Norfolk County Council
at your service

Health and Wellbeing Board

Date: **Wednesday 8 January 2014**

Time: **9.30am**

Venue: **Room 16, Abbey Conference Centre, Norwich**

SUPPLEMENTARY AGENDA

Please find attached the reports for items 7 and 11.

7	**Integration and the Better Care Fund.** Report of the Director of Community Services, NCC.	Harold Bodmer	(**A3**)
11	**Report of the Cambridgeshire, Norfolk and Suffolk Joint Health Scrutiny committee on Proposals for Liver Resection Services.** Report of the Head of Planning, Performance & Partnerships, NCC.	Debbie Bartlett	(**A40**)

Chris Walton
Head of Democratic Services
County Hall
Martineau Lane
Norwich
NR1 2DH

Date Agenda Published: 31 December 2013

IN TRAN
communication for all

If you need this report in large print, audio, Braille, alternative format or in a different language please contact Julie Mortimer on 0344 800 8020 or Textphone 0344 800 8011 and we will do our best to help.

Report to Norfolk Health and Wellbeing Board

8 January 2014

Item 7

Integration and the Better Care Fund

Cover Sheet

What is the role of the HWBB in relation to this paper?

The Health and Social Care Act 2012 and subsequent guidance sets out a clear role for the Health and Wellbeing Board in encouraging integrated working between health and social care commissioners, including encouraging partnership arrangements for health and social care services, such as pooled budgets, lead commissioning, or integrated provision.

The Better Care Fund is a new initiative which requires the creation of a pooled budget for the commissioning of integrated health and social care services. Health and Wellbeing Boards are asked to approve a plan for their local area.

Key questions for discussion

Q.1 What is our level of ambition - and how should this be reflected in the performance measures and targets we set?

Q.2 What is the relationship between these plans and the CCGs wider strategic and operational plans and how will they impact on each other?

Q.3 What plans are there for engagement with providers?

Q.4 How can the Board ensure that these plans will deliver tangible benefits for the Norfolk population – and what should be the role of the Board over the longer-term?

Q.5 What is the best way for the Board to manage the process of approval of the 'first cut' of the plan by 14 February and the final plan by 4th April 2014?

Actions/Decisions needed

The Board is asked to:

- Determine how it will manage the process of approval of the 'first cut' of the plan by 14th February and the final plan by 4th April 2014.

Report to Norfolk Health and Wellbeing Board

8 January 2014

Item 7

Integration and the Better Care Fund

Report of the Director of Community Services

Summary

A key area of responsibility for the Health and Wellbeing Board is the promotion of integration.

The Better Care Fund is an initiative which requires the creation of a pooled budget for the commissioning of integrated health and social care services. The initiative is targeted to progress the integration of services as determined at a local level. Whilst local areas are required to manage a pooled fund for the delivery of restructured services, the fund represents primarily existing investment. It is not intended to address the budget pressures, but to serve as a catalyst to create whole system improvement. The success of this fund is reliant on local partners working together to make changes that really do deliver changed activity and costs in the health and care system.

This paper provides a detailed briefing on the structure of the fund arrangements and sets out progress on developing plans between partners in the geographies of the Clinical Commissioning Groups.

The Health and Wellbeing Board is asked to approve a plan for its local area: a 'first cut' by 14th February and a final plan by 4th April 2014.

The report also notes that the task and finish group for integration has acted as a reference group but that the delivery of the plan will rest within local partnership forums.

Action required:

The Board is asked to:

- Determine how it will manage the process of approval of the 'first cut' of the plan by 14th February and the final plan by 4th April 2014.

1. **Introduction**

1.1 At the October Health and Wellbeing Board, the Board received a paper: 'Integration of health and social care services in Norfolk – an update'. This paper proposed terms of reference for an integration task and finish group and provided an update on the Integration Pioneer bids in Norfolk.

1.2 The Board recognised the significance of the live integration agenda: the Better Care Fund (previously known as the Integration Transformation Fund) and the

Board's role in approving the proposals for the fund. It requested a paper be presented to the January Board which sets out the detail of the fund and how it will be addressed in Norfolk.

1.3 This paper provides the Board with details of the Better Care Fund (BCF) and the process by which plans are being developed in Norfolk which will take integration to the next level.

2. The current state of integration in Norfolk

2.1 Norfolk is in a strong position in terms of integration, but the next steps are a challenge to all health and care systems as they seek to address the pressures of increasing demand with the financial constraints by establishing different ways of working.

2.2 Our fundamental principle has been to start with commissioning. Norfolk has integrated commissioning for health and care between the Clinical Commissioning Groups and Norfolk County Council. With small teams co-located in each CCG, we have a vehicle to support the transformation of integration and we have achievements in integrating community services to build on, such as integration of community equipment services, reablement, carers support and information and advice provision.

2.3 As the main local providers of community health and care for adults, Norfolk County Council and Norfolk Community Health and Care (NCHC) have been working closely to further integrate their delivery of community health and social care. The Assistant Director for Safeguarding for the County Council's Community Services is now co-located with NCHC in order to progress the integration at the front line of social work and community nursing, based around primary care. Over 50 multi-disciplinary teams around the county focus on people most at risk and provide co-ordinated care with the assistance of joint co-ordination posts.

2.4 Since the Board last met, Norman Lamb has confirmed that West Norfolk's pioneer bid was chosen to be one of the 15 successful bids, but due to the Queen Elizabeth Hospital being placed in special measures under both Monitor and Care Quality Commission's regulatory and inspection regimes, they are precluded from becoming a Pioneer. The Minister asserted that the West Norfolk team would still be able to engage with the Pioneer programme and an initial meeting has been attended.

3. The Better Care Fund

Background

3.1 In the Spending Review of June 2013, the establishment of the Better Care Fund was announced (at that time called the Integration Transformation Fund). Guidance has emerged over recent weeks and this paper sets out what has been clarified through NHS England and Local Government Association (LGA) communications and planning communications of 20th December (annex to NHS planning guidance: better care fund).

What is the Better Care Fund?

3.2 The BCF is a national initiative: a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed

between the NHS and local authorities. Local Government Association and NHS England correspondence of November 2013 notes this is 'a real opportunity to create a shared plan for the totality of health and social care activity and expenditure that will have benefits way beyond the effective use of the mandated pooled fund. We encourage Health and Wellbeing Boards to extend the scope of the plan and pooled budgets.'

3.3 The scope calls for a step change in existing arrangements, to change patterns of services and spending. It is noted that Ministers will wish to be assured of how use of the fund will secure improved outcomes and wellbeing for people, with effective protection of social care and integrated activity to reduce emergency and urgent health demand. It is seen as building sustainable health and care for the foreseeable future and acting as a catalyst for agreeing a joint vision for improving outcomes and to build commitment for accelerated change.

3.4 It is important to note that the fund is not all new funding and much is already committed or anticipated to address inflationary pressures in the health service. The fund creates a requirement to use funding in a different way. Commitment to the BCF is likely to lead to NHS and LA partners having to make some major changes to historical patterns of service in the interests of better integration.

The definition of integration

3.5 The BCF is seen as a means to deliver integration as set out in 'Integrated care and support: our shared commitment' where National Voices defined integration from the perspective of the individual as being able to "plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."

3.6 **What funding does the BCF cover?**

2014/15	2015/16
An additional £200m transfer from the NHS to social care, in addition to the £900m transfer already planned	£3.8bn pooled budget to be deployed locally on health and social care through pooled budget arrangements
In 2015/16 the £3.8bn BCF will be created from the following:	
£1.9bn based on existing funding in 2014/15 that is allocated across the health and wider care system. Composed of:	
• £130m carers' breaks funding	
• £300m CCG reablement funding	
• £354m capital funding (including £220m of Disabled Facilities Grant)	
• £1.1bn existing transfer from health to social care	
£1.9bn from NHS allocations	
Includes funding to cover demographic pressures in adult social car and some of the costs associated with the Care Bill.	
Includes £1 billion that will be performance-related, with half paid on 1 April 2015 (expected to be based on performance in the previous year) and half paid in the second half of 2015/16 (which could be based on in-year performance)	

3.7 The funding from which the BCF will be built includes the Disabled Facilities Grant, which at present rests with District and Borough Councils and which relates strongly to the suitability of housing and wider reablement. The statutory responsibility for provision of DFGs will remain with the second tier authorities and guidance sets out minimum funding required to be transferred to authorities for that purpose. The Health and Wellbeing Board has already expressed its commitment to housing as a key underpinning of health and social wellbeing and District and Borough Council chief executives have expressed their commitment to their role in the integration of local services.

