsibility to assess, care plan and deliver services to meet individuals who are eligible for NHS Continuing Healthcare. The CCG CHC team works closely with Southend Borough Council to ensure that individuals have care plans which are quality outcomes-focused, particularly around the Transforming Care agenda.

Engaging people and communities

At NHS Southend-on-Sea Clinical Commissioning Group, overall accountability for the delivery of effective engagement is retained by our Governing Body.

The following governance is in place to provide assurance that the CCG is meeting its statutory duties around patient and public engagement and ensure the strategy for Communication and Engagement is being implemented:

- A regular report is provided to the Quality, Finance and Performance Committee at which the Chair will advise on all risks or issues of public and patient involvement and engagement

- The Governing Body has a dedicated lay member for patient engagement, to ensure that patient and public engagement is considered and demonstrated in organisational planning and throughout the commissioning cycle

- Quarterly engagement and communication insight and activity reports are received by our Governing Body and other committees, to inform our commissioning approach and priorities

- Our patient group – we have an established Community Engagement Steering group, which leads our engagement and involvement work and activities. The group provides strategic level advice, to enable us to achieve our patient and public engagement objectives. The

feedback from the group is fed back both as part of the above QFP report and via the aforementioned patient engagement lay member

How we listen to and involve the community

There are a number of different ways in which we listen to and involve patients, carers, stakeholders, partners and our community including:

- Community Engagement Steering Group
- Local and national patient experience surveys
- Attending Practice Participation Groups
- Public events
- Incorporating patient experience into a wider quality assurance dashboard
- Quality visits
- The utilisation of complaints, concerns and compliments
- Results of the national 360 stakeholder survey
- Specific engagement projects
- Via social media
- Monitoring local press/social media
- Through some of our communications campaigns

Members of the public are regularly invited to attend Governing Body and other decision making committee meetings, including the Joint Primary Care Commissioning Committee, Quality Finance and Performance Committee and Clinical Executive meetings.

We also work closely with partner organisations and stakeholders to undertake joint patient and public engagement where appropriate and relevant.

Regular feedback about the clinical commissioning group's approach to Patient and Public Involvement is sought from workshops and the patient forums we attend and co-ordinate, such as our Patient Participation Group Forum.

Over the past year our activities have been focused on the way we engage and involve people in our work, particularly in our decision making and in the evaluation of services.

Community Engagement and Advisory (steering) Group

Chaired by our Governing Body lay member for patient engagement, this group has a diverse membership across many different areas of our local community, with members of all different age groups from late teens, to older people.

Membership consists of representatives from local voluntary organisations, residents associations, minority and LGBT communities, mental health groups, community advisors; older people's groups; patient participation groups, health specific support groups, Citizens Advice Bureau, Public Health team, Southend Borough Council, Southend Youth Council, Southend YMCA, Southend Healthwatch, local acute trusts, the ambulance trust and learning disability groups.

Meetings are held once a month, at the CCG offices. The style and agenda for meetings is mixed, with a formal agenda for information exchanges and regular 'workshop' sessions, where members are asked to engage in specific pieces of work or projects, to assist the CCG in the development and implementation of the work.

Over the past year the group has supported our work across a variety of themes, examples include:

Ensuring Equality and Diversity in Public Consultation
In 2017/18 our Community Engagement Steering Group supported us to reach local residents with protected characteristics, or those that experience health inequalities in the most appropriate and efficient way.

This information was used to inform the distribution list for the STP public consultation detailed on page 13 and influenced the way it was communicated to different audiences, across local communities.

The group contributed and shared their feedback on a variety of different CCG projects and priorities during 2017-18, including:

- IVF policy changes/a public consultation
- Winter Planning for 2017 (including inappropriate attendances at A&E)
- Pilot Carer support service (joint project between CCG and Local Authority)
- E-referral service in Southend
- Dementia friendly programme 'become an accredited dementia friend'
- Service restriction policy review

The group also shared their feedback in a number of more involved workshops, as per below:

Workshop session: Mid and South Essex STP: Public consultation to reconfigure hospital services
Workshop session: Dementia Awareness / Training to become a 'Dementia Friend'
Workshop session: GP and Clinical Recruitment in Southend
Workshop session: Prevention of inappropriate use of A&E and ED services

Comments from steering group members:

"*The Public Health Team at Southend-on-Sea Borough Council has been an active participant in the Community Engagement and Advisory Group. The Group has provided opportunities for engaging with members who play an active role in representing their organisation. The Group has provided Public Health a space to promote its role of improving population health; informing members about public health services; and, enabling the Group to participate in activities such as the Physical Activity Survey*.**"** **Simon Ford – Health Improvement Practitioner Advanced, Southend Borough Council.**

"As a member of the Community Engagement Advisory Group is part of a journey. Those of us who are active in our community must try and integrate our input into the CCG and utilise all opportunities with our co-members, to assist the work of the group but to ensure we look to develop and keep the work topical and practical for our Community. We cannot all be there every meeting, but I find the feedback is essential, thus to stay up-to-date! It is an essential level I believe as a filter and progressor for process!"
Kim Woodyer-Byers, Squirrels Voluntary Club

"My name is Judith Snell, and on the Community Engagement Advisory Group, I represent a charity called SAFE (Supporting Asperger Families in Essex). Autism is described as a hidden disability and people with the condition are lacking in social skills. By representing this group, I am able to pass on information that may not otherwise be reaching our members, due to their disability.I have also found that I can be the 'voice' for our members that are so very often forgotten. I count it a

privilege to have a seat on the advisory group and trust that our contributions go a little way to making life easier for all the organisations that are represented." **Judith Snell – SAFE, Essex.**

I represent Citizens Advice Southend on the Community Engagement Advisory Group. Our involvement allows us to link issues raised at the CEAG with our social policy work. We can also highlight issues to our clients, our paid staff and volunteers who predominantly live in the Southend area. An example of this is the information received about the introduction of the GP Weekend Service in Southend.

Trish Carpenter Manager Citizens Advice Southend

Patient Participation Focus Group

This group is a representation of all Patient Participation Groups (PPGs) at Southend GP practices. The Chairs of the PPGs hold bi-monthly meetings with the CCG, supported by Southend Healthwatch, to share views, obtain feedback and to receive health care information and updates to cascade to their own GP practices.

Chair of Southend PPFG, Sally Chair, said:

"I have been privileged to Chair the PPFG for Southend CCG. The PPFG is a group of volunteers who care very much about the health of residents across the Borough of Southend and who want to play their part in enabling the CCG to provide services that will lead to our town having excellent primary care services.

Our bi-monthly meetings have interesting agenda items and speakers who lead on the latest healthcare initiatives available for our residents, giving us the opportunity to hear from hospital consultants and those leading primary and social care about the pathways and services available to local residents. We are then able to pass this knowledge on to the patients in our own practices through our PPGs. We have and continue to provide residents feedback on a variety of proposals including the reconfiguration of hospital services. This plays a pivotal role in ensuring the patient voice is heard."

Ensuring we are being inclusive

In a project to target communities who face health inequalities, the CCG has put in plans to embark on some face-to-face engagement led by our partners in the voluntary sector.

The aim of the project is to reduce inappropriate or avoidable attendance at the local A&E department. Growing academic theory suggests that traditional communications channels – such as newspaper stories, posters, social media or radio advertising – do not influence people living in poverty. More so, face to face engagement is increasingly considered the most influential form of communication when dealing with residents living in poorer areas.

A volunteer team will knock on doors in targeted areas supported by a script that provided key messages about alternative health services with easy to read printed online materials. The project is expected to run in April 2018, hence more details on the project will appear in next year's Annual Report.

8 out of 10 mums – Facebook group

In 2017/18 we engaged with a popular Facebook forum aimed at parents in Essex. We asked them which aspect of health they felt least informed about to help them care for their children. Sepsis was identified as the most popular area that local parents wanted to be more informed about. As a consequence, we linked up with the forum and the specialist sepsis nurse at Southend Hospital to

launch a communications campaign to educate followers on sepsis to ensure swift action is taken using a local case study. The video was viewed over 1,500 times over two months, help raise awareness of symptoms to prevent delayed diagnosis and the need for intensive, costly care. A link to the video can be found here: https://www.youtube.com/edit?o=U&video_id=mFJky1zna-Y

Reaching new audiences
We have a developed a good relationship with our local Football club, Southend United. This partnership has helped us to reach a predominantly male audience with two communications, one to encourage appropriate use of NHS services and the other to encourage those with respiratory conditions the importance of self-care. Use of popular football players and a 360 photoshoot of the stadium has helped secure wide engagement for both campaigns.

Reprezent Essex engagement programme
There are almost one million young people in Essex, and at least 10% experience mental health issues. 10% of referrals to the Children and Adolescent Mental Health Service are currently for active self-harm, and 30% for historic self-harm. There are an audience which historically have been hard to reach.

Following 15 years of successful broadcasting and youth-led training and engagement in London, Reprezent was asked to extend its activities to Essex.

With increasing pressure on Mental Health services, it's vital that we increase awareness of issues amongst young people in Essex, and give them the tools to become resilient and to take control of their own health. This will result in better life quality, the ability to support friends and family, and reduced pressure on the NHS.

Equality and Diversity in how we communicate and engage

Making information and events as accessible as possible is essential. As part of contract monitoring, we ensure the Accessible Information Standard is being followed by our providers, aiming to support everyone with information and / or communication needs relating to a disability, impairment or sensory loss. This includes, but is not limited to:

- People who are deaf, blind or deafblind
- People who have hearing and/or visual loss
- People with a learning disability
- People who have communication difficulties following a stroke, such as aphasia, or because of a mental health condition

As part of the broader work, as part of the STP (see page 13), a lot of work has been invested in making sure information has been presented in a number of different formats and languages, where necessary. In addition to a dedicated websites http://www.nhsmidandsouthessex.co.uk, we have also distributed printed documents, summaries and leaflets with the assistance of the CCGs, Hospitals, Councils, Healthwatch and CVS to public places including local libraries, GP practices and community centres.

A number of public events have been organised throughout the year at a number of different times and venues. When designing each event we have considered the barriers people may face when considering attending and tried to offer a mixture of timings/formats, ensuring all venues are accessible with additional support e.g. hearing loops for those that need them.

While promoting links to the consultation website and the local discussion events via social media has been used to good effect in reaching and engaging large numbers of people, we have also

organised focus groups to engage with specific groups with protected characteristics as set out in the Equalities Act 2010. This included specific sessions with Lesbian Gay Bi-sexual and Transgender groups, diversity networks, faith groups, younger people and mothers to discuss any possible impact the proposals may have on them as a group. Easy read documents were also developed and circulated to all of our contacts including, BATIAS, local authority contacts, Project 49, Livability and Scope.

Equality impact assessments (EIA) also help us assess the likely (or actual) effects of any proposals on people in respect of disability, gender, including gender identity, and racial equality. The assessments then inform patient engagement requirements.

How patient feedback informs our work

We are keen to ensure that every part of our health and care system is shaped by those who use local services, ensuring patient representative is involved every step of the way.

In this section you can find out different ways patients have had their say and influenced the development of health services in the past year. Details of all the ways residents can be involved in our work are featured in the 'Be Involved' section of our website.

EXAMPLES

IVF Public Consultation

In 2017/18, NHS Southend CCG launched a public consultation from the 26 July 2017 to the 9 October 2017. People, patients, stakeholders and clinicians were invited to give their views on the proposal in a number of different ways including:

- Completing a consultation questionnaire, either online or by completing a paper version and returning via a Freepost address.
- Attending one of three workshops held during the consultation period.
- Writing direct to the CCG.

The consultation and associated questionnaires/workshops were promoted via the CCGs website, Twitter account and Facebook account. The consultation documents were also distributed to partners including, Hospitals, Councils, Healthwatch and CVS to public places including GP practices.

A number of public workshops were organised at a number of different times. When designing each event we considered the barriers people may face when considering attending and tried to offer a mixture of timings/formats, ensuring venues were accessible. Information about the consultation was also distributed to groups with protected characteristics as set out in the Equalities Act 2010.

What was the impact of patient involvement?

The CCC Governing Body listened to the responses of the public consultation and rather that fully restrict IVF, offered one cycle of IVF to those under the age of 40. We aware that this was a huge disappointment for people affected by fertility issues in Southend with members considering every aspect of its decision and in particular the profound concerns that some people have expressed about revising this policy.

We have made a commitment to review the decision again in February 2019

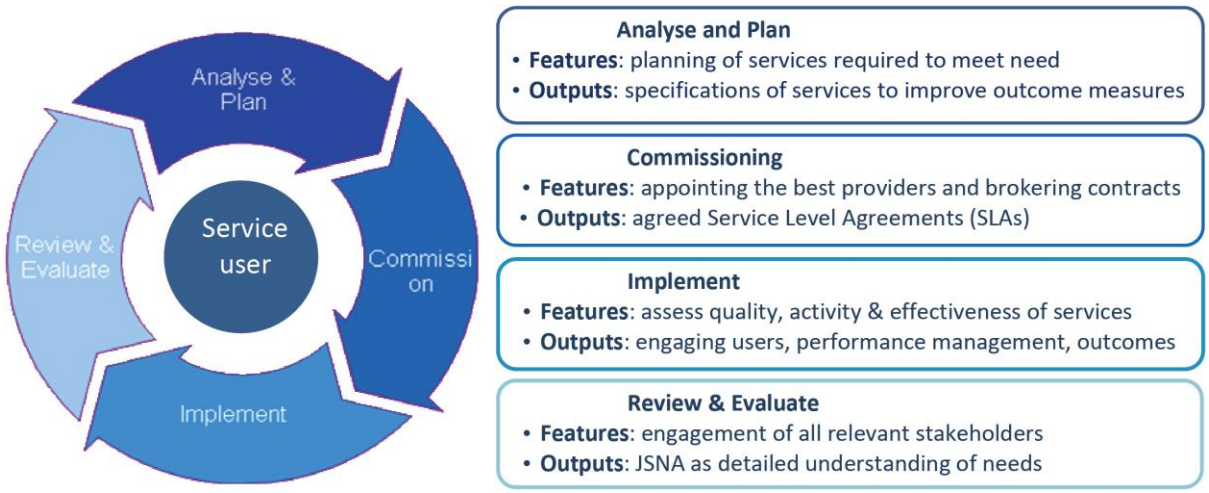
Carers' Experiences in partnership with Southend Borough Council

We appreciate that unpaid carers in Southend play an enormous role in contributing to the economy, by assisting to sustain or NHS, our social care and society itself. However, a lot of the time, carers do not feel understood, valued or appreciated.

In 2017/18, we joined up with Southend Borough Council to look at the support received by non-paid adult carers across Southend, asking for residents to share their experiences across a number of different themes to assist in planning for carers. As experts in the world of caring, we wanted our local residents to be actively involved in decisions made around carers support and services.

What was the impact of patient involvement?

The information we collect will help us to understand what is important to carers and the kind of support/services they would like to have available via joint funding opportunities.



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What was the impact of patient involvement?

The information we collect will help us to understand what is important to carers and the kind of support/services they would like to have available via joint funding opportunities.

You said, we did:

In 2016/17 we launched a big communications campaign with our partner CCGs across mid and south Essex to raise awareness of missed GP and nurse appointments. Social media played a big part of the campaign and consequently we were able to capture a lot of rich patient engagement on the subject of missed appointments. Patients were telling us it that they struggled to cancel their appointments due to difficulties getting through on the telephone. Others mentioned that the patient online service was cumbersome and having to log-in to their account (remembering username/passwords) was a barrier to cancelling unwanted appointments.

In direct response to the feedback, we tested a new technology solution with a small number of our GP practices to understand if there was an easier way for the patient to cancel and unwanted appointment. Following a successful trial that saw missed appointments drop by 19% alongside a reduction in the administrative time with receptionists at GP practice - we have successfully secured funding for GP practices across the mid and south Essex STP. For more information on the iPlato project, see page 58.

Patient feedback

As highlighted in one of NHS England's 10 principles for participation, closing the loop on patient feedback is as important as actually asking for feedback in the first place. As highlighted in the CCG's IAF assessment on patient and community engagement, this is as an area of development. Over the last year, we have improved processes, a full breakdown of the CCG's action plan to tackle how we improve our processes will be available on our website.

Over the course of the year, we have fed back to all those who took the time to be part of our public consultation on IVF.

Future plans
Going forwards, and in line with plans details on page 55 about transforming services, we are exploring methods to further build levels patient engagement and co-production at a locality level that enable people to have input in how we can support them to live a good life and enable communities to flourish.

Stakeholder engagement
We recognise the importance of stakeholder engagement. We work closely with our partner organisations and stakeholders.

The feedback from our 360° stakeholder survey for 2017/18 was disappointing with feedback being less positive than the national average for most questions. The overall response rate was also disappointing at 56%. Although when asked “Overall, how would you rate the effectiveness of your working relationship with the CCG”, 78% responded ‘Good/fairly good’.

However, we recognise the need to strengthen our relationships with our stakeholders in 2018/19 and beyond and will be looking at ways to improve.

Reducing health inequality

We are committed to ensuring that equality and diversity is taken into account in everything we do, both as an employer and as a commissioner of healthcare in line with the Equality and Diversity Act 2010 and the National Health Service Act 2006 as amended by the Health and Social Act 2012.

We respect and recognise that there are differences between people; we aim to commission healthcare services that are equitable to everyone regardless of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation. We also aim to recruit develop and retain a workforce that is able to deliver high quality services, that are accessible, responsive and appropriate to meet the diverse needs of different groups and individuals.

The CCG uses the Joint Strategic Needs Assessment and the Health and Wellbeing Strategy, both of which are informed by views of local residents, when commencing planning or re-commissioning projects.
We aim to be a fair employer achieving equality of opportunity of outcomes in the workplace; to use our influence and resources as an employer to make a difference to the life opportunities and health of its local community.

As commissioners, it’s important that we use a flexible range of methods to hear and engage with potentially excluded groups, or there is risk that participation will reinforce inequalities in access to health services and health outcomes. We therefore ensure our mechanisms for communications and engagement include digital engagement (via our social media accounts), face-to-face communication, ability to write and call us. We support the Accessible Information Standard, making sure disabled people have access to information they can understand and any communication support they need. Any events or activities that we plan ensure equitable access with consideration of a person’s cultural, linguistic, religious background communication and accessibility needs

As part of contract monitoring, we ensure the Accessible Information Standard is also being followed by our providers, aiming to support everyone with information and / or communication needs relating to a disability, impairment or sensory loss. This includes, but is not limited to:

- People who are deaf, blind or deafblind
- People who have hearing and/or visual loss
- People with a learning disability
- People who have communication difficulties following a stroke, such as aphasia, or because of a mental health condition

We have also shared best practice and useful guides to meeting accessibility standards with our service providers such as the Mencap campaign called 'Treat Me Well', which aims to change how the NHS treats people with a learning disability and the Healthwatch Essex toolkit, which is available here: http://www.eclsensoryservice.org/health/ais-toolkit/

Our website aims to reach AA standard in line with the World Wide Web Consortium (W3C) Web Content Accessibility Guidelines (WCAG) version 2.0. Although efforts to cover as wide a range of issues are made, we understand that we are not able to address the needs of people with all types, degrees, and combinations of disability. Users of the website are also able to change the settings of their browser to better suit needs or use the accessibility options provided to change colours and text size.

Over the last year we have worked with our partners and stakeholders to ensure that we uphold the principles of the Equality Act (2010) and the Health and Social Act 2012.

We ensure that all new, redesigned services and our policies have full equality impact assessments carried out to assess the effect and potential benefits for our diverse population (suggest you include a link to the relevant section on website – when EIA are uploaded- and signpost here in the annual report). Within our co-commissioning role we continue to promote improvements to general practice services for our whole population.

We have our equality delivery system for the NHS (EDS2) in place and continue to strive towards our objectives within this. We have our Workforce Equality Standard (WRES) published on our website which is update annually in line with our Human Resources data.

We continue to actively undertake partnership working with the local voluntary, and community sector, to ensure that we engage appropriately with all local groups with protected characteristics. In relation to health inequalities, the need to reduce the gaps experienced by vulnerable groups continues to be embedded in our service design and equality impact assessment process. We have paid particular attention to those people affected by deprivation in our borough as we know this is where the greatest inequality occurs.

As detailed on page 27, our Stakeholder and Community Reference Group also assist us in ensuring we reach local residents with protected characteristics, or those that experience health inequalities in the most appropriate and efficient way**.**

In 2017/18, we have work with the other CCGs and local authorities across greater Essex to re-design pathways for adults with learning disabilities and/or autism in a Transforming Care Programme. Co-production has been key part of this programme to fully engage people using services and their family. For more information on this programme see page 49.

As part of the broader work, as part of the STP (see page 13), a lot of work has been invested in making sure information has been presented in a number of different formats and languages, where necessary. In addition to a dedicated websitehttp://www.nhsmidandsouthessex.co.uk, we have also distributed printed documents, summaries and leaflets with the assistance of the CCGs, Hospitals, Councils, Healthwatch and CVS to public places including local libraries, GP practices and community centres.

While promoting links to the consultation website and the local discussion events via social media has been used to good effect in reaching and engaging large numbers of people, a range of information has also been made available in different formats and languages on request and specific focus groups held to target those groups with protected characteristics as set out in the Equalities Act 2010. This included specific sessions with LGBT groups, diversity networks, faith groups, younger people and mothers to discuss any possible impact the proposals may have on them as a group.

Southend-on-Sea is an accredited dementia friendly town and this year, as part of the Southend Dementia Action Alliance, we launched the work to develop dementia friendly GP practices. In 2017/18 we were delighted that The Pall Mall surgery, in Leigh-on-Sea, received a certificate of accreditation for being 'dementia friendly' on 26 October 2017, from Wessex Academic Health Science Network (AHSN).

Within each GP practice, a member of staff has volunteered to take on the role of a dementia champion and is leading the way to create an environment where people living with dementia and their families and carers can navigate more easily, feel safe and not feel stigmatised.

The aim of the Alliance is to work together to transform the quality of life for people living with dementia and their carers/families and to help Southend-on-Sea to become a Dementia Friendly community.

Going forwards, and in partnership with local authorities we are looking to target areas where there are known health inequalities with lower life expectancy with tailored target health prevention initiatives through our neighbourhood teams. For more information about neighbourhood teams, please see page 56.

