Agenda for a meeting of the East Sussex Better Together (ESBT) Alliance Governing Board to be held in public on Wednesday, 11 October 2017, from 10:00-12:30 in the Forest Room at The Sussex Exchange, Queensway, Hastings, St Leonard's-on-sea, TN38 9AG

Members:

David Clayton-Smith	Chair (DCS);
Dr Adrian Bull	Chief Executive, East Sussex Healthcare NHS Trust (ESHT)(AB);
Simone Button	Chief Operating Officer, Sussex Partnership Foundation NHS Trust (SPFT)(Associate Member)(SB;
Jackie Churchward-Cardiff	Non-Executive Director, ESHT (JCC);
Rose Durban	Governing Body Lay member, Eastbourne, Hailsham and Seaford (EHS) and Hastings and Rother (HR) Clinical Commissioning Groups (CCGs) (RD);
Stuart Gallimore	Director of Children's Services, East Sussex County Council (ESCC)(SG);
Keith Hinkley	Director of Adult Social Care and Health (ASCH), ESCC (KH);
Amanda Philpott	Chief Officer, EHS and HR CCGs (ALP);
Dr David Warden	Chair, HR CCG Governing Body (DW)

Attendees:

Laura Bayford	Interim Chief Operating Officer South Downs Health & Care and Federation (provider lead)(LB);
Jessica Britton	Chief Operating Officer, EHS CCG and HR CCG (JeB);
Bianca Byrne	Acting Head of Policy & Strategic Development, ASCH, ESCC (BBy);
Allison Cannon	Chief Nurse, EHS CCG and HR CCG (AC);
Paula Gorvett	ESBT Programme Director (PG);
Cynthia Lyons	Acting Director of Public Health, ESCC (CL);
Dr Julius Parker	Chief Executive, Surrey and Sussex Local Medical Committees (SSLMCS)(JP);
John Routledge	Director, East Sussex Community Voice (ESCV) (Healthwatch) (JRou);
Vicky Smith	ESBT Accountable Care Strategic Development Manager (VS);
Dr Martin Writer	Chair of EHS CCG Governing Body (MW);
Andy Lane	Corporate and Governance Services Officer, EHS and HR CCGs (minutes)(AL)

There will be the opportunity for members of the public to ask questions after the meeting has finished, in response to the items discussed. A record of these discussions will be appended to the minute of the meeting.

AGENDA

Item No	Item	Action	Lead	Paper Attached	Time
Section 1: Introduction					
24/17	Welcome and apologies for absence	Note	DCS	Verbal	10:00
25/17	Declaration of interests	Note	DCS	Verbal	
26/17	Minutes of previous meeting held on 9 August 2017	Note	DCS	Yes	
27/17	Review of actions and matters arising	Note	DCS	Yes	
28/17	Chair's opening remarks	Discuss	DCS	Verbal	
29/17	A story of someone using our services	Note	AC	Verbal	
Section 2: Strategy and performance					
30/17	Feedback from associated groups: • Alliance Executive (AB); • Clinical Leadership Forum (DW); • Accountable Care Development Group (ALP)	Note	AB, DW, ALP	Verbal	10:20
31/17	Outcomes Framework	Discuss	BBy, JeB	Yes	
32/17	ESBT performance: progress update on delivery against plans	Discuss	JOS, PG	Yes	
33/17	ESBT financial position 2017/18: update and required actions	Discuss	JOS	Yes	
Section 3: Governance and communication					
34/17	Strengthening our ESBT Alliance arrangements for 2018/19: progress update	Discuss	JeB	Yes	11:30
35/17	ESBT Engagement and Communications Strategy: Delivery Plan progress report	Note	JeB	Yes	
36/17	Key messages from this meeting	Agree	DCS	No	12:00
37/17	Any Other Business To be notified to Chair at least 2 working days in advance.	-	DCS	-	
Future public meeting date: Wednesday, 6 December, 2017, from 10:00-12:30 in St Wilfred's, 1 Broadwater Way, Eastbourne, BN22 9PZ					
Public reflection or feedback on the discussions of the Alliance Governing Board during the meeting will be taken prior to the formal closing of the meeting. A record of these discussions will be appended to the minutes of the meeting.					12:10

Freedom of Information Act: Those present at the meeting should be aware that their names and designation will be listed in the minutes of this Meeting which may be released to members of the public on request.

Draft minutes of a formal meeting of the East Sussex Better Together (ESBT) Alliance Governing Board held in public on Wednesday 9 August 2017, from 11.00am to 12:30pm at St Wilfrid's Hospice, 1 Broadwater Way, Eastbourne, BN22 9PZ

Present:

David Clayton-Smith	(Chair)(DCS)
Simone Button	Chief Operating Officer, Sussex Partnership NHS Foundation Trust (SPFT) on behalf of Sam Allen (SB);
Dr Adrian Bull	Chief Executive, East Sussex Healthcare NHS Trust (ESHT)(AB);
Louise Carter	Assistant Director, Communications, Planning and Performance, Children's Services, East Sussex County Council (ESCC) on behalf of Stuart Gallimore (LC);
Jackie Churchward-Cardiff	Non-Executive Director, ESHT (JCC);
Rose Durban	Lay member, Eastbourne, Hailsham and Seaford (EHS) and Hastings and Rother (HR) CCGs (RDu);
Amanda Philpott	Chief Officer, EHS and HR CCGs (ALP);
Dr David Warden	GP Governing Body member and Chair, HR CCG (DW)

In attendance:

Jessica Britton	Chief Operating Officer, EHS and HR CCGs (JeB);
Allison Cannon	Chief Nurse, EHS and HR CCGs (AC);
Steve Dickson	Director, South Downs Health and Care Ltd Federation on behalf of Laura Bayford (SD);
Cynthia Lyons	Acting Director of Public Health, ESCC (CL);
Alison Gale	Deputy Chief Finance Officer, EHS and HR CCGs on behalf of John O'Sullivan (AG);
Karthiga Gengatharan	Medical Director, Surrey and Sussex Local Medical Committees (SSLMCS) on behalf of Julius Parker (KG);
Paula Gorvett	ESBT Programme Director, EHS and HR CCGs (PG);
John Routledge	Director, East Sussex Community Voice (ESCV)(JR);
Vicky Smith	Accountable Care Strategic Development Manager, ESBT, ESCC (VS)
Andy Lane	CCG Governance and Corporate Services Officer (minutes)(AL);
Kerry Okines	CCG Governance and Corporate Services Officer (observer) (KO)

Draft Minutes

Item No	Item	Action
13/17	**Welcome and apologies for absence**	
	David Clayton-Smith welcomed those present and noted apologies from:	

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	Sam Allen — Chief Executive, SPFT; Stuart Gallimore — Director of Children's Services, ESCC; Keith Hinkley — Director of Adult Social Care and Health, ESCC; Laura Bayford — Interim Chief Operating Officer South Downs Health and Care Ltd Federation; Martin Writer — GP Governing Body member and Chair, EHS CCG	
14/17	**Declaration of interests**	
	There were no new declarations of interest considered prejudicial to any of the agenda items.	
15/17	**Minutes of the previous meeting on 27th June 2017**	
	The minutes of the 27 June 2017 formal ESBT Alliance Governing Board were **approved** as an accurate record of the meeting, subject to correction of Joe Chadwick-Bell's recorded role.	
16/17	**Matters arising and review outstanding ongoing activities recorded on the action point log**	
	05/17(ii) i) Our integrated ESBT governance arrangements: an overview **ii) ESBT Integrated Governance arrangements including, Terms of Reference for:** • **This Governing Board;** • **ESBT Alliance Executive;** • **ESBT Accountable Care Development Group; and** • **ESBT Clinical Leadership Forum** - A review of the Board's Terms of Reference has been built into the forward work-plan. The Board agreed to **close** this action. **10/17 System performance: an update on A&E performance with a particular focus on delivery against the 4-hour standard** - Paula Gorvett gave an update. A testing exercise is being undertaken with the NHS 111 programme team across the Sustainability, Transformation Partnership (STP) geography to inform the service specification that will be available in the **Autumn 2017.** We are on track to have a new 111 service provider in place by **March 2019**. In the meantime, the 111 team and South East Coast Ambulance Service (SECAmb) are involved in the Accident and Emergency (A&E) Delivery Board and currently looking at measures to alleviate forthcoming winter pressures, for example trialling voice recognition technology. The Board agreed to **close** this action.	
17/17	**Chair's opening remarks**	
	David Clayton-Smith described the important context provided by the	

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	Sussex and East Surrey Sustainability and Transformation Partnership (STP) within which there are four place-based plans, of which East Sussex Better Together is one. The Sussex and East Surrey STP is one of 44 nationally setting the strategic direction for the transformation of healthcare services. It is also one of five identified nationally as requiring additional help given the challenges we face. It is recognised that across the STP, ESBT is seen very much as leading the way on integration of services in this area.	
18/17	**A story of someone using our services**	
	Allison Cannon gave feedback from several different service areas, focused on some of the more positive experiences of our patients, showing the important impact our work across ESBT has made: • Dolly had been supported by the Frailty Team into a place in a local care home in Hailsham. Since referral, Dolly is receiving just the right level of care and hasn't been readmitted to hospital benefitting both her and her family; • The "i-rock" drop-in service is helping young people aged 14-25 who have mental health problems with a range of services. Formed as part of the health inequalities strand of ESBT the service is helping young people to invest in their own well-being. The professionals were described by one user as being easy to talk to "like a family"; and; • The Welfare benefits team help people access services and the benefits to which they are entitled. The team helped one patient by providing them with "somebody on my side", which had significantly reduced stress and helped them reduce the need for sleeping pills. Another person had been helped to get back their blue badge, providing them with renewed mobility and independence. David Clayton-Smith welcomed the balance provided by relaying some positive outcomes.	
19/17	**Feedback and key issues from associated groups:** • **Alliance executive (AB);** • **Clinical Leadership Forum (DW); and** • **Accountable Care Development Group (ALP)**	
	<u>Alliance Executive</u> Adrian Bull provided feedback with a focus on quality, people and operations, highlights as follows: • The recently extended membership is working well; • Allison Cannon is leading work to develop the new Quality Framework, tying in with her new role at STP level; • The single reporting framework being is designed;	

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	• Performance challenges include levels of demand remaining higher than expected. However, performance against the four hour accident and emergency (A&E) standard remains strong; • Communicating effectively with our people is crucial as we move towards the strengthened alliance next year. We are currently mapping existing roles across organisations. David Clayton-Smith asked what data the Board will get and when, to help provide an informed assessment of the performance of the strategies we have put in place. Adrian Bull said a strong reporting framework is being developed, with initiatives reported line by line. We need to integrate the three current lines of reporting: ESHT, ESCC and the CCGs. Jackie Churchwood-Cardiff asked how good practice was captured and shared across the ESBT geography. This is achieved in a number of ways including the work of the locality and integrated support teams that bring together experience from practices. Amanda Philpott added the example of "Healthy Hastings", as successful initiative which is now being shared within EHS CCG. Learning from General Practice and engagement with Federations is really important in helping us reduce variation and share good practice. Rose Durban welcomed the work on the quality framework but said we need also to develop the ability to forecast trouble ahead and avoid a rear view mirror only approach. Allison Cannon thanked Rose for the helpful steer and undertook to feed that into discussions. **Action:** *Adrian Bull will submit a first cut of a report from the Alliance Executive to the **11 October 2017** meeting of the Alliance Governing Board.* <u>Clinical leadership Forum</u> David Warden reported that the Clinical Leadership Forum: • is monitoring actions arising from the group's Urgent Care Workshop held on 7th June 2017. A key theme of this work continues to be improving the links between consultants and GP practices to ensure smooth handovers and consistency of care; • is giving consideration to extending membership of the group further to bring in a broader range of clinical expertise. • discusses links with the STP and our role on the Clinical Steering Group in particular enables us to feedback local experience and hear what is happening elsewhere; • agreed the creation of a working group, to be set up by Mark Barnes in ESBT to take forward work to introduce "**ReSPECT forms**" which will replace the current DNACPR forms and be an improvement for patients and staff. Patients often feel the current	**19/17(i) AB 11/10/17**

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	form can equate to a withdrawal of care; • considered ESBT Pathways Redesign work being undertaken in four areas Cardiology; Diabetes; Ophthalmology; and Respiratory. The group welcomed the opportunity to provide clinical input and a sense check to help ensure the new pathways deliver the best outcomes for patients in a sensible and efficient way. A key theme is movement towards hub locations providing access to the expertise of secondary care consultants outside of hospital; • discussed Tim Caroe's successful respiratory pilot, operated at the Lighthouse Medical Practice alongside Dr Perera, a respiratory specialist consultant and agreed that the lessons learned in delivering this pilot should be fed into the pathway redesign work in this area. Steve Dickson said that the Federations would like to be involved in the setting up of hubs. The Federations would also like a role towards the end stage of the pathway redesign work. **Action:** *Jessica Britton will work with the Federations to agree a way forward for ensuring they are appropriately engaged in the redesign work and report back to the **11 October 2017** meeting of the Alliance Governing Board.* <u>Accountable Care Development Group</u> This is a task and finish group created to provide recommendations to the Alliance Governing Board on the detailed design and implementation of the legal vehicle for our new model of care in April 2018. The last meeting in July looked at our readiness for decisions from sovereign organisations and communications to all stakeholders on the outcome of the decisions. Increasingly important is the Business Infrastructure Project around which work can now really accelerate following the positive decisions made by alliance partners. Getting the model right is an important element of delivering within our resource envelope. The next meeting was put back to 22 August to enable time to reflect on outcomes of sovereign boards' consideration of recommendations. Jackie Churchwood-Cardiff said that our communications with staff around the new model will be critical, in addition to those with the general public.	**19/17(ii) JeB 11/10/17**
20/17	**Integrated ESBT Alliance Plans: Combined ESBT Strategic Investment Plan (SIP) and Cost Improvement Plan (CIP) Update at Month 2**	
	Paula Gorvett introduced this item. At the last meeting of the Board in public, on 27 June, John O'Sullivan had given a detailed presentation	

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	of the 5-year Strategic Investment Plan (SIP). The SIP sets out the commissioners' perspective of the way in which our resource will be allocated to ensure appropriate care of patients. However, the SIP is only one side of the equation. Of equal importance are the costs of delivering the services and the efficiency of the providers as set out in ESHT's Cost Improvement Plan (CIP). Going forward, we will look at the SIP and CIP together in order to better understand the system as a whole. This session focused on the month two (M2) position. Of 33 SIP projects, 7 are recorded as either red or amber whereas the CIP schemes are reported as being on track for delivery. We are monitoring the schemes in close detail to enable appropriate mitigations to be deployed where necessary. Finance provides us with a common denominator for testing the effectiveness of services (but this isn't all about money, and quality and safety remain critical). We are aligning our Programme Management Offices (PMOs) and we now have a set of consistent documentation. Our presentation of delivery has improved but there is further work to do on securing the right information on projects in a timely fashion. The higher than expected demand for urgent care services coupled with higher than anticipated tariffs (service costs) has increased the financial risk in the plans. The risk rose from £38m in June to £40m in July. Resolution of the remaining issues relating to 2016/17 will help see the risk reduce from that level to around £32m. Mitigation actions are targeted at specific services areas, with investment in Primary and Community Care to positively impact other parts of the system. We need to support localities to take ownership of the strategies we've agreed to enable us holistically to bring resources together more effectively and more efficiently on the ground. The timetable for system-wide action is as follows: Immediate action (1 month): • 1 single Alliance Plan - Integrated SIP / CIP • Single financial schedule : income and expenditure • Proposal for further efficiencies Next 3 months: • Finalise System Demand and capacity model • Fully integrated PMO in place Next 6 – 9 months: • Single pooled budget	

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	• Single point of leadership (for both commissioner and provider) • Integrated business infrastructure Key points made in discussion: • The Board welcomed an excellent presentation; • Central to operating as an alliance is to drive down the cost of services and ensure people receive the most effective, appropriate and efficient care; • Underlying unaffordability of delivering services currently is a factor and we need draw out a clearer view of what the delivery costs should be; • We need to do more to understand demand to enable us to target mitigation activity more effectively; and • We are currently working on the capacity required to cope with winter demand, but there is potential to reduce bed numbers overall as around a third of patients currently in hospital are fit enough for discharge to social care with the appropriate nursing care in place, if that is available. The Alliance Governing Board **noted** the update and **directed** the Alliance Executive to: • Ensure that the conditions for delivery of the plans are in place, and • Confirm commitment to collective actions necessary to ensure delivery of all constituent organisational control totals and overall ESBT system financial balance through an integrated ESBT Alliance Financial Plan. ***Action:*** *Adrian Bull, as chair of the Alliance Executive, to: ensure that the conditions for delivery of the plans are in place; and confirm commitment to collective actions necessary to ensure delivery of all constituent organisational control totals and overall ESBT system financial balance through an integrated ESBT Alliance Financial Plan. An update to be provided on* ***11 October 2017*** *at the next formal Alliance Governing Board*	**20/17 AB 11/10/17**
21/17	**ESBT new model of care: outcome of decisions from Alliance partners following options appraisal recommendation: roadmap, timetable and next steps**	
	Jessica Britton summarised work on the new model of accountable care following a positive response from sovereign organisations to the recommendations from the options appraisal panel (22 June 2017). The timetable now accelerates as we look to implement those recommendations. Key priorities are to have in place single leadership (for both commissioner and provider) and single pooled commissioning budget to underpin the more formal alliance structure from April 2018.	

