CABINET

TUESDAY, 18 JULY 2017

10.00 AM COUNCIL CHAMBER, COUNTY HALL, LEWES

MEMBERSHIP - Councillor Keith Glazier (Chair)
Councillors Nick Bennett, Bill Bentley, David Elkin (Vice Chair), Carl Maynard, Rupert Simmons, Bob Standley and Sylvia Tidy

A G E N D A

1 Minutes of the meeting held on 27 June 2017 *(Pages 3 - 6)*

2 Apologies for absence

3 Disclosures of interests

Disclosures by all members present of personal interests in matters on the agenda, the nature of any interest and whether the member regards the interest as prejudicial under the terms of the Code of Conduct.

4 Urgent items

Notification of items which the Chair considers to be urgent and proposes to take at the appropriate part of the agenda. Any members who wish to raise urgent items are asked, wherever possible, to notify the Chair before the start of the meeting. In so doing, they must state the special circumstances which they consider justify the matter being considered urgent.

5 East Sussex Better Together Alliance Accountable Care Model: Future Organisational Arrangements *(Pages 7 - 38)*
Report by Director of Adult Social Care and Health

6 Internal Audit Annual Report and Opinion 2016/17 *(Pages 39 - 56)*
Report by Chief Operating Officer

7 Ashdown Forest Trust Fund *(Pages 57 - 62)*
Report by Chief Operating Officer

8 Any other items considered urgent by the Chair

9 To agree which items are to be reported to the County Council

PHILIP BAKER
Assistant Chief Executive
County Hall, St Anne's Crescent
LEWES BN7 1UE

10 July 2017

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CABINET

MINUTES of a meeting of the Cabinet held on 27 June 2017 at Council Chamber, County Hall, Lewes

PRESENT Councillors Keith Glazier (Chair)
Councillors Nick Bennett, Bill Bentley, David Elkin (Vice Chair), Carl Maynard, Rupert Simmons, Bob Standley and Sylvia Tidy

Members spoke on the items indicated

Councillor Barnes	– items 5 and 6 (minutes 10 and 11)
Councillor Clark	– item 5 (minute 10)
Councillor Godfrey Daniel	– items 5, 6 and 8 (minutes 10, 11 and 13)
Councillor Field	– items 5, 6 and 8 (minutes 10, 11 and 13)
Councillor Scott	– items 5 and 6 (minutes 10 and 11)
Councillor Stephen Shing	– item 6 (minute 11)
Councillor Shuttleworth	– items 5, 7 and 8 (minutes 10, 12 and 13)
Councillor Taylor	– item 8 (minute 13)
Councillor Tutt	– items 5 and 6 (minutes 10 and 11)
Councillor Ungar	– items 5 and 6 (minutes 10 and 11)
Councillor Whetstone	– items 5, 6 and 8 (minutes 10, 11 and 13)

8 MINUTES OF THE MEETING HELD ON 6 JUNE 2017

8.1 The minutes of the Cabinet meeting held on 6 June 2017 were agreed as a correct record.

9 REPORTS

9.1 Copies of the reports referred to below are included in the minute book.

10 COUNCIL MONITORING QUARTER 4 2016/17

10.1 The Cabinet considered a report by the Chief Executive

10.2 It was RESOLVED – to note the end of year outturns for the Council Plan and Finance and to approve the proposed use of the General Fund surplus as set out in paragraph 2.8 of the report

Reason

10.3 The report set out the Council's position and year end provisional outturns for the Council Plan targets, Revenue Budget, Capital Programme, Savings Plan together with risks at the end of March 2017.

11 RECONCILING POLICY, PERFORMANCE AND RESOURCES - STATE OF THE COUNTY

11.1 The Cabinet considered a report by the Chief Executive

11.2 It was RESOLVED to:

1) note the evidence base on demographics and the policy and resources outlook (Appendix 2);

2) review the priority outcomes which form the basis of the Council's business and financial planning and recommend that County Council agree the change suggested in paragraph 2;

3) note the anticipated financial context for the period 2018/19 - 2020/21 set out in Appendix 3;

4) agree to the continued development of a three-year business and financial plan based on proposed priority outcomes and operating principles;

5) approve the amended Medium Term Financial Plan and note that the 2017/18 Budget has been amended to take account of the additional Adult Social Care Grant announced in March 2017, as set out in paragraph 3.7 and Appendix 3, paragraphs 4.1 to 4.5;

6) agree to continue to develop plans for savings of £21.9m in 2018/19 on the basis set out in Appendix 4 and to bring back high-level proposals for savings allocations in 2019/20 and 2020/21 to Cabinet in October 2017;

7) approve the updates to the current Capital Programme 2017-2023 as set out in Appendix 3 and paragraphs 12.24 to 12.39; and

8) approve the updated Reserves Policy as set out at the end of Appendix 3

Reason

11.3 The report begins the Council's Reconciling Policy, Performance and Resources process for 2018/19 and beyond

12 RODMELL CE PRIMARY SCHOOL

12.1 The Cabinet considered a report by the Director of Children's Services

12.2 It was RESOLVED – to approve the publication of statutory notices in relation to a proposal to close Rodmell CE Primary School by 31 August 2018

Reason

12.3 The governing body has been unable to find an alternative partnership model to deliver a sustainable future for its children. As a result, the governing body has agreed that the school should move to closure by 31 August 2018. Pupil numbers at the school continue to decline, with only 18 children on roll at the beginning of Term 6. No children have been allocated a Reception year place at the school for September 2017. The local authority's view is unchanged from last year in that it remains very concerned about the long term sustainability of the school in terms of its financial stability, securing good outcomes for pupils and the absence of demand for places from within its community area. The local authority supports the governing body's decision to move to closure. This view is shared by the diocese.

13 COUNTRYSIDE ACCESS STRATEGIC COMMISSIONING STRATEGY

13.1 The Cabinet considered a report by the Director of Communities, Economy and Environment

13.2 It was RESOLVED to:

(1) note the results of the public consultation in relation to the draft strategy;

(2) agree the continuation of discussions with external groups in relation to future ownership/management of countryside sites; and

(3) approve the strategy and to delegate the implementation stage of the strategy to the Lead Member for Transport and Environment.

Reason

13.3 The majority of the consultation feedback is positive, and the Cabinet has therefore approved the strategy. The Cabinet also agreed to delegate the strategy's implementation stage (e.g. potential arrangements for the handover of sites) to the Lead Member for Transport and Environment.

14 ITEMS TO BE REPORTED TO THE COUNTY COUNCIL

14.1 The Cabinet agreed that items 5 and 6 should be reported to the County Council.
[Note: The items being reported to the County Council refer to minute numbers 10 and 11]

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Report to:	**Cabinet**
Date of meeting:	**18 July 2017**
By:	**Director of Adult Social Care and Health**
Title:	**East Sussex Better Together (ESBT) Alliance Accountable Care Model: Future Organisational Arrangements**
Purpose:	**To consider the preferred future legal vehicle for the East Sussex Better Together (ESBT) Accountable Care Model, and the map for phased implementation**

RECOMMENDATIONS

Cabinet is recommended to agree:

1. **A new health and care organisation (Option 4) as the preferred option for the ESBT Accountable Care Model and agree the proposed map for implementation by 2020 (Appendix 5), noting that the key next steps and phasing for implementation will take place over the summer.**
2. **Strengthening the current ESBT Commissioner Provider Alliance arrangement by April 2018 by implementing the following elements:**
   - **A single point of leadership for strategic commissioning;**
   - **A single pooled budget for our ESBT health and care economy with Eastbourne Hailsham Seaford and Hastings and Rother Clinical Commissioning Groups (CCGs);**
   - **A fully integrated governance structure to support a single pooled health and social care commissioning budget;**
   - **A single point of leadership for delivery and how services are organised, and;**
   - **Reinforcing performance and monitoring against an integrated Outcomes Framework**

1. Background

1.1 East Sussex Better Together (ESBT) is our whole system (£1billion) health and care transformation programme, which was formally launched in August 2014, to fully integrate health and social care across the ESBT footprint in order to deliver high quality and sustainable services to the local population. Our partners in ESBT are Eastbourne, Hailsham and Seaford (EHS) CCG, Hastings and Rother (HR) CCG and East Sussex County Council (ESCC), East Sussex Healthcare NHS Trust (ESHT) and Sussex Partnership NHS Foundation Trust (SPFT). The programme covers a population base of approximately 370,000. We have a combined resource of approximately £1.042billion, the majority of which is used to commission primary, community, acute, mental health and social care services from ESHT, SPFT, GP Practices and providers in the independent care sector and voluntary sector.

1.2 Our shared vision is that by 2020, there will be a fully integrated health and social care economy in East Sussex that ensures people receive proactive, joined up care, supporting them to live as independently as possible and achieving the best outcomes. This includes strengthening community resilience through an asset-based approach that enables local people to take ownership of their own health and well-being through proactive partnerships. Ultimately by

working together we aim to achieve high quality and affordable care now and for future generations and improve the safety and quality of all the services we commission and deliver.

1.3 The first 150-week phase of the programme has focussed on redesigning and transforming services to improve health and social care outcomes. As a consequence we have established a range of integrated services including Health and Social Care Connect, Joint Community Re-ablement and Locality Teams that have improved client and patient experience and supported more people. We have also established excellent whole system partnerships, scoping the issues and solutions, and agreeing the necessary framework for the delivery of whole system care pathways. We have made significant progress in all these aspects, and much of our initial transformation work is now core business. As reports to Cabinet have however previously highlighted, it is clear that this is not enough in itself to ensure the required transformation and secure a sustainable health and care system and quality services for the population we serve. We have now arrived at a point where we need to decide what the future structure needs to look like to embed all the changes we have already made.

1.3 As our initial 150 week transformation programme draws to a close our next phase is to ensure we fully exploit the opportunities of accountable care, and as we transition to the new ESBT Alliance arrangement we are ensuring a keen focus on delivering in-year improvements as a system and developing the governance to identify the best legal vehicle for the delivery of ESBT into the future. We are now focusing on building a new model of care, accountable care, that integrates our whole system: primary prevention; primary and community care; social care; mental health; acute and specialist care, so that we can demonstrably make the best use of the £860m collective resource we spend every year to meet the health and care needs of the people of East Sussex.

1.4 In line with this, in November 2016, Cabinet approved work to develop a local fully integrated Accountable Care Model (ACM) across the ESBT footprint, involving a transitional year in 2017/18, and to establish a commissioner-provider alliance as the most effective way to develop the evidence base further in East Sussex. Cabinet delegated authority to the Chief Executive, in consultation with the Leader, to finalise the Alliance Agreement and other arrangements for the 2017/18 year. The Agreement and other arrangements have now been finalised and agreed by each the of ESBT Alliance constituent organisations and were collectively agreed by the ESBT Alliance Governing Board on 27th June.

1.5 This report focusses on the outcomes of the options appraisal exercise undertaken in June 2017 to identify the most appropriate future delivery vehicle for our ESBT model of care, and the future strategic commissioning role of the Council that is required to deliver it, in order that recommendations can be made to Cabinet in July 2017.

2 Progress in 2017/18

2.1 The Alliance Agreement and underpinning governance structure provide the framework to enable us to rapidly develop our capacity to manage the health and social care system collectively as an Alliance partnership, operating as an accountable care system, in order to test ways of working, configure resources more flexibly, and improve services for the population in 2017/18 and in the longer-term. To date we have developed the following elements of our shadow accountable care system:

- A formal ESBT Alliance Agreement to provide the framework to operate as an ESBT Alliance
- An integrated governance structure, and a framework for the Alliance arrangement itself, detailing which organisations in the health and care system are involved and in what capacity
- A Strategic Commissioning Board (SCB) with EHS CCG and HR CCG to jointly undertake responsibilities for population needs assessment and commissioning health and social

care through oversight of the Strategic Investment Plan (SIP), as well as overseeing and assuring the delivery of health and social care services in the 2017/18 test bed year

- A pilot integrated Outcomes Framework has been developed to support the role of the Board (SCB) in the 2017/18 test-bed year.
- An integrated Strategic Investment Plan (SIP) was agreed for 2017/18 by the Leader and Lead Cabinet Member for Strategic Management and Economic Development, enabling the Council and EHS and H&R CCGs to align health and social care investment, as part of a medium-term financial plan, to deliver the transformation in how care is provided across the ESBT footprint and establish a clinically and financially sustainable system.
- An integrated financial reporting system to enable the planning and control of ESBT resources through regular monitoring of expenditure against the plan, with corrective action to be taken in year, if required, by the Strategic Commissioning Board.
- Arrangements for patient and citizen integration into the governance framework

2.2 The recent learning from the Kings Fund[1] based on the UK NHS Five Year Forward View Vanguards and international examples of best practice[2] indicates that forming a commissioner-provider alliance for the transitional phase puts us in a strong position to make significant progress within the current regulatory framework. We are now moving into a phase of undertaking the necessary learning and development, with support from NHS Improvement (NHSI), NHS England (NHSE) and the Care Quality Commission (CQC) as the system regulators, to design our future ESBT Alliance ACM, which in the longer-term would be structured around a single organisation, alliance or partnership holding the capitated budget to make sure we have integrated delivery of high quality services for our population.

3 Options appraisal of the future ESBT legal delivery vehicle

3.1 The vehicle for our future model must provide the right platform to enable us to improve the quality of services, improve health outcomes and reduce inequalities across the ESBT footprint offering integrated, person-centred care in a clinically and financially sustainable way. In particular the future organisational form must enable us to deliver the following benefits:

- a reduction in variation and improved outcomes for local people;
- improved population health and wellbeing;
- improved experience of health and care services;
- achievement of our ESBT objective of system balance by 2020/21 and;
- improved connections with other elements of service delivery where working on a larger population basis within the Sussex and East Surrey Sustainable Transformation Partnership.

3.2 In order to design our future ESBT Alliance ACM, we have developed and carried out an appraisal of the options for the delivery vehicle of our future model with our ESBT partners. As signalled in discussions with our stakeholders, the latest learning from the Kings Fund and NHS Vanguards[3] indicates that there are a small number of clear options to explore to help us deliver the future ESBT new model of accountable care:

- **Prime Provider or Prime Contractor (Option 1)** - where one provider holds the contract and acts as an integrator of the services through a subcontracting model.
- **Corporate Joint Venture or Special Purpose Vehicle (Option 2)** – where parties agree to form a limited company or limited liability partnership e.g. a forming a new corporate joint venture or special purpose vehicle to deliver a single contract for the whole population, or parts of it.

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

- **Alliancing: Commissioners and Providers (Option 3)** – a virtual arrangement where parties agree to work together in an Alliance without forming separate legal entity or physically changing existing organisational structures.
- **Forms of organisational merger or new organisation (Option 4)** – for example this could mean building on the NHS Trust legal framework to establish a new East Sussex Health and Care NHS Trust,that would take a lead role across the system, providing the majority of services in the ESBT area.

3.3 It should be emphasised that there is no definitive evidence base for the options over and above what we have learned and recorded from international best practice and the emerging vanguards in the UK in making our case for change. Our learning must be iterative and any recommendation is at a relatively high level, demonstrating our direction of travel to best meet our ambition and needs. There will be an implementation period where much greater detail will emerge and a comprehensive engagement plan for this phase will be implemented. There will also be clear milestones from April 2018 onwards, of what we need to achieve and by when in order to ensure the necessary momentum for success.

3.4 To reflect this, the ESBT Accountable Care Development Group (ACDG), which brings together key stakeholders such as the Local Medical Committee (LMC) and Healthwatch with leads from each partner in the ESBT Alliance, has taken steps to ensure we have a robust process that builds consensus locally. This comprised developing and agreeing evaluation criteria and an options appraisal exercise to test appetite locally for the four options.

3.5 The focus of this exercise is about the way the ESBT partner organisations arrange themselves in the future to deliver our aims and objectives in the most effective way i.e. it is a potential change to the way we structure our organisations in order to deliver better services, rather than a change to services themselves. We have widely discussed ESBT service improvements with local populations and will continue to involve local people and others in improvements to specific care pathways and services.

