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SOUTHEND-ON-SEA BOROUGH COUNCIL

Health & Wellbeing Board

Date: Wednesday, 2nd December, 2015
Time: 5.00 pm
Place: Darwin Room - Tickfield
Contact: Robert Harris

Email: committeesection@southend.gov.uk

AGENDA

1 **Apologies for Absence**

2 **Declarations of Interest**

3 **Questions from Members of the Public**

4 **Minutes of the Meeting held on Monday 29th June 2015**

******** **<u>For Information</u>**

5 **HWB Peer Challenge Feedback Letter**
Report attached.

6 **Better Care Fund Quarter 2 2015/16 Return**
Report attached.

7 **Transforming Care Partnerships Update**
Report attached.

8 **Essex Wide Mental Health Strategic Review**
Report attached.

******** **<u>For Discussion/Decision</u>**

9 **Joint Prevention Strategy**
Report attached.

10 **Health & Wellbeing Strategy Refresh 2015-16, Broad Impact Goal Performance Indicators**
Report attached.

11 **Safeguarding and the Role of the Health & Wellbeing Board** (Pages 103 - 110)
PowerPoint Presentation slides attached.

12 **HWB Forward Plan**
Report attached.

13 **Date and time of next meeting**
Tuesday 9th February 2016 at 5pm – Tickfield Centre, Johnson Room

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SOUTHEND-ON-SEA BOROUGH COUNCIL

Meeting of Southend Health and Wellbeing Board

Date: Monday, 29th June, 2015
Place: Seacole Room, Tickfield Centre, Southend-on-Sea

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Present: Councillor Moyies (Chairman)
Councillors Evans, Lamb, Longley, Velmurugan and Willis
Dr A Atherton (SBC), Mr J Cooke (Healthwatch Southend), Ms A Semmence (SAVS - non-voting member), Ms M Craig (Southend CCG), Dr K Chaturvedi (Southend CCG), *Mr M McCann (SEPT - non-voting member), Ms S Hardy (Southend Hospital - non-voting member), Mr S Leftley (SBC), Mr N Leitch (Pre-School Learning Alliance)

*Substitute in accordance with Council Procedure Rule 31.

In Attendance: Mr R Harris (SBC), Mr R Walters (SBC), Mr N Faint (SBC), Ms S Baker (SBC), Ms F Abbott (SBC), Mr C Cormack (observer Southend CCG - non-voting), Councillor Salter (observer - Chairman of People Scrutiny Committee - non-voting).

Start/End Time: 16.00/17.15

******** **Part I**

94 Apologies and substitutions.

Apologies for absence were received from Ms S Morris (SEPT - sub: Mr M McCann), Mr R Tinlin (SBC), Dr J G Lobera (Southend CCG) and Mr A Pike/Mr A McIntyre (NHS England).

95 Declarations of interest.

The following members declared interests:

(a) Councillor Willis - Agenda Item 4 (Minutes of last meeting - reference to pharmaceutical needs assessment) - non-pecuniary interest - employed by Royal Pharmaceutical Society;

(b) Councillor Salter - Agenda items 4, 7, 8 and 9 - non-pecuniary interest - husband is Business Unit Director at Southend General Hospital for surgical services including oral surgery – urology and son-in-law is a GP in the borough;

96 Public Questions

The Board was advised that a public question had been received from Mr Ali which would be responded to in writing.

97 Minutes of the Meeting held on Wednesday, 25th March, 2015

The Board received two updates in respect of vascular services and safeguarding which had not been included on the agenda for this meeting.

The CCG Accountable Officer provided assurances that no decision has been taken in respect to the transfer of vascular services from Southend.
The HWB Advisor reported that a proposed approach to the Board's role in respect

of safeguarding was being developed and would be presented back to a future meeting of the Board.

Resolved:

That the minutes of the meeting held on 25th March 2015 be confirmed and signed as a correct record.

98 Care Act Update

The Board considered a report of the Corporate Director for People which provided an update on the implementation of the Care Act in Southend.

The Board asked a number of questions concerning safeguarding, carers, universal deferred payment scheme and the funding caps which were responded to by officers.

The Board noted that there was an intensive training programme across partners (CCG, GPs, Council, etc) on the Care Act changes and the implications.

Resolved:

1. That it be noted that phase 1 of the Care Act came into effect from 1st April 2015.

2. That the new duties and responsibilities on the local authority as well as extending existing responsibilities of the Care Act be noted.

3. That it be noted that Southend Borough Council was Care Act compliant on 1st April 2015.

4. That it be noted that the outcome of the consultation on phase 2 of the Care Act would be available in October 2015 and a report would be presented to the Board in December 2015.

99 Better Care Fund – Quarter 4 FY 2014 / 2015 return

The Board considered a joint report of the Corporate Director for People and Chief Officer, Southend CCG, which presented the Better Care Fund quarter 4 2014/15 return.

The Board asked a number of questions concerning emergency admissions and non-elective admissions which were responded to by officers.

The Board noted that the BCF funding was aligned to financial years (April to March).

Resolved:

1. That the BCF return for Quarter 4 2014/15 be noted.

2. That the proposed approval process for subsequent BCF quarterly returns as set out in the submitted report be endorsed.

100 Southend Joint Strategic Needs Assessment (JSNA) emerging themes

The Board received a verbal report on the JSNA covering the statistical performance data on 'health and wellbeing across the lifecourse' and the 'wider determinants of health'. A chart showing the headline data was also provided.

The Board asked a number of questions concerning Southend's age profile, life expectancy of people with mental health conditions and childhood obesity which were responded to by officers.

The Director of Public Health sought the Board's views on the timescales for conducting a full review / refresh of the JSNA and suggested that every 3 years would be an appropriate period of time.

Resolved:

1. That the update on the JSNA be noted.

2. That the JSNA be reviewed/refreshed every 3 years.

101 Health and Wellbeing Strategy Refresh 2015-2016, Broad Impact Goal performance indicators

The Board considered a report from the Partnership Advisor, Health & Wellbeing, which presented the draft performance indicators and areas for measuring the progress of Southend's Health & Wellbeing Strategy refresh 'Broad Impact Goals' for 2015/16.

The Board asked a number of questions which were responded to by officers.

Resolved:

1. That the indicators set out in Appendix 2, subject to further comments, be endorsed and a report be brought back to the Board to agree/sign-off the areas to be established to measure the progress of the HWB strategy 'Broad Impact Goals'.

2. That, following agreement of appropriate indicators, actions to drive forward improved performance be established and implemented and status be reported to future meetings of the Board from September 2015 onwards.

3. That the updated "Health and Wellbeing Strategy on a page" in Appendix 3 of the submitted report, be approved.

102 Older People Joint SBC/CCG Commissioning Strategy 2015-2018

The Board considered a joint report of the Corporate Director for People and Chief Officer of Southend CCG which outlined the key principles of the proposed Older People Joint SBC/CCG Strategy 2015-2018.

The Board asked a question concerning the future provision of 7 day services which was responded to be officers.

Resolved:

That the Older People's Strategy, subject to full consideration of feedback received from members of the public and ongoing refreshment of the strategy document, be adopted.

103 Forward Plan

The Board considered the Forward Plan of Board activity for the period April 2014 to December 2015.

The Board noted that the HWB Peer challenge follow up visit was taking place on 21st and 22nd July 2015 and partners/Board members will have received a pre-visit questionnaire.

Resolved:

That the forward plan be noted.

Chairman: _____

5

Councillor Moyies, Chair of the Health and Wellbeing Board
Rob Tinlin, Chief Executive, Southend-on-Sea Borough Council
Dr José Garcia, Vice Chair of the Health and Wellbeing Board
Southend-on-Sea Borough Council
Civic Centre
Victoria Ave
Southend-on-Sea
SS1 9SB

Dear James, Rob and José

Southend Health and Wellbeing Peer Challenge – follow up: 21st & 22nd July 2015

On behalf of the peer team I would like to say what a pleasure it was to be invited back to Southend as a follow up to the January 2014 health and wellbeing peer challenge as part of the Local Government Association (LGA) Health and Wellbeing System Improvement Programme. This programme is based on the principles of sector-led improvement, i.e. that health and wellbeing boards will be confident in their system-wide strategic leadership role and have the capability to deliver transformational change, through the development of effective strategies to drive the successful commissioning and provision of services, to create improvements in the health and wellbeing of the local community.

The following members from the original peer team returned for the two day peer challenge follow up:

- Caroline Tapster, Director, Health and Wellbeing Improvement Programme, LGA
- Councillor Dale Birch, Chair of the Health and Wellbeing Board, Bracknell Forest Council
- Juliet Hancox, Chief Operating Officer, NHS Coventry and Rugby Clinical Commissioning Group (CCG)
- Kay Burkett, Programme Manager, Local Government Association

Scope and focus of the follow up to the peer challenge

The framework for the two day follow up was the following questions:

- What progress has the HWB made since the initial peer challenge (January 2014)?
- What further improvements can be made to ensure the HWB reaches its full potential?
- What is the appetite for the HWB to become the primary strategic vehicle for system transformation?

- Are there any obstacles to achieving this?
- What would board members personally do to make this a reality?

A confidential survey was conducted with board members prior to the on-site days of interviews and focus groups to help gather a wide range of individual observations and reflections. The peer team also read key documents and looked at local data and information.

It is important to stress that this was not an inspection. Peer challenges are improvement focused. As peers we used our experience and knowledge to reflect on the information presented to us by people we met, things we saw and material that we read.

This letter provides a summary of the peer team's findings. It incorporates the feedback presentation delivered by the team at the end of their on-site visit. In presenting this feedback, the team acted as fellow local government and health officers and members, not professional consultants or inspectors. We hope this recognises the progress Southend-on-Sea's Health and Wellbeing Board has made during the last eighteen months whilst stimulating debate and thinking about future challenges and opportunities.

Headline messages

We were very impressed by the engagement from all relevant partners across the HWB system in Southend to the peer challenge follow up. It was clear to our team that collectively there is enthusiasm and commitment to improving health and wellbeing of residents. This is particularly evident in the way staff have been empowered to embrace opportunities for innovation, such as the Big Lottery Fund award of £40m over ten years to invest in better outcomes for early years through "A Better Start" programme and being selected to be one of the Health and Social Care Integration Pioneers.

There is support for the new HWB chair who is keen to provide strong leadership for the health and wellbeing improvement agenda alongside the CCG lead who is the new HWB vice chair. It is important that this relationship is enhanced further so that these two key partner bodies work hand in glove as effectively as they can.

Whilst partner relationships have continued to develop progress has not been as rapid as anticipated at the last peer challenge in January 2014. This has been in part due to significant political and organisational change over the past 18 months with three different HWB chairs since January 2014 as well as other new board members such as a new Chair of Southend CCG, a new Chief Executive of Southend Hospital and new elected member representatives.

Attention must be paid to developing the board as a health system board rather than as it is viewed at the moment a "council committee". The number of elected members on the board needs to be considered in terms of the actual value they can deliver to the board and those that do remain on the board will need training in the role.

The health and wellbeing strategy refresh 2015-2016 has established “Broad Impact Goals” of prevention, addressing inequality and sustainability through personal responsibility and participation. These broad principles complement the existing nine priorities and provide a focus for operational implementation of the strategy.

You will face further challenges as a health system with significant pressures in terms of finance and future demographic trends. For example, your projections are for a significant increase in terms of both elderly and frail residents. As a consequence you will need a strong, focused and integrated HWB to plan for and respond to this challenge. One of the key responsibilities of the HWB is to ensure an accurate and up to date Joint Strategic Needs Assessment (JSNA) is available that is easily understood by all partners and interested agencies so as to ensure a sound base for commissioning decisions. Greater focus on the JSNA needs to be made and once the JSNA has been updated it will be important that priorities beyond 2016 are agreed using the JSNA as the main basis for commissioning priorities against which all procurement decisions can be measured.

The pre-discussions at board meetings have helped to explore wider issues but the HWB needs to ensure it can prioritise its agenda to focus on the big ticket items such as pressures in the system, health inequalities, quality and access in primary care and health reconfiguration.

What progress has the HWB made since the initial peer challenge?

The peer team noted the following as key areas of progress since the initial peer challenge in January 2014:

- Integrated Commissioning Team set up
- Data sharing for direct care (UK first for patient records) & commissioning
- Jointly managed Better Care Fund (BCF)
- Fulfilling Lives - A Better Start initiative for families with young children and the HWB as a strategic vehicle for early years
- Single Point of Referral (SPOR) further developed
- Older People Strategy being consulted on
- System redesign – e.g. Community Recovery, End of Life pathways
- Refreshed JHWS for 2015-16
    - partners signed up
    - summary on a page
    - draft performance indicators
    - new reporting template
    - engagement event

What further improvements can be made to ensure the health and wellbeing board reaches its full potential?

Based on where the HWB is currently, and taking into account research on the boards that are ahead of the curve in making progress, the peer team offer the suggestions below as areas for further development.

- The HWB to continue to invest in new ways of working by using developmental sessions to develop trust and collaboration to ensure it operates as a board and not a council committee.
- Create firm foundations so the agenda will go forward even when individuals change, this includes continuing to have conversations outside of board meetings.
- Develop a stronger narrative based on a shared and agreed intention about the ambition for Southend. Use the narrative as a basis for the HWB to be more outward looking and develop a joint strategy for community engagement.
- Ensure there is a more strategic focus for the HWB and its agenda is reduced to attend more proactively to the main issues facing Southend, the place and people.
- Build on momentum to keep partners engaged so the HWB can fulfil its role in driving change and unblock obstacles in the system.
- Enable the HWB to develop a common understanding of health inequalities and where health outcomes are poor; agree what needs to be addressed and ensure partners are focused on addressing them collectively and being less protective of their own services and organisations.
- Integrated governance route needs to be streamlined so there are clearer arrangements for reporting on progress, quality and performance

What is the appetite for the HWB to become the primary strategic vehicle for system transformation? Are there any obstacles to achieving this? What would board members personally do to make this a reality?

It was self-evident that the range of partners we spoke with have unequivocal co-ownership of the strategy. Some have less co-ownership of the board and going forward both together will be required if you are to be a successful system leader.

Understanding each other's needs and constraints is key to a successful board. At different times each organisation represented at the board will have different pressures and challenges. It will be mission critical to your progress to share this knowledge and awareness as it will inform you about your strength and resilience and importantly, capacity.

Instil pace and confidence through tackling key challenges in partnership. Consider having in place a range of quick wins, medium term projects, with an eye on the longer term ambition to enable new board members to develop their shared sense of purpose and direction.

We felt it was very important to focus on what the board is and what it is not. It should become the primary strategic forum for driving improvement in the health and wellbeing system it is not a scrutiny committee and partners, elected members in particular, should not seek to use it as such. Inevitably it has focussed on the Better Care Fund (BCF) and also in part suffered from being seen as a useful place to report progress to on a range of issues. It has to be more than that now and a refocus on purpose will help the board refresh itself. This should include being clear of its positioning in relation to wider partnership structures.

After so much 'churn' in the system the time is right to develop a collective understanding of what only the board can or should do. This is about strategically positioning the board and also seeing it as a collective not just a range of partners coming together. From the conversations the peer team were involved in there is clearly a commitment from board members to 'getting it right' for Southend.

Next steps

The Council, CCG and members of the HWB will undoubtedly wish to reflect on these findings and suggestions before determining how the system wishes to take things forward.

Gary Hughes Principal Adviser, East of England is the main contact between your authority and the Local Government Association. Gary can be contacted at gary.hughesl@local.gov.uk , tel. 07771941337 and can provide access to our resources and any further support.

In the meantime, all of us connected with the peer challenge follow up would like to wish you every success going forward. Once again, many thanks to everyone involved for their participation.

Yours sincerely

Kay Burkett
Programme Manager
Care & Health Improvement Programme & Local Government Support
Local Government Association

Tel: 07909 534126
kay.burkett@local.gov.uk

On behalf of the peer challenge team

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Southend Health & Wellbeing Board

Agenda Item No.

6

Report of

to

Health & Wellbeing Board

on

2 December 2015

Report prepared by:
Ian Ambrose, Group Manager – Financial Management and
Nick Faint BCF Project Manager

For discussion		For information only	X	Approval required	

Better Care Fund
Quarter 2 2015/16Return

Part 1 (Public Agenda Item)

1 Purpose of Report

To bring to the attention of members of the Health and Wellbeing Board the Better Care Fund Quarter 2 2015/16 return

2 Recommendations

To note the report.

3 Background & Context

3.1 The Better Care Fund for 2015/16 was established between Southend CCG and Southend on Sea Borough Council from 1 April 2015. It is underpinned by a legal Section 75 Agreement between the two organisations that sets out the proposed schemes to be funded, the required flows of income into the pooled budget and the distribution back to the scheme leads.

3.2 Over and above the agreement between the CCG and the Council, NHS England require a quarterly return from each Health and Wellbeing Board on progress on delivering the National Conditions, the reduction in Non-elective admissions, various metrics and confirmation of the operation of the monetary pool.

4 Quarter 2 Return

4.1 The Quarter 2 Return is shown at Appendix 1.

4.2 A summary of the key points being reported in Southend's return are highlighted below;

- **National conditions** – we report that we are on schedule to meet the set national conditions, for example, these include (1) whether our plans are jointly agreed or not; and (2) the progression Southend has made regarding ability to share data;
- **Non-Elective and P4P** – we report that we have met our target for reducing Non Elective (NEL) admissions and have therefore recovered the P4P money available for Q2 plus the remaining element from the missed Q4 14/15. We are also asked to confirm a Q4 15/16 NEL reduction target. We have proposed a target of 4,885 admissions, which is a 0% reduction on the baseline. Our historic (previous 2 years) trend has been to maintain the previous year NEL's position for the Q4 period. From the 15/16 BCF there is £0 P4P allocated to Q4 15/16.
- **Income & Expenditure** – we report on the money flowing into and out of the BCF pooled fund.
- **Metrics** – we report that our targets for reablement and admissions to residential care are on track to be met. We additionally report that performance data for friends and family and people with a LTC feeling supported is not currently available in the original baseline format.
- **New Integration measures** – we report performance data for 'use of risk stratification' and Personal Health Budgets.
- **Consistency** – the detail within this report is consistent with both Q4 14/15 and Q1 15/16 reports

4.3 The performance data is showing trends that are all moving in the right direction. NELs are reducing (5.2%) when compared against same period (Jan – Sep) last year. Performance data for social services is improving with residential admissions decreasing and reablement (those over 65 still at home 91 days after discharge) is increasing.

Whilst there is significant activity in the Southend system working on improving our activity and the patient experience our challenge is to ensure we understand which activity has been working well and which hasn't.

This work is ongoing and will support the planning process for BCF 2016/17.

5 Financial Operation of the Pool

5.1 The S75 agreement that underpins the Southend Better Care Fund places a requirement on the Pool Manager to report on the financial operation of the pooled budget.

5.2 Health and Wellbeing Members will recall that the pool, in line with national requirements, is financed by £1.153 million Council contribution and £11.619 million CCG contribution. As required, the Council's contribution consists of two existing capital grants, namely Disabled Facilities Grant and Social Care Grant. Similarly, apart from £3.777 million transferred from NHS England to Southend CCG, in lieu of the value of the 2014/15 NHS Transfer Grant to the

Council now incorporated into the BCF, the CCG contribution comes from its existing resources.

5.3 The £12.771 million pool is then distributed in line with the agreed contributions to the schemes set out in the S75, namely:

CCG Led Schemes		
BCF002	End of Life	£3,000,000
BCF003a	Prevention including Intermediate Care (currently known as Community Recovery Pathway)	£3,051,000
BCF004	GP Hub	£50,000
		£6,101,000
Council Led Schemes		
BCF001	Independent Living (currently known as Protecting Social Services)	£4,781,000
BCF003b	Prevention including Reablement	£1,431,000
BCF005	Infrastructure	£459,000
		£6,671,000

5.4 A proportion of the monies distributed to the CCG is subject to a pay for performance requirement, based on the achievement of the 3.5% target reduction in non-elective admissions through A&E. At the outset of the BCF this was assessed at £977,440. Based on updated baseline performance, the pay for performance element is now assessed at £1,047,470. Effectively of the £6,101,000 planned for distribution to the CCG, £1,047,470 is dependent upon achievement of the 3.5% reduction.

5.5 As at quarter 2 the pool has received the following amounts

From the CCG	Core Amount	£5,320,760
	Pay for Performance	£470,840
From the Council	Core Amount	£576,520
		£6,368,120

5.6 The pool has distributed the following amounts

To the CCG	Core Amount	£2,561,800
	Pay for Performance (yet to be claimed by the CCG)	£470,840
To the Council	Core Amount	£3,335,540
		£6,368,180

5.7 These amounts are reflected in the Income and Expenditure section of the return

6 Health & Wellbeing Board Priorities / Added Value

6.1 The Better Care Fund contributes to delivering HWB Strategy Ambitions in the following ways

6.2 Ambition 5 – Living Independently; through the promotion of prevention and engagement with residents, patients and staff the BCF will actively support individuals living independently.

6.3 Ambition 6 – Active and healthy ageing; through engaging and integrating health and social services within the community the services will be aligned to assisting individuals to age healthily and actively; and

6.4 Ambition 9 – Maximising opportunity; Overarching BCF; Southend is the drive to improve and integrate health and social services. Through initiatives within the BCF we will empower staff to personalize the integrated care individuals receive and residents to have a say in the care they receive.

6.5 The Better Care Fund supports the delivery of the HWB added value outcome of;

a) Increased personal responsibility/participation (sustainability)

7 Reasons for Recommendations

7.1 As part of its governance role, Health and Wellbeing Board will have oversight of the Southend Better Care Fund.

8 Financial / Resource Implications

8.1 As set out in the report and appendix

9 Legal Implications

9.1 None at this stage

10 Equality & Diversity

10.1 The BCF plan should result in more efficient and effective provision for vulnerable people of all ages.

11 Background Papers

12 Appendices

Appendix 1 – Quarter 2 Return

Southend on Sea
BCF Quarterly Data C

HWB Strategy Ambitions

Ambition 1. A positive	**Ambition 2. Promoting**	**Ambition 3. Improving**

start in life A. Children in care | B. Education- Narrow the gap | C. Young carers | D. Children's mental wellbeing | E. Teen pregnancy | F. Troubled families	**healthy lifestyles** A. Tobacco – reducing use | B. Healthy weight | C. Substance & Alcohol misuse	**mental wellbeing** A. Holistic: Mental/physical | B. Early intervention | C. Suicide prevention/self-harm | D. Support parents/postnatal
Ambition 4. A safer population A. Safeguarding children and vulnerable adults | B. Domestic abuse | C. Tackling Unintentional injuries among under 15s	**Ambition 5. Living independently** A. Personalised budgets | B. Enabling community living |C. Appropriate accommodation | D. Personal involvement in care | E. Reablement | F. Supported to live independently for longer	**Ambition 6. Active and healthy ageing** A. Integrated health & social care services | B. Reducing isolation | C. Physical & mental wellbeing | D. Long Term conditions– support | E. Personalisation/ Empowerment
Ambition 7. Protecting health A. Increased screening | B. Increased immunisations | C. Infection control | D. Severe weather plans in place | E. Improving food hygiene	**Ambition 8. Housing** A. Partnership approach to; Tackle homelessness | B. Deliver health, care & housing in a more joined up way | C. Adequate affordable housing | D. Adequate specialist housing | E. Strategic understanding of stock and distribution	**Ambition 9. Maximising opportunity** A. Population vs. Organisational based provision | B. Joint commissioning and Integration | C. Tackling health inequality (improved access to services) | D. Opportunities to thrive; Education, Employment

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Southend Health & Wellbeing Board

Agenda Item No.