Process for the notification of allocation of funding

3.8 In 2014/15 the existing £900m s.256 transfer to LAs for social care to benefit health, and the additional £200m will be distributed using the same formula as at present.

3.9 £1bn of the £3.8bn will be linked to achieving outcomes. 50% of the pay for performance element will be paid at the beginning of 2015/16, contingent on the HWB adopting a plan that meets national conditions by April 2014, and on the basis of 2014/15 performance. The remaining 50% will be paid in the second half of the year and could be based on in-year performance. Details are to be agreed still at national level.

3.10 Allocations for 14/15 and 15/16 BCF were announced in late December. Allocations for Norfolk are attached at appendix 1.

The integration transformation fund plan

3.11 The plan is clearly seen within a wider programme of transformation: 'the plan for 2015/16 needs to start from 2014 and form part of a 5 year strategy for health and care'. It is expected that this will require and deliver a step change in our current arrangements to:

- share information
- share staff – work force implications are noted in the latest guidance
- share money – a pooled fund will be established
- share risk – a shared risk register is needed.

3.12 As the fund is required to address several key functions, associated guidance clarified that plans will need to set out:

- allocations for Disabled Facilities Grants
- Carers support provision
- Reablement provision
- Implications of the new care and support reforms, including the Local Authority responsibilities under the Care Bill: information and advice, advocacy, safeguarding and new entitlements including the funding cap.

Clarity about budgets and savings

3.13 The letter of 17th October from NHS England and the LGA states 'the fund does not in itself address the financial pressures faced by local authorities and CCGs in 2015/16. The £3.8bn pool brings together NHS and Local Government resources that are already committed to existing core activity. Councils and CCGs will,

therefore, have to redirect funds from these activities to shared programmes that deliver better outcomes for individuals'.

3.14 The conditions for the current transfer using s256 of the National Health Service Act 2006 of NHS funding for social care 'which also has a health benefit' are attached at appendix 2.

3.15 This fund sits alongside the financial pressures which are faced in the health and care systems and significantly the cuts to budgets which local authorities are facing around the country. Norfolk County Council's budget consultation 'Putting People First' indicates that a substantial proportion of the fund will be needed for care services in Norfolk.

The process and the role of the Health and Wellbeing Board

3.16 Each Health and Wellbeing Board will sign off a plan for its area. The guidance notes that '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.' Ministers will sign off final plans and approval to release funds.

3.17 CCGs and Local Authorities agreed the 'footprint' for developing plans with NHS England in early November. Each CCG areas is developing its plan for integration. For Norfolk, we expect three strategic health and social care system plans will be developed: West Norfolk, Central Norfolk, Great Yarmouth and Waveney. These will be supported by the detailed two year operational commissioning plans for each CCG.

The national conditions

3.18 The Spending Review set out six national conditions for use of the fund (full definitions set out in appendix 3):

1. Plans to be jointly agreed
2. Protection for social care service (not spending)
3. 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
4. Better data sharing between health and social care, based on the NHS number
5. 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
6. Agreement on the consequential impact of changes in the acute sector.

3.19 A template is provided to assist planning and which is to be completed (attached at appendix 4). In addition, a shared risk register is needed with agreed risk sharing, mitigation and clear steps to be taken if activity volumes do not change as planned.

Time lines for producing the plans

3.20 Each Health and Wellbeing Board is asked provide the 'first cut' of their completed planning template as an integral part of the constituent CCGs' strategic and operational plans by **14th February 2014.**

3.21 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 **4th April 2014**.

Performance measures

3.22 As noted, £1bn of the 2015/16 funding will be subject to satisfactory system performance. The national indicators are now confirmed as:

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

3.23 The limitations of these measures are noted in the guidance with mitigating actions. In addition, local areas will need to agree an additional local indicator the menu below based on the health, social care and public health outcome indicators or from local definition. Any local definition must meet certain criteria including a demonstrable link to the joint health and wellbeing strategy.

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

3.24 Health and Wellbeing Boards will be responsible for signing off the performance measures and associated targets, and guidance indicates how Boards will wish to ensure these are sufficiently ambitious.

3.25 Where levels of performance are not met, it is suggested that there will be a process of peer review, facilitated by NHS England and LGA, to avoid large financial penalties which could impact on the quality of services.

3.26 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.

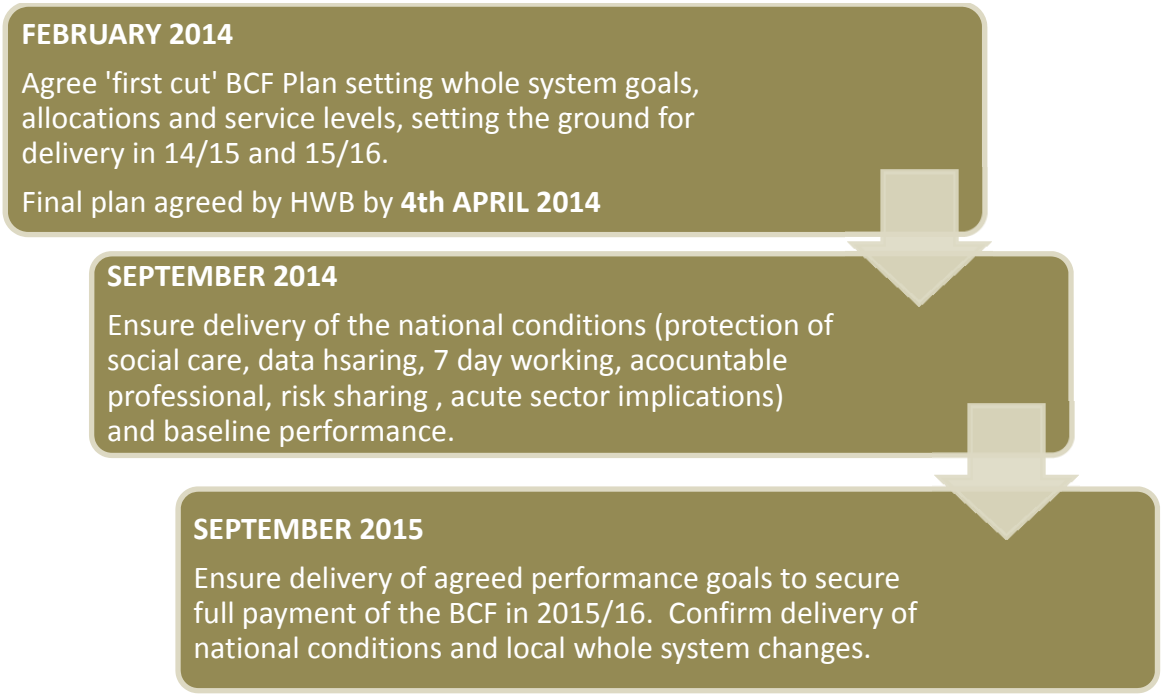
Wider processes

3.27 NHS England and the LGA note they will establish in each region a lead Local Authority Chief Executive who will work with parties to identify how HWBs can support one another with regard to plans and delivery arrangements. Issues will be taken to the Health Transformation Task Group, hosted by LGA, to broker advice and support and make links to Health and Care Integration Pioneers and HWB Peer Challenge. Integrated Care Pioneers are seen as accelerating development of successful approaches.

Working with providers

3.28 It will be essential for CCGs and LAs to engage with providers from the outset to scope the increased capacity requirements across the system and to identify mechanisms to best address these. Work with providers will be crucial to manage the transition to new patterns of provision. The letter notes that it is important that the implications for providers are set out clearly for Health and Wellbeing Boards.

Key timeline



4. The position statement for Norfolk

4.1 The Health and Wellbeing Board is asked to approve a 'first cut' of the local plan by 14th February 2014.

4.2 Whilst this is a short timescale, the plan is intended to underpin major system change and to be set within a 5 year strategic plan for health and care. With a strong foundation of integration, Norfolk is well placed to build these plans within existing partnerships and ambitions and commitments which have already been secured. This gives us a good foundation but it will still be a challenge.

4.3 At the time of writing this report the following has taken place to secure the plans:

- Initial meetings between CCG Chief Officers and Director of Adult Social Services to scope the ambition and the process for the BCF.
- Harold Bodmer, Director of Community Services Norfolk County Council, has set out a commitment to integration beyond the initial BCF pooled fund.
- A briefing for District and Borough Council chief executives with Ray Harding, Chief Executive of the Borough Council of King's Lynn and West Norfolk providing lead District Council representation alongside local engagement in the preparation of the plans and in particular addressing disabled facilities grant and wider housing issues.
- Engagement with NHS England local area team with the Local Authority Chief Officers group to share early thinking and to confirm expectations.
- Development of a financial baseline of current investment in each 'footprint'.
- Scoping of programme management functions to ensure the effective delivery of major change programmes for each 'footprint'.
- Confirmation of the support of Digital Norfolk Ambition - Norfolk County Council's new major partnership with Hewlett Packard for public services ICT - to the integration programme.