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	We will also be working closely with colleagues in Primary Care on the best way for them to work with the new model going forward in order to inform a menu of options. Vicky Smith introduced the updated milestone map which sought to tie together the various strands of work and show how we bring in other parts of the system. The map was still high level and some milestones may shift. Development of proposals will continue into the Autumn with detailed recommendations brought to the Alliance Governing Board in November and taken to sovereign organisations by Christmas. The new strengthened ESBT Alliance arrangements will be in place from April 2018. Key points made in discussion: • We need to have a view on possible pitfalls going forward and part of that was a need to be adaptable and flexible. The Accountable Care Development Group will monitor and manage risks carefully; • A strong link with the overarching STP strategy will be maintained; and • Federations were assured that movement to option four in future would not preclude GPs from retaining independent contractor status with a General Medical Services (GMS) contract. The Alliance Governing Board **noted** the update and proposed timeline to accelerate implementation during the test bed year, to deliver new arrangements from April 2018.	
22/17	**Key messages from this meeting**	
	David Clayton-Smith summarised the key messages from this meeting as follows: • Performance reporting from Alliance Executive to the Board is crucial and we will see the beginnings of the new report at the next meeting ; • We are moving towards a single integrated plan and budget; • The Alliance Governing Board needs sufficient information to understand the implications of data presented (are our strategies working) and the ability to forecast future issues; • The Clinical Leadership Forum is functioning better and supporting transformation. The group is also discussing how federations can take part and helping implement new initiatives such as the ReSPECT forms etc; • Work on the new model of accountable care continues apace with the recommendation on adopting Option 3 with a future goal of Option 4 now agreed. We need to make Option 3 work first and put milestones in place. We are really beginning to operationalise the strategy of the alliance work while retaining a close link with the overarching STP context; and • While we are making good progress, it will take time for the Alliance	

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	Governing Board to bed down into delivering its role, supported by the right level of information and input.	
23/17	**Any Other Business** **To be notified to Chair at least 2 working days in advance.**	
	There was no other business put forward for discussion	
	The next meeting date was confirmed as 11th October 2017, from 10:00-12:30. The Sussex Exchange, Queensway, Hastings, St Leonard's-on-sea, TN38 9AG The meeting closed at 12:45.	

Freedom of Information Act: Those present at the meeting should be aware that their names and designation will be listed in the minutes of this Meeting which may be released to members of the public on request.

Questions from members of the public

No questions were raised by members of the public following this meeting.

Date	Item no.	Item title	Initial Action Required	Staff to Action	Action Due	Action Complete	Further Actions/Comments
09/08/2017	19/17(i)	Feedback and key issues from associated groups: • Alliance executive (AB); • Clinical Leadership Forum (DW); and • Accountable Care Development Group (ALP)	Adrian Bull will submit a first cut of a report from the Alliance Executive to the **11 October 2017** meeting of the Alliance Governing Board.	Adrian Bull	11/10/2017	Propose to complete	A further verbal update will be given at the meeting.
09/08/2017	19/17(ii)	Feedback and key issues from associated groups: • Alliance executive (AB); • Clinical Leadership Forum (DW); and • Accountable Care Development Group (ALP)	Jessica Britton will work with the Federation to agree a way forward for ensuring it is fully engaged in the redesign work and report back to the **11 October 2017** meeting of the Alliance Governing Board	Jessica Britton	11/10/2017	Propose to complete	Update 29/09/17: meeting held with Federations to discuss the way forward. A verbal update will be given at the meeting.
09/08/2017	20/17	Integrated ESBT Alliance Plans: Combined ESBT Strategic Investment Plan (SIP) and Cost Improvement Plan (CIP) Update at Month 2	Adrian Bull, as chair of the Alliance Executive, to: ensure that the conditions for delivery of the plans are in place; and confirm commitment to collective actions necessary to ensure delivery of all constituent organisational control totals and overall ESBT system financial balance through an integrated ESBT Alliance Financial Plan. An update to be provided on **11 October 2017** at the next formal Alliance Governing Board	Adrian Bull	Oct-17		Update 05/10/17: Integrated performance report will be finalised during October and be first submitted to the informal meeting in November.

Updated: 29/09/2017

The East Sussex Better Together Alliance Governing Board

Item Number:

Date of meeting 11 October 2017

30/17

Title of report: Feedback from associated groups: • Alliance Executive (AB); • Clinical Leadership Forum (DW); • Accountable Care Development Group (ALP)
Recommendation: The Alliance Governing Board is recommended to **note** the verbal updates and consider any items raised for escalation.
Executive Summary: The Alliance Governing Board oversees the work of the Alliance Executive, the Clinical Leadership Forum and the Accountable Care Development Group. For this standing item the group chairs or a nominated representative will report relevant summary assurance and highlight any key points from the meetings held during the calendar month prior to each Board meeting. The reports will be provided as verbal updates for: i. Alliance Executive – Dr Adrian Bull ii. Clinical Leadership Forum – Dr David Warden iii. Accountable Care Development Group – Amanda Philpott
Alliance Governing Board sponsors: • Alliance Executive – Dr Adrian Bull Chief Executive, East Sussex Healthcare NHS Trust (ESHT) • Clinical Leadership Forum – Dr David Warden, Chair, HR CCG Governing Body • Accountable Care Development Group – Amanda Philpott, Chief Officer, EHS and HR CCGs

Author(s): The relevant chairs/representatives will provide verbal updates.	**Date of report:** 11/10/17

Review by other committees: The Alliance Executive meets fortnightly and the Clinical Leadership Forum and the Accountable Care Development Group meet monthly. This item allows allocated time for verbal feedback from these meetings.
Health impact: Not applicable for this update.
Financial implications: Not applicable for this update.
Legal or compliance implications: None.
Link to key objective and/or principal risks: Not applicable for this update.
Link to East Sussex Better Together (ESBT) programme: Not applicable for this update.
How has the patient and public engagement informed this work: Minutes of the Alliance Governing Board, including updates from associated meetings, are published on the ESBT website. A programme of communications and engagement is integral to the work of the Alliance.
Equality Analysis (EA) Process - outcome: Negative Impact ☐ Neutral Impact ☐ Positive Impact ☐ No Impact ☐ Not required for report ☒ **EA Summary:** These verbal reports do not require Equality Assessment.
Privacy Impact Assessment (PIA) – outcome: No personal data used ☒ Data processes sufficient ☐ Actions required ☐ **Actions:** Not applicable.

The East Sussex Better Together Alliance Governing Board

Item Number:

Date of meeting 11 October 2017

31/17

Title of report: East Sussex Better Together Outcomes framework
Recommendation: The ESBT Alliance Governing Board is recommended to note the attached report to ESBT Strategic Commissioning Board on 2 October 2017 which sets out progress made with further developing and refining the pilot ESBT Alliance Outcomes Framework, including: • Our progress so far • Finalising baselines, targets and trajectories for each performance measure; • Quarterly reporting arrangements; • Sample trends and direction for Quarter 1 in Appendix 2; and • Further plans for engagement and co-design, including the production of publically accessible performance information.
Executive Summary: The 2017/18 test-bed year for the formal ESBT Alliance 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. Building on our original ESBT work on reporting progress against population health and health inequalities outcomes it has been agreed that during this test-bed year, we will develop our framework of focused, shared system-wide priority outcomes which we can work towards and further test and refine during the year. This will: • Enable us to understand if our ESBT Alliance arrangement is working effectively to deliver improvements to population health and wellbeing; experience and quality, and; sustainability; • 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; and

- Complement the way the ESBT Alliance uses our collective business intelligence to understand the performance of the health and care system as a whole.

Board sponsor: Jessica Britton, Chief Operating Officer, Eastbourne, Hailsham and Seaford Clinical Commissioning Group (CCG) and Hastings and Rother CCG

Author(s): Bianca Byrne, Acting Head of Policy and Strategic Development, Adult Social Care and Health, East Sussex County Council	**Date of report:** 02/10/17

Review by other groups/forum: ESBT Strategic Commissioning Board

Health impact: The framework captures how well our Alliance is delivering the improved health and well-being outcomes that matter to our local populations.

Financial implications: None at this stage.

Legal or compliance implications: None, the framework ensures ESBT is delivering key objectives.

Link to key objective and/or principal risks: The framework directly measures delivery of key ESBT objectives.

Importance to East Sussex Better Together (ESBT) programme: This work is fundamental to understanding how successful the Alliance is in delivering improved healthcare outcomes to the people of East Sussex.

How has the patient and public engagement informed this work: Ongoing public engagement through Patient Participation Group Forums and Shaping Health and Care events.

Equality Analysis (EA) Process - outcome:

Negative Impact	Neutral Impact	Positive Impact	No Impact	Not required for report
☐	☐	☐	☐	☒

Privacy Impact Assessment (PIA) – outcome:

No personal data used	Data processes sufficient	Actions required
☒	☐	☐

Actions:

East Sussex Better Together Outcomes Framework

1. Background

1.1 The 2017/18 test-bed year for the formal ESBT Alliance 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. Building on our original ESBT work on reporting progress against population health and health inequalities outcomes it has been agreed that for this test-bed year, we need a small group of shared system-wide priority outcomes which we can work towards and further test and refine during the year. Although at a developmental stage, ultimately it is envisaged that this will:

- Enable us to understand if our ESBT Alliance arrangement is working effectively to deliver improvements to population health and wellbeing; experience and quality, and; sustainability;
- 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; and
- Complement the way the ESBT Alliance uses our collective business intelligence to understand the performance of the health and care system as a whole.

1.2 At the ESBT Strategic Commissioning Board meeting on 6 June 2017, a draft outcomes framework with key indicators and performance measures organised within four key outcome domains was agreed as a pilot during 2017/18. The pilot integrated framework and measures is included at Appendix 1 for ease of reference.

1.3 The need for an integrated Outcomes Framework to measure performance of our whole ESBT health and care system is further highlighted as a result of the plans agreed by the ESBT Alliance partners in July 2017 for formal integration by 2020/21, initially through strengthening the Alliance arrangement for April 2018. This will mean putting in place single leadership and performance management of our commissioning resource, as well as moving towards single leadership of how we organise delivery of our services (the subject of a separate report to the ESBT Strategic Commissioning Board).

1.4 As we move towards developing the detailed business case for an integrated health and care organisation by 2020/21, our Alliance Outcomes Framework will also need to take account of the national incentive framework that is in development as part of the standard Accountable Care Organisation Contract for procuring new care models.

2. Pilot ESBT Alliance Outcomes Framework progress

2.1 Since the pilot ESBT Alliance Outcomes Framework was agreed on 6 June 2017, work has continued to develop and refine the framework and finalise baselines, targets and trajectories for each performance measure. Targets are being established for a five year period from 2016-2021 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.

2.2 Data sources have been identified for the majority of measures and it is anticipated this will be completed by the end of October. Work is also ongoing to establish targets for the more developmental measures in the framework; however we may not be in a position to set targets for some measures until the end of the current financial year to inform next year's outcomes progress. These are as follows:

- Increase people accessing the support available to them in their local communities
- Waiting time to initiation for home care packages
- Proportion of people who have access to active care coordination
- Activation levels of people receiving services
- Increase in people reporting being treated with care, kindness and compassion

2.3 A small number of additional measures have been proposed to reflect priorities across the system and support measurement of improvements across the system. These will be considered for inclusion in the next iteration of the Outcomes Framework at the end of the pilot year and include:

- Improving mental health of parents
- Identification of carers in primary care
- Health-related quality of life for people with long-term conditions
- Proportion of people feeling supported to manage their long-term conditions

2.4 Dialogue is also taking place with lead commissioners across our health and care system to align future commissioning activity with the four domains within the draft outcomes framework.

2.5 In line with finalising baselines, targets and trajectories for each performance measure, we are also in the process of drawing together quantitative performance data, where available, for each domain. A sample of performance for the first quarter showing trends and the direction of travel for two measures within each domain is included at Appendix 2. In summary:

- Breastfeeding rates have fluctuated between 2012/13 and 2016/17. Rates were highest in 2012/13 (46%) and dropped to their lowest in 2015/16 (41%), whilst 2016/17 saw an increase again (44%).
- Maternal smoking rates for the ESBT area have reduced, however they remain worse than England for each of the last four years.
- The proportion of adults with learning disabilities in paid employment is increasing and is above the national average.
- The proportion of people 65+ who are still at home three months after a period of rehabilitation is increasing and is above the national average.

- The average length of stay has steadily remained under 8 days since 2014 and in Quarter 1 (2017/18) the average rate has decreased further to its lowest rate (7.20).
- The number of non-elective admissions has decreased since 2014 and this trend seems to have continued in Quarter 1.
- The total number of infections in Eastbourne, Hailsham and Seaford increased in by 43 cases between 2015/16 and 2016/17 whilst in Hasting and Rother these have decreased by 27.
- Using the ESSC methodology of data capturing, there has been a uniform trend in the number of falls since 2014 which have ranged between 2332-2330.

2.6 To support monitoring an oversight of the system we plan to produce quarterly highlight reports to show performance across the system. These will be supported by a one-page summary in an infographic format to present the information to the public and other stakeholders. A full report showing performance against targets will also be produced at the end of each year, and will include both quantitative and qualitative data. Within this we will need to manage the challenges of variations in reporting frequencies and the ongoing development of data at an ESBT level.

2.7 The quantitative data in the outcomes framework will be enhanced by qualitative data in the form of case studies and survey data collected through the ESBT Public Reference Forum[1].

3. Engagement with local people

3.1 Following on from engagement in April and May 2017, we will continue to engage with local people during 2017/18 to further inform and shape the Alliance Outcomes Framework and test the pilot outcome measures. Follow up sessions will be held with the Patient Participation Group Forums and at Shaping Health and Care events in the coming weeks and months.

3.2 A range of accessible materials are being produced to introduce the pilot outcomes framework to the public and other stakeholders:

- The outcomes framework overview document can be seen at Appendix 1.
- A one-page infographic has been designed to introduce the framework to the public in an accessible format (see Appendix 3). Further infographics will be produced highlighting areas of progress each quarter and some areas to improve in the next quarter.
- A two-minute introductory video is planned to explain the outcomes framework in simple terms. This will be available by December.
- Dedicated web pages on the ESBT website will contain an introduction to the outcomes framework, relevant background documentation, quarterly reports and qualitative case studies. The design can be seen at Appendix 4. The page will be

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The Public Reference Forum is managed by East Sussex Community Voice and has the following strategic outcomes:

1. [1] Local people are able to engage and participate in the aims, objectives and workstreams of the East Sussex Better Together Alliance; particularly those less likely to be heard and/or those from protected characteristic communities.
2. East Sussex Better Together Alliance is informed and shaped by local people and its progress and success is measured by local people taking part in the Public Reference Forum.

available by the end of October and will include an interactive version of the Outcomes Framework with each of the four domains containing the following information for the public to navigate:

- Introduction
- List of measures and performance summary document
- Latest quarterly infographic
- Relevant case study (after Quarter 3)

4. Next steps

4.1 Work will continue to establish baseline figures and set targets for the five year period. As reporting processes become established, more detailed highlight reports will be available from Quarter 2 onwards. It is proposed that reporting will be quarterly in arrears to allow for data availability.

4.2 Alongside this we will be testing the overall approach and public-facing materials with the public and stakeholders to make sure the pilot outcome measures are the right ones, and that we are communicating our aims and progress clearly.

4.3 We will continue working with lead commissioners to align commissioning activity with the four domains within the draft outcomes framework.

5. Conclusion and reasons for recommendations

5.1 Research and discussions about our new model of accountable care continue to highlight the need for an integrated outcomes framework which to measure improvements on a system-wide basis and test how well our whole health and care system is working.

5.2 The pilot framework has been well-received and will be used to inform our stakeholders about progress made by our ESBT Alliance against our health and care system priorities to deliver improvements to population health and wellbeing, experience, quality and sustainability – including the per capita cost of care.

5.3 Further development of our pilot integrated Outcomes Framework is needed to prepare for the move towards single leadership and performance management of our commissioning resource and strengthened governance by April 2018, as well as the move towards single leadership of how delivery of our Alliance services are organised. An integrated whole health and care system Outcomes Framework will be crucial to ensure oversight of system performance against investment made.

5.4 The ESBT Strategic Commissioning Board is asked to note progress made with further developing and refining the pilot ESBT Alliance Outcomes Framework, including:

- Finalising baselines, targets and trajectories for each performance measure;
- Developing quarterly reporting arrangements;
- Sample trends and direction for Quarter 1 in Appendix 2; and
- Further plans for engagement and co-design, including the production of publically accessible performance information.

