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PETERBOROUGH CITY COUNCIL

HEALTH AND WELLBEING BOARD

MONDAY 24 SEPTEMBER 2012, 1.00 PM
Bourges/Viersen Rooms

AGENDA

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1.	**Apologies for Absence**	
2.	**Declarations of Interest**	
3.	**Minutes of the Meeting held 18 June 2012 and Matters Arising**	1 - 4
4.	**Transition Updates** a) Regional and National developments (Dr Sushil Jathanna) b) Clinical Commissioning Group (Andy Vowles) c) Public Health (Dr Andy Liggins - presentation)	5 - 16
5.	**Joint Strategic Victim And Offender Needs Assessment (Dorothy Gregson)**	17 - 24
6.	**Children's Safeguarding Annual Report (Judy Jones, Malcolm Newsam)** - to note and to identify any strategic issues arising for the Board	25 - 26
7.	**Healthwatch Ambassador (Wendi Ogle-Welbourn)**	27 - 30
8.	**Health and Wellbeing Strategies (Bob Dawson and Sue Mitchell)** a) Peterborough Health and Wellbeing Strategy b) Cambridgeshire Health and Wellbeing Strategy	31 - 34
9.	**Board Development (Sue Mitchell)** • Board Development Plan • Feedback from simulation event • Membership Review	35 - 36
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Committee Members:
Councillor Cereste (Chairman), Councillor Fitzgerald (Vice Chairman), Councillor Scott, Councillor Holdich, Gillian Beasley, David Whiles, Dr Mike Caskey, Dr Paul van den Bent, Terry Rich, Malcolm Newsam and Dr Andy Liggins
Substitutes: Dr Neil Sanders and Dr Harshad Mistry
Further information about this meeting can be obtained from Alex Daynes on telephone (01733) 45244701733 452447 or by email alexander.daynes@peterborough.gov.uk alexander.daynes@peterborough.gov.uk

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MINUTES OF A MEETING OF THE HEALTH AND WELLBEING BOARD
HELD AT THE TOWN HALL, PETERBOROUGH ON 18 JUNE 2012

Members Present: Councillor Wayne Fitzgerald – Cabinet Member for Adult Social Care (Vice Chairman)
Councillor Sheila Scott – Cabinet Member for Children's Services
Councillor John Holdich – Cabinet Member for Education, Skills and University
Gillian Beasley, Chief Executive, PCC
Malcolm Newsam, Executive Director Children's Services, PCC
Terry Rich, Director of Adult Social Care, PCC
Dr Andy Liggins, Director of Public Health, PCC
Dr Paul van den Bent, LCG/CCG Representative
David Whiles, Peterborough LINk – Pathfinder Local HealthWatch
Dr Mike Caskey, GP Commissioning Group

Also in Attendance: Tim Bishop, Assistant Director Strategic Commissioning, PCC
Nick Blake, Adult Social Care Transformation Manager, PCC
Bob Dawson, Independent Consultant, Health and Wellbeing
Alex Daynes, Senior Governance Officer, PCC
Sue Mitchell, Assistant Director Public Health
Wendi Ogle-Welbourn, Assistant Director, PCC
Kim Sawyer, Head of Legal Service, PCC
Andy Vowles, Chief Operating Officer, Cambridgeshire & Peterborough Clinical Commissioning Group
Dr Richard Withers, Borderline GPs

Item	Discussion and Decision	Action
1. Apologies for Absence	Apologies for absence were received from Councillor Cereste, Helen Edwards and Dr Sushil Jathanna.	
2. Declarations of Interest	David Whiles declared an interest in item 4 on the agenda, Peterborough Healthwatch, as a member of LINk.	
3. Minutes of the Setup Meeting held on 26 March 2012	The minutes of the setup meeting held on 26 March 2012 were approved as a true and accurate record subject to the following amendments: • Point 2 of Item 5 on page 3 should include "of the previous 2007 JSNA"; The Board was advised that no response had yet been received from the invitation to the meetings from Lincolnshire.	
5. Clinical Commissioning Group	The Chief Operating Officer, Cambridgeshire & Peterborough Clinical Commissioning Group (CCG) presented information to members of the Board on recent developments in clinical commissioning in Peterborough. Comments and responses to questions included: • It was considered that the benefits of having one CCG for the whole county including Peterborough was more beneficial than	

	two as all decision making would be in one organisation, greater financial security and flexibility and greater economies of scale would be realised; • Peterborough has different needs than rest of county, could review South Lincolnshire inclusion too, increasing population needs to be accounted for; • Peterborough already a unitary health provider, could be more beneficial to have its own CCG; • One CCG provides greater financial capacity and economies of scale; • High population growth and its risks would be better managed through a larger CCG; • Each Local Commissioning Group (LCG - 8 in total) would have an equal vote in the CCG to begin with; • Cannot see direct benefit to Peterborough of only one CCG, boundary issues (overlap) already being managed; • Greater capability of providing services (currently £60 per person to reduce to £25 per person) will be seen in one larger CCG, shared managerial expertise and risk management, CCG would not take all decisions from LCGs and LCGs would not support this; • Cllr Fitzgerald – further comments to be submitted to Andy Vowles outside the meeting and an update to come to the next meeting including views of other GPs.	AV
7. Peterborough Health and Wellbeing Strategy: Developing Themes and Priorities	The Independent Consultant, Health and Wellbeing, with the Director of Public Health presented information to the Board on the process for developing its first Health and Wellbeing Strategy in line with the requirements of the Health and Social Care Act 2012 including headline health issues across Cambridgeshire and Peterborough. Comments and responses to questions included: • Need to show plans for population increase and decrease; • Need greater awareness of health conditions being introduced through immigration; • This Board must inform commissioning priorities of other organisations; • Local groups must contribute to the strategy; Cllr Fitzgerald leaves the meeting, Cllr Holdich assumes the chair. • GPs were already familiar with the priorities and issues raised; The Board **AGREED** the criteria in the report to be used to determine the issues and needs to be included in the strategy as below: a) agreed to be the most important; b) require an innovative multi agency response; c) address the wider determinants of health; d) will deliver the most benefit to the health and wellbeing of the population; e) most likely to impact upon health inequalities, deprivation and disadvantage; and f) will most likely prevent future spend on expensive specialist services. Further comments and responses included: • Strategy must now turn into action;	

	• Financial strategy still required before moving forward; • Acute and Elderly Care plans should be included in Peterborough strategy; • Final version to come to September's meeting with launch in October. The Board **AGREED** the consultation strategy in the report as below: a) June HWBB agrees the broad criteria to underpin the selection of its priorities and associated actions; b) June/July, officer sub-group of the HWBB to develop a draft HWBS, based upon the JSNA findings and with reference to the HWBB criteria; c) July/August/September, consultation with the stakeholder bodies; d) September HWBB agrees final version of the HWBS; and e) October, Stakeholder engagement event to be held to launch the strategy and enable key commissioning bodies to incorporate into commissioning intentions for 2013/14 and beyond and to feed into the CCG authorisation process. Dr Mike Caskey leaves the meeting. Kim Sawyer leaves the meeting. Gillian Beasley leaves the meeting. Malcolm Newsam leaves the meeting.	
8. The Development of the Health and Wellbeing Board	The Assistant Director Public Health introduced a report and presented information providing details of development opportunities available to the Health and Wellbeing Board including a Leadership Academy and a simulation event in September. Comments and responses to questions included: • Need to develop a programme for board members to attend.	SM
6. Public Health Transition Progress Report	The Director of Public Health introduced a report updating Members on progress towards the transition of Public Health from the NHS to the City Council. Members were satisfied with progress.	
4. Peterborough Healthwatch	The Adult Social Care Transformation Manager and the Assistant Director Strategic Commissioning introduced a report providing a detailed project plan to the board. The Board was advised that a new head of the project will be provided by Serco in July and would need to consider whether regional commissioning was most effective.	
9. Learning Disability sub-group	The Assistant Director Strategic Commissioning introduced a report for the Board to note the development of the sub-group, proposing that it be a sub-group of this Board. Comments and responses to questions included: • Would cover adults only along with transitions; • A Children's Services representative would be included in the group.	

