Essex Health and Wellbeing Board

14:00	**Tuesday, 16 July 2013**	**Moot Hall, Colchester Town Hall, High Street, Colchester, CO1 1PJ**,

Quorum:
One quarter of membership and will include:

- At least one Essex County Council elected Member
- At least one Clinical Commissioning Group Representative
- Essex County Council *either* Director of Adults Services, Director for Children's Services or Director for Public Health

Membership:

Councillor David Finch	Essex County Council (Chairman)
Mike Adams	Health Watch
Councillor John Aldridge	Essex County Council
Nick Alston	Essex Police & Crime Commissioner
Sally Burton	Essex County Council
Dr Anil Chopra	Basildon and Brentwood CCG
Councillor Terry Cutmore	District Council
Councillor Ian Davidson	District Council
Jacqui Foile	Voluntary and Crime Sector
Councillor John Galley	District Council
Dr Rob Gerlis	West Essex CCG
Dr Mike Gogarty	Essex County Council
Dr Sunil Gupta	Castle Point and Rochford CCG
Dr Lisa Harrod-Rothwell	Mid Essex CCG
Simon Hart	Independent Chair ESCB & ESAB
Dave Hill	Essex County Council
Joanna Killian	Essex County Council
Councillor David Merchant	District Council
Councillor Ann Naylor	Essex County Council
Andrew Pike	NHS England
Dr Gary Sweeney	North East Essex CCG

For information about the meeting please ask for:
Ann Coldicott, Governance Officer
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Essex County Council and Committees Information

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Part 1

(During consideration of these items the meeting is likely to be open to the press and public)

		Pages
1	**Apologies and Substitution Notices** The Committee Officer to report receipt (if any)	
2	**Minutes of meeting held on 22 May 2013**	**5 - 12**
3	**Declarations of Interest** To note any declarations of interest to be made by Members	
4	**Questions to the Chairman from Members of the Public** The Chairman to respond to any questions relevant to the business of the Panel from members of the public, notice of which has been given in advance.	
5	**Joint Strategic Needs Assessment and Pharmaceutical Needs Assessment** To receive a report by Mike Gogarty - Director of Public Health	**13 - 24**
6a	**Integrated Commissioning Accelerated Design Event** Report by Dave Hill, Executive Director for People Commissioning	**25 - 30**
6b	**Essex Pioneer Expression of Interest** Report by Councillor John Aldridge, Cabinet Member Adult Social Care	**31 - 46**
6c	**Proposal for Use of Sustainability Funding Section 256 2013/14** Report by Dave Hill, Executive Director for People Commissioning	**47 - 78**
7	**"Who Will Care?" Commission** To receive an oral report by Sir Thomas Hughes Hallett.	
8a	**Winterbourne View Stocktake and Progress Update** Report by Sally Burton, Interim Director Adult Social Care	**79 - 108**
8b	**Public Health Grants to the Voluntary and Community Sector Strategy** Report by Dr Mike Gogarty, Director of Public Health	**109 - 112**

9 Date of Next Meeting

To note that the next meeting will be held on

10 Urgent Business

To consider any matter which in the opinion of the Chairman should be considered in public by reason of special circumstances (to be specified) as a matter of urgency.

Exempt Items

(During consideration of these items the meeting is not likely to be open to the press and public)

To consider whether the press and public should be excluded from the meeting during consideration of an agenda item on the grounds that it involves the likely disclosure of exempt information as specified in Part I of Schedule 12A of the Local Government Act 1972 or it being confidential for the purposes of Section 100A(2) of that Act.

In each case, Members are asked to decide whether, in all the circumstances, the public interest in maintaining the exemption (and discussing the matter in private) outweighs the public interest in disclosing the information.

11 Urgent Exempt Business

To consider in private any other matter which in the opinion of the Chairman should be considered by reason of special circumstances (to be specified) as a matter of urgency.

MINUTES OF A MEETING OF THE ESSEX HEALTH AND WELLBEING BOARD HELD AT COUNTY HALL, CHELMSFORD, ON WEDNESDAY 22 MAY 2013

Present:

Members

Councillor David Finch	Essex County Council (Chairman)
Mike Adams	Healthwatch Essex
Councillor John Aldridge	Essex County Council
Dr Kamal Bishai (vice Dr Rob Gerlis)	West Essex CCG
Sally Burton	Essex County Council
Dr Anil Chopra	Basildon and Brentwood CCG
Councillor Terry Cutmore	District Council
Ian Davidson	District Council
Jacqui Foile	Voluntary Sector
Councillor John Galley	District Council
Dr Mike Gogarty	Essex County Council
Dr Sunil Gupta	Castle Point and Rochford CCG
Dr Lisa Harrod-Rothwell	Mid Essex CCG
Dave Hill	Essex County Council
John Mitchell (vice David Marchant)	District Council
Councillor Ann Naylor	Essex County Council
Andrew Pike	NHS England
Dr Gary Sweeney	North East Essex CCG (Vice-Chairman)

Officers

Dr Shane Gordon	Accountable Officer, North East Essex CCG
Clare Hardy	Senior Manager, Health and Wellbeing, Strategic Services
Colin Ismay	Governance Team Manager, Finance
Nick Presmeg	Commissioning and Delivery Director, North East Essex
Loretta Sollars	Senior Policy and Strategy Manager: Adults, Strategic Services

1. Apologies

Apologies were received from:

Nick Alston, Co-opted Member	Essex Police & Crime Commissioner
Simon Hart, Co-opted Member	Independent Chair ESCB and ESAB
Dr Rob Gerlis, with Dr Kamal Bishai as his substitute	West Essex CCG
David Marchant with John Mitchell as his substitute	District Council

2. Chairmanship

In accordance with the Committee's Procedure Rules the Chairman is the Leader of Essex County Council, Councillor David Finch.

3. Appointment of Vice-Chairman

It having been duly moved and seconded it was

Resolved:

That Dr Gary Sweeney be appointed Vice-Chairman.

4. Minutes

The minutes of the meeting of the Shadow Health and Wellbeing Board held on 27 March 2013 were approved as a correct record and signed by the Chairman subject to the first sentence of the second paragraph after the heading Mid Essex in minute 8 (Integrated Plans (including Section 256 agreements)) being amended to read as follows:

"James Roach in introducing the plan explained that it specifically targeted local issues: long-term conditions such as diabetes; urgent care such as the use of 999 calls by care homes and care for the frail; with young people and safeguarding threaded throughout."

5. Declarations of Interest

There were no declarations of interest.

6. Welcome from the new Chairman

The Chairman introduced himself to the meeting as the new Leader of Essex County Council following the County Elections on 2 May. He briefly set out his vision for the County Council going forward, which was about innovation to secure the prosperity of the County and working closely with partners across the County to meet the financial demands facing the public sector.

7. Questions to the Chairman from Members of the Public

Questions, received in writing from Dr Eric Watts DM FRCP FRCPath Dip Hlth Mgt. Dr Watts also attended the meeting.

"How will the Board ensure that the quality and safety standards of community pathology will be maintained?"

I ask this because, at the time of writing there is concern that the proposed arrangements for South Essex may not meet the current standards.

I have specialist knowledge in this area as a retired pathologist but no financial interest. I contributed to Lord Carter's report which has been used as a basis for reconfiguration of services.

I consider that the East of England's competitive tendering process did not include an adequate assessment of the risks in awarding preferred bidder status

and that the lessons learned should be fed back to the National Commissioning Board.

I therefore wish to ask a second question **"Will the Board review the risk assessment process within the East of England's Transforming Pathology Services project to ensure that the dangers of relocating services are adequately addressed in future competitive tendering processes?"**

I have raised this concern directly with the East of England SHA but I do not feel reassured that they appreciate the need for better risk assessment.

Reply

Andrew Pike responded to the question on behalf of the Board. Andrew explained that he had already been in written correspondence with Dr Watts. The contract for this year is still with the Hospitals. No decision has been made on the contract for next year onwards and it is intended to go back to the Health Overview and Scrutiny Committees and the stakeholder groups before a decision is taken. He acknowledged that there were quality issues that needed to be addressed. There were lessons to be learnt for the future in relation to handling reconfigurations on this scale, particularly regarding quality issues and consultation, and a report would be brought to a future meeting of the Board.

On behalf of the Board, Loretta Sollars responded to a number of detailed questions in relation to Agenda item 10 (Outcomes and Evaluation Framework).

8. Protocol for dealing with future questions to the Chairman from Members of the Public

The Board considered a report HWBP/001/13 by Colin Ismay, Secretary to the Board, which set out a procedure for dealing with public questions at meetings of the Board. During the discussion of the item it was made clear that the Chairman had the right to exercise discretion in allowing a question to be put and the procedure would be kept under review to ensure it was fit for purpose.

Resolved:

That the procedure for dealing with public questions at meetings of the Board as set out in report HWB/001/13 be approved.

9. Confirmation of Membership

The Board received a report HWB/002/13 by Clare Hardy, Senior Manager Health and Wellbeing, Essex County Council which set out the latest information on membership of the Board.

Resolved:

That the membership of the Health and Wellbeing Board as set out in report HWB/002/13 be noted.

10. Joint Health and Wellbeing Strategy Outcomes/Evaluation Framework

The Board considered a report HWB/03/13 by Loretta Sollars, Senior Policy and Strategy Manager: Adults Policy and Wellbeing Strategy Service, presenting the Joint Health and Wellbeing Strategy (JHWBS) Evaluation Framework for sign off by the Health and Wellbeing Board.

The Board noted that the Evaluation Framework requested by the Board had been developed to provide a process that would:

- respect the sovereignty of each partner organisation to performance manage its own activities;
- not create an additional or meaningless administrative burden on partners;
- take a holistic approach to assessing the implementation of the strategy – it will include quantitative and qualitative measures and consider the impact on the whole health and wellbeing system in Essex instead of considering selected measures in isolation of their effect on other aspects of the system; and
- secure input to the evaluation and ongoing revisions of the strategy by Board members, partners from the wider stakeholder network and Essex residents.

During the discussion the following points were made.

- Dave Hill emphasised that the Framework had been formulated to enable the Board to focus on Strategy and delivering the Strategy; it was not for the Board to deal with operational issues or focus on detail. Ian Davidson endorsed these comments. He thought "living document" was a useful comment and hoped that the quality of the information in the Joint Strategic Needs Assessment would be maintained.
- Dr Shane Gordon commented that the CCGs are small organisations with large agendas so efficient use needed to be made of their staff's time when planning evaluation work.
- Dr Lisa Harrod-Rothwell commented that more work needed to be done on identifying meaningful indicators for what the Board wanted to measure.
- Councillor Ann Naylor commented that Councillors needed to be kept informed and involved.

Resolved:

That the process and parameters for evaluating the Joint Health and Wellbeing Strategy as set out in the document attached to report HWB/003/13 be approved.

11. Working towards delivering integrated commissioning

The Board considered a report HWB/04/13 by Dave Hill, Executive Director for Schools, Children and Families, Essex County Council, Nick Presmeg, Commissioning and Delivery Director, Essex County Council, and Shane Gordon, Accountable Officer, North East Essex CCG, updating the Board on the progress being made towards delivering integrated commissioning.

The Board was reminded of its duty to encourage integrated working. Significant work was occurring between the Accountable Officers at the CCGs and the commissioning leads at Essex County Council. The annex to the report set out the context to joint commissioning and the priorities and lead commissioning arrangements that had been agreed. The report also set out the next steps which included an accelerated design event.
During the discussion the following points were made.

- Dave Hill commented that as part of the framework for 'Integrated Care and Support: our shared commitment' the Government and partners have put out an expression of interest for Integrated health and social care pioneers. Pioneers will demonstrate the use of ambitious and innovative approaches to delivering integrated care. This is something that will need to be considered.
- Dr Shane Gordon commented that it was necessary going forward to recognise the differences between the CCGs.
- There was some optimism expressed by the CCGs around the progress on integration.
- Councillor Ann Naylor commented that this was new territory and Councillors need to understand what is being done.
- In response to a question from Mike Adams on the work of the Health and Social Care Commission chaired by Sir Thomas Hughes-Hallett and how it sits within the work on integrated commissioning, Dave Hill responded that this was an important point, the work of the Commission is pertinent to the issue and will need to be built in to the work going forward. The Board will have a session on the Commission's recommendations once published. Councillor Terry Cutmore commented that the recommendations should be considered seriously.
- Andrew Pike commented that he was happy to see the report and the progress being made. The matter will be taken to each of the CCG Boards. It will be necessary to keep capturing the governance processes involved and to clarify the role of the Board.
- In response to a question from Ian Davidson regarding the financial challenges, Dave Hill clarified that the proposals assume efficiencies and take account of the work on Community Budgets.
- In response to a question from Ian Davidson regarding Housing, Dave Hill confirmed that Housing was being included in the discussions.

Resolved:

That the progress being made towards delivering integrated commissioning as set out in report HWB/004/13 be noted.

12. Date of next meeting

The Board noted that its next ordinary meeting is scheduled to take place on Tuesday 16 July at 2pm at a venue still to be confirmed.

13. Urgent Business

With the agreement of the Chairman the following matters were taken as items of urgent business.

(a) Urgent Care Capacity Review
Andrew Pike referred to the work which will need to be done to prepare a plan for each CCG.

(b) Voluntary Sector Funding
Dr Gary Sweeney raised the question of funding for the Voluntary Sector, particularly where funding has moved to the County Council from Health. Dave Hill responded that the County Council needed to reach a position quickly and was ready to begin a conversation and to drive in some innovation. The matter will be referred to the Business Management Group to bring a report to a future meeting of the Board.

(c) Delivery of the Winterbourne View Concordat
Reference was made to a letter from Norman Lamb MP regarding the role of health and wellbeing boards in the delivery of the Concordat. The matter will be referred to the Business Management Group.

Chairman
16 July 2013

Report to Health & Wellbeing Board Report of Director of Public Health	**Item: 5** **Reference number HWB/006/13**
Date of meeting 16 July 2013 **Date of report** 3 July 2013	**County Divisions affected by the decision** All divisions
JOINT STRATEGIC NEEDS ASSESSMENT AND PHARMACEUTICAL NEEDS ASSESSMENT	
Report by Director of Public Health **Enquiries to** Duncan Wood, Head of Research & Analysis, ECC, 01245 430051	

1. Purpose of report

1.1 The purpose of this report is to seek the Board's agreement to:

- revising the Joint Strategic Needs Assessment (JSNA) overview reports between now and September, with final versions being published in December; and
- arrangements for producing a Pharmaceutical Needs Assessment (PNA) by March 2015.

1.2 It is proposed that the overview reports for the JSNA will be for:

1. County level
2. City, borough and district level
3. CCG level

2. Recommendations

2.1 Agree the production of the Joint Strategic Needs Assessment reports at
(a) County Level
(b) City, Borough and District Level
(c) Clinical Commissioning Group level
in accordance with the work programme at Annexe A.

2.2 Note the Board's legal duty to produce a single requirement for a single Pharmaceutical Needs Assessment by 31 March 2015.

3. Background and proposal

JSNA - Background

3.1 This report sets out the arrangements for refreshing the strategic JSNA reports – initially by the end of September to support strategic planning, with final copy published in December 2013.

3.2 There are three types of strategic JSNA report:

- A countywide overview
- 12 city, borough or district overviews
- 5 clinical commissioning group overviews

General approach

3.3 The general approach to this task is to produce reports that:

- Are as brief as possible and focused on key issues
- Look at future as well as present need
- Integrate a range of 'voice' data with statistical data
- Consider assets as well as needs
- Distinguish demand from need
- Review evidence of what works and what doesn't
- Consider the impact (of each specific issue) on the whole health and wellbeing system in Essex
- Help policy makers determine priorities

Alignment with the Joint Health & Wellbeing Strategy

3.4 The JSNA reports will be based on the framework provided by the Joint Health and Wellbeing Strategy (ie, three priorities and five cross cutting themes).

3.5 Given that the role of the JSNA is to provide the evidence from which the Strategy is developed, new or emerging data – which may not conveniently fit within these eight topics - will still be included so that it can inform the review of the Strategy itself.

3.6 In addition, the district and CCG overviews will contain the latest performance data for the Strategy's priority indicators so that they can provide a baseline figure against which partners can develop targets and track progress.

Topic reports

3.7 In addition to work on the strategic reports, there is a programme of work on special topic reports. This is shown in Annex A for interest.

JSNA - Proposal

3.8 The proposals for the three sets of reports are as follows.

Countywide overview

3.9 The JSNA planning group proposes to refresh the data and analysis of last year's report, but show this material against the priorities and underpinning themes of the Joint Health & Wellbeing Strategy for Essex published in 2012.

3.10 We will review the potential indicators identified in the section 'Measuring Success'. A key improvement for this year will be to make effective use of performance and cost data in improving the analysis.

3.11 Any newly identified issues will be examined in the report.

3.12 The JSNA countywide report will be used as the basis for the JHWBS progress reports that will set the scene for the in-depth reviews of the Strategy's priorities and themes. The programme of in-depth reviews is being developed with partners so that it will be properly meshed with current partnership activity.

3.13 The outcome of these reviews will then be used to provide feedback to the final version of the JSNA which will be presented to the HWB for sign off at the same time as the Strategy is considered for its annual review.

District overviews

3.14 The district overviews produced in 2012 will be refreshed.

3.15 Public health improvement officers will hold discussions with district councils and their local partnership boards to identify high priority issues and commission more in-depth analysis of these top issues.

CCG overviews

3.16 The reports produced in 2011-12 will be refreshed.

3.17 CCGs have been engaged in planning this development and additional key information synthesis will include:

- Qualitative data with triangulation of locally collated information from different sources (e.g. national NHS survey, local focus groups, etc)
- Detailed analysis on children and young people's needs

- Information relating to CCG-specific nationally defined outcomes and wider health determinants

3.18 However, late publication of some national datasets may impact on our ability to ascertain needs within the local timescale.

PNA - Background

3.19 As a result of the Health & Social Care Act 2012, the Health & Wellbeing Board is now responsible for producing a Pharmaceutical Needs Assessment. This was previously the responsibility of primary care trusts.

3.20 The last PNAs in Essex were produced in December 2011 and PCTs were expected to refresh them once every three years. However, new Ministerial Regulations give Health & Wellbeing Boards until March 2015 to produce their first PNA.

3.21 Government Guidance on PNAs says that:

> "The preparation and consultation on the PNA should take account of the JSNA and other relevant strategies, such as children and young people's plan, the local housing plan and the crime and disorder strategy in order to prevent duplication of work and multiple consultations with health groups, patients and the public. The development of PNAs is a separate duty to that of developing JSNAs as PNAs will inform commissioning decisions by local authorities (public health services from community pharmacies) and by NHS England and clinical commissioning groups (CCGs). HWBs may therefore wish to note that PNAs, as a separate statutory requirement, cannot be subsumed as part of these other documents but can be annexed to them."

3.22 Regulations are much more prescriptive for the PNA than for the JSNA and state that the PNA must include:

- A statement of the pharmaceutical services that the HWB has identified as services that <u>are</u> provided within or outside its area and which are <u>necessary</u> to meet the need for pharmaceutical services in its area
- A statement of the pharmaceutical services that the HWB has identified (if it has) as services that are <u>not</u> provided in the area of the HWB but which the HWB is satisfied <u>need or will need</u> (in specified future circumstances) to be provided (whether or not they are located in the area of the HWB) in order to meet a current need for pharmaceutical services, or pharmaceutical services of a specified type, in its area;
- A statement of the pharmaceutical services that the HWB has identified (if it has) as services that are provided within or outside of its area which although they are <u>not necessary</u> to meet the need for pharmaceutical services in its area, <u>nevertheless have secured improvements, or better access</u>, to pharmaceutical services in its area; or <u>nevertheless affect</u> the assessment by the HWB of the need for pharmaceutical services in its area.

