CLINICAL COMMISSIONING East of England JIP SUPPORT PROJECT

NETWORK BULLETIN – No 13 – 25th May 2012

CLINICAL COMMISSIONING East of England JIP SUPPORT PROJECT Joint Commissioning & Partnership
Project lead: David R Jones davronjones@yahoo.co.uk Mobile: 07860 780616
• Establishing a network; Mapping current joint commissioning; Comparing with national information; Facilitating knowledge sharing; Developing advice; Identifying infrastructure requirements to underpin partnership work & joint commissioning

In this Bulletin – David Jones

Welcome to the 13th Network Bulletin for the East of England.

This project on Clinical Commissioning has a particular focus on joint commissioning & partnership. The work stream is now led by Harold Bodmer, Norfolk's DASS.

The main themes are summarised above after my contact details and include knowledge transfer with clinical partners, Governance arrangements in the new world and Infrastructure to support partnership. The work fits with the national commissioning priorities; including clinical commissioning development & preparing for direct commissioning.

This is the first edition since the Health and Social Care Act 2012 became law. This provides some clarity on the tasks ahead although there are still a number of uncertainties facing Health and Social Care. The Bulletin should provide some assistance through sharing information and stimulating local dialogue.

Items in this edition include:

- Health and Wellbeing Boards – national & regional updates
- CCG development + authorisation
- Healthwatch transition including Healthwatch Essex
- Safeguarding fragmentation fears voiced
- Public Health transition update
- News from Erpho
- Organisational & performance programme including local accounts & sector led improvement
- The EACH project update

NHS Midlands & East has as one of its ambitions
Ensure radically strengthened partnerships between the NHS and local government, which accelerate the integration of services to improve the health & wellbeing of local people

Health and Wellbeing Boards

It is less than a year until Boards need to be fully operational. Generally, the shadow arrangements seem to be proving useful in developing relationships and governance as well as progressing work on refreshing Joint Strategic Need Assessments and on the Joint Health and Wellbeing Strategies.

National ……

A National Learning and Sharing Summit was held on April 24. The products developed by the learning sets are now available on the Knowledge Hub online portal.

If you were already registered on the Communities of Practice website you can use your same user name and password to access the Knowledge Hub. The documents are uploaded within the Groups section, under the 'National Learning network for Health and Wellbeing Boards' group. Within that group's section, there is a forum for 'Health and Wellbeing Board Learning Set Products'.

If you have any questions, please contact lola.Olawole@dh.gsi.gov.uk or david.harrison@dh.gsi.gov.uk

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The King's Fund Information and Library Service produces a monthly bulletin focused around Health and Wellbeing Boards. It will contain the latest news, guidance and policy developments and will be useful for anyone interested in, or working with, Health and Wellbeing Boards. If you would like to subscribe, email HWB@kingsfund.org.uk

The King's Fund Ideas that change health care

If you have any colleagues who are interested in signing up to their alert, they can do so at www.kingsfund.org.uk/alerts. The alert is also available as an RSS feed or follow them on Twitter @kingsfund_ils

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Some key points from recent national meetings:

- HWBs should be ambitious, providing the strategic leadership to deliver transformation, promoting integration and tackling the 'wicked issues'
- The currency of the boards will be leadership and influence, not managerial control.
- The board should be the glue that holds the parts of the local system to account
- Promote collaborative leadership by spending time understanding the roles and responsibilities of board members
- 'Hard wire' public engagement in prioritising, planning & delivering
- Remember the power of case studies & stories in deciding priorities & evaluating effectiveness
- It is not what is done in the meetings but how members work together to improve the health & wellbeing of their population
- When planning developmental programmes remember the 'new kids on the block' - some of the core members will be from organisations still developing e.g. Clinical Commissioning Group, National Commissioning Board, HealthWatch and Director of Public Health

A recent King's Fund study found the overwhelming majority of HWBs have no representation from acute providers. This is perhaps not a surprise if they are seen as commissioning bodies but a challenge will be how to involve health and social care providers in the redesign of local services which improve health and wellbeing.

