EAST SUSSEX BETTER TOGETHER STRATEGIC COMMISSIONING BOARD

TUESDAY, 6 JUNE 2017

2.00 PM COUNCIL CHAMBER, COUNTY HALL, LEWES

MEMBERSHIP - East Sussex County Council Members

Councillors David Elkin, Keith Glazier, Carl Maynard and Sylvia Tidy

Eastbourne, Hailsham and Seaford Clinical Commissioning Group and Hastings and Rother Clinical Commissioning Group Members

Dr Susan Rae, Hastings & Rother Clinical Commissioning Group
Dr Martin Writer, Eastbourne, Hailsham and Seaford CCG
Barbara Beaton, Hastings & Rother CCG
Julia Rudrum, Eastbourne Hailsham and Seaford CCG

A G E N D A

1 Election of Co-Chairs

2 Apologies for absence

3 Disclosure of interests
Disclosure by all Members present of personal interests in matters on the agenda, the nature of any interest and whether the Members regard the interest as prejudicial under the terms of the Code of Conduct and the CCGs' Conflicts of Interest Policy.

4 Urgent items
Notification of any items which the Chair considers urgent and proposes to take at the appropriate part of the agenda.

5 Terms of reference *(Pages 3 - 8)*

6 Procedure rules *(Pages 9 - 14)*

7 Overview of health and care needs *(Pages 15 - 56)*

8 Proposed stakeholder and citizen governance arrangements *(Pages 57 - 64)*

9 ESBT Alliance Outcomes Framework *(Pages 65 - 82)*

10 ESBT Strategic Investment Plan (SIP) *(Pages 83 - 88)*

11 Any other items previously notified under agenda item 4

PHILIP BAKER
Assistant Chief Executive

County Hall, St Anne's Crescent
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29 May 2017

Contact: Claire Lee, Senior Democratic Services Adviser
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NOTE: As part of the ESBT Alliance's drive to increase accessibility to its public meetings, this meeting will be broadcast live and the record archived for future viewing. The broadcast/record is accessible at www.eastsussex.gov.uk/yourcouncil/webcasts/default.htm

Report to:	**East Sussex Better Together (ESBT) Strategic Commissioning Board**
Date of meeting:	**6 June 2017**
By:	**Chief Officer, Eastbourne, Hailsham and Seaford and Hastings and Rother Clinical Commissioning Groups (CCGs)** **Director of Adult Social Care and Health, East Sussex County Council**
Title:	**Strategic Commissioning Board Terms of Reference**
Purpose:	**To note the Terms of Reference for the Board which have been agreed by the CCG Governing Bodies and County Council Cabinet.**

RECOMMENDATION

1) To note the Strategic Commissioning Board's Terms of Reference.

1. Background

1.1. The Strategic Commissioning Board has been established by Eastbourne, Hailsham and Seaford (EHS) CCG, Hastings and Rother (HAR) CCG and East Sussex County Council to enable the three organisations to jointly undertake responsibilities for addressing population health need and for commissioning health and social care in the 2017/18 test bed year of accountable care.

2. Supporting information

2.1. The Terms of Reference for the Strategic Commissioning Board (appendix 1) were agreed by County Council Cabinet on 7 March 2017 and by CCG Governing Bodies on 29 March 2017. They set out the Board's purpose, responsibilities and authority. They also recognise that strategic commissioning responsibilities remain the statutory responsibility of the three individual sovereign organisations and that any significant changes to the commissioning strategy set out in the joint Strategic Investment Plan will be referred back to the individual organisations for decision, informed by the Board's recommendations.

3. Conclusion and reasons for recommendations

3.1. The Terms of Reference set out the role of the Strategic Commissioning Board and will guide the Board's work. Any changes to the Terms of Reference would require the agreement of CCG Governing Bodies and County Council Cabinet.

3.2. The Board is recommended to note the Terms of Reference which have been agreed by the CCG Governing Bodies and County Council Cabinet.

AMANDA PHILPOTT
Chief Officer
EHS and HAR CCGs

KEITH HINKLEY
Director of Adult Social Care and Health
East Sussex County Council

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TERMS OF REFERENCE FOR THE EAST SUSSEX BETTER TOGETHER (ESBT) STRATEGIC COMMISSIONING BOARD

1 Governance

Eastbourne, Hailsham and Seaford Clinical Commissioning Group (EHS CCG), Hastings and Rother Clinical Commissioning Group (HR CCG), and East Sussex County Council (ESCC) have established committees in common known as the 'Strategic Commissioning Board'. The Strategic Commissioning Board is established pursuant to the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 and all other enabling powers.

The Strategic Commissioning Board has the powers specifically delegated in these terms of reference.

2 Purpose

The Strategic Commissioning Board will jointly undertake responsibilities for addressing population health need and for commissioning health and social care in the 2017/18 test bed year, through oversight of the 2017/18 Strategic Investment Plan (SIP), and any other responsibilities agreed by the sovereign statutory commissioning bodies to oversee the effective delivery of outcomes by the ESBT Alliance (to be determined).

3 Responsibilities

The Strategic Commissioning Board will:

- Ensure alignment in our understanding of the health and care needs of the population covered by the ESBT footprint
- Set the outcomes to be delivered by the ESBT Alliance to meet the needs of the population, reflecting national policy where this is appropriate
- Ensure that local people are engaged in discussions to understand local needs and the outcomes to be delivered, so that they are informed by local insight
- Set the direction of the investment patterns and oversee the implementation of the 2017/18 SIP

- Review recommendations from the ESBT Alliance Governing Board with regard to the ongoing development of the SIP and the investment profile in order to meet population health needs and deliver outcomes
- Monitor and evaluate the meeting of needs and the delivery of outcomes.

4 Authority

The Strategic Commissioning Board is authorised by the sovereign bodies of EHS CCG, HR CCG and ESCC to jointly undertake activities, and recommend decisions to Governing Bodies and Cabinet, relating to oversight of the ESBT SIP.

It is recognised that EHS and HR CCGs and ESCC will continue to have their own regulatory and statutory responsibilities. The Strategic Commissioning Board enables the sovereign organisations to undertake and align strategic commissioning activities within the current legislative framework to set outcomes and direction for the Strategic Investment Plan jointly, and monitor delivery of outcomes by the ESBT Alliance jointly, whilst still operating as sovereign organisations as the regulatory framework requires.

5 Membership

Members of the Strategic Commissioning Board will be Elected Members of ESCC and GP and Lay Members of EHS and HR CCG Governing Bodies and this will be maintained at all times. Each member of the Strategic Commissioning Board will be entitled to vote. Following consultation with other Board members any organisation can remove or replace their respective Strategic Commissioning Board Members at any time by notice in writing to the other partners.

The Chair of the Strategic Commissioning Board will rotate between the CCGs and ESCC and will not have a casting vote. The proposed members of the Strategic Commissioning Board will be 4 members appointed by the CCGs and 4 members appointed by ESCC.

The CCGs' Chief Officer and Chief Finance Officer, and ESCC Director of Adult Social Care and Health, Director of Children's Services, Director of Public Health and Head of Finance (Adult Social Care and Health)/Chief Finance Officer or their substitutes will attend in an advisory capacity.

6 Meeting proceedings and quorum

Wherever possible decision-making will be discussion driven to arrive at a 'best for the whole system' consensus in accordance with principles set out in the ESBT Alliance Agreement. In the event that a vote is needed, each individual Strategic Commissioning Board member is entitled to one vote

A quorum shall be 3 members appointed by the CCG and 3 members appointed by ESCC.

7 Attendance

Where a Member cannot attend a meeting of the Strategic Commissioning Board then they may send a substitute who will have full voting rights. All matters will be decided by a majority of those members present and voting.

8 Reporting

The Strategic Commissioning Board will report to each of the sovereign organisations as required by that organisation.

An annual report will be provided to the East Sussex Health and Wellbeing Board on the SIP commissioning strategy and outcomes delivered, with updates provided as required.

9 Administration

ESCC Member Services will provide secretarial support to the Strategic Commissioning Board.

10 Frequency

Meetings will be held every three months. Meetings will be held in public in accordance with the rules adopted by the Board.

Author	V Smith
Sovereign organisations' governing bodies review	March 2017
Strategic Commissioning Board review	June 2017
Strategic Commissioning Board review due	September 2017, March 2018
Sovereign organisations' governing Bodies review due	July 2017, March 2018
Version	1.0

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Report to:	**East Sussex Better Together (ESBT) Strategic Commissioning Board**
Date of meeting:	**6 June 2017**
By:	**Chief Officer, Eastbourne, Hailsham and Seaford and Hastings and Rother Clinical Commissioning Groups (CCGs)** **Director of Adult Social Care and Health, East Sussex County Council**
Title:	**Strategic Commissioning Board Procedure Rules**
Purpose:	**To agree the Procedure Rules which set out how the Board will operate.**

RECOMMENDATION

1) To agree the Strategic Commissioning Board Procedure Rules.

1. Background

1.1. The Strategic Commissioning Board has been established by Eastbourne, Hailsham and Seaford (EHS) CCG, Hastings and Rother (HAR) CCG and East Sussex County Council to enable the three organisations to jointly undertake responsibilities for addressing population health need and for commissioning health and social care in the 2017/18 test bed year of accountable care.

2. Supporting information

2.1. The Procedure Rules for the Strategic Commissioning Board (appendix 1) have been developed by governance leads for the CCGs and the County Council and reflect arrangements already in place for similar Boards. They set out how the Board will operate in practice and provide a framework to guide the Co-Chairs and the Board's secretariat in managing meeting arrangements.

3. Conclusion and reasons for recommendations

3.1. The Board is recommended to agree the Procedure Rules.

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Chief Officer
EHS and HAR CCGs

KEITH HINKLEY
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East Sussex County Council

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East Sussex Better Together Strategic Commissioning Board Procedure Rules

Introduction

1. As part of the East Sussex Better Together (ESBT) Alliance arrangements, Eastbourne, Hailsham and Seaford Clinical Commissioning Group (EHS CCG), Hastings and Rother Clinical Commissioning Group (HR CCG), and East Sussex County Council (ESCC) have established committees in common known as the 'Strategic Commissioning Board' (referred to as 'the Board' within these rules).
2. A 'committees in common' approach ensures that two committees (one a joint committee, and the other a committee of the CCGs) ostensibly act as single committee, the 'Strategic Commissioning Board', with a sufficient mandate to consider the full range of issues covered by the ESBT Alliance without duplicating meetings. The membership of both committees is identical and they meet simultaneously to a common agenda.
3. It is recognised that EHS CCG, HR CCG and ESCC will continue to have their own regulatory and statutory responsibilities. The Board enables the sovereign organisations to undertake and align strategic commissioning activities within the current legislative framework whilst still operating as sovereign organisations as the regulatory framework requires.
4. These rules shall operate alongside the 'Terms of Reference for the ESBT Strategic Commissioning Board' document which has been agreed by the CCGs and ESCC. Any variations to the Terms of Reference would require agreement by both the CCGs and ESCC.

Membership of the Strategic Commissioning Board

5. The Board shall consist of:
    - two EHS CCG Governing Body representatives – one lay representative and one clinical representative
    - two HR CCG Governing Body representatives – one lay representative and one clinical representative
    - four ESCC elected Member representatives.
6. CCG representatives shall be appointed by the relevant Governing Body.
7. ESCC representatives shall be appointed by the Leader of the Council.
8. Constituent provider members of the ESBT Alliance shall have invited observer status (without automatic speaking rights) at all meetings. Representatives of other providers or other relevant NHS organisations may be invited to attend meetings as required.

Term of office

9. The term of office for each Board member shall be determined by their respective organisations. If a vacancy arises, a replacement member shall be appointed by the relevant organisation. Any organisation can remove or replace their respective Strategic Commissioning Board Members at any time by notice in writing to the Administering Authority which shall notify all other partners.

10. Any Board member who wishes to resign shall submit their resignation in writing to the Administering Authority.

Chairing Board meetings

11. ESCC shall nominate one of its Members as Board co-Chair and EHS and HR CCGs between them shall nominate one CCG member as Board co-Chair. The chairing of the Board shall rotate with the CCGs and ESCC chairing alternate meetings. If the relevant co-Chair for a meeting is either absent or unable to act as Chair, the other co-Chair shall preside. Where both co-Chairs are either absent or unable to act as Chair, the Board shall elect one of the members of the Board present at the meeting to preside**.**

12. It will be the role of the Chair to:

- manage the meetings effectively and efficiently
- ensure that all members of the Board show due respect for process and that all views are fully heard and considered
- strive as far as possible to achieve a consensus as an outcome
- ensure that the actions and rationale for decisions taken are clear and properly recorded.

Support arrangements

13. ESCC shall be the Administering Authority. ESCC will provide secretariat, administrative and professional support to the Strategic Commissioning Board in liaison with CCG Governing Body support officers to ensure that both NHS and local authority governance requirements are met. ESCC shall ensure that:

- Board meetings are scheduled for at least four times per year to meet in public and that an annual schedule of meetings is produced
- adequate facilities are available to hold meetings in an accessible venue
- Board agenda items are decided in liaison with senior officers within the CCGs and ESCC
- the agenda is published five clear working days before each meeting except in exceptional circumstances.

Expert advice and information

14. The Board will have access to professional advice and support provided by senior officers of ESCC and the CCGs. Officers normally in attendance (or their substitutes) shall be:

- Chief Officer, EHS and HR CCGs
- Chief Finance Officer, EHS and HR CCGs
- Director of Adult Social Care and Health, ESCC
- Director of Public Health, ESCC
- Director of Children's Services, ESCC
- Chief Finance Officer/Head of Finance (Adult Social Care and Health), ESCC.

Publication of Board agendas and minutes

15. Agenda papers and minutes of Board meetings shall be published on the ESCC website. Links to the agenda shall be available on the CCG and ESBT websites with a clear placeholder on these sites giving meeting details.

16. Agenda papers and minutes shall be made publicly available in accordance with the Access to Information Procedure Rules in the ESCC Constitution.

Access by the Public to meetings

17. Members of the public may attend all Board meetings subject to the exceptions in these rules.

18. Members of the public may submit written questions for the Board no later than five clear working days ahead of a meeting, stating the questioner's name and address. Written answers will be circulated at the meeting. The questions and answers shall not be read out but the Chair may at his/her discretion allow the questioner one supplementary question to clarify the answer given.

19. The public *must* be excluded from Board meetings whenever it is likely in view of the nature of the business to be transacted or the nature of proceedings that confidential information would be disclosed. The public *may* be excluded from Board meetings whenever it is likely in view of the nature of the business to be transacted or the nature of the proceedings that exempt information would be disclosed.

20. Up-to-date information shall be posted on the ESCC website showing:

    - the Strategic Commissioning Board's membership
    - the Board's responsibilities and Terms of Reference
    - dates of Board meetings
    - Board agenda, papers and minutes.

Expense reimbursement, remuneration and allowances

21. Strategic Commissioning Board members shall be eligible to claim any expenses incurred in line with the policies and procedures of their respective organisations.

Decision Making Process

22. Wherever possible decision-making will be discussion driven to arrive at a 'best for the whole system' consensus in accordance with principles set out in the ESBT Alliance Agreement. In the event that a vote is needed, each individual Strategic Commissioning Board member is entitled to one vote

23. In the event of a vote being required, each individual Board member is entitled to one vote. The Chair shall not have a casting vote. Decisions shall be taken by a majority of those present and voting.

24. In the event of an equal number of votes cast for and against a proposal, the proposal shall be considered to have been rejected.

Attendance and quorum

25. The quorum for Board meetings shall be three CCG Board members and three ESCC Board members.

26. Where a Member cannot attend a Board meeting they may appoint a substitute who shall have full voting rights.

Standards of Conduct and conflicts of interest

27. The ESCC Code of Conduct will apply to the ESCC members of the Board. CCG Constitutions, national guidance and relevant codes of practice (including the Nolan Principles, the National Health Service Constitution, CCG Standing Orders and the CCG Conflict of Interests policy) will apply to the CCG members of the Board.

Amendments to procedure rules

28. Any amendment to these procedure rules shall be by agreement of the Strategic Commissioning Board.

Conduct of the meeting

29. Any other matters relating to the conduct of the meeting shall be at the discretion of the Chair.

Report to:	**East Sussex Better Together Strategic Commissioning Board**
Date of meeting:	**6 June 2017**
By:	**Acting Director of Public Health**
Title:	**Overview of Health and Care Needs**
Purpose:	**To describe health and care needs and consider the proposed outcomes for the East Sussex Better Together Alliance**

RECOMMENDATIONS

1) To note the East Sussex Better Together Health and Care Needs Summary Report;

2) To agree the high level outcomes and revised associated targets for inclusion in the East Sussex Better Together Alliance Outcomes Framework.

1 Background

1.1 The Joint Strategic Needs & Assets Assessment (JSNAA) is a process that identifies both the health and wellbeing needs (i.e. problems) and assets (i.e. strengths) of the people, communities and populations in East Sussex. This website provides a central JSNAA resource of local and national information to inform decisions and plans to improve local people's health and wellbeing and reduce health inequalities in East Sussex.

1.2 The JSNAA is continuously added to and updated. It has supported the development of East Sussex Better Together (ESBT) programme since the programme commenced in August 2014.

1.3 The JSNAA informed the development of the ten high level ESBT 'Improvement in Health' and 'Reduction in Health Inequalities' outcomes and associated targets, agreed by the ESBT Programme Board in February 2015. These were developed to assist in demonstrating the health impact, at a population level, of the ESBT Programme.

2 Joint Strategic Needs & Assets Assessment

2.1 Area summaries form part of the JSNAA and provide an overview of an area and are updated and published annually.

2.2 Appendix 1 contains an ESBT Health and Care Needs Summary, based on the latest 2017 data in the JSNAA, at Eastbourne, Hailsham and Seaford Clinical Commissioning Group (CCG) and Hastings and Rother CCG level. This summary is based on over 200 indicators, includes a key statistics table and a topic based narrative, and describes each CCG and each locality within each of the CCGs.

2.3 The 2018 JSNAA programme is in progress and the 2018 ESBT summary will present a more integrated summary of the health and care needs of the ESBT alliance area.

3 East Sussex Better Together High Level Outcomes

3.1 Through ESBT health and social care are being transformed to achieve the best possible outcomes. Based on the JSNAA, ten high level improving health and reducing health inequalities outcomes and associated targets were developed and agreed as success measures of the programme.

The ten high level outcomes and associated targets, agreed in February 2015, are detailed below. These targets, which cover the whole of East Sussex, have been monitored and presented annually to the ESBT Programme Board.

2015 ESBT Programme High Level Outcomes and Targets

IMPROVEMENT IN HEALTH OUTCOMES AND TARGETS	REDUCTION IN HEALTH INEQUALITIES OUTCOMES AND TARGETS
Reduction in preventable mortality for East Sussex Target: 10% reduction between 2010-2012 and 2015-17 for East Sussex based on a steady reduction of 2% per year	Reduce the gap in preventable mortality between the most and least deprived areas across East Sussex Target: Between 2011-13 and 2015-17 achieve a 12% reduction in the gap in preventable mortality between the most and the least deprived area across East Sussex
Reduction in mortality amenable to healthcare for East Sussex Target: 15% reduction in amenable mortality rate for persons aged under 75 years between 2011-13 and 2015-17 for East Sussex based on a steady 4% reduction per year	Reduce the gap in mortality amenable to healthcare between the most and least deprived areas across East Sussex Target: Between 2011-13 and 2015-17 achieve a 14% reduction in the gap in mortality amenable to healthcare for persons aged under 75 years between the most and the least deprived areas in East Sussex
Improve health related quality of life for older people in East Sussex Target: Improve the health related quality of life score for older people in East Sussex to be above the average for the South East region and maintain that position	Reduce the gap in health related quality of life for older people between areas in East Sussex Target: Year on Year reduction in the gap in the health related quality of life score for older people between the best and the worst local authority district/borough in East Sussex
Reduction in excess weight (overweight or obese) in children 4-5 years in East Sussex Target: 4% reduction in the percentage of children aged 4-5 years classified as overweight or obese between 2013/14 and 2017/18. This is based on an annual 1% reduction.	Reduce the gap in excess weight between the most and least deprived areas across East Sussex Target: Between 2013/14 and 2017/18 achieve an 11% reduction in the gap in excess weight for 4-5 year olds between the most and least deprived areas across East Sussex. This is based on an annual 3% gap reduction.
Reduction in excess weight (overweight or obese) in children 10-11 years in East Sussex Target: 4% reduction in the percentage of children aged 10-11 years classified as overweight or obese between 2013/14 and 2017/18. This is based on an annual 1% reduction.	Reduce the gap in excess weight between the most and least deprived areas across East Sussex Target: Between 2013/14 and 2017/18 achieve a 16% reduction in the gap in excess weight for 10-11 year olds between the most and least deprived areas across East Sussex. This is based on an annual 4% gap reduction.

3.2 The latest JSNAA demonstrates that these high level outcomes should remain as success measures. However, as ESBT has moved from a programme to an ESBT Alliance, the targets supporting these high level outcomes have been revised to now include only the ESBT alliance area, rather than the whole of East Sussex, and extended to 2020/21. The revised targets follow the same trajectory using the last performance data as the baseline to project going forward.

3.3 The revised targets are presented below.

Revised ESBT Targets Associated with High Level Outcomes

IMPROVEMENT IN HEALTH OUTCOMES AND TARGETS	REDUCTION IN HEALTH INEQUALITIES OUTCOMES AND TARGETS
Reduction in preventable mortality for ESBT Target: Reduction in amenable mortality rate between 2013-15 and 2019-21 for ESBT based on a steady 2% reduction per year	Reduce the gap in preventable mortality between the most and least deprived areas across ESBT Target: Between 2013-15 and 2019-21 achieve a 16% reduction in the gap in preventable mortality between the most and least deprived areas across the ESBT area. This is based on a steady 3% reduction in the gap per year.
Reduction in mortality amenable to healthcare for ESBT Target: 17% reduction in amenable mortality rate for persons aged under 75 years between 2013-15 and 2019-21 for ESBT based on a steady 3% reduction per year.	Reduce the gap in mortality amenable to healthcare between the most and least deprived areas across ESBT Target: Between 2013-15 and 2019-21 achieve a 16% reduction in the gap in mortality amenable to healthcare for persons aged under 75 years between the most and least deprived areas across ESBT. This is based on a steady 3% reduction in the gap per year.
Improve health related quality of life for older people in East Sussex Target: Improve the health related quality of life score for older people in East Sussex to be above the average for the South East region and maintain that position	Reduce the gap in health related quality of life for older people between areas in East Sussex Target: Year on Year reduction in the gap in the health related quality of life score for older people between the best and the worst local authority district/borough in East Sussex
Reduction in excess weight (overweight or obese) in children 4-5 years in ESBT Target: 5% reduction in the percentage of children aged 4-5 years classified as overweight or obese between 2015/16 and 2020/21 across the ESBT area. This is based on an annual 1% reduction	Reduce the gap in excess weight between the most and least deprived areas across ESBT Target: Between 2015/16 and 2020/21 achieve a 13% reduction in the gap in excess weight between the most and least deprived areas across ESBT. This is based on an annual 3% gap reduction..
Reduction in excess weight (overweight or obese) in children 10-11 years in ESBT Target: 5% reduction in the percentage of children aged 10-11 years classified as overweight or obese between 2015/16 and 2020/21 across the ESBT area. This is based on an annual 1% reduction	Reduce the gap in excess weight between the most and least deprived areas across ESBT Target: Between 2015/16 and 2020/21 achieve a 15% reduction in the gap in excess weight between the most and least deprived areas across ESBT. This is based on an annual 3% gap reduction.