- A statement of the pharmaceutical services that the HWB has identified (if it has) as services that are not provided in the area of the HWB but which the HWB is satisfied would, if they were provided (whether or not they were located in the area of the HWB), secure improvements, or better access, to pharmaceutical services, or pharmaceutical services of a specified type, in its area; or would have the same effect in specified future circumstances
- A statement of any NHS services provided or arranged by a local authority, the NHSCB, a CCG, an NHS trust or an NHS foundation trust to which the HWB has had regard in its assessment, which affect the need for pharmaceutical services, or pharmaceutical services of a specified type, in its area; or whether further provision of pharmaceutical services in its area would secure improvements, or better access, to pharmaceutical services, or pharmaceutical services of a specified type, in its area.
- An explanation of how the assessment has been carried out, and in particular (a) how it has determined what are the localities in its area; (b) how it has taken into account (where applicable) (i) the different needs of different localities in its area, and (ii) the different needs of people in its area who share a protected characteristic; and (c) a report on the consultation that it has undertaken.
- A map that identifies the premises at which pharmaceutical services are provided in the area of the HWB

PNA – Proposal

3.23 The volume of work involved in producing a PNA is considerable, as it has to take account of the economic implications for pharmacy providers as well as the need for pharmaceutical services, and in view of this the Board is asked to agree to the following arrangements:

- Production of a single countywide PNA that nevertheless looks in detail at need and provision locally for pharmaceutical provision
- A consolidation and revision of the PNAs previously produced by the PCTs, with full professional and public consultation as part of this work
- A deadline of having the PNA completed and fully signed off by 31 March 2015

3.24 A project plan has already been drawn up showing in detail how the PNA can be produced based on these assumptions.

4. Policy context

JSNA

4.1 Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies was issued by the Government in March 2013. In introducing the Guidance, the Department of Health states that the purpose of JSNAs and JHWSs is to improve the health and wellbeing outcomes of the local community and reduce inequalities for all ages.

4.2 The Guidance says:

"JSNAs are assessments of the current and future health and social care needs of the local community – these are needs that could be met by the local authority, CCGs, or the NHS CB. JSNAs are produced by health and wellbeing boards, and are unique to each local area. The policy intention is for health and wellbeing boards to also consider wider factors that impact on their communities' health and wellbeing, and local assets that can help to improve outcomes and reduce inequalities. Local areas are free to undertake JSNAs in a way best suited to their local circumstances – there is no template or format that must be used and no mandatory data set to be included."

PNA

4.3 The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 set out the legislative basis for developing and updating PNAs and can be found at: http://www.dh.gov.uk/health/2013/02/pharmaceutical-services-regulations/.

5. Financial Implications

This work should entail no additional costs beyond ordinary operating costs of the relevant stakeholders.

6. Legal Implications

The County Council and the Clinical Commissioning Groups are under a statutory duty to produce a Joint Strategic Needs Assessment through the Health & Wellbeing Board. However, there should be no further legal implications for the Council or the Board of undertaking this work. The Pharmaceutical Needs Assessment will be taken into consideration by the NHS Commissioning Boards when authorising applications from pharmacists to be added to the NHS list.

The Board is under a legal duty to produce a Pharmaceutical Needs Assessment that complies with Regulations in terms of its contents and the way in which it has been produced (eg that appropriate consultations have been undertaken).

7. Staffing and other resource implications

These reports will be produced using existing staff and other resources in the Research and Analysis Unit, Public Health Intelligence Team [need to say who 'the usual contributors' are.

8. Equality and Diversity implications

8.1. In making this decision the Board must have regard to the public sector equality duty (PSED) under s.149 of the Equalities Act 2010, ie have due regard to the need to: A. Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act. B. Advance equality of opportunity between people who share a protected characteristic and those who do not. C. Foster good relations between people who share a protected characteristic and those who do not including tackling prejudice and promoting understanding.

8.2. The protected characteristics are age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

8.3. The PSED is a relevant factor in making this decision but does not impose a duty to achieve the outcomes in s.149, is only one factor that needs to be considered, and may be balanced against other relevant factors.

8.4. This decision was screened for Equality and Diversity issues, and it is considered that the recommendation draw up these documents in this way will not have a disproportionately adverse impact on a protected characteristic. Therefore a Section 2 Equality Impact Assessment is not considered necessary.

8.5 A core purpose of the JSNA is to explore inequalities in health and other circumstances and to review evidence of what works in reducing these inequalities. These inequalities may be defined geographically, socio-economically or in terms of protected characteristics, though data may not always be available in respect of every characteristic. Every effort will be made to break data down to support analysis of inequalities.

8.6 The PNA has to have regard to differing needs of localities and of people with protected characteristics.

9. Background papers

9.1 Annex A gives the current JSNA workplan.

9.2 Existing JSNA reports can be seen on Essex Insight:

http://www.essexinsight.org.uk/grouppage.aspx?groupid=19

9.3 The March 2013 Statutory Guidance on JSNAs can be seen here:

http://healthandcare.dh.gov.uk/jsnas-jhwss-guidance-published/

9.4 Further information on pharmaceutical needs assessments can be found here:

https://www.gov.uk/government/publications/pharmaceutical-needs-assessments-information-pack

JSNA – Work Programme 2013 / 2014

			Timescales			
JSNA Work programme 2013 / 2014	**Lead Officer**	**Comment**	**Scoping**	**Data Gathering**	**Analysis**	**Report Complete**
Countywide Strategic Report	Duncan Wood	This version will inform any revisions to the Essex Health & Wellbeing Strategy and support Commissioning Plans across partner agencies. This will replace (Version 1 - May 2012)	Jun 13	Jul 13	Aug 13	Sep 13
District Strategic Reports.	Duncan Wood	Building on the previous versions (2012), these will give a high level view of key issues for the district and also look at variations across small areas. The portraits will form the basis for discussions with districts about their top priorities. Public health improvement officers should play a major part in shaping these discussions and support local work aimed at reducing health inequalities.	Jun 13	Jul 13	Aug-13	Sep 13
CCG Strategic Reports.	Krishna Ramkhelawon	Building on previous versions (2012) each clinical commissioning group will be provided with a high-level report summarising the key issues facing it. These reports should probably be produced every other year with annual supplements as necessary. The next update will include a broader approach in looking at the wider determinants and further support integrated commissioning.	Jun 13	Jul 13	Aug 13	Sep 13
Pharmaceutical Needs Assessment	Vittoria Polito	The current PNAs that used to cover each of the 5 PCTs in Essex will be reviewed and written to combine the pharmaceutical needs into one document for the area of Essex.	Under Review			
Specialist Topic Reports:						
Strategic Crime Assessment	Duncan Wood/ Gill Butterworth	This Needs Assessment should take a strategic approach to understanding crime in Essex and what can be done about it.	April 2013	May-Jun 13	Jul- Aug 13	September 2013

Homelessness	Tim Elwell-Sutton	Understanding the health needs of homeless people in Essex	Apr 13	May – Jun 13	Jul 13	Aug 13
Early Years & Children's Centres	Vicki James	A needs assessment for children aged 0-11 years across Essex to support the future direction of Children Centres and their work around early intervention and prevention. The needs assessment is part of the current review of Children Centre contracts	Jan 13	Feb 13	Mar 13	Mar 13
Loneliness and social isolation	Alan Dawkes & Stephen Simpkin	A review of the literature on social isolation and loneliness and how to address these issues; and the development of a tool for calculating areas of high risk for social isolation and loneliness.	Nov 12	Dec 12	Dec 12	Jan 13
Built environment and the impact on demand for health and social care services	Duncan Wood & Kate Crofts	Scope to be reviewed				
CAHMS and Emotional Wellbeing	Barbara Herts	ECC have commissioned a review of the 2005 CAMHS and emotional wellbeing Needs Assessment	Dec 12	Jan 13	Feb-Mar 13	Apr 13
Leverton Hall	Barbra Herts	ECC are undertaking a new health (physical & mental health) needs assessment for the Leverton Hall Secure Unit.	Dec 12	Jan 13	Feb-Mar 13	April 13
Carers	Stephen Simpkin & Suzanna Yong-Lee	A review of evidence about the number, geographical distribution and needs of carers, based on the ECC Tracker Survey, 2011 Census and DH Carers' Survey. Support for carers is important in helping to manage demand for social care, and for the health and wellbeing of carers. Feeding into Kathryn Chard's Carers Strategy work.	Dec 12	Jan 13		

Autism	Suzanna Yong-Lee	A review of whether prevalence estimates can be improved. Further work may follow on other aspects of the needs of people with autism in due course. This has been requested by both the service commissioner and a relevant community group.	Nov 12	Dec 12	Jan-Mar 13	Apr 13
Residential Care	Stephen Simpkin	Using data to develop a model identifying our social care service users who may be at risk of increased care needs in the immediate future. This includes service users at risk of residential care admission, and increased home care packages.				
Reablement	Stephen Simpkin	Predictive models for reablement social care packages Understanding how to allocate reablement assistance more efficiently so that people who will benefit from it most get it	Completed. Being presented at the International Conference on Integrated Care, Berlin.			
Dementia	TBD	Evaluation of current services				
Information, advice and advocacy	Anna Saunders	Older peoples Planning Group and other user group keen exploring this topic particularly re: changes to the benefits system. Important in feeding into development currently provided by PALS service				Dec 13
Healthcare needs of migrant workers	TBD					
Learning disabilities	TBD	Understanding patterns of health issues for people with learning disabilities				
Stroke	Emma Sanford	Is it cost effective and health effective to develop early supported discharge for stroke survivors?				
Domestic Abuse	Ruth Weir	Building on analysis needed for the final business case for Whole Essex community Budget				
Reoffending	Ruth Weir	Building on analysis needed for the final business case for Whole Essex community Budget				

Report to Health & Wellbeing Board **Report of Dave Hill, Executive Director for People Commissioning**	**Item: 6a** **Reference number HWB/007/13**
Date of meeting 16 July 2013 **Date of report** *3 July 2013*	**County Divisions affected by the decision** *All Divisions*
Integrated Commissioning – Accelerated Design Event	
Report by *Keith Cheesman, Portfolio Manager, People Commissioning, ECC* **Enquiries to** *Keith Cheesman*	

1. Purpose of report

1.1. To update the Health & Wellbeing Board on the progress to develop integrated commissioning and the outputs of the Accelerated Design Event.

1.2. For the Health & Wellbeing Board to endorse the outcomes of the Accelerated Design Event.

2. Recommendations

2.1. To endorse the outputs of the accelerated design event including:

- citizen and commissioner visions developed through the accelerated design event as set out in 3.2
- the commissioning ambition and approach as set out in 3.3

2.2 To sign up to the values set out in 3.4 and be prepared to be held to account/ to hold each other to account for these values.

3. Background and Outcomes

3.1. Accelerated Design Event

At the Health & Wellbeing Board on the 22nd May, members were informed that we would be holding a systems accelerated design event to really explore and develop key elements of our integration programme. The two day Accelerated Design Event was held on the 18th and 19th June 2013 and involved senior leaders from Essex County Council, the five Clinical Commissioning Groups, NHS England Local Area Team, Health and Social Care Service Providers, District Councils and Voluntary Sector organisations.

Agreement was reached at the event regarding:

- Our vision for service users and for commissioning
- Our collective ambition for commissioning
- How we want to work together
- Identified priority areas for service redesign and developed plans around them
- Identified key barriers and strategies for overcoming

3.2. Our Vision

Our vision for patients, service users and the people of Essex is for a system of care which is designed with them at the centre. We agreed on 6 overarching vision statements for the people who receive care and support in Essex:

- We commission and deliver integrated care that is person centred
- The care we deliver will be consistent in quality with an appropriate response across the whole of the County
- We are able to predict and prevent needs including proactively identifying long term needs
- Our responses will be delivered in a timely fashion. We should be available 24 hours where appropriate
- We will be fair in delivering care. This means being ‘uniform’ across our patients and service user groups
- Our care will take account of the wider context of people’s lives including their families, carers and communities

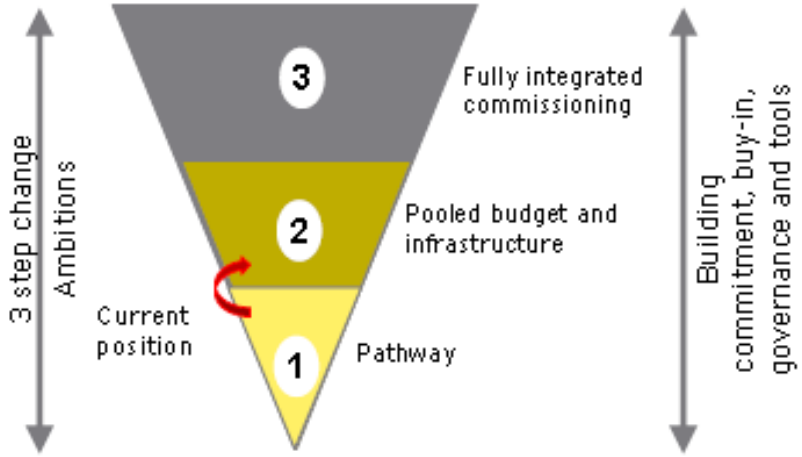
These statements have significant implication for how care is commissioned. On the basis of the above statements, we identified five statements on our vision for commissioning:

- We will practice outcomes based commissioning on the basis of robust evidence and strong analysis, identifying clear triggers for interventions
- We will have a commissioning strategy for the whole of Essex which aims to provide care that is sustainable over the long term
- We will consistently engage with providers to manage markets and aim to reduce the number of providers responsible for delivering the pathway(s)
- We will align budgets and finances to where they can have the most impact, integrating resources where necessary
- We will incentivise provider behaviour which aligns to our overall strategy

We are now looking for the Health & Wellbeing Board to endorse these visions.

3.3. Our collective ambition for commissioning

The event agreed a collective ambition for integrated commissioning. This was based upon a desire to push for the greatest possible integration with single budget, workforce and outcomes but acknowledged that complete integration is probably not viable as we need to respect organisational structures and democratic accountability. It was also recognised that a plural approach then enables us to work at different levels within the system and would balance the range of needs. Thinking developed into a phasing approach to integration.



3.4. How we want to work together

A core objective of the event was to build relationships and redefine the way we work together. A set of behavioural values was agreed which we are now asking partners to commit to living in their interactions with each other:

- Trusted
- Honest
- Collaborative
- Pragmatic
- Disruptive

We also agreed that spending time together to enable relationships to continue to grow was key and follow the design event the HWB Business Management Group has set aside unstructured time on a fortnightly basis to focus on live issues and focus on overcoming barriers. It was also agreed that we would hold a follow up 1 day systems event in the autumn to take stock on progress and ensure momentum.

3.5. Identified priority areas for service redesign and developed plans around them

The design event recognised that if we are to make progress we need to prioritise key areas of activity. Older People/ Frailty and Learning Disabilities emerged as the key priority areas for accelerated focus. The remaining areas identified in the Integrated Plans will continue at the earliest possible opportunity.

On the frailty pathway health and social care are challenged by the increase in demand due to demographic changes and increasing frailty. Our acute services don't have capacity to respond and we need to improve access and availability of community based services supported by empowerment in our communities.

Learning disability is an area of great financial challenge within Essex, we have been on a personalisation journey to independence and now we need to ensure the financial stability of this approach.

Project plans for these areas are now in development.

3.6. Identified key barriers and strategies for overcoming

The design event explored barriers around 4 keys areas of sovereignty, credibility, priority areas and infrastructure. The issue around priorities commenced at the event with the agreement to focus on older people/ frailty and learning disabilities. Elements of the sovereignty were considered through the partnership commissioning structure; however to enable us to progress it was felt that a new leadership and decision making model were required. It was recognised that on credibility we need to build on this with:

- the people of Essex as our patients and service users;
- the staff throughout the system who will be delivering our visions; and
- with providers;

as integrated commissioning is an enabler to integrated provision. On infrastructure we focus on information sharing and commissioning support. High-level strategies were discussed on each of these areas and we are now organising workshop sessions to get into the detail of how we can take these forward as programmes of work.

3.7. Governance and integration project reporting:

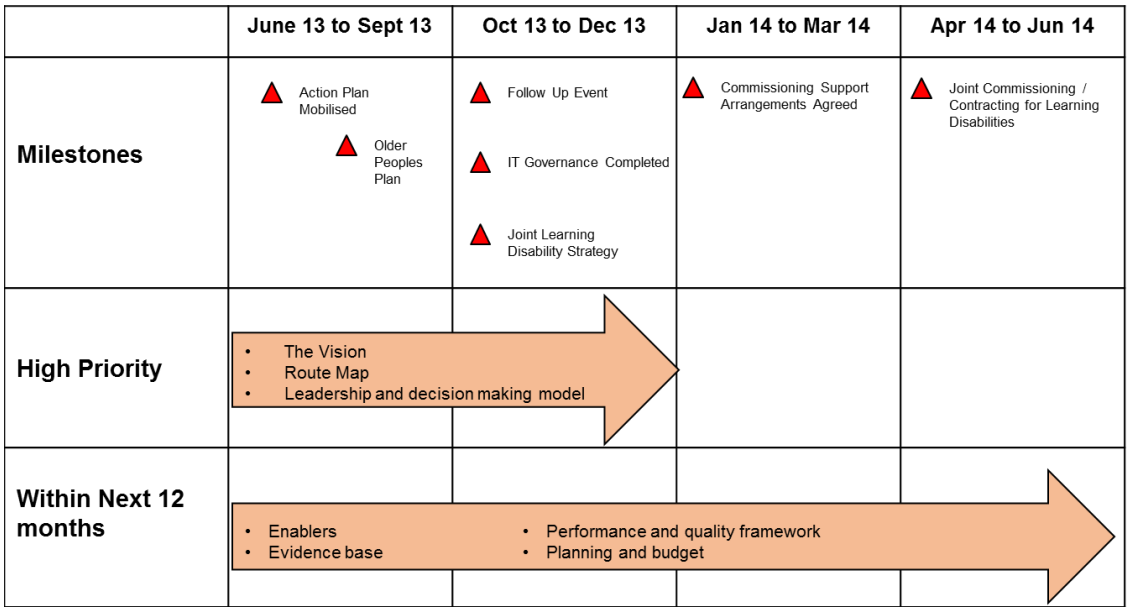
The commissioning structure outlined in the Integrated Plans was reviewed during the design event and overall there was broad agreement around the current arrangements, with a couple of minor issues for the Business Management Group to resolve.

Our integration projects will all follow the key integration priorities that were identified during the Integrated Planning process. It is envisaged that individual projects will either involve single Clinical Commissioning Groups and Essex County Council or combined system levels groups of Clinical Commissioning Groups and Essex County Council. Each project will progress through the governance arrangements of each sovereign organisation for any authorisations required but will be co-ordinated through the Integrated Commissioning Programme Management Board (Health and Wellbeing Board Business Management Group) and project reports on overall progress will be presented to the Health & Wellbeing Board with exception reporting on specific issues.

As identified through the barriers work we need to explore a new leadership and decision making model to facilitate more efficient governance for the future.

3.8. Milestones and next steps:

Accelerated Design Event Key Milestones and Actions



The high level programme plan came out of the design event. Further work is now developing on the project plans for older people/ frailty and learning disabilities and workshop sessions to further explore the barriers and agree a set of shared outcomes are being organised.

Conversations on resourcing this programme of work and the programme office need to take place.

The County Council has also progressed with its commissioning arrangements, as part of its Transformation Mark 2 programme. The formal recruitment process has taken place, involving the County Council and Clinical Commissioning Group leader's and has resulted in offers being made to four Integrated Commissioning Directors who will report to the Executive Director of People Commissioning. The Interim Commissioning Director arrangements will continue until the new officers can take up their posts. Commissioners have also been identified to fill the next layer of the council structure and these appointments are also progressing through the HR and recruitment processes.

4. Policy context

4.1. The role and purpose of the Health and Wellbeing Board is to encourage integration and this is the core enabler of the Joint Health & Wellbeing Strategy as well as being at the heart of the organisational plans of the Council and the CCGs.