4.4 Below is an update on local developments as of the date of drafting this report:

West Norfolk

4.5 West Norfolk has the existing West Norfolk Executive Forum, which has leadership membership (CEO or Director level) from each of the following:

- CCG (chair)
- Norfolk County Council
- Borough Council of King's Lynn and West Norfolk County Council
- West Norfolk Voluntary and Community Services
- Norfolk and Suffolk Foundation Trust
- Norfolk Community Health and Care

4.6 This group is overseeing the development of the plan with the support of an established programme management structure. The 'West Norfolk Alliance' sets out the ambition and scope of integration proposed and is already agreed by the Executive. The BCF plan will sit within these plans and will develop further detail of how this will address the key criteria.

Norwich

4.7 Norwich CCG governing body gave initial consideration to the fund at its December meeting which was attended by Norfolk County Council, and leaders from main NHS providers. The Governing Body have approved an outline model of integrated care, which is ambitious in scope, and will seek to align a significant proportion of all CCG 'out of hospital' expenditure, alongside the Better Care Fund, and the entire social care budget for the City. The outline model consists of four main elements:

1. Primary Care Development – practices will be supported to develop locality clusters around populations of approximately 50,000 registered patients (4 localities within the Norwich CCG boundary). These practices will cooperate to develop shared Primary Care services for older patients, and those with long term conditions; with a particular focus on keeping patients independent, well and at home. Enhanced care for nursing homes, coordinated domiciliary visits, and a shared model of seven day access will be developed.

2. Integrated Community Services - Community, Mental Health, and Social Care Services will be enhanced and reshaped to the same locality footprints. The locality model will enable a multi-disciplinary approach to care, and build relationships, coordination, and mutual confidence between provider organisations. We will develop a new approach to intermediate care – linking with Operation Domino – to enable quicker discharge home, with coordinated packages of health and social care to support reablement and recovery, and reduce the risk of readmission. As with primary care we will seek to invest in seven day working, and extended hours to match the patterns of demand.

3. Information and Communication Technology – This will be a key work stream at a system level. Every health and care professional needs to be able to access a single patient record, and the patient needs to be empowered to access and actively participate in the care record, and decisions about their future care. A

Norfolk-wide approach, linking with NCC Digital Ambition may be the appropriate footprint.

4. Community Assets – we will develop an asset based approach to communities in Norwich. We will invest in equipping patients and carers with the knowledge and skills for sustainable self-care; make the voluntary and not-for-profit sector a stronger player in the delivery of care both upstream and in partnership with statutory provision; and support communities to identify and harness their internal assets: knowledge, skills, relationships, and facilities.

4.8 Norwich CCG will work closely with North and South Norfolk to develop a Central Norfolk model founded on shared principles, but which is built on operational models that address the significant geographic and demographic differences between urban and rural CCGs.

North Norfolk

4.9 North Norfolk has an existing integration programme which has a developed model of integrated care, based around primary care clusters supported by integrated community health and care provision. This is the foundation through which the planning for the BCF is being developed.

South Norfolk

4.10 The development of South Norfolk's plan is also underway, with engagement of partners to capture and to build on existing initiatives which are underpinning integration in local services.

North Norfolk, South Norfolk and Norwich

4.11 The footprint for Central Norfolk has been agreed in recognition of the significance of working with the Norfolk and Norwich University Hospital as one system and the three CCGs, North Norfolk, Norwich and South Norfolk, will co-ordinate plans across the area. Each of the CCGs has a programme to deliver integration and Operation Domino is a major programme of change which is already well developed and delivering system improvements focused on managing urgent care. These will provide the foundations for the Central Norfolk strategic approach. It has been agreed that an integration programme board will support the BCF programme for the Central Norfolk system, which will include commissioners and providers.

Great Yarmouth and Waveney

4.12 Great Yarmouth and Waveney is exceptional in its successful proposal for the planning footprint to be across two County Councils – and therefore two Health and Wellbeing Boards. The CCG will need to provide input for each Board's plan.

4.13 There is an established Great Yarmouth and Waveney System Leadership Partnership which has leadership membership from each of the following:

- CCG (chair)
- Norfolk County Council
- Great Yarmouth Borough Council
- Waveney District Council
- James Paget University Hospitals

- East Coast Community Health
- Voluntary Norfolk

4.14 Great Yarmouth and Waveney has an established integration vision and programme scope which has been agreed by the System Leadership Partnership and which will form the core for BCF plan. A partnership event was convened in December to develop the detailed planning to populate the plan. The Board will want to determine how it may engage with Suffolk Health and Wellbeing Board to sign off a plan for Great Yarmouth and Waveney.

Key principles in the local developments

4.15 There are some key principles emerging for our approach across Norfolk to the BCF:

- This calls for us to restructure services across health and care.
- We will build on what we have already achieved.
- All areas seek to transform services across health and care by considering how we use the whole of funding for our areas, not just that which is in the fund.
- A strong community based approach is key.
- The right service levels must be in place across 7 days a week.
- Services must maximise independence.
- Services must prevent unnecessary admissions to hospital and residential care and reduce time in hospital.
- Transforming services may mean challenging the assumptions of who delivers what.
- A partnership between the statutory, independent and community sectors is required.
- We must achieve cost effective means of delivery.
- Our integrated will need to be supported by shared information and shared systems.

Integration task and finish group

4.16 In July 2013 Board members asked for the formation of an integration task and finish group and commented on proposed terms of reference. The group met as planned on 15th November where it considered the feedback from the October Board. It noted that the key tasks which the Board identified at its October meeting were to prepare the plans for the use of the BCF and to prepare a briefing paper for the Board's January meeting setting out how Norfolk will progress the BCF. Since the guidance has been provided, it is clear that plans will be developed within the CCG planning frameworks and with locality partnership groups.

4.17 The group agreed that rather than meet, it would serve as a reference group for the drafting of the paper to the Board. This paper has been developed with input from the task and finish group.

5. **Conclusion:**

5.1 The Better Care Fund will serve as a structure to focus the development of integrated care in local areas. The Health and Wellbeing Board has a key role in addressing its duty for integration and for the approval of a local plan. It is required

by 14th February to approve the joint commissioning plan which Norfolk County Council and the CCGs will propose, but also has scope to set out its expectations for the ambition and scope of integration which can exceed the requirements of the fund in order to achieve real system integration.

6. Action required:

6.1 The Board is asked to:

- Determine how it will manage the process of approval of the 'first cut' of the plan by 14th February and the final plan by 4th April 2014.

List of Appendices

Appendix 1: Funding allocations for Norfolk

Appendix 2: Guidance on s256 transfers

Appendix 3: definition of national conditions

Appendix 4: integration transformation fund template

Appendix 5: Annex to the NHS planning guidance: the better care fund

Officer Contact

If you have any questions about matters contained in this paper please get in touch with:

Officer Name	Tel No;	email address
Catherine Underwood	01603 224378	catherine.underwood@nhs.net

IN TRAN communication for all

If you need this report in large print, audio, Braille, alternative format or in a different language please contact Jill Blake 0344 800 8020 or 0344 800 8011 (textphone) and we will do our best to help.

Appendix 1: funding allocations for Norfolk

Better Care Fund allocation for Norfolk 2015/16:

Local Authority	Disabilities Facilities Grant £000	Social Care Capital Grant £000	CCG	£ from CCG for BCF £000	Total £000	Council	Minimum Better Care Funding for DFG £000
Norfolk	3,753	2,327	NHS West Norfolk CCG	11,443	62,404	Breckland	535
			NHS South Norfolk CCG	14,020		Broadland	414
			NHS Norwich CCG	12,245		Great Yarmouth	567
			NHS North Norfolk CCG	11,553		King's Lynn and West Norfolk	759
			NHS Great Yarmouth and Waveney CCG	7,063		North Norfolk	595
						Norwich	472
						South Norfolk	410

Better Care Funding allocation for Norfolk 2014/15:

Local Authority	2014-15 BCF £000
Norfolk	3,482

Appendix 2: guidance on s256 transfers

"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.