10. Health and Wellbeing Board Agenda Plan 2012-13	The Board considered the agenda plan for the coming year and agreed to include a couple of main items only for each agenda.	
	The Board was further advised that the Cambridgeshire and Peterborough Pharmaceutical Group had shown and interest in the Board and it was agreed its input to be welcome.	

3.15 pm

Chairman

Relating to:	**ACTIONS**	**By whom**	**By when**
Clinical Commissioning Group	An update to come to the next meeting including views of other GPs.	Andy Vowles	24 September
Development of the Health and Wellbeing Board	Develop a programme for board members to attend	Sue Mitchell	Ongoing

NHS
Commissioning Board
A special health authority

Securing Excellence in Commissioning Primary Care: Key Facts

June 2012

1. From April 2013, the NHS Commissioning Board (NHSCB) will be established and will be accountable for improving outcomes for patients. It will ensure that:

   - the services it commissions are commissioned in ways that support consistency not centralisation
   - there is consistency in achieving high standards of quality across the country.

2. The NHSCB will work through its national, regional and local area teams to discharge these responsibilities.

3. Our ambition for the new primary care commissioning arrangements is for:
   - A common, core offer for patients of high quality, patient-centred primary care services
   - Continuous improvements in health outcomes and a reduction in inequalities
   - Patient engagement and empowerment and clinical leadership and engagement visibly driving the commissioning agenda
   - The right balance between standardisation/consistency and local empowerment/ flexibility.

Roles and responsibilities

4. At a national level, the NHSCB will work with a range of stakeholders to determine the outcomes expected from primary care and the main characteristics of high quality services, and use this as a basis for developing national contracts and for developing national frameworks for local contracts and local commissioning.

5. At a regional and local level, the NHSCB will work in partnership with CCGs and other local networks to ensure that there is a locally responsive approach, supported by joint health and wellbeing strategies, joint strategic needs assessments (JSNAs) and pharmaceutical needs assessments (PNAs).

6. The NHSCB will also be responsible for planning, securing and monitoring an agreed set of primary care services.

7. CCGs will commission the majority of NHS services for their populations – apart from primary care, specialised services and public health. They will

also have a statutory responsibility to support the NHSCB to improve the quality of primary medical care.

8. Some support functions will also be discharged in the NHSCB local area teams, probably through the primary care commissioning arrangements. These include the local responsible officer functions and the local management of the performer lists.

9. The responsibility for the vast majority of payment and associated functions will transfer to the NHSCB and will also be discharged through the primary care commissioning arrangements.

10. The arrangements for these services, commonly known as Family Health Services (FHS), are currently discharged in the following ways:

- Through a PCT held contract with an external supplier
- Through a shared services agreement between PCTs
- Internally (in-house) within a PCT.

11. In April 2013, contracts will be transferred from PCTs to the NHSCB; shared services arrangements and in-house arrangements will, subject to local area team implementation arrangements, be transferred as they are to the NHSCB.

12. There will be a common specification for FHS services transferred to the NHSCB.

13. The NHS Business Services Authority provides services, including pharmaceutical and dental payments, and these arrangements will continue.

The single operating model for primary care commissioning

14. The new arrangements comprise a single operating model for the commissioning of primary care services, which up until now has been done differently by PCTs and their predecessors. The operating model describes the system by which we will use the £12.6bn the NHS spends on commissioning primary care to secure the best possible outcomes.

15. The benefits we hope to achieve from this change are:

- Greater consistency and fairness in access and provision for patients, with an end to unjustifiable variations in services and a reduction in health inequalities
- Better health outcomes for patients as primary care clinicians are empowered to focus on delivering high quality, clinically-effective, evidence-based services
- Greater effiences in the delivery of primary care heath services through the introduction of standardised frameworks and operating procedures.

16. Local, regional and national teams will work in one single system. The local element of the system includes people working in the local area

teams of the NHSCB, CCGs, local authorities and health and wellbeing boards. Most commissioning activity will take place locally, close to contractors and close to patients. The central element will provide the framework to ensure consistency in primary care commissioning.

17. To ensure all parts of the system have the same core intelligence to draw comparisons and make decisions, there will be a single flow of standardised information. Locally derived intelligence, including that relating to patient experience, will be processed at national level and fed back into the system.

Local professional networks

18. Local professional networks (LPNs) will secure clinical involvement in the day to day operational and strategic commissioning processes undertaken by the NHSCB. The evidence of clinical engagement in commissioning is well understood and local professional networks provide a mechanism to do this for dentists, pharmacists and optometrists.

19. Local professional networks have been designed to operate at three levels. The core of the network comprises a lead clinician (or lead clinicians depending on size), such as a dental adviser, a public health specialist and a commissioning manager. This core role will be to identify a network of other clinicians who, dependent on resources, engage in service development and improvement activities. This could include secondary care as well as primary care clinicians. The third level comprises all providers and is a communication and engagement mechanism.

20. Local professional networks are integral to the local area team. They do not stand alone nor are they just for the purpose of engagement. PCTs are currently testing LPNs and will continue to do so during transition.

Role of CCGs in primary care commissioning

21. CCGs will have a critical role in providing clinical leadership to deliver high quality, responsive and safe services for patients.

22. CCGs are very well placed to support quality improvement in primary medical care in partnership and with the support of the NHS CB. However, CCGs will not be responsible for contractual compliance which will be the responsibility of the NHS CB as the national commissioner of primary care services.

23. CCGs are expected to do the following

- provide evidence of benchmarking on primary medical care outcome indicators across member practices
- state their commitment to openness and sharing of data/information (supported by mechanisms/framework to enable sharing)

- have a clear approach to peer review and conversations about improvement across member practices which include assessment of development needs, intended actions and anticipated impact

- to identify primary care commissioning needs within their strategic plans

- to work collaboratively with the NHSCB to address variability and service improvements, to engage patients and the public and to develop any shared models of commissioning support.

Next steps

24. In the coming months, the NHSCB will provide more details about the primary care operating arrangements including:

- The role of the responsible officer
- How dental commissioning will work
- Local professional networks in detail
- Common operating procedures, including performance management
- GP premises arrangements
- GP IT arrangements
- Transitional arrangements for payment and other associated services (FHS).

25. The NHSCB will also set out further information in due course about its overall operations that are not exclusive to primary care commissioning but are important in how the system will work, including:

- The design of the local area teams and sectors
- Patient engagement, including handling complaints
- Information and intelligence, including patient insight
- Financial systems and processes
- Strategic estates development.

26. The operating models for prison and offender health, military health and those public health services commissioned by the NHSCB (i.e. screening, vaccinations, child health for 0-5 year olds and public health for people in prisons) will also be published shortly and each one will have some implications for primary care commissioning arrangements.

27. The NHS CB is working with stakeholders to develop common operating policies and procedures to support local area teams, including contractual management frameworks and guidance on dealing with concerns about individual performance, issues and incidents.

28. The new arrangements as described in the document will be kept under review. The NHSCB will ensure they are achieving what they are designed to do and, that they remain fit for purpose within the context of the emerging commissioning system.

HEALTH AND WELLBEING BOARD	AGENDA ITEM No. 4(b)
24 SEPTEMBER 2012	PUBLIC REPORT

Cabinet Member(s) responsible:	Councillor Wayne Fitzgerald – Cabinet Member for Adult Social Care	
Contact Officer(s):	Andy Vowles, Chief Operating Officer, Cambridgeshire and Peterborough Shadow Clinical Commissioning Group	Tel. (01223) 725575

TRANSITION UPDATE: CLINICAL COMMISSIONING GROUP

R E C O M M E N D A T I O N S	
FROM : Cambridgeshire and Peterborough Shadow Clinical Commissioning Group	**Deadline date : N/A**
That the Board receives this update report outlining the current position relating to the development and authorisation of the Cambridgeshire and Peterborough Clinical Commissioning Group.	

1. ORIGIN OF REPORT

1.1 This report is submitted to the Health and Wellbeing Board as part of its agenda for the meeting to be held on 24th September 2012.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to provide for the Board an update on the transition to the establishment of the Cambridgeshire and Peterborough Clinical Commissioning Group as a statutory commissioning body from 1st April 2013.

