Southend CCG
Annual Report and Accounts
2018/19

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

Version 9
28/05/19

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WELCOME from our Chair

I would like to welcome you to the 2018/19 Annual Report and Accounts for NHS Southend Clinical Commissioning Group, which covers the period between 1 April 2018 and 31 March 2019. The Annual Report has been prepared in accordance with the National Health Service Act 2006 (as amended 2012) Directions by NHS England, in respect of Clinical Commissioning Groups’ annual report.

This report presents us with the opportunity to highlight to you not only how we have fulfilled our statutory duties, but also to showcase some of the work we have undertaken over the last year.

There is no doubt that the last 12 months have proven to be extremely challenging for us and CCGs around the country, but we are proud of the work we have undertaken. The CCG staff and management team have worked incredibly hard under challenging circumstances and we are keen to share some key achievements with you.

A big part of 2018/19 has seen new services and investment that make it easier for local people to access support closer to home, doing more to help people stay well and remain independent. Better support and care for both staff and residents in our care homes has meant that, since October 2017, trips to Accident and Emergency have fallen by nearly 30%. A new nurse-led community service called ‘SWIFT’ has seen over 1,500 patients receive urgent care in their homes. Evidence suggests that over 900 of those patients would have otherwise ended up in a hospital bed, away from their home comforts.

Accessing care closer to home is a big focus in the recently published NHS Long Term Plan which sets out what the NHS wants to do better for people across the country. Collaborative working is another clear theme, both out of necessity and also because it makes sense, where possible, to do things once while reducing risk of duplication and confusion.

Beyond local NHS commissioning, it is increasingly clear that all partners across health and care need to come together and do things differently so that we have a sustainable service in the future. This report highlights how we have worked closely with partners in health, social care and beyond and this will continue into 2019/10 and beyond.

As a clinically-led organisation, our GPs are vital partners in local decision making and as the heartbeat of the local healthcare system. As you will read, much of our work in 2018/19 has been focussed on supporting GP practices to work together to pool their skills and resources to provide patients with access to more health professionals, including practice pharmacists, paramedics and advanced nurse practitioners. The introduction of a wider team has meant more expertise to treat patients for a wide range of illnesses, ensuring they see the right person, in the right place at the right time freeing up the GPs to spend more time with patients who have complex needs. Through joint working, local people have also benefitted from an additional 14,541 evening and weekend GP and nurse appointments in 2018/19.

In addition to developing new ways of working in local GP practices, the CCG has continued to focus on delivering its priorities and has maintained its commitment to engaging effectively with its patients and the public as a whole. Our growing use of patient stories in driving this commitment has helped all of us to realise that everything we do can help individuals, families and carers. Whilst there are various means by which you can get involved with the
work of CCG, we are particularly keen to engage more with people about local services and their transformation.

We know that there are diverse levels of affluence coupled with significant and unacceptable inequalities across the borough, particularly relating to residents' health. Evidence tells us that there is a strong association between deprivation and mental ill health. Data shows that the estimated proportion of Southend-on-Sea’s adult population with a common mental health disorder is higher than both the regional and national average. You can read more about our plans to strengthen mental health support in Southend from page 36.

Understanding local needs, beyond data, is critical as I am sure that the challenges we face now will only grow in the future and 2019/20 is already shaping up to be a testing year both nationally and locally. Southend-on-Sea Borough Council has been leading some important conversations with local residents have set out some clear and exciting ambitions as part on a Southend 2050 project. We fully support this work and our role is to work with council and other local partners and the people to make sure health services are fit for the future.

For us to achieve our ambitions to improve the health and care of local people both next year and into the future, we have to work together with all our partners so that we can make informed decisions to deliver safe and high quality services. By working together we can also make sure that every pound of taxpayers’ money goes as far as possible.

Over the past year, NHS Southend CCG has been delivering an Improvement Plan, in response to being placed in to Financial Special Measures by NHS England in January 2018. I am delighted to report that thanks to rigorous and disciplined financial management the CCG has achieved an in-year breakeven position and the CCG has met its financial targets.

I hope you enjoy reading this report and, if you have any comments or queries on the information within it, please do let us know using the contact details at the end.
Performance Report

Terry Huff
Accountable Officer

24 May 2019

Performance Overview

The purpose of this overview is to give you a short summary of our organisation, our purpose, the key risks to the achievement of our objectives and how we have performed during the year.

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.

NHS Southend Clinical Commissioning Group (CCG) is the organisation that decides how to spend the NHS budget on the majority of health services for 181,800 people living in Southend.

This includes the care and treatment you receive in hospital, maternity services, community and mental health services. NHS Southend CCG is also an active participant in a mid and south Essex Sustainability and Transformation Partnership in which partners across health and care work together to improve the health and care of the wider 1.2 million population.

We also have delegated responsibility for commissioning general practice (GP) services.

Established under the Health and Social Care Act 2012 as a statutory body, every GP from the 28 GP practices is a Member of NHS Southend CCG. As a CCG, we work hard to understand the needs of people living in Southend to commission the right services for the public.

To do this, the vast majority of decisions about how we use the public's money is made by local clinicians who are closest to the people they look after. We work in partnership with health and social care partners (e.g. local hospitals, local authorities, the community and voluntary sector) and our Governing Body is made up of seven representatives of general practice (GPs) from across Southend along with a chief accountable officer, chief finance officer, chief nurse, secondary care (hospital) specialist and two lay members.

A formal document, called a Constitution, sets out the arrangements the CCG has made to ensure it meets its responsibilities for commissioning high quality services for the people of Southend.
It describes the governing principles, rules and procedures which will ensure integrity, honesty and accountability. Also, it commits the CCG to taking decisions in an open and transparent way and places the interests of patients and public at its heart. We last refreshed our Constitution during 2018/19 to reflect joint working arrangements with NHS Castle Point and Rochford CCG.

Our Constitution can be downloaded from our website.

Over the past year, NHS Southend CCG has been delivering an Improvement Plan, in response to being placed in to Financial Special Measures by NHS England in January 2018. This reflected a deterioration in the financial position and concerns in respect of financial leadership and governance at the CCG.

Actions against 97 actions have been regularly monitored with oversight from the Governing Body and NHS England. Thanks to the determination of staff we are now in a much stronger position demonstrating more rigour and financial discipline and compliance with sound governance practice and we will focus on embedding our new ways of working during 2019/20. We are committed to continue our efforts in a bid to be taken out of Special Measures.

The area we serve

Southend is one of the most densely populated areas in Essex and our CCG covers a population of approximately 181,800 people across Southend, Leigh, Westcliff and Thorpe Bay; with more than 18,000 patients over the age of 75.

In Southend-on-Sea, life expectancy of both males and females within Southend is below average compared to the rest of Essex with males on average living to 78 and females to 83.

The life expectancy gap between the most deprived and least deprived wards is just over 11 years for males, and just under 10 years for females.

18% of the adult population smoke.

By 2031, the projected population for Southend-on-Sea will be 202,935. This assumes a growth rate of 12.87% which is higher than the projected growth rate for England (10.11%). The over 65 population is projected to increase by 4%.

Southend-on-Sea has high levels of deprivation compared with Essex and England as a whole. Nine areas have been identified as being in the top 10% most deprived areas in England. Just under 1 in 5 children live in low income families (households where income is less than 60% of the median income before housing costs). In comparison 8 areas in Southend-on-Sea rank in the 10% least deprived, as a consequence Southend-on-Sea is rated as being in the 20% most deprived local authority areas on inequality.

Rates of pregnancy in people under 18 are also statistically significantly worse than the England average.
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 across local agencies 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.

In addition, the HWB has identified violence and vulnerability as a further key priority area during 2018 and the multi-agency Violence and Vulnerability Steering Group has been instigated and operated over the course of the year, developing and implementing a local action plan. This local plan uses multi-agency data and local intelligence to develop evidence-driven interventions to inhibit criminal activity, particularly around the illicit drugs trade. The HWB is partners in this endeavour with the Local Safeguarding Children Board, the Adult Safeguarding Board, and the Community Safety Partnership. The work within Southend-on-Sea is organised around four Ps; preparation, prevention, protection, and pursuit, and has received very favourable national attention.

The 2018/19 Joint Strategic Needs Assessment (JSNA) Summary Report was approved at the January Health and Wellbeing Board. This report covered key issues of demographics, deprivation, and inequity across multiple factors and summary reports on all areas of health and wellbeing where JSNA update had been focused over 2018:

- Work and employment
- Health protection
- The health of our 0-5 year old residents
- Special Education Needs and Disability (SEND)
- Sexual health
- Harm reduction
The Health and Wellbeing Board review of the JSNA report identified two further key areas for prioritisation of work to work to in addition to those noted above; under 18 conceptions, and Stroke and Atrial Fibrillation.

Significant work within the Borough and across the STP will be undertaken in 2019/20 to meet the prevention challenges for these specific issues and conditions. This will include work to build on current health intelligence frameworks including development of population health management systems.

In order to address the key priority challenge areas, the Health and Wellbeing Board endorsed the use of a Health in All Policies (HiAP) approach. This way of working asks that all policy decisions and strategies across organisations such as local authorities and health commissioners/providers consider the impact on health and on potential health impacting behaviours. Where policies consider and address encouragement for health positive behaviour choices, we can begin to create a healthier environment that tackles the wider determinants health and pre-determinates of health.

This Health in All Policies approach is being driven through the Health and Wellbeing Board and is being successfully embedded across Southend-on-Sea Borough Council. This is expected to be a key factor in reducing inequality and deprivation in the Borough.

Throughout 2018/19 the Southend Health and Wellbeing Board has continued to drive discussion and progress on key issues aligned to the focus highlighted above within the local Health and Wellbeing Strategy. The Health and Wellbeing Board hosts regular, additional strategic discussions on relevant issues, particularly relating to the development of localities across the Borough and with Castle Point and Rochford 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.

Our vision, values and objectives

As previously mentioned, a big part of 2018/19 has seen NHS Southend CCG working increasingly closely with our immediate neighbours, NHS Castle Point and Rochford CCG. During 2018/19 we adopted a joint management structure. Together we have a joint vision, as well as joint values and objectives for south east Essex.
**Key facts and figures**

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<th><strong>Headquarters</strong></th>
<th>NHS Southend CCG, Floor 6, Southend on Sea Borough Council, Civic Centre, Victoria Avenue, Southend on Sea, Essex, SS2 6ER</th>
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<tr>
<td><strong>Communities covered</strong></td>
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<td><strong>Population (registered GP)</strong></td>
<td>Approx. 181,800</td>
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<td><strong>Revenue Resource Limit (for 2018/19)</strong></td>
<td>£279.4m</td>
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<tr>
<td><strong>Number of GP practices</strong></td>
<td>28 (as at 31 March 2019)</td>
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<td><strong>Average Number of employees</strong></td>
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**Where we buy your healthcare**

The following table gives a summary of where we commissioned services in 2018/19.

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<th><strong>Type of Healthcare</strong></th>
<th><strong>Where we buy it from on your behalf</strong></th>
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<td>Community Services: This includes, district nursing, speech and language therapy, podiatry, paediatric community nursing.</td>
<td>• Essex Partnership University NHS Foundation Trust (EPUT)</td>
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| NHS hospital services: This includes outpatient clinics, operations and emergency care | • Southend University Hospital NHS Foundation Trust (SUHFT)  
   • Basildon and Thurrock University |
Hospitals NHS Foundation Trust (BTUH)
- Mid Essex Hospital Services NHS Trust (MEHT)
- Hospitals outside Essex such as Addenbrooke’s Hospital in Cambridge and St Bartholomew’s Hospital in central London – referrals to such hospitals are made for some specialist services such as complex emergency trauma cases or as a result of patient choice

Mental Health Services: This includes psychological therapies, community mental health teams emotional health and wellbeing service and learning disability services
- Essex Partnership University NHS 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

Integrated Urgent Care (IUC) Services including NHS 111 and GP Out of Hours
- IC24

Weekend Primary Care GP services
- GP Healthcare Alliance

We also commission primary care services for our local population. See page 23 for more details.

**Financial performance**

Whilst the 2018/19 financial year was a challenging one financially the CCG delivered an in-year breakeven position against our Revenue Resource Limit of £279.4m, thus meeting our statutory requirement to break even, along with the nationally set NHSE financial control total, which was also set at an in-year breakeven position.
Local challenges

There is huge demand on our health and social care services. We know that these challenges will intensify over the coming years as our older population increases and the number of people with multiple and complex health care needs grows.

Our hospitals and community services are under intense pressure, often relying on 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 mean not everyone gets the care they are entitled to in the right place at the right time.

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 the 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 financial and service pressures facing health and social care cannot be tackled by making incremental adjustments to existing services and ways of working, we must do something different.
The NHS Long Term Plan, published in January 2019, sets out ambitious plans for the NHS to improve the quality of patient care and health outcomes. It sets out how the £20.5 billion budget settlement for the NHS, will be spent over the next five years.

The plan has been drawn up to make the NHS fit for the future and to get the most value for patients out of every pound of taxpayers’ investment. In summary, the plan sets out how we need to do much more to improve the physical and mental health of the nation through better prevention and detection of diseases such as cancer.

The NHS Long Term Plan lists a number of important ambitions for the next few years, but central to the delivery of all of them will be the need for people to work together – whether that’s GP surgeries teaming up so they can provide more appointments and services, or whole health and care systems coming together to plan and deliver real improvements for patients in crucial areas like mental health, cancer or stroke care.

**Working with partners and integration**

As a CCG, we rarely work alone, because if we did we would be unlikely to realise our potential.

There is already closer working between different health and social care teams, making it easier for patients to access the care and support they really need.

It is recognised that ‘one size won’t fit all’ and different areas (that are defined as ‘localities’) are shaping services to suit their community’s needs where it makes sense.

To help services meet local needs, the population of Southend has been broken down into four localities.

Southend: East, East Central, West Central & West.

**The Southend Better Care Fund**

The Better Care Fund (BCF) is a programme spanning both the NHS and local government which seeks to join-up health and care services, so that people can manage their own health and wellbeing, and live independently in their communities for as long as possible.

The BCF has been created to improve the lives of some of the most vulnerable people in our society, placing them at the centre of their care and support, and providing them integrated health and social care services, resulting in an improved experience and better quality of life.

The Southend BCF plan continues to support and drive our activities to integrate health and social care. Our plans have continued to focus on reducing distressing trips to hospital and ensuring that more care is provided in local communities. Another focus has been on getting people back home as soon as possible if they have been in hospital. To achieve these objectives, our plans to transform existing services include implementing a Locality approach, commissioning a range of integrated health and care services and engagement with the STP.

Highlights / successes include;
- Implementing a ‘Discharge to Assess’ policy meaning that hospital discharge is planned early on and via an integrated (health and care) assessment. Improved
outcomes for the patient include reduced length of stay, enhanced and integrated level of care in the community post discharge. The implementation of the policy is led by an Integrated Discharge Manager

- Patients receiving appropriate advice, information and guidance at A&E department via a social worker being based in the A&E dept
- Patients receiving integrated care via care worker resource based step down facility;
- The use of a Trusted Assessor to reduce the numbers and waiting times of residents awaiting discharge from hospital and help them to move from hospital back to their care home speedily, effectively and safely.

Southend Health and Wellbeing Board recently led an options appraisal process to evaluate the 'what next' in terms of health and social care integration for Southend. The recommendations of the appraisal have led to the incorporation of a South East Essex Locality Partnership Group. The group have the responsibility for progressing the implementation of an agreed Locality Strategy.

The new Locality Strategy (Living Well in Thriving Communities) sets out the principles of collaborative working and the continued evolution of the south east Essex Locality Partnership. The approach is based around the needs and locations of people, rather than the boundaries of organisations and will focus on prevention and supporting the strengths of communities as individuals.

As set out in the Locality Strategy, system leaders have agreed an approach to implementation that focuses on bottom-up design principles and the empowerment of the public and frontline staff. More information on how we have begun to engage with the community can be found on page 55.

The CCG is committed to working alongside Southend-on-Sea Borough Council to ensure we are working together on shared outcomes that are in keeping with the Southend 2050 themes.

As a south east Essex 'system' we have a role to engage and co-design the most effective ways to put the commitments made to patients in the national Plan into practice locally. We will work with local Healthwatch groups to ensure that the views of patients and the public are heard, as they provide opportunities to hear from people with specific needs or concerns as part of local engagement plans around the NHS Long Term Plan. More information will be available from Healthwatch Southend: http://www.healthwatchsouthend.co.uk/.

In Southend-on-Sea a close collaboration between Southend Borough Council and EPUT NHS Trust, alongside other local providers, has already brought together local health, social care and well-being staff from different specialities and organisations (who may each have been looking after the same person individually) into a single client-focused Locality team.

Since January 2017 individuals living in Southend have benefitted from local multi-disciplinary care co-ordination. Working together, staff identify people at risk of deterioration and could benefit from a multi-disciplinary approach. Led by social care, there are four integrated Locality teams who meet fortnightly in pairs across the four Southend Localities.

To read more about joint schemes that have been put in place by key health and care partners, see page 23.
Commissioning across mid and south Essex

The Mid and South Essex Sustainability and Transformation Partnership (STP)

The mid and south Essex STP is one of 44 such partnerships across England. The Partnership brings together local organisations (acute hospitals, community and mental health providers, Clinical Commissioning Groups), our three local authorities (Essex County Council, Southend-on-Sea Borough Council and Thurrock Council), our three Healthwatch organisations (Essex, Thurrock and Southend) along with clinical and service user representatives to work together to improve the health and care of our 1.2 million population. The organisations meet as a Board, which is independently chaired by Dr Anita Donley OBE.

We are working together to improve the health and wellbeing of the people living in mid and south Essex, by ensuring:

- People get the information, support and access to services they need to live healthy lives for as long as possible;
- When people are unwell or need social, mental health or community support, that those services are delivered in a way that meets their needs and are delivered in the best place – whether that’s in their home, the local community, a GP surgery, or a hospital.

We aim to put our residents at the heart of our health and care system and make sure services are delivered around their needs not individual organisations.

We are working together to develop our staff and teams to ensure we have a health and care workforce of the right size and capabilities able to achieve their full potential, to meet the needs of our residents. We are also committed to developing digital solutions to help support people and deliver care in a safe and efficient way.

The Partnership has agreed three strategic work programmes, led by senior executives across the system:

- Acute hospital services – this is focused on delivering improvements to our three main local hospitals around how we provide specialist services;
- Primary care and localities – supporting the foundation of primary care; developing localities/networks to support our residents to live in good health – see page 23 for more information about specific programmes of work in Southend;
- Population Health – a programme focused on maximising the wealth of data we have and using advanced analytical techniques to improve the services we provide and to target interventions to improve health outcomes.

The Partnership also oversees programmes of work that support these aims:

- Workforce – through working with Health Education England and Skills for Care, we are working to improve recruitment and retention of staff and to support their development - see page 46 for more information;
- Digital – development of digital technologies to support the delivery of health and care services – see page 28 to find out more about new technology solutions now available in Southend;
• Estates – ensuring we maximise the buildings and facilities used by our patients.

The Partnership benefits from advice from a Service User Advisory Group comprising patient and service user representatives from across our statutory organisations, and from our Clinical Cabinet, made up of senior clinicians from all provider organisations.

Over the year, the mid and south Essex STP has:

• Completed a wide-ranging public consultation ‘Your Care in the Best Place’ on changes to some specialist services provided in our three hospitals (Southend, Basildon and Broomfield). Following the consultation and extensive clinical review of the proposals, the CCG Joint Committee approved 19 recommendations to make improvements to our hospital services. At the time of writing, these decisions have been referred, for independent review, to the Secretary of State for Health and Social Care;
• Developed a STP-wide Primary Care Strategy and investment plan, aimed at supporting the foundations of primary care, including enhancing the workforce. The CCG is responsible for implementing the strategy for local residents, see page 23 for more information;
• Been successful in obtaining significant funding to develop an Integrated Care Record which is a joined-up digital care record which will enable clinical and care staff to view real-time health and care information across care providers and between different systems that will support improved care and support for our patients. Implementation of the shared care record will begin in 2019;
• Established an Innovation Advisory Group to embed innovation in all of our work.
• Received funding to support the on-going development of our staff, including on quality improvement, leadership and system working;
• Secured national investment to develop a citizens’ panel to help gain insight from our population to inform our work.

Over the coming year, we will focus on further developing our partnership working, developing a five-year strategy for the STP, and supporting the aims outlined in the NHS Long Term Plan.

**STP Joint Committee**

To reduce duplication and ensure better outcomes for patients where it makes sense to do things once, NHS Southend CCG is part of a wider STP Joint Committee, along with the other four CCGs in mid and south Essex.

The STP Joint Committee commissions and manages the contracts for hospital (acute) services (NHS and independent sector), NHS 111 and Out of Hours services, ambulance services, Patient Transport services and acute Mental Health services. The STP Joint Committee also plays a role in decision making about Learning Disability services within the existing pan-Essex arrangements.

The STP Joint Committee is not an organisation or legal entity, the individual CCGs are the statutory organisations responsible for commissioning healthcare in this area. All CCGs have a statutory obligation to meet a range of constitutional targets including but not limited to:
A&E transit times, Referral to Treatment Times, Cancer waiting times, mental health access targets and others.

The Joint Committee supports the collective planning, securing and monitoring of services to meet the needs of the population of mid and south Essex, as well as representing the STP footprint for services commissioned over a larger area. Working collaboratively in this way allows us to have a stronger influence and deliver better outcomes for patients. It also allows us to provide greater consistency, scrutiny and influence on any decision that affects our area.

360 Stakeholder Survey

Our relationships with key organisations in the local health system have continued to develop over the last year and will help inform our continuing organisational and leadership development. The 360 stakeholder survey is conducted by Ipsos MORI on behalf of NHS England and also forms a central part of the statutory annual assessment of all CCGs.

The diagram on the next page highlights areas where the CCG is performing well and also outlines potential areas for improvement.

A link to the full report can be found here: https://southendccg.nhs.uk/about-us/key-documents/360-stakeholder-survey/2787-360-stakeholder-survey-result-2018/file
Southend CCG: 360 Stakeholder Survey Highlights

As commissioners, we need to have strong relationships with a range of stakeholders in order to successfully support our local health and care systems. These relationships give us valuable intelligence to help us make effective commissioning decisions for our local population.

Below you will find a summary of the feedback we have received as part of the 2018/19 360 stakeholder survey. The insight will help us with our ongoing organisational development, providing a valuable tool to evaluate our progress, celebrate achievements and highlight areas for improvement.

“[We need to] strengthen working relationships with commissioning leads.”

87% of stakeholders reported that they had an effective working relationship with the CCG (up 3% from last year).

77% rated the CCG’s ability to effectively engage with external stakeholders (up 26% from last year).

82% rated the CCG as effective at improving the quality of local health services – 8% higher than the national average.

74% agreed that the CCG involving the right health and social care organisations when commissioning commissioning services – up 6% from last year, and 6% higher than the national average.

64% agreed that the CCG demonstrates that it considers the views of patients and the public – up 13% from last year.

21% of stakeholders disagreed that the CCG asks the right questions at the right time when commissioning commissioning services.

2/5 providers disagreed that the CCG effectively deals with problems to another system partner.

2/3 local CCGs and other stakeholders disagreed that Southend CCG considers the whole health and care system when making a decision (89% total area of stakeholder agreement).

2/5 local CCGs and other stakeholders disagreed that the CCG is not effective at delivering value for money (64% of stakeholders).

74% of providers agreed that the CCG engages effectively with patients and the public – up 19% from last year, and 15% higher than the national average.

87% agreed that the CCG is effective at improving health outcomes for its population – 11% higher than the national average.

A local CCG and other stakeholders (65%) disagreed that we work collaboratively with other system partners to improve the future health of the population across the whole system.

24% of stakeholders reported that the CCG was not effective at reducing health inequalities (including SP members practice, one of our providers and wider stakeholders).

However, only 64% of providers agreed that the CCG has the right relationships with commissioning services.

“[We need to] strengthen working relationships with commissioning leads.”

“We have an open and honest relationship which benefits shared learning and best practice for our patients.”

This data is based on the responses of 30 stakeholders, with a total response rate of 62.4% across all stakeholder groups.

Stakeholder groups involved: GP member practices, Health and Wellbeing boards, Local Healthwatch, other patient groups and voluntary sector organisations, representatives, health providers, other CCGs, other the various local authorities and wider stakeholders.
Performance analysis

Accountable Officer’s Foreword

The following section provides the view of our Accountable Officer, Terry Huff and a summary of our performance during 2018/19.

Although I have only recently joined the CCG from 1 April 2019, I need to recognise the efforts of a number of interim Accountable Officers who have led the CCG over the last year. There are so many examples of great practice and progress from 2018/19 and I look forward to building on this success.

The main positives that have arisen for the CCG in 2018/19 are:

- Huge steps forward in a journey to strengthen GP services, see page 23 for more information
- Further investment in wider community services with a focus on prevention and shortest term hospital stays
- A particular focus on delivering services to support our most vulnerable residents
- Strengthened mental health services
- Delivering more digital solutions than ever before
- More rigour and discipline around financial management

There have also been a number of challenges including:
- a financially challenging year delivering 97 actions of an Improvement Plan. The CCG has already undertaken a significant amount of work in many of these key areas. We have published more information about this on our website.
- a referral from Southend-On-Sea People Scrutiny Committee to the Secretary of State for Health and Social Care around the decisions made by the Mid and South Essex STP CCG Joint Committee, following the public consultation Your Care in the Best Place.
- delivering transformation of services whilst ensuring impact on current services is minimised.

Moving forwards, I am confident that the development of a new joint executive team and staffing structure in 2018/19 has put us in the best possible position to deliver:

✓ A co-ordinated strategic approach
✓ Consistent quality across both CCGs
✓ Stability
✓ Even more financial rigour

I would like to end by thanking all of the local NHS and wider health and care workforce and local volunteers who have helped us to deliver safe and high quality services in 2018/19 as we look to transform services for the better into the future.

You can follow us @SouthendCCG on Twitter, like our Facebook page (NHS Southend CCG) or use any of the other ways listed on our website to stay involved and join us on our journey to give you great care.

Terry Huff
Accountable Officer
Principal risks and uncertainties

We have developed a Governing Body Assurance Framework to ensure that there is a streamlined approach to assurance enabling the Governing Body and delegated committees to focus only on the strategic risks of the organisation. For assurance see the full governance statement on page 83.

This is supported by the Corporate Risk Register which documents all strategic and operational risks of the organisation. The Corporate Risk Register and Governing Body Assurance Framework are reported regularly to the Governing Body, Audit Committee, Quality Finance and Performance Committee and Corporate Management team meetings.

Our risks and uncertainties should be viewed against a back drop of a rising number of older people in the local population, health inequalities and a significant number of people living with long term conditions. Key risks identified are:

- Workforce in primary care which could lead to patient safety risks within practices and patients not receiving the services they need to stay well and lead a healthy lifestyle and GPs voluntarily terminating their contracts. Meeting patient demand where necessary; delivering on KPIs, achieving financial balance as part of QIPP savings, managing strategic and operations plans to ensure best outcomes for patients; meeting national standards and statutory responsibilities; workforce and staff shortages, the impact of a deal or no deal EU exit, managing staff vacancies and sickness; agreeing an effective joint system wide way of delivering healthcare with our partners and stakeholders; patient care and safety for patients; ensuring adequate capacity and response in times of major disease outbreak.

- We will face an increasingly challenging year in 2019/20 as the NHS continues to operate within a tight financial framework during a period of change and movement towards greater integration.

- We are committed to minimising risks to which we are exposed, strategically and corporately. The overriding aim is to reduce the potential for loss of services due to adverse events, financial management or performance and quality management of commissioned services that could ultimately be of detriment to the population the CCG serves.

- Our risks and uncertainties should be viewed against a back drop of a rising number of older people in the local population, health inequalities and a significant number of people living with long term conditions.

Our performance

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 2017/18 - Southend CCG assessed as ‘inadequate’. 2018/19 rating not yet available.
- Urgent and emergency care
• Mental health – including IAPT
• Sustainability

The table that follows shows the CCG key targets that it has monitored during 2018/19. 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 have agreed or are in the process of agreeing constitutional standard recovery trajectories for improved delivery with NHS England and NHS Improvement in conjunction with our partners. 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.

**2018/19 Constitutional Standard Performance**

Please note that this data is for the year 2018/19 (unless otherwise stated).

(Data is as available as at 17 May 2019).

<table>
<thead>
<tr>
<th>Category</th>
<th>Sub-Category</th>
<th>Target</th>
<th>Performance (Year to Date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident and Emergency</td>
<td>Seen within 4 hours</td>
<td>95%</td>
<td>87.03% (Mar-19)</td>
</tr>
<tr>
<td>Referral to Treatment</td>
<td>Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral</td>
<td>93%</td>
<td>83.24% (Feb-19)</td>
</tr>
<tr>
<td>Cancer</td>
<td>Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP</td>
<td>93%</td>
<td>90.34% (Feb-19)</td>
</tr>
<tr>
<td></td>
<td>Maximum two-week wait for people referred for investigation of breast symptoms even if cancer is not initially</td>
<td>93%</td>
<td>62.48% (Feb-19)</td>
</tr>
<tr>
<td></td>
<td>Maximum one month (31-day) wait from diagnosis to first treatment</td>
<td>96%</td>
<td>94.19% (Feb-19)</td>
</tr>
<tr>
<td></td>
<td>Maximum 31-day wait for subsequent treatment (drugs)</td>
<td>98%</td>
<td>97.95% (Feb-19)</td>
</tr>
<tr>
<td></td>
<td>Maximum 31-day wait for subsequent treatment (surgery)</td>
<td>94%</td>
<td>88.15% (Feb-19)</td>
</tr>
<tr>
<td></td>
<td>Maximum 31-day wait for subsequent treatment (palliative)</td>
<td>96%</td>
<td>100% (Feb-19)</td>
</tr>
</tbody>
</table>
### Maximum two-month (62-day) wait from urgent GP referral to first definitive treatment

| Maximum two-month wait for subsequent treatment | 94% | 97.8% (Feb-19) |
| Maximum two-month (62-day) wait from urgent GP referral to first definitive treatment | 85% | 73.06% (Feb-19) |
| Maximum two-month (62-day) wait from urgent GP referral to first definitive treatment for NHS screening | 90% | 89.7% (Feb-19) |

### Improving Access to Psychological Therapies (IAPT)

| Access | Q4 4.75% (equivalent to 19% annually) | 5.36% Quarter 4 |
| IAPT | Recovery Rate - 50% of the people who are treated in IAPT services recover | 50% | 50.0% (Dec-18) |
| Dementia | Diagnosis Rate - 66.7% of the estimated prevalence of people with dementia should have a diagnosis | 66.7% | 78.8% (Feb-19) |
| 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% | 61.2% (Mar-19) |
| Clostridium difficile | C.Diff – number of reported cases | 35 cases | 46 cases (Feb-19) |
| Meticillin resistant Staphylococcus aureus (MRSA) | MRSA | 0 | 4 (Feb-19) |

### Financial Performance

#### Revenue Expenditure

NHS Southend CCG delivered an in-year breakeven position for the 2018/19 financial year, meeting both the control total set by NHS England for the CCG, and its statutory duty to breakeven.