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 the Board, clinical commissioning groups and local authorities on how the funding should be spent, as part of their wider discussions on the use of their total health and care resources.

In line with our responsibilities under the Health and Social Care Act, NHS England is also making it a condition of the transfer that local authorities 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.

NHS England is also making it a condition of the transfer that local authorities 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."

Appendix 3: definition of national conditions

National conditions	**Definition** (To be completed)
1. Plans to be jointly agreed	The Integration Plan covering a minimum of the pooled fund specified in the Spending Review, 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 Wellbeing Board itself and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and Local Authorities 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 requirements across the system. The implications for local providers should be set out clearly for the HWB so that their agreement for the deployment of the fund includes recognition of the service

	change consequences.
2. Protection for social care service (not spending)	Local areas must include an explanation of how local social care service 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 appendix 1.
3. As part of agreed local plans, access to 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 forthcoming national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England will provide guidance on establishing effective 7-day services within existing resources.
4. Better data sharing between health and social care, based on the NHS number	The safe, secure sharing of date 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 will be asked to: • Confirm that they are using the NHS number as the primary identifier for health and care services, and if not, when they plan to; • Confirm that they are pursuing open

	APIs (i.e. systems that speak to eachother); 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, and will make this available alongside the planning template. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by the Department of Health).
5. 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 will be asked to 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.
6. Agreement on the consequential impact of changes in the acute sector	Local areas will be asked to identify, provider-by-provider, what the impact will be in their local area. Assurance will also be sought on public and patient engagement in this planning, as well as plans for political buy-in.

Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**<Name of Local Authority>**
Clinical Commissioning Groups	**<CCG Name/s>**
	<CCG Name/s>
	<CCG Name/s>
	<CCG Name/s>
	<CCG Name/s>
Boundary Differences	**<Identify any differences between LA and CCG boundaries and how these have been addressed in the plan>**
Date agreed at Health and Well-Being Board:	**<dd/mm/yyyy>**
Date submitted:	**<dd/mm/yyyy>**
Minimum required value of ITF pooled budget: 2014/15	**£0.00**
2015/16	**£0.00**
Total agreed value of pooled budget: 2014/15	**£0.00**
2015/16	**£0.00**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	<Name of ccg>
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

<Insert extra rows for additional CCGs as required>

Signed on behalf of the Council	<Name of council>
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

<Insert extra rows for additional Councils as required>

Signed on behalf of the Health and Wellbeing Board	<Name of HWB>
By Chair of Health and Wellbeing Board	<Name of Signatory>
Date	<date>

<Insert extra rows for additional Health and Wellbeing Boards as required>

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

e) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	**Synopsis and links**

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

Please explain how local social care services will be protected within your plans.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

4) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk rating	Mitigating Actions
<Risk 1>		
<Risk 2>		
<Risk 3>		
<Risk 4>		

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**.

Report to Norfolk Health and Wellbeing Board
8 January 2014
Item 11

Report of the Cambridgeshire, Norfolk and Suffolk Joint Health Scrutiny Committee on proposals for Liver Resection Services

Cover Sheet

What is the role of the H&WB in relation to this paper?

A Joint Scrutiny Commitee was set up to receive the formal consultation from NHS England for its proposal to create a single centralised service for liver metastases surgery serving the populations of Cambridgeshire, Norfolk and Suffolk. The Committee has arrived at its conclusions and has made a number of recommendations, including a recommendation to the Health & Wellbeing Board's in each area.

Key questions for discussion

Q.1 What could the Board usefully do which would "add value" – eg how could we stimulate innovative thinking around transport solutions?

Q. 2 Do we understand what the challenges are?

Q.3 How best might the Board take this forward?

Actions/Decisions needed

The Board needs to:

- Consider the recommendation by the Joint Committee that work should take place to explore innovative solutions to transport issues for patients and their families/carers who need to access specialised health care services

Report of the Cambridgeshire, Norfolk and Suffolk Joint Health Scrutiny Committee on proposals for Liver Resection Services

Report of the Head of Planning, Performance & Partnerships, NCC

Summary
This report outlines a recommendation to the Health & Wellbeing Board from the Cambridgeshire, Norfolk and Suffolk Joint Health Scrutiny Committee from its recent review of proposals by NHS England for the reconfiguration of liver resection services affecting patient pathways for the populations of Cambridgeshire, Norfolk and Suffolk.

Action
The Health and Wellbeing Board is asked to:

- Consider the recommendation by the Joint Committee that work should take place to explore innovative solutions to transport issues for patients and their families/carers who need to access specialised health care services

1. Background

1.1 The Cambridgeshire, Norfolk and Suffolk Joint Health Scrutiny Committee was established to receive formal consultation from NHS England on its proposals to create a single centralised service for liver metastases surgery serving the populations of Cambridgeshire, Norfolk and Suffolk.

1.2 The findings and conclusions from the review are set out in the Committee's report (appendix A) along with the Committee's recommendations. A summary of the recommendations is also included at the end of the report (page 15) for ease of reference.

2. Recommendation to the Health & Wellbeing Board

2.1 In scrutinising the proposals, the Joint Scrutiny Committee considered the views of public and patient representatives and issues relating to access to specialised services (sections 60 to 67 of the attached report).

2.2 The Committee noted the recommendations of the External Review Panel report regarding the need to take into consideration the transport needs of a rural and elderly population, especially from the remote areas of the region, given the challenges of distance and limited transport infrastructure. The Committee recognised that this raised a much wider issue, relevant to a number of services and across the whole region, not simply the proposal under consideration.

2.3 In the light of this, the Chairman of the Joint Scrutiny Committee has written to the Chairman of the Health & Wellbeing Board's in all three counties asking if

recommendation 8 could be brought to the attention of the Boards. Recommendation 8 (page 13 of the report) reads as follows:

Recommendation 8

- **To recommend to local authority Health and Wellbeing Boards that work should take place to explore innovative solutions to transport issues for patients and their families/carers who need to access specialised health care services.**

3. Action

3.1 The Health and Wellbeing Board is asked to:

- Consider the recommendation by the Joint Committee that "work should take place to explore innovative solutions to transport issues for patients and their families/carers who need to access specialised health care services"

Officer Contact

If you have any questions about matters contained in this paper please get in touch with:

Name	Tel	Email
Debbie Bartlett	01603 611	debbie.bartlett@norfolk.gov.uk

IN TRAN communication for all

If you need this Agenda in large print, audio, Braille, alternative format or in a different language please contact 0344 800 8020 or 0344 800 8011 (textphone) and we will do our best to help.

Report of the Cambridgeshire, Norfolk and Suffolk Joint Health Scrutiny Committee on Proposals for Liver Resection Services

December 2013

A43

Chairman's Foreword

I would like to thank the members of the Joint Committee for their thorough and focused approach to undertaking this scrutiny. I would also like to thank all the individuals and organisations who have contributed their time, views and experience to the Committee's work. In particular, I would like to thank Professor Derek Manas, Consultant Hepatobiliary and Transplant Surgeon from Newcastle Upon Tyne Hospitals NHS Foundation Trust for coming to Suffolk to contribute his time and experience to assist the Committee as an independent expert clinical witness, which proved to be particularly valuable.

The Committee was established to receive formal consultation from NHS England on its proposals to create a single centralised service for liver metastases surgery serving the populations of Cambridgeshire, Norfolk and Suffolk. The Committee would wish to acknowledge the extensive and detailed process undertaken by the commissioners, initially by NHS Midlands and East Specialised Commissioning Group, and more recently by NHS England (East Anglia) in coming to this point. The Committee has received a significant amount of information, and has covered some complex, and at times controversial, ground in coming to its conclusions and recommendations.

The findings and conclusions from the review are set out in our report below, along with the Committee's recommendations. A summary of the recommendations is also included at the end of the report for ease of reference.

Tony Goldson

Chairman of Cambridgeshire, Norfolk and Suffolk Joint Scrutiny Committee on Liver Resection Services

Report of the Cambridgeshire, Norfolk and Suffolk Joint Scrutiny Committee on Proposals for Liver Resection Services

INTRODUCTION

1. 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.
2. NHS England (East Anglia) has been working on a project to implement a single specialist surgical centre for patients with liver metastases within the boundaries of the Anglia Cancer Network region, which covers people living in Suffolk, Norfolk, Cambridgeshire, and north Bedfordshire.

