

John McElvaney
Solicitor
Director of Legal Services
County Hall
Matlock
Derbyshire
DE4 3AG

Members of the Shadow Health and Wellbeing Board

Tel: 01629 538324
Ask for: Gemma Duckworth
Ref:
Date: 30 June 2011

Dear Member

Shadow Health and Wellbeing Board

Please attend the inaugural meeting of the **Shadow Health and Wellbeing Board** to be held on **Thursday 7 July 2011** commencing at **4.00pm** in **Committee Room No 1, County Hall, Matlock**

The agenda is set out below..

Yours faithfully

John McElvaney.

John McElvaney
Director of Legal Services

AGENDA

1. Introductions and Apologies for Absence
2. Background and Terms of Reference
3. Transition Planning
4. Prevention Spend – Moving Towards Shadow Budgets in Tameside and Glossop
5. Joint Strategic Needs Assessment
6. Framework for Health and Wellbeing Strategy

7. Role of HWB in Commissioning and Proposal to Establish a Children's Services Integrated Commissioning Task Group
8. Development of Local Healthwatch
9. Format and Timing of Future Meetings
10. Development Needs
11. Any Other Business
12. Date of Future Meetings

SHADOW HEALTH AND WELLBEING BOARD

7 July 2011

HEALTH AND WELLBEING BOARD - BACKGROUND AND TERMS OF REFERENCE

Purpose of the Report

To consider the background to the establishment of Health and Wellbeing Boards and to endorse the Terms of Reference for the shadow Board.

Information and Analysis

The Health and Social Care Bill requires the County Council to establish a statutory Health and Wellbeing Board from April 2013. The Bill states that the Board is to be treated “as if it were a committee appointed by that authority under section 102 of the Local Government Act 1972”. Membership of the Board is statutory for some, including a representative from each Clinical Commissioning Group in the area. Boards will be subject to local authority overview and scrutiny arrangements.

The Council has accepted an invitation from the Government to be an “early implementer” for Health and Wellbeing Boards. This requires the establishment of a shadow Board which will act as an advisory Board to the County Council, NHS Derbyshire and the NHS Commissioning Board. Membership of the shadow Board follows the statutory model.

Following the “pause” in the progression of the Health and Social Care Bill through Parliament, the Government has indicated that the role of Health and Wellbeing Boards will be strengthened with a new duty to involve users and the public. The Chief Executive of the NHS, Sir David Nicholson, has stressed the importance of pressing ahead with the establishment of Boards. David Behan, Director General at the Department of Health, has also written to make it clear that Health and Wellbeing Boards are “at the heart of the Government’s plans as the engines for integrating services and improving local people’s health”.

The core purpose of the Health and Wellbeing Board is to join-up commissioning across the NHS, social care, public health and other services to improve health and wellbeing outcomes and better quality of care within available resources.

The main functions are to:

- Develop a Joint Health and Wellbeing Strategy based on a Joint Strategic Needs Assessment
- Support joint commissioning of NHS, social care and public health services
- Ensure close working relationships between Public Health England, NHS, local government, Director of Public Health and Clinical Commissioning Groups.
- Provide a strategic framework for the detailed commissioning plans for the NHS, social care, public health and other services to best meet health and wellbeing needs.
- Ensure that services and commissioners are maximising their effectiveness on health improvement and reducing inequalities.

The shadow Board will operate within the framework of the Derbyshire Partnership Forum, as shown in Appendix A. It will drive the health and wellbeing theme within the Sustainable Community Strategy. The Adult Care Board and the Children's Trust Board will report to the shadow Health and Wellbeing Board and be tasked appropriately.

Initial consultation with stakeholders at a Derbyshire Partnership Forum priority setting and governance workshop took place at the end of April 2011 with many organisations expressing their desire to engage with the Board. Supporting structures will need to be developed to ensure engagement and influence from a wider range of organisations, including all district and borough councils, providers (including hospitals), the voluntary and community sector and other stakeholders and specifically, patients and the wider public.

The aim is to ensure that the Board can work with users, patients, providers, commissioners, professional advisors etc in an effective way so that decisions are well-informed and services are successfully designed.

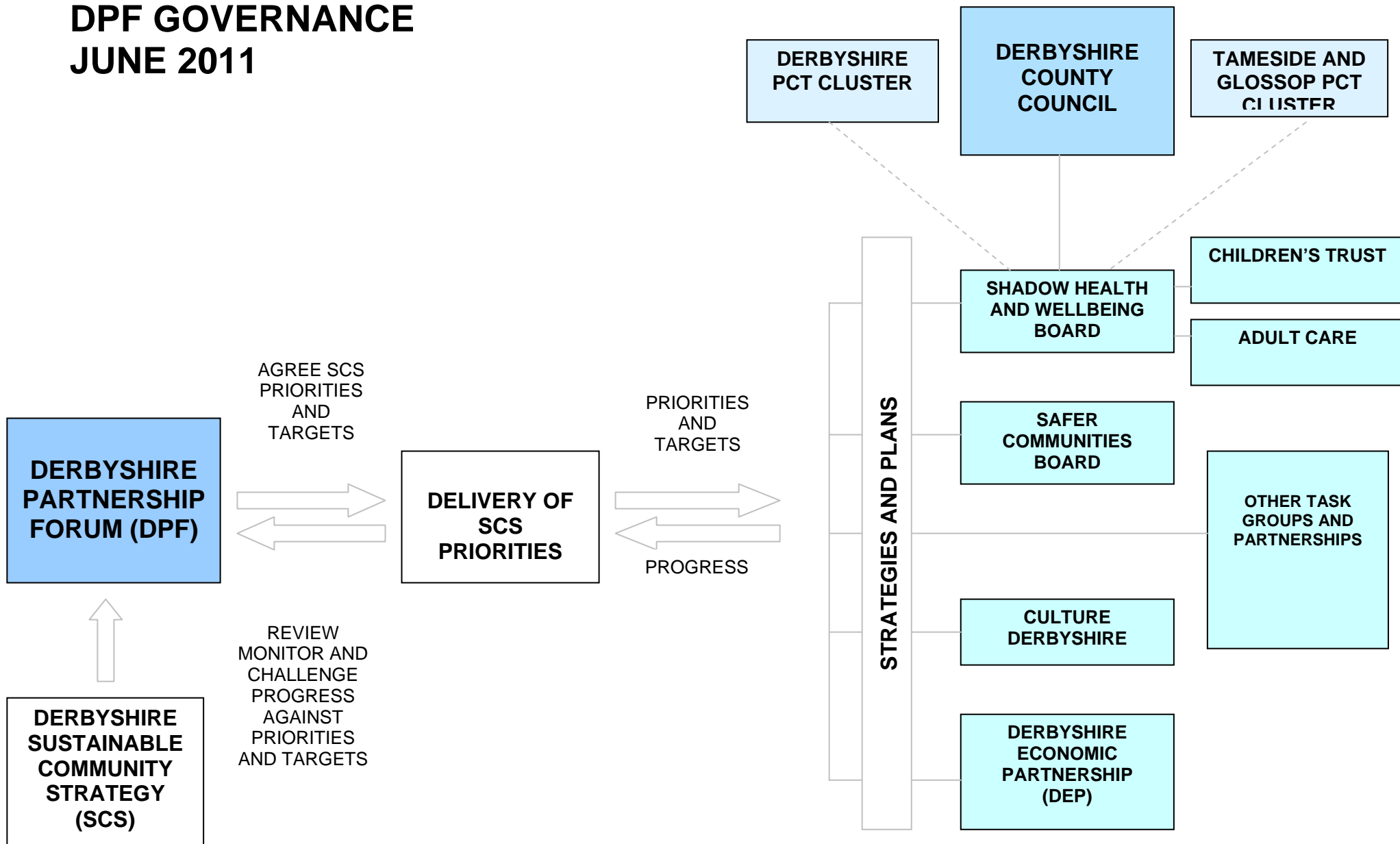
The draft Terms of Reference for the shadow Board are attached at Appendix B for comment and endorsement. The Board is asked to consider substitute arrangements (if any).

RECOMMENDATION

That the proposed Terms of Reference for the shadow Board be endorsed for approval by the County Council's Cabinet.