2.2 This report is for the Health and Wellbeing Board to consider under Terms of Reference No 3.4, that is, "To consider options and opportunities for the joint commissioning of health and social care services for children, families and adults in Peterborough to meet identified needs (based on the findings of the Joint Strategic Needs Assessment) and to consider any relevant plans and strategies regarding joint commissioning of health and social care services for children and adults".

3. BACKGROUND – BRIEF OVERVIEW

3.1 The Shadow Clinical Commissioning Group (the CCG) comprises its member Practices and covers a population of over 850,000 people. If authorised as a statutory commissioning body by the NHS Commissioning Board later this year, the CCG will be one of the largest in the country.

3.2 From the start, our objective was to develop a devolved model of operation with clinical commissioning at its heart. We have also sought to achieve a smooth transition to the national model of Clinical Commissioning by building key elements of the new system well before 2013.

3.3 Clinical Commissioners will be responsible through the CCG for the following:

- Commissioning hospital and community health services – but not specialist services
- Managing prescribing based on clinical and cost effectiveness

- Developing a vision for commissioning local health and health care services with member practices, other professionals and key partners
- Working with the Local Authorities, play a full part as a member of the Health and Wellbeing Boards
- Shaping the culture, behaviours and relationships across the localities
- Implementing structures and systems to safeguard transparency, accountability and good governance

3.4 The CCG will produce and consult on an over-arching Annual Plan setting out the strategic and local commissioning priorities. The plan will take account of the Health and Wellbeing Strategies, the views of the Health and Wellbeing Boards and the work of Local Commissioning Groups.

4. CURRENT POSITION

The CCG's Vision and Values

4.1 These have been agreed with member practices and with the Governing Body as follows:

Our Mission

To empower our communities to keep healthy and to ensure fair access to good quality healthcare for all those who need it.

Our Vision

NHS Cambridgeshire & Peterborough Clinical Commissioning Group will be led locally by clinicians in partnership with their community, commissioning quality services that ensure value for money and the best possible outcomes for those who use them.

Our Values

- Patient focused - Our population, patients and their families are at the centre of our thoughts and actions we will commission care tailored to their needs
- Quality driven - We will constantly strive to be the best we can be as individuals and as an organisation and we will ensure that this is reflected in our commissioning decisions
- Work locally – Through our Local Commissioning Groups working within their communities
- Excellent – Our aim is to be an excellent organisation, for our communities, clinicians and our staff

Leadership

4.2 We have recruited successfully to the key leadership positions. An overview of the posts is attached as Appendix 1.

Recruitment to the remaining staffing structure is progressing well – we are approaching the final phase.
The Peterborough and Borderline LCGs have created A Joint Commissioning Forum which PCC are a member and will be the vehicle to discuss future Joint Commissioning strategies and Plans.
Beneath this forum the Commissioners have a Transformation Board which enables Commissioners and statutory providers/ Independent Sector and Voluntary Sector Providers to develop Projects within this joint governance structure. Membership of the Peterborough Local Commissioning Group and the Joint Commissioning Forum are attached at Appendix 2.

NHS Commissioning Board Authorisation

4.3 The purpose of authorisation is to assure the NHS Commissioning Board that CCGs are able to:

- commission the majority of health care safely;
- discharge their stewardship of NHS budget responsibly; and
- exercise their functions to improve quality, reduce inequality, improve efficiency and deliver better outcomes within resources.

4.4 Within Cambridgeshire and Peterborough, a comprehensive stakeholder survey has been conducted by Ipsos Mori on behalf of the NHS Commissioning Board. Following a period of validation, the results will be available to the CCG for wider discussion and, where required, action planning.

4.5 We have now submitted a comprehensive suite of evidence to the NHS Commissioning Board in support of our request for formal authorisation to become a statutory commissioning group with effect from 1st April 2013.

4.6 The next steps are for the NHS Commissioning Board to:

a) undertake a formal assessment of our submission, the evidence we have provided and whether this meets the authorisation criteria set by the Commissioning Board
b) undertake a formal site visit and hold an assessment by panel on Friday 26th October 2012
c) notify the CCG of their decision by the end of November latest

5. CONSULTATION

Information provided during the meeting will be drawn from a range of sources.

6. ANTICIPATED OUTCOMES

It is anticipated that members of the Health and Wellbeing Board will be fully briefed on the current position relating to the development of clinical commissioning in Cambridgeshire and Peterborough.

7. REASONS FOR RECOMMENDATIONS

To ensure that the Board is kept up to date with current developments.

APPENDIX 1

Chair and Lay Members

Maureen Donnelly, Chair (designate)

Maureen is a Maths Graduate and has spent her career in the telecoms sector. She was head of marketing for BT before leaving to become Commercial Director of Colt Telecom in the City of London. Since then she has set up two telecoms companies (in Germany and in the UK) and now works as an advisor on commercial and acquisition strategy. Maureen, who lives in Cambridge, is Chair of Digital Region, a broadband telecoms company in South Yorkshire and Chair of the Corporation of Hills Road Sixth Form College.

Peter Southwick, Lay Member (designate)

Peter has a first degree and a PhD in Metallurgy from Cambridge University. He spent much of his career in the USA, in the steel industry. His last position in the USA was President and Chief Executive Officer of Ispat Inland Inc (subsequently Mittal Steel USA and now Arcelor Mittal), which was followed by promotion in 2003 to the post of Corporate Director, Quality Assurance, based in London. In the 1990s, he was also a Board member of his local branch of United Way, the largest charitable fundraising organisation in the USA.

Glen Clark, Lay Member (designate)

Glen, who lives in Wicken, near Ely is Finance Director of Marshall of Cambridge Aerospace. He is also a Board member of a number of their subsidiaries, including four companies based overseas - and takes a lead role in Corporate Governance.

Rebecca Stephens, Lay Member (designate)

Rebecca is Founder and Director of Syntax Communications and has previously been a non-executive director at Cambridgeshire and Peterborough NHS Foundation Trust. She has a long career as a journalist which culminated in her being the Editor and Editorial Director for the Peterborough Evening Telegraph from February 2004 until June 2007. Rebecca has also created a corporate social responsibility forum for Peterborough with city-wide engagement from private, public, voluntary, community and charitable sectors. Rebecca's work has given her a wide knowledge of voluntary and community sectors in Greater Peterborough as a former board member of the Greater Peterborough Partnership and Peterborough City Centre Management Executive. She has strong links with a number of community groups and charities in the area and helped to develop the Pride in Peterborough Award and the Women of Achievement award.

Directors

Dr Neil Modha, Chief Clinical Officer (designate)

Dr Neil Modha is a working GP at Thistlemoor Medical Centre in Peterborough, where he has helped to transform the practice into a GP-led training practice with eight doctors, serving 11,500 patients. Neil was previously a member of the shadow Cambridgeshire and Peterborough Clinical Commissioning Group, taking responsibility for acute commissioning. He has been involved in the Finance and Performance sub-committee.

Andy Vowles, Cambridgeshire Chief Operating Officer (designate)

Prior to joining NHS Cambridgeshire, Andy was Deputy Director of Commissioning for NHS East of England. His portfolio included co-ordinating East of England commissioning policy, supporting the development of commissioning expertise within PCTs, and leading on a range of policy areas

including primary care and practice based commissioning. Before joining NHS East of England, Andy was Head of Performance for Essex SHA, and has also worked for a number of national bodies including the Audit Commission and the Department of Health. Andy lives in Cambridge with his wife and three young children.

Jessica Bawden, Director of Communications, Membership and Engagement (designate)

Jessica joined NHS Cambridgeshire from the National Housing Federation, the trade body for housing associations. She has over fifteen years' experience of public campaigning in the not-for-profit sector including working for Age Concern, the business campaign group, London First and the pro-European campaign, Britain in Europe. She also spent five years working in Parliament. She is passionate about social change and believes that successful change happens only when the public's views are truly heard. Jessica was educated at Oxford University and is married with four children.