7

(Joint) Report of Simon Leftley

to

Health & Wellbeing Board

on

2nd December 2015

Report prepared by: Glyn Jones (Learning Disabilities Commissioning and Strategy Manager)

For information only	x	For discussion		Approval required	

Transforming Care

Part 1 (Public Agenda Item) / Part 2

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1. Purpose of Report

1.1. To update the Board on developments in implementing Transforming Care

2. Recommendations

2.1. Members are asked to note the report

3. Background & Context

3.1. Transforming Care is a national programme that seeks to transform the care of people with, or at risk of, demonstrating behaviour deemed to challenge and who have a learning disability and or autism. The national programme is described in the document: 'Building the right support'. (October 2015)

3.2. The programme seeks to implement measures to reduce the risk that people will develop challenging behaviour by having more responsive local services that prevent escalation. It also seeks more responsive specialist services such as crisis support that intervene when necessary. These latter and more specialist services will be commissioned across a wider geographical area than the Health and Wellbeing Board 'footprint'. Services will therefore be improved within the Health and Wellbeing Board footprint area and also wider.

3.3. Nationally there are 55 Transforming Partnership Board areas. These have been specified by NHS England following partnership discussions. The Pan Essex area Transforming Care Partnership Board covers: Southend-on-Sea Borough Council; Essex County Council and Thurrock Council. It also covers the 7 Essex Clinical Commissioning Groups including Southend Clinical

Commissioning Group. All of these organisations are represented on that Board. The letter sent to partners notifying providers is attached as Appendix 10.1

3.4. Whilst the focus of Transforming Care is on adults it encourages the better alignment of services over the lifecycle, particularly for children and young people.

3.5. Southend-on-Sea Borough Council and Southend Clinical Commissioning Group are working closely together to develop an effective response to this agenda, with local partners under the Pan Essex Transforming Care Board. The Pan Essex Transforming Care Board is chaired by Simon Leftley.

3.6. In line with national expectation the Pan Essex Transforming Care Board will produce a Business Plan for options by the end of March 2016 with implementation over the following 3 years to March 2019. . A picture of the future Pan-Essex model is included in Appendix 10.2

3.7. Part of the development is for each area across Pan Essex to improve the services for people with learning disability and autism within its own footprint/area. This for instance means improving the responsiveness of providers to this agenda and which we are progressing through the development of a Provider Activity Plan.

3.8. The Pan Essex Transforming Care Board is working to a timetable for the development of the Business Plan. Key steps are as follows:

1) Agree project resources – October

2) Convene professional/clinical reference group – November

3) Extend service user/family carer reference group to include Southend and Thurrock – November

4) Secure resources to support procurement – November

5) High level service model agreed by reference groups and Board – November

6) Provisional decision about scope of new contract (geographical coverage) – December Board

7) Baseline funding information and cost envelop agreed – December

8) Need and demand analysis completed – December

9) Final decision about service model, scope and procurement approach - January Board

The Southend-on-Sea Health and Wellbeing Board will be updated on developments.

4. Health & Wellbeing Board Priorities / Added Value

How does this item contribute to delivering the;

- Nine HWB Strategy Ambitions

1) A positive start in life: Development of activities that promote Positive Behaviour Support, early in a person's life.
2) Promoting health lifestyles: Person centred approaches and inclusive mainstream activities.
3) Improving mental wellbeing: Responsive services will be developed that will promote emotional wellbeing. There will also be a better link with mental health services.
4) A safer population: Providers with improved safeguarding approaches.
5) Living independently: Enhanced capacity to live independently through better support. and personal budgets
6) Active and healthy ageing: An improved balance of physical and mental wellbeing to be promoted.
7) Protecting Health: Wider measures around Transforming Care include activities to improve primary care and access to screening services.
8) Housing. Opportunities for healthcare and housing to be more joined up.
9) Maximising opportunity: Furthers joint commissioning and the benefits it brings.

- Three HWB "Broad Impact Goals" which add value;

a) Increased physical activity (prevention)

It will foster person centred approaches to care that will include the enhancement of physical activity.

b) Increased aspiration & opportunity (addressing inequality)

It will enable more people to consider employment through the wider Transforming Care, learning disabilities and autism agenda, particularly with the inclusion of transitions.

c) Increased personal responsibility/participation (sustainability)

Approaches will include aspects that increase personal responsibility. Examples include Personal Budgets.

5. Reasons for Recommendations

5.1. NA

6. Financial / Resource Implications

6.1 Implementing Transforming Care will not increase costs. We think that it will reduce costs over the longer terms. The Business Case will help us to confirm this, The Health and Wellbeing Board will be kept informed.

7. Legal Implications

7.1. There are no legal implications at present. This might change as the partnership develops and commissioning arrangements become clearer.

8. Equality & Diversity

8.1. Equality considerations will be embedded in the approach as the people impacted on are those who now have very poor outcomes. Due regard will be given to protected characteristics as the plan develops and is implemented.

9. Background Papers

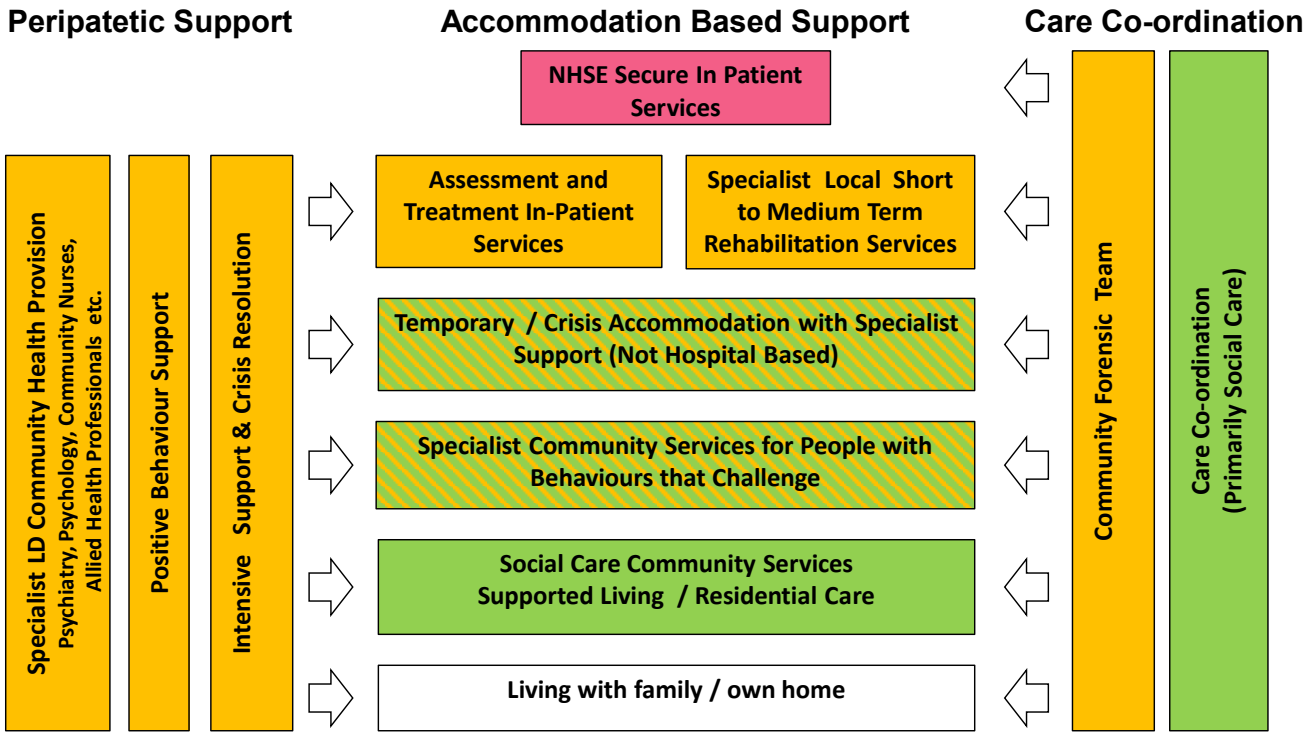
9.1. 'Building the right support', the national programme is available at: www.england.nhs.uk

10. Appendices

10.1. Letter from NHS England; ADASS and the LGA on 'Building the Right Support', outlining Transforming Care expectations to which Transforming Care Partnership Boards need to respond.

10.2. Picture of Pan Essex future model. (A system model to deliver an integrated Learning Disability Pathway).

A system model to deliver an Integrated Learning Disability Pathway



Key

- NHS England Funded Services
- Within Scope of Proposed Contract
- Potential for Joint NHS / LA Services
- Local Authority commissioned services (Initially)

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Skipton House
80 London Road
London
SE1 6LH
Email: jenny.butler6@nhs.net

To:

Clinical Commissioning Group Accountable Officers

Local Authority Directors of Adult Social Services

NHS England: Regional Directors, Transformation Leads, Directors of Commissioning Operations, Directors of Specialised Commissioning

17th November 2015

Dear Colleagues,

Re: Implementing 'Building the right support – A national plan to develop community services and close inpatient facilities'

For a minority of people with a learning disability and/or autism, we remain too reliant on inpatient care. As good and necessary as some inpatient care can be, people are clear they want homes, not hospitals.

To implement this change on Friday 30th October 2015 NHS England, the Local Government Association (LGA), and the Association of Directors of Adult Social Services (ADASS) published **Building the right support** and a new **service model**[1].

Taken together, these documents have asked Local Authorities, Clinical Commissioning Groups (CCGs) and NHS England specialised commissioners to come together to form Transforming Care Partnerships (TCPs) to build up community services and close unnecessary inpatient provisions over the next 3 years and by March 2019.

This letter outlines what commissioners are now required to do, by when, broad planning assumptions, and details of regional briefing events for commissioners, where we will provide more information.

Planning assumptions

Based on national planning assumptions, it is expected that no area should need more inpatient capacity than is necessary at any time to care for:

- 10-15 inpatients in CCG-commissioned beds (such as those in assessment and treatment units) per million population
- 20-25 inpatients in NHS England-commissioned beds (such as those in low-, medium- or high-secure units) per million population

We know that for some local areas, the use of in-patient beds is lower than these planning assumptions. All partnerships will need, however, to work through the complexities of planning for the whole pathway and transfer of commissioning responsibilities for the specialised pathway. It will be important for TCPs to work with their regional leads to ensure that the end states meet the required ambition and that there are no overlaps or gaps between TCPs.

[1] As well as supplementary guidance for commissioners

The four NHS England regional transforming care leads are;

- North – Clare Duggan
- Midlands and East – Lynne Wigens
- London – Matthew Trainer
- South – Sarah Elliott

To deliver on these planning assumptions it is essential that areas build up capacity in communities and redesign pathways in order to better support people at home. An important component of partnership preparations will be analysis to inform plans for commissioning intensive community support services. Plans will need to evidence clear early milestones where such services are not yet fully in place.

To support local areas with transitional costs, NHS England will make available up to £30 million of transformation funding over three years, with national funding conditional on *match-funding* from local commissioners.

In addition to this, £15 million capital funding will be made available over three years.

What we are asking of you

CCGs have been working with NHS England's regions and with Local Authority colleagues to identify the footprint of each TCP and the proposed footprints were published in the plan (**Annex 1).** However we are aware that some strategic alliances are already being formed that may differ from those proposed. Final arrangements for these clusters are expected to be in place by 15th December 2015.

TCPs should allow for areas to commission at sufficient scale to manage risk, develop commissioning expertise and commission strategically for the relatively small number of individuals whose packages of care can be very expensive.

We are asking all TCPs to draw up a joint transformation plan by 8th February 2016. This plan will have to be jointly agreed by all partners in the TCP, including Local Authorities and NHS England specialised commissioning teams and involve people with lived experience of inpatient services and their families/carers[2].

A template for this plan will be shared shortly and further guidance on what the plan should cover is included in **Building the right support**.

Each plan will be reviewed by local panels, including expert clinical input, in order to provide useful feedback. Panels will include NHS England and LGA/ADASS representatives - as well as people with a learning disability and/or autism, their families/carers - looking at:

- Whether the plans fit with national principles and the approach set out in **Building the right support**
- Proposals for a share of the £30 million transition funding and, if appropriate, a share of the capital funding to supplement local match funding and sustainable investment into new service models

Panels may want to probe some areas of the plan in more detail, via calls/meeting with key individuals in February 2016.

To support you to deliver these changes, a bespoke package of support will be put in place to help areas plan for transformation. Each package of support will be discussed with NHS England regional teams. This exercise will also provide further detail on the financial arrangements, including setting out the indicative budget for each TCP to inform the regional team about their expected share of transition funding.

[2] Two tools looking at how areas can assess levels of co-production can be accessed here and here.

We will work to ensure that the process for submitting and assuring plans will align with other planning processes across Local Authorities and the NHS, including the process for assuring CCGs' annual plans. Further guidance will be provided later in the year.

Key Milestones

There are a number of key milestones for 2015/16 which are essential to ensure the effective delivery of Phase 1 of the 'mobilisation' of the programme.

November 2015:

- Agree and confirm organisational / governance arrangements (mobilise 'partnerships')
- Appoint Senior Responsible Officer SRO and deputy from health and social care.
- Agree Lead CCG (for host finance arrangements)
- Agree involvement and engagement with NHS England specialised commissioners;
- Agree launch or 'go-live' date for partnership (where not already working together formally)
- Transformation planning approach formalised, including workforce and financial modelling and the approach to workforce development especially in relation to positive behavioural support and leadership of change across the system

December 2015:

- Agree outline scope of transformation plan and timescale for local delivery (includes publishing meeting dates for governing board)

January to March 2016:

- First governing board meeting (if not already in train)
- Drafting of transformation plans
- First cut transformation plan by 8th February 2016
- Local assurance of plan coordinated through NHS England with stakeholders
- Finalise plan following regional and national moderation and feedback within March 2016

April 2016

- Begin to implement plans
- Final plan due 11th April

Dialogue Events

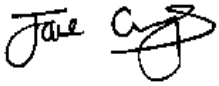
We will be holding multiple dialogue events across the country to bring TCPs and all stakeholders together commencing on the 7th December 2015 wherein we will provide more detail of the support available, timescales and expectations. All events will be held 10am – 1pm at the following venues

- Monday 7th December 2015 – Leicestershire County Cricket Club, LE2 8AD
- Tuesday 8th December 2015 – Gateway Conference Centre, Liverpool, L3 8HY
- Wednesday 9th December 2015 – Cambridge United Football Club, Cambridge, CB5 8LN
- Friday 11th December 2015 – Venue to be confirmed
- Monday 14th December 2015 – Radisson Blu Hotel, Leeds city centre, LS1 8TL
- Wednesday 16th December – The Wesley, 81-103 Euston Street, London, NW1 2EZ
- Thursday 17th December 2015 – Holiday Inn, Regents Park, London, W1 5EE

Booking details for these events will be confirmed. Further events will be held in January 2016 to discuss the implementation of plans and details of these will follow.

Once again, thank you for your involvement so far and we look forward to working with you over the coming weeks.

Yours sincerely,



Jane Cummings

Chief Nursing Officer for England

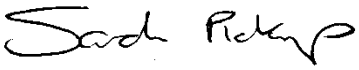
National Director, Nursing

NHS England

Ray James

President

Association of Directors of Adult Social Services



Sarah Pickup

Deputy Chief Executive

Local Government Association

Barbara Hakin

National Director, **Commissioning Operations**

NHS England

Annex A - Summary of Key Actions

Please review actions below and TCPs to confirm arrangements with **jenny.butler6@nhs.net** in line with the timescales below.

Transforming Care Partnerships

	What	Who	When
1	Confirm final partnership organisations and population coverage	TCP	15th December 2015
2	Confirm SRO and deputy	TCP	15th December 2015
3	Confirm lead CCG	TCP	15th December 2015
4	Confirm governance arrangements and board meeting schedule	TCP	15th December 2015
5	First TCP board meeting	TCP	January 2016
6	Draft Plan	TCP	8th February 2016
7	Revise plan	TCP	March 2016
8	Final Plan	TCP	11th April 2016

NHS England

	What	Who	When
1	Confirm Planning template and additional supporting materials	NHS England	December 2015
2	Organise dialogue events	NHS England	December 2015
3	NHS England specialised commissioning hubs to identify named relationship manager for each partnership	NHS England	15th December 2015
4	Confirm Assurance approach	NHS England	December 2015
5	Undertake assurance of TCP plans	NHS England and stakeholders	February 2016

Annex B

Transforming Care Partnership	**Clinical Commissioning Group (CCG)**
South Worcestershire, Redditch, Bromsgrove & Wyre Forest	NHS South Worcestershire CCG
	NHS Wyre Forest CCG
	NHS Redditch and Bromsgrove CCG
Hereford	NHS Herefordshire CCG
Coventry, Rugby, South Warwickshire & Warwickshire North	NHS Coventry and Rugby CCG
	NHS South Warwickshire CCG
	NHS Warwickshire North CCG
Birmingham CrossCity, Birmingham South Central & Solihull	NHS Birmingham CrossCity CCG
	NHS Birmingham South and Central CCG
	NHS Solihull CCG
Walsall	NHS Walsall CCG
Black Country	NHS Dudley CCG
	NHS Sandwell and West Birmingham CCG
	NHS Wolverhampton CCG
Derbyshire	NHS Erewash CCG
	NHS Southern Derbyshire CCG
	NHS Hardwick CCG
	NHS North Derbyshire CCG
Nottinghamshire	NHS Mansfield and Ashfield CCG
	NHS Bassetlaw CCG
	NHS Newark and Sherwood CCG
	NHS Nottingham City CCG
	NHS Nottingham North and East CCG
	NHS Nottingham West CCG
	NHS Rushcliffe CCG
Suffolk	NHS Ipswich and East Suffolk CCG
	NHS West Suffolk CCG
Norfolk	NHS North Norfolk CCG
	NHS Norwich CCG

	NHS South Norfolk CCG
	NHS West Norfolk CCG
	NHS Great Yarmouth and Waveney CCG
Cambridge and Peterborough	NHS Cambridgeshire and Peterborough CCG
Essex	NHS Basildon and Brentwood CCG
	NHS Castle Point and Rochford CCG
	NHS Mid Essex CCG
	NHS North East Essex CCG
	NHS Southend CCG
	NHS Thurrock CCG
	NHS West Essex CCG
Bedford, Luton and Milton Keynes	NHS Bedfordshire CCG
	NHS Luton CCG
	NHS Milton Keynes CCG
Hertfordshire	NHS East and North Hertfordshire CCG
	NHS Herts Valleys CCG
Nene and Corby	NHS Nene CCG
	NHS Corby CCG
Lincolnshire	NHS Lincolnshire East CCG
	NHS Lincolnshire West CCG
	NHS South Lincolnshire CCG
	NHS South West Lincolnshire CCG
Leicestershire	NHS East Leicestershire and Rutland CCG
	NHS Leicester City CCG
	NHS West Leicestershire CCG
Shropshire	NHS Shropshire CCG
	NHS Telford and Wrekin CCG
Staffordshire	NHS East Staffordshire CCG
	NHS North Staffordshire CCG
	NHS South East Staffordshire and Seisdon Peninsular CCG
	NHS Stafford and Surrounds CCG
	NHS Cannock Chase CCG
	NHS Stoke-on-Trent CCG
Gloucestershire	NHS Gloucestershire CCG
Wiltshire and Swindon	NHS Swindon CCG
	NHS Wiltshire CCG
Bristol, Bane and South Gloucestershire	NHS Bristol CCG
	NHS South Gloucestershire CCG

	NHS Bath and North East Somerset CCG
Somerset and North Somerset	NHS North Somerset CCG
	NHS Somerset CCG
Cornwall	NHS Kernow CCG
Devon	NHS North, East, West Devon CCG
	NHS South Devon and Torbay CCG
Kent and Medway	NHS Ashford CCG
	NHS Canterbury and Coastal CCG
	NHS Dartford, Gravesham and Swanley CCG
	NHS Medway CCG
	NHS South Kent Coast CCG
	NHS Swale CCG
	NHS Thanet CCG
	NHS West Kent CCG
Sussex	NHS Brighton and Hove CCG
	NHS High Weald Lewes Havens CCG
	NHS Eastbourne, Hailsham and Seaford CCG
	NHS Hastings and Rother CCG
	NHS Coastal West Sussex CCG
	NHS Crawley CCG
	NHS Horsham and Mid Sussex CCG
Surrey	NHS Guildford and Waverley CCG
	NHS North West Surrey CCG
	NHS Surrey Downs CCG
	NHS East Surrey CCG
	NHS Surrey Heath CCG
Buckinghamshire	NHS Aylesbury Vale CCG
	NHS Chiltern CCG
Berkshire	NHS Bracknell and Ascot CCG
	NHS Slough CCG
	NHS Windsor Ascot and Maidenhead CCG
	NHS Newbury and District CCG
	NHS North and West Reading CCG
	NHS South Reading CCG
	NHS Wokingham CCG
Hampshire & Isle of Wight	NHS North East Hampshire and Farnham CCG
	NHS North Hampshire CCG
	NHS Portsmouth CCG

	NHS South Eastern Hampshire CCG
	NHS Southampton CCG
	NHS West Hampshire CCG
	NHS Fareham and Gosport CCG
	NHS Isle of Wight CCG
Dorset	NHS Dorset CCG
Wirral, Cheshire & Chester Halton, St Helens, Warrington, Knowsley, Liverpool, Sefton, Southport & Formby	NHS Wirral CCG
	NHS West Cheshire CCG
	NHS Eastern Cheshire CCG
	NHS South Cheshire CCG
	NHS Vale Royal CCG
	NHS Halton CCG
	NHS St Helens CCG
	NHS Warrington CCG
	NHS Knowsley CCG
	NHS South Sefton CCG
	NHS Southport and Formby CCG
	NHS Liverpool CCG
Greater Manchester	NHS Bolton CCG
	NHS Bury CCG
	NHS Central Manchester CCG
	NHS Heywood, Middleton and Rochdale CCG
	NHS North Manchester CCG
	NHS Oldham CCG
	NHS Salford CCG
	NHS South Manchester CCG
	NHS Stockport CCG
	NHS Tameside and Glossop CCG
	NHS Trafford CCG
	NHS Wigan Borough CCG
Lancashire	NHS Blackburn with Darwen CCG
	NHS Blackpool CCG
	NHS Chorley and South Ribble CCG
	NHS East Lancashire CCG
	NHS Fylde and Wyre CCG
	NHS Greater Preston CCG
	NHS Lancashire North CCG
	NHS West Lancashire CCG
	NHS Cumbria CCG
	NHS Newcastle Gateshead CCG
	NHS North Tyneside CCG

Cumbria and North East	NHS Northumberland CCG
	NHS South Tyneside CCG
	NHS Sunderland CCG
	NHS Darlington CCG
	NHS Durham Dales, Easington and Sedgefield
	NHS Newcastle North and East CCG
	NHS Newcastle West CCG
	NHS Hartlepool and Stockton-on-Tees CCG
	NHS North Durham CCG
	NHS South Tees CCG
North Yorkshire	NHS Hambleton, Richmondshire and Whitby
	NHS Harrogate and Rural District CCG
	NHS Scarborough and Ryedale CCG
	NHS Vale of York CCG
Barnsley, Wakefield, Kirklees, Huddersfield & Calderdale	NHS Barnsley CCG
	NHS Wakefield CCG
	NHS North Kirklees CCG
	NHS Greater Huddersfield CCG
	NHS Calderdale CCG
Bradford	NHS Bradford Districts CCG
	NHS Bradford City CCG
	NHS Airedale, Wharfdale and Craven CCG
Leeds	NHS Leeds North CCG
	NHS Leeds South and East CCG
	NHS Leeds West CCG
Sheffield, Doncaster, Rotherham, North Lincolnshire	NHS Doncaster CCG
	NHS Rotherham CCG
	NHS North East Lincolnshire CCG
	NHS North Lincolnshire CCG
	NHS Sheffield CCG
East Riding & Hull	NHS East Riding of Yorkshire CCG
	NHS Hull CCG
London North West	NHS Brent CCG
	NHS Central London CCG
	NHS Ealing CCG
	NHS Hammersmith and Fulham CCG
	NHS Harrow CCG

	NHS Hillingdon CCG
	NHS Hounslow CCG
	NHS West London CCG
London North, Central & East	NHS Barking and Dagenham CCG
	NHS Barnet CCG
	NHS Camden CCG
	NHS City and Hackney CCG
	NHS Enfield CCG
	NHS Haringey CCG
	NHS Havering CCG
	NHS Islington CCG
	NHS Newham CCG
	NHS Redbridge CCG
	NHS Tower Hamlets CCG
	NHS Waltham Forest CCG
London South East	NHS Bexley CCG
	NHS Bromley CCG
	NHS Greenwich CCG
	NHS Lambeth CCG
	NHS Lewisham CCG
	NHS Southwark CCG
London South West	NHS Croydon CCG
	NHS Kingston CCG
	NHS Merton CCG
	NHS Richmond CCG
	NHS Sutton CCG
	NHS Wandsworth CCG
Oxfordshire	NHS Oxfordshire CCG

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Southend Health & Wellbeing Board

Agenda Item No.

