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PETERBOROUGH CITY COUNCIL

HEALTH AND WELLBEING BOARD

THURSDAY 16 JANUARY 2014
1.00 PM

Bourges/Viersen Rooms - Town Hall
Contact – Gemma.george@peterborough.gov.uk, 01733 452268

AGENDA

	Page No
1. Apologies for Absence	
2. Declarations of Interest	
3. Minutes of the Meeting held on 12 September 2013	3 - 8
COMMISSIONING ISSUES	
4. NHS England / Local Board	
(a) Primary Care Strategy Update On Progress For the Board to receive an update on the Primary Care Strategy.	9 - 12
(b) Surgical Metastatic Liver Resection Services The Board is requested to consider the recommendations contained within the report.	13 - 16
5. Clinical / Local Commissioning Groups	
(a) Development of Proposals for use of the Better Care Fund (formerly Integration and Transformation Fund) in Peterborough The Board is requested to consider the recommendations contained within the report.	17 - 44
6. Public Health	
(a) Joint Strategic Needs Assessment The Board is requested to consider the recommendations contained within the report.	45 - 48
(b) Interim Arrangements for the Director of Public Health Discussion item.	

There is an induction hearing loop system available in all meeting rooms. Some of the systems are infra-red operated, if you wish to use this system then please contact Gemma George on 01733 452268 as soon as possible.

7. **Children's Services**

(a) **Joint Child Health and Wellbeing Commissioning Unit** **49 - 108**
For the Board to consider the recommendations contained within the report.

8. **Adult Social Care**

(a) **Autism Self Evaluation** **109 - 122**
The Board is requested to consider and comment upon the contents of the report.

INFORMATION AND OTHER ITEMS

9. **Officer Lead for the Health and Wellbeing Board**
Discussion item.

10. **Executive Group Terms of Reference** **123 - 128**
The Board is requested to comment on and agree the terms of reference.

11. **Peer Review Update**
Information to follow.

12. **Health and Wellbeing Board Delivery Plan Update** **129 - 166**
For the Board to note the updated Health and Wellbeing Strategy Delivery Plan.

13. **November Newsletter** **167 - 174**

14. **Schedule of Future Meetings and Draft Agenda Programme** **175 - 176**
To note the dates and agree future agenda items for the Board. To include frequency of reporting from other Boards, where appropriate, including Local Safeguarding Boards, Children's and Adults Commissioning Boards, LCG Commissioning Board. Also to consider how we will monitor progress against the Health and Wellbeing strategy.

(a) **SARC**
Discussion item.

Board Members:
Cllr M Cereste (Chairman), Cllr W Fitzgerald (Vice Chairman), Cllr J Holdich, Cllr S Scott, Cllr I Walsh, Gillian Beasley, David Whiles (Healthwatch), Dr M Caskey, Dr R Withers, Dr P Van den Bent, Jana Burton; Cathy Mitchell; Sue Mitchell; Andrew Reed; Andy Vowles; Sue Westcott.

Substitutes: Dr Neil Sanders and Dr Harshad Mistry

Further information about this meeting can be obtained from Gemma George on telephone (01733) 452268 or by email gemma.george@peterborough.gov.uk

PETERBOROUGH
CITY COUNCIL

MINUTES OF A MEETING OF THE HEALTH AND WELLBEING BOARD HELD AT THE TOWN HALL, PETERBOROUGH ON 12 SEPTEMBER 2013

Members Present: Councillor Marco Cereste – Leader of the Council (Chairman)
Councillor Fitzgerald – Cabinet member for Adult Social Care
Councillor John Holdich – Cabinet Member for Education, Skills and University
Councillor Irene Walsh – Cabinet Member for Community Cohesion, Safety and Public Health
Jana Burton, Executive Director of Adult Social Care, PCC
Rechel Boika, Consultant in Public Health Medicine, Public Health, PCC
Sue Westcott, Executive Director of Children's Services, PCC
Dr Richard Withers, Borderline Local Commissioning Group
Dr Mike Caskey, Peterborough City Local Commissioning Group
David Whiles, Peterborough LINk – Local Healthwatch
Cathy Mitchell, Cambridgeshire & Peterborough Clinical Commissioning Group
Andy Vowles, Cambridgeshire Clinical Commissioning Group
Andrew Reed, NHS England East Anglia Local Team
Claire Higgins, Chairman Safer Peterborough Partnership

Also in Attendance: Alex Daynes, Senior Governance Officer, PCC
Mubarak Darbar, Head of Commissioning Learning Disabilities, PCC
Dr Caroline Lea-Cox, Clinical Lead for Mental Health, Cambridgeshire Clinical Commissioning Group
Wendi Ogle-Welbourn, Assistant Director, PCC
Chas Ryan, Stroke/CHD/Alcohol Programme Manager, PCC
Kim Sawyer, Head of Legal Services, PCC

Item	Discussion and Decision	Action
1. Apologies for Absence	Apologies for absence were received from Gillian Beasley, Sue Mitchell, Dr Ken Rigg and Russell Wate.	
2. Declarations of Interest	None were received.	
3. Minutes of the Previous Meeting	The minutes of the meeting held on 6 June 2013 were approved as a true and accurate record.	

4. Health Watch – (a) Hydrotherapy in delivering outcomes from the Health and Wellbeing Board's Strategy 2012-15	The Board received a report from Healthwatch Peterborough that provided a summary version of a comprehensive report compiled for clinicians for members to review the outcomes and impact of the aquatic therapy service for local residents and reviewed how aquatic therapies provided measurable outcomes and translated into a service that reflected the Health and Wellbeing Strategy 2012-15. The report also provided the Board with detailed information and reviewed recommendations in light of the resent decisions to review the hydrotherapy services. Members discussed the report and the attached user evaluation. Comments included: • Only slight evidence existed for health improvements for users; • Could link with muscular skeletal services; • Investment was needed in improving the facility at St. George's; • The service had developed a client list of around 1600 in two years; • Some clients could be accommodated at other sites; • The St George's site may not be sustainable in the long term; • The hydrotherapy pool could be relocated and provided within other sites and projects currently under development. Following consideration of the report, the Board **AGREED** to endorse the recommendation put forward by Councillor Fitzgerald as below: The Board endorses the important role hydrotherapy can play in the physical and mental wellbeing of people in Peterborough. As recommended by the report the board asks the Clinical Commissioning Group, Public Health and Adult Social Care Commissioners to work together to ensure that access to hydro therapy is part of the council's preventative offer and supports people to live independently.	CM, SM, JB
5. NHS England / Local Board	(a) Metastatic Liver Resection Service Reconfiguration The Board received a report providing background information concerning the service changes required for metastatic liver resection (liver cancer surgery) and to obtain the Committee's views on the process followed to identify a single surgical centre for metastatic liver resection. It was proposed that the single surgical site for the East Anglia region be based at Addenbrookes Hospital in Cambridge. Members discussed the report and comments made included: • Most Peterborough residents currently attend Leicester for this treatment and may choose to continue to do so; • Need to consider and manage transport arrangements for patients going to Cambridge; • Outpatient appointments including chemotherapy can be carried out in Peterborough. Following consideration of the report the Board **AGREED** that it was content with the single centre being located in Cambridge.	
	(b) Primary Care Strategy The Board received a report describing the process NHS England was following to develop primary care strategy at a national level and at an	

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	East Anglia level. Members discussed the report and comments included: • Should not have a single approach for the whole country so partners must work together to ensure local needs were addressed; • NHS commissioned health and justice and primary care for prisons; • The challenge of increasing GP numbers when GP Practices operated under contracts, rather than individual GPs, would need to be addressed. The Board **AGREED** to receive a further update at its next meeting.	AR
6. Clinical / Local Commissioning Groups	(a) Local Area Team (LAT) agreement S256 transfer The Board received a report advising it of a Section 256 funding agreement that had been drawn up between the CCG and Peterborough City Council (PCC) to align with the local needs of the population across the health and social care system. The Joint Commissioning Forum had been asked to comment on the draft plan prior to it being submitted to the Area Team for their input and agreement as the budget holders who would transfer the funding to PCC. Details of the Section 256 including the metrics were also attached for the Board's consideration as it was required that the Final Version of the Section 256 be presented to the Health and Wellbeing Board in September 2013 as part of the national governance and approvals process. Members discussed the report and comments included: • NHS Local Area Team input was required for the final version; • A pooled Integrated Transformation fund would be established from 2015 and a plan for this was required by April 2014 – this would be presented to the Board; • The Integrated Transformation funding agreement would be to provide statutory services and new services; • Other grants could be included in the agreement;eg DFG 's • As the level of funding is due to increase from 2015/16 it was important to have a proper framework in place between all parties based on National Guidance; • NHSE Local Area team to input financial metrics into the Section 256 2013/14 would be addressed.	CM AR
	(b) Commissioning Intentions The Board received a presentation on the commissioning intentions of the Cambridgeshire and Peterborough CCG for 2014-15 that included the priorities, process and emerging issues. It was further confirmed that Specialist Inpatient Mental Health Service was included in the CCG commissioning intentions for 2014/15. The Board **NOTED** the information in the report.	
7. Public Health	(a) Pharmaceutical Needs Assessment The Board received a report updating it on its statutory responsibility to	

	maintain and publish a Pharmaceutical Needs Assessment (PNA). The full background to this was presented in a previous report to the HWB in June 2013. The Board was advised that there was not presently a need for a full assessment but a revised PNA would be required by April 2015. The Board **NOTED** the information in the report.	
8. Adult Social Care	(a) Winterbourn View Report The Board received a report in order to provide an overview of developments to date and to satisfy it that appropriate action was being taken in light of the Winterbourn Review concerning the resettling of all the people placed in secure hospitals being settled back into the community. Comments from the Board included: • The Intensive-behavioural Support Team (IST) should widen its age range for those under 18 years of age. The Board was further advised that the age range for the IST could be looked into and that some vacancies existed in the short term but the long term ambition was that people were prevented from falling into the situation where they were in need of intensive support. The Board was content with the report.	
	(b) Learning Disabilities The Board received a report reflecting on how well, as a region, delivering services for adults with learning disabilities had improved, in order to further the commissioning processes to improve these services, and for consideration of the proposed recommendations. Comments from the Board included: • No information was presented on transitional arrangements. The Board was further advised that the Mencap Charter and performance details were for adults only rather than for children. The Board **AGREED**: 1. to sign up to the Mencap 'Getting it Right Charter'; and 2. Jana Burton would lead on learning disabilities for the Health and Wellbeing Board.	
9. Board Development	(a) Peer Challenge The Board received a report highlighting what a Peer Challenge would focus on. The Board was advised that further work was required before submitting to a Peer Challenge. The Board **AGREED** to wait for further work to be done before conducting a peer review.	

	(b) Health and Wellbeing Strategy – Delivery Plan The Board received a report following the development of the Health and Wellbeing Strategy. The Board was asked to consider the wider determinants of health that it may want to focus on to support delivery of the priorities in the Health and Wellbeing Strategy. Comments from the Board included: • Need to determine the value that the Board can bring; • Need to determine what the Board is looking to deliver; • Wider partner input and involvement was needed in the document; • Focus could be placed on the council's Operation Can Do area in order to improve the health and wellbeing of the residents in this area – this could include a collaboration of partners to apply for EU funding; • Need to determine who would be responsible for commissioning once any funding was received. The Board **AGREED**: 1. To focus on the Operation Can Do Area; 2. To determine the best way to commission services with partners; 3. The Health and Wellbeing Board would be the responsible body for coordinating the work; 4. Relevant aspects of the EU Funding journal to be shared with partners; 5. A project officer should be established for the Health and Wellbeing Board. Wendi Ogle-Welbourn to develop a business case to determine funding required from each partner.	WO-W, PP, CM PP WO-W
10. Public Health England's Longer Life Toolkit	The Board received a report following the publication of the Longer Lives Tool-kit by Public Health England (PHE). The Board noted the information in the report.	
11. Joint Commissioning – Child Health Update	The Board received a report to keep it appraised of the progress in moving towards gaining agreement for a Peterborough Joint Health and Local Authority Child Health Commissioning Unit. The Board noted the information in the report.	
12. Child Health Outcomes	The Board received documents outlining details of a pledge to improve health outcomes for children and young people. The Board noted the information.	
13. Health and Wellbeing Board Event	The Board received information outlining details of a full day event for the East of England to help local government and NHS colleagues think through what arrangements – locally and regionally – were needed to support an integrated approach to health and social care and address the collective challenges and opportunities arising from the NHS reforms. The Board noted the information.	
14. Schedule of Future Meetings and Draft Agenda	The Board received and considered the agenda plan for future meetings and was advised of the schedule of meetings for the year ahead.	

Programme	The Board noted the information.	

3.00 pm
Chairman

Relating to:	**ACTIONS**	**By whom**	**By when**
Health Watch (a) Hydrotherapy in delivering outcomes from the Health and Wellbeing Board's Strategy 2012-15	• Clinical Commissioning Group, Public Health and Adult Social Care Commissioners to work together to ensure that access to hydro therapy is part of the council's preventative offer and supports people to live independently.	Cathy Mitchell, Sue Mitchel, Jana Burton	Ongoing
NHS England / Local Board (b) Primary Care Strategy	• Provide a further update at the next meeting of the Board	Andrew Reed	16 Jan 2014
Clinical / Local Commissioning Groups (a) Local Area Team (LAT) agreement S256 transfer	• Provide pooled funding plan for 2015 to the Board. • Address and resolve delays in NHS local team processes	Cathy Mitchell Andrew Reed	27 March 2014 ASAP
Board Development (b) Health and Wellbeing Strategy – Delivery Plan	• Determine best way to commission services with partners for OP Can Do area; • Share relevant section of EU funding journal with partners; • Develop a business case for a support officer.	Wendi O-W, Paul Phillipson, Cathy Mithcell Paul Phillipson Wendi O-W	January 2014 ASAP ASAP

HEALTH AND WELLBEING BOARD	AGENDA ITEM No. 4(a)
16 JANUARY 2014	PUBLIC REPORT
Contact Officer(s): NHS England Area Team	

PRIMARY CARE STRATEGY – UPDATE REPORT

R E C O M M E N D A T I O N S	
FROM : NHS England Area Team	**Deadline date : N/A**
This report is intended to provide an update on the work being progressed by NHS England East Anglia Area Team to develop a strategic framework to support the development of primary care in East Anglia.	

1. ORIGIN OF REPORT

1.1 This report is submitted to Board following a request from a member – Mr Andrew Reed, Director NHS England East Anglia Area Team

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to provide an update to the Board on the work being progressed by NHS England to provide a strategic framework for primary care development in East Anglia.

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 wellbeing of the community'.

3. BACKGROUND

3.1 As part of the national NHS England *Call to Action* the NHS England East Anglia Local Area Team has been working with local Clinical Commissioning Groups and the Local Professional Networks to consider what we need to do, both at a national and local level, to be confident of ensuring our local population has access to high quality, sustainable and thriving primary care services.

3.2 Through a process of engagement and consultation we have tested the propositions set out within "Improving General Practice – a Call to Action", while also working with our three Local Professional Networks to begin discussions in advance of the launch of the respective Call to Action processes planned for 2014.

3.3 The process undertaken in East Anglia has included a meeting with each Clinical Commissioning Group in East Anglia, the circulation of a questionnaire to stakeholders and county based stakeholder events. Through this process we have engaged directly with over 450 people including professionals working in, or with, primary care, representatives from patient groups, local authorities and the voluntary sector to seek their views, collate evidence and test and shape strategic priorities.

3.4 A key principle of the Area Team approach has been to ensure alignment with our local Clinical Commissioning Group and Local Health and Wellbeing Board strategic planning processes. We are confident that this will ensure that the key themes and issues set out within the strategic framework will support the wider health and social care planning work that is being taken forward led by the CCGs and Health and Wellbeing Boards.

5. Emerging Themes

5.1 The feedback we have had through discussions with local professionals, clinical leaders and the public has confirmed the central role of Primary Care in improving health outcomes and meeting local need. It has confirmed that overall, existing primary care services across East Anglia are good and improving, providing a strong base for future development. The discussions have, however, helped us to be clearer about where we need to focus our efforts over the next five years to ensure that:

- Care is increasingly integrated and provided in a joined up way to meet the needs of the whole person;

- People will be increasingly able to play a full part in the management of their health and wellbeing

- Care is clinically effective and safe, delivered in the most appropriate way

- Primary care can play a full part in helping the wider healthcare system make the best use of limited resources

- We create an environment which ensures that we are able maintain and develop a motivated, skilled and dedicated primary care workforce

- There is a clear and shared understanding among the public and professionals of individuals rights, responsibilities and expectations

- We can be confident that there is equity across East Anglia – equity of “offer”, equity of “access” and equity of “outcome”.

6. Strategic Framework

6.1 Our local discussions have confirmed that there is a shared ambition to create thriving, high quality and sustainable primary care that works to improve health outcomes and support a reduction in health inequalities. To achieve this we recognise that we need to develop a strategic framework that responds to the current and future challenges as summarised in the figure below.

Challenges Facing Primary Care taken from the Royal College of General Practice publication *Patients, Doctors and the NHS in 2022*

6.2 There is a growing acceptance that general practice, and primary care more generally, will be most likely be able to address these challenges and seize new opportunities if it operates at greater scale and in greater collaboration with other providers. At the same time there is also acceptance that general practice should preserve its traditional strengths of providing personal continuity of care and its strong links with local communities.

6.3 Our local discussions have confirmed that there is no single blueprint for how general practice can best meet our shared ambition. It is clear that it will not be achieved simply or primarily by adopting new organisational forms, but these will have a part to play. Our focus will be on working collaboratively to understand how best we can work with primary care professionals to enable them to provide services for patients more effectively and productively, and how we can help practices benefit from collective expertise and resources.

6.4 Locally there are discussions taking place among practices to consider how they might work more collaboratively through coming together in federations, networks or 'super-partnerships' with the aim of addressing a range of issues which may include:

- pooling of clinical expertise, offering a greater range of generalist and more specialist services;
- helping GPs and practice staff maintain and develop their professional skills;
- improving patient access (including greater availability of consultations outside traditional opening hours, and consultations outside of the surgery);
- supporting innovative approaches to planning and delivering services by way of shared learning and ideas;

- working collectively to develop more integrated care with community health providers, out-of-hours providers, community pharmacy, social care and voluntary/charitable providers;

- enabling more systematic approaches to governance and risk assessment;

- providing development opportunities for GPs, practice nurses, practice managers and other staff;

- creating opportunities to provide new services outside hospital;

- creating the potential for greater economies of scale in administrative and business functions to reduce overhead costs.

6.5 With specific reference to Peterborough, the Area Team will be working with the CCG to support these discussions, noting specific issues in relation to:

  - understanding the implications of new national contract frameworks and ensuring fair funding of primary care services;

  - ensuring that there is a framework agreed with the CCG and key partners to enable the re-procurement of a number of time limited general medical contracts to support the continued delivery of high quality, sustainable services that meet the needs of the local population;

  - progressing agreed, priority primary care estate developments with the aim of supporting the delivery of integrated services;

  - reviewing the current equitable access centre at St Neots to ensure that it is aligned to the local urgent care strategy;

7. RECOMMENDATIONS

7.1 The Health and Wellbeing Board are asked to note the progress made to develop a strategic framework to support the development of primary care services.

8. CONSULTATION

8.1 It is expected that the Draft Strategic Framework for Primary Care will be subject to consultation with key partners, including Health and Wellbeing Boards as an integral part of the five year strategic plan development.

9. REASONS FOR RECOMMENDATIONS

9.1 To raise awareness of the work being progressed to support the development of a strategic framework for primary care.

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 4(b)
16 JANUARY 2014		PUBLIC REPORT
Contact Officer(s):	NHS England	

SURGICAL METASTATIC LIVER RESECTION SERVICES

R E C O M M E N D A T I O N S	
FROM : NHS England	**Deadline date : N/A**
The Board is asked to consider the key recommendation to establish a single surgical centre for metastatic liver resection in the Anglia cancer network Area. Of note the Board is asked to confirm: - The importance of ensuring all patients have access to an IOG compliant service; and - The principle of retaining as much care as locally as is appropriate	

1. ORIGIN OF REPORT

1.1 This report is submitted to Board following a request from Andrew Reed, Director, NHS England East Anglia Area Team and member of the Health and Wellbeing Board.

1.2 A review of surgical services for metastatic liver resection has been undertaken with the aim of ensuring high quality, safe and sustainable services for patients. The review has concluded that there should be a single surgical centre for East Anglia, working as part of a network with local services to achieve improved outcomes for patients. The review has concluded that the surgical service should be located at Addenbrookes, Cambridge.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to inform the Board of the review of surgical metastatic liver resection services across the former Anglia Cancer Network.

The Board is asked to:

1. Note the outcome of the review to support improved outcomes for patients.

2. Note the preferred options for a single surgical centre.

2.2 This report is for 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. BACKGROUND

3.1 A surgical resection service provides curative treatment for people with liver metastases. The National Institute for Clinical Excellence Colorectal Improving

Outcomes Guidance (IOG) states that a liver metastases surgical resection service should serve a population base of at least 2 million, with all surgery taking place at a single specialist surgical centre for patients with liver metastases. The IOG seeks to improve outcomes for patients by introducing a dedicated, multidisciplinary team delivering high quality care in a single specialist surgical centre that will deal with sufficient numbers of patients to maximise clinical expertise.

3.2 NHS England became responsible for the commissioning of this service, in April 2013 and is required to commission a service that is compliant with the IOG. NHS England (East Anglia) has therefore been working to take forward the Review of surgical services for liver metastases within the boundaries of the Anglia Cancer Network region, which covers people living in Suffolk, Norfolk, Cambridgeshire, and north Bedfordshire, which was started in January 2011.

4. THE REVIEW

4.1 In 2011, the former Anglia Cancer Network engaged the former Midlands and East Specialised Commissioning Group (SCG) to lead the work needed to review specialist surgical services for patients with liver metastases. The aim of the review was to ensure that all patients have access to an IOG compliant service.

4.2 A Project Steering Group was set up in January 2011 to lead the review of the current service and to ensure broad representation from expert clinicians and commissioners, as well as patient representatives who had used the service. The review found that the number of people undergoing liver resection for colorectal cancer metastases in the region was significantly lower than the national average, with five referral pathways for the population in the Anglia Cancer Network region:

a) Three centres within the network which are non IOG Compliant– The Ipswich Hospital Trust, Norfolk and Norwich University Hospitals NHS Foundation Trust undertaking approximately 25 resections/year and Cambridge University Hospitals NHS Foundation Trust undertaking approximately 45 resections/year (NB: The Ipswich Hospital has recently stopped their liver resection surgery).

b) Two centres outside the network which are IOG compliant– Basingstoke (as part of Hampshire Hospitals NHS Foundation Trust) for the Bedford referral pathway and University Hospitals Leicester for the Peterborough referral pathway

4.3 The Project Steering Group undertook a comprehensive review, which included seeking further advice from the National Cancer Action Team (NCAT). NCAT agreed to conduct a review into possible models that could be used to provide the service and advise on:

a) What the service should look like;
b) What organisations are best placed to deliver the service;
c) What should the expectations be for the reconfigured service?

4.4 In August 2012, the NCAT report was published and concluded that :

a. There is strong and compelling evidence to support the principle that centres that see more patients produce better short and long term outcomes than centres that don’t see a smaller number of patients.

b. Whilst both centres (Norwich University Hospitals NHS Foundation Trust and Cambridge University Hospitals NHS Foundation Trust) do have

good outcomes for patients, both centres are under performing with the amount of patients that are referred for liver resection surgery.

c. Multiple patient pathways that exist in the network are not sustainable in the long term and are likely to continue to impact on the local number of referrals

d. The team did not find any compelling reasons not to support an IOG compliant service. Developing a compliant service was felt most likely to deliver the service capable of delivering increased access to and the highest quality of surgery

e. One site, serving the population of potentially 2.9m is the preferred and recommended service configuration

4.5 The process to establish an IOG compliant service recommenced in September 2012 and following publication of the service criteria, two expressions of interest were received from CUHFT and NNUHFT to become the single centre for liver resection surgical services.

4.6 The bids were assessed using a scoring criteria developed by the Project Steering Group and an External Review Panel, made up of independent expert clinicians, a referring surgeon, a service specialist, a clinical nurse specialist and a patient representative who visited each provider to discuss their service proposal in detail.

4.7 The External Review Panel recommended that the single site surgical liver metastases service for the population of the Anglia Cancer Network region should be developed at Cambridge University Hospitals NHS Foundation Trust (CUHFT). Only surgery and immediate follow up would occur at the single specialist surgical centre, ensuring that as many elements as possible of the pathway would be delivered locally.

4.8 Whilst the External Review Panel found that CUHFT was best placed to deliver the network wide service, a number of recommended actions were identified in the report. In summary, the key recommendations from the External Review Panel report were:

a) Consideration needed to be given to the transport needs of a rural and elderly population, especially from the more remote areas of the region.
b) Leadership of the network wide service needs review, and sufficient time needs to be given to this role.
c) Ensuring effective engagement of all referring units is key to this service.
d) A whole team approach to proactive working from the centre will ensure close team working with each of the referring Multi-Disciplinary Teams.
e) Proactive working from the specialist Liver Metastases surgery team to ensure improved referral and a demonstrable improvement in resection rates.
f) Ensuring at all times that the new model of working, whilst centralising surgery, should at the same time maximise those parts of the care pathway that can be delivered to patients locally.

4.9 A Joint Health Scrutiny Committee has been established to consider the review and the recommendations. The report of the Committee is currently being considered.

5. CONSULTATION

5.1 The process of the review was undertaken with significant stakeholder engagement. A Joint Health Scrutiny Committee has considered the proposals and subject to the outcome of their deliberations consideration will be given to the nature and scope of further engagement and consultation required.

6. ANTICIPATED OUTCOMES

6.1 The review and the recommendations focus on improving outcomes for patients who would benefit from metastatic liver resection surgery.

7. REASONS FOR RECOMMENDATIONS

7.1 The recommendations support the delivery of a compliant, high quality service for people living in the former Anglia Cancer Network area.

8. ALTERNATIVE OPTIONS CONSIDERED

8.1 The review considered a number of options, including the status quo and a rigorous review of the optimal site for a single surgical centre.

9. IMPLICATIONS

9.1 The implications of the proposed service would result in a consistent, equitable and sustainable service for our population which is compliant with national standards.

9.2 There will be a number of patients who may have to access a surgical service in Cambridge, who might previously have been seen in Norwich however the vast majority of care will continue to be provided locally.

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 5(a)
16 JANUARY 2014		PUBLIC REPORT
Contact Officers:	Jana Burton, Executive Director of Adult Social Care, Health and Wellbeing, Peterborough City Council Cath Mitchell, Local Chief Officer, Borderline and Peterborough LCG, for Cambridgeshire and Peterborough CCG.	Tel: 01733-452409 01733-758414

DEVELOPMENT OF PROPOSALS FOR USE OF THE *BETTER CARE FUND* (FORMERLY *INTEGRATION AND TRANSFORMATION FUND*) IN PETERBOROUGH

R E C O M M E N D A T I O N S	
FROM : Jana Burton, Executive Director of Adult Social Care, Health and Wellbeing, Peterborough City Council Cath Mitchell, Local Chief Officer, Borderline and Peterborough LCG, for Cambridgeshire and Peterborough CCG.	**Deadline date : N/A**

1. For the Board to note the background information and planning timescales for the Better Care Fund;
2. For the Board to consider the "long-list" of proposals for use of the Better Care Fund;
3. To request that the Board delegate the authority for the formal sign-off of proposals, and full plans for the Better Care Fund, to the Joint Commissioning Forum, for ratification at a future meeting; and
4. For the Board to offer its support to using the Borderline and Peterborough Transformation Board as a key means of engagement with local stakeholders.

1. ORIGIN OF REPORT

1.1 This report is submitted to the Board from the Integration and Transformation Group, following the Board's previous agreement to the establishment of this group to take forwards this work.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to update the Board on the developing proposals for the use of the *Better Care Fund* (previously known as the Integration and Transformation Fund) in Peterborough.

2.2 The timetable for further development and planning for this fund (as laid down by the Department of Health in its December guidance) is very tight (see 3.3 below), with deadlines falling between this and the next Board meeting; with this in mind, the Board is asked for its views on a long-list of possible proposals, and to delegate the detailed working up of these to the local *Integration and Transformation Group*.

2.3 This report is for the Board to consider under its terms of reference No. 3.5 'To identify areas where joined up or integrated commissioning, including the establishment of pooled budget arrangements would benefit improving health and wellbeing and reducing health inequalities'.

3. BACKGROUND

3.1 The June 2013 Spending Round announced a further £3.8bn of pooled budgets between Health and Social Care, starting in April 2015, and building on existing integration funding; in preparation for this significant increase, an additional £200m of integration funding will also be made available for 2014/15. The fund, originally called the *Integration and Transformation Fund*, but now known as the *Better Care Fund* is not "new monies", but represents a change to the way that some NHS budget is allocated with the explicit intention of integrating health and social care systems and services at a local level. It is described in guidance published in December 2013 as a "financial incentive for Councils and local NHS organisations to jointly plan and delivery services, so that integrated care can become the norm by 2018".

3.2 The DH Guidance, released late in December 2013 (and attached as an **Appendix 1** to this paper) identified allocations for Peterborough as follows (noting the inclusion of two other funding streams into the total in 2015-16):

Year	Disabilities Facilities Grant (£000)	Social Care Capital Grant (£000)	CCG Transfer (£000)	Total (£000)
2014-15	-	-	-	661
2015-16	811	442	10,390	11,643

3.3 The £661k allocated for transfer in 2014-15 is in addition to the existing Section 256 monies of £2,840,646 in 2013-14, providing a total transfer of £3.5m, but is believed to build on Section 256 monies of £455k for the purposes of re-ablement. Overall therefore, the above funding allocations for 2015-16 (and subject to confirmation for 2014-15) should therefore be seen as including the following existing allocations:

- Carers Break funding
- CCG Re-ablement funding
- Capital funding
- Existing transfer from health to adult social care

3.4 The present S256 agreements with Peterborough City Council includes the following priorities, and it is assumed that these will be included in, and indeed may well provide the foundation for future arrangements:

Priority A – Interim beds / Acute hospital / City Care Centre
- Total spend £1,349k
(Including: Interim beds – Independent Sector; Enablement and transitional Support; Community equipment; Telecare development and spend; Transfer of care team)
Priority B – Patients and carers, voluntary sector, prevention, community - Total £575k
(Including: Preventative services – voluntary sector; ISP respite services; Universal Advise and Signposting service)
Priority C – MDT working, Single Assessment, Care plans
- Total £665k
(Including: Assessment and reviews – increased capacity OP, PD and LD; Mental Health assessments)
Priority D&E – Carer support, assessments and safeguarding
- Total £251k
(Including: Carers support Services ; Adult Safeguarding)

Re-ablement – intensive time-limited support following a fall or illness
- **Total: £455k (under separate S256 agreement).**

(Directly provided re-ablement service to prevent deterioration, delay dependency, and support recovery.)