Keith Hinkley
Director of Adult Social Care and Health, ESCC CCGs

Amanda Philpott
Chief Officer, EHS and HR

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Contact Officer: Jessica Britton
Tel No: 01273 403686
Email: jessica.britton@nhs.net

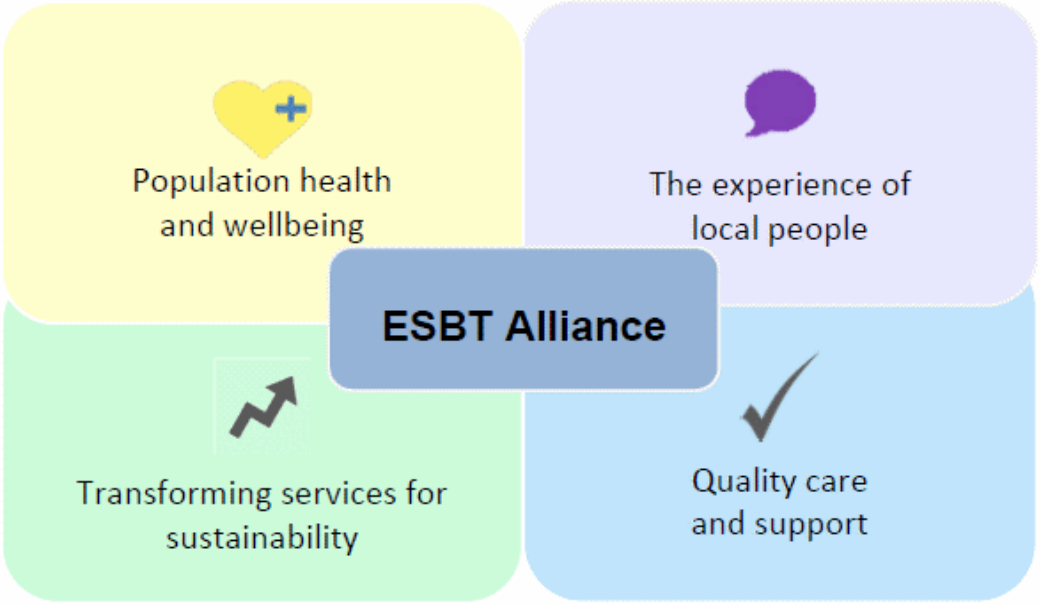
BACKGROUND DOCUMENTS

Appendix 1: Draft outcomes framework overview
Appendix 2: Quarter 1 performance data from a sample of performance measures for each domain
Appendix 3: Infographic showing a selection of targets for 2017/18
Appendix 4: Web pages design and layout

Appendix 1: Draft outcomes framework overview

Outcomes Framework

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.

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 Increase in proportion of people referred with first episode of psychosis who are seen within 2 weeks
	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 people and staff in all health and care settings able to retrieve relevant information about an individual's care from their local system	Proportion of systems feeding in to the integrated personal record Proportion of systems feeding in the integrated reporting system Proportion of systems feeing in to the citizen record

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

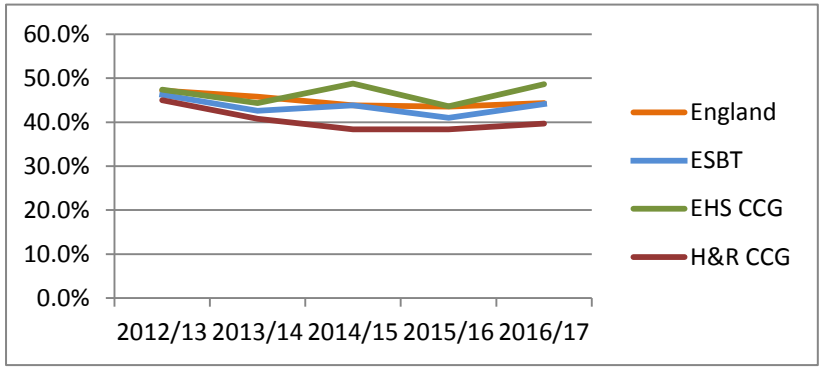
Interventions take place early to tackle emerging problems, or to support people in the local population who are most at risk	The flow of investment from acute hospital services to preventative, primary GP, and community health and care services	Increase the proportion of funding invested in preventative, 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 Number of people who have a care plan from a proactive service Proportion of people accessing services through case finding Proportion of people who have access to active care coordination

Quality care and support

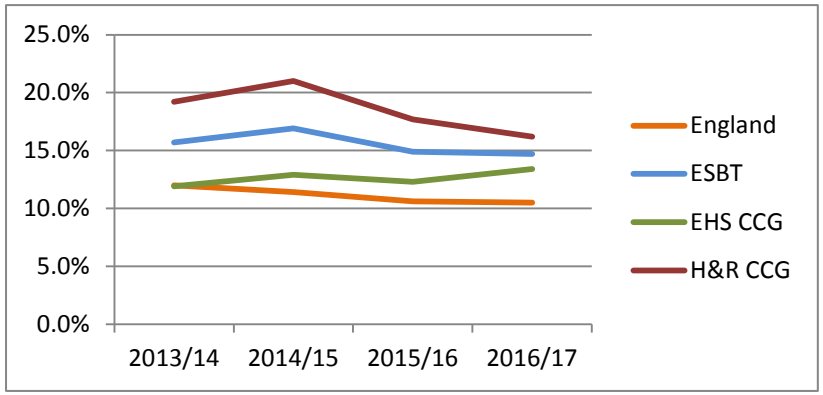
Outcomes	These indicators and measures will tell us how we are doing...	
We want to provide safe, effective and high quality care and support		
People are supported by high quality care and support	The proportion of people reporting satisfaction with the services they have received	Increase in number 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

Appendix 2: Quarter 1 performance data from a sample of performance measures for each domain

<table>
<tr><th>Domain</th><th>Outcome</th><th>Performance measure</th><th>Performance</th></tr>
<tr><td rowspan="2">Population health and wellbeing</td><td rowspan="2">Children are supported to have a healthy start in life</td><td>Increase in the percentage of babies aged 6-8 weeks that were fully or partially breastfed

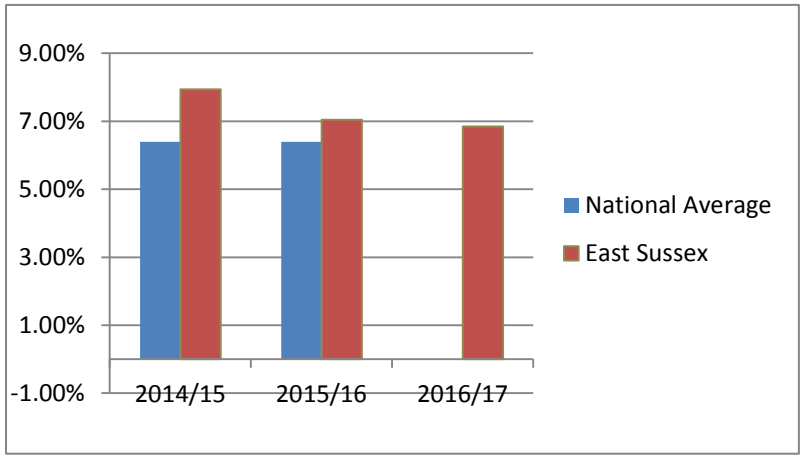
Definition: Percentage of all infants due a 6-8 week check that are totally or partially breastfed.</td><td>


<table>
<tr><th></th><th>2012/13</th><th>2013/14</th><th>2014/15</th><th>2015/16</th><th>2016/17</th><th>Q1 (2017/18)</th></tr>
<tr><td>England</td><td>47.2%</td><td>45.8%</td><td>43.8%</td><td>43.5%</td><td>44.3%</td><td></td></tr>
<tr><td>ESBT</td><td>46.2%</td><td>42.6%</td><td>43.8%</td><td>41.0%</td><td>44.1%</td><td>42.50%</td></tr>
<tr><td>EHS CCG</td><td>47.4%</td><td>44.3%</td><td>48.8%</td><td>43.6%</td><td>48.6%</td><td>45.00%</td></tr>
<tr><td>H&R CCG</td><td>45.0%</td><td>40.8%</td><td>38.4%</td><td>38.4%</td><td>39.7%</td><td>39.80%</td></tr>
</table>
</td></tr>
<tr><td>Reduction in the percentage of mothers known to be smokers at the time of delivery

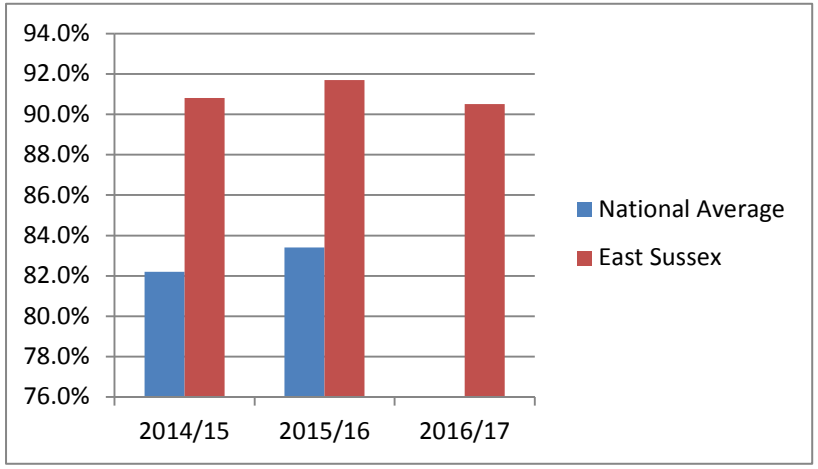
Definition: Percentage of women known to be smokers at the time of delivery.</td><td>


<table>
<tr><th></th><th>2013/14</th><th>2014/15</th><th>2015/16</th><th>2016/17</th><th>Q1 (2017/18)</th></tr>
<tr><td>England</td><td>12.0%</td><td>11.4%</td><td>10.6%</td><td>10.5%</td><td></td></tr>
<tr><td>ESBT</td><td>15.7%</td><td>16.9%</td><td>14.9%</td><td>14.7%</td><td>14.9%</td></tr>
<tr><td>EHS CCG</td><td>11.9%</td><td>12.9%</td><td>12.3%</td><td>13.4%</td><td>9.5%</td></tr>
<tr><td>H&R CCG</td><td>19.2%</td><td>21.0%</td><td>17.7%</td><td>16.2%</td><td>16.0%</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>Domain</th><th>Outcome</th><th>Performance measure</th><th>Performance</th></tr>
<tr><td rowspan="2">The experience of local people</td><td>The proportion of people with support needs who are in paid employment</td><td>Increase in the proportion of adults with learning disabilities in paid employment

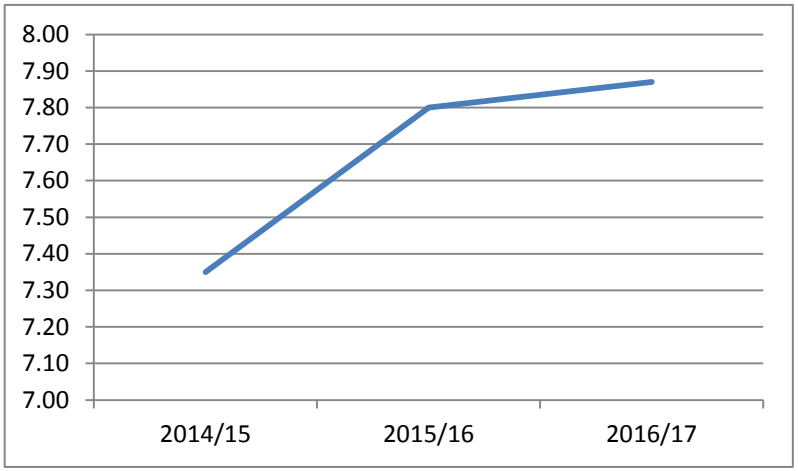
Definition: The proportion of working age adults with a Primary Support Reason (PSR) of Learning Disabilities who are known to the council, who are recorded as being in paid employment within the financial year.</td><td> 

<table>
<tr><th></th><th>2014/15</th><th>2015/16</th><th>2016/17</th><th>Q1 (2017/18)</th></tr>
<tr><td>National Average</td><td>6.40%</td><td>6.40%</td><td></td><td></td></tr>
<tr><td>East Sussex</td><td>7.94%</td><td>7.05%</td><td>6.85%</td><td>6.94%</td></tr>
</table></td></tr>
<tr><td>The proportion of people who regain their independence after using services</td><td>Proportion of people 65+ who are still at home three months after a period of rehabilitation

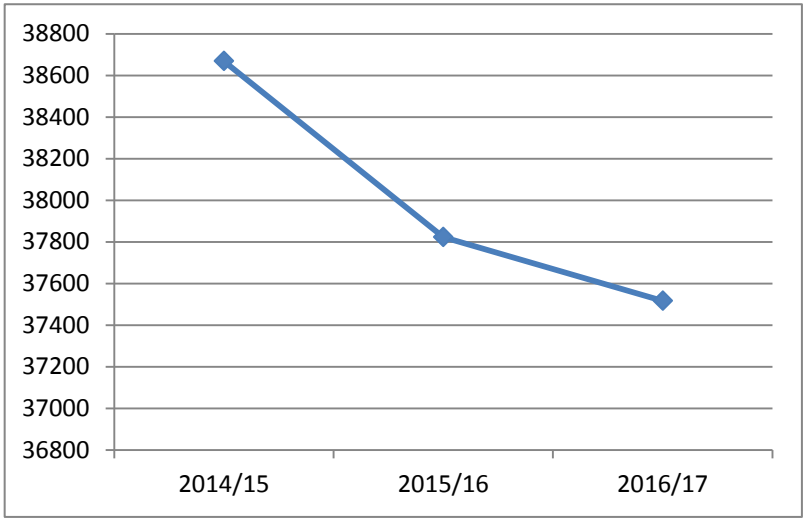
Definition: The proportion of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing bed for rehabilitation, with a clear intention that they will move on/back to their own home who are at home or in extra care housing or an adult placement scheme setting three months (91 days) after the date of their discharge from hospital.</td><td> 

<table>
<tr><th></th><th>2014/15</th><th>2015/16</th><th>2016/17</th><th>Q1 (2017/18)</th></tr>
<tr><td>National Average</td><td>82.2%</td><td>83.4%</td><td></td><td></td></tr>
<tr><td>East Sussex</td><td>90.8%</td><td>91.7%</td><td>90.5%</td><td>94.6%</td></tr>
</table></td></tr>
</table>

<table>
<tr><th>Domain</th><th>Outcome</th><th>Performance measure</th><th>Performance</th></tr>
<tr><td rowspan="2">Transforming services for sustainability</td><td>The length of stay in hospital</td><td>Reduction in length of stay for identified cohort

Data source: Data extracted from Secondary Uses Service (SUS inpatient data based on discharge date and admission method being an Emergency Admission. As a mean Length of Stay (LoS) can be disproportionately affected by small numbers of outlier values a truncated mean is shown, which excludes the top 10% of values.</td><td> 

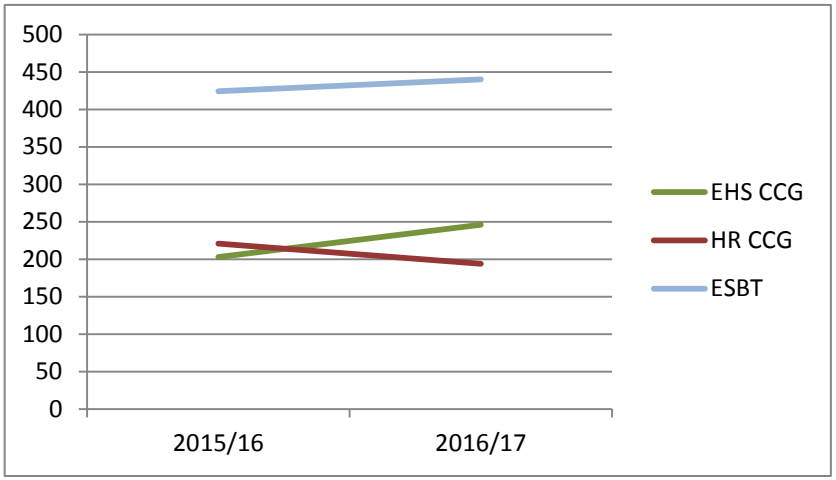
<table>
<tr><th>Year</th><th>2014/15</th><th>2015/16</th><th>2016/17</th><th>2017/18: Q1</th></tr>
<tr><td>No. of days</td><td>7.35</td><td>7.80</td><td>7.87</td><td>7.20</td></tr>
</table></td></tr>
<tr><td>The number of people accessing hospital in a planned way</td><td>Reduction in the number of non-elective admissions

Data source: Extracted from SUS inpatient data based on discharge date and an admission method recorded as emergency admission methods, including through an Emergency Care Department and via a General Practitioner</td><td> 

<table>
<tr><th>Year</th><th>2014/15</th><th>2015/16</th><th>2016/17</th><th>2017/18: Q1</th></tr>
<tr><td>No. of people</td><td>38,669</td><td>37,823</td><td>37,517</td><td>9,342</td></tr>
</table></td></tr>
</table>