3.4 These high level outcomes and revised targets have been included as part of the ESBT Alliance Outcomes Framework (item 8 on the agenda for this meeting).

4. Conclusion and reasons for recommendations

4.1 The JSNAA ESBT Health and Care Needs Summary demonstrates that the high level outcomes agreed by the ESBT Programme in 2015 should remain as success measures for the ESBT Alliance. However, to ensure the validity of the targets associated with the high level outcomes they have been revised to fit the ESBT Alliance area.

4.2 The Board is therefore recommended to:

1. Note the East Sussex Better Together Health and Care Needs Summary Report;
2. Agree the high level outcomes and revised associated targets for inclusion in the East Sussex Better Together Alliance Outcomes Framework.

Cynthia Lyons
Acting Director of Public Health

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BACKGROUND DOCUMENTS

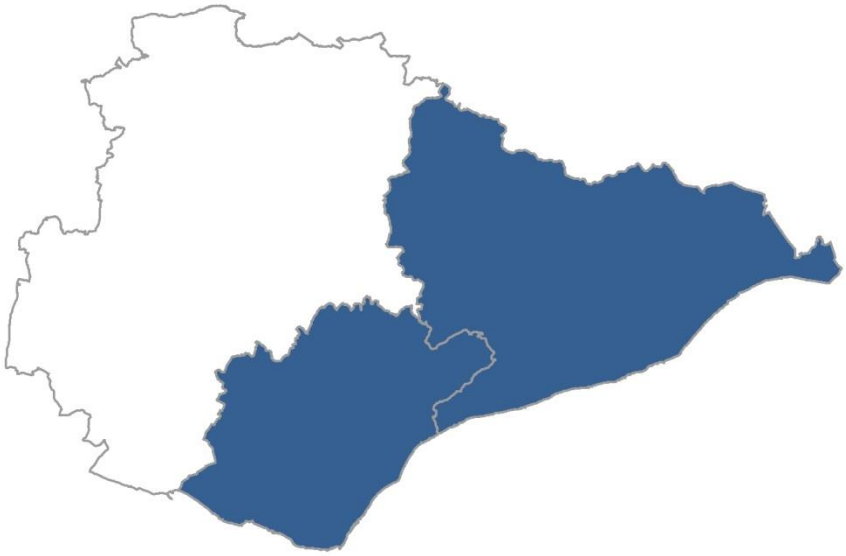
Joint Strategic Needs and Assets Assessment website : http://www.eastsussexjsna.org.uk/

East Sussex Better Together website: http://news.eastsussex.gov.uk/east-sussex-better-together/

Appendix 1

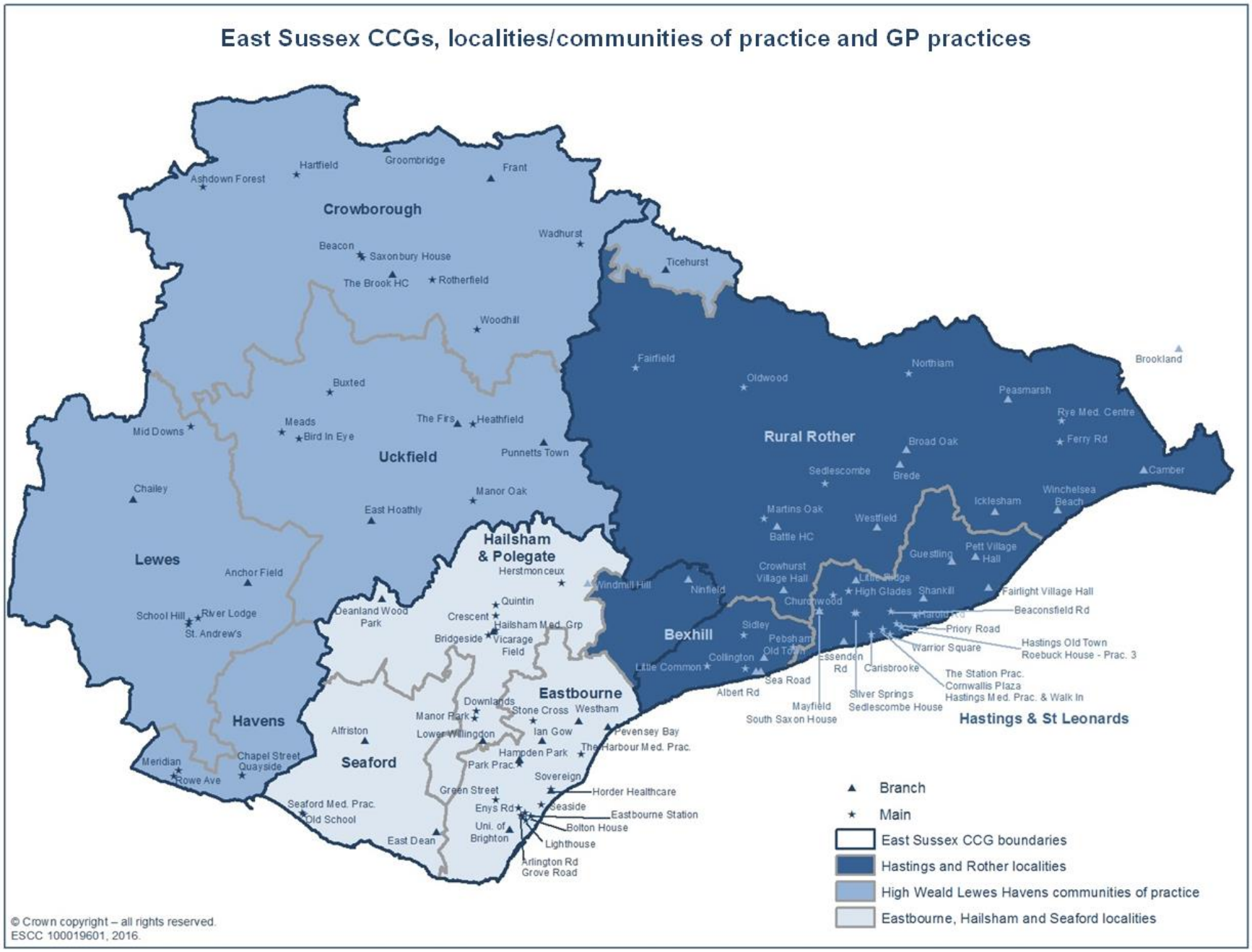
East Sussex Better Together
Health and Care Needs Summary

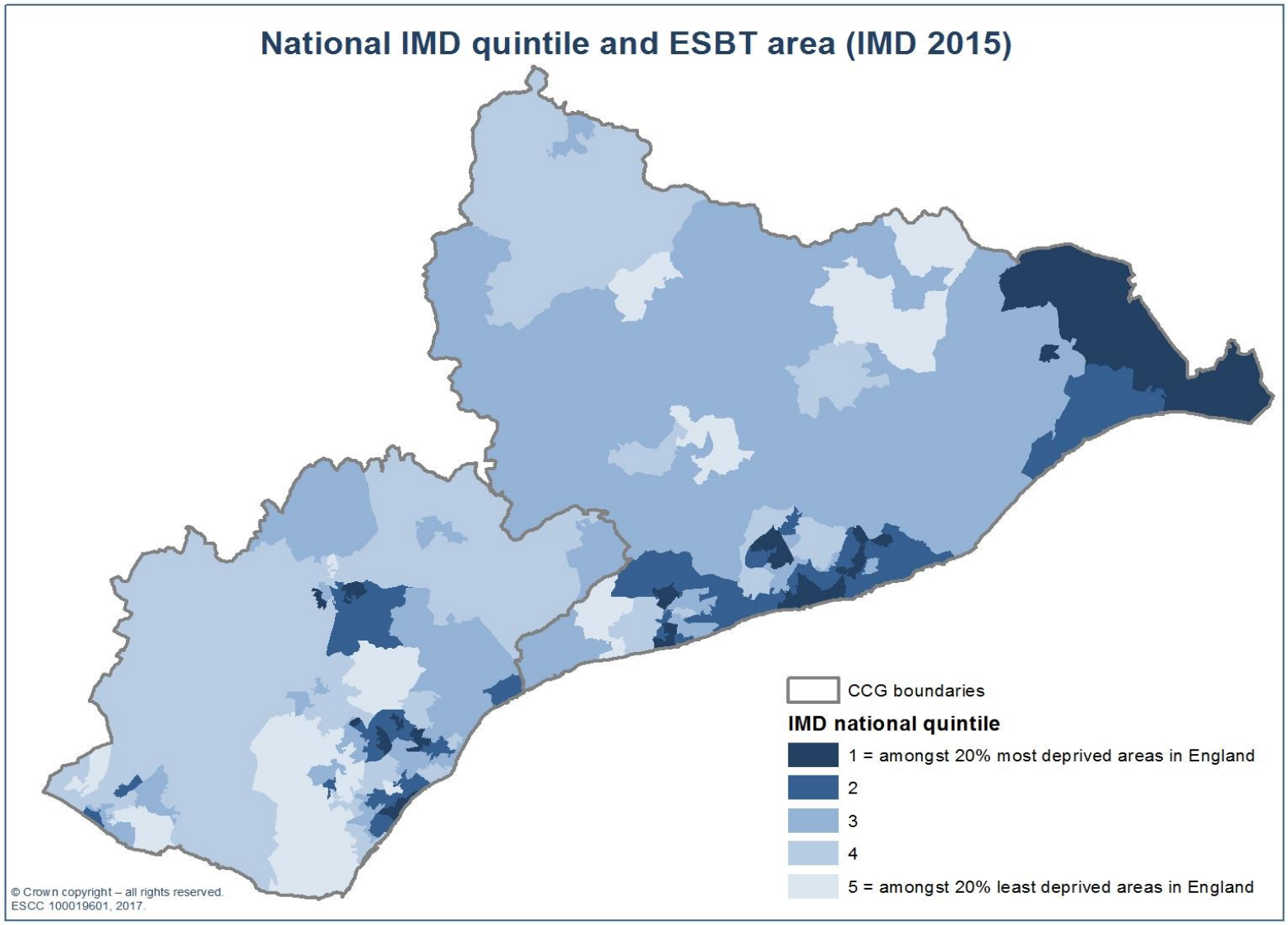
Based on the NHS view of the
Joint Strategic Needs & Assets Assessment
Scorecards 2017



East Sussex
Joint Strategic Needs & Assets Assessment
eastsussexjsna.org.uk

East Sussex CCGs, localities/communities of practice and GP practices




National IMD quintile and ESBT area (IMD 2015)
CCG boundaries
IMD national quintile
1 = amongst 20% most deprived areas in England
2
3
4
5 = amongst 20% least deprived areas in England
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Hastings and Rother CCG

Annex 1: Scorecard Summary Tables

Annex 2: Acronyms and abbreviations

Key statistics

Key Statistics for Eastbourne Hailsham and Seaford CCG			
Ref	Indicator	Number per year	Value
1.01	GP registered population (count), Oct 2015	192,396	
1.02	GP registered population aged 0-19 yrs (%), Oct 2015	39,880	21
1.03	GP registered population aged 20-64 yrs (%), Oct 2015	102,871	53
1.04	GP registered population aged 65+ yrs (%), Oct 2015	49,645	26
1.18	Live births per 1,000 women aged 15-44 yrs, 2014-15	1,823	61
2.02	Income Deprivation (as a percentage), from ID 2015 (M)		13
2.04	Children in low-income families (%), Aug 2014 (M)	5,525	19
3.06	Excess weight in 10-11 year olds (%), 2012/13-2014/15 (M)	456	32
3.09	GP reported prevalence of smoking aged 15+ (%), 2015/16	26,517	16
4.04	Life expectancy at birth (yrs), 2013-15		82.3
4.05	Life expectancy at age 75 (yrs), 2013-15		13.0
4.06	All-cause mortality (SMR), 2013-15	2,442	99
4.08	Mortality from causes considered preventable (SMR), 2014-15	331	100
4.15	GP reported prevalence of dementia (%), 2015/16	2,416	1.2
4.23	GP reported prevalence of hypertension (%), 2015/16	33,801	17.5
4.26	GP reported prevalence of CHD (%), 2015/16	7,971	4.1
4.29	GP reported prevalence of stroke or TIA (%), 2015/16	4,773	2.5
4.32	GP reported prevalence of atrial fibrillation (%), 2015/16	5,820	3.0
4.34	GP reported prevalence of heart failure (%), 2015/16	2,180	1.1
4.49	GP reported prevalence of asthma (%), 2015/16	12,793	6.6
4.52	GP reported prevalence of COPD (%), 2015/16	4,352	2.3
4.57	GP reported prevalence of diabetes aged 17+ (%), 2015/16	10,240	6.4
4.60	GP reported prevalence of epilepsy aged 18+ (%), 2015/16	1,275	0.8
4.62	GP reported prevalence of CKD aged 18+ (%), 2015/16	10,048	6.4
4.65	GP reported prevalence of learning disabilities aged 18+ (%), 2015/16	888	0.5
4.72	First outpatient attendances (SAR), 2015/16	74,240	99
4.74	All MIU and A&E attendances (SAR), 2015/16	52,062	95
4.78	All elective admissions (SAR), 2014/15 to 2015/16	33,056	108
4.80	All emergency admissions (SAR), 2014/15 to 2015/16	19,538	100
6.01	People providing one hour or more of unpaid care per week (%), 2011 (M)	20,270	11.3

Significantly worse than East Sussex	Significantly better than East Sussex
Significantly higher than East Sussex	Significantly lower than East Sussex
Not significantly different to East Sussex	Significance not tested

Key Statistics for Hastings and Rother CCG			
Ref	Indicator	Number per year	Value
1.01	GP registered population (count), Oct 2015	186,117	
1.02	GP registered population aged 0-19 yrs (%), Oct 2015	38,986	21
1.03	GP registered population aged 20-64 yrs (%), Oct 2015	101,446	55
1.04	GP registered population aged 65+ yrs (%), Oct 2015	45,685	25
1.18	Live births per 1,000 women aged 15-44 yrs, 2014-15	1,770	61
2.02	Income Deprivation (as a percentage), from ID 2015 (M)		18
2.04	Children in low-income families (%), Aug 2014 (M)	7,331	25
3.06	Excess weight in 10-11 year olds (%), 2012/13-2014/15 (M)	476	33
3.09	GP reported prevalence of smoking aged 15+ (%), 2015/16	32,888	21
4.04	Life expectancy at birth (yrs), 2013-15		81.3
4.05	Life expectancy at age 75 (yrs), 2013-15		12.5
4.06	All-cause mortality (SMR), 2013-15	2,295	107
4.08	Mortality from causes considered preventable (SMR), 2014-15	381	117
4.15	GP reported prevalence of dementia (%), 2015/16	1,939	1.0
4.23	GP reported prevalence of hypertension (%), 2015/16	32,656	17.5
4.26	GP reported prevalence of CHD (%), 2015/16	7,498	4.0
4.29	GP reported prevalence of stroke or TIA (%), 2015/16	4,552	2.4
4.32	GP reported prevalence of atrial fibrillation (%), 2015/16	4,902	2.6
4.34	GP reported prevalence of heart failure (%), 2015/16	1,879	1.0
4.49	GP reported prevalence of asthma (%), 2015/16	11,173	6.0
4.52	GP reported prevalence of COPD (%), 2015/16	4,588	2.5
4.57	GP reported prevalence of diabetes aged 17+ (%), 2015/16	10,627	6.9
4.60	GP reported prevalence of epilepsy aged 18+ (%), 2015/16	1,390	0.9
4.62	GP reported prevalence of CKD aged 18+ (%), 2015/16	6,357	4.2
4.65	GP reported prevalence of learning disabilities aged 18+ (%), 2015/16	1,115	0.6
4.72	First outpatient attendances (SAR), 2015/16	74,530	103
4.74	All MIU and A&E attendances (SAR), 2015/16	49,528	95
4.78	All elective admissions (SAR), 2014/15 to 2015/16	28,931	99
4.80	All emergency admissions (SAR), 2014/15 to 2015/16	20,085	111
6.01	People providing one hour or more of unpaid care per week (%), 2011 (M)	20,339	11.5

Significantly worse than East Sussex	Significantly better than East Sussex
Significantly higher than East Sussex	Significantly lower than East Sussex
Not significantly different to East Sussex	Significance not tested

Introduction

This report summarises the health and care needs of the two CCGs in the ESBT alliance area compared to East Sussex as a whole. It is based on 2017 JSNAA scorecard data, presented in the form of indicator tables (Appendix 1) in which the CCGs and CCG localities are RAG-rated against East Sussex. Further tables and charts summarise key statistics and specific topics (such as hospital admission and attendance rates) for these CCGs.

The RAG-rated tables highlight statistically significant differences between the CCGs and East Sussex overall. Individual JSNAA scorecards are referenced alongside the indicator titles; if data has been modelled from LA to NHS geographies indicator titles are flagged with (M). For indicators where locality or CCG data is not available, values for Districts and Boroughs (based on the LA view JSNAA scorecards and area summaries) are discussed.

For more in-depth information on how GP practices, as well as localities and CCGs, compare to East Sussex, this report should be read alongside the NHS view JSNAA indicator scorecards.

> Here 'significance' refers to statistical significance at the 95% confidence level.
>
> In the tables (Appendix 1) statistically significant differences between this CCG and East Sussex are flagged in red/green and dark blue/light blue and the indicator values are given. But note that, for values based on large numbers, even small, possibly unimportant, differences can be statistically significant. Conversely, values based on small numbers can be substantially, but not (in statistical terms) significantly different to East Sussex.
>
> Some rates are age and/or sex standardised. For those that are not, such as the GP-reported prevalence of diabetes and other chronic diseases, it is important to take into account the age profile of the population, as they are likely to be higher in areas with older age profiles.

NHS and LA view JSNAA scorecards and area summaries can be downloaded from www.eastsussexjsna.org.uk/scorecards.

The following products can also be downloaded from the East Sussex JSNAA website:

GP Practice Profiles and Locality/Community of Practice Profiles

Spine charts are used to compare the GP practice or locality/community of practice to East Sussex for all available JSNAA indicators.
See http://www.eastsussexjsna.org.uk/PracticeProfiles2017

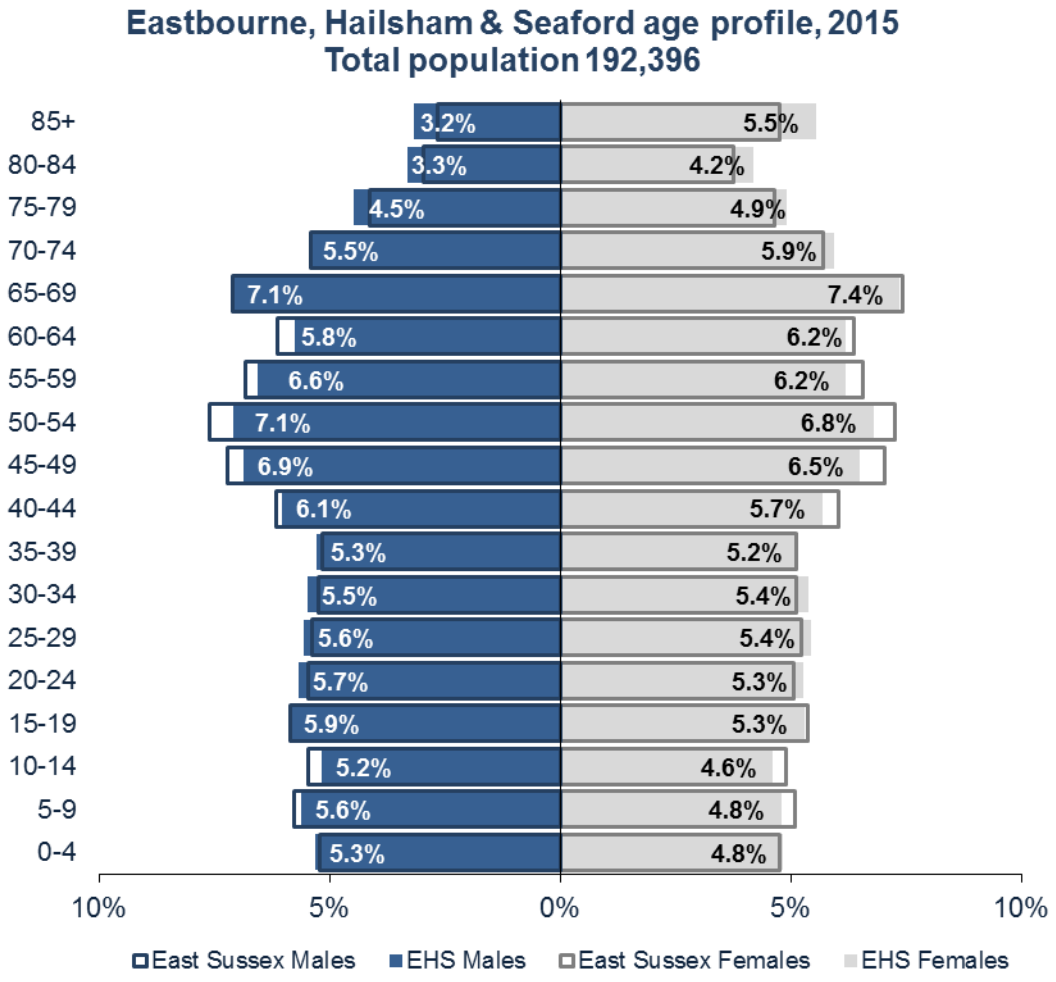
Local Needs and Assets Profiles

East Sussex, its districts/boroughs and CCGs are compared to England. RAG-rated tables similar to those in Appendix 1 (but with England as the benchmark) are

included.
See http://www.eastsussexjsna.org.uk/overviews/localneedsprofile.aspx

Eastbourne Hailsham and Seaford CCG

Population



EHS CCG has the largest population of all East Sussex CCGs. Within the CCG, Eastbourne has the largest and Seaford has the smallest population of all East Sussex localities. This CCG has the highest percentage of older people and the lowest percentage of younger people of the 3 East Sussex CCGs. Seaford has the lowest percentage of younger people and one of the highest percentages of older people of all East Sussex localities.

The dependency ratio (of non-working age people compared to working age people) for the CCG is significantly higher than for East Sussex. Hailsham & Polegate and Seaford have significantly higher (and amongst the highest) dependency ratios of all East Sussex localities whereas Eastbourne has a significantly lower dependency ratio than East Sussex.

The CCG is significantly higher than East Sussex and the highest of all CCGs for non-white British people and children who speak English as an additional language.

Eastbourne is significantly higher (and the highest of all East Sussex localities) whereas Hailsham & Polegate and Seaford are significantly lower than East Sussex.