David Lowe
Strategic Director – Policy and Community Safety

DPF GOVERNANCE JUNE 2011



Appendix B

Derbyshire Shadow Health and Wellbeing Board Draft Terms of Reference

The shadow Derbyshire Health and Wellbeing Board will lead and advise on work to improve the health and wellbeing of the people of Derbyshire through the development of improved and integrated health and social care services.

Terms of Reference

The Board will:

1. Identify and develop a shared understanding of the needs and priorities of local communities in Derbyshire through the development of the Derbyshire Joint Strategic Needs Assessment (JSNA). Specifically, the Board will ensure that:
 - The Derbyshire JSNA is reviewed, refreshed and further developed taking into account the latest evidence and data so that it is fit for purpose and reflects the views of local people, users and stakeholders.
 - The JSNA drives the development of the Joint Derbyshire Health and Wellbeing Strategy and influences other key plans and strategies across the county.
 - The County Council, NHS Derbyshire and Clinical Commissioning Groups demonstrate how the JSNA has driven commissioning decisions.
2. Prepare and publish a Joint Health and Wellbeing Strategy for Derbyshire to ensure that the needs identified in the JSNA are delivered in a planned, coordinated and measurable way. Specifically, the Board will:
 - Take account of the health needs, inequalities and risk factors identified in the Derbyshire JSNA along with recommendations set out in the Director of Public Health's Annual Report.
 - Develop an agreed set of strategic priorities to focus both collective effort and resources across the county.
 - Ensure that plans are in place to deliver the Board's strategic priorities and outcomes.
 - Challenge the performance of delivery plans taking action as necessary to support underperformance through the agreement of recovery and improvement plans.

- Review the commissioning plans for healthcare, social care and public health to ensure that they have due regard to the Joint Derbyshire Health and Wellbeing Strategy and take appropriate action if they do not.
 - Receive reports from other strategic groups and partners in the county responsible for delivery, including specialist commissioning groups.
 - Develop mechanisms to measure, monitor and report improvements in health and wellbeing outcomes ensuring linkages with performance frameworks for the NHS, public health and local authorities.
3. Develop effective mechanisms to communicate, engage and involve local people and stakeholders in Derbyshire to ensure that to the work of the Board reflects local needs. Specifically, the Board will:
- Ensure that appropriate structures and arrangements are in place to ensure the effective engagement and influence of local people and stakeholders.
 - Represent Derbyshire in relation to Health and Wellbeing issues across localities and at a sub regional and national level.
 - Work closely with the Derbyshire LINKs and support transition to the local HealthWatch ensuring that appropriate engagement and involvement with existing patient and service user involvement groups takes place.
4. Oversee the totality of public sector resources in Derbyshire for health and wellbeing and drive a genuine collaborative approach to commissioning. Specifically, the Board will:
- Oversee and develop a shared understanding of the totality of health and wellbeing commissioning expenditure in Derbyshire.
 - Retain a strategic overview of the work of commissioners in the county.
 - Support joint commissioning of NHS, social care and public health services and identify those service areas in Derbyshire where additional improvements in joint commissioning are required to achieve the Board's priority outcomes.
 - Recommend the development of aligned or pooled budgets and encourage partners to share or integrate services where this would lead to efficiencies and improved service delivery.

- Make recommendations on the allocation of resources and on the priority of key projects to service providers and/or localities to achieve jointly agreed objectives.
 - Have an overview of major service reconfigurations in the county by relevant service providers and make recommendations to those providers to enable improved and integrated service delivery.
5. Ensure robust arrangements are in place for the smooth transition to the Statutory Board by April 2013. Specifically, the Board will ensure that its work develops in tandem with other local and national policy developments and relevant legislation building close working relationships between partners.

Membership

The composition of the shadow Derbyshire Health and Wellbeing Board will broadly follow the statutory model. It will comprise:

- Leader of County Council (Chair)
- Cabinet Member for Public Health
- Cabinet Member for Adult Care
- Cabinet Member for Children and Young People
- Director of Public Health
- Strategic Director of Adult Care
- Strategic Director for Children and Younger Adults
- Strategic Director of Policy and Community Safety
- Two elected representatives of the District Councils (supported by one Chief Executive)
- One representative from each of the Clinical Commissioning Groups
- One representative of the local HealthWatch (initially from the Local Involvement Network (LINK))
- NHS Derbyshire County (until the PCT is abolished)
- NHS Tameside and Glossop (until the PCT is abolished)
- NHS Commissioning Board (when required)
- Public Health England (when required)

The Board can co-opt additional members as it considers appropriate.

Meetings of the Board

Frequency

- The Shadow Health and Wellbeing Board will meet initially on a bi-monthly basis.
- Meeting frequency will be reviewed after 12 months.

- The date, time and venue of meetings will be fixed in advance by the Board and an annual schedule of meetings will be agreed.
- Additional meetings may be convened at the request of the Chair.

Voting

- The Shadow Health and Wellbeing Board will operate on a consensus basis.
- In exceptional circumstances, and where decisions cannot be reached by a consensus of opinion, voting will take place and decisions agreed by a simple majority.
- Where there are equal votes the Chair of the meeting will have the casting vote.

Declaration of Interests

- Any personal or prejudicial interests held by members should be declared on any item of business at a meeting.

Quorum

- A quorum of five will apply for meetings of the Shadow Health and Wellbeing Board including at least one elected member from the County Council and one representative of the Clinical Commissioning Groups.

Access to Information/ Freedom of Information

- The Board shall be regarded as a County Council committee for Access to Information Act purposes and meetings will be open to the press/public.
- Freedom of Information Act provisions shall apply to all business.

Papers

- The agenda and supporting papers shall be in a standard format and circulated at least five clear working days in advance of meetings.
- The minutes of decisions taken at meetings will be kept and circulated to partner organisations as soon as possible.
- Minutes will be published on the County Council web site.

Review

The Terms of Reference will be reviewed to support the functioning of the Health and Wellbeing Board from April 2013 onwards.

SHADOW HEALTH AND WELLBEING BOARD

7 July 2011

TRANSITION PLANNING

Purpose of the Report

To seek approval from the Shadow Health and Well Being Board to develop a scheme of delegation from the Derbyshire PCT Cluster supported by the development of a transition plan and assurance process to ensure progress towards the statutory establishment of a Health and Well Being Board by April 2013.

Information and Analysis

As detailed in the previous paper “Health and Well Being-Background and Terms of Reference”, the core functions will require a framework to enable these to be enacted in shadow form.

The legal position is that a PCT can arrange for its functions to be undertaken by other NHS Bodies and certain other non NHS organisations, such as Local Authorities. This is commonly used in the NHS form of Lead Commissioning arrangements or pooled budgets. PCTs though, cannot direct third parties to carry out their statutory duties and therefore the PCT board (operating through the Cluster Board) has to retain accountability for commissioning health services for its population. Until there is a change in legislation, PCTs may only delegate responsibilities for budgets, through creating appropriate governance arrangements to the Board within the current governance structure of the PCT.

The accountability for use of budgets and the associated outcomes will, therefore, remain with the statutorily accountable PCT and will be assured through the Derbyshire PCT Cluster Board.

The Director of External Relations at Derbyshire cluster will work with the County Council to develop a scheme of delegation. Appropriate corresponding amendments will also be made to the Cluster Scheme of Delegation to reflect the role of the Shadow Health and Well Being Board. The Standing Financial Instructions and Standing Orders will also be amended to reflect the delegated authority to the Director of Public Health and their team.

A detailed transition plan will be developed to ensure that the appropriate tasks are mapped out and project managed, and an assurance process will be developed to monitor progress and to offer the necessary assurance to the Cluster Board.

RECOMMENDATIONS

To approve the development of the scheme of delegation,
To approve the development of transition plan,
To approve the development of an assurance framework,
To receive these at future meetings.

Trish Thompson Cluster Director of External Relations

SHADOW HEALTH AND WELLBEING BOARD

7th July 2011

PREVENTION SPEND, MOVING TOWARDS SHADOW BUDGETS 12-13

Purpose of the Report

The report explains the background to the prevention spend and proposes an integrated approach to commissioning preventive outcomes for the population of Glossopdale during the transition period. Such an approach would allow the partnership to identify and address any issues which may arise in relation to commissioning for prevention for this community following transition.