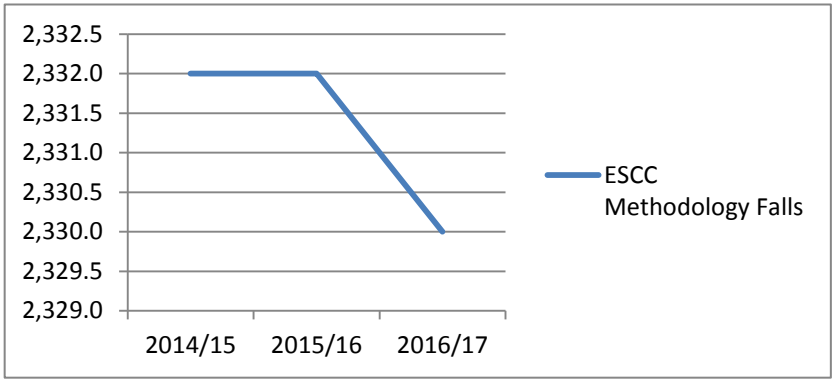
<table>
<tr><th>Domain</th><th>Outcome</th><th>Performance measure</th><th>Performance</th></tr>
<tr><td rowspan="2">Quality care and support</td><td>The number of healthcare-related infections and serious incidents</td><td>Reduction in healthcare related infections

Data Source: Public Health England Data Capture System

Definition: The infections being captured are: e.coli Bacteraemia, Clostridium Difficile and MRSA Bacteraemia.</td><td>


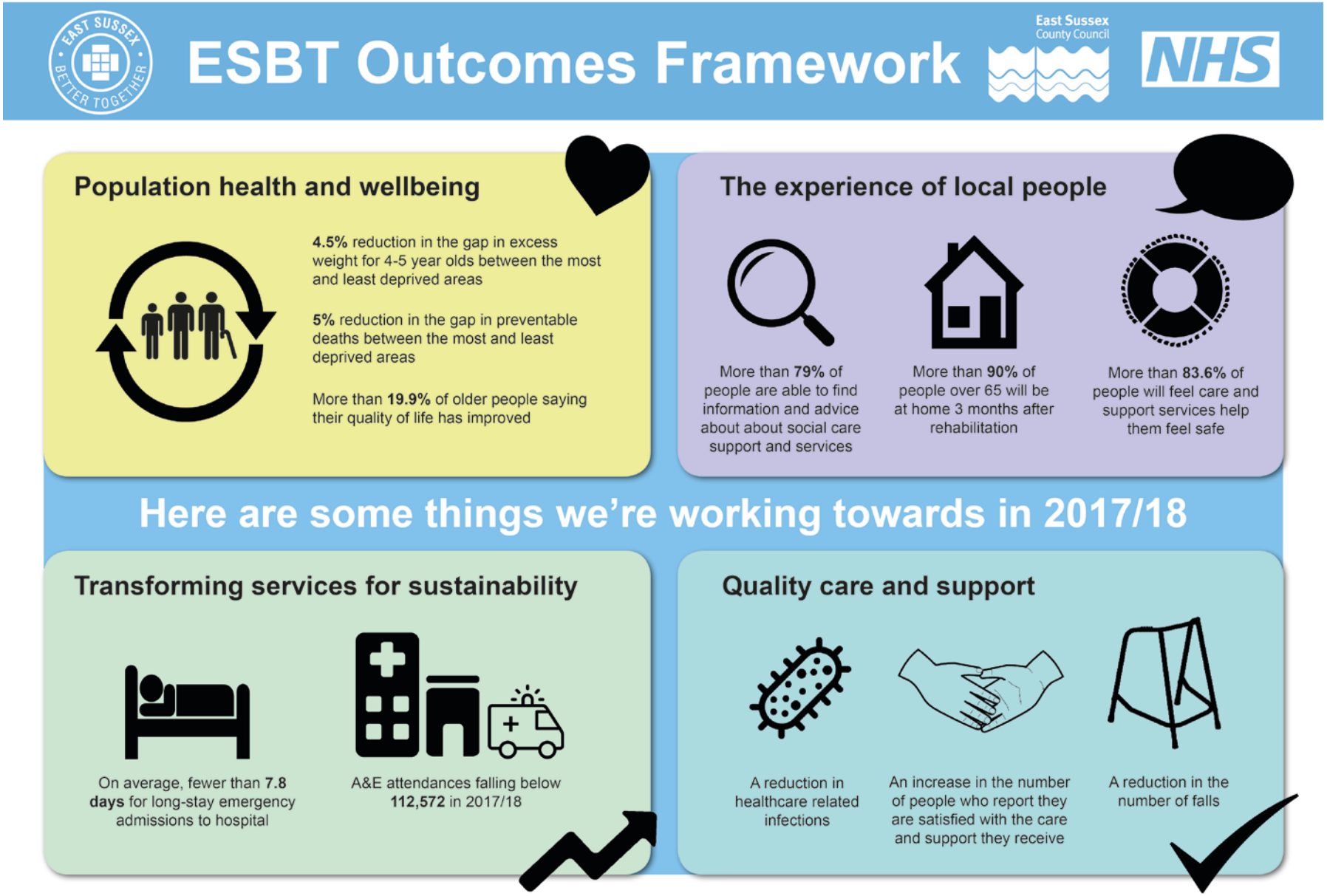
<table>
<tr><th>Year</th><th>2015/16</th><th>2016/17</th><th>Q1 (2017/18)</th></tr>
<tr><td>EHS CCG</td><td>203</td><td>246</td><td>61</td></tr>
<tr><td>HR CCG</td><td>221</td><td>194</td><td>57</td></tr>
<tr><td>ESBT</td><td>424</td><td>440</td><td>118</td></tr>
</table>
</td></tr>
<tr><td>The number of falls in the population of local people</td><td>Reduction in falls

Data Source: ESCC use residents of East Sussex, diagnosis codes in first episode and includes specialised commissioning data.

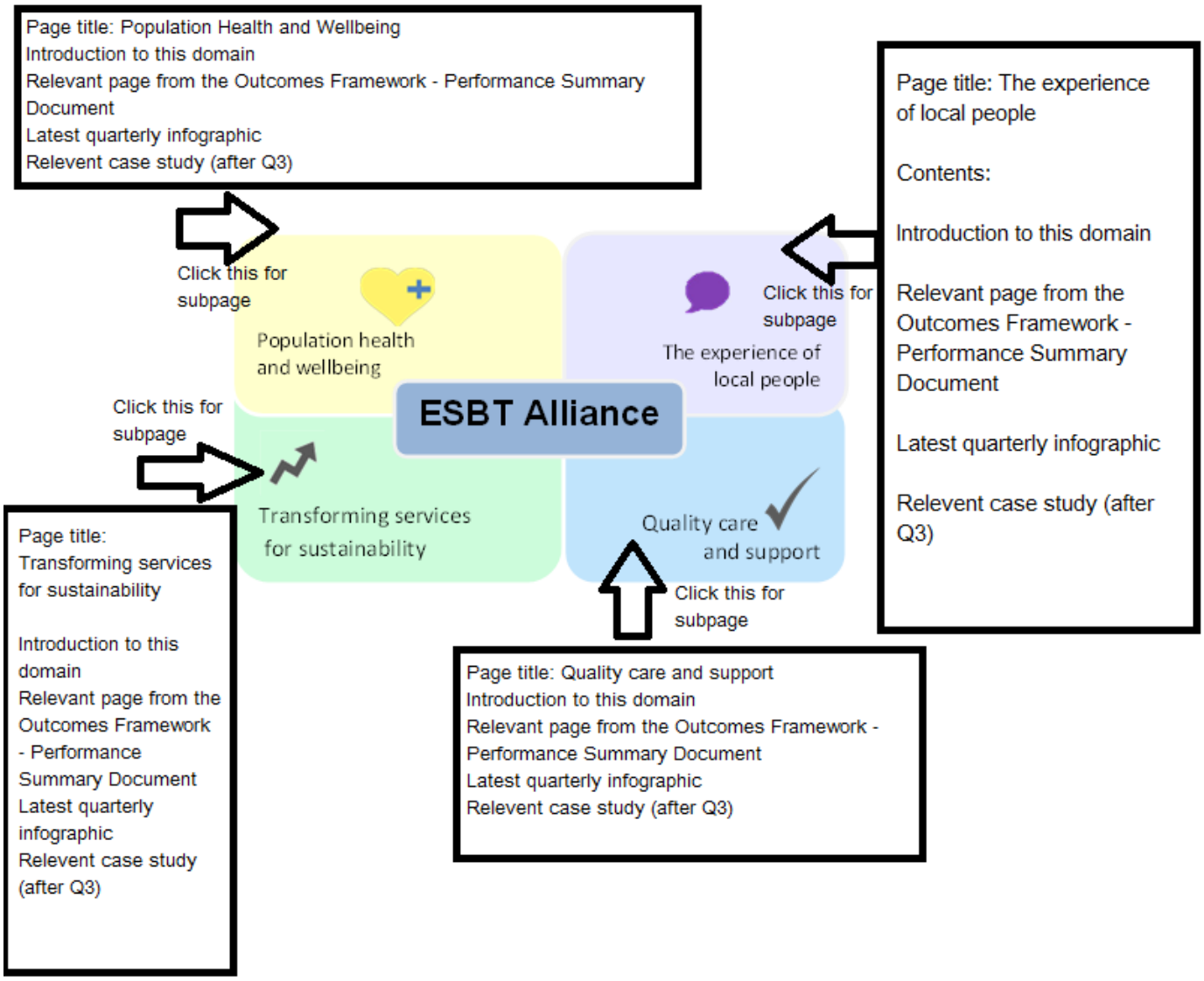
Emergency admissions for falls injuries classified by first diagnosis code, external cause and an emergency admission code. Age at admission 65 and over.</td><td>


<table>
<tr><th>Year</th><th>2014/15</th><th>2015/16</th><th>2016/17</th><th>2017/18: Q1</th></tr>
<tr><td>No of Falls</td><td>2,332</td><td>2,332</td><td>2,330</td><td>577</td></tr>
</table>
</td></tr>
</table>

Appendix 3: Infographic showing a selection of targets for 2017/18



Appendix 4: Web pages design and layout



The East Sussex Better Together Alliance Governing Board

Item Number:

Date of meeting 11 October 2017

32/17

Title of report: ESBT Performance: progress update on delivery against plans
Recommendation: The Alliance Governing Board is recommended to **note** the presentation that will be provided at the meeting and consider any items raised for escalation.
Executive Summary: A presentation will be given to the Alliance Governing Board on current progress against delivery plans, alongside progress with the development of a fully integrated Alliance plan and associated performance framework. As discussed at the informal meeting of the Alliance Governing Board on 13 September 2017, a full range of data is used actively by the Alliance Executive for the purposes of receiving assurance around delivery of ESBT financial and delivery plans. However, this information is largely still not presented in an integrated way that will fully meet the needs of the Alliance. We anticipate being in a position to present an initial integrated report to the informal meeting of the Alliance Governing Board on 8 November 2017.
Alliance Governing Board sponsors: • John O'Sullivan, Chief Finance Officer, Eastbourne, Hailsham and Seaford and Hastings and Rother Clinical Commissioning Groups (EHS and HR CCGs) and • Paula Gorvett, ESBT Programme Director

Author(s): Paula Gorvett, ESBT Programme Director	**Date of report:** 11/10/17

Review by other committees: CCG Governing Bodies and ESHT Board have reviewed quality, activity and financial performance at their sovereign organisation meetings and the Alliance Executive regularly reviews performance.
Health impact: Not applicable for this update.
Financial implications: Deliver financial plans in year and provide significant evidence of good use of resources.
Legal or compliance implications: Delivery against National Constitutional Standards
Link to key objective and/or principal risks: Delivery of high quality services, delivery of agreed plans and delivery of control totals across the ESBT system.
How has the patient and public engagement informed this work: Minutes of the Alliance Governing Board, including updates from associated meetings, are published on the ESBT website. A programme of communications and engagement is integral to the work of the Alliance.
Equality Analysis (EA) Process - outcome: Negative Impact ☐ Neutral Impact ☐ Positive Impact ☐ No Impact ☐ Not required for report ☒ **EA Summary:** These verbal reports do not require Equality Assessment.
Privacy Impact Assessment (PIA) – outcome: No personal data used ☒ Data processes sufficient ☐ Actions required ☐ **Actions:** Not applicable.

The East Sussex Better Together Alliance Governing Board

Item Number:

Date of meeting 11 October 2017

33/17

Title of report: ESBT financial position 2017/18: update and required actions at Month 5
Recommendation: The ESBT Alliance Governing Board is recommended to **note** the: 1. To note the Month 5 ESBT system financial position; 2. To note the size and scale of recovery action needed if financial control totals are to be achieved across the system; 3. To note that recovery actions are being developed and implemented collaboratively through the Alliance structures; and that a request is being made to NHSE and NHSI to support this collaborative approach by agreement to operating effectively with a single control total within 2017/18.
Executive Summary: This report presents work undertaken by the Directors of Finance across our ESBT system to provide a current assessment of the ESBT health and care system financial risk for 2017/18 together with urgent recovery action being considered by the Alliance Executive for the achievement of financial control totals across our system.
Governing Body sponsor: John O'Sullivan, Chief Finance Officer, Eastbourne, Hailsham and Seaford and Hastings and Rother Clinical Commissioning Groups (EHS and HR CCGs)

Author(s): Phil Hall, Strategic Financial Advisor, East Sussex County Council	**Date of report:** 05/10/17
Review by other groups/forum: ESBT Alliance Executive	
Health impact: None – system report.	

Financial implications: As set out in the report.
Legal or compliance implications: None – Financial reporting only.
Link to key objective and/or principal risks: Provides Alliance Governing Board with an assessment of financial position.
Importance to East Sussex Better Together (ESBT) programme: Financial reporting aimed at helping the Alliance deliver appropriate outcomes while achieving sustainability.
How has the patient and public engagement informed this work: N/A
Equality Analysis (EA) Process - outcome: Negative Impact ☐ Neutral Impact ☐ Positive Impact ☐ No Impact ☐ Not required for report ☒
Privacy Impact Assessment (PIA) – outcome: No personal data used ☒ Data processes sufficient ☐ Actions required ☐

ESBT financial position 2017/18: update and required actions at Month 5

1. INTRODUCTION

1.1. The Alliance Executive has received a series of monitoring reports highlighting the financial risks to the system in 2017/18. The Executive and the individual sovereign organisations have endorsed the critical importance of achieving whole system financial balance (ie meeting all individual control totals).

1.2. As a reminder, the scale of budgets within the control of Alliance Partners is c£1 billion. This is illustrated pictorially at Appendix 1.

1.3. Members of the Governing Body will be aware of the complexities of overlaying an Alliance system financial forecast on top of individual organisational forecasting. Considerable progress has been made in understanding and adjusting for those complexities but it remains work-in-progress (and indeed cannot be fully completed while the commissioner/provider organisational split remains). The work to date therefore represents a best estimate and further work will continue to be undertaken to understand fully and reconcile the system position, for example in understanding and forecasting the financial impact of higher-than-expected activity levels.

1.4. The year-to-date position, outturn and risk assessment is presented in this report as a whole system position.

2. MONTH 5 POSITION

2.1. The Executive received the regular Month 5 financial monitor **(Appendix 2)** which is supported by a more detailed monitor to provide greater transparency and granularity of scrutiny across the system.

2.2. Key system budget variations apparent at Month 5 (M5) are as follows:

Budget Heading	Variation, £M	Adverse or Favourable
CCG spending on Acute	-16.0	ADV
CCG spending on Primary	+0.7	FAV
Adult Social Care	-0.2	ADV
Other CCG	+2.2	FAV
CCG use of reserves	+10.2	FAV
Trust spending on Pay	-0.1	ADV
Trust spending on Non-Pay	-0.9	ADV
Trust income	-0.1	ADV
Net	**-4.3**	**ADV**

2.3. The overall Month 5 position is an YTD deficit of £24.0m against a planned deficit ("financial balance") of £19.7m, an adverse position of £4.3m.

2.4. The year to date position shows the pressure on the system, with a reliance on use of reserves as the major balancing item in the current position.

2.5. **Appendix 3** shows the monthly "run-rate" of expenditure against budget. It shows that the Month 5 expenditure figures continue the previous trend of being in excess of budget.

2.6. Previous Finance reports have highlighted a £45.5m difference in Operating Plans income and expenditure assumptions between the CCGs and ESHT. Further analysis has been undertaken to fully understand the differences in activity assumptions between the two plans, it is evident that the £45.5m difference in CCG and ESHT spend/income budget assumptions is largely consistent with the £16.0m adverse variation in CCG acute spend. The level of acute activity is indicative that the SIP interventions have yet to have a mitigating impact to the full extent required, although clear progress is being made. This will be because of implementation delays caused by recruitment issues and, in some cases, low initial take-up of services.