ACCOUNTABILITY REPORT

Margaret Hathaway
Interim Accountable Officer
24 May 2018

Corporate Governance Report

Members' Report

Member practices
The CCG has 30 membership practices. The practices are listed below (as at 31 March 2018):

Members Name	F code & Practice Address
Drs Agha & Siddique	F81121, The Thorpe Bay Surgery, 99 Tyrone Road, Thorpe Bay, SS1 3HD
Dr B Bekas	F81207, 48 Argyll Road, Westcliff on Sea, SS0 7HN
Dr K Dhillon & Partner	F81688, 129 Eagle Way, Shoeburyness, SS3 9YA
Dr H Siddique	F81209, Shaftsbury Avenue Practice, 119 Shaftesbury Ave, Southend on Sea, SS1 3AN
Dr S M Callaghan & Partners	F81097, Valkyrie Surgery, Valkyrie Road PCC, 50 Valkyrie Road, Westcliff on Sea, SS0 8BU Branch site Leigh PCC
Dr M Jack & Partners	F81718, Queensway at Lydia House Practice, 8 Sutherland Blvd, Leigh on Sea, SS9 3PS (wef 4 April 2018 site closed)
Dr J Gul	F81724, New Westborough Road Surgery, North Road Primary Care Centre, 183-195 North Road, Westcliff on Sea, SS0 7AF (wef April 2018 merged)
Dr B R M Houston & Partners	F81112, Highlands Surgery, 1643 London Road, Leigh on Sea, SS9 2SQ Branch site 1448 London Road
Dr A C Irlam & Partner	F81086, Central Surgery, 27 Southchurch Blvd, Southend on Sea, SS2 4UB
Dr M Jack & Partners	F81081, Queensway Medical Centre,75 Queensway, Southend on Sea, SS1 2AB Branch 508 Sutton Rd, Southend, SS2 5PN
Dr G K Jayatilaka & Partner	F81696, The Leigh Surgery, 194 Elmsleigh Drive, Leigh on Sea, SS9 4JQ
Dr W Cordess & Partners	F81164, West Road Surgery, North Road Primary Care Centre, 183-195 North Road, Westcliff on Sea, SS0 7AF
Dr F Khan	F81003, Carnarvon Medical Centre, 7 Carnarvon Road, Southend on Sea, SS2 6LR
Dr A C Krishnan & Partner	F81046, Kent Elms Health Centre, 1 Rayleigh Road, Leigh on Sea, SS9 5UU
Dr Navin Kumar	F81147, Central Surgery, 1st Floor, North Road Primary Care Centre, 183-195 North Road, Westcliff on Sea, SS0 7AF Branch 38 Acacia Dr, Thorpe Bay, SS1 3JX
Dr N Kumar & Partner	F81613, Shoebury Health Centre, Campfield Road, Shoebury, SS3 9BX
Dr S A Malik	F81223, Kent Elms Health Centre, 1 Rayleigh Road, Leigh on Sea, SS9 5UU

Dr M Marasco	F81622, 101 West Road, Shoebury, SS3 9DT Branch site 1 Watkins Way, Shoeburyness, SS3 9NX
Dr P N B Moss	F81684, North Shoebury Surgery, Frobisher Way, Shoebury, SS3 8UT
Dr L Nagle & Partners	F81144, The Pall Mall Surgery, 1st Floor, Leigh Primary Care Centre, 918 London Road, Leigh on Sea, SS9 3NG Branch site 314 Southbourne Grove, Westcliff on sea, SS0 0AF
Dr H W Ng	F81744, Scott Park Surgery, 205 Western App. Southend on Sea, SS2 6XY
Dr S Sathanandan	F81200, 9 Blenheim Chase, Leigh on Sea, SS9 3BZ
Dr F Palacin & Guyler	F81649, Shoebury Health Centre, Campfield Road, Shoebury, SS3 9BX
Dr N K Shah & Partner	F81176, North Avenue Surgery, 332 North Avenue, Southend on Sea, SS2 4EQ
Dr H Siddique & Agha	F81159, Southend Medical Centre, 50-52 London Road, Southend on Sea, SS1 1NX
Dr V Sooriakumaran & Partner	F81092, 3 Prince Avenue, Southend on Sea, SS2 6RL Branch 38 Leigh Road, Leigh on Sea, SS9 1LF
Virgincare	Y02707 St Luke's Health Centre, Pantile Avenue, Southend on Sea, SS2 4BD
The Practice	Y02177, 32 Northumberland Avenue, Southend on Sea, SS1 2TH
Dr S L Vashisht	F81656, 61 Warrior Square, Southend on Sea, SS1 2JJ
Dr S H H Zaidi & Partners	F81128, Eastwood Group Practice, 335 Eastwood Road North, Leigh on Sea, SS9 4LT Branch Kent Elms Health Centre, 1 Rayleigh Road, Leigh on Sea, SS9 5UU 348 Rayleigh Road, Eastwood, SS9 5PU

Composition of Governing Body

The governing body meets on a bi-monthly basis in public and its voting members comprise CCG Accountable Officer, GP governing body members and the CCG's Lay Members. Representatives from Southend-On-Sea Borough Council are non-voting members.

The governing body has the following functions conferred on it by sections 14L(2) and (3) of the 2006 Act, inserted by section 25 the 2012 Act, together with any other functions connected with its main functions as may be specified in its constitution.

The main function of the governing body is to ensure that the group has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the group's principles of good governance. The other key functions are outlined in section 5 of the CCG's constitution.

All members were in post for the whole of the financial year with the exception of:
Dr Sreeman Andole (joined the Governing Body on 1st December 2017)
Matthew Rangué (left the Governing Body on 6th March 2018)
Tricia D'Orsi (joined the Governing Body on 7th March 2018)

Chair
The CCG's Chair for the period 1 April 2017 until 31 March 2018 was Dr José Garcia Lobera.

Details of Members of the Membership Body and Governing Body Details can be found on NHS Southend CCG's website here
http://southendccg.nhs.uk/about-us/our-governing-body

Attendance

Committee	**Attendance (April 2017-March 2018)**		
Voting Governing Body Members	**Eligible to Attend**	**Attended**	**Percentage**
Dr José Garcia Lobera Chair	6	6	100%
Dr Sreeman Andole Secondary Care Consultant	3	2	67%
Dr Kate Baruysa GP Representative	6	6	100%
Dr Krishna Chaturverdi GP Representative	6	4	67%
Tricia D'Orsi Chief Nurse	1	1	100%
Janis Gibson Lay Member (PPI)	6	5	83%
Margaret Hathaway Interim Accountable Officer and Chief Finance Officer	6	5	83%
Dr Brian Houston GP Representative	6	2	33%
Dr Fahim Khan GP Representative	6	6	100%
Dr Kelvin Ng GP Representative	6	3	50%
Matthew Rangué Chief Nurse	5	5	100%
Nicholas Spenceley Lay Member (Governance & Risk)	6	6	100%
Ian Stidston Accountable Officer	3	2	67%
Dr Taz Syed GP Representative	6	3	50%

Non-voting Members of the Governing Body
Mr Robert Shaw Joint Director of Acute Contracting and Commissioning
Dr Andrea Atherton Director of Public Health - Southend Borough Council
Jacqui Lansley Joint Associate Director of Integrated Commissioning

Committee(s), including Audit Committee

Audit and Risk Committee

The committee is required to meet at least five times per year and provides assurance to the governing body in relation to governance, risk management, internal control, internal and external audit and counter fraud. The committee has delegated responsibility from the governing body to review and approve the annual accounts and the annual report.

The committee reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

The composition of the Audit and Risk Committee was as follows during 2017/18:

Members:

- Lay Member for governance (chair of the committee throughout the financial year 2017/18)
- Two other Lay Members
- One GP Governing Body Member.

The Chair of the Governing Body shall not be a member of the committee but is entitled to attend each meeting.

Attendees:

- Internal Auditors and Local Counter Fraud Services (Mazars)
- External Auditor from KPMG
- Chief Finance Officer
- Chief Nurse (minimum attendance requirement is one meeting per year)
- Chief Officer (minimum attendance requirement is one meeting per year)

The committee will be quorate with two members, one of which should be a CCG Lay Member.

Quality, Finance and Performance Committee

The Quality, Finance and Performance (QFP) committee will meet a minimum of ten times per year, with extraordinary meetings at the request of the Committee Chair. The committee continually seeks improvement in quality and places the patient (and the public) at the centre of everything that it does. Its overall purpose is to ensure the CCG fully integrates quality and effective use of resources in all its commissioned services and ensures, through effective financial management, the achievement of economy, effectiveness, efficiency, probity and accountability in the use of resources.

The committee continues to monitor the CCG's financial position and performance, as well as regularly reviewing the corporate risk register and approving internal policies. The committee also monitors Key Performance Indicators and QIPP targets. The committee has also approved certain procurement routes in line with guidance available to it, supported by robust advice from its commissioned procurement service.

Members:

- Accountable Officer
- Secondary Care Consultant*

- Four GP Governing Body Members (including the CCG Chair when a GP)*
- Lay Member Governance*
- Lay Member PPI*
- Chief Nurse
- Chief Finance Officer
- CCG Chair (if the CCG Chair is not a GP Governing Body Member)
- GP Clinical Lead for Quality (if not already one of the four GP GB members)
- Lead Senior Commissioner
- Head of Risk and Assurance (non-voting)

*these members are eligible to act as Committee Chair

Each meeting of the QFP committee is quorate when two of the GP members, Chief Nurse and the secondary care consultant are present and two of the executive and lay members are present.

Clinical Executive Committee

The clinical executive committee (CEC) is the driving force behind the CCG's innovation, driving forward the development of new clinical pathways and delivering robust review and performance challenge. The committee meets monthly but members work on many projects between meetings, with a primary focus on service redesign. CEC ensures the CCG's integrated plan is executed in full with the resultant continuous improvement in the quality and outcomes for patients and carers and a reduction in health inequalities across Southend.

The membership of the committee is as follows:

- GP Governing Body Members including the GP Chair
- GP clinical leads
- Accountable Officer
- Chief Finance Officer
- Chief Nurse
- Director of Transformation and Primary Care
- Associate Director of Acute Commissioning
- Associate Director of Medicines Management
- Public Health Consultant
- Governing Body Local Authority Representative

Each meeting will be considered quorate when a minimum of two-thirds of the total number of GP governing body and clinical lead members, plus at least two CCG Executives from the following (or their nominated deputies):

- Accountable Officer
- Chief Finance Officer
- Chief Nurse

Remuneration committee

The committee makes recommendations to the governing body in relation to very senior manager pay and any changes to an individual's NHS pension arrangements by virtue of working for the CCG.

The committee will also make recommendations to the Governing Body about determining remuneration for CCG executive directors, the remuneration and conditions for all other employees and recommendations on severance payments.

It has no decision- making authority; rather it makes recommendations to the governing body.

Meetings of this committee are convened when needed with reviews taking place at least once annually in accordance with terms and conditions. Members met 6 times during 2017/18.

The membership of the committee is as follows:

Voting Members:

- Lay Member – Governance (Chair)
- Lay Member for Patient & Public Involvement
- Secondary Care Doctor/Consultant

Non-Voting Members:

- CCG's HR business partner – advisory capacity

The meeting will be considered quorate when two members are present, at least one of which must be a Lay Member of the Governing Body.

Register of Interests

Governing Body members' register of interests is available on our website at: https://southendccg.nhs.uk/about-us/key-documents/320-nhs-southend-ccg-governing-body-declarations-of-interests-register/file

Personal data related incidents

There were no Serious Untoward Incidents relating to data security breaches in 2017/18.

Statement of Disclosure to Auditors

Each individual who is a member of the CCG at the time the Members' Report is approved confirms:

- so far as the member is aware, there is no relevant audit information of which the CCG's auditor is unaware that would be relevant for the purposes of their audit report

- the member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG's auditor is aware of it.

Modern Slavery Act

NHS Southend CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

FOI Requests

The Freedom of Information Act 2000 gives a general right of access to recorded information held by public authorities, subject to certain conditions and exemptions.

The CCG received 249 FOI requests during 2017/18. The CCG responded to 99.2% of these within the statutory timescale of 20 working days.

We certify that the CCG has complied with HM Treasury's guidance on setting charges for information.

NHS Constitution
The NHS Constitution became law in November 2009. It sets out the rights and responsibilities for staff and for patients and the public. For more information visit: www.nhs.uk/nhsconstitution

As a CCG, we are responsible for upholding and reinforcing the requirements of the NHS Constitution. We do this by:

- Monitoring compliance against the performance standards set out in the NHS Constitution and working with providers to develop recovery plans to improve performance where necessary.
- Reviewing patient feedback and complaints, and ensuring that lessons learned from incidents are appropriately cascaded to prevent a reoccurrence.
- Encouraging patient engagement and feedback through a variety of different forums
- Supporting staff to comply with the NHS Constitution through implementation of the Essex Workforce Strategy and CCG training, research and education plans.

Planning for Emergencies 2018

Within the Civil Contingencies Act, CCGs have a duty to be prepared for incidents and emergencies. CCGs are classed as a "category two" responder and are seen as a "co-operating body". This means we are less likely to be involved at the heart of the planning, but we will be heavily involved in incidents that affect the health sector through co-operation in response and sharing of information.

The Essex CCGs have an Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity Strategy to ensure that we can respond in accordance with the Civil Contingencies Act 2004, Health and Social Care Act 2012 and NHS England national policy and guidance, including the NHS England EPRR Framework 2015 and NHS England EPRR core standards.

In July 2017, our Emergency Planning team undertook a self-assessment against the NHS England EPRR Core Standards. There were four levels of compliance that could be achieved: full, substantial, partial and non-compliant. The CCG achieved "full" compliance.

Key work undertaken in 2017/18 to ensure continued full compliance included:

- business continuity planning
- training and exercising
- pandemic flu preparedness
- mass casualty preparedness

All CCGs in Essex share a generic Incident Response and Incident Coordination Centre Plan, which details establishing an Incident Coordination Centre and an Incident Response Team within the local CCG. These plans have been updated during 2017 to include the increasing expectations placed upon CCGs by NHS England in the event of an incident and to include key tools introduced to commanders at strategic training.

Business Continuity Management (BCM) is a statutory requirement for all Essex CCGs. Suitable plans aligned to the international Business Continuity Standard ISO22301 have been established to enable us to respond to an internal incident or disruption.

The BCM process is supported by a CCG Business Continuity Management System and Policy and the CCG's individual Business Continuity Plan (BCP). Our BCP outlines response and recovery arrangements and how we would mitigate the impact of a business disruption on the operations and reputation of the CCG. The BCP was tested this year during the NHS Cyber-attack incident in May 2017.

The CCG Emergency Planning team has strong partnership working with NHS England Midlands and East (East) and with local providers and ensures the CCG is a key partner in the Local Health Resilience Partnership and the Essex Resilience Forum.

Audit Arrangements

KPMG LLP are the appointed external auditors from 1.4.2017 by the Governing Body of the CCG. The total planned fee for the 2017/18 audit was £30,201(exc VAT).

No other work was carried out by KPMG LLP during 2017/18.

Improving Care

NHS Southend CCG has worked with our providers to improve care and implement the quality and safety agenda by promoting and embedding the NHS constitution.
The CCG has:

- acted effectively, efficiently and economically
- worked to increase internal and provider awareness with regard to the need to reduce inequalities
- promoted the involvement of patients and carers in decisions about their healthcare
- acted with a view to enabling patients to make informed choices
- obtained appropriate advice and consulted with a range of health professionals and stakeholders to improve the quality and safety of our patients' service provision
- promoted innovation within practice

Here are some examples of how working with our providers, other partners, we have improved care during 2017/18:

Hospital Services

Integrated Dermatology Service
Due to the increasing number of referrals to the acute provider for dermatology treatment, and the existing community dermatology service contract expiring a new service was developed with the GPs. The aim of the new service is to reduce the number of patients receiving their dermatological services within an acute hospital environment and maximise the appropriate diagnosis, treatment and management of skin conditions in a community service. The new model incorporates all dermatology conditions except Cancer and phototherapy, these services will remain in the acute Trust.

Following procurement, the new Integrated Dermatology Service commenced in November 2017 and is provided by Basildon & Thurrock University Hospital (BTUH) who sub contract to About Health and the GP Healthcare Alliance. The service is consultant led and provides assessment, treatment and management of skin conditions. The model developed for this service has four stages or care, patient self-management, GP management, community care and acute care. This model ensures that patients are appropriately managed as per their condition and encourages patient and GP management via education and support. If patients do require support from the community or acute element of the pathway there are regular local clinics available.

Outpatient Reduction
The CCG has worked closely with Primary Care and Southend University Hospital Foundation Trust (SUHFT) to focus on 11 specialities to reduce outpatient activity, where appropriate. The aim of the project is to ensure that patients are following the correct pathway of care and are being seen in the correct clinic. Throughout the project pathways and tops tips have been established for Primary Care to follow before referring patients. Diagnostics have also been reviewed and 24 hour cardiology tests are now carried out in the community only. This ensures that diagnostics are carried out closer to the patient's home and before their first clinic appointment.

Alongside this E-Referral services have been developed in preparation for the 'paper switch off' in June 2018. A number of specialities have developed a Clinical Assessment Service (CAS) where all referrals can be triaged by the acute clinicians and triaged to the appropriate clinic. Advice and Guidance usage has increased throughout the year and in January there were 197 requests with an average response time of 3.2 days.

Atrial Fibrillation
An Atrial Fibrillation (AF) Locally Commissioned Service has been implemented in Primary Care to reduce the number of AF related Strokes. The service supports the screening and management of patients who have AF.

AF is the most common sustained heart arrhythmia in the UK which affects at least 1.5 million people and accounts for between 3-6% of acute medical admissions. Every year in England approximately 150,000 people have a Stroke, AF related Strokes are more severe and cause greater disability.

The current England prevalence is 1.71% and in south east Essex the practice prevalence ranges from 3.02% to 0.72%. AF is currently a Quality Outcome Framework (QOF) indicator which requires practices to have 70% of their AF patients recorded and being treated with anti-coagulation drug therapy. As the threshold is 70% the local service has been commissioned as an incentive to ensure that the other 30% of patients are being treated appropriately. This will increase practice prevalence and decrease the amount of AF related Strokes.

Diabetes
The number of people living with diabetes in the UK tipped over 4 million in 2016. As this number continues to escalate, the need for the NHS to commit to providing adequate care and diabetes education is more urgent than ever. In January 2017 a new service was launched that aims to bring care for adults with Diabetes under one umbrella.

The aims of the service are to improve patient experience and reduce ill health and complications due to diabetes through:

- Single point of contact and triage for all diabetes referrals
- Consultant led community clinics
- Full dietetics service for diabetic patients
- Dedicated podiatry service
- Increased patient education capacity
- Robust support and education in primary care
- A new local Insulin Pump service

Since January 2017 patients with Diabetes have been seen in community clinics across the south east Essex area and over 2000 patients who previously had to journey to hospital to see the teams there can now see their Consultant in clinics in Benfleet, Westcliff, Rochford

or Southend. There has been an increase in the number of patients reporting they feel supported and empowered to manage their condition effectively.

Throughout the next few months we will be undertaking a formal evaluation of the service to allow us to determine if it has met the success criteria laid out at the beginning of the service mobilisation and to guide the onward commissioning decisions regarding the future direction of Diabetes care.

Ophthalmology
Sight loss is one of the major health challenges facing the NHS and addressing its cause is a national as well as local health priority. Currently nearly 10% of all outpatient appointments and 6% of the surgery in the UK is focused on eye care.

For our local eye services there are approximately 20,000 new referrals each year (c1500 per month), and the need for follow-up care continues to grow with c50,000 follow up appointments last year.

The local health system has been working closely to improve and transform services and where appropriate this may mean that many appointments that were previously carried out in hospital eye services can now be done safely and conveniently at a high street Optician.

The transformation work in mid and south Essex has been gradually implemented over the past two years and whilst it is growing in momentum across the STP there is much to be celebrated already. The following pathways are now in place:

Glaucoma Repeat Readings service: Patients with high ocular pressures i.e. possible glaucoma, can have further diagnostic tests in 18 community Optometric practices to avoid the need for many to go to Hospital Eye Service. Since November 2016 over 1,000 patients have been seen in community providers, 722 hospital referrals have been avoided and patient satisfaction with the service is reported at 98%.

Children's Enhanced Service: School nurses who have identified children requiring further investigation following reception age vision screening can now refer to the new community Children's service. It is expected that 400 children will be seen in local Optical practices each year, saving over 1,000 hospital appointments.

Glaucoma Monitoring Service: Over 1,500 patients have been transferred to the community service in south Essex for monitoring meaning these saved hospital appointments can be used for other patients.

Post-operative Cataract: The first STP wide pathway enables patients who are considered appropriate by surgeons having their cataract procedure in the hospital and then post-operative checks at a local Optometric practice 4 – 6 weeks later.

This scheme has had excellent uptake by Optometric practices with 92 practices of 111 in our STP area signed up. 58 are already delivering the service and 34 are undergoing final training and accreditation checks.

Up to 90% of all patients are expected to ultimately have their checks in the community. The scheme launched in January. To date 50 patients have been transferred out and the first 10 have had their checks successfully completed.

The next key step in the transformation programme is the introduction of primary care pathways across the STP.

Mental Health, Learning Disabilities and Dementia Commissioning
Southend CCG, Castle Point and Rochford CCG and Southend Borough Council have a single integrated commissioning team for mental health, learning disabilities and dementia. We are working with other CCGs and local authorities across the mid and south Essex STP and greater Essex to co-ordinate our efforts in a shared response to the priorities identified in the *Mental Health Five Year Forward View* and our common wider goal of transforming mental health services for our populations set out in the *Southend, Essex and Thurrock Mental Health Strategy*. Local people have told us that the things that would make the biggest difference to their lives are:

- 24/7 mental health crisis care including meaningful alternatives to admission, liaison psychiatry and a more integrated approach with police and other agencies.
- Ensuring that people can get rapid access to the most effective treatment and support to shift the focus to earlier intervention and prevention.
- Developing approaches that more effectively integrate mental and physical health services to better meet the needs of people who may have complex health problems.

Plans for transforming our local mental health services to achieve these goals are being developed and implemented and a substantial amount has been achieved over the past year.

Children and young people's mental health – This is overseen by the Essex wide Collaborative Commissioning Forum and a dedicated commissioning team based in West Essex CCG. Southend CCG has allocated an additional £567k to support the transformation of mental health services for children and young people and the development of a specialist eating disorders service.

Perinatal mental health – There has been a successful county wide bid (£1.126m in current year) for development of specialist community perinatal mental health services, linked to the local mother and baby unit in Chelmsford in line with Mental Health Strategy proposals. A local action plan has been developed with proposals submitted through the Southend Success For All partnership board. A South East Essex Perinatal Mental Health Steering Group has been established to ensure local oversight, co-production and engagement in the work.

Common mental health problems – Southend CCG has invested additional £202k recurrently into local primary care psychological therapies service to achieve higher levels of performance for people with common mental health problems like anxiety and depression. Plans emphasise a more integrated approach including further expansion to provide for people with long term physical health problems. There will be further expansion of these services in 2018/19 with an increased focus on integrating this work with other service areas as part of the development of locality based approaches.

Community mental health services – The focus will be on the integration of community mental health services into the new locality approaches to developing expanded primary care services. The CCG has invested an additional £139k in the EPUT Early Intervention in Psychosis Service, including funding for additional capacity to support more people into education and employment. The REACH project, a pilot by SBC and the CCG, will provide a wider range of help for people with recurrent and relapsing mental health problems, shifting towards prevention, earlier more effective intervention, and recovery orientated multi-disciplinary approaches in localities.

Acute inpatient and crisis care – Thurrock CCG leads on developing 24 /7 mental health crisis services across the mid and south Essex STP. Southend has invested in the street triage service to extend its hours of operation, resulting in a 42% reduction in the number of

people detained under section 136. South Essex has received £700k to expand the existing liaison psychiatry services, enabling a range of interventions to reduce avoidable admissions for people with dementia and other long term conditions, and to provide a higher level of 24/7 mental health crisis support for people presenting at Southend Hospital A&E Department. There is consensus about the need to review inpatient mental health services across the county with a view to reducing reliance on them by expanding the work of crisis resolution and home treatment teams to provide more focus on treatment and better support at home.

Throughout 2017/18 we have consistently maintained a dementia diagnosis rate in excess of the national target set for the NHS. This provides a strong foundation for the work we will be undertaking going forward on integrating services for people with dementia into the four localities that will increasingly become the focus of how NHS and social care services will meet the needs of local people.

Transforming Care
We are working with the other CCGs and local authorities across greater Essex to re-design pathways for adults with learning disabilities and/or autism under our Transforming Care Partnership to ensure the delivery of the right outcomes for people wherever they live including the development of interfaces between both autism services and specialist learning disabilities services, mainstream mental health and substance misuse services and the Criminal Justice System. We have three priorities:

- To improve quality and reduce costs in services for people with a learning disability and / or autism
- To contribute to the Essex Transforming Care Partnership Board target for reducing the number of people with a learning disability and / or autism who are in hospital and reduce inpatient bed capacity based on a reduction of between 14-22 admissions a year.
- To comply with specific NHS England requirements

Children and Young People's Emotional Well Being and Mental Health service (EWMHs)
The Southend Essex and Thurrock children and young people's five year Local Transformation Plan (LTP) '***Open up Reach out'*** sets out the agreed priorities for service development and improvement in children and young people's mental health services in order to fulfil the national requirements set out in 'Future in Mind' (FiM) published in March 2015, and – Implementing the Five Year Forward View (FYFV) for Mental Health, published in July 2016.