3.5 Local councils and health services are expected to submit plans to Government explaining how they will use this fund to improve local services, and the CCG are actively working with Peterborough City Council, and Cambridgeshire County Council (and other Local Authority and wider partners), to develop a shared vision and principles for the use of the Fund, as well as a set of schemes for its use.

3.6 Planning timescales for development of proposals are exceptionally tight, with draft plans for use of the Fund to be submitted by 14th February 2014, for formal agreement by NHS England by 4th April 2014. It is with this timescale in mind that the Health and Wellbeing Board is asked to give consideration to plans which remain at such an early stage of development, and to delegate authority for further development of the plans in advance of its next meeting.

3.7 In Peterborough, the further development of plans for the Better Care Fund is being led by the *Integration and Transformation Fund Group* (so called based on the previous name of the fund, and presumably subject to update at its next meeting following the recent change). The group includes representatives from Peterborough City Council, and the CCG (including Jana Burton, Executive Director of Adult Social Care, Health and Wellbeing, Peterborough City Council, and Cath Mitchell, Local Chief Officer, Borderline and Peterborough LCG, for Cambridgeshire and Peterborough CCG).

3.8 Plans for the scheme must fulfil four conditions:

- They must be jointly agreed, and signed off by local Health and Wellbeing Boards, local Councils, and local CCGs.
- They should identify how adult social care services will be protected by the plans
- They should facilitate 7-day services in health and social care to support patients to be discharged and avoid unnecessary admissions at weekends
- They should use the NHS number to develop better data sharing between health and social care

3.9 Of the total funding, the Spending Round indicated that £1bn of the funding would be linked to achieving outcomes; it has now been confirmed that half of this (£500m) will be released in April 2015, as follows:

£250m on the basis of four national conditions:

- Protection of adult care services
- Provision of 7-day access to support discharge
- Agreement of the consequential impact on the acute sector
- Ensuring that there is a lead professional for integrated packages of care

£250m on the basis of progress against locally agreed metrics during 2014/15, to include:

- Delayed transfers of care
- Avoidable emergency admissions

3.10 The final £500m will be released in October 2015 on the basis of further progress against all of the national and local metrics.

3.11 This significant sum or outcome focused funding represents a significant incentive for health and social care to work jointly (and including with other partners) to meet the requirements of this national initiative.

3.12 The work in Cambridgeshire and Peterborough to date has developed the following Vision, Aims, and Objectives:

3.12.1 *VISION FOR HEALTH AND SOCIAL CARE SERVICES*

Our vision is to bring together all of the public agencies that provide health and social care support, especially for older people so that we can:

- *co-ordinate services such as health, social care and housing*
- *maximise individuals' access to information, advice and support in their communities, and*
- *help them to live as independently as possible in the most appropriate setting*

To be successful, this transformation will require the contribution of a range of health and social care providers as well as the greater involvement of the community and voluntary sectors.

The Better Care Fund (BCF) offers an important opportunity to transform the health and social care system and delivery in Cambridgeshire and Peterborough to:

- *meet the needs of a rapidly ageing population better, and by doing so*
- *ease the pressure on the system more generally*
- *enable the health and social care system to provide better services to the whole population of the City*

The BCF offers a unique opportunity to re-think how a significant amount of public money could be more efficiently and effectively spent.

Fundamentally, we agree that BCF will be used for genuine transformation of the health and social care system in Cambridgeshire and Peterborough; through creating greater synergy and hence efficiencies in the provision of social care and health services these can better be protected from pressures brought about by increasing demand and reducing budgets.

The scale of the transformation opportunity is significant. It is much more than just reducing admissions to hospital. Rather, it is about changing the whole system so that services are focused on supporting people wherever possible with person-centred and professionally-led primary / community / social care guided by the goal of living as independently as possible, for as long as is possible.

This approach aligns with the principles set out by Government, NHS England and Local Government Association; it is also well-supported by evidence that clinical and service integration delivers better outcomes for people, particularly if groups of patients or service users are clearly identified and services for them are joined up around their needs.

3.12.2 *INTEGRATION AIMS AND OBJECTIVES*

The model adopted in Cambridgeshire and Peterborough will have the following characteristics:

- ***A united approach to advice and information on community and public sector services.***
  This will include developing robust and reliable sources of advice and support for older people before they become frail or need to access the statutory system; and providing universal information and advice about services from all partner agencies, which should be quick to access, clear, friendly and personalised.
- ***Investment in community capacity to enable people to meet their needs with support in their local community.***
  This could include extension of the community navigator system; and work to consider people's social capital alongside their other assets and support people to be engaged with their families and in their communities. Further development and investment in community capacity building will prevent some people from entering a crisis, accessing

specialist services and potentially reducing long term care costs; and importantly helping people to stay where they want to be – at home.

- ***Coordinated and intelligence-led early identification and early intervention.*** *This might include professionals being proactive in identifying need rather than waiting for it to be presented as a formal referral; ensuring that the workforce are able to feed back as much intelligence as possible as to the needs of the service users they are supporting and how service delivery and deployment of available resources can be improved; further improving information sharing between the range of organisations in contact with older people about individuals at risk of requiring more support in the future; Social Workers having greater identification with a community and working with other agencies to identify those at risk and interventions available , preferably through the voluntary and community sector for needs that might be below the thresholds for statutory assessment; and giving professional freedom to deliver a flexible response to need to avoid escalation of cost (e.g. through use of direct payments, or community development interventions).*
- ***An improved approach to crisis management and recovery.*** *This might include a process for rapid escalation and action when a crisis occurs in the life of an older person; this is likely to involve a coordinated response from all agencies working in or operating as multi-disciplinary teams to provide intensive support in the short term and encompassing services such as respite care. Support should focus on ensuring that when the crisis is over older people and their carers remain as independent as possible and avoid short term crises triggering a deterioration which leads to long term health or social care need.*

4. LONG LIST OF PROPOSED SCHEMES

4.1 The following table outlines some of the schemes that are under consideration for the Better Care Fund in Peterborough. This list has been developed taking into account the national conditions, achieving nationally agreed metrics during the period of the fund, and with reference to both existing local initiatives and evidence of impact, as well a review of evidence recently undertaken by the public health colleagues. Further details relating to some of these criteria or characteristics can be found below.

Scheme	Brief details
Enhanced re-ablement service	Building on the provision successfully provided by the City Council under present pooled funding arrangements, with the proposed impact being reduced admissions, reduced length of stay and reduced (or at least delayed) demand for long term care. Including closer alignment of community therapies to develop a structured and intensively supported discharge service (in particular for conditions such as stroke for which there is an evidence base as to the positive impact of e.g. Early Supported Discharge). In addition to include a focused and preventative approach to (repeat) fallers, including close work with other initiatives including medication review, etc.
Enhanced carers services	Building on the future aspiration of the Carers' Strategy, to join up monies from the Council and the CCG to improve outcomes for carers; including roll-out and implementation of Carers' Prescription Service, support in a crisis, carers breaks, and better advice and upstream support for carers and communities.
Closer alignment of present S256 funding with existing health and care gaps	Increased investment in frontline care services targeted in areas of greatest need which are presently under-provided by the health and care sector, including (for instance): through enhanced Multi-Disciplinary Teams

	(MDT) working with adults as well as older adults (e.g. to reduce admissions for patients with concurrent learning disability and epilepsy); increased social care input to all MDT working; 7-day working through MDT (or similar) teams, including The Firm (or equivalent); improved psychiatric liaison services or mental health presence in MDTs.
Admission avoidance and intermediate care	Building on existing intermediate care and admission avoidance schemes (including The Firm or equivalent), to further reduce the number of avoidable admissions, and emergency bed days. To increase patient flow through intermediate care sector to ensure access to "step-up" as well as re-ablement beds.
Increased funding for home adaptations (and assessment leading to these, including enhanced OT service).	To improve waiting times and capacity by working in partnership with housing providers, to provide timely and preventative adaptations, as well as to enhance re-ablement services following admission etc. To consider how the existing ICES contract might be aligned or more closely integrated with this work.
Increased investment in "upstream" preventative services.	Building on existing 3rd Sector provision, to pro-actively develop community navigator schemes that improve access to advice and information (including for carers, and wider communities); and to promote social and community capital with a particular aim to combat isolation, and the social causes of ill health. To develop a universally accessible and joined up first point of contact, with a view to avoiding escalation of demand (including admission to care or acute settings). To promote empowerment and self-management, building on the philosophy of self-directed support, whether through development of personal health budgets, or associated planning mechanisms for those with long-term conditions. To more closely align community resources that exist for different client groups; this could result in efficiencies and greater community cohesion and support.
Enhanced dementia support services	To develop great community resource, building on the development of the Dementia Resource Centre, with a particular view to early diagnosis, and "upstream" interventions (e.g. psycho-educational, and including support to carers and wider communities) which may maintain independence and reduce (or delay) admission to long-term care settings.
End of Life	Enhanced home care support at end of life through specialist third sector provision, with the aim of improved experience for patients and their families at the end of life as well as reduced unplanned care costs.
Care Sector Review	To develop enhanced services (alongside incoming

Team	Lead Integrator for Older Peoples Community Services, and with reference to the Primary Care Strategy, in partnership with Primary Care) to review the health and care needs of citizens in the care sector, to review quality of care, and to support discharge (back to more independent living), increased independence (for those who require longer term care).
Focussed medications review	Coupled with the above (working in, but not exclusively in, the care sector) to prioritise timely medication review, and with a view to avoid falling.
Telecare and telehealth	To invest in areas for which assistive technologies are proven (e.g. for people with chronic heart-failure, COPD / asthma) with a view to maintaining independence, and reducing unnecessary hospital admissions.

5. CONSULTATION

5.1 In addition to the on-going work of the PCC Integration and Transformation Group, the CCG is actively engaging with both Cambridgeshire County Council, and Northamptonshire County Council, to ensure effective alignment (where possible) and disaggregation (where necessary) of its BCF plans.

5.2 PATIENT, SERVICE USER AND PUBLIC ENGAGEMENT
We have endeavoured to engage with stakeholders as widely as possible given the tight timescales for development of the early drafts of the agreement, and to ensure that the views obtained through dialogue and feedback from our stakeholders are played appropriately into the final version of this plan. We envisage that engagement will continue as an on-going activity throughout the duration of the BCF plan so that we can assure ourselves that the initiatives we implement reflect, as far as possible, the opportunities identified as a result of engagement.

5.3 The scope of engagement in Cambridgeshire and in Peterborough has been comprehensive including:

- Health and Well-being Boards in Cambridgeshire and in Peterborough
- Cambridgeshire Public Sector Board
- Local Authority Cabinet and Scrutiny members
- CCG Executive and Governing Body
- Older People Programme Board
- Local Clinical Commissioning Groups
- Chief Executives of all hospitals (acute sector)
- Several Housing Providers (excluding City/District Councils' housing services)
- Independent Sector Providers (Provider Forum and Strategic Provider group)
- Voluntary Sector Groups

5.4 Our approach throughout has been to:

- secure buy-in to the use of the fund through the active **engagement** of all key and relevant stakeholders
- ensure there is **engagement** on draft proposals prior to discussions at the Health and Wellbeing Boards prior to submission to government
- be **proportionate** given the time and resource constraints - so where ever possible using existing meetings/forums and communication channels e.g. website consultation pages to facilitate the process; and

- ensure there will be **further opportunities** to shape and influence use of BCF once plans have been accepted by government i.e. at the more detailed planning stage

5.5 We have adopted three phases of work:

Phase 1: Stakeholder engagement

- Development of the Vision and Principles document and associated strategies with stakeholders, in particular Health and Social Care providers, public sector bodies, Healthwatch and the community and voluntary sectors. The aim is to seek 'buy-in' to the overall proposition; to clarify issues (e.g. funding, scope) and to manage expectations

Phase 2: User, Patient and Wider Public Engagement

- Formal publication of the Vision and Principles document seeking views from patients and service users across the health and social care system

Phase 3: Further involvement of stakeholders (providers, patients and users) to help shape final proposals and service design (February to March 2014)

- The 'shape' of stakeholder involvement will reflect the nature of the schemes included in the approved plan.

6. ANTICIPATED OUTCOMES

6.1 The future outcome for the BCF will be improved service integration, community cohesion and capacity, and to develop better outcomes for the citizens of Peterborough in terms of health and social care service delivery; it should also improve the medium-term affordability of services in the stretched local health and social care economy. The Health and Wellbeing Board will wish to take a strategic oversight of these plans (once developed, and through their implementation), including through regular qualitative and quantitative reports to this Board.

6.2 In the shorter term, the hoped for outcome of this paper will be to delegate (and indeed authorise) the next step in the planning process, to ensure that local plans can be developed within the required time envelope to allow the full allocation of local funding to be pooled. It is recommended that an update on this process be brought back to the next Board meeting for formal ratification, and to request any recommendations for review and refresh of the plans as their detail is developed during 2014/15. Prior to this it is proposed that the first draft be taken to the February meeting of the Joint Commissioning Forum for approval prior to submission on 14th February, with a revised draft coming to the March meeting of that group, prior to being sent to the Health and Wellbeing Board for virtual sign-off prior to submission of the final draft to NHS England on 4th April.

7. REASONS FOR RECOMMENDATIONS

7.1 The Board should be aware of the development of arrangements (national and local) for the Better Care Fund, the developing plans for its use, and the expectation from central government that Health and Wellbeing Boards take a central role in signing off these plans. The Board is asked to delegate the agreement of more detailed plans for the use of the BCF to the ITF Group since the required timescales for agreeing these do not allow for their being brought to a subsequent meeting.

8. ALTERNATIVE OPTIONS CONSIDERED

8.1 The Board might choose not to consider the plans for use of the BCF at such an early stage, or to withhold its agreement to their development, or to delegated authority to the ITF or other group. This would risk a missed opportunity, both for progressing the development of future integrated working, but also for the development of pooled funding arrangements in the future. Moreover, the DH Guidance (published in December 2013) makes it clear that the £200m of additional funding for 2014/15 will only be released by

NHS England to Councils that have jointly agreed a Better Care Fund two-year plan for the period from 2015. So whilst no action, or alternative delegated authority might be considered, it would risk this additional sum of integration funding to delay the final decision until the next Board meeting.

9. BACKGROUND DOCUMENTS

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

- The BCF guidance, released on 20/12/13.
- Terms of Reference for the ITF Board.

10. Appendices

Appendix 1 – DH Guidance
Appendix 2 – Joint Letter to LA's – Better Care Fund
Appendix 3 – Integration Transformation Fund TOR

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Annex to the NHS England Planning Guidance

Developing Plans for the Better Care Fund

(formerly the Integration Transformation Fund)

What is the Better Care Fund?

1. The Better Care Fund (previously referred to as the Integration Transformation Fund) was announced in June as part of the 2013 Spending Round. It provides an opportunity to transform local services so that people are provided with better integrated care and support. It encompasses a substantial level of funding to help local areas manage pressures and improve long term sustainability. The Fund will be an important enabler to take the integration agenda forward at scale and pace, acting as a significant catalyst for change.

2. The Better Care Fund provides an opportunity to improve the lives of some of the most vulnerable people in our society, giving them control, placing them at the centre of their own care and support, and, in doing so, providing them with a better service and better quality of life.

3. The Fund will support the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community settings. This will build on the work Clinical Commissioning Groups (CCGs) and councils are already doing, for example, as part of the integrated care "pioneers" initiative, through Community Budgets, through work with the Public Service Transformation Network, and on understanding the patient/service user experience.

What is included in the Better Care Fund and what does it cover?

4. The Fund provides for £3.8 billion worth of funding in 2015/16 to be spent locally on health and care to drive closer integration and improve outcomes for patients and service users and carers. In 2014/15, in addition to the £900m transfer already planned from the NHS to adult social care, a further £200m will transfer to enable localities to prepare for the Better Care Fund in 2015/16.

5. The tables below summarise the elements of the Spending Round announcement on the Fund:

The June 2013 Spending Round set out the following:	
2014/15	**2015/16**
A further £200m transfer from the NHS to adult social care, in addition to the £900m transfer already planned	£3.8bn to be deployed locally on health and social care through pooled budget arrangements

In 2015/16 the Fund will be created from:
£1.9bn of NHS funding
£1.9bn based on existing funding in 2014/15 that is allocated across the health and wider care system. This will comprise: • £130m Carers' Break funding • £300m CCG reablement funding • £354m capital funding (including £220m Disabled Facilities Grant) • £1.1bn existing transfer from health to adult social care.

6. For 2014/15 there are no additional conditions attached to the £900m transfer already announced, but NHS England will only pay out the additional £200m to councils that have jointly agreed and signed off two-year plans for the Better Care Fund.

7. In 2014/15 there are no new requirements for pooling of budgets. The requirements for the use of the funds transferred from the NHS to local authorities in 2014/15 remain consistent with the guidance[1] from the Department of Health (DH) to NHS England on 19 December 2012 on the funding transfer from NHS to social care in 2013/14. In line with this:

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

9. *A condition of the transfer is that the local authority agrees with its local health partners how the funding is best used within social care, and the outcomes expected from this investment. Health and wellbeing boards will be the natural place for discussions between NHS England, clinical commissioning groups and councils on how the funding should be spent, as part of their wider discussions on the use of their total health and care resources.*

10. *In line with our responsibilities under the Health and Social Care Act, an additional condition of the transfer is that councils and clinical commissioning groups have regard to the Joint Strategic Needs Assessment for their local population, and existing commissioning plans for both health and social care, in how the funding is used.*

11. *A further condition of the transfer is that local authorities councils and clinical commissioning groups demonstrate how the funding transfer will make a positive difference to social care services, and outcomes for service users, compared to service plans in the absence of the funding transfer"*

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

12. Councils should use the additional £200m to prepare for the implementation of pooled budgets in April 2015 and to make early progress against the national conditions and the performance measures set out in the locally agreed plan. This is important, since some of the performance-related money is linked to performance in 2014/15.

13. The £3.8bn Fund includes £130m of NHS funding for carers' breaks. Local plans should set out the level of resource that will be dedicated to carer-specific support, including carers' breaks, and identify how the chosen methods for supporting carers will help to meet key outcomes (e.g. reducing delayed transfers of care). The Fund also includes £300m of NHS funding for reablement services. Local plans will therefore need to demonstrate a continued focus on reablement

14. It was announced as part of the Spending Round that the Better Care Fund would include funding for costs to councils resulting from care and support reform. This money is not ring-fenced, but local plans should show how the new duties are being met.

    i. £50m of the capital funding has been earmarked for the capital costs (including IT) associated with transition to the capped cost system, which will be implemented in April 2016.

    ii. £135m of revenue funding is linked to a range of new duties that come in from April 2015 as a result of the Care Bill. Most of the cost results from new entitlements for carers and the introduction of a national minimum eligibility threshold, but there is also funding for better information and advice, advocacy, safeguarding and other measures in the Care Bill.

What will be the statutory framework for the Fund?

15. In 2015/16 the Fund will be allocated to local areas, where it will be put into pooled budgets under Section 75[2] joint governance arrangements between CCGs and councils. A condition of accessing the money in the Fund is that CCGs and councils must jointly agree plans for how the money will be spent, and these plans must meet certain requirements.

16. Funding will be routed through NHS England to protect the overall level of health spending and ensure a process that works coherently with wider NHS funding arrangements.

17. DH will use the Mandate for 2015/16 to instruct NHS England to ring-fence its contribution to the Fund and to ensure this is deployed in specified amounts at local level for use in pooled budgets by CCGs and local authorities.

18. Legislation is needed to ring-fence NHS contributions to the Fund at national and local levels, to give NHS England powers to assure local plans and performance, and to ensure that local authorities not party to the pooled budget can be paid from it, through additional conditions in Section 31 of the Local

[2] Sec 75 of the NHS Act, 2006, provides for CCGs and local authorities to pool budgets.

Government Act 2003. This will ensure that the Disabled Facilities Grant (DFG) can be included in the Fund

19. The DFG has been included in the Fund so that the provision of adaptations can be incorporated in the strategic consideration and planning of investment to improve outcomes for service users. DFG will be paid to upper-tier authorities in 2015/16. However, the statutory duty on local housing authorities to provide DFG to those who qualify for it will remain. Therefore each area will have to allocate this funding to their respective housing authorities (district councils in two-tier areas) from the pooled budget to enable them to continue to meet their statutory duty to provide adaptations to the homes of disabled people, including in relation to young people aged 17 and under.

20. Special conditions will be added to the DFG Conditions of Grant Usage (under Section 31 of the Local Government Act 2003) which stipulate that, where relevant, upper-tier local authorities or CCGs must ensure they cascade the DFG allocation to district council level in a timely manner such that it can be spent within year. Further indicative minimum allocations for DFG have been provided for all upper-tier authorities, with further breakdowns for allocations at district council level as the holders of the Fund may decide that additional funding is appropriate to top up the minimum DFG funding levels.

21. DH and the Department for Communities and Local Government (DCLG) will also use Section 31 of the Local Government Act 2003 to ensure that DH Adult Social Care capital grants (£134m) will reach local areas as part of the Fund. Relevant conditions will be attached to these grants so that they are used in pooled budgets for the purposes of the Fund. DH, DCLG and the Treasury will work together in early 2014 to develop the terms and conditions of these grants.

How will local Fund allocations be determined?

22. Councils will receive their detailed funding allocations in the normal way. NHS allocations will be two-year allocations for 2014/15 and 2015/16 to enable more effective planning.

23. In 2014/15 the existing £900m s.256 transfer to councils for adult social care to benefit health, and the additional £200m, will continue to be distributed using the social care relative needs formula (RNF).

24. The formula for distribution of the full £3.8bn fund in 2015/16 will be based on a financial framework agreed by ministers. The current social care transfer of £1.1bn and the £134m of adult social care capital funding included in the Fund in 2015/16 will be allocated in the same way as in 2014/15. DFG will be allocated based on the same formula as 2014/15. The remainder of the Fund will be allocated on the basis of the CCG allocations formula. It will be for local areas to decide how to spend their allocations on health and social care services through their joint plan.

25. The announcement of the two-year CCG allocations, communicated to CCGs and councils alongside this planning guidance, includes the Fund allocations in 2015/16. In 2014/15, the additional £200m will be transferred directly from NHS

England to councils along with the rest of the adult social care transfer. The local authority and CCGs in each Health and Wellbeing Board area will receive a notification of their share of the pooled fund for 2014/15 and 2015/16 based on the aggregate of the allocation mechanisms. The allocation letter also specifies the amount that is included in the payment-for-performance element, and is therefore contingent in part on planning and performance in 2014/15 and in part on achieving specified goals in 2015/16.

26. Allocation letters will specify only the minimum amount of funds to be included in pooled budgets. CCGs and councils are free to extend the scope of their pooled budget to support better integration in line with their Joint Health and Wellbeing Strategy.

27. The wider powers to use Health Act flexibilities to pool funds, share information and staff are unaffected by the new Better Care Fund requirements, and will be helpful in taking this work forward.

How should councils and CCGs develop and agree a joint plan for the Fund?

28. Each statutory Health and Wellbeing Board will sign off the plan for its constituent councils and CCGs. The Fund plan must be developed as a fully integral part of a CCG's wider strategic and operational plan, but the Better Care Fund elements must be capable of being extracted to be seen as a stand-alone plan.

29. Where the unit of planning chosen by a CCG for its strategic and operational plan is not consistent with the boundaries of the Health and Wellbeing Board, or Boards, with which it works, it will be necessary for the CCG to reconcile the Better Care Fund element of its plan to the Health and Wellbeing Board level. NHS England will support CCGs in this position to ensure that plans are properly aligned.

30. The specific priorities and performance goals in the plan are clearly a matter for each locality but it will be valuable to be able to:

- aggregate the ambitions set for the Fund across all Health and Wellbeing Boards;
- assure that the national conditions have been achieved; and
- understand the performance goals and payment regimes that have been agreed in each area.

31. To assist Health and Wellbeing Boards we have developed a template which we expect everyone to use in developing, agreeing and publishing their Better Care Plan. This is attached as a separate Word document and Excel spread sheet. The template sets out the key information and metrics that all Health and Wellbeing Boards will need to assure themselves that the plan addresses the conditions of the Fund.

32. As part of this template, local areas should provide an agreed shared risk register. This should include an agreed approach to risk sharing and mitigation covering, as a minimum, the impact on existing NHS and social care delivery and

the steps that will be taken if activity volumes do not change as planned (for example, if emergency admissions or nursing home admissions increase).

33. CCGs and councils must engage from the outset with all providers, both NHS and social care (and also providers of housing and other related services), likely to be affected by the use of the fund in order to achieve the best outcomes for local people. The plans must clearly set out how this engagement has taken place. Providers, CCGs and councils must develop a shared view of the future shape of services, the impact of the Fund on existing models of service delivery, and how the transition from these models to the future shape of services will be made. This should include an assessment of future capacity and workforce requirements across the system. It will be important to work closely with Local Education and Training Boards and the market shaping functions of councils, as well as with providers themselves, on the workforce implications to ensure that there is a consistent approach to workforce planning for both providers and commissioners.

34. CCGs and councils should also work with providers to help manage the transition to new patterns of provision including, for example, the use of non-recurrent funding to support disinvestment from services. It is also essential that the implications for all local providers are set out clearly for Health and Wellbeing Boards and that their agreement for the deployment of the Fund includes agreement to all the service change consequences.

What are the National Conditions?

35. The Spending Round established six national conditions for access to the Fund:

National Condition	Definition
Plans to be jointly agreed	The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Round, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Well Being Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and councils should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.

National Condition	Definition
Protection for social care services (not spending)	Local areas must include an explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with the 2012 Department of Health guidance referred to in paragraphs 8 to 11, above.
As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends	Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services within existing resources.
Better data sharing between health and social care, based on the NHS number	The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care. Local areas should: • confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to; • confirm that they are pursuing open APIs (ie. systems that speak to each other); and • ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place. NHS England has already produced guidance that relates to both of these areas. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by DH).

National Condition	Definition
Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals. The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.
Agreement on the consequential impact of changes in the acute sector	Local areas should identify, provider-by-provider, what the impact will be in their local area, including if the impact goes beyond the acute sector. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans must not have a negative impact on the level and quality of mental health services.

How will Councils and CCGs be rewarded for meeting goals?

36. The Spending Round indicated that £1bn of the £3.8bn would be linked to achieving outcomes. Ministers have agreed the basis on which this payment-for-performance element of the Fund will operate.

37. Half of the £1bn will be released in April 2015. £250m of this will depend on progress against four of the six national conditions and the other £250m will relate to performance against a number of national and locally determined metrics during 2014/15. The remainder (£500m) will be released in October 2015 and will relate to further progress against the national and locally determined metrics.

38. The performance payment arrangements are summarised in the table below:

When:	Payment for performance amount	Paid for:
April 2015	£250m	Progress against four of the national conditions: • protection for adult social care services • providing 7-day services to support patients being discharged and prevent unnecessary admissions at weekends • agreement on the consequential impact of changes in the acute sector; • ensuring that where funding is used for integrated packages of care there will be an accountable lead professional
	£250m	Progress against the local metric and two of the national metrics: • delayed transfers of care; • avoidable emergency admissions; and
October 2015	£500m	Further progress against all of the national and local metrics.

National and Local Metrics

39. Only a limited number of national measures can be used to demonstrate progress towards better integrated health and social care services in 2015/16, because of the need to establish a baseline of performance in 2014/15. National metrics for the Fund have therefore been based on a number of criteria, in particular the need for data to be available with sufficient regularity and rigour.

40. The national metrics underpinning the Fund will be:

- admissions to residential and care homes;
- effectiveness of reablement;
- delayed transfers of care;
- avoidable emergency admissions; and
- patient / service user experience.

41. The measures are the best available but do have shortcomings. Local plans will need to ensure that they are applied sensitively and do not adversely affect decisions on the care of individual patients and service users.

42. Further technical guidance will be provided on the national metrics, including the detailed definition, the source of the data underpinning the metric, the reporting schedule and advice on the statistical significance of ambitions for improvement.

43. Due to the varying time lags for the metrics, different time periods will underpin the two payments for the Fund as set out in the table below. Data for the first two of these metrics, on admissions to residential and care homes and the

effectiveness of reablement, are currently only available annually and so will not be available to be included in the first payment in April 2015.

Metric	April 2015 payment based on performance in	October 2015 payment based on performance in
Admissions to residential and care homes	N/A	Apr 2014 - Mar 2015
Effectiveness of reablement	N/A	Apr 2014 - Mar 2015
Delayed transfers of care	Apr – Dec 2014	Jan - Jun 2015
Avoidable emergency admissions	Apr – Sept 2014	Oct 2014 – Mar 2015
Patient / service user experience	N/A	Details TBC

44. For the metric on patient / service user experience, no single measure of the experience of integrated care is currently available, as opposed to quality of health care or social care alone. A new national measure is being developed, but will not be in place in time to measure improvements in 2015/16. In the meantime, further details will be provided shortly on how patient / service user experience should be measured specifically for the purpose of the Fund.

45. In addition to the five national metrics, local areas should choose one additional indicator that will contribute to the payment-for-performance element of the Fund. In choosing this indicator, it must be possible to establish a baseline of performance in 2014/15.

46. A menu of possible local metrics selected from the NHS, Adult Social Care and Public Health Outcomes Frameworks is set out in the table below:

NHS Outcomes Framework	
2.1	Proportion of people feeling supported to manage their (long term) condition
2.6i	Estimated diagnosis rate for people with dementia
3.5	Proportion of patients with fragility fractures recovering to their previous levels of mobility / walking ability at 30 / 120 days
Adult Social Care Outcomes Framework	
1A	Social care-related quality of life
1H	Proportion of adults in contact with secondary mental health services living independently with or without support
1D	Carer-reported quality of life
Public Health Outcomes Framework	

1.18i	Proportion of adult social care users who have as much social contact as they would like
2.13ii	Proportion of adults classified as “inactive”
2.24i	Injuries due to falls in people aged 65 and over

47. Local areas must either select one of the metrics from this menu, or agree a local alternative. Any alternative chosen must meet the following criteria:

- it has a clear, demonstrable link with the Joint Health and Wellbeing Strategy;
- data is robust and reliable with no major data quality issues (e.g. not subject to small numbers);
- it comes from an established, reliable (ideally published) source;
- timely data is available, in line with requirements for pay for performance;
- the achievement of the locally set level of ambition is suitably challenging; and
- it creates the right incentives.

48. Each metric will be of equal value for the payment for performance element of the Fund.

49. Local areas should set an appropriate level of ambition for improvement against each of the national indicators, and the locally determined indicator. In signing off local plans, Health and Wellbeing Boards should be mindful of the link to the levels of ambition on outcomes that CCGs have been asked to set as part of their wider strategic and operational plans. Both the effectiveness of reablement and avoidable emergency admissions outcomes metrics are consistent with national metrics for the Fund, and so Health and Wellbeing Boards will need to ensure consistency between the CCG levels of ambitions and the Fund plans.