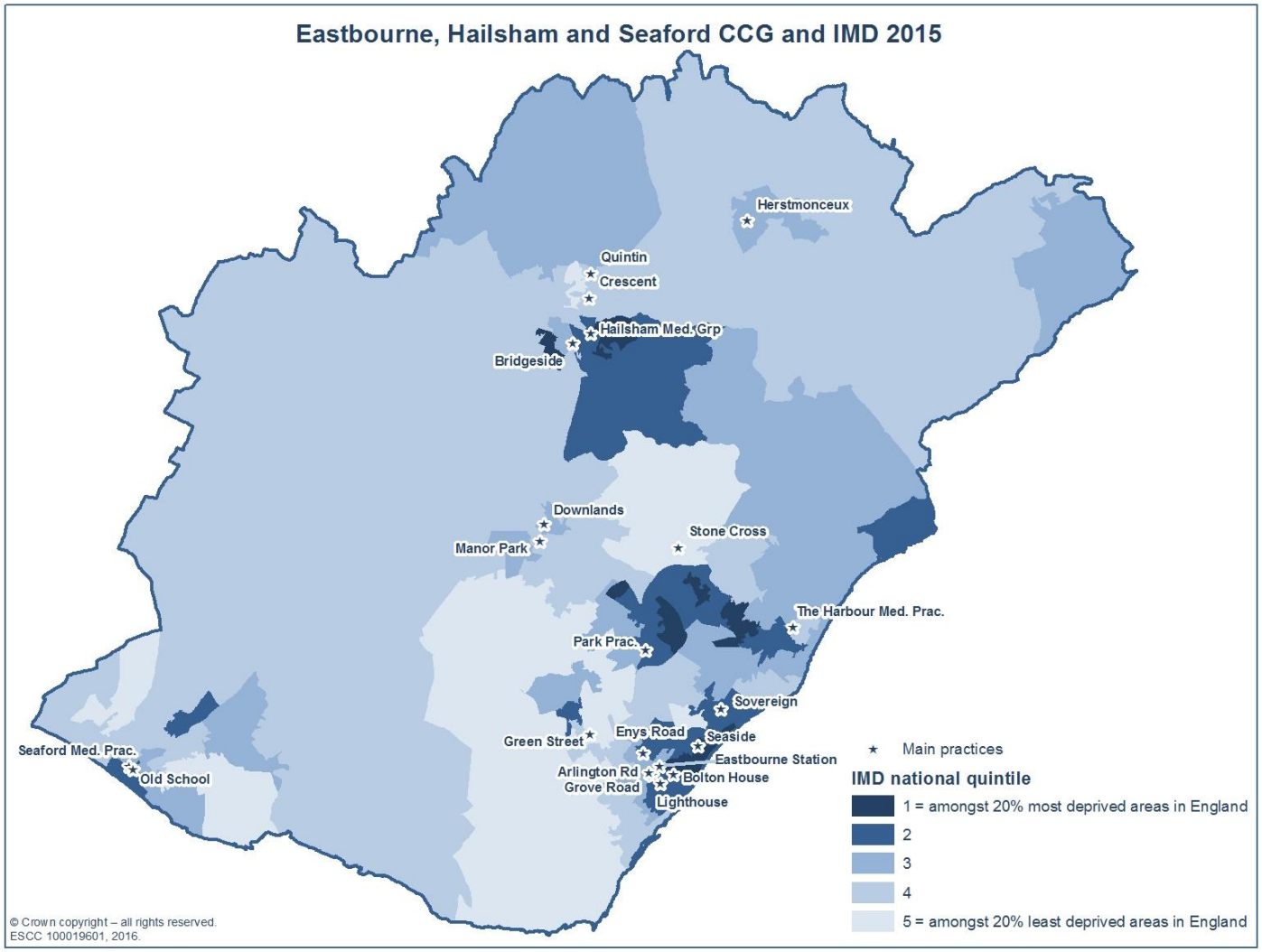
The CCG has similar birth rates to East Sussex, but Eastbourne has the second highest rate of births to teenage mothers, and Hailsham & Polegate has the highest overall birth rate, of all East Sussex localities.

Table 1 shows the estimated population changes between 2015 and 2021 for specific age groups as well as all ages. Using projections modelled from East Sussex districts and boroughs, the table shows that over the next 6 years some age groups are projected to increase in size whilst others will decrease in size. The net effect is that the population of the CCG is estimated to increase, with the largest estimated increase in those aged 85 years and over.

Table 1: Population projections for all persons (number and percentage change) showing the increase (positive) or decrease (negative) from 2015 to 2021 (modelled)

Population projections from 2015 to 2021				
	East Sussex		Eastbourne Hailsham and Seaford CCG	
Population Change	Number	%	Number	%
0-19 years	900	0.8%	100	0.3%
20-64 years	-2,100	-0.7%	-1,200	-1.2%
65+ years	14,600	11.0%	5,200	10.4%
85+ years	3,200	15.8%	1,350	15.7%
All Ages	13,500	2.6%	3,900	2%

Wider determinants



The CCG has similar income and employment deprivation to East Sussex, including children in low-income families and income deprivation affecting older people. Income and employment deprivation is significantly lower in Hailsham & Polegate and Seaford than in East Sussex but significantly higher in Eastbourne. This CCG and each of its localities has significantly lower percentages of households in fuel poverty than East Sussex. The CCG has similar percentages of working age people claiming ESA, JSA and UC to East Sussex. But Eastbourne locality has significantly higher rates than East Sussex whereas Hailsham & Polegate and Seaford have significantly lower rates. Eastbourne has a similar rate to East Sussex of children receiving the pupil premium whereas Hailsham & Polegate and Seaford have significantly lower rates.

Compared to East Sussex, this CCG and its localities have similar levels of educational achievement for pupils at ages 5, 11 and 16, except for pupils aged 11 years, where Seaford has the highest of all East Sussex localities.

Compared to East Sussex, Hailsham & Polegate has a significantly higher percentage of working age people with no or low qualifications whereas the other

localities have significantly lower. The CCG and Eastbourne locality have significantly lower rates of children with SEN on SEN Support.

The CCG has similar levels of households that are owner-occupied and households that are rented to East Sussex. But Hailsham & Polegate and Seaford have significantly more households that are owned and significantly less that are rented. Eastbourne on the other hand has significantly less that are owned and significantly more that are rented. The CCG has a significantly higher percentage of overcrowded households than East Sussex, with Eastbourne having significantly higher overcrowding but the other localities significantly lower. The CCG has a significantly lower percentage of households with no central heating than East Sussex, but the levels are lower in Hailsham & Polegate and Seaford than in Eastbourne locality.

Compared to East Sussex, this CCG has significantly higher A&E attendances due to assaults, but similar levels of recorded crimes, recorded incidents of anti-social behaviour and emergency admissions for violence. Hailsham & Polegate and Seaford localities are similar to East Sussex or significantly better for all crime indicators, however Eastbourne is significantly worse for recorded crimes and incidents of anti-social behaviour, and A&E attendances due to assault.

Overall health status

EHS CCG and its localities are broadly similar to East Sussex in terms of overall health status. Seaford locality has the highest self-reported LLTI or disability in the CCG but the lowest premature and preventable mortality. This CCG has the highest infant mortality (based on very small numbers) of the three CCGs.

Healthy lifestyles

Pregnancy and infancy

EHS CCG is broadly similar to East Sussex for these indicators. Seaford is the only locality in the CCG with significantly higher breastfeeding rates than East Sussex.

Physical activity and excess weight

It has similar levels of overweight or obese reception year and year 6 children to East Sussex, but within the CCG Eastbourne locality is worst and Seaford is best. Seaford has the lowest percentage of overweight/obese reception year children of all East Sussex localities. Eastbourne Borough and Lewes District have similar levels of adults achieving 150 minutes physical activity per week and overweight or obese adults to East Sussex.

Smoking

This CCG has similar levels of smokers and smoking quitters to East Sussex. However Seaford has significantly lower rates than East Sussex of mothers who are current smokers at the time of delivery and Hailsham & Polegate has significantly lower smoking quit rates. Eastbourne Borough has somewhat higher, and Lewes District somewhat lower, smoking-attributable mortality than East Sussex.

Alcohol and drug misuse

This CCG is broadly similar to East Sussex for these substance misuse indicators, but Eastbourne locality has significantly higher rates of adults in drug treatment whereas the other two localities have significantly lower. Eastbourne locality also has significantly higher alcohol-related hospital admissions whereas Hailsham & Polegate has significantly lower.

Sexual health

In this CCG the chlamydia and gonorrhoea detection rates are similar to the East Sussex rates. In Eastbourne Borough they are similar, in Lewes District they are similar or somewhat lower (except significantly higher for gonorrhoea detection), and in Wealden District they are lower. Under 18 conception rates are similar to East Sussex in Eastbourne Borough and lower in Lewes and Wealden districts.

Accidents and injuries

The A&E attendance and emergency admissions rate for accidents and injuries in 0-4 year olds is similar to East Sussex. But these A&E attendance rates are significantly higher in Eastbourne locality and significantly lower in Seaford than in East Sussex, whereas admission rates are similar to East Sussex in all three localities. Both for older children and for young people, emergency admission rates for accidents and injuries in this CCG are significantly lower than in East Sussex. For older children this is the case in Eastbourne and Seaford localities and for young people this is the case in Eastbourne and Hailsham & Polegate. The emergency admissions rate for falls injuries in older people is similar to the East Sussex rate. Eastbourne Borough has a significantly lower rate of people killed or seriously injured on the roads and the lowest rate of all the districts and boroughs whereas for Lewes District the rate is not significantly different to East Sussex.

Health protection

This CCG is significantly better than East Sussex for eligible people receiving an NHS health check. Eastbourne and Seaford localities are significantly better than East Sussex but Hailsham & Polegate is significantly worse. The CCG has similar uptake of screening for cervical, breast and bowel cancers to East Sussex. But uptake is significantly worse in Eastbourne and significantly better for the rest of the CCG, except for bowel cancer screening in Hailsham & Polegate where it is similar to East Sussex.

Hailsham & Polegate has either significantly worse or similar uptake to East Sussex for immunisations, and the rest of the CCG is either similar or significantly better.

Disease and poor health

Mental health and wellbeing

For most of these indicators the CCG is similar to East Sussex. But this CCG has the highest incidence of depression and the highest prevalence of dementia (not age-standardised) of all East Sussex CCGs. The high incidence of depression is driven by Eastbourne, which has a significantly higher incidence than East Sussex and the highest of all localities. Within the CCG the incidence is lowest in Seaford (where it is

significantly lower than East Sussex). The prevalence of severe mental illness is significantly lower in Hailsham & Polegate but similar to East Sussex in the rest of the CCG. Eastbourne locality has significantly higher rates of working age people claiming ESA due to mental health problems than East Sussex but rates are significantly lower in the rest of the CCG. Compared to East Sussex, the prevalence of dementia (not age-standardised) is significantly higher in all three localities, but emergency admissions for persons with dementia are similar.

Circulatory

The CCG has significantly higher prevalences (not age-standardised) than East Sussex of most circulatory conditions. This is because Hailsham & Polegate and Seaford localities have significantly higher prevalences (not age-standardised) than East Sussex. However, emergency admissions and mortality for circulatory diseases are similar to East Sussex across the CCG.

Cancer

Premature mortality due to cancer is similar to East Sussex. The CCG has similar incidence and mortality to East Sussex for lung, colorectal, breast and prostate cancers.

Respiratory

The CCG has a significantly higher prevalence of asthma (not age-standardised) than East Sussex. In Eastbourne, but not the other two localities, emergency admissions for asthma are significantly higher. Hailsham & Polegate has a significantly higher prevalence of COPD (not age-standardised) and Seaford has significantly lower emergency admissions due to COPD. Mortality from respiratory conditions is similar to East Sussex.

Diabetes

The CCG has a similar prevalence of diabetes (not age-standardised) and emergency admissions for diabetes compared to East Sussex. In Hailsham & Polegate and Seaford localities, the prevalence of diabetes is significantly higher than in East Sussex, and in Seaford emergency admissions for diabetes are significantly higher.

Other chronic conditions

Across the CCG the prevalence of CKD (not age-standardised) is significantly higher than in East Sussex.

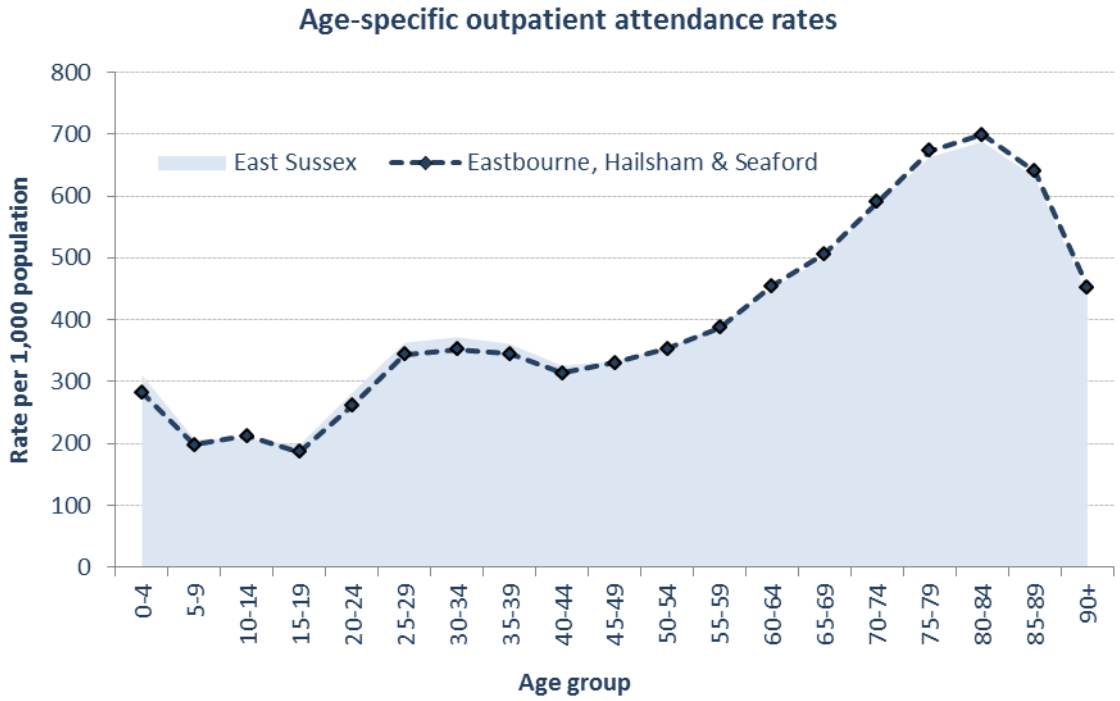
Avoidable admissions

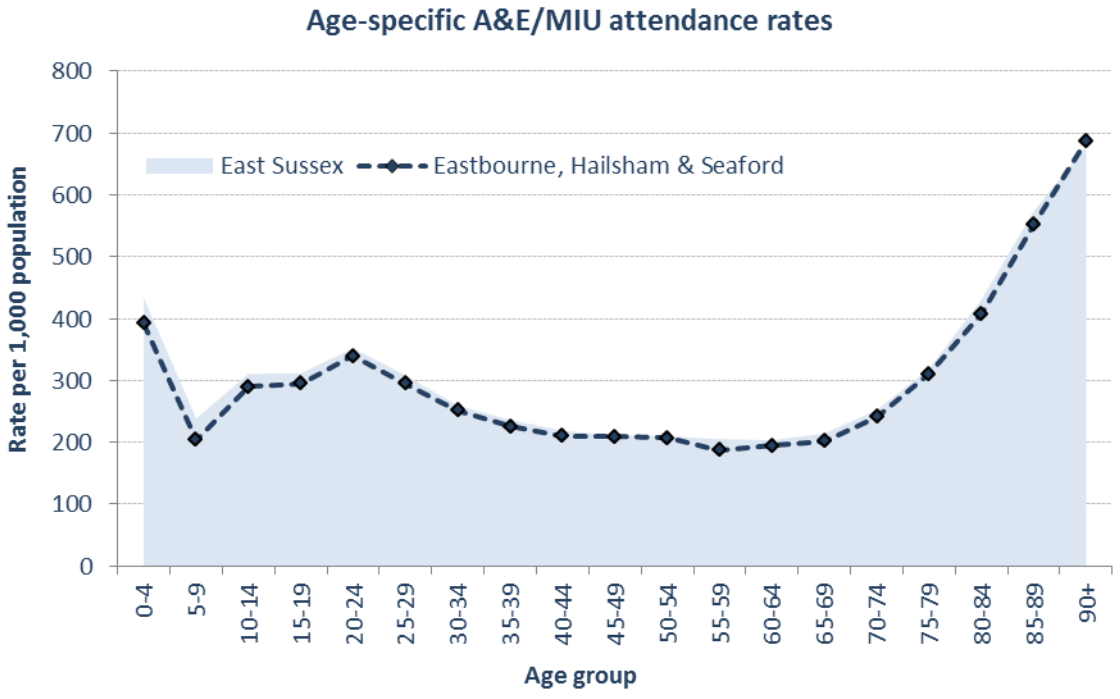
This CCG has the highest emergency admissions for acute ACS conditions (significantly higher than East Sussex) and for diabetes/epilepsy/asthma in under 20s. This is because Eastbourne has the highest emergency admissions for acute ACS conditions and for diabetes/epilepsy/asthma in under 20s of all East Sussex localities, and in both cases significantly higher than East Sussex.

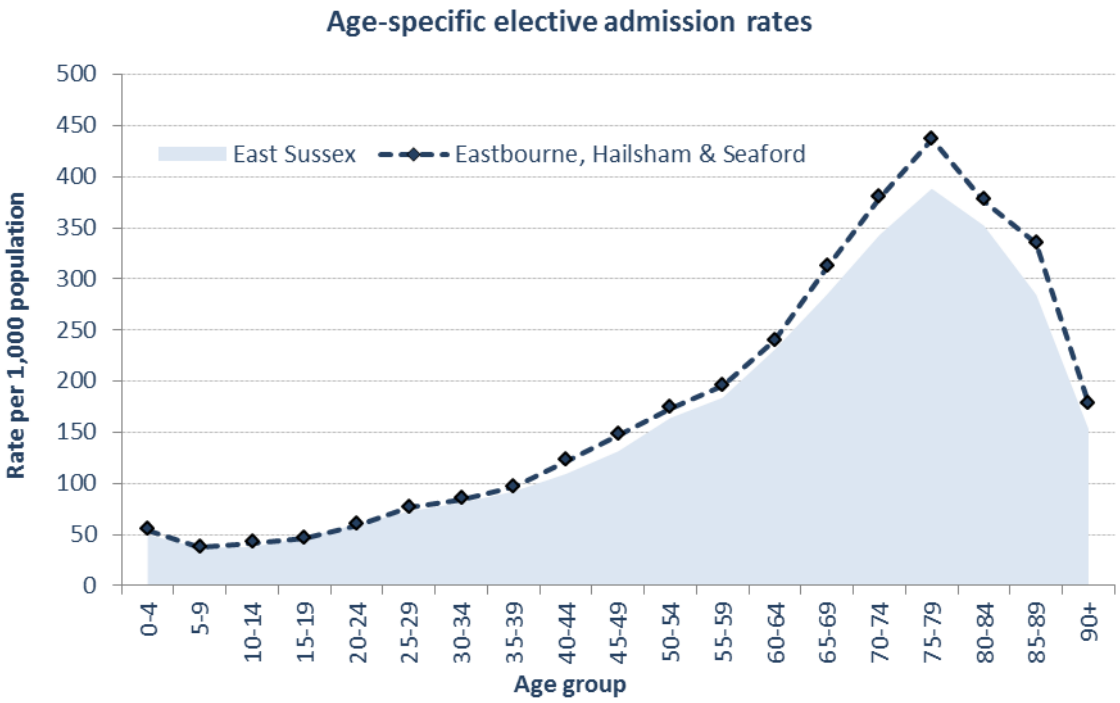
Hospital admissions and attendances

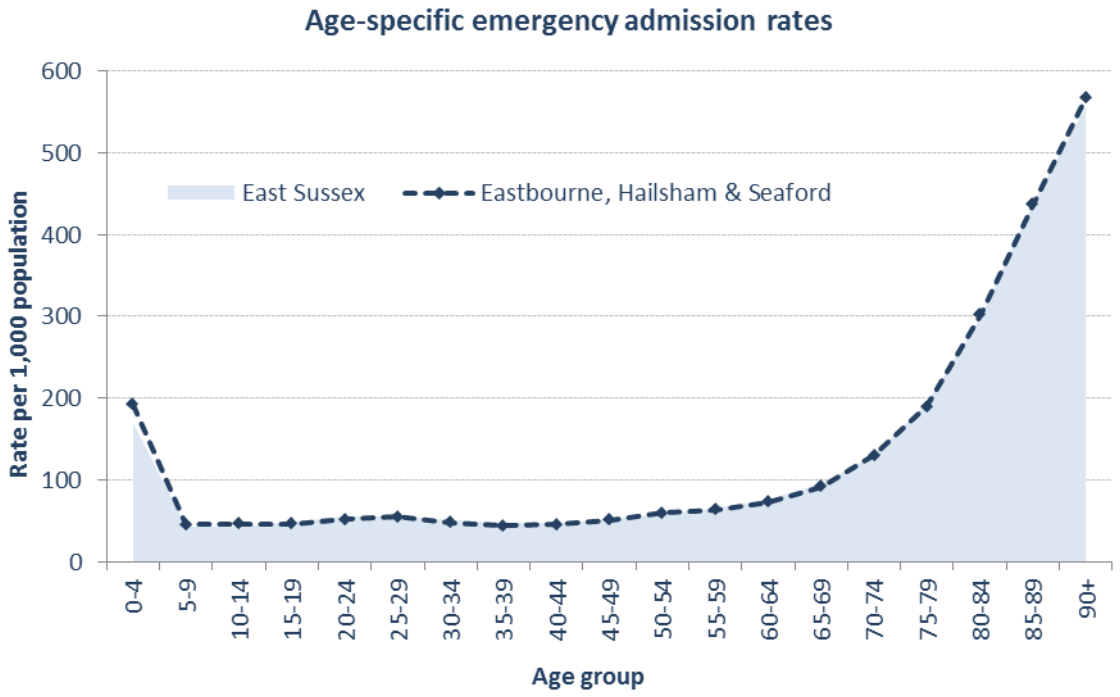
MIU/A&E attendances are significantly lower across the CCG for all ages. Elective admissions are significantly higher across the CCG and emergency admissions are similar to East Sussex for the CCG overall, but significantly higher in Eastbourne locality.

The following graphs present the age-specific overall attendance and admission rates for the CCG compared to East Sussex.









Social care

Children's services

The CCG is similar to East Sussex for referrals to children's social care, children on child protection plans and looked after children. Eastbourne locality is significantly higher for looked after children.

Carers

Compared to East Sussex Eastbourne is slightly lower for people providing one hour or more of unpaid care per week and Seaford is slightly higher. Seaford is significantly lower for unpaid carers providing 20 hours or more care per week and Eastbourne is significantly higher. Seaford is significantly lower for working age people claiming Carers Allowance. Across the CCG carers known to adult social care and those receiving a service or receiving self-directed support are all similar to East Sussex.

Adult social care

Compared to East Sussex, requests for ASC support are significantly higher in Hailsham & Polegate and Seaford. The rate of adults receiving direct payments is significantly lower in Seaford and the rate of older people receiving long term support is significantly higher in Eastbourne and Hailsham & Polegate. Rates of adults receiving ASC funded lifeline or telecare are significantly higher across the CCG.