During Year 3, (2017/18) commissioning partners across Essex continued to invest in the service developments and priorities identified during Years 1 and 2 of the LTP. Additionally in Year 3 of our plan, a growth in national funding created the opportunity to increase our investment from £3.3 million per year in 2016/17 to a planned investment of £5.3 million 2017/18.

Year 3 has been a continuation of service delivery and improvement in those priority service areas already enhanced. Specific service developments addressing our priorities in Year 3 included:

- implementing the Learning Disability CAMH service across Southend Essex and Thurrock**,** improving neurodevelopmental provision
- piloting the Kooth online counselling service, improving use of digital technologies
- producing the Self-Harm management Toolkit for schools, building community resilience

- delivering Phase one of the EWMHS school-education programme, building capacity and capability in the system
- reviewing our Crisis and Transitions service offers, improving access and equality

The 2017 LTP refresh for Southend Essex and Thurrock was published in December 2017 and is available for review here: https://southendccg.nhs.uk/policies/1188-mental-health-services-for-essex-open-up-reach-out .

Community Paediatric Health Services

The CCG in collaboration with Southend CCG approved project initiation to review and transform the delivery of paediatric community health services in South East Essex. The vision is to provide the children of South Essex with the best possible opportunity to access high quality care in the most appropriate place at the optimal time. The project will realise the following outcomes:

- Commission sustainable, high quality outcome focused services that produce the best possible opportunity for children and families to lead health and fulfilling lives
- Ensure all children in need of services have access to high quality care
- Empower families and children to be resilient, remain at home and manage their own health needs with the support of community and primary health care services, maximising Locality Approaches upskilling the role of primary care and locality based approaches to manage care.
- Reduce avoidable A&E attendances and admissions through early intervention and prevention measures for child health
- Reduce variation in the care delivered through training and use of integrated pathways, preventative approaches (including respective 0-19 pathways) and maximising the locality/neighbourhood approach to care.

Initial stakeholder engagement has been undertaken with Southend's Success for All Children's Partnership Board, Parent and Carer Forum and South East Essex GP Time to Learn forum. The project has collated financial and data intelligence in order to build the case for change, undertaken site visits and a literature review of alternative available models and has secured specialist commissioning resource to comprehensively redesign community health for children, young people and families.

Through South East Essex Service Development Improvement Plans with core providers the Integrated Paediatric Community Nursing model has been successful in delivering to specification in the year 2017-2018 whilst also expanding its reach with for the specialist Asthma and Allergy Nursing component to children below the age of 2. This development has improved access and support for children, young people and their families in south east Essex in managing respiratory related conditions independently.

The South East Essex Diabetic Service has commenced local initiation of diabetic pumps for children. An insulin pump is a small device (a little larger than a pack of cards) that delivers insulin into the layer of fat that sits just below the skin (subcutaneous tissue). Because the insulin pump stays connected to the body, it allows the wearer to modify the amount of insulin they take within the press of a few buttons at any time of the day or to program in a higher or lower rate of insulin delivery to occur at a chosen time, which can be when sleeping.

Autism Spectrum Condition (ASC)

The Children's commissioning team have piloted additional Autism Assessment Services for children with suspected ASD. The pilots have resulted in excellent feedback from families and have reduced current waiting lists and times for assessments. These pilots have also

enabled South East Essex CCGs to cement plans for 2018/19 to continue to expand capacity in order to further reduce waiting lists and timeframes for assessment. Our efforts continue, in partnership with Castle Point and Rochford CCG, to significantly reduce the waiting list for ASD diagnostic assessments by March 2019.

The CCG has contributed to the work of the Transforming Care agenda on a Pan-Essex basis and has also actively engaged with the Southend Autism Partnership Board to develop joint priorities for delivering services for supporting children and young people with autism and their families and how we intend to achieve these. Through this forum we have contributed to the development of additional support in collaboration with local voluntary sector organisations to expand peer support opportunities within Children's Centre provision.

Education, Health and Care Planning for Children and Young People
The CCG remains committed to its statutory duties from the Children and Families Act 2014 and Special Educational Needs and Disability (SEND) code of practice. Under the new legislation, the CCG has a statutory obligation to work in partnership with Education and Social Care to ensure the health needs of children and young people with SEND are met appropriately. The CCG, our providers and Southend Borough Council are on track to convert all Statements of Educational Need to Education, Health and Care Plans by the Statutory deadline of 31 March 2018. The development of Joint Commissioning Frameworks for the provision of SEND with Southend Borough Council are continuing to be developed across a range of needs.

Maternity
The CCG acknowledged the outcome of the Maternity Review: Better Births 2016 and contributed to the development of our Local Maternity System plan which was approved across the STP footprint by the Joint Committee. The plan sets out how maternity services across Mid and South Essex will be transformed over the coming years.

Primary Care Co-Commissioning
We have a number of significant programmes of work to build a more resilient and sustainable primary care to over the next 2 – 5 years. These include the following:

- m and member practices supported the CCG's application to move to fully delegated co-commissioning of primary medical services. This delegated responsibility commenced 1 April 2017 and has helped drive local transformation of primary care at pace.
- We have established four localities in Southend serving populations of between roughly 40-60,000 people. Our community and social care services are integrating and restructuring how they provide care to meet the needs of the different localities. Our GP practices, within each locality, have been working with the CCG to consider how they can create alliances across localities that allow delivery of enhanced services at scale. These alliances are key to transforming primary care and creating a more resilience General Practice for the future
- We are investing in Enhanced Access within in Primary Care much of which will come to fruition in next year in 2018/19. This year we mobilised additional access through two weekend hubs (one in central Southend and one in Shoeburyness) that provide GP / Nurse appointments on Saturday, Sunday and bank Holidays.
- We are supporting GP practices in each of the localities to consider their plans for Enhanced Access in the future that will enable them to better manage the rising demand on primary care. We have agreed our delivery plan for General Practice Forward View (GPFV) in conjunction with the mid and south Essex STP. As part of our delivery of this plan we are progressing a number of initiatives, such as a programme to recruit EU GPs to Southend. Our first two practices saw their first two GPs start work in Southend in September 2017

- We have implemented an Enhanced (GP-led) service to provide dedicated support to residents of care homes. This is currently being fully mobilised and aim to have 100% coverage in July 2018.

GP engagement
We engage with individual member practices via dedicated Time to Learn sessions and membership forums. This is used to consult with practices about commissioning plans and proposed service developments, as well as providing clinical training for GPs and nurses for specific areas and via this programme, member practices are able to engage more fully with CCG planning and commissioning.

CCG Member Practices and their respective Patient Participation Groups have once again been active in reaching out to local residents in the community to develop engagement and involvement activities.

Developing clinical engagement in the future
In 2018/19, we are looking to develop a stronger practice nurse forum, this will provide the practice nurse workforce with the opportunity to discuss and experience good practice, review new evidence based guidance and provide the nursing workforce with the forum and platform to engage in meaningful discussion.

The development of the forum is in direct response to the 10 point action plan developed by NHS England, and aims to improve retention within the practice nurse workforce.

Currently, the practice nurse forum is in the initial phases. This is including communications with the locality practice nurses, to ensure that the forum is functional in need and purpose. There has, to date, been 2 clinical education sessions held. The topics discussed were diabetes and clinical mentorship update. The aim of the education sessions are to ensure that the practice workforce has access to relevant and up to date evidence based practice.'

QIPP
Quality, Innovation, Productivity and Prevention (QIPP) is a national, regional and local level programme designed to support clinical teams and NHS organisations to improve the quality of care they deliver, whilst making efficiency savings that can be reinvested into the NHS.

The Health and Social Care Act (2012) outlines the Government's commitment to ensuring that QIPP supports the NHS to make efficiency savings, which is reinvested back into the service to improve the quality of care.

The QIPP programme improves quality and innovation, so that every pound spent brings maximum benefit and quality of care to patients. In order to meet the NHS forecast spend on health care, the service needs to achieve up to £30 billion of efficiency savings by 2025, which will be reinvested back into frontline care for patients.

As part of this programme each NHS organisation is required to deliver QIPP savings year-on-year to contribute towards this overall savings target. Southend CCG's QIPP target for 2017/18 was £18.2m and the CCG's actual year end delivery was £12.6m.

The QIPP agenda continues to be driven by the CCG, with strong clinical and management leadership to ensure process improvement, redesign and a clear system of project delivery. Delivery of our QIPP plans is managed through the Programme Management Office (PMO). To support this, the CCG has a dedicated Head of PMO and a QIPP Finance Lead to work with project leads and stakeholders to develop robust, deliverable plans. In 2017/18, the CCG extended its activity and financial analysis processes for our QIPP programme,

enabling both detailed planning and strong monitoring processes, supported by key members of the Business Intelligence and Contracting team of the CSU.

New for 2017/18 was the agreement with our local providers SUHFT and EPUT, to enter into the development of certain QIPP schemes as partners, to provide a concerted joint and mutually beneficial approach.

This joint programme is intended to further reduce acute activity (in particular emergency attendances and admissions), provide patients with improved access to community services and improve preventive action.

Changing the traditional approach to QIPP delivery has involved establishing close working relationships which are both contractually based and formed through agreement of shared goals and benefits. This has provided the opportunity to enable resolution of a significant barrier to achieving contract sign-off for 2018/19 onwards, by virtue of the jointly managed QIPP schemes and decision-making at the new joint QIPP programme board – joint actions, joint benefits and subsequent agreement in contracts.

Progress on the overall QIPP programme implementation and delivery is now monitored through the Financial Recovery Group. The function of this group has been developed with revised terms of reference and a focus on Executive ownership and reporting of QIPP scheme progress. The (PMO) has continued to develop its assurance role, with weekly reports to the FRG.

The PMO acts as a link between strategic planning and delivery of plans, to ensure that optimal benefits are realised. A member of the CCG Executive oversees each scheme in order to ensure that milestones are met and any barriers to delivery are quickly addressed. Each scheme has a dedicated clinical lead, working with project managers on the implementation of the schemes. All schemes have a detailed project plan and defined methods of measurement.

The QIPP schemes are reviewed at regular intervals with each of the programme leads and then by exception at the FRG. Delivery is reviewed by our Governing Body and the Finance and Performance Committee as part of the monthly finance reporting.

Although the CCG now has a rolling QIPP planning process rather than an annual QIPP cycle, with schemes initiated throughout the year, there has been a rigorous process to identify QIPP schemes for 2018/19. This began in mid-2017 and has entailed reviewing CCG and provider performance against a range of benchmarking data. Instrumental in this has been support provided by NHSE in terms of funding external expertise to assist in analysis and development of schemes and adopting improvements indicated by Right Care data.

Some of the QIPP schemes implemented in 2017/18 are highlighted below:

Continuing Health Care
The 2017/18 CHC QIPP programme savings realisation for was mostly dependent on robust delivery of package reviews and increased team productivity.

The programme was made up of the following schemes:

- Care Reviews: Timely completion of CHC reviews to ensure only patients still deemed eligible for CHC are in receipt of the right level of care.
- Contract Negotiation: Placement officers reviewed existing cases negotiating with providers to achieve fairer market prices. New packages were also negotiated to achieve value for money.

- Occupational Therapist Reviews: Use of Occupational Therapist (OT) to review existing care packages to deliver efficiencies through the promotion of independence via equipment.
- Fast Track Reviews: Completion of FT reviews within one month of eligibility supported by a dedicated in-reach service with the Trust to minimise inappropriate usage of the pathway.

Medicines Management

A range of Medicines Management schemes were implemented that seek to promote safe, cost-effective prescribing through better application of guidance, standardisation and best practice prescribing. Examples include:

- Patients over the age of 75 years old and taking 10 or more medicines have been identified and reviewed, in order to ensure that their medicines are still effective and that patients are not experiencing any problems.

- Patients receiving warfarin, whose time in therapeutic range appears to be inappropriate have been identified, their medication reviewed and where necessary changed, resulting in a reduced risk of stroke. This has been joint work between GP practices and Southend Hospital
- Formularies for stoma care, appliances and respiratory disease amongst others have been agreed between primary and secondary care to improve quality and consistency of local prescribing

Planned Care

- Dermatology: The project involved the implementation of an integrated community dermatology service to improve and enhance existing pathways and improve access to diagnosis, treatment and care within the community. The service will provide advice and support to primary care repatriating patients that would usually be referred to secondary care. Key outcomes of the project is to reduce first outpatient appointments and follow ups for patients with intermediate, primary and a proportion of acute skin conditions. (See Improving care section on page 45 for more details.)

- Service Restriction Policy: Service Restriction Policy updated with stricter criteria for specific procedures as agreed by Clinical Executives Committee; Governing Body and Public Consultation feedback. Alternative services and support identified for those patients affected by the service restrictions applied.

- Outpatient Reduction: This project involved working with the acute Trust and primary care to reduce outpatient activity within specialities that exceed the national activity trend. Through pathway redesign and the use of advice and guidance.

Joint QIPP Programme

- Respiratory –Referral Criteria: Implemented in 2017/18 as part of the Joint QIPP Respiratory project is revised first appointment referral criteria developed by local clinicians enabled by electronic System-One protocol.

- Falls Early Intervention Vehicles: Implemented in December 2017 a CCG commissioned early intervention vehicle which carries trained Paramedics and an Occupational Therapist working together, this car attends to most 999 calls in the area for falls, lifting patients, carrying out treatment at home if this is possible, provides them with holistic assessments, equipment and refers them to appropriate services. Leading to a reduction in ambulance conveyances, A&E attendances and non-elective admissions

- Care Homes: The care home QIPP aims to improve the support available to care home residents and the staff that care for them; ensuring they are educated in relevant health care principals, have regular and timely communication when they need health advice, whilst receiving regular visits with informed choices and health care planning for all. There are three elements to this approach, the main one being the Enhanced Care Home Service (ECHS), which is based on the one GP practice assigned to one care home principal aligned with the NHS Enhanced Health in Care Homes Framework. The second element concerns standardised training and education being provided to those care homes in most need, which helps to empower and support care home staff with their decisions of health care interventions.

Looking to the future: Transforming services

Since 1948, the NHS has constantly adapted itself and it must continue to do so as the world and our health needs also change. We are now able to treat people with new drugs and provide clinical care that wasn't available in the past. As life expectancy increases, so do the ailments of old age and there are now more people with chronic conditions like heart failure and arthritis.

There are also big opportunities to improve care by making common-sense changes to how the NHS works, to improve services and making things simpler.

This is why the NHS and local councils have come together in 44 areas covering all of England to develop proposals for health and care.

In 2016/17 each area produced a Strategic Transformation Plan (STP) for the next few years. With services feeling the strain, collaboration between organisations will give nurses, doctors and care staff the best chance of success. During 2017/18 we have continued the journey of local implementation of local health and care services.

Southend is part of the Mid and South Essex STP planning footprint.

Strengthening and transforming general practice plays a crucial role in the delivery of the STP. The General Practice Forward View, published in April 2016, set out national investment and commitments to strengthen general practice in the short term and support sustainable transformation of primary care for the future.

CCGs were required to translate the aims and key local elements of the General Practice Forward View into a more detailed local delivery plan.

2017/18 saw the development of an STP-wide Primary Care Strategy that builds on the Southend Primary Care Strategy. This has enabled continued delivery of the STP General Practice Forward View plan and the delivery plan specific to Southend

The plans set out the overall vision for primary care across the STP, including how this will improve primary care sustainability, access and quality. It sets out how this supports the transformation described in the STP and contributes to improving the quality of care.

The next section details how we have already begun on our journey to transform both primary care and community services in Southend as part of wider plans.

There are a number of ways we could deliver improved care in the community. This

could mean increasing the number of services delivered in GP practices, health centres or other public settings as well as developing new ones. Regardless of the location, a key focus in 2017/18 and beyond is making sure all services work in a more joined up way. To do this during 2017/18, agreement was reached to work, where appropriate, across south east Essex – this ensures greater collaboration and focus with a single provider of community services, for both physical and mental health needs, and a more aligned interface with the local acute hospital. We want to make sure all residents have access to high quality care in the community when they need it, making a trip to hospital only necessary when specialist help is needed.

Our vision continues to be to create locality networks of health and care that can reach out to its patients. We want to see better collaboration between GP practices to create practice groups who can work more efficiently at scale and reduce duplication, and the agreement to formally commission locality specific services to improve access to primary care services for the next five years. This arrangement will form a cornerstone of the emerging locality models.

Whether local network of health and care services have a single health centre operating as a hub, or services operating across several spokes, its acknowledged that services and professionals can work together to achieve more than if they continued separately.

Integrated Neighbourhood Teams
The Integrated Neighbourhood Care Teams bring together staff from different specialities and organisations (who may each have been looking after the same person individually) into a single client-focused team. Team members will have a common list of individuals living within the locality with different levels of risk, and they will give joint focus and effort to keep people well and independent in the community for as long as possible.

Enhancements to the Community Model
2017/18 also saw developments made in the approach to collaborative working between the two CCG's in south east Essex, the local acute hospital and the community services provider. Through this collaborative approach the system identified service gaps that if closed would help move the system towards a more sustainable footing.

This work led to the CCG Governing Body agreeing to invest in a range of service enhancements, covering service areas including end of life care, community heart failure services and night nursing that would result in improved patient care, and better patient outcomes.

The system also identified a service gap for alternatives to acute admissions for people who need immediate clinical intervention and care, but where an admission to hospital could be avoided. Significant investment has been identified to implement the SWIFT service which will be able to provide short-term reactive care for patients with a medical crisis that can be safely managed in their own home.

It is envisaged these community enhancements will further support the movement towards integrated local health and care solutions.

It is anticipated, following recruitment and mobilisation, that these service changes will be implemented during the first half of 2018/19.

Care homes

We continue to make excellent progress on our journey to transform care in local care homes by delivering a dedicated enhanced GP service to individual care homes. This project will see each care home align with a single GP practice. In doing so, Southend Clinical Commissioning Group (CCG) aims to prevent problems at an earlier stage, prevent avoidable trips to hospital and provide reassurance to residents and their families.

Benefits of the service include:

- regular planned ward-rounds
- regular reviews of medicines
- better monitoring of and management of patients including a plan for out of hours
- establishing better links with support/community services
- full assessment of all new care home residents
- establish care plan with patients goals and wishes
- good working relationships between GPs and care home staff/management
- health education for care home staff.

During 2017/18, we have increased the coverage of this this project to 60% of all care home beds, with the ambition to achieve full coverage during 2018/19.

Feedback continues to be very positive from both the homes and the aligned GP practice. The service provides more proactive care to care home residents and facilitates a strong relationship between General Practice and care home staff to deliver a more responsive service.

Southend Clinical Commissioning Group commissioned extra schemes during 2017/18 to improve the quality of care for our care home residents and ensure care homes receive proactive support whilst we align GP practices to each home.

More information about key achievements and challenges in 2017/18 specific to primary care (GP services) can be found on page 51 (Co-commissioning of primary care).

Digital innovation and Transformation

We work very closely with Castle Point and Rochford CCG who have led many of the digital innovation and transformation initiatives across the Mid and South STP footprint. This year we successfully secured £3.4m of capital investment across the STP for digital transformation initiatives.

There was £160k funding approved from NHSE for a telehealth project in Southend. Telehealth is a pilot that is part of the wider 'Deteriorating Patient' Workstream which 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). The aim of the project is to reduce A&E attendance, NELs, GP and out of hours appointments as well as improved access to UTI and Sepsis care. The Integrated Nursing Team and carers will be trained in the technology to support patients in using it. Patients' vitals are captured by the system and dedicated nurses continuously monitor these, calling patients if certain thresholds are breached; escalating this to GPs only if needed.

This year we have led the rollout of a free WiFi service to patients which will be available in all 201 GP practice buildings across the Mid and South Essex STP footprint. This will not only allow patients to connect to WiFi whilst sitting in the waiting room, but also allow health

care professionals to connect to their native IT applications; a foundation layer of our Digital Essex strategy.

We secured investment to work with i-Plato to deliver a method for patients to cancel their GP appointments by text or mobile phone app. Pilots already conducted in Castle Point and Rochford and Southend have shown consistently that on average, 25 slots per week per GP practice are released by their patients who utilise the iPlato technology (compared to the same data period last year, this has reduced the number of 'Did not Attend' appointments by 30%. The same investment will also provide patients with a free downloadable app (MyGP) which amongst other things will provide information on health promotion schemes, immunisation and medical alerts and offers access to Patient On-Line.

All of our GP practices this year have had an audit conducted of their buildings which has included network cable testing. This information will allow us to prioritise our funding in the coming year to invest in GP practice infrastructure to ensure they can deliver 21st century digital technology.

We secured further funding across the Mid and South Essex STP to enhance the mobile working capabilities of our GPs. This enables them to access the Electronic Patient Records of their patients wherever they are, for example when conducting home visits or visiting care homes.

Further investment has also been secured to install digital dictation technology to interested practices in Castle Point and Rochford and Southend to increase GP efficiency and also to equip some of our GP practices with video conferencing capabilities.

We have secured funding of £166k for new computers which enabled the replacement of 1/5 of our GP practice fleet.

Finally, we secured funding as part of the GP Forward View to begin to look at GP Online Consultation solutions.

Estates
The CCG is working towards developing locality estates strategies which link to our neighbourhood models.

Estates and Technology Transformation Funding (ETTF) was secured towards the St Luke's Health Centre new build; part of the regeneration of the St Luke's area in Southend and one of the first steps in developing a fit for purpose integrated health hub.

We are seeking opportunities for an integrated care hub in Shoeburyness and will be seeking to map our Estates Strategies to new models of care for this area.

The Southend CCG headquarters at Harcourt House will be closing during 2018 and we will be entering an exciting partnership working arrangement with Southend Borough Council to co-locate local NHS commissioners with our local authority partners.

Workforce
According to Health Education England (HEE), the Mid and South Essex Sustainability Transformation Partnership (STP) is the most significantly challenged primary care workforce in the country with 33% of GPs forecast to retire in the next five years which is significantly higher than the national average of 21%. The CCG recognises that due to the significant number of GPs who can retire by March 2020, the STP will be applying significant resources to work with the Local Medical Council (LMC) and the Royal College of General Practitioners (RCGP) to develop a local programme to retain GPs who are eligible to retire.

Within Southend CCG, we currently have 45 GPs in practices who are aged over 55 and 33 nurses who are also aged over 55 (Source: NHS Digital Minimum Data Set March 2017) who are eligible to retire within the next three years.

Within the CCG's geographical area, there are approximately 121 GPs and 78 nurses across 35 member practices who serve a population of 185,000 and approximately 19% of the population are aged over 65. This age group is set to increase to 21.2% by 2025.

The average member of the public now sees a GP almost six times per year, twice as often as a decade ago and the average time a GP spends with each patient is now just under 12 minutes. Demand on GPs in the country will only increase as the number of patients with long term conditions increases. This particular patient group currently makes up around 50% of all GP appointments. Southend has a higher share of people with three or more long term conditions (12.9%) than the England average (10.5%).

New models of care are being planned for Primary Care and many existing healthcare professionals will be able to expand/develop their roles to ensure that our patients will be seen by the most appropriate professional. On behalf of Southend CCG, NHS Castle Point and Rochford CCG who are the lead CCG for workforce in the Mid and South Essex STP recently submitted a workforce delivery plan to NHS England to implement a range of workforce initiatives, that include:

- International GP Recruitment
- Introducing new roles into Primary Care
    - Clinical Pharmacist
    - Advanced Nurse Practitioner
    - Physicians Associates
    - Emergency Care Practitioners
    - Advanced Practice Physiotherapists
    - Medical Assistants
    - Apprenticeships
- GP Retention
- Fellowship Programme
- GP Returners (Induction and Refresher Scheme)
- Promotion of practice based roles
- Up skilling practice nurses and existing roles
- Public communications for recruitment via schools/colleges/job fairs

Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) (the NHS Act 2006) states that each Clinical Commissioning Group (CCG) shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed Margaret Hathaway to be the Interim Accountable Officer of NHS Southend CCG.