50. In agreeing specific levels of ambition for the metrics, Health and Wellbeing Boards should be mindful of a number of factors, such as:

- having a clear baseline against which to compare future performance;
- understanding the long-run trend to ensure that the target does not purely reward improved performance consistent with trend increase;
- ensuring that any seasonality in the performance is taken in to account; and
- ensuring that the target is achievable, yet challenging enough to incentivise an improvement in integration and improved outcomes for users.

51. In agreeing levels of ambition, Health and Wellbeing Boards should also consider the level required for a statistically significant improvement. It would not be appropriate for the level of ambition to be set such that it rewards a small improvement that is purely an artefact of variation in the underlying dataset.

How will plans be assured?

52. Ministers, stakeholder organisations and people in local areas will wish to be assured that the Fund is being used for the intended purpose, and that the local plans credibly set out how improved outcomes and wellbeing for people will be achieved, with effective protection of social care and integrated activity to reduce emergency and urgent health demand.

53. To maximise our collective capacity to achieve these outcomes and deliver sustainable services the NHS and local government will have a shared approach to supporting local areas and assuring plans.

54. The most important element of assurance for plans will be the requirement for them to be signed-off by the Health and Wellbeing Board. The Health and Wellbeing Board is best placed to decide whether the plans are the best for the locality, engaging with local people and bringing a sector-led approach to the process.

55. The plans will also go through an assurance process involving NHS England and the LGA to assure Ministers. The key elements of the overall assurance process are as follows:

- Plans are presented to the Health and Wellbeing Board, which considers whether the plans are sufficiently challenging and will deliver tangible benefits for the local population (linked to the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy).

- If the Health and Wellbeing Board is not satisfied, and the plan is still lacking after a process of progressive iteration, an element of local government and NHS peer challenge will be facilitated by NHS England and the LGA.

- NHS England's process for assuring CCG strategic and operational plans will include a specific focus on the element of the plan developed for the Fund. This will allow us to summarise, aggregate and rate all plans, against criteria agreed with government departments and the LGA, to provide an overview of Fund plans at national, regional and local level.

- This overview will be reviewed by a Departmental-led senior group comprised of DH, DCLG, HMT, NHS England and LGA officials, supported by external expertise from the NHS and local government. Where issues of serious concern are highlighted the group will consider how issues may be resolved, either through provision of additional support or escalation to Ministers.

- Where necessary, Ministers (supported by the senior group) will meet representatives from the relevant LAs and CCGs to account for why they have not been able to produce an acceptable plan and agree next steps to formulate such a plan.

- Ministers will give the final sign-off to plans and the release of performance related funds.

What will be the consequences of failure to achieve improvement?

56. Ministers have considered whether local areas which fail to achieve the levels of ambition set out in their plan should have their performance-related funding withdrawn, to be reallocated elsewhere. However, given the scale and complexity of the challenge of developing plans for the first time, they have agreed that such

a sanction will not be applied in 2015/16. Further consideration will be given to whether it should be introduced in subsequent years.

57. If a local area achieves 70% or more of the levels of ambition set out in each of the indicators in its plan, it will be allowed to use the held-back portion of the performance pool to fund its agreed contingency plan, as necessary.

58. If an area fails to deliver 70% of the levels of ambition set out in its plan, it may be required to produce a recovery plan. This will be developed with the support of a peer review process involving colleagues from NHS and local government organisations in neighbouring areas. The peer review process will be co-ordinated by NHS England, with the support of the LGA.

59. If the recovery plan is agreed by the Health and Wellbeing Board, NHS England and the local government peer reviewer, the held-back portion of the performance payment from the Fund will be made available to fund the recovery plan.

60. If a recovery plan cannot be agreed locally, and signed-off by the peer reviewers, NHS England will direct how the held-back performance related portion of the Fund should be used by the local organisations, subject to the money being used for the benefit of the health and care system in line with the aims and conditions of the Fund.

61. Ministers will have the opportunity to give the final sign-off to peer-reviewed recovery plans and to any directions given by NHS England on the use of funds in cases where it has not been possible to agree a recovery plan.

Support for BCF Planning

62. CCGs and councils can access additional support for Better Care Fund planning from the same routes as for NHS operational and strategic plans: local support via CSUs or external providers, workshops and webinars, and specific tools and resources. Links to these, and contact details can be found on NHS England and the LGA's websites.

When should plans be submitted?

63. Health and Wellbeing Boards should provide the first cut of their completed Better Care Plan template, as an integral part of the constituent CCGs' Strategic and Operational Plans by **14 February 2014**, so that we can aggregate them to provide a composite report, and identify any areas where it has proved challenging to agree plans for the Fund.

64. The revised version of the Better Care Plan should be submitted to NHS England, as an integral part of the constituent CCGs' Strategic and Operational Plans by **4 April 2014**.

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APPENDIX 2

Department of Health

Department for Communities and Local Government

Dear colleagues,

2 0 DEC 2013

Better Care Fund

The way we deliver health and social care services needs to change. One in three children born today expect to live to 100, so demand is only going to increase and we need to make major changes now to create seamless services fit for future generations , and to focus more effectively on preventing ill health and preventing a deterioration to health.

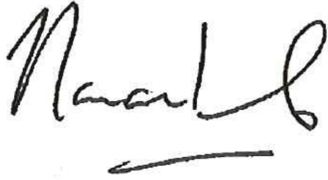
That is why, in June, we announced £3.8 billion worth of pooled budgets between health and social care, starting from April 2015. This will be a multi-year fund, as confirmed by the Autumn Statement, and is the biggest ever financial incentive for councils and local NHS organisations to jointly plan and deliver services, so that integrated care becomes the norm by 2018.

Many places are already working collaboratively and redesigning services to meet the needs of users and communities, but we want to see faster and more widespread change. We have therefore provided an extra £200m in the pool for the transfer from health to social care in 2014/15 to streamline the process. This means that you should be well placed to take maximum advantage of the first full year of the fund in 2015/16. The £3.8 billion fund is the minimum amount to be pooled; some areas may wish to go further.

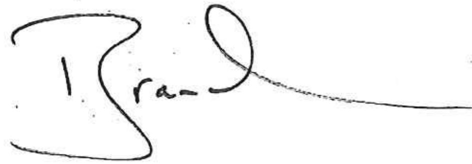
We call on every area to start planning now, with a view to having plans drafted by February 2014. We know the deadlines are tight – this is reflective of the urgency of this work. We need your plans to be innovative and ambitious – the end goal is radical transformation to provide better care.

We have come together in Whitehall so that you can work together at a local level. We need you to link your local plan to those wider determinants of health, and ensure housing and public health priorities and programmes support and enrich this work.

We are pleased to enclose full guidance and allocation information to enable you to make the most of the Better Care Fund.



NORMAN LAMB



BRANDON LEWIS

PETERBOROUGH CITY COUNCIL

NHS Cambridgeshire and Peterborough Clinical Commissioning Group

Scoping Group for developing the Integration Transformation Fund Action Plan

Terms of Reference

1. Purpose

- To deliver integration transformation through partnership
- Targeting the pool budget to maintain independence
- To manage the service change effectively to ensure minimal adverse impact on customers
- To review current plans/services attached to identified funding streams and agree continuation of plans/services or changes as appropriate
- To undertake analysis of local needs and customers views on how these needs may best be met
- To agree priorities against the needs assessment and develop outcome focused specifications
- To create plan for 2014/15 against specified outcomes for people
- To present the plan to the Joint Commissioning Forum
- To submit the Plan to the Health and Wellbeing Board for sign off by 15th February 2014.
- To align with 'The NHS belongs to the people: a call to action'

2. Objectives

- that there is truly integrated multi-agency working so that local health and social care systems work as a whole system to respond to the needs of local people
- to ensure current social care services are protected
- to further develop a 7 day working approach for both health and social care to support patients being discharged from inpatient provision and prevent unnecessary admissions and re-admissions
- to develop better information sharing between health and social care
- to ensure a joint approach to assessments and care planning
- to ensure that where funding is used for integrated packages there is an accountable professional
- agreement on the consequential impact of changes in the acute sector and how these will be managed
- to ensure an integrated preventative offer is developed and easily accessible to the customer
- to ensure an integrated carers strategy

3. Outcomes

- people are in control and are central to the planning of their care so they receive a service that is right for them
- people get the right support, at the right time in the right place and at the right cost
- carers get the right support, at the right time in the right place and at the right cost

Frequency, Structure and Administration

To meet fortnightly to produce the plan, and at agreed intervals thereafter to monitor implementation

4. Membership

Cathy Mitchell (Chair)	Local Chief Officer, Borderline and Peterborough LCGs
Housing/DFG Rep	TBC
Jana Burton	Executive Director of Adult Social Care, Health & Wellbeing, Peterborough City Council
Wendi Ogle-Welbourn	Director for Communities, PCC
Chris Rowland	Older People Project Lead, B&PLCG's
John Ellis	MH Contract Lead, C&PCCG
Area Team Rep.	TBC
Paul Grubic	Asst Director Commissioning, PCC
Debbie McQuade	Asst Director Care Service Delivery, PCC
Tina Hornsby,	Asst Director Quality, Improvement & Performance, PCC
Paul Stevenson	Head of Adult Social Care Finance, PCC
Margaret Osibowale	System Finance Lead, B&PLCG's
Dr Richard Withers	Clinical Lead, Borderline LCG

Substitutes may attend if required

5. Quorum

Where appropriate, identify what is required in terms of a Quorum to enable meeting to go ahead.

6. Reporting Arrangements

Local Commissioning Groups and Health & Wellbeing Board

Author: Cathy Mitchell, Local Chief Officer, B&P LCGs

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 6(a)
16 JANUARY 2014		PUBLIC REPORT
Contact Officer(s):	Jana Burton – Executive Director Adult Social Care, Health and Wellbeing. Tina Hornsby – Assistant Director Quality Information and Performance Adult Social Care, Health and Wellbeing	Tel. 01733 452409 01733 452427

JOINT STRATEGIC NEEDS ASSESSMENT UPDATE REPORT

R E C O M M E N D A T I O N S	
FROM: Executive Director Adult Social Care, Health and Wellbeing.	**Deadline date: N/A**
1. That the Committee support the proposal to refresh the Joint Strategic Needs Assessment via thematic areas. 2. That the committee consider the governance arrangements for agreeing and overseeing the work plan for the thematic refresh 3. That the committee receive the update on the Children's thematic refresh and provide feedback on the model developed in partnership with Green Ventures. 4. That the Committee consider thematic areas they would wish to see within the work plan, and agree the proposed initial work plan.	

1. ORIGIN OF REPORT

1.1 This report is submitted to Board following the senior management restructure and realignment of responsibilities as presented to Full Council on 9 October 2013

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to update the Committee on the work being undertaken to refresh the Children's JSNA and to obtain the Committee's views on the proposed future work plan for targeted thematic JSNA refresh areas.

2.2 This report is for Board to consider under its Terms of Reference No. 3.2 'To develop a shared understanding of the needs of the community through developing and keeping under review the Joint Strategic Needs Assessment and to use this intelligence to refresh the Health & Well Being Strategy'.

3. JOINT STRATEGIC NEEDS ASSESSMENT (JSNA) UPDATE.

3.1 The current Peterborough JSNA was published in 2011and is a large pool of information covering a wide range of areas. Although a great deal of information is contained within this and it is accompanied by an executive summary the volume of information and needs assessments makes it difficult to form a clear picture of Peterborough's needs. The format is also very traditional, and although located on the website it is not interactive or easy to navigate.

3.2 Since the publication of the current JSNA in 2011 we have received updated information from a variety of sources including:

- Peterborough Health Profile 2013 – Evidencing that overall the health of the population in Peterborough is poorer than England with only one green rated indicator and only 4 indicators better than the England average out of the 32 used in national health profiling.
- Local Health 2013 – detailed health profiles at ward and MSOA areas accessible in the form of interactive maps and reports.
- 2011 Census data – which shows marked population increases with lower percentages of all age groups reporting good or very good health. The ward breakdown shows significant variation between wards.
- Child Health Profile 2013 – which shows almost a quarter of our children (23.5%) living in poverty, with a high rate of young people entering the youth justice system.
- Longer lives report 2013 – which ranks Peterborough nationally (and within its cluster) as one of the areas with relatively high premature deaths from the most common conditions - cancers, CHD and stroke, lung disease and liver disease.

3.3 Joint Strategic Needs Assessments should be a readily accessible, easy-to-read document supported by "live" tools which reflect the current make-up of the local population and are regularly updated to take account of changes. Over the past few months the Council has been working in partnership with Green Ventures to pilot a thematic refresh of the children and families JSNA. This refresh has taken 80 data sets containing the wider determinants of health and created an analytical database using Google Earth to allow comparison and contrast of data against geographical areas of the city, either at ward or lower super output area (LSOA) level. The work has so far been useful but has been impacted by limited availability of some health data sets at ward or LSOA level. An information sharing forum has been established with health colleagues to address the inclusion of health data. The wider determinant work has helped us to identify some health data sets for priority focus. We wish to share with the Committee our early work and findings, via some brief video presentations.

3.4 It is proposed that following the Children's thematic JSNA refresh a steering group be set up to take forward further thematic refresh work. Although the steering group would in time identify items for a refresh work plan it is proposed that the initial work plan would focus on the following

- Completion of the Children and Young Peoples JSNA refresh to include gathering of key health data sets to incorporate into the analytical tool.
- Heart disease and stroke – our early death rates for these are falling further behind the improvements seen nationally and hence a refresh of this area is a priority to support identification of high impact actions which could be taken.
- Housing - impact of housing on health and impact of interventions to improve housing on health and social care activity. This is an area which has been under explored in previous JSNA's and one for which there is a volume of emerging research nationally.
- Prepare an updated key dataset of approximately 250 indicators split into domains, and based on Peterborough's performance for these indicators, systematically select additional themes to work on and build the evidence base for future work plan items. (as thematic "deep dive" topics).

4. CONSULTATION

4.1 The Children's thematic refresh has been done in partnership with colleagues from the Council and Health System

4.2 In order to undertake further thematic JSNA work a steering group will need to be set up to lead on focus groups and working groups for the thematic areas. It is possible that the Health and Wellbeing Boards Operational Group, should this be established, could fulfil this role

5. ANTICIPATED OUTCOMES

5.1 It is anticipated that the Committee will review the proposals for thematic JSNA refresh work and the pilot work undertaken with Green Ventures and consider how learning from this may be used to build up a fuller more useful JSNA. The committee are asked to consider how a JSNA steering group might fit into the governance structures of the Health and Wellbeing Board.

6. REASONS FOR RECOMMENDATIONS

6.1 There is a statutory requirement to produce a Joint strategic Needs Assessment and oversight of this work falls within the Terms of Reference of the Health and Wellbeing Board.

7. ALTERNATIVE OPTIONS CONSIDERED

7.1 An alternative option is to produce a full refresh of the JSNA, however this would take a lengthy amount of time before delivery and could risk delay in focussing on key issues. In addition the previous full refresh provided a large volume of data and feedback has been that it is difficult to navigate and to identify the key needs for focus.

8. IMPLICATIONS

8.1 Legal – there are no legal implications.

8.2 Finance – there are no financial implications.

9. BACKGROUND DOCUMENTS

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

- http://www.apho.org.uk/resource/view.aspx?RID=50215&SEARCH=peterborough&SPEAR= – **Peterborough health profile 2013**
- http://www.ons.gov.uk/ons/guide-method/census/2011/ - **ONS census**
- http://www.chimat.org.uk/resource/view.aspx?RID=101746®ION=101633 – **child health profile**
- http://www.localhealth.org/ - **local health**
- http://longerlives.phe.org.uk/ - **longer lives**

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HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 7(a)
16 JANUARY 2014		PUBLIC REPORT
Contact Officer(s):	Wendi Ogle-Welbourn Director for Communities	Tel.

JOINT CHILD HEALTH AND WELLBEING COMMISSIONG UNIT

R E C O M M E N D A T I O N S	
FROM : Wendi Ogle – Welbourn Director for Communities	**Deadline date : N/A**
1. Receive comments from members of the Health and Wellbeing Board on the draft Section 75 Agreement and operational policy; and 2. To get a collective agreement from Health and Wellbeing Board members to support the next steps in the development of the Section 75 Agreement and operational policy.	

1. ORIGIN OF REPORT

1.1. This report is submitted to Board following previous submission of a proposal to the Health and Wellbeing board for support in the development of a joint child health and wellbeing commissioning unit.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to:

- Receive comments on the draft Section 75 Agreement and operational procedure from the Health and Wellbeing Board members; and
- To advise and receive comments from Health and Wellbeing Board members on proposed next steps.

3. DEVELOPMENT OF JOINT CHILD HEALTH AND WELLBEING UNIT

3.1 Over the last twelve months children's commissioners from the City Council and CCG have been working together to consider the development of a joint child health and wellbeing commissioning unit. The result of this has been the development of a Section 75 Agreement and operational policy as attached at Appendix 1 and Appendix 2.

3.2 The next steps in relation to the development of the unit are as follows:

- Include the CCG financial envelope to align with PCC financial envelope;
- Take through the formal governance processes of the City Council and CCG.

3.3 We are planning to have the unit in place by April 2014.

4. CONSULTATION

4.1 Through the Joint Commissioning Forum (Membership includes the Local Clinical Commissioning Groups chairs, Local Authority Commissioners) and in close liaison with the CCG designated lead GP for Children, Malcolm Bishop, we have consulted with appropriate stakeholders and received support for the development of the unit.

5. ANTICIPATED OUTCOMES

5.1 The Joint Child Health Commissioning Unit will see an improvement in the efficiency and

effectiveness of child health and wellbeing commissioning; this will result in improved health outcomes for children in Peterborough.

6. REASONS FOR RECOMMENDATIONS

6.1 It is important that the members of the Health and Wellbeing Board are given the opportunity to comment on and influence the development of the joint child health and wellbeing commissioning unit as they are required to ensure that inequalities in child health are addressed and they need to be sure that the development of the unit will effectively address the health and wellbeing of children in Peterborough

7. ALTERNATIVE OPTIONS CONSIDERED

7.1 We know that the services we have in place to address child health issues need to be improved and that aligning the resources of the CCG and City Council to commission needs led services will be more effective and efficient than commissioning separately; hence continuing as we have been was not seen as the best option. An alternative put forward during the consultation was to have one unit covering both Peterborough and Cambridgeshire; however this option was not supported at this time due to the differing needs of the two areas.

8. IMPLICATIONS

8.1 The CCG and City Council will be going through their respective governance processes in respect of the Section 75 Agreement and this will address any legal, financial or HR issues.

9. BACKGROUND DOCUMENTS

9.1 None

APPENDIX 1

DRAFT

Dated 2013

PETERBOROUGH CITY COUNCIL

NHS CAMBRIDGESHIRE & PETERBOROUGH CLINICAL COMMISSIONING GROUP

AGREEMENT

for the delegation of functions and alignment of funding in respect of children's community health and disability services.

DRAFT

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THIS AGREEMENT is made the day of 2012

BETWEEN:

(1) **Peterborough City Council** (the "**Council**") of Town Hall, Bridge Street, Peterborough, PE1 1HQ

(2) **Cambridgeshire & Peterborough Clinical Commissioning Group** (the "**CCG**") of Lockton House, Clarendon Road, Cambridge, CB2 8FH

(each a "**Partner**" and together the "**Partners**")

WHEREAS:

(A) The Council is a local authority established under the Local Government Act 1972 (as amended) and is a local social services authority by virtue of section 2 of the Local Authority Social Services Act 1970. The Council commissions and provides social care and education services for children in Peterborough and discharges its obligations through its Children's Directorate.

(B) The CCG is a Clinical Commissioning Group established under The Health and Social Care Act 2012 and is a commissioner of health services in the City of Peterborough.

(C) Section 75 of the 2006 Act and the Regulations allows the CCG to exercise various local authority functions and for local authorities to exercise various CCG functions on behalf of either party .

(D) The Partners intend to set up comprehensive arrangements in accordance with the 2006 Act and Regulations to integrate their respective Commissioning functions by delegating the commissioning functions in accordance with this Agreement (the "**Partnership Arrangements**"). The Partners have been working together in relation to the commissioning of services in relation to health and social care before the date hereof and the Partnership Arrangements will formalise the same.

(E) The Partners have agreed that the Council will lead commission the Services on behalf of itself and the CCG and that the Council will be the Host Partner in respect of any Aligned/Pooled contracts using a Section 256 Agreement for specific Services or that may be established throughout the term of this Agreement.

(F) The Partners are satisfied that the Partnership Arrangements are likely to lead to an improvement in the way in which their respective Relevant Commissioning Functions are exercised.

(G) The Council and the CCG Governing Body have approved the terms of this Agreement and each party have obtained such consents as are necessary to allow them to enter into this Agreement.

NOW THIS AGREEMENT WITNESSETH AS FOLLOWS:

1 INTERPRETATION AND GENERAL

1.1. The following definitions are used in this Agreement

2006 Act	the National Health Service Act 2006

Agreement	means this agreement including all Schedules
Aligned Budget(s)	means any aligned budget(s) in respect of the Services as may be agreed by the Partners from time to time in accordance with the provisions of Schedule 4 (Financial Matters)
Best Value	means the duty imposed on the Council by Section 3 of the Local Government Act 1999
Clinical Governance	a duty to continuously seek improvements to the quality of health services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish
Commencement Date	the date hereof
Contract Procurement Requirements	procurement guidelines or requirements, contract standing orders, financial requirements, scheme of delegation and other relevant requirements set out in the Council Constitution and/or procurement requirements required by Law and/or required by the CCG and any other requirements made known to persons letting contracts from time to time
Contributions	the Partners' contributions to the Aligned Budget(s), any Pooled Fund or Non Pooled Fund as may be made and agreed from time to time in accordance with Clause 10 (Pooled Fund, Aligned Budget(s) and Contributions).
Council Constitution	means the written constitution of the Council as the same may be changed from time to time
Eligibility Criteria	means the guidance set out in Schedule 6 providing guidance to (separately) the CCG and the Council about criteria to be met by Service Users in order to be eligible for the Services
Employment Liabilities	means without limitation any and all costs, claims, fines, liabilities or expenses however arising from: (a) the employment of any persons including any claim made by any

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third party arising out of or in connection with or in respect of the employment or engagement of any of the aforesaid persons;

(b) the termination of such employment;

(c) the termination of any collective agreement;

(d) the obligations which may arise with respect to the transfer of such employment under the Transfer of Undertakings (Protection of Employment) Regulations 2006 ("TUPE") as amended from time to time and any other statute or statutory provision which may from time to time implement or purport to implement the Acquired Rights Directive (2001/23/EC) as the same may be amended from time to time;

(e) any dispute whether or not the subject of litigation in any court or tribunal which relates to such employment or collective agreement or their termination;

insofar as not included above those matters referred to in (b) and (d) of "Liabilities"

Existing Service Contract	any contract in place before the Commencement Date with a Service Provider in respect of the Services entered into by an individual Partner
Financial Year	means 1st April in any year to 31st March in the subsequent year (inclusive) save for the First Financial Year which runs for the period referred to in the definition of that term
First Financial Year	means the period from the Commencement Date
FOIA	means the Freedom of Information Act 2000 and any subordinate legislation made under this Act from time to time together with any guidance and/or codes of practice issued by the Information Commissioner or relevant government department in relation to such legislation provided that such guidance shall not contravene such legislation

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Future Service Contract	any contract entered into on or after the Commencement Date in respect of the Services entered into by the Council.
Head of Joint Commissioning	means the person responsible for day to day management of the Joint Commissioning Unit and for carrying out the role ascribed to it hereunder (and the role of the Head of Joint Commissioning is set out in Schedule 9 hereto) or such other agreement as may be agreed to replace or amend the aforementioned agreement from time to time, the Head of Joint Commissioning being, as at the date of this Agreement, xxxxxxxx.
Host Partner	the Council
Joint Commissioning Unit	has the description given to it in Schedule 7
Lead Commissioner	the Council
Law	means:

(a) any Act of Parliament or subordinate legislation within the meaning of Section 21(1) of the Interpretation Act 1978, and any exercise of the Royal Prerogative, any enforceable community right within the meaning of Section 2 of the European Communities Act 1972;

(b) any applicable guidance (including NHS Guidance and (where this is accepted by the Department of Health) BMA guidance), direction or determination with which the CCG or the Council is bound to comply to the extent that the same is published and publicly available or the existence or contents of them have been notified to the CCG or the Council (as relevant);

(c) any applicable judgment of a relevant court of law which is binding precedent,

in each case in the United Kingdom

Liabilities	any costs, claims, liabilities, expenses and demands made against or suffered or incurred either directly or indirectly by any Partner including (but not limited to) the following matters:

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(a) public liability;

(b) employer's liability;

(c) professional indemnity (including but not limited to officers liability and clinical negligence);

(d) employment claims including (but not limited to) claims for:

- damages, costs and expenditure including (but not limited to) claims for wrongful and unfair dismissal and under TUPE;
- damages, costs and expenditure in relation to sex, race or disability discrimination and equal pay claims;
- other claims for breach of employment contract;

(e) Ombudsman awards;

(f) claims for breach of the Human Rights Act 1998 and claims in public law,

and "Liability" shall be construed accordingly

Maladministration means the dishonest administration of the Pooled Fund and/or the Aligned Budget(s) and/or the Non Pooled Fund and/or the Services, or the administration of the Pooled Fund and/or the Aligned Budget(s) and/or the Non Pooled Fund and/or the Services and/or any other obligation hereunder otherwise than in accordance with the terms of this Agreement

Management and Support Services such accommodation, communications, financial, property, transport, information technology, human resources, legal, administrative services and senior management oversight and similar services as are required to support the proper delivery of the Services and the effective and efficient management of Partnership Arrangements pursuant to this Agreement

Non Pooled Funds means any financial contributions of the Partners to the Partnership which are not

	included in the Pooled Fund from time to time whether included in the Aligned Budget(s) or otherwise
Partnership/Partnership Arrangements	the arrangements detailed in this Agreement
Partnership Board	for the Council, the Service Director for People Commissioning, Head of Joint Commissioning; and for the CCG the Local Chief Officer and the Chief Finance Officer.
Partnership Resources	the Management and Support Services and the Service Contracts made available and entered into in accordance with the terms of this Agreement
Pooled Fund? Remove	any pooled fund established in respect of the Services as may be agreed by the Partners from time to time in accordance with the provisions of Clause 10 (Pooled Fund, Aligned Budget(s) and Contributions)
Quarter	means each of the following periods in any Financial Year: 1st April to 30th June 1st July to 30th September 1st October to 31st December 1st January to 31st March and "**Quarterly**" shall be construed accordingly
Regulatory Bodies	means those government departments and regulatory statutory or other entities committees or ombudsmen and bodies which whether under statute, rules, regulations, codes of practice or otherwise are entitled to regulate or investigate the Services or the operation of this Agreement
Regulations	the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (S1 2000/617) (as amended)? Check
Relevant Functions	the functions of NHS bodies and local authorities prescribed under section 75 of the 2006 Act which are set out in Part 1 of Schedule 2
Service Specification	the services specification set out at Schedule 3 for delivery of the Services, or any part, by reference to services carried out under Existing Service Contracts or a description of the relevant services or contracting arrangement, and any changes thereto as may be agreed from time to

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	time between the Partners in accordance with this Agreement.
Services	(a) For the CCG children's community health services and CAMHs (to be confirmed) (b) For the Council those social services for children for Services in respect of emotional health and wellbeing and disability and which fall within the definition of Relevant Functions together with such other services as may fall within the definition of Relevant Functions that the Partners may agree from time to time should be included as part of this Agreement under and pursuant to Clause 16 (Changes and Review).
Service Contracts	contracts with third parties for or in connection with the provision of the Services
Service Provider(s)	third parties providing goods or services under Service Contracts
Service User	an child who is assessed as eligible in accordance with Clause 11 of this Agreement for and/or provided with Services under this Agreement
Staff	the persons from time to time employed, contracted, engaged or seconded by either of the Partners to carry out the Services
Standing Orders	the Standing Orders, Contract Standing Orders, the Constitution and Financial Regulations of the Host Partner
Term	means the period from the Commencement Date until termination of this Agreement in accordance with Clause 3.1 (Duration) and Clause 21 (Termination)

1.2 References to any Act or Regulations include reference to any amendment or re-enactment thereof.

1.3 References to:

1.3.1 masculine include the feminine;

1.3.2 singular include the plural;

1.3.3 persons include companies and corporations,

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1.3.4 and vice versa where the context so admits.

1.4 The headings of the Clauses of this Agreement are for reference only and shall not be construed as part of this Agreement or deemed to indicate the meaning of the relevant clauses to which they relate.

1.5 References made to Clauses Sub-clauses Schedules and Annexes are to clauses schedules and annexes of this Agreement.

1.6 Any decision or act or thing which any Partner is required or authorised to take or do under this Agreement may be taken or done by any person authorised generally or specially by the Partner to take or do that decision act or thing provided that each Partner shall provide any other with the name of any person so authorised upon receipt from any other Partner of a written request for the same.

1.7 The Schedules to this Agreement shall be deemed to be incorporated into the body of this Agreement and shall have full force and effect.

2 AIMS AND OUTCOMES OF THE PARTNERSHIP

2.1 The aims and intended outcomes of this Agreement are set out in Schedule 1.

2.2 The Partners hereby agree that fulfilment of the aims and outcomes referred to in Clause 2.1 will lead to improvements in quality and cost and time efficiencies in relation to the way their Relevant Functions are provided.

2.3 The Partners hereby confirm that they are committed to co-operating with one another under the Partnership Arrangement and agree to keep one another informed, to liaise effectively and to work together in good faith and agree to act in such a way as to achieve the aims set out in Clause 2.1 wherever possible and are committed to the principles set out in this Agreement in relation to governance and financial management.

2.4 For the avoidance of doubt, the Partners shall act in accordance with Clause 2.3 in so far as it is reasonably practicable to do so, taking account of the best interests of Patients/Service Users, statutory obligations and availability of resources.

Standards of Conduct

2.5 The Partners will:

2.5.1 comply with all relevant Law, any other national and local and other guidance on conduct and probity and good corporate governance (including the Council Constitution and the CCG Constitution) and each Partner shall be aware of the obligations affecting the other; and

2.5.2 Ensure that the personnel of each Partner responsible for the day to day management of the Services shall carry out their responsibilities in such a manner as to ensure fulfilment of the Relevant Functions and to ensure compliance with the Partner's obligations hereunder.

3 DURATION, LEGAL STATUS AND GOVERNANCE OF THE PARTNERSHIP AND DELIVERY OF FUNCTIONS

Duration

3.1 The Partners agree that the Partnership Arrangements and this Agreement shall commence on the Commencement Date and shall continue until terminated in accordance with the provisions of Clause 21 (Termination).

