A formal meeting of the East Sussex Better Together (ESBT) Alliance Governing Board to be held in public on Tuesday, 27 June 2017, from 13.00 to 15.30 in the Oak Room, The Boship Lions Farm Hotel, Lower Dicker, Hailsham, BN27 4AT

Members	David Clayton-Smith (Chairing meeting); Sam Allen, Chief Executive, Sussex Partnership NHS Foundation Trust (SPFT); Joe Chadwick-Bell, Chief Operating Officer, East Sussex Healthcare NHS Trust (ESHT) (attending for Adrian Bull, Chief Executive, ESHT); Jackie Churchward-Cardiff, Non-Executive Director, ESHT; Rose Durban, Lay member, Eastbourne, Hailsham and Seaford (EHS) and Hastings and Rother (HR) CCGs; Stuart Gallimore, Director of Children's Services, East Sussex County Council (ESCC); Keith Hinkley, Director of Adult Social Care and Health, ESCC; Amanda Philpott, Chief Officer, EHS and HR CCGs; David Warden, GP member and Chair, HR CCG
In Attendance	Laura Bayford, interim Chief Operating Officer of the EHS Federation; Jessica Britton, Chief Operating Officer, EHS and HR CCGs; Allison Cannon, Chief Nurse, EHS and HR CCGs; (to be confirmed) East Sussex Community Voice (ESCV); Paula Gorvett, ESBT Programme Director, EHS and HR CCGs; Cynthia Lyons, Acting Director of Public Health, ESCC (CL); John O'Sullivan, Chief Finance Officer, EHS and HR CCGs (JOS); Martin Writer, GP member and Chair, EHS CCG; Andy Lane, CCG Governance and Corporate Services Officer, EHS and HR CCGs (minutes)

There will be the opportunity for members of the public to ask questions at the end of the meeting, 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
01/17	Welcome, introductions and apologies for absence	Note	DCS	Verbal	13:00
02/17	Declaration of interests	Note	DCS	Verbal	13:10
03/17	Chair's opening remarks	Note	DCS	Verbal	13:15
04/17	A story of someone using our services	Note	AC	Verbal	13:20
05/17	i) Our integrated ESBT governance arrangements: an overview	Note	i) DCS	Yes	13:30

Item No	Item	Action	Lead	Paper Attached	Time
	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	 Approve Ratify Ratify Ratify	ii) JeB		
06/17	Feedback and key issues from associated groups: • Alliance executive (JCB); • Clinical Leadership Forum (DW/DCS); and • Accountable Care Development Group (ALP)	Agree	JC-B / DW / ALP	Yes	13:45
07/17	ESBT Alliance Agreement	Agree	JeB	Yes	14:00
08/17	ESBT Budget 2017/18: Update on the financial position	Approve	JOS	Yes	14:15
09/17	ESBT Strategic Investment Plan: monitoring our performance	Discuss	JOS	Yes	14:30
10/17	System performance: an update on A&E performance with a particular focus on delivery against the 4-hour standard	Discuss	JC-B	Yes	14:55
11/17	ESBT Communications and Engagement, including an update on alliance citizen engagement plans	Approve	JeB	Yes	15:10
12/17	Key messages from this meeting	Agree	DCS	Verbal	15:20
13/17	Any Other Business To be notified to Chair at least 2 working days in advance.	-	DCS	-	15:25
Opportunity for members of the public to reflect on the meeting and ask any questions.					
Date of next meeting in public: Wednesday, 9 August 2017, 10:00-12:30, St Wilfred's, 1 Broadwater Way, Eastbourne, BN22 9PZ					
Close of meeting					

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.

East Sussex Better Together (ESBT) Alliance Governing Board
Date of meeting: 27 June 2017

Item Number: 5/17

Title of report: ESBT Integrated Governance Arrangements

Recommendation:
The Governing Board is recommended to**:**

- **Note** the ESBT Integrated Governance Arrangements set out in the ESBT Governance Overview paper;
- **Approve** the terms of reference for; the ESBT Alliance Governing Board; and
- **Ratify** the terms of reference for the ESBT Alliance Executive; the ESBT Accountable Care Development Group, and; the ESBT Clinical Leadership Forum.

Executive Summary:

Our 150-week East Sussex Better Together (ESBT) programme, set up to galvanise the transformation of health and social care services, started in August 2014 and we have now moved into our test-bed year of the ESBT Alliance.

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

This paper brings an overview of the ESBT Alliance Governance arrangements (Appendix 1), together with the terms of reference for the key elements of the integrated governance structure for ratification:

- The ESBT Alliance Governing Board (this Board) - Appendix 2
- The ESBT Alliance Executive – Appendix 3
- The ESBT Alliance Accountable Care Development Group – Appendix 4
- The ESBT Clinical Leadership Forum – Appendix 5

The governance structure for our ESBT Alliance includes the ESBT Alliance Governing Board, an ESBT Alliance Executive, as well as the ESBT Clinical Leadership Forum which was established in October 2016. A new ESBT Accountable Care Development Group (task and finish) has been established to undertake the work to develop options for the ESBT Delivery Vehicle and the ESBT Integrated Commissioning Vehicle for the future ESBT alliance model post the test-bed year, for consideration by our sovereign bodies in **July 2017,** alongside a roadmap for implementation.

The overview of the agreed structure, together with the terms of reference for the ESBT Alliance Governing Board, ESBT Alliance Executive, ESBT Accountable Care Development Group and ESBT Clinical Leadership Forum are set out in the Appendices to this paper. The governance structure takes into account the feedback and comments made during January – March, as well as feedback from the first informal meeting of the Alliance Governing Board in May. In summary the key points to highlight are as follows:

- **ESBT Alliance Governing Board** - terms of reference and membership representing the key organisational signatories to the Alliance Agreement (the subject of a separate report to the ESBT Alliance Governing Board). This includes provision for Healthwatch representation to provide public and patient voice in advance of establishing the proposed Citizen Leadership Council, and for every other meeting to be held in public;
- **ESBT Alliance Executive** - terms of reference and membership, including options for clinical provider representation and local General Practice Federation membership in the future, as these bodies develop;
- **ESBT Accountable Care Development Group** - terms of reference and membership. This includes provision for the LMC to attend to support discussions around the practical interface between General Practice and the future ESBT Alliance accountable care model, as well as Healthwatch representation to ensure the public and patient voice is central to consideration of structural design of the future model. In addition, there is a stakeholder engagement plan to inform the options appraisal exercise, including independent care sector and voluntary and community sector organisations as well as health and acre providers and local people;
- A commitment to exploring an integrated **CCG lay, ESHT non-executive and ESCC member oversight** group to scrutinise the activity of the ESBT Alliance during the test-bed year by **September;**
- An agreed plan to put in place a **citizen leadership** arrangement for the test-bed year, as well as explore the options for citizen governance in the future ESBT Alliance accountable care model to secure ownership, influence and insight of the population covered by the ESBT footprint. Significant work has been undertaken with local voluntary and community sector groups to develop an involvement structure that will underpin the governance arrangements and enable local people to be involved in both strategic planning and the on-going delivery and improvement of services. A design group was established in April to take forward this work in partnership and to enable wider stakeholder engagement in this, with the expectation that arrangements will be launched initially in **July 2017;**
- The integrated ESBT Alliance Governance structure has been discussed with Local Medical Committee representatives (LMC) to test ways of **working collaboratively with GPs** as providers during the test bed year and to ensure views are taken on board; as a result it has been agreed that the LMC will be formally invited to meetings of the ESBT Alliance Governing Board and the ESBT Accountable Care Development Group; and
- An **integrated Strategic Commissioning Board** has also been established in June 2017 with ESCC Elected Member and CCG Governing Body GP and lay membership (including lay CCG public and patient involvement lead). This will allow commissioner members of the ESBT Alliance to jointly undertake responsibilities for addressing population health need and for commissioning health and social care on a system-wide basis. A central role of the Board will be joint oversight of delivery of the **2017/18** Strategic Investment Plan (SIP) and the pilot unified outcomes framework. It also

presents an opportunity to test and consider arrangements for undertaking the strategic commissioning role across the Council and CCGs in the longer term under a fully integrated accountable care model by enabling commissioners to shadow potential longer term arrangements for integrated strategic commissioning.

The ESBT Alliance partners have previously agreed that moving to a fully integrated model of Accountable Care offers the best opportunity to achieve the full benefits of an integrated health and social care system, and that a test-bed year of Accountable Care, under an alliance arrangement, would allow for the collaborative learning and evaluation to take place between the ESBT partners and other stakeholders. As such it is recommended that the Alliance Governing Board notes the agreed integrated ESBT governance structure and approves (or ratifies as denoted) terms of reference of the key groups, to make sure we have the right arrangements in place to enable us to act as one; a coherent system to deliver improvements at scale and create a culture where we can continually learn and improve.

Governing Board sponsor: David Clayton-Smith, Independent Chair, ESBT Alliance Governing Board

Author(s): Vicky Smith, Accountable Care Strategic Development Manager, ESBT	**Date of report:** 20/06/17

Review by other committees: These papers have been reviewed by members of the ESBT Alliance Governing Board, the CCG Governing Bodies and shared with all Alliance partners.

Health impact: The ESBT Alliance and the development of a new model of accountable care will support the delivery of the triple aims: improve experience; improve health and well-being outcomes and deliver system sustainability.

Financial implications: There are no direct financial implications related to these terms of reference.

Legal or compliance implications: Any implications would relate solely to the Alliance Agreement and not as a direct result of these terms of reference.

Link to key objective and/or principal risks: Faced with increasing and changing demand pressure on services, and a potential collective funding gap of c£169 million for health and social care services by 2020 (across the ESBT Programme area) if the status quo is maintained, local system leaders will need to design a multi-agency, collaborative and innovative response in order to achieve the overall goal of securing health and care services for future generations in East Sussex.

Link to East Sussex Better Together (ESBT) programme:
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 a move to Accountable Care in East Sussex

How has the patient and public engagement informed this work: Citizen engagement forms part of the proposed governance arrangements.

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: Not applicable.

Appendix 1

EAST SUSSEX BETTER TOGETHER (ESBT) ALLIANCE ARRANGEMENTS FOR THE TEST-BED YEAR 2017/18

ESBT ALLIANCE GOVERNANCE OVERVIEW

1 Context

1.1 The ESBT Alliance Agreement brings together Eastbourne, Hailsham and Seaford CCG, Hastings and Rother CCG, East Sussex County Council, East Sussex Healthcare NHS Trust, and Sussex Partnership Foundation NHS Trust, to undertake whole system transformation activities collaboratively in 2017/18, as the test-bed year for our Accountable Care model.

1.2 The arrangements for the 2017/18 test-bed year must support us to collectively act in a way that delivers improvements for our local populations. We also need to create a learning environment to develop our final proposed ESBT Alliance system of accountable care. In doing this we need to ensure our key principles and characteristics of our local model of care are reflected in all that we do:

	Key principles and characteristics of a local Accountable Care model
1	Our evidence-driven, place-based model will firmly embed the first principle of a prevention-led approach across ESBT as our 'place' that contributes to the Sussex and East Surrey Sustainable Transformation Plan (STP). The model will have a strong emphasis on population health promotion, prevention, early intervention and self-care and self-management to reduce demand for services and allow care to be delivered increasingly out of hospital and at the lowest level of effective care.
2	All health and social care services should be in scope – primary, local acute DGH, community, mental health, social care and public health services for children and adults. Those that are ruled out will be by exception.
3	'Whole person' care needs to be supported by a whole population approach rather than segmenting or subdividing the population by conditions or age, and thus although delivery will normally be based around localities with populations of circa 50,000, accessing health and care should support individual choice and be consistently simple for people regardless of where they access it.

4	The model will have a positive impact and deliver outcomes that are important to local people – both health outcomes and experiential outcomes. This includes involving local people in designing, commissioning and delivering outcomes, as well as communicating about them.
5	The outcomes based contract and capitated budget will be sufficiently large to achieve the economies of scale needed to close the total funding gap, and establish an ongoing in-year budget balance.
6	There will be a focus on reducing the costs of commissioning and transacting the business, as well as avoiding the pathway fragmentation that undermines integration and adds in transaction costs through operating parallel models. We will seek to achieve our aims through collaboration in the way that we procure new models.
7	There will be a strong culture of whole system working on the ground that actively empowers staff to be able to 'do the right thing', putting patients' and clients' and carers' needs first within a single health and social are system covering primary, community, local DGH, mental health, social care, public health services, and independent and voluntary services where appropriate.
8	Our model will align incentives in order to inspire and attract health and social care professionals and offer maximum levels of clinical and staff engagement and leadership, embed system-wide organisational development.
9	The organisational form in the ESBT area will require collective leadership and have governance and operational mechanisms that enable learning and development to take place in stages to share and manage risks between commissioners and providers. This will lead to delivery of full Accountable Care models, as per the ambitions of the FYFV, i.e. the fullest possible levels of integration and maximum ability to achieve the long term vision and benefit of a sustainable and affordable health and social care system.

1.3 The ESBT Alliance Governance structure for the test-bed year is illustrated at the end of this document.

1.4 It includes the following:

- An **ESBT Strategic Commissioning Board** – allowing the Commissioner members of the ESBT Alliance to jointly discharge responsibilities for addressing population health need and for commissioning health and social care through oversight of the 2017/18 Strategic Investment Plan, and any other responsibilities agreed by the statutory commissioning bodies (to be determined). In order to fulfil this role the representatives will be Lay and GP member representatives from EHS CCG and HR CCG Governing Bodies, elected members from East Sussex County Council, with the Chief Officer of the CCGs, Director of Adult Social Care

and Health, Director of Children's Services, Director of Public Health and Directors of Finance attending in an advisory capacity.

- An **ESBT Alliance Governing Board** – the Chief Officers, Board Directors and Governing Body Members responsible for directing and leading the ESBT Alliance and operating the Alliance Agreement, on behalf of the signatories to the Agreement. Reporting to the ESBT Strategic Commissioning Board (EHS and HR CCGs and ESCC), the ESHT Board and the SPFT Board, the Governing Board will take responsibility for developing and agreeing the delivery of the Strategic Investment Plan (SIP), and the operation of the ESBT Alliance Agreement, holding the ESBT Alliance Executive (below) to account for delivery of agreed plans, management of risk and any changes to proposed service arrangements, performance and resource allocations. The Governing Board will also lead the development of proposals for the full ESBT alliance accountable care model.

- An **ESBT Alliance Executive** – an integrated senior management team with responsibility for whole system service delivery and service transformation activities. This includes delivery of agreed plans within the SIP, proposals for service developments or budget changes which need executive authorisation, and managing operational delivery of all specified health and care services as well as escalation of risk as required to the ESBT Alliance Governing Board. As we learn more in the test-bed year, in time we may develop appropriate thresholds to allow the Alliance Executive to make some decisions about resource allocation without sanction by the Governing Board where this makes sense to enable smooth operation of the governance structure.

- An **ESBT Clinical Leadership Forum -** to provide authoritative clinical advice to the ESBT Strategic Commissioning Board, ESBT Alliance Governing Board and ESBT Alliance Executive and clinical leadership to the design and implementation of new models of care and ways of working. The CLF comprises a body of experts from our locally employed medical workforce who will act as the primary resource for care pathway, service specific and medical workforce advice to the ESBT Alliance. It is intended that the membership will expand to include wider representation of the clinical and care workforce.

- An **ESBT Accountable Care Development Group (task and finish group)** – to explore the structural options for our future ESBT Alliance accountable care model and make recommendations for the most appropriate vehicle to deliver high quality, effective care for the population covered by the ESBT footprint after the 2017/18 test-bed year. This will include considering contracting and organisational arrangements and relationships with General Practice and other providers across the health and care system. The Group will also develop proposals for future governance and accountability, citizen governance, and the residual strategic commissioning function (agreeing the outcomes and ensuring monitoring, oversight and accountability for the delivery of the outcomes).

2 Citizen Leadership and Governance

2.1 We are establishing a mechanism for enabling citizen leadership in the governance structure during the test-bed year so that insight, contribution and

influence on ESBT Alliance issues are transparent and meaningful. Proposals for a collaborative health and wellbeing stakeholder representative Council for the test-bed year have been agreed and this is now in development with a launch proposed for July 2017. Representation from this can be sought as representation to the relevant aspects of the structure. We want to develop this throughout the test-bed year, in partnership with local people so we can test and learn what works best.

3 Primary Care representation

3.1 Primary care will be represented within the governance structure from both the perspective of being a clinical commissioner as well as primary care as a provider.

4. Membership categories of the Alliance arrangement

4.1 To move these arrangements forward in 2017/18, the following initial categories of membership are proposed in the Alliance arrangement.

Full Alliance Member

- Plays an active role in the plans for system transformation and place-based systems of health and care in accordance with the ESBT programme aims and objectives, and the contribution this makes to the Sussex and East Surrey Sustainable Transformation Plan and the NHS Five Year Forward View;
- Is entitled to attend and vote at meetings of the ESBT Alliance Governing Board (NB with all members reserving the right to refer to their sovereign organisations as appropriate, in line with relevant levels of delegation);
- Is entitled to attend and contribute to meetings of the ESBT Alliance Executive;
- Subject to what is agreed as part of the test-bed year transformation activities, shares the risks and opportunities for the delivery of the in-scope services and agreed outcomes; and
- Commits to the principles of transparency and open book accounting where possible.

Associate Alliance Member

- May be invited to attend and contribute to meetings of the ESBT Alliance Governing Board but not to vote at such meetings;
- Shall be invited to attend and contribute to the ESBT Alliance Executive and all other meetings in the supporting governance structure;
- Depending on test-bed year activity could have some of its services payments related to the achievement of agreed outcomes;
- Will not be a part of financial and risk sharing arrangements.

4.2 It is acknowledged that primary care will play an integral role in the delivery of ESBT whole system objectives and this is reflected in the proposed governance arrangements, and the developing relationship with emerging GP Federations.

4.3 A further category of ‘Affiliate’ membership will also be explored for individual organisations who share Alliance objectives, and who play a significant role in

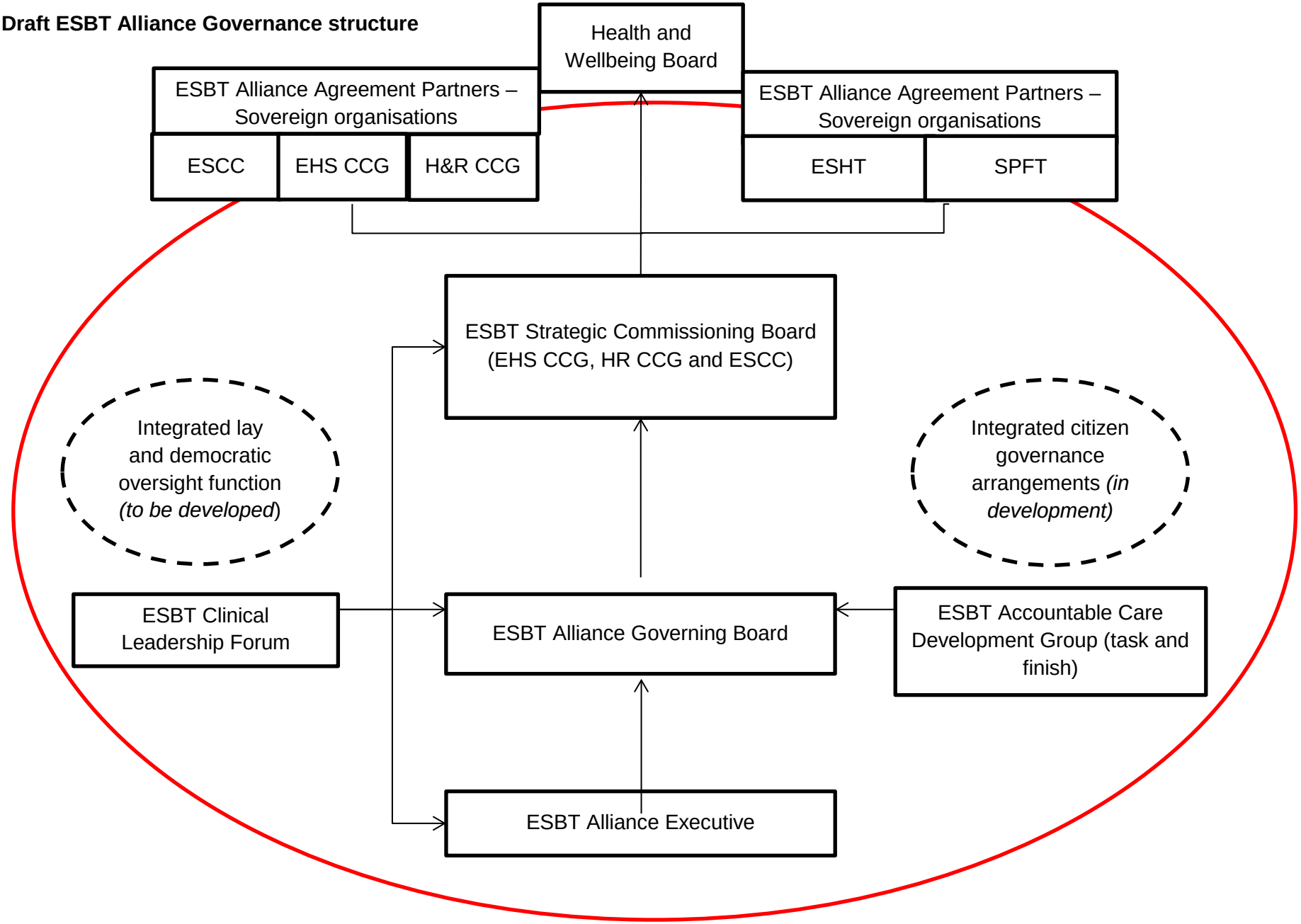
contributing to outcomes in our Place. There are other service provider organisations that the ESBT Alliance will continue to work with and who will have an important role to play in the design and delivery of the services aimed at better achieving the agreed outcomes, including population health and wellbeing outcomes. For example, this could include; SECAmb; GP Out of Hours providers; other NHS Trusts and CCGs; independent care and voluntary organisations; District and Borough Councils; housing providers; and the Police and Fire Services.

4.5 More detail will emerge during the transitional year as the model is further developed and provisions will also be made within the Agreement to allow for potential new members to join the Alliance and movement from one category of membership to another, especially if the Alliance arrangement is extended beyond the test-bed year.

Authors V Smith / J Britton

Date 23 05 17 (updated 20 05 17)

Draft ESBT Alliance Governance structure



Appendix 2

TERMS OF REFERENCE FOR THE ESBT ALLIANCE GOVERNING BOARD

The core parties to the ESBT Alliance Agreement are Eastbourne, Hailsham and Seaford CCG, Hastings and Rother CCG, East Sussex Healthcare NHS Trust, Sussex Partnership NHS Foundation Trust and East Sussex County Council. These sovereign bodies are referred to throughout this document collectively as the ESBT Alliance.

1 Governance

The ESBT Alliance has agreed to establish an ESBT Alliance Governing Board to direct and lead the Alliance and operate the Alliance Agreement. This will allow the undertaking of activities on behalf of the constituent member organisations in the 2017/18 test-bed year. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the ESBT Alliance Governing Board (referred to as the Alliance Governing Board).

2 Purpose

The ESBT Alliance Governing Board is the group of Chief Officers, Board Directors and Governing Body Members who are signatories to the Alliance Agreement. The ESBT Alliance Governing Board will direct and lead the ESBT Alliance in accordance with the principles set out in the Alliance Agreement (to be finalised), setting overall strategic direction in order to meet the Alliance objectives and deliver the shared outcomes.

3 Responsibilities

The Alliance Governing Board will:

- Ensure alignment of all organisations to the ESBT vision and objectives
- Hold each other as partners to account for commitment to the ESBT Alliance principles and outcomes
- Oversee the implementation of the Alliance Agreement
- Formulate, agree and implement strategies for achieving the outcomes and management of the ESBT Alliance
- Be responsible for ensuring local people are engaged and involved appropriately at all levels of the governance structure to enable insight, influence and active participation
- Hold the ESBT Alliance Executive to account for delivery of agreed plans, management of risk and any changes to proposed service arrangements, performance and resource allocations

- Review system performance and agree strategies to transform services and improve performance
- Oversee the ongoing development of the ESBT Strategic Investment Plan and make recommendations to the Strategic Commissioning Board on the overarching investment profile in order to meet population health needs and deliver outcomes
- Collectively determine an agreed framework for the deployment of our collective resource, including integrated approaches to estates, IT systems, and communications and engagement, and performance management infrastructure
- Collectively develop a system approach to organisational development in order to underpin transformation
- Strategically manage and align the approach to existing bilateral contracting arrangements and agreements held by the individual ESBT Alliance organisations
- Reflect national policy appropriately within the Alliance arrangements
- Seek to determine or resolve any matters referred to it by the ESBT Executive Alliance, for example financial and commercial issues, on a 'best for the whole system' basis
- Review and approve or reject any proposals referred to it from any group in the supporting governance structure, in line with escalation and change procedures that are developed and agreed.
- Ensure effective governance and appropriate schemes of delegation and terms of reference are in place to enable smooth operation of the governance structure
- Provide oversight of the work of the Accountable Care Development Group in order to make recommendations to sovereign organisations regarding the future state model.

4. Authority

The Alliance Governing Board is authorised by the sovereign bodies of the constituent member organisations of the ESBT Alliance to undertake activities, and take decisions, relating to the successful operation of the ESBT Alliance Agreement. Decisions of the Alliance Governing Board are to be taken by the Full Alliance members acting and making decisions in accordance with the principles in the Alliance Agreement (principles to be finalised).

It is recognised that each ESBT Alliance member will have their own regulatory and statutory responsibilities and that there will need to be some decisions reserved for consideration and determination by individual Governing Bodies, Cabinet and Trust Boards. This would be undertaken in accordance with schemes of delegation for decision-making within each organisation.

5. Membership

Alliance organisations will each appoint Members to the ESBT Alliance Governing Board, and this will be maintained at all times. Each organisation will nominate one person who is entitled to vote on behalf of the organisation. Any Alliance Member can remove or replace their respective Alliance Governing Board Members at any time subject to the

consent of the other Alliance Governing Board Members, such consent not to be unreasonably withheld or delayed.

Any ESBT Alliance Governing Board representative can nominate an ESBT Alternate Alliance Governing Board representative, of sufficient seniority, to act on their behalf if they are unable to attend a meeting. An Alternate ESBT Alliance Governing Board representative will be entitled to:

- Attend, and in the case of Full ESBT Alliance Members, be counted in the quorum and make decisions at any meeting at which the Full ESBT Alliance Member's Governing Body representative nominating him or her is not personally present; and
- Do all the things which his or her appointing Alliance Governing Board representative is entitled to do

The Alliance Governing Board will have an independent chair. The proposed members of the Alliance Governing Board are as follows:

Representative	**Organisation**
David Clayton-Smith	Independent Chair
Adrian Bull	Chief Executive, ESHT
Keith Hinkley	Director of Adult Social Care and Health, ESCC
Amanda Philpott	Chief Officer, EHS and HR CCGs
Samantha Allen	Chief Executive, SPFT (Associate Member)
Jackie Churchward-Cardiff	Non-Executive Director, ESHT
Rose Durban	Governing Body Lay member, EHS and HR CCGs
Stuart Gallimore	Director of Children's Services, ESCC
David Warden	Governing Body GP member, EHS and HR CCGs
In attendance	**Function**
Laura Bayford, GP Federation representative	To lead on ensuring alignment of intent across primary care provision
Jessica Britton, Chief Operating Officer, EHS CCG and H&R CCG	To lead the governance aspects of the arrangement
Allison Cannon, Chief Nurse EHS CCG and H&R CCG	To lead on strategic quality of services across the alliance
Paula Gorvett, ESBT Programme Director	To lead on the strategic system planning requirements of the alliance
Cynthia Lyons, Acting Director of Public Health, ESCC	To lead on the strategic Public Health priorities of the alliance
Dr Julius Parker	Chief Executive, Surrey Sussex Local Medical Committees
John O'Sullivan, Chief Finance Officer, EHS CCG and H&R	To lead on the financial arrangements of the Alliance Agreement

CCG	
Healthwatch *(this is an interim appointment pending finalisation of citizen governance proposals)*	Citizen Engagement

NB in the event that any matter requires a vote, each full ESBT Alliance member organisation will be entitled to one vote.

6. Meeting proceedings and quorum

Wherever possible decision-making will be discussion driven to arrive at a 'best for the whole system' consensus in accordance with Alliance principles. Each ESBT Alliance Governing Board representative (or their alternate) will have an equal say. In the event that a vote is needed, only Full ESBT Alliance member organisations are entitled to vote, with one partner, and the CCGs acting as one, having one vote *(NB all members reserve the right to refer to their sovereign organisations as appropriate in line with the agreed levels of delegation).*

A quorum will not be present unless all Full ESBT Alliance Member organisations are in attendance. Nominated deputies will count towards the quorum.

Subject to the provisions set out in the Alliance Agreement, a decision made by the ESBT Alliance Governing Board will be binding on the Alliance.

7. Attendance

ESBT Alliance Members will ensure that, except for urgent or unavoidable reasons, ESBT Alliance Governing Board representatives and the officers in attendance, attend all and fully participate in the meetings of the ESBT Alliance Governing Board. Where a full ESBT Alliance Member, or their nominated deputy, cannot attend a meeting of the Alliance Governing Board then, subject to section 6 above, such a meeting shall not be quorate.

The Alliance Governing Board may invite other people to attend meetings as required. ESBT Alliance organisations will ensure that no other employees, agents or representatives (other than its ESBT Alliance Governing Board representatives or Alternate representatives) attends unless expressly invited. In addition, an open invitation will be extended to regulators to attend the Board as observers.

8. Reporting

The Alliance Governing Board will report to the ESBT Strategic Commissioning Board (EHS and HR CCGs and ESCC) and each of the sovereign organisations. Executive representatives from each of the sovereign organisations shall draw to the attention of the constituent sovereign bodies any issues that require disclosure or exception items requiring action by the respective governing bodies of ESBT Alliance member organisations.

The minutes of each meeting of the Alliance Governing Board shall be formally recorded and will be reported to respective sovereign bodies of ESBT Alliance, as required, at the meeting immediately following their approval. The minutes will be published.

9. Administration

The CCGs corporate services will provide secretarial support to the Alliance Governing Board.

10. Frequency

Meetings will be held every two months in public. It is likely that the alternate months will be used for informal meetings.

11. Conduct of the Alliance Governing Board

The Alliance Governing Board shall conduct its business in accordance with the framework and principles set out by the Alliance Agreement, including the Conflicts of Interest policy and data sharing agreement.

12. Review

If a procurement route becomes a strong feature of our future ESBT Alliance model these terms of reference will be reviewed. This applies to all parts of the provider system, i.e. GPs, social care and mental health and acute providers, to achieve a balance between pragmatism and guidance to achieve the outcomes we are seeking for our population. Therefore these terms of reference will be reviewed after the recommendations about the future ESBT Alliance model have been agreed, and subsequently in March 2018.

Author	V Smith / J Britton / P Gorvett
Alliance Governing Board review	March 2017
Governing bodies review	March 2017
Alliance Governing Board adopt	June 2017
Alliance Governing Board review due	July 2017, March 2018
Governing Bodies review due	July 2017, March 2018
Version	9.0

Appendix 3

ESBT ALLIANCE EXECUTIVE
TERMS OF REFERENCE

1. Governance

In accordance with the ESBT Alliance Agreement, the ESBT Alliance Governing Board has established a Sub-group of the Governing Board known as the ESBT Alliance Executive (referred to as the Alliance Executive). These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Alliance Executive.

2. Purpose

As part of transformation activities for the 2017/18 test-bed year as detailed in the Alliance Agreement, the overall purpose of the Alliance Executive is to provide a system-wide operating platform to oversee the operational management of the health and social care system at an executive level. This includes identifying and resolving system, process and capacity issues affecting patient flow, with the aim of delivering high quality, effective care for the population covered by the ESBT footprint.

The Alliance Executive initially brings together senior executive operational commissioning and clinical leads from the Full and Associate Member signatories to the Alliance Agreement; the CCGs, ESCC, ESHT and SPFT. In order to implement transformation of delivery on a whole system basis primary care will also be represented for example through the Federations as they evolve into a collective voice and delivery platform, and over time it may also be appropriate for other key delivery partners to be represented on this body.

3. Responsibilities

The Alliance Executive will:

- Oversee the day to day operational management, at an executive level, of the health and social care system on behalf of the Alliance Governing Board
- Manage service changes and improvements to ensure a shift to prevention and proactive care in community-based settings in line with the objectives set out in the ESBT Strategic Investment Plan (SIP)
- Drive the development of clinical strategies and quality frameworks for the continued development and transformation of services
- Oversee the development of integrated care pathways to reduce variation and increase standardisation in line with evidence-based best practice

- Ensure optimum cost effectiveness in the use if our combined resources through developing integrated services and care pathways
- Inform and make recommendations to the Alliance Governing Board on the deployment of collective resources to support effective service delivery, including integrated approaches to estates, IT systems, and other elements of back office infrastructure
- Enable an active role for primary care in all arrangements as key delivery partners
- Empower front line managers across the health and social care system to deliver performance improvement and issue resolution through the removal or reconfiguration of organisational and process barriers and obstacles.
- Identify and resolve any immediate and underlying system, process and capacity issues that negatively impact on the timely flow of patients through all elements of the health and social care system
- Use and allocate the available collective resources to flexibly deliver integrated locality based services at the lowest level of effective care
- Implement locality based planning and delivery in line with our agreed strategy
- Support further strategic planning activity of the ESBT Alliance Governing Board during the test-bed year to develop the future ESBT Alliance model. This includes testing through learning the balance of services that might be directly provided within a future model, and how the remaining services will be commissioned, and informing the contracting arrangements between individual Alliance partner organisations and third parties.

4. Authority

The Alliance Executive is authorised by the ESBT Alliance Governing Board to ensure robust management of the operational delivery of health and social care services within its terms of reference, and according to the ESBT Alliance Agreement and Strategic Investment Plan.

5. Membership

The ESBT Alliance Joint Senior Responsible Officers (SROs) will attend the Alliance Executive, with the Chief Executive of ESHT Chairing on their collective behalf. The other SROs will chair in the absence of the Chief Executive of ESHT. The proposed members of the Alliance Executive are as follows:

Representative	Organisation
Dr Adrian Bull (Chair)	Chief Executive, ESHT and Joint ESBT Senior Responsible Officer (SRO)
Keith Hinkley	Director of Adult Social Care and Health, ESCC
Amanda Philpott	Chief Officer, EHS CCG and HR CCG
Catherine Ashton	Director of Strategy Improvement and Innovation, ESHT
Jessica Britton	Chief Operating Officer, EHS CCG and HR CCG
Allison Cannon	Chief Nurse, EHS CCG and HR CCG
Louise Carter	Assistant Director, Children's Services, ESCC

Joe Chadwick-Bell	Chief Operating Officer, ESHT
Paula Gorvett	Programme Director – East Sussex Better Together, EHS CCG, H&R CCG, ESCC
Monica Green	Director of Human Resources, ESHT
Graham Griffiths	Director of Performance and Delivery, EHS CCG and HR CCG
Phil Hall	ESBT Resources Lead, ESCC
Martin Hayles	Assistant Director Adult Social Care, ESCC
Dr Rob McNeilly	GP CCG Governing Body and Clinical Leadership Forum representative
John O'Sullivan	Chief Financial Officer, EHS CCG and H&R CCG
Jonathan Reid	Director of Finance, ESHT
Mark Stainton	Assistant Director (Operations) Adult Social Care, ESCC
Dr David Walker	Medical Director, ESHT and Clinical Leadership Forum representative
Neil Waterhouse	Service Director, East Sussex, SPFT
Alice Webster	Director of Nursing, ESHT
Lynette Wells,	Director of Corporate Affairs, ESHT

6. Meeting proceedings

Alliance Executive members will commit to ensuring their attendance at meetings, or to nominate a deputy as appropriate, in order to ensure collective and timely action. In instances where members may have been unable to attend meetings the Executive will ensure discussion takes place outside of the meeting in order to progress shared goals.

7. Attendance

The Alliance Executive may invite other senior managers as required from the constituent organisations and services to support the work of the Executive.

8. Reporting

Minutes of the meetings shall be recorded by the Secretary to the meeting and, if required, submitted to the ESBT Alliance Governing Board. The Chair of the meeting shall draw to the attention of the Alliance Governing Board any issues that require escalation, disclosure or action by the Governing Board.

9. Administration

The Chair will arrange for secretarial support to be provided to the Alliance Executive.

10. Frequency

The Alliance Executive will meet at least once a month and not less than eight times a year.

11. Conduct of the Alliance Executive

The Alliance Executive shall conduct its business in accordance with the framework and principles set out by the Alliance Agreement, including the Conflict of Interests policy, and data sharing agreement.

12. Review

If a procurement route becomes a strong feature of our future ESBT Alliance model these terms of reference will be reviewed. This applies to all parts of the provider system, i.e. GPs, social care and mental health and acute providers, to achieve a balance between pragmatism and guidance to achieve the outcomes we are seeking for our population. Therefore these terms of reference will be reviewed in July 2017, after the recommendations about the future ESBT Alliance model have been agreed, and subsequently in March 2018.

Author	V Smith / J Britton / P Gorvett
Alliance Executive review	February 2017
ESBT Alliance Governing Board review	March 2017
Alliance Executive review due	July 2017, February 2018
ESBT Alliance Governing Board review due	July 2017, March 2018
Version	Final

Appendix 4

ESBT ACCOUNTABLE CARE DEVELOPMENT GROUP
(TASK AND FINISH)
TERMS OF REFERENCE

1. Governance

In accordance with the ESBT Alliance Agreement, the ESBT Alliance Governing Board has established a Task and Finish group known as the ESBT Accountable Care Development Group (referred to as the Accountable Care Development Group). These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Accountable Care Development Group.

2. Purpose

As part of the 2017/18 transformation activities detailed in the ESBT Alliance Agreement, the Accountable Care Development Group brings together key leads from each partner within the ESBT Alliance: Eastbourne, Hailsham and Seaford CCG, Hastings and Rother CCG, East Sussex County Council, East Sussex Healthcare NHS Trust, and Sussex Partnership Foundation NHS Trust. The Group will explore the options for our future ESBT Alliance accountable care model and make recommendations for the most appropriate vehicle to deliver high quality, effective care for the population covered by the ESBT footprint after the 2017/18 test-bed year. We will do this with reference to previously agreed principles and characteristics for our local accountable care model (as noted in the ESBT Alliance Governance Overview).

To ensure that there is representation from key stakeholders who will have views to contribute on what the vehicle for our future integrated ESBT Alliance model looks like there will be GP representation in their role as clinical commissioners and as providers, and Healthwatch will be represented to ensure that the views of patients, clients and the public are central.

3. Responsibilities

The Accountable Care Development Group will:

- Consider the options for organisational form and contract arrangements for our future ESBT Alliance model, with reference to the agreed key principles and characteristics of our local Accountable Care Model, as well as the potential impacts on
    - Our ability to deliver high quality, effective care
    - Statutory responsibilities, future governance and organisational infrastructure

- Levels of organisational change, and the process through which this will be managed
- Consultation processes
- Workforce and organisational design
- Potential procurement processes
- The relationship with non-ESBT Alliance providers for example GPs, other NHS Trusts, and the independent and voluntary sector
- The need to achieve system balance by 2020/21 at the latest

- Develop a proposal for the residual strategic commissioning functions (population needs assessment and outcomes setting) for the ESBT Alliance commissioning organisations (East Sussex County Council, EHS CCG and HR CCG).

- Seek appropriate advice, including legal advice, on the options of organisational form and strategic commissioning, taking into account the learning about new models of care from NHS Vanguards and international examples.

- Seek appropriate permissions from system regulators; NHSE; NHSI; DoH; and CQC for the preferred options. This includes working with NHSI to deliver the Integrated Support and Assurance Process (ISAP) for new care models.

- Identify key stakeholders and ensure appropriate stakeholder engagement in the development of options for the future ESBT Alliance model, and align this with wider communications and engagement in conjunction with the ESBT Communications and Engagement Steering Group (CESG) and Strategic Workforce Development Group

- Recommend the preferred option for our future ESBT Alliance model to the ESBT Alliance Governing Board, for consideration by the sovereign bodies of each constituent organisation

- Develop, enact and support subsequent implementation plans in the following areas (as appropriate):

  - Understand the governance implications of the future ESBT Alliance model, and develop and implement proposals
  - Ensure alignment with any relevant system redesign workstream, for example IT& Digital, Estates, Information Management and other elements of organisational infrastructure, as appropriate
  - Organisational development, workforce and change management
  - Communications and engagement with staff and the public
  - Potential formal consultation processes with staff and the public
  - Due diligence exercises
  - Commercial and procurement processes as appropriate
  - Developing and implementing the menu of options for non-Alliance providers to have a relationship with a future fully integrated ACM
  - Having due regard to the residual statutory responsibilities and functions of all sovereign organisations in relation to the preferred future ESBT Alliance model, and ensuring effective continuity

- Pilot the use of the draft public-facing Outcomes Framework in the test-bed year, based on the things that matter to local people about their health and care services,

to help develop and finalise a set of public-facing outcomes for future ESBT Alliance model. This will be used by the public and commissioners to test and understand whether our model is delivering on evidence-based outcome measures informed by what is important to local people.

- Develop with key stakeholders the model for citizen governance for the future ESBT Alliance model.

- Undertake any other tasks that the ESBT Alliance Governing Board sees as appropriate, either in its own right, or in conjunction with other groups in the ESBT Alliance governance structure, for example the ESBT Communications and Engagement Steering Group, ESBT Strategic Workforce Development Group, ESBT Finance Group and ESBT IT Strategy Group.

4. Authority

The Accountable Care Development Group (task and finish) is authorised by the ESBT Alliance Governing Board to ensure a robust and diligent approach to appraising the options for the future ESBT Alliance accountable care model and to carrying out any subsequent implementation activity as necessary. This includes undertaking appropriate stakeholder engagement activity at key stages of development and seeking specialist advice as and when needed.

5. Membership

The proposed members of the Accountable Care Development Group (task and finish) are as follows:

Representative	Organisation
Amanda Philpott (Chair)	Chief Officer, EHS CCG & H&R CCG and Joint ESBT Senior Responsible Officer (SRO)
Catherine Ashton	Director of Strategy, ESHT
Jessica Britton	Chief Operating Officer, EHS CCG & HR CCG
Louise Carter	Assistant Director, Communication, Planning and Performance, ESCC, Children's Services
Julie Fitzgerald	Director, Healthwatch East Sussex
Paula Gorvett	ESBT Programme Director, ESBT
Monica Green	Director of Human Resources, ESHT
Phil Hall	Resources Lead, ESBT
Dr Julius Parker	Chief Executive, Surrey Sussex Local Medical Committees
Dr Karthiga Gengatharan	Medical Director, Surrey Sussex Local Medical Committees
Martin Hayles	Assistant Director Strategy, Commissioning and Supply Management, ESCC ASC&H
Fiona Kellet	Head of Finance and Primary Care Commissioning, EHS CCG & H&R CCG
Vicky Smith	Accountable Care Strategic Development Manager, ESBT
Dr David Warden	GP Governing Body Member, EHS and HR CCGs / Chair HR CCG
Neil Waterhouse	Service Director East Sussex, SPFT

Lynette Wells	Director of Corporate Affairs, ESHT
Samantha Williams	Assistant Director Planning, Performance and Engagement, ESCC ASC&H

6. Meeting proceedings

Accountable Care Development Group members will commit to ensuring their attendance at meetings, or to nominate a deputy as appropriate, in order to ensure collective and timely action. In instances where members may have been unable to attend meetings the Group will ensure discussion takes place outside of the meeting in order to progress shared goals.

7. Attendance

The Accountable Care Development Group may invite other managers and representatives as appropriate to support the work of the group.

8. Reporting

The identification of the future vehicle for the ESBT Alliance is an ambition shared by the partners to the ESBT Alliance Agreement. The Accountable Care Development Group (task and finish) has been set up to develop the detailed project plans to ensure the production of the recommendations and subsequent implementation plans for the future ESBT Alliance model on behalf of the sovereign organisations. The Group reports directly to the ESBT Alliance Governing Board, where Amanda Philpott (Chief Officer of EHS and H&R CCGs), as the lead Senior Responsible Officer (SRO) for the work, will draw to the attention of the Governing Board any issues that require escalation to the Governing Board, decisions, or exception items requiring action by Governing Board.

The Accountable Care Development Group will also be responsible for proposals about the residual strategic commissioning function in the future integrated ESBT Alliance model and citizen governance of the future model. As such it will also report to the Strategic Commissioning Board.

Project management processes will be used to coordinate the development of the options appraisal and subsequent implementation plans.

Administration

Meetings will be coordinated by the CCGs corporate office and will be scheduled in advance to support the timely delivery of reports to the ESBT Alliance Governing Board, and recommendations to the sovereign organisations, as well as subsequent implementation plans once approval of the Alliance partners has been achieved.

9. Frequency

The Accountable Care Development Group will meet at least once a month in the first instance and this will be kept under review.