8

Report of Southend CCG Chief Officer

to

Health & Wellbeing Board

on

2 December 2015

Report prepared by: Hugh Johnston, Commissioning Manager for Mental Health & Learning Disabilities Services

For information only	**X**	For discussion		Approval required	

ESSEX MENTAL HEALTH REVIEW

Part 1

1. Purpose of Report

1.1. To make the Health and Wellbeing Board aware of the outcomes and recommendations from the Essex Mental Health Review.

2. Recommendations

2.1. The Health and Wellbeing Board is asked to **note** the Mental Health Review and the recommendations for taking the work forward.

3. The Essex Mental Health Review

3.1. Commissioners and providers across Essex have engaged in discussion over the last year around how best to provide mental health care to service users in the context of challenging financial, demographic and operational pressures. In May 2015 we jointly commissioned a formal review in order to assess the current state and make recommendations around the best way forward. The scope of the review focused on mental health services commissioned locally and provided by the local NHS specialist mental health service providers: South Essex Partnership University NHS Foundation Trust (SEPT) and North Essex Partnership NHS Foundation Trust (NEP). The impact and implications of any recommendations on adjacent services (for example, mental health services commissioned by NHS England) were also considered.

3.2. Boston Consulting Group was retained to undertake the review which took place from July to September and involved extensive analysis of data, both publicly available and supplied by SEPT and NEP, and interviews and group discussions with a wide range of GPs, secondary care clinicians, patients and commissioners in both CCGs and local authorities. Appendix 1 contains a copy of the final report from the review.

3.3. The key findings of the review are:

3.3.1. The commissioning landscape for mental health is complex. This complexity is driven by three main factors:

- *Multiple commissioners – commissioning capacity is fragmented across an environment that is specialist and increasingly complex. There is a lack of seniority and capability. There is limited intelligence on needs, service activities and outcomes.*

- *The integration agenda - each CCG is considering different local models of integrated care with different views on which mental health services should be included and are all moving different speeds.*

- *Funding misalignment - the current block contracts originate from PCT days with costs allocated using different approaches in the north and the south.*

3.3.2. SEPT and NEP are facing three significant and inter-related challenges:

- *Shrinking market - the overall market for specialist mental health trusts is shrinking as commissioners pursue their integration agenda.*

- *Challenging finances - mental health funding has been historically challenging, and providers face a 4% year-on-year efficiency requirement as well as significant CIP targets.*

- *Potential brand issues - feedback indicates that both providers face challenges around the strength of their brand – perception amongst commissioners is mixed around responsiveness to changes in policy, communication regarding service changes, and data transparency.*

4. Implications

4.1 The status quo is not an option: the commissioning landscape will become more complicated as the integration agenda plays out; there are not sufficient facts and data to prioritise services in order to make more efficient (and transparent) use of limited available resources; and providers are likely to fail (financially) posing risk to the continuity of services and the safety of service users.

5. Summary of review recommendations

5.1 <u>Simplify the commissioning landscape</u>

5.1.1 Clarify the integration agenda

5.1.2 Align around a clear commissioning path

5.1.3 Work through how best to deploy social workers as the integration agenda plays out

5.1.4 Agree a plan to re-align funding between CCGs

5.1.5 Define where dementia services should sit

5.2 Create a common language and use to clarify needs and expectations

5.2.1 Agree a common language

5.2.2 Clarify the desired provider capabilities

5.2.3 Optimise section 75 partnership arrangements

5.2.4 Work with providers around The Care Act compliance

5.3 Generate and share more data across the system

5.3.1 Conduct robust needs assessments

5.3.2 Develop and track better outcomes

5.3.3 Share the output of ongoing needs assessment work in dementia

5.4 Work more jointly

5.4.1 Create a pan-Essex mental health commissioning team

5.4.2 Optimise approved mental health professional (AMHP) arrangements

5.4.3 Work together to ensure all-age, cross-system care

6. Next steps

6.1. The following next steps for this work have been proposed review steering group:

6.1.1. Develop appropriate governance arrangements for taking the review recommendations forward, with a clear commitment from all to maintain a collaborative strategic leadership group with all 10 commissioners and the 2 Trusts represented at a senior level to drive the work forward.

6.1.2. Commissioners and providers are separately working up implementation plans to take forward recommendations. These will be overseen at a system level by the above group.

6.1.3. Commissioners are working up options for creating a different, collaborative commissioning model that meets the needs and aspirations of all NHS and Local authority commissioners. This will be brought back through organizational governance routes before the end of the year. As part of this work the benefits of developing an all-age team that includes the commissioning function for Emotional Well-being and Mental Health services for children and young people is being considered. This is currently hosted by West Essex CCG on behalf of all 10 commissioners.

6.1.4. Commissioners and providers are making joint representations into the Success Regime diagnostic process to secure funding in year to resource the immediate next phase of work.

6.2. There is a strong commitment from all parties to take this work forward now at pace, and with an emerging direction of travel for services over the next 5 years. (see report page 21).

7. Health & Wellbeing Board Priorities / Added Value

7.1. This report and its recommendations relate directly to the HWB ambition of improving mental wellbeing, and in particular to:

7.1.1. A holistic approach to mental and physical wellbeing

7.1.2. Providing the right support and care at an early stage

7.1.3. Work to prevent suicide and self-harm

8. Reasons for Recommendations

8.1. It is important that the HWB is aware of the outcomes from the review and the implications this has for mental health services in Southend. Southend CCG has approved the recommendations in the report.

9. Financial / Resource Implications

9.1. There may be additional costs for Southend CCG in supporting the development of a central commissioning team for specialist mental health services.

10. Legal Implications

10.1. There are no legal implications.

11. Equality & Diversity

11.1. The recommendations of the report are in line with the overall national policy of establishing parity of esteem for mental health and reducing stigma.

12. Background Papers

12.1. The report of the Essex Mental Health Review is attached as Appendix 1.

13. Appendices

13.1. Essex Mental Health Review report.

HWB Strategy Priorities

Broad Impact Goals – adding value

a) Increased Physical Activity (prevention)
b) Increased Aspiration and Opportunity (addressing inequality)
c) Increased Personal Responsibility and Participation (sustainability)

Ambition 1. A positive start in life a) Reduce need for children to be in care b) Narrow the education achievement gap c) Improve education provision for 16-19s d) Better support more young carers e) Promote children's mental wellbeing f) Reduce under-18 conception rates g) Support families with significant social challenges	**Ambition 2. Promoting healthy lifestyles** a) Reduce the use of tobacco b) Encourage use of green spaces and seafront c) Promote healthy weight d) Prevention and support for substance & alcohol misuse	**Ambition 3. Improving mental wellbeing** a) A holistic approach to mental and physical wellbeing b) Provide the right support and care at an early stage c) Reduce stigma of mental illness d) Work to prevent suicide and self-harm e) Support parents postnatal
Ambition 4. A safer population a) Safeguard children and vulnerable adults against neglect and abuse b) Support the Domestic Abuse Strategy Group in their work c) Work to prevent unintentional injuries among under 15s	**Ambition 5. Living independently** a) Promote personalised budgets b) Enable supported community living c) People feel informed and empowered in their own care d) Reablement where possible e) People feel supported to live independently for longer	**Ambition 6. Active and healthy ageing** a) Join up health & social care services b) Reduce isolation of older people c) Physical & mental wellbeing d) Support those with long term conditions e) Empower people to be more in control of their care
Ambition 7. Protecting health a) Increase access to health screening b) Increase offer of immunisations c) Infection control to remain a priority for all care providers d) Severe weather plans in place e) Improve food hygiene in the Borough	**Ambition 8. Housing** a) Work together to; o Tackle homelessness o Deliver health, care & housing in a more joined up way b) Adequate affordable housing c) Adequate specialist housing d) Understand condition and distribution of private sector housing stock, to better focus resources	**Ambition 9. Maximising opportunity** a) Have a joined up view of Southend's health and care needs b) Work together to commission services more effectively c) Tackle health inequality (including improved access to services) d) Promote opportunities to thrive; Education, Employment

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Essex Mental Health Review

Final Report

28th September 2015

Contents

1. The Essex Mental Health Review: purpose and scope

Commissioners and providers across Essex have engaged in discussion over the last year around how best to provide mental health care to service users in the context of challenging financial, demographic and operational pressures.

In May 2015 they jointly commissioned a formal review in order to assess the current state and make recommendations around the best way forward[1].

The scope of the review is focused on mental health services commissioned locally and provided by the two main local NHS providers: North Essex Partnership NHS FT (NEP) and South Essex Partnership NHS FT (SEPT). The impact and implications of any recommendations on adjacent services (for example, mental health services commissioned by NHS England) are also considered.

This document is the final output of the review, and provides an overview of the context, findings and recommendations. There are additional detailed facts and data in the accompanying document: **Appendix 1.**

The work has been shaped by over 200 individual points of engagement – including with service users, clinicians and other healthcare professionals, and commissioners. For full details of the stakeholders and overall process see **Appendix 2** below**.**

[1] Review commissioned jointly by Basildon and Brentwood CCG; Castlepoint and Rochford CCG; Essex County Council; Mid Essex CCG; North Essex Partnership NHS FT; North East Essex CCG; South Essex Partnership NHS FT; Southend CCG; Southend Unitary Authority; Thurrock CCG; Thurrock Unitary Authority; West Essex CCG.

2. Key messages

Findings

The ***commissioning*** landscape for mental health is complex driven by three main factors:

Multiple commissioners: feedback suggests that the current configuration of 30-50 roles are not commissioning mental health services effectively. This is driven by (i) fragmented resources in a specialist and increasingly complex environment; (ii) insufficient seniority and capabilities; and (iii) the lack of a robust fact base on needs, service activities and outcomes.

The integration agenda: each CCG is considering different local models of integrated care with different views on which mental health services should be included and are all moving different speeds This 'ragged edge' makes planning from a provider perspective challenging – particularly as some of their mental health teams work across more than one commissioning area. Moreover, we expect these emerging models to be further refined as they receive greater clinical and professional input.

Funding misalignment: the current block contracts originate from PCT days with costs allocated using different approaches in the north and the south. This has resulted in a number of misalignments between CCGs: as finances become tighter and CCGs look to fund some services in local models, these subsidies need to be unwound.

The ***providers*** NEP and SEPT are facing three significant and inter-related challenges:

Shrinking market: The overall market for specialist mental health trusts is shrinking as commissioners pursue their integration agenda. In addition, NEP and SEPT have recently lost market share to competitors, for example Essex CAMHS services to North East London NHS FT (NELFT).

Challenging finances: mental health funding has been historically challenging, and providers face a 4% year-on-year efficiency requirement as well as significant CIP targets. NEP in particular is facing significant short term difficulties.

Potential brand issues: feedback indicates that both providers face challenges around the strength of their brand – perception amongst commissioners is mixed around responsiveness to changes in policy, communication regarding service changes, and data transparency.

Implications

The status quo is not an option: the commissioning landscape will become more complicated as the integration agenda plays out; there are not sufficient facts and data to prioritise services in order to make more efficient (and transparent) use of limited available resources; and providers are likely to fail (financially) posing risk to the continuity of services and the safety of service users.

Summary of recommendations

1. Simplify the commissioning landscape

1a Clarify the integration agenda: commissioners should refine the scope of mental health services planned to be within their local integration models with greater clinical and professional leadership. In addition, rather than each moving at their own pace, we recommend commissioners agree a more uniform integration timeline. This will involve a change of pace for some but result in faster and less complicated implementation.

1b Align around a clear commissioning path: building off *1a* above, commissioners should agree a shared commissioning path to clarify what mental health and personal care services will be commissioned, by whom, and when. A draft view has been described as part of this work for commissioners to consider.

For providers, clarity of the path and timing will enable them to refine their strategy - including which services to focus on, and whether collaboration or merger would result in a stronger financial (and clinical) position from which to deliver care.

1c Work through how best to deploy social workers as the integration agenda plays out: as services are integrated and existing pathways change, local authorities and CCGs will need to jointly assess how best to deploy social workers – for example whether these should follow services or whether they should be organised in a more centralised way.

1d Agree a plan to re-align funding between CCGs: commissioners should agree the approach and timeline to reapportion expenditure and Resource Limit to ensure an affordability neutral solution ahead of implementing the local integration agenda.

1e Define where dementia services should sit: local authorities should agree with their local CCGs whether to move dementia under Public Health and Wellbeing as an all-age pathway, whether it should remain split within Adult Social Care

2. Create a common language and use to clarify needs and expectations

2a Agree a common language: commissioners and providers should agree to use a single terminology / language going forward. Clinical input suggests clusters may be the most reasonable lexicon given the national direction – although there is no single perfect solution.

2b Clarify the desired provider capabilities: commissioners should, working with providers, undertake to create a common and shared set of required provider capabilities, for example around IT; culture; flexibility; data transparency.

2c Optimise section 75 partnership arrangements: in the south, the three local authorities should commit to working together to create a common template, shared performance targets, and single joint oversight meeting in order to reduce effort and avoid duplication.

2c Work with providers around The Care Act compliance: local authorities should develop clear and consistent expectations for providers' compliance with the Care Act, including what should be

incorporated into their contracts in terms of access to pathways for people in distress. This will involve discussions around appropriate funding to ensure these are realistic expectations.

3. Generate and share more data across the system

3a Conduct robust needs assessments: commissioners should work with clinicians and professionals to assess service user health and personal care needs, including how these differ by geography, locality (e.g. urban vs. rural), and cluster segment.

3b Develop and track better outcomes: building off *3a* above, commissioners should work with clinicians and professionals develop desired outcomes – these will inform which services should be commissioned, and how they will be monitored. They will also support funding prioritisation decisions.

3c Share the output of ongoing needs assessment work in dementia: local authorities should ensure learnings and outputs are widely disseminated to avoid duplication.

4. Work more jointly

4a Create a pan-Essex MH commissioning team: commissioners should consider a smaller, more senior mental health team – for example around 10 FTEs – that includes senior analytics, business intelligence, and financial expertise. This would provide real leverage and help make necessary trade-offs between services and cost – the need for which was highlighted at the Clinical Conference held in August.

The exact organisational form and governance processes should be jointly agreed by commissioners in the coming weeks. Importantly, a single team does not mean a 'one size fits all' solution. Needs, services, activities and outcomes need to be tailored to local geographies.

The principles behind having a smaller, shared team are to attract and fund the appropriate seniority of resource; support simplification; enable the use of a common language; create a single fact base of needs, activities, and outcomes; and build off the CAMHS experience of joint working across health and social care.

Between now and April 2016 the team would work through recommendations *3a* and *3b* above: conduct robust needs assessments; determine gaps; agree outcomes; describe what services should be commissioned to deliver these; prioritise funding; draft commissioning intentions; and refine the draft commissioning path described in *1a* above. From April onwards, there are choices around what role it should continue to play – for example whether it should take on a more supportive role or commission pan-Essex services.

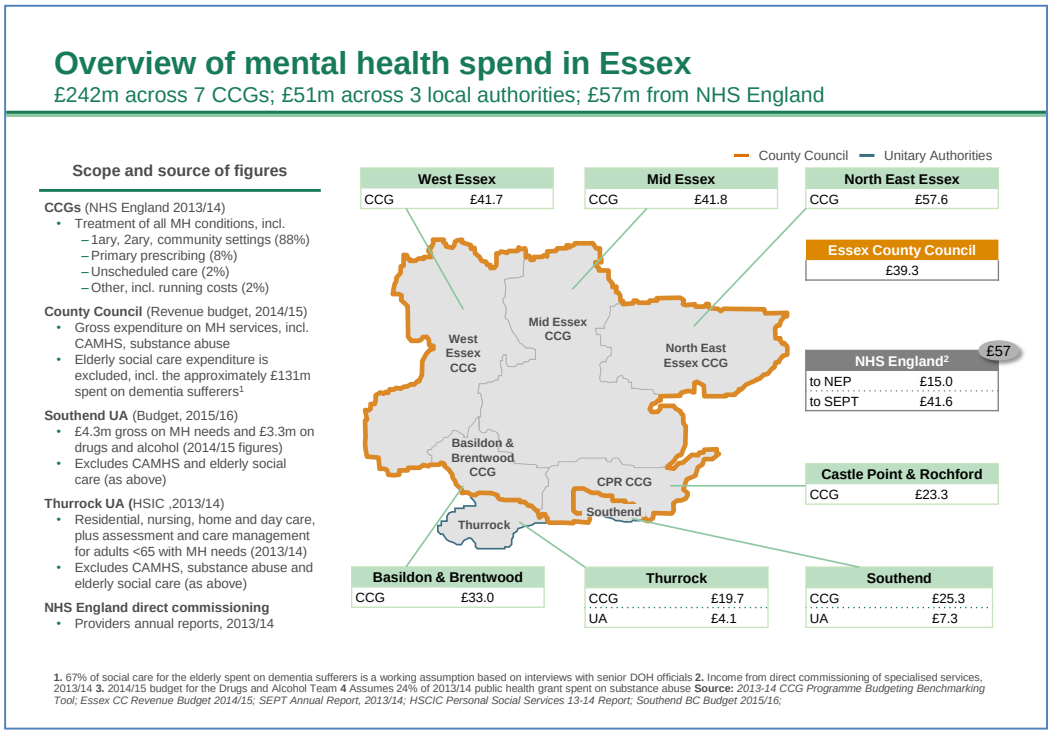
4b Optimise AMPHs arrangements: local authorities should work jointly to increase the overall number of AMPHs, and consider sharing a single rota to maximise efficiency.

4c Work together to ensure all-age, cross-system care: all commissioners should build on the CAMHS experience and commit to working together to improve outcomes for the most vulnerable individuals, and ultimately develop a shared vision for mental health in Essex.

3. Context

(i) Spend on Mental Health (MH) services in Essex

The Essex health economy spends a total of £c.350mm on MH services. Of this, £242m is commissioned by the 7 local NHS CCGs; £51m by Essex County Council (ECC) and the two Unitary Authorities (UAs) in the south; and £57m by NHS England. In addition, ECC spends an additional £195m social care of older adults, of which approximately £130m is spent on dementia[2].



Per capita, the CCGs spend between approximately £98 and £151 per capita when adjusted for differences in population - this is broadly in line with the national average. ECC spend £45 per capita which is slightly above the national average, and the two UAs spend £56 (Southend) and £50 (Thurrock) which is slightly below.

Historically, mental health funding has been constrained. National investment in mental health services fell in real terms between 2011 and 2014[3]. In Essex, CCG spend on mental health has decreased by around 6% p.a. between 2010/11 and 2014/15. The funding challenge has been driven by a number of factors, including a tariff deflator of -1.8% (vs. -1.2% in the acute sector). In addition, services have been impacted by budget cuts on the Local Authority (LA) side: ECC spend on adult mental has declined by 2% and older adult mental health by 3% over the same period.

Going forward, the working assumption is that the mental budget has been ring-fenced and so unlike other areas of the system, will not decline further – but is not expected to increase. See **Appendix 1, Section 1** for additional detail regarding mental health spend.