5. Financial Implications

5.1. Financial implications will emerge from our developing Integration Programme and further decisions will be required. The Business Management Group will need to consider how we will resource this programme of work and the programme office. (Finance to contribute)

6. Legal Implications

6.1. Legal implications will emerge from our developing Integration Programme and further decisions will be required.

7. Staffing and other resource implications

7.1. Appointments set out in 3.8 above are within the County Council's core organisational design. Project and programme resources for the Integration Programme are to be funded from the £5.647m sustainability section 256 funding, which is proposed investment in Integrated Commissioning and whole system transformation between Health and Social Care. Additional resources may be required to address the activities set out in the high level plan at 3.8. A plan and resource requirement will be brought to the Business Management Group of the Health and Wellbeing Board in due course

8. Equality and Diversity implications

8.1. An Equality Impact Assessment will be prepared as part of the Integration Programme requirements.

9. Background papers

Ernst and Young Accelerated Design Event Outputs Document

Essex County Council

Report to Health & Wellbeing Board **Report of** Cllr John Aldridge	**Item 6b** **Reference number HWB/008/13**
Date of meeting 16th July 2013 **Date of report** 2nd July 2013	**County Divisions affected by the decision** All Divisions
Essex Pioneer Expression of Interest	
Report by Cllr John Aldridge, Cabinet Member for Adult Social Care, Essex County Council	
Enquiries to Clare Hardy, Senior Manager: Health & Wellbeing, Essex County Council	

1. Purpose of report

1.1. For the Health & Wellbeing Board to formally consider and endorse the Essex Pioneer expression of interest.

1.2. To seek the Health & Wellbeing Boards views on any additional areas that should be progress through our Integration Programme and contribute to the Pioneer process, if our expression of interest is pursued by the Department of Health.

1.3. To seek the Health & Wellbeing Boards views on any requirements we would need from the Pioneer programme (see paragraphs 3.12 & 3.13).

2. Recommendations

2.1. That the Board endorse the submitted Essex Pioneer submission.

2.2. That the Board consider any further areas that they would recommend should be part of our Integration Programme and could contribute to the next stage of the Pioneer process if our submission progresses.

2.3. That the Board consider any further support we should request from the Pioneer programme to support our work.

3. Background and proposal

3.1. On 14 May 2013 the Department of Health, supported by a range of national health and social care partners, launched a framework document: 'Integrated Care and Support: our shared commitment'. The framework sets out how local areas can use existing structures such as Health and Wellbeing Boards to bring together local authorities, the NHS, care and support providers, education, housing services, public health and others to make further steps towards integration.

3.2. The framework includes an agreed person-centred definition of 'integrated care', developed by National Voices, (a national coalition of health and care charities). National partners have adopted this definition and are asking local areas to sign up to using it too.

3.3. Alongside the publication of this document, the minister announced the desire to see integrated health and social care as the norm by 2018. To support the accelerated development of health and social care integration the government announced an 'Integrated health and social care pioneer' programme.

3.4. Local areas were asked to express an interest in becoming 'pioneers' to act as exemplars, demonstrating the use of ambitious and innovative approaches to efficiently deliver integrated care. Pioneers will need to work across the whole of their local health, public health and care and support systems, and alongside other local authority departments as necessary, to achieve and demonstrate the scale of change that is required. The Government is keen to see pioneers build upon the work started within Community Budgets.

3.5. The benefits from being a pioneer are subject to negotiation but include the allocation of a dedicated account manager who will manage access to:

i. Organisational/development support;
ii. Flexibility to develop local payment systems;
iii. Clarity regarding rules on choice, competition and procurement in an integrated care context;
iv. Employment advice and workforce development;
v. Public engagement expertise;
vi. Data analysis, financial modelling capacity.

3.6. The deadline for submitting expressions of interest was 28 June. The Department of Health originally indicated their intention for there to be 10 pioneers, this may vary depending on quality and there will be further opportunities. The application process stated that submissions should have 'the involvement and support of Health and Wellbeing Boards (as a minimum, by the end of the selection process) will be an essential prerequisite for any area to become a pioneer.' The Department of Health will engage with potential pioneers during July and August to agree the final detail and what the pioneer can offer in terms of support. The final pioneers will be announced in September.

3.7. The Pioneer scheme was raised at the Essex Health & Wellbeing Board on 22 May and through follow up with the members of the Board it was agreed that we would make a submission setting out our developing Integration Programme. Health & Wellbeing Board members were clear that if we participate the programme needs to support our current development plans and not detract us from the journey we have commenced. The Business Management Group was tasked with making this happen.

3.8. The Business Management Group felt the outputs of the accelerated design event on the 18/19th June would provide us with the key elements of our submission; this did however make the deadlines very tight. A submission was developed and sent round to the Health & Wellbeing Board members for support prior to submission on the 28th June.

3.9. Our expression of interest focuses on our current work to develop an accelerated programme of integration that manages the scale of Essex through a plural approach. Developed through the accelerated design event which started with the patient voice, the plural approach enables us to have a county wide programme but explore within that more local models of integration. There is potential to explore different models such as Accountable Lead Provider and Year of Care in different places. We set out that we already have an infrastructure in place through the Health & Wellbeing Board and the Business Management Group and we have a programme office emerging.

3.10. Whilst the HWB provided initial sign off for this submission (copy attached at appendix a), there is an opportunity to consider any areas of omission that we could contribute to our Integration Programme and feed into the next stages of the pioneer process.

3.11. All partners have been clear that the pioneer should support our developing Integration Programme, if the Department of Health are interested in our submission they will engage with us over the summer around what we can offer the programme and how the pioneer can best support us. We need to identify what support we need from the pioneer programme.

3.12. Within the submission we identified the following areas in which we would be looking for the pioneer to support us:

- The application of policy and financial freedoms and flexibilities e.g. around pricing, contracting, competition, data sharing;
- Flexibility of employment;
- The possibilities of revisiting the commissioner/provider split;
- The extended role of primary care and associated contractual freedoms;
- Support in developing our evaluation programmes and local evidence base.

3.13. We would also benefit from additional resources to contribute to the programme office and a commitment from the pioneer programme that it will not involve complex reporting mechanisms which we do not have resource.

4. Policy context

4.1. The purpose of the pioneer programme is to accelerate the development of health and social care integration. The role and purpose of the Health and Wellbeing Board is to encourage integration and this is the core enabler of the Joint Health & Wellbeing Strategy as well as being at the heart of the organisational plans of the Council and the CCGs.

5. Financial Implications

5.1. We are currently at the expression of interest stage and therefore are not committed. Partners are clear that the pioneer needs to add value to our developing Integration Programme and not have additional unfunded resource implications. However it should be noted that there are no additional funds available to support the development of the bid beyond those funds already in budgets.

5.2. Financial implications will emerge from our developing Integration Programme and further decisions will be required.

6. Legal Implications

6.1. We are currently at the expression of interest stage and therefore are not committed. The Department of Health have confirmed that approached developed through pioneers will need to be within the confines of existing legislation as no new primary legislation is planned in this area.

6.2. Legal implications will emerge from our developing Integration Programme and further decisions will be required.

7. Staffing and other resource implications

7.1. We are currently at the expression of interest stage and therefore are not committed. Our Integration Programme has agreed a joint programme management approach, which will also be required for the pioneer, at present the programme office staff are principally from the County Council and we need to consider the scale of programme support required and how this will be fully funded. We may wish to explore with the pioneer programme if that is able to make a contribution to the programme office.

7.2. Further staffing and resource requirements will emerge from the development of our Integrated Programme and further decisions will be required. The Council's new structure has been designed to better support the integration of health, social care and public health.

8. Equality and Diversity implications

8.1. The decision was screened for Equality and Diversity issues and it does not of itself have a disproportionate adverse impact on any equality groups. Our Integration Programme as set out in the pioneer expression of interest is a person-centred approach. As we look to integrate our work around the individuals we will be best placed to respond to their individual needs.

8.2. Our integration work is based upon the needs identified by the Joint Strategic Needs Assessment and prioritised in the Joint Health & Wellbeing Strategy which went through an Equality Impact Assessment. As we develop our Integration Programme further Equality Impact Assessments will be required on the programme as a whole and on individual decisions.

9. Background papers

9.1. Integrated Care and Support: Our Shared Commitment

9.2. National Voices Integrated Care definition

9.3. Pioneer letter

9.4. Joint Health & Wellbeing Strategy

9.5. Whole Essex Community Budgets

Appendix A

Essex Health and Social Care – Pioneers at Scale

Expression of interest – Health & Social Care Integration Pioneer Programme

Within three years, the people of Essex will have single health and social care commissioning and joined up services providing fully personalised care. People will have a better experience of care and we will meet the challenge of our time to manage escalating demands within fiscal constraints.

Councillor David Finch, Chairman, Essex Health and Wellbeing Board

1. Introduction

Our health and social care system is in serious jeopardy. Facing the facts, our older population is expected to reach 28% by 2033. The prevalence of dementia is expected to increase by 38% by 2021. The number of adults with a learning disability supported by Essex has increased by 7% over the last three years, and is likely to increase by 17% by 2030. We have an estimated 332,800 children and young people and this is expected to grow to 361,000 by 2021. Data suggests, not just an increase in the number of people who need care, but also an increase in the number of people and families with complex needs.

Such rising demands, if not managed, create a gap between available budget and demand for Essex County Council services forecast to be £215m by 2016/17. Similarly, over the period, 2013-2017, the five Essex County CCGs face a funding gap of £354m.

All partners are highly motivated and committed to achieving a solution within the next three years. Inspired by the outcomes of integrated care that we have achieved over the last two years, the Essex health and social care system is embarking upon the most ambitious and radical programme in its history. We are agreed that we need an innovative approach to challenge preconceived barriers such as issues of governance and data sharing. As part of the development of our Integration Programme, we held a system wide accelerated design event exploring vision, ambition, priority areas and how we will work together. The senior decision-makers at the event described their ambition to achieve a single budget model of commissioning with a single workforce and single set of outcomes.

The Essex Integration Programme is already in progress with a broad action plan and governance framework. It matches the criteria for Pioneer status and we would maximise the benefits of the Pioneer platform to test radical ideas and navigate the unknown.

In this bid, we explain our three-year Integration Programme, building upon our partnership approach to public service transformation and integration, accelerated through the Whole Essex Community Budget Programme (WECB) that we started as one of four national pilots in 2012.

The following case study from North East Essex offers a strong local example of the person centred approach we are aiming for at scale:

John's story
John is over 70 and has diabetes. One weekend he suffered four falls. On Sunday, his neighbour found him lying on the floor and called an ambulance. While receiving emergency treatment to avoid life-threatening ketoacidosis, John's only concern was to get back home. His wife has Alzheimer's and John is her main carer.

Traditionally, John would have been admitted to hospital, but John lives in an area where there is a "virtual ward", a team or "ward" of nurses working closely with John's GP, all health services, social care and the voluntary sector. Following referral to the virtual ward, John went home and both he and his wife were immediately assessed for health and social care. In addition to the specialist diabetic care John needed, within 48 hours, John and his wife had several service arrangements in place, from outpatient appointments to a new front door lock.

John, who admitted that, until the virtual ward, he thought he would "walk off the pier", tells the story of how his life turned around in a video at the following link:
http://www.youtube.com/watch?v=vzhmJTkMqww

Current outcomes evidence from the Integrated Health and Social Care Pilot for Older Adults (Virtual Ward) in North East Essex:

- Excellent individual and family feedback on their experience of personalised care and involvement in decisions;
- 19% reduction in avoidable hospital admissions, which potentially saves £58k a year per 1,000 patients;
- 40% reduction in hospital bed days;
- 17% virtual ward patients already receiving social care found to need reduced social care input, suggesting yearly savings of around £230k per 1,000 people;
- 85% GPs describe better communications between agencies and professionals
- 72% GPs report better care for long term conditions.

2. The Essex Vision for Integrated Care – a complex, multi-level, three-year programme

We have a vision of a service that anticipates needs and avoids crises; that is delivered through a partnership with shared responsibilities between the person and their service providers; a service that is free from systematic and professional constraints.

2.1 A plural approach
The locality characteristics and diversity in Essex lead to different solutions in different contexts. Already through integrated health and social care plans at CCG level, transformation is exploring, for example; a lead provider approach, Year of Care model, liberating primary care and a step-wise transition from joint to single budget commissioning.

The aim is to develop several pioneering models of integration within a three-year, system-wide programme. This is led strategically by the Essex Health and Wellbeing

Board (HWB), with its Executive Group providing operational leadership, monitoring and evaluation.

Models will include health, social care, mental health and public health and will sit within our wider partnership vision developed through the WECB pilot: '*To create a vibrant, prosperous place with resilient communities who have access to opportunities. Public services will be affordable and play an enabling role, helping people to do more for themselves and others.*'

Some models are developing on a north/south Essex cluster level in partnership with Southend and Thurrock Unitaries. The five Clinical Commissioning Groups (CCGs) in the Essex area each have integrated transformation plans overseen by system leadership groups, which involve both commissioners and providers.

2.2 Outcomes for individuals

Listening to the individual and collective voice of service users, as well as their 'lived experience' of health and social care, we are reminded that, although the majority of professionals are passionate about caring for people, standards of care are variable and often disadvantaged by organisational barriers.

What people will experience in three years' time:

- Pro-active, person-centred care and support taking in the wider context of their lives;
- Consistent quality and continuity between services;
- Early intervention and support that predicts and prevents need;
- Better information, and support to be involved and in control;
- Better health and wellbeing, avoiding the need for hospital and other institutional care.

2.3 Outcomes for commissioners

Essex has already made good progress, learning for example from an Essex Health and Social Care Joint Commissioning for Older People project in 2010 and the WECB in 2012, leading to integrated commissioning plans in March 2013.

Having exploited fully the potential of traditional efficiency savings, health and social care leaders are working as one on more radical transformation for bigger impact. We recognise that this will challenge the sovereignty of existing commissioning organisations in order to focus on what is best for service users. The ambition and collective leadership is stronger than it has ever been.

Clare Morris, Chief Officer, West Essex CCG

The CCGs, with Council Commissioners, are well advanced in their thinking. Improved outcomes are already evident, for example from multidisciplinary approaches that make use of funding transfers between social care and health for reablement, early supported discharge and multidisciplinary team assessment.

From our Integration Programme commissioners will achieve within three years:

- Single commissioning based on shared goals and outcomes, supported by better quality evidence and analysis;
- Pooled budgets, shared records and IT systems reducing bureaucracy and duplication;
- Risk and gain sharing;
- Success in managing the market with incentives for providers to integrate, where this creates efficiency.

2.4 Outcomes for providers
Within the first six months of working within our Integration Programme, we will progress with provider integration. Each CCG through its system leadership group is already bringing commissioner and provider partners together at a senior level to develop contracts that incentivise integrated care.

We would wish, through the Pioneer programme, to explore potential flexibilities around primary care contracting, leading to a step change in both operations and culture.

The provider landscape in three years' time:
- Widespread integrated teams wrapped around GPs and service users;
- Coordinated care and care planning;
- Different models including new joint health and social care providers, single provider with a single workforce and lead providers with sub-contractors;
- Single points of access to all services from simple home support, to diagnostics and specialised care;
- Access to all information;
- Co-producing with people, as partners in managing their individual care;
- Emphasis on prevention;
- Fewer providers, but with new entrants including greater use of the third sector.

Dr Sunil Gupta, Essex GP

We would offer the Pioneer programme a unique meta-analysis of a complex system, potentially demonstrating and comparing a range of integrated models in both commissioning and service provision. Essex would, in effect, provide a controlled experiment and evaluation that could translate to national scale.

3. The Essex experience and background

In this section, we highlight the unique benefits of Essex as a Pioneer in terms of:
- The benefits of size, scale and complexity;
- Examples of delivering national pilots at pace and scale;
- Examples of successful integration;
- A preview of an independent commission, led by Sir Thomas Hughes-Hallett, to propose solutions to the challenges facing health and social care in Essex.

3.1 Why Essex – size, scale and complexity
Essex has a population close to 1.4 million. It has 12 district councils, five CCGs and many tiers and geographies within its landscape. In diversity, it has some of the most

affluent and some of the most deprived areas in the country, creating inequalities that are being tackled, there is an 18.6 year difference in life expectancy across the county.

Given its complexity, Essex offers a challenging, but nonetheless vibrant context for testing the benefits of integration. We intend to take advantage of this to develop a plurality of approaches that we can support with agreed design principles, close monitoring and evaluation. Competitive in a cultural sense, Essex offers fertile ground for rapid change. There will be opportunities for partners within localities to learn from each other and to pilot services using a staged approach dependent upon the needs and priorities of each.

3.2 Examples of delivering national pilots at pace and scale

Essex has a proven track record in delivering national pilots at pace and scale, including:

- Whole Essex Community Budget (WECB);
- Healthwatch Essex Pathfinder status;
- Adult Social Care Putting People First Personalisation Pathfinder;
- Clinical Commissioning Group Pathfinders;
- Year of Care Pilots in CCGs;
- Personal Health and Education budget pilots in Special Educational Needs and Children with Disabilities;
- Innovation in social finance and social impact bonds;
- Integrated Support for Families with Complex Needs;
- RSPH Health Promotion and Community Wellbeing award;
- Systems Change pilot run by the Essex Drug and Alcohol Partnership.

Our Integration Programme will be supplemented by findings from the WECB programme and work streams that support the linkages between health and social care and the wider wellbeing agenda. These work streams cover, for example, families with complex needs, the impact of drugs, alcohol and mental health problems on the criminal justice system and strengthening communities to improve and increase resilience. Enablers work includes the role of housing and the importance of engaging Districts in the health and social care agenda. The WECB programme has identified net benefits of £387 million across Essex public services over five years.

3.3 Examples of successful integration

Over the last two years, bespoke pilots have included proactive case finding, crisis response services and accelerated discharge supported by greater investment in reablement services and the section 256 agreements for social care sustainability. We have successfully reshaped hospital discharge in a new pull model resulting in fewer delayed transfers of care.

Such initiatives have contributed to a local evidence base for evaluation and learning. Nationally, there is limited evidence for the financial benefits of integration at scale. We would envisage playing a key role in the development of nationally coherent evidence of benefits realisation.

Current examples of initiatives that we are monitoring include:

- Multidisciplinary teams and single access to assessments, which have already reduced avoidable hospital admissions in mid Essex. The model is being

developed further by Mid Essex CCG in partnership with the district councils and the voluntary sector to achieve affordable, sustainable and flexible health and social care, associated with a reconfiguration of facilities at a local community hospital;

- Exemplar model of Early Supported Discharge for stroke patients in North East Essex. The scheme has halved the number of rehabilitation beds and reduced need for social care from 8.9% (56) stroke patients to 2.7% (14), reducing costs from around £1,033k to £258k p.a. in the first year post-stroke. Savings forecast countywide could be as much as £512k p.a.;

- All-age Disability Strategic Framework led by ECC to drive forward an all–age strategy and investment for disability commissioning;

- Early Intervention teams working with young people to prevent them entering the care system;

- Integrated Support for Families with Complex Needs, providing integrated support to families' intensive needs in mental health, child behaviour and family relationships;

- Personal Health and Education budget pilots in Special Educational Needs and Children with Disabilities;

- Innovation in social finance and Social Impact Bonds driving our multi-systemic therapy programme for young people with complex needs;

- Agreed integrated Mental Health strategy across South Essex including Southend and Thurrock and currently developing one across North Essex.

3.4 Preview of "Who Will Care?", an independent commission for Essex

Led by Sir Thomas Hughes-Hallett and due to report in the early autumn, the commission is offering real, practical solutions to up scaling integrated care. We expect the findings to provide a catalyst to the pace of change.