The responsibilities of an Accountable Officer are set out under the NHS Act 2006, Managing Public Money and in the Clinical Commissioning Group Accountable Officer Appointment Letter. They include responsibilities for:

- The propriety and regularity of the public finances for which the Accountable Officer is answerable;
- Keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the CCG and enable them to ensure that the accounts comply with the requirements of the Accounts Direction;
- Such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error;
- Safeguarding the CCGs assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities);
- The relevant responsibilities of accounting officers under Managing Public Money;
- Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the NHS Act 2006 and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the NHS Act 2006; and
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the NHS Act 2006.

Under the NHS Act 2006, NHS England has directed each CCG to prepare for each financial year financial statements in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must give a true and fair view of the state of affairs of the CCG and of its net expenditure, changes in taxpayers' equity and cash flows for the financial year.

In preparing the financial statements, the Accountable Officer is required to comply with the requirements of the Group Accounting Manual issued by the Department of Health and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Group Accounting Manual issued by the Department of Health have been followed, and disclose and explain any material departures in the financial statements;
- Assess the CCGs ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and
- Use the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

To the best of my knowledge and belief, and subject to the disclosure set out below, I have properly discharged the responsibilities set out under the NHS Act 2006, Managing Public Money and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

Disclosure: the CCG deficit has been reported by the external auditors under Section 30(b) of The Local Audit and Accountability Act 2014.

I also confirm that:

- As far as I am aware, there is no relevant audit information of which the CCG's auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG's auditors are aware of that information; and
- The annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

Margaret Hathaway
Interim Accountable Officer
NHS Southend CCG

24 May 2018

Governance Statement

NHS Southend CCG is a body corporate established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended).

The clinical commissioning group's statutory functions are set out under the National Health Service Act 2006 (as amended). The CCG's general function is arranging the provision of services for persons for the purposes of the health service in England. The CCG is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population.

As at 1 April 2017, the CCG is subject to Directions from NHS England issued under Section 14Z3 of the National Health Service Act 2006 requiring the establishment of a Joint Committee with NHS Basildon and Brentwood CCG, NHS Mid Essex CCG, NHS Southend CCG and NHS Thurrock CCG. The CCG is to produce a Joint Commissioning Plan which is to be approved in advance by the National Health Service Commissioning Board and which shall include, but shall not be limited to:

- Detailing the functions of the CCGs to be delegated to the joint committee;
- The scheme of delegation to be developed to ensure the delegation of the functions of the CCGs to the Joint Committee
- The scope and nature of the financial delegation of Castle Point and Rochford to the Joint Committee; and

- The membership of the Joint Committee and the appointment of the Chair and lead officers.

Southend CCG shall at all times engage with the establishment of the Joint Committee and the subsequent participation in its operations.

During 2017/18 the Constitution of Southend CCG was amended to enable the establishment of the Joint Committee.

All elements of the Joint Commissioning Plan were approved by the Governing Body.

All elements of the Joint Commissioning Plan shall be approved by The National Health Service Commissioning Board.

NHS Southend CCG shall within 2 weeks of the completion of the Joint Commissioning Plan together with the CCGs agree a detailed implementation plan in accordance with the National Health Service Commissioning Board's instructions and shall subsequently implement that plan.

NHS Southend CCG will co-operate with the National Health Service Commissioning Board including but not limited to the prompt provision of information requested by the National Health Service Commissioning Board and making senior officers available to meet with the National Health Service Commissioning Board and to discuss the Joint Commissioning Plan, the implementation and the progress of the same.

The National Health Service Commissioning Board may direct NHS Southend CCG in other matters relating to the Joint Commissioning Plan and any variation to it.

The National Health Service Commissioning Board directs that NHS Southend CCG shall co-operate with the National Health Service Commissioning Board regarding the National Health Service Commissioning Board's oversight of Southend CCG's compliance with these Directions, including but not limited to the prompt provision of information, documents and records requested by the National Health Service Commissioning Board and making senior officers available to meet with the National Health Service Commissioning Board.

The clinical commissioning group's website can be found by following the attached link http://southendccg.nhs.uk/.

Scope of responsibility

As Interim Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the clinical commissioning group's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I am responsible for ensuring that the clinical commissioning group is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group as set out in this governance statement.

Governance arrangements and effectiveness

The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it. For more information about the Governing Body, its sub-committees and assessment of effectiveness is in the section below.

The main committees providing assurance to the Governing Body are:

- Audit and Risk
- Clinical Executive
- Quality, Finance and Performance
- Remuneration

The CCG's Constitution specifies a core purpose for each of those committees:

Audit and Risk – to provide the CCG Governing Body with an independent and objective review of its financial systems, financial information and its compliance with the laws, guidance, and regulations governing the NHS.

Clinical Executive – to support the Governing Body in setting the CCG's strategic direction (including primary care), developing plans and executing their delivery, providing clinical leadership to the transformation programme.

Quality, Finance and Performance – the over objective is to ensure that the CCG:

- Continually seek improvement in quality
- Places the patient (and the public) at the centre of everything that it does
- Fully integrates quality and effective use of resources in all commissioned services
- Ensures, through effective financial management, the achievement of economy, effectiveness, efficiency, probity and accountability in the use of resources.

Remuneration Committee – makes recommendations to the Governing Body on determinations about the remuneration, fees and other allowances for employees and for people who provide services to the CCG and on determinations about allowances under any pension scheme that the CCG may establish as an alternative to the NHS pension scheme.

Primary Care Committee – to carry out the functions relating to the commissioning of Primary Medical Services including the monitoring of contracts, design of PMS and APMS contracts, taking contractual action such as issuing branch/ remedial notices and removing a contract, commissioning Enhanced Services, design of local incentive schemes, approving practice mergers, making decisions on discretionary payment and promoting quality improvement within GP practice service provision.

The Governing Body has met once every two months. At March 2018, its voting members comprised the Chairman, 6 further GP members, one secondary care consultant. 5 Executive Directors, including the Accountable Officer and 3 lay members. Attendance and membership of the Governing body is available in the members report. The Governing Body and each of the main committees undertook a self-assessment.

The Governing Body and each of the main committees undertook a self-assessment of their effectiveness which was considered at its March 2018 meeting, with recommendations for improvements noted and implemented accordingly. The intention is that these reviews should take place annually, alongside a consideration of the work plans and terms of reference for each committee. The Governing Body regularly monitors an action plan to improve its effectiveness with there being no significant outstanding actions. The Governing Body has promoted the NHS Codes of Conduct and Accountability via its 'Principles and

Values' as set out in the Constitution for the CCG and assessed itself as being compliant with these Codes as part of its annual review of effectiveness.

To support the Governing Body in carrying out its duties effectively, committees of the Governing Body have been established under the constitution. The remit and terms of reference of these committees were reviewed during the year to ensure robust governance and assurance. Each committee submits its minutes regularly to the Governing Body and produces an annual report of its activities and any key findings.

UK Corporate Governance Code
NHS Bodies are not required to comply with the UK Code of Corporate Governance. However, the CCG recognises the UK Corporate Governance Code as best practice and has complied to the extent appropriate for the nature and size of the organisation.

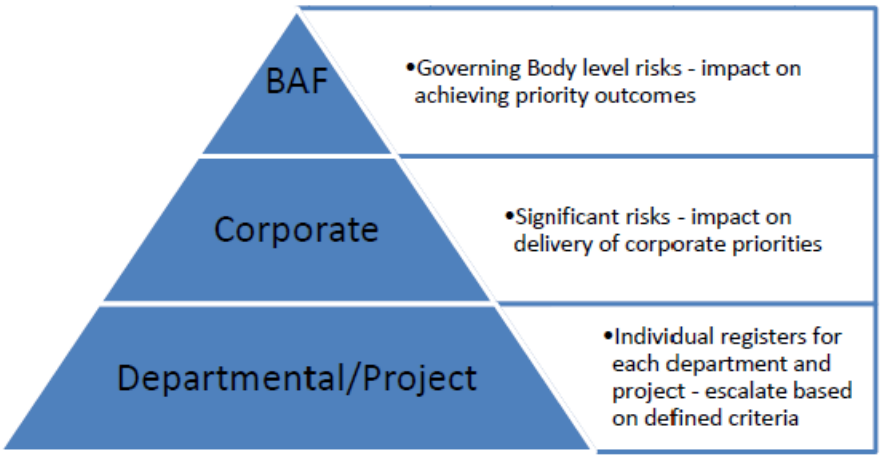
As part of its annual review of effectiveness, the CCG Governing Body and its subcommittees undertook an assessment of effectiveness which encompassed the relevant principles of the UK Corporate Governance Code. The Governing Body concluded from this assessment that it was generally following best practice in relation to providing effective leadership, having an appropriate balance of skills, experience, independence and knowledge to enable Governing Body members to discharge their duties and responsibilities effectively, presenting a balanced and understandable assessment of the CCG's position in its financial and other reporting, and ensuring that remuneration is set appropriately. Areas for improvement identified from the review of effectiveness.

Discharge of Statutory Functions
In light of recommendations of the 1983 Harris Review, the CCG has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the CCG is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the CCG's statutory duties.

Risk management arrangements and effectiveness
The CCG has in place a risk management strategy which is reviewed annually and distributed to all staff and key partners. The Audit Committee is responsible for developing and endorsing the Risk Management Strategy, which is ultimately approved by the Governing Body.

The diagram which follows reflects the overall approach taken by the CCG in relation to risk management and outlines the hierarchy of registers which will record risks to the delivery of specific pieces of work or the overall position of the CCG.



The Joint Board Assurance Framework is the CCG's principal tool for monitoring and managing the risks to the achievement of its strategic objectives and statutory duties. The Joint Board Assurance Framework (JAF), made up of the Board Assurance Framework (BAF) and Corporate Risk Register (CRR), includes the main local priorities (principal objectives) for 2017/18 identified in the CCG's Integrated Plan, identifies the effectiveness of the key controls to manage the risks against achievement of these priorities and the assurance provided for those controls, and includes the operational risks, the controls and assurance in place, and any actions to be taken to reduce the level of risk.

The BAF and CRR are updated on an ongoing basis with a formal review undertaken bi-monthly. The formal review is led by the Head of Governance and Risk Management who meets each risk owner to review changes in the controls and assurances and progress against actions agreed since the previous review.

Following each review, the overall risk profile is then considered by the Corporate Management Team and Clinical Executive Committee in order to agree their view of the 'top risks" being managed by the CCG. This view is then reported to the Governing Body to enable them to consider their own assessment of the risks in question.

The register is also reviewed as a standing item at meetings of both the Audit Committee and Quality, Finance and Performance. The Audit Committee's focus is on providing assurance to the Governing Body that the agreed system is robust and being appropriately applied. The Quality, Finance and Performance Committee's role is to review the actual risks and proposed mitigation actions. Their conclusions are reported to the Governing Body on a monthly basis.

The CCG's stakeholder risks are fed into the CCG's JAF through the following mechanisms:

- Presentation of the JAF at public Governing Body meetings with encouragement from the CCG Chair for members of the public to actively participate in the discussion.
- CCG staff who attend stakeholder meetings such as the Health and Wellbeing Board, Urgent Care Network and other multi-agency groups or boards are required to feed key risks back into the CCG's JAF/Corporate Risk Register where appropriate.
- Escalation of key performance issues by providers to the CCG.

During 2017/18 the CCG defined the amount of risk that it is prepared to accept, tolerate or be exposed to at any one point in time – its risk appetite – against a range of risk categories and added a target risk score to the JAF. This enables the Governing Body to identify those risks where more work needs to be done to bring the risk ratings to a level it is prepared to tolerate. The Governing Body has received training on the issues surrounding risk management during 2017/18 and it will continue to define its risk appetite during 2018/19.

The partnership mechanisms described previously are used to explore potential risks which may impact upon other organisations and public stakeholders. Additionally there are a number of cross organisation forums which support the process for identifying partnership risks.

The CCG provides statutory and mandatory training for all staff groups and sessions on risk management, health and safety, safeguarding, equality and diversity and information governance. Articles on risk management and health and safety regularly feature in internal bulletins and newsletters and internal training has been provided on risk management, adding a risk onto the JAF and incident reporting to all staff.
The CCG has a policy on the reporting and investigation of adverse incidents. Face-to-face training and written guidance and training had been provided to CCG staff in order to support the implementation of the policy.

Risk Assessment in Relation to Governance, Risk Management and Internal Control
The Governing Body has overall accountability for ensuring that the CCG has an effective programme for managing all types of risk and delegated the responsibility for ensuring that key strategic risks are identified and evaluated and that adequate responses are in place and monitored.

The Audit Committee has responsibility for reviewing the establishment and maintenance of an effective system of governance, risk management and internal control, across the whole of the CCG's activities in order to support the achievement of the CCG's objectives. The Audit Committee is chaired by the Lay Member with responsibility for governance and, as a sub-committee of the Governing Body, regularly submits its minutes to the Governing Body and produces an annual report of its activities.

The Quality, Finance and Performance Committee assist the CCG in the identification and management of operational risks. Operational risks are monitored on a monthly basis by the Quality, Finance and Performance Committee and reported to the Governing Body via the JAF. The Quality, Finance and Performance Committee is chaired by a Lay Member and, as a sub-committee of the Governing Body, regularly submits its minutes to the Governing Body and produces an annual report of its activities.

The March 2018 assessment identified the following as the 'top seven' risks to the CCG:

	Risk	Consequence	RAG
JBAF 4	Bed availability severly restricted due to emergency flows through th hospital. Also there is low availability of packages of care and short term care home placements	Failure to deliver 95% A&E Standard Long waits for ambulance off loads > 2hrs Shift an element of risk for medical patients from Acute back into community and primary care Risk to patient care with lack of ambulance	20

		availability due to blocked A&E	
JBAF8	Lack of GP workforce in Primary Care	Impact on the delivery of patient care. Loss of reputation. Increase in complaints. Risk to service delivery. Failure to meet out constitutional standards.	20
JCRR7	The Trust's SHMI remains above the national average	Risk of elevated risk of hospital associated deaths	20
CRR57	Patient harm within opthalmology service at SUHFT due to delays in outpatient appointments.	Patient harm including partial and total loss of vision. Financial implications. Loss of reputation. Increase in serious incidents. Patients are not seen within agreed timescales to appropriately monitor eye disease progression and plan timely interventions.	20
JBAF5	Impact on the delivery of the CCGs transformation programme due to the establishment of the STP, its systems and processes and possible disruption caused.	Local transformtion does not deliver expected benefits. Impact on financial balance. Staff anxiety resulting in a loss of morale, commitment and efficiency. Loss of staff. Loss of reputation. Impact on the achievement of expected benefits.	16
JBAF7	Failure to meet 2017/18 Constitution Standards	Risk to patients safey, reduced quality of service, poor patient experience and satisfaction. The CCG is expected to deliver, through commissioned providers, the NHS Constitution, in particular A&E 4hr waits, national waiting times for 18 weeks referred to treatment and cancer 62 day waits from urgent referral to first definitive treatment targets. Staffing shortages within primary care and the Trust also have a negative impact on performance to accomplish constitutional standards.	16
SCRR2	Increasing number of patients with respiratory conditions attending hospital because of lack of capacity and infrastructure to deliver holistic, high quality respiratory services across primary and secondary care.	Negative patient experience. Long waiting times resulting in unnecessary acute admissions.	16

Capacity to Handle Risk

- The **Chief Nurse** had delegated responsibility for managing the strategic development of clinical risk management and clinical governance.
- The **Chief Finance Officer** had delegated responsibility for managing the strategic development and implementation of financial risk management and for the strategic development and implementation of organisational risk management and corporate governance.

Notwithstanding the specific roles set out above, all managers are responsible for ensuring that appropriate and effective risk management processes are in place within their designated areas and scope of responsibility.

The risk management process is co-ordinated by the Head of Governance and Risk Management for non-clinical risks. Lessons are learnt through incidents, complaints and issues, internal audit recommendations, performance management and individual peer reviews, benchmarking information from the National Patient Safety Agency (NPSA), national inquiries and reviews. These lessons are shared with appropriate staff groups, via monthly staff briefings, Staff Involvement Group meetings, team meetings and through the organisation's internal newsletter, and Local Security Management newsletters.

Risk prevention and deterrence is also undertaken via proactive security and counter fraud risk reviews, proactive risk assessments, the dissemination of guidance on the requirements of the CCG's Standing Orders and Standing Financial Instructions, monitoring compliance against key CCG policies such as Information Governance, and regular staff awareness raising.

Staff have been trained and equipped to manage risk in a way appropriate to their authority and duties. CCG Governing Body members received Counter Fraud and Risk Awareness training at a Governing Body Seminar in 4th May 2017. CCG staff attended a mandatory staff training session on 12 January 2018 and 95% staff are level 2 compliant with the NHS Digital Information Governance toolkit.

The CCG obtains specialist support and advice in relation the management of risk associated with business continuity and emergency planning, resilience and response (EPRR) from a specialist EPRR team which is hosted by NHS Mid Essex Clinical Commissioning Group. This team provides services to all CCGs in Essex and operates under a service level agreement which is formally monitored on a bi-monthly basis.

Other sources of assurance

Internal Control Framework
A system of internal control is the set of processes and procedures in place in the clinical commissioning group to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

Through implementation of the CCG's Risk Management Strategy and horizon gazing tool the CCG has documented its processes and arrangements for the structured identification and evaluation of risk and internal control.

The processes in place within the CCG include:

- Identifying and recording risks.
- Evaluating risks using defined criteria which are applied consistently across the organisation and reviewed on a quarterly basis with Operational and Executive risk leads.
- Communicating risks within the organisation including the level of authority at which a risk can be accepted or managed.
- Implementing the control measures to mitigate or prevent exposure to a given risk;

- Evaluating those controls and identifying additional controls that need to be put into place.
- Reporting of compliance against governance processes and procedures through standard reports to the CCG's Audit Committee and Governing Body.
- Prioritising programmes of work in line with the CCG's Corporate Objectives.
- Ensuring procurement processes and procedures are adhered to and expert advice sought from Attain, providers of the CCG's procurement service where necessary.

Annual audit of conflicts of interest management
The revised statutory guidance on managing conflicts of interest for CCGs (published June 2016) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework.

With the support of the CCG, the internal auditors carried out the annual internal audit on Governance, Assurance Framework and Risk Management of which, conflicts of interests was part of, during January 2018. The internal Auditors gave Satisfactory Assurance and the recommendations for Southend were.

- Review of the Constitution and the terms of reference for the GB sub committees
- All Sub Committee minutes should be presented and considered by the Governing Body
- Register of Interests should be bought up to date and updated on a quarterly basis
- Sub –committees should carry out self-assessments on an Annual basis
- Organisational Development Strategy should be reviewed annually

The CCG continues to work with GP members to ensure that all declarations of interests are received from our GP members.

The CCG has worked with the Procurement Team to ensure that a Register of Procurement Decisions is created and published on our website during 2017/18.

Data Quality
The CCG submitted a satisfactory level of compliance with the information governance toolkit assessment at level two. This compliance level was reassessed during 2017/18 and remains at level two.

The CCG uses a number of mechanisms to check data quality throughout the organisation, including benchmarking information and comparison against previous datasets to identify areas that stand out as being potentially inaccurate.

A Data Quality Policy has been adopted and is available to staff.

The CCG is reliant on the CSU's staff in a number of areas to provide accurate information and has worked with them to improve the quality of data provided.

Information Governance
The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the clinical commissioning group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

The CCG places high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and have developed information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff information governance resource guide to ensure staff are aware of their information governance roles and responsibilities.
There are processes in place for incident reporting and investigation of serious incidents.

We have developed information risk assessment and management procedures and a programme is being established to fully embed an information risk culture throughout the organisation.

Business Critical Models
The CCG, in line with its annual Information Governance toolkit requirements has produced and maintains an Information Asset Register which identifies business critical models and their asset owners in the organisation. The Senior Information Risk Owner (SIRO) has formally nominated Information Asset Owners covering all areas of the organisation. The SIRO and Caldicott Guardian have responsibility for data as part of the overall model including quality assurance.

Data Flow mapping has also been conducted which enables an understanding of the flows of information related to these key business critical models to be identified, and Information Asset Owners are responsible for all quality checking of these processes which informs key decision making.

Third party assurances
The CCG receives services from a variety of providers for which Service Auditor Reports (SARs) are received to provide assurances of the effectiveness of the services. The CCG has received Service Auditor Reports in relation to services provided to the CCG by North East London Commissioning Support Unit, and there are no issues with these reports.

The CCG receives third party assurances in relation to our clinical services from regulatory bodies, such as the Care Quality Commission and reports from their visits. The quality team works closely with GP Practices, CQC and NHS England and to ensure a satisfactory level of quality assurance.

The CCG has received two further SARs linked to the delivery of primary care commissioning, one from NHS Digital relating to GP payments and the other from Capita who deliver administrative functions linked to the delivery of primary care. Both reports contain areas which offer limited assurance to the CCG and consequently will be highlighted and discussed with the CCG's Audit Committee to ensure appropriate action is taken to address the highlighted issues.

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Control Issues
The CCG has received four internal audit reports which gave limited assurance, two that gave satisfactory and one that gave nil assurance, as noted below:

Auditable Area	Level of Assurance (If appropriate)
Procurement Governance	Limited
Quality, Innovation, Productivity and Prevention	Limited
Organisational Policies	Nil
Primary Care Governance	Satisfactory
Business Continuity Planning	Limited
Financial Systems Key Controls	Limited
Governance, Assurance Framework and Risk Management	Satisfactory
Broadcare	No Opinion
Information Governance Toolkit	No Opinion

No opinion was given in relation to the review of the Information Governance Toolkit and Broadcare as the work performed was advisory in nature.

The CCG was alerted to a national outbreak of the WannaCry Ransomware virus on the afternoon of Friday 12 May 2017. Both Southend and Castle Point and Rochford CCGs issued immediate communications to all GP practices and CCG staff to detach all devices from our computer networks. An incident command centre was mobilised to handle communications with NHS England and partners across the local health system to manage the risks to NHS systems. As a result of the swift action taken on Friday and over the weekend, the impact the attack had on local systems has been minimal and all GP practices across Castle Point, Rochford and Southend remained operational with only a few minor issues reported from some practices. Our incident team continues to work across the system to offer support and advice as required.

Review of economy, efficiency & effectiveness of the use of resources
Ensuring economy, effectiveness and efficiency in the use of resources is an important principle of the CCG and is outlined in the CCG's Constitution adopted by our member practices. To ensure economy, efficiency and effectiveness in the use of resources is achieved; appropriate procurement procedures are in place, including the tendering of goods and services where necessary. Part of the role of the internal audit service that the CCG commissions involves reviewing, appraising and reporting upon the use of resources within the organisation.

A key priority for the CCG is to ensure that maximum value for money is being achieved through effective commissioning arrangements, as the majority of the CCG's expenditure is spent on commissioning healthcare services. While all healthcare providers are required to deliver a continuous programme of QIPP, the CCG also must demonstrate that it is properly considering the health needs of the local population and commissioning those services that address those needs. The CCG uses the Joint Strategic Needs Assessment (JSNA) and other benchmarking tools to ensure that it is able to demonstrate a clear relationship between local needs, our commissioning decisions and the QIPP programme.

Leadership for the strategy and direction in ensuring economy, efficiency and effectiveness

in the use of resources comes from the Governing Body and 'Board to Board' sessions held with local providers and neighbouring CCGs. The ongoing monitoring of CCG progress is undertaken by the Audit Committee through the management and direction to the internal audit programme and regular reviews of risk, and also by the Board through receipt of regular financial and commissioning updates.