[2] £131m of the £195m spent on social care for older people in 2014/15 is estimated to have been spent on dementia sufferers based on national estimates from DoH; includes residential and nursing care (£80m), homecare and respite (£26m), reablement (£5m) and cash payments (£6m)
[3] Mental Health Network: The Future of Mental Health, March 2014

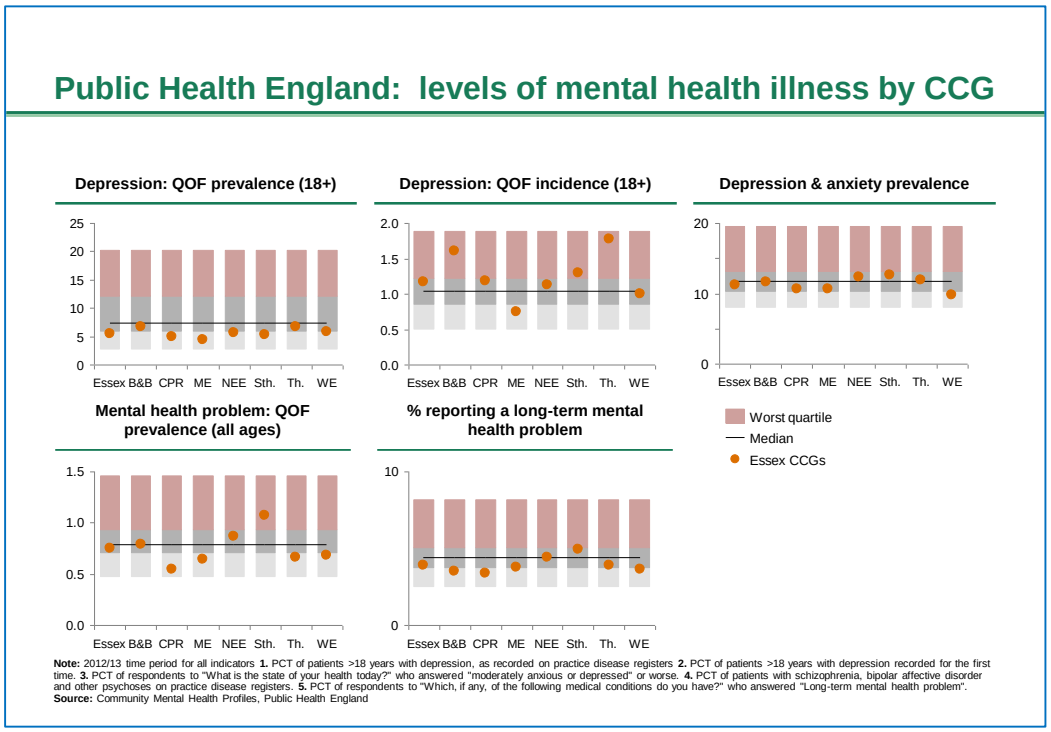
(ii) Demand

The working assumption of this review is that total spend on mental health services in Essex is fixed. However there are no recent, robust needs assessments to properly guide what services should be commissioned, and for which service users[4].

Nationally, demand for mental health services is growing. By 2030, there are likely to be approximately 2 million more adults in the UK with mental health problems due to population growth alone[5]. In addition, prevalence is thought to be increasing, particularly for common mental health disorders such as depression and anxiety[6]. Unmet need is already high. The London School of Economics and Political Science estimates that only around a quarter of people with mental health problems receive treatment[7].

For older adults, demand for dementia services will rise in line with an increasingly elderly population. For example in North Essex, 51% of the population growth by 2016 will be in over-65s[8]. Some estimates suggest that the prevalence of dementia will increase by 40% over the next 12 years[9].

Data from Public Health England for Essex are shown below.

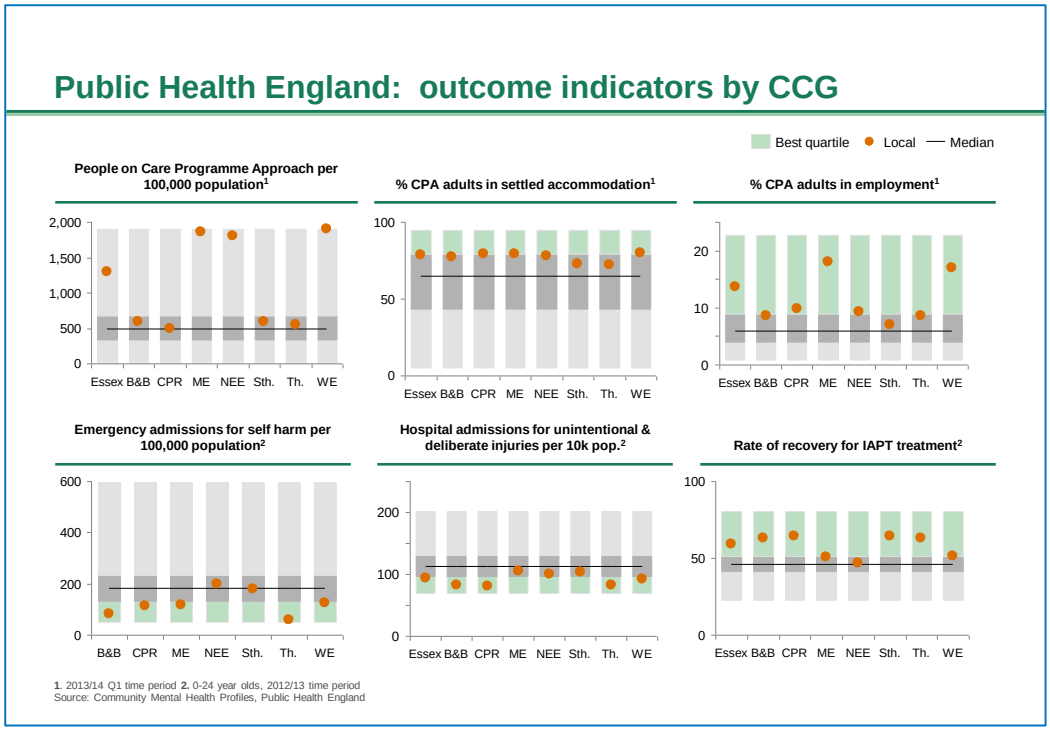


[4] See also Section 7: Recommendations for Commissioners
[5] Mental Health Network factsheet, 2014
[6] Mental Health Foundation: Starting Today: Future of Mental Health Services, 2013
[7] Centre for Economic Performance: How mental illness loses out in the NHS. London School of Economics and Political Science, June 2012
[8] NEP operational plan 2014-16
[9] Alzheimer's Society: http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=412

(iii) Outcomes

There is an overall paucity of robust, consistent outcome data in mental health. This is highlighted in the recent interim report from the Royal College of Psychiatrists[10] which suggests a significant data and information shortfall is making it difficult to understand what is happening throughout the system, to measure variation, and to bring about improvements. The Royal Society of Psychiatry has recently highlighted a significant shortfall in mental health data and wide variations in service models and definitions, which compares poorly to the acute sector.[11] Poor data and inconsistent definitions, compounded by a lack of consensus around outcome measures, is recognised to be undermining management and commissioning of mental health services. Improvements have been made – IAPT is more consistent and data rich for instance – but overall feedback from clinical and professional engagement in Essex reinforces the national viewpoint.

Limited data are available around outcomes for mental health in Essex. Nationally gathered Public Health England indicators are shown below. Over time, there is a need to agree outcome metrics locally to help define the goals for services and against which to monitor provision.[12].



(iv) National policy / trends in mental health

Early intervention

In line with the national policy embodied in *No health without mental health*[13], there has been a push towards increasing investment in early intervention schemes in order to manage demand and avoid costly inpatient admissions. Most notably, the Improving Access to Psychological

[10] Royal College of Psychiatrists: Interim report, Improving acute inpatient psychiatric care for adults, July 2015
[11] Improving acute inpatient psychiatric care for adults in England: Interim report, RCPsych Commission on Acute Adult Psychiatric Care, July 2015
[12] See also Section 7: Recommendations for Commissioners
[13] HMG/DG, No health without mental health, February 2011

Therapies (IAPT) programme aims to improve access to talking therapies for depression and anxiety. The Department of Health estimated that talking therapies can save the public sector £1.75 for every £1 invested.[14] The service model is based on a ratio of ~40 therapists for every quarter of a million of population, and allows both GP and self-referral to maximise access. As at April 2015, there are over one million referrals each year (over 40% are self-referrals) of which around three-quarters enter treatment after an average waiting time of just under 30 days. Of the 40% that complete treatment, over 60% improve and 40-45% recover – although this remains short of the national target of 50%.[15]

The integration agenda

People with severe and prolonged mental illness are now known to die on average 15 to 20 years earlier than the general population, and there are clear benefits to a holistic approach to their care which is unrestricted by provider boundaries. The *Five Year Forward View* set out the ambition and dimensions for integration: physical and mental care, health and social care, primary and specialist care.[16] Commissioners have a critical role in this agenda, particularly in shifting payments and incentive systems to accommodate integrated physical and mental health outcomes.[17] The Kings Fund recently highlighted three main ambitions for commissioners: holding providers to account for outcomes; holding providers to account for streamlining the delivery of patient care across the gaps between service providers; and shifting the flow of money between providers.[18] There are good parallels between the 'diabetes journey' to integrated care and what mental health needs – commissioner and provider engagement; strengthened capability and capacity in primary care; brought about with time and effort from multiple stakeholders; over many years.

Move to commissioning by results / PbR

The mental health sector lags behind the acute sector by more than a decade in moving away from block contracts and towards commissioning and payment by results (PbR). This is related to its relatively poor progress in generating good quality data from a consistent set of outcomes and services. But progress has been made, most notably with the development of the mental health care clusters as a common currency for the sector. Clustering works by assessing patients based on their needs and the severity of their conditions. Each cluster is linked to a set of interventions which have a total cost and for which a tariff could be paid. Widespread adoption of cluster-based PbR could reverse the real terms drop in funding for mental health, as well as facilitate integration.[19] Data quality (and clinical) concerns have delayed creation of a national tariff, but commissioners and providers have been moving ahead on the basis of local data.[20]

However whilst clustering is acknowledged as a potentially helpful commissioning tool, its use clinically is subject to considerable debate: service users within clusters are heterogeneous in terms of diagnoses, needs, risk and severity - which creates challenges around treatment and care packages. Service users themselves are not familiar with the segments and terminology, and clustering has potentially added to the complexity around language and lexicon in mental health[21].

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[14] DH, Impact Assessment of the expansion of talking therapies services as set out in the Mental Health Strategy, 2011
[15] DH, Talking therapies: A four-year plan of action, February 2011
[16] NHS England et al., Five Year Forward View, October 2014
[17] Dr Geraldine Strathdee (National Clinical Director for Mental Health), Treating mind and body together, June 2015
[18] Kings Fund, Commissioning and contracting for integrated care, November 2014
[19] HSJ Intelligence, The future for mental health payment systems, 20 August 2014
[20] RCPsych, Position Statement PS01/2014, January 2014
[21] See also Section 7: Recommendations for Commissioners

The Care Act

The Care Act was introduced in 2014, with many of its provisions coming into effect on 1 April 2015. The Sutton Trust calls it the most comprehensive overhaul of the social care system since 1948.[22] The Act requires a shift from a narrow and clinically-lead focus on the treatment of disease towards a broader conception of promoting individuals' wellbeing – including both physical and mental health – as well as preventing or delaying the need for that support. It also places local authorities under a duty to collaborate and coordinate with other authorities on the integration of social services and health care[23].

The Better Care Fund

The Better Care Fund (BCF) was announced in the June 2013 spending round to promote integration of health and social care. It creates local single pooled budgets to incentivise the NHS and local authorities to work more closely together.

See **Appendix 1, Section 2** for additional detail around key trends and recent publications.

(vi) NHS specialist mental health trusts in Essex

The provision of the majority of specialist mental health services in Essex has been by North Essex Partnership University NHS FT (NEP) South Essex Partnership University NHS FT (SEPT).

NEP

NEP is a £110m turnover organisation headquartered in Chelmsford employing around 2000 staff. It provides a range of mental health services to a population of over 1 million predominantly in Essex. These include adult and older adult mental health services, CAMHS, forensic and substance abuse services. The majority of the adult and older adult work is commissioned by the three CCGs in the north of the county through a block contract worth £69m (lead CCG North East Essex).

NEP – historical data

Financials	2011/12	2012/13	2013/14
Income (£ m)	105.5	108.8	112.7
Special services			*9.4*
Op surplus (£m)	2.9	1.3	-12.2
Ret surplus (£m)	0.8	-1	-14.7

Performance			
2014/15	Q1	Q2	Q3
# Beds	357	356	336
% Bed occupancy	93.1%	95.6%	97.1%
% Patients assigned clusters	55.8%	59.9%	41.6%
% CPA in settled accom	54%	35%	37%
% CPA review within year	68%	51%	63%
Early intv'n psychosis cases	500	450	415

Workforce				
2014/15	Q1	Q2	Q3	Q4
Total workforce	1,798	1,766	1,724	1,699
Medical	*119*	*117*	*109*	*107*
Nursing	*620*	*607*	*597*	*588*
Other	*1,058*	*1,042*	*1,018*	*1,004*

	2012/13	2013/14	2014/15
% Staff recommending care here	60%	59%	55%

Source: HSJ.

[22] Sutton Trust, The Care Act 2014: A briefing, March 2014
[23] See also Section 9: Findings and Recommendations Specific to the Local Authorities

SEPT

SEPT is currently a £324m turnover organisation headquartered in Wickford employing around 5000 staff. It provides a range of services to a population of around 2.5 million in Essex, Luton, Bedfordshire and Suffolk. These include mental health (adults, older adults, IAPT, CAMHS, forensic and substance abuse); general community, and learning disability services. In Essex, mental health services are commissioned via a block contract worth £81m (lead CCG Castlepoint and Rochford).

SEPT – historical data

Financials

	2011/12	2012/13	2013/14
Income (£ m)	314.1	323.9	324.5
Special services			*23.1*
Op surplus (£m)	8,7	10.9	5.3
Ret surplus (£m)	2.4	4.3	-0.5

Performance

2014/15	Q1	Q2	Q3
# Beds	706	707	706
% Bed occupancy	91.2%	90.6%	92.4%
% Patients assigned clusters	83.8%	84.0%	79.3%
% CPA in settled accom	73%	54%	75%
% CPA review within year	88%	41%	42%
Early intv'n psychosis cases	465	425	985

Workforce

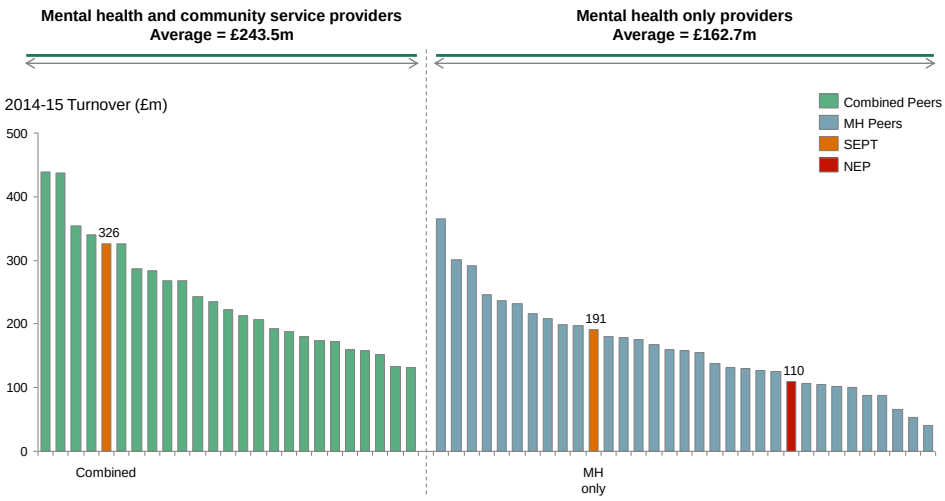
2014/15	Q1	Q2	Q3	Q4
Total workforce	5,114	5,081	5,007	5,007
Medical	*204*	*204*	*193*	*192*
Nursing	*1,590*	*1,568*	*1,529*	*1,524*
Other	*3,319*	*3,309*	*3,285*	*3,291*

	2012/13	2013/14	2014/15
% Staff recommending care here	63%	64%	65%

Source: HSJ.

In terms of scale, the NEP is in the lower quartile; SEPT, in 2014/15, is currently above average.

Relative size (by income) of SEPT and NEP against relevant peer group in 2014/15



Source: Annual Account and Reports 2013-14; HSJ Intelligence; SEPT annual reports; SEPT 2015/16 operational plan; Data received from SEPT, 28 July; NEP Board Papers, May 2015, updated for current LFTM

See **Appendix 1, Section 3** for additional data on NEP and SEPT finances, operations and quality.

4. Findings: Commissioners

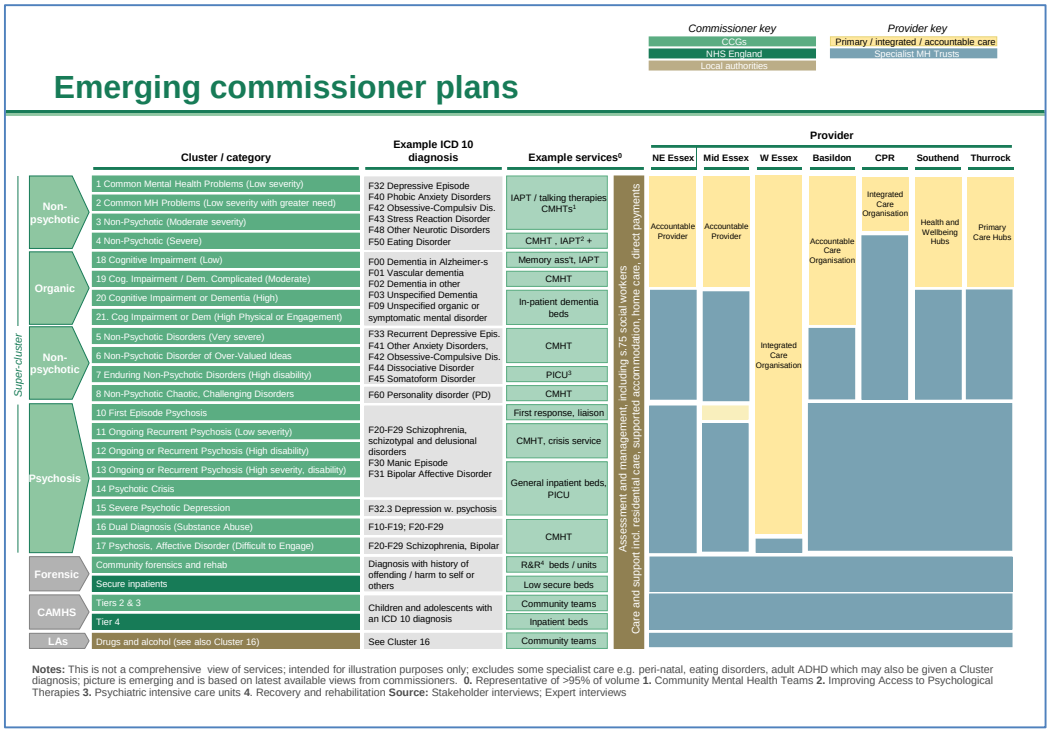
The commissioning landscape for mental health services in Essex is a complex picture which would benefit from simplification. There are three main factors contributing to the complexity:

Multiple commissioners:

Each of the 10 commissioning bodies has resources commissioning mental health services, involving a total of around 40-50 roles, fragmented across the patch. Stakeholder feedback suggest this lacks sufficient contextual oversight and does not have robust data around the services commissioned (outcomes and costs), and service user needs. For example, clinicians have identified potential service gaps – including adult ADHD and community forensic – but there is insufficient data to ascertain whether these should be prioritised. Additionally, there is no shared language – clusters, services, diagnoses, care setting are used interchangeably.

The integration agenda

Each CCG is moving at different speeds and considering different local models of integrated care, and has different views on which mental health services should be included.



Notes: This is not a comprehensive view of services; intended for illustration purposes only; excludes some specialist care e.g. peri-natal, eating disorders, adult ADHD which may also be given a Cluster diagnosis; picture is emerging and is based on latest available views from commissioners. **0.** Representative of >95% of volume **1.** Community Mental Health Teams **2.** Improving Access to Psychological Therapies **3.** Psychiatric intensive care units **4.** Recovery and rehabilitation **Source:** Stakeholder interviews; Expert interviews

This 'ragged edge' makes planning from both commissioner and provider perspective quite challenging – for providers more so given that their teams work across different CCGs. Cfeedback suggests further work is needed to fully understand which service users can appropriately be managed in primary care, new models of care, and shared care teams.

Funding misalignment

The current block contracts originate from PCT days with costs were allocated using different approaches in the north and the south. The impact of this is a number of misalignments between resources and utilisation between CCGs through the block contracts, which creates a complicated picture and hinders pan-Essex commissioning. **See Appendix 1, Section 4** for additional detail around historic CCG allocations.

5. Findings specific to the Local Authorities

In addition to those described above, there are additional findings which are specifically related to Essex County Council, Southend UA and Thurrock UA (the local authorities).

Section 75 partnership agreements

Section 75 of the National Health Service Act (2006) provides – amongst other things – for local authorities to enter into arrangements with NHS trusts for the exercise of authorities' health-related functions, and the provision of staff for those purposes. Essex County Council has section 75 agreements with both NEP and SEPT, and provides social workers to the trusts' multi-disciplinary assessment and care management teams under those agreements. County Council social workers are TUPE'd to NEP and seconded to SEPT.[24] Southend UA and Thurrock UA also have their own section 75 partnership agreements with SEPT. These arrangements ensure mental health and social workers are integrated in operational teams at the front door.

The Essex Local Authorities are not alone in using section 75 to integrate their mental health social workers into healthcare teams – or in facing challenges with this approach. Results of a Freedom of Information request from late 2013 suggest that about half of local authorities use section 75 in this way. But it also highlighted authorities' concerns – including loss of social work focus, slower progress on personalisation, slower progress on recovery models and financial pressures – that had prompted some authorities to withdraw from these arrangements.[25]

In Essex, feedback suggests that integration of social workers into the trusts is variable. There are challenges around communication back into the local authorities so as to ensure the desired ways of working are in place. In the north, recent changes to service models and pathways at NEP (Journeys) have exacerbated concerns around integration within teams. In the south, there are challenges around NHS management and leadership of local authority staff. In addition, there is significant duplication of effort around the section 75 arrangements. SEPT has different partnership agreements with all three local authorities – Essex County Council, Southend UA and Thurrock UA – which involves three sets of monitoring arrangements, performance targets, and oversight meetings. For example, Essex County Council hold monthly performance and budget meetings with both trusts – and a three monthly partnership meeting.

AMHPS

Approved mental health professionals (AMHPS) are responsible for organising and coordinating assessments under the Mental Health Act (1983), including detentions (sectioning) and community treatment orders (CTOs). Traditionally performed by specially trained social workers, the role is increasingly held by occupational therapists, community mental health nurses and psychologists due to shortages of staff and the cost and length of training. The CQC has highlighted falling numbers and rising workload for AMHPs across the county.[26] Most recently, it has highlighted the pressure that AMHPS are under to section users under the Act purely to increase their chances of securing a bed amidst the general shortage.[27] The revised Mental Health

[24] TUPE refers to the Transfer of Undertakings (Protection of Employment) Regulations 2006 regulating terms of employment for staff transferred to new employers.
[25] Andy McNicoll, Councils split on integration of mental health social workers in NHS, Community Care, 24 September 2013
[26] CQC, Monitoring the Mental Health Act 2011/12, January 2013
[27] CQC, Monitoring the Mental Health Act 2013/14, January 2015

Act code of practice – which came into force on 1 April – requires local authorities and providers to support AMHPs in addressing delays to bed access.