Jill Houghton, Director of Quality, Safety and Patient Experience (designate)

Jill is a registered nurse, midwife and health visitor. She has had experience in all sectors of healthcare, clinically and managerially within primary and secondary care, at a Health Authority, Strategic Health Authority and at board level in a Primary Care Group and two Primary Care Trusts as a Director with responsibilities for patient services, quality, safeguarding and infection control. She have been a member of the Nursing and Supportive Care Guidelines Advisory Panel at the National Institute of Health and Clinical Excellence and undertaken national projects, in relation to patient safety and quality, with the Leadership Centre, the National Patient Safety Agency, the Department of Health and the Chief Medical Officer's Office. Jill was most recently the Director of Nursing for West Mercia Cluster which consisted of four Primary Care Trusts and six Clinical Commissioning Groups. Jill's role is to ensure commissioning for quality is delivered through the changing NHS Architecture working with providers, Local Authorities and particularly the shadow Clinical Commissioning Group to ensure our population receive the best quality of care possible within available resources.

Victoria Corbishley, Director of Performance and Delivery (designate)

Victoria joined the CCG from NHS Midlands and East Strategic Health Authority where she was responsible for running the performance and informatics teams across the SHA Cluster. Before the SHA, Victoria was one of the first employees at Monitor, the Independent Regulator of NHS Foundation Trusts where she spent time assessing applicant trusts, overseeing compliance at existing Foundation trusts and developing policy. Victoria is a qualified accountant and has worked in the I.T. industry, with companies such as IBM and Xerox, and as a management consultant.

Harper Brown, Director of Commissioning and Contracting (designate)

Harper joins us from Great Yarmouth and Waveney PCT where he was Deputy Chief Executive and he was Executive Director of Integrated Care at Norfolk & Great Yarmouth and Waveney PCT.

Tim Woods, Chief Finance Officer (designate)

Tim was previously Executive Director of Finance at Derbyshire Healthcare NHS Foundation Trust.

APPENDIX 2

Peterborough LCG Board

GP Members

Dr Michael Caskey (Chair)	Dr Mohsin Laliwala	Dr Harshad Mistry
Dr Neil Modha	Dr Neil Sanders	Dr Paul van den Bent

Patient Representative Members

Barbara Cork	Brian Parsons

Practice Manager Representative Member

Andy Slater

Officers/Management Support

Cathy Mitchell	Sarah Shuttlewood	Caroline Hall
Harriet Murch/Ron Smith	Paul Whiteside	

Others who may attend

Maureen Donnelly (CCG Chair)	Dr Neil Modha (CCG Accountable Officer)	Andy Vowles (CCG Chief Operating Officer)
Sharon Fox (CCG Board Secretary)		

Peterborough Commissioning Joint Forum

GP Members

Dr Michael Caskey	Dr R Withers	Dr A Liggins
Dr Paul van den Bent	Dr G Howsam	

Patient Representative Members

Barbara Cork	Brian Parsons	Michael Bacon

PCC Representatives

Terry Rich	Malcolm Newsom	Wendy Ogle-Welbourn

Officers/Management Support

Catherine Mitchell	Sarah Shuttlewood	Caroline Hall
Ron Smith/Harriet Murch	Paul Whiteside	

Others who may attend:

Maureen Donnelly (CCG Chair)	Dr Neil Modha (CCG Accountable Officer)	Andy Vowles (CCG Chief Operating Officer)
Sharon Fox (CCG Board Secretary)		

HEALTH AND WELLBEING BOARD	AGENDA ITEM No. 4(c)
24 SEPTEMBER 2012	PUBLIC REPORT

Cabinet Member(s) responsible:	Cllr Fitzgerald, Cabinet Member for Adult Social Care	
Contact Officer(s):	Andy Liggins, Director of Public Health	Tel. 01733 758526

PUBLIC HEALTH TRANSITION PROGRESS REPORT

R E C O M M E N D A T I O N S	
FROM : Director of Public Health	**Deadline date :** N/A
1. To note the latest progress being made in the transition arrangements for Public Health.	

1. ORIGIN OF REPORT

1.1 This report is submitted to the Health and Wellbeing Board in order to update Members on progress towards the transition of Public Health from the NHS to the City Council.

2. PURPOSE AND REASON FOR REPORT

2.1 This report is for the Board to consider under its Terms of Reference No. 3.3 ‘to oversee the transition and delivery of the designated public health functions in Peterborough’.

3. PUBLIC HEALTH TRANSITION PROGRESS REPORT

3.1 A transition update report was submitted to the Board at its meeting on 18 June 2012 at which the Board indicated its satisfaction with progress.

3.2 Since 18 June, work has continued and transition arrangements are progressing well.

3.3 Further detail on the transition work to date will be provided in a presentation at the meeting.

4. CONSULTATION

4.1 To be provided in a presentation at the meeting.

5. ANTICIPATED OUTCOMES

5.1 The anticipated outcome for the transition of Public Health into the Local Authority will be to have a fully transformed and integrated public health function within the Council by 1 April 2013.

6. REASONS FOR RECOMMENDATIONS

6.1 The transition of the Public Health service into the Local Authority is a statutory requirement which will need to be complete for April 2013.

7. ALTERNATIVE OPTIONS CONSIDERED

7.1 Various options have been considered as to how the transition will take place and what specific elements of the Public Health service will be integrated within the Council. Once fully developed, these options will be presented in this forum.

8. IMPLICATIONS

8.1 There are implications across the whole Council as a result of this transition. The transition programme has developed plans across each of the following areas to ensure the transition is completed as smoothly as possible:

- Governance/Legal/Procurement
- Finance
- Human Resources
- ICT
- Live Projects
- Information Management/Data Security
- Communications
- Performance Management
- Business Continuity & Risk Management

9. BACKGROUND DOCUMENTS

Used to prepare this report, in accordance with the Local Government (Access to Information) Act 1985)

None.

HEALTH AND WELLBEING BOARD	AGENDA ITEM No. 5
24 SEPTEMBER 2012	PUBLIC REPORT

Cabinet Member(s) responsible:	Insert name and portfolio of Cabinet Member(s)	
Contact Officer(s):	Dr Dorothy Gregson, Chief Executive Cambridgeshire Police Authority	01480 422463

DRAFT VICTIM AND OFFENDER NEEDS ASSESSMENT - A CONDUIT FOR FUTURE JOINED UP WORKING?

R E C O M M E N D A T I O N S	
FROM : Dr Dorothy Gregson, Cambridgeshire Police Authority	**Deadline date :** Ongoing
The Board is asked to consider how the new Police and Crime Commissioner might work effectively with the Shadow Health and Wellbeing Board and the Safer Peterborough Partnership in the future.	

1. ORIGIN OF REPORT

1.1 This report is submitted to the Health and Wellbeing Board following a request from the Chief Executive of the Cambridgeshire Police Authority.

2. PURPOSE AND REASON FOR REPORT

2.1 To inform the Board of the authority's strategic plans to enable completion of the county's first Police and Crime Plan by March 2013 using a Victim and Offender Needs Assessment as an evidence base.

2.2 This report is for the Board to consider under its Terms of Reference No. 1.1, 'to provide a strategic leadership forum focussed on securing and improving the health and well being of Peterborough residents'.

2.3 To seek the views of Board members on how the Draft Victim and Offender Needs Assessment could engender a joined up health and police/crime/community safety approach to strategy setting.

3. BACKGROUND

3.1 The Police Reform and Social Responsibility Act 2011, which abolishes police authorities, places a responsibility on newly elected Police and Crime Commissioners to issue a Police and Crime Plan within the financial year they are elected. Commissioners must keep this plan under review and may at any time vary the plan, or issue a new plan.

3.2 Commissioners must consult Chief Constables on their draft plans before they are sent to the police and crime panels for consideration.

3.3 The plans should set out the Commissioner's police and crime objectives for policing and reducing crime and disorder. In exercising this duty the Commissioner must 'have regard' to

the crime and disorder reduction priorities set by partners, the strategic direction of the criminal justice system and the national strategic policing requirement.

3.4 The Commissioner and responsible authorities ‘must act in co-operation with each other’ to reduce crime and disorder and provide an efficient and effective criminal justice system. This reciprocal arrangement has been described by the Home Office as ‘broadly defined’ to allow for local arrangements.

Victim and Offender Needs Assessment

3.5 The Draft Victim and Offender Needs Assessment provides all agencies with a picture of the needs of both victims and offenders which hasn’t been considered before. There is clearly much cross-over in the work undertaken by all agencies to meet their needs. While the move towards co-commissioning is a long way off, members of the Board are urged to consider how this work could inform their future strategy setting and how the new Police and Crime Commissioner might work effectively with the Shadow Health and Wellbeing Board and the Safer Peterborough Partnership in the future.