One-off responsibilities
During the transition to new local structures, shadow Health and Wellbeing Boards will have a number of important 'one-off' duties to perform. One of these will be to give comments during the authorisation process of Clinical Commissioning Groups,* providing a view to the NHS Commissioning Board of the CCG's level of engagement with local communities and organisational partners. Another is the transfer of public health responsibilities from the NHS to the local authority. Both of these responsibilities are good opportunities for each board to establish the role it wishes to take in the health and care system - strengthening partnerships, offering support to member organisations and leading the focus on improving the lives of local people.
* Part of the 360 degree survey - see CCG update later in the Bulletin

Expected soon:

- JSNA guidance
- Secondary regulations relating to HWBs
- A self-assesment tool being developed through the LGA

In the East of England……..

A **learning set** for development leads across the East of England meets every two months. At the last meeting on 11th May, items included the preparedness survey and support offers (see below), an update on CCGs, children's and young people's issues and governance. It is planned that the July session will cover CCG authorisation, governance & unitary councils, links with other partnerships, HealthWatch and the self-assessment / another preparedness survey.

A survey of HWB preparedness was undertaken at the end of February / early March. Returns were received from 11 areas. Most have self –assessed as 'making real progress' but not surprisingly the following were identified are requiring more development:

- Member development
- Links with other partnership boards
- Involving HealthWatch
- Engaging with patients and the public

Support for Health & Wellbeing Board development is available from a number of different sources

Support from the LGA

- Simulation event run by University of Birmingham on Tuesday 4 September 2012 which will bring together HWB members to work together around a scenario/series of scenarios. The boards will be observed to look at how they work together in making difficult decisions and tough choices. Each board will receive feedback from the observers and an opportunity to take part in an action planning session at the end of the workshop. The 11 boards should send a minimum of 4 and a maximum of 7 board members, including a councillor and CCG member.
- Leadership programme for lead Members for Health – through the Adult Social Services and Health Portfolio Holders Network. Funding will be devolved to East of England LGA to deliver this support.

- Development of an Integration event in September focussing on understanding different cultures and approaches to commissioning for CCGs and LAs and 'What does good look like?' looking at pioneering areas.
- Bespoke support for individual boards to be agreed with LGA (available up to September 2012)

For support requests / further information contact David Jones davronjones@yahoo.co.uk

Support from NHS Leadership academy

- The NHS Leadership Academy is offering a bespoke approach to senior leadership development for a select number of Health and Wellbeing Boards. This offer will vary according to need, but probably 3 days expert support and development work with the board to establish positive ways for the board members to work together.
- This is a unique opportunity for a select number of boards to access expert leadership development that either focuses on the board as a whole or could focus on a subsection of the board, for example to develop leadership capacity across health and social care.
- The facilitators available for this programme have all worked on place based initiatives and have an understanding of the democratic leadership required to deliver broad based health and wellbeing to a community. They are members of a faculty commissioned specifically to work with our most senior leaders and offer deep leadership expertise, focused on collaborative working across the health and care system. (The facilitators come from a range of organisations - e.g. John Deffenbaugh is from Frontline, Eden Charles is from People Opportunities, Laurie McMahon is from Loop2).
- The offer is aligned to the Leadership Academy's HWB support programme and the DH/LGA national development offer and has a particular emphasis on enabling those boards who want additional support to either bring board members up to a level playing field or develop advanced skills.
- We anticipate that any Board wishing to take advantage of this offer will agree the exact nature of the support they require with their facilitator, thus ensuring it reflects local leadership development priorities. The type of support that could be provided ranges from helping develop ways of working; creating vision and values; looking at leadership approaches to tackling "wicked issues"; using psychometrics to help the Board build awareness of the leadership skills that each member brings - and to do this at pace to enhance Board effectiveness