The CCG's central management costs can be found in the staff report. The CCG has a number of controls in place to ensure efficiency controls. These have been described within this Governance Statement.

During 2017/18, the CCG has been working with our NHS and social care colleagues across South Essex in developing system-wide QIPP plans setting out how we will respond to the challenging financial climate in which the NHS and the wider public sector will operate over the coming years. To oversee this work an Interim Joint QIPP Programme Director was appointed and fortnightly QIPP Programme Board meetings held with representation from the CCG, Southend Hospital University NHS Trust and Essex Partnership University NHS Trust.

The CCG's overall financial management arrangements and use of resources were also subject to review by the CCG's external auditors as part of their annual review of the CCG's accounts.

Delegation of functions
As at 1 April 2017, for financial year 2017/18, the CCG committed £12.151m as part of the Better Care Fund (BCF), under a section 75 agreement with Southend Borough Council.

The pooled fund is hosted and managed by Southend Borough Council. Monitoring of the BCF is through the Locality Transformation Group, which meets monthly, with representation from both the Borough Council and NHS Southend CCG.

Counter fraud arrangements
The CCG fully supports the work of our Local Counter Fraud Specialist (LCFS), contracted through Mazars and ensures that any instances of fraud are dealt with thoroughly and appropriately. It is our responsibility as a CCG to ensure we maximise the money that is spent on providing care for our patients and service users and we will not tolerate instances where those resources are abused for the personal benefit of fraudsters.

The CCG Audit Committee receives a report against each of the Standards for Commissioners on an annual basis.

During 2017/18, the CCG Audit Committee approved the revised Counter Fraud Policy and training was provided by Mazars to all CCG staff with dedicated Fraud Awareness sessions.

The Chief Finance Officer has overall responsibility for ensuring compliance with Secretary of State Directions on fraud, corruption and bribery. Under the Secretary of State Directions the Chief Finance Officer has a legal responsibility to make sure fraud and corruption is prevented, detected and investigated.

Our CCG will ensure full commitment is given to applying the guidelines as prescribed by the NHS Protect in respect of Counter-Fraud and we will ensure necessary sanctions are applied where fraud is identified. The CCG has a process in place to ensure that action is taken regarding any NHS Protect quality assurance recommendations, although none were received during 2017/18.

The CCG is against any form of bribery and is committed to the terms and obligations imposed by the Bribery Act. It is a duty of all our staff to consider any hospitality or gifts offered to them, inform their line manager of the offer and to declare any such hospitality on the Gift and Hospitality Register, including hospitality declined. The register is maintained by the Corporate Services Team.

When entering in to contracts with organisations, the CCG adopts best practice in how it contracts for the purchase of goods, services and supplies and follows the NHS standard terms and conditions of contract for the purchase of goods and supplies.

Head of Internal Audit Opinion
Following completion of the planned audit work for the financial year for the CCG, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the CCG's system of risk management, governance and internal control. The Head of Internal Audit concluded that:

The **overall opinion,** based on the work performed to 31 March 2018, is that **satisfactory assurance** can be given that there is a generally sound system of internal control, designed to meet the CCG's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls puts the achievement of particular objectives at risk.

Review of the effectiveness of governance, risk management and internal control
My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the clinical commissioning group who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its principles objectives have been reviewed.

I have been advised on the implications of the result of this review by:

- The Governing Body
- The Audit and Risk Committee
- Quality, Finance and Performance Committee
- Internal audit
- Health and Safety Risk Assessments and Audits

The role and conclusions of each were that as Interim Accountable Officer of NHS Southend CCG, I support the Head of Internal Audit Opinion stating that during 2017/18 there has been a generally sound system of internal control, designed to meet the organisations objectives, and that controls are generally being applied consistently. As stated in the Head of Internal Audit Opinion report there were no significant control issues remaining following implementation of audit recommendations throughout the year.

Margaret Hathaway
Interim Accountable Officer

Remuneration and Staff Report

Remuneration Report

The tables and related narrative notes for salaries and allowances of senior managers, pension benefits of senior managers and pay multiples included in this report have been audited.

Remuneration Committee report (not subject to audit)

The remuneration committee is established in accordance with NHS Castle Point and Rochford's Clinical Commissioning Group constitution, standing orders and scheme of delegation. The committee's terms of reference set out the membership, remit, responsibilities and reporting arrangements of the committee and shall have effect as if incorporated into the CCG's constitution and standing orders.

The remit of the Committee is outlined below:

a) The Committee will make recommendations to the Governing Body on determinations about pay and remuneration for employees of the CCG, and people who provide services to the CCG, and allowances under pension scheme.
b) The Committee will make recommendations to the Governing Body about determining the remuneration and conditions of service for the employed members of the Governing Body.
c) The Committee will make recommendations to the Governing Body after reviewing the performance of the Accountable Officer.
d) The Committee will make recommendations to the Governing Body after considering severance payments for the Accountable Officer and all other employees.
e) The Committee will make recommendations to the Governing Body after considering procurement proposals that do not include the possibility of any financial or service impact on any individual GP Practice within the CCG.
f) The Committee will advise the Governing Body on the adequacy of HR arrangements operating within the CCG.
g) Review plans produced by the Chairs and/or Accountable Officer which set out appropriate succession planning for clinical posts and senior officers, taking into account the challenges and opportunities facing the CCG, and what skills and expertise are therefore needed on the Governing Body in the future.

The Committee is appointed by the CCG from amongst its Governing Body members. The following are core members of the Committee:

- Lay Member – Governance and Risk; Nicholas Spenceley
- Lay Member – Patient & Public Engagement; Janis Gibson
- Secondary Care Governing Body Member; Dr Sreeman Andole
- CCG Chair; Dr Jose Garcia Lobera

The Committee is chaired by the Lay Member – Governance and in the event of split decisions; the Committee Chair has a second, deciding vote.

Attendance at the Committee by other officers is at the discretion of the Lay Members, who should ensure that appropriate professional advice is available as required. This has been exercised within 2016/17 with both the Chief Finance Officer and Head of Human Resources (CSU) attending for specific items.

The Committee is required to meet at least four times per year under its Terms of Reference, but also meets as required. The need for any meetings in addition to a quarterly cycle will be

determined by the Committee Chair who will ensure that members have at least seven days' notice of all meetings.

The policy of the Remuneration Committee (not subject to audit)
All senior managers, with the exception of the Accountable Officer, Director of Integration & Transformation, Chief Finance Officer, Chief Nurse and GP Governing Body members, are subject to Agenda for Change terms and conditions. The Accountable Officer, Director of Integration & Transformation, Chief Finance Officer and Chief Nurse roles are subject to the VSM (Very Senior Managers) framework, with their salaries being determined by the Remuneration Committee, with national and local guidance being taken into account in all decisions.

Performance Conditions (not subject to audit)
The performance of all staff (including the Accountable Officer, Executive members and Senior Managers) is monitored and assessed through the use of a robust appraisal system. A formal appraisal review is undertaken at least annually. There are no performance related pay elements contained in any contracts for 2016/17.

Relevant proportions of remuneration (not subject to audit)
Agenda for Change contracts do not contain provision for performance related remuneration. There is therefore no proportion of remuneration which is subject to performance conditions. However, under the terms of the VSM pay scales, there is the potential for performance related pay under the terms and conditions of the contract.

Policy on the duration of contracts, notice periods and termination payments (not subject to audit)
The longevity of contracts is determined by the duration of the roles and responsibilities to be undertaken. The contracts of the Accountable Officer, Executive Directors and other Senior Managers are permanent unless it applies to vacancies whilst recruitment for permanent positions are taking place, a time limited project or funding in which case contracts will be offered as a fixed term contract. GP Governing Body members' contracts are for a three year period.

The notice period applying to the Accountable Officer, Director of Integration & Transformation, Chief Finance Officer and Chief Nurse is 6 months, other than in cases of summary dismissal. Notice period for Senior Managers is in accordance with Agenda for Change conditions (max 12 weeks). Any termination payments would be in accordance with relevant contractual, legislative and Inland Revenue requirements.

Payments to past Senior Managers (not subject to audit)
NHS Castle Point and Rochford have not made any significant awards to past Senior Managers during the period ending 31 March 2018

Salaries and Allowances (subject to audit)
The information for salaries, benefits in kind and pensions entitlements is required to be detailed in the Annual Report. This information can be found in this report.

There are no elements of remuneration, outside of the standard terms and conditions of the contracts of employment of senior managers.

Senior manager remuneration (including salary and pension entitlements):

Salaries and Allowances of Senior Managers

The table below shows the Salaries & Allowances of Senior Managers in 2017/18 (subject to audit):

	NAME	TITLE	2017-18 Salary (bands of £5,000) £000	2017-18 All pension-related benefits (bands of £2,500) £000	2017-18 Total (bands of £5000) £000	Dates served Commenced	Dates served Ceased
	Executive Directors						
1	Ian Stidston	Accountable Officer	60-65	22.5-25	80-85	01-Feb-15	
2	Margaret Hathaway	Chief Finance Officer	55-60	20-22.5	75-80	01-Mar-15	
3	Kevin McKenny	Director of Integration & Transformation	15-20	5-7.5	25-30	01-Apr-13	
4	Matthew Rangue	Chief Nurse	80-85	255-257	350-355	01-Apr-16	
5	Patrica D'Orsi	Chief Nurse	0-5	0	0-5	01-Apr-13	
6	Robert Shaw	Director of Acute Commissioning and Contracting	25-30	177.5-180	205-210	01-Apr-16	
	Lay Members						
	Janis Gibson	Lay Member, Public and Patient Engagement	10-15	0	10-15	01-Apr-16	
	Nicholas Spenceley	Lay member, Governance	10-15	0	10-15	01-Sep-16	
	GP/ Clinical Members						
	Dr Krishna Chaturvedi	GP Governing Body Member & Clinical Lead	45-50	0	45-50	01-Apr-16	
	Dr José Garcia-Lobera	GP Governing Body Chair & Clinical Lead	90-95	0	90-95	01-Apr-16	
	Dr Brian Houston	GP Governing Body Member	30-35	0	30-35	01-Apr-16	
	Dr Fahim Khan	GP Governing Body Member	30-35	0	30-35	01-Apr-16	
	Dr Kelvin Ng	GP Governing Body Member	30-35	0	30-35	01-Apr-16	
	Dr Kate Barusya	GP Governing Body Member & Clinical Lead	45-50	0	45-50	01-Apr-16	
	Dr Taz Syed	GP Governing Body Member & Clinical Lead	45-50	30-32.5	75-80	01-Apr-16	
	Dr Andrea Atherton	Non voting member	0	0	0		
7	Jacqui Lansley	Non voting member	60-65	0	60-65		

1 From the 1st February 2017 Ian Stidston became joint Accountable Officer for Southend CCG and Castle Point & Rochford CCG. The amounts included above relate to Southend CCG's share of the cost of this post. His full cost is in the £160k-£165k band.

2 Margaret Hathaway's post is joint between Castle point & Rochford CCG and Southend CCG. Her full cost is in the £140k-£145k band. The amounts included above relate to Southend CCG's share of the cost of this post. From 9th February 2018 Margaret assumed the role of Interim Accountable Officer.

3 Kevin McKenny became joint Director of Integration & Transformation with Castle Point & Rochford CCG from 1st July 2017. The amounts included above relate to Southend CCG's share of the cost of this post. His full cost is in the £135k-£140k band.

4 Matthew Rangue has been interim Chief Nurse at Basildon & Brentwood CCG since 6th March 2018.

5 Patrica D'Orsi's became joint Chief Nurse for Castle Point & Rochford and Southend CCG from 6th March 2018. The amounts included above relate to Southend CCG's share of the cost of this post. Her full cost is in the £80k-£85k band.

6 Robert Shaw's is a joint post with Castle Point & Rochford CCG. The amounts included above relate to Southend CCG's share of the cost of this post. His full cost is in the £135k-£140k band. From 1st November 2017 Robert has been seconded to NHS England.

7 Jacqui Lansley is employed by Southend Borough Council. She has a secondary role within the CCG, as Joint Associate Director of Integrated Care Commissioning, for which a payment of £62,350 is made to the Council.

Salaries and Allowances of Senior Managers

The table below shows the Salaries & Allowances of Senior Managers in 2016/17 (subject to audit):

	NAME	TITLE	2016-17 Salary (bands of £5,000) £000	Expense payments (Taxable) to the nearest £100 £00	Performance pay and bonuses (bands of £5000) £000	Long -term performance pay and bonuses (bands of £5000) £000	All pension-related benefits (bands of £2,500) £000	Total (bands of £5000) £00	Dates served Commenced	Ceased
	Executive Directors									
1	Melanie Craig	Chief Operating Officer	95 to 100	0	0	0	42.5 to 45	140 to 145	01-Apr-16	05-Feb-17
2	Jason Skinner	Chief Finance Officer	100 to 105	0	0	0	32.5 to 35	130 to 135	01-Apr-16	
	Linda Dowse	Chief Nurse	40 to 45	0	0	0	0	40 to 45	01-Apr-16	30-Sep-16
	Matthew Rangue	Specialist Nurse Practitioner	80 to 85	0	0	0	0	80 to 85	01-Apr-16	
3	Robert Shaw	Director of Acute Commissioning and Contracting	75 to 80	0	0	0	0	75 to 80	01-Apr-16	
	Lay Members									
	Charles Cormack	Lay member, Governance	15 to 20	0	0	0	0	15 to 20	01-Apr-16	30-Sep-16
	Janis Gibson	Lay Member, Public and Patient Engagement	10 to 15	0	0	0	0	10 to 15	01-Apr-16	
	Nicholas Spenceley	Lay member, Governance	5 to 10	0	0	0	0	5 to 10	01-Oct-16	
	GP/ Clinical Members									
	Dr Krishna Chaturvedi	GP Governing Body Member & Clinical Lead	45 to 50	0	0	0	0	45 to 50	01-Apr-16	
	Dr José Garcia-Lobera	GP Governing Body Chair & Clinical Lead	90 to 95	0	0	0	0	90 to 95	01-Apr-16	
	Dr Brian Houston	GP Governing Body Member	30 to 35	0	0	0	0	30 to 35	01-Apr-16	
	Fahim Khan	GP Governing Body Member	30 to 35	0	0	0	347.5 to 350	380 to 385	01-Apr-16	
	Dr Kelvin Ng	GP Governing Body Member	30 to 35	0	0	0	0	30 to 35	01-Apr-16	
	Dr Devesh Sharma	Secondary Care Consultant	15 to 20	0	0	0	0	15 to 20	01-Apr-16	31-Mar-17
	Kate Barusya	GP Governing Body Member & Clinical Lead	50 to 55	0	0	0	0	50 to 55	01-Apr-16	
	Taz Syed	GP Governing Body Member & Clinical Lead	45 to 50	0	0	0	7.5 to 10	55 to 60	01-Apr-16	
	Dr Rachel Marchant	MacMillian funded Palliative Care GP	5 to 10	0	0	0	0	5 to 10	11-Jan-17	

1. Melanie Craig left Southend CCG on the 5 of Feb 2017 and Ian Stidson was appointed joint Chief Operating Officer; his cost is reflected in Castle Point and Rochford CCG (CP&R) remuneration report. The full cost banding of the Chief Operating Officer is £130-135k.
2. The Chief Finance Officer (CFO) was seconded to Mid Essex from the 8th of June 2016, cost is recharged out. From the 15th of June Southend CCG and CPR have a joint CFO, Margaret Hathway her cost is reflected in CPR's remuneration report . The full cost banding of the Chief Financial Officer is £100-105k.
3. The cost represents 50% of the total cost for Robert Shaw, Castle Point and Rochford CCG have been recharged for the other 50%. Following unsuccessful recruitment of a joint Director of Commissioning by Southend and CP&R CCGs, and the detrimental impact that a vacant post may have had on both a local level and the wider STP system during 2016/17, the CCGs agreed to retain the interim services of Robert Shaw, which also provided consistency in the contract management. R Shaw was paid through a consultancy company. From 1.4.2017 the post has been recruited to on a permanent basis.

Pension benefits as at 31 March 2018

Pension benefits

The table below shows the Pension Benefits of Senior Managers in 2017/18 (subject to audit):

	Name and Title		Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31st March 2018 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31st March 2018 (bands of £5,000) £000	Cash equivalent transfer value at 1st April 2017 £000	Real increase in cash equivalent transfer value £000	Cash equivalent transfer value at 31st March 2018 £000	Employers contribution to stakeholder pension £000
	Executive Directors									
1	Ian Stidston	Accountable Officer	2.5 to 5	7.5 to 10	35 to 40	115 to 120	712	96	815	0
1	Margaret Hathaway	Chief Finance Officer	2.5 to 5	0 to 2.5	25 to 30	55 to 60	367	55	426	0
1	Kevin McKenny	Director of Integration & Transformation	2.5 to 5	5 to 7.5	40 to 45	125 to 130	795	93	896	0
2	Matthew Rangue	Specialist Nurse Practitioner	10 to 12.5	35 to 37.5	35 to 40	105 to 110	440	345	789	0
1	Patrica D'Orsi	Chief Nurse	0 to 2.5	0 to (2.5)	20 to 25	50 to 55	338	34	375	0
1,3	Robert Shaw	Director of Acute Commissioning and Contracting	15 to 17.5	42.5 to 45	15 to 20	40 to 45	0	341	341	0
	GP/ Clinical Members									
4	Fahim Khan	GP Representative	0 to (2.5)	0 to (2.5)	15 to 20	45 to 50	0	0	0	0
	Kate Barusya	GP Representative	0 to (2.5)	0 to (2.5)	15 to 20	40 to 45	222	2	222	0
	Taz Syed	GP Representative	0 to 2.5	0 to (2.5)	10 to 15	20 to 25	118	18	137	0

Notes

1. These members' posts are with Castle Point and Rochford CCG. The values shown here are the whole values for the individuals.
2. The large increase in this CETV arises due to the 2016/17 representing part year only.
3. This member left the scheme in 2007 and only rejoined in 2017.
4. Member is over national retirement age, therefore CETV does not apply.

Those members not included above do not receive pensionable remuneration therefore there will be no entries in respect of those Members.

Cash equivalent transfer values
A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.
The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV
This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Pay Multiples (subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director/Member in their organisation and the median remuneration of the organisation's workforce.

	2017/18	2016/17
The banded remuneration of the highest paid director / member	£120k to £125k	£110k to £115k
Median remuneration of the CCG workforce	£38,684	£35,301
Ratio of highest paid director / member to median paid employee	3.1	3.3
No. of employees who were paid more than the highest paid director / member	0	0
Remuneration ranges in the year	£5k to £125k	£7k to £115k

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The full cost of the highest paid director is used for the above calculation. Note that this is recorded as a shared post with Castle Point & Rochford CCG in the remuneration report and, therefore, does not match the band shown here.

Staff Report

Our staff are key to all that we do and achieve as a CCG. We are keen to listen to and engage with our staff and we do this in a number of different ways.

We hold fortnightly 'staff conversations' meetings where all staff are briefed by our Executive team and have the opportunity to ask questions and provide feedback. Our Executive Directors have an open door policy and staff are encouraged to raise any concerns or feedback any new ideas with any of our Executive team.

Towards the end of 2017/18, we launched a new electronic staff newsletter which will contain a mixture of business information and more informal staff news / updates.

Our staff are also keen to support local and national charities, taking part in charity dress down days and national and local awareness days.

Organisational development

We held a staff away in summer 2017- jointly with Castle Point and Rochford CCG – these days give staff the opportunity to step outside from the day job, work as part of a bigger team, look at our objectives, discuss new ideas and innovations.

The Workforce Strategy has been developed to paint a picture of how we develop integrated roles, support member practices and develop the internal CCG workforce.

As a result of the CCG's Talent Mapping exercise a training budget was set and training needs of individual staff members were met through a wide range of training programmes. This included individual leadership training, group training in relation to minute taking, appraisal training, recruitment training, procurement training programme management, contracting and information training, risk management and incident reporting, budget management, health and wellbeing of staff. The CCG is keen to develop a coaching culture throughout the organisation and internal and external mentors and coaches have been arranged for CCG staff.

The CCG has set a training budget for 2018/19 in line with the 2017/18 budget and will review training needs as part of the talent mapping and appraisal processes undertaken during the year.

The CCG is benefitting from the newly established joint Executive structure with Southend CCG and the opportunity to participate in NHS England's Commissioning Capability Programme.

During 2017/18 the CCG signed up to the Mindful Employer Charter for Employers and has identified a member of staff to lead on ensuring that the CCG is compliant with the Charter.

Number of senior managers

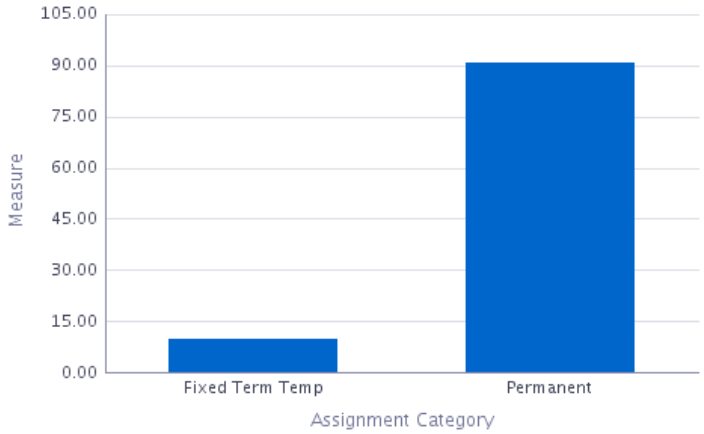
Level	Gender		Grand Total
Senior Manager (Band 8C and above)	Female 4	Male 9	13

Staff numbers and costs

Staff numbers (Substantive Employees Only)

Employee Category	Headcount	%	FTE*
Permanent	62	91.18	56.73
Fixed Term	6	8.82	5.4
Grand Total	**68**	**100**	**62.13**

* Average staff FTE (Full Time Equivalent) is number of staff on payroll for last financial year (Apr 17 – Mar 18).



Staff composition

Ethnic Origin	Adhoc	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8A	Band 8B	Band 8C	Band 8D	VSM	Grand Total
A White – British		3	6	4	7	8	9	3	5	4	3	52
B White – Irish						1		1				2
C White - Any other White background	1	1				1						3
CY White Other European								1				1
GF Mixed - Other/Unspecified					1							1
H Asian or Asian British – Indian					1							1
N Black or Black British – African				1	1	1	1					4
PC Black Nigerian						1						1
PD Black British								1				1
Z Not Stated			1							1		2
Grand Total	1	4	7	5	10	12	10	6	5	5	3	68

4. Employee benefits and staff numbers

4.1.1 Employee benefits

2017-18	Total			Admin			Programme		
	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000
Employee Benefits									
Salaries and wages	3,736	3,660	76	1,462	1,428	34	2,274	2,232	42
Social security costs	334	334	0	270	270	0	64	64	0
Employer contributions to the NHS Pension Scheme	386	386	0	307	307	0	79	79	0
Other pension costs	0	0	0	0	0	0	0	0	0
Apprenticeship Levy	1	1	0	1	1	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0	0
Gross employee benefits expenditure	**4,457**	**4,381**	**76**	**2,040**	**2,006**	**34**	**2,417**	**2,375**	**42**
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0	0	0	0	0	0	0
Total - Net admin employee benefits including capitalised costs	**4,457**	**4,381**	**76**	**2,040**	**2,006**	**34**	**2,417**	**2,375**	**42**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**4,457**	**4,381**	**76**	**2,040**	**2,006**	**34**	**2,417**	**2,375**	**42**

4.1.1 Employee benefits

2016-17	Total			Admin			Programme		
	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000
Employee Benefits									
Salaries and wages	3,604	2,995	609	1,474	1,146	328	2,130	1,849	281
Social security costs	372	372	0	334	334	0	38	38	0
Employer contributions to the NHS Pension Scheme	353	353	0	302	302	0	51	51	0
Other pension costs	0	0	0	0	0	0	0	0	0
Apprenticeship Levy					0	0		0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	23	23	0	23	23	0	0	0	0
Gross employee benefits expenditure	**4,352**	**3,743**	**609**	**2,133**	**1,805**	**328**	**2,219**	**1,938**	**281**
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0	0	0	0	0	0	0
Total - Net admin employee benefits including capitalised costs	**4,352**	**3,743**	**609**	**2,133**	**1,805**	**328**	**2,219**	**1,938**	**281**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**4,352**	**3,743**	**609**	**2,133**	**1,805**	**328**	**2,219**	**1,938**	**281**

Sickness absence data

(1 April 17- 31 March 18)

	Absence Days 2017/18
Total Days Lost	176
Total Number of staff	68
Average Number of Sick Days	2.6 days

Equal opportunities

NHS Southend CCG is committed to equal opportunities for all staff.