4 Options appraisal panel

4.1 The sovereign governing bodies of the constituent ESBT Alliance organisations are ultimately responsible for making decisions about the delivery vehicle for the future ESBT model, and these organisations were represented on the options appraisal panel by senior clinicians and managers. In order to make fully informed decisions about scoring the options appraisal, a panel process was undertaken and supported by three categories of representative:

- Clinical and managerial leaders from each of the constituent ESBT Alliance organisations who were responsible for making decisions about scoring the options against the criteria, after discussion about each option as a whole panel
- Representatives from other organisations that are integral to understanding how the system operates, and that have a key stake in determining the preferred vehicle to deliver the ESBT objectives, for example the LMC, GP Federations, NHS England and Healthwatch. These representatives were invited to contribute views and help agree the scoring but didn't undertake the final scoring.
- Subject matter experts, i.e. members of the Accountable Care Development Group, Workforce Group and IT Board plus others such as Principle Social Workers and Chief Nurses, who were invited to advise the panel representatives on the advantages and disadvantages of specific options but not undertaking scoring.

4.2 We also had early engagement with the NHS national new models of care assurance process, and NHS England also attended the session; we will continue to engage with this as appropriate.

5. Options appraisal exercise and evaluation criteria

5.1 The options appraisal exercise, which took place on 22 June, had the following aims:

- Arrive at a consensus view across our ESBT Alliance about the preferred direction of travel for our Alliance in the future;
- Understand and agree the key steps and the timetable involved to get there, and;
- Agree our priority actions for implementation from April 2018.

5.2 The exercise was facilitated by an independent expert chair.

5.3 A set of evaluation criteria were developed for the options appraisal together with a suggested process, which was tested with key stakeholders and discussed at the local Shaping Health and Care events in May, including views about weightings. The criteria are standard measures which were chosen because they were already well known and understood. They have previously been developed with input from stakeholders in relation to previous local options appraisal exercises to assess different delivery options for health and care services and have since been further tested. The criteria with the percentage weightings as are as follows:

- Quality and safety – 15
- Clinical and professional sustainability - 20
- Access and choice - 15
- Deliverability - 10
- Financial sustainability 10

5.4 To reflect the nature and ambition of this whole system options appraisal, two additional criteria were created to reflect the need to make judgements about the right organisational form to provide the framework for a transformed health and care system:

- Transformation (for sustainable services) – 20
- Governance and accountability - 10

5.5 The weighting of the criteria was tested in discussions with stakeholders where Access and Choice was felt to be of high importance followed equally by Transformation, Financial Sustainability and Quality and Safety. The approach taken to weightings reflects the nature of the options appraisal exercise which is aimed at ensuring sustainability for all health and care services in the ESBT area through identifying the best delivery vehicle for achieving this and our objective of building consensus about our preferred direction of travel for ESBT overall, outlining the key steps to get there and making best use of the flexibilities that are expected to become increasingly available at a national level. All options would be expected to demonstrate ability to deliver high quality safe services that are accessible and support choice, however, the final preferred option would also be expected to demonstrate to a high level the ability to effect the system transformation needed to deliver workforce and financial sustainability within an appropriate timescale.

5.6 A series of joint ESBT staff engagement events were also held during May and June to share information about the options appraisal exercise and organisational forms, grow understanding and test the options to inform how the preferred option was reached. The key criteria and the list of indicators of what good looks like in relation to each of the criteria is attached at Appendix 1.

5.7 In addition to the options appraisal criteria the ACDG produced an information pack for the panellists bringing together some general characteristics and issues about the four options; where they are similar; and how they differ. This was not intended to be a comprehensive assessment, but a consideration of the kinds of issues and risks that might be anticipated with each option, based on our current understanding. The Information pack is contained in Appendix 2, and it contains the following detail:

- High level detail about each of the four options, how they might work, general characteristics and potential risks
- A high level Brief Review of HR and workforce implications for each option
- A high level Brief Review of Digital and IT implications for the options
- Key Public Health assessment criteria and technical requirements

5.8 In addition, the following supplementary information was produced to further grow understanding

- Diagrams illustrating the potential governance and decision-making for each of the four options; these are not presented as the definitive article but are intended to be illustrative guides based on our current understanding (attached at Appendix 3)
- Case study examples from other areas in the UK; to give an understanding of how the different options are being implemented (Appendix 4)

5.9 An initial Equalities Impact Assessment (EIA) screen of the four options was also undertaken. In summary this initial screening did not identify any immediate negative impacts on protected characteristic groups but concluded that a full equalities impact assessment would be required as part of the next stage of the process, taking in relevant data, engagement of protected characteristic groups. It also suggested there should be two separate processes to consider implications for both the workforce and the local population. The EIA is available on request.

6. Outcomes of the options appraisal exercise

6.1 After all the panellists, contributors and subject matter experts had discussed each option the representatives from the ESBT Alliance member organisations scored each option against the seven weighted criteria, using the guidance set out below:

Score	Scoring Guidance
1	Option fails to meet objectives
2	Option performs ok against objectives but doesn't represent an improvement on the current system
3	Option performs reasonably well against objectives and represents a modest improvement on the current system
4	Option performs significantly well against objectives and represents a significant improvement on the current system

6.2 The overall outcome of the scoring exercise was as follows:

Criteria (weighting in brackets)	Option 1 Prime provider/prime contractor 'integrator'	Option 2 Corporate Joint Venture	Option 3 Alliancing Commissioners and Providers	Option 4 Forms of merger or new organisation
Transformation (for sustainable services) (20)	1.33	1.67	2.33	3.00
Governance and Accountability (10)	1.58	1.75	2.67	3.17
Quality and safety (15)	1.67	1.83	2.75	3.00
Clinical and professional sustainability (20)	1.58	1.75	2.42	2.92
Access and choice (15)	1.67	1.75	2.42	3.08
Deliverability (10)	1.42	1.00	2.58	2.08
Financial Sustainability (10)	1.58	1.17	1.92	2.83
Average weighted score	**1.54**	**1.61**	**2.44**	**2.90**

6.3 Overall option 4, a new health and care organisation scored the highest on average as it was felt to deliver the best opportunity for long term sustainability overall and significant improvements compared to the way we are currently organised. This was followed by option 3, a more formal commissioner provider alliance arrangement. Options 1 and 2 were the least preferred options, some way behind. The following points were also noted:

- Options 4 and 3 scored the highest overall and tended to score the highest for each category as well.
- Option 4 finished top and option 3 finished second for six of the seven categories, with one notable exception being deliverability, where option 4 finished second to option 3, acknowledging the complexity of implementing a new health and care organisation when compared with a virtual Alliance arrangement.

- There was far less appetite across the panel to implement options 1 and 2, as it was not felt that they would add any value to our current system and these have therefore been discounted.

6.4 A map was discussed, accepting that option 4 has a longer lead in and the aim should be to have this in place by April 2020. Acknowledging that a start on option 3 has already been made with our ESBT Alliance, it was suggested that strengthening our current Alliance arrangement by April 2018 would be a necessary stepping stone. As a result the following practical steps are proposed to accelerate implementation in the context of year on year delivery of improvements:

- Single point of leadership for strategic commissioning;
- A single pooled budget for our ESBT health and care economy with EHS and HR CCGs;
- A fully integrated governance structure to support a single pooled budget of c£850m;
- Single point of leadership for delivery and how services are organised;
- Strengthened performance and monitoring against an integrated Outcomes Framework, and;
- An integrated approach to regulation.

6.5 The level of organisational change needed to incrementally move to option 4, building on what we have already set in train through our current commissioner provider alliance, is set out in the map in Appendix 5. Further detail is being developed to support the map and the phasing of delivery, and comprehensive plans will be established to ensure robust implementation of our preferred direction of travel. Further reports to Cabinet will make recommendations regarding the implementation of specific elements of the map, given the significant potential implications of the proposed changes, both for 2018 and longer-term, for the discharge of the Council's statutory and financial responsibilities.

7 Conclusion and reasons for recommendations

7.1 This report focuses primarily on the ESBT health and social care system. The potential scale of the proposed changes will have a significant impact on ESCC as well as the other partners. The work will continue to be developed with clear consideration of both aspects.

7.2 Strong progress has been made during the first 150-week phase to redesign care pathways and services, and much of our initial transformation work is now core business. As reports to Cabinet have previously highlighted however, it is clear that this is not enough in itself to ensure the required transformation and secure a sustainable health and care system and quality services for the population we serve. We have now arrived at a point where we need to decide what the embedded structure for our ESBT model needs to look like in the future, to deliver our objective of a fully integrated and sustainable health and social care system for our local population in the long term

7.3 Cabinet has previously agreed that moving to a fully integrated model of accountable care offers the best opportunity to achieve the full benefits of an integrated health and social care system, and that a transition year of accountable care under an alliance arrangement would allow for the collaborative learning and evaluation to take place between the ESBT programme partners and other stakeholders.

7.4 Discussion and engagement with our stakeholders about the evaluation criteria and the proposed weightings has helped to shape the options appraisal exercise. Undertaking an appraisal of the available options collectively as an ESBT Alliance with the involvement of key stakeholders has contributed to and strengthened our decision-making process. This has helped us to develop consensus locally to identify that overall a new health and care organisation (Option 4) is the preferred legal vehicle to deliver our ESBT objectives, in keeping with the expectations of our local stakeholders.

7.5 Taking practical action during 2017/18 to strengthen our current ESBT commissioner provider alliance arrangement, to incrementally change the way we are organised, will ensure that benefits can be realised both in year, as well as helping us to achieve the longer term objective of implementing a new health and care organisation by 2020. Such action, given the significant potential implications of the proposed changes, for the discharge of the Council's statutory and financial responsibilities will be fully considered in further reports to Cabinet. A map setting this out is included in Appendix 5.

KEITH HINKLEY
Director of Adult Social Care and Health

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LOCAL MEMBERS

County Council Members whose electoral divisions are in the Eastbourne, Hailsham and Seaford Clinical Commissioning Group and Hastings and Rother Clinical Commissioning Group areas

BACKGROUND DOCUMENTS

None

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ESBT Future Model Options Appraisal: Scoring Sheet

Option X

Appendix 1

Name:
Organisation:

Score	Scoring Guidance
1	Option fails to meet objectives
2	Option performs ok against objectives but doesn't represent an improvement on the current system
3	Option performs reasonably well against objectives and represents a modest improvement on the current system
4	Option performs significantly well against objectives and represents a significant improvement on the current system

	Appraisal Criteria	**Option X**
Principles and characteristics	**1. Transformation (for sustainable services)** **Key indicators of what good looks like in this category:**	**Weighting 20**
1, 2 ,7, 8, 9 3, 5, 6 2, 7, 8 4, 7, 8 3, 7, 8, 9 1, 2, 7 6, 9 1, 5, 9 1, 5, 9 1,2, 5, 9 1,2, 3, 4, 6, 7, 9 1, 3	• System sustainability with particular reference to primary care; • Scope and scale of services significantly reduce intra-system transactional costs; • Delivery partners outside core service provision work together for the benefit of our local population, including approaches to market development in localities; • Integrated IT system for staff, patients and clients; • 'System-wide' leadership and management culture; • Vertically integrated care system; • Good acute networks across the wider STP delivery platform; • Increase of investment in prevention, primary and community care (including self-care and self-management), to be consistent with the ESBT Alliance Strategic Investment Plan; • Investment in prevention and early intervention reduces average per capita Year of Care cost; • Year on year delivery of the ESBT Alliance Strategic Investment Plan; • Improvements in key deliverables set out in the next steps of the updated NHS Five Year Forward View; • Focus on primary, secondary and tertiary prevention, self- care and self- management, to improve health and wellbeing and reduce health inequalities.	**Score**
Principles and characteristics	**2. Governance and Accountability –** **Key indicators of what good looks like in this category:**	**Weighting 10**
4 5, 6, 8, 9 9 9 7, 8 4, 7, 8, 9 6, 9	• Optimum levels of citizen leadership and governance; • Phased and assured transfer of risk; • CCG and Local Authority statutory functions are discharged; • Collective decision-making and governance structure that aligns with ongoing and continuing individual statutory accountabilities of the constituent bodies; • Optimum levels of clinical and professional governance; • A trusted health and care brand that inspires patient and client confidence; • Delivery within the current regulatory frame work.	**Score**
Principles and characteristics	**3. Quality and Safety –** **Key indicators of what good looks like in this category:**	**Weighting 15**
1, 2, 4, 7 1 6, 8, 9 4, 6, 7, 8 4, 7, 8 3, 4, 7, 8 1, 3, 4	• Uniformly high standards in the management of frailty and LTCs (for example Diabetes, Heart Disease) by integrated primary care, specialist, and community teams; • Provision of care increasingly out of hospital and at lowest level of safe and effective care; • Delivery of constitutional operational standards (A&E, RTT etc.); • Reduction in variation across all services; • Promotion of a safety culture; • Provision of continuity of primary care practitioner, where this exists; • Use of population health management capabilities (i.e. improved prevention, enhanced patient and client activation) to manage avoidable demand.	**Score**
Principles and characteristics	**4. Clinical and Professional Sustainability –** **Key indicators of what good looks like in this category:**	**Weighting 20**
7, 8 1, 7, 8, 9 7, 8	• Provision of the right conditions for innovation, now and into the future; • Delivery of clinically effective care services at lowest level of effective care, and clinical and care excellence; • Workforce flexibility, and recruitment, retention and development of excellent staff across all sectors.	**Score**
Principles and characteristics	**5. Access and Choice –** **Key indicators of what good looks like in this category:**	**Weighting 15**
3, 4 1, 3, 4 1, 3, 4 1, 3, 4, 8 1, 2, 3, 4, 7 3, 4	• Provision of choice and personalised programmes of care for children and adults with LTCs, disabilities and long term care and support needs; • Access to timely care that includes all sections of the community; • Evening and weekend access to GPs (target: 100% of the population covered by March 2019); • Access to community based services to enable people to remain in their own homes; • Patient choice for people with elective (planned) care needs, and increase the use of Personal Budgets and Direct Payments, and Personal Health Budgets (PHBs) where these are coming on line.	**Score**
Principles and characteristics	**6. Deliverability –** **Key indicators of what good looks like in this category:**	**Weighting 10**
5, 6, 9 5, 9 5, 6, 9 5, 6, 9 2, 6, 7, 8, 9 6, 9 1, 5, 9	• Cost to implement this option (system costs including capital costs) is reasonable and viable; • Option can be delivered within a reasonable timescale and no later than 2020/21; • Transition costs are understood and of reasonable value; • Tax, VAT, insurance, procurement of care packages and charging implications are understood and affordable, and are in line with statutory frameworks; • Impacts on health and social care workforce are understood and manageable (Ts&Cs and pensions); • No additional legal risks that will have a significant impact; • No impact on the viability of commissioners and providers outside of the ESBT system.	**Score**
Principles and characteristics	**7. Financial Sustainability –** **Key indicators of what good looks like in this category:**	**Weighting 10**
5, 9 1, 3, 5, 9 3, 5, 6, 9 9 3, 4, 6, 7, 8, 9 2, 7, 8 4, 7, 8, 9	• Efficient working of the system reduces operating costs (including transactional commissioning costs); • Services are transformed to assist with the achievement of financial sustainability; • Financial risk is effectively managed; • Flexibility to respond to changes in future health and care financial regimes; • Organisation/vehicle operates as a going concern, able to meet the financial requirements of regulators and statutory bodies such as HMRC; • Improved provider productivity and reduction in variation • Incentivisation of outcomes and performance improvement	**Score**

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Appendix 2

ESBT future legal vehicle options appraisal information pack

Introduction

This pack has been produced to support a facilitated and open discussion on Thursday 22nd June, with the following aims:

- arriving at a consensus view across our ESBT Alliance about the preferred direction of travel for our Alliance in the future, and;
- growing our understanding of the key steps and the timetable involved for getting there.