If you want to discuss this offer further please contact Deborah McKenzie, Programme Director, Leadership Development for Public Health and Social Care, Deborah.mckenzie@dh.gsi.gov.uk or Tel: 07919 045177

Highlights from the Future Forum's second phrase report on **Integration**:

- Integration should be defined around the patient, not the system – outcomes, incentives and system rules (i.e. competition and choice) need to be aligned accordingly.
- Health and Wellbeing Boards should drive local integration – through a whole-population, strategic approach that addresses local priorities.
- Local commissioners and providers should be given freedom and flexibility to 'get on and do' – through flexing payment flows and enabling planning over a longer term.

Clinical Commissioning Group Developments

On 4 April 2012 draft guidance was released by the NHS Commissioning Board (NHSCB) (see towards the end of the Bulletin under 'links to recent publications') which builds on Developing Clinical Commissioning Groups: Towards authorisation; this was published on 30

September 2011 and is designed to enable aspiring CCGs to prepare their application and determine the timing of their application for authorisation. It is intended to help CCGs develop clear plans to progress through the authorisation process and become an established CCG with full commissioning authorisation.

The guidance sets out the timetable for applications in **four waves: starting in July, September, October and November 2012**. Final guidance will be published by the NHSCB following the publication of secondary legislation on authorisation by the government. The draft guidance reflects the current legal position.

Principles

The CCG authorisation process recognises that CCGs are new, clinically-led organisations coming into being for the first time. However, CCGs must ensure they meet safe thresholds to assume their full statutory responsibilities. Authorisation is not to be seen as an end in itself, but as a first step on a journey towards continuous improvement.

Content

CCGs will be assessed through six domains to provide assurance that they can safely discharge their statutory responsibilities for commissioning healthcare services. The domains are also intended to encourage CCGs to be organisations that are clinically led and driven by clinical added value:

Domain 1: A strong clinical and multi-professional focus which brings real added value.
Domain 2: Meaningful engagement with patients, carers and their communities.
Domain 3: Clear and credible plans which continue to deliver the QIPP challenge within financial resources.
Domain 4: Proper constitutional arrangements with the capacity and capability to deliver all their duties and responsibilities.
Domain 5: Collaborative arrangements for commissioning with other CCGs, local authorities and the NHSCB as well as appropriate commissioning support.
Domain 6: Great leaders who individually and collectively make a real difference.

Process

The authorisation process proposes that applicant CCGs will move through three distinct phases of activity – Pre-application, Application and NHSCB assessment.

Pre-Application: As part of their preparation, emerging CCGs will begin to assemble the evidence required for submission.
Application: Each aspiring CCG will need to submit an application form to the NHS Commissioning Board. The form will: set out some factual detail about the applicant CCG, list the evidence the applicant CCG is submitting to accompany its application and enable the CCG to declare compliance/self-certify with certain criteria for authorisation.
NHSCB assessment: The formal assessment will be based on the evidence gained from several key components including: 360 degree survey, desk-top reviews, case studies and site visits.

Outcomes

There are three possible outcomes to the decision on authorisation for each applicant CCG:

a) authorised,
b) authorised with conditions,
c) established but not authorised to commission (in which case, commissioning of health services for the CCG's population will be conducted by the NHS Commissioning Board).

All CCGs will have a development plan agreed with the NHSCB which reflects the outcome.

The latest in the East of England…..

The NHS Commissioning Board has recently confirmed the timescale for authorisation.

3 CCGs in wave one; Bedfordshire, East & North Hertfordshire and Great Yarmouth & Waveney

3 in wave two; Cambridgeshire & Peterborough, Herts Valleys and North East Essex

7 in wave three; Luton, Mid Essex, North Norfolk, Norwich, South Norfolk, West Essex and West Norfolk

6 in wave four; Basildon & Brentwood, Castle Point & Rochford, Ipswich & East Suffolk, Southend, Thurrock and West Suffolk

Commissioning Support

In the last Bulletin information was given on a stocktake letter sent to local authority Chief Executives: 'The results of this commissioning support stocktake show that there is more to do. All CCGs have been asked to have a further dialogue with local authorities to work through the design of joint place based commissioning arrangements alongside the arrangements for Commissioning Support Services, taking into account the key issues raised in the local stocktake return and to produce a joint vision and a joint plan around integrated/aligned commissioning.' (Extract from letter of 14 May 2012 from Moira Dumma & David White).