There are no employees with the CCG who have declared that they have a disability. The CCG is an equal opportunities employer and adopts the principles of schemes such as "Two Ticks". The CCG follows NHS Employers' guidance and relevant legislation, in respect of recruitment and selection of staff and NHS Employment Check Standards.

The CCG has access to HR and Occupational Health advice in order to support any employees who fall within the scope of the Equality Act 2010. Each employee is different and the support will be tailored depending on the circumstances.

See our Equality Report – Appendix B (produced in April 2018) for more information about our workforce.

Expenditure on consultancy

As detailed in the financial statements, the CCG's expenditure on consultancy was £834,000 for 2017/18.

Off-payroll engagements

Table 1: Off-payroll engagements longer than 6 months

For all off-payroll engagements as at 31 March 2018, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2018	2
Of which, the number that have existed:	
for less than one year at the time of reporting	1
for between one and two years at the time of reporting	1
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

Table 2: New off-payroll engagements

For all new off-payroll engagements between 01 April 2017 and 31 March 2018, for more than £220 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	1
Number of new engagements which include contractual clauses giving NHS Southend CCG the right to request assurance in relation to income tax and National Insurance obligations	0
Number for whom assurance has been requested	0
Of which:	
assurance has been received	1
assurance has not been received	0
engagements terminated as a result of assurance not being received.	0

Table 3: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 01 April 2017 and 31 March 2018.

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both on payroll and off-payroll engagements.	0

Losses and Special Payments

Losses

The total number of NHS clinical commissioning group losses and special payments cases, and their total value, was as follows:

	Total Number of Cases 2017-18 Number	**Total Value of Cases 2017-18 £'000**	Total Number of Cases 2016-17 Number	Total Value of Cases 2016-17 £'000
Administrative write-offs	6	1	0	0
Total	**6**	**1**	**0**	**0**

Parliamentary Accountability and Audit Report

NHS Southend CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report – see Appendix B. An audit certificate and report is also included in this Annual Report on page 89.

Independent Auditor's Report

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS SOUTHEND CLINICAL COMMISSIONING GROUP

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of NHS Southend Clinical Commissioning Group ("the CCG") for the year ended 31 March 2018 which comprise the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the CCG's affairs as at 31 March 2018 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the NHS Commissioning Board with the consent of the Secretary of State as being relevant to CCGs in England and included in the Department of Health Group Accounting Manual 2017/18.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least twelve months from the date of approval of the financial statements. We have nothing to report in these respects.

Other information in the Annual Report

The Accountable Officer is responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information. In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement does not comply with guidance issued by the NHS Commissioning Board. We have nothing to report in this respect.

Remuneration and Staff Report

In our opinion the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health Group Accounting Manual 2017/18.

Accountable Officer's responsibilities

As explained more fully in the statement set out on pages 60 and 61, the Accountable Officer is responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the CCGs ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Qualified opinion on regularity

We are required to report on the following matters under Section 25(1) of the Local Audit and Accountability Act 2014.

In our opinion, except for the effects of the matter described below, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

Basis for qualified opinion on regularity

The CCG reported a deficit of £6.8 million in its financial statements for the year ending 31 March 2018, thereby breaching its duty under the National Health Service Act 2006, as amended by paragraph 223I of Section 27 of the Health and Social Care Act 2012, to ensure that its revenue resource use in a financial year does not exceed the amount specified by NHS England.

Report on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice we are required to report to you if the CCG has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Qualified conclusion

Subject to the matters outlined in the basis for qualified conclusion paragraph below we are satisfied that in all significant respects NHS Southend CCG put in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources for the year ended 31 March 2018.

Basis for qualified conclusion

The CCG incurred a deficit of £6.8million against a budget for the year of a £3.1million surplus. This represents a deterioration against plan of £9.9million. This deterioration has resulted in the CCG being placed into the Special Measures regime.

These issues are evidence of weaknesses in arrangements for sustainable delivery of the CCG's strategic priorities.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on pages 60 and 61, the Accountable Officer is responsible for ensuring that the CCG exercises its functions effectively, efficiently and economically.

We are required under section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the CCGs arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the CCG under section 24 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

We are required to report to you if we refer a matter to the Secretary of State and the NHS Commissioning Board under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

On 25 April 2018 we wrote to the Secretary of State in accordance with Section 30(1)(b) of the 2014 Act as a consequence of the CCG's breaching its revenue resource limit. The CCG's financial statements for financial year end 31 March 2018 identified a deficit of £6.8 million in 2017/18 against its revenue resource limit.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Members of the Governing Body of NHS Southend CCG, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Members of the Governing Body of the CCG, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Members of the Governing Body, as a body, for our audit work, for this report or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of NHS Southend CCG in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Stephanie Beavis
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
Botanic House
100 Hills Road
Cambridge, CB2 1AR

24 May 2018

Glossary

Glossary of non-financial terms

Term	Definition
Care pathway	The route that a patient will take from their first point of contact with an NHS or Social Services member of staff (usually their GP), through referral, to the completion of their treatment.
Clinical Commissioning Group (CCG)	Formally established on 1 April 2013, Clinical Commissioning Groups (CCGs) are statutory bodies responsible for commissioning most healthcare – planning, buying and monitoring services to meet the needs of their local communities.
Civil contingencies act 2004	Provides a single framework for UK civil protection against any challenges to society – it focuses on local arrangements and emergency powers.
Commissioning	The review, planning and purchasing of health and social services.
Community services	Health or social care and services provided outside of hospital. They can be provided in a variety of settings including clinics and in people's homes. Community services include a wide range of services such as district nursing, health visiting services and specialist nursing services.
Commissioning Support Unit (CSU)	Commissioning Support Units provide capacity to clinical commissioners as an extension of their local team to ensure that commissioning decisions are informed and processes structured. This approach helped achieve economies of scale and allow Clinical Commissioning Groups to focus on direct commissioning of services for their patients.
Enhanced services	Enhanced services are: i) essential or additional services delivered to a higher specified standard, for example, extended minor surgery ii) Services not provided through essential or additional services. They are services provided by GPs practices, over and above the core (essential and additional) services to their patients.
Equality delivery system (EDS)	The EDS has been designed nationally as an optional tool launched in 2011 to support NHS commissioners and providers to deliver better outcomes for patients and communities and better working environments for staff, which are personal, fair and diverse. The EDS is all about making positive differences to healthy living and working lives.
Equality impact assessment (EIA)	An equality impact assessment involves assessing the likely or actual effects of policies or services on people in respect of disability, gender and racial equality. It helps us to make sure the needs of people are taken into account when we develop and implement a new policy or service or when we make a change to a current policy or service.

NHS 111	NHS 111 is a new service introduced to make it easier for people to access local NHS healthcare services. People can call 111 when they need medical help fast but it's not a 999 emergency. NHS 111 is available 24 hours a day, 365 days a year. Calls are free from landlines and mobile phones.
Palliative care	The total care of patients whose disease is incurable. Control of pain, of other symptoms, and of psychological, social and spiritual problems is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families.
QIPP	Quality Innovation Productivity and Performance

Glossary of financial terms

Term	Definition
Accounting policies	The Accounting Policies are the accounting rules that the CCG has followed in preparing its accounts. These policies are based on International Financial Reporting Standards and the Treasury's Financial Reporting Manual. The Department of Health's Manual for Accounts and Capital Accounting Manual detail how these rules should apply to CCGs. One of the main policies is that income and expenditure is recognised on an accruals basis, meaning it is recorded in the period in which services are provided even though cash may or may not have been received or paid out.
Budget	A budget usually refers to a list of all planned and expected future expenses and revenues. A budget is set at the beginning of the financial year.
Capital expenditure	Capital expenditure is money spent on buying non-current assets (fixed assets) or to add to the value of an existing fixed asset with a useful life that extends beyond a year.
Capital resource limit	The capital resource limit (CRL) is the amount allocated each year to the CCG for capital expenditure. The CCG must not spend more than the CRL on capital items.
Revenue resource limit	The revenue resource limit (RRL) is the total amount that the CCG may spend on the services that it commissions. This limit is set for the CCG at the start of the financial year by the Department of Health and may change on a monthly basis depending on changes to allocations to the CCG from the Strategic Health Authority for either commissioning or provider functions. Each CCG has a statutory duty not to spend more than its RRL. The RRL takes into account all accrued income and expenditure irrespective of whether income has been received or bills paid.

Depreciation	Depreciation refers to the fact that assets with finite lives lose value over time. Depreciation involves allocating the cost of the fixed asset (less any residual value) over its useful life to the Statement of Comprehensive Net Expenditure (SCNE). This will cause an expense to be recognised on the SCNE while the net value of the asset will decrease on the Statement of Financial Position.
Impairments	Impairments are the losses in the values of non-current assets compared to those values recorded on the Statement of Financial Position. A CCG is required to undertake routinely revaluation reviews of its fixed assets or undertake an impairment review when there is a decline in an asset's value. The impairment (loss) is treated in the same way as depreciation, as a cost in the Statement of Comprehensive Net Expenditure (SCNE), if the change in the value of the asset is permanent.
Intangible assets [formerly intangible fixed assets]	Intangible Assets are invisible or "soft" assets of an organisation that, nevertheless, have a real current market value and contribute to the (future) operation/income generation of the organisation and may include software licences, trademarks and research development expenditure.
International financial reporting standards	International financial reporting standards (IFRS) are the international accounting standards that the Department of Health requires CCGs to follow when they prepare their accounts. 2009-10 was the first year in which CCG were required to prepare IFRS compliant accounts, having previously used UK reporting standards.
Losses and special payments	Losses and Special Payments are payments that Parliament would not have foreseen healthcare funds being spent on, for example fraudulent payments, personal injury payments or payments for legal compensation.
NHS payables (formerly known as NHS creditors)	An NHS Payable is an amount owed to an NHS organisation for services rendered or goods supplied to the CCG or to patients of the CCG.
Provisions	Over spend occurs when more money is spent than was allowed within the cash limit, revenue resource limit or capital limit, or that was planned in the budget.
Pooled budget	A pooled budget is a joint arrangement with other bodies, such as local authorities and other CCG"s, to pool funds for a specific purpose. Each body has to account for its own contribution to the pool within their accounts. Contributions would generally include the resources normally used for the identified services, together with partnership and other grants specific to the services. The host partner will manage the financial affairs of the pooled fund. The pooled budget manager is responsible for managing the pooled fund on behalf of the host authority, and for providing information to enable the partners to monitor the effectiveness of the pooled fund arrangements.

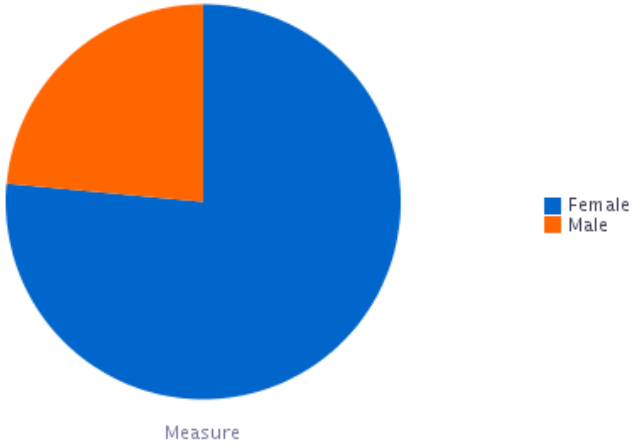
Procurement	Procurement is the acquisition of goods and/or services, generally through a contract, at the best possible total cost, in the right quantity and quality, at the right time and in the right place for the direct benefit of the CCG and its patients.
Property, plant & equipment (formerly tangible fixed assets)	Property, plant and equipment are assets that individually (or with integrally linked other items) cost more than £5,000 and are held for longer than one year and include: land, buildings, transport equipment, IT and furniture and fittings.

APPENDIX A – Equality Report

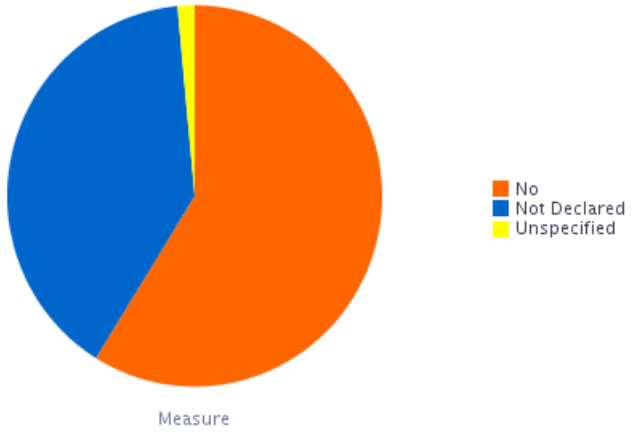
Overview

76% of the total workforce is White English/British and 3% is White Irish. 18 % is BME while 3% of employees did not specify or did not state their ethnicity. 76% of the workforce is female, which equates to 52 people. 29% of employees are between the ages of 46 and 50 (which equates to 20 people). 40 people (60%) have declared that they do not have a disability while 27 people (39%) have not declared a disability either way and 1 person (1%) has reported unspecified. 49% of the workforce are Christian, 13% are Atheist, 2% are Buddhist and 7% have declared themselves as other or unspecified and 29% have not disclosed. 71% of employees are heterosexual – which equates to 48 people – and two people are Gay (3%) , 25% (17 people) did not disclose and 1 person unspecified. 56% of the workforce are married, 26% are single, 14% are divorced, 1% are in a civil partnership and 3% unknown.

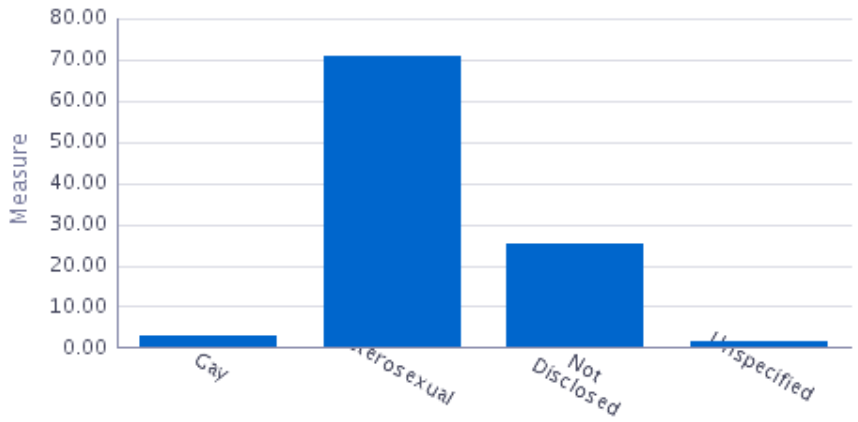
Gender



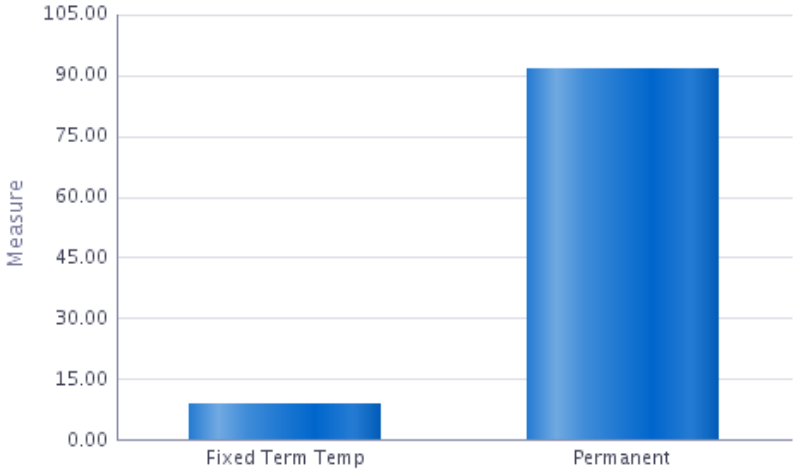
Disability



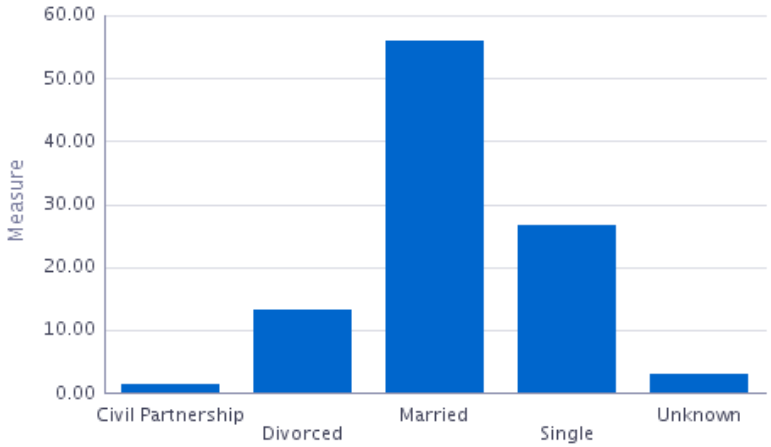
Sexual Orientation



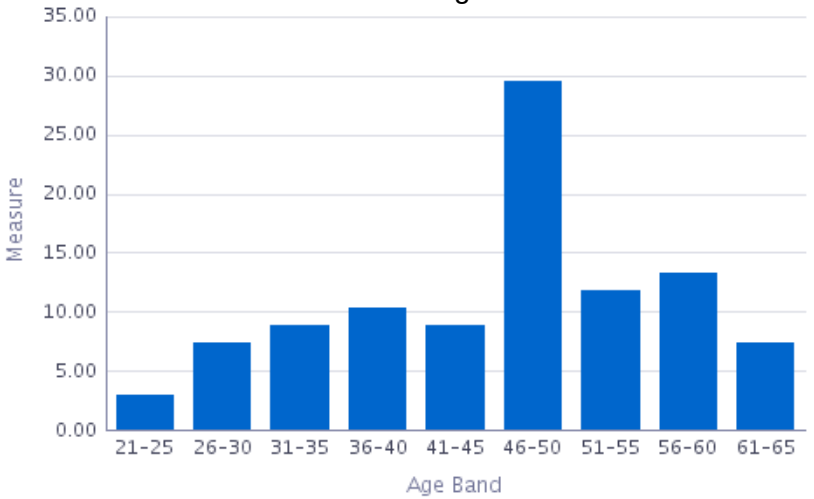
Assignment Category



Marital Status

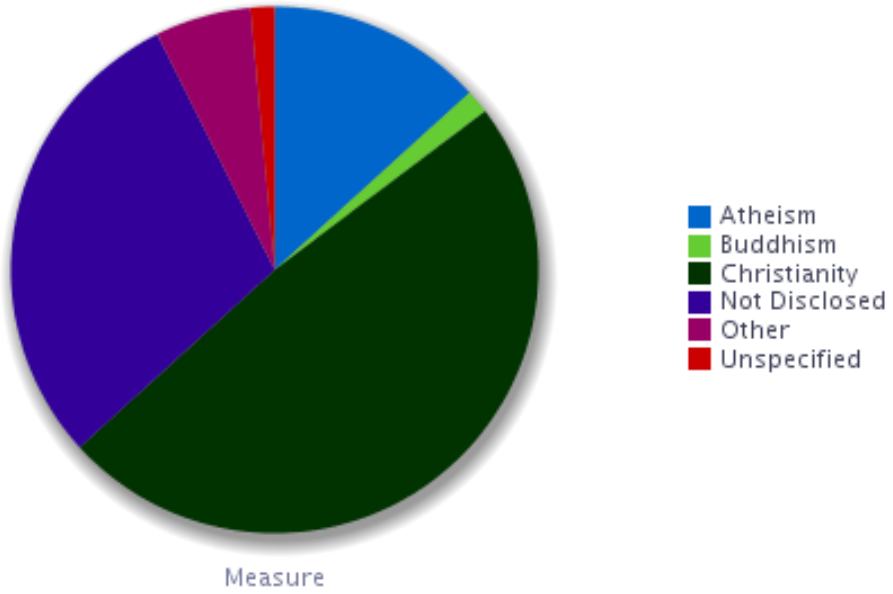


Age Band



Religion

Ethnicity



Ethnic Group	Headcount	%	FTE
A White - British	52	76.5	47.55
B White - Irish	2	2.9	1.43
C White - Any other White background	3	4.4	3.00
CY White Other European	1	1.5	0.60
GF Mixed - Other/Unspecified	1	1.5	1.00
H Asian or Asian British - Indian	1	1.5	1.00
N Black or Black British - African	4	5.9	4.00
PC Black Nigerian	1	1.5	1.00
PD Black British	1	1.5	1.00
Z Not Stated	2	2.9	1.60
Grand Total	**68**	**100.0**	**62.17**

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Starters and Leavers

There were fifteen (15) new starters between 1 April 2017 and 31 March 2018.

There were nine (9) leavers between 1 April 2017 and 31 March 2018. Eight of the leavers were voluntary resignation and one leaver was retired.