Essex is facing a severe shortage of qualified AMHPs (and the trusts bed occupancy are generally above target levels). Essex County Council currently employs 84 AMHPs and estimates that it will need to train and deploy another ~50% by 2017, and then continue to train 20 AMHPs a year to manage the churn. Feedback suggests that the role has become less financially and professionally attractive, partly as a result of these pressures, and failure to maintain numbers has made it more difficult to maintain a reasonable rota, putting more pressure on the remaining personnel. Part of the problem is reported to be a lack of consensus between the trusts and the council around ultimate responsibility for closing the gap and covering the costs. Section 75 of the NHS Act is not clear on this point.

In terms of provision of the service, the providers run the in-hours rota on behalf of the local authorities. In the north, Essex County Council runs the out-of-hours rota. In the south, Southend UA contracts Essex County Council for out-of-hours services, whilst Thurrock UA runs its own out-of-hours rota. In practice, due to the shortage of staff, the same AMHPs work on all of the rotas.

Care Act compliance

As described earlier, the Care Act, key elements of which entered into force on 1 April 2015, shifts the focus in mental health from a narrow conception of disease management to a broader duty to promote wellbeing and early help and prevention for service users and their carers. Local authorities are the responsible bodies under the Act. Feedback included concerns that the two providers were not yet fully compliant with the Care Act, and specifically that the trusts' thresholds for specialist treatment varies across the county. Too high a threshold may not be compatible with the legislative shift to 'wellness'. More generally, feedback has suggested that local authorities would like greater transparency and input earlier in the patient journey to manage the implications of thresholds for admission being set low in some instances.

Dementia

Currently, the vast bulk of local authority spend on older adults suffering from dementia is accounted for under adult social care spend not mental health spend. For example, Essex County Council spent ~£131 million on social care for older adults suffering from dementia in 2014/15. This includes residential and nursing care (£80m), homecare and respite (£26m), re-ablement (£5m) and cash payments (£6m). Note that many of the older adults receiving these services have not been officially diagnosed with dementia, even though their carers will be confident of the fact.

On the one hand, accounting for this spend under social care rather than mental health spend obfuscates the size and shape of the combined spend on mental health in Essex. It can inhibit coordination between the local authority teams responsible for different aspects of care for the same set of service users. On the other hand, shifting the budget and related structures may inhibit coordination between adult social and older adult social care, which also share commonalities.

In addition, this is an area where there is significant unmet demand. The local authorities are currently participating in a needs review around dementia to assess this in further detail.

All age and cross-system working

Evidence suggests that 50% of mental health problems start by the age of 15 and 75% by the age of 18[28]. More work is needed to ensure a joined up, all-age approach to mental health. For Essex County Council for example, mental health services relate to adult mental health for adults up to the age of 65 and sit separately to CAMHS. Within the providers, there have been challenges in securing sufficient Adult Mental Health input into the Children's Social Care Family Solutions teams. There also needs to be good integration into schools and other young peoples' services. More widely, local authorities are a key interface with other parts of the system: police, housing, voluntary and community sectors, district councils and employment as well as public health.

[28] Annual Report of the Chief Medical Officer 2012, Our Children Deserve Better: Prevention Pays, Chapter 10

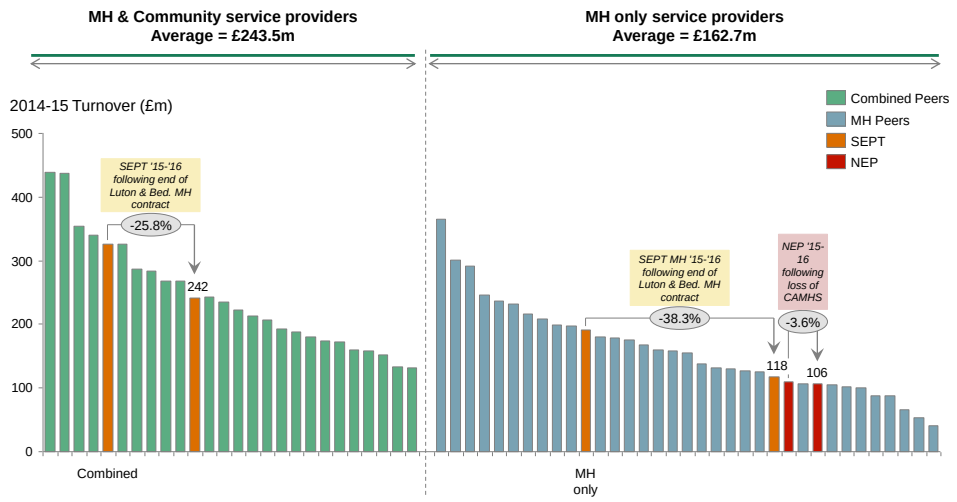
6. Findings: Providers

NEP and SEPT are facing three significant and inter-related challenges:

A shrinking market

The overall market for specialist mental health trusts is shrinking as commissioners integrate the lower acuity services into primary care and new models as described above. In addition, NEP and SEPT are losing market share. They increasingly face competition from out-of-area trusts for local services: the recent pan-Essex CAMHS contract was lost to North East London NHS FT (NELFT); IAPT services in the north are already provided by Hertfordshire Partnership University NHS FT (Herts Parts); SEPT's community mental health contract with Luton and Bedfordshire is not being renewed. These developments will see SEPT lose around 30% of total turnover, and NEP 3.6%.

Relative size (by income) of SEPT and NEP against relevant peer group for 2015/16



Source: Annual Account and Reports 2013-14; HSJ Intelligence; SEPT annual reports; SEPT 2015/16 operational plan; Data received from SEPT, 28 July; NEP Board Papers, May 2015, updated for current LFTM

Challenging finances

As described above, mental health funding has been historically challenging. Funding for the providers is constrained, with a 4% year-on-year efficiency requirement and significant CIP targets. NEP in particular is facing short term difficulties. It posted a deficit in 2013/14 and the plan for 2015/16 as submitted to Monitor is dependent on realising significant CIPs; on CCGs not realising all their planned savings around Clusters 1-4; and on being able to offset activity loss with a reduction in associated costs.

Potential brand issues

Stakeholder feedback indicates that both providers face brand issues. Perception exists amongst some commissioners that there has not been an adequate response to changes in policy, such as The Care Act, and that the threshold for admission into secondary care is too high. Communication around changes to services – for example, Journeys at NEP – has not been deemed sufficient, and there is a perception that providers are not sufficiently data transparent.

7. The momentum case

The status quo is not an option: the commissioning landscape will become more complicated as the integration agenda plays out; there are not sufficient facts and data to prioritise services in order to make more efficient (and transparent) use of limited available resources; and providers are likely to fail posing risk to the continuity of services and the safety of service users.

For providers, as the integration agenda progresses, they may ultimately lose access to between 30-50% of the current available mental health market in Essex[29]. Both trusts risk becoming subscale in mental health care, with difficulties attracting, training and retaining staff, supporting consultant rotas, and having the capacity and capability to effectively bid for new contracts – thus effectively creating a downward spiral.

In the north, NEP has already submitted a challenging financial forecast to its Board which indicates that it is unlikely to be financially viable in the short term.

NEP: Current 5-year financial plan

As discussed at the NEP Board, May 2015

2015/16 plan reflects material changes since April submission
- £2.9m net pressure from changes to the main contract
- £0.5m net pressure from the loss of CAMHS
- Plus a £2.0m reduction in working capital due to unpaid cluster 1-4 activity and reduced property receipts

NEP will need to address 3 non-recurrent items from 2015/16 to break even in 2016/17
- £0.5m of CCG income is for 2015/16 only
- £1m of planned savings are non-recurrent
- £1.2m of full-year impact of CAMHS contract

Plus any additional recurrent cost pressures/income reductions from 2015/16

5-year base case, May 2015

£m	14/15[1]	15/16	16/17	17/18	18/19	19/20
Income	110	106	101.4	100.8	100.2	99.6
Ops surplus	(17.3)	0	0.2	0.2	0.5	1.0
CIP *% income*	*2.5* *2.3%*	4.2 *4.0%*	5.9 *5.8%*	3.2 *3.0%*	3.2 *3.2%*	3.3 *3.3%*
Cash	10.4	8.7	6.6	10.5	15.6	15.2
CoSRR	3	3	3	2	3	4

NEP believes that savings of ~6% in 2016/17 will be difficult to achieve without major service reductions
- Recent savings of 3-4% have been challenging

Downside case models the implications of 3% CIPs in 2016/17
- Cash position deteriorates 53% by 2017/18
- CoSRR deteriorates to 1 by 2017/18

5-year downside case, May 2015

£m	14/15[1]	15/16	16/17	17/18	18/19	19/20
Income	110	106	101.4	100.8	100.2	99.6
Ops surplus	(17.3)	0	(2.6)	(2.7)	(2.5)	(2.1)
CIP *% income*	*2.5* *2.3%*	4.2 *4%*	3.1 *3%*	3.2 *3%*	3.2 *3%*	3.3 *3%*
Cash	10.4	8.7	3.8	4.7	6.8	3.4
CoSRR	3	3	3	1	2	2

1. Actual figures
Source: NEP Board Papers, May 2015, updated for current LFTM

SEPT has other business units in addition to mental health – community healthcare and learning disabilities – which mean that there is more strategic ambiguity over its future. However its 2014-19 strategic plan suggests that without further income growth, "SEPT would need to merge by 2018/19" to ensure sustainability.

[29] Based on approximate costs per cluster grouping and range of ambition around CCG integration plans. See Appendix 3, Section 5 for further details.

SEPT: 2014-19 Strategic Plan, 2014

From Annual Report and Operational Plans

Extracts

"Assuming no other income is secured, SEPT is sustainable over the 5-year planning period ... as long as it is able to deliver the required year on year efficiency requirements [through] 10 programmes of work" *(p.12)*

"Although Trust has an excellent track record of delivering CIPs ... it has been increasingly difficult to deliver planned efficiencies as the 'low hanging fruit' schemes have been delivered" *(p.16)*

" Opportunities for growth will have to be pursued to minimise longer term risk to sustainability...without growth in income SEPT would need to merge by 2018/19" *(p.13)*

5-year base case

£m	13/14[1]	14/15	15/16	16/17	17/18	18/19
Contracted income	325.6	316.6	234.4	194.9	193	191.1
Ops spend	326.0	315.4	234.9	193.1	192.4	189.3
Ops surplus	(0.5)	1.2	-0.5	1.8	0.6	1.8
CIP *% income*		16.5 *5%*	13.7 *6%*	10.8 *6%*	10.8 *6%*	10.8 *6%*
Cash	38.6	40.4	36.5	33.9	29.6	26.5
CoSRR	3	4	3	4	3	4

5-year upside

£m	13/14[1]	14/15	15/16	16/17	17/18	18/19
Contracted income	325.6	316.6	342.7	361.2	358.2	355.1
Ops spend	326.0	315.4	339.4	349.4	347.6	343.3
Ops surplus	(0.5)	1.2	3.3	11.8	10.6	11.8
CIP *% income*		16.5 *5%*	9.0 *3%*	13.7 *4%*	6.9 *2%*	9.4 *3%*
Cash	38.6	40.4	36.5	40.3	45.9	44.6
CoSRR	3	4	3	4	4	4

5-year downside

£m	13/14[1]	14/15	15/16	16/17	17/18	18/19
Contracted income	325.6	316.6	228.4	159.2	157.6	156.0
Ops spend	326.0	315.4	231.8	160.2	159.6	157
Ops surplus	(0.5)	1.2	(3.4)	(1.0)	(2.0)	(1.0)
CIP *% income*		16.5 *5%*	13.7 *6%*	10.8 *7%*	10.8 *7%*	10.8 *7%*
Cash	38.6	40.4	36.5	41.8	40.8	41.8
CoSRR	3	4	3	3	3	3

Notes: 13/14 actuals based on annual report; 14/15 actuals and 2015-19 forecasts based revised data received from SEPT; Text extracts from 2014-19 Monitor Strategy
Source: Annual Report 2013/14; Revised 5-year forecast received 28 July

Clinical and professional feedback supports the need for change: there is broad agreement that the current state is not sustainable. Clinical and operational performance is already under pressure, with bed occupancy over 100% in some areas for example.

Importantly, service users consulted as part of this review also reflected back the increasing complexity of the current landscape. They describe the need to become experts in order to 'navigate' to the right services, and describe having to 'game' the system so as to access the care they need.

See **Appendix 1, Section 5** for additional data around provider findings and the momentum case, and **Section 6** for selected competitor vignettes.

8. Recommendations: Commissioners

In order to change path and avert the momentum case, this review makes a number of recommendations. These are described below, grouped according to four key themes.

1. Simplify the commissioning landscape

1a Clarify the integration agenda: commissioners should refine the scope of mental health services planned to be within their local integration models. This should be done with greater clinical and professional leadership, and tailored to local primary care capacity and capabilities. Clinical risk currently lies with the clinicians in secondary care: how this works in shared and integrated care teams will need to be clarified a part of this process. In addition, rather than each moving at their own pace, we recommend commissioners agree a more uniform timeline. This will involve a change of pace for some but potentially result in faster and less complicated implementation.

1b Align around a clear commissioning path: this review considered a number of paths for commissioners. Each represents different trade-offs and has a range of impacts on providers. A preferred path – 'Option 2b' – has been described below. See **Appendix 3** for the longer list of options and additional detail around the option appraisal process.

As part of this path, and to allow commissioners to de-average their approach to commissioning, mental health has been considered in segments. These segments are based on clusters and have been tested with clinicians[30]. They are intended as a way of approaching service user health and personal care needs in a more customised, de-averaged way in order to ultimately describe which future services should be commissioned. The timelines for each segment are based on how long is needed before any competitive benchmarking, market testing and potential procurement processes can be considered.

For example, for clusters 1-3, all commissioners are aligned that these form part of the integrated care agenda and will provided locally – either in primary care, new models of care, shared care, or by locally commissioned providers. The services that are needed are relatively clear. There is no requirement for a fixed or shared timeline: contracts can be commissioned locally and timelines are variable.

At the other end of the acuity spectrum, for clusters 10 and 13-17, most commissioners are agreed that the majority of care will continue to be provided by specialist mental health trusts. However there is work to be done by both commissioners and providers, as described in the recommendations above, to conduct robust needs assessments; agree outcomes; determine which services to commission; and allocate funding. Moreover, if a competitive process was to be considered around inpatient services, a strategy would need to be found to address the current estate ownership. For this segment, contracts would therefore be continued for a further 5 years. However importantly, there would be clear stage-gates in place. For example, for providers, these would be around meeting pre-agreed conditions around and ways of working; for commissioners, these would be around providing clarity in terms of service specifications.

[30] These segments are not intended to replace clusters as the unit for PbR

Draft commissioning path

All timelines commence April 2016

Commissioner key: CCGs; NHS England; Local authorities

Provider key: Primary care; Shared care; Specialist MH Trusts

Super-cluster	Cluster / category	Example ICD 10 diagnosis	First cut of SUs that could be in primary / new models / shared care (depending on local capacity / capability)[1]	Draft timeline by segment[1]
Non-psych.	1 Common Mental Health Problems (Low severity)	F32 Depressive Episode F40 Phobic Anxiety Disorders F42 Obsessive-Compuls. Dis. F43 Stress Reaction Disorder F48 Other Neurotic Disorders	Up to 95% of SUs	Variable, local, 2 year max
Non-psych.	2 Common MH Problems (Low severity with greater need)			
Non-psych.	3 Non-Psychotic (Moderate severity)			
Non-psych.	4 Non-Psychotic (Severe)	F50 Eating Disorder	~60-70% of SUs	3 years; % (TBC) shift by Y2
Organic	18 Cognitive Impairment (Low)	F00 Dementia in Alzheimer-s F01 Vascular dementia F02 Dementia in other F03 Unspecified Dementia F09 Unspecified organic or symptomatic mental disorder	~80-90% of SUs	2 years
Organic	19 Cog. Impairment / Dem. Complicated (Moderate)			
Organic	20 Cognitive Impairment or Dementia (High)		~60-70% of SUs	
Organic	21. Cog Impairment or Dem (High Physical or Engagement)			
Non-psych.	5 Non-Psychotic Disorders (Very severe)	F33 Recurrent Depression F41 Other Anxiety Disorders, F42 Obsessive-Compuls. Dis. F44 Dissociative Disorder F45 Somatoform Disorder	~50-60% of SUs	3 years % (TBC) shift by Y2
Non-psych.	6 Non-Psychotic Disorder of Over-Valued Ideas			
Non-psych.	7 Enduring Non-Psychotic Disorders (High disability)			
Non-psych.	8 Non-Psychotic Chaotic, Challenging Disorders	F60 Personality disorder (PD)	~50-60% of SUs	
Psychotic	11 Ongoing Recurrent Psychosis (Low severity)		~60-70% of SUs	3 years
Psychotic	12 Ongoing or Recurrent Psychosis (High disability)	F20-F29 Schizophrenia, schizotypal and delusional disorders F30 Manic Episode F31 Bipolar Affective Disorder	~40-50% of SUs	
Psychotic	10 First Episode Psychosis		Up to 5% of SUs	5 years with stage gates at 2 years and 3.5 years
Psychotic	13 Ongoing / Recurrent Psychosis (High severity, disability)			
Psychotic	14 Psychotic Crisis			
Psychotic	15 Severe Psychotic Depression	F32.3 Depression w. psychosis		
Psychotic	16 Dual Diagnosis (Substance Abuse)	F10-F19; F20-F29		
Psychotic	17 Psychosis, Affective Disorder (Difficult to Engage)	F20-F29 Schizophrenia, Bipol.		
Forensic	Community forensics and rehab	Diagnosis with history of offending / harm to self or others		NHS England / LA / recently commissioned
Forensic	Secure inpatients			
CAMHS	Tiers 2 & 3	Children and adolescents with an ICD 10 diagnosis		
CAMHS	Tier 4			
LAs	Drugs and alcohol (see also Cluster 16)	See Cluster 16		

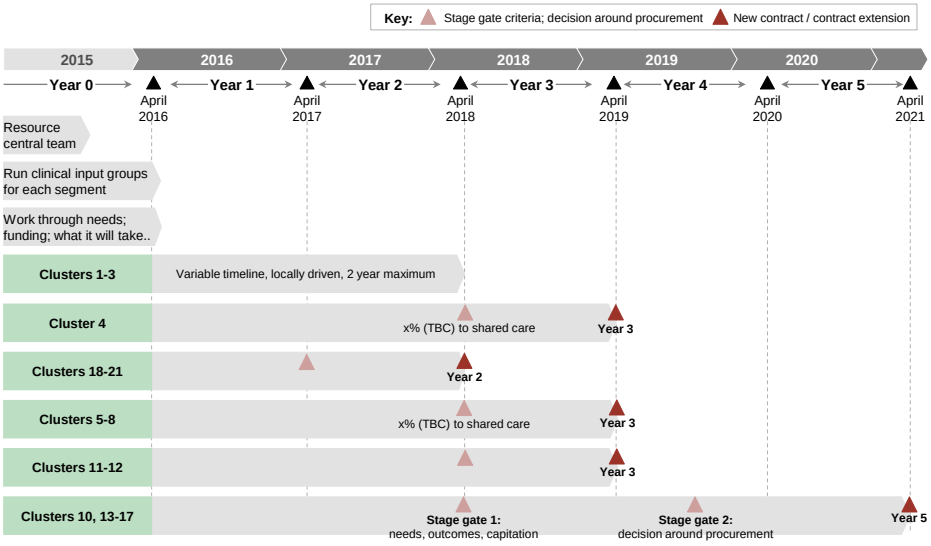
Assessment and management, including s.75 social workers; Care and support incl. residential care, supported accommodation, home care, direct payments

1. Each segment is heterogeneous in terms of diagnoses, severity, and service user (SU) needs: this view will need refining and working through with clinicians. Shared care refers to care shared with a specialist provider.

Notes: This is not a comprehensive view of services; intended for illustration purposes only; excludes some specialist care e.g. peri-natal, eating disorders, adult ADHD which may also be given a Cluster diagnosis; picture is emerging and is based on latest available views.

Source: Stakeholder interviews; Expert interviews

Draft timeline



The belief is that this path potentially represents the best balance between ensuring commissioners have sufficient time to implement the recommendations, whilst ensuring the needs of service users are met in a timely manner. It also provides NEP and SEPT the opportunity – in terms of space and clarity – to rethink their strategies around service and form.

See **Appendix 1, Section 7** for additional detail around the emerging integration agenda and Option 2B.

1c Work through how best to deploy social workers as the integration agenda plays out: as services are integrated and existing pathways change, local authorities and CCGs will need to jointly assess how best to deploy social workers – for example whether these should follow services or whether they should be organised in a more centralised way.

1d Agree a plan to re-align funding between CCGs: commissioners should agree the approach and timeline to reapportion expenditure and Resource Limit to ensure an affordability neutral solution ahead of implementing the local integration agenda. This has already been agreed in principal in the north of the county.

1e Define where dementia services should sit: local authorities should agree with their local CCGs whether to move dementia under Public Health and Wellbeing as an all-age pathway, whether it should remain split within Adult Social Care.

2. Create a common language and use to clarify needs and expectations

2a Agree a common language: commissioners and providers should agree to use a single terminology / language going forward. Clinical input suggests clusters may be the most reasonable lexicon given the national direction. However it remains imperfect: in clinical practice, services users within clusters are heterogeneous and clustering does not align perfectly with diagnoses, nor are services users familiar with the terminology.

2b Clarify the desired provider capabilities: commissioners should, working with providers, undertake to create a common and shared set of required provider capabilities, for example around IT; culture; flexibility; data transparency.

For example, regarding IT systems, commissioners should agree the key requirement – for example that all IT systems be compatible and able to interface effectively – and then work collaboratively with providers and key experts to understand the different options and the trade-offs around these. For example, moving towards System 1, as has been done in Hertfordshire, will have funding implications which would need to be worked through jointly.

2c Optimise section 75 partnership arrangements: in the south, the three local authorities should commit to working together to create a common template, shared performance targets, and single joint oversight meeting in order to reduce effort and avoid duplication.

2c Work with providers around The Care Act compliance: local authorities should develop clear and consistent expectations for providers' compliance with the Care Act, including what should be incorporated into their contracts in terms of access to pathways for people in distress. This will involve discussions around appropriate funding to ensure realistic expectations.

3. Generate and share more data across the system

3a Conduct robust needs assessments: commissioners should work with clinicians and professionals to assess service user health and personal care needs, including how these differ by geography, locality (e.g. urban vs. rural), and cluster segment.

3b Develop and track better outcomes: building off *3a* above, commissioners should work with clinicians and professionals develop desired outcomes – these will inform which services should be commissioned, and how they will be monitored. They will also support funding prioritisation decisions - which clinical feedback suggests are inevitable given the tight funding environment.