The current learning from the UK Vanguards and the Kings Fund[1] indicates that there are a number of clear options to explore for new models of accountable care to help us deliver the future ESBT model:

- Prime provider/prime contractor 'integrator'
- Corporate joint venture (provider collaboration)
- Alliancing: commissioners and providers
- Forms of merger or new organisation

It should be emphasised that there is no definitive evidence base for the options over and above what we have learned and recorded from international best practice and the emerging vanguards in the UK in making our case for change. Our learning must be iterative and the recommendation following this options appraisal will be at a relatively high level, demonstrating our direction of travel to best meet our ambition and needs. There will then be an implementation period where much greater detail will emerge and a comprehensive engagement plan for this phase will be implemented. This information pack provides summarised information about the four options. Whilst not a comprehensive assessment, consideration has been given to the kinds of issues and risks that might be anticipated with each option, based on current understanding.

This information should be read in conjunction with 'The Future ESBT Model Options Appraisal Exercise' paper, which has been previously agreed by the ESBT Alliance as our approach to considering the legal vehicle options, and sets out our key criteria for assessing them along with indicators of what good looks like.

[1] New Care models: Emerging innovations in governance and organisation form (Kings Fund, October 2016)

1 High level detail, how it might work, general characteristics and risks for each option

Option 1: Prime provider/prime contractor 'integrator'

This is a commercial arrangement where a lead provider is identified that will hold the single contract with the CCGs and ESCC as integrated commissioners, and the lead provider would sub contract the services to the individual service providers within a system of accountable care.

How it might work

- There is one provider/integrator who acts as the host, holding the PACS-plus contract on behalf of other providers. The host contract holder can act solely as an 'integrator' who sub contracts with other providers to ensure delivery and performance, or they can also provide some of the services/activity themselves
- The host contractor would need to put in place arrangements to support collaborative delivery. For example this could be through forming a Provider Alliance arrangement with other providers where decision making by the providers is delegated from each provider to their member(s) who sit on a partnership Board which binds their organisations together
- Risk and reward are shared through agreed contractual arrangements, the alliance arrangement would need to be sufficiently strong to effectively pass risk and reward between the alliance partners
- The Provider Alliance would put in place a Board which could have its own has its own Executive Team to cover off the key roles and portfolios e.g. Chief Executive Officer, Medical Director etc. etc.

General Characteristics	Potential Risks
• Organisations remain separate and retain sovereignty for governance and decision-making, subject to the terms of the Alliance Agreement • High reliance on the contract to govern the relationship • Bonuses or penalties for individual organisational performance • Little sharing of assets • Time limited for a contractually specified period contract management • Clear contractual allocation of risks and responsibilities • Ease of contracting for commissioners as they are negotiating with a single provider • Easy to setup operating structure • Able to use NHS Standard Contract with minimal tailoring • Role of commissioners limited to governance of main contract • Performance management and monitoring of the sub-contracted providers is the responsibility of the prime contractor • Ability to design and deliver transformation/transition of the services is managed by a single provider • Fast decision making • Competitive tendering and procurement may be necessary	• There is limited incentive for closer collaboration or integrated care at the sub-contractor level • Primarily a risk transfer mechanism rather than risk sharing, though the Alliance Agreement could mitigate this. • Potentially too high risk to offer a fully or majority integrated contract and services via this type of contract – better suited to sub sections of services and pathways that are delivered by multiple providers. • Whichever organisation assumes 'lead contractor' role has a disproportionate amount of power and risk versus the other providers • Typically more suited to mature markets and well understood demand/services • As the prime contractor has to manage all transferred risks, this requires a provider who has experience in this role • Lack of check and challenge on prime contractor decisions • Difficult to align objectives of the prime contractor with other stakeholders in the health economy not in-scope • Competitive tendering may have a negative impact on collaborative working relationships between providers • Potential confusion of role if strategic commissioners also retain some assessment or provider functions • Different terms and conditions remain for majority of staff creating potential inequalities for staff doing similar/comparable role but with different employer. Could lead to employment relations issues, poor morale, poor motivation and retention

Option 2: Corporate joint venture (provider collaboration)

This would consist of key organisations such ESCC, ESHT, CCGs and potentially others forming a special purpose vehicle or other corporate joint venture (i.e. a new company) to hold a single contract for the whole population, or parts of it.

- ESCC, ESHT and possibly the CCGs and SPFT could partner in a corporate joint venture/special purpose vehicle (SPV) which holds the PACS-plus contract
- The company is established as a company limited by shares. This could take a number of forms, for example a Community Interest Company
- Control of the SPV or Community Interest Company is divided between the owning partners
- The partners in the Joint Venture would provide cash flow for the Joint Venture
- Smaller partners such as GP Federations could put in low amounts of cash flow or a nominal amount with potential consequences for their level of reward and/or control of the entity
- GPs could agree to a way of collectively representing themselves as service providers within the SPV / Community Interest Company
- Regulators would need to confirm that they are content with the approach through ISAP and/or a transaction review

General Characteristics	Potential Risks
• Keep existing separate organisational governance and add in a shared governance arrangement for the new company • Shared decision-making with agreed voting rights • A separate organisation pooling resources to deliver shared objectives • Partners each have a direct stake in the new company and shared rewards or costs • Sharing of some assets within the joint venture • Can hold contractual arrangements in its own right • Promotes a robust risk share arrangement and aligns objectives. • SPV agreement will clearly state nature, responsibilities and terms and conditions of the relationship between the parties • Ability to share the risks and rewards with partners-Incentivises closer collaboration and innovation • Access the expertise of other independent or public sector partners • Combined group of providers to create sufficient capacity to address opportunity • Single SPV entity provides clear accountability to commissioners • Legal contracting SPV structure should be sufficiently commercially defined for private sector investors to fund transformation of services	• The current statutory framework does not give NHS Trusts the power to set up or participate in corporate bodies (only Foundation Trusts are able to do this) • Substantial time and resources required in developing and agreeing the SPV agreement • Slower decision-making until all negotiations are completed • Potentially difficult to align the group of providers who have their own management style, culture and background • VAT/Tax implications • Trust between providers required to co-operate effectively • Potential confusion of role if strategic commissioners also retain some assessment or provider functions • Different terms and conditions remain for majority of staff creating potential inequalities for staff doing similar/comparable role but with different employer. Could lead to employment relations issues, poor morale, poor motivation and retention

Option 3: Alliancing commissioners and providers

A form of contractual joint venture, whereby the partners remain separate legal entities but objectives, incentives, sharing of risks, collective accountability and contracting for outcomes are aligned across multiple providers, which could include the CCGs, ESHT, ESCC and others such as SPFT, and allowing primary care to participate as providers as appropriate at scale.

How it might work

- The providers remain separate legal entities, continue to directly employ their own staff but are bound together by an alliance agreement. In this option, a PACS-plus contract is not let instead the alliance would overlay existing contracts
- A process would be used to identify providers interested in participating in the Alliance, allowing primary care to interact as desired at scale through Federations or other arrangements
- The commissioners and providers come together in a contractual alliance to deliver PACS-plus services under their existing contracts with the commissioners
- Decision making by the commissioners and providers is delegated from each organisation to their member(s) who sit on an Alliance Governing Board on behalf of their organisation
- An overarching robust alliance arrangement which manages risk and reward sharing is put in place
- Services are delivered by the individual members under their existing contracts
- The commissioners (EHS and HR CCGs and ESCC) act as system integrators through holding the budgets and working collaboratively
- The Alliance would likely put in place a governance structure which could have its own has its own Executive Team to cover off the key roles and portfolios e.g. Chief Executive Officer, Medical Director etc.

General Characteristics	Risks
• Shared governance arrangements are overlaid onto separate sovereign organisational governance arrangements • Shared decision-making with agreed voting rights • Willingness to work flexibly to meet shared objectives • Shared rewards or costs of working together • Limited sharing of assets • The arrangement is virtual and there is no ability for the Alliance to enter into hold contracts in its own right • Contracting continues to be undertaken separately by the partner organisations • Time limited • Commissioners and providers share risk • Both incentives and risk sharing is driven by collective for meeting outcomes • Existing bilateral contracts can be retained (less disruption) • System solutions can be co-designed • Offers ability to quickly adapt to changing population/demand without need to enter formal contract variations • Ability to align objectives of Alliance with other stakeholders in the health economy not in-scope. • All parties share the Alliance agreement with common objectives and outputs -win or lose together	• Effort and resource is needed to initially develop the alliance contract. • Would be dependent on existing culture and trust -mutual trust and spirit of openness are pre-requisites for success. • Complex governance arrangements • Potential for reduced clarity on delivery responsibilities. • Commissioners retain risk or that Commissioners will exert too much influence on the Alliance and prevent the required transformation. • Tension between Commissioner/Provider wishes and 'best for Service' decision-making. • Potential confusion of role if strategic commissioners also retain some assessment or provider functions • Different terms and conditions remain for majority of staff creating potential inequalities for staff doing similar/comparable role but with different employer. Could lead to employment relations issues, poor morale, poor motivation and retention

Option 4: Forms of merger or new organisation

For example this could mean using the NHS Trust legal framework to form a new local NHS Health and Care Trust and create a new single health and care organisation responsible for providing the majority of services for the ESBT area. The new organisation would hold the single contract as well as sub contract with other providers to deliver the outcomes.

How it might work

- A new Health and Care NHS Trust for East Sussex is created jointly by ESCC and ESHT, and possibly the CCGs and ESHT as well. The new entity will hold the 'PACS-plus' contract as well as all other contracts for local legacy health and care services thereby creating a single 'Accountable Health and Care Trust or Organisation' for East Sussex
- ESHT and ESCC would use their powers under section 77 of the 2006 Health Act to create a Care Trust. Care Trusts have been established to bring together in one legal entity the commissioning and provision of health and social care services. Care Trusts are set up when the NHS and Local Authorities agree to work closely together, usually where it is felt that a closer relationship between health and social care is needed or would benefit local care services
- New governance and leadership arrangements are put in place which satisfy all partners and regulatory bodies
- The organisation could be built from the registered GP list to be routed in localities , with GP leadership at Governor, Board, Executive, Managerial, Hospital and Neighbourhood (Locality) level
-

General Characteristics	Risks
• Single governance and decision-making • Single management structure • Full pooling of assets which can be redeployed as needed • Full pooling of the risks and rewards of different activities within the organisation • Long-term arrangement • Full flexibility and leadership over totality of resources (workforce, financial, IT and estates) • Evolution of a new organisation using existing provider as the vehicle is a less complex model and potentially quicker. • The other advantages are very similar to Option 1 in that a single organisation and leadership team is accountable for the governance, and delivery of the services. It offers synergies from coordinating and removing duplication from local services. • System solutions can be co-designed	• Merger could be unwieldy if it involves multiple organisations. • If merger involves an NHS Trust and NHS Foundation Trust with other providers of NHS healthcare services may require Competition and Markets Authority (CMA) review - process can be detailed and lengthy. (e.g. if SPFT were merging part of their services with ESHT) • High risk (all the eggs are in one basket), but potentially higher rewards • Limited levers of control/influence for strategic commissioners • Cultural issues • Little experience of such models in UK and limited experience of staff in leading them

2 High Level Brief Review: HR and Workforce

Our Accountable Care Workforce Group has undertaken a high level review of the four options to identify impacts and differences relating to workforce.

Key points for option 1 prime provider/prime contractor 'integrator'

- Preparation for TUPE transfer (scoping of 'in scope' services and staff)
- Dealing with complexities of where roles are spread across in and out of scope functions, e.g. back office functions).
- Agreement on whose terms and conditions for new posts/new recruits (how to harmonise yet retain sovereign organisations, e.g. ILT Manager posts are a mix of health and ESCC employees undertaking same role) and resulting employment relations issues
- Potentials for managing redundancies (if they are likely to arise due to integration of functions) and complexities of different T&Cs and protection of recognised continuous service
- Staff comms and engagement/partnership working is vital to support retention of staff and bring about change with minimal employment relations issues.
- Scoping of contracted out functions and impact of decision on how functions are to be provided in the future (e.g. could staff be 'in scope' for transfer?)
- Consultation on transfer (and organisational change). Managing the transfer and issues post transfer
- Organisational Change Framework that all partner employers and TU reps sign up to (will ensure change process is managed fairly and consistently)
- Leadership development/support to line managers to achieve consistent and fair approach
- Workforce planning to ensure workforce is right fit for new organisation/structures/job roles

Key points for option 2 corporate joint venture (provider collaboration)

- Agreement on whose terms and conditions for new posts/new recruits (how to harmonise yet retain sovereign organisations, e.g. ILT Manager posts are a mix of health and ESCC employees undertaking same role) and resulting employment relations issues
- Managing redundancies (if they are likely to arise due to integration of functions) and complexities of different T&Cs and protection of recognised continuous service
- Preparation for TUPE transfer (scoping of 'in scope' services and staff)
- Dealing with complexities of where roles are spread across in and out of scope functions, e.g. back office functions.
- Scoping of contracted out functions and impact of decision on how functions are to be provided in the future (e.g. could staff be 'in scope' for transfer?)
- Consultation on transfer (and organisational change). Managing the transfer and issues post transfer
- Organisational Change Framework that all partner employers and TU reps sign up to (will ensure change process is managed fairly and consistently)

- Greater OD agenda/investment required to achieve shift in working as an alliance/new models of care
- Leadership development/support to line managers to achieve consistent and fair approach
- Workforce planning to ensure workforce is right fit for new organisation/structures/job roles

Key points for option 3 alliancing: commissioners and providers

- Agreement on whose terms and conditions for new posts/new recruits (how to harmonise yet retain sovereign organisations, e.g. ILT Manager posts are a mix of health and ESCC employees undertaking same role)
- Dealing with complexities of where roles are spread across in and out of scope functions, e.g. back office functions).
- Scoping of contracted out functions and impact of decision on how functions are to be provided in the future (e.g. could staff be 'in scope' for transfer?)
- Organisational Change Framework that all partner employers and TU reps are signed up to (will ensure change process is managed fairly and consistently)
- Staff loyalties divided between Alliance and sovereign organisation
- Employment relations issues that may arise out of similar roles but on different T & Cs
- Greater OD agenda/investment required to achieve shift in working as an alliance/new models of care
- Leadership development/support to line managers to achieve consistent and fair approach
- Workforce planning to ensure workforce is right fit for new organisation/structures/job roles

Key points for option 4 forms of merger or new organisation

- Equity of T&Cs for new staff (and current staff once harmonisation programme/appointments process completed). Harmonisation of pensions required.
- Large scale organisational change and impact on current resources to deliver change plus impact on recruitment and retention during organisational change.
- Employment relations issues arising out of organisational change
- Managing redundancies (if they are likely to arise) and complexities of different T&Cs and protection of recognised continuous service
- Preparation for TUPE transfer (scoping of 'in scope' services and staff). Consultation on transfer (and organisational change). Managing the transfer and issues post transfer
- Scoping of contracted out functions and impact of decision on how functions are to be provided in the future (e.g. could staff be 'in scope' for transfer?)
- Organisational Change Framework that all partner employers and TU reps are signed up to (will ensure change process is managed fairly and consistently)
- Workforce planning to ensure workforce is right fit for new organisation/structures/job roles
- Potential for large scale appointments process for local structure changes/new roles)
- OD/system development plan to support transformation

3 High Level Brief Review: digital and IT

Our ESBT Digital Programme Lead has undertaken a brief high level review of the four options and the following summarises the key differences relating to digital. Broadly speaking, when it comes to digital interoperability, the characteristic and risks for each of the four options from a digital perspective fall into two categories of organisational form:

1. Single organisation i.e. one legal entity in whatever form this takes e.g. option 2 corporate joint venture (provider collaboration) and option 4 forms of merger or new organisation
2. Separate but joined organisations in whatever form this takes e.g. option 1 prime provider/prime contractor 'integrator' or option 3 alliancing: commissioners and providers