NHS dental services

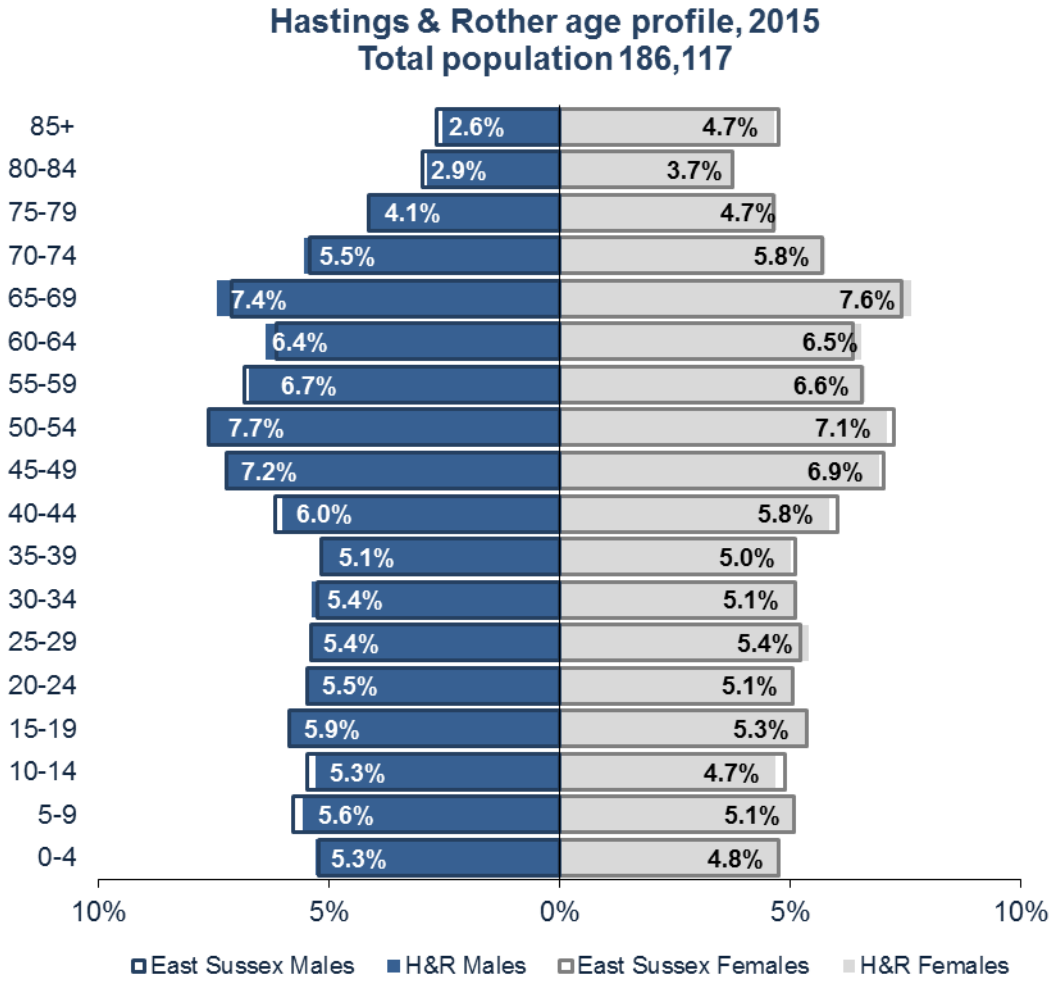
Compared to East Sussex, a significantly higher percentage of children in Seaford, and residents of all ages in Hailsham & Polegate, but significantly lower percentages of older people in Eastbourne, access East Sussex NHS general dental services.

GP patient survey

In Hailsham & Polegate and Seaford the percentage of patients responding to the GP Patient Survey is significantly higher than in East Sussex. The percentage of patients reporting a good experience of making appointments and satisfaction with opening hours is significantly better in Eastbourne and significantly worse in Hailsham & Polegate. Seaford is also significantly better for patients reporting a good experience of their surgery and that GPs involve them in decisions on care.

Hastings and Rother CCG

Population



Within the CCG Hastings & St Leonards has one of the largest and Rural Rother one of the smallest populations of all East Sussex localities. The CCG has an overall population age profile similar to East Sussex, but Hastings & St Leonards has one of the highest percentages of working age people of all East Sussex localities, and one of the lowest percentages of older people, whereas Bexhill and Rural Rother have some of the lowest percentages of working age people and some of the highest percentages of older people, of all East Sussex localities.

The dependency ratio (of non-working age people compared to working age people) for the CCG is similar to East Sussex. But within the CCG Hastings & St Leonards has the lowest and Bexhill has the highest dependency ratio, and the highest of all East Sussex localities.

Overall the CCG has similar levels of non-white British people and children who speak English as an additional language to East Sussex. But within the CCG Hastings & St Leonards has significantly higher levels, and higher than most other East Sussex localities, whereas Bexhill has similar levels to East Sussex and Rural Rother has the lowest of all localities.

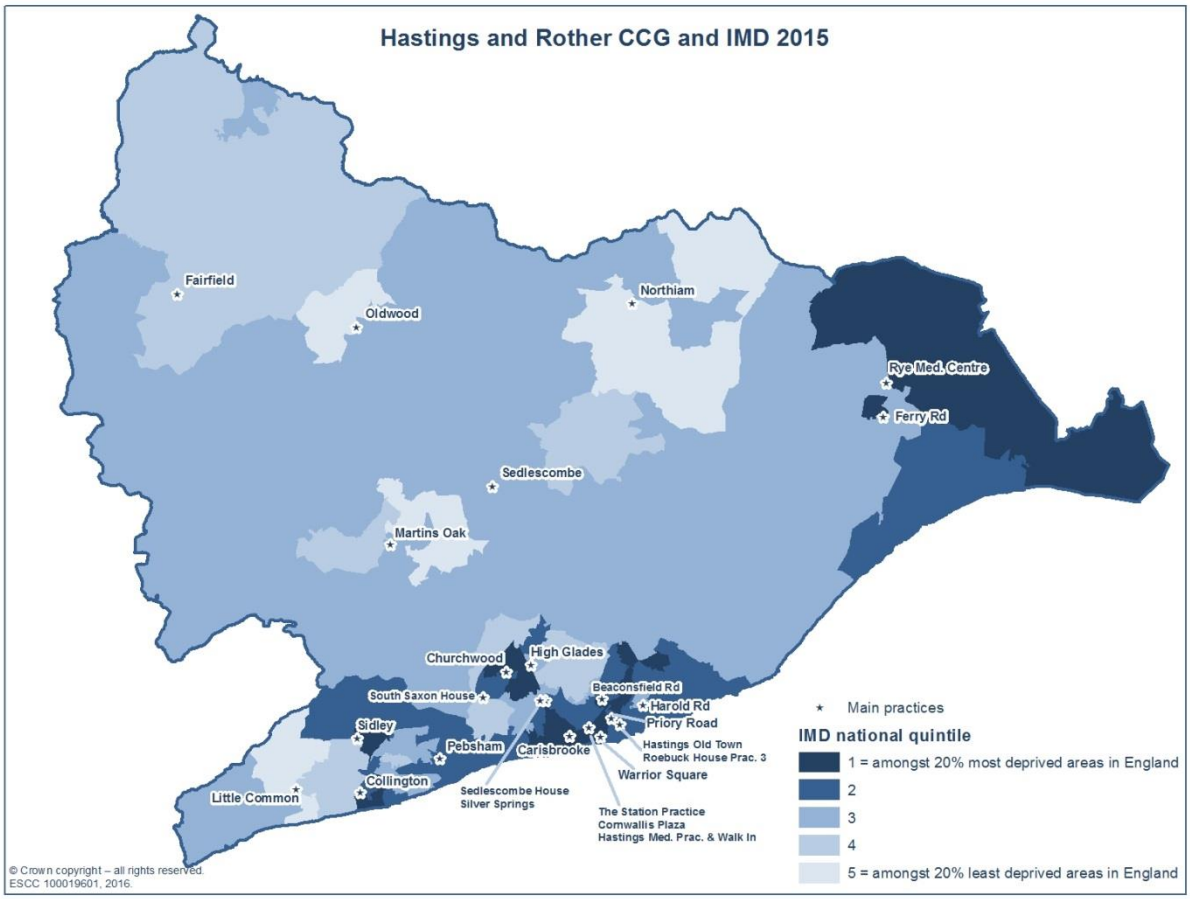
The CCG has similar birth rates to East Sussex. However Hastings & St Leonards has the highest birth rate for teenage mothers and Rural Rother has one of the lowest. The CCG has a significantly higher percentage of lone parent households than East Sussex, with Hastings & St Leonards having the highest and Rural Rother amongst the lowest of all East Sussex localities.

Table 2 shows the estimated population changes between 2015 and 2021 for specific age groups as well as all ages. Using projections modelled from East Sussex districts and boroughs, the table shows that over the next 6 years some age groups are projected to increase in size whilst others will decrease in size. The net effect is that the population of the CCG is estimated to increase, with the largest estimated increase in those aged 65 years and over.

Table 2: Population projections for all persons (number and percentage change) showing the increase (positive) or decrease (negative) from 2015 to 2021 (modelled)

Population projections from 2015 to 2021				
	East Sussex		Hastings and Rother CCG	
Population Change	Number	%	Number	%
0-19 years	900	0.8%	-300	-0.7%
20-64 years	-2,100	-0.7%	-1,600	-1.6%
65+ years	14,600	11.0%	4,750	10.4%
85+ years	3,200	15.8%	700	10.2%
All Ages	13,500	2.6%	2,800	1.6%

Wider determinants



The CCG has the highest income and employment deprivation of all East Sussex CCGs, including income deprivation affecting children and income deprivation affecting older people. Compared to East Sussex, income and employment deprivation is significantly lower in Rural Rother but significantly higher in both Bexhill and Hastings & St Leonard, with Hastings & St Leonards consistently the highest of all East Sussex localities. The CCG also has the highest percentage of households in fuel poverty. In both Hastings & St Leonards (which has the highest levels of all East Sussex localities) and in Rural Rother fuel poverty is significantly higher than in East Sussex, whereas in Bexhill it is significantly lower.

This CCG has the highest rates of children receiving the pupil premium, working age people claiming ESA, JSA and UC, and working age people with no or low qualifications. Hastings & St Leonards generally has the highest, and Bexhill amongst the highest, rates of all East Sussex localities for these indicators. Hastings & St Leonards also has amongst the highest rates for children with SEN on SEN Support, SEN or an EHCP, and young people NEET.

In this CCG a significantly higher percentage of households are rented and a significantly lower percentage are owned than in East Sussex. There are also significantly higher rates of overcrowded households and households with no central heating. Although Bexhill has significantly lower percentages of rented households, and of overcrowded households and households with no central heating, than East Sussex, Hastings & St Leonards has significantly and often substantially higher percentages. The CCG has a significantly higher rate of people living in care homes and Bexhill has the highest rate of all East Sussex localities.

This CCG has the highest rates of recorded crimes and incidents of anti-social behaviour, and emergency admissions due to violence. This is driven by Hastings & St Leonards which has the highest rates of all East Sussex localities for these three indicators. Bexhill and Rural Rother have significantly lower rates of recorded crime than East Sussex.

Overall health status

Self-reported ill-health and LLTI or disability, life expectancy, premature and preventable mortality, are all significantly worse than for East Sussex and the worst of the three CCGs. Hastings & St Leonards ranks worst or second worst of all localities for almost all these indicators and Bexhill has the highest levels of self-reported ill-health and LLTI or disability. Rural Rother is the only locality in the CCG with significantly better life expectancy at birth and premature mortality than East Sussex.

Healthy lifestyles

Pregnancy and infancy

This CCG has the highest percentage of low-birth weight babies and the lowest percentage of mothers initiating breastfeeding and breastfeeding at 6-8 weeks. Hastings & St Leonards and Bexhill have the worst breastfeeding rates of all localities and Bexhill has the highest percentage of low-birth weight babies.

Physical activity and excess weight

Hastings & St Leonards and Bexhill have the highest levels of all localities of overweight or obese reception year and year 6 children, respectively, so this CCG ranks worst for these indicators. Hastings Borough has the lowest level of adults achieving 150 minutes physical activity per week, and Rother District has the highest percentage of overweight or obese adults, of all districts/boroughs.

Smoking

This CCG has the highest levels of smokers and smoking quitters, and significantly higher than East Sussex. Although Bexhill is broadly similar to East Sussex, and Rural Rother somewhat better, Hastings & St Leonards is amongst the worst of all localities for these indicators. Hastings Borough has the highest smoking-attributable mortality and significantly higher than East Sussex (whereas Rother District is similar to East Sussex).

Alcohol and drug misuse

This is the worst CCG for most alcohol and drug misuse indicators. This is because, even though Bexhill and Rural Rother are broadly similar to or better than East Sussex, Hastings & St Leonards is much the worst of all East Sussex localities.

Sexual health

This CCG has the highest chlamydia detection rates and the lowest gonorrhoea detection rate. Although in Rother District the under 18s conception rate and the chlamydia detection rates are not significantly different to the East Sussex rates, in Hastings Borough these are significantly higher (except for chlamydia detection in 15-24 year olds) and the highest of all districts/boroughs. Rother has the lowest gonorrhoea detection rate of all districts/boroughs.

Accidents and injuries

This CCG has the highest A&E attendance and emergency admissions rates for accidents and injuries in 0-4 year olds of the three CCGs, and significantly higher rates than East Sussex. This is because Hastings & St Leonards and Bexhill have the highest rates of all East Sussex localities. Emergency admissions rates for accidents and injuries in 5-14 year olds are similar to East Sussex for all localities in HR CCG. But the CCG has the highest rate for 15-24 year olds because of the substantially and significantly higher rate in Hastings & St Leonards than in all other localities. The emergency admissions rate for falls injuries in older people is similar to East Sussex but significantly lower in Rural Rother locality. Hastings Borough has a significantly lower rate of people killed or seriously injured on the roads than East Sussex, but Rother District has a significantly higher rate and the highest of all the districts and boroughs.

Health protection

This CCG is significantly better than East Sussex for eligible people receiving an NHS health check, but whilst Bexhill and Hastings & St Leonards are the highest of all East Sussex localities, Rural Rother is significantly worse than East Sussex. The uptake of screening for cervical, breast and bowel cancers is significantly worse for

Hastings & St Leonards but significantly better or similar to East Sussex for the rest of the CCG.

In this CCG child immunisation rates by age 1, age 2 and age 5 are similar to East Sussex. But for immunisation by age 5 Bexhill has significantly better uptake than East Sussex and Hastings & St Leonards has significantly worse. The CCG also has similar seasonal flu and pneumococcal vaccination uptake to East Sussex for persons aged 65 years or over, but within the CCG it is highest in Bexhill, similar to East Sussex in Rural Rother and lowest in Hastings & St Leonards.

Disease and poor health

Mental health and wellbeing

This CCG has the highest incidence of depression, prevalence of severe mental illness and rate of working age people claiming ESA due to mental health problems. This is driven by the significantly higher rates in Hastings & St Leonards and Bexhill compared to East Sussex (even though rates in Rural Rother are significantly lower than in East Sussex). This CCG has the highest emergency admissions due to mental health, self-harm, and for persons with severe mental illness, and significantly higher rates than East Sussex. These rates are significantly higher in Hastings & St Leonards, but similar to East Sussex in Bexhill and (mostly) significantly lower in Rural Rother. This CCG has the highest CAMHS caseload, with a significantly higher rate than East Sussex in Bexhill, which has the highest rate of all localities. Within the CCG mortality from suicide is similar to East Sussex. For dementia indicators this CCG is similar to East Sussex. But the prevalence of dementia (not age-standardised) is significantly higher in Bexhill and significantly lower across the rest of the CCG than in East Sussex. Emergency admissions for persons with dementia are significantly higher and the highest of all localities in Hastings & St Leonards, but significantly lower and the lowest of all in Rural Rother. Across most mental health indicators Hastings & St Leonards has the highest rates of all localities.

Circulatory

Compared to East Sussex, this CCG has similar or significantly higher prevalences of most circulatory conditions (not age-standardised). Bexhill has the highest prevalences of all localities for most circulatory conditions and significantly higher than East Sussex, whereas in Hastings & St Leonards the prevalences tend to be significantly lower and in Rural Rother they are mostly similar to East Sussex. The CCG has similar emergency admissions for CHD and stroke as East Sussex, but Hastings & St Leonards has significantly higher emergency admissions for CHD. The CCG has the highest premature mortality from circulatory diseases, driven especially by Hastings & St Leonards which has significantly higher mortality than East Sussex and the highest of all localities.

Cancer

The CCG has similar incidence and mortality to East Sussex for colorectal, breast and prostate cancers and similar premature mortality from cancer. But Hastings Borough has a significantly higher incidence and mortality for lung cancer, and premature mortality from cancer, than East Sussex.

Respiratory

The prevalence of asthma (not age-standardised) is significantly lower in this CCG than in East Sussex. At locality level it is significantly lower in Hastings & St Leonards and similar to East Sussex in Rural Rother, but significantly higher in Bexhill. The CCG has significantly higher emergency admissions due to asthma (and emergency admissions per 1,000 registered asthmatics) than East Sussex, because Hastings & St Leonards rates are significantly higher and the highest of all localities. HR CCG has a significantly higher prevalence (not age-standardised), emergency admissions and mortality for COPD, and premature mortality from respiratory diseases, than East Sussex. The prevalence of COPD (not age-standardised) is significantly higher in Bexhill and Hastings & St Leonards than East Sussex, and significantly lower in Rural Rother. In Hastings & St Leonards emergency admissions for COPD, mortality from COPD and premature mortality from respiratory diseases are all significantly higher and the highest of all localities (or second highest in the case mortality from COPD).

Diabetes

This CCG has the highest prevalence of diabetes (not age-standardised). Bexhill has the highest rate of all localities and both Bexhill and Hastings & St Leonards have significantly higher rates than East Sussex. Emergency admissions for diabetes are similar to East Sussex across the CCG.

Other chronic conditions

The CCG has a significantly higher prevalence of epilepsy (not age-standardised) than East Sussex. Bexhill and Hastings & St Leonards have significantly higher prevalences than East Sussex and the highest of all localities.

Hastings & St Leonards also has the highest premature mortality from liver disease and prevalence of adults with learning disabilities of all localities, whilst the rest of the CCG is similar to East Sussex.

Avoidable admissions

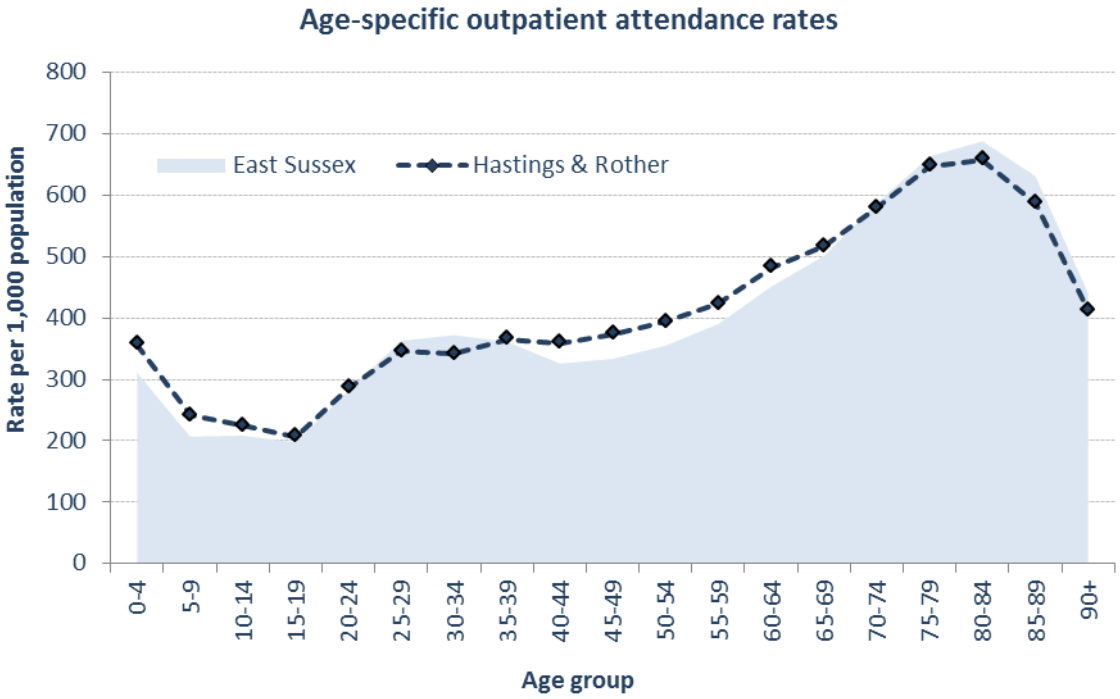
This CCG has significantly higher emergency admissions for chronic ACS conditions than East Sussex, but similar levels of other avoidable emergency admissions. However, within the CCG Hastings & St Leonards has significantly higher emergency admissions for diabetes, epilepsy or asthma in under 20s, and for ACS conditions (chronic, acute and other/vaccine preventable), whereas Rural Rother has significantly lower emergency admissions than East Sussex for all ACS conditions.