10. Conduct of the Accountable Care Development Group

The Accountable Care Development Group shall conduct its business in accordance with the framework and principles set out by the Alliance Agreement, including the Conflict of Interests policy, and data sharing agreement

If a procurement route becomes a strong feature of our future ESBT Alliance model these terms of reference will be reviewed. This applies to all parts of the provider system, i.e. GPs, social care and mental health and acute providers, to achieve a balance between pragmatism and guidance to achieve the outcomes we are seeking for our population.

Therefore these terms of reference will be reviewed in July 2017, after the recommendations about the future ESBT Alliance model have been agreed, and subsequently in March 2018.

11. Review

Author	V Smith
Accountable Care Development Group review	February 2017
ESBT Alliance Governing Board (shadow) review	March 2017
Accountable Care Development Group review due	July 2017, February 2018
ESBT Alliance Governing Board review due	July 2017, March 2018
Version	Final

ESBT CLINICAL LEADERSHIP FORUM

TERMS OF REFERENCE

8th August 2016

1. Constitution

1.1. The ESBT partners hereby formally resolve to establish a ESBT Clinical Leadership Forum (ESBT CLF). The ESBT CLF is a sub-group of the ESBT Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

2. Purpose

The ESBT CLF is established to provide authoritative clinical advice to the ESBT Alliance Governing Board, upon which recommendations may be made to the Stakeholder organisations.

The CLF will comprise a body of experts from our locally employed medical workforce who will act as the primary resource for care pathway, service specific and medical workforce advice to the ESBT Alliance Governing Board (and previously the ESBT Programme Board) and constituent organisations from September 2016 onwards.

The role of the ESBT CLF will be to guide and support the delivery of ESBT by:

- Securing the medical workforce[1] required for East Sussex, by designing the medical workforce which best delivers both the Place-based Accountable care model being developed through ESBT **and**
- Ensuring the effective operation of the acute clinical networks arising from the STP (Sussex and East Surrey Sustainability and Transformation Plan) work. This also requires effectively guiding the strategies for recruitment, retention and education and training which attract and retain the most appropriate workforce for East Sussex health and care services.
- Driving the clinical leadership of the delivery of the 5 year whole system Strategic Investment Plan by;
    - Prioritising the issues to be addressed, according to the evidence for;

[1] *In due course this will extend beyond the medical workforce to cover the clinical workforce*

- urgency,
- scale and impact for our population's health and wellbeing,
- securing the highest quality and safest services
- best use of resources

o Commissioning and overseeing the work of any and all Clinical Commissioning Leads, e.g. for cancer, diabetes, etc. (although these are normally CCG funded GP roles, it may be that these roles can extend to clinicians from any setting)

o Assuring any and all clinical pathway redesign prior to agreement by ESBT and/ or constituent organisations

The CLF is expected to operate as a Leadership Group, guiding work programmes and assuring that necessary work is being undertaken in a timely manner on the basis of the evidence. Therefore, the CLF will establish effective communications between group members and with a wider network of professionals and PPE members.

3. Objectives

3.1 To provide the ESBT Alliance Governing Board and constituent organisations with an ESBT CLF where new models of care including integrated clinical care pathways which underpin the ESBT Programme can be discussed, developed and overseen.

3.2 To provide an ESBT CLF where collective knowledge on clinical issues can be consolidated and provided to the ESBT Board and constituent organisations.

3.3 To provide a mechanism for increased participation and advice, including on clinical management and ethical issues, from clinicians in strategy and policy setting across the ESBT patch.

3.4 To strengthen clinicians' understanding of strategic investment planning and financial management, enhancing alignment of clinical priorities with the local and wider health economy.

3.5 To provide an ESBT CLF for greater co-ordination and integration that transcends current building / location / organisational / professional boundaries along care pathways.

3.6 To provide a vehicle for clinicians to champion reform in health.

3.7 To provide leadership for strategic decisions about the clinical configuration of the emerging accountable care model.

3.8 To strengthen clinical and Professional leadership among the wider body of clinicians within the emerging accountable care model.

4. Membership (including quorum)

- The membership of the CLF will comprise medical representatives of ESBT constituent Health and Care organisations and will be drawn from the medical workforce of those organisations. Representatives will be appointed by their respective organisations. .
- The Chair shall be an independent Chair appointed by the ESBT Programme Board (as at 08.08.16) partners.
- The CCG Chairs and Provider Trust Medical Directors will be appointed Vice-Chairs. In the absence of the Chair, one of the appointed Vice Chairs will by agreement preside over the meeting.
- A quorum will be 50% of members in addition to the Chair or Vice Chair.
- Members are expected to attend at least 75% of meetings annually. Delegation of membership to another member of staff is by exception only.
- Guests may be invited with the express permission of the Chair.

4.1 Core Members

The minimum membership is 13 members and maximum membership is 21 members. Each member is supported by their host organisation in terms of the role they are fulfilling. Each ESBT CLF member will have identified lead roles for progressing the purpose and objectives described above;

The ESBT CLF is constituted from the following:

- The independent Chair
- EHS CCG and H&R CCG – 6 to 8 GPs including 4 Board members, to include the Clinical Chairs
- ESHT – 6 - 8 members from a range of medical specialties, to include the Medical Director
- SPFT – 2 to 4 members
- ESBT Clinical Director

The group will be quorate if the Chair or Vice Chair (drawn from one of the 2 CCG Chairs or provider medical directors) + >50% of members in addition to the chair are present.

Co-opted Members and guests may attend with the explicit agreement of the Chair

4. Attendance

4.1 The Independent Chair will also be the Independent Chair of the ESBT Programme Board (and latterly the ESBT Alliance Governing Board), to ensure effective communications between the Board and the CLF.

4.2 The ESBT Clinical Director will act as lead Senior Managers for the ESBT CLF

4.2 Executive Directors (save those who are members), Lay Members and Non-Executive Directors may attend periodically by invitation as part of the mechanism for Board assurance

4.3 The CCGs will provide administrative support and advice to the ESBT CLF. Duties in this regard include, but are not limited to:

- Agreement of the Annual Agenda Framework, ensuring this regularly reviewed and updated and circulated to all members periodically throughout the year
- Finalisation of each meeting's agenda with the Chair, in conjunction with the lead senior manager(s)
- Circulating a request for papers no later than 10 working days prior to the submission deadline, and collating papers
- Ensuring the agenda and papers are distributed no less than 5 working days in advance of the meeting
- Ensuring minutes of the meeting are taken, including a record of decisions taken, matters arising and that issues to be carried forward are kept in a rolling log
- Ensuring that draft minutes are circulated within 10 working days of the meeting to all members
- Advising the ESBT CLF as appropriate
- Supporting the Chair to conduct the annual review of the ESBT CLF's effectiveness against the Terms of Reference

4.4 All members are expected to attend every meeting

4.5 As the meeting is advisory rather than decision-making, meetings will normally be closed

4.6 ESBT constituent organisations' staff and representatives from partner organisations may be invited to attend meetings to speak on specific matters

4.7 Access to meetings may be granted to other professional colleagues with the express permission of the Chair.

5. Frequency

5.1 In the first instance, we will aim to hold 6 meetings will be held between September 2016 and March 2017 inclusive.

5.2 Thereafter, subject to review of the ToR, meetings will normally be held bi-monthly; the ESBT CLF will meet at least 5 times per year.

5.3 Meetings may also be called by the Chair outside the usual cycle, and may where appropriate take place by webcast / telecom.

6. Authority

6.1 The ESBT CLF is authorised by the ESBT Alliance Governing Board to take action in respect of any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee of ESBT constituent organisations and all employees are directed to co-operate with any request made by the ESBT CLF, within the SFIs and Codes of Conduct and Information Governance arrangements of each organisation.

6.2 Recommendations from the group will usually be by consensus

6.3 In the event of a highly controversial item, the Chair will collate and represent the range of views of the CLF to the ESBT Alliance Governing Board.

7. Reporting

7.1 The minutes of the ESBT CLF meetings shall be formally recorded. The Chair of the ESBT CLF shall draw to the attention of the ESBT Alliance Governing Board any issues that require disclosure, or Executive action

7.2 The ESBT CLF will report annually to the ESBT Alliance Governing Board in respect of fulfilment of its functions as set out in these Terms of Reference. Such report shall include, but not be limited to, functions undertaken in connection with any pertinent matters in respect of which the ESBT CLF has been engaged

7.3 An Annual Agenda Framework will be established at the start of each financial year. Items of any other business may be added in the interim with the agreement of the Chair

7.4 Draft Agenda and call for papers will be circulated at least 3 weeks before the meeting

7.5 The agenda and supporting papers will be circulated by email at least 7 days in advance of the meeting. Papers may not be tabled without the agreement of the Chair

7.6 Minutes and Action Log will be taken by the support officer and routinely circulated to members within 7 days of the meeting

7.7 Minutes will be circulated to the members with an expectation that they will be disseminated internally as they seem appropriate and take any actions agreed at the meeting within specified timeframes

7.8 The Clinical Advisory ESBT CLF is an advisory group to the ESBT Alliance Governing Board and constituent organisations, and as such will be consulted in decision making about the strategic configuration of services and significant pathway redesign from a sufficiently early stage so that they have the greatest opportunity to influence the outputs.

8. Review

8.1 In the first instance, the ToR will be reviewed within 6 months with a view to extending the membership to form a fully-functioning, multi-professional CLF in 2017.

8.2 Thereafter, the Terms of Reference of the ESBT CLF shall be reviewed by ESBT Board at least annually

8.3 During this review the ESBT CLF will be assessed to ensure it has performed in accordance with these terms of reference, specifically that:

- The ESBT CLF has carried out the duties required
- The ESBT CLF has reported to the ESBT Alliance Governing Board and other ESBT CLFs as required
- Reports to the ESBT CLF have been scrutinised by the ESBT Alliance Governing Board, as appropriate
- Membership, frequency of meetings and attendance has been as stated
- The ESBT CLF has been quorate each time it has met

Amanda Philpott
Chief Officer, EHS & H&R CCG,
ESBT Joint SRO
8/8/16

These were updated in June 2017 to reflect the establishment of the ESBT Alliance Governing Board and will be subject to further review during 2017.

The East Sussex Better Together Alliance Governing Board

Item Number:

Date of meeting 27 June 2017

06/17

Title of report: Feedback and key issues from associated groups
Recommendation: The ESBT Alliance Governing Board is recommended to **note feedback from** the: • ESBT Alliance Executive; • ESBT Accountable Care Development Group; and • ESBT Clinical Leadership Forum. This item provides an opportunity for the ESBT Alliance Governing Board to be updated on key issues and any items for escalation from reporting groups in order to discharge its oversight and strategic leadership role. It helps ensure that all groups are fully focused on their remit as set out in the ESBT Alliance Governance structure, with no overlaps, duplication or gaps.
Executive Summary: This is a verbal agenda item only, with input provided from members of the associated groups.
Governing Body sponsors: Adrian Bull, Chair, ESBT Alliance Executive; Amanda Philpott, Chair, ESBT Accountable Care Development Group; Dr David Warden, member of the ESBT Clinical Leadership Forum.

Author(s): Andy Lane, Governance and Corporate Services Officer, EHS and H&R CCGs	**Date of report:** 20/06/17
Review by other groups/forum: N/A	
Health impact: None – feedback from other groups only	

Financial implications: None – feedback from other groups only
Legal or compliance implications: None – feedback from other groups only
Link to key objective and/or principal risks: Provides general support to the smooth, integrated running of the ESBT Alliance.
Importance to East Sussex Better Together (ESBT) programme: Ensures fully integrated and joined up delivery of the governance arrangements supporting East Sussex Better Together.
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 ☐ **EA Summary:**
Privacy Impact Assessment (PIA) – outcome: No personal data used ☒ Data processes sufficient ☐ Actions required ☐ **Actions:**

East Sussex Better Together (ESBT) Alliance Governing Board

Item Number: 07/17

Date of meeting: 27 June 2017

Title of report:
East Sussex Better Together (ESBT) Alliance Agreement

Recommendation:
The ESBT Alliance Governing Board is recommended to:

- **note** the strong progress made with finalising our integrated 2017/18 Strategic Investment Plan to support delivery of improvements to our health and care system in 2017/18; our pilot integrated outcomes framework that we will pilot in the 2017/18 transitional year to monitor progress; and the development of options appraisal process and criteria to inform discussions about the future ESBT delivery vehicle; and

- **collectively agree** the ESBT Alliance arrangement for 2017/18 to further progress the objectives of ESBT.

Executive Summary:
Our 150-week East Sussex Better Together (ESBT) programme, set up to galvanise the transformation of health and social care services, started in August 2014 and we have now moved into our test-bed year of the ESBT Alliance.

By working together as partners - East Sussex County Council (ESCC); Eastbourne, Hailsham and Seaford & Hastings and Rother CCGs; East Sussex Healthcare NHS Trust (ESHT); and Sussex Partnership NHS Foundation Trust (SPFT) - we have already made significant improvements in care pathways across health and social care.

However, as we have previously agreed, care pathway redesign is not, in itself, enough to ensure the required transformation and secure a sustainable health and care system. We are now focusing on building a new model of care – 'accountable care' – that integrates our whole system: primary prevention, primary and community care, social care, mental health, acute and specialist care, so that we can demonstrably make the best use of the c£1billion we spend every year to meet the health and care needs of the people of East Sussex.

The ESBT partner organisations have agreed to a formal Alliance Agreement (the Agreement) to underpin our arrangements for **2017/18**, allowing room to test to best effect what will be the right solution for the people we serve. This will help us reduce variation and

improve outcomes for local people, improving their health and wellbeing while making the experience of using health and care services better and more inclusive.

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

During March 2017 a final draft of the Alliance Agreement has been discussed and formally agreed through the governance processes of EHS and HR CCGs, ESHT and ESCC as prospective Full Members of the Alliance. SPFT will take the Agreement through their formal governance processes for agreement to participate as an Associate Member on 28 June. This paper brings the final agreed draft Alliance Agreement for collective agreement by the ESBT Alliance Governing Board, as well as an update on progress made to date during 2017/18 and an outline of plans going forward.

The Agreement itself articulates the statutory roles of the individual sovereign bodies of the participating organisations, and makes clear the responsibilities of the CCGs and ESCC to continue to articulate outcomes to be delivered for the local population through strategic investment decisions, as well as scrutinising and assuring the delivery of health and care services. Through commitments made in the Agreement the ESBT Alliance partners will enable an integrated commissioner provider response to deliver the outcomes. It also sets out a framework within which our risk share principles will be further developed.

The Alliance Agreement will ensure we have the right arrangements in place to enable us to act as if we are working as one; a coherent system to deliver improvements at scale as well as helping us to create a culture where we can continually learn and improve.

Governing Board sponsor: Joint ESBT SROs; Amanda Philpott, Chief Officer EHS CCG and HR CCG; Adrian Bull, Chief Executive ESHT; Keith Hinkley, Director of Adult Social Care	
Author(s): Vicky Smith, Accountable Care Strategic Development Manager, ESBT	**Date of report:** 20/06/17
Review by other committees: A final draft of the Alliance Agreement has been discussed and formally agreed by the CCG Governing Bodies, ESHT Trust Board and ESCC as prospective Full Members of the Alliance, during March 2017. SPFT will take the Agreement through their formal governance processes for agreement to participate as an Associate Member on 28 June.	
Health impact: Whole system transformation to Accountable Care, underpinned by longer term outcomes based capitated contracts, is seen by many to offer a solution to delivering and managing improved patient and population health outcomes, through positively incentivising the highest possible quality of care.	
Financial implications: Through using a population-based capitation payment method to positively incentivise delivery of the lowest effective and appropriate level of care, and 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 social 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 a move to Accountable Care in East Sussex.
Link to key objective and/or principal risks: Faced with increasing and changing demand pressure on services, and a potential collective funding gap of c£169 million for health and social care services by 2020 (across the ESBT Alliance area) if the status quo is maintained, local system leaders will need to design a multi-agency, collaborative and innovative response in order to achieve the overall goal of securing health and care services for future generations in East Sussex.
Link to East Sussex Better Together (ESBT) programme: Moving to a new model of Accountable Care aimed at improving health, improving quality and reducing the cost per capita of care, is the next phase of our work under ESBT to secure service provision that is clinically and financially sustainable in the long term.
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 emerging outcomes framework for the ACM.
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:** Not applicable.

ESBT Alliance Agreement

1 Background

1.1 Discussions at previous meetings of the ESBT Alliance members have covered the work taking place to develop the ESBT Alliance model, involving a test-bed year in **2017/18**, to establish a commissioner-provider alliance that will manage the health and social care system collectively across the ESBT partners.

1.2 The Alliance Agreement provides the framework to enable us to rapidly develop our capacity to manage the health and social care system collectively as an Alliance partnership, operating as an accountable care system, in order to test ways of working, configure resources more flexibly, and improve services for the population in **2017/18** and in the longer-term. Operating as an Alliance in **2017/18** will also allow us to progress development work to understand what the best vehicle will be to deliver our ESBT objectives in the longer-term.

1.3 The recent learning from the Kings Fund[1] [2] based on the UK NHS Five Year Forward View Vanguards, and international examples of best practice indicates that forming a commissioner-provider alliance for the test-bed phase puts us in a strong position to make significant progress within the current regulatory framework. Our Alliance will create the space and time to undertake the necessary learning and development, with support from NHS Improvement (NHSI) and NHS England (NHSE) as the system regulators, to design our full ESBT Alliance accountable care model, which in the longer-term would be structured around a single organisation, alliance or partnership holding the capitated budget to make sure we have integrated delivery of high quality services for our population.

1.4 Following extensive discussions during January – March, and presentation for formal agreement through the sovereign governance processes of EHS and HR CCGs, ESHT and ESCC during March, this paper presents the final draft Alliance Agreement for collective agreement by the ESBT Alliance Governing Board. The Agreement is due to go through SPFT's formal governance process on 28 June, for agreement of their Associate Membership of the Alliance. The Agreement has been informed by all ESBT partners and supported with appropriate legal advice. The final draft Alliance Agreement is attached at **Appendix 1**.

2 East Sussex Better Together (ESBT) Alliance Agreement (the Agreement)

2.1 The Agreement provides the framework to operate as an ESBT Alliance, in order for us to act 'as if' we are an accountable care model in 2017/18, by bringing together the following elements:

- An integrated alliance governance structure;
- Single system leadership with the ability to deploy resources against a common platform for delivery;
- An alignment of our budgets to test an accountable care operating model;

[1] New care models – emerging innovations in governance and organisational form (Kings Fund, 2016)
[2] The Quest for Integrated Health and Social care, A case Study in Canterbury New Zealand (Kings Fund, 2013)

- A mechanism for opportunity and risk share;
- A potential to test appropriate levels of delegation;
- A shared approach to the management of conflicts of interest;
- Arrangements for patient / citizen integration into the governance framework; and
- A framework for the Alliance arrangement itself, detailing which organisations are involved and in what capacity (Full or Associate member), and how it will relate to the other parts of our health and care system.

2.2 The Agreement is an arrangement within which commissioners and providers work together as a single integrated system to deliver services under a framework that seeks to align investment decisions with the ESBT programme's aims and objectives. Performance will be measured against a shared set of indicators and an ESBT pilot Outcomes Framework has been developed to support this.

2.3 The Agreement seeks to create cooperation between Alliance providers and commissioners so we act in a way that is best for the whole system rather than individual organisations. The Agreement creates this collaborative environment by ensuring all parties are working to the same outcomes and are committed to the same success measures within an agreed governance framework.

2.4 A programme of transformation work is set out in Schedule 2 that the ESBT partners are committing to undertake during the test-bed phase, to both collectively act in a way that delivers improvements for our local populations in **2017/18** through deploying our resources more flexibly and responsively, and to identify the best vehicle to deliver the ESBT objectives of a fully integrated and sustainable health and care system for our local populations.

2.5 The Agreement will enable good system wide operational decision-making within the context of full recognition that existing statutory obligations and duties will still apply. As such, the Agreement will supplement and work alongside the NHS Standard Contracts of healthcare providers and the Local Authority's social care contracts with the independent and voluntary sector.

2.6 The Agreement is generally not a legally binding document, however it contains some provisions which are binding on the signatories to the Agreement: 15.3 (Information Sharing Exercise); 17 (Standard of Conduct and Service); 18 (Conflicts of Interest); 19 (Liabilities and Insurance and Indemnity); 22 (Dispute Resolution); 24 (Confidentiality); 25 (Freedom of Information and Environmental Information Regulations); 26 (Ombudsmen); 27 (Notices); 29 (Change in Law); 30 (Waiver); 31 (Severance); 32 (Assignment and Sub Contracting); 34 (Third Party Rights); and 37 (Governing Law and Jurisdiction).

2.7 The final draft Agreement takes into account all the comments and feedback to date and sets out the principles and planned work to be taken forward in the first phase of **2017/18** in order that we can continue to test and learn. In line with this, work has taken place to finalise the SIP **2017/18** aligned budget; arrangements for citizen leadership have been confirmed; and an overarching conflicts of interest policy is being finalised. An ESBT Alliance Data Sharing Agreement (DSA) to support the work of the Alliance

and any future information sharing exercises as a result of decisions reached about the preferred ESBT delivery vehicle in June will be finalised by the end of July.

3 Membership of the Alliance

3.1 In line with our original ESBT objectives and principles and characteristics for Accountable Care, the ambition is to design and develop a model that integrates our whole system: primary prevention; primary and community care; social care; mental health; acute and specialist care, so that we can demonstrably make best use of the c£1billion we spend every year to meet the health and care needs of the population within the area covered by the ESBT footprint.

3.2 To move this forward in 2017/18, the Agreement initially sets out two categories of Alliance membership for the test-bed year; 'Full Alliance Member' and 'Associate Alliance Member'. The core parties to the Agreement are: Eastbourne, Hailsham and Seaford (EHS) CCG; Hastings and Rother (HR) CCG, ESCC; and East Sussex Healthcare NHS Trust (ESHT). These are the parties that will commit resources[3] to an aligned infrastructure to enable us to collectively manage how we use our resources to best effect for our local populations within the ESBT footprint.

3.3 Therefore, the initial signatories as **Full Members** to the Agreement will be:

- NHS Eastbourne Hailsham Seaford CCG (EHS CCG)
- NHS Hastings and Rother CCG (HR CCG)
- East Sussex County Council (ESCC)
- East Sussex Healthcare NHS Trust (ESHT)

3.4 Sussex Partnership NHS Foundation Trust (SPFT) will be an **Associate Member** of the ESBT Alliance.

3.5 It should be noted that the members are those parties that are formally entering into the Agreement and does not preclude other parties entering over time, or the further refinement of the agreement to incorporate a potential affiliate membership category. This would support the formalisation of wider partnerships where other parties are expressly working within the system to the same aims and objectives and want to work collaboratively alongside the Alliance (for example individual voluntary and community sector organisations).

3.6 Other parties, most notably at this stage general practice, other NHS providers, the voluntary and independent sector, District and Borough Councils and the Police and Fire Services are firmly embedded within the planning framework as key stakeholders in a way that will ensure an opportunity for a more formal role in the Alliance should these stakeholders express an appetite for that. It is envisaged that the Alliance arrangement will evolve over the coming year and this includes the possibility that over time new parties will become signatories to the Alliance Agreement, either as Full members or Associate members, as arrangements to secure a collective voice and

[3] Appropriate to their membership status

platform for delivery become embedded, for example in the case of primary care and the local GP Federations.

3.7 A description of Alliance roles of commissioner and provider, and Full Alliance Member and Associate Alliance Member are contained in Schedule 7 of the Agreement. This acknowledges that some members of the Alliance will fulfil roles of both commissioner and provider.

3.8 This model of categorisation, and which membership category that individual ESBT partners (and possibly in time others) choose, reflects expectations about alignment of financial and risk sharing arrangements needed to achieve our objectives in the test-phase. It recognises and seeks to cater for the vital importance of mental health, which is provided by SPFT over a significantly larger area than the ESBT footprint and the critical role of primary care which needs to be involved from both a commissioner and provider perspective in the governance arrangements and supporting structure.

3.9 It is acknowledged that primary care will play an integral role in the delivery of ESBT whole system objectives and this is already reflected in the ESBT five year strategic investment plan, which has signalled additional investment to transform primary care and general practice services in line with ESBT objectives. It is a commitment of the ESBT partners to fully engage with General Practice on how they would best be able to interface with the Alliance. A menu of options for this is in development and the role of emerging GP Federations and the Local Medical Committee will be significant in enabling a collective approach to this, where appropriate.

3.10 It is also acknowledged that more detail will emerge during 2017/18 as the model is further developed and provisions will also be made within the Agreement to allow for potential new members to join the Alliance and movement from one category of membership to another, especially if the Alliance arrangement is extended beyond the test-bed year.

4 Progress to date

4.1 Elements of the new Alliance Governance structure have started to operate partially, and in shadow form, since February 2017. The Alliance Agreement and underpinning governance structure provide the framework to enable us to rapidly develop our capacity to manage the health and social care system collectively as an Alliance partnership, operating as an accountable care system, in order to test ways of working, configure resources more flexibly, and improve services for the population in 2017/18 and in the longer-term. In addition to developing the formal Alliance Agreement to provide the framework to operate as an ESBT Alliance we have developed the following elements of our shadow accountable care system:

- An integrated governance structure, and a framework for the Alliance arrangement itself, detailing which organisations are health and care system are involved and in what capacity (this is the subject of a separate report to the Alliance Governing Board);
- A Strategic Commissioning Board (SCB) has been established by ESCC, EHS CCG and HR CCG to jointly undertake responsibilities for population needs assessment

and commissioning health and social care through oversight of the SIP, as well as overseeing and assuring the delivery of health and social care services in the 2017/18 test bed year;

- A pilot integrated Outcomes Framework has been developed to support the role of the Board (SCB) in the 2017/18 test-bed year;
- An integrated Strategic Investment Plan (SIP) has been agreed for 2017/18 enabling the Council and EHS and H&R CCGs to align health and social care investment to deliver the transformation in how care is provided across the ESBT footprint and establish a clinically and financially sustainable system;
- An integrated financial reporting system to enable the planning and control of ESBT resources through regular monitoring of expenditure against the plan, with corrective action to be taken in year, if required, by the Strategic Commissioning Board;
- Arrangements for patient / citizen integration into the governance framework have been agreed and are being put in place; and
- An options appraisal process and set of key assessment criteria to support consideration of the future ESBT delivery vehicle has been discussed and shared widely, so that a recommendation on the preferred direction of travel to the ESBT Alliance Governing Board in July 2017, ahead of being taken to the governing bodies of the ESBT sovereign organisations.

5. Next steps in 2017/18

5.1 In addition to working collectively as an Alliance, and operating as an accountable care system, the following areas continue to be taken forward:

- Celebrating the conclusion of the ESBT 150 week programme, and the transition of the transformation work programme to business as usual processes of the ESBT Alliance partners;
- Ensuring a robust process that enables us to make recommendations on the preferred delivery vehicle to meet the ESBT ambitions of a fully integrated and sustainable health and care system, so that ESBT Alliance constituent organisations' sovereign bodies are able to make a formal decision in July;
- Setting out our future approach to integrated strategic commissioning with EHS CCG and HR CCG for our ESBT 'place'; work is taking place to recommend an integrated model that enables the Council and the CCGs to discharge statutory responsibilities for strategic commissioning; and
- Beginning to test out the ESBT Outcomes Framework to help us understand how well our ESBT Alliance is delivering quality services and driving improvements.

5.2 A roadmap is being developed to support this and further understand the phasing of our plans post July 2017; this will emerge in much greater detail once the preferred direction has been agreed and comprehensive plans will be established to ensure robust implementation. In summary our high level milestones are as follows:

	High level milestone	***Complete by***
1	Launch ESBT Alliance transitional year	April 2017

3	Report on ESBT delivery vehicle recommendations to ESBT Alliance Governing Board	July 2017
4	Recommendations to the sovereign bodies of ESBT Alliance Organisations	July 2017
5	Implementation *(plans to be confirmed and further milestones to be set in line with agreed recommendation)*	August 2017
6	New ESBT Alliance model arrangements *(commencement date to be confirmed in line with agreed recommendation and outline roadmap at milestone 4)*	April 2018

5.3 The prioritisation of our work is informed by the findings of independent research into the readiness of our system for Accountable Care by Optimity Advisors, a leading global advisory firm that has developed an evidenced-based Accountable Care System Health Check. Commissioned in February 2017 by the (then) Shadow ESBT Alliance Governing Board, the evidenced-based Health Check tool covers the known features of successful accountable care delivery across ten domains, to summarise a profile of strengths and areas of risk for our system at the current time. The findings from this research were reported this month.

5.4 The previous informal meeting of the ESBT Alliance Governance Board heard that the findings commended the maturity of our partnerships, our evident shared ambition and vision, and our approach to deep and wide stakeholder engagement, recognising the specific continued engagement that will be needed across primary care in particular.

5.5 The report also benchmarked our system against two other systems that Optimity are working with; an advanced Sustainability and Transformation Plan-wide system and an urban authority designated with New Models of Care 'fast follower' status. The findings found us to be ahead of these other systems in the primary areas of Purpose and Understanding, Scope and Care Coordination, as well as their view on our governance, therefore positioning us well to take forward more complex areas of Finance and Contracting, Workforce and Health Information Technology (areas where we were benchmarked as equal to the other systems).

6 Conclusion

6.1 The governing bodies of the sovereign ESBT partner organisations have previously agreed that moving to a fully integrated model of Accountable Care offers the best opportunity to achieve the full benefits of an integrated health and social care system, and that a test-bed year of Accountable Care, under an alliance arrangement, would allow for the collaborative learning and evaluation to take place between the ESBT partners and other stakeholders.

6.2 It is recommended that the ESBT Alliance Governing Board notes the strong progress already made in 2017/18 to take our ESBT partnership to deeper levels, and our plans going forward. Collective agreement of the final draft Alliance Agreement by the ESBT Alliance Governing Board is now sought in order to ensure we implement these arrangements that have been approved by our individual sovereign bodies.

7 **Recommendation**

7.1The Alliance Governing Board is recommended to:

- **note** the strong progress made with finalising our integrated 2017/18 Strategic Investment Plan to support delivery of improvements to our health and care system in 2017/18; our pilot integrated outcomes framework that we will pilot in the 2017/18 transitional year to monitor progress; and the development of options appraisal process and criteria to inform discussions about the future ESBT delivery vehicle**;** and

- **collectively agree** the ESBT Alliance arrangement for 2017/18 to further progress the objectives of ESBT.

Author Vicky Smith, Accountable Care Strategic Development Manager, ESBT
Report date: 20 June 2017

Bevan Brittan | Lawyers for the public, private and third sectors

Dated **2017**

EAST SUSSEX COUNTY COUNCIL

and

NHS HASTINGS AND ROTHER CLINICAL COMMISSIONING GROUP

and

NHS EASTBOURNE HAILSHAM AND SEAFORD CLINICAL COMMISSIONING GROUP

and

EAST SUSSEX HEALTHCARE NHS TRUST

and

SUSSEX PARTNERSHIP NHS FOUNDATION TRUST

ALLIANCE AGREEMENT

relating to the East Sussex Better Together Programme for the integration of health and social care services

DRAFT 13

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Contents

THIS AGREEMENT is made on day of 2017

PARTIES

(1) **EAST SUSSEX COUNTY COUNCIL** of County Hall, St Anne's Crescent, Lewes, East Sussex BN7 1UE (the **"Council"**)

(2) **NHS HASTINGS AND ROTHER CLINICAL COMMISSIONING GROUP** of Bexhill Hospital, Holliers Hill, Bexhill-on-Sea TN40 2DZ ("**HR CCG"**)

(3) **NHS EASTBOURNE, HAILSHAM AND SEAFORD CLINICAL COMMISSIONING GROUP** of 36-38 Friars' Walk, Lewes BN7 2PB ("**EHS CCG"**)

(4) **EAST SUSSEX HEALTHCARE NHS TRUST** of St. Anne's House, 729 The Ridge, St. Leonards-on-Sea, East Sussex TN37 7PT **("ESHT")**

(5) **SUSSEX PARTNERSHIP NHS FOUNDATION TRUST** of Swandean, Arundel Road, Worthing, West Sussex BN13 3EP **("SPFT")**.

BACKGROUND

(A) Our 150-week East Sussex Better Together ("**ESBT**") programme, set up to galvanise the transformation of health and social care services, started in August 2014. It is led by our two local NHS Clinical Commissioning Groups, Eastbourne, Hailsham and Seaford Clinical Commissioning Group and Hastings and Rother Clinical Commissioning Group; East Sussex County Council; East Sussex Healthcare NHS Trust; and Sussex Partnership NHS Foundation Trust.

(B) By working together, we have already begun to make significant improvements in care pathways across health and social care. The formation of Health and Social Care Connect ("**HSCC**"), our integrated adult health and care access point that helps the public and professionals receive the right health and social care support faster; and our nurse-led Crisis Response Teams, which help prevent unnecessary hospital admissions through arranging the right care, in the right place, at the right time, are just two of our successes to date. For more information about the significant improvements already made, please visit: https://news.eastsussex.gov.uk/east-sussex-better-together/.

(C) To complete the transformation we now need to build a new model of care – 'accountable care' – that integrates our whole system: primary prevention, primary and community care, social care, mental health, acute and specialist care, so that we can demonstrably make best use of the spend in the region of £850m that we use each year to meet the health and care needs of the people of East Sussex.

(D) **'**Accountable care' focusses on incentivising professionals and providers, through aligned payment mechanisms, to break down organisational barriers and work more effectively together to improve health and wellbeing outcomes for populations. International examples of accountable care indicate that we could achieve around a 20% reduction in transactional costs at the same time as improving: the experience of those individuals that use health and care services; and the quality and safety of those services. Our move to an accountable care approach is intended to bring together all health and care organisations and professionals within the ESBT area to offer safe, sustainable, high quality physical and mental health services for adults and children.

(E) Through this model of care, we will also aim to empower and enable Service Users to manage their own health and care whenever that's possible. This means ensuring individuals understand how to access services that assist them, as Service Users or as part of a family or wider community, to improve their own health and wellbeing. This is at the same time also being able to access appropriate care and treatment from professionals when they need it, in the best place and at the right time.

(F) We understand our population is increasing in number and people are living longer. This, however, has an impact in increasing the demands on our health and care services, which will continue whilst the commissioning budget will remain largely the same in relative terms. A move towards an integrated health and social care system will assist in expending our funds to target our resources and services in a more efficient and effective matter. More importantly, however, it will help us reduce variation and improve outcomes for Service Users, improving their health and wellbeing while making the experience of using health and care services better and more inclusive.

(G) During 2017/18, the Partners will be working even more closely together as an Alliance to determine the right model of accountable care to 'fit' our population. We will focus on what matters to local people, raising the profile and investment in prevention and proactive care while reducing reliance on secondary care (hospital) services. Our future model will incorporate both the commissioning and delivery of health and care services to the local population and will have an annual income of approximately £850m for this financial year. By learning from international best practice, we anticipate that the future model will deliver around 50% of services directly, with the remaining services subcontracted. In the Test-Bed Period contracting will remain with Alliance partners through their individual contracts with third parties, including GPs, independent care providers, charities, voluntary, specialist clinical/treatment and ambulance services. How this will work in practice in the future model will be agreed through the testing activity and arrangements that will take place during the Test-Bed Period, including further work to determine what is in and out of scope of the core work of the future ACM, as well as engagement with key delivery partners in the health and care system.

(H) We really value the input and contributions of local people, patients, partners, professionals, the voluntary sector, charitable organisations and our health and care staff, who will continue to help us shape the best accountable care model for the ESBT Footprint. As we work more closely together, we will continue to do things differently to improve the experience and outcomes of the individuals that use our services. Furthermore, whilst we are expecting the way in which we deliver services to change, our existing workforce has a vital role in helping make this happen to best effect.

(I) We need to agree the right model of accountable care for our population. This will include:

- learning from other accountable care models and recognised international best practice for example, La Ribera Salud in Spain and Canterbury, New Zealand;
- designing an incentive scheme that rewards population health outcomes more than activity;
- working even more closely with our public, patients and partners in all areas of service delivery; and
- ensuring we really test what's right for the ESBT Footprint.

(J) ESBT is one of three place-based localities in the Sussex and East Surrey Sustainability and Transformation Plan (the "**STP**") footprint. The Partners together with neighbouring Clinical Commissioning Groups, local authorities and providers, are working to develop an STP which will drive transformation of the patient experience and outcomes, over the longer term, to deliver sustainability. The Partners acknowledge that ESBT and arrangements contemplated by this Agreement may evolve in accordance with the development of the STP and the availability of transformation funding through the STP.

(K) The purpose of this Agreement is to:

a) set out the principles on which the Partners have agreed to collaborate to progress towards a local fully integrated accountable care model (the "**ACM**"), which will involve transformation activity during which period the Partners will develop their existing partnering arrangements and subsequently establish formal arrangements to implement the model for the alliance between the Partners as an ACM; and

b) acknowledge and refer to the existing joint working arrangements, which the Partners have in place that will continue to operate alongside this Agreement in accordance with their terms.

1 **DEFINED TERMS AND INTERPRETATION-**

1.1 In this Agreement, save where the context requires otherwise, the following words, terms and expressions shall have the following meanings:

1998 Act means the Data Protection Act 1998.

2000 Act means the Freedom of Information Act 2000.

2003 Act means the Local Government Act 2003.

2004 Regulations means the Environmental Information Regulations 2004.

2006 Act means the National Health Service Act 2006.

2012 Act means the Health and Social Care Act 2012.

2014 Act means the Care Act 2014.

2016 Act means the Cities and Local Government Devolution Act 2016

ACM has the meaning given to the term in Recital (K) (a).

ACM Documentation has the meaning given to the term in Clause 6.3.2(c).

Affected Partner means, in the context of Clause 23, the Partner whose obligations under the Agreement have been affected by the occurrence of a Force Majeure Event.

Agreement means this agreement including its Schedules and Appendices.

Aligned Fund means the budget detailing the financial contributions of the Partners which are consistent with the Strategic Investment Plan and where relevant subject to the requirements of one or more of the Existing Agreements and Contracts.

Alliance means the Alliance Commissioners and Alliance Providers working together as an alliance to achieve the aims and objectives detailed in this Agreement.

Alliance Aims and Objectives means the aims and objectives of the Alliance as set out in Clause 6.1.

Alliance Commissioners means, as at the Commencement Date, either:

a) East Sussex County Council; or

b) NHS Hastings and Rother Clinical Commissioning Group; or

c) NHS Eastbourne, Hailsham and Seaford Clinical Commissioning Group,

(as appropriate) and references to "**Alliance Commissioners**" shall be construed accordingly.

Alliance Principles means those principles and characteristics set out in Clause 4 (General Principles) and Schedule 1 (Principles and Characteristics of our New Model of Care).

Alliance Provider means, as at the Commencement Date, either:

a) East Sussex Healthcare NHS Trust; or

b) Sussex Partnership NHS Foundation Trust; or

c) East Sussex County Council

(as appropriate) and references to "**Alliance Providers**" shall be construed accordingly.

Associate Alliance Member is a category of Partner to this Agreement as described in Paragraphs 1.1 and 1.4 to Part 2 to Schedule 7 (Alliance Roles and Categories of Membership of the Alliance) to this Agreement, which at the Commencement Date comprises of the Partners designated as such at Clause 7.2 of this Agreement.

Authorised Officer means an officer of each Partner appointed to be that Partner's representative for the purpose of this Agreement.

Best Value means the duty to secure continuous improvement in the way in which functions are exercised having regard to the economy, efficiency and effectiveness.

CCG means either:

(a) NHS Hastings and Rother Clinical Commissioning Group; or

(b) NHS Eastbourne, Hailsham and Seaford Clinical Commissioning Group,

(as appropriate) and references to "**CCGs**" shall be construed accordingly.

CCG Statutory Duties means the duties of the CCG pursuant to Sections 14P to 14Z2 of the 2006 Act.

CEDR means the Centre for Effective Dispute Resolution.

Change in Law means the coming into effect or repeal (without re-enactment or consolidation) in England of any Law, or any amendment or variation to any Law, or any judgment of a relevant court of law which changes binding precedent in England after the Commencement Date.

CIPFA Code means the relevant code of practice on local authority accounting issued by the Chartered Institute of Public Finance and Accounting.

Commencement Date means 00:01 hrs on 1 April 2017.

Commissioner means any entity, other than an Alliance Commissioner, responsible for planning, in the ESBT Footprint.

Confidential Information means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement and the Services and:

(a) which comprises Personal Data or Sensitive Personal Data or which relates to any patient, or Service User, or his or her treatment or medical history;

(b) the release of which is likely to prejudice the commercial interests of a Partner or the interests of a Patient or Service User respectively; or

(c) which is a trade secret; or

(d) which is to be kept confidential and provided under an obligation of confidence from a Government Department or required pursuant to a court judgment.

Data Sharing Agreement means the agreement entered into pursuant to Clause 15.3 (Information Sharing Exercise).

Default Notice means a written notice pursuant to Clause 21.2.4 (Exclusion, Termination and Effects of Exclusion and Termination).

DGH has the meaning given to the term in Paragraph 2 to Schedule 1(Principles and Characteristics of our New Model of Care).

Discloser has the meaning given to the term in Clause 24.1.

ESBT has the meaning given to the term in Recital (A).

ESBT Accountable Care Development Group means as described in Paragraph 1.5 to Schedule 3 (Proposed Governance Structure).

ESBT Alliance Executive as described in Paragraph 1.5 to Schedule 3 (Proposed Governance Structure).

ESBT Alliance Governing Board as described in Paragraph 1.5 to Schedule 3 (Proposed Governance Structure).

ESBT Footprint is the geographical area for which the CCGs have responsibility for commissioning health services pursuant to the 2006 Act and it shall include the population residing within that area for whom the Health and Social Care Services are commissioned which are in the scope of this Agreement.

Exclusion Notice means a notice issued pursuant to Clause 21 (Withdrawal, Exclusion, Termination and Effects of Exclusion and Termination) which must specify the grounds on which the Exclusion Notice has been issued and which will have the effects specified in Clause 21;

Existing Agreements and Contracts means those existing arrangements in place between the:

(a) Alliance Commissioners pursuant to Section 75, Section 256 and/or Section 257 of the 2006 Act;

(b) Alliance Commissioner and Alliance Providers pursuant to Service Contracts entered into between one or more of those Partners; and

(c) Alliance Commissioners and other Third Party providers pursuant to Services Contracts entered into by one or more of the Alliance Commissioners and such Third Party providers.

Expiry Date means 31 March 2019.

Extension Period has the meaning given to the term in Clause 2.3.

Financial Contributions means the financial contributions made by the Partners to the Alliance in any Financial Year.

Financial Year means each financial year running from 1 April in any year to 31 March in the following calendar year.

First Partner has the meaning given to the term in Clause 19.1.

Force Majeure Event means one or more of the following:
(a) war, civil war (whether declared or undeclared), riot or armed conflict;

(b) acts of terrorism;

(c) acts of God;

(d) fire or flood;

(e) industrial action;

(f) prevention from or hindrance in obtaining raw materials, energy or other supplies;

(g) any form of contamination or virus outbreak; and
(h) any other event,

in each case where such event is beyond the reasonable control of the Partner claiming relief.

Full Alliance Member is a category of Partner to this Agreement as described in Paragraphs 1.1 and 1.3 to Part 2 to Schedule 7 (Alliance Roles and Categories of Membership of the Alliance) to this Agreement which at the Commencement Date comprises of the Partners designated as such at Clause 7.2 of this Agreement.

Health and Social Care Services has the meaning given to the term in Clause 6.1.1.

HSCC has the meaning given to the term in Recital B.

Indirect Losses includes loss of profits, loss of use, loss of production, increased operating costs, loss of business, loss of business opportunity, loss of reputation or goodwill or any other consequential or indirect loss of any nature, whether arising in tort or on any other basis.

Information Sharing Exercise means the exercise described in Clause 15.1 (Information Sharing Exercise).

Initial Term means the period commencing on the Commencement Date and ending on the second anniversary of the Commencement Date.

ISAP has the meaning given to the term in Paragraph 1.10 to Schedule 2 (Transformation Activities).

Joint Complaints Protocol has the meaning given to the term in Clause 20.1(Complaints).

Law means:

(a) any statute or governmental direction or any delegated or subordinate legislation;

(b) any enforceable community right within the meaning of Section 2(1) European Communities Act 1972;

(c) any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and

(d) any judgment of a relevant court of law which is a binding precedent in England.

Licence Conditions has the meaning given to the term in Clause 17.5.

Losses means all damage, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services), proceedings, demands and charges whether arising under statute, contract or at common law but excluding Indirect Losses and "Loss" shall be interpreted accordingly.

Mediation Notice has the meaning given to the term in Clause 22.4.

Month means a calendar month.

National Guidance means any and all guidance as issued from to time to time by NHS England, NHS Improvement, the Department of Communities and Local Government, the Department of Health, the Local Government Association either collectively or separately.

Other Partner has the meaning given to the term in Clause 19.1.

Overspend means any expenditure in respect of a service that is part of the Health and Social Care Services by a Partner in a Financial Year which exceeds the Financial Contributions for that specific service as agreed by the Partners pursuant to this Agreement for that Financial Year.

Partner means each of the CCGs, the Council, East Sussex Healthcare NHS Trust, and Sussex Partnership NHS Foundation Trust, and references to "Partners" shall be construed accordingly.

Personal Data means Personal Data as defined by the 1998 Act.

Pooled Fund means any pooled fund established and maintained by the Partners as a pooled fund in accordance with the Regulations.