APPENDIX B – Financial Statements

Entity name:	NHS Southend CCG
This year	2017-18
Last year	2016-17
This year ended	31-March-2018
Last year ended	31-March-2017
This year commencing:	01-April-2017
Last year commencing:	01-April-2016

CONTENTS **Page Number**

The Primary Statements:

Statement of Comprehensive Net Expenditure for the year ended 31 March 2018

	Note	2017-18 £'000	2016-17 £'000
Income from sale of goods and services	2	(493)	(3,115)
Other operating income	2	(3)	(421)
Total operating income		**(496)**	**(3,536)**
Staff costs	4	4,457	4,352
Purchase of goods and services	5	269,874	241,994
Depreciation and impairment charges	5	21	21
Provision expense	5	198	0
Other Operating Expenditure	5	104	142
Total operating expenditure		**274,654**	**246,509**
Net Operating Expenditure		**274,158**	**242,973**
Net expenditure for the year		**274,158**	**242,973**
Comprehensive Expenditure for the year ended 31 March 2018		**274,158**	**242,973**

The notes on pages 5 to 25 form part of this statement

Statement of Financial Position as at 31 March 2018

	Note	2017-18 £'000	2016-17 £'000
Non-current assets:			
Property, plant and equipment	8	6	27
Total non-current assets		6	27
Current assets:			
Trade and other receivables	9	5,315	7,680
Cash and cash equivalents	10	76	37
Total current assets		**5,391**	7,717
Total assets		**5,397**	7,744
Current liabilities			
Trade and other payables	11	(25,083)	(18,106)
Provisions	12	(198)	0
Total current liabilities		**(25,281)**	(18,106)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(19,884)**	(10,362)
Assets less Liabilities		**(19,884)**	(10,362)
Financed by Taxpayers' Equity			
General fund		(19,884)	(10,362)
Total taxpayers' equity:		**(19,884)**	(10,362)

The notes on pages 5 to 25 form part of this statement

The financial statements on pages 1 to 25 were approved by the Audit Committee on 24 May 2018 and signed on its behalf by:

Interim Accountable Officer
Margaret Hathaway

24 May 2018

Statement of Changes In Taxpayers Equity for the year ended 31 March 2018

	General fund £'000
Changes in taxpayers' equity for 2017-18	
Balance at 01 April 2017	**(10,362)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2017-18	
Net operating expenditure for the financial year	(274,158)
Net funding	264,636
Balance at 31 March 2018	**(19,884)**

	General fund £'000
Changes in taxpayers' equity for 2016-17	
Balance at 01 April 2016	**(9,657)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2016-17	
Net operating costs for the financial year	(242,973)
Net funding	242,268
Balance at 31 March 2017	**(10,362)**

The notes on pages 5 to 25 form part of this statement

Statement of Cash Flows for the year ended 31 March 2018

	Note	2017-18 £'000	2016-17 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(274,158)	(242,973)
Depreciation and amortisation	5	21	21
Decrease/(increase) in trade & other receivables	9	2,365	(5,157)
Increase in trade & other payables	11	6,977	5,824
Increase in provisions	12	198	0
Net Cash Outflow from Operating Activities		**(264,597)**	(242,285)
Cash Flows from Investing Activities			
(Payments) for property, plant and equipment		0	(13)
Net Cash Outflow from Investing Activities		**0**	(13)
Net Cash Outflow before Financing		**(264,597)**	(242,298)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		264,636	242,268
Net Cash Inflow from Financing Activities		**264,636**	242,268
Net Increase (Decrease) in Cash & Cash Equivalents	10	**39**	(30)
Cash & Cash Equivalents at the Beginning of the Financial Year		**37**	67
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**76**	38

The notes on pages 5 to 25 form part of this statement

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2017-18 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on the going concern basis (despite the issue of a report to the Secretary of State for Health under Section 30 of the Local Audit and Accountability Act 2014).
Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.
Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of Financial Statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 Pooled Budgets

Where the CCG has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 the CCG accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

The CCG has not been part of any pooled budget arrangements in 2017-18. Southend CCG and Southend Borough Council have operated a Better Care Fund during 2017-18 under a Section 75 agreement. The arrangements under which the Better Care Fund has operated during 2017-18 do not constitute a pooled budget as the risks of each scheme have remained with the respective commissioners. Each scheme within the Better Care Fund has been reviewed and accounted for on an appropriate basis (see Note 5).

1.4 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

In the application of the clinical commissioning group's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.4.1 Critical Judgements in Applying Accounting Policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the clinical commissioning group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

· Retrospective Continuing Healthcare Claims (CHC): From 1st April 2017, the CCG is not required to contribute to the CHC Risk Pool. For new claims, the CCG has made a provision based on the number of claims received.
The provision is based on the expected number of days for the claim period at the average daily rate for CHC,an adjustment is then applied for the average number of cases approved through panel and the average number of days actually awarded at panel.

1.4.2 Key Sources of Estimation Uncertainty

The following are the key estimations that management has made in the process of applying the Clinical Commissioning Group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

Prescribing creditor, where the reporting through the NHS Business Development Authority (NHSBDA) has a time lag of two months, actual data was only available up to the end of February. An accrual for the March costs was based on the forecast provided by the NHSBDA.

Retrospective Continuing Healthcare Claims (CHC), where a provision has been made based on the number of claims received. The provision is based on the expected number of days for the claim period at the average daily rate for CHC, an adjustment is then applied for the average number of cases approved through panel and the average number of days actually awarded at panel.

1.5 **Revenue**

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

1.6 **Employee Benefits**

1.6.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, including

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.6.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the clinical commissioning group of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period. Some employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the clinical commissioning group's accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs. Actuarial gains and losses during the year are recognised in the General Reserve and reported as an item of other comprehensive net expenditure.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the clinical commissioning group commits itself to the retirement, regardless of the method of payment.

1.7 **Other Expenses**

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

Expenses and liabilities in respect of grants are recognised when the clinical commissioning group has a present legal or constructive obligation, which occurs when all of the conditions attached to the payment have been met.

1.8 **Property, Plant & Equipment**

1.8.1 **Recognition**

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the clinical commissioning group;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.8.2 **Valuation**

Property, plant and equipment is capitalised if:

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at valuation.

Land and buildings used for the clinical commissioning group's services or for administrative purposes are stated in the statement of financial position at their re-valued amounts, being the fair value at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historical cost as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.8.3 **Subsequent Expenditure**

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.9 **Depreciation, Amortisation & Impairments**

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the clinical commissioning group checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.10 **Leases**

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.10.1 **The Clinical Commissioning Group as Lessee**

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the clinical commissioning group's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.11 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the clinical commissioning group's cash management.

1.12 **Provisions**

Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

- Timing of cash flows (0 to 5 years inclusive): Minus 2.420% (previously: minus 2.70%)
- Timing of cash flows (6 to 10 years inclusive): Minus 1.85% (previously: minus 1.95%)
- Timing of cash flows (over 10 years): Minus 1.56% (previously: minus 0.80%)

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the clinical commissioning group has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.13 **Clinical Negligence Costs**

The NHS Litigation Authority operates a risk pooling scheme under which the clinical commissioning group pays an annual contribution to the NHS Litigation Authority which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHS Litigation Authority is administratively responsible for all clinical negligence cases the legal liability remains with the clinical commissioning group.

1.14 **Non-clinical Risk Pooling**

The clinical commissioning group participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the clinical commissioning group pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.15 **Continuing healthcare risk pooling**

In 2014-15 a risk pool scheme was been introduced by NHS England for continuing healthcare claims, for claim periods prior to 31 March 2013. Under the scheme clinical commissioning group contribute annually to a pooled fund, which is used to settle the claims.

1.16 **Financial Assets**

Financial assets are recognised when the clinical commissioning group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:

- Financial assets at fair value through profit and loss;
- Held to maturity investments;
- Available for sale financial assets; and,
- Loans and receivables.

The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

1.16.1 **Loans & Receivables**

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the clinical commissioning group assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.17 **Financial Liabilities**

Financial liabilities are recognised on the statement of financial position when the clinical commissioning group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

1.18 **Value Added Tax**

Most of the activities of the clinical commissioning group are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19 **Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the clinical commissioning group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.20 **Accounting Standards That Have Been Issued But Have Not Yet Been Adopted**

The DHSC Group accounting manual does not require the following Standards and Interpretations to be applied in 2017-18. These standards are still subject to FREM adoption and early adoption is not therefore permitted.

- IFRS 9: Financial Instruments (application from 1 January 2018)
- IFRS 14: Regulatory Deferral Accounts (not applicable to DH groups bodies)
- IFRS 15: Revenue for Contract with Customers (application from 1 January 2018)
- IFRS 16: Leases (application from 1 January 2019)
- IFRS 17: Insurance Contracts (application from 1 January 2021)
- IFRIC 22: Foreign Currency Transactions and Advance Consideration (application from 1 January 2018)
- IFRIC 23: Uncertainty over Income Tax Treatments (application from 1 January 2019)

The application of the Standards as revised would not have a material impact on the accounts for 2017-18, were they applied in that year.

2 Other Operating Revenue

	2017-18 Total	2017-18 Admin	2017-18 Programme	2016-17 Total
	£'000	£'000	£'000	£'000
Prescription fees and charges	0	0	0	156
Non-patient care services to other bodies	493	0	493	3,115
Other revenue	3	3	0	266
Total other operating revenue	**496**	**3**	**493**	**3,536**

3 Revenue

	2017-18 Total	2017-18 Admin	2017-18 Programme	2016-17 Total
	£'000	£'000	£'000	£'000
From rendering of services	496	3	493	3,536
Total	**496**	**3**	**493**	**3,536**

4. Employee benefits and staff numbers

4.1.1 Employee benefits 2017-18 Total

	Total £'000	Permanent Employees £'000	Other £'000
Employee Benefits			
Salaries and wages	3,736	3,661	75
Social security costs	334	334	0
Employer Contributions to NHS Pension scheme	386	386	0
Apprenticeship Levy	1	1	0
Gross employee benefits expenditure	**4,457**	**4,382**	**75**
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0
Total - Net admin employee benefits including capitalised costs	**4,457**	**4,382**	**75**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**4,457**	**4,382**	**75**

4.1.1 Employee benefits 2016-17 Total

	Total £'000	Permanent Employees £'000	Other £'000
Employee Benefits			
Salaries and wages	3,604	2,995	609
Social security costs	372	372	0
Employer Contributions to NHS Pension scheme	353	353	0
Termination benefits	23	23	0
Gross employee benefits expenditure	**4,352**	**3,743**	**609**
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0
Total - Net admin employee benefits including capitalised costs	**4,352**	**3,743**	**609**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**4,352**	**3,743**	**609**

4.1.2 Recoveries in respect of employee benefits

There were no recoveries in respect of employee benefits (2016-17: Nil)

4.2 Average number of people employed

	2017-18			2016-17
	Total Number	Permanently employed Number	Other Number	Total Number
Total	**73**	**72**	**1**	**66**
Of the above:				
Number of whole time equivalent people engaged on capital projects	**0**	**0**	**0**	**0**

4.3 Exit packages agreed in the financial year

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure. The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

No exit packages were agreed in 2017/18 (2016/17: £22.8k)

4.4 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

4.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.4.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

For 2017-18, employers' contributions of £386,500 were payable to the NHS Pensions Scheme (2016-17: £352,800) were payable to the NHS Pension Scheme at the rate of 14.3% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2012. These costs are included in the NHS pension line of note 4.1.1.

5. Operating expenses

	2017-18 Total £'000	2017-18 Admin £'000	2017-18 Programme £'000	2016-17 Total £'000
Gross employee benefits				
Employee benefits excluding governing body members	4,163	1,759	2,404	4,071
Executive governing body members	294	281	13	281
Total gross employee benefits	**4,457**	**2,040**	**2,417**	**4,352**
Other costs				
Services from other CCGs and NHS England	1,287	1,183	104	1,631
Services from foundation trusts	154,816	0	154,816	147,301
Services from other NHS trusts	15,513	0	15,513	15,760
Purchase of healthcare from non-NHS bodies	43,211	0	43,211	46,004
Chair and Non Executive Members	103	103	0	142
Supplies and services – clinical	2,334	0	2,334	1,128
Supplies and services – general	653	36	617	266
Consultancy services	834	147	687	608
Establishment	793	73	720	701
Transport	0	0	0	1
Premises	659	247	412	967
Depreciation	21	21	0	21
Statutory audit fee	30	30	0	56
Other non statutory audit expenditure				
· Internal audit services	37	37	0	41
· Other services	20	20	0	8
Prescribing costs	26,439	0	26,439	26,680
GPMS/APMS and PCTMS	23,237	0	23,237	213
Other professional fees excl. audit	0	0	0	41
Legal fees	7	4	3	0
Education and training	4	2	2	18
Provisions	198	0	198	0
CHC Risk Pool contributions	0	0	0	570
Other expenditure	1	0	1	0
Total other costs	**270,197**	**1,903**	**268,294**	**242,157**
Total operating expenses	**274,654**	**3,943**	**270,711**	**246,509**

The CCG has operated a Better Care Fund as a pooled budget with Southend Borough Council under a section 75 agreement. The CCG contributes £12.2m to the BCF pool and receives contributions of £6.4m
The CCG has operated a Better Care Fund of £11.653m during 2017-18 (2016-17 £11.539m) together with Southend Borough Council under a section 75 agreement. This arrangement has been reviewed and both parties have agreed that it does not constitute a pooled fund. This conclusion has been reached as both parties have retained the financial risks associated with each of the schemes as existed before the fund was set up.

The arrangements for each scheme within the Better Care Fund have been reviewed to determine the appropriate accounting treatment by the CCG and Southend Borough Council. Control of the commissioning arrangements has been key to determining the nature of each scheme within the fund. Where Southend Borough Council has been identified as acting as Lead Commissioner or Principal the accounting treatment has been for the transaction with Southend Borough County council to be recorded in the CCG ledger (£5.70m) (2016-17 £5.65m) . Where the CCG has control over the commissioning of the service the transactions with the individual provider(s) are recorded in the ledger (£5.90m) (2016-17 £5.89m).

Statutory audit fee: The contract between the CCG and its auditors provides for the latter's liability to be limited to £ 1,000,000.
External audit fees, exclusive of irrecoverable VAT, were £ 30,201 for statutory audit.

6.1 Better Payment Practice Code

Measure of compliance	**2017-18 Number**	**2017-18 £'000**	2016-17 **Number**	2016-17 **£'000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	11,664	76,627	12,847	58,184
Total Non-NHS Trade Invoices paid within target	11,267	73,524	12,447	52,122
Percentage of Non-NHS Trade invoices paid within target	**96.60%**	**95.95%**	**96.89%**	**89.58%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,449	172,389	2,570	167,986
Total NHS Trade Invoices Paid within target	2,322	171,868	2,419	166,184
Percentage of NHS Trade Invoices paid within target	**94.81%**	**99.70%**	**94.12%**	**98.93%**

7. Operating Leases

7.1 As lessee

NHS Southend CCG occupies, and is liable for the cost of space for unoccupied property, owned and managed by Community Health Partnership Limited and NHS Property Services Limited.

7.1.1 Payments recognised as an Expense	2017-18			2016-17		
	Buildings £'000	**Other £'000**	**Total £'000**	**Buildings £'000**	**Other £'000**	**Total £'000**
Payments recognised as an expense						
Minimum lease payments	498	5	**503**	763	2	**766**
Total	**498**	**5**	**503**	**763**	**2**	**766**

8 Property, plant and equipment

2017-18	Plant & machinery £'000	Information technology £'000	Total £'000
Cost or valuation at 01 April 2017	22	54	76
Cost/Valuation at 31 March 2018	**22**	**54**	**76**
Depreciation 01 April 2017	19	30	49
Charged during the year	3	18	21
Depreciation at 31 March 2018	**22**	**48**	**70**
Net Book Value at 31 March 2018	**0**	**6**	**6**
Purchased	0	6	6
Total at 31 March 2018	**0**	**6**	**6**
Asset financing:			
Owned	0	6	6
Total at 31 March 2018	**0**	**6**	**6**

8.1 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Plant & machinery	1	5
Information technology	1	5

9 Trade and other receivables	Current 2017-18 £'000	Current 2016-17 £'000
NHS receivables: Revenue	4,378	6,937
NHS prepayments	706	544
Non-NHS and Other WGA receivables: Revenue	170	123
Non-NHS and Other WGA accrued income	4	28
VAT	38	28
Other receivables and accruals	19	20
Total Trade & other receivables	**5,315**	**7,680**
Total current and non current	**5,315**	**7,680**

The majority of trade is with NHS England. As NHS England is funded by Government to provide funding to clinical commissioning groups to commission services, no credit scoring of them is considered necessary.

9.1 Receivables past their due date but not impaired	2017-18 £'000 DH Group Bodies	2017-18 £'000 Non DH Group Bodies	2016-17 £'000 All receivables prior years
By up to three months	56	5	707
By three to six months	91	0	289
By more than six months	243	62	190
Total	**390**	**67**	**1,186**

£56,857 of the amount above has subsequently been recovered post the statement of financial position date.

NHS Southend CCG did not hold any collateral against receivables outstanding at 31 March 2018 (31 March 2017 £nil).

10 Cash and cash equivalents

	2017-18 £'000	2016-17 £'000
Balance brought forward	37	67
Net change in year	39	(30)
Balance carried forward	**76**	**37**
Made up of:		
Cash with the Government Banking Service	76	37
Cash and cash equivalents as in statement of financial position	**76**	**37**
Balance carried forward	**76**	**37**
Patients' money held by the clinical commissioning group, not included above	0	0

11 Trade and other payables	**Current 2017-18**	Current 2016-17 (Restated)
	£'000	£'000
NHS payables: revenue	2,104	4,715
NHS accruals	5,277	863
Non-NHS and Other WGA payables: Revenue	2,330	3,306
Non-NHS and Other WGA accruals	13,161	6,819
Social security costs	50	45
Tax	47	40
Payments received on account	0	1
Other payables and accruals	2,114	2,317
Total Trade & Other Payables	**25,083**	**18,106**
Total current and non-current	**25,083**	**18,106**

Other payables includes £1,846k (2017: £1,973k) accruals for Continuing Healthcare (CHC) and £142k of outstanding pension contributions at 31 March 2018 (31 March 2017 £58k).

12 Provisions

	Current 2017-18 £'000	Current 2016-17 £'000
Continuing care	198	0
Total	**198**	**0**
Total current and non-current	**198**	**0**

	Continuing Care £'000	Total £'000
Balance at 01 April 2017	**0**	**0**
Arising during the year	198	198
Balance at 31 March 2018	**198**	**198**
Expected timing of cash flows:		
Within one year	198	198
Balance at 31 March 2018	**198**	**198**

Legal claims are calculated from the number of claims currently lodged with the NHS Litigation Authority and the probabilities provided by them.

No provisions were held by NHS Litigation Authority as at 31 March 2018 in respect of clinical negligence liabilities of NHS Southend CCG (31 March 2017: £67,000)

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the CCG. However, the legal liability remains with the CCG. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this CCG at 31 March 2018 is £556k (2017 £912k).

13 Financial instruments

13.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because NHS clinical commissioning group is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The clinical commissioning group has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the clinical commissioning group in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS clinical commissioning group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS clinical commissioning group and internal auditors.

13.1.1 Currency risk

The NHS clinical commissioning group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS clinical commissioning group has no overseas operations. The NHS clinical commissioning group and therefore has low exposure to currency rate fluctuations.

13.1.2 Interest rate risk

When required, the clinical commissioning group borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The clinical commissioning group currently does not have any loans and therefore is not exposured to interest rate fluctuations.

13.1.3 Credit risk

Because the majority of the NHS clinical commissioning group and revenue comes parliamentary funding, NHS clinical commissioning group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

13.1.3 Liquidity risk

NHS clinical commissioning group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS clinical commissioning group draws down cash to cover expenditure, as the need arises. The NHS clinical commissioning group is not, therefore, exposed to significant liquidity risks.

13 Financial instruments cont'd

13.2 Financial assets

	Loans and Receivables 2017-18 £'000	Total 2017-18 £'000
Receivables:		
· NHS	4,378	4,378
· Non-NHS	174	174
Cash at bank and in hand	76	76
Other financial assets	19	19
Total at 31 March 2018	**4,647**	**4,647**

	Loans and Receivables 2016-17 £'000	Total 2016-17 £'000
Receivables:		
· NHS	6,937	6,937
· Non-NHS	151	151
Cash at bank and in hand	37	37
Other financial assets	20	20
Total at 31 March 2017	**7,145**	**7,145**

13.3 Financial liabilities

	Other 2017-18 £'000	Total 2017-18 £'000
Payables:		
· NHS	7,380	7,380
· Non-NHS	17,605	17,605
Total at 31 March 2018	**24,985**	**24,985**

	Other 2016-17 £'000	Total 2016-17 £'000
Payables:		
· NHS	5,578	5,578
· Non-NHS	12,443	12,443
Total at 31 March 2017	**18,021**	**18,021**

There are no financial assets or liabilities at fair value through profit and loss (31 March 2017 None).

14 Operating segments

NHS Southend CCG considers that it has only one segment: Commissioning of Healthcare Services (2016-17: One)

15 Pooled budgets

NHS Southend CCG was not party to any pooled budget arrangements during 2017-18 (2016-17: None)

16. Losses and special payments

No losses or special payments were incurred by NHS Southend CCG in 2017 -18 (2016-17: £nil)

17 Related party transactions

Details of related party transactions with individuals are as follows:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Dr J Garcia-Lobera, GP Elected Member from September 2014, CCG Chair from December 2014, Clinical Lead - Nagle and Partners, Pall Mall Surgery	2,419	-	336	-
Dr B Houston - GP Elected Member, Clinical Lead - Highlands Surgery and Fortis Healthcare:	139	-	72	-
Houston BRM & Partnres total:	1,198	-	107	-
Dr K Ng - GP Elected Member, Clinical Lead - Ng H W & Partner	353	-	41	-
Dr K Chaturvedi - GP Elected Member, Clinical Lead - Dr KK Chaturvedi	250	-	6	-
Dr Syed - GP Elected Member, Clinical Lead - Dr Nagle & Partners	-	-	-	-
Pall Mall Surgery Total	2,419	-	336	-
Dr F Khan - GP Elected Member, Clinical Lead - Carnarvon Road Surgery	483	-	80	-
Dr K Barusya - GP Elected Member, Clinical Lead - N K Shah & Partner North Avenue Surgery	331	-	38	-

The payments disclosed relate to transactions made between the CCG and the associated business interests of those listed above. These include the GP practice and other private business interests.

The Department of Health is regarded as a related party. During the year the CCG has had a significant number of material transactions with entities for which the department is regarded as the parent Department. For example:
- NHS England;
- NHS Foundation Trusts;
- NHS Trusts;
- NHS Litigation Authority;
- NHS Business Services Authority.

Specifically the CCG had contracts / transactions in excess of £1m with the following organisations:
- Southend University Hospital NHS Foundation Trust
- South Essex Partnership NHS Foundation Trust
- Bart's and the London NHS Foundation Trust
- East of England Ambulance Trust
- Mid Essex Hospitals Trust
- Basildon and Thurrock University Hospital NHS Foundation Trust

In addition, the CCG has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Southend-on-Sea Borough Council

Executive Board members have declared that they have no related party transactions.

2016-17	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Dr J Garcia-Lobera, GP Elected Member, CCG Chair, Clinical Lead - Nagle and Partners, Pall Mall Surgery	121	-	3	-
Dr B Houston - GP Elected Member, Clinical Lead - Highlands Surgery and Fortis Healthcare	159	-	6	-
Dr K Ng - GP Elected Member, Clinical Lead - Ng H W & Partner	39	-	3	-
Dr K Chaturvedi - GP Elected Member, Clinical Lead - Dr KK Chaturvedi	17	-	2	-
Charles Cormack - Lay Member, Darby & Joan Organisation	127	-	-	-
Dr Syed - GP Elected Member, Clinical Lead, Dr Nagle & Partners	123	-	-	-
Dr F Khan - GP Elected Member, Clinical Lead - Carnarvon Road Surgery	26	-	-	-
Dr K Barusya - GP Elected Member, Clinical Lead - N K Shah & Partner North Avenue Surgery	24	-	2	-

18 Events after the end of the reporting period

There are no post balance sheet events which will have a material effect on the financial statements of the CCG

19 Financial performance targets

NHS Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended).
NHS Clinical Commissioning Group performance against those duties was as follows:

	2017-18 Target	**2017-18 Performance**	2016-17 Target	2016-17 Performance
Expenditure not to exceed income	267,815	274,654	242,526	246,509
Revenue resource use does not exceed the amount specified in Directions	267,319	274,158	238,990	242,973
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	263,378	270,217	235,060	239,046
Revenue administration resource use does not exceed the amount specified in Directions	3,941	3,941	3,930	3,927

NHS Southend CCG

New address and telephone no. with effect from 25 May 2018:

Floor 6
Southend on Sea Borough Council
Civic Centre
Victoria Avenue
Southend on Sea
Essex, SS2 6ER

Tel: 01702 215050
Email: southend.ccg@nhs.net

www.southendccg.nhs.uk
Twitter: Follow us @SouthendCCG
Facebook: www.facebook.com/southendccg

10

MEETING	AGENDA ITEM
Health & Wellbeing Board	
MEETING DATE	REPORT NUMBER
20 June 2018	
SUBJECT	
A Better Start Southend (ABSS) Programme update	
REPORT AUTHOR	
Jeff Banks, Director ABSS	
PRESENTED BY	
Alex Khaldi, Chair ABSS	

SUMMARY
Since March ABSS programme activity has focused on:

- Contracting with Diet and Nutrition project providers
- Service design for Social and Emotional work stream
- Induction of Director and engagement with Partners
- Development of capacity through recruitment of additional Project Management staff
- Preparation for Big Lottery Annual Review

RECOMMENDATIONS
Board members are asked to note the contents of the report and raise issues and opportunities with the Chair of the ABSS Partnership Board, Alex Khaldi.