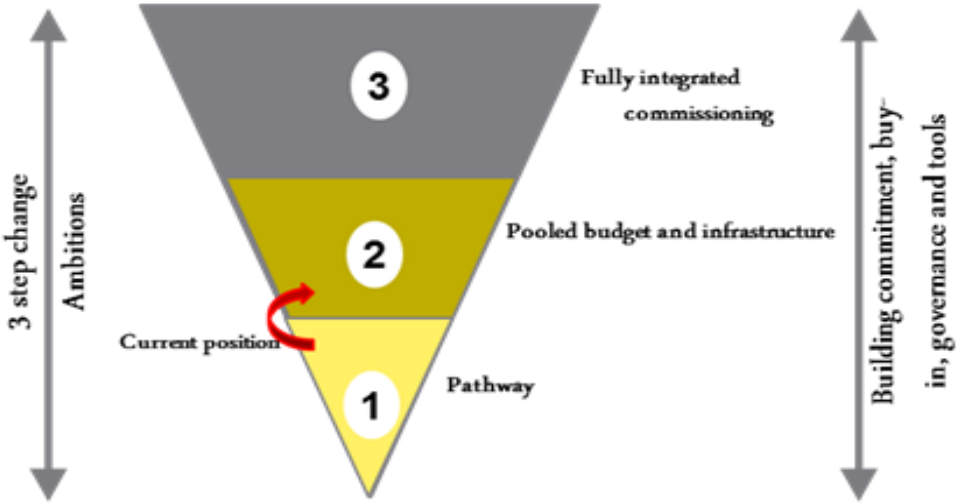
Critical elements of the Commission's thinking include a recasting of the contract between citizen and state, recognising that tax-payer funded services, as currently configured, will soon be unsustainable. Evidence already suggests that, provided they receive clarity about what they can expect, residents recognise the changing realities of public service and are better equipped to deal with them.

The Commission's recommendations are likely to propose ways to clarify the extent of the 'care offer' and support people to take responsibility for their care. It will advise on leadership and accountability to help manage the complexity and cultural issues associated with our Integration programme, and it will include thinking on support for communities and how voluntarism could play a greater role.

4. Delivery and infrastructure

Priorities within our programme have been set to respond to the key risks within the system around capacity in the acute healthcare sector and some of the financial pressures within the community market leading to quality issues.

We have a broad programme framework that begins with frailty and learning disabilities in year one, which will provide a platform for a transition over three years to fully integrated health and social care commissioning with one global budget.



In 2013/14, the Essex HWB endorsed the five CCG integrated plans and a sixth countywide plan which encapsulates the social care and public health alignment.

One example of current developments led by West Essex CCG and partners is a plan to contract on a capitation basis with an accountable lead provider for frailty. This would see the integration of primary, community, mental health and social care around the frailty pathway, led by a single contractor managing a portfolio of sub-contracts, creating a contractual incentive for integrated service provision.

In North East Essex, the forward-thinking GP community is exploring the potential for primary care to lead as a single provider for primary community and social care.

Mid Essex is participating in the national Year of Care scheme, aligning budgets, developing specifications and agreeing shared outcomes.

Promoting safeguarding and protecting the welfare of children, young people and adults is a key component and our commissioning arrangements will ensure all organisations have clear, appropriate and safe procedures in place which reflect government guidance and inspection frameworks linking with the Essex Safeguarding Board procedures policy and practice guidelines.

4.1 Leadership and governance

<u>Established integrated leadership at county level</u>
Our integration programme will be the responsibility of the Essex HWB, and managed by the Board's Executive Group.

The HWB, through its Joint Health and Wellbeing Strategy (JHWBS), has already a vision and commitment to a whole system integrated approach across health, social care, mental health and public health. It has an emphasis on commissioning across a whole life pathway, with a shift to primary and community care settings.

Methods are in place to measure outcomes connected to the national public health, NHS and adult social care outcomes frameworks, and these are included our JHWBS evaluation framework.

We have a ready-made infrastructure, which will include:

- A set of design principles (see below);
- Monitoring, evaluation and analysis;
- Support, research and shared learning;
- Ground breaking advances in shared technology that will start with linked datasets for health and social care and move to universal access.

Achieving the best outcomes for individuals and the best use of resource requires models and solutions of integrated care that demonstrate flexibility. This means identifying what elements of the system are best managed and delivered beyond administrative boundaries and what elements are best managed and delivered locally. We have already had discussions with our partners across the South Essex health and social care economy to identify what parts of the system may require a broader geographical approach - e.g. South Essex or Whole Essex - and how this might best be facilitated.

We are committed to commissioning and delivering integrated care solutions beyond our individual boundaries where it is demonstrated that this is the most effective approach. We are, as a system, self-aware enough to know that there is more to do – as evidenced by the 'Who Will Care?' Commission.

Established integrated leadership at local level

The programme will be structured to support and facilitate five CCGs as the main level for locality leadership. At this level there is already a well-established governance infrastructure where Council Commissioning Directors are members of CCG Boards and a Public Health Consultant is aligned to each CCG. Each CCG has an integrated plan operating within the framework of the Essex JHWBS, endorsed by the HWB.

Commissioners and providers across the whole system of health, social care, mental health and public health engage through the CCG System Leadership Groups to oversee transformation.

Co-production with service users

Healthwatch Essex, working closely with the HWB, will bring the benefits of innovative new methods in engagement, involvement and co-production, drawing on national and international best practice and collaborative links, such as with higher education institutions and the academic health science networks.

At the local level, service users are embedded in transformational change, largely through a new network of patient and public engagement within CCGs and social care, reaching out as far as practice-based patient participation groups.

We are impressed by the research of the national organisation, Patient Voices, in harnessing the power of patients' stories as a training tool for professionals. As part of our work with the Essex Integration programme, we are exploring these storytelling methodologies as aids to innovation and service redesign.

Mike Adams, Chairman, Healthwatch Essex

Programme management
A programme management approach will provide rigour and accountability, but will be designed to encourage flexibility, innovation and empowerment for the frontline – an innovation in itself.

Leadership and Culture
In Essex we recognise that strong relationships between leaders will influence whether we succeed or fail. We have already demonstrated our individual personal commitment to health and social care by organising and participating in the accelerated design event. We were inspired by the stories from other successful integration leaders at this event; as a result in addition to formal business meetings, we have committed to meeting routinely and to invest time in building and maintaining relationships on what we know will at times be a challenging journey.

4.2 Design principles

Transformational plans and developments in integration will be:

- Person-centred and empowering individuals, both service users and professionals;
- Value and needs based;
- Proactive on prevention, early identification and intervention;
- Co-produced with the service user as partner;
- Able to deliver improved outcomes and care quality.

Values:

- Affordable and cost effective;
- Sustainable and long-term;
- Innovative but informed by evidence;
- Shared risk and benefit;
- Effective demand management;
- Honesty, fairness and accountability;
- Continuous learning.

5. Why we need the Pioneer Programme

Essex is fully committed to whole system integration. Our successful track record as a WECB pilot and the significant progress we have made since then through integrated commissioning plans, led by the HWB, and the outcomes of our recent accelerated

design event, make that self-evident. Pioneer status and its access to leading edge thinking would develop further our strong ambitions.

As Pioneers, we would maximise the opportunities offered by other Pioneer areas and the Public Service Transformation Network for support, benchmarking and shared learning. We welcome this research and evaluation framework and potential access to thought leaders and international exemplars. We are keen to take advantage of flexibilities around pricing, employment, competition, contracting and data sharing – even revisiting the commissioner/provider split.

Our Integration Programme aligns well with the Pioneer Programme and we would like to further explore how the programme can support us, with particular interest in:

- The application of policy and financial freedoms and flexibilities e.g. around pricing, contracting, competition, data sharing;
- Flexibility of employment;
- The possibilities of revisiting the commissioner/provider split;
- The extended role of primary care and associated contractual freedoms;
- Support in developing our evaluation programmes and local evidence base.

Our bid for Pioneer status offers to the national programme a grand scale, multi-model, controlled test for the application of integrated commissioning and provision of care.

Furthermore, there is greater confidence than ever before, that Essex now has the relationships and the commitment to develop fully integrated care. The Essex HWB is at the centre of whole system thinking and CCGs, having come through reforms, are already creating a rich ferment of experimental ideas.

We have an infrastructure that can be mobilised immediately and, above all, the ambition and imperative to make integration a reality that will deliver better outcomes for people.

Our integration approach was developed through a systems accelerated design event involving 55 partners. This submission is supported by the Essex Health & Wellbeing Board including: Essex County Council, Healthwatch Essex, Basildon and Brentwood CCG, Castle Point and Rochford CCG, Mid Essex CCG, North East Essex CCG, West Essex CCG, NHS England, Essex Safeguarding Boards, the Children's Partnership Board, representatives of our District Councils and the Essex Police and Crime Commissioner.

Report to Health & Wellbeing Board **Report of Dave Hill, Executive Director for People Commissioning**	**Item 6c** **Reference number HWB/009/13**
Date of meeting 16 July 2013 **Date of report** *2 July 2013*	**County Divisions affected by the decision** *All Divisions*
Proposal for Use of Sustainability Funding Section 256 2013/14	
Report by *Nick Presmeg, Integrated Commissioning Director, ECC* **Enquiries to** *Caroline Fryer*	

1. Purpose of report

1.1. To update the Health & Wellbeing Board on the use of S256 Sustainability funding of £21.187m to be transferred to Essex County Council by NHS England during 2013/14. This includes £15.540m which has been already allocated to ECC base budget to support delivery of services within Social Care, and £5.647m which is proposed to be used to develop Integrated Commissioning and whole system transformation for Health and Social care.

1.2. To retrospectively report allocation of the £15.540m to Essex County Council's base budget for the delivery of Social Care services.

1.3. Agree the proposed approach to use of the additional funding of £5.647m for Integration between Social Care and Health, Transformation and Demand Management Schemes which is intended to address the forecast gap in social care funding over future years.

2. Recommendations

That the Board

2.1. Notes the incorporation of £15.540m funding to Essex County Council's Base budget for the delivery of Social Care services.

2.2. Notes the proposed use of additional £5.647m Sustainability funding to be made available during 2013/14 to support the Integration of Commissioning between Social Care and Health and recommends the Council's Executive to give the necessary approvals.

2.3. Agrees that the Essex County Council Integrated Commissioning Directors will commence discussions with their respective Clinical Commissioning Groups for the specific use of the Demand Management monies (Appendix 2, Schedule 4) in their locality, to ensure that opportunities for system benefits and sustainability are maximised.

3. Background and proposal

3.1. History and context:

3.1.1. Section 256 Sustainability funding transfers occur each year from the NHS to local authorities to contribute to the costs of Adult Social Care, subject to conditions set within Directions from the Department of Health. Funding must be used to support adult social care services in each local authority, which also has a health benefit.

3.1.2. From 2013/14, the funding transfer to local authorities is to be carried out by NHS England.

3.1.3. A decision was taken in 2012 to allocate £15.540m Sustainability funding to ECC Base Budget to support the delivery of Social care services, based on funding announced in previous years.

3.1.4. The allocation to Essex County Council for 2012/13 was £15.540m.

3.1.5. The “Gateway letter” dated 13th Jan 2011 entitled NHS Support for Social Care, stated that the clear intention of the Department of Health was for the funding to be used for social care purposes. The guidance allowed for the investment to be used to support and maintain existing services where “such services or programmes are of benefit to the wider health and care system, provide good outcomes for service users, and would be reduced due to budget pressures in local authorities without this investment”.

3.1.6. The amount to be transferred for 2013/14 was increased to £21.187m towards the end of 2012.

3.1.7. Proposals for use of additional £5.647m funding were discussed with NHS England through the Integrated Planning process, and Clinical Commissioning Groups (CCGs) were informed of our intentions during February and March 2013.

3.2. Health and Wellbeing Board agreement

3.2.1. At the January meeting of the Health & Wellbeing Board, the deployment of Public Health and s256 transfer funds was discussed, and the intention to assist in meeting the goal of jointly managing demand across ECC and CCGs was agreed.

3.2.2. It was proposed that, in addition to funding the programme to integrate commissioning for Social Care and Health, the additional £5.647m Sustainability funding be used to fund demand management schemes:

3.2.2.1. To act as seedbeds for integration alongside projects to be funded from the NHS 2% Transformation Fund

3.2.2.2. To deliver mutual benefits, for example through programmes to address particular areas of need which fall within the 5 strategic priority areas agreed between ECC and Health colleagues and incorporated into the Integrated Plans, for example:

- Consistent frailty pathway supported by joint Multi-Disciplinary Teams
- Alcohol and Falls (ECC Investment)
- Incontinence (CCG Investment)
- Community Nursing (CCG Investment)
- Reablement (ECC Investment)

4. Integrated Planning and development of proposals

4.1.1. Detailed discussions have taken place between Essex County Council and NHS England from February 2013 onwards, taking account of guidance from the Department of Health, the Integrated Plans and feedback from CCGs, to determine how the additional £5.647m funding may be spent to best deliver the objectives jointly agreed with partners.

4.1.2. Proposals for use of the monies, including the £15.540m used to support delivery of Social Care and retrospectively the deployment of funding for Winter Pressures during 2012/13, were discussed and agreed at the North and South NHS Cluster Boards on 26 and 28 March 2013 respectively.

5. Investment 2013/14

5.1. The proposal for the use of the £5.647m for integration, demand management schemes and whole system transformation has been developed based on the Integrated Plans already developed between Essex County Council, NHS England and the Clinical Commissioning Groups. It also takes account of both the existing evidence base and the work carried out by Tricordant during Community Budgets.

5.2. In line with previous discussions and the discussions at the Health and Wellbeing Board, the Essex-wide framework will enable locally integrated planning and commissioning across the following themes:

- Falls Prevention
- Continence Management
- Urgent Care Pathways crisis avoidance and crisis response, long term conditions

- Dementia strategy implementation
- Stroke Pathways

5.3. Some areas of need previously identified will be addressed through demand management initiatives funded separately through Public Health (for example Alcohol Treatment Services).

5.4. CCG alignment with the Local Authority is key, and ECC will continue to liaise with the CCGs to agree the joint framework for delivery. Reducing admissions and readmissions will be a significant focus in the coming year.

5.5. The current list of proposed schemes with costs and potential benefits is set out in Appendix 1. Development of these proposals is under way and details of benefits are yet to be finalised.

6. Strategic Alignment

6.1. Essex County Council has worked in partnership with system partners across Health and Social Care to ensure strategic alignment and organisational priorities within the context of the Health and Wellbeing Strategy which clearly articulates priorities to ensure that people using services:

- Feel safe and exercise maximum choice and control
- Live as independently as possible, as part of a community
- Stay healthy and safe and recover quickly from illness
- Have the best quality of life irrespective of illness or disability
- Retain maximum dignity and respect

6.2. Essex County Council has worked closely with the CCGs and wider system partners to ensure that the investment plans for reablement and adult social care funding align with the expectations of the operating framework and also the strategic vision set out in the Joint Health & Wellbeing Strategy for Essex. It also aligns with the strategy already in place for reablement across the wider system to support people to regain maximum independence.

7. Section 256 Sustainability Agreement

7.1. The Agreement between the NHS England Local Area team (NHS-LAT) and Essex County Council for use of the 2013/14 Sustainability monies is complete and has been attached as Appendix 2. Schedule 4 of the agreement sets out the proposed funding for integration programme funding (including Integration

Director posts), demand management pilots and additional joint schemes which will provide benefits to social care as part of the wider system transformation.

8. Conclusion and next steps

8.1. Development of the Section 256 agreement has taken place within the overall context of the Health and Wellbeing Board discussions and with regard to the evidence base the JSNA, plans for Public Health initiatives and the integrated plans which have been developed and agreed with the five Clinical Commissioning Groups and NHS England.

8.2. The Agreement has been developed in line with original Department of Health guidance, and also the updated guidance issued via the Gateway letter of 19 June 2013 received from NHS England.

8.3. The proposed programme of activity to develop integrated commissioning between Health and Social Care is already under way, with the intention that this is to be funded from the additional £5.647m covered by this agreement.

8.4. It is proposed that the remainder of the £5.647m is invested in a programme of Demand Management schemes and related activity, to be jointly developed between Essex County Council and its Health partners, with the aim of delivering changes to address the forecast gap in funding for social care in future years.

8.5. Following agreement by the Health and Wellbeing Board, and the necessary approvals having been given by the Council's Executive, further planned work will:

- Continue activity to deliver integrated commissioning between ECC and its Health partners
- Complete the schemes to be funded from the S256 monies which are already under way (Colchester Garrison posts, Family Solutions and Strengthening Communities)
- Implement proposals for Demand Management schemes which can address the forecast social care funding gap
- Commence implementation of all schemes by October 2013.

8.6. It is planned that implementation of all S256 funded schemes for the year 2013/14 will have been completed by the end of October 2014.

8.7. Programme activity will be managed by the Business Management Group with progress being reported on a periodic basis and at key milestones to the Health and Wellbeing Board.

9. Policy context

9.1. Guidance recently received from NHS England (via Gateway Letter 00186 dated 19 June 2013) sets out conditions for use of this funding from the Department of Health. NHS England is required to ensure “that the local authority agrees with its health partners how the funding is best used within social care, and the outcomes expected from this investment. Health and Wellbeing Boards will be the forum for discussions between the Area Teams, CCGs and local authorities on how the funding should be spent”

9.2. NHS England “will make it a condition of transfer that local Authorities and CCGs have regard to the Joint Strategic Needs Assessment for their local population, and existing commissioning plans for both health and social care, in how the funding is used.”

9.3. Section 256 funding “can be used to support existing services or transformation programmes, where such services or programmes are of benefit to the wider health and care system, provide good outcomes for service users, and would be reduced due to budget pressures in local authorities without this investment. The funding can also support new services or transformation programmes, again where joint benefit with the health system and positive outcomes for service users have been identified”.

9.4. A copy of the Gateway letter, which contains links to the updated Directions from the Department of Health, is appended to this paper (Appendix 3).

9.5. The proposed use of the S256 funding, for both the £15.540m transferred into ECC Base Budgets, and the use of the additional £5.647m to support Demand Management schemes and Integrated Commissioning between Social Care and Health, was discussed and agreed at the North and South Essex NHS Cluster Boards on 26 and 28 March 2013.

10. Financial Implications

10.1. This is a one year agreement for the funding transfer from the NHS to Social Care in line with the Gateway letter received in December notifying ECC of the 2013/14 allocation of £21.187m.

10.2. The report above details how the funds are to be utilised and the process of negotiation that has taken place between ECC and NHS LAT. The negotiations have included agreeing flexibility around the period over which the increased funds from the 2012/13 base can be utilised. These negotiations have concluded that the funds can be utilised up until September 2014 to reflect the lead in time required to commission some of the services.

11. Legal Implications

11.1. Under S256 (1) and (3) of the National Health Services Act 2006 as amended a Board or a Clinical Commissioning Group may make payments to a local social services authority in furtherance of its social services functions. Such payments must be evidenced by a Memorandum of Transfer otherwise known as a Section 256 Agreement in the prescribed form and taking account of Department of Health Guidance. The attached Agreement meets such requirements

11.2. The body of this report sets out the purpose of the funding and how it will be used.

12. Staffing and other resource implications

12.1. Project and programme resources for the Integration Programme are to be funded from the £5.647m proposed investment in Integrated Commissioning and Whole system transformation between Health and Social Care. Some of these resources are already in place, and work on the programme has commenced.

13. Equality and Diversity implications

13.1. There are no Equality and Diversity implications relating to the agreement as to the use of this funding. Appropriate assessments will be carried out as and when projects are set up to deploy the use of the £5.647m funding to be used for Demand Management schemes.