Provider means a provider, other than an Alliance Provider, of any Services commissioned under the arrangements set out in this Agreement including providers in General Practice, other NHS Trusts, the independent care sector and the voluntary and community sector.

Public Health Duties has the meaning given to the term in Clause 17.3.

Public Health England means the SOSH in the capacity of Public Health England.

Quarter means each of the following periods in a Financial Year:

1 April to 30 June

1 July to 30 September

1 October to 31 December

1 January to 31 March

and "**Quarterly**" shall be interpreted accordingly.

Recipient has the meaning given to the term in Clause 24.1.

Regulations means the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 No 617 (as amended).

Sensitive Personal Data means Sensitive Personal Data as defined in the 1998 Act.

Services Contract means an agreement entered into by one or more of the Partners to secure the provision of the Health and Social Care Services.

Service Users means those individuals for whom the Partners have a responsibility to provide and/or commission the Health and Social Care Services.

SOSH means the Secretary of State for Health.

STP has the meaning given to the term in Recital (J).

Strategic Investment Plan or SIP means an integrated plan, agreed annually by the Alliance Commissioners for the prioritisation of investment by the Alliance Commissioners to enable the transformation of the health and care system towards a new model of care. The total proposed investment must be affordable within the available financial resources of the Alliance Commissioners.

Test-Bed Period means the period for which this means the period that this Agreement remains in force, commencing on the Commencement Date.

Third Party means any individual or organisation other than the Partners.

Transformation Activities means those activities to be carried out by the Partners during the Test-Bed Period set out in Clause 6.2.1.

Underspend means any monies within the Aligned Fund in a Financial Year which accrue, being less than the aggregate value of the Financial Contributions agreed between the Partners pursuant to this Agreement for that Financial Year.

Working Day means 8.00am to 6.00pm on any day except Saturday, Sunday, Christmas Day, Good Friday or a day which is a bank holiday (in England) under the Banking & Financial Dealings Act 1971.

1.2 In this Agreement, all references to any statute or statutory provision shall be deemed to include references to any statute or statutory provision which amends, extends, consolidates or replaces the same and shall include any orders, regulations, codes of practice, instruments or other subordinate legislation made thereunder and any conditions attaching thereto.

1.3 Any headings, together with the front cover and the index are for convenience only and shall not affect the meaning of this Agreement. Unless the contrary is stated, references to Clauses and Schedules shall mean the clauses and schedules of this Agreement.

1.4 Any reference to the Partners shall include their respective statutory successors, employees and agents.

1.5 In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

1.6 Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

1.7 In this Agreement, words importing the singular only shall include the plural and vice versa.

1.8 In this Agreement, "staff" and "employees" shall have the same meaning and shall include reference to any full or part time employee or officer, director, manager and agent.

1.9 Subject to the contrary being stated expressly or implied from the context in these terms and conditions, all communication between the Partners shall be in writing.

1.10 All references to the Agreement include (subject to all relevant approvals) a reference to the Agreement as amended, supplemented, substituted, novated or assigned from time to time.

2 TERM

2.1 Subject to earlier termination in accordance with Clause 21 (Withdrawal, Exclusion, Termination and Effects of Termination) and review pursuant to Clause 2.2, this Agreement will take effect from the Commencement Date and will continue until the Expiry Date.

2.2 The Partners shall meet together prior to 31 January 2018 in good faith to agree whether:

2.2.1 they require the Agreement to continue until the Expiry Date (or such earlier date or extended date as may be agreed pursuant to Clause 2.3); or

2.2.2 the arrangements for the ACM have been implemented such that they shall supersede this Agreement from 1 April 2018 in which case, this Agreement shall be terminated in accordance with Clause 21 (Exclusion, Termination and Effects of Exclusion and Termination).

2.3 The Partners may extend this Agreement beyond the Initial Term by a further period of up to one year ("**Extension Period**") in accordance with the following procedure:

2.3.1 any Partner wishing to extend this Agreement, shall give not less than 3 Months' written notice of such intention before the expiry of the Initial Term.

2.3.2 any Extension Period must be:

(a) mutually agreed between the Partners;

(b) documented in writing; and

(c) signed by all Partners,

in accordance with Clause 2.3.3 below.

2.3.3 The Partners shall agree the details of the Extension Period and any subsequent amendments required to the associated arrangements as a result of the Partners agreeing the Extension Period including, but not limited to, any changes to this Agreement, any amendments required to Existing Agreements and Contracts not less than three Months prior to the end of the Initial Period in accordance with the general principle that, in agreeing the timetable for review and possible extension of this Agreement, it should not be extended beyond 31 March 2020 unless otherwise agreed in writing by the Partners.

2.3.4 In the event that the Partners are unable to agree the terms of any Extension Period or amendments to the Agreement (as appropriate), Clause 22 (Dispute Resolution) shall apply, and if no agreement is reached during the dispute resolution process, the Agreement shall expire on the Expiry Date.

3 STRUCTURE OF THE AGREEMENT

3.1 This Agreement comprises:

3.1.1 principles under which the Partners shall operate and the aims and objectives of these arrangements as referred to in:

(a) the Alliance Principles; and

(b) Alliance Aims and Objectives, and

3.1.2 the arrangements for a period of transition during which the Partners will agree the structure, operational arrangements and terms under which the Alliance shall operate.

3.2 This Agreement shall not be legally binding except for:

3.2.1 the following provisions: 15.3 (Information Sharing Exercise); 17 (Standard of Conduct and Service); 18 (Conflicts of Interest); 19 (Liabilities and Insurance and Indemnity); 22 (Dispute Resolution); 24 (Confidentiality); 25 (Freedom of Information and Environmental Information Regulations); 26 (Ombudsmen); 27 (Notices); 29 (Change in Law); 30 (Waiver); 31 (Severance); 32 (Assignment and

Sub Contracting); 34 (Third Party Rights); and 37 (Governing Law and Jurisdiction); and

3.2.2 any other additional provision agreed by the Partners in writing in accordance with Schedule 6 (Change Control Procedure).

4 GENERAL PRINCIPLES

4.1 Nothing in this Agreement shall affect:

4.1.1 (subject to any risk sharing arrangements agreed pursuant to this Agreement and the ACM Documentation), the liabilities of the Partners to each other or to any Third Parties for the exercise of their respective functions and obligations unless otherwise stated in this Agreement; or

4.1.2 any power or duty to recover charges for the provision of any services.

4.2 The Partners agree to:

4.2.1 treat each other with respect and an equality of esteem;

4.2.2 be open with information about the performance and financial status of each;

4.2.3 provide early information and notice about any relevant problems; and

4.2.4 be guided by the following principles in the operation of the Agreement:

(a) risk and opportunity sharing;

(b) best-for-the-whole-system consensus decision-making processes;

(c) a commitment to act in good faith;

(d) transparency between Partners;

(e) assuming joint responsibility for the achievement of outcomes; and

(f) encourage cooperative behaviour and culture that places Service Users' and clients' needs first, including a no fault, no blame and to resolve disputes where practically possible.

4.3 For the avoidance of doubt, the aims and objectives of the Test-Bed Period are set out in further detail in Clause 6 (Transformation Activity) below.

5 EXISTING AGREEMENTS AND CONTRACTS

5.1 The Partners acknowledge that:

5.1.1 they have entered into the Existing Agreements and Contracts and agree that such agreements shall continue in full force and effect until the expiry or earlier termination in accordance the terms of each individual agreement; and

5.1.2 such Existing Agreements and Contracts will be considered as part of the review of the existing arrangements that is carried out pursuant to Clause 6.2.2 of this Agreement and the Partners may ask the parties to the relevant Existing Agreements and Contracts to consider amendments to them (in accordance with their terms) as part of the service reconfiguration to enable the implementation of the Alliance Principles.

6 TRANSFORMATION ACTIVITY

6.1 Aims and Objectives

6.1.1 The purpose of the Alliance is to achieve a transformation in how the health and social care services are provided to Service Users, their carers and families in the population covered by:

(a) the ESBT Footprint; and

(b) as described in Schedule 4 (Scope).

("**Health and Social Care Services**").

6.1.2 The Partners recognise that in order to achieve the desired change in the provision of the Health and Social Care Services, the Partners will need to agree scope and scale required in order to move towards the ACM. The Partners will therefore undertake two phases of development of the ACM:

(a) the transformation activity during the Test-Bed period as described in this Agreement; and

(b) an options appraisal exercise under which the Partners will agree:

(i) the most appropriate vehicle to deliver Alliance Aims and Objectives following the Test-Bed Period; and

(ii) the strategy and implementation plans to put that vehicle in place, which the Partners will develop in cooperation with relevant key stakeholders as appropriate.

6.1.3 The overarching aims and objectives of the ACM to be operated by ESBT are to implement locally place-based approaches to the provision of care for the population covered by the ESBT Footprint, which:

(a) delivers integration between health and social care;

(b) encourages prevention, proactive care, self-care and self-management;

(c) implements wider population health and wellbeing;

(d) improves the quality and efficiency of health and social care;

(e) focuses on patient and service user needs;

(f) improves health and social inequalities;

(g) addresses the needs of an increasing population in particular the increasing over 65 population;

(h) delivers financial and service sustainability;

(i) designs and develops a model that integrates the health and social care system in the ESBT Footprint including the Health and Social Care Services (without limitation) such as primary prevention; primary and community care; social care; mental health; acute and specialist care so that the Partners can utilise the total quantum of their spend to meet the health and care needs of the population within the area covered by the ESBT Footprint in an efficient and effective manner,

in accordance with the key principles and outcomes set out in Schedule 1 (Principles and Characteristics of our New Model of Care).

6.1.4 The Partners acknowledge that the Agreement is being developed to provide the framework to operate as the Alliance and a shadow accountable care system during the Test-Bed Period by bringing together the following elements:

(a) an integrated Alliance governance structure;

(b) single system leadership with the ability to deploy resources against a common platform for delivery;

(c) an alignment of our budgets to test an accountable care operating model;

(d) a mechanism for opportunity and risk share;

(e) a potential to test appropriate levels of delegation;

(f) a shared approach to the management of conflicts of interest;

(g) arrangements for patient/citizen integration into the governance framework; and

(h) a framework for the arrangement itself, detailing which organisations are involved and in what capacity, and how it will relate to the other parts of the health and care system in the ESBT Footprint.

6.2 **Transformation Activities during the Test-Bed Period**

6.2.1 The Partners agree to work together in good faith to:

(a) establish the **governing structure** for the operational groups as referred to in Schedule 3 (Proposed Governance Structure) responsible for the operation of the whole system and consideration and design of new models of care;

(b) implement the **collective operational arrangements** to enable the ESBT Alliance to transform services and improve system delivery to the standards required in 2017/18;

(c) agree **risk sharing arrangements** under which risks and rewards associated with Health and Social Care Services are shared between the Partners;

(d) develop new ways of working to improve health and wellbeing and care of the Service Users including **developing new pathways of care** with improved outcomes and which make the most efficient use of resources whilst securing the needs of Service Users;

(e) continue to undertake research and development work including (without limitation) an options appraisal to recommend the preferred future model of care for ESBT that can be implemented to achieve the Alliance Aims and Objectives;

(f) as part of research and development review potential **payment and incentivisation model** for the future ACM,

as described in further detail in Schedule 2 (Transformation Activities).

6.2.2 During the term of this Agreement, the provision of Health and Social Care Services will be commissioned pursuant to the Existing Agreements and Contracts and any additional commissioning arrangements that the Partners enter into and the Partners recognise that:

(a) subject to the terms of the Existing Agreements and Contracts and the agreement by the relevant parties those agreements may evolve into the ACM as the Partners develop and agree the commercial principles and models of care as part of the Transformation Activities; and

(b) the Transformation Activities may develop and evolve during terms of this Agreement and the Partners will endeavour to agree the necessary variations and additions to this Agreement in accordance with Clause 28 (Variation), including, without limitation, the inclusion of new Schedules relating to the Alliance Aims and Objectives, payment mechanisms for the Health and Social Care Services and the risk/reward share model subject to Clause 9.2 (Risk Sharing Arrangements, Overspends and Underspends).

6.3 **Implementation of the Transformation Activities**

6.3.1 The Partners:

(a) shall work in good faith and cooperatively in order to enable the Partners to complete the Transformation Activities during the Test-Bed Period; and

(b) shall provide sufficient resource to develop and agree the outputs of the Transformation Activities and deal with any requests for information and/or respond to emerging proposals in a timely manner and within agreed timescales.

6.3.2 The Partners agree to work in cooperation with each other and use all reasonable endeavours to:

(a) establish the governing arrangements set out in Schedule 3 (Proposed Governance Structure) and agree the terms of reference relating to the governing structures referred to in those arrangements;

(b) act in accordance with the timetable which the Partners will agree as part of the Transformation Activities, the first milestone for which is making recommendations following the conclusion of the options appraisal referred to in Clause 6.2.1(e) by 31 July 2017, and following which the Partners will agree the strategy and timetable for implementation of the ACM thereafter;

(c) enter into all necessary legally binding documentation to implement the ACM when the Partners decide to proceed with the delivery mechanism agreed between the Partners and the relevant Providers, which will be implemented from 1 April 2018 or such other date as mutually agreed between the Partners (the **"ACM Documentation"**);

(d) agree appropriate governance arrangements for the implementation of the ACM, which will be set out in ACM Documentation; and

(e) adhere to the principles of engagement between different categories of Partners and potential new Partners as referred to in Clause 7.1.1 below.

7 **CATEGORIES OF MEMBERSHIP**

7.1 The Partners have identified the categories of membership of the Alliance and consequentially the Partners to this Agreement are divided into the following categories:

7.1.1 Full Alliance Member;

7.1.2 Associate Alliance Member; and

7.1.3 any other categories agreed between the Partners are described in Part 2 to Schedule 7 (Alliance Roles and Categories of Membership of the Alliance) to this Agreement.

7.2 As at the date of this Agreement, the Partners have agreed the following categorisation across the Partners:

Partner	Full Alliance Member	Associate Alliance Member
Eastbourne, Hailsham and Seaford CCG	✓	
Hastings and Rother CCG	✓	
East Sussex County Council	✓	
East Sussex Healthcare NHS Trust	✓	
Sussex Partnership NHS Foundation Trust		✓

7.3 The roles and responsibilities of the Full Alliance Members and Associate Alliance Members are as described in Part 2 to Schedule 7 (Alliance Roles and Categories of Membership of the Alliance) to this Agreement, which also sets out the obligation of the Partners to consider the inclusions of other organisations as part of the Alliance, which should be read in conjunction with the roles and responsibilities that apply to all categories of Partners as described in this Agreement including (without limitation) in Clauses 4 (General Principles), 6 (Transformation Activity) and Schedule 1 (Principles and Characteristics of our New Model of Care) to this Agreement.

7.4 The Partners have agreed the categorisation referred to in Clause 7.2 on the basis of the Partners' expectations of the output of the Transformation Activities. The Partners recognise that further details will emerge during the Test-Bed Period, as the Partners' develop and agree the Transformation Activities.

7.5 The Partners recognise that it is possible that the above categorisation of Alliance membership may need to change and that some of the Partners may wish/need to move from one category of Alliance membership to another. Should those circumstances arise, the Partner wishing/needing to move categories shall give as much notice as possible to the other Partners together with full reasons why a change of membership category is desired/required. The Partners commit to considering such requests and to act transparently and in good faith in such circumstances recognising the significant implications for the Alliance that may flow from such a decision.

7.6 Any additions to or removal from the list of Partners set out in Clause 7.2 above will be subject to the approval of the Full Alliance Members [acting unanimously] and in accordance with the Alliance Aims and Outcomes and the procedure set out in Clause 28 (Variations) in

the case of the inclusion of additional members and Clause 21 (Exclusion, Termination and Effects of Exclusion and Termination) in the case of the withdrawal of a Partner.

8 ESBT ALLIANCE GOVERNANCE STRUCTURE

8.1 The Partners have agreed to establish the governance structure referred to in Schedule 3 (Proposed Governance Structure) to this Agreement to deliver the Alliance Aims and Objectives and the Transformation Activities.

8.2 Pursuant to Clause 6.2.1(a), the Partners will work together in good faith to agree terms of reference and working protocols for each of the governing and operational groups referred to in Schedule 3 (Proposed Governance Structure) by 31 May 2017.

9 RISK SHARING ARRANGEMENTS, OVERSPENDS AND UNDERSPENDS

9.1 Pursuant to Clause 6.2.1(c), the Full Alliance Members will agree risk sharing arrangements between themselves in accordance with the overarching principles set out in Schedule 5 (Risk Sharing Arrangements). These arrangements will operate during the Test-Bed Period and upon the establishment of the ACM in accordance the Alliance Principles and Alliance and Aims and Objectives.

9.2 Subject to Clause 9.3, the Full Alliance Members may amend Schedule 5 (Risk Sharing Arrangements) as agreed in writing from time to time in accordance with Clause 28 (Variation).

9.3 The Partners acknowledge that the terms of Schedule 5 (Risk Sharing Arrangements) will not involve Associate Alliance Members and will relate to the Full Alliance Members only and accordingly the Associate Alliance Members will not be involved any decision making relating to Schedule 5 (Risk Sharing Arrangements) which shall include (without limitation) any variations agreed to that Schedule and other than if expressly invited to do so in writing by the Full Alliance Member.

9.4 For the avoidance of doubt, the terms of Schedule 5 (Risk Sharing Arrangements) will not amend or alter the arrangements in place under the Existing Agreements and Contracts during the Test-Bed Period.

10 JOINT STAFFING ARRANGMENTS

10.1 The Partners acknowledge that during the Test-Bed Period they will develop joint staffing arrangements for the Alliance.

10.2 These joint staffing arrangements may (without limitation) include the placing of staff at the disposal of one Partner by another Partner pursuant to Section 113 of the Local Government Act 1972 and the Partners shall enter into documentation which the Partners agree is required to implement any such joint staffing arrangements as referred to in Clause 10.3.

10.3 The Partners:

10.3.1 agree to enter into an agreement in accordance with the principles set out in Schedule 9 (Staffing Arrangements) to make staff available pursuant to Clause 10.2; and

10.3.2 acknowledge that the draft agreement set out in Schedule 9 (Staffing Arrangements) will be subject to amendment and agreement between the relevant Partners on the basis of the requirements of the Health and Social Care Service(s) to which it relates.

11 FINANCE, AUDIT AND RIGHT OF ACCESS BY AUDITORS

11.1 The Partners agree to act transparently and in accordance with open book principles in all financial dealings in connection with this Agreement.

11.2 The Partners shall comply with relevant finance and accounting obligations as required by relevant Law and/or National Guidance including without limitation any specific guidance relating to the CCGs and the Council such as CIPFA Code requirements.

11.3 All Partners:

11.3.1 shall promote a culture of probity and sound financial discipline and control; and

11.3.2 acknowledge that in accordance with the terms of the relevant Existing Agreements and Contracts, the relevant Partners shall arrange for the audit of the accounts of the relevant Pooled Funds and/or aligned funds, which shall require the appropriate person or body appointed to exercise the responsibility for certifying functions of the Account and Audit Regulations 2015 under section 32 of the Local Audit and Accountability Act 2014 for local authorities (or equivalent rules for other Partners) and the Code of Audit Practice issued by the National Audit Office on behalf of the Comptroller and Auditor General (https://www.nao.org.uk/code-audit-practice/wp-content/uploads/sites/29/2015/03/Final-Code-of-Audit-Practice.pdf) which applies to local authorities and NHS Foundation Trusts, as appropriate.

11.4 All internal and external auditors and all other persons authorised by the Partners will be given the right of access by them to any document, information or explanation they require from any employee, member, or board member of the relevant Partner in order to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises, equipment or electronic data used in connection with this Agreement. Access may be required on reasonable notice depending upon the nature of the request.

12 CAPITAL EXPENDITURE

12.1 Except where expressly provided otherwise in this Agreement, the Aligned Fund shall not normally be applied towards any one-off expenditure on goods and/or services, which will provide continuing benefit and would historically have been funded from the capital budgets of one of the Partners. If a need for capital expenditure is identified this must be agreed by the Partners.

12.2 The Partners agree that capital expenditure may be made from an Aligned Fund where this is in accordance with National Guidance.

12.3 Should the requirement for capital expenditure be identified, then a business case will be prepared, to include the identification of sources of capital funding, to be presented to the ESBT Alliance Executive for approval.

13 VAT

13.1 The Partners shall give due consideration and ensure that all relevant VAT guidance and regulations from HM Customs and Excise are adhered to.

14 ALIGNED FUNDS

Establishment/set up of Aligned Funds

14.1 The Aligned Fund constitutes resources contributed by the Alliance Commissioners. The Alliance Providers shall not be required to contribute to the Aligned Fund.

14.2 Subject to Clause 14.1, the Aligned Fund represents those resources identified by the Partners, through the integrated SIP process, to deliver the Health and Social Care Services. The Partners will work together in good faith to agree the total Aligned Fund for:

14.2.1 the period 1 April 2017 to 31 March 2018 by 30 April 2017 and this information will be set out in Schedule 4 (Scope); and

14.2.2 subsequent Financial Years during the Test-Bed Period on an annual basis through the ESBT Alliance Governing Board, by no later than one Month prior to the start of the relevant Financial Year.

14.3 The Financial Contributions, which make up the Aligned Funds will remain within the accounts of each Alliance Commissioner. Notwithstanding Clause 4.1 (General Principles), the Partners acknowledge that this Agreement does not affect the statutory or financial regime of each Partner.

14.4 During the Test-Bed Period, the Partners will consider whether additional or overarching agreement(s) pursuant to Sections 256 and/or 75 of the 2006 Act are required to support any agreed transfer of funds between the Partners (and where appropriate with Third Parties) to deliver the SIP and the Partners will work together in good faith to agree the terms of any such agreements if required.

14.5 The Partners acknowledge the operation of the Existing Agreements and Contracts and such arrangements including (without limitation) pre-existing agreements pursuant to Sections 75, 256 and 257 of the 2006 Act will continue in accordance with their terms and may form a sub-part of the overall Aligned Fund.

14.6 The financial reporting regime for the Aligned Funds will be established within the governance structure as set out in Schedule 3 (Proposed Governance Structure) to bring together the financial resources of the Partners.

14.7 The Alliance Commissioner will be responsible for ensuring the financial and administrative support necessary to enable the effective and efficient management of the Aligned Fund, meeting all required accounting and auditing obligations in accordance with arrangements agreed between the Partners during the Test-Bed Period.

During Financial Year 2017/18

14.8 The Alliance Commissioner are responsible for the financial management and monitoring of their overall financial resources, including those within the Aligned Fund.

14.9 The Alliance Commissioner will ensure that financial monitoring information will be available within 3 weeks of the end of the previous Month-end to enable an Aligned Fund budget monitoring statement to be prepared and circulated within 4 weeks of the end of the reporting Month.

14.10 The Partners acknowledge that:

14.10.1 they will need to consider how to realign resources and budgets within the financial accounts of their own organisations to meet the requirements of the day to day management of resources to deliver Health and Social Care Services and changing demand for those services;

14.10.2 the intention of this Agreement is not to prevent such local management decision-making as referred to in Clause 14.9.1 above; and

14.10.3 the Partners will need report significant and material budget realignment within their own accounts, if they impact on the deliverability of the integrated SIP and the Health and Social Care Services.

14.11 The provision of financial monitoring information on a Monthly basis in accordance with Clause 14.8 will enable the Partners to track changes to the plan agreed between the Partners for the Aligned Fund in accordance with Clause 14.1.

14.12 The Partners:

14.12.1 are not intending on realign budgets between themselves during the Test Bed-Period; and

14.12.2 will address specific funding adjustments in relation to the Health and Social Care Services as part of the year end reconciliation process within the terms of any Existing Agreements and Contracts.

14.13 Except where expressly provided otherwise in this Agreement, no provision of this Agreement shall preclude the Alliance Commissioner from making additional contributions of non-recurrent or recurrent financial resources to the Aligned Fund from time to time by mutual agreement and as included within the integrated SIP.

Overspends in Aligned Funds

14.14 Where within Aligned Funds any Partner forecasts an Overspend in relation to its part of the Aligned Fund that Partner shall as soon as reasonably practicable inform the other Partners and the ESBT Alliance Governing Board

14.15 The following process shall apply to address Overspends:

14.15.1 in the first instance, individual Alliance Commissioner will, themselves, make every effort to resolve the reasons for the Overspend and/or provide mitigation for that Overspend; and

14.15.2 if the ability to resolve or mitigate the Overspend position is beyond the ability of an Alliance Commissioner, then the Overspend should be reported to the ESBT Alliance Executive, where the approach to resolve or mitigate the Overspend will be agreed and recommended to the ESBT Alliance Governing Board.

14.16 **Underspends in Aligned Funds**

14.16.1 In the event that the aggregate net expenditure for the Aligned Fund in 2017/18 is less than the aggregate net value of the Aligned Fund for 2017/18, the ESBT Alliance Executive shall agree how the monies shall be spent, carried forward and/or returned to the Alliance Commissioner. Such arrangements shall be subject to the Law and the Standing Orders and Standing Financial Instructions (or equivalent) of the Alliance Commissioner.

14.16.2 The aggregate net expenditure for subsequent Financial Years during the Test-Bed Period shall be agreed by the Partners as part of the process referred to in Clause 14.1.2.

15 INFORMATION SHARING EXERCISE

15.1 The Partners recognise that as part of future options development, it may be necessary to conduct a due diligence exercise during the Test-Bed Period. Should this be required as part of the options recommended in 31 July 2017 as referred to in Clause 6.3.2(b) above, the Partners will undertake an Information Sharing Exercise as part of subsequent implementation plans. The scope and term of the exercise shall be agreed by the Partners in accordance with the recommended option and informed by the ISAP and individual organisational assurance processes as appropriate, which include (without limitation) allowing their respective employees, advisers and representatives full access to information, documentation such records, key employees, advisers and operations as are reasonably required for the purpose of implementing the recommended option.

15.2 All enquiries and responses relating to the Information Sharing Exercise shall be directed through the following contacts:

Jessica Britton, Chief Operating Officer	EHS and HR CCGs
Kevin Foster, Chief Operating Officer	Council
Lynette Wells, Director of Corporate Affairs	ESHT
Samantha Allen, Chief Executive	SPFT

15.3 The Partners will:

15.3.1 work together in good faith to agree the terms of and enter into a data sharing agreement by 31 July 2017 and in so doing will ensure that the operation of this Agreement complies comply with Law, in particular the 1998 Act; and

15.3.2 such agreement referred in Clause 15.3.1 shall be in accordance with the approach outlined in the draft agreement at Schedule 10 (Data Sharing Agreement).

16 **IMPLEMENTATION OF THE FUTURE ALLIANCE ACCOUNTABLE CARE MODEL FOLLOWING THE TEST-BED PERIOD**

16.1 Following the development of the ACM under the terms of this Agreement, the completion of the ACM Documentation is conditional upon the following:

16.1.1 the ESBT Accountable Care Development Group recommending to the Partners its preferred option for the form and structure of the ACM;

16.1.2 agreement being reached as to the joint delivery or other partnering model to be used, including, but not limited to the administrative, finance, governance, and operational details being agreed between the Partners as appropriate;

16.1.3 the option for the future model selected for implementation continuing to be tested as part of the ISAP exercise, organisational assurance processes and appropriate procurement routes;

16.1.4 no legislation or regulation being proposed or passed that would prohibit or materially restrict the participation in the ACM, or implementation of the ACM Documentation by any of the Partners;

16.1.5 appropriate approval of the ACM and ACM Documentation by the Partners, and the obtaining of any other necessary consents and approvals, such as (without limitation) from system regulators as appropriate through the NHS ISAP;

16.1.6 any Third Party, regulatory or tax consents required for ACM Documentation being received in terms satisfactory to all of the Partners;

16.1.7 the completion of any procurement exercise to secure the involvement of any Providers as may be required for the ACM; and

16.1.8 the Partners agree (without limitation):

(a) mutually acceptable risk sharing arrangements, which will be set out in the ACM Documentation;

(b) Financial Contributions of the Partners to the ACM;

(c) each Partner shall not be responsible for the management of or incur any liability for financial deficits incurred by another Partner prior to the implementation of the ACM Documentation.

17 STANDARDS OF CONDUCT AND SERVICE

17.1 The Partners, which (for the avoidance of doubt) includes the Alliance Providers, will at all times comply with Law and ensure good corporate governance in respect of Existing Agreements and Contracts and this Agreement (including each Partner's respective Standing Orders and Standing Financial Instructions).

17.2 The Council is subject to the duty of Best Value under the Local Government Act 1999. This Agreement and the operation of the Aligned Fund is therefore subject to the Council's obligations for Best Value and the other Partners will co-operate with all reasonable requests from the Council which the Council considers necessary in order to fulfil its Best Value obligations.

17.3 The Council is subject to statutory duties relating to public health services as set out in the 2006 Act, as established by the 2012 Act, which confers duties on the Council to improve public health through a range of mandated and non-mandated functions (the "**Public Health Duties**"). To support the Council in its discharge of these Public Health Duties, it receives a ring-fenced public health grant pursuant to the 2003 Act which has conditions attached to its use and as at the Commencement Date such grant is ring-fenced until 1 April 2019. The Partners acknowledge that this Agreement including (without limitation) the operation of the Aligned Fund is, therefore, subject to ensuring compliance with the Council's Public Health Duties and the conditions of the grant referred to in this Clause.

17.4 The CCGs are subject to the CCG Statutory Duties and these incorporate a duty of clinical governance, which is a framework through which they are accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This Agreement and the operation of the Aligned Funds are therefore subject to ensuring compliance with the CCG Statutory Duties and clinical governance obligations.

17.5 SPFT is subject to licence conditions imposed by NHS Improvement (and previously by Monitor) (the "**Licence Conditions**"). This Agreement and its operation is therefore subject to ensuring SPFT's compliance with the Licence Conditions.

17.6 The Partners, including the Providers, are committed to an approach to equality and diversity as represented in their respective policies. The Partners will maintain and develop these policies as applied to service provision, with the aim of developing a joint strategy for all elements of the service.

18 CONFLICTS OF INTEREST

18.1 During the term of this Agreement, the Partners will develop and operate a conflicts of interest policy that will apply to the Alliance on the basis of the current policies implemented by both CCGs, which the Partners acknowledge accord with relevant guidance.

18.2 During the period of development of such policy, the Partners shall:

18.2.1 comply with their respective conflicts for identifying and managing conflicts of interest;

18.2.2 in event that it identifies a potential conflict of interest in relation to this Agreement, record the action take pursuant to its conflicts of interest policy and report this to the ESBT Governing Board; and

18.2.3 provide all reasonable cooperation and assistance to the other Partners and the ESBT Governing Board in relation to a conflict of interest arising from this Agreement.

19 LIABILITIES AND INSURANCE AND INDEMNITY

19.1 Subject to Clause 19.2, and 19.3, if a Partner ("**First Partner**") incurs a Loss arising out of or in connection with this Agreement as a consequence of any act or omission of another Partner ("**Other Partner**") which constitutes negligence, fraud or a breach of contract in relation to this Agreement then the Other Partner shall be liable to the First Partner for that Loss and shall indemnify the First Partner accordingly.

19.2 Clause 19.1 shall only apply to the extent that the acts or omissions of the Other Partner contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Partner acting in accordance with the instructions or requests of the First Partner or the ESBT Alliance Governing Board.

19.3 If any Third Party makes a claim or intimates an intention to make a claim against any Partner, which may reasonably be considered as likely to give rise to liability under this Clause 19, the Partner that may claim against the other indemnifying Partner will:

19.3.1 as soon as reasonably practicable give written notice of that matter to the Other Partner specifying in reasonable detail the nature of the relevant claim;

19.3.2 not make any admission of liability, agreement or compromise in relation to the relevant claim without the prior written consent of the Other Partner (such consent not to be unreasonably conditioned, withheld or delayed);

19.3.3 give the Other Partner and its professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts, documents and records within its power or control so as to enable the indemnifying Partner and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant claim.

19.4 Each Partner shall ensure that they maintain policies of insurance (or equivalent arrangements through schemes operated by the National Health Service Litigation Authority) in respect of all potential liabilities arising from this Agreement and in the event of Losses shall seek to recover such Loss through the relevant policy of insurance (or equivalent arrangement)

19.5 Each Partner shall at all times take all reasonable steps to minimise and mitigate any loss for which one party is entitled to bring a claim against the other pursuant to this Agreement.

19.6 Without prejudice to Clause 4.1.1 (General Principles), each Partner shall retain its respective functions and obligations as required by relevant Law for insurance, liability for their respective employees and the conduct of their organisation. For the avoidance of doubt, this Agreement shall not affect the liabilities of the Partners to each other for any claims of professional malpractice brought against one or more Partners pursuant to the Alliance Agreement.

Conduct of Claims

19.7 In respect of the indemnities given in this Clause 19:

19.7.1 the indemnified Partner shall give written notice to the indemnifying Partner as soon as is practicable of the details of any claim or proceedings brought or threatened against it in respect of which a claim will or may be made under the relevant indemnity;

19.7.2 the indemnifying Partner shall at its own expense have the exclusive right to defend conduct and/or settle all claims and proceedings to the extent that such claims or proceedings may be covered by the relevant indemnity provided that where there is an impact upon the indemnified Partner, the indemnifying Partner shall consult with the indemnified Partner about the conduct and/or settlement of such claims and proceedings and shall at all times keep the indemnified Partner informed of all material matters; and

19.7.3 the indemnifying and indemnified Partners shall each give to the other all such cooperation as may reasonably be required in connection with any threatened or actual claim or proceedings which are or may be covered by a relevant indemnity.

20 COMPLAINTS

20.1 During the term of the Agreement, the Partners will further develop the way in which they jointly respond to complaints and establish a joint protocol to agree a lead respondent where the complaint is of a joint nature (a "**Joint Complaints Protocol**").

20.2 The Joints Complaints Protocol will be in place alongside each Partner's statutory complaints policies and protocols. The application of the Joint Complaints Protocol will be without prejudice to a complainant's right to use any of the Partners' statutory complaints procedures where applicable.

21 WITHDRAWAL EXCLUSION, TERMINATION AND EFFECTS OF EXCLUSION AND TERMINATION

Withdrawal or Exclusion of a Partner

21.1 A Partner may serve not less than 6 Months' notice in writing to withdraw from the Agreement provided that such termination is possible in accordance with the Law and National Guidance and that the Partners shall agree an orderly exit plan in accordance with Clause 21.9.1.

21.2 Under the circumstances where an Associate Alliance Member does not agree to the scope of the ACM, which the relevant Partners agree as part of the Transformation Activities during the Test-Bed Period, to such an extent that it wishes to withdraw from these arrangements prior to the ACM Documentation being developed in accordance with the terms of this Agreement, that Associate Alliance Member may serve not less than 3 Months' notice in writing to withdraw from the Agreement and where the Partners, acting in good faith, mutually agree that an exit plan is required, the Partners shall agree an orderly exit plan in accordance with Clause 21.9.1.

21.3 Without prejudice to any other right or remedy they may possess, the ESBT Alliance Governing Board may serve an Exclusion Notice on a Partner at any time if:

21.3.1 any Partner substantially or materially ceases to operate, is dissolved, or is de-authorised as an NHS trust or NHS foundation trust;

21.3.2 any Partner is formally designated clinically and/or financially unsustainable as a result of any clinical or financial intervention or sanction by the regulator responsible or it enters into special administration, and those circumstances have a material adverse effect on the Transformation Activities. For the avoidance of doubt, prior to the issue of any such Exclusion Notice by the ESBT Governing Board, the relevant circumstances will be subject to discussion by the Partners acting jointly through the ESBT Alliance Governing Board or other appropriate

body that is part of Alliance's governing structure as set out in Schedule 3 (Proposed Governance Structure); or

21.3.3 any Partner commits a material breach of this Agreement which,

(a) where capable of remedy, is not remedied in accordance with the reasonable action and within the reasonable timescale specified in the Default Notice jointly issued by the Partners acting through the ESBT Alliance Governing Board; or

(b) is not capable of remedy.

21.4 Subject to the provisions of Clauses 21.1, where a Partner is excluded from the Alliance and where, as a consequence of such exclusion or termination, this causes the other Partners Loss then, subject to Clause 19 (Liabilities, Insurance and Indemnity) and the remaining Partners making reasonable efforts to mitigate their Losses, the excluded Partner shall indemnify the remaining Partners as the case may be, in respect of such Losses to the extent that they are incurred in dealing with the exclusion and considering and implementing alternative arrangements for the continuation of the Alliance during the Test-Bed Period.

21.5 Any amounts due in respect of such Losses referred to in Clause 21.4 shall be due and payable when actually incurred by the respective Partner.

Termination upon and costs of legal or regulatory challenge

21.6 If, in relation to the activities of the Alliance, a procurement law, competition law or judicial review claim, action or investigation is brought or instigated by a Third Party then:

21.6.1 the costs and expenses of dealing with/defending such claim, action or investigation shall be borne by each of the Partners to the extent that is proportionate to the level of each Partner's respective involvement and each Partner will bear a share of the costs and expenses incurred to the extent that it has knowingly or recklessly or our conduct has materially contributed to the acts or omissions complained of or being investigated; and

21.6.2 where such claim, action or investigation materially impacts upon a Partner's ability to meets its statutory duties or other contractual commitments, then the affected Partner may terminate its involvement in the Alliance upon the service of 3 Months' notice in writing to the ESBT Alliance Executive. In taking this course of action, the affected Partner shall, where practicable, consult with the ESBT Alliance Executive to consider whether and how the effects of the challenge or investigation might be addressed or mitigated.

Termination upon change in central or local government policies before completion of the Transformation Activities

21.7 If any central government or local government change in policy materially impacts upon an the ability of a Partner to participate in the Alliance in accordance with the terms of this Agreement, then the affected Partner may terminate its involvement in the Alliance upon the service of 3 Months' notice in writing to the ESBT Alliance Governing Board. In taking this course of action, the affected Partner shall, where practicable, consult with the ESBT Alliance Governing Board to consider whether and how the effects of the policy change might be addressed or mitigated

Termination upon failure to complete the Transformation Activities

21.8 This Agreement may be terminated by the Alliance Governing Board in accordance with the provisions of Schedule 8 (Termination Arrangements).

Effects of Termination and Survivorship

21.9 Upon the withdrawal or exclusion of one or more Partner from the Alliance or the termination or expiry of this Agreement for any reason whatsoever the following shall apply:

21.9.1 the Partners agree that they will work together and co-operate to ensure that the orderly winding down and disaggregation of the integrated and joint activities to the separate responsibilities of the Partners is carried out smoothly and with as little disruption as possible to the Service Users, employees, the Partners and Third Parties, so as to minimise costs and liabilities of each Partner in doing so, and agree such arrangements under the terms of an exit plan to be mutually agreed between the Partners;

21.9.2 termination of this Agreement shall have no effect on the liability of any rights or remedies of any Partner already accrued, prior to the date upon which such termination or expiry takes effect; and

21.9.3 those provisions of this Agreement which are expressly or by implication intended to come into or remain in force and effect following such withdrawal or exclusion of a Partner from the Alliance or termination or expiry of this Agreement, will so continue and continue to apply to a Partner that has withdrawn or been excluded from the Alliance, subject to any limitation of time expressed in this Agreement.

22 DISPUTE RESOLUTION

22.1 In the event of a dispute between the Partners arising out of this Agreement, any Partner may serve written notice of the dispute on the other Partners, setting out full details of the dispute.

22.2 All of the Authorised Officers shall meet in good faith as soon as possible and in any event within seven (7) days of notice of the dispute being served pursuant to Clause 22.1, at a meeting convened for the purpose of resolving the dispute.

22.3 If the dispute remains after the meeting detailed in Clause 22.2 has taken place, Becky Shaw (Chief Executive) on behalf of the Council, Dr Adrian Bull (Chief Executive) on behalf of ESHT, Samantha Allen (Chief Executive) on behalf of SPFT, Amanda Philpott (Chief Officer) on behalf of the CCGs or their nominees shall meet in good faith as soon as possible after the relevant meeting and in any event with fourteen (14) days of the date of the meeting, for the purpose of resolving the dispute.

22.4 If the dispute remains after the meeting detailed in Clause 22.3 has taken place, then the Partners will attempt to settle such dispute by mediation in accordance with the CEDR Model Mediation Procedure or any other model mediation procedure as agreed by the Partners. To initiate a mediation, any Partner may give notice in writing (a **"Mediation Notice"**) to the others requesting mediation of the dispute and shall send a copy thereof to CEDR or an equivalent mediation organisation as agreed by the Partners asking them to nominate a mediator. The mediation shall commence within twenty (20) Working Days of the Mediation Notice being served. No Partner will terminate such mediation until each of them has made its opening presentation and the mediator has met each of them separately for at least one (1) hour. Thereafter, the Model Mediation Procedure will apply (or any other model mediation procedure agreed by the Partners). The Partners will co-operate with any person appointed as mediator, providing him/her with such information and other assistance as s/he shall require and will pay his costs as he shall determine or in the absence of such determination such costs will be shared equally.

22.5 Nothing in the procedure set out in this Clause 22 shall in any way affect any Partners' right to terminate this Agreement in accordance with any of its terms or take immediate legal action.

23 FORCE MAJEURE

23.1 No Partner shall be entitled to bring a claim for a breach of obligations under this Agreement by the Affected Partner or incur any liability to the Affected Partner for any Losses incurred by that Affected Partner to the extent that a Force Majeure Event occurs and it is prevented from carrying out its obligations by that Force Majeure Event.

23.2 On the occurrence of a Force Majeure Event, the Affected Partner shall notify the other Partners as soon as practicable. Such notification shall include details of the Force Majeure Event, including evidence of its effect on the obligations of the Affected Partner and any action proposed to mitigate its effect.

23.3 As soon as practicable, following notification as detailed in Clause 23.2, the Partners shall consult with each other in good faith and use all reasonable endeavours to agree appropriate terms to mitigate the effects of the Force Majeure Event and, subject to Clause 23.4, facilitate the continued performance of the Agreement.

23.4 If the Force Majeure Event continues for a period of more than sixty (60) days, one or more of the other Partners shall have the right to terminate the Agreement by giving fourteen (14) days written notice of termination to the Affected Partner. For the avoidance of doubt, no compensation shall be payable by any Partner as a direct consequence of this Agreement being terminated in accordance with this Clause.

24 CONFIDENTIALITY

24.1 In respect of any Confidential Information a Partner receives from another Partner (the "**Discloser**") and subject always to the remainder of this Clause 24, the Law and in accordance with the Data Sharing Agreement, each Partner (the "**Recipient**") undertakes to keep secret and strictly confidential and shall not disclose any such Confidential Information to any Third Party, without the Discloser's prior written consent provided that:

24.1.1 the Recipient shall not be prevented from using any general knowledge, experience or skills which were in its possession prior to the Commencement Date; and

24.1.2 the provisions of this Clause 24 shall not apply to any Confidential Information which:

(a) is in or enters the public domain other than by breach of the Agreement or other act or omission of the Recipient; or

(b) is obtained by a Third Party who is lawfully authorised to disclose such information.

24.2 Nothing in this Clause 24 shall prevent the Recipient from disclosing Confidential Information where it is required to do so in fulfilment of statutory obligations or by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable Law.

24.3 Each Partner:

24.3.1 may only disclose Confidential Information to its employees and professional advisors to the extent strictly necessary for such employees to carry out their duties under the Agreement;

24.3.2 will ensure that, where Confidential Information is disclosed in accordance with Clause 24.3.1, the Recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 24; and

24.3.3 shall not use Confidential Information other than strictly for the performance of its obligations under this Agreement.

25 **FREEDOM OF INFORMATION AND ENVIRONMENTAL INFORMATION REGULATIONS**

25.1 The Partners agree that they will each cooperate with each other to enable any Partner receiving a request for information under the 2000 Act or the 2004 Regulations to respond to a request promptly and within the statutory timescales. This cooperation shall include but not be limited to finding, retrieving and supplying information held, directing requests to other Partners as appropriate and responding to any requests by the Partner receiving a request for comments or other assistance.

25.2 Any and all agreements between the Partners as to confidentiality shall be subject to their duties under the 2000 Act and 2004 Regulations. No Partner shall be in breach of Clause 25 if it makes disclosures of information in accordance with the 2000 Act and/or 2004 Regulations.

26 **OMBUDSMEN**

The Partners will co-operate with any investigation undertaken by the Parliamentary and Health Service Commissioner for England or the Local Government Commissioner for England (or both of them) in connection with this Agreement.

27 **NOTICES**

27.1 Any notice to be given under this Agreement shall either be delivered personally or sent by first class post or electronic mail. The address for service of each Partner shall be as set out in Clause 27.3 or such other address as each Partner may previously have notified to the other Partner in writing. A notice shall be deemed to have been served if:

27.1.1 personally delivered, at the time of delivery;

27.1.2 posted, at the expiration of forty eight (48) hours after the envelope containing the same was delivered into the custody of the postal authorities; and

27.1.3 if sent by electronic mail, at the time of transmission and a telephone call must be made to the recipient warning the recipient that an electronic mail message has been sent to him (as evidenced by a contemporaneous note of the Partner sending the notice) and a hard copy of such notice is also sent by first class recorded delivery post on the same day as that on which the electronic mail is sent.