2.7. Included within the £45.5m difference is approx. £2m relating to changes in national tariff prices and different assumptions, made nationally by NHSe and NHSi, about the effect of these.

3. FINANCIAL RECOVERY

3.1. Work is being urgently undertaken to devise and implement recovery actions that mitigate the extent of financial risk in 2017/18 and assist with the achievement of medium-term financial sustainability. Actions are being developed collaboratively across partner organisations. As partners we all agree that our recovery focus should be on a *whole-system* recovery, and yet our experience is emphasis on *individual*

control totals create behaviours that undermine collective action. To assist our collective focus on delivery of recovery, we are raising again our previous request to NHSE and NHSI to operating effectively within a single financial control total within 2017/18.

3.2. In addition, to further support the transition to a collective system approach and to manage financial risk most effectively, the CCG and Trust have reached in-principle agreement to implement an Aligned Incentive Contract (AIC). A number of health systems elsewhere in the country have adopted AICs as a better means of jointly managing financial risk between commissioner and provider. It involves a move away from PbR. It should be recognised that an AIC is not an end in itself but rather a means to an end. The critical task remains to identify and implement, jointly, the actions needed to achieve system balance and sustainability.

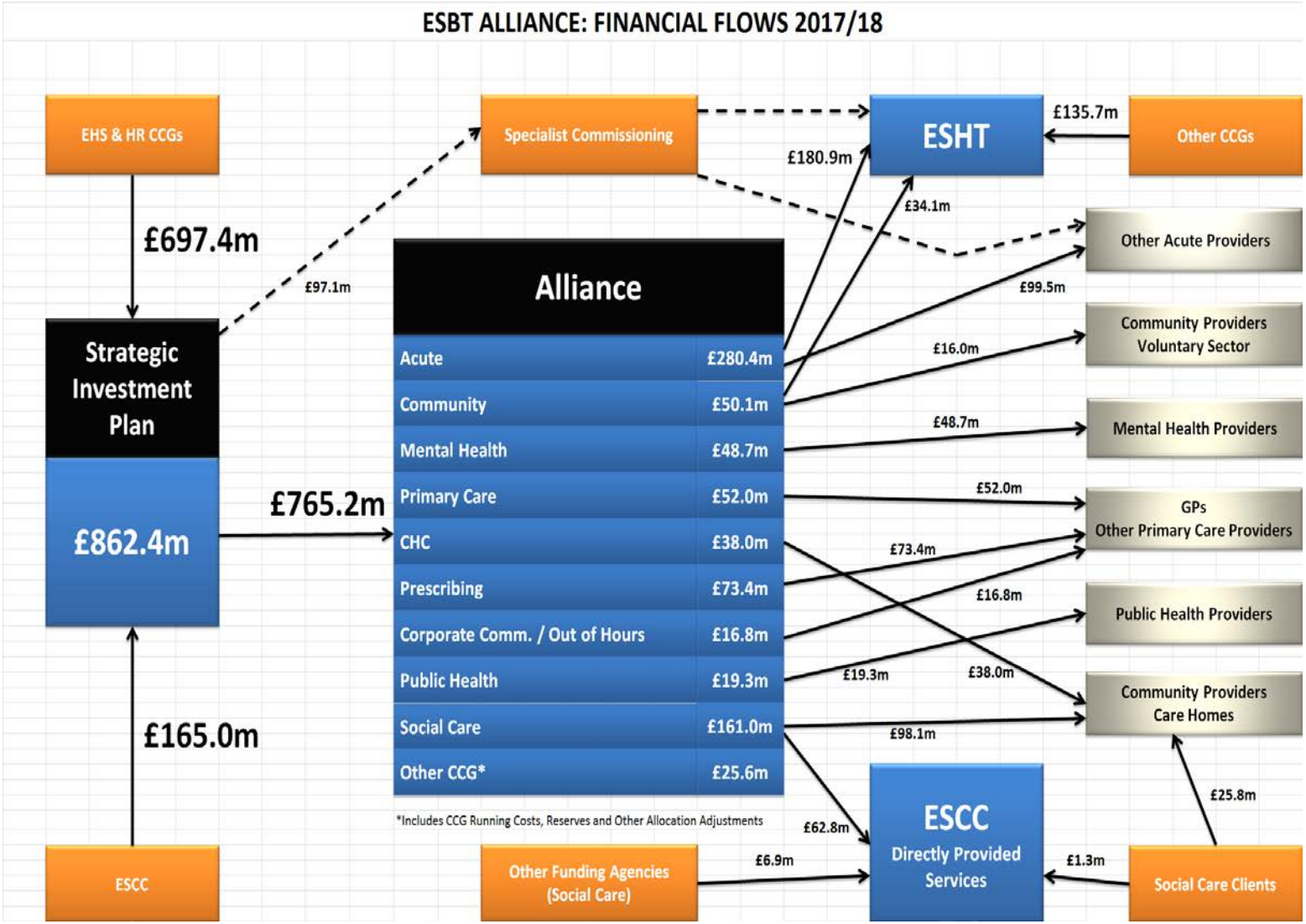
3.3. When finalised, the recovery plan will form part of the Integrated ESBT Finance and Investment Plan, which, by way of reminder, comprises the following elements and incorporates an assessment of the potential adverse impacts of schemes on other parts of the system:

- Re-forecast Strategic Investment Plan schemes
- Approved Trust Cost Improvement Plan schemes
- Financial Recovery Plan actions.

3.4. The Integrated Plan will be managed using PMO disciplines with regular reporting through the Alliance structures. A weekly Delivery Board is being established to drive achievement of the Plan.

3.5. The scale of in-year financial risk means that full in-year recovery will be extremely challenging. In this context, it is important to remember:

- How financial risk in 2017/18 need to be seen in the wider context of the very positive impact of the ESBT programme since in 2013/14, using outcome benchmarks and year of care cost comparators;
- The impact in 2017/18 of pressures that are outside of original organisational plans, notably HRG4+ (£4m) and STP commitments (currently £3m+).



NHS Eastbourne, Hailsham and Seaford Clinical Commissioning Group
NHS Hastings and Rother Clinical Commissioning Group
East Sussex Healthcare NHS Trust
Sussex Partnership NHS Foundation Trust
East Sussex County Council

Appendix 2

ESBT MONITORING PERIOD 5 2017/18 - INCOME & EXPENDITURE

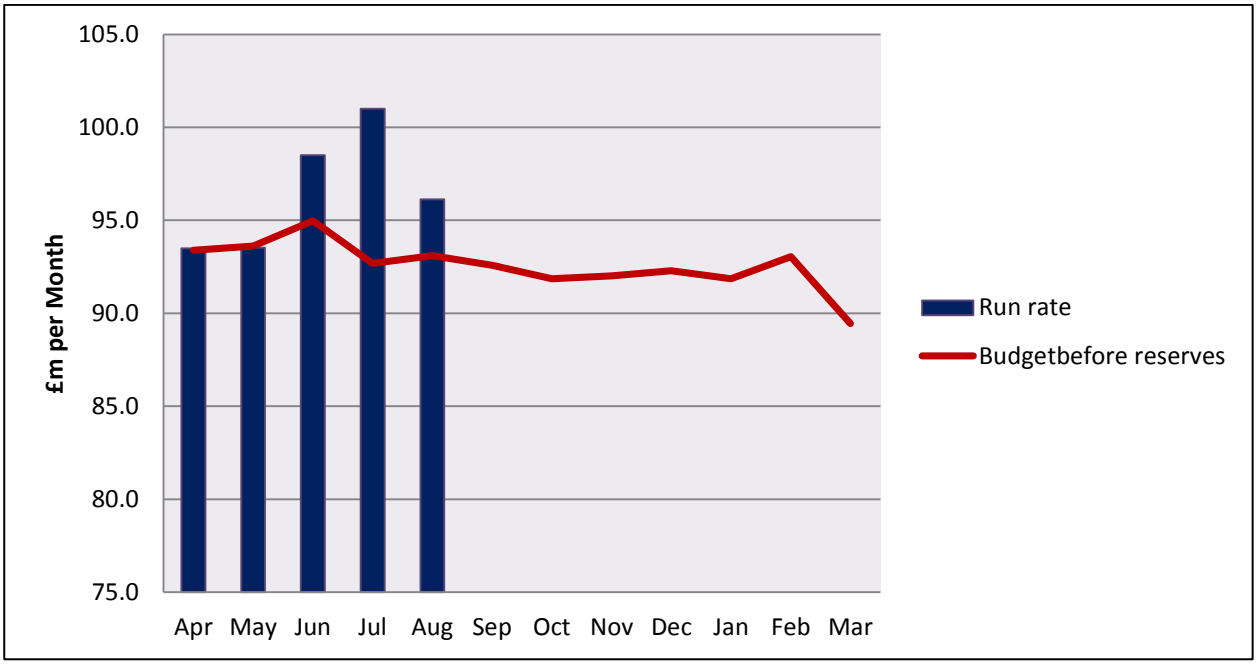
Accountable Care Monitoring Period 5	Plan YTD	Actual YTD	Variance YTD	Plan	Forecast	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
EHS	127,289	127,289	-	292,898	292,898	-
HR	128,997	128,997	-	302,136	302,136	-
CCG Specialist	40,468	40,468	-	97,123	97,123	-
ESCC - Core Budget	68,758	68,758	-	165,020	165,020	-
ESCC - External Income	14,164	14,164	-	33,995	33,995	-
ESCC - Income from HWLH	26,226	26,226	-	62,943	62,943	-
ESHT	52,813	52,713	100	137,044	137,044	-
Total Income	**458,716**	**458,616**	**100**	**1,091,159**	**1,091,159**	**-**
ESHT Gross Exp	180,900	181,900	(1,000)	425,227	425,227	-
ESHT CCG Income*	(108,387)	(108,344)	(43)	(262,956)	(262,956)	-
CCG Acute Spend with ESHT*	76,006	90,319	(14,313)	183,318	183,318	-
CCG Community Spend with ESHT*	14,208	14,208	-	34,098	34,098	-
Acute Spend with Other Providers	41,921	43,644	(1,723)	98,651	98,651	-
Community Spend with Other Providers	6,179	5,980	199	15,251	15,250	-
CCG Mental Health	20,310	20,142	169	48,744	48,744	-
Primary Care	52,228	51,566	662	125,348	125,348	-
CHC	15,843	15,954	(111)	38,023	38,023	-
CCG Spend with Local Authorities	2,797	2,796	1	5,183	5,183	-
Other CCG Spend	6,842	5,094	1,749	16,422	16,422	-
CCG Admin Costs	3,351	3,192	159	8,128	7,315	813
Earmarked Reserves	10,245	-	10,245	6,614	7,426	(812)
CCG Specialist	40,468	40,468	-	97,123	97,123	-
Adult Social Care	78,047	78,263	(216)	187,313	187,832	(519)
Children's Services	2,631	2,631	-	6,314	6,314	-
Public Health	8,601	8,601	-	20,642	20,642	-
HWLH	26,226	26,226	-	62,943	62,943	-
ACO Expenditure	**478,416**	**482,639**	**(4,223)**	**1,116,386**	**1,116,904**	**(518)**
Net Deficit	**19,700**	**24,023**	**(4,323)**	**25,227**	**25,745**	**(518)**

Notes

*EHST CCG income and CCG Acute and Community Spend with ESHT will net-off when agreed position is established

Appendix 3

NET ESBT EXPENDITURE RUN RATE BEFORE RESERVES ARE APPLIED



Notes
ESHT expenditure is shown gross of non-ESBT income
Budget is shown before use of CCG earmarked reserves

The East Sussex Better Together Alliance Governing Board

Item Number:

Date of meeting 11 October 2017

34/17

Title of report: Strengthening our ESBT Alliance arrangements for 2018/19: progress update
Recommendation: The ESBT Alliance Governing Board is recommended to: • **Note** the progress on our proposals for strengthening the alliance on 2018/19, and the specific work to date on the emerging approach to developing a single point of leadership for ESBT strategic commissioning, and a single point of leadership for how we organise service delivery.
Executive Summary: Plans to further formalise health and social care integration were approved in July 2017 by the governing bodies of the core ESBT Alliance Members, demonstrating that consensus has been reached across our system on the overall direction of travel for ESBT, and the best way to continue to improve services, health and wellbeing and ensure long-term sustainability within our resource envelope. We have agreed to strengthen our current ESBT Alliance arrangement for **2018/19** as a stepping stone to our preferred delivery vehicle of a new single health and care organisation by **2020/21**. This is seen to be the best way to continue to improve services, population health and wellbeing and ensure long term sustainability within our resource envelope. This builds on our work already delivered by the ESBT programme since it was established in **August 2014** as we work to integrate health and care in a way that achieves: improved experience for local people; improved health and wellbeing outcomes, and; delivers system sustainability. Formalising our Alliance further will help us to mobilise the current system to manage the service quality, financial and demand risks that we face. As part of this we have agreed to determine a single leadership of our integrated commissioning function, as well as a single

leadership of our provider function and the way in which we organise services. This will help us to strengthen our commissioning expertise in an integrated way, with a clear focus on population health and outcomes to drive improvements.

In line with the original mandate to explore a single point of leadership for commissioning and a single point of leadership for how delivery of services is organised, an initial discussion paper outlining our emerging thinking and how this could be taken forward was shared at the informal meeting of this Alliance Governing Board on 13th September. A similar paper was also taken to the meeting of the Governing bodies of Eastbourne Hailsham and Seaford CCG and Hastings and Rother CCG on 27th September. A copy of this paper is attached as an appendix to this report for contextual information.

Since those meetings, work has continued on this aspect of our ESBT Alliance transformation agenda and plans are progressing to ensure:

- Defined single leadership for our strategic commissioning based on population health need, together with an integrated commissioning budget to underpin this;
- Defined single leadership for the way in which we then provide services as an alliance;
- Defined single leadership of our system transformation to ensure sustainability;
- an alliance business infrastructure proposal
- in-year improvements to service quality and finances, in line with our five year strategic investment plan;
- work towards attaining permissions for a system-wide control total on the road to our accountable care system in order to support the collective action required to deliver improved quality, outcomes, and use of resources.

In order to provide the most current reporting, a verbal update will be given at the meeting and a report with firm proposals will be submitted to the appropriate sovereign bodies and to the Alliance Governing Board in November and December 2017. The proposals will be implemented for April 2018.

Governing Board sponsor: Jessica Britton, Chief Operating Officer, EHS and HR CCGs

Author(s): Vicky Smith, Accountable Care Strategic Development Manager, ESBT and Jessica Britton	**Date of report:** 04/10/17

Review by other groups/forum: Earlier iterations of this paper was discussed at the meeting of the Accountable Care Development Group on 22nd August 2017, 18th September and 6th October 2017, the informal meeting of the ESBT Alliance Governing Board on 13th September, and the meeting held in public of EHS and HR CCGs on 27th September

Health impact: Whole system transformation to the ESBT future model of accountable care, underpinned by whole system integrated strategic commissioning will positively incentivise improvements to individual's care and population health
Financial implications: Through taking a 'one system one budget approach' and developing our risk and reward share arrangements to deliver outcomes as an accountable care Alliance, we will positively incentivise a shift away from reactive acute based care to proactive community based care and preventing demand. In addition through the use of patient centred approaches, self-care and self-management and efficient and effective clinical and care decisions, resources will be invested more wisely and health and care services will become more sustainable overall.
Legal or compliance implications: New approaches are not yet fully embedded in national policy guidance and risks will need to be identified and mitigated. There will be a need to ensure that all regulatory and inspection bodies are fully on board with the move to the future ESBT model of accountable care.
Link to key objective and/or principal risks: a shift from over utilisation of expensive acute services to proactive community based prevention and population health to manage demand, will help achieve our overall goal of securing clinically and financially sustainable health and care services for future generations in East Sussex.
Importance to East Sussex Better Together (ESBT) programme: An integrated commissioning system will support the move to a new model of accountable care and a formally integrated health and care organisation by 2020/21.
How has the patient and public engagement informed this work: A full programme of engagement has informed the development of ESBT and the Accountable Care Model (ACM); most notably the development of integrated care, integrated locality teams, a focus on prevention and well-being and more recently, the pilot integrated outcomes framework for the ESBT Alliance and the criteria for appraising the future ESBT delivery vehicle.
Equality Analysis (EA) Process - outcome: Negative Impact ☐ Neutral Impact ☒ Positive Impact ☐ No Impact ☐ Not required for report ☐ **EA Summary:** An initial Equalities screening of the ESBT legal delivery vehicles has been undertaken to support the options appraisal exercise. At this stage there are no significant impacts to report and it is recommended that further analysis is undertaken once the preferred option is known and developed in more detail; the screening makes some recommendations on key issues to take into account in doing this.
Privacy Impact Assessment (PIA) – outcome: No personal data used ☒ Data processes sufficient ☐ Actions required ☐

Appendix 1 (September 2017 report)

Strengthening our ESBT Alliance arrangements for 2018/19: progress report

1. Introduction

1.1 As previously reported to the meeting of the ESBT Alliance Governing Board in August, plans to further formalise health and social care integration were approved in July 2017 by the governing bodies of the core ESBT Alliance Members.