14. Background papers

14.1. Links to updated Directions from Department of Health as at 19 June 2013:

https://www.gov.uk/government/publications/conditions-for-payments-between-the-nhs-and-local-authorities

https://www.gov.uk/government/publications/funding-transfer-from-the-nhs-to-social-care-2013-to-2014-directions

15. Appendices

15.1. S256 Sustainability Summary of Proposed Schemes 3-7-2013 (Appendix 1)
15.2. Section 256 Sustainability Agreement 2013/14 (Appendix 2)
15.3. Gateway Letter 19 June 2013 (Appendix 3)

Appendix 1

S256 Sustainability Summary of proposed Schemes 3 July 2013

Project Name	Description	Total in year cost £000's	Benefits	Total benefit £000's
Falls – Avoidance and Preventative Measures	Working with third sector (e.g. Age UK and Village Agents) to develop a falls self-risk assessment that focuses primarily on home safety and to deliver an awareness campaign to distribute these assessment	£102	Aim of this project is to inform the service specification and the benefits which it is intended to deliver .	TBC
Integrated Stroke Pathways	Review integrated Early Support Discharge pathways based on the North East model to seek opportunities to secure additional social care savings. This requires social care investment to provide social care input into the pathway.	£264	As a result of the pathway redesign in North West the need for post-stroke social care reduced from 8.9% (n=56) stroke patients to 2.74% (n=14), reducing costs from c. £1,033k to £258k p.a. in the first year post-stroke.	TBC
Test and Learn (April 14-March 15)– inclusion of Physios, Nurse prescribers and OTs in Re-ablement	Procure elements currently not being delivered through current contract – 'community referrals' as a 'test and learn' through an integrated clinically led re-ablement model across Essex from April 14 to March 2015 which includes physios, OTs and nurse prescribers in addition to social care input.	£2,054	Referrals from the community avoid unnecessary hospital admission and people becoming deskilled. Avoid people needing an ongoing social care support package following reablement	£9,947
Home From Hospital	This project is one element of the proposed redesign and intermediate care provision for older people living in Essex, complements current intermediate care options available at the point of discharge	£350	Timely discharge from hospital for OP Reduction in emergency admissions Improvement in health due to improved home conditions, preventing admissions/return to hospital	TBC
Residential Reablement	Maximise the independence of people requiring a further period of reablement in a residential setting and therefore reduce the demand on long term care services.	£550	Gross benefit £850,000, net benefit (saving against interim placement beds) £300,000.	£300
	Total DM Schemes	**£3,320**	**Total DM Schemes**	**£10,247**
Garrison Reablement	Funding posts and support packages at National Reception Centre for injured soldiers	£150	**This is meeting a statutory requirement and will offer preventative benefits against MH, Alcohol, Housing, Telecare**	TBC
Mental Health Enablement Service	Support package to prevent demand for longer term Mental health interventions	£200	**Promote recovery and increasing independence, reduce demand for intensive accommodation based services**	TBC
South Essex Mental Health	Project Management resource	£96	**Project support to implement S Essex Mh strategy**	TBC
West Essex / North Essex System Frail Elderly	Project Management resource	£96	**Project support to develop joint specification to deliver savings in frail elderly pathway**	TBC
WECB Strengthening Communities (community resilience schemes)	Support for community resilience schemes	£250	As per Community Budgets Business Case	TBC
WECB Contribution to Family Solutions	Adult MH workers for Family Solutions multi-disciplinary teams working with families with multiple disadvantage	£250	**As per Community Budgets Business Case**	TBC
	Total Additional schemes	**£1,041**	**Total Additional schemes**	**£0**
Integrated Posts	NHS England Integration Director (Joint Appointment)	£121	**Delivering Integrated Commissioning**	TBC
Integration Programme Resources	Project Management & Financial Analyst resource	£281	**Delivering Integrated Commissioning**	TBC
Support for Transformation and additional programme resources	Development of models and evaluation, planning for pilots in 2014/15, additional programme resources	£884	**Delivering Integrated Commissioning**	TBC
	Total Integration Programme	**£1,286**	**Total Integration Programme**	**£0**
		£5,647	**Current Total**	**£10,247**

DATED 1st April 2013

NHS ENGLAND (1)
(ESSEX AREA TEAM)

and (2)

ESSEX COUNTY COUNCIL

Agreement relating to Transfer of Social Care Monies from NHS England as outlined in the NHS Operating Framework

THIS AGREEMENT is made **1st April 2013**

BETWEEN:

(1) Essex Area Team on behalf of **NHS ENGLAND** of Swift House, Hedgerows Business Park, Colchester Road, Springfield, Chelmsford, Essex CM2 5PF; and

(2) **ESSEX COUNTY COUNCIL** of PO Box 11, County Hall, Chelmsford, Essex CM1 1YS ("**Organisation**");

(together the **"Parties"**).

WHEREAS:

(A) Essex Area Team on behalf of NHS England is empowered by Section 256 of the 2006 Act to make payments to the Organisation in certain circumstances towards expenditure incurred or to be incurred by such Organisation.

(B) Essex Area Team on behalf of NHS England has agreed to make payments to the Organisation to contribute towards or pay the costs of the Scheme.

(C) By resolution of the North Essex Cluster Board dated **26th March 2013** and South Essex Cluster Board dated **28th March 2013** the transfer of funding for the Scheme was recommended pursuant to Section 256 of the 2006 Act.

(D) Essex Area Team on behalf of NHS England is satisfied that this Grant is in accordance with the Act and complies with the Directions.

NOW IT IS HEREBY AGREED as follows:

1 Definitions and Interpretation

1.1 In this Agreement the following expressions shall unless the context otherwise requires have the meanings herein:

"**2006 Act**" means the National Health Service Act 2006;

"**Annual Voucher**" means the statement of compliance with conditions of Grant and expenditure certification as set out in the Schedule 2;

"Directions" means the Directions by the Secretary of State for Health as to the conditions governing payments by health authorities and other bodies under the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000;

"**Financial Year**" means 1 April of one year to 31 March of the following year;

"**Grant**" means the amount of money set out in Schedule 1 payable by NHS England to the Organisation in respect of the Scheme on the understanding that the Organisation will meet the costs of the Scheme to the extent that it is not funded by the grant money;

"**Nominated Officers**" means Andrew Pike (Essex Area Director) and Dave Hill (for the Organisation) or such replacements as may be notified by a Party to the other Party in writing from time to time;

"**Scheme**" means the scheme as more specifically described in Schedule 4.

1.2 The headings in the Agreement are for ease of reference only and shall not affect the construction hereof.

1.3 A reference to any Act of Parliament, Order, Regulation, Statutory Instrument, Directions or the like shall be deemed to include a reference to any amendment or re-enactment of the same.

2 Conditions relating to the Grant

2.1 The Grant shall be paid by NHS England as described in Schedule 1 and if the Grant is to be paid in instalments, in such instalments as described in Schedule 3.

2.2 The Organisation shall submit a completed and certified Annual Voucher to the Director of Finance, Essex Area by no later than the 31st December following the end of each Financial Year.

2.3 The Organisation shall use the Grant:-

2.3.1 in respect of the Scheme;

2.3.2 in such a way as to secure the most efficient and effective use of the amount paid;

2.3.3 in accordance with all relevant legislation and the Directions; and

2.3.4 in accordance with any policies, performance objectives, eligibility criteria and standards set out at Schedule 4.

2.4 The Organisation shall be responsible for the operational management of the Scheme.

2.5 The Organisation shall provide the Essex Area Team with the information detailed in Schedule 5 and access to such other information as NHS England may reasonably request.

2.6 The Essex Area Team and the Organisation shall meet at such intervals as the Parties agree, having regard to the nature of the Scheme, to review the Scheme.

2.7 Any variation to this Agreement or the Scheme must be agreed in writing by an authorised officer of each Party.

2.8 Any complaints in relation to the Scheme shall be notified immediately to the Nominated Officers who shall agree an appropriate course of action to ensure that all such complaints are dealt with appropriately.

3 Authority

3.1 Both Parties warrant that all required approvals and any necessary delegated authority which a Party may be responsible for ensuring, shall be put in place and complied with regarding the execution and performance of this Agreement.

4 Dispute Resolution

4.1 Both Parties agree that it would be in their best interests for any disagreement to be resolved locally as soon as reasonably possible, firstly by the Parties' Nominated Officers or, failing agreement, by the Parties' Chief Executive Officers (or equivalent) or their nominated deputies.

4.2 Failing agreement by Chief Executives (or equivalent) or nominated deputies then the dispute will be referred within five (5) operational days to the Arbitration Service. The outcome of such arbitration will be binding on both Parties.

5 Cancellation and reimbursement

5.1 The Organisation shall inform the Essex Area Team in writing should the Scheme come to an end or the Organisation ceases to carry out those functions in connection with which the Grant is made.

5.2 Should the Scheme come to an end or the Organisation ceases to carry out those functions in connection with which the Grant is made prior to completion of transfer of the Grant, then the Essex Area Team shall be under no obligation to pay the Grant or make further instalments of the Grant.

5.3 In the event the Essex Area Team ceases to pay the Grant or the Organisation is obliged to reimburse the Grant in accordance with this Clause 5, the Essex Area Team and the Organisation shall work together to ensure there is minimal disruption to individuals benefiting from the Scheme.

6 Contracts (Rights of Third Parties) Act 1999

6.1 The Contracts (Rights of Third Parties) Act 1999 shall not apply to this Agreement and nothing in this Agreement shall confer or purport to confer or operate to give any third party any benefit or any right to enforce any term of this Agreement except as expressly provided in this Agreement.

7 Communication

7.1 Any notice to be given by either Party to the other under this Agreement shall be in writing sent to the Nominated Officer of the relevant Party at the address as set out in this Agreement.

8 Governing Law

8.1 This Agreement shall be governed by and construed in accordance with English Law.

Schedule 1
Memorandum of Agreement
Section 256 transfer

Reference number: **[*Insert details*]**

Title of Scheme **Transfer of Social Care Monies from NHS England as outlined in the NHS Operating Framework.**
(the reference number and title of the scheme should give a unique identification of the Scheme)

1. How will the section 256 transfer secure more health gain than an equivalent expenditure of money in the NHS?

1.1 NHS England will transfer £859m nationally from its global allocation to local authorities. The funding is to be used to support "Adult Social Care services which also has a health benefit", as detailed by the Department of Health letter dated 19th December 2012, gateway number 18568 (Appendix 1)

1.2 Towards this aim, the agreement for the transfer is made between the Local Area Team and the organisation. The organisation will use the monies to ensure the sustainability of services which have mutual benefit to health and social care. In line with responsibilities under the Health and Social Care Act, the Essex Area Team is required to ensure that the organisation and clinical commissioning groups have regard to the Joint Strategic Needs Assessment for their local population, and existing commissioning plans for both health and social care, in how the funding is used.

1.3 The organisation and the Essex Area Team will work together during the financial year 2013/14, in conjunction with partners, including the Clinical Commissioning Groups and in line with the guidance. The Health and Wellbeing Board will be the forum for discussions to take place and to jointly agree and implement a programme of work which will include:

- Review the health and social care system to improve care pathways with a view to reducing needs for health and social care interventions, through QIPP
- Put in place appropriate hospital discharge pathways
- Deliver the QIPP programme and the organisation's service plan and budget requirements
- Coordinate with the work streams agreed under the Section 256 agreed between Clinical Commissioning Groups and the organisation for the use of the Reablement monies allocated separately to CCGs by the Department of Health.

2. Description of scheme and relationship to HImP (In the case of revenue transfers, please specify the Scheme for which money is being transferred).

2.1 Funding for social care via the NHS is to mutually benefit social and healthcare services.

2.2 This scheme provides for the transfer of the social care funds to support the sustainability of services for both health and social care and jointly support the agreed priorities for system QIPP priorities.

2.3 The funding will aid the commissioning of a range of services to support the outcomes as detailed in 4 below.

3. Financial details (and timescales):

The amount to be transferred in the financial year 2013/14 is £21,186,856.

1. For the initial £15,540,000 which has been allocated to Base Budget to support Adult Social Care Services, payment will be made in 3 parts as follows:

   The first 40% will be paid on 1 April 2013 or on the seventh working day after the Agreement has received final signoff, whichever is the later. The second payment of 40% will be paid on 1st October 2013. The third payment for the remaining 20% will be paid following an outcomes review on 1st March 2014.

2. For the additional £5,646,856 not allocated to Base Budget, which is to be used over an 18 month period from April 2013 to support integrated working and joint demand management schemes, payment will be made in 3 parts as follows:

   The first 30% will be paid on 1 April 2013 or on the seventh working day after the Agreement has received final signoff, whichever is the later. The second payment of 30% will be paid on 1st October 2013. The third payment for the remaining 40% will be paid no later than 1st March 2014. This arrangement reflects the profile of spend for this part of the sustainability funding.

A new Section 256 for 2014/15 will be completed once confirmation of any funding is received by NHS England.

4. Please state the evidence you will use to indicate that the purposes described at questions 1 & 2 have been secured.

The Organisation will keep proper records in relation to the scheme and will allow NHS England's representatives to inspect all such records and will supply copies on request.
The Parties will have regular meetings for the purpose of discussing the spend, and how it is delivering health and social care benefits in the economy.

<u>Measures of success</u>

The following measures reflect the continuation of the £15,540,000 investment into supporting Social Care base budgets and reflect the jointly commissioned nature of adult social care services. The measures set out below and the metrics set out in schedule 5 are a way to demonstrate improved outcomes for this investment.

(1) Hospitals

Sustained activity in acute finable delayed transfer of care for social care against 2012 activity levels, with the aim of this being zero. This will be assuming the same proportion of Section 2's revoked during the same time period.

Sustained reduction and then stabilisation of non acute community hospital delays for social care against 2012 activity levels, with the aim of this being zero, subject to provision of benchmarking data.

There may be situations where we mutually agree that delays were unavoidable.

The evidence we will seek to obtain:

INPUT	OUTPUT	OUTCOME
Monitoring of the acute and community hospital. - Social care demand will be measured using Section 2 and Section 5 process	Number of delays in social care across both Acute and Community Hospitals. Increased number of Social Care assessments and reviews.	Sustained reduction and stabilisation of social care delayed transfers of care. Discharge in a timely fashion. Sustained reduction and stabilisation of readmissions from social care facilitated discharges. (Monthly data)

(2) Statutory requirements

Meeting our statutory requirements for the increased number of service users arising as a result of demographic pressure, all within the reduced available financial resources.

During the year a transformational programme of work will be jointly developed with partners to ensure that the additional £5,646,856 is appropriately invested in schemes to improve health and social care outcomes in the coming years. It is therefore not possible to precisely define in this agreement what the measures of success would be for this aspect of the investment. Plans for this investment shall be initially agreed by the Health and Wellbeing Board. Progress against outcomes shall be reported to the Health and Wellbeing Board during the period of development and implementation.

For measures of success see Schedule 5.

(3) Variations

Detailed uses of the monies, and any changes to uses should these arise, shall be discussed and agreed at the Business Management Group, which is a sub-committee of the Health and Wellbeing Board. The current terms of reference for the Business Management Group are attached as Appendix 2 to this Agreement.

Schedule 2

Annual Voucher

PART 1 STATEMENT OF GRANT EXPENDITURE FOR THE YEAR [ ]

(if the conditions of the payment have been varied, please explain what the changes are and why they have been made)

Scheme Ref No. and Title of Expenditure Scheme	Revenue Expenditure	Capital Expenditure	Total
	£	£	£

PART 2 STATEMENT OF COMPLIANCE WITH CONDITIONS OF TRANSFER

I certify that the above expenditure has been incurred in accordance with the conditions, including any cost variations, for each scheme agreed by the Essex Area Team in accordance with the Directions made by the Secretary of State under Section 256 of the NHS Act 2006.

Signed ..... Date .....

[*Insert Title of Officer*]
Certificate of Auditor

The Statement of Responsibilities of grant-paying bodies, authorities and appointed auditors in relation to grant claims and returns, issued by the Audit Commission, sets out the respective responsibilities of these parties, and the limitations of our responsibilities as appointed auditors. I/we have:

- examined the entries in this form (which replaces or amends the original submitted to me/us by the authority dated)* and the related accounts and records of the authority in accordance with Certification Instruction A1 prepared by the Audit Commission for its appointed auditors; and

- carried out the tests specified in Certification Instruction HLG03 prepared by the Audit Commission for it's appointed auditors, and I/we have obtained such evidence and explanations as I/we consider necessary.

(Except for the matters raised in the attached qualification letter dated)* I/we have concluded that the entries are

- fairly stated; and
- in accordance with the relevant terms and conditions.

Signature_____Name (block capitals)_____

Date_____

Schedule 3

Grant Monies

In consideration of Essex County Council commencing delivery of services with effect from 1st April 2013, the Essex Area Team will pay Essex County Council a revenue grant of £21,186,856 incorporating £15,540,000 dependent on completion of the outcomes in Schedule 4 and £5,646,856 for funding of Demand Management Schemes and to fund an Integration and whole system transformation, providing the resources to facilitate the wider system transformation of Health and Social Care.

The revenue grant will be paid to Essex County Council in accordance with the terms of this agreement by the Essex Local Area Team or its successors in title.

In this Agreement:

1) Payment of £15,540,000 will be made in 3 parts. The first 40% will be paid on 1st April 2013 or on the seventh day after the Agreement has received final signoff, whichever is the later. The second payment of 40% will be paid on 1st October 2013. The third payment for the remaining 20% will be paid following an outcomes review on 1st March 2014.

2) Payment of £5,646,856 will be made in 3 parts. The first 30% will be paid on 1st April 2013 or on the seventh day after the Agreement has received final signoff, whichever is the later. The second payment of 30% will be paid on 1st October 2013. The third payment for the remaining 40% will be paid no later than 1st March 2014. The agreement in relation to the £5,646,856 is made between the Essex Area Team and the organisation, and the organisation will use the monies to ensure the funding of Demand Management Schemes and to fund an Integration and whole system transformation of Health and Social Care over an 18 month period from 1st April 2013.

Schedule 4

Scheme

Funding for social care via the NHS is to mutually benefit social and healthcare services.

This scheme provides for the transfer of the social care funds to support the sustainability of services for both health and social care and jointly support the agreed priorities for system QIPP priorities, whilst meeting increased population demand.

The funding will aid the commissioning of a range of services to support the outcomes as detailed below.

1. An amount of £15,540,000 which has been allocated to Base Budget to support Adult Social Care Services.
2. An amount of £5,646,856 will be used to fund Demand Management Schemes and to fund an Integration and whole system transformation of Health and Social Care over an 18 month period from 1st April 2013. A schedule of intention for how resources will be spent is shown below:

Sustainability S256 Additional Funding; Proposed Allocation 2013/14		
Funding area/Scheme	Resources	Total Value
Sustainability Schemes:		
S256 funded Demand Management schemes:		
Joint Demand Management schemes	Schemes to be developed with Health for 5 priority areas (Stroke, Urgent Care including MDTs, Dementia, Integrated Falls, Continence)	
Further specific Demand Management schemes (some Test & Learn, some evidence based) to be agreed	Schemes to include: Home from Hospital, Memory Services, Assistive Technology, End of Life, Community Reablement	£3,320,000
Additional schemes:		
Garrison Reablement	Funding posts and support packages at Colchester National Reception Centre for injured soldiers	£150,000
Mental Health Enablement Service	Support package to prevent demand for longer term Mental health interventions	£200,000
South Essex Mental Health	Project Management resource	£95,500
West Essex / North Essex System Frail Elderly	Project Management resource	£95,500
Whole Essex Community Budgets:		
Strengthening Communities	Support for community resilience schemes	£250,000
Family Solutions	Adult MH workers for Family Solutions multi-disciplinary teams working with families with multiple disadvantage	£250,000
Scheme Total Sustainability		£4,361,000
System Transformation & Programme Management:		
Integrated Posts	NHS England Integration Director (Joint Appointment)	£121,000
Integration Programme Resources	Project Management & Financial Analyst resource	£281,000
R & D Support and additional programme resources	Development of models and evaluation, planning for pilots in 2014/15, additional programme resources including communications and specialist R&D skills	£884,000
Integration & Transformation Programme Total		**£1,286,000**
S256 Total Sustainability		**£5,647,000**

There may be variation in value or priority relating to the use of the additional funding for schemes and other integration activity during the 18 month implementation period. If this arises,

the variation(s) will be agreed between the parties via the mechanism detailed in Schedule 1, Section 4 (3) of this agreement and reported to the Health and Wellbeing Board.
The content of the schedule of Demand Management Schemes will have been finalised and all agreed schemes will be in implementation by October 2013.