1) GOVERNANCE

The H&WB meeting on 21 March 2018 saw the first ABSS report in the current format. Members welcomed the layout, format and content of the report which, it was considered, provided a clear focus and the correct level of detail to enable the Board to fulfil its role at the top of the ABSS governance structure. Alex Khaldi undertook to provide details of parental engagement by ward and service delivery by ward and this information is provided below.

The operational governance structure, comprising a Partnership Board (made up of all key partners, ABSS staff and parent representatives) alongside specialist sub-groups, is considered by to be stable and feedback from partners and the Big Lottery Fund is positive. The Chair will be undertaking a routine review of the Governance to ensure appropriateness of the structure for new challenges.

Parent and Ward Forums are well established in all target wards and increasingly well attended. In the Shoeburyness and West Shoebury Ward, a trial is under way to merge panels covering both ABSS and Family Action Children's Centres business. Feedback to date is positive.

Cllr Judith McMahon (Kursaal Ward) has requested breakdown of service provision on a sub-ward level and the Director has made himself available to meet with Cllr McMahon and/or other Members to better understand the request.

2) BIG LOTTERY ANNUAL REVIEW

On 12 June 2018, representatives of ABSS, including Southend Borough Council's Deputy Chief Executive and Directors of Learning and Public Health, attended an Annual Review at the offices of The Big Lottery Fund in London. The results of the review were extremely positive with all performance measures rated Green or Amber on the RAG rating. Officers from the Big Lottery Fund commended the partners and ABSS staff team on their progress and endorsed the programme targets for the coming months/years. In particular, the following was noted:

- good progress on the core work streams (i.e. Communication and Language, Diet and Nutrition and Social and Emotional) beginning to demonstrate positive outcomes for local families;
- progress on local and national research activity;
- consistent use of Service Design Framework and Co-production methodologies;
- strong engagement of stakeholders and families; and
- Community Engagement and Parent Champions team well established.

Moving forward, the developing thinking on sustainability of impact post-ABSS and the programme's contribution to the Southend 2050 agenda was welcomed. Partners shared their commitment to increasing collaborative working and utilisation of ABSS Service Design and Co-Production expertise on service change initiatives.

The Big Lottery Fund expressed strong confidence in the ABSS programme moving forward and thanked the partners for their work in achieving the positive outcomes organisationally and for children and families in Southend.

3) PROGRAMME OFFICE

Jeff Banks joined the ABSS team as Director on 30 April 2018 and has made a positive contribution already. Jeff has met with most partners and has further meetings planned in the coming weeks and is working closely with the Partners to focus thinking moving forward.

The team have successfully recruited to the following new posts:

- Programme Manager (1 FTE)
- Project Manager (1 FTE)

The following posts are currently being recruited:

- Marketing Officer
- Project Support
- Specialist Teacher

The objective of these appointments is to strengthen the team and build capacity to deliver services in the local wards. In addition, ABSS continues to benefit from secondment *from*

partners and places staff members *with* delivery partners. This benefits integrated working approaches. Further secondment opportunities are being explored.

4) PROGRAMME BUDGET:

Appendix 1 provides a summary of the 2017/18 Quarter 4 financial position.

5) KEY DATA

Appendix 2 provides an example of the Performance Data Dashboard which is presented to members of the Partnership Board. This tool is being developed by the Operational Performance & Intelligence Team at SBC, on behalf of ABSS, and will evolve over the coming months to capture targets for programme delivery alongside results from the commissioned research into outcomes and impact for children and families.

- Table 1 – Unique Beneficiaries
- Table 2 – Beneficiaries by Ward
- Table 3 – Beneficiaries by Project

It should be noted, tables cover the 2017/18 financial year and do not take into account recent service developments.

6) SERVICES

Key stakeholders of strategic and delivery partners, together with Parent Champions and other parents with lived experience, have contributed to the Service Design process of services aimed at improving outcomes in Social and Emotional Development.

The current focus for Service Design:

- Preparation for Parenthood (antenatally)
- Family Support
- Parenting Skills
- Support workers for parents and families of children likely to be diagnosed with Autism and other emotional and communication disorders
- Specialist Health Visitor for Perinatal Mental Health

7) BENFICIARY CASE STUDY

Appendix 3 introduces Scott Fowell, a 34 year-old father of 3 from Shoeburyness. Scott tells his story from living on the streets to turning his life around and now volunteering as an ABSS Parent Champion, eager to get other dads involved in A Better Start.

Appendix 1

Summary Management Accounts - Confidential
Period: QUARTER FOUR 2018

	Period: APRIL to MARCH 2018		
	Actual	Budget	Variance (adverse) or favourable
INCOME	£	£	£
REVENUE FUNDING RECEIVED FROM BIG LOTTERY FUND	2,089,000	2,041,000	48,000
CAPITAL FUNDING RECEIVED FROM BIG LOTTERY FUND	176,000	527,000	(351,000)
LEVERAGED INCOME	-	-	-
TOTAL INCOME	**2,265,000**	**2,568,000**	**(303,000)**
EXPENDITURE			
PROJECTS			
SOCIAL AND EMOTIONAL	1,000	12,000	11,000
COMMUNICATION AND LANGUAGE	319,000	336,000	17,000
DIET AND NUTRITION	173,000	171,000	(2,000)
CRECHE SERVICES	52,000	46,000	(6,000)
WORK SKILLS	68,000	64,000	(4,000)
FAMILY NURSE PARTNERSHIP	347,000	348,000	1,000
SYSTEMS CHANGE	353,000	344,000	(9,000)
MONITORING & EVALUATION	8,000	100,000	92,000
DATA ANALYSIS	51,000	55,000	4,000
PROJECT EXPENDITURE	**1,372,000**	**1,476,000**	**104,000**
SALARIES AND SECONDMENTS	452,000	614,000	162,000
OTHER PMO COSTS	301,000	375,000	74,000
PROGRAMME MANAGEMENT EXPENDITURE	**753,000**	**989,000**	**236,000**
TOTAL REVENUE EXPENDITURE	**2,125,000**	**2,465,000**	**340,000**
CAPITAL EXPENDITURE	157,000	103,000	(54,000)
LEVERAGED COSTS	-	-	-
TOTAL EXPENDITURE	**2,282,000**	**2,568,000**	**286,000**
NET FUNDING IN ADVANCE/(OWED)	**(17,000)**	**-**	**(17,000)**

CUMULATIVE FIGURES FROM START UP TO DATE	£
INCOME	**6,613,000**
PROJECT EXPENDITURE	2,697,000
PROGRAMME MANAGEMENT EXPENDITURE	3,274,000
CAPITAL EXPENDITURE	516,000
TOTAL EXPENDITURE	**6,487,000**
NET FUNDING IN ADVANCE/(OWED)	**126,000**

CONVENTION: Brackets around a number signify either an amount owed by the Big Lottery or an adverse variance (ie income less than budget or

Appendix 2 – Table 1 – Unique Beneficiaries

A Better Start Southend Programme Dashboard

Time Period: 01 April 2017 to 31 March 2018

Produced by the Operational Performance & Intelligence Team

Production Date: 10th April 2018

Source: Data recorded by Children's Centres via eStart or sourced directly from providers for all other events

Unique Beneficiaries

This dashboard counts how many unique individuals attended an event funded by A Better Start Southend. Beneficiaries are only counted once per workstream/children's centre/programme but otherwise may be duplicated.

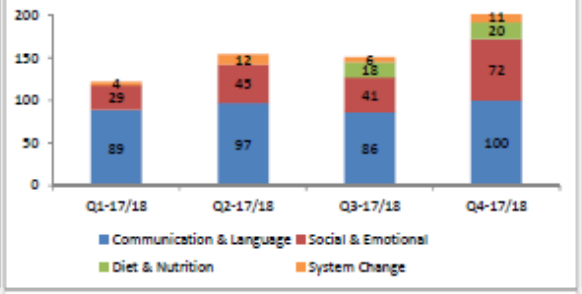
The total number of unique direct beneficiaries, including pregnant mothers, involved in any ABSS projects during the above rolling 12-month reporting period is 419.

For the previous 12-month period ending on 28 February 2018, this figure was 406.

1.1) Status of Current Projects

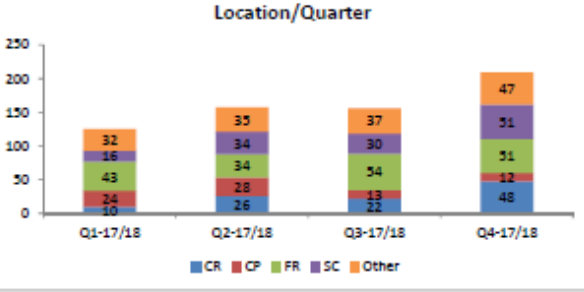
This chart shows the status of all current projects. Note that some projects recently entering into delivery will not appear in other sections of the dashboard as they are at the stage of workforce development.

1.2) Direct Beneficiaries by Workstream/Quarter



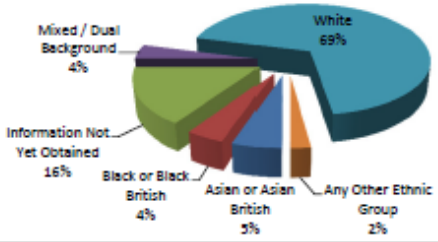
All events have been mapped to one of the programme workstreams and the number of direct beneficiaries involved in each workstream is shown above. See charts 3.1 and 3.2 for further detailsof the projects in each workstream.

1.3) Direct Beneficiaries by Delivery Location/Quarter

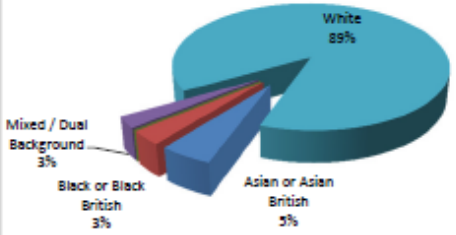


CR = Cambridge Road Children's Centre (Milton ward),
CP = Centre Place Children's Centre (Kursaal ward),
FR = Friars Children's Centre (Shoeburyness ward),
SC = Summercourt Children's Centre (Victoria & Westborough wards)
Other = Non-Children's centre Locations

1.4) Beneficiaries (direct & indirect) by Ethnicity

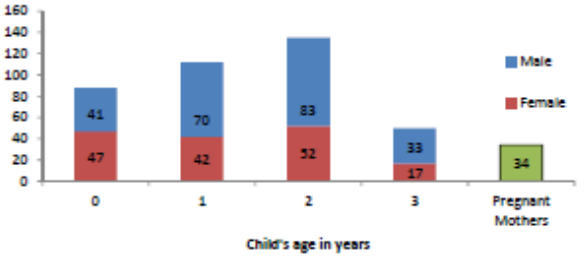


1.5) ABSS Wards Population by Ethnicity



This chart is based on a rolling 12 month period of data. The chart on the left breaks down the unique beneficiaries by ethnic origin. The majority were white although it should be noted that ethnicity was not recorded for a proportion of the beneficiaries. For comparison, the characteristics of the population of the 6 ABSS wards is shown in the chart on the right. The proportions of minority ethnic groups represented in the ABSS projects were higher than those in the target wardslargely due to the speech and language projects where ethnic minority representation was above average.

1.6) Direct Beneficiaries by Gender/Age



This chart is based on a rolling 12 month period of data. The age in years of the direct benefiaries who are children is calculated as at the earliest date of the family's involvement in the project and pregnant mothers are shown separately .

Appendix 2 – Table 2 – Beneficiaries by Ward

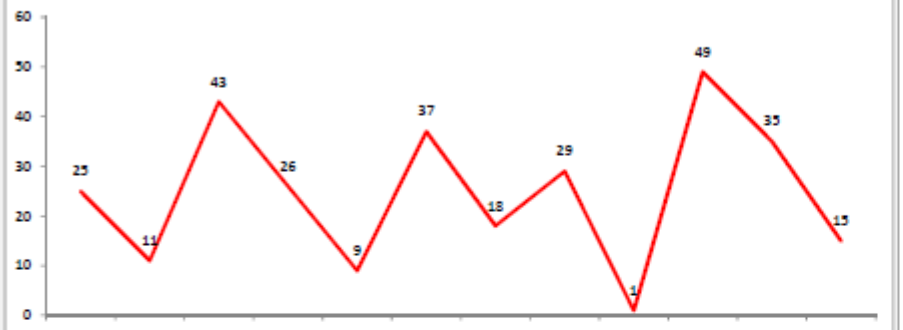
A Better Start Southend Programme Dashboard

Time Period: 01 April 2017 to 31 March 2018

Produced by the Operational Performance & Intelligence Team

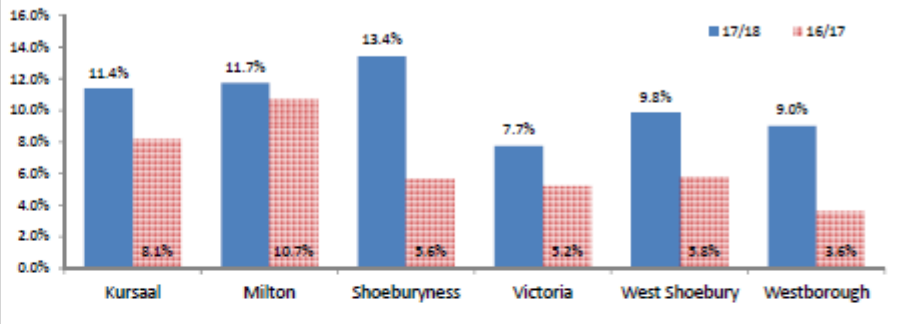
Production Date: 10th April 2018

2.1) Monthly Uptake of New Direct Beneficiaries



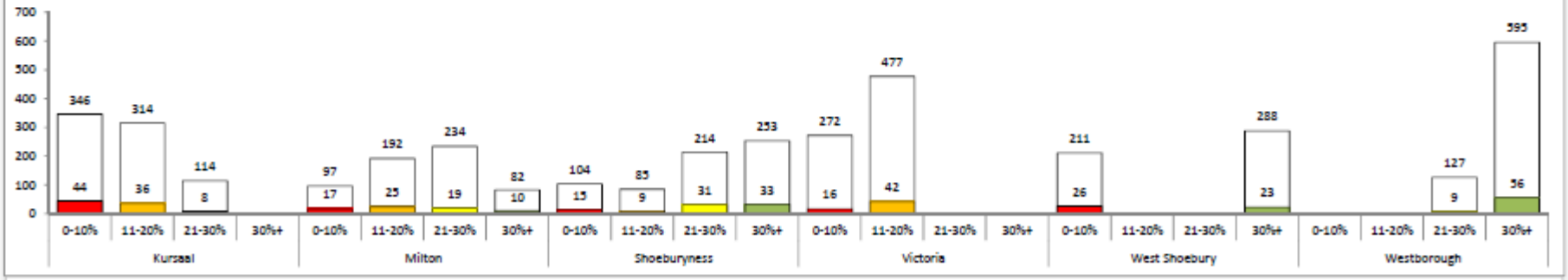
This chart is based on a rolling 12 month period and shows the number of new direct beneficiaries (i.e. children aged 0-3 or pregnant women) recruited into the programme each month who have never been involved in the programme previously.

2.2) % Direct Beneficiary Uptake from 1/4/17



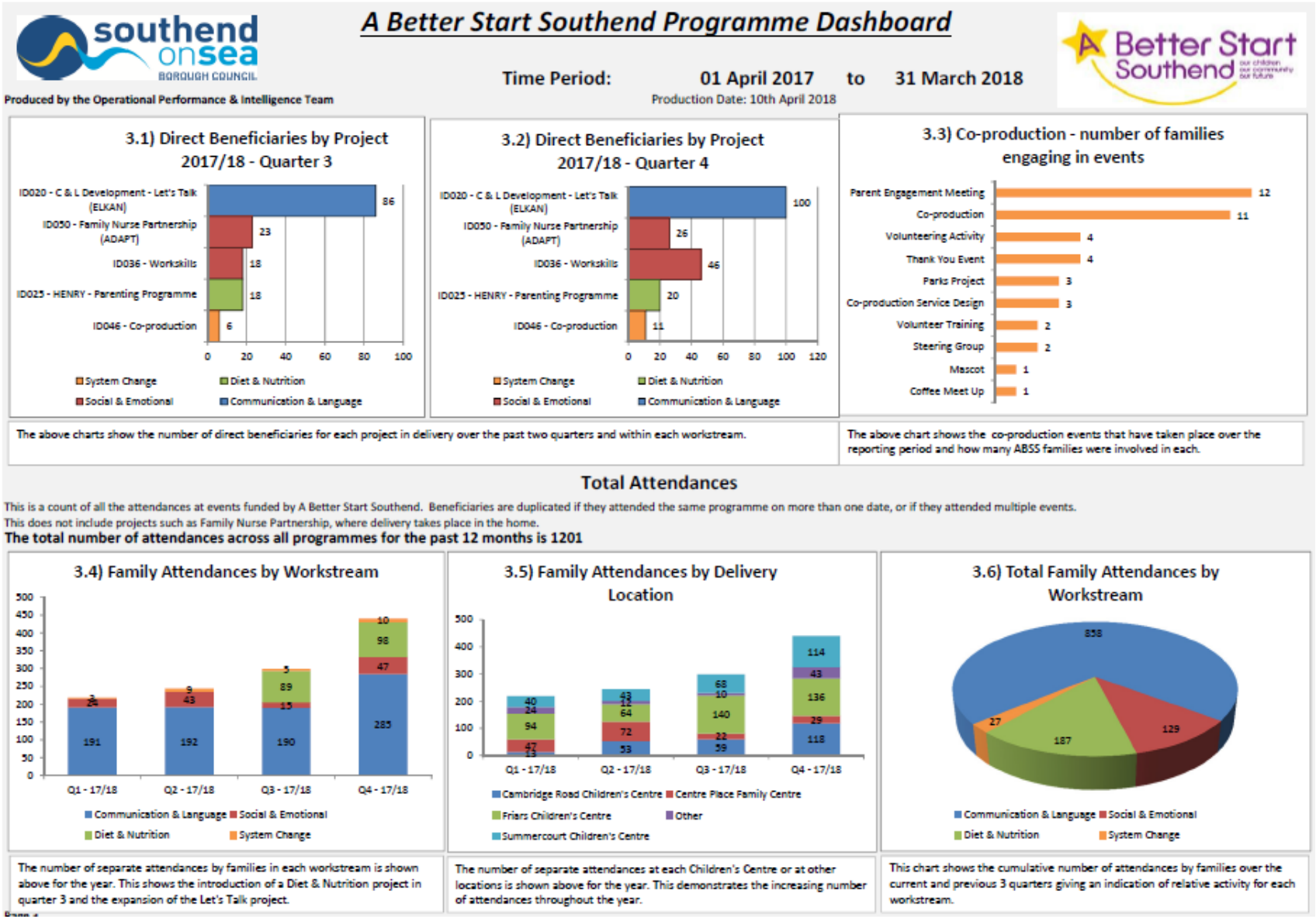
This chart shows the direct beneficiary engagement as a percentage of target children by ward for the current financial year to date, compared to the previous year. In 2017/18 the reach has exceeded that for 2016/17 in all wards.

2.3) Engagement of Target Direct Beneficiaries in ABSS Wards by Deprivation Level



The above chart shows the rolling 12month cumulative number of direct beneficiaries by the target ABSS ward they live in compared to the number of children aged 0-3 according to the mid-2015 population statistics. Each ward is broken down by the number of children living in each deprivation group and the coloured bars represent the proportion of target beneficiaries engaged in an ABSS programme over the course of the year. Areas shaded red are in the most deprived areas in the country and therefore are a high priority for ABSS. Kursaal ward shows the highest number of children living in the top 10% of deprivation.

Appendix 2 – Table 3 –Beneficiaries by Project



Appendix 3

Scott Fowell is a 34 year-old father of three sons from Shoeburyness.

He first came to Southend about seven years ago and was living on the streets. Scott explains his situation: *"I became homeless in 2007, and was living a very unsettled life on the streets in London and moving around the country too. I came to Southend in 2011 and I decided enough was enough. I wanted to turn my life around, to better myself and improve my situation. And over the last seven years my life has turned around."*

He has had previous involvement in parent-led initiatives and was involved in Sure Start, when in a previous relationship and was also the Vice Chair of the Sure Start Parent Forum in the Gascoigne ward in Barking & Dagenham.

He explains why he wanted to get involved with the Co-production project at A Better Start Southend: *"I have strived to give back and do something for the community. I had used different services which helped me turn things around and I wanted to give back and improve others' lives and their wellbeing."*

He first found out about A Better Start though children's services, such as the weigh-in clinic. However, it was when he attended the Let's Talk World Book Week event last year in Shoebury that he really started to get involved with the programme: *"The Bookmobile event was great. I read my kid's favourite 'The Dinosaur That Pooped', which is one of a series of books by Tom Fletcher and Dougie Poynter to all the children, not just my two kids who were with me on the day. Lynsey [Weston] from Let's Talk explained more about A Better Start and the Let's Talk project to me and I wanted to get more involved."*

"Soon after I got involved with the Dad Lab event that Lynsey told me about which was held last October in the SAVS building. I enjoyed all the Dad Lab training. I was definitely looking forward to it, and wanted to show my enthusiasm, to do my bit for the community. I was really happy to be a part of it. Without parents getting involved in all the projects and activities it wouldn't be the same at all."

Getting more dads involved in A Better Start Southend is something close to Scott's heart*: "I always want to get involved in the activities and I want to get other dads involved too. It's important to get dads involved and having fun with their kids as well as having support. I feel that Dads are just as important as mums in bringing up children and they can make as much as a difference as mums can."*

Scott soon got involved in his local A Better Start Parent Forum in Shoebury, to help raise and develop parents' ideas put these forward to professionals. The Parent Forums are run by SAVS who work to involve parents in the co-production of services for A Better Start. *"At the Parent Forums it is all very professional. There's a laid back atmosphere, which I like, but it works as you are there because you want to be and we get things done."*

Scott has recently successfully completed his Parent Champion training, to help promote A Better Start to fellow parents, which was a very positive experience for him*: "It has been fun but constructive, with a relaxed atmosphere. It has given me the confidence to go and do more and I can now say that I am a Parent Champion and I can strive to help other parents. It will give me a bigger input and impact on children's activities and services in the community and help me be a voice for parents that are less able. Being able to use the crèche has been very helpful and gives me peace of mind."*

As part of this desire to get more parents involved, and especially more dads, he has been involved in arranging a Dad's Day in Shoebury. *"The idea went through the Parent Forum and the Ward Panel [which brings together public service providers with community stakeholders at a ward level], and is now in the process of getting final approval (hopefully!) and then it will be going ahead! It is though the Engagement Fund to get more parents involved. A Better Start Southend is helping me achieve this activity day for fathers and children to be together and bond. The event will also be for single parents and those who are doing the 'dad' role too".*

Scott has also taken on the role helping produce a monthly Shoebury parent newsletter; "The role was offered to all of the Shoebury Parent Forum members, and I decided to go forward and help do it. It is going to have information about activities from A Better Start and relevant activities from partner organisations and should go out shortly after the forums, to make sure it has that parent input too."

"The staff involved with the A Better Start programme have been absolutely blinding. They have been absolutely professional and great the way they have put themselves out there and been always ready to help. My 3 year old son is always happy when he comes to A Better Start Southend activities, he's always well-behaved and always wants more."

*"To anyone thinking about getting involved with A Better Start I would say '**Come and join us and get involved!**'"*

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