3.6 It has been recognised nationally that authorities need to ensure the building blocks to draft the first police and crime plans are in place before the November elections.

3.7 To create this foundation for Cambridgeshire and Peterborough, the authority, steered by an inter-agency group, commissioned Cambridgeshire County Council’s Research Unit to conduct an assessment of the needs of victims of crime and offenders in Cambridgeshire and Peterborough.

3.8 The assessment is ‘people’ focused. It allows us, for the first time, to have a joint understanding with partners of the numbers of victims and offenders and their needs. This complements, but does not duplicate, the existing police and community safety partnership strategic assessments and enables responsible authorities to develop a more comprehensive view of how crime and disorder can be jointly addressed.

3.9 The needs assessment identifies concepts such as ‘prolific’ offending, ‘persistent’ offending, the length of criminal careers and how they fit into the local context. It reveals most, but not all, persistent offenders within Cambridgeshire and Peterborough began their offending in the area at a young age. Many of the traits of those young people who could go on to be become future persistent offenders are identifiable, and given the right interventions these young people could be successfully diverted away from crime. This would ensure a positive start to life for many children and their families.

3.10 The needs assessment also identified the link between high crime rates and a concentration of both victims and offenders in deprived areas. The focus on high risk offenders needs to be balanced with “upstream” preventative partnership work which creates a safe environment and helps build strong communities, wellbeing and mental health where offending behaviour is reduced and victims and witnesses are well supported by their communities. The Family Intervention Projects are examples of this type of work.

3.11 Several workshops with colleagues from a range of agencies were held to inform the needs assessment. At these sessions several victim groups were identified. The first group identified was those at high risk of serious harm such as victims of domestic abuse (the largest group in this section), victims of sexual violence, hate crime, honour-based violence and people bereaved by murder, manslaughter or as a result of road traffic incidents. The needs assessment identified that broadly speaking these groups of victims require specialist protective services and long term support. Domestic abuse has identified in the draft Health and Wellbeing Strategy for Peterborough as part of the ‘Securing the foundations of good health’ making this an important shared agenda.

3.12 The crucial role played by witnesses in supporting victims and ensuring offenders are brought to justice is touched upon in the needs assessment. Further work in this area has now been commissioned to ensure the Commissioner and responsible authorities get a

clearer picture of the needs, both met and unmet, of this group. The need to bolster information on the cross cutting theme of mental health has also been highlighted, which again reflects a shared agenda.

4. CONSULTATION

4.1 Significant consultation took place during the creation of the Draft Victim and Offender Needs Assessment; the draft police and crime objectives which will be available to the incoming Commissioner will be drafted in consultation with partners.

4.2 A Partners' workshop is being held on September, 27 to consider the results of the Draft Victim and Offender Needs Assessment. It will enable those with a duty of partnership with the new Commissioner to feed into the work to inform the first Police and Crime Plan.

5. ANTICIPATED OUTCOMES

5.1 The Draft Victim and Offender Needs Assessment provides all agencies with a picture of the needs of both victims and offenders which hasn't been considered before. There is clearly much cross-over in the work undertaken by all agencies to meet their needs. While the move towards co-commissioning is a long way off, members of the Board are urged to consider how this work could inform their future strategy setting, and how the new Commissioner might work effectively with the Shadow Health and Wellbeing Board and the Safer Peterborough Partnership in the future.

6. REASONS FOR RECOMMENDATIONS

6.1 This is a new era of partnership work and planning. It is important that a joint understanding is created regarding how all partners can fulfil the 'reciprocal' partnership duty placed up on them to reduce crime and disorder.

6.2 The work of Safer Peterborough Partnership has provided an effective forum to drive joint work to reduce crime and promote stronger communities. The Partnership's strategy has informed the Police Authority's strategy and vice versa. Linkages with health strategy have been less well developed.

6.3 The creation of the Draft Victim and Offender Needs Assessment, steered by representatives from the responsible authorities and voluntary sector, initiated the dialogue between partners. This assessment will then be used, alongside the Constabulary's Risk Assessment, to inform discussions between key stakeholders on what issues should be included in the police and crime objectives made available for the incoming Commissioner. These discussions will take place at a Partners' Workshop on September 27 hosted by the Police and Crime Partnership Transition Working Group.

6.4 With the importance of safe and stronger communities to health and wellbeing it is going to be important to understand the links between the work of the Commissioner and their new Police and Crime Plan, the Safer Peterborough Partnership and the Health and Wellbeing Board. The Draft Victim and Offender Needs Assessment provides an evidence base of use to all three.

7. ALTERNATIVE OPTIONS CONSIDERED

At this stage no specific proposals are being put forward, although it is suggested that the Police and Crime Commisioner is a member of both the Safer Peterborough Partnership and the Health and Wellbeing Board.

8. IMPLICATIONS

Section 17 of the Crime and Disorder Act 1998 (as amended by the Police and Justice Act 2006) for the Police and Local Authorities, set out that ‘Without prejudice to any other obligation imposed on it, it shall be the duty of each authority to which this section applies to exercise its various functions with due regard to the likely effect of the exercise of those functions on, and the need to do all it reasonably can prevent,

a) Crime and disorder in its area (including anti-social behaviour and other behaviour adversely affecting the local environment) and,

b) The misuse of drugs, alcohol and other substances in its area.’

Clinical Commissioning Groups will be responsible authorities under the Crime and Disorder Act.

9. BACKGROUND DOCUMENTS

Victim and Offender Needs Assessment
Police Authority Transition Plan

Victim and Offender Needs Assessment
Executive Summary
July 2012

Assessment project led by the Research and Performance Team, Cambridgeshire County Council on behalf of Cambridgeshire Police Authority

This is the first time that a joint needs assessment for victims and offenders has been carried out for Cambridgeshire and Peterborough. It was commissioned by Cambridgeshire Police Authority and overseen by a steering group of representatives from a range of local agencies.

The approach was chosen to reflect the way people think about crime, which is based on who they are, where they live and their own or their family's experiences, rather than being primarily statistically-led.

The assessment uses qualitative opinions from a series of bespoke consultation workshops with people who work with victims and offenders, as well as numerical data collected locally. It paints a picture of the numbers of victims and offenders in Cambridgeshire and Peterborough and provides a broad overview of the needs of sub-groups within the population.

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Key Findings - Victims

- Since 1995 the level of crime in England and Wales has fallen[1]. An individual's likelihood of being a victim has fallen with the fall in crime, however being a victim is still a reality for many people.
- Cambridgeshire Constabulary recorded 32,260 victims of crime (excluding businesses) during the calendar year 2011.
- Of these victims 85 per cent were aged between 16 and 65. A total of 80 per cent were white British, or from other white backgrounds e.g. European. A third of victims came from the 20 per cent most deprived areas of Cambridgeshire and Peterborough.
- The British Crime Survey suggests that many people do not report crimes and that at least one in five people in the country are actually victims of crime each year. Applied to the population of Cambridgeshire and Peterborough this infers more than 100,000 people (aged 10-65) could have been a victim of some sort of crime in the last 12 months.

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[1] British Crime Survey (BCS) 2010/11: This is a systematic study of victimisation in England and Wales carried out through interviewing a large sample of the population. The BCS provides a different reflection of crime compared to police crime statistics since it includes unreported offences and those considered too trivial to be worth reporting by the victims.

- The likelihood of someone reporting a crime can depend on the nature of the crime they have experienced. For example the British Crime Survey suggests almost 100 per cent of people who have had their car stolen will contact the police, while only 11 per cent of victims report serious sexual assaults.

- There is also variation in repeat victimisation. Those experiencing domestic abuse are more likely to suffer from repeat victimisation than any other type of victim. Cambridgeshire Constabulary records nearly 13,000 domestic abuse incidents each year; while the actual number of incidents experienced could be significantly higher.

- The impact of becoming a victim of crime varies from person to person. A relatively minor offence can have a serious outcome for a vulnerable victim. All agencies need to appreciate this and take a victim-centred approach; responding to the needs of the individual, rather than the crime type suffered. The demand for victim support services outweighs the resources available which means the highest risk victims are prioritised.