The Organisation and the Essex Area Team will work together during the financial year 2013/14, in conjunction with partners including the Clinical Commissioning Groups, to jointly agree and implement a programme of work which will:

- Review the health and social care system to improve care pathways with a view to reducing needs for health and social care interventions through QIPP,
- Put in place appropriate hospital discharge pathways,
- Deliver the QIPP programme and the organisation's service plan and budget requirements,
- Coordinate with the work streams agreed under the Section 256 between NHS England for Sustainability monies and the organisation for the use of the Reablement monies allocated to CCG's by the Department of Health.

Success for the investment of £15,540,000 into base budgets for Social Care will be measured via:

(1) Hospitals

Sustained activity in acute finable delayed transfer of care for social care against 2012 activity levels, with the aim of this being zero. This will be assuming the same proportion of Section 2's revoked during the same time period.

A sustained reduction and stabilisation of activity in non acute community hospital delays for social care against 2012 activity levels, with the aim of this being zero, subject to provision of benchmarking data.

There may be situations where we mutually agree that delays were unavoidable.

The evidence we will seek to obtain:

INPUT	OUTPUT	OUTCOME
Monitoring of the acute and community hospital. - Social care demand will be measured using Section 2 and Section 5 process	Number of delays in social care across both Acute and Community Hospitals. Increased number of Social Care assessments and reviews.	Sustained reduction and stabilisation of the number of social care delayed transfers of care. Discharge in a timely fashion. Sustained reduction and stabilisation of readmissions from social care facilitated discharges. (Monthly data)

(2) Statutory requirements

Meeting our statutory requirements for the increased number of service users arising as a result of demographic pressure, all within the reduced available financial resources.

Schedule 5

Management Information

The Organisation will keep proper records in relation to the Scheme and will allow the Essex Area Team representatives to inspect all such records and will supply copies on request and other such information as the Essex Area Team may reasonably request.

The Parties will have regular meetings for the purpose of discussing the spend and how it is delivering Health and Social Care benefits in the economy.

Each of the five Essex County Council localities will have a plan showing the level of activity being undertaken to continue to deliver existing levels of service and performance whilst meeting increased population demand. These locality plans are activity in addition to services provided on a county wide basis. These will be shared by local arrangement with each economy.

Social Care Monies Monitoring Arrangements to Measure Impact 2013/14.

Sustainability Allocation Metrics

Ref	Measure	Adult Social Care Responsibility	Monitoring Mechanism TBA	Comments on reportability	Availability
Maintaining or enhancing quality of life for people with support needs					
ASCOF 1C	Proportion of people using social care who receive self-directed support, and those receiving direct payments	Primary	First meeting end April 2013, and quarterly thereafter		Annual
ASCOF 1E	Proportion of adults with a learning disability in paid employment	Primary	First meeting end April 2013, and quarterly thereafter		Annual
ASCOF 1F	Proportion of adults in contact with secondary mental health services in paid employment	Primary	First meeting end April 2013, and quarterly thereafter		Annual
ASCOF 1H	Proportion of adults in contact with secondary mental health services living independently, with or without support	Primary	First meeting end April 2013, and quarterly thereafter		Annual
Delaying and reducing the need for care and support					

ASCOF 2A	Permanent admissions to residential/ nursing care	Primary	First meeting end April 2013, and quarterly thereafter	To cover ages 18+	Annual
ASCOF 2B (1) (NHSOF 3.6)	The proportion of older people (65 and over) who were still at home 91days after discharge from hospital into rehabilitation services	Primary	First meeting end April 2013, and quarterly thereafter		Annual
ASCOF 2C	Delayed transfers of care from hospital, and those which are attributable to adult social care	Primary for social care attributable DToCs	First meeting end Apri 2013l, and quarterly thereafter		Annual
Local plan measure	New people 65+ in receipt of assistive technology	Primary	First meeting end April 2013, and quarterly thereafter		Monthly
Keeping people safe					
Local plan measure	Protection of vulnerable adults. SOVA cases progressing to investigation	Primary	First meeting end April 2013, and quarterly thereafter		Monthly
AVA data return	Proportion of vulnerable adults referrals which are repeat referrals	Primary	First meeting end April 2013, and quarterly thereafter		Annual
NHSOF 3B	Emergency readmissions within 28 days of discharge from hospital	Contributory	First meeting end April 2013, and quarterly thereafter	This will rely on Health data	

IN WITNESS whereof the parties have signed this Agreement

Signed by……..

on behalf of **NHS ENGLAND**

Title: **Essex Area Director**

Name **Andrew Pike**

Signed by……

on behalf of **ESSEX COUNTY COUNCIL**

Title: **Executive Director, Adult Social Care.**

Name **Dave Hill**

Appendix 1

19 December 2012 ,

Paul Baumann
Chief Financial Officer
NHS Commissioning Board

Gateway reference: 18568

Dear Paul,
Funding transfer from the NHS to social care in 2013/14 – what to expect

1. In the 2011/12 Operating Framework for the NHS in England, the Department set out that PCTs would receive allocations totalling £648 million in 2011/12 and £622 million in 2012/13 to support adult social care. This funding was in addition to the funding for reablement services that was incorporated within recurrent PCT allocations of £150 million in 2011/12 rising to £300 million from 2012/13.

2. From 2013/14, the funding transfer to local authorities will be carried out by the NHS Commissioning Board. This letter provides provisional information on the transfer, how it should be made, and the allocations due to each local authority. This is to help the Board and local authorities prepare for the coming year.

3. In the New Year, the Department will make directions to the Board, under Section 256 (5A)(5B) of the 2006 NHS Act, confirming the details in this letter.

Amount to be transferred

4. For the 2013/14 financial year, the Board will transfer £859 million from its global allocation to local authorities. The amounts to be paid to individual local authorities are set out at Annex A. As per the current PCT-level allocations, the Department has used the adult social care relative needs formulae to determine local authority level amounts.

Legal basis for the transfer

5. The payments are to be made via an agreement under Section 256 of the 2006 NHS Act. The Board will enter into an agreement with each local authority. However, before each agreement is made, certain conditions must be satisfied. These conditions are set out below.

Use of the funding

6. The funding must be used to support adult social care services in each local authority, which also has a health benefit. However, beyond this broad condition, the Department wants to provide flexibility for local areas to determine how this investment in social care services is best used.

7. The Board must therefore make it a condition of the transfer that the local authority agrees with its local health partners how the funding is best used within social care, and the outcomes expected from this investment. Health and wellbeing boards will be the natural place for discussions between the Board, clinical commissioning groups and local authorities on how the funding should be spent, as part of their wider discussions on the use of their total health and care resources.

8. In line with their responsibilities under the Health and Social Care Act, the Board must make it a condition of the transfer that local authorities and clinical commissioning groups have regard to the Joint Strategic Needs Assessment for their local population, and existing commissioning plans for both health and social care, in how the funding is used.

9. The Board must also make it a condition of the transfer that local authorities demonstrate how the funding transfer will make a positive difference to social care services, and outcomes for service users, compared to service plans in the absence of the funding transfer.

10. The Board may use the funding transfer to support existing services or transformation programmes, where such services or programmes are of benefit to the wider health and care system, provide good outcomes for service users, and would be reduced due to budget pressures in local authorities without this investment. The Board may also use the funding transfer to support new services or transformation programmes, again where joint benefit with the health system and positive outcomes for service users have been identified.

11. The *Caring for our future* White Paper also set out that the transfer of funding can be used to cover the small revenue costs to local authorities of the White Paper commitments in 2013/14 (excluding the Guaranteed Income Payments disregard, which is being funded through a grant from the Department of Health). The Board should have regard to this when reaching agreements with local authorities.

Reporting

12. As part of its agreement with local authorities, the Board must ensure that it has access to timely information on how the funding is being used locally, in order to assure itself that the conditions for each funding transfer are being met.

Further considerations

13. The Board must not place any other conditions on the funding transfers without the written agreement of the Department.

14. The directions will be updated in November 2013, for the 2014/15 financial year.

Next Steps

15. We will issue the Directions in the New Year, confirming the above details.

16. I am copying this letter to your Chief Executive, Sir David Nicholson, to Bill McCarthy and to Helen Masding.

Yours sincerely,
Shaun Shaun Gallagher
Director General

Social Care, Local Government and Care Partnerships

Appendix 2

The HWB Business Management Group

Functions:

Creative initiation role

1. Initiate and develop the Joint Strategic Needs Assessment (JSNA) with Public Health and partners.
2. Initiate and coordinate development with partners of the Joint Health and Wellbeing Strategy (JHWBS) based on the JSNA.
3. Coordinate and schedule board business within an agreed integrated business cycle across Greater Essex, including CCG Integrated Plans and Community Budget business cases.
4. Design and run the business of the board (including quality assurance of Board papers).

Strategic assurance role

5. Organise and facilitate strategic assurance reviews with local partnerships.
6. Analyse commissioning plans to ensure alignment with Joint strategy.
7. Align work plans with key related bodies (e.g. including Health Overview and Scrutiny Committee and Healthwatch).
8. Have an overview of the whole system and make internal and external connections (e.g. Essex Public Service Board, Safer Essex Board, local HWB arrangements, Children's Trust, Quality Surveillance Group), signposting enquiries and referring issues to other accountable partners.
9. Develop criteria for the Board to determine whether commissioners have fulfilled their duty to have regard to the JSNA and JHWS within their published commissioning plans and to report accordingly to the NHS Commissioning Board and the County Council on the outcome of their review.
10. Identifying system risks and identifying/managing risks to Board functioning.

Relational, inspirational, connective and coordinative role.

11. Work with system partners regarding system trends and issues, e.g. standards of care in care homes or safeguarding issues, and refer onwards.
12. Coordinate and share existing good practice partnership working in Essex.
13. Engagement of the local HWB arrangements, stakeholders and public in commissioning including service planning, design, evaluation and performance management.
14. Communications planning and coordinating delivery of key messages and responding to requests.

Membership:

The membership for the Business Management Group would include: Accountable Officers from the 5 Essex CCGs, Essex County Council's Directors of Adult Social Care (DASS), Children's Services (DCS) and Public Health (DPH), NHS CB Local Area Team, Healthwatch officer and HWB secretariat officer.

This would link to the membership of the Integrated Commissioning system design group which would also include the Southend and Thurrock CCGs and Southend and Thurrock DCS, DASS and DPH. The Essex HWB Business Management Group would meet monthly, one month virtually, the other physical. The physical meetings could be timed to align with the Design group given to similar membership. Ideally the Business Management Group will meet 2-3 weeks before each Health & Wellbeing Board meeting.

Gateway Reference: 00186

Financial Strategy & Allocations
Finance Directorate
Quarry House
Leeds
LS2 7UE

Email address – england.finance@nhs.net
Telephone Number – 0113 82 50779

To:
Area Team Finance Directors
CCG Clinical Leads
CCG Accountable Officers

19 June 2013

Dear Colleagues

Re: Funding Transfer from NHS England to social care – 2013/14

1. With reference to the letter of 19 December 2012 from the Department of Health to Paul Baumann (DH Gateway Reference 18568), funding to support adult social care has been passed to NHS England as part of the 2013/14 Mandate.

2. This letter provides information on the transfer to local authorities, how it should be made, and the allocations due to each local authority under Section 256 (5A)(5B) of the 2006 NHS Act. It is noted that decisions may have already been made for the use of the funding and that this letter is formalising such arrangements.

Amount to be transferred

3. For the 2013/14 financial year, NHS England will transfer £859 million from the Mandate to local authorities. We have undertaken an exercise to map all local authorities to NHS England Area Teams, and the amounts to be paid to individual local authorities from the Area Teams are set out at Annex A.

Legal basis for the transfer

4. The payments are to be made via an agreement under Section 256 of the 2006 NHS Act. NHS England will enter into an agreement with each local authority and will be administered by the NHS England Area Teams (and not Clinical Commissioning Groups). Funding from NHS England will only pass over to local authorities once the Section 256 agreement has been signed by both parties.

For reference, please find below the updated Directions, which set out the conditions, Memorandum of Agreement and Annual Vouchers for use:

https://www.gov.uk/government/publications/conditions-for-payments-between-the-nhs-and-local-authorities

https://www.gov.uk/government/publications/funding-transfer-from-the-nhs-to-social-care-2013-to-2014-directions

In summary, before each agreement is made, certain conditions must be satisfied as set out below:

Use of the funding

5. The funding must be used to support adult social care services in each local authority, which also has a health benefit. However, beyond this broad condition, NHS England wants to provide flexibility for local areas to determine how this investment in social care services is best used.

6. The joint local leadership of Clinical Commissioning Groups and local authorities, through the Health and Wellbeing Board, is at the heart of the new health and social care system. NHS England will ensure that the local authority agrees with its local health partners how the funding is best used within social care, and the outcomes expected from this investment. Health and Wellbeing Boards will be the forum for discussions between the Area Teams, CCGs and local authorities on how the funding should be spent.

7. In line with their responsibilities under the Health and Social Care Act, NHS England will make it a condition of the transfer that local authorities and CCGs have regard to the Joint Strategic Needs Assessment for their local population, and existing commissioning plans for both health and social care, in how the funding is used.

8. NHS England will also make it a condition of the transfer that local authorities demonstrate how the funding transfer will make a positive difference to social care services, and outcomes for service users, compared to service plans in the absence of the funding transfer.

9. The funding can be used to support existing services or transformation programmes, where such services or programmes are of benefit to the wider health and care system, provide good outcomes for service users, and would be reduced due to budget pressures in local authorities without this investment. The funding can also support new services or transformation programmes, again where joint benefit with the health system and positive outcomes for service users have been identified.

10. The *Caring for Our Future* White Paper also sets out that the transfer of funding can be used to cover the small revenue costs to local authorities of the White Paper commitments in 2013/14 (excluding the Guaranteed Income Payments disregard, which is being funded through a grant from the Department of Health).

Governance

11. The Area Teams will ensure that the CCG/s and local authority take a joint report to the Health and Wellbeing Board to agree what the funding will be used for, any

measurable outcomes and the agreed monitoring arrangements in each local authority area.

12. The Health & Wellbeing Board then approves the report which has appended to it the agreed Section 256 agreement between the local authority and NHS England. The agreement is signed by both parties.

13. A copy of each signed agreement should be sent to NHS England Finance Allocations Team at england.finance@nhs.net so that a national review of the transfer can be undertaken.

14. Purchase Orders should then be set up by the Area Teams with each Local Authority that will confirm the precise financial arrangements.

Reporting

15. Area Teams will be supplied with specific budget codes to enable them to set up Purchase Orders, monitor the expenditure on this allocation and to drawdown the necessary cash required to pay local authorities on the agreed basis. Area Teams should use their specific cost centre (Annex B) and the local authority sub analysis 2 code (Annex C) to generate their purchase orders (using the non-catalogue request category 'XXX').

16. NHS England will require expenditure plans by local authority to be categorised into the following service areas (Table 1) as agreed with the Department of Health. This will also ensure that we can report on a consolidated NHS England position on adult social care expenditure.

Table 1:

Analysis of the adult social care funding in 2013-14 for transfer to local authorities

Service Areas- 'Purchase of social care'	***Subjective code***
Community equipment and adaptations	52131015
Telecare	52131016
Integrated crisis and rapid response services	52131017
Maintaining eligibility criteria	52131018
Re-ablement services	52131019
Bed-based intermediate care services	52131020
Early supported hospital discharge schemes	52131021
Mental health services	52131022
Other preventative services	52131023
Other social care (please specify)	52131024
Total	

Furthermore, as part of our agreement with local authorities, NHS England will ensure that it has access to timely information (via Health & Wellbeing Boards) on how the funding is being used locally against the overall programme of adult social care

expenditure and the overall outcomes against the plan, in order to assure itself that the conditions for each funding transfer are being met.

Further considerations

17. Area Teams to copy this letter to their local government colleagues.

18. NHS England will not place any other conditions on the funding transfers without the written agreement of the Department of Health.

If you require any further information, please contact Tim Heneghan, Senior Finance Lead, Financial Strategy & Allocation on 0113 82 50779 or email tim.heneghan@nhs.net

Yours sincerely

Sam Higginson
Director of Strategic Finance

Annex A - 2013/14 Funding by local authority & Area Team
Annex B – List of Area Team Cost Centres
Annex C - List of Local Authority Sub Analysis 2 codes

Essex County Council

Report to Health & Wellbeing Board **Report of Sally Burton, Interim Director Adult Social Care**	**Item 8a** **Reference number HWB/010/13**
Date of meeting 16 July 2013 **Date of report 5th July 2013**	**County Divisions affected by the decision:** *All Divisions*
Winterbourne View Stocktake and Progress Update	
Report by: Peter Tempest, Programme Director, Essex County Council	
Enquiries to: Phil Brown, Commissioning Manager, Adult Social Care, Essex County Council	

1. Purpose of report

1.1. This report outlines the progress made against the commitments in the Winterbourne View Concordat. It is accompanied by the Essex submission of the Winterbourne Stocktake.

Local authorities and Clinical Commissioning Groups were required to submit the Stocktake by the 5th July to report on progress against the commitments within the Concordat to the national Winterbourne View Joint Improvement Board.

2. Recommendations

2.1. The chair of the Health and Well Being Board was asked to sign off the Stocktake on behalf of Board to allow submission by the required deadline.

2.2. The Board are asked to confirm this action and acknowledge the progress made so far against the commitments from the Winterbourne View Concordat.

3. Background and proposal

In December 2012, The Department of Health published a comprehensive review of the service failures that led to abuse that took place at the Winterbourne View Hospital entitled “Transforming Care – A national response to Winterbourne View Hospital” with a clear programme of action agreed by a range of stakeholders.

There were no Essex residents placed at Winterbourne View, however there are Essex residents with learning disabilities placed in out of area Independent Hospitals.

Essex has responded proactively. In October 2012, we invited the National Development Team for Inclusion (NDTI) to undertake an external audit of our challenging behaviour services. It did not find any evidence of abuse in the services they visited. A project entitled “Services for people with learning disabilities and behaviours that challenge” has been instigated in partnership with the Essex Clinical Commissioning Groups (CCGs) and the local authorities and CCGs of Southend and Thurrock to implement the audit recommendations.

Safeguarding Essex, on behalf of Essex County Council, has also been proactive, working closely with the Independent Hospitals in Essex for several years to ensure they have robust safeguarding practices in place.

Context

In patient services for people with learning disabilities are commissioned on behalf of the local Clinical Commissioning Groups (CCGs) by the Central Eastern Commissioning Support Unit (CSU). The regional NHS Specialist Commissioning Group (SCG) commission low volume specialist placements where it is more practical to commission on a regional basis rather than a CCG basis. For this group of people the SCG commission Low and Medium Secure accommodation for those who present the greatest risks to themselves and others.

The table below summarises where people are placed and which organisations fund their services.

Location → / Funding Organisation ↓	NHS Placements within Essex	Independent Hospitals within Essex	NHS Placements outside Essex	Independent Hospitals outside Essex	Total
The 3 North Essex CCGs	3	4		1	**8**
The 2 South Essex CCGs		1		2	**3**
Specialist Commissioning Group		11	4	10	**25**
Totals	**3**	**16**	**6**	**11**	**36**

The Essex residents placed outside Essex are either in Norfolk, Southend, Suffolk or Hertfordshire.

There are 5 Independent Hospitals for people with learning disabilities within Essex providing a total of 145 beds. All of these are in North Essex. Only 17 Essex people are placed in these hospitals.

Progress against the commitments from the Winterbourne View Concordat

The table below summarises the key responsibilities for local authorities and Clinical Commissioning Groups from the Winterbourne View Concordat and provides a progress update against these.