3c Share the output of ongoing needs assessment work in dementia: local authorities should ensure learnings and outputs are widely disseminated to avoid duplication and ensure a shared understanding of what is needed.

4. Work more jointly

4a Create a pan-Essex MH commissioning team: commissioners should consider a smaller, more senior mental health team – for example around 10 FTEs – that includes senior analytics, business intelligence, and financial expertise. This would provide real leverage and help make necessary trade-offs between services and cost – the need for which was highlighted at the Clinical Conference held in August.

The recent CAMHS commissioning points to a more effective model. Despite some initial challenges around the process, the outcome to date is deemed positive. The team was co-led by senior health and local authority resources who had sight of the overall context, the right skills and capabilities, and led joint working across the patch on behalf of all commissioners.

The exact organisational form and governance processes should be jointly agreed by commissioners in the coming weeks. Importantly, a single team does not mean a 'one size fits all' solution. Needs, services, activities and outcomes need to be tailored to local geographies.

The principles behind having a smaller, shared team are to attract and fund the appropriate seniority of resource; support simplification and enable the use of a common language; create a single fact base of needs, activities, and outcomes; and build off the CAMHS experience of joint working across health and social care.

Between now and April 2016 the team would work through recommendations *3a* and *3b* above: conduct robust needs assessments; determine gaps; agree outcomes; describe what services should be commissioned to deliver these; prioritise funding; draft commissioning intentions; and refine the draft commissioning path described in *1a* above. From April onwards, there are choices around what role it should continue to play. It should take on a more supportive role around common templates and sharing best practices; or it could commission pan-Essex services provided by specialist mental health trusts – this would exclude for example clusters 1-3 and the dementia clusters, which will be integrated.

4b Optimise AMPHs arrangements: the three local authorities should confirm the numbers required over the next 3-5 years across Essex and work with the trusts to agree costs and approach. At the same time, local authorities should work with the trusts to ensure AMHPs receive appropriate support in addressing delay, as this may improve retention. Finally they should review the service arrangements to ensure that it is as efficient and cost-effective as possible. For example, they may consider contracting a single provider to run the entire rota.

4c Work together to ensure all-age, cross-system care: all commissioners should build on the CAMHS experience and commit to working together to improve outcomes for the most vulnerable individuals, and ultimately develop a shared vision for mental health in Essex. For example, with the new CAMHS contract in place, there is an opportunity to take a life course approach, setting out the vision and standards of care needed from early life, childhood, teenage years into healthy older age and end of life. In addition, local authorities should ensure that the wider impact of mental illness – on employment, housing, and families for example – are accounted for in future commissioning and service specifications. Finally, local authorities should continue to work with public health and primary care to ensure that the stigma that surrounds mental health is continuously addressed through public awareness campaigns.

9. Recommendations: Providers

Providers need to react strategically to the challenges described above, in the context of greater clarity around the integration agenda and timelines from commissioners.

Focus on the core portfolio of services

Providers should review the current portfolio in order to focus on what is core. This will involve defining what their key competencies are and identifying the key adjacencies, skillsets and capabilities required to support these core services. It may also involve a de-prioritisation of non-core services – providers may choose not to bid for these as they are tendered over time.

Build greater depth of capability

In collaboration with commissioners and service users, they should seek to build greater depth around the capabilities which are seen as 'requirements' by commissioners (see Recommendation 4 above).

Consider the form and scale required to deliver within the confirmed timeframe

For providers, the recommended path creates clarity around timelines – and provides them with space to pursue an appropriate strategy around form and scale for their core services. Doing this economically may involve collaboration or merger.

10. Next steps

The proposed next steps are for stakeholders to:

- Consider the recommendations outlined in this report
- Agree which to take forward
- Work together to agree a robust implementation plan
- Set up appropriate governance processes

Appendix 1 (attached PDF): Contents

Section 1: mental health funding in Essex

Section 2: additional detail around key trends and recent publications

Section 3: NEP and SEPT financial, operational, and quality data

Section 4: historic CCG allocations

Section 5: provider findings and momentum case

Section 6: selected competitor vignettes

Section 7: additional materials around Options 1 and 2

Section 8: commissioning cycle and best practices

Appendix 2: Engagement as part of this review

The project team conducted nearly 50 1:1 interviews with the following stakeholders:

Interviews: providers and CCGs

Providers (10)

NEP (5)	Andrew Geldard, CEO	23 June
	Ian Carr, Area Director (West Essex)	23 June
	Vince McCabe, Director of Operations	23 June
	David Griffiths, Director of Resources	14 July
	Mike Chapman, Director of Strategy	25 June
SEPT (5)	Sally Morris, CEO	22 July
	Dr Llewellyn Lewis, Dep. Medical Director	6 July
	Andy Brogan, Exec. Director of Clinical Gov. & Quality	22June
	Dr Milind Karale – Medical Director	23 June
	Malcolm McCann – Executive Director of Operations	6 Aug

CCGs (22)

North East Essex (4)	Sam Hepplewhite, Chief Officer	16 June
	Lisa Llewelyn, Director Nursing & Quality	16 June
	Christine Dickenson, Head, MH Commissioning	16 June
	Joanne Reay, Commissioning Lead	23 June
West Essex (4)	Clare Morris, Chief Officer	17 June
	Miranda Roberts, Clinical Lead, Mental Health	28 July
	Dean Westcott, CFO	17 June
	Kirsty O'Callaghan , Finance Lead	20 July
Mid-Essex (4)	Caroline Rassell, Chief Officer	22 June
	Dr. Caroline Dollery, Chair	19 Aug
	Daniel Doherty, Clinical Commissioning	30 June
	Dee Davey, CFO	14 July
Basildon & Brentford (1)	Tom Abell, Chief Officer	16 June
Castle Point & Rochford (4)	Ian Stidston, Chief Officer	29 June
	Kevin McKenny, Chief Operating Officer	23 June
	Margaret Hathaway	9 July
Thurrock (2)	Mark Tebbs, Head of integrated commissioning	23 June
	Jane Itangata, Head of MH Commissioning	23 June
Southend (3)	Melanie Craig, Chief Officer	29 June
	Dr José Garcia, Chair & mental health lead	23 July
	Hugh Johnston , MH commissioning mgr	23 June

Interviews: local authorities and external experts

Local authorities (12)

Essex (5)	Mike Boyle, Director of Local Delivery (South)	16 June
	Barbara Herts, Director, Integrated Commissioning & VPs	16 June
	Ben Hughes, Head of Commissioning PH & Wellbeing	16 June
	Emily Oliver, Commisioner, Vulnerable People	16 June
	Matthew Barnett, Senior Analyst	24 June
Thurrock (3)	Catherine Wilson , Lead Commissioner	23 June
	Fran Leddra, Lead Council Ops	15 July
	Roger Harris	18 Aug
Southend (4)	Sharon Houlden, Head of Adult Services & Housing	6 July
	Jacqui Ainsley, Director Integrated Care Commissioning	4 Aug
	Jo Dickenson	4 Aug
	Simon Leftley, Director for Adult Services	16 July

External (3)

Martin Brown	Professor, University of York	9 June
John Richards	Director, J Richards Solutions	16 June
Dr. Geraldine Strathdee	National Clinical Director for MH	28 July

The project team met with service users to understand their perspectives and gain their input on July 14th.

Robust clinical input into the review was ensured through a Clinical and Professional Leadership Group, set up as part of the review, and attended by individuals nominated by each stakeholder organisation. Two meetings were held on July 6th and July 28th.

A wider Clinical Conference, attended by over 50 clinicians and professionals from primary and secondary care, was held at the Marconi Club in Essex on August 3rd.

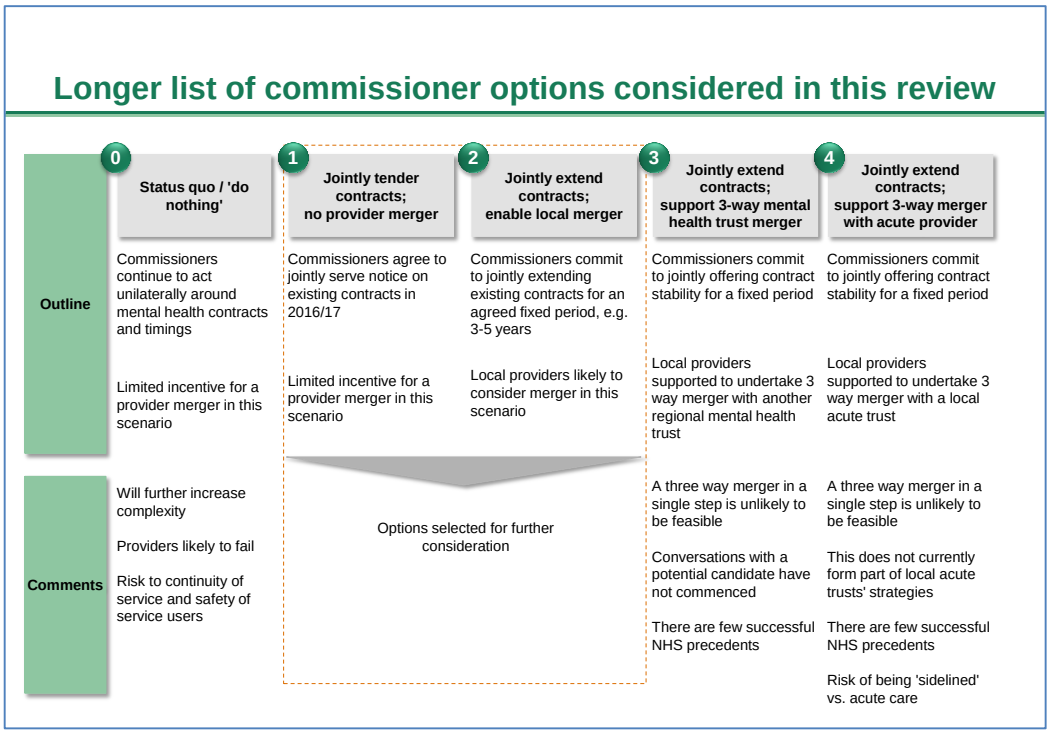
Clinical and professional input: Clinical conference and leadership group attendees

Name	Organisation
Sunil Gupta	CP&R CCG
Michael Bailey	Mid Essex CCG
Elizabeth Towers	Mid Essex CCG
Lisa Llewelyn	N Essex CCG
Miranda Roberts	N Essex CCG
Alexina Weston	N Essex CCG
Liz Carlisle	NEP
Ian Carr	NEP
Benita Christie	NEP
John Cleaver	NEP
Sarah Croot	NEP
Ian Daldry	NEP
Tom Dannhauser	NEP
Lloyd Davies	NEP
Sarah Dowse	NEP
Malte Flechtner	NEP
John Gardner	NEP
Ratna Ghosh	NEP
Harsha Gopisetty	NEP
Natalie Hammond	NEP
Mary Kennedy	NEP
Linda Law	NEP
Ian Lea	NEP
Anna Marley	NEP
Gbolahan Otun	NEP
Hemraj Pal	NEP
Jo Paul	NEP
Lynn Prendegast	NEP
Abdul Raoof	NEP

Name	Organisation
Stephanie Rea	NEP
James Sawtell	NEP
Toni Scales	NEP
Kallur Suresh	NEP
Lizzy Wells	NEP
Russell White	NEP
Gaynor Abbott-Simpson	SEPT
Maria Gutierrez	SEPT
Ron Gutu	SEPT
Annie Heining	SEPT
Milind Karale	SEPT
Gary Kupshik	SEPT
Llewellyn Lewis	SEPT
Julia Renton	SEPT
Karin Thies-Flechtner	SEPT
Andrea Ather	Southend CCG
Sharon Connell	Southend CCG
Linda Dowse	Southend CCG
Hugh Johnston	Southend CCG
Andrea Metcalfe	Southend CCG
Syed Taz	Southend CCG
Anand Deshpa	Thurrock CCG
Jane Itangata	Thurrock CCG
Catherine Wilson	Thurrock UA
Sanjeev Rana	West Essex CCG
Miranda Roberts	West Essex CCG

Appendix 3: Option appraisal

A number of options were considered as part of this review.



These were discussed and assessed against agreed criteria, which included risk to continuity of care and the safety of service users; sustainability; access to services; compatibility with overall national policy; feasibility; and preservation of mental health expertise and parity of esteem.

Based on the discussions, Options 1 and 2 were selected for further more detailed consideration. Both involve trade-offs, and these are different for different commissioners.

Option 1:

In this scenario, commissioners would align around jointly serving notice on the existing NEP and SEPT contracts in 2016 in order to commence new provision in Q1 2017, in line with existing contract timelines. There is little incentive for a provider merger in this scenario; local providers may still choose to bid for services. If the local providers are not successful, a transition plan would need to be agreed to ensure short term continuity of service in the north – in the south, SEPT would still have other business units to consider and may not be immediately financially unsustainable.

The key beliefs around this option are that:

- Service users are best served by moving quickly to a final configuration around provision of mental health services
- Any short term instability and risks to continuity of service can be mitigated
- Commissioner recommendations described as part of this review can be conducted in sufficient time and / or in parallel to the re-procurement process: this includes setting up new models of integrated care and ensuring enablers for the integration agenda are in place, for example new clinics and the necessary support in primary care practices

- A strategy around estates can be worked through in time so as to enable competition around inpatient services (given the incumbent local providers are the legal owners of their infrastructure)
- There is sufficient high quality competition in the system to enable a robust procurement process for all services…
- …and that should the local providers be unsuccessful, having local providers present in Essex longer term is not a key requirement

Option 2:

In this option, commissioners would align around jointly extending the existing NEP and SEPT contracts for a fixed time period, for example 3-5 years. This would be subject to clear conditions, such as agreed outcome metrics and a commitment to joint dialogue around service optimisation – and involve clear stage-gates to review progress. Under these circumstances providers may consider proceeding with a merger, building on discussions that have already commenced.

The key beliefs around this option are that:

- This timeline would ultimately lead to a better final answer for service users with less risk of service disruption in the interim
- Commissioner recommendations described as part of this review will require time to implement, and should be done prior to commencing procurement for new contracts – for example, conducting robust needs assessments, describing what services are required, prioritising funding, and writing robust service specifications
- There is not yet sufficient high quality competition in the system, and competition for inpatient services is not yet possible given the current estates ownership
- Giving local providers the space to consider merger, refocus strategically, and remodel their services will enable them to remain competitive in the longer term – and that having sustainable local providers is in the longer term interest of services users

See **Appendix 1, Section 6** for additional materials around Options 1 and 2.

Following discussion amongst commissioners at the Steering Committees and at three Accountable Officer meetings in July, August and September, a middle ground - Option 2b - was considered the preferred path and is described in detail above.

Southend Health & Wellbeing Board

Agenda Item No.

9

Report of Andrea Atherton
Director of Public Health

to
Health & Wellbeing Board
on
2nd December 2015

Report prepared by: James Williams Head of Health Development

For information only		For discussion X		Approval required	

Southend-on-Sea Joint Adult Prevention Strategy

Part 1 (Public Agenda Item)
James Moyies Executive Councillor for Health and Adult Social Care

1. Purpose of Report

1.1. This report proposes a draft framework and timeline to create a Joint Adult Prevention Strategy for Southend-on-Sea to promote wellbeing and independence.

2. Recommendations

2.1. The Health and Wellbeing Board debate the proposed scope of the Southend Adult Prevention Strategy.

3. Background & Context

3.1. The Care Act (2014) placed a new duty on local authorities to promote individual wellbeing and provide prevention services. This duty requires the Council and its partners to provide or arrange services that prevent, reduce or delay the need for support among local people and their carers.

3.2. Prevention in the context of this paper refers to any intervention or action that prevents, reduces or delays deterioration in the physical and mental health of adults resident in the Borough of Southend. For example, admission (or readmission) to hospital that could have been prevented if an individual was provided with the skills to self-manage their chronic condition. Permanent placement in a residential care setting due to an individual not being able to live independently due to social isolation.

3.3. There are 3 generally accepted types of preventative activity.

3.4 **Primary prevention**

Aimed at people who have little or no particular social care needs or symptoms of illness. The focus is on maintaining independence and good health and promoting wellbeing. Interventions including, providing universal access to good quality information, advice services, creating safer neighbourhoods, promoting healthy and active lifestyles, delivering low level practical services.

3.5 **Secondary prevention/early intervention**

This aims to identify people at risk and halt or slow down any deterioration in their functioning. People may already (knowingly or unknowingly) have a condition that impacts on their health. Interventions include screening and case finding, to identifying individuals at risk of specific health conditions or events. Interventions include tailored support such as structured self-management, postural stability or cardiac/pulmonary rehabilitation.

3.6 **Tertiary prevention**

This is aimed at minimising the impact of disability or deterioration in people who already have an established health condition/s or complex social care need/s and are at risk of needing further or more intensive services at a further point. Interventions need to be specially tailored to reduce or delay deterioration or progression of the condition. Immediate action is taken to manage any adverse event that could trigger entry into a high cost service, emergency care or residential and/or nursing care.

3.7 Within Southend, there are currently a number of strategies and interventions working across the 3 key areas of prevention. These include the prevention work stream working across the Integrated Health and Pioneer programme. Key elements within this work stream include (not exclusively):

- Southend Health and Wellbeing Service: Single point of referral and support for anyone who requires assistance to manage any lifestyle issues (smoking, physical inactivity, weight management)

- Southend Falls Prevention Programme: Community falls prevention programme for older adults support recovery and re-enablement as well as primary prevention

- Social prescribing: Local people can access support provided by local community based voluntary services, includes mental health charities as well as other self-help organisations

- Southend Health Information Portal: Online resources providing signposting to local organisations and services to facilitate self- help management

- Pilot self-management programme: Risk assessment and support for local people living with chronic health conditions to enable them to self-manage

3.8 One challenge for the board to debate is how to align and scale preventative interventions across the Borough and make best use of limited resources. For example, what might be the most effective approach to deal with the

consequences of long term conditions, which account for nearly three-quarters of the NHS budget? In addition, a recent survey of local authorities with a responsibility for adult social care, found since 2010 spending on social care has fallen by 12% at a time when the population looking for support has increased by 14%, requiring savings of 26% to be made.

3.9 The recent Southend-on-Sea long term conditions needs assessment reinforced the national findings. There is an urgent need to put in place measures to improve the way in which local people living with chronic long term health conditions, take control and manage their own health.

3.10 An additional area for discussion is health protection. In 2014/15 only 66.4 % of people aged 65 and over eligible for seasonal influenza vaccination received it. This was below the national average. Given admissions for respiratory problems are one of the major issues impacting on Southend Hospital, The Board might wish to discuss what emphasis the Southend Joint Adult Prevention Strategy should place on bringing partners together to address this particular problem.

3.11 The Board might also wish to discuss it can do to hold partners to account to enable the Joint Adult Prevention Strategy to achieve its objectives. It might also want to consider how it could support and champion the investment in prevention by partners particularly at a time of austerity.

4 Health & Wellbeing Board Priorities / Added Value

How does this item contribute to delivering the;

- Nine HWB Strategy Ambitions (listed on final page)
- Three HWB "Broad Impact Goals" which add value;

a) Increased physical activity (prevention)
b) Increased aspiration & opportunity (addressing inequality)
c) Increased personal responsibility/participation (sustainability)

4.1 The proposed Joint Adult Prevention Strategy aligns with the specific statutory duties of the Southend Health and Wellbeing Board namely:

- To assess the needs of their local population through a JSNA
- Set out how these needs will be addressed
- Promote greater integration, partnership working, including joint commissioning, integrated provision and pooled budgets.

4.2 **Strategy Scope**

It is proposed that the scope of the strategy is restricted to the direct role of adult social care (in partnership with NHS Southend Clinical Commissioning Group). In practice this means adults (persons aged 18+).

These people may:

- require or will require access to information, advice and advocacy services

- care for someone currently in receipt of health and/or social care services
- require or are at risk of requiring intensive health or on-going social care support

- require or will require low level non health or social care based support to maximise their independence

*The strategy aims to deliver improved health and wellbeing outcomes for:

- Older People
- People with Learning Disabilities
- Older People with Mental Health Problems
- Mental Health
- Physical Disability including sensory impairment
- Carers
- People with chronic long term conditions in direct receipt of social care or health service support
  *(baselines and specific health improvement outcomes will be fully quantified in the final strategy. For example increased physical activity in people with long term conditions equating to more people being able to self-care)

4.3 **Programme of delivery**

4.3.1 The Prevention Strategy will be delivered through the Southend Integrated Pioneer Programme Board. There will be a thorough process of collaboration, consultation and engagement with key partners. The proposed time table is set out in the Appendices.

5 Reasons for Recommendations

5.1 The Health and Wellbeing Board are required to determine how the scope of the proposed strategy aligns with the Board's strategic ambitions.

6 Financial / Resource Implications

6.1 There is a strong financial case to invest in evidence based preventative activities. Effective prevention done at the right scale can reduce the cost of expensive hospital treatment or social care placement. For example, the cost to health and social care commissioners of a single hip fracture related to an accidental fall in an older adult is in the region of £28,000 over 2 years. There is strong evidence that community based falls prevention programmes reduce the likelihood of older people falling. The key element for success in such programmes is identification of those at risk and supporting them to attend relevant courses.

6.2 The Southend-on-Sea Joint Adult Prevention Strategy might identify the need to commission new, or increase the resources for prevention focussed activities. Although Southend-on-Sea Borough Council receives a public health ring-fenced grant that is specifically for prevention, there may be future resource implications for partner organisations. Should this be the case, appropriate business cases setting out the costs and benefits of any additional or new investment will be developed and processed through normal governance routes?

7 Legal Implications

7.1 The Health and Social Care Act 2012 placed a statutory duty on Health and Wellbeing Boards to promote partnership working to improve the health of local people. The Care Act 2014 requires local authorities to provide prevention services.