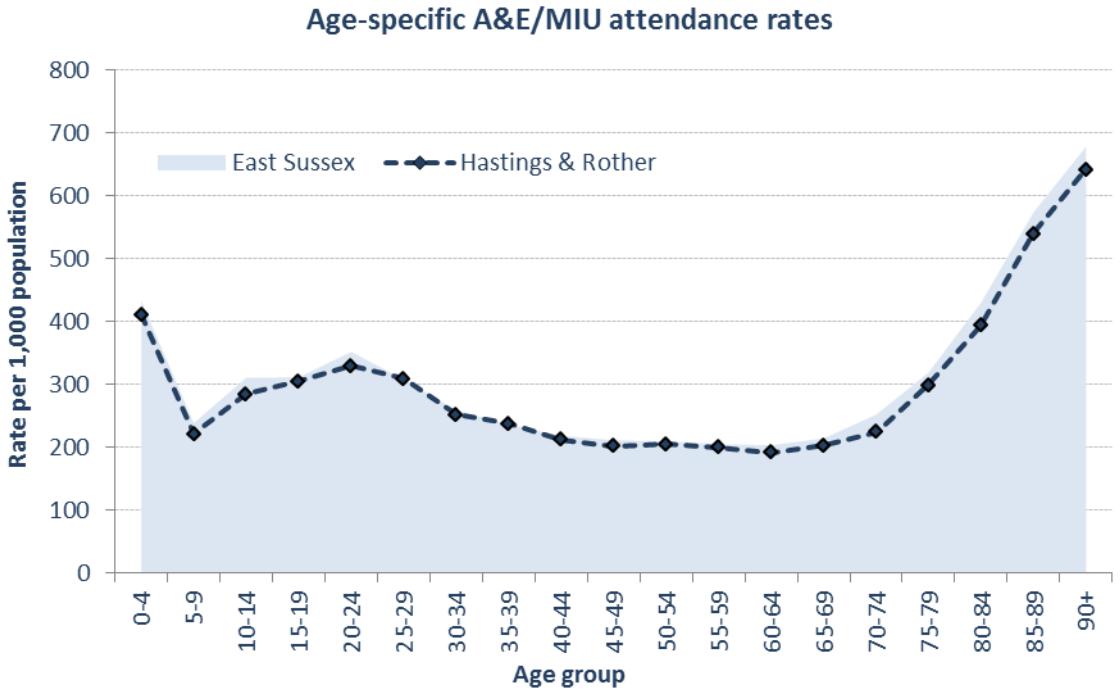
Hospital admissions and attendances

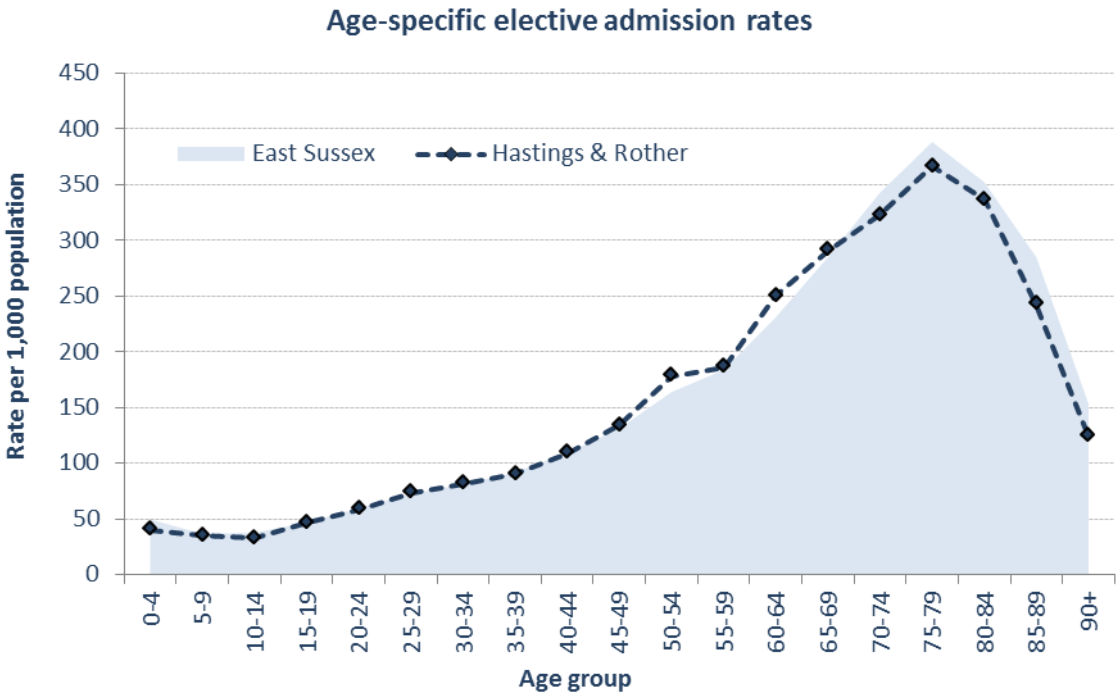
Compared to East Sussex the CCG has higher outpatient attendances, lower MIU/A&E attendances, similar elective admissions and higher emergency admissions. Hastings & St Leonards has significantly higher rates than East Sussex for all these indicators except MIU/A&E attendances for under 5s, all elective admissions and elective admissions for over 65s. It is the second highest locality for outpatient attendances, highest for outpatient DNAs and is the highest for emergency admissions for all ages, ages 70-84 and 85+. In contrast Rural Rother

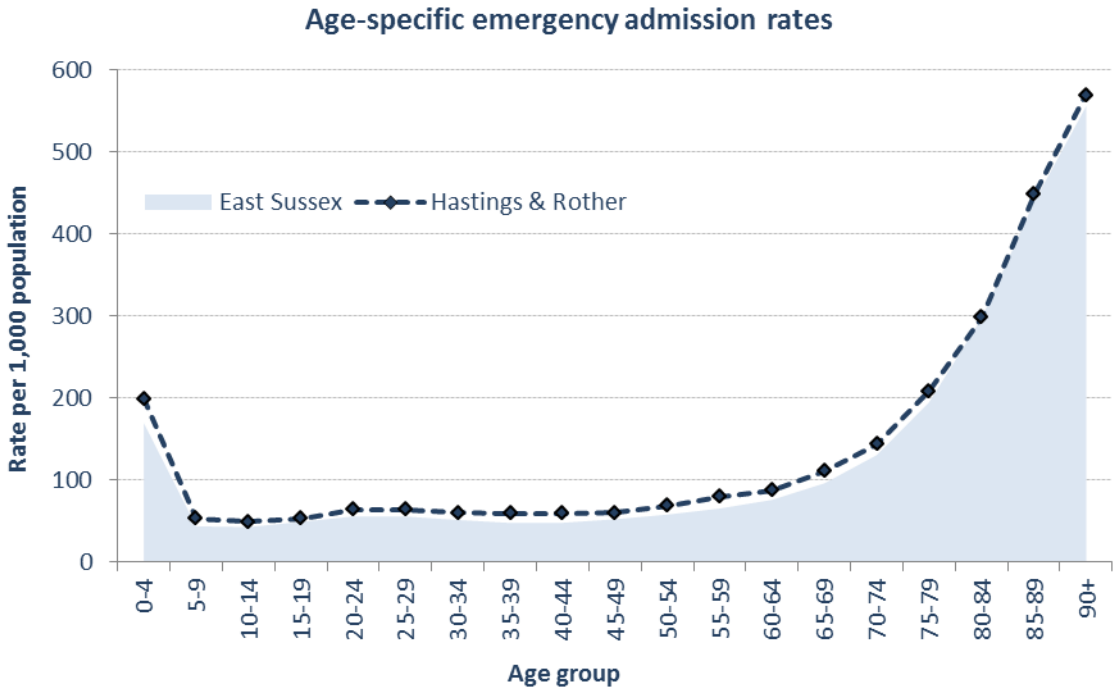
has significantly lower rates than East Sussex for almost all these hospital admissions and attendances indicators.

The following graphs present the age-specific overall attendance and admission rates for the CCG compared to East Sussex.









Social care

Children's services

The CCG is significantly higher for referrals to children's social care, children on child protection plans and looked after children. This is driven by significantly higher rates in Hastings & St Leonards locality.

Carers

Bexhill and Rural Rother are significantly higher for people providing one hour or more of unpaid care per week and Hastings & St Leonards slightly lower. In Bexhill and Hastings & St Leonards unpaid carers providing 20 hours or more per week, working age people claiming Carers Allowance, carers known to adult social care and those receiving self-directed support are significantly higher than East Sussex.

Adult social care

Compared to East Sussex Hastings & St Leonards and Bexhill are significantly higher for requests for ASC support, adults receiving direct payments, self-directed support, long term support for working age people and adults in council supported residential or nursing care. Bexhill is also significantly higher for adults receiving community equipment and ASC funded lifeline or telecare. Hastings & St Leonards is significantly higher for older people receiving long term support and, along with Rural Rother, also for older people discharged from hospital into intermediate care. Compared to East Sussex Rural Rother is significantly lower for adults receiving self-direct support, working age people receiving long term support, working age people with learning disabilities in settled accommodation and adults in council supported residential or nursing care.

NHS dental services

Compared to East Sussex, slightly lower percentages of children, but significantly higher percentages of working age people, in Bexhill and Hastings & St Leonards, and significantly higher percentages of older people across the CCG, access East Sussex NHS general dental services.

GP patient survey

The percentages of patients responding to the GP Patient Survey are significantly higher than for East Sussex in Bexhill and Rural Rother, and significantly lower in Hastings & St Leonards. For Rural Rother significantly higher percentages of patients report a good experience of their surgery, of making an appointment and satisfaction with opening hours than for East Sussex. For Hastings & St Leonards significantly lower percentages of patients report a good experience of their surgery and of GPs involving them in decisions on care, whereas significantly higher percentages report the nurse was good at involving them in decisions on care.

Annex 1: Scorecard Summary Tables

Significantly worse than East Sussex	Significantly better than East Sussex	Significantly higher than East Sussex	Significantly lower than East Sussex	Not significantly different to East Sussex	Significance not tested

Population															
Ref	Indicator	East Sussex	EHS CCG	H&R CCG	HWLH CCG	Eastbn.	Hailsham & Polegate	Seaford	Bexhill	Hastings & St Leonards	Rural Rother	Crowbr.	Havens	Lewes	Uckfield
1.11	Dependency ratio, Oct 2015	0.69	0.72	0.69	0.66	0.67	0.78	0.86	0.89	0.59	0.76	0.69	0.65	0.64	0.65
1.12	Lone older person (aged 65+) households (%), 2011 (M)	16	18	16	14	17	17	20	22	13	17	14	15	15	14
1.13	Lone parent households (%), 2011 (M)	6	6	7	6	7	6	5	5	8	5	5	7	6	5
1.14	Non-White British population (%), 2011 (M)	8	9	8	7	12	6	6	6	10	5	8	8	8	5
1.15	Non-White British pupils (%), 2016 (M)	12	15	12	10	18	10	10	12	14	7	9	12	11	8
1.16	Pupils with English as an additional language (per 1,000), 2016 (M)	57	80	55	31	108	36	33	57	68	15	27	48	28	25
1.18	Live births per 1,000 women aged 15-44 yrs, 2014-15	59	61	61	54	60	68	55	55	64	58	50	65	48	56
1.19	Live births per 1,000 women aged 15-19 yrs, 2014-15	13	15	17	7	18	13	8	15	21	7	5	16	3	8
1.20	Live births per 1,000 women aged 35-44 yrs, 2014-15	34	35	33	35	34	34	37	28	32	38	36	33	39	34

Wider determinants - Economy, income and transport															
Ref	Indicator	East Sussex	EHS CCG	H&R CCG	HWLH CCG	Eastbn.	Hailsham & Polegate	Seaford	Bexhill	Hastings & St Leonards	Rural Rother	Crowbr.	Havens	Lewes	Uckfield
2.02	Income Deprivation (as a percentage), from ID 2015 (M)	13	13	18	9	14	12	10	15	22	11	6	15	9	7
2.04	Children in low-income families (%), Aug 2014 (M)	19	19	25	12	20	19	14	23	28	16	9	21	12	9
2.05	Income Deprivation Affecting Older People Index (IDAOPI) (as a percentage), from ID 2015 (M)	15	15	18	10	16	13	10	15	23	12	8	16	10	9
2.06	Households in fuel poverty (%), 2014 (M)	9	8	10	9	8	7	7	8	12	11	9	7	11	8
2.07	Pupils receiving the pupil premium (%), Jan 2016 (M)	21	20	27	14	22	19	17	24	30	19	9	24	14	11
2.08	Households with dependent children and no adults in employment (%), 2011 (M)	13	12	17	9	13	11	10	16	20	10	6	14	9	7
2.09	Employment Deprivation (as a percentage), from ID 2015 (M)	11	12	15	7	13	10	9	14	18	9	5	12	7	6
2.10	Working age people claiming JSA and Universal Credit (%), Aug 2016 (M)	1.4	1.4	1.8	0.8	1.6	1.1	1.0	1.6	2.2	0.8	0.4	1.5	0.8	0.5
2.11	Working age people claiming ESA (%), Aug 2016 (M)	6.2	6.3	8.3	3.9	6.9	5.5	5.1	7.6	9.8	4.7	2.6	6.6	3.7	3.4
2.12	Households with no cars or vans (%), 2011 (M)	22	24	26	15	27	18	20	24	32	14	9	22	18	11
2.13	Households able to access a GP practice in 15 min by public transport/walking (%), 2014 (M)	78	81	86	65	84	84	66	91	90	69	60	83	67	53

Wider determinants - Education															
Ref	Indicator	East Sussex	EHS CCG	H&R CCG	HWLH CCG	Eastbn.	Hailsham & Polegate	Seaford	Bexhill	Hastings & St Leonards	Rural Rother	Crowbr.	Havens	Lewes	Uckfield
2.16	Pupils (at age 5) reaching a good level of development in the EYFS (%), Jun 2016 (M)	75	75	75	76	74	77	77	75	75	74	74	69	80	80
2.17	Pupils (at age 11) achieving the expected standard at Key Stage 2, Jun 2016 (M)	50	52	49	49	51	51	58	47	50	46	49	54	48	48
2.18	Average GCSE Attainment 8 score for pupils (at age 16) at Key Stage 4, Jun 2016 (M)	49	49	47	52	49	48	52	47	46	50	54	47	53	53
2.19	Working age population with no or low qualifications (%), 2011 (M)	30	30	34	27	30	32	29	33	36	30	23	36	23	27
2.20	Pupils with special educational needs (SEN) on SEN Support (per 100,000), Jan 2016 (M)	90	82	98	88	82	86	77	96	103	87	73	109	100	76
2.21	Pupils with a statement of SEN or an EHCP (per 100,000), Jan 2016 (M)	36	34	40	33	34	34	37	40	41	36	28	39	31	34
2.22	Young people aged 16-18 yrs NEET (monthly rate per 1,000), Nov 2015 to Jan 2016 (M)	32	35	35	24	40	32	22	23	42	30	16	48	20	22

Wider determinants - Housing															
Ref	Indicator	East Sussex	EHS CCG	H&R CCG	HWLH CCG	Eastbn.	Hailsham & Polegate	Seaford	Bexhill	Hastings & St Leonards	Rural Rother	Crowbr.	Havens	Lewes	Uckfield
2.25	Households that are overcrowded (%), 2011 (M)	7	8	7	5	9	5	5	6	9	4	4	7	5	4
2.26	Households with no central heating (%), 2011 (M)	2.8	2.5	3.7	2.2	2.8	2.1	1.8	2.4	4.5	3.4	1.9	2.5	2.6	2.0
2.27	Households owned outright or with a mortgage/loan (%), 2011 (M)	69	69	64	75	64	77	78	72	57	74	78	72	69	78
2.28	Socially rented households (%), 2011 (M)	11	11	12	10	12	10	7	9	14	12	8	10	14	8
2.29	Privately rented households (%), 2011 (M)	18	18	22	13	22	11	13	17	28	12	11	16	14	12
2.30	Persons living in care homes with nursing (%), 2011 (M)	0.5	0.5	0.6	0.3	0.4	0.5	0.6	1.1	0.4	0.3	0.3	0.2	0.3	0.5
2.31	Persons living in care homes without nursing (%), 2011 (M)	0.8	0.9	1.0	0.6	0.9	0.8	1.0	1.3	1.0	0.8	0.7	0.5	0.5	0.6

Wider determinants - Crime															
Ref	Indicator	East Sussex	EHS CCG	H&R CCG	HWLH CCG	Eastbn.	Hailsham & Polegate	Seaford	Bexhill	Hastings & St Leonards	Rural Rother	Crowbr.	Havens	Lewes	Uckfield
2.33	Recorded crimes (per 1,000 population), 2015/16 (M)	51	51	64	36	60	39	36	48	82	38	28	50	42	28
2.34	Recorded incidents of Anti-Social Behaviour (per 1,000 population), 2015/16 (M)	24	25	31	17	30	17	18	25	40	15	12	25	20	12
2.35	A&E attendances by 15-59 yr olds for assaults, 8pm-4am (per 1,000), 2013/14 to 2015/16	1.4	1.7	1.6	1.0	2.1	1.1	1.2	1.3	1.8	1.1	0.7	2.1	0.7	0.8
2.36	Emergency admissions for violence (SAR), 2013/14 to 2015/16	100	85	138	74	94	68	75	89	179	77	78	130	53	44

Overall health status															
Ref	Indicator	East Sussex	EHS CCG	H&R CCG	HWLH CCG	Eastbn.	Hailsham & Polegate	Seaford	Bexhill	Hastings & St Leonards	Rural Rother	Crowbr.	Havens	Lewes	Uckfield
4.01	People reporting that their health is bad or very bad (%), 2011 (M)	6	6	7	4	6	6	6	8	7	5	4	7	4	4
4.02	People reporting a limiting long-term health problem or disability (%), 2011 (M)	20	21	23	16	21	21	23	27	22	20	15	21	16	16
4.04	Life expectancy at birth (yrs), 2013-15	82.3	82.3	81.3	83.6	82.1	82.3	83.2	81.2	80.4	83.4	84.9	81.8	84.8	82.6
4.05	Life expectancy at age 75 (yrs), 2013-15	12.9	13.0	12.5	13.2	12.8	13.1	13.4	12.4	12.0	13.5	14.1	13.0	14.5	11.7
4.07	Premature all-cause mortality (SMR), 2013-15	100	102	113	82	105	106	90	112	129	83	72	117	71	80
4.08	Mortality from causes considered preventable (SMR), 2014-15	100	100	117	80	101	113	78	116	131	89	64	125	69	79

Healthy Lifestyles - Pregnancy and infancy															
Ref	Indicator	East Sussex	EHS CCG	H&R CCG	HWLH CCG	Eastbn.	Hailsham & Polegate	Seaford	Bexhill	Hastings & St Leonards	Rural Rother	Crowbr.	Havens	Lewes	Uckfield
3.01	Low birth weight (%), 2014-15	6	6	6	5	7	5	5	7	7	5	5	6	6	4
3.02	Breastfeeding initiation (%), 2014/15	79	79	73	85	78	78	88	72	71	80	87	79	89	87
3.03	Breastfeeding prevalence at 6-8 weeks after birth (%), 2015/16 (M)	52	51	46	61	50	48	65	46	43	57	66	48	72	59
4.09	Infant mortality (per 1,000 live births), 2014-15	3.5	4.1	3.4	3.0	6.0				4.1				8.4	

Healthy Lifestyles - Physical activity and excess weight															
Ref	Indicator	East Sussex	EHS CCG	H&R CCG	HWLH CCG	Eastbn.	Hailsham & Polegate	Seaford	Bexhill	Hastings & St Leonards	Rural Rother	Crowbr.	Havens	Lewes	Uckfield
3.04	Adults achieving 150+ minutes physical activity per week (%), 2015	59													
3.05	Excess weight in 4-5 year olds (%), 2012/13-2014/15 (M)	21	21	23	19	22	20	17	21	24	20	17	23	19	19
3.06	Excess weight in 10-11 year olds (%), 2012/13-2014/15 (M)	30	32	33	26	33	30	30	35	33	30	23	32	21	27
3.07	Excess weight in Adults (%), 2012/13-2014/15	64.5													

Healthy Lifestyles - Smoking															
Ref	Indicator	East Sussex	EHS CCG	H&R CCG	HWLH CCG	Eastbn.	Hailsham & Polegate	Seaford	Bexhill	Hastings & St Leonards	Rural Rother	Crowbr.	Havens	Lewes	Uckfield
3.09	GP reported prevalence of smoking aged 15+ (%), 2015/16	17	16	21	15	17	14	14	17	25	15	13	21	15	14
3.10	Smoking quitters at 4 weeks (per 100,000 aged 16+yrs), 2015/16	390	351	478	337	387	256	363	440	566	309	145	809	278	279
3.11	Mothers known to be smokers at the time of delivery (%), 2014/15	14	13	21	6	15	12	6	18	24	12	5	9	6	5
3.12	Smoking-attributable deaths in persons aged 35+ yrs (DSR per 100,000), 2012-2014	246													

Healthy Lifestyles - Alcohol and drug misuse															
Ref	Indicator	East Sussex	EHS CCG	H&R CCG	HWLH CCG	Eastbn.	Hailsham & Polegate	Seaford	Bexhill	Hastings & St Leonards	Rural Rother	Crowbr.	Havens	Lewes	Uckfield
3.13	Young people in drug or alcohol treatment (per 10,000 aged 0-18 yrs), Sep 14 to Aug 16 (M)	16	20	19	10	22	18	15	14	25	8	4	19	12	7
3.14	Adults aged 19+ in alcohol treatment (per 100,000), 2015/16 (M)	20	21	25	15	23	18	16	17	33	13	11	16	15	17
3.15	Alcohol-related admissions (DSR per 100,000), 2014/15	571	597	671	438										
3.16	Alcohol-related mortality (DSR per 100,000), 2014	42	40	50	36										
3.17	Adults aged 19+ in drug treatment (per 100,000), 2015/16 (M)	38	41	53	16	52	23	24	25	82	18	8	30	22	11

Healthy Lifestyles - Sexual health															
Ref	Indicator	East Sussex	EHS CCG	H&R CCG	HWLH CCG	Eastbn.	Hailsham & Polegate	Seaford	Bexhill	Hastings & St Leonards	Rural Rother	Crowbr.	Havens	Lewes	Uckfield
3.30	Under 18s conceptions (per 1,000 females aged 15-17), 2014	20													
3.31	Chlamydia detection rate in persons aged 15-24 (per 100,000), 2015	1,616	1,677	1,800	1,342										
3.32	Chlamydia detection rate in persons aged 25+ (per 100,000), 2015	89	85	109	72										
3.33	Gonorrhoea diagnostic rate (per 100,000), 2015	30	30	23	37										

Healthy Lifestyles - Accidents and injuries															
Ref	Indicator	East Sussex	EHS CCG	H&R CCG	HWLH CCG	Eastbn.	Hailsham & Polegate	Seaford	Bexhill	Hastings & St Leonards	Rural Rother	Crowbr.	Havens	Lewes	Uckfield
3.34	A&E attendances for accidents & injuries in 0-4 yr olds (per 10,000), 2015/16	1,326	1,427	1,621	860	1,534	1,402	906	1,701	1,708	1,228	555	1,261	894	827
3.35	Emerg'y admiss'ns for accidents & injuries in 0-4 yr olds (per 10,000), 2013/14 to 2015/16	168	165	219	113	170	155	164	208	231	193	124	109	109	105
3.36	Emerg'y admiss'ns for accidents & injuries in 5-14 yr olds (per 10,000), 2013/14 to 2015/16	91	72	97	106	71	81	57	84	97	111	102	108	133	84
3.37	Emerg'y admiss'ns for accidents and injuries in 15-24 yr olds (per 10,000), 2013/14 to 15/16	133	117	148	135	116	99	163	126	157	146	147	160	118	117
3.38	Emergency admissions for falls injuries for people aged 65+ (SAR), 2014/15 to 2015/16	100	103	98	98	105	100	103	97	105	87	111	99	78	96
3.39	People killed or seriously injured on East Sussex roads (per 100,000), 2012 to 2014	64													

Health protection - Health checks and screening															
Ref	Indicator	East Sussex	EHS CCG	H&R CCG	HWLH CCG	Eastbn.	Hailsham & Polegate	Seaford	Bexhill	Hastings & St Leonards	Rural Rother	Crowbr.	Havens	Lewes	Uckfield
3.18	Eligible people aged 40-74 who received an NHS Health Check (%), Apr 2013 to Mar 2016	33	34	37	27	36	29	37	47	38	26	30	29	18	29
3.19	Eligible women aged 25-64 screened for cervical cancer (%), at Mar 2015	75	75	75	76	74	79	77	75	74	77	74	77	78	77
3.20	Eligible women aged 50-70 screened for breast cancer (%), at Mar 2015	74	74	72	76	71	76	78	75	70	73	73	78	77	75
3.21	Eligible people aged 60-69 screened for bowel cancer (%), at Mar 2016	60	60	59	62	58	61	64	64	55	63	62	58	62	63

Health protection - Immunisation															
Ref	Indicator	East Sussex	EHS CCG	H&R CCG	HWLH CCG	Eastbn.	Hailsham & Polegate	Seaford	Bexhill	Hastings & St Leonards	Rural Rother	Crowbr.	Havens	Lewes	Uckfield
3.22	Children immunised for DTaP/IPV/Hib by age 1 (%), 2015/16	94	96	93	93	96	94	99	93	92	93	90	97	90	97
3.23	Children immunised for pneumococcal infection by age 2 (%), Apr 2015 to Dec 2016	93	93	92	93	94	88	95	94	92	90	91	96	90	94
3.24	Children immunised for Hib/MenC by age 2 (%), 2015/16	93	93	93	92	95	88	96	94	92	93	89	95	90	94
3.25	Children immunised for measles, mumps and rubella (MMR) by age 2 (%), 2015/16	93	92	94	91	93	88	95	94	94	93	87	95	90	94
3.26	Children immunised for DTaP/IPV/Hib by age 5 (%), 2015/16	89	90	88	90	89	92	91	93	86	88	85	94	87	95
3.27	Children immunised for measles, mumps and rubella (MMR) by age 5 (%), 2015/16	89	91	88	89	90	92	92	93	86	88	85	93	86	93
3.28	People aged 65+ receiving seasonal flu vaccination (%), Sep 2015 to Jan 2016	70	72	71	66	72	70	73	76	66	70	64	68	66	65
3.29	People aged 65+ ever receiving a pneumococcal vaccination (%), at 31 Mar 2016	69	67	72	65	68	65	69	78	69	70	64	74	61	64