Legal Status

3.2 The Partnership is established by this Agreement pursuant to section 75 of the 2006 Act and the Regulations.

3.3 The Partners have agreed that the Partnership shall or may embrace the following flexibilities pursuant to section 75 of the 2006 Act:

3.3.1 the alignment of budgets in relation to commissioning of the Services and potentially the pooling of budgets as may be agreed by the Partners from time to time in accordance with the terms of this Agreement; and

3.3.2 lead commissioning by the Council of the Services in accordance with the terms of this Agreement.

and such other actions as are incidental or conducive to the achievement of the same.

3.4 Before the Commencement Date the Partners carried out the consultation required by Regulation 4(2) of the Regulations or any Consultation required pursuant to Section 242 of the 2006 Act and will continue to carry out any consultation that may be required (under Law) during the Term or upon termination of this Agreement for any reason.

3.5 The CCG hereby delegates to the Council at the commencement of the agreement any of the CCG's Relevant Functions in so far as the same are or shall be reasonably required, if any, and not further or otherwise, to enable the Council to fulfil its duties as Lead Commissioner and/or Host Partner as set out in this Agreement, and the CCG hereby further agrees that where any of its Relevant Functions are required to be delegated to enable the Council to fulfil its duties where changes are agreed hereunder from time to time, such Relevant Functions shall be deemed to be so delegated.

Governance and Partnership Arrangements

3.6 The Partnership Arrangements comprise as at the date hereof (and the same may be subject to change from time to time):

3.6.1 the formalisation of lead commissioning arrangements so that the Services may be jointly planned and commissioned by the Partners so as to achieve the aims and objectives set out in Schedule 1 and in fulfilment of the Relevant Functions;

3.6.2 the Council taking the role of lead commissioner when the CCG decides it is ready to transfer these functions as outlined below and as such:

(i) the management of any Existing Service Contracts and Future Service Contracts on behalf of the relevant Partner (in accordance with the terms hereof); and

(ii) that any proposed Future Service Contract shall be entered into by the Council unless the Partners agree to act otherwise in connection with any specific contracts, based on the relevant facts;

3.6.3 the formalisation of the establishment of the Joint Commissioning Unit for Children's Services comprising officers and commissioning staff from the Council to commission and procure contracts in respect of the Services with CCG prior agreement..

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3.6.4 the establishment and formalisation of the role of the Head of Joint Commissioning to head up the Joint Commissioning Unit and such other roles as shall be necessary for the satisfactory performance of the Relevant Functions hereunder.

3.7 The Partners shall comply with their relevant obligations and duties hereunder.

3.8 Without prejudice to the generality of Clause 3.4, the Partners agree to comply with the financial protocols set out in Schedule 4 and the governance and permitted delegation arrangements set out herein as the same may be changed from time to time in accordance with this Agreement.

3.9 The Partners agree to be jointly responsible for ensuring that any changes to the Partnership Arrangements or this Agreement are recorded accurately and in accordance with Clause 17 (Variation).

3.10 In the event that either Partner intends to or is required to change the way any Services in respect of its Relevant Functions are to be provided, and such change will affect the Partnership Arrangements, they shall inform and consult with the other as soon as reasonably practicable, so as to prevent disruption or costs being incurred unnecessarily.

3.11 The Partners shall notify each other wherever consultation is required from time to time in accordance with Law and for the avoidance of doubt neither Partner shall make any relevant decisions unless and until due consideration has been given to the outcome of such consultation process.

Partners' liability to third parties

3.12 The Partnership Arrangements under this Agreement shall not affect:

3.12.1 The liabilities of the Partners to any third parties for the exercise of their respective functions; or

3.12.2 Powers or duties to recover or set charges for the provision of any services in the exercise of any local authority functions.

4 WORKFORCE ARRANGEMENTS

4.1 Pursuant to Section 75 of the 2006 Act and Regulation 10(1) of the Regulations the Partners agree to resource the Partnership in accordance with Schedule 8 of this Agreement, and in addition will make available various staff resources in order to facilitate the Partnership as set out in Schedule 8.

4.2 The overall day to day management of the commissioning function hereunder will be carried out by the Head of Joint Commissioning.

4.3 The process of recruiting and appointing any replacement Head of Joint Commissioning and any changes to management of joint commissioning on a day to day basis shall be subject to the approval of both Partners.

4.4 Subject to clause 4.3, recruitment, changes to staff terms and conditions and any dismissal shall be in accordance with the Joint Protocol on Recruitment and Staffing set out in Schedule 8, provided always that:

4.4.1 the human resources policies and procedures of each Partner in force from time to time and all relevant Law shall be fully complied with; and

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4.4.2 any significant increases in staffing levels in relation to the Partnership Arrangements shall be agreed in advance between the Partners.

5 ACCOMMODATION SERVICES AND GOODS

5.1 Pursuant to Section 75 of the 2006 Act and Regulation 10(1) of the Regulations the Partners will from the Commencement Date provide in connection with the Partnership such accommodation and services as are referred to in Schedule 5 and such other Management and Support Services as are deemed necessary for the needs of the Partnership Arrangements.

5.2 The Partners will so far as is necessary and appropriate to the achievement of the purposes of the Partnership cooperate in respect of what is to be provided under Clause 5.1 and to utilise the accommodation goods and services in an integrated and cooperative manner.

5.3 The Partners will periodically review the needs of the Partnership and by agreement withdraw accommodation goods or services and/or make additional or substituted accommodation goods or services available.

5.4 The Partners will each provide or make available those Management and Support Services as are reasonably necessary to support the Partnership Arrangements.

5.5 For the avoidance of doubt, the Partners will continue to provide any corporate services in the same way as prior to the Commencement Date except where it has been agreed that the Partnership Arrangements will change the way in which these services will be provided.

5.6 As at the date hereof neither Partner will make any charge for the services referred to in this Clause 5.

5.7 Each partner shall record and report to the other as required the costs of providing any of the services referred to in this Clause 5.

5.8 Where either Partner seek to make changes to the services to be provided under this Clause 5 and such changes are deemed by the other to materially affect the Partnering Arrangements, then any such changes must be:

5.8.1 agreed by both Partners; and

5.8.2 the Partners may also seek an appropriate change to their financial contributions arising from such change.

6 COMMISSIONING AND CONTRACTING FRAMEWORK – BEST VALUE CLINICAL GOVERNANCE AND EQUAL OPPORTUNITIES

6.1 All Services directly commissioned pursuant to this Agreement shall be subject to the requirements of Best Value principles and Clinical Governance.

6.2 The Contract Procurement Requirements shall be complied with in relation to any Service Contracts.

6.3 The Partners agree that pursuant to the Partnership Arrangements the Council may enter into Service Contracts pursuant to which there will be areas of service relating to clinical care for which the CCG will have statutory responsibility for discharging and areas of service relating to social care for which the Council will

have statutory responsibility for discharging ("**Mixed Care Service Contracts**") and the Partners have agreed the following so as to clarify so far as possible the responsibility of the Partners under Mixed Care Service Contracts:

(a) As between the Council and the CCG under this Agreement, the CCG shall retain risk and responsibility for all aspects of clinical care, clinical practice, clinical risk (including professional negligence) and clinical governance for which it is statutorily responsible (**"Clinical Care"**), subject always to the other provisions of this Clause 6.3.

(b) In relation to Mixed Care Service Contracts (in relation to which the CCG is not a contracting party but have responsibility as aforesaid in this Clause 6.3 above), the CCG shall:

(i) indemnify the Council against any claims, losses or damages in relation to Clinical Care (except for the avoidance of doubt to the extent that the same has been caused or contributed to by the Council failing to comply with or being in breach of its obligations in Clause 6.3(c) and to such extent the Council shall indemnify the CCG against any resulting claims, losses or damages) and PROVIDED ALWAYS THAT

(A) The liability of one Partner to indemnify the other Partner shall be determined on a just and equitable basis;

(B) Each Partner shall mitigate its losses;

(C) Neither Partner shall be entitled to recover indirect losses or loss of income; and

(ii) provide such monitoring, supervision or other controls in relation to Clinical Care being provided in accordance with the relevant terms of the relevant Mixed Care Service Contract(s) (in so far as such terms are relevant to the CCG's responsibilities under this Clause 6.3)*;* and

(iii) in relation to commissioning, be responsible for checking the terms and conditions and the specification of the Mixed Care Service Contracts in so far as they relate to Clinical Care.

(c) The Council shall:

(i) ensure and procure that its employees do not undertake any services which fall within the definition of Clinical Care;

(ii) ensure and procure that its employees do not (by act or omission) prevent the CCG from complying with its obligations under Clause 6.3(b);

(iii) enforce any relevant provisions of any Mixed Care Service Contract to which it is a party where necessary (and for the avoidance of doubt the CCG will inform the Council if it considers the same is necessary) if a Service Provider is preventing the CCG from complying with its obligations under this Clause 6.3;

(iv) authorise the CCG to take conduct of any issue where the Partners agree that the facts are such that matter would be more effectively managed by the CCG, and the provisions of clause 19 will apply;

(v) not enter into a Mixed Care Service Contract unless the CCG is aware of the same (and for the purposes of this clause 6.3(c)(v) the CCG shall be deemed to be aware of the same where the contract is being commissioned by the Joint Commissioning Unit (in

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relation to which the Head of Joint Commissioning is responsible for reporting to both the LCG's Joint Commissioning Forum /CCG and the Council)); and

(vi) where it is assessing a person's needs (whether or not potential eligibility for Clinical Care has been identified) and the assessment indicates a potential need which may constitute Clinical Care, it will invite the CCG to assist in making the assessment in accordance with section 47 of the National Health Service and Community Care Act 1990.

(e) It is hereby stated that for the avoidance of doubt the Partners do not intend that the Council will be responsible for Clinical Care only as a result of entering into a Mixed Care Services Contract (but that the foregoing does not affect the obligations of the Council under any other provision herein) and/or only by virtue of being the lead commissioner under the terms of this Agreement (but again that the foregoing does not affect the obligations of the Council under any other provision herein).

(f) If and to the extent that the Partner's respective responsibilities referred to in paragraph (a) change, then the Partners shall agree changes to this clause to reflect the change in responsibility.

(g) Any liability arising pursuant to this Clause 6.3 shall also be considered in accordance with the liability provisions detailed in Clause 18.6.

6.4 The Partners agree that pursuant to the Partnership Arrangements the CCG may enter into Mixed Care Service Contracts (as defined in clause 6.3 above) and the Partners have agreed the following so as to clarify so far as possible the responsibility of the Partners under Mixed Care Service Contracts:

(a) As between the Council and the CCG under this Agreement, the Council shall retain risk and responsibility for all aspects of social care for which it is statutorily responsible (**"Social Care"**), subject always to the other provisions of this Clause 6.4.

(b) In relation to Mixed Care Service Contracts (in relation to which the Council is not a contracting party but have responsibility as aforesaid in this Clause 6.4 above), the Council shall:

(i) indemnify the CCG against any claims, losses or damages in relation to Social Care (except for the avoidance of doubt to the extent that the same has been caused or contributed to by the CCG failing to comply with or being in breach of its obligations in Clause 6.4(c) and to such extent the Council shall indemnify the CCG against any resulting claims, losses or damages) and PROVIDED ALWAYS THAT

(A) The liability of one Partner to indemnify the other Partner shall be determined on a just and equitable basis;

(B) Each Partner shall mitigate its losses;

(C) Neither Partner shall be entitled to recover indirect losses or loss of income; and

(ii) provide such monitoring, supervision or other controls in relation to Social Care being provided in accordance with the relevant terms of the relevant Mixed Care Service Contract(s) (in so far as such terms are relevant to the Council's responsibilities under this Clause 6.4); and

(iii) in relation to commissioning, be responsible for checking the terms and conditions and the specification of the Mixed Care Service Contracts in so far as they relate to Social Care.

(c) The CCG shall:

(i) ensure and procure that its employees do not undertake any services which fall within the definition of Social Care;

(ii) ensure and procure that its employees do not (by act or omission) prevent the Council from complying with its obligations under Clause 6.4(b);

(v) enforce any relevant provisions of any Mixed Care Service Contract to which it is a party where necessary (and for the avoidance of doubt the Council will inform the CCG if it considers the same is necessary) if a Service Provider is preventing the Council from complying with its obligations under this Clause 6.4;

(vi) authorise the Council to take conduct of any issue where the Partners agree that the facts are such that matter would be more effectively managed by the Council, and the provisions of clause 19 will apply;

(v) not enter into a Mixed Care Service Contract unless the Council is aware of the same (and for the purposes of this clause 6.4(c)(v) the Council shall be deemed to be aware of the same where the contract is being commissioned by the Joint Commissioning Unit (in relation to which the Head of Joint Commissioning is responsible for reporting to both the Council and the CCG); and

(vi) where it is assessing a person's needs (whether or not potential eligibility for Social Care has been identified) and the assessment indicates a potential need which may constitute Social Care, it will invite the Council to assist in making the assessment.

(e) It is hereby stated that for the avoidance of doubt the Partners do not intend that the CCG will be responsible for Social Care only as a result of entering into a Mixed Care Services Contract (but that the foregoing does not affect the obligations of the CCG under any other provision herein).

(f) If and to the extent that the Partner's respective responsibilities referred to in paragraph (a) change, then the Partners shall agree changes to this clause to reflect the change in responsibility.

(g) Any liability arising pursuant to this Clause 6.3 shall also be considered in accordance with the liability provisions detailed in Clause 18.6.

6.5 The Partners are committed to an approach to equality and equal opportunities as represented in their respective policies. The Partners will maintain and develop these policies as applied to the Services with the aim of developing a joint strategy for all elements of the Services.

7.0 <u>**CONFIDENTIALITY AND DATA PROTECTION Amanda Holloway please check**</u>

7.1 Except as required by Law, each Partner agrees at all times during the continuance of this Agreement and after its termination to keep confidential all documents or papers which it receives or otherwise acquires in connection with the other and which are marked "Confidential" or similar or information which a reasonable person would be expected to treat as confidential.

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7.2 The Partners shall ensure that all Staff (including temporary employees), agents or contractors of the Partners working within the Partnership Arrangements observe the provisions of Clause 8.1; where Staff or an agent or contractor of a Partner discloses confidential information the relevant Partner shall take such action as is necessary and appropriate, and where possible, to the satisfaction of the Partner affected by such disclosure.

7.3 Each Partner shall comply with its statutory obligations under the Data Protection Acts.

7.4 The Council and the CCG shall in relation to information sharing between agencies, having proper regard to the principles of client confidentiality and the Data Protection Act 1998 and any policies or protocols that the Partners may agree from time to time should apply to the provision of information and sharing of data for the purposes of this Agreement.

7.5 Each Partner (the "**First Partner**") acknowledges that in responding to a request received by any Partner (the "**Other Partner**") under the FOIA or the Environmental Information Regulations 2004 (the "**EIR**") the Other Partner will be entitled to provide information held by it relating to this Agreement or which otherwise relates to the First Partner.

7.6 The Other Partner shall use reasonable endeavours to notify the First Partner of any request under the FOIA or the EIR and the intention to disclose the information within 10 Working Days (as defined in the FOIA) of receipt of such request. Before disclosing any information, the Other Partner shall consider any representations made by the First Partner within 4 Working Days (as defined in the FOIA) of notification from the Other Partner to the First Partner in accordance with this Clause 8.6.

7.7 The First Partner acknowledges that, if it does not revert to the Other Partner within the period set out in Clause 8.3, or if its representations do not alter the view of the Other Partner that the information should be disclosed, the Other Partner is under a duty to disclose such information provided that the Other Partner shall not disclose any information that is subject to an FOIA Exemption.

7.8 The First Partner shall co-operate with the Other Partner in connection with any request received by the Other Partner under the FOIA or the EIR and such co-operation shall be at no cost to the Other Partner.

8 THE LEAD COMMISSIONER

8.1 The Partners agree that the Lead Commissioner will have the following responsibilities:

8.1.1 In exercising their functions under this Agreement the Partners shall have regard to other functions in respect of Service Users so as to ensure that services are provided effectively and efficiently.

8.1.2 In relation to Service Contracts entered into by the Council in respect of the Relevant Functions of the CCG, the Council does not guarantee that it will stay within relevant health service budgets due to placements being made based on assessed clinical need, but the Council agrees that (where it is in control of the same) it will regularly provide monthly accurate and up to date information to the LCG'S/CCG on such placements and shall put in place appropriate budgetary control and reporting measures where required and practicable as requested by the CCG.

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8.2 To apply the relevant parts of the Standing Orders and other relevant regulations to the management of any Pooled Fund where the same is established in accordance with Clause 10 (Pooled Fund, Aligned Budget(s) and Contributions) as may be relevant to the Services, subject to Schedule 4;

8.3 To lead on the commissioning and implementation of the delivery of the Services in accordance with the terms of this Agreement (subject to the rights and responsibilities of each Partner set out hereunder) and utilise the Partnership Resources (where and to the extent the Lead Commissioner holds or controls the same) in the way best designed to promote the purposes of the Partnership efficiently and cost effectively;

provided always that this Clause 9 is subject to Clauses 6.3 and 6.4.

8.4 The role of the Lead Commissioner in relation to entering into Contracts will not diminish or transfer the CCG's statutory obligations and responsibilities in relation to health care services.

8.5 Each Partner shall use reasonable endeavours to ensure that any Future Service Contract in respect of Relevant Functions of both Partners are able to be freely assigned (without obligation on either Partner to take such assignment and/or without affecting any decision to novate).

9 **POOLED FUND, ALIGNED BUDGET(S) AND CONTRIBUTIONS**

9.1 The Partners agree that due to the nature of the Services included within the Partnership Arrangements it will be necessary for the Contributions of the Partners to be made on the basis of:

9.1.1 An Aligned Budget (being the arrangement agreed between the Partners as the Commencement Date); or

9.1.2 A Pooled Fund (which may be agreed between the Partners to apply to some or all of the Services from time to time); or

9.1.3 Such other contributions as the Partners may agree will form part of the Non Pooled Fund as the Partners may agree is relevant and should apply to the Services and their respective Contributions from time to time.

9.2 The Partners agree that the provisions of Schedule 4 shall be the financial protocols at the outset of this agreement, and any changes shall be made in accordance with Clause 16 (Changes and Review) and Clause 17 (Variation).

9.3 Any agreement between the Partners (following the procedures set out in the Agreement relating to change in Clause 16 (Changes and Review)) to establish a Pooled Fund or make changes in relation to the Aligned Budget or any Non Pooled Funds at any time are subject to compliance with:

9.3.1 Such consultation and notification to the Health and Social Care Joint Unit of the Department of Health as is required in relation to the exercise of the flexibilities under the 2006 Act and Regulations;

9.3.2 Compliance with audit commission recommendations; and

9.3.3 Any other applicable Law.

9.4 In relation to financial management, each Partner shall:

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9.4.1 provide such information as any of the Partners may require to enable the effective management of the Services and the Pooled Fund, any Aligned Budget(s) and any Non Pooled Fund;

9.4.2 where necessary take account of comply with each others audit requirements;

9.4.3 operate effective audit arrangements which take account of relevant guidance from the Audit Commission retain responsibility for maintaining a clearly identifiable accounting structure to ensure effective monitoring and reporting of the Partnership;

9.4.4 produce a report Monthly (or such other period as the Partners agree) and a memorandum of accounts at the end of each Financial Year showing income received, expenditure and any balance remaining in respect of finances within their responsibility;

9.4.5 keep full and proper records in relation to accounting and financial matters and information will be supplied between the Partners on an "open book" basis; and

9.4.6 comply with all HM Revenue and Customs directions and to have due regard to all guidance issued by HM Revenue and Customs regarding the VAT aspects of the Partnership.

9.5 It is agreed that the Pooled Fund, Aligned Budget(s) and Non Pooled Funds shall only be used for the procurement and commissioning of the Services and in accordance with this Agreement.

9.6 The Partners agree to make such payments to each other as are agreed to reflect their contributions in accordance with the provisions of Schedule 4 (Financial Matters).

Capital Expenditure and other Flexibilities

10.7 All capital expenditure shall be made by one of the Partners and where appropriate funding support may be transferred between the CCG and the Council under Sections 256 and 76 of the 2006 Act as appropriate, but the same shall not absolve either Partner from having to comply with their respective obligations pursuant to the 2006 Act, including entering into separate agreements and ensuring voucher returns and audit arrangements are in place as is appropriate or required by law.

10.8 The following matters shall be agreed in writing between the relevant partners before any Capital Expenditure is incurred in relation to the Partnership Arrangements:

(a) The capital requirement

(b) The proportions in which it is to be met by the Partners

(c) Which of the Partners is to make the Capital expenditure

(d) The transfers of funding to made between the CCG and the Council using sections 256 and 76 of the 2006 Act as appropriate and both Partners shall ensure compliance with the aforementioned sections; and

(e) Ownership of any newly acquired asset and any arrangements for use by the Partners or third parties

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10.9 Each partner shall give reasonable consideration to any proposals that it shall incur any Capital Expenditure but shall not be obliged to provide such funding

10 ASSESSMENT, ELIGIBILITY CRITERIA AND CONSULTATION

10.1 The Council shall have the right and responsibility to determine the Service Users who are eligible to receive services hereunder relating to social care for which the Council has (from time to time) statutory responsibility for discharging and the CCG shall have the right and responsibility to determine the Services Users who are eligible to receive services hereunder relating to any clinical care for which the CCG has (from time to time) statutory responsibility for discharging; and any challenges made by any third party to this agreement in relation to decisions made and Services provided or to be provided shall be the responsibility of the Partner which made or should have made the decision as aforesaid.

10.2 The Partners shall have reference to the relevant Eligibility Criteria, without affecting the rights and responsibilities set out in clause 11.1.

10.3 For the avoidance of doubt, Service Users may fall into eligibility criteria for other services funded by the Partners, such as housing and generic health, in addition to the Services and nothing in this Agreement shall prevent any Service User from using such services if they meets the relevant criteria.

10.4 Any joint local policies that impact on this Agreement shall not be incorporated into this Agreement without the prior consent of both Partners.

10.5 Subject always to clause 11.1, no decision shall be made to make changes to the Services or the way in which they are delivered without prior consultation in accordance with the other Partner and with reference to the other Partner's statutory and other obligations.

11 CHARGES

11.1 Nothing in this Agreement shall detract from the principle that NHS services are free at the point of delivery and may not be charged for.

11.2 The Council shall be at liberty to levy (and shall be responsible for levying) charges for such elements of the Services for which legislation requires or permits it to charge.

11.3 Where the distinction might be blurred between charged for and non-charged for services in Services Users' minds, whether through the operation of assessment arrangements or arrangements for the delivery of jointly commissioned Services under this Agreement, then the Lead Commissioner will be responsible for identifying the Partner levying the charges and the nature of the Services charged for making it clear to Service Users in respect of which element of the Services a charge is being levied (and the CCG shall provide such assistance to the Lead Commissioner as is required).

12 **PERFORMANCE MANAGEMENT, REPORTS AND REPORTING**

12.1 The Partners shall ensure that full and proper records for accounting and all other purposes are kept in respect of the obligations under this Agreement.

12.2 Without prejudice to the generality of Clause 13.1, the Partners shall be responsible for auditing the areas pertaining to their individual organisation and will work together in areas where an overlap of interest occurs.

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12.3 Each Partner shall be permitted full access to the other's internal audit reports and records at any time on an open book basis (in addition to the financial audit rights under Clause 10).

12.4 The Partners will supply all information reasonably required by:

12.4.1 persons exercising a statutory function in relation to either Partner including the external auditor of either Partner and/or any statutory agencies referred to at clause (b) below;

12.4.2 other persons or bodies with an authorised monitoring or scrutiny function, including a Council Overview and Scrutiny Committee/CQC, having regard to the Partner's obligations of confidentiality, and such information sharing protocols as shall be agreed between the Partners from time to time;

12.4.3 the CCG to comply with its duty of Clinical Governance,

12.4.4 the Council to comply with its duty of Best Value.

12.5 The Head of Joint Commissioning shall at the end of each Quarter in each Financial Year (or such other times as the Partners agree) carry out a review of:

12.5.1 the Partnership Arrangements; and

12.5.2 the statutory functions of each Partner which have been carried out by the other Partner using the flexibilities under the 2006 Act and the Regulations;

After conferring with and procuring relevant information from such personnel of the Partners as shall be necessary, and shall within 10 days of the review report to the Partnership Board summarising the review. Individual members of the Partnership Board shall provide copies to the relevant persons and groups within their organisation as shall be appropriate. The Partnership Board may meet after such reviews to discuss any outcomes as they consider necessary.

12.6 The report referred to in Clause 13.5 shall include but not be limited to:

12.6.1 financial report(s) linked to performance against the anticipated expenditure for the relevant period;

12.6.2 a service report linked to the objectives set out at Schedule 1 and the Services and the performance management framework and any agreed key performance indicators, strategic planning objectives and any statutory reporting requirements and quality standards;

12.6.3 details of all Future Services Contracts entered into since the previous report (or the date of this Agreement in respect of the first report)

12.6.4 any changes to the Partnership Arrangements and/or this Agreement pursuant to Clause 16 (Changes and Review); and

12.6.5 such other information as shall be required by the Partners or the or the Partnership Board from time to time.

12.7 Without prejudice to the review and reporting requirements of Clauses 13.5 and 13.6, the reporting and other functions of the Head of Joint Commissioning in relation to the Partnership Arrangements are as set out in Schedule 9

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12.8 The Partners shall carry out an annual review at the end of each Financial Year of the operation of this Agreement including:

12.8.1 a financial report linked to performance against the anticipated expenditure for that Financial Year;

12.8.2 an evaluation of performance against agreed performance measures targets and priorities including objectives set out at Schedule 1, the Services and any agreed performance management framework and key performance indicators referred to at Clause 13.6 above and Clause 13.10 below;

12.8.3 review of the targets and priorities for the forthcoming year;

12.8.4 shared learning and apportionments for joint training;

12.8.5 an evaluation of any statistics or information required to be kept by the Department of Health from time to time;

12.8.6 the statutory functions of each Partner which have been carried out by the other Partner using the flexibilities in Section 75 of the 2006 Act and the Regulations;

12.8.7 such other information as shall be required by the Partners or the Partnership Boards from time to time

and within 6 weeks of the end of each Financial Year the Head of Joint Commissioning shall prepare and submit an annual report documenting the matters referred to and submit to the Partnership Board

12.9 The Partners will work to develop a performance management framework based upon the Services for the Partnership with relevant key performance indicators by reference to Best Value and Clinical Governance for measuring its effectiveness and shall review and update this as relevant.

12.10 In the event that either Partner shall have any concerns about the operation of the Partnership or the standards achieved in connection with the carrying out of the Functions it may convene a review with the other Partner with a view to agreeing a course of action to resolve such concerns at any time.

13 <u>INSPECTION ARRANGEMENTS</u>

13.1 The Partners recognise the potential interest of the various agencies whose names appear below in inspecting different aspects of the Commissioning and Provision of Services and agree to cooperate with each other to facilitate any such inspections:

13.1.1 Care Quality Commission;

13.1.2 The Department of Health;

13.1.3 The Audit Commission;

13.1.4 The Health and Safety Executive;

13.1.5 Ofsted;

13.1.6 Any other Regulatory Bodies;

13.1.7 or their respective successors and similar statutory monitoring bodies.

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13.2 Each Partner will report to the next due meeting of the Partnership Board the key findings of any inspection in respect of the Services to which it has been subject.

14 COMPLAINTS

14.1 Each Partner and all Service Providers will be required to maintain or adopt, as the case may be, complaints procedures internal to their organisation which enable Service Users to be heard in respect of any complaint concerning any element of the Services which are commissioned or provided by or on behalf of a particular Partner and in accordance with each Partner's statutory obligations in this regard.

14.2 Clause 15.1 is without prejudice to any complainant's right to use the Partners' respective statutory complaints procedures where applicable.

14.3 The Partners will co-operate with investigations undertaken by their respective Ombudsman.

14.4 The Partners will agree a protocol for resolving complaints where there are cross service issues.

15 CHANGES AND REVIEW

15.1 By agreement of both Partners and in accordance with Clause 17 (Variations) below any aspect of this Agreement may be changed by addition or otherwise including but not limited to:

15.1.1 the Services;

15.1.2 the Partnership Arrangements;

15.1.3 the financial arrangements detailed in Schedule 4 (Financial Matters); and

15.1.4 the clinical governance arrangements, including the medical director and clinical director functions; and

15.1.5 this Agreement and any ancillary documentation.

15.2 The Partners shall review the operation of the Partnership at appropriate intervals and not less than annually to ensure that this Agreement is operating in the most satisfactory manner.

15.3 **Changes in Legislation etc**.

The Partners shall in any event review the operation of the Partnership Arrangements and all or any procedures or requirements of this Agreement on the coming into force of any relevant statutory or other legislation, directions or guidance affecting the Partnership Arrangements and/or the delivery of the Services so as to ensure that the Partnership Arrangements comply with such legislation.

16 VARIATION

16.1 Changes and variations to this Agreement (whether made under Clause 16 (Changes and Review) or otherwise) shall be in writing and signed by both Partners.

16.2 The Partners agree that changes agreed via the reporting process or meeting arrangements under Clause 13 will be considered to be variations hereunder provided that the relevant report or meeting note is sufficiently certain (and includes

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amendments to other terms of the Agreement where necessary to give effect to the agreed variation), and is signed by both Partners.

17 INDEMNITIES LIABILITY AND INSURANCE

18.1 The following shall apply to insurance:

(a) The Partners shall, so far as is possible at reasonable cost and allowable by law or guidance, agree and effect appropriate insurance arrangements in respect of all potential liabilities arising from the Partnership Arrangements.

(b) In the case of the CCG it may effect, through the National Health Service Litigation Authority, alternative arrangements in respect of NHS schemes in lieu of commercial insurance including maintaining membership of the Liabilities to Third Parties Scheme or equivalent and the Clinical Negligence Scheme for Trusts or such other scheme as may be operated from time to time by the National Health Service Litigation Authority.

(c) In the case of the Council, the Council shall maintain such insurance as it considers appropriate, including self-insurance where applicable or relevant.

(d) The obligations in this Clause shall apply to insurance (or equivalent) arrangements during the Term and after the date of determination of this Agreement in respect of any events acts or omissions arising prior to such determination.

(e) The Partners in consultation with their insurers (or the National Health Service Litigation Authority as appropriate) may agree from time to time common policies and protocols for the handling of claims covered by the Partners' insurance arrangements (or equivalent) in respect of the Partnership Arrangements and in such event such policies and protocols shall be followed by the Partners.

Indemnities

Events prior to the Commencement Date:

18.2 Each Partner (the "**First Partner**") will notify the other in the event that they are or become aware of any potential Liabilities whether arising directly or indirectly from any events acts or omissions in relation to the First Partner's Relevant Functions or not, occurring prior to the Commencement Date.