8 Equality & Diversity

8.1 An equality impact assessment will form part of the development of the Southend-on-Sea Joint Adult Prevention Strategy

9 Background Papers

Southend-on-Sea Long Term Conditions Needs Assessment

King's Fund: Investing in Prevention

10 Appendices

10.1 Prevention Strategy Delivery Timetable

Outline Joint Adult Prevention Strategy Timetable

Date	Action	Comment
17 Nov 2015	Joint Executive Group (JEG)	consider proposed timeframe
Nov 2015	Healthwatch	Engagement with Healthwatch to discuss input required from Healthwatch.
2nd Dec 2015	HWB	Engagement with HWB to discuss scope, objectives and desired outcomes
Jan 2016	CCG Exec Clinical Executive Group People DMT PH DMT JEG	Key stakeholder engagement

Feb 2016	CCG Exec Clinical Executive Group People DMT PH DMT Executive Board Corporate Management Team	Key stakeholder engagement
Mar 2016	Cabinet (15th) Governing Body (TBC)	SBC and CCG sign off
23rd Mar 2016	HWB	Sign off
Apr 2016	Scrutiny (12th) Full Council (21st)	If required

HWB Strategy Priorities

Broad Impact Goals – adding value

a) Increased Physical Activity (prevention)
b) Increased Aspiration and Opportunity (addressing inequality)
c) Increased Personal Responsibility and Participation (sustainability)

Ambition 1. A positive start in life a) Reduce need for children to be in care b) Narrow the education achievement gap c) Improve education provision for 16-19s d) Better support more young carers e) Promote children's mental wellbeing f) Reduce under-18 conception rates g) Support families with significant social challenges	**Ambition 2. Promoting healthy lifestyles** a) Reduce the use of tobacco b) Encourage use of green spaces and seafront c) Promote healthy weight d) Prevention and support for substance & alcohol misuse	**Ambition 3. Improving mental wellbeing** a) A holistic approach to mental and physical wellbeing b) Provide the right support and care at an early stage c) Reduce stigma of mental illness d) Work to prevent suicide and self-harm e) Support parents postnatal
Ambition 4. A safer population a) Safeguard children and vulnerable adults against neglect and abuse b) Support the Domestic Abuse Strategy Group in their work c) Work to prevent unintentional injuries among under 15s	**Ambition 5. Living independently** a) Promote personalised budgets b) Enable supported community living c) People feel informed and empowered in their own care d) Reablement where possible e) People feel supported to live independently for longer	**Ambition 6. Active and healthy ageing** a) Join up health & social care services b) Reduce isolation of older people c) Physical & mental wellbeing d) Support those with long term conditions e) Empower people to be more in control of their care
Ambition 7. Protecting health a) Increase access to health screening b) Increase offer of immunisations c) Infection control to remain a priority for all care providers d) Severe weather plans in place e) Improve food hygiene in the Borough	**Ambition 8. Housing** a) Work together to; ○ Tackle homelessness ○ Deliver health, care & housing in a more joined up way b) Adequate affordable housing c) Adequate specialist housing d) Understand condition and distribution of private sector housing stock, to better focus resources	**Ambition 9. Maximising opportunity** a) Have a joined up view of Southend's health and care needs b) Work together to commission services more effectively c) Tackle health inequality (including improved access to services) d) Promote opportunities to thrive; Education, Employment

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Skipton House
80 London Road
London
SE1 6LH
Email: jenny.butler6@nhs.net

To:

Clinical Commissioning Group Accountable Officers

Local Authority Directors of Adult Social Services

NHS England: Regional Directors, Transformation Leads, Directors of Commissioning Operations, Directors of Specialised Commissioning

17th November 2015

Dear Colleagues,

Re: Implementing 'Building the right support – A national plan to develop community services and close inpatient facilities'

For a minority of people with a learning disability and/or autism, we remain too reliant on inpatient care. As good and necessary as some inpatient care can be, people are clear they want homes, not hospitals.

To implement this change on Friday 30th October 2015 NHS England, the Local Government Association (LGA), and the Association of Directors of Adult Social Services (ADASS) published **Building the right support** and a new **service model**[1].

Taken together, these documents have asked Local Authorities, Clinical Commissioning Groups (CCGs) and NHS England specialised commissioners to come together to form Transforming Care Partnerships (TCPs) to build up community services and close unnecessary inpatient provisions over the next 3 years and by March 2019.

This letter outlines what commissioners are now required to do, by when, broad planning assumptions, and details of regional briefing events for commissioners, where we will provide more information.

Planning assumptions

Based on national planning assumptions, it is expected that no area should need more inpatient capacity than is necessary at any time to care for:

- 10-15 inpatients in CCG-commissioned beds (such as those in assessment and treatment units) per million population
- 20-25 inpatients in NHS England-commissioned beds (such as those in low-, medium- or high-secure units) per million population

We know that for some local areas, the use of in-patient beds is lower than these planning assumptions. All partnerships will need, however, to work through the complexities of planning for the whole pathway and transfer of commissioning responsibilities for the specialised pathway. It will be important for TCPs to work with their regional leads to ensure that the end states meet the required ambition and that there are no overlaps or gaps between TCPs.

[1] As well as supplementary guidance for commissioners

The four NHS England regional transforming care leads are;

- North – Clare Duggan
- Midlands and East – Lynne Wigens
- London – Matthew Trainer
- South – Sarah Elliott

To deliver on these planning assumptions it is essential that areas build up capacity in communities and redesign pathways in order to better support people at home. An important component of partnership preparations will be analysis to inform plans for commissioning intensive community support services. Plans will need to evidence clear early milestones where such services are not yet fully in place.

To support local areas with transitional costs, NHS England will make available up to £30 million of transformation funding over three years, with national funding conditional on *match-funding* from local commissioners.

In addition to this, £15 million capital funding will be made available over three years.

What we are asking of you

CCGs have been working with NHS England's regions and with Local Authority colleagues to identify the footprint of each TCP and the proposed footprints were published in the plan (**Annex 1).** However we are aware that some strategic alliances are already being formed that may differ from those proposed. Final arrangements for these clusters are expected to be in place by 15th December 2015.

TCPs should allow for areas to commission at sufficient scale to manage risk, develop commissioning expertise and commission strategically for the relatively small number of individuals whose packages of care can be very expensive.

We are asking all TCPs to draw up a joint transformation plan by 8th February 2016. This plan will have to be jointly agreed by all partners in the TCP, including Local Authorities and NHS England specialised commissioning teams and involve people with lived experience of inpatient services and their families/carers[2].

A template for this plan will be shared shortly and further guidance on what the plan should cover is included in **Building the right support**.

Each plan will be reviewed by local panels, including expert clinical input, in order to provide useful feedback. Panels will include NHS England and LGA/ADASS representatives - as well as people with a learning disability and/or autism, their families/carers - looking at:

- Whether the plans fit with national principles and the approach set out in **Building the right support**
- Proposals for a share of the £30 million transition funding and, if appropriate, a share of the capital funding to supplement local match funding and sustainable investment into new service models

Panels may want to probe some areas of the plan in more detail, via calls/meeting with key individuals in February 2016.

To support you to deliver these changes, a bespoke package of support will be put in place to help areas plan for transformation. Each package of support will be discussed with NHS England regional teams. This exercise will also provide further detail on the financial arrangements, including setting out the indicative budget for each TCP to inform the regional team about their expected share of transition funding.

[2] Two tools looking at how areas can assess levels of co-production can be accessed here and here.

We will work to ensure that the process for submitting and assuring plans will align with other planning processes across Local Authorities and the NHS, including the process for assuring CCGs' annual plans. Further guidance will be provided later in the year.

Key Milestones

There are a number of key milestones for 2015/16 which are essential to ensure the effective delivery of Phase 1 of the 'mobilisation' of the programme.

November 2015:

- Agree and confirm organisational / governance arrangements (mobilise 'partnerships')
- Appoint Senior Responsible Officer SRO and deputy from health and social care.
- Agree Lead CCG (for host finance arrangements)
- Agree involvement and engagement with NHS England specialised commissioners;
- Agree launch or 'go-live' date for partnership (where not already working together formally)
- Transformation planning approach formalised, including workforce and financial modelling and the approach to workforce development especially in relation to positive behavioural support and leadership of change across the system

December 2015:

- Agree outline scope of transformation plan and timescale for local delivery (includes publishing meeting dates for governing board)

January to March 2016:

- First governing board meeting (if not already in train)
- Drafting of transformation plans
- First cut transformation plan by 8th February 2016
- Local assurance of plan coordinated through NHS England with stakeholders
- Finalise plan following regional and national moderation and feedback within March 2016

April 2016

- Begin to implement plans
- Final plan due 11th April

Dialogue Events

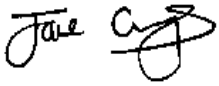
We will be holding multiple dialogue events across the country to bring TCPs and all stakeholders together commencing on the 7th December 2015 wherein we will provide more detail of the support available, timescales and expectations. All events will be held 10am – 1pm at the following venues

- Monday 7th December 2015 – Leicestershire County Cricket Club, LE2 8AD
- Tuesday 8th December 2015 – Gateway Conference Centre, Liverpool, L3 8HY
- Wednesday 9th December 2015 – Cambridge United Football Club, Cambridge, CB5 8LN
- Friday 11th December 2015 – Venue to be confirmed
- Monday 14th December 2015 – Radisson Blu Hotel, Leeds city centre, LS1 8TL
- Wednesday 16th December – The Wesley, 81-103 Euston Street, London, NW1 2EZ
- Thursday 17th December 2015 – Holiday Inn, Regents Park, London, W1 5EE

Booking details for these events will be confirmed. Further events will be held in January 2016 to discuss the implementation of plans and details of these will follow.

Once again, thank you for your involvement so far and we look forward to working with you over the coming weeks.

Yours sincerely,



Jane Cummings

Chief Nursing Officer for England

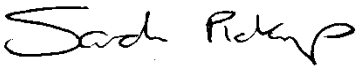
National Director, Nursing

NHS England

Ray James

President

Association of Directors of Adult Social Services



Sarah Pickup

Deputy Chief Executive

Local Government Association

Barbara Hakin

National Director, **Commissioning Operations**

NHS England

Annex A - Summary of Key Actions

Please review actions below and TCPs to confirm arrangements with **jenny.butler6@nhs.net** in line with the timescales below.

Transforming Care Partnerships

	What	Who	When
1	Confirm final partnership organisations and population coverage	TCP	15th December 2015
2	Confirm SRO and deputy	TCP	15th December 2015
3	Confirm lead CCG	TCP	15th December 2015
4	Confirm governance arrangements and board meeting schedule	TCP	15th December 2015
5	First TCP board meeting	TCP	January 2016
6	Draft Plan	TCP	8th February 2016
7	Revise plan	TCP	March 2016
8	Final Plan	TCP	11th April 2016

NHS England

	What	Who	When
1	Confirm Planning template and additional supporting materials	NHS England	December 2015
2	Organise dialogue events	NHS England	December 2015
3	NHS England specialised commissioning hubs to identify named relationship manager for each partnership	NHS England	15th December 2015
4	Confirm Assurance approach	NHS England	December 2015
5	Undertake assurance of TCP plans	NHS England and stakeholders	February 2016

Annex B

Transforming Care Partnership	**Clinical Commissioning Group (CCG)**
South Worcestershire, Redditch, Bromsgrove & Wyre Forest	NHS South Worcestershire CCG
	NHS Wyre Forest CCG
	NHS Redditch and Bromsgrove CCG
Hereford	NHS Herefordshire CCG
Coventry, Rugby, South Warwickshire & Warwickshire North	NHS Coventry and Rugby CCG
	NHS South Warwickshire CCG
	NHS Warwickshire North CCG
Birmingham CrossCity, Birmingham South Central & Solihull	NHS Birmingham CrossCity CCG
	NHS Birmingham South and Central CCG
	NHS Solihull CCG
Walsall	NHS Walsall CCG
Black Country	NHS Dudley CCG
	NHS Sandwell and West Birmingham CCG
	NHS Wolverhampton CCG
Derbyshire	NHS Erewash CCG
	NHS Southern Derbyshire CCG
	NHS Hardwick CCG
	NHS North Derbyshire CCG
Nottinghamshire	NHS Mansfield and Ashfield CCG
	NHS Bassetlaw CCG
	NHS Newark and Sherwood CCG
	NHS Nottingham City CCG
	NHS Nottingham North and East CCG
	NHS Nottingham West CCG
	NHS Rushcliffe CCG
Suffolk	NHS Ipswich and East Suffolk CCG
	NHS West Suffolk CCG
Norfolk	NHS North Norfolk CCG
	NHS Norwich CCG

	NHS South Norfolk CCG
	NHS West Norfolk CCG
	NHS Great Yarmouth and Waveney CCG
Cambridge and Peterborough	NHS Cambridgeshire and Peterborough CCG
Essex	NHS Basildon and Brentwood CCG
	NHS Castle Point and Rochford CCG
	NHS Mid Essex CCG
	NHS North East Essex CCG
	NHS Southend CCG
	NHS Thurrock CCG
	NHS West Essex CCG
Bedford, Luton and Milton Keynes	NHS Bedfordshire CCG
	NHS Luton CCG
	NHS Milton Keynes CCG
Hertfordshire	NHS East and North Hertfordshire CCG
	NHS Herts Valleys CCG
Nene and Corby	NHS Nene CCG
	NHS Corby CCG
Lincolnshire	NHS Lincolnshire East CCG
	NHS Lincolnshire West CCG
	NHS South Lincolnshire CCG
	NHS South West Lincolnshire CCG
Leicestershire	NHS East Leicestershire and Rutland CCG
	NHS Leicester City CCG
	NHS West Leicestershire CCG
Shropshire	NHS Shropshire CCG
	NHS Telford and Wrekin CCG
Staffordshire	NHS East Staffordshire CCG
	NHS North Staffordshire CCG
	NHS South East Staffordshire and Seisdon Peninsular CCG
	NHS Stafford and Surrounds CCG
	NHS Cannock Chase CCG
	NHS Stoke-on-Trent CCG
Gloucestershire	NHS Gloucestershire CCG
Wiltshire and Swindon	NHS Swindon CCG
	NHS Wiltshire CCG
Bristol, Bane and South Gloucestershire	NHS Bristol CCG
	NHS South Gloucestershire CCG

	NHS Bath and North East Somerset CCG
Somerset and North Somerset	NHS North Somerset CCG
	NHS Somerset CCG
Cornwall	NHS Kernow CCG
Devon	NHS North, East, West Devon CCG
	NHS South Devon and Torbay CCG
Kent and Medway	NHS Ashford CCG
	NHS Canterbury and Coastal CCG
	NHS Dartford, Gravesham and Swanley CCG
	NHS Medway CCG
	NHS South Kent Coast CCG
	NHS Swale CCG
	NHS Thanet CCG
	NHS West Kent CCG
Sussex	NHS Brighton and Hove CCG
	NHS High Weald Lewes Havens CCG
	NHS Eastbourne, Hailsham and Seaford CCG
	NHS Hastings and Rother CCG
	NHS Coastal West Sussex CCG
	NHS Crawley CCG
	NHS Horsham and Mid Sussex CCG
Surrey	NHS Guildford and Waverley CCG
	NHS North West Surrey CCG
	NHS Surrey Downs CCG
	NHS East Surrey CCG
	NHS Surrey Heath CCG
Buckinghamshire	NHS Aylesbury Vale CCG
	NHS Chiltern CCG
Berkshire	NHS Bracknell and Ascot CCG
	NHS Slough CCG
	NHS Windsor Ascot and Maidenhead CCG
	NHS Newbury and District CCG
	NHS North and West Reading CCG
	NHS South Reading CCG
	NHS Wokingham CCG
Hampshire & Isle of Wight	NHS North East Hampshire and Farnham CCG
	NHS North Hampshire CCG
	NHS Portsmouth CCG

	NHS South Eastern Hampshire CCG
	NHS Southampton CCG
	NHS West Hampshire CCG
	NHS Fareham and Gosport CCG
	NHS Isle of Wight CCG
Dorset	NHS Dorset CCG
Wirral, Cheshire & Chester Halton, St Helens, Warrington, Knowsley, Liverpool, Sefton, Southport & Formby	NHS Wirral CCG
	NHS West Cheshire CCG
	NHS Eastern Cheshire CCG
	NHS South Cheshire CCG
	NHS Vale Royal CCG
	NHS Halton CCG
	NHS St Helens CCG
	NHS Warrington CCG
	NHS Knowsley CCG
	NHS South Sefton CCG
	NHS Southport and Formby CCG
	NHS Liverpool CCG
Greater Manchester	NHS Bolton CCG
	NHS Bury CCG
	NHS Central Manchester CCG
	NHS Heywood, Middleton and Rochdale CCG
	NHS North Manchester CCG
	NHS Oldham CCG
	NHS Salford CCG
	NHS South Manchester CCG
	NHS Stockport CCG
	NHS Tameside and Glossop CCG
	NHS Trafford CCG
	NHS Wigan Borough CCG
Lancashire	NHS Blackburn with Darwen CCG
	NHS Blackpool CCG
	NHS Chorley and South Ribble CCG
	NHS East Lancashire CCG
	NHS Fylde and Wyre CCG
	NHS Greater Preston CCG
	NHS Lancashire North CCG
	NHS West Lancashire CCG
	NHS Cumbria CCG
	NHS Newcastle Gateshead CCG
	NHS North Tyneside CCG

Cumbria and North East	NHS Northumberland CCG
	NHS South Tyneside CCG
	NHS Sunderland CCG
	NHS Darlington CCG
	NHS Durham Dales, Easington and Sedgefield
	NHS Newcastle North and East CCG
	NHS Newcastle West CCG
	NHS Hartlepool and Stockton-on-Tees CCG
	NHS North Durham CCG
	NHS South Tees CCG
North Yorkshire	NHS Hambleton, Richmondshire and Whitby
	NHS Harrogate and Rural District CCG
	NHS Scarborough and Ryedale CCG
	NHS Vale of York CCG
Barnsley, Wakefield, Kirklees, Huddersfield & Calderdale	NHS Barnsley CCG
	NHS Wakefield CCG
	NHS North Kirklees CCG
	NHS Greater Huddersfield CCG
	NHS Calderdale CCG
Bradford	NHS Bradford Districts CCG
	NHS Bradford City CCG
	NHS Airedale, Wharfdale and Craven CCG
Leeds	NHS Leeds North CCG
	NHS Leeds South and East CCG
	NHS Leeds West CCG
Sheffield, Doncaster, Rotherham, North Lincolnshire	NHS Doncaster CCG
	NHS Rotherham CCG
	NHS North East Lincolnshire CCG
	NHS North Lincolnshire CCG
	NHS Sheffield CCG
East Riding & Hull	NHS East Riding of Yorkshire CCG
	NHS Hull CCG
London North West	NHS Brent CCG
	NHS Central London CCG
	NHS Ealing CCG
	NHS Hammersmith and Fulham CCG
	NHS Harrow CCG

	NHS Hillingdon CCG
	NHS Hounslow CCG
	NHS West London CCG
London North, Central & East	NHS Barking and Dagenham CCG
	NHS Barnet CCG
	NHS Camden CCG
	NHS City and Hackney CCG
	NHS Enfield CCG
	NHS Haringey CCG
	NHS Havering CCG
	NHS Islington CCG
	NHS Newham CCG
	NHS Redbridge CCG
	NHS Tower Hamlets CCG
	NHS Waltham Forest CCG
London South East	NHS Bexley CCG
	NHS Bromley CCG
	NHS Greenwich CCG
	NHS Lambeth CCG
	NHS Lewisham CCG
	NHS Southwark CCG
London South West	NHS Croydon CCG
	NHS Kingston CCG
	NHS Merton CCG
	NHS Richmond CCG
	NHS Sutton CCG
	NHS Wandsworth CCG
Oxfordshire	NHS Oxfordshire CCG

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Southend Health & Wellbeing Board

Agenda Item No.

10

Report of Director of Public Health

……

to

Health & Wellbeing Board

on

Wednesday 2 December 2015

Report prepared by:
Rob Walters, Partnership Advisor, Health and Wellbeing

For information only		For discussion	✓	Approval required	✓

Progress Indicators – Broad impact Goals
Southend Health and Wellbeing Strategy refresh 2015-16

Part 1 (Public Agenda Item)

1. Purpose of Report

1.1. To provide the Board with the first progress report for the HWB Strategy "Broad Impact Goals" indicators.

1.2. To highlight opportunities where Board members can support improved outcomes in specific areas of work.

1.3. To highlight potential next steps for identifying longer term strategic ambitions for the Health and Wellbeing Strategy from 2016 onwards.

2. Recommendations

2.1. That, subject to feedback, the Board approves the format of the indicator report.

2.2. That, where relevant, Board members consider engaging in opportunities to support progress in specific areas, as shown in the indicator report (Appendix 1)

2.3. That Board members consider and voice any other potential opportunities and contributions that might not currently be highlighted.

2.4. That the Board approves the intent to organise an additional informal session to examine relevant data and considerations, in order to inform the longer term priorities of the Health and Wellbeing Strategy from 2016 onwards.

3. Background & Context

3.1. The 2015-16 HWB Strategy refresh identified several "Broad Impact Goals" which seek to add value to the routine business of the Board and stimulate Borough-wide improvements in three specific areas:

A) Increased physical activity (prevention of ill health)

B) Increased aspiration and opportunity (addressing inequality)

C) Increased personal responsibility and participation (sustainability)

3.2. In June 2015, the Board agreed a set of performance indicators to measure progress in these areas (see Appendix 2).

3.3. The initial progress report (Appendix 1), seeks to provide details of current and retrospective progress for each indicator, as well as highlighting actions which are helping to improve each area of work.

3.4. To make this data more meaningful, we are working with departmental contacts to identify potential ways that HWB Board members can support improved outcomes.

3.5. Board members are encouraged to consider these potential opportunities as shown in the section *"Can the HWB Board help to improve performance in this area?" Board members* are also asked to consider if there are other potential ways of supporting progress that are not currently identified. The Partnership Advisor for Health and Wellbeing can link Board members with relevant colleagues to explore any potential participation/solutions.

3.6. The current HWB Strategy refresh (which includes the Broad Impact Goals) runs from 2015-2016. In line with previous strategic discussions, it is proposed that a longer term strategy be established from 2016, potentially until 2020.

3.7. There are several aspects to consider in the development of a longer term HWB Strategy. These being; outcomes of the Joint Strategic Needs Assessment (JSNA); response to the recommendations from the HWB Peer Challenge in July 2015; current HWB priorities, including the 9 Ambitions and 3 Broad Impact Goals.

3.8. It is proposed that by Spring 2016, an additional informal session be arranged for HWB Board members and key colleagues to look at the outcomes of the JSNA and related considerations, in order to identify and establish the focus and priorities for the next HWB Strategy.

4. Health & Wellbeing Board Priorities / Added Value

How does this item contribute to delivering the;

- Nine HWB Strategy Ambitions (listed on final page)
- Three HWB "Broad Impact Goals" which add value;
    a) Increased physical activity (prevention)
    b) Increased aspiration & opportunity (addressing inequality)
    c) Increased personal responsibility/participation (sustainability)

4.1 This item is integral in measuring and driving forward progress for the 3 Broad Impact Goals.

5. Reasons for Recommendations

5.1. To effectively measure progress for the HWB Broad Impact Goals and provide direct opportunities for HWB members to support improvements for each indicator.

5.2. To agree an initial process for Board participation in establishing the priorities of a longer term HWB Strategy from 2016.