Information and Analysis

- The prevention spend, as defined in the 10-11 end of year audit for the DH, will form the basis for Public Health England budgets for commissioning defined preventive activity from 2013-4.
- From 2013-4 Public Health England will make a funding allocation to Derbyshire Council to deliver on prevention outcomes for their population. The formula for this allocation is not yet available.
- This paper explores some of the issues that will need to be addressed for the council to assure themselves that they can deliver on prevention outcomes in Glossopdale from 2013, and proposals for addressing these through a partnership approach.
- It sets out the results of the 10-11 Tameside and Glossop prevention audit as the best estimate of the future total allocation covering Tameside and Glossopdale. An estimated 14% (subject to DH formula) of this will be allocated to Derbyshire. The paper proposes building on the current collaborative approach to commissioning for prevention with a number of areas of prevention spend.
- This will build clarity around shared objectives, and highlight issues around commissioning and public health support, existing contractual obligations, and the council's contribution, to be developed in order to prepare for the shadow budget allocation from 2012-13.

Appendix 1: Total prevention spend 10-11 for Tameside and Glossop

Appendix 2: Detailed breakdown of prevention spend areas highlighted in Appendix 1.

Appendix 3: Summary breakdown and alignment of current prevention allocations

RECOMMENDATIONS

To note the contents of the paper and endorse its recommendations to:

- Agree the principle of an integrated approach to the preventive spend.
- Pilot this in partnership with public health, Tameside and Glossop shadow clinical commissioning group and Derbyshire and Tameside Councils for the areas of health improvement including nutrition, physical activity and tobacco control, substance misuse and sexual health.
- Support work to establish the totality of the resource for prevention– both for programmes and the supporting management resource - available from health and councils.
- Set out action plans for delivering outcome-based commissioning using the model described and building on existing work.
- Develop arrangements for the preventive spend for lead or joint commissioning as appropriate, which may include pooled budget arrangements.
- On the basis of agreed plans develop supporting arrangements for the preventive spend shadow budget for 12-13.
- Use this model to take forward other areas of prevention spend as future accountability is clarified through Public Health Command Paper.
- Establish shared governance arrangements for the preventive spend through the Health and Wellbeing Board and the Joint Health and Wellbeing Strategy.

Lead Director: David Lowe

1. Background

The *Consultation on Funding and Commissioning Routes for Public Health*, published in December 2010, set out how public health funding will flow once the new public health system is established, and included details on the ring-fenced budget.

Much of the accountability for delivering for prevention will in future sit with Local Authorities, supported by Public Health England. Shadow budgets for 2012-3 and the actual budgets for 2013 onward will be determined by Public Health England (PHE) on the basis of 2010-11 prevention spend, subject to a formula to factor-in socio-economic deprivation and top-sliced to cover the costs of PHE. It is likely that the councils' allocations will be subject to an incremental progress towards "fair shares".

This paper describes the Tameside and Glossop preventive spend; identifying in which budgets it currently sits, and proposing future commissioning arrangements. This is in order to provide the council with the fullest possible assurance that they will be in a position to deliver on their new accountabilities for improving health and wellbeing, subject to the final funding formula developed by Public Health England.

2. Integrated working

Tameside and Glossop, as a health economy, has a strong history of partnership working on shared priority outcomes. This includes strategies on reducing alcohol related harm, tobacco control, healthy weight, sexual health and health inequalities. Each of these has been underpinned by a needs assessment setting out local need and the evidence for effective interventions. The strategies build on the recommendations from these needs assessments to identify gaps in provision, the resource available to address these gaps and to set out an integrated approach to achieving improvements in health – including commissioning for health.

This paper set out how the prevention spend could be used as basis for strengthening this approach and preparing for the establishment of shadow budgets for 2012-13.

Although it is not possible to predict accurately Tameside or Derbyshire Councils' final preventive spend allocation on the basis of the 10-11 prevention spend audit, the process described will support the following:

- Further progress to needs and evidence-based integrated commissioning for prevention – supporting cost-effective delivery and better outcomes.
- The full engagement of Tameside and Glossop shadow Clinical Commissioning Group in commissioning for health.
- Increased understanding of the council's contribution to prevention
- Identification of issues such as the level of commissioning support available and the development of strategies to address these.
- Ensuring that commissioning meets the needs of Glossopdale residents
- A shared understanding of existing contractual commitments for the prevention spend.

3. Aim of the paper

The aim of this paper is to:

- Brief Derbyshire Health and Wellbeing Board about the prevention spend and future commissioning and funding routes for prevention, including the roles of Public Health England (PHE) and Local Authorities.
- Brief the HWB Board regarding the resource included in the prevention spend – both for programmes and supporting resource.

- Request the HWB Board support for establishing a joint approach to commissioning to achieve prevention outcomes and to support effective commissioning of the shadow prevention spend for 2012-13.

4. The preventive spend audit

The first step in determining the size of councils' local prevention budgets is to ascertain baseline spend for the activities in question. PCTs were asked to include spend on public health activity as part of the 10-11 year-end accounts, based on a detailed description of the areas that the consultation described as possible public health responsibilities. This process is known as the preventive spend audit. The results of the audit are presented as appendices to this paper.

The audit covers public health activity such as health improvement, obesity, sexual health, cancer screening and emergency preparedness. It also covers a number of commissioning lead areas such as substance misuse, children's health and NHS health checks. These include some areas of spend which are to be delegated to the shadow clinical commissioning group during the next financial year.

Table 1 sets out the areas of prevention spend and identifies where the budgets are currently held.

Public health budgets	Commissioning	Other
Public health leadership	Drug misuse	Information and intelligence functions
Screening	Alcohol misuse	Immunisation
Emergency planning and preparedness	Falls	Specified areas of prescribing for prevention
Nutrition obesity and physical activity	Children 0-5 (may be allocated to the NHSCB)	
Tobacco	Children 5-19	
Dental public health	NHS health checks	
Health improvement	Sexual health	
Infectious disease		

Table 1: main headings of the prevention spend audit (DH March 2011).

The audit includes all staff costs to support the prevention programmes, including commissioners, intelligence, administration and provider management. It also covers non-staff costs including overheads and running costs.

Most of the topic areas are those which the consultation paper on public health funding and commissioning routes proposes should be commissioned by Local Authorities. Exceptions – subject to the final command paper – include the public health of 0-5s, some vaccination, and screening which it is currently proposed will be commissioned through the NHSCB.

The figures from the audit will be used – directly or indirectly - as the basis for establishing the council's ring-fenced preventive spend budget. This will be allocated by Public Health England (PHE) to councils according to a formula. This formula may be based on current spend, and may also include weighting for deprivation, with a move towards a target allocation made on a fair-shares basis. The allocation will be top-sliced to fund PHE and NHSCB preventive activity.

5. Glossopdale

Glossopdale prevention spend will, in 2013, be allocated to Derbyshire County Council. From April 2013 Derbyshire County Council will be responsible for delivering public health commissioned services into Glossopdale. This amounts to 14% of the currently available resource from NHS Tameside and Glossop identified in the audit.

Derbyshire are currently working closely with NHS Tameside and Glossop, aiming for a collaborative approach to the preventive spend which would be strengthened by the recommendations of this paper. This could potentially bring increased resources for prevention in Glossopdale including the benefits of Derbyshire's exercise on prescription scheme, Citizen's Advice in primary care, healthy schools' team and alcohol service. The resources provided may change subject to agreement and negotiation.

The following principles have so far been agreed for transition:

- Aim to disrupt services as little as possible during and immediately after transition.
- NHS Tameside and Glossop and NHS Derbyshire County will share information on public health and commissioning intentions from April 2011 until after transition.
- Any changes made to commissioning and funding arrangements from April 2013 will receive a minimum 6 months' period of notice.

6. Identifying the preventive spend

Appendix 1 outlines where the bulk of the preventive spend budgets were located in the financial year 2010-11. Appendix 2 offers more detail of the components of each category, the contracts in which the spend is currently invested and the current alignment of each.

The current alignment of the prevention spend for these specific areas is summarised in Appendix 3. The process for alignment of PCT budgets involved a definition of the relevant QIPP scheme and then the alignment of each QIPP stream to shadow clinical commissioning group for "rapid devolution", or alternatively categorised as destined for the council or NHS Commissioning Board, or destination not yet clear ("unbundled and allocate to GPCC/Council/NHSCB").