The CCG has a brought-forward deficit of £10.8m, which is due to be eroded over the next three financial years, in line with the CCG recovery plan, agreed with NHS England.

- **Revenue Resource Limit (RRL)**: £279.4m
- **Forecast Performance**: £279.4m

#### Capital Expenditure

The CCG received a 2019/20 Capital Resource Limit of £23k, which was spent in-full, as at 31st March 2019.
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 CCG 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 2018/19, 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 resident population.

2019/20 Financial Plans
The Governing Body approved the 2019/20 budget at its March 2019 meeting. The plan delivers a breakeven position, which is the agreed target control total set by NHS England.

It is worthy to note that within this budget is an inherent requirement to deliver significant efficiency savings of £8.7m, 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 2019.

Improving Care
Here are some examples of how by working with our providers and other partners, we have improved care during 2018/19:

GP Services
Across south east Essex general practices provide approximately 145,000 appointments every month. Every year they also:-

- Handle an estimated 1.8 million phone calls;
- Receive and process over a million letters;
- Issue around 2.7 million prescriptions per year;
- In addition over more than 1/5 patients now use ‘Patient Online’ with practices support.
The focus in 2018/19 has been to develop more sustainable general practice and there has been significant progress across a number of key areas of our plan. In June 2018, the CCG along with our partners, see page 58, approved a new Primary Care Strategy “Investing in our Future” and associated Implementation and Investment Plans.

The key aims of the primary care strategy are to:

- Make it quicker and easier for patients to be seen locally by NHS professionals
- Reduce pressure on GPs so they can focus on patients with the greatest need
- Improve the recruitment of GPs and other healthcare professionals to mid and south Essex

Our Primary Care Strategy is available on our website at:

Our CCG Chairs have also published a blog for NHS England on this work which you can read here:
https://www.england.nhs.uk/blog/your-doctor-can-see-you-now-but-do-you-actually-need-to-see-a-doctor/

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 resilient General Practice network for the future.

For more information about how we involved local people in developing local solutions to support GP services, see page 23.

Progress to date includes:

- New funding provided so that patients can be seen by a healthcare professional on weekday evenings (up to 8pm) as well as at weekends. 14,541 additional GP and nurse appointments were made available in Southend during 2018/19;
- Recurrent investment to enable groups of GP practices working together within their locality as “Primary Care Networks”. This funding has allowed localities to employ additional staff who work across the practices bringing a wider range of clinical and professional skills into Primary Care. These staff complements the traditional GP / Practice Nurse model and patients can now be seen by professionals with a wide range of skills and from a range of backgrounds including Paramedics, Physiotherapists, Clinical Pharmacists and Advanced Nurse Practitioners. From April 2019 this service will be in place across Southend.
Home Visiting Service has already been introduced in one locality to add capacity and support to general practices through providing home visits to patients. GPs allocate visits to the service and this frees up the GP to see more patients. The service is provided by, Advanced Nurse / Emergency Care Practitioners and by working in partnership with Southend Borough Council we have developed a model that includes integrated social work support.

Specialist training has been provided for practice reception staff in Care Navigation skills to ensure that when patients contact the practice to request an appointment, they get the right care from the right healthcare professional.

Supporting our practices to access new GP Forward View investment commitments including ‘GP Resilience’ funding.

We have further developed our Contract Assurance Processes working more closely with NHS England and our own Quality team to develop and more complete process.

Consolidated the Southend and Castle Point and Rochford CCG dashboards into a one single tool and incorporated Quality and Medicines Management data to ensure a complete practice overview is available. Dashboard now more able to provide a potential early warning indicator.
o Pro-active support provided to practices through the national, High Impact Action Programme (HIA). This continues to be well received by practices across the CCG. A range of initiatives are offered to practices including Care Navigation training, Patient Online Services, Patient Online Consultations and Quality Improvement schemes. 89% of Southend Practices have adopted at least two or more and 48% have adopted five or more of the High Impact Actions.

o We have designed a Membership Development Programme, securing training to support longer term business sustainability and development.

o We have introduced surgery pods in two GP practices to help free up additional nurse appointments for other patients, see page 36 for more information.

o We invested in workforce and recruitment in primary care, see page 46 for more information.

o Helping practices improve their capabilities and increase efficiencies through a Productive General Practice Programme (PGP) programme that provides the tools and guidance to make rapid improvement in general practice. Twelve practices signed up and participated in the programme, each selected two modules to use to address and implement changes. The main issues addressed were:
  o Improving internal workflow of clinical correspondence
  o Changing method for issuing repeat prescriptions, and
  o Reducing identified 21 - 30% of inappropriate GP consultations

A total of 161 actions have been delivered and a further 123 are planned

Total hours saved per annum: 8,884, (Admin: 4,762 hrs, Clinical: 4,122 hrs)

o Building on the success of the Productive General Practice programme we have established South East Essex Quality Improvement Collaborative to oversee and bring together partners within localities to develop and implement local initiatives (using a Qi approach) to harness the opportunities presented by the, Five Year Forward General Practice Forward View and to support development of new care models.

Progress so far.

- Recruited two GPs as QI fellows to facilitate and support planned eight QI locality Leads and each CCG / locality;
- Recruiting eight QI locality leads to support delivery of the collaborative and roll out further QI to ensure sustainability.

As part of our role as delegated commissioners for primary care, we have also:

o Continued to roll out an Enhanced (GP-led) service to provide dedicated support to residents of care homes, for more information, see page 52.

o Developed and ratified a revised Emergency Caretaker Policy to ensure efficient and safe coverage for our registered population in times of urgent need and preparing to procure a Caretaker provider framework to enable rapid response.

o A full review of the Special Allocation Scheme (SAS) undertaken across the STP footprint. This service provides primary medical services to those patients immediately removed from normal registration due to perceived or actual threatening or violent behaviour and is essential to ensure our population has access to health services in a safe and secure environment. The review has established the need for a single procurement to be undertaken to secure a sole provider delivering in all of the mid and South Essex CCGs, improving access, continuity and quality to ensure greater benefits
to the wider system. A provider has been identified and the shared service will commence from April 2019.

- Merger facilitated between West Road surgery and their neighbour Dr Gul who has subsequently retired.
- Dr Khan a long established and respected provider at Carnarvon Road Medical Centre was supported to move to purpose built modern premises at the North Road Primary Care Centre just a short distance away. This move has been very well received both by staff and patients alike.
- St Luke’s – after extensive consultation and negotiations plans have now been agreed and work commenced to facilitate the development and refurbishment of nearby premises which will provide a new fit for purpose modern larger site for this registered population. Also providing additional space for development of a locality hub.
- Of the 14 practices revisited across south east Essex in 18/19 by CQC 11 were rated as ‘Good’ with 3 ‘Requires Improvement’. Overall we currently have 48 practices out of the 51 rated as Good overall by CQC

**ImproveWell**

NHS Southend was delighted to be the first nationally to utilise a free mobile application to empower staff to share their innovative ideas for quality improvements directly with senior management. The CCG was awarded a years’ licence by UCL Partners, for the fantastic outcomes realised during a 12 week pilot period, which commenced in May 2018.

By downloading the free ‘Improvewell’ mobile app and creating an account, staff can share their ideas with senior management and healthcare colleagues, with ease.

Submissions have already been received from primary care and general practice colleagues, across all roles, including admin, clinical and practice based pharmacists.

Figure 1: South East Essex ImproveWell Pilot outcomes
GP Engagement
We have continued to 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.

In addition to a fortnightly GP bulletin with information about referrals/pathways, CCG news and dates to note, we also have a dedicated members’ area section on our website. GPs are also invited to attend our monthly Locality Commissioning Group meetings, giving them the opportunity to feedback their views on our commissioning plans and talk to officers of the CCG.

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.

Practice Nurse Forum
In partnership with our practice nurses we reviewed the purpose and functions of our Practice Nurse Forum to develop further a forum that will provide the practice nurse workforce with the opportunity to discuss and experience good practice, review new evidence based guidance and provide a 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.
A number of clinical education sessions have been held to date. The aims of the education sessions are to ensure that the practice workforce has access to relevant and up to date evidence based practice.

**Further plans for 2019/20**

In 2019-20 the primary care team will continue to support general practices by focus on ‘locality development’ and how to ensure that the locality supports individual practices, for example by reducing workload or taking on some work on its behalf where this is appropriate.

Localities will have a key role in:-
- Managing and reducing demand, for example through common triage processes and the deployment of Care Navigators
- Providing a common ‘building block’ for integration of other services, such as community, mental health and social care
- Ensuring that at a locality level there is consistent modelling of demand and capacity
- Providing tools to help practices manage workload
- Supporting practices with the recruitment of staff, potentially building on the existing expertise built up through the Workforce Training Hub and EPIC (now the Essex Primary Care Careers) programme
- Creating the critical mass that will enable some services that have traditionally been provided in a hospital setting to be redesigned and re-provided in the community
- Supporting practices to reduce bureaucracy by, for example, sharing back office functions and implementing digital solutions
- Leading patient education on accessing services and self-care

Further development of schemes and initiatives including:-
- Primary Care Network development and support
- Membership Development Programme
- Improved Front Door Triage & Virtual Care Navigation
- Maximising Digital Opportunities
- Safer Working in Primary Care
- Understanding High Intensity Users of Primary Care
- Redesign of Back Office Function
- First Contact Audiologists
- Physicians Associates
- Introduction of Risk Stratification Tools and Population Health Management

**Digital-enabled care**

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 for use across the STP for digital transformation initiatives.

**Use of technology in care homes (Southend)**
We were successful in securing £160k funding for a telehealth project in Southend. Care homes in Southend are now benefitting from new technology to monitor the health of residents, in order to improve health outcomes and reduce avoidable and distressing trips to hospital. As part of the pilot scheme, 18 residential care homes have been provided with a portable handheld device which connects to Bluetooth medical appliances, such as weighing scales, blood pressure monitors, oximeters and thermometers.

The aim of the project was to: reduce distressing trips to hospital; GP and out of hours appointments, as well as improve access to UTI and Sepsis care. The Integrated Nursing Team and carers have been trained in the technology to support patients in using it. Patients’ vital statistics 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.

Free WiFi in GP practices
We led the rollout of a free WiFi service to patients, which is now available in all 201 GP practice buildings across the Mid and South Essex STP footprint. This not only allows patients to connect to WiFi whilst sitting in the waiting room, but also allows health care professionals to use the authorised Guest WiFi system to connect back to their native IT applications. This is a foundation layer of the STP Digital Essex strategy.

Automatically freeing up GP appointments with iPlato
Our team secured investment to work with iPlato to deliver a method for patients to cancel their GP appointments by text or mobile phone app; automatically removing the cancelled slot from the GP rota so that it can be used by other patients. From July to December 10,863 appointments were automatically freed up for other patients to use by allowing patients to text and cancel GP appointments they no longer need using iPlato. The same investment has enabled patients to download a free downloadable app (MyGP) which amongst other things enabled GP practices to send information on health promotion schemes, immunisation and medical alerts and offers but also enables the patient access to Patient On-Line, Repeat Prescribing and Appointment Bookings (where enabled by individual GP practices).

Mobile ECGs in GP practices to detect Atrial Fibrillation
See page 34 for more information.

Patient On-line
Practices have continued to make services available to patients online including booking and cancelling appointments and ordering repeat prescriptions. The number of people registered for these services continues to rise.

Patients registered to book/cancel appointments online in Southend

<table>
<thead>
<tr>
<th></th>
<th>Jan-18</th>
<th>Jun-18</th>
<th>Dec-18</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>16.0%</td>
<td>18.7%</td>
<td>22.8%</td>
</tr>
</tbody>
</table>

The CCG is preparing to further actively promote sign up to patient on-line services as part of the launch for the NHS App later this year. The NHS App is a new “digital front door” to the NHS. It has been designed to give patients access to a number of health apps using just one user name and password. It has been developed by NHS England. All GP practices in England are being asked to switch on the technology by July 2019. Patients will then be able to use the app to access online appointments, request repeat prescriptions etc. because it will be linked to GP online services. It is currently available on Google Play and App Store and patients can register interest and are notified when their practice is live.

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

Enabling mobile working for GP practice staff
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.

Digital Dictation
Further investment was also 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 secured funding of £166k for new computers to ensure that all computers within GP practices are less than five years old.

Finally, we secured funding as part of the GP Forward View to begin to look at GP Online Consultation solutions. Work has been undertaken this year to build on local pilots of Online Consultation software being used in Primary Care to support service delivery. Clinical and public engagement has informed local plans which now being progressed in line with feedback and alongside implementation of the NHS App. We intend to make software available to all GP Practices during 2019/20.
Improved care in the community

SWIFT helped people to stay at home when unwell

As part of a wider investment in community service, we commissioned a new service called SWIFT. The service has helped people to stay at home when unwell, rather than be transferred to hospital. Designed with a ‘home first’ ethos, SWIFT provides specialist, nurse-led care in people’s own homes visiting patients within two-hours of receiving a referral from their GP practice to stabilise their immediate health need.

Although this was a newly commissioning service in 2018/19, SWIFT is already well established and embedded, successfully treating patients at home and reducing the demand for hospital based care and treatment.

SWIFT has seen 1,588 patients in 2018/19, 243 of those patients avoided a trip to an Emergency Department and 962 patients avoided admission to hospital in general. common conditions treated by the team are UTIs, chest infections and exacerbations of COPD. There is further scope to enhance the service in 19/20 to maximise opportunities to bring more care into the community.

Better support and care for our care home residents

We have rolled out a Red Bag scheme that has been shown to reduce hospital delays, help stop patients losing personal items and improve communication between care home and hospital staff. It was launched in south east Essex this year following collaboration between the CCG, Southend Hospital, East of England Ambulance Service and local care homes.
100% of people in care homes have received improved care and support through the Enhanced Care Home Service, see page 52 for more information.

We have also provided more education for care home staff, see page 35.

**Integrated Urgent Care**

In July 2018, following a successful procurement process, Integrated Care 24 (IC24), became the Integrated Urgent Care provider across Mid and South Essex. The Integrated Urgent Care (IUC) service delivers a 24/7 NHS 111 telephony service supported by a clinical hub and a GP out of hours service for 1.2million people. IC24 is a not for profit social enterprise and was the previous provider of NHS 111 and GP Out of Hours service in South Essex and the previous provider of NHS 111 services across Mid Essex. The addition of a clinical hub allows patients with an urgent care need to receive assessment, advice, signposting or referral (where necessary) to local NHS services. Helping ensure patients get to the right place, at the right time. In the first six months from launch, the service has answered 181,742 calls, assessed 75,877 people in the clinical hub and seen 45,083 patients in the out of hours service, across nine clinic locations.

**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 (c1,500 per month), and the need for follow-up care continues to grow with circa 50,000 follow up appointments last year.

In 2017/18 we implemented a number of community pathways, enabling people to access a wider range of eye care at their local high street Optician. The transformation work in mid and south Essex continued at pace in 2018/19, with the introduction of a large scale change to how acute Ophthalmology services will be provided by the local NHS Trusts.

Following detailed planning with clinicians, a new community pathway was launched in February 2019. Patients referred into the Ophthalmology service at Southend Hospital may now be seen in either a hospital or community setting. The new service aims to provide
patients a quick and convenient assessment, diagnosis and treatment of eye problems. A hospital Ophthalmology consultant will triage the referral and decide the best pathway for the care and treatment needed. Patients suitable for the community service will be given a choice of optician, where they will be seen by an optometrist skilled and qualified to assess and treat a range of ophthalmic conditions.

NHS 111 Online
From June 2018 patients across Mid and South Essex have been able to access the same urgent medical advice from the NHS 111 phone line, online at 111.nhs.uk. This is a new, national service which provides a fast and convenient digital alternative to the phone line and helps to manage increasing demand on 111 telephone services. NHS 111 online helps patients to access urgent healthcare using their smartphone, laptop or other digital device; receiving an assessment, advice or signposting in the same way you would in an NHS 111 telephone contact. For Mid & South Essex patients, if you require a further clinical assessment prior to being directed to another service, NHS 111 Online will directly link you into the IUC clinical hub. Clinicians in the hub will have access to the online assessment outcome and be able to continue the assessment over the telephone, helping enable patients with more complex symptoms to be directed to the most appropriate service for their needs.

Pulmonary Rehabilitation
Pulmonary rehabilitation is a programme of progressive exercise and education for people with COPD and other chronic lung conditions.

A dedicated programme, delivered in south east Essex by Southend Hospital, has recently become even better – offering more options on how people receive their treatment tailoring the care to suit the needs of individual, whether that’s at one of our four centres across the south east Essex region, at home using telephone support or a combination of the two.

Referrals can be made by any healthcare professional you see, including your GP, practice nurse or community nurse.

Non-Emergency Patient Transport Service
In September 2018, the NHS PTS Framework launched across the STP. ECRs (known as extra Contractual requests) from the three Contracted providers in both Mid and South Essex, where demand is high or, a journey is out of Contract, are forwarded to the Joint
Committee Transport Team, working on behalf of the five CCGs and three Trusts, to effectively and safely outsource non-emergency patient transport requests to private providers.

**Prevention**

**Stroke Prevention in Atrial Fibrillation**

Detection and prevention of AF is nationally recognised as a priority in the prevention of Atrial Fibrillation (AF) related strokes.

Estimates suggest AF prevalence is increasing with age and if left untreated is a significant risk factor for stroke and other morbidities. Many preventable strokes occur every year leading to thousands of early deaths.

Southend CCG undertook a joint application to participate in a 12 month national project to improve the detection and treatment of (AF) patients which is funded by NHS England and managed by UCL Partners academic health science partnership.

The successful application resulted in the award of 57 AliveCor Kardia mobile devices that would allow for the distribution of one device for each GP practice.

The mobile ECG device is portable and small enough to be fitted to the back of a smart phone or tablet. A patient makes gentle contact with the device’s two metal pads with two fingers of each hand and it produces a medical grade ECG trace which appears on the GP practice smart phone or tablet within 30 seconds.

Instant analysis occurs through the mobile device APP (compatible with both Apple iOS and Android devices) provides accurate detection of AF. The ECG trace can then be emailed to the GP in order to support clinical decision making and inserted in the patient’s medical record.
Data for the first six months of the pilot shows:

<table>
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<th>Screens undertaken</th>
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<tr>
<td>383</td>
<td>23</td>
<td>295</td>
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</tr>
</tbody>
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**Diabetes Prevention Programme**

Evidence exists which shows that many cases of Type 2 Diabetes are preventable. There is also strong international evidence which demonstrates how behavioural interventions, which support people to maintain a healthy weight and be more active, can significantly reduce the risk of developing the condition.

The good news is that there is plenty of support, advice and information for those who are at risk or are affected by Type 2 Diabetes.

The NHS Diabetes Prevention Programme is a joint commitment from NHS England, Public Health England and Diabetes UK, to deliver at scale, evidence based behavioural programme to support people to reduce their risk of developing Type 2 Diabetes. NHS Southend CCG is one of a number CCGs across England that participated in the roll out of the scheme for our population.

Across Southend we have implemented one to one programs of structured education for patients with Type II diabetes that have specific challenges attending group based education, which has resulted in 119 additional structured education courses being made available (compared to 2017-18), for patients that otherwise would not have been able to attend.

In addition to this additional capacity the funding was also used to appoint a Psychologist as part of a service approach towards addressing educational challenges with patients. This service is providing targeted support for patients to understand their condition and implement behavioural change in conjunction with the delivery of their diabetic education needs.

**Education programmes for care home staff and wider community**

Investment into better education has resulted in 1844 individual training sessions were attended by front line care home staff in 18/19, across a range of 5 subjects (End of Life/Palliative Care, Nutrition, MUST Tool and Dysphagia, Hydration, GULP Tool, Constipation and Oral Care, Catheter Management, Tissue Viability and Pressure Ulcers).

**Winter Ready Clinics**

In the summer of 2018 respiratory nurses in south east Essex delivered ‘Winter Ready Clinics’ for patients with chronic COPD. This new and innovative approach focused on psychology methodology, aiming to support patients to prepare for, and remain well during the winter months. This included how to recognise triggers that could lead to severe breathing difficulty and what to do next. The patient feedback was very positive, patients really welcomed the new approach, people felt listened to and reported increased confidence in recognising when they were unwell and what actions to take. All patients were also presented with a hand knitted scarf to support Asthma UK’s scarfie campaign.
**Surgery pods**
The surgery pods have been introduced in two GP practices to help patients monitor their health without having to wait for a GP or nurse appointment. This has freed up additional nurse appointments for other patients.

**ACE Lifestyle service**
GPs in Southend are now able to refer into the ACE Lifestyle service for those patients who wish to make positive changes to their lifestyle to improve their health and wellbeing. The service includes a personalised programme to help people reach their health goals. This could include 1-to-1 support or referral to other programmes such as weight management, physical activity or stopping smoking.

**Mental Health, Learning Disabilities and Dementia**

NHS Castle Point and Rochford CCG, NHS Southend 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, as detailed below.

**Perinatal mental health** – The specialist community perinatal mental health service, which covers the Essex region, is now operational and showing an increase in referrals. The service is performing well, in line with NHS England targets. A South East Essex Perinatal Mental Health Steering Group is now well established and focussing on local pathways development and enhancing the localities-based support available not only for mothers, but for families. In Southend, there has been the introduction of two new roles (funded by Better Start Southend Big Lottery Fund): Specialist Health Visitors for Perinatal Mental health, who can offer additional support for parents and children under 4 in Better-Start areas. There is a pilot ‘mother and babies group’ due to commence which designed in partnership between IAPT and Better-Start. NHS England requires CCGs to ensure that at least 4.5% of their population birth rate has access to NICE concordant specialist community perinatal MH services in 2019/20. Thanks to the additional investment, NHS Southend CCG is already exceeding this.

**Common mental health problems** – Southend CCG has invested 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. This has been expanded during 18/19 with psychological support available for people with COPD and carers using 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 £77k in the EPUT Early Intervention in Psychosis (EIP) Service, including funding for additional capacity to support more people into education and employment. The introduction of a dedicated employment advisor within the EIP team has resulted in improved outcomes for this client group, with 75% of those supported by this worker retaining employment for at least 6 months, and 83% of those supported completing an educational course.

The REACH project has been procured so it can move out of the pilot phase into a longer standing project. The aim is to provide two separate offers; one will be the continuation of the Recovery College and the other a mental health well-being café that incorporates crisis support. The aim of both is to 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.

Southend CCG was successful in receiving Wave 1 funding from NHSE to accelerate the delivery of employment support through Individual Placement and Support. This has enabled more people with a severe mental illness to gain employment and retain their employment role.

This year has seen the physical health of those experiencing serious mental illness (SMI) take an increased priority. In South East Essex, a Steering group has been set up which brings together partners from across our community with a focus on improving the uptake of physical health checks, and access to interventions. We are aiming to develop locality teams with mental health expertise to work within Primary Care services to support people with SMI to get access to the physical health assessment and interventions in their local area.

**Acute inpatient and crisis care** – Thurrock CCG leads on developing 24/7 mental health crisis services across the mid and south Essex STP. 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. The aim is to reduce reliance on inpatient services and expand the work of crisis resolution and home treatment teams to provide more focus on treatment and better support at home.

**Dementia** - Our local dementia diagnosis rate remains well above the constitutional target of 66.7% (December 2018 the diagnosis rate was 79.3%). Southend continues to have the best dementia diagnosis rate in the STP. We are also planning to improve the support available for people who receive a dementia diagnosis. This will provide 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.
2018-2019 saw us move forward with ISPACE which is a holistic toolkit that supports staff and their understanding of Dementia, having a dementia champion as a point of contact, joining the Dementia Action Alliance, involving the Patient Participation Groups, encouraging End of Life planning which will empower families to make the right decisions at an earlier point of their Dementia journey, and finally looking at the environment from a perspective of someone entering the building with Dementia; and making changes if needed.

There are now 12 Dementia Friendly GP surgeries across South East Essex with a further 6 nearing accreditation. Alongside our partners at Southend-on-Sea Borough Council, we have also created over 10,000 Dementia Friends in South East Essex and this number grows daily.

The Southend Dementia Innovation Grant is designed for grass roots community groups, to support people living with Dementia, to live well. The aim is to target people who are affected by Dementia, and live in the Borough of Southend. The grant amount available is £50-1000, and there are four rounds that groups can apply for.

Projects that have been funded include:
- Seated exercise train the trainer course.
- Active Life – sensory equipment for day centres, 12 sessions.
- Compostable toilet to enable gardening access at the allotment.
- Seated Yoga/ hand massage within five care homes/day centres
- DF flower arranging in Belfairs woods
- 2x Dementia Friendly walks around the wood with a trained guide giving talks about the beautiful surroundings: 21st January and April including hot soup and roll

We have linked the surgeries to the Dementia Action Alliance, so that the staff are aware of any activities going on in their local area that patients may be interested in joining in with; and to combine ideas on up and coming projects for the future year.

Several stakeholders (Public Health England, Social Care Southend Borough Council and Essex County Council) have worked together to create Dementia Friendly Dentist Toolkits. The toolkits have been created to support the two industries in becoming Dementia Friendly in a holistic way just like ISPACE. We hope to link the Care Home Dementia Support to the local Dementia Friendly GPs and Dentists, to give a fully inclusive support system to those living with Dementia in all stages of their journey.
Learning Disability and Autism

NHS Southend CCG is committed to increasing the uptake of Annual Health Checks for People with a Learning Disability aged fourteen plus. A task and finish group has been convened and there has been significant activity around promoting the Learning Disability Annual Healthchecks in the community, including the production of a video, workshops, and a presence in the Community Café/LD Hub in Southend; engagement with GPs has increased, and there is increased confidence in the data on the registers. Planning has taken place around the way we contract for Healthchecks with GPs, and alternative community provision where this is more appropriate for patients to access. Communications improvements include sharing easy-read material and models of good practice in contacting patients, and in 19/20 we will be producing birthday card reminders, which should also help to spread the uptake across the four quarters of the year, as historically the majority are completed at the end of the financial year, which makes it difficult to address missed opportunities for access.

The Essex-wide Learning Disability health contract for Core Services went Live in November 2018, with EPUT delivering in south Essex, and Hertfordshire Partnership NHS Foundation Trust as the overall contract lead. NHS Southend CCG is engaged in planning for the local Learning Disability services we will need within our remaining budgets and these Place Plans will inform the offer from April 2019.

The Autism Diagnosis service, commissioned across a South Essex foot-print, has continued to reduce waiting times and there is an ancillary Occupational Therapy support service for those who have been diagnosed where there is a specific need. The lead psychologist is a strong voice for the needs of people with Autism without Learning Disability, where there are less clear pathways to support and service; in both CCG areas, we engage with the relevant Local Authorities and partner agencies to improve the pathways to support most needed by the people diagnosed.

Children’s Services

Children and Young People’s Emotional Well Being and Mental Health service (EWMHs)

The Children and Young People Emotional Wellbeing and Mental Health service and service transformation are now in their fourth year. 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 4, (2018/19) commissioning partners across Essex continued to invest in the service developments and priorities identified during Years 1, 2 and 3 of the LTP. Additionally in Year 4 of our plan, we increased investment from £5.4 million per year in 2017/18 to £6.4miillion in 2018/19.

Year 4 was a year of delivering, evaluating, adapting and planning across children and young people’s emotional wellbeing and mental health areas and the wider system to support the improvement and sustainability by:
Continuing to embed the Essex wide specialist Community Eating Disorder Service, - By 2020/21, evidence-based community eating disorder services for children and young people will be in place ensuring that 95% presenting cases will receive NICE concordant treatment within the nationally prescribed timescales.

Mobilisation of the Learning Disability CAMHS Pilot across Southend, Essex & Thurrock - with evaluation in order to inform future CAMHS re-procurement options.

Crisis services – enable re-configuration and transformation by piloting the new service model offering the existing A+E liaison pathway together with an Enhanced Community Response pathway (including Home Treatment).

Transitions – Pilot the development and implementation of a transitions service offer to enable young adults to meet their ongoing care/support/discharge plan.

Access – work together to ensure increased numbers of Children and Young People commence treatment in NHS funded community services.

Outcomes – work with partners to sustain a culture of continuous evidence-based, outcomes focused service improvement delivered by a workforce with the right mix of skills, competencies and experience working with the existing Children and Young People’s Improving Access to Psychological Therapies (CYP IAPT) programme.

Continue to improve and build Children and Young People and family engagement and communication.

Continue to develop, integrate and work with the wider children’s service system to provide a seamless offer (Tier 4 inpatient, EHC, TCP, Paediatric care, Children Looked After & Children in Need).

The 2018 LTP refresh for Southend Essex and Thurrock was published in December 2018 and is available for review here: https://southendccg.nhs.uk/policies/1188-mental-health-services-for-essex-open-up-reach-out.

Maternity and paediatrics

Local Midwifery System (LMS)

The CCG leads maternity service transformation on behalf of the mid and South Essex STP in partnership with providers, commissioners and service users. A plan has been developed with the aim of transforming maternity services to make them safer for mother and baby, improve women’s birth choices and to ensure services are as personal as possible.

The partnership includes the three acute hospital maternity units, health visiting services, mental health providers, local authority public health providers, service users and service user representatives including Healthwatch, Academic Health Science Networks (AHSNs) (UCLP) and commissioners from health and public health.

Mid and south Essex remains a safe place for women to give birth, however there is always room for further improvements and partners have worked hard to deliver the objectives within the national maternity strategy, Better Births (2016).
Key achievements of the Local Midwifery System partnership include:

- Initiation of three midwifery pilots to test new models of working. Continuity of Carer aims to make birth safer by ensuring women receive continuity of the midwife caring for them during the ante-natal, labour ward and post-natal period.

- Implementation of the care bundles (best clinical practice), Saving Babies Lives to reduce the risk of harm to the unborn and new-born child across the three STP maternity units.

- Establishment of a Maternity Voices Partnership to listen to the experiences of women using maternity services and seek their views on service changes and developments.

- Development of new ways of digital working including implementing new a midwifery clinical system and development of a patient focused smart phone app to ensure better clinical information and support women’s birth choices.

- Publication of healthy lifestyle and infant care information.

- Increased offer of three birth choices for women including, home, midwife led unit and obstetric unit.

- Development of personalised plans to reflect women’s preferred birth choices.

- Commenced work on a consistent and revised perinatal mental health pathway to ensure variation is eliminated across the STP and to improve the offer of care and support to women.

- Increased access to specialist perinatal mental health services in line with national ambitions (mother and baby units and specialist community services).

- Piloted transitional care arrangements within post-natal wards to reduce the reliance on neonatal units and ensure mother and baby are cared for together on the same unit.

- Increased use of Magnesium Sulphate to prevent neurological damage to children during birth.