BACKGROUND

3. The project to establish a single specialist surgical centre for liver metastases has been subject to a lengthy process. This process may have been complicated further by the reorganisation of commissioning arrangements as a result of the implementation of the Health and Social Care Act, mid-process, in April 2013.
4. In 2011, the former Anglia Cancer Network engaged the former Midlands and East Specialised Commissioning Group (SCG) to lead the work needed to review and establish a single specialist surgical centre for liver metastases.
5. A liver metastases 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 lower (90 patients) than the national average. The number of patients recommended by the IOG is 200 patients. At the time, there were five referral pathways for the population in the Anglia Cancer Network region:
    a) Three centres within the network – The Ipswich Hospital Trust, Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUHFT) and Cambridge University Hospitals NHS Foundation Trust (CUHFT) (NB: The Ipswich Hospital has recently stopped their liver resection surgery).
    b) Two centres outside the network – Basingstoke (as part of Hampshire Hospitals NHS Foundation Trust) for the Bedford referral pathway and University Hospitals Leicester for the Peterborough referral pathway
6. The aim of the project is to offer patients the choice of an IOG-compliant service within the Anglia Cancer Network region. It has been recognised that there are other IOG compliant cross border pathways, which some patients currently choose (i.e. Peterborough residents often go to Leicester). It is proposed that current pathways to IOG compliant centres will not change unless patients choose to go to a different centre.
7. In July 2011, an information event was held for all current service providers. It was clear, from discussions and feedback received at that meeting, that there were key areas where further detail and advice on the IOG was needed [Evidence Set 3: 25.9.13]. Most of the feedback received from the clinicians centred on the IOG requirement for services to be based on a population size, as opposed to the number of surgical procedures carried out by each surgeon.

8. In order to ensure that the views of the local clinicians were represented as part of the process, the Project Steering Group took their comments back to 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?

9. Recognising that, as a result of the NCAT review, the service specification and proposal for a single site centre may need revising, the Project Steering Group recommended a three month pause in the project while the review was carried out.

10. In August 2012, the NCAT report was published and recommended that there should be a single site for colorectal liver metastases resection in Anglia [Evidence Set 4: 25.9.13].

11. The process to establish an IOG compliant service recommenced in September 2012.

12. 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.

13. 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 specialists and a patient representative who visited each provider to discuss their service proposal in detail.

14. The External Review Panel submitted their final report to the Project Steering Group on 12 June 2013 [Evidence Set 6: 25.9.13]. The SCG met with both providers in early June 2013 to provide them with feedback on the External Review Panel's recommendations.

15. The report was submitted to the NHS England East Anglia Executive Team on the 18 June 2013, where the recommendations were supported and the on-going process endorsed.

16. 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.

17. 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.

18. NHS England has indicated to the Joint Health Scrutiny Committee that the final ratification of the proposals will be undertaken by the NHS Regional Management Team in January 2014.

TERMS OF REFERENCE

19. Under Section 23 of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, NHS bodies are required to consult health scrutiny on any proposal for a substantial development of the health service or substantial variation in the provision of such a service. Where an NHS body consults more than one local authority, those authorities are required to appoint a joint committee for the purposes of the consultation.

20. Under its terms of reference, the purpose of the Joint Health Scrutiny Committee was:

    a) to consider NHS England's proposal for the reconfiguration of liver resection services affecting patient pathways for the populations of Cambridgeshire, Norfolk and Suffolk, in relation to:

        i) the extent to which the proposals are in the interests of the health service in Cambridgeshire, Norfolk and Suffolk;

        ii) the impact of the proposals on patient and carer experience and outcomes and on their health and well-being;

        iii) the quality of the clinical evidence underlying the proposals;

        iv) the extent to which the proposals are financially sustainable.

    b) to make a response to NHS England and other appropriate agencies on the proposals, taking into account NHS England's intention to ratify the proposals in January 2014.

    c) to consider and comment on the extent to which patients and the public have been involved in the development of the proposals and the extent to which their views have been taken into account.

MEMBERSHIP

21. The membership of the Joint Committee was:-

    Councillor Sarah Adams, Suffolk Health Scrutiny Committee
    Councillor Peter Ashcroft, Cambridgeshire Adults Wellbeing and Health Overview and Scrutiny Committee
    Councillor Michael Chenery of Horsbrugh, Norfolk Health Overview and Scrutiny Committee
    Councillor Adrian Dent, Cambridgeshire Adults Wellbeing and Health Overview and Scrutiny Committee
    Councillor Tony Goldson, Suffolk Health Scrutiny Committee (Chairman)
    Councillor David Jenkins, Cambridgeshire Adults Wellbeing and Health Overview and Scrutiny Committee
    Councillor Alexandra Kemp, Norfolk Health Overview and Scrutiny Committee
    Councillor Margaret Somerville, Norfolk Health Overview and Scrutiny Committee (Vice-Chairman)
    Councillor Tony Simmons, Suffolk Health Scrutiny Committee

APPROACH

22. The Joint Committee was established on a task and finish basis, and the review ran from September to December 2013. Evidence was received over the course of two public meetings consisting of a half day meeting held on 25 September 2013 in Ipswich and a full day meeting held on 29 November 2013 in Bury St Edmunds.

EVIDENCE RECEIVED

23. A full list of the written evidence considered by the Committee over the course of the two meetings can be found at Appendix 1 to this report.

24. During the two meetings, the Committee also heard verbal evidence from the following:

NHS England East Anglia Area Team
Andrew Reed, Director
Carole Theobald, Head of Specialised Commissioning
Pam Evans, Senior Service Specialist

Independent Clinical Expert and Member of the External Review Panel
Professor Derek Manas, Consultant Hepatobiliary and Transplant Surgeon, Newcastle Upon Tyne Hospitals NHS Foundation Trust

Chair of the Liver Metastases Project Group
Dr Rory Harvey, Clinical Director for the Strategic Clinical Network and Chair of the Liver Metastases Project Steering Group

CUHFT Hospital
Lawrence Ashelford, Assistant Director, Planning and Development
Emanuel Huguet, Consultant Hepatobiliary and Transplant Surgeon
Susan Lawrence, Operations Manager, Surgery
Raaj Praseedom, Consultant Hepatobiliary and Transplant Surgeon

NNUHFT
Jo Segasby, Director of Women, Children and Cancer Services
Simon Wemyss-Holden, Consultant General Surgeon

NHS Communications
Jenni Gospel, Head of Operations and Corporate Affairs, North, Midlands and East Communications Services

Clinical Commissioning Groups
Dr Linda Hunter, Member of the Acute Commissioning Board for Norfolk and the Board's Cancer Lead

Patients and Public
Annie Topping, Chief Executive, Healthwatch Suffolk
Alan Stephens, Patient Representative, Together Against Cancer

FINDINGS

The quality of the clinical evidence underlying the proposals;

The NICE Improving Outcomes Guidance (IOG)

25. The Committee was advised that the Improving Outcomes Guidance (IOG) drew on international intelligence that services treating a higher number of patients ensured that individual team members would develop and maintain skills and the team as a whole would become an expert provider of the service. The Colorectal IOG stated that the liver metastases surgical resection service should have a population base of at least 2 million, with all surgery taking place on the site of the trust hosting the specialist multi-disciplinary team (MDT).

26. The Committee was informed there had been significant challenge from both within and outside the cancer network to the IOG used as a basis for the proposal. As a result the National Cancer Action Team (NCAT) had been asked to undertake a review. The Committee wished to be assured as to the extent to which the National Cancer Action Team (NCAT) report had addressed the concerns raised by clinicians [Evidence Set 4; 25.9.13].

27. The Committee was advised the figure of 2 million population was based on the number of operations surgeons were expected to carry out in order to maintain their specialist skills. This was accepted as being 15 operations a year.

28. The Committee found some disparity of views from the clinicians it heard from regarding the basis of the IOG.

29. Clinicians from the NNUHFT expressed a view to the Committee that the population figure of 2 million was an arbitrary figure, selected at a time when there was no nationally available outcome data, and that more up to date data was now available. These concerns had been set out in a letter from the Medical Director of NNUHFT to Professor Sir Bruce Keogh dated 3 November 2011 [Evidence Set 4 – 29.11.13]. It was also suggested that a recent analysis of outcomes from surgery in the UK suggested there was no simple correlation between mortality and population-based commissioning.

30. Clinicians from CUHFT expressed the view there was a need to look at 3 years of follow up data following the development of colorectal cancer, as liver metastases may take 3 years to develop, or lengthy chemotherapy treatment may be needed in order to make surgery possible. This meant that the 2012 data referred to by NNUFHT was not necessarily representative. The point was also made that comparing outcomes from small volume hospitals and those of large volume hospitals made an assumption that the case mix and the types of surgery being offered were the same, which was not necessarily the case.