The alignment process predates the current prevention spend audit and was carried out on a "best fit" basis using the information available at the time. Table 3 shows that approximately £3.5M of the total prevention spend (£16.3M) is currently aligned with the sCCG shadow budget. The alignment methodology has resulted in some short-term anomalies, for example the Pennine Care block contract includes an element of substance misuse service which has been defined as "mental health".

However the current alignment of the funding is less important than a commitment by the sCCG, council and commissioners to build on the existing integrated approach to commissioning for prevention during the transition process.

The final allocation of the funding to the council in shadow form for 12-13 and the actual budget for 13-14 will be carried out by Public Health England according to a formula which is not yet available. It is possible that less money will be available overall and the audit should not be taken as a direct proxy for the allocation that will be received. In the meantime a more integrated approach by all partners to commissioning this spend will lead to more cost-effective delivery and development of a shared understanding of the issues that need to be tackled in order to use this spend most effectively. This may include identification of commissioning support and the limitations imposed by current contracts and overhead allocations that may require a full 12 months notice before funding can be released.

7. Developing a more integrated approach to commissioning the preventive spend

The model proposed for an evidence, outcome, partnership approach to commissioning for prevention was used as the basis for World Class Commissioning outcome strategies and forms a robust structure for effective partnership action. The relevant parts of that model are shown in Figure 1.

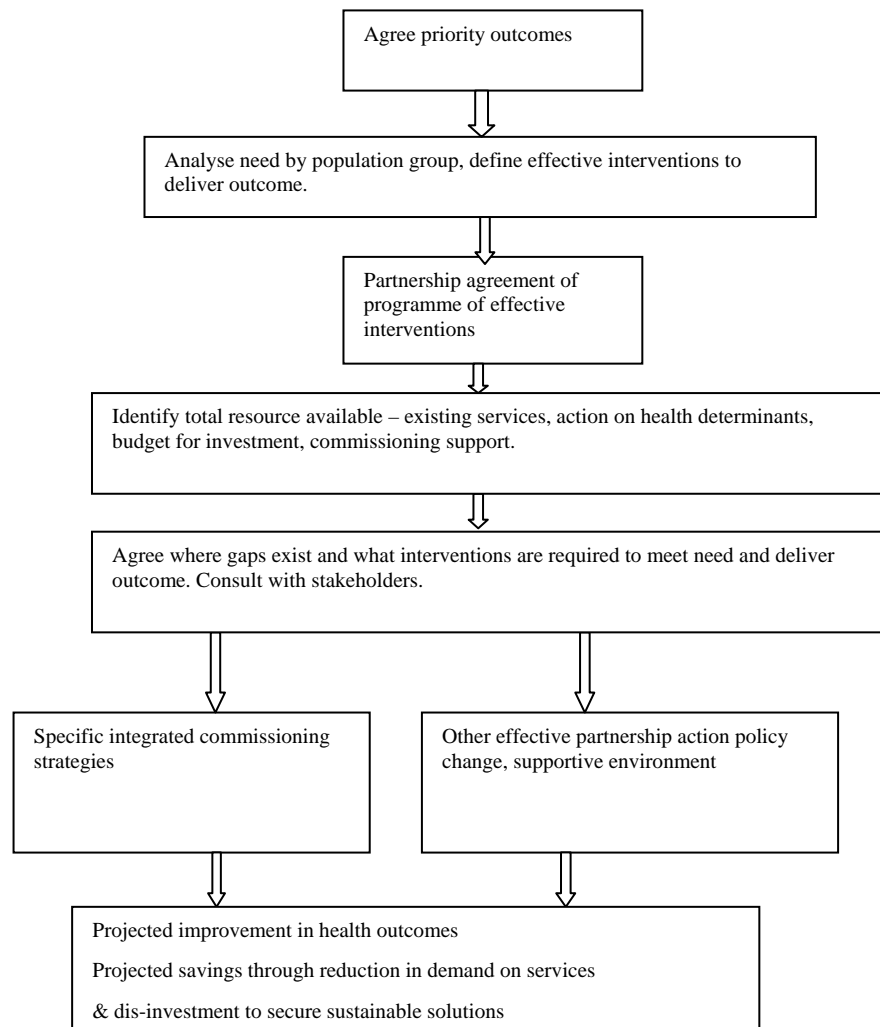


Figure 1: a partnership model for need and outcome based approach to commissioning for prevention

The first stage is to identify a shared set of priority outcomes agreed through the governance systems of the stakeholder organisations and the Health and Wellbeing Board - based on the principal causes of premature death and chronic ill health locally. Then for each agreed priority area the model described requires that the relevant partners come together to agree:

1. A shared understanding of needs of the population based on existing needs assessment and segmentation of the population, supplemented by any additional intelligence required.
2. The needs of the population are reviewed against guidance and the evidence for effective interventions.
3. Understanding local needs and how to meet them effectively enables partners to agree on a programme of effective interventions.
4. Existing services, policies, pathways, environment and provision are reviewed against this list. Gaps are identified as well as investment in ineffective or non-priority interventions.
5. Partners identify the total resource available – commissioned and provided services; other services which may have a contribution; potential for decommissioning to free-up resources, and the potential for interventions at a policy or strategy level.

6. Partners agree a delivery plan to meet need, including plans for commissioning or decommissioning and consult on the plans.
7. Projected improvements in outcome from the different components of the programme and the projected savings through reduced service demand are modelled.
8. Accountabilities for delivery are agreed.
9. Monitoring and evaluation of delivery, impact and outcomes will form an integral part of the plan.

This model already underpins local strategic partnership working on sexual health, alcohol, tobacco control and obesity. Joint commissioning and pooled budgets are one potential, but not assumed, element of such a model.

In addition to individual organisational governance arrangements the Derbyshire and Tameside Health and Wellbeing Boards would provide appropriate shared governance. The resulting plans could form a basis for the Joint Health and Wellbeing Strategy subject to legislation.

8. Next steps

It is proposed that, subject to the content of the command paper on public health to be issued on Public Health England, that this approach is applied to the highlighted areas – alcohol; sexual health; health improvement; nutrition, obesity and physical activity, and tobacco. These are all high spend areas, and are already underpinned by strong partnership working. On the other hand, vaccination and immunisation and screening are more likely to have NHS commissioning pathways in the future. Future accountabilities for children’s public health commissioning are not clear at this time.

To support this, the following actions would be required:

- Agree the principle of an integrated approach to the preventive spend.
- Pilot this in partnership with public health, Tameside and Glossop sCCG and Derbyshire and Tameside Councils in areas with strong existing integrated working – health improvement including nutrition, physical activity and tobacco control, substance misuse and sexual health.
- Support work to establish the totality of the resource for prevention– both for programmes and the supporting management resource - available from health and council.
- Set out action plans for delivering outcome-based commissioning using the model described and building on existing work.
- Develop arrangements for the preventive spend for lead or joint commissioning as appropriate, which may include pooled budget arrangements.
- On the basis of agreed plans develop supporting arrangements for the preventive spend shadow budget for 12-13.
- Use this model to take forward other areas of prevention spend as future accountability is clarified through public health command paper.
- Establish shared governance arrangements for the preventive spend through the Health and Wellbeing Boards and the Joint Health and Wellbeing Strategy.

9. Action required

Derbyshire Health and Wellbeing Board is requested to:

- Note the contents of the paper
- Support for an integrated partnership approach to commissioning for preventive spend.
- Agree the proposals for the next steps in the process.

Appendix Table 1: Tameside and Glossop Preventive Spend 2010-11.