- Participation in the Maternity and Neonatal Health Safety Collaborative to increase staff quality improvement capacity and awareness and reduce the risk of harm to unborn and new-born children.

STP partners will continue work in 2019/20 to embed changes in practice and deliver further improvements to safety, personalisation and choice for women using maternity services.

Community Paediatric Review

A Community Paediatric Review has been carried out which has set out the case for significantly transforming the current service provision for children and young people’s (CYP) services across South East Essex (SEE).

We want to develop a community paediatric service which works for our children, young people and their parents.
Part of this work has included the development of a Joint Paediatric Clinic as a new model of care, bringing primary and secondary care together in the community.

2018/19 has seen the launch of a Joint Paediatric Clinic in one area of Southend providing a platform to share knowledge and develop skills across organisational boundaries, building paediatric confidence and capability, to improve outcomes for our children and young people. Outcomes will be closely monitored and if successful, we will look to introduce further clinics.

Improving care and creating efficiencies

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 are 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.

As part of its QIPP programme each NHS organisation is required to deliver QIPP savings year-on-year to contribute towards this overall savings target. Southend CCG QIPP target for 2018/19 was £14.5m and the CCG actual year end delivery was £14.7m.

In 2018/19, the CCG continued to work in partnership with Castle Point and Rochford CCG and local providers SUHFT (Southend University Hospital NHS Foundation Trust) and EPUT (Essex Partnership University NHS Foundation Trust) to develop QIPP schemes. These schemes are designed jointly and aim to benefit patients reducing avoidable trips to hospital and delivering alternative community healthcare solutions. Cross-organisational innovation to develop pathways has shown to improve effectiveness and enhance the patient experience as well as providing value for money. Robust cross-organisational governance in place to ensure that each scheme is patient centered, is driven by quality for both patients and staff and is monitored regarding performance.

An executive led Joint Demand Management Group meets fortnightly attended by all involved organisations to ensure that each scheme delivers what was outlined at initiation and that there is a system-wide benefit for patients and the organisations. The Joint Demand Management Group report into the A&E Delivery Board and ensures the schemes are consistent and beneficial for the system.

Progress on the overall QIPP programme implementation and delivery is monitored by Finance Leads and a Project Management Office with regular reports to the Corporate Management Team.

A member of the CCG Executive Team 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 to fully implement the schemes. All schemes have a detailed project plan and defined methods of measurement to that we can track the progress of each project.
The QIPP Programme centres on a number of major workstreams, which incorporate the CCG key strategic priority areas, all aimed at delivering system-wide transformational change. These are:

- **Respiratory** - This is the first stage of the respiratory transformation plan for South East Essex. Outpatient criteria and electronic referral process development. This introduces acute and community nurse led clinics.
- **SWIFT (Rapid Response)** - A new community service resulting in a significant expansion of community nursing, providing a rapid response to patients in the community who would otherwise be referred/conveyed to SUHFT due to an absence of acute community support.
- **Care Homes GP Led Service** - To provide a proactive GP-led support service to residents to prevent crisis events, and the introduction of telehealth to provide vital sign monitoring, clinical triage and video link into homes. See page 29 for more information.
- **Cardiology** - Consists of three interrelated initiatives to support Heart Failure patients (> 18 yrs. old) across south east Essex to achieve a reduction in non-elective admissions, A&E attendances and a reduction in bed days.
- **End of Life** - This scheme is doubling the capacity in the community Palliative Care Nursing Team and Palliative Care Support Register Team (PCSR) resulting in fewer unnecessary admissions to hospital and increasing numbers of patients being cared for at home.
- **Night Nursing Service** - This scheme doubles the establishment of the Evening and Night District Nursing Team to enhance contact and response times for patients.
- **Care Coordination NELS and A&E attends** - To combine the ‘Complex Care Service’ in Southend with the ‘Care Coordination’ service in Castle Point and Rochford to deliver a clinically led, single coordinated care service for the people of south east Essex. The service will provide coordinated care & personal care planning for those that are identified as being frail and/or vulnerable and at risk.
- **Urinary Tract Infections, SEPSIS, NELS and A&E attends** - Development and deployment of a comprehensive training and awareness package related to sepsis, UTI and the deteriorating patient and implement telehealth to support the early identification of patients.
- **Falls Early Intervention Vehicle** - A pre-hospital, early intervention vehicle staffed by a Paramedic and Occupational Therapist working together to carry out treatment at home where possible.

**Continuing Health Care**

The CHC QIPP programme savings realisation was mostly dependent on the 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 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. Examples of such initiatives include:

- **Appliance Review** – patients able to get expert support to ensure most appropriate leg bags and catheters being prescribed;

- **Diabetes audits** – ensuring that prescribed medicines are helping patients to control their blood sugar levels in the most cost-effective way;

- **Respiratory audits** – ensuring patients are receiving the most appropriate treatment to manage their asthma/COPD and have clear plans and rescue packs in place if their conditions worsen;

- **Care Co-ordination** - As part of this, patients medications were reviewed and changes made to improve issues such as inhaler technique so that patients get the maximum benefit from their medicines.

**Planned Care**

- **Service Restriction Policy** - updated as agreed by Clinical Executives Committee; Governing Body and Public Consultation feedback. Alternative services and support being 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. An understanding of the number of GP referrals by practice will also help reduce acute demand.

The 2018/19 schemes have realised £14.7m, 101% of the planned Southend CCG QIPP benefits.
Enabling programmes

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 Castle Point & Rochford CCG and Southend CCG, we currently have 32 and 39; respectively, whole time equivalent (WTE) GPs in practices who are aged over 55 and 12 and 17 WTE nurses who are also aged over 55 (Source: NHS Digital Minimum Data Set March 2018) who are eligible to retire.

Within the CCG geographical area, there are approximately 104/105 WTE GPs and 40/41 WTE nurses across 50 member practices who serve a population of 360,000 and approximately 23% of the population are aged over 65, with over 75s amounting to 10%.

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.

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.

NHS Castle Point and Rochford CCG is the workforce lead for the Mid and south Essex STP which covers a wide 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
GP Retention

The Mid and South Essex STP has ‘Intensive Support Site’ status for a local GP Retention funding allocated by NHS England. The STP was been allocated funds to design and implement a local programme from September 2018.

Guidance published by NHS England sets out the availability of new funding in 2018/19 to further support delivery of the commitment set out in the General Practice Forward View (GPFV) to ensure an additional 5,000 extra doctors working in general practice by 2020. This is with a key focus on supporting general practitioners (GPs) who are at risk of leaving or who have already left the profession.

The local GP retention fund is restricted to the following groups:

- GPs who are newly qualified or within their first five years of practice;
- GPs who are seriously considering leaving general practice or are considering changing their role or working hours;
- GPs who are no longer clinically practicing in the NHS in England but remain on the National Performers List (Medical).

Specific schemes we have offered include: GP Retention, Fellowship Programme, GP Returners, up-skilling existing staff, targeted recruitment programmes and Job Fairs.

International GP Recruitment

The Mid and South Essex Sustainability and Transformation Plan (STP) have been one of two national pilot sites in the country recruiting GPs from overseas since October 2016.

The Essex scheme has been a trail blazer for the initial pilot which is highly regarded as ‘Gold Standard’ by Health Education England.

Through a robust, collaborative governance process and notwithstanding significant challenges we have established an effective and efficient local scheme that has now been replicated as the national model for NHS England.

Estates

The CCG is working towards developing locality estates strategies which link to our localities strategy.

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.

Southend CCG headquarters at Harcourt House closed during 2018 and we entered into exciting partnership working arrangement with Southend Borough Council co-locating local NHS commissioners with our local authority partners.
Improving Quality

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

The purpose of the strategy is to define the commissioning of the highest quality care services for the people of the CCGs. The strategy supports the CCGs in discharging their duty under Section 14R of the National Health Service Act 2006 (amended as in Health and Social Care Act 2012). Within this quality looks at three core principles:

- Patient safety
- Clinical effectiveness
- Patient experience

The CCG wants the people of South East Essex to be confident that their healthcare services are amongst the very best available.

The CCG has the delegated responsibility to ensure that the health and wellbeing needs for the local population are met as effectively as possible; taking care to ensure that patient outcomes are the primary importance, whilst trying to ensure it is able to demonstrate value for money for sustainability.

Within the CCG, the joint Nursing and Quality team’s primary function is to ensure that the patient voice is considered for all CCG-commissioned services and that commissioned providers are monitored and challenged to provide safe, effective and equitable care for residents of the South East Essex area.

Our aim is that health and care services within South East Essex will be:

- Effective: Meeting the needs of the person receiving care/treatment and supporting them at their time of need.
- Safe: Without error and in a way that protects people from harm, especially our most vulnerable people.
- Compassionate: Offering a person-centred experience for patients, this promotes choice and empowerment and treats them with dignity, respect and kindness.

Quality Development Journey

Before starting this next chapter of the quality journey, it is useful to analyse and reflect on what has been achieved in the past 5 years. A greater sense of clarity about our ambitions and how they will be achieved has taken place. Additionally, good progress is being made in delivering more services closer to home.

Examples of quality improvements:

- Over 2,000 patients with diabetes who previously had to journey to hospital now see their consultant in clinics in Benfleet, Westcliff, Rochford or Southend.
- Improvements in the monitoring of irregular heartbeats in the community to reduce number of strokes. Patients often ask what additional services could be delivered in the community and advances in technology have meant simple devices that initially detect irregular heartbeats have been introduced in GP practices and in addition 24-hour electrocardiograms (ECGs) are also now available in the community.
• The transformation of ophthalmology services in delivering more convenient healthcare services for the local community with many appointments that were previously carried out in hospital now being done safely and conveniently at a local high street Optician.

• New roles within GP practices such as Pharmacists, Advanced Nurse Practitioners and Emergency Care Practitioners have made a real difference in supporting the GPs and helping to deliver an improved patient experience. The pharmacist, for example, delivers better care by offering more medicine reviews for patients and support with prescription enquiries. There are now nine pharmacists working across Castle Point and Rochford and Southend in this new role, who have been able to demonstrate that they are saving GP time and improving access by dealing with prescription queries and hospital discharge letters. In addition to this a higher number of patients are receiving medication reviews which improve overall safety and patient’s understanding of their medicines. The pharmacists are also running clinics for long term conditions (such as high blood pressure) and supporting prescription clerks to improve processes for repeat prescriptions.

• In Benfleet, additional staff are shared between five practices supporting transformation and innovation.

• More money has been invested to support the transformation of mental health services for children and young people and the development of a specialist eating disorders service.

• Following the transfer of the NHS funded Continuing Healthcare (CHC) team from the Commissioning support Unit (CSU) into the CCG, we have undertaken a period of analysis of processes and systems inherited from the CSU and taken the opportunity to re-consider some of our processes and practices, to try to make our systems more robust. This has resulted in greater understanding of some operational problems which have now been resolved or minimised.

• We have moved all data management to a CHC management system; Broad Care. The process of data transfer allowed a significant opportunity to undertake a data cleanse, resulting in much greater assurance relating to CHC Data.

• We have initiated CHC advanced practitioner training which has had a significant impact.

• We are working more closely with Essex County Council and Southend Borough Council on common initiatives.

• We have supported the Transforming Care Agenda.

• We have led on the Domestic Abuse Agenda for Greater Essex CCGs ensuring a health response to domestic abuse.

• Using the principle of Discharge to Assess, in 2016 we introduced a collaborative approach to the management of NHS Funded Fast Track referrals; commissioning the local Hospice provider to undertake a period of stabilisation and assessment, before making any longer-term decisions about future care needs. This approach has ensured people with rapidly deteriorating conditions benefit from a formal palliative assessment by a specialist EOL provider, as a matter of routine.

During 2018/19, the CCG has worked in partnership to ensure that commissioning of services, which includes striving to meet national and statutory requirements, and that services commissioned, as much as possible are safe and effective. This has been undertaken through a contractual route of measuring and ensuring the compliance of providers against national and local Commissioning for Quality and Innovation (CQUINs), and targets Key Performance Indicators (KPIs), which are set and agreed on an annual basis and by responding to wider system information sharing agreements and processes, with key stakeholders such as the CQC and Local Authority.

The Nursing and Quality Team is a corporate team and provides Quality Nursing oversight for both NHS Castle Point and Rochford CCG and NHS Southend CCG.
The CCG receives performance data from all the providers of services we commission. However there are core services in which these are now delegated responsibility for the Joint Commissioning Team to oversee on behalf of the CCGs within Mid and South Essex. This takes place within the governance and committee meetings within the joint committee structure. The Nursing and Quality Team monitor trends, themes and compliance with national and statutory requirements including:

- Acute hospitals (Now delegated to the Joint Committee)
- Independent hospitals (Now delegated to the Joint Committee)
- Ambulance services (Now delegated to the Joint Committee)
- Community providers
- Mental health providers
- NHS 111 service
- Primary care (Co-Commissioned with NHSE)

The CCGs also work with other stakeholders to gather information regarding

- Care homes
- Domiciliary care agencies
- Support and assisted living services
- Voluntary sector

The Nursing and Quality Team undertake regular and unannounced site visits and undertake face to face dialogue with our providers to gather soft intelligence, to inform Key Lines of Enquiry (KLOE) for discussion at our formal meetings as part of our contract management. Any emerging or immediate areas of concern are escalated immediately. We also work closely with the regulatory bodies such as the Care Quality Commission (CQC) and NHS Improvement (NHSI).

NHS Castle Point & Rochford CCG is the lead commissioner for the community services that are provided by Essex Partnership University NHS Trust (EPUT) within the South East Essex area and also has delegated responsibility for the upholding of primary care contracts within the Castle Point and Rochford and Southend localities. Castle Point and Rochford CCG also hold smaller contracts with other community providers such as those providing endoscopy services or those providing NHS services in the independent sector.

NHS Southend CCG is the lead commissioner for the acute contract. The current provider is Southend University Hospital Foundation Trust (SUHFT) which is part of the, Mid Essex Hospital Services NHS Trust and Southend University Hospital NHS Foundation Trust and Basildon and Thurrock University Hospitals NHS Foundation Trust (MSB Group) who are working together as a single group in transforming the provision of clinical services across Mid and South Essex.

The CCGs within South East, have delegated responsibility of commissioning and quality oversight to The Joint Commissioning Team; allowing consistent and a single approach to the management and oversight for the three hospitals within the MSB Group. As the host CCG, NHS Southend CCG remains closely involved with quality monitoring within the local acute trust. Delegated responsibility for the upholding of primary care contracts within the Southend locality remains the responsibility of NHS Southend CCG.

The Nursing and Quality Teams within the CCG works closely with other CCG Nursing and Quality Teams within other CCGs who hold lead contracting arrangements for services we commission, for which the CCG has delegated this responsibility but are associates within the commissioning arrangements, such as that with the East of England Ambulance NHS
Trust and EPUT Mental Health contract (Thurrock CCG Lead Commissioners). Throughout the year the Nursing and Quality Team has partaken in quality assurance visits, clinical audits as associates to seek assurances that the services commissioned are meeting the quality and safety elements of the contract.

There are monthly Clinical Quality Review Groups (CQRG) with IC24 and EPUT, monitoring quality performance against CQUINs and KPIs, as well as receiving quarterly narrative quality reports and individual subject reports such as infection prevention and control, patient experience, serious incidents, safeguarding and quality accounts.

Monitoring of our performance against key local and national quality measures is an integral part of the monthly Quality, Finance and Performance Committee and the Chief Nurse Quality report is also submitted to the public Governing Body meeting. This includes CCG and provider performance on quality indicators which includes key information from the CQRGs. The CCG is also monitored on a monthly basis against these measurements by NHS England.

The Nursing and Quality Team acts on behalf of the Chief Nurse to seek assurances through the triangulation of hard data and soft intelligence on the quality and safety of service provision by providers from whom we commission services on behalf of the public. The Nursing and Quality Team consists of safeguarding professionals, infection prevention and control Nurse Specialists, quality assurance, complaints and education leads, patient safety and nurses with expertise in clinical quality and nurse commissioning leads.

The Nursing and Quality Team monitor serious incidents and complaints raised to the CCG, to ensure lessons learned influence future practice and commissioning decisions. The CCG meets regularly with Essex Partnership University Trust to review progress with serious incident (SI) investigations and action planning. The Chief Nurse and relevant nursing staff within the quality team undertake and review route cause analysis reports and action plans relating to SIs and work with the relevant key stakeholders to agree the decision to close or request further assurance where necessary.

**Serious Incidents and Never Events**

Serious Incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified. (Serious Incident Framework 2018).

The Serious Incident framework describes the process and procedures to help ensure serious incidents are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents happening again.

Never Events are serious incidents that are deemed as entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.

Under delegated responsibility any serious incidents or never events that occur within the MSB Group are currently reviewed by the Nursing and Quality Team within the Joint Commissioning Team. These are discussed at the Joint Patient Safety and Quality Committee in which a member of NHS Castle Point and Rochford CCG and Southend CCG Nursing and Quality Team attends.

During April 2018 to March 2019 there were no never events reported to the CCG during April 2018 to March 2019 for primary or community care.
NHS Southend CCG had no reported serious incidents within primary care services.

**Patient Experience**

CCG Complaints 2018

<table>
<thead>
<tr>
<th>CCG</th>
<th>Total</th>
<th>CHC</th>
<th>Meds</th>
<th>Commissioning</th>
<th>Other</th>
<th>Upheld</th>
<th>Not upheld</th>
<th>Partially upheld</th>
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<td>9</td>
<td>5</td>
<td>10</td>
<td>1</td>
<td>8</td>
<td>10</td>
<td>4</td>
</tr>
</tbody>
</table>

Themes Upheld / Partial upheld:
- 4 withdrawn
- 1 Ongoing
- CHC Processes
- ASD assessment waiting list
- Closure Branch surgery

With all complaint outcomes, the CCG will examine to determine possible changes required to reduce risk of re-occurrences.

The intelligence data can either be nationally-published information and benchmarking in the case of Patient Safety Thermometer (PST) data and Friends and Family (FFT) test, national patient surveys, CQC inspection reports. NHS digital data is also used to seek assurance in uptake of certain indicators or vaccines. Local data is also sourced through the NHS Choices website or local Serious Incident (SI) reports. This data is used as a basis to monitor and review providers’ standards of care, which may be sought formally through reports at the CQRGs or through quality assurance visits. Any findings and recommendations are delivered to the provider and the outcomes of any action plans are monitored to ensure that progress is made to improve the quality of care and services.

Patient feedback is integral to understanding the quality and experience of the service they receive. Our aim is to listen to, and learn from, our patients’ experiences.

As a CCG we ensure that as much as possible we are listening to the needs of our patients and commissioning value for money, quality services based upon local need. The Nursing and Quality Team consistently reviews information, and use this to influence changes to the way care is delivered, ultimately improving quality of care for patients.

Below are just a few examples:

- Working with and attending clinical meetings with GP’s and SUFHT to review improvements to the referral to treatment times.
- Working with SUHFT to review Ophthalmology services and implement actions to improve the service.
- Working with Local Authorities and SUHFT to review discharge delays and reviewing stranded patients within the hospital.
- Ensuring that all appropriate primary care work streams are focused on the reduction of mortality rates within the hospital.
- Carry out focused quality visits in areas that are a cause for concern.
- The quality team work with out of area services to provide the rehabilitation/ support that the residents of South East Essex may need.
- The Nursing and Quality team undertake reviews of SI’s that are raised against the CCG to ensure patient safety remains a priority.
- The Nursing and Quality team is responsible for ensuring GP member practices are supported with an evidence-based education programme, delivered through the structured ‘time to learn’ schedule.

- The Nursing and Quality Team receive complaints made to the CCG. This allows the team to investigate and where possible, to resolve the presenting issue, but almost more importantly, to focus on lessons learned from individual complaints and individual patient experiences, which can influence practice and inform commissioning decisions made by the CCG.

- As the CCG has delegated authority for co-commissioning of primary care services in their respective areas, the Nursing and Quality team works with member practices to assist them in their quality requirements including their CQC registration. We have led events to share learning with colleagues in regards to delegated responsibilities.
  - The CCG now offers elements of the Time to Care programme commissioned by NHSE.
  - Working collaboratively with Local Authority, the nursing and quality team colleagues are supporting and reviewing health needs of residents within care homes including input to any safeguarding alerts raised. This included supporting the safe transfer of residents from a local care home.

We have fully delegated co-commissioning responsibility for primary care. Co-commissioning offers an opportunity to raise standards of quality within general practice services including:

- Clinical effectiveness
- Patient experience
- Patient safety

This includes work on reducing unwarranted variation in quality and enhancing patient and public involvement in developing services. Member practices are expected to become fully engaged in our work around quality improvement, and each practice is responsible for the development of its own quality improvement plan within the context of the primary care. The nursing and quality team support our member practices in this work. Learning from this support has helped to inform the development of educational opportunities through our workforce strategy based on the local needs of the primary care workforce.

The ability to co-commission GP services has enabled a fully rolled-out ‘Enhanced Health in Care Homes’ (EHCH) programme; specifically targeted at Care Homes with nursing, which provides increased clinical and pharmaceutical review and support within the homes, to support the frailty agenda and to help to improve care and to reduce avoidable admissions or attendances to acute services. See page 29 for more information.

The NHS Funded Care Team operates from within the CCG to support the assessment of people who might be entitled to receive NHS Funded Continuing Healthcare. The team manages the delivery of this service across the CCG including complaints and appeals processes and supports NHSE with the delivery of the National Framework agenda. This year, the team has consolidated its internal processes which are reflected in the reduction of complaints or successful appeals. The team is committed to ensuring that there is an equitable approach to the assessment of and the offers made to, people considered to be eligible for NHS funded care, including NHS funded Continuing Healthcare.
Safeguarding Children and Adults at Risk

“Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework (NHS England 2015) provides specific guidance to NHS organisations which clearly sets out the responsibilities of each of the key players for safeguarding in the NHS. The CCG acknowledges its statutory responsibility to have clear governance processes in place for safeguarding children and adults at risk. 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 Safeguarding Policies.

The CCG has responsibility to procure designated professionals who provide clinical expertise and strategic leadership across the local health system to support other professionals in their agencies on all aspects of safeguarding adults and child protection. The Named GP undertakes a specialist role within the team to support and provide advice General Practitioners and Nurse Practitioners working in Primary Care on matters relating to safeguarding. We work closely with other CCGs through the Safeguarding Clinical Network which brings all designated safeguarding children and adult leads together to collaborate on areas of mutual interest.

The CCG works in partnership with other statutory and relevant agencies and is integrated at all levels of Essex and Southend Safeguarding Children and Adult Boards. Our priorities for 2018/19 included:

• Leading the Health Executive Forum which brings together all the health agency executive safeguarding children/adult leads from across Essex.
• Having strategic oversight of the Emotional Wellbeing and Mental Health Services for Children and Young People to ensure effective arrangements for the delivery of the service and support the agenda to reduce self-harm and prevent suicide.
• Supported the Essex implementation of the national Child Protection Information Sharing (CP-IS) Project to improve information sharing between unscheduled health care services and children’s social care in respect of children looked after or in need of protection.
• Commissioned Hospital Based Independent Domestic Violence Advocates to improved early recognition and support to victims of domestic abuse.
• Supported the implementation of Child Exploitation Toolkit across health services to support risk assessment and sharing of intelligence. Attended strategic and operational meetings to support partner agencies to address risk to adolescents in the Southend locality. This included providing a resource to provide emotional support service to staff working with high risk adolescents in Southend.
• The CCG has provided leadership to local health providers to improve the response to child exploitation following the Joint Targeted Area Inspection that took place in March 2018.
• Completed the NHS England Safeguarding Assurance Tool which demonstrates a high level of compliance.
• Undertaken joint quality visits between adult Health & Social Care and the Senior Nurse for Care Homes which routinely included in safeguarding strategy meetings with the Council.
• Supported the CCG Medication Management Team to enhance their knowledge of safeguarding and the application of the Mental Capacity Act to the administration of medication.

During 2019/20 the CCG will:
• Work with Safeguarding Partners and relevant agencies to implement Multi-agency safeguarding arrangements.
- Work with partner CCGs to develop the Mid and South Essex Sustainability and Transformation Partnership (STP) to improve health outcome for the local population
- Work with the Safeguarding Partnership to deliver the Violence and Vulnerability Strategy
- Work with Primary Care to ensure that safeguarding is integrated into the work of Locality Hubs
- Work with Primary Care to implement to revised requirement of Adult Safeguarding: Roles and Competencies for Health Care Staff.

**Transforming Care**

The Winterbourne View Concordant and Transforming Care policies, published in 2012, set a national target to reduce the number of people with a learning disability who were inappropriately residing in specialist learning disability and mental health inpatient settings. NHS England then developed an agenda in 2014 for Transforming Care that seeks to reduce the number of people with a Learning disability and or autism in hospital and a process for reviewing peoples care and treatment.

This has continued to be a significant priority for NHSE. The Essex Transforming Care Partnership Board, which includes the 7 CCGs and 3 local authorities of Essex, Southend and Thurrock, sets the target of 21 inpatients across Essex to be achieved by March 2019. The current inpatient status in Essex January is 28 inpatients. Southend and Castle Point and Rochford CCG currently has 6 inpatients. 1 patient has a predicated discharge date in February. Southend CCG has discharged 3 people who had been inpatients for over 4 years since 2016. There are no children and young people from Southend and Castle Point and Rochford CCGs with a learning disability and or autism in Tier4 Children’s mental health services (CAMHS) at January 2019.

The Care Education and Treatment review Manager (CETR) for Essex updates Castle Point and Rochford and Southend CCG regarding young people with a Learning Disability and or Autism, who are approaching transition to adult services. The CCG ensures inpatients have Care and Treatment reviews (CTR) in line with NHS England policy for people with a learning disability and or autism who are at risk of admission to assessment and treatment unit. The aim of the CTR is to bring a person-centred approach to ensuring that the care and treatment and differing support needs of the person and their families are met, and that barriers to progress are challenged and overcome ensuing that each patient receives sustainable, high quality care. Patients who are considered at risk of admission are monitored by the CCG in partnership with Social Care and EPUT to ensure where possible admission is avoided. A Community CTR is held for patients on the Essex dynamic register, to ensure support is in place to where possible avoid admission.

The CCG works in partnership with the Programme Director and Operations Manager for the Essex Transforming Care programme and Social Care to ensure patients who are discharged to the community, are supported by services that effectively meet the needs of patients with a Learning Disability and or Autism.

Integrated LD Health Commissioner’s at Essex County Council are coordinating progress against action plans to deliver the Stop the over medication of antipsychotic medication’s (STOMP) Southend and Castle point and Rochford CCGs have raised awareness of the NHS England directive to deliver STOMP working in partnership with Learning disability health provider, Essex university partnership Trust (EPUT).
Engaging people and community

Public, patient and carer voices must be at the centre of the health services we design and deliver. It is only by seeing things through the unique lens of patient, public and carers can we be innovative and ensure maximum benefit within our resources.

In this section, we will explain how we have fulfilled our duties with respect to both our Constitution and the NHS Act 2006 (section 14z2 (2)) and Health and Social Care Act 2012 to involve local people in:

a) The planning of services
b) The development and consideration of proposals for changes which, if implemented, would have an impact on services
c) Decisions which, when implemented, would have an impact on services.

Making patient engagement matter

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 QFP Committee as part of an Integrated Performance Report. The report provides an update regarding public and patient involvement and engagement.

- 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

- We are very fortunate to have a Patient and Public Involvement (PPI) lay member on our Governing Body who brings their unique perspective, informed by their expertise and experience. Part of the PPI lay members role is to help to ensure that, the CCG has effective mechanisms in place ensuring the public voice of the local population is heard in all aspects of CCG business. In additional to attending all of our Community Engagement Steering group meetings, our lay members’ experience helps us to prioritise residents who experience the poorest health outcomes, enabling us to improve access and reduce health inequalities

A summary of patient engagement work is also shared as part of the AO update at the start of all Governing Body meetings. Patient stories have also been shown at every Governing Body meeting to help understand the patient experience of the services we commission. A link to all our patient stories can be found here [https://castlepointandrochfordccg.nhs.uk/get-involved/patient-stories](https://castlepointandrochfordccg.nhs.uk/get-involved/patient-stories)

Partnership working

Members of the communications and engagement team also attend monthly meetings as part of the mid and south Essex Sustainability and Transformation Partnership (STP) work, which brings together commissioners and providers to update on their current work, forward plan and review opportunities for collaboration
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 Advisory and Engagement Group
- Patient Participation Group Forum
- Local and national patient experience surveys
- Attending Practice Participation Groups
- Public events
- Patient stories
- 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

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 have been 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: Primary Care strategy, LD health checks, falls prevention, SWIFT service.

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. The Terms of Reference can be found here https://southendccg.nhs.uk/about-us/key-documents/engagement/2686-ceag-tor/file

Events and Outreach
In order to reach out to patients and the public we organise a number of events across the course of the year, and actively participate in community, voluntary and partner organisation events. See below examples
**Death Café**

To help local people talk more openly about death and bereavement and collect local insight and experiences, we hosted a virtual death café on Facebook Live during Dying Matters Week in May.

The footage from the death café was viewed over 1,000 times, reaching over 1,750 people.

**Locality Stakeholder Event**

The CCG held a successful engagement workshop on 1 November in partnership with local authorities with over 100 community and voluntary organisations joining the conversation to help co-produce solutions to how we can meet the needs of the CCGs eight localities.

Feedback/insight has been collated and will inform the development of new models of care and locality plans as local design teams continue to work together with communities to co-design more proactive and pre-emptive models of care. Local design teams have subsequently been successful in attracting new membership.
Primary Care Strategy
Following the publication of the mid and south Essex Sustainability and Transformation Plan (STP) in July 2018, Southend CCG embarked on a programme of communications and engagement to raise awareness of the pressures facing our GP practices and involve local people and stakeholders in developing local solutions.

Eight engagement events took place during September and October. A report of all feedback has been shared with Primary Care Committee members and with GP leads in each locality. In response to feedback during the events, a new PPG Development Forum was developed.

To reach a wider audience a local video was developed in-house communicating the key messages of the primary care strategy. The video reached over 700 views seizing the opportunity digital media offers to reach large numbers of people quickly and cost effectively.

Winter Engagement
Winter-themed patient groups have also taken place in both Southend, Castle Point and Rochford to help cascade important messages in the community and gather further ideas to ensure preparedness.

Quality Awards
Over 150 primary staff attended the event on 6 November with six awards to recognise for outstanding work, care, innovation and services.

We engaged with all Patient Participation Groups and wider public to gather over 200 nominations.

Winners included senior GPs, nurses and health care assistants, reception staff and vital other roles supporting people and GP practices day-to-day.

Resulting communications saw a double-page spread in the local newspaper and significant social media engagement.

Community outreach
In addition to events which we convened, we also regularly attend and support events and patient meetings held by our partners in both health and social care and the voluntary sector.

In 2018/19 we have taken stock and strengthened our relationships with local community representatives, particularly those representing seldom-heard communities:

We have supported a number of wider Community Wellbeing Events.