27.2 In proving such service, it shall be sufficient to prove that personal delivery was made, or that the envelope containing such notice was properly addressed and delivered into the custody of the postal authority as prepaid first class, or that the electronic mail was properly addressed and no message was received informing the sender that it had not been received by the recipient (as the case may be).

27.3 The address for service of notices as referred to in Clause 27.1 shall be as follows unless otherwise notified to the other Partner in writing:

27.3.1 if to the Council, addressed to Philip Baker, Assistant Chief Executive, East Sussex County Council, County Hall, St Anne's Crescent, Lewes, East Sussex BN7 1UE

Tel: 01273 481564

E.Mail: Philip.Baker@eastsussex.gov.uk;

27.3.2 if to the HR CCG, addressed to addressed to Jessica Britton, Chief Operating Officer NHS Hastings and Rother CCG Bexhill Hospital, Holliers Hill, Bexhill-on-Sea TN40 2DZ

Tel: 01273 403686/0788055826

E.Mail: jessica.britton@nhs.net;

27.3.3 if to the EHS CCG, addressed to Jessica Britton, Chief Operating Officer, NHS Eastbourne, Hailsham and Seaford CCG 36-38 Friars' Walk, Lewes BN7 2PB

Tel: 01273 403686/0788055826

E.Mail: jessica.britton@nhs.net;

27.3.4 if to the ESHT, addressed to Dr Adrian Bull, Chief Executive, East Sussex Healthcare NHS Trust, St. Anne's House , 729 The Ridge, St. Leonards-on-Sea, East Sussex TN37 7PT

Tel: 01323 435653

E.Mail: adrianbull@nhs.net; and

27.3.5 if to the SPFT, addressed to Samantha Allan, Chief Executive, Trust HQ, Swandean, Arundel Road, Worthing, West Sussex BN13 3EP

Tel: 0300 304 0673
E.Mail: Samantha.Allen1@sussexpartnership.nhs.uk.

28 **VARIATION**

28.1 Except where expressly provided otherwise in this Agreement including (without limitation) Clause 9.2 (Risk Sharing Arrangements, Overspends and Underspends), variations to this Agreement will not be valid unless they are made in accordance with Schedule 6 (Change Control Procedure) and for the avoidance of doubt, no variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each of the Partners.

29 **CHANGE IN LAW**

29.1 The Partners shall ascertain, observe, perform and comply with all relevant Laws, and shall do and execute or cause to be done and executed all acts required to be done under or by virtue of any Laws.

29.2 On the occurrence of any Change in Law, the Partners shall agree in good faith any amendment required to this Agreement as a result of the Change in Law subject to the Partners using all reasonable endeavours to mitigate the adverse effects of such Change in Law and taking all reasonable steps to minimise any increase in costs arising from such Change in Law.

29.3 In the event of failure by the Partners to agree the relevant amendments to the Agreement (as appropriate), the Clause 22 (Dispute Resolution) shall apply.

30 **WAIVER**

No failure or delay by any Partner to exercise any right, power or remedy will operate as a waiver of it nor will any partial exercise preclude any further exercise of the same or of some other right to remedy.

31 **SEVERANCE**

If any provision of this Agreement, not being of a fundamental nature, shall be held to be illegal or unenforceable, the enforceability of the remainder of this Agreement shall not thereby be affected.

32 ASSIGNMENT AND SUB CONTRACTING

The Partners shall not sub contract, assign or transfer the whole or any part of this Agreement, without the prior written consent of the other Partners, which shall not be unreasonably withheld or delayed. This shall not apply to any assignment to a statutory successor of all or part of a Partner's statutory functions.

33 EXCLUSION OF PARTNERSHIP AND AGENCY

33.1 Nothing in this Agreement shall create or be deemed to create a partnership under the Partnership Act 1890 or the Limited Partnership Act 1907, a joint venture or the relationship of employer and employee between the Partners or render any Partner directly liable to any Third Party for the debts, liabilities or obligations of the other unless expressly provided for in Clause 19.

33.2 Except as expressly provided otherwise in this Agreement or where the context or any statutory provision otherwise necessarily requires, no Partner will have authority to, or hold itself out as having authority to:

33.2.1 act as an agent of the other;

33.2.2 make any representations or give any warranties to third parties on behalf of or in respect of the other; or

33.2.3 bind the other in any way.

34 THIRD PARTY RIGHTS

Unless the right of enforcement is expressly provided, no Third Party shall have the right to pursue any right under this Contract pursuant to the Contracts (Rights of Third Parties) Act 1999 or otherwise.

35 ENTIRE AGREEMENT

35.1 The terms herein contained together with the contents of the Schedules constitute the complete agreement between the Partners with respect to the subject matter hereof and supersede all previous communications representations understandings and agreement and any representation promise or condition not incorporated herein shall not be binding on any Partner.

35.2 No agreement or understanding varying or extending or pursuant to any of the terms or provisions hereof shall be binding upon any Partner unless in writing and signed by a duly Authorised Officer or representative of the Partners.

36 COUNTERPARTS

This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

37 GOVERNING LAW AND JURISDICTION

37.1 This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the laws of England and Wales.

37.2 Subject to Clause 22 (Dispute Resolution), the Partners irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may arises out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

IN WITNESS WHEREOF this Agreement has been executed by the Partners on the date of this Agreement[1]

THE CORPORATE SEAL of **THE EAST SUSSEX COUNTY COUNCIL** was hereunto affixed in the presence of:)

Signed for on behalf of **NHS HASTINGS AND ROTHER CLINICAL COMMISSIONING GROUP**

_____

Authorised Signatory

Signed for on behalf of **NHS EASTBOURNE, HAILSHAM AND SEAFORD CLINICAL COMMISSIONING GROUP**

_____

Authorised Signatory

[1] Partners to confirm execution blocks

Signed for on behalf of **EAST SUSSEX HEALTHCARE NHS TRUST**

_____

Authorised Signatory

Signed for on behalf of **SUSSEX PARTNERSHIP NHS FOUNDATION TRUST**

_____

Authorised Signatory

SCHEDULE 1 – PRINCIPLES AND CHARACTERISTICS OF OUR NEW MODEL OF CARE

1. Our evidence-driven, place-based model will firmly embed the first principle of a prevention-led approach across ESBT as our 'place' that contributes to the Sussex and East Surrey Sustainable Transformation Plan (STP). The model will have a strong emphasis on population health promotion, prevention, early intervention and self-care and self-management to reduce demand for services and allow care to be delivered increasingly out of hospital and at the lowest level of effective care.
2. All health and social care services should be in scope – primary, local acute DGH, community, mental health, social care and public health services for children and adults. Those that are ruled out will be by exception.
3. 'Whole person' care needs to be supported by a whole population approach rather than segmenting or subdividing the population by conditions or age, and thus although delivery will normally be based around localities with populations of circa 50,000, accessing health and care should support individual choice and be consistently simple for people regardless of where they access it.
4. The model will have a positive impact and deliver outcomes that are important to local people – both health outcomes and experiential outcomes. This includes involving local people in designing, commissioning and delivering outcomes, as well as communicating about them.
5. The outcomes based contract and capitated budget will be sufficiently large to achieve the economies of scale needed to close the total funding gap, and establish an ongoing in-year budget balance.
6. There will be a focus on reducing the costs of commissioning and transacting the business, as well as avoiding the pathway fragmentation that undermines integration and adds in transaction costs through operating parallel models. We will seek to achieve our aims through collaboration in the way that we procure new models.
7. There will be a strong culture of whole system working on the ground that actively empowers staff to be able to 'do the right thing', putting patients' and clients' and carers' needs first within a single health and social are system covering primary, community, local DGH, mental health, social care, public health services, and independent and voluntary services where appropriate.
8. Our model will align incentives in order to inspire and attract health and social care professionals and offer maximum levels of clinical and staff engagement and leadership, embed system-wide organisational development.
9. The organisational form in the ESBT area will require collective leadership and have governance and operational mechanisms that enable learning and development to take place in stages to share and manage risks between commissioners and providers. This will lead to delivery of full Accountable Care models, as per the ambitions of the FYFV, i.e. the fullest possible levels of integration and maximum ability to achieve the long term vision and benefit of a sustainable and affordable health and social care system.

SCHEDULE 2 – TRANSFORMATION ACTIVITIES

1 As described in Clause 6 (Transformation Activity) of this Agreement the Partners have identified a number of transformation activities for development and agreement during the Test-Bed Period, which are set out in further detail below:

1.1 develop and implement a collective integrated operational, financial and performance management platform to enable the Alliance to transform services and improve system delivery to the standards required following the Test-Bed Period;

1.2 design and agree a whole system pilot outcomes framework and performance incentivisation scheme, based on the outcomes that matter to local people, that aligns outcomes across the system and gives an indication of the performance of the system as a whole;

1.3 operate and test a locality based operational model that is based on 'one budget, one system' and is rooted in communities, and develop integrated care pathways to reduce variation and increase standardisation in line with evidence-based best practice to deliver the Alliance Aims and Objectives, and ensure optimum cost effectiveness through delivery of integrated locality based services at the lowest level of effective care;

1.4 in keeping with the key principles and characteristics of our local ESBT accountable care model, build on the SIP, and pooled and aligned funding model to test and design a whole population capitated budget, constructed around localities and a whole life cycle approach,

1.5 develop and agree an appropriate risk and reward sharing model, and test it in shadow form during the Test-Bed Period between the Full Alliance Members to inform future contracting arrangements;

1.6 further develop our IT digital and back office systems and approach to estates to support the delivery of integrated care, and the active participation of patients, clients and local citizens in decisions about their care and support, self-care and self-management;

1.7 continue to work with the emerging local GP federations and the Local Medical Committee to develop a menu of options for the structural relationship of General Practice with the Alliance during the Test-Bed Period and with the future ACM;

1.8 agree the design criteria for our future ACM after the Test-Bed Period, and use these criteria to identify and appraise the options for structural form (including the organisational form and contracting arrangements for the model);

1.9 agree the roadmap and implementation plan for the recommended option by July 2017, and enact implementation plans and due diligence processes as appropriate after July 2017;

1.10 develop an approach to engagement with key stakeholders on the above, including consultation as appropriate and working with system regulators such as NHSE, NHSI, DoH and the CQC, to seek appropriate permissions and using the NHS Integrated Support and Assurance Process ("**ISAP**");

1.11 develop a proposal for the residual strategic commissioning functions (population needs assessment, outcomes setting and oversight of performance) for the Alliance Commissioners;

1.12 develop a 'whole system' organisational development approach in order to underpin transformation and support staff through the transformation to 'one budget, one system', and empower them to become leaders of change and innovation that puts local people at the heart of services;

1.13 design an integrated governance model for the Test-Bed Period and future ACM that integrates citizens into the leadership of the new care model of care and engages them appropriately at all levels of the governance structure; and

1.14 deliver any other activities as agreed by the Alliance Partners during the Test-Bed Period.

SCHEDULE 3 – PROPOSED GOVERNANCE STRUCTURE

EAST SUSSEX BETTER TOGETHER (ESBT) ALLIANCE ARRANGEMENTS FOR THE TEST-BED YEAR 2017/18

DRAFT ESBT ALLIANCE GOVERNANCE OVERVIEW

1 CONTEXT

1.1 The ESBT Alliance Agreement brings together Eastbourne, Hailsham and Seaford CCG, Hastings and Rother CCG, East Sussex County Council, East Sussex Healthcare NHS Trust, and Sussex Partnership Foundation NHS Trust, to undertake whole system transformation activities collaboratively in 2017/18, as the test-bed year for our Accountable Care model.

1.2 The arrangements for the 2017/18 test-bed year must support us to collectively act in a way that delivers improvements for our local populations. We also need to create a learning environment to develop our final proposed ESBT Alliance system of accountable care. In doing this we need to ensure our key principles and characteristics of our local model of care are reflected in all that we do:

	Key principles and characteristics of a local Accountable Care model
1	Our evidence-driven, place-based model will firmly embed the first principle of a prevention-led approach across ESBT as our 'place' that contributes to the Sussex and East Surrey Sustainable Transformation Plan (STP). The model will have a strong emphasis on population health promotion, prevention, early intervention and self-care and self-management to reduce demand for services and allow care to be delivered increasingly out of hospital and at the lowest level of effective care.
2	All health and social care services should be in scope – primary, local acute DGH, community, mental health, social care and public health services for children and adults. Those that are ruled out will be by exception.
3	'Whole person' care needs to be supported by a whole population approach rather than segmenting or subdividing the population by conditions or age, and thus although delivery will normally be based around localities with populations of circa 50,000, accessing health and care should support individual choice and be consistently simple for people regardless of where they access it.

4	The model will have a positive impact and deliver outcomes that are important to local people – both health outcomes and experiential outcomes. This includes involving local people in designing, commissioning and delivering outcomes, as well as communicating about them.
5	The outcomes based contract and capitated budget will be sufficiently large to achieve the economies of scale needed to close the total funding gap, and establish an ongoing in-year budget balance.
6	There will be a focus on reducing the costs of commissioning and transacting the business, as well as avoiding the pathway fragmentation that undermines integration and adds in transaction costs through operating parallel models. We will seek to achieve our aims through collaboration in the way that we procure new models.
7	There will be a strong culture of whole system working on the ground that actively empowers staff to be able to 'do the right thing', putting patients' and clients' and carers' needs first within a single health and social are system covering primary, community, local DGH, mental health, social care, public health services, and independent and voluntary services where appropriate.
8	Our model will align incentives in order to inspire and attract health and social care professionals and offer maximum levels of clinical and staff engagement and leadership, embed system-wide organisational development.
9	The organisational form in the ESBT area will require collective leadership and have governance and operational mechanisms that enable learning and development to take place in stages to share and manage risks between commissioners and providers. This will lead to delivery of full Accountable Care models, as per the ambitions of the FYFV, i.e. the fullest possible levels of integration and maximum ability to achieve the long term vision and benefit of a sustainable and affordable health and social care system.

1.3 The Draft ESBT Alliance Governance structure for the test-bed year is illustrated at the end of this document.

1.4 It includes the following:

- An **ESBT Strategic Commissioning Board** – allowing the Commissioner members of the ESBT Alliance to jointly discharge responsibilities for addressing population health need and for commissioning health and social care through oversight of the 2017/18 Strategic Investment Plan, and any other responsibilities agreed by the statutory commissioning bodies (to be determined). In order to fulfil this role the likely representatives will be Lay and GP member representatives from EHS CCG and HR CCG Governing Bodies, elected members from East Sussex County Council, with the Chief Officer of the CCGs, Director of Adult Social Care and Health, Director of Children's Services, Director of Public Health and Directors of Finance attending in an advisory capacity.

- An **ESBT Alliance Governing Board** – the Chief Officers, Board Directors and Governing Body Members responsible for directing and leading the ESBT Alliance and operating the Alliance Agreement, on behalf of the signatories to the Agreement. Reporting to the ESBT Strategic Commissioning Board (EHS and HR CCGs and ESCC), the ESHT Board and the SPFT Board, the Governing Board will take responsibility for developing and agreeing the delivery of the Strategic Investment Plan (SIP), and the operation of the ESBT Alliance Agreement, holding the ESBT Alliance Executive (below) to account for delivery of agreed plans, management of risk and any changes to proposed service arrangements, performance and resource allocations. The Governing Board will also lead the development of proposals for the full ESBT alliance accountable care model.

- An **ESBT Alliance Executive** – an integrated senior management team with responsibility for whole system service delivery and service transformation activities. This includes delivery of agreed plans within the SIP, proposals for service developments or budget changes which need executive authorisation, and managing operational delivery of all

specified health and care services as well as escalation of risk as required to the ESBT Alliance Governing Board. As we learn more in the test-bed year, in time we may develop appropriate thresholds to allow the Alliance Executive to make some decisions about resource allocation without sanction by the Governing Board where this makes sense to enable smooth operation of the governance structure.

- An **ESBT Clinical Leadership Forum -** to provide authoritative clinical advice to the ESBT Strategic Commissioning Board, ESBT Alliance Governing Board and ESBT Alliance Executive and clinical leadership to the design and implementation of new models of care and ways of working. The CLF comprises a body of experts from our locally employed medical workforce who will act as the primary resource for care pathway, service specific and medical workforce advice to the ESBT Alliance. It is intended that the membership will expand to include wider representation of the clinical and care workforce.

- An **ESBT Accountable Care Development Group (task and finish group)** – to explore the structural options for our future ESBT Alliance accountable care model and make recommendations for the most appropriate vehicle to deliver high quality, effective care for the population covered by the ESBT footprint after the 2017/18 test-bed year. This will include considering contracting and organisational arrangements and relationships with General Practice and other providers across the health and care system. The Group will also develop proposals for future governance and accountability, citizen governance, and the residual strategic commissioning function (agreeing the outcomes and ensuring monitoring, oversight and accountability for the delivery of the outcomes).

2 CITIZEN LEADERSHIP AND GOVERNANCE

2.1 We are establishing a mechanism for enabling citizen leadership in the governance structure during the test-bed year so that insight, contribution and influence on ESBT Alliance issues are transparent and meaningful. Proposals for a Citizen Council or Board for the test-bed year are in development and representation from this can be sought as representation to the relevant aspects of the structure. We want to develop this throughout the test-bed year, in partnership with local people so we can test and learn what works best. In the interim, we will ensure draft proposals in March 2017 and interim representation agreed for April 2017.

3 PRIMARY CARE REPRESENTATION

3.1 Primary care will be represented within the governance structure from both the perspective of being a clinical commissioner as well as primary care as a provider.

4 MEMBERSHIP CATEGORIES OF THE ALLIANCE ARRANGEMENT

4.1 To move these arrangements forward in 2017/18, the following initial categories of membership are proposed in the Alliance arrangement.

Full Alliance Member

- Plays an active role in the plans for system transformation and place-based systems of health and care in accordance with the ESBT programme aims and objectives, and the contribution this makes to the Sussex and East Surrey Sustainable Transformation Plan and the NHS Five Year Forward View;
- Is entitled to attend and vote at meetings of the ESBT Alliance Governing Board (NB with all members reserving the right to refer to their sovereign organisations as appropriate, in line with relevant levels of delegation);
- Is entitled to attend and contribute to meetings of the ESBT Alliance Executive;
- Subject to what is agreed as part of the test-bed year transformation activities, shares the risks and opportunities for the delivery of the in-scope services and agreed outcomes; and
- Commits to the principles of transparency and open book accounting where possible.

Associate Alliance Member

- May be invited to attend and contribute to meetings of the ESBT Alliance Governing Board but not to vote at such meetings;
- Shall be invited to attend and contribute to the ESBT Alliance Executive and all other meetings in the supporting governance structure;
- Depending on test-bed year activity could have some of its services payments related to the achievement of agreed outcomes;
- Will not be a part of financial and risk sharing arrangements.

4.2 It is acknowledged that primary care will play an integral role in the delivery of ESBT whole system objectives and this is reflected in the proposed governance arrangements, and the developing relationship with emerging GP Federations.

4.3 A further category of 'Affiliate' membership will also be explored for individual organisations who share Alliance objectives, and who play a significant role in contributing to outcomes in our Place. There are other service provider organisations that the ESBT Alliance will continue to work with and who will have an important role to play in the design and delivery of the services aimed at better achieving the agreed outcomes, including population health and wellbeing outcomes. For example, this could include; SECAmb; GP Out of Hours providers; other NHS Trusts and CCGs; independent care and voluntary organisations; District and Borough Councils; housing providers; and the Police and Fire Services.

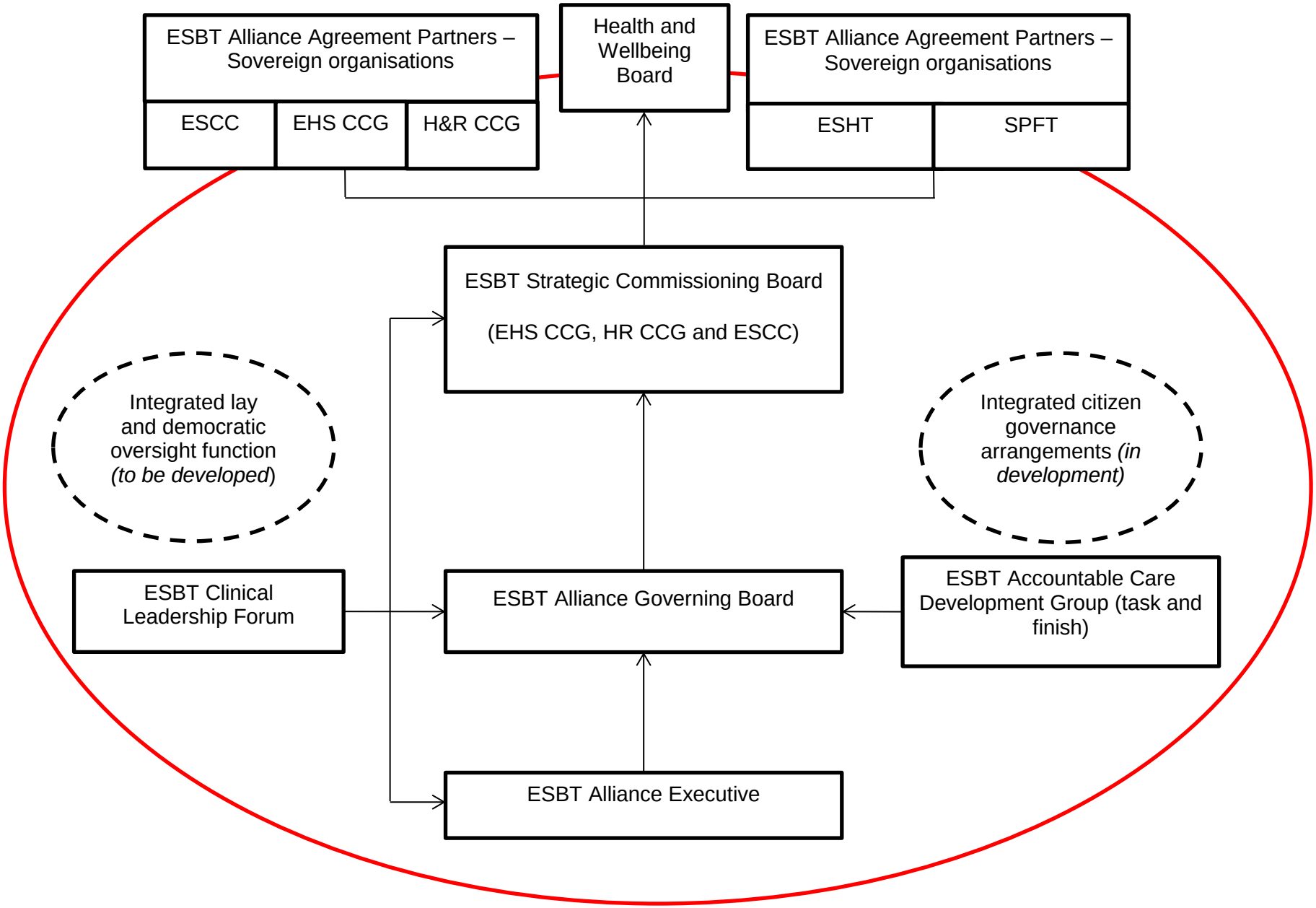
4.4 The proposed initial parties to the Agreement as Full Members are:

- Eastbourne Hailsham Seaford CCG (EHS CCG)
- Hastings and Rother CCG (HR CCG)
- East Sussex County Council (ESCC)
- East Sussex Healthcare NHS Trust (ESHT)

4.5 Sussex Partnership Foundation NHS Trust (SPFT) will be an Associate Alliance Member.

4.6 More detail will emerge during the transitional year as the model is further developed and provisions will also be made within the Agreement to allow for potential new members to join the Alliance and movement from one category of membership to another, especially if the Alliance arrangement is extended beyond the test-bed year.

DRAFT ESBT ALLIANCE GOVERNANCE STRUCTURE



SCHEDULE 4 - SCOPE

1 In keeping with the key principles and characteristics for our local ESBT accountable care model set out in Schedule 1 (Principles and Characteristics of our New Model of Care), all health and social care services should be in scope so that we can make best use of the spend in the region of c.£1billion that we use each year to meet the health and care needs of the people of East Sussex including; primary; local acute DGH; community; mental health, and; social care and public health services for children and adults, and those that are ruled out will be by exception. During the Test-Bed Period we aim to develop our understanding of how a whole-population capitated budget constructed around local communities within the ESBT Footprint will work in practice.

2 To enable a whole systems approach to planning and delivery of health and social care across the ESBT area in the Test-Bed Period, a single Strategic Investment Plan (SIP) has been developed to ensure an integrated approach to our investment decisions to achieve our strategic aims and objectives. The SIP is a five year plan that articulates how we plan to invest in services to achieve our ESBT strategic aims, underpinned by our 6+2 box framework. It outlines how we will collectively invest our c.£1billion to meet local need and shift the balance of service provision from reactive hospital based care to proactive primary and community care. It has been agreed for 2017/18 as set out in the summary below.

3 The scope of the Aligned Funds covers services commissioned and provided by Eastbourne Hailsham and Seaford CCG, Hastings and Rother CCG, the Council and ESHT and the total value of our collective resource as an ESBT Alliance is c.£1billion. This includes services that are directly provided by the Alliance Partners and those that are contracted out to Third Parties to deliver through existing arrangements. As part of the Test-Bed Period activities our aim is to model a single financial reporting process for the Alliance across the quantum total of spend. This recognises that individual Partners to the Alliance will retain responsibility for commissioning or providing services in line with their individual statutory roles.

4 General practice is a key partner to all our work and is integral to local provision of health and care but is not a part of this formal Alliance Agreement. Contracts for general medical services continue to be managed by the CCGs as part of delegated commissioning responsibilities.

5 SPFT is an Associate Member of the ESBT Alliance and as such will not be a contributory partner to the financial and risk sharing arrangements set out in the Aligned Fund.

6 2017/18 STRATEGIC INVESTMENT PLAN (AS AT 7/04/17; FIGURES SUBJECT TO CHANGE)

ESBT Strategic Investment Plan 2017/18	EHS CCG & HR CCG	ESCC	ESBT Total
	£'000	£'000	£'000
Available Resources	697,129	165,020	862,149
Forecast Expenditure pre-Service Redesign	730,059	165,936	895,995
Net Deficit / (Surplus) pre-Service Redesign	**32,930**	**916**	**33,846**
Service Redesign Savings			
Healthy Living & Wellbeing/Maintaining Independence	(2,556)	(422)	(2,978)
Proactive Care/Crisis intervention and Admission Avoidance	(24,558)	-	(24,558)
Bedded Care	(1,435)	-	(1,435)
Discharge to Assess	(3,220)	-	(3,220)
Prescribing	(5,314)	-	(5,314)
Planned Care	(7,567)	-	(7,567)
Primary Care	(500)	-	(500)
Learning Disability	-	(160)	(160)
Enablers	(1,000)	-	(1,000)
Total Service Redesign Savings	**(46,150)**	**(582)**	**(46,732)**
Service Redesign Investments			
Healthy Living & Wellbeing/Maintaining Independence	5,000	658	5,658
Proactive Care/Crisis intervention and Admission Avoidance	10,427	183	10,610
Discharge to Assess	936	2,167	3,103
Mental Health	216	-	216
Prescribing	732	-	732
Planned Care	264	-	264
Total Service Redesign Investments	**17,575**	**3,008**	**20,583**
Mitigations			
Application of Better Care Fund to meet Service Redesign Investments	(7,697)	-	(7,697)
Total Mitigations	**(7,697)**	-	**(7,697)**
Net Deficit including Service Redesign	**(3,342)**	**3,342**	**0**
Health Investment in Social Care			
Health Investment required to protect ASC Activity Levels	916	(916)	-
Health Investment in Social Care Service Redesigns	3,008	(3,008)	-
Direct Social Care Savings	(582)	582	-
Net Health Investment in Social Care	**3,342**	**(3,342)**	**0**

SCHEDULE 5- RISK SHARING ARRANGEMENTS

1 RISK SHARING

1.1 The Partners have agreed the following principles for risk sharing:

1.1.1 **Principle 1:** risk sharing arrangements will reflect the Alliance Principles and Alliance Aims and Objectives and the joint finance arrangements set out in Clauses 11 (Finance, Audit and Right of Access) and 14 (Aligned Funds) of this Agreement and shall be between Full Alliance Members only. Associate Alliance Members shall not participate in the risk sharing arrangements;

1.1.2 **Principle 2:** risk sharing arrangements will occur when the risks and benefits are agreed to be the collective responsibility of the Partners:

(a) risk and reward sharing should only apply to costs that are material in the context of system-wide risks i.e. it should only apply where it makes sense – for example, where as an Alliance we can mitigate risk or deliver benefits/reward.

1.1.3 **Principle 3**: risk sharing arrangements need to be aligned with those Partners who are able to influence specific risks or benefits:

(a) each of the Partners has an obligation to attempt to mitigate risks and leverage benefits, irrespective of risk/reward share arrangements. However, where a collective responsibility is identified the sharing of risk and reward will only apply to those of the Partners whose actions directly impact on the desired result or change required.

1.1.4 **Principle 4:** there will be no removal of individual organisations accountability and, during the Test-Bed Period, there will be no amendment to contractual agreement between Partners with individual organisational agreement, and appropriate consent from local and national regulators:

(a) risk sharing will not dilute accountability of individual Partners for their own risk mitigations and delivery decisions.

1.1.5 **Principle 5:** all risk and reward share decisions must be reviewed from the perspective of the population covered by the ESBT Footprint:

(a) the ultimate test for risk and reward share decisions must be what is right for the population covered by the ESBT Footprint;

1.1.6 **Principle 6:** risk sharing arrangements must be designed to consider both short and longer term implications:

(a) the risk sharing model must allow flexibility (and allow for future adaption) to strike a balance between short term actions and working towards opportunities identified to develop future transformation benefits;

1.1.7 **Principle 7:** The Partners will collectively agree which risks and rewards will be included in the sharing mechanism;

1.1.8 **Principle 8:** There will be an option to suspend the risk/reward share under ‘exceptional’ circumstances:

(a) the definition of ‘exceptional’ will be agreed between the Partners, but the intention is for this to be restricted to truly extreme scenarios e.g. flu pandemic;

1.1.9 **Principle 9**: All of these risk/reward share principles must be delivered together:

(a) All nine principles must be applied concurrently and consistently.

1.2 We have agreed the following timetable for the development of risk and reward options and a period of 'shadow running' of the risk and reward model:

(a) Quarter 1 2017-18 – the ESBT Finance Group will develop risk and reward options for consideration by the ESBT Alliance Governing Board, and a decision will be taken on the most appropriate model to apply;

(b) Quarter 2 2017-18 – the risk and reward model will be trialled within the Alliance;

(c) Quarter 3 2017-18 – formal risk and reward options will be reflected in draft contractual agreements for 2018-19 by amendment.

SCHEDULE 6 - CHANGE CONTROL PROCEDURE

1 GENERAL PRINCIPLES

1.1 Where any Partner sees a need to amend this Agreement, that Partner may at any time request, and the other Partners may at any time recommend, such change only in accordance with the Change Control Procedure set out in paragraph 2 of this Schedule 6.

1.2 Until such time as a change is made in accordance with the Change Control Procedure, the Partners shall, unless otherwise agreed in writing, continue to perform this Agreement in compliance with its terms before such change.

1.3 Any discussions which may take place between the Partners in connection with a request or recommendation before the authorisation of a resultant change shall be without prejudice to the rights of either party.

1.4 Any work undertaken by any Partner which has not been authorised in advance by a change, and which has not been otherwise agreed in accordance with the provisions of this Schedule 6, shall be undertaken entirely at the expense and liability of that Partner(s).

2 PROCEDURE

2.1 Discussion between the Partners concerning a change shall result in any one of the following:

2.1.1 no further action being taken; or

2.1.2 a recommendation to change this Agreement by all the Partners.

2.2 Where a written request for an amendment is received from a Partner, that Partner shall, unless otherwise agreed, submit copies of a change control note within three weeks of the date of the request.

2.3 Each change control note shall contain:

2.3.1 the title of the change;

2.3.2 the originator and date of the request or recommendation for the change;

2.3.3 the reason for the change;

2.3.4 full details of the change, including any specifications;

2.3.5 the price, if any, of the change;

2.3.6 a timetable for implementation, together with any proposals for acceptance of the change;

2.3.7 a schedule of payments if appropriate;

2.3.8 details of the likely impact, if any, of the change on other aspects of this Agreement including:

(a) the timetable for the provision of the change;

(b) the personnel to be provided;

(c) the charges;

(d) the documentation to be provided;

(e) working arrangements;

(f) other contractual issues;

2.3.9 the date of expiry of validity of the change control note; and

2.3.10 provision for signature by the other Partners.

2.4 A change control note signed by all the Partners shall constitute an amendment to this Agreement.

SCHEDULE 7 – ALLIANCE ROLES AND CATEGORIES OF MEMBERSHIP OF THE ALLIANCE

Part 1: Summary of Alliance Commissioner and Alliance Provider roles within the Alliance

1 **CONTEXT**

1.1 This Agreement has been developed to provide the framework to operate as an Alliance during the Test-Bed Period, by bringing together the following elements:

1.1.1 aligning our budgets to test an ACM operating model;

1.1.2 enabling the Alliance finalise what the structure of ACM, which will be implemented following the Test-Bed Period; and

1.1.3 setting the framework for the arrangement itself, which organisations are involved and how it will relate to the other parts of the health and care system.

1.2 The Agreement is drafted on the basis that Alliance Commissioners and Alliance Providers will come together as equal partners to lead and manage the whole health and social care economy within the ESBT Footprint, and develop and deliver Health and Social Care Services in the common interest of the population we serve.

1.3 Within this, it is recognised that the Alliance Commissioners have statutory responsibilities to identify health and social care needs and articulate outcomes for the population in the ESBT Footprint. In that capacity, they will have a role as commissioners of the arrangements described in the Agreement. Equally, they will be members of the Alliance and will share collective responsibilities for the achievement of the Alliance objectives and outcomes as set out in the Agreement. Therefore, within the commitment to work together as an Alliance there will be some circumstances in which the commissioning organisations will have different roles, rights and obligations within the Alliance (reflecting their commissioning function) and the paragraphs below seek to describe this.

1.4 In addition it is acknowledged that a key objective is to secure greater levels of integration of the strategic commissioning function over time, and whilst the full detail and model for this will need to be developed it is our intention to establish an integrated ESBT Strategic Commissioning Board for the Test-Bed Period. This will bring together the Council's elected member representatives with representatives from the two CCG Governing Bodies to jointly undertake statutory accountabilities for population needs planning during in Test-Bed Period.

1.5 All of the Partners will:

1.5.1 provide leadership of the whole system;

1.5.2 deliver the integration of health and social care;

1.5.3 collectively deliver all system ambitions and national standards;

1.5.4 create an environment that encourages collaboration through engaging with all key stakeholders, including all providers of health and social care and local people, in a coordinated and integrated way;

1.5.5 act in good faith in the best interests of local people;

1.5.6 develop new models of care and associated outcomes;

1.5.7 through high performance, unlock and enhance value for the population covered by the ESBT Footprint;

1.5.8 deliver and monitor agreed outcomes;

1.5.9 implement system reporting mechanisms that demonstrate progress against objectives;

1.5.10 publish performance data; and

1.5.11 take responsibility for and managing the risks in delivering the services;

1.6 The Alliance Commissioners will:

1.6.1 engage and involve local people to enable insight, influence and active participation;

1.6.2 identify the health and social care needs and priorities of the population covered by the ESBT Footprint;

1.6.3 set the outcomes and the contractual framework within which they will be delivered;

1.6.4 provide assurance to all stakeholders on the delivery of agreed outcomes;

1.6.5 maintain strong strategic partnerships with other public services such as housing and education to ensure the conditions for success; and

1.6.6 during the financial year 2017/2018 seek to put in place contractual arrangements with other Third Party providers to align incentives and outcomes, as informed by the ESBT Alliance Executive and subject to relevant authorisations and approvals of the Alliance Commissioners.

1.7 The Alliance Providers will:

1.7.1 engage and involve local people to enable insight, influence and active participation;

1.7.2 work with Alliance Commissioners to develop and deliver high quality, cost effective services to deliver the Alliance Aims and Objectives as set out in the Agreement:

1.7.3 provide a healthy and safe working environment;

1.7.4 adhere to standards relevant to the services and outcomes as determined by the Alliance, agreed by the ESBT Alliance Governing Board and signed off by the ESBT Integrated Strategic Commissioning Board;

1.7.5 provide assurance on progress against programme objectives;

1.7.6 promote and develop a co-operative and high performing culture, and a way of working:

(a) that promotes and drives integration, co-operation, innovation and continuous improvement;

(b) where information is shared appropriately; and

(c) where communication is honest and respectful; and is founded on ethical and responsible behaviour and decision-making, without losing sight of corporate and individual and accountability.

Part 2: Categories of ESBT Alliance membership: Full Alliance Members and Associate Alliance Members

1.1 The Partners agree that a Full Alliance Member shall (without limitation to the roles and responsibilities of the Partners (either as Alliance Commissioners, Alliance Providers and/or Partners generally as set out in the main body and Schedules to this Agreement):

1.1.1 play an active role in the plans for system transformation and place-based systems of health and care in accordance with the ESBT programme aims and objectives, the Sussex and East Surrey Sustainable Transformation Plan and the NHS Five Year Forward View;

1.1.2 is entitled to attend and vote at meetings of the ESBT Alliance Governing Board (and the Partners acknowledge that all such Partners and their representatives shall act within the decision making processes of their respective organisations and relevant delegated powers);

1.1.3 is entitled to attend and contribute to meetings of the ESBT Alliance Executive;

1.1.4 subject to what is agreed as part of the Transformation Activities, shares the risks and opportunities for the delivery of the in-scope services and agreed outcomes; and

1.1.5 commits to the principles of transparency and open book accounting where possible.

1.2 The Partners agree that an Associate Alliance Member shall (without limitation to the roles and responsibilities of the Partners (either as Alliance Commissioners, Alliance Providers and/or Partners generally as set out in the main body and Schedules to this Agreement):

1.2.1 shall be invited to attend and contribute to all meetings of the ESBT Alliance Governing Board but not to vote at such meetings;

1.2.2 shall be invited to attend and contribute to the ESBT Alliance Executive and all other meetings in the supporting governance structure;

1.2.3 depending on activity during the Test-Bed Period activity and subject always to its rights and obligations under the Existing Agreements and Contracts could have some of its services payments related to the achievement of agreed outcomes;

1.2.4 will not be a part of financial and risk sharing arrangements as referred to in Clause 9 (Risk Sharing Arrangements, Overspends and Underspends);

1.2.5 will not be required to contribute to the Aligned Fund in accordance with Clause 14 (Aligned Funds).

1.3 The Partners may consider the inclusion of an additional category of membership of the Alliance, a 'Affiliate Alliance Member', which the Partners will consider with those Third Parties that share the Alliance Principles.

1.4 The model of categorisation described in this Part 2 to this Schedule and consequently which membership category that individual Partners (and possibly in time others) choose, reflects the Partner's expectations about the alignment of financial and risk sharing arrangements needed to achieve our objectives in the Test-Bed Period. It recognises and seeks to cater for the vital importance of mental health, which is provided by SPFT over a significantly larger area than the ESBT Footprint and the critical role of primary care which needs to be involved from both a commissioner and provider perspective in the governance arrangements and supporting structure.

1.5 The Partners acknowledge that primary care will play an integral role in the delivery of ESBT whole system objectives, and this is already reflected in the ESBT five year strategic investment plan which has signalled additional investment to transform primary care and general practice services in line with ESBT objectives.

1.6 The Partners agree to fully engage with general practice on how they would best be able to interface with the Alliance in accordance with the process agreed between the Partners for doing so as appropriate. A menu of options for this is in development, and the role of emerging GP Federations and the Local Medical Committee will be significant in enabling a collective approach to this, where appropriate.

1.7 The Partners acknowledge that there are other service provider organisations that the Alliance will continue to work with and who will have an important role to play in the design and delivery of Health and Social Care Services aimed at better achieving the agreed outcomes. For example, current contracts with Third Parties such as general practices and emerging GP Federations; SECAmb; out of hours providers; other NHS Trusts and Clinical Commissioning Groups; independent care and voluntary organisations; District and Borough Councils; housing providers; and the Police and Fire Services. The Partners anticipate that in keeping with the existing principles of ESBT partnership working, the Partners may invite these providers to attend relevant meetings of the supporting governance structure and/or any other groups tasked with service redesign, including relevant meetings of the ESBT Alliance Governing Board when proposals are discussed.

1.8 The Partners acknowledge that they may agree to other organisations joining the Alliance during the period of this Agreement and that the Partners may agree different categories of membership such as 'affiliate members', the roles and responsibilities of such members will be agreed between the Partners in writing and the Partners acknowledge may include (without limitation) by way of example individual voluntary and community sector organisations) that express an interest to work collaboratively alongside the Alliance.

SCHEDULE 8 – TERMINATION ARRANGEMENTS

1 During the Test-Bed Period, the Alliance Governing Board will ensure that any activity undertaken through the governance structure of Alliance (as described in Schedule 3 (Proposed Governance Structure) is appropriate to the terms of the Agreement and can be accounted for, in order that they can be appropriately withdrawn from in advance of the Agreement concluding if necessary, subject to the effects of termination of the Agreement as referred to in Clause 21 (Exclusion, Termination and Effects of Exclusion and Termination) of the Agreement.

Failure to complete the Transformation Activities

2 We recognise that, despite commitments in this Schedule 8, it may not be possible to complete the Transformation Activities before 30 April 2018. If we are unable to complete the Transformation Activities and agree the necessary contract variations by 30 April 2018 then the outstanding matters shall be escalated to the Alliance Governing Board who shall, in accordance with Schedule 2 (Transformation Activities), determine whether to:

2.1 resolve the outstanding matters by agreement between the Full Alliance Members;

2.2 where it appears possible that the matters might be resolved with more time, allow more time for the ESBT Alliance Executive and ESBT Accountable Care Development Group to continue its work on the development and implementation of the Transformation Activities but any extension of time shall not extend time beyond 31 March 2020;

2.3 reconfigure the membership of the Alliance such that it may continue beyond the first phase in accordance with the Alliance Principles and so as to achieve the Alliance Aims and Objectives; or

2.4 resolve to dissolve the Alliance and terminate this Agreement upon reasonable notice.

3 In considering the outstanding matters and making its determination under Paragraph 2 above, the Full Alliance Members shall consider the level of progress made by the Alliance during the first phase and shall strive to find a resolution that accords with the Alliance Principles and which are designed to achieve the Alliance Aims and Objectives. The Full Alliance Members shall comply with the Alliance Principles when considering and making its determination.

3.1 Under the circumstances where the Alliance is unable to complete the Transformation Activities and agree the necessary contract variations by 31 March 2020 at the latest, Alliance Governance Board shall dissolve the Alliance and terminate this Agreement in accordance with Clause 21.7 (Termination upon failure to complete the Transformation Activities).

SCHEDULE 9- STAFFING ARRANGEMENTS

Draft Agreement for Placing Staff at the Disposal of any of the Partners

Background

A. Local authorities and health bodies have powers to place staff at the disposal of other local authorities and health bodies, under Section 113 Local Government Act 1972.

B. Each Partner will retain responsibility for employees employed by them. This means that for many employees the current terms of employment, policies and procedures adopted by their Employing Organisation will continue to apply, even though they will work as part of a shared team with staff of other Partners.

C. For operational purposes management and accountability will flow down from the head of any joint unit. Disciplinary, grievance and other employment policies will, however, remain an Employing Organisation responsibility.

D. Nothing in this Agreement will affect an employee's ongoing continuity of service; pension conditions or entitlements.

1 **DEFINITIONS AND INTERPRETATION**

1.1 The defined terms used in this Agreement shall have the same meaning as those set out in the Alliance Agreement unless the context otherwise requires or as set out below:

Alliance Agreement means the agreement relating to the East Sussex Better Together Programme for the integration of Health and Social Care Services entered into between East Sussex County Council; NHS Hastings and Rother Clinical Commissioning Group; NHS Eastbourne, Hailsham and Seaford Clinical Commissioning Group; East Sussex Healthcare NHS Trust; and Sussex Partnership NHS Foundation Trust to take effect from 1 April 2017;

Employment Agreement means the terms of employment between the Employing Organisation and an Employee, as amended from time to time;

Employing Organisation means the Partner that employs and pays the employee at the Commencement of this Agreement (or subsequent employer if that changes or new staff are appointed);

Management Issues includes all those matters under the Employment Agreement requiring action, investigation and/or decisions by the Employing Organisation, including appraisals and performance issues, pay reviews and the award of other payments and benefits under the Employment Agreement, periods of annual, sick or other leave, absence of Employees for any other reason, any complaint about the Employees (whether or not that would be dealt with under the Employing Organisation's disciplinary procedure) and any complaint or grievance raised by the Employees (whether or not that would be dealt with under the Employing Organisation's grievance procedure);

Services means, in relation to Employees, the services to be performed at such times as are reasonable and necessary by the Employees as agreed between the Employing Organisation and the receiving Partner from time to time; and

Test-Bed Period has the meaning given to this term in the Alliance Agreement.

1.2 Clauses 1.2 to 1.10 of the Alliance Agreement shall apply to the interpretation of this Agreement.

2 **PROVISION OF THE SERVICES**

2.1 The Employing Organisation shall permit the release of such Employees to the relevant Partner as may be necessary to provide the Services for or on behalf of the receiving Partner in accordance

with the terms of the agreement reached between the Partners for the provision of the relevant individual Service.