Commitments	**Progress**
Identifying people with learning disabilities in NHS funded placements	Registers have been completed of all people with learning disabilities in NHS funded services and these registers were transferred to the CCG's on the 1st April 2013.
Ensuring that these people have a person centred review by June 2013	The 2 CCGs in South Essex commissioned independent support planners to review the people they fund. Personal support plans developed from the reviews were presented to ECC and CCG commissioners on the 20th May 2013. For people in placements funded by the 3 CCGs in North Essex, reviews were undertaken by ECC care managers and a senior Community Nurse. The outcomes of the reviews were presented to commissioners on the 25th June 2013. The SCG completed their reviews in May 2013. Neither the CCGs nor the Council have been involved in these reviews so cannot provide assurance about their quality.
To support those people who do not require in-patient services to move to community based settings by June 2014	In South Essex one person in a CCG funded placement has been identified as having the potential to move from an in-patient service to a community based service over the next 12 months. Six people in CCG funded placements from the 3 North Essex CCGs have been identified as having the potential to move from an in-patient service to a community based service over the next 12 months. The SCG have identified seven people that are ready to be discharged and move to community based settings.
To work together to develop a commissioning strategy to meet the needs of adults, children, and young people with challenging behaviour in their area by April	The project that was instigated following the NDTI audit of Challenging Behaviour services has clear milestones to deliver a commissioning strategy for people with challenging behaviours by April 2014, and to develop local services to avoid future unnecessary

2014; with a strong presumption that this will be supported by pooled budget arrangements.	in-patient admissions. This is a joint project with the Essex CCGs and the local authorities and CCGs of Southend and Thurrock. Carers and service users are fully involved in co-producing the strategy and resulting services.
To work collaboratively with all partners to ensure that safeguarding boards are fully effective in safeguarding people with challenging behaviour.	Safeguarding Essex has worked closely with the Independent Hospitals in Essex providing training and support to ensure they have open and robust safeguarding systems in place. Councillor Aldridge has visited the Hospitals to provide assurance about the safeguarding systems in place between the hospitals and ECC.

A more detailed description of progress can be found in the Winterbourne View Stocktake which accompanies this paper.

4. Policy context

4.1. The Winterbourne View Concordat and the project "Services for people with learning disabilities and behaviours that challenge" are fully consistent with the vision of the Health and Well Being strategy for Essex. In particular:

- supporting individuals in exercising personal choice and control, and influence over the commissioning of relevant services;
- enabling local communities to influence and direct local priorities for better health and wellbeing strengthening their resilience and using community assets to reduce demand;
- promoting integration across the health and social care systems to ensure that services are planned and commissioned in an integrated way where it is beneficial to do so.

5. Financial Implications

5.1. In "Transforming Care – A national response to Winterbourne View Hospital" it clearly states that local authorities will not be disadvantaged if people move from health funded to social care funded placements. The council has been working with the local CCG's to develop financial arrangements to ensure this happens.

- The 3 North Essex CCG's are committed to integrating commissioning for learning disability services with the County Council acting as lead commissioner, supported by an alignment of budgets that will allow people to transfer from health funded services to social care services.
- Whilst similar discussions with the 2 CCG's in South Essex are not as advanced, there is a commitment to ensure that the current health funding for these people is available if they transfer to social care services.

- The Specialist Commissioning Group has not been able to give this reassurance about the placements it commissions and there are no plans for the funding from the SCG to transfer to local authorities or CCGs when people are discharged from in-patient services to CCG funded placements or community based social care services.

5.2. The table below identifies the scale of the potential financial implications to the council and the Essex CCGs if the money is not transferred from the current NHS funding organisation when people move.

Current Funding Organisation ↓	No. of People that could transfer to ECC funded services	Potential cost pressure to ECC	No. of people that may transfer from SCG funded placements to CCG funded placements	Potential cost pressure to CCGS
The 3 North Essex CCGs	6	£1.1m		
Castle Point & Rochford CCG	1	£185k		
SCG Funded Placements	7	£1.3m	3 (2 Mid Essex CCG and 1 West Essex CCG)	£550k (£365k Mid Essex and £185k West Essex)
Total	14	**£2.585m**		**£550k**

Representation has been made to the Secretary of State and to the NHS Regional Area Team about our concerns about the money not transferring from the NHS SCG to local authorities and CCGs. Given the extensive costs and the undertaking given in the 'Transforming Care – a national response to Winterbourne View Hospital', it is essential that any transfers from health to social care are properly funded to meet the costs.

6. Legal Implications

6.1. The Council has statutory duties to safeguard people affect by its operations. This includes responsibilities for people placed by the council, regardless of their location. This stocktake therefore represents a useful assurance that the Council is discharging its duties.

6.2. The primary remit of the Health & Wellbeing Board is to encourage integrated working, prepare a number of statutory documents and ensure commissioning plans are in alignment with the Joint Strategic Needs Assessment and Joint Health & Wellbeing Strategy.

6.3. The Minister wrote to the Chairs of all Health and Wellbeing Boards saying that 'Health and Wellbeing Boards have an opportunity through their role in agreeing the CCG and Local Authority Joint Plans to challenge the level of ambition on the plan and ensure the right clinical and managerial leadership and infrastructure is

in place to deliver the co-produced plan. Health and Wellbeing Boards will, no doubt, also want to take an active interest in how far the other commitments…. particularly those relating to care reviews having been completed by June 2013 have been achieved as well as satisfying themselves that commissioners are working across the health and social care system to provide care and support which does not require people to live in inappropriate institutional settings. It will only be through creative local joint commissioning and pooled budgets working with people who use services, their families, advocacy organisations and carers and other stakeholders (including providers) that we will deliver more joined up services from the NHS and local councils in the future and see real change for this very vulnerable group. Health and Wellbeing Boards are well placed to agree when a pooled budget will be established (if not already) and how it will promote the delivery of integrated care – care that is coordinated and personalised around the needs of individual; which is closer to home and which will lead to a dramatic reduction in the number of in-patient placements and the closure of some large in-patient settings.'

7. Staffing and other resource implications

7.1. The actions are being delivered by existing resources from within the council and the Central Eastern Commissioning Support Unit. It should be noted that delivering the commitments from the Concordat and fulfilling the considerable requirements to report to the Department of Health and the Joint Improvement Board is creating additional pressures on these resources.

8. Equality and Diversity implications

8.1. As this is a progress report no Equality Impact Assessment has been undertaken. However the purpose of the Winterbourne View Concordat is to address the inequalities experienced by people with learning disabilities who display behaviours that challenge or who have additional mental health needs.

9. Background papers

9.1. The Essex submission of the Winterbourne Stocktake is attached. This has also been circulated to the Clinical Commissioning Groups for approval.

Winterbourne View Local Stocktake June 2013: Essex County Council			
Context: Essex County Council (ECC) is working in partnership with 5 CCGs across Essex. The work divides into North Essex (3 CCGs) and South Essex (2 CCGs). In South Essex, ECC is also working in partnership with Southend Borough Council, Southend CCG, Thurrock Council and Thurrock CCG.			
1. Models of partnership	Assessment of current position evidence of work and issues arising	Good practice example (please tick and attach)	Support required
1.1 Are you establishing local arrangements for joint delivery of this programme between the Local Authority and the CCG(s).	1.1 ECC has instigated an Essex wide project entitled "Services for people with behaviours that challenge" with the involvement of the two partner local authorities (Southend & Thurrock), the Essex CSU and Essex CCGs. The project will deliver the requirements of the Winterbourne Action Plan and remodel health and social care service for people with behaviours that challenge. In addition local arrangements are in place between ECC and the CCGs. The Council views the Winterbourne View action plan as part of its overall strategy to review the use of institutional models of care for adults with learning disabilities. Although there are 36 Essex citizens directly affected by the Winterbourne programme, we estimate that there are an additional 250 Essex citizens with challenging behaviours receiving social care services, and 1069 living in registered care. **South Essex:** A South Essex Winterbourne Strategy Group (SEWSG) has been meeting since December 2012 with membership of ECC, Southend & Thurrock local authorities; 4 CCGs (Basildon & Billericay; Castle Point & Rochford, Southend & Thurrock); and	The Project Initiation Document for the project is embedded.	

	the south Essex Commissioning Support Unit. **North Essex:** Similar arrangements are established in north Essex between ECC and the north Essex Commissioning Support Unit to drive the programme forward. The programme is being overseen by an executive board with representation from North Essex CCGs.		
1.2 Are other key partners working with you to support this; if so, who. (Please comment on housing, specialist commissioning & providers).	1.2 The Challenging Behaviour Project also includes representation from Children's commissioners (both ECC and the CCGs via Essex CSU); accommodation commissioners; the 2 specialist LD health provider trusts; Carers; Service Users and Advocacy organisations. Social care providers will be involved at a later date to help co-produce services to respond to the needs identified from the reviews and for others with complex needs. Engagement with the east of England SCG to achieve effective joint commissioning has been problematic. Information on the reviews undertaken by the SCG was received in May simply stating whether the person should stay in a long stay unit rather than providing information on how and why that conclusion had been reached. ECC and the other partners are concerned at the difficulty of having an ongoing, fruitful partnership with the SCG.		
1.3 Have you established a planning function that will support the development of the kind of services needed for those people that have been reviewed and for other people with complex needs.	1.3 The Challenging Behaviour project includes detailed plans to develop a requirements document, service specifications, and a procurement approach to support the development of services to meet the needs of people with behaviours that challenge in		

	Essex.		
1.4 Is the Learning Disability Partnership Board (or alternate arrangement) monitoring and reporting on progress.	1.4 This document has been signed off by the Learning Disability Partnership Board and progress will be reported to the Board throughout the year.		
1.5 Is the Health and Wellbeing Board engaged with local arrangements for delivery and receiving reports on progress.	1.5 A presentation will be made to the H&W Board on the 16th July updating them with progress. The board will receive further progress updates throughout the year.		
1.6 Does the partnership have arrangements in place to resolve differences should they arise.	**1.6 South Essex:** Disputes will be resolved primarily through the SWESG. This group has access to joint senior management fora for escalation of issues which cannot be resolved. **North Essex:** Joint commissioning arrangements are being established between the North Essex CCGs and ECC for learning disability services. An Executive Board is in place to oversee these arrangements and any differences arising from the Winterbourne programme will be escalated to this board.		
1.7 Are accountabilities to local, regional and national bodies clear and understood across the partnership – e.g. HWB Board, NHSE Local Area Teams / CCG fora, clinical partnerships & Safeguarding Boards.	1.7 Accountabilities and governance procedures are currently being mapped. These are complex in the context of the Essex-wide partnerships, due to the involvement of 3 local authorities and 7 CCGs.		

1.8 Do you have any current issues regarding Ordinary Residence and the potential financial risks associated with this.	1.8 In Essex there are 145 Independent Hospital Beds of which only 17 are being used by Essex citizens. There could be significant financial risk regarding Ordinary Residence if people from other local authorities move from these hospitals to supported living within Essex. We have already experienced ordinary residence "type" issues when other local authorities place people within Essex and the placement breaks down resulting in admittance to the local assessment and treatment units. On discharge other authorities have successfully claimed that local CCGs and the Council have funding responsibility under s117, placing additional pressures on local health and social care economies.		
1.9 Has consideration been given to key areas where you might be able to use further support to develop and deliver your plan.	1.9 We have engaged the National Development Team for Inclusion to assist us with this work. In October 2012 they undertook an audit of Challenging Behaviour services and we will be using them to help implement the recommendations from the audit and the Winterbourne View action plan as part of the Challenging Behaviour project. A further area of support that would be useful is around the relationship with the SCG. We need to understand much more about the care and support requirements and the risks associated with the people they have reviewed before we can begin planning any moves to community settings and will need assurance that funding will follow the person to enable this to happen at a time of unprecedented		

	cost pressure on the Council's adult social care budget.		
2. Understanding the money 2.1 Are the costs of current services understood across the partnership. 2.2 Is there clarity about source(s) of funds to meet current costs, including funding from specialist commissioning bodies, continuing Health Care and NHS and Social Care. 2.3 Do you currently use S75 arrangements that are sufficient & robust. 2.4 Is there a pooled budget and / or clear arrangements to share financial risk.	 2.1 The costs of current in-patients and health funded people in the community are understood across the partnership (£14.5m including costs of A&T Beds). Work is being completed to identify the cost of current ECC funded services for Essex people with a learning disability and/or autism who have challenging behaviours and/or mental health conditions. 2.2 There is clarity about which organisation is funding existing placements. We are clear about which people are funded by each CCG, which people are currently funded by the SCG, and which people are funded by ECC. There is less clarity about the movement of funds for placements currently funded by the SCG, which is highly pertinent for securing step-down pathways into less restrictive detained services and social care community support. 2.3 There is a S75 agreement in place until August 2013 which was previously agreed with the Essex PCTs. A proposal is under consideration to extended this to March 2014, during which time a new agreement will be developed. 2.4 Currently there are no formal arrangements in place to share financial risk. Joint funding		Representations are being made by Essex County Council and the north & south Essex CCGs on the impact funding not following patients who step down from secure hospitals commissioned by the SCG. Support to consider and draw up effective S75 agreements to meet the requirements of the complex range of partners would be welcomed.

	arrangements are being actively considered and discussed to then form part of a new S75 agreement.		
2.5 Have you agreed individual contributions to any pool.	2.5 This will be included in the work in 2.4		
2.6 Does it include potential costs of young people in transition and of children's services.	2.6 This will be included in the work in 2.4		
2.7 Between the partners is there an emerging financial strategy in the medium term that is built on current cost, future investment and potential for savings.	2.7 This will be included in the work in 2.4		
3. Case management for individuals			
3.1 Do you have a joint, integrated community team.	3.1 Currently, ECC and health community learning disability teams operate separately, but with close working relationships established. Part of the Challenging Behaviour project is to redesign pathways so that health and social care resources are complimentary and duplication is avoided. This reconfiguration will be included in the future S75 agreement. The Council is also undergoing significant transformation to align it's commissioning arrangements with the CCGs and this will include the appointment of 5 Integrated Commissioner posts (to work with each of the 5 CCGs).		
3.2 Is there clarity about the role and function of the local community team.	3.2 The current roles and functions of the ECC learning disability community teams and the specialist health community team are generally, but not always,		

	clear. Work will be done (as in 3.1) to identify and agree redesigned pathways to achieve this clarity.		
3.3 Does it have capacity to deliver the review and re-provision programme.	3.3 The ECC community teams are currently being strengthened to ensure there is effective care management for the in-patient review and reprovision programme. Two independent support planners have supported the teams with the resettlement planning for 3 south Essex people who have been in-patients for over a year.		
3.4 Is there clarity about overall professional leadership of the review programme.	3.4 **South Essex:** Leadership of the review programme rests with the SEWSG which consists of both health and social care commissioners. **North Essex:** Leadership of the review programme sits with health and social care commissioners reporting into a Joint Executive Board. Reviews are being undertaken jointly by ECC care managers and a senior LD community nurse.		
3.5 Are the interests of people who are being reviewed, and of family carers, supported by named workers and / or advocates.	3.5 **South Essex**: All south Essex in-patients have a care manager and a named worker and/or advocate. The independent support planners have specifically ensured that the views of the person and their family are listened to and heard when designing resettlement plans. **North Essex:** All north Essex in-patients have a named care manager and a named worker and / or advocate. The views of the person and their family have been actively sought as part of the review process.		

4. Current Review Programme			
4.1 Is there agreement about the numbers of people who will be affected by the programme and are arrangements being put in place to support them and their families through the process.	4.1 **South Essex:** There is agreement about the number of south Essex people affected by the programme (3 people in South Essex). CPA processes are being reviewed with providers as a result of the independent resettlement planning (3.5) to ensure that there are effective arrangements in place to support people and their families. **North Essex:** There is agreement about the numbers of people affected by the programme (8 people in north Essex), and the approach that will be taken over the next year to support them and their families through the process.		
4.2 Are arrangements for review of people funded through specialist commissioning clear.	4.2 Arrangements for the 25 people funded through the SCG are not clear. There is currently 1 south Essex person and 7 north Essex person who the SCG have reported are ready to move on to community based settings and 3 north Essex people who the SCG have reported could step down from low secure to locked rehabilitation services. The SCG do not plan to be involved in resettlement planning for these people although commissioning responsibility for the current placements rests with them. It is unclear therefore how any difficulties in achieving changes by providers to CPA plans will be resolved when the current SCG commissioner is not engaged in the work. The SCG have had very limited involvement with social care staff as part of the review process which is a further area of concern about the joint working arrangements with the SCG.		

4.3 Are the necessary joint arrangements (including people with learning disability, Carers, advocacy organisations, Local Healthwatch) agreed and in place.	4.3 Joint working arrangements (including people with learning disabilities, carers and advocacy organisations) are in place for the Challenging Behaviour project. The Local Healthwatch will be kept informed of progress against the Winterbourne Action plan throughout this year (with this stocktake providing an initial overview for the Board.)		
4.4 Is there confidence that comprehensive local registers of people with behaviour that challenges have been developed and are being used.	4.4 Local registers of Essex people with behaviour which challenges who are funded by the Essex CCGs are in place. These are being used to scope and plan future commissioning plans.		
4.5 Is there clarity about ownership, maintenance and monitoring of local registers following transition to CCG, including identifying who should be the first point of contact for each individual	4.5 **South Essex:** Ownership and monitoring of local registers rests with the Executive Nurse in each CCG and reported into the appropriate CCG forum. Maintenance of registers rests with the south Essex Commissioning Support Unit (CSU). The CSU is reconfiguring its placement team and, as part of this, will be identifying a commissioning case manager for each person. Alongside this will be consideration and agreement of the respective roles of the commissioning case manager and the community based care/case manager so that there is a single, clear first point of contact for each individual and their family. It is expected that this will be completed in the next 3 months. **North Essex:** Maintenance of registers rests with the Essex Commissioning Support Unit (CSU). Named commissioners will need to be agreed as some placements are the responsibility of LD leads and some sit with MH leads within the CSU.		

4.6 Is advocacy routinely available to people (and family) to support assessment, care planning and review processes	4.6 Advocacy is available to people who need support from a formal advocate. Those people in in-patient services will all have access to formal advocacy to support them during the assessment, care planning and review process.		
4.7 How do you know about the quality of the reviews and how good practice in this area is being developed.	4.7 **South Essex:** The reviews have been undertaken by independent support planners and presented to panel of commissioners, including Executive Nurses from the CCGs to ensure the quality of the reviews. The people in in-patient services all have ECC care managers and are subject to CPA: • Concerns have been raised through the independent resettlement planning work about the quality of CPA processes across NHS and independent providers. These are being actively addressed with providers. • Independent support planners have ensured high quality reviews and resettlement plans for the people who have been an in-patient for over a year. People in the community receiving only health funding have a commissioning case manager through the CSU, although these arrangements are being reviewed as described in 4.5. The SEWSG has recognised that ensuring that reviews and support planning are of a high quality is		

	key to the transformation of services and of people's and is including this in the work on a joint commissioning plan. **North Essex:** The reviews have been undertaken jointly with ECC care managers and a community nurse. The reviews are scheduled to be presented to a panel of commissioners – this will include the quality lead for the CCG's. **Essex Wide:** ECC care management reviews are quality checked through professional supervision and through the confirmation and validation process. Good practice is being developed through the Challenging Behaviour project. This will include developing capacity to promote person centred approaches to reviews and support plans. Additional care management capacity is also being developed to ensure good practice can be maintained and developed. It is difficult to comment on the quality of the SCG reviews as documentation has not been shared nor have local commissioners been engaged in the process.		
4.8 Do completed reviews give a good understanding of behaviour support being offered in individual situations.	4.8 The reviews are giving an indication of the quality of behaviour support that is being provided in each setting. Early indications suggest that the quality is variable and further work is required by commissioners to ensure that people are receiving appropriate support for their individual needs.		