31. The Committee sought evidence as to the effect on outcomes where services had already been centralised. The Committee heard that, prior to the reconfiguration of services for pancreatic cancer in the Anglia Cancer Network region, mortality rates were 2 to 3 times higher than the national average. This had reduced to a third of the national average post centralisation. The Committee was advised that oesophageal and gastric surgery was one of the earliest specialist services to be reviewed in terms of volumes of surgery undertaken. There were originally 10 sites in the East of England performing this surgery and since centralising the service there had been a 10% improvement in mortality rates.

32. In order to clarify this further, the Committee sought additional evidence in respect of outcome data for pancreatic resections, pre and post centralisation [Evidence Set 2: 29.11.13]. The Committee noted that the data provided clearly demonstrated there had been improvement in most outcome measures for pancreatic resections since this service had been centralised. With regard to the number of patients receiving surgery, 77.4 operations per year were conducted prior to centralisation and this had risen to 109 operations per year post centralisation. The Committee questioned the extent to which these improvements may have been down to other factors, such as improvements in training and medical techniques over the period in question. The Committee explored this issue further with Professor Derek Manas, who had been invited to provide independent expert clinical advice to the Committee. Professor Manas confirmed that although many improvements in training and techniques would have been made over the period, the centralisation of a service would improve structure and processes. A bigger service would enable better assessment and better processes to be available if something went wrong, all of which would lead to improved outcomes for patients.

33. The Committee sought information as to whether NHS England could only commission an IOG compliant service. Representatives from NHS England confirmed that although there was not a statutory requirement to commission only IOG compliant services, this was the current practice. NHS England advised that they had inherited the current position from the former

NHS Midlands and East Specialised Commissioning Group. NHS England had a process for defining and reviewing which services did not meet standards. It was confirmed that not every service currently met standards. Those that did not were taking advice on how to improve, or deciding they would no longer deliver those services.

National Cancer Intelligence Network (NCIN) Outcomes Data

34. The Committee sought clarification on information presented in the written evidence stating that, whilst both centres did have acceptable outcome data, both centres were under performing with respect to expected volumes of activity [Evidence Set 4; 25.9.13].

35. Again, the Committee found a degree of disparity of clinical views around the data presented to it.

36. The Committee received NCIN data suggesting that the rate of resections for liver metastases in patients whose colorectal cancers were operated on at CUHFT was well below the 4% national average, at 1.7%, and significantly lower than the rate at NNUHFT.

37. The Committee heard evidence from CUHFT that CUHFT had contested the NCIN figure of 1.7% as this did not reflect the hospital's own records that the rate was over 5%. CUHFT had contacted the NCIN, and the discrepancy between the two sets of data had been confirmed. Initially it was thought this may have been the result of a coding error at CUHFT but this had since been explored and ruled out by the hospital. It was unclear from the evidence available to the Committee as to why the data discrepancy had arisen.

38. The Committee expressed concern that data which had been presented appeared to be flawed and wished to receive absolute assurance as to how this would be rectified, particularly given that reports from NCIN were one of the mechanisms by which the quality and success of the reconfigured service would be reported. The Committee also sought assurance about the extent to which the process of developing the proposals may have relied upon the NCIN data.

39. NHS England confirmed that the data underpinning the process had been provided by the National Cancer Registry Service and that NCIN data had therefore not been relied upon as part of the decision making process. However, the Committee felt it was important that clarity be sought about the current resection rates for each of the hospitals in the Anglia Cancer Network Region in order to understand the implications of this.

Recommendation 1

To ask the Chairman to write, as a matter of urgency, to NCIN to outline the Committee's serious preliminary concerns regarding the reported inaccuracy of the NCIN data relating to the numbers of patients resected for liver metastases and seeking an urgent response to the following:-

a) **the reason for the discrepancy in the published NCIN data on liver resection numbers and rates and what will be done to rectify this;**

b) **clarification of the correct resection numbers and rates and any consequent adjustment of statistical data for each of the hospitals in the Anglia Cancer Network region.**

Recommendation 2

To recommend to NHS England that referral and resection rates, mortality and readmission rates be audited after one year of implementation and the results reported back to the respective local authority health scrutiny arrangements.

The extent to which the proposals are financially sustainable

40. The Committee was informed that treatment at local hospitals would be commissioned by the relevant Clinical Commissioning Group and the part of the pathway relating to the specialised surgery would be commissioned by NHS England. From the perspective of NHS England, a single centre would be easier to commission and its performance would be easier to monitor. The proposed reconfiguration would provide a single team which would be commissioned in order to drive the positive changes needed.

41. With regard to the cost of reconfiguration, representatives from NHS England advised that commissioners used a fixed tariff per patient payment system and therefore costs of the reconfigured service per patient would be the same as they were currently. When asked for clarification on any capital costs associated with transition, assurances were given that it would be cost neutral with no additional capital costs. If there were to be any additional costs, this would be in pursuance of better outcomes for patients. The amount payable to the hospital would rise as more patients were treated.

42. A member of the Committee questioned how CUHFT would deal with the growth in the number of patients anticipated, and asked whether this had been considered in the business plans. NHS England confirmed that the External Review Panel had been convinced by the explanation CUHFT had provided that the hospital had the capacity to deliver the single centre. Representatives from the hospital advised that the theatre staff were already in place, the two Hepato Pancreato Biliary (HPB) consultant surgeons were already in place, and the other two members of the team were still required.

43. The Committee asked about the implications for the NNUHFT of losing tariff. It was acknowledged that this was a challenge for the provider and would need to be dealt with by the hospital. NNUHFT advised that, if the hospital were to lose its liver resection services, this could potentially destabilise the provision of colorectal services. The hospital was also currently managing liver trauma.

The extent to which the proposals are in the interests of the health service in Cambridgeshire, Norfolk and Suffolk;

External Review Panel Recommendations

44. The Committee received independent clinical evidence from Professor Derek Manas. Professor Manas also spoke to the Committee in his role as a member of the External Review Panel which had assessed the bids from the two hospitals to run the service.

45. The Committee wished to establish clarity around how the External Review Panel had assessed the bids to provide the service. Professor Manas explained that the External Review Panel had been asked to assess, if a single centre were established, which hospital would be best placed to provide this. Both hospitals had had an opportunity to put their views to the Panel. Professor Manas outlined the External Review Panel report, and the reasons for recommending CUHFT as the single centre.

46. The Committee sought a view from Professor Manas regarding the reasons for not giving consideration to developing a single MDT but retaining two surgical sites. The Panel had discussed a model of CUHFT as the HPB site with a separate metastatic centre at NNUH, but had felt there were significant advantages of co-location with other HPB services. This was also in keeping with the national direction for liver and cancer services. The Committee heard that to retain two surgical sites and a single MDT would require very good working relationships. Both sites would need to operate in exactly the same manner, under strict rules The concern would be what would be replicated on the second site. This model had been known to work occasionally, in a few cases and there had been some issues If surgeons were

based on two sites, the question was whether they would carry out the instructions of the MDT. There would need to be very clear rules, agreed and adhered to by the clinicians, about which cases would be undertaken on which site. The benefit of a single surgical site was that surgeons would have the clinical support around them to enable them to take risks so that patients on the margins of operability could get the benefit of surgery. Professor Manas emphasised that consideration needed to be given to the number of patients getting access to the surgery. A single surgical centre would be in a position to build expertise and to provide extra-ordinary techniques, as all the resources would be in one place.

47. The Committee agreed that a single centre model consisting of an expert MDT would be in the best interests of the population of the three counties. The Committee acknowledged that a single expert MDT with responsibility for assessing all suspected cases of liver metastases across the network, and making decisions about whether or not the patient was operable, would improve consistency and would potentially enable more patients to receive life-saving surgery who may otherwise not have been considered for surgery, for example due to the complexity of the operation required. The Committee heard that by having a single centralised MDT, every possible patient would be considered by a single team focused on what is medically possible and with the best levels of knowledge and expertise available as medical possibilities improve.

48. The Committee heard from commissioners that the benefits of a single surgical site were that the single MDT would be in a position to provide highly specialised techniques, that communications would be simpler, that surgeons would become more expert in the field by undertaking more operations, and that a single surgical centre would create more efficient use of equipment and resources.

49. The Committee was not convinced that the benefits referred to could not be achieved by implementing a single centralised MDT operating over two surgical sites and felt there were some clear advantages in retaining two surgical sites, particularly in terms of geographical access for patients and their families and carers in what is a rural, dispersed population served by poor transport infrastructure. A two surgical centre model would support greater patient choice. The Committee was of the opinion that the critical factor in the effectiveness of the arrangements would be the process of developing leadership and communication by the MDT, rather than the need for a single surgical site. Retaining some level of surgical service at the NNUFHT would also protect the specialisms necessary in a regional teaching hospital to maintain the high standards of care in the management of other conditions requiring liver expertise.