Healthwatch transition – May 2012

By Claire Ogley, East of England Healthwatch transition project lead
Claire.ogley@enableeast.org.uk Tel: 07533 025751

Local Healthwatch regulations: The DH has begun engagement with major stakeholders on regulations for Local Healthwatch. This will end in mid-June, with details emerging on what's likely in the regulations by July although they won't be formally published until October.

The regulations – or 'secondary legislation' will cover issues such as:

- With whom can a local authority contract
- Contracts between local Healthwatch and its subcontractors
- Referrals to scrutiny committees
- Duty to allow entry

Read about Local Healthwatch: a discussion with you about the issues around the regulations: http://www.local.gov.uk/web/guest/health/-/journal_content/56/10171/3492011/ARTICLE-TEMPLATE
Dialogue continues between the DH, DfE, Ofsted and other interested parties, but it looks like children's social care will be part of Healthwatch's remit. The addition is meant to ensure better health outcomes and better joined-up commissioning of all health and social care services, for both adults and children. What this is likely to mean in practice is that Healthwatch's functions will equally apply to adults as well as children and young people as follows:

- Signposting and access to information about children's health and social care
- Engaging and involving children and young people

- Collating evidence-based information with which to inform and influence commissioning
- Ensuring children and young people have a meaningful voice

More details and scope will follow in due course from the DH, probably through the Healthwatch regulations.

Building successful Healthwatch organisations – new publication

A new report which seeks to help LA commissioners and their supporting stakeholders plan and implement robust and fit-for-purpose Healthwatch bodies has been published.

'Building successful Healthwatch organisations' was researched and written by the LGA, and contains recommendations and advice on the 10 key success ingredients of developing robust, credible and accountable Healthwatch bodies.

It is based on informed observations from emerging practice in 15 local Healthwatch case study areas across England. This report and all other news, information, presentations and reports on Healthwatch are available at http://www.local.gov.uk/web/guest/health//journalcontent/56/10171/3492011/ARTICLETEMPLATE

Healthwatch Essex

Duncan Wood: Head of Research & Analysis, Essex County Council writes:

Perhaps the most important feature of our approach to Local Healthwatch in Essex is that the Council will appoint the core members – on the advice of an independent panel. We have three reasons for building our Pathfinder on this principle.

First, the best way of getting a representative group of people together is to appoint them. This may seem odd but it appears to work. Such things are relative, of course, and the comparison I make is between the newly created Healthwatch Pathfinder Executive – 24 people who have been tasked with turning Healthwatch into an operational body in Essex – and the active core of the LINk. The Executive is much more representative in terms of gender, age and disability; it is geographically better balanced; it is certainly much better balanced for interest in social care as well as health; but it could be more representative still for ethnicity and sexuality. It is important for Healthwatch to be internally diverse. This will make it committed to outreach.

Secondly, appointing people makes them accountable. If they fail to deliver what they are paid to do, then they can be removed from office. This may sound rather stark but Healthwatch Essex will spend over half-a-million pounds of public money a year; and the Council must ensure that taxpayers get good value for this. One way of doing that would be to have a competitive procurement every few years. But that would replicate the tensions between host and members that have bedevilled the LINk. Also, the market for this kind of service is not in my view very strong. If accountability is not being secured through competition, then we need the ability to appoint and remove the people who will run Healthwatch Essex. There is a potential conflict here with the independence of Healthwatch but that can be resolved by using an independent appointment panel.