6. Financial / Resource Implications

6.1 All current work is being carried out within existing resources. Any potential resource implications will be dependent on the Board's response to the opportunities listed within the section "Can the HWB Board help to improve performance in this area?" (see Appendix 1)

7. Legal Implications

7.1. N/A

8. Equality & Diversity

8.1. The indicators inherently focus on addressing inequality.

9. Background Papers

9.1. None

10. Appendices

10.1. **Appendix 1:** HWB Indicator progress report, 2 Dec 2015

Appendix 2: Draft HWB Performance indicators from June 15

HWB Strategy Priorities

Broad Impact Goals – adding value

a) Increased Physical Activity (prevention)
b) Increased Aspiration and Opportunity (addressing inequality)
c) Increased Personal Responsibility and Participation (sustainability)

Ambition 1. A positive start in life	Ambition 2. Promoting healthy lifestyles	Ambition 3. Improving mental wellbeing
a) Reduce need for children to be in care b) Narrow the education achievement gap c) Improve education	a) Reduce the use of tobacco b) Encourage use of green spaces and seafront c) Promote healthy weight d) Prevention and support	a) A holistic approach to mental and physical wellbeing b) Provide the right support and care at an early stage

provision for 16-19s d) Better support more young carers e) Promote children's mental wellbeing f) Reduce under-18 conception rates g) Support families with significant social challenges	for substance & alcohol misuse	c) Reduce stigma of mental illness d) Work to prevent suicide and self-harm e) Support parents postnatal
Ambition 4. A safer population a) Safeguard children and vulnerable adults against neglect and abuse b) Support the Domestic Abuse Strategy Group in their work c) Work to prevent unintentional injuries among under 15s	**Ambition 5. Living independently** a) Promote personalised budgets b) Enable supported community living c) People feel informed and empowered in their own care d) Reablement where possible e) People feel supported to live independently for longer	**Ambition 6. Active and healthy ageing** a) Join up health & social care services b) Reduce isolation of older people c) Physical & mental wellbeing d) Support those with long term conditions e) Empower people to be more in control of their care
Ambition 7. Protecting health a) Increase access to health screening b) Increase offer of immunisations c) Infection control to remain a priority for all care providers d) Severe weather plans in place e) Improve food hygiene in the Borough	**Ambition 8. Housing** a) Work together to; ○ Tackle homelessness ○ Deliver health, care & housing in a more joined up way b) Adequate affordable housing c) Adequate specialist housing d) Understand condition and distribution of private sector housing stock, to better focus resources	**Ambition 9. Maximising opportunity** a) Have a joined up view of Southend's health and care needs b) Work together to commission services more effectively c) Tackle health inequality (including improved access to services) d) Promote opportunities to thrive; Education, Employment

Southend HWB Strategy Refresh 2015-16

HWB Indicators Progress Report Dec15

Name	Ref	Reporting period	Annual Target 2015-16	Previous status +1	Previous status	Current period status	Current period target	Gauge format type	Latest notes/ considerations	What actions are being taken to improve this area?	Can the HWB Board help to improve performance in this area?	Current RAG rating
A) Increased physical activity (prevention)												
Development of a Physical Activity Strategy and Implementation Action Plan/Steering Group	A1	Monthly / Period (Apr to Mar)	Completed March 31st 2016	N/A	N/A	**On track**	N/A	N/A	Successful Expression of Interest to Chief Leisure Officers Association for expert LA/Sport England Support. Expert advisor interviews with LA/CCG senior management 26th November, literature review completed.	Logic mapping of existing provision in development, consultation plan developed.	**Engage with strategy development + consultation process - Consultation process being designed for January 2016 and will be communicated out when finalised**	
Percentage of adults achieving at least 150mins of physical activity per week (Active) (2.13i- Public Health Outcomes Framework)	A2.1	Bi-Annually June & December	Increase % of Southend population defined as active to become statistically similar to England average by 2019 (Southend currently significantly below England average of 57%)	N/A	N/A	**52.1%.** In order to be at the England Average we need to move 8624 to achieve 150mins per week.	Increase % of Southend population defined as active to become statistically similar to England average by 2019 (Southend currently significantly below England average of 57%)	Aim to maximise	Data update due Dec 15	Development of Physical Activity Strategy. Active Southend developing external funding bids for 'at risk' populations such as those with low level Mental Health problems	**Include promoting physical activity through Making Every Contact Count (MECC) in all contracts, consider impact on physical activity in future planning. All partners to promote physical activity to staff. There is free training and support funded by the Public Health Team for providers to deliver MECC**	
Percentage of adults not achieving 30 mins of physical activity per week (Inactive) (2.13ii- Public Health Outcomes Framework)	A2.2	Bi-Annually June & December	Reduce % of population defined as inactive to 27.7% (2014 England Average) by 2019	N/A	N/A	**29.2%** (Active People Survey Results released in June- we would need to move 2640 people from being inactive in order to be on the England Average)	Reduce % of population defined as inactive to 27.7% (2014 England Average) by 2019	Aim to minimise	Data update due Dec 15			
Number of businesses with travel plans that have been reviewed in the previous 12 months featuring active and sustainable travel	A3.1	Quarterly / Period (Apr to Mar)	Awaiting target	N/A	N/A	**Awaiting data**	Awaiting target	Aim to maximise	New business engagement officer employed for Public Health Responsibility Deal, this post engages with businesses around a range of subjects including active and sustainable travel.	Business engagement activity.	**All partners can sign up to the Active Travel pledge of the Public Health Responsibility Deal- actions including developing/updating travel plans, promoting active commuting to staff, cycle2work scheme, cycle parking, showers etc. Future infrastructure planning to promote active travel over less sustainable modes.**	Awaiting
Cycling Counts	A3.2	Bi-annually June & December	Baseline so no target yet established	N/A	129 (q4 average 2014/15)	**237** (q1 average 2015/16)	Baseline so no target yet established	Aim to maximise	Quarterly data always one quarter behind	Ideas in Motion campaign (http://www.ideasinmotionsouthend.co.uk/) Business engagement through new business engagement officer.		Awaiting

Southend HWB Strategy Refresh 2015-16

HWB Indicators Progress Report Dec15

Name	Ref	Reporting period	Annual Target 2015-16	Previous status +1	Previous status	Current period status	Current period target	Gauge format type	Latest notes/ considerations	What actions are being taken to improve this area?	Can the HWB Board help to improve performance in this area?	Current RAG rating
B) Increased Aspiration and Opportunity (addressing inequality)												
Number of children who have participated in extracurricular vocational skills mentoring initiatives (60 minute Mentor) (60 Minute Mentor is an initiative where local business leaders host an hour long session with students, sharing their insights and experience and offering advice on vocational skills such as CV writing as well as answering student's questions)	B1	Academic term: Sept-Dec15, Jan-Mar16, Apr-Jul16	90	Not prev counted	Not prev counted	**50** so far (Sept-Dec15)	30	Aim to maximise	Scheme previously recorded number of sessions rather than participants. i.e.November 14 - July 15, sessions across 7 schools. Moving forward we will aim to target 30 students per academic term.	To expand the 60 Minute Mentor database of schools and industry mentors	**Health Sector Mentors:** **There is currently a gap in our mentor database for mentors across the health sector. We have had schools, such as Westcliff High School for Girls, asking for a session in medicine or nursing. It would be appreciated if the Board could support in finding appropriate mentors from this sector.** **All that is required for each session is a one hour presentation to up to 30 students and a 15 minute pre meet before the session to discuss practicalities.** **Opportunities for HWB:** **If the board feel there are any local skills gaps in terms of the health & care sector then we can assist in addressing this by encouraging schools to host, or by independently holding, sessions specifically on those professions.**	
Number of Southend residents with a learning disability who receive a long term social service and are in paid employment	B2	Quarterly / Period (Apr to Mar)	10%	9.9% (Jul15)	11.3% (Aug15)	**11.5% (Sept15)**	10%	Aim to maximise	In September, we have 405 service users, of which 47 are in paid employment. The employment team continue to support adults and their employers to retain existing employment and continue to market the service to local employers to increase the number of work opportunities available.	No narrative yet provided	**No narrative yet provided**	
Number of pre-start-up & start-up businesses supported in Southend	B3.1	Quarterly / Period (Apr to Mar)	20	N/A	5 (Apr-Jun)	**6 (Jul-Oct)**	5	Aim to maximise	Business support can take the form of 1:1 advice, a workshop or a grant. Support can be given on a number of different topics including: business planning, marketing, finance, human resources, operations, etc. Support will typically be provided for between 2-12 hours. The aim of the support is to enable growth within the company. The business support service is currently going through a step change with the move from Business Southend (which saw the offer of grants, innovation vouchers and workshops) to BEST (Business Essex, Southend and Thurrock) which is a new one stop shop for businesses across Essex which acts as a signposting and referral service. BEST officially launched its website at the beginning of September and thus before this, the team were monitoring already existing clients of Business Southend. Therefore the figures for this quarter are lower than we would expect given the change from Business Southend to BEST.	Actions to improve the uptake of this support include the creation of the new 'Business, Essex, Southend and Thurrock Growth Hub'. This will create a one-stop-shop for accessing business support across the whole of Essex.	**There is potential to deliver specialist support such as workshops or training that targets a specific demography (i.e. those living in deprived wards).** ***Appropriate resource would be required to enable this.**	
Number of Small & medium sized enterprises (SMEs) supported in Southend	B3.2	Quarterly / Period (Apr to Mar)	80	N/A	15 (Apr-Jun)	**5 (Jul-Oct)**	20	Aim to maximise				

Southend HWB Strategy Refresh 2015-16

HWB Indicators Progress Report Dec15

Name	Ref	Reporting period	Annual Target 2015-16	Previous status +1	Previous status	Current period status	Current period target	Gauge format type	Latest notes/ considerations	What actions are being taken to improve this area?	Can the HWB Board help to improve performance in this area?	Current RAG rating
Percentage of total attendance in secondary schools (Cumulative) (Academic Year)	B4.1	Monthly / Period (Apr to Mar)	94.20%	94.35% (Jul15)	95% (Aug15)	**Awaiting (Sept15)**	94.20%	Aim to maximise	No narrative yet provided	The Child and Family Early Intervention Teams (CFEIT) across the three localities in Southend, continue to work with Secondary & Primary schools to improve attendance. Schools carry out level one attendance meetings with pupils showing a cause for concern regarding their attendance. When the case escalates to level 2 and beyond the CFEIT officer allocated to the school will pick up these cases and follow them through, in some cases to court level. Cases are picked up early to help to avoid escalation. CFEIT officers work closely with the families to help overcome any barriers there may be to school attendance.	**No narrative yet provided**	
Percentage of total attendance in primary schools (Cumulative) (Academic Year)	B4.2	Monthly / Period (Apr to Mar)	95.30%	96.2% (July15)	96.2% (Aug15)	**Awaiting (Sept15)**	95.30%	Aim to maximise	No narrative yet provided		**No narrative yet provided**	
Percentage of total attendance in Special Schools (Cumulative) (Academic Year)	B4.3	Monthly / Period (Apr to Mar)	90.40%	86.6% (Jul15)	86.7% (Aug15)	**Awaiting (Sept15)**	90.40%	Aim to maximise	No narrative yet provided	Due to the nature of the cohort of special schools, medical needs are usually exceptionally higher than those of mainstream schools. Special schools work closely with specialist services to ensure health needs of children are met.	**No narrative yet provided**	
The proportion of persistent absence in Primary Schools (Cumulative) (Academic Year)	B4.4	Monthly / Period (Apr to Mar)	3%	1.61% (Jul15)	1.61% (Aug15)	**Awaiting (Sept15)**	3%	Aim to minimise	The Persistent Absence (PA) project has been evaluated and a summary is being prepared for schools. As part of the PA project a number of year 6 pupils moving to year 7 were visited during the summer holidays and given transition packs. These children's attendance will be tracked at the end of their first month and again just before half term to show the impact of the project work	The threshold for PA has reduced to 10% from 15%. Schools are expected to identify students through their school attendance procedures linking and working closely with the allocated Child and Family Early Intervention Team (CFEIT) Officer.	**No narrative yet provided**	
The proportion of persistent absence in Secondary Schools (Cumulative) (Academic Year)	B4.5	Monthly / Period (Apr to Mar)	6.40%	3.86% (Jul15)	3.86% (Aug15)	**Awaiting (Sept15)**	6.40%	Aim to minimise	This information will be reported next month due to persistent absence being reported on a half-termly basis.		**No narrative yet provided**	
Number of Southend residents in apprenticeships	B5	Annually	No local target	1400 starts (12-13)	1250 starts (13/14)	**1400 starts (14/15)**	No local target	N/A	Number of Southend residents accessing apprenticeships has increased slightly from the previous year but only back to the high of 12-13. Apprenticeships are a focus of the current government, looking at increasing to 3 million national (England and Wales) by end of term of the government.	Working with employers to increase the number of apprenticeships available. Working with providers to ensure provision is there to meet demands. Raising awareness in schools of apprenticeship opportunities. SBC developing their own health and social care apprenticeships in addition to its current apprenticeship offer	**There are skills shortages in the health and social care sector and it would be beneficial to increase the opportunities of apprenticeships available in this sector. Health & Care sector partners could identify where vacancies can be accessed by apprentices. Forward planning would be useful, i.e. where are the current and future gaps caused by retirement and increase in demand for social care etc.**	N/A

Southend HWB Strategy Refresh 2015-16

HWB Indicators Progress Report Dec15

Name	Ref	Reporting period	Annual Target 2015-16	Previous status +1	Previous status	Current period status	Current period target	Gauge format type	Latest notes/ considerations	What actions are being taken to improve this area?	Can the HWB Board help to improve performance in this area?	Current RAG rating
Residents who are 16-18 years who are not participating in education, employment or training (NEET)	B6	Monthly / Period (Apr to Mar)	7% (Aiming to provide numerical context in future reporting)	5.9% (Aug15)	6.1% (Sept15)	**6.1% (Oct15)**	7%	Aim to minimise	5Oct15: In September all the destinations of Yr 11from 2015 become unknown. This happens across the country so when information comes in about their post 16 options this will then form the Activity/destination survey which will be published in January. Also, at the end of August/1st September all young people in Yr12/ 13/14 from 2015 cohort will lapse. Personal advisers currently liaising with all post 16 providers to identify destinations of students	4Nov15: Personal Advisers working with local education and training providers to identify courses to support young people who are NEET	**No narrative yet provided**	
Those NEET in the 30% most deprived areas in Southend	B7	Monthly / Period (Apr to Mar)	40% (Aiming to provide numerical context in future reporting)	55.2% (Aug15)	55.4% (Sept15)	**56.9% (Oct15)**	40%	Aim to minimise	4Nov15: Waiting for the data team to migrate destinations of students into one IYSS as this is a new process there are checks that need to be established first. 5Oct15: As with all the NEET and unknown targets, the roll up process impacts on the figure. Once destinations of young people are determined, then the figure should reduce.	Youth & Connexions team are currently contacting young people to identify what their current situation is. If they are not in Education, employment or training, to invite them in to see a Personal Adviser for support in accessing opportunities.	**No narrative yet provided**	
Residents who are 18-24 years who have claimed Job Seeker's Allowance (JSA) for six months or more	B8	Annual comparative snapshot	N/A*	385 (Oct13)	190 (Oct14)	**150 (Oct15)**	N/A*	Aim to minimise	There has been a 21% reduction in numbers of Jobseekers Allowance (JSA) recipients from 18-24 claiming for six months or longer. Note: As Universal Credit (UC) has been available in Southend since March 2015, the JSA numbers are no longer the full picture for unemployed residents and particularly single ones, many of whom are under 25 years of age. There is currently no available public data on the UC numbers. *There is not a specific locally agreed measure for long term youth unemployment itself.	*Department for Work and Pensions (DWP) has an overarching strategy for reducing total level of unemployment. All customers have access to a national offer to support residents into employment See: https://www.gov.uk/browse/working/finding-job , https://www.gov.uk/jobcentre-plus-help-for-recruiters In addition, unemployed residents under 25 receiving a working age benefit have access to the additional offer of the Youth Contract with, in particular, a dedicated work coach for period of their claim (on UC this includes in work support as well), employer led opportunities for work experience and pre-employment training.	**Job Centre Plus would be happy to attend the HWB Board to discuss and agree collaborative measures on youth unemployment (or any other group of working age residents receiving benefits) to improve their health & wellbeing and prosperity**	N/A

Southend HWB Strategy Refresh 2015-16

HWB Indicators Progress Report Dec15

C) Increased Personal Responsibility and Participation (sustainability)												
Name	**Ref**	**Reporting period**	**Annual Target 2015-16**	**Previous status +1**	**Previous status**	**Current period status**	**Current period target**	**Gauge format type**	**Latest notes/ considerations**	**What actions are being taken to improve this area?**	**Can the HWB Board help to improve performance in this area?**	**Current RAG rating**
Number of people having health checks	C1	Monthly / Period (Apr to Mar)	1st Invites: 10,433 HCs completed: 5673	N/A	Apr-Jun 1st Invites: 2257 (23.84%) HCs completed: 1741 (30.69%)	Apr-Oct 1st Invites: **9259** (86.94%) HCs completed: **4582** (80.77%)	10,433 overall	Aim to maximise	Currently on track. Targets will be achieved by 31st March 16. The target for invites is to invite 20% of the eligible population to attend for a health check each year and to reinvite every 5 years.	Outreach service commissioned and delivered to target Routine & Manual workers and areas of the borough where there is a low uptake.	**Yes – Members of HWBB can assist with raising awareness of NHS Heath Checks and Making Every Contact Count training and encourage staff/ individuals to have training on this.**	
Number of people progressing through the scale of the Patient Activation Measures programme (PAM) *(An initiative which identifies the ability and motivation for positive lifestyle change of those with long term conditions and provides interventionary support accordingly)*	C2	Monthly / Period (Apr to Mar)	A maximum of 1200 participants to be PAM'd (and re scored to show an improvement level)	N/A	N/A	**1068 PAM scored** **127 on 3&6 week self-management courses** **134 invited to Market Place Event – 2nd questionnaires to be given then**	1,200 overall	Aim to maximise	Self-Management UK are engaged to provide patients with low PAM scores with the knowledge and skills to better manage their long term condition. This management would be reflected in an improved PAM score.	Public Health are working closely with CCGs, particularly the clinical leads re planned and unplanned care. Also working with pilot GP practices who are identifying relevant patients for the programme.	**Pilot programme.** **Currently no anticipated input from HWB required.**	
Smoking cessation: Number of 'Four week quitters'	C3	Monthly / Period (Apr to Mar)	1,300	N/A	245 (1Apr-6Aug15) Cumulative	**495 (1Apr-31Oct15) Cumulative**	1,300 overall	Aim to maximise	Currently on track. Targets will be achieved by June 2016 (The annual target data collection continues into June to capture those successful quitters who set a quit date in March.)	Public Health are continuing to actively promote stop smoking services through public engagement events, social marketing initiatives and by closely supporting and training stop smoking advisers in general practice and community pharmacy	**Yes – Members of HWBB can assist with raising awareness of stop smoking service and Making Every Contact Count training and encourage staff/ individuals to have training on this.** **H&WB can also assist in the implementation of the recently agreed Tobacco Control Strategy**	

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29 June 2015

Draft performance indicators – Areas for consideration

Southend Health and Wellbeing Strategy refresh Broad Impact Goals 2015-2016

A) Increased Physical Activity (prevention)
1. Development of a Physical Activity Strategy and Implementation Action Plan/Steering Group
2. Percentage of adults achieving at least 150mins of physical activity per week
3. Cycling and Walking Counts
B) Increased Aspiration and Opportunity (addressing inequality)
1. Number of children who have participated in extracurricular vocational skills mentoring initiatives
2. Number of Southend residents with a learning disability who receive a long term social service and are in paid employment
3. Uptake of business start-up support courses by residents who live in deprived wards
4. School attendance figures
5. Number of Southend residents in apprenticeships
6. Residents who are 16-18 years who are not participating in education, employment or training (NEET)
7. Those NEET in the 30% most deprived areas in Southend
8. Residents who are 19-24 years who have claimed Job Seekers Allowance (JSA) for six months or more
C) Increased Personal Responsibility and Participation (sustainability)
1. Number of people having health checks
2. Number of people progressing through the scale of the Patient Activation Measures programme (PAM) (*An initiative which identifies the ability and motivation for positive lifestyle change of those with long term conditions and provides interventionary support accordingly)*
3. Smoking cessation: Number of 'Four week quitters'

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Safeguarding and the HWB

LSCB perspective

Helen Wilson and Chris Doorly

Role of the LSCB

- To co-ordinate activity to promote Safeguarding

- To assure the effectiveness of Safeguarding in Southend

Key Issues in safeguarding

- That safeguarding is everyone's concern
- That a child centred approach should be taken

Governance arrangements:LSCB

- It holds partners to account on safeguarding
- It (LSCB) cannot be subsumed under/into any other bodies
- The Annual Report should analyse how well safeguarding is going and indicate any gaps in services or other issues
- It should be presented to Chief Executive, Leader of LA, PCC, and HWB

Southend Arrangements

- No Childrens Trust
- Annual meeting with Leader, Portfolio lead, and Chief Executive
- Not a regular attender at HWB
- No formal arrangement with PCC
- LSCB Annual report presented to HWB

Areas to explore

- Role of HWB as commissioner
- How to assure Safeguarding in Commissioning role
- Significance of Adult services/issues (mental health , substance misuse, DV etc)
- Where is the Voice of the Child/Child Centred approach in services/commissioning
- Looking for new and “visionary” solutions

Areas to Explore (cont'd)

- Value of a more iterative approach
- Reviewing the interface between the 2 Boards, and the processes we could use

Questions and discussion

- Thank you

Forward Plan 2015/16

Southend Health and Wellbeing Board

v23-11-15

Southend CCG Governing Body		*CCG 30/07/15*		*CCG 24/09/15*		*CCG 26/11/15*	
Southend HWB Board	**HWB 29 Jun 15**			**HWB 2 Sept 15**			**HWB 2 Dec 15**
	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Governance - Progress against plans - Council/Democracy - Key Board decisions	HWB Strategy Refresh Broad Impact Goals draft performance indicators			Meeting cancelled			HWB performance Indicators progress
Policy/Landscape/Stakeholders Policy, Strategy & legislation developments, HWB landscape, Stakeholder engagement	Older People Joint Commissioning Strategy2015-2018 Care Act update JSNA						Joint Adult Prevention Strategy Essex Wide Mental Health Strategic Review
Board development		HWB Peer challenge follow up visit			HWB Peer Challenge recommendations HWB Vision		Safeguarding and the role of the Health and Wellbeing Board
Other	Better Care Fund (BCF) quarterly report						Better Care Fund (BCF) quarterly report

Forward Plan 2015/16

Southend Health and Wellbeing Board

v23-11-15

Southend CCG Governing Body							
Southend HWB Board		**HWB Tue 9 Feb**	**HWB Date TBC**				
Governance - Progress against plans - Council/Democracy - Key Board decisions	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
		HWB Indicators progress Mental Health progress	HWB Indicators progress				
Policy/Landscape/Stakeholders Policy, Strategy & legislation developments, HWB landscape, Stakeholder engagement		LSCB and SAB Safeguarding annual reports					
Board development							
Other		HWB Strategy development session by Spring 2016					