2.2 The receiving Partner acknowledges and agrees that:

2.2.1 Employees will be reasonably consulted, and discussion will take place about any proposed changes to their working arrangements to meet the objectives of the Alliance during the Test-Bed Period;

2.2.2 the Employing Organisation is under no obligation to supply any particular Employee;

2.2.3 the Employing Organisation shall use its reasonable endeavours to arrange that the Employee shall provide the Services;

2.2.4 the identity of the Employees may be subject to change during the Agreement Period; and

2.2.5 in supplying any Employee, the Employing Organisation gives no assurance regarding the competence or ability of such Employee to undertake the Services.

3 EMPLOYEES' EMPLOYMENT

3.1 The Employment Agreements shall remain in force during the term of this Agreement.

3.2 The receiving Partner shall not, and shall not require Employees to do anything which shall or may, breach the relevant Employment Agreements and shall have no authority to vary the terms of the relevant Employment Agreements or make any representations to the Employees in relation to the terms of such Employment Agreements.

3.3 The receiving Partner shall provide the Employing Organisation with such information and assistance as the Employing Organisation may reasonably require to carry out its obligations towards the Employees.

4 PLACE OF WORK

4.1 There are a number of bases for operation of the Alliance arrangement within the partnership boundaries. Staff will usually be based within the boundary of ESBT, however, will be expected to travel to/work from other offices within East Sussex as required.

5 EMPLOYING ORGANISATION'S OBLIGATIONS

5.1 The Employing Organisation agrees, during the term of this Agreement, to provide the services of agreed employees to the other Partner(s) in accordance with the requirements of each individual service and the terms and conditions set out in this Schedule. Staff shall be consulted and discussion will take place with their Employing Organisation about any proposed changes to their working arrangements and prior to them being placed at the disposal of one or more of the other Partners to meet the objectives of the Alliance during the Test-Bed Period.

5.2 There may be a need to negotiate changes to an individual's work location, working pattern, duties and responsibilities and/or changes to working hours. Such changes will be negotiated through the usual joint negotiating machinery adopted by the Employing Organisation.

5.3 The following obligations will remain with the Employing Organisation:

5.3.1 payment of the Employees' salaries and any allowances, providing any benefits due to the Employees or their dependants, any payments to third parties in relation to the Employees and making any deductions which it is required to make from the Employees' salaries and any other payments which may be due to the Employees;

5.3.2 remuneration, expenses (including reasonable mileage, travel and subsistence claims and other expenses wholly, exclusively and necessarily incurred by the Employing Organisation in connection with the exercise of the Services, and where appropriate, in accordance with the receiving Partner's expenses rates which apply to the work undertaken, provided always that such expenses are evidenced in such manner as the Employing Organisation may specify from time to time), and other terms and conditions, unless otherwise agreed. The receiving Partner shall provide information required by the Employing Organisation to evidence such expenses;

5.3.3 Management Issues; and

5.3.4 disciplinary action including dismissal.

5.4 The relevant Head of Service/Manager must ensure that all employees are provided with induction on the Partners' workplace systems, procedures and operations, including absence reporting and recording, training, Health and Safety issues and general information.

5.5 Training and development, appraisal and performance management arrangements will be the responsibility of the Head of Service/Manager and will be in line with the requirements of the Employing Organisation.

5.6 Team briefing, management communication and supervision arrangements will be the responsibility of the Head of Service/Manager.

5.7 The Partners continue to face significant change and in the event of significant organisational change the Partners will jointly agree a change management procedure in line with the employment policies of the Partners.

5.8 The Partners may act jointly in relation to any investigation, grievance, disciplinary, capability or performance issue, raising a concern at work, equality, dignity, bullying, harassment or other claim or action under any of the Employing Organisation's policies or procedures, but any resulting process or action will be undertaken by the Employing Organisation (and the other Partners acknowledge that they are not entitled to take any disciplinary action against another Partner's employee).

6 STAFF OBLIGATIONS

6.1 All staff employed in ESBT Partners shall during the term of being placed at the disposal of other Partner organisations:

6.1.1 Work under the direction of the Head of Service/Managers, irrespective of whether they are employed by the same Employing Organisation;

6.1.2 Exercise reasonable care and skill in the performance of their functions and comply with all regulations and directions that the Partners may prescribe from time to time;

6.1.3 Respect and adhere to the confidentiality requirements of the Partners and not disclose nor make public any confidential, exempt or sensitive information about any of the Partners or customers or business;

6.1.4 Comply with the Partners' reporting requirements and Codes of Conduct;

6.1.5 Comply with the Partners' IT access and compliance policies, including acceptable use and social media policies; and

6.1.6 Comply with health, safety and welfare at work requirements, including the need to be responsible for their own and others health and safety.

6.2 All work and intellectual property rights in the work of an employee shall remain the property of the Employing Organisation.

6.3 There may be requirements to liaise with colleagues from other Partners in determining annual leave and other entitlements to ensure adequate cover across the service.

7 MANAGEMENT DURING THE PERIOD OF PROVISION OF SERVICES

7.1 The Employing Organisation shall continue to deal with any Management Issues concerning the Employees during the period of provision of the Services, where relevant following consultation with the receiving Partner.

7.2 The receiving Partner shall provide any information, documentation, access to its premises and employees and assistance (including but not limited to giving witness evidence) to the Employing Organisation to deal with any Management Issues concerning the Employees.

7.3 In the event that the Employees are supplied to the receiving Partner to provide Services for a continuous period of one Working Day or more, the receiving Partner shall have day-to-day control of the Employees' activities during such period but as soon as reasonably practicable shall refer any Management Issues concerning the Employees which come to its attention to the Employing Organisation.

7.4 Each party shall inform the other as soon as reasonably practicable of any other significant matter which arises during the period of provision of the Services relating to the Employees or their employment.

7.5 The Employing Organisation shall ensure that arrangements are in place for it to be notified where an Employee identifies any actual or potential conflict of interest between the receiving Partner and the Employing Organisation in relation to the provision of the Services.

7.6 The Employees shall continue to be eligible for sick pay, holiday pay and any absence entitlements in accordance with the relevant Employment Agreements, and shall remain subject to the Employing Organisation's approval and notification procedures.

8 DATA PROTECTION AND CONFIDENTIALITY

8.1 The receiving Partner shall notify the Employing Organisation in the event that the receiving Partner considers that it is necessary for the receiving Partner to process data relating to the Employees within the meaning of the Data Protection Act 1998. .

8.2 The Employing Organisation shall use its reasonable endeavours to procure that the Employees shall not (except in the proper course of the provision of the Services, as required by law or as authorised by the receiving Partner) during the period of provision of the Services or thereafter use or communicate to any person, company or other organisation whatsoever (and shall use their best endeavours to prevent the use or communication of) any Confidential Information relating to the receiving Partner that they create, develop, receive or obtain. This restriction does not apply to any information that is or comes in the public domain other than through the unauthorised disclosure by any Employee.

9 TERMINATION

9.1 The Employing Organisation may terminate the supply to the receiving Partner of any Employee by giving the receiving Partner one week's prior written notice.

9.2 The Employing Organisation may terminate the supply to the receiving Partner of any Employee with immediate effect without notice or payment in lieu of notice:

9.2.1 on the termination of the relevant Employment Agreement; or

9.2.2 if the receiving Partner is guilty of any breach of the terms of this Agreement.

9.3 The supply of all Employees shall terminate upon the termination of the Agreement under Clause 23.

10 **LIABILITY**

10.1 The receiving Partner shall indemnify the Employing Organisation fully and keep the Employing Organisation indemnified fully at all times against any loss, injury, damage or costs suffered, sustained or incurred by:

10.1.1 the Employees in relation to any loss, injury, damage or costs arising out of any act or omission by the receiving Partner or its employees or agents during the period of provision of the Services; and/or

10.1.2 a third party, in relation to any loss, injury, damage or costs arising out of any act or omission of the Employees during the period of provision of the Services.

SCHEDULE 10 – DATA SHARING AGREEMENT

[In development]

East Sussex Better Together (ESBT) Alliance Governing Board
Date of meeting: 27 June 2017

Item Number: 08/17

Title of report: East Sussex Better Together Alliance 2017/18 budget and month 2 financial position
Recommendation: The Governing Board is asked to note the 2016/17 Alliance Budget and the financial risks that will need to be managed in order to improve services and meet the system wide control total The Governing Board are also asked to note the month 2 financial position.
Executive Summary: East Sussex Better Together is the plan for clinical and financial sustainability across East Sussex, bringing together EHS and H&R CCGs, the local authority (ESCC) and East Sussex Healthcare NHS Trust into one Alliance. The core financial plan is the Strategic Investment Plan, jointly agreed by all parties, which pools investments and resources to ensure delivery of the key system priorities. This paper sets out for the Governing Board the East Sussex Better Together budget for 2017/18. The paper also sets out the risk to delivering the system control total of £26.5m and the actions being take to manage this
Governing Board sponsor: John O'Sullivan, Chief Financial Officer, EHS and H&R CCGs

Author(s): John O'Sullivan, Chief Financial Officer, EHS and H&R CCGs	**Date of report:** 03/05/17
Review by other committees: This paper has not be reviewed by other committees	

Health impact: The health impact are not addressed in this paper
Financial implications: These are set out in the paper
Legal or compliance implications: Delivering of the ESBT Alliance plans will mean the Alliance will achieve its system wide control total
Link to key objective and/or principal risks: Failure to deliver the 2017/18 plans within available resources may jeopardise the longer term objectives and the establishment of a new accountable care organisation.
Link to East Sussex Better Together (ESBT) programme: The 2017/18 plan sets the financial envelop within which the East Sussex Better Together programme will operate
How has the patient and public engagement informed this work: The wider ESBT programme and Strategic Investment Plan has be subject to considerable public engagement.
Equality Analysis (EA) Process - outcome: Negative Impact ☐ Neutral Impact ☐ Positive Impact ☐ No Impact ☐ Not required for report ☒ **EA Summary:**
Privacy Impact Assessment (PIA) – outcome: No personal data used ☒ Data processes sufficient ☐ Actions required ☐ **Actions:**

East Sussex Better Together Alliance 2017/18 budget

1. Introduction

1.1. East Sussex Better Together is the plan for clinical and financial sustainability across East Sussex, bringing together EHS and H&R CCGs, the local authority (ESCC) and East Sussex Healthcare NHS Trust into one Alliance. The core financial plan is the Strategic Investment Plan, jointly agreed by all parties, which pools investments and resources to ensure delivery of the key system priorities.

1.2. This paper sets out for the Governing Board the East Sussex Better Together budget for 2017/18

2. The ESBT Alliance 2017/18 Budget

2.1. The ESBT Alliance Budget is £1.091bn. The ESBT commissioning budget, including NHS specialist services of £862m has been reduced by a net £3.5m to reflect allocation reductions of £2.6m and an adjustment of £900k to support on-going investment in Adult Social Care. In addition the Alliance budget includes services that East Sussex Healthcare Trust (ESHT) provide to other commissioners, services that East Sussex County Council (ESCC) and Public Health (PH) provide to High Weald Lewes and Havens CCG and client and external income associated with services to ESBT residents.

2.2. The budget is a consolidated budget which removes inter-ESBT transactions for ESHT acute and community services and elements of the Better Care Fund. The detail is set out in Appendix 1

2.3. The ESBT Alliance control total, including sustainability and transformation funding is a £26.5m deficit. This reflects the organisational control totals agreed with NHS England (NHSE) and NHS Improvement (NHSI)

2.4. The consolidated budget is different from the budgets that individual partners agreed in March / April in a number of key areas:

CCG 2016/17 Actual Year End Positions

The CCGs met their control totals in 2016/17. However, the final year end position for 2016/17 represented a £4.2m worsening in the CCGs underlying position entering 2017/18. This excludes any year end differences between the ESHT and the CCGs which are dealt with in the next two paragraphs.

2016/17 Baseline Issues

The CCGs' and ESHT's year-end positions differed by £5.7m. This relates to the cost of winter resilience and contractual issues relating to the treatment of readmissions, the cost of procedures with zero length of stay and no procedures and new to follow- up outpatient attendances.

The Trust and the CCG are meeting NHSI and NHSE on 4 July to resolve these issues. For purposes of the budget paper these disputed issues have been split 50:50 between the CCGs and ESHT.

2017/18 Effect of the Baseline Issues

The flow through into 2017/18 is £4.2m, as the winter resilience issue is not expected to recur in 2017/18. For budget purposes this has been split 50:50 between the CCGs and ESHT

Technical Differences on HRG4+

A revised Payment by Results pricing methodology was introduced for 2017/18. Currently there is a £2.2m income difference between Trust and the CCGs as we have used differing assumptions in determining the financial impact in 2017/18.

This issue is included as a risk and the actual position will become clearer as we report the in year position. The Governing Body will be kept informed of the development of these issues through the regular financial reporting process.

Investment in the RTT Programme

The Alliance has invested heavily in improving RTT compliance and reducing waiting lists during 2016/17 resulting in a significant reduction in waiting lists. Planning assumptions have been refreshed in the light of the improved performance and delivery in the system which means the Alliance is no longer needs to invest the planned additional investment of £3.2m. This is now planned to be used to mitigate risks within financial plans for next year.

2.5. The effect of the above is to increase the Strategic Investment Plan interventions from £27.2m to £36.4m. As the Trust will be only receiving 50% of the expected income for the baseline issues in 2016/17 and 2017/18 their cost improvement programme has increased by £5m to £28m to meet their control total.

	SIP interventions	**Cost Improvement Programme**	**Total**
	£000	**£000**	**£000**
Baseline	-27,200	-23,000	-50,200
CCG outturn position	-4,200		-4,200
ESHT 16/17 Baseline	-2,900	-2,900	-5,800
17/18 effect of baseline issues	-2,100	-2,100	-4,200
Financial Risk	-36,400	-28,000	-64,400

2.6. Effect of SIP interventions on ESHT's cost base

Of the planned £50m gross interventions £42.9m relates to services provided by ESHT. ESHT estimate that they will be able to reduce expenditure by approx. 75%, leaving £10m fixed costs to be managed across the Alliance.

To date the Alliance has identified £3m and is having on-going discussions with NHS England and NHS Improvement about how the balance could be managed. ESHT have indicated that they cannot reflect the overall shift in resources in the plan they have submitted to NHSI until agreement has been reached on the funding of fixed costs otherwise they would be planning to miss their control total. Trust continues to work to secure the overall cost reductions in partnership with the CCG and ESCC.

3. Managing financial and delivery risk

3.1. The agreed ESBT Alliance control total for 2017/18 is £26.5m. Within the overall budget the ESBT Alliance has financial challenges of £85m, relating to changing investment profiles and associated stranded costs, improving provider productivity, the effect of the CCGs 2016/17 year end position, the impact of the baseline issues with ESHT and forecast of further pressures in 2017/18.

ESBT Financial Risk	**May**	**Budget**	**Risk Assessment**		
	Plan	**Plan**	**Best**	**Worst**	**Current**
	£000	**£000**	**£000**	**£000**	**£000**
SIP Interventions	-27,000	-37,000	0	-37,000	-20,000
Cost Improvement Programme	-28,000	-28,000	0	-28,000	-6,000
Stranded Costs	-10,000	-10,000	0		-5,000
16/17 outturn issues	-10,000		0	0	0
17/18 Issues		-10,000		-10,000	-7,000
Financial Risk	-75,000	-85,000	0	-75,000	-38,000

3.2. As described above the 16/17 outturn issues have now been moved against the SIP interventions and the Cost Improvement Programme

3.3. The risk associated with the 2017/18 plans ranges from nil to a shortfall of £75m. The current risk assessment has not changed from the previously reported £38m. However there is more risk with the SIP interventions to reflect the increase to £37m and a reduction in the CIP risk. In addition we have included an estimate of additional pressures that will arise during 2017/18. Further opportunities are being investigated to maximise delivery of current plans and implement additional in year actions to deliver the ESBT Alliance control total.

3.4. The Alliance Executive has four programmes of work to address these issues supported by a single PMO to support delivery of all efficiency savings, and identification of mitigations to financial risk (including the stranded costs).

3.5. Workstreams have been identified, with leads, and work is in train to develop financial mitigations. This approach will be maintained throughout the financial year to ensure delivery of the collective financial plan, developing a pipeline of mitigations to address emerging risks within both the SIP interventions and the CIP plans.

4. Reporting to NHS England and NHS improvement

4.1. The CCGs and ESHT will continue to report separately to NHS England and NHS Improvement during the test bed year. Within the CCG plans the full SIP interventions have been included. As noted above, ESHT have indicated that they cannot reflect the overall shift in resources in their current financial plans with NHS Improvement until agreement has been reached – but the Trust continues to work to secure the overall cost reductions in partnership with the CCG and ESCC as part of the shadow-working agreement.

4.2. Risk share agreement

The Alliance discussions with NHS England and NHS Improvement have concluded that deficits to remain with the appropriate organisation. For our local reports the Alliance will put in place a shadow risk share agreement.

5. Month 2 Financial Position

5.1. The table at appendix 2 presents the ACO 2017/18 full year budget and forecast outturn, and year to date budget and actuals. It consolidates information from each partners sovereign reporting. Figures have been obtained from the respective ledgers at month 2.

5.2. The positon at month 2 is showing a £43k surplus against a planned deficit of £4.4m and is forecast achievement of the year end control total of £26.5m deficit as there is no annual variance currently being reported against organisational budgets at this stage.

5.3. For month 3 the financial report will include the agreed changes to the budget set out in this paper and the outcome of the meeting with NHSE and NHSI on 4 July.

6. Recommendation

6.1. The Governing Board is asked to note the 2016/17 Alliance Budget and the financial risks that will need to be managed in order to improve services and meet the system wide control total.

6.2. The Governing Board are also asked to note the month 2 financial position.

John O'Sullivan
Chief Financial Officer
EHS and H&R CCGs
23 June 2017

ESBT I&E SIP Memorandum

Appendix 1

	SIP v5.6	Non ESBT CCG Income	HWLH Income	Social Care Ext Income	Better Care Funding from ESBT CCGs to ESCC	Other CCG Adjustments	ACO Budget
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
EHS CCG	341,638	0	0	0	0	3,996	**345,634**
HR CCG	355,753	0	0	0	0	-7,490	**348,263**
ESCC	165,020	0	62,943	49,249	-15,254	0	**261,958**
ESHT	0	135,749	0	0	0	0	**135,749**
	862,411	**135,749**	**62,943**	**49,249**	**-15,254**	**-3,494**	**1,091,604**

ESBT MONITORING PERIOD 2 2017/18 - INCOME & EXPENDITURE

Appendix 2

Accountable Care Monitoring Period 2	Plan YTD	Actual YTD	Variance YTD	Plan	Forecast	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
EHS	47,085	47,085	-	293,850	293,850	-
HR	50,307	50,307	-	302,924	302,924	-
CCG Specialist	16,187	16,187	-	97,123	97,123	-
ESCC - Core Budget	27,503	27,503	-	165,020	165,020	-
ESCC - External Income	5,666	5,666	-	33,995	33,995	-
ESCC - Income from HWLH	10,491	10,491	-	62,943	62,943	-
ESHT	22,625	22,625	-	135,749	135,749	-
Total Income	**179,864**	**179,864**	-	**1,091,604**	**1,091,604**	-
ESHT Gross Exp	70,871	70,871	-	425,227	425,227	-
ESHT CCG Income*	(43,826)	(43,826)	-	(262,956)	(262,956)	-
CCG Acute Spend with ESHT*	30,298	30,298	-	181,788	181,788	-
CCG Community Spend with ESHT*	5,683	5,683	-	34,098	34,098	-
Acute Spend with Other Providers	15,143	15,143	(0)	90,856	90,856	-
Community Spend with Other Providers	2,841	2,841	(0)	17,043	17,043	-
CCG Mental Health	8,296	8,296	0	49,777	49,777	-
Primary Care	20,930	20,930	0	125,580	125,580	-
CHC	6,475	6,475	0	38,852	38,852	-
CCG Spend with Local Authorities	1,017	1,017	(0)	6,103	6,103	-
Other CCG Spend	2,829	2,829	0	16,973	16,973	(0)
CCG Admin Costs	1,338	1,296	43	8,114	8,114	-
Earmarked Reserves	-	-	-	12,336	12,336	-
CCG Specialist	16,187	16,187	-	97,123	97,123	-
Adult Social Care	31,219	31,219	-	187,313	187,313	-
Children's Services	1,052	1,052	-	6,314	6,314	-
Public Health	3,440	3,440	-	20,642	20,642	-
HWLH	10,491	10,491	-	62,943	62,943	-
ACO Expenditure	**184,284**	**184,241**	**43**	**1,118,126**	**1,118,126**	**(0)**
Net Deficit	**4,420**	**4,378**	**43**	**26,522**	**26,522**	**(0)**

The East Sussex Better Together Alliance Governing Board

Item Number:

Date of meeting 27 June 2017

09/17

Title of report:
East Sussex Better Together (ESBT) Strategic Investment Plan: monitoring our performance

Recommendation:
The ESBT Alliance Governing Board is recommended to:

- **note** the structure, format and content of our Integrated Strategic Investment Plan as at June 2017 (version 5.6);
- **note** the agreed approach to monitoring and reporting progress in delivering our Strategic Investment Plans; and
- **discuss** current performance (as at month 2) as there will be a verbal update at the meeting with the most recent data.

Executive Summary:

1. Introduction

The aims and objectives of ESBT in transforming health and social care locally are described in our 5 Year Strategic Investment Plan (2016/17 – 2020/21) which summarises the anticipated impacts of our whole system redesign at a strategic level, and in terms of financial and activity shifts. This articulates how we have and plan to invest in services to achieve our strategic aims and shift the balance of service provision from hospital-based care to proactive primary and community care. It outlines the large number of different projects spanning the range of the ESBT "6+2" framework which have been delivered, are in the process of being implemented, or are currently being developed across the system to meet local need.

Whilst ESBT is having a positive impact, the size of the challenge and the scale of transformation required cannot be underestimated. It is therefore recognised that continued implementation of the plans will only be achieved through sustained partnership working across the Alliance together with people who use our services, the public, and other

stakeholders in the transformation of the provision of health and social care. In particular, our move to a new model of accountable care is seen as critical to the future success of our system and, by working together, we will be better equipped to meet the considerable challenges we face.

The purpose of this paper and associated suite of documents is therefore to provide the ESBT Alliance Governing Board members with an overview of the format and content of our strategic investment plan to enable a shared understanding of our current position and an outline of the agreed approach to monitoring and reporting progress in delivering during 2017/18.

2. Strategic Investment Plan Overview

The Strategic Investment Planning documentation for 2016/17 – 2020/21 is provided in three parts.

The narrative, which is provided in **Appendix 1** for information, was produced in 2016 to set out the vision and approach to support the implementation of the ESBT plans and national requirements to achieve a balanced budget to deliver sustainable services. This has provided the context for our subsequent work and is included here for completeness.

Appendix 2, details the ESBT integrated commissioning plan which models the difference between the predicted ESBT income to 2020/21 against what health and social care spending would be if current spending patterns were maintained. It then tracks the impact of the transformational projects being implemented as part of ESBT aimed at improving the health and wellbeing of the population and quality and sustainability of services.

This is a dynamic document which summarises the anticipated impact on activity and money (the impact on improving quality is an inherent consideration as plans are developed) of our plans over a 5 year period in a number of high level financial and activity schedules. It should be noted that these schedules are reguallry reviewed and updated and included here are the most current versions (v. 5.6) at the time of writing:

- Appendix 2.1 - The SIP Overview: This models the predicted income assumptions against the 'Do Nothing' scenario, the anticipated funding assumptions and an outline of the spend by care setting to 2020/21 which outlines the gap between forecast income and the scale of transformation required to operate within the available resources.
- Appendix 2.2 - The 5 Year Plan: This provides a summary of the estimated possible net impact of all our proposed developments and transformation plans being implemented in financial terms across the time period.
- Appendix 2.3 - The Investment and Mitigation: this details the current proposed investment set aside for each scheme over the 5 year time period.

Appendix 3 which provides a set of trajectories that break down our 2017/18 SIP plans and outline the investment profile and estimated impact on activity and finance by scheme and point of delivery over the 12 month time period. These also include an outline of ESHT

Cost Improvement Plans (CIP) trajectory by month.

3. Oversight of delivery of our plans under the Alliance Partnership

As we enter into our formal ESBT Alliance arrangements, and seek to mainstream our existing ESBT Programme workstreams, we have been working together to review and determine the future format, content and governance reporting of our agreed ESBT Alliance plans. This includes the assurance and performance reporting of our Strategic Investment Plan both at an aggregate and high level, in addition to the milestone achievements of each project and their anticipated benefits.

As part of this process, agreement has been reached to establish a fully integrated, system wide Programme Management Office (PMO) to monitor the delivery of the ESBT Strategic Investment Plan as a fourth workstream alongside those already managed by the existing ESHT PMO (the others being Digital Development, CQC Response, ESHT Cost Improvement Plans).

Work therefore continues to standardise, update and amalgamate existing documentation and processes between the different programme offices. This is in order to facilitate integration, and more importantly, support greater understanding and transparency in the progress and implementation of agreed plans to provide assurance on delivery of key milestones and facilitate early escalation of issues as required.

As part of our documentation review and alignment, we have developed 3 initial reports:

- An overview tracker which provides details of all the 2017/18 SIP projects / plans being overseen by the PMO including the stage of development of the plans, the executive, operational and planning leads, the anticipated impact on the system and the governance route (**appendix 4**);
- An ESBT Programme Summary Impact Assessment document which provides and outline of each scheme, a summary of the evidence and the estimated in-year 2017/18 impact (**appendix 5**);
- A proxy monthly 'Activity and Income Performance report' comparing actual activity against the anticipated phased impact of our plans has also been developed which is provided in **Appendix 6**. This currently uses ESHT data to allow a more timely review of activity and demand on the acute setting by point of delivery.

A draft 'prototype' ESBT Project Status Summary report to provide the ESBT Alliance Executive with headline in-month and cumulative performance of each scheme in terms of delivery of milestones, impact on activity and finance. In addition, this will highlight issues for escalation to enable swift resolution to be enacted.

It is proposed that the suite of information, which will be further refined and developed, will support early escalation of issues and be complementary to our formal reporting processes.

4. Governance

It has been agreed that delivery of our ESBT Strategic Investment Plan is the responsibility

of the ESBT Alliance Executive. However, to support this work, it is proposed that Integrated Strategic Planning Group (ISPG) acts as the Programme Board for delivery of the 2017/18 ESBT Alliance Strategic Investment Plan and with reporting to the ESBT Alliance Executive, via the integrated PMO, to provide a single solution covering all of the ESBT Alliance whole system plans. This will enable robust performance management of delivery of our Integrated SIP plans and early escalation of issues to the ESBT Alliance Executive to enable swift resolution.

5. Summary

This plan summarises our whole-system vision to provide joined up, high quality and sustainable services. It recognises our ongoing action and intent to shift our focus from delivering reactive health care in hospitals to taking a more preventative and proactive approach that helps people to manage their needs close to home and prevents escalation of conditions that result in preventable admissions to bedded care environments.

6. Recommendation

The ESBT Alliance Governing Board is asked to:

- **note** the structure, format and content of our Integrated Strategic Investment Plan as at June 2017 (version 5.6);
- **note** the agreed approach to monitoring and reporting progress in delivering our Strategic Investment Plans; and
- **Discuss** current performance (as at month 2) as there will be a verbal update at the meeting with the most recent data

Governing Body sponsor: John O'Sullivan, Chief Finance Officer, EHS and H&R CCGs	
Author(s): Paula Gorvett ESBT Programme Director	**Date of report:** 16/06/17
Review by other groups/forum: These have been reviewed at the ESBT Alliance Executive and the CCGs' Governing Bodies.	
Health impact: This is addressed in the ESBT Updates to the Governing Bodies.	
Financial implications: This is set out in the paper.	
Legal or compliance implications: Individual projects which address these issues.	
Link to key objective and/or principal risks: Improving health and well-being outcomes improving the experience of people using our services; improving the sustainability of our system.	
How has the patient and public engagement informed this work: There is a detailed engagement programme to support ESBT.	

Equality Analysis (EA) Process - outcome:

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

EA Summary:

- Project Overview update. EA assessments within individual projects.

Privacy Impact Assessment (PIA) – outcome:

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

Actions: None required.

East Sussex Better Together

Integrated Strategic Investment Plan

September 2016
Version 1.7

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

Contents

This document was published in 2016 and provides the context for our Strategic Investment Plans. It should be noted therefore that some activity or finance figures may have changed over time as our plans have developed.

Introduction

There has been a rapid rise in demand for health and social care across the country. The population is growing and more people are living with chronic and long term medical conditions. All of which has led to pressure on the finances of health and social care providers, who have consistently seen increased demand for services outstrip budget increases.

Locally, in East Sussex the proportion of elderly residents is significantly higher than other parts of the country. This has meant the health and social care system has been at the forefront of the national pattern of increased demand for services and limited increases in resources in which to meet it. If nothing were to change in the current pattern of demand and service provision there would be a potential funding gap of £135 million by 2021.

Working in partnership, East Sussex County Council (ESCC), Eastbourne, Hailsham & Seaford Clinical Commissioning Group (CCG) and Hastings & Rother CCG established the 150 week East Sussex Better Together (ESBT) whole system transformation programme in 2014. The aim is to transform the way health and social care is provided locally through developing integrated and sustainable services throughout East Sussex. The emphasis of the programme is towards disease prevention/management and proactive care. To develop a number of community-based crisis response schemes that integrates services across organisational boundaries.

Through increasing work on disease prevention and community based health and social care activity, it is envisioned there will be a reduced reliance on expensive bedded care options both in the residential and acute sectors. It is believed that by changing this emphasis, up to 13% of activity can be diverted away from the acute sector.

This document lays out our vision for how, building on what we have achieved already, we will deliver whole system integrated care and a sustainable health and social care economy. This document is made up of three parts:

1. strategic planning intentions
2. strategic investment plan
3. market position statement

Demographic information

East Sussex has a population of 539,800 residents (mid-2014 estimates), this has increased by 7% over the last ten years; migration being the key driver of population growth. East Sussex has an older age profile compared to England and Wales (25% of the

population is currently aged over 65 compared to 18% nationally), this is being compounded by a net inflow of migration of older people into East Sussex.

Between 2014 and 2027 the population is predicted to grow by 5.5%, with the over 65 group alone growing by 27%.

Figure 1: Population structure in East Sussex, 1981, 2014 and 2027 projections

Source: ONS population estimates 1981 & 2014, ESCC projections for 2027

Table 1: East Sussex population projections by age group, 2014-2027

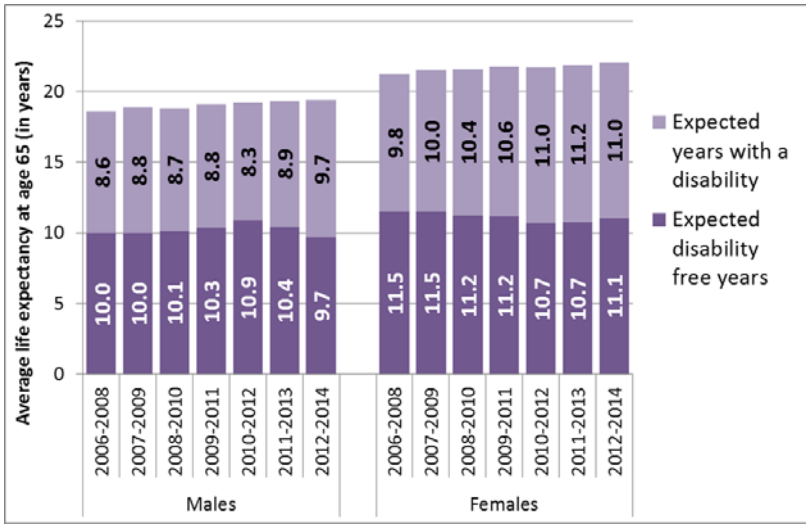
Age bands	2014	2015	2019	2023	2027	% change over the period
People aged 0-9	57,536	58,004	58,874	58,525	57,942	1%
People aged 10-19	59,793	57,977	55,539	58,459	59,754	0%
People aged 20-34	79,589	78,132	74,934	69,776	66,869	-16%
People aged 35-44	60,498	59,908	59,079	61,779	62,275	3%
People aged 45-54	79,086	79,278	77,574	70,788	68,327	-14%
People aged 55-64	70,169	70,612	77,024	83,416	85,004	21%
People aged 65-69	40,140	40,476	35,861	37,055	40,830	2%
People aged 70-74	29,120	30,542	38,988	35,674	35,936	23%
People aged 75-79	24,052	24,155	26,688	35,016	34,022	41%
People aged 80-84	18,653	18,804	20,276	21,723	28,524	53%
People aged 85-89	12,668	12,867	13,485	14,818	16,008	26%
People aged 90 ad over	8,462	8,680	10,131	11,884	14,042	66%
Total	**539,766**	**539,435**	**548,453**	**558,913**	**569,533**	**6%**

Source: ESCC projections (dwelling led), January 2016

Overall the health of people in East Sussex is better than the average for England. This however masks significant variations in health outcomes across the county for both adults and children:

- life expectancy between adults living in affluent and socially deprived areas within the county vary (7.3 years for men, 6.7 years for women)
- there are significant variations in health outcomes amongst children as a result of income deprivation (28% of children in Hastings live in households that are economically deprived).

Figure 2: Life expectancy and disability free life expectancy at age 65 in East Sussex



Source: ONS March 2016

Whilst life expectancy in East Sussex is higher than the national average, the proportion of older people living with long term conditions (LTCs), such as diabetes and heart disease, has also increased. This has contributed to significant pressures on health and social care services.

By 2021 it is projected that 22% of the population in East Sussex will be living with a LTC[1]. People with LTCs account for 50% of all GP appointments, 64% of outpatient appointments, 70% of all inpatient bed days and consume 70% of the total health and care spend[2], signifying a significant demand on health and social care services.

Case for change

The health and social care systems within East Sussex are under significant pressure and face the following challenges:

- **Population health and wellbeing** – the population in East Sussex is aging, with increasing need for long term care and support. The numbers of people with long term conditions is also increasing. There are also significant health inequalities and outcomes across the county.
- **Quality and safety** – there are clinical and financial sustainability issues across our two hospitals and social care which impact on the quality and safety of care.

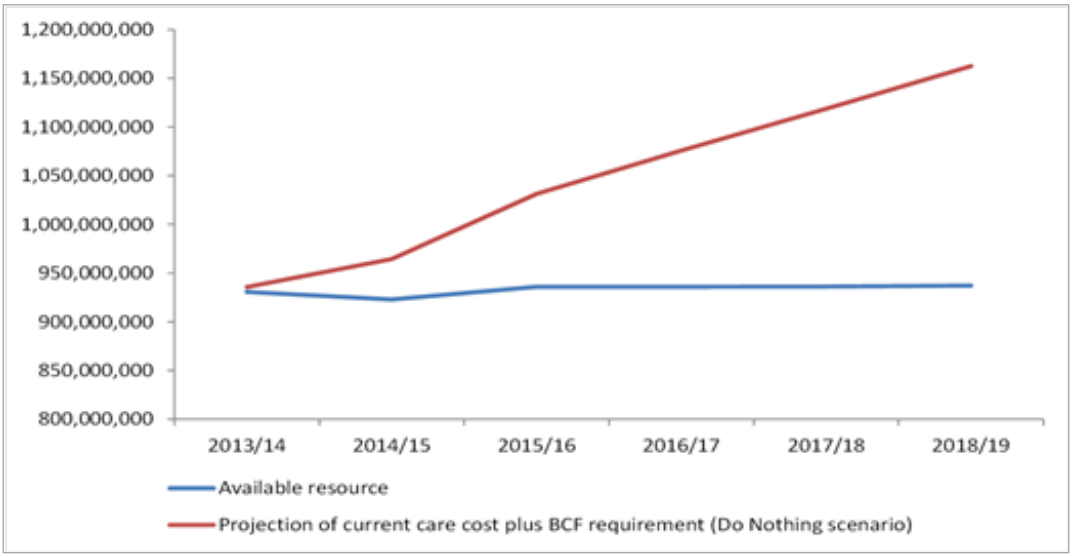
[1] East Sussex in Figures, accessed 18 May 2016 at www.eastsussexinfigures.org.uk
[2] Long Term Conditions Compendium of Information: Third Edition (2012), Department of Health

Primary care services are also under pressure to manage increasing demand for health and care services. Pressure also exists within the local social care market to provide services of the quality expected to help people remain independent.

- **Affordability** – overall the health and social care system within East Sussex is not affordable within the current way it is organised. If services continue to be delivered in the same way as they are at present, it is predicted there will be a funding gap of £135million by 2021.

The graph below illustrates the predicted gap in health and social care funding if they continue to be delivered in the same way.

Figure 3: Do nothing scenario



The current pressure on health and social care provision in East Sussex will not disappear and leaving the system 'as it is' is no longer an option. Taken together, the challenges outlined above need a whole system, multi-agency and innovative response. ESBT is the local response to these challenges. Its aim is to transform the way health and social care is provided locally through the development of fully integrated services, and increased emphasis on disease prevention and community based health and social care solutions. It is envisioned that people can be kept well for longer at home and so reduce reliance on expensive bedded care options both in the residential and acute sectors.

Our vision and values

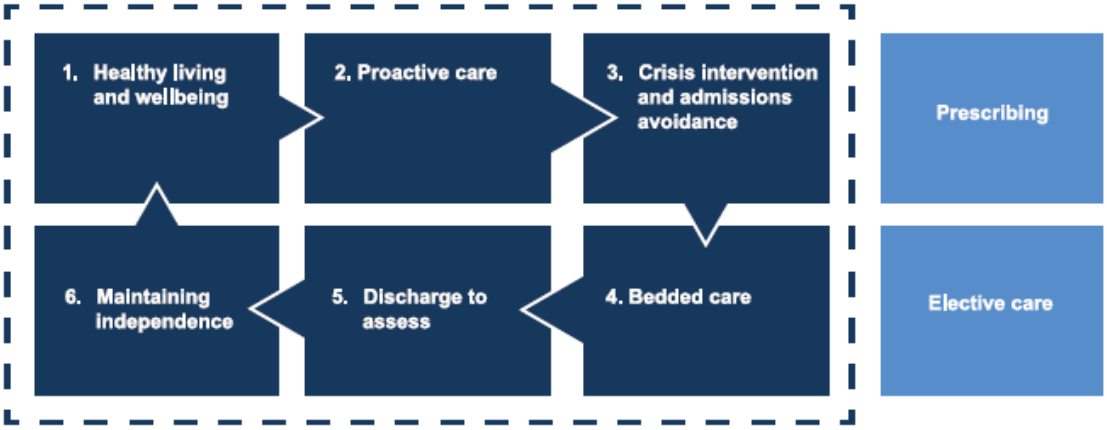
East Sussex Better Together and the principles of whole system integrated care

Our shared vision is that there will be a fully integrated health and social care economy in East Sussex that makes sure people will receive proactive, joined up care, supporting

them to live as independently as possible and achieving the best possible outcomes. In whole system integrated care, health and social care services work together to create innovative ways to deliver high quality person-centred care, to empower and support people to maintain independence and to lead full lives as active participants in their community.

To achieve this we have developed a framework known as the 6 plus 2 box model of care. The six boxes describe the services and support required throughout the whole cycle of an individual's care and support – from prevention through to bedded care, mental and physical health, primary and secondary services. Two further boxes are additional areas where we want to improve the quality and affordability of services.

Figure 4: 6+2 box model of care



The high level outcomes we are seeking to achieve in relation to our model of care are outlined below:

- **Healthy living and wellbeing**: preventing ill health for the whole population including helping all children get a good start in life, promoting independence and improving awareness of and access to services and support for both adults and children that support healthy living, maintain wellbeing and make best use of community assets.
- **Proactive care**: providing integrated and targeted health and social care services to support children and families in need, enabling children and adults with long- term conditions and illnesses to maintain health and independence for as long as possible, promoting self-care and self- management and to avoid having to go into hospital or complex accommodation-based care.
- **Crisis intervention and admissions avoidance**: providing fast and responsive services to keep children safe and prevent family breakdown. Ensuring the right services are in the right place at the right time to help children and adults regain

their independence and well-being quickly following a period of illness, and to avoid admission into hospital or complex accommodation-based care where unnecessary.

- **Bedded care**: making sure that people who require in-hospital and complex accommodation-based care receive the best possible services, and only for the amount of time it is required.
- **Discharge to assess**: ensuring patients and clients in hospitals and care homes are discharged as quickly as possible to an appropriate place, with a package of care to support their recovery.
- **Maintaining independence**: supporting users of health and social care services, and their carers, to live independent lives.
- **Prescribing**: ensuring people receive effective and appropriate medicines when they need them, and reducing the amount of medication that is not taken as prescribed.
- **Elective care**: streamlining planned care to ensure local people have choice, are able to make informed decisions about their care, and have the earliest appropriate intervention.

Achieving our vision of whole system integrated care in East Sussex will mean reshaping the way care is provided, bringing health and social care together in order to improve the quality and experience of care for individuals, the outcomes we achieve, and ensuring financial sustainability for the system. We are finalising our plans for developing a local new model of accountable care to test in the ESBT footprint from 2017/18. Further information can be found at: http://news.eastsussex.gov.uk/east-sussex-better-together/whats-improving/care/

What we have achieved already (it should be noted that this is as September 2016)

We have made good progress with work on the overall vision, pathways and redesign in the following areas:

Improving the health outcomes for populations:

- **Tackling health inequalities** – we are using our combined efforts to address unacceptable differences in health inequalities and improve the health of those with the poorest outcomes fastest, by targeting resources on specific geographical areas or groups who are known to have poorer outcomes
- **Chances for Change** has been commissioned to improve the health of those most at risk of health inequalities, by using asset based approaches to develop and deliver health improvement opportunities and interventions at a local community level

- A **grants programme to support schools** to develop school health improvement plans and initiatives to improve health in the school setting has been offered to all schools in East Sussex
- We are working with our health and social care providers to embed prevention into the care pathway, for example through rolling out **Making Every Contact Count** (MECC) approaches.
- We have funded new **Locality Link Worker** posts to help shape the way that health and social care teams support their clients to access community services and support, and help to shape the support that's available in communities.
- We're working with communities to support them to identify, strengthen and grow the resources and capabilities that exist within communities, groups or individuals to maintain and improve their health and wellbeing - **community resilience**
- We've supported over 7,000 people to maximise their health and wellbeing through our **Joint Community Rehabilitation** service. 77% of people have been helped to stay at home with no need for ongoing support.

Enhancing the quality and experience of people's care:

- We have launched **Health and Social Care Connect -** a new phone and triage service that's helping people to receive care and support faster and ensure professionals can refer people to the right services at the right time.
- We have also established a **single front door for referrals** for Children's social care and non-statutory early help, linked to Child and Adolescent Mental Health Services (CAMHS), so that referrals to CAMHS can be redirected, where possible without referrers needing to re-refer
- We have developed **6 integrated locality-based teams of health and social care professionals** with single line management in the Eastbourne, Hailsham and Seaford localities and in Hastings & Rother. For the first time local people's health and social care needs will be provided by one integrated team
- Locally commissioned services have been agreed for vulnerable adults in **Primary Care** to include avoiding unplanned admissions, advanced care planning and meeting palliative care needs
- We've launched the **Frailty Practitioner Service** to reduce the number of frail elderly people who are in hospital and whose care could be delivered more effectively in the community, and to avoid unnecessary admission to hospital altogether
- We have developed **Proactive Care** teams who are providing monitoring and support to patients identified within practices as being High Risk of developing acute need

- A **new urgent care service model** has been designed that includes the provision of new urgent care hubs at the front of emergency departments and extends access to community-based seven-day urgent care services
- We have launched a new **crisis response service** to prevent unnecessary hospital admission by providing urgent assessment and provision of community nursing care, in people's own homes. The service is made up of a team of Nurse Practitioners, Healthcare Assistants, Occupational Therapists, Physiotherapists and night sitters
- We have established a **Community Provider Education Network** (CEPN) to maximise the opportunities for joint education, training and development initiatives, with the initial focus on supporting sustainability in primary care.