1.2 We have agreed to strengthen our current ESBT Alliance arrangement for 2018/19 as a stepping stone to our preferred delivery vehicle of a new single health and care organisation by 2020/21. This is seen to be the best way to continue to improve services, population health and wellbeing and ensure long term sustainability within our resource envelope.

1.3 This builds on our work already delivered by the ESBT programme since it was established in August 2014 as we work to integrate health and care in a way that achieves: improved experience for local people; improved health and wellbeing outcomes, and; delivers system sustainability.

1.4 Formalising our Alliance further will help us to mobilise the current system to manage the service quality, financial and demand risks that we face. As part of this we have agreed to determine a single leadership of our integrated commissioning function, as well as a single leadership of our provider function and the way in which we organise services. This will help us to strengthen our commissioning expertise in an integrated way, with a clear focus on population health and outcomes to drive improvements.

1.5 This report provides an update on the emerging thinking and timetable to deliver a stronger ESBT Alliance arrangement for April 2018.

2. Single point of leadership for commissioning

2.1 As previously reported a single point of leadership and management of our commissioning resource, together with strengthened integrated governance arrangements, is considered to be the best way to deliver clinically led and locally accountable improvements to the health and wellbeing of our population. It will also better enable us to focus on quality and system finance and sustainability by channelling ESBT resources, staff, time and energy clearly on our 'place'.

2.2 In line with the current regulatory context Eastbourne, Hailsham and Seaford Clinical Commissioning Group (EHS CCG), Hastings and Rother Clinical Commissioning Group (HR CCG) and East Sussex County Council (ESCC) will remain as separate sovereign organisations, and will put in place arrangements for 2018/19 that enable joint accountability through a single leadership. This will help us commission 'as one', based on population health needs in the best interests of our local population. Early discussions have taken place in August to help shape our understanding of how a single point of leadership for integrated commissioning could take place. The emerging approach is underpinned by putting the following key elements in place:

- A single leadership role for strategic commissioning across our whole health and social care system. This will be supported by a single integrated leadership team that would deliver the strategic commissioning functions of both the CCGs and ESCC social care

- Strengthened integrated governance arrangements to enable the proper discharge of our functions, reducing duplication where possible and demonstrating robust decision-making within agreed frameworks.
- A pooled and aligned budget for our whole health and care system will need to be put in place in readiness to support our ambition by April 2018 (work is being taken forward in parallel to put in place the underpinning financial arrangements to support integrated whole system commissioning for our population).
- Statutory responsibility will remain with the sovereign organisations (EHS and HR CCGs and ESCC) and arrangements will need the agreement and assurance of those bodies, as well as NHS England (NHSE).

2.3 Some further assumptions that characterise the emerging model include:

- The single leadership of commissioning will be delivered from our existing system through a probable coming together of the CCG Accountable Officer function and ESCC chief officer functions.
- In order to maximise the benefits of this approach, this is likely to take the form of a secondment arrangement which will need to include formalisation of the accountability of the role and formal recognition across the CCGs, ESCC and NHSE.
- Retention of capability and capacity across our system will be critical to success.
- The single integrated leadership team would need to be able to discharge both CCG and ESCC social care functions in the following areas:

    - Health economics, Public Health and Joint Strategic Needs Assessment
    - Planning, strategy and engagement to identify and set outcomes
    - Nursing and care quality, patient safety and safeguarding
    - Monitoring and performance managing the delivery of outcomes
    - Strategic finance, system governance and risk

- Formal arrangements will need to be put in place to support this to enable both the CCG and ESCC systems of accountability where individuals are responsible for

functions on behalf of the health and care organisations. This will be managed within existing organisational arrangements and to avoid unnecessary disruption there is no intention to make changes to current employment terms and conditions as part of alliance arrangements.

- We will need to take a transitional approach to ensuring we have the right balance of staffing capacity to support the strategic commissioning function, and those that will, over time, be aligned with the move to a health and care organisation. As part of this there will be an ongoing process to involve staff beneath senior management team level in the integration of health and social care strategic commissioning functions as this becomes clear. To support this work is being undertaken to further align functions across our ESBT Alliance to support both remits of strategic commissioning and tactical commissioning to enhance core health and care services and care pathways and to support operational delivery. A brief explanation of the three layers of commissioning that take place across our Alliance is contained in the Appendix.

3. Timetable

3.1 A proposed high level timetable was initially shared at the August meeting of the Alliance Governing Board. This has been refreshed this to reflect growing understanding of our approach as follows:

Ongoing engagement	Activity	Timeline
	Development of approach, discussion and testing	August and September 2017
	Further discussion, testing and finalisation of proposals, including aspects of commissioning to be delegated to STP-level and to locality level.	October 2017
	Final proposals brought to the Alliance Governing Board	November 2017
	Recommendation of proposals to sovereign bodies: • EHS CCG and HR CCG Governing Bodies • ESCC Cabinet	November - December 2017
	Agreed process for single point of commissioning leadership role	January 2018
	Strategic Investment Plan and pooled/aligned budget finalised and agreed • EHS CCG and HR CCG Governing Bodies • ESCC Cabinet	January – March 2018
	Integrated senior leadership team agreed process	February - March 2018
	New formalised ESBT Alliance arrangements in	April 2018

NHS East[illegible]e, Hailsham and Seaford Clinical Commissioning Group
NHS Hasti[illegible]and Rother Clinical Commissioning Group
East Susse[illegible]ounty Council
East Susse[illegible]ealthcare NHS Trust
Sussex Pa[illegible]ship NHS Foundation Trust

	place: • Phased implementation to strengthen integrated governance arrangements Singe leadership role and team in place • High level approach to transitional arrangements and alignment of staff in functional areas of strategic and tactical/operational commissioning	

4. Next steps

4.1 As part of making progress in line with our timetable, in the following weeks we will need to agree and establish a process to support the development of the single leadership role and top tier leadership team. This will also take into account our developing understanding of the transitional arrangements for commissioning capacity across our system.

4.2 Building on previous comprehensive stakeholder engagement throughout the development of ESBT and our new model of accountable care, we will further test our plans with our stakeholders in the coming months and undertake shared impact assessments, ensuring population benefits are clear. This will include regulators and will take in considerations of scope, including which aspects of strategic commissioning would likely take place as part of Surrey and East Sussex STP-wide commissioning where this makes sense.

4.3 In addition we will complete an exercise to review and strengthen governance and assurance of our system ready for 2018/19. This will include looking at the purpose and remit of the existing board meetings within our ESBT Alliance governance arrangements and also sovereign bodies in order to manage commissioning on a system-wide basis. This will involve forming a view of where we can safely reduce duplication by further strengthening the roles and function of the integrated ESBT Strategic Commissioning Board and ESBT Alliance Governing Board and making best use of our existing clinical and lay leadership across the system. In practice, and based on learning from the UK Vanguards and other early implementers, it looks as if this likely to mean:

- Phasing in an alignment of existing governance arrangements across all of the ESBT Alliance partner organisations to reduce duplication and manage the business more efficiently, at the same time as enabling statutory duties and strategic direction to be discharged. This would take place within a clear framework of appropriate delegation and a robust management of statutory functions.
- Strengthening the function of the integrated ESBT Strategic Commissioning Board, through utilising existing roles within the CCG Governing Bodies, such as clinical and lay leadership, in this setting. Similarly we will explore the potential increased role of the ESBT Alliance Governing Board to manage core elements of business.

4.4 Feedback on work undertaken to support the actions will form the basis of a report to the Alliance Governing Board in October.

4.5 Work will also take place in the coming weeks to take forward the single leadership and management of delivery of how services are organised.

4.6 Plans are also in place to carry out a further round of joint ESBT staff engagement events in the coming months to follow up on the engagement events that were held in May.

5. Conclusion and reasons for recommendations

5.1 The ESBT Alliance sovereign organisations' agreement to the recommendations in July demonstrates that consensus has been reached across our system on the overall direction of travel for ESBT, and the best way to continue to improve services, health and wellbeing and ensure long-term sustainability within our resource envelope.

5.2 Strengthening our accountable care system by moving towards single leadership and performance management of our commissioning resource, alongside strengthened integrated governance, by April 2018, will enable a stronger more influential voice to underpin our shared ambitions for the ESBT 'place' and properly focus our work on population health and well-being outcomes based on evidenced best practice.

6. Recommendation

6.1 The ESBT Alliance Governing Board is recommended to:

- **Discuss** the emerging approach to developing a single point of leadership for whole system ESBT strategic commissioning
- **Note** the proposed timetable and next steps, as set out in paragraph 4.3, to progress development

Author Vicky Smith, Accountable Care Strategic Development Manager, ESBT
Report date: 08 September 2017

Appendix 2 – layers of commissioning functionality within the ESBT Alliance*

Based on the learning undertaken so far it is recognised that there three levels of commissioning functionality at play in our ESBT Alliance. These are set out in the table below:

Strategic Commissioning

Longer term strategic planning for the health and wellbeing of the population, in line with the Joint Strategic Needs Assessment, Health and Wellbeing Strategy and other joint commissioning strategies. The strategic commissioning function has responsibility to advocate on behalf of the population and influence across the wider determinants of health: for example, education, housing, employment etc. as well as influencing and commissioning across and beyond ESBT's boundaries; at STP, regional and national level.

The strategic commissioning function is responsible for defining the outcomes required for the population from the system, informed by the JSNA and engagement with our local population. As we move towards creating a formally integrated health and care delivery organisation, it will ultimately be the role of strategic commissioning to develop and manage the outcomes and contractual framework for a capitated outcomes-based contract, as well as monitor and oversee the performance. Strategic commissioning is the term used for all the activities involved in:

- assessing and forecasting needs
- identifying the desired health and wellbeing outcomes for the population
- engaging and consulting with the public and services users
- strategic planning and linking investment to agreed outcomes
- monitoring and performance managing contracts in line with the required outcomes. In the future this would take the form of a single overarching contract with the new accountable health and care delivery organisation
- being responsible for assurance and oversight of statutory responsibilities such as quality, safety and safeguarding, emergency planning and business continuity

Tactical service commissioning, redesign and improvement

This is any activity involved with redesigning, improving or enhancing and supporting the delivery of core public health, health and social care services and care pathways. Where services are commissioned they are often provided by a range of providers, including the voluntary and community organisations, and social enterprises, and developing care markets is critical. Services and care pathways usually cover a specific segment of the population, need or geographical area (particularly as we move to a more locality focussed model of planning and delivery which will be underpinned by this type of commissioning activity).

Involving patients, service users and carers directly, as well as other key stakeholders, is a pre-requisite of making changes to services and care pathways to ensure their expert voice is heard in the process to optimise success and effectiveness.

As we move towards creating a formally integrated health and care delivery organisation, it is envisaged that tactical commissioning will increasingly become the responsibility of the new organisation, to ensure clinical and care leadership necessary to deliver the outcomes in the overarching capitated contract.

Operational (individual) commissioning

This largely refers to decision-making to meet an individual's needs by clinicians and care practitioners; it includes individual packages of care resulting from individual assessments (including Direct Payments, Personal Budgets, Continuing Healthcare and Personal Healthcare Budgets), as well as individual onward referrals for treatment pathways and/or more specialist services. Care packages, services and treatment pathways can be provided internally from within our core health and care system, other NHS Trusts and providers, and the independent care sector, micro businesses and Personal Assistants, and again market development is essential to ensure a diverse range of provision that can respond to health and care needs.

At its most effective operational commissioning with individuals should be done as a partnership between clinicians and care practitioners and individuals to build on people's individual strengths and circumstances.

**Content adapted from Somerset STP 'Proposal for the Development of a Joint Commissioning Function' (July 2017)/Various*

The East Sussex Better Together Alliance Governing Board

Item Number:

Date of meeting 11 October 2017

35/17

Title of report:
East Sussex Better Together (ESBT) Engagement and Communications Strategy: Delivery Plan progress report

Recommendation:
The Governing Board is recommended to note this progress update and our priorities moving forward to the end of this financial year.

Executive Summary:
This progress report sets out how our ESBT Alliance Engagement and Communications Strategy is being delivered through progress on the year two delivery plan for the period April to September 2017. In particular the report highlights our progress against the agreed objectives:

1. To develop **a programme of clear and consistent engagement, information and material** that is targeted, accessible and audience specific.

2. To continue to develop and outline **meaningful opportunities** for stakeholders and local people to be involved in the development of ESBT health and care services and to be **proactive regarding the involvement of minority and seldom heard groups**.

3. **To gather real time information** from local people about the changes they are experiencing in their health and care services; with the aim of helping us to understand the impact of changes and therefore continuously learn and improve.

4. To **continuously evaluate our engagement and communications work** and to be open to new and innovative methods to improve.

5. To embed an **Alliance Communication and Engagement Function** which will bring together communication and engagement leads across all partners. This will enable cross-organisation information, messaging and activity that will seamlessly facilitate the aims and objectives of the ESBT Alliance and ensure streamlined targeted engagement and messaging.

Our achievements to date
Progress against our year two delivery plan is monitored by our Communications and Engagement Steering Group through a Red Amber Green (RAG) rating process. This shows that we are progressing well and in some areas are ahead of our planned timeline. The following extracts provide some highlights of our key achievements to date.

Our engagement and communications function across the ESBT Alliance is now stronger following an extension of membership to colleagues working in staff engagement, corporate media and communications and patient experience across the Alliance partners. We have revised our working arrangements so that we now have a series of workstreams (Digital, Media and Public Relations, Equality and Diversity, Marketing and Communications and Public and Stakeholder). Each workstream has a lead officer with assigned responsibility for driving delivery of our year two plan.

Our new **Collaborative Health and Wellbeing Stakeholder Group** has been launched and terms of reference were co-designed with representatives of the community and voluntary sector. Over 140 people took part in co-designing the role and membership of the group, which will form part of the ESBT Alliance governance arrangement. Its primary role will be to ensure the system continues to develop strong stakeholder engagement arrangements in relation to co-design, equality and diversity and wider connection to community and voluntary sector groups. **A report on the development of this is included at Appendix A.**

Our **digital communications work** has increased in frequency and developed significantly in terms of content in recent months. We use the hashtag #ESBT to raise the profile of the programme across social media and share agreed content with our ESBT partners. This allows us to reach a much wider audience of residents through the established and trusted social media platforms of these partners, such as East Sussex Healthcare NHS Trust's (ESHT's) Facebook page and East Sussex County Council (ESCC) Twitter account. Both CCG Twitter accounts are steadily gaining followers every month, and the content we post is also being retweeted more often, which again enables us to reach a wider target audience. Our 'impression' or reach is 19,100 and 28,900 respectively for both CCG accounts. ESCC's corporate Twitter account has 15,210 followers. Additionally, the council's Facebook page has 4,036 likes and a reach of 71,255.

Furthermore, our video celebrating the end of the ESBT Alliance 150 week programme has been watched by over 500 people on You Tube so far https://www.youtube.com/watch?v=712_SvGeEHc

Our ESBT newsletter is now sent electronically on a monthly database to a growing list of stakeholders. Our analysis (shown in the table below) of the current click rate shows a 300% increase on the average industry standard (government newsletters). Our intention going forward is to segment the newsletter further that content is tailored to specific audiences; for example members of the public and/or local service providers.

Our engagement leads have made contact with new organisations and groups where we need to **reach seldom heard communities and/or those from protected characteristic communities** and we are pleased to have engaged with two local Trans groups and shared the NHS England consultation on Gender Identity Services.

We have **increased visibility and activity in relation to equality and inclusion**; including the establishment of cross ESBT Alliance equality arrangements; a pledges campaign for CCG staff linked to NHS Equality and Diversity Week and an ESBT programme of learning as part of National Inclusion Week at the end of **September 2017**.

Committee sponsor: Jessica Britton, Chief Operating Officer

Author: ESBT communications and engagement team	**Date of report:** 27/09/17

Review by other committees: The content has been reviewed by ESBT partner forums and the appendix regarding the Stakeholder Group was submitted to the ESBT Strategic Commissioning Board on the 2nd October 2017.

Health impact: Involving local people in the identification of their health needs, care experiences and service priorities strengthens effective commissioning of health services.

Financial implications: There are no direct financial implications.

Legal or compliance implications: Health and Social Care Act 012 – duty to involve local patients and the local community in health planning. Equality Act 2010 – public sector equality duty.

Link to key objective and/or principal risks: Deliver our ambition of an integrated Health and Care Communications and Engagement Strategy to further ensure citizen involvement underpins our Alliance.

Equality Analysis (EA) Process - outcome:

Negative Impact	Neutral Impact	Positive Impact	No Impact	Not required for report
☐	☐	☒	☐	☐

EA Summary: Our engagement and communications work helps us achieve our duties under the Equality Act 2010; in particular by engaging with people from protected characteristic communities and ensuring their input into the planning and design of services.