1. Single Organisation:

Characteristics

- Removes barriers to change ("I don't work for your organisation and you can't tell me what to do")
- Simplifies Information Governance
- Removes data sharing issues wholesale as we'll no longer be sharing between organisations
- Enables and possibly requires consolidation of contracts and licensing arrangements
- Enables migration onto the same back office systems (like email)
- A single network and technical architecture
- Single IT service (service desk, support etc.)
- Single portfolio of work for prioritisation
- Single PMO and Gateway processes

Risks

- We will probably have to address some of the licensing and contractual elements as part of creating the new organisation (to avoid breaching certain legal contractual terms) which could distract from other work
- Will be complex and difficult to achieve (but ultimately delivers the most rewards for interoperability)

2. Separate but joined organisations

Characteristics

- Progress with digital integration is carried out in much the same way as the current status quo
- Easier to roll back if the collaboration doesn't work out

Risks

- Critical benefits relating to successful Accountable Care delivery (i.e. the necessity of interoperability) are harder to achieve
- Information sharing is complex and difficult
- Licensing and contract management is complex and difficult
- Federating email etc. is difficult (for example the NHS can't provide access to NHS mail to non-NHS Orgs)
- Access to each-others' systems is technically awkward
- Scheduling and prioritising work across a number of technical teams is slower than it would be with one team (although they have been doing a sterling job so far)

4 Key Public Health assessment criteria technical requirements

Our Public Health Team has reviewed elements of the criteria and indicators of what 'good' looks like from a Public Health perspective and has added the following definitions and technical requirements to those indicators, where this can be drawn out

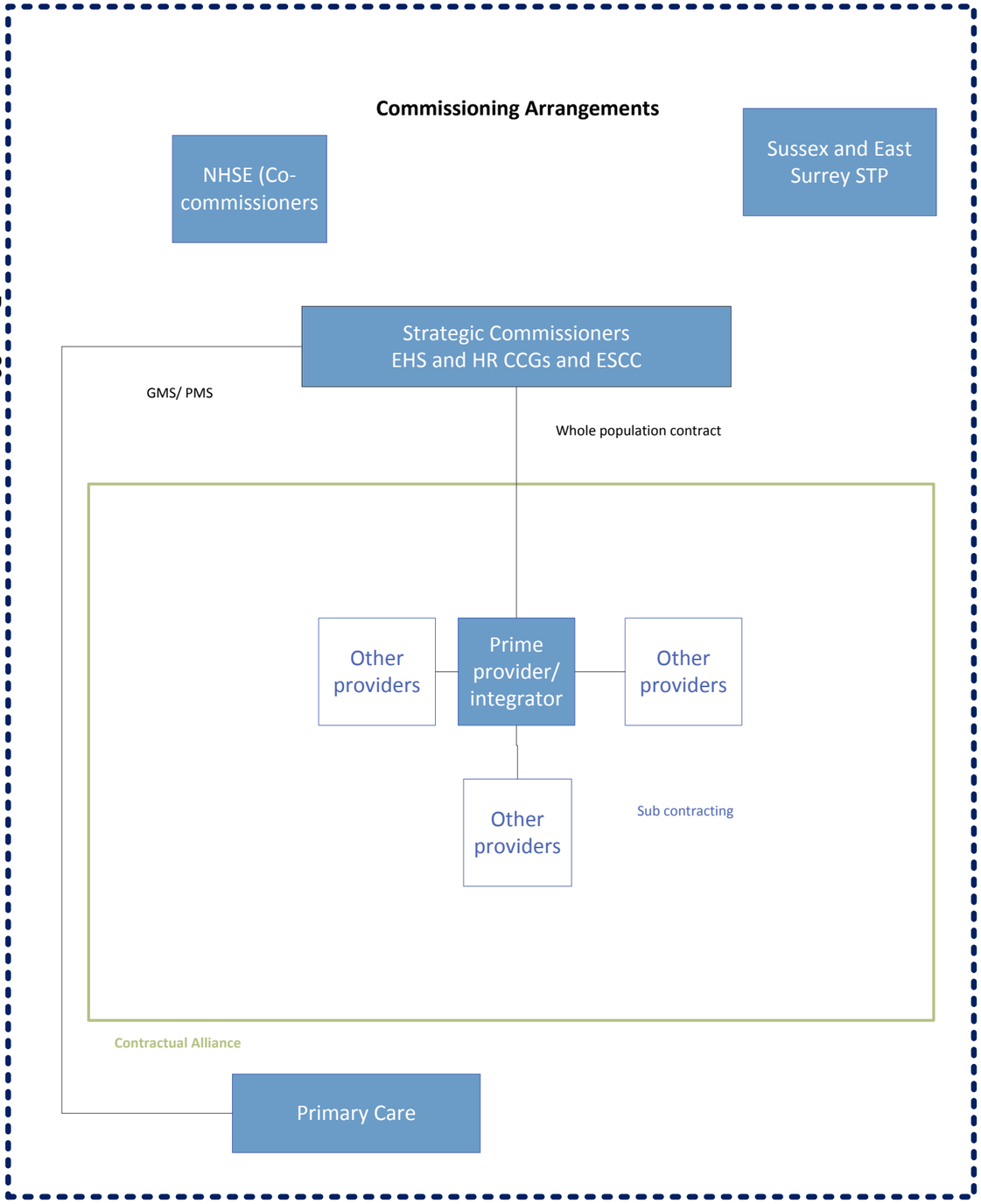
TRANSFORMATION		Definition	Technical requirements
1 (h)	Can the option create the conditions to shift the investment in prevention, primary and community care and be consistent with the ESBT Alliance Strategic Investment Plan?	Allows a population approach to planning wellbeing and care services, using person-level and population data to organise support and care around people's needs and preferences, not those of organisations.	1. A clear link between population-level on demographic need and the planning of services and allocation of resources. 2. Ability to develop data system and capabilities that give deep understanding of the population and the skills and expertise to interrogate, interpret and communicate data. Connected, interoperable data sets that can be accessed across all care settings 3. Business intelligence systems in place that analyse health and care needs at the wider population level 4. Services that are designed based on patient segmentation approach, including risk stratification and evidence of effectiveness
1(i)	How well does the option enable investment in prevention and early intervention and reducing the average per capita Year of Care Cost?	The form of the organisation is able to invest in prevention and early intervention, reduce transactional costs, drive out waste and improve quality to reduce costs.	1. No legal or organisational barriers to redistributing funding to most effective part of the system. 2. Clear mechanisms for identifying and comparing benefits, cost avoidance, effectiveness and savings from different parts of the system over differing time scales. 3. Services that are designed based on patient segmentation approach, including risk stratification and evidence of effectiveness 4. Allows flexible use of capacity and capability across disciplines and organisational professional boundaries to foster shared ownership and prioritisation of prevention (primary, secondary and tertiary) across whole pathways
1 (l)	How well does the model deliver primary secondary and tertiary prevention and embed self-care and self-management to improve health and wellbeing and reduce health inequalities?	The model delivers wellbeing and care services designed to provide pathways that promote health and wellbeing, recovery and independence based on individual and population need.	1. Ensuring prevention (primary, secondary and tertiary), self-care and supported self-management are embedded across all clinical pathways using the clinical programmes approach 2. Active health promotion when individuals come into contact with health and care services (making every contact count) 3. Services are designed based on patient segmentation approach 4. A specific focus on preventative services that are tailored to the needs of different communities 5. Planning services that are accessible for people with different protected characteristics and which consider the potential to generate or address health

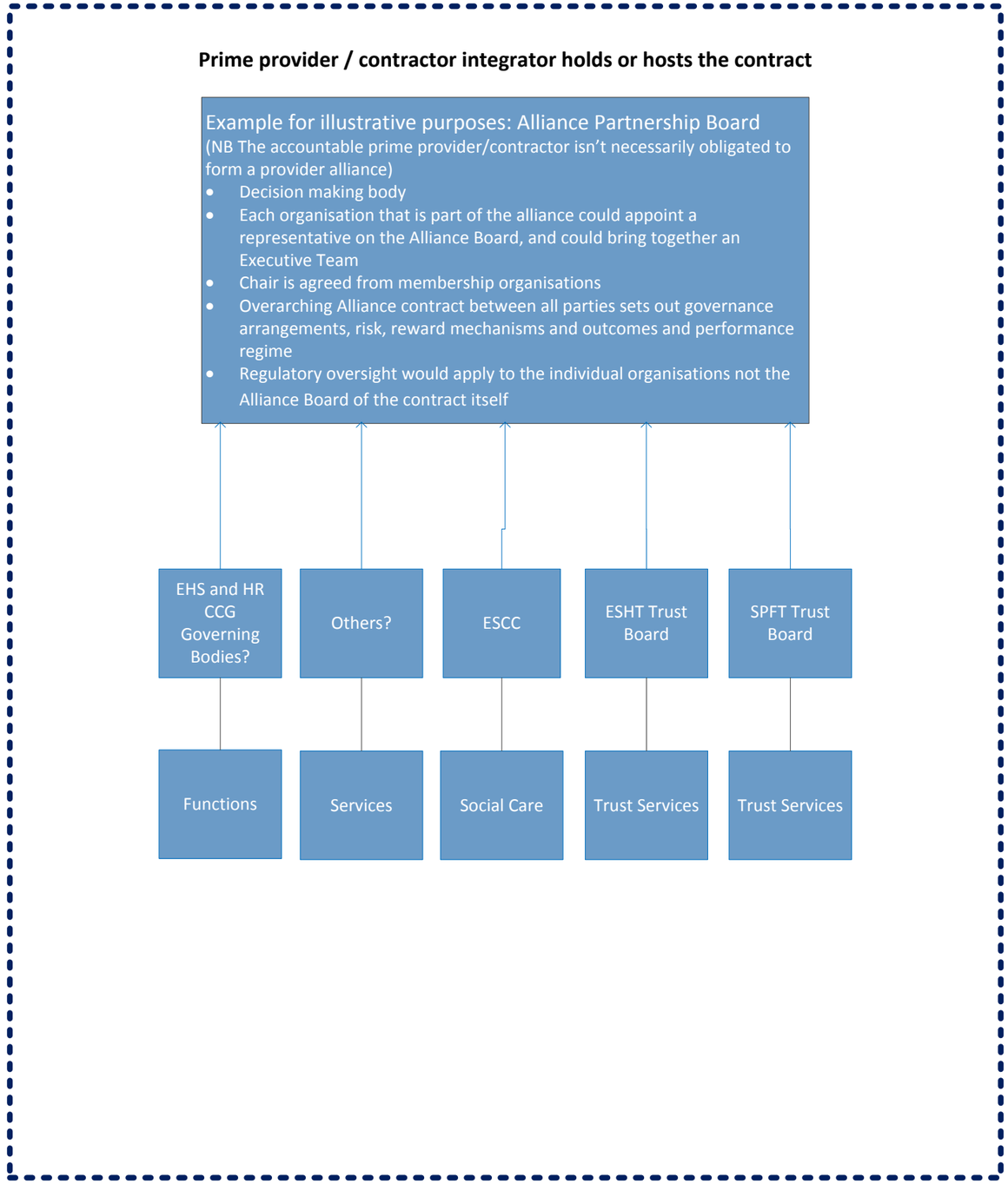
			inequalities and which prioritise the needs of those who experience health inequalities. 6. Develop a shared preventative approach across organisations in the public, voluntary, community and private sector to deliver services 7. Model recognises and actively utilises service users as assets with an active role in improving their own health outcomes
QUALITY AND SAFETY		**Definition**	**Technical Requirements**
3 (g)	How well will the option make use of population health management capabilities (i.e. improved prevention, enhanced patient and client activation) and manage avoidable demand?	The model effectively embeds prevention, self-care and supported self-management, unlocking to the power and potential of communities to reshape the relationship between service users and health and care services.	1. Ensuring prevention (primary, secondary and tertiary), self-care and supported self-management are embedded across all clinical pathways using the clinical programmes approach 2. Improving patient activation through evidence-based approaches such as health coaching, supported self-management, peer support and education programmes. 3. The six principles for effective local engagement approach are implemented 4. Linking people to community assets and other public services 5. Partnership with local government, community groups, voluntary sector, and other organisations that represent people who use services

DRAFT FOR DISCUSSION Option 1: Prime provider / prime contractor 'integrator':

Illustrative Governance Structure and Decision Making - this is not a definitive diagram but an illustration of how the governance might work based on our knowledge to date