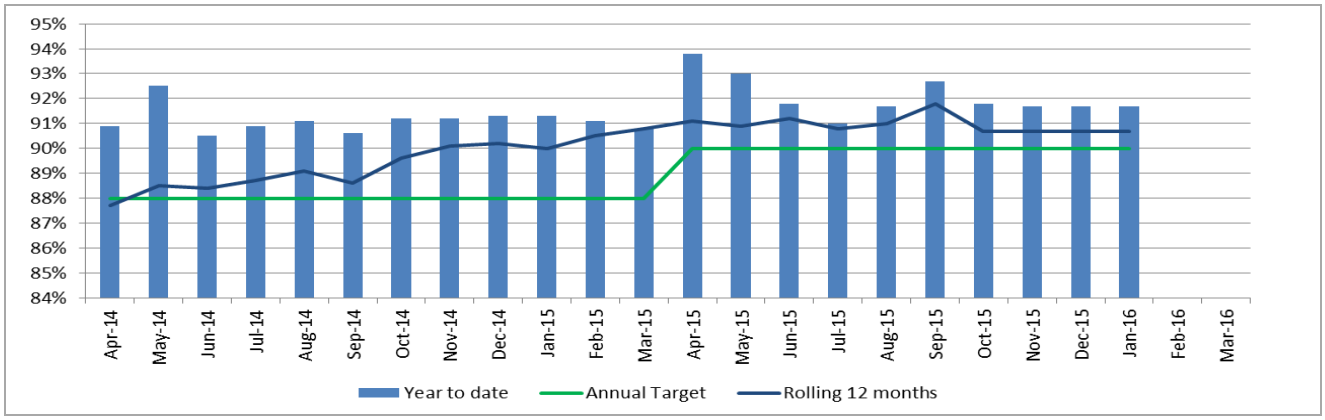
Reducing the per-capita cost of care:

- We are embedding whole systems approaches to **primary prevention, self care and self management,** and are developing core self management tools based on a recent survey of over 700 people with LTC's
- We are implementing a fully integrated stepped **Technology Enabled Care Services (TECS)** model, the level of intervention based on admission risk, and aimed at providing an alternative response to conveyance to hospital and increasing independence of clients in need to remain in their own home
- We have agreed an **integrated workforce plan** for front of each hospital site (Eastbourne District General Hospital and Conquest), with extended multi-disciplinary support 7 days a week. This includes extending voluntary services - Take Home and Settle - and introducing a non-clinical navigator role.
- **Elective care –** we are looking at ways we can streamline this for patients and clinicians, ensuring local people have choice and are able to make informed decisions
- **Prescribing medicines** - bringing together clinicians and pharmacists from across the spectrum to develop ways of working with local patients to ensure they receive effective medicines as and when they need them. The **Medicines Optimisation Service to Care Homes** went live from April 2016.
- **Care-home Plus** - introduction of enhanced support for non-weight bearing patients in residential care home services, providing cost-effective step-up and step-down capacity within the system.

Impact to date

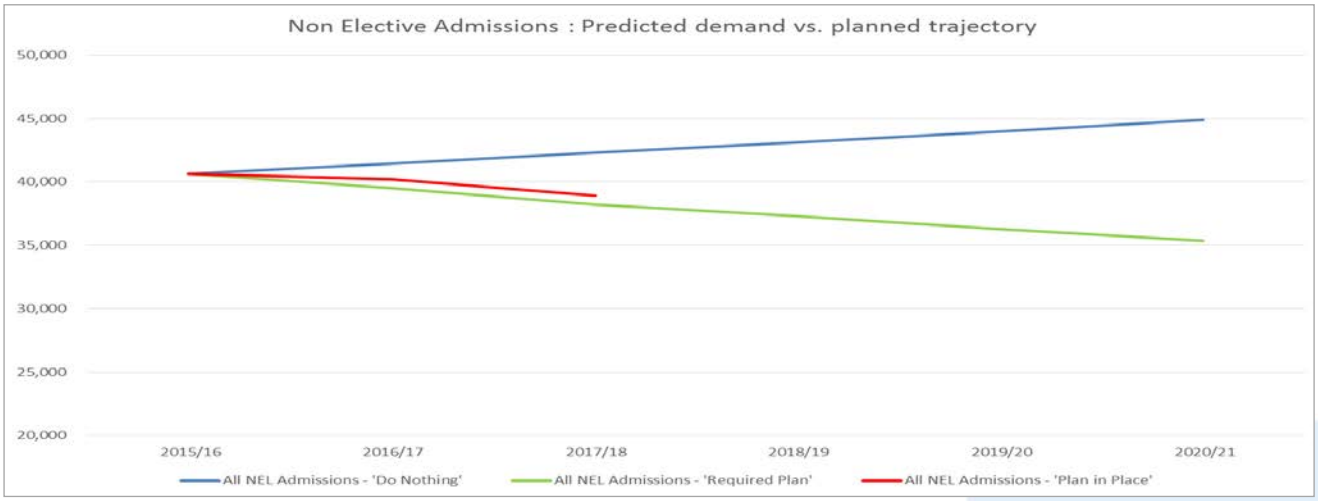
We are starting to see the impact of our initiatives across a range of indicators. For example, in 2016/17 non-elective admissions in East Sussex have dropped by 2%, compared to a national picture which has since an increase of 3% in A&E attendances in the same period.

Figure 5: impact on emergency admissions



Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

Figure 6: predicted impact: emergency admissions



We need to continue to evolve and build on the progress already made in the first phases of the transformation programme. The next section of this document describes our approach to delivering this.

Strategic planning and delivery

Building on the work delivered through ESBT programme transformation workstreams, we are establishing strategic planning and delivery groups across the ESBT footprint. These groups are aligned to the 6+2 box model of care, or reflect specialist client groups, and will

be responsible for delivering an integrated 5 year strategy and investment plan for their service area. A summary of the planned initiatives in each area is below.

Personal & Community Resilience (Model of Care Box 1 & 6)		
Priority areas	**Description of initiatives**	**Anticipated outcomes**
Getting serious about prevention	Reshaping health and social care system so that prevention is at the heart of everything we do, and reviewing prevention services to ensure they meet the needs of local people	• Increase in prevention activity – networks, friendships, feelings of belonging, control and ownership in communities and individuals • Increase in the number of people involved in their communities (formal and informal volunteering) • More opportunities for people with health and social needs to get involved in community activity • Care planning processes which start with understanding what people value and the support and networks they have in place • More people understanding and acting on how they can improve their own health and wellbeing • Integrated prevention services which are targeted to individual motivation and need, and embed self-care to maximise outcomes for the level of investment available
Embedding behaviour change	Developing our workforce so they have the skills and confidence to raise prevention issues by embedding behaviour change across the system using the 'Make Every Contact Count' approach, and to value and understand the contribution that people who use health and care services and their communities can make to improving health and care outcomes	
Communities and integrated locality teams	Creating better links between integrated health and social care teams and their communities through development of Locality Link Worker roles	
Change programmes	Delivering major change programmes in schools, workplaces and hospitals	
Developing community led sustainable support	Freeing up small amounts of resource to enable communities to develop the sustainable support and activities that they identify as priorities	

Proactive, Integrated & Urgent Care (Model of Care Box 2, 3 & 5)		
Priority areas	**Description of initiatives**	**Anticipated outcomes**

Integration of local health and social services	Continuing to enhance provision of services through ILTs to ensure local people are able to see the right professionals at the right time to meet their needs and goals, and only have to tell their story once. Key elements will include: • integrated holistic triage and assessment • supported self-management; • coordination, management & navigation of care • multidisciplinary interventions	• Easy access to information and advice that is personal to them and joined up across health and social care • Residents receive coordinated, timely and tailored assessment, intervention and review from health and social care teams: keeping them safe from harm and/or abuse, helping them to maintain their health and wellbeing, and empowering them to manage their individual needs to achieve their goals • Residents receive coordinated and timely assessment and intervention in times of crisis/urgent need to avoid admission to hospital or long term care • Residents with health and social care needs remain living as independently as possible for as long as possible and experience a good quality of life • Older people are supported to regain their independence as quickly and as close to home as possible after an episode of ill health • Residents who require additional support are able to access this in a timely way and are able to exercise choice in how their needs are met • Residents experience high
Earlier identification and support to those who need it	Developing use of risk stratification tools and Proactive Care Practitioners to identify and support residents that would benefit from earlier intervention to support their wellbeing and prevent unnecessary hospital admission. Proactive care will be an integral part of Integrated Locality Teams (ILTs), and seek to enable patients to remain independent through utilising the range of preventative community resources available in their locality and their capacity to self-manage physical long term conditions. Supported self-management will be delivered through Health Coaches who will work alongside Proactive Care Practitioners to provide 1:1 coaching to those patients who are least activated (as identified through the Patient Activation Measure). In addition there will be direct access to psychological support to ensure the mental health needs of people with a long term condition are being met.	

Increased opportunities for reablement	Building capacity for more residents to be supported to regain and maximise their ability to care for themselves following illness or injury	quality end of life care which promotes choice • Best value is achieved for tax payers' money
Assessment and support for residents with frailty	Developing the Frailty Practitioner Service and pathways to ensure people with frailty are identified, comprehensively assessed and effectively supported across community and acute settings	
Reducing falls & fractures	Enhancing the quality of and capacity for evidence based falls and fracture assessments and interventions in the community, including home hazard assessment, exercise provision & targeted support to care homes	
Access to time limited bedded care in the community	Redesign of current Intermediate Care Bed services to ensure they are best placed to meet the full range of needs of patients and to optimise flow through the whole system	
Safe and timely discharge from hospital	Developing systems to allow safe and timely transfer of medically stable patients from hospital to home (whenever possible) for community assessment of their health and social care needs; reducing delays in discharge and improving flow through the whole system	
Integrated and consistent urgent and emergency care services	Re-organisation of urgent care services including NHS 111, GP Out of Hours and walk-in GP services. Reviewing & developing NHS 111 to provide access to local urgent care services or signpost to alternative self-	

	help/community solutions, such as local pharmacies quickly. Making sure that for those people who may need to speak to, or see, an urgent care professional for their presenting needs, are referred to a local clinician who can assess them and make sure they are seen by the right service first time. This will involve looking at streamlining how different urgent care services are accessed and work together to meet people's needs across physical and mental health. Introducing broader skill mix of staff into both A&E's to better manage those cases with minor ailments/injuries which then supports our emergency care specialist staff to focus on those people with life threatening and acute needs. Developing a communication programme to ensure public messaging about alternative services and choices are tailored to audiences appropriately and available in a variety of formats. Targeting of messages for our high user groups such as 20-29 year olds and parents with young children	
Access to Integrated Community Equipment Services	Ensuring timely provision of equipment and minor adaptations, which underpins all of the above key initiatives to support individuals to meet their assessed needs in a wide range of care pathways	

Accommodation & Bedded Care Solutions (Model of Care Box 4)		
Priority areas	**Description of initiatives**	**Anticipated outcomes**
Integrated solutions	Working to develop a virtual pooled budget and integrated pathway, with	• Flexible use of

	the longer term possibility of a single tender approach and deployment into non-domestic premises	accommodation and bedded acre solutions • Reduction in demand for more cost intensive provision • Reduction in recurrent use of services, particularly mental health and primary care • Reduction in A&E and admissions • Improved quality and innovation of service response • Reduction in length of stay (LOS) • Reduction in DToC's • Reduction in discharge to long term care / permanent placements • Wider range of more cost effective options
Complex and multiple needs	Identifying target households and / or individuals, combinations of specific workers but more importantly cross organisational case work and support, utilising proactive care approaches	
Spend on residential and nursing care placements	Developing a wider range of options to enable reduction in Delayed Transfers of Care (DToC's), including possible use of sheltered, extra care and residential care settings; potential increase in residential and nursing care placements but for short term outcome-based services	
Step up / step down beds	Exploring additional capacity and choice to support hospital discharge and admissions avoidance , e.g. extra care, sheltered housing, live-in carers, etc., and exploring additional models such as care hotels	

Prescribing (Model of Care Box 6+1)		
Priority areas	**Description of initiatives**	**Anticipated outcomes**
Reduction in inappropriate variability in prescribing of medicines	Delivering a Prescribing Support Scheme with benchmarking indicators to incentivise prescribers to change behaviour, and providing additional expertise to support Prescribers in Primary Care through, for example, dietitian to support management of malnutrition; DAAT service to support management of patients addicted to prescription drugs	• The financial resource represents value for money • There is a strong culture of quality and safety • There is a competent and sufficient workforce, supported by integrated information systems

Evidence-based cost-effective use of medicines across pathways	Developing an evidence based cost-effective medicines policy including a joint formulary implemented across the whole health economy, use of opportunity afforded by service redesign to optimise use of medicines, and establishing effective working relationships with the pharmaceutical industry	
Supporting patients with their medicines	Improving the safety and efficiency of the repeat prescribing process, integration of Community Pharmacy Medicines Use reviews into the GP process, implementation of shared decision making tools, and reduction of inappropriate polypharmacy	
Developing the workforce	Providing an integrated pharmacy service that is accessible to both patients and professionals, implementation of CQC Improvement Plan for pharmacy services in ESHT and Trust-wide engagement with high quality clinical pharmacy services	
Information Management & Information (IM&T)	Implementation of IM&T capability to allow better communication between sectors, particularly around transfer of care	

Elective Care (Model of Care Box 6+2)		
Priority areas	**Description of initiatives**	**Outcomes**
Shared Decision Making	Introduction of protocol led discussion aids for GPs to have with patients outlining all of the risks of treatment	• Replicate national findings of 24% reduction in referrals for certain non-essential high risk surgical operations • Increase in out of hospital treatments and reduction in
MSK Re-commissioning	Replicate the commissioning and treatment model established in EHS CCG in H&R CCG locality	

		hospital referrals • Increasing safety by reverting to other diagnostic options. Reducing the need for endoscopies • Increased emphasis on disease prevention and crisis response • Review of current providers to ensure continue to meet the needs of the pathway • Divert non-essential, non-urgent activity to opticians • Support treatments closer to home • Reduce referrals for non-essential conditions away from the acute Trust
Gastro-enterology	Established new referral and procedure protocols for endoscopy	
Cardiology/ Diabetes	Pathway re-design	
Ophthalmology	Re-design of minor eye conditions pathway	

Learning Disability		
Priority areas	**Description of initiatives**	**Anticipated outcomes**
Transforming Care	Strengthening the support pathway an provision to adults with a learning disability and challenging behaviour through developing purpose built services for people ready to discharge from inpatient units; developing a crisis response service to maintain individuals in the community	• Increase in people supported to live in local community settings • Reduction in numbers of people in in-patient settings • Consolidation of our approach to the market and fee levels
Supported living (capital developments)	Development of supported living services to increase the number units available in East Sussex and reduce care and support costs for individuals moving from residential care settings	
Contract savings	Reduction of spend on LD care and support contracts	
Supporting	Identifying cost effective	

young people with complex health needs	accommodation and support services for young people currently at the Futures (Chailey Heritage)	
Reducing Health Inequalities	Increasing the number of adults receiving an annual health check and Health Action Plan, and improving hospital and primary care liaison through targeted activity that ensure reasonable 'adjustments' are made for adults accessing hospital and clinical services	
Transition	Identifying initiatives that support individuals into employment, facilitating community based activities that represent best value, meaningful day opportunities for young people, and supporting families and carers to maintain their caring role	

Mental Health		
Priority areas	**Description of initiatives**	**Anticipated outcomes**
Streamlined Access to Care	Minimising and simplifying routes in to mental health care and support, including exploring potential use of Health and Social Care Connect / 'Skinny' 111	• Improved recovery and independence • Provision of alternative sources of mental health care and support • De-stigmatisation of service provision • Increase in peer support provision • Extension in effective interventions to promote self-care and wellbeing • Increase in community provision • Increase in speed of discharge from hospital
Mental illness: personality disorders	Development of specialist pathways for people with personality disorders, including Tier 3 provision involving third sector / peer support led Centre and psychological therapies	
Mental illness: Crisis Care Concordat & urgent care services integration	Exploring development of crisis response services, including by peer support workers and the third sector, specifically for people with mental health issues who may also be suicidal	

Mental illness: integrated rehabilitation pathways	Exploring pooled budget arrangements to support integrated and streamlined rehabilitation pathways	• Reduction in A&E and admissions
Mental illness & dementia: Integrated care	Exploring the opportunity integrate care pathways by more formally co-ordinating multiple-provider inputs, thereby increasing effectiveness, for example by expanding the role of the third sector and primary care	
Dementia: Well-being Schemes	Exploring more ways to help increase numbers of people living well with dementia	
Dementia: Specialists embedded in Localities	Exploring development of specialist-led programme in Locality Teams to support early recognition and intervention for patients with co-morbid dementia to prevent deterioration and hospital admission	
Dementia: Step-Up/ Down Beds	Pilot of new intermediate tier of bed-based dementia care	
Dementia: Community Crisis Team	Operationalising community-based Dementia Crisis Team in Hastings	
Dementia Shared Care Wards	Establishing one ward at each acute hospital site for patients with have co-morbid dementia	
Dementia: Care Homes - Quality	Raising overall standards and reducing avoidable admission through engagement with Dementia Care Home in-reach Team	

Children & Families

Priority areas	Description of initiatives	Anticipated outcomes
Single Point of Advice (SPoA) for children and families	Developing plans to increase integration of advice and streamline access to services where appropriate, including mental and emotional health and wellbeing. Improving the online / digital support offer. Working more closely with VCS partners.	• Families and children more resilient, better able to self-navigate sources of advice and less reliant on service provision • Reduction in number of children requiring services on Level 3/4 Continuum of Need • Reduction in the number of children on Child Protection Plans • Reduction in the number of Looked After Children • More children able to remain in their local communities with their families • More children in local mainstream schools • Fewer tribunals • More children and families confident and competent to manage their long term conditions • More children achieving age appropriate developmental milestones • Reduction of inequalities in children's school attainment • Improved performance against national indicators for health and wellbeing • Reduction in number of children attending and being admitted to hospital unnecessarily • More integrated workforce
Integrated delivery of Early Help services for children aged 0-19 and their families	Scoping preferred option for further integration of Early Help services for 0-19, including school health, family keywork and emotional health and wellbeing. Piloting 2 year investment in Parenting offer: from self- help to targeted individual support to build resilience and rely less on services Exploring further opportunities to reduce the numbers of Looked After Children	
Improving offer for children with disabilities and special educational needs	Development of life time planning for children with disabilities – from birth through adulthood Recommissioning of Children's Integrated Therapy Service to support children and families in schools Investing in school health in special schools to support a greater number of children locally and avoid costly inappropriate placements. Improving the pathway for children with autism and autistic disorders to improve outcomes and the experience of families, while reducing costs and	

	disputes.	development across health, Children's Services and Adult Social Care
Improving the mental health and wellbeing of children and adolescents through the CAMHS transformation plan	Implementing a dedicated Community Eating Disorders service. Increasing Perinatal mental health provision Expanding the primary mental health workforce, to provide more direct work with children, young people and families and strengthening the links between GPs and schools. Supporting young people who present in crisis and to A&E through mental health liaison support to ensure a more responsive service, especially out of hours. Strengthening mental health expertise to support vulnerable groups such as young offenders, looked after children, care leavers, children who are adopted, children and young people who have experienced sexual abuse and those at risk or in contact with the Youth Justice System. Reviewing current online and digital resources to support children, young people and families to access information, advice and guidance.	
Reducing Avoidable	Exploring opportunities to reduce avoidable hospital attendances and	

Admissions	admissions due to : • Self harm • Mental health • Injuries • Type 1 diabetes • Asthma • Epilepsy • Lower respiratory tract infections	

The successful delivery of our transformation programme and plans is also dependent on a consistent set of enabling activities. Our approach to these is summarised below.

Estates

Changing the point of care radically will have an impact on the estates configuration across the system. Increasing activity in the community relies on access to a modern and flexible infrastructure in both community and primary care premises. Some aspects of the transformation also need specific premises solutions (e.g. co-located locality teams).

We have developed a strategic estates plan that will:

- Ensure access to safe and high quality buildings for our population, as part of a high quality user experience of health and social care
- Establish co-located, integrated community teams, working on a hub and spoke basis – urgent care hubs will be key to this, and increasingly so will Housing and the Voluntary and Community Sector (VCS), with an ambition to co-locate services that provide supported employment, debt advices etc. to deal with the wider determinants of ill health
- Shift services from hospital to/residential care to community settings where quality and value for money are assured
- Invest the minimum we need in buildings to ensure maximum investments in services and staff, making the most that Information Management & Technology (IM&T) had to offer us
- Adapt our estates to modern working methods, to ensure they support fulfilled working lives and enable improved recruitment and retention
- Reduce the environmental impact of our estate
- Establish whole systems working and governance for estates management across the ESBT partner organisations

In considering the shift of care from hospital based provision we will need to assess the impact on existing hospital building stock and that any investment decision on increasing community based capacity takes into account any stranded costs for providers left by underutilised estate. Primary care will also be key to the delivery of our strategic estates outcomes.

Informatics

To successfully deliver whole system integrated care requires professionals working in different organisations being able to share relevant information about clients and patients. The recent publication of 'Personalised Health & Social Care: a vision for 2020' also set out the expectation that patients of the NHS will have a single, integrated record by 2020 and that systems will be paperless by 2018.

We have specified the key characteristics of Informatics Systems under ESBT and to support an accountable care model. These are as follows:

- The infrastructure for integrated working is owned by the commissioner, not any one provider
- The system can function as a single entity when patient/client care requires this and feels like a single entity to the user
- There is a reduction in administration through:
    - No double data entry
    - Data for patient/client care is enough to generate claims/bills/quality monitoring requirements
- There is a single confidentiality process
- The system is capable of alerting commissioners and providers to growing system pressures before a crisis arises
- It supports proactive care through alerts and prompts
- Is jointly owned by patients and clients, to engage them in their own care and enable them, to take more responsibility for it and their data
- Engages software suppliers as innovation partners

We have agreed the principles and approach to change, and have started addressing the operational needs relating to the Integrated Locality Teams and Health & Social Care Connect. The possibility of being able to deliver an 'end to end', whole systems approach redesign of processes presents huge opportunities for efficiencies and improved services to communities. We will be seeking to engage with possible suppliers through soft market testing in the autumn of 2016.

Workforce development

The realisation of the vision set out in this document requires a workforce that has the capacity and is equipped to deliver new models of care. Achieving the right staff, with the right skills in the right place at the right time is crucial albeit challenging given the current national and countywide workforce supply issues across many professions. Corresponding changes in the design, training, planning and deployment of the health and social care cannot be achieved by working in isolation but requires system wide transformation and an approach that responds well to a complex and evolving change programme. A more fluid, innovative and risk taking approach is needed. We have delivered a workforce development strategy that will:

- develop the workforce to become advocates for whole system integrated care, reflecting the programme's values in all that they do, including proactively applying the principles of 'Every Contact Counts' to ensure a focus on prevention and health improvement is embedded across health and social care services
- support leadership development to ensure managers irrespective of sector, are able to effectively lead their teams through the complex change agenda and successfully make the transition to working differently to deliver new models of care
- fulfil the workforce requirements within the Five Year Forward View for General Practice by addressing the current capacity crisis within primary care, ensuring primary care is able to play its crucial role in the shift from hospital to community care whilst creating a sustainable service for the future.

We are also taking action to support the achievement of the three workforce development priorities in the Sussex and East Surrey STP, which are summarised as follows:

- Priority 1: address Agency spend and temporary staffing issues
- Priority 2: the use of newly qualified staff, Assistant Practitioners, and a generic workforce
- Priority 3: a workforce to deliver place-based locality care across the ESBT footprint.

External Support and Income Generation

With our limited local financial resources we are developing a strategic external funding plan to attract additional investment or pump-priming money into East Sussex to support our strategic objectives and delivery of our plans at pace. We will be focusing on two priority areas:

- Funding available to the ESBT programme to principally support the development and/or delivery of formal health and social care interventions, e.g. research grants, innovation awards, etc.

- Funding available to support wider health, wellbeing and preventative objectives identified at a strategic and locality level, and in accordance with the outcomes of community engagement e.g. Big Lottery Reaching Communities, grant making Trusts etc.

Schedule 1.1

EAST SUSSEX BETTER TOGETHER - STRATEGIC INVESTMENT PLAN

OVERVIEW

TABLE 1 - DO NOTHING POSITION - SPEND REQUIRED TO MAINTAIN EXISTING STYLE OF SERVICE PROVISION

Projected Spend 2016/17 to 2020/21 - Do Nothing Option	2015/16 Outturn £'000	2016/17 'Do Nothing' Position £'000	2017/18 'Do Nothing' Position £'000	2018/19 'Do Nothing' Position £'000	2019/20 'Do Nothing' Position £'000	2020/21 'Do Nothing' Position £'000
Spend (based on previous year's spend)						
ESCC: ASC	132,244	132,244	135,844	145,082	154,694	164,552
ESCC: CSD	7,264	7,264	7,264	5,541	5,541	5,541
ESCC: PUBLIC HEALTH	17,844	17,844	19,801	19,313	19,313	19,313
EHS CCG	326,546	326,546	343,104	366,269	380,000	395,059
HR CCG	334,638	334,638	347,693	364,199	378,748	394,547
Spend: Total	818,536	818,536	853,706	900,404	938,295	979,012
Additional In Year Service Pressures (Original)						
ESCC: ASC		3,600	9,238	9,612	9,858	10,194
ESCC: CSD		-	- 1,723	-	-	-
ESCC: PUBLIC HEALTH		1,957	- 488	-	-	-
ESCC: CONTRACT OVERPERFORMANCE			-	-	-	-
EHS CCG		16,558	23,164	13,731	15,060	20,147
HR CCG		13,055	16,507	14,548	15,799	21,431
CCG: CONTRACT OVERPERFORMANCE		12,066	-	-	-	-
Additional In Year Service Pressures: Total	-	47,236	46,698	37,892	40,717	51,771
Adjustment re Growth to account for Public Health Schemes impact	-	-	-	-	-	-
Additional In Year Service Pressures						
ESCC: ASC	-	3,600	9,238	9,612	9,858	10,194
ESCC: CSD	-	-	- 1,723	-	-	-
ESCC: PUBLIC HEALTH	-	1,957	- 488	-	-	-
ESCC: CONTRACT OVERPERFORMANCE	-	-	-	-	-	-
EHS CCG	-	16,558	23,164	13,731	15,060	20,147
HR CCG	-	13,055	16,507	14,548	15,799	21,431
CCG: CONTRACT OVERPERFORMANCE	-	12,066	-	-	-	-
Additional In Year Service Pressures: Total	-	47,236	46,698	37,892	40,717	51,771
Do Nothing Position						
ESCC: ASC	132,244	135,844	145,082	154,694	164,552	174,746
ESCC: CSD	7,264	7,264	5,541	5,541	5,541	5,541
ESCC: PUBLIC HEALTH	17,844	19,801	19,313	19,313	19,313	19,313
ESCC: CONTRACT OVERPERFORMANCE	-	-	-	-	-	-
EHS CCG	326,546	343,104	366,269	380,000	395,059	415,206
HR CCG	334,638	347,693	364,199	378,748	394,547	415,977
CCG: CONTRACT OVERPERFORMANCE	-	12,066	-	-	-	-
Do Nothing Position (Row 1 + Row 2)	818,536	865,772	900,404	938,295	979,012	1,030,783
Population	369665	372,108	374,622	377,222	379,921	382,719
Spend Per Person: Do Nothing Position	***£2,214***	***£2,327***	***£2,403***	***£2,487***	***£2,577***	***£2,693***

Table 1 - Description

Annual commissioner spend until 2021:
- Projected demand and population growth built in
- Assumes 'Do Nothing' i.e. No changes to the current ways health and social care system organised; Current pathways

Non recurrent Impact in 2016/17 only

Non recurrent Impact in 2016/17 only

Non recurrent Impact in 2016/17 only

Non recurrent Impact in 2016/17 only

Non recurrent Impact in 2016/17 only

TABLE 2 - ANTICIPATED FUNDING AVAILABLE BY SOURCE

Source	2016/17 Anticipated Funding £'000	2017/18 Anticipated Funding £'000	2018/19 Anticipated Funding £'000	2019/20 Anticipated Funding £'000	2020/21 Anticipated Funding £'000
ESCC: ASC	128,880	140,202	131,159	131,159	131,159
ESCC: CSD	7,264	5,505	5,436	5,436	5,436
ESCC: PUBLIC HEALTH	19,801	19,313	19,313	19,313	19,313
EHS CCG	339,423	341,638	349,715	358,763	379,112
HR CCG	344,554	355,753	362,886	371,315	379,670
Available Funding for ESBT Strategic Investment Plan	***839,922***	***862,411***	***868,510***	***885,987***	***914,690***

Table 2 - Description

Based on latest guidance, Table 2 outlines the anticipated annual funding available to commissioners of Health and Social Care in East Sussex

TABLE 4 - TOTAL ANTICIPATED FUNDING AVAILABLE BY SOURCE

Source	2016/17 Anticipated Funding £'000	2017/18 Anticipated Funding £'000	2018/19 Anticipated Funding £'000	2019/20 Anticipated Funding £'000	2020/21 Anticipated Funding £'000
ESCC: ASC	128,880	140,202	131,159	131,159	131,159
ESCC: CSD	7,264	5,505	5,436	5,436	5,436
ESCC: PUBLIC HEALTH	19,801	19,313	19,313	19,313	19,313
EHS CCG	339,423	341,638	349,715	358,763	379,112
HR CCG	344,554	355,753	362,886	371,315	379,670
Total Available Funding for ESBT Strategic Investment Plan	***839,922***	***862,411***	***868,510***	***885,987***	***914,690***
Population	369665	369,665	369,665	369,665	369,665
Available Spend Per Person	***£2,272***	***£2,333***	***£2,349***	***£2,397***	***£2,474***
Service Gap (Row 4 less Row 3)	***(25,850)***	***(37,993)***	***(69,786)***	***(93,025)***	***(116,093)***

SPEND PER PERSON 2015/16 to 2020/21 £

TABLE 5 - PLANNED SPEND BY HEALTH AND SOCIAL CARE SERVICE SECTOR

East Sussex Better Together - Strategic Investment Plan Summary	2015/16 Outturn	2016/17 Plan	2017/18 Plan	2018/19 Plan	2019/20 Plan	2020/21 Plan
Spend	£'000	£'000	£'000	£'000	£'000	£'000
Acute - Local	285,809	298,847	274,697	252,906	240,538	226,736
Acute - Specialist	86,199	92,732	97,123	101,447	105,996	111,381
Community	42,004	40,385	47,660	56,671	62,604	69,064
Corporate	12,946	14,827	16,010	16,050	16,089	16,129
Mental Health	47,623	43,817	49,681	51,024	52,545	54,110
Other inc CHC/BCF/reserves	54,748	57,955	66,880	79,888	87,799	106,033
Prescribing	70,973	70,810	73,675	76,444	79,381	82,495
Primary Care	60,882	64,604	71,665	78,170	85,127	92,834
Public Health	17,844	19,801	19,313	19,313	19,313	19,313
Adult Social Care: Accommodation - Nursing	18,952	18,470	20,093	18,797	18,797	18,797
Adult Social Care: Accommodation - Residential	60,695	59,151	64,348	60,197	60,197	60,197
Adult Social Care: Community and other Services	52,597	51,259	55,761	52,165	52,165	52,165
Children's Social Care	7,264	7,264	5,505	5,436	5,436	5,436
Planned Spend: Total (Equal to Row 4)	***818,536***	***839,922***	***862,411***	***868,510***	***885,987***	***914,690***

SPEND BY CORE SECTOR 2015/16 to 2020/21 £m

Schedule 1.2

EAST SUSSEX BETTER TOGETHER - STRATEGIC INVESTMENT PLAN

DETAILED FINANCIAL PLAN: 5 YEAR PLAN - Not Risk Adjusted

TABLE 12 - BRIDGING THE GAP: SCALE OF THE CHALLENGE

	2016/17 £'000	2017/18 £'000	2018/19 £'000	2019/20 £'000	2020/21 £'000
Service Gap (Overview Row 5)	***(25,850)***	***(37,993)***	***(69,786)***	***(93,025)***	***(116,093)***

TABLE 13 - BRIDGING THE GAP: SPEND REDUCTION/CONTRACT PERFORMANCE SCHEMES

	2016/17 £'000	2017/18 £'000	2018/19 £'000	2019/20 £'000	2020/21 £'000
Ongoing Impact of 2016/17 and 2017/18 Disinvestment Schemes (2016/17 & 2017/18: Finance - Short Term Row 2)	3,964	4,000	4,069	4,069	4,069
Ongoing Impact of 2016/17 and 2017/18 Performance Improvement Schemes (2016/17 & 2017/18: Finance - Short Term Row 3)	-	-	-	-	-
Mitigations (Investment & Mitigations Row 2)	12,387	(12,486)	(21,183)	(26,018)	(30,756)
Total Conventional Savings	***16,351***	***(8,486)***	***(17,114)***	***(21,949)***	***(26,687)***

TABLE 14 - BRIDGING THE GAP: TRANSFORMATION PLANS (WHERE FUNDING AGREED): SERVICE REDESIGN - GROSS SCHEME SAVINGS

	2016/17 £'000	2017/18 £'000	2018/19 £'000	2019/20 £'000	2020/21 £'000
Healthy Living & Wellbeing/Maintaining Independence	177	1,978	3,543	5,065	6,483
TECS (including expansion to satisfy demand)	177	913	1,447	1,933	2,306
Public Health - MECC					
Impact of Public Health Initiatives on future year growth in demand		1,065	2,096	3,132	4,178
Proactive Care/Crisis intervention and Admission Avoidance	2,168	9,618	10,987	10,987	10,987
Falls and Fracture Liaison	137	2,220	3,533	3,533	3,533
Children's Paediatric A&E nurse specialist	81	81	81	81	81
Crisis Response	545	2,645	2,645	2,645	2,645
Frailty Practitioners	408	863	863	863	863
Pro-active Care	412	2,341	2,391	2,391	2,391
Vulnerable Patients (Preferred Priorities of Care)	321	581	586	586	586
Condition Specific Redesign: ENT	45	45	45	45	45
Over 85s Discharge Lounge					
Enhanced HIT	219	843	843	843	843
Bedded Care	-	-	-	-	-
Discharge to Assess	-	2,720	4,080	4,080	4,080
Care Home Plus	-	2,720	4,080	4,080	4,080
Mental Health	-	-	-	-	-
Mental Health Initiatives					
Ring Fenced Investment					
Prescribing	2,647	5,322	7,907	10,232	13,057
Prescribing: Medicines Optimisation in Care Homes	1,589	3,174	4,769	6,354	7,939
Prescribing: Repeat Prescribing Process Improvements	542	1,082	1,622	2,162	2,702
Prescribing: Therapeutic Areas	516	1,066	1,516	1,716	2,416
Planned Care	829	2,253	4,388	4,753	4,823
Condition Specific Redesign: Gastroenterology	115	208	208	208	208
Condition Specific Redesign: MSK (EHS)	538	1,398	2,035	2,035	2,035
Condition Specific Redesign: Ophthalmology (WAMD and Minor Conditions)	76	137	137	137	137
MSK Prime Provider (Hastings and Rother)			1,498	1,863	1,933
Shared Decision Making (GP Referrals)	100	510	510	510	510
Children's Services	-	-	-	-	-
Learning Difficulties	-	160	790	790	790
Transformation Schemes	-	160	790	790	790
Enablers	83	1,000	2,000	3,000	4,000
Accountable Care Transaction Costs					
Information Technology					
Estates including Rationalisation of combined ESBT partners Estate					
Back Office Services	83	1,000	2,000	3,000	4,000
Enhanced Projects (Post Lock-In)	595	21,992	48,270	46,256	47,886
Proactive Care/Crisis intervention and Admission Avoidance - Generic Care Workers (inc Integrated Night Service)	595	7,862	14,151	13,949	13,795
Discharge to Assess - Interim Beds for Discharge to Assess (Step-Up)					
Bedded Care - Existing Community Bed Management					
Proactive Care/Crisis intervention and Admission Avoidance - Falls and Fractures Liaison (Enhancement Nov 2016)					
Planned Care - Cardiology Pathway Redesign	-	1,109	2,318	2,318	2,318
Planned Care - Diabetes Pathway Redesign	-	154	309	309	309
Planned Care - Respiratory Pathway Redesign	-	251	504	504	504
Planned Care - Ophthalmology Pathway Redesign	-	1,000	2,000	2,000	2,000
Planned Care - Paediatrics	-	900	1,800	1,800	1,800
Planned Care - New to Follow-up Ratios	-	900	1,800	1,800	1,800
Primary Care - Reduced Referral Variation	-	500	500	500	500
Locality Planning		9,316	24,889	23,077	24,861
NB Please note potential of double counting of savings in Enhanced Projects (Post Lock-In) with savings identified for other transformation plans - impact yet to be assessed					
TRANSFORMATIONAL PLANS: Total Service Redesign Savings (Gross)	***6,499***	***45,043***	***81,965***	***85,163***	***92,106***

TABLE 15 - BRIDGING THE GAP: TRANSFORMATION STRATEGIES (WHERE FUNDING NOT YET AGREED): SERVICE REDESIGN - GROSS SCHEME SAVINGS

	2016/17 £'000	2017/18 £'000	2018/19 £'000	2019/20 £'000	2020/21 £'000
Bedded Care	-	935	935	935	935
Intermediate Care Redesign					
Accommodation Strategy		65	65	65	65
Contract Savings		870	870	870	870
Prescribing	-	-	-	-	-
PURMA					
Planned Care	-	500	4,000	4,000	4,000
Shared Decision Making (extended and into hospital)					
Top 2% spend review - complex needs (reduction in expenditure by 15%)	-	500	4,000	4,000	4,000
Secondary Prevention Schemes (AF, stroke)					
Referral management system (incuding e-Referral and 'virtual' Consultations)	-	-	-	-	-
Primary Care Triage	-	-	-	-	-
Out Patient Follow Up Services (Scheme tbc)					
Children's Services	-	-	-	-	-
Transformation Schemes	-	-	-	-	-
Learning Difficulties	-	-	-	-	-
Enablers	-	-	-	-	-
TRANSFORMATIONAL STRATEGIES Total Service Redesign Savings (Gross)	***-***	***1,435***	***4,935***	***4,935***	***4,935***

TABLE 16 - ACHIEVING FINANCIAL BALANCE

Remaining Gap: Shortfall in savings (Row 1 reduced by Rows 2 to 23)	***(3,000)***	***-***	***-***	***(24,877)***	***(45,739)***
Anticiapted to be met by:					
Additional Savings	***(5,000)***	***-***	***-***	***(41,462)***	***(76,232)***
Additional Investment	***2,000***	***-***	***-***	***16,585***	***30,493***

EAST SUSSEX BETTER TOGETHER - STRATEGIC INVESTMENT PLAN

Schedule 1.3

INVESTMENT AND MITIGATIONS: 5 YEAR PLAN - Not Risk Adjusted

TABLE 17 - MITIGATIONS

	2016/17 £'000	2017/18 £'000	2018/19 £'000	2019/20 £'000	2020/21 £'000
Funding Streams Included in Table 2					
Better Care Fund	31,234	31,234	31,234	31,234	31,234
Healthy Hastings	5,000	5,000	5,000	5,000	5,000
Total Funding Streams Included in Table 2	***36,234***	***36,234***	***36,234***	***36,234***	***36,234***
Commitments Against Funding Streams included in Table 2					
Total ESBT Investments (detailed in Tables 18 & 19 below)	5,638	20,583	28,880	33,715	38,453
Total non ESBT Commitments HH	5,000	5,000	5,000	5,000	5,000
Total non ESBT Commitments BCF	24,453	23,537	23,537	23,537	23,537
Total Commitments against Funding Streams included in Table 2	***35,091***	***49,120***	***57,417***	***62,252***	***66,990***
Uncommited Funding Included in Table 2	***1,143***	***(12,886)***	***(21,183)***	***(26,018)***	***(30,756)***
Non Recurrent Funding (Reserves) Applied					
ESCC		**400**			
EHS CCG	**6,428**				
HR CCG	**4,816**				
Total Non Recurrent Funding (Reserves) Applied	***11,244***	***400***	***-***	***-***	***-***
Total Funding Available in Mitigation	***12,387***	***(12,486)***	***(21,183)***	***(26,018)***	***(30,756)***

TABLE 18: TRANSFORMATION PLANS (WHERE FUNDING AGREED): SERVICE REDESIGN - INVESTMENTS

	2016/17 £'000	2017/18 £'000	2018/19 £'000	2019/20 £'000	2020/21 £'000
Healthy Living & Wellbeing/Maintaining Independence	34	5,658	10,659	15,493	20,231
TECS (including expansion to satisfy demand)	34	658	659	493	231
GP Forward View Initiatives		5,000	10,000	15,000	20,000
Impact of Public Health Initiatives on future year growth in demand					
Proactive Care/Crisis intervention and Admission Avoidance	2,761	5,082	5,377	5,378	5,378
Falls and Fracture Liaison	335	1,436	1,714	1,714	1,714
Children's Paediatric A&E nurse specialist					
Crisis Response	1,063	1,685	1,685	1,685	1,685
Frailty Practitioners	349	349	349	349	349
Pro-active Care	280	878	896	896	896
Vulnerable Patients (Preferred Priorities of Care)					
Condition Specific Redesign: ENT					
Enhanced HIT	734	734	734	734	734
Bedded Care	-	-	-	-	-
Discharge to Assess	231	2,167	3,251	3,251	3,251
Care Home Plus	231	2,167	3,251	3,251	3,251
Mental Health	-	216	216	216	216
Mental Health Initiatives					
Ring Fenced Investment		216	216	216	216
Prescribing	732	732	732	732	732
Prescribing: Medicines Optimisation in Care Homes	442	442	442	442	442
Prescribing: Repeat Prescribing Process Improvements	290	290	290	290	290
Prescribing: Therapeutic Areas					
Planned Care	9	264	264	264	264
Condition Specific Redesign: Gastroenterology					
Condition Specific Redesign: MSK (EHS)					
Condition Specific Redesign: Ophthalmology (WAMD and Minor Conditions)					
MSK Prime Provider (Hastings and Rother)		264	264	264	264
Shared Decision Making (GP Referrals)	9				
Children's Services	-	-	-	-	-
Learning Difficulties	-	-	-	-	-
Enablers	-	-	-	-	-
Accountable Care Transaction Costs					
Information Technology					
Estates including Rationalisation of combined ESBT partners Estate					
Back Office Services					
Enhanced Projects (Post Lock-In)	1,871	6,464	8,381	8,381	8,381
Proactive Care/Crisis intervention and Admission Avoidance - Generic Care Workers (inc Integrated Night Servi	287	5,528	7,445	7,445	7,445
Discharge to Assess - Interim Beds for Discharge to Assess (Step-Up)	234	936	936	936	936
Bedded Care - Existing Community Bed Management					
Locality Planning	1,350				
NB Please note potential of double counting of savings in Enhanced Projects (Post Lock-In) with savings identified for other transformation plans - impact yet to be assessed					
0					
Total Service Redesign Investments (Gross)	***5,638***	***20,583***	***28,880***	***33,715***	***38,453***

Anticipated Investment not yet accounted for	***1.05***	***0.60***	***0.42***	***0.45***	***0.48***
	0.00	***0.00***	***0.00***	***0.00***	***0.00***
	-	***-***	***-***	***-***	***-***

ESBT PROGRAMME IMPACT ASSESSMENTS 2017/18 — **APPENDIX 2**

SCHEME	Transformational Plan			Full Year 2017/18										
				Investment			Gross Activity Reduction							
							No.							Predicted Gross Savings £'000
	Scheme Outline	*Evidence Base for Scheme*	*Patient Target Group*	*Point of Delivery*	£'000	*Point of Delivery*	A&E	NEL	*LOS*	EL	OPFA	OPFU	*Endo*	ESCC	
Enhanced Projects (Post Lock-In)															
Proactive Care/Crisis intervention and Admission Avoidance - Generic Care Workers (inc Integrated Night Service)	Support community resilience and response to the reducing social care markey locally by establishing a substantial team of generic (social care and health) workers to support people in their own homes and avoid hospital admission. They will also be available to provide step-down care to support reducing acute LOS (Step down not included in SIP) Plans are to recruit 250 workers by April 2018		~ Over 65s ~ Working age adults requiring support	ESHT Community	5,528	ESHT Acute	2,968	3,962		-	-	-		-	6,290
Healthy Living & Wellbeing/Maintaining Independence															
TECS (including expansion to satisfy demand)	Increase provision of home-based technological solutions for all Frail and Registered Disabled within East Sussex through: ~ Extending Eligible Patient Group ~Extending proscribing of TECS solutions to NHS staff ~ Imbed staff within SECAMB control to support early detection of patients who would benefit from TECS	Increasing older East Sussex population: - More of frail people >65 to benefit from Telecare - 63% of ambulance attendance to >65s result in hospital admittance - 16k admissions in 2015/16 were Zero Procedure (monitoring only)	~ Over 65s ~Registered disabled working age adults	ESCC	658	ESHT Acute /ESCC Placements	135	179		-	-	-		20	685
Proactive Care/Crisis intervention and Admission Avoidance															
Falls and Fracture Liaison	Establish Community-based falls liaison team to: ~ Identify patients at high risk of falling ~ Undertake multi-factorial Falls Assessment ~ Prescribe falls prevention aids/supports in the home to reduce risk of falling ~ Establish re-balance assessment classes	- RightCare highlights falls a signficant issue locally - Fit for Frailty: British Geriatric Society (2014) - Failing the Frail: British Geriatric Society (2012) - Safe, compassionate care for frail older people using an integrated care pathway: NHS England (2012) - The Silver Book (2012) - Making Services Fit for Our Ageing Population: Kings Fund (Oliver et al, 2013)	~ Frail elderly ~ Over 65s	ESHT Community	1,436	ESHT Acute	174	150		-	-	-		-	555
Children's Paediatric A&E nurse specialist	Establish paediatric nurses within A&E to support treatment of children and reduce the number requirement admission for specialist assessment			ESHT Acute	-	ESHT Acute	-	75		-	-	-		-	147
Crisis Response	Community -based team aimed at providing up to 72 hours emergency support as an alternative to transfer to A&E and an emergency admission. Aimed at those with functional deficits or with a short-term medical condition. Team provides nursing and social care support in the home until a longer term package can be sorted out or the patient recovers from a short-term medical condition	Increasing older East Sussex population over 10 years: - Higher service demands - especially deprived areas. - Expected increase in patients with co-morbidities. - 50% of GP appointments for LTCs - % of people with LTCs expected equal 25% of county. - Inititative aligns to local plans/priorities and national guidance/research - ESBT PWC Analysis 2014	~ Over 65s ~ Working age adults with no other support available	ESHT Community	1,685	ESHT Acute	1,110	1,478		-	-	-		-	2,645
Frailty Practitioners	To proactively support the frail and elderly to live indendently as possible and avoid hospital admission through: ~ Undertaking comprehensive geriatric needs assessments with patients ~ Supporting the coordination of care bewteen different agencies to initiate early intevention where needed to avoid crisis ~ Provide specialist support/education to other care givers i.e. Nursing Home staff	- PEACE Planning tool use has reduced frailty acute readmissions by 49% and 15% for A&E attendances - Services providing Comprehensive Geriatric Assessment of frail elderly reduced hospital admissions by 10% - Fit for Frailty: British Geriatric Society (2014) - Safe, compassionate care for frail older people using an integrated care pathway: NHS England (2012) - Failing the Frail: British Geriatric Society (2012) - The Silver Book (2012)	~ Over 65s	ESHT Community	349	ESHT Acute	390	520		-	-	-		-	863