Privacy Impact Assessment (PIA) – outcome:

No personal data used	Data processes sufficient	Actions required
☒	☐	☐

Actions: N/A

East Sussex Better Together (ESBT) Engagement and Communications Strategy: Delivery Plan progress report

1. This progress report sets out how our ESBT Alliance Engagement and Communications Strategy is being delivered through progress on the year two delivery plan for the period April to September 2017. In particular the report highlights our progress against the agreed objectives and a summary of activity in the last reporting period is included in the information below.

2. Create a culture of co-design – making co-design the way we engage and communicate

2.1. We continue to develop and outline meaningful opportunities for stakeholders and local people to be involved in the development of ESBT health and care services and seek to be proactive regarding the involvement of minority and seldom heard groups.

2.2. Recognising the value voluntary organisations can bring to helping people manage their own health, Hastings and Rother CCG commissioned Hastings Voluntary Action and Rother Voluntary Action to undertake a pilot project that sought to develop a much better understanding of the local Self-Help 'community'. It is recognised that these groups support people living with a long term health condition and play an invaluable role in helping people adapt and live with conditions that can be life limiting. They can positively contribute to a person's overall sense of health and wellbeing.

2.3. All of the events, workshop themes and ideas came from the members of the self-help groups themselves who formed an action group to plan the work and scope. The project mapped the extent, and reach, of the local self-help community with a focus on the top 10 local priority health conditions; organised a number of self-help conferences; and developed a web based presence to enable the self-help community to develop more visibility online acting as a resource repository, enabling groups to post ideas and news.

3. Facilitate a conversation about system-wide transformation and the development of new models of care

3.1. We continue to engage with local people, providers and our members in a range of ways as we move forward with our ESBT Alliance. The outcome of the new model of accountable care options appraisal exercise in June and subsequent sovereign body approval of the recommendations has been communicated to staff and stakeholders and a summary report published on the ESBT website. The milestone map, detailing the proposed timeline, has also been circulated online and at locality meetings.

3.2. Our monthly ESBT Newsletter regularly features articles covering system-wide transformation, new ESBT services and includes updates on our developing accountable care model. In recent editions, articles have covered; planning and partnerships report; events to celebrate Older Peoples Day; green light for ESBT Alliance plans; and our medicines waste campaign.

3.3. We've put what local people tell us is important for them right at the heart of our ESBT Alliance Outcomes Framework which we continue to test and develop through our test-bed year. We will use our award winning Public Reference Forum to capture patient and public stories and experiences to monitor our progress against the Accountable Care Outcomes Framework.

3.4. Our Engagement Team attended Eastbourne Faith Forum; Little Common Catholic Women Group; East Sussex Seniors Association; Harbour Medical PPG; and Old School PPG to discuss and explain our ESBT Alliance as well as providing an opportunity for questions and discussion on a number of proposals including the 'over 75s scheme' and clinically effective commissioning.

3.5. During this period the Engagement Team met with Sussex Community Development Association (SCDA); Hastings and Rother Rainbow Alliance; SDHC GP Federation; and Hastings Trans Group to better understand the work they are doing to improve the health and wellbeing of our local population as well as how we can work collaboratively. Our Engagement Team continue to meet regularly with our local community sector representatives and VCSs to ensure greater partnership working.

3.6. We continue to work with colleagues across our ESBT Alliance to empower local people and support them in making the right choices. Through our social media platforms we continue to share advice and support to ensure people are aware of the range of health and care services available to them.

4. Improve access to and quality of information

4.1. We have worked to substantially improve the 'get involved' section of the CCG websites and ensure information on patient and public participation is easily accessible, up to date and diverse. This clearly signposts to the ESBT website.

4.2. ESHT's new website makes content more accessible, allowing more people to get what they want from the website, first time. Patient information and information about services features heavily. The website contains a new 'get involved' section detailing opportunities input into our work. The new website also offers content about ESBT and provides a better interface with the ESBT website.

4.3. As part of this refresh we have added additional pages including further information on Patient Participation Groups (PPGs); how we support and enable local people to get involved; direct links to helpful information; the opportunity to join our 'Local

Voices Network'; and details of current opportunities for local people to have their say on services and proposed changes both locally and nationally.

4.4. Our Independent Domestic Violence Advisor service at the Conquest Hospital and the Identification and referral to improve safety project based in primary care are enhancing the co-ordination of local victim support services. For example, in order to increase awareness of domestic violence and abuse in NHS settings, training sessions are being provided to staff. These are resulting in an increase in the disclosure of domestic violence and abuse and an increase in the number of referrals to specialist services

4.5. The CCG GP newsletter during this period shared information about falls self-assessment and strength and balance exercise classes; support provided by Age Concern for patients who may be eligible for Attendance Allowance; enhanced services health care checks for those with learning disabilities; IM&T training needs; and a vaccine update from Public Health England.

5. Further develop relationships that are wide, collaborative and inclusive

5.1. We attended Eastbourne Faith Forum; Little Common Catholic Women Group; East Sussex Seniors Association; Harbour Medical PPG; and Old School PPG to discuss and explain our ESBT Alliance as well as providing an opportunity for questions and discussion on a number of proposals including the 'over 75s scheme' and clinically effective commissioning.

5.2. During this period we also met with Sussex Community Development Association (SCDA); Hastings and Rother Rainbow Alliance; SDHC GP Federation; and Hastings Trans Group to better understand the work they are doing to improve the health and wellbeing of our local population as well as how we can work collaboratively. We continue to meet regularly with our local community sector representatives and VCSs to ensure greater partnership working.

6. Empower people in their health and wellbeing (reflecting our shift towards people's health and wellbeing within health and caring communities).

6.1. We continue to work with colleagues across our ESBT Alliance to empower local people and support them in making the right choices. Through our social media platforms we continue to share advice and support to ensure people are aware of the range of health and care services available to them.

6.2. Over the summer across Sussex we launched a five-week survey that asked people what they want the Sussex NHS 111 to do – giving us a better idea about what people want and therefore what we need to procure, within the available resource. With more than 7000 calls a week made to 111 from people in Sussex the NHS 111 phone service is vital not only in terms of providing advice and support for people with urgent, but not life-threatening, health concerns, but it also plays a

central role in managing demand on other parts of the local health service - especially A&E and GP surgeries. The survey was published in our local press; we circulated the survey to our stakeholders and attended a number of meetings with communities and groups to promote completion of the survey.

6.3. In July tens of thousands of local people took to the street as 'Beat the Street' came to East Sussex. This was an opportunity for people of all ages to improve their health by being more active. The programme, delivered by Intelligent Health and funded by both CCGs and Public Health, sought to encourage people to walk, run and cycle more recognising that being more physically active makes people feel better, more energetic and improves mood.

6.4. In order to raise awareness of the risk factors, signs and symptoms of cancer, teams of volunteers have been recruited from most deprived communities of Hastings and Rother. Volunteers are being supported to develop community-based campaigns and initiatives which raise awareness of cancer and encourage participation in the National Cancer Screening Programmes.

6.5. Recent activities have focused on Bowel Cancer Screening and the Be Clear on Cancer Respiratory Campaign. In June and July 2017, the teams attended many diverse community events achieving a total 138 volunteering hours. They had 635 brief advice conversations about cancer and 97% of those individuals followed up demonstrated an increase awareness or intention to act on the advice given.

6.6 Embedding prevention across the whole system is central to ESBT's approach of improving health outcomes and reducing health inequalities. The East Sussex Making Every Contact Count programme contributes to this. A MECC pilot began in 2015/16 at East Sussex Healthcare NHS Trust's (ESHT) Conquest Hospital site to develop and test ways of rolling out the approach in NHS settings. Following the success of the pilot, MECC is being rolled out across the whole health and care workforce, with over 1000 people trained to date across a wide variety of specialities. MECC is also now included in ESHT's mandatory training.

6.7 The learning from ESHT's MECC project was presented at Public Health England's national conference on 13th September 2017 by the CCGs' Health Inequalities team, East Sussex County Council Public Health and ESHT.

7. Our priorities going forward

7.1 In order to ensure we are making the best use of all engagement networks and opportunities in the ESBT Alliance area a cross-sector mapping will be undertaken. This will extend our reach and relationships into seldom heard communities.

7.2 We will continue work to create a sense of community ownership for ESBT and the outcomes we all want to continue to deliver.

7.3 We will deliver further ESBT staff engagement events in 2018 and continue to share regular staff bulletins and updates about ESBT Alliance developments.

7.4 We will use our award winning Public Reference Forum to capture patient and public stories and experiences to monitor our progress against the Accountable Care Outcomes Framework.

7.5 We will build our new Stakeholder Group and recruit 15 members of the community to ensure local people have an opportunity to input into the ESBT Alliance governance arrangements. (See report at Appendix A).

7.6 We will continue to pursue national and local profile for our work by highlighting excellent services and staff members.

7.7 We will also explore how best to evaluate our work; understand its impact and consider what this means for the refresh of our ESBT Alliance Communications and Engagement Strategy.

8. **Recommendation**

8.1 The Governing Board is recommended to note this progress update and our priorities moving forward to the end of this financial year.

Appendix 2

Collaborative health and wellbeing stakeholder[1] group Draft terms of reference

Draft v10: September 2017[2]

[1] By stakeholders we mean people or groups who have an interest in what an organisation does, and who are affected by its decisions and actions. Stakeholders include people who use services, their families and carers, voluntary and community sector organisations and independent providers

[2] This draft terms of reference have been developed by a cross sector working group and will be revised and agreed by the stakeholder group itself upon its formation

Background

This stakeholder group forms part of engagement plans and governance framework for people and organisations to work collaboratively to help shape health and care in East Sussex. The group has been developed following a review of existing arrangements, extensive stakeholder consultation and engagement around alternative approaches and with input from a working group on the development process.

Where the group fits in the governance and operating frameworks for ESBT and C4Y is detailed in the diagram in appendix A. It isn't possible to easily capture on a page the complex interactions which the group will have, e.g. with engagement activities, integration workstreams, strategic planning processes, service pathways etc. The success of the group will depend upon the strategic landscape being well understood and navigated, which the group will be supported with by adult social care and health staff.

The group is about developing a shared responsibility for working together, mobilising and embedding co-production, building trust and creating a space for collaboration which is honest and real. Co-production is taken to include co-design and planning of services, co-decision around the allocation of resources, co-delivery of services, recognising users' assets and the role of volunteers in service provision, and co-evaluation of services. The group will be supporting a wider system move from involvement and participation towards people who use services and carers having an equal, more meaningful and more powerful role in services, where health and care professionals and people who use services work in equal partnerships towards shared goals.

1. The name of the group is:
Collaborative health and wellbeing stakeholder group (known as stakeholder group)[3]

2. The aims of the group are to:

- Ensure that best use is made of the experiences and expertise of stakeholders in improving health and care strategic planning
- Ensure stakeholders can input into and influence the strategic decision making processes in ESBT and C4Y. This will include setting priorities and allocating resources
- Inform the ongoing development of co-production within health and care which will in turn drive practice across the system.

3. The purpose of the group is to:
Help to define the overall strategic direction for commissioning health and care in East Sussex and ensure that stakeholders can input into the decision making process around how priorities are identified and resources are allocated. They will do this by:

- Co-ordinating stakeholder engagement in ESBT and C4Y strategic planning processes, as part of the overall governance framework for accountable care
- Connecting with engagement activities to strengthen input, ensure feedback and provide a meaningful route for stakeholders to have strategic influence
- Helping to develop and champion a countywide approach to co-production in health and care

4. The group will:

- Discuss, agree and make evidenced based recommendation
- Expect its recommendations to be acted upon and to receive feedback on action taken
- Establish co-productive ways of working as relationships between group members develop and the role of the evolves

5. Membership
The group is made of up of stakeholders representing people and communities, including people using health and care services and their carers, staff from the statutory health and care organisations, and staff/volunteers from a range of partner organisations. The group is open to all and will strive to ensure a variety of communities are represented at any given time.

5.1 Core membership
There will be up to 30 members of the stakeholder group. 15 members will bring a community perspective, 13 will be representatives appointed from health and care organisations and 1 place is allocated to Healthwatch East Sussex. The remaining 2 places will be held and recruited to as/when when the group identifies the need for particular input.

Community members
There will be up to 15 representatives bringing a community perspective. They will be provide a focus around priorities/service areas, eg social isolation, mental health, carers.

They will ensure the needs of people with protected characteristics are picked up and addressed by the group including:

[3] This is a working title which the group itself may want to change and make more specific once it is set up

- Age
- Disability
- Gender reassignment
- Race
- Religion or belief
- Sex
- Sexual orientation

Individuals bringing a community perspective will:

- Be recruited every 2 years through an open and transparent requirement process. See the recruitment and selection process in Appendix C for more information
- Be required to demonstrate and fulfil a connection with communities and existing representative structures. For community representatives, it is likely that some of these connections will be fulfilled by individuals being involved in the community and voluntary sector
- Bring forward their expertise and knowledge in relation to this connection, but once on the group, they will be expected to engage in discussions to help shape the delivery of population outcomes
- Have a 3 year term of office. This can be extended at the group's discretion. If members' circumstances change during that time and they can no longer fulfil their community connection eg they no longer volunteer with a relevant community group, they will step down from the group and the vacancy will be advertised/recruited to.

Representatives from health and care organisations

We will seek one appointed representative from each of the following agencies:

- East Sussex County Council
- Eastbourne, Hailsham and Seaford Clinical Commissioning Group
- Hastings and Rother Clinical Commissioning Group
- High Weald Lewes and Havens Clinical Commissioning Group
- East Sussex Healthcare NHS Trust
- Sussex Partnership NHS Foundation Trust
- Sussex Community NHS Foundation Trust
- South East Coast Ambulance NHS Trust
- District and Borough Housing
- Sussex Police
- East Sussex Fire & Rescue Service
- Healthwatch East Sussex
- Registered Care Association

These individuals will be senior decision makers involved in strategic planning for health and social care, and will have an equal role in contributing to the discussions of the group. There will also be an ESCC officer allocated to support the group and an independent facilitator.

The group comprises a maximum of 30 members with a quorum of 12 members of which there must be representation from the CCGs, an NHS provider, East Sussex County Council and 8 community stakeholder members.

Core members can send substitutes and deputies where they feel a colleague's expertise is required for a particular meeting. Regular attendance is required to enable the group to develop the necessary relationships and consistency in approach.

Membership of the group will be reviewed annually and gaps recruited to.

5.2 Other attendees

- Staff from specific ESBT and C4Y workstreams will be required to attend when the group is discussing areas that are their responsibility. If they are unable to attend in person, then they will nominate a suitable deputy to attend in their place.
- Other individuals will be invited to attend if specific specialist advice is required.
- Guest speakers will be invited when specific challenges or items of interest are being discussed.

See appendices for more information on:

- B Role and responsibilities of stakeholder group members
- C Recruitment and selection process
- D Principle and Values

6. Accountability

The group will nominate two community representatives onto the two groups which have responsibility for the whole system strategic overview and planning for health and social care:

- ESBT Strategic Commissioning Board
- C4Y Programme Board

The group will identify and arrange how it inputs to and connects with ESBT and C4Y workstreams/meetings/structures in accordance with its forward plan and priorities, e.g. it is likely to want to connect with the Planning and Design Groups in ESBT and Communities of Practices in C4Y.

7. Meeting arrangements, agenda setting and delegated powers

Meetings

- Meetings will take place every 3 months
- Where possible, they will be hosted in rotation by community members of the group (for which resources will be made available)
- Meetings will be led and facilitated by an independent facilitator
- Where possible, decision-making will be by consensus however it is likely the group may hold differences in opinions and views. Where consensus cannot be reached any differences will be recorded and reflected in the group's reports and actions
- Meetings will be supported by the Policy and Strategic Development Team in ASC&H who will provide a secretariat function for the group. Engagement officers from across health and care organisations will be involved in following up actions and supporting delivery
- Meeting papers will be circulated at least 10 days before the meeting and made as accessible as possible
- Meetings will be interactive and last no longer than 2-3 hours.