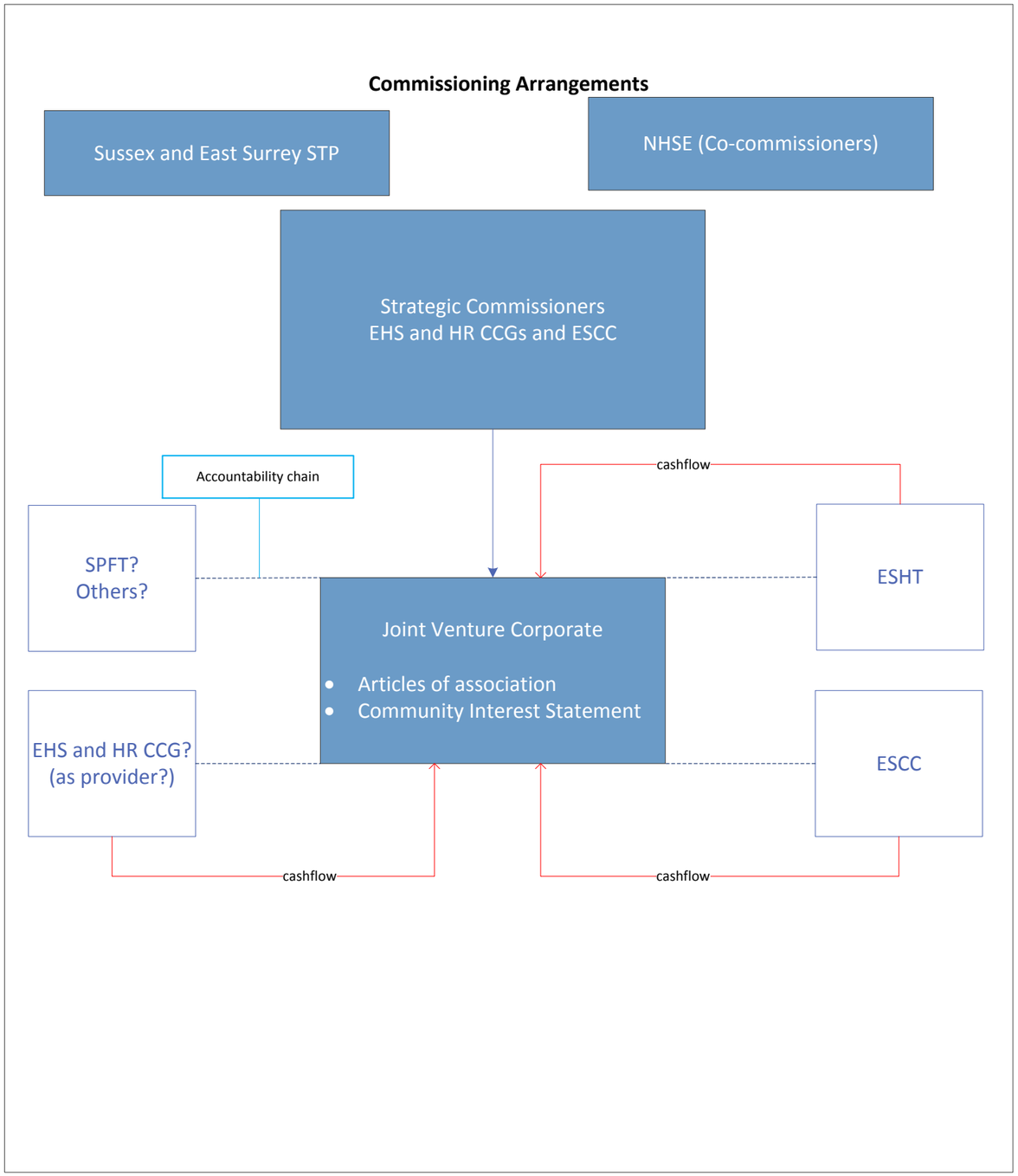
Appendix 3

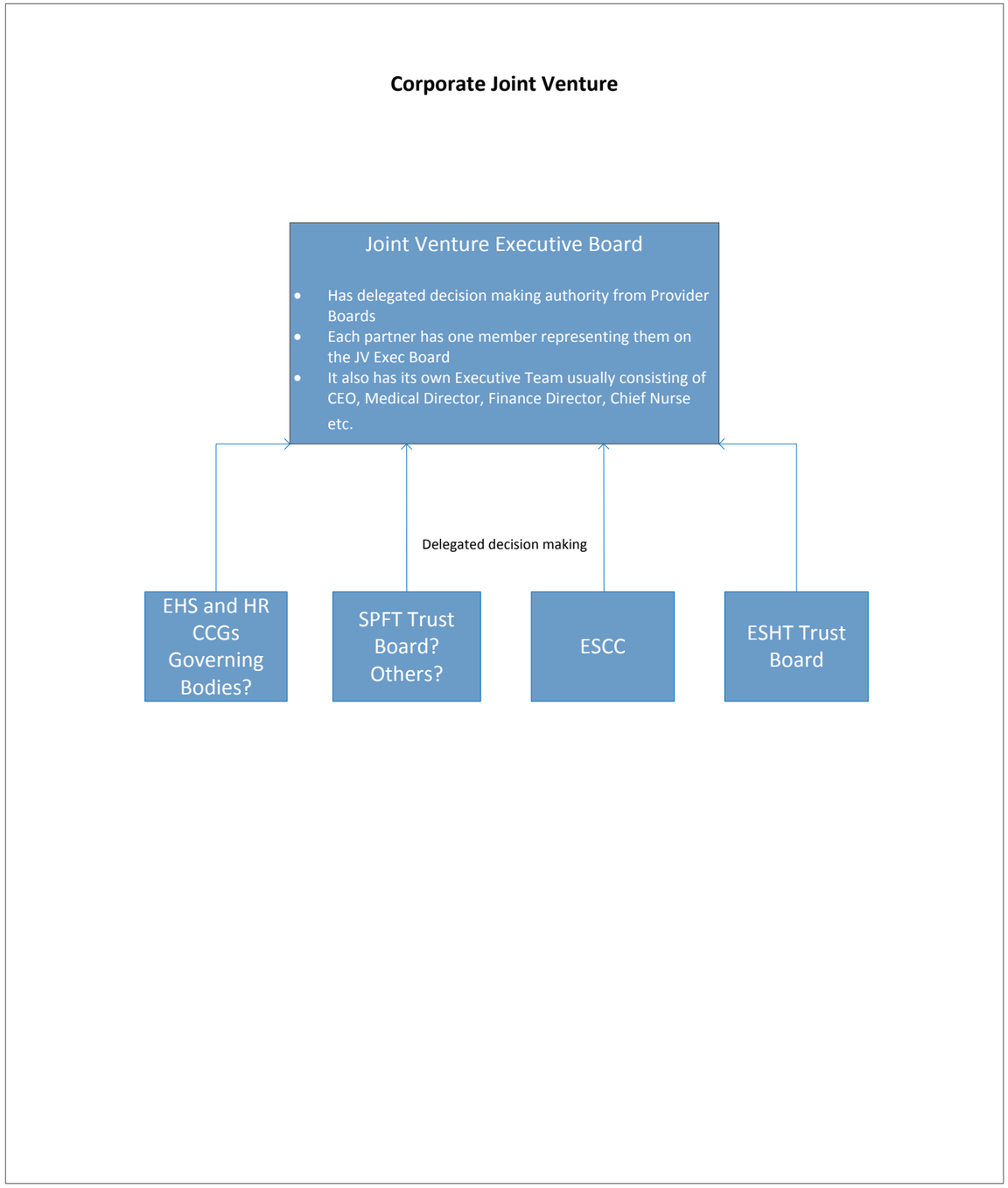




DRAFT FOR DISCUSSION Option 2: Corporate Joint Venture

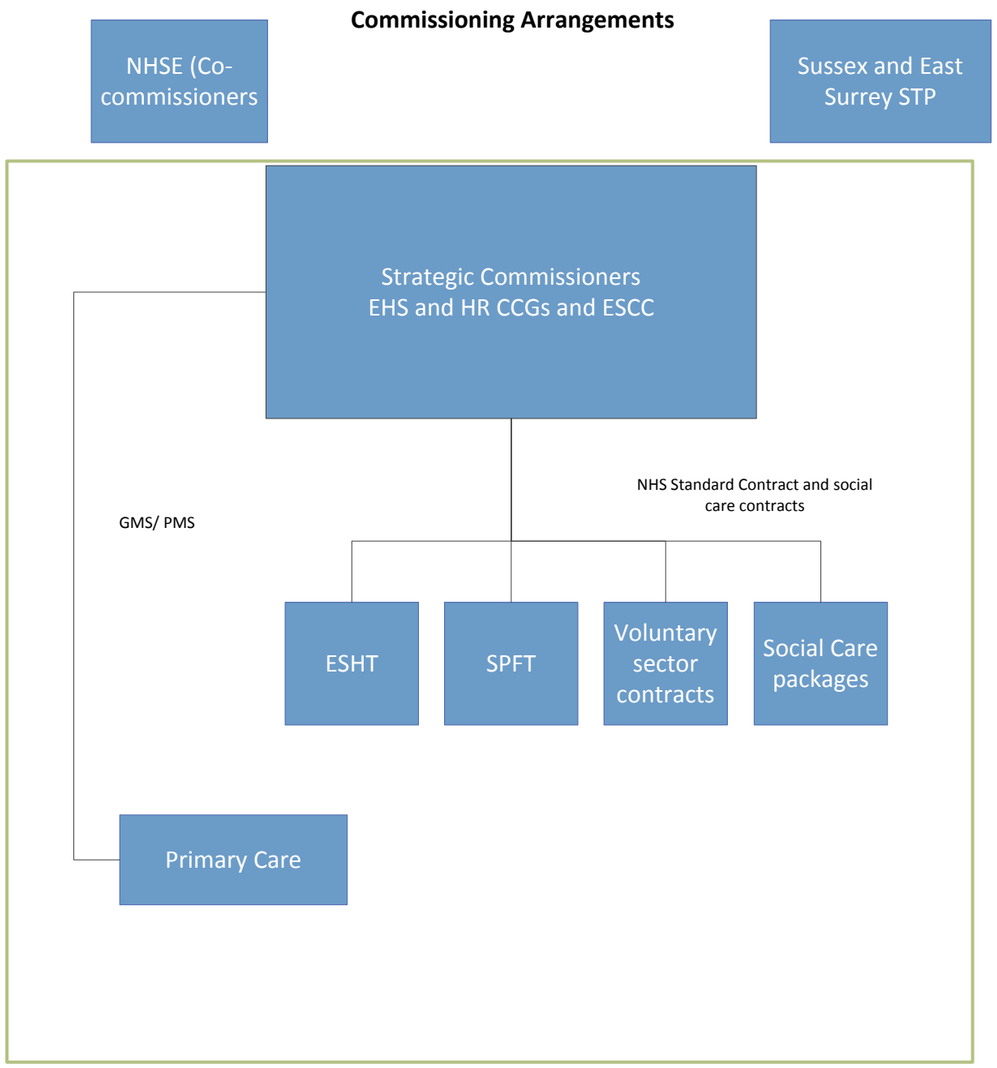
Illustrative Governance Structure and Decision Making - this is not a definitive diagram but an illustration of how the governance might work based on our knowledge to date

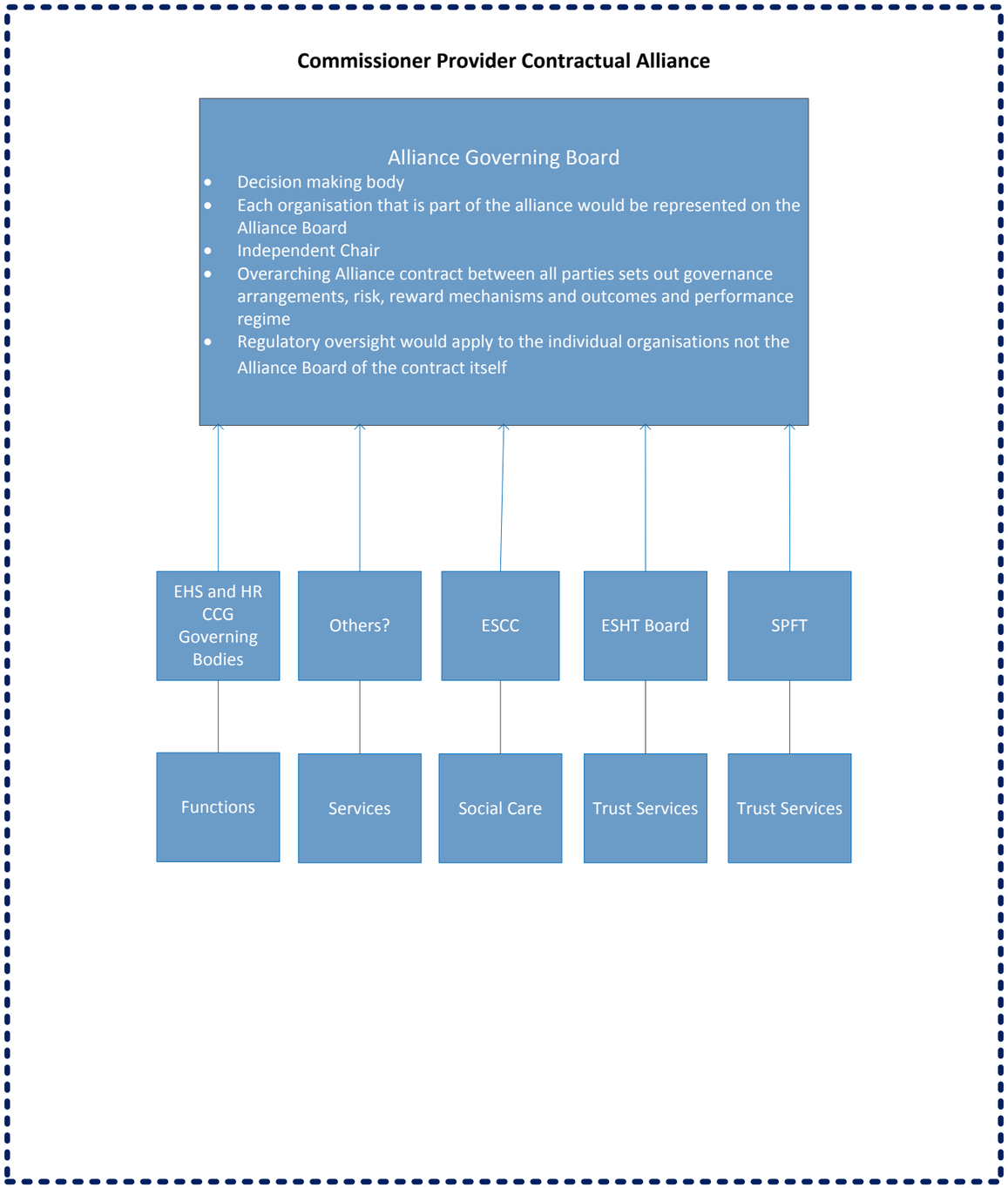




DRAFT FOR DISCUSSION Option 3: Contractual Commissioner Provider Alliance:

Illustrative Governance Structure and Decision Making - this is not a definitive diagram but an illustration of how the governance might work based on our knowledge to date





DRAFT FOR DISCUSSION Option 4: New Health and Care NHS Trust: Illustrative Governance Structure and Decision Making - this is not a definitive diagram but an illustration of how the governance might work based on our knowledge to date

Commissioning Arrangements

Sussex and East Surrey STP

NHS England (co-commissioning

Strategic Commissioners
EHS and HR CCGs and ESCC

GMS contract

Whole Population Contract

A 'Health and Care NHS Trust'

Tactical Commissioning with GPs (enhanced services), other NHS Trusts, SECamb, independent care organisations and voluntary organisations

Primary Care

NB This illustrative and is based on examples emerging elsewhere in the UK. It is not a definitive model

Members

- Vote to elect Governors
- Two constituencies: public and staff
- Future electorate could be based around 6 Localities

Governors

- Public Governors
- Elected Governors representing Localities
- Out of ESBT area
- Staff Governors
- **Nominated Governors**
- GP Locality Leads
- Local Authority reps
- Others

Possible Non Executive Backgrounds

- Chair
- Primary Care
- Local Authority
- Mental Health
- Clinical
- Financial
- Strategic/ Business
- Workforce

Executive Directors

- CEO/ Finance Director/Chief Nurse/ GP
- Medical / Social Care/ Workforce
- Strategy / Corporate Affairs

- High degree of devolved autonomy
- Could be led by an Executive Chair (Clinical/ Practitioner)) who also sits on the main Board of Directors, supported by a Managing Director
- Run by an Executive Board?

NHS Improvement and CQC

- Regulation and oversight

A 'Health and Care NHS Trust'

Council Governors – illustrative example

- Holds Board to account
- Appoints the Chair and Non Executive Directors
- Approves significant transactions
- 51% elected by members (Public Governors that must be the majority and Staff Governors)
- 49% appointed (e.g. GP's, Local Authorities, Voluntary Sector etc.)

Board of Directors – illustrative example

- Key decision making body
- A mix of Non-Executives and Executive Directors
- Must be a majority of Non Executives (?)
- Statutory requirements for Executive Directors: Chief Executive (accountable officer) Finance Director, Chief Nurse, Medical Director
- Additional constitutional requirements could include Directors from a Primary Care and Social Care background
- Executive Directors can be a mix of voting and non voting Directors
- Statutory requirement for Non Executive Chair (NED)
- Additional constitutional requirement could include a Primary care NED, Social Care NED

Community

- Locality Teams
- ED & Ambulatory Care
- Urgent Care
- GP out of hours
- Out Patients
- Care Management
- Social care packages
- Residential care
- Primary Care in scope
- Mental Health
- Public Health

Cross-cutting functions

- Pathology
- Radiology
- Pharmacy
- Therapies
- Prevention

Inpatient Services

- Medical Admissions
- Surgical Admissions
- Critical Care and Theatres
- Emergency sites
- Inpatient psychiatric services
- Specialist services

Appendix 4

Governance of New Care Models: PACS Examples from the Vanguards

Briefing Paper

1 Introduction

The 23 vanguard sites chosen to develop the multispecialty community provider (MCP) and primary and acute care system (PACS) new care models have been working to pool budgets and integrate services more closely. Some are continuing to use informal partnerships, but others are opting for more formal governance arrangements. Commissioners are grappling with how to contract for the new systems, while providers are exploring how to work together within emerging partnerships, how to allocate funding, and how to share risk and rewards

To support consideration of our options for the future ESBT delivery vehicle, this briefing paper looks at three different approaches being taken by some of the PACS vanguards to contracting, governance and other organisational infrastructure. In the case of PACS, many commissioners are considering contracting with a local hospital trust, or a partnership between a hospital and other providers, to hold a population budget and manage the system. Few commissioners have been interested in engaging an 'integrator' organisation that would hold the population budget and coordinate the contributions of different providers but would not have managerial control of services or established relationships with providers[1].

This paper focuses on developments in three areas chosen as examples to give a flavour of the different approaches being taken: Mid Nottinghamshire Better Together Alliance; Torbay & South Devon NHS Foundation Trust Integrated Care Organisation; and Northumberland - Building a Caring Future.

2 Mid Nottinghamshire Better Together Alliance

The Mid-Nottinghamshire Better Together Programme was established in 2013, and is a partnership between Ashfield and Mansfield Clinical Commissioning Group (CCG), Newark and Sherwood CCG, Nottinghamshire County Council (NCC), seven NHS health providers and voluntary sector partners. An Alliance Agreement contract was agreed from April 2016, entering the partners into a contractual joint venture.