Recommendation 3

To confirm the Committee's support of the commissioner's intention to improve outcomes for patients requiring liver resection surgery in the Anglia Cancer Network region by implementing a single centralised model for liver metastases, encompassing a single MDT, assessment and referral process with a view to maximising referrals and improving outcomes (*subject to Recommendation 4)*.

Recommendation 4

To recommend to NHS England that two surgical sites be retained, under the management of the single centralised MDT, and kept under review, in order to assess the viability of the single team working across two surgical sites for the long term.

<u>The views of Clinical Commissioning Groups (CCGs)</u>

50. All Clinical Commissioning Groups across Cambridgeshire, Norfolk and Suffolk were invited to submit their views to the Committee.

51. The Committee received a copy of correspondence (30.01.13) from Dr Cath Robinson, Chair of the Central Norfolk Acute Commissioning Board, the collaborative body for North Norfolk,

Norwich and South Norfolk CCGs, to the Chief Operating Officer, [former] Midlands and East Specialised Commissioning Group, setting out strong support for the NNUHFT bid to continue to provide a surgical service for metastatic liver disease [Evidence Set 6; 29.11.13].

52. The Committee heard from Dr Linda Hunter, member of the Acute Commissioning Board for Central Norfolk. Dr Hunter outlined concerns about the additional difficulties patients would face in travelling to a centralised service, and expressed the view that, given the service at NNUHFT is already good, it would be difficult to explain to patients why they should have to travel further afield. Dr Hunter explained that the Board would support a single MDT, and two surgical sites.

53. Representatives from NHS England highlighted that the NHS East of England Specialised Commissioning Group (which had been responsible for commissioning the service at the beginning of the process) had been made up of Primary Care Trusts (PCTs) and therefore all PCTs had been involved and had supported the proposal to move to a single centralised service at the beginning of the process.

54. No further representations were received by the Committee from the Clinical Commissioning Groups.

Recommendation 5

To ask NHS England to provide evidence to demonstrate whether or not Clinical Commissioning Groups in the three counties are supportive of the proposal.

The views of Referring Hospitals

55. The Committee sought comments from all hospitals within the counties of Cambridgeshire, Norfolk and Suffolk. Other than the evidence and comments received from CUHFT and the NNUHFT hospitals, the only response received was from the Peterborough and Stamford Hospitals NHS Foundation Trust setting out its position as wishing to keep its current relationship with the Hepato-Biliary Department at Leicester [Evidence Set 5; 29.11.13].

56. Despite receiving verbal assurances from NHS England that the clinicians involved would wish to work together in the best interest of the patients, the Committee was concerned that no hospitals, other than those detailed, had indicated their support, or otherwise, to the Committee on the proposals.

57. The Committee was aware of the vital importance of the hospitals within the network being supportive and willing and able to work together to the success of the proposals.

Recommendation 6

To ask NHS England to provide evidence to demonstrate whether or not referring hospitals in the three counties are supportive of the proposal.

The impact of the proposals on patient and carer experience and outcomes and on their health and well-being

Communication and Engagement

58. The Committee received written evidence regarding the proposed communications and engagement plans for the project [Evidence Sets 9/10; 29.11.13]. The Committee heard that some patient engagement had already take place. Discussions with clinicians and hospital chief executives had also taken place but the public engagement exercise would not start in full until the implementation commenced in early 2014. The engagement would last for 12 weeks and comments received would inform plans going forward. The public engagement would consist of a mix of discovery events combined with visits to targeted patient groups. The Committee was pleased to note that discussion had been taking place with Healthwatch to help

inform this work and to identify existing groups and networks of people who may have an interest.

59. The Committee noted that wider public engagement had not commenced. The Committee felt that ongoing dialogue with the public and patients, and particularly with rural communities, was important to enable NHS England, as the commissioner, to fully understand how rural communities in the East of England are affected by the need to travel to access specialised health services.

Recommendation 7

That public engagement work should include strategies to engage with urban and rural communities, giving particular focus to assessing the impact upon rural communities.

The views of Public and Patient representatives

60. The Committee received a joint report from Healthwatch Suffolk, Healthwatch Cambridge and Healthwatch Norfolk presented by Annie Topping, Chief Executive of Healthwatch Suffolk. Healthwatch had undertaken an engagement exercise consisting of two components:- a questionnaire survey for hospital inpatients at CUHFT and NNUHFT and another for the general public, and telephone interviews. A total of 159 people had responded to the two surveys and six people were interviewed.

61. The Committee heard from a patient representative from Together Against Cancer that he had been a member of the Strategy Group and had been involved with the process since the beginning. He felt that, as the patient representative, his views had been listened to but that they had not been taken into account. He expressed a view that little consideration had been given to the option of keeping two centres.

62. Five emails were received by the Chairman of the Committee from individual public and patients in respect of the proposals. All correspondents had received treatment at the NNUHFT and were supportive of retaining a service at the hospital. A further theme arising from the correspondence was a concern around the problems faced finding suitable transport to Cambridge, for patients and their families, and the additional strain on health and general wellbeing this may cause.

Access to specialised services

63. The Committee heard that every patient who was diagnosed with liver metastasis that could benefit from surgery would be given a choice as to which accredited centre they wished to attend to receive treatment.

64. The Committee felt that the access issues faced by an urban population of 2 million were very different from a population of 2 million spread over rural East Anglia and in this sense, the one-size fits all approach of the IOG was not helpful. The Committee noted the recommendations of the External Review Panel report regarding the need to take into consideration the transport needs of a rural and elderly population, especially from the remote areas of the region, given the challenges of distance and limited transport infrastructure. The Committee also recognised that this raises a much wider issue, relevant to a number of services and across the whole region, not simply the proposal under consideration.

65. The Committee received details of the Norfolk and Suffolk Eligibility Criteria for Non-Emergency Patient Transport Services (September 2011) [Evidence Set 12; 29.11.13] and information about the Healthcare Travel Costs Scheme [Evidence Set 13; 29.11.13] which provides those who qualify with help with travel costs to attend hospital. The Committee noted that the provision of non-emergency patient transport was the responsibility of the Clinical Commissioning Groups.

66. The Committee also received examples of public transport journeys to both CUHFT and NNUHFT from randomly chosen locations in the three counties [Evidence Sets 14 A, B and C;

29.11.13]. The Committee noted the complexity of using public transport options to attend CUHFT or the NNUHFT from rural locations in the region and the issues this may cause for people without their own transport needing to visit family members in hospital. In particular, the need to attend appointment or visiting times early or late in the day could often require an overnight stay in order to access the public transport options available.

67. The Committee also noted a number of comments from patients and members of the public, both evidenced by Healthwatch and individuals, about the importance of family members being able to visit sick relatives, and to provide support at a difficult time.

Recommendation 8

To recommend to local authority Health and Wellbeing Boards that work should take place to explore innovative solutions to transport issues for patients and their families/carers who need to access specialised health care services.

<u>The patient pathway and improving referrals</u>

68. The Committee heard that centralisation would rely upon a network of hospitals working together, where hospitals were seen as equal partners undertaking different pieces of work along the patient pathway, and wished to understand how this might work in practice.

69. In response to councillors' concerns regarding the current low referral rate, the Committee was advised there was a need to improve consistency and knowledge amongst local hospitals about current best practice in the field and that keeping local hospitals up to date with the latest developments in treatments was currently a challenge.

70. The Committee heard that, since pancreatic resection services had been centralised, the numbers of patients had increased. MDTs discussed 50 to 60 patients per week and the outcomes from those meetings were sent electronically to referring centres and subsequently detailed letters were dictated and sent by post. All patients were provided direct contact details for a specialist nurse.

71. The Committee heard from CUHFT that, in centralising the pancreatic resection service, clinicians from CUHFT had visited all the referring hospitals (with the exception of NNUHFT initially) to talk about how the new system would work. A lead person was designated in each hospital and pathways and guidelines for the new service were discussed. All suspected cases were considered over a video link and the expert team at CUHFT made the decision as to which cases were operable. Discussion with the NNUHFT and Ipswich hospitals had not taken place until CUHFT had been given the mandate to take on the single centre service in 2010.