Events Post Commencement Date:

18.4 Subject to Clause 18.8 and Clauses 6.3 and 6.4, and without prejudice to the primary liability of each Partner for its Relevant Functions, preserved by Section 75 (5)(a) and (b) of the 2006 Act, each Partner (the "Indemnifying Partner") hereby agrees to indemnify the other against any Liabilities and Employment Liabilities

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arising as a result of any breach of contract, act or omission by the Indemnifying Partner or its/their employees, contractors or agents save to the extent that such liability shall arise out of any breach of contract act or omission of the other Partner or its employees, contractors or agents in accordance with the following provisions:

(a) The liability of one Partner to indemnify the other Partner shall be determined on a just and equitable basis;

(b) Each Partner shall mitigate its losses;

(c) Neither Partner shall be entitled to recover indirect losses or loss of income.

18.5 The Partners may agree alternative insurance and indemnity arrangements from time to time in accordance with Clause 16 (Changes and Review) and Clause 17 (Variation).

Liability

18.6 In this agreement, the Council shall be responsible for any act omission or breach by any employee, agent and/or contractor of the Council and the CCG shall be responsible for any act omission or breach by any employee, agent and/or contractor of the CCG, except where there is express wording or intention to the contrary and further subject to the provisions of clauses 6.3 and 6.4; and provided further that under clauses 6.3 and 6.4 the responsibility of the Council or the CCG for any act, omission or breach of any Service Provider (being a "contractor" for the purposes of this clause) appointed under a Mixed Care Service Contract, whether by the Council or the CCG, will be determined in accordance with the relevant facts, with regard to the statutory and contractual responsibilities of each of the Council and the CCG in relation to the carrying out their Relevant Functions and their obligations under this Agreement.

18.7 Where a liability arises as a result of Maladministration or negligence by one Partner, that liability shall in any event be met by that Partner.

18.8 For the avoidance of doubt, any claims arising in relation to the terms or operation of the Secondment Agreement shall be dealt with in accordance with the terms of the Secondment Agreement.

19. CONDUCT OF CLAIMS

19.1 If the Council or the CCG (the "Indemnified Party") becomes aware of any matter that may give rise to a claim under clause 18 against the other (the "Indemnifying Party"), notice of that fact shall be given as soon as possible to the Indemnifying Party.

19.2 The Indemnified Party shall give the Indemnifying Party the opportunity to have conduct of any relevant claim, and accordingly to defend or enact settlement of any such claim avoid, dispute, deny, defend, resist, appeal, compromise or contest any such claim or liability (including, without limitation, making counterclaims or other claims against third parties) in the name of and on behalf of the Indemnifying Party and to have the conduct of any related proceedings, negotiations or appeals, and in such circumstances it is agreed that no admission of liability shall be made by or on behalf of the Indemnified Party and any claim shall not be compromised, disposed of or settled without the consent of the Indemnifying Party. The Indemnifying Party may elect not to have conduct as aforesaid.

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19.3 Without prejudice to the validity of the claim or alleged claim in question, and whether or not the Indemnifying Party has elected not to defend any such claim, each party shall allow the other and its professional advisors to investigate the matter or circumstance alleged to give rise to such claim and whether and to what extent any amount is payable in respect of such claim, and for such purpose shall give, subject to being paid all reasonable costs and expenses, all such information and assistance, including access to premises and personnel, and the right to examine and copy or photograph any assets, accounts, documents and records, as the other party or its professional advisors may reasonably request PROVIDED THAT nothing in this clause 19.3 shall be construed as requiring either party to disclose any document or thing which is the subject of any privilege. The party receiving the same agrees to keep all such information confidential and only to use it for such purpose.

20 DISPUTE RESOLUTION

20.1 Any dispute shall in the first instance be referred to the Partnership Board.

20.2 In relation to any dispute that the Partners jointly agree may be assisted by obtaining advice and guidance from and/or resolution by an independent expert (for example in relation to accounting disputes) then the Partners may jointly agree to obtain such advice and guidance from and/or resolution by an independent expert to enable them to agree how the dispute may be resolved, provided that neither Partner shall be bound by such advice, guidance or resolution.

20.3 Any dispute not able to be resolved under this Clause (or otherwise in the spirit of Partnership) may be referred to the courts of England and Wales.

21 STATUTORY COMPLIANCE

21.1 The Partners shall comply with all Law relating to the Partnership Arrangements and the Services.

21.2 Each Partner in relation to its own Existing Service Contracts and the Host Partner in respect of Partnership Contracts and Future Service Contracts shall wherever applicable require the acceptance by Service Providers of their status as public authorities when exercising functions of a public nature and shall require such Service Providers to enter into appropriate indemnities in respect of any elements of any claims which arise under any provision of the Human Rights Act 1998.

22 TERMINATION

22.1 This Agreement shall terminate (subject always to Clause 22.2):

22.1.1 Where one Partner gives at least twelve months' written notice to the other Partner (or such shorter period as the Partners may agree in writing) that they wish to terminate this Agreement such notice to expire on 31 March in the relevant Financial Year;

22.1.2 Within such timeframe as is reasonable, where any Partner considers that as a result of legislation or policy requirements of Central Government all or any of the terms of this Agreement are no longer tenable and the Partners have been unable to agree changes that would enable that Partner to fulfil its obligations hereunder and that Partner gives the other Partner reasonable written notice;

22.1.3 Where there has been service failure as a consequence of which the continuation of the Agreement would be detrimental to the Services, a Service User or a Partner and at least three month's written notice is given;

22.1.4 Where the Partners are unable to agree the resourcing of this Agreement either in respect of the Contributions or the Services or the accommodation services and goods made available under Clause 5 and/or if an overspend has arisen and the Partners are unable to agree a recovery plan and/or budget revisions in accordance with the terms of this Agreement. Where such a situation arises and on request by either Partner the Partners will fully discuss the implications and agree on a joint strategy for the dissolution of this Agreement. In the event that a joint strategy cannot be agreed within 28 days of such a request then either Partner may terminate this Agreement by giving at least three months written notice;

22.1.5 Immediately on written notice where a dispute remains unresolved despite the relevant Partners having followed the procedure in Clause 20 (Dispute Resolution);

22.1.6 Immediately on written notice if one Partner commits a material breach of any of the obligations under this Agreement which is not capable of remedy or which is capable of remedy but has not been remedied within the reasonable time specified in the written notice from the Partner serving notice requiring remedy of the breach;

22.1.7 Immediately on notice by either Partner if fulfilment of the obligations pursuant to this Agreement would be Ultra Vires;

22.1.8 In part in respect of a particular Service, immediately where the Partners jointly agree in writing, or in part where one Partner gives at least twelve months' written notice to the other Partner (or such shorter period as the Partners may agree in writing) that they wish to terminate this Agreement in respect of a particular Service.

22.2 Upon termination in whole or part for any reason, the Partners shall work together to:

22.2.1 Ensure relevant Services are decommissioned without harm to the remaining Services or the Service Users; and

22.2.2 Where appropriate (so as to avoid penalties or breakage costs or where of benefit to either Partner or Service Users) Service Contracts shall remain in place notwithstanding the termination, and the Partners shall agree the survival of or variations to any terms and conditions hereunder as are required to give efficacy to the foregoing; and

22.2.3 Ensure that there is an orderly transition to the arrangements that are to supersede this Agreement or the relevant Services.

22.3 In the event that any liabilities shall arise post-termination in relation to the Partnership or there are any contingent liabilities in the final reconciliation account which when crystallised have been over or under provided for in the reconciliation account and, had the Agreement still been in existence, would have been a charge on the Pooled Fund, the Aligned Budget(s) or Non Pooled Fund as may be relevant from time to time then the Partners shall revise the final reconciliation account to take account of the change within 30 days of becoming aware of that change.

22.4 The provisions of Schedule 4 (Financial Matters) as appropriate shall apply in respect of any overspends or underspends in the final reconciliation account. The Partners shall make such payments to each other as shall give effect to the final reconciliation account and/or to reflect such apportionment of liabilities as may be agreed or

determined within 30 days of receipt from the Council of the final reconciliation account or any revised version thereof.

22.5 The Partners shall act in good faith and in a reasonable manner in reaching agreement on the matters referred to in Clauses 22.2 and 22.4 and in default of agreement within the Partnership Board the Partners may refer the matter to be determined in accordance with the disputes procedure in Clause 20 (Dispute Resolution).

22.6 Any costs resulting from the termination of the Agreement or from the termination of any part of the Services may be paid for out of the Pooled Fund, Aligned Budget(s) or Non Pooled Funds as agreed by the Partners from time to time.

22.7 Ongoing costs which arise as a consequence of the termination of the Agreement and its replacement with new arrangements shall be borne separately by the Partners or as agreed between the Partners.

22.8 Termination of this Agreement shall be without prejudice to the Partners' rights in respect of any antecedent breach and survival of clauses as are required to give effect to this Clause.

23 ASSIGNMENT AND SUB-CONTRACTING

23.1 This Agreement and all rights under it may not be assigned or transferred by any Partner without the prior written consent of the other Partners PROVIDED THAT no such consent shall be necessary for an assignment or novation by the CCG or the Council to a statutory successor in respect of their respective functions relevant to this Agreement.

23.2 Upon such assignment or transfer the assignor or transferor shall ensure that the assignee or transferee enters into a written undertaking to comply with the terms and conditions of this Agreement in consideration of which the other parties agree to release the assignor or transferor from further liability except in respect of liability accrued up to the date of such assignment or transfer.

24 CONFLICTS OF INTEREST

24.1 The Partners shall be responsible for ensuring that its employees do not put themselves in a position whereby duty and private interest conflict.

24.2 Without prejudice to the generality of Clause 24.1, the Partners each have and shall comply with their own policies for identifying and managing conflicts of interest which include:

24.2.1 any existing conflicts of interest or potential conflicts of interest;

24.2.2 any conflict of interest or potential conflict of interest which may arise in the future;

24.2.3 ensuring that additional employment (paid or voluntary) may not be undertaken by any staff working within the Partnership Arrangements which conflicts with or is detrimental to any of the Partners' interests, or which in any way weakens public confidence or affects the ability of the Partners to discharge their duties in or under the Partnership Arrangements;

24.2.4 providing that in the event the Head of Joint Commissioning considers that a conflict of interest exists in relation to their own role or position in

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connection with this Agreement they shall in the first instance request guidance from the Partnership Board; and

24.2.5 providing that each Partner shall require that any employee employed as part of the Partnership Arrangements considers that a conflict of interest exists in relation to their own role or position in connection with this Agreement they shall notify and request guidance initially from their line manager and ultimately from the Executive Director of Children and Young People Services (who shall inform the other members of Partnership Board where necessary).

24.3 The Partners shall ensure that their respective policies for managing and identifying conflicts of interest are maintained and, where possible, brought in to line with the highest ethical policy applying.

25 SEVERANCE

If any Clause of this Agreement not being of a fundamental nature shall be held to be illegal or un-enforceable the remainder of this Agreement shall not thereby be affected.

26 NOTIFICATION TO THE DEPARTMENT OF HEALTH

The Partners agree that they shall forthwith notify the Department of Health of the exercise of the flexibilities in Section 75 of the 2006 Act in this Agreement in accordance with the guidance issued by the Department of Health.

27 THIRD PARTY RIGHTS

No rights hereunder may be enforced by third parties pursuant to the Contracts (Rights of Third Parties) Act 1997.

28 AGENCY AND PARTNERSHIP

28.1 Unless agreed otherwise in writing no Partner can act as the agent of any other Partner.

28.2 The Partnership and arrangements hereunder has not created and is not intended to create a legal partnership for the purposes of the Partnership Acts but rather a statutory relationship between the Partners as provided for under the 2006 Act and the Regulations.

28.3 Notwithstanding the commissioning of Services to benefit both Partners, where any Existing Service Contract and/or Future Service Contract having been made by one Partner only hereunder shall be enforceable only by that Partner and no other Partner shall, unless otherwise provided for in a particular Existing Service Contract and/or Future Service Contract, have any right to enforce such a Existing Service Contract or Future Service Contract (as relevant), provided that this Clause shall not for the avoidance of doubt :

28.3.1 prevent reference being made to the Partnership in any Existing Service Contract and/or Future Service Contract; nor

28.3.2 affect a Partner's statutory obligations.

29 NOTICES

29.1 Any notice or communication hereunder shall be in writing.

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29.2 Any notice or communication to the Council hereunder shall be deemed effectively served if sent by registered post or delivered by hand to the Council at the address set out above and marked for the Executive Director of Community Services or to such other addressee and address notified from time to time by the Council to the other parties for service on the Council.

29.3 Any notice or communication to the CCG hereunder shall be deemed effectively served if sent by registered post or delivered by hand to the address set out above and marked for the attention of the Chief Clinical Officer or to such other addressee and address notified from time to time by the CCG to the parties for service on the CCG.

29.4 Any notice served by delivery shall be deemed to have been served on the date it is delivered to the addressee. Where notice is posted it shall be sufficient to prove that the notice was properly addressed and posted and the addressee shall be deemed to have been served with the notice 48 hours after the time it was posted.

30 GOVERNING LAW AND JURISDICTION

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

30.2 The Partners irrevocably agree that the courts of England have non-exclusive jurisdiction to settle any dispute or claim that arises out of or in connection with this Agreement.

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IN WITNESS whereof the parties hereto have executed this Agreement as a deed the day and year first before written

The COMMON SEAL of **PETERBOROUGH CITY**)
COUNCIL was affixed hereto in the presence of:)

Authorised Signatory: ....

EXECUTED AS A DEED by NHS **CAMBRIDGESHIRE &**)
PETERBOROUGH CLINICAL COMMISSIONING)
GROUP whose corporate Common Seal was)
hereunto affixed in the presence of)

Authorised Signatory: ....

Authorised Signatory: ....

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SCHEDULE 1

OBJECTIVES

Aims, Outcomes, Objectives and General Principle

The aims, intended outcomes and objectives of the Partners in entering into this Agreement are to formalise and build on the significant track record of improving outcomes through joint working, Service User empowerment and innovation for children's health and social care services in Peterborough in order to further improve and develop local services and in particular to act so as to fulfil the Partners' respective statutory duties and to achieve:

- Improved service delivery resulting from more closely co-ordinated joint commissioning structures;
- More robust and flexible joint commissioning structures, better placed to respond to the personalisation agenda or other policy shifts;
- Improved financial decision making and possible operational efficiencies;
- More robust governance structures underpinned by firm legal frameworks;
- A firm and enduring foundation for partnership working between the CCG and the Council, by establishing a fit for purpose commissioning contracting and brokerage capacity which is well placed to respond to future challenges
- Improved Services, responding to expert professional opinion, such as from the GP community and delivering the strategic objectives of each party;
- Easier integration of preventative services with intermediate and high dependency care packages across the health and social care spectrum to provide a more seamless service to users;
- A clearly integrated point of contact for other health and social care professionals, in order that they can influence strategic commissioning decisions and future Service Specification;
- Greater local decision making about children's health and social care services;
- General health services which are provided closer to where people live;
- Improved access to health social care services;
- More innovative ways of providing services;EG. CCG Children's Procurement
- Ways of combating social exclusion, tackling inequalities and improving health and social wellbeing of local communities;
- Service users and their carers receiving coherent integrated packages of care so avoiding the anxiety of having to navigate a complicated bureaucracy;
- An ongoing local population needs assessment in accordance with Lewisham's Joint Strategic Needs Assessment
- The provision of high quality services which are safe, sound and comprehensive and supportive;

The aim is that the above will be achieved pursuant to this Agreement by:

- Using the statutory joint commissioning structure;
- Using the Partnership Arrangements as a basis for service planning and delivery and progressively model services to commission within and through them;
- Using evidence on the outcome for service users and Carers as the basis for improving standards and targeting resources;
- Considering the overall strategic direction of the Council and the CCG's;

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SCHEDULE 2

RELEVANT FUNCTIONS

A. Council Functions

Any functions which are engaged in the delivery of the Services to the Service Users and which are conferred on or exercisable by the authority:

- as being emotional health and wellbeing and disability services which relate to children's services

B. CCG Functions

The function of providing or making arrangements for the provision of services:

As being Children's Community Health Services, LAC services and CAMH & Continuing Care (to be decided)

SCHEDULE 3

SERVICES

CCG – LEAD COMMISSIONER CONTRACTS Not at this point in time

Brief description of contract	**Children's Community Health Services** - Paediatric Therapies Services (Speech & Language Therapy, Occupational Therapy & Physiotherapy) - Community Children's Nursing - Community Paediatrics - Special Needs Nursing - Equipment
Principal client group receiving services under the contract	Children and Young People with universal, targeted and complex health needs
Name of provider	Cambridgeshire & Peterborough NHS Foundation Trust
Who was the contract awarded by, PCC or CCG	CCG
Award date	
Annual contract value	
Expiry date of the contract	
Committed budget of PCC and the PCT	

Brief description of contract	**LAC Health Team**
Principal client group receiving services under the contract	Looked After Children
Name of provider	CPFT
Who was the contract awarded by, PCC or CCG	CPFT
Award date	
Annual contract value	
Expiry date of the contract	
Committed budget of PCC and the CCG	

Brief description of contract	**CAMHS**
Principal client group receiving services under the contract	Children and Young People 0-19 with mental health needs
Name of provider	CPFT

Who was the contract awarded by, PCC or CCG	CPFT

Brief description of contract	**Continuing Care/OTTERS**
Principal client group receiving services under the contract	
Name of provider	
Who was the contract awarded by, PCC or CCG	
Award date	
Annual contract value	
Expiry date of the contract	
Committed budget of PCC and the CCG	

Peterborough City Council – LEAD COMMISSIONER CONTRACTS

Brief description of contract	**Short Breaks –** respite care for parents/carers of children and young people with disabilities. Includes after school and holiday clubs, specialist youth clubs, sports, play activities and activities for siblings.
Principal client group receiving services under the contract	Families of children and young people with disabilities aged 0-19, based on assessed needs.
Name of provider	Various – Phoenix School; Papworth Trust; Circles Network; Dial; Vivacity; KIDS
Who was the contract awarded by, PCC or CCG	PCC
Award date	April 2013
Annual contract value	£277,297 total for combined contracts
Expiry date of the contract	Dial contract is one year to march '14. Other contracts to March '16
Committed budget of PCC and the CCG	

Brief description of contract	**3T's Emotional Well-being –** brief 'talking therapy' interventions to young people with emotional well-being issues.
Principal client group receiving services under the contract	Young people 11-17 who are experiencing emotional well-being issues which are impacting on their behaviour and functioning but are not severe enough to reach the criteria for Child and Adolescent Mental Health Services.
Name of provider	Drinksense Social Enterprise
Who was the contract awarded by, PCC or CCG	PCC

Award date	April 2012
Annual contract value	£50,000 (2013/14)
Expiry date of the contract	March 2015

Brief description of contract	**School Nursing –** universal health service for children, young people and their parents which promotes health and mental health, delivers screening programmes to optimise health and promotes learning through well-being and inclusion.
Principal client group receiving services under the contract	Children and young people aged 5-19 and their parents who live in the Peterborough Local Authority area.
Name of provider	CPFT
Who was the contract awarded by, PCC or CCG	PCC
Award date	April 2013
Annual contract value	£701,149
Expiry date of the contract	March 2014

Brief description of contract	**Looked After Children Psychology Service –** clinical psychology service for looked after children. Includes direct assessment and intervention work with children and families, and advice and training for carers and professionals.
Principal client group receiving services under the contract	Looked after children with emotional health and well-being issues, post adoption support and in exceptional circumstances Child in Need.
Name of provider	CPFT to Sept '13. Provision moving in-house to PCC by mutual agreement from Oct '13.
Who was the contract awarded by, PCC or CCG	PCC
Award date	Sept 2010
Annual contract value	£105,000 (budget allotment for 13/14)
Expiry date of the contract	
Committed budget of PCC and the CCG	

Brief description of contract	**Cherry Lodge Respite Care and Residential Care –** provides residential care, day care, after school care and outreach activities.
Principal client group receiving services under the contract	Children and young people with complex disabilities/severe learning disabilities aged

	0-19 and their families, based on assessed needs
Name of provider	PCC
Who was the contract awarded by, PCC or CCG	In-house provision
Award date	On-going
Annual contract value	£541,542 net Budget allotment in 13/14 (includes an income expectation of £506,350)
Expiry date of the contract	N/A
Committed budget of PCC and the CCG	

Brief description of contract	**The Manor – Respite Care –** short breaks and activities for children and young people with disabilities
Principal client group receiving services under the contract	Children and young people with disabilities aged 0-19 and their families, based on assessed needs
Name of provider	PCC
Who was the contract awarded by, PCC or CCG	In-house provision
Award date	On-going
Annual contract value	£502,812 Budget allotment in 13/14
Expiry date of the contract	N/A
Committed budget of PCC and the CCG	

Brief description of contract	**Home Support Services** – domiciliary care
Principal client group receiving services under the contract	Children and young people with complex disabilities/severe learning disabilities aged 0-19 and their families, based on assessed needs
Name of provider	Various – Sahara Care; Saga Homecare; Crossroads Care; Allied Healthcare; Independent Health Services
Who was the contract awarded by, PCC or CCG	PCC
Award date	Spot purchased to meet assessed needs
Annual contract value	£115,100 actual spend for 2012/13. £97,314 allocated for 2013/14
Expiry date of the contract	N/A
Committed budget of PCC and the CCG	

Brief description of contract	**Direct Payments -**
Principal client group receiving services under the contract	Children and young people with disabilities aged 0-19 and their families, based on assessed needs
Name of provider	PCVS contracted to provide information, advice and support to families around direct payments. Payments made directly to families
Who was the contract awarded by, PCC or CCG	PCC
Award date	April '13
Annual contract value	£121,693 (budget allotment in 13/14). Includes £7000 contract with PCVS
Expiry date of the contract	March '14
Committed budget of PCC and the CCG	

Brief description of contract	**Occupational Therapy (Social Care) –** OT assessments and interventions around home based needs
Principal client group receiving services under the contract	Children and young people with disabilities aged 0-18 and their families, based on assessed needs
Name of provider	PCC Adult Social Care
Who was the contract awarded by, PCC or CCG	PCC
Award date	April 2013
Annual contract value	£60,000
Expiry date of the contract	March 2014
Committed budget of PCC and the CCG	

Brief description of contract	**Equipment –** provision of specialist equipment following assessment of need
Principal client group receiving services under the contract	Children and young people with disabilities aged 0-19 and their families, based on assessed needs
Name of provider	Various
Who was the contract awarded by, PCC or CCG	PCC
Award date	on-going
Annual contract value	£103, 419 budget allotment for 2013/14
Expiry date of the contract	
Committed budget of PCC and the CCG	

SCHEDULE 4

FINANCIAL MATTERS

This Schedule 4 contains protocols to cover the following areas:

1. How budgets will be set by either party for future years

2. How agreed budgets will be managed during any given year and how delegated authority will be exercisable to sign contracts and otherwise incur expenditure commitments

3. How financial transactions will be processed

4. Fees and charges

These protocols are based on the agreed budgets set for the 2014/15 financial year

Setting budgets

1.1 The Partners agree the following principles in relation to setting budgets for the Services:

1.1.1 Each Partner retains the right and responsibility to set its own budget, having regard to its available resources, statutory obligations, locally determined priorities and such other factors as it may consider necessary;

1.1.2 Each Partner recognises that the services that it provides or does not provide, and the level to which it provides them, can materially affect the financial position and obligations of the other Partner;

1.1.3 In recognition of this and in the spirit of the partnership between the Partners, each Partner agrees to consult the other on its budgetary proposals, and to have regard to the responses provided (subject to paragraph 1.1.1 above); and

1.1.4 Each Partner acknowledges that its budget setting process is dependent on many other factors, including in particular the allocation of resources from central government agencies, and that the timing of the announcement of such allocations can vary from year to year and outside of the direct control of either Partner. Each Partner therefore recognises that it cannot provide the other with certainty over the timing of final decisions (or even proposals) within its own budget setting process, and therefore agrees to act in the spirit of this Schedule 4 (which for the reasons set out above cannot be wholly prescriptive)

1.2

1.2.1 Each Partner will increase (or decrease) their contribution by an agreed percentage linked to their central government funding. For the Council this will be the increase (or decrease) in its formula grant and for the CCG the increase (or decrease) in overall funding allocation from the Department of Health (referred to as "ring fenced funding streams").

1.2.2 Contributions will then be adjusted to reflect changes to ring-fenced funding streams.

1.2.3 In addition, new ring-fenced funding streams announced for either Partner will in principle be imported 100% to the jointly commissioned budget where they relate to the Services already pooled.

1.2.4 The previous year's contributions, adjusted for Paragraphs 1.1.1 and 1.2.2, above, will form the baseline funding level for next year.

1.2.5 This baseline funding level will then need to be adjusted to reflect changes in need, for example to reflect demographic change, and to reflect the requirement for each Partner to be able to make efficiencies across its budgets.

1.2.6 Paragraphs 1.2.1 and 1.2.2 above are the mechanisms by which the Partners will arrive at the baseline funding level, from which decisions about changes to funding to reflect local priorities and resources need to be made. The example below sets out the form of calculations to be followed in arriving at this baseline level. The actual figures are illustrative only and not binding.

	Council	**CCG**
	£m	**£m**
Agreed xx budgets		
Date xx change in council formula grant		
Date xx change in CCG allocation		
Change in relevant ring-fenced grants/funding allocation		
Revised baseline allocation Date xxx		

2.3 In practice, for the reasons given above, the actual revised baseline allocations for future years may not be known until relatively late in the process, and too late to allow meaningful consultation between the Partners. The Partners will therefore prepare a statement in the above format early in each financial year (and by no later than 31 May) using estimated figures in order to inform one another of their current best estimates of the likely position, finalising the position as and when sufficient certainty on government funding is available (the long-stop date for this in principle being 28 February each year, but subject to this uncertainty).

2.4 Using the estimated baseline funding position and their own information about corporate budget priorities each Partner will inform the other (by simultaneous exchange or as otherwise agreed) of their best estimates of the likely actual resources they are able to contribute to the jointly commissioned services by 30 June each year, and hence the likely level of savings that they will be seeking to make within this area (or growth that they will be seeking to allocate).

2.5 Also by 30 June each year the Head of Joint Commissioning will provide each Partner with their best available estimate of the service pressures (e.g. arising from change in demographics, populations numbers, legislation, re-tendering of services etc) and opportunities (e.g. from efficiencies etc) within the total commissioned budget.

2.6 From this each Partner will formulate proposals as to the changes it considers it may wish to make to the Services and service provision in the following year (normally by 31 July each year, or other date by mutual consent). These proposals will tend to be greater than any net savings or growth assumed to be available within the budget, in order that regard can be had to meaningful consultation (otherwise there is no flexibility to withdraw, alter or amend proposals to fit the available resources in response to consultation).

2.7 Each Partner will respond formally to the others' proposals within at most two months of receipt, although the mutual intention is that responses should be provided much sooner whenever possible.

2.8 At this point, and subject to the uncertainties set out above, the Partners will seek to agree on a set of proposals, subject to either Partners' absolute right ultimately to determine its own budget

2.9 In default of agreement either Partner has the right to terminate this Agreement in accordance with clause 21.

2. Managing budgets during any given year

2.1 General

Whilst Services will be commissioned jointly, with the Council acting as lead commissioner, the practical reality on the Commencement Date will be that each Partner may retain responsibility for contracts for its own statutory areas of responsibility. Until such time as all budgets are pooled and all contracts are let by the Council as lead commissioner each Partner will therefore retain responsibility for provision of relevant financial information to the other in relation to its own expenditure (and where relevant, income).

The principles to be followed in applying the above are as follows:

(a) Each Partner commits to share regular financial management information with the other on an "open book" basis. This will include such monthly or other financial monitoring information as is normally produced, and each Partner commits to acceding to the others' reasonable requests for additional information.

(b) The overarching purpose of sharing such information will be to enable the Partners to view total expenditure across the entire range of jointly commissioned services, in order that reasonable and timely management decisions can be made to react to circumstances that were not foreseen, or could not have been foreseen, at the time the budget for the year was set (for example, to respond to a forecast overspend).

(c) Each Partner recognises that the services that it provides or does not provide, and the level to which it provides them, can materially affect the financial position and obligations of the other Partner, and therefore commits to alert the other promptly to any material circumstance (e.g. a forecast overspend) that will require them to consider changes to their in-year level of service provision and to consult on those as may be reasonably practicable.

(d) Each Partner commits to inform the other in advance of decisions (or proposed decisions) to commit significant sums of expenditure, for example in renewing major contracts. The Partners recognise that for these purposes "significant" is a term not capable of precise definition but could mean significant in financial amount or potential risk.

(e) Notwithstanding that each Partner retains liability for its own areas of expenditure (in advance of any agreement formally to pool budgets) the Partners agree that in the event that there is an underspend in one budget area and an overspend in the other that they shall seek to offset the overspend with the underspend, subject to the absolute right of either Partner to reject this

(f) Where the combined aligned budget is in total underspent in any given year the Partners agree that they will carry forward 50% of this underspend to the operation of the aligned budgets for the following year, returning the balance of those underspends to the respective organisations.

2.2 Letting contracts

The following principles apply:

5.8.1 All Existing Service Contracts that are solely for social care will be let by the Council and all Existing Service Contracts that are solely for health care will be let by the CCG, and in

respect of such contracts payments will be made directly by the contracting organisation (see section 3 of this Schedule 4for how these transactions will be processed)

(a) Where contracts are for health and social care:

(i) a decision will be made in each case by the Head of Joint Commissioning (or nominated member of staff) as to which Partner shall be the contracting Partner (subject to paragraph 2.2(b) below) ; and

(ii) in recognition of the proposed longer term move towards fully integrated lead commissioning by the Council, the default position shall normally be that Future Service Contracts are let by the Council, and the Partners agree only to move from this position where compelling evidence exists to the contrary; and

(iii) section 3 of this Schedule 4 covers how payments between the Partners for their respective share of such Existing Service Contracts and Future Service Contracts will be processed, and follows the principle that, where material, arrangements shall be such that neither Partner suffers (or gains) any material cash flow loss (or gain) on the timing of payments and reimbursements.

(b) In letting contracts on behalf of the Council the Head of Joint Commissioning shall ensure that the Council's procurement guidelines, contract standing orders, scheme of delegation and other relevant requirements and documents shall be complied with at all times. At the date of this Agreement a key term in respect of the foregoing is that authority must be sought from the Cabinet for all contracts with a value over the full contract term of £500,000) exclusive of VAT.

(c) In letting contracts on behalf of the CCG the Head of Joint Commissioning shall ensure that NHS procurement requirements shall be complied with at all times. At the date of this agreement, the key terms in respect of the foregoing is that the Head of Joint Commissioning will ensure that authority is sought from the CCG in accordance with its SFIs or SFO or any other stated procurement requirements that shall be in place from time to time and notified to the Council

(d) As regards paragraph (c), above, there will be instances where the Head of Joint Commissioning has authority to award contracts for the CCG on her own authority that, were they Council contracts, would require authorisation from either the Service Director People Commissioning and Cabinet (Contracts). In relation to these contracts, notwithstanding the fact that the Service Director will be the line manager of the Head of Joint Commissioning the Partners agree that in such circumstances the CCG will retain liability for all such decisions.