The Alliance is made up of three main elements:

i. the collaborative partnership and governance system
ii. transparency on the respective local budgets for the CCGs and NCC
iii. how the money is spent. This includes elements of the CCG contracts with health provider Alliance Members being linked into the Alliance contract, starting to be developed into outcome based capitated contracts. The CCG and NCC also have other contracts that currently sit fully outside of the Alliance Agreement. Alongside this sits the Council's system for assessing eligibility for and allocating personal budgets for people's individual care and support packages. This includes the option of people taking the money in the form of a Direct Payment to purchase their own services. During the transition phase a selection process will be undertaken to select key social care providers who have a contract with the Council, to join the Alliance.

The CCG plans to link the contracts it holds with the seven potential participating health providers into the Alliance contract, with a commitment to develop and implement new

[1] Kings Fund, *New care models – emerging innovations in governance and organisational form*, Oct 2016, p.4

payment mechanisms using outcomes based capitated contracts. The work is in its very early stages and is one of the main areas for the Alliance to develop further in the transition phase. The Council will not be changing the care and support contracts it holds with social care providers to a capitated model because this does not offer the ability to give individuals who have been assessed as eligible for social care a Personal Budget or Direct Payment. The CCG holds other contracts with providers who are not in the Alliance. These, as well as the Council's single and jointly commissioned contracts, currently sit outside of the Alliance.

The Council will not have to change any of its current commissioning arrangements or contracts due to becoming an Alliance Member but will be obliged where possible to review those contracts and consider how they might become a part of the Alliance arrangements, in line with the Alliance principles. As contracts become due for renewal the Council will continue to be able to consider whether there is benefit to increasingly integrated arrangements with the CCGs and/or other partners, what type of contract is most appropriate and how to achieve strategic countywide economies of scale whilst meeting local objectives.

In addition to the 2 CCGs, the partners who are considering signing the Alliance agreement contract are the seven health providers that were selected following a Most Capable Provider process by the CCGs: Central Nottinghamshire Clinical Services, Circle Nottingham Ltd., East Midlands Ambulance Service, Nottinghamshire Healthcare NHS Foundation Trust, Nottingham University Hospitals NHS Trust, Sherwood Forest Hospitals NHS Foundation Trust, United Lincolnshire Hospitals NHS Trust and the voluntary sector Mid-Nottinghamshire special purpose vehicle 'Together Everyone Achieves More' (TEAM). TEAM was established to enable the value of the 3rd Sector to help shape service transformation and is not itself a provider of services.

There is a commitment to secure the engagement of General Practice in mid-Nottinghamshire within the Alliance; this reflects the significant role of General Practice as a provider of care and support and the key role it can contribute to achieving many of the Better Together objectives. The involvement of General Practice in the Alliance is contingent upon the establishment of a collective federated body or bodies with authority and legitimacy to make binding decisions on behalf of General Practice.

No social care providers are currently signed up to the MoU or part of the Alliance. The Council is preparing to carry out an assessment exercise to identify any provider or providers of the social care services who could sensibly become an Alliance participant. District Councils are not currently signed up to the MoU or the Alliance, however, discussion regarding the options are planned.

3 Torbay & South Devon NHS Foundation Trust

The Torbay Care Trust was formed in 2005, when Torbay Care NHS Trust and Torbay Council entered into an Annual Strategic Agreement (ASA) for the Care Trust to provide Adult Social Care services. This led to the creation of a fully-integrated health and social care trust, which had responsibility for both the commissioning and provision of integrated community health and social care services to people in the Torbay area. Vertical integration with the foundation trust began to be explored once the horizontal integration of community services had been secured.

In October 2015, following a procurement process, the Torbay & South Devon NHS Foundation Trust was awarded the contract and launched as the first Integrated Care Organisation (ICO) in the country to bring together acute, community and social care services to form a single provider organisation delivering health and social care to a local population of 375,000 people. The ICO works to provide a set of agreed outcomes based on a new model of care, through a pool of available resources.

The ASA now contains the NHS commissioner and provider elements and the final savings plans and performance required for 16/17, and outlines what outcomes will be delivered within the financial envelope agreed. Specifically for the Council, it also gives transparency to the delivery of Adult Social Care services on behalf of the Council.

A risk-share agreement is in place, the purpose of which is to facilitate the development of integrated health and social care and secure the quality of services and facilitate the changing the model of care through creating a stable financial environment for multi-year investment and aligned financial incentives. The agreement has been completed with parties from South Devon and Torbay CCG, Torbay Council, South Devon Healthcare Foundation Trust and Torbay and Southern Devon Health and Care Trust. This has included oversight from the non-executives and Governors from the Care and Foundation Trusts, the Governing Body of South Devon and Torbay CCG and the Mayor from Torbay Council.

4 Northumberland - Building a Caring Future (SPV)

Commissioners and providers in Northumberland have a long history of partnership working. A care trust was set up in 2002, with most of the council's adult social care functions delegated to it. Since 2011 operational functions have been delegated to Northumbria Foundation Trust, while the council and the CCG have worked closely together as commissioners, with arrangements including delegation of NHS Continuing Health Care commissioning to the council.

The commissioners started working with Northumbria Foundation Trust and other partners to develop these arrangements further with the aim of establishing an accountable care organisation that would oversee the full range of health and care services for adults. Under the new arrangements, the CCG will transfer its funding for most core NHS services to an accountable care organisation, which will operate as a partnership between Northumbria Foundation Trust; Northumberland, Tyne and Wear NHS Foundation Trust; the mental health provider, and other providers. Northumbria Foundation Trust will hold the formal contract, but it will be managed through a type of partnership arrangement with the other providers. The delegation of the council's operational adult social care functions to Northumbria Foundation Trust will continue.

The accountable care organisation will make all 'tactical' decisions about the deployment of health resources, effectively taking over many of the detailed tasks currently carried out by the CCG. A 'strategic' commissioning function will remain outside the accountable care organisation. This will be supported by a joint strategic commissioning unit hosted by the council and reporting to the statutory CCG board on NHS commissioning and to the council on social care commissioning. Funding for partnership arrangements between the CCG and the council, such as the integrated commissioning of Continuing Health Care commissioning, is expected to remain outside the contract for the accountable care organisation.

Primary care leaders in the county are debating which of five organisational form options could most effectively serve to support their role in the accountable care organisation from April 2017 and will conclude these deliberations later this year. There are no immediate plans to include core primary care in the accountable care organisation's pooled budget.

Commissioners are in the process of developing an outcomes framework as a basis for monitoring and incentivising performance within the new system (rather than using financial incentives). Finally, commissioners plan to establish a small joint commissioning unit within the council to make best use of commissioning resources, while transferring tasks such as contracting with and overseeing individual services to Northumbria Healthcare.

Table 1: Summary of approaches taken at the three vanguard sites

	Mid-Notts Better Together Alliance	Torbay & South Devon NHS Foundation Trust	Northumberland SPV
Scope of services in integrated system	• Acute hospital, community health, social care • Maternity and paediatric care	• Acute hospital, community health, mental health, social care	• Acute hospital, community health, mental health, social care • Core primary care not included at present
Budgets and payments	• Commitment by all parties to move towards an outcomes-based capitated budget covering the vast majority of services for the population	• The integrated care organisation manages the combined budget	• Plan to transfer a whole population budget to a host provider to manage within an alliance of partners
Contracting process	• Under consideration	• A procurement process was held to establish the new provider – Torbay & South Devon NHS Foundation Trust – to merge with the existing Care Trust	• CCG has published a prior information notice with intention of negotiating contract with a host provider foundation trust
Contract duration	• 3 years with option to extend for a further 7 years	• An initial term of 5 years, leading to a 3 year contract renewed annually on a rolling basis beyond the first 5 years	• 10 years
Likely incentives	• Full members can share the risks and rewards from joint activities	• Risk share agreement is in place	• Northumbria Healthcare NHS Foundation Trust and partners likely to be able to invest savings from good performance
Agreed or likely organisational structure	• Will manage virtual managed care organisations through an alliance agreement and governance arrangements • Envisage more substantial changes in the longer term as the group builds experience of working together	• Torbay & South Devon NHS Foundation Trust is providing social care under contract from the local authority, community and acute health services	• Northumbria Foundation Trust to hold budget on behalf of the accountable care organisation partnership, which will deliver acute, community and social services
Population size	• 310,000	• 375,000	• 322,000

ESBT MILESTONE MAP

Appendix 5

APR ‘17

MILESTONE

Stakeholder engagement to inform options appraisal on future organisational form

JULY ‘17

MILESTONE

Organisational form and development timeline agreed by sovereign organisations

DEC ‘17

MILESTONE

Clarify menu of options for how primary care, mental health and other parts of system relate to chosen model

APR ‘18

MILESTONE

Integrated single leadership structure for strategic commissioning function implemented; pooled budget and risk share agreed for strengthened Alliance

Single leadership of delivery function implemented.

JULY ‘18

MILESTONE

Business case for accountable care organisation Agreed; NHSE ISAP process initiated

SEPT ‘18

MILESTONE

Plans for consulting with staff in place, as required

APR ‘19

MILESTONE

Integrated business infrastructure in place, including potential delegation to STP level

SEPT ‘19

MILESTONE

New integrated regulatory framework and payment mechanisms agreed

APR ‘20

MILESTONE

Launch of new accountable care organisation

NB this map of high level milestones is intended as a guide, and milestones may be subject to change with detailed implementation planning

Ongoing staff and stakeholder engagement

Year on year delivery of financial balance and quality improvement

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Report to:	**Cabinet**
Date:	**18 July 2017**
By:	**Chief Operating Officer**
Title of report:	**Internal Audit Services: Annual Report and Opinion 2016/17**
Purpose of report:	**To give an opinion on the County Council's control environment for the year from 1 April 2016 to 31 March 2017**

RECOMMENDATIONS

Cabinet is recommended to note the internal audit service's opinion on the Council's control environment.

1. Background

1.1 The purpose of this report is to give an opinion on the adequacy of East Sussex County Council's control environment as a contribution to the proper, economic, efficient and effective use of resources. The report covers the audit work completed in the year from 1 April 2016 to 31 March 2017 in accordance with the Internal Audit Strategy for 2016/17.

2. Supporting Information

2.1 All local authorities must make proper provision for internal audit in line with the 1972 Local Government Act (S151) and the Accounts and Audit Regulations 2015. The latter states that authorities 'must undertake an effective internal audit to evaluate the effectiveness of its risk management, control and governance processes, taking into account public sector internal auditing standards or guidance'.

2.2 It is a management responsibility to establish and maintain internal control systems and to ensure that resources are properly applied, risks appropriately managed and outcomes achieved.

2.3 No assurance can ever be absolute; however based on the internal audit work completed, the Orbis Chief Internal Auditor can provide reasonable assurance that East Sussex County Council has in place an adequate and effective framework of governance, risk management and internal control for the period 1 April 2016 to 31 March 2017.

2.4 This opinion, and the evidence that underpins it, is further explained in the full Internal Audit Services Annual Report and Opinion which forms Annexe A of this report. The report highlights:

- Key issues for the year, including a summary of all audit opinions provided;
- Progress on implementation of high risk recommendations;
- Key financial systems;
- Schools;
- Anti Fraud and Corruption.

2.5 Section 6 of the annual report sets out details of internal audit performance for the year, including details of compliance against the relevant professional standards.

3. Conclusions and Reasons for Recommendation

3.1 Cabinet is recommended to note the internal audit service's opinion on the Council's control environment.

3.2 This report was presented to Audit, Best Value and Community Services Scrutiny Committee on 14 July 2017. Due to the short timescales involved, Cabinet will be informed of any comments raised by this Committee.

Kevin Foster, Chief Operating Officer

Contact Officers: Russell Banks, Orbis Chief Internal Auditor
Tel No. 01273 481447

Background documents:
Strategic Audit Plan 2016-17
Internal Audit Progress Reports 2016/17

ANNEX A

INTERNAL AUDIT SERVICES ANNUAL REPORT AND OPINION 2016/2017

East Sussex
County Council

1. Internal control and the role of Internal Audit

1.1 All local authorities must make proper provision for internal audit in line with the 1972 Local Government Act (S151) and the Accounts and Audit Regulations 2015. The full role and scope of the Council's Internal Audit Service is set out within our Internal Audit Charter and Terms of Reference.

1.2 It is a management responsibility to establish and maintain internal control systems and to ensure that resources are properly applied, risks appropriately managed and outcomes achieved.

1.3 Internal audit is not the only source of assurance for the Council. There are a range of external audit and inspection agencies, as well as processes for internal management review, which can also provide assurance and these are set out in the Council's Local Code of Corporate Governance and its Annual Governance Statement.

2. Delivery of the Internal Audit Plan

2.1 The County Council's Internal Audit Strategy and Plan is updated each year based on a combination of management's assessment of risk (including that set out within the departmental and strategic risk registers) and our own risk assessment of the Council's major systems and other auditable areas. The process of producing the plan involves extensive consultation with a range of stakeholders to ensure that their views on risks and current issues, within individual departments and corporately, are identified and considered.

2.2 In accordance with the audit plan for 2016/17, a programme of audits was carried out covering all Council departments and, in accordance with best practice, this programme was reviewed during the year and revised to reflect changes in risk and priority.

2.3 All adjustments to the audit plan were agreed with the relevant departments and reported throughout the year to Corporate Management Team (CMT) and Audit, Best Value and Community Services Scrutiny Committee (ABVCSSC) as part of our quarterly internal audit progress reports.

3. Audit Opinion

3.1 No assurance can ever be absolute; however, based on the internal audit work completed, the Head of Assurance (as the Council's Head of Internal Audit) can provide reasonable assurance[1] that East Sussex County Council has in place an adequate and effective framework of governance, risk management and internal control for the period 1 April 2016 to 31 March 2017. Audit testing has confirmed that the majority of key controls examined are working in practice, with some specific exceptions.

[1] The use of term 'reasonable assurance' reflects that the opinion has been reached based on the work set out in paragraph 4 below and that it is not possible or practicable to audit all activities of the County Council within a single year.

3.2 Where improvements in controls are required, we have agreed appropriate remedial action with management.

4. Basis of Opinion

4.1 The opinion and the level of assurance given takes into account:

- All audit work completed during 2016/17, planned and unplanned;
- Follow up of actions from previous audits;
- Management's response to the findings and recommendations;
- Ongoing advice and liaison with management, including attendance by the Head of Assurance at monthly Statutory Officers Group meetings;
- Effects of significant changes in the Council's systems;
- The extent of resources available to deliver the audit plan;
- Quality of the internal audit service's performance.

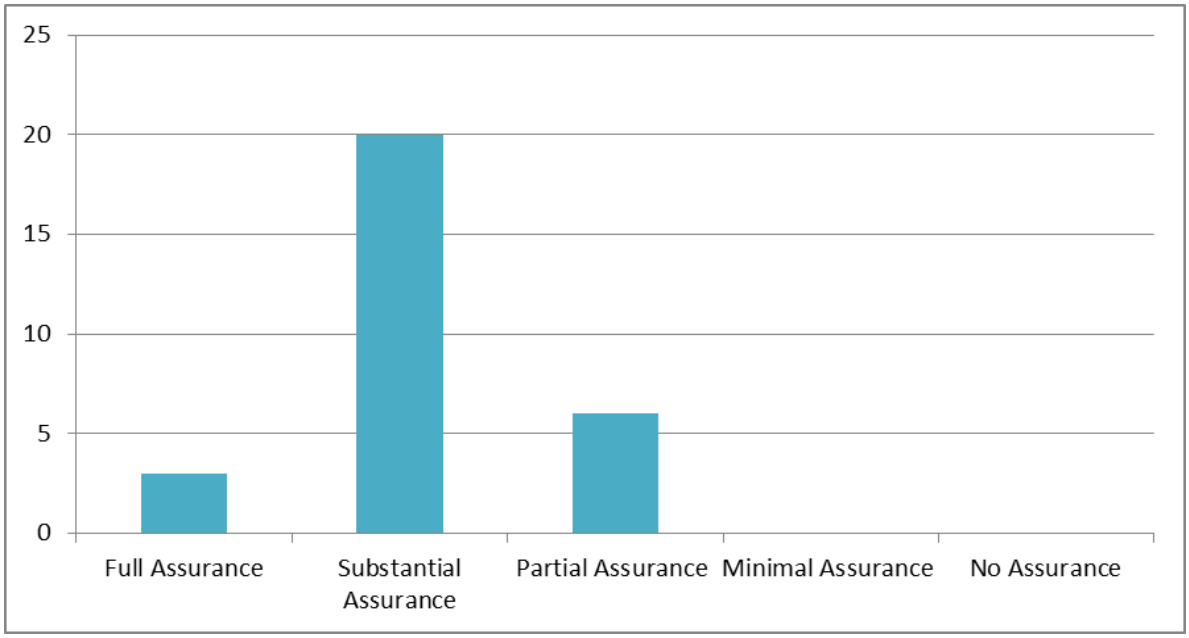
4.2 No limitations have been placed on the scope of Internal Audit during 2016/17.