- The Victim Services' Advocacy Project recommended a common assessment tool should be introduced for victims across Cambridgeshire and Peterborough. It also raised a need for a seamless service for victims.

- The consultation workshops identified that the following victim groups needed to be featured within the needs assessment:
  - Victims of anti-social behaviour
  - Victims of domestic abuse
  - Victims of sexual violence
  - Victims of hate crime
  - People bereaved by murder, manslaughter or as a result of road traffic incidents
  - Young victims of crime
  - Victims of honour-based violence
  - Vulnerable, elderly victims of crime
  - Victims with mental health problems
  - Victims living in deprived / vulnerable localities.

  A brief overview of why each of these groups has been included is within the main body of the needs assessment.

- The impact of crime on each of the key victim groups is potentially more significant. Some of these groups have high volumes of victims and place a great demand on services; for example, it is estimated there are more than 40,000 reported incidents of anti-social behaviour each year. Other victim groups are relatively small in number; with Cambridgeshire Constabulary recording 155 cases of honour-based violence between August 2008 and May 2012.

- The likelihood of becoming a victim varies depending on personal circumstances and lifestyle. For example the risk of being a victim of crime is highest amongst single, 16–24 year old males who live in relatively deprived areas. The lowest risk lies with someone in an older age range living in an affluent rural area.

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Key Findings - Witnesses

- Witnesses play a crucial role in supporting victims and ensuring offenders are brought to justice. If they are witness to a traumatic event then they could be considered a secondary victim group.
- There is only a limited amount of local information available about witnesses and their experiences. Research with a small sample of witnesses as part of the joint inspection of Witness Care Units (WCU) in 2009 found that 14.3 per cent would not be prepared to give evidence should they witness a crime again. This point was also raised by those people who attended the stakeholder workshops in Cambridge and Peterborough. In particular those working within the third sector reported that many witnesses they had come across had expressed the view that "if they had know what it was going to be like, and entail, they would not have come forward as a witness". More research is needed to identify if this is a common experience in Cambridgeshire and Peterborough or not.
- It has been recognised that a more detailed look needs to be taken at witnesses so all agencies can better understand and support their collective needs. This work has now been commissioned by Cambridgeshire Police Authority and will be added to the Joint Victim and Offender Needs Assessment in October.

Key Findings - Offenders

- Cambridgeshire Constabulary identified at least 11,300 individual offenders during 2011 – this includes those linked to a crime as the offender and those who have been convicted, cautioned or recently arrested.
- The total extent of offending is difficult to gauge. Estimates of offending based on the national 2003 Crime & Justice Survey applied locally suggest that more than 50,000 people living in Cambridgeshire and Peterborough aged between 10 and 65 years could have committed some sort of offence in the last 12 months. However many offences, as suggested in the British Crime Survey, go unreported, indeed many would have been considered too trivial to have been reported.
- More than 80 per cent of the offenders identified by Cambridgeshire Constabulary are male. Nearly one third are aged between 18 and 24, and 17 per cent are under the age of 17. Over a third reside in the 20 per cent most deprived areas in Cambridgeshire and Peterborough.
- Many local agencies are involved in managing offenders. Within Cambridgeshire and Peterborough there are three prisons with a total of 2,727 prisoners. Each year more than 2,000 offenders are supervised for periods by the Cambridgeshire and Peterborough Probation Trust – with approximately 10 per cent re-offending each quarter.
- The re-offending rate amongst short-sentence prisoners (those serving less than 12 months, who are not subject to probation supervision) has been highlighted as being the highest of all offender groups[2] even higher with 57 per cent reoffending within a 12 month period.
- More than 950 young offenders (those aged under 18) are managed by youth offending services in Cambridgeshire and Peterborough each year.

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[2] 2011 Compendium of Reoffending Statistics and Analysis, Ministry of Justice

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- The risk factors in childhood which lead to offending can be the same as those which accompany substance misuse, other risk taking behaviours, and mental ill-health. Early interventions with young people can be the most effective, but need to address a broad range of behaviours, not just offending.
- Analysis into the current most prolific adult offenders in the area has revealed most started out as young offenders in Cambridgeshire and Peterborough. In fact it revealed 85 per cent of them started their offending in the county at an average age of 13.
- The Integrated Offender Management Scheme currently manages 169 prolific offenders, many of whom also have drug and/or alcohol dependency problems. This represents less than two per cent of offenders identified in Cambridgeshire Constabulary's nominal database.
- The MAPPA (Multi Agency Public Protection Arrangements) scheme has identified 726 offenders (512 sex offenders and 154 violent offenders) who are specifically assessed to manage the risk they pose within the community in Cambridgeshire and Peterborough.
- No single issue causes someone to re-offend rather it is an interaction between many different factors e.g. drug misuse, homelessness, lack of social skills or lack of employment opportunities. Therefore offenders need to be managed holistically with co-ordinated inputs from a number of relevant agencies.
- The consultation workshops highlighted that many offenders can also become victims of crime. In particular sex workers, substance misusers and chronically excluded adults were identified as being at risk.

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HEALTH AND WELLBEING BOARD	AGENDA ITEM No. 6
24 SEPTEMBER 2012	PUBLIC REPORT

Cabinet Member(s) responsible:	Councillor Sheila Scott Children's Services Portfolio	
Contact Officer(s):Judy Jones 863745	Malcolm Newsam, Executive Director Children's Services	Tel. 863606

PETERBOROUGH SAFEGUARDING CHILDREN BOARD (PSCB) ANNUAL REPORT AND BUSINESS PLAN

R E C O MM E N D A T I O N S	
FROM : Malcolm Newsam	Report was received by Scrutiny Committee on 11 September 2012
Members are requested to comment on and note the contents of the PSCB annual report and business plan.	

1. ORIGIN OF REPORT

1.1 This report is submitted to the Committee following a request from Malcolm Newsam, Executive Director Children's Services

2. PURPOSE AND REASON FOR REPORT

2.1 In June 2010, the Secretary of State for Education commissioned a review of child protection from Professor Eileen Munro. The final report was published in May 2011. With regard to Local Safeguarding Children Board annual reports, Professor Munro has recommended that the legislation is amended to require the annual report be submitted to the Chief Executive and Leader of the Council, to the local Police and Crime Commissioner and the Chair of the Health and Wellbeing Board.

2.2 The Government's response to Munro was published in July 2011. The government has accepted the recommendation described above and is to identify an appropriate legislative vehicle 'as soon as practicable'.

2.3 This report is for the Committee to consider under its Terms of Reference No 3.8, to keep under consideration, the financial and organisational implications of joint and integrated working across health and social care services, and to make recommendations for ensuring that performance and quality standards for health and social care services to children, families and adults are met and represent value for money across the whole system.

3. BACKGROUND

3.1 The Children Act 2004 required each local authority to establish a Local Safeguarding Children Board (LSCB) by 1 April 2006.The LSCB is the key statutory mechanism for agreeing how the relevant organisations in each local area will cooperate to safeguard and promote the welfare of children in that locality and for ensuring the effectiveness of what they do.

3.2 In March 2010, the Apprenticeships, Skills, Children and Learning Act 2009 introduced a requirement for LSCBs to produce and publish an annual report. LSCB's were then required to send a copy of the annual report to the Children's Trust Board which, in turn, was expected to respond to the report through the local Children and Young People's Plan. Safeguarding boards were required to publish their first annual report under the new regulations by 1 April 2011.

3.3 Following the change of government in May 2010, the statutory basis of Children's Trusts and the requirement to produce a Children and Young People's plan was rescinded. However, the statutory requirement for every LSCB to produce and publish an annual report remains and as noted in 2.1, it was recommended that the report be presented to the Chairman of the Health and Wellbeing Board.

4 CONSULTATION

4.1 This annual report has been prepared with contributions from all the partner agencies that form the safeguarding board and was presented to the board in draft form at their meeting on 12 July where it was agreed that, subject to minor changes, the report should be circulated to all partners.

4.2 All partner agencies have been requested to bring the annual report to the attention of the senior management team and governing body of their agency for consideration and that those considerations should be reported back to the Independent Chair of the Safeguarding Board. The role of these bodies is to hold their organisation and its officers to account for their contribution to the effective safeguarding of children and the effective functioning of the safeguarding Board.