Disease and poor health - Mental health															
Ref	Indicator	East Sussex	EHS CCG	H&R CCG	HWLH CCG	Eastbn.	Hailsham & Polegate	Seaford	Bexhill	Hastings & St Leonards	Rural Rother	Crowbr.	Havens	Lewes	Uckfield
4.10	GP reported incidence of depression in persons aged 18+ (%), 2015/16	10.4	11.4	10.4	9.2	12.3	10.6	8.9	10.8	11.3	7.9	8.9	11.5	8.3	8.7
4.11	GP reported prevalence of severe mental illness (%), 2015/16 (M)	1.1	1.1	1.3	0.9	1.1	0.9	1.1	1.3	1.5	0.7	0.8	1.1	1.0	0.7
4.12	Emergency admissions for mental and behavioural disorders (SAR), 2014/15 to 2015/16	100	102	120	75	109	88	96	112	144	75	53	109	89	65
4.13	Emergency admissions, people with severe mental illness (SAR), 2014/15 & 2015/16	100	93	126	79	91	105	79	104	164	62	53	143	80	63
4.14	Emergency admissions relating to self-harm (SAR), 2014/15 to 2015/16	100	92	125	82	91	88	103	105	146	88	61	149	65	71
4.15	GP reported prevalence of dementia (%), 2015/16	1.1	1.2	1.0	0.9	1.2	1.2	1.4	1.7	0.8	0.7	0.9	0.9	0.7	1.0
4.16	GP reported versus expected prevalence of dementia at age 65+ (ratio), 2014/15	61	64	60	59										
4.18	Emergency admissions, people with dementia (SAR), 2014/15 & 2015/16	100	103	104	90	103	101	105	101	128	70	83	114	76	94
4.19	CAMHS caseload (per 1,000 aged 0-18 yrs), Mar 2016	19	18	22	17	17	19	17	24	22	19	14	23	17	16
4.20	Working age people claiming ESA for mental health problems (per 1,000), Feb 2016 (M)	29	30	40	18	33	24	23	36	49	19	12	31	18	15
4.22	Mortality from suicide (SMR), 2012-15	100	107	102	90	94	139	109	77	128	63	104	125	41	89

Disease and poor health - Circulatory															
Ref	Indicator	East Sussex	EHS CCG	H&R CCG	HWLH CCG	Eastbn.	Hailsham & Polegate	Seaford	Bexhill	Hastings & St Leonards	Rural Rother	Crowbr.	Havens	Lewes	Uckfield
4.23	GP reported prevalence of hypertension (%), 2015/16	16.7	17.5	17.5	14.9	16.0	18.9	21.2	22.2	14.9	18.5	15.5	15.9	13.0	14.8
4.24	GP reported versus expected prevalence of hypertension (ratio), 2014/15	61	62	61	58	60	63	64	65	59	61	60	61	55	58
4.25	GP reported prevalence of high blood pressure without established CVD (%), 2015/16	1.3	1.2	1.3	1.3	1.2	1.6	0.7	1.6	1.2	1.2	1.4	1.1	1.1	1.5
4.26	GP reported prevalence of CHD (%), 2015/16	3.8	4.1	4.0	3.1	3.8	4.5	5.0	5.5	3.4	3.9	2.9	3.9	2.8	3.0
4.27	Emergency admissions for CHD (SAR), 2014/15 to 2015/16	100	103	108	86	105	99	102	108	118	92	55	146	90	80
4.28	Emergency admissions for CHD per 1,000 on GP CHD registers, 2015/16	55	50	60	55	49	49	55	54	66	59	38	77	57	52
4.29	GP reported prevalence of stroke or TIA (%), 2015/16	2.3	2.5	2.4	2.0	2.3	2.6	3.1	3.4	2.1	2.3	2.2	2.2	1.8	1.9
4.30	Emergency admissions for stroke (SAR), 2014/15 to 2015/16	100	105	99	95	102	104	117	92	109	91	83	119	96	93
4.31	Mortality from stroke (SMR), 2012-15	100	97	102	101	94	108	92	103	105	93	92	124	84	112
4.32	GP reported prevalence of atrial fibrillation (%), 2015/16	2.7	3.0	2.6	2.3	2.8	3.1	3.9	3.8	1.9	2.9	2.4	2.2	2.2	2.3
4.33	GP reported versus expected prevalence of atrial fibrillation (ratio), 2014/15	72	78	70	68	77	78	80	74	64	72	71	68	66	67
4.34	GP reported prevalence of heart failure (%), 2015/16	1.0	1.1	1.0	0.7	1.0	1.4	1.1	1.4	0.9	0.8	0.7	0.9	0.7	0.7
4.36	Premature mortality from circulatory diseases (SMR), 2012-15	100	104	117	76	105	104	99	110	136	86	71	126	66	57

Disease and poor health - Cancer															
Ref	Indicator	East Sussex	EHS CCG	H&R CCG	HWLH CCG	Eastbn.	Hailsham & Polegate	Seaford	Bexhill	Hastings & St Leonards	Rural Rother	Crowbr.	Havens	Lewes	Uckfield
4.38	Incidence of all cancers (DSR per 100,000), 2012-2014	584	576	593	587										
4.39	Incidence of lung cancer (DSR per 100,000), 2012-2014	64	61	73	57										
4.40	Mortality from lung cancer (DSR per 100,000), 2012-14	51	49	57	45										
4.41	Incidence of colorectal cancer (DSR per 100,000), 2012-2014	71	69	73	71										
4.42	Mortality from colorectal cancer (DSR per 100,000), 2012-14	28	26	29	30										
4.43	Incidence of breast cancer (DSR per 100,000 women), 2012-2014	172	162	172	184										
4.44	Mortality from breast cancer (DSR per 100,000 women), 2012-14	40	37	42	40										
4.45	Incidence of prostate cancer (DSR per 100,000 men), 2012-2014	178	170	171	196										
4.46	Mortality from prostate cancer (DSR per 100,000 men), 2012-14	46	44	45	48										
4.47	Mortality from all cancers (DSR per 100,000), 2012-14	271	274	280	259										
4.48	Premature mortality from cancer (SMR), 2012-15	100	103	105	91	109	101	86	108	112	88	77	126	80	95

Disease and poor health - Respiratory															
Ref	Indicator	East Sussex	EHS CCG	H&R CCG	HWLH CCG	Eastbn.	Hailsham & Polegate	Seaford	Bexhill	Hastings & St Leonards	Rural Rother	Crowbr.	Havens	Lewes	Uckfield
4.49	GP reported prevalence of asthma (%), 2015/16	6.2	6.6	6.0	5.9	6.4	7.0	6.8	6.7	5.6	6.0	5.5	7.0	5.6	5.7
4.50	Emergency admissions for asthma (SAR), 2014/15 to 2015/16	100	110	124	62	122	91	94	126	145	67	66	72	57	53
4.51	Emergency admissions for asthma per 1,000 on GP asthma registers, 2015/16	14	14	19	9	17	10	9	14	26	10	10	11	10	6
4.52	GP reported prevalence of COPD (%), 2015/16	2.1	2.3	2.5	1.7	2.2	2.5	2.3	2.7	2.6	1.9	1.7	2.4	1.3	1.5
4.53	Emergency admissions for COPD (SAR), 2014/15 to 2015/16	100	91	127	79	90	104	75	117	161	78	72	130	57	69
4.54	Emergency admissions for COPD per 1,000 on GP COPD registers, 2015/16	78	73	87	70	64	87	79	90	92	63	66	86	69	56
4.55	Mortality from COPD (SMR), 2012-15	100	92	118	90	97	92	76	102	140	104	77	145	72	81
4.56	Premature mortality from respiratory diseases (SMR), 2012-15	100	96	129	70	103	95	77	112	165	80	70	111	67	46

Disease and poor health - Diabetes															
Ref	Indicator	East Sussex	EHS CCG	H&R CCG	HWLH CCG	Eastbn.	Hailsham & Polegate	Seaford	Bexhill	Hastings & St Leonards	Rural Rother	Crowbr.	Havens	Lewes	Uckfield
4.57	GP reported prevalence of diabetes aged 17+ (%), 2015/16	6.3	6.4	6.9	5.5	6.1	7.0	6.7	7.8	6.6	6.5	5.0	7.4	4.6	5.2
4.58	Emergency admissions for diabetes (SAR), 2014/15 to 2015/16	100	115	101	81	120	85	145	82	122	75	57	113	105	67
4.59	Emergency admissions for diabetes per 1,000 on GP diabetes registers, 2015/16	13	16	11	13	17	13	17	9	15	6	8	16	19	9

Disease and poor health - Other conditions															
Ref	Indicator	East Sussex	EHS CCG	H&R CCG	HWLH CCG	Eastbn.	Hailsham & Polegate	Seaford	Bexhill	Hastings & St Leonards	Rural Rother	Crowbr.	Havens	Lewes	Uckfield
4.60	GP reported prevalence of epilepsy aged 18+ (%), 2015/16	0.8	0.8	0.9	0.7	0.8	0.8	0.7	1.0	1.0	0.7	0.7	0.8	0.7	0.7
4.61	Premature mortality from liver disease (SMR), 2012-15	100	88	130	79	79	101	99	111	170	67	53	153	33	102
4.62	GP reported prevalence of CKD aged 18+ (%), 2015/16	5.1	6.4	4.2	4.6	5.9	7.1	7.2	5.2	3.6	4.4	4.2	5.9	4.4	4.1
4.65	GP reported prevalence of learning disabilities aged 18+ (%), 2015/16	0.5	0.5	0.6	0.5	0.5	0.4	0.4	0.6	0.7	0.5	0.4	0.4	0.3	0.6

Disease and poor health - Avoidable admissions															
Ref	Indicator	East Sussex	EHS CCG	H&R CCG	HWLH CCG	Eastbn.	Hailsham & Polegate	Seaford	Bexhill	Hastings & St Leonards	Rural Rother	Crowbr.	Havens	Lewes	Uckfield
4.67	Emergency admissions for LRTIs in under 20s (SAR), 2014/15 to 2015/16	100	106	95	98	103	98	139	78	104	84	56	162	125	68
4.68	Emergency admiss'ns for diabetes, epilepsy, asthma in under 20s (SAR), 2014/15 to 2015/16	100	118	117	62	134	80	114	115	131	82	69	47	69	58
4.69	Emergency admissions for chronic ACS conditions (SAR), 2014/15 to 2015/16	100	101	118	77	104	99	94	106	144	81	64	111	75	73
4.70	Emergency admissions for acute ACS conditions (SAR), 2014/15 to 2015/16	100	110	104	82	120	100	86	97	120	79	73	104	72	86
4.71	Emerg'y adm'ns for other & vaccine preventable ACS conditions (SAR), 2014/15 to 2015/16	100	97	105	99	103	92	83	89	128	83	65	146	108	101

Disease and poor health - Hospital attendances and admissions															
Ref	Indicator	East Sussex	EHS CCG	H&R CCG	HWLH CCG	Eastbn.	Hailsham & Polegate	Seaford	Bexhill	Hastings & St Leonards	Rural Rother	Crowbr.	Havens	Lewes	Uckfield
4.72	First outpatient attendances (SAR), 2015/16	100	99	103	98	96	99	108	101	109	93	101	114	89	90
4.73	Outpatient appointments where the patient did not attend (%), 2015/16	7	7	8	6	8	7	6	7	9	7	5	9	7	6
4.74	All MIU and A&E attendances (SAR), 2015/16	100	95	95	111	96	94	92	86	107	77	109	123	114	103
4.75	MIU and A&E attendances for 0-4 yr olds (per 1,000), 2015/16	433	392	411	509	396	383	395	404	438	326	445	611	566	441
4.76	MIU and A&E attendances for persons aged 15-29 (per 1,000), 2015/16	324	310	315	351	317	282	330	282	344	261	359	366	343	336
4.77	MIU and A&E attendances for persons aged 70+ (per 1,000), 2015/16	384	379	352	431	385	384	354	344	403	278	415	490	473	374
4.78	All elective admissions (SAR), 2014/15 to 2015/16	100	108	99	91	108	114	102	100	102	92	84	107	89	92
4.79	Elective admissions for persons aged 65+ (SAR), 2014/15 to 2015/16	318	352	304	290	355	361	332	300	309	299	272	329	285	291
4.80	All emergency admissions (SAR), 2014/15 to 2015/16	100	100	111	86	104	98	88	104	126	90	78	110	80	84
4.81	Emergency admissions for persons aged 70-84 yrs (SAR), 2014/15 to 2015/16	194	196	204	180	206	194	170	198	233	161	163	232	164	177
4.82	Emergency admissions for persons aged 85+ (SAR), 2014/15 to 2015/16	485	489	496	464	492	492	474	486	532	455	452	520	479	426

Children's services															
Ref	Indicator	East Sussex	EHS CCG	H&R CCG	HWLH CCG	Eastbn.	Hailsham & Polegate	Seaford	Bexhill	Hastings & St Leonards	Rural Rother	Crowbr.	Havens	Lewes	Uckfield
6.07	Referrals to children's social care (per 1,000 aged under 18 yrs), Feb 2015 to Jan 2016 (M)	30	32	37	20	32	34	27	34	45	18	12	47	15	15
6.08	Children on a child protection plan (per 1,000 aged under 18 yrs), 31 March 2016 (M)	4	4	7	2	4	4	1	6	9	1	2	4	2	1
6.09	Looked after children (per 1,000 aged under 18 yrs), 31 March 2016 (M)	5	5	7	3	7	3	3	4	9	3	2	4	2	3

Carers															
Ref	Indicator	East Sussex	EHS CCG	H&R CCG	HWLH CCG	Eastbn.	Hailsham & Polegate	Seaford	Bexhill	Hastings & St Leonards	Rural Rother	Crowbr.	Havens	Lewes	Uckfield
6.01	People providing one hour or more of unpaid care per week (%), 2011 (M)	11.3	11.3	11.5	11.0	10.9	11.6	12.5	12.7	10.7	12.0	10.5	11.6	11.7	10.7
6.02	Unpaid carers providing 20 hours or more care per week (%), 2011 (M)	34	35	37	28	36	35	29	38	39	32	25	38	25	27
6.03	Working age people claiming Carers Allowance (%), Feb 2016 (M)	1.5	1.6	1.9	1.1	1.6	1.6	1.2	1.9	2.1	1.6	0.8	1.9	1.0	1.0
6.04	Carers known to adult social care (per 1,000 population) Dec 2014 to Nov 2015 (M)	17	18	21	12	17	19	17	23	21	18	10	18	12	12
6.05	Carers (known to adult social care) receiving a service (%), Dec 2014 to Nov 2015 (M)	84	85	85	83	85	84	87	86	84	86	80	86	84	81
6.06	Carers receiving self-directed support (per 1,000 aged 18+), Dec 2014 to Nov 2015 (M)	8	8	10	6	8	9	8	10	11	9	5	9	5	6

Adult social care															
Ref	Indicator	East Sussex	EHS CCG	H&R CCG	HWLH CCG	Eastbn.	Hailsham & Polegate	Seaford	Bexhill	Hastings & St Leonards	Rural Rother	Crowbr.	Havens	Lewes	Uckfield
6.10	Requests for adult social care support (per 1,000 aged 18+), Dec 2014 to Nov 2015 (M)	25	27	29	19	26	28	29	35	27	25	16	26	19	18
6.11	Adults receiving direct payments (per 1,000), at 30 Jun 2016 (M)	4	3	5	3	3	4	2	5	5	4	2	4	3	3
6.12	Adults receiving self-directed support (per 1,000), at 30 Jun 2016 (M)	11	12	13	7	12	12	10	14	14	9	5	10	8	6
6.13	Working age people receiving Long Term Support (per 1,000), Jul 2015 to Jun 2016 (M)	8	8	11	4	8	7	6	12	12	6	3	6	5	4
6.14	People aged 65+ receiving Long Term Support (per 1,000), Jul 2015 to Jun 2016 (M)	30	34	32	24	34	36	31	29	37	27	18	35	24	22
6.15	Learning disabled adults aged 18-64 in settled accommodation (%), Jul 2015 to Jun 2016 (M)	72	77	68	71	75	80	82	78	71	44	58	88	77	67
6.16	Adults receiving community equipment (per 1,000), 2015/16 (M)	10	11	11	8	11	11	11	14	11	10	6	12	9	7
6.17	Adults receiving adult social care funded lifeline or telecare (per 1,000), 2015/16 (M)	12	14	13	8	14	15	14	15	12	11	6	13	8	7
6.18	People 65+ discharged from hosp to intermed care (per 1,000), Sep 2014 to Aug 2015 (M)	7	8	6	8	9	8	8	7	5	5	6	12	9	7
6.19	Adults in council supported residential or nursing care (per 100,000), at 30 June 2016 (M)	579	559	748	365	564	585	497	911	771	466	608	261	224	411
6.20	New ASC clients receiving services, not asking for more ongoing (%), Dec 14 to Nov 15 (M)	90	86	94	92	87	83	88	95	94	92	92	83	100	91

NHS dental services															
Ref	Indicator	East Sussex	EHS CCG	H&R CCG	HWLH CCG	Eastbn.	Hailsham & Polegate	Seaford	Bexhill	Hastings & St Leonards	Rural Rother	Crowbr.	Havens	Lewes	Uckfield
3.40	Residents aged 0-17 accessing East Sussex NHS general dental services (%), 2015/16 (M)	76	78	75	76	76	79	83	74	75	77	61	76	83	87
3.41	Residents aged 18-64 accessing East Sussex NHS general dental services (%), 2015/16 (M)	53	52	58	48	51	57	52	59	61	52	36	51	52	55
3.42	Residents aged 65+ accessing East Sussex NHS general dental services (%), 2015/16 (M)	53	51	60	47	48	58	51	61	62	55	39	50	49	54

GP patient survey															
Ref	Indicator	East Sussex	EHS CCG	H&R CCG	HWLH CCG	Eastbn.	Hailsham & Polegate	Seaford	Bexhill	Hastings & St Leonards	Rural Rother	Crowbr.	Havens	Lewes	Uckfield
5.01	Patients responding to the GP Patient Survey (%), 2015/16	48	49	45	52	46	53	53	54	40	57	55	46	52	53
5.02	Patients whose experience of their GP surgery was good (%), 2015/16	88	89	87	88	90	86	92	90	84	93	92	87	89	84
5.03	Patients whose experience of making appointments was good (%), 2015/16	78	79	80	74	81	73	77	81	78	84	76	77	72	72
5.04	Patients satisfied with GP surgery's opening hours (%), 2015/16	78	79	79	74	81	73	77	81	77	84	76	77	72	72
5.05	Patients who said the GP was good at involving them in decisions on care (%), 2015/16	77	79	74	78	79	76	86	78	71	79	80	77	77	78
5.06	Patients who said the nurse was good at involving them in decisions on care (%), 2015/16	65	65	67	63	65	68	62	62	70	68	62	65	59	67

Annex 2: Acronyms and abbreviations

A&E	Accident and Emergency
ACS	Ambulatory Care Sensitive
AF	Atrial Fibrillation
ASC	Adult Social Care
BP	Blood Pressure
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CHD	Coronary Heart Disease
CKD	Chronic Kidney Disease
COPD	Chronic Obstructive Pulmonary Disease
CV	Cardiovascular
CVD	Cardiovascular Disease
DM	Diabetes Mellitus (used for diabetes QOF clinical domain)
DNA	Did Not Attend
DSR	Directly Standardised Rate
DTaP/IPV/Hib	Diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae type b (also known as the 5 in 1 vaccine)
EHCP	Education, Health and Care Plan
EHS	Eastbourne, Hailsham and Seaford
ESA	Employment and Support Allowance
EYFS	Early Years Foundation Stage
Hib	Haemophilus influenzae type b
HIV	Human Immunodeficiency Virus
HR	Hastings and Rother
HWLH	High Weald Lewes Havens
ID	Income Deprivation
ID 2015	Indices of Deprivation, 2015
IDACI	Income Deprivation Affecting Children Index
IDAOPI	Income Deprivation Affecting Older People Index
IMD	Index of Multiple Deprivation
JSA	Job Seekers Allowance
LD	Learning Disability
LRTI	Lower Respiratory Tract Infection
LSOA	Lower Super Output Area

MenC	Meningococcal C conjugate
MH	Mental Health
MIU	Minor Injury Unit
MMR	Measles, mumps and rubella
MRC	Medical Research Council
NEET	Not in Education, Employment or Training
PAD	Peripheral Arterial Disease
PCV	Pneumococcal conjugate vaccine
PHOF	Public Health Outcomes Framework
PPV	Pneumococcal polysaccharide vaccine
QOF	Quality and Outcomes Framework
RAG	Red Amber Green
RCP	Royal College of Physicians
SAR	Standardised Attendance Ratio/ Standardised Admissions Ratio
SEN	Special Educational Needs
SMR	Standardised Mortality Ratio
STIs	Sexually Transmitted Infections
UC	Universal Credit

Report to:	**East Sussex Better Together (ESBT) Strategic Commissioning Board**
Date of meeting:	**6th June 2017**
By:	**Jessica Britton, Chief Operating Officer**
Title:	**Proposed stakeholder and citizen governance arrangements**
Purpose:	**To describe progress and proposals with plans for citizen and stakeholder engagement in the ESBT Alliance strategic planning and governance arrangements**

RECOMMENDATIONS

The Strategic Commissioning Board (SCB) is recommended to:

1) Agree the proposal to launch a new collaborative stakeholder representative 'Health and Wellbeing Council' as the key mechanism to support citizen and stakeholder engagement in the strategic planning process
2) Agree that a representative(s) from the new 'Health and Wellbeing Council' is invited to sit on the Strategic Commissioning Board.
3) Agree to establishing a single health and wellbeing provider forum to engage voluntary and independent care sector service providers in strategic planning and market development

1. Background

1.1 Involving local people in our work is our underpinning ethos. Since before the formal launch of ESBT, we have ensured an ongoing programme of extensive public and stakeholder engagement that informs everything we do. This has included engagement to inform the establishment of ESBT, engagement in programme design, co-design of pathways and services; co-design of how we engage, evidenced improvements made based on people's experiences and discussion regarding citizen engagement in our strategic planning governance as we move into our ESBT Alliance test-bed year, 2017/18.

1.2 It is the latter aspect, citizen engagement in our strategic planning and governance that forms the subject of this paper.

1.3 As we developed the formal integrated governance arrangements for the ESBT Alliance for 2017/18, we wanted to find a way to strengthen engagement in our overarching strategic planning and in our formal governance structure.

1.4 As such, we have undertaken a review of planning and partnership arrangements with a view to establishing the overarching arrangements for the ESBT Alliance for 2017/18, we wanted to find a way to strengthen engagement in our overarching strategic planning and in our formal governance structure.