Public Health	Admin £000s	Programme £000s	Outturn Total £000s	Income from outside the NHS/DH £000s	Costs of medicines supplied via FP10 prescription included in Outturn £000s
Public health leadership	1,057	336	1,393	24	0
Information & Intelligence functions	125	0	125	0	0
Non-cancer screening	177	1,022	1,199	0	0
Cancer Screening	4	1,279	1,283	0	0
Nutrition, Obesity and Physical activity	4	429	433	68	193
Drug misuse	36	2,928	2,964	269	172
Alcohol misuse	7	875	882	0	29
Tobacco	73	382	455	0	492
Dental public health	19	137	156	0	0
Fluoridation	0	0	0	0	0
Children 0-5	10	2,278	2,288	25	0
Children 5-19	21	1,011	1,032	169	0
NHS Healthchecks	4	47	51	0	0
Misc health improvement and wellbeing	19	817	836	12	0
Emergency Preparedness and response planning	1	19	20	0	0
Childhood immunisations	149	619	768	0	0
Targeted neonatal immunisation programmes	0	0	0	0	0
Seasonal flu and pneumoccal immunisation programmes	16	393	409	0	0
TD/IPV and HPV immunisation programmes	5	91	96	0	0
PCT support for surveillance and control of infectious disease	34	199	233	0	0
Sexual health (STI testing and treatment, contraception, abortion, prevention)	142	1,574	1,716	2	65

Contraception additional service - GP contract	2	4	6	0	287
Prison public health	0	0	0	0	0
TOTAL	1,905	14,440	16,345	569	1,238

Appendix 2: Detailed breakdown of prevention spend areas highlighted in Appendix 1.

Breakdown Public Health Audit 2010-11					
Category	A/P	10-11 Outturn	Contract	QIPP stream	QIPP Group
Nutrition, Obesity and Physical Activity	Admin	3699			
Overhead Commissioner support	Admin	2208	Commissioner	Overhead	Overhead
Overhead General corporate	Admin	1491	PCT	Overhead	Overhead
Nutrition, Obesity and Physical Activity	Programme	429361			
physical activity TMBC	Programme	7000	Commissioner	Public Health	Devolution to NCB and LA
physical activity High Peak	Programme	5000	Commissioner	Public Health	Devolution to NCB and LA
Baby friendly accreditation	Programme	6000		Child & Family	Unbundled and Allocate to GPCC/NCB/LA
Breast feeding support (Little angels contract)	Programme	105000	Independent sector	Child & Family	Unbundled and Allocate to GPCC/NCB/LA
Breast feeding support	Programme	36501	Stockport FT Community	Child & Family	Unbundled and Allocate to GPCC/NCB/LA
Spring Lambs activity group	Programme	2000	Commissioner	Public Health	Devolution to NCB and LA
Childrens Nutrition Service	Programme	127966	Stockport FT Community	Child & Family	Unbundled and Allocate to GPCC/NCB/LA
Weight Matters Service	Programme	114450	Pennine Care FT Community	Adult Obesity	Devolution to NCB and LA
Obesity LES	Programme	25444	Commissioner	Adult Obesity	Devolution to NCB and LA
Alcohol Misuse	Admin	7455			
Overhead Commissioner support	Admin	3452	Commissioner	Overhead	Overhead
Overhead General corporate	Admin	4003	PCT	Overhead	Overhead

Alcohol Misuse	Programme	874437			
Branching Out contract	Programme	75055	Commissioner	Child & Family	Unbundled and Allocate to GPCC/NCB/LA
IBA Training	Programme	24914	Commissioner	Public Health	Devolution to NCB and LA
Hypertension LES (alcohol)	Programme	6323	Commissioner	Alcohol Related	Devolution to NCB and LA
NES Tier 2/3	Programme	146010	Commissioner	Primary Care	Devolution to NCB and LA
Tier 2/3 ADS service	Programme	107089	Independent sector	Alcohol Related	Devolution to NCB and LA
Inpat Detox Smithfield	Programme	25990	Independent sector	Alcohol Related	Devolution to NCB and LA
Inpat Detox CBU	Programme	105737	Secondary care specialist	Specialist	Devolution to NCB and LA
Non Block SMS	Programme	90918	Commissioner	Alcohol Related	Devolution to NCB and LA
Pennine care Core contract element	Programme	292401	Secondary Care MH	Mental Health	Rapid Devolution
Tobacco	Admin	73109			
Smoking Cessation svcs manager	Admin	37882	Pennine Care FT community	Public Health	Devolution to NCB and LA
Smoking Cessation svcs assistant manager	Admin	33660	Pennine Care FT community	Public Health	Devolution to NCB and LA
Overhead General corporate	Admin	1567	PCT	Overhead	Overhead
Tobacco	Programme	382053			
Stop smoking advisors	Programme	172798	Pennine Care FT community	Public Health	Devolution to NCB and LA
Smoking cessation - non pay and LES	Programme	58954	Pennine Care FT community	Public Health	Devolution to NCB and LA
Pharmacy smoking cessation	Programme	60304	Commissioner	Prescribing	Rapid Devolution
Illicit and illegal tobacco	Programme	40000	Commissioner	Public Health	Devolution to NCB and LA
smokefree homes	Programme	3100	Commissioner	Public Health	Devolution to NCB and LA
Promotions	Programme	600	Commissioner	Public Health	Devolution to NCB and LA

Smokefree NW	Programme	46297	Secondary care specialist	Public Health	Devolution to NCB and LA
Misc health improvement & wellbeing	Admin	18968			
Falls Service (manager and admin)	Admin	16090	Stockport FT community	Older People	Rapid Devolution
Overhead General corporate	Admin	2878	PCT	Overhead	Overhead
Misc health improvement & wellbeing	Programme	817102			
Early attachment services	Programme	43150	Secondary Care MH	Mental Health	Rapid Devolution
Off The record (counselling)	Programme	107519	Commissioner	Child & Family	Unbundled and Allocate to GPCC/NCB/LA
Social Prescribing (Isolation in older people)	Programme	37500	TMBC agreed investment	Mental Health	Rapid Devolution
BME community MH workers	Programme	119443	PH development budget	Mental Health	Rapid Devolution
SARC	Programme	8072	Secondary Care Acute	Mental Health	Rapid Devolution
High Peak CAB	Programme	12500	Commissioner	Public Health	Devolution to NCB and LA
Affordable Warmth Project	Programme	7500	Commissioner	Public Health	Devolution to NCB and LA
Workplace health	Programme	20000	Commissioner	Public Health	Devolution to NCB and LA
Intouch Kiosks	Programme	14967	Commissioner	Public Health	Devolution to NCB and LA
VBA training	Programme	17398	Commissioner	Public Health	Devolution to NCB and LA
Community Health Outreach	Programme	258866	Pennine Care FT community	Public Health	Devolution to NCB and LA
Early attachment (community)	Programme	79021	Stockport FT Community	Child & Family	Unbundled and Allocate to GPCC/NCB/LA
Falls Service	Programme	91166	Stockport FT Community	Older People	Rapid Devolution
Sexual Health	Admin	141662			
Commissioning support	Admin	1625	Commissioner	Overhead	Overhead

Sexual Health Community Service	Admin	134132	Stockport FT Community	Sexual Health	Devolution to NCB and LA
Overhead General corporate	Admin	5905	PCT	Overhead	Overhead
Sexual Health	Programme	1573829			
Chlamydia screening	Programme	151111	Commissioner	Sexual Health	Devolution to NCB and LA
Improving access to contraception	Programme	24090	Commissioner	Sexual Health	Devolution to NCB and LA
Young people prevention service	Programme	60000	Commissioner	Public Health	Devolution to NCB and LA
Vasectomy (primary care only)	Programme	54750	Commissioner	Sexual Health	Devolution to NCB and LA
TOP booking svcs	Programme	12904	Commissioner	Sexual Health	Devolution to NCB and LA
Termination services	Programme	205026	Secondary care	Sexual Health	Devolution to NCB and LA
BPAS	Programme	3955		Sexual Health	Devolution to NCB and LA
Brooke clinic (GM recharge accrued)	Programme	27694		Planned Care	Rapid Devolution
Sexual Health Community Service	Programme	1006235	Stockport FT Community	Sexual Health	Devolution to NCB and LA
Sexual Health promotion	Programme	19064	Commissioner	Sexual Health	Devolution to NCB and LA
Sexual Health network	Programme	9000	Network charges	Sexual Health	Devolution to NCB and LA
Contraception (additional GP svcs)	Admin	1641			
Commissioning support	Admin	1625	Commissioner	Overhead	Overhead
Overhead General corporate	Admin	16	PCT	Overhead	Overhead
Contraception (additional GP svcs)	Programme	4109			
NES additional products		4109	Enhanced services	Primary Care	Devolution to NCB and LA

Appendix 3: Summary breakdown and alignment of current prevention allocations (columns 5 and 6 from Table 2)

QIPP GROUPS	2010-11 Outturn
Rapid Devolution	£3,551,181
Prescribing	£196,912
Planned Care	£1,333,316
CVD & Stroke	£46,496
Long Term Conditions	£519,367
Older People	£107,256
Mental Health	£1,347,834
Unbundled and Allocate to GPCC/NCB/LA	£4,596,270
Child & Family	£4,456,084
Oral Health	£140,186
Devolution to NCB and LA	£6,958,794
Primary Care	£1,485,320
Specialist	£1,788,653
Public Health	£1,694,340
Sexual Health	£1,620,267
Adult Obesity	£139,894
Alcohol Related	£230,320
Overhead	£1,238,437
Grand Total	£16,344,682

SHADOW HEALTH AND WELLBEING BOARD

7 July 2011

JOINT STRATEGIC NEEDS ASSESSMENT 2011

Purpose of the Report

This report describes the progress made with Derbyshire's Joint Strategic Needs Assessment (JSNA). It sets out proposals for the JSNA's future direction and makes recommendations to consolidate and strengthen Derbyshire's approach.