4.9 Have all the required reviews been completed. Are you satisfied that there are clear plans for any outstanding reviews to be completed.	4.9 The required reviews (i.e. of in-patients) have all been completed.		
5. Safeguarding 5.1 Where people are placed out of your area, are you engaged with local safeguarding arrangements – e.g. in line with the ADASS protocol. 5.2 How are you working with care providers (including housing) to ensure sharing of information & develop risk assessments.	5.1 Essex is fully engaged with local safeguarding arrangements for individuals placed out of area with some positive examples of joint working. Our safeguarding team, care managers and commercial team are fully aware of the ADASS protocol. We also have a dedicated Out of County team for adults with learning disabilities to ensure the quality of out of area placements. 5.2 Our commercial team has account management arrangements with providers to share information. This is supported by our Quality Improvement Team who work with providers to both share good practice and identify areas for development. We have fortnightly Provider Concerns meetings where care managers, our commercial team, and our safeguarding team meet to triangulate evidence about potential risks with providers, and actions plans with providers are developed as a result. The Essex Market Position Statement 2012 is the vehicle we use to share information about current and future need with providers, as well as providing an overview of our strategic direction as a council. We have also engaged with housing providers about the future accommodation need of adults with disabilities as part of a £6 million capital investment programme in supported housing.		

5.3 Have you been fully briefed on whether inspection of units in your locality have taken place, and if so are issues that may have been identified being worked on.	5.3 Yes. We have a robust relationship with CQC and are fully informed when concerns are identified. A Pan Essex group (including Southend, Thurrock and NHS colleagues) meet regularly with CQC to share information about concerns with providers. Action plans are then developed in partnership with all stakeholders. Health and social care commissioners do have concerns about the numbers of people placed in registered care homes and independent hospitals in north Essex by other authorities. There is a cohort of service users/patients who do not originate from Essex and are not known to local commissioners, so we have little knowledge of the suitability of these placements to meet their health and social care needs.		
5.4 Are you satisfied that your Children and Adults Safeguarding Boards are in touch with your Winterbourne View review and development programme.	5.4 The Essex Safeguarding Adult Board (ESAB) has an action plan around Winterbourne and reports regularly on progress. This has included Safeguarding Essex working proactively with the Independent Hospitals in Essex to ensure they have robust safeguarding processes in place, and hosting a conference so providers could share best practice. The Adult's and Children's Safeguarding Board have been working with commissioners on Safe Commissioning Practices – work that was instigated following Winterbourne and child sexual exploitation in Rochdale. Commissioners are working to take forward recommendations from the report.		
5.5 Have they agreed a clear role to ensure that all	5.5 This activity is undertaken through a number of		

current placements take account of existing concerns/alerts, the requirements of DoLS and the monitoring of restraint.	routes. For social care placements the Provider Concern Meetings described in 5.2 will identify concerns about current placements. Our Behaviour Advisor Team are involved in reviews of people with Challenging Behaviours and will support care managers to monitor the use of restraint. For health placements the use of restraint is monitored through the regular quality monitoring meetings held with health commissioners. The Essex Adult Safeguarding Board provide strategic leadership to ensure that providers and commissioners understand the requirements of DoLS.		
5.6 Are there agreed multi-agency programmes that support staff in all settings to share information and good practice regarding people with learning disability and behaviour that challenges who are currently placed in hospital settings. 5.7 Is your Community Safety Partnership considering any of the issues that might impact on people with learning disability living in less restrictive environments. 5.8 Has your Safeguarding Board got working links between CQC, contracts management, safeguarding staff and care/case managers to maintain alertness to concerns.	5.6 ESAB run multi-agency training programmes to ensure all staff understand their responsibilities regarding Safeguarding which includes sharing information. This includes staff working in hospital settings. 5.7 Not at present. However the Community Safety Partnerships are engaged in our Be Safe programme which is working with communities to ensure people with learning disabilities feel safe. 5.8 A representative from CQC sits on the Adult Safeguarding Board. The working links between CQC, our Commercial Team, and Care managers happens at the Pan Essex Information Sharing meetings described in 5.3. Concerns can be escalated to ESAB who provide oversight to make sure that these arrangements are working.		
6. Commissioning arrangements 6.1 Are you completing an initial assessment of	6.1 This is a key deliverable for the Challenging		The pump priming from the DoH as part of

commissioning requirements to support peoples' move from assessment and treatment/in-patient settings. 6.2 Are these being jointly reviewed, developed and delivered. 6.3 Is there a shared understanding of how many people are placed out of area and of the proportion of this to total numbers of people fully funded by NHS CHC and those jointly supported by health and care services. 6.4 Do commissioning intentions reflect both the need to deliver a re-provision programme for existing people and the need to substantially reduce future hospital placements for new people.	Behaviour project. Planning days have taken place in both north and south Essex to assimilate the information from the reviews and develop the service requirements to enable people to move on from in-patient settings where appropriate. There has been early identification of the need for emergency response services to support people in crisis as part of their discharge plan and as part of the redesign of services to prevent admissions. 6.2 Commissioning requirements are being developed as part of the Challenging Behaviour project which is a joint initiative involving health and social care commissioners from Essex, Southend, and Thurrock 6.3 This information has been developed and shared across the partnership. 6.4 This is the shared intention of the partners. The Challenging Behaviour project is considering both current and future need, and the service models that will be required to meet this need in the most appropriate and least restrictive environments possible. There is recognition that a substantial reduction in hospital placements and therefore the available beds is likely to require a joint commissioning approach across the whole of Essex (i.e. the 5 CCGs and ECC) and with Southend and Thurrock and their respective CCGs.		the original long stay hospital re-provision programme was invaluable to the resettlement process. Further pump priming to fund the development of alternative community based services will enable the decommissioning of existing in-patient services and free up resources to move people on from block contracted health provision, and to prevent further admissions into A&T beds. In Essex up to 3 people are in block funded health placements that could move to community

6.5 Have joint reviewing and (de)commissioning arrangements been agreed with specialist commissioning teams.	6.5 Please see 1.2 and 4.2 responses regarding difficulties in joint working and planning. A major concern for ECC and the Essex CCGs is the current position that SCG funding will not follow the person. This does not meet commitments made in the Transforming Care document regarding local authorities not being disadvantaged by people's transfer of care. The current arrangement will only increase budget pressures on LAs (in ECC this is in the region of £336k p/a for south Essex and £1.3m p/a for north Essex.). There is also potential additional cost pressures to CCGs if people step down from low secure services to locked rehabilitation currently estimated to be in the region of £550k for north Essex CCGs. The failure to transfer funding also disconnects the decommissioning of current SCG placements from the need for reinvestment in local services to replace them. This potentially will cause real tensions in the partnership and, of course, put significant obstacles in the way of offering different placements and lives for people in SCG funded placements.		based services. However without initial pump priming from the DoH it will be extremely difficult to release the money from the system in a timely way to enable this to happen. In Essex we estimate the amount of pump priming needed to be in the region of £600k. This would increase if the funding for SCG placements does not transfer to the LA.
6.6 Have the potential costs and source(s) of funds of future commissioning arrangements been assessed.	6.6 Initial costs have been estimated from the reviews of those people who are in CCG funded placements but these will need further refinement as the support plans are developed and the market is tested. **South Essex:** A budget strategy is starting to be outlined to enable the transfer of funding for community based services to be achieved. This will require some significant work across the local		Support is needed from the DoH to address the structural issues within the NHS that may prevent a fair and transparent

	authority and CCG partners to achieve the decommissioning and recommissioning of services that is required. **North Essex:** Discussions are at early stages as part of the establishment of joint commissioning arrangements to align CCG and ECC budgets for learning disability services. This will be a key enabler for people to transfer from health funded to social care services.		transfer of funding between the SCG and local health and social care economies.
6.7 Are local arrangements for the commissioning of advocacy support sufficient, if not, are changes being developed.	6.7 Advocacy services in Essex are currently being re-commissioned and this will ensure that formal advocacy is available for all those that require it.		
6.8 Is your local delivery plan in the process of being developed, resourced and agreed.	6.8 The local delivery plan will be implemented via the Challenging Behaviour project. The Project initiation Document and Deliverables have agreed by all partners, and resources have been identified to deliver the project. There is a considerable amount of work to reconfigure existing services and pathways, and to develop the market so appropriate local provision is available.		
6.9 Are you confident that the 1 June 2014 target will be achieved (the commitment is for all people currently in in-patient settings to be placed nearer home and in a less restrictive environment).	6.9 ECC and health commissioners are confident, based on progress on the project so far, that those people identified in the reviews as able to move on from their existing placements will have done so by the 1st June 2014. We are committed to ensuring that all move on plans are person centred, and if the detailed support plans indicate that people need a longer period to transition from an in-patient services to a community setting then we would support this.		
6.10 If no, what are the obstacles, to delivery (e.g.	6.10 There are two south Essex people where much		

organisational, financial, legal).	more focussed assessments of their mental health and learning disability are needed. The person centred reviews and the clinicians views indicate that these people still require clinical input within an in-patient setting, and any work to support discharge will be over a longer period of time. For those people funded by the SCG, the issue of funding will impact on whether people can be moved from in-patient services to community based settings because of the reasons highlighted in 6.5		
7. Developing local teams and services 7.1 Are you completing an initial assessment of commissioning requirements to support peoples' move from assessment and treatment/in-patient settings. 7.2 Do you have ways of knowing about the quality and effectiveness of advocacy arrangements. 7.3 Do you have plans to ensure that there is capacity to ensure that Best Interests assessors are involved in care planning.	7.1 The work to develop local teams and services is moving forward as part of the Challenging Behaviour project, which is looking at current and future pathways and the services that are required locally. The resettlement plans for current in-patients has highlighted some key service requirements, whilst a market position statement is being developed across Southend, Essex and Thurrock. 7.2 Advocacy services are monitored on an on-going basis to ensure quality and effectiveness. We are currently in the process of re-commissioning advocacy services so they are targeted at people who need formal advocacy which will include people detained within in-patient services. As part of this we will also be looking to stimulate citizen, peer and self-advocacy within Essex. 7.3. In Essex there is a dedicated team of Best Interest Assessors to support assessment and support planning.		

8. Prevention and crisis response capacity - Local/shared capacity to manage emergencies 8.1 Do commissioning intentions include an assessment of capacity that will be required to deliver crisis response services locally. 8.2 Do you have / are you working on developing emergency responses that would avoid hospital admission (including under section of MHA.) 8.3 Do commissioning intentions include a workforce and skills assessment development.	8.1 The need for crisis response services has already been identified and is being built into commissioning requirements. Assessing the capacity needed will be undertaken across Southend, Essex and Thurrock, as part of the Challenging Behaviour project. 8.2 We envisage that an effective emergency response services will be key to avoiding unnecessary admission to in-patient services, and we will be working with health commissioners as part of the Challenging Behaviour project to develop effective community based response services. 8.3 The Commissioning Intentions being developed as part of the Challenging Behaviour project recognise that a workforce with the right skills and value base (both for care managers and providers) is essential in meeting the needs for this group of people. We will be using the NDTi to facilitate sessions with our specialist care management team that has been set up to support people with behaviours that challenge. Our procurement approach with the market will include requirements about skill levels and training. Our Behaviour Team are also Tizard trained and actively support providers through delivering training to staff.		
9. Understanding the population who need/receive services 9.1 Do your local planning functions and market	9.1 Our Market Position Statement signals our		

assessments support the development of support for all people with complex needs, including people with behaviour that challenges. 9.2 From the current people who need to be reviewed, are you taking account of ethnicity, age profile and gender issues in planning and understanding future care services.	requirements to the market to develop local services for people with complex needs and behaviours that challenge. These messages will be refined as part of the market engagement strategy within the Challenging Behaviour project, and as part of the latest iteration of the Market Position statement that will focus on the need of people with learning disabilities. 9.2 Ethnicity, age and gender are always considered as part of the assessment process and when planning and developing services.		
10. Children and adults – transition planning 10.1 Do commissioning arrangements take account of the needs of children and young people in transition as well as of adults 10.2 Have you developed ways of understanding future demand in terms of numbers of people and likely services.	10.1 The challenging behaviour project includes both children and adult services. Initially the pathways developed will focus on those aged 14+, however we recognise the need to develop these pathways much earlier in people's lives, and plan to look at services for those below the age of 14 at a later stage of the project. 10.2 As part of the Council's transformation programme commissioning for adults and children is coming together under "People Commissioning". We are also reviewing our Children with Disabilities operational teams, and will extend the age of transition to up to 25 when a person has finished education and is settled. Our Behaviour Advisor Team works with both adults and children. All of these will ensure that both commissioners and operational staff have a clear idea of future demand.		

	Young people with challenging behaviours who are coming through transition and are funded by the south Essex CCGs have been identified. Work has not yet started to collate their future service needs.		
11. Current and future market requirements and capacity			
11.1 Is an assessment of local market capacity in progress.	11.1 Yes. Essex, Southend and Thurrock are working together to develop a specific learning disability Market Position Statement (MPS) as part of the national Developing Care Markets for Quality and Choice Programme. The MPS will specifically include an assessment of local market capacity.		
11.2 Does this include an updated gap analysis.	11.2 The MPS will include an updated gap analysis to signal to the market the type, level, and location of services that will be needed in the future.		
11.3 Are there local examples of innovative practice that can be shared more widely, e.g. the development of local fora to share/learn and develop best practice.	11.3 Local and national examples of innovative practice are being collected for sharing across Southend, Essex and Thurrock as part of the Challenging Behaviour project.		

Please send questions, queries or completed stocktake to Sarah.brown@local.gov.uk by 5th July 2013

This document has been completed by

Name……

Organisation……..

Contact……

Signed by:

Chair HWB ……

LA Chief Executive ……..

CCG rep……..

Report to Health & Wellbeing Board **Report of Dr Mike Gogarty, Director of Public Health**	**Item 8b** **Reference number HWB/011/13**
Date of meeting 16th July 2013 **Date of report** 3rd July 2013	**County Divisions affected by the decision** All divisions
Public Health Grants to the Voluntary & Community Sector Strategy	
Report by Mike Gogarty – Director of Public Health **Enquiries to** Jane Richards – Assistant Director of Public Health	

1. Purpose of report

1.1 To inform the Health & Wellbeing Board of the current grant agreement arrangements in place with the voluntary and community sector (VCS) as a result of the Public Health transition from the former PCTs to Essex County Council

1.2 To set out the issues that need to be taken into consideration with respect to future funding of the sector from 1st April 2014 onwards

2. Recommendations

2.1.1 To agree that commissioning leads for voluntary sector funding progress a common approach that is line with the objectives of the Essex Community & Voluntary Sector Strategy and enables processes to be put into place by the beginning of Q3 2013/14 to ensure that projects that meet ECC corporate priorities are commissioned and contracts are in place by 1st April 2014

3. Background and proposal

3.1 The need to have a consistent approach to funding the Voluntary Community Sector (VCS) was identified early in the transition process of the Public Health function from the previous NHS organisations to Essex County Council.

Each of the PCTs had varying levels of investment in the VCS and the following principles were agreed as fundamental to the transition process

- Grants to projects whose outcomes met CCG commissioning priorities to remain with the relevant CCG
- Grants to projects whose outcomes met Public Health commissioning priorities to be transferred to ECC and new contracts to be issued with effect from 1st April 2013 for a period of one year

This approach was articulated through papers that were initially agreed by the then PCT Cluster Board in January 2012 (embedded below) and then individually with the relevant CCGs

3.2 Historically processes for awarding grants to voluntary and community sector organisations have varied between PCTs with a range of projects being supported through different forms of agreement and for varying timeframes. Although Public Health had led the management of grant agreements in two PCTs, Mid and North East Essex, this was not the case in the other PCTs where responsibility lay with a range of functions.
It was therefore agreed as a priority that the transition of PCTs to the new commissioning organisations, and in particular that of Public Health to ECC, should not destabilise the sector.
Thus where existing grants were due to cease on 31st March 2013 new contracts have been drawn up and agreed, extending funding for a further year.
In cases where grants were not due to cease until 31st March 2014 the relevant grants were simply moved over to ECC and continue to be resourced as previously set out in the existing grant agreements.
A spreadsheet that sets out details of all contracts that are in place with the VCS through the Public Health Grant is embedded in section 9 below.

3.3 Throughout the transition period and moving forward it has been a priority to communicate with both the sector and the CCGs and this has been achieved through a range of channels including presentations at sector events, such as the Mid Essex Voluntary Sector Forum and the Essex Rural Partnership.

3.4 It was agreed that during 2013/14 work would be undertaken in ECC to align the commissioning and grant making processes across the organisation to ensure that where projects are delivering shared outcomes, these are being commissioned and performance managed in the most effective way possible avoiding duplication and increasing process efficiency for the benefit of both the recipient organisations and ECC

3.5 Given the length of time required to manage a grant making process agreement must be reached by the end of Q2 of this year with respect to the future intentions for 2014/5 onwards so that these can be communicated to the sector at the earliest opportunity.

It is therefore proposed that ECC commissioning leads should agree a common approach for future commissioning of projects that meet the outcomes required

by corporate priorities by the end of Quarter 2 2013/14 with a view to putting into place a process that will enable contracts to be in place by 1st April 2014. This process will meet the objectives developed as part of the Essex Voluntary & Community Sector Strategy and will form part of a partnership approach to future commissioning intentions.

4. Policy context

4.1. The Whole Essex Community Budget (WECB) programme has initiated two projects that will have an impact on future VCS funding.

4.2. The first is to develop a public sector VCS Strategy, to include all public-sector partner organisations in Essex. This new Strategy will articulate the public sector's commitment to supporting the VCS and ensuring the sector is a key part of our commissioning and grant-funding process. It will provide a clear and consistent public-sector-wide approach to commissioning the VCS, using a set of key principles. It will also outline a number of expectations for commissioners & the VCS to adhere to and will present opportunities for the VCS to engage in commissioning. The strategy will provide a framework against which future funding will take place, whether it be grant-funding or commissioned contracts. It is intended that the new strategy will be published by October 2013.

4.3. The second WECB project is the Community Resilience Fund (CRF). This is a partnership endowment fund that will develop community resilience & capacity and support innovation by providing grants from a sustainable revenue source. The fund will provide grants for voluntary activity to create strong and resilient communities where people help each other, supported by a vibrant VCS. The long term aim is to build the value of the endowment up to circa £50m, which could then, through a process of investment, generate grants in excess of £2.5m per annum, without funding being subject to the unpredictability associated with public sector funding streams. The CRF aims to streamline existing funding and provide a single source of grant funding for voluntary and community activity targeted at addressing shared outcomes.

4.4. It should be noted that the on-going implementation of Essex County Council's Transformation Project means that specific details around how much grant funding will be available and where commissioning responsibility for specific VCS funding streams will lie, is still under discussion which means we are unable at this stage to provide exact figures for 2014-15 and beyond.

5. Financial Implications

5.1. For 2013-14, Voluntary and Community Sector grants total £1.351m. Funding for the grants to these external organisations is contained within existing budgets and is funded from the Public Health Grant of £48.874m for 2013-14, from Department of Health.

5.2. For 2014-15, the Public Health Grant allocation for ECC is £50.242m. Public health related grants to Voluntary and Community Sector organisations will be funded from this grant allocation.

6. Legal Implications

The Council's public health powers derive from the Health and Social Care Act 2012. These are introduced by a series of amendments to the National Health Service Act 2006. The most significant provision is S.12 of the 2012 Act which inserts a new section 2B into the 2006 Act. The new S. 2B gives each local authority a duty to take such steps as it considers appropriate to improve the health of the people in its area. This section also gives the Secretary of State a power to take steps to improve the health of the people in England. The section also gives examples of health improvement steps that local authorities may take. These proposals come within the statutory powers.

7. Staffing and other resource implications

7.1. There are no staffing or other resources implications involved in this issue

8. Equality and Diversity implications

8.1. The projects that are currently funded through this resource seek to reduce inequalities across Essex and therefore are targeted at those communities least likely to access universal services.

8.2. Any decision related to future funding for projects delivered through the third sector is likely to impact on such communities

9. Background papers

9.1. NHS North Essex Board Paper - PCT funding for voluntary organisations from April 2012

Voluntary Sector Funding Board Paper

9.2. Breakdown of Public Health grants to Voluntary and Community Sector organisations for 2013/14

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