Third, appointing people on the basis of their experience and skills should make for a more effective body. This does not imply that some people have nothing to offer. It does imply that not everybody has the savoir-faire to build productive relationships with policy-makers and commissioners, to design business systems for the collection, testing, analysis and presentation of evidence, and to manage a monitoring system that evaluates just how strong an impact for the better the organisation has had. Healthwatch needs to use good evidence to justify both its selection of work priorities and its recommendations. It must operate in a structured way. The most obvious way of doing this is to make it responsible for co-producing the Joint Strategic Needs Assessment with the Council and the local NHS.

So where are we at with Healthwatch in Essex? An independent panel made up of three non-executive county councillors and three service user representatives appointed 23 Pathfinder Executive members in January. These decisions were taken by evaluating 60 paper applications against a role profile that had been advertised in advance. This process was designed by a chartered occupational psychologist. The Chair of the LINk is an ex officio member of the Executive, making 24 people in all. The Executive is meeting once a month. It is legally an autonomous part of the LINk and is being funded by the Council from the LINk grant. It has agreed a constitution for the transitional period and an outline service agreement with the Council. It has elected its Chair and Vice-Chair, who are taking a businesslike approach to developing the organisation. It has an executive officer who has been seconded to the host organisation from the County Council. Other dedicated officers will shortly be found. The Executive is working up its outreach campaign, business processes and list of top projects for the transitional year. I think it is confident but concerned that we should not expect too much of it.

The Pathfinder Executive is required to have regard to the work of the existing LINk groups. However, the Council is keen to absorb existing LINk activity into the Pathfinder by the autumn of 2012 so that we have a period of running in shadow form before the go-live date. This raises the question of associate membership. Like the LINk, Healthwatch needs to be able to offer any interested citizen a chance to get involved in its work. The Executive is therefore developing roles for associate members, who might join committees or task and finish groups. There are encouraging signs that the Executive wants to move away from a 'public meetings culture' and use many ways of engaging people in its work either in localities or in service areas. Associate members will have critically important jobs to do here. The Pathfinder's constitution requires it to have general meetings which involve associates as well as Executive members.

The LINk in Essex failed to develop good relations with social care user groups. This is a failure we are determined not to repeat. Council officers are discussing with those user groups, and with the Pathfinder Executive, how they can work alongside or be merged with Local Healthwatch. At the same time, the shadow Health & Wellbeing Board has set up a task and finish group on public engagement. This is developing a common view across local government and the local NHS about how their plans for, and results from, public and service user engagement can be shared with Local Healthwatch for evaluation, as a way of strengthening the voice aspects of the Joint Strategic Needs Assessment.

The Council and the Pathfinder Executive are currently developing proposals for the final legal form of Healthwatch Essex. One attractive option, because of its flexibility, is to set up a company limited by shares. This company would exist purely to discharge Healthwatch Essex functions. It would appoint its own staff. It is too early to discuss the internal structure of the company here but I can say that the key challenge is to ensure that the core decision makers in the company are accountable for their stewardship of public money, while giving associate members real roles and influence.

Safeguarding fragmentation fears voiced

Safeguarding arrangements for vulnerable children could become "more confusing, fragmented and possibly riskier" under government reforms, the NHS Confederation has warned. It said there was "deep unease" in the NHS about the way the system for safeguarding was to be changed, given that previous examples of poor coordination between organisations had been identified as the root causes of major failings in child protection.

Under the reforms, the current system of safeguarding and child health commissioning and provision by primary care trusts and local authorities will be divided between four types of organisation and spread over six geographical levels. The NHS Commissioning Board and Public Health England will commission services for vulnerable children and young people at national level, while clinical commissioning groups and councils will have responsibility at local level. The NHS Commissioning Board and CCGs will also commission some specialist children's services at a more regional level. Similar issues, of course, apply to safeguarding vulnerable adults.

The Confederation said overarching policy was needed to ensure child health and protection services were properly coordinated.