The event’s offer advice on local support available to patients, lifestyle advice, a juice bike, health checks, dementia support, kids activities, seated exercise and relaxation sessions to name but a few activities. The events have been in conjunction with partners including

- ACE,
- Age Concern,
- Carers Choices,
- CAVS,
- Community Agents,
- EPUT,
- Essex County Council,
- Essex Fire and Rescue,
- Peabody,
- Provide,
Involvement and engagement activities in 2018/19

Our goal is to put patients at the heart of everything we do, learning from their lived experiences, listening to their ideas and thoughts and designing and commissioning services which meet the needs of our diverse population – see page 66.

We strive to involve patients at all stages of the commissioning process. We have successfully engaged stakeholders, patients and the public in a range of activities to facilitate community involvement in how we design, deliver and improve local health services.

Feedback is an integral part of our work, and we ensure that we keep those involved with our engagement work updated on what the next steps are. In the summer we distributed more than 5,000 leaflets to the community about the hospital reconfiguration public consultation.

The following projects highlight some of our work to involve patients in 2018/19.

**Reach Recovery College**

**Brief summary of project**
Click on the link to view a short video about this project: [https://youtu.be/FsQaKqLaQZs](https://youtu.be/FsQaKqLaQZs)

The Reach Recovery College provides courses, social activities, and support that aims to improve the quality of life of people living with mental health conditions.

REACH Recovery College was set up, developed and run as a pilot project in January 2017. In 2017/18, we started the process of looking to set up a permanent Recovery College to start in April 2019. In July 2018, we launched a survey to hear the views of people using the service, those who may encourage people to use the service and anyone else who has an opinion about how mental health recovery can be enabled in Southend and Castle Point and Rochford.

Following the initial research, we then began a process to identify what the future offer from the Recovery College would look like, how it would be delivered and by whom.

**Who did we ask?**
As part of the engagement and consultation process to inform this service specification, a stakeholder survey was answered by 57 professionals from a range of backgrounds, including GPs, social workers, mental health nurses, child and adolescent mental health service staff, Improving Access to Psychological Therapies (IAPT) staff, REACH recovery staff, job centre staff and voluntary and community providers.

A student survey was answered by 43 people. This was split into 75% of people who use the recovery college and 25% who care for or support someone who attends the recovery college.

8-10 focus groups were held between July and October 2018.
What did we ask?
We asked those that had used the Recovery College for feedback about the courses they'd attended, about how accessible they were and which courses people had gained the most from or felt had helped the most and why. We asked how courses could be improved and if there were any suggestions for courses that weren't currently offered.

What did we find out?
The views of over 150 people were used to ensure the Recovery College service delivers the right offer and courses to people across Castle Point, Rochford and Southend in the future.

Summary of findings
As part of the engagement and consultation process to inform this service specification, a stakeholder survey was answered by 57 professionals from a range of backgrounds, including GPs, social workers, mental health nurses, child and adolescent mental health service staff, Improving Access to Psychological Therapies (IAPT) staff, REACH recovery staff, job centre staff and voluntary and community providers. Generally the responses supported the view of the pilot evaluation that the recovery college offer is supportive and enables recovery. A third of respondents, which included GPs, were not aware of the college, but this was not surprising considering the offer to date has mainly focused on step down from secondary care.

As part of the engagement and consultation process to inform the service specification, a student survey was answered by 43 people. This was split into 75% of people who use the recovery college and 25% who care for or support someone who attends the recovery college. Overall, the response was extremely positive with respondents reporting an increase in coping skills, strategies and confidence.

We are seeking two main benefits from our recovery college. First, to assist individuals in their personal and collective journeys of recovery. Second, to assist local organisations and services to become more recovery-focused. The creation of recovery-focused services requires a major transformation in purpose and relationships; a focus on rebuilding lives rather than reducing symptoms alone and a partnership between equals, rather than experts and patients.

Feedback from two surveys plus focus groups informed the content of the ‘brief’ for what we were looking for.

Thanks to patient involvement in the procurement process, we were able to evaluate what success looked like from the patient perspective and ensure the scoring was reflective of this. Training was provided to Michelle, our patient representative to ensure she felt comfortable with the process.

What did we do?
Two surveys were launched, aimed at different groups. One was intended for people with mental health issues and their carers; the other for stakeholders such as GPs; social workers; Department of Work and Pensions; voluntary sector partners and others to complete.
Recruitment of two patient representatives ensured the patient voice was represented in the procurement process.

**Trans-gender referrals**

**Brief summary of project**

We have been working proactively with the Transgender community to help educate and empower GPs to better understand and meet their needs and emphasise the correct pathways for trans people (and impact of not doing these things).

**Who did we ask?**

Transpire is community group which supports transgender persons, their friends and family and the wider LGBTQ+ community in the Southend-on-Sea and surrounding areas.

As a member of the NHS Southend CCG Community Engagement, Advisory and Reference group and they have been proactive in undertaking research with the transgender community.

**What did we find out?**

When discussing barriers to accessing healthcare, Transpire raised the issue of inappropriate referrals and conduct at local GP practices.

**What did we do?**

We hosted a clinical education session for all our GPs across south east Essex. Jess from Transpire came to the event and presented information linked to the lived experience of the transgender community and the impact of inappropriate referrals.

We also re-shared a video that we co-produced with transpire that was aimed at colleagues in GP services: [https://youtu.be/UmlnZU5bz0g](https://youtu.be/UmlnZU5bz0g)

**What was the impact?**

The video has been viewed nearly 500 times. GPs shared positive feedback following the event and felt better informed to undertake more appropriate and effective ways of meeting trans needs.

**Learning Disability Health Checks**

Click on the link to view a short video: [https://youtu.be/AVHyLfOxxNA](https://youtu.be/AVHyLfOxxNA)

**Brief summary of project**

The NHS has a crucial role to play in helping people with a learning disability lead longer, happier, heathier lives, and a local task and finish group with key partners confirms our commitment to do so.

To make sure that people’s physical and mental health needs are met, we sought about improving the uptake of annual health checks and expanded a programme to reduce inappropriate overmedication.
Involvement of those with learning disabilities and those that care for them has been key to this work to ensure local services make reasonable adjustments for people’s needs.

In February 2019, we held a bespoke Learning Disability (LD) workshop, chaired by Dr Taz Syed, to co-produce innovative ways of increasing update to LD health checks with local people affected by LD.

**Who did we ask?**
Together with close partnership working with community Health Facilitation Nurses at Essex Partnership University Trust, who specialise in supporting local people with Learning Disabilities and key local authority partners we engaged with a number of local advocacy and local support groups including:

- Scope
- RE House
- The Attic
- Shields
- Project 49
- Castle Point and Rochford Local Action Groups

**What did we ask?**
We asked what the barriers were to having an annual health check to those with learning disabilities. We asked what was working well and what didn’t work well and how we could make it easier. We asked for their expertise in helping to devise an easy read invitation letters and action plans and for views on the examples provided.

**What did we find out?**
The workshop was well attended with good feedback and useful insight captured. A report will follow.

**Frailty**

*Brief summary of project*
As set out on page 6 we know we have a high proportion of older people living in Southend and this is set to increase.

Frailty presents in more than 10% of those aged over 65 and 25-50% of those aged over 85, with any one of the frailty syndromes including falls, reduced/impaired mobility, cognitive decline / confusion, continence problems or increased susceptibility to the adverse effects of being on different medications.

Failure to detect frailty leads to poorer treatment, inaccurate assessment of care needs for both now and in the near future and ultimately poorer health outcomes.

Locally there is inconsistency in the early identification of a frail person and often care is reactive rather than proactive, leading to missed opportunities to deliver preventative action when it has the greatest potential to improve outcomes and reverse or slow down the progression of frailty.

System partners therefore agreed to work together to define and drive forward the design of a better solution to support local people affected by dementia.

Who did we ask?
In line with the NHS Long Term Plan, a collaborative approach across a wider range of key stakeholders; from health, social care, voluntary and third sector organisations, to patients and carers and our local communities was the agreed approach to inform this work.

What did we find out?
Some emerging thoughts for consideration have included:

- Locality Frailty Teams aligned to the Primary Care Hubs which could include a GP with Extended Role in Frailty & Clinical Nurse Specialist.
- Step up virtual wards for multidisciplinary health, mental health and social care assessment and care planning.

What did we do?
A group made up of both professionals and those with lived experience of falls and frailty was established to help draw on best practice evidence from across the country & help shape local thinking around better solutions to support those affected by frailty.

Youth Council & Mental Health Survey

Brief summary of project

Mental health problems affect about 1 in 10 children and young people.

In autumn of 2018, the Chair of the Youth Council attended the NHS Southend Clinical Commissioning Group (CCG) Patient Participation Group Forum to present the findings of a survey that had gathered the opinions of young people and identify the issues they have with accessing support for their mental health needs.

The overall aim of the survey was to provide evidence for the development of a Mental Health Charter that could be introduced in schools.
Who was asked?
Out of the estimated 16,000 young people aged between 11-18 the survey received 1757 responses.

What was asked?
Key questions about the school environment and how effective it was in helping young people to share issues and concerns about their mental wellbeing were asked alongside wider questions to determine other barriers to getting help. Data around prevalence of mental health issues and cyberbullying was also captured.

What did we find out?
14% of young people indicated there were barriers to accessing support with waiting lists for counsellors, social stigma and a lack of anonymity listed as other barriers.

Reasons for not opening up included:
- Feeling embarrassed
- It may add to already stressful family situations
- Didn’t want to ‘play the victim’
- Would not be believed
- Being scared of being talked about (by peers and staff)
- Would be seen as being weak

What did we do?
Following the presentation, the CCG has supported the Youth Council in taking the findings forward especially relating to early intervention.
Further discussions are also taking place with stakeholders including Southend-on-Sea Borough Council as to how we can progress this. A GP member of NHS Southend CCG Governing Body, Dr Taz Syed has also stepped forward to support members of the youth council in the development of the Mental Health Charter.

Development of a Neurodevelopment Pathway
Brief summary of project
Neurodevelopmental disorders are impairments of the growth and development of the brain or central nervous system that affect emotion, learning ability, self-control and memory and that unfold as an individual develops and grows. This project involved people who use services, along with the organisations that represent their interests, to agree a set of principles to improve the journey of care for children and young people living in south east Essex with neurodevelopmental needs.

A key focus was improving outcomes at the earliest possible time appreciating that children have needs which should be supported in a holistic way, including social, emotional and physical well-being.
**Who did we ask?**
We asked for input from parents with lived experience and local voluntary sector groups, our parent and carer forum for children and families, the Schools SENCO network for Southend, the Emotional Wellbeing and Mental Health Service, Community Paediatric Services, the Special Educational Needs teams for Essex and Southend, Early Help and social care practitioners and GP clinical leads for children and safeguarding.

**What did we ask?**
We asked what the pathway should look like, how to best join up services to provide co-ordinated care and support, what the current gaps were in the system, what support and advice is currently available, what the parent and child journey looks like from the identification of initial need through to diagnosis, outcome and follow-up support.

**What did we find out?**
We found there was a lack of pre and post diagnosis support and sign-posting and variable information provided to make an informed decision. The current system was health-centric, not outcome focused and appointments for paediatric assessments were compounded by having to gather further information from other agencies to inform the decision making process. The current pathway was driven by diagnostics rather than focusing on solutions, and we needed to be able to plan more effectively between system partners.

Partners helped to identify a preferred neurodevelopmental screening tool that we could use locally. Thanks to the shared expertise of those involved, we developed a useful map of current services available for ‘other’ support, both pre and post referral.

We also identified gaps within current services available and have been developing an action plan to address those gaps which feeds into the wider Community Paediatric review. We found if we opened up the referral pathway to schools and school nursing teams, we would be able to assist the process significantly.

**What did we do?**
We held workshops with system partners in April and May 2018 about Community Paediatric provision. We then held specific workshops to look at the neurodevelopmental issues in June and September 2018. A working group is now regularly meeting having designed the revised pathway to implement and commission the changes needed.

We presented the changes to the Southend Borough network who were keen to be involved as principle referrers under the new pathway model. We presented our key findings to the Community Paediatric Clinical Engagement Group and are working across mid and south Essex to join up and standardise the pathways for families and agencies. As a consequence, we made changes to referral protocols based on feedback through the workshops. We are working to jointly commission the services needed with local authority partners in line with the Special Educational Needs and Disabilities Code of Practice under the Children and Families Act.
As a consequence, we made changes to referral protocols based on feedback through the workshops.

**Looking forwards**

2018/19 has been an incredibly busy year, coming together as two CCGs in a joint team has given us the opportunity to take stock of what was working and areas of development and we have begun to refresh our involvement opportunities and the way we deliver engagement with our population. Exciting times lie ahead and we are looking forward to working with our partners in both developing and delivering a new 2019-21 communications and engagement strategy that builds on the successes of previous work.

For more detailed information on our involving patients and the public see the Annual Report on Patient and Public Participation (1 April 2018 to 31 March 2019) appended.

**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, and the 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.ecsensoryservice.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 55, our Community and Advisory Engagement 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 2018/19, 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 54.

As part of the broader work, as part of the STP (see page14), 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 website 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.
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.

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 12.
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.

**NHS Southend CCG**

**Carbon Footprint table - CCG Corporate office**

Southend Clinical Commissioning Group moved to the Southend Borough Council Civic Offices from June 2018. The figures for Gas, Electricity and Water represent the CCG’s share of the total usage for the building in 2018 for 10 months.

<table>
<thead>
<tr>
<th>Resource</th>
<th>Quantity</th>
<th>CO2 Emissions</th>
<th>Cost (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gas (kWh)</td>
<td>6,460</td>
<td>1,188</td>
<td>*</td>
</tr>
<tr>
<td>Electricity (kWh)</td>
<td>56,024</td>
<td>15,859</td>
<td>*</td>
</tr>
<tr>
<td>Water (m³)</td>
<td>302</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>Business miles claimed¹</td>
<td>50,615</td>
<td>49,348</td>
<td>14,953</td>
</tr>
</tbody>
</table>

¹ Estimated figures have been used for Gas and Electric in February and March 2019.
² Estimated figures have been used for Water from January to March 2019.
³ Represents the amount of business miles claimed by staff in the financial year. The cost = the amount claimed in expenses by CCG employees.

* Southend CCG pays Southend Borough Council for Gas, Electricity and Water as part of a single rent payment, therefore no breakdown is available.

No comparative data is available.
Accountability Report

The purpose of this section is to meet key accountability requirements. It is in three sections:

- corporate governance report, which includes the Members’ report, Governing Body report and Annual Governance Statement;
- remuneration and staff report;
- Parliamentary accountability and audit report.

Terry Huff
Accountable Officer
24 May 2019

Corporate Governance Report

Member’s Report

Member practices
The CCG has 28 membership practices. The practices are listed below (as at 31 March 2019):

<table>
<thead>
<tr>
<th>Members Name</th>
<th>F code &amp; Practice Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drs Agha &amp; Siddique</td>
<td>F81121, The Thorpe Bay Surgery, 99 Tyrone Road, Thorpe Bay, SS1 3HD</td>
</tr>
<tr>
<td>Dr B Bekas</td>
<td>F81207, 48 Argyll Road, Westcliff on Sea, SS0 7HN</td>
</tr>
<tr>
<td>Dr K Dhillon &amp; Partner</td>
<td>F81688, 129 Eagle Way, Shoeburyness, SS3 9YA</td>
</tr>
<tr>
<td>Dr H Siddique</td>
<td>F81209, Shaftsbury Avenue Practice, 119 Shaftesbury Ave, Southend on Sea, SS1 3AN</td>
</tr>
<tr>
<td>Dr S M Callaghan &amp;</td>
<td>Branch site, Leigh PCC</td>
</tr>
<tr>
<td>Partners</td>
<td>Branch site, Leigh PCC</td>
</tr>
<tr>
<td>Dr B R M Houston &amp;</td>
<td>Branch site, Leigh PCC</td>
</tr>
<tr>
<td>Partners</td>
<td>Branch site, Leigh PCC</td>
</tr>
<tr>
<td>Dr A C Irlam &amp; Partner</td>
<td>F81086, Central Surgery, 27 Southchurch Blvd, Southend on Sea, SS2 4UB</td>
</tr>
<tr>
<td>Dr M Jack &amp; Partners</td>
<td>Branch site, Leigh PCC</td>
</tr>
<tr>
<td>Dr G K Jayatilaka &amp;</td>
<td>Branch site, Leigh PCC</td>
</tr>
<tr>
<td></td>
<td>Branch site, Leigh PCC</td>
</tr>
<tr>
<td>Partner</td>
<td>SS9 4JQ</td>
</tr>
<tr>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>Dr W Cordess &amp; Partners</td>
<td>F81164, West Road Surgery, North Road Primary Care Centre, 183-195 North Road, Westcliff on Sea, SS0 7AF</td>
</tr>
<tr>
<td>Dr F Khan</td>
<td>F81003, Carnarvon Medical Centre, North Road Primary Care Centre, 183-195 North Road, Westcliff on Sea, SS0 7AF</td>
</tr>
<tr>
<td>Dr A C Krishnan &amp; Partner</td>
<td>F81046, Kent Elms Health Centre, 1 Rayleigh Road, Leigh on Sea, SS9 5UU</td>
</tr>
<tr>
<td>Dr Navin Kumar</td>
<td>F81147, Central Surgery, 1st Floor, North Road Primary Care Centre, 183-195 North Road, Westcliff on Sea, SS0 7AF</td>
</tr>
<tr>
<td>Dr N Kumar &amp; Partner</td>
<td>F81613, Shoebury Health Centre, Campfield Road, Shoebury, SS3 9BX</td>
</tr>
<tr>
<td>Dr S A Malik</td>
<td>F81223, Kent Elms Health Centre, 1 Rayleigh Road, Leigh on Sea, SS9 5UU</td>
</tr>
<tr>
<td>Dr M Marasco</td>
<td>F81622, 101 West Road, Shoebury, SS3 9DT</td>
</tr>
<tr>
<td>Dr P N B Moss</td>
<td>F81684, North Shoebury Surgery, Frobisher Way, Shoebury, SS3 8UT</td>
</tr>
<tr>
<td>Dr L Nagle &amp; Partners</td>
<td>F81144, The Pall Mall Surgery, 1st Floor, Leigh Primary Care Centre, 918 London Road, Leigh on Sea, SS9 3NG</td>
</tr>
<tr>
<td>Dr H W Ng</td>
<td>F81744, Scott Park Surgery, 205 Western App. Southend on Sea, SS2 6XY</td>
</tr>
<tr>
<td>Dr S Sathanandan</td>
<td>F81200, 9 Blenheim Chase, Leigh on Sea, SS9 3BZ</td>
</tr>
<tr>
<td>Dr F Palacin</td>
<td>F81649, Shoebury Health Centre, Campfield Road, Shoebury, SS3 9BX</td>
</tr>
<tr>
<td>Dr N K Shah &amp; Partner</td>
<td>F81176, North Avenue Surgery, 332 North Avenue, Southend on Sea, SS2 4EQ</td>
</tr>
<tr>
<td>Dr H Siddique &amp; Agha</td>
<td>F81159, Southend Medical Centre, 50-52 London Road, Southend on Sea, SS1 1NX</td>
</tr>
<tr>
<td>Dr V Sooriarakumar &amp; Partner</td>
<td>F81092, 3 Prince Avenue, Southend on Sea, SS2 6RL</td>
</tr>
<tr>
<td>Virgincare</td>
<td>Y02707 St Luke’s Health Centre, Pantile Avenue, Southend on Sea, SS2 4BD</td>
</tr>
<tr>
<td>The Practice</td>
<td>Y02177, 32 Northumberland Avenue, Southend on Sea, SS1 2TH</td>
</tr>
<tr>
<td>Dr S L Vashisht</td>
<td>F81656, 61 Warrior Square, Southend on Sea, SS1 2JJ</td>
</tr>
<tr>
<td>Dr S H H Zaidi &amp; Partners</td>
<td>F81128, Eastwood Group Practice, 335 Eastwood Road North, Leigh on Sea, SS9 4LT</td>
</tr>
<tr>
<td>Virgincare</td>
<td>Y02707 St Luke’s Health Centre, Pantile Avenue, Southend on Sea, SS2 4BD</td>
</tr>
</tbody>
</table>
Composition of Governing Body

The governing body meets on a bi-monthly basis in public and its voting members comprise CCG Accountable Officer, CCG Chief Finance Officer, CCG Chief Nurse, 7 GP governing body members and the 2 CCG Lay Members. Representatives from Southend-On-Sea Borough Council and other CCG Executive Directors are regular attendees.

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 constitution.

Chair
The CCG Chair for the period 1 April 2018 to 31 March 2019 was Dr José Garcia Lobera.

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

Attendance

<table>
<thead>
<tr>
<th>Southend Governing Body</th>
<th>Attendance (April 2018-March 2019)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voting Governing Body Members</td>
<td>Eligible to Attend</td>
</tr>
<tr>
<td>Dr José Garcia Lobera Chair</td>
<td>6</td>
</tr>
<tr>
<td>Mr Ian Stidston Accountable Officer (left 15.04.18)</td>
<td>0</td>
</tr>
<tr>
<td>Ms Margaret Hathaway Chief Finance Officer Interim Accountable Officer, seconded (wef 09.02.18 to 01.08.19) Seconed to Mid Essex CCG (wef 01.09.18 to 31.10.18)</td>
<td>2</td>
</tr>
<tr>
<td>Mr Andy Morris, Interim Accountable Officer (wef 01.08.18 to 09.09.18)</td>
<td>n/a as no meetings during this period</td>
</tr>
<tr>
<td>Ms Cathy Gritzner, Interim Accountable Officer (wef 10.09.18 to 15.02.19)</td>
<td>2</td>
</tr>
<tr>
<td>Ms Tricia D’Orsi Chief Nurse and Interim Accountable Officer (wef 15.02.19 to 31.03.19 alongside substantive Chief Nurse role)</td>
<td>6</td>
</tr>
<tr>
<td>Mr Mark Barker</td>
<td>2</td>
</tr>
<tr>
<td>Position</td>
<td>Name</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>Interim Chief Finance Officer (wef 30.10.18)</td>
<td>Ms Katrina Leighton Interim Chief Finance Officer (wef 09.04.18 to 01.08.18 and 04.09.18 to 30.10.18)</td>
</tr>
<tr>
<td>Secondary Care Consultant</td>
<td>Dr Sreeman Andole</td>
</tr>
<tr>
<td>GP Representative</td>
<td>Dr Kate Baruysa</td>
</tr>
<tr>
<td>GP Representative,</td>
<td>Dr Krishna Chaturverdi</td>
</tr>
<tr>
<td>GP Representative,</td>
<td>Dr Brian Houston</td>
</tr>
<tr>
<td>GP Representative,</td>
<td>Dr Fahim Khan</td>
</tr>
<tr>
<td>(left Sept 2018)</td>
<td>Dr Sharon Hadley (wef Sept 2018)</td>
</tr>
<tr>
<td>GP Representative</td>
<td>Dr Kelvin Ng</td>
</tr>
<tr>
<td>GP Representative</td>
<td>Dr Taz Syed</td>
</tr>
<tr>
<td>Lay Member (PPI)</td>
<td>Ms Janis Gibson</td>
</tr>
<tr>
<td>Lay Member (Governance &amp; Risk)</td>
<td>Mr Nicholas Spenceley</td>
</tr>
<tr>
<td><strong>Non-Voting Members:</strong></td>
<td></td>
</tr>
<tr>
<td>Director of Primary Care &amp; Integrated Partnerships (left 19.07.18)</td>
<td>Mr Kevin McKenny</td>
</tr>
<tr>
<td>Chief Nurse (seconded to Basildon Hospital wef 08.03.18)</td>
<td>Mr Matthew Rangué</td>
</tr>
<tr>
<td>Director of Strategy &amp; Planning appointed 07.11.18)</td>
<td>Ms Charlotte Dillaway</td>
</tr>
<tr>
<td>Director of Primary Care &amp; Operations, appointed 01.10.18, end date 15.02.19</td>
<td>Mr John Spicer</td>
</tr>
<tr>
<td>Director of Integration &amp; Partnerships, appointed 01.10.18</td>
<td>Mr Simon Williams</td>
</tr>
<tr>
<td>Director of Integration &amp; Partnerships</td>
<td>Ms Jacqui Lansley</td>
</tr>
<tr>
<td>Joint Director of Acute Contracting and</td>
<td>Mr Robert Shaw</td>
</tr>
</tbody>
</table>
Terry Huff joined the CCG on 1 April 2019 as Accountable Officer.

Committee(s), including Audit Committee

**Primary Care Committee**
The overall objective of the Committee is to provide oversight of the duties delegated to the CCG in respect of contract management of GP practices in line with the delegation agreement with NHS England.

Support the delivery of the strategic vision for the commissioning of primary care (general practice) in Southend.

Oversee the performance management of the Primary Medical Service contractors.

Ensure that appropriate links are made between the implementation of the primary care strategy and the work of the CCG.

Work with the CCG committee responsible for quality and patient safety to overseeing the performance development process for all independent contractor groups and through this and other relevant mechanisms provide assurance to the Governing Body on the quality of primary care.

The members of the Committee and their attendance (2018/19) are listed below:

<table>
<thead>
<tr>
<th>Primary Care Co-Commissioning Committee</th>
<th>Attendance 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lay Member for Primary Care (Chair)</td>
<td>88%</td>
</tr>
<tr>
<td>Lay Member for Patient &amp; Public Engagement</td>
<td>75%</td>
</tr>
<tr>
<td>Lay Member for Governance</td>
<td>63%</td>
</tr>
<tr>
<td>Secondary Care Consultant*</td>
<td>0%*</td>
</tr>
<tr>
<td>Director of Primary Care (new post from Oct 2018, vacant from Jan 2019)</td>
<td>100%</td>
</tr>
<tr>
<td>Accountable Officer</td>
<td>50%</td>
</tr>
<tr>
<td>Chief Nurse</td>
<td>75%</td>
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</tbody>
</table>

*Note: Secondary Care Consultant was unable to attend during 2018/19 due to technical difficulties and this was agreed by the CCG Chair. These issues have now been resolved and the Secondary Care Consultant is expected to dial in.
Audit Committee
The committee meets 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 members of the Committee and their attendance (2018/19) are listed below:

<table>
<thead>
<tr>
<th>Audit Committee</th>
<th>Attendance 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lay Member for Primary Care</td>
<td>60%</td>
</tr>
<tr>
<td>Lay Member for Patient &amp; Public Engagement</td>
<td>80%</td>
</tr>
<tr>
<td>Lay Member for Governance (Chair)</td>
<td>60%</td>
</tr>
<tr>
<td>Lay Member for Governance &amp; Workforce</td>
<td>100%</td>
</tr>
<tr>
<td>GP Governing Body Member</td>
<td>60%</td>
</tr>
<tr>
<td>Secondary Care Consultant</td>
<td>20%</td>
</tr>
</tbody>
</table>

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

Joint 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 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.

The members of the Committee and their attendance (2018/19) are listed below:

<table>
<thead>
<tr>
<th>Joint Quality, Finance &amp; Performance Committee</th>
<th>Attendance 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lay Member for Primary Care</td>
<td>75%</td>
</tr>
<tr>
<td>Position</td>
<td>Attendance</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Lay Member for Patient &amp; Public Engagement</td>
<td>83%</td>
</tr>
<tr>
<td>Chair</td>
<td></td>
</tr>
<tr>
<td>Lay Member for Governance &amp; Performance</td>
<td>75%</td>
</tr>
<tr>
<td>Lay Member for Governance &amp; Workforce</td>
<td>92%</td>
</tr>
<tr>
<td>GP Governing Body Members</td>
<td>67%</td>
</tr>
<tr>
<td>GP Governing Body (Safeguarding)</td>
<td>67%</td>
</tr>
<tr>
<td>Accountable Officer</td>
<td>67%</td>
</tr>
<tr>
<td>Chief Finance Officer</td>
<td>92%</td>
</tr>
<tr>
<td>Chief Nurse</td>
<td>100%</td>
</tr>
</tbody>
</table>

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.

**Joint Clinical Executive Committee**

The clinical executive committee (CEC) is the driving force behind the CCG 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 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 members of the Committee and their attendance (2018/19) are listed below:

<table>
<thead>
<tr>
<th>Joint Clinical Executive Committee</th>
<th>Attendance 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP Governing Body Members x 8 (including Chair)</td>
<td></td>
</tr>
<tr>
<td>1. 74%</td>
<td></td>
</tr>
<tr>
<td>2. 65%</td>
<td></td>
</tr>
<tr>
<td>3. 52%</td>
<td></td>
</tr>
<tr>
<td>4. 78%</td>
<td></td>
</tr>
<tr>
<td>5. 83%</td>
<td></td>
</tr>
<tr>
<td>6. 57%</td>
<td></td>
</tr>
<tr>
<td>7. 74%</td>
<td></td>
</tr>
<tr>
<td>8. 43%</td>
<td></td>
</tr>
<tr>
<td>Clinical Lead Diabetes</td>
<td>74%</td>
</tr>
<tr>
<td>Accountable Officer</td>
<td>47%</td>
</tr>
<tr>
<td>Chief Finance Officer</td>
<td>47%</td>
</tr>
<tr>
<td>Chief Nurse</td>
<td>70%</td>
</tr>
</tbody>
</table>
Director of Primary Care (new post from Oct 2018, vacant from Jan 2018)  75%
Director of Integration & Partnerships  35%
Director of Strategy & Planning  70%
Public Health /Local Health Authority Representative  35%

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 2018/19.

The members of the Committee and their attendance (2018/19) are listed below:

<table>
<thead>
<tr>
<th>Remuneration Committee</th>
<th>Attendance 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lay Member for Primary Care</td>
<td>83%</td>
</tr>
<tr>
<td>Lay Member for Patient &amp; Public Engagement</td>
<td>83%</td>
</tr>
<tr>
<td>Lay Member for Governance &amp; Performance (Chair)</td>
<td>100%</td>
</tr>
<tr>
<td>Lay Member for Governance &amp; Workforce</td>
<td>100%</td>
</tr>
</tbody>
</table>

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.

**Procurement Committee**
The role of the Procurement Committee (the Committee) is to oversee the implementation of the CCG Procurement Strategy ensuring that the CCG follows agreed principles and methods in:
• Procurement planning - using information on population, priorities and providers to ensure good local procurement decision making
• Procurement process - following an agreed local process in undertaking a procurement
• Publishing procurement information – ensuring that the CCG meets its obligation of transparency

The Committee is authorised by the Governing Body to make procurement decisions and approve award of contracts following a procurement process. It is recognised that GP members on the Governing Body are likely to have conflicts of interest with regards to procurement decisions and therefore the Committee is delegated to make decisions provided the parameters set on within commissioning decisions are not breached. The Committee is responsible for assuring that procurements are carried out to deliver the clinical models of care approved within each commissioning case and that there is adequate independent clinical expertise involved in the evaluation process for each procurement. The Procurement Committee is only authorised to make procurement decisions after sufficient discussion and approval of the commissioning case by the Clinical Executive Committee. The Committee is authorised by the Governing Body to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

The Committee will be required to give assurance that conflicts of interest are being managed at all times.