Agenda setting

- Agendas are set collaboratively and inform, and are informed by, whole system planning activity across ESBT and C4Y. The aim is to hold a shared vision and develop shared goals, with people who use services at the centre

- Agendas will make full use of existing intelligence gathered from engagement activities to ensure the focus of the group is shaped on communities' priorities
- Group members will discuss and agree an annual forward plan which prioritises agenda items and ensures all key strategic developments are included. At the end of each meeting the forward plan will be reviewed and any alterations agreed
- Agenda items will be invited as least annually via engagement activities in the system
- Adhoc suggestions will be considered on a needs basis and prioritised where necessary by the group
- Agendas will be realistic not overloaded, strategic and not operational, broad not narrow, and thematic

Sub-groups / tasks and finish groups

- The group may establish permanent or task and finish sub-groups
- Where it is more efficient for some tasks to be carried out by a small group of people, with the necessary capacity, skills and/or experience, this will be agreed by the group, well defined and documented
- Any sub-groups will report into the stakeholder group

8. Confidentiality

- Documents can be shared externally unless expressly stated as confidential or in draft form
- Members are required to respect confidentiality of specific topics discussed at the meeting as requested by other members

9. Resources and support

- Meeting, facilitation and other costs will be covered by Adult Social Care and Health
- Where further resources are required by the group, these will be identified and where possible covered from within existing resource or by seeking additional resource as necessary
- Support for group members from the community is detailed in Appendix E

10. Reporting and review

Reporting

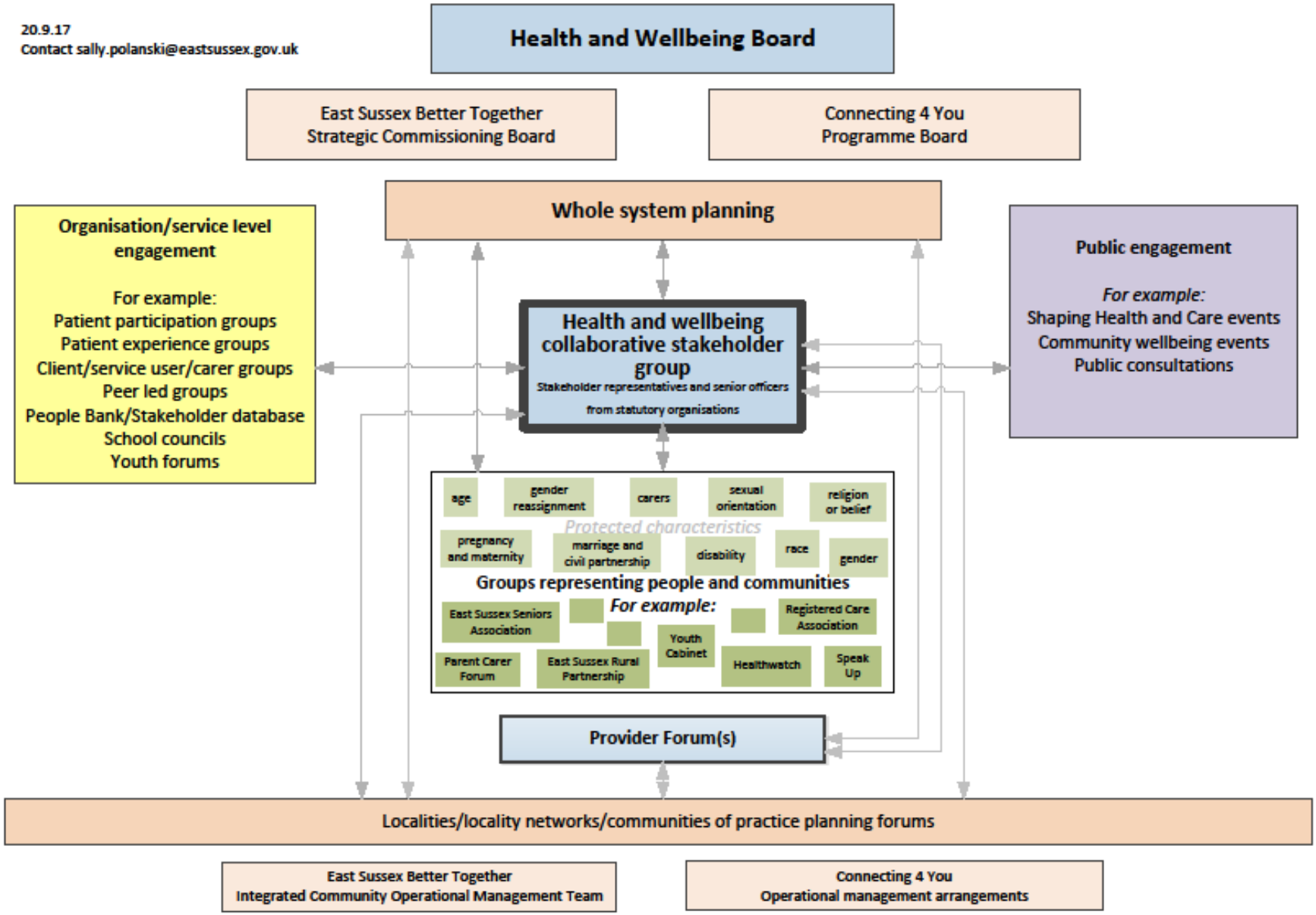
- The group will report in regularly to ESBT Strategic Commissioning Board and C4Y Programme Board
- A brief news update summarising the groups' achievements will be produced every 6 months and disseminated through engagement channels and networks

Review

- The group will review its Terms of Reference once it is set up and annually thereafter
- The group will agree a monitoring and evaluation framework for itself and its work
- In January and Sept 2018, the group will provide updates to the participants in the 7 July Partnerships and Planning workshop. This will provide feedback on how their suggestions are being used to develop the group.

Appendix A

20.9.17
Contact sally.polanski@eastsussex.gov.uk



Appendix B

Stakeholder Group member role description (community members and representatives of health and care organisations): what is expected of you?

1. Champion co-production

1.1 Ensure the perspectives of communities are able to be expressed across the system and are being gathered and used to influence any proposals and decisions that impact on service design, development and evaluation

1.2 Raise the profile and importance of patients, clients, carers and other stakeholder's views in influencing local health and care strategic developments, such as service planning, design and commissioning

1.3 Identify and confront challenges or barriers to co-production and seek to ensure they are overcome

1.4 Champion good practice in co-production at the service level within ESBT and C4Y

1.5 Be realistic about expectations and honest about influence – not everyone can be involved in all decisions and not all contributions can be taken on board

2 Connect with engagement activities

2.1 Receive information from engagement activities across the county to listen to concerns/ideas and reflect on experiences from the wider stakeholder community

2.2 Ensure the group hears about the experiences of people with protected characteristics and locality issues, and from small community groups that can sometimes be harder to reach

2.3 Help strengthen communication with stakeholders around ESBT and C4Y by sharing information and facilitating dialogue wherever possible

2.4 Work closely with engagement and communication leads across statutory organisations to join up activities and maximise synergies for joint work.

3 Inform strategic planning processes

3.1 Identify a forward workplan detailing the areas of focus for the group, linked with, but not limited to, strategic priorities in ESBT and C4Y

3.2 Develop, promote and scrutinise strategies, plans, projects and services

3.3 Provide strategic and evidence-based feedback on needs, concerns and interests

3.4 Identify areas of improvement or development and clear actions

3.5 Ensure follow-up of actions identified, working closely with engagement leads in statutory agencies who can support this

4 Promote the work of the group

4.1 Communicate feedback and achievements to the wider community including patients, clients and the public and across all stakeholders

4.2 Ensure all interested parties are kept informed about the work of the Group

5 Other requirements

5.1 Adhere to the group's values, policies and procedures, including good equalities practice

5.2 Engage in an individual review after 6 months trial period in the role

5.3 Give adequate notice of meeting absence or standing down from the role

5.4 Be prepared to be contacted outside of meetings when required

5.5 Be open-minded and have a flexible approach

Stakeholder group members' responsibilities		Approximate time commitment
1	Read papers, prepare for and attend regular meetings of stakeholder group	4-5 hours per meeting attended, usually 1/4ly
2	Prepare for and attend any other additional meetings	3-4 hours per quarter
3	Provide feedback to community/wider stakeholders by: • Reporting back after strategic meetings • Providing information on key issues as necessary • Presenting / facilitating at engagement events	1-2 hours per quarter
4	Participate in events and activities, to support the development of the shared views.	4-6 hours per quarter
5	Make efforts to consult and engage communities / colleagues on their views and communicate these at stakeholder group meetings[4]	2-4 hours per quarter
6	Participate in induction and training	6 hours

Skills, knowledge, abilities and experience required		Essential/desirable **<u>community members</u> recruitment process**
1	An understanding of communities and their needs. For community members, this will be gained through having some form of community connection (e.g. participant in community activities / linked to representative structures / employee of a voluntary organisation) A willingness to engage with a wide range of networks by attending events, networking, having two way dialogue and feedback with stakeholders, that will assist in developing a mandate and having an informed perspective	Essential
2	An ability to adhere to the values and principles in appendix D	Essential
3	A capacity to advocate and an ability to understand and express the difference between one's own / an organisational viewpoint and that of wider communities and their varied viewpoints	Essential
4	An understanding of the sensitivities of working across multiple sectors (public, private and voluntary) and an ability to develop partnership working, effective relationships, trust, challenge constructively and communicate in a mature / professional manner	Essential
5	An ability to keep up to speed on key agendas that affect the stakeholder group, including reading and digesting papers	Essential
6	Knowledge of health and care (services/strategies/policies/plans)	Desirable
7	Experience of representation and engagement	Desirable

[4] Stakeholder group members need to be able to represent the views of communities / their organisations

Health and care organisations' responsibilities: what you can expect from us

For the stakeholder group to work well, it will be supported in a range of ways by staff in health and care organisations.

- The group needs to :
    - Make full use of links to existing engagement mechanisms to access feedback and intelligence and to facilitate communication with wider stakeholders. This includes 'specialist' groups, forums, locality networks and service level 'customer satisfaction' and 'patient experience' activities. Information exchange will happen with these groups/activities in a variety of ways with and on an ongoing basis
    - Ensure that people with protected characteristics are adequately engaged and their needs considered, and challenge the system when they are not
    - Ensure that new engagement activities are established where necessary to address gaps in community voice
- The Shaping Health and Care events organised by ESCC and CCGs provide a system-wide public facing engagement opportunity. Engagement staff will ensure information flows between these events and the stakeholder group
- The stakeholder meeting process will be supported to enable group members to carry out their responsibilities:
    - Regular information bulletins on the work of the group will invite wider communities to get involved in activities and provide feedback on the work of the group. Proformas/templates will be produced which group members can use to easily cascade across their own networks, in particular those within the VCS which have reach into the community
    - Social media will be used to increase awareness of the group and opportunities to participate
    - Pre-meetings or discussions with individual group members/others will be set up as required to help prepare for meetings/particular agendas
    - Actions will be chased up by engagement officers across the health and care organisations to ensure they are completed
    - Members will receive clear and regular updates on actions and decisions made
- Other ways in which people in the community can communicate their ideas / priorities will be developed, eg
    - A suggestion box / social media equivalent will invite all groups to put forward comments which are analysed and considered
    - Online discussion forums/ app, webinars/live streams, Skype, Survey Monkey etc will be used to maximise opportunities for involvement
    - Contact points across the county will help navigate / sign-post anyone interested to the right point in the system to have a discussion
- A branding for the group will be developed to help with building awareness and trust

Appendix C

Stakeholder Group Recruitment Process

- Recruitment for the community stakeholder members of the group will take place every 2 years through an open application process or in light of a resignation
- Publicity advertising the opportunity to apply to join the group will be cascaded across as many networks as possible, and through targeted communication to seek to disseminate information to traditionally under-represented groups
- The application form will make clear requirements of the role and the selection criteria, to ensure the recruitment process is transparent and robust
- Guidance materials will include examples of the mandate which group members might have in terms of community connection and the types of scenarios they will be engaged in. There will be the opportunity to speak to someone to seek guidance and support in applying
- It will be made clear that support and development is available for individuals with less experience of similar representation and engagement activities
- Applications are sought from a range of representatives able to bring a community perspective on priorities/service areas, eg social isolation, mental health, carers. Applicants will also be sought who bring a perspective on the needs of people with protected characteristics, including:

    - Age
    - Disability
    - Gender reassignment
    - Race
    - Religion or belief
    - Sex
    - Sexual orientation

    Should a recruitment process not secure this representation of priority communities and their needs, then spaces on the group will be held back and further recruitment / co-option opportunities be explored to strengthen the make-up for group at the earliest opportunity.

Stakeholder Group Selection Process

Selection will be based on applicants' skills, knowledge, abilities and experience

Community stakeholder group members **Skills, knowledge, abilities and experience required**		**Essential/ desirable**	**Weighting**
1	An understanding of communities and their needs gained through having some kind of community connection (eg participant in community activities / linked to representative structures / employee of a voluntary organisation) A willingness to engage with a wide range of networks by attending events, networking, having two way dialogue and feedback with stakeholders, that will assist in developing a mandate and having an informed perspective	Essential	30%
2	An ability to adhere to the values and principles set out in appendix D	Essential	15%
3	A capacity to advocate and an ability to understand and express the difference between one's own / an organisational viewpoint and that of wider communities and their varied viewpoints	Essential	15%
4	An understanding of the sensitivities of working across multiple sectors (public, private and voluntary) and an ability to develop partnership working, effective relationships, trust, challenge constructively and communicate in a mature and professional manner	Essential	15%
5	An ability to keep up to speed on key agendas that affect the stakeholder group, including reading and digesting papers	Essential	10%
6	Knowledge of health and care (services/strategies/policies/plans)	Desirable	5%
7	Experience of representation and engagement	Desirable	5%

The selection process will involve:

- Scoring of the application forms received and shortlisting of suitable applicants
- Assessment of applications by a panel. The panel will have diverse representation from the community and in the first instance be drawn from those involved in the development process which lead to the group being set up, e.g. working group members and participants in the 7 July 2017 Planning and Partnerships workshop
- Informal interviews/meetings, providing an opportunity for discussion between potential group members and the above panel and/or other representatives from Adult Social Care and Health supporting the group.

Appendix D

Principles and values of the group

1. To adopt co-production as a way of working
2. To change behaviours, striving to involve people as early as possible
3. To create opportunities for people to participate so they can make things better for others
4. To recognise people's strengths and resilience, embrace diversity and value people's experiences. People who use services and with lived experience are more likely to be able to come up with solutions to the problems faced in their own lives
5. To listen and make sure that all voices are heard and acted upon
6. To empower people to have a say on what matters to them: participants will decide on meeting agendas and priorities
7. To be clear and transparent around what can and can't be influenced, at what level and who is responsible for making decisions. While we all aspire to everyone being equal in and to flatten hierarchy, we know that sometimes power dynamics will impact. The group will be honest about this, monitor power impacts and challenge where necessary
8. To be interested in all things: influencing plans, changing practice/culture and deciding how money is spent
9. To ensure participants can see if and how their views have influenced: to get timely feedback on our input and understand our impact
10. To be mindful of people's capacity to engage and address barriers to participation as much as possible. To use plain English and a wide variety of channels of communication to ensure information is co-ordinated, reaches people in the best way possible and is up to date
11. To view the success of the new approach as everyone's responsibility. To hold different views and be required to make difficult decisions
12. To expect to make mistakes, capture them and learn from them

To ensure these principles and values are embedded and making a difference in the system and the way the group works:

- They be included in induction, training and referenced in ongoing briefings of the group
- At the end of each meeting as a group and individually members will reflect on whether the principles and values are being followed
- The group will oversee implementation of such principles and values in the wider system as part of its remit in championing co-production

Appendix E

Support for stakeholder group members

- The contribution that volunteers make in helping to improve and develop services is valued. This is recognised through a Reward & Recognition Policy (R&R), which offers people the opportunity to claim expenses and reward payments appropriate to their level of involvement. Activities that qualify for a reward payment are paid at a rate of £20 per half day. This covers any preparation, printing of payment, travel time and follow-up work. R&R claims are paid on a monthly basis into people's bank accounts. Individual members of the Stakeholder Group will be eligible to claim both expenses and reward payments for attending the meetings. Before making a reward claim, it will be explained to group members that such a payment is considered as 'income' for tax purposes. Members of the group attending in a professional capacity on behalf of an organisation should claim expenses from their employer
- Regular briefings in writing/person will be provided as required. The focus of these and the need for information will be determined by group members, with support and advice from health and care organisations
- Learning and development opportunities, both generic for all members of the group and tailored to individual members' specific needs, will include:
    - Induction session and briefings on health and care (strategies, policies, plans, services)
    - Skills based training on effective partnership working. Content to be tailored by group members but potential focus on representation, influencing, and assertive communications
    - Facilitated team development for the group on its values and principles, ways of working, possible action learning set approach to this over time
    - Information briefing on health and care strategy
    - Information briefings and support from voluntary and community organisations able to offer a community / service user perspective easily
- Meetings will be well planned
- Independent facilitation, participative methodologies, accessible venue/times/language, and use of ground rules will ensure that everyone has the opportunity to participate. There will be a balance of formality, informality, creativity
- Specialist speakers will attend as required
- Buddying for members of the group will be provided where appropriate
- There will be feedback to group members on what difference their input has made

Benefits of being a member of the stakeholder group

- Increased knowledge of health and care in East Sussex
- Being involved in strategic planning processes and influencing decision making
- Gaining deeper understanding of a particular area of work
- Gaining new opportunities to network and build relationships
- Developing skills in representation, facilitation and giving presentations
- Developing communication skills (diplomacy, negotiation skills, assertiveness)
- Meeting like-minded people and building personal and social connections
- The opportunity to make a difference by:
    - Being part of change to improve local people's lives
    - Influencing agendas to ensure community priorities are addressed
    - Championing inclusion, diversity and the needs of under-represented groups
    - Helping to develop effective community engagement and service user participation

- Identifying gaps and developing solutions
- Sharing good practice
- Building a sense of shared purpose, values and goals, enhancing collaboration and improving communication across different sectors
- Acting as a conduit for information sharing with wider communities

Appendix F

Ground Rules

To be determined by the group itself when it is set up

To include decision-making and managing conflicts of interest