1.5 As such we have undertaken a review of planning and partnership arrangement with a view to establishing the overarching arrangements required to support strategic planning or health and care across our ESBT Alliance in 2017/18. Involving citizens and stakeholders in our strategic planning process is a particular function within our ESBT governance that complements our whole system ESBT Communications and Engagement Strategy. The new overarching arrangements are one part of our engagement and involvement activity, and will be in addition to existing and newly developing mechanisms for involving local people in our work at all levels of our system.

1.6 The maturity of our partnerships and the formal nature of our ESBT Alliance governance arrangements will ensure that our approach is firmly rooted in our place across the ESBT planning footprint. In addition, and in keeping with what local people have told us will be helpful, it is proposed that the approach can also support the different focus of Connecting 4 You (C4Y; the High Weald Lewes Havens CCG programme) where this is appropriate, ensuring a consistent mechanisms for those stakeholders with an interest in both areas within the county.

1.7 This report updates the SCB on the outcomes of the planning and partnerships review and recommendations to set up a new overarching engagement arrangement to support strategic planning activity for the ESBT Alliance.

2 Citizen engagement: planning and partnerships project

2.1 The aim of this project was to establish the overarching engagement arrangements required to support strategic planning for health and care in East Sussex in 2017/18.

2.2 The scope of the project covered stakeholder engagement and contributions to the shared planning processes across the East Sussex Better Together (ESBT) and, latterly, the Connecting 4 You (C4Y) programmes. The aim was to ensure partners make best use of the experiences and expertise of stakeholders to improve health and care across the county by establishing a transparent and meaningful approach to involving and engaging stakeholders in the strategic planning process.

3 Current arrangements

3.1 There are a wide range of established stakeholder groups currently operating across the county. Some of these groups were originally created to play a countywide strategic role while others focus on issues that affect specific groups or populations. The groups are recognised mechanisms for sharing information and involving patients, clients, carers, staff, providers and organisations in developing policy and delivering services however their role in influencing and shaping planning is currently variable.

3.2 Examples of existing groups include:

- **Partnership Boards:** originally driven by a combination of national policy and statutory requirements to demonstrate partnership working across statutory organisations, voluntary and community sector and independent provision and client/patient representatives and a local move to embed Joint Commissioning Strategies in a broad multi sector structure. There are six in operation: Older People; Carers; Improving Life Chances (physical disability and sensory impairment); Mental Health; Learning Disability; and Autism.
- **Provider Forums:** give community based health and care providers, representatives from the voluntary and community sector and other partners regular opportunities to come together and discuss issues such as policy and workforce development, and social care market development.
- **Patient Participation Groups:** a contractual requirement for all GP practices in England. Generally made up of a group of volunteer patients, the practice manager and one or more of the GPs from the practice, they meet regularly to discuss the services on offer, and how improvements can be made for the benefit of patients and the practice.
- **East Sussex Youth Cabinet:** a group of young people who are elected to represent the voice of young people in East Sussex and have a say in how things are run.

3.3 Alongside these groups, partners use a number of additional mechanisms and methods to enable and support the principles of joint working and co-design in planning for example:

- Regular events such as 'Shaping health and care'
- One-off topic or issue-based workshops, summits and conferences
- Linking with external groups such as East Sussex Seniors Association and Hope-G (Hastings Older People's Ethnic Group).
- Online surveys and formal public consultations
- ESCC People Bank and the Eastbourne, Hailsham and Seaford/Hastings and Rother CCG stakeholder database which enable people to register their areas of interest and get involved, as much or as little as they want.

3.4 In addition, funding agreements and other arrangements are in place with the voluntary and community sector to facilitate involvement and joint working. For example:

- The voluntary and community sector are supported to represent, influence and make a positive change for the communities they support through SpeakUp. SpeakUp brings together representatives from countywide organisations, community networks and Councils for Voluntary Services (CVSs).
- Healthwatch East Sussex facilitates public engagement and co-design in health and care and play a key role in ensuring local people are able to influence the development, design and delivery of local services.
- East Sussex Community Voice (ESCV), which also provides Healthwatch East Sussex, manages the ESBT Public Reference Forum which has been set up to increase ways for people to have a say and inform the development of local services under ESBT.
- Regular and one-off commissioned engagement activities.

4 Key findings

4.1 The following Feedback from stakeholders on current engagement arrangements is mixed and highlights the need for change:

- Involving citizens and stakeholders in planning and delivering services is central to the work and ethos of all the partner organisations. The principle of working together to improve outcomes is well established and as shown above, groups and activities operate at a number of levels.

- Some groups are active and facilitate meaningful partnership working and co-design; others no longer fulfil their original aim and purpose. New ways of working are evolving and operating alongside long-standing arrangements and there is a need to streamline activity, reduce duplication and fill any gaps.

- The range of citizen, patient and client engagement mechanisms operating within the ESBT and C4Y partner organisations (such as patient participation and patient experience groups) need to be better linked into the planning process.

- The partnership boards are currently the only joint mechanism for regularly engaging stakeholders in strategic planning. They have been effective in involving stakeholders in developing and monitoring joint commissioning strategies however there is general consensus that the model, built around traditional adult social care groups, is no longer the most effective way of structuring our engagement and doesn't fit easily with the ESBT '6 plus 2 box' model of care.

- Stakeholders value the opportunity to meet with senior officers from statutory health and care organisations.

- There is a desire to broaden the focus of the current arrangements to consider the health and care economy of ESBT and East Sussex as a whole.

- There is a feeling that partnership work is focused on the priorities of the ESBT, and latterly the C4Y partner organisations, and stakeholders feel that proposals are taken to them for approval rather than developed together and are keen to move towards a co-production approach.

- The current system based around client groups is resource intensive and inefficient. Given the scale of change required and the focus on system wide transformation, greater value could be achieved from a collective voice rather than the current fragmented structure.

- The Learning Disability and Autism Partnership Boards currently help to meet statutory duties.

- Further work is required to ensure stakeholders working with children and families are represented and included in the future arrangements.

5 Proposal – a collaborative stakeholder representative 'council'

5.1 It is proposed to establish a single collaborative health and wellbeing stakeholder representative council to shape planning activity. The main purpose of the council will be to help to define the overall strategic direction for commissioning health and care in ESBT, and East Sussex as a whole as appropriate, and ensure that stakeholders can input into the decision making process around how resources are allocated and service development prioritised.

5.2 The council will streamline and replace some of the partnership boards; however existing groups focusing on particular client groups, services or areas would remain an important part of the overall approach and would feed into the proposed representative council.

5.3 Creating a single collaborative stakeholder representative group, with multiple ways for people to feed in, could achieve a number of benefits and will help to:

- give an overview of health and care across the whole of ESBT and the county;
- facilitate a focus on outcomes rather than 'client groups' or labels;
- bring together discussions and planning around physical and mental health;
- create efficiencies for everyone involved;
- make best use of information gathered at a local and service level; and
- improve links between groups.

5.4 The Council will be made of up stakeholders representing people and communities, including people using health and care services and their carers, and staff from the East Sussex Better Together Alliance alongside staff a range of partner organisations for example East Sussex Community Voice, voluntary and community sector organisations; district and borough councils; East Sussex Fire and Rescue Service, and Sussex Police. It is envisaged that staff from the Connecting 4 You programme would also be a part of the Council to enable the approach to be mirrored across the county, and it may be that the meetings will be differently managed to meet the needs of the ESBT stakeholders and those that have a county-wide interest.

5.5 Agendas will be set collaboratively with meetings structured around themes and topics. The meeting process will be supported by a range of additional activity such as regular information bulletins, electronic engagement, social media communication and pre-meetings if required.

5.6 There will be clear links to existing 'specialist' groups, forums and engagement mechanisms such as service level 'customer satisfaction' and 'patient experience' activities to make best use of the range of feedback and intelligence gathered.

6 Proposal – health and wellbeing provider forum

6.1 The current local authority-led provider forums provide a useful mechanism for engaging with providers around operational issues and are a useful part of the supply management process. Only a small proportion of providers usually attend the meetings however despite invitations being extended to all providers within the county. Feedback has suggested that although informative about strategic and workforce development the forums could also provide a better focus on constructive discussion between commissioners, statutory health and care services, and providers in the voluntary and community sector, about market and service development to support delivery of effective integrated care pathways and services.

6.2 It is proposed that the current local authority-led provider forums will be combined to create a single health and wellbeing provider forum. The new forum will be used to develop the dialogue and engagement with all providers within the county across the health and care partnerships.

6.3 The principle area of focus will be to support and develop the market to ensure appropriate, responsive and sustainable services are available to meet the needs of the

local population. Feedback has also suggested that there could be a greater focus on health as well as social care, in particular in the context of the objectives set out in the integrated ESBT Strategic Investment Plan (SIP) and ESBT Market Position Statement to support the social care market, given the impacts on the wider system of delivery.

6.4 Creating a single overarching countywide health and wellbeing provider forum will:

- create efficiencies for all agencies involved;
- remove confusion and potential duplication for providers who work across client groups and service types;
- be easier for senior officers and external speakers, for example the Care Quality Commission, to attend;
- facilitate collaboration, learning and joint working between sectors;
- support delivery of a consistent message to providers;
- bring together discussions in localities and communities of practice; and
- support countywide providers who may struggle to be part of networks in localities and communities of practice.

7 Monitoring and evaluation

7.1 Given the significant changes required to move to the developing model of accountable care within ESBT, the approach will need to be tested and evaluated during 2017/18. It can then be adapted and re-designed as required for April 2018 onwards. The evaluation approach will be developed with stakeholders as part of the implementation process.

8 Key milestones

Further consultation and co-production	April/May/June/July/August 2017
New approach agreed	March/April/May 2017
Working group to plan the launch of the new collaborative stakeholder representative group	April/May/June 2017
New approach to stakeholder engagement launched (workshop event)	June 2017
Recruitment of representatives	July/August 2017
Training for representatives (plus potential opportunities for engagement on current issues)	September 2017
Single countywide provider forum launched	September 2017
First formal meeting of the collaborative stakeholder group	September/October 2017

9 Conclusion and reasons for recommendations

9.1 Engagement with citizens and stakeholders has been a strong feature of our approach to planning and partnerships in ESBT to date, taking place at all levels of our system. Building on this to reflect the new level of maturity and formality in our partnership and governance arrangements as an Alliance, establishing a collaborative health and wellbeing stakeholder representative Council will mean that citizen and stakeholder engagement will be a formal part of the new governance arrangements helping to shape future planning activity in 2017/18. The new Council will be the key mechanism to support citizen and stakeholder engagement in the strategic planning process, complementing activity driven by our wider ESBT Communications and Engagement Strategy.

9.2 The aim of the health and wellbeing stakeholder representative Council will be to ensure partners make best use of the experiences and expertise of all stakeholders to improve health and care across ESBT and the county by establishing a transparent and meaningful approach to involving and engaging stakeholders in the strategic planning process. In line with this it is proposed that a representative is invited to sit on the ESBT Strategic Commissioning Board from the new Council when it is formed.

9.3 Alongside this the current local authority-led provider forums, that bring together independent and voluntary sector providers with statutory sector commissioners and operational teams, will be combined to create a single health and wellbeing provider forum. This new forum will be used to develop the dialogue and engagement with all providers to further develop markets within the county across the health and care partnerships to support delivery of the ESBT SIP and Market Position Statement objectives.

9.4 The Strategic Commissioning Board (SCB) is therefore recommended to:

4) Agree the proposal to launch a new collaborative stakeholder representative 'Health and Wellbeing Council' as the key mechanism to support citizen and stakeholder engagement in the strategic planning process
5) Agree that a representative(s) from the new 'Health and Wellbeing Council' is invited to sit on the Strategic Commissioning Board.
6) Agree to establishing a single health and wellbeing provider forum to engage voluntary and independent care sector service providers in strategic planning and market development

JESSICA BRITTON
Chief Operating Officer, EHS and HR CCG

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Report to: East Sussex Better Together (ESBT) Strategic Commissioning Board

Date of meeting: 6 June 2017

By: Director of Adult Social Care and Health, East Sussex County Council
Chief Officer, NHS Hastings and Rother and Eastbourne, Hailsham and Seaford Clinical Commissioning Groups

Title: ESBT Alliance Outcomes Framework

Purpose: To provide the Strategic Commissioning Board with a progress report on the development of the ESBT Alliance Outcomes Framework, and to seek agreement to adopt as a pilot to further test and refine in the 2017/18 test-bed year

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RECOMMENDATIONS

1) To note progress made towards establishing the pilot ESBT Alliance Outcomes Framework
2) To agree and adopt the pilot Outcomes Framework to further test and refine during the test-bed year

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1. Background

1.1. The ESBT Alliance partners, Eastbourne, Hailsham and Seaford (EHS) and Hastings and Rother (HR) Clinical Commissioning Groups (CCGs), East Sussex County Council (ESCC), East Sussex Healthcare NHS Trust (ESHT) and Sussex Partnership NHS Foundation Trust (SPFT) have agreed to a formal Alliance Agreement to underpin our arrangements for 2017/18, allowing room to test to best effect what will be the right solution for the people we serve and deliver the best outcomes for our population.

1.2 The 2017/18 test-bed year is designed to enable oversight of the whole health and care system from both a commissioning and delivery perspective, supporting us to act collectively in a way that delivers improvements for our local population. In addition it also creates a collaborative learning environment in which we can progress the development work to design our final proposed ESBT Alliance system of accountable care.

1.3 Building on our original ESBT work on reporting progress against population health and health inequalities outcomes, this paper provides detail on the proposed integrated Outcomes Framework that we will seek to pilot in 2017/18 to inform our stakeholders about progress made across the health and social care system on delivering improvements to population health and wellbeing, experience, quality and sustainability – including the per capita cost of care.

2. Supporting information

2.1 Our research tells us that understanding the outcomes that are important to local people and providing feedback on how well we are delivering on these, is part of how accountable care models can be incentivised to deliver improvements. For example, in the La Ribera Salud model of accountable care the focus is on a small number of priority outcomes and performance against these is published; enabling the general public, commissioners and others to understand that improvements are being made.

2.2 Accountable care focusses the delivery of health and care services on achieving positive outcomes, or results, for citizens, patients and clients. The health and care system is geared towards keeping people well and promoting independence and wellbeing, while ensuring we have high quality hospital, care and specialist services when people need them. The important difference to current arrangements is that delivery across the system is fully aligned to achieve shared goals.

2.3 In our test-bed year of accountable care in 2017/18, we need a small group of shared system-wide priority outcomes which we can work towards and further test and refine during the year. Whilst this shared Outcomes Framework will not replace the existing performance requirements that each Alliance organisation currently works to, it will enable commissioners, providers and staff working in the system to recognise and use the same Outcomes Framework to guide their work with patients, clients and carers, and see how their activity or part of the care pathway contributes to delivering the outcomes that are meaningful for local people. The Outcomes Framework will also complement the way the Alliance uses our collective business intelligence to understand the performance of the health and care system as a whole.

2.4 Following local engagement in the Autumn of 2016, a data review took place to provide a picture of what is important to local people about their health and care services. The data review brought together the wide range of qualitative information and feedback that is already available across all our organisations and through our engagement events, and which represents the views of thousands of people who are using local health and social care services, both children and adults. The data review helped to identify common themes across all our organisations about what is important to local people, and thematically collated this information to arrive at statements that are common across all services. The full Data Review of What Matters to Local People is attached at Appendix 1.

2.5 Informed by our data review, the local engagement that has taken place, and the nine principles and characteristics we have agreed for designing and implementing accountable care in East Sussex, we have developed four key outcome domains that underpin the development of the ESBT Alliance pilot outcome framework:

2.6 The definitions of these domains and corresponding proposed key strategic objectives are as follows:

Population health and wellbeing: addressing and improving population health and reducing health inequalities. We want to:

- improve health and wellbeing
- reduce inequalities

The experience of local people: the experience people have of their health and care services. We want to:

- put people in control of their health and care

- improve communication and access to information
- deliver services that meet people's needs and support independence

Transforming services for sustainability: the way services work and how effective they are at impacting positively on the people who use them. We want to:

- demonstrate financial and system sustainability
- deliver joined up information technology
- prioritise prevention and early intervention, self care and self management

Quality care and support: making sure we have safe and effective care and support. We want to:

- provide safe, effective and high quality care and support
- deliver person-centred care through integrated and skilled service provision

2.7 Proposed outcomes and key indicators for each domain have now been identified and aligned to support each objective, and performance measures are being finalised in conjunction with the corresponding service area. These measures have been chosen in accordance with what people have told us is important to them, and to provide high level indicators as to how well we are performing as a system. An overview of the current draft framework and how we are proposing to present it is attached at Appendix 2.

3. Next steps

3.1 Subject to feedback from the ESBT Strategic Commissioning Board, the next stage of development will include:

- Finalising baselines, targets and trajectories for each measure – building on the population indicators we have used throughout the ESBT programme (as indicated in item 6 on the agenda for this meeting), the targets in the Outcomes Framework will be established for a 5 year period to align with the Strategic Investment Plan (SIP) planning horizon. This will be subject to adjustment according to the future contractual model agreed for Alliance provision, and the learning generated in the pilot period. The proposed targets and trajectories will be finalised for presentation at the next ESBT Strategic Commissioning Board meeting. We are expecting in-year improvements to performance from working as an Alliance in the test-bed year, and will be able to measure this across many of the indicators in the Outcomes Framework;
- Continuing and strengthening our engagement with local people during 2017/18 to test whether the pilot outcome measures are the right ones. We propose to do this through a range of different targeted engagement activities including exploration of ways to capture real-time feedback from patients and clients in the test-bed year, and an online survey exercise that is accessible to the wider public and staff, using social media to target specific groups;
- Aligning the developing performance reporting frameworks for the Alliance Executive and operational groups across the system with the domains contained within the Outcomes Framework, to deliver a consistent reporting structure across operational performance frameworks and the pilot Outcomes Framework;
- We will aim to publish performance against the measures in our pilot Outcomes Framework in the Autumn of 2017.

3.2 In July 2017, the County Council and CCGs will consider the options for the legal vehicle that will best deliver our new model of accountable care and achieve the ambition of a fully integrated health and care system. In line with this, and taking account of feedback from the continued engagement with local people through the pilot period, we will refresh and make any final changes to the Framework in early 2018, ready for the new arrangements that will be in place in April 2018.

4. Conclusion and reasons for recommendations

4.1 Research and discussions about our new model of accountable care have highlighted the need for a clear Outcomes Framework with which to measure improvements on a system-wide basis and to test how well our system is working. Building on our original ESBT work on reporting progress against population health and health inequalities outcomes, we have developed an integrated pilot Outcomes Framework to inform our stakeholders about progress made across the

health and social care system on delivering improvements to population health and wellbeing, experience, quality and sustainability – including the per capita cost of care.

4.2 A unified Outcomes Framework will also help the Alliance and our stakeholders locally, and nationally in NHSE, NHSI and the CQC, understand the benefits of managing the health and care system collectively through the new Alliance arrangements we have set up. The suggested outcome measures have been tested with key stakeholders and the final draft framework is presented for endorsement by the ESBT Strategic Commissioning Board for piloting in 2017/18.

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Appendix 1

ESBT Accountable Care Outcomes Framework:
Data Review of What Matters to Local People About Their Health and Care Services

1 Background

This data review, completed in January 2017, is the first step in developing a shared Outcomes Framework for the East Sussex Better Together (ESBT) Accountable Care Model in 2017/18. An outcomes framework sets out publically what you want to achieve, rather than what you want to do.

In East Sussex, as in most health systems across the world, demand for NHS and social care services is increasing rapidly. Our population is growing and people are living longer. There is an increase in chronic conditions, with more and more of us requiring long-term support. As a health and care system we need to achieve the triple aims of improving the health and wellbeing of our population, the quality and experience of health and care services, and keeping this within a resource envelope that is affordable. To make sure we get the outcome measures for this right, we need to design the framework around the things that matter to people.

We already have a wide range of qualitative information and feedback that is available across our organisations and through our engagement events. This data represents the views of thousands of residents who are using health and social care services. The data review is therefore able to provide a picture of what is important to local people about health and care services. We will use it to develop a draft Outcomes Framework which we will explore and test out with patients, clients, carers and the wider public through focus groups and surveys.

This data review:

- Identifies common themes from the feedback
- Describes things in language that people can relate to
- Maps the common themes against four areas that we want our Outcomes Framework to cover:
    - The experience of local people
    - The quality and safety of care services,
    - Population health and wellbeing
    - Transforming services for sustainability

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2 Data sources for the review

We can best understand what matters to people from reviewing qualitative responses to questions and related theming. In other words, when people are given free rein to talk about their experiences of health and social care, what do they choose to talk about?

We looked at the following data sources:

Engagement activity

ESBT Accountable Care Outcomes Framework Workshop: The workshop was attended by representatives from voluntary organisations and patient/client groups in the ESBT Advisory Group, Inclusion Advisory Group and East Sussex Seniors Association (ESSA) health and care Theme Group. The session discussed the four key themes in the Outcomes Framework and possible outcomes for Accountable care.

Shaping Health and Care Events: We looked at the notes from the group discussions about Accountable Care Outcomes at the events in October. We focused on the discussion question asking about what is most important to them.

Engaging Young People to Inform Health Improvement Commissioning and Delivery: We looked at the results of a University of Brighton study commissioned by the Council. There were three topic areas: 1) Whole school approaches to health improvement; 2) Emotional wellbeing and resilience; and 3) Sexual health improvement.

Youth Cabinet Election and UK Youth Parliament feedback

Big Vote Election: We looked at the issues students said they felt most about strongly when voting in the Youth Cabinet elections. They had a list of 10 to choose from.

Make Your Mark 2016: We looked at how young people in the county voted in the national ballot to decide what the UK Youth Parliament should debate when choosing their campaign for the coming year.

Feedback and surveys

Healthwatch Feedback Centre: We reviewed the comment themes identified from reviews left on the Healthwatch East Sussex Online Feedback Centre over the last 12 months.

Listening To You Social Care Survey: We looked at the results from the July 2016 mailing to a sample of clients and carers who had an assessment or review between April and June. We focused on comment questions asking about: a) their service ratings and b) how services help them.

National social care survey: We looked at the local results from the 2015/16 national social care survey carried out with clients. We focused on the comment question about their overall satisfaction with social care and support.

Public Reference Forum: We looked at the recent results for the ongoing health and care survey about ESBT carried out with East Sussex residents. We focused on the comment questions asking about a) how services could be improved and b) why they think services

have improved or got worse. The majority of the comments focused on health services such as GPs and hospitals, although there were also comments about social care services, mental health services, and childrens services.

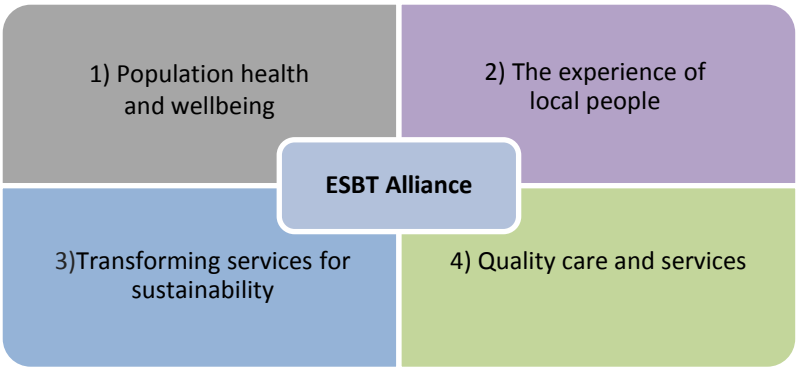
East Sussex Healthcare NHS Trust Patient Experience Report: We looked at the most recent report, particularly focusing on the themes that came out through complaints, Patient Advice and Liaison Service, Friends and Family Test, and NHS choices feedback.