The members of the Committee and their attendance (2018/19) are listed below:

<table>
<thead>
<tr>
<th>Procurement Committee</th>
<th>Attendance 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lay Member for Primary Care</td>
<td>92%</td>
</tr>
<tr>
<td>Lay Member for Patient &amp; Public Engagement (Chair)</td>
<td>75%</td>
</tr>
<tr>
<td>Lay Member for Governance &amp; Performance</td>
<td>83%</td>
</tr>
<tr>
<td>Lay Member for Governance &amp; Workforce</td>
<td>75%</td>
</tr>
<tr>
<td>Secondary Care Consultant</td>
<td>0%*</td>
</tr>
<tr>
<td>Director of Strategy &amp; Planning</td>
<td>100%</td>
</tr>
<tr>
<td>Chief Finance Officer</td>
<td>83%</td>
</tr>
<tr>
<td>Chief Nurse</td>
<td>42%</td>
</tr>
<tr>
<td>Independent GP</td>
<td>83%</td>
</tr>
</tbody>
</table>

*Note: Secondary Care Consultant was unable to attend during 2018/19 due to technical difficulties and this was agreed by the CCG Chair. These issues have now been resolved and the Secondary Care Consultant is expected to dial in.
Personal data related incidents
There were no Serious Untoward Incidents relating to data security breaches in 2018/19.

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.

Freedom of Information (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 229 (Southend) FOI requests during 2018/19. The CCG responded to 99.6% (Southend) 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.

Planning for Emergencies
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 that they are less likely to be at the heart of planning, but we will be involved in any incident that affects the health sector. The CCG role is one of co-operation, coordination and sharing information.

The Essex CCGs have an Emergency Preparedness, Resilience and Response (EPRR) and Business Continuity Strategy this ensures that the Essex CCGs respond according to 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.

Following the July 2018 review by the Emergency Planning team of CCG compliance against the NHS England EPRR Core Standards, the CCG achieved “partial” compliance. The CCG with the Emergency Planning Team have been undertaking work to move the CCG to a fully compliant position, this work will continue into 2019/20.

The Essex CCGs have a generic Incident Response and Incident Coordination Centre Plan which outlines the process for establishing an Incident Coordination Centre and an Incident Response Team within the local CCG. These plans have been updated during 2019.

Business Continuity Management (BCM) is a statutory requirement for all Essex CCGs. Suitable plans aligned to the international Business Continuity Standard ISO22301 have been developed to enable the Essex CCGs to respond to an internal incident or disruption. This process is supported by the CCG Business Continuity Management System and Policy and each of the Essex CCG Business Continuity Plan.

In December 2018, the Department of Health and Social Care published EU Exit Operational Guidance which requires all health and care organisations to undertake local EU Exit readiness planning, local risk assessments and plan for wider potential impacts. The Emergency Planning team are working to ensure that the requirements of this guidance are in place for the Essex CCGs.
On behalf of the Essex CCGs, the Emergency Planning works in collaboration with NHS England Midlands and East (East); they also represent them at the Local Health and Resilience Forum and Essex Resilience Forum.

Audit Arrangements
KPMG LLP is the appointed external auditor from 1 April 2018 by the Governing Body of the CCG. The total planned fee for the 2018/19 audit was £36,241. No other work was carried out by KPMG LLP during 2018/19.
Statement of Accountable Officer’s Responsibilities

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

The responsibilities of an Accountable Officer are set out under the National Health Service Act 2006 (as amended), 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,
- For keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction),
- For safeguarding the Clinical Commissioning Group’s 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 National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section 14R of the National Health Service Act 2006 (as amended)),
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual 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 Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

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 National Health Service Act 2006 (as amended), 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.

Terry Huff
Accountable Officer
NHS Southend CCG

24 May 2019
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 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. As at 5 October 2018 the Directions from NHS England were lifted although the DCO Team continues to monitor and support the CCG.

Scope of responsibility

As 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 Committee
- Clinical Executive
- Quality, Finance and Performance
- Remuneration

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

**Audit** – 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 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 2019, its voting members comprised the Chairman, 6 further GP members, one secondary care consultant, three Executive Directors, including the Accountable Officer and three 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 will be considered at the May 2019 Governing Body meeting. 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 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 2013 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 statutory duties.

**Risk management arrangements and effectiveness**

The CCG has in place a risk management policy which is reviewed annually and distributed to all staff and key partners. The Audit and Risk Committee is responsible for developing and endorsing the Risk Management Policy, 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 Governing Body Assurance Framework is the CCG principal tool for monitoring and managing the risks to the achievement of its strategic objectives and statutory duties. The Joint Governing Body Assurance Framework (JGBAF), made up of the Board Assurance Framework (BAF) and Corporate Risk Register (CRR), includes the main local priorities (principal objectives) for 2018/19 identified in the CCG 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 undertaken on behalf of the Director of Strategy and Planning by the Associate Director of Assurance 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 the Audit and Risk Committee and Quality, Finance and Performance. The Audit and Risk 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 stakeholder risks are fed into the CCG JGBAF through the following mechanisms:
- Presentation of the JGBAF 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 JGBAF/Corporate Risk Register where appropriate.
- Escalation of key performance issues by providers to the CCG.

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 JGBAF 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 and Risk 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 activities in order to support the achievement of the CCG objectives. The Audit and Risk 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 JGBAF. 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 2019 assessment identified the most significant risks to the CCG. There are 12 key risks identified. The highest priority of these is workforce in primary care which could lead to patient
safety risks within practices and patients not receiving the services they need to stay well and lead a healthy lifestyle and GPs voluntarily terminating their contracts. Other key risks include meeting patient demand where necessary; delivering on KPIs, achieving financial balance as part of QIPP savings, managing strategic and operations plans to ensure best outcomes for patients; meeting national standards and statutory responsibilities; workforce and staff shortages, the impact of a deal or no deal Brexit, managing staff vacancies and sickness; agreeing an effective joint system wide way of delivering healthcare with our partners and stakeholders; patient care and safety for patients; ensuring adequate capacity and response in times of major disease outbreak.

**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
- The Director of Strategy and Planning has delegated responsibility 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 Associate Director of Assurance 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 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 February 2019. CCG staff attended a mandatory staff training session on 9 January 2019 and 98.1% 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 Risk Management Policy 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 Audit and Risk Committee and Governing Body.
- Prioritising programmes of work in line with the CCG Corporate Objectives.
- Ensuring procurement processes and procedures are adhered to and expert advice sought from Attain, providers of the CCG 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 2019. The internal Auditors gave a ‘Satisfactory Assurance’ opinion. Stating that no significant issues were raised as a result of the work undertaken in 2018/19 and it is therefore the Assurance Framework and associated processes are sufficient to meet the requirements of the 2018/19 Annual Governance Statement and contribute to an effective system of internal control, designed to manage the significant risks identified by the CCG. The recommendations for Southend were:

- The Constitution for the CCG should be reviewed and formally approved by the Governing Body. Once this has been completed the Constitution should be sent for NHSE Approval. Consideration should be given to including this in the Governing Body's Forward Planner to help ensure completion.

- Sub committees should be reminded of the importance of meeting in line with their stipulated Terms of Reference (ToR). In addition, the sub committees should review their performance annually in respects of fulfilling their duties and meeting in line with the frequency requirements set out within their ToR. This should be included on the Governing Bodies Forward Planner to ensure completion.

**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 2018/19 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 IG Framework is supported by a Data Security & Protection Toolkit and the annual submission process provides assurances to the CCG, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

We place high importance on ensuring there are robust IG systems and processes in place to help protect patient and corporate information. We have established an IG management framework and have developed information governance processes and procedures in line with the Data Security & Protection Toolkit. We have ensured all staff undertake annual IG training and have implemented a staff IG resource guide to ensure members of staff are aware of their information governance roles and responsibilities, and how to access information or assistance.

There are processes in place for incident reporting and investigation of serious incidents. No serious incidents requiring investigation involving personal data were reported to the Information Commissioner in 2018/19.

The CCG has nominated information asset owners who have completed the new data flow mapping and information asset registers to ensure compliance with the General Data Protection Regulations. This was done with support from the IG Team to ensure consistency of approach.

In 2018/19 the CCG met all mandatory assertions in relation to the requirements of the Data Security & Protection Toolkit.

The CCG Caldicott Guardian and Senior Information Risk Owner (SIRO) attended training in February 2019.

**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 Audit and Risk Committee to ensure appropriate action is taken to address the highlighted issues.

Both reports contain areas which offer limited assurance to the CCG and consequently will be highlighted and discussed with the CCG Audit and Risk Committee to ensure appropriate action is taken to address the highlighted issues.

Control Issues
The CCG has received three internal audit reports which gave limited assurance and six that gave satisfactory as noted below:

<table>
<thead>
<tr>
<th>Auditable Area</th>
<th>Level of Assurance (if appropriate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Systems Key Controls</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>Governance, Assurance Framework and Risk Management</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>Primary Care Governance</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>Procurement Compliance</td>
<td>Limited</td>
</tr>
<tr>
<td>NHS Constitution Performance Standards</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>Governance Transformation</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>Continuing Healthcare</td>
<td>Limited</td>
</tr>
<tr>
<td>Quality, Innovation, Productivity and Prevention - QIPP</td>
<td>Limited</td>
</tr>
<tr>
<td>Joint Committee Governance</td>
<td>Limited</td>
</tr>
<tr>
<td>Complaints</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>Serious Incidents Phase 1</td>
<td>No Opinion</td>
</tr>
<tr>
<td>Serious Incidents Phase 2</td>
<td>No Opinion</td>
</tr>
<tr>
<td>Data Security Protection Toolkit</td>
<td>No Opinion</td>
</tr>
<tr>
<td>Follow Ups</td>
<td>N/A – Follow Up</td>
</tr>
</tbody>
</table>

STP Joint Committee Governance
- Internal Audit raised a total of two priority 1 recommendations and eight priority 2 recommendations. The two priority 1 recommendations related to:
The need for the Joint Committee to seek feedback from the CCG regarding the performance measures the CCG would like to see reported. A suggestion was made to hold an engagement event to develop key performance indicators and improvements to the Joint Committee’s performance reporting.

Strengthening the Joint Committee’s risk management processes

Procurement Committee

Internal Audit raised a total of three priority 1 recommendations, one priority 2 recommendation and one priority three recommendation. The three priority 1 recommendations related to:

- The need to produce a Strategic Procurement Plan taking into account the CCG spend analysis contracts register and collaborative opportunities.
- Improving the quality of information provided to decisions makers.
- Critical contacts analysis to be undertaken. For those contracts assessed as critical to the CCG operations, a CCG Business Continuity Plan is to be produced detailing the actions to be taken in the event of supplier failure and including exit strategies in the event of contract failure.

Continuing Healthcare

Internal Audit raised a total of three priority 1 recommendations and four priority 2 recommendations. The three priority 1 recommendations related to:

- Ensuring that there is a robust procedure for service procurement in place taking into account provider selection.
- Ensuring that there is a care plan in place for ever Continuing Healthcare patient which reflects their level of need.
- The development of a policy framework for undertaking quality visits to its service providers.

Quality, Innovation, Productivity and Prevention

Internal Audit raised a total of one priority 1 recommendations and five priority 2 recommendations. The priority 1 recommendation related to:

- Ensuring that all QIPP workbooks are fully completed and subjected to appropriate scrutiny to ensure that the planned savings are realistic.

No opinion was given in relation to the review of Serious Incidents and Data Security as the work performed was advisory in nature.

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 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 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 and Risk 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 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 2018/19, 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 overall financial management arrangements and use of resources were also subject to review by the CCG external auditors as part of their annual review of the CCG accounts.

**Delegation of functions**

As at 1 April 2018, for financial year 2018/19, the CCG committed £12.4m 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 and Risk Committee receives a report against each of the Standards for Commissioners on an annual basis.

During 2018/19, the CCG Audit and Risk 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 NHS Counter Fraud Authority in respect of Counter-Fraud and we will ensure necessary sanctions are applied where fraud is identified. The NHS Counter Fraud Authority (NHSCFA) is a new Special
Health Authority, established on 1 November 2017 and charged with identifying, investigating and preventing fraud within the NHS and the wider health group. The legislation which created the NHSCFA transferred all functions and powers from NHS Protect to the NHSCFA. The CCG has a process in place to ensure that action is taken regarding any NHS Counter Fraud Authority quality assurance recommendations, although none were received during 2018/19.

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 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 2019, is that satisfactory assurance can be given that there is a generally sound system of internal control, designed to meet the CCG 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 2018/19 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 and actions from the CCG Improvement Plan throughout the year.

Terry Huff
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 Southend 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 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 2018/19 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
All senior managers, with the exception of the Accountable Officer, Director of Integration & Transformation, Chief Finance Officer, Chief Nurse, Director of Strategy and Planning, Director of Primary Care and Operations and GP Governing Body members, are subject to Agenda for Change terms and conditions. The latter 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
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 2018/19.

Relevant proportions of remuneration
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
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 and Transformation, Chief Finance Officer, Chief Nurse, Director of Strategy and Planning, Director of Primary Care and Operations 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
NHS Southend have not made any significant awards to past Senior Managers during the period ending 31 March 2019.
Salaries and Allowances (subject to audit)

The information for salaries, benefits in kind and pension 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.
# Salaries and Allowances of Senior Managers

The table below shows the Salaries & Allowances of Senior Managers in 2018/19 (subject to audit):

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Salary (bands of £5,000)</th>
<th>Taxable Benefits (rounded to the nearest £100)</th>
<th>All pension-related benefits (bands of £2,500)</th>
<th>Total (bands of £500)</th>
<th>Southend and Castle Point &amp; Rochford CCG total %</th>
<th>Dates served</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>£000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Commenced</td>
</tr>
<tr>
<td>Executive Directors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Ian Stidston</td>
<td>Accountable Officer</td>
<td>105-110</td>
<td>0</td>
<td>0</td>
<td>105-110</td>
<td>50%</td>
<td>215-220</td>
</tr>
<tr>
<td>Andy Morris</td>
<td>Interim Accountable Officer</td>
<td>0-5</td>
<td>0</td>
<td>0</td>
<td>0-5</td>
<td>50%</td>
<td>5-10</td>
</tr>
<tr>
<td>2 Cathy Gritzner</td>
<td>Interim Accountable Officer</td>
<td>45-50</td>
<td>0</td>
<td>0</td>
<td>45-50</td>
<td>50%</td>
<td>90-95</td>
</tr>
<tr>
<td>3 Margaret Hathaway</td>
<td>Chief Finance Officer</td>
<td>50-55</td>
<td>0</td>
<td>0</td>
<td>20-25</td>
<td>70-75</td>
<td>145-150</td>
</tr>
<tr>
<td>4 Katrina Leighton</td>
<td>Interim Chief Finance Officer</td>
<td>20-25</td>
<td>0</td>
<td>10-12.5</td>
<td>30-35</td>
<td>See note 4</td>
<td>60-65</td>
</tr>
<tr>
<td>5 Mark Barker</td>
<td>Interim Chief Finance Officer</td>
<td>35-40</td>
<td>0</td>
<td>0</td>
<td>35-40</td>
<td>50%</td>
<td>70-75</td>
</tr>
<tr>
<td>6 Tricia D’Orsi</td>
<td>Chief Nurse</td>
<td>45-50</td>
<td>0</td>
<td>35-37.5</td>
<td>80-85</td>
<td>50%</td>
<td>165-170</td>
</tr>
<tr>
<td>Kevin McKenny</td>
<td>Interim Director of Primary Care</td>
<td>▼10-15</td>
<td>0</td>
<td>0</td>
<td>▼10-15</td>
<td>50%</td>
<td>25-30</td>
</tr>
<tr>
<td>7 Simon Williams</td>
<td>Director of Partnerships and Integration</td>
<td>40-45</td>
<td>0</td>
<td>15-17.5</td>
<td>55-60</td>
<td>See note 7</td>
<td>110-130</td>
</tr>
<tr>
<td>8 John Spicer</td>
<td>Director of Primary Care and Operations</td>
<td>30-35</td>
<td>0</td>
<td>15-17.5</td>
<td>50-55</td>
<td>50%</td>
<td>105-110</td>
</tr>
<tr>
<td>Charlotte Dillaway</td>
<td>Director of Strategy and Planning</td>
<td>15-20</td>
<td>0</td>
<td>2-5</td>
<td>20-25</td>
<td>50%</td>
<td>45-90</td>
</tr>
<tr>
<td>9 Jacqui Lansley</td>
<td>Director of Integrated Care and Partnerships</td>
<td>0-5</td>
<td>0</td>
<td>0</td>
<td>0-5</td>
<td>See note 9</td>
<td>0</td>
</tr>
<tr>
<td>Lay Members</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Janis Gibson</td>
<td>Lay Member (Patient and Public Involvement)</td>
<td>▼10-15</td>
<td>0</td>
<td>0</td>
<td>▼10-15</td>
<td>See note 10</td>
<td>10-15</td>
</tr>
<tr>
<td>11 Nick Spenceley</td>
<td>Lay member (Governance and Organisational Development)</td>
<td>▼10-15</td>
<td>0</td>
<td>0</td>
<td>▼10-15</td>
<td>See note 10</td>
<td>10-15</td>
</tr>
<tr>
<td>10 Pauline Stratford</td>
<td>Lay Member (Primary Care, Mental Health and Learning Disabilities)</td>
<td>0-5</td>
<td>0</td>
<td>0</td>
<td>0-5</td>
<td>See note 10</td>
<td>10-15</td>
</tr>
<tr>
<td>10 Peter Murphy</td>
<td>Lay Member (Performance)</td>
<td>0-5</td>
<td>0</td>
<td>0</td>
<td>0-5</td>
<td>See note 10</td>
<td>10-15</td>
</tr>
<tr>
<td>O/P Clinical Members</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>11 Dr José García-lobera</td>
<td>Governing Body Chair &amp; Clinical Lead</td>
<td>90-95</td>
<td>0</td>
<td>0</td>
<td>90-95</td>
<td>100%</td>
<td>90-95</td>
</tr>
<tr>
<td>12 Dr Kate Baruva</td>
<td>Governing Body Member &amp; Clinical Lead</td>
<td>50-55</td>
<td>0</td>
<td>47-55</td>
<td>95-100</td>
<td>100%</td>
<td>95-100</td>
</tr>
<tr>
<td>11 Dr Krishna Chaturvedi</td>
<td>Governing Body Member &amp; Clinical Lead</td>
<td>35-40</td>
<td>0</td>
<td>0</td>
<td>35-40</td>
<td>100%</td>
<td>35-40</td>
</tr>
<tr>
<td>11 Dr Fahim Khan</td>
<td>Governing Body Member &amp; Clinical Lead</td>
<td>20-25</td>
<td>0</td>
<td>0</td>
<td>20-25</td>
<td>100%</td>
<td>20-25</td>
</tr>
<tr>
<td>11 Dr Sharon Hadley</td>
<td>Governing Body Member &amp; Clinical Lead</td>
<td>55-60</td>
<td>0</td>
<td>0</td>
<td>55-60</td>
<td>100%</td>
<td>55-60</td>
</tr>
<tr>
<td>11 Dr Brian Houston</td>
<td>Governing Body Member &amp; Clinical Lead</td>
<td>35-40</td>
<td>0</td>
<td>0</td>
<td>35-40</td>
<td>100%</td>
<td>35-40</td>
</tr>
<tr>
<td>11 Dr Kevin Ng</td>
<td>Governing Body Member &amp; Clinical Lead</td>
<td>30-35</td>
<td>0</td>
<td>0</td>
<td>30-35</td>
<td>100%</td>
<td>30-35</td>
</tr>
<tr>
<td>11 Dr Taz Syed</td>
<td>Governing Body Member &amp; Clinical Lead</td>
<td>50-55</td>
<td>0</td>
<td>0</td>
<td>50-55</td>
<td>100%</td>
<td>50-55</td>
</tr>
<tr>
<td>Dr Sneeman Andole</td>
<td>Secondary Care Consultant</td>
<td>▼10-15</td>
<td>0</td>
<td>0</td>
<td>▼10-15</td>
<td>100%</td>
<td>▼10-15</td>
</tr>
<tr>
<td>9 Dr Ian Diley</td>
<td>Consultant in Public Health, Southend Borough Council</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>See note 9</td>
<td>0</td>
</tr>
</tbody>
</table>

Notes:
1. Ian Stidston left the CCG in April 2018. The salary shown includes a redundancy payment in the £155k-£155k band and payment in lieu of notice in the £50k-£50k band. This payment was set against provisions raised in 2017/18.
2. Cathy Gritzner covered the Interim Accountable Officer role from the 1st September 2018 to the 15th February 2019 and was employed via an agency. The value shown is the payment to the agency rather than the payment received by the individual.
3. Margaret Hathaway acted as Interim Accountable Officer from the 9th February 2018 to 1st August 2018. From the 1st September 2018 to 31st October 2018, Margaret was on secondment to Mid Essex CCG. Following this Margaret has been on long-term sick leave.
4. Katrina Leighton became Interim Chief Finance Officer as of the 9th April 2018 ceasing on the 1st August 2018 when Margaret Hathaway returned to the Chief Finance Officer position. Katrina was reinstated as Interim Chief Finance Officer from the 4th September to the 30th October 2018 to cover Margaret’s secondment until Mark Barker interim Chief Finance Officer commenced.
5. Mark Barker commenced as Interim Chief Finance Officer as at the 30th October 2018 and was employed via an agency. The value shown is the payment to the agency rather than the payment received by the individual.
6. Toscia D’Orsi was appointed as Interim Accountable Officer from the 15th February 2019 to the 31st March 2019 to cover the role until the appointment of the substantive Accountable Officer on 1st April 2019. Full salary costs are incorporated within the Chief Nurse role.
7. Simon Williams was acting as interim Director of Primary Care as from 30th March 2018 to 30th September 2018 after which he was appointed as Director of Partnership and Integration for Castle Point & Rochford CCG. Simon continues as a member of Southend CCG Governing Body.
8. John Spicer was appointed on the 1st October 2018 and left the CCG on 15th February 2019. The salary shown above includes the CCGs 50% share of a payment in lieu of notice in the £25k-£30k band.
9. Jacqui Lansley and Dr Ian Diley are not paid by the CCG so their salary value is zero.
10. Lay members: From 1st April 2018 to 30th September 2018 Pauline Stratford and Peter Murphy were members exclusively for Castle Point & Rochford CCG, while Janis Gibson and Nick Spenceley were members exclusively for Southend CCG. From 1st October 2018 the four lay members’ roles became shared equally between Castle Point & Rochford CCG and Southend CCG. However, the two lay members remain solely voting on Southend CCG governing body.
11. Where a senior manager’s remuneration includes elements for their management role and other roles, e.g. clinical lead, the salary stated represents their total remuneration, including duties that are not part of their management role.
Note Joint Committee Executives

Remuneration paid to the executives shown in the tables below is funded by the five CCGs. These amounts are in addition to the amounts reported by CCGs in respect of their roles specific to individual CCGs.

The CCG received a share of the following costs via a recharge in respect of their roles as Joint Commission Team executives.

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Commenced (if during year)</th>
<th>Ceased (if during year)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mike Bewick</td>
<td>Chair</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caroline Rassell</td>
<td>Accountable Officer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Louis Kamfer</td>
<td>Chief Finance Officer</td>
<td>14-Sep-18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Margaret Hathaway</td>
<td>Chief Finance Officer</td>
<td>01-Sep-18</td>
<td>31-Oct-18</td>
<td></td>
</tr>
<tr>
<td>Andy Ray</td>
<td>Chief Finance Officer</td>
<td>07-Jan-19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Karen Wasson</td>
<td>Director of Commissioning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carol Anderson</td>
<td>Chief Nurse</td>
<td>30-Sep-18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rachel Hearn</td>
<td>Chief Nurse</td>
<td>01-Nov-18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Donald McGeachy</td>
<td>Medical Director</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

100% of costs for the year, shared by 5 CCGs. Our share of the costs were in the remuneration band £10k-£15k.

50% of costs for the year, shared by 5 CCGs. Our share of the costs were in the remuneration band £10k-£15k.

An average of 60% of costs for the period employed, shared by 5 CCGs. Total remuneration paid was in the band £30k-£35k and our share of the costs were in the remuneration band £0k-£5k.

80% of costs for the period employed, shared by 5 CCGs. Our share of the costs were in the remuneration band £0k-£5k.

100% of costs for the period employed, shared by 5 CCGs. Our share of the costs were in the remuneration band £5k-£10k.

100% of costs for the year, shared by 5 CCGs. Our share of the costs were in the remuneration band £15k-£20k.

100% of costs for the period in this role, shared by 5 CCGs. Our share of the costs were in the remuneration band £5k-£10k.

50% of costs for the period in this role, shared by 5 CCGs. Our share of the costs were in the remuneration band £0k-£5k.

100% of costs for the year, shared by 5 CCGs. Our share of the costs were in the remuneration band £10k-£15k.

The total remuneration figure of £30k-£35k for Andy Ray excludes all Pension Related Benefits which are in the range £55k-£57.5k. The Pension Related Benefits for other Joint Committee staff are included in full in the Remuneration Report of the CCG that employs them.
The table below shows the Pension Benefits of Senior Managers in 2018/19 (subject to audit):

| Notes | Name                          | Title                        | Real increase in pension at pension age | Real increase in pension lump sum at pension age | Total accrued pension at pension age at 31st March 2019 | Lump sum at pension age related to accrued pension at 31st March 2019 | Cash equivalent transfer value at 1st April 2019 | Real increase in cash equivalent transfer value at 31st March 2019 | Cash equivalent transfer value at 1st April 2019 related to accrued pension at 31st March 2019 | Share of all pension-related benefits apportioned to Southend CCG (bands of £2,500) | Time spent as a member of Southend CCG (bands of £2,500) | | % |
|-------|------------------------------|------------------------------|-----------------------------------------|-------------------------------------------------|----------------------------------------------------------|-----------------------------------------------------------------|-------------------------------------------------|-------------------------------------------------|-------------------------------------------------|-------------------------------------------------|-------------------------------------------------|----------------------------------------------|
|       |                              |                              | (bands of £2,500)                      | (bands of £2,500)                                | (bands of £5,000)                                         | (bands of £5,000)                                               | £000                                            | £000                                            | £000                                            | £000                                            | £000                                            | £000 |
|       |                              |                              | £000                                    | £000                                            | £000                                                     | £000                                                           | £000                                            | £000                                            | £000                                            | £000                                            | £000                                            | £000 |
| 1,2   | Ian Stidston                 | Accountable Officer          | 0                                       | 0                                               | 30-35                                                    | 100-105                                                        | 0                                               | 0                                               | 815                                            | 50%                                            | 0                                               | 0 |
| 1     | Margaret Hathaway           | Chief Finance Officer        | 0-2.5                                   | 0-2.5                                           | 25-30                                                    | 60-65                                                         | 536                                             | 79                                             | 426                                            | 50%                                            | 20-22.5                                         | 0 |
| 1     | Katrina Leighton            | Interim Chief Finance Officer| 0-2.5                                   | 0-2.5                                           | 5-10                                                     | 0-5                                                           | 84                                              | 16                                             | 56                                             | 50%                                            | 10-12.5                                         | 0 |
| 1     | Tricia D’Orsi               | Chief Nurse                  | 2.5-5.0                                 | 5.0-7.5                                         | 25-30                                                    | 55-60                                                         | 435                                             | 35                                             | 375                                            | 50%                                            | 35-37.5                                         | 0 |
| 1,2   | Kevin McKenny               | Interim Director of Primary Care | 0                                       | 0                                               | 35-40                                                    | 115-120                                                       | 917                                             | 0                                               | 896                                            | 50%                                            | 0                                               | 0 |
| 1     | Simon Williams              | Director of Partnerships and Integration | 2.5-5.0                               | 0-2.5                                           | 20-25                                                    | 45-50                                                         | 402                                             | 61                                             | 319                                            | 50%                                            | 15-17.5                                         | 0 |
| 1     | John Spicer                 | Director of Primary Care and Operations | 0-2.5                                | 0-2.5                                           | 5-10                                                     | 0-5                                                           | 55                                              | 20                                             | 28                                             | 50%                                            | 15-17.5                                         | 0 |
| 1     | Charlotte Dillaway          | Director of Strategy and Planning | 0-2.5                                | 0-2.5                                           | 0-5                                                      | 0-5                                                           | 6                                               | 1                                               | 0                                               | 50%                                            | 2.5-5                                           | 0 |
| GP/ Clinical Members            |                              |                              | (bands of £2,500)                      | (bands of £5,000)                                | (bands of £5,000)                                         | (bands of £5,000)                                               | £000                                            | £000                                            | £000                                            | £000                                            | £000                                            | £000 |
|       |                              |                              | £000                                    | £000                                            | £000                                                     | £000                                                           | £000                                            | £000                                            | £000                                            | £000                                            | £000                                            | £000 |
|       | Kate Barusya                 | Governing Body Member & Clinical Lead | 2.5-5                                  | 0-2.5                                           | 15-20                                                    | 45-50                                                         | 318                                             | 82                                             | 222                                            | 100%                                            | 47.5-50                                         | 0 |
| 2     | Fahim Khan                   | Governing Body Member & Clinical Lead | 0                                       | 0                                               | 0-5                                                      | 0-15                                                          | 0                                               | 0                                               | 0                                               | 100%                                            | 0                                               | 0 |
| 2     | Taz Syed                     | Governing Body Member & Clinical Lead | 0                                       | 0                                               | 10-15                                                    | 20-25                                                         | 163                                             | 12                                             | 137                                            | 100%                                            | 0                                               | 0 |

Notes:
1. These members’ posts are shared with Castle Point & Rochford CCG. The values shown here are the whole values for the individuals.
2. For these members the calculations of real increase in pension, lump sum and CETV result in negative values. In these cases zero is substituted for the negative value.

Members not included in the above table do not receive pensionable remuneration under the standard NHS Scheme and therefore there are 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. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008.

Real Increase in CETV
This reflects the increase in CETV effectively 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.

<table>
<thead>
<tr>
<th></th>
<th>2018/19 (Agency)</th>
<th>2018/19 (On payroll)</th>
<th>2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>The banded remuneration of the highest paid director / member (paid through agency)</td>
<td>£175k to £180k</td>
<td>£120k to £125k</td>
<td>£95k to £100k</td>
</tr>
<tr>
<td>The banded remuneration of the highest paid director / member (on payroll)</td>
<td>£120k to £125k</td>
<td>£95k to £100k</td>
<td>£95k to £100k</td>
</tr>
<tr>
<td>Median remuneration of the CCG workforce</td>
<td>£40,685</td>
<td>£40,097</td>
<td>£38,685</td>
</tr>
<tr>
<td>Ratio of highest paid director / member to median paid employee</td>
<td>4.4</td>
<td>3.1</td>
<td>2.6</td>
</tr>
<tr>
<td>No. of employees who were paid more than the highest paid director / member</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Remuneration ranges in the year</td>
<td>£10k to £180k</td>
<td>£10k to £125k</td>
<td>£0k to £100k</td>
</tr>
</tbody>
</table>

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 and Rochford CCG in the remuneration report and, therefore, does not match the band shown here.