*What do you think? Your views would be welcome – remember the Bulletin does not want to be dominated by the health and care of adults; it is also a forum for issues specifically applying to children and young people.

Public Health transition update

On 27th March, the Health and Social Care Bill received Royal Assent to become the Health and Social Care Act 2012. The Act puts in place the basic architecture of the reformed public health system by giving new duties and powers to local authorities and the Secretary of State for Health.

The Department of Health undertook its second round of Transition Assurance visits to SHA Clusters. Chaired by Ruth Hussey, the meeting included Transition Leads from Regional DH teams and the SHA, as well as DsPH and local authority Chief Executives. The meeting concluded that local authorities have a real appetite to lead the way in the development of local public health services. The meeting felt that change is being embraced and a lot of progress has been made in recent months.

East of England is well placed now with the majority of Public Health teams already located within local authority settings. Many have reported on how much they are enjoying the opportunities this affords them to engage with other staff who have a role in improving the health of the population.

Nationally, Duncan Selbie has been appointed as Chief Executive Designate for Public Health England. He takes up his post formally on 1st July 2012. Work is also being undertaken to maintain delivery up to and upon Day 1 of the new system. The DH is working on a set of

metrics that will help us understand what is happening to local services, as responsibility shifts from the NHS and local government take on responsibility.

On 17th May the Regional DH Public Health team held a stakeholder event for staff working in those organisations which become Public Health England. Over 70 delegates heard a presentation by Ben Morrin, Deputy Director in the Public Health England Transition Team on the latest thinking on the design, the transition principles for staff and securing the long term capability of a modern public health service. PHE will be a civil service body. The proposals suggest that PHE will take a life course approach as well as a thematic approach to its work, using techniques such as social marketing and behavioural insight.

The Public Health Team is planning its next event to be held during July, by which time we expect to have further information on screening and immunisations. This will be a broad reaching event for all stakeholders in improving the health of the local population.

Laurie Rainger
Head of Public Health Delivery and Development

News from Erpho: the Public Health Observatory for the East of England

Claire O'Brien, Communications Manager, writes:

Two new products were launched on 15th May, from the East of England Public Health Observatory (erpho). Details below; our full May 2012 newsletter is available from the erpho website here.

Watch and learn: new training videos from erpho launched

We've produced a series of short video tutorials to introduce you to our work and our online tools, as well as explain some commonly used methods in analysing population health data. You can watch them all at our YouTube channel or, if you cannot access YouTube, run them from the media player on our video webpage.

There are five titles so far, with more to come:

- Introducing erpho
- Introducing the Fingertips tool
- Understanding significance in the Fingertips tool
- Understanding funnel plots
- Understanding spine charts

The introduction to erpho will tell you more about us, what we do and where to find all the free resources on our website. Several of the videos feature the Fingertips tool of online health and wellbeing indicators. Take a tour of the newly updated and expanded Fingertips, then find out more about spine charts, funnel plots and significance, all key tools in health intelligence and data analysis. These tutorials are also a great way to introduce your colleagues to our work.

We will be adding more videos and expanding the range of topics covered, so do please send us your feedback on content, format and style, and what else you would like to see covered: external_training@erpho.org.uk

Remember that videos are just one part of erpho's training resources; visit our Training and development page for details about taught courses and more.

Commissioning intelligence

Fingertips update and improvements: also coverage extended to East and West Midlands

Fingertips has been improved and updated with additional indicators, and the Health and Wellbeing section now reflects the PHOF outcomes Framework:

- Key indicators are grouped into five domains reflecting the outcomes and domains of the Public Health Outcomes Framework: Life expectancy, Wider determinants of health, Health improvement, Health protection, and Healthcare and mortality
- Within domains, indicators are grouped under: PHOF indicators, Similar to PHOF indicators and Supporting indicators

Spine charts can now be benchmarked against England as well as the region - choose your benchmark from the drop-down menu (similarly choose the administrative geography, PCT or county/UA).