3. How financial transactions will be processed

3.1 Each Partner will retain responsibility for its own payments and income processes.

3.2 Each Partner will pay invoices for Existing Service Contracts for which it is the lead. Where one Partner has let contracts on behalf of the other (or on behalf of both Partners) it will pay the Service Provider and will raise invoices to the other Partner for its share of the payment. Invoices will be raised monthly (unless separately agreed). Where possible invoices should be raised on the basis of actual spend. If this is not available when a monthly invoice is raised then the following invoice should be adjusted for the difference between actual and invoiced sum for the preceding month.

3.3 The Partner receiving the invoice will pay the invoice within its normal terms but not later than 30 days after receipt.

4. Fees and Charges

It is recognised that the CCG services are free at the point of use and accordingly fees and charges are not relevant for CCG services. Where the Council raises fees or charges for its services, the same will fall outside the ring fenced funding streams referred to in paragraph 1 above. Risk and benefit in connection with fees and charges raised by the Council in respect of the Services will rest with the Council.

SCHEDULE 5

ACCOMMODATION AND OTHER NON FINANCIAL CONTRIBUTIONS

The Partners shall make available to each other such rooms and hot desking facilities (including the use of desks, space, shelving, information technology and voice and data equipment and services and meeting rooms) as shall be reasonably required for the purposes of this Agreement at their respective premises as agreed by the Partners from time to time and the Partners hereby grant to each other non-exclusive licences for such purpose.

SCHEDULE 6

ELIGIBILITY CRITERIA

1. Guidance in relation to health and clinical care services for which the CCG is statutorily responsible, as the same may be applicable from time to time:

   - Responsible Commissioner Guidance from the Department of Health
   - CCG's Commissioning Policies
   - the Department of Health's Guidance *"Who Pays? Establishing the Responsible Commissioner?"* dated September 2007
   - NHS continuing Care Practice Guidance - Department of Health 2010
   - any of the CCG's Commissioning Policies or Commissioning Strategy Plan and any Ethical Frameworks
   - other continuing care and/or exceptional treatments guidance as may be issued from time to time
   - NICE guidance, at the discretion of the CCG

2. Guidance in relation to children's services for which the Council is statutorily responsible, as the same may be applicable from time to time:

   - Children Act 1989 (as amended)

SCHEDULE 7

GOVERNANCE STRUCTURE

1. **General**

(a) This Schedule will show how the Partners will retain proper influence and control over the joint commissioning function despite the Council assuming the lead commissioning role.

(b) Governance will be in accordance with a framework, with boards made up of representatives of each Partners (as set out below) which together formulate proposals which eventually are put to each of the Council's and the CCG's decision making powers.

(c) The decision making powers of the Council are vested in the Corporate Management Team and Cabinet, taking into account the Council's formal "scrutiny" process and where appropriate full Council.

(d) The decision making powers of the CCG are set out in the CCG's Constitution, with ultimate decisions being taken by the CCG Governing Body.

2. **Framework for decision making**

(a) The Children's Health Strategic Partnership ("CHSP")

This is a partnership body at the head of the framework. On the CHSP, The Council is represented by the Service Director People Commissioning and the CCG is represented by its Director of Quality, Safety & Patient Experience.

It will provide the overall framework and direction for partnership working in Peterborough. The CHSP will agree the outcome requirements to be satisfied by joint commissioning.

The CHSP is not a body with legal decision making powers. The relevant decision making powers are vested in the Council, the CCG and other statutory partners.

(b) Day to Day Management

Joint Commissioning Unit

The Joint Commissioning Unit is responsible for all joint commissioning arrangements. It is made up of staff from the Council, and is headed up by the Head of Joint Commissioning (see definition), the salary of which post is paid by the Council. The CCG makes a contribution to the salary costs of the Joint Commissioning Unit. The Head of Joint Commissioning has a key managing and reporting role as set out in this Agreement and as required by the post generally. The Head of Joint Commissioning and the other managers within the Joint Commissioning Unit be held accountable for their roles and the impact they have on spend against budgets. The managers will make decisions (within their limits of delegated authority – see below) and hold staff in different parts of the system to account for their actions, and the impact on budget.

The relevant managers within the Joint Commissioning Unit, including the Head of Joint Commissioning ensure compliance with clauses 6.3 and 6.4 of this Agreement.

Delegated Authority

The Head of Joint Commissioning reports (inter alia) to the Peterborough and Boarderline CCG's, and to the Service Director People Commissioning within the Council.

The Joint Commissioning Unit is able to take decisions to commission services and use budgets within delegated authority, and subject to the CCG and the Council's internal procedures existing

from time to time, and the other provisions of this Agreement. Issues beyond that authority would be escalated to the CHSP and if appropriate in from there to the Council and the CCG as per the above. This structure will enable managers to ensure that services and budgets can be flexible to respond to changing needs.

(g) CCG Governance in relation to Clinical Safety and Performance

The CCG has responsibility for providing assurance on the quality and safety of the health services it commissions to the Patient Safety and Quality Committee .

SCHEDULE 8

HEAD OF JOINT COMMISSIONING ROLE DESCRIPTION

Purpose of Job

1. To take a strategic lead in planning and commissioning services for Children's Services.

2. To support the Service Director People Commissioning and the Employer's Chief Executive in corporate management to deliver the Host Employer's and Employer's vision, goals and core values.

Main Responsibilities

Corporate Roles

3. In the Host Employer to contribute, through membership of the Directorate Management Team, attendance at Healthier Communities and children Scrutiny Committees.

4. Membership of the CHSP and CFJCB. Chair and contribute to tier 3 planning and partnership groups as required.

5. To represent the Host Employer's and Employer's interests at a senior level with partnership bodies and stakeholders to further the Host Employer's and Employer's strategic objectives aim of delivering excellent service.

6. To contribute to the delivery of the Sustainable Communities strategy, the Prevention and Early Intervention Strategy and the Peterborough and Boarderline Commissioning Strategy and QIPP plans.

Functional Role

7. To be responsible for the provision of a high quality commissioning team for the Host Employer and Employer and for developing a strategic approach to contracting activity management.

8. To plan and commission services within the resources available from the Host Employer and Employer and manage contracts and service level agreements within the commissioning budgets.

9. To develop contact specifications, involving service providers and other appropriate stakeholders in order to provide seamless services for individuals and ensure effective management and monitoring of the Host Employer's and Employer's contracts for children's services.

To represent the Host Employer and Employer and effectively and to build effective partnerships across a range of agencies and forums including the voluntary, community sectors, service users and carers.

10. To ensure that all Local Authority tendering and contracting process comply with the relevant the relevant contracting processes and ensure that all contracted services meet the requirements of the relevant regulatory bodies.

11. To be responsible for writing and presenting reports as required to Host Employer Cabinet Members, other members, relevant Overview and Scrutiny Committees, as required.

12. To lead for the Host Employer and Employer on the management of children's pooled and aligned client group budgets.

13. To specify service objectives for children's services and, and ensure good performance against government targets, Performance Assessment Framework and Healthcare self assessment standards.

14. To advise on policy directives as appropriate and ensure that the Host Employer and Employer is responsive to national and corporate requirements.

15. To undertake any other duties and responsibilities (including taking a lead responsibility for particular issues and projects) as may be required by the Host Employer or Employer.

Personnel and Management

To head up the Joint Commissioning Unit for Children ("JCU") comprising officers and commissioning staff from the Employer.

16. To have full management responsibility for the Employer and Host Employer personnel within JCU, including undertaking recruitment, dismissal, grading, supervision and appraisal of staff and holding staff accountable for their performance and actions acting at all times in accordance with the relevant employment and personnel and other policies and procedures of the Employer (for employees of the Employer) and of the Host Employer (for employees of the Host Employer), and the relevant terms and conditions of any contract applying to any individual employee within the JCU.

17. Keep appropriate written records of all decisions and actions in relation to Personnel

Key Deliverables

18. Deliver Employer and Children's commissioned services within agreed annual budgets for client group commissioning.

19. Support the agreement of levels of financial commitment for Host Employer and Employer in joint commissioning, functions and services including implementing plans for disinvestment where appropriate.

20. Support the integrated joint commissioning with Employer for client groups with robust financial governance arrangements.

21. Support the development of an integrated contracting function for joint client group health and social care functions.

22. Contribute to the delivery of Key Performance Indicator Targets for Host Employer, the Employer and Care Quality Commission requirements

Appendix 2

Operational Policy for Borderline and Peterborough Joint Child Health and Wellbeing Commissioning Unit. (JCU)

Strategic Functions

The strategic aim for the JCU will be to align assessment of local needs, commissioning activity and improve outcomes for children through improved Provider performance :-

Integrating and co-ordinating the commissioning intentions of CCG/LCG's and Councils [Peterborough, Cambridgeshire and Northamptonshire] to reflect local priorities: commissioning intentions and priorities will be aggregated and will form the basis for developing the overall commissioning strategy. This will ensure the JCU strategy is grounded in local priorities and reflects local development needs and fully aligns to the Health and Wellbeing Board strategies and action plans. Plus incorporating the NHS Commissioning Board child health developments in the strategy ensuring comprehensive commissioning approach.

Ensuring equity and quality of service delivery: the JCU will determine the required delivery approach to deliver on the integrated commissioning intentions. This goal ensures that the children's services are aligned to meet the needs of the local population, close gaps in current service provision and enables children and young people to receive quality services in their community. Achieving this goal will also mean that children and families experience a seamless pathway regardless of the different organisations providing services or who commissions them. All those services in the pathway of care will be involved in shaping the outputs produced by the JCU.

Increasing children's services performance and delivering improved health outcomes: the JCU will work with providers and develop a performance framework by which local and national targets including outcome based performance indicators will be measured. Quality and experience of early access and appropriate support will be monitored while effective delivery models will be explored to reduce admission rates into acute and specialist services plus address inequalities in access. This will enable an effective delivery of savings plans as a system wide approach to commissioning and delivery will be adopted.

Ensuring services offer quality and value for money: by developing close collaboration and commissioning relationships with a variety of providers, the JCU will be able to drive up quality and value for money through identification and dissemination of best practice.

Ensuring that the children, young people & families/carers experience continually improves: through improved feedback mechanisms the JCU will fully understand children & young people's concerns such as dignity, choice and quality of care, access, clean and safe environments. The JCU will be able to address these priorities through improved commissioning relationships and more effective performance management of providers.

Delivery of effective children's commissioning function to the partners: the JCU will enable all partners to significantly improve their commissioning competencies relating to children's commissioning. The JCU will operate as a delivery vehicle, which serves its partners equally whilst recognizing their varying needs. It will consider and align its functions with other commissioning priorities and cycles i.e. CCG Governing Body, LCG's Boards, Health and Well Being Board and Children's Joint Commissioning and Delivery Board and work with Public Health and the NHSCB to deliver on the Outcomes Frameworks, inform the

JSNA and facilitate the Healthy Chid Programme and Special Educational Needs and Disability reforms.

Principles of Operation

- The JCU will seek to improve the children, young people, and family/carer experience at every possible opportunity by improving provider performance. Children & Young People are at the heart of all activity. Commissioning is the key lever to ensure children and young people receive quality services and care. The JCU will be designed with the necessary ability to effect positive change for children & young people.
- Do things once rather than multiple times, wherever beneficial. Where there is opportunity to minimize bureaucracy and maximize value for money, activities will be undertaken once only for the CCG/LCG's and Council Children's Services.
- Lean, simple and robust governance. The governance structure of the JCU must not add to bureaucratic procedure; the design will ensure the JCU management structure is lean and the governance is simple to navigate, but not at the expense of quality or effectiveness.
- A delivery vehicle that serves its CCG/LCG's and Council Children's Services as equal customers. The joint arrangement is a delivery vehicle and does not challenge the statutory basis of the CCG/LCG's and Councils Children's Services remain accountable for commissioning. The JCU will undertake commissioning activities to achieve the CCG/LCG's and Council's children's Services strategic goals. In this role, the JCU will serve its partners equally and be responsive to their needs. It will work closely with the Area Team across joint pathways. The JCU will build on the existing capabilities of people including Children's Clinical Lead. The JCU is about all the partners becoming better commissioners, not about removing and changing existing capabilities. To achieve effective commissioning, the CCG/LCG's and Councils Children's Services are committed to enhancing their capabilities and expertise within the JCU by developing expertise as required, to deliver its objectives.

Operational Functions

The JCU will support integrated working and will offer:-

- A comprehensive analysis of need
- A whole system approach to planning and investment
- An alignment of commissioning cycles and intentions
- An effective use of resources that:
  - prevent duplication of activity/effort,
  - offer solution focused early intervention
  - increase efficiencies in activities
  - create seamless, co-ordinated pathways to service delivery
  - deliver value for money, investing to achieve greatest community impact and reduce inequalities
  - deliver safe / quality outcomes
- Improved access to and effective provision for service users/patients
- Seamless, co-ordinated, flexible & responsive services
- A common market development and procurement approach
- Most important, improved outcomes for children, young people and their families.

Our approach to the use of resources will be:-

- Streamlining inputs, achieving statutory targets and measuring outcomes and impact on service users/patients

- Reducing costs by reducing duplication (procurement, labour costs etc.) for the same outputs, results and impact
- Measuring activity against cost and workforce skill mix
- Seeking proportionally more outputs and improved results and impact or improved quality in return for an increased resource

Specifically the JCU will:

Assess needs and prioritise
- Analyse health and local authority data to identify health and wellbeing needs: disease and population group
- Develop detailed plan for service delivery design

Develop Care Pathway and Service Design
- Support roll-out of new pathways and develop comprehensive service specifications
- Provide a basic workforce framework to accompany both care pathways and service design
- Make the necessary links with other CCG/LCG's and NHSCB contracts to support the above

Offer Strategic and capacity planning
- Build a baseline of current activities and capacity (financial and operational)
- Offer strategic options based on trends and models of good practice
- Calculate the necessary capacity to match demand and study how capacity can be further developed
- Provide budget management via aligned budget arrangements
- Prepare reports for Health and Social Care / Boards and Partnerships
- Work across services and directorates to oversee any additional health and Social Care related commissioned work

Ensure Service User/patient feedback
Whilst insight is critical at every stage, this is where it really matters. Finding out as much as possible about the service users/patients; their needs, experiences and barriers. Evidence sources can include surveys, community engagement, focus group participation, demographics, and social trend data. The approach will not just be a dialogue, but will involve co-design, co-production and consultation involving the respective organisations resources.

Stimulate the market
-
- Work with providers to develop new delivery models
- Develop new providers and identify opportunities to commission integrated delivery

Manage the supplier network
- Work with the existing providers to ensure optimum delivery of the strategic plan
- Develop robust performance management methodology and tools
- Monitor provider performance/quality e.g. Clinical and analyse activity
- Benchmark data against national and international standards
- Manage the improvement programme for failing providers
- Identify where pathways are not working or do not exist
- Ensure Action Plans are implemented
- Work with services, directorates and partner agencies to identify need, gaps in provision and plan for system wide delivery
- Decommission existing services where these are no longer required

-
Inform contract and procurement activity
- Develop commissioning strategies
- Develop service specifications
- Inform contract negotiations
- Inform procurement process

Resources Implications

Accommodation

Officers supporting the functions of the JCU will be based at Council premises and should have access to an nhs.net account and other health premise hot desks to enable working across the partners.

Human Resources

The JCU will be managed by the Head of Children's Community Health Commissioning in Peterborough City Council working in partnership with Directors and Heads of services to deliver the aims and exercise key responsibilities of the JCU. There will be close working with other commissioning leads in the CCG/Local Authority and Children's Clinical Lead in the LCG's.

The Local Authority Head of Children's Community Health Commissioning will support:

a) The required clinical governance of all the commissioning activity
b) Interface with CCG and LCG structures
c) Engagement with other CCG commissioning activity and contracts, particularly the Head of Commissioning for Children's acute services and Maternity.
d) Link to CCG/LCG's and LA Commissioning Board structures
e) Guidance and updates on any policies and regulations

Additional Support Requirements

The following support needs have been identified and would be required from CCG and Council

- Performance management data
- Safeguarding information
- Quality information
- Public health support including identifying needs as part of the JSNA process, advice on the evidence base, outcome measures and evaluation
- Links into Participation, Professional and Clinical Networks
- Communication (strategy, protocols and pathways)
- Workforce development
- Specialist input re Procurement and Tendering
- Finance
- Legal services
- HR
- Formalized agreements for information sharing that are Information Governance compliant and appropriate NHS Net Accounts, etc.
- Commercial support for market stimulation and development

What will not be included in the Joint Commissioning Unit

- Children's acute and maternity services

- Specialist services commissioned by NHSCB

Operational Responsibilities

Develop a S75 to delegate the commissioning function and responsibilities from the CCG to the LA and aligned Budget Arrangements within a Joint Commissioning Unit model for:

- The Looked After Children Health Team
- Therapy services including occupational therapy, physiotherapy & speech and language therapy
- Nursing Services including continuing care, community and special school nursing.
- Equipment
- Community Paediatrics/Child Development Centre
- Children's Mental Health Services, including CAMHs
- Early support, including portage and children's centres
- Short break services and home and community services for children with disabilities and complex health needs
- Palliative Care
- Drug and Alcohol Services for children
- Youth Offending Service – Health
- School Nursing
- Sexual health services for children and young people
- Services for children and young people who have been impacted on by domestic abuse

- Working closely with Health Visiting, including Family Nurse partnership and Midwifery services

- Ensuring the requirements of the Special Educational Needs and Disabilities reforms are met by health and local authority providers; particularly in relation to the Education, Health and Social Care Plans.

- Ensuring governance arrangements are in place and further develop performance management and quality assurance frameworks building on existing joint commissioning activity.

- Develop service specifications for future pathways to support children in the local system.

- Establishing the strategic commissioning plans within a devolved budget management infrastructure subject to the Partners agreement.

- Operating in collaboration with CCG/LCG's to a commissioning cycle of identifying need, prioritizing resources, securing effective and efficient services, monitoring impact through robust performance management arrangements and effective business planning.

Financial Baseline

To be agreed

Governance

The JCU will be formally constituted through Section 75 allowing the CCG to delegate its Commissioning function under the Health Act and using a Section 256 Agreement to enable transfer of funding as and when required related to specific projects.

The Children's Health Strategic Partnership (CHSP) will manage the partnership arrangements as outlined in the S75. To oversee the JCU operations, evaluate impact of JCU functions and monitor delivery and impact of services for children and young people in Peterborough. (Including in Cambridgeshire, Northamptonshire and Herts where appropriate) (As set out in the Section 75 Schedule 7)

Furthermore, an operational local JCU group will also be established to provide a focus for the operational functions as described above. Members will include leadership officers across the Council and CCG/LCG's who will review performance management information, identify issues and where provision needs improving, make recommendations and inform planning and future commissioning.

Financial Governance

As set out in the Section 75 Schedule 4.

Compliments and Complaints

Compliments and Complaints will be dealt with through the host organisations policy and procedure.

Risk Management

The JCU will develop and maintain a risk register.

Review

The Section 75/256 Agreements maybe reviewed at the request of Peterborough City Council or the CCG/LCG's .The Agreement will run initially for 2 years.

6th December 2013

HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 8(a)
16 JANUARY 2014		PUBLIC REPORT
Contact Officer(s):	Jana Burton Executive Director Adult Social Care, Health and Well Being Mubarak Darbar Head of Commissioning Learning Disabilities and Autism	Tel. 452407 452509

AUTISM SELF EVALUATION REPORT

R E C O M M E N D A T I O N S	
FROM : *Directors, LD Partnership Board, Autism Working Group*	**Deadline date** : Annual Self Evaluation.
The Health and Wellbeing Board is asked to consider and comment upon the contents of this report.	

1. ORIGIN OF REPORT

1.1 This report is submitted to the Board following *a* request from Public Health England that all local authorities with social care responsibilities complete an Autism Self-Evaluation and share findings with the Health and Wellbeing Board.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to inform members of the outcomes of the NHS England Autism Self Evaluation. NHS England have made it a requirement that the outcomes of the Self - Evaluation be reported to Health and Wellbeing Boards.

2.2 To assure the Board that Peterborough City Council, with its partners, are working collaboratively and have put an Action Plan in place following the Self-Evaluation.

2.3 This report is for 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 wellbeing of the community’, 2.2 ‘to actively promote partnership working across health and social care in order to further improve health and wellbeing of residents’, 3.5 ‘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’ and 3.10 ‘to ensure effective working between the Board and the Greater Peterborough Partnership ensuring added value and an avoidance of duplication’.

3. BACKGROUND

3.1 Public Health England requested all local authorities with social care responsibilities to complete an Autism Self- Evaluation to assess the progress made in each locality in delivering the aims and objectives of the national Autism Strategy, ‘Fulfilling and Rewarding Lives’. The National Autism Strategy was published in 2010 and NHS Peterborough published a local Autism Commissioning Strategy in 2011.

3.2 A key feature of the self-evaluation was the requirement that it be reported to Health and Wellbeing Boards. This requirement is to ensure that the importance of the autism agenda is recognised within each locality. (See summary of the Self-Evaluation **Appendix 1**).

4. AUTISM SELF EVALUATION - OVERVIEW

The self-evaluation had 4 substantive sections covering:

- Planning
- Training
- Diagnosis
- Care and Support.

The questions within the self-evaluation required either a RAG rating or a yes/no response.

4.1 PLANNING

4.1.1 The purpose of the planning section was to gauge the progress made in providing the structure within which service improvements can be made. In response to this the council and its partners have established a multi- agency Autism Working-Group of the Learning Disability Partnership Board which drafted the 3 year Autism Commissioning Strategy in 2011. The council is also able to collect data on adults with autism known to adult social care through Frameworki and from GP practices as part of the Directed Enhanced Support Health Check programme. Whilst autism is included within the JNSA this is only at the level of prevalence rates.

4.1.2 The Clinical Commissioning Group/Local Commissioning Group is engaged in the planning and commissioning of services through the lead GP for Learning Disability and Mental Health and the s.75 Executive Commissioning Board.

4.1.3 An area which the self-evaluation was RAG rated as Red was on the implementation of reasonable adjustments to everyday services to improve access and support for people with autism. The reason this was RAG rated as red was that whilst autism awareness and the requirement is more prevalent within health and social care, this is not the case across everyday services within the wider health and public sector.

4.2 TRAINING

4.2.1 The purpose of the training section was to gauge the progress made in the provision of autism training and associated awareness within health and social care organisations specifically, and the public sector more generally.

4.2.2 In terms of good practice the Autism Sub-Group have developed an autism competencies framework to support organisations identify training requirements within their workforce, and in partnership with City College Peterborough an autism awareness training module. The autism awareness training module has been accessed by a number of social care providers and local Housing Associations in addition to Adult Social Care Staff. Peterborough City Council has developed an eLearning module which can be accessed by all its staff in addition to a 4 day course run by Northumbria University for its health and social care staff. Peterborough City Hospital has also developed an eLearning module.

4.2.3 Whilst there are areas of good practice, further development work within Primary Care is on-going.

4.3 AUTISM DIAGNOSIS

4.3.1 The purpose of this section was to gauge the progress made in developing an autism diagnosis service and associated pathway. The provision of this was a key requirement in the National Autism Strategy.

4.3.2 A Peterborough diagnosis service and pathway was commissioned in April 2013. The Peterborough diagnosis service is an extension of the existing Cambridgeshire wide 'CLASS' Clinic provided by the Cambridgeshire and Peterborough Foundation Trust, with the 'CLASS' clinic providing surgeries at the Cavell Centre in Peterborough. The diagnosis pathway was developed at a multi-agency workshop led by CPFT and has been distributed to all GP Surgeries within the city.

4.4 CARE AND SUPPORT

4.4.1 The purpose of this section was to gauge the progress in identifying and recording those on the autistic spectrum, both with a co-morbidity of a learning disability and a diagnosis of autism, receiving community care services and the support available in accessing support including the provision of advocacy and information

4.4.2 Peterborough City Council provides an integrated health and social care service for adults with a learning disability and autism and through its Frameworki data base is able to collect data on those on the autistic spectrum eligible for community care services. The self-evaluation did identify areas of improvements required in relation to the provision of information and advice for adults on the autistic spectrum, whether or not in receipt of community care services, and provision of advocacy and their skill base of advocates in providing advocacy to adults with autism. The provision of a training programme to ensure advocates are trained to support adults with autism was RAG rated as Red. Both of these issues will be taken forward as part of the Adult Social Care Transformation programme and re-commissioning of advocacy services.

5. CONSULTATION

5.1 The self-evaluation was considered and validated by the Learning Disability Partnership Board Autism Sub-Group on Thursday 19th September 2013 and the outcomes entered on the Public Health England web page: https://www.improvinghealthandlives.org.uk/

6. ANTICIPATED OUTCOMES

6.1 The Autism Sub-Group and its partners have worked successfully to begin the process of raising awareness of autism and improving services through the provision of reasonable adjustments. The autism commissioning strategy has provided a framework within which to undertake the work required and the Autism Working-Group monitors implementation of the strategy action plan. The commissioning of a Peterborough based diagnosis service and associated pathway has been a notable success which will allow people to receive a diagnosis without the requirement to travel to Cambridge. The City College Peterborough training programme has been well attended by local learning disability service providers and housing associations, and the intention is to further develop this going forward to engage providers of everyday services. The deficiencies noted in information and advocacy will be addressed through the Adult Social Care Transformation Programme and re-commissioning of advocacy services. In terms of supporting people on the autistic spectrum who are not eligible for community care services, it has been recognised that transitional support and reablement should be offered to reflect the time required by the individual to gain independent living skills and community support using mainstream services.

6.2 An Action Plan arising from the self-evaluation has been developed and is reviewed by the Autism Working-Group. The Action Plan will inform the Autism Strategy refresh which will take place during 2014 (See Action Plan **Appendix 2**).

7. **REASONS FOR RECOMMENDATIONS**

7.1 Public Health England have made it a requirement that Health and Wellbeing Boards review the outcomes of the Autism Self-Evaluation. The Board is recommended to note the contents of the report as the Self-Evaluation has been reviewed and validated by the

Learning Disability Partnership Board Autism Working-Group and will be presented to the Learning Disabilities Executive Commissioning Board.

8. ALTERNATIVE OPTIONS CONSIDERED

8.1 The option of the Health and Wellbeing Board delegating responsibility to the Learning Disability Partnership Board was considered and rejected due to the requirement with the Autism Self-Evaluation guidance that it be reported directly to the Health and Wellbeing Board. The rationale for this was to ensure that the Autism agenda is recognised and promoted by members of the board.

9. IMPLICATIONS

9.1 There are no legal or governance issues relating to the report.

10. BACKGROUND DOCUMENTS

Autism Self- Evaluation Report 2013

The National Autism Strategy 2010

Peterborough Local Autism Commissioning Strategy in 2011.

APPENDIX A

Autism Self-Assessment Summary 2013

Local Authority Area

1. How many Clinical Commissioning groups do you need to work with to implement the Adult autism strategy in your area?

Answer: One, Cambridgeshire and Peterborough CCG

2. Are you working with other local authorities to implement part or all of the priorities of the strategy?

Answer: No

Planning

3. Do you have a named joint commissioner/senior manager responsible for services for adults with autism?

Answer: Yes. Head of Integrated Health and Social Care Mental Health and Learning Disability Commissioning.

4. Is autism included in the Joint Strategic Needs Assessment?

Score: Amber

Comments: JNSA includes prevalence rates for autism.

5. Have you started to collect data on people with a diagnosis of autism?

Score: Amber

Comments: Data collection protocol being agreed with CCG after commissioning of the Peterborough diagnosis service in April 2013. This will establish a baseline of the gaps in services after diagnosis. Health data is also collected as part of the annual health and social care learning disability self assessment.

6. Do you collect data on the number of people with a diagnosis of autism meeting eligibility criteria for social care (irrespective of whether they receive any)?

Answer: Yes

If yes, what is:

- Total number of people? 105
- The number who also identified as having a learning disability: 83
- The number who are identified as also having mental health problems: 13
- Remaining 9 people have neither a learning disability nor mental health illness.

Comments. Data is sourced via Framework (council ASC database). Frameworki database further informed by GP patient specific documentation, psychology and psychiatry assessments. Data feeds into the annual health and social care learning disability annual self assessment.

7. Does your commissioning plan reflect local data and needs of people with autism?

Answer: Yes

Comments: The Commissioning plan contains local and national data available on autism and reflects the needs of people with autism as expressed during strategy

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development consultation. Strategy action plan has been reviewed and updated every year.

8. What data sources do you use?

Score: Amber

Comments: quantitative data sources include social care data from the councils adult social care database frameworki, transitions and JNSA, health data collected as part of the annual health and social care learning disability annual health self assessment and qualitative data sources such as views and experiences of self advocates and families. A service user satisfaction survey has been developed and was issued during August 2013 in partnership with the local NAS branch which will inform development of new commissioning strategy in 2014.

9. Is your local Clinical Commissioning Group or Clinical Commissioning Group (including the Support Service) engaged in planning and implementation of the strategy in your local area?

Score: Green

Comments. LCG is engaged through the lead GP for Learning Disability and Mental Health and partnership between the council and CCG through the s.75 agreement which permits the council to provide integrated health and social care services for adults with a learning disability and autism. In order to manage the s75 agreement specifically, and develop services more generally, a learning disability commissioning board has been established to which the LDPB nominates two members to attend. The commissioning board reports to the Health and Wellbeing Board. The Autism Sub-Group of the LDPB formally nominates one member to attend the LDPB, thereby establishing a formal link to the commissioning and health and wellbeing board. The lead GP chairs the LDPB Health Sub-Group.

10. How have you and your partners engaged people with autism and their carers in planning?

Score: Green

Comments: The LDPB Autism Sub-Group provides the forum for engaging statutory and voluntary sector partners and self advocates and their families and carers. The sub-group is co-chaired by the learning disability integrated health and social care commissioner and a representative from the local NAS branch. An example of active engagement was the development of a set of staff competencies to support organisations to identify the training requirements of their staff.

11. Have reasonable adjustments been made to everyday services to improve access and support for people with autism?

Score: Red

Comments: The autism sub-group has led on a programme to raise awareness of autism which is leading organisations to improve their services through making reasonable adjustments. The sub-group have worked in partnership with City College Peterborough to develop an autism awareness raising course which has been made available to statutory and voluntary sector organisations to purchase from the college.

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12. Do you have a Transition process in place from Children's social services to Adult social services?

Answer: Yes

Comments. The council has a transitions policy and protocol. This is automatic for young people identified as being eligible for adult social care service. Parental consent for referral of young people's details to adult services is required for those under 18 years of age.

13. Does your planning consider the particular needs of older people with autism?

Score: Amber.

Comments. The commissioning strategy provides a structure to improve services for younger and older adults with autism. No particular emphasis has been made for older people with autism, for example autism awareness training is available to all health and social care provider regardless of their focus on younger or older adults.