5 ANTICIPATED OUTCOMES

5.1 Any considerations reported to the Independent Chair which requires further action will form the basis of an action plan which will be monitored.

6 REASONS FOR RECOMMENDATIONS

6.1 As noted at 2.1 it is a statutory requirement to bring the report to the Health and Wellbeing Board for comment and to note its contents

7 ALTERNATIVE OPTIONS CONSIDERED

7.1 There are no alternative options.

8 IMPLICATIONS

8.1 There are no implications related to this item

9 BACKGROUND DOCUMENTS

Used to prepare this report, in accordance with the Local Government (Access to Information) Act 1985)

The Children Act 2004
Working Together To Safeguard Children, March 2010.
The Munro Review of Child Protection: Final Report, May 2011
A child-centred system, The Government's response to the Munro review of child protection, July 2011

HEALTH AND WELLBEING BOARD	AGENDA ITEM No. 7
24 SEPTEMBER 2012	PUBLIC REPORT

Cabinet Member(s) responsible:	Sheila Scott, Cabinet Member for Children's Services	
Contact Officer(s):	Wendi Ogle-Welbourn Assistant Director Strategy, Commissioning and Prevention Children's Services	Tel. 01733 863749

HEALTH WATCH AMBASSADOR FOR CHILDREN

R E C O M M E N D A T I O N S	
FROM : Midlands and East Regional Strategic Health Authority	**Deadline date:** The deadline was the end of August, however extension negotiated.
The Health and Wellbeing Board is requested to: 1. Determine whether to employ a trained and supported Health Watch Ambassador for Children at a cost of between £11,181 and £18, 181 depending on experience: This would be an apprenticeship and need to be hosted by a local authority, local Health Watch organisation or CCG, with support for the role provided by a regional project manager. Ambassadors would be in place by April 2013; and 2. Agree the host agency and funding share if proposal agreed. A suggestion would be 1/3rd Public Health, 1/3rd Children's Services and 1/3rd CCG.	

1. ORIGIN OF REPORT

1.1 This report is submitted to the Health and Well Being Board following a request from the Midlands and East Regional Strategic Health Authority to the Director of Children's Services.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to obtain the views of the Health and Well Being Board Members on the employment of a Health Watch Ambassador for children.

2.2 This report is for Health and Wellbeing Board to consider under its Terms of Reference 3.4, to consider options and opportunities for the joint commissioning of health and social care services for children, families and adults in Peterborough to meet identified needs (based on the findings of the Joint Strategic Needs Assessment) and to consider any relevant plans and strategies regarding joint commissioning of health and social care services for children and adults.

3. HEALTH WATCH AMBASSADOR FOR CHILDREN

3.1 A proposal is being made by the Midlands and East Strategic Health Authority cluster for each Local Authority to employ a Health Watch Ambassador for children. The proposal has been cited as good practice in the Children and Young People Outcomes Report and is also being considered by London areas.

3.2 The proposal utilises the experience of young people who have completed the SHA funded Prince's Trust 'Get into Health' programme, a five week programme including:-

- 3 weeks training, including: Royal Society of Public Health Level 1 and 2 award, workshops on Sexual Health, Physical Activity, Drug and Alcohol Awareness, Diet and Nutrition. C.V. writing, interview techniques, job/apprenticeship application.
- 2 weeks relevant work experience e.g. in a hospital, support services, facilities management, PCT's or equivalent, GP Practices, Social Care.
- 6 months of on-going support and mentoring.
- Young Ambassador Programme where Young Ambassadors receive tailored support and high quality training to develop their leadership and communication skills.

3.3 Get Into and Young Ambassador training is taking place in each Local Authority area in the East of England over the next 6 months.

3.4 Key tasks of Young Ambassadors:

- The development of a local Children and Young People's Organisation Directory to promote inclusion of all groups, provide local signposting and promote sustainability.
- Meeting with existing local groups of children and young people to hear their views on local priorities and development of themes for reporting back to local Health Watch and therefore health and wellbeing boards.
- •Developing a relationship with local support systems to signpost to those who may be of potential assistance.
- Collating views from local Health Watch to feed into the EOE Strategic Network for Child Health and Wellbeing.

3.5 Please see the attached full proposal.

4. CONSULTATION

4.1 Presentation at the Board is part of the regional cluster consultation process.

5. ANTICIPATED OUTCOMES

- **A Solution to a long standing challenge:** the effective involvement of children and young people in decisions about the health and social care system.
- • **Giving Young People a development opportunity:** This proposal offers localities the opportunity to offer an apprenticeship to invest in their local youth population.
- **Well informed decision making:** through access to children and young people of all ages across the diverse local population, giving more disadvantaged groups the chance to be heard, this role will be able to give a thematic overview of views and feedback to promote well informed decision making by the Health and Wellbeing Boards as well as adding depth to the core of local Health Watch.
- **Evidence based:** the research to date demonstrates that the views of children and young people are more effectively heard by other young people. The proposed model offers a local lead within the local structure to be able to build the dialogue from young people through young people.
- **Proven structure of support**: the model builds on the Princes Trust track record of delivering benefits for both young people and for the local health and social care system to offer a robust framework to fit local structures. This framework secures the effective recruitment of young people from diverse and deprived backgrounds with existing training and experience and supports them to work as a team for Health Watch and to work within their individual locality.

6. REASONS FOR RECOMMENDATIONS

It is recommended that the Health and Well Being Board in Peterborough provides a view on this proposal to provide the Strategic Health Authority the information it requires to make a decision about progressing the proposal.

7. ALTERNATIVE OPTIONS CONSIDERED

None.

8. IMPLICATIONS

If the Health and Wellbeing Board agree with the proposal a discussion and decision around hosting and funding the post will need to be made.

9. BACKGROUND DOCUMENTS

Proposal from the Midlands and East Strategic Health Authority Cluster.

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PETERBOROUGH HEALTH AND WELLBEING BOARD	AGENDA ITEM No. 8
24 SEPTEMBER 2012	PUBLIC REPORT

Cabinet Member(s) responsible:	Councillor Wayne Fitzgerald Cabinet Member for Adult Social Care	
Contact Officer(s):	Terry Rich, Director of Adult Services, Wendi Ogle-Welbourn, Assistant Director for Strategy, Commissioning, Prevention, (Children's Services) Andy Liggins, Director of Public Health	Tel. 758444 863749 758520

PETERBOROUGH DRAFT HEALTH AND WELLBEING STRATEGY 2012-2015: PROGRESS REPORT

<table>
<tr><th colspan="2">R E C O M M E N D A T I O N S</th></tr>
<tr><td>FROM : Director of Public Health; Director of Adult Services; and Assistant Director for Strategy, Commissioning, Prevention (Children's Services)</td><td>Deadline date : N/A</td></tr>
<tr><td colspan="2">The Health and Wellbeing Board is recommended to:

1. Consider and comment on the Health and Wellbeing Strategy that is currently subject to a three month consultation period, ending on the 23rd November 2012;
2. Note the content of the Cambridgeshire Health and Wellbeing Strategy;
3. Note the progress to date of the strategy consultation process; and
4. Request that a revised Health and Wellbeing Strategy is presented to the December meeting of the Health and Wellbeing Board.</td></tr>
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1. ORIGIN OF REPORT

1.1 This report is submitted to the Health and Wellbeing Board following a request from the Directors Group.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to:

2.1.1 Obtain the Board's views on the draft Health and Wellbeing Strategy and the associated consultation process.

2.1.2 Share the content of the draft Cambridgeshire Health and Wellbeing Strategy, noting points of common concern and alignment between the two strategies that may impact upon strategic commissioning and outcomes for residents.

2.2 This report is for the Board to consider under its Terms of Reference No. 3.1, to develop a Health and Well Being Strategy for the City which informs and influences the commissioning plans of partner agencies.

3. PETERBOROUGH DRAFT HEALTH AND WELLBEING STRATEGY 2012-2015

3.1 Introduction and context

3.1.1 On the 18th June 2012, the Health and Wellbeing Board received a report that introduced the process for developing its first Health and Wellbeing Strategy. In addition, the board were presented with a series of "illustrative priorities" that had been drawn from the 2012 Joint Strategic Needs Analysis. In the period that followed, the accountable officer group worked up the priorities in more detail and produced a draft strategy that was shared with members of the board. The final draft document (appendix 1) was issued for consultation to a wide group of stakeholders. The consultation process will be addressed in paragraph four below.