The highest paid director in 2018/19 was paid, through an agency, for an interim period only and only for five months actual employment. The actual salary incurred for the period was in the £75k-£80k band excluding all agency premium and placement fees for the interim appointment. The cost was shared equally with Castle Point and Rochford CCG. The value calculated in the banded remuneration note is stated as a whole time, full year equivalent for comparison purposes year on year and does not reflect the actual salary payments made by the CCG.

The table also includes the highest paid director on the CCGs payroll, allowing comparison with 2017/18. This is shown under the heading 2018/19 (On payroll).
# Salaries and Allowances of Senior Managers

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Salary (bands of £5,000)</th>
<th>All pension-related benefits (bands of £2,500)</th>
<th>Total (bands of £5000)</th>
<th>Dates served</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Executive Directors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Ian Stidston</td>
<td>Accountable Officer</td>
<td>60-65</td>
<td>22.5-25</td>
<td>80-85</td>
<td>01-Feb-15</td>
</tr>
<tr>
<td>2 Margaret Hathaway</td>
<td>Chief Finance Officer</td>
<td>55-60</td>
<td>20-22.5</td>
<td>75-80</td>
<td>01-Mar-15</td>
</tr>
<tr>
<td>3 Kevin McKenny</td>
<td>Director of Integration &amp; Transformation</td>
<td>15-20</td>
<td>5-7.5</td>
<td>25-30</td>
<td>01-Apr-13</td>
</tr>
<tr>
<td>4 Matthew Rangue</td>
<td>Chief Nurse</td>
<td>80-85</td>
<td>255-257</td>
<td>350-355</td>
<td>01-Apr-16</td>
</tr>
<tr>
<td>5 Patricia D’Orsi</td>
<td>Chief Nurse</td>
<td>0-5</td>
<td>0-5</td>
<td>0-5</td>
<td>01-Apr-13</td>
</tr>
<tr>
<td>6 Robert Shaw</td>
<td>Director of Acute Commissioning and Contracting</td>
<td>25-30</td>
<td>177.5-180</td>
<td>203-210</td>
<td>01-Apr-16</td>
</tr>
<tr>
<td><strong>Lay Members</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Janis Gibson</td>
<td>Lay Member, Public and Patient Engagement</td>
<td>10-15</td>
<td>0</td>
<td>10-15</td>
<td>01-Apr-16</td>
</tr>
<tr>
<td>Nicholas Spenceley</td>
<td>Lay Member, Governance</td>
<td>10-15</td>
<td>0</td>
<td>10-15</td>
<td>01-Sep-16</td>
</tr>
<tr>
<td><strong>GP/Clinical Members</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Krishna Chaturvedi</td>
<td>GP Governing Body Member &amp; Clinical Lead</td>
<td>45-50</td>
<td>0</td>
<td>45-50</td>
<td>01-Apr-16</td>
</tr>
<tr>
<td>Dr José García-Lobera</td>
<td>GP Governing Body Chair &amp; Clinical Lead</td>
<td>90-95</td>
<td>0</td>
<td>90-95</td>
<td>01-Apr-16</td>
</tr>
<tr>
<td>Dr Brian Houston</td>
<td>GP Governing Body Member</td>
<td>30-35</td>
<td>0</td>
<td>30-35</td>
<td>01-Apr-16</td>
</tr>
<tr>
<td>Dr Fahim Khan</td>
<td>GP Governing Body Member</td>
<td>30-35</td>
<td>0</td>
<td>30-35</td>
<td>01-Apr-16</td>
</tr>
<tr>
<td>Dr Kelvin Ng</td>
<td>GP Governing Body Member</td>
<td>30-35</td>
<td>0</td>
<td>30-35</td>
<td>01-Apr-16</td>
</tr>
<tr>
<td>Dr Kate Baruysa</td>
<td>GP Governing Body Member &amp; Clinical Lead</td>
<td>45-50</td>
<td>0</td>
<td>45-50</td>
<td>01-Apr-16</td>
</tr>
<tr>
<td>Dr Tat Syed</td>
<td>GP Governing Body Member &amp; Clinical Lead</td>
<td>45-50</td>
<td>30-32.5</td>
<td>75-80</td>
<td>01-Apr-16</td>
</tr>
<tr>
<td>Dr Andrea Atherton</td>
<td>Non voting member</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>7 Jacqui Lansley</td>
<td>Non voting member</td>
<td>60-65</td>
<td>0</td>
<td>60-65</td>
<td></td>
</tr>
</tbody>
</table>

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. Patricia D’Orsi 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.
Staff report

Staff engagement
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 2018/19, 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.

Staff consultation
During 2018/19, we continued to work closely with our colleagues at Castle Point and Rochford CCG.

Castle Point and Rochford CCG and Southend CCG formally consulted with staff from 3 May 2018 to 15 June 2018 on proposals for a revised organisational structure that: produced required NHSE (NHS England) financial savings, is fit for purpose, fully delivers joint working arrangements across both CCGs and is deliverable within the cost envelope.

All feedback received was considered and as a result some amendments were made to the organisational structure. The new structure – a joint structure across both CCGs - was implemented with effect from 1 October 2018.

Organisational development
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 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 2019/20 in line with the 2018/19 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 Castle Point and Rochford CCG.

During 2018/19 the CCG established a joint Staff Involvement Group with Castle Point and Rochford CCG and the group was key to developing the CCGs Staff Survey action plan and is
overseeing the initiatives to be implemented locally as part of our Mindful Employer Charter for Employers.

In October 2018 the Governing Body approved the CCG Organisational Development Strategy and the delivery plan attached to this strategy supports the recommendations outlined in the CCG Improvement Plan to ensure that the organisation is taken out of special measures during 2019/20.

Staff composition
(1 April 2018 to 31 March 2019)

Number of Senior Managers - (Band 8C and Above - Including Board Members)

<table>
<thead>
<tr>
<th>Senior Manager</th>
<th>Female</th>
<th>Male</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanent</td>
<td>3</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Fixed Term Temp</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4</strong></td>
<td><strong>4</strong></td>
<td><strong>8</strong></td>
</tr>
</tbody>
</table>

Staff numbers and costs

Staff numbers (Substantive Employees Only)

<table>
<thead>
<tr>
<th>Employee Category</th>
<th>Headcount</th>
<th>%</th>
<th>FTE*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanent</td>
<td>30</td>
<td>73.17</td>
<td>30.00</td>
</tr>
<tr>
<td>Fixed Term</td>
<td>11</td>
<td>26.83</td>
<td>6.48</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>41</strong></td>
<td><strong>100.00</strong></td>
<td><strong>36.48</strong></td>
</tr>
</tbody>
</table>

Assignment Category

<table>
<thead>
<tr>
<th>Assignment Category</th>
<th>Headcount</th>
<th>%</th>
<th>FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fixed Term Temp</td>
<td>1</td>
<td>2.44</td>
<td>0.00</td>
</tr>
<tr>
<td>Permanent</td>
<td>40</td>
<td>73.56</td>
<td>33.48</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>41</td>
<td><strong>100.00</strong></td>
<td><strong>36.48</strong></td>
</tr>
</tbody>
</table>
## Staff costs

### NHS Southend CCG - Annual Accounts 2018-19

#### 4. Employee benefits and staff numbers

##### 4.1.1 Employee benefits

<table>
<thead>
<tr>
<th></th>
<th>Admin</th>
<th>Programme</th>
<th>Total 2018-19</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Employee Benefits</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>1,389</td>
<td>385</td>
<td>1,774</td>
</tr>
<tr>
<td>Employer contributions to the NHS Pension Scheme</td>
<td>134</td>
<td>-</td>
<td>220</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,654</td>
<td>385</td>
<td>2,039</td>
</tr>
</tbody>
</table>

less

<table>
<thead>
<tr>
<th></th>
<th>Admin</th>
<th>Programme</th>
<th>Total 2018-19</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gross employee benefits expenditure</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,654</td>
<td>385</td>
<td>2,039</td>
</tr>
</tbody>
</table>

Less recoveries in respect of employee benefits (note 4.1.2)

<table>
<thead>
<tr>
<th></th>
<th>Admin</th>
<th>Programme</th>
<th>Total 2018-19</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net admin employee benefits including capitalised costs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,654</td>
<td>385</td>
<td>2,039</td>
</tr>
</tbody>
</table>

Less: Employee costs capitalised

<table>
<thead>
<tr>
<th></th>
<th>Admin</th>
<th>Programme</th>
<th>Total 2018-19</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net employee benefits excluding capitalised costs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,654</td>
<td>385</td>
<td>2,039</td>
</tr>
</tbody>
</table>

#### 4.1.1 Employee benefits 2017-18

<table>
<thead>
<tr>
<th></th>
<th>Admin</th>
<th>Programme</th>
<th>Total 2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Employee Benefits</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>1,428</td>
<td>34</td>
<td>1,462</td>
</tr>
<tr>
<td>Employer contributions to the NHS Pension Scheme</td>
<td>307</td>
<td>-</td>
<td>307</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2,006</td>
<td>34</td>
<td>2,040</td>
</tr>
</tbody>
</table>

less

<table>
<thead>
<tr>
<th></th>
<th>Admin</th>
<th>Programme</th>
<th>Total 2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gross employee benefits expenditure</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2,006</td>
<td>34</td>
<td>2,040</td>
</tr>
</tbody>
</table>

Less recoveries in respect of employee benefits (note 4.1.2)

<table>
<thead>
<tr>
<th></th>
<th>Admin</th>
<th>Programme</th>
<th>Total 2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net admin employee benefits including capitalised costs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2,006</td>
<td>34</td>
<td>2,040</td>
</tr>
</tbody>
</table>

Less: Employee costs capitalised

<table>
<thead>
<tr>
<th></th>
<th>Admin</th>
<th>Programme</th>
<th>Total 2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net employee benefits excluding capitalised costs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2,006</td>
<td>34</td>
<td>2,040</td>
</tr>
</tbody>
</table>
Sickness absence data

**NHS Southend CCG**

**NHS Sickness Absence Figures for NHS 2018-19**

<table>
<thead>
<tr>
<th>FTE-Days Available</th>
<th>FTE-Days Lost to Sickness Absence</th>
<th>Average Sick Days per FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>21788</td>
<td>1128</td>
<td>11.7</td>
</tr>
</tbody>
</table>

* Note: Staff are employed by NHS Southend CCG but also work across NHS Castle Point and Rochford CCG

*Source: NHS Digital- Sickness Absence Publication – based on data from ESR Data Warehouse

**Period covered**: January to December 2018, as per Guidance on Sickness Absence Data Reporting by NHS Bodies for 2018-19

Expenditure on consultancy

As detailed in the financial statements, the CCG expenditure on consultancy was £762,000 for 2018/19.

Off-payroll engagements

**Table 1: Off-payroll engagements longer than 6 months**

For all off-payroll engagements as at 31 March 2019, for more than £220 per day and that last longer than six months:

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of existing engagements as of 31 March 2019</td>
<td>3</td>
</tr>
<tr>
<td>Of which, the number that have existed:</td>
<td></td>
</tr>
<tr>
<td>for less than one year at the time of reporting</td>
<td>1</td>
</tr>
<tr>
<td>for between one and two years at the time of</td>
<td>2</td>
</tr>
<tr>
<td>reporting</td>
<td></td>
</tr>
<tr>
<td>for between 2 and 3 years at the time of</td>
<td>0</td>
</tr>
<tr>
<td>reporting</td>
<td></td>
</tr>
<tr>
<td>for between 3 and 4 years at the time of</td>
<td>0</td>
</tr>
<tr>
<td>reporting</td>
<td></td>
</tr>
<tr>
<td>for 4 or more years at the time of reporting</td>
<td>0</td>
</tr>
</tbody>
</table>
Table 2: New off-payroll engagements

For all new off-payroll engagements between 01 April 2018 and 31 March 2019, for more than £220 per day and that last longer than six months:

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019</td>
<td>4</td>
</tr>
<tr>
<td>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</td>
<td>0</td>
</tr>
<tr>
<td>Number for whom assurance has been requested</td>
<td>0</td>
</tr>
<tr>
<td>Of which:</td>
<td></td>
</tr>
<tr>
<td>assurance has been received</td>
<td>4</td>
</tr>
<tr>
<td>assurance has not been received</td>
<td>0</td>
</tr>
<tr>
<td>engagements terminated as a result of assurance not being received.</td>
<td>0</td>
</tr>
</tbody>
</table>

Off-payroll board members/senior official engagements

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility during the financial year.</td>
<td>4</td>
</tr>
<tr>
<td>Total no. of individuals on payroll and off payroll that have been deemed &quot;board members, and/or, senior officials with financial responsibility&quot;, during the financial year. This figure must include both on payroll and off-payroll engagements.</td>
<td>26</td>
</tr>
</tbody>
</table>

Of the 4 off-payroll engagements recorded above, two were paid through agencies and two were council representatives not paid by the CCG.

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:

<table>
<thead>
<tr>
<th></th>
<th>Total Number of Cases</th>
<th>Total Value of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>2018-19</td>
</tr>
<tr>
<td>Administrative write-offs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2018-19</th>
<th>2017-18</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td></td>
<td>6</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

106
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.

*note, the figures have been rounded to two decimal places which has a cumulative impact on the Grand Totals
*note, the figures have been rounded to two decimal places which has a cumulative impact on the Grand Totals
*note, the figures have been rounded to two decimal places which has a cumulative impact on the Grand Totals
Note: Length of service is calculated from when the CCG first formed in 2013.

*note, the figures have been rounded to two decimal places which has a cumulative impact on the Grand Totals
## Pay Band by Gender

<table>
<thead>
<tr>
<th>Row Labels</th>
<th>Female Count of Gender</th>
<th>Male Count of Gender</th>
<th>Total Count of Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 3</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Band 4</td>
<td>4</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Band 5</td>
<td>4</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Band 6</td>
<td>5</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Band 7</td>
<td>4</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Band 8 - Range A</td>
<td>6</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Band 8 - Range B</td>
<td>7</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Band 8 - Range C</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Band 8 - Range D</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>35</strong></td>
<td><strong>6</strong></td>
<td><strong>41</strong></td>
</tr>
</tbody>
</table>
## Pay Band – Ethnicity Headcount

<table>
<thead>
<tr>
<th>Row Labels</th>
<th>Band 3</th>
<th>Band 4</th>
<th>Band 5</th>
<th>Band 6</th>
<th>Band 7</th>
<th>Band 8 - Range A</th>
<th>Band 8 - Range B</th>
<th>Band 8 - Range C</th>
<th>Band 8 - Range D</th>
<th>Other</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>A White - British</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>7</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>31</td>
</tr>
<tr>
<td>B White - Irish</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>C White - Any other White background</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>CY White Other European</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>GF Mixed - Other/Unspecified</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>N Black or Black British - African</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>PD Black British</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Z Not Stated</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Grand Total</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>8</td>
<td>7</td>
<td>1</td>
<td>5</td>
<td>2</td>
<td>41</td>
</tr>
</tbody>
</table>
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 A. An audit certificate and report is also included in this Annual Report on page 117.
Independent Auditor’s Report

INDEPENDENT AUDITOR’S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS SOUTHBEND 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 2019 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 2019 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 and Social Care Group Accounting Manual 2018/19.

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 CCG 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

The Accountable Officer has prepared the financial statements on the going concern basis as they have not 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. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements (“the going concern period”).

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 a year from the date of approval of the financial statements. In our evaluation of the Accountable Officer’s conclusions we considered the inherent risks to the CCG’s operations, including the impact of Brexit, and analysed how these risks might affect the CCG’s financial resources, or ability to continue its operations over the going concern period. We have nothing to report in these respects.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor’s report is not a guarantee that the CCG will continue in operation.

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 and Social Care Group Accounting Manual 2018/19.

**Accountable Officer’s responsibilities**

As explained more fully in the statement set out on page 81, the Accountable Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for 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 CCG’s 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](http://www.frc.org.uk/auditorsresponsibilities)

**REPORT ON OTHER LEGAL AND REGULATORY MATTERS**

**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, 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 conform to the authorities which govern them.

**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.

We have nothing to report in this respect.

**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 page 81, 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 refer a matter to the Secretary of State 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; or

- 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.

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
100 Hills Road, Cambridge, CB2 1AR
24 May 2019
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Commissioning Group (CCG)</td>
<td>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.</td>
</tr>
<tr>
<td>Civil contingencies act 2004</td>
<td>Provides a single framework for UK civil protection against any challenges to society — it focuses on local arrangements and emergency powers.</td>
</tr>
<tr>
<td>Commissioning</td>
<td>The review, planning and purchasing of health and social services.</td>
</tr>
<tr>
<td>Community services</td>
<td>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.</td>
</tr>
<tr>
<td>Commissioning Support Unit (CSU)</td>
<td>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.</td>
</tr>
<tr>
<td>Enhanced services</td>
<td>Enhanced services are:</td>
</tr>
<tr>
<td></td>
<td>i) essential or additional services delivered to a higher specified standard, for example, extended minor surgery</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>Equality delivery system (EDS)</td>
<td>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.</td>
</tr>
<tr>
<td>Equality impact assessment (EIA)</td>
<td>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.</td>
</tr>
</tbody>
</table>
### Glossary of financial terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accounting policies</td>
<td>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.</td>
</tr>
<tr>
<td>Budget</td>
<td>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.</td>
</tr>
<tr>
<td>Capital expenditure</td>
<td>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.</td>
</tr>
<tr>
<td>Capital resource limit</td>
<td>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.</td>
</tr>
<tr>
<td>Revenue resource limit</td>
<td>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.</td>
</tr>
<tr>
<td>Depreciation</td>
<td>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</td>
</tr>
<tr>
<td>Impairments</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Intangible assets</strong> (formerly intangible fixed assets)</td>
<td>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.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>International financial reporting standards</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Losses and special payments</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>NHS payables</strong> (formerly known as NHS creditors)</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Over spend</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Pooled budget</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Provisions</strong></td>
<td>A provision is a liability arising from a past event where it is probable the CCG will have to settle and a reliable estimate can be made of the amount to be paid.</td>
</tr>
<tr>
<td><strong>Statement of cash flows</strong></td>
<td>The statement of cash flows (SCF) shows the effect of the CCG’s operating activities on its cash position. The purpose of the statement of changes in taxpayers’ equity is to highlight financial transactions that may not be reflected in the statement of comprehensive net expenditure, but which affect the CCG reserves as shown in the ‘Financed by’ section on the statement of financial position. For example, ‘(Reduction)/Additions in the General Fund due to the transfer of assets to/from NHS bodies and the Department of Health’.</td>
</tr>
<tr>
<td><strong>Expenditure (formerly known as operation cost statement)</strong></td>
<td>Expenditure (SCNE) records the costs incurred by the CCG during the year, net of miscellaneous income (which is income other than the CCG’s main funding from the Department of Health which is credited to the general fund on the Statement of Financial Position and not treated as income on the SCNE). It includes non-cash expenses such as depreciation. Under government accounting rules the SCNE shows the net resources used by the CCG in commissioning and providing healthcare rather than the surplus or deficit for the year as shown in the income and expenditure account by NHS trusts. The comprehensive net expenditure is debited to the general fund on the Statement of taxpayer’s equity.</td>
</tr>
<tr>
<td><strong>Tendering</strong></td>
<td>Tendering is the process by which one can seek prices and terms for a particular service/project to be carried out under a contract.</td>
</tr>
<tr>
<td><strong>Trade and other payables (non NHS) formerly known as non-NHS creditors</strong></td>
<td>Trade and other payables creditors are non-NHS organisations owed money by the CCG for goods and services provided to the CCG, e.g. for utilities, equipment, etc.</td>
</tr>
<tr>
<td><strong>Trade and other receivables (formerly debtors)</strong></td>
<td>Trade and other receivables represent money owed to the CCG at the statement of financial Position date for services rendered or goods supplied by the CCG to the receiver.</td>
</tr>
<tr>
<td><strong>Underspend</strong></td>
<td>Under spend occurs when less money is spent than was allowed within the cash limit or that was planned in the budget.</td>
</tr>
</tbody>
</table>
APPENDIX A:
FINANCIAL STATEMENTS
The following pages reflect the Financial Statements of the CCG, with the page numbering re-commencing at page 1

## CONTENTS

### The Primary Statements:

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<th>Page Number</th>
</tr>
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<tr>
<td>Statement of Financial Position as at 31st March 2019</td>
<td>3</td>
</tr>
<tr>
<td>Statement of Changes in Taxpayers' Equity for the year ended 31st March 2019</td>
<td>4</td>
</tr>
<tr>
<td>Statement of Cash Flows for the year ended 31st March 2019</td>
<td>5</td>
</tr>
</tbody>
</table>

### Notes to the Accounts

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<tr>
<th>Notes</th>
<th>Page Number</th>
</tr>
</thead>
<tbody>
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</tr>
<tr>
<td>Other operating revenue</td>
<td>10</td>
</tr>
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<td>Employee benefits and staff numbers</td>
<td>11</td>
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<tr>
<td>Operating expenses</td>
<td>14</td>
</tr>
<tr>
<td>Better payment practice code</td>
<td>15</td>
</tr>
<tr>
<td>Operating leases</td>
<td>16</td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>17</td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>18</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>19</td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>20</td>
</tr>
<tr>
<td>Provisions</td>
<td>21</td>
</tr>
<tr>
<td>Financial instruments</td>
<td>22</td>
</tr>
<tr>
<td>Operating segments</td>
<td>23</td>
</tr>
<tr>
<td>Pooled Budgets</td>
<td>23</td>
</tr>
<tr>
<td>Related party transactions</td>
<td>24</td>
</tr>
<tr>
<td>Events after the end of the reporting period</td>
<td>25</td>
</tr>
<tr>
<td>Financial performance targets</td>
<td>25</td>
</tr>
</tbody>
</table>
### Statement of Comprehensive Net Expenditure for the year ended 31 March 2019

<table>
<thead>
<tr>
<th>Note</th>
<th>2018-19 £'000</th>
<th>2017-18 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income from sale of goods and services</td>
<td>2 -</td>
<td>(493)</td>
</tr>
<tr>
<td>Other operating income</td>
<td>2 -</td>
<td>(3)</td>
</tr>
<tr>
<td><strong>Total operating income</strong></td>
<td>-</td>
<td>(496)</td>
</tr>
<tr>
<td>Staff costs</td>
<td>3</td>
<td>4,552</td>
</tr>
<tr>
<td>Purchase of goods and services</td>
<td>4</td>
<td>273,871</td>
</tr>
<tr>
<td>Depreciation and impairment charges</td>
<td>4</td>
<td>738</td>
</tr>
<tr>
<td>Provision expense</td>
<td>4</td>
<td>264</td>
</tr>
<tr>
<td><strong>Other Operating Expenditure</strong></td>
<td>4</td>
<td>279,429</td>
</tr>
<tr>
<td><strong>Total operating expenditure</strong></td>
<td></td>
<td>279,429</td>
</tr>
<tr>
<td><strong>Net expenditure for the year</strong></td>
<td></td>
<td>279,429</td>
</tr>
<tr>
<td><strong>Total Net Expenditure for the Financial Year</strong></td>
<td></td>
<td>279,429</td>
</tr>
<tr>
<td><strong>Comprehensive Expenditure for the year</strong></td>
<td></td>
<td>279,429</td>
</tr>
</tbody>
</table>
## Statement of Financial Position as at 31 March 2019

<table>
<thead>
<tr>
<th>Note</th>
<th>2018-19 £'000</th>
<th>2017-18 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-current assets:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>7</td>
<td>25</td>
</tr>
<tr>
<td><strong>Total non-current assets</strong></td>
<td>25</td>
<td>6</td>
</tr>
<tr>
<td><strong>Current assets:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>8</td>
<td>3,741</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>9</td>
<td>19</td>
</tr>
<tr>
<td><strong>Total current assets</strong></td>
<td>3,760</td>
<td>5,391</td>
</tr>
<tr>
<td><strong>Total current assets</strong></td>
<td>3,760</td>
<td>5,391</td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td>3,785</td>
<td>5,397</td>
</tr>
<tr>
<td><strong>Current liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>10</td>
<td>(25,623)</td>
</tr>
<tr>
<td>Provisions</td>
<td>11</td>
<td>(202)</td>
</tr>
<tr>
<td><strong>Total current liabilities</strong></td>
<td>(25,825)</td>
<td>(25,281)</td>
</tr>
<tr>
<td><strong>Non-Current Assets plus/less Net Current Assets/Liabilities</strong></td>
<td>(22,040)</td>
<td>(19,884)</td>
</tr>
<tr>
<td><strong>Non-current liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provisions</td>
<td>11</td>
<td>(545)</td>
</tr>
<tr>
<td><strong>Total non-current liabilities</strong></td>
<td>(545)</td>
<td>-</td>
</tr>
<tr>
<td><strong>Assets less Liabilities</strong></td>
<td>(22,585)</td>
<td>(19,884)</td>
</tr>
<tr>
<td><strong>Financed by Taxpayers’ Equity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General fund</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total taxpayers’ equity:</strong></td>
<td>(22,585)</td>
<td>(19,884)</td>
</tr>
</tbody>
</table>

The notes on pages 6 to 25 form part of this statement

The financial statements on pages 2 to 5 were approved by the Governing Body on 24th May 2019 and signed on its behalf by:

Accountable Officer
Terry Huff
Statement of Changes In Taxpayers Equity for the year ended 31 March 2019

<table>
<thead>
<tr>
<th>General fund £’000</th>
<th>Total reserves £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Changes in taxpayers’ equity for 2018-19</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Balance at 01 April 2018</strong></td>
<td>(19,884)</td>
</tr>
<tr>
<td><strong>Changes in NHS Clinical Commissioning Group taxpayers’ equity for 2018-19</strong></td>
<td></td>
</tr>
<tr>
<td>Net operating expenditure for the financial year</td>
<td>(279,429)</td>
</tr>
<tr>
<td><strong>Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year</strong></td>
<td>(279,429)</td>
</tr>
<tr>
<td>Net funding</td>
<td>276,728</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2019</strong></td>
<td>(22,585)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>General fund £’000</th>
<th>Total reserves £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Changes in taxpayers’ equity for 2017-18</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Balance at 01 April 2017</strong></td>
<td>(10,362)</td>
</tr>
<tr>
<td><strong>Changes in NHS Clinical Commissioning Group taxpayers’ equity for 2017-18</strong></td>
<td></td>
</tr>
<tr>
<td>Net operating costs for the financial year</td>
<td>(274,158)</td>
</tr>
<tr>
<td><strong>Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year</strong></td>
<td>(274,158)</td>
</tr>
<tr>
<td>Net funding</td>
<td>264,636</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2018</strong></td>
<td>(19,884)</td>
</tr>
</tbody>
</table>

The notes on pages 6 to 25 form part of this statement.
### Statement of Cash Flows for the year ended 31 March 2019

<table>
<thead>
<tr>
<th>Note</th>
<th>2018-19 £'000</th>
<th>2017-18 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash Flows from Operating Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net operating expenditure for the financial year</td>
<td>(279,429)</td>
<td>(274,158)</td>
</tr>
<tr>
<td>Depreciation and amortisation</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>(Increase)/decrease in trade &amp; other receivables</td>
<td>8</td>
<td>1,573</td>
</tr>
<tr>
<td>Increase/(decrease) in trade &amp; other payables</td>
<td>10</td>
<td>540</td>
</tr>
<tr>
<td>Provisions utilised</td>
<td>11</td>
<td>(188)</td>
</tr>
<tr>
<td>Increase/(decrease) in provisions</td>
<td>11</td>
<td>738</td>
</tr>
<tr>
<td><strong>Net Cash Inflow (Outflow) from Operating Activities</strong></td>
<td>(276,762)</td>
<td>(264,597)</td>
</tr>
<tr>
<td><strong>Cash Flows from Investing Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Payments) for property, plant and equipment</td>
<td>(23)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Net Cash Inflow (Outflow) from Investing Activities</strong></td>
<td>(23)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Net Cash Inflow (Outflow) before Financing</strong></td>
<td>(276,785)</td>
<td>(264,597)</td>
</tr>
<tr>
<td><strong>Cash Flows from Financing Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grant in Aid Funding Received</td>
<td>276,728</td>
<td>264,636</td>
</tr>
<tr>
<td><strong>Net Cash Inflow (Outflow) from Financing Activities</strong></td>
<td>276,728</td>
<td>264,636</td>
</tr>
<tr>
<td><strong>Net Increase (Decrease) in Cash &amp; Cash Equivalents</strong></td>
<td>9</td>
<td>(57)</td>
</tr>
<tr>
<td><strong>Cash &amp; Cash Equivalents at the Beginning of the Financial Year</strong></td>
<td>76</td>
<td>37</td>
</tr>
<tr>
<td><strong>Cash &amp; Cash Equivalents (including bank overdrafts) at the End of the Financial Year</strong></td>
<td>19</td>
<td>76</td>
</tr>
</tbody>
</table>

The notes on pages 6 to 25 form part of this statement.
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 2018-19 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 a going concern basis.

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 Operating Segments
Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the clinical commissioning group.

1.4 Revenue
The transition to IFRS 15 has been completed in accordance with paragraph C3 (b) of the Standard, applying the Standard retrospectively recognising the cumulative effects at the date of initial application.
In the adoption of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows;
• As per paragraph 121 of the Standard the clinical commissioning group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
• The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.
Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.
Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.
Payment terms are standard reflecting cross government principles.
The value of the benefit received when the clinical commissioning group accesses funds from the Government’s apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.
1.5 **Employee Benefits**

1.5.1 **Short-term Employee Benefits**
Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken. 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.