Training

14. Have you got a multi-agency training plan?

Answer: No

15. Is autism awareness training being/been made available to all staff working in health and social care?

Score: Amber

Comments. The Autism Sub-Group have developed a competencies framework to support health and social care organisations to assess their staff knowledge and skills in supporting adults with autism, and in partnership with City College Peterborough (CCP) an autism awareness training module which is delivered in a classroom setting by tutors from the college and a self advocate. The training module is available to purchase to all health and social care organisations in the city. The autism strategy action plan identifies the autism awareness training being provided by health and social care organisations.

Peterborough City Council has developed an on-line training module which can be accessed by all staff within the council. This has been accessed by 37 staff members and completed by 28.

16. Is specific training being/been provided to staff that carry out statutory assessments on how to make adjustments in their approach and communication?

Score: Amber: ASC staff are able to access the CCP autism awareness course training free of charge.

17. Have Clinical Commissioning Groups(s) been involved in the development of workforce planning and are general practitioners and primary care practitioners engaged in the training agenda?

Answer: No.

Comment. The autism staff competencies framework and training module have been made available to the CCG and individual GP practices. Further engagement with CCG and GP practices will be co-ordinated through the lead GP for learning disability

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and mental health. Individual GP practices have benefitted from nurse and receptionist training to support delivery of the Learning Disability Directed Enhanced Service annual health check programme delivered by learning disability health staff within the council, which includes autism awareness.

18. Have local Criminal Justice service engaged in the training agenda?
Answer :Yes.
Comments: Cambridgeshire Police and Safer Peterborough Partnership are members of the LDPB Autism Sub-Group and supported development of the competencies framework.

Diagnosis led by local NHS Commissioner

19. Have you got an established local diagnosis pathway?
Rating: Green
Comments. A Peterborough based diagnosis service and pathway was commissioned in April 2013. The diagnosis service is an extension of an existing Cambridgeshire wide 'CLASS' service provided by Peterborough and Cambridgeshire NHS Foundation Trust (CPFT). The Cambridgeshire wide 'CLASS' service was previously available to residents of Peterborough. The diagnosis pathway was developed in partnership by Peterborough City Council, CPFT, CCG and autism sub-group.

20. If you have an established local diagnosis pathway, when was the pathway put in place?
Answer: April 2013

21. How long is the average wait for referral to diagnostic services?
Answer: Awaiting data.

22. How many people have completed the pathway in the last year?
Answer: Awaiting data.

23. Has the local Clinical Commissioning Group(s)/support services taken the lead in developing the pathway?
Answer. No.
Comments. The responsibility for learning disability health commissioning has been delegated to Peterborough City Council under the s.75 agreement, and as such the council led on the development of the diagnosis pathway. The diagnosis pathway was developed at a multi-disciplinary workshop which included representatives the CCG, provider foundation trust, learning disability health team, council Carers Lead and NAS representative. The pathway was reviewed by the LDPB Health Sub-Group which is chaired by lead GP for mental health and learning disability.

24. How would you describe the local diagnosis pathway, ie integrated with mainstream service with a specialist awareness of autism or a specialist autism specific service?
Answer: Specialist autism specific service.
Comment. The pathway has three elements, for those with co-morbidity of learning disability or mental health referral is into an integrated mainstream service. For those with autism/aspergers referral is to an autism specific diagnosis service.

25. In your local diagnosis pathway does a diagnosis of autism automatically trigger an offer of a Community Care Assessment?

Answer: Yes

26. What post-diagnosis support (in a wider personalisation perspective, not just assuming statutory services, is available to people diagnosed?

Comments: Peterborough City Council is commissioning a range of preventative and transitional support services for those people not eligible for community care services after an assessment.

Care and Support

27. Of those adults who were assessed as being eligible for adult care services and are in receipt of a personal budget, how many people have a diagnosis of Autism both with a co-occurring learning disability and without?

a) Number of adults assessed as being eligible for adult social care services and in receipt of a personal budget: 57
b) Number of those reported in 27a. who have a diagnosis of autism but not learning disability: 4
c) Number of those reported in 27a. who have both a diagnosis of Autism AND Learning Disability: 53

28. Do you have a single identifiable contact point where people with autism whether or not in receipt of statutory services can get information signposting autism friendly entry points for a wide range of local services?

Answer: No.

Comments. The council has launched an on-line community care directory which will be developed to provide range of information on autism friendly services.

29. Do you have a recognised pathway for people with autism but without a learning disability to assessment and other support?

Answer: Yes.

Comment. The council has as an established pathway for all adults to access a community care assessment.

30. Do you have a programme in place to ensure that all advocates working with people with autism have training in their specific requirements?

Answer: No. Red

Comment. Advocates have had the opportunity to access the City College Peterborough autism awareness training course. As part of the new contract this will be a requirement.

31. Do adults with autism who could not otherwise meaningfully participate in needs assessments, care and support planning, appeals, reviews, or safeguarding processes have access to an advocate?

Rating: Amber. Advocacy services are secured to meet this objective as required.

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32. Can people with autism access support if they are non fair Access Criteria eligible or not eligible or not eligible statutory services?

Answer. Yes.
Comments. Those people who are not assessed as being eligible for services will be offered a preventative or reablement service if this is deemed to be appropriate to support/maintain their independence without recourse to statutory services.

33. How would you access the level of information about local support in your area being accessible to people with autism?

Rating: Red
Comments. The council has launched an on-line community care directory which does/will include services for adults with autism.

34. Does your local housing strategy specifically identify autism?

Rating: Green.
Comments A learning disability and autism housing strategy was developed in 2013. This is an appendix to the main council housing strategy.

35. How have you promoted in your area the employment of people on the Autistic spectrum?

Rating: Amber. Comment. Employment opportunities for adults with autism are promoted through the councils in-house supported employment service. An initiative to raise awareness of the benefits of employing adults with autism with the local Chamber of Commerce in partnership with the local NAS will be taken forward during 2013/14. A representative from JCP sits on the Autism Sub-Group.

36. Do transition processes to adult services have an employment focus?

Answer: Yes. Rating – Amber
Comments: The councils' transitions strategy recognises the importance of employment as part of the transitions process.

Criminal Justice System (CJS)

37. Are the CJS engaging with you as a key partner in your planning for adults for adults with autism?

Rating: Amber Cambridgeshire police and the Safer Peterborough Partnership (SPP) are members of the autism sub-group and supported the development of the competencies framework. The police have presented to the sub-group on their approach to hate crime and the SPP have made available funding for the 'safe place' scheme which supports adults with autism in the community.

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APPENDIX B

2013 Autism Self Evaluation

2014/15 Improvement/Action Plan

Question	RAG Rating	Comments	Action	Owner	By When
Is Autism Included in the local JSNA?	Amber	Prevalence rates currently included.	To provide comprehensive data within refresh of JSNA.	RM	Next refresh of JSNA
Have you started to collect data on people with a diagnosis of autism?	Amber	Data collection protocol to be agreed with CCG.	To agree protocol with CCG to collect data from GP practices on outcomes of diagnosis – identify gaps in services and trends.	RM	On-going
What data collection sources do you use to inform commissioning strategy?	Amber	Available health and social care data sourced and utilised.	To utilise data from local NAS branch service users satisfaction survey and conference(s).	RM	31.03.2014
Have reasonable adjustments been made to everyday services to improve access and support for people with autism?	Red	Autism Sub-Group has led on autism awareness raising – CCP course.	Market CCP course to independent health sector organisations. Agree feedback from Serco on contract monitoring – EoE ADAS Contract.	RM RM	31.03.2014 31.03.2014
Is autism awareness training being/been made available to all staff working in health and social care?	Amber	Competencies framework/CCP course	Survey health and social organisations on provision of autism awareness training.	RM	31.06.2014

Is specific training being/been provided to all staff that carry out statutory assessments on how to make adjustments in their approach and communication	Amber	Access to CPP course.	Learning Disability and Autism team to undertake 4 day bespoke autism course run by an external provider early in 2014. Representatives from Community Team and Learning Disability Team to undertake CPP training course.	 RM	On-going 31.03.2014
Have CCG's been involved in the development of workforce planning and are general practitioners engaged in the training agenda?	No	CCP course, DES training	Raise importance of autism awareness training with GP's through Lead GP writing to practices. Offer CCP training as an option.	RM	31.03.2014
Do you have a single identifiable contact point where people with autism whether or not in receipt of statutory services can get information signposting autism-friendly entry points for a wide range of local services?	No	Developing on-line community care directory.	To ensure autism reflected in work streams in ASC Transformation programme.	RM	On-going
Do you have a programme in place to ensure	Red	Advocates have opportunity to access CCP	To include requirement within Advocacy	RM	On-going

that all advocates working with people with autism have training in their specific requirements?		course.	Service Specification for providers to evidence ASC training provided. (Re-commissioning of advocacy services)		
How would you assess the level of information about local support in your area being accessible to people with autism?	Red	PCC is developing an on-line care directory.	To ensure requirements of autism is included within the development of the on-line directory and ‘new front door’.	RM	On-going

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HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 10
16 JANUARY 2014		PUBLIC REPORT
Contact Officer(s):	Wendi Ogle-Welbourn Director for Communities	Tel. 01733 863749

EXECUTIVE GROUP TERMS OF REFERENCE

R E C O M M E N D A T I O N S	
FROM : Wendi Ogle-Welbourn Director of Communities	**Deadline date N/A**
The Board is asked to comment on and agree the Terms of reference for the recently formed executive group that will support the work of the Health and Wellbeing Board.	

1. ORIGIN OF REPORT

1.1 This report is submitted to the Health and Wellbeing Board following the agreement of the Board to the development of an executive group to support the work of the Health and Wellbeing Board.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to seek comments on the Draft Terms of Reference for the Health and Wellbeing Board Executive Group.

2.2 To agree the Draft Terms of Reference for the Health and Wellbeing Board Executive Group.

3. BACKGROUND AND SUMMARY

3.1 It was acknowledged by the Health and Wellbeing Board that to drive the delivery of activity required to address the priorities in the Health and Wellbeing Strategy the formation of an Executive group would be appropriate.

3.2 The Executive group has met twice and developed terms of reference attached at Appendix 1.

4. CONSULTATION

4.1 Members of the Health and Wellbeing Board were in support of the development of an Executive group.

5. ANTICIPATED OUTCOMES

5.1 The Executive group will ensure that the activities required to deliver the priorities in the Health and Wellbeing Strategy are driven and will inform the future development of the Strategy.

6. REASONS FOR RECOMMENDATIONS

6.1 The Health and Wellbeing Board need to be confident that the terms of reference of the Executive Group reflect the needs to support the work of the Health and Wellbeing Board. .

7. BACKGROUND DOCUMENTS

7.1 None

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Draft V1 5th January 2014
Peterborough Health and Wellbeing Board Executive and Delivery Groups Terms of Reference

1. Purpose

The Health and Wellbeing Executive supports the work of the Health and Wellbeing Board and informs the continued development of the Health and Wellbeing Strategy. It draws together the analysis of need, resources, strategic service development and commissioning priorities and outcomes; setting the framework for our joint working and commissioning arrangements. This work will be captured in a delivery action plan.

Health and Wellbeing delivery groups (HWBDG) undertake the detailed work that underpin the work of the Executive.

The work of the HWBB Executive and HWBDGs will be based on our desire to work together to ensure the sustainable delivery of:

- the right services
- to the right people
- by the right people
- in the right place
- at the right time
- for the right price.

Joint working and commissioning arrangements will be established where they can increase quality, effectiveness and efficiency, achieve better results and greater impact and improve citizen access and engagement.

2. Vision

Safeguard and promote the welfare of vulnerable people and narrow the gap between those people who achieve good health and social outcomes and those that don't.

3. High Level Objectives

- To meet people's needs at the earliest stage to prevent them from entrenching or escalating and requiring support from more specialist services.
- To build resilience, competence and confidence in people to enable them to live independently for as long as possible.
- To build resilience and confidence in people to give them the skills to make informed choices, reducing negative influences on their development and increasing their engagement in positive activities.
- To narrow the gap in health, wellbeing and social outcomes between the majority of people and those who are more vulnerable to poor outcomes.
- To develop a common understanding of prevention and early intervention across all services and establish this as a way of working for all agencies – whether they are commissioned or directly delivered.

- To commission and deliver effective, evidence based and timely services.
- To use valuable resources more effectively and efficiently.

4. Activities

The HWBB Executive will ensure:

- A shared vision
- Joint Strategic ownership of shared outcomes and agreement as to each organisations contribution to these
- Transparent resource envelope
- Joint performance framework
- Targeting and alignment of resources
- Commissioning and delivery of activity effective interventions
- Harnessing of the broader coalition required to tackle health inequalities
- Development of community capacity and cohesion to manage demand

5. Accountability and decision making

Accountability will be to the Health and Well Being Board with reports to the Health Scrutiny Committee and any other relevant bodies.

6. Membership and frequency of meetings

The HWBB Executive will comprise of:

- Local Authority Adult, Children and Community Services
- Cabinet Member for Health and Wellbeing
- Police
- Adult and Children Safeguarding Board
- Clinical Commissioning Group
- Schools
- Job Centre Plus
- Health Watch
- Voluntary Sector Representative
- Housing

The HWBBDG's will be focused delivery groups and membership will depend on the work that needs doing, these are some of the groups:

- Better Care Fund
- Joint Commissioning Forum and Better Care Fund
- JSNA
- Children and Families Joint Commissioning Board (this may develop into the people's early intervention and prevention group)

The HWBB Executive CFCB will meet a minimum of 6 weekly. There will also be the option to call additional meetings to address specific issues.

Two wider stakeholder events may be held during the year.

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Agendas and supporting documents will be issued at least one working week before the meetings. Minutes will be produced and circulated within ten working days of the meeting. Peterborough City Council as the responsible Local Authority will provide administrative support for the working of the Executive.

Wendi Ogle- Welbourn

Director for Communities

5th January 2014

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HEALTH AND WELLBEING BOARD		AGENDA ITEM No. 12
16 JANUARY 2014		PUBLIC REPORT
Contact Officer(s):	Wendi Ogle-Welbourn, Director for Communities	Tel. 01733 863749

HEALTH AND WELLBEING STRATEGY DELIVERY PLAN UPDATE

R E C O M M E N D A T I O N S	
FROM : Wendi Ogle-Welbourn Assistant Director Strategy, Commissioning & Prevention Children's Services	**Deadline date N/A**
The Board is asked to note the updated Health and Wellbeing Strategy Delivery Plan (Appendix 1).	

1. ORIGIN OF REPORT

1.1 This report is submitted to Board following an update to the Health and Wellbeing Strategy Delivery Plan.

2. PURPOSE AND REASON FOR REPORT

2.1 The purpose of this report is to present the updated Delivery Plan that supports the Health and Wellbeing Strategy and for the Board to note the updates and progress made on the performance measures.

3. BACKGROUND AND SUMMARY

3.1 Following the development of the Health and Wellbeing Strategy a delivery plan was developed that details work across adult, children and health services that will support delivery of the priorities in the Strategy.

4. CONSULTATION

4.1 A number of consultation events supported the development of the Health and Wellbeing Strategy.

5. ANTICIPATED OUTCOMES

5.1 That the Board notes the updated Health and Wellbeing Strategy Delivery Plan and continues to receive updates as appropriate.

6. REASONS FOR RECOMMENDATIONS

The guidance about health and wellbeing system improvement identifies the need for Health and Wellbeing Boards to focus on the wider determinants of health and not just the more obvious determinants and actions of agencies such as the Local Authority and Health.

7. BACKGROUND DOCUMENTS

7.1 Health and Wellbeing Delivery Plan.

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Health and Wellbeing Board
Strategic Delivery Plan 2013/14
January 2014

Priority One: Securing the foundations of good health
Accountable Lead: Janet Dullaghan
Aims: 1. Ensure that children and young people, including those with complex needs and disabilities have the best opportunities in life to enable them to become healthy adults and make the best of their life chances

Number	Action	Performance Measure	By whom	By when	Progress	RAG
1.1.1	Pregnant mothers who smoke are identified and supported to stop smoking.	• Reduced smoking rates in pregnancy from 17.7% to 16% by 2014 and to 14% by 2016 • Reduced numbers of children born with low birth rates.	Public Health lead Cheryl McQuire	Ongoing Quarterly Reporting against performance measures	The Live Healthy Smoke free service is on track to achieve this outcome and are currently exceeding the number of quitters required to meet the trajectory A specialist smoke free service for pregnant women who smoke is in place at the Healthy Living Centre. We are exploring how referrals to this service can be generated by the recently established electronic referral system in use in Peterborough Hospital. Such an approach would lead to more women who smoke being identified and referred to the service. . 'Low birth rate' is one of the Health Improvement indicators within the Public Health Outcomes Framework. Latest data for Peterborough (2011) is that of all live births at term with low birth weight was 2.83%, this is similar to the England average of 2.85%.	Amber

Number	Action	Performance Measure	By whom	By when	Progress	RAG
					However it is the second highest in the region, Luton stands alone at 5.30% while the lowest in the region is Norfolk 2.03%.	
1.1.2	Implement targeted activities to promote breastfeeding	• Increased rates of breastfeeding; The local target set by commissioners for breastfeeding initiation and prevalence of breastfeeding at 6-8 weeks is 48% initiation	NHS England Sharon Palmer CCG Commissioners	Ongoing Quarterly reporting on current data	Maternity Services are commissioned by the CCG whilst Health Visiting Services are commissioned by NHS England. Issues concerning support to new mothers to continue breastfeeding are being addressed through CPFT contract monitoring process; overall responsibility for improving breastfeeding performance lies with the local partnership. **Performance Update:** Breastfeeding initiation and prevalence in September in Peterborough was 36.6%. These are the most recent figures available; there are delays in obtaining figures that relate to Peterborough separately from Cambridgeshire, where breastfeeding rates are higher. Clearly this remains significantly below target, and while Health Services in Peterborough have achieved UNICEF accreditation which evidences that the service is giving a good quality of breastfeeding support, there is as yet a lack of evidence of impact. **Action**	Red

Number	Action	Performance Measure	By whom	By when	Progress	RAG
					The low rate of breastfeeding locally is now the subject of much closer monitoring in order to improve rates in this area and promote a healthy start to life. The Breast feeding strategy group has been reconvened with all partners and an action plan being developed through this group, lead by public health.	
1.1.3	Implement the Healthy Child Programme	Targets within healthy child programme • New birth visit within first 14 days 95% • Percentage of children seen for their 2 ½ year check 95% • Improving childhood immunisation rates; target for HPV 90% locally, 85% nationally • Reducing rates of obesity through the The National Childhood measurement programme(NCMP) targets for reception and	Sharon Palmer (NHS England HV's) Janet Dullaghan (school Nursing)	Ongoing targets reporting Quarterly	**Performance Update** The healthy child programme has been developed and is currently being implemented by Health Visitors and, school nurses with input from early years' settings. Performance data relates to the 3 month period to September 2013; this data is produced quarterly and so is the most recent available. New birth visits within 14 days are currently 94.3% - Slightly below target of 95%, but a significant increase on previous quarters' performance of 88%. 2½ checks are currently below target at 79.5%; however the trajectory is improving and is an improvement on performance for the previous year which was 75%. HPV immunisation rates are: • 88.5% 1st dose	Amber

Number	Action	Performance Measure	By whom	By when	Progress	RAG
		year 6 children are 90% of children weighed and measured			• 88.2% 2nd dose • 86.7% 3rd dose This performance is above the national target of 85% but slightly below the local target of 90%. This performance continues to be addressed through the contract monitoring; however the trajectory of uptake is predicting that the local target will be met. This performance represents a Significant improvement on 2012-13 performance when performance for the 3rd dose was only just above 50%. **National Childhood Measurement Programme (NCMP)** 95% of reception pupils and 100% of year 6 children have been weighed and measured. The number of children weighed and measured has continued to increase and local figures indicate that: • 10% of reception aged children being identified as overweight or obese • 21% of year six children identified as overweight or obese. The service therefore continues to be within target (11%) for reception aged children but over target (15%) for year six children. The NCMP data is about to be finalised and submitted so we will shortly have	

Number	Action	Performance Measure	By whom	By when	Progress	RAG
					year-end out turn performance data that is comparable with other areas. There is considerable activity in relation to supporting a reduction in the percentage of overweight and obese children, including: Morelife weight management programme – 12 week family based programme for overweight or obese children. There are 5 programmes a year. 2 currently running, 1 for age 4-10 and 1 age 11-17. Data on take up rates and impact available in March '14. 12 places on each course, and take up/retention is better With younger age group. From January will run 2 school based courses (working with those primary schools with higher levels of obese/overweight children) in addition to a further community based programme team is looking at ways of improving take up by teenagers. • Movers and Shakers – will start in Jan 14 – self referral as follow on from Morelife programme (to enable those who want to continue with physical activity to do so in a safe, supportive environment). 6 week physical activity programme Other main activity currently is local promotion and targeting of national campaigns – Change4Life (through	

Number	Action	Performance Measure	By whom	By when	Progress	RAG
					work with Children's Centres and schools). After Christmas will be new campaign – Foodsmart – to promote healthy eating through signing up for recipes and food vouchers.	
1.1.4	Implement effective programmes to reduce rates of teenage pregnancy	• Reduce rates of teenage conceptions • Reduce rates of teenage mothers	Public Health	Quarterly reporting on data	**Baseline Information** Local rates of under 18 conceptions in the quarter to June 2012 have risen sharply compared to those in March 2012 from 28 per 1,000 to 38 per 1,000 – this is considerably higher than in recent quarters and is the highest since September 2010. Tracking high rates of teenage conceptions is a major priority in Peterborough and all partners are now actively involved in developing an overarching pathway and action plan. The Vulnerable Young People's Strategic Partnership has been formed recently. Key partners from all agencies working with vulnerable young people are included within the partnership. Midwives working with young mums have begun to feed local performance date directly into the partnership, which will allow better analysis of changing trends and indications of local need than relying on national data, which is always very out of date. Other work that is taking place includes	Amber

Number	Action	Performance Measure	By whom	By when	Progress	RAG
					developing programmes which work with first time teenage mums to reduce a second unplanned pregnancy As a result of this work the percentage of second time teenage mums has reduced from 5% to 1% over the past year, which is an excellent outcome.	
1.1.5	Ensure delivery of the childcare sufficiency strategy and that provision is of a high quality.	• Number of available child care places • Number of children accessing child care settings • Percentage of child care settings assessed as good or outstanding by OFSTED.	Pam Setterfield	Ongoing	The Early Years Market Sufficiency Report published in March 2013 will be updated with a further needs analysis over the next few months. The 2013 document identified a need for 380 new places for 0-4 year olds across the City by September 2014, with a proportion of those places being available by September 2013. Areas of the City where there were particular shortages have been targeted for the development of provision. For example, in Orton with Hampton ward, and extra 100 places were projected as being required by September 2013. Overall provision has increased by 396 since March 2013 – ahead of the target to be achieved by 2014. However, developing provision in the targeted areas has been challenging and so, for example, only 20 new places have been provided. This shortfall has been partly offset by over provision in neighbouring Orton Longeuville –	Amber

Number	Action	Performance Measure	By whom	By when	Progress	RAG
					based on the knowledge that many parents in Hampton already access provision in the neighbouring ward. The challenge in Orton with Hampton has been a lack of physical space for development, however plans are being discussed for a pre-school to be developed on the Hampton Vale Primary School. There are currently 5,463 places for children aged 0-4 in the City – 4575 at PVI sector pre-schools, 234 in maintained nursery and similar settings and approximately 654 with child-minders. Work to address on-going shortfalls in particular areas of the City is continuing. The updated needs assessment to be available by the end of the financial year will also include further information on demand for placements, taking into account increased government funding for this type of provision. Support for settings, particularly child minders, continues to focus on improving the quality of provision and to meet the expectations of OFSTED's criteria for Good and Above Current rating as of July 2013 for good and above is 74% - an increase from 69% in the same period last year. Nationally, 77% of settings are rated as	

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Number	Action	Performance Measure	By whom	By when	Progress	RAG
					good or outstanding. Provision in Peterborough is closing the gap with national averages. Further comparative data will be available in December 2013. As of 1st November 2013 based on published inspection reports; Of the 106 registered childcare providers; 6 (6% of the total) are awaiting a first inspection. Of those inspected • 18 (*18% of those inspected*) are graded outstanding • 65 (*65% of those inspected*) are graded good • 17 (*17% of those inspected*) are graded satisfactory • 49 (*27% of those inspected*) are graded satisfactory	
1.1.6	Continued effective implementation of the Family Nurse Partnership.	**Baseline information**: Target for Gestational Goal: 60% of clients enrolled by 16th week; Dosage Goal: each client to received 80% of	Kirsty Lynn	Quarterly reporting from FNP Board	**Performance Update**: The referral process to the FNP is now well embedded into most services. The FNP has received referrals from a range of agencies including Children's Social Care and Primary Care Health Visitors and Midwives. Data below is for the quarter to September 2013, which is the most recent available:	

Number	Action	Performance Measure	By whom	By when	Progress	RAG
		expected visits during pregnancy; Attrition Goal: dropout rate of no more that 40% (10% in pregnancy, 20% during infancy, 10% during infanthood.			• Gestational goal Achieved 70.6 % well above target of 60% • Dosage Goal: at 69.2% this is expected to build as project is in first year of operation • Eligible clients enrolled - 73.9% (fidelity goal 75%) Attrition Goal, Data not available until end of the first cohort July2014.	
1.1.7	To develop and deliver the Connecting Mums (peri-natal) project, in conjunction with the roll out of the Solihull parenting programme.	• Number of mothers engaged in the programmes; • Percentage of those engaging with the programmes who report an improved quality of relationship with their child.	Fiona Bauke	March 2014	Barnardos have been working with the Midwifery service to develop the Solihull Programme as a pilot, which commenced in September. If successful, it is intended to roll it out across the City. The programme emphasises the importance of attachment, focusing on pre-birth to 2 year olds. Alongside this Fenland Mind have secured funding for a project to work peri-natally with parents around improving maternal mental health. This work is now part of the conception to 5 pathway work with partners. 15 volunteers have been recruited and trained for the Connecting Mums programme as of October 2013.	Amber

Number	Action	Performance Measure	By whom	By when	Progress	RAG
1.1.8	Ensure two-year funding programme targets those most in need	• Numbers of children accessing two-year funding; • As from Sept 2013 there have been 570 two year olds accessing a two year old place • Percentage of those identified as being eligible for a place who take up the offer; • This data will be updated after head count day in October – which will provide data on those who have had confirmed funding against those who took up the funding. • Narrowing the achievement gap between the most vulnerable children and all children at foundation stage	Pam Setterfield / Karen Hingston	Sept 2013	Considerable work has been undertaken to identify and encourage the most vulnerable families to access the new 2 year funding that came on stream from September 2013. This has included the use of text messages to confirm eligibility for places. Quality of provision: To help narrow the gap between the most vulnerable children and all children at foundation stage, the following support has been provided to early settings: • Birth – 3 early childhood specialist to work within settings. • Childhood specialist for inclusion to support settings for children with additional needs. • Special Educational Needs Coordinator to work within settings to help identify and support vulnerable children.	
1.1.9	Ensure Children's Centres successfully target the most vulnerable children in our community and	• Number of children under 5 years registered with the children's centre (target of 75% of	Pam Setterfield	Monitoring ongoing	Currently a re-visioning of the role and function of the Children's Centres is in operation. The work of the Children's Centres and the monitoring of the outcomes delivered will be in response to:	

Number	Action	Performance Measure	By whom	By when	Progress	RAG
	secure improved outcomes for them	reach community) • Number of children under 5 years accessing the children's centre in each quarter (target of 30% f reach community) • Number of targeted children and families accessing the children's centre on a quarterly basis (targets between 30% and 15%) Targeted families inc: Teenage parents Lone parents Fathers Black and Ethnic minorities Gypsy and traveller families Children and parents with a disability Children with a CP/CIN plan Children living in workless households			• To 0 -5 strategy developed by the Early Years working groups; • The implementation of the new Ofsted Framework for the inspection of Children's Centres; • Current re-visioning work; The changing needs of Peterborough in respect of the arrival of new communities. Consultation on future of children centres commenced December will close on 8th January 2014	
1.1.10	Ensure that families routinely provide feedback on the effectiveness of services within an	• Implementation of the Outcomes Star across all service delivery; • Data captured	Karen Hingston	March 2014	A programme of training for practitioners working with children and their families in use of the Outcomes Star has now commenced [as of November 2013] and performance	Amber

Number	Action	Performance Measure	By whom	By when	Progress	RAG
	evidence based framework and that this data is used to inform service delivery	demonstrates improving effectiveness of services and is used in commissioning process.			monitoring of children's centres will include information from the use of the stars alongside more traditional measures such as OFSTED performance assessment	
1.1.11	Deliver the Connecting Families Programme	• 350 families 'turned around' in the three years of the programme.	Wendi Ogle-Welbourn	Quarterly reporting	Programme on track.	Green

What difference has this made

1. Healthy child programme delivering on new Birth visits and HPV vaccinations.
2. 0-2 pathway developed all children now referred to HV at 22weeks.
3. Solihull pilot started.
4. NCMP working within set targets 11%

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Priority Two: Preventing and treating avoidable illness
Accountable Lead: Adrian Chapman/ Cathy Mitchell
Aims: 1. Narrow the gap between those neighbourhoods and communities with the best and the worst health outcomes, whilst improving the health of all.