Information and Analysis

The Local Government and Public Involvement in Health Act (2007) originally set the requirement for Directors of Adult Care, Directors of Public Health and Directors of Children's Services to carry out regular assessments of the current and future health and wellbeing needs of their local communities. The knowledge that the JSNA gathers, both in the form of hard data and also softer, more qualitative information, should be used to shape health and wellbeing commissioning decisions.

As an existing statutory requirement, the JSNA is "business as usual". However, it is also central to the new policy landscape. Under the terms of the Health and Social Care Bill, the JSNA will set out the priorities to be framed in the Health and Wellbeing Strategy. So now, following the Government's recent approach to health and wellbeing, the JSNA has moved centre stage and sits at the heart of local health and wellbeing improvement.

Under the new arrangements, the Local Authority and Clinical Consortia will have an equal and explicit obligation to prepare the JSNA and to do so through the Health and Wellbeing Board. In so doing, the approach recognises that health and wellbeing promotion requires the combined efforts of public health, local health services and local government, together with partners in the business, community and voluntary sectors.

Derbyshire's JSNA exists within the *Derbyshire Observatory*. This is a web-based, information system which holds the various datasets that are required for the JSNA. In addition, there are reports and commentaries that help to build the big picture and transform the data into knowledge. The Observatory enables data to be viewed according to communities of interest as well as geographic communities. It is being developed and augmented with new datasets on an ongoing basis.

Summaries of the Derbyshire JSNA were published in 2008 and 2009. These summaries provide an overview of Derbyshire's main health and wellbeing issues (eg health inequalities, an ageing older person's population, high teenage pregnancy rates, alcohol misuse) along with more detailed information on a small number of topics (eg cardiovascular disease, autism, carers' needs).

For 2011/12, the JSNA identified a number of additional priorities including Reablement, GP based information on long-term conditions, Prevention and the impact on health and wellbeing of living in a rural community. The *Derbyshire Observatory* can be viewed by following the link <http://observatory.derbyshire.gov.uk/IAS>

Up to now, the JSNA has been steered by the JSNA Board. The Board is attended by information and commissioning staff from Adult Care, Children and Younger Adults, Public

Health and the PCTs. It is chaired by the Assistant Director for Strategy and Commissioning (Adult Care).

There has been considerable progress across the PCTs and County Council in linking the JSNA across our strategic planning cycles. The JSNA was fully embedded in the PCTs' strategic plans. The JSNA has also informed the prioritisation and budget processes for both adult care and health. The Director of Public Health's Annual Health Report for 2009/10 was a joint JSNA Summary publication.

Under the new national policy proposals, Clinical Commissioning Consortia and local authorities, including Directors of Public Health, will each have an equal and explicit obligation to prepare the JSNA. The arrangements for how this will be accomplished will be within the remit of the Health and Wellbeing Board.

The expectation is for the JSNA to be the overarching framework for all health and wellbeing needs assessments. This will help to ensure that the development of the Health and Wellbeing Strategy will reflect the wider evidence base that is available through other statutory processes, such as the Pharmaceutical Needs Assessment, Child Poverty Needs Assessment and the Alcohol and Substance Misuse needs assessment. Accordingly, the JSNA needs to be re-focused to meet the needs of the new users of the JSNA, principally the Health and Wellbeing Board and Clinical Consortia.

To reflect this, it is proposed that new terms of reference for the JSNA Board are prepared, with membership supplemented to include representatives from the Clinical Commissioning Consortia. The new terms of reference for the JSNA Steering Board will need to be agreed by the Health and Wellbeing Board.

The JSNA is a statutory requirement for Derbyshire and so it is of high importance that a high quality and reputable JSNA process is implemented. There are some areas for development for Derbyshire's JSNA which need to be addressed if this is to be achieved. For example, the ongoing work programme for the JSNA will include a requirement for consultation on the evidence prepared in the JSNA.

RECOMMENDATIONS

It is recommended that:

1. the Health and Wellbeing Board is the accountable body for the JSNA Board
2. the Health and Wellbeing Board supports the development of revised terms of reference and membership for the JSNA Board which will be considered at a future Health and Wellbeing Board
3. the Health and Wellbeing Board receive regular progress reports from the JSNA Steering Board and monitor the progress against the agreed workplan
4. the Health and Wellbeing Board receive regular reports on JSNA priority issues for discussion and consideration

SHADOW HEALTH AND WELLBEING BOARD

7 July 2011

A FRAMEWORK FOR DERBYSHIRE'S HEALTH AND WELLBEING STRATEGY

- The establishment of the Derbyshire Health and Wellbeing Board brings with it the possibility of aligning policies and priorities in this area across the whole public sector in far-reaching and imaginative ways.
- To make the most of this opportunity it is necessary that all partners see the potential of this process. Discussing and developing a joint Health and Wellbeing strategy would be an excellent way to begin to explore the potential of this new partnership.
- This paper starts a discussion of how this could proceed and introduces a possible framework within which priorities could be nested.

1. Background

On 30 November 2010 the Government published a White Paper entitled 'Healthy Lives, Healthy People: Our strategy for public health in England'. This outlined a new public health system intended to protect the population from serious health threats, help people to live longer and healthier lives, and to improve the health of the poorest members of society fastest.

The paper specified that each county council must form a statutory "Health and Wellbeing Board" to bring together key NHS, public health and social care leaders to lead on public health work. One of the main responsibilities of the new boards is to devise joint health and wellbeing strategies. The strategies will be informed by the local Joint Strategic Needs Assessments (JSNA) and be prepared by local authorities and GP consortia.

The Future Forum and the government's response to it, envisages a strengthened role of the Health and Wellbeing Board and the government is signalling that it will allow us to take this process of strategic alignment and development of associated activities such as joint commissioning, as far as our collective imagination, capacity and will allows.

This paper is to provide a briefing for discussion on the framework and process for the development of a Derbyshire Health and Wellbeing Strategy.

2. Context

The context is in part provided by the Sustainable Community Strategy for Derbyshire and the agreed governance arrangements for the partnership .

We already have a wide range of strategies for older adults, for children, for sustainable communities, for specific communities, and for a host of specific sectors, subsets of the population and services - so what is to be gained from another?

The first answer is that this will be a first opportunity to develop a strategy that covers all the influences on the health and wellbeing of the whole of the population, enabling us to consider the entire spectrum of activities in relation to each other.

Secondly it enables us to look in more depth than before at how the widest range of public services can be focused to improve the health and wellbeing of the population. This takes advantage of the transition of many public health responsibilities and an appropriately skilled workforce to the county council while maintaining the link between public health and health service commissioning.

Thirdly, and particularly in times of financial constraint when we will have to make choices, it allows us to have a more explicit discussion about which priorities are most pressing.

Finally a health and wellbeing strategy is a public statement of our intention to work together across the public services and of our agreed priorities for action and improvement and, therefore, provides a basis on which to build a dialogue with our communities

3. Process

We will continue to develop the county's Joint Strategic Needs Assessment (JSNA), which will bring together all information about indicators of health and wellbeing available to the health services, the local authorities and other agencies. This assessment will be the foundation on which any strategy will rest. As with the strategy itself it will be important that the JSNA process is "owned" by all relevant partner organisations and that processes are developed in the future to enable wider engagement.