72. It was evident that the process to select the proposed single centre had put CUHFT and the NNUHFT in competition with one another. The Committee wished to receive assurance as to how well the two hospitals might work together in a networked service. The Committee heard that, once the final proposals were agreed, that the clinicians in the service would work together in the best interests of the patient.

73. Representatives from CUHFT advised that for the liver metastases service, it was proposed that weekly MDT meetings would take place with the referring hospitals. Guidelines would be produced and standardised for the whole network. Decisions made during MDT meetings would be either resection surgery or downsizing the tumour via chemotherapy. If surgery was required, patients would then be referred to CUHFT for assessment and surgery. It was confirmed that patients did not attend the MDT meetings.

74. The External Review Panel report highlighted that ensuring engagement of all referring units would be key to the success of the centralised service. The report had found evidence of a lack of emphasis in encouraging communication between the proposed centre and the referring local MDTs.

75. Representatives from NHS England stressed that as no final decision had been made about where the single centre would be based, work towards implementation could not take place until this decision had been made. NHS England advised that there was still a significant amount of work to be done in terms of wider network engagement.

76. The Committee acknowledged that the ability of the hospitals within the network to work together would be critical to ensuring the arrangements worked in the best interests of the patient.

Recommendation 9

To strongly recommend to NHS England as the commissioner that the provider should be required to demonstrate significant two way dialogue is taking place with all referring hospitals with immediate effect, about the proposal and next steps towards implementation.

Recommendation 10

To recommend to NHS England as the commissioner that the provider should be required to demonstrate, as part of the contract terms, what steps it is taking to improve consistency and knowledge amongst local hospitals about current best practice in the field and the latest developments in treatments on an ongoing basis.

SUMMARY OF RECOMMENDATIONS

Recommendation 1: To ask the Chairman to write, as a matter of urgency, to NCIN to outline the Committee's serious preliminary concerns regarding the reported inaccuracy of the NCIN data relating to the numbers of patients resected for liver metastases and seeking an urgent response to the following:-

a) the reason for the discrepancy in the published NCIN data on liver resection numbers and rates and what will be done to rectify this;
b) clarification of the correct resection numbers and rates and any consequent adjustment of statistical data for each of the hospitals in the Anglia Cancer Network region.

Recommendation 2: To recommend to NHS England that referral and resection rates, mortality and readmission rates be audited after one year of implementation and the results reported back to the respective local authority health scrutiny arrangements.

Recommendation 3: To confirm the Committee's support of the commissioner's intention to improve outcomes for patients requiring liver resection surgery in the Anglia Cancer Network region by implementing a single centralised model for liver metastases, encompassing a single MDT, assessment and referral process with a view to maximising referrals and improving outcomes (*subject to Recommendation 4)*.

Recommendation 4: To recommend to NHS England that two surgical sites be retained, under the management of the single centralised MDT, and kept under review, in order to assess the viability of the single team working across two surgical sites for the long term.

Recommendation 5: To ask NHS England to provide evidence to demonstrate whether or not Clinical Commissioning Groups in the three counties are supportive of the proposal.

Recommendation 6: To ask NHS England to provide evidence to demonstrate whether or not referring hospitals in the three counties are supportive of the proposal.

Recommendation 7: That public engagement work should include strategies to engage with urban and rural communities, giving particular focus to assessing the impact upon rural communities.

Recommendation 8: To recommend to local authority Health and Wellbeing Boards that work should take place to explore innovative solutions to transport issues for patients and their families/carers who need to access specialised health care services.

Recommendation 9: To strongly recommend to NHS England as the commissioner that the provider should be required to demonstrate significant two way dialogue is taking place with all referring hospitals with immediate effect, about the proposal and next steps towards implementation.

Recommendation 10: To recommend to NHS England as the commissioner that the provider should be required to demonstrate, as part of the contract terms, what steps it is taking to improve consistency and knowledge amongst local hospitals about current best practice in the field and the latest developments in treatments on an ongoing basis.

APPENDIX 1

The following written evidence was received by the Committee on 25 September 2013:

Evidence Set 1	Anglia Cancer Network Liver Metastases Project Steering Group Terms of Reference
Evidence Set 2	Liver Metastases Data
Evidence Set 3	Liver Metastases - Information Event: 11 July 2011 – Q&A
Evidence Set 3A	Information Day Presentation Material
Evidence Set 3B	Information Day Presentation Material – Designation Process and Timetable
Evidence Set 4	National Cancer Action Team Report on the Configuration of surgical services in Anglia for patients with colorectal liver metastases
Evidence Set 5	Rates of Patients Resected for Liver Metastases – Major Centres and East Anglia
Evidence Set 6	Anglian Region Metastatic Liver Resection Service – Report of the External Review Panel Visit: May 2013
Evidence Set 6 Appendix 1	External Review Panel Membership
Evidence Set 6 Appendix 2	External Review Panel (ERP) – Terms of Reference
Evidence Set 6 Appendix 3	Liver Metastases Service Criteria
Evidence Set 6 Appendix 4	External Review Panel - Itinerary
Evidence Set 6 Appendix 5	External Review Panel Attendance – NNUHFT
Evidence Set 6 Appendix 6	External Review Panel Attendance – Cambridge UHFT
Evidence Set 6 Appendix 7	External Review Panel Scoring – NNUHFT
Evidence Set 6 Appendix 8	External Review Panel Scoring – Cambridge UHFT
Evidence Set 6 Appendix 9	Extract of Presentation to External Review Panel by NNUHFT
Evidence Set 7	Equality Impact Assessment for Liver Metastases
Evidence Set 8	Mortality Data – Bid Hospitals
Evidence Set 9	Mortality Data – Major Centres
Evidence Set 10	Readmissions – Bid Hospitals
Evidence Set 11	Commentary on Data – CUHFT
Evidence Set 12	British Journal of Surgery Article - Surgical management and outcomes of colorectal cancer liver metastases

The following written evidence was received by the Committee on 29 November 2013:

Evidence Set 1	"Liver Metastases Data for East Anglia 2007 – 2011" - provides the data requested by the Committee on 25 September 2013 in relation to where patients receive treatment, in whole numbers rather than percentages.
Evidence Set 2	"Pancreatic Resections Outcome Data for Joint HOSC" as requested by the Committee on 25 September 2013.
Evidence Set 3	Letter from CUHFT to Dr Rory Harvey regarding liver resection rates for CUHFT
Evidence Set 4	Letter from NNUHFT to the Chairman of the Joint Health Scrutiny Committee.
Evidence Set 5	Letter from Peterborough and Stamford Hospitals to the Joint Health Scrutiny Committee
Evidence Set 6	Letter on behalf of the Central Norfolk Acute Commissioning Board to Midlands and East Specialised Commissioning Group dated 30 January 2013
Evidence Set 7	Report for the Joint Health Scrutiny Committee from the East of England Area Team setting out the response to the Committee's Key Areas for Investigation.
Evidence Set 8	"Proposed Example Implementation Plan for Liver Metastases IOG in East Anglia", setting out the key areas the Area Team would expect to be included in the final provider plan.
Evidence Set 9	East of England Area Team - Communications and Engagement Plan.
Evidence Set 10	East of England Area Team – Engagement Summary
Evidence Set 11	Healthwatch Suffolk, Cambridge and Norfolk – Questionnaire
Evidence Set 12	NHS Norfolk and NHS Suffolk Eligibility Criteria for Non Emergency Patient Transport Services (NEPTS) – September 2011.
Evidence Set 13	Information about the Healthcare Travel Costs Scheme
Evidence Set 14 (A, B, and C)	Examples of public transport journeys to attend 1 hour appointments at CUHFT and NNUHFT at 9.00am, 12.00 noon and 3.00 pm Information provided by local authority passenger transport officers. Starting locations chosen at random.

APPENDIX 2: Glossary of Terms and Abbreviations

CCG	Clinical Commissioning Group
Colorectal	Colorectal surgery is a field in medicine dealing with disorders of the colon, anus and rectum
CUHFT	Cambridge University Hospitals NHS Foundation Trust
IOG	Improving Outcomes Guidance (from NICE – the National Institute for Health and Care Excellence)
Liver metastases	Cancerous tumours that have spread from elsewhere in the body to the liver
Liver resection	Surgical removal of all or a portion of the liver (also referred to as hepatectomy)
MDT	Multi Disciplinary Team
NICE	National Institute for Clinical Excellence
NCAT	National Cancer Action Team
NCIN	National Cancer Intelligence Network
NEPTS	Non-Emergency Patient Transport Service
NNUHFT	Norfolk and Norwich University Hospitals NHS Foundation Trust
PCT	Primary Care Trust
SCG	Specialised Commissioning Group