3 What matters to people and mapping to outcome themes

What we've learned from the data review is set out in the first two columns of the table in section four. The first column sets out the broad topics that matter to people when receiving health and care services, such as communication and how they are treated. The second column provides more details on what people want and what they consider a good experience.

The final column of the table maps what matters to people against the four outcome themes that we want to use in our Outcomes Framework.

The four themes and related colour coding are:



The definitions for each theme are:

1) The impact of services on the health of the population such as preventing premature death and overall prevalence of disease.
2) The experience people have of their health and care services.
3) The way services work and how effective they are in a way that positively impacts on people who use services. This includes illness prevention and proactive care, and makes sure people are well supported when recovering from ill-health or require some extra support.
4) Making sure we have safe and effective care and support.

4 Table of what matters and mapped outcome themes

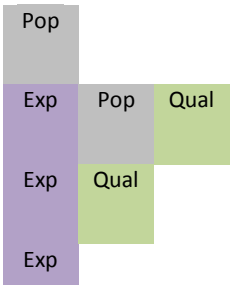
What matters topics	What you want…	Mapping
Information and knowledge	You want… • To be able to find accessible and jargon-free information and advice when you need it and in a format that suits you. • To feel knowledgeable about services so that you are empowered to make decisions and get your needs met.	Exp Exp Qua
Communication	You want… • To feel connected with services through having clear contact points to organisations and departments, as well as target response times. • To be kept informed about your treatment and services. • To be able to talk to someone when you need advice and support. • Simple ways to provide feedback about your experience of using services. • Good communication, cooperation and interconnectedness between all your services. • Better use of digital communication with patients/clients and between services to make services more efficient.	Tran Qua Exp Exp Qua Tran Qua Exp Tran Qua
Choice and control	You want… • To be supported to make choices and have those choices respected by services. • To feel in control of the services you receive and how they are delivered. • Services that help you to feel as independent as possible. • Young people want services that respect their privacy and allow them to decide what involvement their family has in their services.	Exp Exp Exp Pop
How you are treated	You want… • A personal service where you know the names of people treating you, particularly in hospital. • To feel that your support is personalised for you and your family. • To feel listened to by staff and services. • To be supported by professional staff who treat you well. • To have your communication needs understood and	Exp Exp Exp Qual Exp Qual Exp Qual

proactively met – whether that is through the language that is used, access to interpreters and translators, or better use of technology.

How services help you

You want…

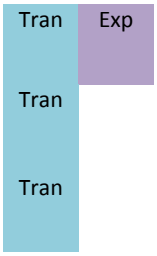
- Services that help you to get better and feel healthier.
- Services that help you to feel safe and have the best quality of life possible.
- Services that make it easier to live your daily life and achieve your goals.
- Services that help you to be part of the community.



Support for long-term conditions

You want…

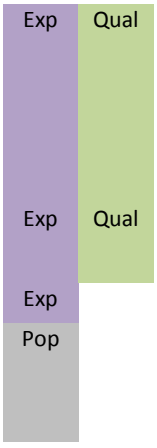
- Consistency of care for people who need to use long-term services.
- Support that encourages people to take responsibility for their own health.
- Services that use technology to empower people to self-manage.



Support for family and carers

You want…

- Clear communication with the family and carers of people who are receiving services about their treatment and needs.
- Peace of mind that your family member, and/or the person you care for, is having their needs met.
- Services to work in partnership with family and carers to support patients/clients.
- To feel supported in your caring role.
- To be supported as carers to do the things that matter, such as working, socialising and managing daily tasks.



Your home

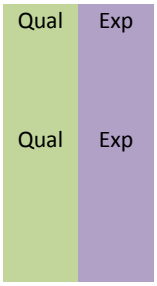
You want…

- To live somewhere that makes you feel safe and secure.
- To have the choice to stay at home.

Access to services

You want…

- To have good access to appointments through a simple booking process, particularly GP and hospital appointments.
- To be able to access services in a fair and timely manner, with reasonable waiting times and clear communication about how long you will have to wait.



- To be able to travel easily to appointments and services, particularly hospital-based services. Tran Qual
- Young people want a more accessible and flexible school-based nursing service.

Staffing

You want…

- Services that are staffed at the right level and a focus on funding front-line staff. Tran Exp
- Staff to be given enough time to do their job properly. Qual
- Professionals who listen to patients/clients. Qual
- To be treated in a consistently professional and helpful way by all staff. Exp
- Staff who take responsibility for doing their job and follow through on their commitments to you. Qual Exp

Service delivery and integration

You want…

- Everyone to have equal access, at the point of need or crisis, to efficient and effective local services. Tran Qual
- Access to all services to be based on need and not funding limitations. Qual
- A clear customer charter and services that put the patient/client first. Qual
- An integrated health and social care service that is operating as a whole system to make life easier for patients and clients. Tran
- A single point of access for public and professionals for health/care services. Tran
- Better use of technology to share data between services and improve the way services are experienced by patients/clients. Tran
- Appointments that give you enough time to discuss your care and treatment needs, particularly GP and consultant appointments. Qual
- Services that take account of mental health needs and how these affect people's lives and other services. Qual Exp
- Young people want improved awareness of mental health needs and support.
- All patient/client groups across all ages and relevant organisations to be represented and have a voice in improving and developing services. Tran
- Services that provide good aftercare for patients, particularly health services. Qual

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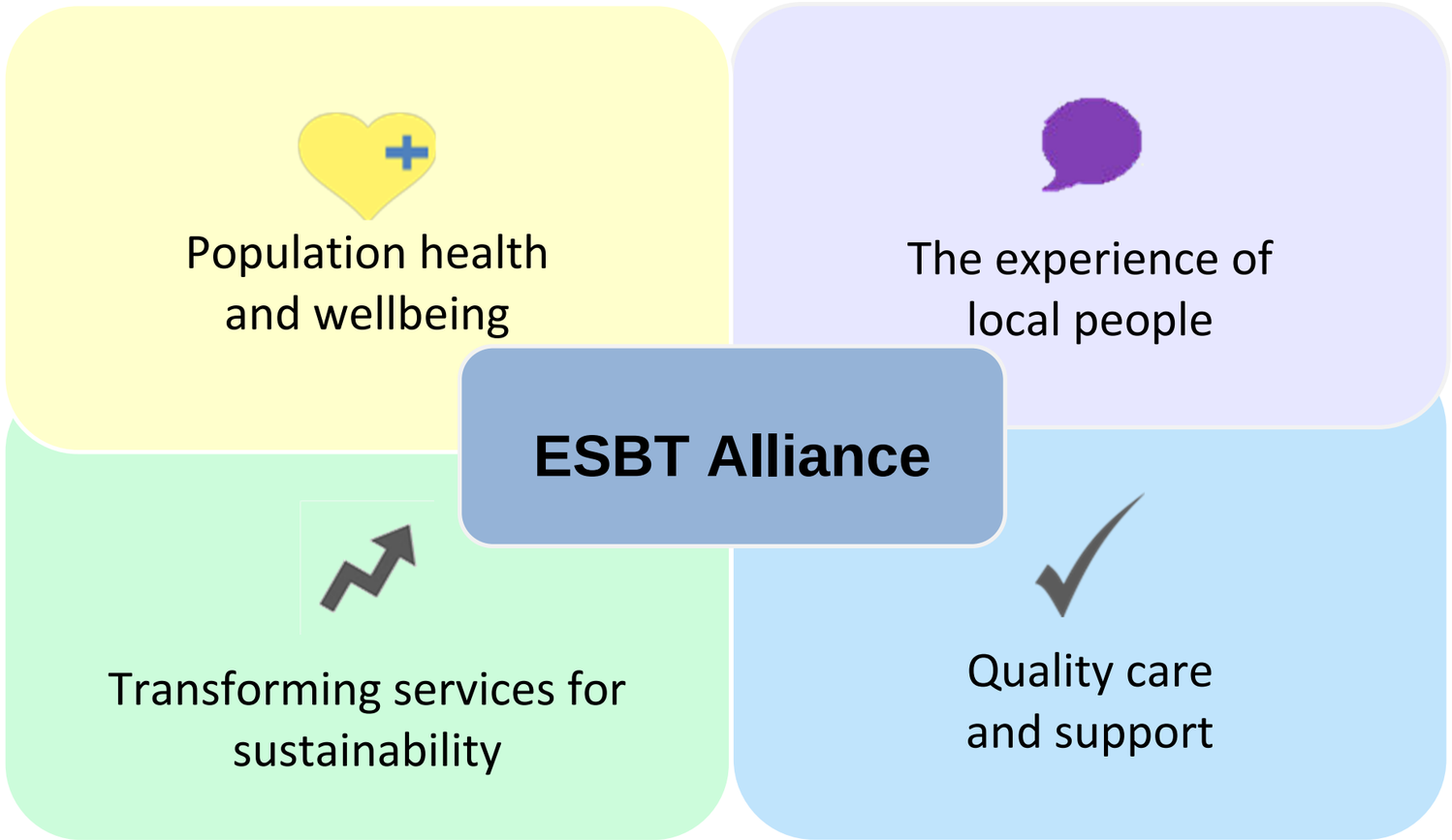
Outcomes Framework

Appendix 2

The ESBT Alliance Outcomes Framework shows our commitment to measuring our progress against the health and care priorities that matter to you. For local people using our services in the new ESBT Alliance, that means a way to measure whether the services they receive (activities) will improve their health, well-being and experience of care and support (outcomes). Overall we want to improve the health and wellbeing of our population, the quality and experience of health and care services, and keep this affordable.



The measures and key indicators in this document have been chosen because they are what people have told us is important to them, and will give us a good indication of overall system performance. The ESBT Alliance Outcomes Framework complements the existing Outcomes and Performance Frameworks that the individual ESBT organisations work to for Adult Social Care, Public Health and the NHS, and is designed to provide an overview of how well we are performing together as a system.

Population health and wellbeing

We want to improve health and wellbeing for local people

Outcomes	These indicators and measures will tell us how we are doing...	
Children are supported to have a healthy start in life	The proportion of babies who were fully or partially breastfed	Increase in percentage of babies aged 6-8 weeks who were fully or partially breastfed
	The rate of obesity among children	Reduction in excess weight in children aged 4-5 years Reduction in excess weight in children aged 10-11 years
	The proportion of mothers known to be smokers at the time of delivery	Reduction in percentage of mother known to be smokers at the time of delivery
People are supported to have a good quality of life	The proportion of people reporting a good quality of life	Improve health-related quality of life for older people Improve social-care-related quality of life for adults Increase in number of people who feel they have enough social contact
	The rate of overall mental wellbeing	Increase in proportion of people who say they are not anxious or depressed Decrease in attendances at A&E for self-harm per 100,000 of local population
People are supported to live in good health	The average number of years a person would expect to live in good health	Healthy life expectancy at birth for men Healthy life expectancy at birth for women
	The rate of preventable deaths	Reduction in preventable mortality Reduction in mortality amenable to healthcare

We want to reduce health inequalities for local people

Inequalities in healthy life expectancy are reduced	The gap in rates of obesity in children between the most and least deprived areas	Reduction in the gap in excess weight of 4-5 year olds between the most and least deprived areas Reduction in the gap in excess weight of 10-11 year olds between the most and least deprived areas
	The gap in health related quality of life for older people between the most and least deprived areas	Reduction in the gap in health-related quality of life for older people between the most and least deprived areas
	The gap in rates of preventable deaths between the most and least deprived areas	Reduction in the gap in preventable mortality between the most and least deprived areas Reduction in the gap in mortality amenable to healthcare between the most and least deprived areas

The experience of local people

We want to put people in control of their health and care

Outcomes	These indicators and measures will tell us how we are doing...	
People and their carers feel respected and able to make informed choices about services	The proportion of people using services who feel they have been involved in making decisions about their support	Ensure people using services receive self-directed support People receiving services feel they have enough choice over their care and support services People receiving services feel they have as much control as they want over their daily life
	The proportion of carers who feel they have been involved in decisions about services	Carers feel they have been involved or consulted as much as they wanted to be, in discussions about the support or services provided to the person they care for Carers feel that their needs as a carer were taken into account in planning their support
People and their carers have choice and control over services and how they are delivered	The number of people in receipt of direct payments for their carer or personal heath budgets	Increase in the number of people using services who receive direct payments for their care Increase the number of people in receipt of personal health budgets
	The number of carers in receipt of direct payments	Increase in the number of carers using services who receive direct payments

We want good communication and access to information for local people

People can find jargon free health and care information in a range of locations and formats	The proportion of people and carers reporting they find it easy to access and use information about services	People find it easy to find information and advice about support, services or benefits. Carers find it easy to find information and advice about support, services or benefits
Health and care services talk to each other so that people receive seamless services	The proportion of people and carers reporting they have only had to tell their story once	People who contact us about their support have not had to keep repeating their story Carers who contact us about support have not had to keep repeating their story

We want to deliver services that meet people's needs and support their independence

People are supported to be as independent as possible	The number of people living at home and accessing support in their communities	Increase in people accessing the support available to them in their local communities Fewer people are permanently admitted to residential and nursing care homes
	The proportion of people with support needs who are in paid employment	Increase in the proportion of adults with learning disabilities in paid employment Increase in proportion of adults in contact with secondary mental health services in paid employment
	The proportion of people who regain their independence after using services	Proportion of people 65+ who are still at home three months after a period of rehabilitation Proportion of people needing less acute, or no ongoing, support after using short-term services
People are supported to feel safe	The proportion of people and carers who report feeling safe	People feel as safe as they want People feel care and support services help them feel safe Carers feel safe and have no worries about their personal safety

Transforming services for sustainability

We want to demonstrate financial and system sustainability

Outcomes	These indicators and measures will tell us how we are doing...	
People have access to timely and responsive care	The waiting times for primary care GP services and community support and care services	Waiting time to get a GP appointment Waiting time to initiation for home care packages
	The referral times for health treatment	Constitutional NHS standards are met
	The length of stay in hospital	Reduction in length of stay in hospital for identified cohort Reduction in delayed transfer of care out of hospital
People access acute hospital services only when they need to	The number of people accessing hospital in an unplanned way	Reduction in number of A&E attendances Reduction in number of non-elective admissions Reduction in emergency admissions for chronic ambulatory care sensitive conditions
Financial balance is achieved across the system	The average Year of Care Costs	Reduction in average Year of Care Costs

We want to deliver joined up information technology

People and staff working within the system have access to shared and integrated electronic information	The proportion of staff in all health and care settings able to retrieve relevant information about an individual's care from their local system	Increase in proportion of staff able to retrieve relevant information about an individual's care from their local system using the NHS number Increase in number of settings across which relevant health and care information is currently being shared (through open APIs or interim solution) Implementation of Digital Integrated Care Records has started

We want to prioritise prevention, early intervention, self care and self management

Interventions take place early to tackle emerging problems, or to support people in the local population who are most at risk	The flow of investment from acute hospital services to preventative, primary GP, and community health and care services	Increase the proportion of funding invested in preventative, primary and community provision
	The proportion of services developed to intervene proactively to support people before their needs increase	Activation levels of people receiving services Number of people being screened for frailty Increase early interventions for people with psychosis Number of people who have a care plan from a proactive service Proportion of people accessing services through case finding Proportion of identified cohort who have access to active care coordination

Quality care and support

We want to provide safe, effective and high quality care and support

Outcomes	These indicators and measures will tell us how we are doing...	
People are supported by high quality care and support	The proportion of people reporting satisfaction with the services they have received	Increase in number of people who report they are satisfied with the care and support they receive Increase in number of carers who report they are satisfied with the care and support they receive Increase in number of people reporting being treated with care, kindness and compassion Increase in proportion of bereaved carers reporting good quality of care in the last three months of life
	The effectiveness of the health and care intervention the person has received	Improve the health gain people experience after elective procedures Increase in number of older people still at home 91 days after discharge from hospital
People are kept safe and free from avoidable harm	The number of healthcare-related infections and serious incidents	Reduction in healthcare-related infections Reduction in number of serious incidents in healthcare
	The effectiveness of the safeguarding enquiry	Increase in the number of adults who were asked what their desired outcomes of the safeguarding enquiry are, and of those how many were fully/partially achieved
	The number of falls in the population of local people	Reduction in the number of falls in East Sussex

We want to deliver person centred care through integrated and skilled service provision

People and their families are engaged in the settings of their outcomes and the management of their care	The proportion of people involved in setting the outcomes they want to achieve from their health and care services	Increase in proportion of people using services who are involved in determining the outcomes that are most important to them Increase in percentage of patients self-reporting improved outcomes in their general health following the elective procedure
People are supported by skilled staff, delivering person-centred care	The levels of staff satisfaction	Increase in staff satisfaction levels Reduction in staff turnover
	The proportion of staff who have received training in person-centred care	Increase in percentage of staff who have completed at least 80% of their mandated training Increase in proportion of staff who have the Care Certificate Increase in staff who have completed person-centred care and support planning training

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Report to:	**East Sussex Better Together (ESBT) Strategic Commissioning Board**
Date of report:	**6 June 2017**
By:	**Director of Adult Social Care and Health, East Sussex County Council** **Chief Officer, Eastbourne Hailsham and Seaford and Hastings and Rother Clinical Commissioning Groups**
Title:	**East Sussex Better Together Strategic Investment Plan**
Purpose:	**To provide the ESBT Strategic Commissioning Board with a summary of the ESBT Strategic Investment Plan**

RECOMMENDATIONS

1. To note the 2017/18 ESBT Strategic Investment Plan.

1. Background Information

1.1 East Sussex Better Together (ESBT) is the whole system health and care transformation programme, which was formally launched in August 2014, to fully integrate health and social care across the ESBT footprint in order to deliver high quality and sustainable services to the local population. Originally formed as a partnership between Eastbourne, Hailsham & Seaford (EHS) Clinical Commissioning Group (CCG), Hastings and Rother (H&R) CCG and East Sussex County Council, the Programme now formally includes East Sussex Healthcare NHS Trust (ESHT) and Sussex Partnership NHS Foundation Trust (SPFT). Our shared vision is to ensure that people receive proactive, joined up care, supporting them to live as independently as possible and achieve the best possible outcomes.

1.2 The partnership is moving to the next phase of the work to fully integrate and embed into core business the commissioning and delivery of health and social care. The Council has, through Reconciling Policy Performance Resources, agreed at County Council on 7th February 2017 to align its Adult Social Care budget, Public Health budget and part of its Children's budget with EHS and H&R CCGs, as part of the transition to the ESBT accountable care model which is intended to take a whole-systems approach to the planning and delivery of health and social care across the ESBT area. The aligned budgets have been drawn together into a Strategic Investment Plan (SIP) which is set out in in summary for 2017/18, in Appendix 1. The SIP is a medium term plan covering the period to 2020/21 which following further development with ESBT partners can now be considered for agreement.

1.3 The Government's Spring Budget announced additional funding of £22.09m to East Sussex County Council over three years to support Adult Social Care. The funding will be allocated, through the Improved Better Care Fund, as follows: £11.027m in

2017/18, £7.343m in 2018/19 and £3.649m the year after. Within the ESBT Alliance, the additional funding allocation equates to £8.491m in 2017/18 (77% of the total East Sussex allocation). This funding will be deployed to meet the needs of the population covered by ESBT and the strategic objectives and programmes of work already outlined in the ESBT SIP. Subject to demonstration that the grant conditions are met, the funding will also help mitigate the risks that planned schemes will not be able to deliver the required system change within the 2017/18 timescales.

1.4 Below is the summary of partners' investment in the SIP:

East Sussex Better Together Strategic Investment Plan	**2017/18 £'000**
Adult Social Care Base Budget	127,604
Council Tax Additional 1% Precept	1,887
Adult Social Care Base Budget	**129,491**
Supporting Adult Social Care Grant (one-off for 2017/18)	2,000
Improved Better Care Fund	220
Additional Adult Social Care Funding (Spring Budget)	8,491
Total Adult Social Care	**140,202**
Public Health	19,313
Children's Services	5,505
Total ESCC Investment in the ESBT SIP	**165,020**
Eastbourne Hailsham & Seaford CCG	341,638
Hastings & Rother CCG	355,753
Total ESBT SIP Investment	**862,411**

2. Supporting Information

2.1 The vision of ESBT is to meet population health need by delivering fully integrated and sustainable health and social care. The SIP sets out a medium term financial plan that enables the Council to set a balanced budget for 2017/18 and creates a sustainable system that promotes health and wellbeing whilst addressing quality and safety issues, in order to achieve the following triple aims:

- Prevent ill health and deliver improved outcomes for our population
- Enhance the quality and experience of care people receive; and
- Ensure the future affordability and sustainability of services.

2.2 From the outset it was agreed that this will be delivered through a focus on population needs, better prevention, self-care, improved detection, early intervention, proactive and joined up responses to people that require care and support across traditional organisational and geographical boundaries. In delivering this vision, we will see services:

- Move from acute to community settings with a focus on maintaining people safely at home.
- Provided by multidisciplinary teams working across health and social care at a local level who will seek to prevent escalation, reduce the need for complex care packages or hospitalisation, and enable people to leave bedded care quickly following an illness.
- Targeted for people based on a risk stratification approach, focused on individuals, or populations to actively engage them in maintaining their health and wellbeing.
- Transformed within 150 weeks from the current service configuration to one that is integrated.

3. Conclusion and reasons for recommendations

3.1 The ESBT Strategic Commissioning Board is asked to note the 2017/18 ESBT Strategic Investment Plan.

KEITH HINKLEY
Director of Adult Social Care and Health

AMANDA PHILPOTT
Chief Officer, EHS and HR CCGs

CONTACT OFFICER

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BACKGROUND DOCUMENTS

Report of the Cabinet, Full Council, 7th February 2017

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Appendix 1

2017/18 Strategic Investment Plan

ESBT Strategic Investment Plan 2017/18	EHS CCG & HR CCG	ESCC	ESBT Total
	£'000	£'000	£'000
Available Resources	697,391	165,020	862,411
Forecast Expenditure pre-Service Redesign	730,321	165,936	896,257
Net Deficit / (Surplus) pre-Service Redesign	**32,930**	**916**	**33,846**
Service Redesign Savings			
Healthy Living & Wellbeing/Maintaining Independence	(2,556)	(422)	(2,978)
Proactive Care/Crisis intervention and Admission Avoidance	(24,558)	-	(24,558)
Bedded Care	(1,435)	-	(1,435)
Discharge to Assess	(3,220)	-	(3,220)
Prescribing	(5,314)	-	(5,314)
Planned Care	(7,567)	-	(7,567)
Primary Care	(500)	-	(500)
Learning Disability	-	(160)	(160)
Enablers	(1,000)	-	(1,000)
Total Service Redesign Savings	**(46,150)**	**(582)**	**(46,732)**
Service Redesign Investments			
Healthy Living & Wellbeing/Maintaining Independence	5,000	658	5,658
Proactive Care/Crisis intervention and Admission Avoidance	10,427	183	10,610
Discharge to Assess	936	2,167	3,103
Mental Health	216	-	216
Prescribing	732	-	732
Planned Care	264	-	264
Total Service Redesign Investments	**17,575**	**3,008**	**20,583**
Mitigations			
Application of Better Care Fund to meet Service Redesign Investments	(7,697)	-	(7,697)
Total Mitigations	**(7,697)**	**-**	**(7,697)**
Net Deficit including Service Redesign	**(3,342)**	**3,342**	**0**

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