Number	Action	Performance Measure	By whom	By when	Progress	RAG
2.1.1	Develop and implement a Smokefree Plan comprehensive tobacco control	• Smoking during pregnancy • Smoking among young people • Smoking among adults • Reduction in exposure to secondhand smoke • Effective communication of the harm caused by tobacco use • Effective local enforcement of tobacco legislation	Julian Base	Dec 2013	Smokefree Plan prepared, Smokefree Alliance established, implementation underway. Highest number of smoking quitters recorded since 2000 achieved during 2012/2013. 'Stoptober' campaign successfully delivered during October at various locations generating over 300 referrals to the service. Plans in place to deliver high profile "health harms" campaign in January 2014. The National Centre for Smoking Cessation and Training (NCSCT) referral system continues to be embedded within the hospital and since July 2013 169 referrals have been received. As a result of the smokefree	

Number	Action	Performance Measure	By whom	By when	Progress	RAG
					services continued improvements and performance it has been ranked among the best 15 smoking cessation services in the country following a review by the NCSCT, commissioned by Public Health England.	
2.1.2	Develop and implement a Change 4 Life Plan targeted physical activity and weight management interventions for children and adults	• Number of referred adults accessing and completing physical activity programmes • Number of referred children and families accessing and completing weight management programmes • National Child Measurement Programme data	Julian Base	Dec 2013	Change 4 Life prepared, Change 4 Life Alliance established, implementation underway. Physical activity pathways for adult "Let's Get Moving" programme implemented, with a significant increase in quality of referrals from health professionals specifically through the Health Checks programme. Attendance at the follow on programme "Let's Keep Moving" is very good and consistent. All programmes operating at full capacity. Eight more due to commence in January with confirmed attendance from 92 clients Child Weight Management programme (Morelife) continues to be delivered with an audit of the two most recent programmes (Nov 2013) demonstrating excellent	

Number	Action	Performance Measure	By whom	By when	Progress	RAG
					standards of delivery and a reduction in BMI's for both children and their parents- 29 families attended. Next three programmes commencing in January 2014 including a pilot in a local primary school following a review of NCMP programme data that demonstrated a high prevalence of overweight and obese children- 45 families confirmed to attend the 10 week programme. As part of National Obesity week (Jan 2014), Live Healthy practitioners will be delivering healthy eating sessions in 12 primary schools supported by volunteer health champions. This will coincide with the high profile Change4Life "foodsmart" campaign. Plans are in place to deliver events across a range of settings. Peterborough short-listed for the National Sustainable Food City Initiative.	
2.1.3	Develop health champion programme within schools, workplaces and neighbourhoods and	• Number of people accessing and completing RSPH programmes	Julian Base	Dec 2013	RSPH accreditation established. To date 300 individuals have successfully completed the Level 1 award in Health Awareness and	

Number	Action	Performance Measure	By whom	By when	Progress	RAG
	communities supported by RSPH health awareness programmes	• Number of people registered as health champions • Number of workplaces signing Responsibility Deal			level 2 award in Understanding Health Improvement. New RSPH accredited training courses will be offered through the centre including levels 1 and 2 in Healthy Eating and Special Diets, level 2 in Understanding Behaviour Change, Level 2 in Smoking Cessation and Level 2 in Mental Health & Wellbeing. Health champion programme implemented. The youth health champion programme continues to gain excellent engagement with 22 active champions and a further 70 YP registered to become champions. In addition 15 volunteers signed up as community health champions and 33 workplace health champions have been recruited and trained. In addition to the core commitments outlined with the Department of Health's Responsibility Deal a total of 9 collective pledges have been identified that will demonstrate the City Council's commitment and act as an example of good practice to other local employers.	

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Number	Action	Performance Measure	By whom	By when	Progress	RAG
2.1.4	Reduce level of non-communicable disease through NHS Health Check programme	• Delivering 6059 Health Checks by GP Practices during 2013/14 to identify patients at higher risk of cardiovascular disease and diabetes, and offer lifestyle modification interventions and treatment to reduce risk • Evaluation of programme to include Number patients with existing disease/at high risk identified; number of onward referrals to treatment/ preventative services • The programme prioritises GP practices with higher levels of deprivation and burden of	Chas Ryan	April 2014	Programme established in local GP Practices, additional targeted development to further reduce health inequalities required. To date a total of 4,192 patients have been assessed with 517 patients receiving information to raise their awareness of Dementia. 231 patients have been identified as having a risk of developing cardiovascular disease while 241 assessed patients have been prescribed statins to lower cholesterol. In addition 72 patients have been identified as being hypertensive and 20 assessed patients as diabetics. This programme is very closely aligned to the CCG priority of reducing the burden of coronary heart disease and stroke in the city. Referrals to associated service programmes have been embedded across all GP practices delivering health checks with 111 patients referred to physical activity programmes and 125 referred to weight management programmes.	

Number	Action	Performance Measure	By whom	By when	Progress	RAG
		cardiovascular disease				
2.1.5	Develop Peterborough as a Sustainable City including the development of a Food for Life programme to support schools and communities to improve diet and nutrition.	• Increased understanding and awareness of healthy and seasonal foods • Number of schools engaged to improve food and food culture	Julian Base / PECT	Review Apr 2014	Programme established in targeted schools and communities, Sustainable Cities bid for Soil Association funding submitted by PECT was unsuccessful, however as a founding partner in the programme local activity will be developed through the Food for Life programme scheduled to commence in 2014/2015.	

What difference has this made

- **Increase in quality of referrals to the LGM programme received from health professionals for patients with a medical or long term condition through the health checks programme and completion of the General Practitioners Physical Activity Questionnaire (GPAAQ) as a screening and brief intervention tool.**
- **Through promotional activity and by establishing clear referral pathways there has been an increase in referrals from the Hospitals Paediatrician's department for clinically obese children to the Morelife programme. Better uptake of programmes at community based locations. NCMP data provided by the PH intelligence team has enabled the service to target interventions in areas with high prevalence of overweight and obese children.**
- **Volunteer Health Champions provide a valuable service and contribute to reducing health inequalities by reaching out to and delivering healthy lifestyle messages to those individuals/communities not accessing mainstream health services.**

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Priority Three: Healthier older people who maintain their independence for longer

Accountable Lead: Nick Blake/ Ewan Kelsall

Aims:

1. Enable older people to stay independent and safe and enjoying the best possible quality of life

Number	Action	Performance Measure	By whom	By when	Progress	RAG
3.1.1	Ensure the transformation of Adult Social Care leads to better outcomes for customers	• New front door established • Better access to information and advice • Better preventative offer in place • Greater access to reablement and transition services • Refocused personalisation offer for people who need longer term support	Tina Hornsby, Debbie McQuade,	March 2013	Transformation in progress.	
3.1.2	Deliver a dementia resource centre for The City	• Improved outcomes for people with dementia and their carers • Higher carer satisfaction	Nick Blake	01.03.13	DRC procurement completed, and new services being implemented. Building refurbishment to begin in Q4 13/14 with likely completion by July 2014	

Number	Action	Performance Measure	By whom	By when	Progress	RAG
3.1.3	Agree and implement the joint health and social care carers strategy	• Better outcomes for carers • % increased of carers recognised and supported • % increase in carer satisfaction in annual national survey	Nick Blake	31. 03.13	Strategy completed and published (November 2013), implementation ongoing through Strategy Working Group. Carers Prescription Service has gone Live Jan 14 across both LCG;s	
3.1.4	New transport options delivered for ASC customers	• More personalised transport options in place • Better use of community options • Better use of contracted services (less down time for vehicles) • Better co-ordination across all transport commissioned by PCC	Nick Blake	31.03.13	New relationship begun with Enterprise as transport partner. Exploring more fully integrated commissioning options with PCC transport team.	
3.1.5	To re-commission home care services	• New home care services in place	Nick Blake, Terry Prior, Mubarak Darbar, Serco		Procurement process completed – new framework start date of 20 January 2014.	

Number	Action	Performance Measure	By whom	By when	Progress	RAG
			contracts and procurement team			
3.1.6	To develop a Market Position statement for ASC commissioning	• Statement written and published • Providers understand the commission intentions for ASC in Peterborough		31.12.13	MPS version three – final comments from the Institute for Public Care to be incorporated prior to final draft being presented for approval by 31 Jan 2014.	

What difference has this made
DRC – increased investment in dementia services, agreed co-location of health, ASC and VCS services leading to a more integrated system of support, providing focal point for the implementation of the Dementia Strategy
Carers Strategy – provided an opportunity for joint strategy and more integrated working between ASC and health as evidenced by recent work to develop GP Carers Prescriptions and coordinate with ASC carer support
Home care service re-tender – more outcome focussed homecare support, more personalised support that is aligned with the ASC transformation agenda, better value homecare services

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Priority Four: Supporting good mental health

Accountable Lead: Terry Prior/ John Ellis/Cathy Mitchell/Janet Dullaghan

Aims:

1. Enable good child and adult mental health through effective, accessible mental health promotion and early intervention and rapid response services to impact upon early signs of mental ill health or deterioration

Number	Action	Performance Measure	By whom	By when	Progress	RAG
4.1.1	Review of operation of ARC single point-of-access	• CQUIN milestones	John Ellis	April 2014	Review Group meets monthly – current work includes:- - Revised referral guidelines for GPs to ensure appropriate referrals and effective use of the ARC; - Formalise the process for referrals from 111 line and other agencies - Local GP mh lead Dr Panday to visit ARC weekly to support triage process and identify further referral support and advice needed by local GPs Further workshops planned locally early 2014 on management of mental health problems and referral process Good progress being made with key milestones and actions.	A
4.1.2	Re-establish local suicide prevention group	• Suicide prevention Group reconvened September 2013	Dr Panday	April 2014	Links to Local Mental Health Stakeholder Group and County Wide Group East of England bid submitted for resources to support implementation	Green

Number	Action	Performance Measure	By whom	By when	Progress	RAG
		• Bi monthly meetings • High Risk Groups identified • Training Programme identified • Police implemented Training Programme this will be extended to Court Staff • Local protocol for dealing with suicide presentation being developed • Wider Wellbeing agenda to be developed			plan Detailed Implementation Plan to be agreed. Good progress being made but may require further capacity and resource.	
4.1.3	Universal settings support children and young people effectively and promote their	Information from the SHU survey of Peterborough pupils and other surveys	Janet Dullaghan		Training for staff within universal services a priority identified in the emotional health and wellbeing needs assessment and will be a commissioning priority from April 2014.	

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Number	Action	Performance Measure	By whom	By when	Progress	RAG
	resilience	of young people undertaken in the city and inform needs assessment and delivery of services			The new specification for school nurses now highlights the role of the school nurse in supporting emotional health and wellbeing. Pathway being developed to support children in schools and appropriate referral to 3T's when need identified.	
4.1.4	Services are commissioned to support children and young people with developing additional mental or emotional health needs at tier 2, preventing need for accessing services at Tier 3	• Number of children and young people accessing Tier 2 services within the city • Waiting times between point of referral and child first being seen within tier 2 services; • Waiting time from assessment appointment to treatment; • Clinical outcomes measures show improvements	Janet Dullaghan Rachel Gomm CPFT. CCG commissioner		There is a gap in adequate services for tier 2. Cambridge and Peterborough Foundation Trust (CPFT) the provider of child and adolescent mental health services (CAMH) currently do not support tier 1 or tier 2 services. A CAMH strategy is currently being developed with all partners to identify priorities in this area and a commissioning plan as part of this work. Tier 2 3 T's service. (short term counselling) The pathway for referral to 3T's is now much clearer and work is going on with the school nursing service to be part of this pathway. Professions can now refer directly into 3T's services and schools continue to be the main single source of referrals. Referrals from CAMHS continue to increase and the interface between CAMHS and 3Ts is also clearer. The service is small with a current	A

Number	Action	Performance Measure	By whom	By when	Progress	RAG
		in the emotional and mental health and well being of children and young people accessing tier 2 services; • Referrals to tier 3 and 4 services is reduced. • Use of the Child and Young Person Outcomes Star as these become available to measure effectiveness of services in building resilience; Feedback from schools			caseload of 50 young people who have 6-8 counselling sessions there is currently a waiting list of 40 children, however the service has been successful in bidding for money to have an additional member of staff to increase the service CPFT Action: Tier 2 does not prevent a need for accessing Tier 3 (it may actually increase referrals) thus the Performance Measure needs amending, also the increase in acuity is a national issue. Progress: plan to introduce Tier 2 (minimal service) /CAPA/CYP IAPT and Single Point of Access (ARC) agreed by commissioners; CAMH work with health colleagues/universal services/schools with Tier 1 & 2 advice. SOP, Standard Operating Procedure being developed for school nurses for Self Harm and Emotional Difficulties. Tier 2 service important for commissioned multi agency offer to be clear. Progress is being made but it would appear further capacity and clarity is required regarding care pathways.	
4.1.5	Tier 3 CAMH services are commissioned such that	• Number of children and young people referred to the	Rachel Gomm CPFT		CPFT Progress: commissioners agreed to CAPA/CYP IAPT; Transitions CQUIN info & CAMHS met CQUIN waiting list target by	A

Number	Action	Performance Measure	By whom	By when	Progress	RAG
	children and young people with more complex needs are able to access tier 3 services in a timely way with resultant improvements in their mental health and emotional wellbeing	tier 3 service; • Percentage of referrals to tier 3 service resulting in appointments being offered and kept; • Waiting time between referral and first appointment • Waiting time between assessment appointment and treatment; • Clinical outcomes measures show demonstrable impact of intervention; • Reduced numbers of children and young people admitted to hospital			31/10/13 CAMHS interface with CIC team and YOS HV's assessing & supporting mother's with PND; TM's from universal services attend MASG fortnightly representing CPFT. Collaborative working with PCH when young people attend or are admitted with emotional health & wellbeing issues. Progress being made but we appear to lack hard data.	

Number	Action	Performance Measure	By whom	By when	Progress	RAG
		because of mental health issues.				
4.1.6	Development of PCC/LCG MH Commissioning Strategy. This will include making links with: Suicide Strategy Development Public Health MH Strategy Police MH Strategy MH Employment Strategy Accommodation Strategy Joint CCG MH Strategy	• Strategy includes Objectives and Desired Outcomes • Strategy includes a range of change initiatives. The resource for these change initiatives has been identified and impact for stakeholders stated.	T. Prior / Dr. S Panday	March 2014	Finalising of Objectives and Outcomes delayed Progress is reported to Stakeholder Group bi – monthly. Good progress being made now need to finalise with stakeholder's key priorities, objectives and outcomes. These to be reflected in a number of change initiatives.	A
4.1.7	Revising policy on parents and carers with mental health problems	• Identification of number of parents and carers • Identification of numbers of children	CCG	Monthly reporting to CPFT/CCG performance monitoring meeting	Jon Chapman PSCB and Carol Davis CPFT taking this forward. CCG to agreed with CPFT performance measures. Table 1 Data from Audit Name of | Number Families | Is there a connection | People from audit that need	

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<table>
<tr><th>Number</th><th>Action</th><th>Performance Measure</th><th>By whom</th><th>By when</th><th>Progress</th><th>RAG</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td><table>
<tr><td>Social Worker</td><td>involved</td><td>with Children and Families (statutory) or CAF(non statutory)</td><td>discussion in terms of CAF

(Other people have no concerns in terms of risk or need to complete CAF))</td></tr>
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<tr><td>SW 2</td><td>3</td><td></td><td>1</td></tr>
<tr><td>SW 3</td><td>9</td><td>2 – CAF
7- Statutory</td><td></td></tr>
<tr><td>SW 4</td><td>4</td><td>2-statutory</td><td>2</td></tr>
<tr><td>SW 5</td><td>2</td><td>1 Young Carers
2 Statutory</td><td></td></tr>
<tr><td>SW 6</td><td>2</td><td>2-Statutory</td><td></td></tr>
<tr><td>SW 7</td><td>2</td><td></td><td>1</td></tr>
</table>
Policy agreed but we lack regular data and follow up Need to establish an implementation plan for the revised policy.</td><td></td></tr>
<tr><td>4.1.8</td><td>Developing a specific and holistic re-ablement response within mental health services that incorporates</td><td>• No of people accessing the service
• No of referrals by political ward</td><td>CPFT</td><td>Monthly performance management</td><td>Re-ablement is a key development area under discussion between ASC and CPFT.

No data available

This aspect is currently subject to</td><td>R</td></tr>
</table>

Number	Action	Performance Measure	By whom	By when	Progress	RAG
	BME and hard to reach communities Services targets most deprived political wards				discussion and development.	

What difference has this made

ARC Review: The ARC has been well – received but all involved recognise the need after one year of operation to review how it operates, how GPs, carers, local agencies and patients might more easily access help when required urgently.

Suicide Prevention: The group is developing its priorities but these will include guidance where to signpost people in need oh help and improved risk assessment for GPs.

Priority Five: better health and wellbeing outcomes for people with life-long disability and complex needs
Accountable Lead: Tim Bishop/ Wendi Ogle – Welbourn / Jon Ellis/Sue Jestice

PETERBOROUGH CITY COUNCIL

Aims:

1. Maximise the health and wellbeing and opportunities for independent living for people with life-long disabilities and complex needs. This is through robust, integrated care pathways, care planning and commissioning arrangements from early years into adulthood and old age

Number	Action	Performance Measure	By whom	By when	Progress	RAG
5.1.1	Provide training to health and social care staff on NHS continuing Healthcare and use of the Joint Funding Tool	• Improved working between Local Authority and Health	Sue Jestice	Dec 2013	150 people trained in the use of the JFT and CHC process. (2014) 200 People trained with 50 further in Joint funding tool. Increase 15% of patients with MH and LDP receiving joint funding.2014 20% patients receiving JF. Improved knowledge of CHC process and increase in numbers being found eligible to receive CHC 100% health funding.	Green
5.1.2	Quarterly Transition Meetings between LA and health	• Children with complex health needs are identified at 16 and CHC assessed or reviewed prior to 18th birthday and transfer to adult services	Sue Jestice	On going	Assessment being completed within agreed time period. Smoother transition to adult services. 2014. Regular Meetings held monthly to identify and promote an earlier transition.	
5.1.3	Ensure the delivery of a range of short break	• Number of children and	Janet Dullaghan/Carrie	March 2013	Baseline and Performance information:	Green

Number	Action	Performance Measure	By whom	By when	Progress	RAG
	services that reduce or delay the need for more specialist services; needs	young people accessing Short breaks: • Number of Short Break sessions delivered across the city	Gamble		Over the last year there were over 300 registrations for commissioned services/activities in addition there are: • 32 receiving direct payments • 6 receiving link care • 26 receiving short breaks at Cherry Lodge **Performance Update:** Work is underway to develop an information system to develop a method or recording all registrations and attendance in order to look at equity of offer, and packages of support. In addition a flexible range of short breaks with local providers is secured . '0-19 activities', '8-19 activities, 'Disability Sports', Siblings (emotional health and well being)' and 'Information, Advice and Guidance'. The plans for the procurement of domiciliary care, one to one support and contracted brokerage support for families who access their support package via Direct Payments are moving to align with Adults Services.	

Number	Action	Performance Measure	By whom	By when	Progress	RAG
					Tickets and passes for entry to local community based activities were distributed through local parent/carer forums. This has maximised the Short Breaks financial allocation. The Short Breaks 'capital' allocation has been utilised. Direct payments actively encouraged at CWD. Consultation with parent/carer forums, linked to "Healthwatch". Parent Participation work is ongoing, moving towards co-production for elements of the SEND reforms including the Single (EHC) Plan and the Local Offer. Joint attendance at regional meetings will strengthen these links in addition to attending joint training. Feedback about the effectiveness of services; contract monitoring includes children, young people and families reporting positive experiences from their own understanding.	
5.1.5	Improve transitional arrangements for young people with disabilities and continuing care	• Children with complex health needs are identified	ASC/CSC	March 2014	Following an agreement to develop a 14-25 transitions team with children's and adult social care. The working party has met	Amber

Number	Action	Performance Measure	By whom	By when	Progress	RAG
	needs;	at 16 and CHC assessed or reviewed prior to 18th birthday and transfer to adult services • Smooth transition between 14 to 25			and are working through the issues. First recruitment to the managers post has been unsuccessful and another underway. A temporary has been appointed and will commence post in mid Jan 2014. Ongoing issues with transition identified. 1, ASC cannot take children for transitions until 17 however the CHC and CSC/ASC working group making good progress. 2. ASC threshold changed to substantial and critical. Children services working to different thresholds.	
5.1.6	Improve joint commissioning and joint working arrangements between health and the local authority for children with continuing care		Janet Dullaghan/CCG	Nov 2013	Currently exploring opportunities with health around aligning budgets under a Sec 75 agreement	
5.1.7	Eligible adults with a learning disability to receive an annual health check through the NHS funded Directed Enhanced Service	• 95% completion	DG	31 March 2014	Q13 data identifies 93 health checks out of 343 completed. Q4 is when the greatest number of health checks are done.	
5.1.8	Commission a learning disability	• Accommodation strategy	Mubarak Darbar	30 September	Meeting local and partner Registered Social Landlords's	

Number	Action	Performance Measure	By whom	By when	Progress	RAG
	accommodation strategy to establish robust pathways into independent accommodation.	approved by various boards and pipeline re housing needs to the procurement phase		2013	working in partnership to find housing solutions.	
5.1.9	Undertake of visioning exercise around learning disability day opportunities to ensure services are person centred and provide community based opportunities and access to employment.	• New model approved by various boards and the implementation phase underway.	Mubarak Darbar	31st March 2014	Cabinet approved on the 16th December 2013 to go to consultation on the recommendations to remodel outdated and traditional day services and bring in line with the transformation and personalisation agenda.	
5.1.10	Implement the SEN and Inclusion Strategy including requirements for all children to have a single plan where appropriate and development of the local offer.	• Development of Single Plan and Local Offer **Baseline Data:** July '12: • 23.9% of children identified as having SEN in Peterborough; national average was 19%; stat neighbour average was 19.2%. • 4% of children	Jonathan Lewis	September 2015	**Performance Update:** July 13: • 22.6% of children identified has having SEN in Peterborough; national average is 18.6% • 3.8% of children and young people have a statement of SEN in Peterborough; national average is 2.8%. Inclusion strategy and action plan approved by DMT in August 13. This includes a baseline of 5.6% in July '12 of children and young people who are placed in out of city provision (below national	

Number	Action	Performance Measure	By whom	By when	Progress	RAG
		and young people had a statement of SEN in Peterborough; national average was 2.8%; stat neighbour average was 2.9%.			average of 5.8% but above stat neighbour average of 4.2%). Work streams to prepare for the implementation of SEND reforms in the Children and Families work are being established, with the CWD Strategy Group overseeing progress. Workshops for parents and professionals to be held in November 13 to shape the local offer for children and young people with SEND.	

What difference has this made

- CWD strategy and eligibility criteria now completed
- Multiagency strategy group now has representation from all partners and has agreed work streams to deliver the priorities in the strategy
- More flexible short break offer available for CWD which included a wide range of clubs and activities
- Increase of 10% in direct payments
- CWD panel now reviews and agrees medical support to schools, medical and school representation on the panel

PETERBOROUGH HEALTH AND WELLBEING BOARD

MONTHLY NEWSLETTER

ISSUE: NOVEMBER 2013

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4. End of Life Care	5-6
5. Introduction letters from the commissioners and the service providers of the new Peterborough Minor Illness and Injury Unit.	7
6. Next meeting: Thursday 16 January, 1pm	-

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Wendi Ogle-Welbourn, 01733 863749, wendi.ogle-welbourn@peterborough.gov.uk

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NHS Sustainability Day 2014

Following the phenomenal success of NHS Sustainability Day 2013 Barts Health are proud to be partnering with social enterprise company, 4 All of us, to deliver the 2014 campaign.

NHS Sustainability day 2013 reached out to the NHS and engaged Trusts and healthcare organisations across the world to take action on climate change. The day aims to make links and break down barriers across professions, organisations and countries in order to support active change to happen across the whole healthcare landscape. Supported by the Prime Minister and a number of leading experts in the field of health and environment, over 100 NHS trusts participated in the day in 2013, sharing knowledge and inspiring others with their actions through the online portal.

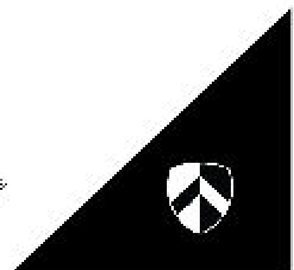
Sustainability within the NHS is an area which has become an increasing focus over the past 5 years with establishment of the NHS Sustainable Development Unit (www.sdu.nhs.uk) and the publication of its carbon reduction strategy in 2009 'Saving Carbon, Improving Health'. The strategy demonstrates that need for reductions in carbon across a range of healthcare services, with the latest consultation strategy (due 2014) focused towards adaptation and changing models of care. The stern review and marmot reviews both demonstrated the close correlation between health and sustainability and inequalities in health driven from unsustainable lifestyles.

For this years campaign we aim to reach out to over 300 Healthcare organisations through a series of workshops, sponsors, events and awards. We hope that NHS Sustainability Day will make lasting changes in our communities, reducing emissions and improving health outcomes.

Barts Heath are delighted to be partnering with 4 all of us to deliver NHS Sustainability 2014 and we would welcome your support in making it a great success.

Trevor Payne	Fiona Daly
Director of Estates and Facilities	**Environmental Manager**
Barts Health NHS Trust	**Barts Health NHS Trust**

Barts Health NHS Trust: Newham University Hospital, The London Chest Hospital,
The Royal London Hospital, St Bartholomew's Hospital and Whipps Cross University Hospital



Cambridgeshire and Peterborough CCG 111 service: Important information

We enter a phased launch of the 111 service in Cambridgeshire and Peterborough on 12 November 2013 from mid-morning.

We received final approval this week to launch the service following strict quality assurance testing and approval from the Area Team and NHS England Central Team.

From **12 November 2013** the 111 service has been established to take calls from NHS Direct GP practices who currently use UCC as their out of hours provider and anyone dialling 111 from a landline or a mobile.

On **28 November**, subject to satisfactory performance, 111 will take calls from GP practices who currently use CCS as their out of hours provider.

It is likely that the 0845 46 47 NHS Direct number will be closed down in the near future subject to approval from NHS England. Further communication will follow on this.

Further Information

Cambridgeshire and Peterborough CCG 111 service:

Important information

We are gradually launching a 111 service in Cambridgeshire and Peterborough from this week. The service will be launched in Cambridgeshire, not including Peterborough, tomorrow (12 November 2013) from mid-morning. The service will then be launched in the Peterborough area on 28 November

111 will get you through to a team of fully trained call advisers, who are supported by experienced nurses and paramedics. They will ask you questions to assess your symptoms, and give you the healthcare advice you need or direct you to the right local service.

The NHS 111 team will, where possible, book you an appointment or transfer you directly to the people you need to speak to. If they think you need an ambulance, they will send one immediately – just as if you had originally dialled 999.

You should use the NHS 111 service if you need medical help or advice urgently but it's not a life-threatening situation.
You should call 111 if:

- It's not a 999 emergency
- you think you need to go to A&E or another NHS urgent care service;
- you don't think it can wait for an appointment with your GP; or
- you don't know who to call for medical help.

For less urgent health needs, you should still contact your GP in the usual way. For immediate, life-threatening emergencies, you should continue to call 999.

It is likely that the 0845 46 47 NHS Direct number will be closed down in the near future subject to approval from NHS England. We will continue to keep you updated on the 111 service in the Cambridgeshire and Peterborough area.

Cambridgeshire and Peterborough Clinical Commissioning Group

Our ref: NM/SKS/nm1nov2013
Your ref:

1 November 2013

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Dear Colleague

We wanted to let you know that, regrettably, Cambridgeshire and Peterborough CCG is reporting a significant deficit at month six. In month five, we had been reporting a small surplus, however, a number of risks have been clarified in recent weeks, which means that the CCG now needs to predict an end of year deficit of £8.6 million, approximately 1% of our total budget.

A combination of factors have led to the revised position, notably that we have now had confirmed the CCG's budget and liabilities for specialist commissioning, putting a pressure of up to £10 million on our budget. We also have continued pressure on acute contracts, revised costs from the prescribing authority and a less than fully delivered savings plan. We are working hard to deliver a recovery plan that focuses on referral support for practices, prescribing support and closer contract management.

We will continue to keep you updated on our progress, but in the meantime, please do not hesitate to contact us.

Regards

Dr Neil Modha
Chief Clinical Officer

Department
of Health

From the Rt Hon Jeremy Hunt MP
Secretary of State for Health

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Dear Colleague,

- 4 NOV 2013

I would like to take the opportunity to inform you of work being done nationally to improve end of life care services and to highlight the importance of ensuring that people throughout the country have access to high quality services at the end of life.

As I am sure you are aware, the Government has specifically highlighted the importance of end of life care in the Mandate to NHS England. End of life care also features in the NHS Outcomes Framework and the updated NHS Constitution. However, whilst significant progress has been made in recent years to improve end of life care services, there is still much more work to do to ensure that people are receiving the highest standards of care at the end of life.

As part of this work, NHS England is currently undertaking a review and refocus of the End of Life Care Strategy, which is due to be completed in early 2014. Alongside this, the Leadership Alliance for the Care of Dying People, under the chairmanship of the National Clinical Director for End of Life Care, Dr Bee Wee, is working to set out the principles of good end of life care and to formulate a system-wide response to the Independent Review of the Liverpool Care Pathway, which was published in July.

NHS England is also undertaking work to develop a fairer, per-patient funding system for palliative care. The eight funding pilots we set up following the report of the independent Palliative Care Funding Review are due to complete in April 2014, with the aim of setting up a new funding system by 2015.

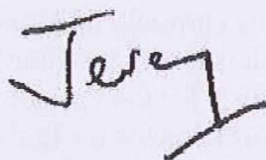
I am keen to ensure that the progress and momentum achieved in recent years in implementing the end of life care strategy is maintained. Health and Wellbeing Boards, as leaders in the local health and care system, are uniquely placed to contribute as part of a joined-up approach to improving care, informed by work being done nationally.

I am therefore keen to support Health and Wellbeing Boards in ensuring that locally-owned processes to develop Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies fully consider end of life services; that the views and experiences of patients and families are fully and appropriately considered in the development process; and the commissioning and planning of local services is joined up with the work being done to improve these services at a national level.

As you will be aware, the Department has produced statutory guidance on JSNAs and JHWSs. We are also funding the Local Government Association and others to develop further resources to support the development of JSNAs, as well as support for local and national Healthwatch on patient and public engagement. https://knowledgehub.local.gov.uk

I know you will share my desire to see end of life care services continue to improve across the country. The work of Health and Wellbeing Boards is central to this goal and I believe that by ensuring local work on end of life care is joined up with, and informed by work being done nationally, we will make progress together towards improving the provision of end of life care and the experiences of patients and families.

Yours sincerely,



JEREMY HUNT

Cambridgeshire and Peterborough Clinical Commissioning Group

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Dear Colleagues

Minor Illness and Injury Unit opens on 1st October 2013

Following extensive consultation in 2011 it was agreed in March 2012 to upgrade services provided at the Walk-in Centre (in the City Care Centre) to a Minor Illness and Injury Unit (MIIU).

The unit will be led by staff with both nursing and medical backgrounds with enhanced skills, enabling them to see, treat and discharge patients independently and provide a range of urgent care services to patients in Peterborough.

The new Minor Illness and Injury Unit (MIIU) will include access to a wider range of treatments and facilities including diagnostics such as x-rays, which will reduce the need for people to attend A&E with non-life threatening illnesses and injuries.

The new MIIU will be available to the public from **1 October 2013**, the services will be delivered by Lincolnshire Community Health Services NHS Trust who were awarded the contract in April this year.

Yours sincerely

Catherine Mitchell
Local Chief Officer
Borderline and Peterborough Local Commissioning Groups

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UPDATED: 8 January 2014

HEALTH AND WELLBEING BOARD
AGENDA PLAN 2014

MEETING DATE	ITEM	CONTACT OFFICER
27 March 2014	Commissioning Intentions: Priorities for 2014/15 NHS England Local Team • Healthy Child Programme 0-5 Project CCG/LCG Public Health Children's Services Adult Social Care Health & Well Being Strategy Review	Board Members Tracey Cogan, Head of Public Health NHS England East Anglia Wendi Ogle-Welbourn, Director for Communities
23 June 2014	TBC	
22 September 2014	TBC	
8 December 2014	TBC	

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