5. Key Issues for 2016/17

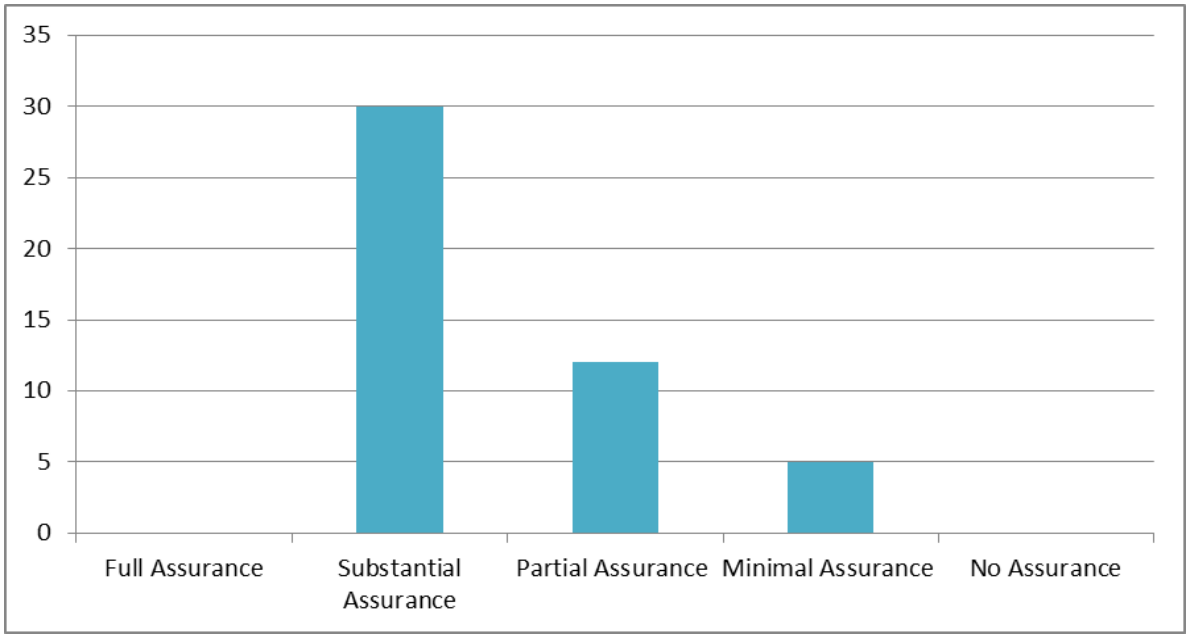
5.1 The overall audit opinion should be read in conjunction with the key issues set out in the following paragraphs. These issues, and the overall opinion, should be taken into account when preparing and approving the Council's Annual Governance Statement.

5.2 The internal audit plan is delivered each year through a combination of formal reviews with standard audit opinions, direct support for projects and new system initiatives, investigations, grant audits and ad hoc advice. The following graphs provide a summary of the outcomes from all non-school audits and school audits finalised during 2016/17 with standard audit opinions:

Non-Schools



Schools



5.3 A full listing of all completed audits and opinions for the year is included at Appendix B, along with an explanation of each of the assurance levels. Significantly, it is pleasing to report that, with the exception of schools, none of the audits completed in the period have resulted in 'minimal assurance' opinions and, there have been no 'no' assurance' opinions in either schools or non-schools.

5.4 Included with the non-schools graph above are a total of three reviews where we have revisited areas which had previously received lower levels of assurance. For one of these (Public Health Local Service Agreements), we have been able to issue a revised opinion of substantial assurance. For the other two audits (Compliance with Procurement Standing Orders and Direct Payments), the original audit opinions of partial assurance remain unchanged. In both cases, we have agreed revised action plans with management who have committed to ensuring the necessary control improvements are made. Both areas will also be subject to further follow-up work to ensure this is the case, with progress to be reported to ABVCSSC during the course of 2017/18.

5.5 As well as conducting formal follow up reviews, we have in place arrangements to track the implementation of all high risk audit recommendations issued during the year. As at 31 March 2017, of the 38 high risk recommendations issued and due by the end of the 2016/17, it is pleasing to report that all had been implemented within the agreed timescales.

5.6 At the time of producing this report, a total of 11 planned reviews remained in progress, all of which will be completed during the first quarter of 2017/18. The finalisation of these reports will result in 100% completion of the 2016/17 internal audit plan.

Key Financial Systems

5.7 Given the substantial values involved, each year a significant proportion of our time is spent reviewing the Council's key financial systems, both corporate and departmental. Of those completed during 2016/17, all of these, with the exception of Pensions Processes and Systems (which received partial assurance), have resulted in either full or substantial assurance being provided over the control environment.

Schools

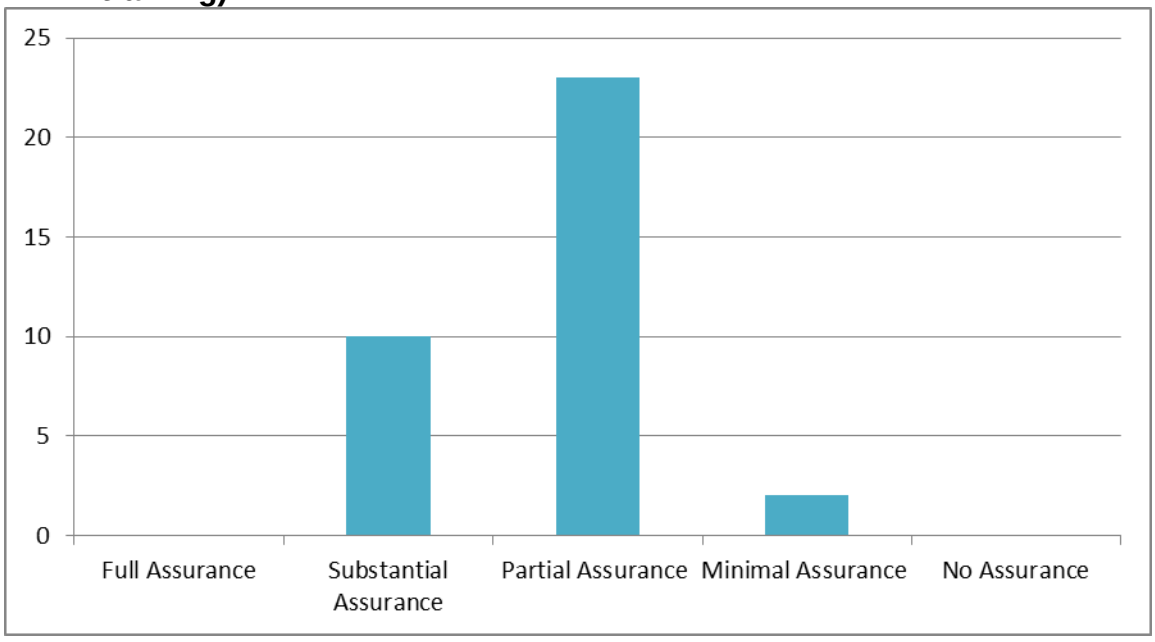
5.8 Throughout the year, we have completed a programme of assurance work in schools in accordance with our agreed Schools Internal Audit Strategy. For 2016/17, this has focussed on two main areas:

- Audits in a sample of higher risk schools and follow-ups where poorer audit opinions have been given. This work was delivered by our own Internal Audit service, and;
- A wider programme of audits of randomly selected schools, delivered through Mazars Public Sector Internal Audit.

5.9 The purpose of this wider sample of school work is to assess financial governance in more schools, not just those deemed to be higher risk, and to gauge the effectiveness of a new training programme delivered jointly by ESCC Internal Audit, Personnel, Finance and Children's Services, to governors, headteachers and school business managers. A full list of all schools audited in the year, along with the relevant audit opinions, is provided within Appendix B to this report.

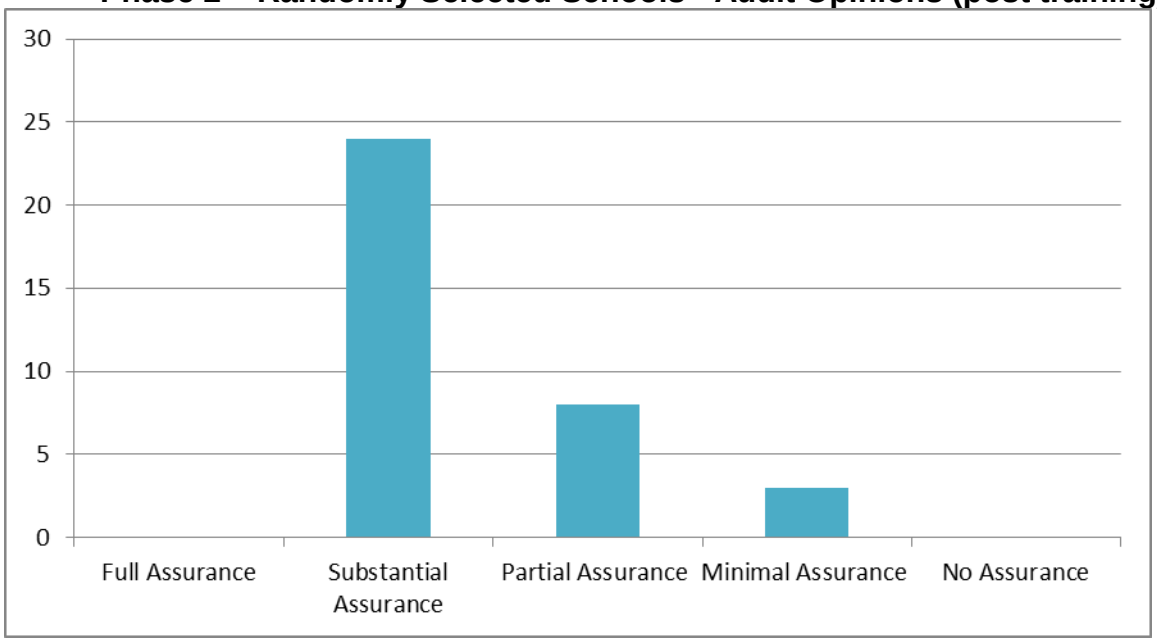
5.10 The following graphs provide a summary of audit opinions issued for those randomly selected schools prior to and after the training programme referred to above.

Phase 1 - Randomly Selected Schools - Audit Opinions (prior to training)[2]



[2] These audits were completed in 2015/16

Phase 2 – Randomly Selected Schools - Audit Opinions (post training)



5.11 These results provide a clear indication that the training programme has contributed to a significant improvement in financial control within our schools.

5.12 Other audit initiatives undertaken during the year to help improve financial governance in schools have included:

- Continuing the work of the Schools Risk Review Group, made up of representatives from Internal Audit, Personnel and Training, Finance, and the Standards and Learning Effectiveness Service (which includes Governor Services), the primary aim of which is to ensure appropriate targeted support and intervention is provided to schools;
- Producing regular information bulletins for all school governors highlighting common themes and issues arising from audit work, encouraging Governors to increase scrutiny of the schools finances and financial position;
- Providing ad-hoc advice and guidance.

5.13 We are also currently consulting with Headteachers, Business Managers and Governors about improving the effectiveness of how we provide information and advice to them. This includes considering the offer of alternative activities, such as self-assessment tools, so that schools are able to gain assurance over their control environment between formal audits.

5.14 Finally, we completed 8 follow-up school reviews during the year where opinions of minimal or no assurance had previously been given. In all cases, clear improvements in internal control were identified.

Cultural Compliance

5.15 Cultural compliance reviews are intended to provide assurance that services are delivered effectively within teams across the Council and in compliance with appropriate policies and procedures. In particular, the reviews focus on service delivery and good management practice, budget management, expenditure, income, staff management and assets / inventory management.

5.16 In 2016/17, following a number of similar reviews in 2015/16, we completed two cultural compliance audits covering teams in BSD and CSD. It is pleasing to report that both of these received audit opinions of substantial assurance, demonstrating the existence of robust management controls in the areas sampled.

Anti-Fraud and Corruption

5.17 During 2016/17, we logged 41 allegations under the Council's Anti-Fraud and Corruption Strategy, in all cases identified through the Council's confidential reporting hotline or notifications from departments. As a result of the allegations, 11 investigations were undertaken by Internal Audit, with the remainder being referred to local management, another local authority or assessed as requiring no further action. The following provides a summary of the investigation activity undertaken by Internal Audit in the last 12 months:

- Five investigations related to the overpayment of pensions identified through the National Fraud Initiative data matching exercise (see below). Two of these resulted in the full recovery of the overpayment, totalling £6,135. For the remainder, no further action was taken as a result of either being uneconomical to pursue or due to an inability to identify next of kin, where pensioners had died.

- An investigation into the theft of income from a secondary school resulted in an employee being dismissed. Following the investigation, a range of actions were also agreed to improve controls at the school.

- An investigation into a clear conflict of interest relating to a member of staff within Children's Services, whereby the individual concerned failed to declare, or seek approval for, secondary employment which conflicted with their County Council duties. They also breached the requirements of the Data Protection Act, resulting in dismissal for gross misconduct.

- One investigation was undertaken into the theft of ICT equipment at a school. Our work found that there were insufficient records to be able to identify exactly what property was removed or to confirm formal ownership of all ICT equipment stored in the school. Consequently, it was not possible to conduct an effective investigation into the potential theft. We were, however, able to provide advice and guidance to the school on appropriate internal controls and assist with its own internal management investigation.

- An investigation into potential over-claiming of mileage identified no specific evidence of any wrong-doing. The investigation concluded, however, that there was a need to improve controls within the service, specifically around the accurate recording of journeys and deducting home to work mileage from claims. Actions for improvement were therefore agreed with management.

- Two further cases remain open at the time of writing this report.

5.18 Any internal control weaknesses identified during our investigation work are reported to management along with appropriate recommendations for improvement. This work is also used to inform future internal audit activity.

5.19 As part of the Cabinet Office's National Fraud Initiative (NFI), the Council is required to provide a range of data in order to carry out a data matching exercise. Data matching involves comparing computer records held by one body against other computer records held by the same or another body for the purpose of identifying potential cases of error or fraud.

5.20 Internal Audit have co-ordinated the production and submission of this data on behalf of ESCC, covering a range of areas including payroll, pensions, creditors, residential care clients, concessionary travel passes, residents parking permits and clients in receipt of direct payments. The results of this cycle of NFI became available in February 2017 and are currently being investigated by the relevant services within the Council. We have requested that these are completed by September 2017 and we will report the results in due course.

5.21 As well as the investigation work referred to above, we continue to be proactive in the identification and prevention of potential fraud and corruption activity across the Authority and in raising awareness amongst staff. During 2016/17, this has included data analysis activities along with the delivery of both targeted and general counter fraud training to teams across the Council.