		- The Silver Book (2012) - King's Fund Integrated Care Summit: Integrated care pathways for frail older people (2013) - Making Services Fit for Our Ageing Population: Kings Fund (Oliver et al, 2013) - Integrated Services for Older People: Building a whole systems approach in England. Audit commission 2002												
Pro-active Care	Establish community-based team to: ~ Use risk assessment tool to identify patients within each GP practice most at risk and who are not known to existing services. To engage with these individuals to identify potential mitigations e.g. Life-style changes - support the utilisation of smoking cessation and exercise classes etc	Modelled on the 15k zero procedure NEL cohort (2015/16) costing £19m - >50% spend on multiple LTC patients (av. 2.2 admissions). Approx. 16k patients at high risk with LTC - Av. cost of NEL £1,298, A&E attendance £100, total £1,398 per admission - £3,075 per patient (£1,398 x 2.2)	~ Over 65s	ESHT Community	878	ESHT Acute	632	853		-	-	-		-	1,171
Vulnerable Patients (Preferred Priorities of Care)	Support GPs to review vulnerable elderly patients to put an active care plan in place and reduce the risk of hsopital admission. As appropriate enhance from other services to further reduce risks		~ Over 65s ~ High risk working age adults	Primary Care	1,360	ESHT Acute	210	278		-	-	-		-	581
Condition Specific Redesign: ENT	Aimed at managing nose bleed patients within the A&E department rather than admit them for a specialist opinion	Total non-elective admissions for epistaxis in 15/16	All patients with nose bleeds	-	-	ESHT Acute	-	122		-	-	-		-	81
Enhanced HIT	Well established Hospital Intervention Team exists within ESHT. The aim of the team is to assess and organise either urgent packages of care or prescribe home aids/support in order to avoid hospital admission from the A&E Department. This plan expands the team to extend HIT coverage from 6pm to 10pm each day.		~ Over 65s ~ Working age adults requiring support	ESHT Community	734	ESHT Acute	-	266		-	-	-		-	422
Discharge to Assess															
Care Home Plus	Investment in enhanced rates for Care Home Providers to support providing a level of care to some residents. This will allow them to accept residents with higher than normalcare needs. This is a response to a significant reduction in the number of nursing home beds available locally. The majority of these patients will be placed from a step down basis and will support a reduction in DTOC	- Reduced nursing bed capacity in the market, affecting timely hospital discharges - Feedback from care managers that not all people placed in nursing homes have nursing needs - the need to develop a provider market that meets service demands	~ Over 65s	ESCC	2,167	CCG	-	-		-	-	-		-	2,720
Planned Care															
Condition Specific Redesign: Gastroenterology	QUIPP Scheme aimeed at changing the pathway for patients with IBS. Established guidance for GPs about management of these patients within the community with diatectic advice, as no need for these patientd to be seen in secondary care		~ Over 18s with IBS	CCG	-	ESHT Acute	-	-		-	535	-		-	208
Condition Specific Redesign: MSK (EHS)	Procurement of whole system MSK contract supporting primary assessment and treatment.		~ Over 18s	CCG	-	CCG	-	-		-	-	-		-	1,700
Condition Specific Redesign: Ophthalmology (WAMD and Minor Conditions)	QUIPP Schemes aimed at reducing cost/activity in Acute Trust: ~ Minor Eye Conditions - train optometrists to treat minor eye conditions rather than refer patients to secondary care ~ WAMD - new diagnostic machine takes 2 scans in 1 reducing the need to scan a patient twice		~ Over 18s	CCG	-	ESHT Acute	-	-		-	156	-		-	137
MSK Prime Provider (Hastings and Rother)	Procurement of whole system MSK contract supporting primary assessment and treatment.		~ Over 18s	CCG	-	CCG/ESHT Acute	-	-		-	-	-		-	2,160
Shared Decision Making (GP	GPs to outline the full risks of a patient undergoing a certain non-urgent treatment route, before referring them to secondary care. Undertanding the full risks will result in some patients wishing not to		~ Over 18s	CCG	-	ESHT Acute	-	-		280	-	-		-	51

Referrals)	be referred and taken up less invasive treatment options			CCG	-	ESHT Acute	-	-		280	-	-		-	31
Planned Care (Being Developed)																
Planned Care - Cardiology Pathway Redesign	End to end pathway redesign. Working across health and social care to support prevention, self management, community based diagnostics/surveillance and reduce the need for referral to secondary care for treatment		~ Over 18s	Whole System	-	ESHT Acute	60	75		188	450	825		-	832
Planned Care - Diabetes Pathway Redesign	End to end pathway redesign. Working across health and social care to support prevention, self management, community based diagnostics/surveillance and reduce the need for referral to secondary care for treatment		~ Over 18s	Whole System	-	ESHT Acute	23	30		-	38	375		-	115
Planned Care - Respiratory Pathway Redesign	End to end pathway redesign. Working across health and social care to support prevention, self management, community based diagnostics/surveillance and reduce the need for referral to secondary care for treatment		~ Over 18s	Whole System	-	ESHT Acute	8	11		38	188	338		-	188
Planned Care - Ophthalmology Pathway Redesign	End to end pathway redesign. Working across health and social care to support prevention, self management, community based diagnostics/surveillance and reduce the need for referral to secondary care for treatment		~ Over 18s	Whole System	-	ESHT Acute	-	-		300	825	2,625		-	750
Planned Care - Paediatrics	End to end pathway redesign. Working across health and social care to support prevention, self management, community based diagnostics/surveillance and reduce the need for referral to secondary care for treatment		~ Under 18s			ESHT Acute	-	413		23	375	638		-	675
Planned Care - New to Follow-up Ratios	RightCare identifies opportunities for ESHT to reduce new: follow-up ratios in line with other local providers. The programme aims to review specialties where ratios are singnifcantly different from the national picture and identify ways in which this will be addressed.		~ Over 18s			ESHT Acute	-	-		-	-	6,750		-	675
Primary Care - Reduced Referral Variation	Significant variation exists between different GP practices in their rates of referral to certain secondary care specialties. Programme will highlight signifcant variations in referral rates within practices directly		~ Over 18s			ESHT Acute	-	-		-	1,275	1,275		-	375
-				-	-	-	-	-		-	-	-		-	-
GRAND TOTAL				**-**	**18,795**	**-**	**5,915**	**8,589**	**7,760**	**828**	**3,841**	**######**	**-**	**20**	**32,290**

EAST SUSSEX BETTER TOGETHER: SIP FINANCIAL SUMMARY BY SCHEME 2017/18

Schedule 3.1

INVESTMENT £'000	2017/18	April	May	June	July	August	September	October	November	December	January	February	March
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
PLANS													
Healthy Living & Wellbeing/Maintaining Independence	5,658	472	472	472	472	472	472	472	472	472	472	472	472
TECS (including expansion to satisfy demand)	658	55	55	55	55	55	55	55	55	55	55	55	55
Public Health - MECC	0												
Public Health - Smoking Cessation	0												
Public Health - Alcohol awareness	0												
Public Health - Obesity/Physical activity	0												
Healthy Hastings Initiatives	0												
GP Forward View Initiatives	5,000	417	417	417	417	417	417	417	417	417	417	417	417
Impact of Public Health Initiatives on future year growth in demand	0												
	0												
Proactive Care/Crisis intervention and Admission Avoidance	5,082	406	425	425	425	425	425	425	425	425	425	425	425
Falls and Fracture Liaison	1,436	120	120	120	120	120	120	120	120	120	120	120	120
Children's Paediatric A&E nurse specialist	0												
Crisis Response	1,685	140	140	140	140	140	140	140	140	140	140	140	140
Frailty Practitioners	349	29	29	29	29	29	29	29	29	29	29	29	29
Pro-active Care	878	56	75	75	75	75	75	75	75	75	75	75	75
Vulnerable Patients (Preferred Priorities of Care)	0												
Condition Specific Redesign: ENT	0												
Over 85s Discharge Lounge	0												
Enhanced HIT	734	61	61	61	61	61	61	61	61	61	61	61	61
	0												
	0												
Bedded Care	0	0	0	0	0	0	0	0	0	0	0	0	0
	0												
	0												
Discharge to Assess	2,167	181	181	181	181	181	181	181	181	181	181	181	181
Care Home Plus	2,167	181	181	181	181	181	181	181	181	181	181	181	181
	0												
	0												
Mental Health	216	18	18	18	18	18	18	18	18	18	18	18	18
Mental Health Initiatives	0												
Ring Fenced Investment	216	18	18	18	18	18	18	18	18	18	18	18	18
	0												
Prescribing	732	61	61	61	61	61	61	61	61	61	61	61	61
Prescribing: Medicines Optimisation in Care Homes	442	37	37	37	37	37	37	37	37	37	37	37	37
Prescribing: Repeat Prescribing Process Improvements	290	24	24	24	24	24	24	24	24	24	24	24	24
Prescribing: Therapeutic Areas	0												
	0												
	0												
Planned Care	264	22	22	22	22	22	22	22	22	22	22	22	22
Condition Specific Redesign: Gastroenterology	0												
Condition Specific Redesign: MSK (EHS)	0												
Condition Specific Redesign: Ophthalmology (WAMD and Minor Conditions)	0												
MSK Prime Provider (Hastings and Rother)	264	22	22	22	22	22	22	22	22	22	22	22	22
Shared Decision Making (GP Referrals)	0												
	0												
	0												
Children's Services	0	0	0	0	0	0	0	0	0	0	0	0	0
	0												
	0												
Learning Difficulties	0	0	0	0	0	0	0	0	0	0	0	0	0
Transformation Schemes - Learning Difficulties	0												
	0												
Enablers	0	0	0	0	0	0	0	0	0	0	0	0	0
Accountable Care Transaction Costs	0												

Information Technology	0												
Estates including Rationalisation of combined ESBT partners Estate	0												
Back Office Services	0												
	0												
	0												
Enhanced Projects (Post Lock-In)	6,464	277	371	465	549	591	601	601	601	601	601	601	601
Proactive Care/Crisis intervention and Admission Avoidance - Generic Care Workers (inc Integrated Night Service)	5,528	199	293	387	471	513	523	523	523	523	523	523	523
Discharge to Assess - Interim Beds for Discharge to Assess (Step-Up)	936	78	78	78	78	78	78	78	78	78	78	78	78
Bedded Care - Existing Community Bed Management	0												
Proactive Care/Crisis intervention and Admission Avoidance - Falls and Fractures Liaison (Enhancement Nov 2016)	0												
Planned Care - Cardiology Pathway Redesign	0												
Planned Care - Diabetes Pathway Redesign	0												
Planned Care - Respiratory Pathway Redesign	0												
Planned Care - Ophthalmology Pathway Redesign	0												
Planned Care - Paediatrics	0												
Planned Care - New to Follow-up Ratios	0												
Primary Care - Reduced Referral Variation	0												
Locality Planning	0												
NB Please note potential of double counting of savings in Enhanced Projects (Post Lock-In) with savings identified for other transf	0												
	0												
TRANSFORMATIONAL PLANS	***20,583***	***1,436***	***1,549***	***1,644***	***1,727***	***1,769***	***1,780***	***1,780***	***1,780***	***1,780***	***1,780***	***1,780***	***1,780***
TOTAL PLANS AND STRATEGIES - INVESTMENT £'000	**20,583**	**1,436**	**1,549**	**1,644**	**1,727**	**1,769**	**1,780**	**1,780**	**1,780**	**1,780**	**1,780**	**1,780**	**1,780**
TOTAL PLANS AND STRATEGIES - INVESTMENT £'000 - CUMULATIVE													

SAVINGS £'000	**2017/18**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
PLANS													
Healthy Living & Wellbeing/Maintaining Independence	-1,978	-165	-165	-165	-165	-165	-165	-165	-165	-165	-165	-165	-165
TECS (including expansion to satisfy demand)	-913	-76	-76	-76	-76	-76	-76	-76	-76	-76	-76	-76	-76
Public Health - MECC	0												
Public Health - Smoking Cessation	0												
Public Health - Alcohol awareness	0												
Public Health - Obesity/Physical activity	0												
Healthy Hastings Initiatives	0												
GP Forward View Initiatives	0												
Impact of Public Health Initiatives on future year growth in demand	-1,065	-89	-89	-89	-89	-89	-89	-89	-89	-89	-89	-89	-89
	0												
Proactive Care/Crisis intervention and Admission Avoidance	-9,618	-756	-806	-806	-806	-806	-806	-806	-806	-806	-806	-806	-806
Falls and Fracture Liaison	-2,220	-185	-185	-185	-185	-185	-185	-185	-185	-185	-185	-185	-185
Children's Paediatric A&E nurse specialist	-81	-7	-7	-7	-7	-7	-7	-7	-7	-7	-7	-7	-7
Crisis Response	-2,645	-220	-220	-220	-220	-220	-220	-220	-220	-220	-220	-220	-220
Frailty Practitioners	-863	-72	-72	-72	-72	-72	-72	-72	-72	-72	-72	-72	-72
Pro-active Care	-2,341	-150	-199	-199	-199	-199	-199	-199	-199	-199	-199	-199	-199
Vulnerable Patients (Preferred Priorities of Care)	-581	-48	-48	-48	-48	-48	-48	-48	-48	-48	-48	-48	-48
Condition Specific Redesign: ENT	-45	-4	-4	-4	-4	-4	-4	-4	-4	-4	-4	-4	-4
Over 85s Discharge Lounge	0												
Enhanced HIT	-843	-70	-70	-70	-70	-70	-70	-70	-70	-70	-70	-70	-70
	0												
	0												
Bedded Care	0	0	0	0	0	0	0	0	0	0	0	0	0
	0												
	0												
Discharge to Assess	-2,720	-227	-227	-227	-227	-227	-227	-227	-227	-227	-227	-227	-227
Care Home Plus	-2,720	-227	-227	-227	-227	-227	-227	-227	-227	-227	-227	-227	-227
	0												
	0												
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health Initiatives	0												
Ring Fenced Investment	0												
	0												

Prescribing	-5,322	-444	-444	-444	-444	-444	-444	-444	-444	-444	-444	-444	-444
Prescribing: Medicines Optimisation in Care Homes	-3,174	-265	-265	-265	-265	-265	-265	-265	-265	-265	-265	-265	-265
Prescribing: Repeat Prescribing Process Improvements	-1,082	-90	-90	-90	-90	-90	-90	-90	-90	-90	-90	-90	-90
Prescribing: Therapeutic Areas	-1,066	-89	-89	-89	-89	-89	-89	-89	-89	-89	-89	-89	-89
	0												
	0												
Planned Care	-2,253	-188	-188	-188	-188	-188	-188	-188	-188	-188	-188	-188	-188
Condition Specific Redesign: Gastroenterology	-208	-17	-17	-17	-17	-17	-17	-17	-17	-17	-17	-17	-17
Condition Specific Redesign: MSK (EHS)	-1,398	-117	-117	-117	-117	-117	-117	-117	-117	-117	-117	-117	-117
Condition Specific Redesign: Ophthalmology (WAMD and Minor Conditions)	-137	-11	-11	-11	-11	-11	-11	-11	-11	-11	-11	-11	-11
MSK Prime Provider (Hastings and Rother)	0												
Shared Decision Making (GP Referrals)	-510	-43	-43	-43	-43	-43	-43	-43	-43	-43	-43	-43	-43
	0												
	0												
Children's Services	0	0	0	0	0	0	0	0	0	0	0	0	0
	0												
	0												
Learning Difficulties	-160	-13	-13	-13	-13	-13	-13	-13	-13	-13	-13	-13	-13
Transformation Schemes - Learning Difficulties	-160	-13	-13	-13	-13	-13	-13	-13	-13	-13	-13	-13	-13
	0												
Enablers	-1,000	-83	-83	-83	-83	-83	-83	-83	-83	-83	-83	-83	-83
Accountable Care Transaction Costs	0												
Information Technology	0												
Estates including Rationalisation of combined ESBT partners Estate	0												
Back Office Services	-1,000	-83	-83	-83	-83	-83	-83	-83	-83	-83	-83	-83	-83
	0												
	0												
Enhanced Projects (Post Lock-In)	-21,992	-932	-1,056	-1,228	-1,376	-1,519	-1,616	-2,371	-2,379	-2,379	-2,379	-2,379	-2,379
Proactive Care/Crisis intervention and Admission Avoidance - Generic Care Workers (inc Integrated Night Service)	-7,862	-114	-238	-410	-558	-701	-798	-834	-842	-842	-842	-842	-842
Discharge to Assess - Interim Beds for Discharge to Assess (Step-Up)	0												
Bedded Care - Existing Community Bed Management	0												
Proactive Care/Crisis intervention and Admission Avoidance - Falls and Fractures Liaison (Enhancement Nov 2016)	0												
Planned Care - Cardiology Pathway Redesign	-1,109							-185	-185	-185	-185	-185	-185
Planned Care - Diabetes Pathway Redesign	-154							-26	-26	-26	-26	-26	-26
Planned Care - Respiratory Pathway Redesign	-251							-42	-42	-42	-42	-42	-42
Planned Care - Ophthalmology Pathway Redesign	-1,000							-167	-167	-167	-167	-167	-167
Planned Care - Paediatrics	-900							-150	-150	-150	-150	-150	-150
Planned Care - New to Follow-up Ratios	-900							-150	-150	-150	-150	-150	-150
Primary Care - Reduced Referral Variation	-500	-42	-42	-42	-42	-42	-42	-42	-42	-42	-42	-42	-42
Locality Planning	-9,316	-776	-776	-776	-776	-776	-776	-776	-776	-776	-776	-776	-776
NB Please note potential of double counting of savings in Enhanced Projects (Post Lock-In) with savings identified for other transf	0												
	0												
TRANSFORMATIONAL PLANS	***-45,043***	***-2,807***	***-2,981***	***-3,154***	***-3,301***	***-3,444***	***-3,541***	***-4,296***	***-4,304***	***-4,304***	***-4,304***	***-4,304***	***-4,304***
STRATEGIES													
Healthy Living & Wellbeing/Maintaining Independence	0	0	0	0	0	0	0	0	0	0	0	0	0
Public Health - Community Resilience	0												
	0												
	0												
Proactive Care/Crisis intervention and Admission Avoidance	0	0	0	0	0	0	0	0	0	0	0	0	0
Crisis Response expansion (x2.5 of current service model)	0												
Fraility Strategy/Practitioners expansion (x4 of current service model)	0												
Pro-active Care expansion(x2.5 of current service model)	0												
Self Management	0												
Urgent Care Enhamcements & Redesign (Hospital based & 111 leading to 20% reduction in low acuity "Type 5" attendances)	0												
	0												
	0												
Bedded Care	-935	-78	-78	-78	-78	-78	-78	-78	-78	-78	-78	-78	-78
Intermediate Care Redesign	0												
Accommodation Strategy	-65	-5	-5	-5	-5	-5	-5	-5	-5	-5	-5	-5	-5
Contract Savings	-870	-73	-73	-73	-73	-73	-73	-73	-73	-73	-73	-73	-73

	0												
Discharge to Assess	0	0	0	0	0	0	0	0	0	0	0	0	0
Care Homes plus expansion	0												
Delayed Transfers of Care Strategy	0												
	0												
	0												
Mental Health	0	0	0	0	0	0	0	0	0	0	0	0	0
Demetia Strategy	0												
	0												
	0												
Prescribing	0	0	0	0	0	0	0	0	0	0	0	0	0
PURMA	0												
	0												
	0												
Planned Care	-500	-42	-42	-42	-42	-42	-42	-42	-42	-42	-42	-42	-42
Shared Decision Making (extended and into hospital)	0												
Top 2% spend review - complex needs (reduction in expenditure by 15%)	-500	-42	-42	-42	-42	-42	-42	-42	-42	-42	-42	-42	-42
Secondary Prevention Schemes (AF, stroke)	0												
Referral management system (incuding e-Referral and 'virtual' Consultations)	0												
Primary Care Triage	0												
Out Patient Follow Up Services (Scheme tbc)	0												
	0												
	0												
Children's Services	0	0	0	0	0	0	0	0	0	0	0	0	0
Transformation Schemes - Children	0												
	0												
	0												
Learning Difficulties	0	0	0	0	0	0	0	0	0	0	0	0	0
	0												
	0												
	0												
Enablers	0	0	0	0	0	0	0	0	0	0	0	0	0
	0												
	0												
TRANSFORMATIONAL STRATEGIES	***-1,435***	***-120***	***-120***	***-120***	***-120***	***-120***	***-120***	***-120***	***-120***	***-120***	***-120***	***-120***	***-120***
TOTAL PLANS AND STRATEGIES - SAVINGS £'000	**-46,478**	**-2,927**	**-3,100**	**-3,273**	**-3,420**	**-3,564**	**-3,660**	**-4,415**	**-4,424**	**-4,424**	**-4,424**	**-4,424**	**-4,424**
TOTAL PLANS AND STRATEGIES - SAVINGS £'000 - CUMULATIVE	**-46,478**	**-2,927**	**-6,027**	**-9,300**	**-12,721**	**-16,284**	**-19,945**	**-24,360**	**-28,784**	**-33,207**	**-37,631**	**-42,054**	**-46,478**

EAST SUSSEX BETTER TOGETHER: SIP SUMMARY BY POINT OF DELIVERY 2017/18 - Financial and Activity Impacts **Schedule 3.2**

INVESTMENT £'000	2017/18	April	May	June	July	August	September	October	November	December	January	February	March
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Point of Delivery													
A&E Attendances	734	61	61	61	61	61	61	61	61	61	61	61	61
Non Elective Spells	0		0		0		0		0		0		0
Elective Spells	0		0		0		0		0		0		0
Outpatient Attendances - First	0		0		0		0		0		0		0
Outpatient Attendances - Follow Up	0		0		0		0		0		0		0
Community Contacts	10,812	622	735	829	913	955	965	965	965	965	965	965	965
Other	9,037	753	753	753	753	753	753	753	753	753	753	753	753
TOTAL PLANS AND STRATEGIES - INVESTMENT £'000	20,583	1,436	1,549	1,644	1,727	1,769	1,780	1,780	1,780	1,780	1,780	1,780	1,780
TOTAL PLANS AND STRATEGIES - INVESTMENT £'000 - CUMULATIVE	20,583	1,436	2,986	4,629	6,357	8,126	9,905	11,685	13,465	15,244	17,024	18,803	20,583

SAVINGS £'000	2017/18	April	May	June	July	August	September	October	November	December	January	February	March
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Point of Delivery													
A&E Attendances	-917	-42	-52	-61	-69	-77	-83	-88	-89	-89	-89	-89	-89
Non Elective Spells	-18,509	-904	-1,068	-1,231	-1,370	-1,505	-1,597	-1,799	-1,807	-1,807	-1,807	-1,807	-1,807
Elective Spells	-1,673	-43	-43	-43	-43	-43	-43	-236	-236	-236	-236	-236	-236
Outpatient Attendances - First	-1,247	-57	-57	-57	-57	-57	-57	-151	-151	-151	-151	-151	-151
Outpatient Attendances - Follow Up	-1,716	-14	-14	-14	-14	-14	-14	-272	-272	-272	-272	-272	-272
Community Contacts	0		0		0		0		0		0		0
Other	-22,416	-1,868	-1,868	-1,868	-1,868	-1,868	-1,868	-1,868	-1,868	-1,868	-1,868	-1,868	-1,868
TOTAL PLANS AND STRATEGIES - SAVINGS £'000	-46,478	-2,927	-3,100	-3,273	-3,420	-3,564	-3,660	-4,415	-4,424	-4,424	-4,424	-4,424	-4,424
TOTAL PLANS AND STRATEGIES - SAVINGS £'000 - CUMULATIVE	-46,478	-2,927	-6,027	-9,300	-12,721	-16,284	-19,945	-24,360	-28,784	-33,207	-37,631	-42,054	-46,478

ACTIVITY - MONTHLY	2017/18	April	May	June	July	August	September	October	November	December	January	February	March
Point of Delivery													
A&E Attendances	-7,679	-350	-435	-517	-586	-654	-699	-736	-740	-740	-740	-740	-740
Non Elective Spells	-11,205	-501	-615	-724	-817	-907	-968	-1,108	-1,113	-1,113	-1,113	-1,113	-1,113
Elective Spells	-1,010	-23	-23	-23	-23	-23	-23	-145	-145	-145	-145	-145	-145
Outpatient Attendances - First	-4,891	-199	-199	-199	-199	-199	-199	-616	-616	-616	-616	-616	-616
Outpatient Attendances - Follow Up	-17,100	-142	-142	-142	-142	-142	-142	-2,708	-2,708	-2,708	-2,708	-2,708	-2,708
Community Contacts			0		0		0		0		0		0
Other			0		0		0		0		0		0

ACTIVITY - CUMULATIVE	2017/18	April	May	June	July	August	September	October	November	December	January	February	March
Point of Delivery													
Point of Delivery	-7,679	-350	-785	-1,302	-1,888	-2,542	-3,241	-3,978	-4,718	-5,458	-6,198	-6,939	-7,679
A&E Attendances	-11,205	-501	-1,116	-1,840	-2,657	-3,563	-4,531	-5,639	-6,752	-7,865	-8,979	-10,092	-11,205
Non Elective Spells	-1,010	-23	-47	-70	-93	-117	-140	-285	-430	-575	-720	-865	-1,010
Elective Spells	-4,891	-199	-399	-598	-797	-996	-1,196	-1,811	-2,427	-3,043	-3,659	-4,275	-4,891
Outpatient Attendances - First	-17,100	-142	-283	-425	-567	-708	-850	-3,558	-6,267	-8,975	-11,683	-14,392	-17,100
Outpatient Attendances - Follow Up			0		0		0		0		0		0
Community Contacts			0		0		0		0		0		0
			0		0		0		0		0		0

EAST SUSSEX BETTER TOGETHER: FINANCIAL TRAJECTORY inc. CIP 2017/18 **Schedule 3.3**

INVESTMENT £'000	2017/18	April	May	June	July	August	September	October	November	December	January	February	March
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
SIP Investments 2017/18	20,583	1,436	1,549	1,644	1,727	1,769	1,780	1,780	1,780	1,780	1,780	1,780	1,780

SAVINGS £'000	2017/18	April	May	June	July	August	September	October	November	December	January	February	March
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
SIP Savngs 2017/18	-46,478	-2,927	-3,100	-3,273	-3,420	-3,564	-3,660	-4,415	-4,424	-4,424	-4,424	-4,424	-4,424

ESHT CIP Plans 2017/18	2017/18	April	May	June	July	August	September	October	November	December	January	February	March
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Elective Pathways	-5,470	-291	-292	-367	-367	-367	-683	-677	-664	-548	-411	-411	-391
Cardiology	-251	-28	-28	-28	-28	-28	-28	-28	-28	-28	0		0
Endoscopy	-423	-47	-47	-47	-47	-47	-47	-47	-47	-47	0		0
Outpatients	-1,853	-131	-132	-207	-207	-207	-207	-201	-201	-95	-95	-95	-75
Radiology	-261	-33	-33	-33	-33	-33	-33	-33	-20	-10	0		0
Theatres	-2,681	-52	-52	-52	-52	-52	-368	-368	-368	-368	-316	-316	-316
Commercial Development	-1,382	-74	-74	-74	-113	-131	-131	-131	-131	-131	-131	-131	-131
Marginal Development	-432	-24	-24	-24	-24	-42	-42	-42	-42	-42	-42	-42	-42
Commercial Opportunities	-100	-8	-8	-8	-8	-8	-8	-8	-8	-8	-8	-8	-8
Overseas	-100		0		-11	-11	-11	-11	-11	-11	-11	-11	-11
Private Patients	-250		0		-28	-28	-28	-28	-28	-28	-28	-28	-28
Provider to Provider Clarifications	-500	-42	-42	-42	-42	-42	-42	-42	-42	-42	-42	-42	-42
Diagnostics	-600	-100	-100	-100	-100	-100	-100	0	0	0	0	0	0
Pathology MES	-600	-100	-100	-100	-100	-100	-100		0		0		0
Clinical Networks and Data Quality	-3,838	-229	-229	-369	-394	-394	-419	-402	-340	-315	-340	-190	-215
A&E Outcomes	-436	-62	-62	-62	-62	-62	-62	-62	0		0		0
Patient Pathway Recording	-1,900		0	-140	-165	-165	-190	-215	-215	-190	-215	-190	-215
T&O Escalations	-1,250	-125	-125	-125	-125	-125	-125	-125	-125	-125	-125		0
Inpatient Data Quality	-252	-42	-42	-42	-42	-42	-42		0		0		0
Procurement	-4,500	-62	-62	-92	-142	-142	-292	-392	-492	-552	-592	-542	-1,142
Core Procurement	-4,000	-20	-20	-50	-100	-100	-250	-350	-450	-510	-550	-500	-1,100
Pharmacy Procurement	-500	-42	-42	-42	-42	-42	-42	-42	-42	-42	-42	-42	-42
Clinical Services Review	-6,323	0	0	0	-395	-395	-790	-790	-790	-790	-790	-790	-790
Key Workstreams	-6,323		0		-395	-395	-790	-790	-790	-790	-790	-790	-790
Grip and Control	-100	0	0	0	0	0	0	0	-20	-20	-20	-20	-20
Managed Print Services	-100		0		0		0		-20	-20	-20	-20	-20
Patient Flow	-686	-21	-21	-21	-76	-76	-76	-76	-76	-76	-55	-55	-55
A&E Activity	-191	-21	-21	-21	-21	-21	-21	-21	-21	-21	0		0
LOS challenges	-495		0		-55	-55	-55	-55	-55	-55	-55	-55	-55
Workforce	-761	0	0	0	0	0	0	-127	-127	-127	-127	-127	-127
Medical Workforce	-247		0		0		0	-41	-41	-41	-41	-41	-41
Specialised Nursing	-229		0		0		0	-38	-38	-38	-38	-38	-38
Workforce Structure	-286		0		0		0	-48	-48	-48	-48	-48	-48
Pipeline	-5,058	0	0	0	-562	-562	-562	-562	-562	-562	-562	-562	-562
Treasury Management/ Financial Delivery	-1,701		0		-189	-189	-189	-189	-189	-189	-189	-189	-189
Other Pipeline	-3,357		0		-373	-373	-373	-373	-373	-373	-373	-373	-373
ESHT CIP Savngs 2017/18	-28,717	-777	-778	-1,023	-2,149	-2,167	-3,053	-3,157	-3,202	-3,121	-3,028	-2,828	-3,433

ESBT Financial Trajectory 2017/18	2017/18	April	May	June	July	August	September	October	November	December	January	February	March
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Investments and Savings ESBT - before pipeline and stranded costs	**-54,612**	**-2,267**	**-2,329**	**-2,653**	**-3,842**	**-3,961**	**-4,934**	**-5,793**	**-5,846**	**-5,765**	**-5,672**	**-5,472**	**-6,077**

Proxy Month 1 Activity and Income Performance Report

Schedule 5.0

FINANCE										
	16/17 M12 Actual £	Baseline M1 17/18 (M12 + growth @ 2.3%) £	M1 adjusted for working days impact (excludes A&E/ NEL)	Impact of SIP schemes (April) $	17/18 Plan (baseline -SIP impact) £	17/18 M1 Actual £	17/18 M1 Variance from Plan £	17/18 M1 Variance from Plan %	17/18 M1 Variance from Baseline £	17/18 M1 Variance from Baseline %
A&E	£1,065,416	£1,089,921	£1,089,921	-£42,096	£1,047,825	£1,129,624	£81,799	7.8%	£39,703	3.6%
NEL	£6,017,012	£6,155,403	£6,155,403	-£903,791	£5,251,611	£5,794,027	£542,416	10.3%	-£361,375	-5.9%
EL	£3,704,712	£3,789,920	£3,100,844	-£42,500	£3,058,344	£2,663,563	-£394,781	-12.9%	-£437,281	-11.5%
OPFA	£1,174,153	£1,201,159	£982,766	-£56,528	£926,239	£793,564	-£132,675	-14.3%	-£189,202	-15.8%
OPFUP	£968,330	£990,602	£810,492	-£13,889	£796,603	£760,080	-£36,524	-4.6%	-£50,413	-5.1%
OPPROC	£888,557	£908,994	£743,722		£743,722	£489,807	-£253,915	-34.1%	-£253,915	-27.9%
Other OP	£945,547	£967,295	£791,423		£791,423	£872,285	£80,863	10.2%	£80,863	8.4%
Path	£448,084	£458,390	£458,390		£458,390	£371,387	-£87,003	-19.0%	-£87,003	-19.0%
Rad	£283,107	£289,618	£289,618		£289,618	£259,036	-£30,582	-10.6%	-£30,582	-10.6%
Therapies	£46,521	£47,591	£47,591		£47,591	£44,540	-£3,050	-6.4%	-£3,050	-6.4%
Grand Total	**£15,541,439**	**£15,898,892**	**£14,470,170**	**-£1,058,804**	**£13,411,366**	**£13,177,914**	**-£233,452**	**-1.7%**	**-£2,720,978**	**-17.1%**

ACTIVITY										
	16/17 M12 Actual	Baseline M1 17/18 (M12 + growth @ 2.3%)	M1 adjusted for working days impact (excludes A&E/ NEL)	Impact of SIP schemes (April)	17/18 Plan (baseline -SIP impact)	17/18 M1 Actual	17/18 M1 Variance from Plan	17/18 M1 Variance from Plan %	17/18 M1 Variance from Baseline	17/18 M1 Variance from Baseline %
A&E	8,727	**8,928**	**8,928**	**-350**	**8,578**	8,590	12	0.1%	-338	-3.8%
NEL	3,257	**3,332**	**3,332**	**-501**	**2,831**	3,069	238	8.4%	-263	-7.9%
EL	3,593	**3,675**	**3,007**	**-23**	**2,984**	2,825	-159	-5.3%	-183	-5.0%
OPFA	7,592	**7,766**	**6,354**	**-199**	**6,155**	4,672	-1,483	-24.1%	-1,682	-21.7%
OPFUP	10,100	**10,333**	**8,454**	**-142**	**8,312**	9,995	1,683	20.2%	1,541	14.9%
OPPROC	5,649	**5,779**	**4,728**		**4,728**	3,840	-888	-18.8%	-888	-15.4%
Other OP	11,383	**11,645**	**9,528**		**9,528**	10,140	613	6.4%	613	5.3%
Path	269,953	**276,161**	**276,161**		**276,161**	228,287	-47,874	-17.3%	-47,874	-17.3%
Rad	5,800	**5,933**	**5,933**		**5,933**	5,231	-702	-11.8%	-702	-11.8%
Therapies	1,568	**1,604**	**1,604**		**1,604**	1,433	-171	-10.6%	-171	-10.6%

Note

Information based on ESHT actual data

Month12 (March 16/17) actual outturn used as proxy start position until full year outturn position agreed.

Month 1 p Month12 (March 16/17) actual outturn used as proxy start position until full year outturn position agreed.

Source: ESHT M12/M1 data (emailed via JR on 19/5/17)

DRAFT - ESBT Project Monitoring 2017/18

The information contained within this report shows status updates on the ESBT schemes in the process of being implemented during 2016/17.
The summary table below shows the most recent information available at the point of the report date.

ESBT Project Status and Summary Report. Information as at: 30 April 2017

	Milestone Progress	Activity Progress	Financial RAG	Trend
Last Report				
Current				

		Expenditure (Cumulative)		No of staff (at report date)		Patients seen: Latest month		Patients seen: Cumulative		Milestones RAG	Activity RAG	Financial RAG	Trend	Operational issues impacting on complete delivery	Activity Summary (briefly note Items requiring support from senior level, especially where Red/Amber noted)
	Project Stage	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual						
Ophthalmology : Fluorescein *	**Business as Usual**	£4,000	£3,000	n/a	n/a	33	17	33	17					Scheme has now gone live. Review underway to identify reasons for uptake not being at planned levels	
Ophthalmology : WAMD *	**Business as Usual**	£2,274	£1,000	n/a	n/a	18	10	18	10					Scheme has now gone live. Review underway to identify reasons for uptake not being at planned levels	
Ophthalmology : MECS *	**Business as Usual**	£16,837	£9,685	10	10	149	161	149	161					Scheme has now gone live and delivering as planned.	
Gastro IBS pathway *	**Business as Usual**	£5,500	£5,000	n/a	n/a	4	6	4	6					Scheme has now gone live and delivering as planned.	
Enhanced TECs	**Implementation**	£2,833	£0	4	0	509	0	509	0					Adult Social Care's DMT agreed in January to pause the launch and associated recruitment until the issues with equipment provider have been resolved.	Scheme on hold until contract resolution
Proactive Care *	**Implementation**	£64,172	£40,630	20	15.6	270	79	270	79					A review of the service model took place in April as planned. Recommendations and impact of the proposed changes will be reported to reported to ICOMT for approval in May. There is variable engagement from GP practices	Pending outcome of review
Frailty Practitioners *	**Business as Usual**	£26,951	£26,079	8	8	80	107	80	107					A communication plan is being developed to increase the volume of referrals Current service model of out of hospital care being reviewed to shift focus more towards in-hospital	
Falls Prevention **	**Implementation**	£19,547	£8,925	9.3	3	37 Exercise places (classes + home) 56 MFAs 2 care homes	7 exercise 0 MFA 5 care home	37 Exercise places (classes + home) 56 MFAs 2 care homes	7 exercise 0 MFA 5 care home					Updated model awaiting sign off Outcome specification / KPIs still awaiting ESHT sign off Issues impacting on delivery are being picked up with the service and general managers	Support required to agree new service model and establish mobilisation plan with partners
Crisis Response *	**Business as Usual**	£52,972	£84,340	34.5	28	180	67	180	67					Reduction in referrals being received – Crisis response lead attending Locality Management Meetings and GP Locality Meetings to promote service.	Director lead agreed to review the rise in costs at the same time as reduction in activity
VPS *	**Business as Usual**	£113,337	£36,520	45	45	949	783	949	783					Uptake of scheme improving each month. Predicted spend on the scheme not materialised and currently being investigated. Current expenditure per patient approx. 30% of that predicted in the plan.	
Paediatric Nurses	**Business as Usual**	£24,750	£24,750	6	6	Not yet available	Not yet available	Not yet available	Not yet available					Budget provided as part of the Winter Pressure funding to deliver the service. Difficulties in identifying appropriate KPIs form part of the overall A&E team/activity	Support to resolve recurrent funding issue for these posts. ESHT currently looking for investment
Care Home Plus *	**Implementation**	£180,610	£30,102	90 beds	15 beds	30	15	30	15					Insufficient dedicated resource within ESCC to take forward the project roll out Whole system savings are calculated as being £32k, compared to the £96k planned by this period	Escelated to Executvie Sponsor for resolution
Enhanced HIT	**Business as Usual**	£61,333	£37,295	13.4	6	44 NELs avoided from patients seen in enhanced hours	Not yet available	294 NELs avoided from patients seen in enhanced hours	Not yet available					Implementation milestones slipped due to recruitment issues. Anticipated extedned service being fully recruited to and enhanced hours to provide 8am-8pm service daily to be complete by June at EDGH and July at the Conquest. Activity KPIs agreed with outturns provided from July '17 (i.e. patients seen by HIT but in the additional hours). Interim indicators show a significant increase in referrals received since Enhanced HIT started while the number of admissions remains level	
Shared Decision Making (GP Referrals)	**Design**	£0		0										Poor update of shared decision making tools from primary care. Existing scheme currently being discussed with secondary care as part of surgical informed consent	

Prescribing: Medicines Optimisation in Care Homes	**Business as Usual**														
Prescribing: Repeat Prescribing Process Improvements	**Business as Usual**														
Prescribing: Therapeutic Areas	**Business as Usual**														
Back Office Services	**Planning**	£0		0										Currently no scheme PMO is aware of	

NB - * April Data ** March Data

Schemes currently in development

		Expenditure (Cumulative)		No of staff (at report date)		Patients seen									
						Latest month		Cumulative		Milestones RAG	Activity RAG	Financial RAG	Trend	Operational issues impacting on complete delivery	Activity Summary (briefly note Items requiring support from senior level, especially where Red/Amber noted)
	Project Stage	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual						
ISWs - Phase 1*	**Implementation**	£301,261	£141,358	**Recruited:** B2 ISWs = 24 B3 ISWs = 26 ISSWs = 1 Qualified = 5	**Recruited:** B2 ISWs = 27 B3 ISWs = 18.8 ISSWs = 10 Qualified = 0.8	0		0						Overall recruitment slightly ahead of planned trajectory Recruited staff currently working within existing community care services to obtain wider experience of current service provision	
Whole System Review: Mental Health, Acute	**Planning**	£0		0		0		0						Whole system planning workshops complete. The design of schemes to support pathway change currently being developed.	
Whole System Review: Mental Health, Dementia	**Planning**	£0		0		0		0						Whole system planning workshops complete. The design of schemes to support pathway change currently being developed.	
Whole System Review: Cardiology	**Planning**	£0		0		0		0						Whole system planning workshops complete. The design of schemes to support pathway change currently being developed. Concerns around the scale of change proposed delivering all objectives in 2017/18. Unknown impact on this scheme of ESHT Cardiology savings programme	
Whole System Review: Diabetes	**Planning**	£0		0		0		0						Whole system planning workshops complete. The design of schemes to support pathway change currently being developed. Concerns around the scale of change proposed delivering all objectives in 2017/18.	
Whole System Review: Respiratory	**Planning**	£0		0		0		0						Whole system planning workshops complete. The design of schemes to support pathway change currently being developed. Concerns around the scale of change proposed delivering all objectives in 2017/18.	
Whole System Review: Paediatrics, Acute	**Planning**	£0		0		0		0						Whole system planning workshops complete. The design of schemes to support pathway change currently being developed.	
Whole System Review: Paediatrics, Community	**Planning**	£0		0		0		0						Whole system planning workshops complete. The design of schemes to support pathway change currently being developed.	
Whole System Review: Maternity & Obstetrics	**Planning**	£0		0		0		0						Whole system planning workshops complete. The design of schemes to support pathway change currently being developed.	
Whole System Review: Trauma & Orthopaedics	**Planning**	£0		0		0		0						Whole system planning workshops complete. The design of schemes to support pathway change currently being developed.	
Whole System Review: Ophthalmology	**Planning**	£0		0		0		0						Whole system planning workshops complete. The design of schemes to support pathway change currently being developed.	
New to Follow-up Ratios	**Planning**													Difficulties in identifying anscheme. Potential cross-over with ESHT internal departmental reviews	
Reduced Referral Variation	**Planning**													Data still being reviewed	
Top 2% spend review - complex needs	**Design**	£0		0		0		0						Whole system planning workshops complete. The design of schemes to support pathway change currently being developed.	
Locality Planning	**Planning**	£0		0		0		0						Whole system planning workshops complete. The design of schemes to support pathway change currently being developed.	

The East Sussex Better Together Alliance Governing Board

Item Number:

Date of meeting: 27 June 2017

10/17

Title of report:
System performance: an update on A&E performance with a particular focus on delivery against the 4 hour standard.

Recommendation:
The ESBT Alliance Governing Board is recommended to **note:**

- The current system performance;
- The governance arrangements underpinning delivery of our whole-system improvement plan;
- The actions completed and in train to support the required performance improvement trajectory; and
- Key next steps.

Executive Summary:

1. Introduction

The NHS Constitution sets out that a minimum of 95 per cent of patients attending an A&E department in England must be seen, treated and then admitted or discharged in under four hours. This is one of the 'core standards' set out in the NHS Constitution and the NHS Mandate, and is often referred to as the four-hour A&E target. This enables patients to access high quality, effective and efficient services thereby improving their experience and outcomes.

East Sussex Healthcare NHS Trust (ESHT) performance against the 4 hour standard has improved in recent months, but is still below expected levels. Year to date performance is 80.8% with the May position showing some improvement at 81.4%. There continues to be growth in A&E attendances which have increased by 7.4% in the last year. Alongside this the number of ambulance conveyances has increased by 9.7% year to date, with Eastbourne experiencing some ongoing issues with ambulance handover delays. An overview of current performance and a detailed trajectory for recovery and system metrics is contained in Appendix 1.