In order to progress this strategy in step with the development of the Health and Wellbeing Board and the planning cycle of the partner organisations, we may chose that the initial strategy captures existing pressures and priorities

within the system and reflects the current intelligence within the JSNA process.

As far as possible, strategies should be focused on outcomes rather than actions. Equally, the activities that underpin outcomes should be those for which there is the best evidence of likely success. However, there should also be some room for innovative approaches which by definition may have a less developed track record.

It will be important, in shaping and implementing this strategy to incorporate a process of engaging at the local level with people, voluntary and community partner organisations and other key statutory bodies in identifying local priorities and local assets and strengths on which to build the approach to improved health and wellbeing. This process may include the use of existing networks, the media and specific events. It is essential to our success to ensure ownership of the strategy by all concerned.

In order to produce a meaningful strategy it is also necessary to consider the three recently published outcomes frameworks; public health, adult social care and the NHS, in conjunction with the outcomes framework for children linked to the 2005 “Every Child Matters” document. But Derbyshire’s strategy should, as far as possible, reflect a local approach and we should avoid our Health and Wellbeing strategy being just the sum of all the individual targets associated with these frameworks.

The general framework being proposed in this paper adopts the very intuitively attractive life course approach identified in the Public Health White Paper which also readily accommodates outcomes from the other two frameworks. In doing so, it neatly links the health care and social care agendas into a strategy that is ultimately about improved health and well being. (see diagram).

4. Strategic Framework (see diagram)

The stages of the life course approach advocated within the Healthy Lives; Healthy People report are;

START WELL To optimise children’s health at the start to life and before school:

Covering physical and mental health during pregnancy and the first years of life particularly within disadvantaged families. This includes the particular importance of early identification.

DEVELOP WELL Children attain potential and make successful transition to adulthood

Covering every developmental aspect of childhood through to early adulthood. This stage addresses the lifestyle issues including the risk taking behaviours of drugs, alcohol, smoking and sexual health, road traffic safety but also identifies the equally important impact which societal issues such as housing, education, and employment has on the health, wellbeing aspirations and self esteem of the developing person.

LIVE AND WORK WELL People are enabled to live healthy independent productive lives of their choosing

Health promoting behaviours of diet, physical activity, smoking, alcohol consumption, drug use and sexual activity are all identified and their influence upon crime, mental health and domestic violence all acknowledged. Measures which enable people to live independently, in their own home, as unhindered as possible by any LTC. This stage also incorporates the issues of socioeconomic/environmental factors and planning upon health and wellbeing, and specifies the importance of community empowerment in achieving and sustaining change at this time.

AGE WELL People are enabled to age in optimal health with dignity and independently in settings of their choice

Active ageing and independence are the focus and that processes to ensure that individuals experience a dignified death are the norm. The impact of social isolation, access to services, living with long term conditions, dementia, fuel poverty, falls, poor or unsuitable housing and bereavement are inherent within this stage.

5. General points about choice of strategic priorities

There are some real choices to be made, not just in terms of specific priorities but in the nature of the strategy itself.

A key question to consider is to what degree the Health and Wellbeing Strategy should reflect a wide set of priorities covering most or all of the main population groups and services, or a very narrow set of areas which we agree that we want to make particular progress on, while recognising that we all continue working across wide areas of responsibility. If the strategy is all things to everyone it will be inoffensive but also dull and unlikely to create much momentum. If it is too narrow it may create good progress in a few areas but will have more limited appeal and leave some groups feeling neglected. Of course it could be a combination of these two approaches so that we both reflect the spread of our work while focusing a narrower beam on specific areas. Literacy would be a good example of a local strategic priority.

Priorities that we particularly highlight should make use of these new cross-cutting opportunities and promote the development of joint approaches including joint commissioning between health and social care services.

Some of the space for innovation might come through exploring the public health potential of services within the local authority sphere whose links to public health have perhaps been a bit dormant while the largest public health capacity has sat in the NHS. These might include planning, transport and a rejuvenation of the links between public and environmental health.

There should be some consideration given to whether this should all be done on a pan-Derbyshire basis or whether there should be some expression of local variation in need and interest. Everyone is in favour of local decision making but no one likes its evil twin the post-code lottery... but we do have a very diverse county and some reflection of that may lead to greater ownership.

6. Underpinning Processes

Essential to the successful delivery and achievement of the outcomes within the health and wellbeing strategy, will be a number of cross cutting issues including workforce planning and development, communication systems, public engagement, intelligence (JSNA), equality and quality assurance.

Appendix I illustrates how individual outcomes from the relevant frameworks integrate into a life course approach. It also aims to identify the partnerships or mechanisms already in place in Derbyshire which could adopt leadership and responsibility within any one area.

7. RECOMMENDATIONS

The contents of the report are discussed by the Health and Wellbeing Board, and agreement reached on the framework for a Derbyshire Health and Wellbeing Strategy.

Timescales for development and implementation of the strategy be agreed and measures to monitor progress are established.

Contact information

Dr Bruce Laurence Deputy Director of Public Health NHS Derbyshire County
Paper prepared by Bruce Laurence, Steve Pintus and Jayne Needham

To increase the healthy life expectancy and disability free years experienced by the people of Derbyshire

START WELL
To optimise children's health at the start to life and before school

- Healthy pregnancy
- Breast /infant feeding
- Optimal health 2.5 years
- Vaccination uptake
- Avoidable Admissions
- Experience of quality maternity services
- Keeping safe from avoidable harm

DEVELOP WELL
Children attain potential and make successful transition to adulthood

- Vaccination uptake
- Risk health behaviours reduced
- Children in care
- Avoidable contact with criminal justice system
- Experience of care services
- Keeping safe from avoidable harm

- School readiness attainment
- Healthy School experience
- Educational attainment
- Children NEET 16-18
- Children in poverty
- Avoidable admissions for chronic illness
- Experience of care services

- Stable domestic harmony
- Mental wellbeing
- Mental health & disabled people living independent
- Health literacy
- Risk behaviours modified
- Utilisation of green space
- Violent crime

LIVE AND WORK WELL
People are enabled to live healthy independent productive lives of their choosing

- Employment
- Employment/ purposeful activity of disabled people
- Workforce sickness absence
- Effective management of disease
- Emergency response plans
- Protection from risk and hazards to health

- Early presentation and diagnosis of disease
- Preventing avoidable admissions
- Recovery and rehabilitation
- Carers support

AGE WELL
People are enabled to age in optimal health with dignity and independently in settings of their choice

- Control and direct influence over resources
- Avoidable re-admissions
- Access to support
- Effective reablement /rehabilitation system
- Experience of care services
- Social network/ connected

- Dignified end of life experience
- Secure income/ entitlement
- Safe and warm living environment
- Perceptions of safety
- Fuel poverty
- Keeping safe from avoidable harm

SHADOW HEALTH AND WELLBEING BOARD

7 JULY 2011

CHILDREN'S SERVICES INTEGRATED COMMISSIONING TASK GROUP

Draft 1.1 Terms of Reference

1. AIMS

The purpose of the group is to jointly oversee and provide strategic leadership to the development of a proposed model for integrated commissioning of services for children and young people on behalf of the Derbyshire Children's Trust and its partners.

The task group will have the following overall aims:

- To establish an integrated approach, budget arrangements and high quality commissioning practice which will reflect organisational accountabilities and result in effective and efficient services that are coherent for children, young people and their families and improve these outcomes
- To ensure that the local arrangements reflect the wider national and local strategic, financial and policy context including the need to make financial savings.
- To ensure that the arrangements can meet the developing roles and responsibilities of GP Commissioning Consortia and schools as commissioners.
- To ensure all legal requirements for the transfer of responsibility and pooling of budgets are met through the development of section 75 or other appropriate legal financial arrangements
- To develop a model which represents value for money for all partner organisations.

The group will work with colleagues in Derby City to maximise the potential of joint delivery of these aims.

2. ACCOUNTABILITY

The task group will report to the Derbyshire Children's Trust Board.