1.5.2 **Retirement Benefit Costs**
Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies are allowed under the direction of the Secretary of State in England and Wales. The schemes 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, the schemes are accounted for as though they were defined contribution schemes: the cost to the clinical commissioning group of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period. 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. The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.
1.6 **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.
## 2 Other Operating Revenue

<table>
<thead>
<tr>
<th></th>
<th>2018-19</th>
<th>2017-18</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>£'000</td>
<td>£'000</td>
<td></td>
</tr>
<tr>
<td><strong>Income from sale of goods and services (contracts)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-patient care services to other bodies</td>
<td>-</td>
<td>493</td>
<td></td>
</tr>
<tr>
<td><strong>Total Income from sale of goods and services</strong></td>
<td>-</td>
<td>493</td>
<td></td>
</tr>
<tr>
<td><strong>Other operating income</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other non contract revenue</td>
<td>-</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td><strong>Total Other operating income</strong></td>
<td>-</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td><strong>Total Operating Income</strong></td>
<td>-</td>
<td>496</td>
<td></td>
</tr>
</tbody>
</table>
3. Employee benefits and staff numbers

3.1.1 Employee benefits

<table>
<thead>
<tr>
<th></th>
<th>Permanent Employees £'000</th>
<th>Other £'000</th>
<th>Total £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Employee Benefits</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>3,290</td>
<td>560</td>
<td>3,850</td>
</tr>
<tr>
<td>Social security costs</td>
<td>348</td>
<td>0</td>
<td>348</td>
</tr>
<tr>
<td>Employer Contributions to NHS Pension scheme</td>
<td>354</td>
<td>0</td>
<td>354</td>
</tr>
<tr>
<td>Apprenticeship Levy</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Gross employee benefits expenditure</strong></td>
<td>3,992</td>
<td>560</td>
<td>4,552</td>
</tr>
<tr>
<td><strong>Total - Net admin employee benefits including capitalised costs</strong></td>
<td>3,992</td>
<td>560</td>
<td>4,552</td>
</tr>
<tr>
<td><strong>Net employee benefits excluding capitalised costs</strong></td>
<td>3,992</td>
<td>560</td>
<td>4,552</td>
</tr>
</tbody>
</table>

3.1.1 Employee benefits

<table>
<thead>
<tr>
<th></th>
<th>Permanent Employees £'000</th>
<th>Other £'000</th>
<th>Total £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Employee Benefits</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>3,661</td>
<td>75</td>
<td>3,736</td>
</tr>
<tr>
<td>Social security costs</td>
<td>334</td>
<td>0</td>
<td>334</td>
</tr>
<tr>
<td>Employer Contributions to NHS Pension scheme</td>
<td>386</td>
<td>0</td>
<td>386</td>
</tr>
<tr>
<td>Apprenticeship Levy</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Gross employee benefits expenditure</strong></td>
<td>4,382</td>
<td>75</td>
<td>4,457</td>
</tr>
<tr>
<td><strong>Total - Net admin employee benefits including capitalised costs</strong></td>
<td>4,382</td>
<td>75</td>
<td>4,457</td>
</tr>
<tr>
<td><strong>Net employee benefits excluding capitalised costs</strong></td>
<td>4,382</td>
<td>75</td>
<td>4,457</td>
</tr>
</tbody>
</table>
3.2 Average number of people employed

<table>
<thead>
<tr>
<th></th>
<th>Permanently employed</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>2018-19</td>
<td>2017-18</td>
<td></td>
</tr>
<tr>
<td>Number</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Permanently employed</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>2018-19</td>
<td>2017-18</td>
<td></td>
</tr>
<tr>
<td>Number</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>£</th>
<th></th>
<th>Number</th>
<th>£</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than £10,000</td>
<td>2</td>
<td>14,682</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>£10,001 to £25,000</td>
<td>1</td>
<td>15,484</td>
<td>1</td>
<td>15,071</td>
<td>2</td>
<td>30,555</td>
</tr>
<tr>
<td>£50,001 to £100,000</td>
<td>1</td>
<td>71,243</td>
<td></td>
<td></td>
<td>1</td>
<td>71,243</td>
</tr>
<tr>
<td>Total</td>
<td>4</td>
<td>101,409</td>
<td>2</td>
<td>15,071</td>
<td>5</td>
<td>116,480</td>
</tr>
</tbody>
</table>

Analysis of Other Agreed Departures

<table>
<thead>
<tr>
<th></th>
<th>2018-19</th>
<th>2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contractual payments in lieu of notice</td>
<td>1</td>
<td>15,071</td>
</tr>
<tr>
<td>Total</td>
<td>1</td>
<td>15,071</td>
</tr>
</tbody>
</table>

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period. Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

Where entities has agreed early retirements, the additional costs are met by NHS Entities and not by the NHS Pension Scheme, and are included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables.

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.
3.4 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.

These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies are allowed under the direction of the Secretary of State in England and Wales. The schemes 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, the schemes are accounted for as though they were defined contribution schemes: the cost to the clinical commissioning group of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

3.4.1 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 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 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.

3.4.2 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 latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.
The CCG has operated a Better Care Fund with Southend Borough Council under a section 75 agreement. The CCG contributes £12.4m to the BCF pool and receives contributions of £6.4m.
The CCG has operated a Better Care Fund of £12.382m during 2018-19 (2017-18 £11.653m) 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.

---

4. Operating expenses

<table>
<thead>
<tr>
<th></th>
<th>2018-19</th>
<th>2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Purchase of goods and services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services from other CCGs and NHS England</td>
<td>616</td>
<td>1,287</td>
</tr>
<tr>
<td>Services from foundation trusts</td>
<td>159,034</td>
<td>154,815</td>
</tr>
<tr>
<td>Services from other NHS trusts</td>
<td>17,018</td>
<td>15,513</td>
</tr>
<tr>
<td>Purchase of healthcare from non-NHS bodies</td>
<td>42,729</td>
<td>43,211</td>
</tr>
<tr>
<td>Prescribing costs</td>
<td>26,050</td>
<td>26,439</td>
</tr>
<tr>
<td>GPMS/APMS and PCTMS</td>
<td>24,325</td>
<td>23,237</td>
</tr>
<tr>
<td>Supplies and services – clinical</td>
<td>1,116</td>
<td>2,334</td>
</tr>
<tr>
<td>Supplies and services – general</td>
<td>95</td>
<td>653</td>
</tr>
<tr>
<td>Consultancy services</td>
<td>762</td>
<td>834</td>
</tr>
<tr>
<td>Establishment</td>
<td>1,194</td>
<td>793</td>
</tr>
<tr>
<td>Premises</td>
<td>752</td>
<td>659</td>
</tr>
<tr>
<td>Audit fees</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Other non statutory audit expenditure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>· Internal audit services</td>
<td>54</td>
<td>37</td>
</tr>
<tr>
<td>· Other services</td>
<td>17</td>
<td>20</td>
</tr>
<tr>
<td>Other professional fees</td>
<td>12</td>
<td>-</td>
</tr>
<tr>
<td>Legal fees</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Education, training and conferences</td>
<td>59</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total Purchase of goods and services</strong></td>
<td><strong>273,870</strong></td>
<td><strong>269,873</strong></td>
</tr>
</tbody>
</table>

| **Depreciation and impairment charges** |         |         |
| Depreciation                        | 4       | 22      |
| **Total Depreciation and impairment charges** | **4** | **22** |

| **Provision expense** |         |         |
| Provisions             | 738     | 198     |
| **Total Provision expense** | **738** | **198** |

| **Other Operating Expenditure** |         |         |
| Chair and Non Executive Members | 264     | 103     |
| Other expenditure          | -       | 1       |
| **Total Other Operating Expenditure** | **264** | **104** |

**Total operating expenditure**  
274,876  
270,197
### 5 Better Payment Practice Code

**Measure of compliance**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>£'000</td>
<td>Number</td>
<td>£'000</td>
</tr>
<tr>
<td><strong>Non-NHS Payables</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Non-NHS Trade invoices paid in the Year</td>
<td>11,690</td>
<td>76,077</td>
<td>11,664</td>
<td>76,627</td>
</tr>
<tr>
<td>Total Non-NHS Trade Invoices paid within target</td>
<td>11,402</td>
<td>73,560</td>
<td>11,287</td>
<td>73,524</td>
</tr>
<tr>
<td>Percentage of Non-NHS Trade invoices paid within target</td>
<td>97.54%</td>
<td>96.69%</td>
<td>96.60%</td>
<td>95.95%</td>
</tr>
<tr>
<td><strong>NHS Payables</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total NHS Trade Invoices Paid in the Year</td>
<td>2,764</td>
<td>182,707</td>
<td>2,449</td>
<td>172,389</td>
</tr>
<tr>
<td>Total NHS Trade Invoices Paid within target</td>
<td>2,620</td>
<td>179,341</td>
<td>2,322</td>
<td>171,868</td>
</tr>
<tr>
<td>Percentage of NHS Trade Invoices paid within target</td>
<td>94.79%</td>
<td>98.16%</td>
<td>94.81%</td>
<td>99.70%</td>
</tr>
</tbody>
</table>
### Payments recognised as an Expense

<table>
<thead>
<tr>
<th>Payments recognised as an expense</th>
<th>Buildings £'000</th>
<th>Other £'000</th>
<th>Total £'000</th>
<th>Buildings £'000</th>
<th>Other £'000</th>
<th>Total £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum lease payments</td>
<td>254</td>
<td>5</td>
<td><strong>259</strong></td>
<td>498</td>
<td>5</td>
<td><strong>503</strong></td>
</tr>
<tr>
<td>Total</td>
<td><strong>254</strong></td>
<td><strong>5</strong></td>
<td><strong>259</strong></td>
<td><strong>498</strong></td>
<td><strong>5</strong></td>
<td><strong>503</strong></td>
</tr>
</tbody>
</table>

Whilst our arrangements with Community Health Partnership’s Limited and NHS Property Services Limited fall within the definition of operating leases, rental charge for future years has not yet been agreed. Consequently this note does not include future minimum lease payments for the arrangements only.

### Future minimum lease payments

<table>
<thead>
<tr>
<th>Payable:</th>
<th>Buildings £'000</th>
<th>Other £'000</th>
<th>Total £'000</th>
<th>Buildings £'000</th>
<th>Other £'000</th>
<th>Total £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>No later than one year</td>
<td>254</td>
<td>-</td>
<td><strong>254</strong></td>
<td>15</td>
<td>-</td>
<td><strong>15</strong></td>
</tr>
<tr>
<td>Total</td>
<td><strong>254</strong></td>
<td>-</td>
<td><strong>254</strong></td>
<td><strong>15</strong></td>
<td>-</td>
<td><strong>15</strong></td>
</tr>
</tbody>
</table>
7. Property, plant and equipment

<table>
<thead>
<tr>
<th></th>
<th>Plant &amp; machinery £'000</th>
<th>Information technology £'000</th>
<th>Total £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018-19</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost or valuation at 01 April 2018</td>
<td>22</td>
<td>54</td>
<td>76</td>
</tr>
<tr>
<td>Additions purchased</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost/Valuation at 31 March 2019</td>
<td>22</td>
<td>77</td>
<td>99</td>
</tr>
<tr>
<td>Depreciation 01 April 2018</td>
<td>22</td>
<td>48</td>
<td>70</td>
</tr>
<tr>
<td>Charged during the year</td>
<td>22</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Depreciation at 31 March 2019</td>
<td>22</td>
<td>52</td>
<td>74</td>
</tr>
<tr>
<td>Net Book Value at 31 March 2019</td>
<td>0</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Purchased</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total at 31 March 2019</td>
<td>0</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Asset financing:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Owned</td>
<td>0</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>Total at 31 March 2019</td>
<td>0</td>
<td>25</td>
<td>25</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Plant &amp; machinery £'000</th>
<th>Information technology £'000</th>
<th>Total £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017-18</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost or valuation at 01 April 2017</td>
<td>22</td>
<td>54</td>
<td>76</td>
</tr>
<tr>
<td>Cost/Valuation at 31 March 2018</td>
<td>22</td>
<td>54</td>
<td>76</td>
</tr>
<tr>
<td>Depreciation 01 April 2017</td>
<td>19</td>
<td>30</td>
<td>49</td>
</tr>
<tr>
<td>Charged during the year</td>
<td>3</td>
<td>18</td>
<td>21</td>
</tr>
<tr>
<td>Depreciation at 31 March 2018</td>
<td>22</td>
<td>48</td>
<td>70</td>
</tr>
<tr>
<td>Net Book Value at 31 March 2018</td>
<td>-</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Purchased</td>
<td>-</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Total at 31 March 2019</td>
<td>-</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Owned</td>
<td>-</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Total at 31 March 2018</td>
<td>-</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>

7.1 Economic lives

<table>
<thead>
<tr>
<th></th>
<th>Minimum Life (years)</th>
<th>Maximum Life (Years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plant &amp; machinery</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Information technology</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>
8.1 Trade and other receivables

<table>
<thead>
<tr>
<th></th>
<th>Current £'000</th>
<th>Current £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2018-19</td>
<td>2017-18</td>
</tr>
<tr>
<td>NHS receivables:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenue</td>
<td>760</td>
<td>4,378</td>
</tr>
<tr>
<td>NHS prepayments</td>
<td>494</td>
<td>706</td>
</tr>
<tr>
<td>NHS accrued income</td>
<td>1,779</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS and Other WGA receivables: Revenue</td>
<td>598</td>
<td>170</td>
</tr>
<tr>
<td>Non-NHS and Other WGA accrued income</td>
<td>72</td>
<td>4</td>
</tr>
<tr>
<td>VAT</td>
<td>28</td>
<td>38</td>
</tr>
<tr>
<td>Other receivables and accruals</td>
<td>10</td>
<td>19</td>
</tr>
<tr>
<td>Total Trade &amp; other receivables</td>
<td>3,741</td>
<td>5,315</td>
</tr>
<tr>
<td>Total current and non current</td>
<td>3,741</td>
<td>5,315</td>
</tr>
</tbody>
</table>

The great 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.

8.2 Receivables past their due date but not impaired

<table>
<thead>
<tr>
<th></th>
<th>2018-19 DHSC Group Bodies £'000</th>
<th>2018-19 Non DHSC Group Bodies £'000</th>
<th>2017-18 DHSC Group Bodies £'000</th>
<th>2017-18 Non DHSC Group Bodies £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>By up to three months</td>
<td>126</td>
<td>18</td>
<td>56</td>
<td>5</td>
</tr>
<tr>
<td>By three to six months</td>
<td>40</td>
<td>43</td>
<td>91</td>
<td>-</td>
</tr>
<tr>
<td>By more than six months</td>
<td>-</td>
<td>(23)</td>
<td>243</td>
<td>62</td>
</tr>
<tr>
<td>Total</td>
<td>166</td>
<td>38</td>
<td>243</td>
<td>67</td>
</tr>
</tbody>
</table>

8.3 Impact of Application of IFRS 9 on financial assets at 1 April 2018

<table>
<thead>
<tr>
<th></th>
<th>Trade and other receivables - NHSE bodies £000s</th>
<th>Trade and other receivables - other DHSC group bodies £000s</th>
<th>Other financial assets £000s</th>
<th>Total £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Classification under IAS 39 as at 31st March 2018</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial Assets held at Amortised cost</td>
<td>76</td>
<td>4,378</td>
<td>174</td>
<td>4,628</td>
</tr>
<tr>
<td>Total at 31st March 2018</td>
<td>76</td>
<td>4,378</td>
<td>174</td>
<td>4,628</td>
</tr>
<tr>
<td>Classification under IFRS 9 as at 1st April 2018</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial Assets measured at amortised cost</td>
<td>76</td>
<td>4,378</td>
<td>174</td>
<td>4,628</td>
</tr>
<tr>
<td>Total at 1st April 2018</td>
<td>76</td>
<td>4,378</td>
<td>174</td>
<td>4,628</td>
</tr>
</tbody>
</table>
9 Cash and cash equivalents

<table>
<thead>
<tr>
<th></th>
<th>2018-19 £'000</th>
<th>2017-18 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 01 April 2018</td>
<td>76</td>
<td>37</td>
</tr>
<tr>
<td>Net change in year</td>
<td>(57)</td>
<td>39</td>
</tr>
<tr>
<td>Balance at 31 March 2019</td>
<td>19</td>
<td>76</td>
</tr>
</tbody>
</table>

Made up of:
- Cash with the Government Banking Service: 19 76
- Cash and cash equivalents as in statement of financial position: 19 76

Balance at 31 March 2019: 19 76
10 Trade and other payables

<table>
<thead>
<tr>
<th></th>
<th>Current 2018-19 £'000</th>
<th>Current 2017-18 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS payables: Revenue</td>
<td>2,998</td>
<td>2,104</td>
</tr>
<tr>
<td>NHS accruals</td>
<td>4,361</td>
<td>5,277</td>
</tr>
<tr>
<td>NHS deferred income</td>
<td>380</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS and Other WGA payables: Revenue</td>
<td>5,004</td>
<td>2,330</td>
</tr>
<tr>
<td>Non-NHS and Other WGA accruals</td>
<td>10,268</td>
<td>13,161</td>
</tr>
<tr>
<td>Social security costs</td>
<td>34</td>
<td>50</td>
</tr>
<tr>
<td>Tax</td>
<td>87</td>
<td>47</td>
</tr>
<tr>
<td>Other payables and accruals</td>
<td>2,491</td>
<td>2,114</td>
</tr>
<tr>
<td><strong>Total Trade &amp; Other Payables</strong></td>
<td><strong>25,623</strong></td>
<td><strong>25,083</strong></td>
</tr>
</tbody>
</table>

Total current and non-current | 25,623 | 25,083 |

Other payables includes £180k outstanding pension contributions at 31 March 2019 (£142k at 31 March 2018)

10.1 Impact of Application of IFRS 9 on financial liabilities at 1 April 2018

<table>
<thead>
<tr>
<th>Classification under IAS 39 as at 31st March 2018</th>
<th>Trade and other payables - NHSE bodies £000s</th>
<th>Trade and other payables - external £000s</th>
<th>Total £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Assets held at Amortised cost</td>
<td>7,382</td>
<td>17,605</td>
<td>24,987</td>
</tr>
<tr>
<td><strong>Total at 31st March 2018</strong></td>
<td><strong>7,382</strong></td>
<td><strong>17,605</strong></td>
<td><strong>24,987</strong></td>
</tr>
</tbody>
</table>

Classification under IFRS 9 as at 1st April 2018

| Financial Liabilities measured at amortised cost   | 7,382                                       | 17,605                                    | 24,987      |
| **Total at 1st April 2018**                        | **7,382**                                   | **17,605**                                | **24,987**  |
### Provisions

<table>
<thead>
<tr>
<th></th>
<th>Current 2018-19 £'000</th>
<th>Non-current 2018-19 £'000</th>
<th>Current 2017-18 £'000</th>
<th>Non-current 2017-18 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restructuring</td>
<td>91</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Continuing care</td>
<td>111</td>
<td>545</td>
<td>198</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>202</td>
<td>545</td>
<td>198</td>
<td>-</td>
</tr>
<tr>
<td>Total current and non-current</td>
<td>747</td>
<td>198</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Restructuring**

- Balance at 01 April 2018: £0
- Arising during the year: £212
- Utilised during the year: (£101)
- Reversed unused: (£20)
- Balance at 31 March 2019: £91

**Continuing Care**

- Balance at 01 April 2018: £198
- Arising during the year: £545
- Utilised during the year: (£87)
- Reversed unused: (£20)
- Balance at 31 March 2019: £656

**Total**

- Balance at 31 March 2019: £747

The Restructuring provision relates to redundancies resulting from the on-going restructure and will be resolved during 2019/20. The Continuing Care 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.

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 2019 is £221k (2018 £556k).
12 Financial instruments

12.1 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 the 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.

12.1.1 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.

12.1.2 Credit risk

Because the majority of the NHS clinical commissioning group revenue comes as parliamentary funding, the 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.

12.1.3 Liquidity risk

The 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.

12.2 Financial assets

<table>
<thead>
<tr>
<th>Financial Assets measured at amortised cost</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2018-19</td>
</tr>
<tr>
<td>Trade and other receivables with NHSE bodies</td>
<td>2,168</td>
</tr>
<tr>
<td>Trade and other receivables with other DHSC group bodies</td>
<td>442</td>
</tr>
<tr>
<td>Trade and other receivables with external bodies</td>
<td>598</td>
</tr>
<tr>
<td>Other financial assets</td>
<td>11</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>19</td>
</tr>
<tr>
<td><strong>Total at 31 March 2019</strong></td>
<td><strong>3,238</strong></td>
</tr>
</tbody>
</table>

12.3 Financial liabilities

<table>
<thead>
<tr>
<th>Financial Liabilities measured at amortised cost</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2018-19</td>
</tr>
<tr>
<td>Trade and other payables with NHSE bodies</td>
<td>2,381</td>
</tr>
<tr>
<td>Trade and other payables with other DHSC group bodies</td>
<td>11,316</td>
</tr>
<tr>
<td>Trade and other payables with external bodies</td>
<td>8,934</td>
</tr>
<tr>
<td>Other financial liabilities</td>
<td>2,491</td>
</tr>
<tr>
<td><strong>Total at 31 March 2019</strong></td>
<td><strong>25,122</strong></td>
</tr>
</tbody>
</table>
13 Operating segments

The clinical commissioning group and consolidated group consider they have only one segment: commissioning of healthcare services as reported in the Statement of Financial Position and Statement of Comprehensive Net Expenditure.

The clinical commissioning group also had only the one segment: commissioning of healthcare services in 2017-18

14 Pooled budgets

NHS Southend CCG was not party to any pooled budget arrangements during 2018-19 (2017-18: None)
### 15 Related party transactions

Details of related party transactions with individuals are as follows:

<table>
<thead>
<tr>
<th>Payments to Related Party £’000</th>
<th>Receipts from Related Party £’000</th>
<th>Amounts owed to Related Party £’000</th>
<th>Amounts due from Related Party £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr J Garcia-Lobera &amp; Dr T Syed (Dr Nagle and Partners, Pall Mall Surgery)</td>
<td>2,929</td>
<td>-</td>
<td>120</td>
</tr>
<tr>
<td>Dr B Houston (Highlands Surgery and Fortis Healthcare)</td>
<td>1,639</td>
<td>-</td>
<td>98</td>
</tr>
<tr>
<td>Dr K Ng (Scott Park Surgery)</td>
<td>360</td>
<td>-</td>
<td>12</td>
</tr>
<tr>
<td>Dr F Khan (Carnarvon Road: April 2018-October 2018)</td>
<td>746</td>
<td>-</td>
<td>49</td>
</tr>
<tr>
<td>Dr K Barusya (N K Shah &amp; Partner North Avenue Surgery)</td>
<td>331</td>
<td>-</td>
<td>14</td>
</tr>
<tr>
<td>Dr S Hadley (St Luke Health Centre (Virgin Care): From Nov 2018)</td>
<td>983</td>
<td>-</td>
<td>34</td>
</tr>
</tbody>
</table>

Transactions in relation to practices where the GP has been a Member of Governing Body

- **Dr J Garcia-Lobera & Dr T Syed (Dr Nagle and Partners, Pall Mall Surgery)**
  - Payments to Related Party: £2,929
  - Receipts from Related Party: £0
  - Amounts owed to Related Party: £120
  - Amounts due from Related Party: £0
- **Dr B Houston (Highlands Surgery and Fortis Healthcare)**
  - Payments to Related Party: £1,639
  - Receipts from Related Party: £0
  - Amounts owed to Related Party: £98
  - Amounts due from Related Party: £0
- **Dr K Ng (Scott Park Surgery)**
  - Payments to Related Party: £360
  - Receipts from Related Party: £0
  - Amounts owed to Related Party: £12
  - Amounts due from Related Party: £0
- **Dr F Khan (Carnarvon Road: April 2018-October 2018)**
  - Payments to Related Party: £746
  - Receipts from Related Party: £0
  - Amounts owed to Related Party: £49
  - Amounts due from Related Party: £0
- **Dr K Barusya (N K Shah & Partner North Avenue Surgery)**
  - Payments to Related Party: £331
  - Receipts from Related Party: £0
  - Amounts owed to Related Party: £14
  - Amounts due from Related Party: £0
- **Dr S Hadley (St Luke Health Centre (Virgin Care): From Nov 2018)**
  - Payments to Related Party: £983
  - Receipts from Related Party: £0
  - Amounts owed to Related Party: £34
  - Amounts due from Related Party: £0
16 Events after the end of the reporting period

There are no events after the end of the reporting period which will have a material effect on the financial statements of the clinical commissioning group (2018 Nil)

17 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:

<table>
<thead>
<tr>
<th>Target</th>
<th>Performance</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenditure not to exceed income</td>
<td>279,500</td>
<td>279,452</td>
</tr>
<tr>
<td>Capital resource use does not exceed the amount specified in Directions</td>
<td>23</td>
<td>23</td>
</tr>
<tr>
<td>Revenue resource use does not exceed the amount specified in Directions</td>
<td>275,906</td>
<td>275,487</td>
</tr>
<tr>
<td>Revenue administration resource use does not exceed the amount specified in Directions</td>
<td>3,971</td>
<td>3,942</td>
</tr>
</tbody>
</table>
CONTENTS

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   • Our Vision
   • Clinical Commissioning Groups (CCGs)
   • Who Are We?
   • Why We Engage
   • Collaborative Working

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   • Rochford
   • Castle Point
   • Southend-on-Sea
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   • Patient and Public Engagement
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   • Where to find information about our patient and community involvement work
   • Other communications channels
   • Partnerships and networks
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4. Involvement and Engagement Projects 2017/18

5. Looking Forward
Welcome

Dr Kashif Siddiqui, Clinical Lead for Communications and Patient Engagement.

It gives me great pleasure to welcome you to the very first Annual Report dedicated to Patient and Public Involvement.

As local Clinical Commissioning Groups (CCGs), it's our job to plan and fund health services across south east Essex. This report is about how we've involved and engaged with our local population from 1 April 2018 to 31 March 2019.

Understanding what our patients want and expect from the NHS allows us to design services that are efficient, effective, sustainable and responsive to patient's needs. By bringing people on the journey with us, we can ensure that we provide the best models of clinically-led care for our patients and carers. We continue to provide opportunities for them to share their stories, insight and influence to help shape local services.

Our Vision

We are working ‘to improve the health and lives of people living in south east Essex both now and in the future.’

To achieve this effectively, we need to ensure our partners in health and social care, members of the public and key stakeholders are all working towards common goals.

These common goals include achieving improvements in services and patient outcomes, whilst reducing health inequalities and ensuring a sustainable health service.
Clinical Commissioning Groups (CCGs)

Who Are We?

We decide which health services to buy (commission) for the people living in south east Essex. Within south east Essex, there are two Clinical Commissioning Groups (CCGs); NHS Castle Point and Rochford CCG and NHS Southend CCG.

The CCGs share a joint management team with a joint approach to external and internal communications and engagement. We work with our community to improve patient care, reduce health inequalities and raise quality and standards in a way which is efficient and financially sustainable.

Why We Engage

The CCGs are committed to ensuring that patients are at the heart of everything we do. Our approach is to work in partnership with our patients, residents, partnership organisations, primary care membership and staff to deliver patient-centred, clinically-led and evidence-based healthcare.

As CCGs we have a responsibility to ensure that local services effectively meet local needs. This includes proactively seeking patient and public feedback and promoting how local residents and community groups can influence and help to shape our work through engagement and consultation.

Collaborative Working

In order to avoid duplication, reduce inequalities and increase efficiency, there is an increasing movement towards commissioning services across a wider area. Both CCGs are part of a Sustainability and Transformation Partnership that covers mid and south Essex.

In terms of the CCGs’ engagement approach, this will mean continuing and increasing our commitment to promoting involvement opportunities collaboratively with our partners.
THE AREA WE SERVE

Demographics

It is essential to good public and patient involvement that we do our best to understand the diversity of our audience, and that this reflects back in our commissioning and planning of local health services. Our ultimate aim is to truly reflect the needs of the local people and improve outcomes for them, their friends and their families.

South east Essex has a combined population of just over 367,000 people. The people living in these areas are diverse and represent many different walks of life and backgrounds.

Rochford

The life expectancy of males within Rochford District is above average compared to the rest of Essex, living on average to 80 years and females living to 84 years. Life expectancy is 3.9 years lower for men and 5.4 years lower for women in the most deprived areas of Rochford than in the least deprived.

Rochford District has an ageing population with a higher proportion of people aged over 65 compared to the national average. The number of people in this age group is expected to increase from 18,800 people to 27,700 by 2035 – a 71% increase.

Rochford District score ranks it 285 out of 354 local authorities, putting it in the top 20% least deprived nationally. There are, however, pockets of deprivation. Around 10% (1,300) of children live in low income families.

In year 6, 16% (146) of children are classified as obese, compared to 20% across England.

In 2017, the rate of dementia diagnosis was significantly worse than the England average.
Castle Point

The life expectancy of both males and females within Castle Point is just below the average compared to the rest of Essex with males living to 79.5 and females living to 83. Life expectancy is 6.6 years lower for men and 3.6 years lower for women in the most deprived areas of Castle Point than in the least deprived areas.

The number of residents living in Castle Point aged 65 and over is expected to increase from 21,700 to 31,600, taking the proportion of people in this age bracket from 24.5% to 32.2% by 2034.

Castle Point has low levels of deprivation compared with Essex, however, similar to Rochford, there are pockets of deprivation and variation. One area has been identified as being within the 10% least deprived in the whole of England.

In year 6, 20% (183) of children are classified as obese, which mirrors the rise in obesity in Year 6 across England. Estimated levels of adult physical activity are worse than the England average. In 2017, the rate of dementia diagnosis was significantly worse than the England average.

Southend-on-Sea

In Southend-on-Sea, life expectancy of both males and females is below average compared to the rest of Essex, with males on average living to 78 and females to 83. The life expectancy gap between the most deprived and least deprived wards is just over 11 years for males, and just under 10 years for females. 18% of the adult population smoke. Rates of pregnancy in people under 18 is also statistically significantly worse than the England average. By 2031, the projected population for Southend-on-Sea will be 202,935. This assumes a growth rate of 12.87% which is higher than the projected growth rate for England (10.11%). The over 65 population is projected to increase by 4%.

Southend-on-Sea has high levels of deprivation compared with Essex and England as a whole. Nine areas have been identified as being in the top 10% most deprived areas in England. Just under 1 in 5 children live in low income families (households where income is less than 60% of the median income before housing costs). In comparison, 8 areas in Southend-on-Sea rank in the 10% least deprived, as a consequence Southend-on-Sea is rated as being in the 20% most deprived local authority areas on inequality.
South East Essex Summary

As of the 2011 census, there is a 10 year age gap between the areas with the highest and lowest expectancy levels across south east Essex. Men born within the Kursaal ward of Southend (within the Southend East Central locality) have a life expectancy of 73.58 years compared to men born in Rochford have a life expectancy of 83.3 years.

Variation in Healthy Life Expectancy is just as stark with men born within the Victoria ward of Southend (Southend East Central) having a Healthy Life Expectancy of 55.62 compared to 64.5 across Essex as a whole.

We will see a growth in population of 6% or 20,000 people over the next 10 years (2018-2027, Office for National Statistics 2016, based on sub-national population projections).

We are expecting a 12.5% growth in the population of those aged 65 and over.

We also know that we have a high number of people with learning disabilities living across south east Essex due to the number of the special needs schools.
Ethnicity

Rochford District

The ethnic structure of Rochford is shown in the table below. Figures for England are shown for comparison purposes.

<table>
<thead>
<tr>
<th>Percentage of resident population in ethnic groups</th>
<th>Rochford</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>98.3</td>
<td>90.3</td>
</tr>
<tr>
<td>Mixed</td>
<td>0.6</td>
<td>1.3</td>
</tr>
<tr>
<td>Asian or Asian British</td>
<td>0.5</td>
<td>4.6</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>0.2</td>
<td>2.3</td>
</tr>
<tr>
<td>Chinese or Other</td>
<td>0.4</td>
<td>0.9</td>
</tr>
</tbody>
</table>

Castle Point

Around 91% of people self-reported their ethnicity as White British in the last census (2011), compared to 85% nationally.