Indicators have been added for East and West Midlands in three sections of the tool: Health and Wellbeing, Child Health and Health Inequalities. You will see new drop-down menus allowing you to select the area of choice.

For more information about using Fingertips, take the NEW video tour linked from the front page and watch the other videos in our new series, explaining significance, spine charts and funnel plots.

Fingertips has been developed by erpho; this release was produced in collaboration with the Midlands and East SHA, and the West Midlands and East Midlands Public Health Observatories.

Remember to follow Fingertips on Twitter **@ErphoFingertips** to hear about the next data updates and other upgrades.

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Follow erpho on Twitter:
@ErphoPHO for news and product information
@ErphoFingertips for specific alerts on indicator updates

Organisation and Performance Programme

Local Accounts

All eleven authorities within the East have signed up to producing a local account. Six authorities, Peterborough, Southend, Essex, Central Bedfordshire, Hertfordshire and Norfolk have published. The remaining authorities all have substantial drafts which are going through various stages of scrutiny. It is hoped that all Eastern accounts will be published by the end of May 2012.

Most local accounts have been through a peer review process with feedback provided on how these can be improved upon prior to publication. Through this process, Peterborough and Southend have been signposted as best practice within the East, Peterborough is very much focused on "you said" and "we did" as a response. Southend is very consumer driven and comprehensive. Suffolk is intending on using a quarterly newsletter update approach which is slightly different from others. Most local accounts have gone through a scrutiny process but

not through cabinet. Where cabinet has been involved, the governance and sign off has been longer and more complex.
Although, authorities have embraced the challenge of producing local accounts, there are some challenging questions which need to be considered for next time:

Are local accounts local enough?

- Where there have been recent budgetary implications e.g. services cut, substantial changes, restructures, how do you respond to this effectively within a local account?
- Do local accounts look forward enough?
- How do we get the correct balance between providing management information and providing information for consumers?

The East intend to go through a second stage of peer review following publication during May to look at accessibility, outcomes, user experience, improvement journey and the extent to which the local account has been consumer focused. The learning from this will be shared with other regions.

National update on Sector Led Improvement

Up to date information about the Towards Excellence in Adult Social Care national programme can be found on the following link: www.local.gov.uk/topic-adult-social-care

Regional update on Sector Led Improvement

The East held their second Regional Sector Led Improvement workshop on the 22nd March which was well attended by Directors and Assistant Directors. The day focused on:

- Understanding how peer review has evolved and how this fits with sector led improvement
- Learning from the experience of peer reviews undertaken to date and methodologies used
- Discussions and agreement on the basic evidence used to support ongoing self assessment and a peer review process
- Discussion on the metrics for a peer review framework within the East.

A proposal for a Performance Assessment Framework and the development of an associated tool was agreed in principle by attendees and will be discussed at the regional ADASS Meeting at the end of May. The regional key themes proposed are:

- Keeping people safe
- Enabling Maximum Choice and Control
- Helping people to stay well and independent
- Enabling accessible information and positive advice and support
- Ensuring effective leadership and a clear vision
- Ensuring effective commissioning and the delivery of value for money

The East continues to have an ongoing rolling programme of improvement. There continues to be a number of networks which drive forward the improvement agenda, these are:

- Safeguarding Board
- Performance Network

- Joint Strategic Needs Assessment Network
- Finance Group
- Carers Leadership Group
- Learning Disability Leadership Group
- Local HealthWatch Development Leads
- HWB Programme Co-ordinators Group

Each network is supported by a lead Director. There is also some themed work around prevention, reablement, procurement, personalisation and long term conditions. For example, there was a reablement/prevention workshop which took place on the 23rd April and we are also in the process of scheduling one on Personalisation. We will be working in collaboration with health wherever possible.
In addition to Local Accounts, Peer Review, Public Health Transition and HWB/JHWS developments, there are some further examples of work being undertaken:

- Care and Healthtrak implemented in Southend and being piloted in Hertfordshire, Central Bedfordshire, Essex and Cambridgeshire. Norfolk has a joint data workshop scheduled with the CCGs as an introduction - mapping care pathways and associated costs.
- Performance Outcomes and Evidence Tool Phase III – Ensuring a system to support the recording of regional best practice and progress against the key priority areas
- Reablement – Joint assessment between health and social care of progress against the PCT/LA reablement plans
- Safeguarding – consistent way of recording safeguarding outcomes

The Directors within the East are committed to driving forward the Sector Led Improvement programme and are continuing to ensure processes and systems are in place to support the need for accountability and transparency.
Please contact Natasha Burberry for further information Natasha@pburberry.wanadoo.co.uk

The East of England Clinical Commissioning website is an important source of information; please take a few minutes to have a look! www.gpc.eoe.nhs.uk

Embedding Ambassadors in Community Health – The EACH Project Update

Regular readers of the 'EACH' Project column will be aware of the project's interactive programme of workshops on cultural awareness and on working well with interpreters.

The project's sixteen Black & Minority Ethnic Community Organisations and Interpreting Agencies will, between them, run over forty workshops on these themes from February to June this year, with more to follow, using both community and hospital venues.

The workshops have been attended by staff from NHS trusts across the region. For example, Cambridgeshire Community Services NHS Trust; NHS Hertfordshire; Luton & Dunstable

Hospital NHS Foundation Trust; Norfolk Community Health & Care NHS Trust; North Essex Partnership NHS Foundation Trust; NHS Suffolk.

Delegates' roles vary enormously, including at just one workshop of seventeen staff - a Dispensary Assistant; Deputy Director of Human Resources; Sexual Health Promotion Practitioner; Student Health Visitor; Practice Development Nurse.

There have been a wide range of interactive activities such as quizzes on culture, faith and health; role plays; film clips and small group discussions – the aim being to equip staff with a range of strategies for communicating well with new migrant patients, and giving them efficient and effective healthcare which is culturally sensitive.

Staff feedback on the workshops typically includes statements such as:

- Really informative
- Helpful, practical tips on how to get the message out to the BME community
- Will share what I have learned today
- Good to speak to local Muslim women's group
- Good to have a group discussion
- Learned about problems accessing translating services

So if you have not yet sampled an EACH workshop yourself, or would like your own staff members to, please use this link to the East of England Local Government Association website where all the EACH project workshops are listed chronologically.

http://www.eelga.gov.uk/events/Conferences.aspx

There are 'Book Now' buttons at the foot of each separate workshop page.

To find out more about the EACH Project, or to order a copy of the project DVD please contact:

Sue Hay – EACH Project Worker with the East of England Local Government Association, Strategic Migration Partnership

(m) 07920-257964 (e) sue.hay@eelga.gov.uk

Links to recent Publications

NHS Commissioning Board

Clinical commissioning group (CCG) authorisation: draft guide for applicants
This document is designed to help emerging CCGs develop clear plans to progress through the authorisation process and become an authorised CCG. It provides a detailed description of the criteria, thresholds and evidence for authorisation and sets out the three phases of authorisation: pre-application, application and Board Authority-led assessment. It then sets out the timetable for applications in four waves and outlines the possible outcomes: fully authorised; authorised with conditions; and established but not authorised (a shadow CCG).

- Guide

NHS Commissioning Board - resources

Local Government Association (LGA)

Baseline spending estimates for the new NHS and public health commissioning architecture
This briefing summarises the Department of Health document published on 7th February 2012 on baseline spending estimates on public health. It also gives the LGA's key messages in relation to public health funding and provides Chief Executives and Directors of Finance with advice on how they can assure themselves that the PCT estimate of public health spending will be adequate to meet the future resource requirements for public health from 2013.

- Briefing
- Funding checklist

LGA - publications

Making this Network Bulletin work for you

- What would be useful for you, especially in relation to joint commissioning and partnership?
- Would you be willing to share local developments – successes & frustrations?

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