3. OUTPUTS

The group will:

- Define the outcomes that future commissioning arrangements will achieve for children, young people and their families
- Scope the organisational responsibilities, including statutory responsibilities, of all partner organisations in the Children's Trust, with specific focus on delivering the changes required under the Health and Social Care Bill.

- Consider possible models which can deliver the above aims, including consideration of models developed in other areas (including the work being undertaken by the Cabinet Office in Peterborough).
- Make recommendations regarding the preferred model for future commissioning arrangements.
- Ensure that all stakeholders are fully engaged.
- Provide regular updates to all partner organisations.
- Identify specific risks and make proposals for managing these.

4. MEMBERSHIP

Chair: Director of External Affairs NHS

Project Lead: Assistant Director Joint Commissioning DCC/NHS

Director of Children’s Services Derbyshire County Council

Director of Children’s Services Derby City Council

Commissioning Consortia GP representatives – one north and one south

Directors of Public Health NHS

5. NOMINATED ATTENDANCE

Permanent members may (with advance notice to the Chair) nominate an appropriate alternative individual to represent them fully at any meeting. Representatives must be fully briefed and able to take a full part in the meeting and delivery of actions. Other individuals may be invited to attend specific meetings or elements thereof with prior agreement of the chair

6. QUORUM ARRANGEMENTS

A quorum will consist of a minimum of four members including the Chair (or nominated representative), and must include representatives from both NHDC and each Local Authority.

7. FREQUENCY OF MEETINGS

Meetings will be scheduled monthly but may be held more or less frequently as deemed necessary by the group. If necessary to meet deadlines or exceptional circumstances additional meetings may be called in between formal meetings.

8. RESPONSIBILITY FOR ADMINISTRATION

The meeting will produce notes and actions; this will be organised by the project lead. Papers may be produced by any member of the group. Administrative support will be provided by the project lead.

9. REVIEW DATE

It is intended that this is a time limited group which will complete its work by October 2011. The group will review its progress in August 2011 or at any time that national policy change necessitates a review.

PROPOSED FUTURE FUNDING STREAMS FOR CHILDREN'S SERVICES

NHS Funded

Local Authority Funded

**NHS
Commissioning
Bid**

Primary Care
Screening
CAMHS Tier 4 and Secure Provision
Neonatal/PICU
Tertiary Care e.g cardiac surgery, cleft lip palate
Planned and Urgent Care
Maternity Services
Immunisations and Vaccinations (some)

Immunisation and Vaccinations (some)
Obesity/Physical Activity/Nutrition
Drug and Alcohol Services
Sexual Health/Teenage Pregnancy
Healthy Child Programme including

- Health Visiting
- School Nursing

**Public
Health/Public
England**

GPCC

CAMHS (Tiers 1, 2 and 3)
Health Needs of Disabled Children

Health Needs of Looked After Children
Continuing Health Care
Therapy Services

CAMHS (Tiers 1, 2 and 3)
Social Care, Education for Disabled
Children
Health Needs of Looked After Children
Complex Cases (Section 75 Agreement)
Therapy Services

**Local
Authority**

**Statutory
Duties of
GPCC**

- Duty of co-operation under the Children's Act to improve the wellbeing of children
- Supporting the local education authority to where necessary to provide suitable education for children and young people (statementing)
- Plan services for young carers
- Duties under the Mental Health Act for children under 18
- Meeting safeguarding duties by having regard for the need to safeguard and promote the welfare of children; follow the requirements for the safe recruitment and employment of staff and be a member of the Local Safeguarding Children's Board(s)

Joint Local Authority/NHS

Report Authors

Colin Selbie, Group Manager Contracting and Compliance, Adult Care
Fiona Worrall, Service Manager - Community and Voluntary Sector

SHADOW HEALTH AND WELLBEING BOARD

7 July 2011

**Local HealthWatch and transition arrangements for LINKs
(Local Involvement Network)**

Purpose

To provide an update on the proposed role of HealthWatch and the planned transition of the local Derbyshire LINK into an effective HealthWatch organisation.

Background

LINKs were established through the Local Government and Public Involvement in Health Act 2007. The Derbyshire LINK was originally funded through a central government ring-fenced grant from 1 April 2008 for three years until 31 March 2011. This contract was awarded to a consortia bid made by Amber Valley CVS and North Derbyshire Voluntary Action to act as Host to the local LINK. LINKs are tasked with positively influencing both health and social care, wherever funded by public money. Their main powers and responsibilities are to influence commissioning, to monitor services by entering and viewing, to make recommendations, to request and receive information and to gather views and experiences of their community. The Government required local authorities to continue to support the provision of LINK from 1 April 2011, whilst it provided guidance as to how a transition could be made to Local HealthWatch.

Transition Plan

The original HealthWatch Transition Plan included a timetable for a Pathfinder programme and action learning sets to be set up during March/April 2011. The 'pause' for consultation on the NHS Reforms, held with patients, professionals and members of the public, was conducted over an eight week period. This consultation, entitled NHS Future Forum, reported to the Secretary of State for Health on 13 June 2011. The NHS Future Forum report on 'Patient Involvement and Public Accountability' provides the detailed recommendations for Local HealthWatch.

The Government response to the NHS Future Forum listening exercise was published on the 20 June 2011. This response includes the following proposals for HealthWatch

- A strengthening of the collective voice of patients and carers in the system at both a local and national level. Local Involvement Networks (LINKs) would evolve to become local HealthWatch, creating a strong local infrastructure

- A representative of local HealthWatch to sit on the Health and Wellbeing Board, to ensure that the local consumer voice is integral to decision making.
- An explicit requirement that local HealthWatch membership is representative of different users, including carers.
- Commissioners and providers will have a duty to have due regard to findings from local HealthWatch organisations.
- Concerns are to be resolved locally to avoid undermining effective partnership working, in line with the Government's localism agenda, rather than top-down through referring issues to HealthWatch England.
- The Health and Wellbeing Board will require the local HealthWatch to provide public and patient insight that will inform the assessment of needs and joint health and wellbeing strategy.
- Local HealthWatch will need to be established from October 2012 – which will allow them the opportunity to play a full role in clinical commissioning groups and health and wellbeing boards when they are set up.
- Local authorities and local HealthWatch will take formal responsibility for commissioning NHS complaints advocacy from April 2013

The East Midlands Public Health and Local Government Network have set up a work stream to be hosted by Derby City to provide support to local authorities to ensure the successful transition of LINKs into HealthWatch organisations. The first meeting of the East Midlands HealthWatch Network took place on Friday 24 June 2011, in Leicester. Mary Simpson, the National HealthWatch Policy Lead from the Department of Health presented the main new requirements and opportunities of local HealthWatch.

Responsibility of Local Authorities

The HealthWatch Advisory group has clarified that Local Authorities will be responsible for:

- Funding Local HealthWatch organisations (there is no information forthcoming about whether there will be any new funds to facilitate this)
- Commissioning of HealthWatch and ensuring that the organisation is body corporate (a legal entity, for instance a community interest company or industrial and provident society, company limited by guarantee and charitable status amongst others). The body corporate status can either be achieved through a host organisation or directly with the LINK officers and volunteers.
- Ensuring the accountability and value for money of their Local HealthWatch.

Derbyshire County Council will, as a consequence, be the commissioners and funders of Local HealthWatch and will also be subject to scrutiny from it in respect of Services for Younger Adults and Adult Care.

Next Steps

The Government will not be prescribing the format of local HealthWatch, but is encouraging local authorities to consider their own transition route for LINK into HealthWatch.

The major challenge for the current LINK and the County Council is how to manage the transition to a 'body corporate'. Discussions will now be held with the LINK Steering Group (volunteers) LINK officers and the current HOST to explore the opportunity of developing themselves into suitable social enterprise (eg a Community Interest Company, a Company Limited by Guarantee, a Company Limited by shares, Workers Cooperatives, Charitable status, or an Industrial or Provident Society).

Background Papers

NHS Future Forum 13th June 2011

Government Response to the NHS Future Forum Report June 2011

HealthWatch Advisory Group Bulletin Issue 1

DoH HealthWatch Transition Plan 29th March 2011

Recommendation

A work stream be developed that will focus on establishing the future role of HealthWatch and exploring how the current LINK can be supported to evolve into HealthWatch.