The religious make up of Castle Point was reported as 64.1% Christian, 26.8% No religion, 0.4% Muslim, 0.3% Hindu, 0.2% Buddhist, 0.2% Jewish in the last census.

The Jewish community in Canvey has grown since 2011, establishing a new synagogue, boarding school and community centre now located there. Families have been moving to Canvey from Stamford Hill since 2016, and it is estimated there could be up to 700-800 residents by 2020. The average family size is between 6-8 people, and they are part of the ultra-orthodox Haredi community.

In 2018/19, we established links with the Jewish Congregation of Canvey Island, attending an event in conjunction with Essex Police to understand more about spiritual requirements which are at least as important as physical problems for this community.

Southend-on-Sea

The great majority of Southenders (87%) self-reported their ethnicity as White British in the last census (2011), compared to 85% nationally. Around 13% therefore self-reported as being from Black, Asian or Minority Ethnic or other groups (BAME) with 87 different ethnicity categories self-reported.

The most prevalent religion across south east Essex is Christianity.

In 2017/18, we built relationships with members of the community who are operating parish nurse schemes to ensure they have the support to refer into some of the wider community services to support people to remain independent at home.
What does this all mean?

With such variation across the area, a significant proportion of our local population could face barriers in accessing health services in the area.

Consequently, engagement with local people is vital for us to understand and identify how to provide the right services for them, in the right place.

Meeting our legal duties for public involvement

We adhere to the statutory guidance set out by NHS England for “patient and public participation in commissioning health and care”, and this is embedded into the methodology we use to deliver engagement.

This requires us to:
1. Involve the public in governance
2. Explain public involvement in commissioning plans/business plans
3. Demonstrate public involvement in annual reports
4. Promote and publicise public involvement
5. Assess, plan and take action to involve
6. Feedback and evaluate
7. Implement assurance and improvement systems
8. Advance equality and reduce health inequalities
9. Provide support for effective involvement
10. Hold providers to account.

This report details how we fulfil these requirements as part of our work.
OUR STRUCTURE AND GOVERNANCE

Engagement Function

Our engagement function falls within the remit of the Quality, Finance and Performance committee. This committee reviews and monitors matters relating to the quality of commissioned services, meeting financial requirements and our performance against local and national priorities including public involvement.

Our Lay Members

Pauline Stratford, Lay member for Patient and Public Engagement, NHS Castle Point and Rochford CCG

Janis Gibson, Lay member for Patient and Public Engagement, NHS Southend CCG

Patient engagement is represented at Governing Body by a Lay Member for Patient and Public Involvement. Their role is to:

• Gain assurance that the CCG is meeting its patient and public involvement (PPI) duties, using expertise to support a particular focus on reducing identified health inequalities. This person will seek assurance that in all aspects of the CCGs’ business, the voice of the local population is heard, including that of all vulnerable groups and communities.

• Gain assurance that the CCG is meeting its duties under the Equality Act, and that a culture of equality and diversity is embedded within the organisation e.g. providing challenge and input around the CCGs’ efforts to eliminate discrimination, advance equality of opportunity amongst people with protected characteristics and tackle prejudice by promoting understanding. Protected characteristics are the nine groups protected under the Equality Act 2010. They are: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity and race.
We are also part of the mid and south Essex Sustainability and Transformation Partnership and align our engagement with the work of the group.

We have a number of ways in which patients and the public can get more involved in our work. During 2018/19, we took stock of what worked well and areas of development and opportunity. We have begun to refresh our involvement opportunities and the way we deliver engagement with our population.

**Patient and public engagement**

**Day to day practice**

We work closely with the CCGs’ Patient Groups – of which we have three: the Commissioning Reference Group in Castle Point and Rochford, the Community Engagement and Advisory Group and the Southend Patient Participation Group Forum. These groups bring together the nominated representatives of local Patient Participation Groups, as well as local voluntary and community organisations such as YMCA, Castle Point Association of Voluntary Services, Healthwatch and also special interest groups such as Trust Links, Breath-easy and Carers Choices.

Supported by the Communications and Engagement Team, the groups hear updates from the CCG and partners on the services commissioned by the CCG, as well as other wider issues affecting the NHS and Social Care.

The groups are also involved in elements of the commissioning cycle. This includes reviewing and informing our plans, supporting procurement and service redesign, and providing feedback to the CCGs on how services are being delivered from a patient perspective.

The diagram below is taken from our draft Communications and Engagement Strategy 2019-21 and illustrates all of the different ways in which we will be involving the public in our work.
Additional ways in which we engage include: focus groups, surveys, workshops, targeted outreach projects, community events and stalls, good relationships in the community, keeping an ‘interested parties’ database, using existing research/findings from Healthwatch, patient stories and demonstrating public involvement in our annual reports.

New areas to be explored/expanded include: closer partnerships with Voluntary Services, STP Citizen’s Panel, GP practice SMS, targeted social media engagement and a new Patient Participation Group Development Forum.

Channels to be regularly reviewed following annual effectiveness surveys.

Patient Stories

We present patient stories at our Governing Body meetings, to show how services or pathways are working, or could be improved, for the people of Castle Point and Rochford and Southend. Below are a few of the videos from previous meetings.

Pulmonary Rehab: https://youtu.be/2ImWD4XJbDE
Mental Health service: https://youtu.be/qgq9ZaCnYKA
Ways to Wellness: https://youtu.be/vx4TFNycZwI
SWIFT: https://youtu.be/h2h2R7E4an0

Where to Find Information About Our Patient and Community Involvement Work

Our Annual Report

Every year, the CCGs must provide an annual report which sets out the work of the CCG over the previous 12 months and detailing how it fulfilled its statutory and regulatory obligations. Our annual report also includes information about some of our engagement highlights throughout the year.

A full copy of our annual reports can be found on the homepage of our CCGs’ websites:

Read Castle Point and Rochford CCG’s Annual Report
Read Southend CCG’s Annual Report
Our Websites

We have two dedicated CCG websites:
- NHS Southend Clinical Commissioning Group
- NHS Castle Point and Rochford Clinical Commissioning Group

Our websites give members of the public information about how they can get involved in shaping the future of local healthcare in a number of ways.

For patients who wish to make a complaint about a service, we have a dedicated complaints email address, as well as a contact telephone number:

- Castle Point and Rochford CCG Complaints and Concerns
- Southend CCG Complaints Contact

Detailed information on how patients can complain is also available on our website, as well as links to Healthwatch and other providers.

Other communications channels

Below are some of our external communications and engagement channels that are used to promote opportunities to get involved.

- **Print**: Publications, engagement and consultation documents, presentations and advertisements, local newspapers, leaflets/flyers, booklets, posters, promotional materials
- **Social media/digital**: @SouthendCCG Twitter and Facebook, @CPRCCG Twitter and Facebook, video content, CCG websites/partner websites and social media channels
- **Face to face**: GPs and frontline staff, patient group members, community events, outreach and engagement events
- **Newsletters**: development of our own and partner newsletters
- **Areas to be explored**: Community Champions, “NextDoor”, GP practice SMS, locality communications and engagement channels.

_Channels to be regularly reviewed following annual effectiveness surveys._
Partnerships and networks

Councils and other Statutory Bodies

We work in partnership with both Southend-on-Sea Borough Council and Essex County Council and their teams.

Working with Partners across Mid and South Essex

We all want to provide the best services for local people, to help them live well and enjoy life, and we know no individual organisation can do this on its own. The way to give patients the best service is to work more closely together. This is why we are working with our partners in a ‘Sustainability and Transformation Partnership’ (STP) so that together, we can develop and build a health and care system fit for the future, and catered to the people of mid and south Essex. We have worked closely with our colleagues across the STP to make sure local people in south east Essex are able to give us their views to help shape any proposals.

Providers

We work in partnership with our providers to deliver engagement across south east Essex. Our providers include Southend University Hospital NHS Trust and Essex Partnership University Trust.

Community and Voluntary sector

We work closely with the community and voluntary sector across the area.

Our relationships with them enable us to engage with those who are harder to reach amongst our population, such as those who are living with long term conditions, learning disabilities, mental health problems, our diverse communities, people with caring responsibilities, older people and more.
Events and Outreach

In order to reach out to patients and the public we organise a number of events across the course of the year, and actively participate in community, voluntary and partner organisation events.

Death Café

To help local people talk more openly about death and bereavement and collect local insight and experiences, we hosted a virtual death café on Facebook Live during Dying Matters Week in May.

The footage from the death café was viewed over 1,000 times, reaching over 1,750 people.

Locality Stakeholder Event

The CCG held a successful engagement workshop on 1 November in partnership with local authorities. Over 100 community and voluntary organisations joined the conversation to help co-produce solutions to how we can meet the needs of the CCGs’ eight localities.

Feedback/insight has been collated and will inform the development of new models of care and locality plans. The local design teams continue to work together with communities to co-design more proactive and pre-emptive models of care. Local design teams have subsequently been successful in attracting new membership.

Locality development: https://youtu.be/Hg0Yj7aahpc

Primary Care Strategy

Following the publication of the mid and south Essex Sustainability and Transformation Plan (STP) in July 2018, both Southend CCG and Castle Point and Rochford CCG, together, embarked on a programme of communications and engagement to raise awareness of the pressures facing our GP practices and involve local people and stakeholders in developing local solutions.

Download Primary Care Strategy

Eight engagement events took place during September and October. A report of all feedback has been shared with Primary Care Committee members and with GP leads in each locality. In response to feedback during the events, we are exploring a new PPG Development Forum was developed.

To reach a wider audience, a local video was developed in-house communicating the key messages of the primary care strategy. The video reached over 600 views seizing the opportunity digital media offers to reach large numbers of people quickly and cost effectively.

Primary Care Strategy south east Essex: https://youtu.be/Ei2wMsQDCoU
Winter Engagement

Winter-themed patient groups have also taken place in both Southend and Castle Point and Rochford to help cascade important messages in the community and gather further ideas to ensure preparedness.

Quality Awards

Over 150 primary care staff attended the Quality Awards on 6 November, with six awards to recognise for outstanding work, care, innovation and services.

We engaged will all Patient Participation Groups and the wider public to gather over 200 nominations.

Winners included senior GPs, nurses and health care assistants, reception staff and other vital roles supporting people and GP practices day-to-day.

Resulting communications saw a double-page spread in the local newspaper and significant social media engagement.

Community Outreach

In addition to events which we convened, we also regularly attend and support events and patient meetings held by our partners in both health and social care and the voluntary sector.

In 2017/18, we have taken stock and strengthened our relationships with local community representatives, particularly those representing seldom-heard communities.

We have supported a number of wider Community Wellbeing Events, including one that took place in Rochford Methodist Church on 11 July 2018 and in Canvey Island on 22 August 2018 at a children's soft play centre.

The event’s offer advice on local support available to patients, lifestyle advice, a juice bike, health checks, dementia support, kids activities, seated exercise and relaxation sessions to name but a few activities. The events have run in conjunction with partners including:

- ACE,
- Age Concern,
- Carers Choices,
- CAVS,
- Community Agents,
- EPUT,
- Essex County Council,
- Essex Fire and Rescue,
- Peabody,
- Provide,
- RRAVS,
- Rochford District Council
- Southend Borough Council.

Learning Disability partner engagement

Attending Scopes Local Programme Get Together meeting on 31 July 2018.

We also attended Project 49's event on 13 July 2018, which had an emphasis on wellbeing and community building. We attended to promote and raise awareness of the importance of having annual learning disability health checks.
INVolVEMENT AND ENGAGEMENT PROJECTS 2017/18

Our goal is to put patients at the heart of everything we do, learning from their lived experiences, listening to their ideas and thoughts and designing and commissioning services which meet the needs of our diverse population.

Through the various engagement channels outlined earlier in the document, we strive to involve patients throughout the commissioning cycle. We have successfully engaged stakeholders, patients and the public in a range of activities to facilitate community involvement in how we design, deliver and improve local health services.

NHS England has developed 10 principles of participation based on a review of research, best practice reports and the views of stakeholders.

During 2017/18, we have taken stock and embedded new processes to ensure all of our work adheres to these principles.

Feedback is an integral part of our work, and we ensure that we keep those involved with our engagement work updated on what the next steps are. In the summer we distributed more than 5,000 leaflets to the community about of the hospital reconfiguration public consultation.

View the leaflet
Reach Recovery College

Brief summary of project

The Reach Recovery College provides courses, social activities, and support that aims to improve the quality of life of people living with mental health conditions.

REACH Recovery College was set up, developed and run as a pilot project in January 2017. In 2017/18, we started the process of looking to set up a permanent Recovery College to start in April 2019. In July 2018, we launched a survey to hear the views of people using the service, those who may encourage people to use the service and anyone else who has an opinion about how mental health recovery can be enabled in Southend and Castle Point and Rochford.

Following the initial research, we then began a process to identify what the future offer from the Recovery College would look like, how it would be delivered and by who.

Who did we ask?

As part of the engagement and consultation process to inform this service specification, a stakeholder survey was answered by 57 professionals from a range of backgrounds, including GPs, social workers, mental health nurses, child and adolescent mental health service staff, Improving Access to Psychological Therapies (IAPT) staff, REACH recovery staff, job centre staff and voluntary and community providers.

A student survey was answered by 43 people. This was split into 75% of people who use the recovery college and 25% who care for or support someone who attends the recovery college.

8-10 focus groups were held between July and October 2018.

What did we ask?

We asked those that had used the Recovery College for feedback about the courses they’d attended, about how accessible they were and which courses people had gained the most from or felt had helped the most and why. We asked how courses could be improved and if there were any suggestions for courses that weren’t currently offered.

What did we find out?

The views of over 150 people were used to ensure the Recovery College service delivers the right offer and courses to people across Castle Point and Rochford and Southend in the future.

Summary of findings

As part of the engagement and consultation process to inform this service specification, a stakeholder survey was answered by 57 professionals from a range of backgrounds, including GPs, social workers, mental health nurses, child and adolescent mental health service staff, Improving Access to Psychological Therapies (IAPT) staff, REACH recovery staff, job centre staff and voluntary and community providers. Generally the responses supported the view of the pilot evaluation that the recovery college offer is supportive and enables recovery. A third of respondents, which included GPs, were not aware of the
college, but this was not surprising considering the offer to date has mainly focused on step down from secondary care.

As part of the engagement and consultation process to inform the service specification, a student survey was answered by 43 people. This was split into 75% of people who use the recovery college and 25% who care for or support someone who attends the recovery college. Overall, the response was extremely positive with respondents reporting an increase in coping skills, strategies and confidence.

We are seeking two main benefits from our recovery college. First, to assist individuals in their personal and collective journeys of recovery. Second, to assist local organisations and services to become more recovery-focused. The creation of recovery-focused services requires a major transformation in purpose and relationships; a focus on rebuilding lives rather than reducing symptoms alone and a partnership between equals, rather than experts and patients.

Feedback from two surveys plus focus groups informed the content of the ‘brief’ for what we were looking for.

Thanks to patient involvement in the procurement process, we were able to evaluate what success looked like from the patient perspective and ensure the scoring was reflective of this. Training was provided to Michelle, our patient representative to ensure she felt comfortable with the process.

What did we do?

Two surveys were launched, aimed at different groups. One was intended for people with mental health issues and their carers; the other for stakeholders such as GPs; social workers; Department of Work and Pensions; voluntary sector partners and others to complete.

Recruitment of two patient representatives ensured the patient voice was represented in the procurement process.

Reach Recovery College Engagement: [https://www.youtube.com/watch?v=FsQaKqLaQZs](https://www.youtube.com/watch?v=FsQaKqLaQZs)
Dementia Diagnosis rates

Brief summary of project

The rate of dementia diagnosis in Castle Point in 2017 was significantly worse than the England average.

Thanks to close partnership working across south east Essex, a team who jointly work on behalf of Southend-on-Sea Borough Council and the NHS across south east Essex were introduced to Castle Point.

The team support local residents affected by dementia to make sure they get the support they need while ensuring the local area is as dementia-friendly as possible.

The local Dementia Community Support Team offers friendly advice and information to local residents and their families throughout the dementia experience along with support and guidance to help understand dementia and the day to day challenges it may bring.

The service is available to people pre-diagnosis as well as post-diagnosis through to end-of-life and provides the crucial link between the person with dementia, their carer and health, social care and community support.

At the point of launch, the service had established links in Canvey Island to help to embed the service.

Dementia Community Support Team: https://www.youtube.com/watch?v=t4N9RVOihmg

Who did we ask?

To help to launch the service in Castle Point, a member from the team came to present to the NHS Castle Point and Rochford Clinical Commissioning Group (CCG) established patient group that acts as a Commissioning Reference Group. The group has a diverse membership across many different areas of our local community. Membership consists of representatives from:

- Local voluntary organisations
- Religious groups with an area dean attending
- Patient Participation Groups
- Healthwatch Essex.

What did we ask?

Members of the group were asked for ideas and local insight about how best to embed the new community dementia team into the local area.

What did we find out?

Since learning about a number of new dementia services, one of our Canvey patient representatives, Kath, took it upon herself to make sure the services are embedded into existing community services and organisations.
Thanks to the extensive contacts and networks in the room, we very quickly had a lot of interest in helping to successfully roll out of the service, particularly on Canvey Island.

What did we do?

Following the meeting, our patient representative, Kath put the team in contact with a number of key people on Canvey that led to:

- An awareness event at Knightswick shopping centre in Canvey on November 2018
- The development of a dementia hub at a day centre for the over 55s (Cisca House) every Thursday morning 9:30am-11:30am
- Free promotional materials donated by members of the community on Canvey
- Support in establishing links with all of the GP practices to ensure all staff were aware of the support available for those affected by dementia in the community
- Support in establishing links with local pharmacists and dentists
- Buy in from local businesses to raise local awareness of the team and staff being trained to become dementia friends
- Support from all of the churches to support help their congregations.

What was the impact?

Since the service went live in April 2017, over 700 referrals have been received across south east Essex.

Thanks to Kath, we are a step closer to making Canvey as dementia friendly as possible.

The local dementia diagnosis rates have improved dramatically and most importantly, it means people affected by dementia are able to get the support they need.
Transgender referrals

Brief summary of project

We have been working proactively with the Transgender community to help educate and empower GPs to better understand and meet their needs and emphasise the correct pathways for transgender people (and impact of not doing these things).

Who did we ask?

Transpire is community group which supports transgender people, their friends and family and the wider LGBTQ+ community in the Southend-on-Sea and surrounding areas.

As a member of the NHS Southend CCGs Community Engagement the Advisory and Reference Group have been proactive in undertaking research with the transgender community.

What did we find out?

When discussing barriers to accessing healthcare, Transpire raised the issue of inappropriate referrals and conduct at local GP practices.

What did we do?

We hosted a clinical education session for all our GPs across south east Essex. Jess from Transpire came to the event and presented information linked to the lived experience of the transgender community and the impact of inappropriate referrals.

We also re-shared a video that we co-produced with Transpire that was aimed at healthcare professionals in GP services.

GP Referrals for Transgender Patients: https://www.youtube.com/watch?v=UmlnZU5bz0g

What was the impact?

The video has been viewed nearly 500 times. GPs shared positive feedback following the event and felt better informed to undertake more appropriate and effective ways of meeting transgender patients’ needs.
Learning Disability Health Checks

Brief summary of project

The NHS has a crucial role to play in helping people with a learning disability lead longer, happier, healthier lives. Improving the health of people with learning disabilities is a priority area for both Clinical Commissioning Group’s. In 2018 the Clinical Commissioning Group established a local task and finish group with key partners reinforcing our commitment to focus on reducing health inequalities for our local Learning Disability Communities.

To make sure that people’s physical and mental health needs are met, we sought to improve the uptake of annual health checks and expanded a programme to reduce inappropriate overmedication.

Involvement of those with learning disabilities and those that care for them has been key to this work to ensure local services make reasonable adjustments for people’s needs.

Who did we ask?

Together with close partnership working with community Health Facilitation Nurses at Essex Partnership University Trust, who specialise in supporting local people with Learning Disabilities and key local authority partners we engaged with a number of local advocacy and local support groups including:

- Scope
- RE House
- The Attic
- Shields
- BATIAS
- Project 49
- Castle Point and Rochford Local Action Groups
- Southend Learning Disability Partnership Forum

What did we ask?

We were keen to understand if there were any barriers stopping people accessing health checks and whether the local community could identify and share what worked well and what didn’t work so well which. We co-designed easy read invitation letters and action plans for views on the examples provided.

What did we find out?

The workshop was well attended with good feedback and useful insight captured. This work is still ongoing with a variety of engagement techniques being used. A report will follow and be published on the CCG website.

What did we do?

We contacted local partners to host a workshop in February 2019 to gain ideas and local insight that would help improve the uptake of local Learning Disability health checks.

Learning Disability Health Checks Engagement: https://www.youtube.com/watch?v=AVHyLfOxxNA
Frailty

**Brief summary of project**

There are currently 78,000 people over the age of 65 in Southend and Castle Point and Rochford, with this set to increase by around 25% by 2025.

Frailty presents in more than 10% of those aged over 65 and 25-50% of those aged over 85, with any one of the frailty syndromes including falls, reduced/impaired mobility, cognitive decline / confusion, continence problems or increased susceptibility to the adverse effects of being on different medications.

Failure to detect frailty leads to poorer treatment, inaccurate assessment of care needs for both now and in the near future, and ultimately poorer health outcomes.

Locally, there is inconsistency in the early identification of a frail person and often care is reactive rather than proactive. This leads to missed opportunities to deliver preventative action when it has the greatest potential to improve outcomes and reverse or slow down the progression of frailty.

System partners therefore agreed to work together to define and drive forward the design of a better solution to support local people affected by dementia.

**Who did we ask?**

In line with the [NHS Long Term Plan](#), a collaborative approach across a wider range of key stakeholders; from health, social care, voluntary and third sector organisations, to patients and carers and our local communities was the agreed approach to inform this work.

**What did we find out?**

Some emerging thoughts for consideration have included:

- Locality Frailty Teams aligned to the Primary Care Hubs which could include a GP with an extended role in frailty and a Clinical Nurse Specialist
- Step up virtual wards for multidisciplinary health, mental health and social care assessment and care planning.

**What did we do?**

A group made up of both professionals and those with lived experience of falls and frailty was established to help draw on best practice evidence from across the country and to help shape local thinking around better solutions to support those affected by frailty.
Youth Council and Mental Health Survey

Brief summary of project

Mental health problems affect about 1 in 10 children and young people.

In autumn of 2018, the Chair of the Youth Council attended the NHS Southend Clinical Commissioning Group (CCG) Patient Participation Group Forum to present the findings of a survey that had gathered the opinions of young people and identify the issues they have with accessing support for their mental health needs.

The overall aim of the survey was to provide evidence for the development of a Mental Health Charter that could be introduced in schools.

Who was asked?

The survey received 1,757 responses from students aged between 11-18, across five schools.

What was asked?

Key questions about the school environment and how effective it was in helping young people to share issues and concerns about their mental wellbeing were asked alongside wider questions to determine other barriers to getting help. Data around prevalence of mental health issues and cyberbullying was also captured.

What did we find out?

14% of young people indicated there were barriers to accessing support with waiting lists for counsellors, social stigma and a lack of anonymity listed as other barriers.

Reasons for not opening up included:

- Feeling embarrassed
- It may add to already stressful family situations
- Didn’t want to ‘play the victim’
- Would not be believed
- Being scared of being talked about (by peers and staff)
- Would be seen as being weak.

What did we do?

Following the presentation, the CCG is keen to support the Youth Council in taking the findings forward especially relating to early intervention.

Further discussions have already taken place with stakeholders including with Southend-on-Sea Borough Council as to how we can progress this. Two GP members from the NHS Southend CCG Governing Body, Dr Taz Syed and Dr Kate Barusya and Lay Member of Patient and Public Involvement, Janis Gibson have all stepped forward to support members of the youth council in the development of the Mental Health Charter.

Southend Youth Council’s (SYC’s) Draft Mental Health Charter

SYC has developed a draft charter containing a series of recommendations and actions that we desire schools to implement in order to improve the mental health of their students, this includes:

- We hope to meet with relevant stakeholders to advise us on the feasibility of the points in the charter in order to help us develop and shape this.
Each item on the charter was directly inspired by the personal experiences and statistics revealed in our survey.

The charter is intended to be cost neutral where possible and to be adopted by all schools in the borough with the support of the Southend Borough Council.

The main sections of our charter are Privacy and Confidentiality, Referral, Internal School Services and Stigma.

Read the Results Report

Engaging patients in new ways of working in GP practices - Rushbottom Lane Surgery

Brief summary of project

As part of the wider Primary Care Strategy, both CCGs engaged patient groups across south east Essex in understanding the role of the extended GP practice team.

As part of this work, we supported a specific GP practice in Benfleet who were involved in testing out a new way of working to free up GPs time.

A big part of this was helping patients to become accustomed to the role of different healthcare professionals within the practice.

This included understanding the role of the reception team in coordinating/navigating their care to the right healthcare professional.

It was clear from the outset that in order for the practice to be successful in introducing new staff and a care navigation service, that we needed to engage with the patients registered with the practice to ask them to support us.

Who did we ask?

The practice have an excellent and active Patient Participation Group (PPG) who were keen to be involved and help the practice to deliver high-quality care for everyone.

What did we ask?

We asked the PPG for ideas about how they could support the implementation of the project.

What did we do?

The group agreed to support in developing communications materials in the right tone. Part of this included the co-production of a ‘partnership deal’ between the practice and patients to help patients share a little responsibility for the smooth running of the practice.

What was the impact?

The pilot is due to launch in March 2019, and any impacts will be published in next years Patient and Public Involvement Annual Report.
Development of a Neurodevelopment Pathway

Brief summary of project

Neurodevelopmental disorders are impairments of the growth and development of the brain or central nervous system that affect emotion, learning ability, self-control and memory and that unfold as an individual develops and grows. This project involved people who use services, along with the organisations that represent their interests, to agree a set of principles to improve the journey of care for children and young people living in south east Essex with neurodevelopmental needs.

A key focus was improving outcomes at the earliest possible time, appreciating that children have needs which should be supported in a holistic way, including social, emotional and physical well-being.

Who did we ask?

We asked for input from parents with lived experience and local voluntary sector groups, our parent and carer forum for children and families, the Schools SENCO network for Southend, the Emotional Wellbeing and Mental Health Service, Community Paediatric Services, the Special Educational Needs teams for Essex and Southend, Early Help and social care practitioners, GP clinical leads for children and safeguarding.

What did we ask?

We asked what the pathway should look like, what would be the best way to join up services to provide co-ordinated care and support, what are the current gaps with the system, what support and advice is currently available, what does the parent and child journey look like from the identification of initial need through to diagnosis outcome and follow-up support.

What did we find out?

We found there was a lack of pre and post diagnosis support and sign-posting and variable information provided to make an informed decision. The current system was health-centric, not outcome focused and appointments for paediatric assessments were compounded by having to gather further information from other agencies to inform the decision making process. The current pathway was driven by diagnostics rather than focusing on solutions, and we needed to be able to plan more effectively between system partners.

Partners helped to identify a preferred neurodevelopmental screening tool that we could use locally. Thanks to the shared expertise of those involved, we developed a useful map of current services available for ‘other’ support, both pre and post referral.

We also identified gaps within current services available and have been developing an action plan to address those gaps which feeds into the wider Community Paediatric review. We found if we opened up the referral pathway to schools and school nursing teams, we would be able to assist the process significantly.

What did we do?

We held workshops with system partners in April and May 2018 about Community Paediatric provision. We then held specific workshops to look at the neurodevelopmental issues in June and September 2018. A working group is now regularly meeting having designed the revised pathway to implement and commission the changes needed.
We presented the changes to the Southend Borough network who were keen to be involved as principle referrers under the new pathway model. We presented our key findings to the Community Paediatric Clinical Engagement Group and are working across mid and south Essex to join up and standardise the pathways for families and agencies. As a consequence, we made changes to referral protocols based on feedback through the workshops. We are working to jointly commission the services needed with local authority partners in line with the Special Educational Needs and Disabilities Code of Practice under the Children and Families Act.

As a consequence, we made changes to referral protocols based on feedback through the workshops.

**Ensuring our providers involve the public**

Part of our duty for engagement is to ensure that our providers are communicating with and involving service users, the public and staff.

Members of the communications and engagement team attend monthly meetings as part of the mid and south Essex Sustainability and Transformation Partnership (STP) work, which brings together commissioners and providers to update on their current work, forward plan and review opportunities for collaboration.

We also work with our providers to jointly engage with local residents. Projects highlighted above such as the locality stakeholder event, improving dementia diagnosis rates, frailty, developing neurodevelopment pathways have all been delivered in partnership, allowing us to be assured that our providers are fulfilling their duties to engage and involve.

We ensure our providers are engaging with service users, the public and staff through regular meetings and discussion. We also jointly engage on projects and work streams and involve providers and their staff in our engagement work.

**Supporting our Staff to Understand and Action Patient Involvement**

Through the communications and engagement team, we champion the importance of patient and public voice and ensure that it is reflected in commissioning activities. In November 2018, we ran a staff education session to help raise awareness.

In 2018/19, we also introduced a new communications and engagement form for staff to complete at the beginning of all projects as part of the project management process, ensuring the patient voice is integral to all projects.

CCG staff are regularly supported by communications and engagement to deliver engagement activities, with the team suggesting appropriate mechanisms, facilitating engagement and supporting effective involvement.
Looking forward

Communications and engagement aims

The change that we want to see:

While 2018/19 has been an incredibly busy year, coming together as two CCGs in a joint team has given us the opportunity to take stock of what was working and areas of development and opportunity. This has allowed us to begin a refresh of our involvement opportunities and the way we deliver engagement with our population.

Exciting times lie ahead and we are looking forward to working with our partners in both developing and delivering a new 2019-21 Communications and Engagement Strategy that builds on the success of previous work.

By April 2021 we want:

- Effective partnerships with stakeholders to promote prevention and self-care
- Ensure that staff and key stakeholders fully understand the need for change and feel empowered to work together to create services/solutions that meet their local population's needs
- Ensure that local people feel actively involved in decision making and that we seek the views of all stakeholder groups, including those who are seldom heard (either directly or through advocates) to enable meaningful engagement at every stage of the commissioning cycle
- To adhere to communications and engagement principles co-produced with our patient and community representatives
- Ensure effective internal communication and staff engagement is in place to make effective change throughout the organisation.

Turning visions into action requires a shift in our approach to communication and engagement. Achieving this will require the active participation of everyone in our CCGs; not just the communications and engagement professionals, but also our Governing Bodies, our members and our staff.

Everyone connected to the organisation shares a responsibility to ensure that our communities have confidence that their needs, both now and in the future, are integral to the decisions we make.