5.22 Whilst it is our opinion that the control environment in relation to fraud and corruption is satisfactory and the incidence of fraud is considered low for an organisation of this size and diversity, we continue to be alert to the risk of fraud. This includes working with local fraud hubs; the aim of which is to deliver a strong and co-ordinated approach to preventing, detecting and responding to fraud.

6. Internal Audit Performance

6.1 Public Sector Internal Audit Standards (PSIAS) require the internal audit service to be reviewed annually against the Standards, supplemented with a full and independent external assessment at least every five years. The following paragraphs provide a summary of our performance during 2016/17, including the results of our latest internal PSIAS assessment, an update on our Quality Assurance and Improvement Programme and the year end results against our agreed targets.

PSIAS

6.2 The new Standards cover the following aspects of internal audit, all of which have been assessed during 2016/17 by the Head of Assurance:

- Purpose, authority and responsibility;
- Independence and objectivity;
- Proficiency and due professional care;
- Quality assurance and improvement programme;
- Managing the internal audit activity;
- Nature of work;
- Engagement planning;
- Performing the engagement;
- Communicating results;
- Monitoring progress;
- Communicating the acceptance of risks.

6.3 The results of this work found a high level of conformance with the Standards with only a small number of actions identified. The main areas for improvement relate primarily to reviewing and updating our internal quality manual and ensuring Internal Audit staff maintain a record of their professional development and training activities. In all cases, work is continuing to address the required actions, many of which will be considered as part of our ongoing work to develop the Orbis partnership with internal audit colleagues from Surrey County Council and Brighton and Hove City Council.

Key Service Targets

6.4 Performance against our previously agreed service targets is set out in Appendix A. Overall, client satisfaction levels remain high, demonstrated through the results of our post audit questionnaires, discussions with key stakeholders throughout the year and annual consultation meetings with Chief Officers.

6.5 We have completed 92.1% of the 2016/17 audit plan, exceeding our target of 90%. As reported in 5.6 above, some outstanding reviews were nearing completion at year end, with all reports due to be finalised early in quarter 1 of 2016/17. We are currently exploring opportunities to improve the benchmarking arrangements for internal audit and will report on this in due course when further information becomes available.

6.6 Internal Audit is continuing to liaise with the Council's external auditors, KPMG, as part of which both teams are endeavouring to ensure that the Council obtains maximum value from the combined audit resources available.

6.7 In addition to this annual summary, CMT and the ABVCSSC will continue to receive performance information on internal audit throughout the year as part of our quarterly progress reports.

Appendix A

Internal Audit Performance Indicators

Measure	Source of Information	Frequency	Specific Measure / Indicator	RAG Score	Actual Performance Year End
Client Satisfaction					
Chief Officer/DMT	Consultation / Survey	Annual	Confirmation of satisfaction with service quality and coverage and feedback on areas of improvement.	**G**	Confirmed through Chief Officer consultations in December 2016 / January 2017, where high levels of satisfaction confirmed.
Client Managers	Satisfaction Questionnaires	Each Audit	>89%	**G**	89.7%
Section 151 Officer	Liaison Meetings	Quarterly	Satisfied with service quality, adequacy of audit resources and audit coverage.	**G**	Confirmed through ongoing liaison throughout the year and via approval of audit strategy and plan.
ABV&CSSC	Chairs Briefing and Formal Meetings	Quarterly / Annual	Confirmation of satisfaction with service quality and coverage and feedback on areas of improvement.	**G**	Confirmed through annual review of effectiveness and feedback from committee as part of quarterly reporting.
Cost/Coverage					
CIPFA Benchmarking	Benchmarking Report and Supporting Analysis Tools	Annual	1. Cost per Audit Day; 2. Cost per £m Turnover; equal to or below all authority benchmark average	**G**	Opportunities to improve benchmarking being explored. Last results available are for 2012, these show: 1. £316 against average of £325 2. £559 against average of £1,004
Local and National Audit Liaison Groups	Feedback and Points of Practice	Quarterly	Identification and application of best practice.	**G**	Ongoing via attendance at County Chief Auditors Network, Home Counties Audit Group and Sussex Audit Group.
Delivery of the Annual Audit Plan	Audits Completed	Quarterly	90% of Audit Plan Completed.	**G**	92.1%

Measure	Source of Information	Frequency	Specific Measure / Indicator	RAG Score	Actual Performance Year End
Professional Standards					
Compliance with professional standards	Self-Assessment against new Public Sector Internal Audit Standards	Annual	Completed and implementation of any actions arising.	**G**	Self-assessment completed, improvement plan in place and being actioned.
External Audit Reliance	Key Financial Systems Internal Audit Activity	Annual	Reliance confirmed.	**G**	Not applicable – KPMG no longer seek to place direct reliance on the work of internal audit.

Appendix B

Summary of Opinions for Internal Audit Reports Issued During 2016/17

Full Assurance:

(Explanation of assurance levels provided at the bottom of this document)

Audit Title	Department
Pension Fund External Control Assurance	BSD
Pension Fund Governance and Investments	BSD
Treasury Management	BSD

Substantial Assurance:

Audit Title	Department
External Funding, Grants and Loans	Corporate
Cultural Compliance Review – Facilities Management	BSD
Procure to Pay	BSD
Accounts Receivable	BSD
HR/Payroll	BSD
Orbis Integrated Budget	BSD
Cloud Computing	BSD
Cyber Security	BSD
ICT Asset Management Follow Up	BSD
Special Educational Needs and Disabilities (SEND) - Expenditure in Schools	CSD
Personal Budgets within Children's Services	CSD
Music Service Income	CSD
Troubled Families	CSD
Cultural Compliance – Looked After Children Community Family Work (Contact) Service	CSD
Controcc (15/16)	ASC
Public Health Local Service Agreements – Follow-Up	ASC
East Sussex Better Together – Programme Management	ASC
ASC Procurement	ASC
Funds Held By Trading Standards South East on Behalf of ESCC	CET
Freedom of Information, Environmental Information Regulations and Subject Access Requests (for Data Protection)	CET

Partial Assurance:

Audit Title	Department
Property Works – Pre Contract Checking Arrangements	BSD
Pension Fund Processes and Systems (15/16)	BSD
Compliance with Procurement Standing Orders	BSD
School Partnerships and Federations	CSD
Information and ICT E-Safety in Schools	CSD
Direct Payments	CSD/ASC

Other Audit Activity Undertaken During 2016/17 (including direct support for projects and new system initiatives and grant audits):

Audit Title	Department
Annual Governance Framework	GS
East Sussex Learning Portal	GS
National Fraud Initiative – Pension Investigations	BSD
Pensions Process Integration and Altair System Merge	BSD
On-Line Staff Claims System	BSD
Accounts Payable Data Analysis	BSD
SAP Development Advice	BSD
ICT Email Fraud Risk	BSD
Homecare Process	ASC
Proactive Anti-Fraud Income Assessment (Financial Assessments)	ASC
Highways DfT Incentive Fund	CET
Highways Contract – Lessons Learnt	CET
Broadband Annual Return to BDUK	CET
Community Infrastructure Levy – Audit Position Statement	CET

Schools

Higher Risk and Follow Up Audits (Delivered in house)	Opinion
Castledown Primary School – Follow-Up	Substantial Assurance
Ocklynge Junior School – Follow-Up	Substantial Assurance
Parkside Community Primary School - Follow-Up	Substantial Assurance
Pells CE Primary School	Substantial Assurance
Priory School	Substantial Assurance
St. Mark's CE Primary School	Substantial Assurance
Northiam CE Primary School – Follow-Up	Partial Assurance
Sacred Heart Catholic Primary School – Follow-Up	Partial Assurance
St. Thomas a Becket Catholic Infant School – Follow-Up	Partial Assurance
Western Road Community Primary School – Follow-Up	Partial Assurance
Langney Primary School	Minimal Assurance
Peacehaven Community School	Minimal Assurance

Randomly Selected Schools (Completed by Mazars)	
Beckley CE Primary School	Substantial Assurance
Blackboys CE Primary School	Substantial Assurance
Burwash CE Primary School	Substantial Assurance
Chiddingly Primary School	Substantial Assurance
Crowhurst CE Primary School	Substantial Assurance
East Hoathly CE Primary School	Substantial Assurance
Fletching CE Primary School	Substantial Assurance
Framfield CE Primary School	Substantial Assurance

Randomly Selected Schools (Completed by Mazars)	
Hellingly Community Primary School	Substantial Assurance
Herstmonceux CE Primary School	Substantial Assurance
Iklesham CE Primary School	Substantial Assurance
Netherfield CE Primary School	Substantial Assurance
Ninfield CE Primary School	Substantial Assurance
Pashley Down Infant School	Substantial Assurance
Peacehaven Heights Primary School	Substantial Assurance
Punnetts Town Community Primary School	Substantial Assurance
Rotherfield Primary School	Substantial Assurance
Sandown Primary School	Substantial Assurance
St. John's CE Primary School	Substantial Assurance
St. Michael's CE Primary School, Playden	Substantial Assurance
St. Pancras Catholic Primary School	Substantial Assurance
Stone Cross School	Substantial Assurance
The Haven CE/Methodist Primary School	Substantial Assurance
Ticehurst and Flimwell CE Primary School	Substantial Assurance
Annecy Catholic Primary School	Partial Assurance
Ashdown Primary School	Partial Assurance
Bourne Primary School	Partial Assurance
Firle CE Primary School	Partial Assurance
Groombridge St. Thomas CE Primary School	Partial Assurance
St. John's Meads CE Primary School	Partial Assurance
St. Michael's Primary School, Withyham	Partial Assurance
St. Peter's CE Primary School	Partial Assurance
Harbour Primary and Nursery School	Minimal Assurance
St. Mary the Virgin CE Primary School	Minimal Assurance
Staplecross Methodist Primary School	Minimal Assurance

Internal Audit Assurance Levels:

Full Assurance: There is a sound system of control designed to achieve the system objectives. Compliance with the controls is considered to be good. All major risks have been identified and are managed effectively.

Substantial Assurance: Whilst there is a sound system of control, there are a small number of weaknesses which put some of the system/service objectives at risk and/or there is evidence of non-compliance with some controls. Opportunities to strengthen controls still exist.

Partial Assurance: Controls are in place and to varying degrees are complied with but there are gaps in the control process, which weaken the system. There is therefore a need to introduce additional controls and/or improve compliance with existing controls to reduce the risk to the Authority.

Minimal Assurance: Weaknesses in the system of control and/or the level of compliance are such as to put the system objectives at risk. Controls are considered to be insufficient with the absence of at least one critical or key control. Failure to improve will lead to an increased risk of loss or damage to the Authority.

No Assurance: Control is generally weak or non-existent, leaving the system open to significant error or abuse and high risk to the system or service objectives. A high number of key risks remain unidentified and/or unmanaged.

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Report to: **Cabinet**

Date of meeting: **18 July 2017**

By: **Chief Operating Officer**

Title: **Ashdown Forest Trust Fund**

Purpose: **To inform Cabinet of the movements on the Trust Fund during 2016/17 and the closing position as at 31 March 2017.**

RECOMMENDATIONS

Cabinet is recommended to note the report and the Ashdown Forest Trust's Income and Expenditure Account for 2016/17 and Balance sheet as at 31 March 2017.

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1 Background

1.1 The Ashdown Forest Trust, a registered charity, was set out by a declaration of Trust in 1988. East Sussex County Council is the trustee and agrees grants made to the Ashdown Forest Conservators, from the Ashdown Forest Trust Fund.

2 Supporting information

2015/16 Accounts

2.1 Subsequent to the 2015/16 accounts being approved, the Independent Examination process has now been completed in accordance with Section 145 of the Charities Act 2011.

2.2 The Examiner's report is attached as Appendix A. It does not identify any issues that require any further action by the Council as the trustees.

2016/17 Accounts

2.3 The Trust's Income and Expenditure Account and Balance Sheet are set out in the attached Appendix B. The Income and Expenditure Account shows an annual deficit in 2016/17 of £2,596 due to additional 'one-off' legal costs incurred because of an increase in the volume of Wayleaves granted during the year.

2.4 The main source of income to the Trust relates to the rent from Royal Ashdown Forest Golf Club at £70,000 per annum. A new lease was signed with the Club in 2014.

2.5 The majority of the expenditure relates to the £65,100 annual grant paid to the Ashdown Forest Conservators.

2.6 The accumulative General Reserve totalled £157,266 at 31 March 2017.

2.7 A formal annual report and statement of accounts will be compiled in accordance with the Charity Commission's Statement of Recommended Practice (SORP) by the 31 January 2018, once the Independent Examiner report has been received.

3. Conclusion and Reasons for Recommendation

3.1 The Trust made an operating deficit of £2,596 during 2016/17 due is one-off costs. The General Reserve as at 31 March 2017 amounts to £157,266. This fund is available to finance expenditure which meets the Trust's objectives.

3.2 Cabinet is recommendation to note the final accounts for the Ashdown Forest Trust.

KEVIN FOSTER
Chief Operating Officer

Contact Officer: Graham Friday
Tel. No. 01273 881579
Email: graham.friday@eastsussex.gov.uk

LOCAL MEMBERS
Councillor Galley, Stogdon, Tidy and Whetstone

Independent examiner's report on the accounts

Report to the trustees/ members of	ASHDOWN FOREST TRUST		
On accounts for the year ended	31st March 2016	**Charity no (if any)**	800437
Set out on pages	1 to 16		

Respective responsibilities of trustees and examiner

The charity's trustees are responsible for the preparation of the accounts. The charity's trustees consider that an audit is not required for this year under section 144 of the Charities Act 2011 (the Charities Act) and that an independent examination is needed.

It is my responsibility to:

- examine the accounts under section 145 of the Charities Act,
- to follow the procedures laid down in the general Directions given by the Charity Commission (under section 145(5)(b) of the Charities Act, and
- to state whether particular matters have come to my attention.

Basis of independent examiner's statement

My examination was carried out in accordance with general Directions given by the Charity Commission. An examination includes a review of the accounting records kept by the charity and a comparison of the accounts presented with those records. It also includes consideration of any unusual items or disclosures in the accounts, and seeking explanations from the trustees concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit, and consequently no opinion is given as to whether the accounts present a 'true and fair' view and the report is limited to those matters set out in the statement below.

Independent examiner's statement

In connection with my examination, no matter has come to my attention (other than that disclosed below *)

1. which gives me reasonable cause to believe that in, any material respect, the requirements:
   - to keep accounting records in accordance with section 130 of the Charities Act; and

- to prepare accounts which accord with the accounting records and comply with the accounting requirements of the Charities Act

have not been met; or

2. to which, in my opinion, attention should be drawn in order to enable a proper understanding of the accounts to be reached.

* *Please delete the words in the brackets if they do not apply.*

Signed: [signature] **Date:** 25/01/2017

Name: Caroline Clarke

Relevant professional qualification(s) or body (if any): ACA

Address: 99 Western Road,
Lewes,
East Sussex BN7 1RS

Only complete if the examiner needs to highlight material problems.

Give here brief details of any items that the examiner wishes to disclose.

APPENDIX B

ASHDOWN FOREST TRUST

Income and Expenditure Account for the year ended 31 March 2016

2015/16	Income	2016/17
£		£
	Fees	0
(70,000)	Rent of Golf Course	(70,000)
(439)	Bank Interest	(276)
(70,439)		(70,276)
	Less Expenditure	
65,100	Conservators of Ashdown Forest – Grants	65,100
2,867	Fees	7,772
(2,472)	(Surplus)/Deficit	2,596

Balance Sheet as at 31 March 2016

2015/16		2016/17
£		£
1,200,000	Fixed Assets: Land and Buildings	1,200,000
	Current Assets:	
160,391	Cash at Bank	159,446
	Current Liabilities:	
(429)	Sundry creditors	(2,080)
1,359,962		1,357,366
	Representing:	
	Reserves	
1,200,000	Endowment Fund	1,200,100
159,962	General Reserve	157,266
1,359,962		1,357,366

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