3.1.2 The three year strategy is intended to:

- Identify health and wellbeing priorities
- Set clear markers for NHS and Local Authority commissioners as they act to put in place the right mix of services and initiatives to meet the needs of the population
- Hold commissioners to account for their decisions
- Help to develop partnerships that provide solutions to commissioning challenges

3.1.3 The priorities selected related closely to the findings of the Joint Strategic Needs Assessment (JSNA) and the draft strategy provides a summary of key JSNA findings in the section titled "How healthy are we?" Whilst it is difficult to do justice to the depth and range of information generated by the JSNA in a relatively brief section, some strong themes were identified and these underpinned the selection of strategic priorities that are presented in section four of the draft strategy. Each priority is accompanied by:

- A more descriptive objective
- Evidence for its inclusion in the priorities
- Broad recommendations on how the priority and objective will be addressed
- The relevant linked outcomes frameworks that will inform the specific outcomes to be selected when the strategy is finalised, post consultation and board approval

3.1.4 In section five the strategy sets out a set of principles that should guide commissioners as they respond to the priorities and outcomes that need to be addressed.These principles represent a checklist for commissioners. This checklist is further supported by a recommended commissioning model that is outlined in the appendix to the draft strategy.

3.1.5 The draft strategy concludes with reference to the consultation process and the main areas that respondents are being asked to comment on (covered in more detail in the next section). In addition it makes reference to proposed schedule of outcomes that will be developed as the board's framework for setting a baseline and monitoring performance on the delivery of the agreed priorities.

4. CONSULTATION

4.1 The Consultation Plan has been developed with the support of NHS Peterborough and Peterborough City Council officers. The consultation will run for three months from 23rd August until 22nd November 2012 in line with the Council/Voluntary Sector Compact Agreement. It includes an electronic mail-out of the document to a wide-ranging list of organisations and individuals across the statutory and non-statutory and community sectors. Groups representing those people with protected characteristics under equalities legislation have been specifically targeted. Responses to the consultation questions are requested either by using the consultation form at the end of the document, by responding electronically using a survey tool, or by responding to the specific email address that has been set-up for the purpose. A stakeholder consultation event is being planned for November. All responses will be collated following the closure of the consultation period

and a report will be brought to the next H&WB meeting on 10th December for consideration by the Board.

5. CAMBRIDGESHIRE DRAFT HEALTH AND WELLBEING STRATEGY: COMMON ISSUES AND POINTS OF ALIGNMENT

5.1 Cambridgeshire Health and Wellbeing Board has produced a draft five year strategy, 2012-2017 rather than the three year period for Peterborough (see attached appendix 2). The consultation on its draft strategy came to an end on the 17th September. In common with Peterborough, the draft strategy is underpinned by the JSNA, it identifies the broad range of factors that impact upon health and wellbeing and references Dahlgren and Whitehead's determinants of health model. It seeks to add value to and not replicate existing stategies.

5.2 Cambridgeshire sets out five priorities for consultation, the first three of which reflect, in large measure priorities one, two and three in the Peterborough draft strategy. Cambridgeshire's fourth priority, which refers to early intervention on mental health, minimising the impact of substance misuse is also referenced in the Peterborough version. Where the strategies are more markedly different, in terms of priorities, is the inclusion in the Cambridgeshire draft strategy, of the fifth priority; "Create a sustainable environment in which communities can flourish". In this priority there is a more overt focus on wider partnership action to make a contribution to health and wellbeing. In the Peterborough draft strategy, alignment between the Health and Wellbeing Board and the key partnership bodies, Greater Peterborough Partnership, Safer Peterborough Partnership, Safeguarding Boards is firmly endorsed. It is however recognised that effective arrangements for ensuring that the principles, messages and priorities outlined in the Health and Wellbeing Strategy, are reflected in work of these other partnerships. Peterborough focuses more specifically on people with life-long disabilities and complex needs as a discrete priority.Cambridgeshire reflects these need groups within other priorities. In Peterborough's case there are compelling reasons both financial as well as needs based that drive this fifth priority.

5.3 The priorities in the Cambridgeshire draft strategy expand upon the areas for action in a different way, but both seek to provide a clear direction for commissioners as those authorities develop commissioning plans. Peterborough has set out an intention to develop key outcomes to monitor the impact of commissioners action on the agreed priority areas. Cambridgeshire makes reference to the important indicators linked to their priorities.

5.4 The consultation process employed by Cambridgeshire asks for more detailed responses from consultees. The results of Cambridgeshire's consultation may prove instructive for future consultation by Peterborough and will be looked at with interest when published.

6. CONCLUDING COMMENTS

6.1 The key test for the relevance and impact of the Health and Wellbeing Strategy is the difference made to the lives of Peterborough's residents. In the first instance this will be evidenced by the degree to which Health and Local Authority commissioners respond to the priorities and incorporate actions and inititiatives that address the priority needs. Subsequently, through the duration of the strategy the focus will be on the impact on outcomes. However the current task is to confirm that the priorities that are selected and the outcomes that will underpin them make sense.

7. BACKGROUND DOCUMENTS

Used to prepare this report, in accordance with the Local Government (Access to Information) Act 1985)

Peterborough Joint Strategic Needs Assessment 2012
Health and Social Care Act 2012
Draft Cambridgeshire Health and Wellbeing Strategy 2012-17

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HEALTH AND WELLBEING BOARD	AGENDA ITEM No. 9
24 SEPTEMBER 2012	PUBLIC REPORT

Cabinet Member(s) responsible:	Councillor Wayne Fitzgerald, Cabinet Member Adult Social Care	
Contact Officer(s):	Sue Mitchell, Assistant Director Public Health	Tel. 01733 758530

HEALTH AND WELLBEING BOARD DEVELOPMENT

R E C O M M E N D A T I O N S	
FROM : Director of Public Health and Director of Adult Services	**Deadline date :** N/A
The Health and Wellbeing Board is recommended to consider and comment on plans to access leadership and Board development facilitation.	

1. ORIGIN OF REPORT

1.1 This report is submitted to the Health and Wellbeing Board following a request from the Directors Group.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to:

2.1.1 Obtain the Board's views and wishes in relation to Board development

2.1.2 Update the Board on the outcomes of the simulation event held in Cambridge

2.2 This report is for the Board to consider under its Terms of Reference No. 2.1, 'to bring together the leaders of health and social care commissioners to develop common and shared approaches to improving the health and well being of the community'.

3. BOARD DEVELOPMENT

3.1 On the 18th June 2012, the Health and Wellbeing Board received a report that introduced the process for Board development. The Board agreed to follow-up the invitation of support offered by the Local Government Association and the NHS Leadership Academy. Subsequently named support from the LGA has been assigned to Peterborough and efforts have been made to organise an initial workshop for Board members. Although initial dates were not suitable a further tranche of dates has now been circulated and it is hoped that this event will take place in November.

3.2 A Board development event was organised for H&WBs across the region and several members from Peterborough attended. Members were challenged to work together as a Board dealing with a range of scenarios. Reflections on the process, individual and collective learning was captured and issues for Board development identified. These included:

- The importance of working together outside formal meetings in a private capacity to enable working relationships and a shared understanding of the issues faced by the Board;
- The importance of developing working partnerships that provide solutions to commissioning challenges (identified for example through the Joint H&W Strategy)
- The importance of good quality work undertaken and officer support provided to Board members, ensuring that they are fully briefed and prepared for Board discussions
- The need to develop the infrastructure that sits under that Board, and also links and relationships to other relevant key strategic areas and associated Boards.

4. BACKGROUND DOCUMENTS

Used to prepare this report, in accordance with the Local Government (Access to Information) Act 1985)

Peterborough Joint Strategic Needs Assessment 2012
Health and Social Care Act 2012
Draft Peterborough Health and Wellbeing Strategy 2012-15

UPDATED: 21 MAY 2012

HEALTH AND WELLBEING BOARD
AGENDA PLAN 2012/13

Meeting Date	Item	Progress
10 December 2012	**1) Commissioning Plans** **Contact Officer: Dr Andy Liggins / Terry Rich**	
25 March 2013		

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