2. Key Issues facing the system

There are a number of issues that underlie the current performance. As outlined previously, growth in attendances and ambulance conveyances contribute to pressure in the system.

Workforce challenges exist within East Sussex, in particular for middle grade doctors in A&E, whilst the Out of Hours GP Service faces ongoing challenge with filling rotas; this can impact on patients being redirected to A&E.

Community capacity has been constrained, with a significant reduction in care home beds locally in the last year. This is exacerbated by workforce challenges facing the independent sector adversely affecting the availability of care packages. This can be of particular note at peak times such as Christmas and Easter, which can lead to patients staying in our acute and intermediate care bed based services longer than clinically needed. Locally our delayed transfers of care have been between 7 – 8% which is above the expected range.

Pathway management of people across health and social care also continues to be a challenge. This includes our ability to support primary care to receive rapid access to specialist advice, patients attending gateways such as the surgical assessment unit rather than attending A&E and our ability to implement a discharge to assess model which requires rapid access to community support. In addition, the Sussex Directory of Services has been identified as a contributing factor and there is a requirement that it is updated to reflect a broader range of options for NHS 111 and the Ambulance Trust to access, in order to help avoid sending patients to A&E unnecessarily.

Finally, length of stay within our acute beds is above the expected range and for many conditions is higher than national comparators. The Trust needs an increase in ambulatory care capacity to reduce admissions and to build on the initial piloting of SAFER, a nationally recognised tool to improve patient flow and reduce delays where possible.

3. System Improvement

3.1. Urgent Care System Improvement Plan

A whole-system improvement plan has been developed by the CCGs in partnership with ESHT, ESCC Adult Social Care and SECAmb ; this focuses on the five nationally mandated principles:

- Improve Streaming to Primary and Community Care;
- Increase the proportion of NHS 111 calls handled by clinicians;
- Implement the Ambulance Response Programme;
- Improve patient flow through the implementation of good practice, such as the SAFER patient flow bundle; and

- Improving Discharge Practices across health and social care.

Oversight of the delivery of this plan is being managed through the Local A&E Delivery Board. Ultimately, much of its success will be measured by the improved performance of the four hour standard.

3.2. Actions Completed

A number of key actions have already been completed. These include:

- There are Daily Operational Executive calls in place to make immediate decisions, for example to provide permissions, remove barriers and resolve issues and to ensure that patient safety is maintained despite operational pressures and / or any concerns appropriately escalated and managed;
- A number of new teams have been established or enhanced to improve discharge and prevent admission. These include; Crisis Response, the Frailty Team and the extended Hospital Intervention Team, which has therapists, nurses and social workers based in A&E supporting discharge;
- The Sussex Directory of service has been reviewed and an action plan to improve this is now in place with additional resource being supplied to make the necessary improvements; and
- A pilot of GPs in A&E has been undertaken with the lessons learnt informing the model for delivery currently being developed as part of our Primary Care Streaming development at the Conquest and EDGH.

3.3. Actions in Progress

As part of the action plan, a number of key actions which we anticipate will have a material impact on delivery are also in progress:

- The SAFER bundle is being piloted on both acute sites with a view to rolling out across the trust in the coming months;
- Internal escalation for ESHT is being revised to include the full hospital protocol and identified clinician response to amber status;
- The Crisis response service is moving to a discharge to assess model to reduce admissions;
- The development and implementation of primary care co-located with A&E services by October 2017;
- Increase “Hear and Treat” and “See and Treat” by SECAmb to reduce ambulance conveyances to A&E;
- Continue to extend Care Home Plus, which supports local Care Homes to take higher acuity patients to reduce the capacity issues for Nursing Home beds;
- Create greater capacity for Ambulatory Care on both acute sites; and
- Develop the Medical Model which will provide rapid access to specialist assessment including a Comprehensive Geriatric Assessment.

4. Next Steps

The A&E Delivery Board will continue to provide whole system executive oversight of delivery of the system improvement plan on a monthly basis whilst the ESBT

Alliance Executive, through the Operational Executive, is responsible for delivering the A&E Performance against the agreed trajectory. As part of this, the Operational Executive has agreed a sub-set of identified priorities for immediate action. These are outlined below.

- Agree and implement full hospital protocol;
- Address out of hours breaches with enhanced clinical cover overnight;
- Implement co-located primary care at weekends by August;
- Agree with Care Homes the trusted assessor model and begin recruitment;
- Develop a robust workforce plan which addresses current issues across health and social care; and
- Agree Winter Escalation Planning.

In the meantime, daily oversight of performance will continue via the Operational Executive with formal reporting of performance against the agreed trajectory to the Alliance Executive being undertaken on a fortnightly basis. In addition, the quality and safety of the service is monitored through the Clinical Quality Review Group, chaired by the Chief Nurse, CCG's, which meets on a monthly basis.

5. Recommendation

The Alliance Governing Board are requested to **note**:

- The current system performance;
- The governance arrangements underpinning delivery of our whole-system improvement plan and oversight of quality and safety;
- The actions completed and in train to support the required performance improvement trajectory; and
- Key next steps.

Governing Body sponsor : Amanda Philpott Chief Officer Eastbourne, Hailsham and Seaford CCG and Hastings and Rother CCG	
Author(s): Pauline Butterworth , Programme Director , Urgent Care Transformation	**Date of report:** 15/06/17
Review by other groups/forum: A&E Performance is overseen by the Local A&C Delivery Board and monitored regularly across our system.	
Health impact: Underperformance in the areas highlighted in the paper has the potential to impact on the quality and health outcomes for the residents using those services.	

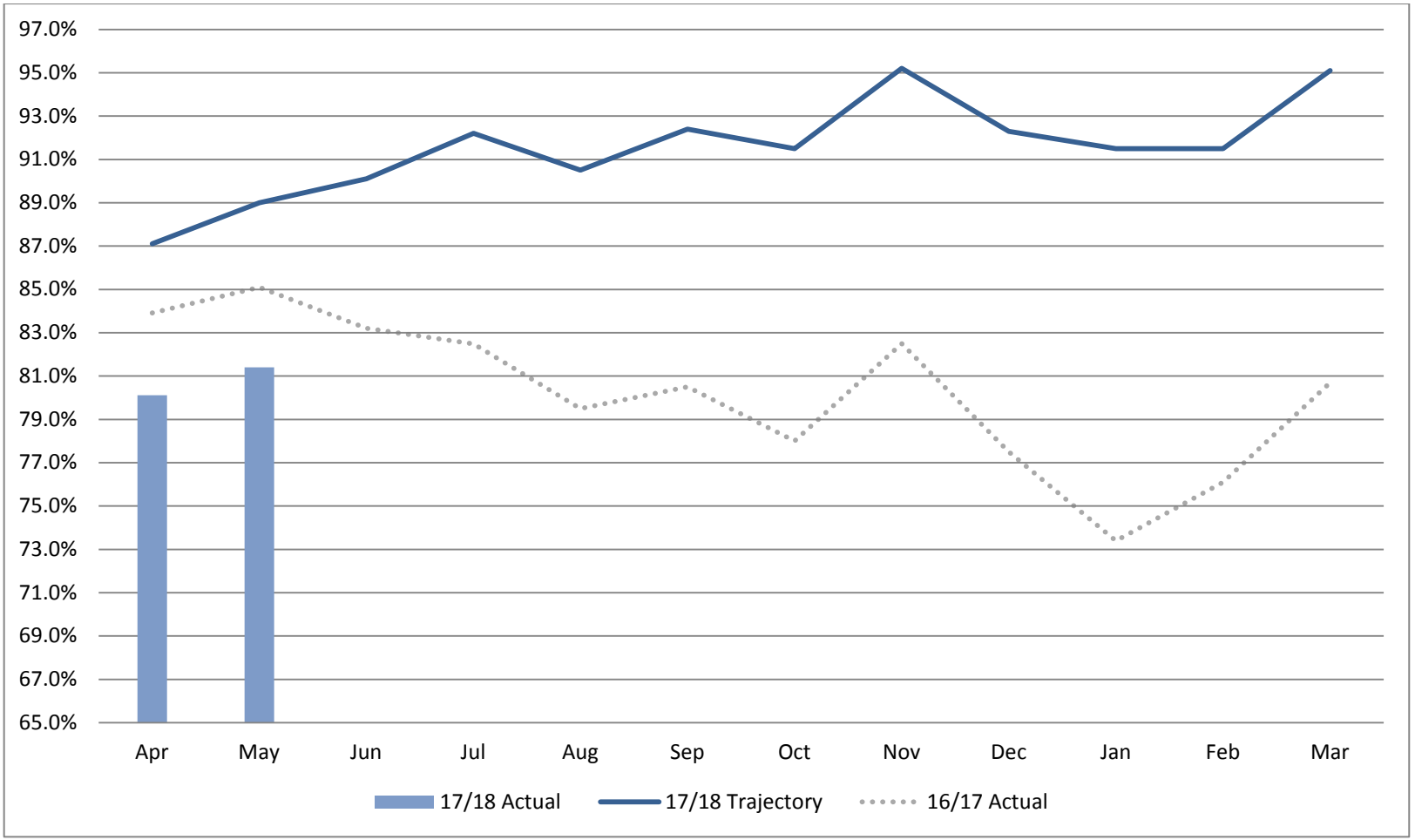
Financial implications: None
Legal or compliance implications: Delivery against National Constitutional Standards
Link to key objective and/or principal risks: Delivering improvements in access to and quality of services
Importance to East Sussex Better Together (ESBT) programme: This report assists in the short and longer term planning relating to transformation of urgent care services and improved patient experience
How has the patient and public engagement informed this work No public engagement has informed this report as this is a status report.
Equality Analysis (EA) Process - outcome: Negative Impact ☐ Neutral Impact ☐ Positive Impact ☐ No Impact ☐ Not required for report ☒ **EA Summary:** None
Privacy Impact Assessment (PIA) – outcome: No personal data used ☒ Data processes sufficient ☐ Actions required ☐

Appendix1 - Emergency Care Dashboard

Indicator Description	Target	Previous Months												Current Month			YTD			Trend
		May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	May-16	Var	This Yr	Last Yr	Var	
A&E 4 Hour Performance (all)	95%	85.0%	83.2%	82.6%	79.5%	80.5%	78.1%	82.4%	77.6%	73.4%	76.1%	80.7%	80.1%	81.4%	85.0%	-3.7%	80.8%	84.5%	-3.8%	
A&E 4 Hour Performance (minors)	95%	91.5%	90.6%	89.8%	88.7%	90.4%	92.0%	95.3%	93.1%	91.4%	94.5%	96.0%	93.7%	94.9%	91.5%	3.3%	94.3%	91.2%	3.1%	
A&E 4 Hour Performance (Majors)	95%	71.9%	69.6%	68.6%	61.6%	63.3%	60.2%	68.5%	65.2%	59.8%	61.2%	64.8%	65.3%	67.3%	71.9%	-4.6%	66.3%	71.9%	-5.6%	
A&E Attendances	M	9573	9239	10144	9711	9470	9397	8989	9136	8771	7951	9442	9572	10063	9573	5.1%	19635	18288	7.4%	
Conveyances	M	3068	2995	3133	3092	3051	3138	3163	3331	3223	2886	3156	3212	3279	3068	6.4%	6491	5916	9.7%	
Time to Initial Assessment (% within 15 mins)	M	93.1%	90.7%	91.8%	90.1%	90.6%	89.6%	92.1%	90.1%	89.9%	81.7%	79.7%	80.9%	80.8%	93.1%	-12.3%	80.9%	93.7%	-12.8%	
Time to treatment A (% within 60 minutes)	M	40.1%	36.6%	36.8%	36.7%	38.8%	39.5%	43.5%	41.6%	45.4%	48.5%	43.0%	41.1%	40.4%	40.1%	0.3%	40.7%	43.4%	-2.7%	
Time to treatment B (% within 120 minutes)	M	65.9%	61.6%	65.0%	64.1%	69.0%	67.3%	73.6%	69.2%	70.1%	76.9%	72.8%	68.5%	67.3%	65.9%	1.4%	67.9%	68.0%	0.0%	
% Ambulance conveyances triaged within 30 minutes	M	96.1%	94.7%	95.2%	93.5%	94.5%	93.1%	95.3%	93.8%	92.7%	87.6%	89.0%	87.4%	88.1%	96.1%	-8.0%	87.8%	96.6%	-8.8%	
Left before being seen rate	5.0%	2.2%	1.3%	1.4%	1.4%	1.2%	1.2%	1.5%	1.8%	1.8%	1.0%	1.2%	1.5%	1.4%	2.2%	-0.8%	1.4%	2.1%	-0.7%	
Unplanned re-attendances	5.0%	3.3%	2.8%	3.0%	2.9%	3.0%	3.1%	3.0%	3.0%	3.2%	2.7%	3.1%	3.0%	3.2%	3.3%	-0.1%	3.1%	3.3%	-0.2%	
NEL Conversion rate (% A&E attends, admitted)	M	25.1%	25.6%	23.7%	23.7%	23.4%	25.3%	26.9%	28.7%	28.1%	28.2%	27.8%	26.6%	26.2%	25.1%	4.4%	26.4%	26.0%	1.6%	
Direct admissions from CDU to Wards	M	211	187	177	188	161	172	155	210	136	100	135	202	151	211	-60	353	386	-33	
Direct admissions from ED to Wards	M	908	934	975	931	1039	1047	979	1119	1170	1049	1192	1014	930	908	22	1944	1813	0	

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

A&E Recovery Trajectory and Performance



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

East Sussex Better Together (ESBT) Alliance Governing Board

Item Number: 11/17

Date of meeting: 27 June 2017

Title of report:

ESBT Communications and Engagement including: Year 2 (2017/18) Delivery Plan of the communications and engagement strategy; and an update on the arrangements for citizen engagement in strategic planning.

Recommendation:

The ESBT Alliance Governing Board is recommended to:

- **agree** the draft Year 2 Communications and Engagement Delivery Plan (Year 2 Delivery Plan), particularly noting the six 2017/18 communications and engagement objectives

- **note** the arrangements for citizen engagement in strategic planning.

Executive Summary:

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

This paper describes the second year of our two year Communications and Engagement Strategy 2016-18 and provides an update on our ESBT alliance citizen engagement plans. (You can currently find full details of the strategy at either of the following links: http://www.eastbournehailshamandseafordccg.nhs.uk/about-us/plans-and-strategies/ http://www.hastingsandrotherccg.nhs.uk/about-us/plans-and-strategies/).

The ESBT communications and engagement strategy originated as a commissioning approach and its delivery now encompasses the ESBT Alliance partners. It aims to support the ambition of ESBT; to develop a fully integrated health and social care system in East Sussex.

The Year Two Plan (attached as Appendix One to this covering report) reflects and builds on work completed in year one as well as bringing in new priorities, for example closer working across our organisations' communications and engagement teams. It outlines objectives and actions to support the delivery of our Strategy. The plan will further develop as the activities to deliver objectives are finalised. It will remain a live operational document to ensure that as the year progress activities are updated.

The Plan was developed following feedback from a communications and engagement workshop with representatives from the local community and third sector. A draft of this plan was then reviewed by the Core Action Group and ESBT Accountable Care Development Group.

<u>Responding to Feedback – our Commitments</u>
In response to feedback on our year one activities we have developed a set of public commitments that will underpin our work. We will use these to create positive and meaningful relationships by:

- Being transparent, accountable, and honest.
- Offering meaningful and diverse opportunities to be involved and feedback on what has happened as a result.
- Working through and with community groups and voluntary organisations; recognising them as experts and equal partners.
- Using jargon free communications and key messages.
- Developing more digital communications and engagement approaches.
- Going to where people are so that the information and engagement is relevant and meaningful.

In order to help us deliver this, there will be a renewed focus on digital and media, as well as more targeted engagement and communications, which will encourage conversation, feedback and co-production.

In line with feedback, we will gather and tell good news stories, and use case studies which evidence and support the good work we've done so far. We will build a more proactive relationship with key influencers to raise the profile of the ESBT Alliance.

To support us in doing this, we have developed some specific objectives for year two:

1. To continue to offer a **diverse range of meaningful opportunities** for involvement and co-production in the development of ESBT and ESBT health and care services;
2. To **gather and publish 'real time' information and stories** from local people about their experiences of ESBT health and care services and use this to continuously

improve our work;
3. To be proactive regarding the **involvement of minority and seldom heard groups** with specific work to engage with children and young people;
4. To regularly **tell people what we are doing and what difference this is making** using a range of formats that is free from jargon;
5. To **build a single ESBT Communications and Engagement Team** so that are messages and activities are consistent and joined up
6. To **continuously evaluate and improve our engagement and communications work**; be open to your feedback and test new ways of working.

A public summary of this plan, which focusses on our communications and engagement commitments, has been developed and will be distributed to our partners (appendix 2).

<u>An update on our ESBT alliance citizen engagement plans</u>

In addition to our collective work to engage our stakeholders in the work of our alliance, we have finalised our plans for ensuring citizen engagement in strategic planning. This is because as we developed the formal integrated governance arrangements for the ESBT Alliance for 2017/18, we wanted to find a way to strengthen engagement in our overarching strategic planning and in our formal governance structure; in particular to support the work of the ESBT Strategic Commissioning Board.

Involving citizens and stakeholders in our strategic planning process is a particular function within our ESBT governance that complements our whole system ESBT Communications and Engagement Strategy and is therefore in addition to existing and newly developing mechanisms for involving local people in our work at all levels of our system.

We have now undertaken the proposed review of planning and partnership arrangements with a view to establishing the overarching arrangements for the ESBT Alliance for 2017/18 required to support strategic planning of health and care across our ESBT Alliance in 2017/18. Proposals regarding this were agreed by the ESBT Strategic Commissioning Board at their meeting earlier this month.

As such, we will now work with stakeholders to establish a collaborative health and wellbeing stakeholder representative Council and this will be the key mechanism to support citizen and stakeholder engagement in the strategic planning process, complementing activity driven by our wider ESBT Communications and Engagement Strategy.

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

Governing Board sponsor: Jessica Britton, Chief Operating Officer, NHS Hastings and Rother CCG & NHS Eastbourne, Hailsham and Seaford CCG	
Author(s): Jenna Khalfan, Associate Director of Communications and Engagement, ESHT	**Date of report:** 27/06/17
Review by other committees: A draft of this Year 2 Delivery Plan has been reviewed by the ESBT Accountable Care Development Group. A draft of this plan has also been discussed at the Governing Bodies of Eastbourne, Hailsham and Seaford and Hastings and Rother CCGs meeting. The proposals regarding the health and wellbeing stakeholder representative Council were agreed by the ESBT Commissioning Board at their meeting on 6 June 2017.	
Health impact: The Year 2 Delivery Plan aims to communicate and engage people in the East Sussex Better Together ambition; to develop a fully integrated health and social care system in East Sussex. Involving local people in the identification of their health needs, care experiences and service priorities strengthens effective commissioning and delivery of health services.	
Financial implications: Much of the activity is planned within our existing resources and there are no direct financial implications arising from this report. .	
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: This Year 2 Delivery Plan aims to realise the mission, vision, model and aims of the Communications and Engagement Strategy 2016-18. In doing so, it aims to support the triple aims of the Alliance: to improve outcomes for local people; to improve the health and wellbeing of local people while making the experience of using our services better; and to create a sustainable health and care system	
Link to East Sussex Better Together (ESBT) programme: This Year 2 Delivery Plan will form the basis of the East Sussex Better Together communications and engagement plan for 2017/18	

How has the patient and public engagement informed this work:

In order to understand the impact of our work to date and to shape the Year 2 Plan, we held a communication and engagement workshop with representatives from the local community and voluntary organisations in March 2017. As well as providing feedback about where we are doing well, it provided us with a clear set of messages about how we can improve our communications and engagement work in year two. This has fed into the development of the plan.

Equality Analysis (EA) Process - outcome:

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

EA Summary:
Improved engagement and communications will enable us to reach a wider range of protected characteristic communities and individuals. Furthermore, the plan includes specific objectives and activities to reach minority and seldom heard groups where we know this has been a gap and/or requires improvement.

Privacy Impact Assessment (PIA) – outcome:

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

Actions: n/a

Appendix 1

DRAFT

Year 2 ESBT Communications and Engagement (2017/18) Delivery Plan

Contents

Introduction

This is the second year of our two year Communications and Engagement Strategy 2016-18 (you can find full details of the strategy at either of the following links: http://www.eastbournehailshamandseafordccg.nhs.uk/about-us/plans-and-strategies/ http://www.hastingsandrotherccg.nhs.uk/about-us/plans-and-strategies/). The Strategy aims to support the ambition of East Sussex Better Together (ESBT); to develop a fully integrated health and social care system in East Sussex by 2018.

This Year 2 Communications and Engagement Delivery Plan (Year 2 Plan) reflects and builds on the work completed in year one as well as bringing in new priorities, for example closer working across our organisations' communications and engagement teams. It outlines objectives and actions to support the delivery of our Strategy.

This Year 2 Plan was developed following feedback from a communications and engagement workshop with representatives from the local community. A draft of this plan was then reviewed by the Core Action Group and ESBT Accountable Care Development Group. A draft summary of this plan has also been discussed at a previous meeting of the Governing Bodies of Eastbourne, Hailsham and Seaford and Hastings and Rother CCGs.

The plan will be submitted to the ESBT Alliance Governing Board in June 2017.

A public summary of this plan, which focusses on our communications and engagement commitments, will be developed and distributed to our partners.

1.1. Where we are now

We have come a long way and undertaken a wide range of communications and engagement activity in the first year of our two year strategy. As we enter year two, we also enter the ESBT Alliance test-bed year and many of the projects and workstreams that we have been developing are becoming a reality.

Since the ESBT programme launched, we have been focusing on communicating with and engaging people in our plans for developing health and care services. We have based this work on the mission, vision and model set out in the Communications and Engagement Strategy. During the test-bed year, it is important that we further illustrate what these changes mean for local people and how they can continue to be involved.

This will require a communications and engagement plan that is flexible enough to help us tell meaningful stories and listen to local people as we continue to improve health and care together.

The broader context

NHS England's 'Next steps on the NHS five year forward view' (which can be found at the following link: https://www.england.nhs.uk/publication/next-steps-on-the-nhs-five-year-forward-view/) offers more detail about integrating care locally and the next steps for Sustainability and Transformation Plans (STPs) and Accountable Care Systems. Our Year 2 Plan needs to firmly reflect the national context and illustrate how it contributes to the aims of

the Five Year Forward View as well as the East Sussex contribution to the Sussex and East Surrey STP.

Communications and engagement: year one review
Our year one communications and engagement delivery plan focussed on supporting the work of ESBT workstreams and establishing our approach and relationships. As the new model has emerged, we are engaging local people in describing and shaping what it is and how it can be delivered. Alongside this, we are developing an outcomes-framework which reflects what local people have said is important to them in their health and social care services.

At the end of year one, it is clear that we are making progress in many areas (see appendix 1) and local people and stakeholders report high satisfaction levels with many of the new services, such as locality link workers, the frailty team and Health and Social Care Connect (HSCC). ESBT projects have received awards and we have established a wide range of relationships, networks and partnerships that have enabled us to reach some of the least heard groups, such as homeless people.

However there is more to do. The Year 2 Plan aims to develop a cross-organisation communication and engagement function, use real time feedback about the services we are providing and facilitate targeted engagement that focuses our audiences on the challenges and work ahead.

In order to understand the impact of our work to date and to shape the Year 2 Plan, we held a communication and engagement workshop with representatives from the local community and voluntary organisations in March 2017. As well as providing feedback about where we are doing well, it provided us with a clear set of messages about how we can improve our communications and engagement work in year two. Our stakeholders told us to:

- **Be more transparent and accountable** and communicate how feedback has influenced decisions and be honest when it has not or cannot.

- **Build a stronger focus on engaging minority and equality groups** (including children and young people) at times and places that are suitable to them and **improve our strategic relationship with the community and voluntary sector** as equal partners.

- **Keep our messaging simple, consistent, joined up and jargon free** so that local people (including those who work for our organisations) can explain what ESBT is and how it has affected or will affect them and their families.

- **Improve our digital work by** using social media and already established digital forums and groups.

- **Avoid using co-production language** unless this is genuinely possible and meaningful.

- Make the work **relevant and local** by using different approaches at different times and places where people naturally meet, go or get their information and news.

- **Create opportunities for clinicians and frontline health and care staff** to engage and work directly with the public and voluntary sector.

1.2. Where we are going

2017/18 will be a year of testing, development and realisation. Over this year and beyond, we will deliver confident, consistent communications and engagement that reflects the ESBT Alliance as a whole – not only in what we do and say, but how we're structured. Our focus will therefore be on the 'who we are as an ESBT Alliance' not what we are, structurally.

The plan will focus on realising the triple aims of the Alliance, which are to:

- Improve the quality and experience of patient care.
- Improve population health and well-being.
- Ensure system sustainability.

We will create meaningful communications and engagement which evolve with developments, so that our staff, stakeholders and local people are confident about what the ESBT Alliance means for them and how they can be involved.

We will be inclusive, meaningful and empowering. There will be a renewed focus on digital and media, as well as more targeted engagement and communications, which encourage conversation, feedback and co-production.

We will gather and tell good news stories, and use case studies which evidence and support the good work we've done so far. We will build a more proactive relationship with key influencers such as local politicians, media and academics to raise the profile of the ESBT Alliance.

As the ESBT Alliance, we recognise that alongside our shared priorities, there are also organisational ones. With this in mind, where relevant we have indicated actions that are organisation-specific which still support the ESBT Alliance strategy.

Communications and engagement principles

We will adhere to a set of principles. We will build positive, productive and meaningful relationships by:

- Being clear, transparent, accountable, and honest.
- Offering meaningful and diverse opportunities to be involved and feedback on what has happened as a result.
- Working through and with local people, including those that work for our organisations and community groups and voluntary organisations; recognising them as experts and equal partners.
- Using jargon free communications and key messages.
- Developing more digital communications and engagement approaches.
- Going to where people are so that the information and engagement is relevant and meaningful.

Our communications and engagement aims and objectives

Our communications and engagement strategy for 2016-18 outlined our five strategic aims:

1. Facilitate transformation and new care models.
2. Enable co-design.
3. Develop relationships.
4. Empower people in their health and wellbeing.
5. Improve accessible information.

For year two, we will have some specific objectives to help us meet the aims in our strategy:

1. To continue to offer a **diverse range of meaningful opportunities** for involvement and co-production in the development of ESBT and ESBT health and care services.

2. To **gather and publish 'real time' information and stories** from local people about their experiences of ESBT health and care services and use this to continuously improve our work.

3. To be proactive regarding the **involvement of minority and seldom heard groups** with specific work to engage with children and young people.

4. To regularly **tell people what we are doing and what difference this is making** using a range of formats that is free from jargon.

5. To **build a single ESBT Communications and Engagement Team** so that our messages and activities are consistent and joined up.

6. To **continuously evaluate and improve our engagement and communications work**; be open to your feedback and test new ways of working.

The outcome of these objectives will be to build a comprehensive communications and engagement function that realises the triple aims of the Alliance:

- Improve the quality and experience of patient care.
- Improve population health and well-being.
- Ensure system sustainability

1.3. Key audiences for communications and engagement

Audience	Examples of audience type	Messages include	Our tools
Local people	Local people include: • Actively interested people (e.g. people who attend events, volunteers) • Patients, clients and carers and their families • Seldom heard groups – users and likely users of health and care services • The general public	• What it means for me • How to get involved • What it means for the health and care I receive • How I can take control of my health and care • Where I can get the health and care support I need	The ESBT Alliance uses a number of different internal and external communication and engagement methods to reach its various target audiences including: • Engagement events and focus groups • Consultations and surveys • FAQs • Case studies, stories, feedback and testimonials • External channels (non-Alliance events, newsletters, social media pages/accounts etc.) • Blogs • Newsletters • Press releases and PR • Presentations • Websites • Social media/digital platforms • Leaflets/banners/ marketing materials
Partners	Partners include: • Community and Voluntary orgs and public and patient interest groups • Charities, lobby and interest groups • Healthwatch East Sussex • Providers of health and care, including GPs • Media • MPs, Councillors and Health Overview and Scrutiny Committee (HOSC) • National bodies: Regulators, Department of Health, NHS Providers	• How I get involved • What it means for the people I represent • What are the benefits and challenges • What are the improvements • The latest updates • How to help to spread the word (e.g. on my website, in my newsletter)	
Staff	Staff include: • Staff who support and deliver health and care • Staff who support and manage our commissioning functions • General Practice	• What this means for me, including structure and model • How I get involved and feed in ideas • Latest updates • What this means for my patients/service users and how to communicate this • How I talk to others/counterparts across ESBT	

1.4. *Objective 1: To continue to offer a diverse range of meaningful opportunities for involvement and co-production in the development of ESBT and ESBT health and care services*

Action	Further detail (if needed)	Outcome	When	Who
Develop engagement forward plan of ESBT events, events across the Alliance organisations (internal and external), and community events (where appropriate)	• Audit of Alliance events • Develop plan to ensure that each of the events has ESBT woven into it as appropriate • Develop list of key Alliance speakers and speaker notes and presentations • Develop ESBT resources for external events	Consistent ESBT messaging across local community networks	Q1 & 2	ESBT Alliance Comms and Engagement Leads
Implement Communications and Engagement action to support delivery of the General Practice Five Year Forward View	• Engagement and Communication to support implementation of the General Practice Five Year Forward View • Member Engagement and Learning events • Support co-design of the primary care role in new model of care, (across health and care sectors) • Involve primary care in how we develop a new model of care together • Continue strengthening our engagement with GP members • Design evaluation tool	Strengthen communication across primary care and the rest of the system. General Practice inform the new model of care and the role of primary care within that Successful implementation of the GP Forward View	Ongoing	Comms and Engagement Team - CCGs

Agree shared approach to equality and diversity monitoring for events and 'About You' forms	• Undertake review of any existing materials used by ESBT Alliance organisations and update existing templates to reflect shared approach • Review and update Adult Social Care Equality Toolkit in view of the Care Act and ESBT developments • Identify gaps in engagement with protected characteristics and develop inclusion plan	Consistency in approach to equality and diversity and improved information and evidence to inform our work	Q1 & 2	ESBT Alliance Equality Leads
Develop digital engagement plan based on the ESBT digital strategy	• Induct ESBT Digital Officer • Review opportunities for digital engagement • Review ESBT organisational digital presence • Training and support for staff to grow digital approaches • Look at different ways of engaging using digital technologies (as appropriate), online forums, blogs, webinars, interactive presentations, online Q&As, surveys	Improved engagement across digital platforms that will engage greater numbers of people, esp. non-traditional groups	Q2	ESBT Alliance Digital Engagement Officer
Develop a plan to support staff across the Alliance to understand how developments will affect their work and offer the chance to input at key points	• Develop a set of targeted messages and engagement activities aimed at staff • Use existing insight from organisations to segment ESBT newsletter for staff and use central messages for internal staff newsletters • Share materials that explain simply what new projects can offer • Staff engagement using a range of channels to clarify the direction of developments • Ensure alignment with Kent Surrey and Sussex (KSS) Organisational Development work • Ensure messages from workforce/HR are supported by staff engagement work	Retain staff and improve their understanding of the aims of the Alliance and its positive impact, allowing staff to act as ambassadors	Ongoing	ESBT Alliance Staff Engagement Leads

Facilitate Alliance-led conversations across health and social care which develop a shared understanding of what ESBT developments will mean for local people	• Use existing insight from organisations to segment ESBT newsletter • Share materials that explain simply what new projects can offer • Ensure events, workshop and focus groups have a clear focus and outcomes • Develop and refine the Shaping health and care event format based on feedback and insight • Review engagement mechanisms including Public Reference Forum • Regular info to HOSC, local MPs and regulators	Local people have a better experience of engaging with health and social care	Ongoing	ESBT Alliance Comms and Engagement Leads
Develop ambassadors in sectors of the community to help us engage with people who don't know us already.	• Identify those who are keen to act as potential ambassadors for ESBT • Provide info and key messages for them to distribute	Local people leading the change	Ongoing	ESBT Alliance Comms and Engagement Leads
Create a new forum for strategic engagement and co-production as part of the ESBT governance arrangements.	• Finalise partnerships review. • Deliver launch event. • Establish new forum and agree form/function and role in Alliance Governance structure.	Strategic decisions are informed by wider stakeholder involvement.	Q1 and 2	ESCC Adult Social Care

1.5. Objective 2: To collect and publish 'real time' information and stories from local people about their experiences of ESBT health and care services and use this to continuously improve our work

Action	Further detail (if needed)	Outcome	When	Who
Develop publication schedule for feedback/service data	• Collate real time information from providers of health and social care • Make this information meaningful for the public • Develop appropriate mechanisms for publication • Ensure links with work on patient information and performance framework for the Alliance • Ensure targets and objectives can feed into comms and engagement work	Publication offers information about improvement of services and gives local people confidence and choice	Q4	ESBT Alliance Comms and Engagement Team
Develop resource of case studies	• Using different media: quotes, photos, video, vox pop • Use these as the basis for print, web and social media content • Shadow teams	Real life experiences of new services offers confidence to local people	On-going	ESBT Alliance Comms and Engagement Team
ESBT cohort study	• Discuss the possibility of a cohort study, which highlights the impact of ESBT services on a section of the local population, with Healthwatch and the Public Reference Forum	Detailed impact of ESBT changes measured	On-going	ESBT Alliance Comms and Engagement Team

Action	Further detail (if needed)	Outcome	When	Who
Develop feedback mechanisms	• Promote opportunities to offer stories for ESBT newsletter and case studies to teams • Promote clear feedback routes from ESBT service teams about what is working and what isn't • Friends and family test for ESBT services • Review Public Reference Forum contract and process for feedback • Establish relationships with insight and performance teams across ESBT Alliance • Promote stories about how local people's feedback has made a difference	Local people feel that they can have a say about how their services are provided and that they have been listened too	Q2	ESBT Alliance Comms and Engagement Leads
Enhance and promote real people's experiences	• Use diverse people's stories to illustrate key developments in appropriate channels • Offer feedback and updates on people's stories so they can see developments	Illustrate how all local people are impacted by the services that we provide	Q2, 3 & 4	ESBT Alliance Comms and Engagement Leads
Highlight excellent services and staff members	• Highlight external awards won by ESBT staff or services	ESBT is seen as a leader in health and care provision	On-going	ESBT Alliance Staff Engagement Leads

1.6. *Objective 3: To be proactive regarding the involvement of minority and seldom heard groups with specific work to engage with children and young people*

Action	Further Detail (if needed)	Outcome	When	Who
Build good working relationships with community and voluntary sector organisations as well as patient and public interest groups working with minority and seldom heard groups.	• Identify key organisations and establish meetings/joint work as appropriate. • Invite key organisations and groups to be part of decision making forums, events and opportunities. • Be visible and engage with events, activities and forums organised by these stakeholders.	Seldom heard groups are able to participate in the development of ESBT service.	On-going	ESBT Alliance Comms and Engagement Leads
Work with and alongside groups and organisations representing and involving children and young people; including those with special educational needs and disabilities.	• Identify key organisations and groups and develop joint work as appropriate. • Adopt and working within the I-SEND co-production agreement. • Work with the Children and Young People's Participation Team at East Sussex County Council (ESCC) to engage with Youth Forums across the county as well as ESCC Youth Cabinet.	Children and young people's voices are included in the development of ESBT services.	On-going	ESBT Alliance Comms and Engagement Leads
Ensure that all key ESBT events and activities are accessible to minority groups and seldom heard groups.	• Where appropriate ensure accessible facilities including provision for translation and interpreting (including British Sign Language (BSL)) are available. • Ensure that activities are designed to take into account the needs of different people and groups. • Where appropriate go to key stakeholder groups to involve them.	ESBT engagement and communications activities are accessible to all.	Ongoing	ESBT Alliance Comms and Engagement Leads

1.7. *Objective 4: To regularly tell people what we are doing and what difference this is making using a range of formats that is free from jargon*

Action	Further detail (if needed)	Outcome	When	Who
Agree a shared ESBT Alliance Communications and Engagement Toolkit	• Develop key documents; How we describe ourselves, branding and style guidelines, logo policy • Develop principles for co-production • Review the existing CCG Toolkit and ESBT branding guidelines and store in shared place • Agree shared communications and engagement sign off process with accompanying risk examples • Work towards embedding usage across relevant ESBT staff	Consistent approach to communication and engagement enabling wider range of staff to effectively communicate and engage with local people	Q1 & 2	ESBT Alliance Comms and Engagement Leads
Further develop ESBT audience mapping and develop core messages for each of our identified audiences	• Test and refine messages across identified segments • Review and update in line with developments as part of Core Action Group (CAG) • Review effectiveness of consistent approach across organisations • Review current stakeholder list and reflect on our audiences	All our audiences are communicated with and offered opportunities to engage	Q1	ESBT Alliance Comms and Engagement Leads
Co-ordinate regular ESBT e-newsletter sent to segmented audiences (staff, stakeholders and local people)	• Develop and agree content plan and timetable for monthly publication • Monitor and report on segmentation engagement	Audiences receive consistent and engaging information about the development of our work and the impact that it is having	On-going	ESBT Alliance Comms and Engagement Leads
Develop website and social media communications content plan	• Induct new ESBT Digital Communications Officer • Audit of website content and analytics and establish future content principles • Use review of digital outputs across the alliance to inform future plans	Reaching wider numbers of local people, meeting them where they are, making the most of	Q1 & 2	ESBT Alliance Comms and Engagement Leads

Action	Further detail (if needed)	Outcome	When	Who
	• Establish and use list of key digital influencers to support digital outputs and outcomes	digital platforms		
Develop core suite of communications and engagement material (presentation, audience briefings) and agree centrally held briefings and statements for key audience groups on ESBT Alliance	• Review existing ESBT briefings and statements and agree statements for key audiences • Ensure information is updated in line with developments • Test and update all materials based on feedback from key audiences	Consistent approach to communication and engagement	On-going	ESBT Alliance Comms and Engagement Leads
Develop a proactive media and PR plan and tools	• Including case studies to raise the profile of ESBT Alliance • Make strategic links to STP and FYFV where necessary • Joint media lists and media digests • Identify key influencers in the media and academia and proactively engage them as needed	High profile media presence, highlighting the impact of ESBT work	Q1 & 2	ESBT Alliance Comms and Engagement Leads
Ensure ESBT Alliance information meets the NHS and Care Act accessible information standards	• Relevant published information is quality controlled and user tested to ensure it meets the information standard	Our communications and engagement is accessible	On-going	ESBT Alliance Comms and Engagement Leads
Closer links with external engagement channels	• Audit East Sussex-wide non-Alliance communications and engagement channels, like charity newsletters, facebook groups, newspapers, blogs • Regularly target channels as appropriate with key messages	Allow us to reach out to more groups and people we are not directly in contact with	Q2	ESBT Alliance Comms and Engagement Leads
Ensure consistency around the description of the Accountable Care model internally and what that means for staff (and external audiences where appropriate)	• Develop FAQs about the model for staff • Opportunities for staff to feed into the development of the model • Engagement events for staff both before and once model has been decided	ESBT model is understood and clearly articulates how it is meeting the objectives of FYFV	Q1&2	ESBT Alliance Comms and Engagement Leads

Action	Further detail (if needed)	Outcome	When	Who
	• Communicate with key local and national decision makers about the model and how this articulates the objectives in the FYFV and STP	and STP		
Contribute from ESBT Alliance perspective to the STP.	• Develop relationships with policy and comms and engagement staff across the footprint as necessary	ESBT plans fit within the STP narrative		ESBT Alliance Comms and Engagement Leads

1.8. Objective 5: To build a single ESBT Communications and Engagement Team so that are messages and activities are consistent and joined up

Action	Further detail (if needed)	Outcome	When	Who
Develop a communications and engagement team plan, outlining leads in specific areas and an accountability structure	• Alliance communications and engagement workshop in March and second workshop planned for May	Reduce duplication and consistent approach to communication and engagement	Q1	ESBT Alliance Comms and Engagement Leads
Develop risk-based communications sign-off process across our Alliance organisations	• Draft being produced	We are quicker at reacting to developments and risks are managed proactively	Q1	ESBT Alliance Comms and Engagement Leads
Form a combined stakeholder database and Customer Relationship Management (CRM) system	• Review existing organisation records of stakeholders and potential format for use • Review software options for CRM database • Segment ESBT newsletter and other communications based on stakeholder database • Monitor and evaluate effectiveness of stakeholder database and implement CRM database	Reduce duplication and develop consistent approach to communication and engagement	Q3	ESBT Alliance Comms and Engagement Leads
Establish a shared place to store a repository of communications and engagement resources	• Ensure access to Project Place for all key communications and engagement staff • Ensure repository is updated in line with developments	Develop 'corporate memory' for communications and engagement	Q1	ESBT Alliance Comms and Engagement Leads

Action	Further detail (if needed)	Outcome	When	Who
Develop a Communications and Engagement activity forward plan	• Review existing forward plans of engagement including events and planned communications and engagement activity and identify gaps • Encourage input from across organisations	Better coordinated communications and engagement	Ongoing	ESBT Alliance Comms & Engagement Leads
Ensure consistent links with Alliance governance structure inc. stakeholder engagement group and workforce and Human Resources (HR).	• Attendance on working group to develop wellbeing board launch event • Develop methods to link communications and engagement work around ESBT Alliance, including with HR and workforce • Develop influence and feedback mechanism for comms and engagement within high level ESBT structures • Test and review methods	Communications and engagement work reflects the objectives of ESBT and is proactive and planned	Q1	ESBT Alliance Comms and Engagement Leads
Review how we oversee work being carried out by communications and engagement staff across alliance and ways to report to Communications and Engagement Steering Group (CESG)	• Review current CAG meetings' effectiveness and ensure Risk Register still monitored by CESG (then yearly)	Appropriate oversight of out communications and engagement work	Ongoing	C&E staff

1.9. Objective 6: To continuously evaluate and improve our engagement and communications work; be open to your feedback and test new ways of working

Action	Apr-June 2017	Outcome	When	Who
Develop an evaluation framework	• Evaluation indicators based on our ten key principles • Impact our communications and engagement has on local people's experience • Outcomes in delivering these five key aims • Ensure communications and engagement evaluation feeds into the ESBT outcomes framework • Develop communications and engagement to support the ESBT Alliance outcomes framework • Review progress against indicators at CAG and C&E Steering Group • External Patient and Public Engagement view to assess if we're on track • Key deliverables to Accountable Care development group, Board and health and wellbeing board • Develop opportunities to highlight excellent communications and engagement work	Communications and engagement work has clear outcomes and we demonstrate how we are supporting the objectives of ESBT. Communications and engagement work feeds into the outcomes framework	On-going	ESBT Alliance Comms and Engagement Leads

Appendix 2

East Sussex Better Together (ESBT) - Communications and Engagement Strategy – Year Two Action Plan - Community Summary

About this Document

East Sussex Better Together (ESBT) is our ambitious programme to create one fully integrated health and social care system that is focussed on the people it serves.

We are now in the second year of our Communications and Engagement Strategy 2016-18 so our plans this year build on year one but also set out new priorities. You can find full details of the strategy and achievements to date at either of the following links:
http://www.eastbournehailshamandseafordccg.nhs.uk/about-us/plans-and-strategies/
http://www.hastingsandrotherccg.nhs.uk/about-us/plans-and-strategies/

This document summarises our year two plans to involve and communicate with local people, community groups and other organisations in the ESBT area.

You Said

Most importantly this plan has been developed following feedback from representatives of the voluntary sector and local community. They told us that we should:

- **Be more transparent and accountable** and communicate how feedback has influenced decisions and be honest when it has not or cannot.

- **Build a stronger focus on engaging minority and equality groups** (including children and young people) at times and places that are suitable to them and **improve our strategic relationship with the community and voluntary sector** as equal partners.

- **Keep our messaging simple, consistent, joined up and jargon free** so that local people can explain what ESBT is and how it has affected or will affect them and their families.

- **Improve our digital work by** using social media and already established digital forums and groups.

- **Avoid using co-production language** unless this is genuinely possible and meaningful.

- Make the work **relevant and local** by using different approaches at different times and places where people naturally meet, go or get their information and news.

- **Create opportunities for clinicians** to engage and work directly with the public and voluntary sector.

Our Commitments

As a result, we are committing to building positive relationships through:

- Being transparent, accountable, and honest.
- Offering meaningful and diverse opportunities to be involved and feedback on what has happened as a result.
- Working through and with community groups and voluntary organisations; recognising them as experts and equal partners.
- Using jargon free communications and key messages.
- Developing more digital communications and engagement approaches.
- Going to where people are so that the information and engagement is relevant and meaningful.

What we will do

Moving forward our priority actions are:

1. To continue to offer a diverse range of meaningful opportunities for involvement and co-production in the development of ESBT health and care services; ensuring that this includes space for communities to set the agenda for discussions and opportunities for them to work directly with clinicians.

2. To collect and publish 'real time' information and stories from local people about their experiences of ESBT health and care services and use this to continuously improve our work.

3. To be proactive regarding the involvement of minority and seldom heard groups with specific work to engage with children and young people.

4. To regularly tell you what we are doing and what difference this is making using a range of formats that is free from jargon.

5. To build a single ESBT Communications and Engagement Team so that our messages and activities are consistent and joined up.

6. To continuously evaluate and improve our engagement and communications work; be open to your feedback and test new ways of working.